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Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Wednesday 31 March 2021

10.00 – 13.30pm

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/0321	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0321	Declarations of interest	Assurance	**Paper**	Chair
10.05	03/0321	Service User Story Presentation	Assurance	Verbal	DoNQT
10.25	04/0321	Draft Minutes of the meeting held on 28 January 2021 • Response to Public Question received at January Board	Approve Assurance	**Paper**	Chair
	05/0321	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0321	Questions from the Public	Assurance	Verbal	Chair
Covid					
10.35	07/0321	Covid Programme Update	Assurance	**Paper**	CEO/COO
Strategic Issues					
10.45	08/0321	Report from the Chair	Assurance	**Paper**	Chair
10.50	09/0321	Report from Chief Executive	Assurance	**Paper**	CEO
11.00	10/0321	Systemwide Update	Assurance	**Paper**	DoSP
11.05	11/0321	Business Planning 2021-22	Approve	**Paper**	DoF
11.20	12/0321	Budget Setting 2021-22	Approve	**Paper**	DoF
11.30	13/0321	Organisational Strategy 2021-26	Approve	**Paper**	DoSP
11.45	14/0321	Our People Strategy	Approve	**Paper**	DoHR&OD
BREAK – 10 Minutes					
Performance and Patient Experience					
12.05	15/0321	Quality Dashboard Report	Assurance	**Paper**	DoNQT
12.15	16/0321	Learning from Deaths Q3	Assurance	**Paper**	MD
12.20	17/0321	Finance Report	Assurance	**Paper**	DoF
12.30	18/0321	Performance Report	Assurance	**Paper**	DoF
12.40	19/0321	Annual Staff Survey Results	Assurance	**Paper**	DoHR&OD

TIME	Agenda Item	Title	Purpose		Presenter
12.50	20/0321	Gender Pay Gap Annual Report	Assurance	**Paper**	DoHR&OD
Governance					
13.00	21/0321	Membership and Engagement Strategy	Approve	**Paper**	HoG
13.10	22/0321	Board Committee Governance Proposals and Terms of Reference	Assurance/ Approve	**Paper**	HoG
Board Committee Summary Assurance Reports (Reporting by Exception)					
	23/0321	Mental Health Legislation Scrutiny Committee Summary (20 Jan)	Information	**Paper**	MHLS Chair
	24/0321	Audit and Assurance Committee (11 Feb)	Information	**Paper**	Audit Chair
	25/0321	Resources Committee Summary (25 Feb)	Information	**Paper**	Resources Chair
	26/0321	Quality Committee Summary (4 Mar)	Information	**Paper**	Quality Chair
	27/0321	Appointments and TOS Committee (Jan & March)	Information	**Paper**	Chair
	28/0321	FoD Assurance Committee (4 March)	Information	**Paper**	FoD Chair
Closing Business					
13.25	29/0321	Any other business	Note	Verbal	Chair
	30/0321	**Date of Next Meeting** **2021** Thursday 27 May Thursday 29 July Thursday 30 September Thursday 25 November	Note	Verbal	All

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Declaration of Interest Register 2020/21

TRUST BOARD MEMBERS

Name	Position	Declaration of Interests
Ingrid Barker	Chair	Trustee, NHS Providers (Board Member) (2013 - current)
		Trustee, Gloucestershire GP Education Trust (Oct 2019 - current)
		Council Member, University of Gloucestershire (March 2020 - current)
Graham Russell	Vice Chair	Chair, Second Step Organisation (2014 - current)
		Chair, Corinium Education Trust (2018 - current)
Jan Marriott	NED	Co-Chair Glos Learning Disability Partnership Board (2010 - current)
		Independent Chair, Glos Mental Health & Wellbeing Partnership Board (2015 - current)
		Co-Chair, Glos Physical Disability and Sensory Impairment Partnership Board (2018 - current)
		Chair, Prime Foundation Charitable Trust (2015 - current)
		Committee Member, Community Hospitals Association (1990 - current)
		Trustee, Crossroads Gloucestershire (Dec 2020 - current)
Marcia Gallagher	NED (Senior Independent Director)	Chair, Crossroads Gloucestershire (Dec 2018 - current)
Sumita Hutchison	NED	NED, RUH Bath (Sept 2019 - current)
Maria Bond	NED	Appointed Lay Person to Council at University of Bath (Aug 2019 - current)
Steve Brittan	NED	Nothing to Delcare
Steve Alvis	NED	Nothing to Delcare
Paul Roberts	Chief Executive	Nothing to Declare
Sandra Betney	Director of Finance	Attendance at training course with Swansea University "Value Based Health and Care". Course attendance sponsored by Boehringer-Ingelheim (Feb 21)
Neil Savage	Director of HR&OD	Nothing to Declare
John Trevains	Director of Nursing, Quality and Therapies	Nothing to Declare
Angela Potter	Director of Strategy and Partnerships	Nothing to Declare
John Campbell	Chief Operating Officer	Nothing to Declare
Dr Amjad Uppal	Medical Director	Private Practice as Consultant Psychiatrist
Helen Goodey	Joint Director, Primary Care/Locality Development	Nothing to Declare

2020/21 Return - 24 February 2021

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AGENDA ITEM: 04

MINUTES OF THE TRUST BOARD MEETING

Thursday, 28 January 2021

Via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Paul Roberts, Chief Executive
Sandra Betney, Director of Finance
Angela Potter, Director of Strategy and Partnerships
Dr. Amjad Uppal, Medical Director
Dr. Stephen Alvis, Non-Executive Director
Graham Russell, Non-Executive Director
Helen Goodey, Director of Locality Development & Primary Care (from Item 12)
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
John Campbell, Chief Operating Officer
John Trevains, Director of Nursing, Therapies and Quality
Marcia Gallagher, Non-Executive Director
Maria Bond, Non-Executive Director
Neil Savage, Director of HR & Organisational Development
Steve Brittan, Non-Executive Director

IN ATTENDANCE:
Matt Blackman, Communications Manager
Lauren Edwards, Deputy Director of Quality and Therapies
June Hennell, Trust Governor (Public)
Anna Hilditch, Assistant Trust Secretary
Kizzy Kukreja, Trust Governor (Staff)
Kate Nelmes, Head of Communications
Louise Penny, Member of the Public (until item 12)
Lavinia Rowsell, Head of Governance/Trust Secretary
Chris Witham, Trust Governor (Public/Lead Governor)

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. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Prob Singh and Kate Birch-Scanlan who had kindly agreed to attend the meeting to talk to the Board about their involvement in the development of the online Recovery College. Mel Reed, Consultant OT for Recovery and Inclusion was also in attendance.

3.2 Prob and Kate are both Experts by Experience and Tutors with the Recovery College. They shared their own personal stories about their journey with the Recovery College. The Severn and Wye Recovery College is an educational approach to self-management for people who live with a mental health condition in Gloucestershire. Students of the College either currently use mental health services provided by GHC or have been discharged from our services within the past 12 months. Carers of people

with a mental health condition are also welcomed as part of our Recovery College community. The Severn and Wye Recovery College is firmly built on the principles of co-design, co-production and co-delivery - the power of lived experience and Peer Support are the foundations of everything we do.

3.3 Courses provided by the Severn and Wye Recovery College were delivered face to face up until March 2020. As a result of Covid 19, face to face delivery ceased and many of the Students, Experts by Experience, and Tutors were either shielding or isolating at home. As part of our response, we have developed and piloted an online course. Prob Singh said that both online and face to face sessions were highly valuable, although it was not easy holding a classroom style environment online and it was not always possible to see body language. With the online course a series of individual follow up calls with students was programmed in to provide additional support.

3.4 Jan Marriott said that she was passionate about the Recovery College. She asked whether the digital solution could be made more widely available to other services such as rehabilitation or offenders. Mel Reed said that the online Recovery College offering was developed as a way of continuing to provide the course through Covid; however, it had become a much more powerful tool than initially thought. She advised that funding for the Recovery College was very stretched which would make extending the course to other areas difficult but Trust commissioners were extremely supportive and discussions about this could take place in the future.

3.5 Marcia Gallagher said she was excited to hear about the autism pilot, which was due to commence on 2 February. Mel Reed noted that the Recovery College online course was available on the Trust's Care to Learn portal and Trust colleagues, including NEDs would be welcome to enroll and join in.

3.6 Graham Russell noted that he worked with the Bristol Recovery College and offered his assistance in providing links for collaborative working.

3.7 Paul Roberts asked Prob and Kate if there was anything that they wished the Board to take away for consideration from today's presentation. Prob said that she would like to see more mental health hubs set up in community settings, including schools and GP surgeries, as well as an increase in social prescribing.

3.8 The Board thanked Prob and Kate for attending and speaking so openly and powerfully about their own experiences. The passion that was felt for the Recovery College was evident and the huge efforts in developing the online recovery college offering was congratulated.

4. MINUTES OF THE PREVIOUS MEETING HELD ON 25 NOVEMBER 2020

4.1 The Board received the minutes from the previous meeting held on 25 November 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 progressing to plan. Paul Roberts advised that a lot of work was taking place to address the recommendations from the Director of Public Health Annual Report, as received at the November Board meeting, and it was planned that a paper would be brought back to the Board at its March meeting.

5.2 There were no further matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 The Trust had received one question from the public in advance of the Board meeting in relation to the Forest of Dean Hospital consultation. A verbal response was given at the meeting and a full written response to the question would be provided in due course. A copy of the full response would be included for reference with the minutes of this meeting presented at the March Board (Appendix 1).

QUESTION – "Bearing in mind both consultation results state that the public strongly disagree with the proposed services and plan for healthcare throughout the Forest of Dean and that we have over 1000 signatures on our petition. Will the Trust please re-look at the case of what is the most beneficial way forward so the residents of the Forest of Dean are confident that the proposal will meet their needs?" *Louise Penny, Campaigner for HOLD*

RESPONSE

- The process of developing the Full Business Case will refresh the benefits and case for change that were developed in the original Outline Business case in terms of providing the new hospital.
- The latest consultation acknowledged that it was building on previous decisions made by both the former Gloucestershire Care Services Board and the Gloucestershire Clinical Commissioning Group with regard to the decision to move to a single hospital and that its location, following the outcome of the citizens jury was to be in Cinderford.
- The decision in relation the specific service components to be commissioned from the new hospital, including the number of beds rests with Gloucestershire Clinical Commissioning Group. They are considering the outputs from the consultation response at their Governing Body meeting and we then expect that they will confirm in writing to the Trust their commissioning specification. Our Board will continue to consider those areas that were raised during the consultation with regard to the actual design and construction of the new hospital.
- Throughout the current pandemic the two hospitals in the Forest of Dean have taken a mix of both COVID positive and negative patients and have not been designated as 'green' or 'red' sites as you indicated in your documentation. This has been in line with the way we have utilised all of our community hospitals and we have implemented a programme of internal zoning to ensure segregation of patients to prevent cross infection. We have also had to take a number of the inpatient beds out of action to ensure a COVID secure environment and social distancing. We have also kept the Minor Injuries Unit at the Dilke closed as we could not ensure a safe COVID environment due to the size of the facility and enable clearly separated access and exit routes.
- With regard to the issue of sustainability, the two existing hospitals are very inefficient to run and are not operating to modern, efficient standards. The new hospital would incorporate the latest thinking with regard to green technology and we aim to achieve an excellent rating in the sustainability standards that apply to new hospitals
- The consultation acknowledged the previous concerns that had been raised regarding access to Minor Injuries care within the South of the Forest and the Trust has committed to work with the CCG to continue to explore any ongoing

opportunities for alternative service provision – we have received nominations from over 100 residents who wish to be involved with this work and we are currently in the process of planning a workshop to be facilitated by the Consultation Institute in the near future.

7. COVID PROGRAMME UPDATE

7.1 This item provided an update to the Board on progress with the ongoing management of Covid.

7.2 Paul Roberts informed the Board that the Trust continued to work extremely hard to manage the challenges of Covid, however he acknowledged the tragic milestone of over 100k deaths nationally and that this would always remain at the back of our minds.

7.3 The Board noted that the rate of new infections was reducing daily, with 369 per 100k in the south west region. Gloucestershire was reporting a rate of 195 per 100k. It was reported that the Acute Trust had peaked a week ago and admissions were now remaining steady. Paul Roberts said that he was extremely proud of the Trust's response to this position, and the collaborative working with partners. John Campbell agreed, noting that GHC had played a significant role across the system. He asked the Board to be mindful of increased pressure on community services following the discharge of patients from the acute hospitals.

7.4 The Board noted that Gloucestershire was the first area in the country to set up Pillar 1 testing, and GHC had now reached the milestone of carrying out over 11k tests. This included GHC and key worker testing, pre-operative tests and tests carried out on people being discharged to care homes

7.5 During Wave 2, the Vale MIIU (Minor Injury and Illness Unit) was closed to enable PCN Mass Vax site and Tewkesbury MIIU was closed to redeploy staff into the Rapid Response Cinapsis Admission Avoidance Scheme. It was noted that there were no other service closures during Wave 2.

7.6 It was reported that 67 people had been redeployed to support core services and the vaccination programme during Wave 2. This was compared to 520 redeployments in Wave 1.

7.7 Good progress was being made with the mass vaccination programme, with Gloucestershire being significantly ahead in terms of the provision of vaccinations for those people in the top 4 priority groups. Gloucestershire had taken a whole system approach to the vaccination programme. John Campbell said that GHC was lobbying for vulnerable groups such as those with learning disabilities to be included within the top priority groups for vaccination. This was welcomed by Board members.

7.8 Sumita Hutchison said that there was a huge opportunity for organisational learning and asked how the Trust was capturing this. Neil Savage advised that a Lessons Learned stock take was carried out in the summer following Wave 1 and much of this learning had already been put into practice. This had also been reflected in the development of the Trust Strategy.

7.9 Steve Brittan joined Board members in acknowledging the huge efforts of Trust colleagues through these challenging times and asked that the Board's formal thanks be communicated out. **ACTION**

8. COVID AND NHSE INFECTION CONTROL ASSURANCE FRAMEWORKS

Covid Board Assurance Framework

8.1 In line with the revised Covid governance arrangements, it was agreed that the Covid element of the Board Assurance Framework (BAF) would be presented to the Board at each meeting alongside the Covid Programme Update. The BAF has been updated in discussion with Executive colleagues.

8.2 Risks relating to 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. In addition, there has been significant progress in the roll out of the mass vaccination programme with over 3000 members of staff vaccinated to date.

8.3 The Board received and noted the updated Covid Board Assurance Framework.

NHSE Infection Control Board Assurance Framework

8.4 The purpose of this report was to present to the Trust Board the completed Infection Prevention and Control (IPC) self-assessment against the NHSE 'Key actions: Infection Prevention and Control and Testing' requirement that was issued on 23rd December 2020. Board level oversight of this self-assessment is required as part of the compliance requirement.

8.5 This paper provided good internal (Trust) and external (CCG, CQC) assurance that IPC and other quality standards are being maintained in light of the COVID-19 response.

9. CHAIR'S REPORT

9.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in November. 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 the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

9.2 The Board noted the content of the Chair's report and joined the Chair in welcoming two new Trust Governors, Kizzy Kukreja and Laura Bailey who had been successfully elected to the Council from 1 January. Ingrid Barker said that she was also pleased to announce that Chris Witham, Public Governor Forest of Dean had been appointed as the Lead Governor from the beginning of January.

10. CHIEF EXECUTIVE'S REPORT

10.1 Paul Roberts asked the Board to formally note the MHA White Paper and the publication of the consultation. An NHS Providers briefing summarising the key points from the white paper was included on the agenda for information. A session for the Board to consider this in more detail was being arranged for March. The consultation would close on 21 April.

10.2 A final draft of the Trust Strategy had now been circulated to both Trust colleagues and key stakeholders, including members of the public for consultation.

10.3 The Chief Executive drew Board members' attention to the EU Exit paper which would be received later on the meeting agenda. It was noted that this briefing provided good assurance regarding the situation for the Trust and for healthcare providers following the end of the EU exit transition period.

11. FOREST OF DEAN HOSPITAL CONSULTATION

11.1 This report provided an update to the Board regarding the response to the public consultation on the services proposed for the new hospital in the Forest of Dean (FoD).

11.2 The public consultation on the proposed service configuration for the Forest of Dean new hospital ran from the 22nd October to the 17th December 2020. The consultation process and report were led by the One Gloucestershire Communication and Engagement team. The consultation resulted in 554 consultation surveys being completed plus some additional responses.

11.3 The consultation output report was compiled and shared with the Health Overview & Scrutiny Committee on the 13th January 2021. The outputs are also to be shared with the GCCG Governing Body for consideration in order to finalise their commissioning specification for the new hospital.

11.4 Angela Potter reported that overall, the feedback to the consultation is generally not supportive of the proposals for inpatient care and urgent care. However, it is supportive of the proposals for diagnostic and outpatient services. The strength of support across all services is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are less supportive of the proposed services for the new hospital than those in the central and northern parts of the Forest of Dean.

11.5 Qualitative feedback notes the benefit of providing services from an improved facility in the Forest of Dean, rather than having to travel to Gloucester or Cheltenham. Concern is voiced about access to the new hospital from Lydney and the south of the Forest, and the ability to provide services from a single site, whilst the population in the Forest of Dean is continuing to increase.

11.6 It was noted that many of the comments made, focused on issues outside of the Consultation including; the decision to provide one new hospital which would result in the closure of the existing hospitals; and the agreed location for the new hospital. Whilst these comments are acknowledged the consultation was not designed to revisit historic decisions taken.

11.7 There was a small number of respondents who commented on the provision of 100% single rooms and the Trust has reconsidered its rationale around this planning assumption from an operational, infection control and quality perspective. Overall, the Trust considers that there remains significant benefit from the proposal for single rooms and that with appropriate day and therapy space and location of staff bases incorporated within the ward layout, the risks raised around isolation and observation can be mitigated. Board members agreed with the proposed 100% single rooms and supported the recommendation that we remain with this proposal within the detailed design. Jan Marriott said that she was heartened to see that efforts had been made to

recognise the feedback received from previous community hospital developments, relating to the creation of single rooms. From an infection prevention and control perspective, single rooms would improve patient flow across the system, with reduced need for patient movement or transfer.

11.8 Marcia Gallagher asked whether discussions had taken place with transport providers in the Forest of Dean, noting concerns around transport to the new hospital. Angela Potter provided assurance that this was a key area of consideration with the hospital development, noting that discussions had been taking place about the creation of new bus routes to the hospital and a dedicated bus stop. She said that the Trust recognised the challenges faced around transport in the Forest of Dean and added that plans would also include adequate car parking facilities on site.

11.9 Neil Savage made reference to the need for the Trust to reduce its carbon footprint, and the new hospital development was a great step forward in addressing this. Angela Potter advised that the Trust's newly appointed Head of Sustainability would be fully involved in the design process.

11.10 Graham Russell said that the hospital development gave the Trust, and the population of the Forest the opportunity to future proof and invest in the future, and having a state-of-the-art facility in such a rural area was a fantastic investment.

11.11 The Board noted the detailed and extensive feedback in response to the public consultation on the proposed services within the new hospital in the FoD, and noted that the GCCG Governing Body were also considering this feedback and would provide the Trust with a final commissioning specification for the new hospital services on conclusion of their commissioning deliberations.

12. QUALITY DASHBOARD REPORT

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

12.2 John Trevains informed the Board that overall the report demonstrated that some fantastic work was being carried out and high-quality services were being delivered. However, there was frustration that not all areas had progressed as quickly as had been planned due to the impact on capacity from Covid. The report highlighted those Quality issues for priority development to the Board:

- To Monitor and drive progress against the Physical Intervention Training recovery plan. The recovery plan has been developed and will be reviewed at January's Quality Assurance Group, prior to ongoing reporting via the Quality Dashboard.
- Monitor and drive improvements in Resuscitation Training compliance figures. Level 3 Resuscitation Training figures for Mental Health and Learning Disability (MH&LD) services remain low. A bespoke Level 3 MH&LD (MERT) course has recently been added to the training system, aimed at increasing compliance.
- Lead a piece of work to understand if the reported increase in bed occupancy correlates with an increase in overall falls, wound care issues and impact that Covid-19 has had on staffing
- Jointly develop with operational colleagues a new ICT staffing and quality of care data set to commence reporting from February 2021.

- Continue to address Trust wide inpatient vacancies, led by operations with support from Nursing Therapies and Quality directorate.

12.3 Those Quality issues showing positive improvement:

- The Trust is compliant with new national Patient Safety Strategy requirements to have identified specialists and ensure a strategy delivery group is in place
- Good progress made by the Trusts Patient Safety Team in progressing delivery of the digital patient safety monitoring system for inpatient areas.
- Good performance in areas of previous concern; IAPT, EIP and VTE assessment which are maintaining compliance despite service pressures.
- New Birth Visits were at 97.7% in December and above the 95% threshold for the first time this year.

12.4 Steve Alvis congratulated colleagues on the performance for new birth visits by Health visitors, however, he noted that breastfeeding visits had reduced and asked whether the reason for this was known. John Trevains agreed to follow this up and provide an update in the next report. **ACTION**

12.5 Maria Bond noted that Covid had put a huge strain on GHC Teams and asked whether it was realistic to believe that this would change in the next 6 months. John Trevains said he was optimistic, noting that new initiatives were in place and the Trust had a very good reporting and learning culture.

12.6 Jan Marriott noted that the number of people contracting Covid within GHC settings had been minimal; however, she asked whether these incidents were reported under the Duty of Candour. John Trevains confirmed that they were.

12.7 Jan Marriott made reference to pressure ulcers, noting that this had been a long reported problem, and asked if these incidents were more prevalent during bad weather, or had been impacted due to Covid. Ingrid Barker said that there was a read across from the Quality Dashboard and the patient safety report around pressure ulcer incidents and asked where such incidents were occurring – within inpatient services or in the community. John Trevains informed the Board that the Deputy Director of Nursing had been carrying out a focussed piece of work on pressure ulcers and a report would be coming to the next Quality Committee. He said that many incidents were due to the knock-on impact of Covid and the increase in staffing capacity required. It was agreed that a specific report would be brought to the next Board meeting to provide assurance on the work taking place to manage pressure ulcer incidents. **ACTION**

12.8 Ingrid Barker noted that there had been some delays reported in responding to complaints and asked for the reason for these delays. John Trevains advised that team members had been redeployed due to Covid; however, there was now extra resource in the team and a review of process maps would be carried out. It was agreed that it would be helpful for complaints response times to be followed up at the Quality Committee for assurance. **ACTION**

12.9 Ingrid Barker asked about out of county placements, noting that 3 recent placements had been made due to no acute beds being available. John Trevains said that this related to individual patient need and the level of service they required. The Trust maintained daily contact with the placement unit, and he offered the Board good

assurance regarding the level of communication and flow of information. He added that GHC also carried out its own checks on the providers that it used.

12.10 The Board welcomed this report, noting the developments underway and the good level of assurance provided.

13. PATIENT SAFETY REPORT

13.1 The purpose of this report was to provide a summary of mental health and physical health Patient Safety Incidents reported during Quarter 3 2020/21.

13.2 In quarter 3, a total of 3355 patient safety incidents were reported, compared to 3269 the previous quarter. 93% of these were reported as either 'no' or 'low harm' incidents. A total of 6 serious incidents requiring investigation (SIRI) were reported in quarter 3; 1 in physical health services and 5 in mental health services.

13.3 A higher level of patient incidents was noted at Stroud General Hospital. Amjad Uppal informed the Board that Stroud was the largest unit in terms of bed numbers so although reporting rates were higher this quarter, in comparison with other hospitals performance remained in line with previous. A suggestion was made that it might be helpful to correlate the inpatient incidents with the number of beds and bed days by way of providing more context. **ACTION**

13.4 The Board agreed that the format of the report was helpful and clear in terms of presenting a high-level analysis of patient safety incidents.

14. FINANCE REPORT

14.1 The Board received the month 9 Finance Report for the period ending 31 December 2020.

14.2 There is a Covid interim financial framework for the NHS in place for October to March 2021. The Trust will receive increased block payments to cover Covid costs and some developments but will receive no further top ups. The Trust has spent £2.721m on Covid related revenue costs between April and December.

14.3 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 9 was a surplus of £98k. The Trust is forecasting a year end deficit of £1.080m. This is due in the main to an increase in the Trusts annual leave accrual estimate by £887k to £2.265m. Sandra Betney advised that there may be an allowance for annual leave accruals, but this had not yet been confirmed.

14.4 The revised recurring Cost Improvement Plan (CIP) target for GHC is £3.230m and the amount delivered to date is £3.492m.

14.5 The cash balance at month 9 was £68.9m.

14.6 The Board was asked to note that the Trust intended to write off Cleeve House with a loss of £745k in next month's accounts. This impairment had not yet been included.

14.7 Capital expenditure was £2.334m at month 9. The Trust has a capital plan for 20/21 of £10.182m. Sandra Betney advised that there had been significant slippage with the

capital plan due to Covid, with no capital expenditure in the early part of 2020/21. The Capital Management Group had carried out a detailed review and it was hoped that the target would be achieved. 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, including backlog maintenance which had been moved into this financial year from 2021/22.

14.8 It was noted that the Trust had been successful in bidding for a £625k Public Sector Decarbonisation Scheme grant. The existing governance structure for managing this going forward was being reviewed.

14.9 In terms of payments, Sandra Betney reported that GHC had improved its PSPP (Public Sector Payment Policy) compliance during Covid which was excellent. The Trust was also in a better place around receipts and had worked hard with local system partners to get payments moving.

15. PERFORMANCE DASHBOARD

15.1 Sandra Betney presented the Performance Dashboard to the Board for the period December 2020 (Month 9 2020/21). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

15.2 At the end of December, there were 11 mental health key performance thresholds and 12 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. It was noted that the 4 Trust wide workforce indicators included within the dashboard were also in exception this month.

15.3 The Board was asked to note that good progress was being made in terms of moving to fully integrated reporting, with the planned timescale of end of quarter 4 for completion.

15.4 John Campbell highlighted the service challenges currently being experienced within the Trusts Eating Disorders service. The service continued to experience a higher than average number of urgent referrals for the third quarter with an average of 11 referrals per month for adolescents compared to 5 for the same period in the last year. Adult referrals were also noted to be increasing as the average number of urgent referrals per month is 9 compared to 5 in the same period last year. In response the service has closed day treatment temporarily and the extra staff capacity is being used to accommodate the increase in urgent referrals. The current wait profile for the service at the end of December indicates that 38% (49) of all clients waiting for assessment are waiting over 4 weeks. This is seen to be a significant increase of 22% compared to November and wait times will continue to increase until the service can fill their workforce vacancies. John Campbell assured the Board that regular service review meetings were taking place and the team was well sighted on the concerns and challenges being faced. Temporary redeployment from other services such as IAPT to the Eating Disorder service to provide support and capacity was being considered until the service was back up to its full staffing complement. Amjad Uppal said that he would be undertaking a review of the medical input into the eating disorder service.

The Board noted that this was a significant clinical and operational risk and would as such be escalated to the CCG. A further discussion was scheduled to take place at the Executive Team meeting the following week.

15.5 The Performance Dashboard also highlighted the performance of the Children and Young People's service and it was agreed that a more detailed briefing for the Non-Executive Directors on the CYPS service would be arranged. **ACTION**

16. CQC NATIONAL MENTAL HEALTH PATIENT SURVEY RESULTS

16.1 The purpose of this report was to summarise the results of the 2020 CQC National Community Mental Health survey. These results provide assurance of the quality of adult community mental health services delivered by GHC.

16.2 In 2019, Quality Health was commissioned by GHC to undertake the 2020 Survey, which is a requirement of the Care Quality Commission. Within the results report, the CQC makes comparison with 55 English NHS mental health care providers' results of the same survey. It was noted that the full results were published on the CQC website. A summary of the key points was as follows:

- The Trust's results are 'better' than the expected range for 13 of the 28 questions (45%) and 'about the same' as other Trusts for the remaining 15 questions (54%) These results represent a further improvement on our results from last years' service user feedback (Better = 38%, about the same = 62%)
- The Trust is categorised as performing 'better' than the majority of other mental health Trusts in 8 of the 11 domains (73%) (last year: 7 out of 11, 64%)
- The scores for feedback are disappointing, although are 'about the same' as other Trusts (the highest score in England was only 3.5). This will continue to be a significant area of focus for development, with the work being led by the Patient and Carer Experience Team.
- An action plan will be co-developed with senior operational and clinical leaders and seeking input from Experts by Experience.
- An infographic has been produced to support effective dissemination of findings to colleagues and local stakeholders.

16.3 The Board received and welcomed this report, which demonstrated that the Trust was performing well. The report did identify some challenges but offered significant assurance that the Trust's strategic focus and dedicated activity to deliver best service experience was having a positive effect over time. Assurance was also received that the results of the survey would be used to identify the key areas of focus for practice development activity over the next 12 months.

THE FOLLOWING ITEMS WERE REPORTED BY EXCEPTION

17. COVID GOVERNANCE ARRANGEMENTS

17.1 The purpose of this report was to set out the proposed changes to Trust Board and Committee Governance arrangements during the current wave of the Covid-19 Pandemic. This report had previously been reviewed by both Executive and Non-Executive Directors and was therefore presented to note.

18. EU EXIT UPDATE

18.1 As referenced in the earlier Chief Executive's report, this report provided good assurance regarding the situation for the Trust and for healthcare providers following

the end of the EU exit transition period. Graham Russell noted the potential impact on construction, specifically the cost and supply of materials. The Board was assured that this was being considered.

19. COUNCIL OF GOVERNOR MINUTES

19.1 The minutes from the Council of Governors meeting held on 19 November 2020 were received and noted for information.

20. USE OF THE TRUST SEAL – QUARTER 2 2020/21

20.1 The Board noted this report which set out the use of the Trust Seal during Quarter 2 2020/21 (July – September). The Seal was used on 4 occasions during this period.

21. BOARD COMMITTEE SUMMARY REPORTS

21.1 Mental Health Legislation Scrutiny Committee

The Board received the summary report from the MHLS Committee meeting held on 18 November 2020. Ingrid Barker noted that there had been an increase in S136 detentions and said that she would welcome a briefing on this to fully understand the position. John Campbell agreed to provide a brief to the Chair. **ACTION**

21.2 Resources Committee

The Board received the summary report from the Resources Committee meeting held on 17 December 2020. Graham Russell confirmed that the Committee had approved the Montpellier Unit refurbishment business case, as delegated by the Trust Board.

21.3 Quality Committee

The Board received the summary report from the Quality Committee meeting held on 7 January 2021. Maria Bond advised that the Committee had received a clinical presentation of Learning Disabilities Services during Covid by one of the Trust's Consultant Clinical Psychologists. The presentation described the different ways in which people with learning disabilities had been affected by the pandemic and the actions that had been taken to support vulnerable patients.

22. ANY OTHER BUSINESS

22.1 The Board was informed of the need to take a decision for approval outside a Board meeting. This related to a capital scheme for anti-ligature works that was approved by the Capital Management Group, in line with SFIs at the time that now required Board level approval given the increased costs of the project. The Board was informed that the Chief Executive and the Chair had consulted two non-executive directors and approval was given for the business case. In line with the Trust's Standing orders, it was necessary to report this action to the next formal meeting of the Trust Board in public session for formal ratification. The Board ratified this action.

23. DATE OF NEXT MEETING

23.1 The next meeting would take place on Wednesday 31 March 2021.

Signed: ……..….. **Dated: ……**
Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Chair's office
Edward Jenner Court
1010 Pioneer Avenue
Gloucester Business Park
Brockworth
Gloucestershire
GL3 4AW

Email: Ingrid.barker@ghc.nhs.uk

Ms Louise Penny
Via Email

15th February 2021

Dear Ms Penny

Thank you for attending the Gloucestershire Health and Care NHS Foundation Trust Board meeting on the 28th January and for taking the time to submit a public question, along with a copy of the petition submitted on behalf of HOLD (Hands off Lydney & Dilke) on the 27th January 2021. A brief verbal response was provided at the Trust Board meeting on the 28th January 2021 and this letter fulfils the commitment to provide a full written response to both the question and the petition following the meeting.

1. Question posed of the Public Trust Board Meeting

"*Bearing in mind both consultation results state that the public strongly disagree with the proposed services and plan for healthcare throughout the Forest of Dean and that we have over 1000 signatures on our petition. Will the Trust please re-look at the case of what is the most beneficial way forward so the residents of the Forest of Dean are confident that the proposal will meet their needs?*"

The decision to develop a new hospital for the Forest of Dean was made in January 2018 by both the former Gloucestershire Care Services Trust Board and the Gloucestershire Clinical Commissioning Group (GCCG), as was the decision on where to locate the new hospital.

We have previously confirmed that the two existing sites are no longer fit for purpose and we are unable to deliver safe and effective services from the existing estate. This fact has been further highlighted during the recent COVID-19 pandemic where a significant proportion of services operating from these sites have had to be closed as the facilities could not meet the required infection, prevention and control standards. For these reasons, we do not intend to reopen the decision to build a single, new community hospital for the Forest of Dean.

The Trust has already made significant progress towards this development, including investing in the purchase of a site for the new hospital. It is our intention, as we have previously stated, that this new hospital will be a replacement for the existing Lydney and Dilke hospitals, both of which are no longer 'fit for purpose' facilities to deliver modern NHS services.

When we develop the Full Business Case for the new hospital, we will refresh the case for change for this development and the benefits that we are aiming to achieve so that we can continue to review whether these remain valid and that we have achieved them when we open the hospital.

2. Response to HOLD Petition

Gloucestershire Clinical Commissioning Group and Gloucestershire Health and Care Foundation Trust, have stated that they will replace the two existing hospitals (Lydney & Dilke) with one in the Forest of Dean.

We believe this is not an adequate replacement because:

- **The number of beds in the Forest of Dean will be cut from 47 to 24** as stated in the current consultation, this will not be substantial for the increase of population. The elderly and vulnerable in the community depend on local outpatient appointments and the rehabilitation beds are extremely important.

  *Throughout the consultation process we have worked with the GCCG to develop a range of bed modelling information which has been made available on the website **www.fodhealth.nhs.uk/consultation**. This modelling provides a county-wide picture and shows that the number of beds to meet the needs of Forest of Dean residents is 24. This is because current beds are frequently utilised by residents from outside of the Forest who needs may be better met by being able to access a more locally spot purchased bed nearer to home particularly within Gloucester City and Cheltenham – as the bed numbers reduce in the Forest we will increase the number of spot purchased beds to ensure all people in our county are able to receive care as close to home as possible. In addition, we have continued to develop our services that provide support directly into people's own homes. This again impacts on the number of beds that we need available as increasingly people are able to stay at home to recover or recuperate.*

  The new hospital will continue to provide a broad range of outpatient services, similar to those provided within the current hospitals to enable people to receive local appointments and reduce the need to travel to Gloucester or Cheltenham wherever possible.

  The GCCG in its role as commissioner of services has the ultimate decision on where beds are to be commissioned from and shortly we hope to be in receipt of their commissioning intentions for the new Forest hospital.

- T**here will be one hospital instead of two**. In the first consultation that was in December 2017 the public responded to the first question which asked - Do you agree with our preferred option to invest in a new community hospital in the Forest of Dean, which would replace Dilke Memorial Hospital and Lydney and District Hospital? The result was a No, 46% of people didn't agree with the option that was preferred by the trust.

  The current consultation was not intended to re-open the decisions made in 2018 following this first consultation, but to focus on the services to be provided within the new hospital. We recognise that there will always be a range of views received to any consultation and we take this into account when we are considering the best way to provide healthcare services along with the advice from clinicians and specialists. We will continue to work with ICS partners and our commissioners to consider all of these competing perspectives and consider the

most effective way in which to distribute resources and ensure best value from the Gloucestershire pound (£).

- **It would take people at least 40 minutes from Sedbury to get there.** We affirm it is going to have a huge impact on people from the south of the Forest of Dean because of the length of travel to Cinderford. Public transport is a huge issue, communities depend on these hospitals and closing them would cause people to vitally go without care, or put even extra pressure on district nurses, that are under an enormous amount of pressure already.

  We acknowledge that travel and access has been a consistent theme in all conversations that have taken place and we recognise the challenging nature of this across the Forest. We will continue to liaise with public transport providers and have already reached a commitment to have a bus stop either adjacent to, or within the site. However, we will continue to work with local providers to understand the viability of new or amended transport routes in order to improve access to the new hospital.

- **Population growth**, with 8,000 new homes to be built in accordance with the government target in the Forest of Dean. The decrease in site, services and beds that has been proposed will be a huge problem because of the increase in population?

  We can confirm that the population growth numbers were considered when considering the planning for the new hospital.

- **Significant more pressure will be put on larger hospitals and the Welsh health service.** People will use these other services because there is less services in their area and with increased waiting times as there will only be one MIU.

  Historically, operating both units in a consistent and effective manner across the Forest has been a challenge and we have many occasions where the units have had to close early either due to numbers of people waiting or lack of staff. We believe that moving to a single MIIU will provide much more resilience and effective services and we do not anticipate any change in access or waiting times from moving to a single unit.

- **Pandemics** In recent months the two existing hospitals have during this Covid 19 pandemic, been able to operate as “green” and “red” hospitals, containing Covid within one of them and using the other for non-Covid treatment. This would not be possible with the Trusts preferred option.

  Throughout the current pandemic the two hospitals in the Forest of Dean have taken a mix of both COVID positive and negative patients and have not been designated as ‘green’ or ‘red’ sites as you indicated in your documentation.

  This has been in line with the way we have utilised all of our community hospitals and we have implemented a programme of internal zoning to ensure segregation of patients to prevent cross infection. We have also had to take a number of the inpatient beds out of action across the Dilke and Lydney sites (47 beds down to 30) to ensure a COVID secure environment and social distancing. We have also kept the Minor Injuries Unit at the Dilke closed as we could not ensure a safe COVID environment due to the size of the facility and enable clearly separated access and exit routes.

- **Environmental Impact** The new hospital would mean people having to travel further afield, in a time where it is vital for our planet, we will be polluting this wonderful area further.

  Whilst we do acknowledge that for some the travel distance will increase, overall the two existing hospitals are very inefficient to run and are not operating to modern, efficient environmental standards. The new hospital would incorporate the latest thinking with regard to green technology and we aim to achieve an excellent rating in the sustainability standards that apply to new hospitals

- **Inadequate proposals & builds.** From previous examples up and down Gloucestershire including Tewkesbury we can clearly see that their proposals are not fit for purpose and are totally inadequate. These projects have resulted in diminished services, half the number of beds, buckling floors, broken lifts, low staff recruitment and retention levels.

  We are confident that the provision of a new hospital will provide a modern, fit for purpose healthcare environment that is therapeutically beneficial to patients, but also a great place for staff to work. Feedback from our staff within the Forest confirms that they feel unable to provide high quality care due to the constraints of the environment and are keen to move to a new modern facility.

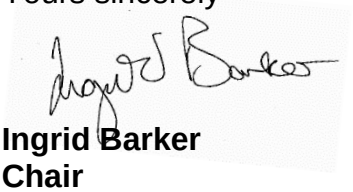
- **One Minor Injuries Unit.** Families throughout the Forest of Dean vitally depend on these services in our local hospitals that both have an MIU department.

  Over recent years the provision of the MIIU services across the Forest, and in particular the x-ray provision, has often been fragmented and subject to change due to staff levels and capacity at short notice. We are committed to providing an MIIU 8am-8pm seven days a week in the Forest which will be supported by an x-ray unit also being available seven days a week which will reduce the need for patients to return or have multiple visits.

I trust that this response goes some way to explaining the rationale for the decisions made and confirms our commitment to continue to provide excellent healthcare services for the residents in the Forest.

Should you have any further queries or questions then please do not hesitate to get in touch with myself (Ingrid.barker@ghc.nhs.uk) or Angela Potter, the Trust's Director of Strategy and Partnerships (angela.potter@ghc.nhs.uk), who is the Executive lead for the development of the new hospital.

Yours sincerely



Ingrid Barker
Chair

c.c. *Paul Roberts, Chief Executive*
Angela Potter, Director of Strategy and Partnerships
Lavinia Rowsell, Head of Corporate Governance and Trust Secretary

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AGENDA ITEM: 05

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 31 March 2021

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
25 Nov 2020	3.6	An initial organisational response to the recommendations sets out in the DPH Annual Report, with specific actions and commitments to be presented to the Board in January 2021.	Paul Roberts	~~28 January 2021~~ 31 March 2021	Update item scheduled for presentation as part of CEO Report at March Board meeting	
28 Jan 2021	7.9	Formal message of thanks from Board members to acknowledge the huge efforts of Trust colleagues through these challenging times to be communicated	Kate Nelmes	31 March 2021	Complete.	
	12.4	Reduced performance in relation to Breastfeeding Visits to be followed up and an update provided in the next Quality Dashboard report.	John Trevains	31 March 2021	Complete.	
	12.7	A specific report would be brought to the next Board meeting to provide assurance on the work taking place to manage pressure ulcer incidents	John Trevains	31 March 2021	Complete. Focussed slide on Pressure Ulcers provided within the Quality Dashboard to be presented at March Board meeting	

Meeting Date	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
	12.8	Delays in responding to Complaints identified in the Quality Dashboard to be followed up at the Quality Committee for assurance	John Trevains	31 March 2021	Complete. Assurances regarding recovery plan provided to Quality Committee on 4 March. Oversight of performance is provided in weekly monitoring discussions, fortnightly briefings, and monthly within the Quality Dashboard.	
	13.3	Future Patient Safety Reports to correlate the inpatient incidents with the number of beds and bed days by way of providing more context	Amjad Uppal	31 March 2021	Complete. Report under development and information will be included from Q4 onwards	
	15.5	A briefing for the Non-Executive Directors on CYPS would be arranged.	John Campbell / Trust Secretariat	31 March 2021	Complete. Session taking place on 29th April for all Board members	
	21.1	A briefing on the increase in S136 detentions to be provided for the Trust Chair	John Campbell	31 March 2021	Complete. Information collated and shared with Trust Chair for information	

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AGENDA ITEM: 7

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: John Campbell, Chief Operating Officer

AUTHOR: Rebecca Shute, Assistant to the Chief Operating Officer

SUBJECT: **COVID 19 RESPONSE 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:

Provide an overview and assurance of the current activity underway within the Trust in support of the system wide COVID 19 pandemic response.

Recommendations and decisions required

The Board is asked to:

- Note the contents of this report
- Be assured that robust processes remain in place to ensure safe and effective service delivery and support staff health and wellbeing.

Executive summary

This briefing paper provides an overview of the Trust's Covid 19 response and assurance of the continuation of a robust organisation wide approach.

The Covid 19 response aligns with the Trust values. A renewed focus on *'people before processes'* has been adopted. As the paper describes this approach ensures that: -

- our workforce and those using our services remain safe,
- that we continue to effectively work in partnership and contribute to the mass vaccination programme in Gloucestershire
- our service delivery is maintained and staff supported to regroup, reconnect and recover.

Risks associated with meeting the Trust's values
There is a continued risk due to the duration of the pandemic that the health and wellbeing of the GHC workforce is adversely affected but mitigation are in place and additional resources to support this.

Corporate considerations	
Quality Implications	The response functions aim to ensure that high quality services can continue to be delivered and enablers in place to support efficiency whilst operating differently as a result of the pandemic.
Resource Implications	At present the response efforts continue to require additional investment. This is continually reviewed as functions transition into business as usual.
Equality Implications	As required EQIAs are undertaken to assess impact of any changes to services or processes.

Where has this issue been discussed before?
A weekly update is provided to the Executive Committee.

Appendices:	

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

COVID 19 Response Briefing

1.0 INTRODUCTION

This briefing paper provides a further update following the Covid Board briefing sessions which took place on the 9th and 23rd March 2021. The briefing on the 9th March detailed current Covid 19 rates within the county, how we are supporting patient flow through the Gloucestershire health system, our contribution to vaccinating staff and the wider population in eligible JCVI cohorts, particularly focusing on vulnerable groups and how we are supporting the health and wellbeing of our workforce. This briefing also provided an update on our intended approach to service recovery as we start to move beyond the peak of the second wave. The briefing on the 23rd March, exactly a year after the first lockdown was instigated, focused on sharing our learning and best practice examples within our service delivery.

2.0 COVID 19 RESPONSE

Over the last 12 months since the initial impact of COVID 19, the Trust's Incident Co-ordination Centre (ICC) has provided day-to-day oversight and communication of information from national and regional routes, supporting information returns to NHS E/I and ensuring business continuity.

In addition to the ICC, a number of COVID response functions remain in place to ensure safe and effective service delivery within and across the Gloucestershire health system during the ongoing pandemic.

3.0 KEEPING PEOPLE SAFE

3.1 Covid Testing Team

The Covid Testing Team continues to offer a drive through service for key workers and elective surgery patients for GHFT. In partnership with Gloucestershire Fire and Rescue a home test delivery service is also provided for those unable to access the test centre.

Work is underway with Public health to scope how the team could support additional surge testing should it be required in the future for any new variants of concern identified within the county.

3.2 Lateral flow testing

Self-testing continues within our frontline workforce ensuring a proactive approach to identify asymptomatic cases. A new reporting application has now been developed for staff to upload their results. These can then be downloaded as required and presented to care home environments as assurance they are covid negative in line with new guidance.

3.3 Central Stock Management team

The central stock management team continues to ensure there is a supply of PPE across all our sites ensuring our staff and those in our care are protected. In conjunction with GHFT our stock supply will continue to be stored in the hangar at Staverton Airport until March 2022 as required. An audit of the PPE stock which has an estimated value of circa £10 Million is underway.

3.4 Fit Testing

83% of colleagues who may be required to use FFP3 masks have been successfully fit tested. This is a rolling programme of activity as new staff join the trust and new models of mask are in circulation.

Two automated machines are now in use to enhance this process, the stock team are trained in their use. Transitioning fit testing with the use of these machines into a business as usual model is now being considered.

3.5 Covid Secure Environments

Since June 2020 the Covid Secure Environment Team have undertaken significant level of activity to ensure all GHC sites have measures in place to ensure they are covid secure reducing the risk of transmission of Covid 19.

From the 1st April the covid secure oversight will be undertaken by the Health and Safety team as part of business as usual and incorporated within overall health and safety requirements. This will include providing support alongside infection control colleagues and site-based workplace safety representatives as teams begin to increase face to face activity and return to using building spaces as lock down relaxes.

4.0 MAINTAINING CORE SERVICE DELIVERY

During the second covid surge, a commitment was made to continue where possible to maintain all service delivery. Two services were however closed with full system support, the Vale MIIU to enable a PCN vaccination site to be established and Tewkesbury MIIU with staff redeployed to enable Rapid Response to be available via Cinapsis to the Ambulance service which is seeking to avoid hospital admissions where possible. Apart from these two specific system supported closures, no GHC services were closed with 13 providing a reduced service offer to focus on urgent priority referrals.

Re prioritising services enabled the release of staff to support essential services and the enhance offers required to enable effective operational flow.

4.1 Staffing Taskforce

The Staffing Taskforce was established to ensure oversight of staffing during escalation towards the second peak within core service and work in conjunction with the temporary staffing team to utilise bank and agency staff as needed. The Taskforce provided support to ensure redeployment (70 colleagues) was approach in a supportive way with ‘people before processes’ using learning from wave one.

The staffing taskforce is now working through project closure, focusing on lessons learnt and ensuring operating procedures are developed to enable a rapid reestablishment should it be required in a future surge.

4.2 Regroup, Reconnect and Recover

Work has commenced to support teams and services to **'Regroup, Reconnect, Recover'** as we begin to shape service delivery post the second covid surge in Gloucestershire.

This process is underpinned by principles of inclusion and collaboration, considering the needs of all stakeholders and a realistic evaluation of time frames and capacity required to meet increased demands.

Each service is producing a plan on a page and has the opportunity for bespoke support via Working Well and the health and wellbeing hub to enable individual and team recovery.

Progress to date and key themes will be presented to the executive team on 30th March.

5.0 GHC VACCINATION PROGRAMME

GHC are contributing to the covid 19 vaccination programme across the county in three key areas: -

1. GHC and PCN collaboration vaccinating housebound and care homes
2. GHC inpatients and other cohorts requiring additional support (e.g. homeless, LD, mental health)
3. GHC staff through the use of pop up clinics and working well support.

The programme is operating successfully across all three domains.

GHC has a roving team of 36 vaccinators made up of 3 redeployed staff and a pool of bank staff, all trained and competent to deliver both Oxford Astra Zeneca and Pfizer vaccines. This model enables flexible deployment aligned with demand across the three workstreams without impacting on any core GHC service delivery.

Focused work continues to support uptake in the GHC workforce for those in eligible cohorts. Progress has been made in the last 4 weeks as a result of targeted communications, advice and education through Working Well, learning from a staff survey and additional pop up clinics in areas of lower uptake.

COVID VACCINATIONS - WEEKLY REPORT

ROLE	BASE NUMBERS - FEB 2021	1st vaccine up to 19 Mar 2021	%	2nd vaccine up to 19 Mar 2021	%
All Doctors/Dentists	125	106	84	49	38.9
All Qualified Nurses inc students	1421	1183	83	374	26.3
All other professionally qualified	735	642	87	188	25.6
Support to Clinical Staff	1595	1508	95	460	28.8
TOTAL	**3877**	3439	**89**	1071	27.6
NHS Infrastructure Staff	611	203	33	31	5.1
TOTAL GHC WORKFORCE	4488	3642	81	1102	24.6

Frontline staff now at 89%

BAME staff now at 64%

Bank staff uptake remains low, plan in place to promote uptake and capture those who have had vaccine utilising the temporary staffing team distribution lists and text message system. Impact will be reviewed in 3 weeks' time.

Work is under way in conjunction with the PCN colleagues to review the current use of three GHC sites as vaccination centres and explore futures options to enable GHC service recovery in a timely manner.

GHC mass vaccination team are working alongside the vaccine equity group to undertake a deep dive into the data on vaccine uptake for those with a learning disability, severe mental illness and dementia. This will help to identify areas of need and bespoke solutions can be tailored. This may include support to make reasonable adjustments within PCN clinics, more targeted communication in a range of formats and bespoke clinic delivery aligned with needs.

6.0 NEXT STEPS

The Government have laid out a four-phase approach to the lifting of lockdown in the coming months. There are some concerns, particularly in relation to new variants of Covid with cases rising in mainland Europe that we may yet see a third wave of the pandemic.

The Executive Team remains vigilant and continues to monitor the position both across Gloucestershire and within the Trust as we embark on our journey towards service recovery.

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AGENDA ITEM: 8

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

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

Inevitably how we, as a Board work, and where we are focusing continues to be impacted by the need to respond to the very significant challenges of the ongoing COVID pandemic. At the same time, we continue to balance the need to take forward our ongoing development as a Board and an organisation.
I would like to again formally record my thanks to both my fellow Board members, Executive and Non-Executive, and my colleagues throughout the organisation who

continue to prioritise meeting the needs of our community despite their own worries and the heavy demand we are experiencing. The progress Gloucestershire is making with its vaccination programme is an area of activity which the Trust is actively supporting and championing and I have been pleased to hear about how we are engaging with colleagues and our communities to support its roll out across our communities, demonstrating once again how the NHS can work collectively.

Since my last report there has been significant stakeholder engagement in relation to health care provision in the Forest and the planned new hospital. We are keen to listen to the community in the Forest and respond to concerns highlighted and the meetings detailed demonstrated the time and energy I and the wider GHC management team are committing to this important development.

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 January to 28th February

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

REPORT FROM THE CHAIR

1. 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. BOARD

2.1 Non-Executive Director Update

The Non-Executive Directors and I continue to hold our monthly meetings and virtual meetings were held on 25th February and 23rd March. These meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive at this difficult time and to continuously improve the way we operate.

I continue to have regular meetings with the Vice-Chair and Senior Independent Director, along with individual 1:1s with all NEDs. During this time when in person meeting is not possible these sessions are virtual, but continue to support us to work effectively together as a team.

2.2 **Board Updates:**

COVID briefings:
Board COVID briefings have been held on 10th February, 9th March and 23rd March. These sessions ensure the Board is up to date with the latest challenges, and can support, and where necessary challenge, and understand the difficult decisions the Executive is needing to action.

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 session has taken place:

- **10th February - Board Seminar – Digital -** ensuring we have an understanding of how digital can improve the ways we work and understand how this can be progressed. It was a hugely valuable session which drew out the digital developments which have been put in place to support the pandemic response

but also looked at what next, and checks and balances required recognising that connectivity varies across the county and in different communities.

I chaired a meeting of the **Appointments and Terms of Service Committee** (ATOS) on 17th March which is a key part of our performance management processes for our Executive Team.

As part of my **rotational attendance at the Trust's Board Committees**, I attended a meeting of the **Resources Committee** on 25th February and a meeting of the **Quality Committee** on 4th March. I plan to attend other committee meetings over the course of the next few months.

3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 2nd February, 10th February and 3rd March.

- A **Membership and Engagement** meeting took place on 23rd February. The level of engagement of Governors in ensuring that the membership of the Trust is actively engaged, growing and reflects our communities was extremely positive. The Membership and Engagement Strategy was updated to reflect feedback, taken forward to the Council of Governors where it was approved and it has been brought to the Board for endorsement.

- I chaired a meeting of the **Nominations and Remuneration Committee** on 24th February, which included consideration of succession planning for current Non-Executive Directors.

- A meeting of the **Council of Governors** was held on 10th March. Over the last year the Council has been reviewing its ways of operation through a number of review and refresh working group sessions and through development sessions from Governwell. This has led to some revised way of working including consideration of new ways of holding the Non-Executives to account for the performance of the Board. As an element of this Graham Russell, Vice Chair of the Board and Chair of the Resources Committee, gave a very useful presentation on the role of the Resources Committee and how it in turn holds the Executive to account. The engagement of the Governors in this first of a planned series of sessions demonstrated that this approach provided very helpful assurance to the Council.

- The Trust currently has 3 Governor vacancies - 1 public Governor vacancy for Tewkesbury and 2 vacancies for staff Governor positions - one Health and Social Care Professions Governor and one Medical, Dental and Nursing. A virtual Q&A session for potential Governor applicants was held on 30th March.

4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in January, I have attended a breadth of national meetings, all of which considered COVID plus more routine business:

- **NHS Providers Board** – 3rd February and 24th March, where we discussed important policy and national operational issues and current challenges and opportunities.

- **NHS Providers Chairs and CEOs Network** – 16th March – where we received a policy and strategic update from the CEO of NHS Providers; an update from the Chief Operating Officer for NHS England and Improvement; and an update from the Chief People Officer for NHS England and Improvement..

- **NHS Confederation NHS Reset Webinars** continue to take place on a regular basis and 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 past months.

- **South West Region NHS Provider Chairs meeting** – 10th February.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits.

- **NHSE/I COVID-19 webinar for community health services** – 12th February

- To mark **International Women's Day on 8th March,** I was invited to take part in a nationwide celebration about **Women in health and care: Achieving an equal future in a COVID-19 world,** hosted by Prerana Issar, Chief People Officer of the NHS; and Samantha Allen, Chair of the Health & Care Women Leaders Network

- Two online virtual events arranged by the **Good Governance Institute:**

  16th February where "**The New NHS: ICS Series 'The White Paper'** was debated. An interesting starting point as we wait to see how the proposals are developed and how we can contribute to the process.

  11th March where we discussed '**Governance of Mental Health Trusts' Commissioning Role: How Boards can assure best practice'**

5. WORKING WITH OUR PARTNERS

I have continued my regular virtual 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:

- Paul Roberts (CEO), Angela Potter (Director of Strategy and Partnerships) and I attended a meeting of the County's **Health Overview and Scrutiny Committee** (HOSC) on 2nd March where the Committee received an update on changes to the Community Phlebotomy Services; an update on temporary service changes introduced in response to the COVID-19 pandemic; an update on the performance of the Gloucestershire Clinical Commissioning

Group against NHS Constitutional and other agreed standards; an update on the work of the One Gloucestershire Integrated Care System (ICS) Partnership, including updates on COVID-19 response, Fit for the Future Consultation and the Forest of Dean Community Hospital Consultation.

- **An extra meeting** of the County's **Health Overview and Scrutiny Committee** took place on 22nd March to discuss the Output of the Fit for the Future Consultation and the decisions made at the NHS Gloucestershire Clinical Commissioning Group Governing Body meeting on Thursday 18 March 2021. The Trust was represented at this meeting by Angela Potter (Director of Strategy and Partnerships).

- Bi-monthly meetings with the **County's Health Chairs** continue to take place and we met on 2nd March. These sessions are very helpful in supporting our partnership working.

- 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.**

- **ICS Board** meetings were held on 18th February and 18th March. A number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported.

- Paul Roberts (CEO) and I met with a wide group of colleagues from across the Trust on 4th February for **potential partnership scoping discussions with the University of Gloucestershire**. A working group is now being put together to further discuss options.

6.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- I have attended **several meetings** over the last few weeks in relation to developments with the new **Forest of Dean Community Hospital**. These are detailed below:

- 4th February, Angela Potter (Director of Strategy and Partnerships) and I met with the CEO and Corporate Director (Operations) from **Two Rivers Housing** based in Newent to discuss Forest of Dean hospital developments.

- 12th February – Paul Roberts (CEO) and I, along with colleagues from the Gloucestershire Clinical Commissioning Group, met virtually with **Mark Harper, MP for the Forest of Dean**, where we specifically discussed matters relating to health care in the south of the Forest of Dean.

- 22nd February - Angela Potter (Director of Strategy and Partnerships) and I were invited by the **Forest of Dean District Council** to attend a meeting to discuss developments with the new hospital.

- Following a request from **Sir Geoffrey Clifton Brown, MP for the Cotswolds**, for a further virtual meeting where he could thank Cotswold colleagues for all the work undertaken during the latest wave of COVID-19, I was pleased to be able to chair the conversation which took place on 11th February which included a cross-section of colleagues from across the Cotswolds who gave an overview of their work undertaken during the pandemic.

- I was very pleased to be invited to attend one of the regular "**Experts by Experience get together"** meetings on 18th February. I very much look forward to joining the group again when my diary allows.

- On 12th March I was represented by Non-Executive Director, Steve Brittan, at a virtual meeting with **Richard Graham, MP for Gloucester**, who spoke with Gloucester based staff about their work during the latest Coronavirus wave.

- Along with a variety of organisations, MPs, media, education professionals, youth workers, members of Child Friendly Gloucestershire and leaders from various sectors and organisations in Gloucestershire, Sarah Birmingham (Deputy Chief Operating Officer), Melanie Harrison (Service Director, Children and Young People's Services) and I took part in **The Bishop of Gloucester's Youth Forum** on 15th March. This particular event was arranged to hear from young people across Gloucestershire and beyond about how COVID-19 has impacted their lives and their concerns and hopes for the future. Mental health is a big issue and there is a need to think about how we better hear and respond to young voices.

- Paul Roberts (CEO), Angela Potter (Director of Strategy and Partnerships) and I held a quarterly meeting with the **Chairs of the County's Leagues of Friends** on 18th March. This was an opportunity for the Trust to give updates on a number of important activities that have been taken place over the last few months, including COVID-19. The next meeting will be held in June.

7.0 ENGAGING WITH OUR TRUST COLLEAGUES

- Along with Non-Executive Directors Steve Brittan and Marcia Gallagher, a meeting was held with Director of Finance Sandra Betney for an update about **Digital planning** which helped us understand the drivers and challenges of taking forward this agenda.

- I attended a meeting of the **Women's Leadership Forum** on 1st March

- As part of my regular activities, I continue to have a range of **1:1 meetings with Executive colleagues**, including a weekly meeting when possible with the Chief Executive and the Trust Secretary/Head of Corporate Governance.

Whilst drop in chats with services and colleagues need to be virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I have an active presence on social media to fly the GHC flag and highlight great work and issues across the county.

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 January and February 2021.

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 January to 28th February 2021

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Graham Russell	NEDs meetings (2) 1:1 with Trust Chair (2) Quarterly meeting with Trust Chair and Senior Independent Director ICS NEDs and Lay Members meeting 1:1 with Medical Director	Council of Governors Governors Membership and Engagement meeting (2) Resources Committee agenda planning Good Governance Institute meeting ref NHS White Paper	GHC Board ICS Board (2) COVID briefing (2) Board Seminar (2) ATOS Committee Audit Committee Nomination and Remuneration Committee Resources Committee
Marcia Gallagher	Quarterly meeting with Chair and Vice-Chair 1:1 with NED 1:1 with Trust Chair (3) Meeting with Trust Chair, Director of Finance, Director of Strategy & Partnerships 1:1 Chief Operating Officer ICS NEDs and Lay Members meeting Pre-meet with Internal and External Auditors MHAM Hearings (2) NEDs meetings (2) 1:1 with Trust Secretary/Head of Corporate Governance 1:1 with Director of Finance 1:1 with Associate Director of Quality Assurance and Compliance 1:1 with CEO Meeting with NED and Lead Governor	Council of Governors Council of Governors Governwell Training session NHS Reset Chairs meeting (2) FoD CH DQI Review NHSI Good Governance Institute	Quality Committee COVID briefing (2) Board Seminar (2) NHLSC GHC Board Audit Committee Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr. Stephen Alvis	NEDs meetings (2) 1:1 with Associate Director of Quality Assurance and Compliance 1:1 with Director of Strategy and Partnerships Senior Leadership Network ICS NEDs and Lay Members meeting 1:1 with Director of Strategy and Partnerships CYPS Delivery and Governance Forum Consultant CEO Meeting	Council of Governors Governwell training session Good Governance for NEDs (8 meetings) NED Audit of Complaints FoD CH DQI Review NHS Reset: Chairs meeting (2) Good Governance Institute White Paper event NHSP Digital Transformation meeting	Quality Committee COVID briefing (2) Board Seminar (2) ATOS Committee MHLS Committee GHC Board Ethics Committee Mental Health Operational Committee Audit Committee
Maria Bond	Meeting with NHSI 1:1 with Trust Chair Meeting with Expert by Experience and Governors post-Quality Committee 1:1 with Associate Director of Quality Assurance and Compliance NEDs meetings (2) 1:1 with Director of Nursing, Quality & Therapies Senior Leadership Network ICS NED and Lay Members meeting 1:1 with CEO Governor meeting with Graham Hewitt Meeting with External Auditors Meeting with Internal Auditors Governor meeting with Jenny Hicks	FoD CH DQI Review NHS Reset Chairs meeting Council of Governors Governwell training session Good Governance meeting Good Governance Institute meeting ref BAME Good Governance Institute meeting ref Clinical Negligence Good Governance Institute meeting ref NHS White Paper Good Governance Institute ICS breakfast meeting Good Governance Institute meeting ref Wellbeing Guardian NHS Providers Digital Boards NHSP Chairs meeting	Quality Committee COVID briefing (2) Board Seminar (2) ATOS meeting GHC Board Audit Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Steve Brittan	NEDs meeting (2) 1:1 with NED GHFT (2) Introductory meeting with Lead Governor 1:1 with Senior Independent Director (2) ICS NED and Lay Members meeting 1:1 with Head of Sustainability Meeting ref scoping a potential partnership with University of Gloucestershire Meeting with Governors Josephine Smith and Laura Bailey Meeting with NED and Lead Governor Meeting with Chair, Vice-Chair and Senior Independent Director	Council of Governors FoD CH DQI Review Mentoring meeting Oxevision Project Group NHS Chairs Reset meeting (2) HSJ Digital Transformation Virtual Series Digital Strategy Community Health Services Workshop Good Governance Institute NHS White Paper briefing	Board Seminar (2) ATOS meeting GHC Board COVID briefing (2) Resources Committee Audit Committee
Jan Marriott	1:1 with FTSU Guardian 1:1 with Director of HR 1:1 with Associate Director of Quality Assurance and Compliance 1:1 Trust Chair 1:1 with MCA/MHA Manager, Gloucestershire County Council Meeting with Clinical NEDs – GHT and CCG NEDs meetings (2) Farewell event Marieanne Bubb-McGhee ICS NED and Lay Members meeting Meeting ref MHLSC ToR, Committee feedback and workplan ICS Clinical Council 1:1 with Vice-Chair Mental Health Operational meeting	FoD CH DQI Review Council of Governor's Governwell training session Good Governance Institute	Quality Committee Board Seminar (2) MHLSC GHC Board COVID briefing (2) Audit Committee Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Sumita Hutchison	NED meetings (2) 1:1 with Director of Finance 1:1 with Medical Director 1:1 with Associate Director of Quality Assurance and Compliance 1:1 with Trust Chair Health and Wellbeing meeting with Marie O'Neil Trust staff wellbeing core project team 1:1 with Director of Strategy and Partnerships 1:1 with Director of HR 1:1 with Linda Gabaldoni 1:1 with Head of Sustainability Senior Leadership Team Meeting with Governor, Juanita Paris	Organisational Development training course – "reinventing organisations" Meeting with NHSE/I re Health and Wellbeing Guardian Role 1:1 with Jane Ginnever Council of Governors Governwell Training Session Wellbeing in the Workplace webinar	GHC Board Ethics Committee Board Seminar (2) COVID briefing (2) Resources Committee Quality Committee

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 9

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

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 of the Chief Executive and the Executive Directors continue to be dominated by the ongoing response to the Covid-19 pandemic. However, the Trust is also balancing this demanding agenda with: individual recovery, service recovery, establishing new business as usual norms and making tangible progress on our strategic/transformational ambitions. Significant projects are also being progressed, including the planning of the new Forest of Dean hospital and finalising work on the overarching Trust strategy and enabling strategies, including the "People Plan".

Our work on Equality, Diversity and Inclusion (EDI) is an ongoing area of priority, within our response to the pandemic, recovery and our business as usual work. Ensuring the Trust EDI commitments are authentic and embedded remains at the heart of the Trust. It is also a key driver in the Gloucestershire wide vaccination programme and the CEO is leading on vaccination equity for the system.

The last year has proven to be an extraordinary time for GHC, the NHS and the country as a whole. I am incredibly proud of the way our colleagues have

continuously risen to the challenge and to reflect on what has been achieved by the organisation, and its system partners, throughout this turbulent and unrelenting year. We were encouraged by the positive progress indicated through our staff survey (measured in October/November 2020) but continue to see staff satisfaction and morale as a key priority in order to deliver the best patient care.

We are hopeful that there is now a glimmer of light at the end of what has been a very long tunnel and we are looking ahead to anticipate what business as usual may look like over the coming months.

An update on out of area placements is provided, as well as an update on team changes and the EU exit.

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?

Appendices:	Report attached

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

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE ENGAGEMENT

Since the January Trust Board, the organisation continued to operate at "level 5" and then, towards the end of February "level 4" incident response, in conjunction with our system partners. The last two months have proven to be particularly challenging for our operational and patient-facing colleagues, who have been working to support Covid-positive patients but also large numbers of Covid recovering patients alongside increases in demand for non-Covid patient care, together with the annual pressures brought on by winter and colder weather.

The whole Trust team has pulled together to continue to deliver high quality services for patients despite the pressures and has worked tirelessly to support our partners at the CCG and Gloucestershire Hospitals Trust. In some instances, this has required the review of services and the redeployment of colleagues into alternative teams where there is a more urgent need for resources. We are extremely grateful to everyone who is going the extra mile to keep our services running and our communities supported. In February I wrote on behalf of the Board to all staff who have faced the personal and professional disruption of Covid to thank them for their extra service.

The reduction in community Covid-19 infection rates and the announcement made by the Prime Minister, setting out the roadmap to recovery, has thankfully provided some light at the end of what has been a very long tunnel. The Executive team, on behalf of the Board, is exploring what "business as usual" may look like over the coming months and the Board and Executive team have begun to concentrate on a balanced "recovery and refocus" programme balancing:

- Individual recovery - ensuring the Trust continued to focus on the health and wellbeing of colleagues.
- Service recovery – ensuring that there are plans to restore services, accommodate changing demand patterns and to embed innovative practice associated with the pandemic response.
- Refocus on strategic ambitions – increase effort to deliver the strategic ambitions of the organisation, set out when it was formed on October 2019.

The GHC team can be justly proud of its response to the pandemic, however at a time when colleagues are tired, stressed and often overwhelmed, the Executive team is prioritising the continuing support of the workforce given the significant challenges which still remain. I continue to focus my energies on supporting colleagues across the organisation, through an open door policy and regular one-to-one meetings with the Executive and senior leaders and recently appointed senior managers.

Whilst some staff are remote working and we are using Teams software for many meetings, we are ensuring that we remain accessible as an Executive. Indeed, in many areas the use of virtual attendance has enabled more colleagues to engage with our regular organisation meetings, such as TeamTalk, which is a welcome development.

The feedback from our first joint **staff survey** undertaken as a merged Trust carried out in October and November 2020 but published this month was encouraging. We have benchmarked the findings against the last separate reports and are very pleased that there has been a significant increase in the numbers completing the survey and improved ratings in 80% or rating themes, despite the extremely challenging background context of the pandemic. Given our ongoing focus on wellbeing, it was very pleasing that there was a 10% improvement in relation to positive action on health and wellbeing. This is discussed in more detail later in the meeting.

I have continued to develop my work as **lead CEO for equality, diversity and inclusion (EDI)** for the Gloucestershire ICS. The partnership is developing its approach to the systematic tackling inequality and to co-ordinate its response to the recent challenges brought to light by the pandemic. As part of this work, I am working with a wide range of colleagues who have expertise in this area, including those from Public Health England, Gloucestershire County Council (Public Health), Gloucestershire Clinical Commissioning Group and Gloucestershire Hospitals Trust, Gloucestershire Voluntary and Community Services, Inclusion Gloucestershire to gain a wider understanding of health inequalities and to consider how the ICS can contribute to this agenda.

The “eight urgent actions” outlined by NHS England in August 2020 provide a useful framework for this work:

1. Protect the most vulnerable from COVID-19
2. Restore NHS services inclusively
3. Develop digitally enabled pathways in ways which increase inclusion
4. Accelerate preventative programmes which proactively engage with those at greatest risk
5. Support those with mental ill health
6. Strengthen leadership accountability for inequalities
7. Ensure there is data available to underpin this work
8. Collaborate and engage locally to deepen partnerships to tackle inequality more effectively.

I chair the **Gloucestershire Covid-19 Vaccination Equity Group**, which convenes on a weekly basis. The purpose of the group is to support equitable uptake of Covid-19 vaccinations across the population of Gloucestershire. The work is fast-paced and the group works closely with the Gloucestershire Covid-19 Mass Vaccination Command Group to address effectively inequalities and hesitancy in uptake within the mass vaccination programme timelines. The group endeavours to co-design interventions, guided by local and national evidence and insights. Feedback from Governors at our recent Council of

Governors meeting welcomed this approach of working with and delivering in our community.

I also attended the webinar chaired by Professor Keith Willetts on "**Vaccination and Health Inequalities (Covid-19 - Update for System Leaders)**".

As part of my wider ICS role I continue to co-ordinate the NHS input into the **Walk In My Shoes (WIMS) Community Led Mentoring Programme** which is gaining momentum. The reverse mentoring sessions have continued and both the NHS Leaders and community advocates involved in the programme have reported valuable insight and learning.

The WIMS programme recently hosted a webinar on "**Facts and Myths – Covid-19 Vaccines and BAME Community**". The webinar provided an opportunity for an informal discussion with members from the BAME community to provide information on Covid-19 vaccinations and to allow people to make an informed choice about uptake.

The **Race and Health Observatory** held a webinar on **"Black, Asian and minority ethnic people: Covid-19 and the Vaccine"** on 11th February. The webinar addressed the impact of the Covid-19 virus in general and specifically its impact on diverse communities. Designed as an information giving and sharing event, it provided factual information with regards to the vaccines, with a series of presentations being delivered by a panel of leading healthcare experts. These webinars are an excellent way of raising awareness to enable people to make reasoned decisions based on the evidence and facts available.

Gloucestershire has been very successful with its **mass vaccination programme** and huge amounts of work have been carried out with partners in primary care and the Gloucestershire Hospitals Trust to vaccinate patients and colleagues. The Trust has played an increasing role supporting Primary Care Networks to deliver vaccinations to housebound people, people with a learning disability, a serious mental illness and homeless people and in vaccinating staff.

Our **vaccination rate for frontline colleagues in the Trust is now** (19th March) **close to 90%** (and should exceed this by the time of the meeting). The rate for colleagues from an ethnic minority continues to lag at around 64% - there continues to be targeted activity to address this concerning issue.

Our Covid swabbing service, based at Edward Jenner Court, recently celebrated its first anniversary and carried out its **15,000th test since setting up the service in March last year**. The team provides PCR (polymerase chain reaction) testing for people who work in health and care organisations, as well as members of their household. Testing is also carried out on pre-operative patients, who are either tested at the drive-through pod at EJC or tested in their own homes or nursing homes by Trust clinicians or members of the fire service. Up to 150 people are being tested per day through this service.

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 as we enter the next phase of the pandemic.

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

1.1 Internally

Board Covid briefings were held on 10th February, 9th March and 23rd March. In order to keep the Board regularly updated with the fast pace of change caused by the third wave of the pandemic, briefings have been scheduled to update on various matters including the overall system position and response, the GHC service recovery and staff taskforce and health and wellbeing. The briefings allow the Board to keep pace with the work of the Trust and to provide support, and where appropriate challenge, to the Executive team.

An **Executive Development Seminar** was held on 11th March, 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 the health and wellbeing of the Executive and wider senior leadership team and provided an opportunity to reflect on useful tools and practices for management. Time was also spent considering the 'recovery and re-focus' work and provided invaluable time to facilitate leadership development, helping to achieve our core value of always improving.

A **Board Development Session** was held on 10th February, which focused on the Trust's digital strategy. The session outlined the digital framework and provided an update on the digital strategy work achieved within the 2019 to 2020 period. The session provided an opportunity for Board members to discuss the Trust's strategy and digital needs and how to enhance digital culture and digital inclusion moving forwards. Digital work has formed a huge part of GHC's Covid Response, from implementing virtual consultations and patient iPads on wards, to home working and remote meetings and so it is vitally important to give this work the focus and attention it deserves.

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 an update on Oliver McGowan Training and Tack Research Study. 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 virtual **Senior Leadership Network** (SLN) meeting was held on 16th March, which provided an excellent opportunity to update the SLN on Trust and national developments. The March session had a particular focus on recovery and refocus following the latest Covid-19 wave, with an opportunity for the SLN to voice their opinions on individual recovery, team and service recovery and aims/transformation. Dr Amjad Uppal, Medical Director, also provided a presentation on research champions and there was an interactive session to discuss the staff survey results.

Corporate Induction has continued to be run as a weekly virtual event throughout the lockdown period. 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 has continued to hold its **Covid-19 Briefing calls** for senior and on call managers. The frequency of these meetings is dictated by the level of activity in the Trust and system and are currently being held twice weekly. 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. Twice weekly **Oversight Calls** are also being held, led by the Operations Directorate.

I attended the **Non-Executive Director's meeting** on 25th February and 23rd March to provide an informal update. This meeting is reported on in more detail in the Chair's report.

I attended the **JNCF** meeting on 24th March 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 general updates on finance and HR were provided. Neil Savage provided feedback from the ICS Social Partnership Forum and the Staff Survey Report.

I attended a **Council of Governors** meeting on 10th March to provide the CEO update on a number of important matters, including the FoD Consultation, Trust Strategy Progress and an update on Covid-19. This meeting is reported on in more detail in the Chair's report.

I attended the regular meetings of the **Medical Staffing Committee** on 5th February and 5th March, the **Local Medical Council** on 11th March, and the **Medical Management meeting** on 26th March, all via virtual forums.

I chaired the regular meetings of the **Enhanced Independence Offer (EIO) Working Group,** which is working to support the development of the Reablement Strategy across Gloucestershire. Positive progress has been made with the longer term aspirations around the new delivery model of EIO and Reablement services. The meetings provide an opportunity for discussions on how the delivery of the longer term transformation can be achieved, whilst also meeting this year's priority around delivery.

Angela Potter (GHC Director of Strategy and Partnerships), James Powell (GHC Sustainability Manager) and I attended a meeting with **Public Health England**, South West region on 17th March to discuss the **South West Greener NHS Programme**. The meeting provided an opportunity for a discussion of the important work being progressed in relation to sustainability both in Gloucestershire and the region as a whole.

I am involved, along with other GHC Directors, in the **Reciprocal Mentoring Scheme**. 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 meeting was held on 25th January with the Leadership Academy to design the programme for the coming year. A number of full day workshops have now been arranged over the next six months. 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**

A "White Paper" on the future of Integrated Care Systems was published in February (see section 3.0 below).

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, including Sarah Scott, **Executive Director of Adult Social Care and Public Health.** A number of my Executive colleagues and I recently had a meeting with the **Gloucestershire Police and Crime Commissioner** to ensure effective sharing of knowledge and learning across the Gloucestershire organisations.

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 2nd March, where the committee discussed various matters including community phlebotomy services and Covid-19 temporary service changes. At each meeting there is an opportunity for members of the public to make representations on any matter which relates to an item on the agenda and for the Committee to respond to any representations raised. This allows for any person who lives or works in the county or who is affected by the work of the County Council to have a voice directly to the Committee 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 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.

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.

I continue to chair the **Diagnostic Programme Board**, which met on 11th March. The Board is continuing to progress the important work on Community Diagnostic Hubs (CDH). A CDH is a 'free standing multi-diagnostic facility that is preferably located away from main 'acute' hospital sites, including on the high street and in retail locations. The service will provide quick and easy access a range of elective diagnostic tests on the same day, supporting earlier diagnosis, greater convenience to patients and the drive to reduce health inequalities. A workshop was held to discuss the migration from the current delivery of diagnostics to a CDH model, focusing on design principles, the long-term vision and short-term delivery.

The Chair and I attended a meeting with the **University of Gloucestershire** on 4th February to discuss potential future partnerships, engagement and collaborative working. A task and finish group is now being set up to progress further this work.

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, the key meeting has included:

- NHS England's MH (Mental Health) Trusts CEO Meeting;
- SW Regional Chief Executive meetings, chaired by Elizabeth O'Mahoney; and

- SW MH (Mental Health) CEO's meetings, chaired by Anne Forbes.

I attended the **NHS Providers Chairs and Chief Executives Network event** on 16th March, chaired by Sir Ron Kerr. Chris Hopson, (NHS Providers Chief Executive) presented the strategic policy update, Amanda Pritchard (NHS E/I Chief Operating Officer) provided an overview of the current NHS state of play and key priorities moving forward and Prerana Issar (NHSE Chief People Officer) provided an update on workforce issues. The event provides an opportunity for Chairs and Chief Executives to share ideas and exchange information, which is particularly valuable during these challenging and unprecedented times.

The South West region is proceeding with the development of **Imaging Networks** in line with the national imaging strategy as well as the recommendations of the Richards Review and GIRFT radiology reports. An engagement session was held at the end of January with various clinical teams, which provided an opportunity to discuss current working practices, including image sharing, and to review the challenges and opportunities available in establishing the Imaging Networks. The NHSE-NHSI SW region is supporting this important work and I am pleased to have have been invited to join the **SW Imaging Regional Focus Group** to steer the development of this programme.

I attended the virtual **West of England Academic Health Science Network (AHSN)** Board meeting on 5th March. The main focus of this meeting was an overview of the work being carried out by the AHSN and the progress that has been made in developing their local innovation pipeline model. The meeting was followed by the **CRN West of England Partnership Group** meeting.

2.0 OUT OF AREA PLACEMENTS

Within the Mental Health 5 Year Forward View and subsequently the NHS Long Term Plan, the Department of Health and Social Care (DHSC) set a national ambition to eliminate inappropriate Out of Area Placements (OAP's) in mental health services for adults in acute inpatient care by March 2021. The definition includes both adult acute mental health and Psychiatric Intensive Care Unit (PICU) provision.

In 2019/20 the Trust utilised 1,742 OAP Occupied Bed Days (OBDs). In April 2020, the CCG agreed a threshold with NHSE/I with the aim of further reducing OAPs setting a target of no more than 800 OBDs for 2020/21. The Trust have utilised 592 OAP bed days as of the end of February 2021 therefore will fall below the threshold reported to NHSE/I. The 7-day working of the Integrated Discharge Hub has continued to have an impact on avoiding out of area placements.

It is understood that only a small number of Mental Health Trusts are expected to meet the national target of zero OAP by the end March 2021, this being where they have the full range of acute / PICU provision in their locality.

Of the 592 OAP OBDs utilised to date in 20/21, 64% relate to Psychiatric Intensive Care (PICU) and 36% acute. 168 days of the PICU usage related to one individual awaiting access to the Specialist Commissioned Secure Services and this accounted for 46% of all PICU OAP's. 136 days were a consequence of requiring single sex PICU environments (sexual disinhibition) which is not available at Greyfriars and this accounted for 37% of all PICU OAP's. All other OAP admissions to PICU and acute (36%) were due to lack of bed availability.

A revised trajectory has not yet been agreed by the CCG with NHSI/E but this will no doubt expect to evidence further reduction. The Trust is committed to making these further reductions and has a number of schemes which are being implemented over the next 12 months which will help contribute to this. These include: hotel hospital discharge; Allied Health Professional support to timely discharge; VCS supported discharge including Young Glos and ELIM housing supporting safe discharge to avoid homelessness.

3.0 WHITE PAPER ON INTEGRATED CARE SYSTEMS

NHS England recently released its White Paper, Integration and Innovation, working together to improve health and social care for all.

The proposals would lead to Integrated Care Systems becoming statutory bodies and a mandate to work more closely with Local Authority and other system partners including the voluntary sector.

It is anticipated providers will retain their current structures but they will need to work in greater partnership with other providers and commissioners with a greater role for provider collaborative/s with responsibilities for tactical/operational commissioning.

You can read more about the proposals on the NHS England website here: https://www.england.nhs.uk/integratedcare/integrated-care-systems/

4.0 BEYOND COVID: RACE, HEALTH AND INEQUALITY IN GLOUCESTERSHIRE

In November 2020 Sarah Scott (now Executive Director of Adult Social Care and Public Health) attended the Board to present her annual report. The report focussed on race, health and inequality in the context of Covid. The report discussed six areas of action and response to Covid which were incorporated into eight recommendations for the county. This section provides a brief update on Trust activity in the six themed areas.

4.1 **Community resilience** – working with communities is core business for the Trust through community-based teams caring for people with mental illnesses, physical health conditions and learning disabilities. Specifically, the Trust has a

Partnership and Inclusion Team led by Dominika Lipska-Rosecka which work with local communities, including ethnic minority and faith group communities. The focus is to improve their experience of our services and develop co-produced responses to specific needs. The Trust has two directors participating in the WIMS reverse mentoring programme and the CEO has been leading the Covid Vaccination Equity programme.

4.2 **Workplace Health and Wellbeing** – Following national guidance the Trust has undertaken a risk assessment programme with staff including colleagues from ethnic minorities and made appropriate responses to their particular individual needs. There has also been a supportive but targeted approach to staff Covid vaccination where colleagues from ethnic minorities have shown a higher than average vaccine hesitancy. The Trust has increasingly thriving diversity network including a sub-network for staff from ethnic minorities. The staff survey shows and improved and above average score for the Trust (compared with the combined predecessor organisations) on the Equality, Diversity and Inclusion Theme and improved score for general health and wellbeing.

4.3 **Communication** – The Trust has put communication with patients and staff at the heart of its Covid response with frequent bulletins and significantly increased use of social media. Patient (and staff) feedback has been used to help to shape services as they adapt to Covid.

4.4 **Prevention** – The Trust is significantly involved in work on prevention with specific population groups such as the homeless, people with serious mental illnesses and people with a learning disability. We are also working with the WIMS Programme to undertake a series of workshops on health issues specifically for people from ethnic minority groups and faith communities.

4.5 **Becoming a culturally competent organisation** – The Trust has made its EDI programme a priority working both internally and externally. The Diversity Networks have become a forum for discussion and action and inclusion and diversity is now at the heart of the Trust's leadership training. Encouragingly the Trust's staff survey shows and improvement in staff perception of EDI compared with predecessor organisations and above average for its benchmark group.

4.6 **Co-operation and co-production** – on merger a number of Trust services had good track-records of working with communities to develop and deliver services through co-production and co-operation. The "Recovery Programme" designed to design post (continuing) Covid services has encouraged the use of full patient and staff co-production. For this to become fully embedded across the organisation there is clearly more to do.

Good data on ethnicity, socioeconomic status and demography lies at the heart of successful programmes on tackling inequality and there is certainly more work to do to improve on this – Covid, whilst awful in its impact, has, as a silver lining, helped to develop a renewed focus on this issue.

5.0 EU EXIT UPDATE

There have been some supply chain issues reported nationally and across the South West Region since 1st January 2021, however these have not been attributed to EU Exit and the Trust's provision of goods and services have not experienced any disruption.

Follow the end of transition across the Trust there have been no issues raised via the Incident Coordination Centre or via the dedicated EU Exit email account.

6.0 CONCLUSION AND RECOMMENDATIONS

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

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AGENDA ITEM: 10

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2022**

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

This paper provides an overview of a range of activity taking place across the Integrated Care System. This update includes;

Ongoing dialogue with the **Health Overview and Scrutiny Committee** took place on the 2nd March 2021 and sought support to extend the temporary service changes put in place associated with Covid. An extra-ordinary meeting is in place for the 22nd March to further consider the Fit for the Future proposals.

The Health and Well Being Board met on the 16th March with a focused agenda on health inequalities and the activities taking place across the county to take forward this complex and important agenda.

A number of service developments continue to happen across the county including the opening of Trevone House to provide semi-independent accommodation for vulnerable care leavers and the extension to a project to support vulnerable women.

The Integrated Locality Partnerships have now also re-commenced some of their activities and started to revisit their priority actions moving forward, taking into account the impact of COVID. The ICS Lead Officers report is available in the reading room for further information.

Risks associated with meeting the Trust's values **None**

Corporate considerations	
Quality Implications	None specific to the Trust
Resource Implications	None specific to the Trust
Equality Implications	None specific to this report

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

Appendices:	One Gloucestershire ICS Lead Officer 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 (ICS).

1. Health Overview and Scrutiny Committee (HOSC) Activities

Two HOSC meetings have taken place in March 2021. The first one supported proposals made by the Trust and Gloucester Hospitals NHS Foundation Trust (GHT) to extend the temporary service changes made in response to the Covid pandemic.

For the Trust, this has meant the continued closure of the Dilke and Vale Minor injury and illness units (MIIU) with the remainder operating on an 8am – 6pm opening hours. The MIIU and the theatre activity at Tewkesbury hospital is due to re-commence on the 1st April 2021. In addition, the system has requested that there is a continuation of the changes at the Vale Stroke Unit with all 20 beds being utilised for specialist stroke services until the end of June 2021.

An extra-ordinary meeting is due to take place on the 22nd March 2021 to undertake a detailed review of the Fit for the Future proposals following the conclusion of the public consultation in January 2021. The Decision Making Business Case is due to be considered by the GHT Trust Board and the Clinical Commissioning Group (CCG) Governing Body at their respective March meetings.

2. HEALTH AND WELL-BEING BOARD (HWB)

The HWB met on the 16th March 2021. The meeting received a presentation on the proposed changes contained within the *White Paper, Integration and Innovation, working together to improve health and social care for all*. There is a strong focus on the wider health and well-being agenda within the white paper in terms of understanding the needs of the population and the development of the strategic direction to tackle inequalities and therefore ongoing work will help shape our understanding as to the role the HWB will take moving forward with any ICS Health Partnership Board that may be created.

The meeting had a strong focus on our Health Inequalities agenda in light of the workshop planned for November being cancelled and how this work spans across the 7 priorities contained within the HWB Strategy. Despite the challenges of Covid, there have been a range of activities still continuing to focus on this complex area of strategic challenge.

The principal area of focus on health inequalities since January has been the COVID-19 Vaccinations Equity Programme. This work is being progressed by a multiagency group, chaired by Paul Roberts (Chief Executive of Gloucestershire Health and Care NHS Foundation Trust). The purpose is to support equitable uptake of COVID-19 vaccinations across the population of Gloucestershire; both

critical for helping to mitigate against COVID-19 related health inequalities and protecting the wider community from the virus. It was noted that a side benefit to this work has been the deepening of relationships across our communities and the development of community champions.

The HWB also received an update on the work that has been taken forward to develop our approach to Anchor Institutions (AI). The HWB previously recognised that Anchor Institutions can play a key part of its plan to address health inequalities, initially focusing on tackling health inequalities post-COVID-19 among BAME communities. The AI approach capitalises on the significant leverage of organisations such as local authorities, the NHS and educational institutions as employers, purchasers, land and asset owners and community leaders. Initial steps that have been taken forward include:

- Develop a set of principles to support a shared understanding among anchor institutions of what anchor institutions in Gloucestershire are, and what could be done to support the local economy
- Collate a baseline of current anchor institution activity in the county
- Develop an agreed way forward for building on this.

A set of draft principles for anchor institutions in Gloucestershire, which are being been developed in consultation with representatives from the relevant organisations were submitted to the HWB. The Trust has actively engaged with this initiative and will continue to support the work plan as it emerges.

3. WIDER ICS AND PARTNERSHIP UPDATES

3.1 **Semi-Independent Accommodation at Trevone House** – The project to develop Trevone House was approved in 2019 by Gloucestershire County Council (GCC) and the capital works have now been completed to transform a former nursing home into semi-independent accommodation units to enable vulnerable young care leavers approaching adulthood to learn the skills they need to live independently.

Previously the Council would have had to place young people who needed this type of accommodation outside of the county but there is evidence that these placements are not in the young person's best interests. Young people placed at a distance from home are likely to achieve poorer educational and other outcomes than those placed closer to their home. By bringing these placements in to the county, young people can keep strong links with their family and friends and achieve better outcomes.

3.2 The '**Vulnerable Women with Complex Needs'** project has been extended for a further 12 months. The aim of this work is to continue to support women who have experienced significant trauma to break the cycle and make sustainable, positive changes in their lives. It provides support for women who have experienced significant trauma in their lives, leading to issues such as homelessness, involvement in crime, sex working, drug and alcohol addiction, as well as difficulty in maintaining relationships and looking after their children.

Each woman is provided with a key worker who supports them practically and emotionally to address their individual issues, as well as supporting them with training and activities to increase their employment prospects. Support is provided through a variety of methods such as one to one support sessions, group sessions, access to personal care, health and laundry services, and a dedicated outreach service. Support is delivered by the Women's Centre of Gloucestershire based charity The Nelson Trust.

4. INTEGRATED LOCALITY PARTNERSHIPS (ILPS)

A number of the ILP's have once again suspended meetings, whilst others have continued to meet with a focus on core activities only due to the priority of rolling out the mass vaccination programme. The below table provides a brief outline of the key priorities across the ILP's and the current level of activity in light of Covid.

The Trust remains an active partner in all ILPs and is supporting projects as appropriate which are all at varying stages of progression.

Locality/Place	Priority	Suggested approach
Forest of Dean	Children and young people including poor mental health and obesity	Continue
Cheltenham (Peripheral)	Population Health Management (PHM) Development Programme cohort: Moderately frail cohort at rising risk of falls, excluding patients in Care Homes.	Continue
Cheltenham (Central)	PHM Development Programme cohort: Rising risk for high intensity users with 6 or more LTCs, living alone with anxiety or depression. – adult cohort, C&YP cohort	Continue
Cheltenham (St Pauls)	PHM Development Programme cohort: Housebound cohort with 5+ outpatient/acute contacts in prior 12 month, not EOL or palliative and from 20% most deprived postcode.	Pause
Cotswolds	Building better communities of support: Social isolation & Loneliness	Slower progress
Cotswolds	Building a better community of support - Healthy Lifestyles & Prevention priority.	Slower progress
Stroud & Berkeley Vale	Frailty and dementia including carers	Slower progress
Stroud & Berkeley Vale	Children and young people's mental health and wellbeing (including fitness)	Continue
Gloucester City	Respiratory education and link to housing	Continue
Gloucester City	High Intensity Users	Pause
Gloucester City	Connecting up our services	Continue

Gloucester City	Children and young people's mental wellbeing	Pause
Gloucester City	Health Equalities	Slower progress
Tewkesbury	Healthy Lifestyles & Prevention	Continue
Tewkesbury	Social isolation & Loneliness	Continue
Tewkesbury	Mental Health	Continue
Tewkesbury	Employment & Financial Stability	Continue

5. PATIENT AND CARER FEEDBACK AND ENGAGEMENT

Healthwatch Gloucestershire have published their findings from a patient survey on improving access to Gloucestershire GPs. The focus of the survey was how accessible information was in regard to primary care, particularly the practice websites and how easy it was to make an appointment. It also looked at people's thoughts around the use of telephone/remote appointments which as one may expect, resulted in a mixed response. The report has been shared with the Clinical Commissioning Group to consider the recommendations.

6. ICS LEAD OFFICER REPORT

The ICS Lead Officers report provides an update on the clinical programme activities and is available to Board Members in the reading room.

Angela Potter
Director of Strategy & Partnerships

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AGENDA ITEM: 11

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

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

AUTHOR: Lisa Proctor, Associate Director of Contracts & Planning

SUBJECT: **BUSINESS PLANNING OBJECTIVES FOR 2021/2022**

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

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

The purpose of this report is to:

This report sets out the Trust Annual Business Planning process for 2021/22 and the proposed Business Planning Objectives for operational and corporate teams. There are a total of 173 objectives which are listed in Appendix 1 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 known key deliverables identified in the National Planning guidance for 2021/22 quarter 1.

This report sets out the business planning process that was launched in December to support Directorates and Teams in developing their business planning objectives for 2021/22. The business plan is key to the delivery of the Trust Strategy and the business planning structure has been updated and underpinned by our four strategic aims.

This paper also sets out the known and emerging national and local priorities that have informed the business planning objectives. Further National Planning

Guidance is expected in April that will set out the planning requirements for the remainder of the year.

A business planning refresh is proposed at the 6-month mid-point to allow for further national guidance and in-year changes.

Risks associated with meeting the Trust's values

The key risks to delivering the Business Plan for 2021/22 are identified as follows:

Continued Impact of Covid: The business planning objectives have been developed while we are still going through a major health pandemic. The impact of a repeat of Covid waves on our recovery and refocus and the delivery of new objectives is unknown.

Impact of System Prioritisation on Investments: At the time of writing the financial settlement for 2021/22 is not yet known and the financial regime is expected to change later in the year. There are key investment opportunities awaiting the outcome of system prioritisation.

Impact of emerging enabling strategies: There is a risk that the business plan will not fully reflect the requirements for the Trust Strategy due the enabling strategies being developed after the business planning objectives have been agreed.

Corporate considerations	
Quality Implications	Identified within the report
Resource Implications	Identified within the report
Equality Implications	No equality implications identified

Where has this issue been discussed before?

The Business Planning process has been presented to the Resources Committee in December 2020, the Executive Team in January 2021 and the Council of Governors in March 2021.

Appendices:	Appendix 1 – Table of Business Planning Objectives

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

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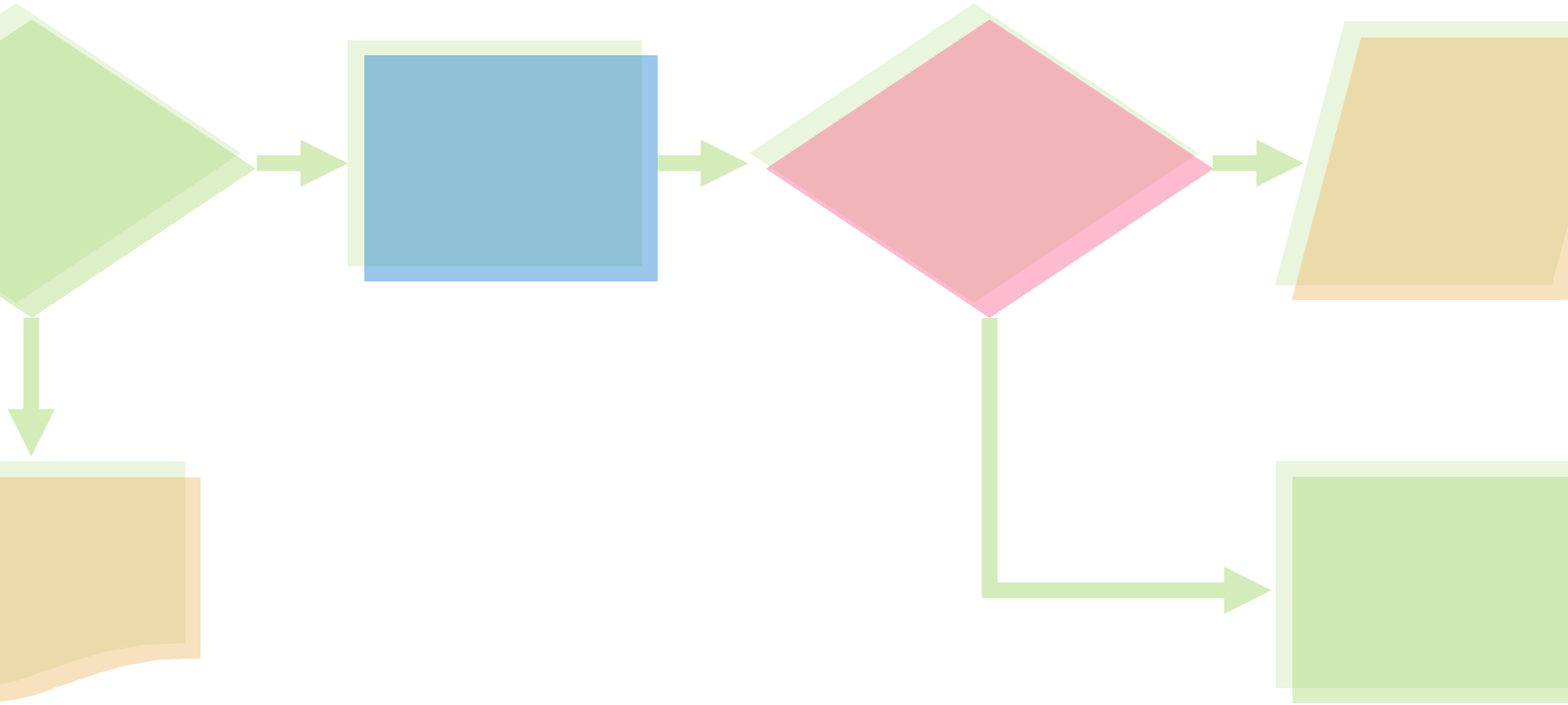
Annual Business Plan 2021-22



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

Contents

1. Introduction

This business planning report sets out the planning process for 2021/22 including the approach to planning, timescales, risks and a short summary of key objectives. The full list of business planning objectives is included in Appendix 1.

2. Background and context

2.1 The business plan is key to the delivery of the Trust Strategy. The planning structure for 2021/22 has been updated and is now underpinned by our four strategic aims. Each business planning objective has a clear link to one of the strategic aims to ensure everything we do contributes to achieving our vision. The business plan will also have links to the emerging enabling strategies that support the long term delivery of the Trust Strategy.

The business planning online tool has been developed around this structure and will show the balance of activity at directorate, team and organisational level. This will more easily identify any gaps in planning or where there is too much focus in only one area. The online tool will also monitor progress and more easily identify risks in delivery. It also enables business plans to be 'live' to allow in-year updates from local and national policy changes.

2.2 The business plan is normally informed by national and local agreed priorities as part of the annual planning cycle. At present, national planning guidance for 2021/22 focusses on the response to Covid and recovery during the first quarter of the year. Fuller planning guidance is expected shortly which will set out the key priorities for the whole year including the requirements for a wider system planning submission anticipated in April. This also means Operational Planning and Contract Management processes are delayed for 2021/22. In the meantime, the business plan has been developed based on the available planning information determined by the following key requirements:

- Trust Strategic Aims
- Organisational requirements
- NHSE/I planning process (Covid response and recovery)
- Integrated Care System (ICS) Delivery Plans including NHS Long Term Plan ambitions
- Quality Goals
- Quality Improvement
- Cost pressures and budgetary framework

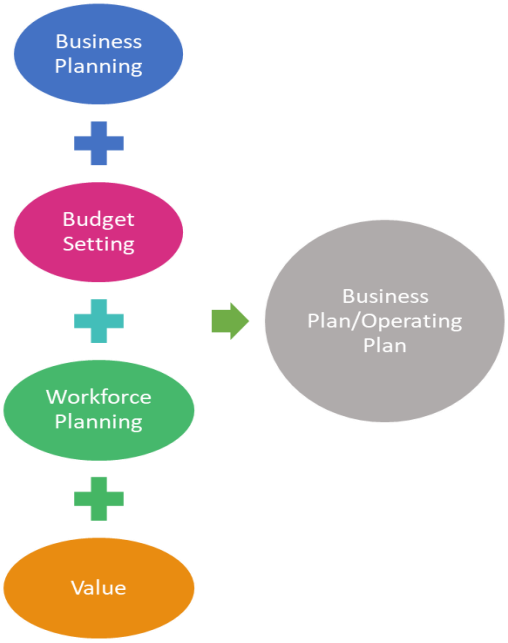
2.3 It is important to acknowledge that the business planning objectives for 2021/22 have been developed at a time when a significant number of our current business planning milestones have not been met and services have been scaled back in response to Wave 1 and Wave 3 of the Covid pandemic. As the year progresses we will become more aware of the impact of long Covid and the increases in demand, waiting times and potential access problems resulting from a backlog in referrals or increased prevalence. While we monitor this impact throughout the year, we will continue to learn from the changes made and embed these throughout our internal process of recovery and refocus:

- Individual Recovery—putting our people first
- Service & Team Recovery—getting back to business as usual (BAU)
- Refocus on our aims and on our transformation—why we merged and re-energising our ambitions

3. Business Planning Approach 2021/22

3.1 Our business planning approach for 2021/22 was launched against the backdrop of a major health pandemic when national planning guidance has focussed on our national Covid response. As a result our business planning approach was slightly delayed but we have continued to develop our plans in alignment with our internal annual business planning cycle. We will continue to review and learn from the changes made during Covid and will introduce a business planning refresh at the 6 month mid-point to ensure business plans remain up to date and relevant.

3.2 The Trust's internal planning approach is aligned with budget setting, workforce planning and contract management processes to form a coordinated annual planning cycle. This brings together our 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.

This coordinated planning approach is also aligned with the ICS planning stages which ensures the business plan is linked to the wider system prioritisation.

4. Planning Stages

4.1 The business planning objectives have been developed with directorates and teams for delivery during the 12 month period from April 2021 to March 2022. The business plans were developed in three stages as follows:

Stage 1:

* The business planning process was launched with the issuing of the Business Planning structure and updated Business Planning template.
* National and local priorities were highlighted including those aligned with ICS system planning.
* Clear links and cross referencing were made during Budget setting and Cost Improvement Plan conversations with business planning leads to ensure the objectives are affordable.

Stage 2:

* One-to-one meetings with managers were offered to business plan 'owners' to discuss their business planning SMART objectives.
* Further national and local priorities were shared as they emerged.
* Draft business planning objectives were developed during February 2021.

Stage 3:

* Feedback was sought from the Council of Governors to refine the business plan process
* The business planning objectives were cross referenced with our Trust Strategy, capital schemes, service and workforce developments, cost pressures and system priorities.
* The final business planning objectives were reviewed and agreed by Senior Managers.

5. Business Planning Timeline

5.1 The Trust's internal planning timescales have been condensed to align with the capacity of Trust colleagues in developing their business plans and the delay in national planning guidance. This has meant the time available for cross referencing business planning objectives has been shortened. However, the business plans have been developed to achieve our original timescale of the end of March.

5.2 The business planning process for 20/21 was launched in December 2019. The timetable for completion was as follows:

● December	Executive Directors set their key priorities
● January	External planning guidance applied
	Alignment with coordinated internal planning including budget setting
● February	Plans drafted
● March	Executive review of plans
	Feedback from Council of Governors
	Board oversight

The business planning approach was presented at the Resources Committee in December, the Executive Team in January and the Council of Governors in March to ensure appropriate oversight of the business planning process and timelines.

5.3 As a next step, a business planning refresh will be introduced at the end of quarter 2 to update business planning objectives and reset milestones to reflect any national policy changes or new local requirements as necessary.

6. Interim Planning Guidance 2021/22

6.1 Known key policy changes that impact our business plans for 2021/22 are as follows:

● **National Priorities for 2021/22 Quarter 1:** in December 2020, NHSEI set out the interim planning guidance for the first quarter of 2021/22. This included the following summary of the role of community and mental health service providers working with ICS partners:

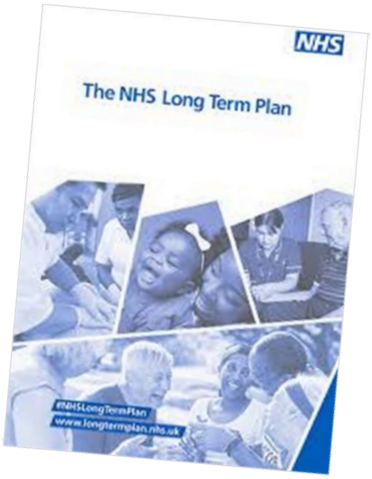
- **Recovery of non-COVID services**
- Strengthen delivery of local **People Plans** and make ongoing improvements on equality, diversity and inclusion, growing the workforce, designing new ways of working and delivering care, and supporting staff health and wellbeing.
- Address the **health inequalities** that Covid has exposed, as well as reduce variation in outcomes including reducing inequalities for those with learning disabilities and mental illness.
- Accelerate the planned expansion in **mental health services** through delivery of the Mental Health Investment Standard together with tackling the surge in mental health cases. This should include enhanced crisis response and continuing work to minimise out of area placements.
- Deal with the backlog and likely increase **in primary and community care** for people with ongoing health conditions and supporting prevention through vaccinations and immunisations.
- Build on the development of **effective partnership working at place and system** level.
- The priorities should be supported by the use of **data and digital technologies**,

6. Interim Planning Guidance 2021/22 (contd)

- **NHS Standard Contract:** The NHS Standard Contract for 2021/22 was published on the 22nd March 2021. The requirements that impact community and mental health providers are:

* Support Primary Care to deliver new service specifications for Enhanced Care in Care Homes
* Offer choice between remote consultations and a face to face consultation
* Requirement for designated infection control and prevention lead at Board level.
* A new Health Inequalities Action Plan Schedule
* Strengthened Green NHS Service Conditions including Board Lead,
* New Workforce requirements in line with the NHS People Plan including: use of workforce sharing toolkit, Violence prevention and reduction standard General Condition, a five-year action plan setting out how it will ensure that the level of black, 5 Year Asian and minority ethnic representation plan re Board and Senior Workforce, provision of Core Skills Training Framework. These are also linked to the Best People Strategy.
* Support the expansion of additional roles in primary care for Mental Health First Contact Practitioners

- **The Long Term Plan: LTP Delivery:** The key priority areas for the Trust in continuing to deliver the 2021/22 elements of the NHS Long Term Plan commitments are:



* Integration of primary medical and community services
* Digital Transformation
* Workforce Development - NHS People Plan
* Reducing health inequalities
* Mental Health investment and deliverables (also linked to the Mental Health Implementation Plan 2019-2024).

This also drives the Mental Health performance trajectories that were rebased in 2020/21 to take account of the impact of Covid. A further rebasing is anticipated for 2021/22 to ensure realistic projections are made against increasing performance trajectories. These include:

* Increase IAPT- increased access and decrease in-treatment pathway waits
* Increase Availability of IAPT Long Term Condition pathways
* Reduced waiting times for eating disorders
* Reduced 4 week wait for childrens and young peoples services
* Increase Perinatal Mental Health
* Increase Number of people accessing individual placement and support
* Eliminate out of area inpatient placements for acute care (Mental Health)
* Physical health checks for people with a Serious mental illness
* Reduce reliance on inpatient care for people with a learning disability and/or autism

The majority of these key areas benefitted from transformation funding or Mental Health Investment Standard investment (MHIS) in 2020/21. The MHIS will continue to be funded from quarter 1. Agreeing the spend is a priority to achieve the increasing trajectories for 2021/22.

- **Local/System Priorities**

The recent **White Paper: Integration and Innovation: Working together, to improve health & social care for all,** supports us to build on our already strong ICS and developments in 'place based care' as we go forward as one of seven test sites for the ICS implementation programme.

6. Interim Planning Guidance 2021/22 (contd)

Our Trust business planning process is aligned to the ICS planning process and system prioritisation and supports our partnership working.

There are no national requirements for system planning currently nonetheless the following items are some of the local priorities considered as part of our business planning for 2021/22:

- **System Prioritisation:** services that have been funded non-recurrently or developed in response to Covid and will require further long term investment include:
    - Home First model of care has been expanded and informs the system wide flow planning work in partnership with the Emergency Care Integrated Support Team
    - Complex Care at Home Vulnerable People Virtual Hub has been introduced in response to Covid and may be rolled out in the system subject to funding.
    - Stroud & Berkeley Vale Dementia pilot will be evaluated and may also be rolled out in the system subject to funding
    - Cirencester Phlebotomy Service was transferred to our Trust in part in October 2020 – the investment proposal to be confirmed

- **Additional funding opportunities:** the following includes some of the known central investments opportunities:
    - Mental Health Community Service transformation funding – linked to the Gloucester City Service Development including a focus on personality disorder services and developing the role of first contact mental health practitioners
    - Ageing Well System Development Funding to support urgent community response for crisis and reablement
    - Winter pressures funding linked to improvements in patient flow in and out of hospital care
    - Mental Health Discharge Funding Allocation (Non Recurrent) to support a range of discharge initiatives
    - Long Covid investment in supporting local triage services and the impact on long term conditions pathways
    - Rapid Response expansion using digital referral system to reduce A&E attendances
    - Elective waiting list funding priorities including where waiting lists have developed during Covid or demand is expected to increase eg eating disorders, memory assessment service, IAPT, autism and Childrens and Young Peoples Services.

Further planning is required to identify all local schemes requiring investment beyond quarter 1. This will be supported alongside our business planning objectives and quarter 1 milestones.

7. Business Planning Objectives

7.1 Key highlights from the business planning objectives for 2021/22 are as follows: (the complete list of business planning objectives is included in Appendix 1)

Organisational Resilience

- Ensure Trust compliance with NHS Core Standard for Business Continuity Planning training, exercising and validation for all services and teams. Align all plans with directorate and corporate Emergency Response Guides for all sites.
- Maintain annual plan for all operational pressured periods (bank holidays, school holidays and winter pressures) in line with Operational Pressures Escalation Level (OPEL) actions.

7. Business Planning Objectives (contd)

Adult Community Services:

- Continue to work closely within the Primary Care Networks over the coming year on joint initiatives based on local need informed by population health management
- A key priority for community teams in 20/21 is to extend the impact of the ICTs on people's ability to live well in their homes by implementing of an improved community offer of reablement/ rehabilitation. This proposed new integrated Home First and therapy led reablement model seeks to improve system flow out of hospital, maintain people at home and improve health outcomes.
- Undertake a comprehensive review of the Speech and Language Therapy Service with system partners. with well defined and achievable KPI's
- Engage and contribute to ICS Equipment and Technology review to ensure better outcomes for patients and best value

Hospitals:

- Continue to play an active role in the SW Collaborative redesign of community forensic services in Gloucestershire to improve the flow between PICU and low/medium secure facilities.
- Co-produce and implement a service design and workforce plan to deliver an assessment and treatment model to improve clinical outcomes for people with a learning disability
- Work with system partners to redesign the recovery/rehabilitation pathway for mental health that improves local services and avoids the need for out of county placements.
- Continue to review and ensure multi-disciplinary staffing models on inpatient wards are safe, sustainable and resilient and embed best practice in ward processes.

Childrens and Young Peoples Services:

- Provide a targeted response regarding specific areas of health inequalities including Adverse Childhood Experiences (ACEs), healthy lifestyles, health promotion including emotional resilience, obesity, immunisations promotion to enhance experience and clinical outcomes
- Review our school age immunisations service ahead of the anticipated tender. The review will explore the current IT clinical system and develop a clear health inequalities pathway and engagement strategy for all parts of the community.
- Continue to deliver Phase 2 of the nationally supported CAMHS Transformation Plan to implement new ways of working across 5 key areas of focus: Multi Agency Front Door, New Operating Model, Workforce, Digital & IT, Communication & Engagement. We will also explore options for self referrals, closer integration of our CAMHS services working with schools and improving the reach of our CAMHS service for people with a learning disability.

Adult Mental Health and Learning Disability Services:

- Develop a blended approach of delivering Step 3 treatment in IAPT between digital and face to face through a test and learn pilot and build on the learning from our Covid response.
- Work with PCN partners to agree a three year workforce and delivery plan for the new Mental Health First Contact Practitioner roles as part of the Additional Roles Reimbursement programme to increase capacity in primary care.
- Continue to support the development of a new integrated model for the Community Mental Health Transformation programme in the Gloucestershire City locality.
- Review changes in demand and capacity for our eating disorders service and develop a new service model to improve waiting times and explore alternative methods of provision eg digital.

Urgent Care and Specialty Services:

- Review our Community Urgent Care service in MIIUs with our system partners to ensure we offer a streamlined and efficient urgent care provision across the county building on the learning and response to Covid.

7. Business Planning Objectives (contd)

Urgent Care and Specialty Services (contd):

- Extend the access times of the First Point of Contact Centre to support the Long Term Plan ambitions in offering a 2 hour crisis response out of hours also linking with NHS 111.
- Extend the Rapid Response Service offer to support patients with increased acuity at home including the phase 2 initiation of diagnostics (ECG, Point of Care Testing) and equipment.
- Continue to work with the commissioners to develop and introduce an intravenous sedation offer for special care dental services in line with clinical best practice
- Explore the potential for strong partnership working in the transformation and delivery of extended SARC services in preparation for the impending tender.
- Continue to redesign our service capacity and capability to deliver new treatments and pathways including HIV to improve patient and public health outcomes.

7.2 In addition to our clinical and operational plans, our corporate services plans are aligned to support the programmes of work across the organisation including the following key highlights:

Communications

- Increase our engagement through social media to support the wider dissemination of messages about our services, promoting inclusion, sources of support and self help advice for communities to stay safe, healthy and well.
- Streamline our internal communications to ensure our workforce feels well informed and up to date on the information and guidance they need to carry out their role

Corporate Governance

- Support the Gloucestershire Information Governance Group, which includes JUYI, providing advice, expertise and guidance and work collaboratively with ICS partners to overcome IG issues.
- Develop and deploy a robust Trust wide Security Audit tool to provide reports detailing security risks across the Trust and ensure the Trust complies with the Violence Prevention and Reduction Standards.

Medical

- Continue to work towards ‘university status’ along with our Gloucestershire health and education partners
- Explore the development of an innovation hub where colleagues can come together to champion change and new ways of working and ensure we work together towards better care outcomes.

Nursing, Therapies & Quality

- Embed learning assurance initiatives across the organisation alongside National Patient Safety Strategy aims to ensure we continuously improve patient safety, quality and experience
- Design and deliver our quality framework to promote clinical effectiveness, safety and good experiences, utilising patient feedback to continuously develop our services in line with best practice, evidence and emerging innovations.

Strategy & Partnerships

- We will launch the Partnership Hub, aligning to place based localities and working alongside service development at a system level linked to specific locality based programmes of work including links to Experts by Experience, Voluntary and Community Sector and local communities.
- Assemble a network of Green Champions across the Trust and promote environmental and sustainability awareness in line with our Trust Strategy.

7. Business Planning Objectives (contd)

IT & Clinical Systems

- Complete a full Clinical Systems review including user engagement and feedback to inform our future clinical systems plan including the scoping of potential new systems for dental, sexual health and School Age Immunisation service.
- Work with system partners to explore options to provide a fit for purpose Wide Area Network (WAN) going forward to enable the improvements to be made across the county resource.

Estates, Facilities & Medical Equipment

- Finalise plans to support our aspiration for the Forest of Dean in developing a fit for purpose new hospital in Cinderford to open in 2023.
- Develop a controlled and documented approach to delivering the Backlog Maintenance programme to ensure our estate continues to provide a good quality environment.

Operational Finance

- Embed our new finance system to enable efficient and effective use of new single accounting system across the Trust.
- Develop finance training for system users and budget holders to aid understanding and stewardship of our financial management

Business Intelligence

- Develop and maintain the data warehousing infrastructure and technical solutions to ensure robust and reliable Business Intelligence and introduce new data sources into data warehouse and further develop existing flows in line with our Trust strategy
- Further develop our BI reporting to ensure efficient use of information, integrate information for cohesive insight to inform decision making including supporting population health management

Contracts and Planning

- Upgrade and integrate both physical and mental health Patient Level Costing (PLICS) models to present patient pathway costing information to better understand the drivers for clinical costs.
- Continue to improve our approach in the procurement of goods and services and work with system partners to scope further opportunities for system level working.

HR & Organisational Development

- We will agree our Recruitment and Retention Strategy & implementation plan to mitigate against current challenges and deliver the requirements of the NHS People Plan and the proposed Trust People Strategy
- Provide three Stepping Up programmes, specifically aimed at supporting the development needs of BAME and LGBTQ+ staff, and those with a disability.
- Help ensure a competent, compassionate and safe workforce through continued provision of a range of high quality educational, learning and development activity
- Improve accountability for monitoring e-rostering across all workforce groups to support workforce planning.

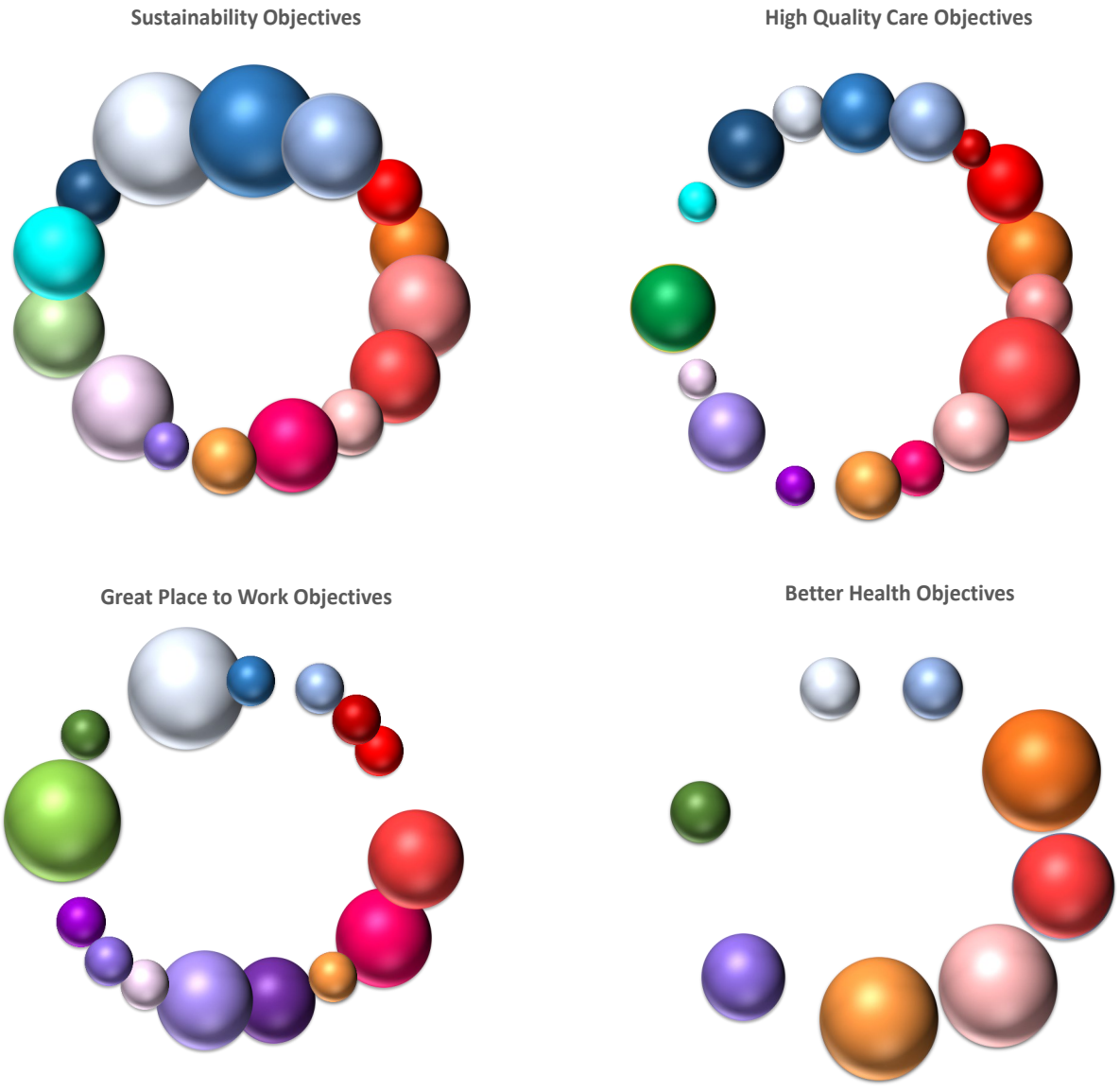
Working Well

- Creation of a Health and Wellbeing Strategy and implementation plan building on staff engagement, feedback from Annual Staff Survey, Pulse Survey, Health and Wellbeing Needs Assessment and the number of staff accessing health and wellbeing support
- Offer occupational health/health and wellbeing leadership to support workforce recovery as a result of the Covid pandemic

8. Business Planning Outcomes 2021/22

8.1 The full business plan for 2021/22 includes 173 objectives and demonstrates an ambitious level of delivery. To mitigate the risk of under resourcing our plan, objectives may be ranked in 'order of importance' to enable the support required to be phased across the year. The ranking will be completed by mid April 2021.

8.2 One of the key aims for the business planning process is to demonstrate a preferred balance of objectives across our strategic aims. The bubble diagram below shows the balance of business planning objectives for each team/directorate for each of our four strategic aims. 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.)



(see 8.4 for key to identify teams)

8.3 The diagram shows some teams focus more on one theme than another. Better Health has the least objectives currently and we will explore this aim in more detail during the business planning refresh as we are better able to work in partnership and learn more from population health management. We recognise this strategic aim is not something we can achieve alone.

8.4 The table below shows the key for identifying teams in the previous bubble diagram.

Key	Team
	Business Intelligence
	Contracts & Planning
	Estates, Facilities & Medical Equipment
	Information Technology & Clinical Systems
	Finance
	Corporate Governance
	Nursing, Therapies & Quality
	Communications
	Adult Community Services
	Adult MH & LD Community
	Childrens & Young People's Service
	Hospitals
	Medical Team
	Organisational Resilience
	Strategy & Partnerships
	Urgent Care & Specialty Services
	Workforce Systems & Planning
	Working Well
	Recruitment & Retention
	Organisation Development / Learning & Development
	HR Operations

8.5 The complete list of business planning objectives are included in Appendix 1. Please note: this does not include the full details of each objective, for ease of reading.

9. Business Planning Forecast Delivery 2020/21

9.1 Teams were asked to provide a forecast for the delivery of their 2020/21 business planning objectives. There were 118 objectives at the beginning of 2020/21. Performance was monitored throughout the year by an online self assessment of progress via the business planning website.

9.2 The results below reflect the self assessment forecast for 2020/21. A small number of plans were not scored and these were removed from the results table. Where objectives were pending a score, these were included as Red.

Themes*:	Red	Amber	Green
Co-design	31%	16%	53%
Experience	21%	13%	67%
Quality	24%	27%	49%
Sustainability	35%	5%	59%
Total	**27%**	**18%**	**55%**

*previous business planning themes now superseded.

9.3 Our ability to deliver the business plan during a major pandemic was highlighted as a significant risk at the start of the year. The results show that just over a quarter of the business plan will not be achieved. For objectives that remain a priority, these have been carried forward to our 2021/22 business plan.

9.4 The results also show that despite the unprecedented challenges this year over half the business planning objectives are expected to be delivered by the end of March 2021.

10. Business Planning Risks 2021/22

10.1 The key risks to delivering the Business Plan for 2021/22 are identified as follows:

Risk: L likelihood, I impact, R risk rating	L	I	R	R
Continued Impact of Covid: The business planning objectives have been developed while we are still going through a major health pandemic. The impact of a repeat of Covid waves on our recovery and refocus and the delivery of new objectives is unknown. A business planning refresh of objectives will be required during quarter 2 which will include an assessment of the long term impact of Covid on our priorities and the resources required for delivery throughout the year.	3	4	12	●
Impact of System Prioritisation on Investments: At the time of writing the financial settlement for 2021/22 is not yet known and the financial regime is expected to change later in the year. There are key investment opportunities awaiting the outcome of system prioritisation. We will use the business planning refresh to rebalance the business plan and assess the affordability of our objectives. Any unfunded objectives will be removed or an alternative delivery method will be explored.	3	3	9	●
Impact of emerging enabling strategies: There is a risk that the business plan will not fully reflect the requirements for the Trust Strategy due the enabling strategies being developed after the business planning objectives have been agreed. The business plan will be cross referenced against the enabling strategies as they emerge and the business planning objectives will be adjusted during the business planning refresh to reflect any additional key requirements .	4	2	8	●
● Low Risk ● Moderate Risk ● Significant Risk ● High Risk				

10.2 The introduction of a business planning refresh at the end of quarter 2 is key to mitigating the identified risks. Feedback from the **Council of Governors** also endorsed the need for a refresh and welcomed the introduction of this secondary business planning stage.

11. Recommendations

The Board is asked to:

- approve the business planning objectives
- note the proposed refresh of objectives during quarter 2.

Team	Directorate	Description of Objective
Adult Community Services	Operations	To continue to work closely within the Primary Care Networks over the coming year on joint initiatives based on local need
Adult Community Services	Operations	Develop the Home First / Therapy Led Re-ablement model across the Integrated Community Teams (ICTs)
Adult Community Services	Operations	Undertake a comprehensive review of the Speech and Language Therapy Service with system partners
Adult Community Services	Operations	Adopt a health coaching approach ethos across all services.
Adult Community Services	Operations	To support staff to regroup and recover following the COVID pandemic, and enable them to improve their health and wellbeing
Adult Community Services	Operations	Managers and staff in the Adult Community Directorate's services connect and reconnect with each other in order to reduce duplication and increase efficiency
Adult Community Services	Operations	To Improve access to services and reduce duplication by developing an ICT public facing offer and an MSK Hub.
Adult Community Services	Operations	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.
Adult Community Services	Operations	Engage and contribute to ICS Equipment and Technology review to ensure better outcomes for patients and best value for money.
Adult Community Services	Operations	Undertake a review and restructuring of the Integrated Community Teams leadership
Adult MH & LD Community	Operations	The Service will agree a new model of care for Supported Accommodation, with commissioning and funding of placements moving to Gloucestershire County Council (GCC) and Placement review function remaining in Gloucestershire Health & Care (GHC).
Adult MH & LD Community	Operations	The service will complete a review with detailed demand and capacity mapping with agreement and plan for implementation of new service model by end of Financial year
Adult MH & LD Community	Operations	Development of revised Community Mental Health Team (CMHT) as part of transformation programme in partnership with local partners and communities.
Adult MH & LD Community	Operations	Review of Learning Disabilities Services to agree sustainable model
Adult MH & LD Community	Operations	Service will be expanding in line with Long Term Plan (LTP) investments and will implement Maternal Mental Health (MH) Trauma service with this becoming Business As Usual (BAU) by year end.
Adult MH & LD Community	Operations	Develop a blended approach of delivering Step 3 treatment in Improving Access to Psychological Therapies (IAPT) between digital and face to face. Test and learn through a pilot to identify the distribution of face to face and digital options (i.e. 50/50). This will need to be clinically led and run alongside Covid secure environment work and recovery plans.
Adult MH & LD Community	Operations	Primary Mental Health is in scope as part of the community mental health transformation. The configuration of community mental health services and the interface between primary and secondary care is being explored to develop place based models of care.
Adult MH & LD Community	Operations	Revised community dementia and memory assessment service model with distinct primary and secondary care delivery
Adult MH & LD Community	Operations	Agree three year plan for rollout of Mental Health First Contact Practitioner roles in Primary Care Networks.
Adult MH & LD Community	Operations	The Service will review funding arrangements for psychiatric inpatient provision with commissioners and implement a more sustainable and resilient service delivery model.
Adult MH & LD Community	Operations	Work with Estates to develop an estates strategy in IAPT which supports the model of growth outlined within the long-term plan. Estates strategy to focus on office space for increasing workforce and clinic space for delivery of Step 3 treatment - both digital and face to face.
Adult MH & LD Community	Operations	Develop a 2 year workforce plan for IAPT against the long-term plan ambitions.
Business Intelligence	Finance	To maintain an efficient data warehouse that maximises data quality and raises analytical productivity by the end of Q4
Business Intelligence	Finance	To conclude legacy reporting requirements by the end of Q4
Business Intelligence	Finance	To develop next level Business Intelligence (BI) reporting needs and integrate information for cohesive insight by the end of Q4
Business Intelligence	Finance	To further develop our established BI reporting and ensure efficient use of information to inform decision making by the end of Q3
Business Intelligence	Finance	To develop the data warehousing infrastructure and technical solutions to ensure robust and reliable BI by the end of Q2

Team	Directorate	Description of Objective
Business Intelligence	Finance	To introduce new data sources into data warehouse and further develop existing flows in line with Trust strategy by the end of Q4
Children's & Young People's Service	Operations	Transfer the Permanency (Adoption) Medical Team to integrate with our Children's & Young People's Service (CYPS) Physical Health (PH) Children in Care Team to ensure improved clinical care.
Children's & Young People's Service	Operations	As a Public Health Nursing initiative, provide a targeted response regarding specific areas of health inequalities to improve access to services, enhanced service experience as well as clinical based outcomes for children, young people and their families. This may include Adverse Childhood Experiences (ACEs), healthy lifestyles, health promotion including emotional resilience, obesity, immunisations promotion.
Children's & Young People's Service	Operations	To produce and submit two business cases to Commissioners to secure additional clinical capacity to meet identified commissioned gaps in current service provision that is leading to poorer health outcomes or service experience for our children and young people
Children's & Young People's Service	Operations	CAMHS Learning Disabilities (LD) will implement a number of initiatives over 2021/22 targeting Under 18's to promote the benefits of signing up to be included on Glos LD Register and be part of the Annual Health Check
Children's & Young People's Service	Operations	Build Back Better aligns with Covid Recovery Plans and Phase 2 of the nationally supported Children & Adolescent Mental Health Services (CAMHS) Transformation Plan and aims to implement new ways of working across CAMHS based on 5 areas of focus: Multi Agency Front Door, New Operating Model, Workforce, Digital & IT, Communication & Engagement
Children's & Young People's Service	Operations	Developing self-referral pathways is a key outcome within CAMHS Service Transformation and Mental Health Support Team (MHST) service development. During 2021/22, to complete feasibility work (including piloting initiatives and participation based work) to understand how self-referral processes should be rolled out for Gloucestershire's children and young people.
Children's & Young People's Service	Operations	Map CAMHS options and complete risk/benefit analysis for closer alignment of separate mental health based provision to schools (MHST & Primary Mental Health Workers (PMHW))
Children's & Young People's Service	Operations	Develop an engagement strategy that would collate meaningful feedback around new ways of working/adjusted service delivery across Children's & Young People's Service (CYPS) such as use of Attend Anywhere, use of PPE, 15 Steps, what is experience of new access routes into CAMHS
Children's & Young People's Service	Operations	Design a clinically resilient system, develop a clear health inequalities pathway and an engagement strategy for all parts of the community in preparation of the anticipated school age immunisation tender.
Children's & Young People's Service	Operations	Develop and embed an integrated system for meeting commissioned expectations of statutory requirement for Special Educational Needs & Disability (SEND) data submission on a quarterly basis
Communications	Communications	An increase in engagement, month on month on our social media channels
Communications	Communications	Ensure at least one weekly internal newsletter is published each week and maintain Trust intranet so content is timely, accurate and accessible to all colleagues.
Contracts & Planning	Finance	Work with Integrated Care System (ICS) partners to lead and support the Patient Level Costing programme to overcome data sharing issues and move forward to better understand the drivers for clinical costs.
Contracts & Planning	Finance	Update the contracts & planning intranet site to enable the team and service leads and other customers of the team to access important documents and guides more easily
Contracts & Planning	Finance	Make improvements to business planning tool to be more dynamic and user-friendly following engagement with users
Contracts & Planning	Finance	Develop and update the Gloucestershire Hospitals Foundation Trust (GHFT) and Clinical Commissioning Group (CCG) Income Contracts and review expenditure to ensure costs are within budget envelope.
Contracts & Planning	Finance	Co-ordinate and support the tender development programme of work for the SARC service, including Sexual Offences Examination (SOE)
Contracts & Planning	Finance	Support colleagues to co-ordinate the design stage of the tender development programme of work in preparation for the School Aged Immunisation commissioning intentions

Team	Directorate	Description of Objective
Contracts & Planning	Finance	Complete robust financial modelling to support the business case for the new Community Hospital in the Forest of Dean to comply with NHS England (NHSE) green book requirements
Contracts & Planning	Finance	Transfer Mental Health Patient Level Information Costing System (PLICS) data to CostMaster Costing Transformation Program (CTP) from Classic, and integrate both physical and MH models
Contracts & Planning	Finance	Continue to improve our approach in the procurement of goods and services and work with system partners to scope further opportunities for system level working.
Contracts & Planning	Finance	Complete review of clinical sub-contracts to ensure delivery is in line with commissioned services and align associated income and costs
Contracts & Planning	Finance	Update our process for the payment of treatment received by overseas patients in line with national guidance
Corporate Governance	Corporate Governance	Develop and deploy a Trust wide Security Audit tool
Corporate Governance	Corporate Governance	Ensure compliance with Violence and Aggression Risk Assessment standards
Corporate Governance	Corporate Governance	Ensure compliance with Lone Working Risk Assessment standardisation
Corporate Governance	Corporate Governance	Ensure Violence Prevention and Reduction Standards are met
Corporate Governance	Corporate Governance	Provide accredited mandatory Supervising Safety training to allow team managers to fulfil their obligations under Health & Safety law.
Corporate Governance	Corporate Governance	Provide accredited mandatory Supervising Safety training to allow team managers to fulfil their obligations under Health & Safety law.
Corporate Governance	Corporate Governance	Provide appropriate representation at the ICS Gloucestershire Information Governance (IG) Group, which includes Joining Up Your Information (JUYI), providing advice, expertise, guidance to ensure Trust perspective to the Information Governance agenda and practices in the ICS.
Corporate Governance	Corporate Governance	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.
Corporate Governance	Corporate Governance	Provide a Data Protection Officer and data protection advice and guidance to the Trust Board, the Trust Senior Managers along with the wider staff and patient groups.
Corporate Governance	Corporate Governance	Embed risk management oversight arrangements within each directorate
Estates, Facilities & Medical Equipment	Finance	Assess and implement appropriate learning from the Food Panel review.
Estates, Facilities & Medical Equipment	Finance	Assess and implement agreed lessons learnt from the covid pandemic and provide appropriate support to staff "returning" to the physical environment
Estates, Facilities & Medical Equipment	Finance	Transform the "moves" function into an end to end "Space Management" service and deliver a cost effective, professional service to all colleagues
Estates, Facilities & Medical Equipment	Finance	Enrich the roles of the internal workforce by targeted, cost effective insourcing of current outsourced duties
Estates, Facilities & Medical Equipment	Finance	Ensure all "customers" have clear pathways to raise requests, concerns, issues & compliments with the department through a combination of Building User Group meetings, Locality leads and more formal management processes
Estates, Facilities & Medical Equipment	Finance	Implement the Microfibre mopping system across all Trust sites
Estates, Facilities & Medical Equipment	Finance	Implement the MICAD work management system, helpdesk, reporting and associated modules to enable efficient performance management and "self-service" for customers
Estates, Facilities & Medical Equipment	Finance	Develop an action plan to implement the Estates Strategy and then deliver against agreed milestones / objectives
Estates, Facilities & Medical Equipment	Finance	Progress the Medical Devices service both in terms of visibility and in terms of value add, including development of a long term plan.
Estates, Facilities & Medical Equipment	Finance	Progress the development of the Forest of Dean Community Hospital in line with (to be agreed) milestone plan and budget
Estates, Facilities & Medical Equipment	Finance	Support / drive the progression of strategic developments (to be agreed) milestone plans and budgets
Estates, Facilities & Medical Equipment	Finance	Re-enforce and document appropriate controls and management of all 3rd party contractors entering Trust premises (permits to work, evidence of competence, auditing of work etc.)

Team	Directorate	Description of Objective
Estates, Facilities & Medical Equipment	Finance	Develop a controlled and documented approach to delivering the Backlog Maintenance programme
Estates, Facilities & Medical Equipment	Finance	Fully adopt "ownership" of the Trust fleet and identify and capture cost savings through working with operational colleagues and sister support teams
Estates, Facilities & Medical Equipment	Finance	Provide effective Estates & Facilities (E&F) support to all Trusts bids for new (or retained) services
Estates, Facilities & Medical Equipment	Finance	Identify future plan savings initiatives to facilitate Cost Improvement Plan (CIP) achievement at Budget setting each year
Estates, Facilities & Medical Equipment	Finance	Rationalise and standardise the cleaning products used across the Trust estate
Finance	Finance	Perform a review of the merged Standing Financial Instructions and Scheme of Delegation
Finance	Finance	Ensure greater understanding of responsibilities and working practices across the Finance Function (primarily Operational Finance / Financial Accounts / Contracts and Planning
Finance	Finance	Develop finance training - primarily system based for users of Centros but also wider to aid understanding of financial management. Ensure training provision for Finance staff is comprehensive and supports Contining Professional Development (CPD) requirements
Finance	Finance	Implement new CENTROS finance system to enable Trust wide efficient and effective use by Summer 2021
Finance	Finance	Within the next financial year, review data sources for accruals and reports and consider what can be obtained directly from other systems or automated
Hospitals	Operations	Review and ensure multi-disciplinary staffing models on inpatient wards are safe, sustainable and resilient (Medical, nursing and therapies)
Hospitals	Operations	Commitment to National zero suicide plan compliance with statutory and mandatory training compliance - particularly L3 resuscitation, restraint, manual handling & fire safety
Hospitals	Operations	Co-produce and implement a service design and workforce plan to deliver an assessment and treatment model for people with a learning disability
Hospitals	Operations	Play an active role in the South West Collaborative redesigning of forensic services in Gloucestershire
Hospitals	Operations	Co-produce a service design and workforce plan to deliver a recovery/rehabilitation pathway for the people of Gloucestershire that avoids the need for out of county placements.
Hospitals	Operations	Ensure sufficient bed capacity is available to meet the needs of the people of Gloucestershire
Hospitals	Operations	Ensure ambulatory care services are cost efficient and fit for the future
HR Operations	HR	Introduce a just and learning culture thereby reducing the number of formal disciplinary, grievance and freedom to speak up cases
HR Operations	HR	Develop a way of capturing the data around flexible working so that policies, learning, and training can be implemented to improve take up
HR Operations	HR	Review the HR Ops structure and put in place Oraganisatonal Development (OD) interventions/training to support their development
HR Operations	HR	Ensure the International Recruitment programme delivers high quality recruits in line with the targets set
Information Technology & Clinical Systems	Finance	Ensure all network switches that were bought and rolled out across the county in 2015 As part of the LAN/WAN project are replaced
Information Technology & Clinical Systems	Finance	Complete roll out of RIO Electronic Prescribing Medication Administration (EPMA) Project Year 2 to Mental Health In-patients and then deployment for Community Mental Health Teams.
Information Technology & Clinical Systems	Finance	Review SystmOne build with Business Intelligence colleagues to identify how it can be improved in line with the national dataset and made to be more consistent across Clinical teams.
Information Technology & Clinical Systems	Finance	Deliver gradual roll out of RiO Physical Health eObs across Mental health wards following EPMA
Information Technology & Clinical Systems	Finance	Decommission SOELhealth and migrate to new system for Dental Services
Information Technology & Clinical Systems	Finance	Launch digital total mobile with Crisis Teams & evaluate a 3 month Pilot to ensure deployment and use of the 100 licences purchased.
Information Technology & Clinical Systems	Finance	Complete Clinical Systems review and agree outcomes and procedure for future use

Team	Directorate	Description of Objective
Information Technology & Clinical Systems	Finance	Review options and work with the organisation to support staff to become more digitally enabled
Information Technology & Clinical Systems	Finance	Review options for the further use of O365 across the trust working with ICS colleagues to ensure collaboration opportunities are put in place
Information Technology & Clinical Systems	Finance	As part of the N365 contract GHC need to further expand on the use of its Microsoft Software estate this provides a number of opportunities to replace other software current utilised and implement a number of new security features
Information Technology & Clinical Systems	Finance	There are a range of IT hardware deployment projects that have been signed off to provide a more consistent experience for all GHC staff
Information Technology & Clinical Systems	Finance	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 there is work required on the Voice Over Internet Protocol (VOIP) estate to ensure there is just one solution for GHC
Information Technology & Clinical Systems	Finance	The current WAN network has been causing a number of network issues that been impacting on GHC users and need to be resolved. The current WAN contract is also up for renewal so a new network contract needs to be put into place to provide a fit for purpose network going forward. As the network is a county resource this work needs to be completed in conjunction with the ICS to enable the improvements to be made
Medical Team	Operations	We will continue to work towards achieving a 'university status' along with our Gloucestershire health and education partners
Medical Team	Operations	We will explore the development of an innovation hub where colleagues can come together to champion change and new ways of working and ensure we work together towards better care outcomes.
Nursing, Therapies & Quality	NTQ	Improving access / removing barriers / equality
Nursing, Therapies & Quality	NTQ	Work with colleagues to reduce unwarranted clinical variation across our services using benchmarking information where available that impact on quality and safety
Nursing, Therapies & Quality	NTQ	Co-ordinate and lead the roll out programme for Civility Saves Lives across our organisation
Nursing, Therapies & Quality	NTQ	Design and deliver our quality framework to promote clinical effectiveness, safety and good experiences, utilising patient feedback to continuously develop our services in line with best practice, evidence and emerging innovations.
Nursing, Therapies & Quality	NTQ	Embed learning assurance initiatives across the organisation alongside National Patient Safety Strategy aims to ensure we continuously improve patient safety, quality and experience
Organisation Development / Learning & Development	HR	Finalise and implement comprehensive actions plans which support delivery of the Trusts Workforce Disability Equality Scheme (WDES) and the Workforce Race Equality Scheme (WRES).
Organisation Development / Learning & Development	HR	All Trust staff have access to a comprehensive resource on the Trust's intranet which provides details of the Trusts Diversity Network, and its sub groups.
Organisation Development / Learning & Development	HR	The Trust provide three Stepping Up programmes, specifically aimed at supporting the development needs of BAME and LGBTQ+ staff, and those with a disability.
Organisation Development / Learning & Development	HR	Work will be undertaken to strengthen the Trust's Reciprocal Mentoring programme.
Organisation Development / Learning & Development	HR	The Trust has a well-developed understanding of and delivery plan for Essential to Role training.
Organisation Development / Learning & Development	HR	Help ensure a competent, compassionate and safe workforce through continued provision of a range of high quality educational, learning and development activity which are consistently well evaluated by course participants.
Organisation Development / Learning & Development	HR	A link exists between Care to Learn and Tableau which provides training compliance data for manager dashboards
Organisation Development / Learning & Development	HR	Establish Care to Learn as the default system for recording and reporting on Clinical Supervision.

Team	Directorate	Description of Objective
Organisational Resilience	Operations	Work through the Trainee Nursing Associate (TNA) rolling programme for the Trust and for On Call in line with Business continuity arrangements and incident management.
Organisational Resilience	Operations	Maintain substantial compliance on the Emergency Preparedness, Resilience & Responce (EPRR) annual core standards and move to fully compliant.
Organisational Resilience	Operations	Maintain annual plan for all operational pressured periods (bank holidays, school holidays and winter pressures) in line with Operational Pressures Escalation Levels (OPEL) actions.
Organisational Resilience	Operations	Review of On Call ensuring there is a robust 'fit for purpose' On Call system in place with a clear recruitment process and updated framework.
Organisational Resilience	Operations	Contribute and participate in the review into the Trust's vehicle fleet arrangements year round and during adverse weather.
Organisational Resilience	Operations	Review Trust adverse weather plans and Business Continuity Planning (BCP) arrangements in line with current legalisation and guidance from PHE.
Organisational Resilience	Operations	Ensure Trust compliance with NHS Core Standard for Business Continuity Planning training, exercising and validation for all services and teams. Align all plans with directorate and corporate Emergency Response Guides for all sites.
Organisational Resilience	Operations	Undertake review of the current organisational resilience team structure.
Recruitment & Retention	HR	To agree a Recruitment and Retention Strategy & implementation plan to mitigate against current challenges and deliver the requirements of the NHS People Plan and the proposed Trust People Strategy
Strategy & Partnerships	Strategy & Partnerships	Development and roll out of on line QI training available for all trust colleagues at Bronze level by Q1 2021 and Silver by Q3 2021.
Strategy & Partnerships	Strategy & Partnerships	Development of Quality Improvement (QI) governance framework that ensure appropriate level sign off and monitoring of QI work is embedded as part of QI hub function by Q1 2021
Strategy & Partnerships	Strategy & Partnerships	Develop our people participation programme by quarter 2.
Strategy & Partnerships	Strategy & Partnerships	Ensure the workforce development plan and training needs analysis is completed for new strategy and partnerships directorate
Strategy & Partnerships	Strategy & Partnerships	Launch the Partnership hub, aligning to place based localities and working alongside service development at a system level to ensure staff and partners understand the purpose of the hub
Strategy & Partnerships	Strategy & Partnerships	Develop a strategic plan for the delivery of Quality Improvement culture across the trust by end Q1
Strategy & Partnerships	Strategy & Partnerships	Develop and embed a new governance and assurance process to replace the Operational Development Forum
Strategy & Partnerships	Strategy & Partnerships	Complete 5 year overarching plan to develop organisational strategies relating to all aspects of sustainable development between 2021-26.
Strategy & Partnerships	Strategy & Partnerships	Assemble a network of Green Champions across the Trust and promote environmental awareness - sustainability awareness.
Strategy & Partnerships	Strategy & Partnerships	Ensure Trust wide Estates Strategy is developed through Q1 and signed off by Board Q2
Urgent Care & Specialty Services	Operations	Continue Sexual Assault Referral Centre (SARC) transformation work ensuring the service fits criteria for accreditation following our expression of Interest and engagement meetings.
Urgent Care & Specialty Services	Operations	To work with the commissioners to develop and introduce intravenous sedation service for the special care dental service
Urgent Care & Specialty Services	Operations	To develop the train a trainer package for care homes to raise awareness and improve oral health outcomes for the patients in residential homes.
Urgent Care & Specialty Services	Operations	Work with system partners in a test and learn approach to deliver the nationally mandated Clinical Advice & Assessment Service. Demand & Capacity (D&C) and Single Point of Clinical Access (SPCA). SPCA description is to be re-defined and an additional line is required around patient flow. A new line to be added to illustrate what is offered to the system (flow).
Urgent Care & Specialty Services	Operations	Developing an efficient multidisciplinary team which works together efficiently and embracing the diversity of the staff groups with the sexual health service.
Urgent Care & Specialty Services	Operations	Review current medical staffing provision of the Sexual Health Service and plan future needs of the service in line with national guidelines. Start Q2.

Team	Directorate	Description of Objective
Urgent Care & Specialty Services	Operations	Develop Advanced Clinical Practioner (ACP) development strategy into Urgent Care services to improve retention and improve recruitment.
Urgent Care & Specialty Services	Operations	Work with system partners to describe and implement the Community Urgent Care service in our Minor Injury & Illness Units (MIIUs) and our phased approach to recovery.
Urgent Care & Specialty Services	Operations	Work with commissioners to develop the intravenous therapy team model Intravenous Therapy (IVT) - and redefine clinic to home model.
Urgent Care & Specialty Services	Operations	Extend the days of the First Point of Contact Centre to work 07.00 to 22.00hrs across the week in line with Long Term Plan and local CCG led Crisis Review.
Urgent Care & Specialty Services	Operations	To review the Homeless Health Care Service provision and service specification to improve capacity and efficiency.
Urgent Care & Specialty Services	Operations	Review the current Lillie Electronic Patient Record (EPR) system to ascertain whether the current IDOX system is sustainable as the clinical system for our sexual health service
Urgent Care & Specialty Services	Operations	Continue Rapid Response Service development to improve access to admission avoidance services and extend provision of community based urgent care to support patients with increased acuity at home. Including the phase 2 initiation of diagnostics (ECG, Point of Care Testing (PoCT)), and equipment Automated External Defibrillator (AED) as well as training and development for retention and recruitment. Start Q1.
Urgent Care & Specialty Services	Operations	Extend the Rapid Response residential care home offer to reduce acute admissions for patients in residential care homes.
Urgent Care & Specialty Services	Operations	Continue service development in accordance with national Core 24 model for mental health crisis service for ages 11 and above.
Urgent Care & Specialty Services	Operations	Continue service development and progress alignment with Complex Emotional Needs service.
Urgent Care & Specialty Services	Operations	Development of the Long Covid Service (further details and breakdown of phased approach to delivery TBC).
Urgent Care & Specialty Services	Operations	Integration of County wide Diabetes services to improve access, ensure seamless care. Ensure quality care and support with appropriate primary, community and secondary care.
Urgent Care & Specialty Services	Operations	Heart Failure service review to ensure service able to grow to develop resilience to meet increased referral rate including the provision of rehabilitation for heart failure patients following the outcomes of the pilot.
Urgent Care & Specialty Services	Operations	Understand the recovery timeline for each service across the urgent and specialty services.
Urgent Care & Specialty Services	Operations	Agree transformation work regarding the expansion of the service provided from the Alexandra Wellbeing House (and Gloucestershire High Intensity Network (GHIN) project).
Workforce Systems & Planning	HR	Create an admin champion network for Workforce Systems.
Workforce Systems & Planning	HR	Lead the workforce planning element of the new hospital within the Forest of Dean.
Workforce Systems & Planning	HR	Ensure monthly updates to establishment control totals accurately reflected in Electronic Staff Record (ESR) Accurate workforce data pertaining to vacancies.
Workforce Systems & Planning	HR	Ensure attainment of organisational e-rostering, board-level accountability for monitoring e-rostering across all workforce groups, ensuring audit and review so team objectives, departmental budgets and the trust's objectives are aligned to respond dynamically to services' changing needs.
Workforce Systems & Planning	HR	Ensure mileage rate consolidation through alignment of mileage rates in expenses system
Workforce Systems & Planning	HR	Ensure accountability for monitoring e-rostering across all workforce groups through HealthRoster Data Packs implementation
Workforce Systems & Planning	HR	Additional resource able to provide place based advice and guidance for colleague and managers following payroll merger
Working Well	HR	Vaccination of all required staff groups against seasonal flu and potentially COVID-19 in line with Public Health England (PHE) requirements
Working Well	HR	Creation of a Health and Wellbeing Strategy and implementation plan to cover the period 2021-2025
Working Well	HR	Occupational health/health and wellbeing leadership to support workforce recovery as a result of the COVID-19 pandemic

Team	Directorate	Description of Objective
Working Well	**HR**	**Provision of an enhanced working well portal experience for staff and managers for management referrals including text reminders**

AGENDA ITEM: 12

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **BUDGET SETTING PAPER 2021/22**

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 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 2021/22 and approve in principle the five-year capital plan
- **Note** the risks associated with the proposed budgets for 2021/22

Executive summary
The paper sets out the budget setting process for 2021/22. 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.

In the absence of agreed contracts, or having a clear financial regime for 21/22 there is a risk that the budgets proposed do not reflect the national planning assumptions and are significantly different to the financial plans of the NHS.

The budgets proposed in this paper form the financial governance of the Trust for 21/22. Although national interim funding arrangements will remain in place for the first half of the next financial year these budgets will provide a clear financial framework in which all Trust staff can continue to operate and make financial decisions.

National planning guidance has not yet been issued for 21/22 so the Trust has used the planning assumptions from the NHS Five Year Plan where appropriate e.g income and pay uplifts.

These budgets form the basis of the plans on which the Trust will deliver its business planning objective and strategic aims for the year ahead.

The financial planning assumptions used mean these budgets will deliver a surplus. It is possible that the new financial regime may not encourage, or may even prohibit, surpluses for Foundation Trusts. These budgets will deliver a surplus of £0.790m, which includes delivery of a non-recurrent £600k surplus in order to generate cash for the Forest of Dean Hospital scheme. If the surplus needs to be reduced then the Trust can reduce the level of non-recurring savings, but needs to continue to deliver all recurring savings so that it stays in recurring balance.

In order to deliver these budgets recurring cost improvement schemes of £3.90m will be required. In addition, £1.600m of non-recurrent savings will need to be found to support non-recurrent expenditure and non-recurrent cost pressures. During budget setting 67% of recurring savings have already been identified.

A capital expenditure budget of £14.363m is proposed for 2021/22. The disposal of the Holly House site for c.£2m has been moved in 22/23 so there are no capital disposals planned for 21/22. 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, the completion of the ensuite upgrade of the Montpellier Low Secure facility and addressing c.£2.0m of outstanding Condition C & D High or Significant risk backlog maintenance issues.

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?
Executive team meetings Dec 22nd and Jan 18th, Resources Committee 24th February 2021, Capital Management Group meetings

Appendices:	

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

BUDGET SETTINGS 2021-22

1. 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 2021/22.
2. Risks arising from the budget setting process.
3. To give the Board sufficient information to approve budgets for 2021/22.

National planning guidance has not yet been issued to the NHS for the 21/22 planning process. It is anticipated that the interim arrangements where the Trust is paid a block income payment by its lead commissioner to cover its contract, Covid income and some lost income will definitely continue for quarter 1 and probably quarter 2 as well. The Trust has used some planning assumptions from the NHS Five Year Plan as the most appropriate framework on which to base the budget setting process. These budgets however provide the financial framework on which the Trust can provide services and deliver its objectives.

2. FINANCIAL CONTROL TOTALS FOR 2021/22

In order to create a clear financial framework against which to measure budget proposals from directorates the Trust has calculated Financial Control Totals (FCTs). These are indicative budgets based on a number of assumptions against which budget proposals can be assessed.

The financial control totals for 2021/22 were based on the following steps:

Recurrent 2020/21 month 8 budgets, adjusted for:

a. Pay and non-pay inflation
b. Cost pressures funded by the Trust
c. Efficiency 1.0% CIP target
d. Differential CIP targets for Directorates
e. Delivering Value CIP schemes
f. Non-recurrent income and expenditure for services
g. CQUIN (Care Quality and Innovation) income expected
h. Known developments including Mental Health Investment Standards (MHIS)
i. Requirement of ICS and system partners
j. Final FCTs are set

These calculations resulted in a budget position of a £1.091m surplus overall, including an additional surplus of £600k which the Trust aims to generate additional cash for the Forest of Dean capital scheme.

These financial control totals 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. This resulted in a reduction to the final surplus proposed.

Table 1: Financial Control Totals

Directorate Financial Control Totals	
Directorate	**£m**
Hospitals	37.672
Adult Community	20.213
Specialist	32.201
Children & Young People	10.231
Urgent Care	17.817
Medical	11.936
Chief Exec. & Corp Gov	4.319
Finance	27.820
Human Resources & OD	4.925
Nursing, Therapies & Quality	6.595
Strategies & Partnerships	1.815
Operations Mgt	1.436
Sum of Financial Control Totals	176.981
Unallocated Budgets	3.278
Non Operational	9.634
Savings	-2.500
Contract Income	-188.484
TOTAL Indicative surplus	**-1.091**

3. BUDGET SETTING

The budget setting process for 2021/22 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.

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

- Cost pressures were submitted, considered and, where approved, included within Financial Control Totals
- Financial Control Totals were calculated that gave an outline financial framework against which budget proposals could be measured. These were approved by the Executive Team in early January 2021
- Business partners met with budget holders during December and January to prepare draft 2021/22 budgets
- As part of preparing the 2021/22 budgets the Efficiency cost improvement of 1.0% was identified across all budgets
- Differential cost improvements were identified in some budgets. Other directorates have identified plans and ideas for Differential savings that require a longer timescale over which to deliver
- Budget resolution meetings were held with a number of directorates that proposed budgets above their FCT
- Budgets were finalised with budget holders
- 2021/22 contracting discussions are continuing to take place with Gloucestershire CCG. The Trust has submitted proposed finance schedules which are now under review

The assumptions used for budget setting are;

- Net tariff inflator of 1.3% (inflation 2.4%, efficiency -1.1%) per NHS Plan guidance
- pay award of 2.8% per NHS Plan guidance

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 2021/22 within FCTs. 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 2021/22.

The impact of Covid on expenditure patterns was also taken into account when calculating the required level of budget for 21/22. This was to assess whether costs had either increased or decreased as a result of changes to working practices from dealing with the pandemic.

A similar approach to dealing with costs pressures has been followed to that used in previous years. A list of cost pressures was gathered from all services and submitted to the Deputy Director of Finance which totalled £5.766m. These were reviewed and discussed before a refined list of potential cost pressures was put forward to the Executive Team in December. These were then reviewed and either approved, or rejected because they were deemed either avoidable or affordable within existing resources.

£1.395m of recurring cost pressures were approved and added to the proposed financial control totals.

4. BUDGET SETTING OUTCOMES

Cost Pressures

As budget setting progressed the cost pressures list was reviewed to ensure that they had been appropriately managed. A small number of cost pressures not funded in Financial Control totals have been included in budgets as part of this review.

Table 2: Summary of Cost Pressures

Cost Pressures	£000's	Recurring £000's	Non Recurring £000's
Funded;		1,395	562
of which Brexit	140		
Budgeted		551	22
Affordable		119	230
COVID		1,105	1,035
Avoided		547	
In risks		200	
Total		**3,917**	**1,849**

Covid

Costs relating to Covid were excluded from directorate budget proposals with the expectation that central income funding will be made available, as per 20/21, to cover these costs (c£2.1m). The Trust expects some of these costs to be recurring and anticipates that funding will be made available to cover these costs across the NHS c.£1.1m. There is a risk that funding to cover these recurring Covid costs will not be made available. The Trust will then need to either identify additional cost improvements or reduce these costs.

Brexit

Brexit related cost pressures were identified and have been put into a central budget that can be utilised should these costs materialise. These pressures totalled £140k and predominantly related to support service costs such as linen, food and utilities.

Budget Resolution Meetings

Budget resolution meetings were held with Hospitals, Urgent Care, Finance, Nursing Therapies & Quality, Specialist Services and Adult Community Care. These directorates all identified pressures in setting budgets within FCT and met with the Director of Finance to agree ways forward to close the gap between the target and budget, where possible.

Urgent Care, Finance, and Nursing, Therapies and Quality all had one meeting in which they were able to identify ways to set a budget in line with their FCT.

Hospitals, Specialist Services and Adult Community Care all had two meetings to help agree a proposed budget for 21/22. The final conclusions from these 3 directorates were as follows;

- Hospitals – Gap of £211k. Differential savings of £211k have a clear plan of areas to review and the directorate plans will be confirmed in quarter 1.
- Specialist Services – Gap of £396k. Differential savings of £132k have a clear plan of areas to review and the directorate plans will be confirmed in quarter 1. The remaining £264k relates to MH Complex Care cost pressure. The directorate are reviewing the causes of this issue and mitigations. A further review is scheduled with the Directorate of Finance. There is a risk that there will be a cost pressure in 21/22.
- Adult Community Care – A gap of £170k after excluding an adjustment to reflect an error in budgets of £160k. Differential savings of £126k have a clear plan of areas to review and the directorate plans will be confirmed in quarter 1.

The risk of non-delivery of differential savings is identified in the risk table.

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 again by the Department of Health and Social Care in 2021/22 and not affect Trust finances.

Non-recurrent budgets

The Trust has set a small number of non-recurrent budgets to cover one off developments or cost pressures that have been identified for 2021/22. These may cover items that fall randomly across directorates such as pay protection or may fund one off initiatives. These are shown below;

Non Recurrent Budgets 21/22	
	£000s
Locum Consultant - Eating Disorders	100
Out of Area Inpatient budget	110
Miscellaneous budgets	337
Backlog Maintenance	184
Asset Disposal budget	45
Excess travel/Pay protection	155
TOTAL	**931**

Within the Adult Community directorate there is one post that has been funded non-recurrently through winter pressures funding but has been appointed to substantively in order to ensure this important Home First post is filled. The directorate are aware this is a financial risk and will be looking at ways to ensure this is resolved during 2021/22.

Non-Operational budgets

Depreciation and Public Dividend Capital (PDC) budgets have been based on the current asset register. Work to review the asset register in April 2021 will lead to a reduction in these budgets at the start of 21/22.

The Trust has retained central merger savings of £0.153m. This will be held centrally until the end financial year 2021/22 as per the Trust's merger business case.

There is also a demographic growth allocation relating to 20/21 of £471k held centrally to be utilised for identified demographic growth issues. Expected calls on this funding that were raised in budget setting include proposals from Adult Community, Gloucester Recovery and MH Complex Care.

The budget setting process this year has been more complicated due to the impact of Covid. 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.

5. INCOME

Contract discussions are progressing with Gloucestershire CCG from which the Trust will get over 80% of its income in 21/22. A number of schemes funded non-recurrently in past years will be recurrently funded in 21/22, 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 added to the contract to meet the Mental Health Investment Standard (MHIS) as this remains a key NHS commitment for 21/22. The Trust has identified up to £5.8m of potential investments but has not yet built these into budget proposals. 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. A full reconciliation of the contract to budgets will be completed once the contract is agreed.

Proposed areas of investment currently include IAPT, Trailblazers (CYPs) and Crisis service expansion.

As part of the discussions to agree the contract with Gloucestershire CCG it is anticipated that some demographic growth funding will be received for 21/22. Due to the delayed planning guidance and limited contract negotiations that have taken place so far with the CCG no income or expenditure has been assumed in budgets for 21/22 at present.

The Trust has assumed a non-recurrent reduction in income of £100k for 21/22 from the Low Secure facility while the building works to upgrade the facilities is in progress.

6. COST IMPROVEMENT PLANS (CIPS)

The national savings requirement in the planning guidance for 2021/22 has been assumed to be 1.1% of NHS income, as per previous years, c£2.0m. The Trust CIP is significantly higher than this, as illustrated in Table 3. 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.

The cost improvement target must also support the impact of cost pressures, both recurring and non-recurrent. In 21/22 the Trust aims to make an increased surplus of £600k to generate additional cash to support the funding of the new hospital in the Forest of Dean.

There also non-recurrent budgets that need establishing to cover costs such as pay protection, and excess travel. These are funded through the identification of non-recurrent savings during 21/22.

In contrast to previous years the Trust has not had to increase its cost improvement programme to pick up a shortfall of recurring savings not delivered in 20/21. As part of the Covid financial framework the NHS was told it did not have to make the 1.1% recurring efficiency saving in 20/21 c £2.1m. There is a high probability however that this efficiency saving from 20/21 will be need to be found across the NHS in 21/22 or beyond. We have set budgets without including the requirement to make this additional level of savings because the

value is unknown, the timing is unclear but likely to be in the latter part of the year, and because our CIP requirement is already challenging in the light of covid recovery.

Table 3: Calculation of CIP requirement

21/22 Indicative CIP Requirements	
	£m
Contract Efficiency (assumed 1.1%)	2.400
Cost Pressures (estimated)	1.500
Recurrent total	**3.900**
Non Recurrent - budgets	0.400
Non Recurrent costs pressures (estimated)	0.600
Forest of Dean Hospital funding	0.600
Non Recurrent total	**1.600**
Total CIP required	**5.500**

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 £2.0m. 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, £1.0m. This is spread over all areas between 0.25% and 0.75%, and is allocated based on previous delivery, and the ability and scope to deliver additional following the merger.

c) Delivering Value, £0.9m. The Trust will be working across the ICS to deliver system wide efficiencies and these schemes will support the delivery of our Delivering Value savings requirement. This may bring greater opportunities to generate savings but it does also bring the risk that the Trust's savings schemes are reliant on our partners and are no longer in the sole control of the Trust. It is expected that a small number of transformational schemes will be developed across the Trust. They will require QEIAs to be completed. Two areas where Delivering Value schemes have already been identified and are well developed are Digital Efficiencies and the Legal contract. The Digital efficiencies savings from reduced mileage has generated savings but some of these will be used to support the alignment of mileage rates from the two predecessor organisations and pay from the increased IT infrastructure costs that have enabled successful home working.

d) Non-Recurring, £1.6m. £600k of non-recurring savings are to be identified to deliver an increased surplus to support funding for the Forest of Dean capital project. 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 £5.500m equates to 2.4% of total Trust income in 21/22. This compares to 3.5% last year.

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. It shows the Trust currently has 27% not identified which highlights a significant financial risk for 21/22. Delivery of these efficiency savings will only be confirmed once the QEIAs are signed off.

Table 4: CIP schemes and delivery to date

CIP Summary Scheme	Target £000s	Delivered in budget Setting £000s	Planned not delivered £000s	Identified not planned £000s	Not Identified £000s	Total £000s	Delivered in budget Setting %
Efficiency	2,000	2,192	0	0	0	2192	110%
Differential	1,000	426	0	514	0	940	43%
Delivering Value	900	0	150	0	750	900	0%
Non Recurring	1,600	0	914	0	719	1633	0%
Total	**5,500**	**2618**	**1064**	**514**	**1469**	**5,665**	48%
% of Target		48%	19%	9%	27%		

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.

7. SUMMARY POSITION

The summary Income and Expenditure position for the Trust from the proposed budgets is as follows;

Table 5: Trust Income and Expenditure budgets v FCT 21/22

Trust Budgets proposed v Financial Control Totals				
Directorate	**FCT £000s**	**Proposed budget £000s**	**Variance £000s**	**Comment**
Hospitals	37,672	37,782	110	Out of County beds cost pressure
Adult Community	20,281	20,441	160	Correction of budgets 20/21
Specialist	34,088	34,087	-1	
Children & Young People	10,654	10,654	0	
Urgent Care	18,244	18,244	0	
Medical	11,936	12,037	101	Non recurring eating disorders cost pressure
Chief Exec. & Corp Gov	4,565	4,561	-4	
Finance	28,006	28,032	26	non recurring pay costs
Human Resources & OD	4,836	4,838	2	
Nursing, Therapies & Quality	6,594	6,594	0	
Strategies & Partnerships	1,535	1,528	-7	
Operations Mgt	1,556	1,559	3	
Sub total of Directorate position	179,967	180,357	389	
Unallocated Budgets	1,679	1,580	-99	Demo growth for Eating disorder pressure above
Non Operational	9,857	9,867	10	
Savings	-2,533	-2,533	0	Delivering Value & Non recurring savings
Contract Income	-190,062	-190,061	1	
TOTAL Indicative surplus	**-1,091**	**-790**	**301**	

The proposed budgets give a surplus position for 2021/22 of £0.790m.

The conclusions of budget discussions resulted in a small number of directorates with a budget proposal above the Financial Control Total set.

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 set in line with those planned, and cost improvement plans are delivered then the Trust will have a recurring underlying surplus of £0.188m, which is an improvement on the underlying deficit of £0.192m that the Trust had at the start of 20/21.

If the new financial regime limits or prohibits the making of surpluses in the future then the Trust will have scope to reduce non-recurrent savings, but will need to continue to deliver all recurring savings so that it doesn't slip into a recurring deficit.

Table 6: Recurring v Non-Recurrent budgets

Recurring and Non recurring I & E position 21/22			
Recurring position	**FCT**	**Proposed budgets**	**Variance**
	£000s	**£000s**	**£000s**
Income	-225,859	-227,298	-1,439
Pay	167,856	169,243	1,387
Non Pay	48,502	49,066	564
Non Operational	9,148	8,800	-348
Recurring (Surplus)	**-353**	**-188**	**165**
Non Recurring position			
Expenditure	862	1,031	169
Savings	-1,600	-1,633	-33
Non Recurring (Surplus)	**-738**	**-602**	**136**
Trust total (Surplus)	**-1,091**	**-790**	**301**

8. RISKS IN THE BUDGET

There are a number of potential risks in the proposed budget that should be noted:

Table 7: Risk analysis

Year	Risk	Mitigations	Likelihood	Impact	Risk Score
21/22	There is a risk that because CIP plans for the Delivering Value Schemes are not yet worked up and are linked to ICS wide agreement and delivery that this may impact on the ability of the Trust to deliver them	Regular attendance at ICS savings meetings. Strong support to maintain momentum. Continue internal review of Delivering Value programme and identification of new schemes	4	3	12
21/22	There is a risk that the final income schedule agreed with Glos CCG does not reflect the income assumptions made in budget setting and the Trust has a lower level of income than anticipated	Negotiations with CCG. Development only allowed to proceed with confirmed funding	3	4	12
21/22	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.	2	2	4
21/22	There is a risk that the budgets will need to be adjusted once the planning guidance is issued if the assumptions are different to those assumed by the Trust	Adjustments will be net neutral unless aproved by the Board	4	3	12
21/22	There is a risk that the recurring savings not required in 20/21 due to Covid will be required to be found on top of the 21/22 CIP targets (£2.1m)	Non recurrent underspends will be used to support the position. Further recurring savings will need to be identified. The Trust will aim to identify savings above the current assumptions	2	4	8
21/22	There is a risk that agency staffing costs rise again as services become fully operational again, 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, and the Trust's Single Oversight Framework score being adversely affected (£1.9m)	Agency Management Group reviews, Non recurrent savings and establishment budgets	3	3	9
21/22	There is a risk that as the Hospitals directorate income will not return to previous levels (£0.7m)		3	2	6
21/22	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	3	3
21/22	Non-Medical Education & Training Tariffs payments in 2021/22 are being standardised. There is a risk the Trust will receive less income as a result	Assess impact of the final proposed payment. Review mitigation from increased activity that is expected during the year	2	2	4
21/22	There is a risk that a review of the Staff Bank staffing model during 21/22 will lead to additional costs and a recurring cost pressure will emerge	Reviewing the overall requirements of the service for the merged organisation.	4	1	4
21/22	International Nurse recruitment leads to non recurring cost pressure	Review impact and identify vacancy savings to offset non recurringly	3	1	3
21/22	There is a risk that the capital envelope for Gloucestershire is lower than anticipated and the Trust is required to reduce the size of its capital programme	Review of capital spend priorities. Negotiate with organiations in Gloucestershire to retain sufficient capital envelope to deliver programme	1	2	2
21/22	There is a risk that the Trust will not be able to reduce costs by as much as income if the Berkshire LD patients are transferred to a private community provider	A review of budgets will be undertaken to ensure the appropriate level of funding is provided on the ward	2	2	4
21/22	There is a risk the recurrent costs of Coronavirus will not be funded by central income leading to significant additional expenditure that has not been budgeted for in the 21/22 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.	3	3	9
21/22	There is a risk that 3 directorates, Hospitals, Adult Community and Specialist Services will not be able to identify their outstanding Differential savings target. (£513k)	Close monitoring by CIP management Group including attendance by each directorate.	2	2	4
21/22	There is a risk that Adult Community will not be able to identify recurring funding to cover a Home First post that is currently occupied by a substantive postholder with non recurring funding (£55k)	Close monitoring by CIP management Group including attendance by each directorate.	2	1	2
22/23	There is a risk that the ICS capital envelope will be insufficient to allow the Trust to undertake its proposed programme	Close working with systems partners and NHSE to ensure capital programme can be delivered	2	4	8
22/23	If surpluses are not allowed in the future then there is a risk to funding future capital schemes	Monitor the guidance to ensure all opportunities are maximised	2	5	10

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.

9. OPPORTUNITIES

The Trust's review of its balance sheet in 20/21 may lead to the need for a reduced budget for depreciation and PDC in 21/22. Once the year end accounts are completed and audited the Finance department will review the level of budgets required for next year.

The organisation has consistently delivered its financial control totals over a number of years. This has often been due to non-recurrent 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 has been able to review its balance sheet and resolve a number of financial issues that puts it in a strong financial position at the start of 21/22 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.
- Margin benefits from any new developments e.g. IAPT or AMHPs as these have not been accounted for in the Trust's financial plans

10. CAPITAL EXPENDITURE

During 2021/22 the Trust intends to take forward two major building schemes. A scheme to make the Montpellier Ward Low Secure facility fully ensuite will be completed during 2021/22, and work on the construction of a new hospital for the Forest of Dean will commence, subject to sign-off of the business case.

In addition, the Trust will invest £2.2m on various Backlog Maintenance projects as part of the strategic aim to improve the quality of the Trust's facilities. The Trust carried out a six-facet review of the estate in 20/21 and identified c.£6.9m of High/Significant backlog maintenance issues. The Trust addressed £1.5m in 20/21, is covering £3.4m through existing controls, and intends to tackle c.£2m in the capital programme for 21/22.

The overall Capital Plan for the Trust anticipates a spend of £14.363m in 2021/22, which includes £5m on the Forest of Dean new hospital. The breakdown by type of scheme is shown in the table below.

The Trust does not intend to dispose of any sites in 21/22. The sale of the Holly House site has been put back to 22/23 in this proposed capital budget, in order to provide additional funding to support the large capital expenditure forecast in 22/23.

The size of the programme may need to be adjusted once the capital envelope for Gloucestershire is known. The capital priorities for the whole of Gloucestershire will be assessed against the capital envelope and may result in adjustments to the programme. At this stage it is anticipated that the capital envelope will be similar in size to last year and so the risk of the capital programme needing to be reduced is low.

There is a risk that the capital envelope may not be enough for 22/23 and the potential change to the financial regime that will limit surpluses a Trust can make is a further risk to the delivery of the proposed future capital programme.

Table 8: Capital Plan for 2021/22

CAPITAL PLAN 2021/22 TO 24/25	Final Plan	Final Plan	Final Plan	Final Plan	Final Plan	Final Plan
£000s	**2021/22**	**2022/23**	**2023/24**	**2024/25**	**2025/26**	**Total**
Land and Buildings						
Buildings	3,629	2,500	2,500	1,000	1,000	10,629
Backlog Maintenance	3,020	1,050	1,050	250	250	5,620
Urgent Care	750	0				750
Berkeley House		2,000				2,000
Cirencester Scheme			5,000			5,000
IT						
IT Device and software upgrade	200	600	600	600	600	2,600
IT Infrastructure	1,086	996	1,300	1,300	1,300	5,982
Medical Equipment	678	730	730	1,030	1,030	4,198
To be Confirmed				2,300	2,300	4,600
Sub Total	**9,363**	**7,876**	**11,180**	**6,480**	**6,480**	**41,379**
Forest of Dean	5,000	10,500	3,500			19,000
Total prior to proceeds/donations	**14,363**	**18,376**	**14,680**	**6,480**	**6,480**	**60,379**
Disposal Proceeds		(3,260)	(6,500)			
Total after proceeds/donations	**14,363**	**15,116**	**8,180**	**6,480**	**6,480**	**60,379**
Nb Total Forest of Dean scheme £20.4 including 18/19 to 20/21						

11. 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. Approve the budget totals for revenue and capital

c. Note the risks within the proposed budgets

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Angela Potter – Director of Strategy & Partnerships

AUTHOR: Angela Potter – Director of Strategy & Partnerships

SUBJECT: **OUR TRUST STRATEGY 2021- 2026**

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 paper presents to Board Members the Trust's Five-Year Strategy 2021-2026 following the Boards ongoing input and the engagement process that has taken place to finalise the document.

Recommendations and decisions required

Trust Board members are asked to approve the five-year strategy.

Executive Summary

We have spent considerable time prior to the COVID pandemic hearing from our staff, patients, experts by experience and stakeholders as to what is important to them in terms of the priorities for the Trust and how we should work together to take forward our ambitions as a new organisation.

We have undertaken a final period of engagement to refine the work that Board Members have participated in to develop the mission, vision, aims and objectives of the strategy. The latest stage of engagement was predominately undertaken by an online survey with a small number of postal/easy read surveys and a small number of facilitated Expert by Lived Experience workshops. Over 400 people participated in the survey from colleagues, experts by lived experience and a small number of trust members.

Our strategy has now been finalised based on the feedback received and is presented today for Board final comment and approval.

Risks associated with meeting the Trust's values None – the work programme proposed would align with our Trust Values	
Corporate considerations	
Quality Implications	X
Resource Implications	X
Equality Implications	X

Where has this been discussed before?
Trust Public Board – September 2020

Appendices	Out Strategy 2021-2016

Report authorised by: Angela Potter	**Title:** Director of S&P

OUR FIVE-YEAR STRATEGY 2021 - 2026

1. INTRODUCTION

1.1 This paper presents our five-year strategy for 2021 – 2026 and highlights the final process of engagement and drafting refinements. 'Our strategy 2021-2026' is for all our staff, service users, patients, carers and our partners. It seeks to provide clarity on who we are, what is important to us, what we want to achieve and how we will do it. This remains a public facing document, ensuring that everyone can access, understand and contribute to implementing our strategy.

1.2 This strategy is supported by our Annual Business Plan for 2021/22, which articulates the detailed plan for delivering year one of our five-year strategy. Throughout the life of this strategy, subsequent annual plans will provide the specific annual actions and milestones.

2. OUR STRATEGY 2021- 2026

2.1 The Trust's strategy is presented at Appendix 1 and has been developed with the support and engagement of a significant number and range of stakeholders across a 2-phase process. We have engaged with colleagues, people who access our services and partners to shape and test our strategy as it has progressed. Due to Covid the timings of these phases were elongated but key activities have included:

- Colleague engagement workshops, across all levels of the organisation, to seek initial views on the key aspects of our strategy;
- Better Together Stakeholder event
- Perception audit across key stakeholder groups, to understand our baseline as a new organisation and identify any areas of priority moving forward;
- Senior Leadership Network meetings to share updates and receive feedback on the emerging strategy;
- Expert by Experience engagement sessions;
- On-line survey

2.2 The latest stage of engagement was a survey to gain feedback on the work undertaken to develop the Mission, Vision, Strategic Aims and Strategic objectives. Over 400 people participated in the survey from colleagues, experts by lived experience and a small number of trust members. There was a mixture of individual and group feedback received – the majority being received in an online form but postal/easy read surveys were also utilised as well as facilitated Expert by Lived Experience workshops.

Overall the majority of responses agreed or partially agreed with the work we had completed to date. To look at this in a little more detail;

- 50% of all respondents agreed and 43% partially agreed with the Mission Statement. There was however, a consistent theme in the narrative responses that we should remove the 'with you, for you' which we had

placed at the end of the mission statement as it made the statement disjoined and unclear. This has been taken forward into the final version of the document.

- 78% of all respondents agreed and 21% partially agreed with the Vision Statement. There was no consistent theme in the narrative response to indicate making any changes – some respondents would prefer not to use the word 'outstanding' and some felt it was a bit too generic and should clearly include a reference to health, but overall the conclusion having considered the feedback was to leave the statement unchanged.

- 83% of all respondents agreed and 16% partially agreed with our four strategic aims. There was significant positive feedback in the narrative statements about including 'great place to work' and 'sustainability' but some felt that they would like to see a more positive inclusion of words such as 'consistently' or 'continuously' to demonstrate innovation and continuous improvement. This is included in the milestones and goals and therefore we have left the aims as drafted. 89% of the respondents felt that these were the right aims to guide the Trust to achieve it's vision and goals.

- 84% of all respondents felt that their work would contribute to achieving the vision and aims. It is worthy of note that there were a small number of comments where colleagues felt they were 'too small a cog in the big wheel of the organisation' to be able to directly support the delivery of the strategy so this is something we will need to consider in how we communicate and translate the strategic aims into personal and team objectives.

To summarise, we believe the survey demonstrated the service vision and strategic aims are sound and also align with the vision and plans of our wider health and care economy.

The final strategy presented therefore reflects;

- A refined Mission statement based on the feedback from our engagement work to ensure that it presents a concise message that is engaging and clear for our colleagues and partners.
- Refined presentation of our aims and objectives based on feedback from staff in our Strategy Development Group and from input in the wider discussion groups to reduce duplication and jargon and ensure they are clear and meaningful to all parties.

2.3 Our strategy remains focused on providing personalised care for everybody who comes into contact with our services. Our service vision emphasises the need for integrated care, internally across our services and directorates, and externally with other health and care providers. Reducing inequalities and encouraging people to stay well through prevention, self-care, well-being and recovery are key components for our services moving forward.

2.4 Our strategy sets out an exciting and challenging plan for the Trust as we look to achieve our Vision and Aims and work towards being a strong and resilient partner across the system. We are confident that our strategy reflects the views and challenges set out by all those that engaged with us in developing the proposals.

3. NEXT STEPS

3.1 Our aim is to communicate this strategy widely with our staff and partners and we are in the process of developing a communication and engagement strategy. Following approval of the strategy we will take forward the development of a plan on the page and an easy read version of the strategy.

We will work with our senior leaders to support cascading our strategy and build it into their team and individual objectives and plans.

3.2 Trust Board is therefore asked to;

- **Note** the outputs from the engagement exercise and the amendments made as a result of this
- **Approve** the Trust five-year strategy 2021-2026.

Angela Potter
Director of Strategy & Partnerships
22nd March 2021

with you, for you

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NHS Foundation Trust

Our Strategy for the Future 2021 – 2026

Better Care Together – With You, For You

Our **five-year strategy** for 2021 to 2026 will take us on an exciting journey. We pledge to put people at the heart of our services, focussing on personalised care by asking ‘what matters to you?’ rather than ‘what is the matter with you?’

We have produced this document to explain how we will work towards our priorities and achieve our mission:

Enabling people to live the best life they can.

We want everyone to help us deliver our overarching vision to:

Working together to provide outstanding care.

We want to be **innovative and forward-thinking**. We have a ‘Good’ Care Quality Commission (CQC) rating and a strong financial position. We will use this firm baseline to thrive as a **single community, mental health and learning disability provider**.

This journey will include:

- Developing services around the needs of our communities
- Tackling health inequalities – unfair and avoidable differences in health caused by things like unemployment, poor education, race, disability, and where people live
- Using technology to improve access and choice in how patients receive care
- Improving our buildings to make them more efficient and a better environment for our patients and staff
- Promoting quality improvement and innovation
- Working towards university status with our Gloucestershire health and education partners
- Being an environmentally proactive organisation working with our communities to tackle the health impact of pollution and climate change
- Embedding co-production and engagement

Our journey so far…

We formed in October 2019, following the merger of two strong, high performing NHS Trusts. We now provide **integrated services** for people with physical health, mental health and learning disability needs.

We began co-producing this strategy with our colleagues, people who use our services, and through listening to our other stakeholders and partners by developing our **Trust Values** before our Trust was established.

We commissioned an **independent perception audit** to hear the views and opinions of a wide range of our stakeholders, including the local authorities, local Primary Care Networks (PCNs) which are made up of local GPs, the voluntary sector, governors and members. The overall view was that the newly formed Trust was in a great position to make a real impact and have a leading role in taking forward our health and care system in partnership with those who use it.

Thank you to everyone who has contributed to shaping the future direction and ambitions for our organisation.

Our development work was temporarily put on hold while our teams and services concentrated on responding to the Covid pandemic, but engagement picked up again at the beginning of 2021.

This strategy reflects **what matters most** to the people we've spoken to and sets out our ambitious but realistic plans for **the next five years**. In line with our values, we will continue to listen to and work in partnership with colleagues, patients, carers and our communities to ensure that we deliver '**Better Care Together**'.

About our organisation

We work with **people of all ages** who need support and treatment in both hospital and community settings. The majority of our services are provided in private homes or close to where people live and we try and support patients to avoid a hospital admission whenever possible.

Our services cover the whole of Gloucestershire. We work out of health centres and children's centres, community venues such as libraries or schools as well as in people's own homes. We also provide services from our seven community hospitals, our learning disability unit, our two specialist mental health hospitals and our two recovery units.

Many of our services are delivered in partnership with primary care, social care and the voluntary sector. As a Foundation Trust we also have a Council of Governors and a membership of circa 10,000 staff and public members who provide a level of assurance and support to the Trust Board as we continue to develop and deliver our services.

To find out more about us and our services, please visit **www.ghc.nhs.uk**

Our staff are our most precious resource. They ensure we have the right culture and values to meet the needs of our patients and service users.

We employ **5,400** colleagues working in a variety of roles across the organisation. We have over 40 different professional groups **working across our 140 sites**.

6.4% of our people are from a Black, Asian and Minority Ethnic background (BAME)

3.2% of our people have declared themselves as living with a long-term condition or a disability

84% of our colleagues are female

16% of our colleagues are male

Our services

‘Good’ overall by CQC with XX% of our services rated good or outstanding

£220m
Our annual turnover

XXX
Service users seen by us in 2020/21

XX
inpatient beds to provide care for rehabilitation and specialist learning disability and mental health care

We received **XX** complaints and **XX** compliments in 2020/21

Where are we now

This is our first strategy as a new Trust and it has been developed against the backdrop of a **major health pandemic**.

Covid-19 has impacted not only on the health and wellbeing of our colleagues and the population that we serve, but also the way in which we deliver services. We will continue to review and learn from the changes made during Covid-19 and embed these into business as usual where it is right to do so.

As an organisation we have undertaken an internal review. This helped us to understand our current strengths, weaknesses, opportunities and threats to ensure our strategy recognises our challenges and builds on possibilities.

Key considerations for our services

We offer a diverse range of physical, mental health and learning disability and autism services that cover all age groups. This includes:

- early years services focusing on giving **children and young people** the best start to life and supporting their families to help them thrive;
- helping **people to stay well** by providing support when they experience an acute episode of illness or have a long-term health condition; and
- caring for those who are needing care at the **end of life**.

Our teams work in an **integrated way** to ensure people receive seamless care. This is not just across teams within our organisation, but with our primary care, social care and wider partners.

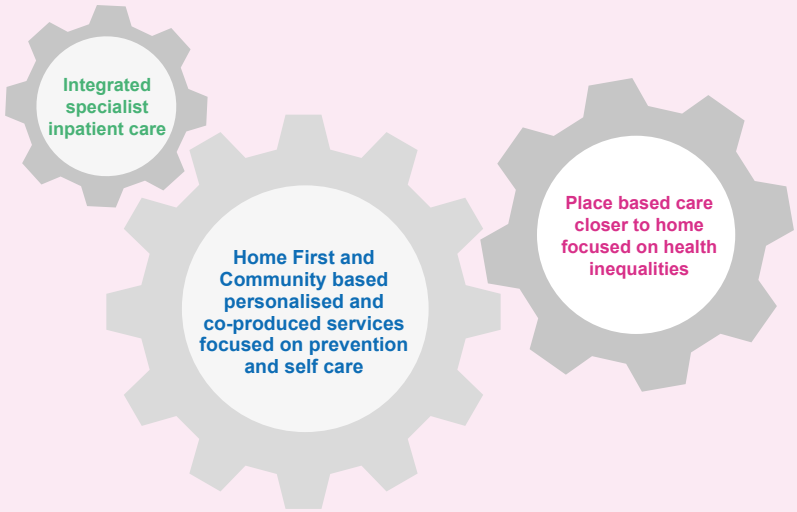
Sometimes **we lead on this work** and at other times we are one of **multiple partners** focused on achieving improved health outcomes for our communities.

We will continue to promote the benefits of **supporting people to live independently in their own homes** and enabling them to **avoid hospital admission**. We will do this by offering **personalised care** where the person and their family/carers are truly able to take more control of their health and well-being. We also recognise the benefit that Experts by Experience and Peer Support can have in planning and developing our services. We will continue to develop our **People Participation approach** and embed the role of **Peer Support Workers** across many of our services.

We will focus on using a **population health management approach** - targeting the right services to those most in need.

We know there are times when people may need specialist mental health or learning disability care or support in hospital. When people do need hospital care due to acute or complex healthcare needs then we want this to be in the least restrictive environment to meet their individual needs. Our services support people throughout their recovery pathway, enabling people to return safely to their homes and communities.

The development of Provider Collaboratives for some of our specialist services has started to deliver clear service and patient benefits and we will continue to develop these where appropriate.



We are currently operating effectively in two provider collaboratives: The Adult Secure/Learning Disability collaborative in the South West and the Children and Adolescent Mental Health Services (CAMHS) /Eating Disorder collaborative in the South East.

Keeping People Safe and Well at Home

A Case Study

The countywide Rapid Response service supports people who are seriously unwell in their own homes or care settings. This not only reduces pressure on the hospitals, it also keeps patients in a familiar setting. The high level of care is delivered 24 hours a day, seven days a week. Team members include nurses, occupational therapists, and physios. Patients are referred by their GP, the ambulance service, and other professionals.

Co-production

A Case Study

The Severn and Wye Recovery College and Live Better 2 Feel Better self- management service provide an educational, one health approach to living well with a range of mental health and long term physical health conditions. It is underpinned by the principles of co-production and jointly led by people with lived experience and professional experience. Working collaboratively with local communities, the people we serve and their carers brings a richness to our teams and services and also supports recovery and inclusion.

Volunteers and Experts by Lived Experience provide us with valuable insights and enhance the quality of care we provide, whilst also challenging us to think differently and address health inequalities across the system in a creative way.

Peer Support

A Case Study

Peer Support Workers use their lived experience to support others and promote hope and recovery. We have Peer Support Workers within our Criminal Justice Liaison Service, Self-Management Hub (Recovery College and Live Better 2 Feel Better) and Perinatal Mental Health Team. We want to build on this and Peer Support Workers will also be part of our Integrated Discharge Hub based at Wotton Lawn Hospital, as well as other services.

Jane McGraham is a Peer Support Worker with the Severn & Wye Recovery College. She said: "I got involved in Peer Support because I had struggled with mental health for several years, and I had been in and out of services. Then in 2014/15 I heard about Recovery College. I went on to do a taster and to take part in several courses. I went on to do a BTEC course so that I could become a co-tutor and an Expert by Experience and in 2016 I became a Peer Support Worker. Whenever we hold courses, students tell us that having Peer Workers makes all the difference, because they have lived experience of mental illness. For me personally it's not just about what I can share with students and the empathy I have, It's also about the continued support I'm able to give to our Experts by Experience and Tutors. Peer Workers have a really strong connection with individuals that live with a mental illness. With their support they can enhance recovery and reduce relapses. I think it would be brilliant to see more Peer Support Workers, and to do this the trust needs to look at where the opportunities are."

Our Approach and Aspirations

We have an exciting future ahead.

Our Mission sets out our purpose as a provider of healthcare:

Enabling people to live the best life they can

Our Vision shares where we want to be in the future:

Working together to provide outstanding care

We will develop our services with those who use them, and in ways that integrate with our communities, the acute hospitals, primary care and social care services delivered by other partners. We will also ensure we reach out to communities that are seldom heard and those groups who don't traditionally access our services.

We will **pursue excellence** in research-based healthcare and be a **learning organisation** focused on delivering the highest possible quality and safest care to the people who use our services.

Our Values define who we are, what we believe, how we will work and the way that we want our patients and service users to describe the experience they receive. We have developed our values with colleagues, members and partners.

We have also codeveloped **behaviours** that reflect these core values and will help us embed them across the organisation.

working together

- Listen closely and consider everyone's point of view
- Work in partnership and recognise each other's expertise
- Communicate openly, honestly and effectively
- Cooperate and support one another

respectful and kind

- Value each other's individuality
- Show appreciation when things go well
- Be friendly, approachable and welcoming
- Uphold and protect dignity and wellbeing

always improving

- Actively seek solutions and ways to improve
- Speak up to promote safety and quality
- Keep learning and developing to make things better
- Be a role model with a positive, can do approach

making a difference

- Take responsibility for our actions
- Take time to understand
- Be open to feedback
- Make the best use of available resources

Our Strategic Aims

We have considered the national and local challenges that we need to address and how we think we can best meet them. As such, we have identified four strategic aims.

Against each of our **strategic aims**, we have identified an **overarching goal and a number of milestones**. We will continue to develop and identify clear measures of success for each strategic aim.

The **goals we have set are challenging**, but we believe this is the best way to ensure we improve the health and well-being of the people we serve.

Each year our **annual business plan will set out the key targets** we will aim to achieve and confirm that our priorities align to the delivery of our overarching strategic aims and strategy.

Strategic Aim One: **High Quality Care**

We will deliver safe, effective, accessible services that meet individual needs. We will work with people who use our services, with carers, and with our colleagues to improve services through **co-production, peer support and personalised care**. We will constantly **listen, innovate, and learn from others** to ensure we deliver the best possible outcomes.

Our Goals over the next five years are to ensure that:

- The people who use our services and their carers report high levels of satisfaction and 'being heard'
- We co-produce quality outcome measures that demonstrate good care
- We achieve an overall CQC rating of 'Outstanding'

For the people who use our services, high quality care means receiving timely, safe and effective care, every time and as close to home as possible. **Our Quality Strategy** will set out the framework for driving further improvements to deliver High Quality Care.

Our High Quality Care Objectives are to:

- Develop and embed our Quality Improvement approach to ensure continuous learning and improvement
- Develop our approach to co-production, personalisation, and the Triangle of Care
- Ensure robust quality assurance processes are in place, helping us to learn when we get things wrong and embed evidence-based practice

Strategic Aim Two: **Better Health**

Better Health means we will work together with people who use and work in our services to meet the needs of our **diverse communities with services that are culturally sensitive and focus on early intervention and prevention**. We will be an active partner at both a locality and system level to tackle the root causes of health inequality and use information, evidence and experience to guide us.

Our Goal over the next five years is to ensure that:

- We work in partnership with our communities to improve the health outcomes of those who are most disadvantaged

Achieving **Better Health** and reducing health inequalities is not something we can achieve alone. It is influenced by many other factors such as housing and educational issues. We will continue to make the best use of our resources; providing interventions that have been proven to make a difference but we must also work with our system partners to deliver the priorities identified in both this strategy and those in the aligned **Health and Wellbeing strategy**.

We need to continue to find alternative ways to ensure we reach out to those communities that don't access our services through our traditional routes and maximise access to all of our communities.

Our Better Health Objectives are to:

- Identify inequalities in our service delivery and develop targeted initiatives to improve them
- Further integrate our physical, mental health and learning disability services by working closely with partners to improve experience and outcomes
- Use Population Health Management and health data at a locality level to identify how people and communities can best be supported
- Implement the universal Personalised Care Model, the Peer Support Worker Model and develop a clear approach to co-production across our services

Strategic Aim Three: **Great Place to Work**

Being a **Great Place to Work** means taking care of our people, with a strong focus on their health and wellbeing. Our organisation will celebrate diversity, ensure real inclusivity and enable everyone to reach their potential. We will make sure colleagues are heard, valued and influential.

We will develop a culture where working life can be **passionate, vibrant and inspiring**. This will help us to attract new people who are as great as those we already have, and we will make sure that those already with us, want to stay.

Our Goal over the next five years is to ensure that:

- A healthy and happy high-quality workforce, performing well in all local and national performance standards

This means that we will have a culture that ensures we **live our values** and that people are supported to be their best. We want to be an organisation that adds value to individuals and to the local economy by creating exciting new roles, apprenticeships, and sustainable job opportunities. Colleagues will be supported to remain healthy both as individuals and as part of a happy team.

Our **People Strategy** sets out the framework for driving further improvements to ensure we deliver our Great Place to Work ambitions.

Our Great Place to Work Objectives are to:

- Invest in our health and well-being offers to ensure our colleagues are healthy, happy and that our workplace is safe
- Create an organisational culture that is welcoming, builds and celebrates inclusivity and diversity and provides a sense of belonging and trust
- Promote flexible working, digital enablement and innovative roles that embrace new ways of working
- Focus on recruitment, retention and talent management at an individual and team level, working in partnership to secure our future workforce supply
- Work closely with system partners and education providers to optimise funding and training that enables workforce transformation

Strategic Aim Four: **Sustainability**

What Sustainability means for us

Sustainability will be central to how we do business and will involve **embracing the latest technology**. It means ensuring we source our goods and supplies responsibly, and that we are an **ethical and respectful partner** whilst striving to make a positive social impact on our local economy.

Our Goal over the next five years is to:

- Demonstrate that we are reducing our total carbon footprint

We will take on a system leadership role and be one of a number of key anchor institutions for economic development and sustainability in the county. This will include helping Gloucestershire to become a **carbon neutral county by 2050**. To achieve this we will need to increase the speed, scale and scope of our sustainability activities.

These will be set out in our **Green Plan** which will be developed during 2021.

Our Sustainability Strategic Objectives are:

- Understand our baseline position in all aspects of sustainable development and set clear and measurable targets
- Take positive action to reduce our carbon footprint and improve air quality
- Take forward Digital by Design to transform our service delivery.
- Maximise our position as a major contributor to our local economy - promoting local, high quality employment opportunities and investment to add wider value across Gloucestershire

Delivering the Strategy

This **strategy is ambitious** and we recognise that there is much for us to do, but it is also measured and **we will be realistic**. We are confident that this strategy will help us achieve our vision and enable us to support people to live well.

We will deliver our strategy through our **Enabling Strategies** and a number of strategic programmes of work, which will focus on delivering our four strategic aims.

The following provides a summary of the key enabling strategies:

Quality

We place quality at the heart of everything we do in order to deliver services and make a positive difference to our communities.

Our focus on quality includes:

- **Patient and Carer Experience** – providing a friendly and welcoming approach from colleagues who communicate openly and clearly
- **Patient Safety** - Providing services that are safe and will not do any harm whilst being open and transparent about any mistakes and ensuring we learn from them
- **Clinical Effectiveness** - Continuously developing our services and learning from best practice and the latest innovations and clinical evidence

Great care comes from working together with people – when we understand people's needs, goals and lived experience we can work with them to support their future aspirations and help them meet their personal goals. Co-production and personalisation are therefore key ambitions for us.

People

We want to create a culture that truly enables colleagues to deliver the best possible care and support services in whatever role or place they work. Compassionate and accountable leadership is key and we need to ensure that we develop both our current and our future leaders to ensure we drive this forward.

We aim to be a leading healthcare employer in Gloucestershire with an inclusive culture that celebrates diversity and attracts, develops and retains its people.

Locally, we are a key partner within the One Gloucestershire Integrated Care System (ICS). This ensures a joined-up approach to workforce management and planning and helps us to collectively develop, agree and access funding for workforce transformation and innovative new roles across all partners.

Our values ensure we focus on equality of opportunity for all, treating people as individuals. We will continue to focus on our Reciprocal Mentoring scheme and being a system leader in rolling this out across the county and in ensuring that everybody is treated with respect and feels valued for the contribution they make.

We will also continuously focus on ensuring we offer great training, development opportunities, succession planning and talent management. The greater use of technology will continue to alter the way in which we operate and we will support our colleagues to be technology enabled and skilled.

We need to think innovatively and creatively to ensure that our roles are attractive and that we recruit the right and best people.

We recognise that having colleagues who feel highly engaged, are healthy and happy in their work and feel appreciated and appropriately rewarded is key to the delivery of high quality services and outcomes for our population.

The NHS People plan was published in mid-2020 and we will build on the six key themes contained within this within our **People Strategy** that will be published in 2021.

Digital

Digital technology will be a key driver and enabler for the Trust over the next five years. It will help us be efficient and effective, make better use of our precious workforce and help improve the experience and outcomes for service users, their families and the wider community.

Through forming the organisation, we have already brought together a number of diverse information systems - including both clinical and non-clinical systems - to ensure that we continue to provide colleagues with access to relevant information and technology from any location and at any time.

However, we know that there is still much for us to achieve if we are to be a system leader that fully utilises technology to drive and shape the way in which we operate. The use of technology will help us with:

- supporting out of hospital care and remote monitoring and support in people's own homes;
- delivering our sustainability ambitions with greater use of virtual meetings and clinical consultation apps;
- smarter and potentially reduced use of phyical buildings;
- using data to drive our decision making and targeting of resources; and
- integrating health and care information across the ICS and the wider region

Where appropriate, we will continue to work on a system wide basis to ensure transformation and best use of the scarce digital resources but we also recognise that there are some projects that will be specific to our services.

Estates

We deliver services from over 140 sites across Gloucestershire and we need to ensure that these offer a good quality, therapeutic environment.

Our **Estates Strategy** will ensure that our buildings are not only fit for purpose, but that they are also in accessible locations that meet the needs of our services now and into the future.

We recognise that the greater use of technology is altering the way in which we use our buildings and this may mean we need to consider using our estate differently.

Our **Estates Strategy** will therefore focus on the consolidation of our existing estate with an emphasis on working collaboratively with our system partners. We have completed an extensive condition survey on all of our sites and we are identifying where we need to invest in strategic sites that have backlog or ongoing maintenance requirements. Our strategy will also identify where we need to upgrade or dispose of our older estate that is no longer fit for purpose.

Research and Innovation

We are well placed to continue to work in partnership across Gloucestershire and the wider South West to ensure we build a strong reputation in running and contributing to local, regional and national clinical research trials and clinical audit.

Our aspiration is to develop an innovation hub where colleagues can come together to champion change and new ways of working. We will work more closely across our academic and research teams, as well as our quality improvement hub and audit teams to ensure we are working together towards better care outcomes and reduce overlap.

We are also committed to working towards 'university status' along with our Gloucestershire health and education partners and exploring how and where we can expand our participation in commercially funded research projects.

Best Value Resourcing

Our best value resourcing approach underpins the delivery of our four strategic aims and all of our enabling strategies and strategic objectives.

We are pleased to be a financially stable organisation with a strong track record of delivering our efficiency programmes and resourcing for value. We have taken forward a number of strategic pieces of work around Patient Level Costings (PLICS) that mean that we are increasingly able to understand our cost base and the drivers around clinical costs.

There is a new financial regime on the horizon as we move towards a more blended payment system and we will continue to use the growing body of community and mental health benchmarking data to continually identify new efficiencies.

The **NHS Long Term Plan** places an ongoing emphasis on the shift to thinking about the financial health of the system rather than at an individual organisation level. In Gloucestershire we are already moving in that direction through the stewardship of our resources at the Integrated Care System level. We will continue to explore the system wide changes and implications on the financial regime within our **Finance Strategy**.

Strategic Service Developments

The following is an overview of a small number of the strategic projects that the Trust is currently working on to support the delivery of our strategic aims. The list is by no means exhaustive, but highlights the range of service developments across our services.

Integrated Community Teams (ICTs) – Continuing to develop our integrated community teams at a locality level and work collaboratively to take forward the new Primary Care Network (PCN) roles to deliver local priorities, identify inequalities and those in greatest need of focused care and support.

Urgent Care Transformation – Embedding our rapid response offer as a core first line service across the community and develop the mental health NHS111 service to support admission avoidance.

Liaison psychiatry services – Continuing to develop the service to meet the two hour wait standards in the Emergency Department.

Community Hospitals – Working within each locality to understand the future role of our community hospitals, including the future need for inpatient based care, minor injury and illness care as we take forward our home based care and clinical triage plans. Our aspiration for the Forest of Dean is to develop a fit for purpose new hospital in Cinderford to open in 2023.

Community Mental Health Transformation – Responding to the national guidance to reshape our community mental health services aligning more closely with the voluntary and community sector, primary care and social prescribing.

Learning Disability Services – Continuing to support the delivery of the Transforming Care work and reviewing the future requirements from our learning disability inpatient service at Berkeley House and understanding the need for an Acute Assessment and Treatment unit (ATU). We will continue to identify and address preventable physical health issues which impact on life expectancy and health inequalities for people with learning disabilites.

Children and Young People's Mental Health Services – Developing our outreach model, working in partnership with other agencies across our system and building on our trailblazer work that interfaces into schools – these approaches will enable children to stay at home rather than need a hospital admission.

Community Forensic Pathway – Developing a new element of our secure services pathway to support people within community settings.

Mental Health Transformation - Implementing necessary changes to our pathways and models of care from the changes to the Mental Health Act with a focus on reducing the length of stay in our inpatient units and the number of people cared for outside of Gloucestershire. This will then link into how our recovery pathways and community pathways align with our inpatient services.

Sustainability Plans – Developing our Green plan to ensure we reduce our carbon footprint where-ever we can including local purchasing of supplies, using green energy and reducing our business miles.

What will delivering our strategy achieve and how will we monitor it?

This strategy sets out our vision, values and strategic aims and our priorities for the next five years.

We recognise that things are increasingly challenging and that we will need to consider innovative approaches to continue to deliver high quality and sustainable services.

Each year we will set our annual actions to keep us on track with our strategic plans – these will be set out in our annual business plans. The Board and Council of Governors will receive regular reports on the progress we are making and importantly, the impact we are having for services users, carers and our colleagues. We will review our strategy each year to ensure that it remains up to date and responds to any changes in the local or national context.

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AGENDA ITEM: 14

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Neil Savage, Director of HR & OD

AUTHOR: Neil Savage, Director of HR & OD

SUBJECT: **DRAFT "OUR PEOPLE STRATEGY"**

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:

Present the Board with the draft "Our People Strategy" – a subset of the emerging Trust Five-Year Strategy – for consideration, comment and agreement in principle prior to it being formatted for launch

Recommendations and decisions required

The Board is asked to:

- Review and endorse the final draft Our People Strategy,
- Provide any further comment or amendments prior to it being reformatted in the style of the new Trust Strategy

Executive summary

Final changes have been made to the earlier versions of the draft strategy to incorporate comments and requests made from individuals, teams, and engagement sessions, Staff Side, Executives and the Resource Committee.

The Strategy highlights our strategic goal "To be a great place to work with a healthy, happy and high-quality workforce" and how we intend to deliver our third strategic aim of being "A Great Place To Work".

Our People Strategy sets out the vision and framework for achieving our goal. It translates the six strategic objectives from the main Trust strategy into six easy to remember "commitments" to deliver our Great Place to Work ambition. These are:

- Model Recruitment & Retention
- Health & Well-being
- Great Culture, Values & Behaviours
- Strong Voice
- Equality, Diversity & Inclusion, and
- Full Potential

The strategy also includes the proposed road map outlining how we intend to approach delivering our goal, aims and commitments, alongside key measures of performance.

Importantly, in view of timing, it is not yet formatted in the style, colour theme and images recently received for the main draft Trust strategy. However, if the Board approve the latter alongside the draft narrative, commitments, road map and key measures of performance contained here, it will be professionally formatted in line with the draft Trust Strategy with infographics after consideration prior to launch.

Risks associated with meeting the Trust's values

The risks to delivery are the ability to deliver at pace with our COVID response and recovery.

Corporate considerations	
Quality Implications	The Our People Strategy and implementation plan is the workforce medium through which the Trust will achieve its strategic aims and ambitions. It presents a real opportunity for the Trust to improve the quality of workforce experience individually and collectively.
Resource Implications	Delivery is largely expected to be completed within existing resources with potential one-off funding opportunities expected to be considered to support emerging implementation plans
Equality Implications	Our People Strategy presents a number of opportunities for the Trust to improve its focus on and related performance on equality, diversity and inclusion within the workforce

Where has this issue been discussed before?
Board Development Session September 2020 Engagement events Resource Committee & Executive Committee December 2020

JNCF January 2021 and further Staff Side meeting February 201 Executive Committee February and March 2021 Resources Committee February 2021

Appendices:	Draft Our People Strategy

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

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Our People Strategy

2021 – 2026

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Our People Strategy 2021 – 2026
"A great place to work"

Introduction

Our **People Strategy** for 2021 – 2026 will take us towards being a **Great Place To Work**. We pledge to put all colleagues, at all levels and roles across our organisation at the heart of this strategy and to focus on the things that colleagues have told us are the most important.

The Trust formed in 2019 following the merger of two strong, high performing Trusts and this strategy will build on the creativity, passion, drive and expertise shown by our colleagues in that process as well as building on the experiences of our responses to COVID and the NHS People Plan.

*We have produced this strategy to explain how we will work with our colleagues to deliver our ambition and intent to be a **Great Place To Work**. It outlines our need to continue to reflect, learn and adapt at pace to the unprecedented challenges our workforce have, and continue to face.*

We have co-produced this strategy with our colleagues and by reflecting on what we've been told through the Staff Survey and other engagement events. This strategy reflects **what matters most to our colleagues** and sets out our ambitious but realistic plans for the next five years. In line with our values we will continue to listen and work in partnership with colleagues as well as patients, carers and communities.

Our strategy therefore outlines a wide range of plans and priorities, including:

- Attracting and retaining colleagues with a focus on job design, digital enablement, flexible working and innovative roles
- Developing our health and well-being offers to support all colleagues
- Creating a supportive culture with great values and behaviours
- Enabling people to have strong voices, to be influential and empowered
- Ensuring equality, diversity and inclusion are at the heart of what we do
- Offering opportunities for people to reach their full potential, by ensuring they are appropriately skilled to provide consistently great services, that there are succession planning and talent management approaches in place to ensure a sustainable future workforce.

About our organisation

We work with **people of all ages** who need support and treatment in both hospital and community settings. The majority of our services are provided in private homes or close to where people live and we try to support patients to avoid a hospital admission whenever possible.

Our services cover the whole of Gloucestershire. We work out of health centres and children's centres, community venues such as libraries or schools as well as in people's own homes. We also provide services from our seven community hospitals, our learning disability unit and our two specialist mental health hospitals.

Many of our services are delivered in partnership with primary care, social care and the voluntary sector. To find out more about us and our services please visit www.ghc.nhs.uk

INFOGRAPHIC ON KEY PEOPLE FACTS WILL BE ADDED HERE

Our People are our most precious resource. They ensure we have the right culture and values to meet the needs of our patients and service users.

We employ 5,500 colleagues working in a variety of roles across the organisation. We have over 40 different professional groups working in our community and across circa 200 bases.

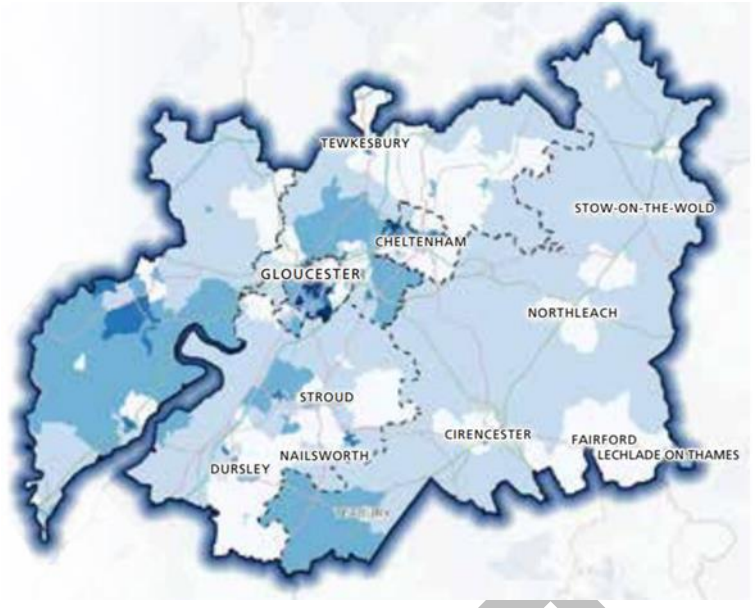
- **Ethnicity** - 6.2% of our people are from a Black and Ethnic minority background (BAME), coming from at least 68 different countries, from Australia to Zimbabwe.
- **Disability** - 3.2% of our people have declared themselves as living with a long-term condition or a disability
- **Gender** - 77% of our people are women and 23% are men
- **Turnover** - 10 to 13% of our workforce leave annually for retirement or other roles
- **Vacancies** - 6 to 7½% of our posts are vacant at any one time
- **Recruitment** - 100 to 200 recruitment adverts are live over any given month

Our Services

Our services were rated 'Good' overall by the Care Quality Commission (CQC) in 2018 for both legacy organisations. For physical health services we were rated 'Good' on Safe, Effective, Caring and Well-led domains. Our Responsiveness needed improvement. For mental health and learning disabilities services, we were rated 'Good' for Effective, Caring, Responsive and Well-led. We required improvement for aspects of our learning disabilities services and staffing in two specialist areas.

Our annual turnover is circa £220m, with **70-75% of our income being invested in our people.**

We are a key partner within the Gloucestershire Integrated Care System (ICS) which enables a strong focus on the development of system wide strategies for recruitment, retention, workforce development and planning. It is also pivotal in accessing **funding for workforce transformation, innovative new roles and ways of working.**



We have strong relationships with a wide range of local and regional organisations including Health Education Institutes (HEIs), Health Education England (HEE), the NHS Leadership Academy, apprenticeship providers and the Academic Health Science Network (AHSN). We will continue to foster and develop these relationships as they are pivotal to supporting the supply of our future workforce and the ongoing development of our colleagues.

As we have worked in partnership with the University of Gloucestershire to tackle our recruitment challenges, we have also continued to work with Universities of the West of England and Bath, alongside more recently, the University of Worcestershire and ICS partners in Gloucestershire, Herefordshire and Worcestershire to create a new Three Counties Medical School to improve the supply of local medical staff.

OUR CURRENT PERFORMANCE

We assess our current **workforce performance** using a number of HR Key Performance Indicators (KPIs), alongside the Staff Survey, Friends and Family Tests (FFT) and regular well-being pulse checks.

Key highlights include:

- 71% of colleagues would recommend the Trust as a place to work
- 79.5% of colleagues would recommend the Trust to provide care
- Appraisal – 90% of our people have an annual appraisal though this has been impacted by the pandemic (76% March 2021)
- Training – 90%+ of our people are typically up to date with their statutory and mandatory training, although again this has been impacted by the pandemic (85% March 2021)
- Sickness Absence – between 3.9 and 5% of our people are off sick at any given time
- 2020 Staff Survey tells us that we have **modestly improved our scores since 2019** but still have more work to reach consistent top quartile performance
- Response rate - 46.3% demonstrating a 10% to 13% increases in our response rate over the two legacy organisations
- Most highly rated in the questions relating to:-

    - Safe Environment – Violence
    - Equality, Diversity & Inclusion
    - Safe environment - Bullying & Harassment
- 56% of our ratings improved; 24% remained unchanged whilst 20% worsened
- Of the Ten Themes - 7 had improved, two were unchanged, and one worsened
- There was a 10% improvement on colleagues agreeing the Trust takes positive action on Health and Well-being

Where are we now

This is our first People Strategy as a new Trust and it has been developed against the backdrop of a **major global health pandemic.**

Covid-19 has impacted not only on the health and well-being of our colleagues and the population that we serve, but also the way in which we deliver services. We will continue to review and learn from the changes made during Covid-19 and embed these into business as usual where it is right to do so.

Crucially, much of the strategic and operational focus for our colleagues will continue to be on health and well-being, retention, recruitment and leadership.

In responding to the pandemic we fully recognise that;

- Colleagues have worked far more closely together integrating their approaches to the people who use our services to provide outstanding care
- Digital communications and home working have become the norm
- Colleagues have become empowered to deliver fast, personalised care following effective risk assessed practices
- People have shown real flexibility and adaptability through redeployment
- Working Well and our Health and Well-being Hub have worked highly effectively to support colleague's health and resilience
- In many cases recruitment, induction, on-boarding and training have become radically different

In tackling the pandemic we recognise our colleagues have been utterly fantastic.

Our Strategy has taken account of and **needs to be aligned** with the following national, regional and local guidance and plans;

- The ***NHS People Plan*** published in mid-2020
- *Stepping Forward to 2020/21: the mental health workforce plan*
- *The **Gloucestershire ICS People Plan and Strategy** (2021)*

The **NHS People Plan** focusses on prioritizing the following themes:

- **Looking after our people** particularly the actions we must all take to keep our people safe, healthy and well – both physically and psychologically

- **Belonging in the NHS** highlighting the support and action needed to create an organisational culture where everyone feels they belong

- **New ways of working** and delivering care emphasising that we need to make effective use of the full range of our people's skills and experience to deliver the best possible patient care

- **Growing for the future** particularly by building on the renewed interest in NHS careers to expand and develop our workforce, as well as retaining colleagues for longer

In turn, these national strategic themes aim to deliver improvements in each of the following areas across the NHS:- NEW INFOGRAPHIC WILL BE ADDED HERE

The **Gloucestershire ICS** People Plan reflects and aligns to the national priorities and themes and has been updated in 2021 to reflect the following achievements which the Trust has made a significant contribution to:

- Introducing a range of new and different approaches to education and learning that is unique to Gloucestershire and supports the increased number of healthcare staff becoming registered
- Implementation of an ICS Apprenticeship Hub (hosted by the Trust)
- Training 2,000 colleagues in health coaching, supportive technology and healthy lifestyles
- Delivering improvements against the national 7-day working standards
- Achieving further integration of back office functions across our system
- Achieving a reduction in agency and temporary staff costs and joined up
- approaches to workforce capacity and planning across all partners

Our Approach and Aspirations

The **goal** of Our People Strategy over the next 5 years is:-

To be a healthy and happy high quality workforce, performing well in all local and national performance standards

Through this goal we will enable the delivery of our wider organisational strategic aims of:-

Our overarching Trust Strategy describes being a **Great Place to Work** as;

Taking care of our people, with a strong focus on their health and well-being. Our organisation will celebrate diversity, ensure real inclusivity and enable everyone to reach their potential. We will make sure colleagues are heard, valued and influential.

We will develop a culture where working life can be passionate, vibrant and inspiring. This will help us to attract new people who are as great as those we already have, and we will make sure that those already with us, want to stay.

Our Six Strategic Objectives & Our Commitments

Our People Strategy sets out the framework for achieving our goal. To this end, the main Trust Strategy has established six strategic objectives for our Great Place to Work ambitions.

- Invest in our health and well-being offers to ensure our colleagues are healthy, happy and that our workplace is safe
- Create an organisational culture that is welcoming and celebrates inclusivity and diversity and provides a sense of belonging and trust
- Promote flexible working, digital enablement and innovative roles that embrace new ways of working
- Focus on recruitment, retention and talent management at an individual and team level, working to secure our future workforce supply
- Work closely with system partners and education providers to optimize funding and training that enables workforce transformation

For the purposes of Our People Strategy, following consultation and engagement, these have been captured and defined as six easy-to remember commitments which are outlined below:-

Model Recruitment & Retention

We will attract new people who are as great as those we already have. We will do what we can to encourage people to stay, welcoming flexible working, innovative roles & new ways of working

Health & Well-being

We will put the physical & mental health & wellbeing of our people as one of our top workforce priorities

Great Culture, Values & Behaviours

We will develop a great culture with kind, compassionate leadership, strong values & behaviours, & where working life can be passionate, vibrant, innovative & inspiring

Strong Voice

We will make sure people have a strong voice, are heard, valued & influential in the organisation & in the wider local, regional & national systems

Equality, Diversity & Inclusion

We will be a fair organisation that celebrates diversity & ensures real equality & inclusion. People will be able to bring their hearts to work, free from bullying or discrimination

Full Potential

We will make this a place where people get great training & development to realise their full potential. We will develop stronger partnerships with education & training providers

Against each of these commitments**,** we have identified a number of key deliverables and measurements.

We will keep our approach dynamic and responsive, continuing to develop and review our implementation plans on an annual basis. The Road Map in Appendix 1 highlights our general approach.

Commitment 1 - Model Recruitment & Retention

"We will attract new people who are as great as those we already have. We will do what we can to encourage people to stay, welcoming flexible working, innovative roles & new ways of working"

This means we will continue to **develop our recruitment and retention practices, policies and procedures**. We will increasingly use innovative ways to recruit and retain a more diverse workforce, reducing recruitment times and removing un-necessary processes.

We will provide a range of corporate and local **tools to support retention**. New colleagues will be warmly welcomed with comprehensive local and corporate induction. New colleagues will undertake a "Starting Well With Working Well" health and well-being programme which will support their journey with the Trust.

We will embrace innovative roles, new ways of working and delivering care, and flexible working to support recruitment and retention.

Commitment 2 - Health & Well-being

"We will put the physical and mental health & wellbeing of our people as one of our top workforce priority"

This means we will look after our people, by prioritising **health and wellbeing**, investing in **Working Well** occupational health services and develop innovative new ways to support great well-being at work and beyond.

We will ensure access and signposting to well-being resources with regular opportunities for conversations with line managers and Working Well that support health at work and more widely. We will champion our Wellbeing Guardian and Health and Wellbeing Hub to ensure we take a dynamic and effective approach to the wellbeing needs of the workforce.

Colleagues will have a **personal health and well-being plan** through corporate induction and appraisal. We will also ensure health and wellbeing conversations are not seen as an 'extra' or necessarily 'separate' conversation, taking a holistic approach to every conversation we have with our staff, and viewing them as opportunities to check on health and wellbeing.

Commitment 3 - Great Culture, Values & Behaviours

"We will develop a great culture with kind, compassionate leadership, strong values & behaviours, where working life can be passionate, vibrant, innovative & inspiring"

Our Values define who we are, what we believe, how we will work and the way that we want our patients and service users to describe the experience they receive. We have developed our values with colleagues, members and partners.

We have also co-developed **behaviours** that reflect these core values and will help us to mainstream them into policies, procedures and practices, embedding them across our organisation.

Leadership and management development will be provided which nurtures our values and behaviours, and which fosters kindness, civility and compassion in our workplace.

Our appraisal, performance management and reward and recognition approaches will focus on supporting a great workplace culture.

Commitment 4 - Strong Voice

"We will make sure people have a strong voice, are heard, valued & influential in the organisation & wider local, regional and national systems"

We will provide the right culture, practices and opportunities for colleagues to have a strong voice with routes to co-develop and co-design what matters.

We want colleagues to 'speak their truth', by being confident to get involved, sharing great ideas, speaking up, and raising concerns. We will encourage colleagues to report issues, incidents and near misses, and we will ensure there is timely feedback on actions taken.

We will champion and develop the roles of the Guardian of Safe Working, Freedom To Speak Up Guardian and Advocates.

Wider Staff Forums, the Chief Executive's "Open Door", surveys, focus groups and wider engagement and reporting systems will ensure colleagues are heard, valued and influential in the organisation and greater system.

Commitment 5 - Equality, Diversity & Inclusion

"We will be a fair organisation that celebrates diversity & ensures real equality & inclusion. People will be able to bring their hearts to work, free from bullying or discrimination"

We will proactively champion equality, diversity and inclusion through our practices, policies and procedures to ensure fairness. We will tackle inequalities, bullying and discrimination decisively and our leaders will recognise, listen to and act on any issues. We will welcome people with an inclusive culture of belonging and trust which creates a sense of real belonging.

We will embed evidence based training on equality and diversity, whilst ensuring equal access to training and development and fair promotion opportunities. We will also recognise and act when people are coming from a place of great disadvantage and need extra help.

Our Diversity Networks and its sub-groups will be key and appropriately invested in to provide supportive and welcoming spaces for all our colleagues. Our Networks will looks beyond the boundaries of the Trust to work with colleagues across the system, regionally and nationally.

We will improve diversity at all levels in the organisation by taking positive action, particularly at more senior levels.

Commitment 6. Full Potential

> *"We will make this a place where people get great training & development to realise their full potential. We will develop stronger partnerships with education & training providers"*

We will provide great training and development opportunities to help people realise their full potential in the workplace. We will continue to strengthen and further develop our partnerships with HEIs, apprenticeship, education and training providers.

Our leaders and managers will work in partnership with colleagues to take action and provide support to nurture a culture where people have clear plans for training, personal development, appraisal, succession planning and talent management.

We will ensure all colleagues have access to CPD resources. Working closely with the ICS, HEE, Leadership Academy, HEIs and other education and training partners, we will optimise funding & training to enable workforce sustainability and transformation.

Digital enablement will be key to help colleagues work efficiently and we will ensure people are skilled and have access to the right technology to support their role.

DELIVERY PLAN AND PERFORMANCE MEASURES

We will know we have achieved our goal when we are consistently performing in the top quartile of ratings as measured by the Staff Survey, Staff Friends and Family Tests, and Health and Well-being Pulse Surveys.

Importantly, as we developed Our People Strategy, colleagues told us clearly what over the coming five years they would like people to increasingly say about working in the organization. Comments included:-

We like and want to be at work

We enjoy our work and have great colleagues

We are able to take rest breaks and not feel guilty

We rate the Trust as a quality health and care provider

We recommend the Trust as a model employer of choice

Our managers and leaders listen to us, respond, empower and support us

Everybody believes this is a fair place where equality, diversity and inclusion are core

Everyone lives our values and the values are embedded in everything we do

People are genuinely valued, recognized and rewarded for their contributions and service

We will have developed a coaching culture throughout the organization with an infrastructure to support this

We will have a culture of trust, openness and compassion that supports our colleagues to be themselves, to innovate and be the best they can be

In order to achieve our people goals we will need to be clear about how awe measure our progress and success. To this end, alongside delivery of our annual business plans, the following will be used as **key measures of our performance**.

Our Aims	Our Targets	Our Actions	Link to Objectives
Embedded high quality annual appraisal reviews and regular 121s	**Completed appraisal rates** March 2022 – 90% March 2023 – 95% Increase response to questions 4, 5, 8 of Staff Survey	• Line Manager and Directorate action plans • Revised Appraisal and 121 documentation • Appraiser & appraisee training resources & guidance • e-Appraisal option	1, 2, 3, 4, 5, 6
Job Planning embedded, ensuring improved clarity of role responsibilities	**Completed Medical Job Planning rate** March 22 - Consultants – 90% % increase in response to questions 4, 5, 8 of Staff Survey	• Consultant Job planning audit action plan • Updated guidance, training and support developed in partnership with the Local Negotiating Committee • e-job planning system & guidance for nurses and AHP's	1, 3, 4, 6
Colleagues will be up to date in their essential to role training and feel more confident in their work	**Training compliance rates** March 2022 - 90% March 2023 - 95%	• Corporate, Directorate & Line Manager action plans • Monthly training KPI reports • Embedding & developing new Care to Learn e-learning platform • Dynamic targeted reviews of staff group training profiles	1, 2, 3, 5, 6
Colleagues will be more inclined to stay with the organisation for their career development	**Turnover rates** March 22 – 11% reducing 0.5% annually to 9% by 2026 Annual increase in Q 19 b & c of Staff Survey	• Retention Lead and & retention implementation plan in-year pilot • On-boarding check-ins in 1st year • Flexible working, flexible retire & return, & internal secondments policy reviews • Local recruitment & retention premia	1, 2, 3, 4, 5, 6

		(RRP) & 'golden hellos & tie-ins' for difficult to recruit roles • Refreshed self e-rostering targets	
Reduced turnover and a reduction in time to fill vacancies will less temporary staffing / agency need	**Vacancy Factor** 6% by March 2022, with 0.5% reduction year-on-year, reaching 4% by March 2026. **Time to Hire** - from 'advert live to candidate cleared to start' from 54 working days average to <40 by end March 2026.	• Increase targeted fast track recruitment • Improve system, processes & risk management • Retention Lead and implementation plan • Roll out all electronic aspects of NHS Jobs for approvals/ shortlisting& KPI reporting • Targeted interventions in higher vacancy factor areas	1, 2, 3, 4, 5, 6
Lower use of agency staffing, with lower costs, higher continuity and quality of patient care	Zero HCA vacancies Reduction of registered general nursing vacancy factor to 3% by end Q3 2021/22 10% in-year reduction of medical locums by end March 2022 5% year-on-year growth of internal bank workforce numbers	• Planned over-recruitment plans for HCA • Completion of International Recruitment pilot of 60 registered nurses • Growth of internal locum bank and embedding Locum's Nest for Medical Staffing temporary staffing • Review of Master Vendor Contract and HTE framework opportunities • Targeted recruitment fayres e.g. RCN and RCP • Review & further development of the peripatetic HCA temporary staffing model for Community & Community Hospitals	1, 6
Colleagues will be better supported to be healthy and well alongside	Improved attendance management - March 2022 - 4% sickness absence, with 0.25% reduction year-on-year, reaching 3% by	• Development of a Health and Well-being strategy • Annual Health and Well-being Needs Assessment survey.	1, 2, 3, 4, 5, 6

clear Working Well processes to support people with appropriate return to work plans.	March 2026 Consistent top Quartile ratings from colleagues in health & well-being Pulse Surveys by 2022	• Improvement plans in place across services • Review Supporting Attendance Management At Work policy in 2021 • Development of wider health and well-being offers • Ensure high take up of COVID and annual seasonal flu vaccinations	
Better support to implement the conduct and capability management and resolution tools and processes.	March 2026 - 25% total reduction in both March 2021 baselines – 5% reduction year-on-year	• On-going roll out of just culture and appreciative enquiry principles • A new leadership development programme with a focus on people management • Expansion of our internal and external coaching resources and training, alongside values based recruitment • Working in partnership with trades unions • Review our Dignity At Work policy and officers model • Treble the number of workplace mediators to assist in resolution and use professional external mediation where necessary	1, 2, 3, 4, 5, 6
Our colleagues will be more likely to recommend the Trust as an employer and care provider (Friends & Family Tests – FFT)	75% target approval rating in 20/21 for "I would recommend my organisation as a place to work" 80% by 2022/23, reviewable thereafter 82.5% approval rating in 20/21 for "If a friend or relative needed treatment, I would be happy with the	• Increased communications with staff on our patient survey and FFT performance • Seek views of colleagues on what would improve the scores • Embedding the learning from the leadership development programme	1, 2, 3, 4, 5, 6

	standard of care provided by the organisation" by 21/22 85% by 2022/23, reviewable thereafter		
Increased engagement and responses to the survey & demonstration of clear action being taken.	55% for 2021/22 60% for 2022/23 65% for 2023/24 70% for 2024/25 75% for 2025/26.	• Targeted OD interventions in identified low response teams • Continued development of our hybrid paper/ electronic survey options • Increased completion prizes and "you said, we did" communications	1, 2, 3, 4, 6
Consistent top quartile performance across all ten survey Themes	By 2025 Survey	• Development of in-year Staff Survey action plans	1, 2, 3, 4, 5,6
Higher engagement from our people and increased involvement in improving the organisation	Engagement scores of 7.3 for 2021/22 7.4 for 2022/23 7.5 for 2023/24 Reviewable thereafter	• Development of in-year Staff Survey action plans and other strategy actions actions • Relaunch the Executive Director Walkabout programme • Roll out polling software to improve engagement and involvement	1, 2, 3, 4, 5, 6
To have 95% of colleagues trained in equality, diversity and inclusion, to have reduced Gender Pay Gap reporting, and to have increased diversity in senior roles with BAME	Increasing the % of disabled / long term condition colleagues in AfC Bands 5,6,7, 8a and 8b roles to 4% by end 2022/23 Match the 2020 % representation of BAME colleagues in Band 2 to 6 roles in Bands 7, 8 and 9 roles.	• Deliver the in-year suite of Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) implementation plans • Review of our equality and diversity training provision in 2021 • Positive recruitment and promotion	1, 2, 3, 4, 5, 6

and Disabled staff feeling opportunities for development are more equal.		actions on gender, ethnicity & disability	
Colleagues feel empowered to report incidents, issues and near misses	Staff Survey Q17 – increase all three aspects to 85% by 2025/26 Increase in annual numbers of Datix incident reports	• Corporate communication plan ensuring feedback from each of the key platform / routes • Directorate level targets and plans for improvement and feedback routes	3, 4

GOVERNANCE

Subject to the current review of Trust Board Committees, the delivery of Our People Strategy will be overseen by the Trust's Resource's Committee, and assurance will be given to the Board via committee updates alongside an annual Board progress update.

An Our People Strategy operational oversight group will be created to assist with delivery. Similarly, a number of committees and working groups will report through to the Executive Committee and Resources Committee. These include Agency and Bank Management Group, Workforce Management Group, Joint Negotiating and Consultative Committee, HR Policies Working Group, Health and Well-being Hub, and the International Recruitment Working Group.

Standing 6-monthly progress reports will be provided to Resources Committee alongside annual progress reporting to the Board of Directors. Exceptional developments will be reported on as and when required to both Committee and Board.

SUMMARY

We know that our services face significant challenges and opportunities in the coming years over the life of this strategy, whether these are from how we provide services, the cost of services or who provides them. Achieving our stated goal of being a great place to work, with a healthy, happy and high quality workforce, will not be easy or straightforward. However, it is the ambitious goal we wish to achieve to maximize the benefits to the health, wealth and well-being of our community and workforce.

Our People Strategy aims to deliver our goal by identifying the important areas of focus and action in areas we know will help us to make a positive difference and achieve our wider Trust vision, aims, and objectives.

We appreciate that the strategy will need to remain dynamically under review and will be subject to changes over the coming years. To this end we will review the strategy annually alongside using the cycles outlined in our **Road Map** contained in appendix 1 - Establish, Build & Embed, Consolidate & Review. We also very much appreciate that new issues, new opportunities and new technologies will arise over the life cycle of the strategy. In responding to these our intent is to ensure we continue to engage and involve our colleagues and our partners in coming up with fresh ideas and solutions.

We hope we have got our approach right, but realise that it also won't be perfect. In mitigating this, we will rely on colleagues at all levels in the organisation in speaking up and flagging what we are getting right and what we can improve on or do differently going forwards.

Thank you for taking the time to read our strategy and joining us on the journey.

Appendix 1

Strategic Aim Three: Great Place To Work – A Road Map

Year 1: ESTABLISH

- Pandemic Workforce Recovery Programme
- Develop Recruitment & Retention Strategy & implementation plan
- Launch revised Health & Well-being Strategy & implementation plan
- Revise & refresh key workforce policies & procedures e.g. Flexible working, Flexible retire & return, Dignity at Work, Speaking Out
- Complete clinical services harmonisation of e-rostering
- Implement values-based Monthly Recognition & new Annual Staff Awards framework
- Launch Civility Saves Lives programme with Freedom to Speak Up and Just Culture e-learning
- Optimal use of full NHS Jobs functionality
- Embedding of new Care to Learn e-learning management platform
- Review EDI training & agree EDI Network action plans
- Commence Brilliant Essentials, Leading Better Care Together & Stepping Up leadership development programmes

Year 2: BUILD & EMBED

- Introduce and develop new roles to tackle long-term staff shortages e.g. assistant & advanced practitioners, associate physicians
- Develop Career Progression pathways and case studies e.g. Apprentices, HCAs, registered nurses & AHPs
- Develop succession planning & talent management framework
- Explore alternative sources of workforce supply, e.g. volunteering, military, schools & colleges
- Identify & implement a local digital engagement programme & tool
- Develop pre-employment Values & Behaviour e-learning pre-application resources
- Review & refresh

Year 3: CONSOLIDATE

- Introduce an in-house or ICS Careers, Stretch Projects & Secondment Advisory Service
- Strength Veterans & Military Network & achieve Gold status.
- Develop Good Work Job Design Framework
- Introduce in-house or ICS Careers Advisory Service
- Develop a programme of in-house / ICS secondment opportunities stretch projects
- Scale up new roles to tackle key staff shortages
- Review & refresh

Years 4 & 5: REVIEW

- Review, refresh & detail years 4 & 5 activities, in line with current Trust risks and needs, alongside our first 3 years' learning and significant national NHS, regulatory and good practice developments

MEASURES OF IMPACT

- Staff Survey
- KPIs
- Staff Friends & Family Test

Our Ambitions:

Taking care of our people, with a strong focus on their health and well-being. Our organisation will celebrate diversity, ensure real inclusivity and enable everyone to reach their potential. We will make sure colleagues are heard, valued and influential.

We will develop a culture where working life can be passionate, vibrant and inspiring. This will help us to attract new people who are as great as those we already have, and we will make sure that those already with us, want to stay.

This goal supports & enables our other Strategic Goals of High Quality Care, Better Health Outcomes & Sustainability

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD**

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 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:

- **Receive, note** and **discuss** the February 2021 Quality Dashboard

Executive summary

This report provides an overview of the Trust's quality activities for February 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forum for assurance.

Quality issues for priority development

- Work is underway to design the 2021/22 Quality Dashboard, the quality team will be using quality metrics from a wider range of Trust services such as sexual health, dental, complex leg and specialist mental health/learning disability services, to commence from April 2022.
- A quality deep dive into the Memory Assessment Service is planned for inclusion in the next Quality Committee Dashboard.
- CPA compliance remains under threshold and a CPA audit has commenced to understand challenges.

- Continued focus and quality improvement work to enhance recovery within the complaint management process following the national pause.
- To support the NHS Long Term Plan to eliminate out of area mental health placements, there is a comprehensive quality improvement plan in place which focuses on governance and leadership, operational practice, and service development.

Quality issues showing positive improvement

- The number of Category 1 and 2 acquired pressure ulcers has reduced to below threshold and for the first time since September there were no reported Category 4 acquired pressure ulcers in the month of February
- 89% of all GHC staff have now received their first vaccination for Covid-19
- An action plan is being delivered and a monthly exception reporting regime in place for recovering resuscitation and restrictive physical intervention training (PMVA and PBM) compliance.
- The regrouped training strategy for medical emergency training has been well received by frontline staff and found to increase staff confidence in the application of skills following the reduction in face to face training resulting from COVID.

Are Our Services Caring?

Good assurance is available with regard to satisfaction levels via FFT which are sustained at above 95%. The Board has previously asked for assurance regarding physical health interventions for people accessing our mental health services; there is a focus on this within the Dashboard and the Board is asked to note the assurance this provides. The Q3 Non Executive Director audit of complaints provided assurance overall regarding the quality of complaint investigations, but final response timescales were noted as requiring significant improvement and these remain a priority for the service in line with Covid 19 disruption recovery work.

Are Our Services Safe?

The Board are asked to note that for the first time since November a reduction in the percentage of patient safety incidents meeting moderate, severe and death thresholds which are now below 8%. This is attributable to the reduction in the reported total number of developed or worsened acquired pressure ulcers within the Trust. Good assurance is available that our serious incident management remains robust, with all open investigations on trajectory for completion within defined timescales. Stocks of PPE remain good and the Trust is fully assured on future supply of all stock items via national supply routes. The Trust also published a research study regarding the use of PPE and mental health physical interventions that has been well received.

Are Our Services Effective?

Board are asked to note the critical role that the Trust is playing in system-wide patient flow. Daily robust clinical challenge to ensure that 'Home First' is considered as the first option for patients moving across the system and Community Hospitals beds are being

utilised to maximise a person's sub-acute and or rehabilitation needs. GHC are active participants of the ECIST improvement 30-day plan for One Gloucestershire. Early Intervention and IAPT services continue to perform above threshold and it is reassuring to note that the National Childhood Measurement Programme can recommence following the reopening of schools. The occupied bed days for inappropriate out of area placements in January was 28 days. To support the NHS Long Term Plan to eliminate out of area placements there is a comprehensive quality improvement plan in place which will focus on Governance & Leadership, Operational Practice & Service Development. This will include a better understanding of patient flow within the Mental Health Units and is expected to identify opportunities for improvement.

Are Our Services Responsive?

Good assurance is available that the Trust are adhering to national PHE admission guidance in order to minimise the risk of nosocomial transmission whilst supporting an increased demand for Community Hospital beds. Following agreement at the Health Overview and Scrutiny Committee Tewkesbury MIIU will reopen from 1 April 2021. CPA compliance remains below threshold and is likely to remain so until the impacts of Covid-19 disruption reduce within community services although Board are asked to note that an audit has commenced which will inform recovering the position.

Are our Services Well Led?

The Board are asked to note the increase in overall training compliance to 85.2% this month, and the increased focus on improving compliance for both resuscitation and physical intervention training. The Trust is able to report good levels of staffing maintained in inpatient areas set against safe staffing levels despite Covid challenges. International recruitment work continues and 20 new registered nursing colleagues will be joining our Community Hospitals in April and May 2021. Trust colleagues featured in a recent WHO film documenting the experience of health care staff through the pandemic and the impact on psychological wellbeing. Veteran support within the organisation is progressing well and work is ongoing regarding the Military Charter accreditation recently awarded. This month we also include the Medical Directorate Guardian of Safe Working Hours update. The Q3 report identifies that there were 4 exceptions in this period, along with an explanation as to why these occurred.

Risks associated with meeting the Trust's values

Specific initiatives or targets that are not being achieved are highlighted in the Dashboard. Key quality and safety risks are included 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?
Quality Assurance Group and monthly reports to Quality Committee

Appendices:	Quality Dashboard Report

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

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AGENDA ITEM: 15.1

Quality Dashboard 2020/21

Physical Health, Mental Health and Learning Disability Services

Data covering February 2021

Executive Summary

NHS
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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. 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?

Nine complaints were received in February; a marginal increase on historical norms. The number of complaints open for 7-12 months is now beginning to reduce due to recovery work and temporary reallocation of resources. The Q3 Non Executive Director audit of complaints provided assurance overall regarding the quality of complaint investigations, but final response timescales were noted as requiring significant improvement and these remain a priority for the service in line with Covid 19 disruption recovery work. The number of compliments received each month has remained relatively stable over the past 6 months but these are lower than the monthly average of 245 in 2019/20. FFT levels of satisfaction have remained at or above the 95% threshold for three consecutive months. As requested at the last Board meeting when discussing CQC Community Mental Health Survey results, the Quality Dashboard contains a focused slide on the physical health interventions for people accessing our community mental health services. The 2020 score for this question shows an improvement compared to 2019 (from 5.2 to 5.7 out of 10), and for the 3rd consecutive year. The range of interventions and initiatives in place provide assurance that support is offered and continuously improving.

Are Our Services Safe?

Incident reporting rates are consistent with established averages and, for the first time since November, we are seeing the percentage of patient safety incidents meeting moderate, severe and death thresholds dropping below 8%. This coincides with a reduction in the reported total number of developed or worsened pressure ulcers. The number of Category 1 & 2 acquired pressure ulcers has reduced to below threshold and, for the first time since September, there were no reported Category 4 acquired pressure ulcers. There are currently 8 active SIRIs. All current active SI investigations are on target to complete within statutory time frames. Greater detail is provided this month regarding ongoing developments to improve pressure ulcer care. Three Covid-19 deaths were reported by GHC inpatient services during February and the number of community Covid-19 deaths decreased. There were no new cases of Covid-19 detected in GHC in February other than those who were positive prior to admission to GHC. Stocks of PPE remain good and the Trust is fully assured on future supply of all stock items via national supply routes**.** The Trust also published a research study regarding the use of PPE and mental health physical interventions that has been well received. As of 19/03/21 89% of all GHC staff have now received their first vaccination for Covid-19 and 28% have received their 2nd vaccination. BAME colleague vaccination numbers are 64%. Robust systems are in place to vaccinate all eligible inpatients and vulnerable service users such as homeless health care and those with a learning disability.

Are Our Services Effective?

GHC continue to play a critical role in system-wide patient flow, The Demand and Capacity team has been strengthened to enable daily robust clinical challenge to ensure that 'Home First' is considered as the first option for patients moving across the system and Community Hospitals beds are utilised to maximise a persons sub acute and or rehabilitation needs. GHC are active participants of the ECIST improvement 30 day plan for One Gloucestershire, focussing specifically on; refining the processes between the Trust and Adult Social Care, admission avoidance and strengthening the reablement offer to support early discharge. Early Intervention and IAPT services continue to perform above threshold. The National Childhood Measurement Programme will recommence now that schools are reopening. The occupied bed days for inappropriate out of area placements in January was 28 days, this related to 1 PICU placement. To support the NHS Long Term Plan to eliminate out of area placements, there is a comprehensive quality improvement plan in place which focuses on governance and leadership, operational practice, and service development. This will include a better understanding of patient flow within our Mental Health Units.

Are Our Services Responsive?

In response to a sustained increased demand for Community Hospital beds NTQ have led a daily 'single room' challenge with operational colleagues. In order to adhere to national IPC guidance and minimise nosocomial transmission all new admissions are required to be admitted to single rooms within the Community Hospital Estate. A clear process has been developed that enables the Demand and Capacity team to identify patients who are able to be transferred from a single room into a bay bedded area based upon their Covid exposure history in other Trust environments and their Covid swab results. A risk assessed approach is taken in order to meet non Covid related nursing needs that would require a person to stay in a single room such as someone who is at the end of their life. The Single Point of Clinical Access (SPCA) calls received has reduced further and exploration of the relatively high number of calls since November has found this was not a data quality issue, but due to the service handling daytime dental calls which were historically handled by dental service staff. CPA compliance will remain under threshold until the impacts of Covid-19 disruption reduce for community services. Health visiting KPI reporting now routinely includes virtual methods, including video calls and clinical telephone contacts.

Are our Services Well Led?

Overall statutory and mandatory training compliance has risen to 85.2%. Due to Covid-19 disruption Resuscitation and Restrictive Physical Intervention training continues to require improvement. There is a monthly exception reporting regime in place for recovering resuscitation and restrictive physical intervention training (PMVA and PBM) compliance. Resuscitation training is improving and there is a recovery plan in place to return compliance in the next 3 months. Physical intervention training compliance is targeted for further improvement. Appraisal compliance is 76% against a target of 90%. There is 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 Trust target of 4%. Staff health and wellbeing remains a priority. Veteran support within the organisation is progressing well and work is ongoing regarding the Military Charter accreditation recently awarded. The Trust is able to report good levels of staffing maintained in inpatient areas set against safe staffing levels. International recruitment work continues and 20 new registered nursing colleagues will be joining our Community Hospitals in April and May 2021.Trust colleagues featured in a recent WHO film documenting the experience of health care staff through the pandemic and the impact on psychological wellbeing. This month we also include the Medical Directorate Guardian of Safe Working Hours update. The Q3 report identifies that there were 4 exceptions in this period, along with an explanation as to why these occurred.

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
No of C-19 Inpatient Deaths reported to CPNS		N-R			30	7	1	0	0	0	0	4	12	8	3		65			N/A
Total number of deaths reported as C-19 related.		L-R			66	18	4	1	0	1	1	13	17	26	7		154			N/A
No of Patients tested at least once		N-R			195	214	226	261	291	270	301	302	296	307	237		2900			N/A
No of Patients tested C-19 positive or were admitted already positive		N-R			116	39	4	1	0	0	2	27	103	112	32		436			N/A
No of Patients discharged from hospital post C-19		N-R			27	52	18	3	1	0	0	6	32	79	44		262			N/A
Community onset (positive specimen <2 days after admission to the Trust)		N-R					0	0	0	0	0	0	11	19	0		30			N/A
Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)		N-R					0	0	0	0	0	0	6	0	0		6			N/A
Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)		N-R					0	0	0	0	0	2	7	1	0		10			N/A
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust		N-R					0	0	0	0	1	8	14	4	0		27			N/A
No of staff and household contacts tested		N-R			276	521	104	57	204	342	215	517	328	308	152		3024			N/A
No of staff/household contacts with confirmed C-19		L-R			85	38	0	0	0	7	12	46	80	41	14		323			N/A
No of staff self-isolating: new episodes in month		L-R			597	174	63	39	43	49	153	413	279	226	73					N/A
No of staff returning to work during month		L-R			333	118	25	10	28	30	54	347	238	216	70					N/A
No staff GHC who received Covid-19 vaccine first dose													751	2348	575		3674			

Additional Information

Patient Reporting

The number of Covid-19 (C-19) related inpatient deaths has fallen in Feb 21, with 3 inpatient deaths meeting criteria for national reporting to CPNS. The number of community patient deaths reported as C-19 related has also fallen, both corresponding to the downward curve of the second peak of the pandemic. C-19 related patient deaths since April 20 by team/hospital site are shown in the chart opposite. Patient deaths will be subject to further Gloucestershire system-wide mortality reviews in line with guidance. Due attention is being paid to communicating with relatives and duty of candour requirements. Further updates will be provided to the Quality Committee.

Patient Testing

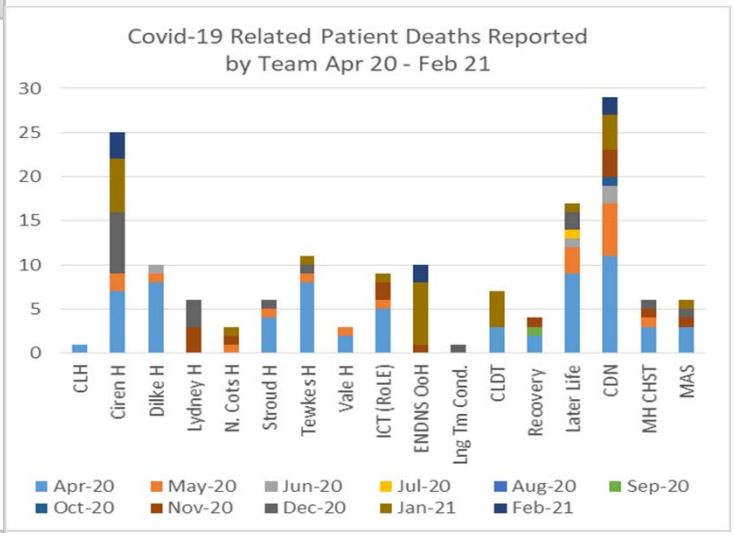
A reduction in the number of positive patient results was seen in February, which is in line with the national dataset. As agreed with ICS Bronze IPC cell, GHC undertakes inpatient testing on days 1,3,5,7 and 10 and every subsequent 5th day of a patient's admission. This exceeds the national recommendation but is a local enhancement to improve system-wide surveillance. An IPC-led audit to monitor swabbing compliance has provided good assurance across the Trust.

Staff and Household Contacts Testing

C-19 related staff absences are reducing in line with reduction in community infections

Infection Prevention and Control

All patients are swabbed on direct admission or transfer from GHNHSFT to GHC Inpatient Units and every 5 days during admission. There were no new cases of Covid-19 detected in GHC in February other than cases that were confirmed as Covid-19 positive prior to admission to GHC.



COVID-19 - KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

GHC inpatients and priority groups

- Rolling weekly programme in place to provide first and second doses for eligible new admissions to Community Hospitals, learning disability and mental health units.
- Robust Standard Operating Procedure developed to enable administration of AZ different second dose if not able to provide Pfizer.
- Work continues in partnership with IHOT, GPs and GHC roving team to provide bespoke reasonable adjustments to those with complex needs
- Scoping work underway to identify additional support requirements for SMI cohort to ensure effective uptake.
- Work proposed in conjunction with vaccine equity group to explore uptake in key groups
- Homeless Healthcare Team vaccinated 42 people, with further clinics planned

GHC staff

- **89 % "frontline" workforce received first vaccine – 64% BAME colleagues received first vaccine -19/03/2021**
- Vaccine uptake data is monitored weekly and submitted to NHSE/I every 14 days
- Workstream in place led by Working Well to enhance uptake include of staff conversations to compassionately address vaccine hesitancy
- Proactive and targeted communication in place
- Staff survey utilised to understand experience and develop actions in response
- Staff reserve list in place for equitable use of spare vaccine doses

Data as of 19-3-2021

ROLE	TOTAL NUMBER Feb 2021	1ST VACCINE (up to 19/03/21)	%	2nd VACCINE (up to 19/03/21)	%
All doctors/dentists	125	106	84	49	38.9
All qualified nurses, including students	1421	1183	83	374	26.3
All other professional qualified staff	735	642	87	188	25.6
Support to clinical staff	1595	1508	95	460	28.8
TOTAL GHC CLINICAL STAFF	**3877**	**3439**	**89**	**1071**	**27.6**
NHS infrastructure staff	611	203	33	31	5.1
TOTAL GHC WORKFORCE	4488	3642	81	1102	24.6

Supporting the Primary Care Network public programme in GHC

- Housebound and care home vaccination underway in collaboration with PCNs; first and second doses.
- GHC Roving team well established, with a bank of 36 vaccinators
- IHOT team supporting learning disability shared care environments.
- GHC bank vaccinators available to support PCN clinic staffing at short notice to prevent cancellations

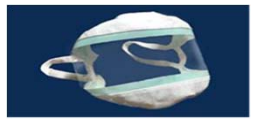
COVID-19 - KEEPING STAFF SAFE (Are services well led?)

Personal Protective Equipment (PPE) and home testing

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 Trust continues to maintain 14 days supply of all key PPE items at central stores and are maintaining 14 days of supplies at each PPE locality hub.

GHC have received and distributed the second phase of lateral flow testing kits. All colleagues who have volunteered to use lateral flow test when asymptomatic have access to them. Work is ongoing to move the recording of these results into the Covid portal in order to streamline the process for colleagues and the weekly SITREP. Colleagues who have a positive lateral flow continue to get a confirmatory PCR test.

The stock team have now received samples of the clear masks (pictured alongside). These have been given local IPC approval.
GHC has ordered a modest number of masks in order to carry out a PDSA cycle where SLT, perinatal, and health visitor colleagues will be asked to trial them to ensure that they are suitable from an operational perspective before larger orders are placed. The responsibility for ordering and distribution will sit with the stock team, as opposed to local team ordering.



Confirmation has been received by the Director of IPC that there is currently no national evidence for the need to widely use FFP3 instead of Type II R masks. The Trust have an emergency protocol in place to enable a swift roll out of additional FFP3 masks if guidance changes .There was a recall of the Fang Tian FFP3 mask and those who had been fit tested on these masks have been provided with an alternative.

FFP3 fit-testing

Fit-testing compliance data as of 04/03/2021 shows that a total of **932** colleagues have been successfully fit-tested, representing **83%** of the target number who require additional testing for future mask supply challenges.

Work continues to fit test away from the FFP3 masks for which we do not have assurance regarding future supply, using a blended model of qualitative and quantitative methods. Colleagues from the Fit Testing Team were able to respond swiftly to the Fang Tian recall. The redeployed individuals from the CYPS physical health teams are to be repatriated at the end of March, work is ongoing to establish the future fit testing model and its place within the Covid Response Strategy.

Work is continuing to streamline the data collection methods for the fit testing programme in order that the stock team and fit test team utilise the same information to aid decision making on priority areas, as well as stock levels at each site, based on pass rates.

The oversight of the Respiratory Protective Hoods (RPH) offered to those who fail on FFP3 masks has been brought in to the stock team's portfolio in order to provide assurance on: the number and location of the RPH; the expiry date of consumables e.g. filters; having a central point of contact to respond in the event of mutual aid requests (as happened with a request from GHFT).

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

No		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
	Number of Friends and Family Test Responses Received	N - T	15%	33836	Suspended			699	496	1179	1631	1427	1466	1880	1616		8763			
	% of respondents indicating a positive experience of our services	N - R	95%	88%	Suspended			93%	93%	93%	94%	94%	96%	95%	95%		94%			
	Number of Compliments	L - R		2,938	228	58	166	74	67	159	123	117	123	85	123		1323			
	Number of Concerns	L - R		620	31	24	44	60	31	45	25	20	25	22	23		350			
	Concerns escalated to a formal complaint							2	1	0	0	2	3	3	2		13			
	Number of Complaints	N - R		117	5	6	1	4	6	5	1	16	13	6	9		72			
	Number of open complaints (not all opened within month)							33	38	41	38	53	64	65	68					
	Percentage of complaints acknowledged within 3 working days							100%	86%	100%	100%	88%	100%	100%	89%		95%			
	Number agreeing investigation issues with complainant							7	10	13	11	23	25	12	13					
	Number of complaints awaiting investigation							2	1	0	1	0	5	6	3					
	Number of complaints under investigation							6	9	9	6	6	9	21	17					
	Number of Final Response Letters being drafted							12	12	11	9	12	13	15	34					
	Number of Final Response Letters awaiting Exec sign-off							0	0	2	0	0	2	2	1					
	Number of complaints closed							4	1	2	4	1	1	6	6					
	Number of re-opened complaints (not all opened within month)							5	4	4	3	3	4	4	3					
	Current external reviews							4	4	3	2	3	3	3	4					

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

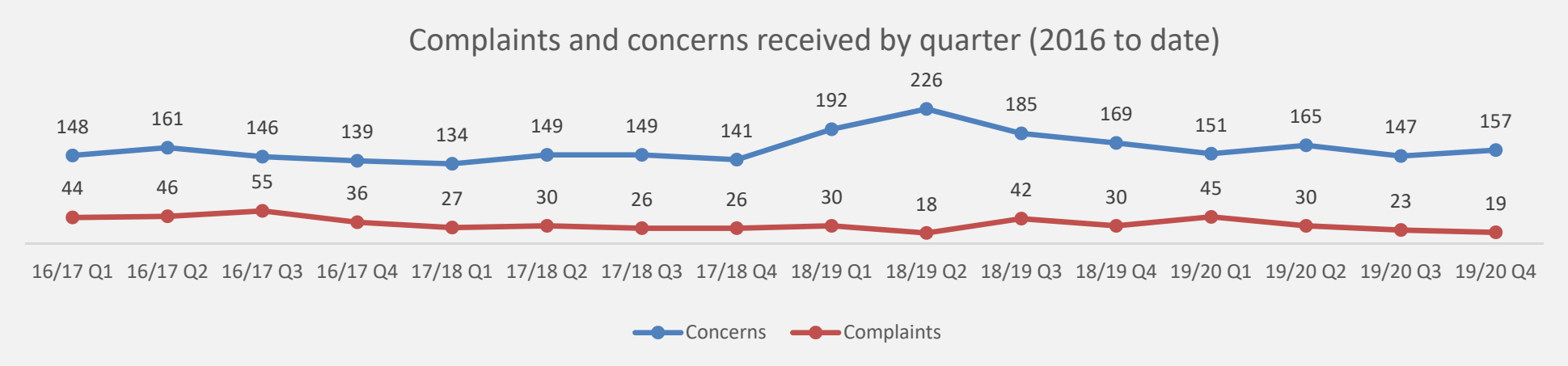
RAG Key: R – Red, A – Amber, G - Green

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

Complaints, concerns and compliments

- The average number of complaints received in February over the past four years is **7**. In February 2021 we received **9 complaints**.
- In February 2021, **6** complaints were closed: **2** were withdrawn, **1** was upheld, **1** was partly upheld, and **2** were not upheld.
- The numbers of concerns have remained consistent over the past 5 months and are significantly lower than the monthly average of 52 concerns during 2019/20.
- The number of compliments received each month has remained relatively stable over the past 6 months but are lower than the monthly average of 245 in 2019/20.

The chart below summarises the number of complaints and concerns received by quarter since 2016/17. This offers assurance that services are not receiving a significant increase in complaints in 2020/21. The impact of Covid-19 (national pause, redeployment, services in recovery), PCET staffing challenges, and a cluster of complaints received in November and December, have all contributed to the current increase in complaint response times but recovery work is well underway.



Assurance regarding complaint management

- Each complaint is triaged to check for any immediate actions required. Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- Trend analysis of the recent increase in complaints shows indicative themes* associated with Mental Health Act application and care, treatment and communication at Wotton Lawn. Integrated Care Teams received complaints regarding tissue viability, End of Life care and communication. Recovery Teams received complaints about care and treatment, discharges, referrals and communication.
- The number of complaints open for 7-12 months is being actively addressed through the recovery work in progress.

**As these are the themes from open complaints, investigations have not been completed and so it has not been identified whether these issues will be upheld/not upheld.*

Satisfaction with complaints/concern processes

- **3** active re-opened complaints
- **30** concerns were closed in February 2021, of which **2** were escalated to complaints

External review

- There are currently **3** complaints with the PHSO for external review; these are complaints from 2016, 2017 and 2019.

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

Timeframes

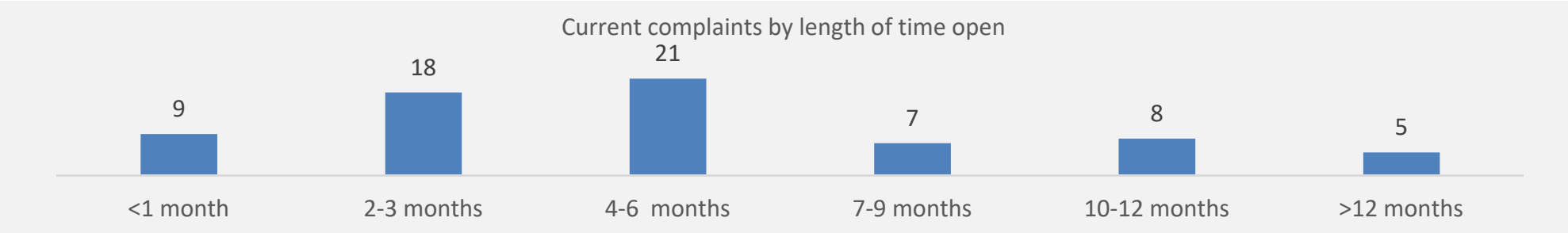
- PCET remains in active recovery following the national pause in the complaint management process between April and June 2020.
- **8** of the **9** complaints received in February 2021 were acknowledged within the 3-day target timeframe.

- Of the **68** open complaints, **14** do not have agreed response times. Of these **14**:
  - **3** have been delayed due to Covid-19; complaints were received either during or very close to the national pause period. As a result, completion dates were not set and complainants were advised that their concerns would be progressed as soon as possible.
  - **7** are in the very early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set.
  - **4** are complaints being managed by other NHS organisations, for which we are providing input/comments

- Of the **54** complaints with agreed response dates:
  - **21** are within the agreed timeframe
  - **33** exceeded the initially agreed timeframes, and of these:
    - **3** responses were due during the national pause
    - **30** responses were due following the end of the pause and there are a range of reasons for these delays including:
      - Extended time agreeing issues for investigation with complainants
      - Delays in the investigation process (allocating investigators, timeliness of investigation report, and availability of staff for interviews)
      - Delays in the drafting and review of final responses (e.g. capacity, quality of investigation, availability of colleagues to review draft responses)
    - A QI piece of work is underway to identify and address delays in the complaints process

The chart below shows the timeframes for all open complaints, inclusive of the 3 month national pause. It should be noted that it can often take up to 8 weeks to agree issues with complainants dependent on complexity and complainant availability. PCET are focusing efforts on completing investigations for those open for the longest duration. A weekly meeting provides high-level oversight of the complaints tracker. Fortnightly updates to the Director of NTQ are in place and regular briefings to the Board and Quality Committee provide assurance of targeted recovery of complaints open for the longest period.

Additional resource has been secured via redeployed colleagues and 2 existing members of the team have temporarily increased their working hours. Further support has been supplied by senior NTQ colleagues to assist with final response letter completion and to increase triangulation with patient safety and Freedom to Speak Up learning. The Trust's Quality Improvement Team are undertaking a LEAN assessment to identify process improvements and areas for efficiency.



CQC DOMAIN - ARE SERVICES SAFE? - NON-EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS Q3 2020/21

PURPOSE

The agreed aim of the Non Executive Director 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 auditor
- 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 Q3 2020/21 audit provided assurance overall regarding the quality of complaint investigations and that the Trust is managing complaints appropriately
- Response timescales were noted as requiring significant improvement and these remain a priority for the service in line with Covid 19 disruption recovery work. Waiting times are monitored via the monthly Quality Dashboard.

FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues - an ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN -ARE SERVICES SAFE? Non-Executive Director audit of complaints Q3 2020/21

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 • Wotton Lawn Hospital • Partner's diagnosis, escorted leave, discharge, ward activities and telephone contact.	**LIMITED ASSURANCE** • Very apologetic regarding the long delay due to the national pandemic and national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic, conveyed a personal apology from the ward staff member. • A detailed account of investigation • A real understanding of the issues raised. Where an issue was not upheld the explanation was given sensitively • Plain language was used with truly little jargon	**FULL ASSURANCE** • Learning for the individual concerned as well as the organisation was identified in the letter. • Suggested changes in practice.	• The complainant was offered the opportunity to make any further amendments following the summary letter prior to the investigation commencing.
Complaint 2 • Recovery Team • Care Programme Approach (CPA) • Request for new Care Coordinator (delay)	**LIMITED ASSURANCE** • Very apologetic regarding the long delay due to the national pandemic and national pause in complaints	**FULL ASSURANCE** • Thorough and well-documented investigation	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic	**FULL ASSURANCE** • Recovery Teams will be reminded of the importance of explaining the CPA process to patients' families and carers • Learning shared	• A new care co-ordinator was appointed eight weeks after the original request
Complaint 3 • Wotton Lawn (Maxwell Suite) • Assessment and discharge • Delay in response	**LIMITED ASSURANCE** • Delay in conclusion of investigation due to national pandemic and national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic • Explained how issues had arisen	**FULL ASSURANCE** • Small learning need identified • Learning shared	

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

2020 CQC Adult Community Mental Health Survey

Question 30. In the last 12 months, did NHS mental health services support you with your physical health needs?
The 2020 score for this question showed an improvement compared to 2019 (from 5.2 to 5.7 out of 10), and for the 3rd consecutive year.

At the previous Board meeting, further information was requested regarding physical health interventions for people accessing our mental health services.

Progress to date

- PCET, operational managers, and clinical colleagues are developing an action plan in response to the 2020 survey results, inclusive of areas to be improved regarding physical health needs. This will involve Experts by Experience. This action plan will be reported to the Quality Committee.
- Operational managers and Business Intelligence have developed a report that is about to go live. This will identify the current position and facilitate monitoring of improvements. Teams will be sighted to their performance in order to own and progress developments

Assurance of physical health support

- Community Mental Health Team (CMHT) colleagues are trained to undertake annual cardiometabolic health checks (BP, BMI, smoking and alcohol use, blood tests for cholesterol and diabetes checks)
- Staff trained as smoking cessation mentors to support our patients
- All of our community hubs now have an ECG machine and staff are receiving training. This means that our patients no longer need to see their GP surgery for this procedure. The machines are portable and so housebound patients can have an ECG performed at home.
- Many of our community staff have been trained in phlebotomy. This results in out patients being able to have their blood taken by our staff rather than attending a further appointment elsewhere.
- Within our Clozaril Clinics, bloods can be tested with specialist facilities available at Pullman Place. Patients can receive their medication within 10 minutes of providing a blood sample, rather than 24 hours later. A similar service will be rolled out to Weavers Croft and Leckhampton Lodge this year.
- CMHTs have a portable bag of physical health equipment and are trained to undertake a full set of observations and record a NEWS score. This allows early recognition of a deterioration in physical health. These assessments are often used when referring patients to the GP or 999.
- Our community staff have the opportunity to discuss national screening programmes with their patients. Within Pullman Place, we have successfully delivered cervical screening to women who did not feel comfortable attending their GP surgery. Our teams have also supported attendance of appointments at the mammogram centre.
- Mental health colleagues have liaised with physical health teams such as the tissue viability service and the complex lower limb team, to help with the ongoing care of our patients. The clinical facilities at Pullman Place have been used to undertake wound care. The Trust Pressure Ulcer policy has been refreshed to ensure parity of esteem of care across all physical and mental health services.
- The Nursing and Quality team have two RGNs working specifically to improve the physical health of patients, responding to referrals from the CMHTs.
- Monthly Physical Health Clinical Forums are well attended within the community hubs.
- Work is underway to scope the relaunch of onsite training for staff so that physical health topics will be covered at Team Training Days. Planned topics include asthma, COPD, CHD, wound care, smoking cessation, and Women's and Men's specific health concerns.

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

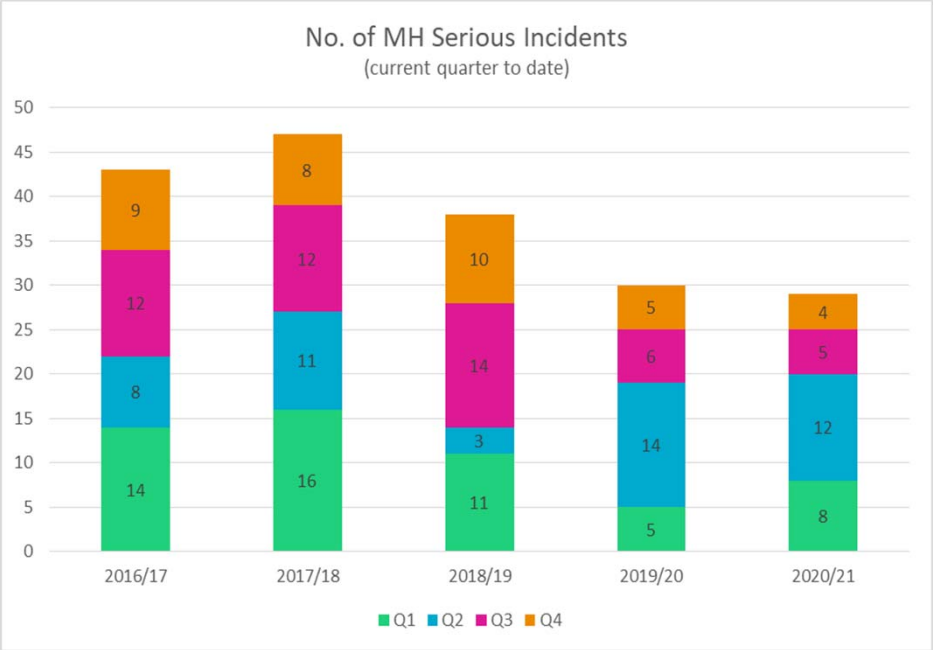
		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	1	0	0	0	0	0	0	0	0	0	0	0		0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		49	4	3	3	7	2	5	1	3	3	3	2		36			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	0	0	1		1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		6	0	1	0	1	0	0	1	0	0	0	0		3			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		5	0	0	1	0	0	0	0	1	0	0	0		2			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		18	2	0	0	3	2	3	0	1	2	1	0		14			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	1	1	0	0		9			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		1	0	0	0	0	0	0	0	0	0	0	0		0			N/A
	Total number of Patient Safety Incidents reported	L - R		12,109	688	867	1002	1052	1140	1082	1131	1077	1146	1042	1018		11245			N/A
	% incidents resulting in low or no harm	L - R		94.71%	90.55%	92.62%	93.01%	94.68%	94.82%	95.38%	93.46%	94.05%	91.80%	91.94%	93.71%		n=10501 93.38%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		5.29%	9.45%	7.38%	6.99%	5.32%	5.18%	4.62%	6.54%	5.95%	8.20%	8.06%	6.29%		n= 744 6.62%			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%	4.24%	2.44%	2.86%	1.94%		2.91%			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%	0.00%	1.96%	0.00%	0.00%	0.00%	0.00%		0.95%			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	0	0			0			N/A

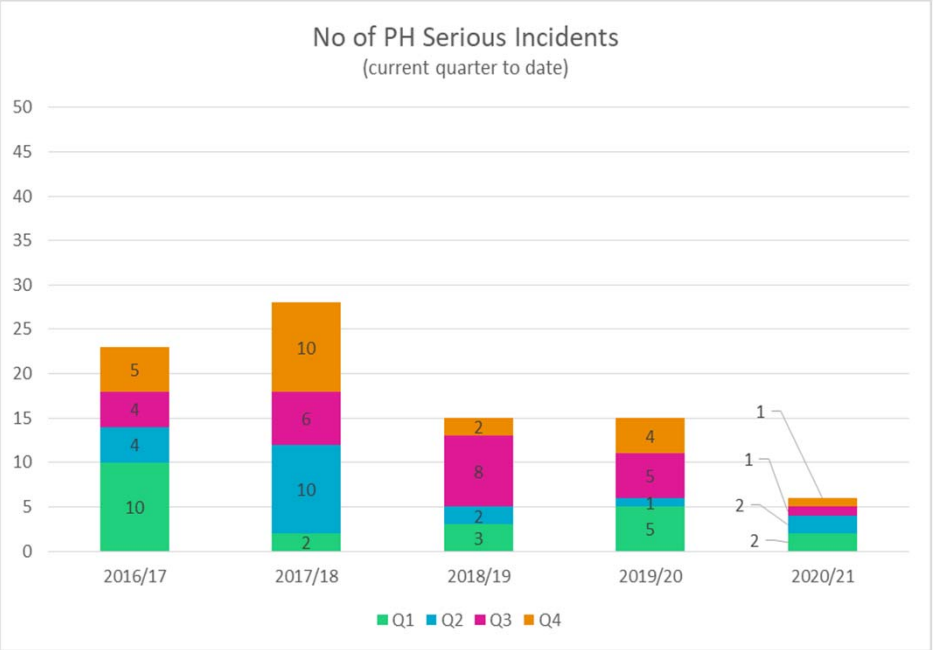
N - T	National measure/standard with target	L - I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L - R	Locally reported (no target/threshold) agreed
L - C	Locally contracted measure (target/threshold agreed with GCCG)	N - R/L - C	Measure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

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

CQC DOMAIN - ARE SERVICES SAFE? – additional information

Two SIRIs were declared in February 2021, one medication related incident at Charlton Lane Hospital (mental health services), and one unexpected patient death for the Forest of Dean District Nurses (physical health). All incidents were escalated in line with SIRI reporting requirements. The Patient Safety Team continue to monitor 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 Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues.





One SIRI final report, a mental health suspected suicide, was completed and submitted to Gloucestershire CCG in February 2021. Incident on a Page (IoaP) has been disseminated for discussion throughout the Trust to promote learning. All IoaP documents are uploaded to the Trust intranet.

There are currently 8 active SIRIs. All current active SI investigations are on target to complete within statutory time frames.

Regarding all patient safety incidents:

- The total number of patient safety incidents reported fell from January (1042) to February (1018).
- The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from January (8.06%) to February (6.29%)
- The percentage of falls resulting in moderate and above levels of harm decreased from January (2.86%) to February (1.94%).
- To note, there have been some minor adjustments to total numbers of patient safety incidents for previous months due to reclassification of some incidents. 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? 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%	93.5%	96.2%	100.0%	96.5%	98.7%	96.7%	95.2%	100%	100%	99.3		98.0%	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	60	70	72	63	59	47	65	60	83	79	63		721	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	737	53	68	66	59	52	41	50	51	68	67	56		631	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	46	3	1	3	3	6	6	12	6	13	6	7		56	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	8	4	1	3	1	1	0	3	3	2	6	0		24	R		

ADDITIONAL INFORMATION - PRESSURE ULCERS (PU)

Improvement and development plan for Forest & TNS: This has been informed by themes from 4 SIRI reports. The 10 point plan contains one theme related to pressure ulcer management. The Clinical Pathways Lead (CPL) has supported the locality through training and clinical support, as well as being available to discuss issues and concerns relating to complex patient care. The CPL and locality Professional Lead (PL) have formulated an electronic questionnaire for all nurses to survey PU knowledge to further inform targeted training offers.

Improvement and development plan for Gloucester: Following increases in Datix incidents of PUs developed or worsened in our care in Gloucester, the Community Manager (CM) worked with the CPL and NTQ colleagues to produce a comprehensive 5 point improvement plan to embed learning and address 4 other issues impacting on the increase of PU incidents. CPD led by the PL & supported by CPL, as well as questionnaires used to check learning were implemented and CPD is ongoing. The key to the success of this plan is the oversight the CM & management team now have of real time Datix incidents detailed down to each community nursing team. This up-to-date virtual knowledge enables the district nursing professional lead to pin point any emerging themes, and support clinical practice within the community nursing caseload.

Update on Quality Improvement work: The QI approach to rolling out the assurance and learning that resulted from the Gloucester plan is currently in the "plan stage" of the PDSA cycle. CPL and Quality manager have scoped the aim and drivers and have invited the CM's from Gloucester & F& TNS to review and scope the stakeholder map to ensure buy in from all operational colleagues.

Focus on PU data for services: Following on from the success of the 'Datix dashboard oversight' described for the improvement plans in Gloucester & Forest & TNS, the CPL recommends that Datix dashboards and reports specific to inpatient services for governance & assurance across all our PH, MH & LD inpatient services should be considered using a QI approach.

Opportunities for new ways of working : CPL has been hosting webinars highlighting PU categorisation and encouraging an interactive approach from participants and active feedback. Resource into the Tissue Viability (TV) team would enable more frontline clinical support and improved Datix reviews. TV education delivery and support into inpatient services across the trust. This is currently being explored by CPL and TV head of service. A 20 minute OPEN INVITE: District Nurse Discussion on safe and effective pressure area assessment, monitoring & management hosted by CPL. Both pressure Ulcer QI virtual groups are due to recommence in May and invitations have been sent out

PU Trust policy alignment: Work is underway to amalgamate the 2 legacy policies into one trust wide policy with the aim of the policy being reviewed in April.

Detail of the data cleansing that is required with the Datix: The review of Datix incidents by handlers and the Patient Safety team (PST) is a challenge without the specialist TV clinical knowledge and experience needed to categorise a pressure ulcer injury. Consideration is being given as to how best to progress this as there are opportunities to support the PST with reviewing PU Datix if TV team can have additional hours to support review of cat 3 & $ & unstageable PU's.

TV SoP that would aid the patient safety team: Other work streams include: suggested review and reissue of SOP used by TVN's to review the Datix reports for accuracy of reporting. This links to the PST PU questions developed during the pandemic.

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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

NHS
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%	94.3%	93.8%	92.9%	94.9%	94.3%		87.7%	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%	88.9%	100%	87.5%	100%	100%	88.9%	75.0%		81.8%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered **Re-audit being developed for March**																				
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%	59.0%	53.5%	55. 5%	53. 4%	53. 3%	52.7%		52. 3%	G		
Admissions to adult facility of patient under 16yrs		N - R		0	0	0	0	0	0	0	0	0	0	0	1		1	N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	1742	30	42	68	53	76	139	43	32	66	15	28		592	G		
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 Childhood 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 was due to commence Jan 2021. Delayed due to school closures.							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 was due to commence Jan 2021. Delayed due to school closures.							0.0%	R		

Additional Information

Bed Occupancy
Occupancy levels within Community Hospitals are sustained at expected levels given the pressure within the One Gloucestershire system. The Demand and Capacity team has been strengthened to enable daily robust clinical challenge to ensure that 'Home First' is considered as the first option for patients moving across the system and Community Hospitals beds are utilised to maximise a persons sub acute and or rehabilitation needs. GHC are active participants of the ECIST improvement 30 day plan for One Gloucestershire, focussing specifically on; refining the processes between the Trust and Adult Social Care, admission avoidance and strengthening the reablement offer to support early discharge.

Mental Health
An under 16 yrs of age admission to Wotton Lawn Hospital via the 136 Suite occurred in February. The admission was for approximately 12 hours and was the result of a multi-agency agreement. All appropriate notifications were made and constant observations were undertaken, in line with Policy. The admission was managed safely and in the best interests of the individual until an appropriate out of area bed was available.
Monthly and year to date data for the Early Intervention in Psychosis (EIP) service demonstrates that the service has now met the target threshold for the eighth consecutive month.
Cardio-metabolic assessment and treatment for people with psychosis is delivered routinely, although auditing was paused through Covid-19 disruption. An audit is currently underway to ascertain compliance levels.

Length of stay (bed days)
The occupied bed day for inappropriate out of area placements in February was 28 days. This relates to 1 PICU placement. A data cleansing exercise was completed last month to align data with the Monthly Out of Area Report utilised by the bed management team. To support the NHS Long Term Plan to eliminate out of area placements there is a comprehensive quality improvement plan in place which will focus on Governance & Leadership, Operational Practice & Service Development. This will also include a better understanding of patient flow within the Mental Health Units.

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	R / A / G	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	0.13	0.15	0.13	0.13		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%	94.8%	91. 8%	95.9%	97%	96.8 %		95.9%	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%	98.5%	98.3%	96.7%	95.2 %		89.5%	A		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	83.5%	81.1%	62.6%	93.6%	94.9%	98.4%	99. 5%	99.2%	97.8%	96.9%	96.8%	98.5 %		92. 7%	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%	98.6%	100%	100%	99.1 %		94. 3%	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%	97.4%	100%	97.2%	96.1 %		95.7%	G		
	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%	98.8%	99.5%	92.8%	93.5 %		97.9 %	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	35939	1787	1731	1774	1712	1702	1746	1835	3661	3567	3016	2977		25508	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	96.9%	88.9%	89.7%	88.6%	90.1%	91.6%	93. 3%	95. 5%	94.1%	94.3%	91.9%	90.9 %		91.7%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	100.0%	96.8%	100.0%	100%	100%	100%	100.0%	100.0%	100%	100%	100%	100 %		99.7%	G		

Additional information

MIIUs

- Dilke remains closed due to Covid-19 secure restrictions
- Vale remains closed and may open in July after discussion with local PCNs regarding mass vaccinations
- Tewkesbury re-opens on 1st April 2021
- All open units operating 8am-8pm
- Telephone Triage is offered to anyone who calls their local unit so they can be directed to the right place at the earliest point; this includes the closed units as telephones are linked

ICTs

- For the seventh consecutive month, ICT therapy services have maintained or exceeded the required threshold indicators.

Mental health

- CPA compliance reduced marginally. Work to understand if the increased community circulation of Covid-19 is impacting on performance due to delayed appointments has been currently paused due to colleagues within the Nursing, Therapies and Quality Directorate being redeployed to support frontline services since December. This will be resumed when the team reforms end of April, in line with the organisational recovery plan. The CPA audit is due to commence in March.
- CRHTT continues to achieve 100% compliance with gatekeeping admissions to hospital.

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Quality Dashboard

NHS
Gloucestershire Health and Care
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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.		95%*	N/A	66.6%	66.6%	66.6%	66.6%	66.6%	81.8%	93.1%	Programme Delayed Nationally					72.6%	R		November: project completed. Year-end mop-up completed
Number of Antenatal visits carried out			944	46	42	35	24	24	40	65	44	56	56	46		478	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%	43.3%	31.2%	59.1%	75.7%	82.6%	86.4%	94.6%	93.9%	97.7%	93.3%	97.6%		77.8%	R		
Percentage of children who received a 6-8 weeks review.		95%	94.1%	29. 0%	31.2%	59.1%	76. 7%	86.4%	85.4%	94.8%	95.4%	95.9%	95.3%	97.9%		79.6%	R		
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	84.8%	83.9%	75.6%	67. 2%	69.5%	63.9%	65.1%	72.9%	73.6%	71.8%	72.7%	71.2%		71. 6%	R		
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	90.2%	90.2%	87.4%	90.3%	87.7%	82.7%	73.4%	82.1%	76.8%	79.0%	81.8%	82.3%		83.1%	A		
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	83.5%	81.9%	85. 6%	82.4%	74.0%	61.5%	60. 6%	73.5%	66.2%	65.1%	67.1%	65.8%		71.2%	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%	54.8%	55.1%	57%	53.6%		55.8%	A		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81.1	81.2	84.4	78.9	81.8	77.6	83.3	83.5	80.5	79.6	82.9	78.5		81.1			
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	1929	895	676	844	963	1233	1047	1064	1013	1098	980	861		970			
Number of Positive Screens		169	1329	53	40	50	57	73	62	63	60	65	58	51		632			
Average Number of Community Hospital Beds Open		196	195.4	173.3	168.8	155.8	162.5	177.7	177.6	177	173	176.3	183.6	186.8		173.9	R		
Average Number of Community Hospital Beds Closed		0	1.1	22.3	27.2	40.2	33.5	18.3	18.4	19	23	19.7	12.4	9.2		22.1	R		

Additional Information

Data shown from October 2020 onwards is inclusive of virtual methods – video calls and clinical telephone contacts.

Vision Screening: Paused due to ongoing school closures**.**

Health Visiting: Antenatal contacts are delivered face to face (F2F) for those who accept a targeted offer. Group universal contacts are commencing from February 2021. There is no formal KPI for this indicator . The 9-12 month, 12-15 month and 2–2.5 year reviews are not mandatory requirements. The team have continued to offer face to face contact to those families that were assessed as needing a Universal plus or Universal partnership plus visit at either ante natal, birth and 6-8 week reviews. A number of families on the standard Universal offer have declined the virtual offer and preferring to wait for a face to face visit which has impacted the KPI timeframe. When contacted by the team some families have then declined face to face visits as they do not have any development concerns. The team have left open offers for those families and since the start of the pandemic the team have completed 689 catch up virtual and face to face visits for those that missed or initially declined the first planned visit. The team are currently working with Gloucester County Council to improve the 2-2.5 year uptake and will update in April. Where clinicians are concerned about families the safeguarding protocols are initiated.

NBV 97. 6%: These are being delivered predominately F2F but there is a virtual offer. 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 in the home when the family will allow the practitioner access.

6-8 week review 97. 9%: These are being delivered both virtually and F2F, dependent on the Health Visiting assessed level of service and where families feel comfortable to meet F2F in regard to social distancing. All families who are not seen are tracked and reoffered a family health needs assessment

Ages and Stages developmental reviews 9-12 months and 2-2.5 years- All children are offered a developmental review. A virtual contact is currently offered to all *Universal* families and if any concerns are identified by the practitioner or raised by the parent, they are invited to a F2F appointment. All outstanding requests are being managed as part of the recovery process. A number of parents previously assessed as *Universal* initially asked to delay the developmental assessment until F2F available. Now when offered F2F they are declining the review as have no concerns with their child's development. Public Health messages are discussed over the phone and SMS sent with links to the Health Visiting website and social media pages. Families that are assessed as having an enhanced service of *Universal Plus* and *Universal Partnership Plus* are offered F2F contacts within the home to ensure a full Family Health Needs Assessment is undertaken.

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%	86.8%	85.4%	85.9%	87.0%	82.5%	83.5%	85.2%		85.80%	A			
	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	80.38%	72.7%	69.9%	65.4%	60%	60%	69.7%	66%	67.5%	71.2%	79%	76%		70.8%	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%	4.84%	4.56%	4.46%	4.45%		4.89%	A		
	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 in line with national guidance. As an alternative, the Trust takes part in the Covid-19 People Pulse survey. The out-turn of this survey is reported to the Trust Board every 2 weeks and is discussed in detail at the Trust Health and Wellbeing group with survey findings informing future interventions.

Mandatory training, appraisal and absence

The initial pause on statutory/mandatory training was lifted in July 2020 but was reinstated with the second lockdown in November to support maintain frontline service provision. Overall compliance is at 85.2%. However due to compliance concerns there is an exception reporting regime in place for recovering resuscitation and restrictive physical intervention training (PMVA and PBM) compliance, reporting monthly to QAG. Performance in these areas is improving as a result of the additional training put in place to recover compliance substantially by May 2021 alongside mitigation plans to manage risks and support staff.

Appraisal compliance is 76% against a target of 90%. 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 remain above the Trust target of 4.00%. Sickness absence levels for February are 4.45%

Staff Health and Wellbeing

The Health and Wellbeing hub meets fortnightly and recent discussions have considered how best to embed interventions to support staff morale and resilience now and beyond the pandemic. There is a continued focus on making sure that staff have access to appropriate rest areas to take their breaks away from their work environment, including pergola-style outside area at Colliers Court. Veteran support within the organisation is progressing well and work is ongoing regarding the Military Charter accreditation, recently awarded, with a possible staff network development for veterans working within the Trust. Recent health and wellbeing newsletters have included 'You said, we did' in relation to funds from NHS Charities and also a feature on 'Time for you' (T4U) health and wellbeing sessions available for all. Trust colleagues have been involved in a recent WHO film documenting the experience of health care staff through the pandemic and the impact on psychological wellbeing.

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CQC DOMAIN – ARE SERVICES WELL LED?

Guardian of Safe Working Report 2021

PURPOSE

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed 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. 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. 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.

Reporting time period October 2020 – December 2020	Guardian of Safe Working Hours: Dr Sally Morgan
Number of doctors in training (all on 2016 contract)	38 doctors in training posts: • 12 higher trainees • 6 CT3 • 4 CT2 • 2 CT1s • 5 GP trainees • 5 FY2s • 4 FY1s – FY doctors rotate posts in December 2020
Exceptions in this period	• **10 on call shifts covered** by our own junior staff acting as locums due to sickness. • **4 exceptions reports in this time period:** 2 FY1s, 2 FY2s (therefore all relating to work in inpatient settings). All raised , reviewed and resolved within an appropriate time frame. **Outcomes of TOIL or no further action required.** o **1 exception relating to pattern of work**: Doctor finished a medical rotation on night shifts and was unable to attend the first day of induction to psychiatric post but did attend the second day. Therefore only had one day of compensatory rest after night shifts rather than two. o **1 exception relating to hours worked**: Doctor required to stay late due to clinical work and the locum consultant having left the post, adding to the workload. o **2 exceptions relating to service support available** (same doctor reporting both times): Less than minimum staffing on these dates due to COVID isolating

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Mental Health Inpatient – February 2021

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	7.5	1	0	0	0	0	0	0	0	0
Abbey	97.5	13	0	0	0	0	0	0	0	0
Priory	292.5	35	0	0	0	0	0	0	0	0
Kingsholm	17.5	2	0	0	0	0	0	0	0	0
Montpellier	22.5	3	0	0	0	0	0	0	0	0
Greyfriars	0	0	465	48	0	0	0	0	0	0
Willow	0	0	7.5	1	0	0	0	0	0	0
Chestnut	22.5	3	0	0	0	0	0	0	0	0
Mulberry	15	2	0	0	0	0	0	0	0	0
Laurel	0	0	15	1	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	280	26	22.5	3	0	0	0	0	0	0
Total In Hours/Exceptions	755	85	510	53	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	Sickness
Dean Ward	173.75%	15.47%
Abbey Ward	129.82%	2.00%
Priory Ward	108.39%	4.64%
Kingsholm Ward	99.76%	23.51%
Montpellier	101.34%	8.07%
PICU Greyfriars Ward	114.73%	3.62%
Willow Ward	109.89%	1.65%
Chestnut Ward	100.99%	7.2%
Mulberry Ward	112.86%	3.47%
Laurel House	104.17%	3.50%
Honeybourne Unit	100.60%	2.79%
Berkeley House	99.75%	2.53%
Totals (Jan 2021)	**113.00%**	**6.54%**
Previous Month Totals	112.73%	8.34%

PHYSICAL HEALTH		
Ward	Average Fill Rate	Sickness
Coln (Cirencester)	124.99%	5.54%
Windrush (Cirencester)	103.45%	8.12%
The Dilke	100.48%	0.89%
Lydney	100.42%	6.90%
North Cotswolds	116.60%	11.49%
Cashes Green (Stroud)	110.02%	8.89%
Jubilee (Stroud)	112.77%	3.88%
Abbey View (Tewkesbury)	104.64%	2.00%
Peak View (Vale)	110.58%	4.15%
Totals (Feb 2021)	**109.33%**	**5.76%**
Previous Month Totals	109.38%	3.79%

Staffing data not available due to the Ledger Merger project. As a result, it is not possible this month to report in-post and vacancy data, or apportion Bank/agency use.

Mental Health & LD Inpatient

- 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 continues 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.

Physical Health

- The Trust continues to work to homogenise safe staffing reporting methods across the new organisation.
- The Trust is able to report good levels of staffing maintained in inpatient areas set against agreed safe staffing levels.
- A detailed piece of work will be undertaken to enable the reporting of physical health exceptions as currently delivered in MH/LD services.
- 20 colleagues will be joining the Trust via International Recruitment routes in April & May 2021

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN – ARE SERVICES WELL-LED? INTEGRATED CARE TEAM (ICT) STAFFING – (OT = Occupational Therapy PT = Physiotherapy)

Nursing	Cheltenham				Cotswolds				Forest & TNS				Gloucester				Stroud				Total				
	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	
Total Est	10	29.8	8.18	10.5	9	22	6.32	6.73	10	29.2	6.93	8.45	10	38.6	8.32	10.7	9.5	28.8	6.6	7.08	48.50	148.41	36.35	43.41	
Total in post	10.1	22.3	7.06	10.7	7.6	18.7	5.3	6.1	7.4	23.5	5.4	5.75	8.13	34.7	7.1	13.6	9.5	23.9	5	8.9	42.73	123.13	29.86	45.02	
	1%	-25%	-14%	2%	-16%	-15%	-16%	-9%	-26%	-20%	-22%	-32%	-19%	-10%	-15%	27%	0%	-17%	-24%	26%	-12%	-17%	-18%	4%	
																	VACANCIES				5.77	25.28	6.49	-1.61	35.93

OT	Cheltenham				Cotswolds				Forest & TNS				Gloucester				Stroud				Total				
	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	
Total Establishment	5.7	6.2	1	3.43	3.4	4.4	1.7	2.6	3.7	3.7	1.8	2.8	4.6	4.3	2.4	3.4	4.2	4.2	2.1	3.1	21.60	22.80	9.00	15.33	
Total In Post	7.18	3	1	2.8	3.2	2.93	0.82	1.8	4.07	2.6	1	3.9	4.8	3.4	0	3.5	3.4	3.64	1	4.89	22.65	15.57	3.82	16.89	
	26%	-52%	0%	-18%	-6%	-33%	-52%	-31%	10%	-30%	-44%	39%	4%	-21%	-100%	3%	-19%	-13%	-52%	58%	5%	-32%	-58%	10%	
																	VACANCIES				-1.05	7.23	5.18	-1.56	9.80

PT	Cheltenham				Cotswolds				Forest & TNS				Gloucester				Stroud				Total				
	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	
Total Establishment	3.5	3	0	2.7	4.03	2.8	0	4.21	3.5	2	1.69	0.6	5	2.8	0	3.92	3.6	2.18	0	2.12	19.63	12.78	1.69	13.55	
Total In Post	3.6	0	0	2.7	4.33	2	0	4.21	4.02	2	1.69	0.6	4.2	2	0.8	3	4	1	0	2.31	20.15	7.00	2.49	12.82	
	3%	-100%	0%	0%	7%	-29%	0%	0%	15%	0%	0%	0%	-16%	-29%		-23%	11%	-54%	0%	9%	3%	-45%	47%	-5%	
																	VACANCIES				-0.52	5.78	-0.80	0.73	4.46

Additional information

The NTQ team continue to progress development work to provide additional safe staffing type data for Trust services. Challenges in ICT staffing and increasing demand has been noted and we are now able to report accurate staffing data for these services as detailed above. Work is in progress to triangulate the impacts of staffing levels , increased demand and changes in tasks requested with potential impacts on quality. There is no nationally mandated guidance for community safe staffing levels. ICT staffing and vacancies are discussed in monthly Professional Clinical Governance meetings for Nursing, OT and Physiotherapy. Regular conversations are underway with our commissioning colleagues to review ICT modelling and specifications

Nursing

There have been national and local historic challenges recruiting, particularly at Band 5 level but there has been good responses to recent recruitments. Objectively, senior ICT management report recruitment has improved since Trust Merger but additional recruitment initiatives are required. Positively there are new nurses coming into post in the next 6 weeks: 4.64wte band 6, 4.4wte Band 5. The Trust supports development of Band 4 Nursing Associate roles and this has resulted in successful recruitment. The Trust is developing a recruitment pathway into community roles as part of our International Recruitment project and has applied to join a national project to develop this work. The ICTs have a commitment to the development of Specialist Practitioner Qualification (SPQ) for District Nursing. There are 5.0wte nurses presently in training who are undergoing recruitment processes for the 2021/22 intake. The Professional Development Team continues to support new staff in developing competencies and confidence alongside wider professional support to maintain quality of care. Additional support was strengthened during peak Covid pressures to support ICT staff.

Therapy

There are challenges to recruit at Band 5 level, with areas of vacancies across the county. There was insufficient availability for a physiotherapy rotation into the ICTs in Gloucester and Cheltenham in this cycle. Recruitment for the rotational posts has been successful and there will be new graduates joining in the Summer of 2021. Physiotherapy trainee Assistant Practitioners are due to complete their apprenticeship in May 2021 and will then be eligible to apply for a Physiotherapy Assistant Practitioner Post - these are the first within the organisation.

There is a future workforce pipeline with the local BSc undergraduate Physiotherapy programme and the pre-registration MSc programme being delivered by the University of Gloucestershire. It is important that these student placements are supported by ICTs to enable growth and future recruitment. ICTs remain a highly visible practice area for the profession and optimise future recruitment success.

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AGENDA ITEM: 16

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Mortality Review Officer

SUBJECT: **LEARNING FROM DEATHS 2020/21 QUARTER 3**

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 Trust Board of the mortality review process and outcomes during 2020/21 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 Learning from Deaths report which covers 2020/21 Quarter 3.

Executive summary

- During 2020/21 Q3, there were 139 reported GHC patient deaths. At time of writing this report (15 Feb 2021), none of the 139 patient deaths are judged to be more likely than not to have been due to problems in the care provided by the Trust.

- An overview of the impact of the second wave of the Covid-19 pandemic upon GHC patient death reporting during 2020/21 Q3 is presented in Section 5.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths associated with the Trust's 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: Dr Amjad Uppal	**Title:** Medical Director

LEARNING FROM DEATHS 2020/21 QUARTER 3

1.0 INTRODUCTION

1.1 The purpose of this report is to inform the Trust Board of the mortality review process and outcomes during 2020/21 Quarter 3.

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 joint Datix system, which went live on 1st April 2020.

1.3 The timing of the second wave of the Covid-19 pandemic corresponds to 2020/21 Q3. An overview of the impact of the second wave of the Covid-19 pandemic upon GHC patient death reporting during 2020/21 Q3 is presented in Section 5.

2.0 OVERVIEW

2.1 During 2020/21 Q3, 139 GHC patients died. This comprised the following number of deaths which occurred in each month of that reporting period:
57 in October;
44 in November;
38 in December.

2.2 At time of writing, 12 case record reviews and investigations have been carried out in relation to the 139 deaths included in 2.1. The number of deaths in each month for which a case record review or an investigation was completed was:
5 in October;
2 in November;
5 in December.

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 October;
Zero representing 0.0% for November;
Zero representing 0.0% for December.

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 range of questions based on SJR tools is being used 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 Clinical Director and the Quality Lead (Mortality, Engagement and Development), 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 prior to the start of 2020/21 Q3. The number of deaths in each reporting quarter, prior to 2020/21 Q3, for which a case record review or an investigation was completed was:
15 in 2020/21 Q2;
1 in 2019/20 Q4.

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 care record reviews or comprehensive investigations, including Root Cause Analysis, for any deaths meeting Serious Incident or Clinical Incident criteria.

3.0 LEARNING

3.1 Following the suspected suicide of a Recovery Team patient by sodium nitrate, where the team and the investigation were unable to gain information from the Independent Stalking Advocacy Caseworker and the Gloucestershire Rape and Sexual Abuse Centre regarding their interaction with the patient due to their confidentiality policies, GHC will discuss with neighbouring organisations, including the two organisations previously mentioned, regarding appropriate sharing of information.

3.2 Following the death of a patient who ended their life on a family holiday whilst receiving extended support from the Mental Health Intermediate Care Team, the Trust has reviewed the future provision for primary mental health care during Covid-19 restrictions.

3.3 During the investigation into the death of a Crisis Team patient who was found hanged at home, it was found that a telephone call the patient made to the Crisis Team on the day of his death was not recorded, as the extension had not been added to the recording loop. A quarterly audit will be carried out to ensure that all Crisis Team extensions that should be recorded are added to the recording loop.

3.4 Following the death of an inpatient at Wotton Lawn Hospital via ligature (bed linen) tied to the bedroom door, the Trust is continuing its work with regard to installing electronic countermeasures (door top sensors).

3.5 Following the investigation into the death by asphyxiation by helium gas of a Recovery Team patient, staff have been encouraged to make clear assessments of risk when a patient discloses the possession of a suicide kit, and to remain up to date with latest developments in methods of suicide and the associated potential lethality.

3.6 During the investigation into the suspected suicide by asphyxiation of an Assertive Outreach Team patient, it was found that documentation from other statutory agencies and providers revealed that the patient's partner had a criminal history which was not known at the time to the clinical team. 5 days prior to the patient's death, the risks had changed significantly as the patient had been subject to assault from her partner. The Trust has raised awareness of the importance of sharing learning with neighbouring organisation regarding mutual awareness of risk factors, the ability to escalate Safeguarding or Domestic Abuse concerns appropriately, and the use of the DASH form.

3.7 Following the death of a patient who took her own life 13 days after discharge from a Recovery Unit, an investigation found that the Trust's mental health teams involved in the patient's care exercised due diligence and adhered to policy and best practice guidelines. It was clear that Covid-19 impacted on the delivery and consistency of care for third party providers but it did not significantly impact on the care delivered by Trust staff and services.

3.8 Following an investigation into the death of a Recovery Team patient who had reduced their antipsychotic medication against medical advice, and after an alternative therapist had suggested that their symptoms could be treated without medication, staff are recommended to be proactive in asking for details of any private therapists. If appropriate and with consent, they should consider contacting the therapist to discuss the provision of safe and holistic care. Staff are also recommended to share with carers (with the patient's consent) decisions which are made against medical advice, so that carers can be alert to the associated risks.

3.9 Following the review of the expected death of a patient on the End of Life Shared Care Pathway (EoL SCP) at Charlton Lane Hospital, the Mental Health MRG noted that recognising when to place a patient onto EoL SCP can be complex. Mental Health MRG advises the use of various indicator tools, e.g. SPICT, for

recognising the most appropriate time. Mental Health MRG also advises that should a patient rally, it is perfectly acceptable to take the patient off the EoL SCP.

3.10 Following the review of the expected death of a patient on EoL SCP on Willow Ward, Charlton Lane Hospital, the Mental Health MRG noted the excellent work by an HCA in preparing and maintaining the EoL facilities and the positive impact this has had upon patients and their loved ones. Mental Health MRG has recommended that this approach is widened to all wards at Charlton Lane Hospital. Charlton Lane Matron will identify a lead individual to take the work forward and the Mental Health MRG chair has formally written to the HCA thanking her for her commitment to excellent EoL patient care.

3.11 During the review of a Recovery Team patient who passed away from terminal cancer, it was found that there was a delay to the patient receiving a medication review from the Recovery Team consultant. Mental Health MRG has asked the Clinical Director, for Community Working Age Adult Services, to review the case and offer an opinion as to whether the patient was disadvantaged by the delay to receiving the medication review.

3.12 Following the review of a Cashes Green Ward, Stroud Hospital, inpatient, who was placed on the EoL SCP, the Physical Health MRG recommends that staff ensure family members with dementia are engaged with for as much as they are able to process, supporting inclusive and participative engagement. Mental Health MRG are currently considering how to best support Community Hospitals with this recommendation.

3.13 Following the review of an EoL patient's death on Coln Ward, Cirencester Hospital, Physical Health MRG has made the following recommendations regarding ReSPECT forms:

- ReSPECT forms should be reviewed as part of patient clerking and also ideally every time the patient's situation changes, including discharge.
- ReSPECT forms document recommendations only, thus clinical decisions can override recommendations.

3.14 Following concerns raised by Community Hospital ward staff regarding out of hours GPs and reluctance to prescribe EoL medication, Physical Health MRG heard that similar concerns have been raised amongst community colleagues delivering EoL care at home. Physical Health MRG has fed back to the Deputy Clinical Chair, Gloucestershire CCG and also to the Care UK Governance Lead. A response from Care UK is awaited.

3.15 Following review of Covid-19 positive patients on EoL care on Coln Ward, Cirencester Hospital, Physical Health MRG recommends that review of the Advanced Care Plan should be undertaken upon patients receiving a Covid-19 positive result, and that anticipatory medication should be prescribed to provide as many options as possible to nursing staff out of hours. Physical Health MRG also recognised the importance of maintaining effective relationships with

relatives and that when done well, it helps loved ones to, wherever possible, accept the prognosis and come to terms with the outcome.

3.16 Following review of Covid-19 positive patients on EoL care at Lydney Hospital, Physical Health MRG recommends that Midazolam and Morphine can be used for symptomatic treatment and are not necessarily EoL treatments only. Physical Health MRG also recognised the Lydney Ward staff for the immense care and compassion displayed to two patients, a husband and wife, who were facilitated to spend the last few hours together in a 2 bedded bay before the wife's sad passing.

3.17 Physical Health MRG would like to highlight and thank Coln Ward colleagues and Lydney Ward colleagues for their tireless hard work, unwavering resolve and dedication to excellent patient care during what has been a very challenging and difficult time for all ward staff. The emotional and psychological impact upon staff has been recognised and the Trust's psychology colleagues have already begun supporting ward staff with group and one to one sessions where necessary.

3.18 The Gloucestershire specific LeDeR report for LD patient deaths occurring 1 April 2019 to 31 March 2020 has now been published. 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.

3.19 LeDeR have made no specific recommendations regarding the care and treatment provided by GHC during 2019/20.

4.0 UPDATES FROM MRG

4.1 LeDeR have now caught up with the back-log of cases to review in Gloucestershire. The basis for the inception of Learning Disability 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 contributory to a patient's death that required immediate action. Now that LeDeR have caught-up, our Learning Disability MRG will review in 2021/22 Q1 whether to continue to review GHC Learning Disability Services patient deaths.

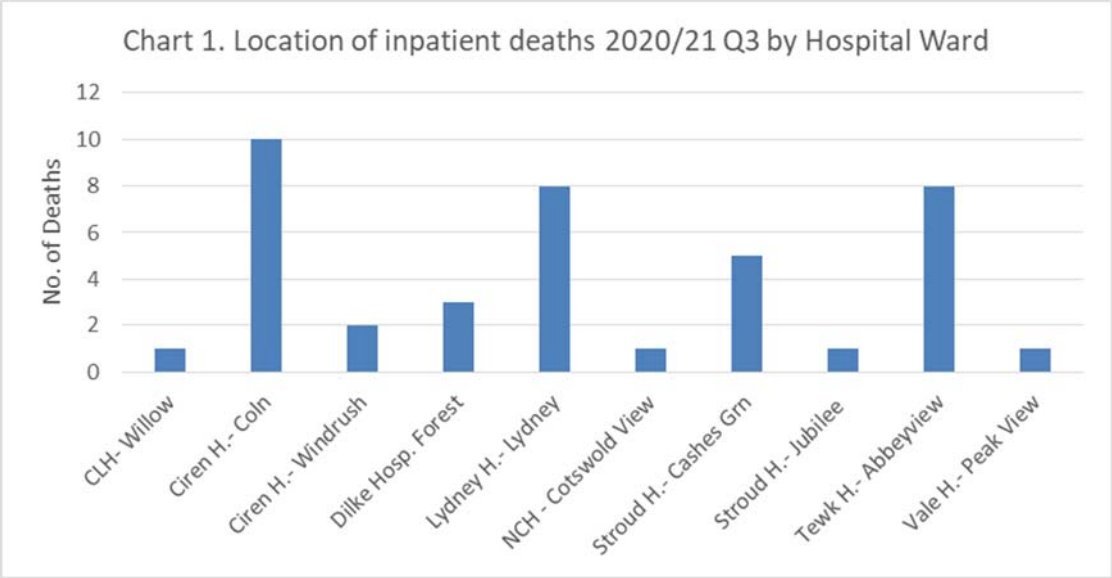
4.2 Physical Health MRG has continued to review and refine the new Datix triggering process which automatically flags community hospital inpatient deaths for review by Physical Health MRG. Physical Health MRG was unable to meet in December 2020, due to operational pressures caused by the second wave of the Covid-19 pandemic. The Countywide Medical Examiner has also been unable to attend meetings in 2020/21 Q3 due to operational pressures.

4.3 Mental Health MRG continues to meet to discuss and review deaths of mental health patients, both in the community and GHC inpatient settings.

5.0 IMPACT OF THE SECOND WAVE OF THE COVID-19 PANDEMIC UPON GHC PATIENT DEATHS REPORTED 2020/21 Q3

5.1 Impact Upon GHC Inpatient Deaths

5.1.1 During 2020/21 Q3, there were a total of 40 inpatient deaths across all inpatient settings. Chart 1 shows the distribution of the 40 inpatient deaths by hospital ward location.

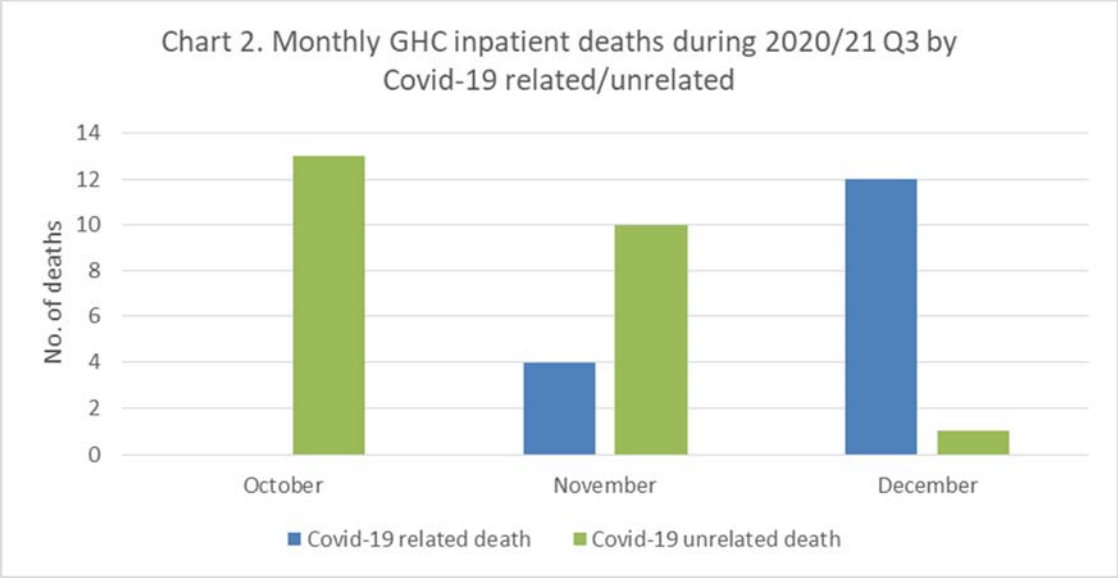


5.1.2 Of the 40 inpatient deaths, 16 met the criteria for national onward reporting to NHS England Covid-19 Patient Notification System (CPNS). NHS England defines a Covid-19 related death as any death that occurs within 28 days of a patient receiving a positive test result, or Covid-19 being recorded on a patient's

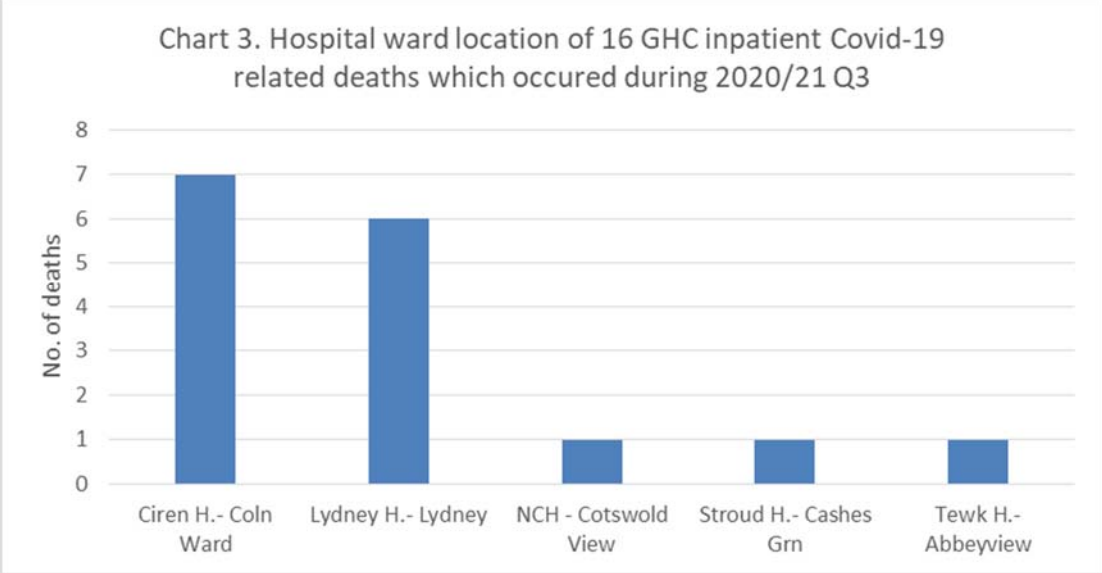
Medical Certificate of Cause of Death (MCCD), regardless of a positive test result.

5.1.3 The first Covid-19 related GHC inpatient death of the second wave occurred 07/11/2020 at Lydney Hospital.

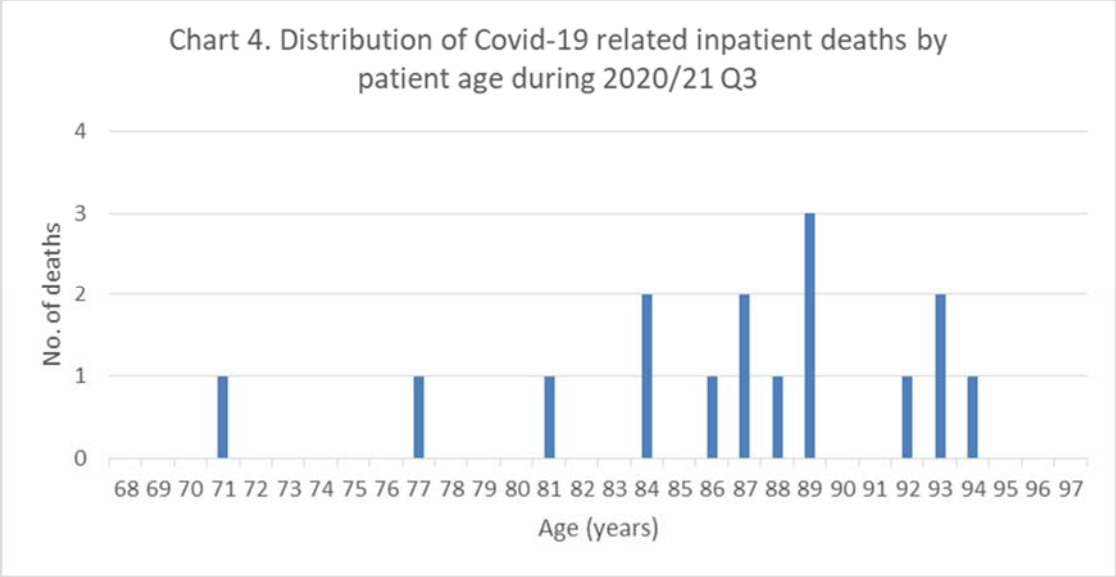
5.1.4 Chart 2 shows the distribution of the 40 inpatient deaths during October, November and December 2020, together with whether the deaths were Covid-19 related or unrelated.



5.1.5 The distribution of the 16 Covid-19 related inpatient deaths by hospital ward is shown in Chart 3.



5.1.6 At date of death, the age range for these 16 patients ranged from 71-94 years, shown in Chart 4. The mean is 86.5 years of age and the median is 87.5 years of age. The data in Chart 3 relates to 12 male and 4 female inpatient deaths.

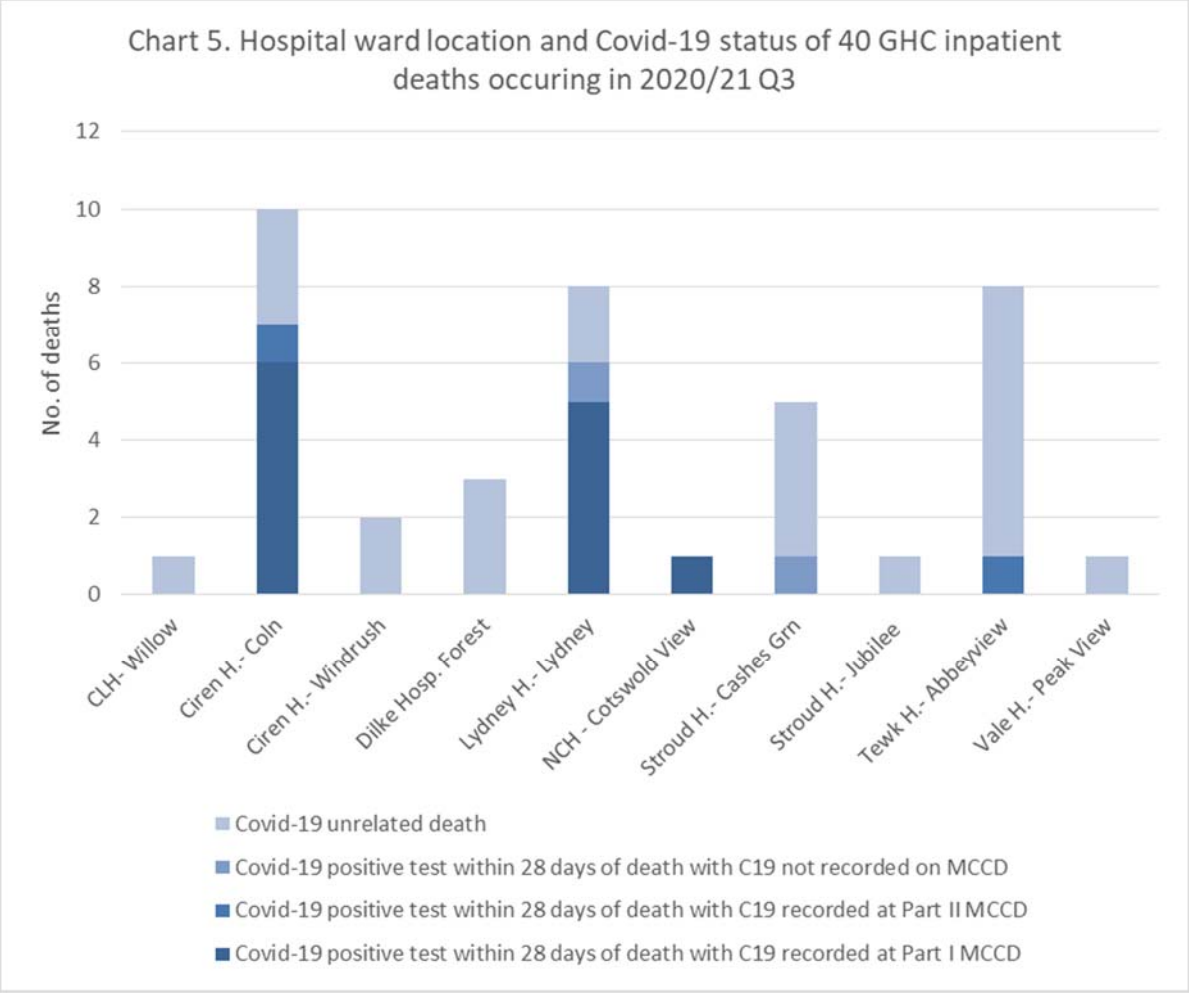


5.1.7 Of the 16 inpatient deaths that met national CPNS reporting criteria, all 16 patients had tested positive for Covid-19 within 28 days of their death. Covid-19 was recorded on 14 patients' MCCDs. For the remaining 2 patients, Covid-19 was not recorded on the MCCDs.

5.1.8 Table 1 and Chart 5 show the breakdown of the 40 inpatient deaths referred to in 5.1.1 by hospital ward location, and whether the death was unrelated to Covid-19 or whether Covid-19 was:

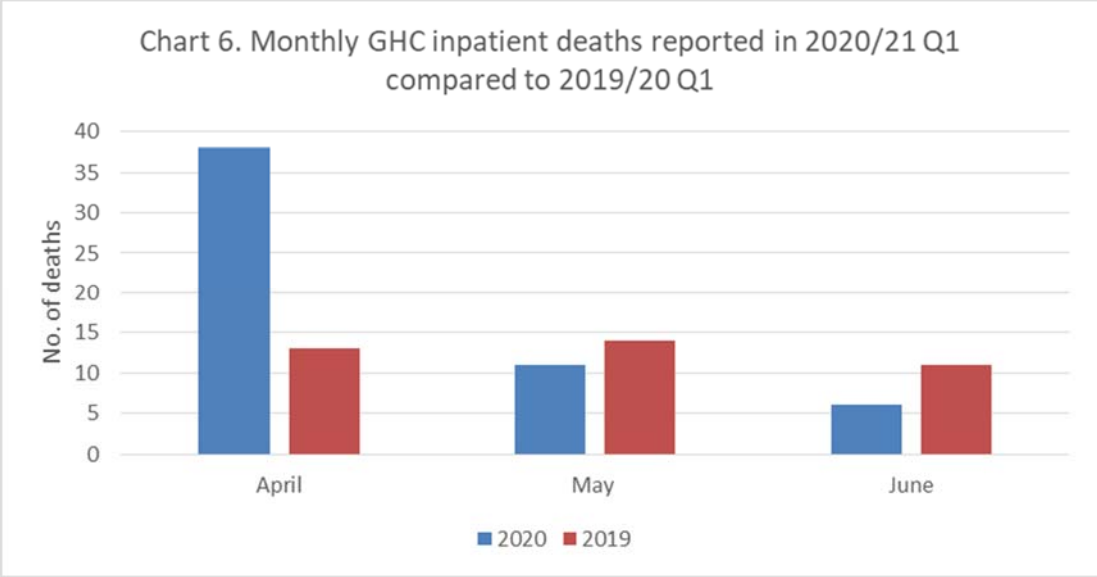
- recorded as the cause of death at Part I of the MCCD, together with a positive Covid-19 test result within 28 days of death;
- recorded at Part II of the MCCD, indicating a significant condition that could have hastened death, but is not related to the condition recorded as cause of death at Part I of the MCCD, together with a positive Covid-19 test result within 28 days of death;
- not recorded at either Part I or II of the MCCD, but the patient had received a positive Covid-19 test result within 28 days of death;
- not recorded on the MCCD and no positive test result within 28 days of death, indicating the death was unrelated to Covid-19.

Hospital Ward Location	Covid-19 positive test within 28 days of death with C19 recorded at Part I MCCD	Covid-19 positive test within 28 days of death with C19 recorded at Part II MCCD	Covid-19 positive test within 28 days of death with C19 not recorded on MCCD	Covid-19 unrelated death	Total
CLH- Willow	0	0	0	1	1
Ciren H.- Coln	6	1	0	3	10
Ciren H.- Windrush	0	0	0	2	2
Dilke Hosp. Forest	0	0	0	3	3
Lydney H.- Lydney	5	0	1	2	8
NCH - Cotswold View	1	0	0	0	1
Stroud H.- Cashes Grn	0	0	1	4	5
Stroud H.- Jubilee	0	0	0	1	1
Tewk H.- Abbeyview	0	1	0	7	8
Vale H.- Peak View	0	0	0	1	1
Total	**12**	**2**	**2**	**24**	**40**

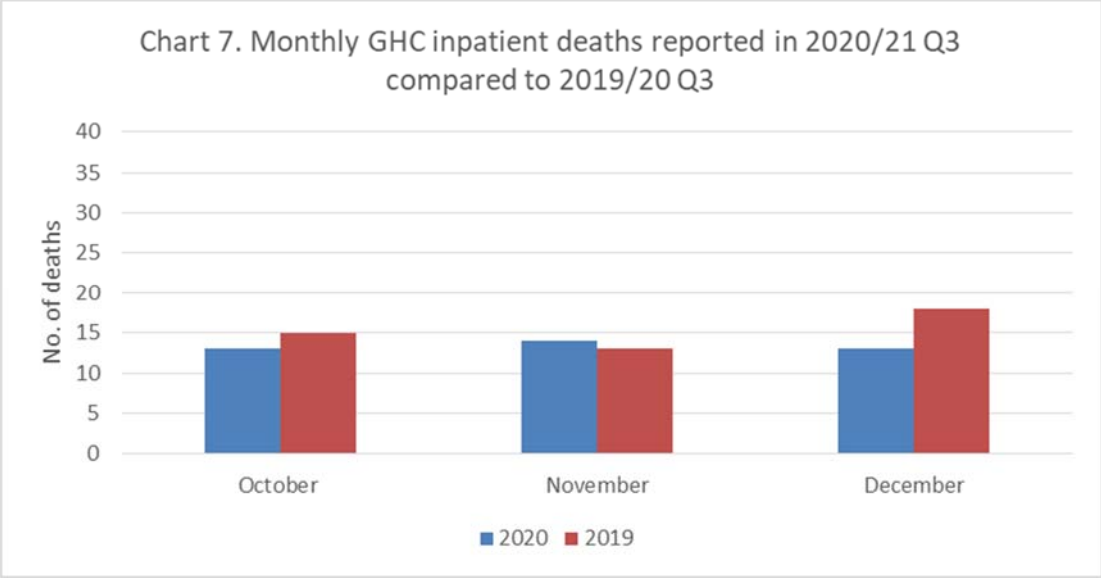


5.1.9 All patients where Covid-19 was recorded at Part I MCCD were suffering with significant comorbidities at the time of their death.

5.1.10 During the first wave of the Covid-19 pandemic, in 2020/21 Q1, there was an overall increase of GHC inpatient deaths compared to 2019, as shown in Chart 6. At the peak of the first wave, during April 2020, there was a 2.9 fold increase in the number of inpatient deaths compared to deaths reported in April 2019.



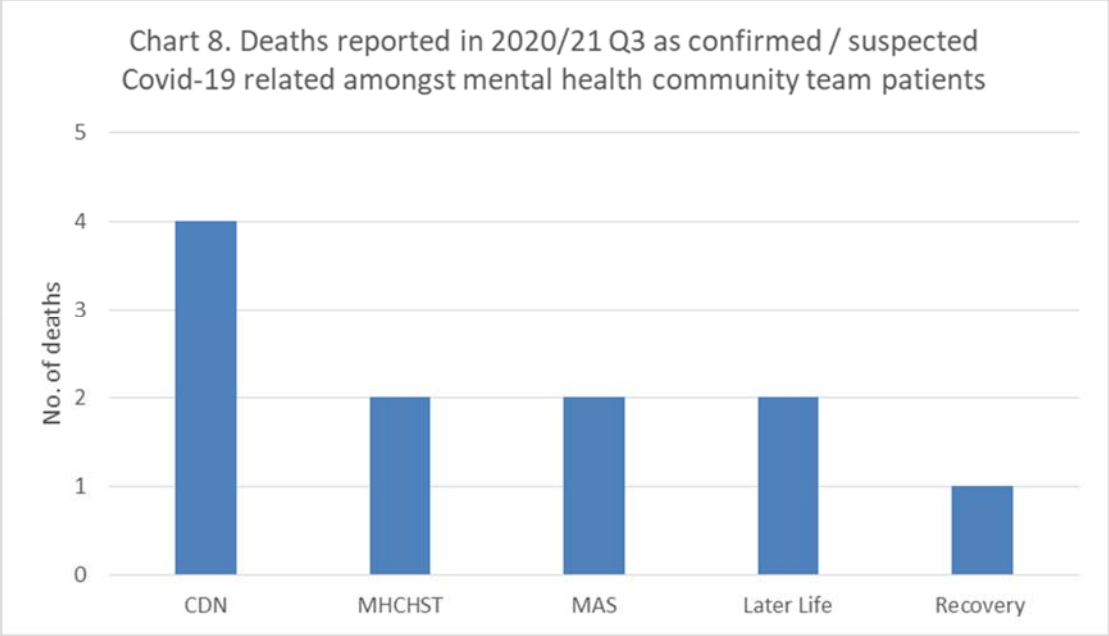
5.1.11 During 2020/21 Q3, numbers of overall inpatient deaths compared to 2019 figures have not increased, shown in Chart 7.



5.2 Impact upon GHC mental health and learning disability community patient deaths

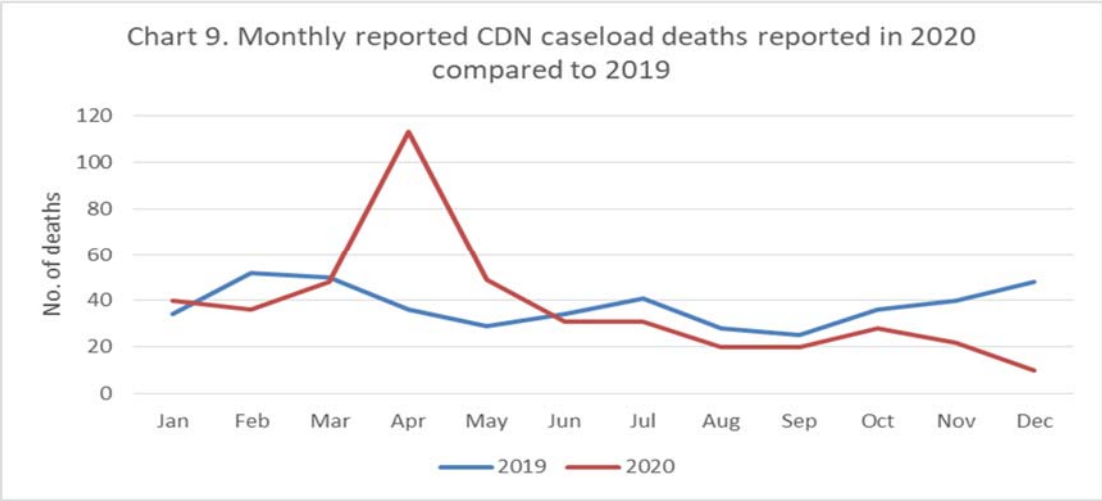
5.2.1 All deaths of patients open to community mental health and LD caseloads are reported on the Trust's Datix system. During 2020/21 Q3, there were 11 deaths reported as being Covid-19 confirmed / suspected. As the reporters of deaths

on Datix are not always aware of the cause of death, these figures may not represent the true impact of Covid-19 mortality amongst these caseloads. Chart 8 shows the distribution of the 11 deaths distributed across the various mental health community teams.



5.2.2 At time of writing, during 2020/21 Q3, there had been no confirmed / suspected Covid-19 related deaths amongst patients open to LD community teams.

5.2.3 During the first wave of the pandemic, in April 2020, there was a sharp increase in the number of deaths reported amongst patients open to the Community Dementia Nurse (CDN) caseloads, when compared to 2019 figures. Chart 9 shows that a similar increase in reported deaths during the second wave of the pandemic has, as yet, not been observed.



5.2.4 When compared to total Gloucestershire whole county death data, the spike in deaths reported in April 2020 amongst CDN patients corresponded to the same spike in excess deaths and Covid-19 related deaths observed in the whole Gloucestershire data, which was presented in 2020/21 Q2 Learning From Deaths report.

5.2.5 If necessary, further analysis will be carried out on CDN 2020/21 Q3 caseload death data as further deaths are reported, to ascertain whether any observed spike in deaths reported amongst this cohort of patients corresponds, once again, to a peak in deaths seen across Gloucestershire, resulting from the second wave of the pandemic.

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AGENDA ITEM: 17

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 28th February 2021**

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 11 position
- Approve the write-off of 4 debtor invoices for HIV drugs charges
- Approve the delegation of the review and approval of the Digital Patient Observation business case to the Resources Committee in April

Executive summary

- The Trust has received additional block contract payments to cover Covid costs, lost income and some new developments
- The Trust has reviewed its balance sheet and released a number of provisions, and proposed a number of asset and debtor write-offs
- The Trust has identified 4 HIV drugs invoices to CCGs, dating back to 2014-2017, that require Board approval to be written off
- The Trust has decreased its annual leave accrual estimate by £520k to £2.514m
- The Trust has reflected the transfer of assets to Herefordshire and Worcestershire Health & Care Trust
- The Trust has an interim plan of a deficit of £439k for October to March
- The Trust's position at month 11 is a deficit of £145k
- The Trust is forecasting a year end surplus of £0.163m
- The cash balance at month 11 is £68.8m

- Capital expenditure is £5.269m at month 11. The Trust has a revised capital plan for 20/21 of £10.772m.
- The revised recurring Cost Improvement Plan (CIP) target for the merged Trust is £3.230m and the amount delivered to date is £3.492m
- The Trust has spent £3.213m on Covid related revenue costs between April and February
- The Trust has amended the capital programme to increase the Forest of Dean scheme to £20.4m and moved the sale of Holly House back one year to 22/23
- In order to progress the introduction of a Digital Patient Observation system into the Trust a full business case is being completed in March/April
- 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 progressing this scheme

Risks associate 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:	AI-17.1 - Finance Report – Month 11

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

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AGENDA ITEM: 17.1

Finance Report Month 11

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Overview

Gloucestershire Health and Care NHS Foundation Trust

- The Trust has a revised year end forecast surplus of £0.163m, a significant improvement on the £2.596m deficit previously reported
- The Trust has reduced the forecast for the cost of untaken annual leave at year end following a review of the level of outstanding leave at the end of February by £0.520m, bringing the total increase to £2.514m
- The Trust has received £0.63m from the CCG to support Covid costs, and £0.800m to cover lost non clinical income caused by the Covid pandemic
- A review of the balance sheet has released provisions of £0.93m
- The Trust has recorded Covid related expenditure of £3.213m for April to February
- The adjusted recurrent Cost Improvement Plan target for the Trust following the extension of the interim planning guidance is reduced to £3.230m, CIP removed so far is £3.619m which is above the revised target
- 20/21 revised Capital plan is £10.772m, an increase of £590k for additional national IT funding
- Spend to month 11 is £5.269m which is £2.5m less than the revised year to date plan to NHSI. Capital Management Group is monitoring the £5.5m forecast spend in March on a scheme by scheme basis
- Agency cost forecast is £4.947m which is £1.48m lower than 2019/20
- Cash at the end of month 11 is £68.8m due to receiving block contract income early c.£20m and reduced capital spend of £2.5m
- Capital scheme costs for Forest of Dean increased by £2m, and Holly House disposal moved back to 22/23

Annual Leave accrual

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has updated its annual leave accrual estimate
- Current estimates of leave outstanding on ESR indicate significant leave still to be booked (200,567 hours)
- However the amount of leave taken and booked during February increased compared to previous months
- For each staff group a calculation of the average leave taken and booked over the past 3 months in ESR has been used to assess the likely level of outstanding leave at 31st March
- The revised annual leave accrual in the forecast has reduced to £2.515m
- There is risk of audit challenge of this calculation at year end
- We are reviewing annual leave levels weekly and updating the figure each month.
- DoH&SC has indicated that some funding for the increase in the annual leave accrual will be made available

Staff Group	% of leave booked and taken	Remaining leave (yet to book)	Cost of leave not taken	Av Hrs remaining/wte	Total WTE	Av hourly rate	Adjusted hours carried forward/wte	Cost of carry forward
			£		a	b	c	a x b x c
Professional, Scientific and Technic	87.63%	6357.57	168221.40	33.53	189.6	26.46	19.24	96,536
Additional Clinical Services	79.17%	45803.42	620636.31	56.30	813.6	13.55	46.91	517,125
Administrative and Clerical	81.77%	40422.73	721141.54	50.80	795.7	17.84	35.48	503,638
Allied Health Professionals	79.96%	25487.28	587481.77	56.56	450.7	23.05	38.76	402,636
Estates and Ancillary	69.16%	13342.15	168644.78	82.10	162.5	12.64	67.52	138,699
Medical and Dental	74.19%	1464.10	75108.33	14.57	100.5	51.3	45.66	235,303
Nursing and Midwifery Registered	80.15%	67484.08	1463054.94	55.90	1207.2	21.68	44.79	1,172,205
Students	56.33%	206.33	2216.02	54.30	3.8	10.74	39.30	1,604
Total	80%	200567.67	3806505.09		3,723.5			3,067,747
Less Provision from 19/20								-553,122
Annual Leave Provision increase 20/21								**2,514,625**

Debtors write-off - HIV

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NHS Foundation Trust

- The Trust has been reviewing its bad debts as part of a wider balance sheet review
- A number of old CCG Debtors relating to out of county HIV drugs charges relating to 2014-2017 are unpaid
- CCGs do not feel they were funded for these costs and have consistently refused to pay
- It is not thought advisable that the Trust should seek clarity to seek legal redress
- All invoices have been provided for so there is no financial impact on the Trust to write them off
- Under the terms of the SFIs the Board has the responsibility to authorise the write-off of bad debts over £15,000
- There are four invoices totalling £151k that require Board authorisation

Category	Invoice	£
TOTAL Amount Outstanding as at Oct 2019		**£280,725.00**
Amount Paid since	10	-£49,350.00
Amount written off by Chief Executive	23	-£80,375.00
Amount to be written off by Board		
NHS BANES, SWINDON AND WILTSHIRE CCG	5000000206	-£94,000.00
	5000000441	
	5000000530	
NHS SOUTH GLOUCESTERSHIRE CCG	5000000301	-£57,000.00
TOTAL Outstanding		**£0.00**

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	GHC Month 11				GHC mths 1-12				
	2020/21				2020/21				
	Original Plan	Revised NHSI Interim plan	Actual	Variance	Original Plan	Revised NHSI Interim plan	Spending Limit	Full Year Forecast	Variance
Operating income from patient care activities	175,778	203,354	201,973	(1,381)	211,417	220,772	224,052	218,660	(2,112)
Other operating income	7,560	6,112	9,868	3,756	9,068	8,460	6,753	10,825	2,365
True up income	0	1,761	1,841	80	0	1,761	1,761	1,841	80
	0	0	0	0	0	0	0	0	0
Employee expenses	(134,679)	(156,115)	(155,077)	1,038	(161,631)	(169,469)	(170,256)	(165,724)	3,745
Operating expenses excluding employee expenses	(44,697)	(52,453)	(56,022)	(3,569)	(53,635)	(57,264)	(59,221)	(58,239)	(975)
PDC dividends payable/refundable	(3,350)	(3,172)	(2,840)	332	(4,019)	(3,482)	(2,800)	(3,400)	82
Other gains / losses	7	42	16	(26)	21	48	46	60	12
Surplus/(deficit) before impairments & transfers	**619**	**(471)**	**(241)**	**230**	**1,221**	**826**	**335**	**4,023**	**3,197**
impairments / exceptional items*	0	0	(5,006)	(5,006)	1	(1,378)		(8,966)	(7,588)
Remove capital donations/grants I&E impact	0	104	96	(8)		113	102	100	(13)
Surplus/(deficit)	**619**	**(367)**	**(5,151)**	**(4,784)**	**1,222**	**(439)**	**437**	**(4,843)**	**(4,404)**
Adjust (gains)/losses on transfers by absorption			**5,006**					**5,006**	5,006
Risk allowance				0			(670)		0
Revised Surplus/(deficit)	**619**	**(367)**	**(145)**	**(4,784)**	**1,222**	**(439)**	**(233)**	**163**	**602**

Note. The variances compare 'Revised NHSI Interim budget' against 'Actual' and 'Full Year Forecast'
* Exceptional items - increase in annual leave accrual and Cleeve House write-off

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		GHC	GHC Month 11				
		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	556	(686)	505
	Property, plant and equipment: other	115,916	124,670	113,885	105,292	(8,593)	110,403
	Total non-current assets	**117,939**	**126,953**	**115,127**	**105,848**	**(9,279)**	**110,908**
Current assets	Inventories	288	245	283	283	(0)	283
	NHS receivables	11,017	8,456	3,072	6,137	3,065	14,339
	Non-NHS receivables	8,973	5,723	11,914	12,730	816	1,825
	Cash and cash equivalents:	26,619	26,448	66,910	68,848	1,938	42,500
	Property held for sale	0	500	0	0	0	0
	Total current assets	**46,897**	**41,372**	**82,179**	**87,998**	**5,819**	**58,947**
Current liabilities	Trade and other payables: capital	(2,143)	(1,784)	(509)	(2,684)	(2,175)	(3,684)
	Trade and other payables: non-capital	(5,580)	(10,551)	(18,007)	(20,120)	(2,113)	(11,909)
	Borrowings	(76)	(104)	(53)	(104)	(51)	(104)
	Provisions	(371)	(604)	(634)	(853)	(219)	(853)
	Other liabilities: deferred income including contract liabilities	(16,655)	(2,120)	(30,100)	(28,317)	1,783	(10,004)
	Total current liabilities	**(24,825)**	**(15,163)**	**(49,303)**	**(52,078)**	**(2,775)**	**(26,554)**
Non-current liabilities	Borrowings	(1,773)	(7,938)	(1,483)	(1,373)	110	(1,347)
	Provisions	(3,491)	(451)	(4,075)	(3,440)	635	(3,871)
	Total net assets employed	**134,747**	**144,773**	**142,445**	**136,954**	**(5,491)**	**138,082**
Taxpayers Equity	Public dividend capital	127,526	125,181	125,826	125,884	58	126,577
	Revaluation reserve	6,566	7,098	7,204	6,207	(997)	6,207
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(0)	(1,241)
	Income and expenditure reserve	1,896	13,735	10,656	6,104	(4,552)	6,539
	Total taxpayers' and others' equity	**134,747**	**144,773**	**142,445**	**136,954**	**(5,491)**	**138,082**

Note. £20m deferred income. March income received in February. In March the Trust will not receive April's income

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 19/20		ACTUAL YTD 20/21		FORECAST 20/21	
Cash and cash equivalents at start of period		**33,553**		**37,720**		**37,720**
Cash flows from operating activities						
Operating surplus/(deficit)	1,308		2,758		3,701	
Add back: Depreciation on donated assets	0		127		178	
Adjusted Operating surplus/(deficit) per I&E	**1,308**		**2,885**		**3,879**	
Add back: Depreciation on owned assets	4,944		8,734		9,122	
Add back: Impairment	3,489		5,006		5,006	
(Increase)/Decrease in inventories	(38)		0		0	
(Increase)/Decrease in trade & other receivables	(3,516)		5,720		4,451	
Increase/(Decrease) in provisions	2,485		492		492	
Increase/(Decrease) in trade and other payables	2,580		13,651		491	
Increase/(Decrease) in other liabilities	(863)		756		(5,123)	
Net cash generated from / (used in) operations		**10,389**		**37,244**		**18,318**
Cash flows from investing activities						
Interest received	206		8		18	
Purchase of property, plant and equipment	(4,835)		(5,269)		(10,771)	
Sale of Property	560		0		0	
Net cash generated used in investing activities		**(4,069)**		**(5,261)**		**(10,753)**
Cash flows from financing activities						
PDC Dividend Received	570		679		826	
PDC Dividend (Paid)	(2,565)		(1,170)		(3,242)	
Finance Lease Rental Payments	(158)		(363)		(370)	
		(2,153)		**(854)**		**(2,786)**
Cash and cash equivalents at end of period		**37,720**		**68,849**		**42,499**

Covid 1

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- Urgent Covid related capital costs have been incurred in 20/21 and funding of £137k received which fully covers the expenditure
- Not all covid costs are covered by central funding - £174k
- Pillar 1 testing income has been included at £203k
- Recurring costs are £1.307m in a full year

For periods up to and including 28/02/2021 (M1-11)	TOTAL costs Months 1-6	TOTAL costs Months 7-11	Forecast £
Internal and external communication costs	0	10,587	19,797
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	329,891	359,514	762,689
Sick pay at full pay (all staff types)	28,636	5,584	34,720
COVID-19 virus testing (NHS laboratories)	101,069	231,337	349,238
Remote management of patients	51,816	87,500	152,421
Plans to release bed capacity	35,430	17,257	57,477
Segregation of patient pathways	3,439	0	4,585
Existing workforce additional shifts	128,595	116,068	266,905
Decontamination	148,912	65,134	243,928
Backfill for higher sickness absence	819,302	261,601	1,179,167
Remote working for non patient activites	78,286	87,500	187,715
National procurement areas	203,873	0	203,873
PPE - other associated costs	0	0	0
Other	41,480	0	41,480
TOTAL EXPENDITURE	£1,970,729	£1,242,082	£3,503,996
Retrospective Top up paid	-1,761,000		-1,761,000
Covid envelope system pot		-963,333	-1,156,000
COVID-19 virus testing Pillar 1		-202,566	-212,780
Lateral Flow testing		-66,667	-80,000
School Aged Immunology		-100,000	-120,000
TOTAL INCOME	-£1,761,000	-£1,332,566	-£3,329,780
Net Expenditure over Income	£209,729	-£90,484	£174,216

Note £174k = £210k shortfall M1-6, £36k forecast decrease

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Updated Plan	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan	
£000s	2020/21	2020/21	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Land and Buildings								
Buildings	3,383	1,798	3,276	3,629	4,500	2,500	1,000	15,012
Backlog Maintenance	1,600	959	1,686	3,020	1,050	1,050	250	6,970
Urgent Care	200	25	0	750		0		950
Cirencester Scheme						5,000		5,000
Medical Equipment	587	153	461	678	730	730	3,330	6,055
IT								
IT Device and software upgrade	1,270	714	1,275	200	600	600	600	3,270
IT Infrastructure	2,705	984	2,666	1,086	1,400	1,300	1,300	7,791
Sub Total	**9,745**	**4,633**	**9,364**	**9,363**	**8,280**	**11,180**	**6,480**	**45,048**
Forest of Dean	200	363	581	5,000	10,500	3,500	0	19,200
Total of Original Programme	**9,945**	**4,996**	**9,945**	**14,363**	**18,780**	**14,680**	**6,480**	**64,248**
Covid	137	139	137					137
Critical Infrastructure Reserve	100	100	100					100
Cyber Security	34	34	34					34
IT Electronic Observations	200		200					200
IT - NHX Remote Working	286		286					286
IT _ Digital Pods/Digital Inclusion Equip	70		70					70
Total of Updated Programme	**10,772**	**5,269**	**10,772**	**14,363**	**18,780**	**14,680**	**6,480**	**65,075**
Disposals					(3,260)	(1,500)		(4,760)
Donation - Cirencester Scheme						**(5,000)**		(5,000)
	10,772	**5,269**	**10,772**	**14,363**	**15,520**	**8,180**	**6,480**	**55,315**

Forest of Dean - £900k spent in 2018/19 and 19/20, total planned spend increased to £20.4m, an additional £2m in 23/24
Disposals of £3.26m moved into 22/23, including Holly House
We have spent £5.269m to date. This is £2.5m behind the NHSI plan year to date.
New externally funded schemes during 20/21 have been separated out below the original programme to highlight the expansion in the programme

Risks

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Risks to delivery of the 2020/21 position and 21/22 potential risks are as set out below:

Risks 20/21	20/21 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Capital envelope not fully spent	400		400	3	2	6
Annual Leave income received might be different to forecast	500		500	2	2	4
Annual Leave accrual is challenged at year end	600		600	2	2	4
	1,500	**0**	**1,500**			
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%)	100	100	0	3	1	3
Delivering Differential CIP schemes	500	500	0	3	2	6
Delivering Value Scheme CIPs	900	900	0	5	3	15
Delivering non recurring savings	2,200	0	2,200	1	4	4
Efficiencies need to be higher than assumed (0.9% more)	1,900	1,900	0	3	3	9
Do not sell proposed capital disposals	2,000	0	2,000	2	4	8
Insufficient Covid funding to cover recurring costs	1,307	1,307	0	3	3	9
	8,907	**4,707**	**4,200**			

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AGENDA ITEM: 18

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Sandra Betney, Deputy Chief Exec & Director of Finance

AUTHOR: Chris Woon, Associate Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD FEB 2021 (MONTH 11)**

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.

Performance covers the period to the end of February (Month 11 of 2020/21). It is of note that performance period remains aligned to our operational priority to recover services from the pandemic waves and winter pressures.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led updates will more fully account for 2020/21 performance indicators in exception and provide legacy Service Recovery Action Plans (SRAP) updates. Example of this include CYPS and Eating Disorders in Q4.

Recommendations and decisions required
Board members are asked to:

- Note the aligned Performance Dashboard Report for February 2020/21.
- Acknowledge the impact of the **Covid-19** response 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 pandemic recovery programme.

Executive summary

It is of note that all of indicators within this period have been in exception within the last 12 months with the exception of; *'1.05: Delayed Transfers of Care'* and '*50: Psychosexual Service - % treated within 8 weeks'*.

Trust Wide Services

There are currently 4 workforce indicators in exception that apply to all GHC services. There is an improvement in the supporting commentary however further discussions have been held with the Workforce team to add operational context similar to what is shown in 77: Mandatory Training. Conversations have begun about making further workforce indicators available in 2021/22. It is anticipated this will include a vacancy factor.

Mental Health & Learning Disability Services (National & Local)

The Board's attention is requested to review the 10 key performance thresholds listed in the dashboard (with associated narrative) that were not met for the period. Of note is;

- the increasing Delayed transfers of Care (discharge) position (1.05) which has fallen over threshold in February. Operational services were well sighted on this developing situation
- that Eating Disorder Services continue to face major performance challenges due to a high number of referrals and high vacancy rate (3.35, 3.37, 3.39 & 3.40)
- Although no cases are presented in CLH this month there is still a case whereby a patient with dementia did not have a weight assessment or delirium screen near discharge (3.28 & 3.31)

Physical Community Health Services (National & Local)

In addition, attention is drawn to the 16 key performance thresholds listed in the dashboard (with associated narrative) that were not met for the period. Of note are;

- 5 KPIs under threshold within CYPS. Note the performance figure now includes all modes of contact (i.e. Face to Face, telephone and video)
- 3 within Wheelchair Services but our wheelchair services are presenting positive improvements over the last three months

We are awaiting the final report from the PWC internal audit (for Wheelchair and Health Visiting services) but initial briefings suggest it has been a positive learning and assurance process.

Non-exception reporting

It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy '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.

There will be a further briefing paper intended for the April 2021 Resources Committee outlining a proposal to manage 'proxy' indicators in 2021/22.

Risks associated with meeting the Trust's values Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Service Recovery Action Plan (SRAP) which outlines appropriate risk and mitigation will be commissioned and monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
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 18th March 2021 & ODGF 24th March 2021

Appendices:	None

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

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Snapshot Month
February

Performance Dashboard Report & BI Update

Aligned for the period to the end February 2021 (month 11)

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 or administrative 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, the Covid-19 response 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.

For example,specific updates have been provided by operational services in Quarter 4 for two areas with consistent performance challenges; Children and Young People's Services (CYPS) and Eating Disorder Services.

Business Intelligence Update
In spite of ongoing Covid-19 BI demands, 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 high profile tasks have been completed recently;

- Progress to date has been successful regarding Workforce (ESR) and Finance (Integra) data processing. Warehouse data has been validated and is flowing into the reporting tools for the planned automated integration beginning in April 2021. Final checks are being completed with the data that is available. Some technical connection issues are being prioritised for resolution
- Datix data validation has begun so that this can also be automated into our dynamic, regular reporting for both the corporate dashboard and service level needs
- Service level recovery, surge planning and response engagement has continued through roubust business partnering
- Final legacy GCS reports migrated to Tableau with Birtie being decommissioned in February 2021.
- A more comprehensive discovery exercise has begun to evaluate the scale of the existing data source adjustments required (proimarily to support data quality monitoring) in new environment.
- Draft Performance Management Framework has been shared for initial stakeholder input/ feedback

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

- Dashboard visualisation capability further developed to include; automated benchmarking observation, SRAP alerts and data quality alerts (2021/22). This is incorporated within the aforementioned Performance Management Framework.
- Internal service specification review, considering Commissioner led contractual KPI review (2020/21 Q4 and 2021/22 Q1)

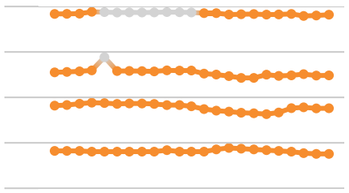
PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO BE RESPONSIVE TO THE DEMANDS ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC (e.g. C19) REPORTING.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements

		FEBRUARY		2021		
77	Mandatory Training	85.2%	90.0%	85.7%	90.0%	
78	% of Staff with completed Personal Development Reviews (Appraisal)	67.4%	90.0%	66.5%	90.0%	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	75.6%	90.0%	70.3%	90.0%	
79	Sickness absence average % rolling rate - 12 months	4.4%	4.0%	4.8%	4.0%	

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

77: Mandatory Training
Performance was 85.2% in February, below the target of 90%. The average compliance over the past 6 months is 85.1%. Performance is below the SPC chart lower control limit based on 2018/19 data. Since December 2020, the mandatory training figures now include Bank Staff, who had previously been excluded from the calculation.

As part of service recovery plans, work has commenced to improve training compliance where it is lower than the required Trust target of 90%. In particular this has focussed on resuscitation and physical intervention training (PMVA and PBM) both of which have recovery plans in place and a more detailed breakdown of the figures is being presented monthly to the Quality Assurance Group (QAG). In the main, the areas requiring the greatest increase in compliance for these two training topics are Mental Health and Learning Disability Inpatient settings, and Matrons in the relevant wards are aware of the position and working to help support staff to attend training. It is hoped that a number of measures in the two plans will start to improve these figures over the next few months.

Unfortunately social restrictions on class sizes along with service pressures have resulted in some staff being out of date with their physical intervention refresher training. Staff on all the wards across both Wotton Lawn and Charlton Lane Hospitals can respond to an incident if required which helps mitigate any variance in compliance or staffing levels between the different wards. Additional, on-site training sessions are also taking place to support new members of staff or anyone who feel they need some additional support to bolster their confidence or competence.

78: % of Staff with completed Personal Development Reviews (Appraisal)
Performance in February was 67.4% compared to a target of 90%. There continued focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only.
Performance in February was 75.6% compared to a target of 90%. There is increasing focus to improve compliance rates across the Performance is below SPC chart normal variation based on 2018/19 data.

79: Sickness absence average % rolling rate - 12 months
Performance presented in February is actually to the end of January 2021 due to the way that data is currently managed within the ESR system. Performance for this period was 4.4% compared to a threshold of 4.0%. This is measured on a rolling 12 months basis. Performance is below SPC chart normal variation based on 2018/19 data. The general trend month on month from September 2020 is that sickness absence, both long and short term, is reducing for all service areas. Overall the total sickness absence rates across the trust continue to fall from 4.8% in September 2020 to 4.4% in February 2021.

The Finance directorate 4.42% and the Operations directorate (4.7%) both have above threshold sickness absence levels. Within Finance the areas above threshold are Estates & Facilities at 5.8% and Finance at 6.6%. Within the Operations directorate; Adult Community services (4.2%), Hospitals (6.2%), Urgent Care (4.4%) and Specialist services (4.3%) are all above the threshold. The Strategic Planning team within the Strategy and Partnership Directorate are above threshold at 9.4% however this is a drop from last month (10.3%) .

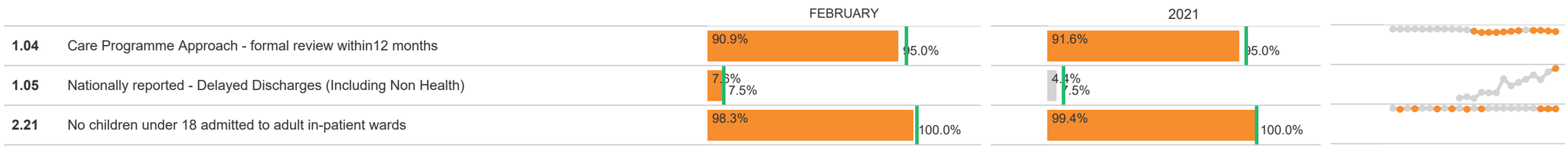
Sickness absence appears to have contributed to the performance of *indicators such as; '46: Diabetes Nursing - % treated within 8 Weeks'* during the period, '*50: Psychosexual Service - % treated within 8 weeks' and '1.04: CPA Approach – Formal review within 12 months'.*

Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & 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 with the exception of *'1.05: Delayed Transfers of Care'.*

1.04: CPA Approach – Formal review within 12 months
Performance for February is 90.9% (92 cases) against a performance threshold of 95%.

The majority of cases are within the following services: Recovery (51), CPI (10) and Assertive Outreach (6).

Within the Adult Community services there has been a reduction in some teams' capacity due to staff movement, sickness and the impact of COVID-19 absences. These are ongoing challenges and teams are continuing to plan CPA's and address historical cases within available capacity. The service is planning to focus on this area in April.

1.05: Nationally reported – Delayed Transfers of Care
February is reported at 7.6% against a threshold of 7.5%

The number of bed days attributed to delayed transfers of care has been steadily rising since August 2020. This is being monitored operationally through the service dashboard. Charlton Lane has risen from 7% (93 days) to 12% (148 days) and Wotton Lawn from 1.8% (40 days) to 4.8% (96 days)

The increase is associated to more complex cases regarding either risk or overall presentation and delay responsibility is associated to external agencies including ASC, Local Council and Secure services. For patients currently delayed, the longest waits are due to awaiting supported accommodation.

The nationally reported delays referred to above are for patients that are not detained. There are also delays for detained patients (Indicator 1.06) and these are reported in February at 6.1%, with Charlton Lane at 7.4% (88 bed days) and Wotton Lawn at 5.4% (107 bed days).

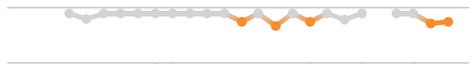
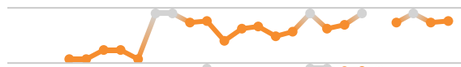
2.21: Admissions of Under 18s to Adult Inpatient Wards
There was 1 admission of an under 18 in February.

A young person under the care of EI and Crisis services was admitted initially to the Maxwell Suite and then to Wotton Lawn overnight. A Tier 4 placement was found and the young person transferred the next day.

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

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract

		FEBRUARY	2021	
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	59.5% 100.0%	45.1% 100.0%	
3.28	Patients with Dementia have weight assessments near discharge	83.3% 85.0%	90.9% 85.0%	
3.31	Patients with Dementia have delirium screening near discharge	83.3% 85.0%	78.1% 85.0%	
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	6.6% 95.0%	69.4% 95.0%	
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	0.0% 95.0%	47.0% 95.0%	
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	66.6% 95.0%	91.4% 95.0%	
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	88.8% 95.0%	84.3% 95.0%	

Mental Health & Learning Disability - Social Care

There are no Social Care indicators in exception for this period.

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

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded
February is reported at 59.5% against a local performance threshold of 100%.

Compliance continues to improve slowly and a review of the reporting structure for this indicator continues with Commissioners and the National Team in preparation for 2021/22 reporting. A ROMs action plan, monitored quarterly by CAMHS ODGF, is in place.

The service is awaiting to update their action plan with clearer milestones once there is clarity from the national team around methodology.

3.28: Patients with Dementia that have not had a weight assessment near discharge
February performance is reported at 83.3% against a performance threshold of 85%. See 3.31 for narrative.

3.31: Patients with Dementia that have not had delirium screening near discharge
February performance is reported at 83.3% against a performance threshold of 85%.

There was 1 non-compliant case in February which is the same case for this and indicator 3.28.

The patient was originally admitted to Charlton Lane Hospital and was screened and weighed regularly before transfer to Wotton Lawn Hospital 26 days into the admission. The service has identified that weighing and screening processes have not been adopted as robustly as they have in Charlton Lane due to the number of small cases in Wotton Lawn. The service will disseminate the guidance appropriately to staff.

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
February performance is reported at 6.6% against a performance threshold of 95%. There were 14 non-compliant cases in February.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
February performance is reported at 0% against a performance threshold of 95%. There were 6 non-compliant cases in February.

3.39: Adult Eating Disorders: Referral to assessment within 4 weeks
February performance is reported at 66.6% against a 95% performance threshold. There were 5 non-compliant cases reported in February.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks
February performance is reported at 88.8% against a 95% performance threshold. There was 1 non-compliant case reported in February.

Note on 3.35, 3.37, 3.39 and 3.40 – Eating Disorders waiting times

The Eating Disorders service currently has an unprecedented amount of vacancies and are actively recruiting to fill these posts.

The current wait profile for the service at the end of February indicates that 70% (156) of all patients waiting for assessment, are waiting over 4 weeks and waiting times will continue to increase until the service can fill the vacancies.

Teams are expected to be fully recruited to establishment by July 2021. However, full capacity mapping work is being undertaken as even if the team was at full establishment they would not be able to meet current demand and undertake all the different treatment strands/ functions that were previously offered.

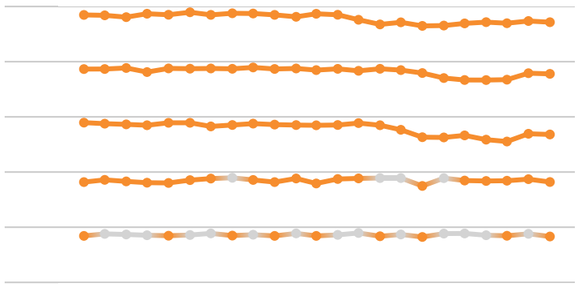
Routine assessment and treatment will continue to be paused until May 2021 which will impact on future reported waiting times. A Digital provider service is being explored and may be in place by end April 2021 meaning some routine treatment offers from May 2021. If this can't be established the service are considering re-deployment of therapists from other teams. Day treatment is likely to remain closed until at least September 2021.

Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		FEBRUARY	2021	
86	% of children who received a 9-12 month review by the time they turned 12 months	70.9% 95.0%	70.8% 95.0%	
87	% of children who received a 12 month review by the time they turned 15 months	80.6% 95.0%	79.7% 95.0%	
88	% of children who received a 2-2.5 year review by 2.5 years	65.8% 95.0%	68.6% 95.0%	
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	53.6% 58.0%	55.8% 58.0%	
92	% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks	78.4% 80.0%	81.1% 80.0%	

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

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
71.0% of eligible children received the 9-12 month visit by a health visitor in February compared to a target of 95%. 301 out of 424 reviews were completed within the target timeframe 9-12 months. This is below SPC Chart control limits based on 2018/19 data. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video).

37% of these exceptions declined this contact and 15% DNA'd their first appointment and have been rebooked. The parents of all children within this cohort were offered the opportunity to receive a 9-12month review. The service continues 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.
80.6% of eligible children received the 9-12 month visit (by 15 months) by a health visitor in February, compared to a target of 95%. 387 out of 480 reviews were completed within the target timeframe of 15 months. This is below SPC Chart control limits based on 2018/19 data. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video).
14% of these exceptions declined this contact. The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

The performance percentage displayed does not include late data entry but will reflect correctly in the Performance Dashboard next month. We anticipate this update will move performance to approximately 82.3%.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
65.8% of eligible children received the 2-2.5 year mandated contact by a health visitor in February, compared to a target of 95%. 370 out of 562 reviews were completed within the target timeframe of 2-2.5 years. This is below SPC Chart control limits based on 2018/19 data. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video).

Around 48% of parents of children not seen declined this contact and a did-not-attend (DNA) rate of around 30%. The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

91: % of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence)
53.6% of infants were recorded as totally or partially breastfed in February compared to a target of 58%. The average in the past 6 months was 54.9%. This is however within SPC Chart control limits based on 2018/19 data.

The Infant Feeding Lead Health Visitor has been made aware of localities where there are low staff numbers and where some staff need extra support to improve performance. The Gloucestershire Breastfeeding Network (GBSN) have now re-opened face-to-face support groups and continue to offer video, phone and text support. Specialist Breastfeeding Support continues to be provided by the Infant Feeding Lead Specialist Health Visitor and liaising with the Midwifery Service for specialist support, along with other services such as Dieticians and Paediatricians.

It has been acknowledged by commissioners that this is really a midwifery indicator and outside the influence of Health Visiting.

92: % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks
78.4% of mothers are breastfeeding at 8 weeks who were breastfeeding at 2 weeks in February compared to a target of 80%. The average in the past 6 months was 81.1%. This is however within SPC Chart control limits based on 2018/19 data.

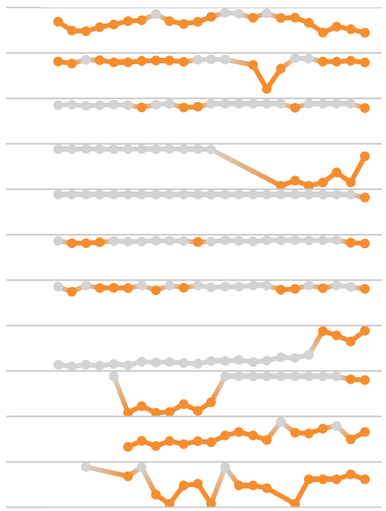
The service continue to offer face to face, telephone or virtual support. The service was awarded BFI accreditation in February and await the results to be published as an opportunity to develop practice.

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		FEBRUARY	2021	
40	Adult Speech and Language Therapy - % treated within 8 Weeks	51.4% 95.0%	75.1% 95.0%	
42	MSKAPS - % treated within 8 Weeks	89.5% 95.0%	88.3% 95.0%	
46	Diabetes Nursing - % treated within 8 Weeks	89.4% 95.0%	97.5% 95.0%	
47	Bone Health Service - % treated within 8 Weeks	80.0% 95.0%	20.3% 95.0%	
50	Psychosexual Service - % treated within 8 Weeks	92.8% 95.0%	99.2% 95.0%	
54	Paediatric Occupational Therapy - % treated within 8 Weeks	90.9% 95.0%	97.5% 95.0%	
59	Stroke ESD - Proportion of patients discharged within 6 weeks	91.6% 95.0%	96.2% 95.0%	
64	SPCA % of calls abandoned	11.0% 5.0%	6.3% 5.0%	
68	Wheelchair Service: Adults: Priority referrals seen within 5 working days	90.9% 95.0%	97.9% 95.0%	
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	75.0% 90.0%	72.1% 90.0%	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	66.6% 92.0%	64.4% 92.0%	

<u>Performance Thresholds not being achieved in Month</u> - Note all indicators, *<u>with the exception of 50: Psychosexual Service - % treated within 8 weeks</u>* have been in exception previously in the last twelve months.

40. Adult Speech and Language Therapy - % treated within 8 Weeks
February compliance was 51.4% compared to an average of 71.5% in the past 6 months and a threshold of 95%. 50 out of 103 patients seen in February were seen outside the 8 week target of time from referral to first contact.

Due to the service experiencing significant operational pressures they are currently only providing a support service to the acute trust. The service agreed that exception reporting for January was stepped down so that all resources could focus on direct patient care.

42. MSKAPS - % treated within 8 Weeks
February compliance was 89.5% compared to an average of 91.5% in the past 6 months and a threshold of 95%. 28 out of 269 patients seen in February were seen outside the 8 week target of time from referral to first contact.

A significant number of the breaches are due to patient choice where the patient did not book an appointment on time. Often the patients do not book their appointments until a reminder is sent by the service, approximately 3 weeks after the initial communication. Others breaches are where the method of 1st contact was by telephone, which currently is not a stop-clock for the MSKAPS RTT pathway.

The Business Intelligence team is currently working with the MSKAPS service to capture clinically significant telephone contacts within the RTT pathway, however this is proving to be a more complex piece of work than was initially anticipated due to the structure of the physical health dataset.

46: Diabetes Nursing - % treated within 8 Weeks
February compliance was 89.4% compared to an average of 98.3% in the past 6 months and a threshold of 95%. 2 out of 19 patients seen in February were seen outside the 8 week target of time from referral to first contact.

Staff sickness in December has created a backlog of appointments which are now being addressed as staff return.

47: Bone Health Service - % treated within 8 Weeks
1 out of 5 face to face contacts in February breached the 8-week target. The service are currently clearing the backlog of referrals after the service reopened in the Summer. Delays in community hospital availability has slowed the progress, however the service is making significant progress in reducing waiting times but more exceptions are expected 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 alongside face to face contacts.

The service model is changing to include telephone contacts in the Referral to Treatment criteria. These changes have now been agreed by all relevant stakeholders and Business intelligence is working to deploy the amendments, however this is proving to be a more complex piece of work than was initially anticipated due to the structure of the physical health dataset.

50: Psychosexual Service - % treated within 8 Weeks

50: Psychosexual Service - % treated within 8 Weeks
February compliance was 92.8% compared to an average of 100% in the past 6 months and a threshold of 95%.1 out of 14 patients seen in February were seen outside the 8 week target of time from referral to first contact.

Consultant sessions have been temporarily suspended due to Covid-19 to focus on other areas of the service. Staff absence has also been a factor in a slightly longer wait time, approximately two weeks.

54. Paediatric Occupational Therapy - % treated within 8 Weeks
February performance was 90.9% compared to an average of 97.8% in the past 6 months. The target is 95%. 10 children were seen outside of the 8 week target.

The exceptions are due to a combination of reduced staffing levels following redeployment, recording issues in SystmOne and treatment contacts conducted by School staff. The service is undertaking a review of the referral to treatment (RTT) times with the Business Intelligence team to ensure that appropriate contacts with school staff are included in the referral to treatment pathway.

59: Stroke ESD - Proportion of patients discharged within 6 weeks
February performance was 91.6% compared to an average of 95.1% in the past 6 months. The target is 95%. 10 patients were discharged outside of the 6 week target.

A further 2 week extension has been granted by the commissioners to allow the achievement of patient goals. The two patients were discharged within 7 weeks.

64. SPCA % of calls abandoned
329 out of 2,977 calls received by the SPCA team in February were abandoned. This is 11% of the total number of calls received compared to a threshold of 5.0%. This is above the SPC chart upper control limit based on 2018-19 figures.

It is of note that since performance has been impacted in November 2020, SPCA has been trialling handling of daytime dental calls, historically handled by dental staff and receptionists in Southgate Moorings. This continues to impact SPCA call handling pick up times and abandonment KPI's. A review in February has taken place and Service leads are currently looking at costings regarding staffing numbers with the Deputy Dental Service Director for Urgent Care and Specialty Services. Since the end of January, daytime dental calls were aligned to designated SPCA staff members and this has confirmed that the dental calls are impacting SPCA abandonment figures. With daytime dental calls removed performance is within threshold.

68: Wheelchair Service: Adults: Priority referrals seen within 5 working days
10 out 11 (90.6%) of Adult Priority referrals were seen within 5 working days in February. This is below the target of 95%.

The Wheelchair Service continues to collaborate 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 dataset. This work is reflected in the improved performance data.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
3 out 4 (75%) of new under 18 referrals were assessed within 8 weeks in February. This is below the target of 90%.

The Wheelchair Service continues to collaborate 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 dataset. This work is reflected in the improved performance data.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
6 of the 9 (66.6%) equipment deliveries in February met the 18 week threshold of 92%.

The Wheelchair Service continues to collaborate 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 dataset. This work is reflected in the improved performance data.

Additional commentary for 68, 69 & 71:
The monthly performance figures positively now show;
- *Urgent referral assessments are higher in February than the YTD average of 9 per month*
- *An increasing number of handovers, which have remained consistent since November, which is now thought to be much more representative of service activity.*
- *100% performance for the adult and under 18 'urgent referral to assessment' KPI, with the exception of June and January, where the target was missed by only by only one exception per month.*
- *Continued reduction in waiting list numbers and caseload.*

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 19

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Neil Savage, Director of HR and OD

AUTHORS: Neil Savage, Director of HR and OD

Ruth Thomas, Associate Director: OD, Learning and Development

SUBJECT: **2020 STAFF SURVEY RESULTS**

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

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

The purpose of this report is to:

Present the Board of Directors with a summary of the 2020 Annual Staff Survey, published in February 2021 but which was embargoed until 11 March 2021.

Recommendations and decisions required

The Board of Directors is asked to:

- **Note** and **discuss** the report, appendices and key focus areas
- **Take assurance** that our approaches to people management, workforce culture and communications over the past year, since the merger, are paying positive dividends, with generally improving scores, and,
- **Recognise** that, in light of our new benchmarking, we still have much more improvement work to do if we are to become a consistent top quartile performer.

Executive summary

This is Gloucestershire Health and Care NHS Foundation Trust's first ever single Staff Survey feedback report, covering data gathered from colleagues during Quarter 3 of 2020/21.

Due to the national rules relating to the timing of our merger, the results of the previous 2019 Survey, carried out in the two months immediately following the merger, were reported through two separate reports representing the data for staff working in the

former 2gether and GCS services. This means that these new survey results are effectively the new Trust's "ground zero", as the national reporting system is not able to provide historic trend comparisons with our legacy organisations. However, our survey provider, Quality Health, has provided an average of the combined scores of our legacy organisations, enabling a degree of comparison to be made, and this is referred to in the report.

Importantly, the 2020 Survey came at a time when colleagues, the organisation and the wider NHS was significantly impacted by COVID-19 and the response to the second wave of the pandemic, having already been responding to the on-going incident for 7/8 months without relent.

Summary Results Overview

A summary of the results, using the 2019 comparison data provided by Quality Health is attached as **Appendix 1. Appendix 2** includes the national report, **while Appendix 3** includes an infographic on the main Theme findings.

This year's survey was changed from previous years, with a shorter core survey, the addition of COVID-19 questions, and the option for Trusts to have some additional questions. The Trust's additional questions are contained in the report.

The Trust is also now in a new benchmarking category - *"Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts."*

The survey presents a performance we should be proud of given the context of the post-merger period and the pandemic. Many post-merger organisations have historically suffered a notable reduction in staff ratings.

The key headlines include: -

- Significantly **improved response rate – 46.3%.**
- **80%** of ratings **improved or remained unchanged**
- **56% improved**
- **24%** remained **unchanged**
- **20% worsened**
- Of the **Ten Themes - 7 improved, two were unchanged,** and **one worsened**
- **Highest improvement** rating is an **11% increase** (colleagues reporting that they do not "come to work when feeling unwell in the last 3 months"), with a number of other statistically significant improvements in the order of 5%, 6%, 7%, 8% and 10%
- **10% improvement** on colleagues agreeing the Trust takes **positive action** on **Health and Well-being**
- Colleagues agreeing **senior managers act on staff feedback is up 8%**
- **71%** of colleagues **would recommend** the Trust as a **place to work**
- **79.5%** of colleagues **would recommend** the Trust to **provide care**

- Largest reduced rating is '**During the last 12 months have you felt unwell as a result of work-related stress?'** which is up by 3%
- All the other reduced scores are in the low 1-2% reduced rating range
- The **highest % of improved scores/stayed the same** are in the **line manager** and **health and wellbeing** sections
- **The highest % of the reduced scores** are in the **Your Job** section

Further details are included in the body of the report and the appendices attached to this paper.

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. Therefore, the potential risks of not achieving good Staff Survey ratings include:

- Heightened reputational risk, with poorer recruitment success and lower retention
- Further reputational risk, as the perception and knowledge of results may impact the views of patients, service users, carers and other stakeholders
- Lower colleague engagement, contributions and morale
- Higher sickness absence
- Higher temporary staff use and costs (bank and agency)
- Lower efficiency and effectiveness leading to a lower quality service to our patients and service users

Corporate considerations	
Quality Implications	The results form part of a range of feedback that reflects how staff view the Trust, including the quality of the services it provides and of the Trust as an employer
Resource Implications	Unless additional actions are agreed with the 2021 action plan, the delivery of actions arising are expected to be managed within existing resources
Equality Implications	The survey's 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 key pointers which will be taken forwards in actions through the WDES and WRES action plans.

Where has this issue been discussed before?
Executive Committee December 2020 (unweighted & non-benchmarked data)

Resources Committee December 2020(unweighted & non-benchmarked data) Joint Negotiation and Consultative Forum January 2021(unweighted & non-benchmarked data) Executive and Resources Committees February 2021

Appendices:	**Appendix 1:** Summary of the results, using the 2019 comparison data provided by Quality Health **Appendix 2:** National report (this full report is available to Board members in the Reading Room) **Appendix 3:** Infographic

Report authorised by: Neil Savage	**Title:** Director of Human Resources & Organisation Development

2020 NHS NATIONAL STAFF SURVEY

1. INTRODUCTION

1.1 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).

1.2 All colleagues in post and registered with ESR on 1st September 2020 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 has or hasn't responded to the survey.

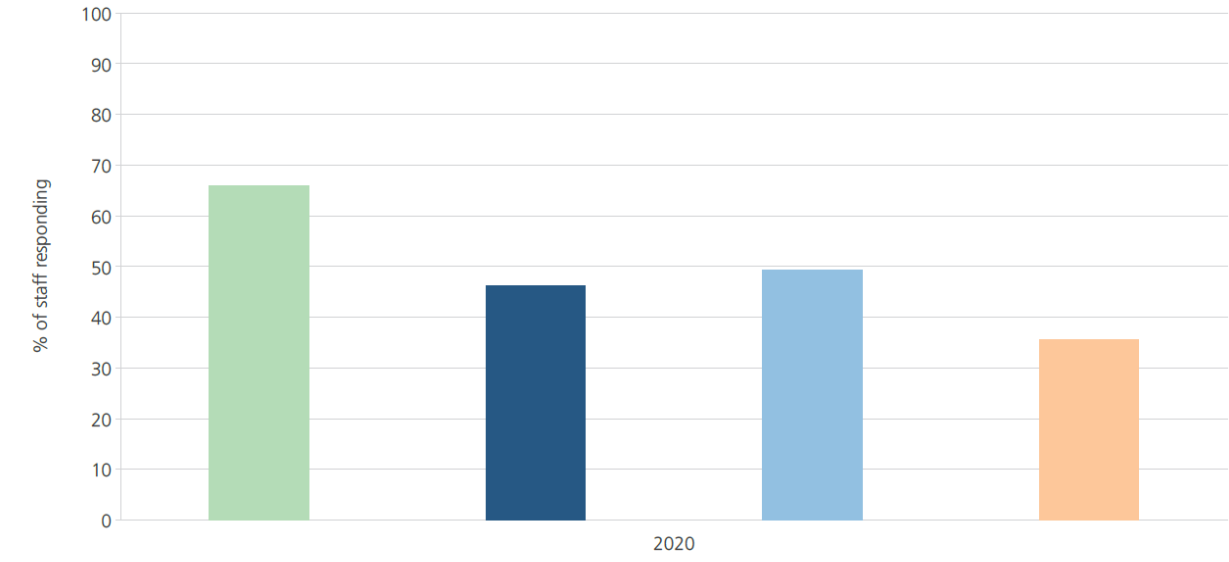
1.3 As a result of last year's action plan, the majority of colleagues were sent the survey electronically, however, identified colleagues working in estates and facilities management were sent paper copies of the survey this year to help improve accessibility and subsequent response rates.

2. SURVEY RESPONSE RATE

2.1 **2,023 colleagues (46%) responded** to the 2020 Survey which is **427 more colleagues than last year**. This was a marked improvement over both former Trusts' response rates. While the response rate for trusts in our new benchmarking group's was higher at 49%, this remains a sizable improvement of 10% and 13% respectively over GCS's 2019 response rate of 36% and 2G'sof 33%. However, when compared with the benchmarked group average response rate of 49%, this also highlights both the opportunity and need for future improvement. The higher response rate, the more accurate and informative the data.

2.2 The 2020 Survey was carried out in Quarter 3 2020/21 and Table 1 below shows the comparative response rate to other trusts in the **new benchmarking category – "Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts".**

Table 1



Best	66.0%
Your org	46.3%
Median	49.3%
Worst	35.6%

2.3 The highest clinical team response rates came from **Lydney and Dilke community hospitals**. These teams had response rates of 76% (Lydney) and 72% (Dilke). This is a truly great achievement given the context of the COVID experiences of these clinical areas over 2020/21.

2.4 The highest responding corporate teams were the **Executive and Finance Directorate teams** at 86%.

2.5 To encourage response rates, this year we offered a number of prizes to colleagues for participating.

2.6 The first prize was won by a healthcare assistant working in inpatients at Dilke Hospital, and the second prize went to an admin and clerical officer working in the Podiatry Service at St Paul's Medical Centre in Cheltenham.

2.7 The £500 team prizes to be spent on staff benefits for the teams with the highest response rate was won jointly by Lydney and Dilke Hospitals and the Finance and Executive teams. The Executive team agreed to forgo the team prize.

2.8 The lowest responding clinical teams were **Mental Health inpatients** (Wotton Lawn, Charlton Lane), Mental Health Specialist Services and Mental Health Urgent Care. These areas will factor in the action plan in terms of an OD engagement programme similar to the ones run previously in the Forest of Dean hospitals.

3. SURVEY THEMES

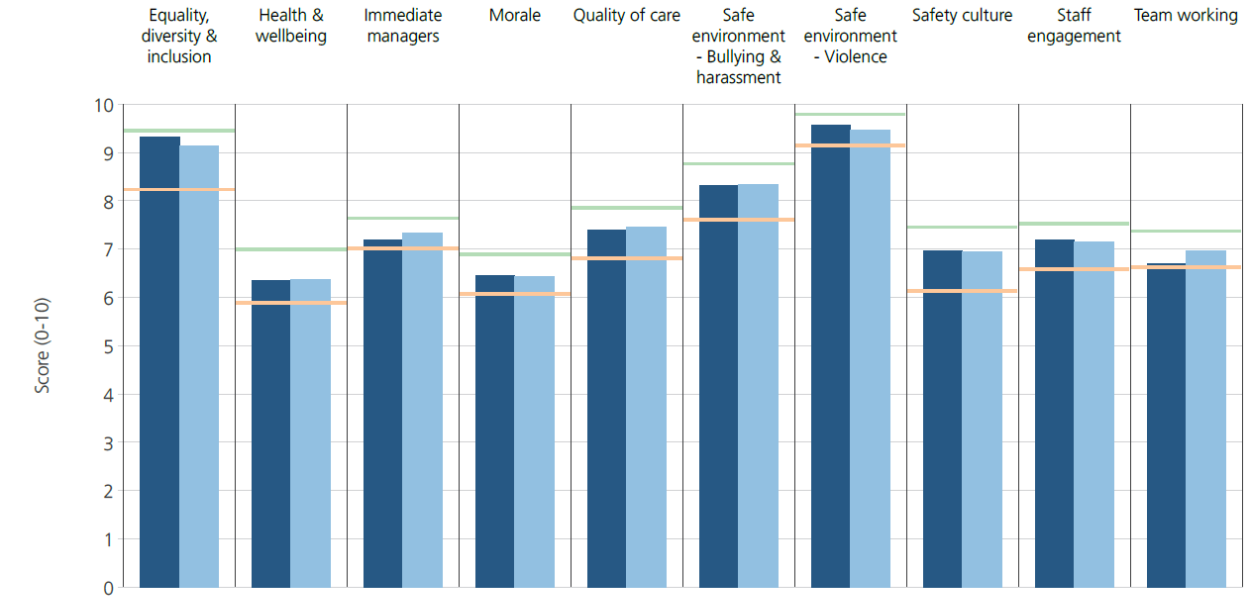
3.1 The survey report is shown through a series of 10 established Themes as detailed below:

1. Equality, diversity &inclusion
2. Health & wellbeing
3. Immediate managers
4. Morale
5. Quality of care
6. Safe environment- Bullying &harassment
7. Safe environment- Violence
8. Safety culture
9. Staff engagement
10. Team working

3.2 The 10 Themes have been designed to provide a balanced overview of organisational performance on staff experience and are benchmarked against our new benchmarking category Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts. The Themes are scored on a scale of 1-10.

3.3 The Trust's ratings against each of these Themes alongside our comparator grouping is shown in Table 2 below.

Table 2



Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.3	6.4	7.2	6.5	7.4	8.3	9.6	7.0	7.2	6.7
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	2,012	2,016	2,017	2,013	1,684	2,008	2,016	2,019	2,022	1,995

3.4 In summary, **four of the Themes ratings are above average (better), three are average, and three are below average (worse)** in comparison with **the benchmark group.**

3.5 In comparison with our **legacy organisation** combined scores in the 2019 Theme Scores, **7 have improved, two remained the same and one worsened** as outlined in Table 3 below. The only statistically significant change is in the Health and Well-being category which has improved.

Table 3

Theme	2019 score	2020 score	Statistically significant change?
Equality, diversity & inclusion	9.1	9.3 ↑	N
Health & wellbeing	6.0	6.4 ↑	Y
Immediate managers	7.2	7.2 =	N
Morale	6.3	6.5 ↑	N
Quality of care	7.4	7.4 =	N
Safe environment - Bullying & harassment	8.2	8.3 ↑	N
Safe environment - Violence	9.5	9.6 ↑	N
Safety culture	6.8	7.0 ↑	N
Staff engagement	7.1	7.2 ↑	N
Team working	6.9	6.7 ↓	N

3.6 Going forwards, in future years, we will built up a track record that will show trends that have developed over the previous annual surveys, however, as this is our first year as the single organisation, the national reporting centre cannot provide its usual 5-year historical trend analysis.

3.7 Of the ten Themes:

- The three with the highest score were **"Safe Environment – Violence" "Equality, Diversity & Inclusion", "Safe environment - Bullying & Harassment"**
- The three with the lowest scores were **"Health and well-being", "Morale" and "Teamworking"**
- One Theme, "Teamworking" is close to the bottom of the benchmarking class.

3.8 The Theme results are available for Staff Groups and Directorates and are benchmarked against the overall Trust ratings. These detailed reports are being provided to directorates and professional leads to choose priorities action areas for 2021.

4. COMPARISONS WITHIN THE NHS AND ICS

4.1 Some comparisons are provided below from the recently available national All NHS Trust / Organisation data alongside the performance of Gloucestershire Hospitals NHS Foundation Trust (GHT) and Gloucestershire Clinical Commissioning Group (CCG).

- All NHS organisations - 66.8% of staff would recommend their organisation as a place to work (up by 3.4%). GHC's rate was 71% while GHT's was 64.3%
- 38.4% of staff reported that 'there are enough staff at this organisation for me to do my job properly' (up by 6.1%). GHC's rate was 41.3% while GHT's was 33.6%
- 33.4% of staff said their organisation definitely takes positive action on health and wellbeing (up by 4%). GHC's rate was 40.3% while GHTs was 31.9%
- The percentage of staff working when unwell fell from 56 to 44% nationally. However, GHC's rate was 45.7% while GHT's was 46.1%
- 69% of BAME staff said their organisation provided equal opportunities compared to 87.3% of white staff who said the same. GHC's rate was 74.1% (BAME) and 87.8% (White), while GHT's was 60.7% (BAME) and 84.6% (White)

4.2 A table summarising the response rates, the 10 Themes and countywide comparisons is provided below:

	NHS	GHC	GHT	GCCG
1. Equality, diversity & inclusion	9.0	9.3	9.0	9.3
2. Health & wellbeing	6.1	6.4	6.1	7.1
3. Immediate managers	6.9	7.2	6.8	7.4
4. Morale	6.2	6.5	6.2	6.6
5. Quality of care	7.5	7.4	7.3	7.1
6. Safe environment-Bullying & harassment	8.1	8.3	8.0	8.9
7. Safe environment-Violence	9.5	9.6	9.5	10
8. Safety culture	6.8	7.0	6.5	7.1
9. Staff engagement	7.0	7.2	6.9	7.2
10. Team working	6.5	6.7	6.4	6.7
Comparison with national NHS		> 9/10	0/10	9/10
		= in 0	4/10	0/10
		<in 1	6/10	1/10
Response Rates %	49.1	46.3	47.6	72.3

GHC was higher than GHT on all 10 Themes, higher than the GCCG on 1, equal on 3 and lower in 6. Sadly, despite the Trust's response rate improvement, this was the one where we were bottom of the class in all the above comparisons.

4.3 One notable national comparison was that the Trust was in the "Top five" of trusts providing Mental Health services on the Staff FFT for rating on quality of care.

1. Solent NHS Trust 84.2%

2. Northamptonshire Healthcare NHS Foundation Trust 81%

3. Dorset Healthcare University NHS Foundation Trust 80%

4. Berkshire Healthcare NHS Foundation Trust 80%

5. Gloucestershire Health and Care NHS Foundation Trust 79%

5. FURTHER SUB THEME COMMENTARY

5.1 As the usual 5-year historic trends graphs and tables are not provided for this first year, Quality Health, have provided the Trust with a rating, showing the combined scores in 2019, compared to scores in 2020, attached as **Appendix 1.**

5.2 Based on 82 key questions excluding questions where there is either no comparison data or the question is neither negative nor positive in outcome the following summarises our 2020 performance compared with 2019.

up or improved – 56%
= stayed same –24%
down or worsened –20%

5.3 Within the full report, these scores have then been further broken down into four main sub-categories which help to inform the focus of our recommended actions. These sub categories cover colleagues' views on:

- YOUR JOB
- YOUR MANAGERS
- YOUR HEALTH, WELLBEING AND SAFETY AT WORK
- YOUR ORGANISATION

5.4 For the **YOUR JOB** categories: -

- 73% improved/ stayed the same, with the highest improvement 4%
- 27% worsened, with the highest worsened score 2%

5.5 For **YOUR MANAGERS**

- 91% improved/ stayed the same, with the highest improvement 8%
- 9% worsened, with the highest worsened score 1%
- There are usual ratings from colleagues on the quality of their managers in the Directorate Level reports – highlighting some variance across the Trust

5.6 For **YOUR HEALTH, WELLBEING AND SAFETY AT WORK**

- 82% improved/ stayed the same, with the highest improvement 11%
- 18% worsened, with the highest worsened score 3%

5.7 **YOUR ORGANISATION**

- 87% improved/ stayed the same, with the highest improvement 7%
- 13% worsened, with the highest worsened score 1%

5.8 For the **WORKFORCE RACE EQUALITY STANDARD** (WRES – pages 161-165 of Full Report **Appendix 3**) there are 4 key questions: -

i. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
ii. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
iii. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion
iv. Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months

5.9 BAME colleagues rated the Trust better than the benchmark average in three out of these (all but the first). In 2019 the former 2G had been rated above average on all 4 questions but within a different benchmarking group. The former GCS had been rated above average for 2 questions and below for 2, again within a different benchmarking group. Compared with the legacy Trusts' combined score in 2019, the ratings for the first two question have worsened and the ratings for the second two improved.

5.10 For the **WORKFORCE DISABILITY EQUALITY STANDARD** (WDES – pages 166-175) there are 9 questions/areas:

i. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
ii. Percentage of staff experiencing harassment, bullying or abuse from manager in last 12 months
iii. Percentage of staff experiencing harassment, bullying or abuse from other colleagues in last 12 months
iv. Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
v. Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion
vi. Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
vii. Percentage of staff satisfied with the extent to which their organisation values their work
viii. Percentage of staff with a long-lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work
ix. Staff engagement

5.11 Colleagues with a Long-Term Conditions/Illness rated the Trust better than the benchmarking group average in six of these, equal in one (vii) and below average in two (iv & vi).

5.12 In 2019, the former 2G had been rated above average on 6 out of 9 questions and below average in 3. The former GCS had been rated below average on all 9 questions, albeit with different benchmark groups.

5.13 Notably, compared with the combined scores in 2019, colleagues with Long Term Conditions/Illness rated the Trust better on 8 of the 9 questions/areas. The only question rated lower was number vi (pressure to come to work when ill).

5.14 The **STAFF FRIENDS AND FAMILY ratings** from both former organisations are shown in Table 4 below, alongside the 2020 ratings:

Table 4

Question	GCS 2019	²g 2019	GHC 2020
I would recommend my organisation as a place to work	62%	70%	71%
If a friend or relative needed treatment, respondents being happy with the standard of care provided by the organisation	82%	74%	79.5%

6. DEMOGRAPHICS

6.1 The benchmark report also presents a picture of our colleagues based on the background of the survey respondents. This is summarised below:

- 83.2% of respondents were female (higher than the benchmark group average of 76.7%)
- 39% of respondents were aged between 51 and 65 (lower than last year but higher than the 36.4% benchmark average)
- 95.1% were white (lower than last year and higher than the 88.8% benchmark average)
- 89.8% were heterosexual (lower than last year, but higher than the benchmark 88.4%)

- 47.7% were Christian (lower than last year, but higher than the benchmark of 45.7%), 42% were Atheist and 4.1% holding other religions
- 21.3% reported that they had a disability of which 84.3%% felt the Trust had made adequate adjustments to enable them to carry out their roles (both %s are higher than last year)
- 39.6% of respondents reported having children or someone requiring care living with them
- 36.1% of respondents reported giving care or help to others more than 15 years' service

7. CONCLUSION, NEXT STEPS & RECOMMENDED FOCUS AREAS

7.1 This is a survey outcome which demonstrates a positive number of improvements. The Trust should be proud of such a strong outcome during the COVID-19 pandemic and following so shortly after the organisational merger. Mergers have a track record of more often than not producing worse survey results.

7.2 Importantly, the survey results also evidences that there is plenty of room for further improvements, particularly in terms of response rates, morale, team working, health and well-being, and the wider "Your Job" themes.

7.3 While sustained improvements can be challenging, as a new organisation, with these survey results, we have a firm foundation to build on. Of note, colleagues rated the Trust highly on the two key Friends and Family (FFT) questions – whether they would recommend the Trust as an employer and as a care provider. In fact, the Trust scored above the benchmark average on these particular questions – 4.8% above for employment and 9% above for care provision. Coupled with a solid staff engagement score, these FFT scores provide a firm foundation upon which to make other improvements.

7.4 The Executive and Resources Committees have considered the detailed results and headline priority areas for the coming year. The action plan is being worked up this month and will be finalised at the next 3 weeks.

7.5 The results are communicated in March and April via Senior Leadership Network, Joint Negotiating and Consultative Forum, Local Negotiating Committee, Team Talk, the Diversity Network, Staff Forum and global communications. A one side infographic has been prepared to accompany and support discussions. This is attached as an appendix. Additionally, we are providing a series of drop in Teams presentation and engagement events to inform an approach and action plan.

7.6 Executive Committee will be asked to consider and agree the final action plan at the end of March, with this being reported to the next Resources Committee.

7.7 In terms of proposed action themes, subject to completion of current discussions, it is proposed that actions are built around the following five areas:

1. **Engagement & response**
   - ✓ Focus on improving response rates generally and to targeted low response areas, with a suggested Trust target of 55% for this coming year's survey. This will be supported by targeted OD interventions supporting managers and team leaders in identified low response teams
   - ✓ Comprehensive and sustained communication programme on results and actions on both a corporate and a directorate level basis. A continuation of the You Said, We Did communication programme through the year for both the Staff Survey and the Monthly Pulse Checks
   - ✓ Relaunch of the Executive Director Walkabout programme (virtual and physical)
   - ✓ Roll out of polling software to improve engagement and involvement, for example, for Staff Forum sessions and colleague focus groups

2. **Health & Wellbeing**
   - ✓ Creation of a fresh Health and Wellbeing strategy and action plan based on the national Framework informed by the work and experience of our own Health and Well-being Hub
   - ✓ Implementation and delivery of charitably funded well-being services, with intent to bid for further funding if this becomes available
   - ✓ Continued focus on supporting individuals personally and teams collectively on their health and well-being, ensuring we continue to grow and advertise widely our help offers
   - ✓ Provision of sleep support programmes and individual and team resilience and stress workshops
   - ✓ Communication programme for our wider Staff Benefits offer alongside existing offers such as our web resources, apps, counselling, clinical psychology and self-referral musculo-skeletal physiotherapy services.

3. **Leadership & Management**
   - ✓ Launch and delivery of "Brilliant Essentials" and "Leading Better Care Together" leadership development programmes with added focus on improved practices and behaviours in the "Your Job" category, including more regular management support and supervision, team huddles and meetings
   - ✓ Further support for Teamworking, including utilisation of NHS Elect subscription for team support and training packages e.g. Psychological Safety in Teams, Online Facilitation for Groups and Teams, Teaming and Psychological Safety, Building Stronger Teams and Team development
   - ✓ Review of appraisal training, guidance and its related documentation and software support

4. **WRES and WDES**
   - ✓ Engagement with the Diversity Network and its BAME and Disability sub groups to agree delivery actions

5. **Local & Directorate Actions**
   - ✓ Operational service directorates, heads of profession and corporate teams to be asked to review results the results for their own areas, with local action plans agreed and in place by end of April. It is proposed that each directorate and professional group will be asked to come up with 2 or 3 local actions and to report on these. This is critical as great local line management is arguably what makes the biggest difference to work experience.

8. RECOMMENDATIONS

8.1 The Board of Directors are asked to:

- **Note** and **discuss** the report, appendices and recommended focus areas
- Take **assurance** that our approaches to people management, workforce culture and communications over the past year, since the merger, are paying positive dividends, with generally improving scores, and,
- **Recognise** that, in light of our new benchmarking, we still have much more improvement work to do if we are to become a consistent top quartile performer.

APPENDIX 1 2020 Staff Survey responses Comparisons with 2019 & 2020 Benchmark Grouping					
Question	**2019***	**2020**	**Improved Worsened**	**Above / Below Bench-mark Group Average**	**Themes**
Performance compared with 2019 Based on 82 questions excluding Q1, Q10a1, Q10a2 & Q10b, Q18e, Q18f –where there is either no comparison data or the question is neither negative nor positive in outcome. **up or improved – 56% (46)** **= stayed same –24% (20)** **down or worsened –20% (16)**					
1 Do you have face to face contact with patient	63	62	N/A	0.1% below	**YOUR JOB** **73% improved/ stayed same, highest improvement 4%** **27% worsened, highest worsened 2%**
2a Look forward to work	60	62	2	0.4% above (+ve)	
2b Enthusiastic about job	74	73	1	2.1% below (-ve)	
2c Time passes quickly in work	78	78	=	0.4% below (-ve)	
3a Know my responsibilities	85	83	2	0.8% below (-ve)	
3b Trusted to do job	90	91	1	0.2% above (+ve)	
3c Pleased with job standard	79	79	=	2% below (-ve)	
4 Opportunities to show initiative	74	75	1	0.5% below (-ve)	
4b suggestion to improve work	78	78	=	0.7% below (-ve)	
4c involved in changes	53	53	=	2.9% below (-ve)	
4d make improvement happen	59	58	1	3.9% below (-ve)	
4e meet conflicting demands	43	44	1	4.6% below (-ve)	
4f adequate equipment	63	67	4	3.1% above (+ve)	
4g enough staff to do job	37	41	4	0.4% above (+ve)	
4h team shared objectives	74	74	=	1% below (-ve)	
4i team often meet to discuss effectiveness	63	61	2	9.1% below (-ve)	
4j respect I deserve from colleagues	77	75	2	0.9% below (-ve)	

5a satisfied with recognition for good work	64	65	↑1	1% above (+ve)	
5b satisfied with support from immediate manager	75	75	=	1.6% below (-ve)	
5c satisfied with support from colleagues	86	85	↓1	1.4% above (+ve)	
5d satisfied with responsibility given	75	77	↑2	0.4% above (+ve)	
5e Opportunities to use skills	72	72	=	1.2% below (-ve)	
5f Extent Trust values my work	47	51	↑4	1.3% below (-ve)	
5g Satisfied with level of pay	39	39	=	1.8% below (-ve)_	
5h Opportunities for flexible working	57	61	↑4	5.2% below (-ve)	
6a I have unrealistic time pressures – never	26	28	↑2	0.9% above (-ve)	
6b I have a choice in how I do my work	65	64	↓1	0.5% below	
6c relations at work are strained – never	55	54	↓1	=	
7a satisfied with care to patients	82	82	=	0.2% below (-ve)	
7b role makes a difference to patents/service users	90	90	=	0.7% above (+ve)	
7c deliver care I aspire to	64	67	↑3	2.2% below (-ve)	
8a My immediate managers encourages me at work	74	76	↑2	2% below (-ve)	**YOUR MANAGERS** **91% improved/ stayed same, highest improvement 8%** **9% worsened, worsened score was 1%**
8b my immediate manager can be counted on with difficult task	74	76	↑2	1.8% below (-ve)	
8c my immediate manager gives clear feedback	66	67	↑1	3.2% below (-ve)	
8d my immediate manager asks for my opinion that affect my work	61	61	=	2.7% below (-ve)	
8e my immediate manager is supportive in a personal crisis	81	80	↓1	1.2% below (-ve)	
8f my immediate manager takes an interest in my H&W	75	75	=	2.1% below (-ve)	
8g my immediate manager values my work	77	78	↑1	1% below (-ve)	
9a I know who the senior managers are	83	86	↑3	1.2% below (-ve)	
9b Comms between senior managers and colleagues is effective	44	49	↑5	0.9% above (+ve)	
9c senior managers try to involve staff in decisions	36	40	↑4	0.5% below (-ve)	

9d senior managers act on staff feedback	32	40	↑8	0.8% above (+ve)	
10a1 Staff working part-time hours up to 30	27	28	N/A	8.4% above (+ve)	**YOUR HEALTH, WELLBEING AND SAFETY AT WORK** **82% improved/ stayed same, highest improvement 11%** **18% worsened, highest worsened 3%**
10a2 hours 30 and above	73	72	N/A	8.4% below (+ve)	
10b additional paid hours – never	79	79	N/A	2.4% below (+ve)	
10 c additional unpaid hours – never	40	40	=	0.2% below (+ve)	
11a Org takes positive action on H&W	30	40	↑10	1.7% above (+ve)	
11b last 12 months experienced MSK problems- no	77	74	↑3	0.9% below (+ve)	
11c last 12 months felt unwell due to work related stress – yes	40	43	↓3	0.1% below (+ve)	
11d last 3 months come to work not feeling well – no	43	54	↑11	0.1% above (-ve)	
11e Felt pressure to come to work from manager – no	79	81	↑2	0.2% above (-ve)	
11f pressure from colleagues to come to work – no	81	80	↓1	1.7% above (-ve)	
11g put yourself under pressure to come to work – yes	95	95	=	1.4% above (-ve)	
12a last 12 months experienced physical violence from patents/public	89 (no)	88 (no)	↓1	2.7% below (the yes % +ve)	
12b last 12 months experienced physical violence managers	100 (no)	100 (no)	=	0.1% below (the yes % +ve)	
12c last 12 months experienced physical violence other colleagues	99 (no)	100 (no)	↑1	0.5% below (the yes % +ve)	
12d last time experienced physical violence did you report it	84 (yes)	85 (yes)	↑1	7.3% below (the no % -ve)	
13a in last 12 months experienced harassment bullying abuse from patients/public	74 (no)	75 (no)	↑1	1.6% below (the yes % +ve)	
13b in last 12 months ever experience harassment bullying abuse from managers	90 (no)	90 (no)	=	0.8% below (the yes % +ve)	
13c in last 12 months ever experience harassment bullying abuse from other colleagues	84 (no)	84 (no)	=	0.4% above (the yes % -ve)	

13d when you experience harassment, bullying, abuse did you report it	50 (yes)	55 (yes)	↑5	6.1% below (-ve)	
14 does trust act fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	86	87	↑1	0.5% above (+ve)	
15a in last 12 months ever experience discrimination from patient/public	96 (no)	95 (no)	↑1	2% below (+ve)	
15b in last 12 months ever experience discrimination from manager/colleagues – no	94 (no)	95 (no)	↑1	1.8% below (+ve)	
15c.1 Grounds you experienced discrimination-Ethnic background	17	25	↓8	14% below (+ve)	
15c.2 Grounds you experienced discrimination-gender	25	28	↓3	5.7% above (-ve)	
15c.3 Grounds you experienced discrimination-Religion	4	1	↑3	3.4% below (+ve)	
15c.4 Grounds you experienced discrimination-Sexual Orientation	8	5	↑3	1.4% below (+ve)	
15c.5 Grounds you experienced discrimination-Disability	8	4	↑4	6.7% below (+ve)	
15c.6 Grounds you experienced discrimination-Age	25	25	=	2.4% above (-ve)	
15c.7 Grounds you experienced discrimination-Other	34	30	↑4	4.6% above (-ve)	
16a Trust treats staff fairly who are involved in error, incident or near miss	66	66	=	4.7% above (+ve)	
16b Trust encourages you to report error, incident or near miss	91	92	↑1	1.9% above (+ve)	
16c when error, incident or near miss happens Trust takes action to ensure do not happen again	74	75	↑1	0.9% above (+ve)	
16d colleagues given feedback on changes in	63	64	↑1	0.8% below (-ve)	

response to error, incident near miss					
17a If you were concerned about unsafe clinical practice, would you know how to report it	96	96	=	0.1% below (-ve)	
17b I would feel secure raising concerns about unsafe clinical practice	77	76	↓1	0.1% above (+ve)	
17c I am confident that my organisation would address my concern - agree	64	66	↑2	2.4% above (+ve)	
18a Care of patients/service users is my organisation's top priority - agree	81	82	↑1	1% above (+ve)	**YOUR ORGANISATION** **87% improved/ stayed same, highest improvement 7%** **13% worsened, worsened score 1%**
18b My organisation acts on concerns raised by patients/service users – agree	77	76	↓1	0.9% below (-ve)	
18c **I** would recommend my organisation as a place to work – yes	65	71	↑6	3.3% above (+ve)	
18d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	78	80	↑2	9.1% above (+ve)	
18e I feel safe in work	-	85	no data	4.6% above (+ve)	
18f I feel safe to speak up about concerns in Trust	-	68	no data	=	
19a I often think about leaving Trust - disagree	46	51	↑5	0.3% below (+ve)	
19b I will probably look for a job at a new organisation in the next 12 months	22	18	↑4	1% below (+ve)	
19c As soon as I can find another job, I will leave this organisation	14	11	↑3	1.5% below (+ve)	
26b Have your Trust made adequate adjustments to enable you to carry out your work?	78	85	↑7	1.5% below (+ve)	
The Covid19 pandemic		**YES**	**NO**	**Benchmark**	
20a Have you worked on a Covid19 specific ward or area at any time?		28	72	9% above	**THE COVID19 PANDEMIC** **New questions**
20b Have you been redeployed due to the Covid-19 pandemic at any time?		20	80	9% above	

20c Have you been required to work remotely/from home due to the Covid-19 pandemic?	54	46	11% below	
20d 1 Have you been shielding for yourself?	7	93	1% below	
20d 2 Have you been shielding for yourself?	4	5	1% below	
20d 3 Have you been shielding – no?	90	10	2% above	

Ethnic background	**2020**	**Benchmark**
White	95%	6% above
Mixed	1%	1% below
Asian/Asian British	2%	2% below
Black/African/Caribbean/Black British	1%	3% below
Other	0%	0% below

Do you have any physical or mental health conditions or illnesses lasting or expected to last for 12 months or more?	**2019***	**2020**	**Benchmark**
Yes	22%	21%	3% below

Which of the following best describes how you think of yourself?	**2019***	**2020**	**Benchmark**
Heterosexual or Straight	89%	90%	1% above
Gay or lesbian	3%	2%	=
Bi sexual	1%	1%	1% below
Other	0%	0%	=
I would prefer not to say	7%	6%	1% below

What is your religion?	**2019***	**2020**	**Benchmark**
No religion	41%	42%	1% above
Christian	48%	48%	2% above
Buddhist	1%	1%	=
Hindu	1%	1%	=
Jewish	0%	0%	=
Muslim	1%	1%	1% below
Sikh	0%	0%	=
Any other religion	2%	2%	=
I would prefer not to say	7%	6%	1% below

*= Average for legacy Trusts calculated by Quality Health, our Survey Providers and not included in the national benchmarking report. Scores are rounded up for 0.5% and above, down for below 0.5.

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 19.2

AI-19.2 - Staff Survey Results 2020
Appendix 2 – Full National Survey Report

Please note that the full report is available for Board Members to view via the Reading Room on Diligent.

For members of the Public who would wish to see the full report, please contact anna.hilditch@ghc.nhs.uk who will ensure that a copy is provided.

2020 NHS Staff Survey
Results Summary

Gloucestershire Health and Care
NHS Foundation Trust

All 10 of the themes are scored on 0-10 scale, where a higher score is more positive then a lower score.

You can see how we have scored on each of the themes compared to average below. Our response rate was an improvement on last year at 46%. However, when compared with the benchmarked group average response rate of 49%, this highlights the opportunity and need for future improvement.

Equality diversity & inclusion
2020 GHC Score

9.3 ↑

Average Community and MH Trust Score - 9.1

Health & Wellbeing
2020 GHC Score

6.4 ↑

Average Community and MH Trust Score - 6.4

Immediate managers
2020 GHC Score

7.2 ↔

Average Community and MH Trust Score - 7.3

Morale
2020 GHC Score

6.5 ↑

Average Community and MH Trust Score - 6.4

Quality of care
2020 GHC Score

7.4 ↑

Average Community and MH Trust Score - 7.5

Safe environment - Bullying & harassment
2020 GHC Score

8.3 ↔

Average Community and MH Trust Score - 8.3

Safe environment - Violence
2020 GHC Score

9.6 ↔

Average Community and MH Trust Score - 9.5

Safety culture
2020 GHC Score

7.0 ↔

Average Community and MH Trust Score - 6.9

Staff engagement
2020GHC Score

7.2 ↑

Average Community and MH Trust Score - 7.2

Team working
2020 GHC Score

6.7 ↔

Average Community and MH Trust Score - 7

How our scores compare to other mental health and learning disability and mental health, learning disability and community trusts:

Same or better than

Worse than

How our 2020 scores compare to our 2019 scores:

↑ Higher
↔ Same
↓ Lower

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NHS Foundation Trust

AGENDA ITEM: 20

REPORT TO: **TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**

PRESENTED BY: Neil Savage, Director of HR & OD

AUTHOR: Andrew Mills, Workforce Systems & Planning Manager

SUBJECT: **GENDER PAY GAP REPORT 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:

The purpose of this report is to inform the Board of Directors on the 2020 gender pay gap within Gloucestershire Health & Care NHS Foundation Trust.

Recommendations and decisions required

The Board is asked to:

- **Note** and the 2020 report
- **Note** that the report has been previously received in March 2021 by the Appointment and Terms of Service Committee
- **Agree** to publish this report on the Trust website with a link to the government website, and
- **Agree** the commitment statements that will be published on the Trust website and via the government website.

Executive summary

The UK Gender Pay Gap legislation requires NHS Trusts to annually publish 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 4 April 2021 and is based on data drawn from 31 March 2020.

Organisations with 250 or more employees, public and private sector, are also required to publish their gender pay gap information on their own website and also 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.

In 2020 the reporting rules were relaxed in light of COVID and many organisations did not report their Gender Pay Gap. However, the Trust reported on its previous two legacy Trust's reports from 2019.

The most recently viewable HMRC figures from early 2020 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.

This report contains the statutorily required calculations, presenting the gender pay gap against the six requisite indicators. These are the result of a snapshot of the Trust's workforce on the required date of 31st March 2020 as required and are summarised below:

- **Mean average gender pay gap**. Women earn less than men by 18.63%. This compares with the 2019 gap of 22% in 2G and 12% gap in GCS.
- **Median average gender pay gap**. Women earn less than men by 7.55%. This compares with a previous 2019 gap of zero in GCS and 14% in 2G.
- **Mean average bonus gender pay gap**. Women are paid less than men by 11.8%. This compares with a previous 2019 gap of 7% in 2G and 71% in GCS.
- **Median average bonus gender pay gap**. Women are paid more than men by 16.67%. The latter figure is impacted by the small number of staff that fall into this category (6 women and 26 men). This compares with a previous 2019 gap in women being paid more than men by 35% in 2G, and by 83% less in GCS.
- **Employee numbers by quartile.** The proportion of men and women (when divided into four groups) ordered from lowest to highest pay shows there are a higher proportion of women in all quartiles and the gap closes with progression toward the upper quartile.

This data shows a 2020 position whereby the Trust has effectively landed in the middle, between the previously slightly lower pay gap for GCS and the higher 2G gap. It also shows a small widening of the gender pay gap in year when reviewing the average hourly rate, while also showing an improvement on the median average bonus pay for women over 2019.

However, at its core, it presents an all too typical position highlighting the scale of challenge and the inherent unfairness in the system within and beyond the Trust. Sustainable improvements will arguably require further changes in legislation,

continued application of good practice, such as positive action in recruitment and Clinical Excellence Award marketing and support, alongside changes in education, careers advice, flexible working, management and leadership culture.

Previous legacy Trusts confirmed a similar statement of commitment as the one outlined below, and, on the recommendation of the Appointment and Terms of Service Committee, the Board is asked to endorse this statement:

"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."

The Appointment and Terms of Service Committee also asked that the Board consider an additional statement to strengthen the Trust's commitment to closing the gap which also sends a positive message to colleagues and applicants.

"Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove the gender pay gap."

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.
Risk implications:	Failure to provide equality of opportunity may result in claims of discrimination and damage to the reputation to the Trust as a fair employer thus impacting its ability to deliver its commitment to being a Great Place To Work.

Where in the Trust has this been discussed before?	
Appointment & Terms of Service Committee. Gender Pay Gap Reporting has been in existence since 2018 and has been reported each year since then.	17 March 2021

Appendices:	

Explanation of acronyms used:	GCS – Gloucestershire Care Services 2G – 2gether NHS Foundation Trust ESR – Electronic Staff Record VSM – Very Senior Manager GHC – Gloucestershire Health and Care NHS Foundation Trust

Report authorised by: Neil Savage	**Title:** Director of HR and Organisational Development

GENDER PAY GAP REPORT 2020

1. CONTEXT

What is gender pay gap reporting?

UK 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 woman and man 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 at that time required to be reported by the end of March 2018.

The Government has required subsequent rounds of reporting 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 2020.

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.

Importantly, 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.

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.

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.

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.

The majority of GHC 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.

Medical and Dental colleagues have different sets of national Pay, Terms and Conditions, depending upon their seniority and roles. However, these too are based on the principles of equal pay and opportunity. Similarly, these are set across a number of pay scales for basic pay, which have varying thresholds within them based of length of tenure in the position. Directors have been appointed on Hay or similar equal opportunity job evaluation methods, informed by the national NHS Improvement VSM Guidance and benchmarked using national surveys, for example from NHS Providers, regional and local labour market data.

2. GENDER PAY GAP INDICATORS

Employers must publish the results of six calculations showing their:

1. Average gender pay gap as a mean average
2. Average gender pay gap as a median average
3. Average bonus gender pay gap as a mean average
4. Average bonus gender pay gap as a median average
5. Proportion of men receiving a bonus payment and proportion of Women receiving a bonus payment
6. Proportion of men and Women when divided into four groups ordered from lowest to highest pay.

These calculations are taken from the pay and ESR system. It should be noted that Consultant Medical colleagues are now the only employees to receive bonus payments within the Trust in the form of either national or local Clinical Excellence Awards.

3. GENDER PAY GAP ANALYSIS (31st March 2020 snapshot)

Table 1 – Employee headcount as at 31 March 2020

Payband	Women	% make up	Men	% make up
Band 1	30	94%	2	6%
Band 2	495	88%	66	12%
Band 3	669	89%	79	11%
Band 4	362	92%	32	8%
Band 5	688	87%	100	13%
Band 6	930	86%	150	14%
Band 7	412	82%	88	18%
Band 8a	115	79%	31	21%
Band 8b	46	71%	19	29%
Band 8c	15	68%	7	32%
Band 8d	10	71%	4	29%
Band 9	0	0%	3	100%
Board Member	2	25%	6	75%

Medical	72	61%	47	39%
Student	38	84%	7	16%
Grand Total	**3884**	**86%**	**641**	**14%**

The percentages in table 2 remain similar to the previous two years' combined data. Last year's percentages were 77% women and 23% men in 2G and 89% women and 11% men for GCS.

Table 2– Average and Median Hourly Rates – all eligible staff and pay schemes.

Gender	Avg. Hourly Rate 2020	Avg. Hourly Rate 2019 2g/GCS	Median Hourly Rate 2020	Median Hourly Rate 2019 2g/GCS
Women	£15.67	£15.76/14.98 (15.37)	£14.79	£14.34/£14.34
Men	£19.26	£20.21/£17.07 (18.64)	£16.00	£16.45/£14.34
Difference	£3.59	£4.45/2.09 (3.27)	£1.20	£2.11/£0.00
Pay Gap %	18.63%	22%/12.25% (17.13)	7.55%	14.74%/0.00%

(Average for 2019 across both Trusts shown in brackets)

The figures above show as might be expected, following the Trust merger, a 'coming together' of the overall gap. However, there is a small widening of the gender pay gap in year when reviewing the average hourly rate.

Table 3 – Number of employees – Q1 = Low, Q4 = High

Quartile	Women	Men	Women %	Men %
1	1105 (1,117)	156 (167)	87 (85)	12 (15)
2	1075 (1,093)	198 (179)	84 (85)	16 (15)
3	1084 (1,140)	184 (168)	85 (85)	15 (15)
4	985 (1,011)	284 (274)	77 (77)	23 (23)

(Last year's figures in brackets)

Table 3 above shows a reasonably static workforce in relation to gender breakdown.

Table 4 – Average Bonus* Gender Pay Gap

Gender	Avg Bonus Pay 2020	Avg. Pay 2019 2g /GCS	Median Bonus Pay 2020	Median Bonus Pay 2019 2g/ GCS
Men	£11,142.23	£11800.08/ £15,080.04	£9,048.00	£8922.35/ £15,080/04
Women	£9,827.13	£10857.60/ £5,876.00	£10,555.98	£12063.96/ 2938.00
Difference	£1,315.10	£942.475/ £9,204.04	-1,507.98	-3141.63/ £12,142.04
Pay Gap %	11.80%	7.99/71.96%	-16.67%	-35.21/83.69%

The figures in table 4 above illustrate a significant reduction in the gender pay gap for bonus pay. This is particularly evident when median pay is reviewed.

Table 5 – Proportion of men and Women receiving a bonus against the overall totals

Year	Total	Gender		% of total		Number receiving a bonus		% receiving bonus	
		Men	Women	Men	Women	Men	Women	Men	Women
2019	137	58	79	42.3%	57.67%	27	6	46.55%	7.6%
2020	119	72	47	60.5%	39.5%	26	6	36.11%	12.77%

Figures in the table above illustrated that there has been an increase in the number of woman consultants receiving a Clinical Excellence Award and a percentage reduction in the number of men receiving an award. As part of previous pay gap actions agreed, the Trust has strived to communicate and encourage applications from women and also BAME colleagues, alongside providing extension training and support to maximise the quality of applications.

4. CONCLUSIONS AND RECOMMENDATIONS

The headline figure based on all eligible Trust employees and pay schemes indicates that women are paid 18.63% less on average than men compared to 22% and 12% in the previous year.

The gap for median (middle point) earnings is closer standing at 7.55% less for women. This figure was 14.74% and 0% less for women in the previous year.

The data shows that 86% 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 Women and Men evens out towards the more senior end of the pay bands which suggests that there are currently 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 a complex range of factors including incremental progression. With progression it takes many years to rise through the nationally set pay bands. The previous Agenda for Change Pay Award and related pay structure which was agreed in 2018 is expected to help with closing the gap in the longer term to a small 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. However, the 2021 pay announcement will have little impact on improving matters.

Changes in working patterns, colleague turnover, positive action in targeted recruitment advertising, improved flexible working and wider choices about career breaks will also factor into this, alongside improved gender ratios in our degree supply chain, particularly in medical school and nursing.

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 men and women consultants, considerably more men than women traditionally apply for 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 men and women were in receipt of lower CEAs during the reporting period and the median bonus pay gap has now reversed. While the 2020 CEA round has not completed, a similar low number of awards is expected.

The gender pay gap is also significant at Executive Director level with an average hourly rate which is 33% lower for women than men. Six of the post holders were men and two were women. The committee is reminded that this is a snapshot was taken on the 31 March 2020 and that the numbers are now two women and five men.

It should be noted that of the 12 organisations that had uploaded their Gender Pay Gap reporting information on or before 11 March 2020 when this report was written, five 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 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 continue to take to make a positive difference.

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 continue to apply the similar "all other things being equal" approach taken to the recent Non-Executive Director appointments and to other senior appointments, allowing positive action to be taken. Positive action (but not positive discrimination) is lawful under the Equality Act. Local action plans and broader longitudinal societal actions are required to work toward closing the gap, accepting that there is no single 'quick fix'.

4.1 **Recommendations**

Going forwards, our Trust 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.

All parts of our workforce, irrespective of gender, or other protected characteristics are vital to our sustainability and our recruitment and promotion practices are rooted in these principles.

However, in order to further tackle the gender pay gap differences, additional actions, supported by the Appointment and Terms of Service Committee, are recommended as being taken forward as follows: -

1. **Positive action in leadership training and development** - encouraging women to participate in our Stepping Up, Brilliant Essentials and Leading Better Care Together leadership development programmes.
2. **In-year review of our equality and diversity training provision** - with an emphasis on the importance of using positive action to get the changed representation we need at senior levels.
3. **Further review of the Flexible Working Policy and Flexible Retire and Return Schemes** - which were last reviewed and 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.
4. **Recruitment action** - by continuing to take positive recruitment gender action for areas of under-representation.
5. **Coaching and Mentoring offers** - re-initiation of the development of the coaching and mentoring network offer which was mostly put on hold during COVID, with the focus on opportunities for underrepresented roles for more senior roles
6. **Strengthening supportive networking** - the continued sponsorship, support and facilitation of the Trust's Women's Leadership Network. This will include a facilitated discussion and engagement event to review the 2020 pay gap report

and actions prior to finalisation of these suggested actions, with any additional identified actions being adopted and reported to the Appointment and Terms of Service Committee

7. **Communications** - continued refreshed communications on related assistance such as paternity leave, access to Little Oaks and Little Apples NHS Childcare Nurseries alongside our Childcare Vouchers offer though VIVUP
8. **Clinical Excellence Awards (bonus pay)** - follow up presentations and training session in 2021/22 run by the Medical Director and the Director of HR and OD to continue to encourage additional woman applicants to the next year's Consultant Clinical Excellence Award round.
9. **Commitment Statement** - 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'

The Appointment and Terms of Service Committee also asked that the Board consider an additional statement to strengthen the Trust's commitment to closing the gap which also sends a positive message to colleagues and applicants. The suggested wording for this is contained below: -

"Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove the gender pay gap."

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AGENDA ITEM: 21

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**
PRESENTED BY:	Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
AUTHOR:	Gillian Steels, Governance Adviser
SUBJECT:	**MEMBERSHIP AND ENGAGEMENT STRATEGY**

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

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

The purpose of this report is to:

Put in place an agreed Membership and Engagement Strategy and related initial action plan to build a membership which is engaged and reflects the breadth of the communities we serve.

Recommendations and decisions required

The Board is asked to:

- **Endorse** the Membership and Engagement Strategy for 2021-24
- **Note** the initial Action Plan and Partnership Methodology which has been agreed by the Membership and Engagement Committee and Council of Governors.

Executive summary

The Governors Membership and Engagement Committee has met twice since it was agreed to establish it at the November Council of Governors meeting.

The Strategy was considered and updated in the light of feedback from the Committee who highlighted the need to clearly communicate the benefits of membership, to target our communications effectively to different audiences and to use partnership working to help spread the message of membership.

An Action Plan was developed to put in place some of the key foundations needed to support this strategy and the work on this is now ongoing. This work will be taken forward by the Communications Team, Corporate Governance Team and

Partnership and Engagement Team with support from other colleagues at GHC.

The Partnership Methodology to reflect how the Membership and Engagement Strategy plans to work with partners to achieve its aims is also provided.

The success of the Strategy will also need the active support of governors to engage and communicate the benefits of membership. Governors on the Membership and Engagement Committee have confirmed their commitment to helping with this engagement. Their enthusiasm, energy and ongoing thoughtful contribution is much appreciated.

The Strategy was approved by the Council of Governors at their meeting on 10 March 2021 and is now being presented to the Trust Board for endorsement.

Risks associated with meeting the Trust's values
None

Corporate considerations	
Quality Implications	An Engaged and diverse membership will help ensure that our services are of the necessary quality for our diverse community.
Resource Implications	Time from the following Teams: Communications, Governance, IT, Partnerships
Equality Implications	Ensuring a diverse membership will support the Trust in meeting its commitments to EDI.

Where has this issue been discussed before?
The development of a membership and engagement strategy was discussed and agreed at the Council of Governors in November 2020.

Appendices:	Appendix 1 - Action Plan Appendix 2 - Partnership Methodology

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance/Trust Secretary

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 21.1

Membership and Engagement Strategy 2021-24

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Contents

1. Summary

1.1. As a Foundation Trust, we are accountable to service users and their families and carers, staff and local residents who can become Members and Governors. Members are represented by a Council of Governors comprising elected public and staff Members together with representatives of partner organisations, local authorities and Commissioners in the local community.

1.2. A representative and engaged Membership will help our Trust to ensure we can build our services to meet the needs of our community – it is an important objective for the Council of Governors.

1.3. This strategy outlines the Trust's vision for Membership and Engagement over the period 2021-24. It sets out the methods that will be used to identify and build an effective, responsive and representative Membership body that will assist in ensuring that our Trust is fit for its future in the changing NHS environment.

1.4. This strategy was approved by the Council of Governors in March 2021 and confirms our overall ambition of increasing the active engagement with existing Members as well as increasing the number and representativeness of our overall membership. This will mean that Membership is more meaningful and attractive for new Members from groups or areas which have previously been underrepresented.

2. Current Position

2.1. As of December 2020, the Trust has approximately 10,000 Members. Membership is voluntary and is drawn from the Trust's public and staff constituencies which include:

Public

- Cheltenham
- Cotswolds
- Forest of Dean
- Gloucester
- Greater England and Wales
- Stroud
- Tewkesbury

Staff

- Medical, Dental and Nursing
- Management, Admin and other
- Health and Social Care Professions

2.2 Our constitution sets out details of eligibility for Membership, as well as restrictions and arrangements for termination of Membership. Members must be at least 11 years of age.

Constituency	No. of Governors	Current no. of Members (Jan 21)
Cheltenham	2	933
Cotwolds	2	386
Forest of Dean	2	625
Gloucester	2	1562
Greater England and Wales	1	984
Stroud	2	900
Tewkesbury	2	698

2.3 Membership is an expression of public support for the Trust. Members have the opportunity to become involved in a number of areas including:

- being invited to Membership events, including the Annual General Meeting, information sessions and planned visits
- voting in the election of representatives to the Council of Governors
- being able to stand for election to the Council of Governors
- receiving discounts on a wide range of goods and services by registering on the www.healthservicediscounts.com website
- receive regular information about the Trust, including our magazine, With You For You
- being consulted, for example, on how the provision of services could be improved by completing surveys, taking part in events
- Attending Council of Governor meetings as observers
- being involved in the development of the Trust Strategy by completing surveys, taking part in events

Recruitment of Members

2.4 The Trust has a simple process for becoming a Member via an online application on its website and Membership application form which is made available at Membership events and within the Trust premises. Members don't need an email address to join but this is the Trust preferred method of communication with members. Governors are encouraged to help with the recruitment of Members by engaging with Members of the public who may also be part of other groups outside of their role as Governors.

3 Membership and Engagement Vision, Aim and Objectives

Vision:
To ensure the Trust Membership supports the Trust in embodying the core principle of the NHS Constitution – The NHS belongs to the people.

Aims:
- Promote and increase membership, particularly among groups and areas who are currently under represented
- Support Engagement of Members
- Raise public awareness of the work of the Trust

Key Priorities: -
- Membership Community – to maintain and grow (uphold) our membership community by addressing natural attrition and membership profile gaps
- Membership Engagement – to develop and implement best practice engagement methods
- Governor Development – to support the developing and evolving role of Governor (membership representatives) by equipping Governors with the skills and knowledge in order to fulfil their role

NB
To ensure effective working with other areas of the Trust which are supporting community engagement to ensure synergy and effective working together.

This section outlines the objectives that the Trust has set for completion over the next three years, the approach to meet these objectives and how the Trust will monitor and evaluate the effectiveness of the objectives.

3.1 Membership Representation

Objective 1: To maintain and develop a Membership that is representative of the Constituencies that the Trust serves.

3.1.1 Membership is an important part of being a Foundation Trust as it shows public support for the Trust. A representative sample of the local constituencies will also allow the Trust to gauge local views and priorities which can help the Trust to shape its development of services.

3.1.2 The Trust will advertise the benefits of being a public Member to the Constituencies by:

- Encouraging Governors, both public, appointed, partner and staff Governors, to recruit Members when attending events outside the Trust.
- Encouraging Members to share the With You For You membership magazine and information on Membership events with their family, friends and local community contacts.
- Utilising social media such as the Trust's Website, Facebook, and Twitter to communicate the benefits of being a Member.
- Membership forms to be available in all appropriate areas of the Trust.
- Recruiting new Members at Trust events, Job Fairs, public and patient involvement events.
- Human Resources will look into the possibility of updating the staff exit questionnaire to include asking staff if they would like to be a Member if they leave the Trust to contact the Corporate Governance Team.
- Reflect the benefits for the individual through volunteering as a member or governor – opportunity to grow as a person
- Working in partnerships with other organisations

Monitoring and Evaluation

3.1.3 A report of Membership figures is provided to the Membership and Engagement Committee. The report includes a breakdown of Members by constituency, ethnicity, disability, gender and age. The change in overall number of Members is also to be provided. The Membership and Engagement Committee then provides an update to the Council of Governors.

Objective 2: Increase the Membership of Males, under 19's, Cotswolds and keep under review Black and Minority Ethnic (BAME) membership to ensure reflects latest population statistics (Census 2021).

3.2.1 As a Foundation Trust we continue to welcome new Members for all constituencies but our main focus for recruitment during the next three years will be on increasing the Membership of Males, under 19's, Cotswolds and keep under review Black and Minority Ethnic (BAME) membership to ensure continues to reflect latest population statistics (Census 2021).

3.2.2 During the next three years, The Trust will aim to attract these groups by:

- Providing Membership forms to local sixth forms, colleges and Universities to distribute at their Open Days.
- Contacting local Universities to attend Freshers' week to promote Membership to young people moving to the local area.
- A younger Member's programme to be investigated
- The Trust Diversity forum at the Trust to be contacted to ask if they could engage with contacts in the local Community to promote the benefits of being a Member.
- Consideration links governors can suggest from their networks of less

represented groups/areas.

Monitoring and Evaluation

3.2.3 Achievement of this objective will include:

- The Membership and Engagement Committee monitoring figures for identified groups to identify if there has been an increase in these groups compared to the previous year.
- Membership events specifically targeting young Members being run at a local school, college or university by the end of 2022.
- Contact with the Diversity forum to promote Membership of the Trust and the benefits of being a staff Governor and also to highlight Membership to their external links. This would raise awareness of the role of Governors and encourage Diverse staff to apply for staff Governor vacancies as they arise and increase diversity of membership.
- Membership of males and Cotswolds to increase.

Engagement

Objective 3: Membership activities will be held in each of the Trusts constituencies, linking to other ongoing events, where possible

3.3.1 Membership events for the period of the Strategy to be developed, subject to Covid restrictions.

Monitoring and Evaluation

3.3.2 The Trust will know it is being successful if:

- Figures of attendance would be reported to the Membership and Engagement Committee to monitor, aim would be to demonstrated increased involvement.

Objective 4: To encourage partnership working for Governors and Members to attend events run by the Trust, Communities, local Partnership groups etc.

3.4.1 Governors will continue to be encouraged to reach out to local external groups which they may be involved in in order to interact with the public and potential Members and promote the role of the Council of Governors.

3.4.2 A toolkit would be developed that Governors could take with them when attending groups they are involved with in the local Community. This toolkit would include a generic presentation, a leaflet about the benefits of being a Member and Membership application forms.

3.4.3 The Trust could approach GHFT to ask if they would like to plan a joint event and allow us to attend other external events.

3.4.4 The Trust runs a number of recruitment days to engage with potential new staff Members. Membership information would be provided to staff who facilitate the recruitment day.

Monitoring and Evaluation

3.4.5 The Trust will know it is being successful by:

- The creation of a generic toolkit for Members to take out to local community groups.
- Attendance at two events facilitated by a local school or college in the next two years.
- A joint Membership event held between GHFT and the Trust within the next three years.

Communication

Objective 5: To build and develop good communication and interaction between the Council of Governors and Trust Members.

3.5.1 Governors are an essential element of Membership recruitment, communication and engagement. We will provide a more focused role for Governors within Membership engagement by agreeing a programme of activity which will include:

- Governors are encouraged to attend as many Membership events as possible
- 'meet your Governor' activities – in the members magazine or on the website to be explored
- Updates from governors to member constituencies inform them of developments at the Trust, the benefits of Membership, the role of the Council of Governors, activities of the Council and any vacancies
- A greater emphasis will be placed on making Governors more visible to Members of the Trust. Consideration of development of a video to be created where Governors would have the opportunity to introduce themselves to Members, talk about their role as a Governor and why they became a Member of the Trust.
- Thought should also be given as to whether we would want to contact Members to ask if anyone would be interested in a video to talk about what made them become a Member. A welcome email will be sent to new Members Joining the Trust confirming their membership, along with an information sheet about the Council of Governors and a list of Governors/Trust Contact emails.

Monitoring and Evaluation

3.5.2 The Trust will know it is meeting the objective if:

- A video is created; and at least two Governors over the period of two years have taken part in the video.
- Governor attendance at events/involvement in activities will be monitored at the Membership and Engagement Committee. It is also anticipated that involvement in activities will increase over the life of the Strategy.
- The welcome email is reviewed and sent to any new Members that join

Objective 6: To review the Trust "With You For You" Membership Magazine and ensure appropriate information is shared with Members that is relevant to what is happening in the Trust

3.6.1 The Trust has a magazine, "With You For You", which is circulated to Members generally four times a year.

3.6.2 More opportunities to update on what governors are doing, activities of the Council of Governors, upcoming election dates to be included.

3.6.3 Members will have the opportunity to take part in surveys which are relevant to what is happening in the Trust.

3.6.4 A biannual Members Communication survey will be circulated to make sure the Trust is meeting the needs of the Members and keeping Members informed on information that is important to them.

Monitoring and Evaluation

3.6.5 The Trust will know if this objective is being met if:

- The "With You For You magazine" is reviewed and includes more governor focused information and contents section to draw people in
- There is engagement with the regular surveys.

Staff Engagement

Objective 7: To provide opportunities for staff to become more actively engaged as Members.

3.7.1 Staff and volunteers will be actively encouraged to take on an active role in involving themselves in Membership activities. They will receive the same communications and opportunities to be involved as public Members. The Volunteer Manager will be asked to cascade information to all Volunteers.

3.7.2 Information will be circulated to staff and volunteers to keep them informed on

Membership events, in addition to receiving:

- A copy of the With You For You magazine to keep them up to date
- Membership application forms would be electronically circulated to all new staff Members and volunteers that join the Trust to pass onto friends and family.

3.7.3 The Trust will look to encourage more staff and volunteers to talk to other Members about the work they are involved with at the Trust through informative and engaging presentations at events.

3.7.4 The Membership page on the Trust internet will be kept up to date with relevant information about current Membership events and Staff and public Governor vacancies.

3.7.5 The Chief Executive and Chair will continue to promote the Annual General Meeting, Membership and Council of Governors within their regular communications.

Monitoring and Evaluation

3.7.6 Monitoring the attendance of staff Members at the events/activities by the Membership and Engagement Committee.

Objective 8: To increase understanding of the role of staff as Governors.

3.8.1 Staff are a valuable resource to the NHS, not only does every staff members make a difference to the health of the local population but they also make valuable contributions to steering the organisation's direction by getting involved in services and generating plans for the future.

3.8.2 The methods we will use to build understanding will include:

- Email specific work groups that have vacant Governor seats to make them aware of the vacancy.
- Information about governor vacancies to also be cascaded down from Directors and managers to show support for their staff member being a Governor.
- A leaflet could be developed by Governors to show how through their representation on the Council of Governors, staff will have a greater voice to develop ways of working that reflect patients' needs and priorities. Staff will be encouraged get involved to make a real impact on local health provision and service design.
- Updates from staff governors on activities of the Council
- Opportunities for staff governors to talk about the role of the staff governor and to encourage staff engagement.

Monitoring and Evaluation

3.8.3 The Trust will know if this objective is being met if:

- In the next three years we successfully fill all vacant Staff Governor seats
- A leaflet is created specifically for staff Governors to showcase what it means to be a Governor and the difference the impact they can have on local health provision and service design.
- Staff Governors are involved in providing updates and other wider engagement activities

APPENDIX 1 **AGENDA ITEM: 21.2**

GHC Membership and Engagement Action Plan

1.	Communication and Engagement – Core Aim – To improve Engagement						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**
1.1	Governor and Membership Information on website.	To be reviewed and updated	To be easier to navigate, more engaging and increase transparency on who the Council are and what they do	A Hilditch (Governance Team)	Governors on the M&E Committee, Comms Team, Claire Kenny	31st March 2021	Initial review undertaken. Feedback obtained from governors. Information held review to identify where further information is required. Initial discussions with Comms on ways to increase accessibility of information.
1.2	Newsletter	Timetable of Comms to be agreed	To ensure regular comms are in place and members build relationship with the Trust	M Blackman (Comms)	Governance Team, Comms	23rd Feb 2021	Proposed to issue enewsletters every other month. Traditional Format newsletter to be continued and issued every 6months (issued electronically to those who have email as preferred contact.
1.3	e-Newsletter Focus on moving to e-communication to increase timeliness, ability to target, increase frequency, build greater engagement	Format	To increase engagement by increasing "exposure" to governors and work of Council, to include health focused information – "how to take care of yourself"	M Blackman (Comms)	Governance Team, Comms Team	23rd Feb 2021	Newsletter in revised format trialled Feb 2021. Feedback from governors on it welcomed to inform next edition.
1.4	Traditional format Newsletter	Content to be reviewed and updated	To ensure regular comms are in place and members build relationship with the Trust	M Blackman (Comms)	Comm. Team, Governance Team	31st March 2021	Newsletter in updated format to be issued.

	Core Area	Action	Target Outcome	Action Lead	Others Involved	By When	Actions to Date
1.5	Survey	Short survey to be issued to members	To identify what members want from comms on the Trust. To move more members towards email communications.	M Blackman (Comms)	Comms Team	31st March 2021	Initial discussions on format and purpose of questionnaire.
1.6	Flyer	To be redesigned – to target 22+	To increase understanding of Trust membership – bite sized	G Steels (Governance)	Comms/Governance Team	23rd Feb 2021	Flyer has been redesigned and tested in small user group – age ranging 20-50. **4/3/21** Matt Blackman to further review based on feedback from the group – revised timeline to be agreed.
1.7	Flyer	To be redesigned – to target under 22	To increase understanding of Trust membership – bite sized	Dominika Lipska-Rosecka (Partnerships & Inclusion)	Comms/Governance Team	April 2021	Partnership and Inclusion Team contacted to see if they have possible group which could support this age strand. **Once 1.6** has been completed Dominika to arrange for this to be tested on different age group, additional option of UoG health and care students and Gloscol students also to be explored.
1.8	Trust facemask	Suggested for consideration.	To be explored	A Hilditch		April 2021	
1.9	Add Membership link to Trust email footer	To be explored		M Blackman		April 2021	Supported in principle by M&E Committee.
2.	**Partnership Working – Core Aim to increase Membership**						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**

2.1	Potential Partners identified	Initial partners to be identified	List initial partners agreed	G Steels	M&E Committee	23rd Feb 2021	M&E Committee reviewed and supported proposed list. To be endorsed at CoG 10/3/21 Other options to explore GCHQ, Chelt Civil Service Club, Football Clubs, Gloscol, Gloucestershire Farmers. Network mapping from Strategy and Partnership to be shared. Also consider unusual suspects as develop.
2.2	Methodology for Working with Partners	Initial Methodology to be proposed	Methodology Agreed	G Steels	Comms/Governance Team/ Partnership & Inclusion Team	31st Mar 2021	M&E Committee had supported proposed partnership methodology. To be endorsed at CoG 10/3/21
2.3	Comms with selected partners to be set in place	Agreed partners to be contacted	Partners to be contacted and comms issued by partners Up to 30 new members per partnership comms	Tbc	Comms/Governance Team	30tht April	Process to be further considered. D Lipska Rosecka has confirmed link with the Gloucester Race Equality Commission and agreed to explore potential opportunities for links
3.	**Events – Core Aim – to improve Engagement and Increase Membership**						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**
3.1	Events Programme	Event Programme to be drafted	Agreed Programme in place	K Nelmes	Comms/Governance Team – other teams as identified	23rd Feb 2021	Supported in principle by Membership & Engagement Committee Proposed Forest Hospital be added and potentially a “Celebrate Members” event.
3.2	Events to take place	Event to be organised and attended	Event take place successfully	K Nelmes	Comms/Governance Team – other teams as identified	On going	
3.3	Events to be reviewed for impact	Review of attendance and feedback	Up to 30 new members signed up per event. Positive feedback from event	A Hilditch	Comms/Governance Team – other teams as identified	As events take place	

4.	**Public Governor Promotion – Core Aim to utilise governor networks**						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**
4.1	Governor Contacts	Governors to distribute flyer to their networks to promote membership or promote via social media.	10 new members per month of activity	A Hilditch	Governors	Ongoing through year	A number of governors have engaged with groups they are members of and promoted on social media – e.g. linked in. Once the flyer has been finalised it and presentation to be distributed to governors to share with their networks.
4.2	Governors to support planned events	Governors to be advised of planned events and to commit to attending at least one event in the event cycle.	Governors to commit to attending at least one event in the event cycle.	A Hilditch	Governors	On-going through year	Suggestions of ways to engage with health and Care U oG students to be explored.
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions To Date**
4.3	Governors to identify potential areas where they could promote membership	Supporting presentation to be agreed. Support on presenting/talking in public to be provided on request.	Attendance at five events over year where governors promote membership	Anna Hilditch	Governors, Comms, Strategy and Partnership Teams	Feb 2022	Presentation endorsed by Membership and Engagement Committee.
5	**Membership Database Improvement – Core Aim – to improve ability to monitor membership, measure impact activities and review and retarget as necessary.**						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**
5.1	Review current database	Review how current database works and identify required improvements.	Clear understanding of requirements defined and	Anna Hilditch	IT Team	31st March 2021	Additional reporting capability requested. Feedback from last Committee, and its identified needs being used to scope further work required.

			gaps in current system identified				
5.2	Improve Database Reporting	IT to refine current database	Improved Reporting	IT	Anna Hilditch	tbc	IT request submitted and acknowledged, timeline awaited.
5.3	Mechanisation Membership Data	Investigate process required to automate feed of new members from website to database	Reduction in re-entry of data	IT	Anna Hilditch	tbc	This is to be included in additional work to be scoped with IT. The scoping of this work is ongoing, along with consideration of other refinements to the database to ensure the monitoring data required can be accessed.
6	**Make every Contact Count – Core Aim – increase membership and engagement by linking to existing Trust mechanisms for engaging with service users**						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**
6.1	Experts by Experience and other patient participation groups	To advise if such groups could be used to promote membership	To identify groups which could be used for promotion membership	Dominika Lipska Rosecka	Anna Hilditch/Comms	1st Mar	Dominika has confirmed this can be taken forward with groups linked to the Partnership and Engagement directorate once materials area ready. Ruth McShane has already raised the issue with Experts by Experience Group.
6.2	Volunteers	To put in place ongoing process to promote membership when new volunteer signed up	Process in place	Anna Hilditch/ Volunteering Lead	Governance Team	1st April	Promotion of membership to volunteers has been done on an ongoing basis. This action would make this ongoing.
6.3	Friends and Family Feedback	To investigate whether this could be used as area to promote membership – would be mechanism to	To confirm whether this is possible and identify steps required to achieve	A Hilditch/Marit Endresen	Governance Team/ Patient and Carer Experience Team	1st April	It has been confirmed this is technically possible. Anna Hilditch to draft some wording to be added to the surveys which will then be actioned by Marit Endresen. These surveys are issued to a significant number of service users each month.

		reach service users					
6.4	Transition to Adult Services	To investigate whether this could be used as area to promote membership – would be mechanism to reach younger service users. Would need to see if appropriate and not a distraction	To confirm whether Transition to Adult Services process could include membership promotion and identify required steps to achieve if so.	Anna Hilditch/COO		1st April	Appropriate contact to be identified.
6.5	Young People Services in the Trust link	To investigate best mechanism for this.	Good practice from other Councils investigated.	Charlie Presley	Outline of processes at Bristol Hospitals obtained for comparison.	1st May	Following up contact obtained from Bristol Hospitals Trust which has a young person's council which has a member on the Council of Governors for 12 months to explore options.
7.	**Staff Governors – Core Aim- ensure making best use of Staff Governors as Recruiters of Members**						
	Core Area	**Action**	**Target Outcome**	**Action Lead**	**Others Involved**	**By When**	**Actions to Date**
1.	Staff Governor networking options to be explored	To meet staff governors and explore networking opportunities to support membership	To increase number of members	Anna Hilditch	Staff Governors	1st April	Part of work being developed to clarify how staff governors can contribute as governors. Anna in the process of establishing group. Group to include Dir WF & OD and Sumita Hutchison – lead NED for E&D and staff engagement.

APPENDIX 2 **AGENDA ITEM: 21.3**

Partnership Methodology for Membership and Engagement Committee

1.	**Communication Partners**
	Organisations contacted to see if they will include information about membership within materials they issue to their contacts. Recognising current agreed focus is younger individuals, males, Cotswolds and maintaining breadth of ethnicity of members suggested organisations to link with are: **University of Gloucestershire** – younger age range, students background is significant number from local area – this is already part of an ongoing relationship with the Trust. **Active Gloucestershire –** younger age range – part of ongoing relationship with the Trust **Cheltenham Trust –** breadth of age range – Governor links with the Trust. **Gloucester Race Equality Commission –** this group was established in Nov 2020 with a 1-year remit – there is an ongoing consideration of health and links with the NHS. **Cotswold Council –** option to explore as way of reaching individuals who work in the Cotswolds by investigating if they would email flyer to their staff. Post Covid restrictions this would also include exploring options to attend events such as Freshers Fair, Open Days, hospital reception areas etc where governors and staff colleagues could attend to promote membership (governors attended these events in the past and they were positive recruitment opportunities.
2.	**On-going Partners**
	In the past 2gether NHS Foundation Trust had a broader partnership relationship with Gloucester Rugby. The possibility of identifying partners who would help more broadly support the Trust could be further explored once the impact of Covid is reduced. It is suggested this would be an area for the Director of Strategy and Partnerships to advise on, and also need to be considered in the context of the People Participation Committee and the need to ensure that any identified partner aligned to the Trust's ethos.
3.	**Partners – consideration for Appointing Governor status**
	When the Constitution was last revised, following the work of the Review and Refresh Working Groups it was agreed that the number of appointed governors could rise from two (Gloucestershire County Council and Gloucestershire Clinical Commissioning Group currently) to up to five. The Committee are asked to note that it would be possible to identify a partner organisation in this way to build longer term relationships if it was considered appropriate and that consideration of how such a partner could support

	Membership and Engagement could be an element of the appointment decision making process. **The option of asking GCC to support a membership drive through issuing the email to its staff is flagged for consideration**. NB Within the Health and Care White Paper it confirms that; "**NHS Trusts and Foundation Trusts (FTs) will remain separate statutory bodies with their functions and duties broadly as they are in the current legislation."** And advises that the proposals plan to create Health ICS Bodies which will merge the functions of the ICS Health and Clinical Commissioning Groups. The implications of this for Appointing Bodies to the Council of Governors will need to be reviewed once further detail is available.

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AGENDA ITEM: 22

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 31 MARCH 2021**
PRESENTED BY:	Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
AUTHOR:	Anna Hilditch, Assistant Trust Secretary
SUBJECT:	**BOARD COMMITTEE EFFECTIVENESS REVIEW AND TERMS OF REFERENCE**

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 a summary of the outcome from the Annual Board Committee evaluation process and set out the proposed next steps.

Recommendations and decisions required

The Board is asked to:

- **Note** the outcome of the Annual Committee Evaluation process
- **Support** the proposed next steps in taking forward a wider review of the Board Committee structure
- **Approve** the revised Terms of Reference (TOR) for the Board Committees

Executive summary

An annual self-assessment of performance was carried out by each of the main Board Committees during October-December 2020. This was the first self-assessment for a number of the Board Committees since the merger of 2gether and Gloucestershire Care Services in October 2019. An annual self-assessment of performance forms part of the Committee Terms of Reference and is considered good practice.

The self-assessment was concerned with how the Committee operates, and asked respondents to indicate their agreement or otherwise to a series of statements grouped under 5 themes: Committee Focus, Committee Team Working, Committee

Effectiveness, Committee Engagement and Committee Leadership.

The results of the assessments were received and considered individually by each of the relevant Board Committees and reported to the Board as part of the Committee summary reports. Overall responses received were positive, with the main functions of the Committees working effectively. Members commented on the huge improvements that had been made in relation to the quality of reports received, key focus areas at the meetings and general organisation of the Committees and their work plans. Each Committee was asked to consider the review period and in particular this year the impact of Covid. All agreed that the Committees had adapted well to being held virtually via MS Teams and continued to be effective, with some feeling that meetings seemed much more focused and efficient.

Key Themes
A key theme identified from the effectiveness reviews related to a perceived overlap of assurance on performance between the Quality and Resources Committees and the need to ensure clarity in this area.

A second theme related to the broad remit of some of the Committees and the need to have further collective governance focus on HR and workforce matters, potentially through the establishment of an additional Board Committee.

On identifying these themes, it was agreed that a wider review be carried out to see how the Board Committee structure, and the interplay and reporting between the Committees could be further developed and strengthened.

Discussions have already commenced to review the role and structure of the MH Legislation Scrutiny Committee and these discussions will need to feed into any wider review.

Next Steps
During April, discussions will take place with the Committee Chairs and Executive Leads to address the themes identified and propose any revisions to the Committee structure as required to ensure the ongoing effectiveness of the Trust's governance framework. Any changes will be brought to the May Board meeting for approval, with work then taking place to ensure implementation by Quarter 3.

Terms of Reference
The Terms of Reference for each of the Board Committees are reviewed annually, with any change recommended to the Trust Board for approval. This year the TOR were reviewed with specific focus on consistency and formatting, in line with the recommendations arising from the Internal Audit on Corporate Governance. In addition to this, a number of changes have been made to membership and attendance at the Committees to take into account the transfer of Herefordshire MH services to Worcestershire in April 2020.

The terms of reference for the Board Committees may require further revisions during the year dependent on the outcome of the wider Committee Review as set out in this paper. It was deemed prudent however, to have a full set of consistent

and up to date terms of reference in place to refer to as part of this review.

The Board is therefore presented with the following Terms of Reference for approval:

- Appointments and Terms of Service Committee
- Forest of Dean Assurance Committee (New)
- MH Legislation Scrutiny Committee
- Quality Committee
- Resources Committee

The Terms of reference for the Trust's Audit and Assurance Committee were revised and presented to the Trust Board for approval in November 2020.

Risks associated with meeting the Trust's values

It is important to assess the effectiveness of the Board Committees on an annual basis to ensure that they continue to operate effectively and to identify whether any improvements can be made.

Corporate considerations	
Quality Implications	None other than those identified in the report
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?
Board and Board Committees

Appendices:	Board Committee TOR for approval

Report authorised by:	**Title:**
Lavinia Rowsell	Head of Corporate Governance and Trust Secretary

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AGENDA ITEM: 22.1

TERMS OF REFERENCE

Appointments and Terms of Service Committee

(for the Chief Executive, Executive Directors and Very Senior Managers) (VSMs)*

Version 3

1.	**Purpose**
1.1	The purpose of the ATOS Committee is to advise the Board on the appointment, remuneration and terms of service and performance of the Chief Executive and Executive Directors of the Board.
2.	**Membership**
2.1	The Committee will comprise: • The Trust Board Chair • All Non-Executive Directors • Chief Executive 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 person's absence the Committee will elect a Non-Executive Director from those present. The Chief Executive will not be present when the Committee is dealing with matters concerning them. **In attendance:** If requested, the Director of HR and Organisational Development and Director of Finance should be available to attend in an advisory capacity only. Any attendees will not be present when matters discussed affect them personally.
2.2	Other Officers or Directors of the Trusts may attend at the discretion of the Chair.
2.3	**CONFIDENTIALITY** 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. 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.
3.	**Quorum**
3.1	Three members including two Non-Executive Directors.
4.	**Reporting Arrangements**
4.1	The ATOS Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
5.	**Powers**

5.1	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.
5.2	The Committee will 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).
5.3	Seek opinion from NHSI where required with reference to 'Guidance on Pay for Very Senior Managers in NHS trusts and foundation trusts'. (March 2018)
5.4	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the ATOS Committee.
5.6	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 of reference of the sub groups.
6	**Responsibilities**
6.1	<u>Nominations role</u> The Committee shall, in respect of nominations: 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. 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. Be responsible for identifying and nominating for appointment, candidates to fill Executive Director posts within its remit as and when they arise. Be responsible for identifying and nominating a candidate, for approval by the Council of Governors, to fill the position of Chief Executive. Ensure that Executive Directors meet the requirements of the 'Fit and Proper Persons Test'. 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. 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. To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities
6.2	Remuneration Role The Committee shall in respect of remuneration: Establish and keep under review a remuneration policy for Executive Directors. Consult the Chief Executive about proposals relating to the remuneration of Executive Directors 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. Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Executive Directors. Approve the arrangements for the termination of employment of any Executive Director and other contractual terms, having regard to any national guidance. Approve all redundancies which attract a monetary value over and above contractual entitlement. 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. Oversee the performance review arrangements for the Executive Directors ensuring that each Executive Director receives an annual appraisal. 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.
7.	**Frequency and Review of Meetings**
7.1	The Committee will convene as often as is necessary, but normally 4 meetings will be scheduled each year. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.

8.	Administration
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	The Committee will agree an annual plan which will outline the business to be discussed at each meeting. This will include the content and frequency of reports from sub-groups.

*VSMs is defined by NHS Employers as 'other senior managers with Board level responsibility (March 2018)

Version:	**Date Approved:**	**Approved by:**
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
Version 2	29/01/20	Approved at Trust Board
Version 3	17/03/21	Draft reviewed by ATOS Committee
Version 3	31/03/21	Approved at Trust Board

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 22.2

TERMS OF REFERENCE

Forest of Dean (FoD) Assurance Committee

Version 1

1.	**Purpose**
1.1	The purpose of the FoD Assurance Committee is to receive and provide assurance to the Trust Board on the overarching delivery of the FoD Hospital programme, ensuring that the programme is delivered on time, to the agreed budget, and to a satisfactory quality.
2.	**Membership**
2.1	Membership Steve Brittan (Chair) Graham Russell (NED/Resources Committee Chair) Maria Bond (NED/Quality Committee Chair) Angela Potter (Director of Strategy and Partnerships) Sandra Betney (Director of Finance) Neil Savage (Director of HR&OD) In Attendance Kevin Adams (Associate Director of Estates, Facilities & Medical Equipment) Andrew Paterson (Strategic Project Manager) In Attendance (at Request of Committee) Alison Halmshaw (Gleeds) Adrian Speller (Speller Metcalfe)
2.2	Other Officers or Directors of the Trust may attend at the discretion of the Chair.
3.	**Quorum**
3.1	**Three** members, at least two of whom should be Non-Executive Directors and one should be an Executive Director. Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.
4.	**Reporting Arrangements**
4.1	The FoD Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
4.2	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee or the Resources Committee which require consideration by one or both

	of these committees.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the FoD Assurance Committee.
6	**Responsibilities**
6.1	The Committee will receive regular progress assurance reports from the FoD Project Board who are leading on the development of the Full Business Case The Committee will provide an oversight and assurance function on the delivery of the new hospital. The Committee will have oversight of the costing plan and will review and consider any significant changes to this. The Committee will also oversee and approve any value engineering recommendations.
7.	**Frequency and Review of Meetings**
7.1	Committee meetings will be held monthly, commencing in February 2021. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.

Version:	**Date Approved:**	**Approved by:**
Version 1	04/03/2021	FoD Assurance Committee
Version 1	31/03/2021	Trust Board

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 22.3

TERMS OF REFERENCE

Mental Health Legislation Scrutiny Committee

Version 2

1.	**Purpose**
1.1	The purpose of the Mental Health Legislation Scrutiny (MHLS) 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 (MHA), Mental Capacity Act (MCA) and Human Rights Acts and associated codes of practice.
2.	**Membership**
2.1	**Membership** • Two Non-Executive Directors • Chief Operating Officer • Medical Director **Ex-officio Member** • Trust Chair • Chief Executive **In attendance:** • Deputy Director of Nursing • MCA/DOLS Organisational Lead • Quality Assurance Representative • AMHP Lead • Deputy Head of Corporate Governance • Chair of MH Operational Group • S12 Approved Doctor • Head of Health Care Records • Social Care Lead • Chair of the Interagency Monitoring Group (IAMG) • Gloucestershire CCG Representative • Assistant Trust Secretary
2.2	Any Board member may attend and speak at the meeting. They will not count towards the quorum or vote unless acting as a substitute for a committee member.
3.	**Quorum**
3.1	Two members, including at least one Non-Executive Director and one Executive Director.
3.2	Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.

4.	**Reporting Arrangements**
4.1	The minutes of the Mental Health Legislation Scrutiny Committee meetings shall be formally recorded.
4.2	The MHLS Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
5.	**Powers**
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.
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 of reference of the sub-groups.
5.4	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the MHLS Committee.
6	**Responsibilities**
6.1	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 MHA 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 MHA 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 MHA 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 Responsible Clinicians Policy
- Supervised Community Treatment – 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 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 regarding issues associated with the Mental Capacity Act.

p. Receive reports from the Mental Health Operational Group on matters within that group's terms of reference

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 or escalated where appropriate.

r. Raise issues for action and review by the Executive Committee, other Board Committees or partner organisations as appropriate.

7.	**Frequency and Review of Meetings**

7.1	The Committee will usually meet 4 times a year. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Mental Health Legislation 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.
8.2	The Committee will agree an annual plan which will outline the business to be discussed at each meeting. This will include the content and frequency of reports from sub-groups.

Version:	**Date Approved:**	**Approved by:**
Version 1	29 Nov 2019	Board and MHLS Committee
Version 2	20 Jan 2021	MHLS Committee
Version 2	31 March 2021	Trust Board

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 22.4

TERMS OF REFERENCE

Quality Committee

Version 2

1.	**Purpose**
1.1	The purpose of the Quality Committee is to hold the Executive Directors to account for the establishment, maintenance and monitoring of appropriate integrated systems, processes and reporting arrangements for the management of all aspects of clinical governance and associated risk, and to provide onward assurance to the Board on all aspects of the Committee's work.
2.	**Membership**
2.1	**Core Membership:** • 4 Non-Executive Directors • Director of Nursing, Therapies & Quality • Medical Director • Chief Operating Officer **In attendance:** • Deputy Director of Nursing • Deputy Director of Quality and Therapies • Head of Patient Safety • Associate Director of Clinical Governance and Compliance • Associate Director of Quality Assurance and Development • Head of Corporate Governance/Assistant Trust Secretary • Board Committee Secretary • Directors, clinicians and managers for specific agenda items as required • Representative from Gloucestershire CCG • Expert by Experience
2.2	Provided the Chair or Trust Secretary is notified in advance, members of the Committee may nominate a suitably qualified substitute to attend the meeting in their absence
3.	**Quorum**
3.1	Three members including one Non-executive and two Executive Directors. In exceptional circumstances, and with the prior agreement of the Chair, the meeting shall be deemed quorate with at least one Non-Executive member and one of the Executive Director members present, provided that a suitable substitute has been identified for the other Executive Director, in accordance with section 2 of these terms of reference.
4.	**Reporting Arrangements**
4.1	The Quality Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
4.2	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee or the Resources Committee which require consideration by one or both of these committees.

5.	Powers
5.1	The Committee is authorised by the Board to investigate 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 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 of reference of the sub-groups.
5.3	On behalf of the Board, the Committee is authorised to approve local policies, procedures, annual reports and plans that relate to its areas of responsibility.
5.4	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Quality Committee.
6	**Responsibilities**
6.1	<u>General</u> To provide leadership for an open, responsive and documented approach to clinical risk management and clinical governance which actively involves staff at all levels and, where appropriate, service users, carers and the public.
6.2	<u>Patient Safety</u> To seek assurance that the Trust develops, monitors and maintains a Quality Strategy and annual plan that addresses safety, quality and the outcomes experienced by patients and carers and that fulfils and is consistent with the requirements of the CQC. This will include: • Delivering a programme of clinical safety, effectiveness and quality improvement; • Monitoring safeguarding partnership arrangements for both children and adults; • Ensuring the professional regulation of staff and that clinical professional training supports the provision of safe services; • Ensuring that Cost Improvement Plans are accompanied by a Quality Impact Assessment which has been appropriately completed.
6.3	<u>Patient Experience</u> To seek assurance on the standards of care and services provided (and associated outcomes) giving particular attention to risk and the need to treat people equitably, with dignity and respect at all times and, taking into account individual needs, preferences and choices, as appropriate. To seek assurance that feedback from service users, carers and the public about service provision and quality is properly evaluated and responded to.
6.4	<u>Risk</u> To seek assurance that risk management is integrated into decision making at all levels and creates an environment for learning and continuous improvement. This will be achieved through;

	• Monitoring of allocated corporate and strategic risks from the Trust's risk register, ensuring that potential risks at strategic and operational levels are systematically identified, assessed and, as far as is reasonably practicable, mitigated. • Ensuring that responsibilities for the management of Health and Safety at Work and Fire Safety Regulations are effectively discharged.
6.5	Compliance and Regulation To seek assurance that the Trust's services are delivered in accordance with regulatory and other requirements of the DoH, CQC, NHSI and NHS Resolution and that evidence of this is systematically generated, reviewed and catalogued. This will include; • Thematic analysis of, and learning from, incidents, complaints and claims; • Monitoring arrangements for the safe, efficient, ethical and lawful use of information; • Ensuring that there are arrangements for ethical review and research governance which comply with national guidelines.
6.6	Effectiveness Seek assurance regarding the development and implementation of the Trust clinical audit plan and the follow up of audit results ensuring that it is in line with the Trust's strategic objectives and supports the Board Assurance Framework. To seek assurance from the Quality Assurance Group, and other sub-groups, regarding matters defined within their respective terms of reference.
7.	**Frequency and Review of Meetings**
7.1	The Committee will usually meet 6 times a year. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.
7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Quality Committee. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	The Committee will agree an annual plan which will outline the business to be discussed at each meeting. This will include the content and frequency of reports from sub-groups.

Version:	**Date:**	**Approved by:**
Version 1	16/10/19	Approved by Quality Committee
Version 1	28/11/19	Approved by Trust Board
Version 2 (Draft)	07/01/21	Draft received by Quality Committee
Version 2	04/03/21	Approved by Quality Committee
Version 2	31/03/21	Approved by Trust Board

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NHS
Gloucestershire Health and Care
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AGENDA ITEM: 22.5

TERMS OF REFERENCE

Resources Committee

Version 2

1.	**Purpose**
1.1	The Resources Committee will be a crucial part of developing a sustainable, transformative, innovative and forward-looking organisation.
1.2	The Resources Committee will be responsible for making recommendations to the Trust Board in respect of business development opportunities, in addition to major business cases that require capital investment.
1.3	The Resources Committee will ensure relevant Strategies are in place, ensuring the Trust has an appropriate: • Best People Strategy • Finance Strategy • Estates Strategy • Green Plan • Communication and Engagement Strategic Framework • Digital Strategy The Committee will maintain an overview of procedures for and performance in respect of business planning, sustainability, performance, investment and capital expenditure procedures, and transformation. Maintain robust oversight of the implementation of the strategies and where performance or activities are not in line with proposed timescales or budgets, oversee the development and discharge of action plans to ensure improvement.
1.4	Undertake high-level, exception-based monitoring of the delivery of workforce, financial and operating performance to ensure that the Trust is operating in line with its annual plan objectives Business Planning.
2.	**Membership**
2.1	Four Non-Executive Directors, one of whom will be appointed Chair (the Chair may not be the same person as the Chair of the Audit and Assurance Committee) Director of Finance and Director HR & OD (Executive Leads) Chief Operating Officer Director of Strategy & Partnerships **<u>In attendance:</u>** Deputy Director of Finance Associate Director, Business Intelligence Associate Director, Contracts and Planning Deputy COO

	Head of Corporate Governance /Assistant Trust Secretary
2.2	Other Officers of the Trust may attend at the discretion of the Committee Chair. Any other Trust Board Member may attend the meetings and will count towards the quorum.
3.	**Quorum**
3.1	**Four** members, at least two of whom should be Non-Executive Directors and two should be Executive Directors. Where a member is unable to attend a meeting of the Committee, that member may, with the agreement of the Committee Chair, nominate a deputy who will count towards the quorum.
4.	**Reporting Arrangements**
4.1	The Resources Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and issues requiring further consideration or decision by the Board.
4.2	The Committee will highlight any key issues or concerns to the Audit and Assurance Committee or the Quality Committee which require consideration by one or both of these committees.
5.	**Powers**
5.1	The Trust's Standing Orders, Standing Financial Instructions, Scheme of Reservation and Scheme of Delegation shall apply to the Resources Committee.
5.2	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 of reference of the sub groups.
6	**Responsibilities**
6.1	<u>Annual Plan Delivery and Future Development</u> To oversee the Trust's business planning process and agree principles and approach for internal budget setting and the development of directorate business plans, including workforce plans, linked to the Trust's strategic aims. To review the Trust's Annual Plan, including medium and long term plans required by NHS Improvement Gloucestershire System Plans, to confirm that the financial plan supports the Trust's wider strategy; to scrutinise assumptions underpinning the financial modelling and advise the Trust Board accordingly. To take an overview of the Trust's performance against financial and performance objectives ensuring that resources are being appropriately managed to deliver effective and efficient services, receiving advice regarding remedial action being taken as necessary by the Executive Team and ensure regular reports are provided to the Trust Board. Assure that the Trust's Cost Improvement Programme (CIP), CQUIN (Commissioning Quality and Innovation) and QIPP (Quality Innovation, Productivity and Prevention) Schemes are delivering to time, and therefore that all necessary efficiencies are being achieved and reflected within financial reports.

	To monitor key financial ratios against current and strategic plans, particularly those required by NHS Improvement, and agree any appropriate action. To monitor Trust Reference Costs, PLICS and SLR and report any significant implications from variances against national averages or historical trends to the Trust Board. To oversee and consider market share analysis reports and business development opportunities and assess any identified business risks. To confirm that the Trust manages its asset base efficiently and effectively and to confirm capital projects of significant value, whether related to property or other assets, are properly identified, managed and controlled. This definition relates equally to both the acquisition of assets and to their disposal.
6.2	<u>HR and Workforce:</u> To review the Trust's Best People Strategy, its further development and implementation, its links to clinical service and financial strategies and ensure it supports the delivery of efficient and effective healthcare and meets all legislative duties and national targets. To take a strategic view of the Trust's workforce plans to ensure that they are robust and support the delivery of the Trust's financial and clinical objectives. To seek assurance that the Trust's HR Strategy and function is operating effectively, ensuring that it is developing and routinely reviewing appropriate HR performance indicators and benchmarks to report to the Board of Directors. To receive exception performance reports, with due explanation, ensure remedial actions are taken as necessary by the Executive Team and regular reports provided to the Board of Directors. To liaise with the Quality Committee, to co-ordinate HR plans. To oversee HR Policy Development within the Trust, reviewing and approving on behalf of the Trust Board policies and procedures that, under the Trust's Standing Orders, require Board approval and fall within the scope of the Committee's terms of reference, elsewise receive assurance from the appropriate management committee around the implementation of a robust process for the review and approval of relevant policies. To ensure that the Trust has an effective Workforce Communications and Engagement Strategy
6.3	<u>Estates Strategy:</u> To review the Trust's Estates Strategy, its formulation, development and implementation, its links to service and financial strategies and compliance with all legislative duties, system strategies and national targets and thus ensure that the Trust's capital assets are properly and effectively utilised. To seek assurance on behalf of the Board of Directors that the Estates Strategy is linked to the delivery of the Trust's financial and clinical service objectives; that

	there is an up to date asset register linked to service provision; there is effective space utilisation and a robust disposal policy for redundant estate. To seek assurance on behalf of the Board of Directors that the Trust has appropriate strategies relating to the environment and sustainability and policies are effectively implemented and monitored.
6.4	<u>Investment Strategy:</u> To scrutinise business cases for all major capital investments (all material and significant investments) to provide assurance to the Board of Directors that in reaching its decision on the business case it has complied with the independent regulator's requirements and that it has considered any other factors which the Committee feels is relevant to the decision. To approve to progression of ITT stage of strategically significant tenders or tenders requiring the commitment of resources above a limit set in the Trust's Scheme of Delegation. To recommend to the Board of Directors, and, on approval, oversee and regularly review all Trust policies and procedures with respect to investment strategy in line with current NHS guidance and relevant accounting standards to ensure the delivery of agreed financial objectives. To agree principles and approach for substantial or material contracts and be a point of referral in negotiations if required. To agree principles and approach for lease arrangements. To review all business cases to confirm Trust resources are focussed on relevant areas
6.5	<u>Business Development</u> Consider, review and advise the Trust Board, in respect of any proposals for significant new business development opportunities, including tender submissions and bid status, ensuring that these will minimise financial and clinical risk, and increase service effectiveness and efficiency. Undertake a regular review of provider competition and potential business partners in the county and wider health economy and maximise business opportunities. Review the Trust's business development plans and all underlying principles. Review any market analysis undertaken by, or on behalf of, the Trust.
6.6	<u>Governance</u> Ensure that the indicators and outcomes used to evaluate financial and workforce performance are appropriate to enable the Board to monitor the organisation's adherence to its vision, values and strategic objectives. Ensure that all risks as appropriate to the Committee are captured and recorded, and that salient risks are escalated to the Board Assurance Framework: moreover, identify and enact all mitigations as may be relevant.
7.	**Frequency and Review of Meetings**
7.1	The Committee will usually meet 6 times a year. The Chair may agree further meetings if necessary. Virtual meetings, at the discretion of the Committee Chair, may take place using appropriate electronic methods.

7.2	These Terms of Reference will be reviewed annually, with any change recommended to the Trust Board for approval following approval by the Resources Committee. This review will include a self-assessment of the Committee's effectiveness in discharging its responsibilities as set out.
8.	**Administration**
8.1	The Trust Secretary will ensure appropriate support is provided to the Committee.
8.2	The Committee will agree an annual plan which will outline the business to be discussed at each meeting. This will include the content and frequency of reports from sub-groups.

Version:	**Date:**	**Approved by:**
Version 1	24/10/19	Approved by Resource Committee
Version 1	28/11/19	Approved by Trust Board
Version 2 (Draft)	17/12/20	Draft received by Resources Committee
Version 2	25/02/21	Approved by Resources Committee
Version 2	31/03/21	Approved by Trust Board

AGENDA ITEM: 23

MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE SUMMARY REPORT

DATE OF MEETING 20 JANUARY 2021

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

REVIEW OF CQC MONITORING VISITS

The Committee was informed of the positive feedback received following the visit to Willow Ward. Good morale was reported and that the teams were well prepared for the next wave of Covid. Feedback also included patients welcoming being taken out on visits. No actions were required following the visit.

WESSELY REPORT/ UPDATE ON THE MENTAL HEALTH ACT WHITE PAPER

John Campbell, Chief Operating Officer circulated the briefing from NHS providers informing of the publication of reforming the Mental Health Act White Paper. The Committee was informed that there would be a consultation period on the White Paper to 21st April before the legislation then goes through parliament and the House of Lords. A System response would need to be considered.

The Committee was informed of the 4 new guiding principles detailed in the report;

- Choice and autonomy – making sure people's views and choices are respected
- Least restriction – making sure the Act's powers are used in the least restrictive way
- Therapeutic benefit – making sure patients are supported to get better, so they can be discharged from the Act as quickly as possible
- The person as an individual – making sure patients are viewed and treated as rounded individuals.

The Committee was informed of the government's proposal of the introduction of advance choice documents, making care and treatment plans statutory, as well as the introduction of a new framework for patient consent and refusal of medical treatment. It was also bought to the Committees attention the government's plans to replace the current 'nearest relative' role with a new statutory role, known as the 'nominated person'. This person would have additional powers and rights, to be consulted on transfers between hospitals and the power to apply for discharge on the patient's behalf.

The White paper also proposed to change the Act to be clearer that autism or a learning disability were not considered to be 'mental disorders' for the purposes of most powers under the Mental Health Act.

The Committee was informed that a response from the ICS would be agreed at the ICS Board where they would endorse the response from the Trust. Separate responses from the different organisations was also welcomed by the Committee. A Board session would be arranged for early April to consider the consultation in more detail.

REPORT ON CQC MONITORING THE MENTAL HEALTH ACT

The Committee received the report on CQC Monitoring the Mental Health Act informing the Committee of the key findings of the Care Quality Commission's *Monitoring the Mental Health Act* reports for 2018/19 and 2019/20 and their relation to the Trust.

The Committee **noted** the report and the significant assurance that many national findings had not been reflected in local reports and, where they have been, the action taken.

COMMITTEE EFFECTIVENESS REVIEW AND TERMS OF REFERENCE

The Committee discussed where the MHLS Committee should sit and whether it should report to the Quality Committee. John Campbell commented that the Committee needed to provide transformation oversight, as well as assurance oversight. It was agreed that the MHLS Committee would continue but there may be a need to reframe the Committee's purpose and structure. The Committee agreed that this would be discussed further at the NED meeting and the meeting arranged for 5th February with the Committee Chair, the Committee Executive Lead and the Corporate Governance Team.

The Committee **noted** the outcome of the self-assessment and considered how best to take forward the comments received, and suggested areas of focus for 2021/22.

The Committee **reviewed** and **considered** any proposed changes to the Committee's Terms of Reference, noting a final version would be presented to be March Board for approval.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	21 April 2021

AGENDA ITEM: 24

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 11 FEBRUARY 2021

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 following four completed internal Audit Reports.

- Covid-19 Compliance review of non-clinical areas *Classification: medium risk*
- Consultant Job Planning Review: *Classification: High risk*
- Supplier Data Transfer: *Classification: High risk*
- HR Recruitment: *Classification: High Risk*

The Committee discussed the high-risk reports in detail and Amjad Uppal, Medical Director and Neil Savage, Director of HR and OD attended to answer questions relating to the Job Planning and Recruitment audits respectively.

EXTERNAL AUDIT

The Committee received the External Audit Progress Report and Technical update.

The Committee was informed since the last meeting, audit planning meetings with management had taken place. The year-end timetables had been published by NHSI with a deadline for Trust submission of the audited annual report and accounts of 15th June. The timetable of Audit and Assurance Committee meetings to approve the accounts would remain as scheduled.

The Committee was informed the '*going concern'* risk had decreased and updated the Committee that NHSI would be removing from the guidance that the Trust could have material uncertainties, and instead the guidance would be focused on a continuity of service point.

The Committee **noted** the Progress Report and Technical update.

COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee received the Counter Fraud, Bribery and Corruption Progress Report. Lee Sheridan, Head of Gloucestershire NHS Counter Fraud Service highlighted that a Board Satisfaction Survey would be sent to all Board Members regarding their awareness of Counter Fraud.

The Committee received and considered the final report on the review of the usage of Purchase Cards within the Trust. It was noted that this was a proactive review as part of the Counter Fraud 2020-2021 work plan, and requested by the Director or Finance, to provide assurance to the Trust regarding the current arrangements and identify opportunities for improvements. It was noted that whilst the report did highlight system weaknesses, it did show that there was no area of fraud for concern.

The Committee **noted** the final report on Purchase cards and the action plan provided.

COMPLIANCE REPORT

Sandra Betney highlighted the positive progress which had been made on aged creditors/debtors and that the position had further improved since the report was written. It was reported that work was underway with a number of non-NHS outstanding suppliers to understand issues preventing payment.

It was noted that five special payments had been made during the period totalling £3,085. Stephen Andrews assured the Committee the governance around special payments had been checked and procedures was correctly followed.

The Committee was advised that during the period there had been two breaches of SFIs and four items which subsequently breached thresholds after being originally approved. The breaches were detailed within the report, alongside actions required to prevent a reoccurrence. Each breach was discussed by the Committee.

The Committee **noted** the report.

SFIS & SCHEME OF DELEGATION UPDATES

The Committee received the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) updates report proposing a number of amendments which were proposed to either seek to clarify or strengthen certain aspects of the SFIs and SoD.

The Committee **endorsed** the proposed changes to the Standing Financial Instructions and Scheme of Delegation.

The Committee received the notification of Asset Disposal for Cleeve House. The Committee **noted** the loss from the write-off of Cleeve House following the decision to demolish the building; which will result in a loss of £745k.

CORPORATE RISK REGISTER AND BOARD ASSURANCE FRAMEWORK

The Committee received the Corporate Risk register and Board Assurance Framework (BAF).

RISK APPETITE AND POLICY REVIEW

The Committee **approved** the revised Organisational Risk Management Policy subject to sign off by the JNCF.

The Committee **approved** on behalf of the Board the final risk appetite statement which has been updated following discussion at the January Board Seminar.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	**06 MAY 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 25

RESOURCES COMMITTEE SUMMARY REPORT
DATE OF MEETING 25 FEBRUARY 2021

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 10

The Committee noted that the year-end forecast included £3.035m for annual leave provision and was advised that it was expected that part of this annual leave accrual would be funded. Funding was also expected to be received for non-NHS income. The Committee was informed that initial indications from NHSEI were that the Trust would receive £1.1m for non-patient care income, in addition to the annual leave accrual. Confirmation of the value was expected in March.

The Committee **noted** the month 10 position and **approved** the increase to the Forest of Dean capital scheme to £18.4m and the movement of proposed capital disposals of £1.260m from 21/22 to 22/23.

SURPLUS PROPERTY DISPOSALS UPDATE REPORT

The Committee received the Surplus Property Disposals update report which provided the Committee with an update on the current status of the asset disposal strategy for surplus land and property. The update included an outline of the proposed disposal process, recommended procurement route and fee budget for the appointment of a disposals team.

The Committee **noted** the proposed asset disposal strategy and process. The Committee **approved** the appointment of a disposals team and a fee budget, subject to competitive tenders using established public sector frameworks to meet the needs of the Capital Programme.

PERFORMANCE REPORT – MONTH 10

The Committee received the Performance Report for month 10 providing the Committee with a high-level view of key performance indicators (KPIs) in exception across the organisation. The performance period remained aligned to the Trust's operational priority to recover services from the first pandemic wave and also to respond to the current pandemic surge and winter pressures.

The Committee received an update on the Eating Disorder Service, noting that a slight improvement in performance had been seen. Regular meetings were taking place to review improvement actions which could be further taken. The Committee received assurance that the Executive Team would oversee the improvement actions.

The Committee **noted** the aligned Performance Dashboard Report for January 2020/21. The Committee **acknowledged** the impact of the Covid-19 response on operational performance and data quality. The Committee **noted** the report as a **significant level of assurance** that contract and regulatory performance measures were being met or that appropriate service recovery action plans were being developed to address areas requiring improvement - in line with the C19 Recovery Programme.

BUDGET SETTING – 2021/22 CONTROL TOTALS

The Committee received a presentation providing an update on the Budget Setting Process and the Budget Control Totals for the year 21/22. The Trust Board would receive the final budget for sign off at the end of March. The Chair expressed his thanks to Sandra Betney, Stephen Andrews and the wider finance team for the great work that had been carried out in challenging financial times.

2020 STAFF SURVEY - RESULTS

The Committee received the 2020 Staff Survey results summary, noting that the report remained embargoed until 11th March 2021. The significantly improved response rate to the survey of 46.3% was noted. The highest clinical team response rates came from Lydney and Dilke community hospitals. The teams had response rates of 76% (Lydney) and 72% (Dilke). The highest responding corporate teams were the Executive Directorate, and Finance at 86%.

The Committee noted a comparison of theme scores in both 2019 and 2020. Of the ten themes compared; 7 had increased scores, 2 had remained the same and one had reduced. The reduced score was regarding team working. The Committee also received the national report summary, the full national report and the directorate level report for information.

The Committee was assured that there would be a further opportunity to review and discuss the Staff Survey results. The Board would receive the report at its March meeting; however, given the limited time available to drill down into the detail, it was suggested that a separate deep dive session would be organised for Board members to focus solely on the staff survey results.

The Committee agreed that the report contained some very important information and provided an excellent learning opportunity. It was excellent to see an increase in a number of the scoring areas, and response rates, especially as the survey was carried out during Covid.

OTHER ITEMS RECEIVED

- The Committee **received** and **considered** the updated Board Assurance Framework (BAF) and **noted** the information and assurance provided within the Risk Register.
- The Committee received an update on the changes to HR Policies and Procedures, and an update on policy development within the Trust.
- The Committee formally **received**, **noted** and **endorsed** the Working Well Annual Assurance Report
- The Committee **approved** the revised Committee Terms of Reference, for onward presentation to the Trust Board for sign off at its March meeting.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	**29 APRIL 2021**

AGENDA ITEM: 26

QUALITY COMMITTEE SUMMARY REPORT
DATE OF MEETING 4 MARCH 2021

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

CLINICAL PRESENTATION – REDUCING RESTRICTIVE PRACTICE

The Committee received a clinical presentation on Reducing Restrictive Practice. The presentation set out a comparison of the use of prone and supine restraints from April 2016 – January 2021. The data showed that use of supine and prone restraint had varied until Autumn 2018, after which the data showed supine had been used more. The Committee was informed a small working group had been set up to report into the Positive and Safe Group which included matrons, ward managers, AHPs, Psychology, Psychiatry and an Expert by Experience. The overall aim continued to be to reduce the use of restrictive practice (especially physical interventions) across the Trust where safe to do so.

PATIENT SAFETY AND EXPERIENCE REPORT

The Committee received the Patient Safety and Experience Report for January 2021. The report also included information of the number of complaints and concerns received and the Friends and Family Test (FFT) responses, as well as an overview of Medical alerts which had been received.

In January, 957 "no" and "low harm" incidents were reported to the Patient Safety Team and 84 "moderate" and above incidents were reported. Of the 84 moderate and above incidents reported, seven initial investigation meetings were held to gain further information. Five were physical health incidents and two were mental health incidents. Of the seven incidents further investigated, two were declared SIRIs.

The Committee noted there were 65 open complaints (not all of which had been received within the month). Of the 65, 12 were in the process of agreeing investigations with the complainant. 27 complaints were under investigation. Final response letters were being drafted for 25 complaints. 1 complaint was awaiting Executive sign off. 4 complaints had been reopened and 3 complaints were under external review by PHSO. The remaining 6 had been closed.

The Committee **noted:**

- There were 3 SIRIs declared in January 2021.
- There are currently 7 active SIRIs in investigation.
- The PCET received 6 formal complaints in January 2021.
- A total of 1880 FFT responses were received, of these 95% reported a good experience of the Trust's services.

LEARNING FROM DEATHS – QUARTER 3

The Committee received the Learning from Deaths report, informing the Committee of the mortality review process and outcomes for quarter 3. During quarter 3, there were 139 reported

GHC patient deaths. None of the 139 patient deaths were judged to be more likely than not to have been due to problems in the care provided by the Trust. A total of 40 inpatient deaths occurred across all inpatient settings in quarter 3. Of these, 16 met the criteria for national onward reporting to NHS England Covid-19 Patient Notification System (CPNS). The Committee was informed NHS England defined a Covid-19 related death as any death that occurs within 28 days of a patient receiving a positive test result, or Covid-19 being recorded on a patient's Medical Certificate of Cause of Death (MCCD), regardless of a positive test result. It was noted all patients where Covid-19 was recorded at Part I MCCD were suffering with significant comorbidities at the time of their death.

OXEVISION DEVELOPMENTS

The Committee received a presentation on the developments of the use of Oxevision in Mental Health inpatient settings and moving from reactive to proactive care. The Committee was informed how the Oxevision platform would work and what it was capable of. The costs of the platform would be approximately £20k - £30k per year, per ward. It was noted that the break down costs for each ward would prove cost effective. The Committee supported the use of Oxevision and agreed that the benefits outweighed the cost factors. The business case would be presented to the Resources Committee in April for approval.

QUALITY DASHBOARD

The Committee received the Quality Dashboard which updated the Committee on the progress and achievement of the quality priorities and indicators across the Trust's physical health, mental health and learning disability services.

The Committee noted those quality issues for priority development, including the requirement to address Trust wide compliance rates and associated recovery plans for resuscitation and restrictive physical intervention training (PMVA and PBM).

Work continued to deliver a refreshed approach and associated improvement trajectories learning from the successful roll out of the new Trust pressure ulcer improvement approach in Gloucester City and the Forest of Dean services. This was in preparation for the National Wound Care strategy.

The Committee was informed of the good early work achieved in the administrating of Covid-19 vaccinations to eligible vulnerable patients of the Trust and also to staff who had chosen to receive the vaccine. It was acknowledged that the Trust had worked well with GHFT to deliver this.

LIGATURE STRATEGY UPDATE

The Committee received the Inpatient Ligature Reduction Strategy providing the Committee with an update on work to provide a Trust corporate level strategy for the areas of work, both planned and currently being undertaken by the Trust to reduce deaths by ligature across all inpatient units. This was received and noted.

RESUSCITATION TRAINING COMPLIANCE REPORT

The Committee received the Resuscitation Training Compliance report which provided the Committee with oversight on the current resuscitation training compliance figures, the challenges in delivering training and details on the mitigating actions and escalation measures being taken to ensure the Trust could deliver safe and effective resuscitation in line with best practice in all service areas.

The two principle areas for concern (from a quality perspective) were around PMVA restrictive practice training and resuscitation. The Committee was assured recovery plans were in place to address both. A risk still remained within mental health and learning disability inpatient estates, in terms of level three resuscitation training. The Committee was informed this had been escalated and additional rapid recovery plans would be put in to place to mitigate risk and

to recover the situation in the following three months. The Committee **noted** the information supplied within the report and **supported** the proposed recovery plan for training compliance.

OTHER ITEMS RECEIVED

- The Committee **received** and **noted** the Medical Education Annual report.
- The Committee received and considered the updated Board Assurance Framework and Risk Register
- The Committee **noted** the progress made to date and **endorsed** the next steps of the Quality Strategy 2021.
- The Committee **approved** the revised Committee terms of Reference

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	**11 May 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 27

APPOINTMENT AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT
DATE OF MEETING 17 MARCH 2021

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Attendance (membership) – 88.8% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

ANNUAL BOARD DECLARATIONS INCLUDING (FPPT)

The Committee received a paper on the annual cycle of Board Member declarations. The purpose of the paper was to provide assurance to the Committee that the required checks has been undertaken to ensure that the Executive Directors continued to meet the requirements of the Fit and Proper Persons Test. Lavinia Rowsell, Head of Corporate Governance and Trust Secretary confirmed that there were no issues to be brought to the attention of the Committee as a result of the checks.

DRAFT EXECUTIVE REMUNERATION POLICY

The Committee received for consideration a draft remuneration policy for the Trust. The policy aimed to provide a clear framework and ensure transparency with regard to remuneration arrangements for Executive Directors, following good practice and mirroring the national guidelines and directives set out by NHSI regarding Executive Director and VSM remuneration

The report also provided an update on some anticipated developments over the next two years. This included the intention to bring NHS VSM within the remit of the Senior Salaries Review Body (SSRB), the independent pay review body which makes recommendations to government on pay for senior civil servants and public officials, from 2021/22.

The Committee considered and provided feedback on the policy. The Committee **endorsed** the policy for consultation with key stakeholders.

GENDER PAY GAP

The Committee received the Gender Pay Gap Report for 2020 which will be received elsewhere on the board agenda.

The data shared indicated that the 2020 Trust position falls in the middle, between the previously slightly lower pay gap for Gloucestershire Care Services and the higher NHS 2gether gap. It also showed a small widening of the gender pay gap in-year when reviewing the average hourly rate. The Committee considered the report and the actions proposed to reduce the gender pay gap. It was agreed that there needed to be a focus on understanding why, and supporting women to apply for senior roles within the organisation.

The Committee agreed the proposed action plan for addressing the gender pay gap should be discussed with the Trust's Women's' Network before being finalised.

Following careful consideration, the Committee **agreed** to recommend to the Board the publication of the report on the Trust website with a link to the government website. The Committee also agreed that the required statement be published on the Trust website (see Item 20 on the agenda). In addition to the standard wording, it was requested that the statement be strengthened to demonstrate the Trust's commitment to this issue and in order that it resonate more with colleagues.

EXECUTIVE REMUNERATION – BENCH MARKING REPORT

Neil Savage, Director of HR and OD introduced a report confirming current Executive remuneration within the Trust, alongside comparisons with the most recent benchmarking data from NHS Improvement Guidance (2018) and the NHS Providers Remuneration Survey which was published in summer 2020. The report also included a summary from the NHS Providers survey data which captured how the Trust's Executive remuneration compares with national averages.

The findings of the report indicated that Executive remuneration within the Trust was broadly comparable to other NHS organisations. The report also found that from the NHS Providers survey, the Trust's average Executive basic pay and total remuneration fell just below the national average.

The Committee **noted** and debated the benchmarking findings outlined in the report, and**, endorsed** the recommendation to complete the annual review of Executive remuneration later in summer when the annual appraisal and performance reviews were complete, subject to any additionally available NHS Providers benchmarking, and national uplift recommendations or new VSM guidance.

ATOS COMMITTEE TERMS OF REFERENCE

The Committee received and **approved** the revised terms of reference noting minor changes made to ensure consistency with other Board Committee terms.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	**07 July 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 28

FOREST OF DEAN (FoD) ASSURANCE COMMITTEE SUMMARY REPORT
DATE OF MEETING 4 MARCH 2021

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

TERMS OF REFERENCE

The Committee received and endorsed the terms of reference for the FoD Assurance Committee. These would be presented to the March Trust Board for approval.

UPDATE AND BACKGROUND

The Committee received a presentation providing a general update on progress with the different stages of the FoD business case development. This included the strategic, commercial, and economic cases. It was noted that all revenue assumptions were being reviewed, using the 2019/20 financial year as a comparison. Income and workforce assumptions had also been reviewed and these were set out within the presentation.

The Committee reviewed the current funding assumptions which outlined the basis of an £18.4m envelope for the project currently being considered affordable to the Trust. The capital envelope and system limits were also discussed, noting a potential capital shortfall in 2022/23.

The Committee discussed the local approvals that would be required to proceed with the FBC. Internally, the FoD Assurance Committee would have oversight and be assured that FBC costings are complete prior to being presented to the Trust Board. The Board would then approve the capital and revenue affordability of the scheme within the Full Business Case. In terms of the ICS, it was noted that no formal approval was required; however, the business case would be shared for oversight once approved by the Board.

The Committee noted the need for potential regulatory oversight from NHSEI and discussed the reporting thresholds. On the basis of current assumptions on project costs vs total assets, it was possible that this would mean the Trust would be entering a Material transaction. Internal discussions had taken place as to when to instigate initial discussions with NHSEI. If the Trust did require NHSEI approval, it was likely that this would run concurrently with the full planning permission timeline and it was hoped this would not therefore add additional time to the overall scheme.

DESIGN AND CONSTRUCTION UPDATE

The Committee received this presentation which provided a visual of the Pre-Planning Application assumptions for the site and design parameters, and initial layout of the new hospital development.

A number of Site abnormals had been identified and the Committee received a detailed update on progress with addressing these, such as mine workings, storm/water discharge, ecology and highways, specifically relating to the main access road to the new hospital. Given the updated understanding of the abnormals, highways and attenuation requirements, two new designs were currently being considered and the revised provisional costings for these designs were received.

The Committee received the contingency risk register which set out the key financial risks. A value management document had also been developed which compiles ideas to make the scheme more economically efficient. This document targets cost reductions for specific ideas and relates closely to fiscal allowances both within the project cost plan and project risk register (contingency pot).

The Committee received the key proposed milestones associated with the project. The FBC was due to be presented to the Trust Board for approval on 27 May. It was suggested that a further meeting of the Committee take place in mid-May to have the opportunity to receive this in advance of the Board.

DISCUSSION AND SUMMARY

The Chair thanked colleagues for providing such a detailed update, which had given good assurance about the degree of rigor and planning that had been taking place. A number of unforeseen challenges had been identified but it was clear that mitigations were either in place or well considered to manage these. Focus would be placed at the next meeting on the key risks and costs.

The FoD Programme Board Update report and the risk registers also included on the agenda for the meeting were noted. The Programme Update report had been provided to offer the Committee assurance on what was received and monitored at the Programme Board meetings.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	**16 APRIL 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday 29 July 2021

10.00 – 13.30pm

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/0721	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0721	Declarations of interest	Assurance	**Paper**	Chair
10.05	03/0721	Service User Story Presentation	Assurance	Verbal	DoNTQ
10.25	04/0721	Draft Minutes of the meetings held on: • 27 May 2021 • 15 July 2021	Approve	**Paper**	Chair
	05/0721	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0721	Questions from the Public	Assurance	Verbal	Chair
Performance and Patient Experience					
10.40	07/0721	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
11.00	08/0721	Learning from Deaths Q4	Assurance	**Paper**	MD
11.10	09/0721	Performance Report	Assurance	**Paper**	DoF
11.25	10/0721	Finance Report	Assurance	**Paper**	DoF
11.35am - BREAK – 10 Minutes					
Strategic Issues					
11.45	11/0721	Report from the Chair	Assurance	**Paper**	Chair
11.50	12/0721	Report from Chief Executive	Assurance	**Paper**	CEO
12.00	13/0721	Systemwide Update	Assurance	**Paper**	DoSP
12.10	14/0721	Quality Strategy	Approve	**Paper**	DoNTQ
12.25	15/0721	Estates Strategy	Approve	**Paper**	DoSP
12.40	16/0721	Stroud Hospital Refurbishment BC	Approve	**Paper**	DoF/COO
12.50	17/0721	Southgate Moorings BC	Approve	**Paper**	DoF
Governance					
13.00	18/0721	Audit Committee Annual Report	Assurance	**Paper**	HoCG/Audit Cr
13.05	19/0721	Council of Governor Minutes – May	Assurance	**Paper**	HoG

TIME	Agenda Item	Title	Purpose		Presenter
Board Committee Summary Assurance Reports (Reporting by Exception)					
13.10	20/0721	Audit and Assurance Committee (26 May)	Information	**Paper**	Audit Chair
	21/0721	Appointments and Terms of Service (1 June and 16 June)	Information	Verbal	Chair
	22/0721	Charitable Funds Committee (9 June)	Information	**Paper**	CF Chair
	23/0721	Resources Committee (24 June)	Information	**Paper**	Resource Chair
	24/0721	Quality Committee (1 July)	Information	**Paper**	Quality Chair
	25/0721	Mental Health Legislation Scrutiny Committee (21 July)	Information	**Paper**	MHLS Chair
Closing Business					
13.25	26/0521	Any other business • Quality Account Approval	Note	Verbal	Chair
13.30	27/0521	**Date of Next Meetings** **Board Meetings 2021** Thursday 30 September Thursday 25 November **AGM 2021** Wednesday 22 September	Note	Verbal	All

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 04.1/0721

MINUTES OF THE TRUST BOARD MEETING

Thursday, 27 May 2021

Via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Dr. Stephen Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
Steve Brittan, Non-Executive Director
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
John Trevains, Director of Nursing, Therapies and Quality
Dr. Amjad Uppal, Medical Director

IN ATTENDANCE:
Laura Bailey, Trust Governor
Lauren Edwards, Deputy Director of Quality and Therapies
June Hennell, Trust Governor
Bob Lloyd-Smith, Healthwatch
Gill Morgan, Chair, Gloucestershire ICS
Kate Nelmes, Head of Communications
Rachelle Reid, PA to the Chief Executive
Lavinia Rowsell, Head of Governance/Trust Secretary
Hilary Shand, Acting Chief Operating Officer
Sydney Walsh, Strategy and Partnership Team (Mgt Trainee)

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from John Campbell and Helen Goodey.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Laura Canty to the meeting, who was in attendance to speak about her personal experience of post-natal depression and the Perinatal Service, to whom she was referred in 2018.

3.2 During her first pregnancy, Laura was diagnosed with pre-eclampsia at 34 weeks and had an emergency c-section. On returning home following the birth, Laura said that she and her partner went through the “Honeymoon period” and went out for dinner, to food festivals and everything seemed great. However, 2

weeks after the birth Laura said that she started getting more and more obsessed with dirt and cleaning and she started hating the family dog being around the baby. Her environment very quickly reduced to a few chairs, not able to sit on soft furnishings and she felt unable to leave the house. One night Laura decided that she wanted to end her, or her baby's life and that she simply could not be a parent. Family encouraged Laura to see her GP after 4 weeks, and she was very quickly referred to the Crisis Team, and onward to the Perinatal team. At week 12, Laura's consultant referred her to a mother and baby unit. Laura said that there were no spaces in Bristol but she was lucky to get a place at the Barberry Unit in Birmingham. Laura was at the unit for 10 weeks before starting periods of home leave and then ultimately being transferred back to the Perinatal Team in Gloucestershire. Laura worked with Occupational Therapists at the Barberry to have a goal when she started coming home for leave, with the first time to have Sunday lunch with friends.

3.3 Laura said that this had also been especially difficult for her partner; one day he has a fiancé, a new baby and a dog, and the next he's in an empty house alone. This had a real impact on their relationship. However, Laura informed the Board that since she was discharged, happily they got married and had travelled to Australia to see her husband's family. Laura is now a very active Expert by Experience for GHC and sits on the Gloucestershire Perinatal MH Network. She said that this offered her a real opportunity to reach out to other people and to express her views and experiences. Laura had also written a book about her experiences which had been published.

3.4 Steve Alvis thanked Laura for her very impressive and professional presentation. He said that it was pleasing to hear that she received a prompt referral from the GP, but he asked whether there was anything from her experience or from hearing from other people that might improve awareness and timeliness of people picking up this illness at an early stage. Laura said that education was key. She was lucky to have received a GP appointment with someone who recognised the concerns. There were routine GP follow up appointments for new mothers, but she said that these often focused on the baby and left little time to discuss any concerns the mother may have about her own wellbeing.

3.5 Sandra Betney said she was very pleased to hear about Laura's positive experience at the Barberry Unit as she had fought for extra beds to be provided at the unit when working in her previous role in Birmingham. Sandra asked about the handover of care that Laura had experienced when coming back to Gloucestershire services. Laura said that monthly meetings would take place at the unit with her Gloucestershire MH Nurse in attendance to discuss her care and the transition arrangements back to the Perinatal Service. She said that really good communication took place and her transition was seamless.

3.6 Paul Roberts said that there were some communities that did find it more difficult to get access to services or to get diagnosed and asked Laura whether this was something that was discussed by Experts by Experience. Laura said that this was discussed, with agreement that more was needed to reach those communities, such as Army wives and deprived communities. Trish Butler said that it was important to work closely with midwives and health visitors to try and

pick up and identify people from those communities who may need more assistance. However, she said that this outreach was not always possible due to capacity within the services.

3.7 Maria Bond thanked Laura for her presentation and said that there were so many people who could relate to her experiences. Maria said that Laura appeared to have had a good experience of services but asked whether there was anything that didn't go as well. Laura agreed that she had received a fantastic service and a good experience, however, she had heard from others that hadn't been as lucky. One learning point that Laura asked the Board to take on board related to the Crisis Team. She said that this was a great service, but it was always someone different who visited her every day, and therefore no continuity of care which meant that she needed to repeat herself and tell her whole story to a new person every day which wasn't helpful given her condition.

3.8 Marcia Gallagher said that the inclusion of the slides and photographs in Laura's presentation had made such an impact. Given the Trust's links with primary care, Marcia asked if there was an opportunity to share the story with pregnant mums. Laura said that she had presented on a number of occasions but this was mainly to people in training such as midwives and GPs. She had presented on her experiences to a group of expectant mums in the Forest of Dean recently and said that she would be very happy to talk to more people.

3.9 Sumita Hutchison said that there had been some reviews carried out looking at gender equality within the NHS and how women experience the NHS. She noted an earlier point where Laura mentioned that she had requested an appointment with a new GP ("a middle-aged woman who may have had children"), who had successfully picked up her condition and ensured a quick referral. However, thinking about the first GP contact that Laura had received, the Board noted that this had been a young male locum GP. Laura said that he had asked her to give it time and "see how you go". If it hadn't been for very insistent family members Laura would not have sought a second appointment. The Board agreed that there was some very important learning as a system to take on board here.

3.10 Amjad Uppal acknowledged the point raised about the continuity of care by the Crisis Team and assured Laura that he would feed this back to the Team and ensure it was considered. Amjad said that work to improve GP training was ongoing, with particular focus on MH diagnoses. He said that there was sometimes a very fine line between the presentation of women experiencing "baby blues" and those with post-natal depression. In response to this, Amjad Uppal invited Laura to attend and present at a Monday afternoon academic programme for doctors which he felt would be hugely beneficial.

3.11 The Board once again thanked Laura for attending and speaking so openly and professionally about her experiences. Ingrid Barker said that it really did make the Board focus down on those key areas of performance and patient experience, hearing first-hand about the impact and difference that this made to individuals.

4. MINUTES OF THE PREVIOUS MEETING HELD ON 31 MARCH 2021

4.1 The Board received the minutes from the previous meeting held on 31 March 2021. These were accepted as a true and accurate record of the meeting.

4.2 The Board also received a copy of the formal written response to the public question asked at the March Board meeting regarding the Forest of Dean Hospital development.

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action log and noted that all actions were now complete or progressing to plan. There were no further matters arising.

5.2 Ingrid Barker noted that it had been agreed at the previous meeting to present the Gender Pay Gap annual report to the Women's Leadership Network. This would be logged as a formal action. **ACTION**

6. QUESTIONS FROM THE PUBLIC

6.1 The Trust had received no written questions in advance of the Board meeting. No further questions were raised at 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 since the previous meeting of the Board in March. 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 the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

7.2 Following the recent annual committee evaluation process and consideration of the outcomes of an internal audit on governance, the Trust's Committee structure has been reviewed in discussion with Board Members and in the context of the Trust's new 5-year strategic framework. The following changes have been agreed:

- That a dedicated People/Workforce Committee be established
- That oversight of performance reporting remains within the remit of the Resources Committee.
- That the terms of reference for all Committees be reviewed to embed Equality Diversity and Inclusion within each Committee's remit with oversight at Board level.

The terms of reference for the People/Workforce Committee were currently being developed. The resulting governance structure will be reviewed against the aims of the strategic framework to ensure that there is a governance space for all aims with consideration of our work on Better Health and Place, and People Participation. Consideration will also be given to the relationship between the Trust's governance structure and developing plans for changes to the Integrated Care System.

7.3 Ingrid Barker informed that the Board that the Trust had received a letter from the Patron and Chair of the Veterans Covenant Healthcare Alliance (VCHA)

advising that as a result of the hard work undertaken by Jonathan Thomas, Sophie Ayre and Andrew Mills in demonstrating the Trust's commitment to the Armed Forces Covenant, the Trust has received Accreditation as a Veteran Aware Hospital which recognises the Trust's work in identifying and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community. This was an excellent achievement to be recognised in this way and Ingrid Barker joined Board colleagues in recognising and thanking those named colleagues for the work carried out to achieve this.

7.4 The Board noted that the local elections had now taken place and there were some new faces in the county, at the Local Authority and a new Police and Crime Commissioner. Ingrid Barker advised that she had written to those people new in post to welcome them and to provide a brief introduction to GHC.

7.5 The Board noted the content of the Chair's report.

8. CHIEF EXECUTIVE'S REPORT

8.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in March.

8.2 Paul Roberts opened his report by thanking and congratulating the teams at Stroud General Hospital and Cirencester Hospital for successfully passing the JAG assessment for the Stroud Endoscopy services. The JAG accreditation is only awarded to high quality gastrointestinal endoscopy services after a rigorous assessment process. This accreditation is hugely beneficial for our services and highlights the quality of work that these exceptional teams produce. Ingrid Barker informed the Board that she would write to these colleagues on behalf of Board to congratulate them. **ACTION**

8.3 Following our approval at the March Board meeting, our new Trust Strategy was launched for 2021 to 2026. The strategy – called 'Better Care Together' – was developed in partnership with our colleagues, volunteers, people we serve, carers, members, and a wide range of other stakeholders. It is our road map for the next five years and through it we pledge to put people at the heart of our services, focusing on personalised care by asking 'what matters to you?' rather than 'what is the matter with you?'. It describes our Mission and our vision, and it also details our four strategic aims – High Quality Care, Better Health, Great Place to Work and Sustainability – each of which are underpinned by measurable, specific goals and objectives. We will be using this framework to shape the ambitions and priorities of the organisation. Paul Roberts added that it was hoped that the Strategy would start to generate the enthusiasm and excitement again from colleagues across the Trust, looking at innovation and personalisation and looking at being the best we can be.

8.4 The Oliver McGowan Mandatory Training Trial in LD and Autism launched in Gloucestershire on 1st April with over 90 people attending the training on the first day. This training is named after 18-year-old Oliver McGowan, whose tragic death in 2016 highlighted the need for health and social care staff to have better training in learning disabilities and autism. It is part of a national commitment to develop a standardised training package, and GHC was one of four national

partners appointed to co-design and co-deliver the training as part of a national pilot. All the training is fully co-designed and co-delivered with people with a learning disability, autistic people, family carers and people working within learning disability and autism services. This training is now available for all staff within GHC to register with many training dates available throughout the remainder of the year. Paul Roberts advised that ways to ensure that all Board members could participate in training was being considered.

8.5 The Board noted that GHC launched its pilot of the NHS Leadership Academy's Reciprocal Mentoring programme in late November 2019. Since then, a number of colleagues have benefited from the programme and, in particular, from their reciprocal mentoring relationship. Nationally, the Leadership Academy are reinitiating the programme with 34 Trusts across England now participating in the programme. Inevitably, COVID has impacted our ability to make the level of progress at the pace we would have liked. The Leadership Academy paused the programme for much of 2020, while the Trust itself also temporarily paused much of its training and education activity at the same time. After a soft relaunch earlier this year and the most recent session on 19th May 2021, Paul Roberts said that it would be helpful to schedule a discussion with the Board with a view to gaining an explicit recommitment to growing and developing the programme as part of our strategic ambition of being a Great Place to Work. There is now a timely opportunity to recommit and set our future strategic ambition on our approach to reciprocal mentoring. The Board supported this, and it was agreed that a future Board development session could be used to carry out further discussions.

9. ORGANISATIONAL PRIORITIES UPDATE

9.1 The purpose of this report was to remind and update the Board on the short-term priorities adopted in 2019 and 2020, and to recommit to the balanced approach to delivering Trust priorities in 2021/22.

9.2 When Gloucestershire Health and Care NHS Foundation Trust was launched in October 2019 following the merger of 2gether and Gloucestershire Care Services it was impossible to predict the context in which it was to operate for most of the first twenty months of its existence. This context has clearly had significant implications for the pursuit of the priorities and ambitions identified through the merger process and on operational capacity to deliver priorities beyond the Covid response.

9.3 Nevertheless, the Board agreed several short-term priorities in September 2019 and a larger number in 2020 to ensure that an achievable strategic progress was made. In November 2020 the second wave of Covid had a further and arguably more significant impact on the Trust's capacity to deliver its wider ambitions; however, despite this, good progress has been made.

9.4 Paul Roberts said that organisationally the Trust had now moved to something looking more like business as usual. There was still a delicate balance to be had between individual recovery, service recovery and ambitions and this needed to sit behind the detailed objectives.

9.5 Marcia Gallagher said that she welcomed this report and found the format of the report very helpful in clearly setting out the progress made to date. She noted that the agreement of the MH Investment standard had been challenging and asked for an update on what the actual status of this was. Sandra Betney advised that the 2020/21 MHIS programme agreed with the CCG was smaller than in a normal non-Covid year. In 2021/22 the plan was to catch up on priorities and to have a full investment programme, in addition to the MH Recovery fund and Strategic Development fund. There would be really good investment in MH this year. Sandra Betney advised that despite less investment significant progress was made in 2020/21 on areas such as IAPT and Perinatal MH services.

9.6 Ingrid Barker said that it had been really helpful to have clear visibility of where the Trust was and where it is now. There was an appetite from the Board to get on with some of the more ambitious transformation work and the recommendation for the Board to recommit to a balanced approach was therefore supported.

10. REGROUP, RECONNECT, RECOVER

10.1 The purpose of this report was to provide the Board with an overview of the comprehensive approach to recovery across Gloucestershire Health and Care NHS Foundation Trust following the first and second wave of the Covid-19 pandemic.

10.2 Following the undertaking of recovery clinics across all Operational Directorates, recovery plans have been agreed and formalised that take into account the need to regroup, reconnect and recover. This has identified 4 major risk/issues across the organisation that may hinder recovery and impact upon the delivery of patient care. These include Colleague Wellbeing, Demand & Capacity, Workforce and Estates. The Directorates have RAG rated their ability to recover and identified mitigation working collaboratively with partners. Hilary Shand advised that a Recovery Task Force was in place and included both operational and corporate colleagues.

10.3 Sumita Hutchison noted that much as this recovery would take time and asked how the Trust was balancing the time needed for individual recovery against the system pressures to recover. Hilary Shand said that this had been discussed and agreed that there was a fine balance to see how this would all fit together. She said that it would be helpful to receive support from the Board to enable the necessary time to recover. There was a need to enable services to take their time, and a need to pace this work so it was truly effective. However, the balance between looking after our colleagues and being able to provide timely access to services to the people we serve was recognised.

10.4 Maria Bond said that it felt like the Trust had a real grip on the systems and management in place for what was a challenging programme. Maria Bond noted that there was an increased demand for services and asked whether the Trust was providing colleagues with everything that they needed, such as the estate, IT solutions etc, to make life as easy as possible in delivering these services. Hilary Shand advised that one of the key streams of this exercise was to identify things that would help with recovery, including practical help. The

Team was proactively listening and gaining an understanding of the day to day needs of services. It was noted that the process of wider communication to staff to let them know what we were doing had started, but that there was more that needed to be done.

10.5 Maria Bond asked how she as a NED would receive information about waiting times for the different services. Sandra Betney advised that the Trust has established a monthly Health Inequalities and Waiting List Forum to review ethnicity and demographic data across mental and physical health waiting lists, and data on waiting lists was provided regularly to teams. It was planned that waiting list data would be incorporated into the performance dashboard in future once certain data quality issues had been ironed out and this would then be visible regularly to Board members.

10.6 Ingrid Barker expressed her thanks and congratulations to Hilary Shand and Sarah Birmingham for their work and the huge progress made in this area. The involvement of service users and carers in the recovery clinics was also welcomed.

10.7 The Board noted the approach being taken by the Operational Directorate in order to Regroup, Reconnect and Recover, and noted the 4 key areas identified as risk and issues across the organisation.

11. INTEGRATED CARE SYSTEM UPDATE

11.1 This paper provided an overview of a range of activity taking place across the Integrated Care System.

11.2 A Commission has been set up by Gloucester City Council and is headed by local businessman and social entrepreneur Rupert Walters. Running for a year, it aims to identify areas where it can help to improve the lives and opportunities for those who experience racism and disadvantage because of their colour. The Commission members are made up of representatives from both major institutions and from ethnic minority communities within the city and will be tasked with putting together a strategy based on the findings of the Commission. Angela Potter advised that GHC was represented by the Strategy & Partnerships Directorate. The work programme has been now agreed by the Commissioners and will consist of seven focused events that will explore or investigate a particular issue, service, or experiences. The evidence provided will be used to inform recommendations in the Commission's final report, to be shared with the city's key organisations and decision makers. This development was welcomed by the Board.

11.3 It was noted that discussions were underway with regard to a timetable to recommence formal ILP activities within the Forest, but priority work areas had continued where possible. Angela Potter said that it was pleasing to note that a new Chair for the Forest ILP had been nominated, Phillipa Lowe.

11.4 Ingrid Barker said that she welcomed the breadth of coverage within this report. Gill Morgan, Chair of Gloucestershire ICS was in attendance at the meeting and Ingrid Barker invited Gill to provide the Board with an update on current developments and plans moving forward for the ICS. This included an update on the establishment of the new Boards and appointment processes, provider

collaboratives, and key tasks of the ICS come 1 April 2022, which included the safe close down of the CCG. Gill Morgan noted the earlier report received on Regroup, Reconnect and Recover, and said that supporting the whole system to recover was seen as a top priority to ensure that we could start to develop the innovative relationships we see at the heart of the ICS. The Board welcomed this update and thanked Gill Morgan for taking the time to attend and present.

12. SYSTEM OPERATING PLAN 2021/22

12.1 Sandra Betney informed the Board that work was continuing on the system operating plan submission, so it was not possible to provide greater detail at this time. A discussion around the key components of the plan had taken place at the last Resources Committee. Feedback had been received as a system from NHSI, and Regional and internal meetings had taken place in time for the next submission due next week.

12.2 A fuller update would be presented to the Board at the private session meeting later in the day, and it was hoped that we would be in a position to discuss the key implications of the plan at the next Resources Committee in June.

13. FREEDOM TO SPEAK UP REPORT

13.1 The Board welcomed Sonia Pearcey, Freedom to Speak Up Guardian to the meeting. Sonia was in attendance to present this report and 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, and that speaking up processes are in line with national requirements.

13.2 This report for Q3 & Q4 2020-21 provided an update to the Trust Board, including an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

13.3 It was noted that 25 cases were raised in Q3 and 30 in Q4, with a total of 120 cases for 2020-21, an increase of 74% on 2019-20.

13.4 The Board was asked to note that 12 colleagues had reported a detrimental effect from speaking up. Qualitative feedback was actively sought, and a recurring theme raised by colleagues related to speaking up to their line manager and the negative knock-on impact of this on working relationships. Sonia Pearcey advised that a new leadership development programme had been launched and there were some key training and development sessions available for colleagues on Freedom to Speak Up and culture.

13.5 In 2020-21 nurses accounted for the biggest portion (32%) of speaking up cases raised through the Freedom to Speak Up route.

13.6 Sonia Pearcey informed the Board that GHC had been ranked in the Top 20% of NHS Trusts (36 out of 220) in the Freedom to Speak Up index, published annually looking at specific questions arising from the Staff Survey. GHC was also performing above the national average, which was excellent news.

13.7 Sumita Hutchison noted the Board's ambitions to be the best and asked about the KPIs in place for Freedom to Speak Up. With regard to KPIs, it was noted that there were some clear KPIs and the Trust also looked at those measures such as the Friends and Family Test which were gathered with feedback direct from colleagues.

13.8 Sonia Pearcey said that the majority of colleagues did feel confident speaking up and the culture was now embedded in the organisation. There were approximately 40 FTSU Champions/advocates within the Trust.

14. DIGITAL STRATEGY 2021-2026

14.1 The purpose of this report was to present the Board with the Trust Digital strategy for approval. The Digital Strategy is one of the key enabling strategies supporting the overarching Trust strategy.

14.2 The digital strategy presented at the meeting was an evolution of work that had taken place since May 2019. What started life as the digital framework for the merging organisation has subsequently considered feedback from many stakeholders and the consequences of the Covid Pandemic. This has radically impacted on how NHS organisations and patients think about digital and provided opportunities to move forward in many areas such as remote consultations which has been built into the updated strategy. The Trust had also engaged with Experts by Experience and ICS colleagues in developing the strategy.

14.3 The digital strategy has introduced a new digital vision and moved towards a plainer English version removing the technical language that was utilised previously. This alongside the more visual look of the strategy will hopefully support a wider organisational engagement and understanding in the digital strategy and what is trying to be achieved over the next 5 years.

14.4 Marcia Gallagher said that she was delighted to see the strategy at the Board, and the details of the Trust's ambitions. Marcia referred to funding limitations and capital availability and asked for assurance as to how the strategy would be resourced. Sandra Betney advised that in terms of capital, the Trust had a well-resourced plan for infrastructure. There was a need to get better at looking at digital as an enabler and ensuring that large projects were clear at the outset about the benefits and potential cost savings of using digital intervention, such as moving towards paperless working and reduced travel time due to the use of MS Teams for meetings.

14.5 Steve Brittan congratulated Lee Charlton and the wider team for the strategy which had moved a long way since work first commenced. He welcomed the message that this was not simply an IT strategy, it was about changing the way we work as an organisation. He said that he was fully supportive of the work being carried out and the objectives of the strategy going forward.

14.6 In response to a question from Sumita Hutchison, Sandra Betney advised that proposals were being developed to ensure that colleagues could move frictionlessly and seamlessly between Trust sites and other partner organisations and not have to worry about network coverage and access to files. She said that there were 'friction' areas but that workstreams were in place

to address and manage these. Sandra Betney added that there was an active part of the ICS looking specifically at digital inclusion, which included things such as network coverage, access and patient preference.

14.7 The Board agreed that the digital strategy was a very readable and exciting document. It was clear about the aims and objectives, in particular on the benefits for the people we serve such as personalised care, population health management initiatives and work around inequalities. The Board approved the digital strategy and once again thanked colleagues for their huge efforts in producing this.

15. QUALITY DASHBOARD REPORT

15.1 This report provided an overview of the Trust's quality activities for April 2021. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led. The dashboard also contained the Q4 NED Audit of Complaints and Guardian of Safe Working data.

15.2 John Trevains informed the Board that overall the report demonstrated that some fantastic and dynamic work was being carried out and high-quality services were being delivered. The report highlighted those Quality issues for priority development to the Board:

- Continued focus on complaints recovery plan including a redesign of complaint pathway management and delivery of a new internal quality indicator for 21/22 regarding time to completion of complaints. Good progress was being made in managing longer waiters and two new colleagues would be joining the Complaints team in the coming month. It was acknowledged that there were delays, however, feedback from complainants and the recent NED Audit of Complaints demonstrated that the quality of complaint investigations and the handling of complaints was of a high standard.

- Continued NTQ led focus on the prevention, identification and management of Pressure Ulcers building upon the lessons learnt from recent quality improvement work. This now includes targeted support and education into Community Hospitals.

- Appraisal rates have a slow recovery rate and additional work is being undertaken. Ongoing focus on recovery of mandatory training rates with particular attention on resuscitation and restrictive practices. Additional scrutiny of the effectiveness of the planned activity recovery work will be required via Quality governance structures.

- Significant pressures on mental health beds for both children and adults is noted and requiring additional support and management to address. The Director of Nursing, Therapies and Qualities (NTQ) has commenced additional work with Commissioners on this matter.

- Ongoing workforce vacancy pressures are noted with particular attention required for in-patient mental health areas. The Director of Human

Resources & Organisational Development is leading work on the matter. The NTQ team are leading work on international recruitment solutions and this is gaining pace.

15.3 Those Quality issues showing positive improvement:

- CPA recovery work has enabled further progress against the target with a 1.7% increase in month with the overall validated performance figure being 94.1% (0.9% from target).
- Greater understanding and identification of services requiring support with PU management as detailed within the dashboard. Early indicators are positive that this is an improving area
- There is ongoing improvement in staff Covid-19 vaccination rates with good progress made on closing the gap for BAME colleagues (67%)
- 149 compliments received regarding care provided by the Trust in April – above monthly average
- International Recruitment: 25 new physical health nursing colleagues are in the process of joining the Trust. 3 new mental health nursing colleagues are joining with additional recruitment underway in this area. The Trust has received additional funding to be part of a national project to develop direct entry into community services for international recruits.

15.4 John Trevains informed the Board that work was taking place with the Business Intelligence Team and future Quality Dashboards would include data around high-risk waiters to enable the necessary scrutiny and oversight of this important area.

15.5 The Board welcomed this report, noting the developments underway and the good level of assurance provided.

16. PATIENT SAFETY REPORT – QUARTER 4

16.1 The Board received the Patient Safety Report for the period January to March 2021 which provided high level information with regard to patient safety incidents reported through the Trust's Datix Incident Reporting System. The report provided a summary of mental health and physical health Patient Safety Incidents reported during Quarter 4 2020/21, a summary of the prevalence of patient safety incidents by categories including level of investigation and provision of data for Mental Health and Learning Disability Hospitals, Physical Health Community Hospitals, MIIUs and community teams for mental health and physical health by quarter, demonstrating change.

16.2 The Board was asked to note that the Patient Safety Team aim to review 10% of the No and Low Harm Patient Safety Incidents. This has not always been achieved, particularly in Q2 due to redeployment of some of the team due to Covid-19. However, significant progress has been achieved during Q3 and Q4. In Q4 a total of 373 low and no harm incidents were reviewed (12.2%).

16.3 Amjad Uppal informed the Board that there had been 5 Mental Health and 1 Physical Health SIRIs reported during Q4 and a high-level summary of these incidents was presented.

16.4 Marcia Gallagher said that she welcomed the new format of the patient safety report. However, as a Non-Executive Director she said that she struggled to understand the direction of travel for patient safety. Referring to the prevalence of falls at Stroud hospital for example, she said that it would be helpful to include comparisons to be able to assess whether the position was deteriorating or improving. The Board agreed that it would be helpful to include trends within the report, as well as improved triangulation of data, and contextualisation such as the inclusion of bed numbers. **ACTION**

17. PERFORMANCE DASHBOARD

17.1 Sandra Betney presented the Performance Dashboard to the Board for the period April 2021 (Month 1 2021/22). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation. In opening the report, Sandra Betney encouraged Board members to focus on the Business Intelligence Team update included within the report, which set out the key infrastructure developments taking place over the coming months, which offered good assurance.

17.2 At the end of April, there were 8 mental health key performance thresholds and 13 physical health key performance thresholds that were not met. It was noted that all of these indicators had been in exception previously within the last 12 months.

17.3 In mental health services, it was noted that Eating Disorder (ED) Services accounted for three indicators and two are within Children and Young Person Services (CYPS). The ED service continues to face major performance challenges due to a high number of referrals and high vacancy rate. The perinatal exception is similarly due to a higher referral rate, staff sickness and the eased induction of new staff. Recovery is however expected within the month through bank staffing support. The Board was assured that the Executive Team continued to closely monitor and review the service challenges, and a further focus on Eating Disorders would be provided to the Resources Committee.

17.4 There were 4 workforce performance indicators in exception this month that apply across the Trust. A manually produced visualisation presenting additional workforce activity indicators has been prototyped, however further tactical conversations need to be held in developing this presentation with data source owners to ensure reader value. Additionally, further data metrics such as Pulse survey results, annual leave consumption and agency usage needs to be incorporated. An early working draft is to be presented to Resources Committee in June 2021.

17.5 The Board was asked to note that there were additional indicators outside of threshold but are either within normal, expected variation, have a legacy ‘proxy’ threshold, are formally suspended or have a confirmed data quality issue that is administrative only and is being resolved. These had not been highlighted for exception. A briefing paper outlining a proposal to manage ‘proxy’ indicators for 2021/22 is in final draft and would be presented at the next Resources Committee in June 2021.

18. PROVIDER LICENCE DECLARATIONS

18.1 In order to comply with NHSE/I regulatory requirements, the Board is required to make a number of declarations each year regarding compliance with the Trust's provider licence and the systems and processes for ensuring such compliance. The Board also needs to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance. The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

18.2 The Board's declarations must be made having regard to the views of Governors. Lavinia Rowsell advised that the appendices to this Board report were provided to the Governors at their Council meeting on 12 May. The Governors noted the report and no concerns were raised in respect of the systems and processes for compliance with licence conditions.

18.3 The Board received this report and supported the recommendations to:

a) Have regard to feedback received from Governors in respect of these declarations
b) Agree to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.
c) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration.
d) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended
e) Agree to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

19. CHANGE TO THE TRUST CONSTITUTION

19.1 As part of the recent Governors Review and Refresh work, the Council of Governors and the Trust Board supported the proposals around changes to the composition of the Council, in particular with regard to the reduction in Staff Governor positions. The revised composition and subsequent change to the constitution was approved at the November Council of Governor and Trust Board meetings.

19.2 The Medical, Dental and Nursing staff constituency reduced from 4 posts to 3 and this took effect from 1 January 2021. There is a provision within our constitution which states that of the 3 seats within the Medical, Dental & Nursing staff class – 1 must be reserved for a nurse, 1 for a doctor and 1 for a doctor or dentist. This specific provision about reserved seats was not updated at the time to accurately reflect the revised composition and meant that the Trust could only ever have 1 nurse representative on the Council. A small amendment to the constitution was therefore suggested, to ensure that one of the 3 seats was open to all staff within that constituency to apply.

19.3 The Board approved the revision to the Constitution and noted that the equivalent paper to this one had also been considered and approved by the Council of Governors at its meeting on 12 May 2021.

20. USE OF THE TRUST SEAL – QUARTERS 3&4 2020/21

20.1 The purpose of this report was to provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders.

20.2 The Board noted that the Trust seal had been used 4 times during the reporting period October 2020 – 31 March 2021 (Q3 & Q4 2020/21).

21. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING – MARCH 2021

21.1 The Board received and noted the minutes from the Council of Governors meeting held on 10 March 2021.

22. BOARD COMMITTEE SUMMARY REPORTS

22.1 Forest of Dean Assurance Committee

The Board received and noted the summary report from the FoD Assurance Committee meeting held on 16 April 2021.

22.2 Mental Health Legislation Scrutiny Committee

The Board received and noted the summary report from the MHLS Committee meeting held on 21 April 2021.

The Board was asked to endorse the reappointment of MHA Manager Ivars Reynolds until 31st March 2024. It was noted that the reappointment was made via the normal reappointment process of completion of self-assessment forms and two peer review forms, followed by a personal development review with Steve Alvis, Non-Executive Director. This endorsement was given.

22.3 Resources Committee

The Board received and noted the summary report from the Resources Committee meeting held on 29 April 2021.

22.4 Audit and Assurance Committee

The Board received and noted the summary report from the Audit and Assurance Committee meeting held on 6 May 2021.

22.5 Quality Committee

The Board received and noted the summary report from the Quality Committee meeting held on 11 May 2021.

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 Thursday 29 July 2021.

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: 4.2

MINUTES OF THE EXTRAORDINARY TRUST BOARD SESSION

Thursday 15 July 2021

Via Microsoft Teams

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

IN ATTENDANCE:
Anna Hilditch, Assistant Trust Secretary
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
Kate Nelmes, Head of Communications
Margaret Dalziel, Acting Deputy Chief Operating Officer
Matt Blackman, Communications Manager
Andrew Paterson, Strategic Project Manager
Kevin Adams, Associate Director of Estates, Facilities and Medical Eqmt
Sally Clark, Executive PA to Director of Strategy and Partnerships
Chris Witham, Lead Governor
John and Mary Thurston, Friends of Lydney Hospital
Ken Brown, Forest Locality Reference Group
Caroline Smith, Gloucestershire CCG
Ellen Rule, Gloucestershire CCG
Cllr Terry Hale, Forest of Dean District Councillor
Albert Weager, Chair, Forest Health Forum
Bob Lloyd-Smith, Gloucestershire Healthwatch
Chris Brown, CEO, Forest Voluntary Action Forum

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to this extraordinary meeting of the Trust Board. Apologies for the meeting had been received from Helen Goodey and Hilary Shand.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. QUESTIONS FROM THE PUBLIC

3.1 The Board was asked to note that four questions had been received in advance of the meeting. Ingrid Barker asked that these questions, and the Trust's response to them be read out in full and included within the minutes of the meeting.

QUESTION 1 - Albert Weager, Chair, Forest Health Forum (received 12th July)

My concerns are about ventilation adequacy. I am told plans incorporate existing regulations. My question is, are these up to standard having regard to COVID-19 and its transmission capability.

The Trust has employed Mechanical and Electrical consultants to support the design of the ventilation system at the proposed new hospital. This work will be completed with full consideration of ventilation requirements in light of Covid -19 with input from our Trust infection control specialists.

The detailed design work is currently being undertaken and will reflect latest guidance and best practice in infection prevention and control to ensure that the Air Handling Units are capable of providing the appropriate level of filtration and air exchanges at all times. The relevant national guidance, Health Technical Memorandum – HTM 03 parts a and b, was updated last week so we will be taking account of the latest national standards and learning from Covid-19.

The level of ventilation and air exchange requirements differ for individual parts of the hospital and the system will take full account of this. So for example – in our new endoscopy unit we will need to provide at least 10 air exchanges per hour and for it to be run under negative pressure system whilst the ward areas will have a slightly different level with at least 6 air changes per hour and negative pressure is not required.

Additionally, the Trust, through its Infection Prevention and Control development work is linking in with a national project at Leeds University on Covid ventilation studies and air handling to ensure we are using the best evidence and date guidance for our proposed new hospital

QUESTION 2 - Brian Pearman (received 13th July)

Regarding the Cinderford site I understand that there have been issues re GCC Highways traffic and water run off/potential flooding from the EA. The topography of the site has resulted in a move from a single storey building with all its benefits to a double storey building. Planning permission may not be as straightforward to justify your high level of confidence. Why was this site approved, including transfer of Dockham Rd health centre, relocating the skate park, and re-providing the MUGA, when it meant such a compromise to the design of the building. A site could have been provided free of charge in Lydney, already allocated in the Local Plan for employment, easy access from the A48 bypass and access to all major services.

The previous engagement work committed to taking forward the development of an independent Citizen Jury process to determine the location of the new hospital within the Forest. The recommendation from the Jury was for that the hospital should be located in Cinderford. This decision was accepted by the former GCS Trust Board and the Clinical Commissioning Group in August 2018.

At this point, although we were aware that there were potential sites in other parts of the Forest (and indeed 3 potential sites had been identified in Lydney) the option appraisal for sites was focused on those in Cinderford in line with the decisions made.

We undertook a detailed option appraisal to compare this site to any others available at the time in Cinderford and have provided details of the criteria used in this process in Table 5 in the Full Business Case itself. We believe that the selected site was (and remains) the best available site in the Cinderford area when considered against the key criteria specified by the Jury.

When entering into the land transaction we undertook a process of 'desk top' due diligence – looking at the recorded site information, as would be normal for any property purchase. This has subsequently been followed up by further invasive site investigations once we owned the site so we now understand in detail things such as the pre-existing mineworking and have been able to have dialogue with organisations such as Severn Trent Water who have advised on their expectations regarding water attenuation and drainage requirements to deal with the topography of the site and with the Highways agency regarding new access routes to the site.

These discussions could not have happened at the earlier stages of the process as we did not have all of the information regarding the size of the new hospital or the technical information obtained from our site investigation work. This process would have been the same for any site that we purchased. We also recognise that any site in the Forest of Dean could have presented similar or different challenges as is typical in any development of this size and scale.

Whilst there are benefits of a single storey option (including reduced circulation space from the removal of stairwells and lifts) in some ways this can result in longer distances between departments and also results in the need for central courtyards to allow natural light into rooms. With less internal rooms and a more compact design the two storey option provides a more effective solution in this regard.

With regard to planning permission we of course take nothing for granted. We have however appointed a planning consultant to support this element of the work and have worked closely with the planning authority to seek their views and understand the pre-requisites to any application.

In terms of the broader transfer of Dockham Rd health centre, relocation of the skate park, and upgrading of the MUGA, these were conditions applied to the site by stakeholders including Sports England and Cinderford Town Council which we were happy to support as public sector partners. We believe that each, in time, will add value to the community. The MUGA will be available year-round, the skate park will be in a more central location in Cinderford and benefit from lighting and the town council can utilise the Dockham Road premises to create a town centre green zone.

It also seems that compared to earlier anecdotal estimates of the cost of the new hospital the real cost has risen significantly.

There has been a considerable passage of time since the early estimates were undertaken and the current costings have been based on market rates, soft market testing and quotations and quantity surveyor judgement. Construction costs have risen dramatically over recent years for both materials and labour and building inflation has been driven by both Brexit and Covid. The costs in this business case reflect the latest market position and any scheme taken forward would be subject to the same market conditions.

What is estimated to be the value of the current Lydney and Dilke sites on the open market, and will any sums raised remain in the Forest or go into the County pot?

The Net Book Value (NBV) of the two existing hospital sites is £4.4m. The cash proceeds will be determined on sale and it is likely to be lower, although this depends on the market at the point of sale. The sale proceeds, currently estimated at £1.5m, contribute to the Trust's cash which funds the capital programme including the costs of the new hospital in full. Under current NHS guidance we are allocated a Capital Delegated Expenditure limit (CDEL) and the amount of cash we can spend has to be matched with a CDEL allocation.

In terms of Net Zero Carbon targets no account has been taken of the patient miles that will be required to access the hospital from Lydney and the Southern Forest where the bulk of the population increase is taking place. Apparently ignored by the Citizens Jury!

We did not do a total travel or sustainability estimate for all journeys as we do not have access to all the data necessary. We do recognise that for some, the new hospital will result in an increased travel distance whilst for others there may be a reduction in travel and benefits from increased reliability and service sustainability will hopefully also reduce journeys to services outside of the Forest. This would be the case for where-ever we placed the new hospital. We have appointed a transport consultant – Cotswold Transport Planning to work with us on developing our Travel Plan which whilst initially focuses on staff will also consider the sustainability and travel impact to the public.

The new hospital itself will deliver significant carbon reductions based on the modern heating and ventilation system.

On a general note I am concerned that the Lydney Hospital will close to facility the opening of the Cinderford building before any improvements take place to Primary Care in the town which is already under severe stress, and with a population likely to increase to approximately 16,000 in the next few years.

GHC has maintained a commitment that the current range of services provided at Lydney Hospital will continue until they transfer to the new community hospital, this remains the Trust's intention. Services delivered at the current health centre and in other locations will remain in Lydney until any new primary care facility is developed.

The CCG is working with primary care partners to take forward the development of improved primary care facilities and is currently starting to scope out a business case. We will be a key partner to this development for the re-provision of the services that we provide within the health centre currently. Whilst this is still in the early procurement stages and a definitive timetable is not yet know we anticipate a new centre may open in 2025. Up to that point all existing health centre, and all its current community services run by GHC will continue to operate once the new hospital has opened.

In the interim, should new services be agreed or pilots put in place such as a minor injury service run by primary care then accommodation will need to be considered as part of establishing the pilot

QUESTION 3 - Sylvia Francis, West Dean Parish Council (Received 14th July)

Will there be any eye clinics based at the new hospital as this is quite important for the older generations in the Forest of Dean community?

Gloucestershire Hospitals NHS Foundation Trust currently provide ophthalmology activity in the existing hospitals and we have therefore planned on the basis that this will continue to be provided in the new facility. In light of all the changes to delivery models for outpatient activity and some services taking forward more virtual activity we will be confirming with GHT the exact service provision closer to the opening of the new facility.

QUESTION 4 – John Thurston (Received 14th July)

1 (a) There will be a gap in the service provision before the new hospital opens

(b) currently despite many rumours and consultations there are no concrete plans for either the service to be provided let alone the site or plans to build or people to run the necessary facilities in a new south Forest Medical Facility. There is an estimated date of 2025, which even if everything goes to plan is a gap of at least a year or two.

In absence of any other deliverable solution, we request that services continue to be provided from the existing (excluding inpatients) facilities at Lydney Hospital.

GHC has maintained a commitment that the current range of services provided at Lydney Hospital will continue until they transfer to the new community hospital, this remains the Trust's intention. Services delivered at the current health centre and in other locations will remain in Lydney until any new primary care facility is developed.

The Trust's business case is focused on the building of the new hospital and its case for change continues to demonstrate that a range of workforce and resilience benefits are achieved by continuing to develop the new hospital. It also assumes that disposal proceeds from the existing sites are required to support the capital programme which funds the new hospital. As such, it is not possible for the Trust to make the requested commitment.

The CCG is working with primary care partners to take forward the development of improved primary care facilities and is currently starting to scope out a business case. We will be a key partner to this development for the re-provision of the services that we provide within the health centre currently. Whilst this is still in the early procurement stages and a definitive timetable is not yet known, as you mentioned we anticipate this new centre may open in 2025. Up to that point all existing health centre services, and all the current community services run by GHC from that facility will continue to operate once the new hospital has opened.

In the interim, should new services be agreed or pilots put in place such as a minor injury service run by primary care then accommodation will need to be considered as part of establishing the pilot

2 (a) As the relative costs between the options have changed was the initial decision still optimal?

The decision to move to a single hospital site was not solely based on costs, it included a range of other issues in the case for change as follows;

- *More consistent, reliable and sustainable community hospital services eg. staffing levels, opening hours*
- *A wide range of community hospital services, including beds, accommodation to support outpatient services and urgent care services*
- *Significantly improved facilities and space for patients and staff*
- *Services and teams work more closely together*
- *Better working conditions for staff and greater opportunities for training and development to recruit and retain the best health and care professionals in the FoD.*

The full range of these benefits cannot be achieved from working across both existing sites and any refurbishment we took forward would still result in a sub-optimal solution against many of the criteria identified. As such, we maintain that the single site solution remains the optimal way forward to best meet the case for change objectives identified.

It should also be noted that the costing figures referred to are not comparable. Building inflation and changes to the construction market have had a significant impact on the costs within the

business case and the other figures have not been refreshed and are therefore not at today's prices.

(b) should a more cost-effective site be found to suit the new local demographics?

The previous engagement work committed to taking forward the development of an independent Citizen Jury process to determine the location of the new hospital within the Forest. The recommendation from the Jury was for that the hospital should be located in Cinderford. This decision was accepted by the former GCS Trust Board and the Clinical Commissioning Group in August 2018.

We undertook a detailed option appraisal to compare this site to all others available at the time in Cinderford and have provided details of the criteria used in this process in Table 5 in the Full Business Case itself. We believe that the selected site was (and remains) the best available site in the Cinderford area when considered against the key criteria specified by the Jury.

(c) Notable that the reduction in annual premises cost is only £100k

Further clarification on this question would be sought from the questioner in order to provide a response.

3.2 The Board noted that a further question had been received shortly before the meeting from Cllr Jeremy Charlton Wright. Due to timescales, it had not been possible to consider a response to this in advance of the meeting. However, assurance was given that a full formal response to all the questions received for this meeting would be provided in due course.

3.3 Ingrid Barker thanked those people who had submitted questions, and those in attendance at the meeting for their interest and engagement throughout.

4. FOREST OF DEAN HOSPITAL FULL BUSINESS CASE

4.1 Paul Roberts introduced this item by once again welcoming those people who had joined the meeting today and thanking them for their contributions in helping to shape the thinking about the future of health services in the Forest of Dean.

4.2 The new Hospital represented a major investment in healthcare infrastructure which was much needed in the Forest of Dean. It was recognised that there had been some contention about the developments, but since the key decision made some time ago to build one new hospital to replace the two existing sites in the Forest, Paul Roberts said that he felt that this business case set out a workable and affordable scheme that would be of huge benefit to the local population. He said that this was an exciting and overdue investment.

4.3 Paul Roberts advised that as a community trust, GHC did provide hospital services, but it was important to note that the emphasis was increasingly on the services that we provide for people in or close to their own homes.

4.4 Paul Roberts provided assurance that the whole development process had received robust scrutiny and challenge throughout, from partner organisations, key stakeholders, and Trust colleagues. A dedicated FoD Assurance Committee was established to oversee the development of the Business Case and had ensured that strong governance processes were in place.

4.5 Steve Brittan, Chair of the FoD Assurance Committee advised that due to the strategic importance of this development, it was agreed that sufficient time needed to be given to

review, scrutinise and challenge the proposals being put forward. The FoD Assurance Committee was set up 5-6 months ago and has drilled down into the detail of the design, site and highways considerations, risks to budget and value for money. The Trust through this committee had worked collaboratively with partners and appointed contractors to get to the final business case position.

4.6 Angela Potter presented the full Business Case to the Board. She started by thanking colleagues for the huge amount of work, time and effort that had been carried out to get to this final position, work which had been taking place over a number of years.

4.7 The Full Business Case (FBC) seeks approval for Gloucestershire Health & Care (GHC) NHS Foundation Trust to invest £23.9m in the development of a new community hospital to serve the people in the Forest of Dean. The scheme is funded from Trust's capital programme which is funded through cash reserves and the disposal proceeds of the Dilke and Lydney Hospital sites. This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest and beyond.

4.8 Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital when the new hospital opens in 2023.

4.9 The new hospital is considered a key part of the wider system investment proposed in the Forest of Dean to address primary and community infrastructure needs. This investment will ensure that the Forest of Dean services support the delivery of place-based integrated care as part of the One Gloucestershire Integrated Care System's (ICS) plans.

4.10 This FBC is developed in line with the 5-case model as per HM Treasury guidance and includes the following sections:

Section 1 - The Strategic Case sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme. The Case for Change remains consistent with that outlined within the Outline Business Case which was previously approved by Gloucestershire Care Services NHS Trust Board and builds on the extensive engagement and consultation processes that have taken place in relation to this programme. Five strategic investment objectives have been identified as part of this FBC.

Section 2 – The Economic Case demonstrates that the preferred option and associated investment meets the future needs of the service and demonstrates value for money (VFM) from the investment made. A Comprehensive Investment Appraisal (CIA) model has been completed which has confirmed that a cost to benefit ratio of 4.08 has been demonstrated confirming that the preferred option offers good value for money when compared with the business as usual option.

Section 3 - The Commercial Case demonstrates that we have taken a considered and viable approach to the procurement of our construction partner, Speller Metcalfe which was completed utilising the Gloucestershire County Council (GCC) procurement framework. We have worked collectively to develop a detailed schedule of accommodation and associated design that has undergone rigorous confirm and challenge and been the subject of soft market testing for pricing and cost packages. This has led to the development of the not to be exceeded price (NTBEP) for the construction elements of the costings at £16.5m excluding VAT with the overall value of the FBC at £23.9m including VAT. A clear schedule of works is in place to move this to a Guaranteed

Maximum Price (GMP) by November 2021 and there is an agreed construction contract structure to be entered into at this point.

Section 4 – The Financial Case confirms the Trust has the necessary funding arrangements to take forward this business case and support its five-year capital plan which includes the Forest of Dean new community hospital. Revenue affordability has been modelled and confirmed as affordable and we have confirmed that approval of this FBC will not have a negative impact on the overall financial standing of the Trust.

Section 5 – The Management Case demonstrates that the Trust has the appropriate governance arrangements in place to deliver the new hospital to time, quality and budget through the oversight of the Programme Board and the Forest of Dean Assurance Committee.

4.11 Angela Potter advised that the FBC demonstrates that the preferred option being taken forward from the OBC delivers a viable and affordable solution to meeting the requirements laid out in the case for change. The Trust has been presented a NTBEP price from its construction partner, Speller Metcalfe and we have confirmed that these costs are affordable from a capital and revenue perspective. The economic modelling demonstrates that the scheme offers good VFM when compared to business as usual. It is recognised that the business case is a multi-year scheme and that future year's capital envelopes are only released on an annual basis therefore we do not know the 22/23 or 23/24 position at this point in time. We have confirmed the associated phasing expenditure within our FBC and can confirm that the anticipated cost plan is within the available cash but that future capital envelopes will continue to pose a potential risk to the Trust.

4.12 The FBC was therefore commended to the Trust Board for approval to enable the progression of developing a new community hospital in the Forest of Dean. Following Trust Board approval this FBC will be shared with the ICS Board for wider consideration and support.

4.13 The Board noted that the Trust had reviewed the final costings for the scheme against the NHSEI approval thresholds contained within the Capital regime, investment and property business case approval guidance for NHS and FT providers. The scheme falls above the threshold for a material transaction and therefore we will continue dialogue with NHSEI colleagues as to next steps within their processes.

4.14 Ingrid Barker thanked Angela Potter on behalf of the Board for preparing and presenting this report and opened it up for Board questions before moving to consider the recommendations.

4.15 Graham Russell asked for top line assurance about the affordability of the project. Sandra Betney advised that extensive cash modelling had been carried out regularly. Assurance was received that the Trust would still have a capital buffer after the agreed expenditure for the forest hospital which could be used for maintenance and unexpected requirements.

4.16 Marcia Gallagher asked about access to the new hospital and asked for an outline of the work that had taken place to consider transport arrangements. Angela Potter said that the Trust had been working with the CCG on linking with local bus companies and looking at extensions to current bus routes and timetables. The new hospital would have a bus stop located adjacent to the site. Car parking facilities, electric vehicle charging points and secure cycle sheds had also been built into the plans. Cotswold Transport Planning had been commissioned to look at a travel plan, and the Trust would also be working with Forest voluntary driver schemes. Angela Potter acknowledged that transport was one of

the biggest concerns for Forest residents. She added that the Trust would continue to lobby transport providers.

4.17 Steve Alvis made reference to the benefits of having more staff located on one site, such as better facilities, interaction, clinical governance arrangements and resilience of care. Angela Potter added that a Clinical skills lab would be built as part of the hospital design which would mean that staff could carry out their training on site. Neil Savage said that colleagues had been involved throughout the design process and had been consulted with regard facilities, rest areas etc.

4.18 Sumita Hutchison referred to environmental sustainability and asked how the Trust could ensure that it was taking on board all national guidance. Angela Potter said that the Trust worked closely with its construction partner who had strong expertise in this area and would continue to undertake energy modelling and ensure that the design incorporated aspects such as solar panels and sustainable construction materials which would all work towards the Trust's net zero carbon targets.

4.19 Maria Bond referred to pricing and said that it was good to see a contingency built in of £800k. She asked whether this was a general contingency or if it was for something specific. It was noted that some of this would be used in case of any planning adjustments or additional works by Severn Trent.

4.20 Maria Bond noted that the hospital was now planned to be a 2 storey building, having moved away from the original single storey design. She asked whether the Trust had carried out any dialogue with the planners since this change had been made and whether there had been any issues raised. Angela Potter advised that the Trust had employed a planning consultant and that there continued to be dialogue with the local planners and no areas of significant concern had yet been raised. The current plans had also been shared with local residents and no negative feedback had been received. Angela Potter informed the Board that further stakeholder engagement would be carried out on the actual design of the hospital, and feedback received from previous engagement events would be taken into account.

4.21 Jan Marriott noted that community hospitals were still highly valued in Gloucestershire, and she asked that consideration be given around how the Trust could ensure that the "soul" of the 2 existing sites could be retained.

4.22 Steve Brittan asked how the business case had evaluated the benefit to the local community. Sandra Betney said that the Economic Case had been prudent and had not included the wider societal benefits. However, it was noted that the new hospital development would be using the local labour market including apprentices, local materials, and the local supply chain.

4.23 Graham Russell noted that the design incorporated single rooms with ensuite facilities and asked for the rationale behind this. John Trevains advised that most new hospital builds were moving in this direction rather than having "bays" as there was increased patient safety, dignity and patient flow, as well as improved infection control measures. It was noted that patients also often preferred single rooms.

4.24 Marcia Gallagher referred to the disposal of the Dilke and Lydney Hospitals, noting that the net book value was £4.4m. She asked about the feasibility of selling these sites and whether there was any concern about timing. Angela Potter said that the Trust was working with local stakeholders to try and understand local aspirations for future use. Discussions would continue.

4.25 The Board received and considered the recommendations set out in the report, and fully supported the following to:

- **Approve** the Full Business Case (FBC) for the development of a new community hospital in the Forest of Dean at a value of £23.9m and the confirmation that this is affordable in both capital and revenue terms.
- **Confirm** that this decision will result in the closure and relocation of services from the existing Dilke Hospital in Cinderford and the Lydney and District Hospital in Lydney when the new hospital opens in 2023.
- **Approve** the next phase of design development and the commitment of the associated expenditure in order to progress the detailed design and planning application through a Pre-Construction Services Agreements (PCSA) with our construction partner Speller Metcalfe at a value of c£925k + VAT.
- **Note** that scheme falls above the threshold for a material transaction and dialogue with NHSEI and ICS colleagues will continue as to appropriate next steps
- **Note** that the process to complete and submit the full planning application process will be taken forward on approval of this FBC

4.26 Ingrid Barker expressed her thanks again to colleagues for the huge amount of work and time that had been spent carefully considering and developing this business case. This decision marked a significant milestone to developing a fantastic new facility for the people of the Forest of Dean. The Trust would continue to work closely with stakeholders moving forwards to further develop specific plans, designs and service provision.

5. FOREST OF DEAN ASSURANCE COMMITTEE SUMMARY

5.1 The Board received and noted the summary report from the Forest of Dean Assurance Committee which had taken place on 23 June.

6. ANY OTHER BUSINESS

6.1 There was no other business.

7. DATE OF NEXT MEETING

7.1 The next meeting would take place on Thursday 29 July 2021.

Signed: …….. **Dated: ……**

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

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 29 July 2021

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
27 May 2021	5.2	Gender Pay Gap annual report to be presented at the Women's Leadership Network	Sandra Betney	29 July	Complete	
	8.2	Ingrid Barker to write thanking and congratulating the teams at Stroud General Hospital and Cirencester Hospital for successfully passing the JAG assessment for the Stroud Endoscopy services.	Ingrid Barker	29 July	Complete	
	16.4	Future Patient Safety Reports to include trends, as well as improved triangulation of data, and contextualisation such as the inclusion of bed numbers.	Amjad Uppal	September	Q1 Patient Safety report to reflect additional information when presented to the Board in September	

AGENDA ITEM: 07/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD – June 2021 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 GHC Board members 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

Board members are asked to:

- **Receive, note** and **discuss** the June 2021 Quality Dashboard

Executive summary

This report provides an overview of the Trust's quality activities for June 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forum for assurance.

Quality issues for priority development

- Significant pressures on adult mental health beds persist, a task and finish group led by NTQ has been established to deliver opportunities.
- RMN recruitment at Wotton Lawn Hospital remains a significant service challenge and further work is being delivered to address this issue in partnership with Operations and Human Resources Directorates
- There were 4 post-48-hour Clostridium Difficile (C.diff) cases reported in June which is an increase on the figure last month. Regionally and nationally the numbers of C.diff cases are increasing. It is likely that this is associated with increased antibiotic use during Covid-19. Further work is being undertaken by IPC to understand in greater detail and this work will be reported upon when results are available.

- CPA compliance slightly decreased compared to the previous month's figure of 92.4%. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and are setting up weekly schedules with early warnings for reviews that are due.

Quality issues showing positive improvement

- The 2 remaining 12 months plus complaints were finalised, reflecting the complex nature of the complaints and the reach over a number of teams, including a legacy complaint from Hereford.
- The Pressure Ulcer (PU) indicators are showing that there have been fewer skin integrity incidents and reduced numbers of pressure ulcers that were considered as avoidable under our care as numbers reduced by 25 between May and June. The number of PU's in category 1&2 has decreased by 1, however, the numbers in Category 3 have increased by 6 with Category 4 reducing by 1. Further detail relating to occurrences is detailed within the dashboard. Early indicators are positive that this is an improving area and that initiatives taken to reduce PU's are effective.
- 'Embedded learning' workshops have now commenced within clinical environments and have been welcomed by front line colleagues. This is a key milestone in our journey to becoming a learning organisation.
- There is ongoing improvement in staff Covid-19 vaccination rates with good progress within the 1stnd dosage of vaccinations for Clinical staff being 82% and 72.8% for 2nd dosage.
- The sickness rolling average indicator was maintained under threshold of 4% this month.
- International Recruitment: In total 30 new physical health nursing colleagues are in the process of joining the Trust. 9 have arrived in the UK and 7 have passed their OSCE to date. New mental health nursing colleagues are joining with additional recruitment underway in this area in July. The Trust has received additional funding to be one of 6 national pilot sites with NHSE and the Queens Nursing Institute to support direct entry into community services for international recruits. The Trust Quality Team are leading this initiative.

Are Our Services Caring?

Board will note that 11 complaints were received in June which is the same as the previous month. Actions associated with the complaint's recovery plan continue with the number of complaints open for 10-12 + months reducing again this month. The 2 remaining 12 months plus complaints were finalised in month, these cases were very complex and involved a number of different teams, with one case relating to services in Hereford. This month 100% of complaints received in June 2021 were acknowledged within the 3-day target timeframe, thus returning this indicator to the desired 100% threshold. This month FFT levels of satisfaction remain below the 95% threshold but maintain their 2% points increase made in year to stay at 94% thus matching the 20/21 outturn and are improved on the 2019/20 outturn.

Are Our Services Safe?

Board are asked to note that incident reporting rates have reduced this month by 115 incidents and the percentage of patient safety incidents meeting moderate, severe and death thresholds decreased to 7.66% providing assurance that there was a marginal uplift in data last month rather than an increasing trend line, this will be kept under review.

Are Our Services Effective?

Board are asked to note that we have agreed Trust Quality Priorities for 2021/22 and these are now presented in the dashboard. Good progress continues to be made towards achieving the set targets within the National Childhood Measurement Programme which is on target to conclude at the end of the academic year. The Child and Adolescent Mental Health Services have completed a small-scale evaluation of the waiting list and have plans to implement a 'Waiting List Support Clinic'. This will be in addition to the triage service and the signposting already in situ to support demand.

Are Our Services Responsive?

Good assurance is available regarding adherence to national PHE admission guidance in order to minimise the risk of nosocomial transmission, whilst supporting an increased demand for Community Hospital beds. In line with system partners and an easing of national lockdown requirements our inpatient units continue to enable increased visiting and plans are in place to re-open MIIU at the Vale next month.

Are Our Services Well – Led

Overall statutory and mandatory training compliance has dropped marginally this month to 88.3%. Restrictive Physical Intervention training continues to be an area of focus and is showing gains month on month this financial year. Appraisal training has shown a small increase this month and risen to 76.2% with sickness rolling 12-month rate being under the 4% threshold for the 2nd month running. There is continued focus on staff health and wellbeing with July being "Be Kind to Yourself month". This month we present the latest Guardian of Safe Working report (GOSW) to provide assurance and an evidence-based report in relation to the working hours and practices of junior doctors within the Trust.

Risks associated with meeting the Trust's values

Specific initiatives or targets that are not being achieved are highlighted in the Dashboard. Key quality and safety risks are included 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?
Quality Assurance Group and bi-monthly reports to Quality Committee

Appendices:	

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

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

Quality Dashboard 2021/22

Physical Health, Mental Health and Learning Disability Services

Data covering June 2021

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

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 2021/22 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

Are our services CARING?

Eleven complaints were received in June, the same as the previous month and comparable to year on year data. The number of complaints open for 10-12 months continues to reduce in line with the recovery work and temporary reallocation of resources. The 2 remaining 12 month plus complaints were finalised in month, these cases were complex and involved a number of different teams, with one case relating to services in Hereford. At time of writing there are no 12 month plus complaints waiting 100% of complaints received in June 2021 were acknowledged within the 3-day target timeframe, thus returning this indicator to the expected 100% threshold. This month's FFT levels of satisfaction were still below the 95% threshold but maintain their 2% points increase made in year to stay at 94% thus matching the 20/21 outturn and improved on the 2019/20 outturn.

Are our services SAFE?

The number of incidents reported this month has decreased on the previous month. The percentage of patient safety incidents meeting moderate, severe and death thresholds has also decreased to 7.68%. There are currently 7 active SIRIs. Enhanced detail is provided again this month regarding ongoing developments to improve pressure ulcer management and there are continuing indicators of improvement in this area. We are pleased to report that zero C-19 deaths were reported by GHC inpatient services during June. There were no new cases of C-19 detected in GHC in June . As of 30/06/21, 82% of patient facing GHC staff have received their first vaccination for C-19 and 72.8% have received their second. Systems remain in place to vaccinate all eligible inpatients and vulnerable service users. We are reporting 4 Clostridium Difficile cases in June and Health Care Acquired Infections (HCAI) reporting has replaced the historical safety thermometer data in the dashboard. HCAI's are being monitored through our Trust Infection Prevention Control Team (IPC) and reported into Quality Assurance Group for executive oversight.

Are our services EFFECTIVE?

This dashboard includes the new report for the 201/22 quality priorities. In 20/21 Trusts were not required to agree with commissioners quality priorities. whilst this requirement has not returned for 21/22, alongside the absence of CQUIN's, NTQ have set a range of priority indicators to support ongoing quality improvement and assurance in the Trust for the wellbeing of the patients we care for. Indicators and measures are being developed in Q1 &2 with services to report performance in Q's 3&4. Early Intervention and IAPT services continue to perform above threshold. The National Childhood Measurement Programme has recommenced and good progress is now seen towards achieving targets of 95% of children measured by the end of the academic year - Cumulative target (July 2021). The occupied bed days for "inappropriate" out of area Mental Health placements in June has increased to 200 days which relates to 10 patients. There has been a significant surge in demand for inpatient beds in month with increased levels of acuity and dependency observed amongst inpatients which has has resulted in a shortage of bed availability, this is reflected regionally and nationally. We are working with voluntary community partners to facilitate enhanced discharge support and a task and finish group with associated action plans to improve Adult Mental Health admission and discharge pathways is underway led by the Director of NTQ. GHC maintains a vital role in system-wide patient flow and work continues through reablement, community hospital, MIIU's and ICT's to support the wider physical health system. The Child and Adolescent Mental Health Services have completed a small scale evaluation of the waiting list and have plans to implement a 'Waiting List Support Clinic'. This will be in addition to the triage service and the signposting already in situ to support demand.

Are our services RESPONSIVE?

Good assurance remans in place demonstrating adherence to national IPC admission guidance in order to minimise the risk of nosocomial transmission with zero reported in June, set against the challenges of increased demand for Community Hospital beds. Following agreement at the Health Overview and Scrutiny Committee Tewkesbury MIIU reopened on the 1st April 2021 and it is planned that the Vale MIIU will re-open on mid August 2021 with Dilke remaining closed . CPA compliance slightly decreased compared to the previous month's figure of 92.4%. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases, with a focus on scheduling reviews and ensuring the clinical systems are updated to reflect activity and improve data quality. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and setting weekly schedules with early warnings for reviews that are due. In line with system partners and an easing of national lockdown requirements our inpatient units have enabled increased visiting, recognising the importance of human contact to patients whilst maintaining appropriate measures to keep everyone safe. The quality team is supporting operational colleagues regarding access pressures in services , as reported through resources committee.

Are our services WELL LED?

Overall statutory and mandatory training compliance has marginally declined this month to 88.3%. Due to C-19 disruption, Resuscitation and Restrictive Physical Intervention training continues to be an area of focus. There is monthly exception reporting in place for recovering training compliance. The focus on Physical Intervention training shows continued improvement month on month and the focus going forward will be on the areas with lower compliance and ensuring the improvements achieved are maintained. Appraisal compliance has increased again this month to 76.2% against a target of 90%. There is continued emphasis on appraisal completion over the coming months, including the re-introduction of appraisal training. Sickness absence levels have maintained their green RAG rating as they have remained at 3.9%. Staff health and wellbeing remains a priority. There is an informative portal in the staff intranet and this July is featured as, " Be Kind to Yourself Month". There are many activities for staff to engage with which are being delivered by virtual methods which included: On line cookery demonstration, Pilates, Yoga, Horticulture ,Mindfulness, Spiritual Care, Menopause issues, Diversity and Fitness taster sessions. Registered Nurse international recruitment continues with a total of 31 RGN's being appointed and 11 have now arrived in the UK. Further interviews for mental health nurses will take place in July. This month the latest Guardians of Safe working (GOSW) report statistics have been included that show there were 4 exceptions in period reported upon . This report 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.

Quality Priorities – 2021-2022 – (1)

Despite no national or local commissioning requirements for formal Trust quality priorities set within the Trust quality schedule for this year (due to national Covid-19 disruption impacts) we have agreed with our Trust Board to set the following 9 GHC Quality Priorities. This is to facilitate an ongoing focus on quality for the organisation to improve care for the people we seek to serve in Gloucestershire. Since the last update to Trust Board there has been further development of the quality priorities following on from the quality seminar and reflects work that was undertaken in quarter 1. In quarter 2 further work will develop and agree a range of metrics/thresholds using baseline assessments in order to inform our progress over quarter 3 & 4 (H1 & H2 are the reporting cycles for NHSE/I)

	NHSE/I Reporting Period	H1		H2	
	Quality Priority - GHC Reporting Period	Q1	Q2	Q3	Q4
1	Pressure ulcers (PUs) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PUs. Developing a PU collaborative within the One Gloucestershire Integrated Care System.		Develop and agree metrics and/or threshold from baseline assessments	% Improvement on PU 1-4	% Improvement on PU 1-4
2	Falls prevention – with a focus on reduction in medium to high harm falls based on 2020/21 data. Developing a falls collaborative within the One Gloucestershire Integrated Care System.		Develop and agree metrics and/or threshold from baseline assessments	% Reduction on medium to high falls	% Reduction on medium to high falls
3	End of Life Care (EoLC) – with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county. This will support the 6 ambitions for Palliative and End of Life Care. This will include improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advance care planning and the ReSPECT V3 form, and increasing symptom management training for staff to support non-cancer patients.		Develop and agree metrics and/or threshold from baseline assessments	% Improved fidelity to EoLC Pathway	% Improved fidelity to EoLC Pathway
4	Patient and Carer Experience – with a focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services. Improvement in completion times will be achieved quarter on quarter.		Develop and agree metrics and/or threshold from baseline assessments	% Reduction in PCET response rates & resolution times	% Reduction in PCET response rates & resolution times
5	Friends and Family Test (FFT) – with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Adult Community Mental Health Survey action plan.		Develop and agree metrics and/or threshold from baseline assessments	Develop FFT additional questions - quality of care	Increase our CQC Adult Community Mental Health Survey score

Quality Priorities – 2021-2022 – (2)

Continued from previous page.

	NHSE/I Reporting Period	H1		H2	
	Quality Priority - GHC Reporting Period	Q1	Q2	Q3	Q4
6	Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero Suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022.		Outline and agree workplan with the Southwest Partnership which will also look at AWOL etc	Staged implementation NHSE/I mandated Zero Suicide Plan for inpatient MH servies	Finalise 6 stategies of implementation and review patient safety data
7	Learning disabilities – with a focus on the Hospital/Personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and Tier 2 training programme. The Trust aims to train 90% of our workforce (circa 5000 people).		Develop and agree metrics and/or threshold from baseline assessments	Tier 1 uptake improvement circa 50%	Tier 1 uptake improvement circa 90%
8	Children's services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care. Fidelity to the care pathways will be evaluated through participation in the NCEPOD study.		Develop and agree metrics and/or threshold from baseline assessments	Engage NCEPOD Study	NCEPOD Study result
9	Embedding learning following patient safety incidents – with a focus on sharing and learning from experiences and investigations to develop and improve standards of care. This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons learned bulletins issued. Alongside Implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period.		Develop and agree metrics and/or threshold from baseline assessments	5 completed embedded learning events	8 completed embedded learning events

Quality Dashboard

NHS
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	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A	Exception Report?	Benchmarking Report
No of C-19 Inpatient Deaths reported to CPNS		N-R		66	0	0	0										0			N/A
Total number of deaths reported as C-19 related.		L-R		161	0	0	0										0			N/A
No of Patients tested at least once		N-R		2004	281	298	306										885			N/A
No of Patients tested C-19 positive or were admitted already positive		N-R		322	0	0	0										2			N/A
No of Patients discharged from hospital post C-19		N-R		271	9	0	0										10			N/A
Community onset (positive specimen <2 days after admission to the Trust)		N-R		30	0	0	0										0			N/A
Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)		N-R		6	0	0	0										0			N/A
Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)		N-R		10	0	0	0										0			N/A
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust		N-R		27	0	0	0										0			N/A
No of staff and household contacts tested		N-R		3123	65	76	342										485			N/A
No of staff/household contacts with confirmed C-19		L-R		323	0	0	28										28			N/A
No of staff self-isolating: new episodes in month		L-R			34	40	153													N/A
No of staff returning to work during month		L-R			29	30	100													N/A
No staff GHC who received Covid-19 vaccine first dose				4046	17	8	8										33			

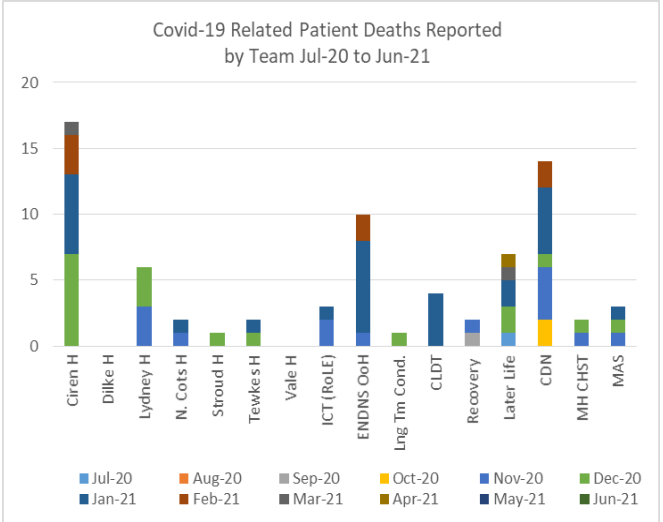
Additional Information

Patient Reporting

The number of Covid-19 (C-19) related inpatient deaths remains at zero for the third consecutive month with zero inpatient deaths meeting criteria for national reporting to CPNS being reported in April - June 2021. The number of community patient deaths reported as C-19 related also continues as zero. C-19 related patient deaths since July 2020 by team/hospital site are shown in the chart opposite, previous year data being included for comparison. One Gloucestershire NHS partners have agreed to declare a countywide serious incident for HOPHA and HODHA Covid-19 cases in our hospitals in response to NHSE/I guidance. The GHC Executive Sponsors for this are Amjad Uppal and John Trevains, a core project team has been established, HOPHA and HODHA Covid-19 cases at the Trust have been identified and the level of harm as a result of acquiring Covid-19 is being established for each case. Once levels of harm are known our Duty of Candour responsibilities will be better understood and the Trust's next steps can be planned for.

Staff Testing

The number of staff and household contacts tested increased by 266 in June however the associated number for staff and household contacts testing positive only increased by 28 . There was similar increases in the number of of new episodes of staff self isolation which were increased by 113 and numbers of isolating staff returning increased by 70 cases in June compared to the previous month .



COVID-19 - KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

- June data - 82 % “frontline” workforce received first vaccine; with 72.8% having received their second.
- 68% BAME colleagues received first vaccine and 61% received their second as at 30/06/2021 .
- Vaccine uptake data is monitored weekly and submitted to NHSE/I every 14 days
- Workstream in place led by Working Well to enhance uptake that includes staff conversations to compassionately address vaccine hesitancy
- Proactive and targeted communication in place with intention to reinforce the importance second dosages in case of a 3rd wave and Variants of concern .
- Pop up clinics remain in place to support enhanced access for staff
- Systems remain in place to vaccinate all eligible inpatients and vulnerable service users.
- Total ‘active’ bank staff is 857 – 350 of them have had their 1st jab (41%) and 302 their 2nd (35%). However, not all 857 will have worked even if they are ‘active’ and many will have had their vaccinations elsewhere, which has not fed through to reporting system

Validated Data as of 30-6-2021

ROLE	TOTAL NUMBER June 2021	1ST VACCINE (up to 30/06/21)	%	2nd VACCINE (up to 30/06/21)	%
All doctors/dentists	128	111	87	97	75.8
All qualified nurses, including students	1467	1205	82	1063	72.5
All other professional qualified staff	775	651	84	597	77.0
Support to clinical staff	1755	1413	81	1245	70.9
TOTAL GHC CLINICAL STAFF	**4125**	3380	82	3002	72.8
NHS infrastructure staff	482	354	73	298	61.8
TOTAL GHC WORKFORCE	4607	3734	81	3300	71.6

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

Personal Protective Equipment (PPE) and home testing

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 Trust continues to maintain 14 days supply of all key PPE items at central stores and are maintaining 14 days of supplies at each PPE locality hub.

The Local Resilience Forum (LRF) has now been brought in to the Trust's PPE stores and distribution processes.

Transparent masks

Following confirmation from NHSEI that there are currently no transparent masks with sufficient assurance on suitability for health and care settings available, GHC have completed a risk assessment which has directed us to use transparent masks but with additional guidance for colleagues on the considerations that they should have when determining if to use transparent masks. This is currently drafted as an action card and will be shared with NTQ senior leads for comment.

Lateral flow (Asymptomatic testing)

There has been a decision at a national level to move the provision of lateral flow kits to an 'individual pull' model. This means that colleagues will request their own lateral flow kits (7 tests at a time) to be delivered to their own home, collect from a test centre or a pharmacy. They will report these results via the national reporting tool. GHC will be provided with the number of test kits reported (as a total) and the number of tests reported (including results). The risks are that the process of ordering could result in reduced use of lateral flow. The Trust will also lose its oversight of the reporting process which will reduce the need for the weekly SITREP (stock team and incident team as backup) and reduced need for processes of receipt, storage and distribution of kits (stock team) but as yet, we don't know when or how the data from national submissions will be provided to GHC. There are currently 725 boxes of lateral flow in stock and we plan to utilise all of these (plus ensure that stocks that have been provided to teams but not yet provided to individuals) before moving to the individual pull model and gain learning from other Trusts through the Asymptomatic Testing Cell (regional).

FFP3 fit-testing

GHC Fit test compliance is now at 91%. The fit tester/co-ordinator has been recruited and commences her post in early August with bank fit test resource being available until end of July. The Trust have received a letter from the Department for Health outlining steps to be taken (below). Although this letter was directed to Acute Trusts, GHC will work towards delivering these steps. This will, at an operational level be co-ordinated by the Fit tester/co-ordinator within the stock team with a proposal on the governance arrangements to be described in a ' GHC Fit Test Strategy' to be shared with John Trevains by the end of July for comment, discussion and eventual endorsement.

1. Identify an FFP3 resilience lead/champion within the trust and develop an implementation plan
2. If not already doing so, start using ESR to record all fit testing outcome and usage data at an individual level. This should include all historical data and be updated with any new changes.
3. Increase the number of masks an individual is fit tested too and ensure the different masks are available to the user to wear interchangeably
4. Implement and support a fit testing solution to enable to above principles to be achieved for all existing staff and new staff who will be users of FFP3s.
5. Monitor progress against the above principles

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

No		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
	Number of Friends and Family Test Responses Received	N - T		11990	1786	1490	1562										4838			
	% of respondents indicating a positive experience of our services	N - R	95%	94%	92%	94%	94%										93%			
	Number of Compliments	L - R		1478	149	123	129										401			
	Number of Concerns	L - R		390	41	34	37										112			
	Concerns escalated to a formal complaint			14	1	3	4										8			
	Number of Complaints	N - R		83	11	11	11										33			
	Number of open complaints (not all opened within month)				76	79	82													
	Percentage of complaints acknowledged within 3 working days		100%	96%	73%	91%	100%										88%			
	Number agreeing investigation issues with complainant				15	17	13													
	Number of complaints awaiting investigation				4	0	2													
	Number of complaints under investigation				10	15	21													
	Number of Final Response Letters being drafted				44	43	45													
	Number of Final Response Letters awaiting final check before Exec sign-off				3	1	1													
	Number of complaints closed				7	9	8										24			
	Number of re-opened complaints (not all opened within month)				5	6	6													
	Current external reviews				4	4	4													

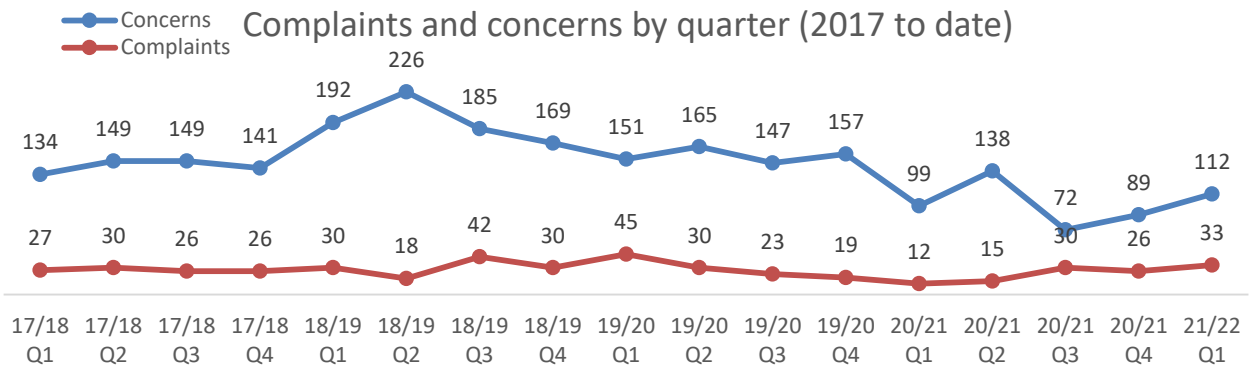
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure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

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

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

Complaints, concerns and compliments

- The average number of complaints received in June over the past four years is **8**. In June 2021 we received **11 complaints**.
- In June 2021, **8** complaints were closed: **1** was withdrawn, **1** was upheld, **3** were partly upheld, and **3** were not upheld
- **37** concerns were raised in June 2021, which is slightly more than the monthly average of 32 concerns during 2020/21.
- **129** compliments were received in June 2021, which very slightly more than the monthly average of 123 during 2020/21.



This chart summarises the number of complaints and concerns received by quarter since 2017/18. This offers assurance that services are not receiving a significant increase in complaints in 2021/22. The impact of Covid-19 (national pause, redeployment, services in recovery), PCET staffing challenges, and a cluster of complaints received in November and December 2020, have all contributed to the current increase in complaint response times.

Assurance regarding complaint management

- Each complaint is triaged to check for any immediate actions required. Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- The Non-Executive Director Audit of complaints for quarter 1 2021/22 will be undertaken in July 2021.

Satisfaction with complaints/concern processes

- **6** active re-opened complaints
- **36** concerns were closed in June 2021, **4** of which were escalated to a complaint

External review

- There are currently **4** complaints with the PHSO for external review.
- PHSO reviewed a complaint from 2019 and devised an action plan for the Trust to complete. All actions have now been completed, including an action related to carers assessments. Trust wide learning was shared June 2021's Patient Safety Report.

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

Timeframes

- PCET remains in active recovery following the national pause in the complaint management process between April and June 2020.
- **100%** of the 11 complaints received in June 2021 were acknowledged within the 3-day target timeframe.

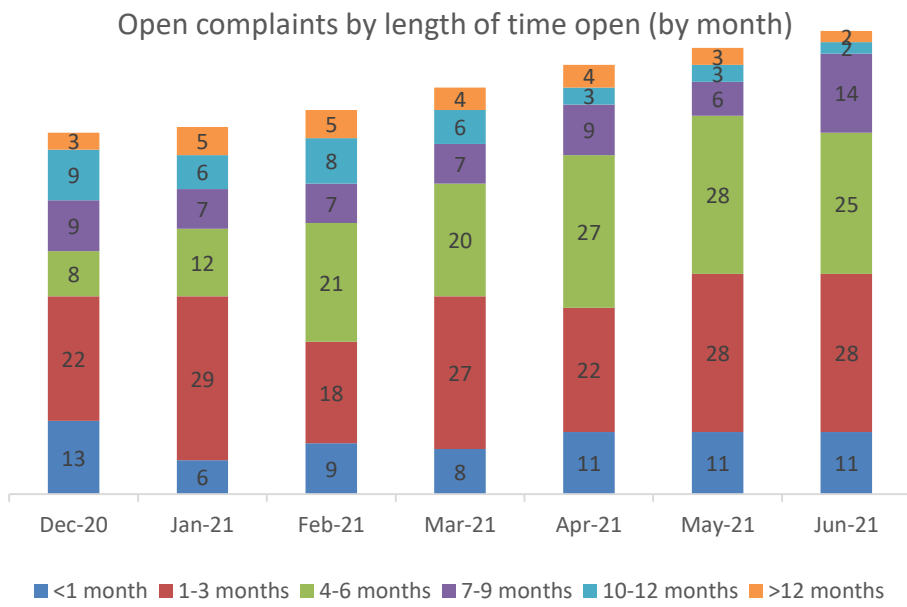
- Of the **82** open complaints, **9** do not have agreed response times. Of these:
  - **5** are in the very early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set
  - **4** are complaints being managed by other NHS organisations, for which we are providing input/comments.

- Of the **73** complaints with agreed response dates:
  - **27** are within the agreed timeframe
  - **46** have exceeded the initially agreed timeframes, and of these:
    - **2** responses were due during the national pause
    - **44** responses were due following the end of the pause – there are a range of reasons for these delays including:
      - Agreeing issues for investigation with complainants
      - Delays in the investigation process (e.g. allocating investigators, timeliness of investigation report, and availability of staff for interviews)
      - Delays in the drafting and review of final responses (e.g. capacity, quality of investigation, availability of staff to review draft responses)
    - Work is underway to address delays in the complaints process in order to minimise them where possible

The chart opposite shows the timeframes for all open complaints, inclusive of the 3 month national pause (please note that it can take up to approx. 8 weeks to agree issues with complainants depending on complexity and availability). The PCET are focusing efforts on completing responses for those open for the longest period. A weekly meeting provides high-level oversight of the complaints tracker. Fortnightly updates to the Director of NTQ are in place and regular briefings to the Board and Quality Committee provide assurance of recovery.

Additional resource has been secured via redeployed colleagues and 2 existing members of the team have agreed to temporarily increase their working hours. Additional investment has resulted in recent recruitment to 2 additional substantive posts, and one fixed term 12-month contract. to support complaint response times. 1 of these new post commenced duties in June 2021, second appointment anticipated in August 2021.

Further support has been supplied by senior NTQ colleagues to assist with final response letter completion and to increase triangulation with patient safety and Freedom to Speak Up learning.



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

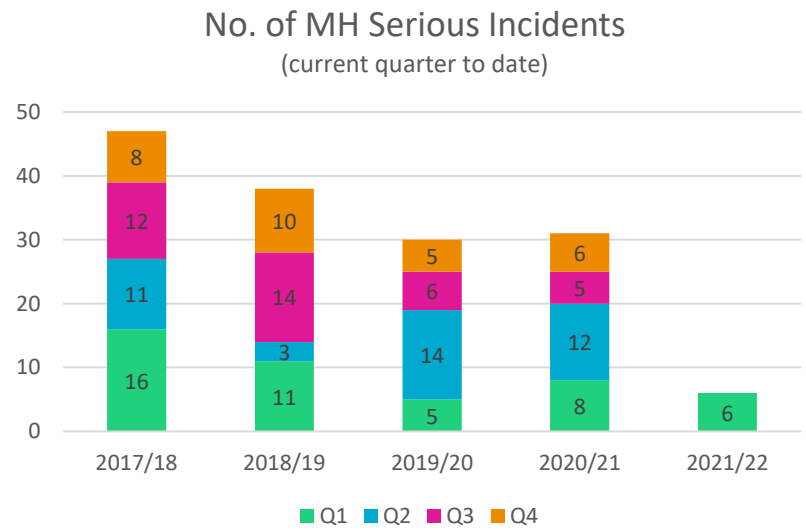
		Reporting Level	Threshold	20-21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021-22 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	0	0	0	0										0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	4	3	1										8			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		1	1	1	0										2			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		3	0	1	0										1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		2	0	0	0										0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		15	3	1	1										5			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		10	0	0	0										0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		0	0	0	0										0			N/A
	Total number of Patient Safety Incidents reported	L - R		12474	985	1185	1070										3240			N/A
	% incidents resulting in low or no harm	L - R		93.41%	92.99%	91.05%	92.34%										92.07%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		6.59%	7.01%	8.95%	7.66%										7.93%			N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.75%	1.10%	2.17%	2.78%										2.06%			N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.83%	0.00%	1.64%	0.00%										0.58%			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	1	0	0	0	0	0	0	0	0	0	0	0			N/A

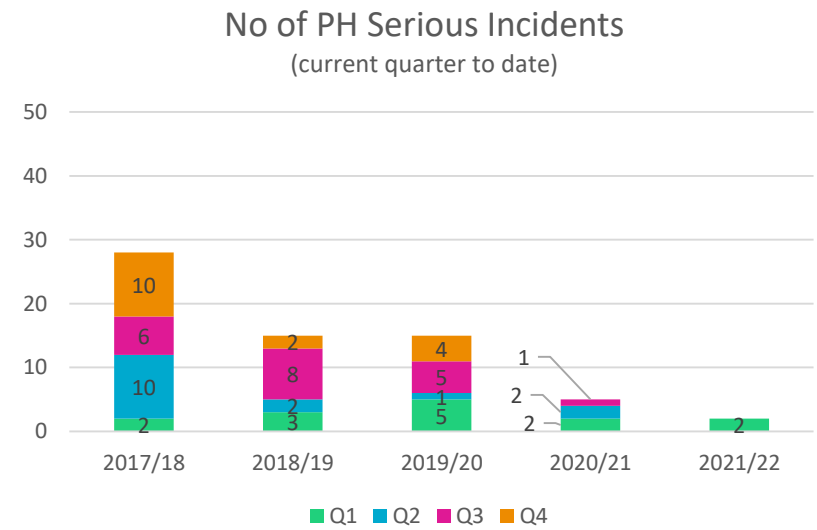
N-T	National measure/standard with target	L-I	Locally agreed measure for the Trust (internal target)
N-R	Nationally reported measure but without a formal target	L-R	Locally reported (no target/threshold) agreed
L-C	Locally contracted measure (target/threshold agreed with CCG)	N-RL-C	Measure that is treated 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? – additional information

One SIRI was declared in June 2021, a Forest of Dean Recovery Team patient. All incidents were escalated in line with SIRI reporting requirements. The Patient Safety Team continue to monitor 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 Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues.





There are 7 active SIRIs. Two active SIRI investigation are likely to complete outside of statutory time frames. An extended submission date for both final report have been agreed with commissioners, citing (1) complexity and (2) engagement with the family of the deceased at a pace to suit them rather than the process. 3 SIRI final reports, (2 mental health and 1 physical health), were completed and submitted to commissioners during June 2021.

Regarding all patient safety incidents:

- The total number of patient safety incidents reported decreased from May 2021 (1185) to June 2021 (1070).
- The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from May (8.95%) to June (7.66%).
- The percentage of falls resulting in moderate and above levels of harm increased from May (2.17%) to June (2.78%). 1 moderate and 1 severe harm fall were reported in May and 3 moderate harm falls and no severe harm falls were reported in June.
- The percentage of medication incidents resulting in moderate and above levels of harm decreased from May (1.64%) to June (0.00%).
- To note, there have been some minor adjustments to total numbers of patient safety incidents for previous months due to reclassification of some incidents following review by operational managers and/or the Patient Safety Team. 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? Trust Wide Physical Health Focus

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.0%	97.2%	98.8%	98.8%										98.0%	G		
	Number of post 48 hour Clostridium Difficile Infections (C Diff)	N	1			2	4										6	R		
	Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0			0	0										0	N/A		
	Number of MRSA Bacteraemia	N	0			0	0										0	N/A		
	Total number of developed or worsened pressure ulcers	L - R	61	797	84	66	70										220	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	698	75	58	57										190	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	70	8	5	11										24	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	29	1	3	2										6	R		

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

4 post 48-hr Clostridium Difficile (C. Diff) cases were detected in June. The cases were identified at Coln ward, Jubilee ward at Stroud , North Cotswold Hospital and Abbey ward at Wotton Lawn. The post infection meetings have not yet taken place in relation to these incidents, however, are planned as per protocol. There has been an noticeable increase in C. Diff toxin positive nationwide, GHNHSFT have also had an increase in the number of cases .The Infection Prevention and Control team are reviewing the C. Diff policy and associated documentation following a change to initial first line treatment with the aim of achieving a One Gloucestershire approach to the management of C.Diff.

The Trust has reported fewer skin integrity incidents this month and there are a reduced number of pressure ulcers considered avoidable under our care. The active work with teams continues in terms of improving practice to meet significant rising demand in pressure area care referrals from primary care and care homes. Following the success of the Gloucester Quality Improvement (QI) Pressure Ulcer (PU) plan the Forest & Tewkesbury, Newent & Staunton (TNS) QI PU approach is currently in the 'do' stage of the Plan, Do, Study, Act improvement methodology (PDSA) cycle. Leadership from operational managers and clinicians in Gloucester and Forest remains at a high level and the datix team have provided historical data from these areas that has supported the development of a baseline for improvement focusing on category 2 damage.

Further to the success of the 'Datix dashboard oversight' described within the previously shared improvement plans for Gloucester and Forest & TNS, the community managers from Forest & TNS & Gloucester are sharing their progress with the remaining Integrated Community Team (ICT) managers and are leading the work to embed this across all ICT's. The Clinical Pathway Lead (CPL) has continued to host educational webinars highlighting PU categorisation and encouraging an interactive approach from participants and active feedback. Attendance at a national conference has expanded networks and evidenced the national increase in incidence and severity of PU's . This aligns with our regional involvement in the emerging community benchmarking collaborative.

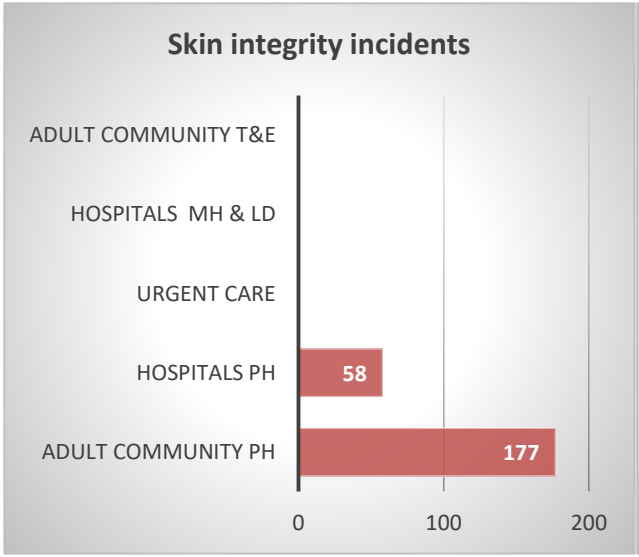
The 20 minute open invite for a focussed District Nurse discussion on safe and effective pressure area assessment, monitoring and management will be repeated in September following requests from colleagues. The focus will continue to be sharing the national and local themes observed in relation to PU incidence and severity, encouraging debate and involvement in improvement.

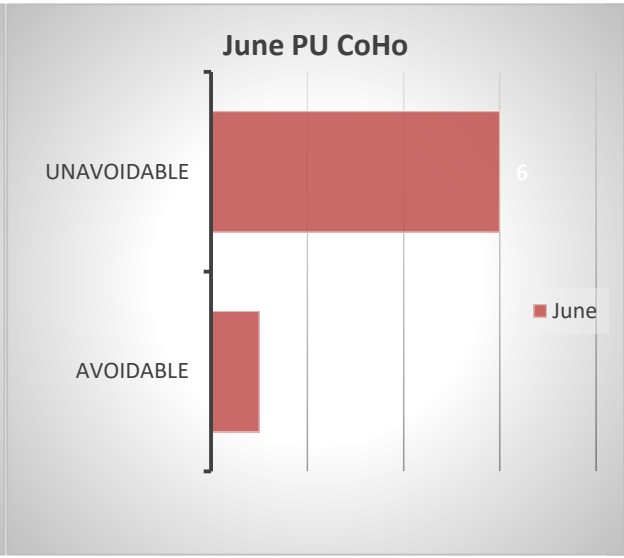
Additional clinical support has been made available to the CPL in order for all PU Datix reports to be screened for accuracy prior to final submission.

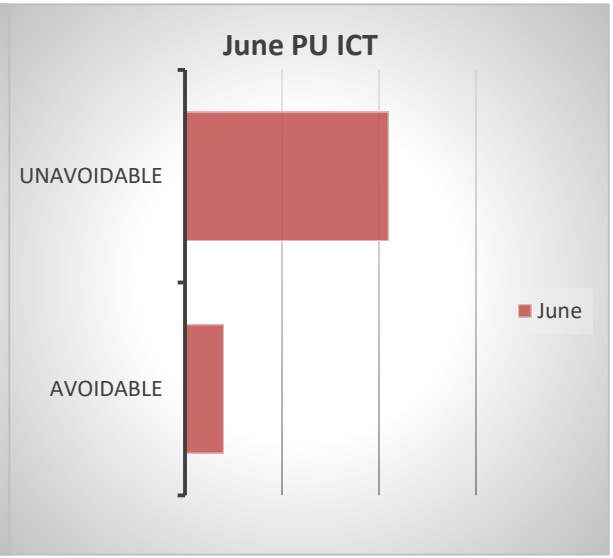
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure 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? Trust Wide Physical Health Focus
Pressure Ulcers – June 2021 Additional Information







Bar chart showing skin integrity incident reports per service.

- Adult community PH: **177**
- Hospitals PH: 58
- Urgent care & specialist services: 1
- Hospitals MH & LD: 1
- Adult comm. Therapy & Equipment 1

Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in June 2021

- Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed*** as being unavoidable or avoidable because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 6 unavoidable
- 1 avoidable

Bar chart showing data reported in community PH in June 2021

- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed by handlers*** as being unavoidable or avoidable. These decisions may have been made because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 21 unavoidable
- 4 avoidable

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

Minor Injury and Illness Units

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R / A / G	Exception Report?	Benchmarking Report Feb Figure
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	0:14	0.14	0.12	00.16										.14	G		
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	96.0%	96.6%	96.6%	96.8%										96.7%	G		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	89.8%	97.0%	95.4%	93.8%										95.4%	G		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	93%	96.1%	96.7%	96.9%										96.6%	G		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	94,8%	97.2%	95.6%	96.5%										96.5%	G		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	96.0%	99.2%	99.6%	98.9%										99. 3%	G		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	97.8%%	95.7%	98.9%	97.9%										97.6%	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	28960	3101	2920	2825										8846	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	91.8%	94. 7%	92.4%	90.2%										92.4%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	99.5%	95.2%	100%	100%										98.4%	G		

Additional information

MIIUs

- There were minor variances in the ambulance arrival to initial assessment times observed in Cirencester and Lydney affecting this indicator. This was down to administration delays and retrospective logging of the initial assessment on SystmOne. Matron's have been supporting colleagues with reminders about recording and will monitor activity levels in July.
- Dilke remains closed due to Covid-19 secure restrictions and reflects the physical environment and the inability to maintain social distancing between the booking in and waiting areas.
- Vale remains closed and will open Mid August due to delays in PCN vaccination team moving to new base.

Mental health

- CPA compliance slightly decreased compared to the previous month's figure of 92.4% .There are 93 CPAs outstanding with 51 of the cases being within the Recovery Service , and 10 within Eating Disorders. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and are setting up weekly schedules with early warnings for reviews that are due. In parallel GHC are working with the Integrated Care System (ICS) to develop a universal minimum standard for high quality care in the community to move away from the current CPA classifications. The aim is to develop a more flexible, responsive and personalised approach to care with the support from the multiple partners that make up the Mental Health Integrated Community Team. NHSE/I have directed CCG's and providers to review the CPA metrics in order to reduce reporting requirements and impact on teams. The shift will release time to develop the integrated approach and universal approach to mental health community care.

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

NHS
Gloucestershire Health and Care
NHS Foundation Trust

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

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Community Hospitals																				
Bed Occupancy - Community Hospitals		L - C	92%	88.9%	93.2%	92.5%	96.7%										94.2%	A		90.4%
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%	85.7%	90%	88.8%	44.4%										75.0%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
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%	52.9%	54.2%	53.6%	52.2%										53.4%	G		
Admissions to adult facility of patient under 16yrs		N - R		1	0	0	1										1	N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	1742	82	100	200										382	G		
Children's Services – Immunisations				2020/21 Academic Year																
HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)		N - T	90%*	11.9%	44.4%	55.7%	80.2%										80.2%			
Childrens Services - National Childhood Measurement Programme				2020/21 Academic Year	Academic Year 2020/21 - Target 95% of children measured by end of academic year - Cumulative target (July 2021)					Academic Year 2021/22										
Percentage of children in Reception Year with height and weight recorded		N - T	95%*	21.9%	35.9%	64.2%	87.4%										87.4%	G		
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	0%	9.0%	75.8%	83.9%										83.9%	G		

Additional Information

Early Intervention in Psychosis – There were 5 non compliant cases in month, with 3 related to data quality issues which are due to be rectified. The 2 other cases reflect patient complexity with one person being too unwell and declined to attend and although assessed 2 weeks later this is outside the KPI. The second person was assessed within 7 days, however, required a further period of assessment which included an allocation of a care coordinator which resulted in a short delay and impacted on the KPI.

Children's Services - National Childhood Measurement Programme (NCMP) is progressing at pace as can be seen in the positive differentials between April and June of 51.5% reception height & weight and 74.9% Y6 Height & weight, clinical activity is scaling up and the nationally supported agreement which is to complete 10% NCMP for Reception and Year 6 by the end of the current academic year is on target. The GHC School Nursing service remains committed to providing system partners with data to support development of the local obesity strategy.

HPV - The forecasted delivery is changing daily due to social isolation and school declines however all activity is either scheduled in school or has been reassigned to a community delivery model .The academic year finishes 20/07/21 and then whole programme then reverts to a countywide community model in GHC and community estates.

Length of stay (bed days) - The occupied bed days for inappropriate out of area Mental Health placements in June was 200 days which relates to 10 patients (8 x acute & 2 PICU admission beds). There remain a significant surge in demand for inpatient beds in month and the levels of acuity and dependency has resulted in a shortage of bed availability, this picture is mirrored regionally and nationally. GHC were awarded improvement funds to support early discharge and have developed discharge planning support with a number of Voluntary Community Providers who are providing networking links and crisis management planning. This represents some early work to the developing Integrated Care System approach being explored with the CCG.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Additional KPIs - Physical Health

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)		95%*	93.1%	35%	61.4	82.8										82.8%	G	Y	
Number of Antenatal visits carried out			530	47	51	51										149	R		
Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	94.1%	93.4%	96.6%	93.3										94.4%	A	Y	
Percentage of children who received a 6-8 weeks review.		95%	95.9%	98.3%	97.2%	97.6										97.7%	G		
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	72.6%	74.0%	84.7%	82.3%										80.3%	A	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	83. 7%	83.9%	79.6%	82.8%										82.2%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	72.5%	72.0%	74,4%	81.5%										75.8%	R	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	56.0%	61.3%	59.2%	60.1%										60.2%	G		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81. 3%	81.7%	81.5%	85.4%										82.8%	G		
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	970	No Data															
Number of positive Chlamydia screens		169	632																
Average Number of Community Hospital Beds Open		196	174,9	186.0	187	188										187	R		
Average Number of Community Hospital Beds Closed		0	21.1	10.0	9	8										9	R		

Additional Information

New Birth Visiting (NBV):

- NBV are offered F2F with a telephone/virtual consultation available on request. Robust exception reporting is completed regarding babies not seen within the mandated timeframe.

Percentage of children who received a 9-12-month review by the time they turned 12 months:

- The parents of all children within this age group were offered the opportunity to receive a 9 -12mth and 2 year review.
- These figures show a small decline from last month . For all children classified as 'Universal ', virtual appointments via Attend Anywhere are being offered for developmental reviews.
- To improve take up following 1st DNA contact details are cross referenced and a review undertaken to see if there needs to be a different offer of appointment .

Percentage of children who received a 12-month review by the time they turned 15 months:

- There has been an increase in the number of children that have been seen by the time they are 15 months of 3.2%. These contacts are optional for parents and although team members offer the appointments, this is not always taken up by the parents.
- There was a reduction in the number of declines from last month of 38.5% down to 17% which is a good trajectory going forward .
- 2nd appointments following a DNA are currently offered within 15 months against the usual standard of 12 months, this is expected as part of service recovery, in June there was a 21% DNA rate of the first appointment .

Percentage of children who received a 2-2.5-year review by 2.5 years:

- 50% of parents have declined this contact which is the same rate as the previous 2 months however the DNA rate is 22% which is a decrease on last month' figure . The virtual offer has not increased rates of acceptance of the developmental review as was anticipated, to mitigate this as lockdown eases and estate space allows, the service will be returning the 2-year Ages & Stages Questionnaire (ASQ) to face to face with an additional intervention called Early Language Identification Measure (ELIM) to use alongside ASQ.
- The service continues to scope non GHC sites to support the delivery of the F2F offer.

CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	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%	85.8%	87.5%	88.7%	88.3%										88.2%	A		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	70.4%	71.2%	72.5%	76.2%										73.3%	R		
Sickness absence average % rolling rate - 12 months	L - I	<4%	4.80%	4.3%	3.9%	3.9%										3.9%	A		
Sickness absence % monthly rate	L-T	<4%	New	3.55%	4.4	4.28%										3.55%	G		

Additional information

Mandatory training, appraisal and absence

- The work that services/teams have been undertaking to re-instate training compliance levels has shown good improvement over recent months although the Trust's overall training compliance figure is still short **of** the 90% training compliance target. There are still topics and/or service areas where figures remain lower than required and work is continuing to ensure any deficits are rectified in a timely manner; this includes work with the Trust's Staff Bank.
- The Trust's overall training compliance figure minus staff bank is 92.7%
- Sickness absence has dropped to below 4% to 3.9% rolling rate for the second month running .

Resuscitation and Restrictive Physical Intervention training

- The focus on Physical Intervention training shows continued improvement of the training compliance figures. The focus going forward will be on the areas with lower compliance and ensuring the improvements achieved are maintained.
- Progress on this workstream reports monthly to QAG. The Trust target is 90% compliance and the % figures to target are shown in the table opposite .

June 21	PBM Theory			PBM Full			PMVA Breakaway			PMVA Full		
	April	May	June	April	May	June	April	May	June	April	May	June
Wotton Lawn Hospital							74%	74%	83%	71%	76%	77%
Charlton Lane Hospital	64%	79%	89%	74%	84%	92%						
Berkley House	59%	75%	71%	77%	85%	88%						

Health and Wellbeing Hub

This group has a broad representation of colleagues from across the Trust with data and themes being collated and monitored through the hub . There is an informative portal in the staff intranet and this July is planned to be featured as, " Be Kind to Yourself Month". There are many activities for staff to engage with which are being delivered by virtual methods which include : On line cookery demonstration, Pilates, Yoga, Horticulture ,Mindfulness, Spiritual Care, Menopause issues, Diversity, Fitness taster sessions.

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Mental Health Inpatient – June 2021

	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	17.5	2	0	0	0	0	0	0
Abbey	180	23	17.5	2	0	0	0	0	0	0
Priory	195	24	32.5	3	0	0	15	1	0	0
Kingsholm	15	2	0	0	0	0	0	0	0	0
Montpellier	80	9	85	10	0	0	0	0	0	0
Greyfriars	180	23	15	1	0	0	0	0	0	0
Willow	45	6	67.5	9	0	0	0	0	0	0
Chestnut	60	8	0	0	0	0	0	0	0	0
Mulberry	60	8	0	0	0	0	0	0	0	0
Laurel	0	0	0	0	45	6	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	82.5	9	205	21	0	0	0	0	0	0
Total In Hours/Exceptions	897.5	112	440	48	45	6	15	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

MENTAL HEALTH & LD				
Ward	Average Fill Rate	Absence	Vacancy WTE HCA	Vacancy WTE RMN
Dean Ward	152.00%	15.21%	2.30	2.80
Abbey Ward	106.67%	7.28%	0.00	10.50
Priory Ward	107.56%	5.80%	0.00	12.20
Kingsholm Ward	105.28%	8.70%	1.69	2.78
Montpellier	106.92%	1.16%	4.20	1.90
PICU Greyfriars Ward	152.36%	8.39%	3.60	4.10
Willow Ward	112.62%	7.70%	0.00	0.00
Chestnut Ward	105.37%	6.12%	3.35	0.00
Mulberry Ward	119.28%	5.41%	0.30	2.60
Laurel House	100.00%	5.33%	1.07	1.40
Honeybourne Unit	104.44%	6.18%	0.60	1.20
Berkeley House	98.33%	3.37%	0.00	0.00
Totals (June 2021)	114.24%	6.72%	17.11	39.48
Previous Month Totals	120.54%			

Physical Health				
Ward	Average Fill Rate	Absence	Vacancy WTE HCA	Vacancy WTE RN
Coln (Cirencester)	118.08%	8.97%	0.00	4.10
Windrush (Cirencester)	107.73%	10.36%	0.00	3.32
The Dilke	109.03%	10.36%	1.80	0.00
Lydney	102.13%	8.06%	0.00	5.53
North Cotswolds	110.38%	10.44%	0.00	1.99
Cashes Green (Stroud)	99.71%	5.14%	1.80	0.00
Jubilee (Stroud)	111.92%	3.95%	2.70	0.63
Abbey View (Tewkesbury)	93.69%	10.17%	0.60	1.75
Peak View (Vale)	116.31%	8.52%	2.08	2.73
Totals (June 2021)	107.66%	8.44%	8.98	20.05
Previous Month Totals	107.57%			

Mental Health and Learning Disability Inpatients

- The International Recruitment project continues and 3 x RMNs have been appointed for Wotton Lawn. Expectation arrival is in Q3.and Q4. We continue to source 12 week block bookings for RMN's from framework agencies to ensure continuity of care and fulfil the named nurse role.
- Code 3 relates to short terms absence, however, the unit manager picked up the registered nurse shift hours above to ensure continuity and safe care, although this impacted on some of operational duties. Code 4 relates to last minute absence of an agency nurse. The ward was supported by allied health professionals to support ward activity, however, was under the nominated staffing levels. All were escalated to Matrons for oversight as part of the local protocol and safety checks.

Physical Health

- The International Recruitment project continues and to date, 30 RGN's have been appointed, of these , 9 have arrived in the UK.
- 7 nurses have taken and passed the OSCE, 4 have received their NMC PIN numbers and 3 are awaiting them. 2 nurses are due to undertake their OSCE training in July

Staffing Data – Absence/Vacancy Data Quality Notice

- Additional staffing data is available for this reporting period, however, the workforce and finance systems are still transitioning data and there remain variances between systems. The quality team are collaborating with colleagues to data cleanse to ensure future data reflects operational understanding of workforce metrics for teams.

CQC DOMAIN – ARE SERVICES WELL LED? - Quarter 1 - Guardian of Safe Working Report 2020/21

PURPOSE

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed 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. 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. 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.

Reporting time period April 2021 – June 2021	**Guardian of Safe Working Hours: Dr Sally Morgan**
Number of doctors in training (all on 2016 contract)	In April to June (Q1) 2021 there were 36 doctors in training posts. • 12 higher trainees • 6 CT3s • 2 CT2s • 3 CT1s • 5 GP trainees • 4 FY2s • 4 FY1s • FY doctors rotated posts in May 2021
Exceptions in this period	• **17 on call shifts covered** by our own junior staff acting as locums due to sickness. • **3 on call shifts covered** by agency locums due to sickness • **4 exception reports in this time period** • **3 by one CT1, 1 by FY2, both posts in WLH** • **3 relating to hours worked** (needing to stay late due to clinical work load) • **1 relating to pattern of work** (covering WLH) – this has since been raised as issue with Medical Lead and the Clinical Director to ensure adequate cover arrangements in place at WLH when trainees take leave • None requiring work schedule reviews • **2 resolved with TOIL, 2 outstanding** **There was a Junior Doctors forum held via Microsoft Teams on 30th April 2021.**

AGENDA ITEM: 08/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

SUBJECT: **LEARNING FROM DEATHS 2020/21 QUARTER 4**

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.

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.

Executive summary

- This report summarises the year's activity regarding Learning from Deaths.
- During 2020/21 there were 829 patients who died whilst receiving care from Gloucestershire Health and Care NHS Foundation Trust (GHC) whilst either a physical health inpatient or in the care of our mental health or learning disabilities services. At the time of writing (30 April 2021) none of these deaths are judged likely to have been due to problems in the care provided

by the Trust. However, learning has been obtained from serious incident investigation and mortality review of these deaths, the learning is presented in this report.

- One, representing 5.3% of the patient deaths before the reporting period, is judged to be more likely than not to have been due to problems in the care provided to the patient. This related to a mental health homicide that took place in 2019 and previously reported to Trust Board, the outcome of which has been shared with both the victim's and the perpetrator's family with whom there was positive engagement, as well as NHSE/I. Significant learning from this has been achieved and continues to be developed. A learning assurance event is due to take place on 1st July 2021

- Covid-19 related inpatient deaths following definite and probable nosocomial infections will be subject to further Gloucestershire system-wide review and investigation in line with guidance. Work is currently underway and due attention is being paid to communicating with relatives and duty of candour requirements.

- The format of this report is currently under review, and looking forwards will be presented as a concise slide deck from the end of Quarter 1 2021/22 whilst still retaining the mandated requirements.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths associated with the Trust's 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?

Appendices:	None

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

1.0 INTRODUCTION

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

1.2 The Board is asked to note that from 1 April 2020, Gloucestershire Health and Care NHS Foundation Trust (GHC) reports both mental health and physical health mortality data in a combined manner; facilitated by the joint Datix system, which went live on 1st April 2020.

2.0 OVERVIEW

2.1 During 2020-2021, there were 829 patients who died whilst receiving care from Gloucestershire Health and Care NHS Foundation Trust (GHC) whilst either a physical health inpatient or in the care of our mental health or learning disabilities services. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

336 in the first quarter;
182 in the second quarter;
177 in the third quarter;
134 in the fourth quarter.

2.2 By 8th April 2021, 42 case record mortality reviews and 14 comprehensive investigations had been carried out in relation to the 829 deaths included above. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

16 in the first quarter;
21 in the second quarter;
14 in the third quarter;
5 in the fourth quarter.

2.3 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. However, there is learning obtained from these investigations and reviews, which is highlighted in Section 3 of this report.

2.4 By 8th April 2021, 14 case record reviews and 5 investigations completed after 31st March 2020 related to deaths which took place before the start of the reporting period. These were deaths that occurred in the 2019/20 reporting period, however the reviews and investigations were concluded in the 2020/21 reporting period.

2.5 1, representing 5.3% of the patient deaths before the reporting period, is judged to be more likely than not to have been due to problems in the care provided to the patient. This related to a mental health homicide that took place in 2019, the outcome of which has been shared with both the victim's and the

perpetrator's family with whom there was positive engagement, as well as NHSE/I. Significant learning from this has been achieved and continues to be developed. A learning assurance event is due to take place on 1st July 2021.

2.6 The numbers in paragraphs 2.3 and 2.5 have been estimated using Comprehensive Investigations and Structured Judgement Review (SJR).

2.7 For any deaths meeting Serious Incident a full Comprehensive Investigation is carried out, including Root Cause Analysis. Comprehensive Investigations are subject to full panel review chaired by the Medical Director or Deputy Medical Director.

2.8 For patient deaths subject to the Mortality Review process (case record reviews), the Royal College of Psychiatrist's SJR Mortality Review Tool 2019 is employed to review mental health patient deaths. For learning disability patient deaths, a similar Trust-developed SJR tool is utilised which pre-dates the Royal College of Psychiatrist's SJR. This approach has been maintained to allow consistency with the Learning Disability Mortality Review programme. Finally, for physical health patient deaths, a range of questions based on SJR tools is being used to assess the standard of care provided to patients that die during an inpatient stay at a community hospital.

2.9 Case record reviews are discussed at Mortality Review Group (MRG) meetings chaired by a Clinical Director or Quality Lead (Mortality, Engagement and Development). The community hospital MRG meetings also extend an invitation to the County Medical Examiner.

2.10 The case record review and investigation figures given above do not include current ongoing reviews and investigations.

3.0 Learning

The Trust has identified the following learning points and themes in relation to serious incident investigations and mortality reviews.

3.1 Communication

3.1.1 Subsequent to mortality reviews of patients receiving End of Life Care (EoLC) in the Trust's seven community hospitals, quality of referral and transfers from the acute trust has remained a theme throughout 2020-21. The need for improved communication between Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) Onward Care Team and GHC's Demand and Capacity/SPA Teams has been identified as a contributory factor to poor quality discharges/transfers by NHSE/I's Emergency Care Improvement Support Team (ECIST). A new piece of work has commenced in March 2021, which should improve the quality of transfers from GHNHSFT going forward. ECIST are working with GHNHSFT and GHC on a quality improvement project and are developing a 90-day improvement plan. Telephone reviews (between GHNHSFT and GHC) of all patients awaiting transfer have now been introduced twice daily. From a clinical perspective, this should ensure that GHC:

- Have up to date information about patients, irrespective of the length of time between referral and transfer;
- Have a more accurate reason for transfer, e.g. EoLC rather than rehabilitation.

3.1.2 As a result of the investigation into the death of a patient who suffered an unwitnessed fall at one of our inpatient facilities, and who passed away later the same day at the acute trust, difficulties in multi-agency communication between the mental health services and other providers were identified, and although it was not considered to be contributory to the outcome for the patient, the investigation felt there to be areas for learning and improvement. The Multi-Agency communication difficulties will 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:

- Multi agency working in relation to hospital discharge planning (sharing of information).
- Recognising when to undertake a mental capacity assessment, particularly with someone thought of as 'eccentric'.
- 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.

3.1.3 Following investigation into a suspected suicide of a patient open to a mental health community team by sodium nitrate highlighted challenges in obtaining information from system partners. This acknowledged that each organisation who had supported the patient had its own information governance processes, which prevented partners from sharing relevant information in a manner to support the delivery or care and investigating incidents. GHC have undertaken to make arrangements with these organisations to agree a protocol for sharing relevant and appropriate information in a timely way.

3.1.4 Following an investigation into the death of a patient open to a mental health community team who had reduced their antipsychotic medication against medical advice, and after an alternative therapist had suggested that their symptoms could be treated without medication, it was recommended that staff are reminded to be proactive in asking for details of any private therapists. If appropriate and with consent, they should consider contacting the therapist to discuss the provision of safe and holistic care. Staff are also recommended to share with carers (with the patient's consent) decisions which are made against medical advice, so that carers can be alert to the associated risks.

3.1.5 Post investigation into the suspected suicide by asphyxiation of a patient open to a mental health community team, staff were reminded of the importance of carrying their mobile phone during lone visiting and having an appropriate voicemail message when out of hours. The mobile phone policy is currently under review, and where necessary, will be updated and recirculated.

3.1.6 After a mortality review into the death of a patient who was on the caseload of both mental health and physical health services provided by GHC, it was identified that clinicians working in the individual services were not fully aware

of the interventions being provided by the discreet teams involved. Work is underway to improve the knowledge that teams have of the scope of services that the trust provides post-merger, and how information sharing between the services can be maximised.

3.2 Risk

3.2.1 As a result of an investigation into the suspected suicide of a Mental Health Intermediate Care Team (MHICT) patient who was found deceased two weeks' after discharge, all individuals supervising colleagues have been 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.

3.2.2 Following the investigation into the death by asphyxiation by helium gas of a patient open to a mental health community team, staff have been encouraged to make clear assessments of risk when a patient discloses the possession of a suicide kit, and to remain up to date with latest developments in methods of suicide and the associated potential lethality.

3.2.3 Subsequent to the death of a patient who ended their life on a family holiday whilst receiving extended support from MHICT, GHC will continue to review the Trust's risk assessment policy and practices, ensuring that complex and fluctuating risks are captured and considered when agreeing appropriate risk management plans.

3.2.4 During the investigation into the suspected suicide by asphyxiation of a patient open to a mental health community team, it was found that documentation from other statutory agencies and providers revealed that the patient's partner had a criminal history which was not known at the time to the clinical team. 5 days prior to the patient's death, the risks had changed significantly as the patient had been subject to assault from her partner. The Trust's Safeguarding Team will:

- Raise awareness and remind all staff across the Trust of the 'Gloucestershire safeguarding Adult Board Escalation Protocol'.
- Remind all staff of the across the Trust of the Domestic Abuse pathway and GHC Domestic Abuse Policy, including advice for completion of the DASH form.
- To advise staff on where training is available for working with Domestic Abuse and Sexual Violence (internal to GHC and externally in Gloucestershire).

3.2.5 As a resulting action following the death of a patient at one of our inpatient facilities via ligature (bed linen) tied to the bedroom door, GHC is continuing its work with regard to installing electronic countermeasures (door top sensors).

3.2.6 Following the investigation into the suspected suicide of a mental health inpatient by ingestion of sodium nitrate:

- Staff have been 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.

- GHC has highlighted to staff that how online pro-suicide resources can impact on the risk to vulnerable individuals, and also raised at the Gloucestershire Suicide Prevention Strategy.

3.2.7 Post investigation into the suicide of a patient open to a community mental health team, where the patient had expressed concern regarding her menopausal state and its impact upon her mental health, the investigation recommended that a focused learning project be undertaken to consider the impact of all stages of menopause, to include the impact of menopause on mental state and emotional deregulation when assessing risk.

3.3 Training

3.3.1 After the suspected suicide by asphyxiation of a patient open to a community mental health team, the Resuscitation and Training Team have now included in training packages guidance for mental health community team colleagues and clarity as to when resuscitation should be commenced in the community.

3.3.2 Following the suspected suicide of a patient who had been assessed by a Liaison Team and then referred to a Crisis Team, 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 (RoLE) during resuscitation training will be discussed with the Resuscitation and Training Team Lead.

3.3.3 Subsequent to the review of a death of a community mental health patient, which occurred at an acute hospital, it appeared to the Mental Health (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 older adult inpatient sites.

3.4 Recording and Documenting

3.4.1 As a result of the investigation into the death of a patient who sustained an unwitnessed fall at one of our inpatient facilities and who passed away later the same day at the acute Trust, the system of recording on RiO (electronic record notes) when a patient makes an allegation of abuse or neglect against a member of staff should be reviewed to capture evidence that a patient's allegations are clearly recorded and responded to in terms of their Care Plan and to ensure a safeguarding chronology is available.

3.4.2 Following mortality review of patients on the End of Life Shared Care Pathway (EoL SCP) at one of our inpatient facilities, the MH MRG has recommended that once a patient has been placed onto the EoL SCP, then the EoL SCP booklet becomes the patient's primary document, taking over from RiO, as agreed across the Integrated Care System. 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 and can refer to the more detailed account on RiO, so that other clinicians know there is more detail to be found on RiO.

3.4.3 Post-investigation into the death of a Crisis Team patient who was found hanged at home, it was found that a telephone call that the patient made to the Crisis Team on the day of his death was not recorded, as the extension had not been added to the recording loop. A quarterly audit will be carried out to ensure that all Crisis Team extensions that should be recorded are added to the recording loop.

3.4.4 Following the death of a patient open to a community mental health team who died of their injuries following an unsuccessful suicide attempt, community mental health teams will provide detail in the medical record with respect to timings of contact with patients.

3.4.5 After an investigation into the suspected suicide by asphyxiation of a patient open to a community mental health team, it was recommended that consideration to be given to usual protocol for recording notes following assessment and reviews by medical staff, specifically with regard to reliance on Medical Secretaries copying and pasting risk relevant updates from dictated clinic letters into the RiO record.

3.4.6 The investigation into the suspected suicide of a mental health inpatient by ingestion of sodium nitrate resulted in staff being reminded that risk assessment is a dynamic process and 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.

3.4.7 Following the suicide of a patient open to a community mental health team, the investigation noted the lack of a formal telephone message system within the team for messages, but noted that there was no breakdown of communication. The investigation recommended a robust telephone messaging system to be implemented within the team office, noting that this work has been completed and tested in another locality.

3.5 Service Development

3.5.1 Following the death of a patient open to a community mental health team who died of her injuries following a suicide attempt, the investigation supported the ongoing development of a Complex Needs Service currently commissioned and being piloted in the county. The investigation recommended that when patients are supported by the Gloucestershire High Intensity Network (GHIN) programme and mental health services, regular meetings and the development

of shared care plans with shared goals and shared priorities are recommended. Co-ordination of the GHIN contact with patients under the care of mental health services will sit within the Complex Needs Service.

3.5.2 An investigation relating to the death of a patient who ended their life on a family holiday whilst receiving extended support from the MHICT, recommended that reviews into the provision of advice for carers of a person with Emotional Unstable Personality Disorder be undertaken. This is forming part of the project plan for the Complex Needs Service, as described in the previous paragraph.

3.5.3 Following the suspected suicide of a MHICT patient who was found deceased two weeks after discharge, the investigation recommended that Service Leads 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. The MHICT Nursing Group now meets monthly to review supervision. Future transformation is currently paused due to the pandemic. The investigation highlighted that 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. Teams have been reminded of this via team meetings and locality forums.

3.6 End of Life

3.6.1 Subsequent to mortality review of EoL patients by the Mental Health (MH) MRG and Physical Health (PH) MRG:

a) The MH MRG noted that recognising when to place a patient onto EoL SCP can be complex. The MH MRG has advised the use of various indicator tools, e.g. SPICT, for recognising the most appropriate time. The MH MRG also advises that should a patient's condition improve, it is perfectly acceptable to take the patient off the EoL SCP.

b) MH MRG noted the excellent work by an HCA in preparing and maintaining the EoL facilities and the positive impact this has had upon patients and their loved ones. MH MRG has recommended that this approach is widened to all wards at Charlton Lane Hospital. The Charlton Lane Matron has identified a lead individual to take the work forward.

c) PH MRG has recommended that staff ensure family members with dementia are engaged with as much as they are able to process, supporting inclusive and participative care. Mental Health MRG are currently considering how to best support Community Hospitals with this recommendation.

d) PH MRG has made the following recommendations regarding ReSPECT forms:
- ReSPECT forms should be reviewed as part of patient clerking and also ideally every time the patient's situation changes, including discharge.

- ReSPECT forms document recommendations only, thus clinical decisions can override recommendations.

e) Following concerns raised by Community Hospital ward staff regarding some out of hours GPs being reluctant to prescribe EoL medication, PH MRG was made aware that similar concerns had been raised amongst community colleagues delivering EoL care at home. PH MRG has fed back to the Deputy Clinical Chair of Gloucestershire CCG and to the Care UK Governance Lead. In response, Care UK has now facilitated training sessions for the out of hours GPs from the Palliative Care Consultant.

f) MH MRG has recognised the need for a second EoL room at Charlton Lane Hospital and recommended the exploration of charities to support the renovation. This worked is currently delayed due to the pandemic.

g) MH MRG has recommended a review of nurse handovers regarding palliative care patients to ensure that all the relevant information and plans are handed over. MH MRG will forward the recommendation to the newly formed EoL Quality Improvement Group for consideration.

h) Due to some confusion regarding the dosing of glycopyrronium bromide for use during EoL SCP of patients suffering end stage dementia, MH MRG has sought clarification from Palliative Care Consultant for dissemination amongst ward staff.

3.7 COVID-19 pandemic related

3.7.1 Following the investigation into the death of a patient with a personality disorder who ended their life on a family holiday whilst receiving extended support from MHICT augmented by the a community mental health team, it was found that during the first wave of the pandemic, MHICT had a large and complex caseload which staff found challenging. After the first wave, the Trust reviewed future provision for primary mental health care in the event of further restrictions due to a second wave. When the second Covid-19 wave hit in late Autumn/Winter, learning was utilised from the first wave and the Trust did not step-down MHICT services or redeploy staff from MHICT teams.

3.7.2 In one case where a community mental health team patient took their own life 13 days after discharge from one of the Trust's inpatient facilities, the investigation found that it was clear that Covid19 had impacted upon the delivery and consistency of care from third party providers but did not significantly impact on the care delivered by Trust staff and services, with staff exercising due diligence in adhering to policy and best practice guidelines.

3.7.3 Following the investigation into the death of a patient who sustained an unwitnessed fall at one of the Trust's inpatient facilities and who passed away later the same day at the acute Trust, the investigation recommended:

- A short introductory video about the hospital was prepared, which can be shared with families, carers and friends at times when access to the hospital

is limited. Filming for this video has now been completed and is due to be circulated.

- Developments to improve communication pathways between inpatient wards and families/carers/friends will be continued in preparation for further restrictions or periods of lockdown due to Covid-19. This includes solutions involving the use of technology to extend visiting opportunities.

3.7.4 After review of patients on the EoL SCP, the MH MRG noted 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 first wave of the pandemic, which led to much enhanced patient and family satisfaction during very difficult circumstances. It was recommended that this be carried forward to further periods of restrictions and this was indeed implemented by the Trust during the second wave across all inpatient settings.

3.7.5 Following mortality review of Covid-19 positive patients on EoL SCP PH MRG has:

a) Recommended that review of the Advanced Care Plan should be undertaken upon patients receiving a Covid-19 positive result, and that anticipatory medication should be prescribed to provide as many options as possible to nursing staff out of hours;
b) Recommended that Midazolam and Morphine can be used for symptomatic treatment and are not necessarily EoL treatments only;
c) Recognised the immense care and compassion displayed to two patients, a husband and wife, who were facilitated to spend the last few hours together in a 2 bedded bay before the wife's sad passing. PH MRG has reassured ward staff that where safety can be maintained, PH MRG would support clinical decisions made which display humanity and compassion to patients and their families as part of EoL care;
d) Recognised and highlighted the importance of maintaining effective relationships with relatives and that when done well, it helps loved ones to, wherever possible, accept the prognosis and come to terms with the outcome.

3.7.6 Covid-19 related inpatient deaths following definite and probable nosocomial infections will be subject to further Gloucestershire system-wide review and investigation in line with guidance. Work is currently underway and due attention is being paid to communicating with relatives and duty of candour requirements.

4. LEARNING DISABILITY MORTALITY REVIEW

4.1 Learning Disability Mortality (death) Review (LeDeR) have now caught up with the back-log of cases to review in Gloucestershire. Percentages below are correct as of 12 April 2021:

Year	CLOSED	Open	ON HOLD	Grand Total	% Completed
2017	46			46	100%
2018	49			49	100%
2019	46			46	100%
2020	49	3	5	57	86%
2021		8	4	12	0%
Grand Total	190	11	9	210	90%

4.2 The Trust awaits the end of the 2020-21 Q4 reporting period for the annual 2020/21 LeDeR report containing learning themes. Learning themes identified during the 2019/20 reporting period are:

a. Focus on improved communications between professionals and with family/carers.
b. 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.
c. Focus on referral to the eating and drinking pathway.
d. Continued focus on improving uptake of the annual health checks and flu vaccinations.
e. Focus on encouraging the ReSPECT form to be completed earlier on for people who are considered palliative, so there is a baseline in place to review frailty and advanced care planning with individuals, their family and carers.
f. Greater inclusion of people with lived experience in the work programme, including attendance at steering groups, quality assurance panels, and other training events.
g. Share the learning – plans to host an action from learning event during 2020/21.

4.3 LeDeR has made several recommendations for NHSE and DHSC in terms of policy making. The full LeDeR 2019/20 annual report can be accessed here: http://www.bristol.ac.uk/sps/leder/resources/annual-reports/

4.4 LeDeR have made no specific recommendations regarding the care and treatment provided by the Trust during 2019/20.

5. SUMMARY

5.1 GHC is committed to the National Quality Board's (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 LeDeR programme in Gloucestershire.

5.2 All GHC staff are required to notify, using the Datix system, the deaths of all mental health patients, both inpatient and community (which comprises any individual open to a GHC community mental health caseload at the time of their death together with those who die within 30 days of discharge), and also deaths of all physical health inpatients.

5.3 Deaths recorded on Datix are collated for discussion at the MRG meetings chaired by a Clinical Director and Quality Lead (Mortality, Engagement and Development). Patient deaths meeting serious incident criteria are subject to a comprehensive investigation with panel review chaired by the Medical Director and Deputy Medical Directors. All deaths of patients with a learning disability are reported through the appropriate LeDeR process, and deaths of people under the age of 18 are reported through the current child death reporting methodology.

5.4 Learning from death continues to provide vital guidance. GHC is 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 Incident investigation and mortality review processes.

AGENDA ITEM: 09/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **COMBINED PERFORMANCE DASHBOARD JUNE 2021 (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.

Performance covers the period to the end of June (Month 3 of 2021/22). It is of note that the performance period remains aligned to our operational priority to recover services from the pandemic (within Regroup Reconnect Recover) and support forthcoming operational planning and transformation developments.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Performance Exception Action Plans (PEAP) will be presented to the Business Intelligence Management Group (BIMG) and will more widely account for performance indicators in exception. Example of this include CAMHS, Eating Disorders (both June) and CYPS Community (July).

Recommendations and decisions required

The Board are asked to:

- **Note** the aligned Performance Dashboard Report for June 2021/22.
- **Acknowledge** the ongoing impact of the pandemic and service recovery on operational performance.
- **Note** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service action plans are being developed to address areas requiring improvement
- **Agree to a recommendation** that;
  - A*dministrative,* data quality issues are no longer escalated by exception if clinical quality and safety can be assured, unless there are two consecutive periods of data quality concern.

Executive summary

As shown within the spark charts, it is of note that all of indicators within this report have been in exception within the last 12 months.

Mental Health & Learning Disability Services (National & Local)

The Board's attention is requested to review the 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Eating Disorder (ED) Services account for four indicators. The service continues to face major performance challenges due to a high number of referrals and high vacancy rate which is further outlined within the narrative. A Regroup, Reconnect, Recover update is provided at the end of the Local Requirements narrative.

Physical Community Health Services (National & Local)

In addition, attention is drawn to the 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Within these, four are within CYPS and three within Wheelchair Services. 'Time to initial assessment for patients arriving by ambulance (95th percentile)' is a data entry issue that will be corrected. This item would not be escalated if the recommendation above is agreed. A Regroup, Reconnect, Recover update is provided at the end of the Local Requirements narrative.

Trust Wide Services

There are currently 3 Workforce indicators in exception this month. Once again, it is of note that sickness absence is compliant in June (3.8% against a 4% threshold).

Tactical plans are being held to develop further workforce performance metrics within the performance dashboard. This will lead to a phased process that will be deployed over the year which will provide more granular analysis. Next steps will be presented to Resources Committee in August 2021. Additionally, interactive operational workforce (appraisal and sickness) and interactive budget management dashboards are now being deployed across the Trust after a comprehensive validation phase.

There were 11 complaints recorded in June 2021 which is above SPC control limits. This is not presented in exception within the report as there is not a defined threshold for performance monitoring (indicator known as having a 'proxy threshold'). Complaint activity is monitored through the Quality Committee.

Non-exception reporting

It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are available for operational monitoring within the online Tableau storyboard.

It has been agreed that 8 proxy indicators will be re-introduced into the performance dashboard as soon as possible as *internal* KPIs using Statistical Process Control (SPC) limits as thresholds. These include;

- **7** Number of Serious Incidents Requiring Investigation (SIRI)
- **8** Number of SIRI where Medication errors cause serious harm
- **11** % incidents resulting in moderate harm, severe harm or death
- **12** % falls incidents resulting in moderate harm, severe harm or death
- **13** % medication errors resulting in moderate harm, severe harm or death
- **18** Safer staffing fill rate – community hospitals
- **22** Total number of acquired pressure ulcers
- **33** MIIU number of breaches of 4-hour target

The remaining 16 proxy indicators will be removed from the active performance reporting schedule but will continue to be monitored and may compliment formal indicators as 'context' narrative in the future.

Risks associated with meeting the Trust's values

Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
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 been discussed before?
BIMG 15 July 2021

Appendices:	

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

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
June

Performance Dashboard Report & BI Update

Aligned for the period to the end June 2021 (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 variation control limits that warrant escalation and senior oversight. Additionally, confirmed data quality or administrative 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, and where appropriate, and in response to significant, ongoing and wide-reaching performance issues; an operational Service Recovery Action Plan (SRAP) which outlines appropriate risk and mitigation will be commissioned and monitored through BIMG. For example, specific updates have been provided by operational services in June and July 2021 for two areas with consistent performance challenges; Children and Young People's Services (CYPS including CAMHS) and Eating Disorder Services.

Business Intelligence Update
Althought there are currently high demands, Business Intelligence services continue to deliver key infrastructure development tasks and ensured the continuity of business critical reports during the period. Some development projects delays beyond BI's control - such as the server migration project and maintenance of the SystmOne data warehouse - are impacting the delivery of wider plans.

The following high profile tasks continue to be the focus;

- Server migration to allow for reconfiguration and resolve licensing concerns
- Finance (Integra) reports were deployed to users in July 2021.
- Service level recovery and operational planning is being supported and prioritised wherever possible through robust business partnering
- Operational engagement continues to establish a project to improve Community Health (PH) reporting within our clinical systems and new BI environment. This predominantly focuses on clinical system data capture, governance adjustments and data warehouse remapping. This project is called *'SystemOne Simplicity; Improving accuracy, consistency and quality assurance'.*
- Engagement with the e-rostering supplier to establish a new data extract continues
- Ongoing stakeholder feedback for the Draft Performance Management Framework has been collated and will inform the development of a second draft.
- Measuring What Matters Board Seminar learning being collated to inform
- Further Workforce Performance Indicators are in development. Further data source items need to be incorporated offering further service level granulation. The first development phase will be presented next month.
- Initial operational Workforce (ESR) reports covering sickness, appraisals and headline vacancies to be published in early August 2021.
- Tableau subscriptions and alerts are now in place, allowing users to setup regular visualisation mail-outs and performance led notifications.

The following tasks continue to be 'in the development pipeline' in line with the service's 2021/22 Business Plan;

- Dashboard visualisation capability further developed to include; automated benchmarking observation, SRAP alerts and data quality alerts (2021/22).
- Internal service KPI review (2021/22 Q2/Q3)
- BI Infrastructure Development; Further development of the data warehousing infrastructure and technical solutions to ensure robst and reliable BI (2021/22 Q2)
- Core Reporting Delivery; To further develop our established BI reporting and ensure efficient use of information to inform decision making (2021/22 Q3)
- Maintain Data Warehouse; Further develop and maintain efficient data warehouse that maximised data waulity and raised analytical productivity and efficiency (2021/22 Q4)
- Delivering System Data Flows; Introduce new data sources into data warehouse and futher develop existing flows in line with Trust Strategy (2021/22 Q4)
- Legacy Reporting Migration; To conclude legacy reporting requirements (2021/22 Q4)
- Progressive Insight Delivery; To develop next level BI reporting needs and integrate information for cohesive insight (2021/22 Q4)

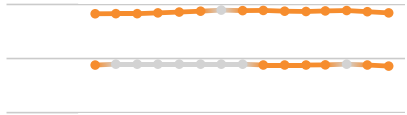
PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO ADAPT TO BUSINESS DEMANDS, SPECIFICALLY REGARDING THE PANDEMIC RESPONSE AND RECOVERY.

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

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		JUNE		21/22		
1.04	Care Programme Approach - formal review within12 months	90.1%	95.0%	92.4%	95.0%	
2.21	No children under 18 admitted to adult in-patient wards	96.1%	100.0%	98.2%	100.0%	

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

1.04: CPA (Care Programme Approach) – Formal review within 12 months [Community MH Services]
Performance for June is 90.1% (93 cases) against a performance threshold of 95% and is below Statistical Process Control (SPC) limits. Most of the cases are within Recovery (51), Eating Disorders (10), Assertive Outreach (6) and Early Intervention (6).

There is a Service Recovery Action Plan which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place.
Team managers are raising compliance with teams, assisted by Business Intelligence reports, and are setting up weekly schedules with early warnings for reviews that are due.

2.21: Admissions of Under 18s to Adult Inpatient Wards [Hospitals MH]
There were 2 admissions of under 18s in June.

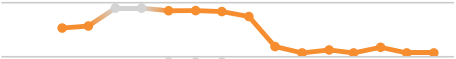
A young person aged 15 and previously known to services was admitted to Wotton Lawn with psychotic presentation. They were transferred 6 days later to a Tier 4 Unit. The other admission, also to Wotton Lawn, was a young person, nearing their 18th birthday with psychotic presentation and under the care of our Early Intervention Service. They were transferred 4 days later to a Tier 4 Unit.

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

		JUNE	21/22	
3.07	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	94.0% / 95.0%	96.0% / 95.0%	
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	51.5% / 100.0%	50.0% / 100.0%	
3.32	CPI: Referral to Assessment within 4 weeks	66.6% / 90.0%	83.9% / 90.0%	
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	0.0% / 95.0%	6.6% / 95.0%	
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	0.0% / 95.0%	12.9% / 95.0%	
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	57.8% / 95.0%	59.5% / 95.0%	
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	88.8% / 95.0%	71.0% / 95.0%	

<u>Performance Thresholds not being achieved in Month</u> - *Note all indicators have been in exception previously within the last twelve months. 3.07 has been in exception but retrospective data entry now presents compliant periods within the visualisation above.*

3.07: CPA (Care Programme Approach) – Formal review within 13 months [Community MH Services]
Performance for June is 94.0% against a performance threshold of 95% and is below Statistical Process Control (SPC) limits. This indicator is a subset of 1.04 and of those non-compliant records there were 55 where the CPA review is not recorded as having taken place within 13 months. Of these, 31 were within the Recovery service and 8 within the Eating Disorders Service.

There is a Service Recovery Action Plan which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place.
Team managers are raising compliance with teams, assisted by Business Intelligence reports, and are setting up weekly schedules with early warnings for reviews that are due.

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded [CYPS MH]
June is reported at 51.5% against a local performance threshold of 100%.

A target of 100% was set by NHS England as an ambition across all CAMHS services and a local target set at 100% to reflect this. It has now been recognised that this is not achievable, and local agreement has been reached with Commissioners to reduce this in line with the pre-COVID CQUIN target to 50%. The threshold in the performance report will be updated once a contract variation has been received.

The service has developed individual caseload trackers for each evidence-based intervention that is being delivered and ROMS (Routine Outcome Measures) reporting is included within this for each Intervention Lead to review. Further development is required to flow the new Goal-Based ROMS into the data warehouse to allow inclusion within the caseload trackers and the Mental Health Data Set. There is a ROMS action plan which is monitored within the Operational Directorate Governance Forum (ODGF).

3.32: CPI (Complex Psychological Intervention): Referral to assessment within 4 weeks [Community MH Services]
June performance is reported at 66.6% against a performance threshold of 90% and is below Statistical Process Control (SPC) limits.

There were 9 non-compliant cases in June. Two clients were offered appointments within 4 weeks but did not attend. The remaining 7 clients were seen within 6 to 9 weeks after referral.
The service continues to operate with a shortage of staff due to vacancies and long-term sickness. The service is experiencing issues with recruitment and vacancies have been advertised on several occasions and for extended periods. The service has engaged with HR (Human Resources) to support and raise profiles. Extended hours are being offered to existing staff, staff bank used where possible and job specifications being adapted to offer preceptorships (supported transition bridge to becoming skilled).

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]
June performance is reported at 0% against a performance threshold of 95%. There were 2 non-compliant cases in June.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
June performance is reported at 0% against a performance threshold of 95%. There were 9 non-compliant cases in June.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
June performance is reported at 57.8% against a 95% performance threshold. There were 8 non-compliant cases reported in June.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]
June performance is reported at 88.8% against a 95% performance threshold. There was 1 non-compliant case reported in June.

Note on 3.35, 3.37, 3.39 & 3.40 – Eating Disorders waiting times
The service continues to recruit to the current vacancies with successful candidates due to take up posts over the coming months. The service is now expecting to be at, or very near, full establishment by mid-August 2021.The current wait profile for the service at the end of June indicates that 78.4% (360) of all patients waiting for assessment, are waiting over 4 weeks and waiting times will continue to increase until newly recruited staff are fully in post.

Demand remains high overall with a 24% increase in referrals during 2020/21 compared to 2019/20 and a significant increase in urgent referrals for under 18s (28% in 2020/21 compared to 17% in 2019/20) and this is continuing with 43.7% of referrals received in June being flagged as urgent. The main impact of this referral increase appears to be the detrimental effect that the pandemic, lockdown and school closures have had on Children and Young Peoples' wellbeing and mental health. This is validated by the replication in demand across other teams treating CYP. Day treatment has been closed temporarily and staff capacity used to accommodate the increase in urgent referrals and is likely to remain closed until at least September 2021, however the service is looking at a temporary model for patients that would benefit from tailored group interventions.

The service is accepting routine referrals, which are being triaged and placed on a waiting list, however, assessment and treatment will continue to be paused throughout July 2021 which will impact on future reported waiting times and has led to several referrals being expedited due to the patients deteriorating condition.

The service has a development and improvement plan which focuses on all areas of recovery and has been actively engaging with commissioners to ensure that the staffing establishment can meet business as usual demands. The latest capacity mapping work shows that the team require 5 additional WTE (whole time equivalents) to keep up with current demands.

Mental Health Services: Regroup, Reconnect, Recover Update
Operational Services have been RAG rated by Service Directors in relation to the risks associated with their ability to deliver post-Covid service recovery. Services with a predicted recovery plan in place that would take 12 months+ to recover to pre-Covid levels have been identified.

There are 6 services within Mental Health Services that, based on current trajectories, have been identified as taking 12 months+ to recover. The services are:

- Eating Disorders
- ASC
- ADHD
- Memory Assessment Service
- CAMHS Level 2/3
- CAMHS Learning Disabilities

Work has taken place throughout June/ July to establish the pre-covid baseline for each of these services from Quarter 3 (October to December) 2019, clarifying service demand, the number of those waiting and the length of waits period pre-covid. This exercise was then repeated to ascertain the post-Covid position for Quarter 1 (April to June) 2021. This is enabling a better understanding of recovery to be achieved and the focus for recovery actions. A number of these services had challenging historic wait times pre-covid which have now been extended post-covid including some with increased referrals. Some of these services are now subject to service redesign as pre-covid models of service delivery were not optimum to secure effective and timely delivery. This work and reporting is now being further developed to inform recovery focus, progress and improvements.

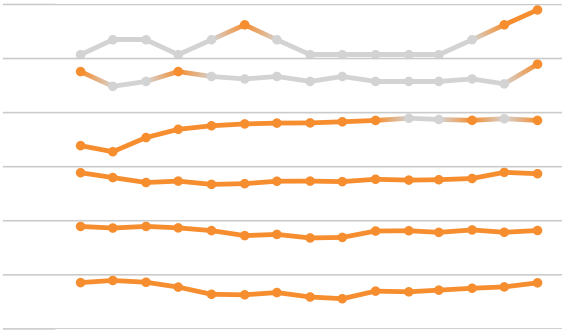
Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		JUNE	21/22
14	Number of post 48 hour Clostridium Difficile Infections	300.0% / 100.0%	200.0% / 100.0%
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	133.3% / 100.0%	102.2% / 100.0%
84	% of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor	93.2% / 95.0%	94.4% / 95.0%
86	% of children who received a 9-12 month review by the time they turned 12 months	82.2% / 95.0%	80.4% / 95.0%
87	% of children who received a 12 month review by the time they turned 15 months	82.8% / 95.0%	82.1% / 95.0%
88	% of children who received a 2-2.5 year review by 2.5 years	81.4% / 95.0%	75.8% / 95.0%



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

14. Number of post 48-hour Clostridium Difficile Infections [Community Hospitals]
There were 3 cases in June. There has been an noticeable increase in C.Diff toxin positive nationwide, GHNHSFT have also had an increase in the number of cases.

One patient was transferred to Coln Ward for Rehab but was subsequently transferred back to GRH following a further fall. The patient was recorded as C.Diff positive the day before the fall occurred. The second case was a transfer from GHNHSFT following treatment for hospital acquired pneumonia. The patient developed further Hospital acquired pneumonia whilst on Jubilee Ward. The patient tested positive for C.Diff and has had three courses of antibiotics. The third case of C.Diff was a patient who was transferred from GHNHSFT following surgery for fractured neck of femur, treated with two courses of antibiotics post-operatively. The patient had been prescribed three different laxatives whilst in GHNSFT, transferred to North Cotswold Hospital for rehab. The patient tested positive for C.Diff a week into their admission at NCH.

The IP&C team are in the process of reviewing the C.diff policy and will relaunch once approved. They are also undertaking a review of the cases shortly to see if there are any themes. The IP&C team are supporting clinical teams to help to reduce HOHA (Hospital Onset Healthcare Associated) cases. There appears to be a national rise in C.diff cases but need to understand possible reasons. The C.diff documentation is being reviewed by the ICS (across the county).

38: Time to initial assessment for patients arriving by ambulance (95th percentile) [Minor Injuries and Illness]
The 95th-percentile time for ambulance arrivals to initial assessment was 00:20 mins in June 2021, this is above the 00:15mins threshold. The above-threshold times occurred in Cirencester and Lydney MIIUs. The service confirmed this is due to retrospective logging of the initial assessment time due to delay in writing notes and the patients were assessed within the expected timeframe. The Matron for MIIUs will remind staff to ensure times are entered accurately in SystmOne and data validation will be completed to adjust the time reported. The June figure is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a National indicator.

84: Percentage of live births that receive a face to face New Birth Visit within 7-14 days by a Health Visitor. [Children and Young People Service]
93.2% of eligible children received a face to face New Birth Visit by a Health Visitor in June 2021 compared to a target of 95%. 431 out of 462 reviews were completed within the target timeframe 7-14 days. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a National indicator. 96% were seen by day 30.

Unless a family decline the Health Visiting Service completely the offer of a new birth visit will be made and all children will be seen. If the children are in NICU, a home visit will be agreed with the parent as close to when the baby is discharged as possible. Three of the families that were inaccessible to the HV within timeframe have since been seen. Four families that were not seen within timeframe have also now been seen and had an assessment.

At the outturn of 2019/20, GHC performed at 91.5% against a 86.8% National benchmark. GHC continues to perform favourably in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

86: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]
82.2% of eligible children received the 9-12 month visit by a Health Visitor in June 2021 compared to a target of 95%. 432 out of 525 reviews were completed within the target timeframe 9-12 months. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a National indicator.

The parents of all children within the cohort were offered the opportunity to receive a 9-12mth and 2-year review. For all children classified as Universal, virtual appointments via Attend Anywhere are being offered for developmental reviews. This will be reverted to face to face offers dependent upon an estate within the locality being available and it being COVID secure. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

At the outturn of 2019/20, GHC performed at 84.8% against a 77.0% National benchmark. GHC continues to perform favourably in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

87: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]
82.8% of eligible children received the 9–12-month visit (by the time they were 15-months old) by a Health Visitor in June, compared to a target of 95%. 367 out of 443 reviews were completed within the target timeframe of 15 months. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a National indicator.

Most of the cohort not seen by the time they are 15 months is mainly due to parental decline of the review. The service has completed a total of 877 'catch up' developmental reviews where parents have requested to delay their child's developmental review initially and then accepted the offer when comfortable to do so. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

At the outturn of 2019/20, GHC performed at 90.2% against a 83.6% National benchmark. GHC continues to perform satisfactorily in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

88: Percentage of children who received a 2-2.5-year review by 2.5 years [Children and Young People Service]
81.4% of eligible children received the 2-2.5-year mandated contact by a Health Visitor in June, compared to a target of 95%. 431 out of 529 reviews were completed within the target timeframe of 2-2.5 years. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a National indicator.

All UP (Universal Partnership) and UPP (Universal Partnership Plus) are seen Face to Face (F2F) in the home setting for a full family health needs assessment. As lockdown eases and estate space allows, the service will be returning the 2-year ASQ (Ages and Stages Questionnaire) to face to face with an additional intervention called Early Language Identification Measure (ELIM) to use alongside ASQ. The virtual offer has not increased rates of acceptance of the developmental review as was hoped.

The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

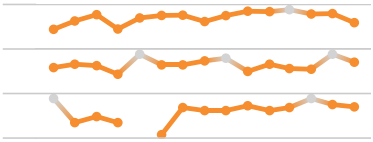
At the outturn of 2019/20, GHC performed at 83.5% against a 78.6% National benchmark. GHC continues to perform favourably in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		JUNE	21/22	
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	62.7% (90.0%)	74.7% (90.0%)	
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	80.0% (90.0%)	81.4% (90.0%)	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	76.9% (92.0%)	81.8% (92.0%)	

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

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks [Adult Community Services]
19 out of 51 new adult referrals were assessed outside of the 8-week threshold in June. Performance is 62.7% and below the target of 90%.

There is an improving trajectory for waiters, with 111 patients waiting over 8 weeks, of which 48 are over 18 weeks. This compares to 146 over 8 weeks and 102 over 18 weeks in Dec 2020. It is anticipated that all over 18 week waiters will be cleared by Dec 2021.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks [Adult Community Services]
2 out of 10 new under 18 referrals were assessed outside of the 8-week threshold in June. Performance is 80% and below the target of 90%.

There is an improving trajectory for waiters, with 9 patients waiting over 8 weeks, of which 2 are over 18 weeks who are in complex situations with clear plans in place. This compares to 11 over 8 weeks and 4 over 18 weeks in Dec 2020. There is a plan to meet our KPI thresholds by Dec 2021.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral [Adult Community Services]
3 out of 13 equipment were not delivered within 18 weeks of referral in June. Performance is 76.9% compared to a target of 92%.

There is an improving trajectory for adult and Under 18 (year old) waiters, with 95 patients waiting over 18 weeks of which 17 are Under 18 years old. This compares to 172 over 18 weeks of which 27 were Under 18 years old in Dec 2020. It is anticipated that all over 18 week waiters will be cleared by Dec 2021.

Additional Commentary for 67, 69 & 71
The Wheelchair Service continues to collaborate with the Business Intelligence team (BI) 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, alongside actions agreed following an external audit, is reflected in the improved performance data.

The Dashboard figures now show:

- Urgent referral assessments in June are slightly higher than the 12 month average of 11 per month.
- 100% performance for the adult and under 18 'urgent referral to assessment' KPI, with the exception of June, January and February, where the target was missed by only by only one exception per month. 12 month performance is above the 95% target at 97.5%.
- February to June has seen an increase in routine assessments, particularly for adults, as colleagues have returned to the service from long term sickness and have created the capacity to address longer routine waits.
- Total numbers waiting for handover have reduced in June after having remained level since January 2020.

It should also be noted that routine referral and handover KPIs are much more stable over the last 6 months and there are now single figure referral numbers transferred from the old system (BEST) waiting for assessment or handover.

Physical Health Services: Regroup Reconnect Recover Update
Operational Services have been RAG rated by Service Directors in relation to the risks associated with their ability to deliver post-Covid service recovery. Service with a predicted recovery plan in place that would take 12 months+ to recover to pre-Covid levels have been identified.

There are 9 services within Physical Health Services that, based on current trajectories, have been identified as taking 12 months+ to recover. The services are:

- Respiratory – Home Oxygen Service
- Pulmonary Rehab
- Diabetes
- Heart Failure
- Cardiac Rehab
- Adult MSK
- Wheelchair Assessment Service
- Children's S&LT

• Children's Immunisation

These services use SysmOne to record their activity, and so work is currently underway to improve and standardise service reporting by the BI team with operational services. Work will be carried out in August/ September to establish the pre-covid baseline for each of these services from Quarter 3 (October to December) 2019, clarifying service demand, wait times and numbers waiting at the period pre-covid. This will be repeated to ascertain the post-Covid position from Quarter 1 (April to June) 2021. This is enabling a better understanding of recovery to be achieved and the focus for recovery actions. A number of these services had challenging wait times pre-covid which have now been extended post-covid including some with increased referrals. Some of these services are now subject to service redesign as pre-covid models of service delivery were not optimum to secure effective and timely delivery. This work and reporting will be further developed to inform recovery focus, progress and improvements.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements

		JUNE	21/22	
77	Mandatory Training	88.4% (90.0%)	88.2% (90.0%)	
78	% of Staff with completed Personal Development Reviews (Appraisal)	71.1% (90.0%)	71.1% (90.0%)	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	76.1% (90.0%)	73.3% (90.0%)	

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

77: Mandatory Training [Trust Wide Workforce]
Performance was 88.3% in June, below the target of 90%. Performance is below the SPC chart lower control limit based on 2018/19 and 2019/20 data. Mandatory training figures include Bank Staff.

The work that services/ teams have been doing to help re-instate training compliance levels continues to show improvement to the Trust overall compliance figure, although it is still just short of the Trust's 90% training compliance target. There are still some topics and/ or service areas where figures remain lower than required and work is continuing to ensure any deficits are rectified in a timely manner; this includes work with the Trust's Staff Bank. The Trust's overall training compliance figure minus staff bank is 92.7%.

78: % of Staff with completed Personal Development Reviews (Appraisal) [Trust Wide Workforce]
Performance in June was 71.1% compared to a target of 90%. There is increasing focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. [Trust Wide Workforce]
Performance in June was 76.1% compared to a target of 90%. There is increasing focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data.

Commentary for KPIs 78 and 78a
The Workforce team continues to encourage appraisals to be completed and recorded on the Electronic Staff Record (ESR) and reminders are sent out to all managers giving 3 months' notice of when the appraisal for their teams is due and encouraging managers and colleagues to book their meetings. Bookings have been made by colleagues to attend the appraisal conversation training.

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AGENDA ITEM: 10/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 30th June 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
Provide an update of the financial position of the Trust.

Recommendations and decisions required

- The Board are asked to **note** the month 3 position
- **Approve** the revised capital programme

Executive summary

- Final audited accounts were submitted by the 29th June deadline
- There were no material movements to the accounts. The year end surplus remained at £47k
- The Trust has a H1 plan of break even
- The Trust's position at month 3 is a surplus of £42k
- The Trust is forecasting a H1 position of break even
- The cash balance at month 11 is £58.2m
- Capital expenditure is £0.980m at month 3
- The Trust has revised the capital plan
- The 21/22 plan remains at £15.993m but reflects increases to some buildings scheme costs and reduced backlog maintenance spend
- It should be noted that these changes require the Estates Strategy to be updated before it is published
- Future years of the programme have also been amended to reflect rephrasing and the inclusion of some leases due to IFRS16
- The Trust has spent £0.468m on Covid related revenue costs between April and June

Risks associated with meeting the Trust's values
Risks identified within the report.

Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	

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

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Finance Report
Month 3

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Overview

- Final audited accounts were submitted by the 29th June deadline
- There were no material amendments to the accounts and the year end surplus for GHC remained at 0.047m
- Gloucestershire ICS has been given an overall funding envelope that it collectively has to manage for the first six months of 21/22, known as H1
- The Trust has a H1 financial plan of break even following allocation of the system envelope
- At month 3 the Trust has a small surplus of £21k and a six month forecast position of break even in line with the plan
- The Trust has recorded Covid related expenditure of £0.468m for April to June
- The Trust has revised its five year capital programme. In 21/22 the plan remains at £15.993m but a number of adjustments to scheme costs and priorities have been proposed by the Capital Management Group.
- Adjustments to future years have also been made including the inclusion of potential future leases
- The Board is asked to approve the proposed revised capital programme
- 21/22 Capital plan is £15.993m and spend to month 3 is £0.980m which is £1.257m less than the year to date plan to NHSI
- Cash at the end of month 3 is £58.2m
- The Trust has begun preparation work for the implementation of IFRS 16 across the NHS. This Reporting Standard affects the way organisations record leases, or lease components of a contract

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2021/22	2021/22	2021/22				2021/22
	Mth 1-12	Mth 1-6	Mths 1-3				Mth 1-12
	Original Plan	NHSI H1 plan	Original Plan to date	NHSI H1 plan to date	YTD Actual	Variance	Full Year Forecast
Operating income from patient care activities	220,598	112,680	55,150	56,340	57,800	1,460	225,360
Other operating income	6,700	5,634	1,675	2,817	1,229	(1,588)	11,268
Employee expenses	(170,274)	(84,531)	(42,569)	(42,266)	(43,605)	(1,340)	(169,062)
Operating expenses excluding employee expenses	(53,533)	(32,454)	(13,383)	(16,227)	(14,755)	1,472	(64,908)
PDC dividends payable/refundable	(2,701)	(1,353)	(675)	(677)	(648)	29	(2,706)
Other gains / losses	0					0	0
Surplus/(deficit) before impairments & transfers	**790**	**(24)**	**198**	**(12)**	**21**	**33**	**(48)**
impairments / exceptional items*	0	0	0	0		0	0
Remove capital donations/grants I&E impact	100	24	25	12	0	(12)	48
Surplus/(deficit)	**890**	**0**	**223**	**0**	**21**	**21**	**0**
Adjust (gains)/losses on transfers by absorption/impairments	**0**	0	**0**	0	**0**	0	0
Revised Surplus/(deficit)	**890**	**0**	**223**	**0**	**21**	**21**	**0**

Note. The variance compare 'Revised NHSI HI1 plan to date' against 'Actual'
It is assumed forecast is to plan at six and 12 months while further analysis is undertaken

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2020/21	2021/22	2021/22	Mths 1-3 2021/22 Year to Date				2021/22
		Actual	Original Plan	Revised NHSI H1 plan	Original Plan ytd	Revised NHSI H1 plan ytd	Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	488	488	488	488	488	346	(142)	488
	Property, plant and equipment: other	109,796	119,881	115,135	111,970	111,970	109,329	(2,641)	119,881
	NHS receivables	276	0	0	0	0	0	0	0
	Non-NHS receivables	316	0	0	0	0	251	251	0
	Total non-current assets	**110,876**	**120,369**	**115,623**	**112,458**	**112,458**	**109,926**	**(2,532)**	**120,369**
Current assets	Inventories	718	418	568	668	668	718	50	418
	NHS receivables	6,077	5,877	5,977	6,044	6,044	7,052	1,008	5,877
	Non-NHS receivables	5,928	5,928	5,928	5,928	5,928	4,523	(1,405)	5,928
	Cash and cash equivalents:	52,333	38,340	44,547	50,001	49,211	58,164	8,953	38,340
	Property held for sale	0	0	0	0	0		0	0
	Total current assets	**65,056**	**50,563**	**57,020**	**62,641**	**61,851**	**70,457**	**8,607**	**50,563**
Current liabilities	Trade and other payables: capital	(5,108)	(3,108)	(4,108)	(4,775)	(4,775)	(2,674)	2,101	(3,108)
	Trade and other payables: non-capital	(23,762)	(20,262)	(22,012)	(23,179)	(23,179)	(30,308)	(7,129)	(20,262)
	Borrowings	(107)	(107)	(107)	(107)	(107)	(107)	0	(107)
	Provisions	(3,526)	(1,526)	(2,526)	(3,193)	(3,193)	(3,524)	(331)	(1,526)
	Other liabilities: deferred income including contract liabilities	(2,273)	(773)	(1,523)	(2,023)	(2,023)	(2,620)	(597)	(773)
	Total current liabilities	**(34,776)**	**(25,776)**	**(30,276)**	**(33,276)**	**(33,276)**	**(39,233)**	**(5,957)**	**(25,776)**
Non-current liabilities	Borrowings	(1,363)	(1,363)	(1,363)	(1,363)	(1,363)	(1,337)	26	(1,363)
	Provisions	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	0	(1,423)
	Total net assets employed	**138,370**	**142,370**	**139,580**	**139,037**	**138,247**	**138,390**	**144**	**142,370**
Taxpayers Equity	Public dividend capital	126,578	126,578	126,578	126,578	126,578	126,578	0	126,578
	Revaluation reserve	6,826	6,826	6,826	6,826	6,826	6,826	0	6,826
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	6,207	10,207	7,417	6,874	6,084	6,227	144	10,207
	Total taxpayers' and others' equity	**138,370**	**142,370**	**139,580**	**139,037**	**138,247**	**138,390**	**144**	**142,370**

Creditors action plan in place to reduce level of trade and other payables

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 20/21		ORIGINAL PLAN 21/22		ACTUAL YTD 21/22		YEAR END FORECAST 21/22	
Cash and cash equivalents at start of period		**37,720**		**52,333**		**52,333**		**52,333**
Cash flows from operating activities								
Operating surplus/(deficit)	(203)		**2,800**		665		0	
Add back: Depreciation on donated assets	127		0		21		126	
Adjusted Operating surplus/(deficit) per I&E	**(76)**		**2,800**		**686**		**126**	
Add back: Depreciation on owned assets	8,734		6,500		1,545		6,204	
Add back: Impairment	5,006		0					
(Increase)/Decrease in inventories	0		300		(0)		300	
(Increase)/Decrease in trade & other receivables	5,722		200		771		(1,221)	
Increase/(Decrease) in provisions	492		(1,500)		(2)		(1,669)	
Increase/(Decrease) in trade and other payables	7,758		(1,500)		3,463		(4,073)	
Increase/(Decrease) in other liabilities	(1,409)		0		347		24	
Net cash generated from / (used in) operations		**26,227**		**6,800**		**6,810**		**(310)**
Cash flows from investing activities								
Interest received	9		0		4			
Purchase of property, plant and equipment	(10,769)		(17,993)		(952)		(11,721)	
Sale of Property	0		0					
Net cash generated used in investing activities		**(10,760)**		**(17,993)**		**(948)**		**(11,721)**
Cash flows from financing activities								
PDC Dividend Received	679		**0**		0			
PDC Dividend (Paid)	(1,170)		**(2,800)**		0		(1,962)	
Finance Lease Rental Payments	(363)		**0**		(31)			
		(854)		**(2,800)**		**(31)**		**(1,962)**
Cash and cash equivalents at end of period		**52,333**		**38,340**		**58,164**		**38,340**

Covid 1

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has spent £468k up to 30th June 2021
- The Trust has received system COVID funding for the In Envelope expenditure
- Out of envelope income has been included at £186k

For periods up to and including 30/06/2021 (M3)	Plan 21/22 £	YTD Plan £	YTD costs £	Full Year Forecast £
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	507,832	126,958	**97,911**	**346,643**
Vaccine Program - Local Vaccination Service	0	0	**21,302**	**85,208**
Remote management of patients	186,000	46,500	**46,500**	**186,000**
Existing workforce additional shifts	223,440	55,860	**24,313**	**72,090**
Decontamination	82,510	20,628	**19,156**	**37,156**
Backfill for higher sickness absence	223,440	55,860	**28,591**	**92,832**
Remote working for non patient activites	186,000	46,500	**46,500**	**186,000**
National procurement areas	72,000	18,000	**0**	**0**
Other	174,000	43,500	**0**	**0**
TOTAL IN ENVELOPE EXPENDITURE	**£1,655,222**	**£413,806**	**£284,273**	**£1,005,929**
Out of Envelope Expenditure				
COVID-19 virus testing (NHS laboratories)		**0**	**159,652**	**638,610**
Vaccine Program - Vaccine Centres			**23,863**	**95,452**
TOTAL OUT OF ENVELOPE EXPENDITURE	**£0**	**£0**	**£183,515**	**£734,062**
Out of Envelope Income				
COVID-19 virus testing (NHS laboratories)			**-£159,653**	**-638,611**
Vaccine Program - Vaccine Centres			**-£26,689**	**-106,756**
				0
TOTAL OUT OF ENVELOPE INCOME	**£0**	**£0**	**-£186,342**	**-£745,367**

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Original Plan	Updated Plan	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan
£000s	2021/22	2021/22	2021/22	2021/22	2022/23	2023/24	2024/25	2025/26
Land and Buildings								
Buildings	3,563	4,737	619	4,737	1,500	2,500	2,500	1,000
Backlog Maintenance	5,657	3,831	259	3,831	0	2,876	1,250	1,393
Urgent Care	750	750	4	750	0	0	0	0
LD Assessment & Treatment Unit						2,000		
Cirencester Scheme						5,000		
Medical Equipment	1,569	2,221	57	2,221	0	130	1,030	1,030
IT								
IT Device and software upgrade	200	200	2	200	600	600	600	600
IT Infrastructure	1,086	1,086	43	1,086	996	1,300	1,300	1,300
Unallocated	168	168	0	168	0	0	2,300	2,300
Sub Total	**12,993**	**12,993**	**985**	**12,993**	**3,096**	**14,406**	**8,980**	**7,623**
Forest of Dean	3,000	3,000	(5)	3,000	16,000	3,500	0	0
Total of Original Programme	**15,993**	**15,993**	**980**	**15,993**	**19,096**	**17,906**	**8,980**	**7,623**
Disposals					(1,349)	(2,454)	(2,000)	0
Donation - Cirencester Scheme					0	(5,000)	0	**0**
	15,993	**15,993**	**980**	**15,993**	**17,747**	**10,452**	**6,980**	**7,623**

Forest of Dean scheme includes prior year spend of £1.4m giving total scheme cost of £ 23.9m

Revised 21/22 plan with increased building scheme costs and new xray equip.

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the Trust's financial position are as set out below:

Risks 21/22	21/22 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Differential CIP schemes	363	363	0	3	2	6
Delivering Value Scheme CIPs	900	900	0	5	3	15
Delivering non recurring savings	800	0	800	1	3	3
Efficiencies need to be higher than assumed (0.9% more)	950	950	0	3	3	9
Risks 22/23	**22/23 Risks**	**Made up of: Recurring**	**Made up of: Non Recurring**	**Likelihood**	**Impact**	**RISK SCORE**
IFRS 16 cost implications not fully funded	1,300	1,300	0	2	3	6
Total of all risks	**4,313**	**3,513**	**800**			

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AGENDA ITEM: 11/0721

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 29 JULY 2021**
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.
- **Note** the planned changes of Non-Executive Directors

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 – including planned changes of Non-Executive Directors
- Governor activities – including updates on changes in Council of Governor membership
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

It is highlighted that as the move out of lockdown continues that the Chair and Non-Executive Directors will be moving back to more face to face visits and quality visits where appropriate.

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** (Pages 11-13) Non-Executive Director – Summary of Activity – 1st May – 30th June 2021

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

REPORT FROM THE CHAIR

1. 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. BOARD

2.1 Non-Executive Director (NED) Update

Maria Bond's term of office concludes on 30th September and she will therefore be stepping down from her Board position as part of the regular renewal and refresh process within Board membership. We will be saying our formal farewell to Maria at the September Board, but I would like to record here the Board and my thanks for the important contribution Maria has made: first to the 2gether Board, and then on the GHC Board following the merger. Her contribution, as Chair of the Quality Committee, in shaping the Committee to focus effectively on both mental and physical heath, was significant as we moved forward as a merged Trust and during the pandemic.

A recruitment process has been under way to identify a successor and following a competitive interview process, I am very pleased to announce that we have appointed **Mr. Clive Chadhani** who will be joining the Trust on 1st October 2021. Clive is a FCCA qualified Finance Director with over 26 years global finance work experience within different industry sectors. Clive has agreed to begin some induction activities ahead of his formal start date and we look forward to welcoming him to the Trust and to the Board.

The Non-Executive Directors and I continue to hold our **monthly meetings** and virtual meetings were held on 22nd June and 20th July.

NED meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive at this difficult time and to continuously improve the way we operate.

I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

2.2 **Board Updates:**

Extra-ordinary Trust Board – 15th July

An extra-ordinary meeting of the Trust Board was held on 15th July to consider the Final Business Case for the new community hospital in the Forest of Dean. Following approval by Board, the Trust will now seek planning permission for the new 24 bed hospital in Steam Mills Road, Cinderford, with a view to starting construction in early 2022. Further information is available on the Trust's website using this link https://www.ghc.nhs.uk/about-us/fod-hospital/

This major investment in a modern, fit for purpose new facility is an important development for both the Trust and the Forest of Dean. We will continue to engage with local people and key stakeholders as we take the next steps in delivering this project.

Board Strategy:
The Trust launched it's new "**People Strategy**" on 6th July. This is our five-year strategy confirming the Trust's goals, aims and ambitions for its 5,400 strong workforce, made up of more than 40 different professions. The Trust's ultimate goal over the next five years is "to be a healthy and happy high-quality workforce, performing well in all local and national performance standards". The Trust's aim is to be a "Great Place to Work". More information can be found on the Trust's website.

I am delighted that this cornerstone strategy has been put in place and know that the Board is committed to taking it forward and ensuring that the key resource of the Trust, our colleagues, are empowered and supported to achieve their best for our communities.

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 high quality care and colleagues' wellbeing. The following sessions have taken place:

Wednesday 16th June – two Board Seminars were held - High Quality Care (a.m.) and Measuring What Matters (p.m.). These were two insightful sessions which included input from the teams involved to allow us to be both strategic but grounded in an understanding of current practice. We look forward to taking the issues raised to the next stage.

3. GOVERNOR UPDATES

- I attended a meeting of the **Nominations and Remuneration Committee** on 30th June where the Committee considered the outcome of the appraisals for the Non-Executive Directors for the period 2020-2021.

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 17th June and 8th July. These sessions are helpful as we work together to further develop the Council of Governors.

- A meeting of the **Council of Governors** was held on 14th July where matters covered included the recommendations of the Nomination and Remuneration

Committee held on 30th June; an update on out of area placements for mental health inpatients; Receipt of the Annual Report and Accounts for the Trust. The meeting was followed by a helpful Development Session on the Trust Strategy, focusing on Quality Care and a Better Place to Work.

- A **Membership and Engagement Committee** was held on 23rd June and matters discussed included a report on public membership statistics; a Membership and Engagement Strategy Action Plan; discussion around developing opportunities for membership and engagement activity and a support pack for Governors. The next meeting is due to be held in September. The enthusiastic support of Committee members to take forward effective membership engagement is much appreciated.

- **Governor changes**:
  Josephine Smith's Term of Office as a Public Governor representing Tewkesbury ended on 14th July and she was thanked for her contribution to the Council over the period she has served.

  I am pleased to welcome to new Governors Andy Holness (Public Governor - Tewkesbury) and Rebecca Halifax (Appointed Governor - Gloucestershire County Council).

4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in May, I have attended a breadth of national meetings:

- **NHS Providers Board** – 2nd June - where we discussed important policy and national operational issues, along with current challenges and opportunities. Having served eight years as a Trustee, this was my last meeting. I am succeeded as the community sector chair representative by Mary Elmore of Cambridgeshire Community Trust. I am pleased to note that Gloucestershire Hospitals NHSFT Chief Executive, Deborah Lee, has also been elected to the Board.

- **NHS Confederation Virtual Annual Conference** –15-17 June. I attended the morning session on Tues 15th June for the opening speech by the new Confederation CEO, Matthew Taylor and also the keynote address by Sir Simon Stevens. I also attended a Chair's session on Weds 16th June.

- **NHS Providers Chairs and CEOs Network** – I attended a meeting on 1st July where we were joined by Sir Simon Stevens, Chief Executive of NHSE/I, who is shortly stepping down from this position. We also heard from Samantha Jones, a former NHS Trust CEO and newly appointed health adviser to the Prime Minister and received a strategic policy update from Chris Hopson, Chief Executive of NHS Providers.

- **NHS Providers Community Provider Chairs Networking session** – 8th July – where we discussed community sector priorities.

- **NHS Providers Community Network** – 8th July – matters included a strategic policy update from Matthew Taylor, Chief Executive of the NHS Confederation; an update from Matthew Winn, Director of Community Health at NHS England and a panel session on place-based partnerships.

- **South West NHS Provider Chairs meeting** – 9th July

- I have recently been invited to be a **Member of the NHS Executive Search Chair and Chief Executive Advisory Board** and attended its inaugural meeting on 9th July.

- **NHS Confederation NHS Reset Webinars** continue to take place on a regular basis and 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 past months. Our Non-Executive Director, Dr. Steve Alvis, recently hosted a session on primary care.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits. At the most recent meeting we received a briefing from Mental Health Chair lead, Claire Murdoch.

5. WORKING WITH OUR PARTNERS

I have continued my regular virtual 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:

- **Health Overview and Scrutiny Committee (HOSC)**:

    - **15th June** - following the local government elections in May, a virtual induction HOSC was held on 15th June. The Committee appointed a new Chair, Cllr Andrew Gravells MBE and Deputy Chair Cllr David Drew. The HOSC meeting on 15th June was intended as an induction session for the new committee, but also received a presentation from Healthwatch Gloucestershire; an update on the Gloucestershire Integrated Care System (ICS) which included updates on Covid-19 emergency response and the Forest of Dean Community Hospital consultation development. The Committee also received an update on the Fit for the Future Programme including recent proposals for developing specialist hospital services in the county.

    - **13th July** – this meeting was held at Shire Hall, Gloucester, with COVID secure restrictions in place, including numbers of attendees. I attended along with the Trust's Chief Executive and matters included an update on the Covid-19 emergency in Gloucestershire; a review of Temporary Services Changes and an update on Fit for the Future Consultation Programme.

- The **County's ICS Health Chairs** continue to meet virtually and we held meetings on 15th June and 13th July.

- Along with a number of the Trust's Non-Executive Directors, I attended a meeting of the **ICS NED Network** organised by the Clinical Commissioning Group, on 15th June.

- 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, Dame Gill Morgan.**

- **ICS Boards** were held on 17th June and 15th July. A number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported. Discussions also took place regarding the development plans for the ICS over the coming year.

- On 7th July, along with other members of the ICS Board, I attended a virtual meeting with the **Chief Executive and Chair of the NHS Confederation.**

- On 21st July I attended a meeting arranged by the **University of Gloucestershire** to discuss the **City Campus** (ex-Debenhams) along with various Gloucestershire health system partners.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- On 24th June I chaired a quarterly meeting with the **Chairs of the county's Leagues of Friends**. Angela Potter, the Trust's Director of Strategy and Partnerships, was also in attendance. Updates were given on the Trust's response to COVID-19; the Integrated Care System; Fit for the Future; the Forest of Dean Hospital; Minor Injury and Illness Units; Stroke unit. It was interesting to receive updates from the Chairs on activities which have taken place within their areas, despite the constraints of the pandemic. I would like to place on record my grateful thanks to **Graham Hewitt, the Chair of Fairford and Lechlade Communities Trust,** who will be stepping down from the Chair's position shortly. He will continue in his role as public governor so will not be lost to the Trust.

- The Chief Executive, the Director of Strategy and Partnerships and I held a meeting on 6th July with **Mark Harper MP** to update him on developments with the new Forest of Dean Hospital.

- Following recent appointments to the County Council's Health Overview and Scrutiny Committee, I have held discussions with the following **HOSC Members**:

Cllr Andrew Gravells MBE (Chair of HOSC) – I held a virtual meeting with Cllr Gravells on 6th July to congratulate him on his new appointment and brief him on current matters. We have agreed to hold our usual annual informal briefing between the Trust and HOSC Members in October.

Cllr David Drew (Deputy Chair of HOSC) – a presentation and visit to Stroud services is being planned for Cllr Drew and Stroud Councillor Helen Fenton on 25th August.

Cllr Gill Mosely (new Gloucestershire County Councillor, Newent Town Councillor and Member of the Forest of Dean District Council) – where I updated her on the latest developments on the Forest of Dean hospital.

- **Calls with the Chairs of the Leagues of Friends for the Forest of Dean hospitals** - Lydney (Mary Thurston) and Dilke (Bob Young) – to update on proposals for the new Forest of Dean Hospital, ahead of Trust Board discussions on 15th July.

- I was delighted to be invited to the **Bishop of Gloucester's Annual Garden Party** at Bishopscourt in Gloucester on Fri 23rd July. This is always a lovely occasion and presents a good opportunity to catch up with a wide range of third sector partners.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- **NHS 73rd birthday celebrations – 5th July 2021**

The NHS as a whole was honoured to be awarded **The George Cross by Her Majesty The Queen** to mark its public service over seven decades. The award recognised all NHS staff, past and present, across all disciplines and all four nations.

As part of the national celebrations, Paul Roberts, CEO, wrote to Trust colleagues to thank everyone for their incredible contributions over the course of the last unprecedented year and for upholding the values of the NHS in such a magnificent way. I, along with the County's Health Chairs, recorded a video message of thanks to all colleagues.

- Following feedback from ICS Partners and colleagues, I carried out the **Chief Executive's annual appraisal** on 1st June 2021.

- An **Appointment and Terms of Service Committee** was held on 1st June 2021 to consider the appointment process for the Chief Operating Officer following the resignation of John Campbell, as updated in the Chief Executive's Report.

- As part of my informal visits to Trust services, I visited **Charlton Lane Hospital** on 3rd June and **Hope House and the Sexual Assault Referral Centre (SARC)** on 21st July. My grateful thanks to Modern Matron, Steve Ireland (Charlton Lane), Lead Sexual Health Nurse, Adam Godwin, Crisis Worker Karen Lowden

and SARC/VANS Co-ordinator Claire Raven (Hope House and SARC) for sparing time during their business schedules to accompany me on my visits.

- As part of the **Big Health and Wellbeing Week** which took place from 21st to 25th June, the Chief Executive and I were pleased to be asked by event organiser **Simon Shorrick** to launch the Big Health Check Day on Monday 21st June. This year due to the pandemic the week's events all took place via Zoom. This is the thirteenth year of the Big Health event and the aim of the Big Health Week is to deliver an inclusive week with the theme of staying healthy and active, to meet friends, to have fun, to reduce health inequalities for people living with a learning disability, a physical disability and / or mental health problems, and help people to help themselves through activities arranged.

- As part of Armed Forces Week, the Trust was officially awarded its **Veteran Aware Accreditation** on 23rd June during a visit to Trust Headquarters by Deputy Lord Lieutenant, Colonel Andy Hodson. A brief ceremony at Edward Jenner Court was attended by some of the Trust's Veterans and the Accreditation was received by myself, along with the Chief Executive, and Community Services Manager, Jonathan Thomas, the Trust's Veterans Steering Group Lead. More information can be found via GHCcomms@ghc.nhs.uk

- Continuing with my rotational attendance at Board Committees, I attended the **Resources Committee** on 24th June.

- A **Summer Diversity Celebration** organised by Firoza Shaikh, HR/OD Engagement Manager, was held online on 15th July for colleagues to celebrate the diversity and range of experience across the Trust. I gave a short introduction, highlighting how diversity and inclusion is at the heart of the Trust and its values. This was an excellent event and was recorded so I would encourage those of us who were unable to be there to watch it on 'catch up'.

- **Formal Quality Visits** in person by myself and the NEDs had to be put on hold throughout the pandemic. However, with restrictions now easing a schedule of formal in person Quality Visits for myself and the Non-Executive Directors is now currently taking place and outcomes will be reported to Committee and Board meetings.

- Non-Executive and Executive Director informal "**pairing" meetings** continue to take place and I was pleased to meet with the Interim Chief Operating Officer, Hilary Shand, on 22nd July.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting when possible with the Chief Executive and the Trust Secretary/Head of Corporate Governance.

Whilst drop in chats with services and colleagues need to be virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I have an active presence on social media to fly the GHC flag and highlight great work across the county.

8. 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 May and June 2021.

9. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity – 1st May to 30th June 2021

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr. Stephen Alvis	Team Talk Governor Medical Director MHAM Individual Review meeting (2) Trust Chair Joint Director of Locality Development and Primary Care Quality Visit to Berkeley House Senior Leaders Network	NHS Reset Chairs meeting NHSP Governance and Quality Committee (2) Good Governance Institute webinar (4) NHSP Digital Inclusion event	Quality Committee NEDs meetings (4) FoD Assurance Committee Trust Board Board Seminars (3) ATOS Committee
Maria Bond	Director of Nursing, Quality and Therapies (4) Internal Auditors pre-meet (2) External Auditors pre-meet (2) Director of Strategy & Partnerships ref FoD economic modelling Chief Executive Expert by Experience Senior Leaders Network (2) Medical Director (2) Head of Corporate Governance/Trust Secretary Interim Chief Operating Officer Quality Visit – Charlton Lane Hospital MHAM Appeal Hearing ICS NED Network Reciprocal Mentoring meeting	NHS Reset Chairs meeting (2) Action on ACES conference Good Governance Institute ref Mental Health	Board Seminars (3) Audit and Assurance Committee (2) Quality Committee Trust Board Council of Governors NEDs meetings (4) Board Briefing (FoD) ATOS Committee (2) FoD Assurance Committee
Steve Brittan	Task and Finish Group (ref UoG) Sustainability Manager Director of Strategy and Partnerships (4) Internal Auditors pre-meet (2)	Digital Workshop NHS Reset Chairs meeting HSJ Webinar – Digital Priorities NHS Providers Digital Inclusion meeting	Board Seminars (3) Audit and Assurance Committee (2) Council of Governors NEDs meetings (4)

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	External Auditors pre-meet (2) Trust Chair (3) Vice-Chair Senior Independent Director Estates Strategy workshop Director of Finance/Dep CEO ICS NED Network		Board Briefing (FoD) Trust Board ATOS Resources Committee Forest of Dean Assurance Committee
Marcia Gallagher	Trust Chair (2) Internal Auditors (pre-meet) (2) External Auditors (pre-meet) (2) NHSI/E Regional Director Director of Finance Internal Auditors Joint Director of Locality Development and Primary Care Julie Mackie Longlisting for NED recruitment CYPS Delivery and Governance Forum ICS NED Network Quality visit to Dilke Hospital Senior Leaders Network NED recruitment – longlisting	NHS Reset Provider Collaboratives Good Governance Institute seminars (2)	Board Seminars (3) Audit and Assurance Committee (2) Council of Governors NEDs meetings (4) Trust Board ATOS Committee (2) Nom and Rem Committee
Sumita Hutchison	Meeting with Staff Governors (3) Estates Strategy workshop Director of HR & OD (2) Director of Strategy & Partnerships (pre-meet for Charitable Funds Committee) Interview Panel – Dep Director HR Diversity Network	Complaints Audit South West Wellbeing Guardian meeting NHS Confederation Annual Conference Freedom to Speak up event	Board Seminars (3) Staff Governor session Quality Committee Council of Governors NEDs meetings (4) Board Briefing (FoD) Trust Board Charitable Funds Committee Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Jan Marriott	CH Clinical Director and Community Hospitals Association FTSU Guardian Cheltenham Governors and Cheltenham Partnership Leads Non-Executive Director Director of Nursing, Therapies and Quality (2) Director of HR&OD NED ICS NED Network Mental Health Operational Group Quality Visit to Wotton Lawn Hospital Consultant Psychiatrist Interview Panel County MCA meeting		Board Seminars (3) Quality Committee Council of Governors NEDs meetings (4) Trust Board ATOS Committee (2) Resources Committee
Graham Russell	Director of Strategy and Partnerships ICS pre-meet with Chair and CEO Chief Executive Quality Visit to Charlton Lane Hospital Trust Chair NED recruitment – discussions with candidates ICS NED Network	Mental Health and Housing Seminar NHS Providers Digital Inclusion event Gloucestershire Community Mental Health event	Board Seminars (3) Audit and Assurance Committee (2) Council of Governors FoD Assurance Committee (2) Estates Strategy ICS Board (2) Trust Board NEDs meetings (4) Charitable Funds Committee ATOS Committee (2) Resources Committee Nom and Rem Committee

AGENDA ITEM: 12/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

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 and **Approve** the Modern Slavery Policy.
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Executive Summary

The Executive team and I remain working collaboratively and adaptably as we continue to respond to the ever-changing situation presented by the continuing pandemic. Whilst we follow government guidance as it is issued, particularly given the removal of lock-down restrictions on 19th July, we note the advisory and permissive nature of the guidance and continue to prioritise ensuring that all colleagues are working in a safe environment. It is likely that guidance will further change in the coming weeks and our priority will remain that of ensuring staff and service users understand the safety requirements within our services and that a safe environment is maintained.

The Trust continues to make progress on key programmes and projects including the recent approval of the Forest of Dean full business case, significant and welcome Mental Health investments, Covid-19 service recovery, an extension to our home first service (Enhanced Independence Offer), Equality, Diversity and Inclusion (EDI) initiatives, and following on from the May Board meeting the launch of the Trust's People Strategy.

The efforts put in by all colleagues to continue to move services and projects forward, while responding to the pandemic continues to be extraordinary. I am proud and grateful for the hard work, determination, and motivation of all those working within the Trust as we continue to work towards achieving our goals. As well as updates on the activity and focus of the CEO this report provides an update on the **Trust's People Strategy** is provided as well as an update on the **Trust's Modern Slavery Policy**, and changes to the **Executive Team**.

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

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

1.1 Covid-19

Transmission levels have continued to rise slowly but steadily in the past few weeks with levels in our county initially among the highest in the South West and above the national average. Thankfully, hospitalisations, while rising, have not reached the levels they did earlier in the year, mainly because of the successful vaccination roll out. The 19th July was the date when most of the remaining Covid-19 restrictions were moved from mandatory requirements to advisory or personal or organisation-based decisions. We continue to consider what this means for our colleagues, teams and services and will be doing what we can to keep everyone safe and healthy.

Discussions with the Executive Team and Senior Managers have established that it is prudent to continue with the existing application of Covid-19 secure guidance and local IPC guideline implementation. Following the Gloucestershire ICS IPC leads review of best practice, the current Gloucestershire Covid-19 infection rate and the need to continue to maintain the safety of our patients, families and colleagues, the following local guidance will be maintained from 19th July 2021.

Established IPC protective practises within Gloucestershire NHS Healthcare environment (clinical and administrative) regarding wearing a mask, social distancing and enhanced hand hygiene will continue. This will be of course under regular review and will respond to future changes in national guidance and community infection rates.

The Trust will continue to meet to develop further health and safety plans regarding transition on receipt of anticipated national guidance. We will continue to provide regular updates in light of any changing guidance or infection prevalence through our standard Trust communication routes. I would like to thank colleagues for their cooperation and understanding.

The co-incidence of the intense pandemic recovery programme, the third Covid-19 wave and the additional demand that appears to have resulted from the pandemic have meant that the system, as with the rest of the country, has been under considerable pressure over recent weeks. We have been dealing with significant demand in primary care, urgent and emergency care and planned care in hospital and community settings.

1.2 Internal engagement and developments

Since May I have continued to do a number of **service visits** (in person – where this can be done safely). Recently I have based myself at **Vale Community Hospital**, **Pullman Place, Hope House, North Cotswolds Community Hospital** and **Southgate Moorings**. Each day spent in these locations has been a very valuable experience providing substantial insight into colleagues' experiences with their working environment and how they address the challenges presented by the ever-changing circumstances. I value the opportunity to be able to continue to meet with

colleagues and patients, and to be on hand to discuss any topics or issues they would like to raise.

We are delighted that GHC has been named a **Veteran Aware** Trust, in recognition of our commitment to driving improvements in NHS care for veterans, reservists, members of the armed forces and their families. Veteran Aware Trusts are leading the way in improving veterans' care within the NHS as part of the Veterans Covenant Healthcare Alliance (VCHA). The Chair and I were very pleased to be present for the presentation of the Veteran's Aware accreditation by Deputy Lord Lieutenant, Colonel Andy Hodson. A brief ceremony was held at Edward Jenner Court and was attended by some of the Trust's very own Veterans. We continue to work to ensure that we provide the best possible care and experience for veterans and their families.

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-19 and workforce news, amongst other recent items of interest, such as: Be Kind to You Month (during July we are encouraging colleagues to consider a range of activities to support their wellbeing and reinforce the importance of taking time out to focus on themselves – whilst recognising the difficulties in this. There have been cookery demonstrations, exercise classes and mindfulness activities to name but a few), the Summer Diversity Celebration, the Big Health and Wellbeing Week, online fraud training, overseas recruitment, and more. The Team Talk sessions help to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team.

Virtual **Senior Leadership Network** (SLN) meetings were held on 29th June and 27th July. These provided an excellent opportunity to update the SLN on Trust and national developments. The June session featured a service recovery story relating to Speech and Language Services presented by Sarah Birmingham, Deputy Chief Operating Officer. Maddy King, Organisational Development Expert, also provided a useful update on the THRIVE leadership programme. Neil Savage, Director of HR & OD, further updated the group on our People Strategy and health and wellbeing. The feedback from these sessions continues to be overwhelmingly positive.

After careful deliberation with the recruitment team, **Corporate Induction** as of July is switching from taking place weekly to fortnightly. The hope is that once it is safe to do so and in line with government guidance we may be able to resume face-to-face inductions. As and when this is allowed, the recruitment team will prepare for these sessions to take place at Invista. For now, they will continue to be virtual, but are nonetheless an excellent opportunity for myself and/or the Executive Team to welcome new colleagues into the Trust, introduce our core values, and ensure that everyone feels included.

The Trust has continued to hold its **Covid-19 Briefing calls** for senior and on call managers. The frequency of these meetings is dictated by the level of activity in the Trust and system and are currently being held three times a week. These calls provide daily national, regional and local updates and data on the number of Covid-19 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 (especially as we enter into phase 3), and are able to assess resilience in these key areas on a regular basis and put in place any actions required.

A half day **Executive Development session** was facilitated by the **Kings Fund** for the Executive Team on 16th July. This session helped to develop the Executive Team's skills for individual recovery and wellbeing, reflected on service recovery, and spent time reconnecting with the leadership agenda.

1.3 Forest of Dean Hospital

On 15th of July the **Trust Board approved the Forest of Dean Hospital full business case**. The plans, including artist impressions, have now been shared publicly so that people can comment on them. The next steps will be securing capital and revenue support from system partners and agreeing the NHSE/I approval process. The submission of a planning application will take place shortly, with building scheduled to start in early 2022 subject to system and regulator support. Further updates are provided in the Systemwide Update provided by the Director of Strategic Partnerships.

1.4 Mental Health focus

As was widely predicted mental health services for children young people and adults have been under significant pressure in recent months. Demand has increased as has complexity and there continue to be significant issues with securing sufficient workforce. Colleagues in these services have worked under considerable pressure to maintain and recover services and review patient pathways in order to respond to demand.

My own focus on mental health has be local, regional, and national to progress the mental health agenda as the wider impacts of the pandemic manifest themselves and as services consider how mental health services can continue through the service recovery process. Throughout these conversations and meetings, it is evident that all colleagues and partners believe in the importance of Mental Health Services and are working tirelessly to ensure the best possible service is given across the Trust. The aim at the establishment of the Trust to provide joined up services, which consider a service users physical and mental health concerns, continue to be an important strand of this work.

I chair the monthly **South West (Regional) Mental Health CEO's** meeting, which acts as the overarching governance summit for the regional South West NHS Provider Collaborative. As well as making a number of key decisions about specialist services we have also been exploring the potential shape of the provider collaborative to reflect the recent White Paper and healthcare Bill.

In Gloucestershire I now chair the **Community Mental Health Transformation Programme Board**. The CMHT meeting held virtually on 23rd June discussed the terms of reference, governance structure, work streams and design development of the Gloucester City project, as well as future projects. The Programme Board has been set up to work alongside a "People's Participation" Board to ensure that there is equal

input into the development of community services from people who use services. This is facilitated by Inclusion Gloucestershire.

John Trevains and I met Assistant Chief Constable Jon Stratford and Deputy CEO of the Gloucestershire Police and Crime Commissioner, Ruth Greenwood on 10th June to discuss the relationship between the police service and mental health services in the light of an incident in 2020. We had a productive and positive discussion. I have also had an introductory meeting with Superintendent Emma Davies and Inspector Sarah Simmons of the Local Policing Cheltenham & Tewkesbury Gloucestershire Constabulary to discuss the **Community Mental Health Transformation**, held on 9th July. The local police are keen to join with our efforts respond to the community mental service health challenges and transformation.

On the 5th July I chaired a "round table" meeting to reflect on the role and pressures in our **Mental Health Liaison Services**. This meeting was attended by relevant stakeholders who work in MHLS as well as members of the Executive Team. We discussed a number of priorities including the need to develop a better framework for measuring the impact and outcomes of the service.

I attended the bi-monthly national NHS England **Mental Health Trusts CEO meeting**, chaired by Claire Murdoch. These useful sessions provided discussions on mental health as lockdown eases, and a presentation from Jake Mills, Founder and CEO of Chasing the Stigma – Hub of Hope (mental health charity) on their initiatives and innovative partnership with the NHS to provide accessible mental health services.

I had many informative meetings to discuss Mental Health initiatives across the South West including a meeting with NHS England's National Mental Health Director Claire Murdoch, meetings with Regional Director of Commissioning, Rachel Pearce, and a meeting with Programme Director for New Care Models, Anne Forbes.

Ensuring these initiatives are joined up and learn from best practice is central to the Trust's work in these areas and my wider input into regional mental health strategy is useful to our local focus as it enables me to be aware of and influence developments across the region.

1.5 Tackling inequalities

I have continued to develop my work as **lead CEO for tackling inequality,** for the Gloucestershire ICS (Integrated Care System). I regularly convene and attend meetings that seek to respond to and in the longer term prevent the systematic inequalities brought to light by the pandemic, as well as the long-standing inequalities which were already recognised. As part of this work, Gloucestershire County Council and the ICS have established an "**inequalities panel**", which I have joined. This is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme. The first meeting was held on 14th July and discussed the scope of the panel, how best to be impactful, key areas of focus, and key enablers who will assist with achieving goals. I look forward to the influential work this panel will contribute to in tackling inequalities.

I am a member of the **South West Inequalities Leadership Forum** which is designed to share good practice and monitor progress across the South West NHS Region.

I chair the monthly **Gloucestershire Covid-19 Vaccination Equity Group.** This group, which supports the equitable uptake of Covid-19 vaccinations across Gloucestershire, has been doing incredible work for vaccine hesitant communities. Through innovative communications, community engagement and outreach this group has made a positive impact in ensuring the Covid-19 vaccine is accessible to all individuals. Their efforts have greatly helped to reduce vaccination hesitancy. The group continues to meet monthly to assess vaccine equity across all cohorts within Gloucestershire as vaccine rollouts continue and as we head into phase 3 of the pandemic.

I am a member of the **SW Equality Diversity and Inclusion Board** and attend monthly meetings that discuss various initiatives focusing on improving the experience of NHS colleagues. The meeting held on 24th June featured a perceptive presentation on Ethnic Minority Action Planning, an update on creating equitable recruitment and promotion practises with a deep dive into disparity ratios, and presented an interim Equality and Inclusion Strategy Action Plan. We are also the sponsors of the Leading for Inclusion Programme mentioned below.

I regularly attend the **SW Regional Chief Executives** meeting. On 8th July, we were presented with the launch of the **Leading for Inclusion Programme.** This programme aims to make the South West the best and most inclusive place to work. The programme will nurture, challenge and extend our collaboration and impact as we work with an ambitious vision for equity across the region. It should help to deepen understanding of what is possible and develop the insights and knowledge of leaders so that we can go beyond what we have achieved so far.

On 10th June I attended a **virtual discussion for the Gypsy, Roma, Traveller community** which provided an opportunity to hear from the community on any inequalities and injustice that they experience. This also provided a good opportunity to hear their perceptions on health and care as well as vaccination uptake.

On 15th July the Trust held the **Summer Diversity Celebration**. All colleagues from across the Trust were invited to celebrate being part of the GHC team. The event was a celebration of diversity and the range of experiences and people who we are lucky to have as colleagues. Participants were encouraged to discuss any key issues affecting them. I was able to welcome all participants to the event. This provided a good opportunity to discuss the value of working together, and how proud I am of the diversity of people within the wider GHC Team. This session really demonstrated and celebrated the importance of diversity and inclusion throughout the Trust and throughout our everyday lives as well.

I gave a welcome and introduction at the opening of the **Big Health and Wellbeing Week.** This event that used to be held face-to-face, adapted to virtual this year and expanded to a full week of events (12 years previously this event was held over a single day). The celebratory event aimed to reduce health inequalities and support the health and wellbeing of people with learning and other disabilities.

Involvement in this breadth of celebration, reflection and transformation activities demonstrates the commitment of the Trust to ensuring Equality, Diversity and Inclusion are at the core of how we operate.

1.6 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. I also continue to have regular meetings with senior officers and Leaders at Gloucestershire County Council, including Sarah Scott, **Executive Director of Adult Social Care and Public Health,** we have reinstated our informal operational senior team meetings to share common priorities and issues**.**

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. 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 system Gold Health System Strategic Command CEOs (now called the **Executive Review Group**) has continued to take place weekly as part of the **Gloucestershire ICS Covid-19 Response Programme.** This forum has proved essential in overseeing the system response to the Covid pandemic (and continues to do so as we enter wave 3) and in providing a regular liaison point between senior leaders in the NHS and social care system.

I continue to attend the bi-weekly **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. These continue to largely focus on the latest developments in the management of the Covid-19 pandemic including providing updates on vaccination mobilisation and PPE. Elective diagnostics recovery, system flow delivery and primary care updates are also provided at these meetings.

I chair the **ICS Diagnostic Programme Board**, which met on 8th July. The Board is continuing to progress the important work on developing local proposals for potential **Community Diagnostic Hubs** (CDH). The current focus of these efforts is in the development and coordination of networked diagnostic services which are equitable and consistent; aiming to get the right patient to the right test, in the right location, in the fewest number of visits (and referrals) and in the shortest amount of time. The aim is to maximise the limited diagnostic capacity through triage, stratification and prioritisation which is personalised and sustainable across Gloucestershire whilst seeking to invest / innovate and expand existing services so that they meet current and future demands.

I attend the monthly **Community Chief Executives Network** meetings. The meeting held on 30th June featured an informative presentation from the Integrated

Communities System Director, Helen Childs on Delivering Ageing Well UCR during a pandemic with a case study from Cornwall and the Isles of Scilly's response.

The **Health and Overview Scrutiny Committee** Induction Session to welcome new members took place on 15th June, which I attended virtually. On 13th July the Chair and I attended the Health Overview and Scrutiny Committee meeting at Shire Hall. At this meeting Sarah Scott, Executive Director of Adult Social Care and Public Health, provided a Public Health COVID-19 update. There was also a review of temporary service changes as well as an update provided on the Fit for Future Programme.

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 as we navigate phase 3 of the pandemic.

2.0 LAUNCH OF THE TRUST'S PEOPLE STRATEGY

I am delighted to report that we have launched our new Trust People Strategy. This is our new five-year strategy confirming our goals, aims and ambitions for our 5,400+ strong workforce, made up of more than 40 different professions.

Our ultimate goal over the next five years is: "To be a healthy and happy high-quality workforce, performing well in all local and national performance standards."

Our aim is to be a "**Great Place to Work**".

Being a great place to work means: "Taking care of our people, with a strong focus on their health and wellbeing. Our organisation will celebrate diversity, ensure real inclusivity and enable everyone to reach their potential. We will make sure colleagues are heard, valued and influential. We will develop a culture where working life can be passionate, vibrant and inspiring. This will help us to attract new people who are as great as those we already have, and we will make sure that those already with us, want to stay."

We have a number of actions and programmes in place or planned to realise our people ambitions, and these include a commitment to 6 key Commitments or areas we will focus on:

1. Model Recruitment and Retention
2. Health and Wellbeing
3. Great Culture, Values and Behaviours
4. Strong Voice
5. Equality, Diversity and Inclusion
6. Full Potential

The Trust's people strategy was co-produced with our colleagues and by reflecting on what we've been told through the staff survey and other engagement events. The strategy is a collaborative effort and reflects what matters most to our colleagues and sets out our ambitious but realistic plans for the next 5 years. In line with our values

we will continue to listen and work in partnership with colleagues as well as patients, carers, and communities. We recognise that our people make our Trust the place it is and taking forward and achieving this challenging agenda will be an area of focus for the Board over the coming months.

3.0 MODERN SLAVERY POLICY

There is a mandatory requirement for the Trust to have a public statement by the Board on our recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act).

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHCNHSFT) fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

Ongoing assurance from relevant leads within Safeguarding, Procurement, Counter Fraud and HR teams that combatting and eradicating modern slavery is ongoing business as usual work.

It was confirmed that there had been no specific actions or initiatives during 2019/20; the statement has been updated to provider greater assurance that this is very much a continuous element for the Procurement team. The updated statement is provided for approval by the Board and publication on the Trust's website.

The Trust's full Modern Slavery Policy can be found here:
https://www.ghc.nhs.uk/equality-and-diversity/

4.0 EXECUTIVE TEAM CHANGES

John Campbell – Chief Operating Officer
I would like to formally record that John decided to step down from his role with the Trust in June. John made a significant contribution to [2]gether and then, following our merger, to GHC. Indeed, his role in ensuring the merger was grounded in our values and our ambitions for the new organisation was more significant than many will realise.

Board and Executive Director colleagues are saddened but respectful and supportive of his decision. I am sure we would all want to wish him well for his next venture to which, I have no doubt, he will make an important contribution.

In terms of next steps, the **Chief Operating Officer** role is a significant and important one for the Trust and we have commenced a recruitment process so that an

appointment can be made as soon as possible. In the meantime, I can confirm that **Hilary Shand** has agreed to continue to act up as Interim Chief Operating Officer with the continued support of executive and senior colleagues.

5.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided and **APPROVE** the Modern Slavery Policy.

AGENDA ITEM: 13/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

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

This paper provides an overview of a range of activity taking place across the Integrated Care System. This update includes:

- An update on the reconvened Health Overview and Scrutiny Committee
- Update from the Health & Well-being Board
- Progress report from the Integrated Locality Partnerships
- HealthWatch Gloucestershire's Annual Report and highlights 20/21
- One Gloucestershire ICS Accountable officers report is attached for information

Risks associated with meeting the Trust's values

None

Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our surveys and include them within future service reviews and developments.

Resource Implications	None specific to the Trust.
Equality Implications	The Trust is actively engaged in wider inequalities work and will build any findings into the Trust service developments moving forward.

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

Appendices:	Appendix 1 - ICS Board Minutes Appendix 2 - One Gloucestershire Accountable Officer Report Note: Board members please note these are in the Reading Room on Diligent

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 (ICS).

1. Health Overview and Scrutiny Committee (HOSC) Activities

A new HOSC Committee has been formed following completion of the recent election process. The Chair has been confirmed as Cllr Andrew Gravells. It held its first formal meeting on the 13th July 2021. The agenda covered a review of the temporary services changes that the Trust has instigated as part of the Covid-19 pandemic response and an update on Fit for the Future.

The following recommendations were supported;

- The Minor Injury and Illness units will work towards a plan of normal re-opening i.e. extension of hours until 11pm in appropriate units (with the exception of Dilke – which needs to remain closed due to Covid Secure environmental issues). There is an exercise underway by operational colleagues to understand the impact of taking this forward on the clinical triage services that we have put into the units as a response to Covid which appears to be offering significant system benefit.
- The Stroke beds at Vale were extended from 14 to 20 in September 2020. Again, this has appeared to offer system wide benefits with an increase in stroke audit scores, particularly in the acute trust. A formal pilot has been approved to undertake a full review of the impacts, benefits and pathway in order to determine any long term recommended changes. The results of this will be brought back in due course.

2. Health & Well-Being Board

The Health & Well-Being Board has met on the 20th July. The following key areas of discussion were of particular note;

- Update on the health inequalities work, particularly the vaccine equity work and the ongoing impact of Covid-19. The Board also recognised that whilst there is a wide range of activity taking place to tackle health inequalities, this activity needs to be brought together strategically into a more coherent whole. As such, a Health Inequalities Panel has now been established to coordinate and align current action; ensuring priorities for strengthening this work are agreed, impact is monitored and learning is shared. Additionally, it will ensure a sustainable, community-centred, whole systems approach to reducing health inequalities is taken forward.
- Anchor Institutions work - A virtual event in the autumn has been supported to launch the *Gloucestershire Anchors Partnership Programme*. The intention is that this will serve as a call to action, and be an opportunity to share local and national examples of good practice and to gather views about how we can

collectively maximise the benefits from this approach. The Trust is fully engaged in this work and will support the event moving forward.

- A focus on children's services including the work of the Children's Wellbeing Coalition and the Adverse Childhood Experience work particularly around trauma informed care and feedback from an extremely successful Ambassadors networking event held in May.

3. Wider ICS and Partner updates:

3.1 Healthwatch Gloucestershire have released their Annual Report for 2020/21 which can be found at https://www.healthwatchgloucestershire.co.uk/news/hwg-annual-report-2020-21-published/

In its latest Annual Report, Healthwatch Gloucestershire explains how it worked throughout the year to understand people's health and care needs, and how it used public feedback to help services respond and improve care for local people. The report also identifies the most common issues people raised, and outlines work planned for 2021-22.

Healthwatch Gloucestershire published 6 reports and made 27 recommendations for improvement to health and social care providers in 21/22. The most common areas of comment and enquiry raised with Healthwatch Gloucestershire last year were GP services (34%), dentistry (20%), Covid-19 vaccinations (12%), patient transport (3%) and care at home services (3%).

3.2 Investment in Greener Fire Engines

Gloucestershire Fire and Rescue Service (GFRS) has received funding worth £3.7m over the next few years through Gloucestershire County Council's (GCC) capital programme to secure 12 new vehicles. The vehicles will be more environmentally-friendly using greener technology, so the amount of emissions produced will be significantly reduced and will reduce service risks due to vehicle failure as the old fleet becomes more unreliable.

3.3 Home-Start UK report on the impact of Covid-19 on families

Home-Start UK have released findings from a piece of national research *Home Is Where We Start From* that has focused on measuring the impact of Covid-19 pandemic on parents of young children. They heard from over 1200 parents they support about the issues that have affected them the most.

Poverty, mental health issues and the social development of children were found to be the three main concerns for parents of young families. Findings revealed that families are facing unprecedented challenges, with the pandemic acting both as a magnifier of existing disadvantage, as well tipping more people, who were just about managing before, into poverty.

3.4 Quayside House

Two GP practices (GP Health Access and Severnside Medical Practice who were formerly Gloucester City Health) have relocated into Quayside House in Gloucester which opened on the 12th July. It will serve around 18,000 patients, as well as

providing a pharmacy and office space. The new health centre has been built on land owned by Gloucestershire County Council and cost £5.3m. It is part on an ongoing regeneration of the Quayside area which is bringing high quality services, investment and job opportunities to the city.

3.5 Digital Projects in Gloucestershire

Through its Digital Innovation Fund Gloucestershire County council has £200,000 worth of grants available to community or voluntary groups and charity organisations to fund digital and technology-led initiatives.

This is the second year of the fund and applications have been accepted up to £20,000 per project or greater if they are Collaborative partnership bids. There has been a push to address digital exclusion and help people remain independent and projects are welcomed that aim to supporting adults in Gloucestershire by:

- Improving literacy, including digital literacy
- Preventing a decline in independence, health or wellbeing
- Encouraging digital access opportunities amongst Black and Minority Ethnic communities
- Providing equipment and support to those with disabilities and sensory impairments

4. Integrated Locality Partnerships Updates (where appropriate)

Gloucester ILP

Angela Potter, Director of Strategy & Partnerships has currently picked up the Chair for this ILP. Wider partnership presentations were given at the June meeting with a focus on health inequalities including the Matson Community Health Equalities Partnership Group who are currently exploring community engagement approaches.

Work has also progressed on the Community Builders project across the City and a map of community builders and social prescribing services in Gloucester City has been produced along with initial work taking place to develop an Engagement Strategy. It was recognised that as this project further develops, there may an opportunity to align this work as a work stream within the Health Equality work.

Stroud ILP

Stroud District Council reported they have been awarded funding to deliver a summer activity programme for CYP in receipt free school meals. Plans are also being developed to take forward a health and wellbeing program working with local schools to be delivered September through to December.

There remains a focus on Healthy Lifestyles and physical activity: working with partners to restart physical activity offers and linking with physiotherapy services to improve partnership working.

Cotswolds ILP

Update received from Young Gloucestershire and *Infobuzz* regarding local services and digital developments which recognised that not all young people need a counsellor, sometime just someone to talk too.

A review of the CYP data for Cotswolds noted increased referral rates into CAMHS. Further data to be explored and opportunities to connect young people with their communities and increase resilience will be considered.

Forest ILP

The group have had their first reconvened meeting since the Covid pandemic. A new interim chair is in place - Philippa Lowe from FOD District Council and it gave members the opportunity to review and refresh connections and consider what the priority pieces of work need to be across the Forest.

5. Focus on Patient, Carer and Staff feedback and engagement

5.1 Healthwatch Gloucestershire have completed a review into access and the information provided by GP surgeries during Covid. People reported that there were a number of routes to get access to primary care and indeed both face to face and telephone consultations available. A number of recommendations have been included in the report particularly around e-consult and the choice and range of appointment types to suit individual need.

5.2 Inclusion Gloucestershire are undertaking a survey that has been co-designed with people with a variety of lived experiences to capture the views of disabled people and those with mental health conditions to help inform their organisational strategy for the next few years. The survey closes on the 20th July and we look forward to seeing the results which will be shared in due course and will continue to support GHC is our partnership working with Inclusion Gloucestershire. Inclusion Gloucestershire want to encourage as many people as possible to complete it.

The survey can be completed by people who do not have lived experience themselves but those people are asked to consider the questions from their experience of disabled people and those with mental health conditions.

6. One Gloucestershire ICS Accountable Officer report

This report is available as **Appendix 1**. The report provides a general overview of the Covid position and latest data plus an update from the clinical programme groups and ongoing activities across the system.

Additionally, there is a focus on social prescribing as a means of enabling GP's and other health professionals to refer people to a range of local, non-clinical services. It recognises that people's health needs are met by a range of environmental, social and economic factors thus social prescribing seeks to help address people's needs in a holistic way.

Gloucestershire has been selected as a pilot hub site to work with the National Centre for Creative Health to share good practice and move forward our strategic thinking for social prescribing.

Angela Potter
Director of Strategy & Partnerships

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 14/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

PRESENTED BY: John Trevains, Director of Nursing Therapies & Quality

AUTHOR: John Trevains, Director of Nursing Therapies & Quality

SUBJECT: **DRAFT "GHC QUALITY STRATEGY 2021-2026"**

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:

Present to the Board the draft GHC Quality Strategy – a key part of the emerging Trust Five-Year Strategy – for consideration, comment and agreement in principle prior to it being formatted for launch via our Trust Communications Team.

Recommendations and decisions required

The Board is asked to:

- **Review** and **Endorse** the final draft GHC Quality Strategy – Attached in **Appendix 1**
- Provide any further comment or amendments prior to it being reformatted in the style of the Trust strategy format.

Executive summary

This Strategy highlights our quality pledge: To place continuous improvement and working together at the heart of everything we do so that we can consistently deliver high quality care and make the changes that matter to people.

It contains our three Trust quality ambitions:

- Safe – Everyone can trust our care will cause no harm and can be accessed when they need it.
- Effective – Everyone receives care that is beneficial, based on evidence and efficiently delivered.
- Experience – Everyone has access to person-centred, responsive and respectful care. ".

We want our Trust to be a learning organisation. We will focus on delivering the highest possible quality care, meeting the health and care needs of people using our services, and improving the health outcomes of the population we serve. This strategy seeks to provide a high level guide for the organisation in achieving these aims.

For the purposes of review and for Board colleagues assurance, final changes have been made to previously shared versions of the draft strategy to incorporate comments and requests made from individuals, teams, and various engagement sessions, commissioning colleagues, Trust Executives and the Quality Committee.

Please do note that the attached version for approval it is not yet formatted in the style, colour theme and images recently agreed for the main Trust strategy. If the Board approve the content and approach it will be professionally formatted in line with the Trust Strategy with associated infographics.

Risks associated with meeting the Trust's values

No significant risks identified

Corporate considerations	
Quality Implications	This strategy is focused on enabling innovative improvements and maintaining robust assurance regarding the Trusts quality of care delivery
Resource Implications	Delivery is largely expected to be completed within existing resources with potential one off funding opportunities expected to be considered to support emerging implementation plans
Equality Implications	Our Quality Strategy presents a number of opportunities for the Trust to improve quality considerations and monitoring within equalities and associated responsibilities

Where has this issue been discussed before?

- Board Development Session 16th June 2021
- Engagement and development events
- Quality Committee April & June 2021
- Executive Committee updates
- Quality Directorate team meetings and discussions

Appendices:	Appendix 1 - Draft Quality Strategy

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Quality

GHC Quality Strategy 2021 – 2026

Better Care Together – with you, for you

An easy read version of this document is available at XXXX – insert web link to easy read version

This strategy is also available in different languages at - XXXXXX

WELCOME

We want to be considered an outstanding organisation by everyone – people using services, their families and carers', our colleagues, local communities and our system partners.

Gloucestershire Health and Care NHS Foundation Trust colleagues are passionate about delivering the very best care for the population we serve and the people who use our services. This is what drives our shared ambition to **achieve 'outstanding' care status**. To achieve this at a consistent level for all our services is no easy task; it will require a strong commitment to undertake Trust wide culture change. Our organisation has a solid foundation on which to build and we will become 'outstanding' by **listening, learning and working together** on a continuous improvement journey.

How we will reach 'outstanding' status:

We want to make sure that we are meeting the health and care needs of all our communities. We will achieve this by **becoming a learning organisation[1].** What people will see is that:

- we are doing everything we can to make ***everyone's*** health and care experience the best it can be, delivering safe and effective services;
- our **colleagues, our most precious asset**, are valued, work in safe and secure environments, are supported and empowered to act when things can be improved;
- the **people we serve** are heard, included, involved and empowered;
- we **embrace transparency, accountability and knowledge**, celebrate success, share learning and actively seeking to improve.

How our Quality Strategy will achieve these things:

Our Quality Strategy sets out our quality ambitions, strategic goals, priorities, and the approaches we will take to measure our progress. It does not sit in isolation but is one of **six integrated enabling strategies** delivering Gloucestershire Health and Care NHS Foundation Trust's (GHC) strategy: **'Our Strategy for the Future 2021-2026'**.

By developing this Quality Strategy, we are making clear our commitment and approach to **empower the people** at the heart of our services: Our colleagues will have the **freedom, skills, tools and resources** to work in partnership with the people we serve to **improve and innovate safely** towards defined quality goals.

Our journey will include:

- Becoming a **true learning organisation** to improve patient safety, experience and clinical effectiveness. This will include embedding the national **Patient Safety Strategy** and developing our **Quality Improvement Hub**.
- Treating people who use our services and each other with dignity and respect. This will be delivered by embedding agendas such as **Civility Saves Lives** and **Freedom to Speak Up** across our Trust.

[1] 'A promise to Learn – a commitment to act: Improving the safety of patients in England 2013

- **Empower our workforce** to deliver outstanding care by supporting the professional development of colleagues, giving them the mandate, tools and resources to innovate and improve.
- Expanding how we **work in partnership and collaborate** with the population we serve and as an active partner in One Gloucestershire Integrated Care System, enabling us to deliver personalised care, improve services and develop new models of care that reflect local need.

Our Quality Strategy at a glance:

Our Trust Strategy - 'Our Strategy for the Future' 2021-2026 - sets out our vision and aims that will be delivered by enabling strategies.

Our vision:

Working together to provide outstanding care

Our four strategic aims:

Better Health; High Quality Care; Great place to work; Sustainability

Our 6 enabling strategies:

Quality, People, Digital, Estates, Research & Innovation, Finance

This enabling Quality Strategy outlines how our quality goals will contribute to achieving our Trust's vision and aims

Our quality pledge:

To place continuous improvement and working together at the heart of everything we do so that we can consistently deliver high quality care and make changes that matter to people.

Our three ambitions ensure our goals and priorities are quality focused.

Safe – Everyone can trust our care will cause no harm and can be accessed when they need it.

Effective – Everyone receives care that is beneficial, based on evidence and efficiently delivered.

Experience - Everyone has access to person-centred, responsive and respectful care.

GHC Quality Management System (QMS) is the method we use to deliver quality care.

Quality **planning**, **control**, **assurance, improvement and participation** are the five elements of our QMS process. Participation means that people experiencing care and all our staff are actively encouraged to be involved in the continuous cycle of improvement to ensure consistently high quality care.

Our Trust values underpin all our behaviours and attitudes.

working together

always improving

respectful and kind

making a difference

Our strategic goals:

1. **Become a true learning organisation, with people participation at our core.**
2. **Treat people who use our services, their families and carers, and each other with dignity and respect.**
3. **Develop and empower our workforce to deliver outstanding care.**
4. **Work in partnership to consistently deliver safe and effective personalised care.**
5. **Drive a just culture which promotes safety through people being supported to speak up.**
6. **Be an active partner in the One Gloucestershire Integrated Care System, ensuring that new models of care reflect local need and address inequalities.**

INTRODUCTION

Gloucestershire Health and Care NHS Foundation Trust formed in 2019 following the merger of two high-performing Trusts and is built upon an ambition to improve the lives of people with physical and mental health needs, and supporting people with learning disabilities in our communities. This is our first Quality Strategy as a new integrated Trust. Created through collaboration: by listening to colleagues and people who use our services; by reviewing feedback from our community, commissioners and system partners. This strategy represents how we want to **progress: openly and together**.

We want our Trust to be a **learning organisation.** We will focus on delivering the highest possible quality care, meeting the health and care needs of people using our services, and improving the health outcomes of the population we serve. Developed against the backdrop of a global health pandemic, Covid-19 has impacted not only on the health and well-being of our colleagues and the population that we serve, but also the way in which we deliver services. This enabling strategy highlights our creativity, passion, expertise and our commitment to learn from experiences. Our quality pledge and ambitions aim to put **quality, equality and learning** at the heart of our service.

Our Quality Pledge:
To place continuous improvement and working together at the heart of everything we do so that we can consistently deliver high quality care and make the changes that matter to people.

Our three Quality ambitions:

Safe – Everyone can trust our care will cause no harm and can be accessed when they need it.
Effective – Everyone receives care that is beneficial, based on evidence and efficiently delivered.
Experience – Everyone has access to person-centred, responsive and respectful care.

We have used an **appreciative inquiry** approach throughout this document to illustrate the stories of real people. Each story represents a **learning journey**: identifying what works well and what we want to develop to help us be even better, so that we can achieve our ambitions.

Our ambitions are associated with strategic goals developed through consultation and collaborative processes. These align with our Trusts' **People** and **Digital** strategies and are supported by our **Quality Improvement** and **people participation** implementation frameworks.

The **GHC Nursing, Quality and Therapy** directorate teams are the key enablers that work closely with all Trust services, the population we serve, our Integrated Care System (ICS) partners, and national bodies to support delivery of our Quality Strategy.

WHAT IS QUALITY?

We are using the NHS and WHO definition of quality care[2]. Simply put: **It is care that meets standards to ensure it is effective, safe and provides as positive an experience as possible.**

Quality is concerned with setting and assessing standards that tell us if healthcare is **high quality**, can achieve good **health outcomes** and **meets the needs** of people we serve. Care can only be considered high quality when all three pillars of quality - **safe, effective and experience** – are present and includes ensuring care is patient-centered, timely, efficient, and equitable.

How do we deliver quality care?

Safe

Delivering health care that minimises risks and avoids causing harm.

Provide accessible care that is timely, geographically reasonable and in a setting where skills and resources are appropriate to meet the needs of people.

Effective

Providing services based on evidence, produce a clear benefit and improve health outcomes for individuals and communities, based on need.

Delivering health care that is efficient, maximising resource use and avoids waste.

Experience

Delivering health care that is person centred, based on partnership working that takes into account the preferences and aspirations of individuals and the cultures of their communities.

Providing care that is responsive to diverse-ability and does not vary in quality because of a persons characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.

Defining Quality does not guarantee success.

We know that **outstanding care** does not happen by accident but **by design and from working together.** Key to delivery of our plans is to develop a **GHC 'Quality Management System'** approach to embed a culture of learning: a culture where people **listen, think, feel and act** '**quality**' - promoting openness and learning, continuous improvement and service transformation. This includes working closely with colleagues to embed a positive culture of continuous improvement by resourcing a **Quality Improvement Hub**, expanding training programmes and creating more opportunities for people to **participate and collaborate** with citizens, communities and our established **Experts by Experience** programme.

Quality standards and reporting

This strategy has set quality ambitions and strategic goals based on the three pillars of quality to ensure that there is a clear quality focus. Each year we publish quality reports, providing an over view of our quality achievements, reporting on issues identified through our quality management system, and setting specific annual quality improvement goals. Our quality reporting structure will provide a way for us to set progressive implementation plans, adapt plans based on experiences and learning, and monitor progress against our strategic goals.

[2] WHO, 2006: 'Quality of Care: A process for making strategic Choices in Health systems')

WHO ARE WE?

Gloucestershire Health and Care NHS Foundation Trust provides a range of services for the population of Gloucestershire and the surrounding areas, providing physical health, mental health and learning disability services.

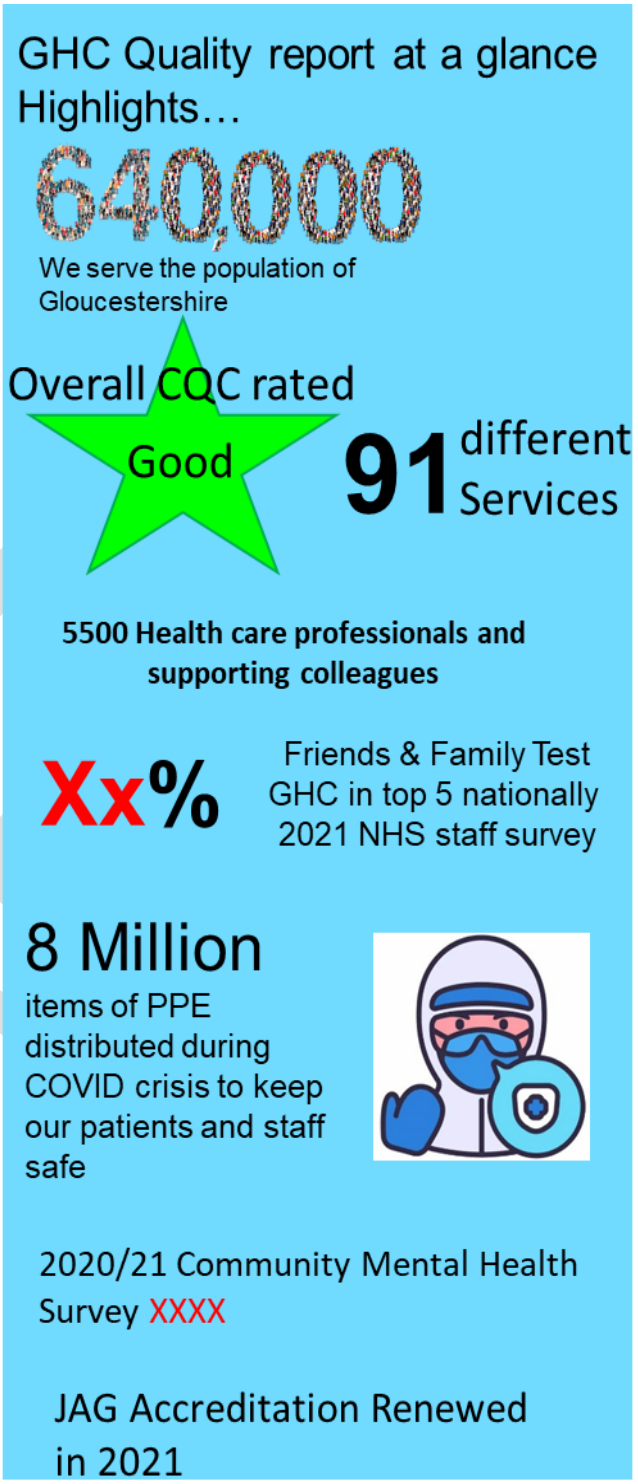
Our services

We work with people of all ages who need support and treatment in both hospital and community settings.

The majority of our services are provided in a person's usual place of residence or close to where they live, and we support people to avoid a hospital admission whenever possible.

Our services cover the county of Gloucestershire. We work out of health centres and children's centres, community venues such as libraries or schools, as well as in people's own homes or place of residence. We also provide services from our seven community hospitals, our learning disability unit and our two specialist mental health hospitals.

Many of our services are delivered in partnership and we work closely with our partners in the **One Gloucestershire Integrated Care System**. This includes: Gloucestershire Hospitals NHS Foundation Trust acute hospital services; Primary Care and GP services; Gloucestershire Council and Local Authority social care and community services; local community groups, voluntary, charity sector services; Ambulance, Housing and Commissioning groups – to name a few of our partners.



Please visit our website to find out more about our services and quality reports: www.ghc.nhs.uk

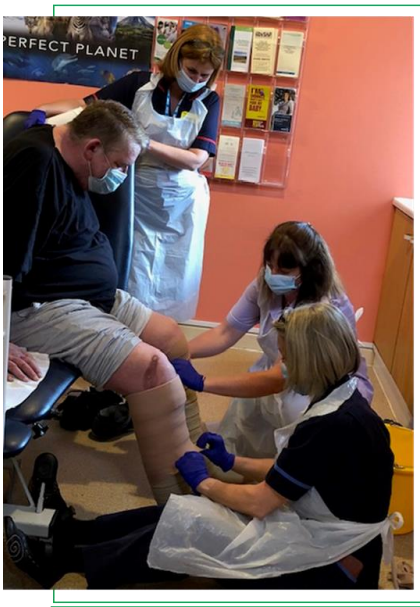
Trust Strategy: Our Strategy for the Future 2021-2026
Quality Strategy – this document
Annual Quality Account (2020-21)
2021/22 Trust Quality Priorities

OUR SERVICES AT A GLANCE

Gloucestershire Health and Care NHS Foundation Trust provides 91 different types of clinical services delivering all age physical health, mental health and learning disability services to the population of Gloucestershire and surrounding areas.

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services and Improving Access to Psychological Therapies
- Specialist services including Early Intervention, Mental Health Acute Response Service, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Eating Disorders, Intensive Health Outcome Team and the Learning Disability Intensive Support Service
- Two Psychiatric and a Learning disabilities & Autism inpatient care centres (total number of beds XXXXX)
- In-reach services into acute hospitals, nursing and residential homes and social care settings;
- Community services in peoples' homes, community clinics, outpatient departments, community hospitals, schools and GP practices;
- Seven community hospitals (total 196 beds) , provide nursing, physiotherapy, reablement and adult social care in community settings and minor injury & illness units
- Health visiting, school nursing and speech and language therapy services for children
- Other specialist services including sexual health, heart failure, community dentistry, diabetes, intravenous therapy (IV), tissue viability and community equipment.

What's working well: This is a great example of joint working within the ICS, caring for mental and physical health with fantastic results to ensure a quality care experience.



Andrew was depressed and fed up with ongoing problems with his legs. His condition affected every aspect of his life, he needed to use a mobility scooter, struggled to mobilise around his flat and rarely went out of the house. He got so desperate he said he just wanted someone to "cut his leg off".

Colleagues in the GHC Lymphoedema Service completed a joint visit with Andrew at his GP surgery, suggesting a new treatment and different techniques for applying effective compression therapy with the Practice Nurse.

Three months later Andrew says he feels like a new man! 2 and a half stones lighter, 25cm diameter loss from his calf - not only is he physically better, able to walk to local shops, less breathless and able to see his toes again - he says he feels so much better in himself. Andrew said he didn't used to take care of himself when his leg was so swollen, but now wants to make himself look better so had a haircut and wearing clothes he hasn't worn for years. Andrew said he now feels more confident when out and about.

Even Better If…

- More of our services worked in an integrated way enabling efficient and holistic care delivery.
- We work more effectively as an integrated Care System to address health inequalities.
- All our staff use Quality Improvement as part of our approach to continuous improvement.
- More people jointly produced care plans with a focus on 'what matters to me?'.
- We had more options for people to access services as part of addressing access inequalities

OUR JOURNEY SO FAR

In developing our Quality Strategy, we have spent time reviewing and reflecting on our journey so far. We have engaged with and listened to people about their thoughts, concerns, and ideas about high quality care in our Trust.

Engagement and co-production

This strategy has been developed collaboratively with Experts by Experience, our colleagues and critical friends through workshops, questionnaires and virtual opinion sharing tools. We place high importance on the learning, contributions and feedback obtained and have included all the key areas identified in this strategy:

- Improving access and equity of services, removing barriers to access;
- Developing our workforce, ensuring they are happy, confident, have capacity and capability to deliver effective care;
- Patient safety and safeguarding;
- Partnership working across the One Gloucestershire Integrated Care system;
- Consistent partnership working between patients, their families and carers, and our practitioners;
- Learning from experiences to develop and improve models of care.

National and Local context for our Strategy

There are a number of local and national drivers for change that have influenced our direction of travel and the priorities we have included in our strategy. These include:

- Delivering the shared ambitions of the NHS England Long Term Plan, the One Gloucestershire Integrated Care System and the 2021 NHS White Paper *Integrating care: next steps to building strong and effective integrated care systems across England*
- Supporting NHS People Plan (2021) workforce development and transformation alongside Health Education England Nursing, Allied Health Professionals (AHP).
- Together with operational colleagues and commissioning partners we will focus on delivering 2 of the 5 national Improving Care Programmes: Managing Deterioration; and Mental Health transformation.
- Implementation of new Patient Safety Strategy (2019), PHSO NHS Complaint Standards (2021), and Violence Prevention and Reduction Standards (2021).

We recognise the difficulties of delivering a new Quality Strategy in the challenging times we all currently live in, both personally and professionally:

- National and local recovery from the impacts of the Covid-19 pandemic.
- Different organisational priorities, timeframes and levels of resource will make it difficult to deliver solutions for large- and small-scale system changes and complex issues.
- Re-energising our colleagues to continue or start transformation, service integration and improvement drives as part of our merger, ICS and national priorities.
- Ongoing issues that continue to place a strain on our services and across Gloucestershire's health and care system, including: our growing and ageing population; increasing health inequalities; national and local shortages of health and care workforce; and operating community services in a large rural and urban geography.
- Our Trust provides services where the nature of work means colleagues are at a greater risk of experiencing abuse, aggression and violence.

We will aim to reduce the risks these challenges might pose to our plans by:

- Working closely to support our operational and corporate services in their plans to prioritise welfare, professional development and develop support options for all our colleagues;
- Applying learning from our Covid-19 experience about making changes, ensuring colleagues and people we serve have the freedom, skills, tools and resources to improve and innovate safely.
- Remaining committed as an organisation to understand, develop, influence and lead in our roles as an Anchor Institution and an ICS partner.
- Responding to learning and guidance from our Quality Management System, local and national groups, adapting our plans and priorities to ensure we are doing the right things.
- Supporting safe and secure working environments by managing risks in accordance with the Violence Prevention and Reduction Standards.

Our quality journey so far…

Where we want to be…

NB – graphic for this section is in development and will feature the following points:
2019 post merger- Quality Governance structure
2020 CHA & Parliamentary awards
2020- Establishing the Pillar 1 testing team
2020 – Delivering services through the Pandemic wave 1 & 2
2020 Trust recognised in WHO welling in healthcare
2020 – Internationally recognised research in safe use of PPE in mental health services
2020 integrated PH, MH and LD quality dashboard
2021 Covid vaccinations
2021 – Oliver McGowan training launched
2021- New International Recruits arriving in GHC & one of 6 national pilot sites for community nurse recruitment in partnership with the QNI and NHSE

Then Milestones

2021 Quality Improvement groups established in PU, EoL
2021 first embedding learning event
2021 Develop and Test Quality maturity index tool
2021 August- Civility Saves Lives Launch
2022 Launch People Quality Forum
2022 New Public Health Service Ombudsmen complaints standards launched
2022/23 Establish EbE for all sites
2022/23 Launch QMS
2023 Achieve Quality maturity Index targets
2024 CQC outstanding

OUR QUALITY AMBITIONS AND STRATEGIC GOALS

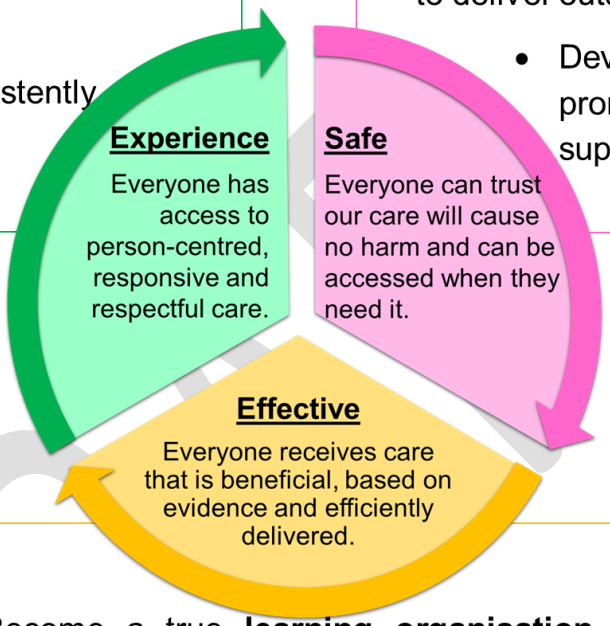
Our three inter-dependent **ambitions,** based on the three pillars of Quality, underpin our strategic goals for the next five years and ensure a focus on high quality health and care**.**

Our six strategic goals have been developed through talking and listening with colleagues, experts by experience and stakeholders; by listening and reviewing feedback from our community and system partners; reviewing our quality indicators; and national improving care programmes.

Our quality ambitions and strategic goals:

- Treat people who use our services, their families and carers, and each other with **dignity and respect.**
- Work in partnership to consistently deliver safe and effective **personalised care.**

- **Develop and empower our workforce** to deliver outstanding care.
  - Develop a **just culture** which promotes safety through supporting people to **speak out.**



- Become a true **learning organisation,** with people participation at our core.
- Be an active partner in the One Gloucestershire Integrated Care System, ensuring that **new models of care reflect local needs.**

Each of our strategic goals has several key priorities and objectives that we will achieve as part of a programme of work. The sections below provide more detail about how we will achieve our quality ambitions and strategic goals.

OUR AMBITION: SAFE
Everyone can trust our care will cause no harm and can be accessed when they need it..

Our strategic goals:

- **Develop and empower our workforce** to deliver outstanding care.
- Develop a **just culture** which promotes safety through supporting people to **speak out**

What works well: Our staff and services are keen to learn, work with families and experts by experience to improve services.

Rozz McDonald, Mental Health and Learning Disability Education Team Lead, and Kate Allez, Clinical Psychologist are leading the team piloting **'Oliver McGowan Mandatory Training in Learning Disabilities and Autism'** in our Trust.

This training is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training in learning disabilities and autism. It is part of a national commitment to develop a standardised training package.

Launched on 1st April 2021 all of the training is fully co-designed and co-delivered with people with learning disabilities, autistic people with or without a learning disability, family carers and people working within learning disability and autism services. The trial aims to help shape the development of the final training package, which will become mandatory across England in 2022.

Gloucestershire Health and Care NHS Foundation Trust (GHC) is one of four national partners appointed to co-design and co-deliver the training for groups of health and social care staff as part of a national pilot.

Even better if....

- Enable our workforce to be happy, confident and competent – introducing civility saves lives programme and supporting our People Strategy.
- Be more open and transparent about incidents, errors or complaints and the actions we take to make changes.
- Establish a 'People Forum' as part of our quality assurance process.

What we do now that works well and how we can achieve our ambition:

How we ensure safe care now...	What we are going to do differently...
Governance structures Investigations and learning Freedom to Speak Up Guardian Our values Support and develop our workforce Clinical audits Engage in national Patient Safety Programmes Clinical alerts Datix incident reporting process and review	Increase learning from positive events Increase benchmarking Embed Patient Safety Partners and Specialists Progress the Civility Saves Lives programme Embed Violence Prevention and Reduction Standards

Objective	Our measures of success
Increase the extent to which we learn from positive events. Develop robust processes to ensure all learning is embedded in practice	- Number of Embedding Learning Events held - Assurances and workstreams delivered by the Learning Assurance Group - Develop a process to share 'Learning on a Page' for compliments, case studies, etc - Develop system to review actions 6 months after the incident/complaint to ensure they remain in place
Compare our safety indicators with our previous performance and also with those of similar organisations	- Benchmarking data within governance reports - Active members of national collaboratives - Rapid identification of any outliers, triggering a deep dive and action plan
Continue to progress the recommendations within the Patient Safety Strategy (2019)	- Embed Patient Safety Specialists - Embed Patient Safety Partners - Process to effectively support and engage Experts by Experience - Improve our scores on patient safety questions within the Staff Survey, year on year
Continue to progress the Civility Saves Lives programme	- Training developed and number of colleagues attending sessions - Colleagues report a culture of psychological safety and a just culture - Reductions in reports of institutional/systemic prejudice and racism - Delivery of Leadership Development Programmes for Creating a Compassionate Culture; Strategies for inclusion; and Creating Psychological Safety.
Review our current Freedom to Speak Up Advocate model	- Engagement with colleagues to seek their views on the current model - Adherence to the National Guardian's Office new guidance regarding the development and support of Freedom to Speak Up Champion/Ambassador networks
Review and embed Violence Prevention and Reduction Standards to support risk management maximise safe and secure working environments.	- Reduced number of incidents of violence towards staff - Reduced number of incidents of restraints used on patients - Engagement and feedback from people using services and colleagues in risk management and review processes.

In the next 12 months we will……

Deliver **Embedding Learning workshops** following patient safety incidents. A fundamental element will be sharing and learning from experiences and investigations in a compassionate way to develop and improve standards of care. This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons learned bulletins issued.

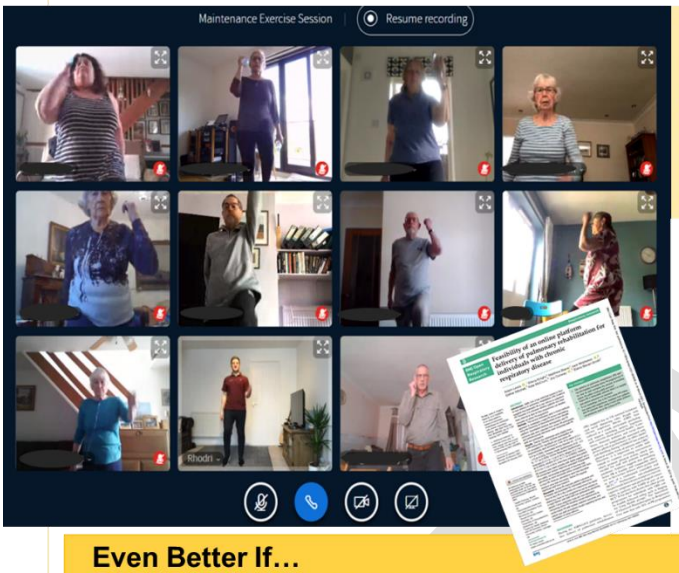
Implementation of the **Civility Saves Lives initiative**, with assurance measured against the co-produced project implementation goals and evaluation over the reporting period.

OUR AMBITION: EFFECTIVE
Everyone receives care that is beneficial, based on evidence and efficiently delivered.

Our strategic goals:

- Become a true **learning organisation,** with people participation at our core.
- Be an active partner in the One Gloucestershire Integrated Care System, ensuring that **new models of care reflect local needs.**

What's working well: Colleagues can undertake research and evaluation. GHC's Pulmonary Rehabilitation (PR) team evaluated their on-line programme and published a research paper. Objective evidence of the effectiveness of the approach and feedback from participants encouraged an reassured the team about this new mode of delivery.



"I am really feeling the benefit of taking part in the Wednesday maintenance exercise class held via zoom. I would find it difficult to attend a face to face meeting as I have to rely on public transport so using the link via zoom in my own home. I have talked to the group prior to the class and several find it easier too. I do hope we can continue with zoom classes."

Ester Mitchell (Interim Community manager for Long term Conditions Services) said "SARS-C19 restricted access to face to face pulmonary rehabilitation sessions. So the team undertook to evaluate a rapid service remodelling using the University of Gloucestershire eLearn Moodle platform. Our results indicated that On-line PR improved clinical outcomes and was feasible to deliver. The team are continuing to explore how they can further develop and improve on-line service delivery and incorporate it as part of their service options."

Even Better If…

- Ensure our people have the time and resources to contribute to research and evidence based practice.
- More colleagues and people who use our services were trained and confident to use Quality Improvement tools and techniques as part of our approach to improving and evaluating the effectiveness of changes.
- People who use our services had more and different ways to participate in service design and improvement.

What we do now that works well and how we can achieve our goals:

How we ensure effectiveness now...	What we are going to do differently...
Many measures of performance and activity	Capture more quality outcome measures
Report training compliance against profiles	Increase co-production
Supervision and appraisals	Support workforce development and transformation
Take part in relevant National Improving Care programmes	Increased use of Quality Improvement methods across services
Quality Improvement to learn and develop	Further develop our learning assurance process

Objective	Our measures of success
Increase the number of quality outcome measures used across out services, including patient-rated outcome measures	- Increased number of services capturing quality outcome measures - Quality outcomes measures being used to inform service performance discussions - Increasing reporting of quality outcomes measures within Quality Dashboard
Increase co-production across our organisation	- Increasing number of co-production events reported, increasing year on year - Training available for our workforce regarding co-production. Number of colleagues who have completed the training will increase year on year - Independent reports from our partners will reflect our increasing partnership working - Launch of our People Participation Strategy and committee
Support the continuous development and transformation of our workforce	- New training courses developed in response to local needs of our workforce and population - Improved scores on the Staff Survey in relation to effectiveness, support and feeling valued, year on year - Improved sickness and turnover rates, year on year
Continue to be active partners in the One Gloucestershire system	- Improved population health indicators for the county - Advocate for our communities by recognising unmet need and inequalities; driving innovation to seek solutions - Increasing number of services and pathways demonstrating integrated care
Embed the use of Quality Improvement (QI) methodology across all our service	- Increasing percentage of colleagues who have completed QI training, year on year - Increasing number of active Quality Improvement projects within the Trust, year on year
Continuously improve our learning assurance processes	- Embed a reflective discussion approach to ensure compassionate leadership and just culture approaches when learning from serious incidents - A combination of methods in use to ensure effective cascade of learning (learning on a page, safety bulletins, interactive sessions) - Embed a learning culture whereby a safety culture and lessons learnt are part of our business as usual

In the next 12 months we will……

Improve the transition to adult services for children and young people. A specific focus will be placing the young person at the heart of everything we do, ensuring a safe and prompt transfer between services. We aim to achieve this through developing pathways, standardising practice, and reducing delays in care. Fidelity to the care pathways will be evaluated through participation in the NCEPOD study.

OUR AMBITION: EXPERIENCE

Everyone has access to person-centred, responsive and respectful care.

Our strategic goals:

- Treat people who use our services, their families and carers, and each other with **dignity and respect**
- Work in partnership to consistently deliver safe and effective **personalised care**

What works well: Our staff are committed and passionate about the work they do across all sectors – Childrens', mental health, learning disabilities, hospital and community services.
In April 2021 BBC Points West featured two people who were receiving end of life care at home delivered by GHC's Community Nursing Services. The presenter said: "families and patients identify this type of care as a gift, a privileged and makes the most difficult time easier to bear."

Lizzie said: **"We won't let people face death alone. When people are told there is nothing more treatment can do it is important people know we can help. People can feel vulnerable and scared at end of life. We support in every way possible – with symptom control, nursing, care, compassion and reassuring family members."**

'C' has terminal cancer and said: **"Its been good in hospital but I'd still rather be at home. At the end of the tunnel there is someone standing up for you"**

'M' a young man and former security guard has a brain tumour and said: **"It makes a difference being at home, close to family and friends"**

Even better if….

- Ensure more personalised care approach programmes and resources are integrated into clinical systems;
- Ensure more of our teams have the technology, training and infrastructure to improve mobile working and enabling safe and effective care peoples homes.
- We were clearer about our learning and improvements when care is not as good as it should be or we have made mistakes.
- Ensure more options for different ways people could be involved in improving service delivery.

What we do now that works well and how we can achieve our goals:

How we measure experience now...

Compliments
Friends and Family Tests
Incidents, complaints and concerns
CQC Adult Community Mental Health Survey
Quality visits (NTQ and NEDs)
Staff Survey

What we are going to do differently...

Improve complaint resolution times
Increase assurances regarding learning from people's experiences, ensuring learning is embedded into practice
Reduce variablity in how we engage with carers
Provide ongoing health and wellbeing support for our colleagues
Establish Expert by Experience quality visits for all of our sites
Increase co-production at every level, in every team

Objective	Our measures of success
Review our complaint handling process for opportunities to provide swifter resolution for people when they raise concerns.	- Earlier resolution of complainants. - Incremental reduction in complaint resolution times until most are resolved within 3 months and only the most complex take up to 6 months to resolve - Support our teams to resolve concerns at the earliest opportunity, through improved processes and training opportunities - Co-produced complaints policy developed and in place
Increase opportunities for people to tell us about their experiences of contact with our services	- Incremental increase in compliments and Friends and Family Test responses, quarter on quarter - Additional question within standard Friends and Family Test (FFT) to specifically ask for people's views on their quality of care - Launch of a Carers Friends and Family Test
Increase the extent to which care is personalised	- Improved scores on the 'Planning Care' section of the CQC Community Mental Health Survey, year on year - Develop qualitative audit of care plans, to include co-production and personalisation
Reduce variability in how well we engage and communicate with carers	- Engage with carers and triangulate feedback with other sources of information and national guidance to co-produce a Trust Carer Strategy - Refresh and relaunch of Carer Aware training for our colleagues - Work towards achieving the third and final star from the national Triangle of Care Scheme

In the next 12 months we will……

Deliver an improved 'Patient and Carer Experience' by developing a GHC Always Events log.

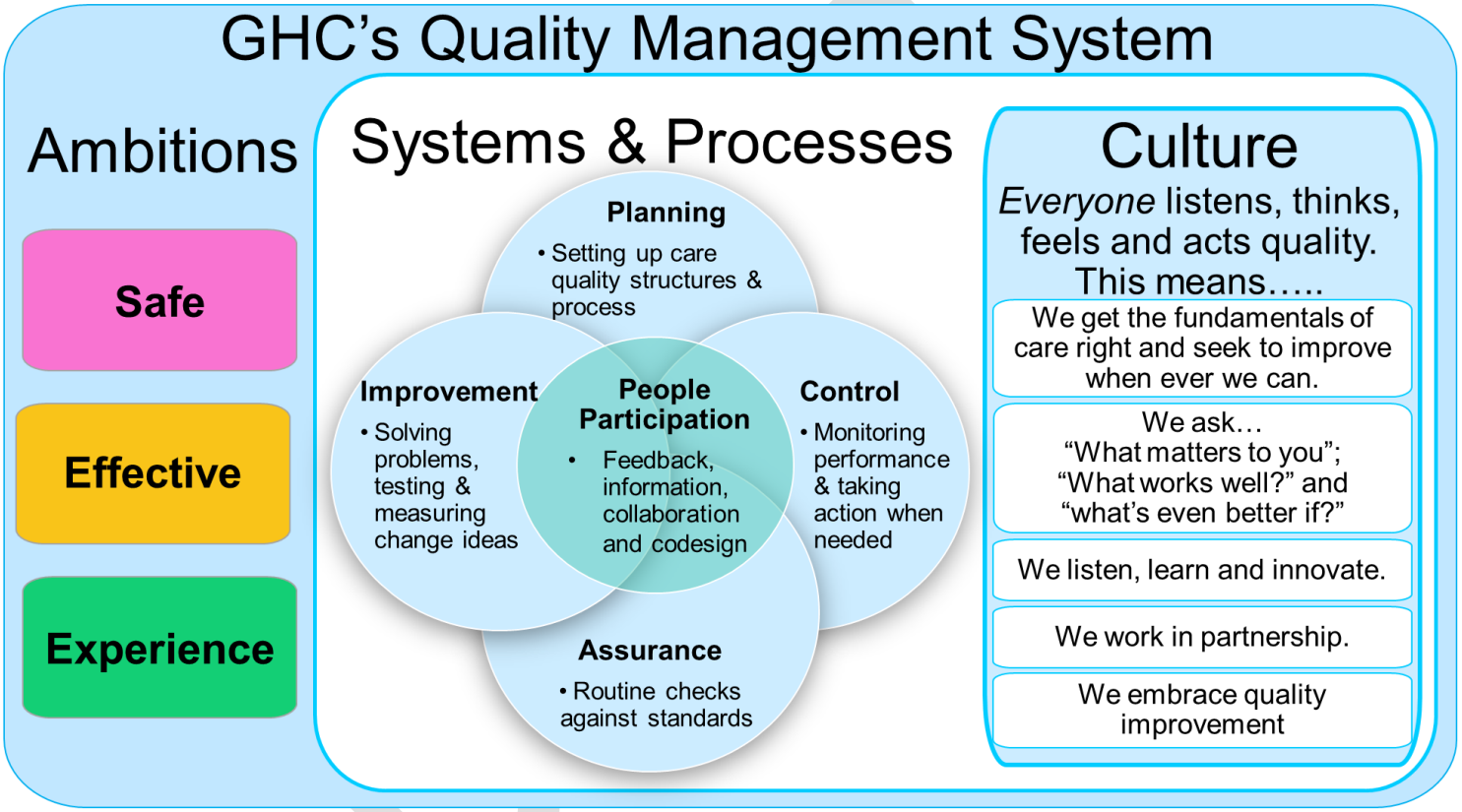
Nobody will wait for longer than 6 months for a final response to a formal complaint. This will be achieved by improving our complaints process and incrementally reducing current response times. Improvement in completion times will be achieved quarter on quarter.

OUR QUALITY APPROACH TO BECOMING A LEARNING ORGANISATION.

We are developing an approach that we are calling GHC's Quality Management System (QMS). It is based on the concept developed by W. Edward Deming, that continual improvement towards a quality aim provides better services, increases quality, and reduces costs. Our approach is informed by the work of Don Berwick in the context of improving quality in health care services. By continuously striving for quality, understanding what works well and what can be done better, we can achieve our Trust's vision and aims.

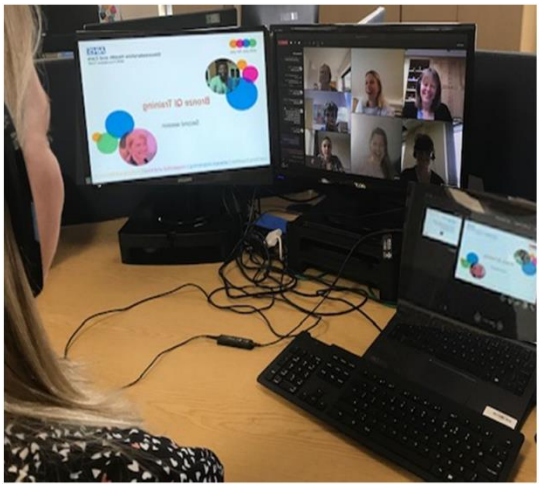
Implementing our QMS requires the development and embedding of processes, practices and a learning culture across the whole organisation. This will take time and commitment to develop.

GHC's Quality Management System at a glance:



- We will further develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance to ensure we provide excellent standards of care and set quality goals to continuously improve the services we provide.
- We will identify and use maturity index tools to help us measure our progress and guide our actions towards becoming a learning organisation.
- We will grow and mature our Quality Improvement (QI) approach as our methodology for solving complex problems, and to provide a consistent approach to testing change ideas and informing our decisions. Developing our new QI Hub is a key enabler and the strategic implementation plan in progress.
- People participation is key – engaging, consulting, co-designing and co-producing with our colleagues, our partners, and the population we serve. We will work with our Partnership and Inclusion team to develop experts by experience roles within our QMS processes, governance structures and improvement projects.

What's Working Well: GHC continue to embed a culture of quality and continuous improvement. Despite Covid restrictions colleagues and experts by experience have been busy co-designing Quality Improvement on-line training programmes and developing the QI strategic implementation plan.



Wotton Lawn's Well Woman Wednesday offers ward based health and cervical screening – addressing health inequalities and increasing the likelihood of early detection of cervical cancer by screening for women with serious mental illness. **Angela Willan (Lead Nurse)** said: "QI helped this project progress & develop using Plan-Do-Study-Act cycles. Women on the ward got involved to co-design and co-produce the Well Woman Wednesday project that has now won national awards. Next steps…Men's Health Mondays".

GHC's Wheelchair service put people at the centre of decision making by improving processes to reduce waiting times and increase personalisation. **Jenny Smith (QI manager) said "**A QI approach helped this passionate and highly skilled team shift their thinking from service criticism to continuous improvement. Understanding route causes of problems, unravelling complex systems through mapping and testing changes led to measurable improvement. Not only did people's experience of the service improve by reduced waiting-time; staff satisfaction and personal pride increased."

Even better if: QI was everybody's business. **GHC's Claire Lait (Quality Improvement Hub manager)** said "GHC's QI Hub supports improvement projects large and small as the examples show. As a new service we have a lot to do to expand training, resources, expert advice and coaching to all colleagues and experts by experience as well as play a vital role in our systemwide 'Improvers without Boundaries' network. Ensuring improvement is a key focus and has parity over planning, control and assurance in GHC's Quality management system can embed a culture of quality is our ultimate goal."

What is Quality Improvement?

"Working together, using methods, tools, data measurement, curiosity and an open mindset to improve healthcare'.

(GHC QI Hub quote)

A key enabler for the Trust Strategy, Quality Strategy and component of the GHC Quality Management System, the QI Hub was set up in September 2020. The Hubs purpose is to form a more robust QI approach in the organisation and embed QI into our trust culture.

Our QI approach seeks to support the experts – the people who use our services and those that deliver them, to understand the problem identified, find change ideas, test them out, upscale and make them sustainable using reputable, researched tools and proven methodology.

Our QI Hub is new and therefore has a specific QI strategic implementation plan over the next five years. This includes 5 key strategic priorities:

1. Create a dedicated QI hub
2. Create a QI centre of excellence
3. Utilise information and data systems to drive QI
4. Expand our QI community
5. Foster, nurture and embed a culture of continuous improvement.

HOW WILL WE KNOW WE ARE ACHIEVING OUR AMBITIONS?

ENABLING, MONITORING AND EVALUATING DELIVERY

Our Quality Strategy sits alongside our annual operating plans – these set out detailed objectives for each year to help us achieve our overall strategy by 2025.

Progression towards delivering our annual objectives will be monitored through our Trust governance structures, inclusive of feedback and collaboration with our stakeholders and will form part of our formal reporting structures. Through regular review, our Trust Board and Council of Governors will ensure our Quality Strategy continues to meet the needs of our organisation

There are a number of ways in which we will measure our progress and adjust our actions as necessary in order to achieve our ambitions. These include external reviews by CQC, feedback from Health Watch and other partners, internal peer review, and also our Quality Management System and quality governance structures.

Advanced evaluation tools and approaches

To stretch our ambition in our improvement journey we will use advanced evaluations tools and approaches that are evidence based and internationally recognised in the fields of evidencing embedding learning and quality improvement measurement. These include:

- Quality Maturity Index Assessment – *work completed on evaluating our Trust QI approach will help us build a more robust Quality Management System.*
- Embedding Learning Assessment Tool - Kirkpatrick Model: Four Levels of Learning Evaluation[3]. *Currently being utilised in Trust Civility Save Lives programme as part of our post serious incident embedding learning workshops.*

Care Quality Commission Rating

Gloucestershire Health and Care NHS Foundation Trust was formed in October 2019, following the merger of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. The CQC rating displayed at the time of writing our strategy is for the combined Gloucestershire Care services and 2gether NHS Foundation Trust completed in 2018. Our new organisation will be inspected and given its own rating in due course.

[3] Kurt, S. "Kirkpatrick Model: Four Levels of Learning Evaluation," in Educational Technology, October 24, 2016. Retrieved from https://educationaltechnology.net/kirkpatrick-model-four-levels-learning-evaluation

CONCLUSION

Our Quality Strategy sets out Gloucestershire Health and Care NHS Foundation Trusts ambitions and goals for the next five years. We have pledged to place **quality at the heart of everything** we do; for the population that we serve and for our workforce that strives to deliver the best possible care at all times. To achieve this, we set ambitions that focus our activity on quality outcomes:

- **Safety** - providing services that are safe and will not do any harm whilst being open and transparent about any mistakes and ensuring we learn from them.
- **Clinical Effectiveness** - continuously developing our services and learning from best practice, clinical evidence and the latest innovations.
- **Peoples Experience** - providing a friendly and welcoming approach from colleagues who communicate openly and clearly

Our shared ambitions focus our actions so that we can **improve the health and care of people we serve,** people with physical and mental health needs, and learning disabilities; **work better together** to understand peoples needs, lived experience, goals and aspirations**;** and ensure we **meet the needs of local communities**.

Our approach is about **empowering people** and includes **working together** and **continuous improvement** to embed quality initiatives, consistently deliver high quality care and make the changes that matter to people. This will be underpinned by developing our **Quality Management System** that aims to build a culture where everyone **listens, thinks, feels and acts 'quality'**.

We want to be a **learning organisation** that delivers **outstanding care** by working **better together:** this strategy describes how we will meet that challenge.

We want to take this opportunity to say a heartfelt thank you to everyone who has contributed to shaping our first Quality Strategy. We could not, and would not, have done it without you.

THANK YOU!

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

PRESENTED BY: Angela Potter, Director of Strategy and Partnerships

AUTHOR: Peter Hadley, Estates Strategy Manager

SUBJECT: **ESTATES STRATEGY 2021-2026**

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:

Present to the Trust Board the Estates Strategy for final comment and approval.

The Estates Strategy will continue to evolve as a live document as service priorities and working patterns embed and change as a consequence of Covid-19.

Recommendations and decisions required:
Trust Board is asked to:

- **Approve** the Estates Strategy subject to any final comments

Executive summary

We have spent a considerable amount of time engaging with Trust colleagues, system partners and experts by experience to understand what is important from our estate moving forward. This strategy is the culmination of this engagement and co-production and builds on feedback received from members of the Resources Committee.

Our Estates Vision is " To enable the delivery of outstanding, place-based care by providing high quality settings in the right locations for people". Our Estates strategy sits as one of our six enabling strategy and it fully acknowledges the inter-relationships between them. It also recognises that not all services are delivered from buildings that we own or lease – but are integrated into our communities with staff working out of health centres and community venues such as libraries or schools or frequently delivering services in people's own homes. Many of our

services are delivered in partnership with primary care, social care and the voluntary sector and our estates strategy will be a key way in which we can continue to facilitate wider integration and partnership working.

The impact of COVID-19, at a time of major transformational change in the NHS provides a platform for Estates processes, projects and partnership to be re-evaluated and thus this strategy will continue to evolve as a live document to reflect changing working practices and thus estate and building need.

With a solid foundation of the asset base owned, leased or occupied by the Trust, this strategy outlines the roadmap for embedding technology, adopting efficient processes and working with system partners to realise efficiencies.

There are potential developments in the pipeline, a need to consider rationalisation of the estate and, most importantly, a framework to create an Estates over the next 5 years that is flexible, value for money and fit for new ways of working.

Risks associated with meeting the Trust's values

The ability to implement strategic Estates decisions while service delivery models and new ways of working evolve and ICS partnerships develop.

Corporate considerations	
Quality Implications	There is strong alignment with our quality strategy and quality priorities in terms of delivery of outstanding care. The quality of the environment has a significant impact on the theraputic outcomes for people who use our services and on the morale of our colleagues.
Resource Implications	Alignment with the capital programme however, additional resources are likely to be necessary if we are to achieve our full aspirations
Equality Implications	None noted

Where has this issue been discussed before?
.

Appendices:	N/a

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

with you, for you

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NHS Foundation Trust

Estates Strategy

2021 – 2026

Our Estates Strategy 2021 – 2026

1. Introduction

Our **Estates Strategy** for 2021 – 2026 will take us forward on our journey to ensure that we are delivering services in the right locations, from high quality, effective estate.

We formed in 2019 following the merger of two strong, high performing Trusts and this strategy will build on the creativity, passion, drive and expertise shown by our colleagues in the process as well as building on the experiences of our responses to COVID.

This strategy does not sit in isolation but as one of six integrated enabling strategies that underpins the delivery of our overarching strategic aims and the Trust's vision; *Working together to provide outstanding care.*

Our services cover the whole of Gloucestershire and we have produced this strategy to explain how we utilise the estate as an asset and key enabler to deliver outstanding services.

It recognises that not all services are delivered from buildings that we own or lease – but are integrated into our communities with staff working out of health centres and community venues such as libraries or schools or frequently delivering services in people's own homes. Many of our services are delivered in partnership with primary care, social care and the voluntary sector and our estates strategy will be a key way in which we can continue to facilitate wider integration and partnership working.

Our strategy recognises the importance of providing fit for purpose physical buildings in settings close to our patients' homes. We recognise that the quality of the environment impacts on the quality of the services we provide thus ensure that our services are delivered in fit-for-purpose settings close to our patients' homes is key. This includes occupying our system and public sector partners' buildings, and vice versa where this is functionally and financially viable.

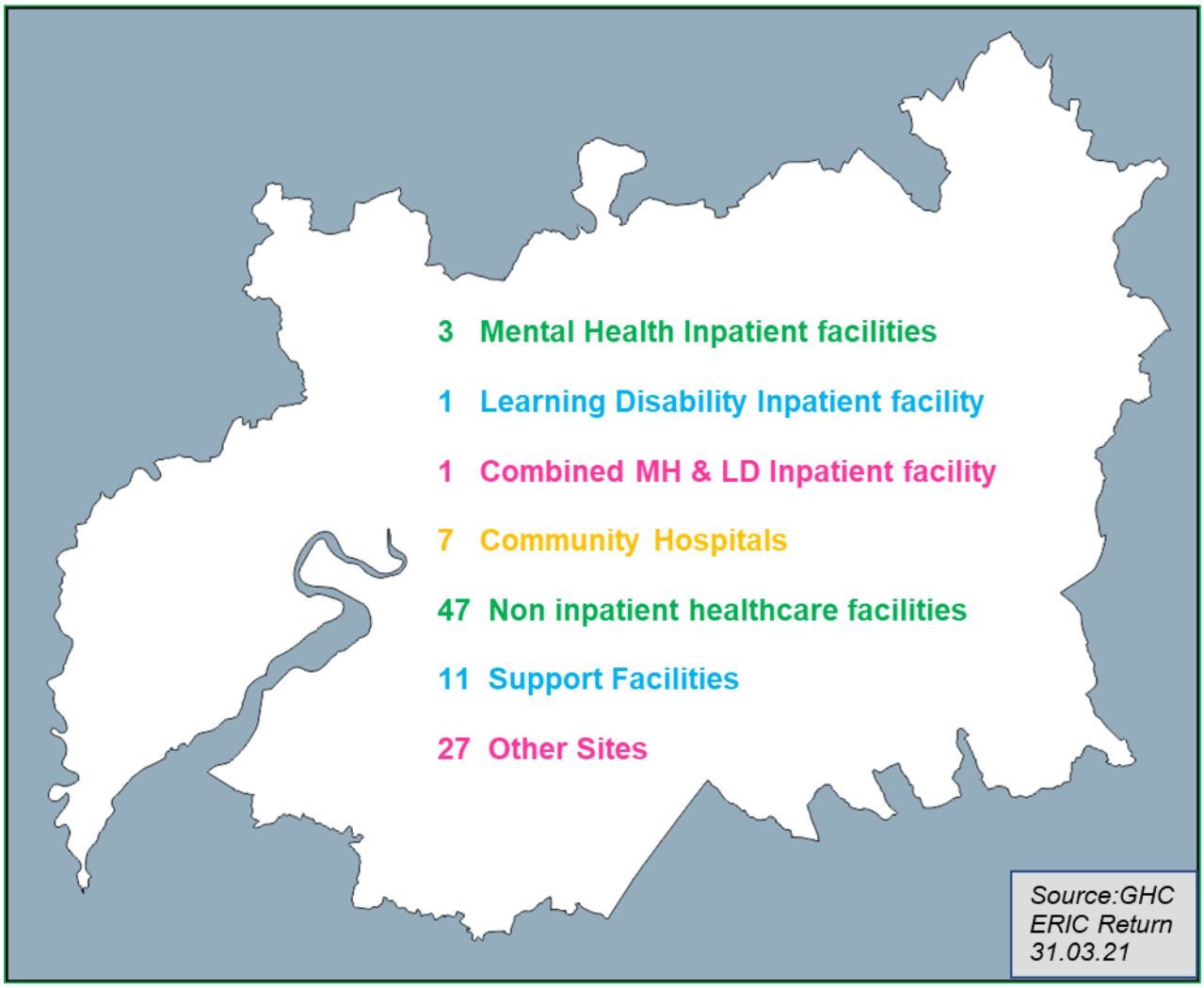
We have co-produced this strategy with our colleagues and by reflecting on what we've been told through a range of engagement events. This strategy is not a static document, as service strategies evolve and develop, so must our estate, but it lays out a roadmap for our ambitious but realistic plans for the next five years.

In line with our values we will continue to listen and work in partnership with colleagues as well as patients, stakeholders and communities.

2. The GHC Estate – Where are we now?

We operate from over 140 premises which includes 7 Community Hospitals, 2 Mental Health in-patient units and a varied portfolio of clinical and non clinical buildings across the whole of Gloucestershire.

Figure 1: The GHC Estate



An analysis of the GHC property portfolio is undertaken in March each year through the NHS Estates Return Information Collection (ERIC). This provides real time estates information allowing organisations to benchmark their performance.

The Trust currently has 49 freehold ownerships totalling 74,300 sq.m. The annual ERIC analysis provides a breakdown of this total owned estate into 'Inpatient Units' and 'Other Reportable Sites' (freehold buildings more than 150 sq.m.) as follows:

Table 1: GHC Freehold ownerships

Estate type	Description	No. of Sites	Gross floor area (Square metres GIA)	Approx total site area (hectares)
Inpatient Units (IPU)	Mental Health and Learning Disability inpatient units and Community Hospitals	12	47,943	21.1
Other reportable sites (ORS)	Non inpatient healthcare facilities, support and other sites	37	26.357	5.6
Source: GHC ERIC Return 31.03.21	**TOTAL**	**49**	**74,300**	**26.7** (66 acres)

The impact of the COVID-19 pandemic has changed the landscape of delivery across health care services and at the time of writing the strategy, it remains unclear exactly what the long term impact will be on how people want to utilise our physical Estate. It has however, provided a platform for Estates processes, projects and partnerships to be reviewed. We have taken the opportunity to embed technology, adopt more efficient processes and strengthen working with system partners to realise efficiencies.

This work will continue to be key to delivering clear estate development and rationalisation plans and ensuring that over the next 5 years our Estate continues to offer flexible, value for money and fit for purpose accommodation that meets the needs of our new ways of working.

3. Our Achievements

Ensuring that good quality, therapeutic environments are in accessible locations and designed to meet the needs of our services now and into the future has been a key priority. Our aspiration to reduce health inequalities and continue to improve accessibility are key strategies for the future. To date, we have achieved:

- Providing the foundation of a fit for purpose Estate
- Supporting strategic service initiatives
- Optimising Asset Holdings
- Revenue savings from moving to lower cost settings
- Disposals to generate capital receipt

Table 2: Estates & Facilities Achievements 2019-2021

<table>
<tr><td colspan="4">← Statutory compliance across estate →</td></tr>
<tr><td>Developments, re-purposing and disposals</td><td>Optimising Asset Holdings</td><td>Revenue savings from moves to lower cost sites
(to 31.03.21)</td><td>Supporting strategic service initiatives</td></tr>
<tr><td>Enabling Trust response to Covid-19 requirements</td><td>Montpellier upgrade
£1.5 million project</td><td rowspan="2">Vacation of GCC sites by GHC ICT staff
Total Saving £400,000 per annum</td><td>Stroud AHU Endoscopy & General Liquid Oxygen</td></tr>
<tr><td>Refurbishment for Learning & Development Hub at Invista</td><td>The Maxwell Suite
£80,000 upgrade</td><td>Flat refurbishments and decant at Berkeley House</td></tr>
<tr><td>New Forest of Dean Community Hospital (Full Business Case)</td><td>Acorn House (CYPS)
£380,000 upgrade</td><td rowspan="2">Vacation of NHSPS sites by GHC colleagues
Total Saving £150,000 per annum</td><td>Homeless Healthcare relocation to Rikenel</td></tr>
<tr><td>Holly House & Hatherley Road site disposals (Due to market)</td><td>Backlog maintenance:
£2.7 million cleared 2020/21</td><td>Estates & Facilities Hub at Rikenel</td></tr>
<tr><td colspan="4">← Sustainability Improvements →</td></tr>
<tr><td colspan="2">Trust-wide Electric Vehicle charging points
18 available (to 31.03.21)</td><td colspan="2">Boiler and generator replacements (6 locations) / LED upgrades (5 locations) and Solar PV installation (2 locations)</td></tr>
</table>

We undertook an extensive condition survey undertaken in 2019. This identifies where we need to invest in strategic sites and where backlog maintenance may prove uneconomic as the older estate is not capable of becoming fit for purpose.

Having identified those parts of our estate that require modernisation, technology upgrades or re-purposing, our Capital Management Group assesses our service needs and prioritises investment in a rolling five year capital plan.

The capital plan is funded through our cash reserves and disposal proceeds from assets identified as surplus to operational requirements. Table 3 below summarises the capital plan for the duration of this strategy with our current priority being the development of a new Community Hospital for the Forest of Dean.

A number of sites, confirmed as surplus by clinicians and commissioners, will be sold over the next 2-3 years, with a process in place to initially offer the asset for acquisition by other public sector partners. The proceeds of these sales are used to fund future capital projects.

The Trust occasionally benefits from individual donations of assets of funds which are also directed to fund our capital plan.

Table 3: The current GHC capital plan

GHC Five Year Estates Capital Plan (£000s)	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Developments						
Forest of Dean Community Hospital	3,000	16,000	3,500	0	0	22,500
LD Assessment & Treatment Unit	0	0	2,000	0	0	2,000
Cirencester Campus	0	0	5,000	0	0	5,000
Sub-total	3,000	16,000	10,500	0	0	29,500
Land & Buildings						
Buildings	4,737	2,500	2,500	1,000	1,000	11,737
Backlog Maintenance	4,431	0	1,050	1,250	1,393	8,124
Urgent Care	750	0	0	0	0	750
Sub-total	9,918	2,500	3,550	2,250	2,393	20,611
Total prior to proceeds / donations	**12,918**	**18,500**	**14,050**	**2,250**	**2,393**	**50,111**
Disposal proceeds (NBV)						
Ambrose House		-785				-785
Holly House		-164				-164
Hatherley Road		-400				-400
Forest of Dean sites			-4,454			-4454
Donations						
Charitable Funds - Cirencester scheme (Malmesbury)			-5,000			-5000
Total after proceeds / donations	**12,918**	**17,151**	**4,596**	**2,250**	**2,393**	**39,308**
Note: The above extract excludes IT, Medical Equipment and Unallocated capital from the current GHC five year capital plan						

In addition to the proposed major capital development in the provision of a new Community Hospital for the Forest of Dean, investment is currently scheduled for the refurbishment of the Minor Injuries and Illness Unit (MIIU) and Jubilee Ward at Stroud General Hospital.

The Trust continues to be a key participant in the One Gloucestershire Estates Board and ICS-wide Estates initiatives.

4. Our Challenges

This strategy is not a static document. As service strategies evolve and develop, so must our Estate. In order to meet the Trust's ambitious strategic aims, we must accelerate their transition. Our Estate must adapt and innovate to accommodate future ways of working.

One such recent change has been the speed and agility of change with digital services. The Covid-19 pandemic has altered the expectations of staff and the wider public to one where many interactions are now virtual or online . This, in turn, can alter the way in which we use our buildings.

We will continue to review the way in which we need to use the Estate - embedding greater use of technology may help to support rationalisation of our estate. A strategic estate utilisation project will be a key development piece for us moving forward.

System-wide integration of Estates Strategies is also key to providing agile, technology-enabled accommodation, providing the capacity to address the assessment, diagnosis and treatment backlog and the additional space requirements for COVID-secure environments.

Our Challenges

- Limited access to capital – internally sourced cash for capital projects;
- Estates efficiency savings increasingly challenging;
- Large, diverse portfolio – resource implications to manage 140 sites;
- Balancing service accessibility with Estate quality and affordability;
- Net Zero Carbon targets by 2050;
- Changes to International Financial Reporting Standard (IFRS) with leasing now treated as capital spend;
- Backlog maintenance affordability increasingly challenging;
- System-wide capital envelope reduces ability to use cash reserves;
- Community Estate requires expansion with new services and colleagues;
- Housing solutions required with more treatment closer to home;
- Estate needs to be 'Pandemic-ready' for future challenges.

Our Estates Strategy sets out a vision of an efficient, sustainable and clinically fit for purpose estate. This adheres to national NHS Policy for the delivery of the Five Year Forward View and the implementation of new models of care.

5. Our ambition – formulation of the Estates Strategy

An Estates Strategy is defined as "A long-term plan for developing and managing the estate in an optimum way in relation to the Trusts service and business needs. On a practical level, the Estates Strategy identifies and manages the risk of compliance with statutory building responsibilities, CQC standards and financial risk from voids, backlog maintenance and capital costs.

Across Gloucestershire we have a shared ICS Estates group and the Trust is a key partner in the One Public estate work. However, there is more work to do here to understand our collective estate utilisation and future aspirations and as one of a number of anchor institutions in the system we recognise the importance of playing a pivotal role in the system wide estate development.

Co-production and collaboration are key to how we will achieve our Trust's strategic aims and estate ambitions. We have completed an analysis of our Estates aims to assess how they support the Trust's overarching strategic aims:

TRUST STRATEGIC AIMS	ENABLERS						ESTATES
	QUALITY	PEOPLE	DIGITAL	RESEARCH & INNOVATION	FINANCE		
HIGH QUALITY CARE							High quality, accessible locations. Therapeutic settings. Safe, effective and efficient delivery.
BETTER HEALTH							Embedded technology. Partnership with community and system. Integrated, cost-effective services.
GREAT PLACE TO WORK							Safe workplace. Welcoming settings and culture. Adoption of new ways of working.
SUSTAINABILITY							Reduced carbon footprint. Cost-effective re-purposing of estate. Supply chain realignment.
SYSTEM-WIDE INTEGRATION							

During the development of the Estates Strategy we undertook a series of engagement, co-design and participation events with people who use our services, colleagues and system partners. Our goal was to make sure we understood what Service's aspirations were, what benefits or important outcomes needed to be achieved and what was important to people who use our services.

6. Our Estates Vision

"To enable the delivery of outstanding, place-based care by providing high quality settings in the right locations for people".

Improving our patients' health and well-being and the way in which they experience our services, through the effective use of our Estate and facilities is at the core of our strategy. This means that we will ensure that people can access services that are in the right place, for the right person at the right time.

To deliver our vision we have identified six strategic aims that align with the Trust's priorities. Against each of our aims we have identified overarching goals, a number objectives and how we will measure success.

7. Our Estates Strategic Aims

Ensure our Estate provides efficient and effective spaces that are fit for purpose;

1. **Strengthen Estate integration by working with System Partners;**
2. **Ensure we are making the best use of our Estate;**
3. **Embedding Sustainability models and approaches into our Estate management;**
4. **Maximise innovative property solutions;**
5. **Ensure our Estate supports the health and wellbeing of our people.**

Estates Strategic Aim 1 - Ensure our Estate provide efficient and effective spaces that are fit for purpose

We will proactively manage our assets and have a clear plan for reducing backlog maintenance. Where assets cannot be cost-effectively maintained or the estate is deemed surplus it will be released, with capital receipts reinvested into the capital programme.

Ensure our Estates provide efficient and effective spaces that are fit for purpose	
Our goals over the next 5 years are to:	**Objectives and Actions**
• Ensure the physical condition of the Estate is fully compliant with health & safety and business risks; • Improve the utilisation of clinical space and maximise the use of higher quality assets in line with NHSE/I metrics (Carter review); • Reduce operating costs through effective use of robust disposal/reconfiguration asset management and environmental performance improvements; • Support development of accommodation reporting to enable better understanding of the cost and performance of our Estate; • Provide easily accessible care settings that reflect the Trust's aims for high quality and better care.	• Maximise high quality space; disposal of buildings with uneconomic backlog costs • Full analysis of Estate utilisation to inform strategic Estate decisions • Develop integrated portfolio management processes and adopt robust disposal / acquisition processes • Develop cost analysis for individual buildings and services integrated with space utilisation data; • Positive working environments with opportunities for user surveys and feedback; • Work in partnership with stakeholders to ensure our facilities are accessible and welcoming to all and support the wider health inequalities work
Key tasks over the next 12 months	
• Formulate implementation plan with phased delivery of Estates Strategy • Work alongside implementation of other enabling strategies • Continue Estates consolidation process • Embed Estates utilisation survey and develop a Trust-wide roll-out plan • Develop model of Estate cost and performance •	

Measures of Success

- Improvements against key measures in the 6 facet survey categories
- Demonstrable improvements from colleague surveys, PLACE, 15 steps
- Continued space utilisation improvements - Non-clinical use < 35% of total and unoccupied/underused < 2.5%
- Continued development of Service line cost analysis.

Case Study – Pullman Place, Gloucester
Refurbishment of clinical space using a co-design process



As new and old services integrated and developed, a different solution was needed to ensure people could wait and have appointments in rooms that meet their needs.

An experience led, co-design approach was used with people and partners to ensure the design was aligned with not only building regulations, but the needs of all users of the building.

The clinical needs and operational processes were considered in tandem within the design process.

Estates Strategic Aim 2 - Strengthen Estate integration by working with System Partners

Working in partnership with partners to provide a wider foundation of estate assets to enable the delivery of wider system benefits and reduce inequalities. These partnerships will extend beyond the traditional health partnerships and consider how we develop relationships with the local community and third sector to support mutual service delivery objectives but also to maximise opportunities from disposal of surplus sites in order to support the reduction of health inequalities.

Strengthen Estate integration by working with System Partners	
Our goals over the next 5 years are to:	**Objectives and Actions**
• Integrate system-wide strategic Estate plans into formal and regularly reviewed ICS Strategy; • Build strong partnership links with Third Sector providers;	• System wide utilisation and capital project database for efficient management of ICS Estate; • Establish working group for integration of thinking and approach with third sector; • Fully utilise Experts by Experience panel for strategic proposals;

• Integrate co-production processes into formulation of Estates strategies and business cases;	

Key tasks over the next 12 months
• Pull together individual Provider Estate Strategies in Gloucestershire; • Update Joint ICS Estate Strategy with One Gloucestershire partners; • Prepare Trust-wide enabling strategy summary and timeline; • Establish Third Sector working group for strategy and projects; • Define criteria for assessment of social value for projects; • Identify and participate potential OPE funding.

Measures of Success

- Evidence of estate co-production and co-design in service transformation
- Robust ICS estates strategy
- Further co-location and integration of services with partners

Estates Strategic Aim 3 – Ensure we are making the best use of our Estate

We wil maximise estate utilisation and work with commissioners and other partners to develop locality based estate plans to ensure we achieve greater co-location and integration with partners.

Ensure we are making the best use of our Estate	
Our goals over the next 5 years are to:	**Objectives and Actions**
• Estate rationalisation with a focus on better quality estate; • Achieve greater co-location of colleagues and agile co-working; • Ensure development support to embed cultural change with agile working; • Ensure we are getting best value .	• Provide stability for financial modelling and service planning; • Reduce footprint based on space analysis and service needs; • Balance provision of specialist accommodation with local accessibility; • Reduce costs and retain flexibility of occupation;

	• Negotiate lease costs at renewal points (rent review / lease renewal).

Key tasks over the next 12 months
• Continuous challenge to the holding of assets and their use; • 'Right Service, Right Estate - set out what services require and where • Ensure site rationalisation /co-location undertaken to promote integrated working rather than to reduce Estate costs; • Consider opportunities from currently under-utilised buildings where leasing to third party, re-purposing or mothballing may allow longer term decisions. • Service delivery will be focused on community settings, either single facilities or a network of local facilities

Measures of Success

- Robust programme of lease review and renewals – taking opportunities from break clauses etc. where appropriate
- Space utilisation benchmarks (internal and external)

Estates Strategic Aim 4 – Embedding Sustainability models and approaches into our Estate management

Establishing strong links between the Estates Strategy and Green Plan will enable us to improve the environmental management of our estates. We will develop an approach that recognises social and ecological value of our estates.

Embedding Sustainability models and approaches into our Estate Management	
Our goals over the next 5 years are to:	**Objectives and Actions**
• Adopt sustainable construction and asset management processes; • Maximise opportunities for adding social value through the utilisation and development of our estate; • Establish links between nature and preventative healthcare - develop Biodiversity Plan to promote use of natural greenspace;	• Ensure the estate delivers its contribution to the sustainability targets in line with guidance and Green Plan e.g. LED lighting and renewable energy; • Include assessment criteria for sustainability benefits as part of procurement process for estate schemes;

• To understand how can we measure the social value of our estates.	• Expand NHS Forest Programme for creating allotments, dementia gardens, outdoor gyms and green health routes.

Key tasks over the next 12 months

- Establish links with the Sustainability Action Group to support delivery of Net Zero Carbon initiatives;
- Benchmark performance against peers and other NHS providers;
- Support delivery of Trust-wide Biodiversity Plan to enable preventive healthcare and access to green space;
- Consider and develop social value measures for Estates.

Measures of Success

- Key milestones in Green Plan delivered through improved estate infrastructure.

Case Study – Sustainability cost saving programme and Trust environmental initiatives

NHS FOREST
growing forests for health

FOR A GREENER NHS

NHS allotments for Montpellier Unit

"The Montpellier unit has given me a lot and this is my way of helping others and repaying the good things they did for me."

Montpellier allotments are on a 0.5 acre site near central Gloucester providing a multifunctional accessible, safe, green space for people who use our services. The allotments enable people to access therapeutic, occupationally focused activity in a safe supportive environment engaging in a range of activities such as horticulture and creative writing.

The allotments have recently secured funding for a co-designed allotment area, creating a new space for people from across the trust who can access the area and expanding the opportunities the allotment can offer.

The allotments are an exciting example of the opportunities for sustainability within healthcare, recognising the value of accessing nature and the impact of environments on people's health and wellbeing.

"I view my role as being particular inspiring to other patients as I have been in their shoes and my volunteering demonstrates to them that there is hope and an alternative path." Kevin Mckenzie Volunteer Patient representative.

Estates Strategic Aim 5 – Maximise innovative property solutions

We need to ensure we have a flexible Estate capable of rapid repurposing to meet ongoing service change and transformation. It needs to be able to support new ways of partnership working and enable staff to maximise the use of new technology.

Maximise innovative property solutions	
Our goals over the next 5 years are to:	**Objectives and Actions**
• Ensure the Estate is 'Future pandemic-prepared'; • Enable capital investment through Estate rationalisation; • Investigate alternative models of capital investment or partnership working where it is appropriate to do so;	• Digitally enabled Estate for clinical and non-clinical activities; • Opportunity for transformation of Estate through collaborative working; • Consider third party or ICS partner joint ventures; • Support the roll-out of a hybrid working model between home, office and clinical space requirements.

Key tasks over the next 12 months
• Develop and embed our approach to Space Utilisation and develop a database to inform our estate planning; • Work with ICS partners to assure future pandemic preparedness;

- Investigate alternative sources of capital investment where appropriate;
- Working with the HR team take forward key aspects from the People Strategy to support different working models for our colleagues

Measures of Success

- Space utilisation benchmarks (internal and external)
- Embed integrated working and innovation within a robust ICS estates strategy
- Further co-location and integration of services with partners

Case Study – Estates Challenge of COVID-19 response

Repurposing of Edward Jenner Court during first wave of COVID-19

In response to COVID-19 and to support our essential clinical services, GHC Estates needed to adapt at pace. Our head office became the COVID testing site with a drive through testing pod. The testing pod continues to provide pre-operative testing to ensure people can continue to access essential elective operations and supports testing for colleagues and their families, allowing them quick and easy access to testing.

Adaptation of the building at Edward Jenner Court was integral to the success of this service, ensuring we had everything we needed to run a safe department, despite all the changing guidance.

GHC Estates & Facilities have continued to adapt and re-purpose accommodation as demands for testing services has increased and in support clinical service delivery.

Estates Strategic Aim 6 – Ensure our Estate supports the health and wellbeing of our people

To ensure our Estate supports the health and wellbeing of our people	
Our goals over the next 5 years are to;	**Objectives and Actions**
• Ensure our estate promotes health and wellbeing; • To reduce inequalities for our people by providing estates that are accessible and inclusive wherever possible; • To enable flexible and adaptable working through integrating estates and digitial delivery.	• Enable people work in safe positive healthy environments that also provide for rest, relaxation and effective team working; • Develop an approach to identify and monitor risks to wellbeing within our estates; • Create spaces that promote health and wellbeing through partnerships with people, services and partners across the ICS; • Work in partnership with diversity networks and people to understand accessibility and inclusion needs;

Key tasks over the next 12 months
• Undertake an audit of our key work bases to understand the level of rest facilities and develop a gap analysis and associated action plan • Work in collaboration with people plan • Create/adopt hybrid model of working • Support trust biodiversity plan to enable access to green space • Engage with colleagues to understand how Estates can support their health and wellbeing

Measures of success

- Evidence of estate co-production and co-design in service transformation
- Demonstrable improvements from colleague surveys, PLACE, 15 steps
- Reduction in staff absence
- Improved Staff survery results

8. How our Estate will change over the next five years

Our Estate Strategy will increasingly focus on local delivery and implementation of changes across the wider system focusing on mechanisms such as population health management to develop targeted iniatives to help reduce health inequalities.

There is now a step-change in collaboration with NHS providers, primary care and local authorities which will accelerate multi-agency service delivery models and multi-occupied buildings. Stakeholder engagement will be integral in the process for assessing and developing our estates proposals moving forward.

How our Estate will change over the next 5 years?

- The overall footprint will reduce with the disposal of non-compliant or non-essential buildings or settings;
- Co-location of colleagues will increase, both internal teams and collaborative partners;
- The target is for fewer, higher quality facilities;
- Best practice will continue to be adopted and adapted in the design of space and the management of our Estate;
- Wherever possible, new technologies will be incorporated as part of the Digital strategy to be a fully digital Trust;
- Agile working will undoubtedly reduce the amount of non-clinical space as both colleagues and service users are enabled to interact remotely.

9. How do we measure the success of our strategy

During the first year of the strategy we will continue to develop our implementation plan and measures for success. For example, as we continue to roll out our utilisation audits, we will gain a better understanding of how we can utilise and occupy our space differently and therefore set more quantifiable targets with which to measure our progress.

We will share these with Resources Committee for ongoing sign-off as this Strategy evolves.

Scrutiny and Governance

With a wide and complex strategy over the next 5 years, the Estates function at GHC requires support within the Trust and from across the wider ICS.

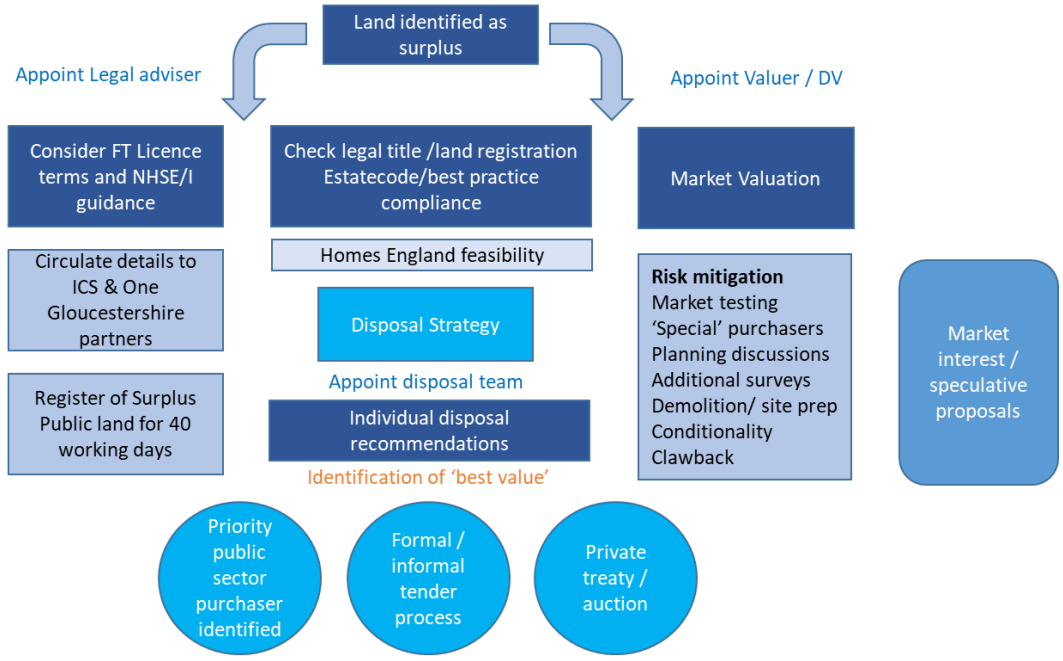
Any Estates proposal will continue to proceed through the existing governance framework of the Capital Management Group and Resources Committee before scrutiny by the Trust Board.

Case Study – Disposal criteria and recommended process

In considering whether a building should be identified for disposal, the following criteria should be adopted:

1. It does not align to clinical locality service delivery strategies;
2. Non compliance with design/space/regulatory and service standards;
3. It is significantly under utilised or vacant;
4. Uneconomic operational costs or backlog maintenance over time;
5. It is is not required by GHC for core business.

GHC adopts the following formal process for disposing of property following a decision to declare the asset surplus to requirements:



10. Conclusion

This strategy sets out plans for our Estate at a time when the future level of occupancy of buildings and the adoption of new ways of working remains uncertain.

The Estate will continue to provide the foundation required for a high quality, safe and effective clinical and working environment for our service users, colleagues and partners in Gloucestershire.

We have approved the Full Business Case for the development of a new Community Hospital in the Forest of Dean hospital demonstrating the Trust's commitment to continued investment in our estate and this strategy also acknowledges that where appropriate, we will also rationalise assets that are not fit for purpose or become

surplus to service requirements, adopting a robust assessment and disposal process.

We propose that this Strategy is delivered through an implementation plan where individual processes, projects and partnerships are identified to deliver the Trust's vision and aspirations. Additionally, we recognise that increasingly we need to work with our system partners and maximise the opportunities for Estates collaboration, and partnership working across the public and third sector to deliver excellent care at the heart of our communities.

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

PRESENTED BY: Sandra Betney, Director of Finance / Deputy CEO
AUTHOR: Andrew Paterson - Strategic Project Manager

SUBJECT: **REFURBISHMENT OF JUBILEE WARD AND MIIU, STROUD GENERAL HOSPITAL**

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 document presents the business justification for the refurbishment of Jubilee Ward and the Minor Illness and Injuries Unit at Stroud General Hospital.

The proposed Jubilee Ward refurbishment and the complete redesign of MIIU are part of an ongoing programme to upgrade the hospital's facilities to the standards expected in the 21st century.
[

Recommendations and decisions required

.
The Trust Board is asked to **approve** the Business Case at a value of approximately £1.5m [£1.964m less League of Friends contribution (c £400k) less applicable VAT reclaim]

Executive summary

Jubilee Ward and Stroud MIIU are important contributors to local services. Neither has benefitted from significant investment in recent years and this is now impeding the ability to deliver care.

This business case demonstrates a pressing case to upgrade the facilities in both units to meet the standards now expected.

Schemes have been proposed that will deliver substantial benefits for patients, staff and service operations. The schemes will make notable improvements to patient privacy and dignity, enable better isolation and infection control, improve operational

effectiveness through better adjacencies and layout and will greatly improve the working conditions for staff. Much improved air handling will result in a better environment for both staff and patients.

The preferred option – to proceed with both schemes at the same time, instead of undertaking the work in two separate stages, avoids the need for multiple decants and is more economical.

Taking into account the donation from the Stroud Hospital League of Friends and the allocation in the Trust Capital Plan, the preferred option is affordable.

Risks associated with meeting the Trust's values

The refurbishment requires the vacating of both Jubilee Ward (to be relocated at Cirencester Hospital) and MIIU (with some work retained in booked appointments in Stroud and demand diverted to Cirencester and the Vale). Detailed planning is underway to ensure continuity of service and minimal impact on patient care.

Corporate considerations	
Quality Implications	The benefits derived from this investment have major quality implications including for patient privacy and dignity, infection control and clinical effectiveness. These are set out in the paper and in Appendix 1.
Resource Implications	The investment is part of the Trust Capital Plan. There are some transition revenue costs which will be met from non-recurrent underspend.
Equality Implications	A Quality and Equality Impact Assessment has been completed - this shows that impact on protected characteristics is either neutral or beneficial.

Where has this issue been discussed before?
A summary paper was discussed at Executive Team meeting on 13th July 2021.

Appendices:	1. Strategic Objectives and Benefits for the Refurbishment 2. Terms of Reference for Stroud Jubilee Ward and MIIU Refurbishment Project Group 3. Refurbishment Project Plan 4. Operational Project Plan 5. Refurbishment risk matrix 6. Operational risk matrix 7. Quality and Equality Impact Assessment

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

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

Refurbishment of Jubilee Ward and MIIU, Stroud General Hospital

Business Case July 2021

Contents

Appendices

1. Strategic Objectives and Benefits for the Refurbishment
2. Terms of Reference for Stroud Jubilee Ward and MIIU Refurbishment Project Group
3. Refurbishment Project Plan
4. Operational Project Plan
5. Refurbishment risk matrix
6. Operational risk matrix
7. Quality and Equality Impact Assessment

Introduction

This document presents the business justification for the refurbishment of Jubilee Ward and the Minor Illness and Injuries Unit at Stroud General Hospital.

The proposed Jubilee Ward refurbishment and the complete redesign of MIIU are part of an ongoing programme to upgrade the hospital's facilities to the standards expected in the 21st century.

Stroud General is one of the oldest buildings in the Trust estate. Parts of the current site date back to 1875 and to an extension in 1890. In 2017, Gloucestershire Care Services successfully applied for the building to be included in the Register of Assets of Community Value reflecting the esteem in which the building is held locally.

The old building presents many challenges for delivering modern efficient health care.

Over recent years, there has been considerable investment in bringing facilities at Stroud General to bring facilities up to more modern standards. In addition to the development of the Bowbridge Outpatient unit, improvements have included an extension to the theatre, a refit of endoscopy, new air handling units for theatre and endoscopy, piped oxygen for a part of the building, and some frontage window replacement. In 2018, a major scheme financed jointly by Gloucestershire Care Services and the Stroud Hospital League of Friends, refurbished Cashes Green ward providing additional side rooms and generally improving facilities across the ward.

Jubilee Ward and MIIU occupy the building at the Trinity Road end of the hospital site. This end has missed out on previous remodelling and refurbishment. There were some improvements on Jubilee in 2012 (e.g. to shower rooms), also jointly funded by the League of Friends, but these did not address major issues regarding the configuration of the ward. There has been no significant investment in MIIU.

This business case describes how the proposed scheme:

- Meets the Trust's strategic objectives and addresses the case for change (Strategic Case)
- Is worthwhile and provides value for money (Economic Case)
- Will be procured (Commercial Case)
- Will be affordable (Financial Case)
- Will be implemented (including transitional arrangements) and how it will be evaluated (Management Case).

1 Strategic Case

1.1 The role of community hospitals in health care in Gloucestershire

The Gloucestershire Integrated Care System Fit for the Future consultation and planning for hospital services in the county has focused attention on the best location for sustainable high-quality hospital services and the need for local services to continue to proactively prevent avoidable admission and to facilitate care pathways that enable people to return home in a timely manner.

This emphasises the role for effectively run community hospitals with community inpatient beds working closely with community-based rehabilitation services to deliver the most efficient use of resources. It also emphasises the need to prevent admission to the main acute hospitals wherever possible and to deal with as much urgent care as is clinically feasible away from the main hospital Emergency Departments.

The community hospitals operated by the Trust in Gloucestershire play an important role in bringing services within easier reach of local populations. Whilst the range of services offered varies between the hospitals, 7 of the hospitals play a role in providing community beds and delivering tier 3 urgent care services through Minor Injury and Illness Units (MIIU).

In addition to inpatient beds and MIIU, Stroud General offers a wide range of services enabling local residents to avoid travel to either Cheltenham or Gloucester:

There are two wards at Stroud General Hospital. Jubilee Ward is a 16-bed ward that works in tandem with Cashes Green Ward (22 beds) to provide both step-down beds facilitating earlier discharge from acute hospitals and step-up care as part of the Trust's response to preventing avoidable acute admission and to maintain care as close as possible to local communities.

Both wards are well utilised although the difficulty in managing infection in the bed bays in Jubilee does lead to a loss of bed days.

In 2019/20 (pre-Covid), Stroud MIIU was the busiest unit within the county in terms of overall attendances.

Table 1: Attendances at MIIU 2019/20

	Attendances			
MIIU	Illness	Injury	Other	**Total**
Cirencester Community Hospital	1165	13295	2677	17,137
Dilke Community Hospital	1537	7836	147	9,520
Lydney Community Hospital	581	8690	75	9,346
North Cotswold Community Hospital	826	8071	166	9,063
Stroud General Hospital	1053	16255	181	17,489
Tewkesbury Community Hospital	692	6871	309	7,872
The Vale Community Hospital	1009	5933	612	7,554
Grand Total	6863	66951	4167	**77,981**

Jubilee Ward is located directly above MIIU at the Trinity Road end of the site. Although there is little clinical link between the two services any work undertaken in either unit will have a significant effect on the operation of the other.

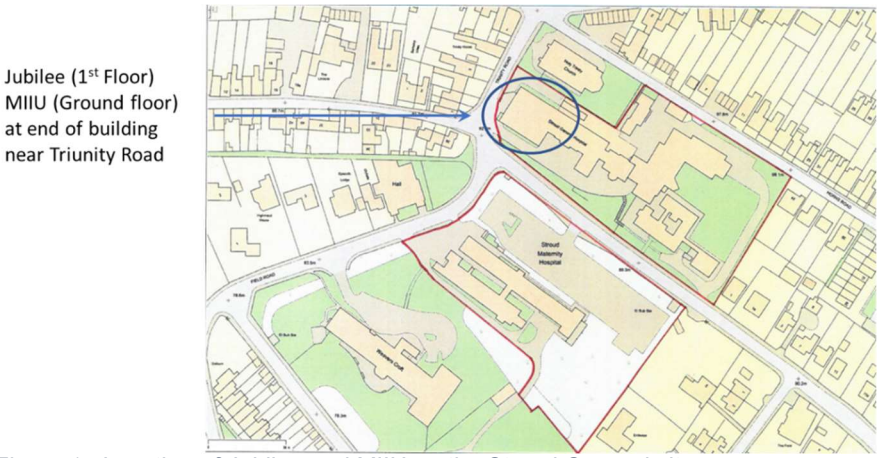


Figure 1: Location of Jubilee and MIIU on the Stroud General site

1.2 The Case for Change

1.2.1 Jubilee Ward

The 16 beds on Jubilee ward are currently configured across 3 bays (2 x 4 beds; 1 x 6 beds) and 2 single side rooms/cubicles. The issues and challenges the ward faces are summarised below.

Key issues include:

- The bed bays (including the 6-bed bay) have a number of physical issues resulting in both clinical and quality risks and compromises:

- There is only one toilet within each bay, with no modern showering facilities. Two additional toilets, the shower and the bath can only be accessed by walking across the general circulation area. This not only seriously compromises patient privacy and dignity, but critically makes it impossible to close off any of the bays for isolation purposes creating a clinical risk.
- The limited number of toilets within easy reach of the beds also makes it difficult to ensure full separation of sexes in the ward as patients may have to leave the bay to use a toilet.
- Handwashing facilities in the bays are limited to just one sink per bay meaning staff have to walk past a number of beds to wash hands between working with different patients.

- The two single bedrooms/cubicles pose significant clinical and health & safety risks to patients and staff:
  - Neither have ensuite facilities so cannot be used to isolate patients, adding to the clinical risk encountered on this ward.
  - They are very small, hindering round-the-bed clinical and other care, nor can they accommodate bariatric patients and equipment.
  - The circulation space and door openings of the side rooms are not big enough to enable a bed to be moved in or out of the single rooms without having to lift the bed which presents unacceptable health and safety risks for both staff and patients.

- There are serious ventilation problems on the ward leading to overheating especially in the summer months. The large windows cannot be opened and there is no other means of controlling the environment within the bays.

- Medical gases and suction are not provided to every bedhead and can only be delivered from stand-alone bottles/units. These take up considerable space and present challenges for safe handling and patient and staff safety.

- Essential ward administrative areas are inadequate and badly located:
  - Staff do not have access to a comfortable place in which to work quietly. The ward office is small and has poor ventilation with no external windows
  - The senior nurse's office is located off the ward which adversely affects productivity and makes supervision difficult.
  - There is no place to meet with patients' family and carers to break bad news or discuss care plans, compromising confidentiality and the patient/family experience.

- Essential support areas are also inappropriately located and sized:

  - A large equipment store occupies a significant space on the ward which could be more appropriately used for clinical care.

- The current patient social room which is also used as a “vintage” memory room is outside the ward area, a short distance down the corridor, and opposite the doors accessing theatres. As such, it can only be used by patients with assistance or under supervision, and consequently is underutilised. Patients with dementia cannot be left without supervision due to the risk of access to stairs and lifts and unlocked doors to Theatre/endoscopy and the Princess Anne Unit.
- The staff changing area is also poorly located being in the clinical ward area. It is small so cannot accommodate staff at shift change.

- Overall, the ward has an outdated and tired appearance, especially when compared with the facilities of Cashes Green Ward (refurbished in 2018).

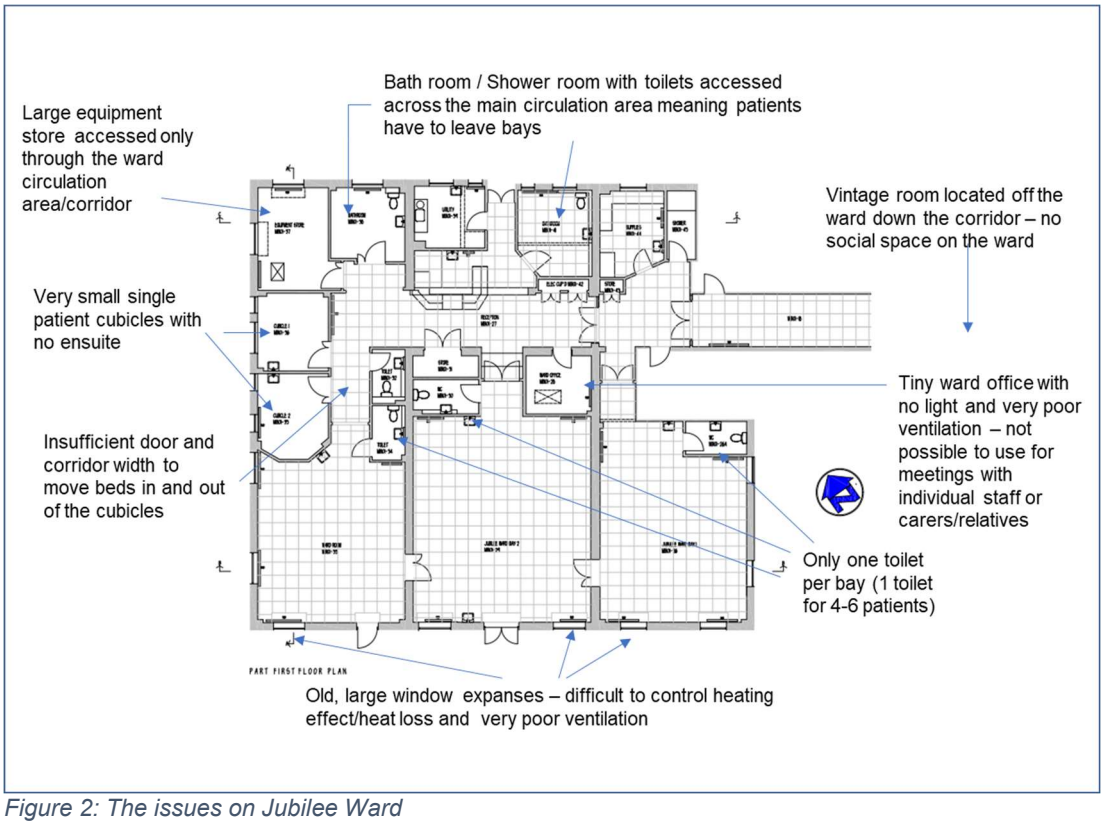


Figure 2: The issues on Jubilee Ward

1.2.2 MIIU

The MIIU area provides the clinical space for the busiest MIIU service in Gloucestershire and for the local primary care Out of Hours service. The issues and challenges the unit faces are summarised below.

- The area comprises a series of poorly configured clinical spaces, some providing little privacy and dignity. Adjacencies do not enable efficient and effective patient flow and reduce effective use of space. Circulation routes for patients and staff are confusing.

- The **entrance lobby** is small and narrow meaning that both doors will often be open at the same time leading to draughts and heat loss.
- The **reception area** has one access point only to the side of the unit, and has no clear line of sight to the entrance lobby, the waiting area, to the two disabled toilets or other circulation areas that are readily accessible to members of the public entering the building. There can be no overall monitoring or control of patient movements. The reception area is not immediately visible to patients or carers on entering the unit from the street.
- The **waiting area** is the main thoroughfare through the unit, to the outpatients and to other service areas beyond, with no access to natural light.
- The **triage area** is completely separated from the main assessment area. Patients who have been triaged for urgent assessment have then to walk across the waiting area past the front door to the assessment bays.
- The **consulting spaces** (currently used by outpatients and out of hours services) are accessed from a separate narrow corridor on the opposite side of the waiting area from the assessment bays.
- The separate **children's waiting area** is very small and there is no dedicated children's treatment area. With Covid restrictions only one family can use the room at a time.
- The **treatment and consulting areas** are very small with some only around 8 sq m. This is an unacceptable size for clinical use. The **dirty utility room** is very small (4.7 m2). The **eye treatment room** is less than 7 m2 much of which is taken up by the equipment. The size alone makes these rooms inaccessible to many people with disabilities, to bariatric patients and to patients who need to be accompanied. There is no space for undressing.
- The **main assessment area** provides space for 2 curtained bays only with no effective separation, thus confidentiality is breached as conversations can be overheard. Sound can travel from the assessment area to the waiting area. Space is constricted so trolleys are against the wall and can only be accessed from one side.

- There are no showering facilities for patients who may require this before treatment (e.g. those with burns).

- The only space that can be isolated for an infectious patient is the resuscitation room.

- Medical gases and suction are delivered from stand-alone bottles/units. These take up considerable space and present challenges for safe handling and patient and staff safety.

- There is a continual ventilation problem throughout the unit, which is worst in summer months, leading to a lack of fresh air and excessive heat. This makes conditions for both staff and patients oppressive at times. Windows are large expanses with little or no control over light and air.

- There is limited ability to close down clinical areas to public access should this be required in an emergency.

- There is no staff rest area within the unit.

- There is no office for the matron leading the service or space for any staff to work quietly with access to the online system.

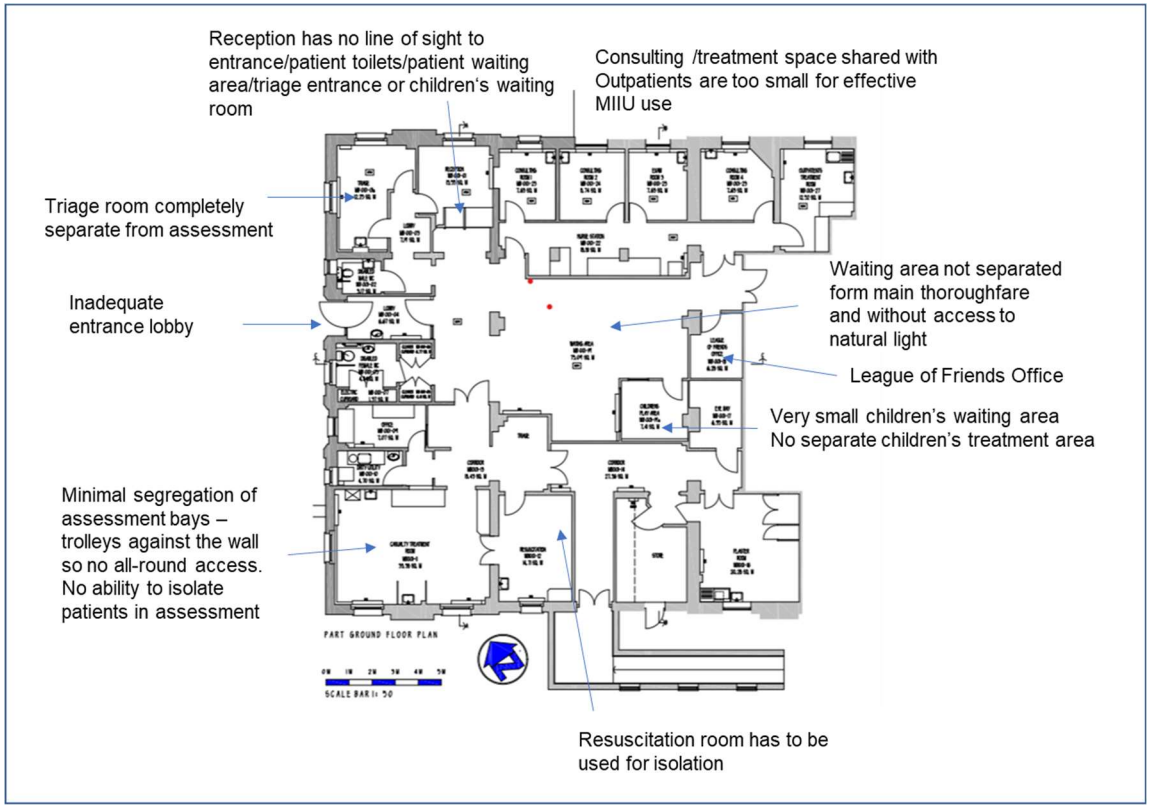


Figure 3: Issues in MIIU

1.3 Investment objectives and benefits to be achieved

A series of objectives have been agreed which underpin the proposed investment in both Jubilee and MIIU. These are summarised below and set out in detail at Appendix 1 along with the benefits that will be achieved by the completion of the proposed works.

Table 2: Summary of Investment Objectives and benefits - see Appendix 1 for detail

Investment Objective	Benefits
1. To provide clinical facilities that deliver safe and appropriate standards of clinical care	• Improved infection control • Improved clinical standards
2. To provide the best possible conditions for patients	• Improved access to facilities Improved privacy and dignity • Better patient facilities • Provision for those with dementia
3. To provide the most efficient and effective operational configuration	• Improved clinical and service adjacencies • Improved operational control
4. To provide a pleasant and healthy working environment that enables staff and public well being	• Improved ventilation and temperature control • General improvements to the environment • Better staff facilities

1.4 Constraints and dependencies

1.4.1 Constraints

- Work on either unit will require closure of both as this will involve substantial physical change – addressing the issues in MIIU requires gutting of most existing partitions and internal walls. Both units require new windows and substantial changes to services, utilities and drainage. This and the installation of piped medical gases necessitates intrusion into both ceilings and floors. In order to facilitate this, services will need to be relocated temporarily.
- It is essential to achieve the changes in a period before the anticipated start of winter pressures in 2021/22 when both MIIU and Jubilee will be important resources for the system and need to be operating at full capacity.
- The refurbishment of Jubilee and MIIU is included in the Trust's capital plan for 2021/22. There is a requirement to complete the investment in this period in order to secure the capital funding.

1.4.2 Dependencies

To maintain services during the building works depends on:

- Reinstatement of MIIU at the Vale to help deal with displaced attendances, still closed due to the use of the unit for COVID vaccinations. This is due to become free in August.

- Availability of space locally in Stroud to conduct booked MIIU appointments.
- Reproviding beds at Cirencester Hospital and undertaking minor works to facilitate side room capacity within decant ward.
- A carefully planned programme of running down inpatient admissions in the lead up to decanting in line with experience in previous transitions of service in community hospitals.

1.5 Support of Stakeholders

The key local stakeholder is the Stroud Hospital League of Friends. This organisation has played a key role over the years in promoting the need for a hospital in Stroud. They have been supportive of capital developments and are prepared to make a substantial contribution to the works required to bring Jubilee Ward and MIIU up to modern standards.

2 Economic Case

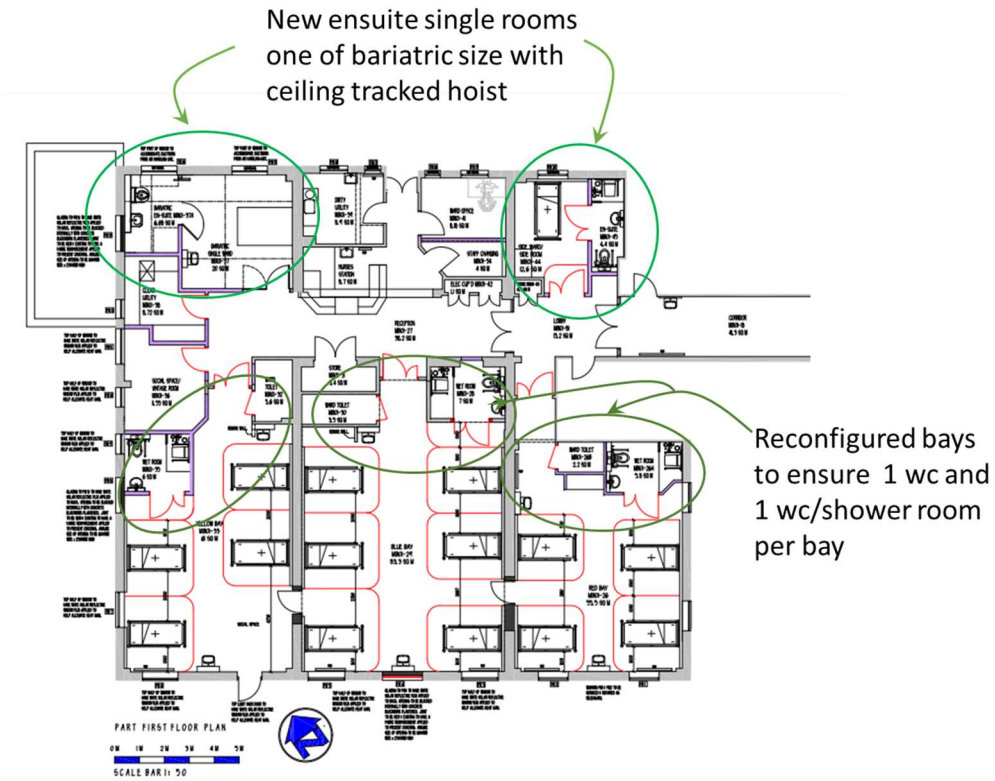
2.1 Schemes to address the Investment Objectives

A scheme has been proposed for each of Jubilee and MIIU that addresses the case for change and delivers the benefits listed in Section 1 and detailed at Appendix 1. Both schemes have been designed with the view that this is a one-off opportunity to make a significant difference talking advantage of the closure of the units to make substantial change. They are prudent, no-frill proposals and there is little, if any, scope within either scheme to reduce the specification to save costs. Therefore, they are presented below as whole schemes without a Do Minimum option. Key changes are listed below and annotated on the proposed floor plans.

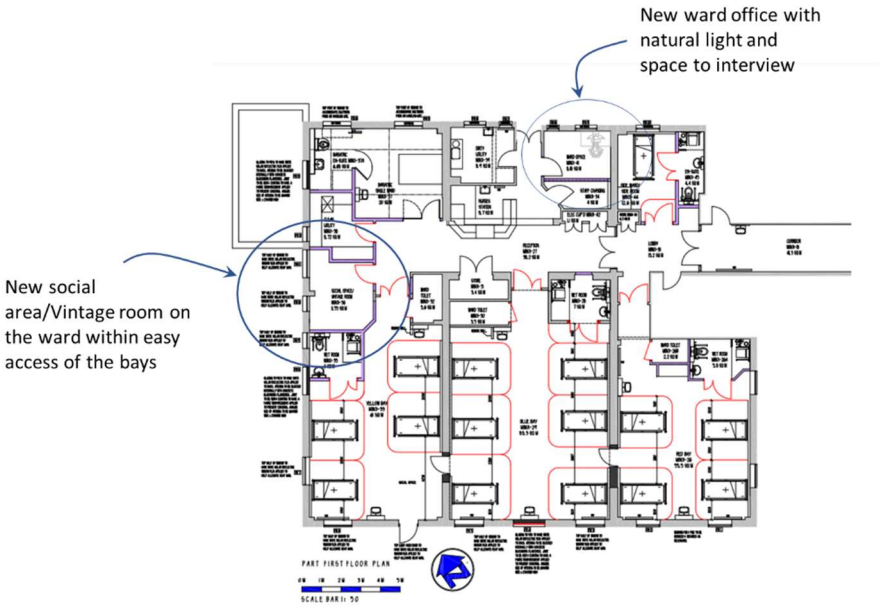
2.1.1 Jubilee Ward scheme

Key structural changes include:

- Effective separation of each bay, with each containing a WC and WC/shower room, removing the need for any patient to move outside the bay.
- Ensuite single rooms, one built to bariatric proportions and with a ceiling tracked hoist.



- New social area/vintage room on the ward within easy access of the bays.
- New ward office with natural light and large enough to interview staff or others as required.



In addition, the ward will have:

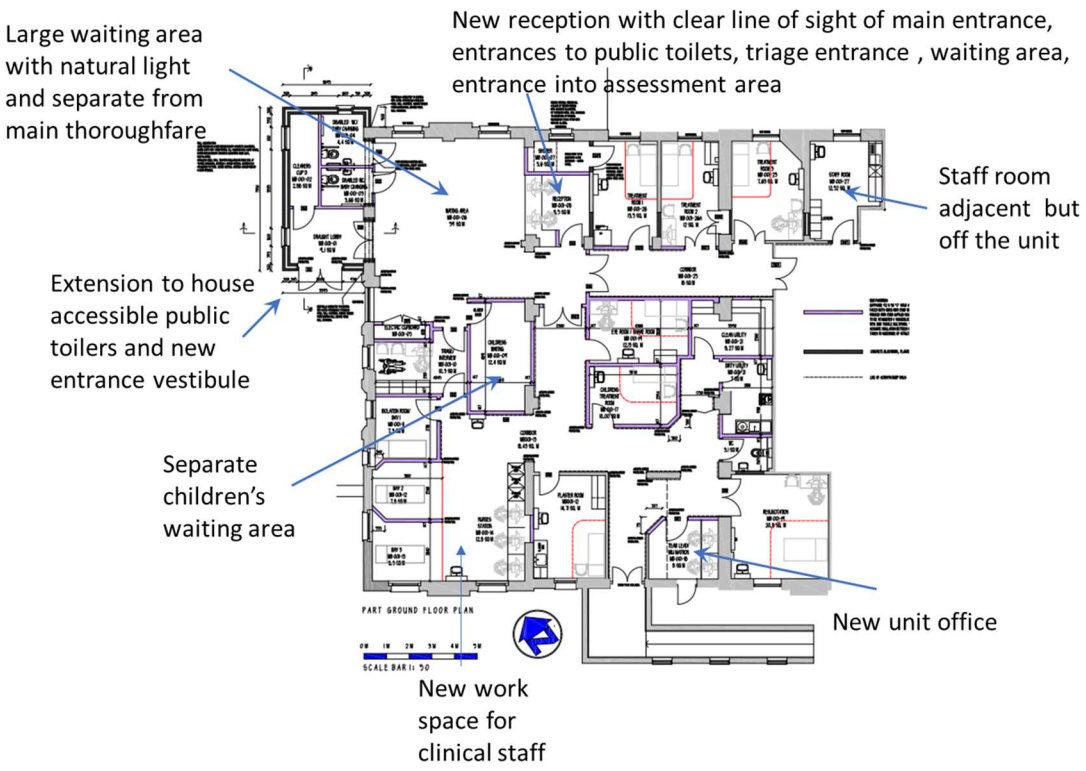
- New air handling and temperature control throughout
- Replacement of windows to address overheating and light issues
- Replacement of sanitary fittings and additional sinks in line with infection control requirements
- Piped medical gases at each bedhead.

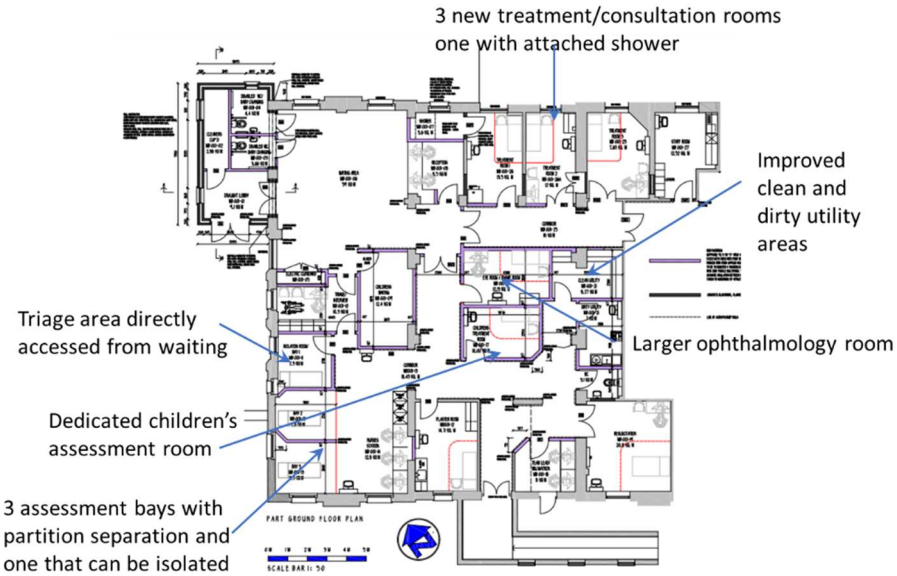
2.1.2 MIIU scheme

Key structural changes include:

- Provision of 3 well-appointed treatment/consulting rooms, one with attached shower room
- A triage area linked both to waiting and assessment areas
- Separate assessment bays – one able to be isolated for infection
- Dedicated children's assessment/treatment room.
- Larger ophthalmology room
- Improved clean and dirty utility
- Replacement of resuscitation, plaster rooms
- New entrance and lobby – in an extension also containing new accessible toilets/baby changing areas
- Large waiting area with natural light and separate from main thoroughfare

- A separate children's waiting area
- New reception with clear line of sight of main entrance, entrances to public toilets, triage entrance, waiting area, entrance into assessment area
- Better staff facilities: new work space for clinical staff, new matron's office and new staff room adjacent to the unit.





In addition, the new MIIU unit will have:

- New air handling and temperature control throughout
- Replacement of windows to address overheating and light issues
- Replacement of sanitary fittings and additional sinks in line with infection control requirements
- Piped medical gases in the resuscitation area.

2.2 Costed options

As already explained, the schemes have taken the approach that, given the disruption created by any change, this is a one-off opportunity to get things right within the constraints of the building. It therefore makes no sense to pursue a "Do Minimum" option in either scheme.

Four possible options for delivering the schemes have been costed (including VAT):

Option 1 - Business as Usual (backlog maintenance cost of £0.161m)

Not to proceed with any of the planned changes. Reliance would be made on routine maintenance of the fabric and addressing backlog maintenance but no improvements would be possible.

The Case for Change is strong and given that the Trust has already made a commitment in the Capital Programme, there is little justification in continuing Business as Usual providing that the changes proposed are affordable.

Option 2 - Refurbish Jubilee Ward only (£1.052m)

This option would deliver the above changes to the ward area only. There would be no improvement to the MIIU below. Both areas would still have to be vacated during the refurbishment as the work on Jubilee would intrude into the MIIU so much that it would not be possible to continue deliver a service.

Option 3 - Refurbish MIIU only (£1.172m)

This option would deliver the above changes to the MIIU area only. There would be no improvement to the ward above. Both areas would still have to be vacated during the refurbishment as the work on MIIU would intrude into the ward so much that it would not be possible to continue deliver a service.

Option 4 Proceed with both schemes at the same time (£1.964m)

This would deliver all the benefits for both areas. This will require both areas to be vacated and this would be for a marginally longer period than in Options 2 and 3.

To deliver the scheme in two stages (i.e. undertaking Option 2 and then separately at a later stage, Option 3) would at current prices cost would cost an additional £260k.

Option 4 delivers all the benefits for both areas and financially, with both schemes delivered with a single decant rather than requiring both departments to be disrupted twice.

2.3 Other costs

2.3.1 Avoided costs (addressing backlog maintenance)

Delivery of the schemes for Jubilee and MIIU will avoid an estimated £141,000 and £22,100 respectively of backlog maintenance programmed for the period 2020 to 2025, including work that has been put on hold pending a decision to proceed with the schemes. See Financial Case for further details.

2.3.2 Operating costs

It is not anticipated that there will be any change in costs of clinical and service operations as there will be no change to the scope of services delivered and no changes in staff employed.

The refurbishment gives the opportunity to ensure the most sustainable approach is adopted given the limitations of working with a very old building (see Section 3 .5). Energy savings from new lighting and better insulation will be countered by increased costs from more extensive (although more efficient) air handling and cooling.

2.3.3 Transitional costs and double running costs

These would apply for Options 2,3 and 4 as both units would need relocating for the duration, whichever option was chosen. These costs are set out in Section 4, the Financial Case.

2.3.4 Equipment costs

The capital costs cited above include Group 1 equipment which includes the air handling, gas supply, bedhead points, all sanitary fittings etc and the tracked ceiling hoist. It is anticipated that existing equipment on the ward and MIIU will be used in the refurbished units and no additional equipment will be required.

2.3.5 Income

Since there are no changes in service, no change in income will arise although here may be a reduction of Trust income for the duration of the works as only 13 beds will be made available at Cirencester to replace Jubilee services.

The Stroud Hospital League of Friends have indicated a preparedness to contribute significantly to the capital required. At this stage, the contribution is assumed to be £400,000 for Option 4 i.e. the two schemes undertaken at the same time. The contribution to the other Options has not been discussed.

2.4 Costing of benefits

As seen in Section 1, delivering the scheme for Jubilee and MIIU will result in substantial improvements in terms of:

- Safe and appropriate standards of care
- Best possible conditions for patients
- Effective and efficient clinical configuration
- A pleasant and healthy working environment

It is difficult to attribute a cost to these benefits in a meaningful way:

- There will be no change to overall clinical activity although the number of bed days lost due to infection could decrease.
- MIIU capacity is most affected by surges in demand and staffing numbers and skills. The new MIIU will not change the staff structure so that although the better use of space in MIIU will increase its ability to hold more patients, it is not believed that the number of hours in which MIIU may have to close to new patients will be greatly affected.

2.5 Conclusion on preferred option

Option 4 Proceed with both schemes at the same time £1.964m

This would deliver all the benefits for both areas. As in the other options, this will require both areas to be vacated.

Option 4 deliver all the benefits for both areas and financially, this results in a cost reduction of approximately £260k compared with doing the two schemes I n separate stages. In addition. both schemes are delivered with a single decant rather than requiring both departments to be disrupted twice.

As such the recommended way forward is a combined refurbishment of both Stroud MIIU and Jubilee Ward.

3 Commercial Case

3.1 The Design team

In the period up to procurement, the Trust Capital Delivery Manager has been supported by external specialists to enable a full technical design for each scheme to be developed to provide a detailed specification for tendering.

External specialists and advisers for RIBA stages 1-4 were as follows:

Function	Specialist firm
Project Management	Gleeds
Architects	Anderson Architecture
Quantity Surveyors	Adam Fletcher & Partners
Structural Engineers	Waterman Group
Mechanical and Engineering	Service Design Solutions

3.2 Tender process

Following detailed work by the design team, working with end users in both units, the proposed schemes were costed by the Quantity Surveyors to produce a Pre-tender Estimate to function as a benchmark against tendered prices. The original intention was to test the Pre-tender Estimates in a conventional competitive tender exercise in June/July 2021.

Delays in the design stage have been caused by the complexity of working with an old building with a number of unknowns. This has reduced the time available for a conventional tendering exercise if the project is to meet the deadlines for returning both the ward and MIIU to operations before the expected upsurge in winter pressures.

An alternative approach to use the South West Procurement Alliance framework has therefore been adopted. The framework enables the Trust to engage with contractors who have already passed quality and price criteria. This has the key advantage of shortening the procurement process. The Trust has approached Speller Metcalfe on the framework to tender for the work.

The tender period is no running until the second week of August enabling the Trust to come to a decision to be made in the week commencing 16 August.

3.3 Type of contract

An Intermediate JCT contract will be used in order to facilitate liaison and control of deliverables.

3.4 Stroud Hospital League of Friends

The investment is dependent on an anticipated donation from the Stroud Hospital League of Friends.

Discussions are underway to ensure that the donation is used in areas which can maximise the VAT reclaim that the League may be entitled to.

This will require separate contract for the work that will be undertaken on behalf of the League of Friends.

3.5 Planning permission

A planning application *for a proposed single storey extension to provide new entrance lobby together with associated external ventilation plant and alterations to windows* was submitted to the planning authority (Stroud District Council) on 13 January 2021, receiving permission on 5 March 2021. This was the only planning permission required.

3.6 Sustainability

Refurbishment provides the opportunity for complete refitting of lighting and the replacement of large window expanses that can both excessive heat loss in winter and heat gain sin summer leading to current problems with the war d and MIIU environment. The two existing air handling units are extremely inefficient and will be replaced.

Savings created e.g. through the use of LED lighting throughout will be offset by the increased energy costs of the new air handling and cooling system.

The system has been specified to be as energy efficient as practical and specifies the use of PIR in toilets etc, and individual room control.

The air handling in MIIU will be shut down when the unit is not in use.

All energy using systems in Jubilee and MIIU will be linked to the hospital's building management system for monitoring and control

4 Financial Case

4.1 Capital costs and funding.

Refurbishment of Jubilee and MIIU is part of the Trust Capital Programme for 2021/22 for which an allowance of £1.5m has been made.

The pre-tender estimate for the preferred option is £1.964m before any VAT reclaim. Once a price has been agreed with the contractor, the Trust will engage its tax advisers, Liaison Financial, to examine all elements for potential VAT reclaim. Allowing for the anticipated contribution of £400,000 from the Stroud Hospital League of Friends and VAT reclaim, the preferred option remains affordable.

4.1.1 Capital cost by element

Table 3: Breakdown of capital costs

Element	Net Cost	Vat	Gross
RIBA Stage 1 - 7 Fees	£135,151	£27,030	£162,181
Building works	£1,463,365	£292,673	£1,756,038
Total	**£1,636,709**	**£319,703**	**£1,964,051**

4.1.2 Avoided cost (Backlog maintenance)

The refurbishment of both units will address all internal backlog maintenance requirements that have been identified in the Oakleaf 6-facet survey. These have been costed at £163,000, so this call on the backlog maintenance allowances in the Trust Capital Plan will be avoided. Details of the identified maintenance requirements that will be subsumed by the two schemes are set out below:

Table 4: Backlog maintenance identified for Jubilee and MIIU

Unit	Description	Cost	Year	Comments
Jubilee	Floor	£46,000	2020	Vinyl sheet flooring: Worn and aged to Bed bays require replacement.
Jubilee	Sanitary Fittings	£6,000	2020	Wash hand basin: Aged and not to modern standards.
Jubilee	Fixed Units	£15,000	2021	Clinical storage: Showing signs of age and wear and requires replacement within the maintenance schedule.

Unit	Description	Cost	Year	Comments
Jubilee	Sanitary Fittings	£6,000	2021	Patient WC to Wet Room: Showing signs of age and require refurbishment within the maintenance schedule.
Jubilee	Sanitary Fittings	£30,000	2021	Patient WC and Wet Room to Bed bay: Requires refurbishment within the maintenance schedule.
Jubilee	Decorations	£23,000	2021	Redecoration required as part of a regular maintenance schedule.
Jubilee	Fixed Units	£15,000	2023	Nurse station: Requires refurbishment within the maintenance schedule.
Subtotal for Jubilee		£141,000		
MIIU	Fixed Units	£6,000	2020	Clinical units to Treatment Rooms: Are considered aged and require replacement.
MIIU	Decorations	£9,000	2020	Redecoration required as part of a regular maintenance schedule.
MIIU	Floor	£5,000	2023	Vinyl sheet flooring: Sections are aged and worn flooring with replacement required within the maintenance schedule.
MIIIU	Sanitary Fittings	£2,100	2025	Patient WCs: long term refurbishment expected to be required within the maintenance schedule.
Subtotal for MIIU		£22,100		
Total for Jubilee and MIIU		**£163,100**		

4.2 Other project related costs

4.2.1 Capital

Minor works are required to enable space at Cirencester to be used again as part of Thames Ward, creating two side rooms and increasing decant capacity from 13 to 15. A sum of £60k+VAT has been agreed by the Capital Management Group so that this work can proceed and be completed to facilitate the transfer of services towards the end of August.

4.2.2 Revenue costs

The Refurbishment Project Group have concluded that:

- Any patient transport for the few remaining patients moving from Jubilee to Cirencester and on return to Stroud will be covered by existing arrangements with SW Ambulance NHS Trust.
- There are unlikely to be additional costs for medical cover or agency costs resulting from the temporary change in location.
- Storage in the interim period will be found within Trust premises and not incur cost.

The following costs have been identified:

- Shuttle bus transport for staff from Stroud to Cirencester - £41k for the period of relocation
- Removal costs from Stroud to Cirencester and on return - £12k .

These will be funded from non-recurrent underspend.

4.2.3 Other costs

Table 5: Capital cost elements

Element	Per annum	How funded
Additional capital charges at 3.5%	£68,741 (year 1)	Included in Trust Financial plans
Depreciation over the life of the asset (straight line depreciation over 35 years)	£56,115	Included in Trust Financial plans

4.3 Potential contribution from League of Friends

Discussions are at an advanced stage with the Stroud Hospital League of Friends who are greatly supportive of the refurbishment and who wish to make a substantial donation of up to £400,000 to the final costs.

4.4 Conclusion of affordability

Taking into account the contribution of £400,000 from the Stroud Hospital League of Friends, Option 4 is affordable in terms of the Trust Capital Programme.

5 Management Case

5.1 Project governance arrangements, roles and responsibilities

A small Programme Board will oversee the delivery of the programme of work required to complete the refurbishment (RIBA stages 5-7). This Board will be chaired by the Trust Associate Director of Estates, Facilities & Medical Equipment and will comprise a Trust Capital Delivery Manager and a Deputy Chief Operating Officer to represent service interests.

The Capital Delivery Manager will liaise with the contractor on a day to day basis. The contractor will maintain the construction project plan and the construction risk register. The Capital Delivery Manger will oversee the management of the contract and change control, escalating issues as required.

The operational arrangements (decanting, interim provision and re-establishing services in Jubilee Ward and MIIU on completion of the building works) will be overseen by the *Stroud Jubilee Ward and MIIU Refurbishment Project Group* (Terms of reference at Appendix 2). This Project Group has been meeting for over two months and is an operational oversight group that reports to the Chief Operating Officer. The Group is chaired by a Deputy Chief Operating Officer. The Associate Director of Estates, the Capital Delivery Manager, the Deputy Service Director of Community Hospitals and the Service Director Urgent Care and Specialty Services are members of the Group along with key service leads for Jubilee Ward and MIIU.

5.2 Transition arrangements, contingency and business continuity

Jubilee Ward services

The Trust will be re-providing at least 13 beds within Cirencester Hospital by utilising Thames and Churn Wards; these wards will be renamed Preston Ward for reporting purposes. A detailed bed management plan is being prepared to reduce the number of patients occupying beds in Jubilee ward over the two weeks prior to the ward closure so that a reduced number of patients will actually be transferred. Once Preston Ward is operational, bed numbers will be increased over a week up to operating capacity.

GHC have previous experience of this process having undertaken similar ward decants for refurbishment in the past few years. Staff working on Jubilee Ward will transfer with the patients and work from Preston Ward in Cirencester for the duration. The Trust will provide transport between the two sites and shift patterns will be amended as required to ensure travel times and shift handovers are included. The Trust has

embarked on staff engagement sessions to ensure that all staff are kept fully informed and have the opportunity to raise any concerns they have.

Stroud MIIU

The Operational plan to manage the temporary closure of the MIIU at Stroud focuses on developing the role of telephone triage. Approximately 20% of the GHC MIIU activity is now delivered through pre-booked appointments following telephone triage with patients choosing to call their local unit. However, In Stroud only 5% of activity is in booked appointments. The MIIU closure provides an excellent opportunity to further develop and implement the 'Talk before you Walk' initiative and increase this pre-booked rate in line with other areas, supporting the National direction of travel for booked appointments. This would also support post Stroud refurbishment MIIU activity and flow. Provision will be made for some booked appointments in rooms in Stroud Maternity Hospital, temporarily vacated by Children's and Young People's Services. Appointments will also be offered at MIIUs at the Vale (Dursley) and at Cirencester. Stroud MIIU staff will be distributed between the three MIIUs in line with anticipated demand.

5.3 Project plan

In order to ensure that both MIIU and Jubilee are operational for the main winter pressure period from January 2022 onwards, it is essential that the procurement and construction time table and the associated operational plans are adhered to.

Key dates are:

- Decant of existing services in the weekend of 21st and 22nd August 2021.
- Contractor Mobilisation 23rd August
- Contractor Programme 14-16 weeks aiming to complete before Christmas 2021.

The construction project plan is included at Appendix 3.
The operational project plan is included at Appendix 4.

5.4 Project risks, mitigation and management

The Programme Board is responsible for the monitoring and management of the risks associated with the refurbishment. A risk matrix is included at Appendix 5. Key risks include:

- The current volatile market for materials leading to unstable and high prices and availability

- The availability of labour to carry out construction due to increased demand on the construction industry
- The extent of asbestos containing materials is unknown (survey will be undertaken as soon as practically possible following the engagement of the contractor).

The Project Group is responsible for the management and monitoring of operational risks leading up to the decant, the interim period of service relocation and the return of services to Stroud. A risk matrix is included at Appendix 6. Key risks include:

- Further waves of COVID and social distancing requirements affect movements of staff and
- The reduction in beds (in the temporary move to Cirencester and the rundown of inpatient numbers in the lead up to decanting, places additional strains of the system.
- Moving some work to Cirencester places pressure on services that have to remain at other parts of the hospital in Stroud (e.g. therapy).

All risks are identified and managed according to the Trust Risk Management Policy and are reviewed regularly for mitigation and scoring.

5.5 Benefits realisation

There are three types of benefit that will be realised:

- Benefits that will be realised through the agreed design and the satisfactory completion of the refurbishment – these will have been achieved in December 2021/January 2022 when the refurbished units are commissioned.
- Benefits enabled by the building but requiring specific action to fully realise. Realisation will be over the initial operating period January to April 2022 – for example the use of the single rooms in Jubilee to the best effect and achieving the consistent segregation of sexes on the ward. Realising these benefits is the responsibility of the Deputy Service Director of Community Hospitals and the Service Director Urgent Care and Specialty Services.
- Benefits as perceived by patients and staff using the building (these will be assessed by the end of the initial operational phase (January to April 2022 and again in the period June to September 2022). Assessing these benefits will be the responsibility of the Deputy Service Director of Community Hospitals and the Service Director Urgent Care and Specialty Services.

5.6 Public and staff engagement

The Trust Communications Manager has worked closely with service leads to agree a stakeholder map identifying leads for various elements of communications required across a range of groups and stakeholders.

Internal engagement around the moves began on July 15 and there has been on-site engagement with Trust staff, as well as colleagues from systems partners working in X-ray, theatre, ultrasound and outpatient clinics. Prior to that service leads and staff within both units had an opportunity to discuss the proposed schemes and comment on evolving plans.

Engagement with patients, families and carers is being led by Stroud Hospital Matron with support the communications team.

Communication with neighbours to the Stroud site is being planned by Trust communications and Partnerships and Inclusion Teams.

System-wide communications to ensure public awareness and appropriate signposting to alternative services (especially around the closure of Stroud MIIU) are being developed with the Communications teams at GHC, GHFT and the CCG

5.7 Post project evaluation

The Trust is committed to evaluating both the project processes and the success of the investment created through this project.

The Project Implementation Review will be undertaken within two months of the commissioning of the units and the transfer of services back to Stroud in order to capture the lessons learnt. The process will be a combined exercise by the Programme Board and the Project Group.

Areas of focus will include:

- Effectiveness of the project structure.
- Effectiveness of service planning, the anticipation of issues and the ability to take action where required.
- Any unforeseen impact on other services.

A Post-Evaluation Review (PER) for reviewing how well the service is running and delivering its anticipated benefits will take place after the initial operational period and will link with the benefits realisation monitoring described above.

5.8 Equality Impact Assessment

A Quality and Equality Impact Assessment has been completed and submitted to the Trust's Improving Care Group. This QIA EIA is attached at Appendix 7.

Conclusion

This business case has shown a pressing case for change for both Jubilee Ward and the MIIU at Stroud General Hospital and how the proposed schemes deliver the investment objectives that will result in the substantial benefits identified for patients, staff and service operations.

The preferred option – to proceed with both schemes at the same time, instead of undertaking the work in two separate stages, avoids the need for multiple decants and is more economical.

Taking into account the donation from the Stroud Hospital League of Friends and the allocation in the Trust Capital Plan, the preferred option is affordable.

This Business Case is therefore commended to the Trust Board for approval to enable work to progress and the schemes to be completed in time to meet anticipated winter pressures.

Appendix 1: Strategic objectives and benefits for the refurbishment

A series of objectives have been agreed which underpin the proposed investment in both Jubilee and MIIU. These are set out in detail below along with the benefits that will be achieved by the completion of the proposed works.

Investment objective 1

1. *To provide clinical facilities that deliver safe and appropriate standards of clinical care*

BENEFITS: Improved infection control	
Jubilee Ward	**MIIU**
Full compliance to infection control measures by ○ enabling the isolation of each bay ○ providing adequate toilet and showering facilities on each bay ○ ceasing the movement of patients outside their bay area. ○ Improved handwashing facilities that comply with standards.	The ability to isolate infectious patients in a segregated assessment bay without closing down the resuscitation room (as is current practice).
Re-providing 2 single rooms with ensuite facilities to enable effective isolation of suspected or actual infectious patients. This will also reduce the need to transfer patients to Cashes Green ward which involves moving patients across the hospital.	
BENEFITS: Improved clinical standards	
Jubilee Ward	**MIIU**
Medical gases and suction at each bedhead in the bays and single rooms	Greatly improved space standards in modern assessment/consulting and treatment rooms that are fit-for-purpose potentially expanding the range of treatment that can be offered.
Ability to cater for a bariatric patient increasing the opportunity to transfer such patients from acute hospitals.	Patient showering facility to improve treatments of burns patients.
	Sufficient space to allow access to assessment trolleys from all sides.

Appendix 1: Strategic objectives and benefits for the refurbishment

Investment objective 2

2. To provide the best possible conditions for patients

BENEFITS: Improved access to facilities	
Jubilee Ward	**MIIU**
Improved and convenient access to toilets and to modern shower/wet rooms which patients prefer to baths. 2 toilets will be provided for each bay. Facilities with full disabled access.	Improved patient toilets with baby changing facilities in both male and female toilets.
BENEFITS: Improved privacy and dignity	
Jubilee Ward	**MIIU**
Improved privacy and dignity by removing the need to walk across the general circulation area, thus ensuring more effective sex segregation.	Improved privacy and dignity in the separation of assessment spaces in individual bays, reducing the risk of sound travel and conversations being overheard. Removing the travel of sound from assessment area to waiting area
2 single rooms that could be used for patients who particularly need their own space eg those at end of life	
BENEFITS: Better patient facilities	
Jubilee Ward	**MIIU**
A new social area /vintage room as an integral part of the ward which can provide: • Better access for patients and their families • Opportunities for patients to have time away from distractions • Another space to have difficult conversations with patients and their relatives away from the other patient	Greatly improved waiting area for both adults and children in a separate children's waiting room, with waiting areas set apart from general circulation and with access to natural light.
BENEFITS: Provision for those with dementia	
Jubilee Ward	**MIIU**
Better provision for patients with dementia through the reduction of the need for movement within the ward. The use of colour etc in the new fabric and easier access to the vintage room. Ability to allow patients walking with purpose to access vintage room without need for close observation (if appropriate) therefore reducing stress and anxiety to patient.	Better provision for patients with dementia through the better configuration of the rooms, a clearer patient flow and through the use of new colours in the fabric etc.

Appendix 1: Strategic objectives and benefits for the refurbishment

Investment objective 3

3. To provide the most efficient and effective operational configuration

BENEFITS: Improved clinical and service adjacencies	
Jubilee Ward	**MIIU**
Less need to spend time supervising the movement of patients within the ward and in the social area	Ensuring triage is adjacent to the assessment area reducing unnecessary patient movement and helping to maintain flow.
	A clear route to and from assessment and to treatment rooms
	A short journey from children's waiting to the dedicated children's treatment room.
BENEFITS: Improved operational control	
Jubilee Ward	**MIIU**
The ability to manage effectively areas of the ward for both sex separation and infection control.	Excellent line of sight from the reception area to entrance lobby, waiting area, public toilet entrances, triage area and entrance to children's waiting area
A reasonably sized office on the ward enabling greater senior nurse presence and improved communication with staff and patients/carers.	Much better separation of circulation space from waiting space.
Sufficient space in the circulation area and appropriately sized door openings to enable beds to be moved easily in and out of all bed areas	The ability to lock down areas within the unit in the event of an emergency in order to protect and contain.
Reduced disruption and infection transmission risk caused by movement of large equipment as the store will be relocated off the ward.	
More efficient circulation for both patients and staff reducing wastage of time.	Clearer, less confusing routes through MIIU.

Appendix 1: Strategic objectives and benefits for the refurbishment

Investment Objective 4

4. To provide a pleasant and healthy working environment that enables staff and public well being	
BENEFITS: Improved ventilation and temperature control	
Jubilee Ward	**MIIU**
New ventilation system and new windows with control for each area ending the extreme temperature and poor circulation that currently affect the ward.	New ventilation system and new windows with control for each area ending the extreme temperature and poor circulation that currently affect the unit.
BENEFITS: General improvements to the environment	
Jubilee Ward	**MIIU**
General refurbishment of walls and floors and all fittings including new colours to assist those with dementia.	General refurbishment of walls and floors and all fittings including new colours to assist those with dementia.
BENEFITS: Better staff facilities	
Jubilee Ward	**MIIU**
A properly sized ward office where interviews can be held.	Better provision of staff changing and other facilities where staff can take a break way from patient care.
Better provision of staff changing and other facilities where staff can take a break way from patient care.	A dedicated office where interviews can be held and where staff can work quietly and where the unit Matron can be based

Appendix 2: Stroud Jubilee Ward and MIIU Refurbishment Project Group

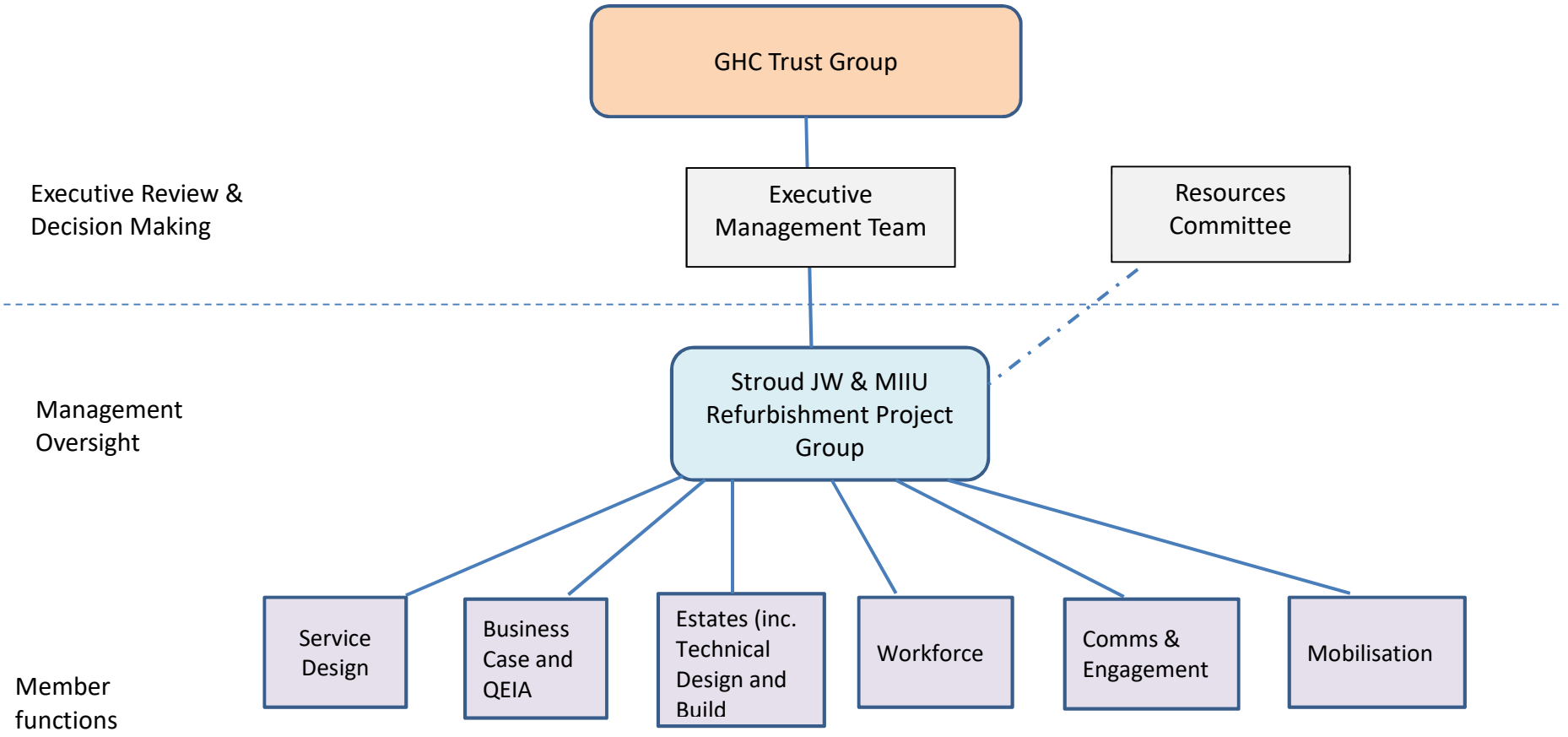
TERMS OF REFERENCE

1.	**Purpose**
	The Jubilee Ward and MIIU Stroud Refurbishment Project Group is responsible for the management and operational delivery of the programme of work required to facilitate the refurbishment of Jubilee Ward and the MIIU in Stroud General Hospital. This includes the relocation of the MIIU, the inpatient ward and redeployment of staff as identified, as well as contributing to the business plan development, finalisation of the estates design plans and timelines in order to manage and respond to the expectations of key stakeholders.
2.	**Membership**
	The core membership consists of: • Deputy COO - Margaret Dalziel *(Chair)* • Deputy Service Director of Community Hospitals *(co-chair)* - Juliette Richardson • Associate Director of Estates, Facilities & Medical Equipment – Kevin Adams • Service Director for Urgent Care – Helen Mee • Communications Manager – Matt Blackman • Matron, Stroud General Hospital – Liz Lovett • Matron, Cirencester and Fairford Hospitals – Linda Edwards • MIIU Lead – Lee Iddles • HR Advisor – Keri Barrow • Capital Estates Manager – Gavin Rowcraft • Project Manager – Fiona Smith • Facilities Lead – Amy Bennett Other attendees, as required: • Jubilee Ward Senior Sister – Sarah Gazzard • Business Intelligence - Ashley Jones • Clinical Systems – Amanda Linley • Service Director Hospitals – Julie Goodenough • Finance – Melissa Skelton • MIIU Team Lead - Ali Hicks • Facilities Lead, Cirencester – Di Foster • Strategic Project Manager – Andrew Paterson
3.	**Quorum**
	To be quorate the following must be in attendance: Chair or Co-Chair, one Matron or Senior Sister, one MIIU representative and one Estates/Capital representative.

4.	**Reporting Arrangements and Relationships**
	The Jubilee and MIIU Stroud refurbishment project group is an operational oversight group that reports to the Chief Operating Officer, aligned to the Business Case that reports to Director of Finance. It monitors the refurbishment programme of work and receives updates on progress from the Estates Capital team. Verbal reports are provided fortnightly by the Chair to the COO. Execs received presentation on scheme and will receive Full Business Case at the end of July. The project is regularly reviewed at the Transformation Hub who receive updates by exception.
5.	**Powers**
	The Project Group has delegated responsibility from the Executives to oversee, facilitate and manage this project, alongside the responsibilities delegated to Associate Director of Estates, Facilities & Medical Equipment to submit a Full Business Case and implementation plan to the Trust Group.
6.	**Roles and Responsibilities**
	The Project Group will be responsible for: • Ensuring that operational services are involved in the design of the refurbishment of Jubilee Ward and the MIIU • Ensuring that all operational services impacted in Stroud are kept fully informed on progress of the refurbishment. • Establishing and maintaining an action log, a risk and issue register and to escalate any concerns and risks through the agreed reporting route. • Contributing to the development of a robust Full Business Case for approval by Gloucestershire Health and Care Foundation NHS Trust (GHC) Trust Board • Ensuring that appropriate and timely communications are provided to all stakeholders both internally and externally. • Holding staff engagement sessions ensuring that staff are kept fully informed at all times and have the opportunity to raise concerns and also that Staffside is kept fully informed. • Preparing a mobilisation plan to illustrate transition into the implementation of the project. • Preparing the benefits realisation documentation for handover to operational teams at the end of the project • Collating and maintaining any revenue finance costs associated with this refurbishment • Monitoring the delivery of the project within agreed timescales, budget and quality.

7.	**Frequency and Review of Meetings**
7.1	The Jubilee and Stroud MIIU Project Group will have regular weekly meetings with support from the Transformation Hub during the set-up and transition phase of this project. During the implementation phase meetings will be fortnightly and under regular review.

Stroud Jubilee Ward and MIIU Refurbishment Governance



0517 01 Jubilee Ward and MIIU
INDICATIVE PROGRAMME

Version-04	17/08/2020	24/08/2020	31/08/2020	07/09/2020	07/06/2021	14/06/2021	21/06/2021	28/06/2021	05/07/2021	12/07/2021	19/07/2021	26/07/2021	02/08/2021	09/08/2021	16/08/2021	23/08/2021	30/08/2021	06/09/2021	13/09/2021	20/09/2021	27/09/2021	04/10/2021	11/10/2021	18/10/2021	25/10/2021	01/11/2021	08/11/2021	15/11/2021	22/11/2021	29/11/2021	06/12/2021	13/12/2021	20/12/2021	27/12/2021	03/01/2022	10/01/2022	17/01/2022
Project Wk.	1	2	3	4	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70
	RIBA STAGE 1- 2														Ward & premises decant - indicative programme		RIBA STAGE 5																Christmas	Christmas	RIBA STAGE 6		
Business Case Submission																																					
Design Freeze 15/06																																					
M&E / Structural drawings update																																					
CDM 2015: Prepare PCI																																					
QS - Prepare PTE																																					
Design team review of technical pack prior to issue																																					
Technical design pack issued to Trust for GHCT team review																																					
GATEWAY 2: GHCT Technical Proposal Review																																					
Technical Design Pack issued to Trust Procurement to Tender																																					
Tender Pack Issued - Tender period assumed 6 weeks at this stage)																																					
Tender Return: TARs, Contractor recommendations for appointment																																					
GATEWAY 3: Trust consideration and contractor appointment/Award Contract																																					
CONTRACTOR APPOINTED																																					
RIBA STAGE 5																																					
CDM 2015: F10 Notification																																					
Contractor lead-in/mobilisation period (say 3 weeks)																																					
Pre Start Meeting																																					
Construction Phase (say 14-16 weeks) TBC																																					
RIBA STAGE 5 COMPLETED																																					
RIBA STAGE 6																																					
PROJECT COMPLETED PC/Handover - Rectification Period Commences)																																					

RIBA STAGE 2 (Concept Design) Completed

Todays Date

Jubilee Ward and Stroud MIIU Refurbishment Programme - Project Plan

May 2021 to December 2021

Last updated: 19 July 2021
Last updated by: Fiona Smith
Version No: 004
Exec Sponsor: Hilary Shand / SRO:Margaret Dalziel
Project Lead: Fiona Smith

Dashboard:

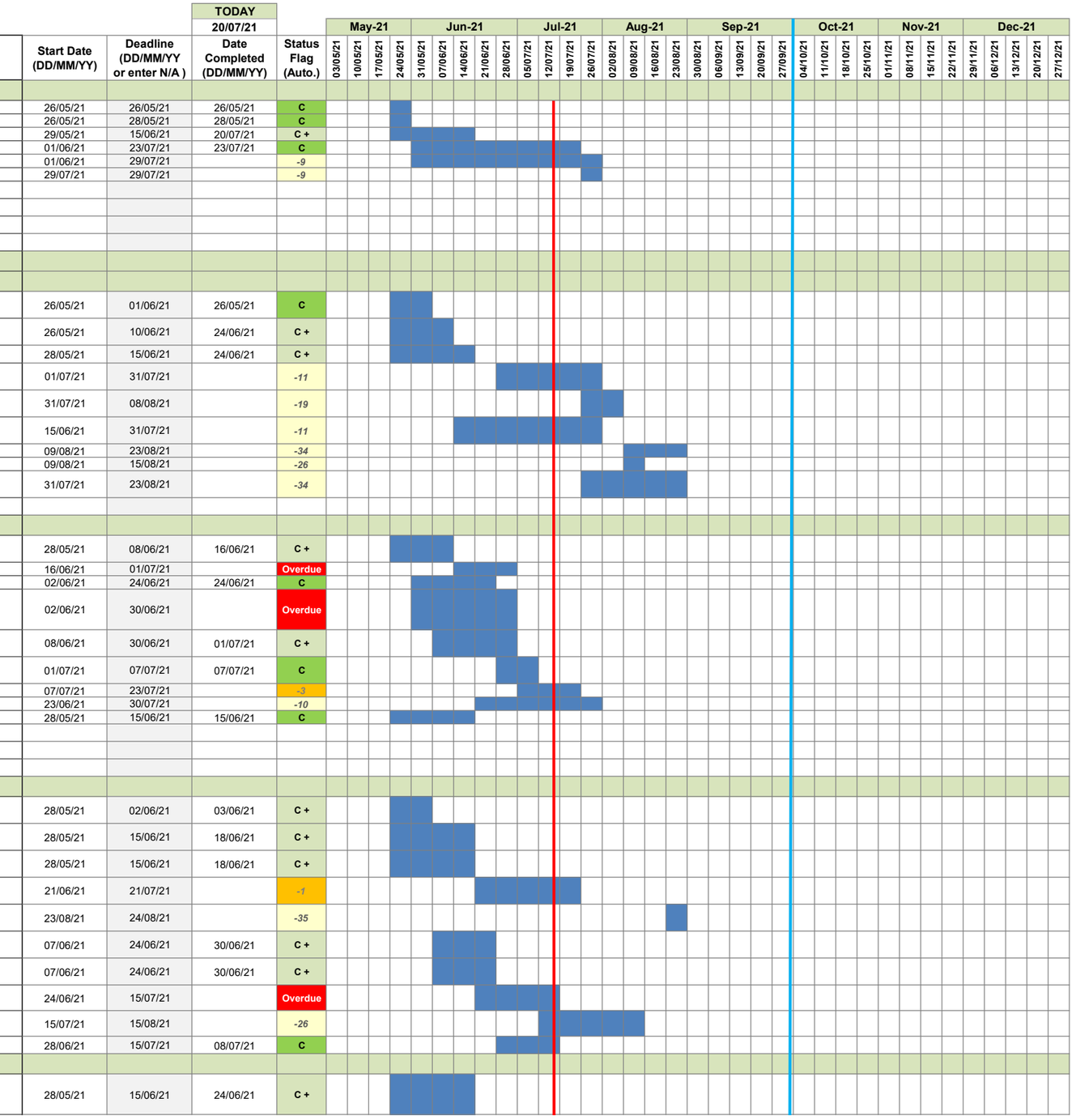
Total Tasks	63
Total Tasks with a Deadline	63
Tasks Completed	28
Tasks Outstanding	35
Tasks due within 7 days	5
Tasks due today	1
Tasks Overdue (Immediate action needed)	5

Key / Notes:

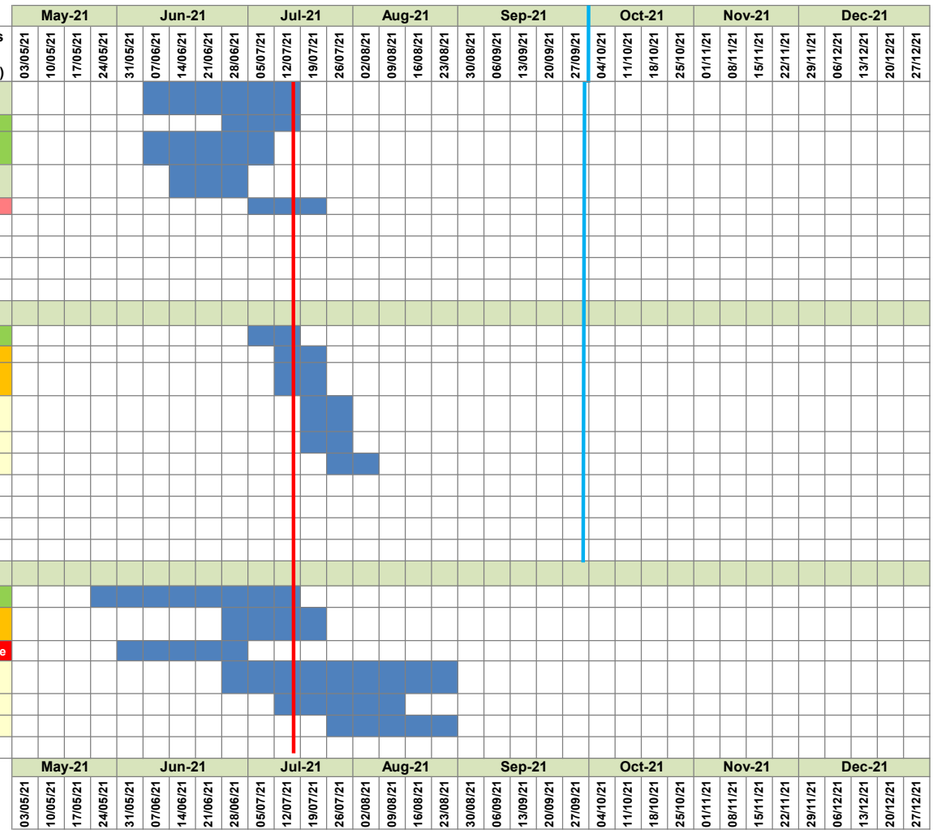
Planned timescale *(maps against dates for start & finish automatically)*
Checkpoint *(Copy & Paste to required date)*
Project Milestone to be delivered *(Copy & Paste to required date)*
Current point in time *(Drag to reflect 'current' date)*
'Go Live' / Day 1 *(Drag to reflect 'go live' / Day 1 date)*

Note: For additional rows, ensure you copy the entire 'Work Stream' and / or 'task' rows from existing plan & then 'insert copied cells' (rows) into the spreadsheet
Note: Date headings (**in row 16**) start on a Monday
Note: You only need to enter the first date in the heading range (**in Cell 'H16'**)

ID		Milestones / Tasks	Responsible Person	Notes / Comments	Start Date (DD/MM/YY)	Deadline (DD/MM/YY or enter N/A)	Date Completed (DD/MM/YY)	Status Flag (Auto.)
							TODAY →	20/07/21
1. Governance								
1.1		Agree membership of Project Group and meetings schedule	Margaret Dalziel		26/05/21	26/05/21	26/05/21	C
1.2		ToR drafted and project documentation agreed	Fiona Smith		26/05/21	28/05/21	28/05/21	C
1.3		ToR agreed and signed off by project group	Margaret Dalziel		29/05/21	15/06/21	20/07/21	C +
1.4		Business Case submitted to Capital Management Group	Andrew Paterson		01/06/21	23/07/21	23/07/21	C
1.5		Business Case submitted to Trust Board	Andrew Paterson		01/06/21	29/07/21		-9
1.5		Board decision on agreed way forward	Hilary Shand		29/07/21	29/07/21		-9
2. Estates Work Stream - see refurbishment project plan								
3. Jubilee Ward - Closure and re-location								
3.1		Clarify bed numbers and confirm location for re-provision of beds	Margaret Dalziel		26/05/21	01/06/21	26/05/21	C
3.2		Scope impacts of ward closure on other areas of SGH i.e. theatre to inform Comms plan	Liz Lovett		26/05/21	10/06/21	24/06/21	C +
3.3		Agree name with BI for receiving ward in Cirencester	Liz Lovett		28/05/21	15/06/21	24/06/21	C +
3.4		Prepare bed flow management plan to reduce from 16 beds to 13 prior to move	Liz Lovett		01/07/21	31/07/21		-11
3.5		Advise CCG/GHFT and gain agreement to bed reduction and bed flow plan	Hilary Shand / Margaret Dalziel		31/07/21	08/08/21		-19
3.6		Comms/engagement with partners impacted i.e. GHFT/Inhealth	Julie Goodenough		15/06/21	31/07/21		-11
3.7		Commence reduction to agreed bed numbers for move	Liz Lovett		09/08/21	23/08/21		-34
3.8		Patient transfer booked	Liz Lovett		09/08/21	15/08/21		-26
3.9		Equipment reviewed for transfer and for storage and labelled appropriately	Liz Lovett		31/07/21	23/08/21		-34
3.10								
4. Minor Injuries Unit								
4.1		Capture occupancy of all rooms impacted by the refurbishment in MIIU	Fiona Smith		28/05/21	08/06/21	16/06/21	C +
4.2		Engage with OOHs re options for temporary relocation	Liz Lovett		16/06/21	01/07/21		Overdue
4.3		Review impact on adajacent activity: x-ray and ultrasound	Lee Iddles		02/06/21	24/06/21	24/06/21	C
4.4		Prepare Comms, to include social media campaign and posters to increase take up of MIIU booked appts vs walk ins and agreeing criteria for 'booked appts'	Lee Iddles / Kate Nelmes		02/06/21	30/06/21		Overdue
4.5		Consider options for alternative space in SGH for MIIU booked appts and recommend preferred option	Lee Iddles		08/06/21	30/06/21	01/07/21	C +
4.6		Identify any issues and remedial work required with preferred option	Lee Iddles		01/07/21	07/07/21	07/07/21	C
4.7		Space confirmed for MIIU booked appointments	Lee Iddles		07/07/21	23/07/21		-3
4.8		Equipment review and transfer or storage identified	Lee Iddles		23/06/21	30/07/21		-10
4.9		Staff redeployment plan to be worked up	Lee Iddles		28/05/21	15/06/21	15/06/21	C
5. Cirencester Hospital								
5.1		Agree bed allocation in Cirencester between Thames and Churn	Linda Edwards		28/05/21	02/06/21	03/06/21	C +
5.2		Review storage provision and agree additional space if required	Linda Edwards		28/05/21	15/06/21	18/06/21	C +
5.3		Review impact on any services currently using Thames, Churn and HMP	Linda Edwards		28/05/21	15/06/21	18/06/21	C +
5.4		Agree any staffing support available for SGH i.e. therapy/facilities/portering	Linda Edwards		21/06/21	21/07/21		-1
5.5		Cirencester staff to undertake walkabout/induction for SGH staff transferring	Linda Edwards		23/08/21	24/08/21		-35
5.6		Options for lack of isolation beds to be agreed	Linda Edwards/Liz Lovett		07/06/21	24/06/21	30/06/21	C +
5.7		Preferred option agreed and actions identified to enable	Linda Edwards/Liz Lovett		07/06/21	24/06/21	30/06/21	C +
5.8		Estates to agree costs to enable solution to work	Kevin Adams		24/06/21	15/07/21		Overdue
5.9		Estates work to be undertaken	Kevin Adams		15/07/21	15/08/21		-26
5.10		Confirm medical cover for additional beds	Liz Lovett		28/06/21	15/07/21	08/07/21	C
6. Workforce								
6.1		Confirm and provide list of all staff impacted by closure of Ward and re-location and staff from MIIU requiring redeployment	Liz Lovett / Lee Iddles		28/05/21	15/06/21	24/06/21	C +



ID		Milestones / Tasks	Responsible Person	Notes / Comments	Start Date (DD/MM/YY)	Deadline (DD/MM/YY or enter N/A)	TODAY 20/07/21 Date Completed (DD/MM/YY)	Status Flag (Auto.)
6.2		Hold engagement / Q&A session with all impacted staff and HR	Margaret Dalziel		08/06/21	14/07/21	15/07/21	C +
6.3		Agree amended staffing levels and shift changes	Liz Lovett		01/07/21	15/07/21	08/07/21	C
6.4		Staff travel plans to be agreed, i.e requirement for shuttle bus	Liz Lovett		08/06/21	05/07/21	05/07/21	C
6.5		Inform Staffside of planned changes and invite to staff engagement sessions	Margaret Dalziel		15/06/21	30/06/21	07/07/21	C +
6.6		Obtain shuttle bus quotes from procurement	Fiona Smith		05/07/21	20/07/21		0
6.7								
6.8								
6.9								
6.10								
7. MIIU Temporary Solution - Stroud Maternity								
7.1		Engagement with Children's Services in Stroud Maternity	Helen Mee		07/07/21	15/07/21	15/07/21	C
7.2		Look for alternative space for Children's services	Fiona Smith		16/07/21	23/07/21		-3
7.3		Confirm and plan for any work required to make identified space usable	Kevin Adams		16/07/21	23/07/21		-3
7.4		Space confirmed at Stroud Maternity for MIIU booked appointments	Lee Iddles		23/07/21	29/07/21		-9
7.5		Alternative space for Children's identified and agreed	Jo Ritter		23/07/21	30/07/21		-10
7.6		Comms to all staff impacted	Jo Ritter		30/07/21	02/08/21		-13
7.7								
7.8								
7. Comms and Engagement								
7.1		Share plans with staff	Liz Lovett		26/05/21	15/07/21	08/07/21	C
7.2		Hold internal engagement workshops /Q&A with all staff impacted	Margaret Dalziel		28/06/21	21/07/21		-1
7.3		Undertake stakeholder mapping and prepare Comms plan	Matt Blackman		01/06/21	30/06/21		Overdue
7.4		External engagement with system partners / Councillors / CCG etc.	Matt Blackman		01/07/21	23/08/21		-34
7.5		Comms to local service users	Matt Blackman		15/07/21	15/08/21		-26
7.6		Comms / letters to patients	Matt Blackman		01/08/21	23/08/21		-34
7.7								



01 Jubilee Ward and MIIU Risk & Issue Register

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Risk Register					Assessment						
Ref	Date Identified	Risk	Risk Impact	Risk Type (Programme/ Cost)	Probability (1-10)%	Severity (1-10)	Risk Rating (1-100)	Proposals / Actions to Mitigate	Owner / Action By	Status Open / Closed	Date Closed
3	29 Jan 21	Project Affordability - pre-tender - pre-tender estimates exceed the Trust budget cost	Project is delayed allowing for re-design and value engineering and or the project is withdrawn. Additional fees required as consultants undertake additional work.	Cost	8	8	64	Project was to be competitively tendered to ensure value for money achieved. Now following framework route. Scrutiny of Contractor costs to ensure value for money	Trust	Open	
24	22 Jun 21	Increased Construction costs due to increased material costs (Covid/Brexit/availability),	Increased Project Costs	Cost	8	8	64	Choose competitive tender route. Scrutiny of Contactor costs	Trust	Open	
25	22 Jun 21	Availability of labour / resources to carry out construction due to increased demand on the construction industry	Increased Project Costs / delay	Programme/ Cost	7	7	49	Ensure programme is robust and refelcts availability of resources. Extra assurances from supply chain	Contractor	Open	
11	15 Oct 20	Asbestos -ACMs noted in management survey: Unknown location and condition above ceiling or floor within floor voids. ACMs may also be present within electrical apparatus, plant equipment etc and cold water services.	Ongoing risk to health.	Cost	6	7	42	The building is operational and is expected to remain so until end of winter 2021. Trusts to consider phasing / decant and surveys works to be programmed accordingly. Trust have decided to award the Intrusive R&D inspection/surveys to the Contractor once in place	Trust	Open	
1	23 Oct 20	User Group input - inability of stakeholders to devote sufficient time to adequately support the project. Reliance of staff resilience and goodwill whilst doing the 'day job'	Delays in the design whilst allowing for user group input and review on proposals	Programme	5	8	40	Provide as appropriate the opportunity for users to be included in DTM's and or additional forums to review proposals and project reviews of plans where plans can be presented by the design team and seek confirmation from all groups at sign off	Trust	Closed	
2	15 Oct 20	Stakeholder Engagement - engagement with end users/stakeholders is fragmented and does not provide for the input from all parties; designs are not fully bought into by all stakeholder groups	Delays in providing for the re review of design information pre tender and costly changes post tender.	Programme	5	8	40	Input from wider user groups and Trust stakeholders is being managed and channelled by Gavin as Estate Lead for the project - emails / signatory list of sign off from the defined user groups for each Gateway is sought and note Gateways in place to fix the design to allow progress to continue to the next stage.	Trust	Closed	
13	15 Oct 20	Structural Support -Reconfiguration of internal space requires removal of internal walls, which may be load bearing.	Change of proposed internal layout to accommodate load bearing walls. Incorporation of structural lintels to support ceiling/roof structure over. Increased construction costs.	Cost	5	8	40	03/12/2020 > Watermans have attended a site visit with Gleeds and Trust to assess investigations required both for internal alterations and external extension. Feedback to be given early December and arrangements for intrusive surveys etc. made. > Structural layout plans issued and previous reports made available; layouts to be issued to Watermans once frozen and as part of design team review of the developing design	Designer	Open	
10	15 Oct 20	Covid-19 -Lockdown- Second or subsequent waves of infection, national/localised lockdown.	Extended programme. Increased project, contractor, and professional team costs to complete project. Delayed project delivery. Affects on supply chain/materials, labour force. Key Stakeholder engagement/decision making could be delayed.	Programme	6	6	36	Monitor national/local guidance - Restrictions. Regular contact with client and project team to mitigate risks. Client/Team/Contractor etc to ensure they have a mitigation and business continuity plan in place.	Trust / Contractor / Design Team	Open	
6	15 Oct 20	Changes in Estate Operations -for Jubilee and MIIU Jubilee Ward and minor injuries unit can not be made available for the purposes of carrying out intrusive works and/ or the commencement of construction	Programmes delays to reflect the new phasing and project start with cost increase and or abortive costs to consider		4	9	36	Trust to continue to inform the project team on operational plans and draft phasing occupation plans accordingly. Project to be tendered in this financial year with a break in the programme for decant. Contractor to assume Qu2 2021 start on site for the proposes of pricing?	Trust	Open	

12	23 Oct 20	Covid -19 -impact on methods of working -The social distancing measure specifically the 2m distancing rule has impacts on activities on site	Reduction in productivity elongating programmes with additional prelims, hop, and causing risk to programme delivery	Programme	5	7	**35**	Discuss impact and working methodologies with Speller Metcalfe during ECI and ensure tender returns reflect patterns of working; make provision accordingly in pre tender estimates	Trust	Open	
7	23 Oct 20	Gaps in Design - poorly coordinated design	Gaps in design leading to inaccuracies in costs estimates and/or costly contractor provisional sums / escalated costs to deal with gaps in design detail	Programme	4	8	**32**	Procurement approach is for the production of fully designed technical design solutions at RIBA Stage 4 for Tender. Programme to allow sufficient time for design team reviews.	Trust	Open	
23	15 Feb 21	Results from the Site Investigation surveys means changes to the Design Team pack	Delays in design impacting on overall programme as target dates. Additional fees required as consultants undertake additional work.	Programme / Cost	5	6	**30**	Design unknowns are being mitigated as far as possible using reasonable assumptions to enable the project to be tendered	Design Team / Trust	Open	
5	15 Oct 20	Delays in release of information to the design team- Record drawing information for the building and building services are not available and or are made available in good time to inform the developing design	Delays in design production impacting on overall programme as target dates and Trust gateways are missed. Additional fees required as consultants undertake additional survey work as required to inform the developing design proposals.	Programme/ Cost	5	5	**25**	Consultant team meeting with Trust maintenance teams to build knowledge and understanding of building and building systems held 23/10/2020; useful information gathering; SDS advising on next steps and information needs to progress Design unknowns are being mitigated as far as possible using reasonable assumptions to enable the project to be tendered	Trust	Open	
22	29 Jan 21	Jubilee Ward is being used for COVID patients, preventing access by the design team for intrusive surveys.	It is unknown when the ward will be safely available again. This creates a drag on the programme and completion of the technical design packages of unknown duration.	Programme	4	6	**24**	Design Team are mitigating this by making assumptions and considering worse-case scenario's in order to produce a design package that can be traditionally tendered and costed with investigative surveys undertaken when possible to finalise technical design / firm up costs (if that stage is reached).	Trust	Closed	
14	15 Oct 20	Working in an operational setting	Noise and dust from works impacting NHS staff & patients Safety concerns for NHS staff & patients		4	6	**24**	The Ward and MIIU will be fully decanted - Trust to confirm the operation of any remaining Services on the site and work to be scheduled with due regard to any continued operations on site to reduce noise & impact.	Trust	Open	
19	03 Dec 20	Decision on positioning of AHU unit.	May have planning permission / fire escape route / maintenance considerations.	Programme	4	5	**20**	Intrusive surveys are being organised and Design Team are to advise on statutory consents / fire etc.	Design Team / Trust	Closed	
16	15 Oct 20	Damage to property	Damage to an existing structure not associated with the project during delivery and other activities		3	5	**15**	Site compound to be setup by contractor, contractor to provide localised protection to buildings/structure. Construction traffic routes, agreed. Contractor to develop and mitigate risks as part of their CDM CPP.	Contractor	Open	
17	03 Dec 20	Additional design challenges / elements discovered during intrusive investigations.	Delivery of design elements.	Programme	5	3	**15**	This is being mitigated by organising investigative surveys, arranged with guidance of Design Team and for Structural and M&E investigations, now before further development of design.	Design Team / Trust	Open	
15	15 Oct 20	Site access issues	Patient/public safety to internal/external areas.		4	3	**12**	Access routes, site compound to be agreed with Trust prior to works commencing. Loss of some car parking spaces likely. Trust to provide alternative provision.	Contractor	Open	
21	24 Nov 20	Party Wall etc Act 1996: Agreeing works with adjoining owner: Historic church building/wall may be affected during construction works (Foundation Design)	Adjoining Buildings (vibration) Dispute arises under the Act.	Programme/ Cost	3	3	**9**	Undertake Site Appraisal: Appoint Party Wall Surveyor: Engage with adjoining Owner: Programme duration allows sufficient time to serve notices if required to serve and subsequently prepare Award in advance of construction works	Trust	Open	

Risk Register - Operational Risks for the Transition and Implementation of the Jubilee Ward and Stroud MIIU project

Last updated: 19 July 2021

Ref	Date opened	Raised by	Title / Theme	Description	Controls / Mitigations in place	Gaps in controls	Initial Risk			Risk Owner	Progress (Action Plan Summary)	Current Risk			Review Date	Next Review Date	Open/Closed	Date Closed
							Likelihood	Consequence	Risk Score* (Auto Fill)			Likelihood	Consequence	Risk Score* (Auto Fill)				
1	27-May-21	Fiona Smith	Infection Control	There is an IP&C risk with no isolation beds on Thames Ward/Churn Ward if an infection breaks out resulting in the ward being closed to new patients	Discussion with IP&C and a SOP to be agreed and signed by JT and communicated to all staff and On Call Managers.		3	4	12	Liz Lovett/Linda Edwards	Estates actively looking to converting flat to create 2 side rooms	2	4	8	08/07/2021	20/07/2021	Open	
2	27-May-21	Fiona Smith	Operational	There is a risk that theatre lists and/or x-ray activity will be disrupted due to noise from the contractors resulting in theatre lists and x-ray appointments being cancelled	Regular contact with Contractor is kept to a minimum during key hours. Good communication with GHFT service leads to ensure they are kept informed of major demolition works and other very noisy activity on site so they can plan accordingly.		4	3	12	Liz Lovett	Informed Sarah Bayliss at GHFT. Room 1 which is adjacent to the MIIU area is not as well used as the main room which has digital x-ray.	2	3	6	30/06/2021	20/07/2021	Open	
3	27-May-01	Lee Iddles	MIIU/ ED	There is a risk that very sick patients will walk in to SGH MIIU when it is closed resulting in an increased risk of delayed response to emergency care plus, risk of not being found if attending the main hospital MIIu and collapsing.	Good communication to the public that Stroud MIIU is closed to walkins , call NHS111 or 999 if emergency. Good comms around telephone triage for MIIU and booked appointments only. Strict criteria for booked appointments to be developed.	Public choice and learned behaviours mean patients may continue to walk in.	3	4	12	Lee Iddles	A review of Stroud Maternity for suitability and available space taken place. There are suitable rooms. Helen to contact Mel and Jo in CYP regarding the use of these rooms before Estates carry out any work required. Additional risk of crossing the car park if SM used, uneven surface in car park and poor lighting. Comms going out to improve the use of booked appointments.	3	4	12	30/06/2021	20/07/2021	Open	
4	27-May-21	Fiona Smith	Contingency	There is a risk that the work programme may take longer than the 14-16 weeks allowed resulting in a delay in reopening SGH MIIU and the beds on Jubilee Ward resulting in pressures across urgent care and beds during winter pressures.			4	3	12	Margaret Dalziel	Clear project plans and timelines with regular review and updates on each element of the programme Keep all partners in the loop Plan contingencies for bed base Project Group agreed that MIIU was the priority area to hand over to BAU first.	3	3	9	06/07/2021	20/07/2021	Open	
5	07-Jun-21	Margaret Dalziel	Financial	There is a risk that there is insufficient revenue to cover all potential project costs i.e. removals, storage, shuttle bus etc. resulting in cost pressures within the directorate	Consider using charitable funds.		2	3	6	Juliette Richardson /Kevin Adams	Costs being collated. As this project is early in the financial year there may be additional capital funding available, Kevin to review funding once pre-tender estimates are returned. Potential for NR funding to be used.	2	2	4	30/06/2021	20/07/2021	Open	
6	08-Jun-21	Liz Lovett	Workforce	There is a risk that there will be reduction of therapy cover on the Ward due to therapists having to cover both SGH and Thames in Cirencester plus due to vacancies and maternity leave resulting in increased length of stay and the need to rationalise patient dependency when admitting patients. There is also a risk to therapy staff well being.	To use locum therapists on Thames, they could support other Cirencester wards too. Remaining therapist could divide time across both hospital wards but this will limit the amount of therapy she can deliver. Ongoing recruitment to take place.	Ability to not accept high therapy needs or complex patients but this would go against GHC's admission criteria	4	4	16	Liz Lovett	Currently no bank/locums available. Bank team chasing as urgent. Currently reviewing 3 options: 1. over recruit into establishment (preferred option) 2. look at different cohorts of patients for admission 3. use Band 3 rehab technicians with qualified staff oversight	4	3	12	06/07/2021	20/07/2021	Open	

Ref	Date opened	Raised by	Title / Theme	Description	Controls / Mitigations in place	Gaps in controls	Initial Risk			Risk Owner	Progress (Action Plan Summary)	Current Risk			Review Date	Next Review Date	Open/Closed	Date Closed
							Likelihood	Consequence	Risk Score* (Auto Fill)			Likelihood	Consequence	Risk Score* (Auto Fill)				
7	08-Jun-21	Liz Lovett	Operational	There is a risk that a further Covid surge may impact on travel from SGH to Cirencester resulting in transport company or staff being concerned re safety of transport especially if Covid positive in hospital.	Transport to be able to accommodate staff with social distancing, Clear information for transport company and ward staff on IP&C guidance and reassurance will be needed. Staff would have to travel by themselves which would lead to increased need for parking spaces and travel expenses.		2	3	6	Marion Johnson	Travel requirements being captured.	2	3	6	30/06/2021	20/07/2021	Open	
8	05-Jul-21	Liz Lovett	Operational	There is a risk that emergency call bells in Theatre and Endoscopy will not be heard by staff in Cashes Green Ward	Urgent request to Estates to install emergency call bell in Cashes Green. Use the Mitel phones to be explored.		3	3	9	Liz Lovett		3	3	9	08/07/2021	20/07/2021	Open	
9	08-Jul-21	Margaret Dalziel	MIIU capacity	There is a risk that MIIU are not able to secure any temporary space in Stroud for booked appointments resulting in a lack of UC capacity in Stroud and pressure elsewhere in the system	Looking to secure clinic rooms in Stroud Maternity that are currently occupied by Children's Services. Helen meeting with CYP to progress this		3	4	12	Helen Mee	Meeting held 19 July with Urgent Care and CYP. CYP will move some of their clinical activity to SGH Outpatients. There is still a requirement to resolve storage and the use of a group room. Space still to be found for the IMMS service through September - December. Activity being mapped.	2	4	8	19/07/2021	20/07/2021	Open	
10	08-Jul-21	Helen Mee	MIII Operational	There is a risk that the DOS will book inappropriate patients i.e. lower limb injuries to booked appointments in Stroud resulting in patients having to be either taken across the car park to x-ray by porters or redirected to other sites.	Clear and regular communication with the DOS.		3	3	9			3	3	9	08/07/2021	20/07/2021	Open	

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Date: 23/06/2021

Scheme Name:	Redesign and refurbishment of the MIIU and Jubilee Inpatient Ward at Stroud General Hospital

Scheme Overview:	The scheme proposed is the redesign and refurbishment of the Minor Injuries and Illness Unit and Jubilee Inpatient Ward, at Stroud General Hospital. The redesign and refurbishment of Jubilee Inpatient Ward will firstly ensure compliance with infection, prevention and control standards, by creating two en-suite siderooms, toilet and showering facilities in each bay, improve handwashing facilities and allow isolation of each bay, if infection is detected. It will also address inequalities, because one of the the en-suite side rooms witll be spacious and kitted out with overhead tracking, allowing the ward to meet the needs of bariatric patients. There will be improved provison of care for patients with dementia, through the creation of a Vintage Room/social area within the ward, that can be better accessed by patients and their relatives allowing inproved visiblity to staff for the purpose of observation and promote independence , when appropriate. It is also expected that the refurbishment of both departments will improve the experience of patients and staff morale, thus ensuring overall complaince stipulated by the Care Quality Commission. The scheme will also have a positive impact on patient flow throughout the system..The MIIU and Inpatient Ward will temporarily close. MIIU activity will be diverted to Cirencester and The Vale MIIU. Jubilee Ward will temporarily redeploy to Cirencester Hospital, Thames Ward/Churn Suite at Cirencester Hospital, The scheme is estimated to take 12 weeks.

Director Lead:	Name: Hilary Shand/Margaert Dalziel	Role: Acting COO and Interim DCOO
Completed By (Work Stream Lead):	Name: Juliette Richardson	Role: Deputy Service Director - Community Hospitals

Specific Quality Indicator(s):	

Please complete all fields highlighted:

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Quality Impact Assessment (QIA)

Patient Safety	Details	Impact	Score
Please record the impact / risks of making this change on Patient Safety	**Jubilee IMPACT 1. IP&C**-a) Two single rooms with en-suite facilities, to enable isolation of patients with suspected or known infections, without the need to use commodes that need to be taken in and out of the room, or the requirement to transfer patients across the floor, via the surgical unit, to Cashes Green Ward. b) Toilets and shower/wet rooms in each bay, will stop the movement of patients outside of their bay area. c) The redesign will enable isolation of each bay area, if required. d) Improved hand washing facilities in each bay to aid compliance. e) Two toilets in each bay will promote continence and reduce the risk of urinary infection, through improved access. **2. Improved provision of care for patients with dementia**-a) The creation of a Vintage Room/social area within the ward will be more readily accessible for patients and their relatives. The room will create a calming environment and aid reminiscence, or aid as a distraction technique; the current room is situated off the ward. This should reduce the risk of distress and or agitation; this may result in a reduction in falls. **3.** The redesign of the ward will support patient flow, hence improve patient safety. **RISKS**- 1. There may not be sufficient space to safely move around the patient on a bariatric bed in the lift nearest Jubilee Ward, if they need to go for an x-ray. **2.** During the temporary move to Cirencester, there is an IP&C risk as there are no isolation beds on Thames/Churn Ward and if an infection breaks out, nosocomial infection may occur. Also if the ward closes due to infection this will result in the ward being closed to new patients, which will impact on patient flow. **3.** Ward medical cover will be split over both SGH and Cirencester sites; currently it is 10 hours a day; 5 hours per ward, but if a patient deteriorates on the adjacent ward the Dr will attend. **4**. Minimum staffing levels may not be met, if staff cannot independently travel to Cirencester. 5. Noise disruption may affect clinicians concentration in the Theatres. **MIIU Impact 1.** The layout of the new waiting room will ensure that children and adults are able to wait safely in separate areas with oversight from the central triage room . The Triage room /waiting room is positioned so in case of escalation full lockdown of the unit and safety of staff and patients can be maintained . **2**.clinical rooms are overseen by the central nursing station ensuring consistent monitoring of unwell patients **3.** Clinical cubicles with doors enable isolation of patients with suspected infections and individual hand washing sinks in each room reduce cross contamination. **RISKS**- 1.There may continue not be sufficient waiting space during Covid to maintain social distancing when the department is busy. 2. The unit will need to move to Stroud Maternity to provide booked appointments only- there is a risk that patients will still walk into the main hospital or walking to the maternity unit with significant injury/ illness.. 3.During the temporary location there is a long walk to x-ray over a poor surface carpark, there is a risk of further injury.	3	6
Please record the mitigations to be put in place to address the risks / impacts identified	**Jubilee Ward:**	**Probability**	
	Jubilee. The purchase of a bariatric chair and trolley will reduce the risk of not being able to move around the patient safely in the lift nearest to Jubilee Ward. 2. The conversion of the "flat" on Thames Ward would create two isolation rooms for infectious patients or patients could be moved to Windrush or Coln. 3. Planned rotas, so that there is cover on both sites, 5 hours a day. If there is a rapidly deteriorating patient, Cirencester medical cover will attend, if able to do so. SGH Staff will receive an induction in Cirencester, so they are aware of process to call for help. 4. Hiring of a shuttle bus. **MIIU**- 1. Patients will be assessed and asked to wait outside if the department is busy , this is also reduced by being booked appointments only .2.good communication of the relocation and booked appointments only of the MIIU will reduce the risk. 3 estates to improve car park surface and improve lighting for when it's dark, signage to be in place directing patients to x-ray.	2	

Clinical Effectiveness	Details	Impact	
Please record the impact / risks of making this change on Clinical Effectiveness	**IMPACT 1. Improved Clinical Standards and Reduced Inequalities-** a) Piped medical gases and suction at each bed head; improved responsiveness. b) One of the single rooms will be spacious, allowing for the provision of care to bariatric patients, with over head tracking fitted, also improving compliance with moving and handling. The size of the room will also facilitate improved rehabilitation through the use of specialised equipment that will fit in the room. c) Toilets and ensuite in each bay, improving mobility as patients will be able to walk to toilet more freely, instead of walking to the bathroom, promote continence by walking to the toilet, improved patient exp instead of using a commode, improve independence and dignity and privacy. **2. Improved Privacy and Dignity**- a) Toilets and shower/wet rooms in each bay will reduce the need for a commode at the bed side and remove the need to travel across the general circulation area, ensuring more effective same sex segregation. b) En suite side rooms for patients who need their own particular space, such as those at end of life. This will also afford privacy for their relatives. **3. Leadership-** A reasonably sized office on the ward will enable greater Senior Nurse visibility. 4. The Vintage room/social space will enable independence, as patients without cognitive impairment may not always have to have a member of staff in the room. **RISKS 1.** There is a risk that there will be reduction of therapy cover on the ward due to therapists having to cover both SGH and Thames in Cirencester plus due to vacancies and maternity leave resulting in increased length of stay and the need to rationalise patient dependency when admitting patients. There is also a risk that the ward will not be able to accept patients with high therapy or complex needs or complex patients, which would go against GHC's admission criteria There is also a risk to therapy staff well being. **2.** There is a risk that theatre lists and/or x-ray activity will be disrupted due to noise from the contractors, resulting in theatre lists and x-ray appointments being cancelled. There is a risk of possible disruption and potential dust ingress in theatres at Stroud while the building work is being completed . **3**. There is a risk that Cirencester will lose storage temporarily, when Jubilee decants. This could mean that timely access to equipment may be delayed. **MIIU-** 1. Improved clinical standards- Spacious, purpose built MIIU cubicles with ease to work around, purpose built Resus ensuring best care can be delivered . Improved working environment for both patients and staff . 2. Privacy and Dignity, cubicles with walls and separate rooms will ensure privacy and dignity are maintained . Purpose built children's room will also ensure a positive experience for children in the unit. 3 Leadership - an office will allow the team lead and Matron to work in the unit , staff meetings can be held with confidential surroundings. 4. Staff breaks - there will be a separate break room where staff can take a break on site and not be disturbed by patients of staff trying to access the office or drug cupboards. RISKS. There will be a reduction in service during the refurb due to booked appointments only .	2	**Score** 6
Please record the mitigations to be put in place to address the risks / impacts identified		**Probability**	
	1.To use locum therapists on Thames; they could support other Cirencester wards too. Remaining therapist could divide time across both hospital wards but this will limit the amount of therapy she can deliver. Ongoing recruitment to take place. **2.** Good communication with contractors to identify when they will be carrying out the noisy demolition work may aid the planning of lists when they will do their noisy demolition work, will minimise disruption doing it all at once. Good communication with GHFT service leads to ensure they are kept informed of major demolition works and other very noisy activity on site, so they can plan accordingly. 3. Cirencester equipment will be moved to the Healthy Market Place.	3	

Patient Experience	Details	Impact	
Please record the impact / risks of making this change on Patient Experience	**Jubilee IMPACT** 1. En-suite side rooms will improve privacy and dignity for patients and their relatives, particularly at end of life. Likewise, the toilets and shower/wet rooms in each bay will afford improved privacy and dignity; patients will not need to walk across the general circulation area of the ward and this limits same sex breach interactions. 2. The patient experience will be enhanced through a modernised and aesthetically improved environment 3. A new ventilation system and windows will control temperature and air circulation. 4. A bespoke Vintage Room/social room will provide better provision for patients and their relatives. RISKS 1. Well being of patients if relatives cannot travel to Cirencester. 2. Patients may not receive their planned surgical intervention in a timely manner when demolition work occurs. 3. Patients and clinicians may complain about the impact of being unable to access services at SGH and complain about the noise caused by demolition work. 4. Increased traffic to Cirencester may cause congestion on access roads and car parking. 5. Security risk at SGH, as the main entrance doors to the Hospital will need to remain open over the weekend for access to x-ray. **MIIU-** activity to the redeployed MIIU at Stroud Maternity, may outweigh capacity, thus resulting in patients being re-directed to other MIIUs.	3	**Score** 6
Please record the mitigations to be put in place to address the risks / impacts identified	**Proposed Mitigation**	**Probability**	
	1. Letters to patients and their relatives about the planed move, to include bus route timetable**. 2 and 3.** GHC Communications and Management team will work closely with system partners to ensure a coordinated communication plan is in place to support and communicate consistent messages about the planned refurbishment timetable. Communication and signage to direct direct people to x-ray from Trinity Entrance and support people navigate to the correct area at the correct time. **4.**		

	Signage for car parking **5.** Ward doors are locked and bell/key pad entry only. **MIIU-** clear criteria for patients appropriate to MIIU Stroud to be agreed , telephone triage and NHS111 to be informed of criteria, other patients to be redirected to other MIIU sites.	2

Consideration has been given to the safeguarding of adults and children
(Add comments if required) ☑

The impact on equalities has been assessed in line with policy
(To view EIA click button below) ☑

View EIA

Maximum Risk Score	6

EIA Residual Risk Score: 9

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	Does the Policy, Strategy or other process contain statements, conditions or requirements that could impact on any protected group more than another?	Impact (Drop down)	Impact Score (Autofill)	1. Please state why the impact may be postive or negative. 2. Show mitigation for negative impact or benefits in Section 2.	Outline the adjustments identified. How they will eliminate or minimise the potential adverse impact. OR Outline the benefits that will result from the change	Residual Risk (Probability) (Drop down)
1	Age?	Neutral	0			1
2	Gender?	Neutral	0			1
3	Disability?	Benefit	1	Bariatric patients. Patients with cogitive issues, such as dementia.		1
4	Race or Ethnicity?	Neutral	0			1
5	Religion or Belief?	Neutral	0			1
6	Sexual Orientation?	Benefit	1	The en-suite side rooms and dedicated toilets and shower/wet rooms per bay will eliminate the need to enter the general circulation area		1
7	Gender Reassignment?	Neutral	0			1
8	Pregnancy or Maternity?	Neutral	0			1
9	Marriage or Civil Partnership?	Neutral	0			1
	Impact Total Score:		2		Residual Risk Total Score:	9

Adverse	-1
Neutral	0
Benefit	1

PROBABILITY	Score
Rare	1
Unlikely	2
Possible	3
Likely	4
Almost certain	5

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AGENDA ITEM: 17/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

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

AUTHOR: Kyra Boon, Capital Delivery Manager

SUBJECT: **SOUTHGATE MOORINGS REFURBISHMENT**

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 a business justification and establish costs for the refurbishment of the ground floor of Southgate Moorings.
- To request Board approval for this scheme to progress

Recommendations and decisions required

An initial indicative budget of £750k was allocated in 21/22 for this scheme. Costs have been returned which exceed the original budget allocation. The project team have undertaken a rigorous challenge process with the services involved to minimise the costs of the scheme. The scope of the scheme has undertaken several revisions to reduce the cost to a point where it cannot be reduced further without impacting on the needs and requirements of the service.

The Trust Board is asked to:

- Agree to the investment of a total project cost of £1,127,026
- Acknowledge that this will be investing a significant sum in a leased building with 12 years remaining of a 15-year lease agreement.
- Note the current status of the building industry supply chain and its impact on the availability of materials; timescales; and costs of building schemes.

Executive summary

Southgate Moorings (ground floor) requires an upgrade to meet compliance and improve patient and staff experience.

The building has 12 years left of a 15-year lease. The ground floor was last refurbished in 2008. The scope of the proposed project includes replacement of the majority of the ground floor's internal fabric, furniture and fittings and mechanical and electrical systems. The project also includes minor improvements externally to secure the waste bins with a new compound for bicycles. The project excludes work to the staff WCs and locker rooms apart from new sustainable lighting.

The building industry is witnessing significant price rises of between 10-15% across the board leading to increased costs of supply of essential materials. The price rises are not unique to this project, they are also impacting a number of current and planned capital schemes. As a consequence, lead times for orders are lengthening while prices are increasing.

The project has been priced by Speller Metcalfe under a framework, and the total project costs are £1,127,026 inclusive. Given approvals the project could start in September and be complete by Christmas.

Risks associated with meeting the Trust's values

This project is centred around improving the patient and staff experience **(Making a Difference),** as well as ensuring compliance with ventilation requirements **(Always Improving)**

Corporate considerations	
Quality Implications	This project ensures that the ground floor is on par with the remainder of the building.
Resource Implications	Capital allocation would need to be agreed as feasible.
Equality Implications	This project ensures that service users have inclusive access throughout the ground floor.

Where has this issue been discussed before?
Capital Management Group – April 2021 and 21st July 2021

Appendices:	Page 14 - Appendix A - Outline floor plan Page 15 - Appendix B - Backlog maintenance list

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

SOUTHGATE MOORINGS REFURBISHMENT

1.0 STRATEGIC CASE

1.1 Purpose

This business case refers to Southgate Moorings, Kimbrose Way, Gloucester.

GHC have a 15-year lease on the whole building, from 27th June 2018, with 12 years left to run.

This project proposes a refurbishment of the ground floor which is predominantly used by the community dental service, with two clinical rooms and an office used by the Lymphoedema service. The community dental service provides specialist care to a wide range of service users with additional needs. The 1st and 2nd floor were refurbished for other services in 2018.

The scope of the proposed project includes replacement of the majority of the ground floor's internal fabric, furniture and fittings and mechanical and electrical systems. The project also includes minor improvements externally to secure the waste bins with a new compound for bicycles. The project excludes work to the staff WCs and locker rooms apart from new sustainable lighting.

1.2 Approvals

The Capital Management Group (CMG) have supported the referral of this paper onto Board given the value of over £1million.

1.3 Background/case of need

The ground floor was refurbished in 2008/9 to accommodate the dental service, so the fixtures and fittings and building services are now dated and end of life. The floor layout has grown organically and is not efficient for staff to work in. The mechanical ventilation system is old and requires replacing to ensure it is compliant with the latest Health Technical Memorandum (HTM 03-01). The functional space does not accommodate bariatric patients easily, nor patients in electric wheelchairs. The reception is not welcoming to patients with additional needs. The foul drainage system is not efficient which results in a malodorous smell filtering through parts of the building

1.3.1 Ventilation

As part of the survey work to underpin the design a report was commissioned on the current ventilation system and found it required a significant upgrade to meet the requirements under HTM 03-01 Specialised Ventilation for Healthcare premises. The original cost plan assumed the current system could be adapted but the survey showed this is not the case. The dental surgeries and clinic rooms require 10 air changes per hour, with the 4 surgeries and recovery room that undertake anaesthetic treatments requiring 15 air changes per hour. The proposal to remedy this is to provide an external air handling unit.

1.4 Project aims

The project aims were agreed by the operational project team as:

- Improvement of patient and staff experience
- Efficient location of dental surgeries to improve clinical service/practice
- Improved accessibility and use of services for patients
- Compliance with Infection Control standard
- Comply with current Health Building Notes (HBNs) and Health Technical Memorandum (HTMs)
- Improve sustainability to assist in meeting our obligations under the Climate Change Act

1.5 Main benefits

1.5.1 Benefits

Aim/benefits	*Measure benefits*
Improvement of patient and staff experience and well being	• Pre and post survey to patients to measure their experience. • Pre and post survey to staff to measure their experience.
Efficient location and refurbishment of dental surgeries to improve clinical service/practice	• Part of surveys above
Improve accessibility and use of services for patients	• Part of surveys above
Compliance with Infection Control standards	• 100% compliance
Meet all current HBNs and HTMs *	• 100% compliance. This project ensures that the actions from the Infection Control June 21 audit are complete. • Reduce backlog maintenance schedule to low risk
Improve sustainability to assist in meeting Trust targets.	• Savings of £1,647 p.a. in utility costs, and £277 in maintenance. • Savings of 5,466 kg C02 p.a.
Improve Health and Safety	• Monitor Datix incidents

1.6 **Main Risks**

1.6.1 Inability to provide dental service for service users with additional needs. Investment would be needed to provide alternative accommodation or cease provision.

1.6.2 Future service disruption for any users of the floor whilst backlog maintenance is being undertaken.

1.6.3 Loss of staff morale as environment not comparable with the other two floors of the premises, nor other dental facilities.

1.6.4 Loss of reputation with Commissioners

1.6.5 The design of the premises is not inclusive (poorly designed reception, narrow doorways, small rooms)

1.7 **Trust Strategic Aims**

The Trust Strategic Aims that are met by the refurbishment are:

Aims	How it is proposed they are met:
High Quality Care	Facilities that are fit for 2021 with inclusive design
Great Place to Work	Improved functional layouts, refurbished staff room and drainage system.
Sustainability	Using low energy technology wherever possible.

1.8 **Summary of Strategic Case**

Without the full investment in the ground floor facility, the Trust risks a loss of dental service, of operational reputation and staff morale. Progression of this is therefore seen as in line with Trust strategic objectives.

2.0 ECONOMIC CASE

2.1 **Option 1** - Business as usual.

'Do nothing' is not an option. The current clinical and treatment rooms fail to deliver the required air changes per hour. To address the air changes only will cost in the region of £0.5 million once site set up, builders work in connection with the services and design costs are factored in. This option would not address any of the other aims and would still be disruptive to the service and require a decant.

2.2 **Option 2** – Refurbishment (preferred option)

The recommended option, whilst addressing the air change compliance, would be to take the opportunity to undertake all of the work and capture all of the benefits.

2.2.1 Scope of works

The outline approved plan is shown in **Appendix A**

Aim	How this option meets the objectives
Improvement of patient and staff experience	<u>Patient</u> • Wider entrance to waiting area • New flooring, lighting and redecoration to all patient facing areas • New reception desk that is at a lower, more welcoming height, (security is provided by the depth of the worktop, some higher areas, panic button and two escape doors). • Improving the acoustics where there are problems • Improving patient dignity by adding a bariatric toilet, widening doorways and ensuring door + half where required, ensuring rooms have sufficient space for wheelchairs to turn <u>Staff</u> • Refurbished staff welfare room • Air conditioning in clinical rooms (8 in total) • Improving the acoustics where there are problems • Eliminating the sewerage smell that is present in most of the floor
Efficient location and refurbishment of dental surgeries to improve clinical service/practice	• Relocating the main staff office to behind reception, freeing up space for a larger 6th surgery with the others • Relocating all surgeries together
Improve accessibility and use of services for patients	• Only two of the dental surgeries have a door plus half, this will ensure that all 8 clinical rooms plus the OPG room and any corridors have wider doorways • Addition of a bariatric WC facility
Compliance with Infection Control	• Addition of a dirty utility for the non-dental clinical rooms • Removal of carpet and replacement with vinyl • 100% compliance with Infection Control June 21 audit
Meet all current HBNs and HTMs *	• This is an opportunity to address backlog maintenance and the full extent of items replaced are at **Appendix B**. £65,000. They include distribution boards, flooring, doors, kitchen units.

Aim	How this option meets the objectives
	• The ventilation will meet the HTM_03-01– recommended air-change rates
Improve sustainability to assist in meeting Trust targets.	• Installing LED lighting throughout. • Adding a new bike shelter to encourage cycling to work
Improve Health and Safety	• Creating a fenced waste compound to prevent rough sleepers and the public using the area for waste and as a urinal. • Installing an access-controlled gate to prevent the general public using the car park as a pedestrian short cut • Full drainage review and elimination of waste odours

* Health Building Note 11-01 – Facilities for Primary and Community Care Services, Health Technical Memorandum 01-05 decontamination in primary care dental practices (2013), Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises, Health Technical Memorandum 07-07 Sustainable health and social care buildings: Planning, design, construction and refurbishment, Health Technical Memorandum 08-01: Acoustics

2.3 Summary of Economic Case

The preferred option (2.2):

- Ensures safety with compliance with HTM 03-01 with the provision of a new AHU
- Improves patient journey, dignity and general experience
- Improves staff morale, wellbeing and operational working
- Meets inclusive design requirements
- Ensures 100% compliance with infection control
- Addresses 65k backlog maintenance for a number of years which would disrupt service if operational.
- Supports the sustainability agenda
- Improves security and safety

On this basis the preferred option is deemed value for money.

3.0 COMMERCIAL CASE

3.1 Procurement route

The project is currently being developed with the contractor Speller Metcalfe with Gleeds as the main designer, maintaining design liability. The proposal is that Speller Metcalfe will be appointed from the South West Procurement Alliance (SWPA) framework. Spellers bid has been evaluated by Gleed's QS and those costs are included under 4.1.

3.2 Construction phase

The services will move to alternative clinics whilst the work is being undertaken, to facilitate a quicker project and a lower price. It is likely that the site compound will take up a considerable amount of the parking spaces and the first and second floor staff will be impacted accordingly. An alternative option has been found and included within the commissioning costs.

3.3 Permissions

Landlord permissions have been agreed for the internal work but not for the additional AHU requirement, this is currently being sought. This is not anticipated to be a problem. There will be legal fees for the agreed licenses which are included in the costs.

Planning permissions will need to be sought for the air handling units on the outside of the building as this building is located in a conservation area. Pre-application advice has been sought on the preferred location and approval verbally given by a Planning Officer, in order to minimise the risk of rejection. Next steps are a full planning application average length 8 weeks. The Trust could then proceed at a low risk to maintain the programme. Planning permission is already granted for the external works for the waste compound and cycle shelter.

3.4 Decommissioning and commissioning

The area will need to be cleared completely in order for the contractors to undertake the work, this includes a number of specialist suppliers to remove and store expensive imaging and decontamination equipment. The remainder will be removed into storage. Costs for this have been included in the table below.

3.5 Summary of Commercial Case

Speller Metcalfe have put a viable cost in for this work and are interested and resourced to undertake the project. On this basis the project is deliverable.

4.0 FINANCIAL CASE

Earlier this month CMG, in response to the cost pressures experienced by this scheme and others, redistributed the 21/22 capital programme and allocated the full project cost. In doing so CMG deferred some backlog maintenance activity to 23/24. No high or significant risk items have been deferred as a result of this reallocation.

4.1 Capital costs

The table below is based on the preferred option and costs from Speller Metcalfe.

Element	£	
Works cost	£	**698,255.52**
Contractor prelims	£	51,872.60
Contractor profit at 5%	£	37,804.94
Sub total	£	787,933.06
Risk allowance at 5%	£	34,912.78
Sub total	£	822,845.84
VAT at 20%	£	164,569.17
Sub total	£	987,415.00
Less VAT reclaim @ 20%	£	32,913.83
Build costs including applicable VAT	**£**	**954,501.17**
Design/legal fees /surveys	£	136,525.00
Plus commissioning costs	£	36,000.00
Total project cost	**£**	**1,127,026.17**
Less spend in 20-21	£	74,000.00
Total for 21-22	**£**	**1,053,026.17**

4.2 Revenue

Element	Per annum	How funded
Heat/light/power/maintenance and additional cleaning	£500 for air conditioning maintenance £1,000 for new filters/maintenance of AHU £5,132 for the additional cleaning Total £6,632	Will be met from the current estates and facilities budget
Capital charges at 3.5%	£37,802 in year one £1,644 in year 12	
Depreciation over the life of the asset (12 years)	£93,919 per annum	
Total revenue	£138,353 (in year 1) £102,194 (in year 12) £1,443,285 (whole project cost with interest)	

4.3 Cash flow 21/22

Indicatively, if approved, the project would be spent as follows;

April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
£ 4,000	£ 2,000	£ 8,000	£ 14,000	£ 14,200	£ 252,825	£ 252,825	£ 252,825	£ 252,325	£ 1,053,001

4.4 VAT treatment

Internal Vat advice is that this project will be banded as Major Alterations and will have a 20% of applicable VAT reclaim.

4.5 Project cost increase rationale

At concept design stage an indicative budget of £750,000 was set. Whilst there has bene some additional scope in relation to backlog and air handling, increases otherwise are broadly due to the economic climate as highlighted under 5.6. The preferred option represents the fundamentals required to deliver the benefits outlined.

4.6 Summary of Financial Case

On the basis of the above and the work undertaken by CMG the project is considered affordable.

5.0 PROJECT MANAGEMENT CASE

5.1 Professional advice

Gleeds Building Surveying Ltd have been appointed via the SWPA framework to manage the project and have professional liability for any other professionals.

5.2 Project Group

A project group meets at least monthly and have been involved with design sign off and reviewing plans. Members include Operational staff, Radiation Protection Advisor, Infection Control, Fire Safety Manager, Local Security Management Specialist and Estates and Facilities colleagues.

5.3 Project Board

The Project Board are available to resolve any issues and comprise:

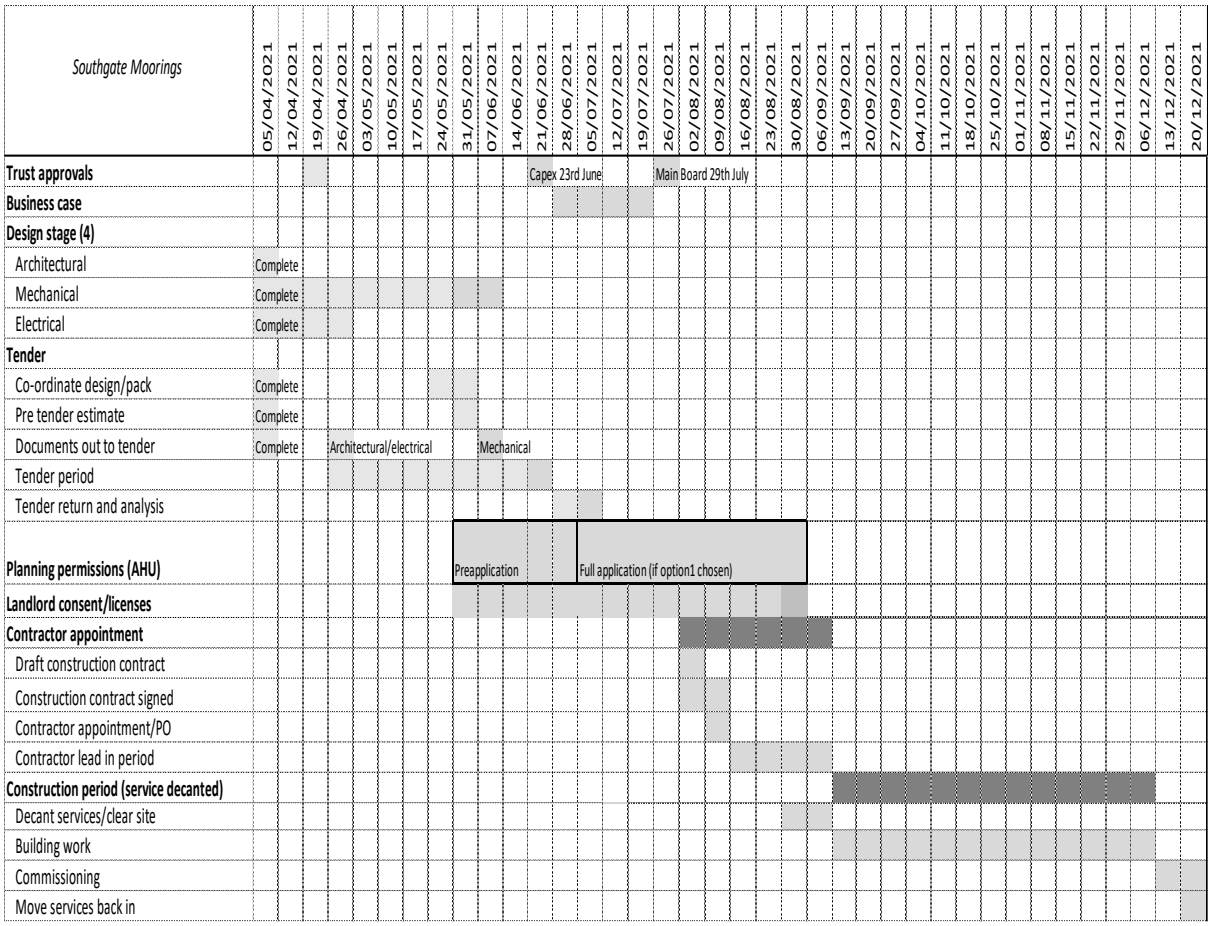
- Associate Director of Estates and Facilities
- Deputy Service Director for Urgent Care and Specialty Services
- Deputy Director of Adult Community Services

The Project Board will be responsible for managing to the agreed budget including the spend of the risk allocation. Any issues likely to take the spend over the agreed budget will require further authorisation, and will initially be escalated to CMG.

5.4 Programme

Proposed key dates are:

- Start on site mid-September
- Estimated completion before Christmas
- Estimated build programme 13 weeks



5.5 Risks of project delivery

Risk	Likelihood	Impact	Mitigation	Owner
Planning permission - Non-approval of air handling unit (AHU) location	Low	Medium	Pre-application advice sought. Alternative options are available.	Project Manager
Programme delay if preferred location of AHU not approved	Medium	Low	Likely delay 1 month, still achievable in financial year though	Project Manager
Contractor insolvency	Low	Low	Speller Metcalfe are a large and	Project Manager

Risk	Likelihood	Impact	Mitigation	Owner
			reliable contractor	
Supply chain issues causing programme delay See 5.6 below	High	Low	Clause in contract to mitigate financial loss.	Project Manager
Landlord consent	Low	High	Dialogue opened already and no issues envisaged.	Project Manager

5.6 Cost and Supply Risk

The British building industry is in the midst of a supply crisis. The Construction Leadership Council recently warned that cement, electrical components, timber, steel and paints are all in short supply due to unprecedented levels of demand that are set to continue. As a result, it has been necessary for many building contractors to delay projects and others have been forced to close down altogether.

With demand globally increasing and the UK importing many of its raw materials, lead times for orders are lengthening while prices are increasing. The industry is witnessing price rises of between 10-15% across the board with timber seeing between 50-80% increase and 30-50% increase on cement. Steel joists are more expensive because iron ore has gone up by more than 80%

The supply shortages stem from a number of factors including:

- Warmer winter affecting timber production in Scandinavia
- Sharp rise in shipping costs due to COVID-19 and Brexit related issues also leading to delays at ports
- The increase in domestic activity seeing a sharp rise in home improvement projects

5.7 Summary of Project Management Case

On the basis that the issues above have been factored into planning and noting the risks highlighted there is confidence that this project is deliverable.

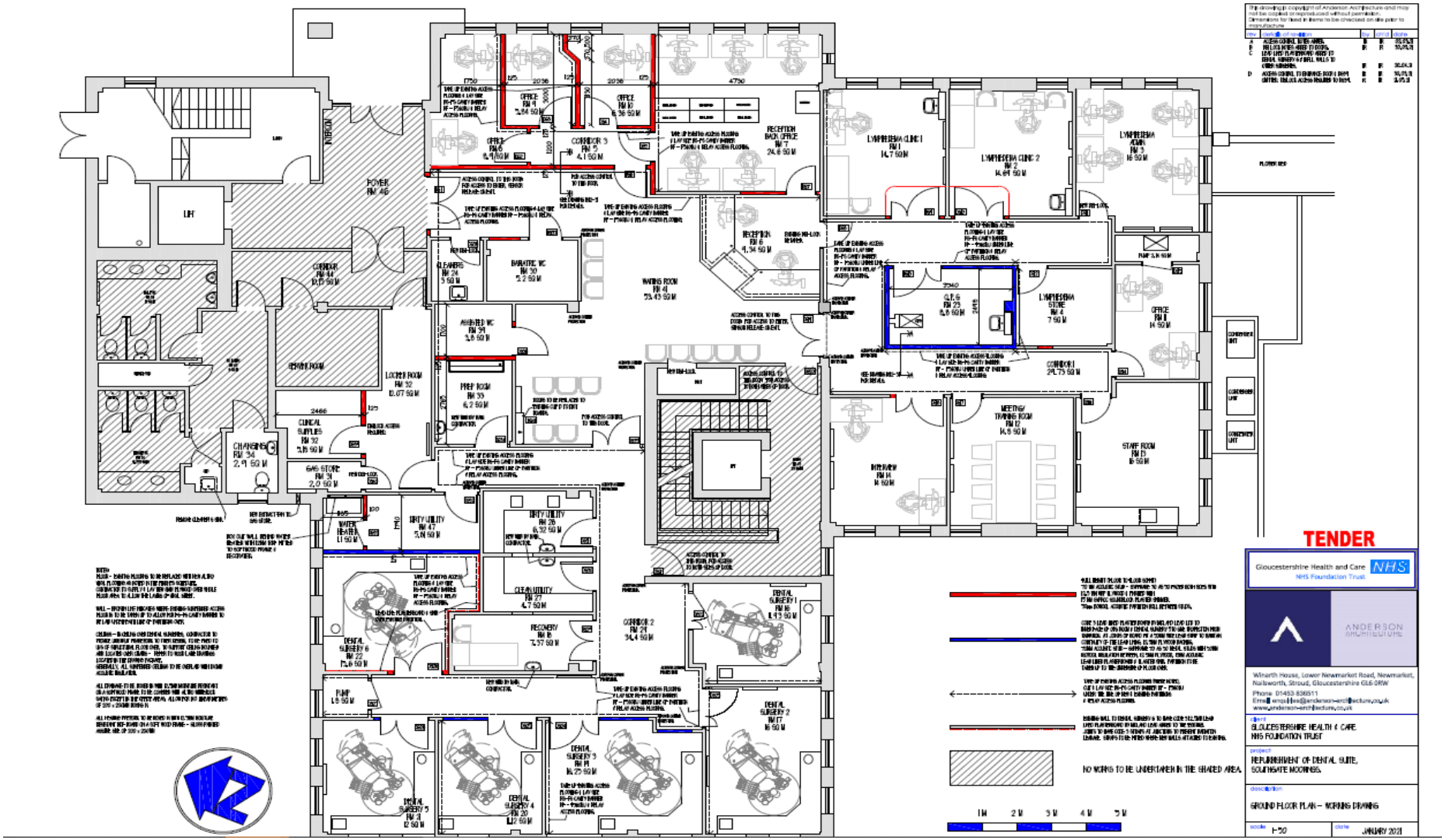
6.0 SUMMARY

The Trust Board is asked to:

- **Agree** to the investment of a total project cost of £1,127,026

- **Acknowledge** that this will be investing a significant sum in a leased building with 12 years remaining of a 15-year lease agreement.
- **Note** the current status of the building industry supply chain and its impact on the availability of materials; timescales; and costs of building schemes.

Appendix A – **Outline plan**



Appendix B – Backlog maintenance schedule

Site Name	Block No.	Block Name	Zone Name	Summary	Description	Type	Condition	Rem Life Years	Oakleaf Cost	Adjusted cost	Year	Comments	Remedial Action	Consequence	Likelihood	Risk Score	Risk Rank
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	07 - Internal Doors	Building	C	0	£150.00	£150.00	2020	Timber entrance door: Operation is poor.	Cost allows for repair.	3	5	15	SIGNIFICANT
Southgate Moorings	001	Main Building	00 - Ground Floor - Reception Electrical Cupboard	R - Engineering - Electrical	03 - Distribution Boards	M&E	C	0	£2,500.00	£3,750.00	2020	MEM distribution board is beyond expected lifecycle.	Cost allows for replacement.	3	4	12	SIGNIFICANT
Southgate Moorings	001	Main Building	00 - Ground Floor - Reception Electrical Cupboard	R - Engineering - Electrical	03 - Distribution Boards	M&E	C	0	£2,500.00	£3,750.00	2020	MEM distribution board is beyond expected lifecycle.	Cost allows for replacement.	3	4	12	SIGNIFICANT
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	03 - Floor	Building	C	0	£6,000.00	£6,000.00	2020	Vinyl sheet floor: Is aged and marked.	Cost allows for like for like replacement of the existing floor finish.	2	5	10	MODERATE
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	05 - Fixed Units	Building	C	0	£5,000.00	£5,000.00	2020	Kitchen units: Allow to upgrade.	Cost allows to upgrade conforming to modern standards.	2	5	10	MODERATE
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	01 - Decorations	Building	C	0	£22,000.00	£22,000.00	2020	Redecoration is required as part of a regular maintenance schedule.	Cost allows for two coats of emulsion and includes gloss work.	1	5	5	LOW
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	03 - Floor	Building	C	0	£4,000.00	£4,000.00	2020	Carpet: Is marked and worn.	Cost allows for like for like replacement of the existing floor finish.	1	5	5	LOW
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	06 - Sanitary Fittings	Building	B	1	£10,000.00	£10,000.00	2021	Male/female WC's: Although well maintained, are considered dated.	Cost allows to upgrade conforming to modern standards.	2	4	8	MODERATE
Southgate Moorings	001	Main Building	00 - Ground Floor	K - Engineering - Vent & Cooling	02 - Controls	M&E	B	5	£500.00	£500.00	2025	Air Force Vent Products control panel coming towards the end of its life expectancy.	Cost allows for replacement.	3	3	9	MODERATE
Southgate Moorings	001	Main Building	00 - Ground Floor	M - Engineering - Hot/Cold Water	08 - Expansion Vessels	M&E	B	3	£200.00	£200.00	2023	Boss expansion vessel coming towards the end of its life expectancy.	Cost allows for replacement.	3	3	9	MODERATE
Southgate Moorings	001	Main Building	00 - Ground Floor - Reception Electrical Cupboard	R - Engineering - Electrical	03 - Distribution Boards	M&E	B	5	£2,500.00	£3,750.00	2025	MEM distribution board is coming towards the end of its life expectancy.	Cost allows for replacement.	3	3	9	MODERATE
Southgate Moorings	001	Main Building	00 - Ground Floor	C - Building - Internal Fabric	05 - Fixed Units	Building	B	4	£6,000.00	£6,000.00	2024	Clinical units: Are showing signs of age.	Cost allows to upgrade conforming to modern standards.	2	3	6	LOW

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0721

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 July 2021**

PRESENTED BY: Marcia Gallagher, Chair of the Audit and Assurance Committee

AUTHOR: Lavinia Rowsell – Head of Corporate Governance and Trust

SUBJECT: **AUDIT AND ASSURANCE ANNUAL REPORT 1 April 2020 – 31 March 2021**

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

The purpose of this report is to

Receive the annual report of the Audit and Assurance Committee for 2020/2021.

Recommendations and decisions required

The Board is asked to note the Committee's Annual Report 2020/21.

Executive summary

The Audit and Assurance Committee 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*."

The attached report provides an overview of the Committee's work in the last financial year, from 1 April 2020 to 31 March 2021 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.

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	Non-Executive Director

Gloucestershire Health and Care NHS Foundation Trust

Audit and Assurance Committee Annual Report

1st April 2020 – 31 March 2021

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 with four NEDs as core members. 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 5 times during the period 1 April 2020 to 31 March 2021, 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:

Members*	28/05/20	17/06/20	06/08/20	05/11/20	11/02/21
Marcia Gallagher (Chair)	Y	Y	Y	Y	Y
Graham Russell	Y	Y	Y	Y	Y
Maria Bond	Y	Y	Y	N	Y
Steve Brittan	Y	Y	Y	Y	Y

**There are four core members of the Committee but all Non-Executive Directors (excluding the Board Chair) are invited to attend and can count towards the quorum.*

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
- Other Directors as required
- 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.

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.

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. The Board Assurance Framework has been reviewed in year to align with the Trust's new strategic framework.

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 2020/21 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 other issues of mutual interest. It was agreed that in order to a greater understanding on issues facing partner organisations within the system, Audit Committee Chairs may attend each other's meetings as observers.

2.9 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. An Internal Audit on risk management was conducted in year and was rated as 'low risk'. The Committee acknowledges the progress made in year and 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.

2.10 Internal Audit

2.11 In completing its work, the Committee places considerable reliance on the work of the Internal Auditors. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. During the year the Committee reviewed and approved the internal audit plan for 2020/21 and considered the findings of internal audit in relation to work on the following issues:

	Report Rating
Corporate and Quality Governance	Low
Risk Management	Low
Information Governance (DSP toolkit)	TBC
Performance Management/ Data Quality	Medium
System Working (advisory)	Advisory
Consultant Job Planning	High
Supplier Data Transfer	High
Financial Governance	Low
Financial Systems (Accounts Payable)	TBC
HR	High
Cyber Security (advisory)	Advisory
IT Problem Solving	Medium
ESR (Payroll)	Medium
Multi-site COVID	Medium

2.12 Over the year, a number of audits have been included at the request of management including Supplier Data Transfer, ESR (payroll) and IT problem solving. Where audits were rated as high risk, the responsible Director was invited to attend the meeting to discuss the findings and planned response. On each occasion the Committee sought assurance that measures had been put in place to ensure that the recommendations were to be taken forward with timeliness. Of the three high risk rated reports, the Internal Auditors were satisfied that the Trust has action plans in place to address the risks.

2.13 The audits produced a total of 34 findings. There were 11 low, 18 medium and 4 high risk-rated findings and 1 advisory finding. 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.

2.14 During the year, and in line with government guidelines, the majority of the Internal Audit programme has continued to be undertaken remotely.

2.15 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 is reviewed at each meeting.

2.16 External Audit

- The Committee received and noted the final audit in respect of the 2020/21 Annual Report Financial Accounts.
- The Committee reviewed and agreed the external audit plan for 2020/21.
- 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.

2.17 Private Meeting with the Auditors

2.18 Committee Members 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.

2.19 Other Assurance Functions

2.20 The Committee has reviewed the findings of other significant assurance functions where appropriate, and has considered any governance implications for the Trust.

2.21 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2020/21 and the Counter Fraud work plan for 2021/22. The Trust has maintained compliance with the Standards for Providers throughout the year through the delivery of proactive and reactive work in accordance with the approved workplan. The agreed planned total of 200 days of counter fraud activity was delivered during 2020/21 across the 4 generic areas of Counter Fraud activity as defined by the NHS Counter Fraud Authority (NHS CFA); Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

2.22 During the year, proactive local reviews have included a review of Estates and the appointment of professional consultants, the use of purchase cards, and an Association of British Pharmaceutical Industries data set review.

2.23 The NHS CFA requires all NHS providers to sustain their compliance with the standards for countering fraud, bribery and corruption. The new standards for the year were implemented in January 2021. For 2020/2021, the Annual Self Review Tool (SRT) (the mechanism used to annual report compliance against the standards) has been replaced by the Counter Fraud Functional Standard Return (CFFSR). Despite all activity for the year being devised and undertaken in accordance with the previous standards, the CFFSR must be based on the new standards which have a greater level as specificity. This will result in an increase in red and amber ratings for the Trust in certain areas. The NHS CFA has acknowledged that this will be a base line measurement only, and there will be an increase in red and amber ratings. The counter fraud workplan for 2021/2022 identifies the work required for the Trust to meet the new requirements.

2.24 Management

2.25 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.

2.26 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.

2.27 Compliance Reporting

2.28 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.

2.29 The Committee has regular reports at meetings on waivers over £25k applied in the preceding period. This reporting includes nil returns.

2.30 The Committee reviewed the 2020/21 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.

2.31 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 formally reviewed its 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 reviewed its terms of reference during the year with minor amendments approved by the Board.

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
May 2021

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday, 12 May 2021
Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Sarah Nicholson
	Katie Clark	Jo Smith	Mervyn Dawe
	Chris Witham	Graham Hewitt	Tracey Thomas
	Ruth McShane	June Hennell	Anneka Newman
	Laura Bailey	Karen Bennett	Alison Feher
	Kizzy Kukreja	Katherine Stratton	

IN ATTENDANCE: Graham Russell, Non-Executive Director/Deputy Chair
Marcia Gallagher, Non-Executive Director
Maria Bond, Non-Executive Director
Steve Brittan, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Paul Roberts, Chief Executive
Neil Savage, Director of HR & OD
Lavinia Rowsell, Head of Corporate Governance & Trust Secretary
Anna Hilditch, Assistant Trust Secretary
Gillian Steels, Trust Secretary Advisor
Kate Nelmes, Head of Communications
Sandra Betney, Director of Finance (From Item 18)
John Trevains, Director of Nursing, Therapies and Quality (Item 12)

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Brian Robinson, Anne Roberts, Dan Brookes, Juanita Paris, Said Hansdot, Jenny Hincks and Julie Clatworthy. Apologies were also received from Steve Alvis, Non-Executive Director.

1.2 Ingrid Barker welcomed everyone to the meeting. It was noted that this would be Alison Feher's last Council meeting as she would be standing down as a Staff Governor on 31 May 2021. Ingrid Barker led the Council in expressing thanks to Alison for her contribution over the last 3 years.

1.3 Since the last meeting of the Council, it was noted that Dawn Rooke, Public Governor for the Forest had tendered her resignation. Following a recent Governor election, the Council noted that a new Public Governor for Tewkesbury had been appointed to replace Josephine Smith when her final term ended on 14 July. An election was still underway for the Health & Social Care Professions staff group, with the results being known on 31 May 2021.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 10 March 2021 were agreed as a correct record, subject to a small addition at 6.10 to state that Governors had also expressed their concerns regarding the proposed 1% national pay uplift for NHS staff.

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 informed the Council that he was liaising with James Wright about the production of a report for Governors offering assurance around Out of Area placements. It was planned that a full report would be presented to the Council at its next formal meeting.

5. MEETING EVALUATION AND FEEDBACK

5.1 The Council received the collated evaluation and feedback received from the previous meeting in March. Ingrid Barker thanked Governor colleagues for their helpful and valuable feedback, advising that all feedback would be reviewed, and the learning taken on board for future meetings.

6. CHAIR'S REPORT

6.1 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 31 March meeting and was presented to the Council for information and reference. This report and its content were noted.

7. CHIEF EXECUTIVE'S REPORT

7.1 Paul Roberts, Chief Executive presented a verbal report to the Council.

7.2 The Council noted that this continued to be a very busy time operationally. There had been a huge reduction in Covid infection rates and the number of Covid patients in the system had also reduced. GHC currently had no Covid inpatients however community beds continued to care for those in recovery.

7.3 GHC had now lifted its strong visiting restrictions with hospitals operating under Covid Secure Environment regulations.

7.4 GHC runs 96 services, and all services were now back up and running fully with a few high-profile exceptions, including the Vale MIIU which would re-open in the summer. Innovation and the use of technology had come to the fore during the pandemic and the Trust would continue some of this practice going forward, looking at a blended approach of face-to-face and digital solutions.

7.5 GHC had been very involved in the mass vaccination programme, with the Trust's focus being on frontline staff and supporting the Primary Care Networks (PCN) to vaccinate patients. GHC had also focused on the homeless, the travelling community and ethnic minorities as it was important to ensure equitable access to all communities. Mervyn Dawe said it was good to see the work being carried out to ensure that vaccinations were promoted and made available to all communities and asked whether there were any specific groups that had been identified where more work was needed to promote the vaccinations. Paul Roberts said that a number of communities had been identified and the Trust and its partners were working closely with community and faith leaders to get specific communications out, as well as setting up roving vaccination clinics to make access available to as many people as possible. There had also been a lower uptake of the vaccine from younger people.

7.6 Paul Roberts advised that the Trust was currently finalising its Business Plans for 2021/22. He said that there was good investment in mental health services this year, and a key focus on frailty and complex care at home services. The Council noted that staffing and the ability to recruit qualified staff remained a real challenge. There had been Inpatient and Community nursing shortages before Covid hit, and the Trust had been able to adapt with different working models during Covid, but there was a real need to review the staffing models as demand for services was increasing. Neil Savage advised that the Trust was in discussion with system partners to look at developing system wide recruitment programmes.

7.7 The Council was informed that the Trust Strategy had now been officially launched and Governor colleagues were thanked for their input during the development of this.

8. MEMBERSHIP UPDATE REPORT

8.1 The purpose of this report was to provide an update on Trust membership, including progress with the Membership & Engagement Strategy action plan.

8.2 The Trust's Membership & Engagement Strategy was approved at the March Council of Governors meeting. This was subsequently approved by the Trust Board at their meeting on 31 March. The associated action plan is progressing well, and this will be monitored and reviewed by the Governors Membership & Engagement Committee, the next meeting of which will take place on 23 June.

8.3 The Council received an overview of Public membership statistics, which included a breakdown by constituency, ethnicity, disability and age profile. As of 6 May 2021, the Trust had 5926 Public members, of which 4971 were in Gloucestershire. The last membership report received by the Council in November reported the total number of Public members at 6096, of which 5110 were in Gloucestershire. This represents an overall reduction in Public members of 170.

8.4 Work to develop and increase the functionality of the Trust's in-house membership database has taken place, and as of 1 March 2021 it is now possible to accurately see how many Public members join and how many leave the Trust each month. A record is also kept of those members leaving the Trust to get an understanding about the reasons why people no longer wish to remain as a Trust member.

8.5 Laura Bailey noted that there was a much higher percentage of woman signed up as public members than men. Anna Hilditch advised that this had always been the case, however, the Membership & Engagement Strategy had identified this as a key focus point so further work would be taking place to review this and to encourage more men to join as members.

9. FEEDBACK FROM GOVERNOR PRE-MEETING

9.1 The Council received a summary of the key items discussed at the earlier pre-meeting, which included:

- Discussed the new Public Governor/NED/Strategy and Partnership Team pairings and the need to consider how links with the staff Governors could be developed
- Provided feedback and comment on the first draft of the Governor Dashboard
- Discussed the Holding to Account presentations and how to get the most out of these sessions, noting that the information provided to Governors in advance did not provide enough detail to form effective questions and challenge in advance.
- Asked that consideration be given to providing Governors, particularly Public Governors with ID badges and Trust email addresses for correspondence.

9.2 Ingrid Barker said that she really welcomed the feedback around the HTA process, agreeing that this was an important element of the Governor role which would evolve over time. It was agreed that action would be carried out to provide ID badges for Trust Governors and the suggestion of Trust email addresses would be explored further. **ACTION**

10. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

10.1 Chris Witham, Lead Governor presented this report to the Council, summarising the key business conducted at the meeting of the Nominations and Remuneration Committee held on 28 April. He provided strong assurance to the Council that the Committee ensured best practice that was in line with national guidance.

10.2 The Committee received a report setting out a recommendation for the reappointment of Jan Marriott whose first term of office would come to an end on 30 September 2021. As set out in the Trust's Standing Orders, Jan was eligible to be re-appointed for a further 3-year term. In considering its decision, the Nominations and Remuneration Committee received a review of Jan's experience, performance and attendance during 2020/21. It was noted that Jan had received a positive appraisal and had a very good attendance record at Trust Board and Committee meetings. The Committee considered this report and was happy to recommend to the Council of Governors that Jan Marriott be reappointed for a period of 3 years, beginning on 1 October 2021. **The Council of Governors approved this recommendation.**

10.3 At the February meeting of the Nominations and Remuneration Committee a report was presented setting out the process and timeline for both the Chair and Non-Executive Director appraisals for 2020/21. It was proposed that these processes would both be carried out during March/April, with the outcome being

reported to the April meeting of the Nominations and Remuneration Committee. The Committee noted at the previous meeting that NHS England/Improvement (NHSEI) had advised that they would be issuing revised guidance, specifically related to the Trust Chair appraisal process. It was therefore proposed that the process for seeking multisource feedback from external stakeholders and partner organisations would be paused until this new guidance was received. Despite this delay, the Committee supported the decision for the Trust to proceed with its internal systems for seeking feedback, self-assessment and objective setting. The revised guidance was received on Friday 9th April. This was reviewed, and no fundamental changes to the appraisal process were identified. A decision was made that the Trust would proceed with seeking external feedback as part of the Chair's appraisal. Considering this delay, it was agreed as sensible that the outcome of both the Chair and the NED appraisal processes be delayed until the June meeting of the Nominations and Remuneration Committee to allow sufficient time to receive and evaluate this valuable external feedback. The Committee had supported this proposal.

10.4 The Committee received a report which provided an update on changes to the membership of the Council of Governors and an update on progress with Governor elections.

10.5 The Health and Social Care Act requires that Trusts ensure that all Executive and Non-Executive Director positions are filled by people that meet the requirements of the Fit and Proper Persons Regulations. In line with the legislation, an annual process for monitoring and reviewing the ongoing fitness of existing directors to ensure that they remain fit for their role, had been undertaken. All Directors have been asked to complete a FPPT self-declaration and annual conflicts of interest return. In addition, the Trust Secretariat has checked the insolvency register and register of disqualified Directors. The declarations register was presented to the Committee for information. It was noted that there were no issues to be brought to the attention of the Committee following the checks.

10.6 The Nominations and Remuneration Committee received an update on progress and current timelines for the recruitment for a Non-Executive Director. The Committee received an update on potential candidate numbers and contacts made so far. The Committee also received the updated recruitment timeframe, noting that it was proposed to have a preferred candidate identified for approval by 14th July Council of Governors meeting.

11. NON-EXECUTIVE DIRECTOR PORTFOLIOS

11.1 The purpose of this report was to provide the Council with an annual update on the key roles and responsibilities of the Non-Executive Directors, including chairing arrangements, statutory roles and locality focus. This item was for information.

11.2 Ingrid Barker advised that a review of the Trust's governance structure was taking place and it was likely that a number of changes would be made to the NED portfolios in light of this, in particular around Committee membership and chairing. Once this process was complete an updated portfolio would be recirculated to Governors for information.

12. HOLDING TO ACCOUNT SESSION

12.1 The Council received a HTA presentation from Maria Bond, NED and Chair of the Quality Committee. The presentation provided Governors with an overview of the purpose of the Committee, the key ways of working, those things that had worked well and a summary of the areas where development was underway.

12.2 The Quality Committee look at three areas which are nationally mandated: Patient Experience, Patient Safety and Patient Outcomes.

12.3 Maria Bond informed the Governors that a recent meeting of the Audit & Assurance Committee received the Internal Audit Plan for 2021/22 and it was agreed that stronger links were needed with the Quality Committee around clinical audits. The receipt of the annual Clinical Audit plan has now been built into the Audit Committee schedule, once received and signed off at Quality.

12.4 Pressure ulcers has been a long-standing issue for the Trust and the Quality Committee requested a "deep dive" to be able to gain better assurance on the work taking place to address this. A detailed analysis was presented to the Committee with real data and provided a real understanding of the issues and the specific areas where GHC could improve. Discussions also took place about how we can work as a wider system.

12.5 There had been a dip in the performance of complaints and the timeliness of responses to complainants. Assurance was sought on this. A number of team members had been redeployed during Covid and since returning to the team performance had improved. However, the Quality Committee requested more granularity to be able to review the underlying performance.

12.6 The Quality Committee receive the Quality Dashboard at each of its meetings. This is a dynamic document and during Covid, specific Covid measures and monitoring indicators were added to include PPE and vaccination rates. Work was now underway to streamline this data into business as usual reporting. The Quality Dashboard includes data on services with agreed key performance indicators (KPIs); however, it also maintains a focus on those areas without KPIs to ensure nothing is overlooked. A key focus area is identified for presentation at each meeting.

12.7 Maria Bond said that the Trust was performing well overall in its Friends and Family Test (FFT) results which was excellent. However, she was interested in drilling down into this performance to look at whether there were any areas that were not performing as well and whether any improvements were needed. Further analysis of the FFT results has now been provided for the Committee. Maria said that it was very important to not simply accept the information presented at the Committee and that asking for further analysis to seek greater assurance was key.

12.8 It was noted that an Expert by Experience attended each meeting of the Quality Committee, and this was an excellent opportunity to get feedback and to ensure that the focus was on what matters to the patients. The Committee focused on outcome measures – people may receive an appointment within a specified timeframe, but it was important to focus on the outcome of those appointments.

12.9 The Committee receives a Clinical presentation at every meeting. These presentations take time out to look at those areas of the Trust and specific services that were performing well, but more importantly also focussed on areas requiring more attention.

12.10 Maria Bond closed her presentation by expressing her thanks to June Hennell and Josephine Smith for their attendance and participation as Governor observers at the Quality Committee up to April 2021.

12.11 Graham Hewitt said that it was good to hear that the Committee maintained a focus on all services, regardless of KPIs. He also welcomed knowing that the Committee had sought additional assurance on the feedback received from services to help identify areas requiring more focus.

12.12 Graham Hewitt asked whether there had been any key changes in clinical practice due to Covid. John Trevains, Director of Nursing, Therapies and Quality advised that it had been vital to continue quality monitoring processes during Covid and noted that only 1 Quality Committee had been cancelled during the year. The increased use of virtual appointments and consultations had been great, however, consideration about the increased risks around safeguarding needed to be managed, for example health visiting services where it was not possible to fully see or assess the home environment. It was noted that health visiting and children's services teams were using a mix of appointment types to limit this risk, but these were important considerations when looking at the use of digital going forwards. The Trust's digital appointments platform "Attend Anywhere" did enable instant feedback from patients which had been a helpful development. The Trust would be introducing associated quality measures alongside any new clinical practice.

12.13 Chris Witham thanked Maria for her presentation which had been informative and had offered good assurance around blind spots and the level of scrutiny. He said that the Quality Committee could often receive some excellent "good news stories" and asked whether there were any links through to the Trust's Communications Team to publicise these. Maria Bond advised that there was a section at the end of the agenda which acted as a checklist for referring items to other committees, Governors or the Trust Board and agreed that it would be helpful to include a referral to Communications. The Trust did need to get better at recognising and celebrating the good news stories. **ACTION**

13. STAFF SURVEY RESULTS 2020

13.1 Neil Savage, Director of HR&OD was in attendance to present the key results and findings from the 2020 Staff Survey to the Council.

13.2 This was Gloucestershire Health and Care NHS Foundation Trust's first ever single Staff Survey feedback report, covering data gathered from colleagues during Quarter 3 of 2020/21. It was important to note that the 2020 Survey came at a time when colleagues, the organisation and the wider NHS was significantly impacted by Covid.

13.3 Neil Savage said that the results presented a performance that the Trust should be proud of given the context of the post-merger period and the pandemic, with many post-merger organisations having historically suffered a notable reduction in staff ratings.

13.4 The Council received the key headlines which included:

- Significantly improved response rate – 46.3%.
- 80% of ratings improved or remained unchanged
- Of the Ten Themes - 7 improved, two were unchanged, and one worsened
- Highest improvement rating is an 11% increase (colleagues reporting that they do not "come to work when feeling unwell in the last 3 months"), with a number of other statistically significant improvements in the order of 5%, 6%, 7%, 8% and 10%
- 10% improvement on colleagues agreeing the Trust takes positive action on Health and Well-being
- Colleagues agreeing senior managers act on staff feedback is up 8%
- 71% of colleagues would recommend the Trust as a place to work
- 79.5% of colleagues would recommend the Trust to provide care
- Largest reduced rating is 'During the last 12 months have you felt unwell as a result of work-related stress?' which is up by 3%
- All the other reduced scores are in the low 1-2% reduced rating range
- The highest % of improved scores/stayed the same are in the line manager and health and wellbeing sections
- The highest % of the reduced scores are in the Your Job section

13.5 It was noted that the survey results had been discussed widely throughout the Trust and the draft staff survey results action plan had been developed and presented to the Executive Team. A dedicated session for Board members to review and discuss the Staff Survey results would be taking place later in the month.

13.6 Ruth McShane noted that the response rate from Gloucestershire CCG had been very high and asked whether the Trust had discussed the reasons for this for potential learning. Neil Savage informed the Council that this was the first year that the CCG had taken part in the staff survey. They had far fewer members of staff and these were largely office based. However, he said that GHC was considering a hybrid survey for future years, with colleagues having the ability to complete the survey online or via a paper copy as it was acknowledged that front line clinical staff did not spend as much time at their computers as office-based colleagues.

13.7 Given the limited time available at the meeting, it was suggested that a small working group meeting would be helpful for Governors to discuss the results in more detail. This was supported and a date would be sought and circulated. **ACTION**

14. CHANGE TO TRUST CONSTITUTION

14.1 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. The revised composition and subsequent change to the constitution was approved at the November Council of Governors meeting.

14.2 The Medical, Dental and Nursing staff constituency reduced from 4 posts to 3 and this took effect from 1 January 2021. There is a provision within our constitution which states that of the 3 seats within the Medical, Dental & Nursing staff class – 1 must be reserved for a nurse, 1 for a doctor and 1 for a doctor or dentist. This specific provision about reserved seats was not updated at the time to accurately reflect the revised composition and meant that the Trust could only ever have 1 nurse representative on the Council. A small amendment to the constitution was therefore suggested, to ensure that one of the 3 seats was open to all staff within that constituency to apply.

14.3 Mervyn Dawe advised that the Nominations and Remuneration Committee had received this report at their previous meeting on 28 April and had supported this revision, for onward presentation to the Council for approval.

14.4 The Council approved the revision to the Constitution and noted that the equivalent paper to this one would also be considered by the Trust Board at its meeting on 27 May 2021.

15. COUNCIL OF GOVERNOR ANNUAL WORK PLAN

15.1 The Council received and noted the annual work plan for the Council of Governors, which was presented to the Council for information.

16. GOVERNOR ANNUAL DECLARATIONS

16.1 The Council of Governors received and noted the 2020/21 Annual Governor declarations, for information and record. This included declarations of interest, Fit and Proper Person Test and confirmation of compliance with the Governors Code of Conduct.

17. PROVIDER LICENCE DECLARATIONS

17.1 The provider licence requires the Board to make a series of annual declarations to confirm the Trust's compliance with the licence conditions, and also to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance. The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

17.2 The Board must sign off its self-certification on systems for compliance with the licence by 31 May and must publish this declaration by 30 June. In addition, the Board makes these declarations 'having regard to the views of Governors'. The Council of Governors should express its views in the context of its statutory duty to hold the Non-Executive Directors to account for the performance of the Board,

therefore basing its views on the robustness of the Board's own assurance process in coming to a decision.

17.3 This report sought to provide evidence of that assurance process to Governors and Governors were invited to comment on the declaration process to allow the Board to take account of Governors' views when making these declarations.

17.4 The Council of Governors received this report and supported the submission of the declarations, as set out.

18. APPOINTMENT OF EXTERNAL AUDITORS - TIMELINE

18.1 Sandra Betney, Director of Finance was in attendance to present the Governors with the background and proposed timeline for the appointment of the Trust's external auditors.

18.2 KPMG were appointed as the Trust's external auditor by the 2gether Council of Governors. The contract from 1 April 2017 covered three audits and two extension options were enacted. The current contract ends on 31 March 2022 (covering the 2021/22 audit of accounts).

18.3 The Council of Governors will work with the Director of Finance and members of the Audit and Assurance Committee to undertake the appointment process, with the final decision on the appointment being made by the Council of Governors.

18.4 Sandra Betney advised that it is good practice to go through a process for the appointment of the external auditor every 3-5 years. This is usually a competitive process which includes seeking quotes from interested audit firms, assessing the quality of the work that they will perform and agreeing the price they will charge for delivering the services. It was noted that although the Auditors would start from 1st April 2022 the Trust would need to allow time for handover from the current auditors.

18.5 The proposed timeline was presented to the Council:

- Agree specification - July 2021
- Market Exploration - October 2021
- Decision to tender - November 2021 (Council)
- Issue Tender - December 2021
- Evaluation - January 2022
- Decision plus stand still - February 2022
- Contract commences - 1st April 2022

18.6 The Council discussed some of the current market considerations, noting the lack of external auditor firms available. This was recognised nationally. Sandra Betney advised that the barrier to entry into the market was very high for local firms, who simply did not have the resources to go through tender processes.

18.7 Mervyn Dawe noted that he had participated in the previous appointment and provided assurance to the Council that this had been a very thorough process.

18.8 The Council noted the content of the presentation, and the proposed timeline. The next report scheduled for the Council of Governors would be in November when the decision would be made whether or not to tender for the services. In the meantime, Governors were encouraged to contact Sandra Betney directly with any further questions or queries.

19. GOVERNOR ACTIVITY UPDATES

19.1 Governors provided verbal updates on their activities over the past months.

19.2 Ruth McShane said that she had recently met with the Greater England Governor at Gloucestershire Hospital's Trust which had been a very helpful networking opportunity.

19.3 Chris Witham advised that he had had an excellent meeting with Annie Nightingale in the Trust's Communications Team around digital services and accessibility. He had also asked the Director of HR&OD about EU Settled Status and said that the response received demonstrated some exemplary practice within GHC.

20. ANY OTHER BUSINESS

20.1 June Hennell reported on problems people were experiencing accessing services. She asked whether the Trust ensured that GPs were up to date with the services available and understood the current position with waiting lists as there was a concern that GPs were not referring people as they thought there were long wait times. Ingrid Barker advised that the CCG were the leads for Primary Care (GPs) but this was a very important issue and it was therefore vital to ensure that these comments were fed back to them. **ACTION**

21. DATE OF NEXT MEETING

21.1 The next meeting would take place on Wednesday, 14 July 2021 at 5.00pm.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
12 May 2021			
9.1	Consideration be given to providing Governors, particularly Public Governors with ID badges and Trust email addresses for correspondence	Anna Hilditch	**ID badges** **Complete** Now printed and awaiting distribution. **Email addresses** **Progressing** Approval now received for the setting up of GHC email addresses for Public Governors. New user forms to be completed.
12.13	Section at the end of Quality Committee agendas to be included for referring items to the Communications Team for onward publicising	Anna Hilditch	**Complete**
13.7	A small working group meeting would be set up for Governors to discuss the results of the Staff Survey in more detail with the Director of HR&OD	Anna Hilditch	**Complete** Session took place on 9 June
20.1	Concerns raised about people accessing services and communication with GPs to be referred to colleagues at the CCG		**Complete** Concerns raised with Director of Primary Care and Locality Development for consideration

AGENDA ITEM: 20/0721

AUDIT AND ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 26 May 2021

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 ANNUAL REPORT 2020/21 DRAFT

The Committee **received** the final draft Internal Audit Report for 2020/21 which provided a summary of the work undertaken by Internal Audit and included the Head of Internal Audit opinion for the year.

The Head of Internal Audit opinion received was; *Generally satisfactorily with some improvements required.*

FINAL ACCOUNTS AND CERTIFICATES

The Committee received the Final Accounts and Certificates for 2020/2021 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. It was noted that there may be some minor amendments as the audit was finalised.

The Committee **approved** the 2020/2021 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.

The Committee formally thanked Sandra Betney and the Finance Team for their work in producing the Accounts and for a successful outcome.

ANNUAL REPORT 2020/21

The Committee received the Annual Report 2020/21 for Gloucestershire Health and Care NHS Foundation Trust. All comments received at the previous meeting had been considered and incorporated within the report. It had been subject to External Audit and no issues remained outstanding from this process.

Following consideration, the Committee:

- **Approved** the signing off of the Report and Accounts by the Chief Executive and Finance Director
- **Approved** the submission of the Report and Accounts to NHSE/I
- **Approved** 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 year-end report for 2020/2021. The External Auditors presented their report, and confirmed that their provisional audit conclusion was an unqualified audit opinion. It was reported that no uncorrected audit misstatements had been identified.

The External Auditors thanked the Finance Team for their assistance during the audit acknowledging the challenges introduced by Covid-19 and continuing to work from two finance ledgers. The new finance system would introduce efficiency in the process and support greater team working.

The Committee **noted** the report.

EXTERNAL AUDIT – VALUE FOR MONEY RISK ASSESSMENT 20219/20

The Committee received the Value for Money (VFM) Risk Assessment for 2020/21, providing the outcomes of the External Audit value for money risk assessment procedures under the new VFM responsibilities for 2020/21. It was reported no significant risks had been identified and a clean audit opinion was given.

The Committee **noted** the report.

OTHER ITEMS RECEIVED BY THE COMMITTEE

The Committee **considered** the evidence presented in the Considerations prior to the approvals of the Accounts and Risk of Material Misstatements report and declared it was satisfied with the reliability of the Annual Accounts and the Letter of Representation.

The Committee **considered** the Committee's Annual report 2020/21 and **endorsed** it for presentation to the Trust Board subject to minor amendments.

The Committee **commented** on the Internal Audit Plan and **approved** the plan of work for 2021/22.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	12 August 2021

AGENDA ITEM: 22/0721

CHARITABLE FUNDS COMMITTEE SUMMARY REPORT

DATE OF MEETING 9 June 2021

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – 66% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT

The Committee received the Finance Report for the Trust's charities which reported the funds balance at 31st March 2021 had increased from £284k to £406k, an increase of £122k.
The Committee was informed that the increase in funding was largely due to funds received from NHS Charities Together and reported a total of £169k had been received to date from the charity.
The Committee **noted** the report.

BIDS AND UPDATES ON PROGRESING BIDS

The Committee received the report on Bids and Updates on Progressing Bids which provided an overview of the bids which had been completed and were in progress for the Trust as of 31st March 2021.

The Committee **reviewed** the current position of the funds and **noted** the overspend on the NHS Charities Fund.

MONTPELLIER ALLOTMENT PROPOSALS

The Committee **noted** the current request for funding from the South West Provider Collaborative and that a decision was yet to be received regarding this. The Committee would be updated in due course.

VOLUNTEER SERVICE SUPPORT

The Committee received the charitable funding bid to support the Volunteer Service and the Director of HR and OD informed the Committee the bid sought to support the Volunteer Services across the Trust for 2021/2022 by providing catering and travel expenses; covid testing and full uniform. The bid totaled £13,000.

The Committee was informed the Volunteer Services had in the past been funded through Charitable Funds. It was reported that discussions were taking place with the Director of Finance and Chief Executive Officer about whether this could be funded from core funding going forward. This would need to be considered further and a decision made by the Trust Board.
The Committee agreed to ring fence £13k funding, given how important volunteering is to the Trust, allocating 50% of the required funding now to enable certainty to the service and allow work to progress. A paper on the future funding arrangements for the volunteer services would be prepared for consideration at a forthcoming meeting of the Trust Board by the HR Director.

NHS CHARITIES TOGETHER

The Committee received the NHS Charities Together report which provided the Committee with an overview of the expenditure against the grant funds the Trust had received from the NHS Charities Together in response to the Covid-19 pandemic. This funding had mainly been used to support Health and Well Being initiatives in the Trust. The Committee was informed that detailed Pulse Surveys would be run from July which would provide feedback on the impact of the health and wellbeing offer funded

by charitable funds as there would be a specific questions on this. A further discussion would take with the Executive Team and Board regarding ongoing funding for staff health and wellbeing.

The Committee **noted** the ongoing expenditure and progress against the NHS Charities Together allocations.

DEVELOPING A CHARITABLE FUNDS STRATEGY – PROGRESS REPORT

The Committee received an update on Developing a Charitable Funds Strategy for the Trust and the proposed next steps in developing a future direction for Charitable Funds activities. The Committee endorsed the proposal to seek external support for developing the strategy.

OTHER ITEMS RECEIVED BY THE COMMITEE

- The Committee **received** the Log of Approvals made Outside of the Committee.
- The Committee **received** a verbal update on Brockenborough.
- The Committee **received** and **noted** the League of Friends update.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Discuss** the funding of the Volunteer Service Support.

DATE OF NEXT MEETING	10 September 2021

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 24 June 2021

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 2

The Committee received the Finance Report for month 2 which provided an update on the Trust's financial position. The Director of Finance highlighted the Trust was only managing to the H1 plan (Gloucestershire ICS had been given an overall H1 funding envelope that it collectively would have to manage for the first six months of 21/22). The H2 position had not yet been agreed for the Trust or the System.

The Committee noted that the capital expenditure to date was running behind plan. This was due to a number of factors which included asbestos issues and prolonged tenders amongst other works. The Committee was assured this was being closely monitored.

The Director of Finance informed the Committee of an issue which had been discussed at the Capital Management Group [the previous day] concerning emerging pressures on the capital programme. The pressures were due to a delay in supplies and also a delay to works starting as an impact of difficulties in obtaining materials. It was reported an increase in price of up to 80% for some items which were required in building works. i.e. steel and concrete. This was recognised as a national position and it was unknown when or if the prices would reduce.

The Committee was informed that discussions had been held in regards to three of the Trust schemes which were underway; in which the materials had not yet been fully purchased. The three schemes affected were:

- Montpellier scheme
- Wotton Lawn ligature work (concerning windows and doors)
- Southgate Moorings scheme

The Committee noted it was likely to see the impact across the whole of the capital programme.
The Committee noted schemes and projects were being re-prioritised to ensure delivery of pressures.

PERFORMANCE REPORT – MONTH 2

The Committee received the Performance Report for month 2 which provided a high-level view of the key performance indicators in exception across the Trust. It was reported that there were no new indicators which had not been seen in the previous 12 months. There were 9 indicators in exception for Mental Health and Learning Disability Services and 10 indicators in exception in Physical Community Health Services.

It was highlighted that the Trust wide indictor for sickness absence was compliant in the month of May, performing at 3.94% against the 4% target. This was the first time that GHC as a merged Trust had achieved this target which was excellent news.

The Committee **noted** the aligned Performance Dashboard Report for May 2021/22.
The Committee **acknowledged** the ongoing impact of the pandemic on operational performance.

The Committee **noted** 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 pandemic response & operational planning.

SARC AND SOE TENDER PARTNERSHIP APPROACH

The Committee received the SARC (Sexual Assault and Referral Centre) and SOE (Sexual Offences Examiner) tender. The Trust had responded to the tender and discussions would soon commence regarding the partnership approach. The Committee supported the tender process, noting that this presented a good partnership approach.

2020 STAFF SURVEY PROGRESS UPDATE AND PULSE SURVEY RESULT SUMMARY

The Committee received the 2020 Staff Survey Progress update and Pulse Survey Result Summary. The report showed an increase of 3.1% of staff feeling overworked or that their workload was too high. This indicated staff were feeling fatigued. It was also highlighted that 29.3% of staff supported more frequent team huddles and virtual check-ins. This was an increase of 11.4% from the previous wave.

The Committee **noted** the progress with taking forward the Staff Survey action plan.
The Committee **noted** the results of the most recent Staff PULSE survey on health and well-being and that the Health and Wellbeing Hub were considering the next actions to take forward with Executive and Communications support.
The Committee was **assured** that the Trust was continuing to engage with colleagues and progress actions identified as an output of the 2020 Staff Survey results.

OTHER ITEMS RECEIVED BY THE COMMITTEE

The Committee **noted** the final Our People Strategy and **noted** the launch plan.
The Committee **noted** and **commented** on the draft Estates Strategy.
The Committee **noted** the Working Well – Occupational Health Annual Assurance Report.

CHAIR'S ACTION TAKEN OUTSIDE OF THE MEETING

A new return required this year is the Premises Assurance Model (PAM). The PAM has been developed to provide a nationally consistent basis for assurance for Trust Boards on regulatory and statutory requirements relating to their Estates, Facilities and associated functions.

The Trust undertook a self-assessment and overall assessed itself as "good". Prior to submission the self-assessment required Board approval; however, given the timescales this had not been possible at a meeting. A detailed paper and action plans were presented to the Chair of the Resources Committee and assurance was received that the process followed had been robust with evidence based self-assessments undertaken and challenged by colleagues. Actions plans are in hand to ensure those areas not already achieving "good" ratings do so when we re-assess in March 2022. On the basis of the detailed report and assurance provided, the Chair of the Resources Committee had approved the Submission of the PAM assessment.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Note** the Chair's Action taken outside of the meeting to approve the submission of the Premises Assurance Model Assessment

DATE OF NEXT MEETING	26 August 2021

AGENDA ITEM: 24/0721

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 01 July 2021

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive Director • Attendance (membership) – 71% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard and was informed that there had been an increase from 7% to 9% of "moderate" and upwards safety issues. The issues related to Wotton Lawn and it was noted that some issues had been retrospectively reported as part of the covid system.
The Committee was assured that there had been no new inpatient Covid deaths or inpatient Covid cases.
The Director of Nursing, Therapies and Quality reported that there had been 2 cases of Clostridium Difficile Infections (C Diff) and it was noted the safety thermometer data remained paused.
It was reported the Trust had been successful in recruiting the first District Nursing direct entry international recruit and the Trust would be the first Trust within the Pilot sites to achieve this. The Committee also noted that 32 RGNs had now been appointed which was excellent news.
In response to concern raised relating to the significant surge in demand for inpatient beds (in the month of May) with increased levels of patient acuity and dependency which had resulted in a shortage of bed availability; the Director of Nursing, Therapies and Quality assured the Committee he was leading the task and finish group, which would be looking to develop the admission and discharge pathways to ensure these were running smoothly, and working with partner organisations to look at the processes in place. Community processes and delays to hospital transportation were also being reviewed. The Committee agreed the Trust Board should be sighted on this issue.

The Committee **received, noted** and **discussed** the May 2021 Quality Dashboard.

CLINICAL INCIDENTS AND ALERTS

The Committee received the Clinical Incidents and Alerts report and was asked to note
the increase in incidents reported specifically relating to inpatient care at Wotton Lawn and the Director of Nursing, Therapies and Quality provided assurance that all Trust incidents were reviewed by the Safety team.
The Committee was informed that two incidents had occurred of patients having positive MRSA results on Coln Ward, Cirencester Hospital. One patient was not able to be determined if they had contracted MRSA whilst out of the ward, therefore an investigation was not required. The other positive patient had not had swabs taken on admission and therefore could also not be determined if contracted on the ward. The Committee was informed learning was identified reminding staff to take MRSA swabs upon admission.
The Committee was informed of the occurrence of a sudden unexpected death of a 68-year-old inpatient detained under the Mental Health Act on Greyfriars PICU. The incident was not declared as a SIRI due to awaiting the Cause of Death from HMCO. It was reported the decision would be reconsidered if the post-mortem notes issues of significance. At this point, further investigation will be passed to colleagues in Mortality Review to feed into LeDeR.

The Committee **noted**:
The actions taken in respect of clinical incidents reported and escalated for investigation
The learning and change made following a clinical incident.

The clinical alert received by the trust and actions outstanding.

LEARNING FROM DEATHS

The Committee received the Learning from Deaths – quarter 4 report which provided information about the mortality review process and outcomes found during 2020/21.

It was reported during 2020/21 there were 829 patients who died whilst receiving care from the Trust; whilst as either a physical health inpatient or in the care of the Trust's mental health or learning disabilities services. The occurrence of deaths was as follows:

- 336 in the first quarter
- 182 in the second quarter
- 177 in the third quarter
- 134 in the fourth quarter

The Committee was informed 42 case record mortality reviews and 14 comprehensive investigations had been carried out (by 8 April 2021) in relation to the 829 deaths. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 16 in the first quarter
- 21 in the second quarter
- 14 in the third quarter
- 5 in the fourth quarter

The Medical Director assured the Committee that at the time of the report being written (30 April 2021) none of the deaths were judged likely to have been due to problems in the care provided by the Trust.
It was noted that the findings from the 2019 MH Homicide case had now been shared with all parties, and it was noted that NHSE had sent in an external review team to carry out an assurance exercise. The Medical Director thanked John Trevains, Director of Nursing, Therapies and Quality for the support that he provided to both families during the investigation and praised his vast levels of compassion and understanding.

The Committee **noted** the contents of the Learning from Deaths Report covering 2020/21.

OTHER ITEMS RECEIVED BY THE COMMITTEE

- A Volunteer Patient Experience Representative presentation was **received** by the Committee.
- The Committee **received** the Patient safety and Experience Report.
- The Committee **received** a verbal update on Medical Staffing.
- The Committee **noted** the contents of the Quality Assurance Group Summary Report.
- The Committee **received** and **discussed** the Quality Strategy and noted it would be received by the Trust Board on 29 July, and would then be formatted and finalised by the Communications Team.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Note** the issue raised relating to the significant surge in demand for inpatient beds

DATE OF NEXT MEETING	02 September 2021

AGENDA ITEM: 25/0721

MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE SUMMARY REPORT

DATE OF MEETING 21 July 2021

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

UPDATE ON THE CONSULTATION ON REFORMS TO THE MHA WHITE PAPER

The Government had now published its response to the Consultation on Reforms to the MHA. The Trust submitted its response to the consultation, incorporating comments and feedback received at the April Committee meeting. It was noted that a Task and Finish Group would be established to look in more detail at how the reforms would be implemented and to carry out a scoping exercise of the key workstreams including legislative and procedural changes, care planning and workforce. The Task and Finish Group will have to identify the considerable additional resources required in order to implement the recommended changes in response to the reforms of the MHA; in particular the changes to tribunals but balanced against the planned increase in resources to provide better 24/7 community support for people which may reduce the need for inpatient beds by preventing/and or better supporting people in crisis.

There was no certainty yet about the future of the Mental Health Act Managers but the Committee recognised that it would not wish to lose the skills the group have if the White Paper dissolves the role in favour of only Tribunals.

Following discussion, it was agreed the Committee would receive presentations on the new Complex Needs (predominantly personality disorders) Service pilot and Transforming Community MH Services. The presentations would be received at the next MHLS Committee meeting 20th October.

The Committee agreed that there was a need to have senior operational representation at its meetings and the Chief Operating Officer (or a senior level deputy) would be asked to attend all future MHLS Committee meetings. The Chair of the Interagency Monitoring Group would also be invited to attend future meetings.

MHA ACTIVITY 2012 – 21

The Committee received the MHA Activity report which provided information on MHA Activity and trends from 2012 – 2021.

It was reported that the predominant themes confirmed within the report had previously been considered by the Committee; The themes were as follows:

- an upwards trend in the use of some sections of the MHA, especially sections 2 and 3
- an upwards trend of direct admissions on section, with a corresponding downwards trend of detentions after informal admission
- disproportionately higher use of the MHA with people of ethnic minority background, including CTOs.

The Chair referred to the increase in detentions of people with an ethnic minority background (detailed in the report), which showed an additional increase in 'White – other European' and requested a further understanding of the increase in numbers. The Committee would request the joint commissioners provide an update at the next meeting on the work they are undertaking to understand and address the issues.

AMHP UPDATE

The Committee was informed of the increasing pressure and demand for inpatient beds locally and nationally, both in terms of the number of people being admitted on section and the acuity of patients. The increase in referrals received between midnight and 8am was highlighted. This showed an increase from the 28 (Quarter 1 2020/21) to 57 (Quarter 1 2021/22). The Committee was informed that the increase would continue to be monitored, along with the impact on colleagues – particularly AMHPs and Crisis teams who were having to carry significant risks as a result of there being no beds available. It was suggested that this might be a key risk to refer to the Risk Register. The committee felt that it was vital that messages from the Board and senior leadership team are routinely shared with colleagues re-enforcing that the potential risks faced due to the service pressures are shared and owned collectively.

It was suggested that many of the referrals received between the hours of midnight – 8am were due to a person being in distress but were not necessarily mental health related. It was agreed that this would be analysed further, and an update provided back at the next MHLS Committee meeting. The Committee also asked that further consideration be given to how the lack of inpatient beds could potentially influence and impact the choices of the mental health assessments carried out.

OTHER ITEMS RECEIVED BY THE COMMITTEE

- The Committee received the SCT Concerns of Family policy
- The Committee received the Audit of timings of Hearings.
- The Committee received and noted the review of DOLs Applications

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	20 October 2021

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday 30 September 2021

10:00 – 13:30

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/0921	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0921	Declarations of interest	Assurance	Verbal	Chair
10.05	03/0921	Service User Story Presentation	Assurance	Verbal	DoNTQ
10.25	04/0921	Draft Minutes of the meetings held on: • 29 July 2021	Approve	**Paper**	Chair
	05/0921	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0921	Questions from the Public	Assurance	**Paper**	Chair
Performance and Patient Experience					
10.40	07/0921	Quality Dashboard Report • Respiratory syncytial virus 2021 preparedness	Assurance	**Paper** Verbal	DoNTQ
11.00	08/0921	Patient Safety Report Q1	Assurance	**Paper**	MD
11.10	09/0921	Learning from Deaths Q1	Assurance	**Paper**	MD
11.20	10/0921	Performance Report	Assurance	**Paper**	DoF
11.40am - BREAK – 10 Minutes					
11.50	11/0921	Finance Report	Assurance	**Paper**	DoF
12.00	12/0921	Medical Revalidation Annual Report	Assurance	**Paper**	MD
Strategic Issues					
12.10	13/0921	Report from the Chair	Assurance	**Paper**	Chair
12.15	14/0921	Report from Chief Executive	Assurance	**Paper**	CEO
12.25	15/0921	Systemwide Update	Assurance	**Paper**	DoSP
12.35	16/0921	Operational Resilience and Capacity Plan (including Winter Plan)	Assurance	**Paper**	Deputy COO
Governance					
12.45	17/0921	Annual SIRO Report	Assurance	**Paper**	DoF
12.55	18/0921	Well-Led Governance Review	Assurance	**Paper**	HoG
13.05	19/0921	Digital Update	Assurance	**Paper**	DoF
13.15	20/0921	Council of Governor Minutes – July	Assurance	**Paper**	HoG

TIME	Agenda Item	Title	Purpose		Presenter
Board Committee Summary Assurance Reports (Reporting by Exception)					
13.20	21/0921	Audit and Assurance Committee (12 August)	Information	**Paper**	Audit Chair
	22/0921	Appointments and Terms of Service (25 August & 1 Sept)	Information	**Paper**	Chair
	23/0921	Resources Committee (26 August)	Information	**Paper**	Resource Chair
	24/0921	Quality Committee (2 September)	Information	**Paper**	Quality Chair
Closing Business					
13.25	25/0921	Any other business	Note	Verbal	Chair
	26/0921	**Date of Next Meetings** **<u>Board Meetings 2021</u>** Thursday 25 November **<u>Board Meetings 2022</u>** Thursday 27 January Thursday 31 March Thursday 26 May Thursday 28 July Thursday 29 September Thursday 24 November	Note	Verbal	All

MINUTES OF THE TRUST BOARD MEETING

Thursday, 29 July 2021

Via Microsoft Teams

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

IN ATTENDANCE:
Laura Bailey, Trust Governor
Margaret Dalziel, Deputy Chief Operating Officer
Bob Lloyd-Smith, Healthwatch
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Governance/Trust Secretary
Anna Hilditch, Assistant Trust Secretary

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from Hilary Shand.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Claire to the meeting, who was joined by Trust colleagues Cathy Ford and Angela Willan. Claire was in attendance to speak about her personal experience of anxiety, and a debilitating skin condition, and her subsequent life changing interaction with the Trust's Recovery Team.

3.2 Claire was 36 and lived with her parents in Gloucester. She informed the Board that she had suffered with anxiety for most of her life and this has prevented her from working and in later years has prevented her from leaving her home at all.

3.3 During lockdown last year, Claire's anxiety along with a chronic skin condition meant she had a period of self-neglect which ultimately led to her being sectioned in May 2020 for treatment. After her discharge, things deteriorated, and Claire was on the verge of being admitted again to hospital. However, in

September 2020 Claire was referred to the Trust and colleagues from across GHC worked collaboratively to help Claire both with her physical and mental health. The Trust has a small team of general nurses who are specifically working to improve the physical health of people with serious mental illnesses. This team engaged with Claire and helped with her anxiety around caring for her skin condition, visiting 3 times a week initially to build a rapport and treat her. Since that time her skin condition has improved vastly, and she has also had input from the community recovery team and a psychologist who is helping Claire with her anxieties. Claire has also benefited from community physio and now goes to exercise classes once a week at GL1 and she is currently spending some time at Wheatridge Court for some rehabilitation as part of her recovery.

3.4 Jan Marriott asked Claire whether there was anything that could have been improved for her when she was struggling. Claire said that she had started attending face to face therapy sessions in May 2021 which she had found really helpful and said that she could have benefited from these earlier on.

3.5 Sumita Hutchison asked Claire which of the services she had received had stood out as making the most difference to her. Claire said that the support she had received from Angela and Cathy had been invaluable. She said that her eczema had been very debilitating but they had built up her confidence so she felt able to accept the help and support of the Recovery Team.

3.6 Neil Savage said that people are sometimes fearful of accessing services or asking for help, and asked Claire what message she would give to other people about seeking help. Claire said that she would encourage anyone to seek help. She said that the service had helped her incredibly and she wouldn't be where she was if it wasn't for the support she had received. Angela Willan informed the Board that Claire had fully engaged with the service and had taken everything on board. She had worked really hard. Claire's goal was to use her experiences to become an Expert by Experience and volunteer, possibly working towards becoming a MH nurse. Claire said that she was really proud of herself to see how far she had come over the past year.

3.7 Graham Russell asked Angela and Cathy whether they had any suggestions to put to the Board for further investment or improvements. Cathy said that they had not been made aware of Claire or her situation until she was at crisis point. The service could have got involved with her much sooner and it was important to ensure that patients didn't fall between the cracks. Claire may have been physically well but her mental health state meant that she was unable to leave the house. Angela Willan advised that different approaches were being trialled and the team was working closely with the Trust's Intensive Health Outreach Team (IHOT).

3.8 The Board thanked Claire for attending and speaking about her experiences. This was a positive story and really demonstrated the progress made since the merger in ensuring parity of esteem and improving physical health for people with mental health conditions, and vice versa. Ingrid Barker said that it really did make the Board focus down on those key areas of performance and patient experience, hearing first-hand about the impact and difference that this made to individuals.

4. MINUTES OF THE PREVIOUS BOARD MEETINGS

Board Meeting – 27 May 2021

4.1 The Board received the minutes from the previous Board meeting held on 27 May 2021. These were accepted as a true and accurate record of the meeting.

Extraordinary Board Meeting – 15 July 2021

4.2 The Board received the minutes from the Extraordinary Board meeting held on 15 July 2021. Subject to the inclusion of a question from Steve Alvis regarding heat pumps, these minutes were accepted as a true and accurate record of the meeting. **ACTION**

5. MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action log and noted that all actions were now complete or progressing to plan. There were no further matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 The Board was asked to note that two questions had been received in advance of the meeting. Ingrid Barker asked that these questions, and the Trust's response to them be read out in full and included within the minutes of the meeting. A formal written response to all the questions received for this meeting would be provided in due course.

Question One - Cllr Jeremy Charlton-Wright

I would like to know whether the awful plans can be redrawn, as the proposed new hospital looks more like a garden centre, and not what a hospital should look like.

The images included are artists impressions to demonstrate the shape of the building – the work to finalise the materials, colours and textures etc have not yet been completed and will be part of the next phase of work. We will undertake this being mindful of the natural heritage of the Forest and with input from staff, patients, local stakeholders, the neighbouring residents and the planners and they will form a detailed part of our planning application pack.

I mentioned about both hospitals being awarded "outstanding" in 2012 for healthcare, but any health service provided, automatically includes the surroundings & facilities, the equipment as well as the healthcare provided by the staff working at each hospital.

As you rightly indicate, the facilities and environment do indeed form part of the CQC ratings and the current environment at both hospitals would not be compliant with modern standards. Overall, we currently have a good CQC rating and we anticipate a further review by CQC within the next 12 months.

When the Dilke was built, it was in the centre of the coal mining industry and so acted as a satellite hospital for the outer lying coal mines such as Brierley, Northern United & other mines around there, as well as New Fancy. This is where the bottom line is - can anyone confirm what will

happen with these two sites (Dilke & Lydney) if they were to close, as the Lydney Hospital is on a prime development site.

The business case confirms that both sites will be declared surplus and a disposal plan put in place by the Trust. We are mindful that the sites have been registered as Assets of Community Value due to their significant local and historic value to the communities. We are committed to exploring use by other public sector bodies and working in partnership with third sector organisations and local stakeholders to ensure that all disposal opportunities that offer ongoing public benefit are explored and that our disposal takes accounts of all the options available.

Can confirmation be given that should both hospitals be closed, then the South of the Forest of Dean won't suffer from a lack of healthcare and facilities that are desperately needed now, and not in four or five years' time, and also that services won't be cut before and that there will be an overlap period before any closure.

Gloucestershire Health & Care has maintained a commitment that the current range of services provided at both Lydney and Dilke Hospital will continue until they transfer to the new community hospital, this remains the Trust's intention. Services delivered at the current health centre and in other locations will remain in Lydney until any new primary care facility is developed.
The Clinical Commissioning Group is working with primary care partners to take forward the development of improved primary care facilities in Lydney and is currently starting to scope out a business case. We will be a key partner to this development for the re-provision of the services that we provide within the health centre currently. Whilst this is still in the early procurement stages and a definitive timetable is not yet known, we anticipate this new centre may open in 2025.
In the interim, should new services be agreed or pilots put in place such as a minor injury service run by primary care then accommodation will need to be considered as part of establishing the pilot.

Question Two – Joy Hibbins, on behalf of the charity Suicide Crisis

I would like to ask a question about the Gloucestershire High Intensity Network (GHIN), a service which has been provided for some patients under Gloucestershire Health and Care NHSFT. I refer to a presentation about GHIN which was given to the Gloucestershire Suicide Prevention Partnership (GSPPF) in October 2019, which I found online recently (the link to the document was provided). My question is about the statements relating to "crisis response plans" on page 28. On page 28, within the GHIN presentation, it says "What information would you need to trust a plan?" and then, underneath "Crisis response plans" it gives the reply: "PSD, CQC and Coroner endorsed". Please can you explain what a "coroner endorsed" crisis response plan is (or was) i.e. what kind of crisis response plan is "coroner endorsed"? If a second question is permitted, I would ask the Trust: Were the GHIN crisis response plans "coroner endorsed"?

Lavinia Rowsell informed the Board that unfortunately, it was not possible to respond to this question at the meeting. The reason for this was that the question in part related to a presentation and work being led by other partner organisations, not GHC, and until the Trust could liaise with them it was not felt appropriate to provide a response on their behalf. A full response would be provided to the questioner in due course.

6.2 No further questions were raised at the meeting.

7. QUALITY DASHBOARD

7.1 This report provided an overview of the Trust's quality activities for June 2021. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

7.2 John Trevains informed the Board that overall, the report demonstrated that some fantastic and dynamic work was being carried out and high-quality services were being delivered.

7.3 The report highlighted those Quality issues for priority development to the Board:

- Significant pressures on adult mental health beds persist, a task and finish group led by NTQ has been established to deliver opportunities. RMN recruitment at Wotton Lawn Hospital remains a significant service challenge and further work is being delivered to address this issue in partnership with Operations and Human Resources Directorates. John Trevains assured the Board that good progress was being made.
- There were 4 post-48-hour Clostridium Difficile (C.diff) cases reported in June which is an increase on the figure last month. Regionally and nationally the numbers of C.diff cases are increasing. It is likely that this is associated with increased antibiotic use during Covid-19. Further work is being undertaken to understand in greater detail and this work will be reported upon when results are available. John Trevains offered the Board good assurance that effective reporting processes were in place. Steve Alvis asked whether we were seeing the emergence of resistant strains. John Trevains said that the Trust was working with partners in the county around education in issuing antibiotics, working alongside Public Health and the CCG. This was a piece of work being taken forward by the ICS and John agreed to provide further details about this to Steve Alvis outside the meeting. **ACTION**
- CPA compliance slightly decreased compared to the previous month's figure of 92.4%. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and are setting up weekly schedules with early warnings for reviews that are due. Maria Bond said that it was good to see the progress made in improving CPA compliance, however, the target was 95% and although the Trust was essentially dealing with small numbers, the target was not being achieved and she asked that further

assurance about this position and the recovery plan in place be provided at the next meeting of the Quality Committee. **ACTION**

7.4 Those Quality issues showing positive improvement included:

- The 2 remaining 12 months plus complaints were finalised, reflecting the complex nature of the complaints and the reach over a number of teams, including a legacy complaint from Hereford.
- The Pressure Ulcer (PU) indicators are showing that there have been fewer skin integrity incidents and reduced numbers of pressure ulcers that were considered as avoidable under our care as numbers reduced by 25 between May and June. Early indicators are positive that this is an improving area and that initiatives taken to reduce PU's are effective. Sandra Betney welcomed this update and asked whether the causality behind the reduction in pressure ulcers was known. John Trevains advised that the new initiatives in place would have had a significant impact such as improved first point of contact nursing care, education and quality assessment.
- 'Embedded learning' workshops have now commenced within clinical environments and have been welcomed by front line colleagues. This is a key milestone in our journey to becoming a learning organisation.
- There is ongoing improvement in staff Covid-19 vaccination rates with good progress within the 1stnd dosage of vaccinations for Clinical staff being 82% and 72.8% for 2nd dosage.
- The sickness rolling average indicator was maintained under threshold of 4% this month.

7.5 Maria Bond congratulated John Trevains and his team, noting that the Quality Report continued to improve month on month. She said it was pleasing to see the great improvements reported for children's services discharge planning.

7.6 The Board discussed the continuing pressure on adult MH beds and staffing at Wotton Lawn. John Trevains advised that a system had been established with operational colleagues and reviews were carried out daily looking at patient flow. A standard operating procedure was in place to manage escalation. Paul Roberts informed the Board that Gloucestershire was not an isolated case with regard to staffing challenges or service demand pressures, and this was currently being considered by the National Team. The Trust needed to build this current position into its plans for future investments in mental health, working to develop partnerships with third sector organisations to get better interventions in place so people don't need to be admitted. He said that this was not a quick fix, however, Gloucestershire had managed its capacity well.

7.7 In relation to International Recruitment, the Board noted that in total 30 new physical health nursing colleagues are in the process of joining the Trust. 9 have arrived in the UK and 7 have passed their OSCE to date. New mental health nursing colleagues are joining with additional recruitment underway in this area in July. The Trust has received additional funding to be one of 6 national pilot sites with NHSE and the Queens Nursing Institute to support direct entry into community services for international recruits. The Trust Quality Team

are leading this initiative. Graham Russell asked about the welcome and support package offered to international recruits by the Trust. Neil Savage said that the dedicated support package had some very explicit requirements for pastoral support and the feedback received so far was that this felt supportive and fresh. The Trust also ensured that it linked in with national organisations for additional support.

7.8 Marcia Gallagher noted the reference to "data quality" issues with regard to early intervention in psychosis services. It was noted that this related to the recording of interventions in a timely way, but work was being progressed to address this.

7.9 The Board welcomed this report, noting the developments underway and the good level of assurance provided.

8. LEARNING FROM DEATHS REPORT – QUARTER 4 2020/21

8.1 The Board received the Learning from Deaths report which provided information about the mortality review process and outcomes found during 2020/21.

8.2 Amjad Uppal reported during 2020/21 there were 829 patients who died whilst receiving care from the Trust; whilst as either a physical health inpatient or in the care of the Trust's mental health or learning disabilities services. The occurrence of deaths was as follows:

- 336 in the first quarter
- 182 in the second quarter
- 177 in the third quarter
- 134 in the fourth quarter

8.3 The Board was assured that none of the deaths were judged likely to have been due to problems in the care provided by the Trust.

8.4 It was noted that the findings from the 2019 MH Homicide case had now been shared with all parties, and it was noted that NHSE had sent in an external review team to carry out an assurance exercise. Amjad Uppal thanked John Trevains for the support that he provided to both families during the investigation.

8.5 Steve Alvis noted the development of a second end of life care room at Charlton Lane and asked whether support was being received from physical health colleagues. Amjad Uppal advised that there was close working with a Palliative Care Consultant. He agreed to provide further details to Steve Alvis outside the meeting. **ACTION**

8.6 Ingrid Barker noted that last year had been an extraordinary year. She said that there were a lot of learning points highlighted within the report and sought some assurance on the implementation and impact of these. Amjad Uppal informed the Board that there would be more emphasis on the learning and reflections from serious incidents moving forward, with a Learning Assurance

group now in place, embedded learning workshops and the cascade of "learning on a page". He said that the Trust was always looking to improve and offered good assurance on the mechanisms for doing this.

8.7 The Board noted that the Learning from Deaths reporting would be presented to the Board in a revised format going forward.

9. PERFORMANCE DASHBOARD

9.1 Sandra Betney presented the Performance Dashboard to the Board for the period June 2021 (Month 3 2021/22). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

9.2 Sandra Betney informed the Board that the new proposed National Standards for MH services were currently out for consultation. It was noted that these include 5 waiting list guarantees. Scoping work was taking place and the performance dashboard would be updated to reflect the new standards, once agreed.

9.3 At the end of June, there were 9 mental health key performance thresholds and 9 physical health key performance thresholds that were not met. It was noted that all of these indicators had been in exception previously within the last 12 months. The Eating Disorder (ED) Services account for four of the MH KP indicators. The service continues to face major performance challenges due to a high number of referrals and high vacancy rate. Of the Physical health indicators within exception, four of these relate to CYPS and three to Wheelchair Services.

9.4 With regard to non-exception reporting, the Board noted that there were additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are available for operational monitoring within the online Tableau storyboard. However, it has been agreed that 8 proxy indicators will be re-introduced into the performance dashboard as soon as possible as *internal* KPIs using Statistical Process Control (SPC) limits as thresholds. The remaining 16 proxy indicators will be removed from the active performance reporting schedule but will continue to be monitored and may compliment formal indicators as 'context' narrative in the future. By way of keeping exception reports focussed for the Board, the Board was asked to support the decision that administrative, data quality issues are no longer escalated by exception if clinical quality and safety can be assured, unless there are two consecutive periods of data quality concern. This was supported.

9.5 There are currently 3 Workforce indicators in exception this month. Once again, it is of note that sickness absence is compliant in June (3.8% against a 4% threshold). Progress was being made on agreeing which workforce performance metrics would be included within the performance dashboard going forward. This will lead to a phased process that will be deployed over the year which will provide more granular analysis. Next steps will be presented to the Resources Committee in August 2021.

9.6 Marcia Gallagher noted those services currently in exception and asked how the Board could be assured about the scale of the problems being faced and the expected timescales for resolution. Margaret Dalziel advised that all services had recovery plans in place which were monitored via BIMG and governance structures were in place to support the Refocus, Regroup and Recovery programme. Regular meetings took place and corporate support offered.

9.7 Maria Bond welcomed the BI updates within the report; however, she said that she found these difficult to track through in terms of timescales and progress made. Sandra Betney said that she would be happy to review the presentation and format of this section of the report with the BI Team. **ACTION**

9.8 Further to a question about waiting times, the Board noted that waiting time indicators were included within the dashboard. However, waiting list information was collated and shared directly with operational services. It was noted that there were data quality issues currently being worked through and it was therefore not appropriate for exception dashboard reporting, however, some high-level targets could be pulled out.

9.9 The Board agreed that it would be helpful to receive a collective briefing on the issues around data quality currently being experienced, to gain a better understanding of what the key issues were, how the issues were going to be addressed and by when. Sandra Betney agreed to consider the best way of providing this briefing for Board members. **ACTION**

9.10 Following the questions and discussions received on the report, it was also agreed that it would be helpful to consider how the risks and issues associated with the Regroup Refocus Recover programme should be presented to the Board for assurance at future meetings. It was noted that this would be discussed in more detail later in the meeting.

10. FINANCE REPORT

10.1 The Board received the month 3 Finance Report for the period ending June 2021. It was noted that the final audited accounts were submitted by the 29th June deadline and there were no material movements to the accounts. The year-end surplus remained at £47k. The Trust had received an unqualified opinion from the external auditors on the accounts and the Board offered their huge thanks and congratulations to Sandra Betney and the finance team for this achievement, in what had been a very difficult and challenging year.

10.2 The Trust has an H1 plan of breakeven and the Trust's position at month 3 was a surplus of £42k.

10.3 The cash balance at month 3 is £58.2m

10.4 Capital expenditure was £0.980m at month 3. The Trust has revised the capital plan. The 21/22 plan remains at £15.993m but reflects increases to some buildings scheme costs and reduced backlog maintenance spend. Future years

of the programme have also been amended to reflect rephasing and the inclusion of some leases due to IFRS16. Marcia Gallagher noted that the impact of IFRS16 had been built into the capital programme and was presented in the table under "buildings"; however, she asked that this be presented as a separate line in future reports so it was readily identifiable. **ACTION**

10.5 Marcia Gallagher noted the Trust's plan to breakeven and asked about the impact on this of funding the recently agreed 3% pay award. Sandra Betney advised that this had been flagged nationally by NHS Providers and the consequences to individual Trusts if the pay award was not fully funded. There was likely to be some impact in H1 but nothing had yet been confirmed. Guidance was still awaited on when the pay award would be made.

10.6 Graham Russell noted that the provision for back log maintenance in 2022/23 was 0 and asked for assurance around this figure. Sandra Betney advised that the plan for 2021/22 had been increased to try and push this into the following year. She said that there were no concerns about this currently, with all plans having been assessed at the Capital Management Group, with quality and operational colleagues present.

10.7 The Board noted the Finance Report for month 3 and approved the revised capital programme.

11. CHAIR'S REPORT

11.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in May. 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 the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

11.2 Ingrid Barker was pleased to report that Coln Ward at Cirencester Hospital, was officially named the South West winners in the NHS Parliamentary Awards Care and Compassion category. Coln Ward were nominated by colleagues at the hospital for the way in which they adapted to caring for COVID-19 patients while maintaining the highest levels of care and compassion. The nomination was submitted by Sir Geoffrey Clifton-Brown, MP for the Cotswolds. The Board offered their congratulations to all colleagues involved.

11.3 The Board was asked to note two new appointments in the wider NHS system. Gill Morgan had now been formally appointed as Chair Designate for the Gloucestershire ICS following approval by the Secretary of State. Amanda Pritchard had been appointed as the new NHS Chief Executive. Amanda would be the first female NHS leader. The Board welcomed these fantastic appointments. It was noted that Amanda Pritchard had visited Gloucester the previous week and had commented on the "breathtaking" work taking place. This had been a great visit and outstanding feedback had been received.

11.4 Ingrid Barker said that the past few months had continued to be very busy but she was happy to report that the NED quality visits were now back up and running which was excellent.

11.5 The Board noted the content of the Chair's report.

12. CHIEF EXECUTIVE'S REPORT

12.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in May.

12.2 Paul expressed his continued gratitude to colleagues across the Trust for their management of Covid, noting the Trust had a prudent approach to lockdown easing in place.

12.3 Following approval of the Forest of Dean business case on 15 July, conversations had now commenced on next steps, including securing capital and revenue support from system partners and agreeing the NHSE/I approval process. The submission of a planning application will take place shortly, with building scheduled to start in early 2022 subject to system and regulator support.

12.4 Paul Roberts was delighted to report that GHC had now launched its new Trust People Strategy. This is our new five-year strategy confirming our goals, aims and ambitions for our 5,400+ strong workforce, made up of more than 40 different professions. Our ultimate goal over the next five years is: "To be a healthy and happy high-quality workforce, performing well in all local and national performance standards", with the aim to be a "Great Place to Work". A number of actions and programmes are already in place or planned to realise our people ambitions. The Trust's people strategy was co-produced with our colleagues and by reflecting on what we've been told through the staff survey and other engagement events. The strategy is a collaborative effort and reflects what matters most to our colleagues and sets out our ambitious but realistic plans for the next 5 years. Paul Roberts said that the Trust recognises that our people make our Trust the place it is and taking forward and achieving this challenging agenda will be an area of focus for the Board over the coming months.

12.5 There is a mandatory requirement for the Trust to have a public statement by the Board on its recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act). Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. The Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses. Ongoing assurance from relevant leads within Safeguarding, Procurement, Counter Fraud and HR teams that combatting and eradicating modern slavery is ongoing business as usual work. The Board had approved the Trust's updated statement virtually and this had now been published on the Trust's website.

12.6 Paul Roberts wished to formally record that John Campbell, Chief Operating Officer had decided to step down from his role with the Trust in June. John

made a significant contribution to [2]gether and then, following our merger, to GHC. Indeed, his role in ensuring the merger was grounded in our values and our ambitions for the new organisation was more significant than many will realise. Board and Executive Director colleagues were saddened but respectful and supportive of his decision. In terms of next steps, the Board was aware that the Chief Operating Officer role was a significant and important one for the Trust and Paul Roberts advised that a recruitment process had commenced so that an appointment can be made as soon as possible. In the meantime, Hilary Shand has agreed to continue to act up as Interim Chief Operating Officer with the continued support of executive and senior colleagues.

12.7 Paul Roberts informed the Board that he had attended a virtual discussion for the Gypsy, Roma, Traveller community which had provided an opportunity to hear from the community on any inequalities and injustice that they experience. This also provided a good opportunity to hear their perceptions on health and care as well as vaccination uptake. Marcia Gallagher welcomed this report and she asked for further detail on what the Trust was actually doing with this community and the progress that had been made. Paul Roberts advised that this had been a specific session, however, ongoing links with that particular community were already in place through the Trust Strategy and Partnerships Team. He said that people had made assumptions that the take up of the Covid vaccine would be low amongst the population; however, many expressed the views that vaccination was important and there was a good level of take up amongst that community which was excellent.

13. INTEGRATED CARE SYSTEM UPDATE

13.1 This paper provided an overview of a range of activity taking place across the Integrated Care System.

13.2 Sumita Hutchison noted the Home-Start UK report which included the findings from a piece of national research *Home Is Where We Start From* that has focused on measuring the impact of Covid on parents of young children. Poverty, mental health issues and the social development of children were found to be the three main concerns for parents of young families. Sumita asked how the Trust was addressing the findings from this report. Angela Potter said that this would be embedded into the work of the ILPs and the Trust would be working closely with system partners on this piece of work. Helen Goodey added that Covid had been a catalyst for discussions about population health.

13.3 The Board noted that the Stroke beds at the Vale Hospital were extended from 14 to 20 in September 2020. This had appeared to offer system wide benefits with an increase in stroke audit scores, particularly in the acute trust. A formal pilot has been approved to undertake a full review of the impacts, benefits and pathway in order to determine any long term recommended changes. The results of this would be brought back in due course.

13.4 The Board noted the content of this report, welcoming the breadth of coverage.

14. QUALITY STRATEGY

14.1 The purpose of this report was to present to the Board the draft GHC Quality Strategy – a key part of the emerging Trust Five-Year Strategy.

14.2 The Strategy highlights our quality pledge: To place continuous improvement and working together at the heart of everything we do so that we can consistently deliver high quality care and make the changes that matter to people. It contains our three Trust quality ambitions:

- Safe – Everyone can trust our care will cause no harm and can be accessed when they need it.
- Effective – Everyone receives care that is beneficial, based on evidence and efficiently delivered.
- Experience – Everyone has access to person-centered, responsive and respectful care.

14.3 The Board was asked to note that final changes had been made to previously shared versions of the draft strategy to incorporate comments and requests made from individuals, teams, and various engagement sessions, commissioning colleagues, Trust Executives, and the Quality Committee. Once approved, the strategy would be professionally formatted in line with the Trust Strategy with associated infographics. An accessible version of the strategy would also be made available, to include easy read and versions in different languages.

14.4 Steve Alvis noted that the Strategy only referred to providing services to the people of Gloucestershire and asked whether this could be reviewed to take into account those out of county patients who also accessed Trust services. **ACTION**

14.5 The Board fully supported and endorsed the Quality Strategy, noting that there was good read across to the Trust strategy and other enabling strategies, and there had been excellent engagement with colleagues both internally and externally.

15. ESTATES STRATEGY

15.1 The purpose of this report was to present to the Board the Estates Strategy for final comment and approval.

15.2 The Trust has spent a considerable amount of time engaging with Trust colleagues, system partners and experts by experience to understand what is important from our estate moving forward. This strategy is the culmination of this engagement and co-production and builds on feedback received from members of the Resources Committee.

15.3 Our Estates Vision is “To enable the delivery of outstanding, place-based care by providing high quality settings in the right locations for people”. Our Estates strategy sits as one of our six enabling strategies and it fully acknowledges the inter-relationships between them. It also recognises that not all services are delivered from buildings that we own or lease – but are integrated into our communities with staff working out of health centres and community venues

such as libraries or schools or frequently delivering services in people's own homes. Many of our services are delivered in partnership with primary care, social care and the voluntary sector and our estates strategy will be a key way in which we can continue to facilitate wider integration and partnership working.

15.4 The impact of COVID-19, at a time of major transformational change in the NHS provides a platform for Estates processes, projects and partnership to be re-evaluated and thus this strategy will continue to evolve as a live document to reflect changing working practices and thus estate and building need.

15.5 With a solid foundation of the asset base owned, leased or occupied by the Trust, this strategy outlines the roadmap for embedding technology, adopting efficient processes and working with system partners to realise efficiencies. There are potential developments in the pipeline, a need to consider rationalisation of the estate and, most importantly, a framework to create an Estate over the next 5 years that is flexible, value for money and fit for new ways of working.

15.6 Marcia Gallagher said that it was great to see this key enabling strategy. She said that the Estates Strategy was dynamic and ambitious, and therefore asked for assurance around the Trust's capacity to deliver the proposals set out within it. Sandra Betney advised that work had already started to look at those areas where additional resource was required and some proposals would be shared with the Executive Team for consideration in the coming months. An implementation plan to sit alongside the strategy, to include reference to the resources required would be worked up. Sandra Betney offered the Board assurance that the capital programme did reflect the content of the Estates Strategy.

15.7 Graham Russell noted that preparing the Estates Strategy had been a major exercise and thanked colleagues for the work that had gone into this. He said that a draft of the strategy had been received at the Resources Committee. Having reviewed the strategy again, Graham said that he would welcome additional information such as the scale of the estate rationalisation, interplay with Trust finances, future investment requirements and measures of success. Steve Brittan agreed, noting that the strategy felt qualitative rather than quantitative. Angela Potter said that it was difficult to pin down the metrics as the position was constantly changing and there was a huge amount of data collection required. It was agreed that further discussions about the development of quantifiable measures would be delegated to the Resources Committee. **ACTION**

15.8 The Board supported the broad strategic direction and tone of the Estates Strategy, and this was approved subject to further discussion at the Resources Committee.

16. REFURBISHMENT OF STROUD JUBILEE WARD & MIIU BUSINESS CASE

16.1 The purpose of this report was to present the business justification for the refurbishment of Jubilee Ward and the Minor Illness and Injuries Unit at Stroud General Hospital. The proposed Jubilee Ward refurbishment and the complete

redesign of MIIU are part of an ongoing programme to upgrade the hospital's facilities to the standards expected in the 21st century.

16.2 Jubilee Ward and Stroud MIIU are important contributors to local services. Neither has benefitted from significant investment in recent years and this is now impeding the ability to deliver care. This business case demonstrates a pressing case to upgrade the facilities in both units to meet the standards now expected.

16.3 Schemes have been proposed that will deliver substantial benefits for patients, staff and service operations. The schemes will make notable improvements to patient privacy and dignity, enable better isolation and infection control, improve operational effectiveness through better adjacencies and layout and will greatly improve the working conditions for staff. Much improved air handling will result in a better environment for both staff and patients.

16.4 The Board was asked to note that the preferred option was to proceed with both schemes at the same time, instead of undertaking the work in two separate stages. This would avoid the need for multiple decants and was more economical.

16.5 The Business Case had a value of approximately £1.5m [£1.964m less League of Friends contribution (c £400k) less applicable VAT reclaim]. Steve Brittan asked whether the scheme would still be affordable if this funding from the League of Friends was not received, noting that this had not yet been confirmed. Sandra Betney said that it would be but noted that the capital plan did assume that this £400k would offset overall expenditure.

16.6 The Board noted that the refurbishment would require the vacating of both Jubilee Ward (to be relocated at Cirencester Hospital) and MIIU (with some work retained in booked appointments in Stroud and demand diverted to Cirencester and the Vale). Detailed planning was underway to ensure continuity of service and minimal impact on patient care. Margaret Dalziel said that this would have a significant operational impact; however, she assured that Board that the proposals had the full support of Trust clinicians and project support was in place to manage the transition arrangements.

16.7 Steve Alvis asked whether this business case would include improvements to administrative areas as well. Sandra Betney advised this this was not included in this business case; however, a separate piece of work had been carried out looking at the whole estate to consider administrative working areas.

16.8 Maria Bond supported the decision to proceed with both schemes at the same time for the reasons set out in the report. She did express some concern that the process seemed a little rushed in terms of contractor appointments, also noting that the asbestos survey had not yet been carried out. These points were noted.

16.9 The Board agreed that this was a well-articulated and much needed business case. A robust operational plan was in place to manage the relocation of

services during the refurbishment. The Board was happy to approve the business case, as presented. Thanks, were also expressed to the Stroud Hospital League of Friends for their planned donation which was substantial.

17. SOUTHGATE MOORINGS BUSINESS CASE

17.1 The purpose of this report was to provide a business justification and establish costs for the refurbishment of the ground floor of Southgate Moorings, to enable Board approval to be received for this scheme to progress

17.2 Southgate Moorings (ground floor) requires an upgrade to meet compliance and improve patient and staff experience. The building has 12 years left of a 15-year lease. The ground floor was last refurbished in 2008. The scope of the proposed project includes replacement of the majority of the ground floor's internal fabric, furniture and fittings and mechanical and electrical systems. The project also includes minor improvements externally to secure the waste bins with a new compound for bicycles. The project excludes work to the staff WCs and locker rooms apart from new sustainable lighting.

17.3 The building industry is witnessing significant price rises of between 10-15% across the board leading to increased costs of supply of essential materials. The price rises are not unique to this project, they are also impacting a number of current and planned capital schemes. As a consequence, lead times for orders are lengthening while prices are increasing. The project has been priced by Speller Metcalfe under a framework, and the total project costs are £1,127,026 inclusive. Given approvals the project could start in September and be complete by Christmas.

17.4 Margaret Dalziel presented an operational overview of the business case, setting out the current position and rationale for the business case.

17.5 The Board noted that an initial indicative budget of £750k was allocated in 21/22 for this scheme. Costs have been returned which exceed the original budget allocation. The project team have undertaken a rigorous challenge process with the services involved to minimise the costs of the scheme. The scope of the scheme has undertaken several revisions to reduce the cost to a point where it cannot be reduced further without impacting on the needs and requirements of the service.

17.6 The Board received the business case, and some queries and reservations were made. These included using the contractor (Speller Metcalfe) without following a competitive tender route. There was also a question around the timing of the business case, noting that it would be helpful to have had more time to consider the Value for Money aspect.

17.7 Marcia Gallagher noted that the business case had not been through a Board Committee in advance of coming to Board, and from a governance perspective she therefore felt uncomfortable this this had received no previous NED scrutiny or oversight. Sandra Betney said that she understood the concerns, however, delegated power to approve business cases sat with the Trust Board, not the Committees so prior viewing at a Committee was not required.

17.8 Paul Roberts said that there was a need to be mindful of any delays to progressing this business case in terms of the impact on CDEL. He said that the Trust was committed to the scheme, but he fully appreciated the issues raised by NED colleagues around governance oversight and value for money. He said that he would reflect further on whether this business case should have been presented to the Board at this point, or whether it should have been presented elsewhere first for scrutiny and NED oversight.

17.9 The Board approved the Southgate Moorings Business Case in principle, subject to a rapid review meeting with Sandra Betney, Steve Brittan and Graham Russell. This would then be followed up for final approval at a meeting with Paul Roberts, Ingrid Barker and Graham Russell (as Vice Chair). **ACTION**

18. AUDIT AND ASSURANCE COMMITTEE ANNUAL REPORT

18.1 The Board received the annual report of the Audit and Assurance Committee for 2020/2021.

18.2 The Audit and Assurance Committee 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."*

18.3 This report provided an overview of the Committee's work in the last financial year, from 1 April 2020 to 31 March 2021 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 Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board.

18.4 Marcia Gallagher, Chair of the Audit and Assurance Committee said that she was pleased to present such a positive report to the Board. She expressed her thanks to Sandra Betney and the finance team for their efforts during what had been a very challenging year, noting the earlier reported receipt of an unqualified audit opinion on the 2020/21 Annual Accounts.

19. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING – MAY 2021

19.1 The Board received and noted the minutes from the Council of Governors meeting held on 12 May 2021.

20. BOARD COMMITTEE SUMMARY REPORTS

20.1 Audit & Assurance Committee

The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 26 May 2021.

20.2 Appointments and Terms of Service Committee

Ingrid Barker informed the Board that the ATOS Committee had met twice since the last Board meeting, on 1st and 16th June, with meetings focused on the recruitment process for a new Chief Operating Officer and agreement of the interim arrangements.

20.3 Charitable Funds Committee

The Board received and noted the summary report from the Charitable Funds Committee meeting held on 9 June 2021.

20.4 Resources Committee

The Board received and noted the summary report from the Resources Committee meeting held on 24 June 2021.

The Board was asked to note Chair's action taken outside of the meeting. A new return required this year is the Premises Assurance Model (PAM). The PAM has been developed to provide a nationally consistent basis for assurance for Trust Boards on regulatory and statutory requirements relating to their Estates, Facilities and associated functions. The Trust undertook a self-assessment and overall assessed itself as "good". Prior to submission the self-assessment required Board approval; however, given the timescales this had not been possible at a meeting. A detailed paper and action plans were presented to the Chair of the Resources Committee and assurance was received that the process followed had been robust with evidence based self-assessments undertaken and challenged by colleagues. Actions plans are in hand to ensure those areas not already achieving "good" ratings do so when we re-assess in March 2022. On the basis of the detailed report and assurance provided, the Chair of the Resources Committee had approved the Submission of the PAM assessment.

20.5 Quality Committee

The Board received and noted the summary report from the Quality Committee meeting held on 1 July 2021.

20.6 Mental Health Legislation Scrutiny Committee

The Board received and noted the summary report from the MHLS Committee meeting held on 21 July 2021.

The Committee had noted an increase in detentions of people with an ethnic minority background, which showed an additional increase in 'White – other European' and requested a further understanding of the increase in numbers. The Committee had requested the joint commissioners provide an update at the next meeting on the work they are undertaking to understand and address the issues.

21. ANY OTHER BUSINESS

21.1 For the record, it was noted that the Trust's Quality Account 2020/21 had been formally endorsed by the Board outside the meeting and this had been submitted in line with required timescales.

22. DATE OF NEXT MEETING

22.1 The next meeting would take place on Thursday 30 September 2021.

Signed: ……..….. **Dated: ……**

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

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 30 September 2021

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 No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
27 May 2021	16.4	Future Patient Safety Reports to include trends, as well as improved triangulation of data, and contextualisation such as the inclusion of bed numbers.	Amjad Uppal	November	The patient safety team have approached the BI Team to request their input to present comparable information across our entire inpatient estate as this level of data is not currently available for physical health community hospitals which would likely result in an unbalanced report. An update on progress would be provided back to the Board in November.	
29 July 2021	4.2	Extraordinary Board meeting minutes from the meeting held on 15 July 2021 to include the question asked by Steve Alvis regarding heat pumps, and the response received *(after the meeting by email correspondence).*	Trust Secretariat	September	Complete	
	7.3	John Trevains to provide further details about the increase in C.diff cases and the work being taken	John Trevains / Steve Alvis	September	Complete. Discussed further at September Quality Committee – Increase in cases is believed to be a national issue related to	

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
		forward by the ICS to address this to Steve Alvis outside the meeting.			changes in prescribing through Covid Pandemic. Plan - continue monitoring and reporting though QAG, QC & Quality Dashboard.	
	7.3	Maria Bond asked that further assurance about the CPA compliance position and its associated recovery plan be provided at the next meeting of the Quality Committee.	John Trevains	September	Complete. Discussed further at September Quality Committee – James Wright and Quality Assurance team to supply further update on national changes to CPA guidance and explain how this is influencing compliance.	
	9.7	Sandra Betney to review the presentation and format of BI Updates within the performance dashboard report with the BI Team to ensure this was easy to track through in terms of timescales and progress made.	Sandra Betney	September	In progress. Will be included in September Performance Dashboard.	
	9.9	Sandra Betney to consider the best way of providing a briefing for Board members on the issues around data quality currently being experienced, to gain a better understanding of what the key issues were, how the issues were going to be addressed and by when.	Sandra Betney	September	Complete. Included in report on Board agenda.	
	10.4	Finance report to be updated to reflect the impact of IFRS16 as a separate line so it was readily identifiable.	Sandra Betney	September	Complete. Leases are now shown on separate line	

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
	14.4	Quality Strategy to be updated to also refer to providing services to those out of county patients who accessed Trust services.	John Trevains	August	Complete.	
	15.7	Further discussions about the development of quantifiable measures and metrics for the Estates Strategy would be delegated to the Resources Committee.	Trust Secretariat / Angela Potter	September	Added to Resources Committee work plan for future discussion.	
	17.9	The Board approved the Southgate Moorings Business Case in principle, subject to a rapid review meeting. This would then be followed up for final approval at a meeting with Paul Roberts, Ingrid Barker and Graham Russell (as Vice Chair).	Sandra Betney / Paul Roberts / Trust Secretariat		Rapid review meeting took place, implementation of Business case now progressing.	

AGENDA ITEM: 06/0921

RESPONSE TO QUESTIONS RAISED AT PUBLIC BOARD MEETING – July 2021

Questions Raised: ***Joy Hibbins, on behalf of the charity Suicide Crisis***

I would like to ask a question about the Gloucestershire High Intensity Network (GHIN), a service which has been provided for some patients under Gloucestershire Health and Care NHSFT. I refer to a presentation about GHIN which was given to the Gloucestershire Suicide Prevention Partnership (GSPPF) in October 2019, which I found online recently. This is the link to it below. The GHIN presentation starts at page 15 of the online document. I have also attached it as a PDF document:

https://www.gloucestershire.gov.uk/media/2092932/gsppf-oct-19-workshop-presentation.pdf

My question is about the statements relating to **"crisis response plans"** on page 28.

On page 28, within the GHIN presentation, it says "What information would you need to trust a plan?" and then, underneath "Crisis response plans" it gives the reply: "PSD, CQC and Coroner endorsed".

Please can you explain what a "coroner endorsed" crisis response plan is (or was*) i.e. what kind of crisis response plan is "coroner endorsed"?*

If a second question is permitted, I would ask the Trust: Were the GHIN crisis response plans "coroner endorsed"?

Response:

Question 1:

There was a consultation process in the conception of the Gloucestershire High Intensity Network and a variety of stake holders including HM Coroner's office were consulted. It was felt that a multi-agency and person-centred care plan should stand up to scrutiny, including scrutiny in the event of a serious incident and this is what was needed in the county. The purpose was to improve the quality of crisis plans.

Question 2:

The aim of the GHIN approach is to develop person focused, co-produced (with the person) multi-agency care plans with clearly defined roles and responsibilities which are of a standard which would stand up to external scrutiny in the event of an unfortunate incident. We hope this is helpful and you may wish to direct any further queries to HM Coroner's Office on this subject.

August 2021

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AGENDA ITEM: 07/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD REPORT – AUGUST 2021 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 GHC Board with a summary assurance update on progress and achievement of quality priorities and indicators across Trust physical health, mental health and learning disability services.

Recommendations and decisions required
Board members are asked to:

- **Receive, note** and **discuss** the August 2021 Quality Dashboard

Executive summary
This report provides an overview of the Trust's quality activities for August 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forums for assurance.

Quality issues for priority development

- Pressure on adult mental health beds continues, as does the task and finish group led by the quality team to support opportunities to create capacity. Positively, the situation does appear to be slowly improving and is reflected in the reduction of out of area bed usage reported in this dashboard.
- Wheelchair Services, Podiatry, Physiotherapy and Paediatric Speech and Language Therapy remain under enhanced observation by the quality team noting the additional challenges with referrals and wait times.

- There are no 12 months plus complaints outstanding and all 7+ month complaint cases have their progress reported upon weekly. However, the previously reported backlog remains and though beginning to improve it requires ongoing attention. All the additional resource (2 new experienced colleagues) is now in place alongside a new more efficient process. Reporting zero 6 month + complaints is a 2021/22 Quality Priority for the Trust.
- RMN recruitment at Wotton Lawn Hospital remains a significant service challenge and further work is being delivered to address this issue in partnership with Operations and Human Resources Directorates. This is alongside recruitment challenges recognised in other services notably Integrated Community Teams.
- CPA compliance has decreased further compared to previous month's data to 86.8%. Trust Recovery Teams continue to report increased caseloads, increased levels of acuity alongside staffing challenges. There is a service recovery action plan in place which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due.

Quality issues showing positive improvement

- The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. The percentage of patient safety incidents meeting moderate, severe and death thresholds has decreased to 5.75%. Further data analysis has identified reductions in self-harm incidents at Wotton Lawn and continued good progress from the Pressure Ulcer Improvement programme linked to the reduction in recorded incidents.
- The Pressure Ulcer (PU) indicators report there have been fewer incidents in all categories of (PU) this month. The number of PU's in category 1&2 has decreased by 4, category 3 have decreased by 1 with Category 4 remaining at 0. Indicators are positive that this is a sustainable improving area and that quality initiatives taken to reduce PU's are effective.
- In total 33 new international nursing colleagues are in the process of joining the Trust. 19 have arrived in the UK and it is anticipated that our remaining new colleagues will have arrived by March 2022. It is excellent to note that the first cohorts of international nurses have all passed their accreditation exams and are very much a valuable addition to our Gloucestershire Health Care nursing family. Our international recruitment approach is developing routes for mental health and direct entry community nurses into District Nursing Teams.
- This dashboard reports strong compliance and sustainable process in place for FFP3 mask training requirements.

Are Our Services Caring?

11 complaints were received in June which is slightly more than the previous month. Actions associated with the complaint's recovery plan continue. When considering the trend lines it is encouraging to note that Q2 19/20 showed 30 complaints

received whist Q2 21/22 shows 20, a similar pattern is seen with concerns. Compliments were slightly less than the previous month at 118. The achievement of the 95% FFT target that was achieved last month has decreased by 1% to 94%. It is expected that the figure will improve as services continue on their recovery trajectories. The results of the Non-Executive Director audit of complaints for Q1 have been included this month for Board assurance. An additional audit undertaken by Price Waterhouse Cooper, as part of the Trust audit programme is currently underway, results will be reported when available providing further independent assurance of the quality of complaint handling.

Are Our Services Safe?

The Board are asked to note that overall incident reporting rates have reduced this month and the percentage of patient safety incidents meeting moderate, severe and death thresholds decreased to 5.75%. Additional data is provided which benchmarks pressure ulcer incidence rates against comparable services in the southwest region. The data provides good assurance that our reported levels of pressure ulcers are lower than comparable services in the southwest. We have a positive reporting structure and the additional data and practice development with the network will inform developments in our local teams. We are reporting 1 Clostridium Difficile case in August. VTE risk assessment compliance continues to be in our required level of achievement.

Are Our Services Effective?

In line with the NTQ 'Quality Mapping' exercise further work is taking place in collaboration with operational colleagues over the next quarter to assess a range of specialised nursing services to include; Lymphoedema, Complex Leg, Tissue Viability, Heart Failure, Diabetes and other smaller Trust nursing services. The aim is to develop quality metrics with the clinical teams to expand the data set currently being afforded via the dashboard and increase the range of reporting and improve the visibility for these smaller services. The work will also inform a range of metrics which will underpin our Trust Quality Priorities for 2021/22 which were outlined in July's dashboard and these priorities will begin to be reported upon in the dashboard from Q3. The targets set within the National Childhood Measurement Programme were achieved, however, the School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort, owing to the Covid pandemic, schools being closed from January until the 8th March 2021. The SAI team are working closely with Public Health England (PHE) to agree access to all schools in the area to recover this shortfall. The occupied bed days for "inappropriate" out of area Mental Health placements in August has decreased to 77 days.

Are Our Services Responsive?

Good assurance is available regarding adherence to national PHE admission guidance in order to minimise the risk of nosocomial transmission, whilst supporting an increased demand for Community Hospital beds. In line with system partners and an easing of national lockdown requirements our inpatient units continue to

enable increased visiting. The Vale MIIU reopened mid-August and Stroud MIIU is open to booked appointments only due to refurbishment. Challenges with a range of service access targets is reported within this month's dashboard.

Are Our Services Well – Led

Overall statutory and mandatory training compliance has slightly decreased this month to 85.3% in part due to summer leave and Covid absences impacting attendance. The Tier 1 Oliver McGowan training is progressing well with 21.4% of Trust colleagues now having completed the e-learning session. Appraisal training has shown a decrease this month of 2.4% and further approaches to improve this are being developed. We are offering increased leadership training for staff and funding of £600K has been provided by NHSE/I to create a system-wide Mental Health and Wellbeing Hub to provide support to all health and social care colleagues who work within Gloucestershire ICS organisations. Recruitment to the project has commenced. We are working closely with the Operational recovery and performance lead to ensure that our H&W support are targeted to the areas and services in most need.

Risks associated with meeting the Trust's values

Specific initiatives or targets that are not being achieved are highlighted in the Dashboard. Key quality and safety risks are included 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?
Quality Assurance Group, updates to the Trust Executive Committee and bi-monthly reports to Quality Committee.

Appendices:	Quality Dashboard Report

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

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Quality Dashboard 2021/22

Physical Health, Mental Health and Learning Disability Services

Data covering August 2021

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

Executive Summary

NHS
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This Quality Dashboard reports quality-focussed performance, activity, and developments regarding key quality measures and priorities for 2021/22 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

Are our services CARING?

The number of complaints received in August increased to 11, 2 more than July but comparable to year on year data. The total number of complaints open for 10-12 months remains as previous months and these cases are being prioritised . Work on reducing the backlog continues. At time of writing there are no 12 month plus complaints waiting. **9** of the 11 complaints received in August 2021 were acknowledged within the 3-day target timeframe – of the remaining 2, one was acknowledged within 4 days and the other within 5 days. Unfortunately the achievement of the 95% target FFT that was achieved last month has decreased by 1% to 94% this time however, it is expected that the figure will improve as services continue on their recovery trajectories . The results of the non executive director audit of complaints for Q1 have been included this month for Board , the purpose of the audit is to provide assurance that overall, the Trust is investigating and responding to complaints appropriately and in line with national requirements. An additional audit undertaken by Price Waterhouse Cooper, as part of the Trust audit programme is currently underway, results will be reported when available providing further independent assurance of the quality of complaint handling.

Are our services SAFE?

The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. This was the fewest incidents reported in a month for this financial year. The Patient Safety Team validate and analyse changes monthly and note a reduction in self harm incidents at Wotton Lawn and a number of expedited reviews of grade 1 pressure ulcers which is associated with the overall improvement programme. The percentage of patient safety incidents meeting moderate, severe and death thresholds has also decreased to 5.75% which is the lowest reported figure this year .There are currently 7 active SIRIs. Enhanced detail is provided again this month regarding ongoing developments to improve pressure ulcer (PU) management and there are continuing indicators of improvement in this area. Additional data is provided which benchmarks PU incidence rates against comparable services in the southwest region. We are pleased to report that zero C-19 deaths were reported by GHC inpatient services during August. As of 25/08/21, 84% of patient facing GHC staff have received their first vaccination for C-19 and 75.4% have received their second. Systems remain in place to vaccinate all eligible inpatients and vulnerable service users. Preparations are being made to deliver booster vaccinations to appropriate groups. We are reporting 1 Clostridium Difficile case in August and Health Care Acquired Infections (HCAI) reporting has replaced the historical safety thermometer data in the dashboard. HCAI's are being monitored through our Trust Infection Prevention Control Team (IPC) and reported into Quality Assurance Group for executive oversight.

Are our services EFFECTIVE?

Development work continues in collaboration with operational colleagues over the next quarter to assess a range of specialised nursing services .The aim is to develop quality metrics with the clinical teams to expand the data set currently being afforded via the dashboard and increase the range of reporting and improve the visibility for these smaller services. The occupied bed days for "inappropriate" out of area Mental Health placements in August has decreased to 77 days which relates to 9 patients. The surge in demand for inpatient beds continues with increased levels of acuity and dependency observed amongst inpatients which has has resulted in a shortage of bed availability. A task and finish group to improve Adult Mental Health admission and discharge pathways led by the Director of NTQ s demonstrating progress in improving bed access. Vacancies and Covid absences has had an impact on services with wait times for routine appointments within Occupational & Physiotherapy and Podiatry being extended. GHC maintains a vital role in system-wide patient flow and work continues through reablement, community hospital, MIIU's and ICT's to support the wider physical health system. The Child and Adolescent Mental Health Services have completed a small scale evaluation of the waiting list and have implemented a 'Waiting List Support Clinic'. This will be in addition to the triage service and the signposting already in situ to support demand. Service recovery work , led by operational colleagues continues.

Are our services RESPONSIVE?

Good assurance remans in place demonstrating adherence to national IPC admission guidance in order to minimise the risk of nosocomial transmission , set against the challenges of increased demand for Community Hospital beds. The Vale MIIU has re-opened. The Dilke remains closed and Stroud MiiU is open to booked appointments only due to refurbishment .CPA compliance has decreased compared to the previous month's figure to 86.8% with the majority of outstanding cases being within recovery. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are focusing on raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due. The quality team continue to supporting operational colleagues regarding 'access pressures' in services , as reported through resources committee.

Are our services WELL LED?

Statutory and mandatory training compliance has shown a slight decrease this month to 85.3%, this was anticipated over the summer due to annual leave, the position will be closely monitored to ensure that it is recovered in the coming months. Positively, the overall training compliance figure minus staff bank has increased to 93.3% .The current focus on Physical Intervention training shows fluctuation in the improvement levels along with some plateauing of numbers due to holidays and absence, focus will continue on the specific wards with lower compliance and in ensuring that the improvements are maintained. Work continues to improve appraisal rates and conversations are taking place with staff side representatives to evaluate paperwork and to look at ways to improve completion rates . Sickness absence levels have risen marginally above the 4% target for both indicators but Staff health and wellbeing remains a priority. Funding of £600K has been provided by NHSE/I to create a system-wide Mental Health and Wellbeing Hub . The Hub has a "Go Live" Date of 4th October and the first staff member started in September .The first designs for the "brand " have gone out for consultation . Progress against the many challenges is being achieved at pace with this exiting and innovative project .Registered Nurse international recruitment continues with a total of 30 RGN's and 3 RMN's being appointed and it is planned that all of these will be in post by March 2022.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

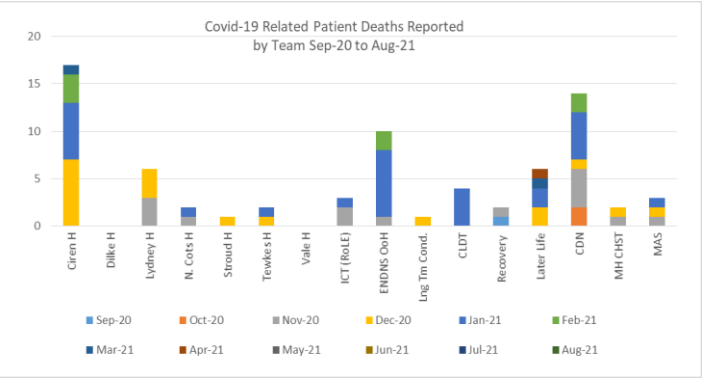
COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

No	Reporting Level	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A	Exception Report?
No of C-19 Inpatient Deaths reported to CPNS	N-R	66	0	0	0	0	0								0		
Total number of deaths reported as C-19 related.	L-R	161	0	0	0	0	0								0		
No of Patients tested at least once PH	N-R	2004	281	298	306	322	262								1469		
No of Patients tested at least once MH	N-R	775	157	129	169	176	167								798		
No of Patients tested C-19 positive or were admitted already positive PH	N-R	322	0	0	2	2	1								7		
No of Patients tested C-19 positive or were admitted already positive MH	N-R	33	0	0	0	1	2								3		
No of Patients discharged from hospital post C-19 PH	N-R	271	9	0	1	1	1								12		
No of Patients discharged from hospital post C-19 MH	N-R	28	1	0	0	1	1								3		
Community onset (positive specimen <2 days after admission to the Trust)	N-R	30	0	0	2	3	1								5		
Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)	N-R	6	0	0	0	0	0								0		
Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)	N-R	10	0	0	0	0	0								0		
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust	N-R	27	0	0	0	0	1								1		
No of staff and household contacts tested	N-R	3123	65	76	342	221	211								915		
No of staff/household contacts with confirmed C-19	L-R	323	0	0	28	25	29								82		
No of staff self-isolating: new episodes in month	L-R		34	40	153	223	199										
No of staff returning to work during month	L-R		29	30	100	210	169										
No staff GHC who received Covid-19 vaccine first dose		4046	17	8	8	7									40		

Additional Information

Patient Reporting: The number of Covid-19 (C-19) related inpatient deaths remains at zero for the fifth consecutive month with zero inpatient deaths meeting criteria for national reporting to CPNS being reported in April - August 2021. The number of community patient deaths reported as C-19 related also continues as zero. C-19 related patient deaths since Sept 2020 by team/hospital site are shown in the chart opposite, previous year data being included for comparison. One Gloucestershire NHS partners agreed to declare a countywide serious incident for HOPHA and HODHA Covid-19 cases in our hospitals in response to NHSE/I guidance. The work identifying the level of harm for each case, as a result of acquiring Covid-19, will be completed by mid-October with Duty of Candour letters being prepared with the aim of sending this by the end of October. Case reviews have commenced and the learning will inform both internal and system wide learning.

Staff Testing : The numbers of staff being tested has reduced and will continue to monitored going forward .



COVID-19 - KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

- August data - 84 % “frontline” workforce received first vaccine; with 75.4% having received their second dose. 69% BAME colleagues received first vaccine and 61.4% received their second as at 25/08/2021.
- Vaccine uptake data is monitored weekly and submitted to NHSE/I every 14 days
- Workstream in place led by Working Well to enhance uptake that includes staff conversations to compassionately address vaccine hesitancy
- Proactive and targeted communication in place with intention to reinforce the importance of second dosages.
- Pop up clinics remain in place to support enhanced access for staff
- Systems remain in place to vaccinate all eligible inpatients and vulnerable service users as required with consent.
- Preparations are in place to deliver booster vaccines to identified groups and support the recently announced 12-15 yr old programme

Validated Data as of 25-8-2021

ROLE	TOTAL NUMBER Aug 2021	1ST VACCINE (up to 25/08/21)	%	2nd VACCINE (up to 25/08/21)	%
All doctors/dentists	127	111	87	97	76.4
All qualified nurses, including students	1444	1223	85	1086	75.2
All other professional qualified staff	780	671	86	617	79.1
Support to clinical staff	1872	1549	83	1384	73.9
TOTAL GHC CLINICAL STAFF	**4223**	3554	84	3184	75.4
NHS infrastructure staff	358	245	68	198	55.3
TOTAL GHC WORKFORCE	4581	3799	83	3382	73.8

COVID-19 - KEEPING STAFF SAFE

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 Trust continues to maintain 14 days supply of all key PPE items at central stores and are maintaining 14 days of supplies at each PPE locality hub.

The Local Resilience Forum (LRF) has now been brought in to the Trust's PPE stores and distribution processes, a collection model has been set up to facilitate access to PPE for social care.

Transparent masks

Following confirmation from NHSEI that there are currently no transparent masks with sufficient assurance on suitability for health and care settings available,
GHC have completed a risk assessment which has enabled us to use transparent masks where need when working with people with acute communication challenges but with additional guidance for colleagues on the considerations that they should have when determining to use transparent masks.

Lateral flow (Asymptomatic testing)

Following the decision at national level to move the provision of lateral flow kits to an 'individual pull' model the Trust have now ceased providing lateral flow kits to individuals. This means that colleagues will now request their own lateral flow kits (7 tests at a time) to be delivered to their home or they can collect them from a test centre or a pharmacy. Colleagues will then report these results via the national reporting tool. The risks are that the process of ordering could result in reduced use of lateral flow tests and that the Trust will also lose its oversight of the reporting process, whilst the benefit is that this will remove the need for storage and distribution of kits within the Trust . However, as yet we don't know when or how the data from national submissions will be provided to GHC. There are currently reserve boxes of lateral flow tests in stock and we will continue to utilise all of these at the most appropriate places prior to their expiry date to avoid waste of resources.

FFP3 fit-testing

The new fit tester/co-ordinator commenced in role in August and is working towards the Trust meeting the requirements as detailed in a letter received from Department of Health and Social Care . Although this directive was to Acute Trusts, GHC will work towards delivering these requirements . This will, at an operational level be co-ordinated by the Fit tester/co-ordinator within the stock team and progress against each requirement will be reported via the Fit Test Oversight Meeting and through to this Quality Dashboard. The refreshed GHC Fit Test Strategy is now in final draft form and includes the Key Success of the programme to date:

- We have successfully tested 1257 staff members for an FFP3 mask throughout the Trust in 2021. This has brought our current overall compliance rate to 95%.
- Through the Covid Stock Management Team, we have created a safe and reliable supply system for masks. This has ensured that we can depend on the ongoing availability of masks that our staff have been tested on.
- The ""Request a Test" process has been created to make receiving a test more accessible to a wider range of staff.
- The Trust has created a role of Fit Test Co-ordinator. The co-ordinator's role is not only to Fit Test throughout the trust to ensure a high compliance rate, but to ensure that Fit Testing continues to be a priority for our staff's safety.

Programme development plan for the next 6 months:

- Strive to test all regular AGP users on two different types of masks. This is so that, if a mask is recalled or the stock becomes unavailable the staff will not have to delay urgent tasks or be unable to give care to patients.
- Ensure that staff tested on two masks are able to regularly alternate what masks they wear.
- Ensure that a range of FFP3 masks are available to users on the frontline and should not exceed 25% usage on any one type of FFP3
- Register FFP3 users and fit test results in ESR and review individual usage every quarter.

Quality Dashboard

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

No		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
	Number of Friends and Family Test Responses Received	N - T		11990	1786	1490	1562	1552	1118								7508			
	% of respondents indicating a positive experience of our services	N - R	95%	94%	92%	94%	94%	95%	94%								94%			
	Number of Compliments	L - R		1478	149	123	129	131	118								650			
	Number of Concerns	L - R		390	41	34	37	37	34								183			
	Concerns escalated to a formal complaint			14	1	3	4	2	2								12			
	Number of Complaints	N - R		83	11	11	11	9	11								53			
	Number of open complaints (not all opened within month)				76	79	82	86	88											
	Percentage of complaints acknowledged within 3 working days		100%	96%	73%	91%	100%	100%	82%								89%			
	Number agreeing investigation issues with complainant				15	17	13	12	20											
	Number of complaints awaiting investigation				4	0	2	3	2											
	Number of complaints under investigation				10	15	21	19	22											
	Number of Final Response Letters being drafted				44	43	45	49	43											
	Number of Final Response Letters awaiting Exec sign-off				3	1	1	1	1											
	Number of complaints closed				7	9	8	7	8								39			
	Number of re-opened complaints (not all opened within month)				5	6	6	6	7											
	Current external reviews				4	4	4	3	3											

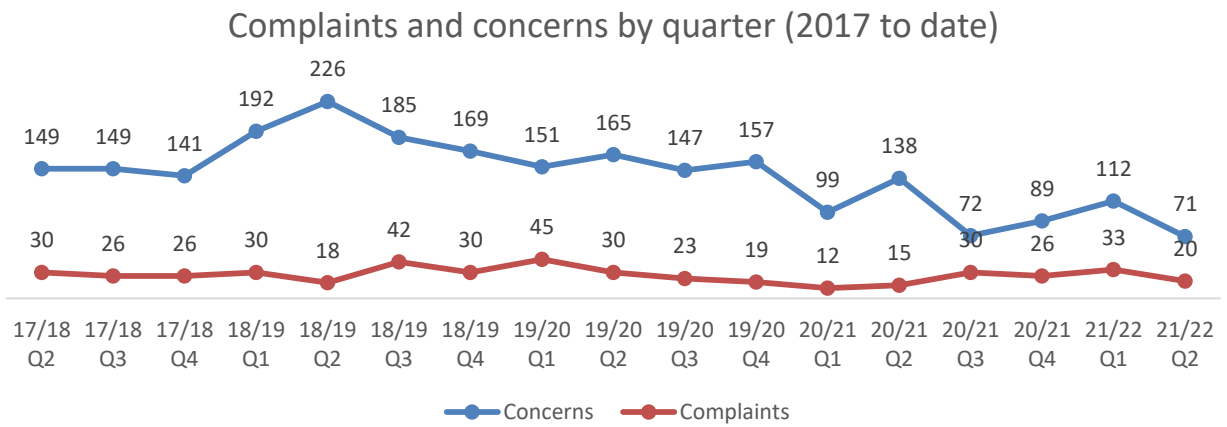
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure 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 CARING? Patient and Carer Experience Team (PCET)

Complaints, concerns and compliments

- The average number of complaints received in August over the past four years is **9**. In August 2021 we received **11 complaints**.
- In August 2021, **8** complaints were closed: **2** were withdrawn, **1** was upheld, **1** was partly upheld, and **4** were not upheld
- **34** concerns were raised in August 2021, which is slightly more than the monthly average of 32 concerns during 2020/21.
- **118** compliments were received in August 2021, which very slightly more than the monthly average of 123 during 2020/21.



This chart summarises the number of complaints and concerns received by quarter since 2017/18. This offers assurance that services are not receiving a significant increase in complaints in 2021/22. The impact of Covid-19 (national pause, redeployment, services in recovery), PCET staffing challenges, and a cluster of complaints received in November and December 2020, have all contributed to the current increase in complaint response times.

Assurance regarding complaint management

- Each complaint is triaged to check for any immediate actions required. Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- The Non-Executive Director Audit of complaints for Quarter 1 2021/22 was reported in July 2021.
- Price Waterhouse Cooper are currently undertaking an audit of complaints closed between 1st April 2021 and 31st July 2021 – results will be reported when available.

Satisfaction with complaints/concern processes

- **7** active re-opened complaints – we openly encourage complaints to challenge responses they are not fully satisfied with
- **40** concerns were closed in August 2021, **2** of which were escalated to a complaint

External review

- There are currently **3** complaints with the PHSO for external review.

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

Timeframes

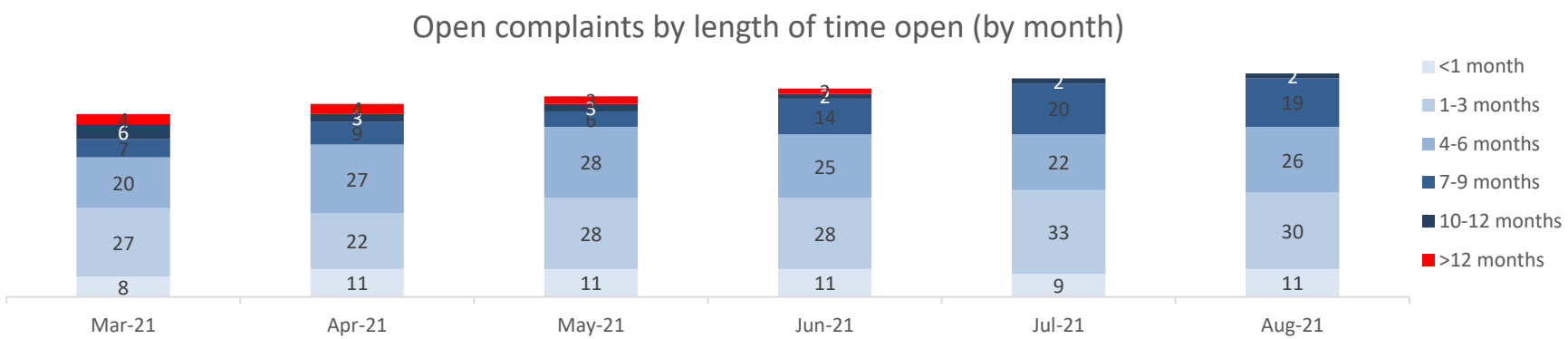
- PCET remains in active recovery following the national pause in the complaint management process between April and June 2020.
- **9** of the 11 complaints received in August 2021 were acknowledged within the 3-day target timeframe – of the remaining two, one was acknowledged within 4 days and the other within 5 days.

- Of the **88** open complaints, **18** do not have agreed response times. Of these:
  - **13** are in the very early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set.
  - **5** are complaints being managed by other NHS organisations, for which we are providing input/comments.

- Of the **70** complaints with agreed response dates:
  - **18** are within the agreed timeframe
  - **52** have exceeded the initially agreed timeframes, and there are a range of reasons for these delays including:
    - Agreeing issues for investigation with complainants
    - Delays in the investigation process (e.g. allocating investigators, timeliness of investigation report, and availability of staff for interviews)
    - Delays in the drafting and review of final responses (e.g. capacity, quality of investigation, availability of staff to review draft responses)
  - Work is underway to address delays in the complaints process in order to minimise them where possible

The chart below shows the length of time complaints have been open (please note that it can take up to approx. 8 weeks to agree issues with complainants depending on complexity and availability). The PCET are focusing efforts on completing responses for those open for the longest period. A weekly meeting provides high-level oversight of the complaints tracker. Fortnightly updates to the Director of NTQ are in place and regular briefings to the Board and Quality Committee provide assurance of recovery.

Additional resource has been secured via redeployed colleagues and 2 existing members of the team have agreed to temporarily increase their working hours. Additional investment has resulted in recent recruitment to 2 additional substantive posts, and one fixed term 12-month contract to support complaint response times. Further support has been supplied by senior NTQ colleagues to assist with final response letter completion and to increase triangulation with patient safety and Freedom to Speak Up learning. The Trust Quality Improvement Team are undertaking a LEAN assessment to identify process improvements and areas for efficiency.



ARE SERVICES CARING? Non-Executive Director audit of complaints Q1 2021/22

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 auditor (NED)
- The Patient and Carer Experience Team (PCET) 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 summarised within the table on the following slide
- The Q1 2021/22 audit provides assurance that overall, the Trust is investigating and responding to complaints appropriately. Of the 3 complaints that were audited, 2 related to Herefordshire based services
- Delays in responses have been recognised and work continues to address the backlog of complaints. A Recovery Plan is in place using QI methodology to improve processes. Additional resource and capacity within PCET have been delivered. Waiting response times are monitored via fortnightly report to the Director of Nursing, Therapies and Quality report and monthly Quality Dashboard.

FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS

- To note the contents of the report
- To note the assurances provided regarding the Trust's management of complaints

NHS
Gloucestershire Health and Care
NHS Foundation Trust

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q1 2021/22					
	Time scale of response	**Quality of investigation**	**Accessibility, style and tone of letter**	**Learning actions identified**	**Comments**
Complaint 1 • Family raised concerns regarding communication about their relative's care and treatment during an inpatient stay and changes to visiting restrictions due to the pandemic	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and the Trust's recovery following national pause in complaints	**FULL ASSURANCE** • Thorough investigation acknowledging failings appropriately • Issues clearly identified with evidence to support conclusions • Need to ensure the acknowledgement of distress families experience of not living locally and being able to visit their relatives	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate	**FULL ASSURANCE** • Learning identified and shared	
Complaint 2 • Family raised concerns about care and support provided during an assessment appointment (Herefordshire)	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and the Trust's recovery following national pause in complaints	**LIMITED ASSURANCE** • Investigation limited as the member of staff involved was unable to be interviewed as they no longer work for the Trust • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate	**FULL ASSURANCE** • Investigation findings shared with Worcestershire Health and Care NHS Trust to consider and take forward	• Outlined actions to be considered regarding learning if the staff member was still employed by the Trust
Complaint 3 • Family raised concerns about the care and support provided to their child by CAMHS (Herefordshire)	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and the Trust's recovery following national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate and acknowledged perceptions of the family's experience	**FULL ASSURANCE** • Investigation findings shared with Worcestershire Health and Care NHS Trust to consider and take forward	• Timing of providing information to a young person regarding options for ongoing support from adult mental health services

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

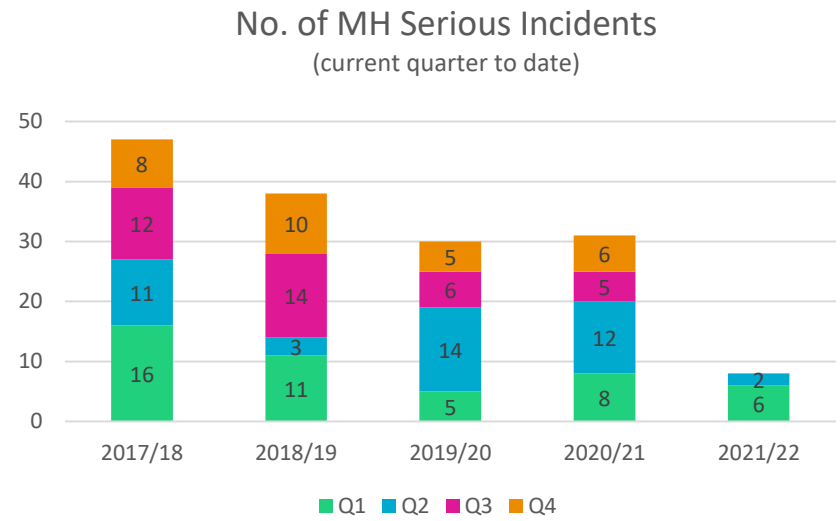
		Reporting Level	Threshold	20-21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021-22 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	0	0	0	0	0	0								0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	4	3	1	2	1								11			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		1	1	1	0	0	0								2			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		3	0	1	0	0	0								1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		2	0	0	0	0	0								0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		15	3	1	1	1	0								6			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		10	0	0	0	0	0								0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		0	0	0	0	0	0								0			N/A
	Total number of Patient Safety Incidents reported	L - R		12474	985	1185	1070	1026	921								5187			N/A
	% incidents resulting in low or no harm	L - R		93.41%	92.99%	91.05%	92.34%	93.37%	94.28%								92.72%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		6.59%	7.01%	8.95%	7.66%	6. 63%	5.75%								7.29%			N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.75%	1.10%	2.17%	2.78%	0.00%	1.75%								1. 53%			N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.83%	0.00%	1.64%	0.00%	0.00%	1.64%								0. 69%			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	1	0	1	0	0	0	0	0	0	0	0	2			N/A

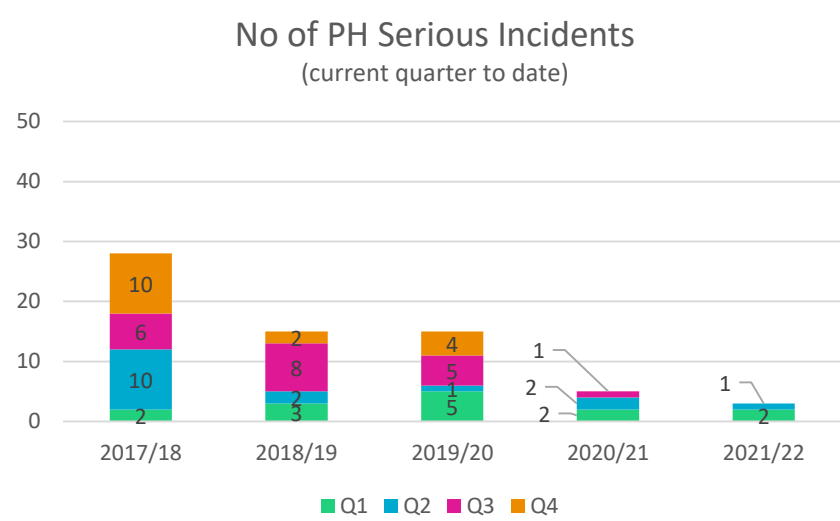
N - T	National measure/standard with target	L - I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L - R	Locally reported (no target/threshold) agreed
L - C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure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

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

CQC DOMAIN - ARE SERVICES SAFE? – additional information

One SIRI was declared in August 2021, regarding commissioning of dental equipment. This resulted in disruption to service provision and due to potential risks was considered as an SI, we are fully assured no patient harm occurred but we are keen to fully investigate to prevent reoccurrence . All incidents were escalated in line with SIRI reporting requirements. The Patient Safety Team continue to monitor regional and national trends in terms of suicide rates and work towards our Trust's zero suicide ambitions . The tables below represent SIRI reporting over the past 5 years. These reports are stimulating good clinical discussions across operational governance forums and the Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues.





There are 7 active SIRIs, at the time of writing, a Final Report had been submitted to commissioners on 1 September, leaving 6 in process. One active SIRI investigation is likely to complete outside of statutory time frames. An extended submission date for the final report has been agreed with commissioners and remains in place, this is due to compassionate engagement with the family of the deceased at a pace to suit them rather than suit the process. The preliminary investigation has been completed and an internal review held; the final report is being completed. One active SIRI has been formally paused by commissioners whilst GHC awaits detailed information from Gloucester Hospitals NHSFT.
Regarding all patient safety incidents:

- The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. This was the fewest incidents reported in a month for this financial year. The Patient Safety Team validate and analyse changes monthly and note in this reporting period a reduction in self harming incidents at Wotton Lawn and a number of expedited reviews of grade 1 pressure ulcers which is associated with the overall improvement programme.
- The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from July (6.72%) to August (5.75%).
- 2 falls resulted in moderate and above levels of harm in August.
- 1 medication incident resulted in moderate and above levels of harm in August.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.0%	97.2%	98. 7%	98.7%	100%	98.4%								98.6%	G		
	Number of post 48 hour Clostridium Difficile Infections (C Diff)	N	1		1	2	3	3	1								10	R		
	Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0			0	0	0	0								0	N/A		
	Number of MRSA Bacteraemia	N	0			0	0	0	0								0	N/A		
	Total number of developed or worsened pressure ulcers	L - R	61	797	84	64	70	61	56								335	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	698	75	60	59	57	53								304	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	70	8	1	9	4	3								2	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	29	1	3	2	0	0								6	R		

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

HCAI

- 1 post 48-hr Clostridium Difficile (C. Diff) cases was detected in August. The case was identified at Abbey View ward at Tewkesbury Hospital . A post incident review (PIR) meeting for the clinical team, facilities, pharmacist and IP&C has been arranged as per protocol to discuss if there are any lapses in care that may have contributed to patient acquiring a C diff infection, or lapses in care of management of C diff. The IPCT discuss any themes or lessons to be learned with the Consultant Medical Microbiologist. The Infection Prevention and Control team are continuing to review the C. Diff policy and associated documentation following a change to initial first line treatment with the aim of achieving a One Gloucestershire approach to the management of C.Diff.

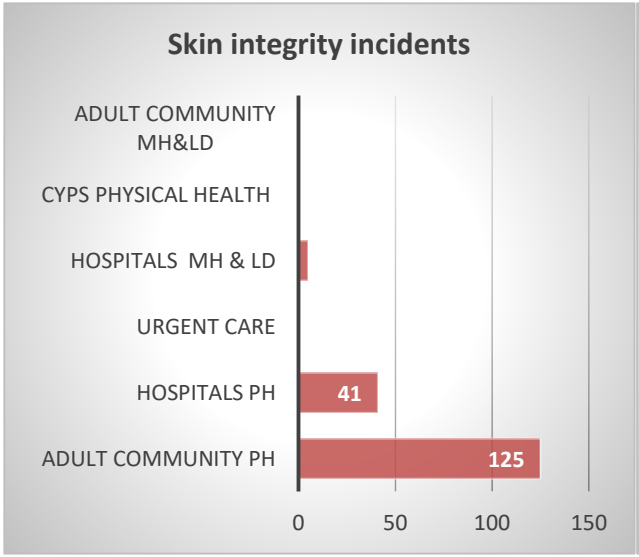
Pressure Ulcers

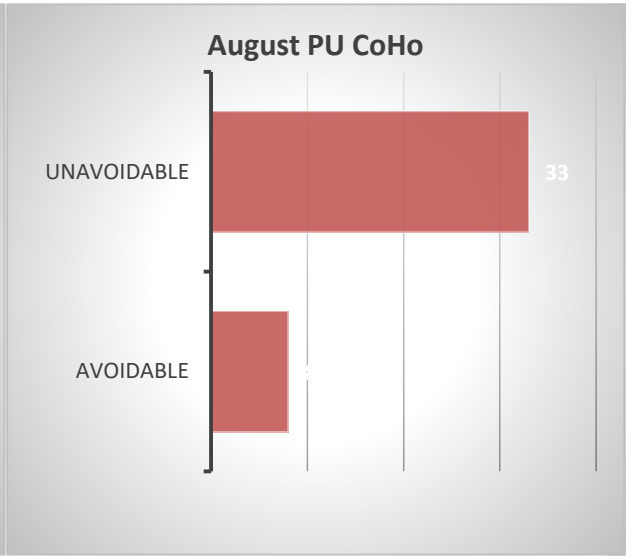
- The Trust has reported fewer skin integrity incidents this month. The active work with teams continues in terms of improving practice to meet significant rising demand in pressure area care referrals from primary care and care homes. Following the success of the Gloucester Quality Improvement (QI) Pressure Ulcer (PU) plan the Forest & Tewkesbury, Newent & Staunton (TNS) QI PU approach is currently in the 'do' stage of the Plan, Do, Study, Act improvement methodology (PDSA) cycle. Leadership from operational managers and clinicians in Gloucester and Forest remains at a high level and the Datix team have provided historical data from these areas that has supported the development of a baseline for improvement focusing on category 2 damage.
- Further to the success of the 'Datix dashboard oversight' these are now available to all community ICT managers and their senior teams. This has resulted in timely review of Datix incidents and thematic review for teams as well as assurance and governance oversight for the trust.
- Educational webinars highlighting PU categorisation continue and these will be uploaded onto care to learn in September. The Tissue viability page has been relaunched on the trust's intranet and includes pressure ulcer resources. Tissue viability and District Nursing leads from neighbouring trusts are scoping a community benchmarking collaborative with initial data sharing planned in September.
- The 20 minute open invite for a focussed District Nurse discussion on safe and effective pressure area assessment, monitoring and management will be repeated in September following requests from colleagues. The focus will continue to be sharing the national and local themes observed in relation to PU incidence and severity, encouraging debate and involvement in improvement.
- Additional clinical support has been made available to review the most severe pressure ulcer damage: Category 3,4, suspected deep tissue injury and unstageable pressure ulcer Datix reports are all reviewed for any errors in categorising PU's at the end of each calendar month. The monthly reports can be rerun and enable accuracy of submission and numbers.

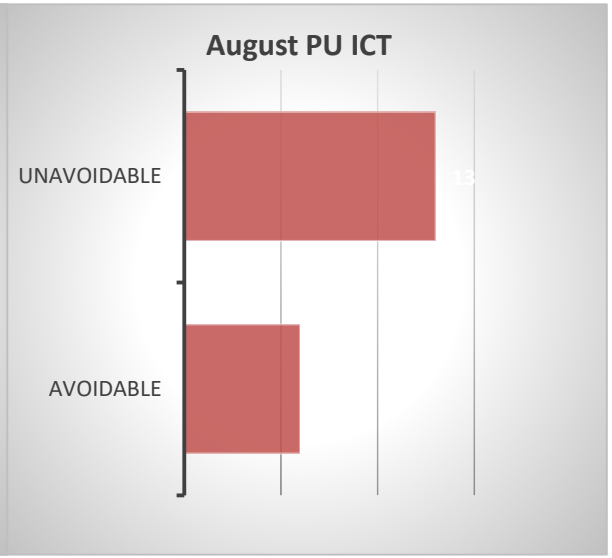
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure 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?
Pressure Ulcers – August 2021 Additional Information Trust Wide







Bar chart showing skin integrity incident reports per service.

- Adult community PH: 125
- Hospitals PH: 41
- Urgent care & specialist services:1
- Hospitals MH & LD: 5
- Adult comm. Mental Health & LD 0
- CYPS Physical Health 1

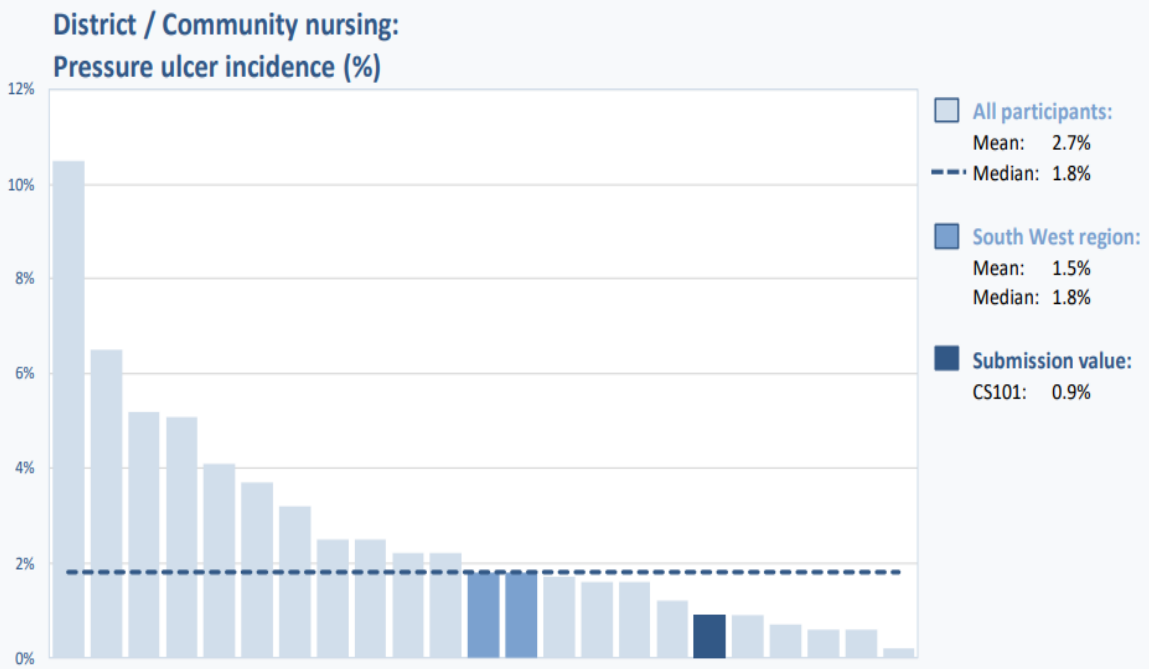
Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in August 2021

- Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed*** as being unavoidable or avoidable because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 33 unavoidable
- 8 avoidable

Bar chart showing data reported in community PH in August 2021

- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed by handlers*** as being unavoidable or avoidable. These decisions may have been made because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 13 unavoidable
- 6 avoidable

CQC DOMAIN - ARE SERVICES SAFE? Pressure Ulcers – June 2021 datapoint - Additional Information



Submission CS101: Gloucestershire Health and Care NHS Foundation Trust
Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. Pressure ulcer incidence can give an indication of the quality of care.
At 0.9% the submission's response was below average. This compares to a median value from all participants of 1.8%.

Benchmarking Data:

The table provides benchmarking information from the NHS Benchmarking Network High Performance Report. It provides a systematic review of high performance from Network projects and a review of the Network outputs that support the exchange of good practice and innovation.

The GHC Pressure Ulcer Lead is part of a benchmarking network made up from services in Oxford, Buckinghamshire & Bristol. The aim of the group is to develop practice and share data on pressure ulcer incidents and severity.

We are now moving our improvement work into business as usual. The data table provides good assurance that our reported levels of pressure ulcers are lower than comparable services in the southwest. We have a positive reporting structure and the additional data and practice development with the network will inform developments in our local teams.

Quality Dashboard

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CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R / A / G	Exception Report?	Benchmarking Report
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:14	0.14	0.12	0.16	0.15	0.13								0.14	G		
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	96.00%	96.60%	96.60%	96.80%	91.3%	76.3%								91.52%	G		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	89.80%	97.00%	95.50%	93.80%	90.8%	91.1%								93.64%	A		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	93%	96.10%	96.70%	96.90%	93%	94.0%								96. 34%	G		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	94,8%	97. 1%	95.50%	96.50%	71.2%	58.8%								83.82%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	96.00%	99.10%	99.50%	98.90%	98.2%	98.0%								98.74%	G		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	97.8%%	95.70%	98.90%	97.70%	99.4%	99.4%								98.22%	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	28960	3101	2920	1339	1305	1190								10036	R		
	Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	TBC	82.70%	82.20%	65.40%	50.0%	72.3%								70.52%	R		
	Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	TBC	62.50%	92.3%	80.00%	93.7%	92.8%								84.26%	A		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	91.80%	94. 9%	92.80%	92.20%	89.09%	86.8%								91. 32%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	99.50%	95.20%	100%	100%	96.5%	100%								98.34%	G		

Additional information

Physical Health

Podiatry – Treatment times have been impacted in month due to an increase in referrals rates, supporting annual leave requests against a pressure of increased sickness absence and a number of staff having to self isolate. New members of the team start in September and will help mitigate against the increased challenges noted in this reporting period.

Community OT and PT (ICT) - The service is experiencing a high demand for OT and PT emerging from the Home First (HF) and Reablement pathways combined with the MDT referral desk activity. Available workforce are managing immediate demand which supports hospital discharges and admission prevention, but people are now waiting longer for routine and long term assessments. There is an expected increase of 7.0 wte funding for therapy resources to support the HF model, but this may not be sufficient to address the backlog developing in the routine care waiting lists. Additional work is being undertaken with the service leads to fully understand the effect and this will inform the recovery action plans. **Paediatric SLT** : There are significant gaps in service due to maternity leave and vacant posts. Additional recruitment is planned as part of the overall recovery plan. The service continues to offer a blended model of delivery based on clinical need and risk assessment and is also setting up an advice line and training for schools, and increasing the resources available to schools on their website in anticipation of increasing demand in the new academic year. Face to Face delivery will start again at Rikenel following the completion of works and new clinic space being made available

.

Wheelchair Services :The current waiting time for adults is below target although improved marginally this month, whilst the time for under 18's is above target . The service has been balancing planned annual leave with episodes of staff sickness within the same time period ,this has reduced the capacity of staff available for assessment in order to balance triage and urgent requirements of the service. All urgent referrals have been seen.

Mental Health

CPA compliance has decreased compared to the previous month's figure to 86.8% and there are currently 124 CPAs outstanding. 82 cases are within recovery. The Recovery service continues to experience high caseloads, high levels of acuity and a high turnover of staff in the Tewkesbury team. However, the staff shortage in Cheltenham due to short-term sickness have been resolved. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are focused on raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due. NTQ have requested a trajectory to be produced for return to compliance.

Quality Dashboard

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

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Community Hospitals																				
Bed Occupancy - Community Hospitals		L - C	92%	88.9%	89.6%	90.0%	94.3%	95.1%	91.6%								92.12%	G		90.4%
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%	85.7%	90%	90%	75%	80.0%	100.00%								84. 6%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
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%	52.9%	54.2%	54.%	52.2%	50.2%	51.6%								52. 4%	G		
Admissions to adult facility of patient under 16yrs		N - R		1	0	0	1	0	0								1	N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	1742	82	100	199	187	77								568	G		
Children's Services – Immunisations				2019/20 Academic Year	ACADEMIC YEAR 2020/21 - Target 90% of all 2 immunisations by end of academic year (July 2021) and new cohort 1st immunisations															
HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)		N - T	90%*	73.1%	30.7%	42.9%	74.4%	86.9%	90.7%								90.7%	G		
Childrens Services - National Childhood Measurement Programme				2019/20 Academic Year	Academic Year 2020/21 - Target 95% of children measured by end of academic year - Cumulative target (July 2021)					Academic Year 2021/22										
Percentage of children in Reception Year with height and weight recorded		N - T	95%*	69.7%	36.0%	64.5%	87. 8%	96. 8%	96.8%								96.8%	G		
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	73.9%	9.0%	76.3%	84.5%	96.1%	96.1%								96.1%	G		

Additional Information

Children's Services - National Childhood Measurement Programme (NCMP) has met target.
HPV – The target of 90% of the 1st Immunisation was achieved in August . The School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort. Owing to the Covid pandemic, and schools being closed from January until the 8th March 2021, over 700 Year 9 - 1st doses were not delivered until March. For the 2nd HPV vaccination to be given there is the requirement for a 6 month interval between HPV 1 and HPV 2 vaccinations hence this interval had not passed by the end of August.

EIP – The recommendation of the Mental Health Taskforce, NHS England outlines its commitment to ensuring that, by 2020/21, at least 60% of people experiencing first episode psychosis receive treatment. The standard has been carried forward to 21/22. There was a data cleansing process completed in month which has refreshed the compliance rates for Jul and Aug and now show our compliance with this standard.

Out of area bed days - The occupied bed days for inappropriate out of area Mental Health placements in August was 77 days which relates to 9 patients (7 x acute & 2 PICU admission beds). This work has been supported by the admission and discharge pathway task & finish group.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

Additional KPIs - Physical Health

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)		95%*	93.1%	35%	61. 7%	83.2%	92.1%	92.1%								92.1%	G	N	
Number of Antenatal visits carried out			530	47	51	51	54	30								233	R	Y	
Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	94.1%	93.4%	96.6%	93.3%	93.4%	94.5%								94.2%	A	Y	
Percentage of children who received a 6-8 weeks review.		95%	95.9%	98.3%	97.2%	97.6%	97.8%	94.6%								97.1%	G		
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	72.6%	74.0%	84.7%	82.3%	84.2%	80.6%								81.2%	A	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	83. 7%	83.9%	79.6%	82.8%	86.8%	91.6%								85.1%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	72.5%	72.0%	74,4%	81.5%	84.0%	84.1%								78.9%	R	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	56.0%	61.3%	59.2%	60.1%	54.2%	56.1%								58. 1%	G		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81. 3%	81.7%	81.5%	85.4%	82.2%	81.2%								82. 4%	G		
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	970	No Data															
Number of positive Chlamydia screens		169	632																
Average Number of Community Hospital Beds Open reduced by 8 due to social distancing measures.		196*	174,9	186.	187	188	187	181								181	R		
Average Number of Community Hospital Beds Closed		0	21.1	2	1	0	1	7								9	R		

Additional Information

Antenatal Visit: Delivery of sessions was impacted in month due to changes in the scheduling by midwifery services. Some activity in Stroud has not been updated and reflect the change in visit numbers above. The data should be corrected for October.

New Birth Visiting (NBV) – There is a robust triage process to identify those children who are 'hard to reach' to ensure equity of access. The service is working with Maternity Voice Partnership to increase engagement with service users and pre-appointment reminders are being sent to carers/parents. NBV are offered face to face (F2F) with a telephone/virtual consultation available on request. There is a gradual improvement in month, however, the increase in babies remaining in Neonatal Intensive Care Units (NICU) impacts on the teams ability to engage within the timeframe and results in a breach of the threshold. In month there were 14 babies in NICU.

Percentage of children who received a 6-8 week review within 8 weeks by a Health Visitor - Overall a minor variation in month with 6 families not available in timeframe but have since been seen, 8 babies were seen late due to rescheduling of priorities.

Percentage of children who received a 9-12-month review by the time they turned 12 months - The parents of all children within this age group were offered the opportunity to receive a 9 -12mth and 2 year review. For all children classified as universal with low risk, virtual appointments via Attend Anywhere are being offered for developmental reviews as the estate available for face to face is reduced. Some families are still request face to face contact and decline the virtual offer. In these cases there is a small wait list, resulting in assessment being completed outside of agreed threshold.

Percentage of children who received a 12-month review by the time they turned 15 months - There has been an increase in this indicator of 5.6% on last month. These contacts are optional for parents and catch up developmental clinics have been completed where parents have rebooked the review, now they are more comfortable to do so.

Percentage of children who received a 2-2.5-year review by 2.5 years - All universal partnership (UP) and universal partnership plus (UPP) are seen face to face in the home setting for a full family health needs assessment. The service will be returning the 2-year ASQ (Ages & Stages Questionnaire) to face to face activity with an additional intervention called the Early Language Identification Measure (ELIM).

Community Beds open and no of occupied bed days - The occupied bed days reduction result from the need to reduce occupancy in Jubilee Ward, in readiness for the planned move to Preston Ward. This forms part of the planned refurbishment programme.

CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 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%	85.8%	87.5%	88.7%	88.3%	89%	85.3%								87.7%	A		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	70.4%	71.2%	72.4%	73.0%	72.5%	70.1%								71.82%	R		
Sickness absence average % rolling rate - 12 months	L - I	<4%	4.80%	4.3%	3.9%	3.8.%	3.9%.	4.1%								4%	G		
Sickness absence % monthly rate	L-T	<4%	New	3.5%	4.4	4.3%	3.9%	4.07%								4.03%	A		

Additional information

Mandatory training, appraisal and absence

- The work that services/teams have been undertaking to re-instate training compliance levels has shown good improvement over recent months although the Trust's overall training compliance figure has shown a slight dip this month, this was anticipated due to annual leave and the position will be closely monitored. Positively ,overall training compliance figure **minus staff bank** has increased to 93.3%, which is above the Trust overall compliance target. Progress with improving the appraisal rate continues to focus on reminding managers to complete and record the process with work being undertaken with staff side to assist progress and suggest any new initiatives .
- Sickness absence has risen by .02% and .08% on the previous month , to be above the 4% target set for both the rolling and snapshot sickness rates.

Resuscitation and Restrictive Physical Intervention training

- The focus on Physical Intervention training shows fluctuation in the improvement levels this month, There is some plateauing of numbers due to holidays and absence and therefore the focus going forward will continue to be both on the specific wards with lower compliance and in ensuring that the improvements are maintained and recovered.
- Progress on this workstream reports monthly to QAG. The Trust target is 90% compliance and the % figures to target are shown in the table opposite .

June 21	PBM Theory			PBM Full			PMVA Breakaway			PMVA Full		
	June	July	Aug	June	July	Aug	June	July	Aug	June	July	Aug
Wotton Lawn Hospital							83%	81%	82%	77%	80%	75%
Charlton Lane Hospital	89%	90%	89%	92%	91%	84%						
Berkley House	71%	71%	67%	88%	86%	86%						

Health and Wellbeing Hub

Funding of £600K has been provided by NHSE/I to create a system-wide Mental Health and Wellbeing Hub in order to provide support to all health and social care colleagues who work within Gloucestershire ICS organisations, recruitment has commenced and we have sent out , and received feedback on the first designs for "Brand" and Webpage. We are working closely with the Operational recovery and performance lead to ensure that our H&W support and OD interventions are targeted to the areas and service in most need. It is encouraging to report that we have increased the number of members of our H&W hub to circa 20 people from across the organisation and are introducing the role of H&W champion across the Trust..

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Inpatient – August 2021

	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	17.5	3	0	0	0	0	0	0
Abbey	175	23	32.5	3	0	0	0	0	0	0
Priory	195	26	70	8	0	0	0	0	0	0
Kingsholm	70	9	15	2	0	0	0	0	0	0
Montpellier	187.5	22	50	5	0	0	0	0	0	0
Greyfriars	220	27	0	0	0	0	0	0	0	0
Willow	15	1	105	14	0	0	0	0	0	0
Chestnut	90	12	15	2	0	0	0	0	0	0
Mulberry	30	4	7.5	1	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	52.5	6	290	30	0	0	0	0	0	0
Total In Hours/Exceptions	1035	130	610	69	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

There were no code 3-5 exceptions in August.

MENTAL HEALTH & LD				
Ward	Average Fill Rate	Vacancy WTE HCA	Vacancy WTE RMN	Sickness
Dean Ward	117.20%	0	5.18	8.69%
Abbey Ward	103.76%	0	10.48	6.00%
Priory Ward	113.39%	0	11.18	13.64%
Kingsholm Ward	102.53%	.89	3.18	3.38%
Montpellier	93.63%	1.18	3.08	6.62%
PICU Greyfriars Ward	132.80%	0.58	4.08	5.67%
Willow Ward	106.16%	2.51	1.5	5.67%
Chestnut Ward	102.87%	4.16	.62	2.26%
Mulberry Ward	113.98%	0	5.62	7.05%
Laurel House	99.73%	1.08	0.42	1.60%
Honeybourne Unit	100.27%	0.61	2.3	6.37%
Berkeley House	96.95%	8.82	.92	7.48%
Totals (Aug 2021)	**106.94%**	19.83	48.56	**6.20%**
Previous Month Totals	109.31%	26.32	49.47	9.32%

PHYSICAL HEALTH				
Ward	Average Fill Rate	Vacancy WTE HCA	Vacancy WTE RGN	Sickness
Coln (Cirencester)	118.54%	0	4.23	2.92%
Windrush (Cirencester)	118.55%	0	3.54	6.18%
The Dilke	108.11%	.44	4.17	3.78%
Lydney	98.59%	0	4.17	7.76%
North Cotswolds	113.86%	0	.63	11.91%
Cashes Green (Stroud)	117.02%	5.6	1.93	8.13%
Jubilee (Stroud)	88.15%	2.68	.24	7.41%
Abbey View (Tewkesbury)	87.55%	2.2	.75	7.55%
Peak View (Vale)	115.10%	.37	2.47	4.47%
Totals (Aug 2021)	**107.27%**	11.29	22.13	**6.68%**
Previous Month Totals	110.01%	8.89	19.66	7.54%

Staffing Data – Absence/Vacancy Data Quality Notice

Shift fill rates remain high to support safer staffing numbers across a number of wards. A dedicated inpatient recruitment programme is being developed with support of the Matrons and Deputy Service Managers. The quality team are collaborating with colleagues to improve data access to team managers, matrons etc. This will enable teams and services to have the appropriate data to support local recovery plans.

Recruitment Mental Health, Learning Disability Inpatients & Physical Health

International Recruitment: 3 x RMNs have been appointed for Wotton Lawn and 1 has now arrived in the UK. RMN recruitment remains at a slow pace but we are continuing to actively interview.30 RGN's have been appointed, of these, 19 have arrived in the UK and It is anticipated that the remaining staff will be here by March 2022 , there are 7 planned arrivals for the remainder of 2021.

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AGENDA ITEM: 08/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Paul Ryder - Patient Safety Manager, Nicola Mills - Clinical Incident and Learning Manager

SUBJECT: **QUARTER 1 2021/22 PATIENT SAFETY REPORT (INCLUDING SIRIS)**

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 report provides the Board with high level information with regardto 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:

1. **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 1 (1st April to 30 June 2021).
- A summary of the prevalence of patient safety incidents by categories including level of investigation.

- Provision of data for Mental Health and Learning Disability Hospitals, physical health Community Hospitals, plus MIIUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the Patient Safety Team (PST) will examine in further detail a different category reporting a significant number of incidents. Q1 2021/22 provides an update of the PUQ's Project focusing on timely triage of pressure damage in community ICTs.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q1 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental and physical health patient safety incidents.

Risks associated with meeting the Trust's values

Effective systems must be in place to manage all patient safety incidents and reduce risk.

Corporate considerations	
Quality Implications	Increased numbers of reported incidents is seen to indicate and open and transparent reporting culture.
Resource Implications	Quarterly reporting and analysis is resource and labour intensive.
Equality Implications	None.

Where has this issue been discussed before?

Quality Assurance Group – August 2021
Quality committee – Sept 2021

Appendices:	PowerPoint presentation (slide deck) Q1 2021/22 PSR

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

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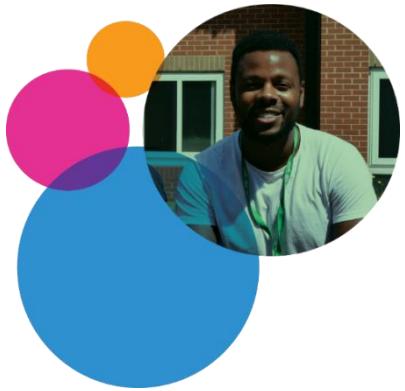
AGENDA ITEM: 08.1/0921



Q1 Patient Safety Report 2021/22

Paul Ryder, Patient Safety Manager
Nickki Mills, Clinical Incidents Manager

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

Q1 PSR 2021/22

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This report provides the Board with:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 1 2021/22 (1 April to 30 June 2021).
- A summary of the prevalence of patient safety incidents by categories including levels of investigation where relevant.
- Provision of data for Mental Health and Learning Disability Hospitals, physical health Community Hospitals, plus MIIUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the PST will examine in further detail a different category reporting a significant number of incidents. Q4 2020/21 looked at pressure damage in community ICTs and the developing “PUQs Project”. Q1 2021/22 provides a helpful update to this project following a PDSA Cycle 4 evaluation.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q1 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental health and physical health patient safety incidents.

Summary of all Patient Safety Incidents reported in the last rolling 4-quarter period

	Q2 (%)	Q3 (%)	Q4 (%)	Q1 (%)
No Harm	2148 (65.5)	2104 (62.7)	2072 (63.0)	1967 (60.71)
Low Harm	963(29.4)	1018 (30.3)	990 (30.1)	1016 (31.36)
Moderate Harm	130 (4.0)	198 (5.9)	188 (5.7)	218 (6.73)
Severe Harm	23 (0.7)	27 (0.8)	30 (0.9)	23 (0.71)
Death	15 (0.5)	8 (0.24)	8 (0.24)	16 (0.49)
Total	3279	3355	3288	3240

Number of No and Low Harm Incidents Reviewed in the last rolling 4-quarter period

	Q2	Q3	Q4	Q1
No Harm	2148	2104	2072	1967
Low Harm	963	1018	990	1016
Total	3111	3122	3062	2983
Reviewed (%)	184 (**5.9%**)	299 (**9.6%**)	374 (**12.2%**)	411 (**13.8%**)

The Patient Safety Team aim to review 10% of the No and Low Harm Patient Safety Incidents. This has not always been achieved due to redeployment of some of the team due to Covid-19, the recovery plan of SIRIs and competing workstreams, such as completing SIRI investigations. Significant progress has been achieved during Q3 and Q4 2020/21 and this is carried successfully into Q1 2021/22.

Q1 PSR 2021/22

No harm and low harm incidents

Of the 1967 no harm incidents, and the 1016 low harm incidents, the Patient Safety Team aimed to review a blind sample of 10% (PST intended to review more than 298 incidents in Q1). This target was set during the reconfiguration of the Patient Safety Team following merger in October 2019 and due to the impact of Covid work the team have not previously met this target.

In Q1 a total of 411 low and no harm incidents were reviewed (13.8%). The Patient Safety Team have met this ambitious target for the last 2 quarters running

Q1 PSR 2020/21

Never Events, Serious Incidents and other reportable incidents

	Q2	Q3	Q4	Q1	Rolling Total
Never Events	0	0	0	0	0
Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Serious Incidents	14	6	8	8	36

Q1 ‘Sub Serious Incident’ Incidents (moderate and above harm)

During Q1 the Patient Safety Team convened 25 72-hour Initial Investigation meetings (including incidents that have gone on to be declared as a SIRI which are featured on slides 18 and 19).

6 mental health incidents and 2 physical health incidents met the criteria for a Serious Incident Requiring Investigation (SIRI).

One physical health incident (palliative patient with a diagnosis of Metastatic Osteosarcoma) under the care of the District Nurses for palliative support and symptom control. The patient’s pain was not managed well at home which resulted in a transfer to the acute trust (the patient did not want this) but needed to due to the lack of clarity on the drug chart. This situation was felt to be avoidable and has been managed as a Clinical Incident needing additional comprehensive investigation which will conclude in due course.

Q1 ‘Sub Serious Incident’ Incidents (moderate and above harm)

One mental health incident where the patient was referred to the First Point of Contact Centre (FPCC) and then to Gloucestershire Recovery in Psychosis (GRiP), but sadly died on the day of their initial assessment by suspected suicide. This has been managed as a Clinical Incident needing additional comprehensive investigation and will conclude in due course.

Local learning from these incidents, including evidence of good practice, will be shared via Incidents on a Page following the internal reviews.

Detailed analysis of high frequency incidents

Service provision has seen further disruption due to another national lockdown as a result of the Covid-19 pandemic, however Q1 continues to demonstrate more established incident reporting trends. The data an “Top 10” categories have been refreshed for Q1 an is presented in the following slides.

The high frequency incidents within Mental Health inpatient continue to 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 some 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 (54.2%).

High Level Analysis of Mental Health Inpatient Incidents - By Rolling Financial Quarter

Top 10 Categories Reported	Deliberate Self-Harm				Physical Intervention & RT				Falls				AWOL				Violence & Aggression				Medication				Clinical Care				MERT				Accidents and Injuries				Suicide Attempts			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Wotton Lawn Hospital (excluding PICU)	391	311	426	154	240	269	204	114	16	24	18	10	50	57	72	77	55	23	38	39	13	10	20	21	4	4	5	5	42	10	4	4	2	4	2	6	11	16	7	5
Berkeley House	278	280	251	290	169	125	83	76	7	6	1	1	0	0	0	0	0	0	0	3	2	2	2	2	1	0	3	1	1	2	1	0	7	14	6	8	0	0	0	0
Wotton Lawn - Greyfriars PICU	4	16	28	9	110	83	50	98	1	1	1	3	7	10	18	1	34	6	5	6	0	6	5	0	0	6	1	1	1	8	2	2	0	3	0	1	0	0	9	1
Charlton Lane Hospital (functional)	4	5	0	7	17	10	20	28	31	30	26	55	0	2	0	0	1	0	1	1	13	12	11	8	55	8	4	6	2	4	3	7	8	6	6	3	1	2	0	1
Charlton Lane Hospital (organic)	1	0	3	1	22	29	17	18	62	122	51	32	1	0	1	0	16	7	7	5	0	1	3	3	2	0	0	0	4	5	3	0	4	1	1	1	0	0	0	0
Laurel House & Honeybourne	0	0	0	0	0	0	0	0	0	2	1	4	2	3	4	3	3	0	3	1	4	2	2	13	0	0	0	1	0	0	1	1	1	1	0	3	0	0	1	0
Montpellier Low Secure Unit	1	0	0	0	0	0	0	4	0	0	1	2	4	0	1	1	0	0	1	1	0	1	1	1	1	0	0	0	1	0	1	0	2	1	0	0	0	0	0	0
Total	679	612	708	461	558	516	374	338	117	185	99	107	64	72	96	82	109	36	55	56	32	34	44	48	63	18	13	14	51	29	15	14	24	30	15	22	12	18	17	7

The increase in reported falls for functional CLH wards relates to them taking more patients with organic illnesses when the organic (dementia) wards remain at capacity. Deliberate self-harm is much reduced at Wotton Lawn as several higher frequency self-harmers have been discharged home. Laurel House and Honeybourne Units have seen an increase in medication incidents, but the Patient Safety Manager has not been able to discuss the detail of these incidents with the Units' Matron.

High Level Analysis of Community Hospital Incidents – by Rolling Financial Quarter

Top 10 Categories Reported	Falls				Skin Integrity				Admissions, Discharges & Transfers				Medication				Clinical Care				Infection Control				Accidents & Injuries				Communication & Handover				Appointments, follow up & referrals				Equipment & Medical Devices			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Cirencester Hospital	11	26	25	17	35	25	26	39	5	4	0	7	5	4	2	1	3	2	6	3	3	24	7	3	4	4	0	2	3	6	0	4	1	3	0	4	0	0	0	3
Dilke Hospital	34	31	31	27	13	9	9	12	3	2	0	9	5	2	4	2	3	2	0	0	3	3	1	1	6	5	2	3	0	1	0	4	0	0	0	3	0	0	0	0
Lydney Hospital	15	18	26	16	16	10	18	16	0	1	3	4	7	1	5	3	1	3	4	4	0	12	0	0	1	2	0	0	2	0	0	3	0	0	0	1	1	2	0	1
North Cots Hospital	10	19	17	23	4	10	13	7	0	1	1	2	0	1	1	3	0	2	0	0	0	1	0	2	0	1	0	0	1	0	4	3	0	1	2	6	1	1	0	0
Stroud Hospital	21	52	29	28	39	38	30	39	13	14	7	6	7	4	1	1	4	7	3	1	1	4	1	3	6	4	3	5	2	0	7	5	2	1	1	3	0	1	0	3
Tewkesbury Hospital	12	20	40	15	13	21	11	13	1	1	3	3	2	2	2	1	2	1	2	3	0	3	1	1	2	0	1	0	4	0	1	3	0	0	2	0	0	1	1	0
The Vale Hospital	23	28	20	27	10	14	13	10	1	6	0	1	3	5	5	10	2	5	6	12	0	2	0	2	4	8	5	6	1	0	0	2	0	1	0	0	0	1	1	2
Total	126	194	188	153	130	127	120	136	23	29	14	32	29	19	20	21	15	22	21	23	7	49	10	12	23	24	11	16	13	7	12	24	3	6	5	17	2	6	2	9

Incident reporting is of a similar order and differences are representative of the changing inpatient population.

The prevalence of falls at Stroud hospital in Q3 is notable and is seen to drop back to a level more consistent with reporting from other hospitals in Q1.

High Level Analysis of Community Mental Health Incidents – by Rolling Financial Quarter

Top 10 Categories Reported	Clinical Care				Deliberate Self-Harm				Admission, discharge & transfer				Information Governance				Medication				Communication & handover				Appointments, follow up & referrals				Suicide attempts				Death/ SIRI				MERT			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
AMHP	0	5	1	0	0	0	0	0	3	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AOT	0	1	0	0	1	0	1	0	0	1	0	0	0	0	0	0	1	2	3	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	0	0	0
CYPS/CAMHS LD, T2, T3	0	5	3	0	1	0	8	0	0	0	0	1	0	1	2	6	0	0	0	0	0	0	0	2	0	5	2	1	0	0	0	0	0	0	0	0	0	0	0	0
CLDT	1	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CPI	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRHTT	5	5	3	2	4	4	2	11	3	2	1	12	0	0	0	0	0	2	1	0	1	1	3	2	3	1	1	0	1	1	0	2	2	0	1	1	0	0	0	2
Eating Disorders	1	1	2	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	1	0	1	3	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Later Life	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	1	1	1	0	0	0
MHICT	2	0	1	1	2	0	0	2	0	1	2	0	1	0	7	2	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	3	0	1	0	1	0	0	1	0
Memory Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	1	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
MH Liaison	0	2	1	3	1	4	1	0	1	2	0	1	0	0	2	0	1	0	1	0	1	5	0	0	0	2	1	0	0	2	2	1	1	0	1	1	0	0	0	0
Recovery	4	1	0	0	3	0	1	3	0	2	1	1	0	0	0	0	2	2	3	7	0	2	1	1	0	1	1	0	2	1	1	0	4	1	2	2	1	2	1	3
Specialist Services	1	0	0	0	0	1	0	1	0	0	0	1	0	1	1	2	3	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	1
Total	16	21	12	6	13	9	13	17	7	12	6	18	2	4	13	11	9	8	9	8	4	11	7	7	9	9	6	1	4	4	3	6	8	4	5	8	3	2	2	6

Mental Health community teams clearly report far fewer patient safety incidents than their inpatient colleagues (n=323 for Q1). There is limited analysis available from this data with no apparent concerns.

High Level Analysis of Community Physical Health Teams Incidents (not ICT/ENDN) – by Rolling Financial Quarter

Top 10 Categories Reported	Diagnosis, Imaging & Testing				Clinical Care				Medication				Communication & handover				Information Governance				Equipment & Medical Devices				Appointments, follow up & referrals				Skin Integrity				Admissions, discharges & transfers				Accidents and Injuries			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Complex Care at Home	0	0	0	0	2	1	2	1	2	2	2	4	0	1	0	4	0	1	2	0	0	1	1	3	0	0	0	0	4	5	13	5	0	0	2	1	0	0	0	0
Complex Leg (CLWS)	0	0	0	0	2	1	4	3	0	0	0	0	1	0	0	1	0	0	0	0	1	0	1	0	0	0	0	1	3	2	6	0	1	1	1	1	0	0	0	0
CYPS/PH Community Specialist	0	0	1	0	1	9	1	2	1	5	6	9	2	3	3	3	5	2	4	3	9	12	5	10	3	4	0	0	1	2	2	2	1	5	0	1	3	2	0	2
CYPS/PH Public Health Nursing	0	0	0	0	1	5	0	1	0	6	0	0	4	5	7	10	0	3	5	3	0	0	1	0	1	4	4	3	0	0	0	0	2	2	2	2	0	1	0	0
Dental & Sexual Health	22	14	5	16	8	11	9	4	10	8	5	2	5	5	7	4	7	10	4	7	0	1	2	2	2	0	1	2	0	0	0	0	0	0	0	1	0	0	0	0
Intravenous Therapy Team	0	0	0	1	1	3	0	0	1	0	2	0	0	0	0	0	1	0	0	0	2	0	0	1	0	0	0	1	0	0	0	0	0	1	1	1	0	0	0	0
Long Term Conditions	0	1	0	0	0	0	2	4	6	3	3	1	3	1	0	0	3	2	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
MIiUs	7	26	31	18	1	13	9	13	1	0	1	1	2	3	3	2	0	0	0	1	1	0	0	2	9	10	4	12	0	0	0	0	1	2	3	3	0	3	0	1
Rapid Response	2	0	0	0	1	1	5	5	2	1	1	1	0	0	0	0	1	1	0	1	2	0	0	0	0	0	2	3	3	6	4	2	0	1	0	3	0	0	0	2
Spec Therapy & Equip Services	0	0	0	0	2	2	1	0	0	0	0	0	1	0	0	0	2	1	3	0	1	3	1	5	0	0	1	1	1	0	1	1	0	0	0	1	1	3	0	2
Tissue Viability	0	0	0	0	2	0	3	1	0	0	0	0	0	0	0	2	1	0	0	0	5	1	2	2	0	0	0	0	0	4	1	0	1	4	2	4	0	0	0	0
Total	31	41	37	35	21	46	36	34	23	25	20	18	18	18	20	26	20	20	21	16	21	18	13	25	15	18	12	23	12	19	27	10	6	16	12	18	4	9	0	7

There is a notable upturn in reporting of Diagnosis, Imaging and Testing within MiiUs during Q4. All 30 incidents report no harm and describe a sub-category of Wrong Diagnosis, or Delayed Diagnosis. The Patient Safety Team has completed a deep dive report of Diagnostic Imaging at MiiUs and this required additional analysis.

High Level Analysis of Community Physical Health Teams Incidents for ICT/ENDN – by Financial Quarter

Top 10 Categories Reported	Skin Integrity				Medication				Clinical Care				Admissions, discharges & transfers				Equipment & Medical Devices				Appointments, follow up & referrals				Communication & handover				Falls				Safeguarding concerns				Accidents and Injuries			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
ENDNS – Out of Hours DN	4	6	7	9	5	5	10	12	8	9	6	2	2	0	1	2	1	0	0	0	0	0	5	2	1	1	2	0	0	1	0	1	0	1	1	0	1	0	0	0
Chelt ICT	52	81	93	93	15	11	13	21	8	9	13	6	12	8	6	15	6	6	5	10	5	4	1	7	5	11	6	14	2	9	1	5	1	0	0	0	0	0	0	0
Cotswold ICT	84	76	107	111	6	7	10	11	7	10	9	13	8	8	6	11	9	7	7	15	6	2	4	3	1	0	2	2	0	2	4	3	2	2	1	3	0	0	1	0
Forest ICT	71	79	89	83	2	3	8	3	5	8	3	5	3	2	5	2	5	10	9	12	5	8	3	4	5	9	2	14	0	1	0	0	1	1	1	0	1	2	0	1
Glos ICT	110	121	116	130	9	21	20	10	10	15	8	12	8	16	16	5	5	11	13	20	3	6	5	4	8	6	9	4	1	0	2	4	1	3	0	0	1	2	2	1
Stroud ICT	48	58	55	52	8	3	8	8	6	3	4	5	4	6	12	2	5	6	3	14	2	2	0	3	2	1	4	4	3	3	3	6	0	0	0	0	0	0	0	1
TWNS ICT	67	70	59	73	8	11	12	5	11	9	2	3	3	5	2	4	4	5	2	0	6	3	0	1	1	1	0	2	1	1	1	1	0	0	0	2	1	0	0	2
Total	436	491	526	551	53	61	81	70	55	63	45	46	40	45	48	41	35	45	39	71	27	25	18	24	23	29	25	40	7	17	11	20	5	7	3	5	4	4	3	5

Gloucester ICT report higher frequencies of incidents due to the size of the population served.

High Level Analysis of Community Physical Health Teams Incidents for ICT/DN – by Financial Quarter

The consistently high volume of Skin Integrity incidents reported within the District Nursing Service is clear to see on the previous slide.

A separate paper has been prepared for QAG by Belle Hyslop, PST Clinical Incident Lead and Investigator, detailing the “PUQs Review Process”. A brief overview was provided for the Q4 2020/21 Patient Safety Report, and a progress update is provided for Q1 2021/22 Patient Safety Report on the following slide.

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Moderate and above Pressure Ulcer (PUs) Review Process by PST

The Pressure Ulcer Question template underwent PDSA cycle 4 evaluation and has been approved by QAG as the GHC process by which Category 3+ pressure ulcers are reviewed by ICT Community nursing teams and, subsequently, by the Patient Safety Team.

1. **Headline results for PST :**
    - Impact of COVID evident in Dec 20-Jan 21 was an increased number of incidents and reduced closure rate. Likely to be due to PST handling rises in the other types of moderate and severe incidents being reported.
    - PST ***doubled the amount reviewed*** and closed or escalated in the 6 months to December 2020 – June 2021.
    - PST have Finally Approved ***5 times more*** moderate pressure ulcers than in April 2020.

2. **Headline results for Operations:**
    - ***64% reduction*** of pressure ulcers awaiting PUQ review since September 2020.
    - **Consisten**t monthly reduction since Feb 21 in total numbers of pressure ulcers awaiting PUQ completion.

3. **Next steps**:
    - Integration of PUQs into Datix will ensure that the Datix becomes a one stop-shop for reporting, investigation documentation and further develop link with learning and assurance work.
    - Development of a similar document to support the review of pressure ulcers in Community hospital inpatient setting.

Developments within the Patient Safety Team

- The National Patient Safety Specialists programme continues to inform the development of our localised Patient Safety Incident Response Plan (PSIRP) to meet the guiding principles of the Patient Safety Incident Response Framework (PSIRF). This work is held within the Trust's Patient Safety Group.
- The Patient Safety Team and key medics associated with the SI process, including Medical Director, Deputy Medical Directors and other doctors who chair SI review meetings, will attend 2 days' Root Cause Analysis training in September 2021 with an external accredited provider.
- Assurance processes following the development of recommendations and/ or actions resulting from Serious Incidents have re-started in the form of monthly follow up meetings with the Community Service Managers and Hospital Matrons. Commissioners actively support this process and have been invited to attend the meetings.
- Dave Anderson (previously Physiotherapy Manager at Charlton Lane hospital) was successful at interview and was appointed as a Clinical Incident Lead & Investigator. He took up his new post on 12 July 2021 and is undergoing local induction and initial training.
- Patient Safety Team is being notified of **all** mental health and physical health patient safety incidents categorised as moderate and above. This has gathered pace in recent months and the 10% target was exceeded in both Q4 2020/21 and Q1 2021/22.

with you, for you

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AGENDA ITEM: 09/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

SUBJECT: **LEARNING FROM DEATHS 2021/22 QUARTER 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:

The purpose of this report is to Inform the Trust Board of the mortality review process and outcomes during Quarter 1 2021/22.

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.
- **Note** the KPIs and feedback from Medical Examiner input.
- **Consider** additional data/information which would enhance the content and format of the report.

Executive summary

- This report summarises Quarter 1 2021/22 activity regarding Learning from Deaths.

- During Quarter 1 2021/22 there were 129 patients who died whilst receiving care from Gloucestershire Health and Care NHS Foundation Trust (GHC) whilst either a physical health inpatient or in the care of our mental health or learning disabilities services. At the time of writing none of these deaths are judged likely to have been due to problems in the care provided by the Trust.

- In addition, during Quarter 1 2021/22,13 care record reviews and 3 comprehensive investigations were completed relating to deaths occurring prior to the reporting period. One of the comprehensive investigations, representing 6.25% of the patient deaths before the reporting period, is judged to be more likely than not to have been due to problems in the care provided to the patient. Learning from this incident was previously reported to QAG in May 2021 as part of the Clinical Incidents & Alerts presentation.

- The report contains, for the first time, KPIs and feedback from the Medical Examiner input which was rolled out in community hospitals from May 2021. This provides independent assurance relating to the quality of End-of-Life care and invaluable feedback from families.

- The format of this report is currently under review, and this is the first iteration as a slide deck. Required mandated information is contained within but the authors are conscious that there is still a high narrative content. The learning elements in subsequent reports will all be summarised via the 'Learning on a Page' document, which will enhance the format and reduce narrative. The Group are asked to identify additional data, graphs, or information which they feel will improve both the quality and accessibility of this report.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths associated with the Trust's 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 Groups Quality Assurance Group 20th August 2021 Quality Committee 2nd Sept 2021

Appendices:	None

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

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 9.1/0921

Q1 2021/22 Learning from Deaths Report

Zoe Lewis, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

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

Purpose

The purpose of this report is to Inform the Quality Committee of the mortality review process and outcomes during Quarter 1 2021/22.

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.

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

Scope

The following categories of patient are considered in scope for a mortality review process (including application of the serious incident process where appropriate);

- All inpatient deaths in community hospitals;
- All inpatient deaths mental health inpatient units or who had been discharged from in-patient care within the last month;
- All deaths of those with learning disabilities under our care;
- 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 6 months prior to their death;
- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death;
- All perinatal/maternal deaths (perinatal mental health service for us);

Scope (cont.)

- All deaths of patients where a complaint or significant concern about the quality of care provision has been raised (within 12 months of the date of death);

- All deaths of patients receiving care from a service where an ‘alarm’ has been raised with the Trust through whatever means (for example via an elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator). This will include situations where another organisation has reviewed a death and suggests that our Trust reviews its care processes;

- Deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.

Overview

- During Q1 2021/22, 129 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died. This comprised the following number of deaths, which occurred in each month of that reporting period:
  37 in April;
  59 in May;
  33 in June.

- By 21 July 2021, 14 case record reviews and 1 comprehensive investigation had been completed in relation to the 129 deaths included above. The number of deaths in each month for which a case record review or an investigation was carried out was:
  8 in April;
  7 in May;
  0 in June.
  .
- 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.

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

Overview (cont.)

- Additionally, during Q1 2021/22,13 care record reviews and 3 comprehensive investigations were completed relating to deaths occurring prior to the reporting period.

- 1, representing 6.25% of the patient deaths included above, are judged more likely than not to have been due to problems in the care provided to the patient.

- For learning relating to comprehensive investigations, including the above incident, please refer to the Clinical Incidents & Alerts reports.

Learning Disability

Gloucestershire Health and Care
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- The University of Bristol's contract with NHS England to provide the Learning Disabilities Mortality Review (LeDeR) came to an end in May this year. NHS England has subsequently published a new policy which sets out the core aims and values of the LeDeR programme and the expectations placed on different parts of the health and social care system in delivering the programme from June 2021. The new policy can be found here.

- From June 21, the Integrated Care System will take over responsibility for making sure LeDeR reviews are completed and LeDeR reviewers will need to have a NHS employment contract.

- From this winter, LeDeR reviews will also include people with just an autism diagnosis. The name will change to *Learning From Lives And Deaths – People With A Learning Disability*, however the Acronym will remain as LeDeR.

- Cheryl Hampson remains as our Gloucestershire's Local Area Contact, Cheryl.hampson@gloucestershire.gov.uk

- A new website has been launched which includes a new webportal for reporting deaths, which can be found at https://leder.nhs.uk/

Learning Disability (cont.)

- Prior to the recent changes, LeDeR in Gloucestershire had caught-up with the back-log of cases to review, however, due to recent changes, LeDeR report that there is currently a 3 month lag.

- In light of this, and to provide assurance, LD MRG have decided to carry on for the time being with the current process of GHC LD operational teams completing care record review paperwork for discussion by LD MRG. LD MRG will review this decision if / when LeDeR catch-up in order to avoid duplication of work.

- LeDeR has recently published its 2020 annual report, which includes 10 recommendations to NHS England / NHS Improvement, NHS Race and Health Observatory, Department of Health and Social Care, NICE, Local Authorities, ICSs and Primary Care Networks. The report can be found at: https://leder.nhs.uk/images/annual_reports/LeDeR-bristol-annual-report-2020.pdf

- LeDeR has made no direct recommendations to GHC.

Medical Examiner Input

The role of the Medical Examiner (ME) is set out in the Coroner & Justice Act (2009) following recommendations from the Shipman Inquiry (2004) and subsequently the Francis report (2013). The ME has a duty to review deceased patient records and speak to their relatives to ensure that the wording used on the medical certificate of cause of death (MCCD) accurately describes the circumstances leading to the death and is acceptable for release to the Registration Service. This includes:

- Support and challenge the certifying doctors to ensure the best quality and most accurate MCCD and associated mortality data.
- Provide proportionate scrutiny of all non-coronial deaths.
- Enabling the bereaved to raise any concerns through the ME system in a safe and transparent way.
- Supporting the appropriate direction of deaths to the coroner allowing the ME to act as a specialist resource.

Medical Examiner input within community hospitals commenced from 17 May 2021; this section aims to provide an overview of activity against identified Key Performance Indicators (KPIs) key activity and learning from the first 4 weeks of implementing the service. Subsequent reports will report on full quarter's data.

Medical Examiner KPIs

1. **Percentage of deaths generating MCCD resolved with the input of the ME service**.
    a. GHC inpatient deaths which do not go through this pathway should be subject to Datix.
    b. These will be identified monthly at the point of the Mortality Review meetings.

    Outcome = 100%

    - *4 at the Dilke, 29/5, 1/6 and 13/5 (x2)*
    - *2 at Tewkesbury, 20/5, 6/6*
    - *1 at Lydney 23/5*
    - *2 at Cirencester 23/5 and 14/6*
    - *1 at Stroud 20/5*
    - *3 at North Cotswolds 23/5, 29/5 and 14/6*

2. **Number of times a MCCD is rejected by Registrar and reason this occurs.**

    Outcome = 0

    However, ME service records show that the ME in one case suggested a revised wording which would have 'bounced' at the Registration Office as Renal Failure was unqualified in part 1 of the MCCD.

Medical Examiner KPIs (cont.)

3. Percentage of potential Coroner referrals resolved with the input of the ME service.

a. These will be identified monthly at the point of the Mortality Review meetings.

Outcome* - Only *1 patient death was reported to the ME service that required Coroner involvement. *The ME suggested a 100A for sacral sore. We are still defining numerators and denominators for the metric.*

4. Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)

- the discussion with the ME or their officer has added further distress.
- information was not clear or helpful, lacking in compassion, professionalism etc.
- the cause of death did not match their understanding of what their relative died from.

Outcome = 0

For each reported death, the ME service turned around the process within 24 hours and no concerns were raised by families.

Feedback & Learning from ME Input

Specific feedback from families to the ME service is provided below by hospital ward and site.

- **Dilke**
  Case 1 - Feedback from Niece: "*Care at the Dilke was brilliant with him".*
  Case 2 - Feedback from Son: "*The staff were marvellous – like home from home".*

- **Lydney**
  Feedback from daughter:" Brilliant *care given – could not fault anyone".*

- **Coln Ward, Cirencester**
  Feedback from son: *"Staff kept mum comfortable, and she had said everyone was nice to her".*

- **Cashes Green, Stroud**
  Feedback from daughter: *"wonderful care"*

- **North Cotswolds Hospital**
  Feedback from sister: *"Lovely care - all staff did very well and were so polite and caring".*

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NHS
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AGENDA ITEM: 10/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Sandra Betney, Director of Finance & Deputy Chief Exec.

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **COMBINED PERFORMANCE DASHBOARD AUGUST 2021 (MONTH 5)**

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.

Performance covers the period to the end of August (Month 5 of 2021/22). It is of note that the performance period remains aligned to our operational priority to recover services from the pandemic (within Regroup Reconnect Recover) and support forthcoming operational planning and transformation developments. RRR briefings are provided to the Business Intelligence Management Group (BIMG). There is now a new section within the performance dashboard (from page 2-11) providing highlights on operational recovery.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Performance Exception Action Plans (PEAP) will be presented to BIMG and will more widely account for performance indicators in exception. Example of this include CAMHS (June & Sept), Eating Disorders (June), CYPS Community (July) and Wheelchair Services (August).

In addition, a separate paper has been provided outlining the high-level learning from the recent Measuring What Matters Board Seminar on 16th June 2021. A timetable monitoring
progress will be integrated into the Performance Dashboard for future months.

Recommendations and decisions required
The Board are asked to:

- **Note** the aligned Performance Dashboard Report for August 2021/22.
- **Acknowledge** the ongoing impact of the pandemic and service recovery on operational performance.
- **Note** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service action plans are being developed to address areas requiring improvement
- **Advise** if the layout of the new look report (incorporating operational recovery is helpful and whether further amendments to detail can be made)

Executive summary

Recovery Update

Operational recovery continues, with many services settling back to business as usual. All services are being tracked and coded as red, amber or green. This month there are 15 services in red recovery support indicating they are at present, unlikely to return to pre-pandemic state within 12 months (using a comparator of November 2019 as the pre-pandemic metric). These teams, many of which are undergoing service transformation and business case construction, continue to receive support both in addressing demand through recovery plans, Service Development and Improvement Plans (SDIP) and Performance Exception Action Plans (PEAP). We continue to support staff in their own health and wellbeing recovery post-pandemic. There are 27 services identified as amber RAG status, indicating a predicted recovery within 12 months. These teams remain under review to explore change and progression.

From this month we have implemented a recovery performance oversight process which incorporates business intelligence, workforce data, quality surveillance intelligence, service narrative and governance and risk information. Key information this month: District Nursing is included as red – due to sustained increase in referral activity (+10% pre-pandemic) and workforce challenges, the Memory Assessment Service is expected to move to amber status due to assured performance recovery plans and reduced numbers waiting (20% less than pre-pandemic). CYPS SaLT is already red for recovery due to workforce challenges and demand, has completed a PEAP and exception briefing to detail its position against reduced 8week KPI compliance for the past 2 months (58.9% this month from 71.3% in July and 96.5% in June).

Performance Update

As shown within the spark charts, it is of note that all the indicators within this report have been in exception within the last 12 months.

Mental Health & Learning Disability Service (National & Local) Performance

The Board's attention is requested to review the 6 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Eating Disorder (ED) Services account for three indicators and CPA two. The ED service continues to face major performance challenges due to a high number of referrals and high vacancy rate which is further outlined within the

narrative. NHSE/I have proposed the replacement of CPA which is being considered within the Nursing, Quality & Therapies directorate.

Physical Community Health Service (National & Local) Performance
In addition, attention is drawn to a further 14 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Within these, eight are within CYPS, two Musculoskeletal and two are within Wheelchair Services. As planned, there will be a review of our Statistical Process Control baseline methodology for Q3 across indicators.

Trust Wide Service Performance
There are currently 4 Workforce indicators in exception this month. Sickness absence is no longer compliant in August like it was in the last three periods.

There is a phased plan to deploy further workforce performance metrics within the performance dashboard over the next year. This is expected to begin next month with headline performance indicators for Vacancy (Sept), Annual Leave (Oct) and Turnover/ Stability (Nov). More granular analysis will be provided as automated data sources are developed. Additional monitoring items will inform this and be discussed within the new People Committee.

Non-exception reporting
It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are available for operational monitoring within the online Tableau storyboard.

It has been agreed by Board (July) that 8 proxy indicators will be re-introduced into the performance dashboard from October as *internal* KPIs using Statistical Process Control (SPC) limits as thresholds. These thresholds are just being finalised.

Risks associated with meeting the Trust's values

Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
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 16/09/2021

Appendices:	None

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

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
August

Performance Dashboard Report & BI Update

Aligned for the period to the end August 2021 (month 5)

This performance dashboard provides a high level view of Key Performance Indicators (KPIs) in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consequtive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available within the dynamic, online server version of this Tableau report.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Additionally, and where appropriate, and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines appropriate risk, mitigation and actions will be monitored through BIMG. For example, specific updates have been provided by operational services in across Q1 and Q2 2021 for areas with consistent performance challenges; Children and Young People's Services (CYPS including CAMHS), Eating Disorder Services and Wheelchair Services.

Business Intelligence Summary Update
Althought high demands continue, Business Intelligence services continue to prioritise key infrastructure development tasks and has ensured the continuity of business critical items during the period. Some development projects outside of BI's control - such as the server migration project, school aged immunisation project and maintenance of the SystmOne data warehouse - are delaying some planned objectives.

The following high profile tasks continue to be the focus;
- Server migration to allow for reconfiguration and resolve licensing concerns - complications have delayed closure but expected by Q3
- Service level recovery and operational planning is being supported and prioritised through robust business partnering
- The project *'SystemOne Simplicity; Improving accuracy, consistency and quality assurance' is* established to improve Community Health (PH) reporting within our clinical systems and new BI environment. This predominantly focuses on clinical system data capture, governance adjustments and data warehouse remapping. A timeline of key milestone objectives is expected from the Project Management Office.
- Further Board Performance Workforce Performance Indicators are in development. Operational ESR workforce reporting is being deployed but further data source items need to be incorporated offering further service level granulation. The first development phase will include;
    - Monthly Vacancy Rate (expected Sept)
    - Monthly (Cumulative) Annual Leave Consumption (expected Oct)
    - Turnover and Stability (expected Nov)
- Progress has been made with the KPI review having completed National indicators and 60% of local indicators. Conclusion is expected in October 2021.

The following tasks continue to be 'in the development pipeline' in line with the service's 2021/22 Business Plan;
- Dashboard visualisation capability further developed to include; SPC, automated benchmarking observation, PEAP alerts and data quality alerts (Extended to 2022/23).
- BI Infrastructure Development; further development of the data warehousing infrastructure and technical solutions to ensure robst and reliable BI (2021/22 Q2)
- Core Reporting Delivery; To further develop our established BI reporting and ensure efficient use of information to inform decision making (2021/22 Q3)
- Maintain Data Warehouse; Further develop and maintain efficient data warehouse that maximised data quality and raised analytical productivity and efficiency (2021/22 Q4)
- Delivering System Data Flows; Introduce new data sources into data warehouse such as Allocate and Care to Learn and futher develop existing flows in line with Trust Strategy (2021/22 Q4)
- Legacy Reporting Migration; To conclude legacy reporting requirements (2021/22 Q4)
- Progressive Insight Delivery; To develop next level BI reporting needs and integrate information for cohesive insight (2021/22 Q4)

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Operational Recovery Update

Data sources: *Recovery services report, performance exceptions and governance data relates to August 2021 (Month 5)*

Service RAG summary + all RED rated services

Operational Service Recovery RAG Rating Key		Aug Status	July status
Service recovery plan in place to support recovery to pre-Covid levels. Identified as low risk		57	48
Service recovery plan in place to support recovery to pre-Covid levels within 12 months. Moderate level of risk Identified which may involve workforce, estates or service design challenges		15	27

Service area	Specialism	Service	RIO/ S1	Current RAG
Long Term Conditions	PH	Respiratory - Home Oxygen Service	S1	
Long Term Conditions	PH	Respiratory - Core	S1	
Long Term Conditions	PH	Pulmonary Rehab	S1	
Long Term Conditions	PH	Diabetes	S1	
Long Term Conditions	PH	Heart Failure	S1	
Long Term Conditions	PH	Cardiac Rehab	S1	
Therapy & Equip	PH	Adult MSK	S1	
Adult PH	PH	District Nursing	S1	
Adult PH	PH	ICT Occupational Therapy	S1	
Adult PH	PH	ICT Physiotherapy	S1	
Adult Specialist MH	MH	Eating Disorders	RIO	
Adult Specialist MH	MH	ASC	RIO	
Adult Specialist MH	MH	ADHD	RIO	
Children & Young People	PH	SALT - core	S1	
Children & Young People	PH	Immunisation Service	RIO	
Children & Young People	MH & LD	CAMHS LEVEL 2/3	RIO	
Children & Young People	MH & LD	CAMHS LD	RIO	

Services rated AMBER rated this month

Service areas	Specialism	Service	RAG	Rationale
Long Term Conditions	PH	McMillan		Estates -clinical space
Therapy & Equip	PH	SALT - IP & community		Service review underway
NEW Therapy & Equip	PH	Adult MSKAPS		New model and workforce transition
Adult Community	PH	Lymphoedema service		Workforce Challenge
Adult Specialist MH	MH	MHICMAS		Service review
Adult Specialist MH	MH	Accommodation Team		Service review
Adult Specialist MH	MH	AOT		Workforce Challenge
Adult Specialist MH	MH	Recovery		Workforce Challenge
Adult Specialist MH	MH	OP CMHT		Workforce Challenge
NEW Adult specialist MH	MH	Later Life services		Workforce Challenge
Children & Young People	PH	OT - core		Demand & Capacity and Workforce Challenge
CYPs	PH	Children in Care		Demand & Capacity
Children & Young People	MH & LD	CAMHS VCS		Workforce Challenge
Children & Young People	MH & LD	CAMHS LD		Demand & Capacity

Adult MH & LD Directorate RAG Summary

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21
RED	4	4	3
AMBER	5	5	6
GREEN	14	14	15

Directorate Current Recovery Red Services & Performance Exceptions

Community Mental Health Services Directorate		
Memory Assessment Service (MAS)	Recovery amber service (decreased from red this month)	Referrals have fallen this month Total waiting is 20% fewer than pre-pandemic The number waiting over 52 weeks has increased this month, trend over last quarter. Service improvement plan is well established and provides assurance and grip. This service was reduced to amber at this month's recovery and performance review and will not be reported in depth unless the RAG changes
Eating Disorders	Recovery red service	Now fully established but new staff need time to embed into their role and deliver the required clinical functions to enable recovery. The service is presently assessing only urgent referrals and is closed to non-urgent activity. An SDIP is in place and reviewed formally in August. Referrals have increased April to August and higher than previous 2 years The overall total waiting at the end of August is 17.5% higher than the same position at the end of June 21. There are early plans to recommence some day treatment services (in Nov 21) which enables both improved patient pathway and prevention of admission as well as staff enrichment in clinical function and improving patient outcomes. There is early work to divert some of the future low level referrals to VCS and other providers, but it is noted this will not remove from the existing waiting list for non-urgent assessment.
Care programme Approach (CPA)	Performance exception	Formal review necessary within 12 months. Performance for August is 86.8% (124 cases) against a threshold of 95%. A Service Recovery Action Plan now in place. Referral numbers remain above average but could be a symptom of pressure in other teams such as MH recovery teams, related to this patient acuity at referral is noted to be higher.
Autistic Spectrum Conditions (ASC)	Recovery red service	Referrals above levels of previous 3 years. Wait times increasing with 317 people now over 52 weeks (256% higher than pre-pandemic levels). Service may benefit from inclusion in CMHT programme but this is to be progressed. This service was historically been under resourced for the delivery model commissioned and the population health need. They have embraced virtual working and are completing some assessments virtually with good effect and positive patient feedback.
Attention Deficit Hyperactivity Disorder (ADHD)	Recovery red service	Referrals fallen as expected in August but remains higher than previous financial years. Total waiting list this month is 66% higher than pre-pandemic levels. Service may benefit from inclusion in CMHT programme but this is to be progressed. This service was historically been under resourced for the delivery model commissioned and the population health need. They have embraced virtual working and are completing some assessments virtually with good effect and positive patient feedback.

Directorate Decisions Agreed this Month

Service	RAG change proposed	Notes	Decision by COO
Memory Assessment Service	Move red to amber	20% reduction in referrals compared to pre-covid. Pilot project in SBV working effectively, team back from redeployment, moved to virtual model, good service grip. Recovery is established and predicted fully within 12 months	☒Approved ☐Not-approved
Dementia education	Move amber to green	Service lead identifies this is a stretched service due to commission arrangements – esp with care homes, no covid impact, not in recovery. Links to MAS improvement plans and virtual ways of working as well.	☒Approved ☐Not-approved
Later life team	First status – amber	This service had not been RAG rated previously. The team feel there is some distress esp in Tewks and Chelt teams, but SD clear this needs an independent review. Likely to be amber due to staff working from home, but WW support to bring back is in place. Caseloads require review – SD will commence. Hold at amber until further intel gathered.	☒Approved ☐Not-approved
Recovery team	Hold RAG at amber	Team lead is of the belief this is a red service but SD clear this needs an independent review. Likely to be amber due to staff working from home, but WW support to bring back is in place. Caseloads require review – SD will commence. Hold at amber until further intel gathered. SD needs to discuss with deputies and look objectively at activity and workforce data before would support step up to red. Service lead is shared with later life and has been working from home. Issues regarding leadership identified as well as discharge behaviours, SD wishes to explore before further step up.	☒Approved ☐Not-approved

Children's and Young People Directorate RAG Summary:

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21
RED	4	4	4
AMBER	6	6	4
GREEN	17	17	19

Directorate Current Recovery Red Services & Performance Exceptions

Children's and Young Peoples Services (CYPS) Directorate		
CYPS Speech & language Therapy	Recovery red service + Performance exception	58.9% compliance to 8 week target against a threshold of 95%. There are significant workforce challenges within this service and combined with a referral peak in June 2021 the service is under pressure. Total waiting list this month = 1777. The team have adopted virtual assessments and find these are well received by children and families. They have also created advice and support functions for schools to access to advice and signpost.
Health Visiting	Performance exceptions	New Birth Visits 94.5% compliance against target of 95%. 9 – 12 month reviews, 80.6% compliance against 95% target. 12 month review, 91.6% against 95% target. 2 – 2.5 year developmental review, 84.1% compliance against 95% target. PEAP in place
Childhood Immunisations Service	Recovery red service	The team continue to recover the 19/20 and 20/21 programmes which were impacted by school closures during the pandemic as well as commencing the 21/22 academic year programme this month. They have successfully run catch up clinics through the summer and have just a few schools left to complete the 19/20 programme by the end of the month. They have received additional resource to manage the expanded flu vaccination programme which brings an additional 35,000 children into eligibility and developed new roles to support this. The recovery team continues to work with this service to support the demands of their programmes.
CAMHS (core)	Recovery red service	Expected reduction in referrals this month during school holidays. Some data quality work required to streamline recording and reporting which may account for some of the long waits. Greater number of waiters for treatment than pre pandemic (723 this month versus 466 pre-pandemic (Nov 2019)). There are safe waiting list calls in place for those waiting for treatment and options to re-prioritise children if necessary or provide simple advice and information. Working with recruitment the service are accelerating their on-boarding processes and to create new roles such as the Clinical Associate Psychologist role.
CAMHS LD	Recovery red service	Average referral rate April to August 2021 is higher than previous 2 financial years A number of long waiters requiring specific therapy interventions which run bi-annually (Sorrow & Joy group), many families are offered this multiple times before accepting the offer when the time is right for them. The current number waiting for treatment = 97. The team note they accepted 2 new schools from Spring this year and did receive new resource to manage this new demand, but the demand came before those new staff were fully established resulting in increased service pressure. The team have new roles in place such as the family support practitioner to help support in new ways and follow up treatment plans.

Directorate Decisions Agreed this Month

Service	RAG change proposed	Notes	Decision by COO
School Nursing	Move amber to green	Hard to recruit vacancies now filled, improved preceptorship and training programme established, no KPI breaches, no redeployed staff. BAU was always challenging, settled back now. On target for vision screening programmes.	☒Approved ☐Not-approved
CAMHS L2 parenting	Move amber to green	F2F groups back up and running and using virtual offers very effectively. Many of the long waiters have been offered groups but have declined. Cannot 'force' attendance and parents need to attend when the time is right, need to keep the offer on the table for them hence not discharged. Running more groups at present which is causing an over-spend but is addressing backlog.	☒Approved ☐Not-approved

Adult Physical Health & Therapies Directorate RAG Summary

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	
RED	3	2	4	NB. No previous RAG for Falls Assessment Service or Blue badge – brought into Aug data
AMBER	7	9	4	
GREEN	9	8	13	

Directorate Current Recovery Red Services & Performance Exceptions

Adult Physical Health Directorate		
MSK Physio	Recovery red service + Performance exception	57.2% compliance to 95% target for 8 week RTT. This service endured significant workforce challenges following redeployment during both waves of the pandemic. +52 week waits may be a recording anomaly – the team are reviewing Total waiting in August 2019 – pre pandemic was 2782, this month it is 2638. There is a steady reduction in 0-8 week waits, but a rise in 18-36 week waits. There is a robust recovery plan in place which includes waiting list initiative work and new ways of working – especially virtual assessment and self-care resources on the website.
MSKAPS	Performance exception	51.5% compliance against 95% target within 8 weeks
Wheelchair service	Performance exception + Moved to recovery amber this month	72.3% compliance to 8 week RTT for new referrals. Robust improvement plan in place which has provided assurance and improvement across all expected domains.
NEW – Adult Speech & Language Therapy	Performance exception	KPI breach related to vacancies. The service are struggling to prioritise community demand due to requirements to cover GHFT in-patient workload, this commonly takes priority to enable urgent assessment and / or discharge facilitation. At present this is recovery rated amber and may require some cross system conversations about risk share for the diverse activity required. .
District Nursing	Recovery red service	Referral increases have not settled post-pandemic with a 10% increase in referrals being reported across the county with some clinically interventions being significantly increased in the 20/21 FY (phlebotomy is of note). Workforce recruitment and retention remains a concern, especially at staff nurse (band 5). The recovery team are working with the service to better understand the potential for recovery.
NEW - ICT Occupational Therapy	Recovery red service	Rising waiting times for routine referrals. This is reported to be induced by the front door demand to support Home First, Reablement and the MDT referral desk. This activity is commonly urgent; prevents unnecessary admission or facilitates discharge. This however means resources are unavailable to meet the routine referral demand, often for long term conditions. There are discussions with GCC & CCG re additional resources for HF & Reablement to address this.
NEW - ICT Physiotherapy	Recovery red service	Rising waiting times for routine referrals. This is reported to be induced by the front door demand to support Home First, Reablement and the MDT referral desk. This activity is commonly urgent; prevents unnecessary admission or facilitates discharge. This however means resources are unavailable to meet the routine referral demand, often for long term conditions. There are discussions with GCC & CCG re additional resources for HF & Reablement to address this.

Directorate Decisions Agreed this Month

Service	RAG change proposed	Notes	Decision by COO
Reablement	Move amber to green	Doesn't run a waiting list so no recovery to be addressed	☒Approved ☐Not-approved
Home First	Move amber to green	Doesn't run a waiting list so no recovery to be addressed	☒Approved ☐Not-approved
Adult MSKAPS	Move green to amber	Struggling to switch from virtual working through pandemic to hybrid delivery in new model. Will take a few months to settle into new approach. Need to pull data to review impact of service closure – may not be a concern but need to look at as amber and then review. Small team with some sickness and people using leave to support difficult home situations so impacting upon capacity.	☒Approved ☐Not-approved
Integrated equipment Service	Move amber to green	Small but stable (x 5 staff) just recruited to new full-timer so is now resourced for demand. Struggling to switch behaviours of referrers to expect the service to undertake all of the decision making and ordering process – as was brought in during covid to support staff – but now back to BAU. Need to sort out education packages to help referrers become more confident in decision making – new starter will allow this. Plans in place and stability rapidly returning.	☒Approved ☐Not-approved
Blue badge scheme	First status – green	Service had not been RAG rated previously. No concerns evident. FYI rate as green	☒Approved ☐Not-approved
ICT Referral centres	Move amber to green	Doesn't hold a waiting list manages demand at front door therefore no waiting list to recover.	☒Approved ☐Not-approved
ICT Occupational Therapy	Move amber to red	Demand at front door and within Home First and reablement is drawing OTs away from routine LTC work, thus waiting lists rapidly rising. Need data extract and reporting to sight organisation to patient impacts. Some vacancies also a concern	☒Approved ☐Not-approved
ICT Physiotherapy	Move amber to red	Demand at front door and within Home First and reablement is drawing Physios away from routine LTC work, thus waiting lists rapidly rising. Need data extract and reporting to sight organisation to patient impacts. Significant vacancies also a concern.	☒Approved ☐Not-approved

UCASS Directorate summary:

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21
RED	5	5	6
AMBER	6	4	1
GREEN	4	6	8

Directorate Current Recovery Red Services & Performance Exceptions

Urgent Care & Specialist Services (UCASS)		
Respiratory – Home Oxygen Assessment Service (HOAS)	Recovery red service	This month all pathways within the respiratory team are coded red due to the interdependency on the same workforce. The respiratory team is identified for a service support review approach next month. There has been a positive reduction in the total waiting in HOAS this FY compared to 2019/20 however the number of waits over 52 weeks is currently 31, compared to 23 in Aug 20 and 14 in Aug 19. Total waits is rising – 141 this month, 132 in July and 127 in June. Discussions with CCG re wider sources of prescribing and monitoring for Oxygen is underway.
Respiratory – Pulmonary Rehab (PR)	Recovery red service	Activity this FY to date is broadly tracking 2019/20 levels but the service is still managing the surge in referrals since between December 2020 and March 2021. The number of people waiting over 52 weeks is at 205 currently against a total of 588. In August 2020 this was 51 over 52 weeks among a total of 621, in August 2019 this was 17 among a total of 308. People are waiting longer – this month 205 of the 588 waiters have been +52 weeks, in August 2019 this was 17 out of 308 total waiters. Group sessions have now restarted, but they are running with reduced numbers due to covid. The team also use virtual delivery options, but at present this is only accepted by 20% of referrals, the rest are choosing to wait for face to face sessions.
Diabetes service	Recovery red service	Referral increase during pandemic. Whilst the average waiting time remains comparable to pre pandemic levels, it has risen quickly back to pre-pandemic levels since a low in June 2020. In August 2021, there were 14 people waiting 8 – 18 weeks for a first contact, this is the highest it has been for the last 2 years. Successful recruitment to dietician and education posts is positive. Whilst the team are resilient and coping well, there are limits to what GHC alone can do to address the demand the service is feeling as population health needs change.
Heart Failure	Recovery red service	Business case in progress for additional resource to meet demographic growth demand 2021/22 referrals are consistently higher than the previous 2 years This month 263 people are waiting for the service, all are currently below 36 week wait. There are plans to recruit to a senior clinician to use Cynapsis to prevent unnecessary / inappropriate referrals and support clinical decision making in primary care.
Cardiac Rehab	Recovery red service	Impacted by the inability to run face to face exercise programmes during the pandemic and latent demand emerging as primary care returns to BAU. Referrals in 2021/22 are above 20/19 but below the previous FY average. The number waiting has reduced to 35 this month from a peak of 97 in July 2020. 0-8 week waits have also reduced 61 in June to 26 this month, there is positive progress in this service.

Directorate Decisions Agreed this Month

Service	RAG change recommended	Notes	Decision by COO
Respiratory services:	Respiratory Core + HOAS + Pulmonary rehab to all to be red status.	HOAS is recovering but using the same workforce as the other 2 functions under the respiratory umbrella. Work needed to define functions across the service and consider is addressing 1 aspect is contributing to waiting lists in other functions. Until fully scoped and appraised recommend all 3 are red	☒Approved ☐Not-approved
Homeless Healthcare	Move amber to green	Lead now in place, estates issues resolved. Stable.	☒Approved ☐Not-approved
Bone health	Move amber to green	Well managed, no waiting lists. Current workload is manageable but less than pre-covid, Rag would change if demand increased back to pre-covid levels but hasn't been seen yet	☒Approved ☐Not-approved

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Hospitals Directorate summary:

Hospitals Directorate		
All sites	Performance exception	1 C. Diff case in August 21, whilst this is not above threshold, there have been 5 cases in the last 3 months. Re-admission within 30 days of discharge following a non-elective admission 8.1% against threshold of 8% Average Number of Community Hospital Beds Open – 181 compared to traditional bedstock of 196

There are currently no recovery programmes in place in the hospitals directorate.

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	21/22	
1.04	Care Programme Approach - formal review within12 months	86.8% (95.0%)	91.1% (95.0%)	

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

1.04: CPA (Care Programme Approach) – Formal review within 12 months [Community MH Services]
Performance for August is 86.8% (124 cases) against a performance threshold of 95% and is below Statistical Process Control (SPC) limits. Most of the cases are within Recovery (82) and Eating Disorders (6) services.

The mean number of days between the CPA review due date and the end of August is 84 days. The median is 40 days. Cases in exception are being validated with the services.

The Recovery service continues to struggle with high caseloads, high levels of acuity and a high turnover of staff in the Tewkesbury team. The staff shortage in Cheltenham due to short-term sickness have been resolved.

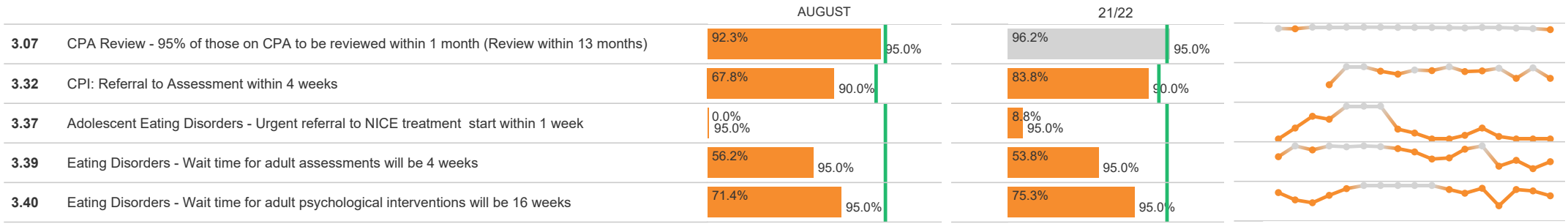
We have received National NHSE/I guidance outlining a CPA position statement which proposes replacing the Care Programme Approach using new principles. The NQT Directorate are considering alternative options to manage this going forward.

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



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

3.07: CPA (Care Programme Approach) – Formal review within 13 months [Community MH Services]
Performance for August is 92.3% against a performance threshold of 95% and is below Statistical Process Control (SPC) limits. This indicator is a subset of 1.04 and of those non-compliant records there were 70 where the CPA review is not recorded as having taken place within 13 months. Of these, 45 are within the Recovery Service. Cases in exception are being validated with the services.

The Recovery service continues to struggle with high caseloads, high levels of acuity and a high turnover of staff in the Tewkesbury team. The staff shortages in Cheltenham due to short-term sickness have been resolved.

We have received National NHSE/I guidance outlining a CPA position statement which proposes replacing the Care Programme Approach using new principles. The NQT Directorate are considering alternative options to manage this going forward.

3.32: CPI: Referral to assessment within 4 weeks [Community MH Services]
August performance is reported at 67.8% against a performance threshold of 90% and is below SPC the lower control limit. There were 9 non-compliant cases in August. Two patients cancelled multiple appointments and one client was waiting for a group to be re-started after COVID restrictions had been lifted

The remaining 6 clients were seen within 5 to 8 weeks with delays being due to staff vacancies and annual leave. The service continues to have vacancies with a particular issue in the South. A further advert, with a different approach, has recently gone out to attract applicants by inviting expressions of interest and offering some flexibility around the 'make up' of posts. The Service have a meeting planned to discuss workforce related issues and consider ways of creatively managing the current challenges.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
August performance is reported at 0% against a performance threshold of 95%. There were 5 non-compliant cases in August.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
August performance is reported at 56.2% against a 95% performance threshold. There were 7 non-compliant cases reported in August.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]
August performance is reported at 71.4% against a 95% performance threshold. There were 2 non-compliant cases reported in August.

Note on 3.37, 3.39 & 3.40 – Eating Disorders waiting times
The service now has very few remaining vacancies and are commencing workforce planning meetings to discuss how to proceed within the CMHT (Community Mental Health Transformation) programme.

The current wait profile for the service at the end of August indicates that 86.9% (458) of all patients waiting for assessment, are waiting over 4 weeks, and waiting times will continue to increase until

newly recruited staff are working at full capacity.

Capacity mapping for the service has indicated that the team is significantly under established to meet business as usual demands. This has been discussed and highlighted with commissioners and further investment has been secured as part of the CMHT (Community Mental Health Transformation) submission.

Demand remains high overall with a 24% increase in referrals during 2020/21 compared to 2019/20 and a significant increase in urgent referrals for under 18s (28% in 2020/21 compared to 17% in 2019/20) and this is continuing with 30.9% of referrals received in August being flagged as urgent. The main impact of this referral increase appears to be the detrimental effect that the pandemic, lockdown and school closures have had on Children and Young Peoples' wellbeing and mental health. This is validated by the replication in demand across other teams treating CYP.

The service is accepting routine referrals, which are being triaged and placed on a waiting list, however, assessment and treatment will continue to be paused throughout September 2021 which will impact on future reported waiting times and has led to several referrals being expedited due to the patients deteriorating condition. The service is working on reducing the urgent assessment waiting lists and hoping to bring the urgent assessment waiting times back in line with KPI's during October 2021.

Day treatment remains closed at this stage with staff capacity used to accommodate the increase in urgent referrals and is likely to remain closed until at least November 2021, however the service is working up a model to re-open this service and support reducing pressures in other areas such as RHED (High-risk) team and demand on specialist out of county in-patient beds and local acute medical beds.

The service has a development and improvement plan which focuses on all areas of recovery and will now begin to focus on how the future investment will be spent ensuring that the needs of the local population can be met and working towards bringing KPI's back in line.

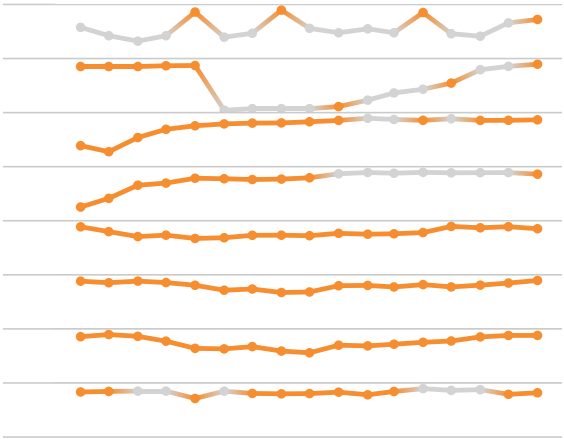
Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		AUGUST	21/22
26	Re-admission within 30 days of discharge following a non-elective admission	8.1% (8.0%)	6.9% (8.0%)
31a	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2	88.0% (90.0%)	69.5% (33.3%)
84	% of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor	94.4% (95.0%)	94.2% (95.0%)
85	% of children who received a 6-8 weeks review	94.5% (95.0%)	97.0% (95.0%)
86	% of children who received a 9-12 month review by the time they turned 12 months	80.6% (95.0%)	81.2% (95.0%)
87	% of children who received a 12 month review by the time they turned 15 months	91.5% (95.0%)	85.0% (95.0%)
88	% of children who received a 2-2.5 year review by 2.5 years	84.0% (95.0%)	78.8% (95.0%)
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	56.1% (58.0%)	58.1% (58.0%)



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

26. Re-admission within 30 days of discharge following a non-elective admission
The readmission rate for Community Hospitals in August is 8.1% compared to the threshold of 8.0%. This is within SPC chart upper and lower control limits based on 2018/19 and 2019/20 data but as a National indicator is highlighted. There were 11 readmissions during August out of a total of 135 admissions. The service has identified that these patients were transferred from the wards to GHT because of a deterioration in their condition that required a higher level of assessment and or intervention and returned to trust community beds following this.

31a: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
August performance was 88.1% compared to a target of 90%. 3,027 of the year 9 girls school cohort 3,437 have been vaccinated to the end August.

The School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort. The contributing factor to not meeting this target is that, owing to the Covid pandemic, and schools being closed from January until the 8th March 2021, over 700 Year 9 1st doses were not delivered until March.

For the 2nd HPV vaccination to be given there is the requirement for a 6 month interval between HPV 1 and HPV 2 vaccinations. This interval had not passed by the end of August and this is the contributing factor to an 88.1% uptake for HPV 2. In addition, the Service were unable to access one Secondary School within Gloucestershire in a high deprivation area whose cohort was 154 young people. These students were invited to our community clinics however, due to the nature of the school this offer was not accessed. The SAI team have worked closely with PHE to resolves this access issue and this has been resolved for the 2021/2022 academic year.

84: Percentage of live births that receive a face-to-face New Birth Visit within 7- 14 days by a Health Visitor [Children and Young People Service]
94.5% of the eligible children who received a New Birth Visit (NBV) in August 2021 was within 7-14 days of birth against a threshold of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator. The increase in babies remaining in NICU (Neonatal Intensive Care Unit)/ hospital is impacting on access for timely delivery resulting in the breach. Of the 29 exceptions, 14 babies were in NICU/ hospital. 1 declined the service and were unable to be seen to be seen in timeframe.

85: Percentage of children who received a 6-8 week review within 8 weeks by a Health Visitor [Children and Young People Service]
94.6% of the eligible children who received a 6-8 week review in August 2021 was within 8 weeks of birth against a threshold of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator. 16 families (64% of exceptions) were not available in timeframe but have since been seen. 8 babies were seen late due to rescheduling of visits to support priorities in service.

86: Percentage of children who received a 9–12-month review by the time they turned 12 months [Children and Young People Service]
80.6% of eligible children received the 9-12 month visit by a Health Visitor in August 2021 compared to a threshold of 95%. 97 out of 501 children did not receive the visit within timeframe of 9-12 months. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

The parents of all children in this cohort were offered the opportunity to receive a 9-12 month review. For all children classified as universal with low risk, virtual appointments via Attend Anywhere are being offered for developmental reviews as the estate available for face to face is reduced. Some families are still request face to face contact and declining the virtual offer. In these cases there is a small wait list, resulting in completion out of timeframe. This accounted for 41.2% of exceptions. 50% of exceptions declined or did not attend the appointment.

87: Percentage of children who received a 12-month review by the time they turned 15 months [Children and Young People Service]
91.6% of eligible children received the 9–12-month visit (by the time they were 15-months old) by a Health Visitor in August, compared to a target of 95%. 40 out of 476 reviews in August were not completed within the target timeframe of 15 months. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

Catch up developmental clinics have been completed where parents have rebooked the review, now they are more comfortable to do so. 85% of exceptions were declines or did not attend the appointment.

88: Percentage of children who received a 2-2.5-year review by 2.5 years [Children and Young People Service]
84.1% of eligible children received the 2-2.5-year mandated contact by a Health Visitor in July, compared to a target of 95%. 75 out of 471 reviews were not completed within the target timeframe of 2-2.5 years. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

All universal partnership (UP) and universal partnership plus (UPP) are seen face to face in the home setting for a full family health needs assessment. The service will be returning the 2-year ASQ (Ages & Stages Questionnaire) to face to face activity with an additional intervention called the Early Language Identification Measure (ELIM). 89% of exceptions were declines or or did not attend the appointment.

Additional Commentary for 84, 85, 86, 87 and 88
The health visiting service is a universal service and so all families in Gloucestershire are offered the mandated contacts and are included in the denominator but not all may wish to engage in all contact types.

The Health Visiting Service have a number of performance exceptions, which are reported further in the service's Performance Exception Action Plan (PEAP) tabled at BIMG. The service is trying to increase the offer of face-to-face capacity as estates allows, they are continuing to offer parental choice of virtual appointments and are working with Early Years to target the most vulnerable children.

Robust triage aims to identify those children who are 'hard to reach' but classified as universal to increase equity of access. The service is working with Maternity Voices Partnership to increase engagement with service users and pre-appointment text message reminders are being sent to parents/carers. The service in the month of August had reduced capacity due to 7.2% sickness rate, 2.5wte vacancy and 3.72wte maternity, and 3.3wte capacity moved across to support District Nursing.

91. % of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) [Children and Young People Service]
Breastfeeding prevalence was 56.1% in August compared to a threshold of 58%. Performance has averaged 57.8% in the previous 3 months to July 2021. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

The service suggests this indicator is not a true reflection of its delivery around Breastfeeding rates. The number of children being breastfed at 6 weeks after birth depends how many started being breastfed in the first place (i.e. Breastfeeding Initiation), and Breastfeeding Initiation is a midwifery indicator. Hence in contract monitoring with Commissioners, it is acknowledged that this indicator is outside of GHC Health Visiting service influence.

The related indicator which measures maintenance of breastfeeding by looking at the percentage of mothers who are still breastfeeding at 8 weeks since breastfeeding at 2 weeks, is at 81.2% with a target of 80%. The service will continue to promote breastfeeding antenatal and support the wider system to increase initiation rates.

91. % of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence). [Children and Young People Service]
Breastfeeding prevalence was 56.1% in August compared to a threshold of 58%. Performance has averaged 56.8% in the previous 3 months to July 2021. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

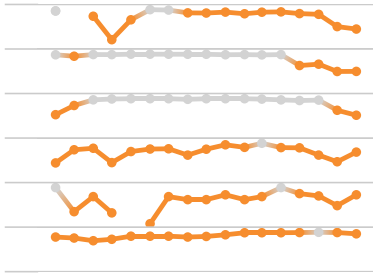
Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		AUGUST	21/22
42	MSKAPS - % treated within 8 Weeks	51.5% 95.0%	78.2% 95.0%
43	MSK Physiotherapy - % treated within 8 Weeks	57.1% 95.0%	68.9% 95.0%
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	58.8% 95.0%	84.2% 95.0%
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	72.3% 90.0%	69.7% 90.0%
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	80.0% 92.0%	77.4% 92.0%
95	Average Number of Community Hospital Beds Open	96.2% 100.0%	98.8% 100.0%



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

42. MSKAPS - % treated within 8 Weeks [Adult Community Services]
August performance was 51.5% compared to a threshold of 95%. 108 out of 223 patients seen in August were seen outside the 8-week target of timeframe of referral to first contact. This is below SPC lower control limit based on 2018/19 and 2019/20 data.

Some instances are due to patient choice where the patient has not booked their next appointment within the expected timeframe. A reminder is sent by the service, approximately 3 weeks after the initial communication. Other, additional influencing factors include staff annual leave, staff self-isolation, sickness and awaiting the start dates of recent recruits.

The Business Intelligence team is currently working with the service to capture clinically significant telephone contacts within the referral to treatment (RTT) pathway. The service is predicting that recovery will be achieved from October as the new model and staffing settles.

43. MSK Physiotherapy - % treated within 8 Weeks [Adult Community Services]
August performance was 57.2% compared to a threshold of 95%. 558 out of 1,303 patients seen in August were seen outside the 8-week target of timeframe of referral to first contact. This is below SPC chart lower control limit based on 2018/19 and 2019/20 data.

The service continues to work through their recovery plan and again has seen an increase in patient contacts in August despite accommodating annual leave. Further recruitment is underway with new colleagues expected to start in October. Sickness, maternity & adoption leave continue to impact capacity.

52. Paediatric Speech and Language Therapy - % treated within 8 Weeks
August performance was 58.9% compared to a target of 95%. 81 out of 187 young people seen in July were seen outside of the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit based on 2018/19 and 2019/20 data.

There are significant gaps in service due to 5.4 WTE on maternity/adoption leave, and 8.15 WTE vacant posts (including 5 WTE posts being recruited to as part of the recovery plan). The service continues to offer a blended model of delivery based on clinical need and risk assessment. The service is also setting up an advice line and training for schools, and also increasing the resources available to schools on their website in anticipation of increasing demand in the new academic year.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks [Adult Community Services]
13 out of 47 new adult referrals were assessed outside of the 8-week threshold in August. Performance is 72.3% and below the threshold of 90%. The service has been balancing planned annual leave with episodes of staff sickness within the same time period. This has reduced the capacity of staff available for assessment in order to balance triage and urgent requirements of the service.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral [Adult Community Services]
1 out of 5 equipment were not delivered within 18 weeks of referral in August. Performance was 80% compared to a threshold of 92%. This was due to the client requiring an additional assessment for moulded seating, the handover date was agreed at the assessment and fixed by the Specialist Seating Rep's availability – this meant we were 3 days outside the time frame. Average performance in the previous 6 months to July was 80%.

Additional Commentary for 67 & 71

The Wheelchair Service continues to collaborate with the Business Intelligence team (BI) 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, alongside actions agreed following an external audit, is reflected in the improved performance data.

95: Average Number of Community Hospital Beds Open [Hospitals]
The average number of beds open in Community Hospitals in August was 181. When compared to the traditional bed stock of 196 beds and reduced bed stock of 188 beds), the indicator is below SPC Chart lower control limits based on 2018/19 and 2019/20 data.

This is due to the need to reduce occupancy in Jubilee Ward, In readiness for the planned move to Preston Ward, Cirencester for the refurbishment programme. The service reduced the number of beds gradually throughout the month before all patients had been transferred over to Preston Ward.

Admissions to Jubilee Ward ceased from 2nd August and discharges progressed, so that on the day the ward moved to there were only 6 patients. When at Preston Ward the service increased their patient numbers by two a day until they reached 13 patient occupying beds on the 27th August.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements

		AUGUST	21/22	
77	Mandatory Training	88.8% (90.0%)	88.4% (90.0%)	
78	% of Staff with completed Personal Development Reviews (Appraisal)	29.7% (90.0%)	63.0% (90.0%)	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Exclusions Applied	29.3% (90.0%)	63.4% (90.0%)	
79	Sickness absence average %	4.1% (4.0%)	4.0% (4.0%)	

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

77: Mandatory Training [Workforce]
Performance was 88.9% in August, below the target of 90%. This is below the SPC chart lower control limit based on 2018/19 and 2019/20 data. Excluding Bank staff, compliance is at 93% which is above the threshold of 90%.

The work that services/teams have been undertaking to re-instate training compliance levels has shown good improvement over recent months although the Trust's overall training compliance figure has shown a slight dip this month, which is often the case over the summer due to annual leave. However, the overall training compliance figure minus staff bank has remained at 93.4%, above the Trust overall compliance target.

78: % of Staff with completed Personal Development Reviews (Appraisal) [Workforce]
Performance in August was 70.3% compared to a threshold of 90%. This is below SPC chart normal variation based on 2018/19 data. Performance has been at an average of 68.6% in the previous 12 months.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. [Workforce]
Performance in August was 70.7% compared to a target of 90%. There is increasing focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data.

Additional commentary for 78 & 78a
There has been a slight reduction in the % of completed appraisals this month which could be due to a number of factors including annual leave, capacity and not recording on ESR. Reminders are sent out to all managers giving 3 months' notice of when the appraisal for their teams is due and encouraging managers and colleagues to book their meetings. This is to encourage appraisals to be completed and recorded on the Electronic Staff Record (ESR). Managers are regularly reminded of the need to complete appraisals as an important part of being a supportive and inclusive leader in the Trust. In conversation with staff side the Trust are working on slightly revised paperwork to help support effective and meaningful conversations, which will be launched soon.

The new trust leadership programme includes a module entitled Appraisal Conversations. The aim of the programme is to encourage leaders to engage with their staff and this module will assist and provide practical advice and support in doing so, which it is hoped will continue to improve performance for this indicator.

79: Sickness absence average % rolling rate - 12 months
The sickness absence rate for the Trust to the end of August is 4.1% (the Trust target for sickness absence is 4.0%). Performance is below SPC chart normal variation based on 2018/19 data. Sickness absence reporting on the new operational Workforce Tableau report now reflects reporting for the current month only.

The Executive Directorate shows sickness absence at 5.3% for Corporate Governance. Similarly, within the Finance Directorate sickness absence within Estates and Facilities sits at 5.3%. Nursing, Therapies & Quality have a sickness absence rate of 10.8% within Quality Assurance.

Within the Operations Directorate the sickness absence rate for CYPS is 4.4%, with the CYPS Learning Disabilities team reported at 18.3%. The sickness absence rate for Hospitals is 4.2%. Working Well alongside the HR Managers assigned to the service areas are continuing to support line managers on all aspects of the operation of the Supporting Attendance Policy, helping to maintain consistency in its application. With the new Workforce tableau report this will enable HR Managers to further understand the services with higher sickness absence levels to be able to provide additional support focused in those areas.

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Measuring what matters

A performance management plan

2022/23

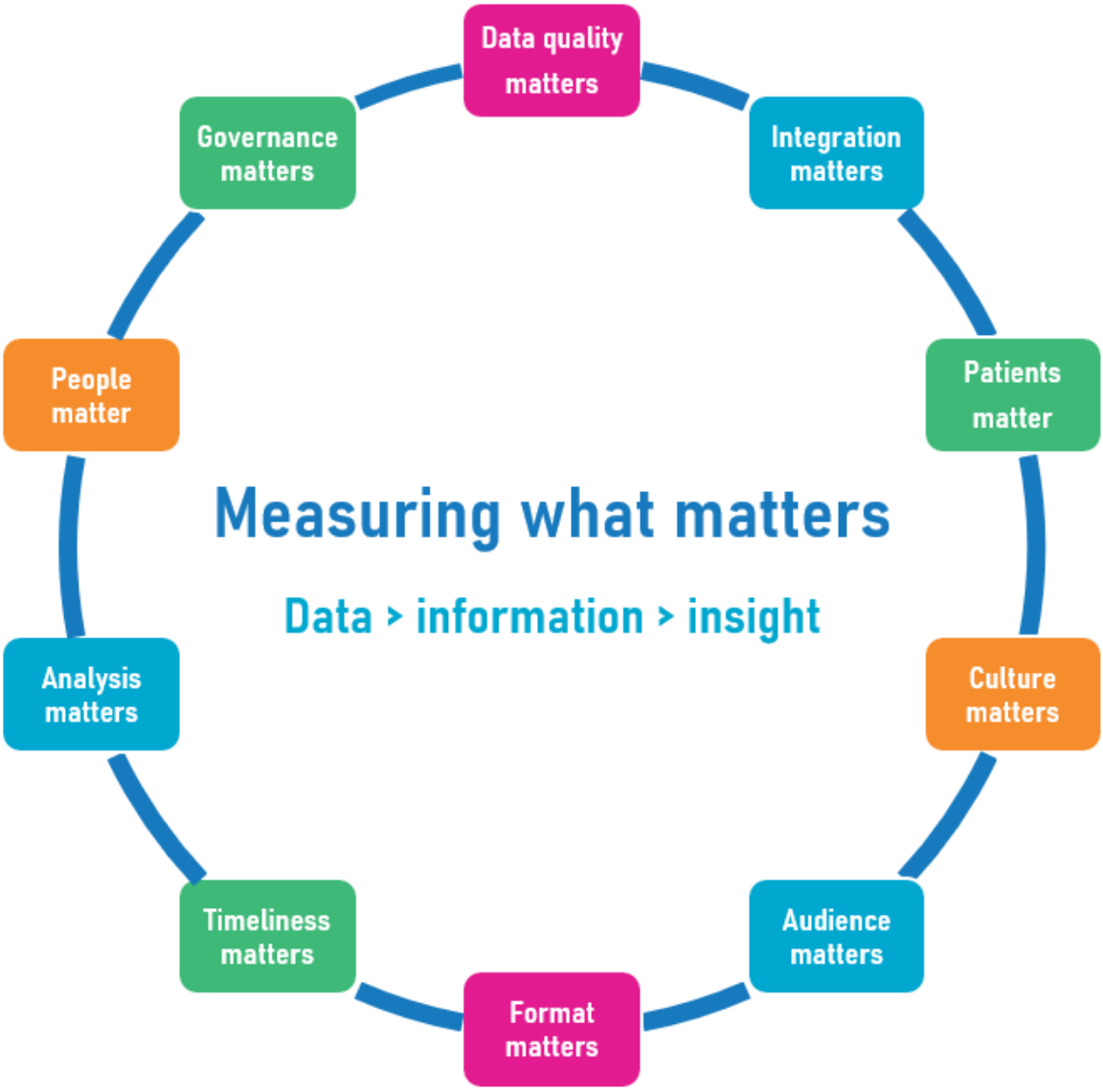
Introduction

In July 2021, leaders within Gloucestershire Health and Care NHS Foundation Trust (GHC) came together to ask themselves whether the organisation was measuring what matters most to the business. The aim was to inform and develop a high-level, long-term performance plan to further improve care outcomes, experiences, clinical safety and inequalities.

This document summarises the key ideas that came from this Seminar and all the discussions that followed with wider stakeholders. Although there is crossover, the learning is clearly summarised through **ten high level themes** with associated aims and high-level milestones* that can provide a robust performance reporting foundation for the organisation and help to measure progress.

**Milestones are currently provisional whilst wider stakeholder engagement on theme structure, detail and dates is underway*

Key themes



Data quality matters: *The numbers need to make sense*

Business intelligence services, clinical system teams and operational managers work together every day to ensure that clinical and administrative staff have access to informative performance reports that reflect their daily activities. However, difficult, routine challenges can often mean that data quality remains an ever-present, important risk for the organisation.

To achieve the full potential of reporting, there must be robust data recording within all Trust data systems. All systems users have a responsibility in assuring their data capture is timely, accurate and of high quality so that it reflects actual delivery and can be relied upon; for themselves and their colleagues. Additionally, support services, systems managers and processes must work collectively to support system users with the training and time to coordinate a routine cycle of data validation and audit to ensure that it is meaningful and representative.

Aims:

- *Automated, regularly available data quality exception monitoring for all services*
- *Subscription and alert functionality setup to automatically inform staff of key data quality exceptions when they occur*
- *Routine data quality conversations and checks within all staff supervision sessions*
- *Regular data quality audits within services and at a clinical and corporate level*
- *Coproduced schedule for contractual, but clinically relevant and operationally beneficial Data Quality Improvement Plans (DQIPs)*
- *Corporate and operational collaboration to improve training, digitalise processes and upgrade technology and system software to minimises the burden of data collection*

Key Milestones:

- *Tableau subscriptions and alert functionality promoted across services by December 2021*
- *Nursing, Quality and Therapies (NQT) Directorate Data quality audit schedule for 2022/23 to be agreed by Jan 2022 for April 2022 start*
- *SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered by the end of Q2 2022/23 (by October 2022)*
- *Revised data quality reporting portfolio deployed within Tableau for physical health services through 2022/23 but concluded by October 2022*

Integration matters: *Multiple systems but a single truth*

Where it is available, native system reporting can offer value to an organisation however unconnected access to disparate data can be frustrating and confusing when things don't align with each other or make sense. Although equally relevant to corporate systems, independent clinical system data doesn't deliver GHC's merger ambitions of aligning mental health, learning disabilities and physical health services. Although challenging, triangulating information from multiple sources into unified presentations can aid staff at all levels understand how their services are really performing.

Alongside better system interoperability, GHC is bringing together data from multiple data sources such as workforce, finance, quality and clinical systems into a single data warehouse. This integrated data warehouse unifies multiple data sources across clinical and corporate systems using a common language and organisational hierarchy which is now managed through a strict change control process. Collectively, this will ensure that stakeholders will have a holistic presentation of how they are performing within the organisation; a single version of the truth that resonates with services.

Ultimately, through the single BI visualisation platform 'Tableau' this holistic performance management will aid user understanding, data confidence and engagement. Integrated intelligence will help consumers better understand their services and the wider system it operates within. It will allow them to ask the right questions, better inform their planning and strengthen their decision making.

Aims:

- *Further develop existing clinical and corporate system extracts and dataset reporting capabilities such as appraisals (within ESR) and improve (near) real-time data feeds*
- *Plan for the ongoing data integration of additional clinical and corporate systems where feasible and valuable such as Datix, Totara (Care to Learn Training) and Allocate (Rostering)*
- *Consider and plan for wider complimentary data systems data warehouse inclusion such as Mitel (telephony), Sustainability (carbon outputs) sources, Security and Estates*

Key Milestones:

- *Server migration to allow for reconfiguration and resolve licensing concerns by November 2021*
- *Develop additional Board performance dashboard workforce indicators to include:*
    - *Deployment of monthly Vacancy Rate by Sept 2021*
    - *Development of monthly (Cumulative) Annual Leave Consumption by Oct 2021*
    - *Development of monthly Turnover/ Stability Rate by Nov 2021*
- *Deploy first Datix Reports by April 2022*
- *Deliver Totara (Care to Learn) extraction by April 2022 and first report deployment by Oct 2022*
- *Deliver Allocate (e-Rostering) extraction by April 2022 and first report deployment by Oct 2022*

Patients matter: *Clinical outcomes drive the business*

Although performance monitoring tools for wait times and patient experience feedback provides an outline; for the organisation to be able to effectively monitor whether it is fulfilling its strategic goals the organisation should move towards value-based healthcare. This meaningful approach should optimise interventions, be personally focused and clinically valid to deliver the best patient outcome. These measures can be Clinically Reported Outcome Measures (CROMs), Patient Reported Outcome Measures (PROMs) or Patient Reported Experience Measures (PREMs). This approach should consider whole clinical pathways from prevention, early intervention, early accurate diagnosis, treatment and discharge and be led by clinical experts in the field. Wherever possible, transferable global measures can also help inform wider performance evaluation and benchmarking.

In addition, GHC needs to continue to work closely with system partners to tackle health and inequalities across Gloucestershire and improve health and care for its citizens.

Aims:

- *Through co-production, more time should be invested on understanding patient needs and what matters most to them.*
- *Use clinical leadership across the Integrated Care System (ICS) to review national guidance and regional best practice to inform strategic approaches to value-based healthcare within services and identify what outcome measures are available to service areas*

- *Engage with system owners, users, Commissioners and patients to understand what value measures should be adopted to ensure that they are meaningful to services and patients*
- *Work with system partners to invest more capacity to understand inequalities across provision, particular to improve accessibility of groups underserved within the population or whom aren't accessing GHC services*

Key Milestones:

- *Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23*
- *Deploy trial of first tranche of new outcome measures by March 2023*

Culture matters: *Organisational values inform behaviour*

The Digital Strategy prioritises programmes which digitally progress the organisation and specifically outlines a priority for Information Management, namely to: Empower people; Empower clinicians; Integrate systems; Revolutionise information and Build the future. In turn, GHC's aims, values and culture need to embrace the potential of data, information and insight across all roles if the Trust is to embed business intelligence as a primary source for decision making. This includes incorporating performance management concepts across its governance processes, operational practices and documentation in an effort to underpin how the Trust expects its staff to operate.

To achieve these performance ambitions, there needs to be strong information leadership across the Integrated Care System (ICS) and within the Trust. Supported by documentation, GHC leaders need to promote the benefits of a strong data culture at all levels which allows others the time to engage, contribute and collaborate.

Aims:

- *Ensure digital technology and infrastructure is in place to enable reliable data extraction, organisation, and presentation*
- *Roll out of (near) real time, point of contact performance and activity monitoring reports and dashboards*
- *Colleagues and system partners have access to reliable, robust data and information*
- *Ensure reliable and simple information interpretation to all staff through a single visual analytics tool*
- *People can be assured that all data sharing and any increase in data use consistently aligns to legal and regulatory compliance with cyber security and information management standards*
- *Increase professionalised informatics accreditation and achievement of professional analyst standards*

Key Milestones:

- *Decommissioning of final ad-hoc Excel physical health reporting by July 2022*

Audience matters: *all perspectives are different*

Performance reporting means different things to different people. To some audiences it can provide assurance that they are moving in the right direction, that they are progressing their strategic aims or can acknowledge strong performance. To others it can be about benchmarking against peers, or it could be about highlighting issues or forewarning risk. More so, people often only really engage with

information if it is provided to them in a format that is easy to use, interpret and it is meaningful to their role. Given every audience member is different there will never be a single format that is right of all stakeholders.

Regardless of the consumer, simplicity is often a common BI requirement as providing clear, headlines from information allows a consumer the time for their own thoughtful consideration, wider debate and further bespoke questioning. Ironically, there can sometimes be conflict with this approach as it can come at the expense of the granular detail which many desire, if not need. Market leading BI tools can offer flexibility to dynamically respond to multiple audience lenses. This approach can often provide reassurance that their interpretation is accurate, but also to allow for tailored interrogation to inform users to ask better questions.

Aims:

- *All colleagues across the Trust, including Board members feel confident to use powerful data interrogation self-service tools and value compelling dashboards to effectively support their own decision making, identify questions, drive improvement and target resources*

Key Milestones:

- Review Key Performance Indicator portfolio by Jan 2022 to inform 2022/23 contract schedule and operational/ strategic needs
- *Publish proposal to restructure the current performance dashboard to support various audience level perspectives by April 2022*

Format matters: *Easily understood data*

Staff are now working across multiple sites at differing times of the day through a variety of devices. Although consumers have different information needs, they also require autonomy and responsiveness to inform the direction of their services. As such it is no longer sufficient for fixed data reports or reminders to be sent to stakeholders intermittently or made periodically available in a single location within a Trust's server at a certain time of day. Data consumers need to be able to pull the data they need whenever they want it.

Good business Intelligence needs to support constant scheduling of information, automating the regular delivery of relevant, user informed reports which will allow stakeholders to access and interact with consolidated information from multiple sources across multiple devices using web browsers wherever they need it. Modern-day business Intelligence must offer flexibility, allowing data to be visualised in a number of different ways; placing the power literally at the fingertips of the individual user so that they can effectively apply their knowledge to add context and answer the question posed. Furthermore, 'seeing is understanding', meaning visual leverage (as opposed to tabular data) can aid consumers to confirm or conflict their assumptions and should be the new normal.

Finally, efficient, user friendly and intuitive data visualisations will improve autonomous usability and release analytical capacity to better support information consumers with education and operational analysis.

Aims:

- *Rationalisation of the current information systems and reports, dynamically automating reporting and linking them to automatically updating datasets wherever possible*
- *Improved visibility and promotion of information leading to higher consumer motivation*

- *The information output from our performance systems is clear, understood and used to actively monitor the status of individual, team, service and Trust performance*
- *Engaged business partnering across all corporate support functions to discuss evidence-based performance and meaning*
- *Expand implementation and scope of BI Analytics tool enabling reports, dashboards, and alerts to be viewable on all devices.*

Key Milestones:

- *Deliver real-time performance dashboard interrogation pilot for Resources Committee members by Sept 2022*

Timeliness matters: *Data when it is needed*

As data appetites increase, the Trust must ensure information is available to stakeholders when they need it, and it needs to be as up to date as possible. It also needs to have the ability to draw out the insight as they require it, probing patient and itemised level data where available. System users also want to see the impact that their interactions can make on data quality through immediate response.

Readily accessible business Intelligence reduces the burden on an overcrowded BI development portfolio and can supply users with dynamic, (almost) real-time information that could be manipulated by the user. This will transform the user engagement within the Trust, free up finite development time which in turn offers capacity to better analyse the data they are supplied.

Aims:

- *Automated reporting direct from system sources using direct and full dataset extracts, updated at least daily wherever possible*
- *Leveraging system suppliers to provide real time, or near real time data extraction, building it into contractual negotiations where appropriate*

Key Milestones:

- *Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly for April 2023 when RiO and SystmOne contracts are due for renewal*

Analysis matters: *take time to ask "so what"*

With aggregated data there is always a risk of overlooking insights only recognised within the detail. Unfortunately, although often desired, busy agendas rarely allow the time to present or analyse the detail that many would like.

However, modern business intelligence tools can now provide the dual benefit of dynamic multi-level interrogation which can be investigated on demand, often by users. In other words, headlines can be presented, but the detail made available. Members, be them clinicians, administrators, managers and analytical business partners can collaborate to ask "*why*" or "*so what*" quickly and repeatedly. This allows for trends and answers to be spotted quickly so that insights can be acted upon. Not that users should be left to find the answers alone. Cohesive business partnering should be established across corporate services to support operational staff. These skilled area experts can help users define their problems, identify who is affected, what is the problem, where it happens

and why it matters. In collaboration they can collectively use empathy to experience the patient pathway and gain the most from the data.

Within GHC, progressive Business Intelligence tools such as Tableau allows users to visualise and analyse their data and iterate it to answer their questions and find the compelling story threads within their arguments, or challenge long held assumptions. Automation also reduces the administrative burden of traditional ad-hoc reporting allowing for more proactive analysis to be undertaken such as trend prediction and forecasts.

Aims:

- *An integrated portfolio of service reports that presents historical trends, indicates predicted performance and demand and capacity forecasting*
- *Managers changing the way they distribute resources, design service pathways and seek development investment based on accurate forecasting models*
- *Health population analysis and benchmarking to inform whole system strategy*

Key Milestones:

- *Realising holistic business partnering across all corporate partners by January 2022*

People matter: *Digital learning and development*

Digital skills are a competitive advantage, but they are often overlooked in a crowded workload of competing activities. They can arm colleagues with the skills to work optimally with data and technology which are now essential for key decision making. Unfortunately, although we all have the potential for further learning, for various reasons there is currently inconsistent digital literacy, confidence, and competence across most large organisations. Some colleagues use information every day to inform their actions and service delivery, whilst others have never realised its benefit and rarely interact with data.

By supporting staff with the time to learn the appropriate skills necessary to improve their digital literacy, colleagues can perform more efficiently in their roles. By delivering the Trust's Digital Strategy and investing in the universal language of data, GHC can improve data fluency across all roles to the benefit of the business.

Empowering all patients, carers and citizens within the County can also progress the organisation. Health literacy and behaviours will help patients and families inform and make good health and lifestyle choices. Recognising early signs of illness will give them the confidence to seek help and can co-create their healthcare decisions, importantly supporting clinicians in their complex roles.

Aims:

- *Self-evaluation of digital skills and knowledge levels determined through audits and surveys*
- *Digital needs assessed for new staff at recruitment and induction*
- *Evaluation of adequate digital skills and knowledge within three months of starting the post*
- *Identify development and ongoing needs in supervisions and appraisals*
- *Robust business partnering between system specialists, analysts and consumers to inform practice and support staff with their decision making*

Key Milestones:

- *Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day business processes*
- *BI support guidance will be made available through the intranet to support users from Oct 2021*
- *Learning & Development Service to inform a Digital Competency timetable for 22/23 by April 2022*

Governance matters: *principles for a high performing organisation*

GHC needs to successfully deliver national performance standards alongside the contractual thresholds expected by its Commissioners. In addition, it needs to maintain oversight on strategically and operationally important, internally agreed context indicators. These priorities need to be balanced within a safe governance structure which protects its activities, its workforce and its patients.

Alongside existing documentation and governance structures, the Trust seeks to implement a clear, supportive and transparent Performance Management Framework which sets out the overarching principles and approach to delivering a high performing organisation. The primary purpose of a Performance Management Framework is to provide guidance, support, tools and intervention for systematic, continuous improvement and a mechanism for monitoring, managing and escalating service level performance across the organisation. Areas within scope of the Project Management Framework are Key Performance Indicators (KPIs), management by exception, Statistical Process Control (SPC), audience lenses, benchmarking, data quality, performance assurance and operational Performance Exception Action Plans (PEAP). The framework is also a key engagement tool to demonstrate ownership and accountability of performance at every level of the organisation.

In addition, GHC is increasingly recognising the value that effective information sharing can bring across partners within an Integrated Care System. GHC needs to understand where the CCG and other stakeholder programmes are on long term data sharing for both direct and indirect patient care so it can play a full and active part in its development and implementation.

Aims:

- *Performance Management Framework to be agreed and published*
- *Review all contractual and internal service KPIs*
- *A fully supported mechanism of data sharing strategy to be developed across the local health economy*

Key Milestones:

- *Cleanse proxy indicators from Q3; October Data (for Nov 2021 reporting)*
- *Publish Performance Management Framework in Dec 2021*
- *Remove superseded National and Local Performance Indicators by April 2022*
- *Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline for March 2022 for April 2022 Resources Committee*
- *Introducing new internal performance indicators into performance dashboard by July 2022*

Summary

Data isn't an end within itself, but it can help the organisation move to where it needs to be. Through engagement and shared system learning, GHC believes that data can become informative to help our colleagues better understand what has happened, why it happened and how it happened. Furthermore, through balanced co-production, an understanding of our information can provide evidence-based insight to legitimise opinions or inform its future decisions, mitigate risk or allow repeated success.

By working together through a cycle of continuous improvement, GHC can establish the best digital and intelligence capabilities to provide outstanding care which makes a difference and enables people to live the best lives they can.

A high-level timetable to monitor progress against this plan and the milestones listed within this paper (as presented on the next page) will be provided regularly within the monthly Performance Dashboard from October 2021 (Q3).

Measuring what matters

A performance management plan

2022/23

Theme	(Provisional) Milestone	Target date	Progress
Data Quality matters	*Tableau subscriptions and alert functionality promoted across services*	*Dec 2021*	
	NQT Data quality audit schedule for 2022/23 to be agreed	*Jan 2022 for Apr '22 start*	
	SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered	*by Oct 2022*	
	Revised data quality reporting portfolio deployed within Tableau servers for physical health services	*by Oct 2022*	
Integration matters	*Server migration to allow for reconfiguration and resolve licensing concerns*	*by Oct 2021*	
	Develop additional Board performance dashboard workforce indicators to include: o *Deployment of monthly Vacancy Rate* o *Development of monthly (Cumulative) Annual Leave Consumption* o *Development of monthly Turnover/ Stability Rate*	 *by Sept 2021* *by Oct 2021* *by Nov 2021*	
	Deploy first Datix Reports by April 2022	*by April 2022*	
	Deliver Totara (Care to Learn) extraction by April 2022 & first report deployment	*by Oct 2022*	
	Deliver Allocate (e-Rostering) extraction by April 2022 & first report deployment	*by Oct 2022*	

Patients matter	*Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23*	*By Dec 2022*	
	Deploy trial of first tranche of new outcome measures	*by April 2023*	
Culture matters	*Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day business processes*	*by April 2022*	
	BI support guidance will be made available through the intranet to support users	*by Oct 2021*	
	Learning & Development Service to inform a Digital Competency timetable for 22/23	*by April 2022*	
Audience matters	Review Key Performance Indicator portfolio to inform 2022/23 contract schedule and operational/ strategic needs	by Jan 2022	
	Publish proposal to restructure the current performance dashboard to support various audience level perspectives	*by April 2022*	
Format matters	*Deliver real-time performance dashboard interrogation pilot for Resources Committee members*	*by Sept 2022*	
Timeliness matters	*Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly when RiO and SystmOne contracts*	*by April 2023*	
Analysis matters	*Realising holistic business partnering across all corporate partners by January 2022*	*by Jan 2022*	
People matter	*Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day business processes*	*from Nov 2021*	
	BI support guidance will be made available through the intranet to support users	*from Oct 2021*	

	Learning & Development Service to inform Digital Competency timetable for 22/23	*by April 2022*	
Governance matters	*Cleanse proxy indicators*	*Oct Data (for Nov 2021 reporting)*	
	Publish Performance Management Framework	*in Dec 2021*	
	Removing superseded National and Local Performance Indicators	*by April 2022*	
	Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline	*for March 2022 for April 2022 Resources Committee*	
	Introducing new internal performance indicators into performance dashboard	*by July 2022*	
	Deliver real-time interrogation pilot for Resources Committee	*by Sept 2022*	

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AGENDA ITEM: 11/0921

REPORT TO: **Trust Board – 30th September 2021**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st August 2021**

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 5 position

Executive summary

- The Trust has a H1 plan of break even
- The Trust's position at month 5 is a surplus of £34k
- The Trust is forecasting a H1 position of break even
- The cash balance at month 5 is £58.8m
- Capital expenditure is £1.651m at month 5
- The Trust has spent £0.825m on Covid related revenue costs between April and August
- Guidance on financial framework H2 (October 21 to March 22) is not expected until the end of September

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: Sandra Betney	**Title:** Director of Finance

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Finance Report
Month 5

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

Overview

- Gloucestershire ICS has been given an overall funding envelope that it collectively has to manage for the first six months of 21/22, known as H1
- The Trust has a H1 financial plan of break even following allocation of the system envelope
- At month 5 the Trust has a small surplus of £34k and a six month forecast position of break even in line with the plan
- The Trust has recorded Covid related expenditure of £0.825m for April to August
- The Trust has revised its five year capital programme. In 21/22 the plan remains at £15.993m but a number of adjustments to scheme costs and priorities have been agreed.
- 21/22 Capital plan is £15.993m and spend to month 5 is £1.651m which is £2.7m less than the year to date plan to NHSI. Backlog maintenance schemes are being brought forward to replace schemes that have slipped.
- Cash at the end of month 5 is £58.8m, a increase of £1m on last month
- Guidance on the financial framework H2 (Oct 21 – March 22) has been delayed by 5 weeks and is not expected until the end of September. This is expected to advise;
    - Efficiency Averages to 2% (no system exceeds 3%) which is reflected in the Risk slide
    - Covid funding will be reduced by 5% compared to H1
    - Pay award will be funded

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2021/22 Original Plan	2021/22 NHSI H1 plan	2021/22 NHSI H1 plan ytd	2021/22 Actual ytd	2021/22 Variance	2021/22 H1 Forecast	2021/22 Full Year Forecast
Operating income from patient care activities	220,598	112,680	93,900	95,197	1,297	114,220	228,751
Other operating income	6,700	5,634	4,695	3,475	(1,220)	4,086	9,663
Employee expenses	(170,274)	(84,531)	(70,443)	(73,223)	(2,781)	(87,326)	(175,894)
Operating expenses excluding employee expenses	(53,533)	(32,454)	(27,045)	(24,388)	2,657	(29,751)	(60,048)
PDC dividends payable/refundable	(2,701)	(1,353)	(1,128)	(1,079)	49	(1,295)	(2,612)
Other gains / losses	0	0		6	6	8	20
Surplus/(deficit) before impairments & transfers	**790**	**(24)**	**(20)**	**(12)**	**8**	**(58)**	**(120)**
Remove capital donations/grants I&E impact	100	24	20	46	26	60	120
Surplus/(deficit)	**890**	**0**	**0**	**34**	**34**	**2**	**0**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	**0**	0		0
Revised Surplus/(deficit)	**890**	**0**	**0**	**34**	**34**	**2**	**0**

Note. The variance compare NHSI H1 plan ytd against Actual

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2020/21	2021/22	2021/22	2021/22			2021/22
		Actual	Original Plan	NHSI H1 plan	NHSI H1 plan ytd	Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	488	488	488	488	289	(199)	200
	Property, plant and equipment: other	109,796	119,881	115,135	113,552	108,662	(4,890)	118,892
	NHS receivables	276	0	0	0	0	0	0
	Non-NHS receivables	316	0	0	0	248	248	252
	Total non-current assets	**110,876**	**120,369**	**115,623**	**114,040**	**109,199**	**(4,841)**	**119,344**
Current assets	Inventories	718	418	568	618	718	100	418
	NHS receivables	6,077	5,877	5,977	6,010	6,968	958	5,512
	Non-NHS receivables	5,928	5,928	5,928	5,928	3,475	(2,453)	4,698
	Cash and cash equivalents:	52,333	38,340	44,547	46,878	58,880	12,002	47,288
	Property held for sale	0	0	0	0		0	0
	Total current assets	**65,056**	**50,563**	**57,020**	**59,434**	**70,041**	**10,607**	**57,916**
Current liabilities	Trade and other payables: capital	(5,108)	(3,108)	(4,108)	(4,441)	(2,671)	1,770	(5,345)
	Trade and other payables: non-capital	(23,762)	(20,262)	(22,012)	(22,595)	(29,963)	(7,368)	(24,493)
	Borrowings	(107)	(107)	(107)	(107)	(108)	(1)	(108)
	Provisions	(3,526)	(1,526)	(2,526)	(2,859)	(2,603)	256	(2,933)
	Other liabilities: deferred income including contract liabilities	(2,273)	(773)	(1,523)	(1,773)	(2,785)	(1,012)	(3,144)
	Total current liabilities	**(34,776)**	**(25,776)**	**(30,276)**	**(31,775)**	**(38,130)**	**(6,355)**	**(36,022)**
Non-current liabilities	Borrowings	(1,363)	(1,363)	(1,363)	(1,363)	(1,331)	32	(1,246)
	Provisions	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	0	(1,423)
	Total net assets employed	**138,370**	**142,370**	**139,580**	**138,913**	**138,356**	**(557)**	**138,569**

Taxpayers Equity	Public dividend capital	126,578	126,578	126,578	126,578	126,578	0	126,576
	Revaluation reserve	6,826	6,826	6,826	6,826	6,826	0	6,828
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	6,207	10,207	7,417	6,750	6,193	(557)	6,406
	Total taxpayers' and others' equity	**138,370**	**142,370**	**139,580**	**138,913**	**138,356**	**(557)**	**138,569**

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 20/21		ORIGINAL PLAN 21/22		ACTUAL YTD 21/22		YEAR END FORECAST 21/22	
Cash and cash equivalents at start of period		**37,720**		**52,333**		**52,333**		**52,333**
Cash flows from operating activities								
Operating surplus/(deficit)	(203)		**2,800**		1,060		2,574	
Add back: Depreciation on donated assets	127		0		55		147	
Adjusted Operating surplus/(deficit) per I&E	**(76)**		**2,800**		**1,115**		**2,721**	
Add back: Depreciation on owned assets	8,734		6,500		3,259		7,238	
Add back: Impairment	5,006		0					
(Increase)/Decrease in inventories	0		300		(0)		300	
(Increase)/Decrease in trade & other receivables	5,722		200		1,907		1,795	
Increase/(Decrease) in provisions	492		(1,500)		(923)		(593)	
Increase/(Decrease) in trade and other payables	7,758		(1,500)		2,322		(3,346)	
Increase/(Decrease) in other liabilities	(1,409)		0		512		871	
Net cash generated from / (used in) operations		**26,227**		**6,800**		**8,192**		**8,985**
Cash flows from investing activities								
Interest received	9		0		7		15	
Purchase of property, plant and equipment	(10,769)		(17,993)		(1,621)		(11,965)	
Sale of Property	0		0					
Net cash generated used in investing activities		**(10,760)**		**(17,993)**		**(1,614)**		**(11,950)**
Cash flows from financing activities								
PDC Dividend Received	679		**0**		0			
PDC Dividend (Paid)	(1,170)		**(2,800)**		0		(1,959)	
Finance Lease Rental Payments	(363)		**0**		(31)		(121)	
		(854)		**(2,800)**		**(31)**		**(2,080)**
Cash and cash equivalents at end of period		**52,333**		**38,340**		**58,880**		**47,288**

Covid 1

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has spent £825.0k up to 31st August 2021
- The Trust has received system COVID funding for the In Envelope expenditure
- Out of envelope income has been included at £80.7k

For periods up to and including 31/08/2021 (M5)	Plan 21/22 £	Plan ytd £	Income ytd £	Expenditure ytd £	Full Year Net Forecast £
Expand NHS Workforce - Medical / Nursing / AHPs / H	507,832	**211,597**		**189,637**	**346,643**
Remote management of patients	186,000	**77,500**		**77,500**	**186,000**
Existing workforce additional shifts	223,440	**93,100**		**25,520**	**72,090**
Decontamination	82,510	**34,379**		**20,788**	**37,156**
Backfill for higher sickness absence	223,440	**93,100**		**76,399**	**92,832**
Remote working for non patient activites	186,000	**77,500**		**77,500**	**186,000**
National procurement areas	72,000	**30,000**		**0**	**0**
Other	174,000	**72,500**		**0**	**0**
COVID-19 virus testing (NHS laboratories)			**(276,934)**	**276,934**	**0**
TOTAL IN ENVELOPE	**1,655,222**	**689,676**	**(276,934)**	**744,278**	**920,721**
Vaccine Program - Local Vaccination Service	0	**0**	**(51,544)**	**51,544**	**0**
Vaccine Program - Lead Employer	0	**0**	**(29,226)**	**29,226**	**0**
TOTAL OUT OF ENVELOPE	**0**	**0**	**(80,770)**	**80,770**	**0**
TOTAL	**1,655,222**	**689,676**	**(357,704)**	**825,048**	**920,721**

Capital – Five year Plan

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Capital 5 year Plan	Revised Plan	Plan to Date	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan	
£000s	2021/22	2021/22	2021/22	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Land and Buildings									
Buildings	4,737	2,181	721	4,737	1,500	2,500	1,000	1,000	10,737
Backlog Maintenance	3,831	700	505	3,831	0	2,876	1,250	1,393	9,350
Urgent Care	750	188	34	750	0	0	0	0	750
Buildings - Finance Leases							1,500		1,500
LD Assessment & Treatment Unit						2,000			2,000
Cirencester Scheme						5,000			5,000
Medical Equipment	2,221	643	57	2,221	0	130	1,030	1,030	4,411
IT									
IT Device and software upgrade	200	0	0	200	600	600	600	600	2,600
IT Infrastructure	1,086	455	256	1,086	996	1,300	1,300	1,300	5,982
Clinical Systems	0		0	0	1,000	0	0	0	1,000
Unallocated	168		0	168	0	0	2,300	2,300	4,768
Sub Total	**12,993**	**4,167**	**1,573**	**12,993**	**4,096**	**14,406**	**8,980**	**7,623**	**48,098**
Forest of Dean	3,000	230	78	3,000	16,000	3,500	0	0	22,500
Total of Original Programme	**15,993**	**4,397**	**1,651**	**15,993**	**20,096**	**17,906**	**8,980**	**7,623**	**70,598**
Disposals					(1,349)	(2,454)	(2,000)	0	(5,803)
Donation - Cirencester Scheme					0	(5,000)	0	**0**	(5,000)
	15,993	**4,397**	**1,651**	**15,993**	**18,747**	**10,452**	**6,980**	**7,623**	**59,795**

Capital – Five year Plan Continued

Forest of Dean scheme includes prior year spend of £1.4m giving total scheme cost of £23.9m

Projects involving building works are experiencing the highest slippage due to national shortages in building materials.

A review of the capital schemes that might be delayed has been carried out and it has been determined that there are none that are potentially delayed that will have an impact on patient safety, effectiveness or experience. The schemes that would impact on this are replacement windows and ligatures but these are due to continue.

Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the Trust's financial position are as set out below:

Risks 21/22	21/22 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Differential CIP schemes	363	363	0	3	2	6
Delivering Value Scheme CIPs	900	900	0	5	3	15
Delivering non recurring savings	450	0	450	1	2	2
Efficiencies need to be higher than assumed	950	950	0	4	3	12
Risks 22/23	**22/23 Risks**	**Made up of: Recurring**	**Made up of: Non Recurring**	**Likelihood**	**Impact**	**RISK SCORE**
IFRS 16 revenue impact not fully funded	1,300	1,300	0	2	3	6
If 21/22 CIP made non recurrent, then delivery needs to be made rec	900	900	0	3	3	9
Total of all risks	**4,863**	**4,413**	**450**			

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AGENDA ITEM:12/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Emma Abbey, Medical Appraisal Committee Chair
Dr Raeema Patel, Member of Medical Appraisal Committee

SUBJECT: **MEDICAL APPRAISAL & REVALIDATION ANNUAL REPORT 20/21**

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:

1.1 The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy.

1.2 It provides assurance as to the application of national policy with regard to the regulation and Revalidation of Medical Practitioners and insight into the processes and resources that are required to undertake this work.

Recommendations and decisions required

1) That the Trust Board **accepts** and **endorse** the Medical Appraisal Annual Report and:

- **Recognise** that levels have been maintained in the application of appraisal, recording and quality assuring is recognised and that this has occurred without significant additional funding.
- **Recognise** that the figures for engagement in appraisal reflect a snap shot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the Revalidation statistics provided.
- **Recognise** that there are a number of exceptions / reasons for non-compliance that contribute to a compliance point of less than 100%.

- **Recognise** that effective appraisal has supported timely and appropriate Revalidation for all Doctors to date.
- **Recognise** that the good employment practice with regard to recruitment is supporting safe practice.
- That locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.
- **To note** in particular the assurance for NHS England in section 13 that the Trust meets requirements.

2) That the Board **agrees** the content and submission of the Statement of Compliance to NHS England and that this signed by the Chair on behalf of the Trust (section 13 page 11-16).

Executive summary

- Medical Appraisal has continued to be instituted within Gloucestershire Health and Care NHSFT aligned with national policy.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures at the end of March 2021 demonstrate that at that time 83% of Doctors had a currently valid appraisal. Of the 17% non-compliant, 12.5% are explained by exclusion criteria such as being a new starter or long-term sick leave. The 4 (4.5%) without a reason were overdue by two months or less.
- Doctors revalidation was effectively managed with no non-engagement referrals.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and used to sustain service commitments and activity appropriately.
- The MAC membership includes a range of subspecialties, including non-psychiatry, and both consultant and SAS level doctors. Ivars Reynolds, a long established MH Act Manager, was welcomed to the Committee in 2019 in order to provide Lay oversight for the work of the Committee and input into medical appraisal.

Risks associated with meeting the Trust's values

There are no identified risks associated with the Trust's values.

Corporate considerations	
Quality Implications	Required and monitored by NHSE.
Resource Implications	Time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Medical Appraisal Committee – July 2021 Quality Committee – Sept 2021

Appendices:	Annual Report

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

Annual Medical Appraisal Board Report

Appraisal year:	**1st April 2020 – 31st March 2021**
Author:	**Dr Raeema Patel** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Trust Quality Committee**

1. Executive summary

Of the 88 doctors requiring appraisal during the 2020-21 appraisal year, 73 (83 %) were compliant as at 1st April 2021; this is slightly down on the previous year (87.6% at end of 2020); and represents a sustained improvement (75% end of 2014).

When the Medical Appraisal Committee (MAC) was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors engaged in and completed a standardised medical appraisal. Since then the MAC have focussed on improving the quality of medical appraisals undertaken in the organisation.

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to Governance Committee and Board that the organisation is fulfilling its statutory obligations. The most recent verification visit by NHS England was in June 2019, with future visits expected on a 5-year cycle.

2. Purpose of the Paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board over the preceding appraisal year. It is also to report on progress made towards further developing and refining systems and procedures to support medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which

revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

All non-training grade doctors in an organisation relate to a senior doctor, the Responsible Officer (usually the Medical Director). Completion of satisfactory annual appraisals over a five-year period is a crucial factor in enabling the Responsible Officer (RO) to make a positive affirmation of fitness to practice to the GMC.

4. Governance Arrangements

The Trust Medical Appraisal Committee (MAC) was set up in 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the trust; to maintain robust systems for the recruitment, training, support and performance review of all medical appraisers within the organisation; and to review and quality assure the standard of appraisals conducted within the trust.

The MAC comprises of the Medical Director/Responsible Officer, Revalidation Officer, a separate chair, the director of medical education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical & sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative (currently 2).

The MAC convenes quarterly; this includes a year-end away half-day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee review the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key outputs from the MAC during the last year include:

- Review of the medical appraisal policy
- Review of the appraisal systems for doctors joining the trust following the merger process, and how these will be included into the current systems.
- Further refinement of the user-friendly guide for completion of appraisal portfolios (including how to obtain data, and what supporting information to include)
- Further refinement / development of 6-monthly medical appraiser support forums
- Review of the membership of the MAC (including proactive turnover of members) to ensure compliance with the aim of 3-year terms
- Completion of the annual quality assurance audit and further improvement in systems for disseminating learning from this. The March 2021 audit covered all appraisals completed from 1st April 2019 to 31st March 2021.
- Continued review of the currently active appraiser list
- Performance review of newly qualified medical appraisers
- Ensuring the continuation of high-quality appraisal during the global pandemic, which adhering to the principles of a light touch appraisal, as proposed by NHS England.

Alongside these new and ongoing developments, the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline and refresher training for medical appraisers (provision is determined by current need); monitor training compliance and output of approved appraisers; enforce required minimum and maximum numbers of completed appraisals conducted by each approved

appraiser within a 2 year cycle (this is currently under review); and regularly review appraisee feedback.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and job plans are completed and documented in this software package. Use of SARD JV contributes significantly to the ease and transparency of compliance monitoring, and hence maintaining the overall high compliance rates seen since its introduction.

Administrative support for the MAC, and for the use of SARD JV, is provided by the Medical Director's office. Additional technical support is also provided by SARD JV staff. All doctors requiring appraisal are sent email reminders 3 months and 6 weeks before their appraisal due dates. Weekly emails and correspondence are then undertaken from the due date onwards. If a doctor becomes non-compliant the Medical Director sends an assertive reminder. If the doctor remains non-compliant after 1 month and no appraisal meeting date has been set, a face to face meeting with the Medical Director is arranged. A process for escalation to the GMC if non-engagement continues is also in place.

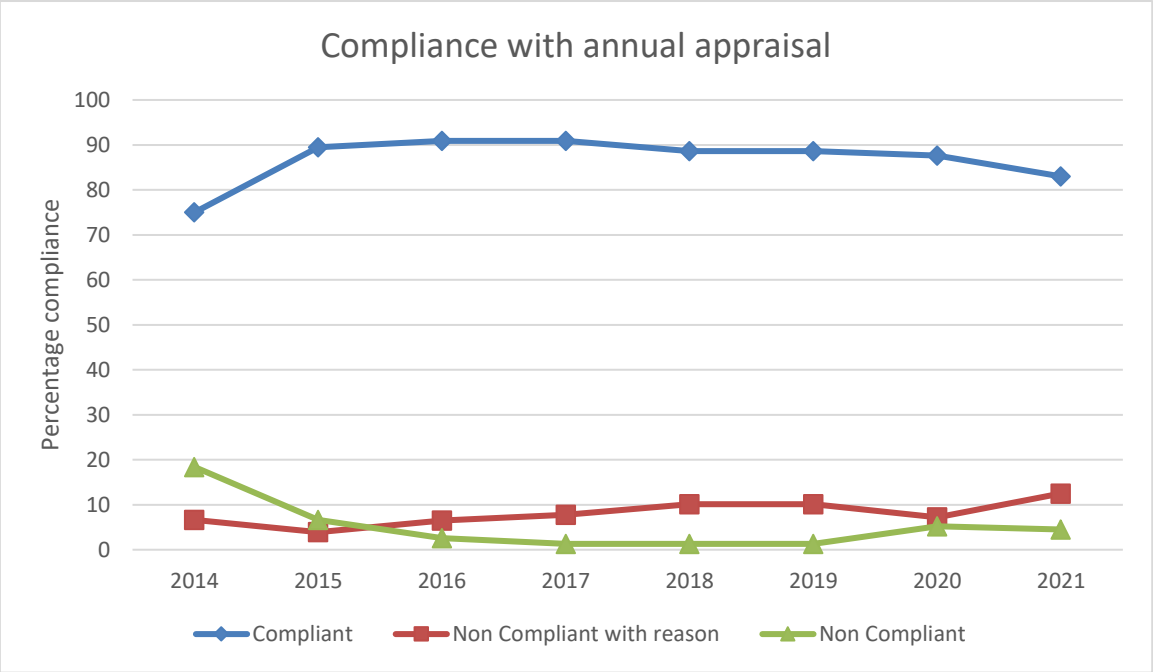
Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes (held back by continuing difficulty in identifying a fit-for-purpose process); further refinement of the number and nature of active qualified medical appraisers within the organisation; and focus on moving beyond compliance towards further quality improvement. The committee are in the process of sourcing an easy read patient feedback form for 360-degree feedback, acknowledging that clinicians from certain sub-specialities have identified this as being a barrier to collecting patient feedback.

5. Medical Appraisal

5.1. Appraisal and Revalidation Performance Data

Of the 88 doctors requiring appraisal during the 2020-21 appraisal year 73 (83 %) were compliant as at 1st April 2021; this is slightly lower than the previous year (87.6% at end of 2020); and represents a sustained improvement (75% end of 2014). Of particular note is the reduction in non-compliant without a reason (see chart below).

In 2018-19 the "appraisal year" was introduced (1 April to 31 March). This aims to prevent slippage of appraisal date, and expects that each appraisee will have one completed appraisal per appraisal year unless authorised by the RO.



Sub-group numbers were insufficient to conduct any meaningful statistical analyses; however general trends in the data reviewed suggest that there were no significant differences in compliance rates between different grades of doctor, or locality or specialty worked. Notably compliance remains reasonable within trust locums (currently 50%; and of those non-compliant all had an acceptable reason); typically a group in which engagement and compliance is hard to establish and maintain.

Of the 15 doctors who were non-compliant; 11 (12.5%) had acceptable reasons (8 being new starters; 2 on or returning from long term sickness; and 1 having an agreed extension due emergency leave. The 4 (4.5%) without a reason were overdue by two months or less.

The system for monitoring compliance (SARD JV) does not allow for any flexibility around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore unlikely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any time there will be a small number of doctors currently non-compliant with a reason, the MAC agreed in 2018 that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see appendix A.

5.2. Appraisers

There are currently 19 trained medical appraisers within the establishment of non-training grade doctors. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

The merger with GCS has brought 12 doctors into the Trust workforce. These doctors received appraisal via an external source. Over the past 2 years the majority of these doctors have transitioned over to the SARD appraisal system with a GHC appraiser. We have noted an increase in appraisers running at full capacity in consequence and will be monitoring this over the coming year.

The MAC have set minimum numbers of completed appraisals required in a 2-year period by an appraiser. These standards were introduced in 2014 and enforced in 2016; 8 appraisers were then removed from the active list, and this review of activity has continued annually. Appraisers who consistently do small numbers are asked whether they wish to continue in this role.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. The MAC continue to encourage SAS doctors to become trained and practising appraisers.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom GHC has a prescribed connection. Some appraisals are undertaken for colleagues working outside GHC, in retirement or within other roles such as the Deanery.

5.3. Quality Assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; whose purpose is to assess and validate the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to trust boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities. A comparator report is received each year from NHS England, which allows the Trust to benchmark itself against other Trusts. As GHCNHSFT is comparatively small compared to other Trusts, a small number of doctors can make a significant difference to percentages quoted.

Overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all core standards; scoring highest for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and few suggestions made for improvement, mainly concerning HR procedures (since enacted). Many areas of good practice were noted including the overriding focus on quality of medical appraisals, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within individual appraisal portfolios, and the processes to support learning and quality improvement from the annual quality assurance audits. An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

As RO/Deputy RO the Medical Director and/or Deputy Medical Director is required to individually review all completed appraisals for both completion and quality. The MAC has developed additional assurance processes to support this, as below:

5.3.1. Support for appraisers

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within 6 monthly appraiser support

forums, existing consultant CPD peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

5.3.2. Feedback from appraisees

Appraisee feedback forms are automatically generated by SARD-JV and sent to appraisees after all completed appraisals. Return rates are high. Completed returns are screened by the medical director's office and reviewed quarterly by the MAC. Any concerning feedback is followed up individually by the MAC chair in order to address potential problems in a timely manner. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers, and individualised (anonymised) feedback to appraisers. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and considered comparable).

5.3.3. Automatic uploading of complaints and anonymised SI reports

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of appraisal.

5.3.4. Annual Quality Assurance audit

The annual medical appraisal quality assurance re-audit was conducted in April 2021 by all members of the MAC, using a nationally recognised medical appraisal QA tool. New appraisers were audited at the time of completion to avoid delay in scrutiny. Due to Covid, this audit covered years 19-20 and 20-21.

8 (11% of all) completed appraisal summaries were randomly selected for both years (16 in total) for audit for completeness and quality; 5 additional appraisals done by new appraisers this year were also audited. Consent was sought from individual appraisees. Results were reviewed at an away day and an action plan subsequently developed, including:

- Preparation of a comprehensive audit report,
- dissemination of key learning points to all appraisers and appraisees and
- individualised feedback provided to appraisers in relation to the specific cases audited.

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool stayed the same but the score range was very tight, indicating a more uniform high standard of appraisal documentation.

SARD JV has informed the MAC of its intention to develop its own audit tool, based on the ASPAT, which will be able to automate a lot of the data gathering currently done by this audit. The committee will consider this once it is available, as previous trial of the ASPAT tool in 2019 found that the Excellence tool still provided better scrutiny of appraisal than ASPAT.

The audit will be repeated annually.

Please refer to appendix B.

5.4. Access, security and confidentiality

Appraisees are advised to only upload anonymised documents to their appraisal portfolios so that no patient identifiable information is included. The Medical Director's office has administrative access to SARD portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

5.5. Lay Participation in medical appraisal

Ivars Reynolds, a long-established member of the Mental Health Managers Review panels remains a member of the MAC. His background is in social work and performance management.

5.6. Clinical Governance

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will be readily available to both appraiser and appraisee so that they can be discussed and reflected on in the course of the pre-appraisal preparation and appraisal meeting.

The MAC has set an expectation of 2 completed multi-source feedback (MSF) exercises within each 5-year revalidation cycle. This is greater than the national minimum standard (one completed cycle per 5 years) but provides opportunity to gain more frequent and appropriate feedback allowing the identification, addressing and review of any issues highlighted. Provided the national standard is achieved and there is appropriate consideration in appraisal of one MSF this does not prevent recommendation for revalidation being made. NHS England has a position statement on when to repeat MSF exercises following a change of role which the trust adheres to.

6. Revalidation Recommendations

During the last year 6 revalidation recommendations were due; positive recommendations were made for all of these (100%). All doctors due for a recommendation in the period March to September 2020 were automatically deferred for a period of one year by the GMC due to the Covid pandemic. The GMC are clear that deferral should not be considered as a negative outcome; rather acknowledgement that doctors require more time (for a variety of valid reasons) to gather sufficient evidence for appraisal to take place and revalidation recommendations to be made.

Deferrals are typically recommended either due to long term sickness or to provide additional time in order to gather further evidence required; such as Statutory and Mandatory training compliance or completion of a multi-source feedback exercise.

See appendix C for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at Gloucestershire Health and Care NHS Foundation Trust; they are in line with the Trust's

Pre-Employment Checks Policy. All pre-employment checks for substantive doctors are completed before employment is started. These checks include:

- Occupational Health Clearance, including any night working
- Identity Verification
- Qualifications
- Right to Work
- DBS - Disclosure and Barring Service - Enhanced Level checks
- References from two line-managers over the last two years
- Medical Practice Transfer Form - information from previous medical director

Please see Appendix E.

8. Monitoring Performance

The performance of Doctors is monitored through the combination of perspectives provided by the following source materials and processes: -

- ❖ Initial design of Job Description and Person Specification
- ❖ Effective recruitment and selection processes
- ❖ Job planning
- ❖ Peer Group membership and attendance
- ❖ Appraisal
- ❖ Monitoring of Serious Incidents, Complaints and Compliments
- ❖ Participation in Supervision
- ❖ Activity data
- ❖ Participation in Continuing Professional Development
- ❖ Completion of Statutory and Mandatory Training
- ❖ Diary Monitoring Exercises
- ❖ Attendance / sickness absence

These perspectives are available through a combination of routine reports and intermittent reviews reporting to the RO, Clinical Directors, Clinicians and Managers. Most also constitute areas that are considered as part of the Appraisal process.

Please refer to appendix D.

9. Responding to Concerns and Remediation

The Policy on the Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners provides a framework that interprets national policy and best practice for local delivery.

No doctors are currently in receipt of input within the framework provided by this policy.

Please refer to appendix D.

10. Risk and Issues

Overall engagement in and compliance with appraisal has remained high throughout the last appraisal year despite the challenges presented by the pandemic. This is largely due to the improved engagement of doctors achieved over recent years and also to the

ongoing work of the Medical Director's team in monitoring compliance and providing prompting and support. This has been possible due to the universal use of the SARD-JV software.

However, the sensitivity of the monitoring system, which allows no latitude in completion date before a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are again accounted for mostly by new starters.

There is a significant time and therefore cost associated with both completion of appraisals as an appraisee (estimate 16-36 data collection hours per annum) and appraiser (4-6 hours per appraisal). This does not take account of the activity associated with populating appraisal documentation or undertaking multi-source feedback, audits, peer groups, supervision and training. This impacts on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health service provision in the future.

Recruits from outside the UK have not taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue and one further expanded on in the Pearson review.

The scope of work that a doctor can undertake is determined by and determines their CPD and CME requirements. There is a raised expectation that any activities have an associated CME/CPD function. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective Actions, Improvement Plan and Next Steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust medical appraisal policy was reviewed in November 2020. Priorities for the MAC for the next year include ongoing consideration of ways to improve patient and public involvement in appraisal and revalidation processes; further refinement of the number and nature of active qualified medical appraisers within the organisation; and continuing focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal is not completed (without reason) within a reasonable time frame. Subsequent investigation reports will be submitted to the Medical Director/Responsible Officer who will decide on further action. Doctors who have not completed annual appraisal are not eligible for routine pay progression or local clinical excellence awards; Gloucestershire Health and Care NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo annual appraisal without having good reason.

Workforce planning will need to take account of the possible limitations to the scope of practice and perhaps the limited workforce that may be available due to retirement.

12. Recommendations

The Board is asked to accept the Annual Report on Medical Revalidation and Appraisal and:

- Recognise the support provided to Appraisal and Revalidation within GHC NHSFT through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work undertaken and planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.
- Recognise that snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is for 100% of doctors with a prescribed connection to this Designated Body to be appraised; however, there will be exceptions which will reduce the overall figure.
- Appropriate processes are in place for the review of Appraisals, Appraiser performance, maintenance of Appraisal capacity and the quality of appraisals.
- Employment checks are undertaken consistent with national standards and best practice.
- Locum use, whilst significant, is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence including long term sickness and recruitment.
- To note in particular the assurance in section 13 and for the Chair of the Trust to complete the Statement of Compliance on behalf of the Trust.

13. NHSE Statement of Compliance

Section 1 – General

The board / executive management team – of Gloucestershire Health and Care NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: None Comments: Dr Uppal has already been appointed at Responsible Officer for the new merged organisation. Dr Haynes is Deputy Responsible Officer. Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes/No [delete as applicable] Yes Action from last year: None Comments: Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Yes Comments: Maintained by Medical Director's office. Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: None Comments: Action for next year: Policies will need to be reviewed and aligned for new merged organisation.

5. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year: None Comments: Undertaken in April 2021 on 19/20 and 20/21 by the Medical Appraisal Committee. Action for next year: Repeated annually at the MAC away half day.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: None Comments: Process is in place and actively monitored by the Medical Secretariat Action for next year: Continue with current provision.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year: None

Comments: Except those where there is an accepted reason agreed by the Responsible Officer.

Action for next year: Continue with current practice.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None

Comments: Yes a full record of non-compliance and reasons for exemption is maintained by the Medical Secretariat.

Action for next year: Continue with current practice. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: Submitted to the board annually.

Action for next year: Continue with current practice.

3. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None

Comments: Appraiser numbers are regularly monitored by the MAC, and a minimum and maximum number of appraisals per year stipulated for appraisers.

Action for next year: Continue with current practice.

4. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: None

Comments: 10% appraisals audited annually for quality control. Appraisers are monitored for attendance at update training. Feedback is sought from appraisees and followed up by the MAC chair.

Action for next year: Continue with current practice.

5. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action from last year: None

Comments: Annual audit of 10% appraisals, and the first 3 appraisals done by each new appraiser. This considers whether the appraisal has covered (at appropriate depth) scope of work, progress towards previous year's PDP, and a SMART PDP for next year which reflects the trust's aims and objectives. It considers whether appropriate challenge and support has been present, and whether the doctor is on course for successful revalidation.

Action for next year: Continue with current practice.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat.

Action for next year: Continue with current practice.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: None

Comments: Doctors are informed at regular intervals of the status of their revalidation and what recommendation will be made. If a recommendation other than positive is made the doctor would be fully informed as to the reasons for this.

Action for next year: Continue with current practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: None

Comments: The appraisal system combined with job planning is an effective means of delivering effective clinical governance for doctors.

Action for next year: Continue with current practice.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat.

Action for next year: Continue with current practice.

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat and supported by a current responding to concerns policy.

Action for next year: Continue with current practice.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: None

Comments: An annual report to the board provides quality assurance on concerns.

Action for next year: Continue with current practice.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: None

Comments: Yes

Action for next year: Continue with current practice.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: None

Comments: Yes

Action for next year: Continue with current practice.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: None

Comments: A thorough process is in place within Medical Staffing and HR.

Action for next year: Continue with current practice.

Section 6 – Summary of comments, and overall conclusion

The Medical Appraisal Committee supports the RO and his office by ensuring high quality appraisals for all doctors within the trust. These systems are now established and repeated annually; they ensure medical governance. Data collection is possible via the SARD JV software, with all doctors using this for appraisal to ensure immediate knowledge of poor compliance.

There are no actions outstanding for this report, as the annual reviews will continue to ensure the provision of high quality appraisals for trust doctors. Policies have been reviewed and aligned for the new merged organisation.

Section 7 – Statement of Compliance:

The Board of Gloucestershire Health and Care NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Gloucestershire NHS Foundation Trust

Name: Ingrid Barker Signed: _ _ _ _ _ _ _ _ _ _

Role: Chair Date: _ _ _ _ _ _ _ _ _ _

Appendix A

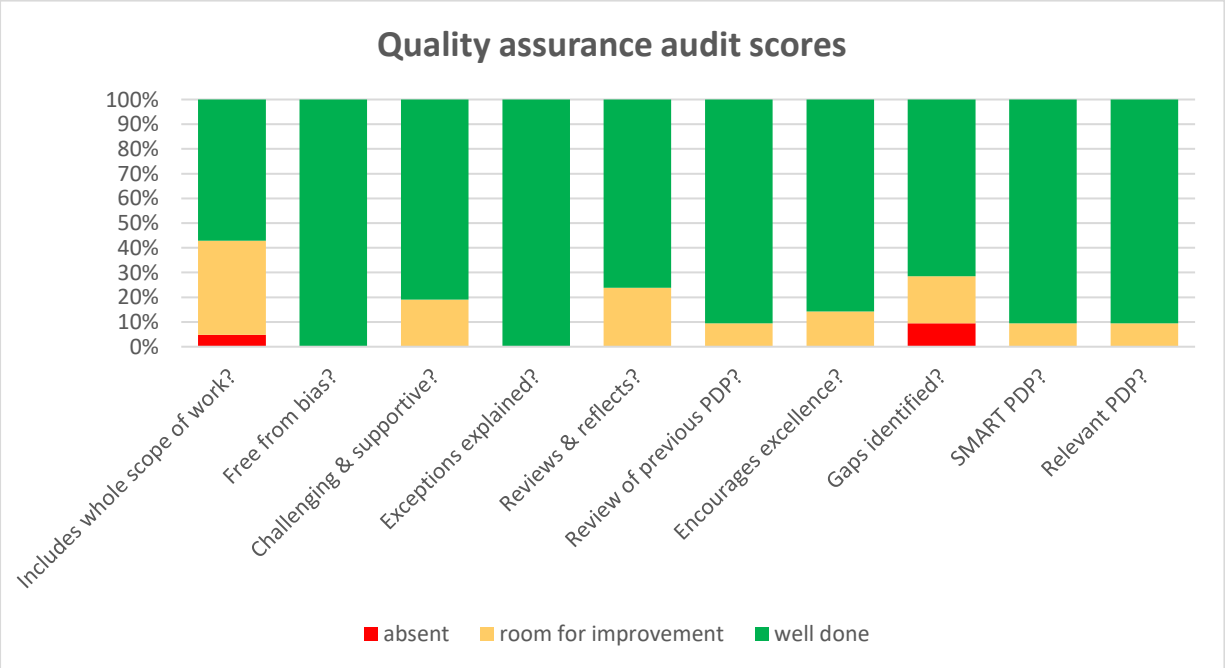
Audit of all missed or incomplete appraisals (as of 1st April 2021)

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	
Sickness absence during the majority of the 'appraisal due window'	2
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	5
New starter more than 3 months from appraisal due date	3
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	4
Lack of time of doctor	
Lack of engagement of doctor	
Other doctor factors	
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	
Other appraiser factors (not known)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe)	
Total	15

Appendix B

Quality assurance audit of appraisal inputs & outputs using the Excellence audit tool

		Frequency (% in brackets)		
Number	**Criterion** (following scrutiny of the appraisal summary, score 0-2 for each criteria)	absent	room for improvement	well done
1	Includes whole scope of work?	1 (5%)	8 (38%)	12 (57%)
2	Free from bias?	0	0	21 (100%)
3	Challenging & supportive?	0	4 (19%)	17 (81%)
4	Exceptions explained?	0	0	21 (100%)
5	Reviews & reflects?	0	5 (24%)	16 (76%)
6	Review of previous PDP?	0	2 (10%)	19 (90%)
7	Encourages excellence?	0	3 (14%)	18 (86%)
8	Gaps identified?	2 (10%)	4 (19%)	15 (71%)
9	SMART PDP?	0	2 (10%)	19 (90%)
10	Relevant PDP?	0	2 (10%)	19 (90%)



Appendix C
Audit of revalidation recommendations

Note: The GMC automatically deferred doctors' revalidation for one year due to Covid-19.

Revalidation recommendations between 1st April 2020 to 31st March 2021	
Recommendations completed on time (within the GMC recommendation window)	6 (Positive) 0 (Deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	6 (Positive) 0 (Deferral)
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other – Trust was in negotiations with Doctor and GMC	0
TOTAL [sum of (late) + (missed)]	0

Appendix D

Audit of concerns about a doctor's practice (1st April 20 to 31st March 21)

Please note this does not include information about dentists. This will be incorporated next year.

Concerns about a doctor's practice	High level[4]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	1		2	3
Capability concerns (as the primary category) in the last 12 months	1 - Concerns cover all areas			
Conduct concerns (as the primary category) in the last 12 months				
Health concerns (as the primary category) in the last 12 months			2	3
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2021 who have undergone formal remediation between 1 April 2020 and 31 March 2021 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0

[4] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Concerns about a doctor's practice	High level[4]	Medium level[2]	Low level[2]	Total
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies				0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies				0
TOTALS				0
Other Actions/Interventions				
Local Actions:				
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included				0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months				
Number of doctors who have had local restrictions placed on their practice in the last 12 months?				0
GMC Actions: Number of doctors who:				
Were referred by the designated body to the GMC between 1 April and 31 March				0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March				0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March				1 (c/f from 17/18)
Had their registration/licence suspended by the GMC between 1 April and 31 March				0
Were erased from the GMC register between 1 April and 31 March				0
National Clinical Assessment Service actions:				
Number of doctors about whom the NHS Resolution (previously NCAS) has been contacted between 1 April and 31 March for advice or for assessment				2
Number of NHS Resolution assessments performed				0

Appendix E

Annual Report (1st April 2020 to 31st March 2021)

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	5
Temporary employed doctors	9
Temporary employed doctors who became substantive	5
Locums brought in to the designated body through a locum agency	16
Locums brought in to the designated body through 'Staff Bank' arrangements	9
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	**44**

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)?																
	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS	Disclosure and Barring Service	2 recent references	Name of last responsible officer	Reference from last responsible	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance
Permanent employed doctors	5	5	5	5	5	5	5	5	0	5	0	5	5	0	0	5
Temporary employed doctors	9	9	9	9	9	9	9	9	0	9	0	9	9	0	0	9
Temporary employed doctors who became substantive	5	5	5	5	5	5	5	5	n/a	5	n/a	5	5	n/a	n/a	n/a
Locums brought in to the designated body through a locum agency	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Locums brought in to the designated body through 'Staff Bank' arrangements	8	8	8	8	8	8	8	8	0	8	0	8	8	0	0	0
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	44	44	44	44	44	44	44	44	16	44	16	44	44	16	16	16

NB. MPIT forms from previous Designated Body

These forms provide information from previous Responsible Officer. We have experienced huge difficulty getting responses to these requests for MPIT forms especially within 1 month of starting; the GMC have been made aware. Plus, this form is not required for all new doctors employed, i.e. Covid FTC exempt, trainees who are then appointed etc.

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	0	0	0	0	0
Medicine	0	0	0	0	0
Psychiatry	104.62(Total WTE)	3 WTE	4 WTE	0	7 WTE
Obstetrics/Gynaecology	0	0	0	0	0
Accident and Emergency	0	0	0	0	0
Anaesthetics	0	0	0	0	0
Radiology	0	0	0	0	0
Pathology	0	0	0	0	0
Other – Occ Health	0	0	0	0	0

Total in designated body (Includes all doctors, not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	0	0	0	0	0
3 days to one week	0	0	0	0	0
1 week to 1 month	4	4	4	0	0
1-3 months	3	3	3	0	0
3-6 months	5	5	5	0	0
6-12 months	2	2	2	0	0
More than 12 months	2	2	2	0	0
Total	16	2	2	0	0

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 13/0921

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 SEPTEMBER 2021**
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.
- **Note** the changes within the Non-Executive Directors and subsequent Portfolio amendments

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 – including updates on Non-Executive Directors
- Governor activities – including updates on Governors
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

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 Portfolios from 1st October 2021 **Appendix 2** - Non-Executive Director – Summary of Activity – July and August 2021

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

REPORT FROM THE CHAIR

1. 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. BOARD

Bereavements

It is my sad duty to report that the Trust has lost two senior colleagues over the past few weeks.

Alison Willmott-Miller who passed away in August after a long battle with illness. Alison had been the Deputy Director of Human Resources for GHC until she took ill health retirement a couple of months ago. She joined the former 2gether NHS Foundation Trust in 2014 as Assistant HR Director. Prior to this, having first started working in the NHS in catering, Alison worked from 1997 in various Medical Staffing and HR roles in the Royal Orthopaedic Hospital NHS Foundation Trust, Worcestershire Health and Care and Worcestershire Community and Mental Health NHS Trust. Alison was a respected, dedicated and hardworking colleague who will be deeply missed by those who worked with her over the years. Trust colleagues are being invited to contribute to a fundraising collection for St. Richard's Hospice, who cared for Alison in her final stages of illness, through their @JustGiving page.

Dr. Mike Roberts who passed away on 14th August after a period of illness. Mike was the Medical Director for Gloucestershire Care Services NHS Trust from May 2015 until January 2019 when he stepped down to focus on his role as a GP at Rosebank Surgery in Gloucester. Mike had previously served as Professional Executive Chair for West Gloucestershire Primary Care Trust, Medical Professional Lead (and responsible officer) for Gloucestershire PCT and as a member of the Gloucestershire Local Medical Committee. He also had a particular interest in clinical governance and was a member of the Performance Advisory Group of NHS England, which dealt with complaints about concerns about GP performance. Mike's warmth and humour, as well as his deep commitment to the community he served in inner city Gloucester, were his hallmarks. He will be greatly missed by many. A collection from Board colleagues was made and a donation was sent to the family's chosen charity, Amnesty International.

The Trust was represented by friends and colleagues at both funerals and our thoughts are with Alison and Mike's families at this very sad time.

2.1 **Non-Executive Director (NED) Update**

- Today's meeting will be Maria Bond's last meeting with the Trust Board. I recognised Maria's significant contribution to 2gether and GHC in my July Report, so here I would just like to record my personal thanks to Maria for being such a key member of the Non-Executive Team during the pandemic and for the support, advice and assistance she has given to me and the rest of the Board during her time with us. I know she will continue to be a strong advocate for the Trust and the NHS as a whole. We wish her well as she embarks on her new role as a NED with Gloucester City Homes

- With the departure of Maria Bond on 30th September and the arrival of new Non-Executive Director Clive Chadhani on 1st October, we have taken the opportunity to review the Non-Executive **Portfolios**, a copy of which is appended to this report (Appendix 1).

- The Non-Executive Directors and I continue to hold our **monthly meetings** and meetings were held on 24th August and 21st September. NED meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive at this difficult time and to continuously improve the way we operate.

- I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

2.2 **Board Updates:**

An **Extra-ordinary meeting of Private Board** was held on 18th August to consider our Trust response to proposals for the development of the ICS.

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 high quality care and colleagues' wellbeing. The following sessions have taken place:

Board Seminar – 18th August – Research and Innovation (more detail within the CEO's Report)

Board Training – 18th August – Oliver McGowan (more detail within the CEO's Report)

3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 25th August, along with Trust Secretary / Head of Corporate Governance Lavinia Rowsell, and Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for the Council meeting on 8th September, and I had a

one-to-one meeting on 2nd September. These sessions are helpful as we work together to further develop the Council of Governors.

- A meeting of the **Council of Governors** was held on 8th September where matters covered included an update on the development of the Governor Dashboard and a Holding to Account presentation in relation to the Audit and Assurance Committee. Both of these developments help to ensure the Council of Governors knows what is happening at the Trust and can challenge and ask informed questions of the Non-Executive Directors to support the effective working of the Trust.

- I had an introductory meeting with **Councillor Rebecca Fairfax**, the County Council's nominated Governor on 16th September.

- **Governor changes**:
  June Hennell, Public Governor for Stroud, has recently stood down as a Governor with immediate effect. June is unwell at the moment and we all send her our very best wishes for a speedy recovery. June's experience and passion will be greatly missed on the Council. Arrangements are being put in train to hold an election for this public governor vacancy in Stroud.

4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in July, I have attended a breadth of national
meetings:

- **South West Provider NHS Chairs** – 6th September – where we heard from the Director of Primary Care and Population Health for the South West talk about the challenges and plans for primary care in the region.

- **NHS Providers Chairs and Chief Executives Network** – 14th September – where we received a strategic policy update from the Deputy CEO for NHS Providers and an update on Integrated Care Systems

- **National Chair's Advisory Group** on 20th September.

- **NHS Confederation NHS Reset Webinars** continue to take place on a regular basis and 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 past months.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits.

- **South West/South East Regional Roadshow with Amanda Pritchard (CEO) and Mark Cubbon (Interim COO), NHS England – 17th September** – this was an opportunity for Chairs and CEOs to discuss top priorities with the NHS Leadership Team.

5. WORKING WITH OUR PARTNERS

I have continued my regular virtual 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:

- The Chief Executive and I had an introductory meeting with the newly appointed **Police and Crime Commissioner, Chris Nelson**, and his **Deputy, Nick Evans**, on 25th August where we discussed matters of joint interest and concern. A follow up meeting is being scheduled for the Autumn and we look forward to working with them going forward.

- The **County's ICS Health Chairs** continue to meet virtually and we held a meeting on 14th September.

- 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, Dame Gill Morgan.**

- **ICS Boards** were held on 19th August and 16th September. A number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported. Discussions also took place regarding the development plans for the ICS over the coming year.

- A **joint meeting of Gloucestershire County Council's Health and Wellbeing Board and the ICS Board** was held on 21st September where the Boards considered future working arrangements as part of the new ICS developments.

- As part of the Trust's continuing partnership working with the **University of Gloucestershire**, I attended a **multi-disciplinary/agency workshop** on 13th September where we discussed broader partnership ambitions and potential areas for development.

- **Children and Young People's Mental Health Summit – 7th October 2021**
  One in eight children and young people already have a diagnosable mental health condition, and research suggests that the pressures created by the Covid-19 pandemic are exacerbating their needs. We know that children and young people from certain demographics are already disproportionately affected by mental health issues, with the pandemic widening these inequalities as well as increasing the overall prevalence. While our children's mental health support services in Gloucestershire deserve enormous credit for responding to the challenges of the pandemic so far, we are unfortunately already seeing an unprecedented and sustained surge in need across the county. There has also been ongoing work to make improvements to support across the county including

on line options, support in schools and creative health, as well as further recruitment of staff to services. With demand likely to continue, we cannot afford to lose momentum. I have been asked to Chair a Summit taking place on Thursday 7th October and which is being organised by Gloucestershire Clinical Commissioning Group, to further develop our county-wide commitments to better support our young people's mental health

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

The Trust was pleased to welcome several high-level visitors throughout August, as follows:

- **11th August – Sir Kier Starmer, Leader of the Labour Party**, visited Stroud Hospital as part of a 'summer tour'. He was welcomed by Trust colleagues including Senior Independent Director, Marcia Gallagher, who kindly attended on my behalf (I was on annual leave). Sir Kier spent time talking to colleagues about a range of issues, including how the pandemic had impacted on the Trust's teams and services. Stroud Hospital Matron, Liz Lovatt, gave him a guided tour of the hospital, which included introducing Sir Kier to teams. He then spent time in the garden answering questions and asking staff about the issues that matter to them.

- **12th August – Richard Graham, MP for Gloucester**, accompanied by Deputy Chief Operating Officer, Sarah Birmingham, spent time with colleagues at mental health inpatient units at Wotton Lawn Hospital, CAMHS and CYPS at Acorn House, the Integrated Care Team at Collingwood House and Adult Community Mental Health colleagues at Pullman Place in Gloucester.

- **25th August – County Councillor David Drew,** newly appointed Member and Vice Chair of Gloucestershire County Council's Health Overview and Scrutiny Committee, visited the Vale Hospital in Dursley. The Trust's Director of Nursing, Quality and Therapies, John Trevains, and I welcomed him to the hospital. We received a presentation on sites and services in the Stroud and Berkeley Vale communities. We were then joined by Angela Dodd, Head of Therapies, who led a tour of the hospital noting the full reopening of the Minor Injuries and Illness unit, the rehab garden and allotment. My thanks to John Trevains, Angela Dodd and colleagues for sparing time in their busy schedules.

- **31st August – County Councillor Stephen Davies, Gloucestershire County Council's Cabinet Member for Children's Safeguarding and Early Years -** I was delighted to host this visit to Evergreen House at Charlton Lane, where Cllr Davies received presentations from colleagues who work within the Trust's Children's Services area, including CYPS Physiotherapy Service, Children's Learning Disabilities Service, Health Visiting overview, Immunisation Team, Vulnerable Children's Service and Young Minds Matter.

- On 7th September, Justine Hill (Deputy Service Director, Mental Health Specialist Services) and I met with **John Nolan, Chief Executive of the Nelson Trust**, at their Women's Centre in Gloucester, to discuss matters of mutual interest.

- I chaired a quarterly meeting of the **County's Leagues of Friends Chairs** meeting on 9th September. Angela Potter, the Trust's Director of Strategy and Partnerships, was also in attendance and gave updates on the Trust's response to COVID-19; the Integrated Care System; Fit for the Future; Forest of Dean Hospital; Minor Injury and Illness Units; Stroke Unit. It was interesting to receive updates from the Chairs on activities which have taken place within their areas.

- I met with the Chief Executive of the **Barnwood Trust,** Sally Byng, for a discussion on matters of mutual interest on 15th September.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- **Appointment and Terms of Service Committees (ATOS**) were held on 25th August and 1st September.

- Formal **quality visits** by myself and the Non-Executive Directors have now resumed to services across the Trust. I visited **Colliers Court in Cinderford** on Tuesday 24th August. My thanks to Jonathan Thomas, Community Services Manager, for sparing time in his busy schedule to introduce me to the various teams based at Colliers Court, which is a base for several mental health and learning disability teams as well as the complex care at home team.

- Following a comprehensive national recruitment process supported by NHS Executive Search, I am delighted to confirm that David Noyes will be joining the Trust as **Chief Operating Officer (COO).** David is currently the COO at Solent NHS Trust; prior to that he was Director of Planning, Performance and Corporate Services at Wiltshire CCG, and previously David was a Naval officer for 28 years, specialising principally in logistics, including a deployment as Chief Operating Officer for logistics with the Army's Logistics Brigade in Afghanistan. David's start date with the Trust will be confirmed as soon as possible.

- I carried out an informal visit to the **Mental Health Liaison Team** based at Gloucestershire Royal Hospital on 1st September, where I was met by Gill Hughes, Deputy Lead Nurse. My thanks to Gill and the team for sparing time in their very busy schedules.

- I attended a meeting of the Trust's **Women's Leadership Forum** on 6th September where we heard a fascinating presentation from Superintendent Jane Probert from Gloucestershire Constabulary.

- The **Trust's AGM** took place on 22nd September. This was again a virtual event which provided the latest updates about the Trust including our response to the pandemic and our financial position. There was an opportunity to ask questions of the Council of Governors and the Board.

- I attended a **Reciprocal Mentoring Development Workshop** on 23rd September which reinforced the benefits to both parties in these partnerships.

- I attended a meeting of the **Senior Leaders Network** on 28th September.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting when possible with the Chief Executive and the Trust Secretary/Head of Corporate Governance.

Whilst drop in chats with services and colleagues continue to be mainly virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I have an active presence on social media to fly the GHC flag and highlight great work across the county.

8. NED ACTIVITY

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

See **Appendix 2** for the summary of the Non-Executive Directors activity for July and August 2021.

9. CONCLUSION AND RECOMMENDATIONS

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

APPENDIX 1 - NON-EXECUTIVE DIRECTOR – PORTFOLIOS – FROM 1ST OCTOBER 2021

NON-EXECUTIVE DIRECTOR	LOCALITY	CHAMPION	AUDIT *	RESOURCES	QUALITY	MHLS	REAT PLACE TO WORK	CHARITABLE FUNDS	ATOS	FOREST ASSURANCE
Graham Russell (Vice-Chair) Graham.russell@ghc.nhs.uk	Stroud		X		X		C		X	VC
Marcia Gallagher (Senior Independent Director – SID) Marcia.gallagher@ghc.nhs.uk	Forest	• Counter-fraud, Security and Procurement • Health & Safety	C		X			VC	X	
Dr Stephen Alvis Steve.alvis@ghc.nhs.uk	Cotswolds	• Primary Care Networking countywide • Learning from Death		X	VC	VC (C MHAMF)			X	X
Steve Brittan Steve.brittan@ghc.nhs.uk	Tewkesbury	• Technology and Innovation	X	C			X		X	C
Sumita Hutchison Sumita.hutchison@ghc.nhs.uk	Gloucester	• Equality and Diversity • Climate Protection • Wellbeing Guardian				C	VC	C	X	
Jan Marriott Jan.marriott@ghc.nhs.uk	Cheltenham	• FTSU • Learning Disabilities		VC	C				X	

Clive Chadhani clive.chadhani@ghc.nhs.uk	Greater England & Wales	• TBC	VC	X				X	X	

**All NEDs are members but 4 are nominated as regular attendees*

Quality/Resources link – Jan Marriott

Quality/Great Place to Work link – Graham Russell

Resources/Great Place to Work link – Steve Brittan

Appendix 2

Non-Executive Director – Summary of Activity – 1st July – 31st August 2021

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr. Stephen Alvis	Nosocomial Transmission Panel Meeting with Governor NHS Reset Chairs meeting Team Talk Chief Operating Officer Recruitment – discussion group Senior Leadership Network	GGI meetings (3) Planning meeting for GGI meeting	Quality Committee MHAM Forum Council of Governors Extraordinary Trust Board MHLSC Trust Board (Public and Private) NEDs meetings (2) Board Seminar Board Training Extraordinary Private Board
Maria Bond	Meeting with Trust Chair Senior Leadership Network Meeting with Joint Director of Locality Development and Primary Care Serious Investigation Review meeting Chief Operating Officer Recruitment – discussion group Chief Operating Officer feedback meeting	NHS Reset Chairs meetings	Quality Committee Council of Governors Extraordinary Trust Board NEDs meetings (2) Trust Board (Public and Private) Audit and Assurance Committee Board Seminar Board Training Extraordinary Private Board Appointment and Terms of Service Committee
Steve Brittan	Quality Visit – Tewkesbury Hospital Meeting with Director of HR	NHS Reset Chairs meeting	Council of Governors Extraordinary Trust Board

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Director of Strategy and Partnerships Meetings with NEDs (3) Meetings with Director of Finance (3) Meeting with Sustainability Manager Governor Chief Operating Officer recruitment discussion group		Trust Board (Public and Private) Forest of Dean Programme Board Audit & Assurance Committee Board Seminar Board Training Extraordinary Private Board NEDs meetings (2) Appointment and Terms of Service Committee Resources Committee
Marcia Gallagher	Meeting with ICS Chair Meeting with Trust Chair (2) Meetings with Chief Executive (2) Senior Leaders Network GHFT Audit Committee Mentoring meetings with new NED	Good Governance Institute (3) Meeting with Sir Keir Starmer at Stroud Hospital NHS Reset – Digital Visit to Friendship Café and Gloucester City Farm	Extraordinary Trust Board Trust Board (Public and Private) NEDs meetings (2) MHAM Forum Council of Governors Development session Forest of Dean Programme Board Audit and Assurance Committee Board Seminar Board Training Appointment and Terms of Service Committee Resources Committee
Sumita Hutchison	NED recruitment – panel interviews Meeting with SW HWB Guardian Meeting		Quality Committee Extraordinary Trust Board NEDs meetings (2)

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Trust Chair Meeting with HR and OD Manager Summer Diversity Event Meeting with NED Meeting with Governor Meeting with Sustainability manager Meeting with Director of Nursing		MHLSC Trust Board (Public and Private)
Jan Marriott	Dragon's Den Style assessment for MSC ANP Project with University of Gloucestershire Meetings with Trust Chair (2) Meeting with Trust Chair and ICS Chair Meeting with Medical Director Meeting with Director of Strategy and Partnerships Meeting with NED Meeting with FTSU Guardian Meeting with Patient and Carer Experience Manager Learning Disabilities Services away-day Summer Diversity Celebration Meeting with Vice-Chair and Operational colleagues Meeting with Chief Executive	Mental Health Operational Group	Extraordinary Trust Board MHLSC Trust Board (Public and Private) NED meetings Council of Governors Board Seminar Board Training Extraordinary Trust Board (Private)
Graham Russell	Meetings with Director of Finance (2) Meetings with Trust Chair (2)	Pre-meet for meeting with MPs	Council of Governors (2) ICS Board (2)

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Senior Independent Director ICS Board pre-meet Resources Committee pre-meet Chaired Mental Health focused meeting with Gloucestershire MPs Mental Health and Wellbeing Partnership Board (CCG) Meeting with NED Mental Health accommodation discussion Chief Operating Officer shortlisting and interview panel		Extraordinary Trust Board Trust Board (Public and Private) NED meetings (2) Forest of Dean Programme Board Board Seminar Board Training Extraordinary Private Board Appointment and Terms of Service Committee Resources Committee

AGENDA ITEM: 14/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

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

Recommendations and decisions required

The Board is asked to note the report.

Executive Summary

The Executive team and I remain working proactively and adaptably as we continue to respond to the ever-changing situation presented by the ongoing pandemic, recovery, and service pressures. We continue to work on ensuring our response to the pandemic follows government guidance and works to meet the needs of our service users and on achieving the aims set out in the Trust Strategy.

As we near the end of the summer we have been working on establishing an effective plan for the winter months with a strong consideration for current and predicted system pressures.

We are working in partnership across the region to ensure effective collaboration and system working so we can create the best possible care for our patients and a great place to work for our colleagues.

The efforts put in by all colleagues to continue to move services and projects forward, while responding to the pandemic continues to be extraordinary. I am proud and grateful

for the hard work, determination, and motivation of all those working within the Trust as we continue to work towards achieving our goals.

The Report demonstrates the Trust's ongoing commitment and focus on inclusion, diversity and equality which continues to receive significant focus despite the operational pressures.

As well as updates on the activity and focus of the CEO, this report provides updates on Bereavements, Awards, the Chief Operating Officer Appointment, and People & Workforce.

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 CONTEXT AND ENGAGEMENT

1.1 Covid-19 and service pressures

Gloucestershire numbers at the time of writing this report are lower than other areas across England with 109 cases per 100,000 in the last 7 days. The current expected trajectory is that these numbers will flatten at this level and then are likely to rise in the coming weeks. At time of writing we have no current positive cases within our services. Colleagues are working hard to continue to plan and implement vaccine delivery, including booster vaccines, school immunisation programmes, and winter flu vaccines. Additionally, health and safety training and policies are being put in place to deliver this new programme for colleagues and patients, for example dry ice handling courses are taking place (supported by estates) to manage the cold chain for vaccines. Risks are being assessed on a regular basis including vaccine supply, workforce availability and meeting additional demands. While there is a great deal to deliver, colleagues feel confident that we will be able to meet these expectations.

The pressures faced by all our patient services remain extremely high. A great deal of work has been undertaken to ensure that patients who need to move from acute care to community-based care can do so as quickly and efficiently as possible. Achieving this is clearly better for patients but it also relieves pressure on our acute Trust partner too. The numbers and complexity of patients remains very high indeed and therefore all parts of the health and social care system are working unrelentingly to deliver these services together.

Bed availability continue to be a critical concern. Due to unprecedented pressures on beds in our Gloucestershire Health and Social care system we took a risk assessed operational decision to reopen 8 beds, closed for social distancing requirements, across our community hospitals. This decision was taken due to higher risks to our patients in Gloucestershire. The reopening of these beds is being done in the safest manner with consideration for staff and patient safety. Our enhanced pre-admission screening procedures and our inpatient swabbing schedules alongside our diligence with staff PPE, regular LFD testing and our enhanced cleaning measures, establish that our protective controls can be considered strong. We will also only be admitting double vaccinated patients to these areas with a recorded antibody response within agreed parameters. This is a necessary step needed to be able to offer the best care to our service users within the Trust and our health and care system. John Trevains, the Director of Nursing, Therapies & Quality and Infection Prevention & Control has assured me he feels confident that this is the safest course of action in the circumstances faced by patients and our wider system.

Mental health services for children, young people and adults also continue to have significant pressure. Demand has increased as has complexity and there continues to be significant issues with securing sufficient workforce. Colleagues

in these services have worked under considerable pressure to maintain and recover services and review patient pathways in order to respond to demand.

Board members will also have read in the national press that during August and September there has been a significant shortage of **blood tubes**, which will be pressing over the coming weeks before supplies start to improve. As recommended in the letter issued by our national medical leads setting out expectations for the NHS in England, we are preserving supplies for the most-pressing needs. Supplies are expected before the end of September.

1.2 Internal engagement and developments

The Trust has continued to hold its **Covid-19 briefing calls** for senior and on call managers. The frequency of these meetings is dictated by the level of activity in the Trust and system and are currently being held twice weekly. These calls provide daily national, regional and local updates and data on the number of Covid-19 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 regular basis and put in place any actions required.

Virtual **Senior Leadership Network** (SLN) meetings were held on 24th August and 28th September. These provide an excellent opportunity to update participants on Trust and national developments. The August session featured a presentation on ***Civility Saves Lives*** by Dr Chris Turner. This session discussed how our behaviour towards each other impacts team performance including: the impact rudeness has in the workplace, ways of getting the best out of each other, and finding the value of explicitly respecting each other. A great deal of positive feedback was received following this session – and this campaigning approach is a component part of the Trust quality strategy approved at the last Board meeting.

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-19 and workforce news, amongst other recent items of interest, such as: Clinical System Review updates, Stroud Hospital refurbishment, the approved Quality Strategy, the implementation of Electronic Document Management System, the accreditation of Endoscopy units, the creation of 'Flourish', Immunisation updates, and an update on the 'Be-Kind to You' month. The Team Talk sessions help to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team.

Due to the rise in demand, **Corporate Induction** for the month of September reverted back to being held weekly as opposed to the previous shift to fortnightly sessions. Corporate Inductions continue to provide an excellent

opportunity for myself and/or the Executive Team to welcome new colleagues into the Trust, introduce our core values, and ensure that everyone feels included.

On 18th August a **Board Seminar** session was held. During the morning session, Dr Amjad Uppal, Medical Director, facilitated a session on Research and Innovation. Presentations were given by senior colleagues followed by collaborative breakout sessions that explored the Trust's values within Research and Innovation initiatives. The morning's session was closed off with a presentation of good news stories on grants, sexual health, and our own account of research within the Trust.

Following the morning session **all seminar participants took place in the Oliver McGowan training**. This Learning Disability and Autism training was provided by Inclusion Gloucestershire. This training is provided across the Trust for Tier 1 (all staff working in any sector who may occasionally interact with people with a learning disability and/or autistic people, but who do not have responsibility for providing direct care or making decisions about care or support) and Tier 2 (Health and social care staff and others with responsibility for providing care and support for an autistic person or people with a learning disability, but who would seek support from others for complex management or complex decision-making) staff. The training was developed following joint working with Oliver McGowan's mother, after Oliver's tragic death. She introduces the training, and vividly recreates Oliver the individual, to help ensure that, as with any service user, we listen and respond to the story and views of individuals with learning difficulties and autism.

On 24th August and 21st September I attended the **NED's meeting** to provide the Chief Executive's update.

I attended the **Appointment and Terms of Service Committee** meeting on 25th August for the annual review of Executive Directors performance and remuneration. It is the responsibility of the Chief Executive to complete the annual appraisals and reports to the Appointment and Terms of Service Committee. I also provided an update on the COO Recruitment (more details outlined in section 4.0).

Weekly **Executive Director Meetings** continue, where collectively the executive team oversee the day to day, and longer term executive management of the Trust. Key agenda items over the past two months have included: clinical service pressures, support for the health and wellbeing of staff, ICS development and transition, recruitment and retention, winter planning and prioritisation, as well as specific operational and workforce pressures in Wotton Lawn Hospital.

I chair the **Trust Senior Team Meetings** bi-monthly which were launched in June. The Trust Senior Team is a forum to bring together senior management and clinical leaders to provide advice to the Executive on the direction and operational management of the Trust. The meeting held on 17th August

included an informative presentation and discussion from Rosemary Neale, Service Director, on Adult Mental Health and the Learning Disability (LD) community, as well as a useful presentation from the Quality Improvement (QI) team on Quality Improvement within a system context and a deeper look into the Quality Strategy. There were also updates provided on the Diversity Networks within the Trust. The Senior Team meetings support the Executive in the delivery of the Trust's strategic aims and objectives through a focus on performance, delivery and leadership development.

The **Trust Annual General Meeting (AGM)** was held on 22nd September where the Chair and I facilitated the latest Trust updates including the Trust's response to the ongoing Covid-19 pandemic, our financial position, as well as a question and answer session with our Council of Governors and Board.

1.3 Mental Health Focus

My own focus on mental health is local, regional and national to progress the mental health agenda as the wider impacts of the pandemic manifest themselves and as services consider how mental health services can continue through the service recovery process. Throughout these conversations and meetings, it is evident that all colleagues and partners believe in the importance of Mental Health Services and are working tirelessly to ensure the best possible service is given across the Trust. As well as the implications for individual citizens these pressures have an impact on all public services. The aim at the establishment of the Trust to provide joined up services, which consider a service users physical and mental health concerns, continue to be an important strand of this work.

I chair the monthly **South West (Regional) Mental Health CEO's** meeting, which acts as the overarching governance summit for the regional South West NHS Provider Collaborative.

On 2nd September I attended the **SW Regional & National Mental Health and Learning Disability and Autism "Deep Dive" meeting**. This meeting, led by national director Claire Murdoch, was broken up into two sessions. The first focused on mental health with an overview of performance, finance, and workforce. The second session centred on learning disabilities and autism looking at a performance review of 2020-2021 and then discussed quality improvement across the regions.

I attended the **extended SW Regional Mental Health** meeting 27th September.

The bi-monthly national NHS England **Mental Health Trusts CEO meeting**, chaired by Claire Murdoch continues to take place. Over the last two months these useful sessions provided updates on mental health, learning disabilities and autism and featured presentations on mental health services data sets, as well as the EPR usability survey, and the IPS resource pack.

I chaired the **South West Mental Health Programme Board** on 26th August. The Mental Health Programme Board looks to develop, implement and support the long-term plan, ambitions, and South West-wide Mental Health priorities. The August meeting discussed the quality and alignment project for mental health data, included mental health performance narratives provided by each system, a discussion on mental health finance, as well as CYP (Children and Young People) benchmarking update and next steps.

I had many informative meetings to discuss Mental Health initiatives across the South West including monthly meetings with Regional Director of Commissioning, Rachel Pearce, and a meeting with Programme Director for New Care Models, Anne Forbes.

Ensuring these initiatives are joined up and learn from best practice is central to the Trust's work in these areas and my wider input into the regional mental health strategy is useful to our local focus as it enables me to be aware of and influence developments across the region.

In Gloucestershire, I now chair the **Community Mental Health Transformation Programme Board**. The CMHT meeting held virtually on 20th September discussed updates on the CMHT People Participation Board (facilitated by Inclusion Gloucestershire), VCSE, as well as NHSE feedback and reporting. We also discussed the programme board's structure with the aim to agree purpose, participation, responsibilities, workstreams and interdependencies.

On the 25th October, the Chair and I had an introductory meeting with the **Police & Crime Commissioner, Chris Nelson** along with his Deputy Nick Evans. During this meeting we discussed **Mental Health** services at length and agreed to progress the conversation further in the coming months.

Following the **Mental Health Liaison Services** meeting on the 5th July the Executive team and I have been working collaboratively to see how we can support the team's concerns pertaining to CYPS and consultant support. Execs have met with the team to discuss implementing actions to address these highlighted areas.

1.4 Tackling Inequalities

I have continued to develop my work as **lead CEO for tackling inequality,** for the Gloucestershire ICS (Integrated Care System). I regularly convene and attend meetings that seek to respond to and in the longer term prevent the systematic inequalities brought to light by the pandemic, as well as the long-standing inequalities which were already recognised. As part of this work, Gloucestershire County Council and the ICS have established an "**inequalities panel**", which I have joined. This is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme. The second meeting of this panel, which took place on 12th August, discussed allocation of responsibilities,

health inequalities posts, initial priorities, and included an update on anchor institutions.

I am a member of the **South West Inequalities Leadership Forum** which is designed to share good practice and monitor progress across the South West NHS Region. The most recent meeting took place on 20th September.

I chair the monthly **Gloucestershire Covid-19 Vaccination Equity Group.** The most recent meeting took place on 21st September. The group discussed the latest data report, activities and interventions by the Communications, Operations, and Community Engagement teams, an update on the Better Conversations training, as well as a plan for future meetings. Katie Hopgood, Consultant in Public Health, kindly chaired this meeting on my behalf while I attended the Joint HWB and ICS Board session.

I am a member of the **SW Equality Diversity and Inclusion Board** and attend monthly meetings that discuss various initiatives focusing on improving the experience of NHS colleagues. The meeting held on 23rd September included presentations on talent management and equality, health inequalities, an update on the leading for inclusion programme (for which we are the sponsors for), and an update on the NHS Race Ahead – Big Conversation on Race.

Following the launch of the **Leading for Inclusion Programme** presented at the **SW Regional Chief Executives** meeting on 8th July, the programme has now launched its first workshop which was held on 8th September. This session started the conversation about the role we can play as leaders and how we can affect the cultural change we need to see so that all of our NHS workforce have a positive experience. While I was unable to attend this session due to annual leave, I fully support the initiative and look forward to progressing these values throughout the Trust.

I have attended recent meetings for the **Walk In My Shoes (WIMS)** community reverse mentoring programme at which we have been discussing the approach to putting this programme on a more sustainable longer term basis.

The **Reciprocal Mentoring for Inclusion in GHC Workshop** took place on 23rd September. This full day workshop was well received by all having featured important discussions on building the success of this programme, removing/reducing obstacles, social identities, sharing lifelines, and what needs to happen next.

I continue to meet with new **International Nurses** who join the Trust each month. Recently I have had the pleasure of welcoming Haila Forbes, Archana Achtuthan, Divya Davis, Rinmariya Jose and Jancy James. We are very privileged as an organisation to have such a diverse workforce and greatly benefit from the knowledge and experiences that international team members bring to the Trust.

Equality, Diversity and Inclusion continues to be at the core of how we operate as a Trust. I will continue to support and encourage these values across all that we do.

1.5 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)** – Deborah Lee and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** - Mary Hutton to keep abreast of any issues facing our partner organisations.

The **ICS Board**, **ICS Executive** and **ICS CEO Meetings** continue to take place monthly focusing on system-wide planning and resilience, and provide updates on organisational matters and projects. 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. Additionally, fortnightly I have met with Mary Hutton and Deborah Lee to discuss the **ICS Transition.**

On 31st August I attended the **ICS Provider Collaborative Leads Meeting** which discussed workstreams, communications, benefits and concerns as well as patient flow. Good discussions were had to ensure proactive and productive ways of working across the collaborative moving forward.

The **Joint Health and Wellbeing and ICS B**oard meeting took place on 21st September. The purpose of the meeting was to understand the current function and membership of the two boards, to understand the existing governance architecture as it relates to the Boards, to understand the proposed function of the Health and Care Board and to explore options for how the Boards will operate in Gloucestershire in the future. There was a great deal of common ground and both Boards are hoping to agree much closer working arrangements reflecting opportunities in the new ICS legislative framework.

The system Gold Health System Strategic Command CEOs (now called the **Executive Review Group**) has continued to take place weekly as part of the **Gloucestershire ICS Covid-19 Response Programme.** This forum has proved essential in overseeing the system response to the Covid-19 pandemic (and continues to do so as we enter wave 3) and in providing a regular liaison point between senior leaders in the NHS and social care system.

Our work on **Organisational Development** continues in collaboration with the Gloucestershire County Council facilitated by Insightful Exchange. On 2nd September we had a collaborative meeting to assess and plan the next steps of this project moving forward into 2022. At this meeting, all participants reinforced the commitment to this programme around partnership working and building these working relationships between the two organisations.

I am the Executive sponsor for the **Improvement Community Programme** and have had two meetings in the past couple months with Kathryn Hall, Associate Director Service Improvement and Redesign (GCCG) to help progress the programme's agenda. The improvement community is a co-operative network led by our system QI leads, building shared best practice and collaborating on innovative system development initiatives. July to September has been a planning period to mobilise, connect, consult and create the interim plan for current delivery and agree resources and integration. The next 2 quarters will see further development, action and delivery.

I continue to attend the **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. The frequency of these meetings has changed as of August from fortnightly to monthly. These meetings provide updates on the Covid-19 situation in Gloucestershire including testing and vaccinations, as well as updates on elective diagnostics recovery, system flow delivery, PPE equipment and supplies, transport and communication.

The Chair and I are in the process of scheduling annual meetings with each of the Gloucestershire MPs in order to give a briefing on Trust activities. These meetings will be taking place over the next 2-3 months with the aim to ensure proactive communication, address any concerns, and encourage working together.

I attend the monthly **Community Chief Executives Network** meetings. The meeting held on 25th August featured informative discussions on shared learning for system support, community restoration and where we are in the SW, pressures on social care, as well as the NSHX survey on ESR usage.

I attended the **Urgent & Emergency Care Extraordinary meeting** on 3rd August.

I attended the meeting pertaining to **Therapy Support for Assessment Beds** on 26th August.

The **Health and Overview Scrutiny Committee** on 14th August was rescheduled and will take place on 12 October 2021.

1.6 Site Visits

We have had a few recent site visits across the Trust. On 11th August Sir Keir Starmer, Leader of the Labour Party, visited **Stroud Hospital** as part of a 'summer tour', I was represented by acting COO Hilary Shand. He spent time speaking to colleagues about a range of issues, including how the pandemic had impacted our teams and services. Matron Liz Lovett gave him a guided tour of the hospital, which included introducing him to teams. He then spent time out in the garden answering questions and asking staff about the issues that matter to them.

12th August Richard Graham visited **Wotton Lawn Hospital** for a presentation by MH inpatient colleagues, Acorn House for CAMHS (Children and Adolescent Mental Health Services) and CYPS (Children and Young Peoples Services) presentations, **Collingwood House** for presentations for the Integrated Community Team and **Pullman Place** for presentations from Adult Community MH colleagues. Deputy COO Sarah Birmingham represented me for this visit.

On the 25th August Cllr David Drew visited the **Vale Hospital**. John Trevains, Director of Nursing Therapies and Quality, and Ingrid Barker, Trust Chair, welcomed him to the hospital where he received a presentation on sites and services in the Stroud and Berkeley Vale communities and included a tour of the hospital.

31st August Cllr Stephen Davies visited **Evergreen House**. This visit featured enlightening presentations on CYPS and CAMHS which were very well received by all participants.

2.0 BEREAVEMENTS

It is with great sadness that I report the Trust has recently lost two senior friends and colleagues: Alison Wilmott-Miller (Deputy Director of Human Resources) and Dr Mike Roberts (previously Medical Director for GCS). Our thoughts are with the families during this very sad time. More details are included in the Chair's report.

3.0 AWARDS

I am delighted to announce that there have been some exciting awards nominations and recognitions for certain individuals and initiatives within the Trust. Firstly, the Trust has been shortlisted as **Employer of the Year in the 2021** GloucestershireLive **Apprenticeship Awards**. In addition, Evie England and Elle Yemm have been shortlisted in the Outstanding Apprentice of the Year (Business, Administrative & Financial Services) category and Zoe Carter has been shortlisted in the Outstanding Apprentice of the Year (Health, Wellbeing, Care & Education) category.

One Gloucestershire ICS has been shortlisted in the prestigious 'Integrated Care System of the Year' category at the HSJ Awards 2021. The Gloucestershire award entry 'Integrated Working During COVID-19' sets out the remarkable contribution and joint working over this period from health and care professionals on the frontline and in support services. It recognises the strength of the One Gloucestershire partnership including the vital role and work of public health, social care, local councils and those in the voluntary and community sector.

The ICS has also been shortlisted in another category – **Provider Collaboration of the Year**. This nomination was for the Gloucestershire dementia 'Co diagnosis' project. Covid had a catastrophic effect on people with dementia – who represented 36% of Covid deaths. During the pandemic our

memory assessment service (MAS) was closed to referrals with staff redeployed, which meant some patients could not be assessed or treated. Virtual multi-disciplinary teams were set up with GPs and GHC nurses to diagnose and start treatment. This led to over 60 patients being diagnosed and greatly decreased waiting times.

Higher Trainee Ross Runciman is celebrating the news that he has been shortlisted in this year's RCPsych Awards. Ross was nominated for the Higher Psychiatric Trainee of the Year category by Dr Joe Stratford, Consultant Psychiatrist and Director of Medical Education. Winners will be announced at the RCPsych Awards virtual ceremony on Thursday 11 November.

The Trust has also been approached as an exemplar Trust for the National NHS Food Review. This offers up an excellent opportunity to lead on innovation and participate in pilot programmes.

Additionally, we have officially launched the first annual **Better Care Together awards**. This event will be held virtually on 01 December 2021 and will celebrate outstanding commitment, dedication, care, compassion and expertise within the Trust. Nominations are open for the eight award categories that fully embrace and celebrate the Trust's core values. A judging panel, chaired by the Trust Chair, will meet to consider the submissions and create a shortlist in October. We look forward to receiving nominations for these categories and thank everyone within the Trust for their outstanding efforts towards creating better care together.

4.0 CHIEF OPERATING OFFICER APPOINTMENT

Following a comprehensive national recruitment process, supported by NHS Executive Search, we are delighted to confirm that **David Noyes** has accepted our offer of the Chief Operating Officer post.

David is currently the Chief Operating Officer (Southampton and County Wide Services) at Solent NHS Trust, where he has been for the past four years. Prior to that, he was Director of Planning, Performance and Corporate Services at Wiltshire CCG - also for four years. Before joining the NHS David was a Naval officer for 28 years specialising principally in logistics, including a deployment as Chief Operating Officer for logistics with the Army's Logistics Brigade in Afghanistan.

David is very much looking forward to joining the Trust during this exciting time and looks forward to working with colleagues both within the Trust and the ICS. David is excited about delivering the best possible outcomes for the people we serve and looks forward to making a difference.

We are immensely grateful to Hilary Shand, our Deputy COO, who has agreed to continue as interim COO until December, a role she has been holding since April 2021 following John Campbell's departure. We look forward to Hilary's

continued support in the interim COO role until December. David's start date will be confirmed in due course.

I would like to thank all colleagues, system partners and experts by experience who supported the recruitment process.

5.0 PEOPLE AND WORKFORCE

Following the launch of the Trust's People Strategy, we are continuing to put our people first and are working on many different projects and programmes to help ensure and where required further develop a great working environment for all colleagues. This includes work on recruitment and retention, the establishment of the People's Participation Board, the creation of a Wotton Lawn Hospital Task and Finish Group (see below), the Future Ways of Working programme, and staff surveys. We encourage colleagues to participate in the staff surveys so we can ensure all team members can contribute their voice to the conversation as we look at making improvements across the Trust.

Additionally, following the announcement that the Government has accepted recommendations of a 3 per cent pay award through the NHS Pay Review Board, we can confirm that the pay award will be made in September's payroll run. This will be backdated to 1 April 2021.

This year has certainly not been without challenges, but I am grateful to say that the Gloucestershire Health and Care team has stepped up to every challenge presented with rigor, dedication, and excellence. I thank colleagues for their exceptional effort and look forward to working with you to find new opportunities and achieve our goals as health care providers within the community of Gloucestershire.

Given the system pressures described earlier in the report the **GHC Recruitment Team** are currently facing an exceptionally high volume of work, with over 160 job advertisements going out in July. **Wotton Lawn** continues to be an area of focus with the sort of higher vacancy rates that are experienced across the sector nationally. A Wotton Lawn Hospital Task and Finish Group has been established to help identify potential recruitment and retention solutions. Although the recruitment pressures are high at the moment, all team members are working to create new innovative solutions to address the areas of concern and progress is being made.

6.0 CONCLUSION AND RECOMMENDATIONS

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

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 15/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

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

This paper provides an overview of a range of activity taking place across the Integrated Care System. This update includes:

- Joint development session between the Health & Wellbeing Board and the Integrated Care Board to consider future structures and working arrangements.
- Fit for the Future update
- The Build Back Better Fund and grants being made available to local communities
- Integrated Locality Partnership updates

Risks associated with meeting the Trust's values

None

Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our surveys and include them within future service reviews and developments
Resource Implications	None specific to the Trust
Equality Implications	The Trust is actively engaged in wider inequalities work and will build any findings into the Trust service developments moving forward

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

Appendices:	ICS Board minutes – 16th August 2021

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 (ICS).

1.0 JOINT HEALTH AND WELLBEING BOARD (HWB) AND ICS BOARD DEVELOPMENT SESSION (21ST SEPTEMBER 2021)

The normal HWB meeting was replaced by a joint development session with members of the ICS Board to consider how the HWB Boards functions under the new ICS structures beyond April 2022. It was recognised that there is a considerable overlap across the roles and functions between the current remit of the HWB and the new Integrated Partnerships Board which is a mandated part of the ICS structures and the group have considered the potential options for this which will continue to evolve over the coming months.

2.0 FIT FOR THE FUTURE UPDATE

A number of service reviews continue as part of the Fit for the Future programme with the lung function and sleep services solutions appraisal workshops taking place on the 26th August 2021 and the public engagement on these services completed on the 6th September and an outcome report will be produced in due course which will help inform the next steps for these services.

3.0 WIDER ICS AND PARTNER UPDATES:

3.1 Support for victims of domestic abuse

Gloucestershire County Council has recently approved the investment of £1m grant funding into supporting the development of services to support people affected by domestic abuse across the county.

A Domestic Abuse Local Partnership Board (LPB) was formed in May this year, and has recommended a number of options where the funding could make the most difference to supporting victims. These include additional support in Places of Safety and Stroud Beresford Refuge, support in new Dispersed Refuge units and providing mobile advocacy. This investment will enhance the current support offer already available in Gloucestershire which includes: core services for victims of domestic abuse; services to address perpetrator behaviour; services for young people (13-19) and support for victims of stalking.

3.2 Build Back Better Fund

Funding has been allocated to help communities recover from the pandemic. This could be into the economy the county's market towns and high streets or

into the electoral divisions whereby each county councillor can support bids in their area to support a range of initiatives such as community health and well-being, digital inclusion, nature and the environment or healthy lifestyles and safer neighbourhoods. Funding can be applied for up to March 2025.

3.3 Appointment of National Director of Learning Disability & Autism

NHS England has appointed Tom Cahill as the national director of Learning Disability & Autism on the 9th September 2021. He will be leading a review, working with commissioners, of every single inpatient with a learning disability, autism or both in a mental health inpatient care setting to ensure that each person has a clear care and treatment plan and discharge date in place. If these are not in place, the review will explore why not.

3.4 100 Days Together - Partnership engagement

Organisations across Gloucestershire have spent all summer celebrating positive work being done in Gloucester City. It aimed to show how people and organisations are working together as the county re-emerges from lockdown and has included input from the health sector along with a wide range of partners such as Gloucestershire Constabulary, The Craven, Gloucester City Homes, and Gloucester City Council.

This has been a great opportunity to highlight our wider partnership working and promote our services whilst simultaneously raising awareness around how to access our services and engage with our partner organisation.

4.0 INTEGRATED LOCALITY PARTNERSHIPS (ILPS) UPDATES

Helen Goodey and colleagues gave an excellent presentation to the ICS Board in September encompassing a range of the projects that system partners are taking forward across a range of the ILP's.

4.1 Gloucester ILP

The Trust teams provided partnership presentations at the September meeting with a focus on the community mental health transformation programme and the Individual Placement scheme which focuses on the support into employment that our teams give to people who are under the care of a secondary mental health team.

The health inequalities including the Matson Community Health Equalities Partnership Group continues with some strong links into strengthening local communities and some strengths-based research has been funded with the Black South West research programme into the level of voluntary sector organisations that are black or Asian led.

4.2 Cheltenham ILP

Cheltenham ILP met in August 2021. The group reviewed the health inequalities data for the locality recognising that whilst Cheltenham has a

younger population there is a higher than average over 80s population and a correlating higher than average over 65s emergency admission rate. This data will continue to be used to inform priority areas for programmes of work moving forward and link it into the population health management work.

4.3 **Stroud ILP**

The Trust's team along with the CCG provided a partnership presentation on the Community Mental Health Transformation programme and there was a focus on hospice services. Berkeley Vale Primary Care Network (PCN) have appointed a Young Persons Social prescribing link worker who has been receiving a number of queries regarding Eating Disorder problems – two forums were held in September to explore these issues further and feedback will be provided through the PCN moving forward.

4.4 **Cotswolds ILP**

The Cotswolds ILP are next due to meet on the 28th September.

4.5 **Forest ILP**

Members continue to take the opportunity to review and refresh connections and consider what the priority pieces of work need to be across the Forest. The meeting had a focus on children and young people and the links with schools moving forward and also looked at the data regarding pregnancy and flu vaccination and actions to try and improve the uptake moving into this year's vaccination programme.

4.6 **Tewkesbury ILP**

The group are actively taking forward the planning necessary to consider the impact on health and care services from both an increase in the number of Afghanistan refugees to Gloucestershire and also that the Tewkesbury garden town will see 10,000 new homes built between now and 2050.

5.0 FOCUS ON PATIENT, CARER AND STAFF FEEDBACK AND ENGAGEMENT

5.1 Healthwatch Gloucestershire – Discharge experience

Healthwatch Gloucestershire have now completed a report which focused on people's experiences on being discharged from hospital in Spring 2021. The report reflects the in-depth experiences of 11 respondents and found that although people considered services in hospital to be good, improvements were identified in the discharge and transfer processes from and between hospitals, particularly around communication with the patients and their carers. The Trust is keen to utilise this feedback in order to improve people's experiences and it has continued to flag important areas for us to continue to improve the care and support that we provide to our patients and their carers.

5.2 Expert by Experience Programme

The Trust has 7 new Experts registered since the last meeting and recruitment training is being delivered. Additionally, we have a Quality Improvement programme running specifically involving Experts by Experience to look at how they can continue to add value to the Trust's recruitment process.

6.0 ICS ACCOUNTABLE OFFICERS REPORT

Due to meeting timings there is no Accountable Officers report this month. The minutes from the previous ICS Board meeting in August are available in the reading room.

Angela Potter
Director of Strategy & Partnerships

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AGENDA ITEM: 16/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Sarah Birmingham, Deputy Chief Operating Officer

AUTHOR: Sarah Birmingham, Deputy Chief Operating Officer

SUBJECT: **OPERATIONAL RESILIENCE AND CAPACITY PLAN**

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:

Present to the Board three papers for assurance, that together provide the overall details of operational resilience and sustainability plans and tools implemented through periods of service disruption be that surge, adverse weather conditions, pandemics and any other interruption requiring business continuity, escalation or enhanced preparatory plans to be put in place.

This plan embraces the Trust Operational Winter Planning, Surge management and escalation and Covid-19 arrangements for the Trust.

Recommendations and decisions required

The Board is asked to:

- **Assure** the operational resilience and capacity plans and tools to be implemented through surge and escalation ensuring business continuity.

Executive summary

The Trust is required to have a robust resilience and capacity plan in place with particular emphasis on the winter period (November – March).

Within this presentation there are three papers that complement each other as follows:

- Operational Surge and Resilience document v1.8: outlining the corporate breadth of business continuity and resource
- Surge and Escalation Plan v.1.0: details escalation processes in place from service to system
- Winter Plan (Operations) – A paper outlining approach, staff voice and priorities of schemes

The Gloucestershire A&E Delivery Board is the forum in which capacity planning and operational delivery across the health and social care system is coordinated, and funding available for winter schemes is prioritised across all providers.

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, as response and escalation to surge is the same regardless of the source of the disruption.

The 2021/22, Operational Resilience and Capacity Plans includes additional assurance and planning around prioritisation of the operational (service) winter schemes, escalation, Covid-19 and general incident/surge response.

The operational plan reflects the learning from the experience of the first waves of Covid, and last winter overall and was the basis for this year's planning arrangements, prioritising the operational schemes to be focused on in agreement with partner organisations and identifying new ways of working as we enter the winter period.

Risks associated with meeting the Trust's values

Specific risks are identified within the body of the report

Corporate considerations	
Quality Implications	All escalation action cards will be approved through QAG and the EPRR forum
Resource Implications	Resources required to enact the service winter schemes are approved through the A&E Delivery Board.
Equality Implications	None identified

Where has this issue been discussed before?
The Operational Resilience and Capacity Plan has been through a number of consultation processes across the operational directorates within the Trust. Sign off for the Service operational winter schemes were discussed and endorsed at the Executive Committee 10th Aug 2021. All papers where tabled for assurance and endorsement at the Resources Committed on the 26 August 2021.

Appendices:	**Appendix 1 -** Operational Surge and Resilience document v1.8 **Appendix 2 -** GHC Surge and Escalation Plan Surge and Escalation Plan v.1.0 **Appendix 3 -** Winter Plan (Operations) -Paper outlining approach, staff voice and priorities of schemes

Report authorised by:	**Title:**
Sarah Birmingham	Deputy Chief Operating Officer

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16.1/0921

OPERATIONAL RESILIENCE AND CAPACITY PLAN

Policy Number	**ORT 012**
Version:	FINAL
Purpose:	This plan sets out the Trust's approach for maintaining continuity of services during increased demand and/or reduced capacity for service users, partner agencies and the health and social care system of Gloucestershire.
Consultation:	Chief Operating Officer, Pan Directorate Governance Forum, Organisational Resilience Team
Approved by:	EPRR Governance Forum
Date approved:	16th August 2021
Author:	John Hudson – Resilience Manager
Date issued:	
Review date:	July 2022
Audience:	All Staff
Dissemination:	Trust Intranet, On-Call Managers Information Portal
Impact assessments:	

THIS IS A CONTROLLED DOCUMENT

Whilst this document may be printed, the electronic version maintained on the Trust intranet is the controlled version.
Any printed copies of this document are not controlled; therefore, it is the responsibility of every individual to ensure that they are working to the most current version of this document.

Version History

The version history should be updated each time the document is revised

Version	Date	Reason for Change
1.1	15/01/2021	Updated OPEL 4 actions to reflect learning from extreme Covid-19, flu outbreak and Winter pressures.
1.2	30/01/2021	Amending OPEL actions / re format
1.3	16/08/2021	Updated 4x4 arrangements Updated IPC arrangements

CONTENTS

1. INTRODUCTION

1.1. Background

Gloucestershire Health and Care NHS Foundation Trust is required to have a robust resilience and capacity plan in place with particular emphasis on the winter period (November – March). From here on this plan will refer to the organisation as “the Trust”.

The Gloucestershire A&E Delivery Board is the forum in which capacity planning and operational delivery across the health and social care system is coordinated.

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. For 2020/21, the plan will include additional assurance and planning around Covid-19 and general incident/surge response.

Surge Management - to ensure the learning from the Covid-19 incident was fully captured, there were a series of facilitated sessions to capture, what had worked well, what could be improved and could be done differently in the future. This then fed into a series of surge workshops. These sessions consider a range of scenarios to test our plans. Following these sessions teams have worked with the Trust Business Continuity Planning specialist to update their plans.

1.2. Aim and Objectives

The aim of this plan is to manage the challenges of increased demand and/or reduced capacity and minimise the impact on service users.

The objectives of the plan are to:

- establish a shared understanding of surge and escalation issues across the Trust for the services it provides;
- define a flexible approach for response which can be utilised irrespective of situation, duration, scale and type;
- define procedures and processes with regard to escalation to be utilised in the event of an actual or potential surge and capacity issues or issues;
- set out the principles by which mutual aid is requested locally to support the system; and
- Describe triggers in services that indicate escalation.

2. PROCESS FOR ENSURING OPERATIONAL RESILIENCE AND CAPACITY

2.1. Information

2.1.1. The Trust has used a range of information sources (see figure 1) to compile a situational picture of the likely demand for services over the winter period. This picture considers the risks and challenges in identifying and providing the necessary capacity to meet the demands of its local population

Figure 1: Information sources used to inform situational picture (not an exhaustive list)

The Trust			
Capacity modelling (including Covid-19 restrictive modelling)	GHC Daily SitReps	Gloucester CCG performance data (SHREWD - Escalation)	South West Regional COVID-19 Healthcare Setting Outbreak Framework
Review of previous winter issues	Operational resilience and capacity guidance 2021/22	NHS Operational Pressures Escalation Levels (OPEL) Framework	Gloucestershire CCG Escalation Plan and Framework 2020/21
Local Outbreak Management Plan	Second Wave and Surge Management Scenario planning	Trust and system-wide learning from the Covid-19 pandemic response	Single Point of Clinical Access

2.1.2. Learning from previous experiences the Trust has identified a number of risks, Appendix 4, mitigation of the risks are supported by the Trust response arrangements.

Covid-19 Risk Management

As the Covid-19 incident has continued over many months we have moved from the traditional command and control structure to a programme approach. The programme approach has allowed a wider group of staff to be involved in the decision making and delivery of all the work associated with Covid-19. The Programme team work closely with the incident team. We have been establishing more semi-permanent teams such as testing and PPE/Stock Management. Each project within the programme, submits a fortnightly highlight report and any new risks get added onto the risk log. These are reviewed by a risk group, including IPC, incident team and governance input. This process ensures there is a weekly review of all risks and ensures mitigating actions are progressed. New risks are reviewed by the risk group and a decision is taken whether to escalate to Trust risk register (as it would be more effectively managed at that level) or to manage in a detailed way by the Programme team and Programme Executive.

The risk process is constantly reviewed and updated and regular review of risks ensures mitigation is progressed to lower the risk probability or close the risk.

2.2. System Level Reporting

Demand on services during winter can lead to unexpected pressures, requiring departments, services, directorates and the Trust as a whole having robust systems in place for effectively escalating and deescalating services and resources to meet fluctuations in demand. For the winter period, there will be daily escalation status reporting processes to NHS England and NHS Improvement in place (by exception). The required level of reporting is determined by a number of triggers set by NHS ENGLAND – Improvement. System level reporting is inline Operational Pressures Escalation Level (OPEL) as identified in Figure 2.

Figure 2: Definition of Operational Pressures Escalation Level

OPEL 1	**Patient Flow Management** The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided.

OPEL 2	**Mitigation of escalation** The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible.
OPEL 3	**Whole system compromised** The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in Opel 2 have not succeeded. Further urgent actions are now required across the system by all A&E Delivery Board partners and increased external support may be required.
OPEL 4 (Whole System**)**	**Severe pressure and failure of actions** Pressure in the local health and social care system continues to escalate, leaving organisations unable to delivery comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions have been taken, and external extensive support and intervention may be required.

OPEL 1: No reporting required.

OPEL 2: No local reporting required relating to CCG or NHSE/I.

OPEL 3: NHSE/I trigger/ SitRep and escalation reporting. The reporting process is as follows:

09:00 - escalation status declared OPEL 3 by SHREWD, or declaration of internal incident by partner/s;

09:00 – Demand and Capacity OCT discuss Plans for discharges in next 48 hours;

09:30 - Daily call required, is now with Microsoft Teams with the focus being the content for the exception report, de-escalation and ensuring that the appropriate action cards are being implemented, in hours the Demand and Capacity team attend this call, Out of Hours this is attended by the On-Call Manager. A system wide action plan is circulated with the expectation it is completed and returned to the Clinical Commissioning group;

11:00 (next day) – Submit exception report to NHSE/I.

OPEL 4: The Clinical Commissioning Group Chief Executive must be informed of this decision who will inform NHSE/I of escalation. NHSEI South West On-call - **0303 033 8833**

2.2.1. If the reporting falls on a Friday, Saturday or Sunday, a handover will be required between the reporting leads (5pm on Friday and 9am on Monday), with the relevant reports being submitted by 11am on the Monday. If the reporting falls on a bank holiday, the reporting will need to be handed over to the reporting lead by 9am the next working day.

2.2.2. The Trust has considered the possibility of preventative measures becoming overwhelmed and the requirement to activate and mobilise resources under a command and control framework that ensures disruptions and variability in the standards of service delivery to patients can be managed effectively. Response, adaption and recovery measures to maintain demand and capacity balance activated through robust escalation triggers have been developed as part of the planning process.

2.2.3. External triggers and escalation – Gloucestershire Clinical Commissioning Group through their A&E Delivery Board oversees the development and maintenance of their Escalation Framework. The framework sets out agreed actions (see figure 3 and figure 4 below) to be taken when capacity constraints have the possibility of compromising patient care and to prevent / resolve capacity issues that cause individual providers and/or the wider health system to escalate into an OPEL 3 or 4 status.

2.2.4. Internal triggers and escalation – the whole system escalation is described in Figure 5.

2.2.5. Command, Control and Coordination arrangements – Are based on the Trust's existing management structure. The Trust's Incident Command System Policy (ORT 003), provides a standardised approach to incident command, control and coordination from which managers designated with key functional roles (Coordination, Operations, Planning, Logistics and Finance) are able to effectively and efficiently resolve an incident as quickly as possible, while maintaining core critical services, at any time including the winter period.

2.2.6. Directorate/Service leads will monitor pressures across their areas of responsibility. If circumstances dictate, a decision will be taken to activate more formal command and control arrangements to support the operational response to growing pressures. In the event that pressure continues to increase, putting service quality and/or safety at risk, (requiring the Trust to Escalate to OPEL 3 or OPEL 4, a decision will be taken to extend the Incident Coordination Team provision and/or to review the Incident Coordinator in relation to their decision-making powers in light of the increased pressures. Figure 7 below provides a visual depiction of the teams and resources that may be required, but the roles activated will ultimately depend on the scale and type of pressures being experienced.

2.2.7. No mixed sex wards exist within the Trust and an Executive decision was taken that this will not be breached in a Community Hospital without the Chief Executive Officer agreement.

Figure 3: Escalation and Protocol Flow Chart: Local partners, NHS England and NHSE Improvement

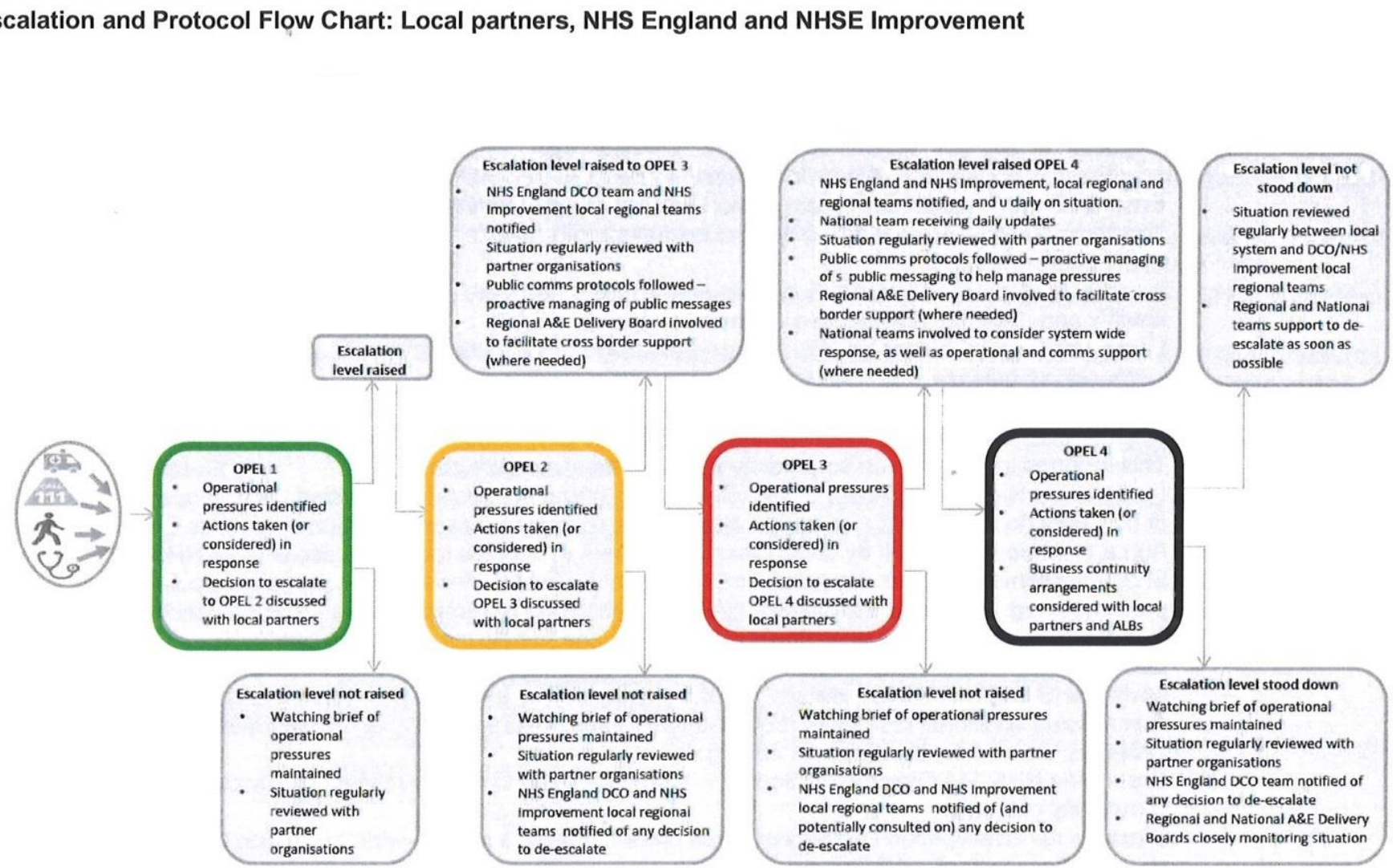


Figure 4: SHREWD Escalation Triggers

PRE-HOSPITAL
IN HOSPITAL
DISCHARGE

WHOLE SYSTEM

DEMAND

Metric	PRE-HOSPITAL Level 1 - Normal	PRE-HOSPITAL Level 2	PRE-HOSPITAL Level 3	PRE-HOSPITAL Level 4	IN HOSPITAL Level 1 - Normal	IN HOSPITAL Level 2	IN HOSPITAL Level 3	IN HOSPITAL Level 4	DISCHARGE Level 1 - Normal	DISCHARGE Level 2	DISCHARGE Level 3	DISCHARGE Level 4
Single Point of Clinical Access call volume per hour Weekday	8	10	13	<=15								
Weekend – not included on SHREWD, these are Single Point of Clinical Access specific Key Performance Indicators	3	5	6	7								
Rapid Response RAG rating (Referral rate in and Nos in service)	1	2	3	4								
Number of patients on Single Point of Clinical Access working list at time of report									<=10	11	12-14	>=15
Number of Single Point of Clinical Access patients with no plan									0	1-5	6-11	>=12

CAPACITY

	PRE-HOSPITAL				IN HOSPITAL				DISCHARGE			
Metric	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4
Single Point of Clinical Access Abandoned call rate	<5%	<8%	<12%	12%>								
MIiU longest wait	<3 hrs	3-4	4+ in 1 unit	4+ in 1+ units								
Total number of Community Hospital beds available weekdays Saturdays Sundays					>=10 >=5 3	6-9 3-4 2	0-5 1-2 1	0 0 0				
Total Number of Reablement Beds available Weekdays Saturdays Sundays					>=6 >=5 >=3	3-5 3-4 2	1-2 1-2 1	0 0 0				
Beds closed due to Infection Control					0	1 ward /area	2-3 wards / areas	>4 wards/ areas				
No of Unfilled shifts (agency & Bank) - Community Services									1	2	3	4
No of Unfilled shifts (agency & Bank) - Community Hospitals					1	2	3	4				
% MIiU patients seen within 4 hours	100%	98%	85%	75%								

The table below identifies Trust wide escalation and the key roles and responsibilities that will be required to ensure resources are used effectively to manage the possible challenges and risks that the Trust may experience. Should this be a specific Covid-19 related escalation the Trust would follow the system wide Local Outbreak Management Plan

Figure 5 - Trust Escalation and Actions

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
Trust services functioning as normal and able to manage any fluctuation in services without consequence Sickness absence within normal limits for time period Demand and Capacity Team will participate in the daily whole system conference call to review activity and demand and pre-empt surges and take mitigating actions Influencing factors: • Premises • Workforce • IT • Resources, assets, utilities and supplies • Surge in demand • Queuing ambulances		**Demand and Capacity Lead** • Review GHC Kit bag • Complete actions • Contribute to whole system solutions • Take internal and external actions • Escalate issue to Deputy Chief Operating Officer • Initiate communication strategy Trust surveillance systems in place to monitor for increased D & V or Flu or Covid-19 activity or rising staff absence.	*Pre-surge periods: circulation of plans and procedures to partner organisations.* **Communications (internal)** Comms Team to rest of Trust (various times): Various campaigns e.g. vaccination, winter preparedness. **Communications (external)** Designated Locality Lead to contribute to Teleconferences as required.	**Command and Control in place:** Maintain normal Trust structures and operational management hierarchies (includes On-Call arrangements). **Responsible for activation:** N/A **When and where will it be triggered:** In hours: N/A Out of hours: N/A **Communication requirements;** Internal: N/A External: N/A	No impact at present – Trust services operating within normal tolerances	No implications for other organisations at this stage.
• Community Services experiencing sustained rise in activity • Minimal bed capacity at inpatient sites impacting patient flow. • No Psychiatric Intensive Care Unit beds in County • Significant disruption to travel • Cancelled Patient Transport Service provision • Covid-19 staff testing capacity limited, delaying return to work • Weather conditions impacting on service continuity in 1 locality • Staff absence has risen 4% on seasonal average in anticipated surge areas or 10% across Trust • Multiple infection outbreaks (e.g. D&V) • Localised Covid-19 outbreak/lockdown affecting single locality or Service		OPEL 1 action plus the following: Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. Maximise use of reablement/intermediate care beds All services to identify blockages to discharge and escalate to relevant Head of Service SPCA lead to call IDT to prioritise working list Community hospitals to bring forward discharges to allow transfers in as appropriate. Community hospitals to liaise with Social and Healthcare providers to expedite discharge Additional ward rounds to take place within community providers to expedite discharge and create capacity Community providers to lower admission/treatment thresholds wherever possible through implementation of previously agreed flexible working arrangements to alleviate pressure Apply flexibility regarding beds and staffing to increase capacity where possible Expedite rapid assessment by multidisciplinary team (MDT) including Social Care assessment	**Communications (internal)** In addition to the above; Any specific directorate/service pressures likely to have an impact on other services. **Communications (external)** In addition to the above; Lead Locality Directors to; Clinical Commissioning Group/ NHS England to participate in any addition telephone conferences	In addition to the above; **Command and Control in place:** Consider requirement for additional internal telephone conferences. **Responsible for activation:** Winter Director in consultation with winter Locality Directors. **When and where will it be triggered:** In hours: As required | virtual via telephone conference Out of hours: As required | virtual via telephone conference **Communication requirements;** Internal: Community Service Manager/ Matrons and Executive Management Team, On-Call Team (as required) External: N/A	Maintain communication flows between operational leads and overall coordinator. Add additional control if required by pressures and circumstances. Minimise disruption to services upstream and downstream of potential issues. Ensures a shared situational picture of current pressures and mitigation.	Mental Health Liaison Team/Crisis Teams/ Rapid Response – additional support to facilitate admission avoidance and discharge planning processes. Community teams/ CYPS – additional resource may be required to support admission avoidance and early transfer/ discharge Clinical Commissioning Group/NHS England – requirement for additional telephone conferences.

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
• Intermittent corporate systems issue e.g. intranet or Electronic Staff Records • Clinical systems outage for < 2hours • Intermittent IT infrastructure e.g. telephony & network • Escalation Level in the County at 2 (Pressure) or 3 (Severe Pressure) – requirement to support mutual aide		Ensure all staff in MHLT are aware of escalation level and to reflect this within their working day and prioritisation of system. MHLT to ensure pathways are being used appropriately, confirm that guidance is accessible and communicate when information cannot be found Where possible, community-based services to increase support and/or communication to patients at home to prevent admissions. Expedite rapid assessment for patients waiting within another service e.g. ED For inpatients in acute hospitals prioritise MH assessments where delays are impacting on quality/capacity of service provision MHLT to ensure all referrals are verbally responded to within 2-hour target and subsequent response is in keeping with level of risk identified using risk matrix MHLT Manager to ensure that all patients awaiting review before discharge are to be prioritised so that they are seen within 4 hours where staffing capacity permits				
• *Inpatient bed occupancy is reached* • 136 suite unavailable • *Sustained, very significant increase in activity with demand outstripping supply for critical services* • Significant Planned activity unable to be delivered • Severe weather conditions impacting on service continuity in > 1 locality • Covid-19 outbreak/lockdown in > 1 localities or teams • Sustained (> 2 hours) corporate systems issues e.g. intranet or ESR • Sustained Clinical systems outage (> 2 hours) • Sustained IT infrastructure outage e.g. telephony & network • infection control outbreak, impacting on > 1 clinical area		All actions from OPEL 1 & 2 plus below: Senior Nurses to review patients that could be moved with ongoing support requirements in order to realise capacity Mix sex breach requests to be sent to CEO for review and decision - CEO agreement only. Head of Services to escalate blockages to Deputy COO/COO SPCA - Prioritise discharge from relevant GHT site As able, Rapid Response to send staff into ED MIIU social media push to advise capacity Capacity Manager / Deputy Director to monitor escalation status, taking part in teleconferences as required. SPCA - call in bank staff to handle call volumes Assess and reprioritise any non- housebound DN visits Review all daily visit patterns to identify bi-daily options Review all non-urgent visits All community care teams to review all patients awaiting assessments (with single point of access) in order to expedite discharge or transfer	**Communications (internal)** In addition to the above; Incident Coordinator (IC) (ED/DD) – Establish the Integrated Care System Planning Section to facilitate robust communication to all relevant stakeholders. Comms/ Media representatives to support, advise Incident Coordinator and to facilitate core messages (in conjunction with partners) **Communications (external)** In addition to the above; Incident Coordinator to work within NHS formal/informal response structures. Manage any media interest (in conjunction with partners) Prepare responses to any additional SitRep report requirements, including but not limited to; ○ Service pressures & disruption	In addition to the above; **Command and Control in place:** Additional daily Microsoft Teams/Tele conferences. Decide if Incident Coordination Centre should be activated, and if so if in part or full Pre-allocation of Incident Coordination Centre roles in the event that a more formal structure is activated. **Responsible for activation:** Winter Executive in consultation with Lead Winter Locality Directors. **When and where will it be triggered:** In hours: As required | virtual via Microsoft Teams/Telephone conference or Incident Coordination Centre Out of hours: As required | virtual via Microsoft Teams/Telephone conference or Incident	Improved communication flows and situational awareness. Clear lines of authority, accountability. Clear decision-making forum Centralised decision making on resource allocation. Centralised decision making of service prioritisation and service reductions/closures. Ensures a shared situational picture of current pressures and mitigation. Central point for all external stakeholders to communicate through.	In addition to the above; Patients/ Relatives - Possible reduced standards of care. No mutual aid likely Psychiatric Intensive Care Unit – No beds Department of Health – Performance targets not being achieved. Clinical Commissioning Group – Not fulfilling all contractual obligations

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
• Gloucestershire Clinical Commissioning Group Escalation Plan at Level 3 (Red) **Patient safety at risk due to demand on services**		where possible – this to include In-reach teams and community hospitals Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible Community providers to expand capacity wherever possible through additional staffing and services, including primary care Community providers to consider the use of wider group of agencies (e.g. higher cost agencies) to increase staffing capacity Patients waiting at home for admission to be referred to Community Teams (by In-reach nurses) and/or single point of access and Emergency Medical Unit (EMU) Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible. Review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities, where possible. Community based teams to increase support to service users at home to prevent admission. Escalation to relevant on call manager Liaison with Social Care if delays relate to arranging MH Act Assessment Liaison/joint working with Social Care and Housing to identify appropriate accommodation/care packages Regardless of level of risk and within resource available will prioritise ED referrals MHLT manager to prioritise ED referrals and recruit additional resources from off duty staff and staff bank MHLT manager to recruit additional resources from off duty staff and staff bank. MHLT Manager to prioritise assessments in ED from 2 hours to 1 hour where staff capacity permits Close smaller MIIUs and reallocate staff to strategic MIIUs (Stroud, Cirencester, North Cotswolds & Lydney) Provide senior clinical support for weekends across Community Services and Community Hospitals	○ Staffing issues ○ Capacity issues ○ Planned reductions/ closure of services. ○ Mutual aid support	Coordination Centre **Communication requirements;** Internal: Executive Management Team/ Community Service Manager Teams/ Matrons/ Comms/ others as required. External: Gloucestershire Clinical Commissioning Group, Gloucester Hospital Trust, South Western Ambulance Service, NHS England, Commissioning Support Unit, Gloucester Council.		

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
		Professional Leadership (Clinical) rota - with time off in lieu and payment for hours worked Provision of clinical leadership for all out of hours service provision Dial into escalation calls, link with shift/ward leads and available for clinical queries advice and guidance, based on site with a clinical team Inpatients ICT Home First DN Rapid Response SPCA Implement GHC Operational Flow Hub to run alongside ICC. Implement additional afternoon (and evening if required) GHC Operational Flow meeting. Review staffing levels and manage Staff shortages with flexible use of the incentive policy for the following staff groups: - RN - HCA - All Bank Staff MIiU offering ED Streaming of 15 appointments for the Streaming Nurse in ED to use per day in MIIUs across working closely with system partners with implementation planned for 2 weeks' time MIiU's supporting the supply of grab bags/ oximeters for Covid-19 Virtual Ward with the aim of less Covid-19 admissions and preventing undiagnosed deterioration. Post discharge Covid-19 Virtual ward, managing respiratory and non-respiratory patients. CHST continue to offer seasonal Covid-19/ Flu vaccination as part of mass vaccine programme Hold internal meetings - 09:00 Flow meeting - 12:30 Flow meeting - 16:00 GHC Covid-19 briefing, Monday and Friday - 16:30 Daily Oversight Call, Monday and Thursday Ensure Medical resilience in Hospitals particularly at weekends Ensure estates/facilities teams have resources				

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
• Sustained, extreme activity experienced having a detrimental impact on services • Significant impact on several community services that are a high clinical risk • Unable to continue some/all business-critical services • Critical Community/Children & Young Persons Services struggling or unable to cope • Severe weather conditions impacting on service continuity in all localities • Covid-19 outbreak/lockdown countywide/nationally • Prolonged (> 24 hours) corporate systems issues e.g. intranet or ESR • Prolonged Clinical systems outage (> 24 hours) • Prolonged (>24 hours) IT infrastructure outage e.g. telephony & network • Services struggling to provide priority care • Unable to continue some/ all business-critical services • Gloucestershire Escalation Plan at Level 4 (Black) **Patient safety risks due to demand on services**		All actions from OPEL 1, 2 & 3 plus below: Hold daily virtual board rounds 3 times a week for Community Hospitals led by Hospitals Directorate with inclusion of the Demand and Capacity team and Adult Social Care colleagues Continue to flex criteria for admission to a Community Hospital. Further caseload review and reprioritisation of therapy in community services. Divert therapists to support Home First. Weekend on call rota all Service Directors and Deputies with time off in lieu and payment for hours worked MH and PH Services On-Call Manager, have a second person on call rota in place with time off in lieu and payment for hours worked Enhance the ICC cover with second person on call, with time off in lieu and payment for hours worked Review lowering levels of care Rapid Response to become a Receiver as well as a User on Cinapsis providing easy access to RR for SWAST to prevent admissions. Review opening hours of SPCA at weekends Explore options of opening additional inpatient bed capacity across our estate, with mutual aid as required if demand increases during the preceding week. Gain agreement from the system to cease elective activity within and outpatients and redeploy staff to inpatient wards. Gain agreement from the system to cease elective activity including theatre, endoscopy and redeploy staff to inpatient wards. Increase non-clinical support on inpatient wards Complex care at home to support with Adult PH Community Health Teams under the Directions of the Service Director Further caseload review and reprioritisation of therapy. Divert therapists to support Home First model Response team and colleague redeployment to add capacity into Home First and reablement pathways Ensure IPC cover on site with time off in lieu and payment for hours worked	As above	As above	As above	In addition to the above; Patients/ Relatives - Possible reduced standards of care. No mutual aid likely Psychiatric Intensive Care Unit – No beds Department of Health – Performance targets not being achieved. Clinical Commissioning Group – Not fulfilling all contractual obligations

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
		Redeploy colleagues from NQT to provide additional clinical rota to support colleagues Targeted short-term redeployment colleagues from NQT, finance and strategy and partnership's into HCA, admin and support worker rolls. Review of all current placement of RN and AHP colleagues across GHC and ensure colleagues are deployed as per priority.				

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations

2.2.8. Critical Services Categorisation – We recognise service prioritisation is a dynamic assessment and dependant on the nature and duration of the incident our priority ratings may change.

The current service prioritisation status is illustrated below in figure 7.

Figure 7 - **Operational Services Impact Assessment (Covid-19)**

Service areas	Specialism	Service	Priority Rating
Hospitals	Physical Health	Inpatients (+ supporting functions)	1
Hospitals	Physical Health	*Out-patients*	*2*
Hospitals	Physical Health	*Theatre*	*2*
Hospitals	Physical Health	*Endo*	*2*
Hospitals	Learning Disabilities & Mental Health	Inpatients (plus supporting functions)	1
Hospitals	Learning Disabilities	LDISS	1
Hospitals	Learning Disabilities	IHOT	2
Urgent Care	Physical Health	Rapid Response	1
Urgent Care	Physical Health	Integrated Assess Team	1
Urgent Care	Physical Health	Minor Injury and Illness Units	1
Urgent Care	Physical Health	Single Point of Clinical Access	1
Urgent Care	Physical Health	IV Therapy	1
Urgent Care	Physical Health	Evening and Overnight District Nursing	1
Urgent Care	Mental Health	Contact Centre	1
Urgent Care	Mental Health	Crisis incl. Street Triage	1
Urgent Care	Mental Health	AMHP	1
Urgent Care	Mental Health	Psychiatric Liaison	1
LTC	Physical Health	Care Home Support Team	2
LTC	Physical Health	Respiratory - Home Oxygen Service	1
LTC	Physical Health	Respiratory - Core	2
LTC	Physical Health	Pulmonary Rehab	2
LTC	Physical Health	Diabetes	2
LTC	Physical Health	Homeless Healthcare	1
LTC	Physical Health	Heart Failure	2
LTC	Physical Health	Cardiac Rehab	2
LTC	Physical Health	Bone Health	2
LTC	Physical Health	McMillan	2
Sexual health	Physical Health	Sexual Assault Referral Centre	1
Sexual health	Physical Health	Pregnancy Advisory Service	1
Sexual health	Physical Health	Sexual health - GUM/HIV	1

Service areas	Specialism	Service	Priority Rating
Dental	Physical Health	Dental - Springbank	2
Dental	Physical Health	Dental OOHs/Urgent	1
Therapy & Equip	Physical Health	Podiatry - Inpatients	1
Therapy & Equip	Physical Health	Podiatry - Core	2
Therapy & Equip	Physical Health	Adult MSK	2
Therapy & Equip	Physical Health	Adult MSKAPS	2
Therapy & Equip	Physical Health	SALT - IP services	1
Therapy & Equip	Physical Health	SALT - community	2
Therapy & Equip	Physical Health	Wheelchair Assessment service	2
Therapy & Equip	Physical Health	Integrated Community Equipment Service	1
Therapy & Equip	Physical Health	Telecare	1
Specialist	Mental Health	IAPT	2
Specialist	Mental Health	MHICT	2
Specialist	Mental Health	Eating Disorders	2
Specialist	Mental Health	ASC/ADHD	2
Specialist	Mental Health	Perinatal Team	2
Specialist	Mental Health	Criminal Justice Liaison Team	2
Specialist	Mental Health	GRiP	2
Specialist	Mental Health	MHICMAS	2
Specialist	Mental Health	Accommodation Team	2
Adult Community	Physical Health	Referral centre	1
Adult Community	Physical Health	Reablement	1
Adult Community	Physical Health	District Nurses	1
Adult Community	Physical Health	OT - core	2
Adult Community	Physical Health	Physio - Core	2
Adult Community	Physical Health	Complex leg wound/lower limb	1/2
Adult Community	Physical Health	Lymphoedema service	1/2
Adult Community	Physical Health	Complex care at home	1/2
Adult Community	Physical Health	Tissue Viability Service	2
Adult Community	Mental Health	AOT	2
Adult Community	Mental Health	Recovery	2
Adult Community	Mental Health	OP CMHT	2
Adult Community	Mental Health	Dementia Education	2
Adult Community	Mental Health	MAS	2
Adult Community	Learning Disabilities	CLDT	2
Adult Community	Mental Health	CPI	2
Adult Community	Mental Health	Back 2 Work	2
Adult Community	Mental Health	Homeless MH	2
CYPs	Physical Health	Children's Community Nursing Team	1
CYPs	Physical Health	Children’s' Complex Care Service	1

Service areas	Specialism	Service	Priority Rating
CYPs	Physical Health	Physiotherapy - IP only	1
CYPs	Physical Health	Occupational Therapy - IP only	1
CYPs	Physical Health	SALT - IP only	1
CYPs	Physical Health	Physio - Core	2
CYPs	Physical Health	OT - core	2
CYPs	Physical Health	SALT - core	2
CYPs	Physical Health	Immunisation Service	2
CYPs	Physical Health	IMMS - BCG	1
CYPs	Physical Health	School Nursing	2
CYPs	Physical Health	Children in Care	1
CYPs	Physical Health	HV	2
CYPs	Mental Health & Learning Disabilities	CAMHS VCS	1
CYPs	Mental Health & Learning Disabilities	CORE CAMHS LEVEL 2/3	1
CYPs	Mental Health & Learning Disabilities	CAMHS Level 2 Parenting	2
CYPs	Mental Health & Learning Disabilities	CAMHS Interagency Teams (GMAT)	2
CYPS	Mental Health & Learning Disabilities	TACS (Turnaround for children)	1
CYPs	Mental Health & Learning Disabilities	Functional Family Therapy	2
CYPs	Mental Health & Learning Disabilities	CAMHS LD	1
CYPs	Mental Health & Learning Disabilities	CAMHS MHST	2
Covid	Covid	Stock Team	1
Covid	Covid	Testing Team	1
Medical	Medical	Medical staffing MH / LD	1
Medical	Medical	Medical staffing PH	1
Facilities	Facilities	Facilities PH, MH / LD	1

N.B. A separate service impact assessment was carried out in March 2020 for Corporate Services and is available on request.

3. OUT OF HOURS ARRANGEMENTS

3.1. The On-call Management Team arrangements are as follows:

Executive On-Call;

Mental Health Services Manager On-Call;

Physical Health Services Manager On-Call;

The rotas for the three On-Call groups are managed by the Organisational Resilience Team, details of roles and responsibilities are identified in Appendix 3.

3.2. **Directorate/Locality escalation plans –**

Each Locality has operational management protocols/principles in place to manage increases in demand. These principles are used to support the Trust wide Escalation Plan and the Public Health England Local Outbreak Management Plan.

3.3. Mutual Aid

The Trust Escalation Procedures support operational capacity and demand across the health economy, however, the organisation works closely with partner organisations and key stakeholders. Whilst the actions that the organisation take is crucial it recognises the vital role of mutual aid and support in ensuring that the whole system stays safe during times of pressure. Should there be a requirement or request for mutual aid the Trust will follow the Local Health Resilience Partnership Mutual Aid policy. There may also be a requirement or need to work with other non-health related interested parties therefore the Local Resilience Partnership Mutual Aid policy will be followed.

4. ON-GOING MANAGEMENT, MAINTENANCE AND MONITORING

4.1. Capability Maintenance

Plans, procedures, training, equipment, escalation processes and response systems are constantly reviewed and amended as we learn from events, new National guidance and identified best practice, to ensure the most up to date information is contained within documents. The Organisational Resilience Team works in collaboration with ward/department/directorate and site leads to ensure response capabilities are monitored and maintained.

4.2. This document will be reviewed by winter planning leads and the Organisational Resilience Team annually or earlier if changes are required. Any changes will be viewed and agreed by the Trusts respective assurance processes and Executive committee.

4.3. Document availability

A full and up-to-date copy of this document will be available electronically via the Trust Intranet Page.

4.4. It is the responsibility of all staff to ensure they are reading the most up-to-date version of this document (verification can be sought from either the Organisational Resilience Intranet page or the Organisational Resilience Team).

5. SOURCES OF ADDITIONAL INFORMATION

- Incident Management and Coordination Policy
- Incident Command System Policy
- Site/Team Emergency Response Guides/Business Continuity plans
- GHC Internal Escalation Action Cards

- Operational Pressures Escalation Levels (OPEL) NHS Standard Contract
- NHS Commissioning Board Command and Control Framework
- Everyone counts: Planning for Patients 2013/14
- Flu Plan - Winter 2020/21
- Attendance in Adverse Weather or Emergency Event Policy
- On-Call Manual
- Communications Plan
- Seasonal Flu and Testing Plan
- Covid-19 Service Plan
- Demand and Capacity Modelling
- Scenario Planning
- Response and Second Wave position

Appendix 1 – Staff Seasonal Flu Vaccination Action Plan 2021/22

A	**Committed leadership**	**Trust self- assessment**
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Target is 100%
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Working Well ordered 6,000 vaccines for GHC Staff in April 2021
A3	Board receive an evaluation of the flu programme 2021/22, including data, successes, challenges and lessons learnt	The Trust achieved 86% uptake
A4	Agree on a board champion for flu campaign	Director of HR & OD Director of Nursing, Therapies & Quality Director of Infection Prevention & Control
A5	All board members receive flu vaccination and publicise this	Need to organise with Comms
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu Team members – Working Well Head of Nursing & Quality Chief Pharmacist Lead Nurse for Infection Control for Mental Health and Learning Disability Lead Nurse for Nursing Projects PA to Head of Nursing & Quality Admin Support, Flu Co-ordinator Communications Team Complex Case Clinical Lead for Demand and Capacity
A7	Flu team to meet regularly from September 2021	Meetings commenced in June 2021
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	To be done
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Elaine Tingle is working on the clinic plan
B3	Board and senior managers having their vaccinations to be publicised	To be done
B4	Flu vaccination programme and access to vaccination on induction programmes	Being co-ordinated by Elaine
B5	Programme to be publicised on screensavers, posters and social media	To be organised by Comms

B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	To be organised by Comms, with data being provided by Elaine
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer Vaccinators being sought and training being organised by Chief Pharmacist and Health and Wellbeing
C2	Schedule for easy access drop in clinics agreed	Being prepared (to include potential home visits for staff who may continue to be shielding)
C3	Schedule for 24-hour mobile vaccinations to be agreed	To be discussed

Appendix 2 - Flu Vaccination 2021/22

Communications Plan– 2021/22

1. **Background**

   Each year we promote our flu vaccine programme to Trust colleagues, with the aim of increasing uptake of the vaccine by frontline colleagues and ensuring clinics are as accessible as possible across our sites.

   This year, with circulation of Covid-19 the flu vaccination is more important than ever and we will need to look at innovative ways to reach colleagues including those shielding and working from home. We will also need to look at how we can deliver clinics both safely and efficiently within available settings and ensure they are communicated in the most effective way.

   This year's campaign will be launching in October 2021.

2. **Lessons learnt from last year's campaign /areas to focus on**

   - Regular communications to staff to say when clinics are being held
   - Planned clinics with posters
   - Incentives including sweets, badges
   - Make it easy for staff to tell us if they have had the jab elsewhere (using Smart Survey)
   - Communications to keep workforce informed of flu outbreaks
   - Flu stories – service users and staff

3. **GHC key communications**

   - Clinic times/ locations
   - Online booking system
   - Myth busting
   - Uptake encouragement /incentives

4. **Key messages for this year's campaign**

   We have agreed key messages, which we will seek to promote at every opportunity through our engagement and communication.

   - It's important to take up the offer of a vaccine to reduce your risk of becoming unwell with flu at a time when Covid-19 could still be circulating
   - You can have no symptoms of flu but spread it to your friends and family
   - The NHS is well prepared and can safely vaccinate you and your loved ones against flu this year

   PHE key messages for this year's campaign

   - Every year flu hospitalises and kills thousands, and this is anything but an average year
   - The flu virus spreads from person to person, even amongst those not showing any symptoms
   - It can cause severe complications, particularly for high risk groups
   - Keep your guard up against the flu virus. Get the flu jab
   - Whilst the threat may be invisible, the protection against it is clear.
   - Protect yourself and others with the flu vaccination (for those eligible)
   - Flu can be serious and is different from the common cold. Symptoms include a high temperature, body aches and fatigue
   - Aside from having your flu vaccine, the best way to prevent the spread of flu is to practice good hand/respiratory hygiene. Catch coughs and sneezes in a tissue, throw the tissue away and wash your hands.

5. Ongoing Evaluation

We will evaluate the effectiveness of our Communications Plan by:

- Monitoring vaccination and booking system data and focusing our communications on areas/teams with low uptake
- Introducing flu champions to encourage uptake
- Ensuring clinics are accessible across the Trust, including those working from home and/or shielding
- Capturing those colleagues who have had the jab elsewhere e.g. GP Surgeries
- Providing ongoing clear and informed myth busting messages

Appendix 3 - On-Call Roles and Responsibilities

Executive On-Call
The Executive On- Call is a 24-hour function.

Role purpose to –

- Provide overarching strategic support and management to the On-Call managers and any incidents

Key responsibilities to -

- The Executive On-Call is primarily responsible for but not limited to:
  - Staff and patient welfare
  - Reputational damage
  - Media Management
  - Exceptional Financial Spend
  - Escalation and capacity support when required
  - Advising/supporting On-Call managers
  - Major Incidents (decision to open the incident Co-ordination Centre)

- ***Within the Trust, the Executive On-Call will only be contacted through either of the On-Call Services Managers, should the issue be deemed serious enough.***

- The Mental Health Services Manager On-Call or Physical Health Services Manager On-Call will contact the Executive On-Call in the following circumstances:
  - The event is of wider public interest and it requires a timely response;
  - It requires resources beyond those at the disposal of the Services On-Call managers;
  - It extends beyond the Services On-Call manager's area of responsibility and/or expertise

- The Physical Health Services Manager On-Call along with the Patient Flow lead will act as the Trust representatives on the System escalation calls, however the Executive On-Call attendance will be required to support if:
  - The system is at OPEL level 4/Black
  - Director level attendance is requested by the CCG
  - If the health system has been level 3/Red for three consecutive days

- The Executive will act as the press officer for the Trust and deal with enquiries from the press or the public should any untoward incident or serious emergency arise.

- The Executive will act as the Strategic (Gold) Lead for Out of Hours GHC internal incidents.

- The Executive On-Call will be the first point of contact for external agencies alerting that an Incident has been declared through the Local Resilience Forum Operation Link protocols. They will act as the Trust's Strategic (Gold) Lead and may be required to liaise with multi-agency partners at a Strategic level, participating in any relevant calls and meetings.

- For both internal and external incidents, the Executive On-Call, in discussion with the On-Call managers, will decide whether there is a need to open the Incident Coordination Centre.

- The Executive On-Call will keep the Chief Executive and the Chair briefed regarding any incidents which occur and update them on developments. The seriousness of the incident will be determined by the On-Call Exec and reported to the CCG on call manager if

required.

- The Executive On-Call should contact the Chief Executive if an event is likely to enter the political domain or if the consequences of an event pose a dramatic risk. The Chief Executive will decide whether or not to alert the Chair.

- A serious event is defined as an incident that may be of concern to the general public and may attract the attention of the media. It may involve patients, staff or buildings in the Trust, e.g.,
    - an unexpected/unexplained deaths or major injury where foul play within the service is suspected;
    - the suicide of any person under NHS care or detained under the Mental Health Act;
    - accidental death and/or serious injury to any individual (patient, staff or visitor) on NHS premises where this might be due to negligence;
    - any incident involving serious outbreak of an infectious disease;
    - serious damage to NHS property including by fire;
    - security risks
    - any other incident likely to give rise to national media interest involving the Trust.

- Operational issues will continue to be dealt with by the Services Manager On-Call.

Mental Health Services Manager On-Call

Role purpose -

- To provide clinical leadership, support and advice out of hours to the Trust Mental Health Services.

Key responsibilities to -

- maintain a *default telephone/ pager-based* advice and support function;

- provide clinical leadership / advice / support to Trust services out of hours;

- facilitate complex clinical decisions and support liaison with partners and other providers as required;

- respond to mental health bed management situations liaise with the Trusts single point of access to facilitate these requests;

- support with staffing issues and provide authorisation of agency staff as appropriate

- in liaison with Flow Team facilitate a request for an out of area/ Tier 4 placement for a Trust patient;

- support with estates concerns where, on occupied sites there is a perceived significant impact on the safety and wellbeing of service users/ visitors and staff;

- provide support and leadership for any serious incidents acting as the Trust's tactical (silver) lead for any out of hours internal or external wider issues

- attend a site if a serious incident occurs resulting in serious injury or death of a patient, or to support the Physical Health Services Manager On-Call in such a scenario;

- provide a written initial report as outlined in the Policy for Reporting Incidents for any

serious incident;

- liaise directly with the Physical Health Services Manager On-Call to:
  - Resolve issues requiring operational and clinical resolution;
  - Manage Serious Incidents requiring an operational and clinical response;

- escalate the following to Executive On-Call;
  - Serious injury or harm to a patient or staff member;
  - Substantial or significant estates concerns;
  - Media contact;
  - Significant or adverse event requiring service continuity escalation

- record all contacts out of hours within the On-Call log and follow up necessary 'in hours' actions;

- hand over all issues to the relevant locality managers on the next working day;

- the Mental Health Services Manager On-Call may be contacted for variety of issues, as this is not an exhaustive list.

- In extreme situations or major incident declaration the On-Call team, in discussion with the Executive On-Call, may be required to open or attend the Incident Coordination Centre, Malvern Room at Edward Jenner Court.

Physical Health Services Manager On-Call

Role purpose to -

- provide operational leadership, support and advice to Physical Health Trust services out of hours

Key responsibilities -

- maintain a *default telephone/ pager-based* advice and support function;

- support continued service provision/capacity issues

- represent the Trust on system escalation calls, supporting the Patient Flow Lead, and support with any follow up actions or requests liaising with Single Point of Clinical Access (SPCA) and other relevant services e.g. Rapid Response;

- assess the initial information received in respect of a potential or actual disruption to services, advising and facilitating the management of the situation and escalating when appropriate;

- provide support and leadership for any serious incidents acting as the Trust's tactical (silver) lead for any out of hours internal or external wider issues

- when required, contact a relevant staff member via the Executive On-Call for additional support with an issue e.g. IT, legal, Comms, security

- attend a site/ service if a Serious Incident occurs requiring immediate senior operational support;

- support estates concerns, where on occupied sites there is a perceived significant impact on the safety and wellbeing of service users/ visitors and staff;

- support with potential or actual disruptions to operational service delivery, e.g. capacity/case load issues and advise and facilitate the management of the situation;

- when required, have discussions with Minor Injury and Illness Units who are wishing to close the unit and to also ensure to inform the Executive On-Call when there are closures;

- provide support to staff when IT or Clinical Systems issues are escalated. This includes ability to unlock offline working for RIO and access to Community Hospital SystmOne drug charts

- ability to utilise an ESR application to search for members of staff who may be reported uncontactable/missing due to lone working

- escalate the following to Executive on call;
    - Serious injury or harm to staff member;
    - Substantial or significant estates concerns;
    - Media contact;
    - Significant or adverse event requiring service continuity escalation;

- record all contacts out of hours within the On-Call log and follow up necessary 'in hours' actions;

- hand over any ongoing issues to the next On-Call Manager or to the relevant leads/ managers on the next working day where required

- On-Call manager may be contacted for a variety of issues, as this is not an exhaustive list.

- In extreme situations or major incident declaration the On-Call team, in discussion with the Executive On-Call, may be required to open or attend the Incident Coordination Centre, Malvern Room at Edward Jenner Court.

Appendix 4 – 4x4 capabilities

To ensure service continuity during periods of adverse weather the Trust has a number of different options available for implementation:

- Localised Emergency Response Guides
- Business Continuity Planning
- Attendance at Work Policy

The use of 4x4 support is only considered when all other options have been exhausted and:

- there is a need to get staff to patients;
- there is a need to get staff to inpatient facilities.

This would be in an extremist situation and require coordinating as most of the health care providers will draw from the same limited providers and organisations. If the situation is critical or major incident the Local Resilience Forum will coordinate all 4x4 requirements.

To support the Trust requirements, there is a number of vehicles, identified below, within the fleet. Additional internal arrangements are vehicles hired in for a defined period of time. Should the 4x4 element of the plan be required this will mean the Incident Coordination Centre (ICC) is activated and all 4x4 requests coordinated via this function.

The Organisational Resilience Team will coordinate the 4x4 requirement through the ICC arrangements during business hours, and then the ICC On Call manager will assist out of hours.

Trust vehicles are in constant use and if required for other duties this will be on an ad hoc basis. Staff volunteers are trained to drive the hired vehicles, the Organisational Resilience Team hold a list of staff who have volunteered to support the Trust 4x4 capability. Their availability will need to be confirmed at the time of their request for support, noting that this will be an advance identification of risk and all arrangements will be in place prior to the event.

Additional vehicles will be available via the voluntary sector, Gloucester Worcester 4x4, as detailed below.

The following governance arrangements are in place to support the volunteer arrangements.

Insurance: Our insurance covers all staff and volunteers of GHC for personal injury and accidental damage whilst driving any vehicle which has been hired, leased or purchased by GHC. A copy of the insurance certificate will be provided to be kept in each hired vehicle.
Human Resources: We would need to check that Staff Volunteer Drivers, if using their own vehicles had completed their annual appraisal declaration within the past 12 months, which includes the line manager and employee signing off the following declaration:
“I have a valid driving licence, business insurance (appropriate for your role within the Trust) and if appropriate a valid MOT certificate.”
IPC: Will depend - if staff collecting have had Covid and recovered then can share the vehicle with probably 3 other staff, (also recovered) should still wear type 11R facemasks but will be reduced risk. If staff have not had Covid then It would be sensible to have 1 driver (wearing a mask) and 1 passenger (also wearing a mask), a lot would depend on the duration of the journey etc, would also need to try to keep the windows open to allow for

ventilation.
Remuneration: It has been agreed that TOIL can be taken, this needs to be agreed with the individual line Manager.

The following table identifies the 4x4 resources available to support the Trust arrangements.

Trust Resources Location	Car Make	Car Model	**Licence Plate**
Lexham Lodge Crisis Team	DACIA	DUSTER 5DR 4X4 1.6 ESSENTIAL	LJ68 BKA
WEAVERS Croft Crisis Team	DACIA	DUSTER 5DR 4X4 1.6 ESSENTIAL	LJ68 BKD
PULLMAN PLACE CRISIS Team	DACIA	DUSTER 5DR 4X4 1.6 ESSENTIAL	LJ68 BKE
CHARLTON LANE	DACIA	DUSTER 4X4 1.5BD COMFORT	LK69 EYT
Cirencester	DACIA	DUSTER 4X4 1.5BD COMFORT	LK69 EYU
Tewkesbury Hospital	DACIA	DUSTER 4X4 1.5BD COMFORT	LK69 EYV
COLLIERS COURT	DACIA	DUSTER 4X4 1.6 ESSENTIAL	MB19 FBJ
Dilke/ Lydney	SKODA	YETI 4 x 4	VO13 VXV
Rapid Response EJC	SKODA	YETI 4 x 4	VO13 VXX
Stroud	SKODA	YETI 4 x 4	VO13 VYW
North Cots Hospital	SKODA	YETI 4 x 4	VO13VXY

TRUST CONTRACTED SUPPLIER OF 4x4 TRANSPORT (EXTERNAL)			
Supplier	**Contact No.**	**Email**	**Additional information**
A&D 4x4	0193 484 2212	aandd4x4@gmail.com	
GLOUCESTERSHIRE 4X4 VOLUNTEERS (EXTERNAL)			
Name	**Contact No.**	**Email**	**Additional information**
GLOS CCG (OOH)	07623 514563	-	
Gloucestershire and Worcestershire 4x4 Coordinator	Tel: 0330 818 2477	CONTROL@GW4X4R.CO.UK	New telephone number is automatically redirected to the controller on call, telephone is the best form of contact to access support.

Appendix 4 – IPC

INTRODUCTION

The Infection Prevention and Control (IPC) Team provides Consultant led specialist infection prevention and control expertise, training, education and support for all staff and sites across Gloucestershire Health and Care NHSFT (GHC). This service is provided 08:30 to 16.30, Monday to Friday.

Outside of these hours, including weekends, Bank Holidays and overnight, GHC has a contract with Gloucestershire Hospitals NHSFT (GHT) to provide urgent IPC advice and support via the GHC On-Call process (GHC On-Call Manager contacts On-Duty Microbiologist). See below for an example of a Standard Operating Procedure for On-Call Managers, where patients develop symptoms of Covid-19:

SOP for on-call managers for 7b 25.0

The team also has Service Level Agreements (SLA) in place to provide IPC advice and support to Tetbury Hospital as well as Leckhampton Court Hospice (Sue Ryder), Great Oaks and Longfield hospices.

This Winter Surge Plan (WSP) describes the actions which will be taken in order to ensure priority IPC services provided to the Trust can continue in the event of a surge in demand due to a serious outbreak of infectious disease (e.g. Norovirus, C-diff, RSV, influenza, Covid-19 etc.).

IPC TEAM

Name	Title	Substantive WTE	July 2021 WTE
Philippa Moore	Infection Control Doctor (ICD)	4 PA (16 hours per week)	4 PA (16 hours per week)
Sam Lonnen	Infection Control Lead Nurse	0.6	0.6
Marion Johnson	Infection Control Lead Nurse	0.5	0.7
Natalie Matthews	Senior Infection Control Nurse	0.68	0.68
Lisa McLean	Senior Infection Control Nurse	1.0	1.0
Amy Barnes	Infection Control Nurse	1.0	1.0
Louise Forrester	Lead Nurse for Infection Control for MH and LD	0.4	0.4
Emma Bray	Team PA	0.8	0.8

Responsibilities of Infection Control Lead Nurse(s):

- Ensure they have up to date contact details for each member of the team
- Ensure each member of the team has signed the Working at Home agreement in line with Trust Policy
- Ensure each member of the team is set up to work from home, or remotely at other Trust sites, in a way that does not put their health at risk if the need arises
- Ensure a plan is in place for a timely cascade to staff of guidance/instructions when a Winter Surge Event occurs, so that staff are kept informed
- Risk Assessments to be reviewed as appropriate depending on staff circumstances, e.g. Lone Working, Occupational Health Covid-19 Risk Assessments etc.

- Ensure SLA providers are contacted immediately, advised of situation, know how to contact the team and receive regular updates
- Review the position with DIPC/Deputy DIPC daily/weekly as required

Responsibilities of the IPC team staff member:

- Ensure they have the Infection Control Lead Nurse(s) mobile number
- Ensure their contact details are up to date
- Make every effort to get to work, or work from alternative Trust sites, providing there is no risk to self or others (e.g. severe weather)

WINTER SURGE EVENT (SERIOUS OUTBREAK):

The Trust and IPC team's response to an outbreak depends on the severity and nature of the outbreak. The varying levels of response are outlined in the Trusts IPC Outbreak of Serious Infection Policy CLP133. Severe outbreaks may involve local Public Health or Public Health England involvement.

During times of surge, including winter surge and Bank Holidays, if the IPC team are required to work across 7 days this would be built into existing GHC On-Call process, i.e.:

- 7 day working would be agreed with HR/IPC team
- Names/contact details and rotas would be developed
- Names/contact details would be sent to the Incident Co-ordination Centre for inclusion in the On-Call Managers pack and circulated

Actions to be Taken to Increase IPC Team Capacity During Surge

To ensure a serious outbreak is managed effectively, various actions will be considered in order to increase the capacity of the GHC IPC team. These actions would include:

- Lower priority activities would be temporarily paused. The situation would be reviewed with the Deputy DIPC on a daily/weekly basis as required. Appendix 1 gives an indication of the activities that can be safely temporarily paused
- IPC team would be asked if they wish to increase their hours
- Deputy DIPC would engage with HR/IPC if 7-day working is required
- Re-deployment of staff to support the IPC team, for example:
    - 1 member of staff is qualified as an IPC nurse and could be deployed into the team to provide specialist IPC advice and support
    - Staff could be re-deployed to other roles to support outbreak management, e.g. PPE Safety Champions role during Covid-19

Annex – IPC Team Activity with Priorities

Activity	Activity Priority	Can it be Paused?	Comment
Outbreak Management	1	No	Key activity
Outbreak Reporting to PHE	1	No	Mandatory requirement
Daily Results and Surveillance	1	No	Key Activity
IPC Advice and Support (including for new builds, new equipment etc.)	1	Partly	Advice and support prioritised to manage outbreak(s), other non-priority advice and support to be paused
SLA Advice, Support and Audit	1	No	Contractual obligations need to be delivered
Clinical Visits	1	No	Prioritise visits to areas with outbreak(s)
Monthly audits - monitor and follow-up	1	No	Monitor for assurance, prioritise where compliance poor
System Crisis Management Meetings (Bronze, Silver, Gold)	1	No	IPC attendance required
Matron's Walkabouts	2	Yes	Not a priority
Education and Training	2	Yes	Training transferred to e-learning (Level 1 and Level 2)
Policy Reviews	2	Yes	Policies can be extended and reviewed when outbreak over
Annual IPC Audit	2	Partly	Seek alternatives if Annual Audit can't be undertaken (e.g. Covid-19 Assurance Framework) Monitoring of Hospital Audits for assurance
Meetings and other activity	3	Yes	Non-IPC Assurance activity and non-essential meetings can be deferred

Appendix 5 – Staff Health & Wellbeing

The health and wellbeing of every colleague is important at all times.

- ✓ Health and wellbeing is everyone's responsibility
- ✓ Leaders and managers are required to ensure they are setting the tone for their team
  - Set an example and make sure you are supporting your own wellbeing.
- ✓ It is ok to say you are not ok
  - Seek help and support, whether that be taking a break; talking to a colleague; or talking to your manager, accessing resources

There are a range of formal resources available access on the health and wellbeing intranet pages

Team time
Colleagues are encouraged to do simple as a 15-minute check-in, ensuring we know how people are feeling, what they worked on yesterday and what they are doing today and do they need any support. Helpful tools are available on the intranet to help.

Rest and Relaxation
Colleagues are reminded to ensure they take care of themselves and take regular breaks, it can be as simple as a quick walk around or stepping away from your immediate environment. Leaders and managers are encouraged to role model and encourage their team to do the same.
Colleagues are reminded that it is important to look after the basics, eating well, exercise, sleep, rest and relaxation.

Formal Resources
All the resources can be found on the intranet

Working Well
Our occupational health service provides advice on how to support colleagues with a physical or mental health issues. They also provide direct support for colleagues, including confidential advice including counselling and other health and wellbeing support. If colleagues need to access a trained counsellor about any issue, financial, home, work etc, they can email workingwell@ghc.nhs.uk to arrange, putting 'Counselling request' in the subject heading. This is available 24 hours per day.

Let's Talk
Provides support for people with anxiety and depression, using a range of therapies, to support colleagues in managing their emotional wellbeing. This is a confidential service which is available on: 0800 0073 2200

Psychology
Our psychologists support individuals or teams, this can be accessed directly the Head of Psychological Services.

Vivup
Is our Employee Assistance Programme (EAP) with advice, counselling and support, for more information click here

Speaking Up
As an organisation we seek to create an environment where people have the confidence to raise questions and concerns. We aim to actively listen to feedback, reflect and learn. Creating a culture of continuous learning. Colleagues can raise a concern directly to our freedom to speak up guardian.

Online resources
There are also a range of free apps available to colleagues, the passwords can be found on the GHC intranet mental health pages.

Digital Wellbeing
It's important that we ensure we take regular breaks as being on digital meetings can be very tiring. We suggest that people start meetings on the hour but finish meetings 10 minutes before t

Appendix 6 – Trust Risk Summary

The risk process is constantly reviewed and updated and regular review of risks ensures mitigation is progressed to lower the risk probability or close the risk.

Ref	Risk Theme	Description of the risk	The Trust Risk Assessment without controls			Existing Controls/ Capabilities	Additional Risk Treatment required	Residual Risk rating		
			L	C	Risk Rating			L	C	Risk Rating
1	Severe weather	Prolonged heavy snowfall causing travel disruption and difficulty in community staff reaching service users.	2	3	Moderate	Service Continuity Plans Service. Director/Community Service manager – prioritisation of staffing and services. Prioritised patient severity list. Policy relating to Staff attending work during severe weather. 4x4 vehicle support arrangements including Staff volunteers, Contracted Transport and LRF 4x4 Protocol.	N/A	2	2	Moderate
2	Staff absence (Severe Weather – Snow and low temps)	Increase in staff absences (above average levels) due to difficulty in getting to work that may have an impact on service quality and patient safety.	2	3	Moderate	1. Service Director/Matron – prioritisation of staffing and services 2. Directorate and Locality contingency arrangements 3. Support from Temporary Staffing Team with providing Bank Staff	1. Severe Weather Procedure (includes 4x4 protocols). 2. Estates grounds and maintenance contracts	2	3	Moderate
3	Staff absence (sickness)	Increase in staff absences (above average levels) due to circulating seasonal viruses.	3	4	High	1. Hand Hygiene Policy 2. Flu Vaccination 3. Combined occupational health and communications team awareness campaign. 4. Service continuity arrangements outlining staffing contingencies 5. Staff self- referral to physiotherapy 6. Increase in hygiene compliance as service now managed in house, Trigger notification of staff absence / return to work interviews and referral to Occupational health 7. Utilisation of the Covid-19 Absence App	N/A	3	4	Moderate
4	Staff absence (Holiday period)	Increase in staff absences (above average levels) due to holiday period.	2	3	Moderate	1. Staff rotas developed, reviewed and agreed in October by Service Directors. 2. Local staff bank co-ordination 3.Use of electronic rota, noting 2 systems currently being utilised	N/A	2	2	Moderate
5	Flu Vaccination	The Trust will not be able to achieve the target to vaccinate 100% of its workforce against flu.	1	3	Low	1. Combined occupational health & communications team awareness campaign 2. Flu Champions 3. peer Vaccinators	N/A	1	3	Low

Ref	Risk Theme	Description of the risk	The Trust Risk Assessment without controls			Existing Controls/ Capabilities	Additional Risk Treatment required	Residual Risk rating		
			L	C	Risk Rating			L	C	Risk Rating
6	Outbreaks	Flu/other circulating viruses impacting on the resources of a site(s), subsequently leading to reduced capacity.	4	4	High	1. Outbreak Plan 2. Hand Hygiene Policy 3. Patient Isolation Policy 4. Enhanced cleaning 5. Gastroenteritis Policy 6. WVT Infection control audits 7. Sepsis awareness packs	N/A	4	3	High
7	Increased demand on Operational Service Teams	Demand likely to outstrip capacity leading to performance targets not being met	2	3	Moderate	1. Service Escalation triggers and actions 2. On-call team 3. Site briefings/ conferences 4. Staffing strategies 6. GCCG Escalation Framework 7. Staff requirements managed in line with the demand modelling that has been developed.	N/A	1	3	Low
8	Bed capacity	Demand for beds likely to outstrip normal capacity	3	4	High	1. Robust Bed Management Process, Weekly MFSD meetings. 2. Availability to purchase private beds to extend capacity for mental health provision 3. Negotiate with commissioners to open assessment beds	N/A	2	3	Moderate
9	Covid-19 Specific	Second wave of pandemic	3	4	High	1. Surge planning workshops completed 2. linked to the corporate		2	3	Moderate
11	Covid-19 Specific	Local outbreak of Covid-19 (including organisational outbreak)	3	4	High	1. Local Ward bed management plans 2. LOMP 3. SHREWD 4. Demand and Capacity for bed management		2	3	Moderate
12	Covid-19 Specific	National Lock down	3	4	High	Work from home BCP implemented		2	3	Moderate
13	Covid-19 Specific	Local lock down	3	4	High	As above		2	3	Moderate

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16.2/0921

OPERATIONAL ESCALATION PLAN

Version	1.0
Author:	Sarah Birmingham
Date	16th August 2021

Contents

1.0 Introduction

This Surge and Escalation Plan has been developed to guide leaders and managers through periods of surge at any point in the year, including winter.

Surge occurs when, for any reason, there is a mis-match between demand and capacity which risks compromising essential patient care and safety.

Surge can occur in two ways;

- Within the Trust and individual service when internal escalation actions may be required to be put in place to support a system response.
- Across the system when system escalation actions may be required to be put in place to support a system response.

Surge may impact Priority 1 services, these are services that require a timely response and whose patients cannot be put on a waiting list. A list of P1 services can be found in Appendix 1.

1.1 Business Continuity Plan

All GHC operational services hold their own Business Continuity Plans which ensures that they can maintain service resilience and effectively manage risk and continuity of quality patient care in the event of disruption from local, regional, national or global incidents.

1.2 Related Documents

This document aligns with:

GHC Winter Plan
GHC On Call Pack
GHC Major Incident Plan
GHC Emergency Response Plan
GHC Business Continuity Plans

1.3 Aim & Objectives of the Plan

The overall aim of this surge and escalation plan is to provide a framework for GHC colleagues to use in order to manage and respond to surge in demand and capacity issues.

The objectives of the surge and escalation plan are as follows:

- To establish a shared understanding of surge and escalation issues across GHC managed services
- To establish a shared understanding of service prioritisation across GHC.
- To describe triggers in services that indicate escalation.
- To define organisational actions to be enacted in surge for response which can be utilised irrespective of situation duration, scale and type
- To define a mechanism for escalation in the event of surge.

1.4 Equality & Diversity

Participating services will ensure that the diverse needs of the community are appropriately assessed in response to surge and escalation situations and that suitable response measures, including warning and informing arrangements, are implemented relative to identified needs.

2.0. Approach to escalation

2.1 Definitions – levels of escalation

This surge plan follows the NHS England alert levels, comprising 4 distinct alert levels.

Table 2: Definition of Escalation Statuses	
GREEN	**Level 1: patient flow management** - The Local Health and Social Care System capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. Commissioned levels of service will be decided locally.
AMBER	**Level 2: mitigation of escalation –** The Local Health and Social Care System starting to show signs of pressure. Focused actions are required in organisations showing pressure to mitigate further escalation. Enhanced co-ordination will alert the whole system to take action to return to green status as quickly as possible.
RED	**Level 3: whole system compromised** – Actions taken in Level 2 have failed to return the system to Level 1 and pressure is worsening. The Local Health and Social Care System is experiencing major pressures compromising patient flow further urgent actions are required across the system by all partners.
BLACK	**Level 4: severe pressure and failure of actions** – All actions have failed to contain service pressures and the local Health and Social Care system is unable to deliver comprehensive emergency care. There is potential for patient care to be compromised and a serious untoward incident is reported by the system. Decisive action must be taken to recover capacity.

2.2 Information

GHC uses a range of information sources to enable it to understand and share intelligence related to surge and escalation.

Source	Information	Access
SHREWD	Sets out key information relating to performance of organisation across the system	Link to SHREWD
Daily GHC sitrep	Collates data about bed capacity and pressures	Incident room
Operational Situation Report (SitRep)	Method of escalating issues and identifying possible solutions which cannot be implemented without wider support and agreement	Link to SitRep: https://app.glos-care.nhs.uk/covid19sitrep
Daily SPCA sitrep	Collates data about bed capacity, HomeFirst and flow.	

2.3 GHC Triggers and Actions

The tables below illustrate the agreed GHC escalation triggers

DEMAND

PRE-HOSPITAL

Metric	Level 1 - Normal	Level 2	Level 3	Level 4
SPCA call volume per hour Weekday	8	10	13	<=15
Weekend	3	5	6	7
Rapid Response RAG rating (Referral rate in and nos in service)	1	2	3	4
Number of patients on SPCA working list at time of report				
Number of SPCA patients with no plan				

IN HOSPITAL

Level 1 - Normal	Level 2	Level 3	Level 4

DISCHARGE

Level 1 - Normal	Level 2	Level 3	Level 4
<=10	11	12-14	>=15
0	1-5	6-11	>=12

CAPACITY

Metric	Level 1 - Normal	Level 2	Level 3	Level 4
SPCA Abandoned call rate	<5%	<8%	<12%	12%>
MIiU longest wait	<3 hrs	3-4	4+ in 1 unit	4+ in 1+ units

Level 1 - Normal	Level 2	Level 3	Level 4

Level 1 - Normal	Level 2	Level 3	Level 4

Rapid Response											
Total number of Physical Hospital beds available weekdays Saturdays Sundays					>=10 >=5 3	6-9 3-4 2	0-5 1-2 1	0 0 0				
Total number of Mental Health Hospital beds available weekdays Saturdays Sundays					Under development							
Total Number of Reablement Beds available Weekdays Saturdays Sundays					>=6 >=5 >=3	3-5 3-4 2	1-2 1-2 1	0 0 0				
Total Number of HomeFirst starts available Weekdays Saturdays Sundays	Under development											
Community Nursing	Under development											
IVT	Under development											
Beds closed due to Infection Control					0	1 ward /area	2-3 wards / areas	>4 wards/ areas				

No of Unfilled shifts (agency & Bank) - Community Services											1	2	3	4
No of Unfilled shifts (agency & Bank) - Community Hospitals						1	2	3	4					
MH Crisis	Under development													
MH Liaison	Under development													

3.0 Service level thresholds for escalation
3.1 Daily Service Assessment of Capacity & Demand

At time of surge all priority 1 services will undertake a daily assessment of their service in order to allocate an escalation level.

The purpose of assessment is to determine the service's capability to deliver routine, essential and critical services and identify when this has changed and for what reason.

Services will agree a set of triggers applicable to their service area set out below:

Service	Factor	Elements	Rationale for normal working
Community based services	% of available Capacity to receive routine, essential and critical visits	Number of • Units of activity • Caseload size • Staffing levels	Community teams work at capacity which is part of normal business
Minor Injury & illness Units (MIiUs)	% of workload being managed within targets	Number of • Breaches • Length of wait • Staffing capacity • Acuity of patients	100% of patients treated and discharged within 4 hours No clinical breaches
Community bed-based services	% of beds available	Number of • Admissions • Transfers • Discharges • Vacant beds	95% occupancy rate
Staff Absence	% of staff absence and impact on service delivery	Number of shifts not covered and impact on individual services	Staff Shortages: Level 1 – Managed within normal business

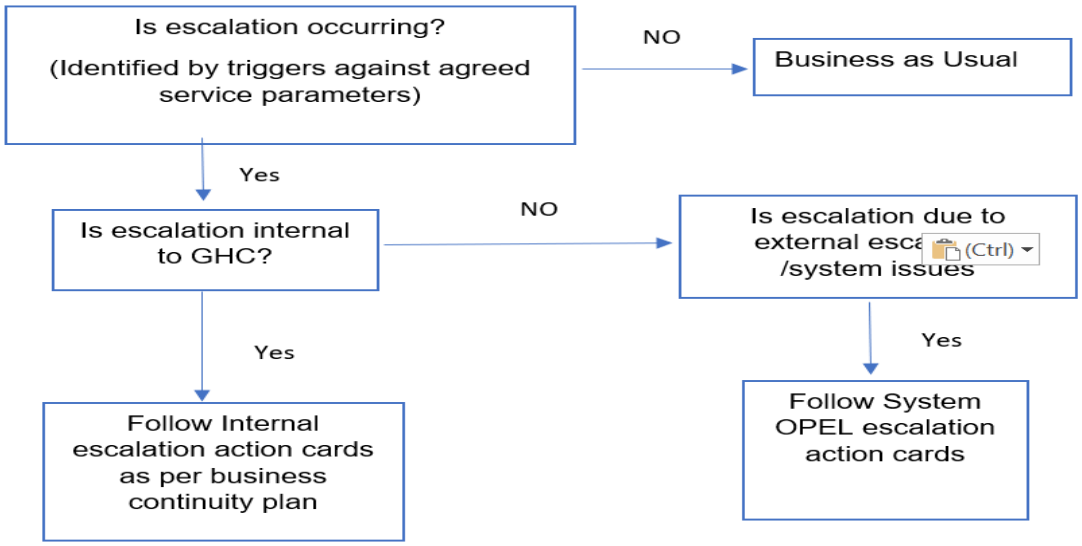
3.2 Rag Rating

A RAG (Red, Amber, Green) Assessment of Demand and Capacity has been designed to support report daily. An example of the RAG rating currently used by the GHC Rapid Response service is available within Appendix 1

3.3 Is Escalation occurring?

Escalation maybe experience due to internal pressures or external system pressures.

The process below guides the service response to escalation:



The following escalation action cards are available:

1. Internal Escalation response for P1 services
2. OPEL System escalation actions.

4.0 Service Prioritisation

During periods of escalation service prioritisation is a dynamic assessment and dependant on the nature and duration of the incident. The GHC service prioritisation descriptors are identified in the table below:

GHC: 3 levels of service/function prioritisation		
Level	**Descriptor**	**Maximum Tolerable Period of Disruption (MTPD)**
Priority 1 - (P1)	**Plan to maintain services in all scenarios**	**8 Hours**
Priority 2 - (P2)	**Plan to maintain accepting referrals, triage/advice and wait list maintenance offering a service for urgent and priority patients only**	**24 Hours**
Priority 3 - (P3)	**Plan to cease service for duration of incident**	**72 Hours +**

The GHC services currently identified as Priority 1 Services are available in Appendix 1

6.0 Daily sitrep

The purpose of the Situation Report (SitRep) is to provide managers and leaders with a method of escalating issues and identifying possible solutions which cannot be implemented without wider support and agreement.

Where possible decision making should be at grass roots by giving managers authority to act.

It also provides organisational system oversight and transparency of the situation as it develops. Link to SitRep: https://app.glos-care.nhs.uk/covid19sitrep

7.0 Incident Control centre

In the event of surge services can escalate their escalation level via contacting the Incident Room email: incident-room@ghc.nhs.uk

8.0 GHC Escalation Actions

Un the event of surge all identified GHC Priority 1 Services will implement a series of escalation actions cards in place which:

- Identify the triggers to levels of escalation (2,3,4)
- Identify the actions taken by the service in the event of escalation

An example of these escalation action cards in available in Appendix 3

In addition, in the event of external system escalation GHC services will enact the OPEL system escalation actions available within Appendix 4

Appendix 1 GHC Priority 1 Services

Service areas	Specialism	Service	Priority Rating
Hospitals	PH	Inpatients	1
Hospitals	LD & MH	Inpatients	1
Hospitals	LD	LDISS	1
Urgent Care	PH	Rapid Response	1
Urgent Care	PH	Integrated Assess Team	1
Urgent Care	PH	Minor Injury and Illness Units	1
Urgent Care	PH	Single Point of Clinical Access	1
Urgent Care	PH	IV Therapy	1
Urgent Care	PH	Evening and Overnight District Nursing	1
Urgent Care	MH	Contact Centre	1
Urgent Care	MH	Crisis incl. Street Triage	1
Urgent Care	MH	AMHP	1
Urgent Care	MH	Psychiatric Liaison	1
LTC	PH	Respiratory - Home Oxygen Service	1
LTC	PH	Homeless Healthcare	1
Sexual health	PH	Sexual Assault Referral Centre	1
Sexual health	PH	Pregnancy Advisory Service	1
Sexual health	PH	Sexual health - GUM/HIV	1
Dental	PH	Dental OOHs/Urgent	1
Therapy & Equip	PH	Podiatry - Inpatients	1
Therapy & Equip	PH	SALT - IP services	1
Therapy & Equip	PH	Integrated Community Equipment Service	1
Therapy & Equip	PH	Telecare	1
Adult Community	PH	Referral centre	1
Adult Community	PH	Reablement	1
Adult Community	PH	District Nurses	1
Adult Community	PH	Complex leg wound/lower limb	1/2
Adult Community	PH	Lymphoedema service	1/2
Adult Community	PH	Complex care at home	1/2
CYPs	PH	Children's Community Nursing Team	1
CYPs	PH	Children's' Complex Care Service	1
CYPs	PH	Physiotherapy - IP only	1
CYPs	PH	Occupational Therapy - IP only	1
CYPs	PH	SALT - IP only	1
CYPs	MH & LD	CAMHS VCS	1
CYPs	MH & LD	CAMHS LEVEL 2/3	1
Covid	Covid	Stock Team	1
Covid	Covid	Testing Team	1
Medical	Medical	Medical staffing MH / LD	1
Medical	Medical	Medical staffing PH	1
Facilities	Facilities	Facilities MH / LD	1

Appendix 2 Rapid Response Assessment of Demand and Capacity RAG

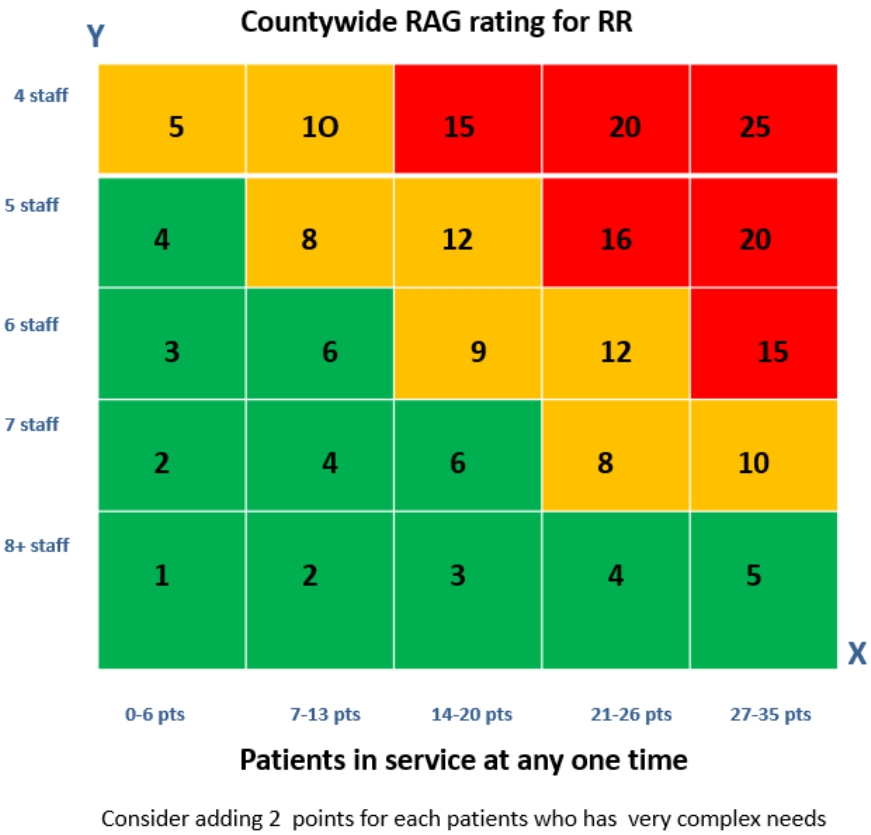
Consider adding 2 points for each:

Lack of staff with the required level of competency on shift

Lack of locality staff resource e.g. Falls pick up /double up

Geographical restrictions; staff cannot get to areas quickly so reduce ability to respond to new referrals

Conditions prevent effective response e.g. weather



Consider adding 2 points for each patients who has very complex needs

The RAG (Red, Amber, Green) rating has been designed to help us all report daily

The Urgent Care Lead rates the current countywide RR status before 9.00 every weekday

The Urgent Care Red Lead rates the current countywide RR status before 9.00 weekends/BH and reports

Please note:

- Add 2 points on each axis if there are issues that affect the scoring e.g. 'X' axis on each very complex pts, and 'Y' axis on staffing issues
- Consider reporting on any foreseeable issues affecting the late and night shifts

Appendix 3 Rapid Response Internal Escalation Action Cards

Local escalation Level 2 Actions

	Trigger
	• Below minimum staffing levels as illustrated in the table below Locality / Early Shift / Mid Shift / Late North / 2 / 1 / 2 South / 2 / 1 / 2 Forest / 1 / 1 / 1 • Urgent care service rated amber capacity to meet presenting demand. • Limited capacity to take referrals and assess within expected timescales (20% above normal) • Assessed increase in patient acuity with impact upon capacity. • Requirement for RR to ensure resilience for system partners.
	Action
1	Complete Service Assessment of Capacity & Demand
2	Service Directors enact directorate consolidation strategies to manage rotas.
3	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
4	Prioritise referrals from Primary/Community Care
5	Rapid Response to triage all referrals directly
6	Liaise directly with clinical teams in OOH and MiiU to flow patients appropriately

Internal Escalation Level 3 Actions

All actions from Level 2 plus below

	Trigger
	• Below minimum staffing continues over 24 hr period • Unable to transfer patients to on-going services (delays of up to a week, involving several patients) • Limited ability to accept further referrals into Urgent care services with an impact upon response time. • System partners in extremist and RR capacity to be reallocated to support.
	Action
1	Review 24-hour staffing - increase staffing as required through within directorate deployment use of enhanced rates for internal bank
2	Additional staffing (bank/agency) to referring services to manage flow out of RR – IVT/ONDNS/HomeFirst/ ICT/Resp
3	Deploy operational managers to clinical work (DD UCASS, CL UCASS, OL UCASS)
4	Update DoS to reflect pressure
5	SWAST/GHT/PC update to advise of capacity
6	Implement GHC Operational Flow Hub to run alongside ICC. Implement additional afternoon (and evening if required) GHC Operational Flow meeting.
7	Stand down non-essential meetings and training.
8	Complete Operational Sitrep

Local escalation Level 4 Actions

	Trigger
	• Below minimum staffing continues over 48 hr period • Unable to transfer patients to on-going services (delays of up to a week, involving several patients) • Extreme weather preventing staff travel
	Actions
1	Staff deployed to maintain critical service provision only
2	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
3	Enact 4X4 transport
4	Suspend all annual leave and request staff to attend workplace
5	Request Response team workforce
6	

Appendix 4 Organisational OPEL Actions for system Response

OPEL 2 Amber

NHS Specific OPEL Actions	
GHC Actions available to be implemented	
GHC Actions currently in place	✔

	Lead	Action	In Place
1	GHC	Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. Maximise use of reablement/intermediate care beds	✔
2	GHC	All services (RR, DNs, CHs) to identify blockages to discharge and escalate to relevant Head of Service	✔
3	GHC	SPCA lead to call IDT to prioritise working list	✔
4	GHC	Community hospitals to bring forward discharges to allow transfers in as appropriate. Community hospitals to liaise with Social and Healthcare providers to expedite discharge	✔
5	GHC	Additional ward rounds to take place within community providers to expedite discharge and create capacity	✔
6	GHC	Community providers to lower admission/treatment thresholds wherever possible through implementation of previously agreed flexible working arrangements to alleviate pressure	✔
7	GHC	Apply flexibility regarding beds and staffing to increase capacity where possible	✔
8	GHC	Expedite rapid assessment by multidisciplinary team (MDT) including Social Care assessment	✔
9	GHC	Ensure all staff in MHLT are aware of escalation level and to reflect this within their working day and prioritisation of system.	✔
10	GHC	MHLT to ensure pathways are being used appropriately, confirm that guidance is accessible and communicate when information cannot be found	✔
11	GHC	Where possible, community-based services to increase support and/or communication to patients at home to prevent admissions.	✔
12	GHC	Expedite rapid assessment for patients waiting within another service e.g. ED	✔
13	GHC	For inpatients in acute hospitals prioritise MH assessments where delays are impacting on quality/capacity of service provision	✔
14	GHC	MHLT to ensure all referrals are verbally responded to within 2-hour target and subsequent response is in keeping with level of risk identified using risk matrix	✔

15	**GHC**	MHLT Manager to ensure that all patients awaiting review before discharge are to be prioritised so that they are seen within 4 hours where staffing capacity permits	✔

OPEL 3 Red

All actions from OPEL 2 plus below

	Lead	Action	In Place
1	**GHC**	Senior Nurses to review patients that could be moved with ongoing support requirements in order to realise capacity	✔
2	**GHC**	Mix sex breach requests to be sent to CEO for review and decision - CEO agreement only.	
3	**GHC**	Head of Services to escalate blockages to Deputy COO/COO	✔
4	**GHC**	SPCA - Prioritise discharge from relevant GHT site	✔
5	**GHC**	As able, Rapid Response to send staff into ED	
6	**GHC**	MIIU social media push to advise capacity	
7	**GHC**	Capacity Manager / Deputy Director to monitor escalation status, taking part in teleconferences as required.	✔
8	**GHC**	SPCA - call in bank staff to handle call volumes	
9	**GHC**	Assess and reprioritise any non- housebound DN visits	
10	**GHC**	Review all daily visit patterns to identify bi-daily options	
11	**GHC**	Review all non-urgent visits	
12	**GHC**	All community care teams to review all patients awaiting assessments (with single point of access) in order to expedite discharge or transfer where possible – this to include In-reach teams and community hospitals	✔
13	**GHC**	Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible	✔
14	**GHC**	Community providers to expand capacity wherever possible through additional staffing and services, including primary care	✔
15	**GHC**	Community providers to consider the use of wider group of agencies (e.g. higher cost agencies) to increase staffing capacity	✔
16	**GHC**	Patients waiting at home for admission to be referred to Community Teams (by In-reach nurses) and/or single point of access and Emergency Medical Unit (EMU)	✔
17	**GHC**	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.	✔
18	**GHC**	Review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities, where possible.	✔
19	**GHC**	Community based teams to increase support to service users at home to prevent admission.	✔
20	**GHC**	Escalation to relevant on call manager	✔

21	**GHC**	Liaison with Social Care if delays relate to arranging MH Act Assessment	✔
22	**GHC**	Liaison/joint working with Social Care and Housing to identify appropriate accommodation/care packages	✔
23	**GHC**	Regardless of level of risk and within resource available will prioritise ED referrals	
24	**GHC**	MHLT manager to prioritise ED referrals and recruit additional resources from off duty staff and staff bank	✔
25	**GHC**	MHLT manager to recruit additional resources from off duty staff and staff bank.	✔
26	**GHC**	MHLT Manager to prioritise assessments in ED from 2 hours to 1 hour where staff capacity permits	✔
27	**GHC**	Close smaller MIIUs and reallocate staff to strategic MIIUs (Stroud, Cirencester, North Cotswolds & Lydney)	✔
28	**GHC**	Provide senior clinical support for weekends across Community Services and Community Hospitals Professional Leadership (Clinical) rota - with time off in lieu and payment for hours worked Provision of clinical leadership for all out of hours service provision Dial into escalation calls, link with shift/ward leads and available for clinical queries advice and guidance, based on site with a clinical team Inpatients ICT Home First DN Rapid Response SPCA	
29	**GHC**	Implement GHC Operational Flow Hub to run alongside ICC. Implement additional afternoon (and evening if required) GHC Operational Flow meeting.	✔
31	**GHC**	Review staffing levels and manage Staff shortages with flexible use of £100 incentive for the following staff groups: - RN - HCA - All Bank Staff	
32	**Urgent Care**	MIiU offering ED Streaming of 15 appointments for the Streaming Nurse in ED to use per day in MIIUs across working closely with system partners with implementation planned for 2 weeks' time	
33	**Urgent Care**	MIiU's supporting the supply of grab bags/ oximeters for Covid-19 Virtual Ward with the aim of less Covid-19 admissions and preventing undiagnosed deterioration.	✔
34	**Urgent Care and Specialty Services**	Post discharge Covid-19 Virtual ward, managing respiratory and non-respiratory patients.	✔
35	**Urgent Care**	CHST continue to offer seasonal Covid-19/ Flu vaccination as part of mass vaccine programme	✔
36	**GHC**	Hold internal meetings - 09:00 Flow meeting	✔

		- 12:30 Flow meeting - 16:00 GHC Covid-19 briefing, Monday and Friday	
37	**GHC**	Ensure Medical resilience in Hospitals particularly at weekends	✔
38	**GHC**	Ensure estates/facilities teams have resources	✔

OPEL 4 Black Organisational level

All actions from OPEL 3 and 2 must be completed before escalation to OPEL 4

Department		Actions	In Place
1	**GHC**	Hold daily virtual board rounds 3 times a week for Community Hospitals led by Hospitals Directorate with inclusion of the Demand and Capacity team and Adult Social Care colleagues	
2	**GHC**	Continue to flex criteria for admission to a Community Hospital.	✔ (Within IPC Guidelines)
3	**GHC**	Further caseload review and reprioritisation of therapy in community services. Divert therapists to support Home First.	
4	**GHC**	Weekend on call rota all Service Directors and Deputies with time off in lieu and payment for hours worked	
5	**GHC**	MH and PH Services On-Call Manager, have a second person on call rota in place with time off in lieu and payment for hours worked	
6	**GHC**	Enhance the ICC cover with second person on call, with time off in lieu and payment for hours worked	
7	**GHC**	Review lowering levels of care	
8	**Urgent Care**	Rapid Response to become a Receiver as well as a User on Cinapsis providing easy access to RR for SWAST to prevent admissions.	
9	**Urgent Care**	Review opening hours of SPCA at weekends	
10	**Hospitals**	Explore options of opening additional inpatient bed capacity across our estate, with mutual aid as required if demand increases during the preceding week.	
11	**Hospitals**	Gain agreement from the system to cease elective activity within and outpatients and redeploy staff to inpatient wards.	

12	**Hospitals**	Gain agreement from the system to cease elective activity including theatre, endoscopy and redeploy staff to inpatient wards.	
13	**Hospitals**	Increase non-clinical support on inpatient wards	
14	**Adult Community**	Complex care at home to support with Adult PH Community Health Teams under the Directions of the Service Director	
15	**Adult Community**	Further caseload review and reprioritisation of therapy. Divert therapists to support Home First model	
16	**Adult Community**	Redeployment to add capacity into Home First and reablement pathways	
17	**GHC**	Ensure IPC cover on site with time off in lieu and payment for hours worked	
18	**GHC**	Partial Closure of School Age Immunisation Service	
19	**GHC**	Partial closure of Public Health Nursing	
20	**GHC**	Redeploy colleagues from NQT to provide additional clinical rota to support colleagues	
21	**GHC**	Targeted short-term redeployment colleagues from NQT, finance and strategy and partnership's into HCA, admin and support worker rolls.	
22	**GHC**	Review of all current placement of RN and AHP colleagues across GHC and ensure colleagues are deployed as per priority.	

WINTER SCHEMES – OPERATIONS 2021

1.0 INTRODUCTION

The organisation recognises that there is a requirement to prioritise and strengthen services to manage internal patient flow efficiently and safely through the winter period 2021-22 and to fully support the Gloucestershire health and care system keeping people at home as much as possible, maintaining patient safety, privacy and dignity at all times.

2.0 BACKGROUND

This year there are a number of additional unique considerations and risk factors to mitigate which includes:

- the ongoing impact of waves 1, 2 and 3 of COVID-19 on service demand and capacity, on staffing and morale, with ongoing preparation for further waves,

- the impact from lockdown and social distancing predicted to result in a surge of serious respiratory illness specifically in the very young, the older person and the vulnerable, which requires additional precautionary measures,

- the estates refurbishment of Stroud MIIU, Jubilee ward, Southgate Moorings, Charlton Lane, Wotton Lawn,

- Increase in primary care demand by up to 40% to date and the roll-out of further vaccination programmes

Service developments that will further affect the capacity and resilience of our services include Ageing Well, development of the post-Covid service, complex emotional needs service, introduction of the hospital discharge service operating model.

The expected impact of these risk factors and challenges are;

- The ongoing risk of a depleted clinical workforce as a result of either Covid-symptoms / positive result itself or contact with a Covid-positive person, with consequent impact from prioritising services and of redeployment.

- Increased length of stay and number of medically fit patients within inpatient beds due to capacity constraints in adult social care and care provider agencies/homes with the consequent potential of impact on that patients' outcomes.

- Increase in acuity and dependency of patients, and increased risk of incorrect pathways being applied in response to whole-system distress.
- A reduced bed-base and waiting area/assessment area capacity to ensure Covid-security adding to system-wide pressures through reduced capacity and regular short-term closures.

- Increased number of Out of Area placements for our tier 4/most challenged clients in mental health resulting in impact on them, their families, and financial position of the Trust.

- Overcrowding in the Emergency Department (ED) resulting in system pull to provide more services from partners to strengthen all access routes and points.

- Increase in MH crisis presentations with consequent impact on provision of 136 suite on the crisis workforce.

- Increased demand on community nursing teams through primary care referrals, on SPAC and dental triage line.

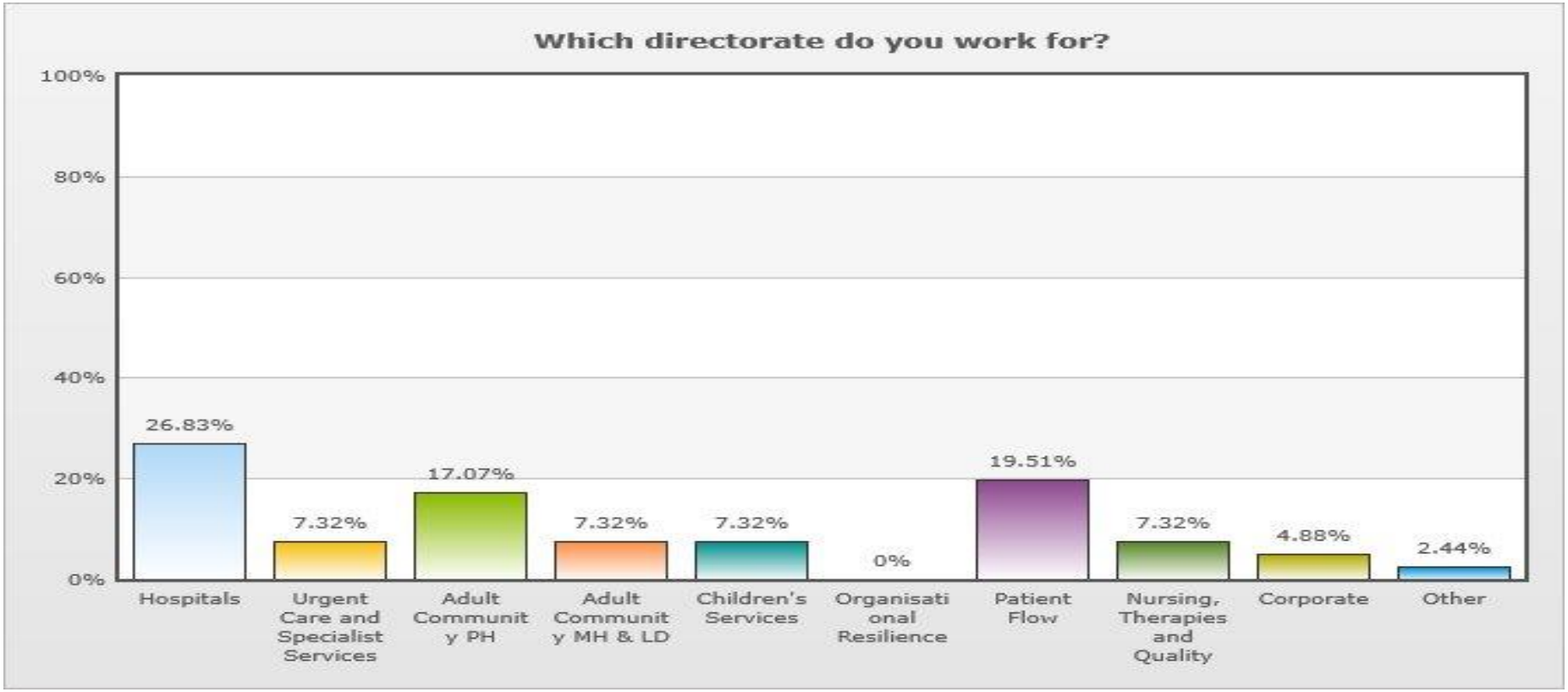
2.0 LESSONS LEARNT

Lessons learnt from recovery check-ins:

Estates	- Snow Risks and access to 4X4 - Signing in process for all buildings – to support track and trace with staff - Need for confidential areas for virtual services - Covid secure venues/Space for teams	**Digital**	- Equipment needs - Clarity on emergency apps/tech use - IT infrastructure – equipment and connectivity - Attend anywhere – not good for **all** service users, limitations using from home - Digital services – staff and patient support/training needs
BI	- Updating team BCPs - IT downtime impacting digital services - Review of policies/procedures - Real time data access	**Quality & Patient safety**	- Local outbreaks – isolation guidance - Increasing acuity & dependency of patients – review staffing levels - Reduced staff training levels - PPE guidance/social distancing concerns - Specialist PPE delays - Social isolation/community engagement changes - Increased DNAs to virtual appointments
Corporate	- Workforce resilience required Redeployment planning - Training – including PPE training - Vulnerable staff – shielding continuing, support and meaningful employment required. - All colleagues supported and protected - School lockdowns – staffing plan/pay arrangements	**Comms**	- When/how/why to inform incident room - Emergency grab boxes and locations - Communication cascades - Action cards - Incident management training - Reporting structures clear with structured reporting format

Lessons learnt from winter 2021:

A staff survey was undertaken across the Trust in July 2021 forming the basis of this summary.



What went well:

Corporate

- Team working, team briefings
- Workforce = flexible working, good managerial support, redeployment of staff
- Advance planning and communications

Patient Flow

- System wide collaboration
- Patient flow team communications – internal meetings, bed tracker and situation reports.

EPR

- Support with transport network
- Weather preparation

Digital

- Digital services – enabling working from home and team working
- Equipment to work from home

Quality & Patient Safety

- PPE guidance was clear and succinct
- Patient flow – prioritising decision making with clinical decision matrix
- IP&C
- Vaccine roll out

What could be improved this year?

Corporate

- Staffing redeployment plans now
- Workforce – recruitment and retention
- Clear communication of all contingency planning
- Robust communications across all teams

EPR

- Weather planning – floods, snow, heatwaves
- Support transport network and awareness of access to transport

Digital and IT

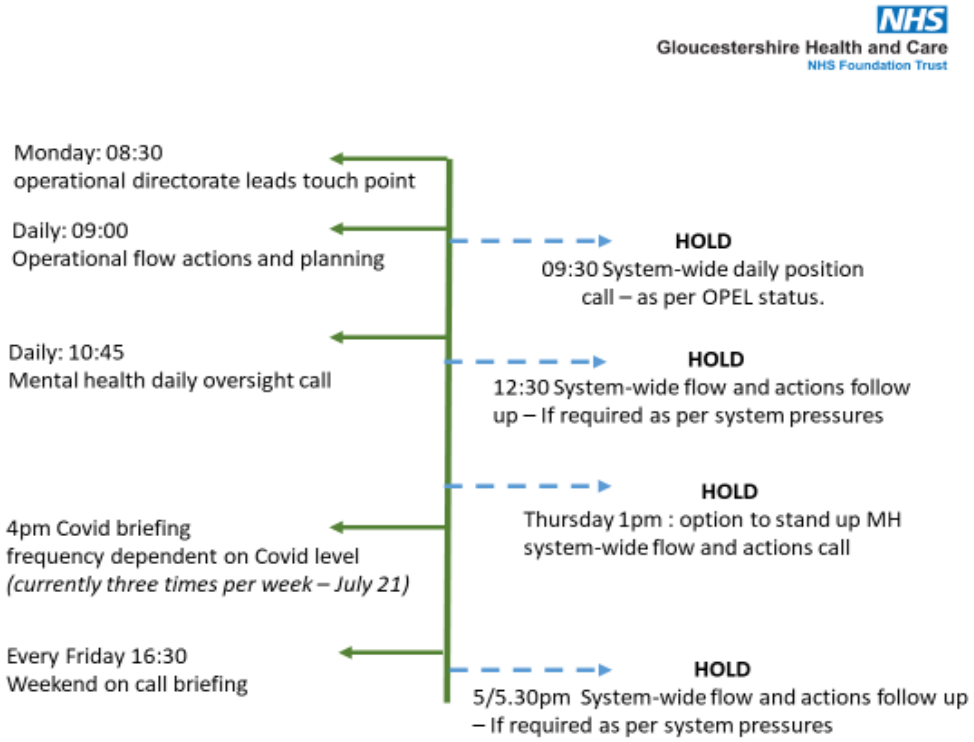
- More support for teams to continue to work from home
- Digital solutions readily available

Quality & Patient Safety

- PPE availability
- Staff wellbeing and value
- Weather appropriate uniform options for community staff

3.0 OPERATIONAL OVERSIGHT

There is strengthened operational oversight and grip this year with the full development of the patient flow team and the Incident response team all of which work 7/7. This daily/weekly oversight is depicted below with the links to the System-wide processes.



4.0 RISK MANAGEMENT IN PLACE (not an exhaustive list – for example)

Demand & Capacity:

- MiiU telephone clinical triage, SPAC and Dental line providing a CAS function to navigate patients into appropriate services
- Minor Injury Service operating 7 days per week with bookable appointment function
- Rapid Response service in place countywide supporting Acute Trust as well as Primary Care
- In reach into the acute by Rapid Response and ONDN to expedite discharges,
- HAT in place to identify patients for discharge into community/primary care services
- Robust on-call arrangements
- Introduction of BH working for senior managers/clinicians in key services
- Integrated teams working across the 7-day period
- Discharge integrated team in place at WLH
- Covid-team in place corporately to coordinate provisions

Staffing:

- Close management of the rotas and vacancy situation is in place and will continue to ensure early identification of potential pressures.
- Forward planning for staffing supported by block booking of bank and agency staff
- Full implementation of and adherence to Allocate
- Enhanced HR workforce support to target specific areas of pressure
- Close systems working to focus the right staff into the right places when in surge
- Flexibility of roles with generic and specialist skills being developed

IPC: (see corporate paper for full details)

- Face, Space, Mask message to continue with social distancing within all areas
- Robust Flu Immunisation Programme in place
- Flowcharts and action cards in place to manage outbreaks or positive results in patients or contacts
- Identification of red and green wards and staff

5.0 WINTER SCHEMES

Following a thorough and collaborative exercise with all Services, ten schemes have been identified and prioritised as outlines in accompanying spreadsheet.

These have been discussed with GHC COO and Dep COO to ensure alignment of priorities so that the top three schemes deemed as Priority 1(Critical) are also reflected in their scheme priorities for overall system prioritisation.

These schemes are:

1. Development of a Community Assessment Unit for older people within our PH community bed base.
2. Increasing Home First capacity to meet system demand.
3. Continuation of clinical telephone triage by MiiU senior clinicians, alongside the resetting of extended hours into MiiU in order to establish booked appointments system.

The other seven schemes deemed as priority 2 (Essential) are:

4. Develop IV Therapy team provision into 7/7 (establishment Sat and Sun matched to Mon-Fri).
5. Provision of HF/Reablement therapy service over the weekends and BH to continue ongoing care and commence treatment plans for new starters on this pathway.
6. Enhance the MLHT resource to provide support into ED in order to case find and reduce front-door pressures with increased risk of admissions.
7. The use of e-learn to deliver online groups for all LTC services.

8. Discharge coordinators into all PH wards as implemented during wave 1 of Covid providing immediate impact on patient flow.
9. Weekend ward clerks into all PH wards as implemented during wave 1 of Covid enabling release of nursing and therapy staff from admin duties and Covid screening of visitors.
10. The development of generic rehab/HCA roles into the wards ate weekends in order to support reductions in length of stay and improve care offered to patients.

6.0 NEEDS IDENTIFIED OUTSIDE OF THE SCOPE OF WINTER SCHEMES

Tab 2 on the accompanying Excel spreadsheet outlines the Service requests from corporate functions or external providers as listed below;

- The development of sub-acute pathways – this is being enacted in partnership with GHC and the GHC Patient Flow team.
- Requirement to implement cover arrangements for the Maxwell (136) suite in order to release capacity within the Crisis team. This is being progressed with a working group led by Dep Service Director and supported by the interim Dep COO.
- Adding resilience to MiiU workforce capacity through training of urgent care practitioners – this is being progressed within the services.
- Wider use of telehealth for LTC – being developed by UCASS.
- Enhanced Bank staff training for specialist services such as MiiU, Dental, Community Nursing.
- Estates support to base Rapid Response team in Cotswolds base.
- Renewed focus on Best practice Board rounds across the Hospitals.
- Re-establishment of care navigators form GCC Stood down during Covid 1 within the PH Hospital wards.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

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

AUTHOR: Paul Griffith-Williams, Information Governance Manager/DPO

SUBJECT: **SENIOR INFORMATION RISK OFFICER (SIRO) ANNUAL REPORT 2020/2021**

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:

To provide assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.

Recommendations and decisions required

Following review by the Audit and Assurance Committee, the Board is asked to:

- **Note** the Annual SIRO report
- Take **assurance** that the Trust has effective systems and processes in place to maintain the security of information it holds and controls.

Executive summary

The Senior Information Risk Owner is responsible for ensuring that organisational information risk is identified and managed across the organisation. This Annual Report provides assurance on practice, progress and developments around Information Governance, Clinical Coding and Health Records, Data Quality and Cyber/Data Security.

It should be noted that the Trust was able to achieve the DSPT submission (self-assessment) of 'exceeding standards' for the 2019/2020 year with the Trust meeting the 95% mandatory training target for Data Security and Awareness Training.

Covid 19 has significantly impacted on the information governance environment during the year. The move by Trust services to more digitally based delivery models led to an increase in demand for advice and support from the IG team and a more agile way of working requiring the approval of 20 Data Protection Impact Assessments. The pandemic did have a negative impact on the Trust's ability to respond to all requests for information within the required timeframes with 91 of 273 being over time.

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with a complex range of national guidance and legislation.

Following consideration by the Audit and Assurance Committee at its meeting on the 12 August 2021, the report has been updated to include addition information and context around the risk of Phishing emails (paragraph 4.5) to aid the understanding of the risk in this area.

Risks associated with meeting the Trust's values

- IG breaches can result in the disclosure of sensitive patient and staff information.
- IG breaches can result in significant financial penalties and have a negative impact on the Trust's reputation if breaches occur.

Corporate considerations	
Quality Implications	Ensure the quality of information available to delivery patient care
Resource Implications	Can result in financial penalties if IG breaches occur
Equality Implications	

Where has this issue been discussed before?
Information Governance Group

Appendices:	Appendix A – Information Governance Structure

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

AGENDA ITEM: 17.1/0921

ANNUAL SIRO REPORT – 2020/2021

INTRODUCTION

This is the first annual report from the Senior Information Risk Owner (SIRO) for Gloucestershire Health and Care NHS Foundation Trust (GHC). The purpose of the report is to provide assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality. This assurance is provided by the SIRO who has executive responsibility for information risk and information assets.

Throughout 2020/2021 there has been continuing progress with embedding and improving the effectiveness and profile of the Trust's Information Governance structures and processes (appendix A), which have continued to evolve the meet the needs of the recently merged organisation.

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with a complex range of national guidance and legislation whilst also achieving an ability to ensure operational effectiveness so that progress is not undermined or damaged by poor Information Governance (IG) practices.

Recognising the breadth of the legislation, this SIRO report is divided into the following four sections.

- Section 1: Information Governance
- Section 2: Clinical Coding and Health Records
- Section 3: Data Quality
- Section 4: Cyber / Data Security

Each section reports on the progress and achievements in 2020/21, a summary is provided below:

Key highlights 2020/2021

- The Information Governance Group and met six times and approved 20 Data Protection Impact Assessments to support services in moving to more digital/remote methods of service delivery during the Covid-19 Pandemic
- The 19/20 final submission for the Data Security and Protection Toolkit was assessed as 'exceeding standards.'
- There have been no data breaches that have met the threshold for onward reporting to the Information Commissioners Office
- The Trust achieved the requisite 95% mandatory target for Data Security and Awareness training
- There have not been any significant health records incidents or losses reported

1.0 INFORMATION GOVERNANCE

The arrangements for Information Governance are managed and overseen by the Information Governance Group (the Group), which reports to the Trust Board via the Audit and Assurance Committee. The IGG is chaired by Head of Corporate Governance. Membership comprises the Senior Information Risk Owner, Caldicott Guardian and Data Protection Officer and directorate representatives.

1.1 Information Governance Group and IG Team

The Group's role is to oversee and guide the strategic direction of IG within the Trust, ensure IG compliance, support best practice and ensure that all Trust information is:

- Confidential and Secure;
- Of High Quality;
- Relevant and Timely; and,
- Processed Lawfully, Transparently and Fairly

In 2020, the Covid-19 pandemic required the Group to adopt a more flexible and agile way of working to meet and increased demand for advice and support from Trust Services as they moved to a more digitally based delivery model. The Group has met six times during the year. Following each meeting a report is provided to the Audit and Assurance Committee.

During 2020/2021, the group has:

- Established a Governance framework (**Appendix 1**);
- Set a work plan for the group to formalise and focus activity;
- Reviewed the asset register and the assigned asset owners;
- Reviewed the data flows;
- Reviewed and approved the interim and final submission for the 19/20 Data Security & Protection Toolkit (DSPT) submission;
- Reviewed and approved the interim 20/21 DSPT submission;
- Reviewed and approved 20 Data Protection Impact Assessments (DPIA); and,
- Reviewed and agreed the Trust's training analysis for IG.

The IG team has delivered operational support, advice and guidance to staff at all levels in the Trust. It also represents the Trust's information governance interests at the ICS level being an active member of the Gloucestershire Information Governance Group, and the South West Strategic Information Governance Network. The IG Team also delivers the Data Protection Officer (DPO) role for the Trust and supports the Trust's full compliance with data protection legislation and good practice.

1.2 Data Security and Protection Toolkit

The Trust submitted the 19/20 DSPT interim and final submissions within the required timescales. The 19/20 final submission was assessed as exceeding standards. The Trust has submitted its interim 20/21 DSPT submission and is on track to submit 'standards met' in June 21.

1.3 Breaches and near misses

There have been no breaches that have met the threshold for onward reporting to the Information Commissioners Office (ICO). There have however been three near misses that have been reported to the SIRO and Caldicott Guardian for review and consideration.

1.4 Subject access requests & Freedom of Information

This year continued to be a busy year for Subject Access Requests (SARs) and Freedom of Information Requests (FOIs). Although the total number of SARs in physical and mental health were down on previous years, this was a difficult year give the impact of the C19 pandemic which necessitated remote working and a change in working practices, principally a move to a more digital process for gathering and reviewing information. Additionally, services were stretched with their responses and support to the C19 pandemic resulting in not all FOIs and SARs being answered in time. Where they were not, requesters were advised of the delays.

Team	Total Requests	Total over time
FOI	273	91
SAR Mental Health	282	10
SAR Physical Health	504	2

The FOI team identified the following themes from requests received in year. These are being considered to identify if there is anything that can be published that would provide more publically available information thereby reducing the need for FOIs in the future.

Service Area	Theme
Finance	Agency spend.
IT	Systems used, contact dates, structure charts.
Procurement	Confirmation of service contracts, contract start and end dates.
Recruitment	Staff recruited in what areas, what recruitment companies used, highest paid agency staff.

1.5 IG Training Standard 95%

The Trust achieved the requisite 95% mandatory target for Data Security and Awareness training in compliance with the DSPT. This was evidenced by the training team from the training system, Care to Learn.

The SIRO, Caldicott Guardian and the DPO have undertaken update training specific to their roles in year. Additionally, the IG Group has reviewed and signed off the Trust's

IG training needs analysis.

1.6 Summary of DPIAs completed and any high risks identified

The Group has reviewed and approved 20 DPAI's in year. There have not been any residual high-risk processing issues identified that needed onward reporting to the ICO.

1.7 Information Asset Registers

The Trust maintains an information asset register that is regularly reviewed. The asset register contains assigned Information Asset Owners (IAO). The Trust's SIRO has written to all IAO line managers this year to ensure that they are aware of which colleagues are IAOs and to that they are provided sufficient time to complete their duties.

1.8 Data Processor update any issues, contractual updates on compliance with GDPR

In year there has been only one issue that was raised with a data processor. This related to a 'TPP' SystmOne update release. That release enabled for patient appointments at GHC to be visible and cancelled by patient. The Trust has since turned off the enabled cancelations, however they are not able to turn off the share for patient appointments. The Trust has fully tested the impact of the release and concluded there was no other special category data, journal notes or confidential information that had been put at risk by this release.

1.9 Data Flows

The Trust maintains a list of its data flows and information asset owners are developing their own to feed into the Trust's flows register. The Group has reviewed the flows register this year and agreed that all known flows were identified and mapped.

2.0 CLINICAL CODING AND HEALTH RECORDS

2.1 Privacy Officer

There have been 28,958 privacy officer checks performed between April 2020 and February 2021. Of the checks carried out 69 resulted in queries being raised with staff as to why patient records were accessed. 67 reasons for access were received with 2 queries outstanding. No concerns have been raised following the responses received from staff.

There have been 6,776 Summary Care Record privacy officer checks performed between April 2020 and February 2021. 2,167 queries raised as to why patient records were accessed. The Privacy Officer was unable to check 6 queries with 2 members of staff as they had left the Trust.

2.2 Clinical coding report

Finished completed episodes for coding are out sourced to Capita who review

episodes across the Trust's services and ensure they are coded correctly. Coding is received every two weeks and usually resolved in the intervening two-week period. Where there remain uncoded episodes these are usually resolved with the next list issued.

- Mental Health; predominantly the coding team relies on nursing summaries to code episodes as there is a significant delay in doctor's discharges summaries being available.

- Sexual Health; there have been issues with coding sexual health episodes. As such monthly coding reports are provided back to the service so that coding can be completed at a later date. There have also been issues around codes not available in Lillie to fully reflect the stay.
- Physical Health; there have been episodes that were unable to be coded in year. This has primarily been down to data quality or insufficient data in the patient's journal.

These issues have all be highlighted to the relevant teams in the Trust and the coding team continues to work with Trust on improving coding.

There have not been any significant issues that have warranted escalation.

2.3 Health records

There have not been any significant health records incidents or losses reported.

The records team has destroyed 17,704 records in line with the Records Management Codes of Practice (RMCoP) for deceased Patients. Additionally, 954 records have been destroyed that were non-active notes, in line with the RMCoP. The Trust is currently working through uploading paper records to a digital format. As part of this programme 18 records have been uploaded and the hard copy destroyed. These numbers will increase as the team works through paper records of deceased and non-active notes.

A new RMCoP was released by NHS X in October 2020 and all GHC records are retained in line with this guidance.

2.4 Summary of audits which have Data Privacy/Quality implications

This year has been an exceptional year for the team and the Trust due to the C19 pandemic. Actions to cope with the emerging spread of the virus resulted in the suspension of clinical audit by the Trust. This was to enable and facilitate delivery of the C19 programme for the county in line with the National and Trust priorities.

The audit programme recommenced on 1 April 2021 and will report findings into the Regulatory Compliance Group and then on to the Improving Care Group. Any actions that are identified within the audit programme are overseen by the audit team. This will result in the majority of cases in a re-audit to assess improvement and fidelity to the standard we have agreed upon. Any significant issues that have implications on the Trust's compliance with Data Protection Legislation will be raised with the SIRO, Caldicott Guardian and DPO who in turn will share with the IGG.

3.0 DATA QUALITY

3.1 Policies

The Trust has a suite of IG related policies that were reviewed in 2019 as part of the merger process. They have not been reviewed in year as there has been no legislative change to reflect therein. The Business Intelligence team however did introduce a Data Quality Policy that was reviewed by the Group and ratified and signed off by the SIRO.

3.2 Business Continuity/Disaster Recovery

The Trust has an incident response policy that forms the back bone of its disaster recovery and business continuity planning. The policy has been tested in year through our response to the C19 pandemic. Additionally, with there has been the following network access issue that was managed:

National HSCN network outage; this resulted in the loss of HSCN network access for the whole of the country. The GHC network relies upon the secure HSCN network connection for our community settings to access our network over Direct Access. As such critical clinical systems and email was not available to large parts of the Trust. This did not affect internal network connections on primary sites. The GHC IT team was able to reroute other systems such as email and internet quickly. This did not however resolve all issues for community teams accessing patient data and some community hospitals accessing patient data and drug charts. Drug charts were emailed where 4g connection was available at sites. Where this was not possible alternative options were implemented. There was no harm reported as a result of the loss of the HSCN network.

A full review of the incident was completed with a number of recommendations made to improve resilience and business planning.

3.3 Business Intelligence (BI)

We recognise that, as with any large organisation managing multiple corporate and clinical systems, there will be underlying data quality issues, both stemming from business as usual data entry errors or oversights. There are published data quality reports which can feed audit and help monitor operational practice to mitigate this issue however there are far fewer active data quality monitoring reports within Physical Community Health at this present time. BI manage the portfolio of these reports; however, it is a combination of the Nursing, Quality and Therapies Directorate and the Operations Directorate that monitor compliance and undertake audits.

It has recently come to light that there are wider Physical Community Health data quality issues which stem from the architectural design of the clinical systems (predominantly SystmOne), and the maintenance of the hard-coded mapping of system data extracts into the data warehouse. It is initially estimated that 10-11% of events are not flowing into the appropriate monitoring table, however at this point it's unclear as to how much of this is patient level or administrative and therefore less impactful. Additionally, it is recognised that there are almost 300k open referrals within the data warehouse with many without events, or attributed to services such as Health Visiting and MIIUs. This does not present an accurate reflection of caseloads. Therefore, as part of the harmonisation and wider integration of systems there is a

longer-term strategy being developed to tactically improve and develop a more sustainable and accurate data process. This requires holistic engagement with operational services, Business Intelligence and Clinical Systems Teams to ensure that the right pace is applied and such a sizeable improvement can be effectively delivered without impacting day to day priorities. This will undoubtedly be through a phased approach of staged improvements and as the status improves, will allow for the reintroduction of Physical Health Data Quality audit monitoring reports.

The national data opt out applies to the use of *confidential* patient information for research and planning purposes. It *does not* apply where anonymised data is used. Organisational compliance has been extended to the end of September 2021.

Although the majority of our *identifiable* data use is for direct patient care (acceptable) and any planning or development reporting uses *confidential* data (also acceptable); we do need to be aware of the policy and ensure that we have a plan and a technical solution and process in place for instances such as research where future disclosures should have data opt-outs applied. We will then be able to implement the technical solution in readiness or for future use. We currently maintain a full BI reporting suite that maintains pseudonymised data (through clinical system or NHS numbers) with the following exceptions that use patient identifiable information however it can be confirmed that these are used for direct patient care and clinical monitoring, *not* research or planning purposes;

- Bed Management Report - Digital Whiteboard (Name and Age)>> Secure to bed management team and select senior operational managers to manage patient flow and went through a DPIA process
- C19 Pathology Details Results report (Patient Name) >> Secure to senior management and pandemic response leads
- Covid Self Isolation Details (Staff Names) >> Secure to workforce team and select senior operational managers to manage workforce management and assure service delivery

Access to reports of this nature are currently managed through named authorisation groups within the BI reporting server tool but as this is difficult to sustain safely, going forward it will need to be linked to a more robust, ESR linked AD. This is expected from June 2021 and is being led by IT.

Alongside the possible need for Research projects, the Stroke & Rehab service are being supported with an exercise that adopts the national data opt-out process. The MESH client that the National Opt-out relies upon was already setup within the legacy GCS organisation so is still available to GHC. This will give the organisation an opportunity to pilot the technical solution in readiness to deploy an established and tested process for any requirements from September 2021; ensuring compliance.

3.4 ESR

There was one system security breach involving personal data for employees within GHC caused by a central team change release on 3 Jan 2021. This was reported through the Trust's Datix System and the SIRO informed accordingly. The incident was unlikely to result in a risk to individuals due the type of data shared and recipients involved. It was assessed by the provider as not meeting the threshold for onward reporting to the ICO.

Data quality audits and reviews are carried out monthly using system reports. There are no emerging themes or trends following these reviews.

4.0 CYBER/DATA SECURITY

4.1 Access Controls

The Trust has an established process for starters and leavers access to IT and clinical systems. The leaver process is automated based on an ESR report from workforce on a weekly basis. The process disables the account and archives it in leavers accounts. In the last year we have seen an increase in new accounts due to the C19 response. There have been 1466 new accounts set up, while there have been 1322 leavers processed. There are no outstanding starter or leavers. It is recognised that this process does not suitably cover inter organisational moves, this is reliant on leads notifying IT of the access changes needed. Going forward it is planned this will be linked to a more robust, ESR linked Active Directory link. This is expected from June 2021 and is being led by IT.

4.2 Cyber report

The Countywide IT service is responsible for managing the cyber response for the ICS. CITS provides, on a quarterly basis, cyber security updates to the ICS Digital Executive steering Group, which the SIRO is a member. These reports are then shared with the GHC Digital group. GHC has however retained two cyber leads to ensure that GHC needs are met, such as Cyber Essentials Plus, which the Trust was recertified for again this year. Part of the recertification involved a penetration test of relevant GHC systems, additionally a vulnerability scan was carried out by the CITs managed Nessus, the report is currently being developed by CITs. All CAREcerts are assessed and actioned by the server team, along with CITs where there is an ICS network implication. There is one CAREcert that is outstanding for GHC that is going through the test phase.

4.3 Data Destruction

- IT equipment - there have been no reported issues around data destruction or disposal. The contract is held with Hewlett Packard (HP), and was reviewed in year. Devices are collected by HP who in turn issues reports of what has been destroyed, recycled etc. All with data is wiped/destroyed to the required standard. There were approx. 8 collections in the last 12 months, for which we have received certification of destruction or disposal.

- Print waste - the contract is held and managed through the Trust's estates team. All print waste is shredded on site. The contract has been reviewed this year and extended for a further year. There have not been any significant issues reported by the contractor, or sites. There were some minor teething issues with the opening up of the Trust's Invista offices where secure waste bins on site had their keys left in them, however this was addressed and no confidential waste was put at risk as a result. Certificates of destruction are provided by the supplier.

4.4. Cyber data security risks

The Digital Group manages the cyber security risks for the Trust. The assessment is made with risks identified from the CITs data along with GHCs own cyber risk knowledge from their cyber leads. The risk is notified to and managed by the Digital Group through its risk register, the top three risks are currently:

Risk	Information/Mitigation
Email Phishing	GHC has seen over 144,000 thousand phishing emails sent to ghc.nhs.uk throughout 20/21 to individual or shared mailboxes (report from O365). Four identified successful attacks initiated via Phishing emails causing multiple credentials to be compromised and required IT intervention to remediate and reduce spread further. The Trust has, multi factor account authentication, Azure ID protection on all office 365 accounts, KnowBe4 second chance installed, MS Defender on all end points, annual phishing test, annual data security training and cyber awareness training in place.
Staff Education /Training	Staff Cyber Awareness training was proposed to be made mandatory but this was rejected at the GHC Digital Group due to the current volume of existing mandatory training. Cyber eLearning currently only completed by those involved in a Cyber Breach. There are currently global phishing comms (email/intranet/screensavers) shared regularly, and an annual Phishing simulation.
Unsupported Software	Unsupported software identified by Cherwell Asset Management and removed or updated.

4.5 Phishing

GHC's Advanced Threat Protection (ATP) identified and stopped 144,000 phishing emails from being delivered to GHC individual or shared mailboxes:

- On average the Trust receives 95,000 emails per week;
- 2,769 emails received per week were phishing emails, which equates to 3% of emails received per week; and,
- Of the phishing emails received 175 emails were not blocked by ATP, equivalent to 0.18% of all emails received per week.

There are currently no comparable local phishing stats for GHC to benchmark against, however the annual Anti Phishing Working Group report found there to have been an average of 46,561 phishing emails received per month by organisations in 20/21.

Of the phishing emails not blocked by ATP four resulted in remedial action being taken by IT to protect our network and data.

- April 20, 30 devices were removed from the domain and fully scanned;
- May 20, Qbot malware, multiple devices required removal from the domain and wiping or replacing;
- May 20, Phishing email purporting to be form finance was clicked by 100 staff,

resulting in the removal of all the emails from all recipients and 100 accounts being reset; and,

- Sept 20, compromised email account for a partner organisation SGMind resulted in 125 GHC password resets and 20 GHC devices removed from the domain and wiped.

IT are currently reviewing MS defender for O365 to protect against malicious links.

4.6 Patching

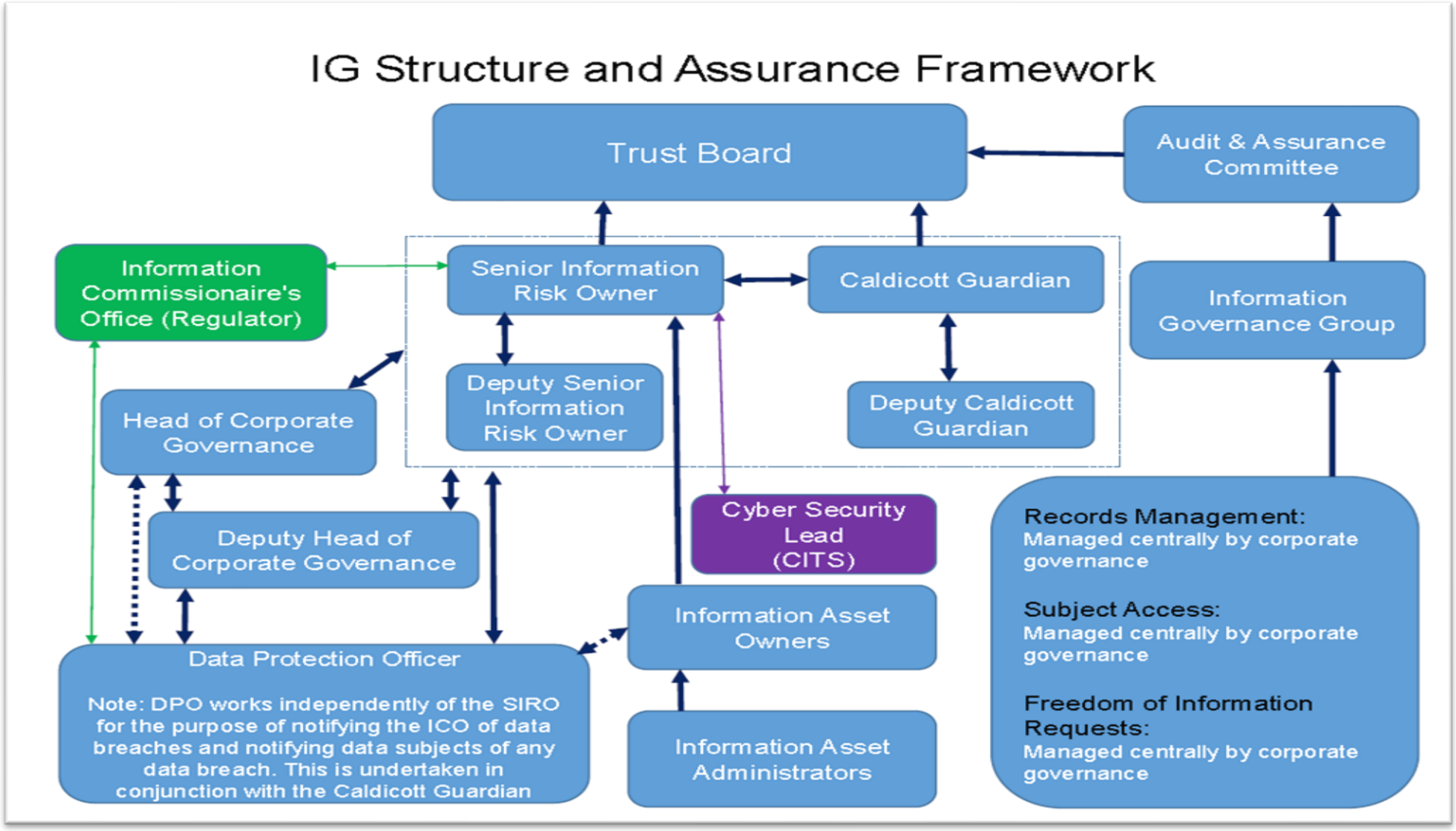
Windows Servers Update Service (WSUS) has issued 766 patches in year for Microsoft operating systems and software on workstations and servers. Which have been pushed out to all end points. There are currently no unpatched devices registered with WSUS. Due to the C19 work from home agenda, patching of endpoint devices has had to be managed through a combination of staff working from home attending GHC sites to install updates through WIFI and through a manual push using Direct Access (DA). Due to the data costs associated with pushing data over DA the manual push through DA was carried out on a two-month rolling programme, which meant that last year no device was more than 60 days out of date with patches. Any updates with errors were managed through the IT support desk and on-site technicians. The 'KACE' patch management system was utilised for non-windows patching.

4.7 Unsupported software

The Trust currently holds 82 devices or servers that are running unsupported software. The devices are due to legacy partner systems that will not work on newer software. The servers are part of an older servers' estate that is the process of replacement, this risk is however being mitigated by additional security software. As part of the rolling programme to update unsupported software to supported models the Trust has replaced all existing windows 2007 software on devices and removed the out of support Adobe flash player for all devices.

There is however an inherent risk that GHC carries as part of the Countywide IT set up as other ICS partners, on the network, are running different software on their server and device estates.

APPENDIX A


IG Structure and Assurance Framework
Trust Board
Audit & Assurance Committee
Information Commissionaire's Office (Regulator)
Senior Information Risk Owner
Caldicott Guardian
Information Governance Group
Deputy Senior Information Risk Owner
Deputy Caldicott Guardian
Head of Corporate Governance
Deputy Head of Corporate Governance
Cyber Security Lead (CITS)
Information Asset Owners
Data Protection Officer
Note: DPO works independently of the SIRO for the purpose of notifying the ICO of data breaches and notifying data subjects of any data breach. This is undertaken in conjunction with the Caldicott Guardian
Information Asset Administrators
Records Management:
Managed centrally by corporate governance
Subject Access:
Managed centrally by corporate governance
Freedom of Information Requests:
Managed centrally by corporate governance

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AGENDA ITEM: 18/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Lavinia Rowsell, Head of Governance/Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance/Trust Secretary

SUBJECT: **DEVELOPMENTAL REVIEW OF LEADERSHIP AND GOVERNANCE USING THE WELL-LED FRAMEWORK**

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

The purpose of this report is to:

Set out a proposed approach for the delivery of the next developmental review of leadership and governance using the Well Led Framework.

Recommendations and decisions required

The Board is asked to **endorse** the proposed approach to the review.

Executive summary

The Trust's mission is to '***enable people to live the best life they can'*** and to achieve 'outstanding care' status. To do this we need to continually strive to raise the bar on performance across the organisation, including the Board. The Board has a duty to conduct its affairs effectively and demonstrate measurable outcomes that build and maintain patient (service users, carers and family), public and stakeholder confidence that GHC is providing high quality, sustainable care.

In-depth, regular and externally facilitated developmental reviews of leadership and governance are seen as good practice across all sectors. Rather than assessing current performance (as reflected in the CQC assessment of well led), these developmental reviews focus on continuous improvement and seek to identify the areas of leadership and governance that would benefit from further targeted development work to secure and sustain future performance.

NHS England and NHS Improvement strongly encourages all providers to carry out externally facilitated reviews, every three to five years. The paper sets out the proposed approach for the review. Planning will commence with a Board self-assessment exercise in November 202 with the review taking place in Q1 of 2022/2023.

Risks associated with meeting the Trust's values
A lack of capacity and capability to lead the organisation effectively will impact the ability to deliver the strategic ambitions as set out in the Trust Strategy. CQC inspection framework for all registrants includes an assessment of current performance of well led, which is explicitly linked to the well-led framework. Failure to demonstrate that the Trust is well led and has robust governance processes in place may lead to enforcement and regulatory actions.

Corporate considerations	
Quality Implications	None
Resource Implications	Cost associated with the commissioning of the external review will be built in 2022/2023 budget.
Equality Implications	None

Where has this issue been discussed before?
Chair and Chief Executive

Appendices:	

Report authorised by: Lavinia Rowsell	**Title:** Head of Governance / Trust Secretary

DEVELOPMENTAL REVIEW OF LEADERSHIP AND GOVERNANCE USING THE WELL-LED FRAMEWORK

1.0 INTRODUCTION

1.1 The Trust's mission is to '***enable people to live the best life they can'*** and to achieve 'outstanding care' status. To do this we need to continually strive to raise the bar on performance across the organisation, including the Board. The Board has a duty to conduct its affairs effectively and demonstrate measurable outcomes that build and maintain patient (service users, carers and family), public and stakeholder confidence that GHC is providing high quality, sustainable care.

1.2 NHSI guidance strongly encourages Trusts to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, in line with corporate governance guidance in many other sectors. Rather than assessing current performance (as reflected in the CQC assessment of well led), these developmental reviews focus on continuous improvement and seek to identify the areas of leadership and governance that would benefit from further targeted development work to secure and sustain future performance.

1.3 External developmental reviews were last undertaken in both 2Gether NHS Trust and GHC prior to the Trust merger and then externally reviewed as part of the pre-merger process. Given the recent circumstances with the Covid-19 pandemic and in order to allow the governance and leadership of the new post-merger Trust to fully bed in, it is recommended that the first review of the merged Trust, GHC takes place in Q1 2022/2023. In the meantime, the internal and external audit functions will continue to keep governance under review and update the Audit and Assurance Committee and the Board through their annual processes. Additionally, reviews against the required governance standards will continue to be completed as part of the annual report and the provider license reporting processes. Any specific areas of concern can also be considered through the Internal Audit Annual Plan.

2.0 WELL-LED DEVELOPMENTAL REVIEW PROGRAMME

2.1 The well-led developmental review programme has six steps:

Figure 1: Overview of well-led review.

2.2 Self-Review

2.2.1 Background

Self- review is an important first step in preparing for the externally facilitated developmental review. It is important to assess ourselves to provide insight, both for ourselves as a Board and the external facilitator, into how we gauge our own leadership and governance performance and identify any particular areas of interest, areas for development, or concern either within or outside the eight areas. Confirmation that the Board knows itself – strengths and weaknesses, and has in place plans to respond to weaknesses and to share good practice is at the heart of effective self-review.

Figure2: Well-led Framework Eight KLOE

There is clear guidance on 'what good looks like' and key documents / reports that may be used as part of the assessment published by both NHSI and by the CQC in their inspection framework. Rating each of the KLOEs (Key Lines of Enquiry) using good practice examples in the framework will help ensure a focus on continuous improvement rather than a compliance checklist.

2.2.2 Proposed Timing and Format of Self-Review

It is proposed that the Board undertake this self-review collectively as part of the Board Seminar Programme. A preparatory self-assessment will be undertaken by a small working group comprising members of the Trust's CQC team, Trust Secretariat and nominated members of the Board (Marcia Gallagher - Senior Independent Director and Chair of the Audit and Assurance Committee and John Trevains – Director of Nursing, Therapies and Quality) to propose provisional ratings for discussion, testing, challenge and confirmation by the wider Board.

2.3 Setting the Scope for the External Developmental Review

Following the self- review, the Board will be asked to agree the scope for the facilitated developmental review, keeping in focus that its purpose is to drive continuous improvement.

As part of this process the Board may choose to omit components of the framework (e.g. one or more of the eight KLOE) where it considers there is clear evidence, ideally externally verifiable, that it is already achieving or exceeding the expectations set out within the framework. The Board may however choose to keep in such an area if it wishes to explore how it could develop the identified practice in other areas or in other trusts. The Board may also wish to include other development areas outside the framework, for example, issues arising from internal/external audit.

Again, it is suggested that the small working group develop a proposal for the Board to consider, challenge, review and approve.

2.4 Commissioning an External Developmental Review

External facilitation is a key part of developmental reviews: it provides objectivity and challenge that may not available in house. This can be delivered through an external facilitator or a process of peer-review.

The appointed external facilitator or peer review team is required to be independent and be able to provide robust and reliable judgement of the Trust leadership and governance. They should also be able to demonstrate:

- credibility and experience in carrying out leadership and governance reviews
- be multidisciplinary with a broad range of skills relevant to all aspects of Board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis
- experience in supporting healthcare providers to develop their leadership and governance with an understanding of continuous quality improvement and methodologies
- knowledge of the healthcare sector, and the internal and external challenges faced by providers knowledge of the regulatory framework in which providers operate
- ability to manage the review process, providing a credible and detailed plan of the proposed project governance regime including the approach to the quality assurance of the work, risk management, reporting and escalation lines, and evidence of clear leadership for the work with a named individual.

A specification will be drafted using the national template and, subject to decision by the Board, a final draft will be set.

An options appraisal will be undertaken regarding the delivery approach.

2.5 Board Reporting and Action Planning

The external facilitator should be commissioned to work with the Board to prioritise the review findings, and agree recommendations and developmental actions in response. These should be detailed in a formal report to the Board.

2.6 **Notification to NHS Improvement**

Once the action-planning is done, the Trust is required to send NHS Improvement a letter confirming that the completion of the review, any material issues that have been found and/or any areas of good practice that could be shared with others, for example through a case study.

2.7 **Delivery of Improvement Programme**

The most important part of the process is the implementation of any leadership and governance improvement actions that arise from the review.

3.0 NEXT STEPS AND TIMELINE (PROVISIONAL)

Stage	Date by	Who
Governance arrangements in place	Mid- September	
Board briefing	September Board	Head of Corporate Governance
Self-Assessment Preparatory Work	Mid-October	Working Group - members of the Trust's CQC team, Trust Secretariat, nominated members of the Board (Marcia Gallagher and John Trevains
Board Self-Review – facilitated workshop	Early November	Board
Draft External Developmental Review Scope developed	Start November	Working Group (membership as above)
External Developmental Review Scope debated and agreed by Board Consider use of peer reviews as part of external facilitation team	End Nov	Board
Commissioning external developmental reviewer - Undertake procurement exercise	January / February	Lead by Head of Corporate Governance, supported by procurement team

Stage	Date by	Who
- Chose external facilitator, managing conflicts of interest.		Chair, CEO, Head of Corporate Governance, SID, DirNT&Q
Detailed review	April / May	Board
Board report and action planning	June	Board
Letter to NHSI	July	Head of Corporate Governance
Update on Action Plan Monitoring	September	Head of Corporate Governance/Board

4.0 REFERENCES

NHS England » Well-led framework

Well-led_guidance_June_2017.pdf (england.nhs.uk)

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AGENDA ITEM: 19/0921

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Sandra Betney, Director of Finance & Deputy Chief Executive

AUTHOR: Informatics Team

SUBJECT: **DIGITAL 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:

To get endorsement / feedback on the first Trust digital update to enable a regular quarterly paper to be provided to the board. The digital agenda is increasingly important and this report will hopefully provide the wider view of the breadth of work ongoing in this area.

Recommendations and decisions required

The Board is asked to:

- **Endorse** the content of the Digital Update

Executive summary

With the Digital agenda increasingly important to the NHS and Gloucestershire Health and Care NHS foundation Trust (GHC) this year saw the release of the new GHC Digital Strategy.

It was felt that with the ambition this strategy is attempting to deliver and with the importance of Digital to both this organisation and the ICS it would be useful to provide a regular board update on progress against the strategy and the delivery of digital services.

This is the first report that will hopefully provide this wider view on the breadth of work ongoing in this area.

Risks associated with meeting the Trust's values
It is important that the trusts digital work reflects the wider strategic vision of the trust to ensure alignment with what the organisation wants to achieve over the next 5 years.

Corporate considerations	
Quality Implications	Implementing the digital agenda should impact on all aspects of the trust and its patients including quality, resource and health inequalities
Resource Implications	Implementing the digital agenda should impact on all aspects of the trust and its patients including quality, resource and health inequalities
Equality Implications	Implementing the digital agenda should impact on all aspects of the trust and its patients including quality, resource and health inequalities

Where has this issue been discussed before?
As part of the work on the Digital strategy it was discussed at the resource committee and at the board that it would be useful to get wider oversight of the digital agenda with a more regular board report provided against progress.

Appendices:	N/A

Report authorised by: Sandra Betney	**Title:** Director of Finance & Deputy Chief Executive

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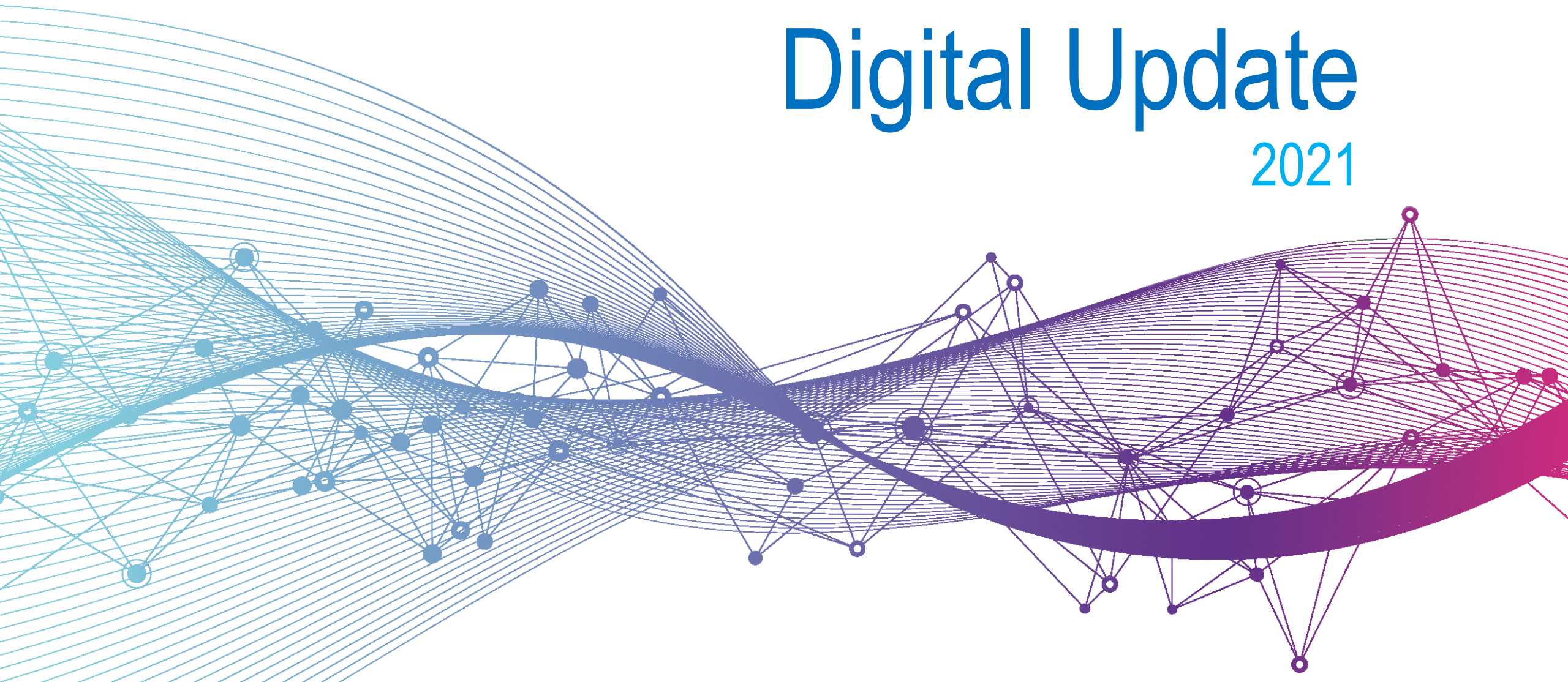
AGENDA ITEM: 19.1/0921

Digital Update

2021



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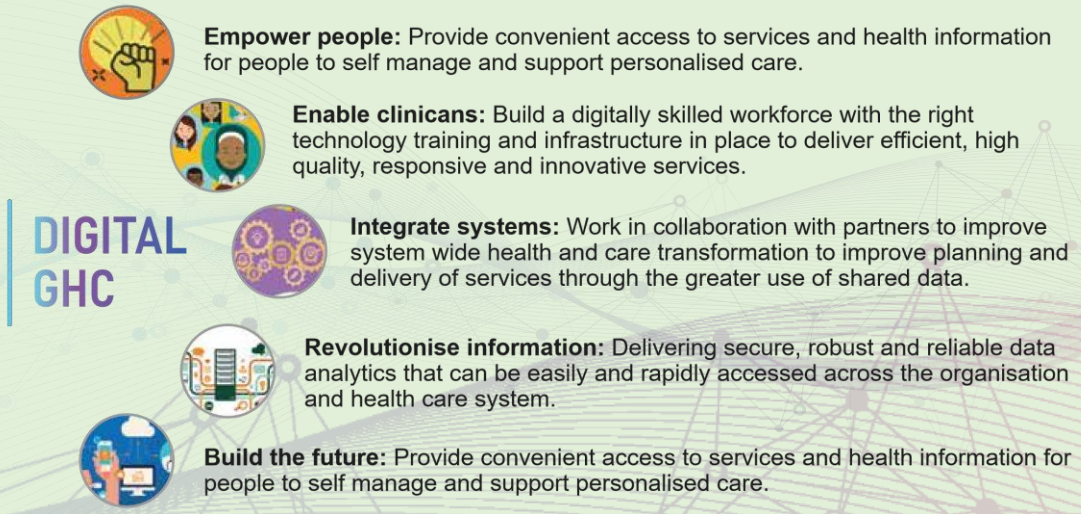
Why…

With the Digital agenda increasingly important to the NHS and Gloucestershire Health and Care NHS foundation Trust (GHC) this year saw the release of the new GHC Digital Strategy.

It was felt that with the ambition this strategy is attempting to deliver and with the importance of Digital to both this organisation and the ICS it would be useful to provide a regular board update on progress against the strategy and the delivery of digital services.

This is the first report that will hopefully provide this wider view on the breadth of work ongoing in this area.



To become a fully digital Trust

Our vision means that we intend to integrate digital solution into every interaction to improve the quality and experience of care. We have identified five strategic aims that will help us in our journey.

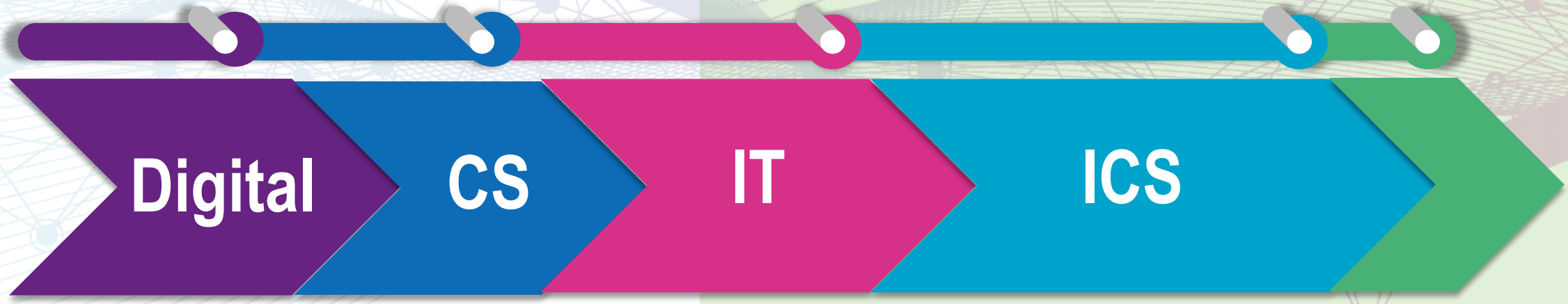
Empower People; Enable clinicians; integrate systems; Revolutionise information; Build the future

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Looking Back…

A glance back at the key changes and project milestones that have been met over the last 3 months – **Introduction to next three slides and how is ties in with the Strategy**



Digital

Projects & Change

•**Site Moved progressed** including site moves to Rikenel, Jubilee ward, informatics team to EJC, IAPT to Eastgate House .
•**Care Home Digital Consultation** pilot progressing with GHC mental health services
•**Video Conferencing Renewal progressing**
•**Cannon Devices Refresh,** Ensuring multifunction devices are up to date across the estate
•**Workstation on wheels** replacements have been rolled out across and physical health community hospitals.

Corporate Systems

•**Centros Go Live** One finance system for the whole trust
•**System Interoperability** Work progressing om Care to Learn and Rostering interface with ESR.
•**MultiFactor Authentication** deployment pro gressing for trust staff
•**GHC CCTV system Upgrade progressing**
•**Corporate Systems review**, corporate systems managed in line with GHC standards and policies
•**ELearn with University of Gloucestershire** Further work to complete finance model before sign off
•**Prism System** BAU and financing elements being worked through

Applications & Development

•**Covid App** provided to all staff to update lateral flow tests results
•**Case note tracker** application created replacing legacy application that was no longer supportable
•**HR Recruitment App** created to digitise the current manual process
•**MIU Escalation App** texting functionailty to mobiles and pagers being tested
•**Childrens Speech & Language Therapy,** Website update, guidance materials and digital assessment work progressed
•**Speech and Language Therapy** Apps signed off through Orcha platform review .

Innovation Workstream

•**Cinapsis review** looking at how we can get the best use of this Realtime guidance tool in GHC and in the ICS
•**Malinko Demonstration** A tool that enables efficient use of staff visit scheduling for community staff – Work progressing to create a business case .
•**Orcha Demo (app library)** GHC group setup to look at how best to use this platform for GHC staff and patients
•**SYstemOne Demo of systems improvements** including Bridend and Communications Annexe
•**OxeVision Review** Understanding the benefits of remote monitoring and how this could be used within the trust

CS

Training

- **Trainers moved to remote training** within a few weeks of lockdown
- **Adapted to changes in clinical induction** going to weekly sessions
- **Created numerous training videos and eLearning**
- Taken on training for **SoelHealth**
- Trainers have **cross trained on systems** so have a good mix of knowledge
- Provided support for **EPMA project**
- **Tasking workshops** set up and running
- **Wholesale review of training offer started**

2nd Line/Admin

- Took on regular **configuration tasks** for **SystmOne** and **Lilie** from the Change and Development Team
- Taken on **support for SoelHealth**
- **Herefordshire services decommissioning support**
- **Learned SystmOne and Lilie** and can now fully support all systems
- **Letter changes due to merge**
- Provided support for **Totalmobile project**
- Provided support for **EPMA project**
- Took on **management of SystmOne releases**
- **Overseen 2 Sexual Health System releases**

RA & Audit Team

- **RA Team redeployed 65 Rio Users and 296 SystmOne users** from their normal Smartcard roles to the redeployed roles.
- **Assisted with TACS cards solutions** for electronic prescribing rollout
- **Worked with Operational leads to introduce a new JUYI role** for non-qualified patient-facing staff to have access to JUYI.
- **Assisted with EPS project** so patients can have their prescriptions sent directly to a nominated Pharmacy
- **Assisted with recent Decommissioning of PAS project**, ensuring that GHC users were given access to ICE or Sunrise instead of PAS

Change & Development

- **e-RS (formerly Choose and Book)** delivered to Mental Health Services
- **Post-COVID Service set up**
- **Link to ICE Pathology results embedded within RiO**
- **Oversaw PAS decommissioning**
- **Process embedded for managing unidentified patients in clinical systems**
- **WhatsApp** for connecting young people rolled out for childrens cervices
- **Electronic correspondence to GPs** now available from IAPTus
- **ePMA** rolled out to Mental Health Inpatient wards

586

Change & Development service requests and incidents completed since April 2021

IT

Server

- **Change of Internet lines at EJC (6D to Gamma)** - involving the reconfiguration of outgoing internet traffic and incoming reverse proxy traffic .
- **Virtual Smartcards** - Test and configure desktop software to support virtual smartcards.
- **2G IT SQL Migration** - Migrate the older ex-2G SQL servers into one data warehouse cluster.
- **RightFax server migration** - Migrate and merge RightFax servers into one fully supported GHC server.
- **Decommissioning of 2G Server infrastructure**
- **Hyper-V installation at Cirencester** to improve Disaster Recovery and failover provision
- **Web Filtering applied through Microsoft Advanced Threat Protection** – which secures the client side

Infrastructure

- **Telephony Consolidation** – Phase 1 involves the provisioning of back-end equipment
- **Local Area Network Upgrade** is continuing site survey being undertaken and delivery of new equipment.
- **Mobile Device Management system** migrating from MobileIron to Microsoft's solution, INTUNE.
- **Telephone survey tool** for Dental is being progressed
- **Telephony call flow** for Central Referral Line has been created

Ticket Reduction

- **Email functionality improved** by importing email archive files into Office 365 .
- Further **deployment of SIM enabled laptop** to all collegues
- **A separate Wi-Fi network for mobile devices**
- **P:Drives are being migrated to OneDrive**, making personal files more accessible and enhancing capabilities.
- **Home working guides** updated and shared.
- **Softphones implemented** for colleague's home working to simplify the process.

Digital Instructors

- **IT equipment ordering portal**
- **Video support guides**
- Delivering **"Improve your digital skills" sessions**
- **Creation and support of " Tech Champions"** group which includes wider Trust colleagues in testing new IT technology and systems
- **Management of Audio Visual Equipment** in all meeting rooms
- **Improving digital inclusion** across the county
- **Cyber Campaign** to promote Cyber Awareness across the Trust

IT

September 2020 >> August 2021

Ticket Stats

- Tickets opened: 61,036
- Tickets closed: 61,1103
- First time fix: 88%

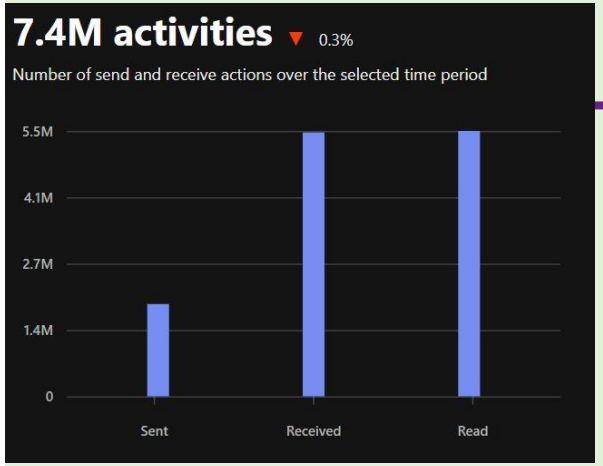
Phone Stats

- Calls received: 58,004
- Service level: 91% answered
- AV speed of answer: 28 secs
- Av handling time per call: 5 mins 30 secs

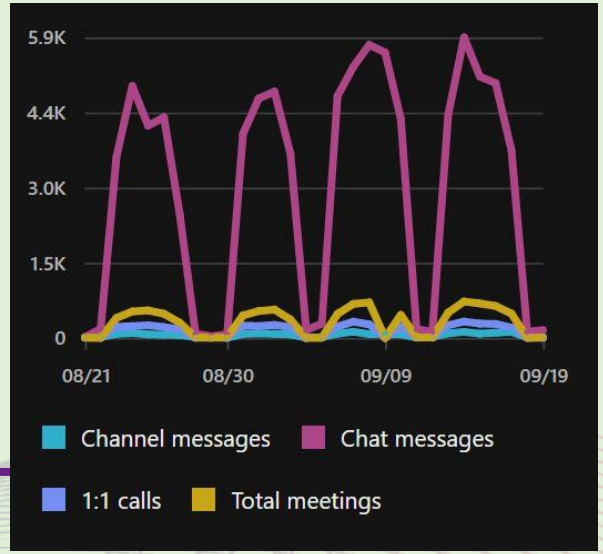
Laptops Issued

- Stock stats are unavailable for the first part of the time period
- Av of 62 laptops issued per month.
- Approx 744 laptops issued in total

Email Activity



MS Teams Activity



Microsoft 365 usage reports show how people in your business are using Microsoft 365 services.

Usage >> Past 90 days

GHC Digital Strategy Progress

Empower People

- Digital Front door for Children's mental health scheduled to go live in early 2022
- Electronic patient appointment booking systems reviewed and preferred solution chosen
- ICS Digital inclusion workstream stood up with three sub projects in GHC started
- A range of Apps looked at to support digitally enabled self-care including speech and language therapy and MSK
- Orcha – Digital Apps library signed off at the regional level with Gloucestershire ICS project to implemented started August
- ICS – Video Conferencing review started to progress next steps in this area

Enable Clinicians

- Technology Champions setup with 90 active members and monthly meetings and technology reviews/ testing with MFA recently tested, Find time, Desktop Encryption and 365 Defender testing
- GHC Digital workforce task and finish group setup to deliver a roadmap to progress this key area
- ICS Digital inclusion workstream stood up with three sub projects in GHC started
- A range of Apps looked at to support digitally enabled self-care including speech and language therapy and MSK
- Orcha – Digital Apps library signed off at the regional level with Gloucestershire ICS project to implemented started August

GHC Digital Strategy Progress

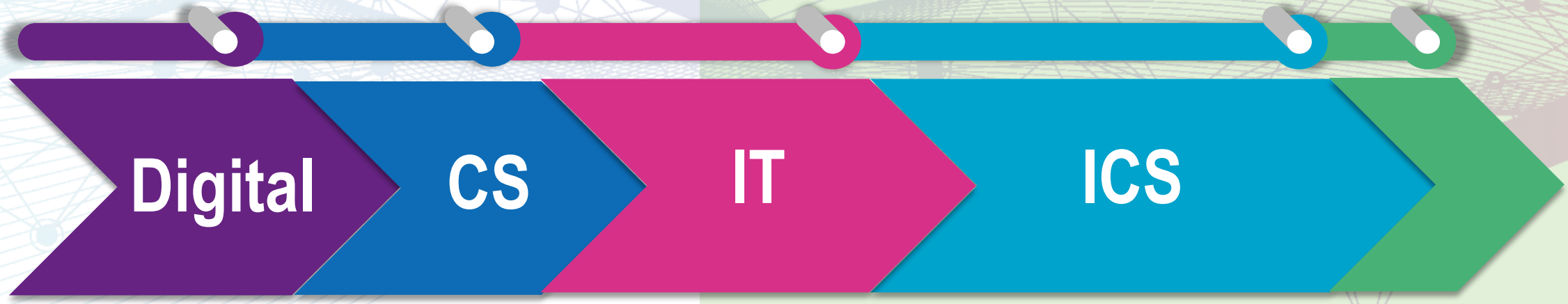
Integrate Systems 	Clinical system's vision project first area complete with sign off to proceed with area's 2 and 3 looking at the potential options to progress with system changes and integrations
	Electronic patient appointment booking systems reviewed and preferred solution chosen
	E-Rostering system rationalisation project progressing
	University of Gloucestershire Digital workstream meeting being finalised
	GHFT System information available on the local shared care record with social care information shortly
Revolutionise Inform 	Centros finance information available through Tableau to all budget holders
	System One Simplicity project moved forward to support improved reporting clarity on data reporting for clinical services
	Projects signed off and progressing to include corporate system information within the Trust Datawarehouse including Rostering and Care to Learn
Build the Future 	Programme of work to review Automation opportunities with Finance
	Electronic Prescribing rolled out in Mental Health hospitals
	Electronic Document Management system project progressing for Mental health documents
	ICS Wide Area Network project signed off and progressing with GHC leading for the county

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

Looking Forward…

Where next… Our plan for the upcoming 3 months, **introduction to next set of slides and how it aligns to strategy**



Digital

Projects & Change

- **Digital Inclusion** Tablets for patients to interact with services benefits of progress reviewed
- **CYPH Digital Front Door** Project to go live after initial pilot with a small number of schools.
- **Cyber Soultion confirmed** Immutable backup option confirmed and bid progressed
- **Student system access options** assessment for GHC complete with proposal put forward
- **Digital Workforce Roadmap,** GHC Digital workforce roadmap completed after initial workshop review
- **Communication Tools** confirmed preferred solution for supporting wider communication alerts for staff
- **Microsoft Software Utilisation progressing** fast track work to look at the use of SCCM for application patching

Corporate Systems

- **Costmaster** Planning progressing for Costmaster Integration
- **Datix System** review the option of moving Datix to the new cloud based offering
- **GHC BMS system Upgrade progressing**
- **Tableu** Expansion and wider use of Tableu across the trust
- **Room Booking System** review completed, and options paper presented

Applications & Development

- **Pauls Open Door** Application created to support secure anonymous messaging
- **GHC App review for Cloud possibilities** Review project to look at the use of externally hosted servers for internally developed applications
- **Analytics Tool,** scoped for the use of GHC applications
- **E-Consent App for Covid** created to support covid roll out for 12-to-15-year olds
- **ICS Working Well Hub** Project implemented including website and application for recording progress
- **Trust Membership App** updated to increase functionality

Innovation Workstream

- **Remote Monitoring** Several tools and options looked at to support the trust in this area
- **Scheduling Tool** Options paper pulled produced after the Malinko Demo.
- **SYstemOne Mobile working** development and pilot of Bridgend tool as opposed to disconnected mobile working
- **Population Health Management** Development of a technical roadmap
- **Remote working solution** proposed and piloted
- **Self-care digital information** library system review to take place

CS

Projects

- **SystmOne Simplicity project**
- **Simplifying lists** to adhere to the National Dataset
- **Clinical Systems Vision Project** Options
- **Service review** of clinical IT solutions
- **RiO e-observations project**
- **Recording observations on tablet devices**
- **Electronic Document management project**
- **PH documents linking directly to trusts EPRs**
- **Support for School Aged Immunisations Project**
- **Rationalising Role** based access project
- **Virtual smartcards project**
- **Gemplus project** to upgrade old smartcards

Developments

- **School Aged Immunisations Team to go live on RiO**
- **Automated link from SystmOne** MIUs to SHREWD
- **Home First/Reablement Service** to go live on SystmOne
- **Persisting Physical Symptoms Service** to go live on SystmOne
- **Completion of PWC internal Audit for CS OLA** and support processes
- **Redesign of training packages**

IT

Server & Infrastructure

- **Wide Area Network upgrade** - Improving links to connected sites
- **Local Area Network upgrade**– Replacement project to so reliable secure and robust equipment is in place
- **Windows Server 2019 migration** - Implement latest server operating system for a more advanced security platform
- **Pager replacement** - Implement newer communication technology
- **Implementation of warm standby infrastructure at Cirencester** - Robust solution for disaster recovery with minimal downtime
- **Mobile Device management Review and INTUNE migration**

IT Systems Management

- **Review of Supplier Contracts and Supplier agreements** -Collate and evaluate contracts ensuring best value
- **Consolidation of IT Management applications** - Assess endpoint asset management solutions
- **Cyber penetration testing**-Identifying areas of weakness that can be improved to secure the trusts IT environment

Improving User Experience

- **Endpoint equipment refresh** - Deploy 300 laptops to clinical colleagues, replacing desktop devices for a mobile working ethos. Replacement of Workstation on Wheels devices ensuring wards have reliable and high performing laptops
- **Mobile Device management Review and INTUNE migration-Streamlining** the management of mobile devices with improved security protection and patch deployment
- **Improved mitigation of Cyber threats** -Threat protection policies implementation secure data

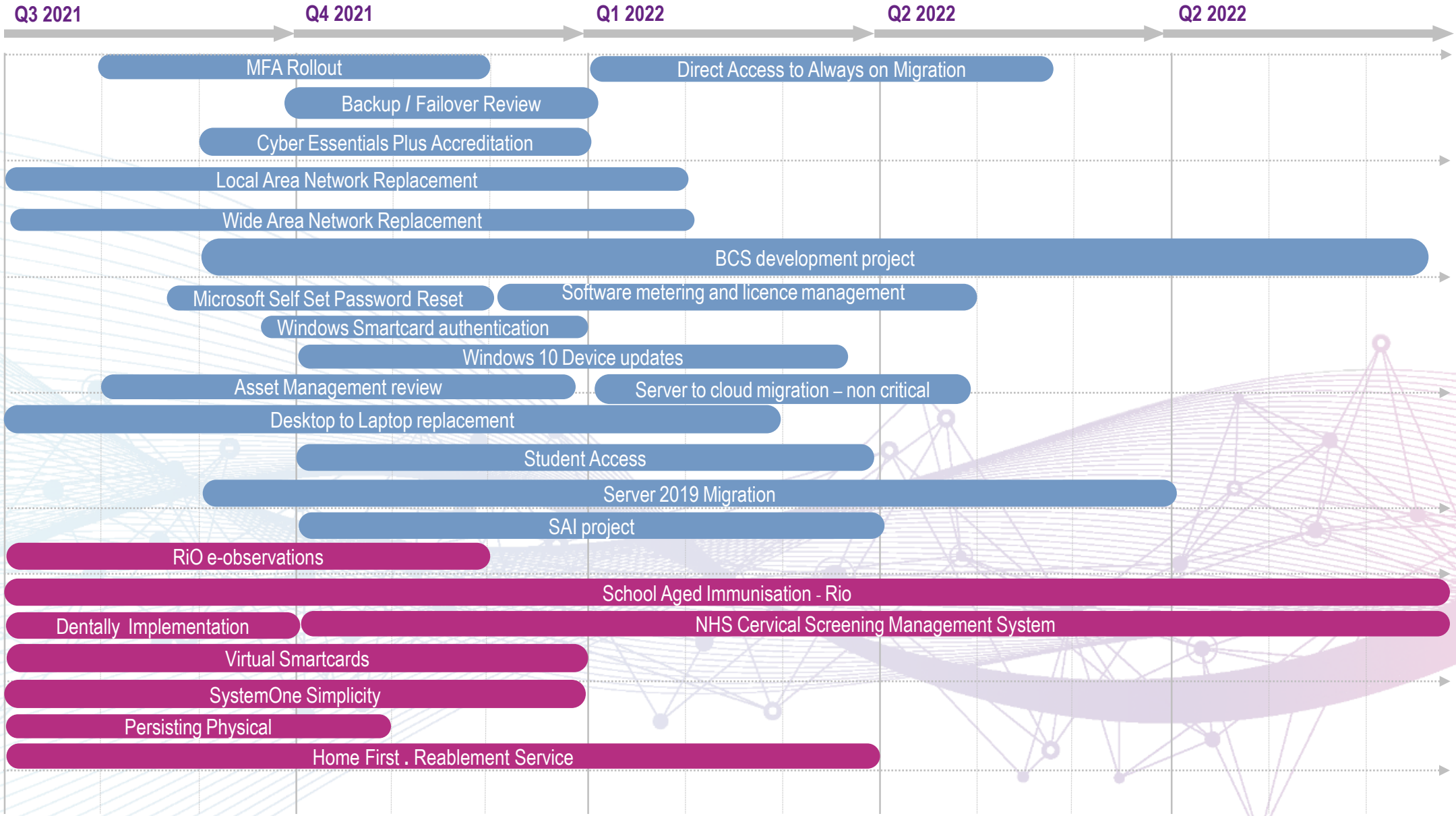
IT Skills Development

- **British Computer Science project** - SFIA PLus framework to upskills and validate IT skills within IT team
- **Skills Matrix**
- **Roles and responsibilities**
- **Skip meetings**

12 Month Road Map

IT Systems

Clinical System



ICS

Our ICS Digital Vision

- We will 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.

Our Delivery Goals

1. Deliver a modern flexible infrastructure
2. Provide a holistic view of the citizen's direct care needs
3. Join up intelligence
4. Provide streamlined systems and tools
5. Offer people and their circle of care consistent and usable digital access

ICS

Empower The Person

- **Mental Health Children's and Young People Digital front door project** completing initial stage of readiness.
- **GHC online consultation levels remain some of the highest in the country**, however, there has been a steep drop off of video consultations for both secondary care providers in the last quarter, in line with the national trend (-18% in GHC and – 45% in GHT for last 2 months)
- **GP Online enquiries increased 16% to 172k for Q1, with 1 to 1 SMS increasing 20% and GP video consultations steadily dropping another 35%.**
- **The NHS App is now seeing a dramatically increased uptake**, following the inclusion of Vaccination information (from 3.7 – 5.2% of the county's registered GP population in 3 weeks)
- **Empower the Person Roadmap drafted for review.** E-learning rehab proposal drafted and reviewed at ICS Digital Executives.
- **Digital Inclusion Group initial plan drafted.**
- **Contract awarded to supplier with BNSSG for Autism pathway** Discovery work package.

Clinical Information Sharing

- **Shared Care Record** – Children's Social care system - GCC to complete configuration to connect to Staging environment to complete testing. -Acute PAS - Connection of live PAS system to shared care record Staging environment completed.
- **Cinapsis** – GHC Rapid Response configured as specialist service for paramedic triage calls. Gloucestershire partnered with BSW & BNSSG to procure 3-year contract for Advice & Guidance via Clinical Communications framework. Regional funding secured for contract first year
- **Primary Care Data Warehouse** - EMIS data feed implemented & penetration testing completed. Activity underway to implement data feed for additional purposes i.e. commissioning and population health management.
- **Care Homes and Hospices** - Options appraisal completed for Hospice access to SystmOne. Business case drafted but not yet finalised.
- **PACS regional sharing on-hold** as now superseded by regionally funded Insignia solution.
- **E-Messaging and Correspondence** - Cheltenham MIU are live with sending discharge summaries electronically to GP Practices
- **Outpatient letters to GPs now nearing completion**
- **IAPT letters to GP undertaking further issue fixing** , following pilots

ICS

Providers in Gloucestershire

- **Electronic Prescribing System (EPS4) utilization** - Outstanding tasks to be completed at Blakeney and Rendcomb
- **GHC Mental Health Services -** implemented a new system to send letters to registered GP practices electronically via the MESH and received into the document workflow in EMIS.
- **GPIT Futures** - Regular meetings with the procurement team who are following up procurement routes.
- **Evaluation of batch messaging and reminders solutions has started .**
- **Primary Care I.T. Infrastructure projects** – Scheduling for Office 365 Deployment and GP Cabinet Upgrade have been arranged
- **Hospital Discharge Service on EPR** –Usage is being monitored to ensure compliance.
- **Digitising the Sepsis Pathway alignment with the** implementation of EPR into ED.
- **TCLE** went live in late June with a revised scope
- **Continuing to support the Cheltenham MIIU transition** back to a consultant-led service
- **GHT Data Centre Refurbishment -** Slippage on a number of milestones has put the completion date at risk.
- **GHT SQL Migration & Windows 2003 Upgrade** – Re-planned to accommodate resource availability.
- **GHT N365 Transition and Change -** Continuing data validation to identify 'true' user base.

Digital Workforce

- **Phase 4 workforce narrative was submitted**
- **Chartered Institute of IT skills profiling programme plan** being developed.
- **Digital & Data team audit** for the ICS completed

Infrastructure & Cyber Security

- **Cyber Security** – Cyber Security Plan in progress. Increase in Advanced Threat Protection & Sophos detections owing to penetration testing Proof of Concept work by cyber team. Virtual Cyber Response Exercise completed with support from NHSD & police.
- **Wide Area Network Refresh** – Sign-off for BT solution given at ICS to join up with the GP and GCC partners in the county to create a new one countywide network.

GCC

- **Organisational design** - a new Assistant Director for Digital & ICT Karl Grocock commenced in May
- **Commence critical remediation project work** to support technical roadmap.
- **Network** – detailed WAN / LAN design signed off; complete Shire Hall fibre refresh; network implementation commenced.
- **Liquid Logic Adults** - System successfully went live across the whole of adult social care and partners on 29th March 2021.

ICS

Project Milestones Status

Network Refresh	Sign-off for ICS to join up with the GP and GCC partners in the county to create a new one countywide network with BT soultion.
Regional Shared Care Record	National requirement that all ICS areas have a shared care record in place. Key targets for September 2021 and March 2022. Devon & Cornwall procurement completed. Programme implementation has been initiated. Somerset and Bristol leading on exploring a technical approach.
Cyber Security Plan	Cyber Security Plan in progress. Increase in ATP & Sophos detections owing to penetration testing PoC work by cyber team. Virtual Cyber Response Exercise confirmed for 4th June, with support from NHSD & police.
Office 365 deployment by October 2021	**GCCG & Primary Care** - Scheduling for Office 365 Deployment taking place. AMBER status is the result of the completion of Tranche 1 being at risk owing to the slow run rate. **GHT** – Continuing data validation to identify 'true' user base for inclusion in the migration. **GHC** – Completed
Advice & Guidance deployment	BAU transition plan and Outpatient evaluation required before further roll out to new specialties. New functionality for ERS integration and signposting ahead of calls under development.
Discharge Summaries to GP's	This work to send electronic comms to GPs through inpatients, outpatients and emergency departments nearing completion.

Digital Update 2021 - Sway Edition

AGENDA ITEM: 20/0921

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday 14 July 2021
Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Katie Clark
	Jo Smith	Chris Witham	Graham Hewitt
	Tracey Thomas	Ruth McShane	June Hennell
	Anneka Newman	Laura Bailey	Katherine Stratton
	Said Hansdot	Dan Brookes	Jenny Hincks
	Julie Clatworthy	Rebecca Halifax	

IN ATTENDANCE: Andy Holness, Shadow Public Governor
Graham Russell, Non-Executive Director/Deputy Chair
Jan Marriott, Non-Executive Director
Lavinia Rowsell, Head of Corporate Governance & Trust Secretary
Gillian Steels, Trust Secretary Advisor
Marcia Gallagher, Non-Executive Director
Maria Bond, Non-Executive Director
Paul Roberts, Chief Executive
Neil Savage, Director of HR & OD
Steve Alvis, Non-Executive Director
Steve Brittan, Non-Executive Director
Sumita Hutchison, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Sarah Nicholson, Mervyn Dawe, Karen Bennett, Kizzy Kukreja and Juanita Paris.

1.2 Ingrid Barker welcomed Rebecca Halifax and Andy Holness to the meeting. Rebecca had commenced in post on 1st July as an Appointed Governor representing Gloucestershire County Council. Andy Holness would be formally commencing as a Public Governor for Tewkesbury on 15th July, replacing Jo Smith when her term ended.

1.3 Ingrid Barker expressed her thanks and good wishes to both Anneka Newman and Jo Smith for which this would be their final Council meeting. Anneka would be standing down after her first term as a Staff Governor representing Medical, Dental & Nursing colleagues on 1 August 2021. Jo Smith would be coming the end of her final term as a Public Governor for Tewkesbury later today. The Council expressed their thanks to Anneka and Jo for their contributions and commitment to the roles.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 12 May 2021 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.

5. APPOINTMENT OF A NON-EXECUTIVE DIRECTOR

5.1 The purpose of this report was to seek the agreement and approval of the Council of Governors to the appointment of a Non-Executive Director.

5.2 At its February 2021 meeting, the Nominations and Remuneration Committee received and endorsed a report on the way forward with the recruitment of a NED with a background in finance/accounting. This appointment would ensure that appropriate succession planning arrangements were in place for the Chair of the Audit and Assurance Committee.

5.3 The Trust subsequently commissioned Gatenby Sanderson, an Executive Search agency, which has previously successfully assisted in sourcing applicants and supporting long listing, short listing and pre-interview processes for potential appointees. Gatenby Sanderson worked in partnership with the Trust and the position was advertised nationally on job-boards and through social media.

5.4 Interviews for the position took place on Thursday 1st July via Microsoft Teams. The interview panel comprised; the Chair of the Board, 3 Governors (members of the Nominations and Remuneration Committee), 2 Non-Executive Directors (including the Chair of the Audit & Assurance Committee) and the Chief Executive (in an advisory capacity). Discussion groups took place on the morning of 1st July in advance of the interviews consisting of Governors, Experts by Experience and senior Trust managers. One to one conversations had also taken place with each of the 3 shortlisted candidates with Sandra Betney, Director of Finance and Graham Russell, Deputy Trust Chair and Chair of the Resources Committee.

5.5 Having taken into account the feedback from the discussion groups and individual meetings, and undertaken a rigorous interview, the recommendation to the Council of Governors was the appointment of Clive Chadhani as a Non-Executive Director.

5.6 Ingrid Barker informed the Council that the panel agreed that we had three appointable candidates, each bringing their own strengths and distinctive experience. It was agreed that the candidate recommended by the panel would be a good 'fit' with the rest of the board, bringing a strong commercial background and perspective which would benefit the skill mix of the team.

5.7 The Council of Governors supported the recommendation and approved the appointment of Clive Chadhani as a Non-Executive Director of the Trust from 1st October 2021 for an initial period of 3 years, at an annual remuneration of £14,000.

5.8 Graham Hewitt had participated in one of the discussion groups with the candidates. He said that it had not been made clear to the discussion groups that the appointment was specifically for the chair of the Audit and Assurance Committee, and they had also not been made aware that each of the candidates was attending a range of sessions in the morning. Graham said that this would have been helpful to have known in advance by way of being able to plan for appropriate questioning. Graham Hewitt added that he had not seen the collective feedback that the group had submitted to the interview panel and queried therefore whether this had been received and considered. Neil Savage provided assurance that verbal feedback from each of the discussion groups was received and this had been taken on board, with some of the interview questions amended in response to this feedback. However, it was agreed that the process would be reviewed next time to ensure that a clearer briefing was provided for discussion participants and consideration would also be given as to whether collective feedback from the groups would be submitted in written form, to ensure this was available for the record. Ingrid Barker thanked Graham Hewitt for his helpful feedback, which was always encouraged to ensure improvements could be made.

6. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

6.1 Chris Witham, Lead Governor presented this report to the Council, summarising the key business conducted at the meeting of the Nominations and Remuneration Committee held on 30 June. He provided strong assurance to the Council that the Committee ensured best practice that was in line with national guidance.

Chair's Appraisal 2020/21

6.2 The Committee received the outcome of the appraisal of the Trust Chair for 2020/21. Marcia Gallagher, Senior Independent Director was in attendance to present the report which highlighted the key themes emerging from the feedback received from Directors, Governors and stakeholders which formed the basis of the appraisal process with the Chair. It also identified areas that have arisen out of that feedback that might contribute to development plans for the forthcoming year. Assurance was received that the appraisal had been conducted in accordance with guidance issued by NHSE/I in April 2021.

6.3 This was a positive appraisal and was a real tribute to Ingrid Barker's performance that she had continued to engage in a number of national and local forums over the past year. This was Ingrid's second year as Trust Chair and her leadership during Covid had been greatly valued. Ingrid had taken the sensible approach with Board colleagues to focus on achievable targets during what was an extremely challenging year. Ingrid has a strong and effective

working relationship with the Chief Executive, and positive feedback was received from the Chair of the Gloucestershire ICS and the Chair of Gloucestershire Hospitals Trust who valued Ingrid's support and engagement.

6.4 The Committee received the key objectives for the Chair for 2021/22, noting that these personal objectives were aligned with those of the Chief Executive and the new Trust Strategy.

6.5 The Committee thanked Marcia Gallagher for the report, which was well written, clear and thorough. The report contained a good balance of celebratory strengths whilst ensuring that the process carried out had been appropriately rigorous and robust.

6.6 The Committee formally noted the outcome of this year's Chair appraisal process, noting that this would also be submitted to NHSE/I.

Non-Executive Director Appraisal 2020/21

6.7 The Committee also received the outcome of the appraisal of the Non-Executive Directors for 2020/21.

6.8 Appraisal meetings for all NEDs took place in April 2021. In advance of each meeting, NEDs were asked to undertake a self-review focusing on their achievements over the past year and previously agreed objectives. Following the meeting, a summary of the discussion, proposed objectives and development plans were shared with each NED and signed off by both parties. The Committee received assurance that the appraisals had been conducted in accordance with guidance issued by NHSE/I in April 2021.

6.9 Appraisals were completed for Marcia Gallagher, Graham Russell, Maria Bond, Sumita Hutchinson, Jan Marriott, Dr. Stephen Alvis and Steve Brittan. Ingrid Barker informed the Committee that this had been a positive round of appraisals, and there were no areas of concern to raise with the Committee.

6.10 The Nominations and Remuneration Committee noted the outcome of this year's NED appraisals process and agreed to report formally to the full Council that this information had been received.

Other Business

6.11 The Committee received a report which provided an update on changes to the membership of the Council of Governors and an update on progress with Governor elections. A verbal report was also received providing an update on progress and current timelines for the recruitment for a Non-Executive Director.

7. RECEIPT OF THE ANNUAL REPORT AND ACCOUNTS 2020/21

7.1 The purpose of this report was to present the Council of Governors with the final draft Annual Report and Accounts 2020/21, to meet their statutory duty to "Receive the Trust's Annual Accounts and any report of the Auditor on them".

7.2 The Annual Report was Laid before parliament on 9th July and would be formally presented to the AGM taking place on Wednesday 22nd September 2021.

7.3 As done in previous years, the Trust would be arranging a briefing session for Governors to learn more about the Annual Report and Accounts, with the session led by Marcia Gallagher (Chair of Audit & Assurance Committee), Sandra Betney (Director of Finance) and a representative from our External Auditors. It was proposed that this session be scheduled at the end of August, and Governors would be notified of the date and invited to attend in due course. **ACTION**

7.4 Governors were asked to note that Marcia Gallagher has been invited to lead the next Holding to Account session at our Council of Governors meeting in September, in her role as Chair of the Audit & Assurance Committee.

7.5 The Council of Governors formally received the Annual Report and Accounts 2020/21.

8. BED MANAGEMENT – OUT OF AREA UPDATE

8.1 The Council welcomed James Wright (Associate Director of Quality Assurance and Clinical Compliance) and Leon Meek (Deputy Service Director - Hospitals Directorate) to the meeting who provided the Governors with a briefing on Out of Area (OOA) Placements. This was in response to a long-standing action requested by Mervyn Dawe, Public Governor for Stroud.

8.2 **How often does an out of county placement occur?**
Current data informs us that on average at least 3 people will be placed in OOA Placements each month.

8.3 **For what reason does such a placement occur?**
Historically, the majority of OOA Placements occurred due to the requirement for more specialised care such as Psychiatric Intensive Care Units (clinical presentation). However, due to a recent surge in demand for mental health services nationally there has been an increase in Working Age Adult OOA Placements.

8.4 **What is the average cost of a stay and length of stay?**
The average daily costs of OAA Placements vary depending on the clinical requirement (PICU/Acute) but on average placements cost the Trust £50k per month. The average length of stay for people in OOA placements is 18 days.

8.5 **Who is responsible for transport costs for the service user?**
The current transport cost to facilitate an OOA placement is funded by the Trust, but the recently observed increase in activity and the impact of this is being discussed with Gloucestershire Clinical Commissioning Group.

8.6 In terms of supporting discharge, it was noted that GHC had recently submitted a bid to the local CCG as part of the Mental Health Investment Fund to support discharge projects from hospital to prevent readmissions. GHC were awarded £477k and a number of projects have evolved, working with Voluntary sector organisations which are now operational as of 1st July 2021.

8.7 An Allied Health Professional/Peer Support: Supporting Discharge Service had been set up and early feedback from this service has been very positive from both service users and staff and has the potential to not only expedite discharges from hospital but support with reducing readmissions. Graham Hewitt noted that the service had only become operational from 1 July and asked who the feedback had been received from and some examples of what people had reported as being positive. Leon Meek said that the information had been received directly from the cohort of individuals currently being supported by the scheme. He said that people had provided feedback that this service had helped them to understand the discharge process better and had given them more confidence about being discharged. The assessing team and community teams worked with the service users and their families on the care plans and the Trust had worked with service users to co-produce information leaflets on discharge pathways and OOA placements. This feedback from service users and their direct experiences would be used to further develop services.

8.8 A pilot Hotel Discharge service had also been set up and this service has an operational policy in circulation, that could support service users leaving hospital utilising a short-term accommodation solution. Laura Bailey asked whether this service would relate more to older people. Leon Meek advised that the service supported working age adults currently, however, this had been set up as a pilot scheme so could be used as a learning opportunity to potentially expand to older age adults.

8.9 Julie Clatworthy asked about the units the Trust used to place PICU patients and sought assurance around the checks carried out. James Wright advised that most OOA placements were made with Cygnet or The Priory. The Trust had developed good working relationships with these providers; however, he offered assurance that in advance of every OOA placement, the Trust carried out assessments of quality and safety, and spoke to the hospitals directly to confirm current CQC ratings and performance. James Wright added that where possible the Trust tried to arrange placements as close to the patient's home as possible.

8.10 Ingrid Barker thanked James Wright and Leon Meek for attending and presenting to the Council. Governors were invited to contact James and Leon directly if they had any further questions about this important area of Trust work.

9. ANY OTHER BUSINESS

9.1 There was no other business.

10. DATE OF NEXT MEETING

10.1 The next meeting would take place on Wednesday 8 September 2021 at 10.00am.

COUNCIL OF GOVERNORS ACTIONS

Item	Action	Lead	Progress
12 May 2021			
9.1	Consideration be given to providing Governors, particularly Public Governors with ID badges and Trust email addresses for correspondence.	Anna Hilditch	**Email addresses** **Progressing** New user forms completed and submitted. Awaiting notification from IT.
14 July 2021			
7.3	Briefing session for Governors on the Annual Report & Accounts to be arranged, with the date circulated inviting attendance.	Anna Hilditch	**Complete**. Session taking place on 2 September 2021.

AGENDA ITEM: 21/0921

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 12 August 2021

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 and considered the following Internal Audit Reports:

- Accounts Payable. Report Classification: Medium risk. Two medium findings, two low risk findings. The review considered the key processes and procedures carried out by the Trust in relation to the accounts payable and supplier on boarding process.

- Data Security and Protection Toolkit (DSPT). Report Classification: Low risk. One medium finding, three low risk findings and one advisory rated finding.

The Committee reviewed and was satisfied with progress being made against the internal audit plan and with implementing audit recommendations.

COUNTER FRAUD BRIBERY & CORRUPTION

The Committee received the Counter Fraud, Bribery and Corruption Progress Report which provided an update on the progress of Counter Fraud activity against the approved workplan.

It was highlighted that an exercise to consider the Trust's approach of salary overpayments was being undertaken which would be done as a countywide exercise.

The Committee was informed that the mandatory NHSI National Procurement exercise which was being rolled out by the Cabinet Office to all central organisations;
would be examining purchase order (PO) spend against non-PO spend during the pandemic and the compliance against procurement notices.

The Committee received the final report on the proactive counter fraud exercise looking at the usage of Estates Vehicles. The report set out a number of findings including that the management controls around the use of estates vehicles required review. It was reported that all recommendations had been accepted by management and implemented.

BOARD ASSURANCE FRAMEWORK

The Committee **received** and **considered** the Board Assurance Framework (BAF), providing assurance on the management of the Trust's strategic risks.
It was reported that there had been a reduction in the risk ratings for two of the risks; *Resources Targeted at Acute Care* and *National Economic Issues.*

CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register and was informed of seven new risks. Seven risks had scores reduced and three risks had been closed. The Committee discussed in detail and a number of risks were referred to the relevant Governance Committee for further consideration. The Committee **noted** the information and assurance provided.

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance Report, which provided an update on actions taken under delegated powers. The Committee received an update on progress with aged debtors.

The Committee was informed that the Better Payment Practice report for month 4 would be submitted to NHSE/I on 16 August.

STANDING FINANCIAL INSTRUCTIONS & SCHEME OF DELEGATION UPDATES

The Committee **endorsed** the proposed amendments to the Standing Financial Instructions and Scheme of Delegation which were required following changes to government procurement regulations. The amendments lowered the threshold value at which NHS Trusts must undertake a full procurement tender exercise from £181k to £122k with effect from the 16 August 2021.

ANNUAL REPORTS

The Committee received the following Annual Reports:

- **SIRO Annual Report:** The Committee took **assurance** that the Trust has effective systems and processes in place to maintain the security of information and **endorsed** the report for submission to the Trust Board.

- **Health & Safety Annual Report:** Providing assurance that the organisation has in place the processes and structures to lead Health and Safety at Work as set out by the Health & Safety Executive.

- **Security Management Annual Report:** Providing assurance that the risks associated with Security Management were being managed and mitigated. The report also highlighted the forthcoming new standards for violence prevention and reduction.

REVIEW OF THE ACTIONS ARISING FROM LESSONS LEARNED PROJECT – WOTTON LAWN

The Committee received a verbal update on the Review of Actions Arising from Lessons Learned Project – Wotton Lawn. All actions had been progressed with the majority of actions completed. It was reported that the project implementation review had been put in to place to ensure the outcomes of the original brief had been achieved.

OTHER ITEMS

The Committee:

- **Received** and **noted** the Final Internal Audit Plan 2021/22.
- **Received** and **noted** the Internal Audit Progress Report.
- **Received** and **noted** the External Audit Progress Report
- **Received** the Counter Fraud, Bribery & Corruption Annual Report, Functional Standard Return and Board Survey Report (Results).
- **Received** and **noted** the Counter Fraud Referral Benchmarking Report.

- **Received** the BAF Review against PwC Comparator Report and **considered** the areas of discussion highlighted, and **agreed** the proposed actions to take them forward through discussion at the responsible governance committee.
- **Received** the Review of External Auditor Effectiveness and **noted** the outcome of the assessment.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	11 November 2021

AGENDA ITEM: 22/0921

APPOINTMENT AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT
DATE OF MEETING
25 AUGUST and 1 SEPTEMBER 2021

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

25 AUGUST 2021

CLINICAL EXCELLENCE AWARDS (CEA)

The Committee received a report setting out the process and outcome from the 2019/20 CEA process. A total of 34 Consultants were eligible to apply for awards and 8 applications were received. Prior to application forms being sent out, a letter was sent to all eligible consultants from the Chair of the Trust to encourage applications, particularly from female and Minority Ethnic consultants. Support and communications were provided by the Medical Staffing department and the Director of HR and OD. Dr Amjad Uppal, Medical Director, also gave a training presentation on this to potential applicants at the Continuing Medical Education training session. The number of applications was unfortunately lower than usual; however, given the pressures of Covid this was not unexpected. Further consideration would be given to providing additional support and encouragement to applicants for future rounds. The Committee was pleased to note that those applications received were of a high standard and were representative in terms of gender and ethnicity.

The Committee reviewed the report and endorsed the Employer Based Award Committee recommendations to award the CEAs as listed, in line with the scheme.

EXECUTIVE REMUNERATION POLICY

At its meeting in March 2021, the Committee considered, and approved in principle the proposed Executive Remuneration Policy subject to consultation with members of the Executive Team. The policy aimed to provide a clear framework and ensure transparency with regard to remuneration arrangements for Executive Directors, following good practice and mirroring the national guidelines and directives set out by NHSI regarding Executive Director and VSM remuneration. This consultation had now taken place, with all members of the Executive Team having been provided with the opportunity to comment on the policy. No further amendments had been received and the Committee was therefore content to approve the policy.

EXECUTIVE DIRECTOR PERFORMANCE REVIEWS 2020/21

The Committee received a report providing a summary of the 2020/21 appraisal of members of the Trust's Executive Team which had been conducted in line with the Trust's appraisal policy. It is the responsibility of the Chief Executive to complete the annual appraisals and report to the Appointments and Terms of Service Committee. This report summarised the appraisal process, the outcome of the appraisal conversations and agreed/draft objectives for each Director. The Committee received and discussed the appraisal summaries, noting the

key objectives set for the Executive Directors for the coming year. Assurance was received that the Chief Executive carried out regular 1:1 meetings with Executive colleagues.

EXECUTIVE DIRECTOR PORTFOLIOS

This report provided a summary of the outcome of the review of Executive Director portfolios undertaken in discussion with members of the Executive team, individually and collectively and considering recent performance review discussions. The Chief Executive informed the Committee that he was satisfied that the report clearly represented the current portfolios held by each Executive Director and that the portfolios were appropriately distributed across the team. The Committee noted that an annual review of the portfolios would be carried out.

CHIEF EXECUTIVE PERFORMANCE REVIEW 2020/21

The Committee received a report providing a summary of the 2020/21 appraisal of the Chief Executive which had been conducted in line with the Trust's appraisal policy. It is the responsibility of the Trust Chair to complete the annual appraisal and report to the Appointments and Terms of Service Committee. This report summarised the appraisal process, the outcome of the appraisal conversation and agreed objectives for the coming year.

1 SEPTEMBER 2021

RECRUITMENT TO THE POST OF CHIEF OPERATING OFFICER

The Committee received an update from the CEO on the recruitment and selection process for the new Chief Operating Officer (COO). It was reported that the post had been offered to David Noyes, subject to Fit and Proper Person and standard NHS Employment checks.

The Committee endorsed the appointment of David Noyes to the post of COO, and the remuneration package which would include access to the Trust's relocation expenses policy. It was noted that the candidate had a 6-month notice clause but that early release was being sought. A start date would be confirmed as soon as possible,

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	17 November 2021

AGENDA ITEM: 23/0921

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 26 August 2021

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 66% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 4

The Committee received the Finance Report for month 4. The month 4 position was a £40k surplus with a six-month forecast of break even. The Trust had spent £0.639m to date for all covid related costs. Of this amount, £0.62m was out of the envelope expenditure. It was reported that the covid allocation was significantly higher than what was required and it was expected this would be reduced in H2. It was anticipated that this would have a significant impact on the Trust's position.

Backlog maintenance had been brought forward in order to replace schemes which had slipped. The Committee was assured there would be no high-quality impacts or significant items being moved from the current financial year and that colleagues from the Nursing, Quality and Therapies directorate had been involved in discussions regarding this.

Brokerage agreed with NHSI had agreed an additional £2m allocated to the Forest of Dean (FoD) scheme for the current financial year. Sandra Betney asked the Committee to consider whether the £2m should be used for the FoD scheme or be re-allocated to be used on backlog maintenance, and noted that this would be dependent on approvals relating to the FoD scheme,

PERFORMANCE REPORT – MONTH 4

The Committee received the Performance Report for month 4 which provided a high-level view of the key performance indicators in exception across the Trust.

Discussions had taken place at the Business Intelligence Management Group (BIMG) and it had been agreed that the Performance Dashboard would include a new section focussing on recovery going forward, and additional proxy indicators had been agreed by the Trust Board.

The Committee **acknowledged** the ongoing impact of the pandemic and service recovery on operational performance. The Committee **noted** the report as a **significant level of assurance** that the Trust's contract and regulatory performance measures were being met or that appropriate service action plans were being developed to address areas requiring improvement.

SOUTH WEST PROVIDER COLLABORATIVE LEARNING DISABILITIES AND AUTISM

The Committee received the South West Adult Secure Learning Disability and Autism Provider Collaborative report; providing the background and progression of the New Care Models agenda and development of the Provider Collaborative arrangements, specifically focussing on the South West Adult Secure Learning Disability and Autism Collaborative.

The Committee was informed that the collaborative for Adult Secure Learning Disability & Autism Services would formally go live from the 1 October 2021; subject to appropriate NHSE

approvals. It was reported that the risk share arrangement had been adjusted from 14% down to 12%. This was following the proposal to change from a weighted mental health population basis to a normalised population basis. The Committee **endorsed** the Provider Collaborative arrangements, with the caveat that how it aligned with the Gloucestershire Strategy be added prior to submission to Trust Board.

SARC TENDER UPDATE

The Committee was informed that the Trust had successfully passed the assessment process for the SARC tender; and noted that it was the only trust to do so.
The Committee welcomed the news and acknowledged that it was good news for the service.
The Director of Finance informed the Committee the service would begin in April 2022.

OPERATIONAL RESILIENCE & CAPACITY PLAN (INC WINTER PLAN)

The Committee received the Operational Resilience and Capacity Plan which provided overall details of the operational resilience and sustainability plans and tools implemented through periods of service disruption be that surge, adverse weather conditions, pandemics and any other interruption requiring business continuity, escalation or enhanced preparatory plans to be put in place. The plan outlined the processes for ensuring capacity, including System level reporting. This included the out of hours arrangements and the 4x4 arrangements to ensure resilience. The Committee received the Escalation Plan, and it was noted that this was an internal document which had been developed for the first time. The escalation plan outlined the approach to internal and external escalation policies from a Trust position. The Committee was informed that the plan would be used to guide colleagues through the use of a daily assessment, capacity and the implementation of service escalation action cards. The action cards would identify triggers to escalation and actions in which the service would enact in the event of surge.

The Committee **endorsed** the three documents presented, and **noted** the contents of the operational schemes submitted to the A&E Delivery Board in priority order for system-wide support and funding. The Committee thanked the Operational Team for their work.

HR POLICIES & PROCEDURES UPDATE

The Committee was informed that the Learning and Development Policy had been agreed through the Joint Negotiating and Consultative Forum (JNCF). It was also reported the Counter Fraud and Corruption Policy and the Supporting Attendance Policy had both been updated.

OTHER ITEMS

The Committee:

- **Received** the Internal Business Plan for quarter 1, noting the huge achievement in progressing objectives to date. A proposed refresh of objectives at the end of quarter 2 was **noted**.
- **Received** and **noted** an update on the People Strategy, acknowledging the huge amount of work that had been carried out.
- **Received** and **noted** the progress with taking forwards the Staff Survey Action plan; and **noted** the results of the most recent Staff Pulse Survey, noting that the Health and Well Being Hub were considering next actions to take forward with Executive and Communication support; and **noted** the Staff FFT ratings, and took **assurance** that the Trust is continuing to engage with colleagues and progress the actions identified as an output of the 2020 Staff Survey results.
- **Received** and **noted** the Risk Register and the Board Assurance Framework

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	28 October 2021

AGENDA ITEM: 24/0921

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 02 September 2021

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard for July 2021, which provided a summary assurance update on progress made and achievements of quality priorities and indicators across physical health, mental health and learning disability services.

The Committee was informed that the ligature works at Wotton Lawn had to be paused due to pressures; however, a plan was in place for this to commence again this month [September].
The Director of Nursing, Therapies & Quality reported whilst recruitment remained a significant issue, he was happy to share the news that the first mental health national recruit had landed in the country and a further circa 10 nurses would be joining Wotton Lawn.

The Director of Nursing, Therapies & Quality referred to the further decrease in CPA Compliance, detailed within the report and expressed disappointment with the lack of progress. The Committee was informed that operational colleagues were reviewing this and assured the Committee that further action would be taken to ensure compliance. The Committee would receive a further update at the next meeting.

The Committee **received, noted** and **discussed** the July 2021 Quality Dashboard Report.

CLINICAL PRESENTATION – FOSTERING AND VULNERABLE CHILDREN SUPPORT

The Committee received a clinical presentation about Fostering and Vulnerable Children Support which was presented by the Pathway Lead for Children in Care.

The Committee was informed of the Fostering Development project, which involved aiming to improve the understanding and skill bases of newly approved GCC foster carers and understanding the impact that adverse childhood experiences on the emotional and relational needs of children in care.

There would be the opportunity to share the presentation and the work done at the Mental Health Summit, which would be chaired by Ingrid Barker, Trust Chair.

The Committee thanked David Hinchcliffe, Pathway Lead for Children in Care for the presentation and praised his valuable work.

LEARNING FROM DEATHS REPORT

The Learning from Deaths Report was received, which informed the Committee of the mortality review process and outcomes for quarter 1 2021/22.

The Medical Director reported during quarter 1 2021/22, 129 Trust patients died. None of the patient deaths during the reporting period, were judged more likely than not to have been due to problems in the care provided to the patient.

This was comprised of the following numbers of deaths which occurred in each month of that reporting period.

- 37 in April
- 59 in May
- 33 in June

This report would be presented to the Trust Board in September.

EXPERTS BY EXPERIENCE IN QUALITY GOVERNANCE - UPDATE

The Committee received the Experts by Experience (EbyE) in Quality Governance update, providing a summary of learning identified by having an Expert by Experience in attendance at the Quality Committee; and also outlining the next steps for the Trust with regards to people participation.

The Committee was informed that Angela Potter, Director of Strategy and Partnerships had presented a draft proposal of the People Participation Plan at the EbyE Working Group. The Committee noted that this would be received by the Trust Board in November. Dan Beale-Cocks would be in attendance.

The Committee noted the learning obtained through having an Expert by Experience in attendance at the Quality Committee.

The Committee received assurance that the Trust was progressing an organisation-wide position with regards to people participation.

MEDICAL APPRAISAL & REVALIDATION ANNUAL REPORT

The Committee received the Medical Appraisal and Revalidation Annual Report, providing a summary of the work which had been undertaken by the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy. This report would be presented in full to the Trust Board in September.

OTHER ITEMS

The Committee:

- **Received** and **noted** the Risk Register and the Board Assurance Framework and the assurance and information provided.
- **Received, reviewed** and **noted** the information relating to quarterly patient safety incident reporting.
- **Received, noted** and **discussed** the Whole Trust Quality Management report and supported further work which was described.
- **Received** and **noted** the contents of the Quality Assurance Group summary report.
- **Received** and **noted** the Research and Development Annual report.
- **Received, noted** and **discussed** the Allied Health Professionals update for quarter 1 2021; and agreed for the report to progress to the Board.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	04 November 2021

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD PUBLIC SESSION
Thursday, 28 January 2021
10:00 – 13:00
To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose	Comms	Presenter
Opening Business					
10.00	01/0121	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0121	Declarations of interest	Assurance	Verbal	Chair
10.05	03/0121	Service User Story Presentation	Assurance	Verbal	DoNQT
10.25	04/0121	Draft Minutes of the meeting held on 25 November 2020	Approve	**Paper**	Chair
	05/0121	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0121	Questions from the Public	Assurance	Verbal	Chair
Covid					
10.35	07/0121	Covid Programme Update	Assurance	Verbal	CEO/COO
10.50	08/0121	Covid Board Assurance Framework	Assurance	**Paper**	HoG/DoNQT
Strategic Issues					
11.00	09/0121	Report from the Chair	Assurance	**Paper**	Chair
11.10	10/0121	Report from Chief Executive	Assurance	Verbal	CEO
11.20	11/0121	Forest of Dean Hospital Consultation Output Report	Approve & Note	**Paper**	DoSP
11.30 - BREAK – 10 MINUTES					
Performance and Patient Experience					
11.40	12/0121	Quality Report	Assurance	**Paper**	DoNQT
11.55	13/0121	NHSE Infection Control BAF	Assurance	**Paper**	DoNQT
12.05	14/0121	Patient Safety Report – Q3	Assurance	**Paper**	MD
12.15	15/0121	Finance Report	Assurance	**Paper**	DoF
12.25	16/0121	Performance Report	Assurance	**Paper**	DoF
12.45	17/0121	CQC National MH Patient Survey	Assurance	**Paper**	DoNQT

NOTE: Items below this line will be reported by exception only.
Board Members are requested to raise any questions relating to these items, to the Assistant Trust Secretary in advance of the meeting.

Covid and Strategic Issues (Reporting by Exception)					
	18/0121	Covid Governance Arrangements	Information	**Paper**	Chair/HoCG
	19/0121	End of EU Transition Period update	Information	**Paper**	COO
Governance (Reporting by Exception)					
	20/0121	Council of Governor Minutes (Nov)	Information	**Paper**	Chair
	21/0121	Use of the Trust Seal (Q2)	Information	**Paper**	HoCG
Board Committee Summary Assurance Reports (Reporting by Exception)					
	22/0121	Mental Health Legislation Scrutiny Committee Summary (18 Nov 2020) • Mental Health Act (MHA) White Paper – NHSP Briefing	Information Information	**Paper** **Paper**	MHLS Chair COO
	23/0121	Resources Committee Summary (17th Dec 2020)	Information	**Paper**	Resources Chair
	24/0121	Quality Committee Summary (7th Jan 2021)	Information	**Paper**	Quality Chair
Closing Business					
12.55	25/0121	Any other business	Note	Verbal	Chair
13.00	26/0121	**Date of Next Meetings - 2021** Wednesday, 31 March Thursday, 27 May Thursday, 29 July Thursday, 30 September Thursday, 25 November	Note	Verbal	All

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 04

MINUTES OF THE TRUST BOARD MEETING

Wednesday, 25 November 2020

Via Microsoft Teams

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

IN ATTENDANCE:
Julie Houlder, NHSP Aspirant Chairs Programme
June Hennell, Trust Governor
Kate Nelmes, Head of Communications
Lauren Edwards, Deputy Director of Quality and Therapies
Lavinia Rowsell, Head of Governance/Trust Secretary
Ruth McShane, Trust Governor
Sunil Patnaik, Regional Director – Healthcare, Totalmobile
Anna Hilditch, Assistant Trust Secretary

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from Sumita Hutchison.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT

3.1 The Board welcomed Sarah Scott, Director of Public Health to the meeting to present the highlights from the 5th Director of Public Health Annual Report - "Beyond Covid: Race, Health and Inequality in Gloucestershire". Sarah Scott informed the Board that this was the first time that the annual report had been co-authored with another group, with this year's report having been co-produced with the Black Workers Network.

3.2 The report set out information around health inequalities, housing, employment and education, specifically focusing on the BAME community. The Board noted the impact of COVID-19 on Gloucestershire's BAME residents, noting that 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. Sarah Scott informed the Board that the number of "Unknown/not recorded" ethnicity cases was relatively high; however, she provided assurance that work was taking place to address this and an improvement in data recording had been seen.

3.3 The report provided information about community resilience and some case studies from local organisations and charities were included talking about the support and help that had been given to people during Covid. It was agreed that there were some excellent examples of community working and it was important that this could be captured and support given to these voluntary organisations to continue this work going forward.

3.4 An analysis of the awareness of public health and economic measures during COVID-19 by ethnicity had been carried out and demonstrated a differing level of understanding between ethnic groups. This reinforced the message that one message doesn't fit all and 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.

3.5 The report set out 8 key recommendations, and these included:

- Require comprehensive and good quality ethnicity data collection in all public services (directly provided and commissioned), including at death registration and put in place culturally competent training and messaging to improve response rates

- System-wide commitment to the implementation of culturally competent occupational risk assessment tools,

- 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.

- 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.

3.6 It was noted that the report had also been formally presented to the ICS Board the previous week and it was clear that close partnership working and collaboration was required to progress the recommendations. Paul Roberts said that it was important for this to be looked at jointly in the ICS, however, it was equally as important for GHC to look at its own requirements and

suggested that an initial organisational response to the recommendations, with specific actions and commitments could be presented to the Board in January. **ACTION**

3.7 Neil Savage advised that he planned to take the presentation to the Diversity Network and BAME sub-group to set out the direction of travel. He suggested that there would be many colleagues wishing to get involved with this work.

3.8 Ingrid Barker thanked Sarah Scott for her time in attending and presenting this report to the Board. Thanks, were also expressed to Althea Lynn, Chair of the Black Workers Network. The Board fully supported the annual report and the recommendations.

4. PATIENT/STAFF EXPERIENCE PRESENTATION

4.1 The Board welcomed David Sheppard to the meeting who had kindly agreed to attend and speak about his personal experience of working with the Trust in the management of Type 2 diabetes.

4.2 David was diagnosed with Type 2 diabetes in 2003, which progressively worsened and significant weight gain was seen. He was referred to the Trust's Diabetic Dietician service in 2017. David used the service until February 2019 but no real impact on his weight or diabetes was seen. At this point Sarah Hughes was introduced to David. Sarah provided coaching and mentoring on how to look after himself, introducing an 800 calorie a day diet. A weekly diary was kept and regular contact and encouragement was made over the phone. David said that he had now lost over 30kg in weight and was no longer diabetic, with no need to take any further medication. He said that the help, support and most importantly encouragement that he had received from the service had been immense. David said that one of the most important aspects was listening to people and finding out what they want and what approaches would work for them. There was a lot of will power involved but he was of the mind to follow the strict regime, which had worked for him.

4.3 Angela Potter noted that there were lots of people in the same position as David, with many people resorting to surgery to lose weight. She asked whether there was more that the Trust could do to encourage and promote this coaching and mentoring role. David said that it did take some persuasion, and it needs to be clear that it is for the person's own good. He said that keeping a weekly diary and seeing the progress made each week was huge encouragement. Sarah Hughes said that evidence from bariatric surgery was that it could reverse diabetes; however, a surgery free option to manage a person's weight and diabetes would always be the preferred and safer route.

4.4 The Board thanked David for attending and speaking so positively and powerfully about the Trust's Diabetic Dietician service, and the personal service he had received. The Board also congratulated David on this huge achievement, and expressed their thanks to Sarah Hughes who had played such a key part in David's successful recovery.

5. MINUTES OF THE PREVIOUS MEETING HELD ON 30 SEPTEMBER 2020

5.1 The Board received the minutes from the previous meeting held on 30 September 2020. These were accepted as a true and accurate record of the meeting, subject to one amendment at 12.6 in relation to the Trust's IAPT access rate.

6. MATTERS ARISING AND ACTION LOG

6.1 The Board reviewed the action log and noted that all actions were now complete or included on the agenda. It was noted that Sumita Hutchison had been nominated as the Board's Health and Wellbeing Guardian.

6.2 There were no further matters arising.

7. QUESTIONS FROM THE PUBLIC

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

8. CHAIR'S REPORT

8.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in September. 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 the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

8.2 The Board was asked to note that the Council of Governors approved the appointment of Dr Steve Alvis as a Non-Executive Director at their meeting on 19 November. This follows the appointment of Steve Brittan as a Non-Executive Director in September. Both had previously been Associate NEDs. Ingrid Barker informed the Board that now a full complement of NEDs was in place, the Appointments and Terms of Service Committee which met on 12 November had agreed that the Director of Strategy and Partnerships would now become a full voting member of the Board. Board members congratulated all those involved.

8.3 Congratulations were given to Sonia Pearcey, the Trust's Freedom to Speak Up Guardian, who had been awarded an MBE for services to the NHS in the Queen's Birthday Honours. Ingrid Barker said that she was delighted that the way Sonia had taken forward this key role, embedded it across the Trust and supported its development across the region and nationally had been recognised.

8.4 The Board noted that a lot of activity was taking place with the Council of Governors, with the Review and Refresh work continuing to take forward the Council in line with best practice and reflecting the expanded remit of the Trust. At its November meeting, the Council approved the establishment of a Membership and Engagement Committee, to take forward the development of a new Membership and Engagement Strategy. The strategy will focus on how

we can ensure our membership is vibrant, engaged and represents our wider community. Ingrid Barker said that she had now met with all newly appointed Governors for a one to one induction, and a group induction session had also taken place. The Board was asked to note that the interim Lead Governor, Dr. Faisal Khan would be stepping down from the Governor role when his term of office comes to an end on 31st December. Ingrid Barker formally thanked Faisal for the contribution he had made to the Council, noting that his thoughtful and inclusive approach had been much appreciated.

8.5 Nationally, Ingrid Barker had been invited by Lord David Prior, CEO of NHS England, to join the NHSE/I Chairs' Advisory Group and attended the first meeting on 27th October 2020. The meeting considered forthcoming potential legislative changes through the draft NHS Bill. A further meeting would be held in the New Year.

8.6 The Board noted the content of the Chair's report.

9. CHIEF EXECUTIVE'S REPORT

9.1 The Board received the Chief Executive's Report which highlighted the activity of the Chief Executive and Executive Directors since the previous meeting of the Board in September.

9.2 A steady increase in the number of Covid positive cases in the local community had been seen over the past months, 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 is a significant and challenging focus for the Trust, and Paul Roberts acknowledged the huge amount of work being carried out by the Trust's Senior Team to keep things on track.

9.3 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. Presentations from the Memory Services and resus updates and developments were also well received.

9.5 The 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. Promoting equality and diversity and ending discrimination needs to become 'business as usual', and the Trust continues to work hard on developing its EDI strategy. The 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. Paul Roberts added that he had been nominated as the Lead ICS CEO for Tackling Inequality and that work was currently being scoped.

9.6 The public consultation for the new Forest of Dean Hospital was launched on Thursday 22nd October and will run until Thursday 17th December. 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

9.7 The Trust's flu vaccination programme was well underway and has already received more than 2,000 online bookings from colleagues. Peer vaccinators were doing a fantastic job of vaccinating colleagues and teams across our sites. It was noted that there would be a real push over the next 2 weeks encouraging all colleagues to take up the flu jab offer with the aim of achieving 90%. The Trust had already achieved 70%.

9.8 The Board noted the content of the Chief Executive's 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).

10.2 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.

10.3 The Integrated Locality Partnerships have now re-commenced their activities and started to revisit their priority actions moving forward, taking into account the impact of COVID. Jan Marriott asked whether the Trust's Governors could get more involved with the work of the ILPs. Angela Potter said that the Trust was fully represented on each of the integrated locality boards. She advised however, that the Trust's Service Development and Partnership Team was being restructured into a locality focused model in line with NED portfolios, and suggested that work could take place to engage with Governors within that revised structure.

10.4 The report provided an update on the ongoing system response to Covid, including 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.

10.5 The Board was asked to note that Speller Metcalfe had been appointed as the main contractor for the Forest Hospital development. Speller Metcalfe were a local construction company and had extensive knowledge of the local area and community. Marcia Gallagher said that she had received some very positive feedback about this appointment from the forest community.

10.6 The Board noted the content of this report and the partnership working taking place within the Gloucestershire ICS.

11. DIVERSITY NETWORK UPDATE

11.1 The purpose of this report was to provide an update to the Board on the recent creation of the Trust's first Diversity Network and related sub groups

11.2 One of the Trust's 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 the Trust created a Diversity Network with four sub groups; for BAME, LGBTQ+ colleagues, for colleagues with a Disability, alongside one for Women's Leadership.

11.3 Neil Savage noted that prior to creating the Network, the Trust surveyed colleagues and held a series of focus group engagement sessions to talk about the issues and experiences of BAME, Disabled and LGBTQ+. The Women's Leadership Network was already well established under the leadership of Sandra Betney.

11.4 The Network has met twice, in July and 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. The Network is 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 and administrative support for the Network and its sub groups.

11.5 The Network's next steps were to appoint a Network Chair; create a shared space on the intranet; agree the Network's Terms of Reference and agree a work and communications plan for 2021.

11.6 Amjad Uppal informed the Board that he had been approached by BAME Consultant colleagues who had expressed their thanks and appreciation to the Trust on the efforts being carried out to address the EDI agenda, in particular in relation to the efforts to carry out the Covid risk assessments for BAME colleagues.

11.7 Jan Marriott referred to terminology, noting that the "Disability" group could discourage people from participating. Many MH experts by experience did not necessarily associate their MH experience as a disability. This was noted.

11.8 Ingrid Barker welcomed the progress report and asked how the output from the Network and sub-groups would be pulled together and how the Trust could demonstrate more widely the work that was taking place. Neil Savage informed the Board that each of the sub-groups and the Diversity Network would be producing an annual report, and would ensure that this took the form of a "You said, we did" report which could clearly reflect the key areas of work being addressed.

11.9 The Board noted the progress report, the work that had taken place to date and welcomed the proposed way forward.

12. BOARD ASSURANCE FRAMEWORK

12.1 The purpose of this report was 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.

12.2 The Board noted the changes to the BAF since last presented and the movement of risk ratings, noting a reduction in risk rating applied to 2 risks. It was noted that no strategic risks had been added or removed during the quarter.

12.3 Risks relating to Covid were regularly reviewed via the Covid Programme Board. The strategic risk rating had been reviewed and no increase in risk rating was recommended at the current time. Local management expertise was in place, there are strong PPE supplies and Covid secure controls have been established. An additional Board Assurance Framework for infection prevention control was being reviewed by the Nursing and Quality Directorate and compliance would be reported to the next meeting of the Board.

12.4 The Board received and endorsed the updated Board Assurance Framework, noting the changes that had been made since previously reported.

13. COVID PROGRAMME UPDATE

13.1 This item provided an update to the Board on progress with the ongoing management of Covid.

13.2 John Campbell informed the Board that the Trust was trying to maintain access to all services. During the first wave of Covid, GHC closed 14 out of its 91 services to ensure the key services had the required capacity. Learning from the first surge, the Trust has defined three levels of service/function prioritisation. The governance framework in place aims to keep decision making as close to services as possible, with oversight at weekly Senior Operational Team meetings where service delivery is kept under review.

13.3 The Trust has established routine reporting and oversight to ensure a forward view of staffing challenges within inpatient services and ensure that systems and processes are in place to proactively fill gaps in rotas due to reduced availability of agency staff at short notice nationally. The significant workforce requirements for the mass vaccination programme were acknowledged.

13.4 In terms of testing, the GHC Pillar 1 drive thru testing team based at EJC were increasing their capacity to deliver up to 150 swabs per day. On a peak day the team were carrying out 100 tests, reducing to 50 on quieter days. Lateral Flow testing was now available for all patient facing staff. 3800 packs had been distributed, with 25 tests per pack. John Campbell advised that as of yesterday, 75 staff had carried out testing and there had been no positive tests. The availability of this testing offered the Trust good assurance around reducing rates of transmission for asymptomatic staff members.

13.5 The Board noted that all 77 GHC sites had had on site Covid Secure Environment risk assessments completed. A recent PwC audit verified that the Trust had robust processes in place and internal audits were currently being carried out following the risk assessments to ensure continued compliance with the Covid Secure Environment guidelines.

13.6 John Campbell informed the Board that a team had been assigned to carry out the modelling work required for the mass vaccination programme looking at staffing requirements and logistics such as storage and transportation. This was a huge programme and one of the most significant to date for the NHS. Supporting the programme and maintaining current service activity was going to be a challenge.

13.7 Graham Russell asked whether lateral testing would be made available for members of the public. John Trevains advised that there were no immediate plans to issue tests to the public and were currently only being used for GHC staff. He said that this would happen in the future, but not at this time.

13.8 John Trevains informed the Board that a strategic plan for the roll out of staff vaccinations was being prepared, and it was expected that vaccinations would commence at the start of December.

13.9 Ingrid Barker welcomed this helpful and informative update. She noted that the approach the Trust was taking to Wave 2 felt very different and was encouraged that the plan was to try and keep all services operational. There had been no national guidance issued in relation to governance arrangements being scaled down, as had been received during Wave 1. However, she said it was important for colleagues to be mindful of Executive Team time commitments and pressures over the coming months.

14. QUALITY DASHBOARD REPORT

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

14.2 John Trevains highlighted those Quality issues for priority development to the Board:

- 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. The Board noted that the Deputy Director of Nursing had been focussing on this priority area and great progress had been made.

- Strengthening the reporting metrics and quality monitoring for those services which have joint commissioning arrangements. John Trevains reported that the Trust Board had been updated previously on the issues relating to the Reablement Services and that the work on a service recovery plan was being progressed well. A more detailed report would be presented back to the Board in January. **ACTION**

14.3 Those Quality issues showing positive improvement:

- Significant improvement was 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.

14.4 The Board was informed that the Trust's Health and Wellbeing work, and the offering during Covid had been picked up and recognised by the World Health Organisation (WHO) who would be producing a short film highlighting the work. It was agreed that this was tremendous news and the Board congratulated all those involved in ensuring the Trust's offering was robust.

14.5 Neil Savage and John Campbell offered the Board assurance around the reported sickness absence rates at Wotton Lawn. Work was underway to review the emerging themes arising and to ensure that staff were supported.

14.6 The Board received the new format NED Audit of Complaints report, which would be integrated into the Quality Report going forward. The report covered the period quarter 4 2019/20 and offered significant assurance. The NED Audits had been delayed due to Covid but a schedule was in place to ensure that all outstanding quarters were completed and reported to the Quality Committee and Trust Board by year end.

14.7 The Board welcomed this report, and the assurances provided.

15. PATIENT SAFETY REPORT

15.1 The purpose of this report was to provide a summary of mental health and physical health Patient Safety Incidents reported during Quarter 2 2020/21. Amjad Uppal informed the Board that this was the first time that this report had

been presented in public and it would continue to be so going forward. This transparency of reporting was welcomed by the Board.

15.2 In quarter 2, a total of 11 serious incidents requiring investigation (SIRI) were reported; 1 in physical health services and 10 in mental health services.

15.3 The Board agreed that the format and presentation of the report was helpful and clear. A suggestion was made that it might be helpful to correlate the inpatient incidents with the number of bed days by way of providing more context.

15.4 Jan Marriott asked whether the Trust had seen an increase in the number of suicides/attempted suicides reported. John Trevains said that work had been carried out to review this and fortunately there had not been any upward reporting seen, as had been predicted during Covid and lockdown.

15.5 The Board noted this report and the high-level analysis of patient safety incidents. The key developments within the Patient Safety Team were also noted.

16. GUARDIAN OF SAFEWORKING – QUARTER 2 REPORT

16.1 Amjad Uppal presented the Guardian of Safe Working Hours report for the period Quarter 2 2020/21.

16.2 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.

16.3 It was reported that six exception reports were received in Quarter 2. There were no overarching themes for the exceptions raised; however, Amjad Uppal offered the Board full assurance that any exceptions raised had been addressed and actioned appropriately.

16.4 The Board noted the report and the assurance provided.

17. LEARNING FROM DEATHS – QUARTER 2 REPORT

17.1 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.

17.2 The Board received the Learning from Deaths report for Quarter 2 2020/21. In total 129 GHC patient deaths were recorded in the quarter. Further analysis was due to be carried out and reported, but there was no concern raised in

regards to the deaths that occurred and none were judged to be related to problems in care.

17.3 Amjad Uppal reported that at the time of writing the report, 6 case record reviews and investigations had been completed for deaths related to Quarter 2. These reviews were chaired by the Deputy Medical Directors.

17.4 An understanding of the impact of Covid on the Trust's mortality rates and vulnerable groups was included in the Learning from Deaths report.

17.5 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. An investigation was carried out in order to establish whether the increase in deaths during this period could be attributable to the Covid pandemic, and it was apparent that it was.

17.6 The Board noted the report and the assurance provided.

18. FINANCE REPORT

18.1 The Board received the month 7 Finance Report for the period ending 31 October 2020.

18.2 There was a Covid interim financial framework for the NHS in place for October to March 2021. 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 spent £2.222m on Covid related revenue costs between April and October.

18.3 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 was a deficit of £62k. The Trust is forecasting a year end deficit of £233k

18.4 The cash balance at month 7 was £67m.

18.5 Capital expenditure was £1.276m at month 7. The Trust has a capital plan for 20/21 of £10.182m. 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, including backlog maintenance which had been moved into this financial year from 2021/22.

18.6 In order to progress the introduction of ensuite facilities into the Montpellier Ward a full business case was being completed in November. In accordance with SFIs the Board was 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 Board approved the delegation of the review and approval of the Montpellier Ensuites Business Case to the Resources Committee, who would receive this at their December meeting.

18.7 The Board was also asked to delegate authority to the Resources Committee to review and approve the LAN/WAN Network business case. Due to reporting timescales this business case had not been referenced within the Finance report. The Board approved the delegation to the Resources Committee.

18.7 The revised recurring Cost Improvement Plan (CIP) target for the Trust was £3.230m and the amount delivered to date was £3.419m. The Trust had achieved and exceeded its CIP target for the year and the Board expressed its thanks and congratulations to colleagues and their teams for their efforts in contributing to the delivery of CIP.

18.8 Work was being carried out to look at the key financial risks for 2021/22 and these were included within the report. Sandra Betney advised that some of the risks identified had been based on assumptions on the potential financial regime, however, until this was confirmed it was difficult to set these as final risks.

18.9 Marcia Gallagher noted the challenging capital position and asked whether the Trust had the scope to spend capital on equipment for the new Forest hospital. Sandra Betney said that it would be possible however, as the FoD Hospital business case had not yet been formally approved there would be a need to refer to the SFIs. She added that it would only be possible to spend money on equipment that the Trust intended to purchase in line with the business case. Angela Potter advised that a cost for equipment was not included in the business case, with the Trust working on the basis of using equipment from the 2 existing hospital sites.

19. PERFORMANCE DASHBOARD

19.1 Sandra Betney presented the combined Performance Dashboard to the Board for the period October 2020 (Month 7 2020/21). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

19.2 At the end of October, there were 7 mental health key performance thresholds and 15 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.

19.3 The Board was asked to note that good progress was being made in terms of moving to fully integrated reporting, with the planned timescale of end of quarter 4 for completion.

19.4 Sandra Betney advised that there were 4 workforce indicators residing within the physical health section that now applied to all GHC services. These indicators would be made more prominent in future reports.

20. FREEDOM TO SPEAK UP REPORT

20.1 Sonia Pearcey, FTSU Guardian was in attendance to present her six-monthly update report to the Board. It was noted that 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".

20.2 The Board was asked to note that 42 concerns were raised in quarter 1 and 23 in quarter 2. The breakdown of concerns received was presented within the report, and looked at key themes, as well as staff group and protected characteristics.

20.3 The report also identified the planned actions and priorities for the Freedom to Speak Up agenda for the next six months.

20.4 The Board agreed that this report provided good assurance 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 and that a positive speaking up culture is reflected in the health and wellbeing offer to colleagues. The Board also supported the recommendation within the report 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.

20.5 Ingrid Barker took the opportunity to thank and congratulate Sonia Pearcey, who had been awarded an MBE in the Queen's Honours list. Huge efforts had been made to inform colleagues of how they can speak up, and this was all the more important in the current challenging times.

21. CHANGE TO THE TRUST CONSTITUTION

21.1 As part of the recent Council of Governor Review and Refresh work, the Governors had supported the proposals around changes to the composition of the Council, in particular with regard to the reduction in Staff Governors and an increase in Appointed Governor posts.

21.2 During the merger process in 2019 it was agreed to increase Staff Governor numbers to enable representation from the former Gloucestershire are 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.

21.3 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.

21.4 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.

21.5 The Board approved the proposed change to the Trust Constitution as set out in the report, noting that the Council of Governors had also approved the change at their Council meeting on 19 November.

22. COUNCIL OF GOVERNOR MINUTES

22.1 The minutes from the Council of Governors meeting held on 16 September 2020 were received and noted for information.

23. BOARD COMMITTEE SUMMARY REPORTS

23.1 Resources Committee

The Board received the summary report from the Resources Committee meeting held on 22 October 2020. This summary was noted.

23.2 Quality Committee

The Board received the summary report from the Quality Committee meeting held on 3 November 2020. This summary was noted.

23.3 Audit and Assurance Committee

23.3.1 The Board received the summary report from the Audit and Assurance Committee meeting held on 5 November 2020.

23.3.2 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 benchmarking, the Committee agreed the extension of the

current contract for a final one-year term. This extension was reported to the Council of Governors at its meeting on 19 November.

23.3.3 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 was presented to and subsequently approved by the Board.

23.4 Appointments and Terms of Service Committee

The Board received the summary report from the Appointments and Terms of Service Committee meeting held on 12 November 2020. This was noted.

23.5 Charitable Funds Committee

The Board received the summary report from the Charitable Funds Committee meeting held on 13 November 2020. This was noted.

23.6 Mental Health Legislation Scrutiny Committee

The Board received a verbal report from the MHLS Committee meeting which had taken place on 18 November, and a written summary from the previous meeting held on 23 September. This was noted.

Jan Marriott, Chair of the MHLS Committee expressed her thanks to Steve Alvis who had agreed to take on the Chair of the MHA Managers Forum meetings.

24. ANY OTHER BUSINESS

24.1 There was no other business.

25. DATE OF NEXT MEETING

25.1 The next meeting would take place on Thursday 28 January 2021.

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: 05

PUBLIC SESSION TRUST BOARD: Matters Arising Action Log – 28 January 2021

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
25 Nov 2020	3.6	An initial organisational response to the recommendations sets out in the DPH Annual Report, with specific actions and commitments to be presented to the Board in January 2021.	Paul Roberts	28 January 2021	Due to Covid operational pressures, this item has been deferred to a future agreed meeting	
	14.2	A more detailed report on progress with the Reablement Service would be presented to the Board in January 2021.	John Trevains	28 January 2021	Update on Reablement service to be provided within the Quality Report received at the January Board meeting	

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08

REPORT TO: **TRUST BOARD PUBLIC SESSION – 29 January 2021**

PRESENTED BY: Lavinia Rowsell, Head of Governance and Trust Secretary
John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: Lavinia Rowsell, Head of Governance and Trust Secretary

SUBJECT: **COVID BOARD ASSURANCE FRAMEWORK**

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

The purpose of this report is to:

To provide assurance on the management of strategic risk in relation to Covid. 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** the updated Covid-Board Assurance Framework.

Executive summary

In line with the revised Covid governance arrangements, the Covid element of the Board Assurance Framework (BAF) will be presented to the Board at each meeting alongside the report from the Covid Programme Board. The BAF has been updated in discussion with Executive colleagues.

Risks relating to 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**.** In addition, there has been significant progress in the roll of the mass vaccination programme with over 3000 members of staff vaccinated to date. An additional Board Assurance Framework for infection prevention control has been completed and will be considered under a separate item on the agenda.

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?
n/a

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

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 Leads**	**Director of Nursing**
			Chief Operating Officer

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**	January 2021
Current Risk Score	**4**	**4**	**16**	**Date Next Review**	Ongoing and February 2021
Tolerable (Target) Score	4	3	12	**Date to Achieve Target**	June 2021

Key 2021 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. Trust contribution to roll out of Mass Vaccination Programme.	

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 incident management plans in place	Covid Programme Reports Executive briefings. Board briefings.	Management	Regular Board briefings re-established		Completed	COO	Programme management approach adapted to longer term incident management. Daily Oversight Calls in place.
Covid programme established with Exec work-stream leads	Fortnightly Covid Programme Board and weekly Executive Covid discussions.	Management		Recovery programme structure in place.		COO	Programme Structure in place reporting to Exec.
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.
Covid 19 vaccination of staff	Executive review	Executive	Full vaccination of eligible staff	Continuing review of vaccination programme in line with JCVI guidelines.	Ongoing	DoNTQ	GHC working group established. >3000 GHC staff vaccinated GHC registered as vaccine hub and in receipt of AZ vaccine.

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
Plans in place for response to second surge	Executive review	Management			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. Covid Secure Environment Task and Finish Group PwC Covid secure internal audit	Management	Covid secure environments across trust.	Action plans for covid secure compliance across Trust to be finalised.	Ongoing	COO	Joint working with ICS partners. Regular review of PPE guidance. GHC stock management team established. IP&C assurance framework in place and under review. Covid secure environmental toolkit rolled out. Lateral flow testing in place. HSE assurance template and staff action plan in place. 4 new recruits to fit testing programme. 100 work-place safety reps 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
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. Establishment of Workforce Task Group – service prioritisation plans. Appointment of dedicated clinical psychologist. Recruitment and retention advisor in post
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.

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
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 20/01/20 – 99% of BAME colleagues have had a risk assessment. 73% of all other at-risk colleagues have been assessed inc. 100% of those shielding. Roll out of returning sheilders toolkit risk assessment and guidance.
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. Daily push delivery

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:

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 09

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th January 2021**

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

Inevitably how we, as a Board work, and where we are focusing continues to be impacted by the need to respond to the very significant challenges of the ongoing COVID pandemic. At the same time, we continue to balance the need to take forward our ongoing development as a Board and an organisation.

I would like to formally thank both my fellow Board members, Executive and Non-Executive, and my colleagues throughout the organisation who continue to prioritise meeting the needs of our community despite their own worries and the heavy demand we are experiencing. Every day I see and hear more about how the GHC Team are living our values and feel proud to be the Chair of an organisation where people continue to rise to meet the next hurdle. These are extraordinary times, but we are so fortunate to be an organisation made up of extraordinary people.

As part of our more regular operation 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. These sessions are well focused to ensure we are learning and developing as we go along, and taking the opportunity to learn from the last nine months. 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. These issues have been reinforced by the response to the pandemic as well as feedback from stakeholders.

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 November to 31st December 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 Non-Executive Directors and I continue to hold our monthly meetings. Virtual meetings were held on 8th December and 19th January. These meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive at this difficult time and to continuously improve the way we operate.

I continue to have regular meetings with the Vice-Chair and Senior Independent Director, along with individual 1:1s with all NEDs. During this time when in person meeting is not possible these sessions are virtual, but continue to support us to work effectively together as a team.

2.2 Board Updates:

COVID briefings – briefings have been held on 10th December and 7th January. Due to the seriousness of the present situation fortnightly briefings for Board are being scheduled. These sessions ensure the Board is up to date with the latest challenges, and can support, and where necessary challenge, and understand the difficult decisions the Executive is needing to action.

Trust Appreciation Evening - the Trust was due to hold its first awards event in the autumn of 2020, but unfortunately the COVID pandemic meant plans were put on hold and an alternative event was then planned for the evening of Thursday 26 November. This was an 'appreciation event' rather than an awards ceremony, and was an online event to say thank you to all Trust colleagues for everyone's efforts throughout 2020 to support our communities. The event also celebrated the achievements of colleagues who have worked for the NHS for 20, 30, 40 and even 50 years. There were many messages of thanks and support from all corners of the Trust and the wider communities, including some from high profile and national

figures, including the Secretary of State for Health, Matt Hancock.

Some of the highlights included a film about Coln Ward, at Cirencester Hospital, which has won the NHS Parliamentary Award for Care and Compassion, in the South West.

My thanks to the Head of Communications (Kate Nelmes) and her team for their excellent organisation of a very enjoyable and heart-warming evening.

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:

- **8th December – NHSE/I policy paper on integrating care**. This included consideration of the report's main themes: 1. Provider collaboratives; 2. Place-based partnerships; 3. Clinical and professional leadership; 4. Governance and accountability; 5. Financial framework; 6. Data and digital; 7. Regulation and oversight; 8. How commissioning will change

  The proposals within the report were out for consultation until 8th January. The Board has submitted its own response to the consultation alongside the response from the ICS. We now await feedback on this and how it is planned to take the proposals forward, recognising that the timelines may be impacted by the pandemic.

- **14th January** – **Risk Appetite and Strategic Risk** - as the Trust's Strategy and related Objectives are developed we looked at how we need to update the Board Risk Appetite and confirm our strategic risks and the related mitigations. Further work on refining the Board Assurance Framework will continue over the next few months in readiness for the new operational year in April. The formal approval of the Risk Appetite Statement, following this session was delegated to the February Audit and Assurance Committee.

3.0 GOVERNOR UPDATES

I am pleased to announce that **Chris Witham, Public Governor Forest of Dean** has been appointed as the **Lead Governor** from the beginning of January. Chris currently works as a Digital Delivery Lead in the NHS Leadership Academy and is a town councillor in Cinderford. Chris joined the Council in September and his feedback on his first meeting was *"Fantastic to see staff wellbeing and equality, diversity & inclusion as golden threads through the whole agenda. Excited for the journey ahead."* Chris takes over from Dr Faisal Khan who stood down in December after helpfully taking an important role supporting us through the transition to a significant new membership of the Council. I have arranged a schedule of regular meetings with Chris for the forthcoming year and look forward to continuing to work with him to support the development of the Council.

I would also like to welcome two new Governors who, following recent elections, were appointed from 1st January:

Laura Bailey - Public Governor (Tewkesbury)

Kizzy Kukreja - Staff Governor (Medical Dental & Nursing)

I have held introductory meetings with Laura and Kizzy.

Council of Governors meetings:

Two Governwell development sessions have taken place: **9th December** - a Governor focused session to build understanding of the key role of the Council of Governors and its place within the wider governance framework and a wider session on **21st January** for Governors and Non-Executive Directors to consider how we can best work together to meet our shared goals.

Membership and Engagement Committee - following agreement at the November meeting, a new Governor led Membership and Engagement committee has been created. This Committee is being set up to provide a dedicated focus on Membership going forward, with an initial focus being on the potential additional Appointed Governors and the development of the Trust's Membership and Engagement Strategy and aims to meet twice a year. I will Chair the Committee, which will include representation from the Trust's Communications Team, Strategy and Partnership directorate and the Trust Secretariat. An initial meeting was held on 26th January, with a further meeting arranged for 23rd February.

4.0 NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in November, I have attended a breadth of national meetings, all of which considered COVID plus more routine business:

- **NHS Providers Board** – 2nd December and 13th January - where we discussed important policy and national operational issues and current challenges and opportunities.

- **NHS Providers Chairs and CEOs Network** – 3rd December – where we received a policy and strategic update from the CEO of NHS Providers; an update on forward plans from Health Education England CEO Dr Navina Evans; an update on Brexit from Professor Keith Willett and an update from NHSI/E.

- **NHS Confederation NHS Reset Webinars** held on 7th December and 18th January 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 past months.

- **South West Region NHS Provider Chairs meeting** – a meeting was held on 18th December and a further meeting is scheduled for 10th February.

- **NHS England and NHS Improvement** – **Chairs Advisory Group** – I attended a further meeting of this important group on 21st January.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I hope to attend when my diary permits.

5.0 WORKING WITH OUR PARTNERS

I have continued my regular virtual 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 a meeting of the County's **Health Overview and Scrutiny Committee** (HOSC) on 12th January where the Committee discussed outputs from the Fit for the Future consultation; outputs from the Forest of Dean Community Hospital consultation; a performance update from South West Ambulance Service; an update on the work of the One Gloucestershire Integrated Care System (ICS) partnership.

- I attended a **joint meeting** of the County's **Health Overview and Scrutiny Committee and Adult Social Care and Communities Committee** on 26th January. The purpose of the meeting was to focus on public health updates. I was accompanied at this meeting by the Deputy Director of Strategy & Partnerships, Eddie O'Neil, where we were invited to give an update on the Trust's work in relation to COVID since January.

- Bi-monthly meetings with the **County's Health Chairs** have been scheduled for this year and a meeting was held on 12th January. These sessions are very helpful in supporting our partnership working.

- 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.**

- **ICS Board** meetings were held on 17th December and 21st January. A number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported.

- 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. As part of my Governor role, on 30th November I was invited to attend a conference which looked at **reimagining the relationship between universities and the NHS.**

- The CEO and I met with the Chair and Vice-Chancellor of the **University of Gloucestershire** on 7th January where we discussed potential partnerships and joint working. An internal meeting to further discuss this subject has been arranged for February.

- I attended a meeting of the **ICS NED and Lay Member Network** on 27th January where current priorities within the system were discussed.

6.0 WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- On 26th November I attended a **Stakeholder Listening Event – making adjustments to support those with learning disabilities in Primary Care.** This excellent event was organised by Simon Shorrick (Strategic Health Facilitator - Learning Disabilities team) in order to gain observations and experiences to help give a steer and guidance in moving forward, as well as identifying the work that partner organisations are doing as part of the co-produced communication plan.

- Unfortunately, the quarterly meeting due to be held in December with the **Chairs of the County's Leagues of Friends** had to be cancelled due to the pressure the Trust is under in dealing with the COVID situation. It was agreed that the next meeting will now take place in March 2021.

7.0 ENGAGING WITH OUR TRUST COLLEAGUES

I attended the third meeting of the **Trust's Diversity Network** on 10th December where we reviewed progress to date and a look forward to plans for the next year.

Along with several NEDs I met with the Director of Finance on 7th December to receive a **Digital update** to consider what we are already using and what developments are planned.

On 13th January, I had an introductory meeting with **James Wright**. James joins the Trust on 1st February as the Associate Director of Quality and Learning and I welcome him to the organisation.

As part of my regular activities, I 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.

Whilst drop in chats with services and colleagues need to be virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I

have an active presence on social media to fly the GHC flag and highlight great work and issues across the county.

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 November and December 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 November to 31st December 2020

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Graham Russell	Strategy – Sustainability trio Chair and Vice Chair HOSC Annual Review NEDs meetings (2) Chair (2) Director of Strategy and Partnerships (2) Resources Committee agenda planning (2)	Good Governance Institute for NEDs (2)	Board COVID briefing (2) Nomination and Remuneration Committee Audit and Assurance Committee ATOS Committee Charitable Funds Committee ICS Board Council of Governors Board meetings Board briefing ref NHS Integrated Care Resources Committee
Marcia Gallagher	Medical Director Strategy Trio Gloucestershire Audit Chairs Deputy Director of Finance Trust Chair Lead Governor Director of Finance and Steve Brittan D. Rooke (Governor) NEDS meetings (2)	MHAM Hearing (2) Good Governance Institute for NEDs (3) NHS Confederation Chairs/NEDs Trust Appreciation evening NHS Confederation Chairs/NEDs (2)	Board COVID briefing (2) Audit and Assurance Committee Charitable Funds Committee ATOS Committee Council of Governors Board meetings Board briefing ref NHS Integrated Care

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Medical Director		
Dr. Stephen Alvis	NEDs meetings (2) Quality Trio Staff Forum MHAM Forum Preparation meeting Senior Leaders Network Trust Chair	Good Governance Institute for NEDs (6 meetings) NHS Reset Chairs (2) MHAM Forum Company Secretaries / NEDs network	Board COVID briefing (2) Ethics Committee (2) ATOS Committee MHLS Committee Council of Governors Board meetings Board briefing ref NHS Integrated Care
Maria Bond	Chief Operating Officer (3) Director of Nursing, Quality & Therapies (4) Post Quality Committee meeting with Governors and Experts by Experience Reciprocal Mentoring Programme Trio meeting Sumita Hutchison (2) NED meetings (2) Senior Leaders Network Trust Chair and Trust Secretary ref governance Trust Chair Interview Panel and pre-meet for DCOO (2) Reflection on recruitment processes	NHS Reset Chairs Trust Appreciation evening MHAM Forum	Quality Committee Board COVID briefing (2) ATOS Committee Board meetings Council of Governors Board briefing ref NHS Integrated Care

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Chris Woon		
Steve Brittan	Reciprocal mentoring programme Sustainability strategy planning NED meetings Chief Operating Officer Technology Briefing Oxehealth Project meeting Digital meetings (2) Head of Sustainability interview prep Head of Sustainability interviews Head of IT ref Digital Strategy update Trust Chair	NHSP Finance for Senior Leaders course NHS Reset Chairs Visit to Oxehealth HQ, Oxford	Audit and Assurance Committee ATOS Committee Board meetings Resources Committee Board COVID briefing (2) Board Seminars Council of Governors
Jan Marriott	Strategy Trio NEDs meetings (2) FTSU Guardian New Cheltenham Governors Director of Finance Chief Operating Officer	ICS Clinical Council Reasonable adjustments webinar	Quality Committee Audit and Assurance Committee MHLSC Board meetings Council of Governors
Sumita Hutchison	People Participation meeting Head of Sustainability interview planning Linda Gabaldoni ref Health & Wellbeing Interviews for Head of Diversity	Meeting with consultant ref self-managing teams	Ethics Committee Board meetings Board COVID briefing Resources Committee

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	NED meetings Trust Chair Diversity Network (chair) Director of HR Maria Bond (2)		

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 January 2021**

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships

SUBJECT: **FOREST OF DEAN PUBLIC CONSULTATION – OUTPUT REPORT**

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 regarding the response to the public consultation on the services proposed for the new hospital in the Forest of Dean (FoD). The Trust will specifically acknowledge and respond to those areas of the consultation that are pertinent to the design and operating of the new hospital moving forward.

This report will acknowledge those aspects of the consultation that are regarding the wider service configurations but note that these will be considered by Gloucestershire Clinical Commissioning Group (GCCG) in their role as commissioner at their Governing Body meeting.

Recommendations and decisions required:

The Trust Board is asked to;

- Receive the detailed and extensive feedback in response to the public consultation on the proposed services within the new hospital in the FoD.
- Note that the GCCG Governing Body are also considering this feedback and will provide the Trust with a final commissioning specification for the new hospital services on conclusion of their commissioning deliberations.
- Consider the rationale relating to the proposed 100% single rooms and to **support the recommendation** that we remain with this proposal within the detailed design.

Executive Summary

The public consultation on the proposed service configuration for the Forest of Dean new hospital ran from the 22nd October to the 17th December 2021. The consultation process and report were led by the One Gloucestershire Communication and Engagement team.

The consultation resulted in 554 consultations surveys being completed plus some additional responses.

The consultation output report has been compiled and shared with the Health Overview & Scrutiny Committee on the 13th January 2021. The full report is available for Trust Board Members in the Reading Room or can be accessed via www.fodhealth.nhs.uk. The outputs are also to be shared with the GCCG Governing Body for consideration in order to finalise their commissioning specification for the new hospital.

Overall, the feedback to the consultation is generally not supportive of the proposals for inpatient care and urgent care. However, it is supportive of the proposals for diagnostic and outpatient services. The strength of support across all services is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district are less supportive of the proposed services for the new hospital than those in the central and northern parts of the Forest of Dean.

Qualitative feedback notes the benefit of providing services from an improved facility in the Forest of Dean, rather than having to travel to Gloucester or Cheltenham. Concern is voiced about access to the new hospital from Lydney and the south of the Forest, and the ability to provide services from a single site, whilst the population in the Forest of Dean is continuing to increase.

Many of the comments made, focussed on issues outside of the Consultation including; the decision to provide one new hospital which would result in the closure of the existing hospitals; and the agreed location for the new hospital. Whilst these comments are acknowledged the consultation was not designed to revisit historic decisions taken.

The report provides analysis in each of the four areas consulted on – inpatient services, urgent care, diagnostics and outpatient services. The majority of the feedback requires further consideration by the CCG in order for them to confirm their commissioning intentions for the new hospital. There was a small number of respondents who commented on the provision of 100% single rooms and the Trust has reconsidered its rationale around this planning assumption from an operational, infection control and quality perspective. Overall the Trust considers that there remains significant benefit from the proposal for single rooms and that with appropriate day and therapy space and location of staff bases incorporated within the ward layout the risks raised around isolation and observation can be mitigated.

Risks associated with meeting the Trust's values:	
Corporate considerations	
Quality Implications	Failure to deliver the scheme increases the ongoing risks associated with maintaining service delivery at the existing Dilke and Lydney sites in terms of both the environmental and backlog maintenance issues and the staffing resilience risks.
Resource Implications	No additional financial impact is anticipated in terms of the cost of the new FoD hospital
Equality Implications	EQIA has been undertaken as part of the consultation process including a breakdown of respondents

	demographics where provided and specific events to reach minority populations.
Working Together	The consultation has been undertaken by One Gloucestershire with strong input from both the Trust and the CCG along wide wider stakeholders

Where has this issue been discussed before?
Health Overview and Scrutiny Committee – 13th January 2021

Appendices	Outcome of Consultation Full Report in Reading Room

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

FOREST OF DEAN NEW COMMUNITY HOSPTIAL UPDATE REPORT FOR TRUST BOARD

1. INTRODUCTION

Trust Board members have received regular updates on the consultation and engagement activities that have taken place over many years in relation to this project.

This paper outlines the outputs from the public consultation on the proposed service configuration for the Forest of Dean new hospital which ran from the 22nd October to the 17th December 2021. The consultation process and report were led by the One Gloucestershire Communication and Engagement. We would like to take the opportunity to thank everyone who took the time to respond to this consultation and provide their views on the proposed services moving forward.

The consultation documentation outlined that it did not cover the decision to move from two hospital to a single site nor the preferred location for a single hospital which was previously confirmed as Cinderford following the Citizens Jury process.

2. OUTPUTS FROM THE CONSULTATION

2.1 The Consultation key facts

- 3,400 Consultation booklets distributed, 495 requests for information following door-to-door leaflet distribution.
- 20 consultation events.
- More than 250 socially distanced contacts with members of the public & community partners and over 100 with staff.
- 10 Facebook posts with a reach of over 56,000 and 200 ‘engagements’.
- 8 tweets generated over 7,000 impressions and 100 ‘engagements’.
- **554 consultation surveys completed, plus additional written responses**.

3. SUMMARY OF FEEDBACK

The consultation output report has been compiled and has been shared with the Health Overview & Scrutiny Committee on the 13th January 2021. The full report is available for Trust Board Members in the Reading Room or can be accessed via www.fodhealth.nhs.uk

The output report provides a full breakdown of all public contacts made, an update regarding Equality and Diversity Impact assessment activities and details of how the consultation sought to reach out to voices seldom heard or harder to reach communities. It acknowledges that the consultation took place in a socially distanced manner and the mechanisms put in place for the periods of lockdown when the socially distanced use of the information bus was not possible.

Overall, the feedback to the consultation is generally not supportive of the proposals for inpatient care and urgent care. However, it is supportive of the proposals for diagnostic and outpatient services. The strength of support across all services is dependent upon the individual respondent's or groups of respondents' geographical partiality. Respondents from the south of the district being less supportive of the proposed services for the new hospital than those in the central and northern parts of the Forest of Dean.

Qualitative feedback notes the benefit of providing services from an improved facility in the Forest of Dean, rather than having to travel to Gloucester or Cheltenham. Concern is voiced about access to the new hospital from Lydney and the south of the Forest, and the ability to provide services from a single site, whilst the population in the Forest of Dean is continuing to increase. Many of the comments made focussed on issues outside of the Consultation; the decision to provide one new hospital which would result in the closure of the existing hospitals; and the agreed location for the new hospital.

Taking each of the four service areas in turn;

Inpatient Care; 43.8% agreed or strongly agreed that the inpatient services proposed would meet the needs of local people whilst 52.4% of people disagreed or strongly disagreed and 3.8% were neutral. Of the 52.4% of people who felt the services would not meet requirements, 67.9% of these responses were from respondents with a South of the Forest postcode.

Qualitative feedback noted that those who agreed with the proposals for inpatient care thought the new hospital would reduce the need for travelling out of the Forest of Dean, but also recognised the need to provide high quality care in the community if the reduced bed numbers were to be sustained. Feedback from those who disagreed with the proposals asked for consideration of an increase in the local population and questioned whether the 24 beds provided sufficient capacity to support the needs of people in the Forest of Dean. There were comments about a lack of capacity across the county and the need for end of life care to be provided.

Specifically related to the proposed provision of the inpatient accommodation within 100% single rooms, 9 people specifically referenced this within their qualitative feedback. 3 out of the 9 comments were supportive of having all single rooms within the new hospital whilst the remaining 6 comments referenced aspects such as the need to ensure we mitigate social isolation, particularly for anybody who has a long length of stay and the inability for neighbouring patients to call for assistance if somebody is unable to do it for themselves.

The Trust is therefore requested to consider the previous assumption regarding single room proposals. We have therefore sought the views from operational, infection control and quality colleagues to re-confirm why we are proposing single rooms and whether we should recommend continuation with this route.

Our rationale for this design has included:

- Learning from Covid-19 which has clearly demonstrated that single rooms are a much safer option from an infection prevention and control perspective
- Increased privacy and dignity for people if they have their own room with their own en-suite bathroom
- People often feel more confident to move around their own room, reducing the risk of falls and helping people to keep mobile
- Greater use of digital technology to enable patients to keep in touch with their loved ones via virtual means outside of normal visiting hours which they can do without disturbing others if in their own room
- We have recognised the challenges around patient observation and the need to consider this within the building design to ensure risk of falls etc is minimised – The wards layout will include multiple staff observation pods rather than just a ward office to increase visibility and observation points and this can also be mitigated by the use of monitoring/sensory technology on an individual patient perspective
- The new hospital will have good social space on the ward (both a day area/dining room and a therapy area are proposed within the ward environment) where patients will be able to gather to reduce risk of isolation or loneliness
- The model of care within the unit is nursing and therapy led and patients will be encouraged to take their meals in the dining area and to participate in activities within the therapy area to work on exercise programmes, progression of mobility, range of movement, balance and other personal goals 7 days per week
- Social activities will take place within the dining and social space – encouraging small groups of patients to make their own drinks and socialise together
- The wards will have direct access to safe and theraputic garden areas to help motivate and increase engagement and activity and all indivdual rooms will have natural light and views into courtyard gardens or the main communal garden.
- Operational flexibility – incorporation of 4 bed bays further reduces the flexibility of bed utilisation and is known to impact on patient flow through the system. It increases the need for staff to do patient moves to balance the gender mix based on the daily operation need for gender specific beds on any particular day.

We were also asked to consider feedback from those who have used our existing community hospitals. Feedback from operational leads suggests that in general people who currently use our hospitals prefer to have their own bedroom but staff recognise that this can often lead them to preferring to remain in their rooms and that people then have to be actively encouraged to use the shared space for socialising and dining. This would be something that the operational team and Hospital Matron would need to be constantly mindful of as they undertake individual care planning with each patient.

The recommendation therefore from the operational, infection control and quality leads is that we stay with the proposed model of 100% single rooms but take account of this feedback in the ongoing detailed design of the new hospital.

Urgent Care; 42.6% agreed or strongly agreed that the urgent care services proposed would meet the needs of local people whilst 54.6% of people disagreed or strongly disagreed and 2.7% were neutral. Of the 54.6% of people who felt the services would not meet requirements, 71.7% of those were from respondents with a South of the Forest postcode.

The majority of the qualitative feedback centred around accessibility to a single unit from the south of the forest particularly for those who rely on public transport and the need to meet the proposed population growth. A small number of comments related to the proposed opening hours of 8am – 8pm and a desire to see this extended.

During earlier engagement about the new hospital, concerns were raised about people accessing a single urgent care facility located in Cinderford. A commitment to undertake a further review of urgent care services in the south of the Forest has therefore been made and, through this Consultation, people were offered the opportunity to be involved in this work. Almost 100 people have expressed an interest in participating in further discussions. The Trust will continue to work with the CCG and wider stakeholders including primary care as to whether there are indeed viable options for additional services within the Lydney area.

Diagnostic Services; 55.5% agreed or strongly agreed that the diagnostic services proposed would meet the needs of local people whilst 39.6% of people disagreed or strongly disagreed and 4.8% were neutral. Of the 39.6% of people who felt the services would not meet requirements, 54.8% of those were from respondents with a South of the Forest postcode.

The majority of the qualitative feedback centred around a positive impact of accessing services within the Forest to save the need to travel to Gloucester or Cheltenham, particularly if these are available 7 days per week. The accessibility issues from those travelling from the South of the Forest to a single diagnostic hub was also noted within the comments received.

Outpatient Services; 54.4% agreed or strongly agreed that the outpatient services proposed would meet the needs of local people whilst 41.5% of people disagreed or strongly disagreed and 4.2% were neutral. Of the 41.5% of people who felt the services would not meet requirements, 59.5% of those were from respondents with a South of the Forest postcode.

Qualitative feedback noted support for the proposals which would result in a reduced need to travel outside the Forest of Dean, and a desire to continue to increase the range and type of outpatient services delivered locally but also reflected the overall difficulty in accessing services for those living in the south of the Forest.

4. RECOMMENDATIONS AND NEXT STEPS

The Trust welcomes the feedback provided by the local population and their continued input in shaping the service provision within their new hospital. We recognise that the Trust needs to continue to work with wider system partners to ensure we get the right balance of local service provision to meet the needs within each of our communities and that this consultation is a key component of that exercise.

The Trust Board is therefore asked to:

- Receive the detailed and extensive feedback in response to the public consultation on the proposed services within the new hospital in the FoD.
- Note that the CCG Governing Body are also considering this feedback and will provide the Trust with a final commissioning specification for the new hospital services on conclusion of their commissioning deliberations.
- Consider the rationale relating to the proposed 100% single rooms and to **support the recommendation** that we remain with this proposal within the detailed design.

Angela Potter
Director of Strategy & Partnerships

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 12

REPORT TO: **TRUST BOARD PUBLIC SESSION - 28th January 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD – DECEMBER 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:

- **Receive, note** and **discuss** the December 2020 Quality Dashboard

Executive summary

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

Quality issues for priority development

- Monitor and drive progress against the Physical Intervention Training recovery plan. The recovery plan has been developed and will be reviewed at January's Quality Assurance Group, prior to ongoing reporting via the Quality Dashboard.
- Monitor and drive improvements in Resuscitation Training compliance figures. Level 3 Resuscitation Training figures for Mental Health and Learning Disability (MH&LD) services remain low. A bespoke Level 3 MH&LD (MERT) course has recently been added to the training system, aimed at increasing compliance.

- Lead a piece of work to understand if the reported increase in bed occupancy correlates with an increase in overall falls, wound care issues and impact that Covid-19 has had on staffing
- Jointly develop with operational colleagues a new ICT staffing and quality of care data set to commence reporting from February 2021.
- Continue to address Trust wide inpatient vacancies, led by operations with support from Nursing Therapies and Quality directorate**.**

Quality issues showing positive improvement

- The Trust is compliant with new national Patient Safety Strategy requirements to have identified specialists and ensure a strategy delivery group is in place
- Good progress made by the Trusts Patient Safety Team in progressing delivery of the digital patient safety monitoring system for inpatient areas.
- Good performance in areas of previous concern; IAPT, EIP and VTE assessment which maintaining compliance despite service pressures.
- New Birth Visits were at 97.7% in December and above the 95% threshold for the first time this year.

Are Our Services Caring?

Whilst it should be noted that there is an increase in the number of complaints received in December when compared with historical averages good assurance is available that these are being responded to in a timely fashion. Potential hotspot areas are identified swiftly and engagement with appropriate senior clinical colleagues is sought to provide independent challenge to ensure that all areas of learning are identified.

Numbers of compliments received have remained largely static during Quarter 3 and are at 50% of the pre Covid-19 monthly average. FFT response rates are improving and the level of satisfaction was at 96%. The Board are asked to note that this is above threshold.

Are Our Services Safe?

Incident reporting rates have increased during December and the percentage of patient safety incidents meeting moderate, severe and death thresholds increased to 8.2%. Further analysis reveals that this is due to an increase in Categories 1-3 of Acquired Pressure Ulcers. Robust systems and processes remain in place to monitor Covid-19 related activity. In December, 851 frontline colleagues were vaccinated and this figure has increased significantly in January.

Are Our Services Effective?

System pressures reported last month continue to increase demand for community hospital beds and increase occupancy levels. Cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in inpatient services, the Early Intervention Services, and mental health community teams. Auditing of this was paused through Covid-19 disruption but an audit is being developed for January-March Q4 2020/21 to enable us to report on this KPI at year-end. Early Intervention Services retained the 100% compliance with KPIs first seen last month, and IAPT services continue to perform above threshold for the seventh consecutive month.

Are Our Services Responsive?

Single Point of Clinical Access (SPCA) calls offered (received) has continued to exceed the set threshold due to changes in services offered (this also explains previous lower reported numbers), threshold target to be adjusted for future reporting. CPA compliance reduced slightly in December and work continues in efforts to understand if the increased community impact of Covid-19 seen both locally and nationally is impacting on performance due to delayed appointments. The agreed inclusion of virtual appointments (video calls and telephone contacts for those families who would prefer not to have face to face contacts) for Health Visiting Services has positively impacted upon recorded performance levels despite there being some variation seen this month, most notably on the percentage of children who received a 2-2.5-year review by 2.5 years.

Are our Services Well Led?
Health and Wellbeing support remains a key organisational drive, the Board are asked to note the peer support sessions provided at both Lydney and Cirencester Hospitals following the outbreaks there and the associated increased demand on ward colleagues. Majority of face to face mandatory training remains paused but updates are supplied on the robust recovery plan developed for Resuscitation Training. Sickness absence levels have remained broadly consistent since April 2020 but are above the Trust target of 4.00%. A range of measures and initiatives to support staff health and wellbeing continue to be promoted and implemented.

Risks associated with meeting the Trust's values
Specific initiatives or targets 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?
Quality Assurance Group and monthly reports to Quality Committee

Appendices:	December Quality Dashboard

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

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AGENDA ITEM: 12.2

Quality Dashboard 2020/21

Physical Health, Mental Health and Learning Disability Services

Data covering December 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?
The increase in complaints initially seen in November has continued in December, this follows a reduction in complaints through Q1 & 2 , partly influenced by the initial Wave 1 national lockdown. Positively performance in response to acknowledging complaints has returned to 100%. At the NED meeting in December, members decided to postpone the NED audit of complaints due to Covid disruption in Q1 and Q2 2020/21, work to progress the Q3 audit is underway. Numbers of compliments increased slightly this month but it is noted that this is approximately a 50% reduction in compliments received compared to 2019/20 figures. FFT responses have improved and levels of satisfaction are at their highest reported rate this year and are above threshold. Additional teams continue to arrange for the inclusion of the FFT at the end of Attend Anywhere consultations.

Are Our Services Safe?
Incident reporting rates increased in December and the percentage of patient safety incidents meeting moderate, severe and death thresholds increased from November (5.95%) to December (8.20%). Analysis reveals that there has been an increase in reported Categories 1-3 of Acquired Pressure Ulcers; a Datix Dashboard has been developed to enable services to monitor prevalence in real time and improvement plans continue to be implemented. A piece of work has been initiated to understand if the reported increase in bed occupancy correlates with an increase in overall falls, wound care issues and impact that Covid-19 has had on staffing. There is good progression and completion of SIRI investigations, with learning being disseminated via the Incidents on a Page documents. The percentage of inpatients with VTE Risk Assessment completed in inpatient settings has continued to exceed the 95% target in December for the seventh consecutive month, with compliance now reaching 100%. Twelve Covid-19 deaths were reported by inpatient services during December. Community infection rates continue to rise in line with the national situation. Stocks of PPE remain good and increasing numbers of staff are being fit-tested. Numbers of staff vaccinated for Covid-19 are included in this month's dashboard, with 851 frontline colleagues vaccinated in December with their first dose. Good progress has been made with implemented the National patient safety strategy with regular Trust wide development meetings taking place led by the Trust Medical Director. Also good progress made with development of the Trusts digital patient safety programme to introduce an enhanced inpatient monitoring system to improve patent safety.

Are Our Services Effective?
System pressures reported last month continue to increase demand for community hospital beds and delayed discharges further compound this. Early Intervention Services retained the 100% compliance with KPIs first seen last month, and IAPT services continue to perform above threshold for the seventh consecutive month. The average length of stay for inappropriate out of area placements increased from 9.6 (November) to 17.8 (December) bed days due to bed pressures. Cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in inpatient services, the Early Intervention Services, and mental health community teams. Auditing of this was paused through Covid-19 disruption but an audit is being developed for January-March Q4 2020/21 to enable us to report on this KPI at year-end.

Are Our Services Responsive?
Integrated Care Team therapies activity continues to be sustained at pre Covid-19 levels. Single Point of Clinical Access (SPCA) calls offered (received) has continued to exceed the set threshold due to changes in services offered (this also explains previous lower reported numbers), threshold target to be adjusted for future reporting. CPA compliance reduced slightly in December and work continues in efforts to understand if the increased community circulation of Covid-19 seen both locally and nationally is impacting on performance due to delayed appointments. The agreed inclusion of virtual appointments (video calls and telephone contacts for those families who would prefer not to have face to face contacts) for Health Visiting Services has positively impacted upon recorded performance levels despite there being some variation seen this month, most notably on the percentage of children who received a 2-2.5 year review by 2.5 years. Paediatric SALT and Physio referral to treatment times were 100%.

Are our Services Well Led?
The initial pause on statutory/mandatory training was lifted in July 2020 but had to be reinstated with the second lockdown in November . Overall compliance reduced from 87% (November) to 84% (December). There is a revised process in place for monitoring Resuscitation Training (which has to be provided face to face) via Quality Assurance Group (QAG). A similar process for monthly monitoring of restrictive intervention training (PMVA and PBM) will be reported to QAG in January, with subsequent reporting of compliance via this dashboard. Appraisal compliance is sustained at 78% for the second month. Sickness absence levels have remained consistent since April 2020 but are above the Trust target of 4.00%. A range of measures and initiatives to support staff health and wellbeing are being promoted and implemented.

The Quality Dashboard 'deep dive' sections on individual services remain paused due to the system pressures on operational services and quality infrastructure staff supporting frontline services. This will resume when the situation improves.

Quality Dashboard

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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 Inpatient Deaths reported to CPNS	N-R			30	7	1	0	0	0	0	4	12				54			N/A
2	Total number of deaths reported as C-19 related.	L-R			65	17	4	1	0	1	1	11	15				115			N/A
3	No of Patients tested at least once	N-R			195	214	226	261	291	270	301	302	296				2356			N/A
4	No of Patients tested C-19 positive or were admitted already positive	N-R			116	39	4	1	0	0	2	27	103				292			N/A
5	No of Patients discharged from hospital post C-19	N-R			27	52	18	3	1	0	0	6	32				139			N/A
6	Community onset (Positive specimen <2 days after admission to the Trust)	N-R					0	0	0	0	0	0	11				11			N/A
7	Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)	N-R					0	0	0	0	0	0	6				6			N/A
8	Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)	N-R					0	0	0	0	0	2	7				9			N/A
9	Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust	N-R					0	0	0	0	1	8	14				23			N/A
10	No of Staff and household contacts tested	N-R			276	521	104	57	204	342	215	517	328				2564			N/A
11	No of Staff and household contacts with confirmed C-19	L-R			85	38	0	0	0	7	12	46	80				268			N/A
12	No of Staff self-isolating new episodes in month	L-R			597	174	63	39	43	49	153	413	279							N/A
13	No Staff returning to work during month	L-R			333	118	25	10	28	30	54	347	238							N/A

Additional Information

Patient Reporting

The number of Covid-19 (C-19) related patient deaths has increased during Dec 20, corresponding with the 2nd wave of the pandemic. 12 inpatient deaths met the criteria for national reporting to CPNS. 15 patient deaths were reported to be C-19 related in Dec 20. Total to date C-19 deaths by hospital site/community team are shown in the graph opposite. Patient deaths will be subject to further system wide mortality reviews in line with guidance

Patient Testing

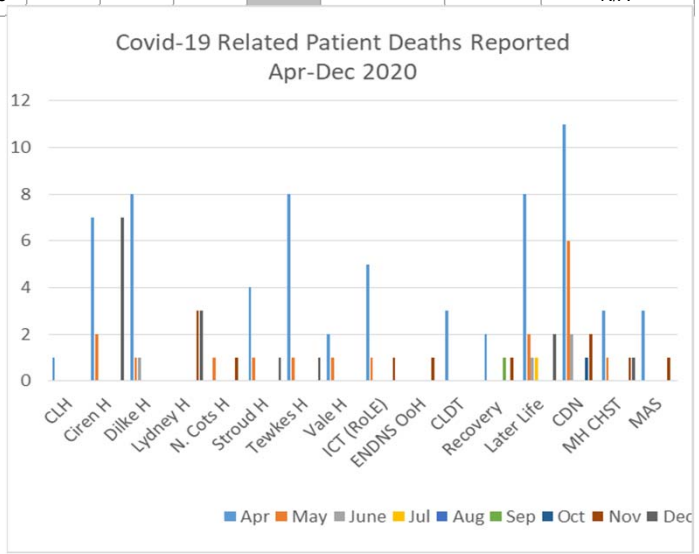
Figures for patients tested remains consistent, in line with national testing guidance. There was an anticipated rise in the number of positive patient results, in line with the national dataset. As agreed with ICS Bronze IPC Call, GHC undertakes inpatient testing on days 1,3,5,7 and 10. This is above national recommendation on frequency but is a local enhancement to improve system wide surveillance. A quality audit to monitor and seek assurance of compliance is planned for January 2021.

Staff and Household Contacts Testing

Number of staff tested in December is lower than the previous month but the proportion of positive tests is higher.

Infection Prevention and Control - Covid 19

The IPC team receive confirmation emails of all C-19 positive results and record the information on a local password protected database. The Community onset cases and HOIHA are likely to be attributable to transfers to GHC from other healthcare settings and/or admissions. facilitated via GP's as the patient has potentially been exposed to C-19 prior to their transfer.
HOPHA are likely to be nosocomial cases and HODHA are definite nosocomial cases and the reported associated Community Hospital outbreaks support this likelihood. Irrespective of time spent in a previous healthcare facility, cases are determined by admission to GHC being recorded as day 1. Al outbreaks are subject to IPC team investigation and sharing of learning.



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

Staff Vaccinations

The Staff Vaccination programme led by Gloucestershire Hospitals Trust commenced in December via the GHT vaccine hub at the Gloucestershire Royal site with the Pfizer Biontech vaccine . **851** members of GHC staff had been vaccinated with their first dose in December with priority being given initially to those staff identified via working well risk assessments as being at a higher risk of ill health. Further extension of the programme included identifying those at a high risk of exposure to Covid. The figure is significantly higher for January and progress will be monitored and reported in future Dashboards, together with a description of surveillance methodology. The January dashboard will provide data in relation to inpatients who have been vaccinated.

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 Trust continues to maintain 14 days supply of all key PPE items at central stores and are maintaining 14 days of supplies at each PPE locality hub in readiness for inclement weather.

PPE for the delivery of the Covid-19 vaccination will be provided with the vaccine itself and so there will be no impact on the current stock levels, although the team are ready to support the provision of PPE should the planned PPE with the vaccine not arrive in the early days.

All Clear Masks that teams requested have now been issued, leaving a small number remaining with the stock team in the event of further requests.

FFP3 fit-testing

Fit-testing compliance data as at 08/01/2021 shows that a total of **853** colleagues have been successfully fit-tested, representing 76% of the target number who require testing.

Due to the changes in the FFP3 mask provision, a re-focus of the fit-testing programme has been carried out. As of the 04/01/21, 4 additional colleagues have been redeployed to the fit-testing team. These individuals are now all trained and fit-testing colleagues with alternatives to the 8833 and Cardinal masks. A review of the data collection for this re-focus is underway as it is important that the activity associated with this is captured to provide assurance on the progress as a subset of the total fit-test activity. This data will be provided for the next quality dashboard.

Funding for the qualitative fit-testing machines has been approved and the machines are expected to be delivered imminently, with the company providing training to the recently expanded fit-test team.

Quality Dashboard

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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	RAG	Exception Report?	Benchmarking Report
	Number of Friends and Family Test Responses Received	N - T	15%	33836	Suspended			699	496	1179	1631	1427	1466				6898			
	% of respondents indicating a positive experience of our services	N - R	95%	88%	Suspended			93%	93%	93%	94%	94%	96%				94%			
	Number of Compliments	L - R		2,938	228	58	166	74	67	159	123	117	123				1115			
	Number of Concerns	L - R		620	31	24	44	60	31	45	25	20	25				305			
	Concerns escalated to a formal complaint							2	1	0	0	2	3				8			
	Number of Complaints	N - R		117	5	6	1	4	6	5	1	16	13				57			
	Number of open complaints (not all opened within month)							33	38	41	38	53	64							
	Percentage of complaints acknowledged within 3 working days							100%	86%	100%	100%	88%	100%				96%			
	Number agreeing investigation issues with complainant							7	10	13	11	23	25							
	Number of complaints awaiting investigation							2	1	0	1	0	5							
	Number of complaints under investigation							6	9	9	6	6	9							
	Number of Final Response Letters being drafted							12	12	11	9	12	13							
	Number of Final Response Letters awaiting Exec sign-off							0	0	2	0	0	2							
	Number of complaints closed							4	1	2	4	1	1							
	Number of re-opened complaints (not all opened within month)							5	4	4	3	3	4							
	Current external reviews							4	4	3	2	3	3							

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

Complaints, concerns and compliments

- The average number of complaints received in December over the past four years is **8**. In December 2020 we received **13 complaints**.
- In December 2020, **1** complaint was closed. Whilst this complaint was **not upheld, l**earning was identified and will be shared with the relevant team.
- In December 2020, PCET worked with **20** patients and carers to resolve their concerns. This is a decrease compared to November 2020 and significantly lower than the monthly average of 52 concerns in 2019/20.
- **123** compliments were recorded in December 2020 and whilst this is very similar to the number received in November 2020, it remains lower than the monthly average of 245 during 2019/20.

Assurance regarding recent increase in complaints

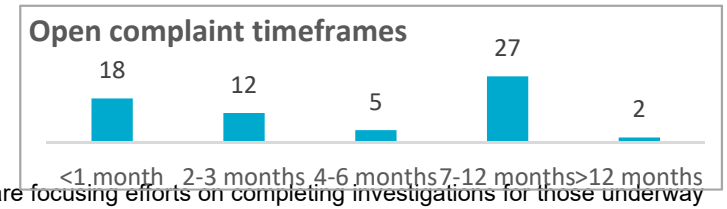
- Each complaint is triaged to check for any immediate actions required.
- Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- Within our *open complaints, the following hotspots have been identified and flagged to appropriate senior colleagues:
- Wotton Lawn (n=10): the use of the Mental Health Act, care and treatment and communication .ICTs (n=9): wound care, end of life care, and communication. Recovery Teams (n=9): care and treatment, discharges, referrals not being accepted, and communication.
- Herefordshire services (n=7): communication and the use of the Mental Health Act. Worcestershire Health and Care Trust are partners in the investigations.

*As these are the themes from open complaints, investigations have not been completed and so it has not been identified whether these issues will be upheld/not upheld.

Timeframes

- PCET remains in active recovery following the national pause in the complaint management process between April and June 2020.
- All of the **13** complaints received in December 2020 were acknowledged within the 3-day target timeframe.
- Of the **64** open complaints, **14** do not have agreed response times. Of these 14:
    - **6** have been delayed due to Covid-19 (coronavirus), e.g. complaints were received either during or very 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 were received in 2019 but an investigation was not possible due to the availability of a member of staff who was key to the investigation.

- Of the **50** complaints with agreed response dates:
    - **31** are within the agreed timeframe
    - **19** exceeded the initially agreed timeframes, and of these:
        - **3** responses were due before the pause
        - **7** responses were due during the pause
        - **9** responses were due following the end of the pause



The chart opposite shows the timeframes for all open complaints, inclusive of the 3 month national pause. The PCET are focusing efforts on completing investigations for those underway for the longest period. Additional resource has been secured via redeployed colleagues and 2 existing members of the team have agreed to temporarily increase their working hours. The recent rise in complaints is adding to the team's current workload.

Satisfaction with complaints/concern processes

- **4** active re-opened complaints
- **20** concerns were closed in December 2020, of which **3** were escalated to complaints

Internal review

- At the NED meeting in December, members decided to cancel the NED audit of complaints of the two quarters delayed due to Covid (Q1 and Q2 2020/21)
- The Q3 2020/21 NED audit is in progress

External review

- There are currently **3** complaints with the PHSO for external review; these are complaints from 2016, 2017 and 2019.

Surveys

- PCET are leading work to develop an action plan based on the CQC Community Mental Health Survey results. This will involve operational colleagues and Experts by Experience.
- Friends and Family Test (FFT) paper surveys are due to be relaunched in early 2021.
- A number of new teams, including Adult SLT, Bone Health, Community Dental Services, Diabetes, Heart Failure, Podiatry, MSK Physio, MSKAPS, ASC, ADHD, Eating Disorders, CYPS and CAMHS, have now arranged for the inclusion of the FFT at the end of Attend Anywhere consultations.

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	0				0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		49	4	3	3	7	2	5	1	3	2				30			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	0				0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		6	0	1	0	1	0	0	1	0	0				3			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		5	0	0	1	0	0	0	0	1	0				2			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		18	2	0	0	4	2	3	0	1	1				13			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	1	1				9			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		1	0	0	0	0	0	0	0	0	0				0			N/A
	Total number of Patient Safety Incidents reported	L - R		12,109	689	867	1002	1052	1140	1083	1132	1076	1147				9188			N/A
	% incidents resulting in low or no harm	L - R		94.71%	90.42 %	92.62 %	93.01 %	94.68%	94.82 %	95.38%	93.46%	94.05 %	91.80%				n=8591 93.50%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		5.29%	9.58%	7.38%	6.99%	5.32%	5.18%	4.62%	6.54%	5.95%	8.20%				n= 597 6.50%			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%	4.24%	2.44%				2.91%			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%	0%	0%				1.19%			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	0				0			N/A

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

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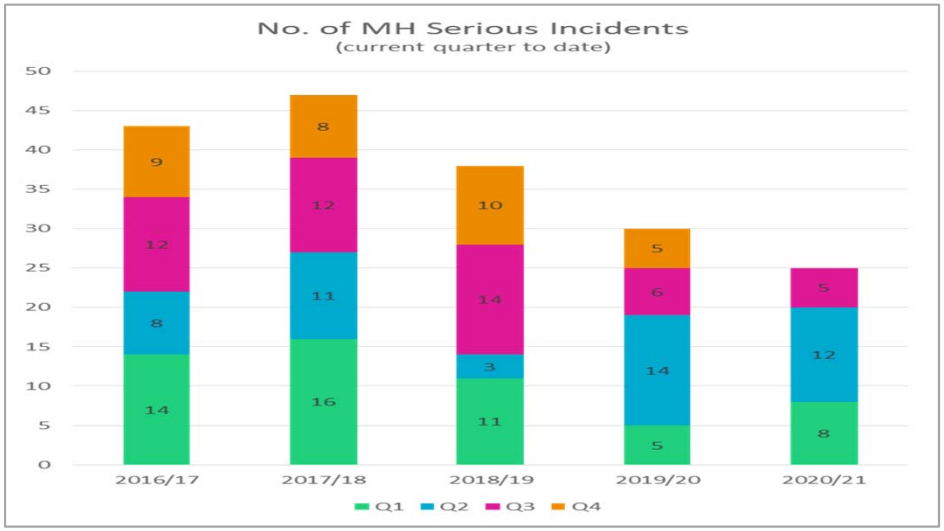
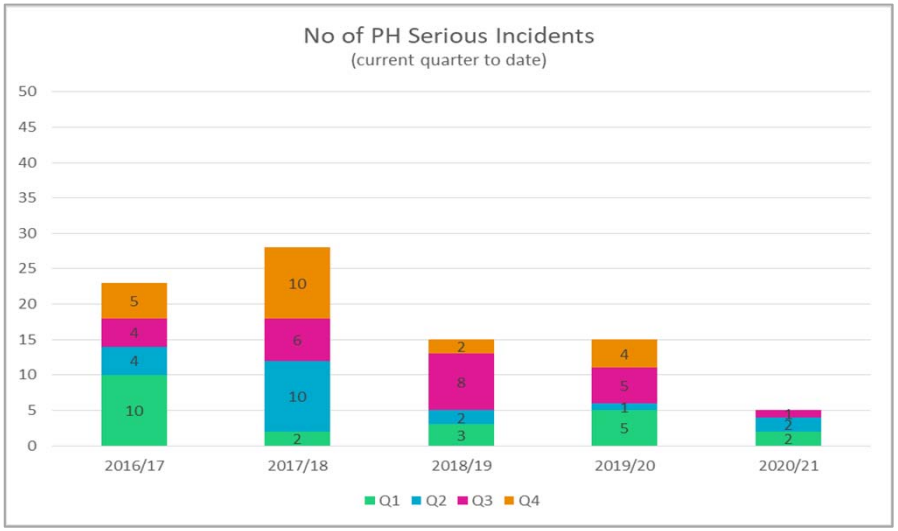
ARE SERVICES SAFE? – additional information

Two SIRIs were declared in December 2020, both in mental health 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 Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues in order to determine that Covid disruption was not noted as a theme in mental health SIs during the pandemic.





Five SIRI final reports, all Mental Health, were completed during December 2020. Three Incidents on a Page (IoaP) have been disseminated for discussion throughout the Trust to promote learning. Two additional IoaP remain outstanding. All Incidents on a Page documents are uploaded to the Trust intranet.

There are currently 6 active SIRIs. All current active SI investigations are on target to complete within statutory time frames.

Regarding all patient safety incidents:

- The total number of patient safety incidents rose from November (1076) to December (1147).
- The percentage of patient safety incidents resulting in moderate or severe harm and death increased from November (5.95%) to December (8.20%). This is attributed to a rise in reported Category 1,2 and 3 acquired pressure ulcers, which is explored further in Slide 8.
- The percentage of falls resulting in moderate and above levels of harm decreased from November (4.24%) to December (2.44%). There were 4 moderate harm falls in both November and December, with one severe harm fall in November. The number of no harm and low harm falls increased from November (113) to December (160), reducing the percentage of falls resulting in moderate and above harm.
- No medication errors resulted in moderate or above harm in December.
- To note, there have been some minor adjustments to total numbers of patient safety incidents for previous months due to reclassification of some incidents. 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? 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%	95.2%	100%				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	60	70	72	63	59	47	65	62	83				579	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	737	53	68	66	59	52	41	50	51	68				508	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	46	3	1	3	3	6	6	12	6	13				53	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	8	4	1	3	1	1	0	3	2	3				18	R		

Additional information

VTE Risk Assessment

The percentage of inpatients with VTE Risk Assessments completed in inpatient settings has continued to exceed the 95% target for the seventh consecutive month, with compliance now reaching 100%.

Safety Thermometer

Reporting remains suspended due to Covid-19 in agreement with commissioners.

Focus on Pressure Ulcers

Quality Improvement (QI) groups have been temporarily suspended in December and January in order for colleagues to be redeployed to support clinical frontline services and this includes partial redeployment of the Clinical Pathways Leads (CPL).

In January, the improvement and assurance plan for Gloucester ICTs has been completed and presented by the community manager (CM) to the Head of ICTs and CMs from all ICT localities.

The focus to provide evidence of learning and improvement for assurance has been realised by an emphasis on locality ownership of incidents and a key support has been in the form of a pressure ulcer live dashboard in Datix. This enables the CM and PL to have instant information on the type and number of pressure ulcer incidences. The Gloucester team report that this dashboard has been an excellent tool in helping them to ensure best practice and treatment for patients.

Forest and Tewkesbury (F&TNS) ICT is continuing to develop an improvement plan using similar approaches and embracing the live pressure ulcer dashboard tool. F&TNS will necessarily have a different focus, particularly around MDT engagement in recognition and treatment of patients at risk of developing pressure ulcers, as these were the themes highlighted by the panel review of F&TNS incidents. In order to accelerate embedding the tool within F&TNS locality the pressure ulcer clinical pathways lead has been redeployed to that locality to provide senior District Nursing support whilst continuing to meet the trajectories for rolling out the tool.

Pressure ulcer webinars for the Patient Safety Team to enhance their knowledge of pressure ulcer management and risk hosted by the CPL have been reported as very helpful, with further virtual sessions arranged for February. A similar approach for newly recruited community nurses commencing in Tewkesbury is planned, based on the successful ‘everybody’s business’ approach, which is used across GHC.

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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%	94.3%	93.8%	92.9%				86. 2%	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%	87.5%	100%	100%				75.0%	G		
	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: * auditing paused through Covid-19 Disruption **– Re audit being developed for January**																			
	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%	59.0%	53.6%	55.2%	53.7%				52. 2%			
	Admissions to adult facilities of patients under 16 years old.	N - R		0	0	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	9.6	17.8				15.6	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 Childhood 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 January 2021							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 January 2021							0.0%	R		

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CQC DOMAIN - ARE SERVICES EFFECTIVE?

Additional Information

Bed Occupancy

The demand for community hospital beds continues to increase in response to multi faceted delays across system discharge pathways. System partners are regularly reviewing options to target existing resource which includes the re-allocation of system therapists to the Home First discharge model jointly delivered by the Trust. A piece of work has been initiated to understand if the reported increase in bed occupancy correlates with an increase in overall falls, wound care issues (pu's) and impact that Covid-19 has had on staffing.

Mental Health

The IAPT recovery rate indicator continues to exceed the required threshold and this has been maintained for 7 months.

Monthly and year to date data for the Early Intervention in Psychosis (EIP) service demonstrates that the service has now met the target threshold for the fourth consecutive month, and maintained 100% during December.

Cardio-metabolic assessment and treatment for people with psychosis is delivered routinely, although auditing was paused through Covid-19 disruption. An audit is being developed to be undertaken for January-March Q4 20/21

Length of stay (bed days) - inappropriate out of county placements

The average length of stay for inappropriate out of area placements has risen to 17.8 bed days within the month of December. This relates to 3 acute and 2 PICU placement. The 3 patients requiring an acute placement were due to no bed availability within county. One PICU patient required a female-only ward whose needs could not be managed on Greyfriars ward. The 2nd PICU placement required out of county care for specific needs.

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	0.13	0.14				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%	94.8%	94.9%	95.9%				96.1%	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%	98.5%	98.3%				91.2%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	83.5%	81.1%	62.6%	93.6%	94.9%	98.4%	99. 5%	99.2%	97.8%	96.9%				93.9%	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%	98.6%	100%				93.3%	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%	97.4%	100%				95.9%	G		
	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%	98.8%	99.5%				98.7 %	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	35939	1787	1731	1774	1712	1702	1746	1835	3661	3567				19515	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	96.9%	88.9%	89.7%	88.6%	90.1%	91.7%	93.4%	95. 4%	93.0%	92%				91.4%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	100.0%	96.8%	100.0%	100%	100%	100%	100.0%	100.0%	100%	100%				99.6%	G		

Additional information

MIIUs

- The Dilke remains closed as part of the Covid-19 response.
- The Vale closed on 14th December to allow for PCNs to deliver Mass Vaccinations on the site
- 5 remaining units all open 8am -8pm, 7 days per week

ICTs

- For the fifth consecutive month, ICT therapy services have maintained or exceeded the required threshold indicators.
- The Single Point of Clinical Access is reporting exceeding the required threshold in December. Data quality work is underway to understand Single Point of Clinical Access (SPCA) Calls Offered (received) performance from April to September.

Mental health

- CPA compliance continues to reduce marginally. Work to understand if the increased community circulation of Covid-19 seen both locally and nationally is impacting on performance due to delayed appointments has been currently paused due to quality staff supporting frontline services in December .
- CRHTT has continued to achieve 100% compliance with gatekeeping admissions to hospital for the seventh consecutive month this year.

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Quality Dashboard

NHS
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	66.6%	66.6%	66.6%	66.6%	66.6%	81.8%	93.1%						72.6%	R		November: project completed. Year-end mop-up completed
Number of Antenatal visits carried out			944	46	42	35	24	24	40	65	44	56				376	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%	87.9%	94.2%	97.7%				73.56%	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%	81.9%	95.6%	95.9%				74.3%	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%	76%	72.3%				71. 5%	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%	78%	78.6%				87.6%	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%	64.3%	71.0%	64.8%				65.2%	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%	55.0%	55.1%				56.0%	A		
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	1929	895	676	844	963	1233	1047	1064	1013	1098				981			
Number of Positive Screens		169	1329	53	40	50	57	73	62	63	60	65				523			
Average Number of Community Hospital Beds Open		196	195.4	173.3	168.8	155.8	162.5	177.7	177.6	177	173	176.3				171.3	R		
Average Number of Community Hospital Beds Closed		0	1.1	22.3	27.2	40.2	33.5	18.3	18.4	19	23	19.7				24.7	R		

Additional Information

Data shown from October 2020 onwards is inclusive of virtual methods – video calls and clinical telephone contacts.

Vision Screening: paused due to school closure**.**

Health Visiting: Antenatal contacts are delivered face to face (F2F) for those who accept a targeted offer. Group universal contacts are commencing from February 2021. There is no formal KPI for this indicator

NBV 97.7%: these are being delivered predominately F2F 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 in the home when the family will allow the practitioner access into the home.

6-8 week review 95.9%: these are being delivered both virtually and F2F, dependent on the health visiting assessed level of service and where families are reluctant . All families who are not seen are tracked and reoffered a family health needs assessment

Ages and Stages Developmental reviews 9-12 months and 2-2.5 years- All children are offered a developmental review. A virtual contact is currently being offered to all universal families and if any concerns are identified by the practitioner or raised by the parent, they will be invited into a F2F appointment in a COVID secure setting. All outstanding requests are being managed as part of the recovery process. A number of parents previously assessed as Universal initially asked to delay the developmental assessment until F2F available. Now when offered F2F in COVID safe clinic are declining the review as have no concerns with their child's development. Public Health messages are discussed over the phone and SMS sent with links to HV website and social media pages. Families that are assessed as having an enhanced service of Universal Plus and Universal Partnership Plus are offered F2F contacts within the home to ensure a full Family Health Needs Assessment is undertaken.

Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks – 79.6 % (target is 80%). This figure shows the maintenance rate of breastfeeding mothers which is GHC activity but not shown in this dashboard .The overall figure for breastfeeding reported in the dashboard is impacted by initiation, which is GHT activity. If less of the cohort commences breastfeeding then this will impact GHC delivery of the 58% target.

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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%	86%	87.0%	84%				86.4%	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%**	78%	78%				69.9%	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%	4.84%	4.56%				4.94%	A		
	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 in line with national guidance. As an alternative, the Trust takes part in the Covid-19 People Pulse survey. The out-turn of this survey is reported to the Trust Board every 2 weeks and is discussed in detail at the Trust Health and Wellbeing group with survey findings informing future interventions.

Mandatory training, appraisal and absence

The initial pause on statutory/mandatory training was lifted in July 2020 but was reinstated in October. A number of courses have been converted into on-line delivery and virtual Corporate Induction commenced in November. 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-19 compliant. Resuscitation Training compliance is being monitored via the Quality Assurance Group (QAG) and the latest compliance figures are included in Slide 14. As Physical Intervention training continues to show reduced compliance, a recovery plan is being developed which will be reported to QAG in January 2021 with compliance figures being reported in this dashboard from February 2021.

Appraisal compliance has remained the same for December and currently stands at 78% against a target of 90%. 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 remain above the Trust target of 4.00%. Sickness absence levels for December are 4.56%

Staff Health and Wellbeing

The Health and Wellbeing (H&WB) hub meets fortnightly and recent discussions have considered how best to build morale and resilience during the current Covid-19 surge.
Peer support sessions have been provided recently at Lydney and Cirencester hospitals following Covid-19 outbreaks/increased demand.
Charitable funds have been used to increase the individual psychological therapy/counselling resource for staff within Working Well and to appoint a dedicated Clinical Psychologist for staff health and wellbeing, coming into post in January. This role will support the work that has already started and provide strategic direction for H&WB work within the Trust going forward.

Discussions are underway to finalise how best to spend monies that have come into Gloucestershire to facilitate the development of an ICS-wide staff mental health hub.

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 WELL LED?

Safe Staffing Mental Health Inpatient – December 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	192.5	25	47.5	6	0	0	0	0	0	0
Priory	285	38	15	1	0	0	0	0	0	0
Kingsholm	22.5	3	10	1	0	0	0	0	0	0
Montpellier	0	0	77.5	10	0	0	0	0	0	0
Greyfriars	295	32	0	0	0	0	0	0	0	0
Willow	7.5	1	25	3	0	0	0	0	0	0
Chestnut	22.5	3	22.5	3	0	0	0	0	0	0
Mulberry	0	0	15	2	0	0	0	0	0	0
Laurel	37.5	5	0	0	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	60	7	205	20	0	0	0	0	0	0
Total In Hours/Exceptions	922.5	114	417.5	46	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**	**Absence***
Dean Ward	163.23%	86.85%	49.33%	27.04%	13.15%	26.66%
Abbey Ward	122.47%	89.92%	18.60%	33.95%	30.08%	1.43%
Priory Ward	106.45%	77.29%	4.33%	24.83%	22.71%	8.03%
Kingsholm Ward	114.09%	85.48%	11.98%	16.63%	14.52%	15.31%
Montpellier	99.66%	91.70%	6.63%	1.34%	8.30%	16.27%
PICU Greyfriars Ward	130.51%	82.51%	27.03%	20.97%	17.49%	2.25%
Willow Ward	116.76%	100.00%	11.77%	4.99%	0.00%	5.28%
Chestnut Ward	100.54%	85.95%	13.07%	1.52%	14.05%	7.43%
Mulberry Ward	106.45%	102.51%	3.65%	0.29%	0.00%	4.96%
Laurel House	100.27%	90.24%	10.02%	0.00%	9.76%	6.56%
Honeybourne Unit	101.61%	92.21%	9.41%	0.00%	7.79%	4.61%
Berkeley House	103.04%	78.81%	19.30%	4.93%	21.19%	3.38%
Totals (Dec 2020)	**113.76%**	**86.96%**	**15.43%**	**11.37%**	**13.25%**	**8.51%**
Previous Month Totals	110.61%	84.67%	16.24%	9.70%	15.33%	6.66%

No budget data was available for December 2020 therefore figures from November 2020 were used.

*

Mental Health & LD Inpatient

- There are currently 8 x 12wk agency contracts in place in Wotton Lawn to enable continuity of care through agency staff to support vacancy rate challenges.
- * Absence rates include sickness, long term absence and maternity leave are influencing data presented above . OD support with operational services is addressing this
- An agency Guaranteed Volume Contract 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 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 – December 2020

Physical Health

The Trust continues to work to homogenise safe staffing reporting methods across the new organisation. The Trust is able to report good levels of staffing maintained in inpatient physical health areas set against agreed safe staffing levels. A detailed piece of work will be undertaken to enable the reporting of physical health exceptions in the same way as MH/LD services, currently delayed due to Covid disruption.

PHYSICAL HEALTH						
Ward	Average Fill Rate	In-Post (RGN & HCA)	Bank	Agency	Vacancies	Absence*
Coln (Cirencester)	111.05%	88.47%	8.18%	14.40%	11.53%	2.36%
Windrush (Cirencester)	112.21%	88.03%	10.52%	13.66%	11.97%	2.01%
The Dilke	105.71%	97.18%	4.69%	3.85%	2.82%	0.18%
Lydney	97.54%	92.02%	3.22%	2.31%	7.98%	5.05%
North Cotswolds	103.81%	105.95%	0.00%	0.00%	0.00%	5.91%
Cashes Green (Stroud)	103.51%	95.04%	5.76%	2.71%	4.96%	6.24%
Jubilee (Stroud)	116.21%	91.33%	20.47%	4.41%	8.67%	0.29%
Abbey View (Tewkesbury)	108.57%	91.76%	11.74%	5.07%	8.24%	2.89%
Peak View (Vale)	100.53%	88.87%	8.91%	2.75%	11.13%	0.25%
Totals (Dec 2020)	**106.57%**	**93.18%**	**8.16%**	**5.46%**	**7.48%**	**2.80%**
Previous Month Totals	105.13%	88.34%	10.40%	5.52%	11.66%	6.09%

CQC DOMAIN - ARE SERVICES WELL LED?

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

Development data for ICT services staff not available this month due to services pressures. A new data set has been developed and reporting will recommence next month. In response to service pressure through Covid-19 additional quality support has been provided to support staffing levels in ICT's and operational services are supporting workforce through redeployment and agency.

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AGENDA ITEM: 13

REPORT TO:	**TRUST BOARD PUBLIC SESSION - 28th January 2021**
PRESENTED BY:	John Trevains, Director of Nursing, Therapies and Quality and Director of Infection, Prevention and Control
AUTHOR:	John Trevains, Director of Nursing, Therapies and Quality and Director of Infection, Prevention and Control
SUBJECT:	**BOARD ASSURANCE OF NHSE KEY ACTIONS: INFECTION PREVENTION AND CONTROL AND TESTING**

This report is provided for:			
Decision	Endorsement	Assurance ☑	Information

Purpose

The purpose of this report is to present to the Trust Board the completed Infection Prevention and Control self-assessment against the NHSE '**Key actions: Infection Prevention and Control and Testing**' requirement that was issued on 23rd December 2020. Board level oversight of this self-assessment is required as part of the compliance requirement

This paper provides internal (Trust) and external (CCG, CQC) assurance that IPC and other quality standards are being maintained in light of the COVID-19 response.

Recommendations

The Board are asked to **accept** this report and **receive** good assurance that the Trust is adhering to national guidance in relation to Infection, Prevention and Control and Testing.

Executive summary

The report is structured around the 10 criteria set out by NHS England on the 23rd December 2020. These criteria are in place to protect patients and staff from avoidable harm in a healthcare setting.

Robust risk assessment processes are central to protect the health, safety and welfare of patients, service users and staff. Where it is not possible to eliminate risk, Trust's must assess and mitigate risk, and provide safe systems of work. In the context of COVID-19 as there is with all infectious diseases, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves unless these risks are mitigated to acceptable levels. The Trust ensures that risks are identified, managed and mitigated effectively by:

1. Ensuring that there are systems in place to manage and monitor the prevention and control of infection.
2. Provides and maintains a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3. Ensures appropriate antimicrobial use (antibiotics) to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. Provides suitable accurate information on infections to patients, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5. Ensures prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Develops systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7. Provides adequate isolation facilities if appropriate
8. Secures adequate access to laboratory support
9. Develops and adheres to policies designed for the individual's care and provider organisations that will help prevent and control infections
10. Has a system in place to manage the occupational health needs and obligations of staff in relation to infection?

The following paper sets out the 10 key actions and evidence that the Trust has met the requirements.

Risks associated with meeting the Trust's values
Risks are managed via the Trust's risk register.

Corporate considerations	
Quality Implications	This report ensures we are delivering IPC and Testing activities to the required standard. This supports quality of care through improving and maintaining safety, outcomes and experience.
Resource Implications	Delivered within existing budgets and national support for Covid-19 related activity
Equality Implications	No equality implications have been identified within this paper or supporting activity

Where has this issue been discussed before?
Discussed in Trust IPC meetings

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

Board Assurance: NHSE Key actions: Infection Prevention and Control and Testing.

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Themes and assurance detail as follows:

1. Theme 1: Staff consistently practice good hand hygiene and all high touch surfaces and items are decontaminated multiple times every day, with systems in place to monitor adherence.

1.1 High touch areas – Cleaning standards are monitored in clinical areas by Facilities teams. Staff in non-clinical areas have increased frequency of cleaning by cleaning high touch areas located in their areas. Clinell wipes are available in all areas of GHC to enable effective decontamination which includes meetings rooms and staff rooms.

1.2 Covid secure toolkit assessments for all GHC sites includes a question that relates to frequent cleaning schedule of work areas.

1.3 Covid secure environment health and safety audit tool questions if there are sufficient cleaning and sanitising products in place throughout buildings plus a local process in place to ensure high touch areas are cleaned regularly also if hand hygiene posters are in place

1.4 Covid secure audit spreadsheet of hand driers location and driers put out of use for all Trust sites

2. Theme 2: Staff maintain social distancing (2m+) in the workplace, when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace.

2.1 A programme to undertake a Covid secure environment toolkit assessment of all Trust sites has been undertaken from April to September 2020 and contains an objective to assess 2m social distancing wherever possible including arrival and departing from work, while in work and when travelling between sites. The Covid secure environment health and safety audit assessing compliance during the unannounced visits in place from September to December 2020.

2.2 GHC posters and floor signage detail requirement for social distancing in all areas Trust communication has included car sharing and production of Action Card for travelling in and cleaning of Trust vehicles.

2.3 Risk mitigation -all staff entering all clinical and non-clinical GHC buildings wear type 11R face masks public and outpatient wear face covering, posters in place to promote the wearing of masks.

2.4 External auditors Price Waterhouse Coopers have undertaken an external audit to review Covid secure compliance which included some site visit reports. Good assurance supplied from this audit

3. Theme 3: Staff wear the right level of PPE when in clinical settings, including use of face masks in non-clinical settings, with systems in place to monitor adherence. Movement of staff between COVID and non-COVID areas is minimised.

3.1 Covid secure audit tool for Trust sites questions are the correct type of mask worn in the areas required.

3.2 Clear Action Cards adhering to national guidance produced by GHC IPC team and circulated to all staff. Reviewed frequently in line with national guidance and staff feedback. Well established in clinical practice and Trust staff behaviours.

4. Theme 4: Moving patients increases their risk of transmission of infection. For urgent and emergency care, hospitals should adopt pathways that support minimal or avoid patient bed/ward transfers for the duration of their admission (unless clinically imperative). The exception will be patients who need a period of care in a side room or other safe bed while waiting for their COVID test results. On occasions when it is necessary to cohort COVID or non-COVID patients because of bed occupancy, then reliable application of IPC measures must be implemented. It is also imperative that any vacated areas are cleaned as per guidance.

4.1 Decision made by Gloucestershire ICS IPC Bronze management cell and agreed by ICS Silver Health that further guidance is required to clarify what is meant by 'moved'. IPC Bronze chair has confirmed that the South West regional IPC lead has been consulted and further national guidance will be issued. Local protocols in place to safely manage patient movement.

4.2 Inpatients are swabbed upon admission and days 3,5 and 7 of their inpatient stay and every 5 days thereafter.

5. Theme 5: Daily data submissions have been signed off by the Chief Executive, the Medical Director or the Chief Nurse, and the Board Assurance Framework is reviewed and evidence of assessments is available.

5.1 Delegated responsibility for daily submissions is managed and assured through the Trust Covid-19 Programme board which reports to the Trust Executive Committee. This document fulfils requirements for reporting this assurance to Board as part of the BAF. The Trust Quality Dashboard reports monthly to Board on Covid related matters and regular reports are reported to the Trust Executive Committee.

6. Theme 6: Where bays with high numbers of beds are in use, they must be risk assessed and where 2 metres cannot be achieved, means of physical segregation of patients are strongly considered. The concept of 'bed, chair, locker' should be implemented. All wards should be effectively ventilated.

6.1 All inpatient areas have been reviewed and beds have been removed across the total bed stock in order to maintain adherence to social distancing rules with 2m distance between each bed space where clinically required.

6.2 Where appropriate and in order to maintain good system flow with respect to bed availability a number of approved Perspex screens have been put in place between bed spaces.

7. Theme 7: a, Staff are tested: Implementation of twice weekly lateral flow antigen testing for NHS patient facing staff. Whilst lateral flow technology (LFT) is the main mechanism for staff testing, this can continue to be used alongside PCR and LAMP testing.

7.1 Good assurance that that the LFT's have been deployed and are being used by patient facing staff

b. If your trust has a high nosocomial rate you should undertake additional targeted testing of all NHS staff, as recommended by your local and regional infection prevention and control/Public Health team. Such cases must be recorded, managed and reported using agreed regional/national escalation systems

7.2 Processes already in place so that additional targeted testing can take place when needed.

8. Theme 8: Patients are tested: a. All emergency patients must be tested at admission, whether or not they have symptoms.

8.1 All patients admitted to an inpatient bed are swabbed upon admission. There is a clear process in place which is supported by the electronic inpatient record system. An audit in January 2021 showed 90% compliance across both community and mental health hospitals for taking a COVID-19 swab on Day 1 of admission.

b. Those who go on to develop symptoms of COVID-19 after admission must be retested at the point symptoms arise.

8.2 Clear protocol in place within inpatient wards that supports nursing and medical staff to perform a test if clinically indicated during their inpatient stay.

c. Those who test negative on admission must have a retest on day 3 of admission, and again between 5-7 days post admission.

8.3 Clear flowchart and electronic patient record prompts in place in place within inpatient wards indicating when patients should be screened.

8.4 The January 2021 audit results show good compliance overall from community hospital wards. Mental Health wards in taking COVID-19 swabs after Day 1 of admission are requiring additional support. However high levels of monitoring and low rates of nosocomial transmission, to date, within our Mental Health and Learning Disability inpatient environments mitigates against this and there is an acknowledgment that at times patient compliance with swabbing is a factor.

d. Sites with high nosocomial rates should consider testing COVID negative patients daily.

8.5 The Trust is not considered to have experienced high rates of nosocomial transmission. However, at the onset of an outbreak the situation is reviewed and discussed with the consultant microbiologist and daily patient testing is always considered.

e. Patients being discharged to a care home must be tested 48 hours prior to discharge and must only be discharged when their test result is available. Care homes must not accept discharged patients unless they have that person's test result and can safely care for them.

8.6 All patients who are being discharged to another care facility or receiving a package of care at home are swabbed 48 hours prior to discharge.

8.7 A clear process is in place and good assurance available that demonstrates it is being adhered to.

8.8 One Gloucestershire have developed a Covid discharge certificate specifically for care homes and care providers that documents the patients Covid status and dates of testing whilst in NHS care.

f. Elective patients must be tested within 3 days before admission and must be asked to self-isolate from the day of their test until the day of admission.

8.9 There is a clear process in place across the system and GHC provide the testing facility on behalf of the system and receive relevant patient lists prior to elective procedures and manage the testing and results service for this cohort. The system Testing bronze management cell monitor activity and escalate to Health silver if required.

9. Theme 9: Local systems must: Assure themselves, with commissioners, that a Trust's Infection Prevention and Control interventions (IPC) are optimal, the Board Assurance Framework is complete, and agreed action plans are being delivered

9.1 This document fulfils requirements for reporting this assurance to Board as part of the detailed BAF. The Trust Quality Dashboard reports monthly to Board on Covid related matters and regular reports are reported to the Trust Executive Committee.

9.2 GHC Quality Assurance Group receive a monthly IPC dashboard and surveillance report. In addition, the monthly quality dashboard provided to Quality Committee and Commissioners includes information dedicated to nationally mandated Covid data.

10. Theme 10: Local systems must: Review system performance and data; offer peer support and take steps to intervene as required.

10.1 System data reviewed at daily escalation/silver/gold briefing across the ICS and appropriate action taken.

11. Summary

11.1 The Trust can provide good assurance on all 10 themes. Ongoing actions include:

- Regular audits to be conducted to ensure frequently touched surfaces e.g. door/toilet handles, patient call bells, over-bed tables and bed rails are decontaminated at least twice daily.
- Further inpatient COVID-19 Swabbing Audits to provide ongoing assurance of compliance with prescribed swabbing regime.
- Regular review of all IPC action cards
- Monthly IPC clinical visits to inpatient units to audit to assess compliance with; Cleaning, Hand Hygiene and PPE.
- IPC dashboard and surveillance report scrutinised at Quality Assurance Group
- System wide approach being developed to agree threshold for nosocomial transmission being declared as a serious incident

- o IPC team working in partnership with the Patient Safety team undertaking investigations into all Covid outbreaks within inpatient areas.

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AGENDA ITEM: 14.1

REPORT TO: **Trust Board PUBLIC SESSION – 28 January 2021**

PRESENTED BY: Amjad Uppal, Medical Director

AUTHOR: Paul Ryder, Patient Safety Manager,
Ian Main, Head of Patient Safety

SUBJECT: **QUARTER 3 2020/21 PATIENT SAFETY REPORT (INCLUDING SIRIS)**

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 report provides the 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:

1. **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 3 2020/21 (1 October to 31 December 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.
- Data labels are added where the charts permit.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q3 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental and physical health patient safety incidents.

Risks associated with meeting the Trust's values

Effective systems must be in place to manage all patient safety incidents and reduce risk.

Corporate considerations	
Quality Implications	Increased numbers of reported incidents is seen to indicate an open and transparent reporting culture.
Resource Implications	Quarterly reporting and analysis is resource and labour intensive.
Equality Implications	None.

Where has this issue been discussed before?

This presentation will be discussed at the Quality Assurance Group before being presented to Board.

Appendices:	PowerPoint presentation (slide deck) Q3 2020/21 PSR

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

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AGENDA ITEM: 14.2

Q3 Patient Safety Report 2020/21

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Q3 PSR 2020/21

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This report provides:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 3 2020/21 (1 October to 31 December 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, MIiUs and community teams for both mental health and physical health.
- The data has been reviewed by the Operational Governance Forum. Data labels and comparators are added where the charts and tables permit.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q3 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental health and physical health patient safety incidents.

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Summary of all Patient Safety Incidents reported in Q3 2020/21

Whole Trust	Q3 Total 3355 (%)	Previous Q 3269
No harm	2104 (62.7)	< 2140
Low harm	1018 (30.3)	> 961
Moderate harm	198 (5.9)	> 130
Severe harm	27 (0.8)	> 23
Death	8 (0.24)	< 15

Q3 Sub 'Serious Incident' Incidents (moderate and above harm)

During Q3 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.

2 mental health incidents have been managed as Clinical Incidents needing additional comprehensive investigation and will conclude in due course. Local learning, including evidence of good practice, will be shared via Incidents on a Page following the panel meetings.

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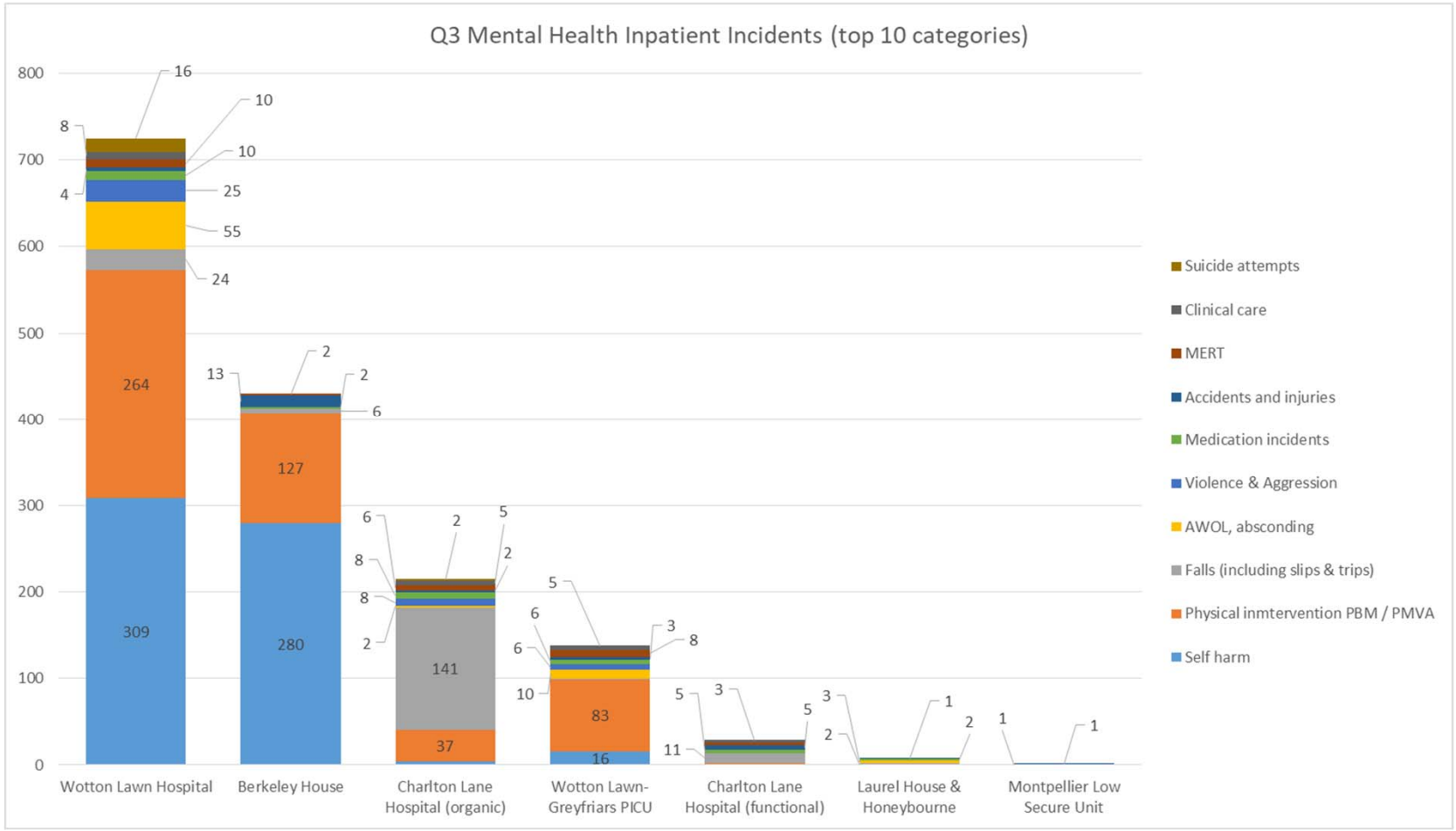
High Level Analysis of Mental Health Inpatient Incidents



Total number of MH inpatient incidents = 1547

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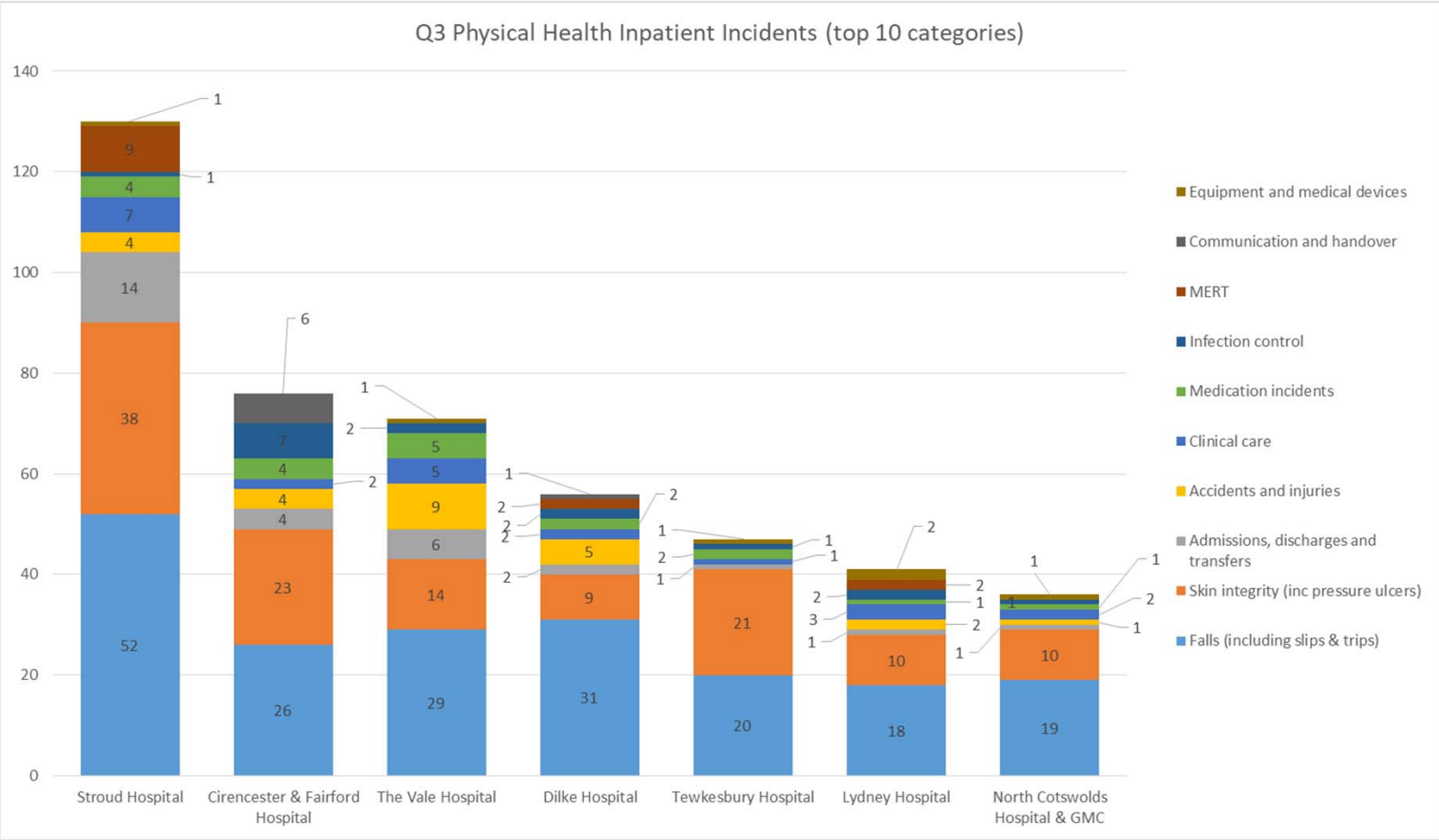
High Level Analysis of Physical Health Inpatient Incidents



Total number of physical health inpatient incidents = 457

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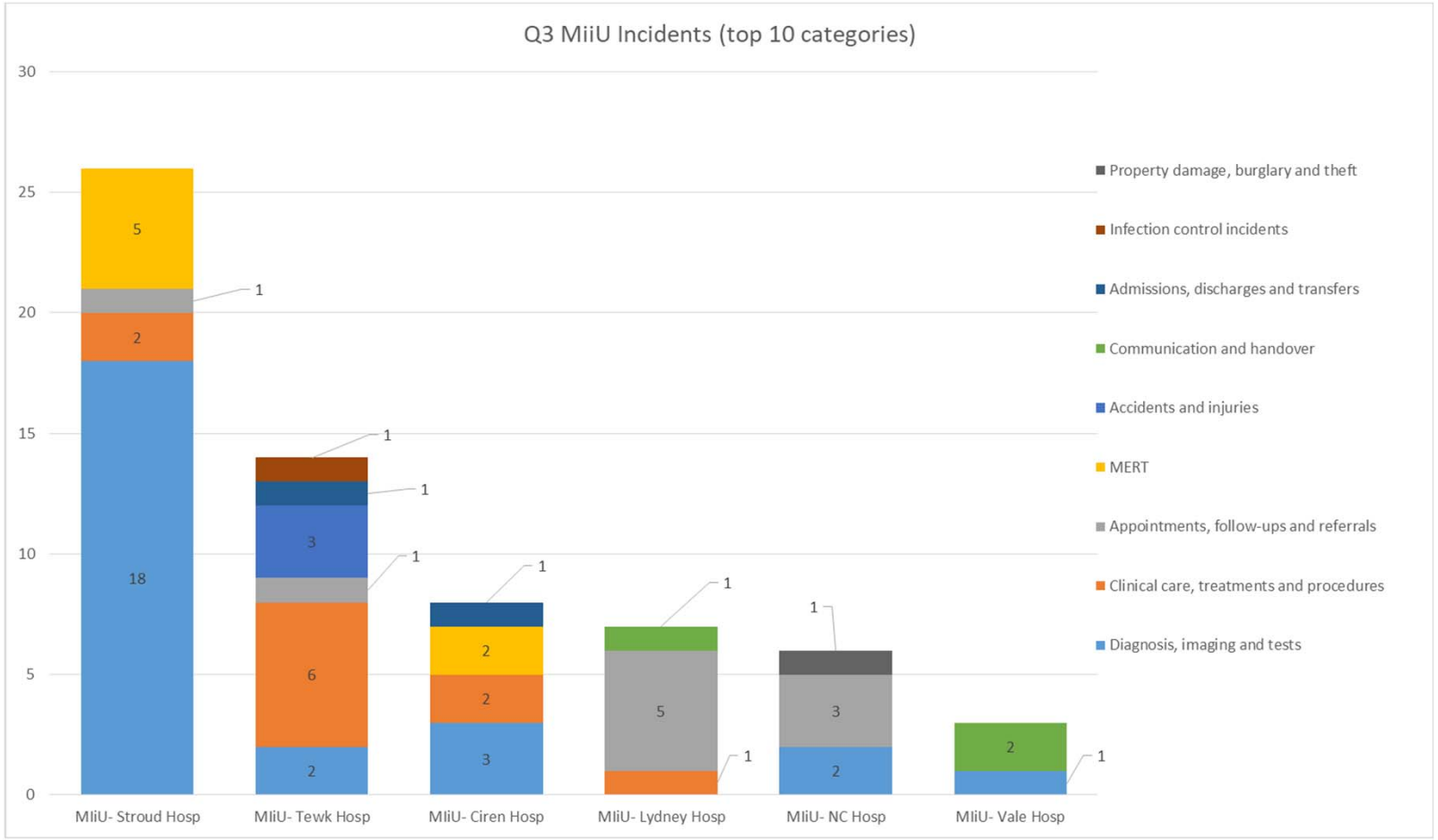
High Level Analysis of MiiU Incidents



Total number of MiiU incidents = 64

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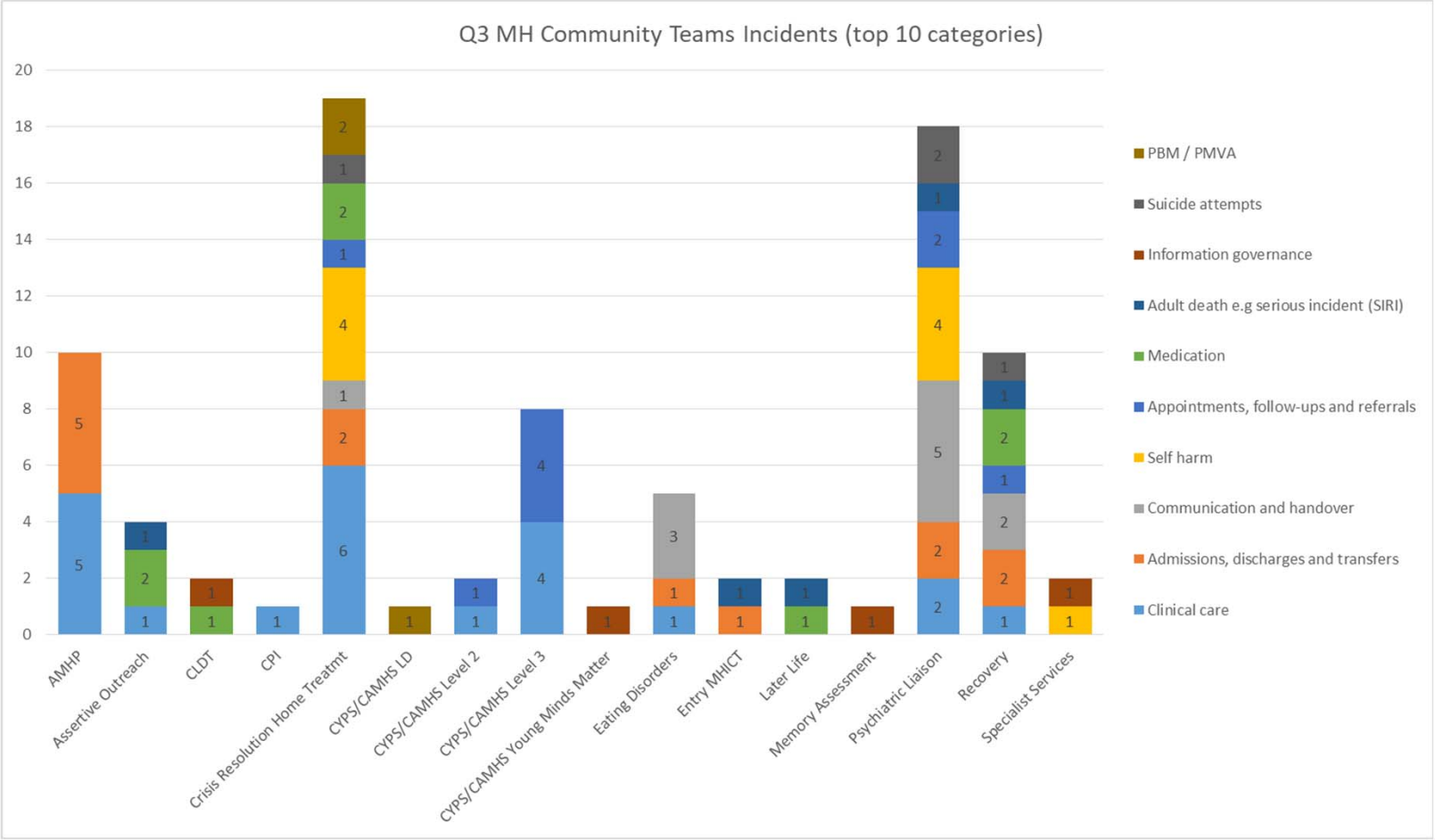
High Level Analysis of MH Community Teams Incidents



Total number of MH Community Team incidents = 88

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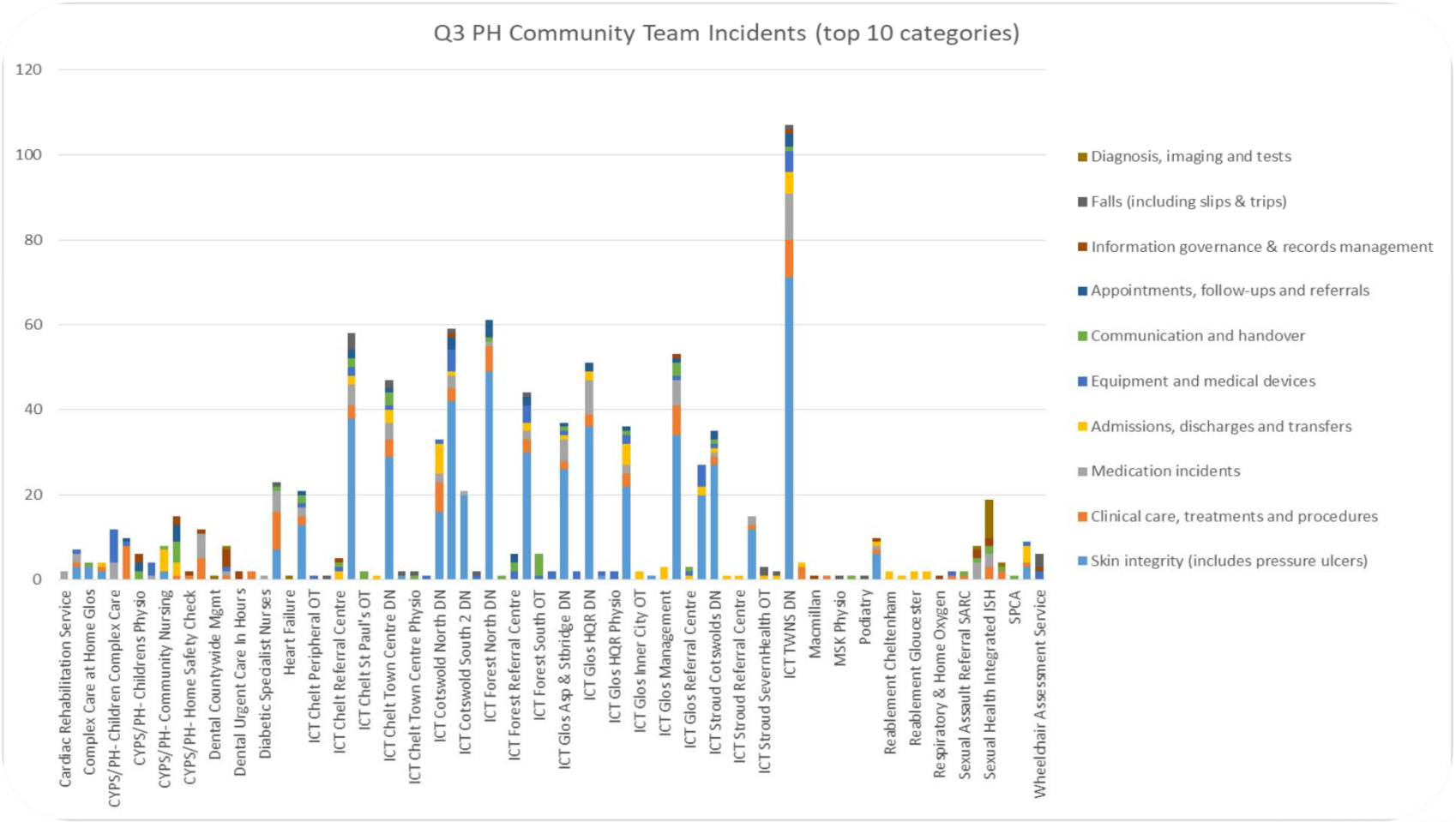
High Level Analysis of PH Community Teams Incidents



Total number of PH Community Teams incidents = 961

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Detailed analysis of high frequency incidents

The high frequency incidents within Mental Health inpatient continues 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 continue to report large numbers of skin integrity incidents (53.5% - same figure as Q2).

Q3 Physical Health SIRIs reported

1. **12 November 2020 – Palliative care and necrotic wound care of left foot with Gloucester District Nurses** – the patient also developed an unstageable pressure ulcer to his right heel during the episode of care. There were a number of other care delivery problems related to continuity of care in regard to catheter management, venous blood sampling care plans, infection control, End of Life Care, and implementation of the named nurse role. The patient passed away one month later.

Q3 Mental Health SIRIs reported

1. **19 October 2020 – unwitnessed fall and fracture** Chestnut Ward, Charlton Lane Hospital.
2. **3 November 2020 – suspected suicide (hanged)** patient open to Stroud Recovery Team.
3. **23 November 2020 – hypoxic brain injury following overdose of Quetiapine** patient recently discharged (June 2020) from Gloucester Recovery. Previously a Looked After Child with history of contact with CAMHS.
4. **1 December 2020 – attempted suicide** Gloucester Crisis Team, patient drove into a lorry in an attempt to end her life. Spinal fractures initially suspected but excluded, and confirmed injuries limited to fracture of pelvis and right humerus. Full recovery is expected.
5. **23 December 2020 – suspected suicide** a patient known to Gloucester MHICT Nursing was discovered hanged.

Developments within the Patient Safety Team

- The Patient Safety 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.
- The Duty of Candour requirements have transferred to the Patient Safety Team. Initial disclosure letters (often referred to as condolence letters following suspected suicide incidents) provide an apology that the incident occurred, describe the process of investigation, offer supportive contact, and the opportunity for relatives to be involved with the investigation process. Final summary letters also sit with the Patient Safety Team, particularly where disclosure of the final report is not appropriate, or not required by the family.
- 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: 15.1

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th January 2021**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31ST DECEMBER 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
Provide an update of the financial position of the Trust.

Recommendations and decisions required

- The Board to **note** the month 9 position

Executive summary

- The Trust is receiving increased block payments to cover Covid costs and some developments but will receive no further top ups.
- The Trust has an interim plan of a deficit of £439k for October to March.
- The Trust has increased its annual leave accrual estimate by £887k to £2.265m.
- The Trust's position at month 9 is a surplus of £98k.
- The Trust is forecasting a year end deficit of £1.080m.
- The Trust introduced net spending limits to give directorates a clear understanding of their financial targets.
- The Trust intends to write off Cleeve House with a loss of £745k in next months accounts.
- The cash balance at month 9 is £68.9m.
- Capital expenditure is £2.334m at month 9. The Trust has a capital plan for 20/21 of £10.182m.
- The revised recurring Cost Improvement Plan (CIP) target for the merged Trust is £3.230m and the amount delivered to date is £3.492m.

• The Trust has spent £2.721m on Covid related revenue costs between April and December

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: Sandra Betney	**Title:** Director of Finance

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AGENDA ITEM: 15.2

Finance Report Month 9

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Overview

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- As part of the revised financial framework for months 7-12 the Trust submitted an interim plan of a deficit of £439k at year end
- The Trust has added £0.887m for the cost of untaken annual leave at year end
- The Trust has a revised year end forecast deficit of £1.08m
- To monitor financial performance against the revised plan we've introduced net spending limits from month 9
- The Trust has recorded Covid related expenditure of £2.721m for April to December
- 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 £3.492m which is above the revised target
- 20/21 revised Capital plan is £10.182m
- Spend to month 9 is £2.334m which is £2.9m less than the revised year to date plan to NHSI. Capital Management Group is monitoring forecast outturn and has assured NHSI/E that we will meet the capital plan
- The Trust plans to write-off Cleeve House as a result of capital works on the site with a loss of £745k
- Agency cost forecast is £5.164m which is £1.26m lower than 2019/20
- Cash at the end of month 9 is £68.9m due to receiving block contract income early c.£20m and reduced capital spend of £2.9m
- The Trust has been successful in bidding for a £625k Public Sector Decarbonisation Scheme grant

Annual Leave accrual

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has reviewed its annual leave accrual estimate
- The current forecast already included a £1.378m increase on the 19/20 figure (£553k)
- Current estimates of leave outstanding on ESR indicate significant leave still to be booked (26%)
- This equates to over 36,000 days still to be taken
- In discussion with Human Resource it is estimated a further £0.887m should be added to the forecast to reflect the potential carry forward cost of the annual leave not taken at year end
- This would assume that many staff would have c. 5 days of leave left at 31st March 2021
- The revised annual leave accrual in the forecast is £2.265m
- We will be reviewing annual leave levels weekly and updating the figure each month. A further update will be given to the Resources Committee in February

GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	GHC Month 9				GHC mths 1-12				
	2020/21				2020/21				
	Original Plan	Revised NHSI Interim plan	Actual	Variance	Original Plan	Revised NHSI Interim plan	Spending Limit	Full Year Forecast	Variance
Operating income from patient care activities	140,351	164,996	164,550	(446)	211,417	222,533	224,052	221,023	(1,510)
Other operating income	6,048	4,937	5,787	850	9,068	6,699	6,753	6,443	(256)
True up income	0	1,761	1,761	0	0	1,761	1,761	1,761	0
	0	0	0	0	0	0	0	0	0
Employee expenses	(107,744)	(126,650)	(124,739)	1,911	(161,631)	(170,847)	(170,256)	(169,467)	1,380
Operating expenses excluding employee expenses	(35,759)	(42,829)	(45,062)	(2,233)	(53,635)	(57,264)	(59,221)	(56,598)	666
PDC dividends payable/refundable	(2,680)	(2,552)	(2,300)	252	(4,019)	(3,482)	(2,800)	(2,800)	682
Other gains / losses	7	30	15	(15)	21	48	46	19	(29)
Surplus/(deficit) before impairments & transfers	**223**	**(307)**	**12**	**319**	**1,221**	**(552)**	**335**	**381**	**933**
impairments / exceptional items*	0	0	0	0	1	0		(887)	(887)
Remove capital donations/grants I&E impact	0	86	86	0		113	102	96	(17)
Surplus/(deficit)	**223**	**(221)**	**98**	**319**	**1,222**	**(439)**	**437**	**(410)**	**29**
Risk allowance				0			(670)	(670)	0
Revised Surplus/(deficit)	**223**	**(221)**	**98**	**319**	**1,222**	**(439)**	**(233)**	**(1,080)**	**29**

Note. The variances compares 'Revised NHSI Interim budget' against 'Actual' and 'Full Year Forecast'
* Exceptional items - increase in annual leave accrual

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		GHC	GHC Month 9				
		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	1,066	(176)	1,096
	Property, plant and equipment: other	115,916	121,248	112,714	110,798	(1,916)	116,110
	Total non-current assets	**117,939**	**123,531**	**113,956**	**111,863**	**(2,093)**	**117,205**
Current assets	Inventories	288	245	283	283	(0)	283
	NHS receivables	11,017	8,456	3,072	4,059	987	15,187
	Non-NHS receivables	8,973	5,723	11,914	8,742	(3,172)	1,803
	Cash and cash equivalents:	26,619	28,469	67,575	68,946	1,371	36,840
	Property held for sale	0	500	0	0	0	0
	Total current assets	**46,897**	**43,393**	**82,844**	**82,030**	**(814)**	**54,113**
Current liabilities	Trade and other payables: capital	(2,143)	(1,784)	(509)	(765)	(256)	(1,765)
	Trade and other payables: non-capital	(5,580)	(10,551)	(17,387)	(12,638)	4,749	(8,638)
	Borrowings	(76)	(104)	(53)	(104)	(51)	(104)
	Provisions	(371)	(604)	(634)	(1,164)	(530)	(514)
	Other liabilities: deferred income including contract liabilities	(16,655)	(1,482)	(30,100)	(30,821)	(721)	(12,226)
	Total current liabilities	**(24,825)**	**(14,525)**	**(48,683)**	**(45,492)**	**3,191**	**(23,246)**
Non-current liabilities	Borrowings	(1,773)	(8,338)	(1,483)	(1,419)	64	(1,533)
	Provisions	(3,491)	(451)	(4,075)	(4,039)	36	(3,871)
	Total net assets employed	**134,747**	**143,610**	**142,559**	**142,943**	**384**	**142,667**
Taxpayers Equity	Public dividend capital	127,526	125,181	125,776	125,784	8	125,784
	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	10,820	11,196	376	10,920
	Total taxpayers' and others' equity	**134,747**	**143,610**	**142,559**	**142,943**	**384**	**142,667**

Note. £20m deferred income. January income received in December. In March the Trust will not receive April's income

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 19/20		ACTUAL YTD 20/21		FORECAST 20/21	
Cash and cash equivalents at start of period		**33,553**		**37,720**		**37,720**
Cash flows from operating activities						
Operating surplus/(deficit)	1,308		2,307		2,784	
Add back: Depreciation on donated assets	0		79		105	
Adjusted Operating surplus/(deficit) per I&E	**1,308**		**2,386**		**2,889**	
Add back: Depreciation on owned assets	4,944		5,871		7,695	
Add back: Impairment	3,489		0		0	
(Increase)/Decrease in inventories	(38)		0		0	
(Increase)/Decrease in trade & other receivables	(3,516)		7,418		2,571	
Increase/(Decrease) in provisions	2,485		838		704	
Increase/(Decrease) in trade and other payables	2,580		5,372		(4,934)	
Increase/(Decrease) in other liabilities	(863)		12,467		2,348	
Net cash generated from / (used in) operations		**10,389**		**34,351**		**11,272**
Cash flows from investing activities						
Interest received	206		5		19	
Purchase of property, plant and equipment	(4,835)		(2,368)		(9,215)	
Sale of Property	560		0		0	
Net cash generated used in investing activities		**(4,069)**		**(2,363)**		**(9,196)**
Cash flows from financing activities						
PDC Dividend Received	570		545		134	
PDC Dividend (Paid)	(2,565)		(1,170)		(3,067)	
Finance Lease Rental Payments	(158)		(138)		(24)	
		(2,153)		**(763)**		**(2,957)**
Cash and cash equivalents at end of period		**37,720**		**68,946**		**36,839**

Covid 1

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- Urgent Covid related capital costs have been incurred in 20/21 and funding of £137k received which fully covers the expenditure
- Not all covid costs are covered by central funding - £310k
- Recurring costs are £1.307m in a full year

For periods up to and including 31/12/2020 (M1-9)	TOTAL costs Months 1-6 £	TOTAL costs Months 7-9 £	Forecast £
Internal and external communication costs	0	4,478	19,797
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	329,891	238,265	762,689
Sick pay at full pay (all staff types)	28,636	2,311	38,447
COVID-19 virus testing (NHS laboratories)	101,069	104,869	358,238
Remote management of patients	51,816	62,500	152,421
Plans to release bed capacity	35,430	421	41,851
Segregation of patient pathways	3,439	0	4,585
Existing workforce additional shifts	128,595	71,824	249,559
Decontamination	148,912	39,685	251,463
Backfill for higher sickness absence	819,302	163,221	1,231,783
Remote working for non patient activites	78,286	62,500	187,715
National procurement areas	203,873	0	203,873
PPE - other associated costs	0	0	0
Other	41,480	0	41,480
TOTAL EXPENDITURE	**£1,970,729**	**£750,074**	**£3,543,902**
Retrospective Top up paid	-1,761,000		-1,761,000
Covid envelope system pot		-578,000	-1,156,000
		-60,000	-120,000
TOTAL INCOME	**-£1,761,000**	**-£638,000**	**-£3,037,000**
Net Expenditure over Income	**£209,729**	**£112,074**	**£506,902**

Note £507k = £210k shortfall M1-6, £206.3k system contribution, £90k forecast increase

Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Original Plan	Revised Plan	Actuals to date	Forecast	Plan	Plan	Plan	Plan	
£000s	2020/21	2020/21	2020/21	2020/21	2021/22	2022/23	2023/24	2024/25	Total
Land and Buildings									
Buildings	4,259	3,383	534	3,344	3,202	4,500	2,500	1,000	14,585
Backlog Maintenance	1,393	1,700	322	1,622	1,371	1,050	1,050	250	5,421
Urgent Care	475	200	0	0	275		0		475
Covid	0	137	140	140	0				137
Cirencester Scheme							5,000		5,000
Medical Equipment	1,220	587	45	464	1,059	730	730	3,330	6,436
IT									
IT Device and software upgrade	600	1,270	607	1,300	0	600	600	600	3,070
IT Infrastructure	1,468	2,675	390	2,731	132	1,400	1,300	1,300	6,807
Sub Total	**9,415**	**9,952**	**2,038**	**9,601**	**6,039**	**8,280**	**11,180**	**6,480**	**41,931**
Forest of Dean	500	200	296	581	4,500	8,000	300	0	13,000
Total	**9,915**	**10,152**	**2,334**	**10,182**	**10,539**	**16,280**	**11,480**	**6,480**	**54,931**
Disposals					(2,000)	(1,260)	(1,500)		(4,760)
Donation - Cirencester Scheme							**(5,000)**		(5,000)
	9,915	**10,152**	**2,334**	**10,182**	**8,539**	**15,020**	**4,980**	**6,480**	**45,171**

Forest of Dean - £900k spent in 2018/19 and 19/20, total planned spend £13.9m
We have spent £2.334m to date. This is £2.9m behind the NHSI plan year to date. There is a risk that not all the capital envelope will be spent by upto £750k.
The Capital Management Group continues to review all schemes and has introduced weekly monitoring.
A number of building and maintenance schemes have been brought forward eg Comfort Cooling, Door Ligature works. New schemes have been identified too to accommodate any slippage . IT orders have been placed well in advance to ensure delivery before the end of March, and a large number of schemes have been put to the Digital Group for approval to ensure there is sufficient time for the schemes to be completed.

Run Rate

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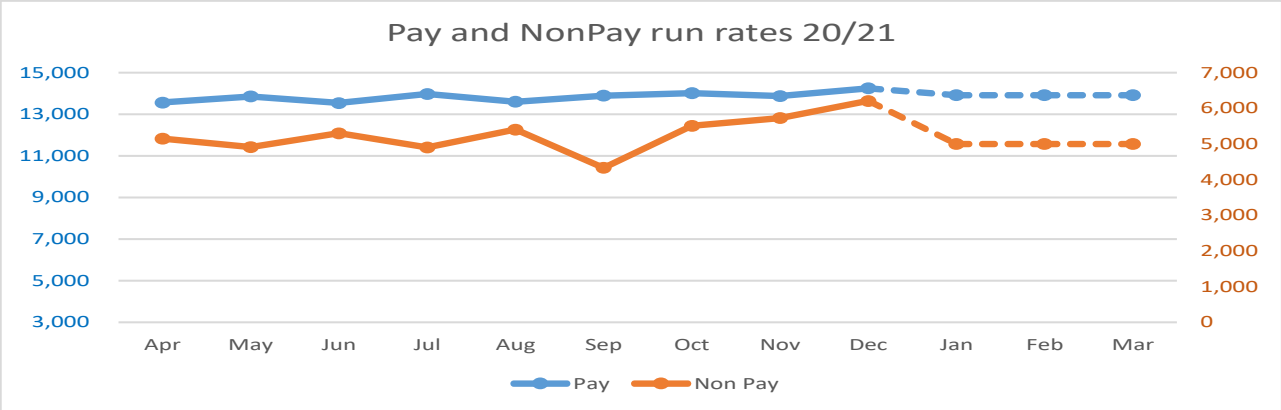
The Trust has estimated a net run rate

- The net run rate is an extrapolation of current financial performance into the future
- The run rate has been adjusted by removing non recurring items such as Covid costs, provisions increases and asset write offs but adding an estimate to the projections for Business as Usual costs/income that will increase
- Income has been difficult to extrapolate due to the interim arrangements currently in place
- Expenditure run rates may be used as the basis of monitoring for all Trusts at the start of 21/22
- The summary of the findings are shown below and suggests the Trust has a small average net run rate surplus of £57k
- Further work will continue to refine the run rate analysis in the coming weeks

SUMMARY		Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Projected Month 10	Projected Month 11	Projected Month 12	TOTAL
Revised Run rate	Income	19,636	17,280	18,068	19,135	19,073	17,901	19,469	19,671	20,538	18,974	18,974	18,974	227,694
	Pay	(13,562)	(14,037)	(13,723)	(14,159)	(13,664)	(14,187)	(14,088)	(13,837)	(14,026)	(13,920)	(13,920)	(13,920)	(167,044)
	Non Pay	(5,150)	(4,511)	(5,298)	(5,009)	(5,230)	(4,009)	(5,390)	(5,210)	(5,169)	(4,997)	(4,997)	(4,997)	(59,967)
Net Recurring surplus/(defiict)		**924**	**(1,268)**	**(953)**	**(33)**	**179**	**(295)**	**(9)**	**625**	**1,344**	**57**	**57**	**57**	**683**



Risks

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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
Covid spend increase	100		100	2	2	4
Capital envelope not fully spent	1,250		1,250	3	3	9
Brexit risk - No Deal Scenario	75	75		2	2	4
	1,425	**75**	**1,350**			
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 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	1,307	1,307	0	3	3	9
Brexit risk No Deal Scenario	885	885	0	2	3	6
	12,588	**7,728**	**4,860**			

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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: 16.1

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28th January 2021**

PRESENTED BY: Sandra Betney, Director of Finance

AUTHOR: Chris Woon, Associate Director of Business Intelligence

SUBJECT: **COMBINED PERFORMANCE DASHBOARD DEC 2020 (MONTH 9)**

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

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

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

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

- Trust Wide Requirements
- 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 December (month 9 of 2020/21). It is of note that performance period remains aligned to our operational priority to recover services from the first pandemic wave, but also respond the current pandemic surge and winter pressures.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led updates will 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 December 2020/21.

- Acknowledge the impact of the **Covid-19** response 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

It is of note that all of indicators within this period have been in exception within the last 12 months. Additionally, there is a brief focus on CYPS (including CAMHS), its challenges and its achievements during the pandemic.

Mental Health & Learning Disability Services
The Board's attention is requested to review the 11 key performance thresholds listed in the dashboard (with associated narrative) that were not met for the period. Of note is that Eating Disorder Services have faced major performance challenges recently due to a high number of referrals and high vacancy rate.

Physical Community Health Services
In addition, attention is drawn to the 12 key performance thresholds listed in the dashboard (with associated narrative) that were not met for the period. Within these, 4 are within CYPS and 3 within Wheelchair Services. Both health visiting and wheelchair services are about to engage in an internal data quality audit with PWC during Quarter 4.

Trust Wide Services
There are currently 4 workforce indicators in exception this month that apply to all GHC services. Discussions have begun to routinely monitor wider workforce performance metrics beyond what is already available within the dashboard in 2021/22.

Non-exception reporting
It is further noted that there are additional 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. Within the February Resources Committee there will be a further briefing and discussion around our approach to 'proxy' indicators.

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?	N/A

Appendices:	None

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

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Snapshot Month
December

Performance Dashboard Report & BI Update

Aligned for the period to the end December 2020 (month 9)

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 or administrative 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, the Covid-19 response 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.

As an example, the area of spotlight this month is Children and Young People's Services (CYPS);

- **CAMHS Performance:** *Services remain fully open. There has been an increase in service demand (referrals and referrals accepted) within CAMHS since Sept 2019, but this has been managed through embracing digital (virtual) delivery tools and collaborative working with stakeholders with positive feedback.*
- **CAMHS Outreach:** *Reduction in Tier 4 admissions by managing a high-risk young cohort through intensive home support*
- **CAMHS Developments/ Transformations:** *Trailblazers and wider investments*
- **Immunisation Programme:** *Successful immunisation delivery of seasonal flu achieving 77% update.*
- **Allied Health Professionals:** *Strong AHP service performance across indicators regardless of increased demand. They have adapted delivery throughout the pandemic and successfully achieved their access target thresholds.*
- **Public health nursing:** *Although PHN services are reporting performance in exception, services have continued using a combination of f2f and virtual contacts and performance compares very favourably when benchmarked against national organisations and South West services.*

Business Intelligence Update

In spite of ongoing Covid-19 BI demands, 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 recently;

- There has been significant progress with the data validation processing of Workforce (ESR) and Finance (Integra) data
- Service level recovery, surge planning and response engagement
- Final legacy GCS reports migrated to Tableau
- Birtie decommissioning process begun

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

- Integrated Business Intelligence Performance Dashboard (Q4 2020/21) for Board/ Resources Committee (incorporating full BI stack).
- 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)
- Supplementary system sources brought into BI reporting (Datix, Service Experience, Q4 2021/22)
- Dashboard visualisation capability further developed to include; benchmarking observation, SRAP alerts and data quality alerts (2021/22).

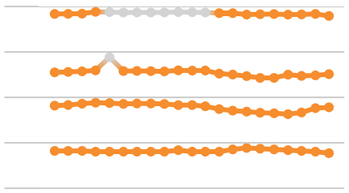
PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO BE RESPONSIVE TO THE DEMANDS ON CURRENT CORPORATE/ OPERATIONAL BAU & ADHOC (e.g. C19) REPORTING.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements

		DECEMBER	2021	
77	Mandatory Training	82.4% 90.0%	86.1% 90.7%	
78	% of Staff with completed Personal Development Reviews (Appraisal)	71.1% 90.0%	66.3% 91.8%	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	77.6% 90.0%	69.1% 91.8%	
79	Sickness absence average % rolling rate - 12 months	4.5% 4.0%	4.9% 4.0%	

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

77: Mandatory Training
Performance was 82.5% in December 2020, below the target of 90%. There is increasing focus to improve compliance rates across the Trust. Performance is below the SPC chart lower control limit based on 2018/19 data.

These numbers have been amended for the first time this month to include Bank Staff, this had previously been excluded from the calculation.

78: % of Staff with completed Personal Development Reviews (Appraisal)
Performance in December was 71.2% compared to a target of 95%. There is increasing focus to improve compliance rates across the Trust in the coming months. Performance is below SPC chart normal variation based on 2018/19 data.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only.
Performance in December was 77.7% compared to a target of 95%. There is increasing focus to improve compliance rates across the Performance is below SPC chart normal variation based on 2018/19 data.

79: Sickness absence average % rolling rate - 12 months
Performance is 4.5% compared to a threshold of 4% for the rolling 12 months to December 2020. Performance is outside SPC chart normal variation based on 2018/19 data. The level has however been consistently reducing month on month since June 2020 when it was at its highest point for the year at 5.2%.

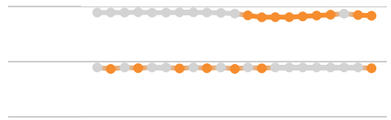
Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		DECEMBER	2021
1.04	Care Programme Approach - formal review within12 months	91.4% (95.0%)	91.1% (95.0%)
2.21	No children under 18 admitted to adult in-patient wards	98.3% (100.0%)	99.6% (100.0%)



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
Performance for December is 91.4% (83 cases) against a performance threshold of 95%. The majority of cases are within the following services: Recovery (52), CPI (8), and Assertive Outreach (7).

Within the Adult Community services there has been a reduction in some teams' capacity due to staff movement and sickness. These are ongoing challenges and although the service has noted that compliance may drop further, teams are continuing to plan CPA's and address historical cases within the available capacity.

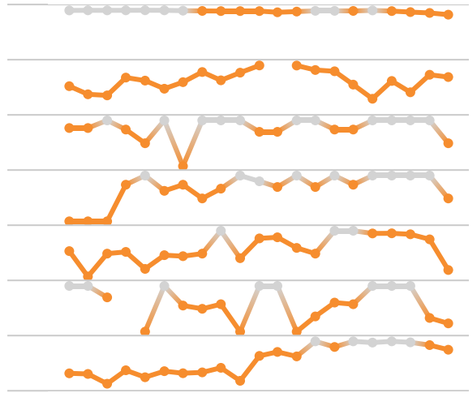
2.21: Admissions of Under 18s to Inpatient Wards
There was 1 admission of an Under 18 in December. A young person under the care of CAMHS was admitted out of hours to Wotton Lawn following suicidal intent with significant attempts to ligature. The young person was admitted for 4 days while a community discharge package involving CAMHS, Crisis and Social Care was put in place.

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

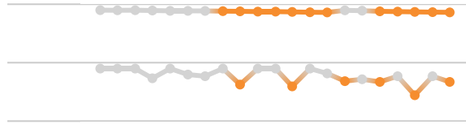
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract

		DECEMBER	2021	
3.14	Children and young people who enter a treatment programme to have a care-coordinator - (Level 3 services) (CYPS)	90.5% 98.0%	96.2% 98.0%	
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	42.3% 100.0%	44.0% 100.0%	
3.26	Patients with Dementia have weight assessments on admission	50.0% 85.0%	87.5% 85.0%	
3.29	Patients with Dementia have delirium screening on admission	50.0% 85.0%	87.5% 85.0%	
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	14.2% 95.0%	83.0% 95.0%	
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	18.1% 95.0%	56.1% 95.0%	
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	83.3% 95.0%	94.2% 95.0%	

Mental Health & Learning Disability - Social Care

		DECEMBER	2021	
4.05	% of WA & OP service users on the caseload who have a carer, who have been offered a carer's assessment	87.7% 90.0%	88.8% 90.0%	
4.12	Ensure that reviews of new short or long term packages take place within 12 weeks of commencement	75.0% 80.0%	79.1% 80.0%	

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

3.14: Children and young people who enter treatment to have a care coordinator
December is reported at 90.5% against a performance threshold of 98%.

The methodology for this indicator uses the assumption (agreed with commissioners) that treatment begins at the 2nd attended appointment and that it is appropriate to allocate a care coordinator at this point. The service has recently changed their care pathway to support young people on the waiting list and have introduced extra patient contacts (tel/ video) to provide support. These extra contacts then trigger the 2nd contact and although it may still be the appropriate point to define the beginning of treatment, it is not necessarily the appropriate stage at which to allocate a care coordinator like it was previously. This means that the underlining assumptions which the indicator is based on may now be out of date. The service will be discussing with Commissioners the change in pathway in relation to this indicator.

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded
December is reported at 42.3% against a local performance threshold of 100% and has shown improvement over the last 2 months.

Compliance continues to be affected by the recording of Reported Outcome Measures (ROMs) via a paper-based system. After discussions with the National 4WW team, it has been identified that other CAMHS services are reporting similar issues with reduced compliance due to virtual working. The National team have agreed to look wider at other viable options to support this. Locally the service is exploring options regarding emailing of editable PDF questionnaires and piloting direct collection during video calls. Discussions have also begun with external providers of the CYP Questionnaires. An action plan has been produced and is monitored quarterly at CAMHS OGF.

3.26: Patients with Dementia that have not had a weight assessment within 24 hours of admission
December performance is reported at 50% against an 85% performance threshold. There were 2 non-compliant cases in December. The non-compliant cases for both indicator 3.26 and 3.29 relate to the same patients.

One patient was admitted with a primary diagnosis of a psychotic illness and was not identified as also having a dementia diagnosis until 3 days later. The service agrees that the current process for identifying these patients needs to be more robust and are exploring new ways of working to ensure compliance going forward. This includes requesting a report which identifies all patients on the ward with a dementia diagnosis.

The 2nd patient was admitted to Wotton Lawn and was weighed 3 days after admission and screened 12 days after admission. The service has identified that the procedures are not as routine for Wotton Lawn as they are in Charlton Lane and have issued guidance to staff.

3.29: Patients with Dementia that have not had a delirium screening within 24 hours of admission
December performance is reported at 50% against an 85% performance threshold. There were 2 non-compliant cases in December. The non-compliant cases for both indicator 3.26 and 3.29 relate to the same patients. See 3.26 for detail.

3.35 Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
December performance is reported at 14.2% against a performance threshold of 95%. There were 6 non-compliant cases in December.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
December performance is reported at 18.1% against a performance threshold of 95%. There were 9 non-compliant cases in December.

3.39: Adult Eating Disorders: Referral to assessment within 4 weeks
December performance is reported at 83.3% against a 95% performance threshold. There were 6 non-compliant cases reported in December.

Note on 3.35, 3.37 and 3.39 – Eating Disorders waiting times
The Eating Disorders service currently has an unprecedented amount of vacancies and are actively recruiting to fill these posts.

The current wait profile for the service at the end of December indicates that 38% (49) of all clients waiting for assessment are waiting over 4 weeks. This is seen to be a significant increase of 22% compared to November and wait times will continue to increase until the service can fill their workforce vacancies.

The service also continues to experience a higher than average number of urgent referrals for the third quarter with an average of 11 referrals per month for adolescents compared to 5 for the same period in the last year. Adult referrals were also noted to be increasing as the average number of urgent referrals per month, is 9 compared to 5 in the same period last year. In response the service has closed day treatment temporarily and the extra staff capacity is being used to accommodate the increase in urgent referrals.

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 87.7% for December (215 cases) against a performance threshold of 90%. The majority of cases are within the Older People services (Managing Memory Together: 86, OP Community Services: 62) and Recovery Service: 38.

Teams have been working hard to ensure that data is captured and 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 Social Care Packages not reviewed within 12 weeks of commencement
Performance is reported at 75% against a performance threshold of 80%. There is 1 non-compliant case in December due to staff sickness. The service has confirmed that the review has now been booked.

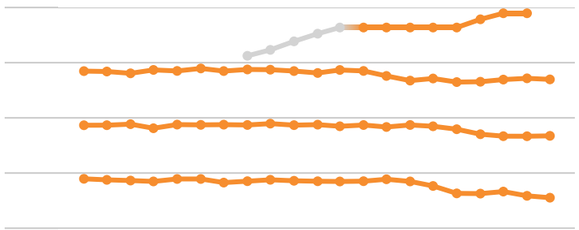
Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - National Requirements

		DECEMBER	2021
82	% of eligible children who receive vision screens at or around school entry.	100.0%	75.1% (93.3%)
86	% of children who received a 9-12 month review by the time they turned 12 months	69.1% (95.0%)	70.5% (95.0%)
87	% of children who received a 12 month review by the time they turned 15 months	69.9% (95.0%)	79.3% (95.0%)
88	% of children who received a 2-2.5 year review by 2.5 years	53.7% (95.0%)	69.1% (95.0%)



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 in November for the 2019/20 academic year schools Vision screening programme was 93.0% and remained behind the internal trajectory of 95%. Out of a cohort of 6,677 eligible children, 6,215 were screened up to November 2020. The 2019/20 programme is now closed.

The service had a catch-up programme in place from September to November 2020 as the vision screening programme was suspended between March - August 2020 due to the Covid-19 pandemic. The catch-up cohort are Reception year children who would be in Year 1 since September 2020.

The programme normally runs from November – August of each year for children in Reception year and the new programme should have begun. However the new programme had been delayed until January 2021, this is now under review with NHS Digital due to the National Lockdown.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
69.2% of eligible children received the 9-12 month visit by a health visitor in December compared to a target of 95%. 334 out of 483 reviews were completed within the target timeframe 9-12 months. This is below SPC Chart control limits based on 2018/19 data. This figure increases to 72.3% when all contact methods are included (i.e. Face to Face, telephone and video). There has been a steady month on month increase in the performance year to date.

The parents of all children within this cohort were offered the opportunity to receive a 9 -12month review. The service continues 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.
70.0% of eligible children received the 9-12 month visit (within 15 months) by a health visitor in December, compared to a target of 95%. 408 out of 583 reviews were completed within the target timeframe of 15 months. This is below SPC Chart control limits based on 2018/19 data. This figure increases to 78.6% when all contact methods are included (i.e. Face to Face, telephone and video).

The parents of all children within this cohort were offered the opportunity to receive a 9 -12month review. The service continues 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.
53.8% of eligible children received the 2-2.5 year mandated contact by a health visitor in December, compared to a target of 95%. 298 out of 554 reviews were completed within the target timeframe of 2-2.5 years. This is below SPC Chart control limits based on 2018/19 data. This figure increases to 64.8% when all contact methods are included (i.e. Face to Face, telephone and video).

The parents of all children within this cohort were offered the opportunity to receive a 2 year review. The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

Additional Information for 86, 87 & 88.
A Community Nursing focus group was held in November and information disseminated to reflect discussion. Public health information to be addressed, media work stream to meet in January 2021 to look at health promotion tools/ video and social media to promote ASQ alongside other health promotion subjects that relate to six high impact areas.

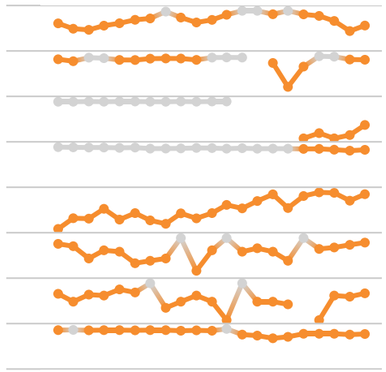
Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		DECEMBER	2021
40	Adult Speech and Language Therapy - % treated within 8 Weeks	64.0% (95.0%)	71.3% (95.0%)
42	MSKAPS - % treated within 8 Weeks	91.2% (95.0%)	87.2% (95.0%)
47	Bone Health Service - % treated within 8 Weeks	36.3% (95.0%)	15.7% (95.0%)
65	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	92.4% (95.0%)	94.1% (95.0%)
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	76.7% (90.0%)	69.7% (90.0%)
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	88.8% (90.0%)	72.7% (90.0%)
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	72.7% (92.0%)	60.5% (92.0%)
95	Average Number of Community Hospital Beds Open	89.7% (100.0%)	87.1% (100.0%)



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

40. Adult Speech and Language Therapy - % treated within 8 Weeks
December compliance was 64.0% below the threshold of the 95%. In total 75 patients started treatment, 27 of which were seen over the 8-week target.

Due to the service experiencing significant pressures they are currently only providing a service to the acute trust. The service agreed that exception reporting for December was stepped down so that all resources could focus on direct patient care. The waiting list profile at the end of December shows that 21.9% (71) of all patients were waiting longer than 8 weeks for a first contact from the service.

42. MSKAPS - % treated within 8 Weeks
In December 2020, 91.3% of patients were seen within 8 weeks compared to a target of 95%. 28 out of 321 patients were seen outside of the 8 weeks target in December.

A significant number of the breaches are due to patient choice where the patient did not book an appointment on time. Often the patients do not book their appointments until a reminder is sent by the service, approximately 3 weeks after the initial communication. Others breaches are where the method of 1st contact was by telephone, which currently is not a stop-clock for the MSKAPS RTT pathway. The Business Intelligence team is currently working with the MSKAPS service to capture clinically significant telephone contacts within the RTT pathway.

47: Bone Health Service - % treated within 8 Weeks
The service reopened in August 2020 after being closed due to Covid-19 with a backlog of patients to see. 7 out of 11 face to face contacts in December failed to meet the 8-week threshold.
The service are currently clearing the backlog of referrals after the service reopened. Delays in community hospital availability has slowed the progress, however the service is making significant progress in reducing waiting times but more challenges are expected 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 alongside face to face contacts. The service model is changing to include telephone contacts in the Referral to Treatment criteria. These changes have now been agreed by all relevant stakeholders and Business intelligence is working to deploy the changes.

65. 95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing
1,006 out of 1,088 priority 1&2 calls (92.5%) were answered within 60 seconds compared to a target of 95%. This is below SPC Chart control limits.

From November 2020 SPCA has been trialling handling of daytime dental calls, historically handled by dental staff and receptionists in Southgate Moorings. For example; 3,567 calls were received in December, above the proxy threshold of 3,279 which is based on 2018-19 activity figures. This is above the SPC chart upper control limit based on 2018-19 figures. *This continues to impact SPCA call handling pick up times and abandonment KPI's. A review has taken place and Service leads are currently looking at costings regarding staffing numbers and call alignment with the Deputy Dental Service Director for Urgent Care and Specialty Services.*

67. Wheelchair Service: Adults: New referrals assessed within 8 weeks
33 out of 43 (76.7%) of new adult referrals were assessed within 8 weeks in December. This is below the target of 90%.

The Wheelchair Service continues to collaborate 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 dataset. This work is reflected in the improved performance data.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
8 out 9 (88.9%) of new under 18 referrals were assessed within 8 weeks in December. This is below the target of 90%.

The Wheelchair Service continues to collaborate 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 dataset. This work is reflected in the improved performance data.

dataset. This work is reflected in the improved performance data.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral
8 of the 11 (72.7%) equipment deliveries in December met the 18 week threshold of 92%.

The Wheelchair Service continues to collaborate 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 dataset. This work is reflected in the improved performance.

Additional information for 67, 69 ands 71.
The monthly performance report figures now show:

- *An increasing number of first assessments, both face to face and telephone*
- *An increasing number of handovers which is now thought to be much more representative of service activity.*
- *100% performance for the adult and under 18 'urgent referral to assessment' KPI, with the exception of June*

There still is a fluctuating trajectory for 'routine referral to assessment' and 'referral to handover' KPIs, which are areas of current focus. Starting with under 18s, the service expects to take the learning and apply to adults. This will be a much larger piece of work, reflected by the waiting profiles which the service believe are mainly historic artefacts from the data migration from the clinical system, BEST, but are pleased to now be involved in an external data quality audit that will support this.

95: Average Number of Community Hospital Beds Open
The average number of beds open in Community Hospitals was 176 in December (compared to a traditional bed stock of 196 beds) and is below SPC Chart lower control limits. This is due to the agreed reduced bed base as a result of social distancing on the wards in the wake of the Covid-19 pandemic.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 17

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 January 2021**

PRESENTED BY: Marit Endresen, Patient Survey Manager
Lauren Edwards, Deputy Director of Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **CQC SURVEY OF ADULTS WHO USE COMMUNITY MENTAL HEALTH SERVICES - 2020 RESULTS AND ACTION PLAN**

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 summarise the results of the 2020 CQC National Community Mental Health survey. These results provide assurance of the quality of adult community mental health services 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 and decisions required

The Board is asked to:

- **Note** the contents of this report
- **Receive assurance** of our ongoing delivery of high-quality adult community mental health services
- **Receive assurance** that this feedback has been used to identify 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.
- In 2019, Quality Health was commissioned by Gloucestershire Health and Care NHS Foundation to undertake the 2020 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 Gloucestershire Health and Care NHS Foundation Trust services. The CQC makes comparison with 55 English NHS mental health care providers' results of the same survey. Results are published on the CQC website.
- The Trust's results are '*better*' than the expected range for 13 of the 28 questions (45%) and '*about the same*' as other Trusts for the remaining 15 questions (54%) These results **represent a further improvement** on our results from last years' service user feedback (Better = 38%, about the same = 62%), although direct comparison should be avoided (see section 1.4).
- The Trust is categorised as performing 'better' than the majority of other mental health Trusts in 8 of the 11 domains (73%) (last year: 7 out of 11, 64%)
- The scores for feedback are disappointing, although are '*about the same*' as other Trusts (the highest score in England was only 3.5). This will continue be a significant area of focus for development, with the work being led by the Patient and Carer Experience Team.
- An action plan will be co-developed with senior operational and clinical leaders and seeking input from Experts by Experience. The proposed areas of focus are outlined in 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.

Risks associated with meeting the Trust's values

Feedback from service experience offers an insight into how services are received. The results will be publicly available and it is important to offer assurance that the organisation is taking appropriate action to effect positive practice development. The reputation of the organisation, which may impact on uptake of services. However, it should be noted that the results suggest 'low risk' in this area.

Corporate considerations	
Quality Implications	This report offers assurance that the Trust is delivering high quality adult community mental health services and is striving to continually improve these, based on feedback.
Resource Implications	Actions to develop positive service experience in the areas where scores are lower may require additional or realignment of resources
Equality Implications	The demographic results of the survey show that a very small proportion of respondents were from Black, Asian and minority ethnic (BAME) groups (n=3%, national average=9%). Work will continue to encourage people from our BAME communities to take part in the survey. A higher percentage of people over 66 years of age completed our survey (n=52%, national average=40%). This has occurred for several years and reflects the local population demographic. It is also understood that older people are more likely to complete a survey request of this nature.

Where has this issue been discussed before?
• Quality Assurance Group, December 2020 • Quality Committee, January 2021 There will be liaison with relevant colleagues across the organisation, including Experts by Experience, in order to co-produce the action plan

Appendices:	**Appendix 1, 2 and 3** 2020 CQC National Community Mental Health Survey Action Plan

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

CQC 2020 SURVEY OF ADULTS WHO USE COMMUNITY MENTAL HEALTH SERVICES

1. 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. The Trust commissioned Quality Health to undertake this work.

1.2 The 2020 survey of people who use community mental health services involved 55 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 2020 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 2019.

1.4 The peak of the Covid-19 pandemic in England and the subsequent lockdown on the 23rd March 2020 occurred approximately midway through the fieldwork period for the survey. Whilst the Community Mental Health survey primarily asked people to reflect on their experience of care over the previous 12 months, and therefore prior to the pandemic, the CQC's analysis has shown that the national lockdown likely impacted the way service users responded to the survey.

When comparing with equivalent time periods from previous surveys, responses received after the lockdown was introduced differ significantly across the majority of questions this year. **The 2020 Community Mental Health survey is therefore classed as not directly comparable with previous iterations**.

1.5 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/2020/Gloucestershire%20Health%20and%20Care%20NHS%20Foundation%20Trust.pdf

2. Scores for Gloucestershire Health and Care NHS Foundation Trust in 2020

2.1 The CQC results for the 2020 survey of people who use community mental health services were published on the 24th November 2020[1]. The Trust's overall results in relation to other Trusts are summarised in Table 1.

2.2 The Trust response rate for this survey was 31.4% (380 responses). This is above the national average response rate of 26%.

2.3 The Trust obtained the **highest Trust scores in England** on 6 of the 28 (n=21%) evaluative questions and on 2 of the 11 domains.

Table 1

Key to Table 1

2.4

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		

2020 Community Mental Health Survey
Gloucestershire Health and Care NHS Foundation Trust

Our results are 'better' than most Trusts for 13 of the 28 questions (45%) and

[1] https://www.cqc.org.uk/provider/RTQ/survey/6

'about the same' as other Trusts for the remaining 15 questions (54%). These results represent a further improvement when compared with our results from last year's performance in the same survey (Better = 38%, about the same = 62%), however direct comparisons should be made with caution due to the impact of COVID-19 (see section 1.4, above).

2.5 An infographic of our results has been developed to share the results in a more accessible format with colleagues and local stakeholders **(Appendix 2).**

2.6 The Trust scored well in questions relating to person-centred care such as knowing who to contact, being treated with respect and dignity, organisation of care and services, and discussions regarding care and medication.

Table 2
Trust's top 5 results

	Top 5 Questions	Score
9.	Do you know how to contact this person if you have a concern about your care?	100.0%
24.	In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines?	89.6%
36.	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	88.7%
10.	How well does this person organise the care and services you need?	85.6%
14.	In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?	85.5%

3. Priority areas for further development

3.1 Adult community mental health services provided by GHC scored well this year overall, being **classed as 'better than expected' for the fourth 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.

Table 3
Trust's lowest 5 results

	Bottom 5 Questions	Score
37.	In the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	21.4%
32.	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work?	51.8%
33.	In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity?	54.1%
31.	In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	54.4%
30.	In the last 12 months, did NHS mental health services support you with your physical health needs?	57.2%

3.2 The following areas for further practice development have been identified:

- Giving people support to join a group or to take part in an activity
- Providing help or advice about finding support to find or keep work
- Providing help or advice about finding support for financial advice and benefits
- Asking people for their views on the quality of their care

4. 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, however caution must be shown in comparing results due to COVID-19. The results are a testament to the expert and dedicated effort that colleagues are making to understand need, involve and respond 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 will be co-developed with senior operational and clinical leaders and will be monitored via the appropriate governance meetings. A mid-year update will be brought to the Quality Assurance Group.

4.5 The 2020 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 various communication methods in liaison with our Communications Team. 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 **(Appendix 2).**

Appendix 1: 2020 CQC National Community Mental Health Survey Action Plan

- **To be co-produced – update to Quality Committee**
-

Area for development	Action	Timescale	Lead
Giving people support to join a group or to take part in an activity			
Providing help or advice about finding support to find or keep work			
Providing help or advice about finding support for financial advice and benefits			
Asking people for their views on the quality of their care			

Appendix 2

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC Adult Community Mental Health Survey 2020

380 respondents

28 questions → 11 domains

26% National Response rate

31% Our response rate

Our results

- In the top 20% of Trusts for 8 of the 11 domains.
- 'About the same' as other Trusts in 3 domains.
- These results represent a further improvement when compared to last year's service feedback.

Results of 11 domains

Each domain compared to other trusts

Better | About the same | Worse

Health and social care workers	7.7/10
Organising care	9.0/10
Planning care	7.1/10
Reviewing care	8.2/10
Crisis care	7.6/10
Medicines	7.6/10
NHS therapies	7.6/10
Support and wellbeing	5.8/10
Feedback	2.1/10
Overall views of care and services	8.0/10
Overall experience	7.5/10

Rated nationally as amongst the highest performing Trusts for:

- Health and social care workers
- Organising and reviewing people's care
- Crisis care
- Medicines
- Helping people to find support for financial advice and work
- Involving family or friends
- People's overall views of care and services
- People's overall experience

Areas for further focus

- Giving people support to join a group or to take part in an activity
- Helping people to find support for financial advice and work
- Asking people for their views on the quality of their care

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

Appendix 3

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC Adult Community Mental Health Survey 2020

Results for 28 questions

Each domain includes a number of questions. These are each compared to other trusts using this key:

Better | About the same | Worse

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 January 2021**

PRESENTED BY: Lavinia Rowsell, Head of Governance / Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance / Trust Secretary

SUBJECT: **COVID-19 BUSINESS CONTINUITY – GOVERNANCE ARRANGEMENTS**

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

The purpose of this report is to

To set out proposed changes to Trust Board and Committee Governance arrangements during the current wave of the Covid-19 Pandemic.

Recommendations and decisions required

The attached paper was considered by Board Members at the Executive Meeting held on 12 January 2021 and the meeting of the Non-Executive Directors held on 19 January 2021 at which Board Members approved the proposals to be implemented with immediate effect.

Executive summary

It light of the situation with Covid-19, it has been necessary to review the Trust's current governance arrangements. The attached proposal looks to balance the need to ensure that resources are focused on necessary clinical and operational matters to enable safe and sustainable service delivery whilst maintaining the robustness of decision making in a fast-moving environment and providing the appropriate level of Board assurance.

The proposals set out below reflect the lessons learned from the changes to the governance arrangements implemented during the first wave of the pandemic and the findings of the internal audit on Covid governance undertaken in November 2020.

It should be noted that there has been further guidance from the centre regarding the relaxation of governance arrangements as received in the first wave of the pandemic.

Risks associated with meeting the Trust's values

A strong system of governance, even in times of crisis is essential to ensure decision making continues to be undertaken within agreed frameworks. Having a strong business continuity plan for governance:

- will ensure that decisions continue to be made in the best interests of the patients
- will help colleagues to understand their responsibilities and accountabilities,
- is essential for patients and the public to be able to hold the organisation to account
- will enable a smooth transition back to 'business as usual'

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
Executive Meeting – 12 January 2021, Non-Executive Directors Meeting – 19 January 2021.

Appendices	None

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

COVID-19 BUSINESS CONTINUITY – JANUARY 2021

Board and Committee Governance Arrangements and Delegated Authorities

Board and Committees

1) The Board will continue to meet as per its usual cycle (bi-monthly) with agendas focussed primarily on urgent/exceptional business.

2) Board Committees will continue to meet; however, agendas will be streamlined and the frequency of meetings considered. The quorum of Board Committees will be relaxed to 1 Executive and 2 Non-Executive Directors.

3) The Council of Governors will continue to meet but with reduced agendas.

4) Effort will be made to continue aspects of 'business as usual' activity, based upon the existing business cycles / forward agenda. The business cycles for the Board and Committees will be reviewed and updated within Corporate Governance in discussion with Committee Chairs and Executive Directors, to maintain an accurate record of items considered / approved or deferred (placed in parking lot).

5) It is likely that those responsible for preparing assurance papers for Committees and the Board may not be in a position to do so. Therefore, matters for information or assurance will be either:

- Put on hold until further notice,
- Circulated via email, or
- Where it is possible for Board assurance/information reports to be provided, these will be included on the agenda to maintain transparency and public accountability but will be discussed by exception only. Board members will be asked to raise any questions relating to these items in advance of the meeting.

6) At a minimum, the Board will receive and consider at each meeting the following assurance reports; Quality Report, Performance Report, and Finance Report.

Covid-19 specific Board Governance Arrangements

7) Fortnightly Board Covid briefings will be implemented. Briefings will be attended by Board members and senior members of the Operations, and Nursing, Therapies and Quality Directorates. Meetings will be chaired by the Board Chair. Briefings will focus on the impact of the measures being taken in response to the pandemic with respect to:

- patient safety

- staff health and wellbeing
- service changes
- risk

8) The Ethics Group will continue to meet on an ad-hoc basis/as required to support executive directors who are making decisions that have complex ethical considerations resulting from the Covid-19 pandemic. This Group will report to the Quality Committee.

9) The element of the Board Assurance Framework relating to Covid will be considered at each meeting of the Board.

Decision making

10) Decisions made during this period will continue to be made in line with the current Scheme of Delegation and Standing Financial Orders. Decisions usually made by Committees or the Board, and/or where speed is of the essence will be taken forward as set out below.

11) For ad hoc items agreed by the Executive Directors as requiring a decision by the Board/Committee:

- Circulated to Board / Committee members via email for approval, whilst allowing sufficient time for review / response or
- Discussed via telephone / digital technology with the decision recorded by Corporate Governance or
- Discussed between the Chief Executive or nominated Executive Director with the Board / Committee chair for Chairs Action

In these circumstances the quorum will be 1 Executive Director and 2 Non-Executive Directors.

In implementing these recommendations, the health and wellbeing of colleagues will be a central consideration. Where feasible, meetings will be scheduled to take place during core business hours.

Version	Date	
1	*12.01.21*	*Proposals approved by Executive Team*
2	*19.01.21*	*Proposals approved by Non-Executive Directors*

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 19

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 January 2021**

PRESENTED BY: John Campbell, Chief Operating Officer

AUTHOR: David Nankivell, Head of Organisational Resilience

SUBJECT: **EU EXIT END OF TRANSITION PERIOD BRIEFING**

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:

Level of assurance provided.
This paper provides an update to the Board of Directors regarding the situation for the Trust and for healthcare providers following the end of the EU exit transition period.

Recommendations and decisions required

The Board is asked to:

- **note** the contents of the briefing in relation to the end of the EU exit transition period.

Executive summary

Overview: An EU/UK Trade Agreement was finalised on the 24th Dec 2020, and ratified by the UK Parliament and EU Ambassadors. The South West Regional EU End of Transition Period Team are overseeing potential impacts from the deal working with suppliers. To date none have been reported.

Risks: The focus of the agreement is on trade and cooperation with the EU which means that any potential issues are more likely to be limited to regulatory rather than financial issues.

It should be noted that significant mitigations remain in place to reduce potential supply chain disruption and therefore the risk to delivery of healthcare in the South West remains assessed as **Amber** at this time.

More detailed assessments are underway on a number of key work streams to look at the longer-term impact on the NHS.

Continuity of Supply: The primary elements of the continuity of supply are:

- **Government Secured Freight Capacity (GSFC)**
  The Department for Transport (DfT) has procured capacity for 'Category 1' goods, including all health supplies. This allows for 3,000 HGV vehicles bookings to be available per week on ferries from Europe to the UK.

- **Express Freight Service.**
  The Department of Health and Social Care (DHSC) has retained its Express Freight Service (EFS) arrangements with 3 specialist logistics providers to support the urgent movement of medicines and medical products to care Providers and patients if other measures experience difficulties.

- **Supporting Trader Readiness.**
  DHSC has worked with around 4,000 traders that support health and care providers, to assure that these traders are ready.

- **Buffer Stocks**.
  DHSC continue to encourage companies to make stockpiling a key part of contingency plans and have asked industry, where possible, to stockpile to a target level of 6 weeks' total stock on UK soil.

- **Regulation.**
  The Medicines and Healthcare products Regulatory Agency (MHRA) published guidance on the regulation of medicines and medical devices at the end of the transition period to help ensure continuity of supply of medicines and medical devices.

- **Shortage Management Response.**
  The National Supply and Disruption Response (NSDR) service remains operational in order to assist with the response to CoVid-19 and the end of transition period.

Medical devices: Nationally and regionally we are seeing some very low-level stock disruption, none of which are critical to patient care or service delivery. This disruption is being closely monitored by both EU Exit and Supply cells within NHSE/I.

Clinical Consumables: there is currently no supply issues to report.

GHC: No specific EU related issues have been raised within the Trust. Learning from feedback via our regional colleagues, we have bolstered mitigation arrangements for the Trust in relation to supply chain for any goods that may be provided from our suppliers who dispatch direct from Europe to the Trust. These arrangements are to ensure goods are not held up with customs and any additional costs as a result of this.

The Trust arrangements will continue to be:

- aligned to Covid-19 and Winter etc;
- Escalation of issues through the Emergency Preparedness, Resilience and Response (EPRR) routes as used presently;
- Local response will be system-wide working with partner agencies within the Integrated Care System (ICS);
- A single unified response structure;
- SitRep reporting will be aligned to Covid-19 and Winter.

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?
Daily Oversight Calls chaired by the COO

Appendices:	None

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

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Thursday 19 November 2020

Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Sarah Nicholson	Katie Clark
	Brian Robinson	Anne Roberts	Jo Smith	
	Mervyn Dawe (partial)			
	Faisal Khan	Katherine Stratton	Julie Clatworthy	Dan Brookes
	Chris Witham	Graham Hewitt	Tracey Thomas	Dawn Rooke
	Ruth McShane	June Hennell	Jenny Hincks	Said Hansdot
	Alison Feher	Juanita Paris		

IN ATTENDANCE:
Angela Potter, Director of Strategy and Partnerships
Gillian Steels, Trust Secretary Advisor
Graham Russell, Non-Executive Director/Deputy Chair
Jan Marriott, Non-Executive Director
Lavinia Rowsell, Head of Corporate Governance
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Sumita Hutchison, Non-Executive Director
Maria Bond, Non-Executive Director
Paul Roberts, Chief Executive
Steve Alvis, Associate Non-Executive Director
Steve Brittan, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Karen Bennett and Anneka Newman.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 16 September 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.

5. CHIEF EXECUTIVE'S REPORT

5.1 Paul Roberts, Chief Executive presented a verbal report to the Council.

5.2 As would be expected, a huge amount of time was being spent focussing on and managing the second surge of Covid, with GHC and partner organisations being incredibly busy. It was noted that inpatient admissions at GRH were now at the same level as they were at the height of the outbreak in March 2020; however, there were fewer admissions to intensive care beds. GHC was currently managing 10 Covid positive patients in its hospitals.

5.3 It was noted that GHC continued to provide the "Pillar 1" testing service for Gloucestershire. The service could test up to 100 people a day, and included GHC staff and family members, and other local NHS and Social Care organisations. A service was also provided for elective patients.

5.4 Lateral Flow tests were being introduced for frontline, patient facing colleagues and it was expected that these would be delivered and distributed to teams next week. Colleagues receiving the testing kits will be asked to carry out tests twice a week at home, even if they have no symptoms. It was hoped that home testing will help reduce the spread of Covid, both within our services and within our families/communities. It will also help reduce sickness absence, ensuring we can continue to keep services running during the winter.

5.5 Paul Roberts assured the Council that the Trust was doing all it could to ensure that colleagues felt supported during this challenging time. It had been an exhausting year and some colleagues had experienced very tough circumstances, working through isolation and additional PPE requirements. The Trust had an extensive programme of Health and Wellbeing support in place and feedback received on this had been very positive.

5.6 A Board seminar had taken place focussing on the Equality Diversity and Inclusion agenda; work that would continue to be developed and embedded into the Trust.

5.7 The Council noted that October was Freedom to Speak Up month and Paul Roberts took the opportunity to congratulate Sonia Pearcey, the Trust's FTSU Guardian who had been awarded an MBE in the Queen's Honours list. He said that huge efforts were made to inform colleagues of how they can speak up, and this was all the more important in the current challenging times.

5.8 The Council was informed that GHC continued to hold regular meetings with councillors and the Health Overview and Scrutiny Committee. Recent discussions at the HOSC had focussed on Covid as well as current consultations, including Fit of the Future and the Forest of Dean Hospital (on meeting agenda for discussion).

5.9 Ingrid Barker thanked Paul Roberts for providing his update, expressing her thanks to both Paul and the wider senior team and acknowledging the huge challenges and pressures that the team was under.

6. FOREST OF DEAN HOSPITAL CONSULTATION

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. **ACTION**

6.2 The formal consultation had commenced on the proposals for the hospital development, and would close on 17 December 2020. To date over 300 responses had been received.

6.3 Ruth McShane asked whether provision would be given for MH patients in relation to design considerations for the new hospital. Mervyn Dawe added that there had been extensive research around the effect of environmental factors such as lighting and decoration on the health and wellbeing of patients. Angela Potter said that the Trust was not that far along in the design phase yet but fully agreed that these aspects would need to be considered.

6.4 Mervyn Dawe asked about the current thinking around transport for the new hospital. Angela Potter said that it was recognised that transport/accessibility in the Forest of Dean was difficult. Discussions had taken place about the provision of parking on site and a new bus stop would be put in place outside the main entrance to the hospital.

6.5 Governors were encouraged to participate in the consultation process and were signposted to the consultation website – www.fodhealth.nhs.uk

7. FIT FOR THE FUTURE CONSULTATION

7.1 The Council received a presentation and short video setting out the key aspects of the Fit for the Future consultation, which was focussing on how best to provide specialist hospital services across the Cheltenham General and Gloucestershire Royal Hospital sites in the future. A copy of the presentation and video link would be sent to Governors after the meeting. **ACTION**

8. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

8.1 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 3 November and setting out one key recommendation for approval.

8.2 **Non-Executive Director Appointment** – Dr Steve Alvis was appointed as an Associate Non-Executive Director on 20 January 2020 for an initial one-year term. This followed a full appointment process with appropriate due diligence and input from key stakeholders including Board members, governors, staff and colleagues and experts by experience. Following discussions with the Chair, Steve Alvis had indicated that he was keen to be appointed as a full NED and to continue to contribute to the delivery of the organisational five-year strategic

framework. Whilst the decision to appoint Steve as a full NED resides with the Council of Governors, it was noted that Members of the Board of Directors had indicated their support for his appointment.

8.3 The Committee considered a report, which set out the detail of Steve Alvis's engagement and development since appointment, including his active engagement in Board and Committee discussions and Board Development activities, and attendance at the NED induction programme run by NHS Providers which covered key aspects of the role and the operating environment.

8.4 Faisal Khan advised that the Nominations and Remuneration Committee had supported the recommendation to the Council of Governors that Dr Steve Alvis be appointed as a Non-Executive Director of the Trust with effect from 19 November for an initial three-year term. The Council of Governors approved this appointment.

8.5 **Succession Planning/NED Skills Audit** - The Committee noted the initial outcome report from the NED Skills Audit. A paper would be brought to the February 2021 Nominations and Remuneration Committee setting out recommendations for future NED recruitment, which would be informed by the results of the skills audit and the future needs of the Trust.

8.6 **Non-Executive Director Remuneration** - Following the merger of the Trusts in October 2019, the Committee considered the remuneration of the NEDs and the Chair in light of the new responsibilities within the larger organisation, a new NHSI/E framework and benchmarking data, and made recommendations to the Council of Governors on changes to remuneration levels. It was agreed by the Council that the remuneration of NEDs and the Chair would be pegged for three years (to October 2022). This paper was therefore presented to the Committee for information as, in line with the decision of Governors, no changes to remuneration levels were being recommended.

9. LEAD GOVERNOR APPOINTMENT PROCESS

9.1 The Council of Governors received a report setting out the process for the appointment of a Lead Governor. It was noted that Faisal Khan kindly stepped in to the Interim Lead Governor role following the departure of the previous Lead Governor earlier in the year. He was supported by Mervyn Dawe as Interim Deputy Lead Governor. Faisal Khan would be stepping down from the Council when his first term comes to an end on 31 December and the Council will therefore need to nominate and approve the appointment of a successor.

9.2 The role of Lead Governor is for one year from the date of election and is subject to annual elections thereafter. A Governor can be reappointed as the Lead Governor for a maximum of 3 years. All Governors were invited to express an interest in being appointed as Lead Governor; however, it was good practice for a Public Governor to hold this position by way of avoiding any potential conflicts of interest.

9.3 An outline of the Lead Governor role description was presented to the Council.

9.4 In terms of process for appointment, Governors interested in nominating themselves as Lead Governor were asked to complete a nomination form and return this to Anna Hilditch by Friday 18 December 2020. A copy of the nomination form was included in the report. If more than one expression of interest was received, a short report would be prepared and circulated to all Governors in early January, asking people to vote for their preferred candidate. The Lead Governor would be appointed by the majority vote. The process for conducting this vote would be clearly set out within the report.

9.5 The Council of Governors was asked to note that there would be a period 1st – 21st January 2021 where the Trust does not have a Lead Governor in post. However, the Interim Deputy Lead Governor, Mervyn Dawe had agreed to stand in during this time.

9.6 The Trust proposes to review its Lead Governor arrangements and carry out a nomination process on an annual basis at its March Council meeting. A process paper would therefore be presented at the November meeting annually.

10. GOVERNOR REVIEW AND REFRESH UPDATE

10.1 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.

10.2 Following discussion and agreement at the September Council meeting, a Membership and Engagement working group was set up and had met twice, once in October and once in November. This group included governors, Non-Executive Directors and individuals from the Trust Secretariat and Comms Team and the Deputy Director of Strategy and Partnerships. The working group considered how the membership of the Trust could be revised to ensure that the engagement aims of the Trust were reflected in its operation. The key discussion points, decisions and outputs from this were presented in the report. These included a review of membership data to identify any target areas or area where growth could be promoted, consideration of ways for public and staff governors to engage with their membership, an increased clarity on benefits of membership and a review of the information collected on members to see if there is additional information we could gather to support more targeted communication.

10.3 In terms of Committees going forward, it was proposed that a Membership and Engagement Committee be set up on an ongoing basis in addition to the Nominations and Remuneration Committee. The initial focus for this group would be the potential additional appointed Governors and the development of the

Membership and Engagement Strategy. The draft terms of reference for this committee were presented to the Council.

10.4 The Council welcomed this report and the work carried out and progress made. The Terms of Reference for the Membership and Engagement Committee were approved. The Council endorsed the key elements of the Review & Refresh work to date and the draft Strategy to take this forward.

11. CHANGE TO THE TRUST CONSTITUTION

11.1 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 Governors and an increase in Appointed Governor posts.

11.2 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.

11.3 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.

11.4 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 Council was assured that the additional Appointed Governors would be jointly agreed and formalised through a further change to the Constitution.

11.5 The Council of Governors approved the proposed change to the Trust Constitution as set out in the report.

11.6 Any changes to the Trust Constitution requires approval from both the Council of Governors and the Trust Board. The equivalent paper to this one would therefore be considered by the Board at its meeting on 25 November 2020.

12. CHAIR'S REPORT

12.1 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 30 September meeting and was presented to the Council for information and reference. This report and its content was noted.

13. GOVERNOR MEMBERSHIP AND ELECTION UPDATE

13.1 This report provided an update on the current membership of the Council of Governors, an overview of vacant Governor positions, and future election requirements. This report was noted.

14. TRUST MEMBERSHIP REPORT

14.1 This report provided an update on Trust membership to the Council. A report was received at the last Council meeting in September and there had been minimal changes in that time. A full benchmarking exercise of Membership Data will be carried out and presented annually going forward at the September Council meeting.

14.2 As of 11 November 2020, the Trust had 6,096 Public members, of which 5,110 were in Gloucestershire. The Council was asked to note that the "Greater England" constituency listed in the data report would be updated to ensure that the correct constituency name was displayed for future reports – "Greater England and Wales".

14.3 This report was noted.

15. EXTERNAL AUDITOR REAPPOINTMENT

15.1 The Council of Governors received a report setting out the decision by the Audit and Assurance Committee at its meeting on 5 November to extend the current contract for the Trust's external auditors (KPMG) for a final one-year term from 1 April 2021 – 31 March 2022 as per the terms of the contract. KPMG was appointed as the Trust's external auditor by the Council of Governors for an initial period of three years from 1 April 2017, with the option of two extensions of one year each. There remained the option for a further one-year extension to 31 March 2022.

15.2 In considering the extension to the contract the Committee reviewed the outcome of the evaluation of the performance of the external auditors. The results showed a strong level of satisfaction with KPMG's performance. The Committee also considered benchmarking data of external audit fees paid by other NHS Trusts. This review suggested that the fee charged by the external auditors was in line with comparable NHS Trusts.

15.3 The Council was asked to note that the current contract for the provision of External Audit Services would therefore end in March 2022. In advance of this, a tender process will need to be undertaken to identify a provider from 1 April 2022. The Council of Governors, usually through a small group representing the

Council, will work with members of the Audit and Assurance Committee to undertake the appointment process, with the final decision being made by the Council of Governors. A timetable for this process would be provided to the Council in due course.

15.4 The Governors noted this report.

16. GOVERNOR ACTIVITY UPDATES

16.1 It was noted that a number of Governors had participated in the NHS Providers Annual Governor Conference held on 3-5 November. Discussions and feedback from the event had taken place at the Governor pre-meeting, and it had been agreed that a short briefing would be pulled together collating this feedback and key learning points for onward sharing with colleagues. Those Governors who had participated would be contacted and invited to share their feedback with Anna Hilditch. **ACTION**

16.2 June Hennell advised that she had required a Covid swab test and expressed her thanks to the Trust's Covid testing teams who were doing a fantastic job.

16.3 Ruth McShane referred to the recently published Healthwatch Gloucestershire report which had gathered and analysed patient feedback about mental health A&E care in local hospitals. Their report, "Experiences of urgent mental health care in accident and emergency: A Gloucestershire perspective", had made several recommendations for how services could be developed to put mental health care on a par with physical health care in the county. It was noted that the report focussed in the main on the acute Trust's A&E departments; however, the report had also been considered internally by the Trust to inform ongoing improvements.

17. ANY OTHER BUSINESS

17.1 There was no other business.

18. DATE OF NEXT MEETING

18.1 The next meeting would take place on Thursday 21 January 2021 at 2.00pm. This meeting would be a Governor Development session.

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.
19 November 2020			
6.1	A copy of the FoD Hospital consultation presentation – and link to the consultation website to be shared with Governors	Anna Hilditch	Complete
7.1	A copy of the Fit for the Future consultation presentation and link to the short video setting out the key aspects of the consultation to be shared with Governors	Anna Hilditch	Complete
16.1	Feedback and learning points from the NHS Providers Annual Governor Conference held on 3-5 November to be collated and a short briefing paper would be pulled together for onward sharing with colleagues.	Anna Hilditch / Governor attendees	

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AGENDA ITEM: 21

REPORT TO: **TRUST BOARD PUBLIC SESSION – 28 January 2021**

PRESENTED BY: Lavinia Rowsell – Head of Corporate Governance and Trust Secretary

AUTHOR: Anna Hilditch – Assistant Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL Q2 – 1st July – 30 September 2020**

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 1st July – 30 September 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 four times since the last report to the Board in July 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?

Appendices:	Appendix 1: Register of Seals

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance and Trust Secretary

Register of Seals 1st July 2020 – 30 September 2020

APPENDIX 1

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
11/2020	17.08.20	Lease relating to Invista Management Block, Ermin St, Brockworth. Between Invista Textiles UK Limited and GHCNHSFT	1	Paul Roberts CEO	John Campbell Chief Operating Officer	Louise Moss Deputy Head of Corporate Governance	17/08/2020
12/2020	17.08.20	Licence for Landlord Works – relating to Invista' s Management Block, Ermin St, Brockworth	1	Paul Roberts CEO	John Campbell Chief Operating Officer	Louise Moss Deputy Head of Corporate Governance	17/08/2020
13/2020	17.08.20	Licence for Alternations - relating to Invista's Management Block, Ermin St, Brockworth	1	Paul Roberts CEO	John Campbell Chief Operating Officer	Louise Moss Deputy Head of Corporate Governance	17/08/2020
14/2020	17.08.20	Licence to occupy on a short-term basis - relating to Security Office at Invista's Management Block, Ermin St, Brockworth	1	Paul Roberts CEO	John Campbell Chief Operating Officer	Louise Moss Deputy Head of Corporate Governance	17/08/2020

MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE (MHLS)
SUMMARY REPORT

DATE OF MEETING: 18 November 2020

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

Key Points to Draw to The Board's Attention

REVIEW OF CQC MONITORING VISITS

The feedback received from the CQC remote visits of Abbey Ward and Willow Ward was shared and the Committee was informed that patients felt more comfortable and more able to talk during remote visits, rather than physical ones with conversations held virtually via Microsoft Teams. The visits are producing very few required actions now and in the case of Willow Ward there were none.

REVIEW OF LEGAL UPDATES

The Committee received the review of Legal Updates and it was reported that the government had recently issued amended regulations. From 1st December 2020 statutory forms would be allowed to be sent and received electronically. Further guidance was anticipated before the implementation date of 1st December.

The Committee noted the new regulations and the action to be taken by the Trust.

UPDATE ON AMHP COVER

The Committee received an 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 an 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 for 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.

WESSLEY 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).

OTHER ITEMS RECEIVED BY THE MHLS COMMITTEE

- The Committee received the summary report from the Mental Health Operational Group.
- The Committee received the minutes of the Mental Health Managers' Forum and it was noted that Steve Alvis would now chair the forum.
- The Committee received the report of Issues Arising in Mental Health Reviews, noting the assurance provided.
- The Committee received the report on Monitoring of Provision of Patients' Rights and it was noted that the paper had previously been received by the Mental Health Operational Group. The actions and assurance provided was noted.
- Philip Southam informed the Committee that an audit had been carried out on a random selection of AMHP applications for admission and medical recommendations. Assurance was provided that there were no issues or errors found which could have invalidated the section.
- A verbal update was provided relating to the Risk Register informing the Committee there were no new risks for the Committee's consideration.
- The Committee received the process for the Committee Effectiveness Reviews. The results would be received by the Committee in January.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**20 January 2021**

Reforming the Mental Health Act White Paper

The government has published the Reforming the Mental Health Act White Paper, which sets out proposed changes to the Mental Health Act 1983. The paper also sets out proposals and ongoing work to reform policy and practice to support the implementation of a new Mental Health Act. The proposals take forward the majority of the recommendations made by the Independent Review of the Mental Health Act 1983.

This briefing summarises key points from the white paper, but we encourage providers to read the document in full for a comprehensive overview. The government is now seeking views, until 21 April 2021, on the implementation and impact of the reforms. Feedback will inform the drafting of the Bill to amend the Act, which will be brought forward when parliamentary time allows. We will submit a consultation response based on member feedback – please contact ella.fuller@nhsproviders.org to share your views. To guide professional practice, the code of practice will later also be revised to align with the reformed legislation.

Key points

- The Reforming the Mental Health Act White Paper proposes a wide range of changes to improve mental health services and people's experiences under the Mental Health Act (MHA). The changes aim to make sure that:
  - people are detained for shorter periods of time, and only detained when absolutely necessary
  - the care and treatment of someone detained is focused on making them well
  - people have more choice and autonomy about their treatment
  - everyone is treated equally and fairly, and disparities in people's experiences are tackled
  - people with a learning disability and autistic people are treated better in law and there is reduced reliance on specialist inpatient services for this group of people
- The white paper is split into three main parts: legislative reforms proposed to the MHA itself; proposals and ongoing work to reform policy and practice to improve patient experience; and the government's response to the Independent Review of the Mental Health Act 1983.
- The paper confirms reforms will require additional funding and expansion of the workforce over and above commitments made in the NHS long term plan (LTP) and the delivery of the proposals will therefore be subject to future funding decisions.

Context

An Independent Review of the Mental Health Act 1983 was published in December 2018, which set out what needed to change in both law and practice in order to improve mental health services and people's experiences under the MHA. The government has accepted, and will take forward, the majority of the review's recommendations for change. Some actions, based on the review's recommendations, have been taken already. For example, £400 million has been committed to eradicate mental health dormitory provision and people detained under the MHA can nominate a person of their choice to be involved in decisions about their care. The development of a Patient and Carers Race Equality Framework is also underway.

Proposals for reform

New guiding principles

There are four new guiding principles that people working to provide care will need to consider while carrying out their duties. They are:

- choice and autonomy – making sure people's views and choices are respected
- least restriction – making sure the Act's powers are used in the least restrictive way
- therapeutic benefit – making sure patients are supported to get better, so they can be discharged from the Act as quickly as possible
- the person as an individual – making sure patients are viewed and treated as rounded individuals.

Summary of proposals

Detention criteria and challenging detention

Those taking the decision to detain someone will need to document the specific risk that justifies detention and how detention will deliver therapeutic benefit. Decisions about when and whether to discharge a patient should include an assessment about whether the hospital or an alternative community setting provides the most therapeutic package of care.

The government will seek to introduce more checks on whether a patient's detention continues to be appropriate. The government will also increase access to the mental health tribunal by extending time limits and opportunities to apply for discharge. Independent Mental Health Advocates (IMHAs) will be given a new statutory power to apply to the tribunal to challenge the patient's detention. When considering applications for discharge, tribunals will be given the power to grant leave, transfer

patients and to direct services in the community. The government is also considering increasing the number of automatic referrals to the tribunal and removing the hospital manager hearing.

Choosing and refusing treatment

The government proposes introducing advance choice documents, making care and treatment plans statutory, as well as introducing a new framework for patient consent and refusal of medical treatment. Further changes proposed include: bringing forward the point at which the second opinion appointed doctor reviews a patient's treatment; and the ability for patients to appeal treatment decisions at the tribunal if evidence suggests wishes and preferences were inappropriately overruled.

Improving support for people detained

The government plans to replace the current 'nearest relative' role with a new statutory role, known as the 'nominated person'. This person will have additional powers and rights, such as the right to be consulted on transfers between hospitals and the power to apply for discharge on the patient's behalf. The government proposes expanded powers for IMHAs and invites views on how to improve the role and whether this can be achieved by professionalising advocacy services.

Community treatment orders

The government wants to reform community treatment orders (CTOs), for example by strengthening criteria and increasing evidence requirements, so that they are only used where there is strong justification for doing so and where the CTO is considered to deliver a genuine therapeutic benefit to the patient. The effects of these reforms would be monitored over an initial five-year period.

Interface with the Mental Capacity Act

The government is exploring the introduction of a simpler 'dividing line' between the MHA and the Mental Capacity Act to make it clear which framework a clinician should use to detain a patient in these circumstances. This proposal would mean decision makers would not use the MHA if a patient: lacks the relevant mental capacity to consent to detention and treatment; and is not objecting to detention or treatment. The paper also discusses provision for prior consent to be admitted as an informal patient and improving the powers available to health professionals in A&Es so that individuals in need of urgent mental health care stay on site pending a clinical assessment.

Caring for patients in the Criminal Justice System

Some of the proposed reforms will not apply to patients in the criminal justice system, for example the new criteria for detention and changes to the detention criteria for individuals with learning disability and/or autism. The 'nominated person' will also have limited powers in this context, and tribunal powers and automatic referrals to the tribunal will differ also for these patients compared to civil patients.

People with a learning disability and autistic people

The government proposes to change the Act to be clearer that autism or a learning disability are not considered to be 'mental disorders' for the purposes of most powers under the Act. The government is also developing a duty on health and social care commissioners to collaborate to ensure provision of community-based support and treatment for these individuals. This will be set out in the new MHA.

Children and young people

In addition to legislative changes, all of which will be available to children and young people, the government proposes care and treatment plans are provided to all children and young people receiving inpatient mental health care. The government wishes to fully consider any reforms concerning consent and decision making as part of its review of the code of practice.

People from Black, Asian and minority ethnic backgrounds

The paper highlights a series of reforms underway to tackle the inequalities that exist across mental health services and under the Act for people from Black, Asian and minority ethnic (BAME) communities. These include the introduction of the Patient and Carers Race Equality Framework and the development of culturally appropriate advocacy services. The government will legislate for culturally competent advocacy services to be available to detained patients, subject to funding and learnings from current pilot work.

Reforming policy and practice

This section describes how the government and the NHS will work, along with other partners, to bring about an overall culture change within mental health services, so that people have a better experience of care under the Act. It summarises a significant amount of ongoing work to reform policy and practice that members will be aware of and engaged with. Below is a summary of further key proposals put forward to reform policy and practice to support implementation of the new Act.

Quality improvement programme

An implementation support plan will be developed in partnership with NHSE/I and HEE to create the best ward cultures to improve patient experience. This will include a national quality improvement (QI) programme led by NHSE/I, which will look specifically at care under the Act to enable and support this system-wide drive for change.

Inpatient safety and risk

The government will work with arm's length bodies and stakeholders to consider how best to ensure that the implementation of new patient safety interventions and programmes have positive contributions to the therapeutic environment of mental health settings.

The physical ward environment

NHSE/I will review whether the guidance and data collection on mixed sex accommodation is adequate for mental health settings, or otherwise needs to be revised, better communicated or measured differently.

The role of the Care Quality Commission

The government supports extending the CQC's monitoring role to consider the effectiveness of local joint working in principle, but would like to explore this further. Under this proposal the CQC would not be responsible for regulating or taking enforcement action against CCGs, local authorities or any other partner organisation in exercising its powers under the Act. The government intends to explore what, if any, changes in legislation might be needed to make sure the CQC can effectively discharge an extended monitoring power cooperatively with system partners. Proposals for consultation will be published at a later stage.

Care planning in the community

The government intends to explore how a new statutory care plan could work in practice and what further information, guidance and support it can provide on care planning, as well as the practicalities and implications placing care planning on a statutory footing would have on the workforce.

National guidance on section 117 aftercare

The government will update national guidance so that there is greater clarity on how budgets and responsibilities should be shared to pay for aftercare provided under section 117 of the MHA. The

government will also develop a clear statement in the new code of practice of the purpose and content of section 117 aftercare.

Use of police custody

The government has committed to remove police stations as a designated place of safety by 2023/24. There is a recognition in the paper this may require new capital funding to be available to provide the estate needed, including health-based places of safety. The government will establish a national agreement between mental health services, social care and the police to ensure that people detained under section 136 are safely and effectively transferred into health services in a timely way.

The mental health workforce

The government anticipates that the reforms will require further expansion of the workforce, over and above that to be delivered through the LTP, to meet additional demands. In addition to setting out ongoing work, the paper states the government will be working with NHSE/I, HEE, Skills for Care and the Chief Social Worker's office over the coming months to look at further national support requirements, including on training on the changes to the Act, and supporting meaningful co-production and the development of expert-by-experience leadership roles.

Data and digital

The government is working to establish how the Act's pathway may be modernised in further ways, following the developments during the pandemic period in 2020. The government aims to eventually look to deliver a "digital first" approach to processes and procedures, governed by the Act.

Impact assessment

The government has estimated likely costs and benefits of implementing the proposed changes to the Act. It would be grateful for any further data or evidence that might improve the methods used and the resulting estimates, and in particular the effect the proposals would have on the following:

- the current workloads for clinical and non-clinical staff, Independent Mental Health Advocates, Approved Mental Health Professionals, Mental Health Tribunals, second opinion appointed doctors, and other relevant positions
- specific interest groups that have not currently been considered
- health outcomes
- individuals' ability to return to work or any other daily activity
- the health and social care system and the justice system more broadly.

Next steps

The government is now seeking views, over a 14-week period until 21 April 2021, on the implementation and impact of the reforms. We will submit a consultation response based on member feedback – please contact ella.fuller@nhsproviders.org to share your views.

Feedback will inform the drafting of the Bill to amend the Act, which will be brought forward when parliamentary time allows. The proposals set out in this white paper are also subject to future funding decisions, including at the Spending Review 2021. To guide professional practice, the code of practice will later also be revised to align with the reformed legislation.

NHS Providers view

We welcome the publication of the white paper. Reform of the Mental Health Act is more important than ever as COVID-19 has accelerated mental health trends and intensified the challenges facing services. We look forward to exploring the implications of the proposals with members, responding to the consultation and supporting subsequent stages of the Act's reform on their behalf.

Putting patients at the heart of how they access treatment is vital to high quality care. The CQC's latest assessment of the care provided to people detained under the Act during the pandemic period highlighted how a wide range of services have empowered their patients and service users by applying the principles of least restriction and focusing on care planning and co-production. We welcome the government also highlighting in the paper that there are many examples of good practice across the country which need to be shared.

We previously recommended the simplification of the legislation, along with changes that maintain appropriate safeguards but enable greater individual rights and liberties, with service users having a more active role in care planning with a recovery focus. We have also stressed the need for the provision of appropriate post-discharge care and support.

However, reform of the Mental Health Act alone will not be enough to improve how and where good quality mental health services are accessed. We welcome the government making it clear that new legislation is only part of the story. The white paper helpfully highlights a significant amount of ongoing work, and puts forward further proposals, to reform policy and practice to support implementation of the new Mental Health Act. We need to address the underlying issues driving the pressures on services and the rising severity and complexity of people's needs. As we have said previously, system and financial pressures on providers, combined with inconsistent investment in

mental health services at local levels, are exacerbating bed capacity pressures and increasing the likelihood that a person may reach crisis point necessitating use of the Act to admit.

We note the government confirms that reforms will require additional funding and expansion of the workforce, over and above commitments made in the NHS long term plan, and the delivery of the proposals set out in the white paper will therefore be subject to future funding decisions. We will work with members to feed back any further data or evidence we think would assist the government's estimations in the current impact assessment. All the changes taken forward must be fully funded and take account of the current operational and financial pressures facing providers.

The rapid expansion of services required to meet extra demand for mental health care and support over the months and years ahead must be fully and promptly funded on a sustainable basis. The expansion of community-based specialist mental health care capacity, and ensuring these services are accessible to everyone, is key to reducing the need to detain under the Act and providing care in the least restrictive setting. Adequate investment to maintain and build on the steps being taken to grow the mental health workforce, and the sector receiving its fair share of capital funding, are both also crucial. Alongside this, there must be increased support for public health and social care given the crucial role these services play in providing people with the care and support they need before they reach a crisis.

We welcome the government emphasising its commitment to working closely with national and local health and care organisations to understand the impact of legislative reform on the system and to develop a robust and achievable plan for implementation. It is right to recognise that other demands placed on the system by wider transformation plans and the capacity of the health and care workforce to deliver what is required need to be carefully taken into account as this work progresses.

Our press statement responding to the white paper's publication can be accessed here.

Contact

For further information please contact Ella Fuller, policy advisor, ella.fuller@nhsproviders.org

AGENDA ITEM: 23

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING: 17th December 2020

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 88% • Quorate – Yes

Key Points to Draw to the Board's Attention

FINANCE REPORT

The Committee received the Finance Report for month 8 and was informed that the Trust was now operating under the newly revised financial framework.

It was reported that the planned deficit for the Trust was £439k at year end. However, current indications predict that the deficit will be lower. It was reported that the Trust was on track to deliver a surplus position at the end of the year.

The Committee was informed that there was a risk around the Capital Plan and ensuring the whole financial envelope would be spent before year end. The Committee was assured that discussions were taking place weekly focusing on achieving the intended spending amount. The Capital expenditure was reported currently being £2.3m behind plan. The Director of Finance assured the Committee that if there was any slippage, IT schemes could be brought forward further to ensure money would not be unspent. This would include laptop and PC replacements.

PERFORMANCE REPORT

The Committee was informed of 10 mental health indicators in exception and 16 physical health indicators. It was noted that there were no new indicators in both mental and physical health.

The Committee was informed that of the mental health indicators, the majority of the exceptions were due to data quality issues within CYPS transition cases and challenges within the eating Disorder Services.

Of the 16 physical health indicators, it was reported 7 were within Children and Young People Services (CYPS) and 2 were within Wheelchair Services. In order to identify improvement recommendations; internal auditors PwC had been commissioned to undertake an internal audit on data quality within Health Visiting and Wheelchair Services in quarter 4 2020/21.

The Committee agreed that a whole Board discussion on identifying measurable KPIs would be welcomed and this would be followed up as an action.

BUSINESS PLANNING AND BUDGET SETTING PROCESS 21/22

The Committee received a Business Planning and Budget Setting 21/22 update, informing the Committee that there would be an alignment between business planning and budget setting across the organisation. This was received as a requirement from NHSI.

A copy of the presentation was shared with all Board members after the meeting for information.

FOREST OF DEAN DEVELOPMENT UPDATE

The Committee received an update report on the development of the new Community Hospital in the Forest of Dean, providing an update on the Board's preferred option process to appoint a construction partner and commencing further exploration of an estates partner. A Forest of Dean Hospital update report would be received at the January Board meeting.

BUSINESS CASE – MONTPELLIER UNIT REFURBISHMENT

The Committee received the business case for the refurbishment of the Montpellier unit. The Director of Finance informed the Committee that the total cost for the project would be £1.6m.
The Committee approved the project at a total capital cost of £1,602,340 including VAT.

OTHER ITEMS RECEIVED BY THE RESOURCES COMMITTEE

- The Committee received a progress update on the Best People Strategy and Implementation Plan. Results of the Staff Survey would be received in February.
- An update was provided on Trust's plans with respect to its Workforce Race Equality Standard (WRES) and its Workforce Disability Equality Standard (WDES) actions for 2020/21 and the Committee endorsed actions therein.
- The Business Development Report was received and the Committee was informed of upcoming tender opportunities.
- The Committee Effectiveness Review and Terms of Reference were received by the Committee and reviewed.
- The Committee received and noted the update on the changes to HR Policies and Procedures.
- The Committee received the summary report of the Digital Group held 30th November 2020.
- The Committee received the summary report of the Capital Management Group held 23rd October 2020 and 18th November 2020.
- The Committee received the summary report of the Business Intelligence Management Group held 19th November 2020.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**25 February 2021**

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING: 7th January 2021

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive Director • Attendance (membership) – 83% • Quorate – Yes

Key Points to Draw to the Board's Attention

PATIENT SAFETY AND EXPERIENCE REPORT

The Committee received the Patient Safety and Experience Report and was informed that there were currently 7 active Serious Incidents Requiring Investigation (SIRIs), all of which were reporting as being on track in terms of investigation and submission. It was noted that this was a good position for the organisation to be in. It was reported that there had been a significant reduction in physical health SIRIs.

The Committee was assured that all "moderate harm and above" incidents were continuing to be reviewed following the first wave of Covid and recovery, as a result of the backlog.

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard Report, providing the Committee with an update on progress and achievements of quality priorities and indicators across physical health, mental health and learning disability services.

Improvements made in pressure ulcers following the positive impact of the Quality Improvement project developed with the Gloucestershire Integrated Care Team was highlighted in the report. The Committee was informed of the development of a live pressure ulcer dashboard which had been developed unique to each locality; allowing control and robust challenge from professional leads and the new band 7 senior support roles. The Committee was informed of the next steps, which would be rolling the dashboard out to the Forest of Dean and Tewkesbury; both places where pressures ulcer occurrences were at their highest.

It was reported that resuscitation training compliance was currently below target. This was largely due to Covid and the stepping down of services. The Committee was reassured however that a robust recovery training plan had been developed and had been approved by the Executive. The Committee would receive a further update in March on the progress being made with statutory and mandatory training compliance.

The Committee was informed of 2 Covid outbreaks in Cirencester Hospital, on Coln Ward and Windrush Ward in December. The investigation on the outbreak on Coln

RD Ward concluded the trigger point was a positive patient that was transferred from Swindon Hospital and the Trust had been informed the patient was negative upon admission. The outbreak on Windrush Ward was ongoing, therefore the investigation was not yet able to conclude the trigger point of the infection.

An update was provided to the Committee on the progress of the Covid vaccination programme. The Committee was informed that 1000 staff had received their first vaccine, some had received their second. The Quality Dashboard would include vaccination figures going forward.

CQC COMMUNITY MENTAL HEALTH SURVEY

The Committee received the CQC Community Mental Health Survey results and action plan.
Lauren Edwards informed the Committee that 380 responses had been received, which was the highest nationally. The Trust had also received the highest scores within England on 6 of the questions asked in the survey.

The Committee noted the results and assurance provided of the ongoing delivery of high-quality adult community mental health services.

OTHER ITEMS RECEIVED BY THE QUALITY COMMITTEE

- The Committee received a clinical presentation of Learning Disabilities Services during Covid by one of the Trust's Consultant Clinical Psychologists. The presentation described the different ways in which people with learning disabilities had been affected by the pandemic and the actions that had been taken to support vulnerable patients.
- The Committee received the draft Clinical Audit Programme 2021/22, noting the contents would be reviewed by the Operational Delivery and Governance Forum prior to the approval by the Improving Care Group.
- The Committee received and reviewed the summary reports from the Quality Assurance Group which took place 20th November and 18th December 2020.
- The Committee noted the outcome of the Committee Effectiveness Review and considered the proposed changes to the Terms of Reference received.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**04 March 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday 25 November 2021

10:00 – 13:30

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/1121	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/1121	Declarations of interest	Assurance	Verbal	Chair
10.05	03/1121	Service User Story Presentation	Assurance	Verbal	DoNTQ
10.25	04/1121	Draft Minutes of the meetings held on: • 30 September 2021	Approve	**Paper**	Chair
	05/1121	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/1121	Questions from the Public	Assurance	**Paper**	Chair
Performance and Patient Experience					
10.40	07/1121	Performance Report	Assurance	**Paper**	DoF
10.55	08/1121	Quality Dashboard Report	Assurance	**Paper**	DoNTQ
11.10	09/1121	Patient Safety Report Q2	Assurance	**Paper**	MD
11.20	10/1121	Learning from Deaths Q2	Assurance	**Paper**	MD
11.30	11/1121	Freedom to Speak Up Report	Assurance	**Paper**	DoNTQ
11.45am – BREAK – 10 Minutes					
11.55	12/1121	Finance Report	Approve	**Paper**	DoF
Strategic Issues					
12.05	13/1121	Report from the Chair	Assurance	**Paper**	Chair
12.15	14/1121	Report from Chief Executive	Assurance	**Paper**	CEO
12.25	15/1121	Community MH Transformation Update	Assurance	**Paper**	DoSP
12.40	16/1121	Systemwide Update	Assurance	**Paper**	DoSP
12.50	17/1121	Board Assurance Framework	Assurance	**Paper**	HoCG
Governance					
13.05	18/1121	Use of the Trust Seal – Q1 & Q2	Assurance	**Paper**	HoCG
13.10	19/1121	Council of Governor Minutes – Sept	Assurance	**Paper**	HoCG
Board Committee Summary Assurance Reports (Reporting by Exception)					
13.15	20/1121	MHLS Committee (20 Oct)	Endorse	**Paper**	MHLS Chair

TIME	Agenda Item	Title	Purpose		Presenter
NOTE	21/1121	Great Place to Work Committee (21 Oct)	Information	**Paper**	GPTW Chair
NOTE	22/1121	FoD Assurance Committee (26 Oct)	Information	**Paper**	FoD Chair
NOTE	23/1121	Resources Committee (2 Nov)	Information	**Paper**	Resource Chair
NOTE	24/1121	Quality Committee (4 Nov)	Information	**Paper**	Quality Chair
NOTE	25/1121	Appointments and Terms of Service (9 Nov)	Information	**Paper**	Chair
NOTE	26/1121	Audit and Assurance Committee (11 Nov)	Information	**Paper**	Audit Chair
Closing Business					
13.25	27/1121	Any other business	Note	Verbal	Chair
	28/1121	**Date of Next Meetings** **<u>Board Meetings 2022</u>** Thursday, 27 January Thursday, 31 March Thursday, 26 May Thursday, 28 July Thursday, 29 September Thursday, 24 November	Note	Verbal	All

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 04/0921

MINUTES OF THE TRUST BOARD MEETING

Thursday, 30 September 2021

Via Microsoft Teams

PRESENT:
Ingrid Barker, Trust Chair
Dr. Stephen Alvis, Non-Executive Director
Sandra Betney, Director of Finance
Maria Bond, Non-Executive Director
Steve Brittan, 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
John Trevains, Director of Nursing, Therapies and Quality
Dr. Amjad Uppal, Medical Director

IN ATTENDANCE:
Sarah Birmingham, Deputy Chief Operating Officer
Clive Chadhani, Non-Executive Director Designate (from 1 Oct)
Jacqui Cooper, CQC
Marie Martin, CQC
Ruth McShane, Trust Governor (until Item 4)
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
Anna Hilditch, Assistant Trust Secretary

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from Marcia Gallagher, Hilary Shand and Helen Goodey.

1.2 Ingrid Barker noted that this would be Maria Bond's final Board meeting, with her second term as a Non-Executive Director coming to an end later that day. On behalf of the whole Board, Ingrid Barker expressed her thanks and appreciation to Maria for her huge contribution.

1.3 Ingrid Barker welcomed Clive Chadhani who was in attendance as an observer at the meeting. Clive had been appointed as a new Non-Executive Director and would be commencing in post from 1 October 2021.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Elaine to the meeting who had kindly agreed to speak to the Board, with consent, about her daughter's experience of health services.

Elaine was supported by James Lewis-Watkins, Eating Disorder Service Manager.

3.2 Elaine and her family moved to Gloucestershire in April 2021. Elaine's daughter Christina was now 24 years old. In 2017/18 Christina had intermittent periods when she felt unwell and struggled with stomach problems. She saw a number of different clinicians during this time who prescribed varying medication but there was no consistency. In 2019 they saw a GP who was determined to help and referred Christina to the Gastric Team. In July 2019 she had an appointment with the team but received no follow up. In October 2019, Christina started being sick on a daily basis and when they contacted the Gastro Team they were told that they had dropped off the list. They were passed from pillar to post and end up back with the GP. In July 2020 they contacted the GP for help again, to be told that Christina should take paracetamol for the pain. One week later Christina was admitted into hospital with sepsis.

3.3 In April 2021, Elaine and her family moved to Gloucestershire. She said that they felt welcomed and after the first appointment with a new GP they had been referred to the Eating Disorder Team and received a face-to-face appointment within weeks. Elaine said that the support received from the ED Team had been immense, and they continued to monitor her. Elaine said that a member of the ED Team even contacted Christina during a recent stay in hospital.

3.4 Before moving to Gloucestershire, Elaine said that their experience of services had been frustrating and distressing, highlighting the impact of services that don't communicate with each other and 'bounce' patients between services when they don't neatly meet access criteria. As soon as the family moved into Gloucestershire, they received appropriate and swift referrals and communication between services (GP, GHC, GHT), along with shared management of care across services. The support and compassionate care provided by the ED Service, and the confidence in the GP and the wider system working together had had a positive effect on the family's quality of life.

3.5 Ingrid Barker thanked Elaine for presenting her story which was hugely powerful and emotional. She opened the item up for questions from Board members.

3.6 Steve Alvis asked whether Elaine had shared her experience and learning with the previous (unnamed) Trust to try and improve services for other people. Elaine said that she had written to them and had suggested improvements around better communication within the system. She said that to date the previous Trust had yet to send Christina's medical notes on to Gloucestershire. Elaine informed the Board that once Christina received gastro treatment, she did plan to contact the previous Trust again to tell them the outcome so they knew the correct treatment path that should have been taken.

3.7 Paul Roberts said that GHC were keen to ensure the provision of integrated services, and asked Elaine whether she felt that her experience had demonstrated this. Elaine said that the service received since moving to Gloucestershire had felt joined up and had worked, but unfortunately this joined up care did not appear to be in place in other parts of the country.

3.8 Paul Roberts noted that there were significant pressures within the Eating Disorders service currently, and asked Sarah Birmingham and James Lewis-Watkins what additional support they felt the service needed from the Trust Board. Sarah Birmingham said that strong clinical triage was vital. The Trust's ED Team listened to Elaine and Christina so that support could be offered. She said that the service was still in recovery so ongoing support and patience from the Board would be welcomed. James Lewis-Watkins said that demand for the Eating Disorder service was high and recruitment to vacant posts was ongoing. In terms of Elaine's presentation, James said that he welcomed hearing about the positive experience they had had with the GP and the swift referral that had been made.

3.9 The Board thanked Elaine for the presentation, and asked that their thanks and best wishes also be passed on to Christina who had given consent for her story to be told.

4. MINUTES OF THE PREVIOUS BOARD MEETINGS

4.1 The Board received the minutes from the previous Board meeting held on 29 July 2021. 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 progressing to plan. There were no further matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 The Board had received a written question in advance of the July Board meeting from Joy Hibbins, on behalf of the charity Suicide Crisis. At the time of the July meeting, it had not been possible to provide a full written response as the question in part related to a presentation and work being led by other partner organisations, not GHC, and until the Trust could liaise with them it was not felt appropriate to provide a response on their behalf. Since that time Trust colleagues had liaised with partners and a written response had now been provided to the questioner. A copy of the full question and response was presented to the Board.

6.2 No further questions were raised at the meeting.

7. QUALITY DASHBOARD

7.1 This report provided an overview of the Trust's quality activities for August 2021. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

7.2 John Trevains informed the Board that overall, the report demonstrated that some fantastic and dynamic work was being carried out and high-quality services were being delivered.

7.3 The report highlighted those Quality issues for priority development to the Board:

- Pressure on adult mental health beds continues, as does the task and finish group led by the quality team to support opportunities to create capacity. Positively, the situation does appear to be slowly improving and is reflected in the reduction of out of area bed usage reported in the dashboard.
- Wheelchair Services, Podiatry, Physiotherapy and Paediatric Speech and Language Therapy remain under enhanced observation by the quality team noting the additional challenges with referrals and wait times.
- There are no 12 months plus complaints outstanding and all 7+ month complaint cases have their progress reported upon weekly. John Trevains advised that the number of complaints received month on month remained relatively static, the challenge had been clearing the backlog in the system due to reduced resources within the team. However, all the additional resource (2 new experienced colleagues) is now in place alongside a new more efficient process. Reporting zero 6 month + complaints is a 2021/22 Quality Priority for the Trust.
- RMN recruitment at Wotton Lawn Hospital remains a significant service challenge and further work is being delivered to address this issue in partnership with Operations and Human Resources Directorates. This is alongside recruitment challenges recognised in other services notably Integrated Community Teams.
- CPA compliance has decreased further compared to previous month's data to 86.8%. Trust Recovery Teams continue to report increased caseloads, increased levels of acuity alongside staffing challenges. There is a service recovery action plan in place which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due. John Trevains assured the Board that this drop in compliance did not mean that the standard of care being received was poor and related to data quality/data entry issues. However, he said that this remained a key priority and would therefore not accept a continued decline.

7.4 Those Quality issues showing positive improvement

- The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. The percentage of patient safety incidents meeting moderate, severe and death thresholds has decreased to 5.75%. Further data analysis has identified reductions in self-harm incidents at Wotton Lawn and continued good progress from the Pressure Ulcer Improvement programme linked to the reduction in recorded incidents.
- The Pressure Ulcer (PU) indicators report there have been fewer incidents in all categories of (PU) this month. The number of PU's in category 1&2 has decreased by 4, category 3 have decreased by 1 with Category 4 remaining at 0. Indicators are positive that this is a sustainable improving area and that quality initiatives taken to reduce PU's are effective.
- In total 33 new international nursing colleagues are in the process of joining the Trust. 19 have arrived in the UK and it is anticipated that our remaining new colleagues will have arrived by March 2022. It is excellent to note that

the first cohorts of international nurses have all passed their accreditation exams and are very much a valuable addition to our Gloucestershire Health Care nursing family. Our international recruitment approach is developing routes for mental health and direct entry community nurses into District Nursing Teams.

- This dashboard reports strong compliance and sustainable processes in place for FFP3 mask training requirements. John Trevains said that he was proud of this performance as it underpinned the Trust's commitment to safe services.

7.5 Steve Alvis noted the uptake of the HPV vaccine. Sarah Birmingham reported that the Trust was working closely with schools to achieve vaccination targets. It was noted that local monitoring was also in place for the uptake of the vaccine for boys as well as girls. Sarah Birmingham agreed to provide Steve Alvis with additional data. **ACTION**

7.6 Jan Marriott said that she had carried out a recent Quality visit to the Wheelchair Service. This was an all-age service and from her visit, Jan said that she had real confidence in the team and there was a good patient centred culture in place. John Trevains thanked Jan Marriott for her comments, noting that the feedback from the NED Quality visits was invaluable. All feedback was collated, and a process of reporting was now in place via the Quality Committee to ensure any learning or key actions from the visits was appropriately captured and followed through.

7.7 Graham Russell noted the excellent progress being made around Pressure Ulcers. This had been a long-term issue for the Trust and he asked whether any reflective learning had been taken on board. John Trevains said that good quality nursing assessments on entry to the services was key. There was a positive QI approach with some exciting developments which had encouraged positivity and vibrancy from the teams.

7.8 Paul Roberts asked about the data around occupied bed days within the dashboard. John Trevains said that there were challenges across the whole system but robust risk assessments and close collaboration was taking place. It was noted that the Trust had recently been able to reopen 8 beds that had been removed for covid secure reasons and this was in line with peers across the system.

7.9 Sandra Betney noted the medication error which had been reported as a SIRI in August and asked whether the introduction of RiO EMPA would have a positive impact on reducing any errors in future. John Trevains said that it would assist; however, he advised that the main cause of medication errors was human error. Amjad Uppal had attended a recent training session on Human Errors and overworked, stressed and pressured staff did impact on the number of errors made. The Board agreed that it would be helpful to look at this further and asked that the Quality Committee receive a fuller briefing on medication/prescribing errors.

7.10 The Board welcomed this report, noting the developments underway and the good level of assurance provided.

8. PATIENT SAFETY REPORT – QUARTER 1 2021/22

8.1 The Board received the Quarter 1 Patient Safety Report which provided high level information with regard to patient safety incidents reported through the Trust's Datix Incident Reporting System.

8.2 It was reported that 8 SIRIs had been recorded in quarter 1. Neil Savage said that staff could be massively impacted by serious incidents, and he asked about the level of and access to support offered to colleagues. Amjad Uppal informed the Board that the Trust had a lot of support available, and colleagues were encouraged to seek and accept this support. He said that people did sometimes find it difficult to ask for support and a national event was taking place in the coming months looking at the impact of serious incidents on clinicians. The Trust would continue to review the sources of support available.

8.3 Ingrid Barker noted the high incident rate being reported for Dental and Sexual Health services in relation to diagnosis, imaging and testing. Amjad Uppal advised that the Patient Safety Team would be carrying out further analysis and a deep dive into these figures and once complete the findings would be reported back to the Board.

9. LEARNING FROM DEATHS REPORT – QUARTER 1 2021/22

9.1 The Board received the Learning from Deaths report which provided information about the mortality review process and outcomes found during Quarter 1 2021/22.

9.2 During the quarter there were 129 patients who died whilst receiving care from Gloucestershire Health and Care NHS Foundation Trust (GHC) whilst either a physical health inpatient or in the care of our mental health or learning disabilities services. The Board was asked to note that none of these deaths were judged likely to have been due to problems in the care provided by the Trust.

9.3 The report contained, for the first time, KPIs and feedback from the Medical Examiner input which was rolled out in community hospitals from May 2021. This provides independent assurance relating to the quality of End-of-Life care and invaluable feedback from families. The role of the Medical Examiner (ME) is set out in the Coroner & Justice Act (2009) following recommendations from the Shipman Inquiry (2004) and subsequently the Francis report (2013). The ME has a duty to review deceased patient records and speak to their relatives to ensure that the wording used on the medical certificate of cause of death (MCCD) accurately describes the circumstances leading to the death and is acceptable for release to the Registration Service. The Board was asked to note that since the introduction of the ME input, no certificates had been rejected and positive feedback had been received from families and carers.

9.4 The Board noted that the University of Bristol's contract with NHS England to provide the Learning Disabilities Mortality Review (LeDeR) came to an end in May this year. NHS England has subsequently published a new policy which sets out the core aims and values of the LeDeR programme and the expectations placed on different parts of the health and social care system in delivering the programme from June 2021. LeDeR has recently published its 2020 annual report, which includes 10 recommendations to NHS England / NHS Improvement, NHS Race and Health Observatory, Department of Health and Social Care, NICE, Local Authorities, ICSs and Primary Care Networks. It was noted that LeDeR had made no direct recommendations to GHC. John Trevains informed the Board that the Quality Committee had invited Cheryl Hampson, Gloucestershire's Local Area Contact to its next meeting to offer further assurance on LeDeR.

9.5 The Board welcomed the new format of the Learning from Deaths Report and was assured by the work taking place.

10. PERFORMANCE DASHBOARD

10.1 Sandra Betney presented the Performance Dashboard to the Board for the period August 2021 (Month 5 2021/22). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

Recovery

10.2 Operational recovery continues, with many services settling back to business as usual. All services are being tracked and coded as red, amber or green. This month there are 15 services in red recovery support indicating they are at present, unlikely to return to pre-pandemic state within 12 months (using a comparator of November 2019 as the pre-pandemic metric). These teams, many of which are undergoing service transformation and business case construction, continue to receive support both in addressing demand through recovery plans, Service Development and Improvement Plans (SDIP) and Performance Exception Action Plans (PEAP). We continue to support staff in their own health and wellbeing recovery post-pandemic.

10.3 The Board welcomed the incorporating of the recovery data into the performance report by way of increasing Board oversight and providing a helpful overview. The huge challenges ahead for services were acknowledged.

10.4 Ingrid Barker noted that District Nursing services had been RAG rated as Red and asked about the specific challenges relating to this team. Sarah Birmingham reported that this service had been Red rated due to a sustained increase in referral activity (+10% pre-pandemic) and workforce challenges. She said that recruitment was ongoing and weekly monitoring meetings were taking place. A Sustainable Workforce Group had also been established.

Performance Dashboard

10.5 At the end of August, there were 6 mental health key performance thresholds and 14 physical health key performance thresholds that were not met. It was noted that all of these indicators had been in exception previously within the last 12 months. The Eating Disorder Services account for three indicators, with

the service continuing to face major performance challenges due to a high number of referrals and high vacancy rate. Of the Physical health indicators within exception, eight are within CYPS, two Musculoskeletal and two are within Wheelchair Services.

10.6 In relation to the Trust wide indicators, the Board was asked to note that there were 4 Workforce indicators in exception this month. Sickness absence was no longer compliant, noting that this had been slowly increasing over the past 3 months. This position would continue to be closely monitored, with further detail and analysis presented at the newly established Great Place to Work Committee.

Measuring What Matters

10.7 An additional paper was presented to the Board which provided an outline of the high-level learning from the recent Measuring What Matters Board Seminar held on 16th June 2021. The key themes had been identified along with the goals/aims and milestones. Angela Potter advised that work was also taking place to pull together the measures within the Trust Strategy and integrating this into the plan. Sandra Betney advised that this was a long-term development plan, and a timetable monitoring progress would be integrated into the Performance Dashboard for future months.

10.8 Steve Brittan asked whether the information would be automated. Sandra Betney said that the data would be autogenerated by the BI Team and it was hoped that future reporting would be received using Tableau rather than static month end reports as this would provide a more interactive experience for Board members.

10.9 Board members thanked Sandra Betney, BI Team and Operational Team colleagues for this report and the great work that was taking place. The implementation of the Measuring What Matters plan would be focussed on in more detail at the Resources Committee.

11. FINANCE REPORT

11.1 The Board received the month 5 Finance Report for the period ending August 2021.

11.2 The Trust has an H1 plan of breakeven and the Trust's position at month 5 was a surplus of £34k.

11.3 The cash balance at month 5 was £58.8m

11.4 Capital expenditure was £1.651m at month 5. Sandra Betney advised that expenditure against the capital plan was £2.7m behind year to date; however, plans for backlog maintenance and 2 large capital schemes – Stroud Hospital Refurbishment and Southgate Moorings, had been approved so there was confidence that the plan would be achieved. The capital plan would be adjusted to take into account the timing of this planned expenditure. Close monitoring would continue via the Capital Management Group.

11.5 The Trust had spent £0.825m on Covid related revenue costs between April and August. The Trust has received system COVID funding for the In Envelope expenditure. Out of Envelope income has been included at £80.7k.

11.6 Guidance on financial framework H2 (October 21 to March 22) was not expected until the end of September; however, the Board noted that the guidance was expected to advise:

- Efficiency Averages to 2% (no system exceeds 3%)
- Covid funding will be reduced by 5% compared to H1
- Pay award will be funded

Sandra Betney advised that if the efficiency requirement was set at 3%, this would represent a gap of approximately £950k (worst case). However, if this were the case, she informed the Board that the Trust would keep the level of CIPs previously agreed and would not go back out and seek further efficiencies from services, recognising the pressures currently being faced. This gap would be funded through non-recurrent savings.

11.7 Paul Roberts said that this remained a challenging position with a lot to work through as a system, but GHC had kept its discipline throughout and continued with its annual financial and business planning processes, which had put us in a better-grounded position to build from. Huge thanks were given once again to Sandra Betney and the Finance Team for steering the Trust through these challenging and uncertain times.

11.8 The Board noted the Finance Report for month 5.

12. MEDICAL REVALIDATION ANNUAL REPORT

12.1 The Board received the Medical Appraisal and Revalidation Annual Report. The report provided assurance as to the application of national policy with regard to the regulation and revalidation of medical practitioners and insight into the processes and resources that were required to undertake this work.

12.2 The Board endorsed the Annual Report, acknowledging the work that had been taking place.

13. CHAIR'S REPORT

13.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in July. 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 the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

13.2 Ingrid Barker opened her report by sharing the sad news that the Trust had lost two senior colleagues over the past few weeks. Alison Willmott-Miller passed away in August after a long battle with illness. Alison had been the Deputy Director of Human Resources for GHC until she took ill health retirement a couple of months ago. Dr. Mike Roberts also passed away on 14th August after

a period of illness. Mike was the Medical Director for Gloucestershire Care Services NHS Trust from May 2015 until January 2019 when he stepped down to focus on his role as a GP at Rosebank Surgery in Gloucester. The Trust was represented by friends and colleagues at both funerals and our thoughts are with Alison and Mike's families at this very sad time.

13.3 The Board noted the content of the Chair's report and the activity updates included within it covering attendance at regional and national meeting and events, and local meetings with partner organisations.

14. CHIEF EXECUTIVE'S REPORT

14.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in July.

14.2 The Board noted that the Local Resilience Forum had been meeting daily due to the recent fuel crisis. Paul Roberts advised that there had been little disruption to services locally and expressed his huge thanks to the Resilience Team for their coordination.

14.3 Virtual Senior Leadership Network (SLN) meetings continue to take place monthly and these provide an excellent opportunity to update participants on Trust and national developments. The August session featured a presentation on Civility Saves Lives by Dr Chris Turner. This session discussed how our behaviour towards each other impacts team performance including: the impact rudeness has in the workplace, ways of getting the best out of each other, and finding the value of explicitly respecting each other. A great deal of positive feedback was received following this session – and this campaigning approach is a component part of the Trust quality strategy approved at the last Board meeting.

14.4 Paul Roberts informed the Board that he was now the chair of the Gloucestershire Community Mental Health Transformation Programme Board. The CMHT meeting held virtually on 20th September discussed updates on the CMHT People Participation Board (facilitated by Inclusion Gloucestershire), VCSE, as well as NHSE feedback and reporting. The group also discussed the programme board's structure with the aim to agree purpose, participation, responsibilities, workstreams and interdependencies. Graham Russell asked when the Board might receive more information about this. Paul Roberts noted that this was a key programme and work would take place to build this into the upcoming Board Seminar schedule.

14.5 Following a comprehensive national recruitment process, supported by NHS Executive Search, Paul Roberts said that he was delighted to confirm that David Noyes has accepted our offer of the Chief Operating Officer post. David is currently the Chief Operating Officer (Southampton and County Wide Services) at Solent NHS Trust, where he has been for the past four years. Prior to that, he was Director of Planning, Performance and Corporate Services at Wiltshire CCG - also for four years. Before joining the NHS David was a Naval officer for 28 years specialising principally in logistics, including a deployment as Chief Operating Officer for logistics with the Army's Logistics Brigade in Afghanistan.

David was very much looking forward to joining the Trust during this exciting time and looks forward to working with colleagues both within the Trust and the ICS. David Noyes would commence in post on 10 January 2022.

15. INTEGRATED CARE SYSTEM UPDATE

15.1 This paper provided an overview of a range of activity taking place across the Integrated Care System.

15.2 The Board noted that a joint Health and Wellbeing Board and ICS Board development session took place on 21st September 2021. This session took place with members of the ICS Board to consider how the HWB Boards functions under the new ICS structures beyond April 2022. It was recognised that there is a considerable overlap across the roles and functions between the current remit of the HWB and the new Integrated Partnerships Board which is a mandated part of the ICS structures and the group have considered the potential options for this which will continue to evolve over the coming months.

15.3 The Board noted the content of this report, welcoming the breadth of coverage.

16. OPERATIONAL RESILIENCE AND WINTER PLANNING

16.1 The purpose of this report was to present to the Board three papers for assurance, that together provided the overall details of operational resilience and sustainability plans and tools implemented through periods of service disruption.

16.2 The Trust is required to have a robust resilience and capacity plan in place with particular emphasis on the winter period (November – March). Within this report there were three papers that complemented each other as follows:

- Operational Surge and Resilience document v1.8: outlining the corporate breadth of business continuity and resource
- Surge and Escalation Plan v.1.0: details escalation processes in place from service to system
- Winter Plan (Operations) – A paper outlining approach, staff voice and priorities of schemes

16.3 The Gloucestershire A&E Delivery Board is the forum in which capacity planning and operational delivery across the health and social care system is coordinated, and funding available for winter schemes is prioritised across all providers.

16.4 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, as response and escalation to surge is the same regardless of the source of the disruption.

16.5 The 2021/22 Operational Resilience and Capacity Plans include additional assurance and planning around prioritisation of the operational (service) winter schemes, escalation, Covid-19 and general incident/surge response. The

operational plan reflects the learning from the experience of the first waves of Covid, and last winter overall and was the basis for this year's planning arrangements, prioritising the operational schemes to be focused on in agreement with partner organisations and identifying new ways of working as we enter the winter period.

16.6 The Board received the Operational Resilience and Capacity Plans, noting that these had also been received and endorsed by the Resources Committee in August. The report and the plans offered good operational service assurance. A huge amount of work had taken place to develop these plans and the Board asked that their thanks be extended to Sarah Birmingham and the wider operations team.

17. ANNUAL SENIOR INFORMATION RISK OWNER (SIRO) REPORT

17.1 The Board received the first annual report from the Senior Information Risk Owner (SIRO) for Gloucestershire Health and Care NHS Foundation Trust (GHC). The purpose of the report was to provide assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality. This assurance is provided by the SIRO who has executive responsibility for information risk and information assets.

17.2 Throughout 2020/21 there has been continuing progress with embedding and improving the effectiveness and profile of the Trust's Information Governance structures and processes, which have continued to evolve to meet the needs of the recently merged organisation.

17.3 This report provided assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with a complex range of national guidance and legislation whilst also achieving an ability to ensure operational effectiveness so that progress is not undermined or damaged by poor Information Governance practices.

17.4 The Board noted that the Trust was able to achieve the Data Protection and Security Toolkit (DSPT) submission (self-assessment) of 'exceeding standards' for the 2019/2020 year with the Trust meeting the 95% mandatory training target for Data Security and Awareness Training.

17.5 Steve Alvis said that he felt this was a very helpful and well-presented report. He made reference to the Privacy Officer section of the report where is stated "The Privacy Officer was unable to check 6 Summary Care Record queries with 2 members of staff as they had left the Trust." He asked whether this should be flagged as a concern. Lavinia Rowsell agreed to seek further detail and report back to Steve Alvis. **ACTION**

17.6 The Board noted the SIRO Annual Report and received good assurance on performance and compliance.

18. LEADERSHIP AND GOVERNANCE REVIEW

18.1 The purpose of this report was to present the Board with a proposed approach for the delivery of the next developmental review of leadership and governance using the Well Led Framework.

18.2 The Trust's mission is to 'enable people to live the best life they can' and to achieve 'outstanding care' status. To do this we need to continually strive to raise the bar on performance across the organisation, including the Board. The Board has a duty to conduct its affairs effectively and demonstrate measurable outcomes that build and maintain patient (service users, carers and family), public and stakeholder confidence that GHC is providing high quality, sustainable care.

18.3 In-depth, regular and externally facilitated developmental reviews of leadership and governance are seen as good practice across all sectors. Rather than assessing current performance (as reflected in the CQC assessment of well led), these developmental reviews focus on continuous improvement and seek to identify the areas of leadership and governance that would benefit from further targeted development work to secure and sustain future performance.

18.4 NHS England and NHS Improvement strongly encourages all providers to carry out externally facilitated reviews, every three to five years. This paper set out the proposed approach for the review. Planning will commence with a Board self-assessment exercise in November 2021 with the review taking place in Q1 of 2022/2023.

18.5 The Board supported and endorsed the approach outlined within the report, noting that this was important work that the Trust could use as a real opportunity for development and learning.

19. DIGITAL UPDATE

19.1 The purpose of this report was to provide an update on progress against the Digital Strategy, the delivery of digital services and provide a wider view on the breadth of work ongoing in this area.

19.2 Steve Brittan welcomed this report and the update on progress provided. He asked about the work being carried out to host mixed format meetings – face to face meetings that also accommodated people joining via MS Teams, noting that this would be a huge enabler. Sandra Betney advised that work had commenced to look at how this could be put in place as it was recognised as a key enabler moving forward.

19.3 Sumita Hutchison said that she would welcome a better understanding of digital spend and how this compared with other organisations. Sandra Betney said that this could be difficult as other organisations used different definitions of what was and wasn't "digital" so getting a like for like comparison would not be possible.

19.4 Graham Russell also welcomed this report and suggested that some highlight areas should be included in future to provide a snapshot for the Board. He said that he would find it helpful to know whether the Trust was on track with its plans, were there any resource issues to be made aware of, had there been any patient benefits identified that could be shared for learning purposes and also seeking the views from staff though surveys.

19.5 Ingrid Barker noted that there was a lot of work taking place and it was important that this received Board level oversight. Steve Brittan suggested that the

Resources Committee could receive an update 2 times a year, with all NEDs invited to attend those meetings if they wished to, and one summary report being presented to the Board annually. This was agreed and would be scheduled into work plans as required. **ACTION**

20. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING – JULY 2021

20.1 The Board received and noted the minutes from the Council of Governors meeting held on 14 July 2021.

21. BOARD COMMITTEE SUMMARY REPORTS

21.1 Audit & Assurance Committee

The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 12 August 2021.

21.2 Appointments and Terms of Service Committee

The Board received and noted the summary reports from the ATOS Committee meetings held on 25 August and 1 September 2021.

21.3 Resources Committee

The Board received and noted the summary report from the Resources Committee meeting held on 26 August 2021.

21.4 Quality Committee

The Board received and noted the summary report from the Quality Committee meeting held on 2 September 2021.

Maria Bond informed the Board that the Committee had received a clinical presentation about Fostering and Vulnerable Children Support which was presented by the Pathway Lead for Children in Care. This had been an excellent and informative presentation, highlighting the extremely valuable work taking place.

22. ANY OTHER BUSINESS

22.1 John Trevains informed the Board that cases of Respiratory Syncytial Virus (RSV) in young children was currently very high, and the situation would continue to be monitored.

23. DATE OF NEXT MEETING

23.1 The next meeting would take place on Thursday 25 November 2021.

Signed: …….. **Dated: ……**

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

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AGENDA ITEM: 05/1121

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 25 November 2021

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 No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
27 May 2021	16.4	Future Patient Safety Reports to include trends, as well as improved triangulation of data, and contextualisation such as the inclusion of bed numbers.	Amjad Uppal	November	Update on progress included in Patient Safety Report.	
30 Sept 2021	7.5	Sarah Birmingham to provide Steve Alvis with additional data regarding the HPV vaccine take up.	Sarah Birmingham	Nov 2021	Complete. Recovery briefing sent.	
	17.5	"The Privacy Officer was unable to check 6 Summary Care Record queries with 2 members of staff as they had left the Trust." Lavinia Rowsell agreed to seek further detail and report back to Steve Alvis for assurance.	Lavinia Rowsell	Nov 2021	Complete. Response provided. Process to be reviewed working with HR colleagues.	
	19.5	Resources Committee to receive a Digital update 2 times a year, with all NEDs invited to attend those meetings if they wished to. A summary report would be presented to the Board annually. This would be scheduled into work plans as required.	Trust Secretariat	Nov 2021	Complete.	

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AGENDA ITEM: 07/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

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

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: **PERFORMANCE DASHBOARD OCTOBER 2021 (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.

Performance covers the period to the end of October (Month 7 of 2021/22). It is of note that the performance period remains aligned to our operational priority to recover services from the pandemic (within the Operational Recovery Programme) and support forthcoming operational planning and transformation developments. There is a section within the performance dashboard (from page 3-6) providing highlights on operational recovery.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Performance Exception Action Plans (PEAP) are presented to BIMG and more widely account for performance indicators in exception. Recovery briefings are also provided to the Business Intelligence Management Group (BIMG).

Recommendations and decisions required

The Board are asked to:

- **Note** the aligned Performance Dashboard Report for October 2021/22.
- **Acknowledge** the ongoing impact of the pandemic and service recovery on operational performance.
- **Note** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service action plans are being developed to address areas requiring improvement

Executive summary

Business Intelligence Update

A high-level timetable developed from the recent Measuring What Matters Board Seminar in June 2021 has been integrated into the Performance Dashboard on page 2. This allows for periodic business intelligence development monitoring.

Recovery Update

The movement of RAG (Red Amber Green) recovery statuses are outlined on pages 3-6. Diabetes Nursing, Cardiac Rehabilitation, Complex Psychological Intervention (CPI) service, Mental Health Individual Care Management Service (MHICMS), Accommodation services, Assertive Outreach Team and Mental Health Schools Team have improved their RAG rating in the period. New services requiring increased support include Respiratory Specialty Service and Post-Covid Service.

Performance Update

The performance dashboard is presented from page 7. As shown within the spark charts, it is of note that all the indicators within this report have been in exception within the last 12 months.

- **Mental Health & Learning Disability Service (National & Local) Performance**
  Membership attention is requested to review the 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Eating Disorder (ED) Services account for five indicators, with CPA two.

- **Physical Community Health Service (National & Local) Performance**
  In addition, attention is drawn to a further 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Within these, six were within children services.

- **Trust Wide Service Performance**
  There are currently 3 Workforce indicators in exception this month. Positively, *'77: Mandatory Training'* is now at 88% and this is within SPC control limits based on 2018/19 and 2019/20 baseline and therefore *not* presented in exception. Excluding bank, compliance is at 93% which is above the 90% threshold.

  Within Measuring What Matters there is a phased plan to deploy further workforce performance metrics within the performance dashboard over the next year. This was planned to begin in Quarter 3 with headline performance indicators for Vacancy, cumulative Annual Leave consumption and a Turnover/ Stability rate. Although competing work priorities have delayed deployment, all items will be recovered for the next report. More granular analysis will be provided as automated data sources are developed in 2021/22.

- **Non-exception reporting**
  It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are routinely available for operational monitoring within the online Tableau reporting server.

  It was agreed by Board in July that 8 proxy indicators will be re-introduced into the performance dashboard with October data) as *internal* KPIs using Statistical Process Control (SPC) limits as thresholds. These thresholds were not finalised

in time for the publication of this report. This will be available within the next report.

Risks associated with meeting the Trust's values
Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) or (internal) Service Development and Improvement Plan (SDIP) which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality-of-care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
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 - 18 November 2021

Appendices:	

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

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Snapshot Month
October

Performance Dashboard Report & BI Update

Aligned for the period to the end October 2021 (month 7)

Business Intelligence Summary Update

Althought high demands continue, Business Intelligence (BI) services continue to prioritise key infrastructure development tasks and has ensured the continuity of business critical items during the period. Some development projects outside of original 2021/22 business planning - such as the server migration project, school aged immunisation project and maintenance of the SystmOne data warehouse - have delayed some planned, but lower profile team objectives. Although a temporary fix has been deployed to ensure that ECDS can once again be submitted, there is a requirement of our clinical system supplier TPP to enact some changes to resolve issues. Positively, all our system databases have finally been migrated onto a new integrated server and legacy servers are being decomissioned or repurposed.

Page 2 highlights high level progress against the recently established **Measuring What Matters** plan. There are currently three items behind schedule due to other priorities. These will all be resolved within the next month as the tasks are in process.

Operational Recovery Programme Update *(pages 3-6)*

- **Decreasing risk levels**

The Diabetes Nursing service and the Cardiac Rehab team are back to pre-pandemic referral levels and waiting times. This reflects the huge investment these teams have made to stabilise and support their staff over the last 6 months. Also reducing their RAG status is the Complex Psychological Intervension (CPI) service who are back to green after a period of review, it is likely waiting times will increase once the true referral profiling is completed but at this stage stability is noted. The Mental Helath Individual Care Management Service (MHICMS) team move to green from amber recognising their improved position, as does the Accommodation Service who have improved their vacancy position. The Assertive Outreach Team also switch to green from amber; a small team but now coping well with just 4 people waiting and referrals below pre-pandemic levels now. In CYPS, the Mental Health Schools Team reduce to green as waits fall below 6 weeks and the total waiting reduces again this month.

- **Escalating risk levels**

The new respiratory specialist service's RAG rating has worsened to red as part of the wider respiratory services position as it is sharing the workforce. Also moving to red is the post-covid service recognising the challenges of increasing waiting times and uncertain future funding arrangements which may leave a significant number of people needing alternative pathways for assessment.

Work is being supported by the Recovery and Governance Leads to explore the Telecare service provision and address their waiting list which needs greater understanding. This will report in due course. The recovery programme continues to work to better understand the data of some service such as the CYPS Speech and Language and Occupational Therapy services and SystmOne Simplicity programme is aiding this. SystmOne Simplicity is also a key enabler for adult Podiatry and MSKAPS in stopping the clock for their clinically meaningful first assessments which are undertaken over the telephone which will allow true reflection of their situation. Finally, the first Service Support Review was conducted for the Respiratory service this month, positive engagement has resulted in bespoke team building and health and wellbeing offers being implemented, at this stage service improvement will need to be held whilst the team forms and strengthens, a review is planned in early February 2022.

Performance Dashboard Summary *(from page 7)*

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

Where performance is not achieving the desired results, operational service leads are prioritising appropriately to address issues. Additionally, where appropriate, and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines appropriate risk, mitigation and actions will be monitored through BIMG. For example, specific updates have been provided by operational services across 2021/22 for areas with consistent performance challenges such as Children and Young People's Services (CYPS including CAMHS), Eating Disorder Services and Wheelchair Services.

Measuring What Matters Key Milestones

Theme	(Provisional) Milestone	Target date	Progress Tracker
Data Quality matters	Tableau subscriptions and alert functionality promoted across services	Dec-21	On target
	NQT Data quality audit schedule for 2022/23 to be agreed	Jan 2022 for Apr '22 start	Stakeholder engagement required
	SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered	by Oct 2022	On target
	Revised data quality reporting portfolio deployed within Tableau servers for physical health services	by Oct 2022	On target
Integration matters	Server migration to allow for reconfiguration and resolve licensing concerns	by Dec 2021	Complete
	Develop additional Board performance dashboard workforce indicators to include: o Deployment of monthly Vacancy Rate o Development of monthly (Cumulative) Annual Leave Consumption o Development of monthly Turnover/ Stability Rate	 by Sept 2021 by Oct 2021 by Nov 2021	 Overdue, expect Dec '21 Overdue, expect Dec '21 Overdue, expect Dec '21
	Deploy first Datix Report(s) by April 2022	by April 2022	On target
	Deliver Totara (Care to Learn) extraction by April 2022 & first report deployment	by Oct 2022	On target
	Deliver Allocate (e-Rostering) extraction by April 2022 & first report deployment	by Oct 2022	On target
Patients matter	Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23	By Dec 2022	Stakeholder engagement required
	Deploy trial of first tranche of new outcome measures	by April 2023	On target
Culture matters	Decommissioning of regular Excel physical health reporting use	by July 2022	On target
Audience matters	Review Key Performance Indicator portfolio to inform 2022/23 contract schedule and operational/ strategic needs	by Jan 2022	On target
	Publish proposal to restructure the current performance dashboard to support various audience level perspectives	by April 2022	On target
Format matters	Deliver immediate performance dashboard interrogation pilot for Resources Committee members	by Sept 2022	On target
Timeliness matters	Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly when RiO and SystmOne contracts	by April 2023	On target
Analysis matters	Realising holistic business partnering across all corporate partners by January 2022	by Jan 2022	On target
People matter	Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day	from Nov 2021	Complete
	BI support guidance to support users will be made available through the intranet	from Oct 2021	Complete
	Learning & Development Service to inform Digital Competency timetable for 22/23	by April 2022	On target
Governance matters	Cleanse proxy indicators	Oct Data (for Nov 2021 reporting)	On target
	Publish Performance Management Framework	in Dec 2021	On target
	Remove superseded National and Local Performance Indicators	by April 2022	On target
	Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline	for March 2022 for April 2022 Resources Committee	On target
	Introducing new internal performance indicators into performance dashboard	by July 2022	On target

Operational Recovery Status Summary (October 2021)

Operational Service Recovery RAG Rating Key		Sept'21 Status	Oct '21 Status
Service recovery plan in place to support recovery to pre-Covid levels. Identified as low risk		56	**60**
Service recovery plan in place to support recovery to pre-Covid levels within 12 months. Moderate level of risk Identified which may involve workforce, estates or service design challenges		15	**12**
Service recovery plan in place to support recovery to pre-Covid levels predicted to take 12+ months. High level of risk identified which involves workforce, estates or service redesign challenges.		18	**18** (inc 1 new pathway in respiratory)

Directorate	Specialism	Service	RIO or S1	Current RAG
UCASS	PH	Respiratory – HOAS	S1	
UCASS	PH	Pulmonary Rehab	S1	
UCASS	PH	Respiratory – Core	S1	
UCASS	PH	**NEW - Respiratory Specialist Physio**	S1	
UCASS	PH	Diabetes Education	S1	
UCASS	PH	Heart Failure	S1	
UCASS	PH	MacMillan Next Steps	S1	
UCASS	PH	**NEW – Post Covid Syndrome**	S1	
Adult Comm PH	PH	Adult MSK	S1	
Adult Comm PH	PH	District Nursing	S1	
Adult Comm PH	PH	ICT Occupational Therapy	S1	
Adult Comm PH	PH	ICT Physiotherapy	S1	
Adult Specialist MH	MH	Eating Disorders	RIO	
Adult Specialist MH	MH	ASC	RIO	
Adult Specialist MH	MH	ADHD	RIO	
Children & Young People	PH	SALT - core	S1	
Children & Young People	PH	Immunisation Service	RIO	
Children & Young People	MH & LD	CAMHS LEVEL 2/3	RIO	

Operational Recovery Status Summary (October 2021)

Operational Service Recovery RAG Rating Key		Sept'21 Status	Oct '21 Status
Service recovery plan in place to support recovery to pre-Covid levels. Identified as low risk		56	60
Service recovery plan in place to support recovery to pre-Covid levels within 12 months. Moderate level of risk identified which may involve workforce, estates or service design challenges		15	12
Service recovery plan in place to support recovery to pre-Covid levels predicted to take 12+ months. High level of risk identified which involves workforce, estates or service redesign challenges.		18	18 (inc 1 new pathway in respiratory)

Directorate	Specialism	Service	RIO or S1	Current RAG
UCASS	PH	Respiratory – HOAS	S1	
UCASS	PH	Pulmonary Rehab	S1	
UCASS	PH	Respiratory – Core	S1	
UCASS	PH	**NEW - Respiratory Specialist Physio**	S1	
UCASS	PH	Diabetes Education	S1	
UCASS	PH	Heart Failure	S1	
UCASS	PH	MacMillan Next Steps	S1	
UCASS	PH	**NEW – Post Covid Syndrome**	S1	
Adult Comm PH	PH	Adult MSK	S1	
Adult Comm PH	PH	District Nursing	S1	
Adult Comm PH	PH	ICT Occupational Therapy	S1	
Adult Comm PH	PH	ICT Physiotherapy	S1	
Adult Specialist MH	MH	Eating Disorders	RIO	
Adult Specialist MH	MH	ASC	RIO	
Adult Specialist MH	MH	ADHD	RIO	
Children & Young People	PH	SALT - core	S1	
Children & Young People	PH	Immunisation Service	RIO	
Children & Young People	MH & LD	CAMHS LEVEL 2/3	RIO	

RAG changes approved this month: (on Recovery & Performance Meeting held 10th November 2021)

Urgent Care Directorate:

Service	RAG change recommended	Notes	Decision by DCOO
Post-Covid Syndrome service	Move up from green to red	Concern for service function with time lag for recruitment and changeable purpose and function of the service. Funding due to end in new financial year and as yet no plans for those already referred. Wait times presently	☒Approved ☐Not-approved
Diabetes Nursing Service	Move down from red to amber	Referral levels and waiting times are now at pre-pandemic levels for the 2nd consecutive month. Great work with ICS wide integration and whilst there remain challenges this is felt to be back to BAU	☒Approved ☐Not-approved
Cardiac Rehab Service	Move down from red to amber	Excellent progress on alignment of waiters to pathways and offers for either face to face or virtual education. Waiters this month is lowest since pre-pandemic (15 people). Commissioning of E-learn will enable efficient future virtual delivery of programmes.	☒Approved ☐Not-approved

Directorate summary:

	Recovery RAG June 21	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	Recovery RAG Oct 21
RED	5	5	6	8	8
AMBER	6	4	1	0	2
GREEN	4	6	8	9	7

Adult Physical Health Directorate:

Service	RAG change proposed	Notes	Decision by COO
No changes this month			

Additional services note:

- The Lymphoedema service remains amber principally due to long term sickness impact on waiting times. There is work underway to support data quality as waiting profiles do not match the teams local reporting.
- The Telecare service is being reviewed and is yet to be recovery rated. A future options review has been conducted jointly with GCC to understand how it is functioning which is due to report in December. The team is principally GCC staff but has some GHC funded posts and is GHC managed. Early intelligence suggests that it is focused on hospital discharge which inhibits delivery to lower level needs and has rising waits many of which could be lengthy. There is no access data for this service as it reports on GCC systems. There is an early action plan in place to structure the GHC review and to start to surface the challenges believed to reside within this service.

Directorate summary:

	Recovery RAG June 21	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	Recovery RAG Oct 21
RED	3	2	4	4	**4**
AMBER	7	9	4	4	**4**
GREEN	9	8	13	13	**13**

Adult MH & LD Directorate:

Service	RAG change proposed	Notes	Decision by DCOO
Mental Health Integrated Case Management Service	Move amber to green	No concerns within team, coping well, stable.	⊠Approved ☐Not-approved
Accommodation Team	Move amber to green	Referrals remain below pre-pandemic levels, 8 people waiting of which 2 are over 28 weeks. No concerns. Green – yes BAU new proposal through CMHT in future	⊠Approved ☐Not-approved
Assertive Outreach Team (AOT)	Move amber to green	Referrals remain below pre-pandemic levels, 4 people waiting. No concerns. Green 21% vacancy in sept, so small team, not big numbers	⊠Approved ☐Not-approved
Complex Psychological Interventions (CPI)	Move amber to green	Referrals have increased for the 2nd consecutive month but not quite at the high of 70/month in February 2020. Total waiters = 61 this month an increase of 29% from pre-pandemic. Of those 3 have waited over 12 weeks. CPI mtg 10.11.21 generic advert out now to replace senior roles, some work will flow CEN and CMHT in future – this is traditional model – PEAP and step down to green	⊠Approved ☐Not-approved

Additional services note:

- Recovery teams remain amber - Referrals are below pre-pandemic levels for the 3rd consecutive month. Total waiters this month is 46% higher than pre-pandemic levels (133 this month compared to 91 in November 2019) therefore remain as amber. North Cots main concern small team – but high referrals through summer. Unable to get agency staff in to support. Plan for BI to separate recovery report into the 7 teams and then review next meeting, some areas are more stable than others.
- Later life services remain amber - Referrals have been variable over the last year but are not far from pre-pandemic patterns. 95 referrals this month is 6% higher than the same month in 2019. Total waiters is 20% higher than pre-pandemic (65 compared to 54 in November 2019) – hold at amber this month but review Patient Tracking List (PTL) and reduce to green when PTL completed.
- Memory Assessment Service - Referrals are below pre-pandemic levels for the 2nd month and is the 3rd month of reduction in the referral rate from a peak of 214 in July this year. Total waiters are 9% less than pre-pandemic levels but people seem to be waiting longer. Proposal for recovery monies to work on long waiters was declined by commissioners – stay amber until sure of future plans and funding. Expansion of Primary care GP diagnosis pilot in SBV, now starting in Forest of Dean as well – we will then only do secondary care part of pathway in these areas.

Directorate summary:

	Recovery RAG June 21	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	Recovery RAG Oct 21
RED	4	4	3	3	**3**
AMBER	5	5	6	7	**4**
GREEN	14	14	15	12	**15**

CYPS Directorate:

Service	RAG change proposed	Notes	Decision by COO
(Trailblazers) (Schools Team) CAMHS MHST Young Minds Matter	Move amber to green	Referrals of 170 this month mirroring referrals rates through last year at this same time. No one is waiting over 6 weeks. 81 total waiters compared to 111 in November	☒Approved ☐Not-approved

Additional services note:

- Children's OT is an amber service and is meeting 8WW for first assessment, but data needs to improve to better show the wait to second contact and treatment – this is work which needs prioritisation under the S1 simplicity programme. Vacancies are lower than reported on tableau. Pathway streamlining work underway, remain amber.
- Need to review the children in care outstanding waiters as no October data known for figures, remains amber service.
- Young adults service – green service – for information, now fully recruited, new starters excepted in January
- Social Communication Autism Assessment Team (SCAAT) (green), discussion re issue of pending waiting list coming from GHFT, as yet numbers unknown but concern for what it means form January. Commissioners aware and working with us. Need to explore the issue once better defined and consider if it is a risk or not.

Directorate summary:

	Recovery RAG June 21	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	Recovery RAG Oct 21
RED	4	4	4	3	**3**
AMBER	6	6	4	4	**3**
GREEN	17	17	19	19	**21**

Hospitals Directorate: NB most services in this directorate are excluded from recovery as they do not hold waiting lists

Service	RAG change proposed	Notes	Decision by COO
No changes this month			

Directorate summary:

	Recovery RAG June 21	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	Recovery RAG Oct 21
RED	0	0	0	0	**0**
AMBER	0	0	0	0	**0**
GREEN	3	3	3	3	**3**

Amber Rated Services (provided for information only – see last page of appendix for a summery review)

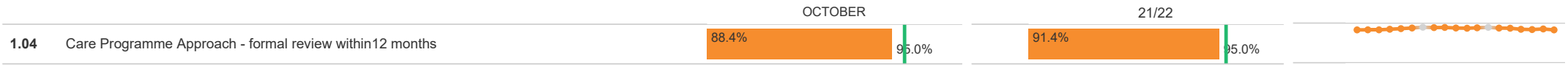
Directorate (n = 12)				
UCASS	Adult Community Physical Health	Adult Comm Specialist MH	Children's & Young Peoples Services	Hospitals
• **NEW - Diabetes Nursing (reduced from red)** • **NEW – Cardiac rehab (reduced from red)**	• MSKAPS • Speech & Language Therapy (SaLT) • Wheelchair Services • Lymphoedema Service	• Recovery Teams • Later Life / Older Peoples CMHT • Memory Assessment Service (MAS)	• Children in care • CAMHS Learning disabilities • Children Occupational Therapy	• None

Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & 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 (Care Programme Approach) – Formal review within 12 months [Community MH Services]
Performance for October is 88.4% (106 cases) against a performance threshold of 95% and is below the lower Statistical Process Control (SPC) limit. Most of the cases are within the Recovery Service (62 cases).

Since the end of October, 13 overdue CPA reviews have been completed and of the remaining non-compliant cases the average number of days between the due date and the end of October is 45 days and the median, 31 days.

Within the Recovery service, a few non-compliant cases are due to data quality and are being amended on the clinical system. The remaining cases are a priority with the care coordinators and reviewing this indicator will become a regular event during staff supervision.

Unfortunately, workforce pressures (including vacancies, lack of temporary staffing, increases in staff self-isolation and short-term sickness) along with the summer increase in referrals and acuity continue to impact capacity to plan CPA reviews.

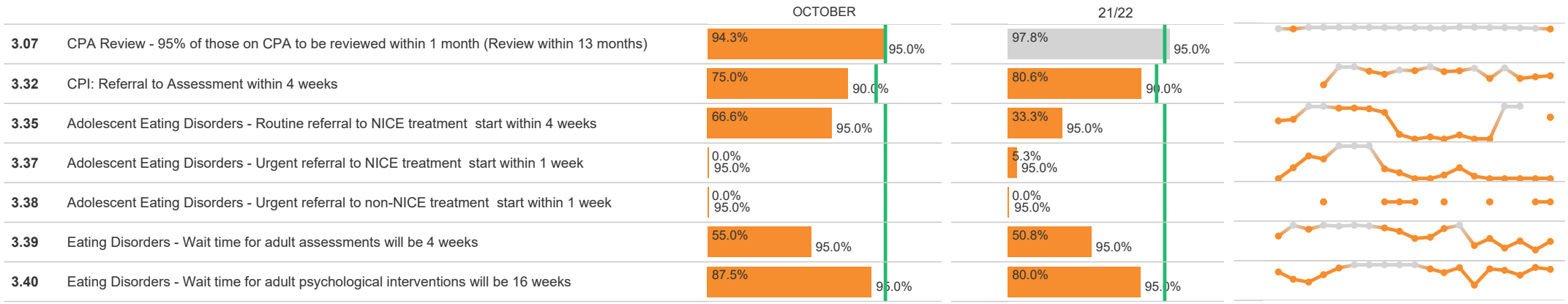
The Mental Health Commissioner has acknowledged the updated guidance from NHSE/I regarding the proposed changes to the CPA metrics. As an interim measure we will continue to report on the 12 month CPA review as a safety net until revised metrics are developed through the Integrated Community Mental Health Transformation project.

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

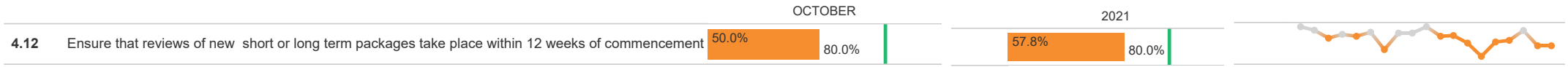
Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract



Social Care - Local Contract



Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously within the last twelve months. Please note that '3.07 CPA Review – 95% of those on CPA to be reviewed within 1 month (Review within 13 months)' has been in exception previously, but recent clinical recording updates now present previous periods as compliant.*

3.07: CPA (Care Programme Approach) – Formal review within 13 months [Community MH Services]
Performance for October is 94.3% against a performance threshold of 95% and is below the lower SPC (Statistical Process Control) limit. This indicator is a subset of 1.04 and of those non-compliant records there were 51 where the CPA review is not recorded as having taken place within 13 months. Of these, 35 are within the Recovery Service.

Within the Recovery service, a few non-compliant cases are due to data quality and are being amended on the clinical system. The remaining cases are a priority with the care coordinators and reviewing this indicator will become a regular event during staff supervision.

Unfortunately, workforce pressures (including vacancies, lack of temporary staffing, increases in staff self-isolation and short-term sickness) along with the summer increase in referrals and acuity continue to impact capacity to plan CPA reviews.

The Mental Health Commissioner has acknowledged the updated guidance from NHSE/ I regarding the proposed changes to the CPA metrics. As an interim measure we will continue to report on the 12 month CPA review as a safety net until revised metrics are developed through the Integrated Community Mental Health Transformation project.

3.32: CPI (Complex Psychological Intervention): Referral to assessment within 4 weeks [Community MH Services]
October performance is reported at 75.0% against a performance threshold of 90% and is below the SPC (Statistical Process Control) lower limit.

There were 9 non-compliant cases in October. Of these, 2 were seen within 5 weeks, 4 were seen within 7 weeks and 3 within 11 weeks.

The ongoing issues with vacancies and sickness within the service have reduced capacity and recruitment to posts remains a significant problem. Considerable effort and thought is going into recruitment planning to try and address the situation but filling posts will inevitably take some time.

While waiting for CPI assessment and treatment, the clients care is held by either the Recovery or AOT services.

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]
October performance is reported at 66.6% against a performance threshold of 95%. There were 2 non-compliant cases in October. Current predictions estimate a stable waiting list recovery for under 18s accessing routine treatment within 4 weeks by October 2023.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
October performance is reported at 0% against a performance threshold of 95%. There were 11 non-compliant cases in October. An urgent trajectory forecast for adolescents has been modelled with the currently known assumptions. This predicts a waiting list recovery of 95% for under 18s accessing urgent treatment within 1 week by April 2022.

3.38: Adolescent Eating Disorders: Urgent referral to non-NICE treatment within 1 week [Community MH Services]
October performance is reported at 0% against a performance threshold of 95%. There was 1 non-compliant case in October.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
October performance is reported at 55.0% against a 95% performance threshold. There were 9 non-compliant cases reported in October.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]
October performance is reported at 87.5% against a 95% performance threshold. There were 2 non-compliant cases reported in October.

Note on 3.35, 3.37, 3.38, 3.39 and 3.40 – Eating Disorders waiting times
The service continues to recruit to its few remaining vacancies and workforce planning meetings are continuing to discuss suitable recruitment opportunities to fulfil the service's needs. Capacity mapping for the service has indicated that the team is significantly under established to meet business as usual demands. This has been discussed and highlighted with commissioners and further investment has been secured as part of the CMHT submission.

The current wait profile for the service at the end of October indicates that 88% (519) of all patients waiting for assessment, are waiting over 4 weeks, and waiting times will continue to increase until team establishment is increased and the service able to see routine referrals. Demand remains high overall with a 24% increase in referrals during 2020/21 compared to 2019/20 and a significant increase in urgent referrals for under 18s (28% in 2020/21 compared to 17% in 2019/20) and this is continuing with 45.8 % of referrals received in October being flagged as urgent. The main impact of this referral increase appears to be the detrimental effect that the pandemic, lockdown and school closures have had on Children and Young Peoples' wellbeing and mental health. This is validated by the replication in demand across other teams treating CYP.

The service is accepting routine referrals, which are being triaged and placed on a waiting list, however, assessment and treatment will continue to be paused throughout November 2021 which will impact on future reported waiting times and has led to several referrals being expedited due to the patients deteriorating condition. The service is working on reducing the urgent assessment waiting lists and bringing the Urgent KPI's back in line.

Day treatment remains closed at this stage with staff capacity used to accommodate the increase in urgent referrals and is likely to remain closed until at least November 2021, however the service is working up a model to re-open this service and support reducing pressures in other areas such as RHED (High-risk) team, demand on specialist out of county in-patient beds and local acute medical beds. An urgent trajectory forecast for adolescents has been modelled with the currently known assumptions. This predicts a waiting list recovery by April 2022.

4.12: Ensure review of new short or long-term care packages take place within 12 weeks [Community MH Services]
October performance is reported at 50.0% against an 80% performance threshold. There were 2 non-compliant cases reported in October. The distribution of the data doesn't recommend the application of SPC monitoring.

One case is recorded as needing a review, but as only partly funded by the Trust the review is not logged on the clinical system as having taken place. Currently there is no way of identifying on the system, these cases that fall outside the requirements of the indicator.

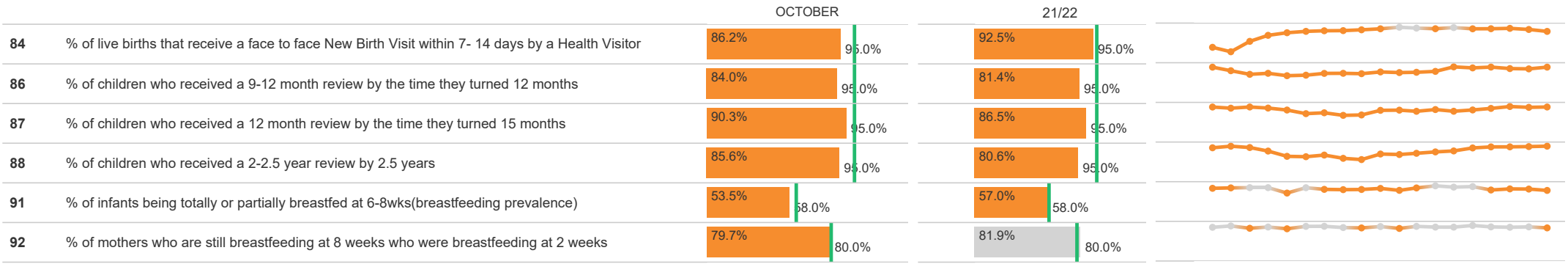
The other case was booked within the required period, but the client was unable to attend. It was rebooked but unfortunately the social worker was required to isolate due to COVID and then had annual leave. It wasn't approporiate for a colleague to review. The review was completed in early November.

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.*

84: Percentage of live births that receive a face-to-face New Birth Visit within 7- 14 days by a Health Visitor. [Children and Young People Service]
92.3% of eligible children who received the NBV in September were seen within 7-14 days against a threshold of 95%, (an increase of 1.5% on last month). This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.
Of the 43 exceptions, 25 babies, (58%) were in NICU (Neonatal Intensive Care Unit)/hospital therefore were unable to be seen in timeframe. This is an increase of 5 babies from last month (20). There were 14 in August 2021. The service is working collaboratively with NICU and will provide the additional and potential ongoing support required on discharge. All of the NICU babies have been visited at home apart from 3 that remain in NICU.

All 5 UP (Universal Partnership) and 7 UPP (Universal Partnership Plus) that didn't meet the threshold due to parents unavailable in timeframe have now been seen. All other contacts have now been seen out of timeframe the influencing factors for this group were parental choice, no access at first contact and decline of HV service.

86: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]
84.1% of eligible children received the 9-12 month visit from a Health Visitor in October, compared to a target of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.
This is a 4% Increase in uptake from September. 96 out of 478 did not receive the review within this timeframe. The parents of all children in this cohort were offered the opportunity to receive a 9-12-month review. A blended offer remains all ASQs (by 15 months and 2 years) for those families previously assessed as universal with low risk; face to face appointments are offered where estates allow and virtual appointments via Attend Anywhere are being offered for developmental reviews where availability of estates outweighs number of reviews needed. Some families still request face to face contact, declining the virtual offer. 56% of breeches declined or DNA the appointment, (reduction of declines and DNAs from last month's 62%).

87: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]
90.4% of eligible children received the 12-month review by the time they were 15 months old by the health visiting team in October, compared to a target of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

This is a 0.5% increase in uptake on last month. 48 out of 498 reviews were not completed within the target timeframe. Catch up developmental clinics have been completed where parents have rebooked the review now they are more comfortable to do so. 72% of breeches were declines or DNA.

88: Percentage of children who received a 2-2.5-year review by 2.5 years. [Children and Young People Service]
85.7% of eligible children received the 2-2.5-year mandated contact by a Health Visitor in October, compared to a target of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

This is a 1% increase on last month. 76 out of 454 reviews completed were not within the target timeframe of 2-2.5 years. All universal partnership (UP) and universal partnership plus (UPP) are seen face to face in the home setting for a full family health needs assessment. An additional intervention called the Early Language Identification Measure (ELIM will be introduced within the 2-year developmental review from the beginning of 2022). 83% of the non-compliant cases were declines or DNA.

91. % of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) [Children and Young People Service]
Breastfeeding prevalence was 57.0% in October compared to a threshold of 58%. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

The September and October prevalence reduced as result of reduced breastfeeding initiation prior to the first 2 weeks so Joint collaborative work with other stakeholders in identified localities has continued. Moving forward into Nov/ Dec the Infant Feeding Lead Specialist health visitor and the champions will work to support an increased initiation.

92. % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks [Children and Young People Service]
Breastfeeding continuation was 79.8% in October compared to a threshold of 80%. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

The Infant Feeding Lead Specialist health visitor and the champions continue to offer tailored packages of care for families that require additional support in order to maintain breastfeeding.

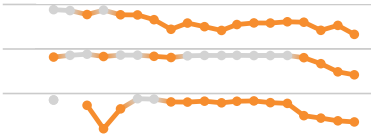
Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		OCTOBER	21/22	
40	Adult Speech and Language Therapy - % treated within 8 Weeks	38.4% (95.0%)	63.2% (95.0%)	
41	Podiatry - % treated within 8 Weeks	48.6% (95.0%)	81.5% (95.0%)	
42	MSKAPS - % treated within 8 Weeks	42.0% (95.0%)	69.1% (95.0%)	



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

40. Adult Speech and Language Therapy - % treated within 8 Weeks [Adult Community Services]
October compliance was 38.4% compared to a target of 95%. 32 out of 52 patients seen in October were seen outside the 8-week target of timeframe of referral to first contact. Since April 2018, the only periods of compliance (above 95%) were aligned to the first pandemic lockdown in April, May and July 2020. October performance is below SPC lower control limit based on 2018/19 and 2019/20 data.

The service is aware of the situation, and it continues to work to assess those patients with the longest waits. Capacity continues to be a challenge within this small service. The main issue is vacancy, very hard to recruit to community posts, and maternity leave. The previous locum cover is no longer in place, and it has not been possible to secure additional locum cover. The service continues to work to enhance recruitment and attract new colleagues to GHC and to look for alternative locum or agency short term cover, but this is a national issue. There is a re-specification project that is underway between GHC and GHT which will address some of these performance challenges.

41. Podiatry - % treated within 8 Weeks [Adult Community Services]
October compliance was 48.6% compared to a threshold of 95%. 239 out of 465 patients seen in October 2021 were seen outside the 8-week target of timeframe of referral to first contact. Performance continues on a declining trajectory since July 2021. Performance is below SPC lower control limit based on 2018/19 and 2019/20 data.

The Podiatry service has dipped considerable in its 8-week Referral to treatment (RTT) performance. Progress is being made through SystmOne Simplicity to review these figures to ensure all clinically meaningful 1st contacts are reflected in the RTT calculation which is not currently the case. This could be impacting indicator compliance. Other validation work within the service is also underway to address data quality issues. The service has experienced some delay with new starters although new colleagues have come into post in the last few weeks which will increase activity. There are particular issues with appropriately trained colleagues for some areas of service delivery and this has been addressed with additional recruitment and some internal training. These new recruits are not expected to come into post until the new year however. The service anticipated a further increase in activity next month but this will focus on those with the longest waits.

42. MSKAPS - % treated within 8 Weeks [Adult Community Services]
October performance was 42.0% compared to a threshold of 95%. 157 out of 271 patients seen in October were seen outside the 8-week target timeframe of referral to first contact. This is below SPC lower control limit based on 2018/19 and 2019/20 data. Performance continues to decline since April 2021 and October performance is lowest so far, this financial year.

Progress is being made through SystmOne Simplicity to review these figures to ensure all clinically meaningful 1st contacts are reflected in the RTT calculation which is not currently the case. This could be impacting indicator compliance.

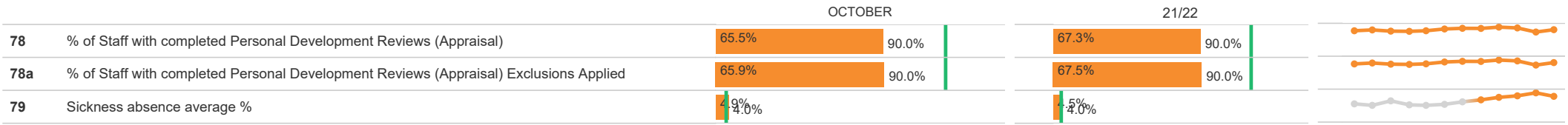
Overall activity this month has reduced. The impact of sickness absence and other wellbeing related absences have reduced capacity within this small team significantly. Recruitment is underway to fill vacancy but numbers of applicants into posts continue to be low. The Business Intelligence team is currently validating new data structures to align to a new operating model which will capture valid clinical telephone contacts within the referral to treatment (RTT) pathway. All patients continue to have the choice to wait to book their appointment via the electronic referral service (eRS) which is outside of the control of the service. A reminder is sent by the service, around 3 weeks after the initial communication to increase timely bookings but this remains an issue with waiting time compliance.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements



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

78: % of Staff with completed Personal Development Reviews (Appraisal)
Performance in October was 65.5% compared to a threshold of 90%. This is below SPC chart normal variation based on 2018/19 and 2019/20 data. October performance is a 5.7% increase from September (59.8%).

The increase of completed appraisals this month which, although an improvement, is still due to a number of factors including annual leave, capacity and not recording on ESR. Managers are regularly reminded of the need to complete appraisals as an important part of being a supportive and inclusive leader in the Trust. In conversation with staff side revised paperwork for appraisals has been informally agreed and will be going to JNCF in December 2021.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only.
Performance in October was 65.9% compared to a threshold of 90%. This is below SPC chart normal variation based on 2018/19 and 2019/20 data. October performance is a 6.0% increase from September (59.9%).

The increase of completed appraisals this month which, although an improvement, is still due to a number of factors including annual leave, capacity and not recording on ESR. Managers are regularly reminded of the need to complete appraisals as an important part of being a supportive and inclusive leader in the Trust. In conversation with staff side revised paperwork for appraisals has been informally agreed and will be going to JNCF in December 2021.

79: Sickness absence average % rolling rate - 12 months
The sickness absence rate for the Trust to the end of October is 4.9% (the Trust target for sickness absence is 4.0%). The figures indicate in-month sickness absence an increasing trajectory since April 2021. Performance is below SPC chart normal variation based on 2018/19 and 2019/20 data.

October performance does not include inpatient data from the e-rostering system (Allocate) because it is not available at the time of reporting. However, full data (incorporating Allocate) from September 2021 compared with August suggests that the Hospitals sub-directorate is on an upward trend and is above 6% sickness absence rate.

Areas in exception include:

- Operations Directorate (5.8% in September) - Adult Community MH and LD, Adult Community Services PH, Children & Young People Service (CYPS) and Urgent Care & Speciality Services are on an upward trend and are all above 5% sickness absence in October 2021.
- Finance Directorate (6.6% in October) - Estates and Facilities have a sickness absence rate of 9.8% in October, highest within the Finance directorate since start of this financial year.
- Executive Directorate (5.0% in October) - Corporate Governance sickness rate has remained above target for the past 5 months with October sickness rate at 5.9%.
- Strategy & Partnerships Directorate (4.5% in October) - Quality improvement sub-directorate sickness rate in October was 7.9% compared to 1.2% in September. However it is a relatively smaller cohort of staff in Quality improvement, about 14 in total.

Working Well alongside the HR Managers assigned to the service areas are continuing to support line managers on all aspects of the operation of the Supporting Attendance Policy, helping to maintain consistency in its application. The Workforce tableau report enables HR Managers to understand the services with higher sickness absence levels to be able to provide additional support focused in those areas.

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AGENDA ITEM: 08/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD REPORT– OCTOBER 2021 DATA**

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

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

Recommendations and decisions required
Board members are asked to:

- **Receive, note and discuss** the October 2021 Quality Dashboard

Executive summary
This report provides an overview of the Trust's quality activities for October 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forums for assurance.

Please note that this dashboard includes the

- Non-Executive Director Quality Visit Report Q1 & Q2
- Trust Quality Priorities H1 2021/2022 - November 2021 Quality Dashboard Update

Quality issues for priority development

- Ongoing Trust recovery continues to address waiting times and backlogs. Good assurance work has been undertaken to assure quality of a range of smaller yet vita physical health nursing/therapy services, such as Diabetes and Lymphoedema and the output of this work will be reported to the next Trust Quality Committee.

- Recruitment and retention within key service critical areas remains a significant challenge. The Code 3 & 4 safe staffing exceptions in mental health services reported this month were as a result of unexpected additional clinical need requirements unable to be filled by bank or agency. All immediate patient needs were met in order to maintain safe care. Senior colleagues within NTQ continue support with OD and operational teams to support recruitment and retention recovery work. Additional support work has also been commenced for Integrated Community Teams regarding increasing demand and staffing pressures.

- Work on the development of appropriate alternatives to support capacity within adult mental health inpatients continues. Improvements can be noted as reflected in the continued reduction in out of area bed usage this month.

- CPA compliance recovery remains an area of priority and will continue to be supported by NTQ colleagues with associated scrutiny and reporting via Quality Assurance Group. Workforce issues and acuity and dependency of the Recovery Team caseloads continue to impact the improvement plan overseen by the Operations Directorate.

Quality issues showing positive improvement

- It is encouraging to see the progress made within the complaint's planned recovery work. The number of complaints received in October reduced to 5 which is the lowest number recorded in an individual month this year. The recovery plan for PCET aims to have no 6+ outstanding complaints by the end of December 2021. At time or reporting we have a further improved position regarding open complaints of 66.

- For the fifth successive month there has been a reduction in the number of pressure ulcers that have worsened or developed under our care.

- NED quality visits have fully recommenced following the 'pause' during Covid-19 with visits being planned for the remainder of the financial year.

Are Our Services Caring?

Good assurance is available that the planned improvement work within PCET is on track to deliver its agreed milestones. The number of complaints received in October reduced to 5 which is the lowest number recorded in an individual month this year. The team have been working diligently with people to engage early on complaint issues and to seek to resolve matters as concerns. It is encouraging to see a further reduction in the total number of historical complaints within the month. There is one 1 complaint that exceeds 12 months, however at the agreement of the complainant the process was paused to allow for treatment to be received prior to progressing the complaint. The complaint process has now completed. The Q2 Non-Executive Director Audit of Complaints report is included in this Dashboard and the audit

provides assurance that overall, the Trust is investigating and responding to complaints appropriately.

Are Our Services Safe?

The number of patient safety incidents reported has increased slightly from 858 in September to 941 in October. Skin Integrity, Restrictive Interventions, Self-Harm and Falls continued to be the most frequently reported categories of incident across the Trust.
Activity and trends continue to be closely monitored by the Quality Assurance Group. The percentage of patient safety incidents meeting moderate, severe and death thresholds has decreased from 7.81%% to 7.44% and we are pleased to report zero C-19 deaths reported by GHC inpatient services for October.

Are Our Services Effective?

It is encouraging to note that this month the occupied bed days for "inappropriate" out of area Mental Health placements in October has decreased to 31 days which relates to 1 patient. Planned development work continues in collaboration with operational colleagues to design quality metrics for a cohort of our smaller services. Future metrics will be representative of; Friends and Family Test, Patient and Carer Experience, Workforce and Access to services. The output of the triangulation of data will provide an opportunity to identify any areas of good practice and opportunity to develop services alongside standard performance data. The continued impact of vacancies and Covid-19 related absences have resulted in increased wait times particularly for Occupational Therapy, Physiotherapy and Podiatry. Priority is given to those who have been waiting longest and have greatest therapeutic need.

Are Our Services Responsive?

Despite operating within an environment of increasing demand for all services good assurance is available that demonstrates the Trust continues to prioritise active recovery work with monthly reporting and assurance provided through QAG with service specific improvement plans being developed where required. CPA compliance has unfortunately reduced in month compared to the previous month's figure however every effort is being made to recover this position. The majority of outstanding cases being within recovery teams. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. External CPA reporting to the CCG has been suspended pending the development of the new National CPA approach.

Are Our Services Well – Led

Board are asked to note that this dashboard includes the detail of the proactive Non-Executive Director Quality Visits in addition to the most recent reporting for the Trust 2021/22 quality priorities. It is encouraging to note that all are progressing well with targets being met within the agreed timeframes with additional input being provided to support those plans that require further development to achieve the in-year targets. Board are asked to note that in this month's dashboard we have provided the Quarter 2 - Guardian of Safe Working Report and we are pleased to report that

no exceptions have been reported It is encouraging to see that the overall training compliance figure minus staff bank is above target at 93.6%.

Risks associated with meeting the Trust's values
Specific initiatives or targets that are not being achieved are highlighted in the Dashboard. Key quality and safety risks are included 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?
Quality Assurance Group, updates to the Trust Executive Committee and bi-monthly reports to Quality Committee.

Appendices:	Quality Dashboard Report

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

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NHS Foundation Trust

AGENDA ITEM: 08.1/1121

Quality Dashboard 2021/22

Physical Health, Mental Health and Learning Disability Services

Data covering October 2021

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

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 2021/22 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

Are our services CARING?

The number of complaints received in October reduced to 5 which is the lowest number recorded in an individual month this year. The team have been working diligently with people to engage early on complaint issues and to seek to resolve matters as concerns. The total number of complaints open for 10-12 months has increased slightly, whilst those open 7-9 months have decreased, 1 complaint exceeds 12 months, these cases are being prioritised and work on reducing the backlog continues. 100% of the complaints received in October 2021 were acknowledged within the 3-day target timeframe. The recovery plan for PCET aims to have no 6+ outstanding complaints by the end of December 2021. The achievement against the 95% target FFT was stable this month at 93%, however, it is expected that the figure will improve as services continue on their recovery trajectories . The number of compliments received has decreased slightly from last month but remains higher than the preceding months. The Q2 Non Executive Director Audit of Complaints report is included in this dashboard and the audit provides assurance that overall, the Trust is investigating and responding to complaints appropriately. Although some delays in responses there is good confidence in the recovery plan and work continues to address the backlog of complaints which at time of writing has reduced further to 66 open complaints from a reported peak of 88.

Are our services SAFE?

The total number of patient safety incidents reported increased from 858 in September to 941 in October with skin Integrity, restrictive Interventions, self – harm and falls being the most frequently reported. This remains within previous reported ranges. There was an overall reduction in self harm reporting in month primarily due to the reduced number of incidents at Berkeley House. Activity and trends continue to be closely monitored by the Quality Assurance Group. The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from September (7.81%) to October (7.44%). We are pleased to report that there were zero C-19 deaths reported by GHC inpatient services for October. As of 29/10/21, 85% of patient facing GHC staff have received their first vaccination for C-19 and 77% received their second. Systems remain in place to vaccinate all eligible inpatients and vulnerable service users. The Covid vaccination team continue to support the roll out of the 12-15 years school programme. All secondary schools will be visited by mid December 2021. The Trusts staff Flu vaccination programme has commenced and reports for the first time this year in the dashboard with 66% of clinical staff having received vaccinations by the end of October.

Are our services EFFECTIVE?

Development work continues in collaboration with operational colleagues to design quality metrics for a cohort of our smaller services. Future metrics will be representative of; Friends and Family Test, Patient and Carer Experience, Workforce and Access to services. The occupied bed days for “inappropriate” out of area Mental Health placements in October has decreased to 31 days which relates to 1 patient. A task and finish group to improve Adult Mental Health admission and discharge pathways led by the Director of NTQ is demonstrating progress in improving bed access which is dynamic in response to demand. Vacancies and Covid absences has had an impact on services with wait times for routine appointments within Occupational & Physiotherapy and Podiatry being extended. GHC continues to maintain its vital role in system-wide patient flow/admission avoidance across all of our services.

Are our services RESPONSIVE?

The Dilke MIIU remains closed and Stroud MiiU is open to booked appointments only due to refurbishment . Recovery of Trust services impacted by Covid -19 disruption is underway with monthly reporting and assurance provided through QAG with service specific improvement plans being developed where required CPA compliance has reduced this month compared to the previous month’s figure to 88.4% and this is due to workforce pressures with the majority of outstanding cases being within recovery. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. External CPA reporting to the CCG has been suspended pending the development of CPA with the ICS, with the exception of monitoring those on CPA with a 12 month review. This allows teams to focus time and resources to developing the Integrated Community Mental Health Team..

Are our services WELL LED?

This months dashboard provides a summary of Non Executive Director quality visits including subsequent actions, these visits have recommenced and are welcomed by colleagues across the Trust. Good assurance is available that demonstrates Physical Intervention and the Positive Behaviour Management Training (Full Course) are now above the Trust’s 90% compliance target following a successful recovery plan. Statutory and mandatory training compliance has shown an increase over the year from last years out turn figure to reach 88.% and is showing recovery from the anticipated summer decline with the overall training compliance figure minus staff bank now showing above target at 93.6%. Sickness absence levels have risen above the 4% target however Staff health and wellbeing remains a priority. Funding of £600K has been provided by NHSE/I to create a system-wide Mental Health and Wellbeing Hub - “The Wellbeing Line” launched on the 4th October. Safe staffing numbers have been maintained noting significant pressures. and exception reporting in WLH. International Nurse recruitment continues with the Trusts first IR RMN passing their OSCE examination in October. The guardians of safe working fro medical colleagues slide is included this month with no exceptions needing to be reported. This dashboard includes reporting on the H1 Trust 2021/22 quality priorities. It is encouraging to note that all are progressing well with targets achieved or plans in place to rectify this where required and these will report again at the end of H2.

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Overview of Non Executive Directors Quality Visits H1 Report

April to September 2021

Working together - Purpose of NED quality visits

- To explore the experience of staff, patients, families and carers across our services
- To provide greater understanding and insight into the services provided by our Trust
- To seek assurance that our staff, patients, families and carers are given the high level of support and care expected by our Trust
- To reinforce a culture of listening, so that we can improve how we support and deliver our services

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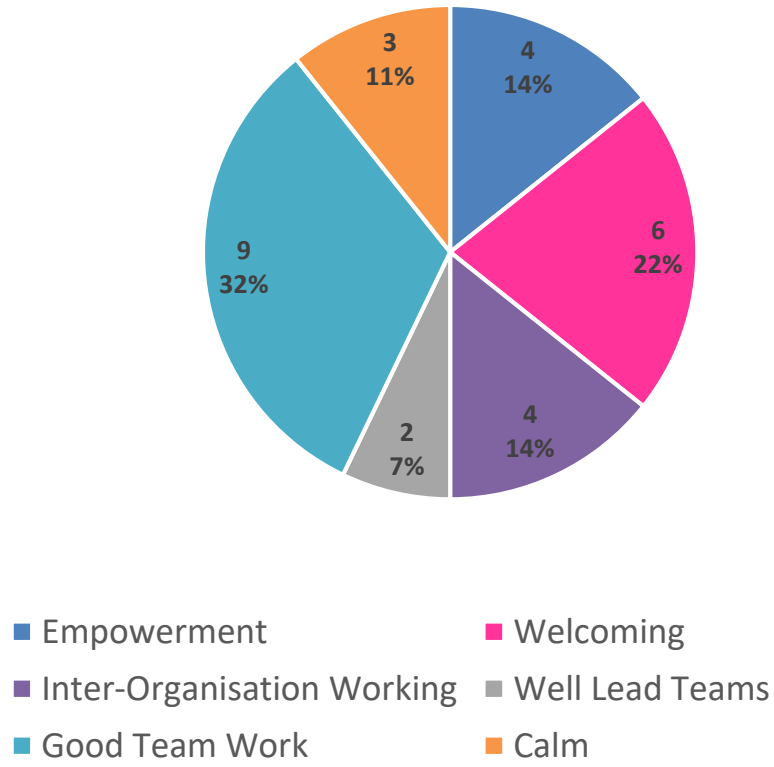
Working together – Visit Schedule

Q1 (April to June 2021)	Q2 (July to September 2021)
Chestnut Ward, Charlton Lane Hospital	**Mental Health, Learning Disabilities and Complex Care at Home**, Colliers Court
Dilke Community Hospital	**Mental Health Recovery**, Cirencester Memorial Centre
Kingsholm Ward, Wotton Lawn Hospital	**Wheelchair Service**, Independent Living Centre
Learning Disabilities Team, Berkeley House	**Dental Services**, St Paul's Clinic
Tewkesbury Community Hospital	**Homeless Healthcare**, Rikenel
	Perinatal Mental Health, Pullman Place

Making a difference – Reported Themes



- Significant recognition of good team work across most services
- Good leadership was recognised and many staff felt empowered
- An atmosphere of calm was noted by several NEDs, despite operational pressures
- There were several examples of ICS working shared

Making a difference – Feedback Examples

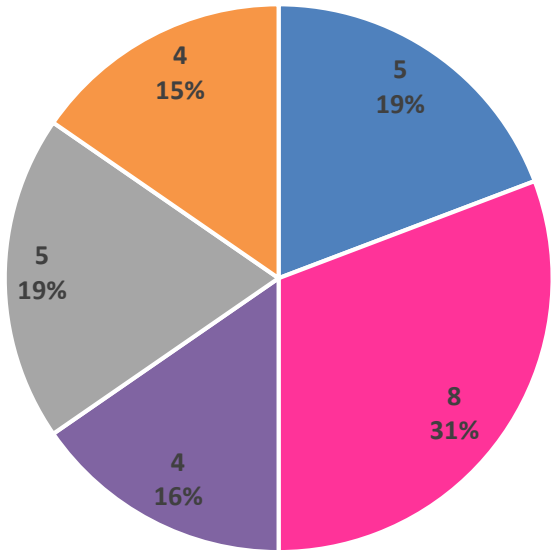
"This is an exceptional team who are focused on making a difference to the lives of their patients. (An) exemplary and high performing team. Could the Trust learn from (them)?" **Perinatal Mental Health, Pullman Place**

"The teams are to be commended for their clear focus on the needs of the people we serve and there were many examples of where individuals had gone above and beyond to secure a good outcome for people." **Colliers Court**

"(The patients) felt safe and secure and had nothing but praise for the team, the peaceful environment and the food…the staff we excellent, without exception, and listened and cared." **Kingsholm Ward, Wotton Lawn**

"Matron leads by example…it is clear that she is widely respected and provides leadership and support to the team; in particular, she encourages people to speak up, which I found very encouraging." **Tewkesbury Hospital**

Always Improving – Reported Themes



- Significant opportunities to improve working environments through minor maintenance
- Time required to navigate/input to clinical systems, reduces ward time
- More joined up working within Trust and across system required
- Localised wellbeing initiatives would benefit teams

Access/Provision of Services
Estates Improvements
ICS Working Improvements
IT and Systems Issues
Staff Wellbeing Issues

Always improving – Feedback examples

"(The IT systems are) more time consuming that the previous paper held records and the long list of requirements to complete within a set time-frame gets longer all the time." ***Kingsholm Ward, Wotton Lawn***

"Some good estates work...but appears to be an issue around minor repairs and maintenance…and the system for reporting such estates issues does not appear to keep the person reporting the issue in the loop." **Charlton Lane**

"The health and wellbeing offer can be too corporate and not localised enough. Also, it can take too long to process health and wellbeing requests." **Pullman Place**

"There is a wish to strengthen the benefits of integration…rotational posts are being considered with interlinks to with the ICT." **Colliers Court**

Outcomes and learning

SERVICE	RECOMMENDATION	ACTION
Homeless Healthcare	1. Explore better dental pathways/specific service 2. Consider flexible access to community nursing	1. Feedback provided to service leads to explore opportunities 2. Joint working agreed and now in place with Community Nursing
Dilke Community Hospital	1. Review estates and equipment requirements 2. Review MIIU (closed) comms to prevent attendances	1. Locality Estate leads now in place and linking with Matrons 2. MIIU comms continuously reviewed in partnership with Service Directors and system partners to ensure clear messages are shared with the public
St Paul's Dental Clinic	1. Review estates and equipment requirements 2. Explore commissioning of preventative work	1. Locality Estate leads now in place and linking with Clinical Directors on a regular basis 2. Service Director will raise within contractual meetings with the commissioner

Outcomes and learning

SERVICE	RECOMMENDATION	ACTION
Charlton Lane	1. Review estates requirements 2. Consider increased (7/7) physiotherapy provision	1. Locality leads for Estates now in place and meet regularly with Matrons 2. HoP Physiotherapy aware and is engaged in wider conversations regarding 7/7 Therapy across all inpatient units
Wotton Lawn	1. Review IT and clinical systems requirements 2. Consider positive comms piece on working at WL 3. Explore 'loyalty' scheme to promote retention	1. MH inpatients represented at the Trust's Clinical systems group and encouraged to raise specifics within the group 2. Recommendation has been presented to HR as part of the wider recruitment and retention work specifically focussed within WLH 3. Recommendation has been presented to HR as part of the wider recruitment and retention work specifically focussed within WLH – currently testing 'golden hello' approach within band 5 WLH recruitment
Berkeley House	1. Work with commissioners/ estates to review requirements 2. Review IT and clinical systems framework	1. Escalated to Head of Estates and Service Director to identify outstanding works required and timelines 2. LD and MH inpatients represented at the Trust's Clinical systems group and encouraged to raise specifics within the group

Outcomes and learning

SERVICE	RECOMMENDATION	ACTION
Mental Health Recovery	1. Engage staff in 'Transformation Programme' 2. Review estates and equipment 3. Review IT and clinical systems requirements	1. Staff being encouraged by service lead to actively participate in Transformational work, this includes colleagues being encouraged to undertake QI bronze training 2. Locality leads for Estates now in place and meet regularly with service leads 3. MH services represented at the Trust's Clinical systems group and encouraged to raise specifics within the group
Wheelchair Service	1. Explore inequalities experienced by people who cannot afford outdoor chairs (commissioning) 2. Consider alternative feedback routes for regular patients	1. Commissioning leads for Personalisation are aware. GHC colleagues reminded of the local VCS offers that can support service users to purchase additional equipment 2. PCET currently reviewing all methods of feedback to explore new opportunities

Outcomes and learning

SERVICE	RECOMMENDATION	ACTION
Tewkesbury Community Hospital	1. Review estates and equipment requirements 2. Explore provision of areas for staff to take breaks 3. Installation of Air Conditioning	1. Locality leads for Estates now in place and meet regularly with Matrons to identify issues and agree solutions 2. Currently being explored as part of the wider HWB offer for colleagues across the Trust 3. This has now been installed
Colliers Court	1. Consider 'local' wellbeing initiatives 2. Work with GCC to improve social care pathways	1. Managers now know they can use their local budgets flexibly to address local team health and wellbeing needs as part of the wider Trust offer to support wellbeing 2. GHC working in partnership with all ICS partners to strengthen existing pathways
Perinatal Mental Health	1. Consider 'local' wellbeing initiatives 2. Work with GPs and Health Visitors to promote referrals	1. Managers now know they can use their local budgets flexibly to address local team health and wellbeing needs as part of the wider Trust offer to support wellbeing 2. CCG colleagues asked to support referrals with Primary care colleagues, this includes a social media campaign

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Trust Quality Priorities H1 2021/2022 - November 2021 Quality Dashboard Update

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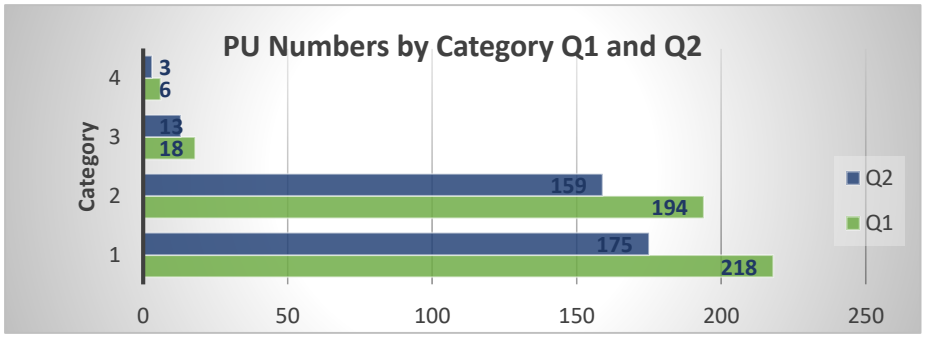
In year there were no quality indicators set through the usual national or local commissioning arrangements. In support of our aspirations as a Trust and in line with the themes identified in the Quality Strategy we have identified 9 quality priorities. There a number of quality improvement projects being supported across the Trust with a view to improving services and outcomes for patients who use our services. This dashboard now includes reporting on the Trust 2021/22 quality priorities and it is encouraging to note that all are progressing well with H1 (Half 1) targets achieved or plans in place to rectify this where deemed necessary.

SAFE : QUALITY PRIORITIES 2021-2022

Standard	**1 - Pressure Ulcers (PU's) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PU's , developing a PU collaborative within the One Gloucestershire Integrated Care System.**
Performance	**Target** – the reduction quarter on quarter in the amount and severity of pressure ulcers within GHC : During Q1 there were 218 developed or worsened pressure ulcers , during Q2 there were 175 developed or worsened pressure ulcers .
Commentary	• The Trust has reported 353 skin integrity incidents in the first half of this year (H1). The active work with teams continues in terms of improving practice to meet significant rising demand in pressure area care referrals from primary care and care homes. Following the success of the Gloucester Quality Improvement (QI) Pressure Ulcer (PU) plan the Forest & Tewkesbury, Newent & Staunton (TNS) QI PU approach is currently in the 'do' stage of the Plan, Do, Study, Act improvement methodology (PDSA) cycle. Leadership from operational managers and clinicians in Gloucester and Forest remains at a high level and the Datix team have provided historical data from these areas that has supported the development of a baseline for improvement focusing on category 2 damage. • Further to the success of the 'Datix dashboard oversight' these are now available to all community ICT managers and their senior teams. This has resulted in timely review of Datix incidents and thematic review for teams as well as assurance and governance oversight for the trust. • Educational webinars highlighting PU categorisation continue and these will be uploaded onto care to learn . The Tissue viability page has been relaunched on the trust's intranet and includes pressure ulcer resources. Tissue viability and District Nursing leads from neighbouring trusts are scoping a community benchmarking collaborative with initial data sharing. • The 20 minute open invite for a focussed District Nurse discussion on safe and effective pressure area assessment, monitoring and management will be repeated following requests from colleagues. The focus will continue to be sharing the national and local themes observed in relation to PU incidence and severity, encouraging debate and involvement in improvement. • Additional clinical support has been made available to review the most severe pressure ulcer damage: Category 3,4, suspected deep tissue injury and unstageable pressure ulcer Datix reports are all reviewed for any errors in categorising PU's at the end of each calendar month. The monthly reports can be rerun and enable accuracy of submission and numbers.
Lead	NF



Target Achieved H1 Y

Target Achieved H2

Next steps : Evaluation of the maturity and success of the PU collaborative to be reported end Q4.

SAFE : QUALITY PRIORITIES 2021-2022

Standard	**2 – Falls prevention – with a focus on reduction in medium to high harm falls based on 2020/21 data . Developing a falls collaborative within the One Gloucestershire Integrated Care System**
Performance	**Target** – the % reduction quarter on quarter in the number of medium and high harm falls within inpatient units.
Commentary	• The number of falls resulting in medium to high harm in Quarter 1 20-21 and Quarter 1 21-22 are unchanged at 6 . • There is a reduction seen in Q2 of 21-22 against the previous years figure of 6 incidents which is a 66 % reduction year on year in the comparable time frame . • So far this year there has been a reduction of 3 incidents of falls resulting in medium to high harm between Q1 and Q2 . • Statistics are monitored on a monthly basis and early indicators relating to the downwards trajectory could indicate that this target will be achieved at year end .
Lead	RK

Year	No	Year	No
Q1 20-21	6	Q1 21-22	6
Q2 20-21	9	Q2 21-22	3

Target Achieved H1 Y

Target Achieved H2

Next steps : Evaluation of the maturity and success of the Falls Collaborative within the one Gloucestershire ICS collaborative to be reported end Q4.

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SAFE : QUALITY PRIORITIES 2021-2022

Standard	**3- End of Life Care (EoLC) - with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county . This will support the 6 ambitions for Palliative and End of Life Care including improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advanced care planning and the ReSPECTV3 form, and increasing symptom management training for staff to support non - cancer patients.**
Performance	**Target** – Our aim is to enable all our staff to be compassionate, confident and competent in delivering EoLc in our hospitals and in the community

Commentary

Quality Priority Plan	Q1	Q2	Q3	Q4
GHC EoLc priorities align with the One Gloucestershire approach to improving EoLc across the county and support the Six Ambitions for Palliative and EoLc. Our aim is to enable all our staff to be compassionate, confident and competent in delivering EoLc in our hospitals and in the community.		Develop and agree metrics from baseline assessments	Compassionate: • Early involvement in EoL concerns and complaints to recognise sensitivities and achieve early resolution. Confident: • Pre/post education and training confidence surveys Competent: • Number of people attending education and training • ReSPECT audit . • ReSPECT training • 2055 staff required L2 training 89.7% trained • 1028 staff required L3 training 81% trained.	Compassionate: • Reduction in number of EoLc complaints • Celebration event of good practice/ compliments Confident: • Pre/post education and training confidence surveys Competent: • Number of people attending education and training

Lead	DW

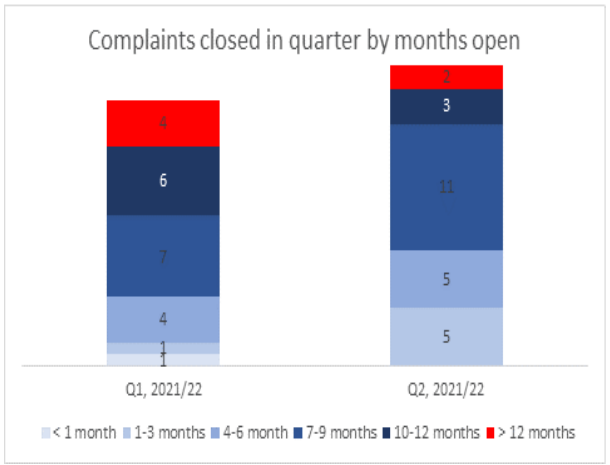
• Plan - Early involvement in EoL concerns and complaints to recognise sensitivities and achieve early resolution. Thus leading to an overall reduction in complaints .	Progress - The EoL lead is now involved in any complaints or concerns at an early stage to enable the families concerns to be addressed in a compassionate and timely manner and at a point where a real difference can be made to the care path for the patient.
• Plan - Pre/post education and training confidence surveys	Progress - The education programme (Masterclass in End of life Care) commenced on 2nd September and consists of 14 bookable 1 hour sessions . The next course has a planned start date of 6th January 2022 . The classes were collaboratively developed following discussions with Community Hospital staff and District Nurse teams. A course evaluation will take place at the end of each to inform future course content and evaluate success .
• Plan - Number of people attending education and training	Progress - To be confirmed , there are 30 spaces available on each course.
• Plan - ReSPECT audit	Progress - The ReSPECT Audit is in the planning stage with the audit tool about to be signed off .

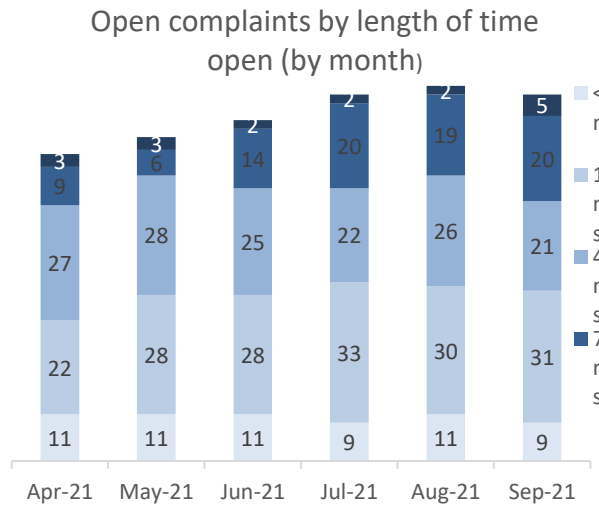
Target Achieved H1	Y
Target Achieved H2	

Next steps : Statistical analysis to be undertaken in relation to reduction in complaints, numbers of class attendees and results of the respect audit , to be reported end Q4.

RESPONSIVE : QUALITY PRIORITIES 2021-2022

Standard	**4 – Patient and Carer Experience - with a focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services improvement in completion times will be achieved quarter on quarter .**
Performance	**Target** – Our aim is to achieve a % reduction in PCET response rates and resolution times.
Commentary	• There has been an incremental improvement of 50% in the reduction of response times that exceeded 10 months shown between Q1 and Q2 of this year. • Between Q1 and Q2 there was a 50% improvement shown in the reduction of response times greater than 12 months which is evidenced by the number of response times reducing from 4 in Q1 to 2 in Q4. • In Q1 there were 6 response times that exceeded 10 months and this figure was subsequently reduced to 3 in Q2 demonstrating a 50% improvement . • In Q1 there were 9 complaints open that had been open in excess of 12 months and this reduced in Q2 to 1 demonstrating an 88% reduction, however the number of complaints open that had been open from 10-12 months increased by 1 demonstrating a 12% increase . • These trend lines will need to mature over the next 2 quarters to evaluate the direction of travel, however early indicators are positive . • By the end of Q3 the team plan to resolve those outstanding complaint of 6 months plus.
Lead	HW





Target Achieved H1

Y

Target Achieved H2

Next steps : Statistical analysis to be undertaken in relation to reduction in complaints, ensure that the metrics being shown are what the initiative was aiming to report to be completed by end Q4.

RESPONSIVE : QUALITY PRIORITIES 2021-2022

Standard	**5 - friends and Family Test (FFT) - with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Audit Community Mental Health Survey action plan .**
Performance	**Target** – To establish a new question in the survey with a focus on "What really matters" to the patient .
Commentary Asking people for their views on the quality of their care	**Scoping exercise on Quality of Care** • A scoping exercise will take place as part of the wider Community MH Transformation work to identify what is important and meaningful to service users and carers and What Matters to Me… **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. • Patients providing for feedback on discharge via SMS and email. • Patient providing feedback via link on Attend Anywhere • Launch of a carers FFT to seek feedback on the experience of carers who are in contact with our services – to be launched during Carers week in June 2021 • FFT, Carers FFT, and Carers survey all available on Trust website • Communications campaign to raise awareness of our feedback mechanisms **Leaflets and comment cards** • New complaints leaflets, posters and comment cards to be made available throughout all Trust service.
Lead	HW

Action	**Update Q2**
Scoping Exercise	• Not yet started and been identified as aspirational as there has been no resource available to take this forward as a separate project, potential to align with other workstreams .
FFT	• We have achieved the implementation of the patient FFT and the carer FFT, but there is a new project now in place to look at the processes in order to streamline these and make them less labour intensive. This work is ongoing in collaboration with Snap Surveys, and the BI and IT teams. We are looking at implementing this over the next 6-9 months as there has not been resource available within the team to take this work forward, although plans are in place to address this. It is not possible to add additional questions to the current FFT, therefore a new question regarding quality of care can only be implemented when the process change takes place . • The current FFT question does encompass quality of care, although is broader: • <u>The question currently asked is:</u> *Overall, how was your experience of our service* (this is the National FFT question) Answer options: very good -good – neither good nor poor – poor – very poor – don't' know
Leaflets and Comment Cards	• There has been in delay in the ordering of the leaflets and posters due to changes required; new order to be placed in October and will then be distributed

Target Achieved H1 NA

Target Achieved H2

Next steps : All workstreams to be progressed.

SAFE : QUALITY PRIORITIES 2021-2022

Standard	**6 - Reducing suicides - with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022.**
Performance	**Target** – To establish an outcome of zero suicides within our mental health inpatient units by 2022
Commentary	There will be a staged implementation of NHSE/I mandated zero Suicide Plan for inpatient MH services.
Plan - The Positive & Safe Group will develop and deliver a work plan with a clear focus on suicide prevention, ligature reduction programmes, use of assistive technologies, and proactive and collaborative clinical risk management.	**Progress** • Positive & Safe Group has met monthly and has oversight of suicide prevention activity including routine review of themes and trends concerning self-harm and ligature incidents. Currently developing a Clinical Protocol for Ligature and Near Hanging Incidents. • Gap analysis re ligature reduction activity completed and used to inform Reduction of Ligature Risk Policy review. • Reduction of Ligature Risk Policy revised and approved July 2021. • Inpatient ligature audit advancing. WLH, CLC, Recovery Units all complete, Berkeley House in progress. Additional governance of progress via quarterly Ligature Audit Action Planning Meetings chaired by Hospitals Directorate Service Director, with further oversight via quarterly Executive Led Ligature Management meetings. • Installation of new anti-ligature windows and door alarms at WLH as part of the Capital Programme began April 21 however works were suspended until September 21 due to patient flow challenges. This work has now resumed. • 'Oxevision' Project Group established with the case being finalised. It is anticipated that the introduction of this technology will lead to a reduction in reported ligature incidents. • Ward based suicide prevention champions have been identified at WLH.
Plan – To develop a comprehensive and robust training programme focussed on suicide reduction, suicidal thinking, assessment and conversation. This will be provided for all grades of staff, across all fields, beginning with those working in inpatient settings.	• GHC now offers 2 online courses via Care to Learn 1) 'Suicidal Thoughts and Assessment' – Having the Conversation, 2) 'We need to talk about suicide' – Health Education England • In addition, the Positive & Safe Group identified 3 other freely available online course which are indicated in the 'Its safe to talk about suicide' leaflet' these are – Zero suicide alliance -www.zerosuicidealliance.com,'Real talk' – Grassroots, 'Suicide Prevention Awareness' – The learning pool • Statutory & Mandatory training for inpatient staff also includes assessing and managing clinical risks, searching of patients and observations and therapeutic engagement
Plan – To fully integrate, where possible, experts by experience, carers and families in the action plan to improve overall outcomes and service delivery in keeping with trust values. To further promote existing good practice such as the Letter of Hope, Little Red Book and the Stay Alive app and also to develop and implement the Its safe to talk about suicide leaflet.	• Letter of Hope relaunched and circulated via the Gloucestershire Suicide Prevention Partnership Forum. A further 1000 copies were printed. • An 'Its safe to talk about suicide' leaflet was developed based on the work at Exeter University Medical School with the Alliance of Suicide Prevention Charities originally produced in Devon. The GHC version was launched on World Suicide Prevention Day . There are plans to develop a version of this leaflet for use within CYPS.
Plan – To develop specialist practitioner roles. The focus of the Advanced Nurse Practitioners will be working with complex patients at risk of harm, supporting ward teams and medical staff in assessing, managing and reducing risk inclusive of serious self-harm.	• Appointment of 3 x Advanced Nurse Practitioners (ANPs) to work with complex patients at risk of harm in MH & LD inpatient units completed. • The 3 ANPs are currently undertaking training and development
Plan – For the Inpatient teams to continues to assist in the provision of good follow-up and transition across teams to reduce risks and ensure safe discharges.	TBC Q4
Plan – To fully engage with the Gloucestershire Suicide Prevention Partnership Forum, neighbouring trusts and those further in the South to work together to share thoughts, ideas and experiences.	• GHC remains an active member of the Forum and inputs actively into the multiagency twice monthly 'real time' suicide surveillance group within the county. • The Trust's Quality Lead attended the Regional Suicide Prevention Virtual Summit 3 & 10.9.21 to participate in sharing of ideas and experiences.

Target achieved H1

Target achieved H2

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SAFE : QUALITY PRIORITIES 2021-2022

Standard	**7 - Learning disabilities - a focus on the Hospital /personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and tier 2 training programme .The trust aims to train 90% of our workforce .**
Performance	**Target** – To achieve a target of circa 50% of the workforce to be trained at L1 by Q3 and 90% of the workforce to be trained at L1 by the end of Q4. To provide an update and focus on the utilisation of patient passports .
Commentary	• Oliver McGowan - Level 1 training: The Compliance level is currently at 28% (equivalent to 1149 people) having completed the training. This is equivalent to 34% of the target audience if Staff Bank figures are removed. The training compliance figure for Level 1 is behind the target position. However, this reflects the enormous pressures that services are currently experiencing and the fact they have been concentrating on recovering statutory and mandatory training compliance levels which understandable slipped during the months of the Covid pandemic. • There has been enormous amounts of positive feedback received in relation to the training , some of the quotes which come from social media (e.g. Facebook and Twitter) are shown below . • We actively promote and share the My Health Passports and work is being scoped to liaise with other organisations such as the Hospitals Steering Group and Inclusion Gloucestershire to evaluate usage .
Lead	HW

"Fantastic training, really can't recommend enough to all heath and social care staff"

"The best training I've been on for a long time and I learned so much (really truly – I'm not just being kind). I though I knew stuff but realised I was working with a lot of unconscious bias. Go on the training and see for yourself"

"Completed the online training and joined one of the experts by experience team members who was incredibly informative and made the session very engaging. Most definitely worth attending both training sessions to create an understanding and awareness"

"The Oliver McGowan Training is an insightful, informative and emotive training package. The training is predominately delivered by those with lived experience who truly understand the impact of conditions, diagnosis and the important discussions required in relation to their health and social care needs. I feel this training is extremely important for all health professionals in highlighting the individual behind the documentation and their desires to be seen, heard and to lead a fulfilled life. It will change my approach to communications ensuring I adhere to Ask, Listen, Do in order to achieve the most positive outcomes for the individuals themselves."

"Some of my staff did Tier 2 this week and it was brilliant… really brilliant, a must for ALL who work in the care sector. Very powerful stories. Excellent training!"

"Tier 1 of the excellent Oliver McGowan training completed today. Tears flowing at his story and missed opportunities to listen. Highly recommend staff do this training and we learn from his sadly entirely avoidable death. Ask. Listen. Do."

"Brilliant training, so powerful, highly recommended"

Target Achieved H1 N

Target Achieved H2

Recovery plan/Next steps : Staff, and their managers, will continue to receive automated notifications from the Care to Learn training system about this (and any other training) which is out of date. Communication notices to encourage uptake continue to be issued by way of the intranet, newsletters and Indie-to-Go. Further work planned to explore usage of patient Passports is being scoped .

SAFE : QUALITY PRIORITIES 2021-2022

Standard	**8- Children's Services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care . Fidelity to the care pathways will be evaluated through participation in the NCEPOD study .**
Performance	**Target** – To engage and report in line with the NCEPOD Study.
Commentary	• As a trust we have been asked to support a NCEPOD submission around CYP with specific conditions transitioning to adult services. • The spreadsheets were circulated however in GHC we are not in a position to complete as we are unable to identify the cohort of children as we don't hold diagnosis codes in electronic records and also don't see CYP in our community hospitals . • We have contacted the transition team who are leading and coordinating this project and they have agreed to send us cases from other trusts who have identified us as a partner in the care delivery . The maximum we will receive is 15 CYP . • We therefore are awaiting other trust submissions before our identified cohort will be provided .
Lead	JR

Target Achieved H1 NA

Target Achieved H2

Next steps : The audit will take place once the cohort concerned has been established.

SAFE : QUALITY PRIORITIES 2021-2022

Standard	**9-Embedding learning following patient safety Incidents - with a focus on sharing and learning from experience and investigations to develop and improve standards of care . This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons bulletins issued. alongside implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period .**
Performance	**Target** – To deliver 5 embedded learning events by the end of Q3 and 8 embedded learning events by the end of Q4.
Commentary	
Lead	NM

SI Reference	Datix	Team	Session Date	Comment
Historical		The Vale Hospital	29/04/2021	Session Completed
SI-36-21	GHC12830	ICT TWNS DN	19/07/2021	Session Completed
SI-03-22	GHC17086	AOT West	05/10/2021	Session Completed
SI-06-22	GHC17783	North Cots Hospital		Session was planned for 18/08/21, however cancelled on the day due to clinical demands

Narrative	Number
SI Incidents on a page included in Patient Safety Team (PST) monthly reports since April 2021	11
Clinical Incidents on a page included in PST monthly reports since April 2021	4

Target Achieved H1 NA

Target Achieved H2

Next steps : 5 further teams who have recently been involved in SI's have been contacted to arrange embedded learning sessions.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

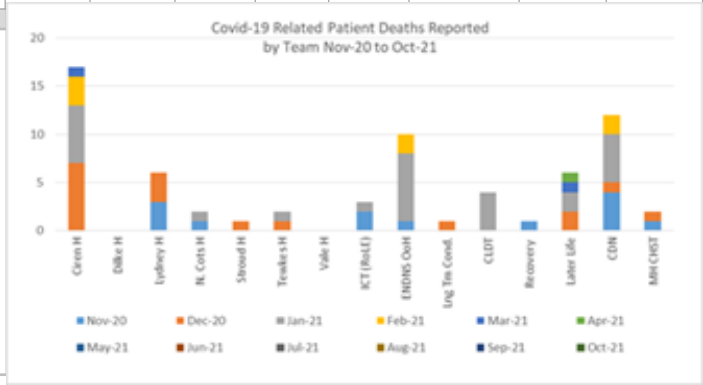
COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

No	Reporting Level	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A	Exception Report?
No of C-19 Inpatient Deaths reported to CPNS	N-R	66	0	0	0	0	0	0	0						0		
Total number of deaths reported as C-19 related.	L-R	161	0	0	0	0	0	0	0						0		
No of Patients tested at least once PH	N-R	2004	281	298	306	322	262	278	279						2026		
No of Patients tested at least once MH	N-R	775	157	129	169	176	167	159	153						1110		
No of Patients tested C-19 positive or were admitted already positive PH	N-R	322	0	0	2	2	1	3	2						10		
No of Patients tested C-19 positive or were admitted already positive MH	N-R	33	0	0	0	1	2	1	2						6		
No of Patients discharged from hospital post C-19 PH	N-R	271	9	0	1	2	1	2	2						17		
No of Patients discharged from hospital post C-19 MH	N-R	28	1	0	0	1	1	0	2						5		
Community onset (positive specimen <2 days after admission to the Trust)	N-R	30	0	0	2	3	1	0	0						5		
Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)	N-R	6	0	0	0	0	0	0	0						0		
Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)	N-R	10	0	0	0	0	0	0	0						0		
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust	N-R	27	0	0	0	0	1	0	1						2		
No of staff and household contacts tested	N-R	3123	65	76	342	221	211	287	617						1819		
No of staff/household contacts with confirmed C-19	L-R	323	0	0	28	25	29	32	168						282		
No of staff self-isolating: new episodes in month	L-R		34	40	153	223	199	146	255								
No of staff returning to work during month	L-R		29	30	100	210	169	145	207								
No staff GHC who received Covid-19 vaccine first dose		4046	17	8	8	7	3	0	0						43		

Additional Information

As part of our ongoing commitment to support the One Gloucestershire NHS partners in declaring a countywide serious incident for HOPHA and HODHA Covid-19 cases in our hospitals work has continued to progress during this reporting period. Levels of harm as a result of acquiring Covid-19 have been identified, Duty of Candour conversations have taken place with next of kin and 19 DoC letters have been sent. Case reviews where harm was severe or resulted in death, are being undertaken and IPC reviews covering IPC measures and the management of outbreaks are in progress. The findings from this work will inform both internal and system wide learning, with a final report due at the end of November.

In October we had 1 case of a HODHA which related to an inpatient at Wotton Lawn Hospital. The IPC team working closely with the ward team were able to contain the case to a single event. Track and Trace of this case supports that the patient came into contact with a relative whilst on home leave who had tested positive to COVID. All IPC measures were introduced to initially isolate the patient on the ward and onward transfer to home.



KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

- Flu - annual vaccination programme is making steady progress with plenty of availability in clinics with 66% of GHC clinical staff now vaccinated. This equates to just under 1200 vaccinations being given in 2 weeks.
- COVID 19 (October data) - 85 % "frontline" workforce received first vaccine; with 77% having received their second dose. 70% BAME colleagues received first vaccine and 63% received their second as at 29/10/2021.
- Vaccine uptake data is monitored weekly and submitted to NHSE/I every 14 days
- Proactive and targeted communication in place with intention to reinforce the importance of second dosages and boosters
- Systems remain in place to vaccinate all eligible inpatients and vulnerable service users as required with consent.
- The Covid vaccination team have commenced the roll out of the 12-15 years school programme. All secondary schools in the county will be visited by mid December, the programme is currently on target. Work is under way with our PCN colleagues to create a supplementary offer for those children turning 12 throughout the year and those who have missed the school session.

FLU VACCINATIONS ROLE	BASE NUMBERS Oct 2021	FLU JABS TO W/E 12th Nov	%
All doctors/dentists	131	73	56
All qualified nurses, including students	1453	988	68
All other professional qualified staff	791	472	60
Support to clinical staff	1879	1209	69
TOTAL CHC CLINICAL STAFF	4254	2823	66
NHS infrastructure staff	363	203	56
TOTAL GHC WORKFORCE	4617	3026	66

COVID-19 VACCINATIONS ROLE	BASE NUMBERS Sept	1ST VACCINE 29th Oct	%	2nd VACCINE 29th Oct	%	Boosters 29th Oct	%
All doctors/dentists	127	111	87	104	82	15	12
All qualified nurses, including students	1444	1243	86	1113	77	108	7
All other professional qualified staff	780	675	87	623	80	71	9
Support to clinical staff	1872	1568	84	1412	75	152	8
TOTAL GHC CLINICAL STAFF	**4223**	3597	85	3252	77	346	8
NHS infrastructure staff	358	248	69	205	57	27	8
TOTAL GHC WORKFORCE	4581	3845	84	3457	75	373	5

COVID-19 - KEEPING STAFF SAFE

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 and will continue until end of March 2022.The Trust continues to maintain 14 days supply of all key PPE items at central stores and are maintaining 14 days of supplies at each PPE locality hub.

The Stock Management Team continues to deliver emergency PPE for the local resilience forum (LRF). GHC has proposed some changes to the service delivery model with a proposed start date of 1st December 2021, we are awaiting confirmation from the CCG that this is acceptable. The proposal is to rationalise the hubs and timings of LRF collection to offer a more responsive service heading in to winter.

Transparent masks

The transparent mask situation has not changed, with no transparent masks having sufficient assurance to be certified as suitable to use in place of a Type IIR. GHC's offer to be a pilot site still stands but NHSEI have not yet contacted these pilot sites. Teams continue to use an individual risk assessment to utilise transparent masks when necessary.

Lateral flow (Asymptomatic testing)
Colleagues are continuing to order their own lateral flow tests. The Stock Management Team will ensure that any remaining kits are used ahead of their expiry date.

Product recall

There has been a product recall on specific batches of Obisk Blue Tree Type IIR masks. While the Trust has received these in the past, we have not identified that any of the affected batches are currently in circulation.

FFP3 fit-testing
The fit test co-ordinator continues to work towards the Trust meeting requirements as detailed by the Department of Health and Social Care. The GHC Fit Test Strategy includes the Key Success of the programme to date:

Successes and progress made against strategy :
- We are pleased to report that current fit testing compliance **is 99.5%** for regular users (i.e. those performing regular AGPs) and **93.6%** for general users (i.e. those wearing FFP3s for resus purposes).
- The intranet has been updated to include information on the safe use of masks in order to protect our colleagues in the workplace.
- Fit testing is now available at clinical induction every Tuesday, so new starters can be tested. This has proven to be very successful so far.
- Cleansing and analysis of data to reflect a more accurate picture is still taking place and is enabling us to build a more detailed picture of fit testing within the trust.

Programme development plan for the next 6 months:
- Continue to strive to test all regular AGP users on two different types of masks. This is so that, if a mask is recalled or the stock becomes unavailable the staff will not have to delay urgent tasks or be unable to give care to patients.
- Ensure that staff tested on two masks are able to regularly alternate what masks they wear, and encourage them to do this.
- Ensure that a range of FFP3 masks are available to users on the frontline and should not exceed 25% usage on any one type of FFP3
- Register FFP3 users and fit test results in Care to Learn and for colleagues to then be notified through this when they need a test.

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

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

No		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
	Number of Friends and Family Test Responses Received	N - T		11990	1786	1490	1562	1552	1118	1283	1378						10169			
	% of respondents indicating a positive experience of our services	N - R	95%	94%	92%	94%	94%	95%	94%	93%	93%						94%			
	Number of Compliments	L - R		1478	149	123	129	131	118	147	140						937			
	Number of Concerns	L - R		390	41	34	37	37	34	44	46						273			
	Concerns escalated to a formal complaint			14	1	3	4	2	2	1	0						13			
	Number of Complaints	N - R		83	11	11	11	9	11	9	5						67			
	Number of open complaints (not all opened within month)				76	79	82	86	88	87	80									
	Percentage of complaints acknowledged within 3 working days		100%	96%	73%	91%	100%	100%	82%	100%	100%						92%			
	Number agreeing investigation issues with complainant				15	17	13	12	20	15	8									
	Number of complaints awaiting investigation				4	0	2	3	2	5	5									
	Number of complaints under investigation				10	15	21	19	22	22	27									
	Number of Final Response Letters being drafted				44	43	45	49	43	42	45									
	Number of complaints closed				7	9	8	7	8	11	12						62			
	Number of re-opened complaints (not all opened within month)				5	6	6	6	7	5	6									
	Current external reviews				4	4	4	3	3	3	2									

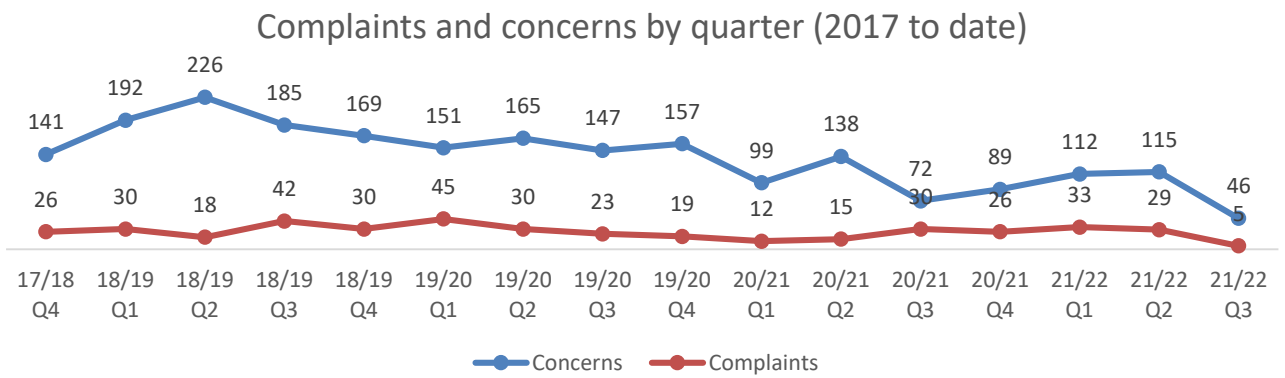
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure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

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

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

Complaints, concerns and compliments

- The average number of complaints received in October over the past four years is **10**. In October 2021 we received **5 complaints**.
- In October 2021, **12** complaints were closed: **2** were withdrawn, **1** was upheld, **2** were partly upheld, and **7** were not upheld
- **46** concerns were raised in October 2021, which is more than the monthly average of 32 concerns during 2020/21. An increase in concerns is expected as we move to resolve issues at concern level rather than as a formal complaint
- **140** compliments were received in October 2021, which is more than the monthly average of 123 during 2020/21.



This chart summarises the number of complaints and concerns received by quarter since 2017/18. This offers assurance that services are not receiving a significant increase in complaints in 2021/22. The impact of Covid-19 (national pause, redeployment, services in recovery), PCET staffing challenges, and a cluster of complaints received in November and December 2020, have all contributed to the current increase in complaint response times.

Assurance regarding complaint management

- Each complaint is triaged to check for any immediate actions required. Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- The Non-Executive Director Audit of complaints for Quarter 2 2021/22 was completed this month
- Price Waterhouse Cooper are concluding their NTQ requested audit of complaints and findings will be shared in future dashboards

Satisfaction with complaints/concern processes

- **6** active re-opened complaints
- **31** concerns were closed in October 2021, and none were escalated to a complaint

External review

- There are currently **2** complaints with the PHSO for external review.

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

Timeframes

- PCET remains in active recovery and work is underway to improve response times.
- **All 5** complaints received in October 2021 were acknowledged within the 3-day target timeframe.

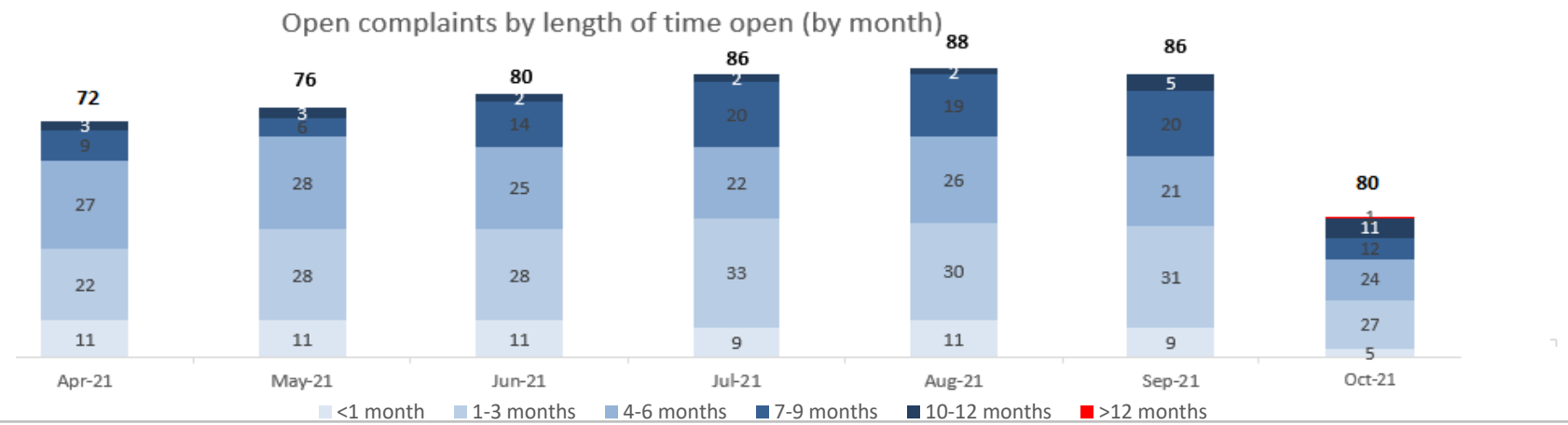
- Of the **80** open complaints, **9** do not have agreed response times. Of these:
  - **7** are in the very early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set
  - **2** are complaints being managed by other NHS organisations, for which we are providing input/comments.

- Of the **71** complaints with agreed response dates:
  - **21** are within the agreed timeframe
  - **50** have exceeded the initially agreed timeframes, and there are a range of reasons for these delays including:
    - Agreeing issues for investigation with complainants
    - Delays in the investigation process (e.g. allocating investigators, timeliness of investigation report, and availability of staff for interviews)
    - Delays in the drafting and review of final responses (e.g. capacity, quality of investigation, availability of staff to review draft responses)
    - Work is underway to address delays in the complaints process in order to minimise them where possible

- **At time of reporting there are 66 open complaints which gives assurance that recovery work is progressing well**

The chart below shows the length of time complaints have been open (please note that it can take up to approx. 8 weeks to agree issues with complainants depending on complexity and availability). The PCET are focusing efforts on completing responses for those open for the longest period. A weekly meeting provides high-level oversight of the complaints tracker. Weekly updates to the Director of NTQ are in place and regular briefings to the Board and Quality Committee provide assurance of recovery.

Additional resource has been secured via redeployed colleagues and 2 existing members of the team have agreed to temporarily increase their working hours. Additional investment has resulted in recent recruitment to 2 additional substantive posts, and one fixed term 12-month contract. to support complaint response times. Further support has been supplied by senior NTQ colleagues to assist with final response letter completion and to increase triangulation with patient safety and Freedom to Speak Up learning. The Trust Quality Improvement Team are undertaking a LEAN assessment to identify process improvements and areas for efficiency.



ARE SERVICES CARING? Non-Executive Director audit of complaints Q2 2021/22

INTRODUCTION

The agreed aim of the audit is to provide assurance that standards of complaint management are being met in relation to the following areas:

- 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 auditor
- The Patient and Carer Experience Team completes section 1 of the audit tool and provide 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 Q2 2020/21 audit provides assurance that overall, the Trust is investigating and responding to complaints appropriately.
- Delays in responses have been noted and work continues to address the backlog of complaints. Response and waiting times are monitored via the monthly Quality Dashboard.

FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS

- To note the contents of the report
- To note the assurances provided regarding the Trust's management of complaints

ARE SERVICES CARING? Non-Executive Director audit of complaints Q2 2021/22

	Time scale of response	Quality of investigation	Accessibility, style and tone of letter	Learning actions identified	Comments
Complaint 1 • Patient attended MIiU following injury to their hand. • Patient reported that staff member was dismissive and belittled them for attending MIiU.	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay in responding to the complaint	**FULL ASSURANCE** • Investigation was clear and concise. • Investigation conclusions appear sound.	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay • Compassionate	**FULL ASSURANCE** • Learning identified and shared	
Complaint 2 • Relative complained that discharge planning had been started despite the patient continuing to significantly self-harm.	**LIMITED ASSURANCE** • Delayed • Lengthy delay in completing the response to the complainant following completion of the investigation	**FULL ASSURANCE** • Thorough investigation which highlighted appropriate care • Date of completion was omitted from the investigation document	**FULL ASSURANCE** • Apologetic and sincere • Appropriate response • Apologetic regarding the long delay	**FULL ASSURANCE** • Learning identified and shared	
Complaint 3 • Complainant reported issues accessing systemwide specialist palliative care and generalist end of life care. • Complainant described some staff within systemwide services as uncaring / not compassionate.	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and national pause in complaints	**LIMITTED ASSURANCE** • Some of the wording in the investigation could appear evasive	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay	**LIMITED ASSURANCE** • A number of clinical records were not completed fully and it was not always possible to identify staff members who were on duty at the time when some of the issues raised occurred • Some of these actions are no more than “reminders” and it is difficult to confirm that these have been effectively achieved	• Joint complaint – GHC / GHFT / OOH GP’s. • GHC actions have subsequently been strengthened and form part of the Trusts End of Life improvement group plan, one action focussing on bespoke training has been actioned immediately. Learning will be further evidenced within the EoL QIG highlight reports

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

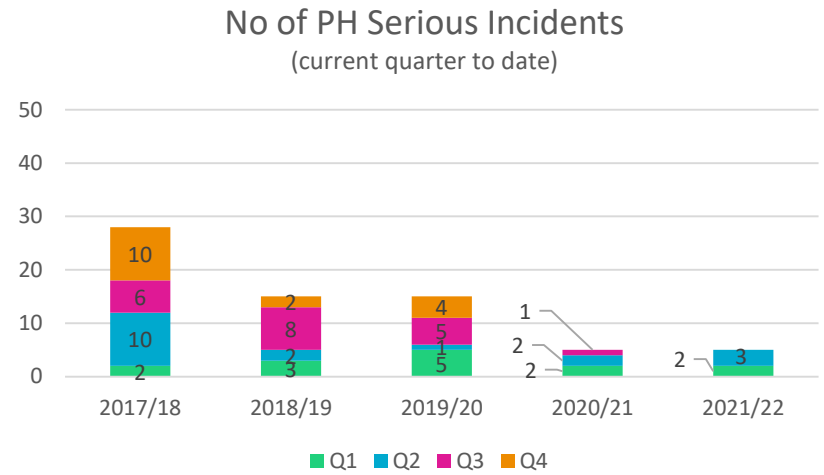
		Reporting Level	Threshold	20-21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021-22 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	0	0	0	0	0	0	0	0						0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	4	3	1	2	1	3	2						16			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		1	1	1	0	0	0	0	0						2			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		3	0	1	0	0	0	0	0						1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		2	0	0	0	0	0	0	0						0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		15	3	1	1	1	0	0	2						8			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		10	0	0	0	0	0	0	0						0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		0	0	0	0	0	0	0	0						0			N/A
	Total number of Patient Safety Incidents reported	L - R		12474	985	1185	1069	1025	919	858	941						6982			N/A
	% incidents resulting in low or no harm	L - R		93.41%	92.99%	91.05%	92.42%	93.37%	94.23%	92.19%	92.56%						92.64%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		6.59%	7.01%	8.95%	7.58%	6.63%	5.77%	7.81%	7.44%						7.36%			N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.75%	1.10%	2.17%	2.78%	0.00%	1.75%	1.96%	1.00%						1.52%			N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.83%	0.00%	1.64%	0.00%	0.00%	1.61%	2.86%	1.85%						1.05%			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	1	0	0	1	0	0	4	0	0	0	0	0	6			N/A

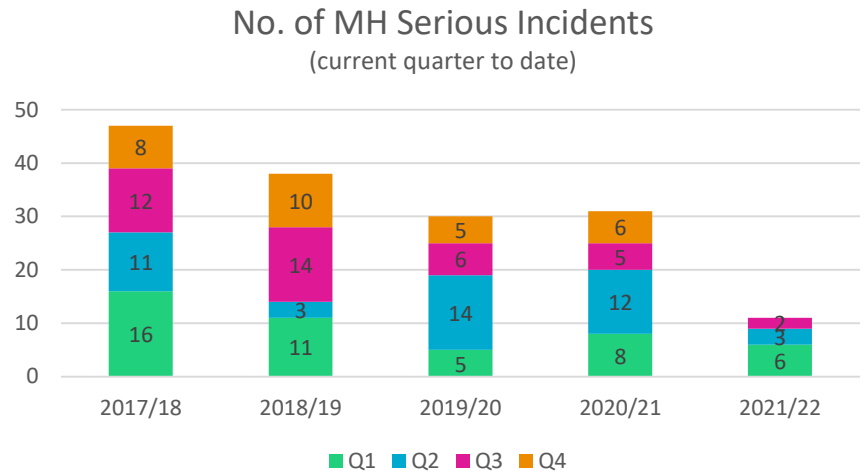
N-T	National measure/standard with target	L-I	Locally agreed measure for the Trust (internal target)
N-R	Nationally reported measure but without a formal target	L-R	Locally reported (no target/threshold) agreed
L-C	Locally contracted measure (target/threshold agreed with GCCG)	N-R/L-C	Measure that is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

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

CQC DOMAIN - ARE SERVICES SAFE? – additional information

Two SIRI's were declared in October 2021, both mental health and suspected suicides. The first, a male patient known to the Older People's Community Mental Health Team. The second Mental Health SIRI was also a suspected suicide known to Cirencester Recovery Team. All incidents were reported in line with SIRI reporting requirements. The Patient Safety Team continue to monitor regional and national trends in terms of suicide rates and work towards our Trust's zero suicide ambitions. The tables below represent SIRI reporting over the past 5 years. These reports are stimulating good clinical discussions across operational governance forums and the Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues.





There are 7 active SIRIs. One SIRI investigation had been extended although this has now completed, albeit outside of statutory time frames. It was submitted to Gloucestershire CCG on 29 October 2021. The physical health SIRI that had been formally paused by commissioners has been progressed, and a report is near completion. A verbal update will be given to the committee on new SIRIs declared in November 2021. Final Reports were completed and submitted to commissioners during October 2021. The most recent report was submitted on 29 October 2021 and the associated Incident on a Page is not yet completed.

Regarding all patient safety incidents:

- The total number of patient safety incidents reported increased from 858 in September to 941 in October with skin Integrity, restrictive Interventions, self – harm and falls being the most frequently reported , although a reduction in self harm was seen primarily due to the reduced number of incidents at Berkeley House.
- The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from September (7.81%) to October (7.44%).
- 1 patient fall (1.00% of patient falls) resulted in moderate and above levels of harm in October.
- 1 medication incident (1.85% of October medication incidents) resulted in moderate and above levels of harm in October, following 1 medication incident causing moderate harm during September (2.86% of September medication incidents). There was however an increase from 34 (September) to 53 (October) no and low harm medication incidents reported.
- To note, there have been some minor adjustments to total numbers of patient safety incidents for previous months due to reclassification of some incidents. 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? Trust Wide Physical Health Focus

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.0%	97.2%	98. 7%	98.7%	100%	98.4%	98.6%	100%						98.8%	G		
	Number of post 48 hour Clostridium Difficile Infections (C Diff)	N	1		1	2	4	2	1	3	1						14	R		
	Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0			0	0	0	0	0	0						0	N/A		
	Number of MRSA Bacteraemia	N	0			0	0	0	0	0	0						0	N/A		
	Total number of developed or worsened pressure ulcers	L - R	61	797	84	64	70	61	56	58	56						449	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	698	75	60	59	57	53	49	46						399	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	70	8	1	9	4	3	6	7						38	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	29	1	3	2	0	0	3	3						12	R		

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

HCAI

- It is of note that In October there was a reduction in the number of post 48-hr Clostridium Difficile (C. Diff) cases . There was 1 case in our physical health inpatient facilities. The patient was isolated after I episode of diarrhoea and was not treated for C.diff as the Dr thought diarrhoea was due to other medical conditions and at that point in time treatment was considered to potentially cause the patient additional complications. The refreshed C.Diff policy has now been ratified and relaunched during International Infection Prevention and Control week which took place between 15th and 22nd October where we saw the IPC Team visit community and mental health hospitals raising awareness across the Trust of non - pandemic IPC risks, including C.Diff and norovirus in addition to providing a week long programme of seminars and events.

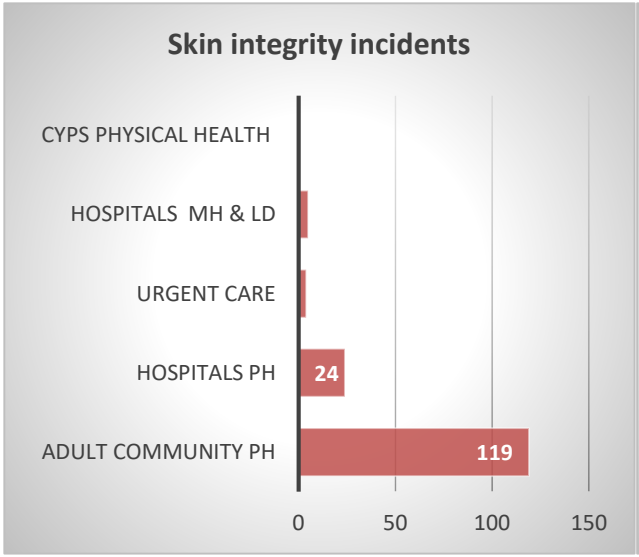
Pressure Ulcers

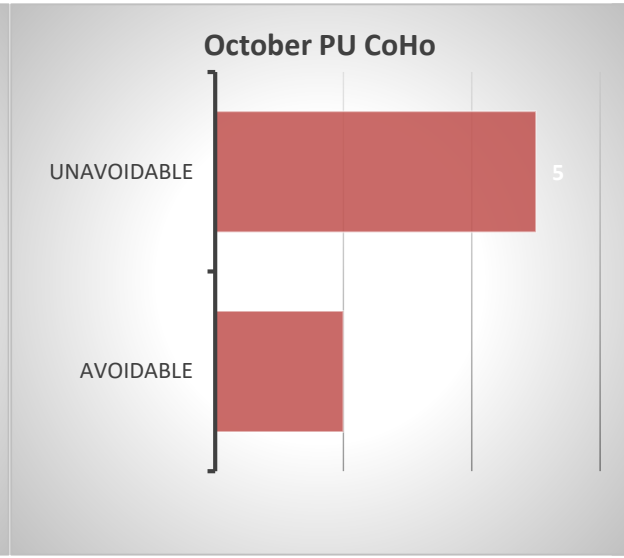
- The Trust has reported a decrease in the total numbers of pressure ulcers that developed or worsened under GHC care this month.
- The Interim Clinical Pathways Lead for Pressure Ulcers came into post on November 1st to continue the planned work to embed the pressure ulcer action plan into BAU.
- Additional clinical support has been made available to review the most severe pressure ulcer damage: Category 3,4, suspected deep tissue injury and unstageable pressure ulcer Datix reports are all reviewed for any errors in categorising PU's at the end of each calendar month. Recent analysis of this monthly accuracy audit has highlighted that correct reporting of categorisation has dropped from around 50% to 30% between August and September 2021. This highlights the importance of this resource to provide accurate reporting at months end and indicates the need for sustained drive on education around recognition and correct categorisation of PUs.
- The active work with teams continues in terms of improving practice to meet significant rising demand in pressure area care referrals from primary care and care homes. Following the success of the Gloucester Quality Improvement (QI) Pressure Ulcer (PU) plan the Forest & Tewkesbury, Newent & Staunton (TNS) QI PU approach is currently in the 'do' stage of the Plan, Do, Study, Act improvement methodology (PDSA) cycle. Leadership from operational managers and clinicians in Gloucester and Forest remains at a high level and the Datix team have provided historical data from these areas that has supported the development of a baseline for improvement focusing on category 2 damage.
- Further to the success of the 'Datix dashboard oversight' these are now available to all community ICT managers and their senior teams. This has resulted in timely review of Datix incidents and thematic review for teams as well as assurance and governance oversight for the trust.
- The Tissue viability page has been relaunched on the Trust's intranet and includes pressure ulcer resources. The Trust will be participating in world-wide Stop Pressure Ulcers Day on 18th November.

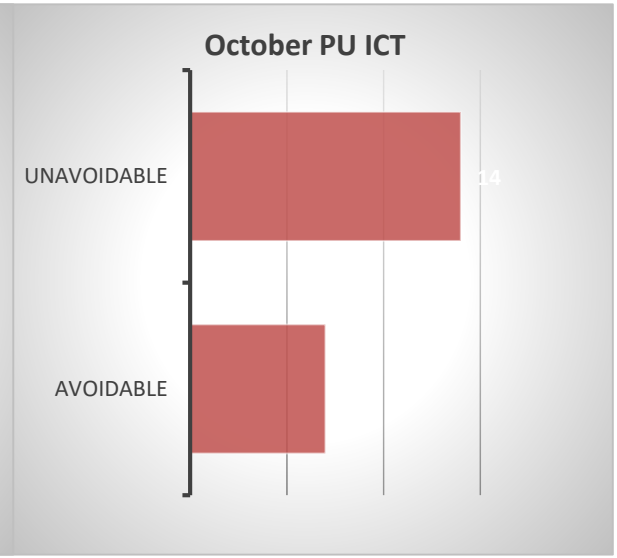
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure 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?
Pressure Ulcers – October 2021 Additional Information Trust Wide







Bar chart showing skin integrity incident reports per service.

- Adult community PH: 119
- Hospitals PH: 24
- Urgent care & specialist services:4
- Hospitals MH & LD: 5
- Adult comm. Mental Health & LD 0
- CYPS Physical Health 0

Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in October 2021

- Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed*** as being unavoidable or avoidable because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 5 unavoidable
- 2 avoidable

Bar chart showing data reported in community PH in September 2021

- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed by handlers*** as being unavoidable or avoidable. These decisions may have been made because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 14 unavoidable
- 7 avoidable

Quality Dashboard

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CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R / A / G	Exception Report?	Benchmarking Report
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:14	0.14	0.12	0.16	0.15	0.13	0.14	0.13						0.14	G		
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	96.0%	96.6%	96.6%	96.8%	91.3%	76.3%	56%	48.6%						80.3%	A		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	89.8%	97.0%	95.5%	93.9%	90.9%	91.4%	81.5%	74.5%						89.24%	A		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	93%	96.3%	96.7%	96.9%	93.1%	93.8%	87.6%	88.3%						93.24%	A		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	95,4%	97. 2%	95.6%	96.5%	71.3%	58.9%	86.9%	86.2%						84.8%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	96.5%	99.2%	99.6%	98.9%	98.2%	97.3%	96.9%	97.7%						98.4%	G		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	98.1%	95.7%	98.9%	97.7%	99.5%	99.4%	98.1%	99.3%						98.4%	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	28960	3101	2920	1339	1305	1190	1257	1338						12631	R		
	Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	TBC	83.3%	82.6%	66.0%	56.8%	75.0%	77.2%	68.1%						72.7%	R		
	Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	TBC	62.5%	92.3%	80.0%	100%	93.3%	100%	92.8%						88.7%	A		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	91.8%	95. 2%	93.2%	92. 8%	90%	89.3%	90.9%	88.4%						91. 4%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	99.5%	95.2%	100%	100%	100%	100%	100%	96.2%						98.8%	G		

Additional information

Physical Health

Podiatry – A review is underway with BI colleagues to review data to ensure all clinically meaningful 1st contacts are reflected in RTT calculations. The service has experienced delay with some new starters with further vacancies arising . Good assurance is available that shows priority is being given to those with the longest wait times and highest clinical need.

Community OT and PT (ICT) - The service is continuing to experience a high demand for OT and PT emerging from the Home First (HF) and Reablement pathways combined with the MDT referral desk activity. Available workforce are managing immediate demand which supports hospital discharges and admission prevention, but people are now waiting longer for routine and long term assessments. There is an expected increase of 7.0 wte funding for therapy resources to support the HF model, however this may not be sufficient to address the backlog developing in the routine care waiting lists. Additional work is being undertaken with the service leads to fully understand the effect and this will inform the recovery action plans.

Paediatric SLT : There are still gaps in service due to maternity leave and vacant posts however due to successful recruitment there will be increased capacity from January. The service continues to offer a blended model of delivery based on clinical need and risk assessment and has remodelled the mainstream school pathway to include an advice line. Digital packages of care have been developed and training packages offered to service users. Resources are being added to the service website to enable signposting to universal and targeted advice.

Wheelchair Services :The current waiting time for adults and children has increased slightly this month although children remain within target range, with all urgent referrals having been seen. The Service is continuing to collaborate with BI to address data quality issues and is managing the consequence of reduced OT capacity following redeployment of 2.0 WTE OTs for 3 months to ICT, alongside reduced clinical capacity due to sickness & annual leave and continued reduced Rehabilitation Engineer capacity as a result of NBT (North Bristol Trust) being unable to supply 0.2 WTE contracted post.

Mental Health – There are currently 62 overdue CPA reviews within recovery teams. There is a Service Recovery Action Plan (SRAP) and teams continue to take a targeted approach to review all overdue CPA's with managers. Progress is monitored via the Directorate Governance meetings, however, to support system pressure the recovery teams are supporting early discharge from hospital and this is impacting on the recovery plan. There remain challenges owing to ongoing workforce pressures (including vacancies, lack of temporary staffing, increases in staff self-isolation and short-term sickness) along with the increase in referrals and completion of initial assessments. Acuity and dependency has increased requiring more clinical input and this is impacting on pre planned work including CPA reviews. All patients on the caseload continue to be supported and despite the pressures the team continue to complete a number of CPA reviews, however, the recovery will take a number of months to realise unless staffing and system pressures can recover .

Quality Dashboard

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CQC DOMAIN - ARE SERVICES EFFECTIVE?

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Community Hospitals																				
Bed Occupancy - Community Hospitals		L - C	92%*	89.5%	87.0%	89.9%	94.2%	95.%	91.2%	94.5%	94.9%						92.38%	G		90.4%
*** Indicates optimum occupancy to enable flow**																				
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%	85.7%	90%	90%	75%	72.7%	100%	83.3%	100%						83.%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
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%	52.9%	54.2%	53.8%	52.2%	50.2%	51.4%	49.9%	50.2%						51.7%	G		
Admissions to adult facility of patient under 16yrs		N - R		1	0	0	1	0	0	0	0						1	N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	1742	82	100	199	187	77	30	31						706	G		
Children's Services – Immunisations				2019/20 Academic Year	Academic Year 2020/21 - Target 90% of all 2 immunisations by end of academic year (July 2021) and new cohort 1st immunisations					Academic year 2021/22 – Target 90% of all 2 immunisations by end of academic year (July 2022) and new cohort 1st immunisations										
HPV Immunisation coverage for girls aged 12/13 years old (Target for all 2 immunisations to be completed)		N - T	90%*	73.1%	30.7%	42.9%	74.4%	86.9%	90.8%								90.7%	G		
Childrens Services - National Childhood Measurement Programme				2019/20 Academic Year	Academic Year 2020/21 - Target 95% of children measured by end of academic year - Cumulative target (July 2021)					Academic Year 2021/22 – Target 95% of children measured by end of academic year – Cumulative target (July 2022) **Programme starts November 2021**										
Percentage of children in Reception Year with height and weight recorded		N - T	95%*	69.7%	36.0%	64.5%	87. 8%	96. 8%	98.4%									G		
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	73.9%	9.0%	76.3%	84.5%	96.1%	96.2%									G		

Additional Information

Children's Services – Last academic year the National Childhood Measurement Programme (NCMP) met target , the next Programme commences November 2021 and data will be reported accordingly in the December Dashboard.
HPV – Last academic year the target of 90% of the 1st Immunisation was achieved in August . The School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort. Owing to the Covid pandemic, and schools being closed from January until the 8th March 2021, over 700 Year 9 - 1st doses were not delivered until March. For the 2nd HPV vaccination to be given there is the requirement for a 6 month interval between HPV 1 and HPV 2 vaccinations hence this interval had not been met by the end of September. The new programme commences in November 2021 and data will begin to be reported in the December dashboard.

EIP – The recommendation of the Mental Health Taskforce, NHS England outlines its commitment to ensuring that, by 2020/21, at least 60% of people experiencing first episode psychosis receive treatment. The standard has been carried forward to the next financial year. There have been updates to the data for late entries which shows an overall improvement.

Out of area bed days - The occupied bed days for inappropriate out of area Mental Health placements in October was 31 days which relates to 1 patient (1 x Acute) . This work has been supported by the admission and discharge pathway task & finish group.

Quality Dashboard

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Additional KPIs - Physical Health

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)		95%*	93.1%	35.1%	61. 7%	83.2%	92%	92%	93.5%	93.5%						93.5%	G	N	
Number of Antenatal visits carried out			530	47	51	51	54	30	70	46						349	R	Y	
Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	94.1%	93.4%	96.6%	93.3%	93.6%	95.0%	91.7%	92.3%						92.7%	A	Y	
Percentage of children who received a 6-8 weeks review.		95%	95.9%	98.3%	97.2%	97.6%	97.8%	94.6%	95.4%	96.6%						96.7%	G		
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	72.6%	74.0%	84.7%	82.3%	84.2%	80.6%	80.0%	84.1%						84.1%	A	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	83. 7%	83.9%	79.6%	82.8%	86.8%	91.6%	89.5%	90.4%						86.6%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	72.5%	72.0%	74.4%	81.5%	84%	84.1%	84.7%	85.7%						80.6%	A	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	56.0%	61.3%	59.2%	60.1%	54.2%	56.1%	55.9%	53.5%						57. 0%	A		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81. 3%	81.6%	81.5%	85.4%	82.1%	81.2%	82.1%	79.7%						81. 9%	G		
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	970	No Data															
Number of positive Chlamydia screens		169	632																
Average Number of Community Hospital Beds Open reduced by 8 due to social distancing measures.		196	174,9	186.	187	188	187	181	192	195						188	R		
Average Number of Community Hospital Beds Closed		0	21.1	2	1	0	1	7	0	0						9	R		

Additional Information

New Birth Visiting (NBV) – 43 eligible children were seen outside of the planned timeframe. 25 babies within this exception were in Neonatal Intensive Care unit (NICU) and therefore were unable to be seen within timeframe. The service continues to work collaboratively with NICU and aim to identify and provide any ongoing support required on discharge. All 5 UP (Universal Partnership) and 7 UPP (Universal Partnership Plus) that breeched due to parents being unavailable in timeframe have now been seen. All other contacts have now been seen out of timeframe. The offer for support is not mandatory and outcomes are influenced by parental choice who might chose to decline the HV offer at first contact.

Percentage of children who received a 6-8 week review within 8 weeks by a Health Visitor – Improvement seen this month with all families being seen within timeframe.

Percentage of children who received a 9-12-month review by the time they turned 12 months - In October 84.1% of eligible children received the 9-12 month visit from a Health Visitor, compared to a target of 95%. This is a 4% Increase in uptake from last month. 96 out of 478 did not receive the review within this timeframe, although all parents of all children in this cohort were offered the opportunity to receive a 9-12-month review. There remains a blended offer remains for all Ages & Stages Questionnaire (ASQ) (by 15 months and 2 years) for those families previously assessed as universal with low risk; face to face appointments are offered where estates allow and virtual appointments via Attend Anywhere are being offered for developmental reviews where availability of estates outweighs number of reviews needed. Some families still request a face to face contact, declining the virtual offer. 56% of breeches declined or DNA'd the appointment. On a positive note there is a reduction of declines and DNAs from last month's 62%.

Percentage of children who received a 12-month review by the time they turned 15 months - In October 90.4% of eligible children received the 12-month review by the time they were 15 months old by the health visiting team, compared to a target of 95%. This is a 0.5% increase in uptake on last month. 48 out of 498 reviews were not completed within the target timeframe. The HV team continue to offer catch up developmental clinics and work with families who have reconsidered the offer for a review. 72% of breeches were declines or DNA.

Percentage of children who received a 2-2.5-year review by 2.5 years - In October 85.7% of eligible children received the 2-2.5-year mandated contact by a Health Visitor, compared to a target of 95%. This is a 1% increase on last month. 76 out of 454 reviews completed were not within the target timeframe of 2-2.5 years. All universal partnership (UP) and universal partnership plus (UPP) are seen face to face in the home setting for a full family health needs assessment. An additional intervention called the Early Language Identification Measure (ELIM will be introduced within the 2-year developmental review from the beginning of 2022). 83% of the breeches were declines or DNA.

Percentage of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks: The maintenance rate of breastfeeding at 8 weeks that were at breastfeeding at 2 weeks has reduced to below 80% target. The Infant Feeding Lead Specialist health visitor and the champions will continue to offer tailored packages of care for families that require additional support in order to maintain breastfeeding.

Quality Dashboard

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CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 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%	85.8%	87.5%	88.7%	88.4%	88.9%	88.8%	87.4%	88%						88.3%	A		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	70.4%	71.2%	72.4%	73.0%	72.5%	70.6%	68%	**65.5%**						71.2%	R		
Sickness absence average % rolling rate - 12 months	L - I	<4%	4.80%	4.3%	3.9%	3.8%	3.9%.	4.1%	4.2%	4.9%						4.0%	G		
Sickness absence % monthly rate	L-T	<4%	New	3.3%	3.8	4.2%	4.7%	5.07%	5.6%	4.9%						4.51%	A		

Additional information

Mandatory training, appraisal and absence

- Training compliance continues to show a slow, but gradual improvement on the out turn from last year following extensive focus by team and service leads. The overall training compliance figure **minus staff bank** is currently 93.6%, so this is above the Trust compliance target of 90% .
- There remain challenges to improving the appraisal rate, recovery continues to focus on reminding managers to complete and record the process with work being undertaken with staff side to assist progress and suggest any new initiatives. This collaborative work has involved the revision of the paperwork to help support effective and meaningful conversations during appraisals.
- Sickness absence 4.9% in month data has been refreshed from April to reflect the automated in month data collection ,plus adjustments for previous months. Data reflecting rolling 12 months will no longer be displayed .

Resuscitation and Restrictive Physical Intervention training

- Physical Intervention training figures remain consistent and in some areas show improvement. The figures for the Positive Behaviour Management Training (Full Course) are now above the Trust's 90% compliance target.

- Progress on this workstream reports monthly to QAG. The Trust target is 90% compliance and the % figures to target are shown in the table opposite .

Sept 21	PBM Theory			PBM Full			PMVA Breakaway			PMVA Full		
	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct	Aug	Sept	Oct
Wotton Lawn Hospital							82%	73%	76%	75%	78%	78%
Charlton Lane Hospital	89%	89%	85%	84%	91%	92%						
Berkley House	67%	67%	69%	86%	91%	92%						

Health and Wellbeing Hub

The first month of ICS Wellbeing Line saw 16 contacts, mostly, but not exclusively, from GHC. 3 members of staff have taken up posts and are focused on responding to direct contacts, alongside service development and outreach work. Further recruitment is ongoing. Wellbeing support was also provided directly to several teams (all within GHC). The service has been widely publicised across the ICS, with targeted areas receiving presentations. Plans are in place to engage with social media for the adult social care sector in mid-November, along with the provision of some printed material for distribution and further presentations to key leaders and teams.

Quality Dashboard

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CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Inpatient – October 2021

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	45	6	22.5	2	0	0	80	10	0	0
Abbey	65	8	47.5	5	0	0	0	0	0	0
Priory	157.5	21	32.5	4	0	0	0	0	0	0
Kingsholm	32.5	4	0	0	0	0	0	0	0	0
Montpellier	7.5	1	47.5	6	0	0	0	0	0	0
Greyfriars	205	27	0	0	0	0	0	0	0	0
Willow	45	6	85	10	52.5	5	15	2	0	0
Chestnut	37.5	5	67.5	9	0	0	30	3	0	0
Mulberry	0	0	0	0	0	0	0	0	0	0
Laurel	0	0	22.5	3	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	82.5	10	317.5	31	0	0	0	0	0	0
Total In Hours/Exceptions	677.5	88	642.5	70	52.5	5	125	15	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 exceptions were due to additional clinical need requirements not being filled by bank or agency above established staffing levels. Essential patient needs and safety issues were met however some additional ward activity could not happen .

Mental Health & LD

Ward	Average Fill Rate %	Sickness %	Vacancy %
Dean Ward	98.54	14.8	20.2
Abbey Ward	125.97	3.2	47.8
Priory Ward	103.98	9.7	17.0
Kingsholm Ward	99.84	12.1	4.87
Montpellier	100.40	12.3	24.4
PICU Greyfriars Ward	136.42	6.8	5.59
Willow Ward	99.02	11.3	16
Chestnut Ward	97.85	5.1	23.4
Mulberry Ward	110.00	6.1	14.5
Laurel House	99.19	3.1	2.63
Honeybourne Unit	100.27	7.1	6.8
Berkeley House	99.42	11.2	14.1
Totals (Oct 2021)	**105.91**	8.5	15.9
Previous Month Totals	106.94	7.2	15.1

Physical Health

Ward	Average Fill Rate	Sickness %	Vacancy %
Coln (Cirencester)	116.84	4.5	-3.2
Windrush (Cirencester)	103.26	7.9	6.2
The Dilke	110.55	9.8	8.4
Lydney	98.50	6.5	-2.0
North Cotswolds	111.40	11.6	-2.4
Cashes Green (Stroud)	102.68	2.1	3.4
Jubilee (Stroud)	97.74	13.9	4.3
Abbey View (Tewkesbury)	88.26	12.2	-1.4
Peak View (Vale)	112.28	4.3	-1.9
Totals (Sept 2021)	**104.61**	7.5	**3.2**
Previous Month Totals	107.27	6.1	4.0

Staffing Data – Absence/Vacancy Data Quality Notice

Shift fill rates remain high to support safer staffing numbers across a number of wards. The in month vacancy and sickness figures have been produced from Tableau and represent all staff whose assignment is a ward rather than just RGN,RMN and HCA statistics . The vacancy figure is shown as a % rather than WTE . Positively WLH improved position re vacancies on Priory Ward is noted

Recruitment Mental Health, Learning Disability Inpatients & Physical Health

International Recruitment: 6 x RMNs have been appointed for Wotton Lawn. One IR RMN has passed their OSCE examination. 31 RGN's have been appointed, of these, 22 have arrived in the UK and it is anticipated that the remaining staff will be in post by March 2022. Productive conversations have been held with new recruitment agencies to further develop both direct entry district nursing and inpatient mental health recruits.

CQC DOMAIN – ARE SERVICES WELL LED? - Quarter 2 - Guardian of Safe Working Report 2020/21

PURPOSE

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed 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. 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. 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.

Reporting time period July 2021 – September 2021	**Guardian of Safe Working Hours: Dr Sally Morgan**
Number of doctors in training (all on 2016 contract)	In July 2021 there were 36 doctors in training posts. In Aug and Sep 2021 there were 41 doctors in training posts • 12 higher trainees (July - Sept) • 6 CT3s (July) 3 (Aug - Sept) • 2 CT2s (July) 6 (Aug - Sept) • 3 CT1s (July) 7 (Aug - Sept) • 5 GP Trainees (July) 6 (Aug - Sept) • 4 FY2s (July) 3 (Aug – Sept) • 4 FY1s (July) 4 (Aug – Sept) • FY doctors rotated posts in August 2021
Exceptions in this period	• **27 on call shifts covered** by our own junior staff acting as locums due to sickness. • **1 on call shifts covered** by agency locums due to sickness • **0 exception reports in this time period** **There was a Junior Doctors forum held via Microsoft Teams on 20th August 2021.**

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AGENDA ITEM: 09/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHORS: Sally King, Deputy Service Director for Covid Services, Interim Patient Safety Manager
Paul Ryder, Patient Safety Manager
Nicola Mills, Clinical Incidents and Learning Manager

SUBJECT: **PATIENT SAFETY REPORT Q2 2021/22**

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

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

The purpose of this report is to:

This report provides the Trust Board with a summary of mental health and physical health Patient Safety Incidents reported during Quarter 2 2021/22 (1 July to 30 September 2021).

Recommendations and decisions required

Members of Trust Board are asked to **note** the contents of the report.

Executive summary

The Q2 patient safety report provides a summary of all Patient Safety incidents reported in the last rolling four quarter period which has seen a quarter by quarter reduction in the total number of incidents with the reductions being consistent across the harm categories.

The patient safety team aim to review at least 10% of the no and low harm incidents and this has been achieved for the 3rd consecutive quarters.

There were 6 serious incidents reported in Q2 but no other reportable incidents.
The team convened 14, 72-hour initial investigations of which 6 met the criteria for a serious incident requiring investigation (SIRI).

The patient safety team supported the progression of an investigation into an incident that was reported to the Information Commissioners Office (ICO). This has now been closed by the ICO with no further action required.

A reduction in incidents related to self-injurious behaviours was noted at Wotton Lawn Hospital. This was due to the discharge of individuals who had been in an in-patient setting in Q1 but were discharged during Q2.

MIIU's have seen a number of incidents reported regarding events associated with missed fractures. A deep dive has been carried out and a peer review is to take place This will reported through governance channels as the approach and review take place.

The patient safety team are working with colleagues from Business Intelligence to understand the metrics that are available and in particular to triangulate data in order to develop our reporting processes.

Risks associated with meeting the Trust's values

No risks.

Corporate considerations	
Quality Implications	Failing to provide the Patient Safety Team function would negatively impact the quality of services provided by the Trust.
Resource Implications	The monitoring of patient safety incidents across the Trust, and the formal investigation of incidents, is a resource intensive activity.
Equality Implications	None.

Where has this issue been discussed before?

- Quality Assurance Group – 22 October 2021
- Quality Committee – 4 November 2021

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

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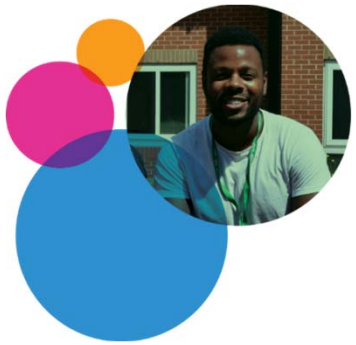

Q2 Patient Safety Report 2021/22

Paul Ryder, Patient Safety Manager
Nicki Mills, Clinical Incidents Manager

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

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Report on the Trust's Patient Safety Incidents during Q2 2021/22

Presented to: GHC Board – 25 November 2021
Presented by: Dr Amjad Uppal

Q2 PSR 2021/22

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This report provides the Board with:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 2 2021/22 (1 July to 30 September 2021).
- A summary of the prevalence of patient safety incidents by categories including levels of investigation where relevant.
- Provision of data for Mental Health and Learning Disability Hospitals, physical health Community Hospitals, plus MiiUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the PST will examine in further detail a different category reporting a significant number of incidents. Q4 2020/21 looked at pressure damage in community ICTs and the developing “PUQs Project”. Q1 2021/22 provided a helpful update to this project following a PDSA Cycle 4 evaluation.
- An additional update is provided with regard to the recent review of MiiU services across the county which will inform a peer review of services.
- Progression of the developing governance arrangements for the management of mental health and physical health patient safety incidents.

Summary of all Patient Safety Incidents reported in the last rolling 4-quarter period

	Q3 (%)	Q4 (%)	Q1 (%)	Q2 (%)
No Harm	2104 (62.7)	2072 (63.0)	1967 (60.71)	1744 (62.24)
Low Harm	1018 (30.3)	990 (30.1)	1016 (31.36)	869 (31.01)
Moderate Harm	198 (5.9)	188 (5.7)	218 (6.73)	160 (5.71)
Severe Harm	27 (0.8)	30 (0.9)	23 (0.71)	17 (0.61)
Death	8 (0.24)	8 (0.24)	16 (0.49)	12 (0.43)
Total	3355	3288	3240	2802

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Number of No and Low Harm Incidents Reviewed in the last rolling 4-quarter period

	Q3	Q4	Q1	Q2
No Harm	2104	2072	1967	1744
Low Harm	1018	990	1016	869
Total	3122	3062	2983	2613
Reviewed (%)	299 (**9.6%**)	374 (**12.2%**)	411 (**13.8%**)	405 (**15.5%**)

The Patient Safety Team aim to review 10% of the No and Low Harm Patient Safety Incidents. This has not always been achieved due to redeployment of some of the team due to Covid-19, the recovery plan of SIRIs and competing workstreams, such as completing SIRI investigations. Significant progress has been achieved since Q3 2020/21 and this is carried successfully into Q2 2021/22.

Q2 PSR 2021/22

No harm and low harm incidents

Of the 1,744 no harm incidents, and the 869 low harm incidents, the Patient Safety Team aimed to review a blind sample of 10% (PST intended to review more than 262 incidents in Q2). This target was set during the reconfiguration of the Patient Safety Team following merger in October 2019 and due to the impact of Covid work the team have not previously met this target.

In Q2 a total of 405 low and no harm incidents were reviewed (15.5%). The Patient Safety Team have met this ambitious target for the last 3 consecutive quarters.

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Q2 PSR 2020/21

Never Events, Serious Incidents and other reportable incidents

	Q3	Q4	Q1	Q2	Rolling Total
Never Events	0	0	0	0	0
Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Serious Incidents	6	8	8	6	28

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Q2 ‘Sub Serious Incident’ Incidents (moderate and above harm)

During Q2 the Patient Safety Team convened 14 72-hour Initial Investigation meetings (including incidents that have gone on to be declared as a SIRI).

3 mental health incidents and 3 physical health incidents met the criteria for a Serious Incident Requiring Investigation (SIRI).

Detailed analysis of high frequency incidents

Service provision has seen further disruption due to another national lockdown as a result of the Covid-19 pandemic, however Q2 continues to demonstrate more established incident reporting trends. The data and “Top 10” categories have been refreshed for Q2 and data is presented in the following slides.

The high frequency incidents within Mental Health inpatient continue to focus on self-injurious behaviour, 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 some 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.

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High Level Analysis of Mental Health Inpatient Incidents - By Rolling Financial Quarter

Top 10 Categories Reported	Self-Injury				Physical Intervention & RT				Falls				AWOL				Violence & Aggression				Medication				Clinical Care				MERT				Accidents and Injuries				Suicide Attempts			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Wotton Lawn Hospital (excluding PICU) (66 beds)	312	427	153	47	268	205	114	85	24	18	10	14	56	73	77	45	23	38	39	38	10	20	21	16	4	4	6	5	10	4	4	2	4	2	6	3	16	7	5	0
Berkeley House (7 beds)	281	251	290	317	127	81	78	93	6	1	1	5	0	0	0	0	0	0	3	0	2	2	2	0	0	3	1	0	2	1	0	0	14	6	8	4	0	0	0	0
Wotton Lawn - Greyfriars PICU (10 beds)	16	28	9	1	83	49	98	91	1	1	3	10	10	18	1	1	6	5	6	11	6	5	0	11	6	1	1	2	8	2	2	1	3	0	1	0	0	5	5	0
Charlton Lane Hospital (functional) (32 beds)	5	0	7	15	9	21	28	38	30	26	55	49	2	0	0	1	0	1	1	1	12	11	8	7	8	4	6	4	4	3	7	1	6	6	3	3	0	0	1	2
Charlton Lane Hospital (organic) (16 beds)	0	3	1	0	29	17	18	10	122	51	32	75	0	1	0	0	7	7	5	10	1	3	3	0	0	0	0	0	5	3	0	0	1	1	1	3	2	0	0	0
Laurel House & Honeybourne (23 beds)	0	0	0	1	0	0	0	0	2	1	4	1	3	4	3	3	0	3	1	1	2	2	13	4	0	0	1	0	0	1	1	0	1	0	3	0	0	1	0	0
Montpellier Low Secure Unit (12 beds)	0	0	0	0	0	0	4	7	0	1	2	0	0	1	1	0	0	1	1	2	1	1	1	3	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0
Total	614	709	460	381	516	373	340	324	185	99	107	154	71	97	82	50	36	55	56	63	34	44	48	23	18	12	15	11	29	15	14	4	30	15	22	13	18	13	11	2

Incidents of self-injury have reduced, mainly due to the discharge home of patients from Wotton Lawn who indulge in self-injurious behaviour with significant frequency. Laurel House and Honeybourne Units has seen an increase in medication incidents during Q1, which was due to the introduction of Electronic Prescribing leading to a greater focus on reporting anomalies; this has returned to previously reported figure for Q2.

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High Level Analysis of Community Hospital Incidents – by Rolling Financial Quarter

Top 10 Categories Reported	Falls				Skin Integrity				Admissions, Discharges & Transfers				Medication				Clinical Care				Infection Control				Accidents & Injuries				Communication & Handover				Appointments, follow up & referrals				Equipment & Medical Devices			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Cirencester & Fairford Hospitals (49 beds)	51	40	32	31	41	40	67	34	12	4	12	6	8	2	1	5	5	7	4	5	8	4	29	9	6	3	5	1	6	5	7	2	3	0	5	1	1	0	3	4
Dilke Hospital (27 beds)	31	31	27	42	9	9	12	10	2	0	9	3	2	4	2	2	2	0	0	2	3	1	1	3	5	2	3	2	1	0	4	0	0	0	3	0	0	0	0	1
Lydney Hospital (20 beds)	18	26	16	12	10	18	16	14	1	3	4	6	1	4	4	5	3	4	4	3	2	0	10	0	2	0	0	1	0	0	3	0	0	0	1	1	2	0	1	1
North Cots Hospital & GMC (22 beds)	19	17	23	15	10	13	7	6	1	1	2	0	1	1	3	1	2	0	0	2	1	0	2	1	1	0	0	0	0	4	3	2	1	2	6	4	1	0	0	0
Stroud Hospital (38 beds)	28	14	13	30	22	16	11	13	6	2	1	7	0	1	1	1	4	1	1	4	1	0	0	2	2	0	2	1	0	2	2	4	1	1	2	1	0	0	3	0
Tewkesbury Hospital (20 beds)	20	40	15	9	21	11	13	19	1	3	3	3	2	2	1	1	1	2	3	5	1	2	2	1	0	1	0	1	0	1	3	3	0	2	0	0	1	1	0	4
The Vale Hospital (20 beds)	29	22	29	19	14	12	12	11	6	1	1	5	5	5	10	5	5	7	3	4	2	0	2	0	9	5	5	10	0	0	2	1	1	0	0	0	1	1	2	3
Total	196	190	155	158	127	119	138	107	29	14	32	30	19	19	22	20	22	21	15	25	18	7	46	16	25	11	15	16	7	12	24	12	6	5	17	7	6	2	9	13

Data for Q2 remains consistent with previous quarters.

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High Level Analysis of Community Mental Health Incidents – by Rolling Financial Quarter

Top 10 Categories Reported	Clinical Care				Self-Injurious behaviour				Admission, discharge & transfer				Information Governance				Medication				Communication & handover				Appointments, follow up & referrals				Suicide attempts				Death/ SIRI				MERT			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
AMHP	5	1	0	0	0	0	0	1	5	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
AOT	1	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0	2	3	1	2	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0
CYPS/CAMHS LD, T2, T3	5	2	1	0	0	8	0	0	0	0	1	0	1	2	6	1	0	0	0	1	0	0	2	0	5	2	1	0	0	0	0	0	0	0	0	0	0	0	0	1
CLDT	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CPI	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRHTT	6	3	2	4	4	2	11	6	2	1	12	6	0	0	0	0	2	1	0	1	1	3	2	2	1	1	0	1	1	0	2	2	0	0	1	0	0	0	2	1
Eating Disorders	1	2	0	0	0	0	0	0	1	0	1	1	0	0	0	0	0	1	0	0	3	0	3	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Later Life	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	1	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0
MHICT	0	0	2	1	0	0	2	1	1	2	0	1	0	7	7	2	0	0	0	0	0	0	0	1	0	1	0	1	0	0	3	0	0	0	1	2	0	1	0	0
Memory Assessment	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MH Liaison	2	1	3	4	4	1	0	1	2	0	1	1	0	1	1	2	0	1	0	2	5	0	0	0	2	1	0	2	2	2	1	0	0	0	1	1	0	0	0	0
Recovery	1	0	0	0	0	1	3	1	2	1	1	1	0	0	0	0	2	3	7	1	2	1	1	0	1	1	0	0	1	1	0	1	0	0	2	4	2	1	3	1
Specialist Services	0	0	0	1	1	0	1	0	0	0	1	0	1	1	0	0	3	0	0	1	0	1	0	0	0	0	0	5	0	0	0	0	0	0	2	0	0	0	1	0
Total	22	10	8	10	9	14	17	10	13	7	18	11	4	12	15	9	11	9	8	8	11	5	9	4	9	6	1	12	4	3	6	4	0	0	9	7	2	2	6	3

Mental Health community teams clearly report far fewer patient safety incidents than their inpatient colleagues. There is limited analysis available from this data with no apparent concerns.

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High Level Analysis of Community Physical Health Teams Incidents (not ICT/ENDN) – by Rolling Financial Quarter

Top 10 Categories Reported	Diagnosis, Imaging & Testing				Clinical Care				Medication				Communication & handover				Information Governance				Equipment & Medical Devices				Appointments, follow up & referrals				Skin Integrity				Admissions, discharges & transfers				Accidents and Injuries			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Complex Care at Home	0	0	0	0	1	2	1	2	2	2	4	2	1	0	4	2	0	3	0	0	1	0	4	1	0	0	0	1	6	13	5	17	0	2	1	2	0	0	0	0
Complex Leg (CLWS)	0	0	0	0	1	4	3	1	0	0	0	0	0	0	1	2	0	0	0	0	0	1	0	2	0	0	1	2	2	6	0	4	1	1	1	0	0	0	0	0
CYPS/PH Community Specialist	0	1	0	0	9	1	2	3	5	6	9	8	3	3	3	5	3	4	3	3	12	5	10	12	4	0	0	10	2	2	2	3	5	0	1	6	2	0	2	0
CYPS/PH Public Health Nursing	0	0	0	2	6	0	0	5	6	0	0	1	5	7	10	9	3	5	3	7	0	1	0	0	4	5	2	4	0	0	0	0	3	2	2	0	1	0	0	0
Dental & Sexual Health	13	7	14	13	9	10	6	7	8	5	2	4	5	7	4	14	10	3	9	4	1	2	2	3	0	1	2	1	0	0	0	0	0	0	1	0	0	0	1	0
Intravenous Therapy Team	0	0	1	1	3	0	0	2	0	2	0	3	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	1	1	2	0	0	0	0
Long Term Conditions	1	0	0	2	0	2	4	0	3	3	1	0	1	0	0	0	2	3	1	1	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	0	0
MIiUs	26	30	23	13	11	12	12	15	0	1	1	2	3	3	2	2	0	0	1	1	0	0	2	0	10	4	12	17	0	0	0	0	2	3	3	7	3	0	1	0
Rapid Response	0	0	0	1	1	4	6	4	1	1	1	0	0	0	0	0	1	0	1	0	0	0	0	0	0	2	3	2	6	4	2	3	1	0	3	0	0	0	2	0
Spec Therapy & Equip Services	0	0	0	0	2	1	0	0	0	0	0	0	1	0	0	0	1	3	0	0	3	1	5	1	0	1	1	0	0	1	1	0	0	0	1	0	3	0	2	2
Tissue Viability	0	0	0	0	0	3	1	0	0	0	0	0	0	0	2	0	0	0	0	0	1	2	2	3	0	0	0	0	3	2	0	2	4	1	5	4	0	0	0	0
Total	40	38	38	32	43	39	35	39	25	20	18	20	19	20	26	34	20	21	18	16	18	12	26	22	18	13	21	39	19	28	10	29	17	11	19	21	9	0	8	2

There is a notable upturn in reporting of Diagnosis, Imaging and Testing within MiiUs during Q4. All 30 incidents report no harm and describe a sub-category of Wrong Diagnosis, or Delayed Diagnosis. The Patient Safety Team has completed a deep dive report of Diagnostic Imaging at MiiUs which has resulted in a piece of work described on slide 16. A peer review will follow.

There was an upturn in reporting of Communication & Handover within Dental and Sexual Health during Q2. All 14 incidents report no harm. A number of these incidents highlight the shortage of Sexual Offence Examiners (SOE), which is a role within G4S and not a service that GHC is currently commissioned to provide.

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High Level Analysis of Community Physical Health Teams Incidents for ICT/ENDN – by Financial Quarter

Top 10 Categories Reported	Skin Integrity				Medication				Clinical Care				Admissions, discharges & transfers				Equipment & Medical Devices				Appointments, follow up & referrals				Communication & handover				Falls				Safeguarding concerns				Accidents and Injuries			
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
ENDNS – Out of Hours DN	6	7	9	6	5	10	12	8	9	6	2	2	0	1	2	0	0	0	0	0	0	5	2	2	1	2	0	1	1	0	1	0	1	1	0	0	0	0	0	0
Chelt ICT	82	88	94	54	11	13	21	8	9	13	6	6	8	6	15	3	6	3	12	7	4	1	7	5	11	6	13	6	9	1	5	2	0	0	0	2	0	0	0	0
Cotswold ICT	78	105	113	86	6	10	11	13	10	9	12	18	8	5	12	12	8	7	15	10	3	4	2	7	0	2	3	2	2	4	3	3	2	1	3	0	0	1	0	2
Forest ICT	79	89	83	65	3	8	3	7	9	3	5	4	2	5	2	4	9	8	14	10	8	3	4	0	9	2	14	4	1	0	0	1	1	1	0	0	2	0	1	0
Glos ICT	119	116	129	99	21	19	11	14	15	8	12	6	15	17	5	8	9	14	20	8	6	4	5	5	6	8	5	9	0	2	4	3	3	0	0	0	2	2	1	0
Stroud ICT	59	57	50	50	3	8	8	10	3	4	5	4	7	13	2	6	6	3	14	9	2	0	3	3	1	4	4	1	3	2	7	1	0	0	0	1	0	0	1	2
TWNS ICT	71	59	71	40	11	12	5	2	9	2	3	3	5	2	4	5	5	1	1	0	3	0	1	1	1	0	2	1	1	1	1	1	0	0	2	0	0	0	2	0
Total	494	521	549	400	60	80	71	62	64	45	45	43	45	49	42	38	43	36	76	44	26	17	24	23	29	24	41	24	17	10	21	11	7	3	5	3	4	3	5	4

Gloucester ICT report higher frequencies of incidents due to the size of the population served.

Gloucestershire Health and Care
NHS Foundation Trust

High Level Analysis of Community Physical Health Teams Incidents for ICT/DN – by Financial Quarter

The consistently high volume of Skin Integrity incidents reported within the District Nursing Service is clear to see on the previous slide.

Belle Hyslop, PST Clinical Incident Lead and Investigator, has recently been successful in attaining a secondment to further develop, test and roll-out her Pressure Ulcer Questionnaire to allow for rapid triage and forward planning of pressure ulcer incidents.

Activity within MIIUs across Gloucestershire

There is currently additional focus on the county's MIIUs, particularly with regard to the number of imaging incidents reported leading to increasing numbers of missed fractures. The scope of the review is now clarified and a peer review will follow.

The MiiU work completed earlier in the year has helped to triangulate a number of quality issues around missed fractures, local protocols and different systems of working across the MIIU's which will inform a peer review.

Additional analysis of trending metrics

Further analysis of the rate of change of reported incidents was requested by Trust Board, including the rate per occupied bed day for inpatient areas, and per 1000 on caseload for community incidents.

BI colleagues have engaged with the patient safety team to develop helpful dashboards providing the required data and metrics. Further meetings are planned during early Q3 to ensure an appropriate level of automation in producing helpful run charts and metrics, but system pressures have not permitted this work to complete during Q2.

VTE assessments

- Following publication of the revised VTE assessment policy in April 2021 there was evidence that the policy had not been fully embedded in mental health inpatient settings.
- Initial project meeting held on 3 August 2021 and audit established.
- Audit completed and shared with project group on 10 September 2021.
- Audit findings confirmed that 85% of records audited were not using ‘editable letter’ in RiO as per policy
- Reminder email from Dr Runciman to medical colleagues was sent on 10 September 2021.
- Template now live in RiO with further developments scheduled to add a prompt
- VTE template in RiO added to Dr’s training to ensure awareness of the need to utilise
- Proposal to re-audit in 3 months and report back to QAG.

Developments within the Patient Safety Team

- The National Patient Safety Specialists programme continues to inform the development of our localised Patient Safety Incident Response Plan (PSIRP) to meet the guiding principles of the Patient Safety Incident Response Framework (PSIRF). This work is held within the Trust's Patient Safety Group and milestones have been discussed and agreed in order to progress this development work.
- The Patient Safety Team and key medics associated with the SI process, including our Medical Director, Deputy Medical Directors and other doctors who chair SI review meetings, attended 2 days' Root Cause Analysis training in September 2021 with an external accredited provider. This was well attended and received positive feedback.
- Assurance processes following the development of recommendations and/ or actions resulting from Serious Incidents are now well established with the Community Service Managers and Hospital Matrons. Commissioners actively support this process and have been invited to attend the meetings.
- Patient Safety Team is being notified of **all** mental health and physical health patient safety incidents categorised as moderate and above, which are reviewed by the team. In recent months the target to review 10% of No and Low Harm incidents has gathered pace was exceeded in Q4 2020/21, Q1 and Q2 2021/22.

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NHS Foundation Trust

AGENDA ITEM: 10/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

SUBJECT: **LEARNING FROM DEATHS 2021/22 QUARTER 2 REPORT**

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 Trust Board of the learning from the mortality review process, data analysis and outcomes during Quarter 2 2021/22.

The report aims to present a broad range of available demographic and clinical data, and a trend analysis comparing current data with previous years as requested previously by the Board.

Recommendations and decisions required

The Board is asked to:

- **Note** the contents of this Learning from Deaths report which covers Quarter 2 2021/22.
- **Take assurance** that following comprehensive review zero deaths were judged more likely than not to have been due to problems in the care provided to the patient

Executive summary

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. In line with this requirement, the Trust reviews

mortality data and learning on a quarterly basis with detailed consideration at the Quality Assurance Group and Quality Committee.

The following report presents the data from Quarter 2 for 2021/2022 in which:

- 135 GHC patients died
- 20 comprehensive investigations and care record reviews were completed, and **zero deaths were judged more likely than not to have been due to problems in the care provided to the patient**.

The report provides a breakdown of information by community hospitals, mental health services and learning disability

Medical Examiner Input: Medical Examiner input within community hospitals commenced from 17 May 2021 and associated processes are now well established with all KPIs being met.

Learning and Report Development: The learning from individual mortality reviews is now presented as 'Learning on a Page', consistent with dissemination of learning from serious incidents, clinical incidents, and complaints. These documents are available to the Board in the Reading Room.

The format of the attached report will be reviewed in light of feedback received from the Quality Assurance Group and the Quality Committee.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths which impact upon the Trust's 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?

- Monthly Mortality Review Group meetings.
- Quality Assurance Group 22 October 2021
- Quality Committee 4 November 2021

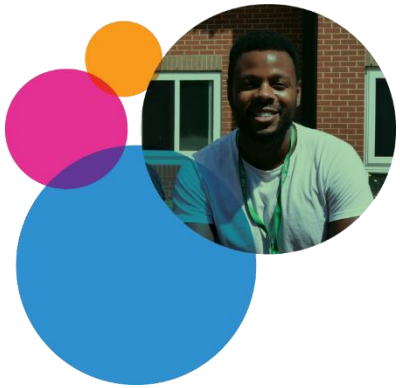
Appendices:	None

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

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: **10.1**/1121



Q2 2021/22 Learning from Deaths Report

Zoë Lewis, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

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

Purpose

The purpose of this report is to Inform the Board of the mortality review process and outcomes during Quarter 2 2021/22.

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.

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

Scope

The following categories of patient are considered in scope for a mortality review process (including application of the serious incident process where appropriate);

- All inpatient deaths in community hospitals;
- All inpatient deaths mental health inpatient units or who had been discharged from in-patient care within the last month;
- All deaths of those with learning disabilities under our care;
- 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 6 months prior to their death;
- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death;
- All perinatal/maternal deaths (perinatal mental health service for us);

Scope (cont.)

- All deaths of patients where a complaint or significant concern about the quality of care provision has been raised (within 12 months of the date of death);

- All deaths of patients receiving care from a service where an ‘alarm’ has been raised with the Trust through whatever means (for example via an elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator). This will include situations where another organisation has reviewed a death and suggests that our Trust reviews its care processes;

- Deaths where learning will inform the provider’s existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.

Overview

Gloucestershire Health and Care
NHS Foundation Trust

- During 2021/22 Q2, 135 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died:

No. of GHC patient deaths reported during 2021/22 Q2			
Jul	**Aug**	**Sep**	**Total**
63	41	31	**135**

- During 2021/22 Q2, 20 case record reviews and comprehensive investigations were completed:

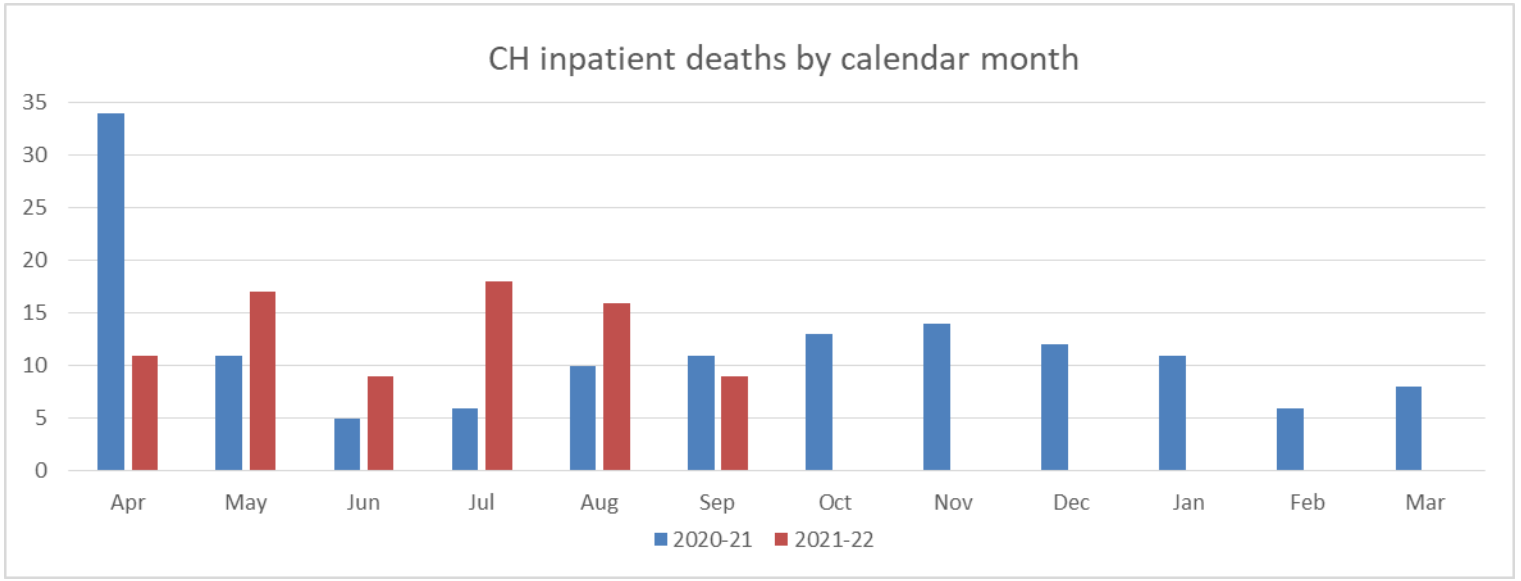
No. of Investigations and care record reviews completed during 2021/22 Q2				
	2020/21 Q4	**2021/22 Q1**	**2021/22 Q2**	**Total**
Comprehensive investigations	1	5	0	**6**
Care record reviews	1	11	2	**14**
Total	**2**	**16**	**2**	**20**

- The numbers above do not include open comprehensive investigations and care record reviews.
- 0, representing 0.0% of the patient deaths reviewed during 2021/22 Q2, are judged more likely than not to have been due to problems in the care provided to the patient.
- Learning from completed mortality reviews is now presented as ‘Learning on a Page’ and these documents have been reviewed by QAG and the Quality Committee. For learning relating to comprehensive investigations, please refer to the Patient Safety Report.

Community Hospitals Deaths per Month

Gloucestershire Health and Care
NHS Foundation Trust

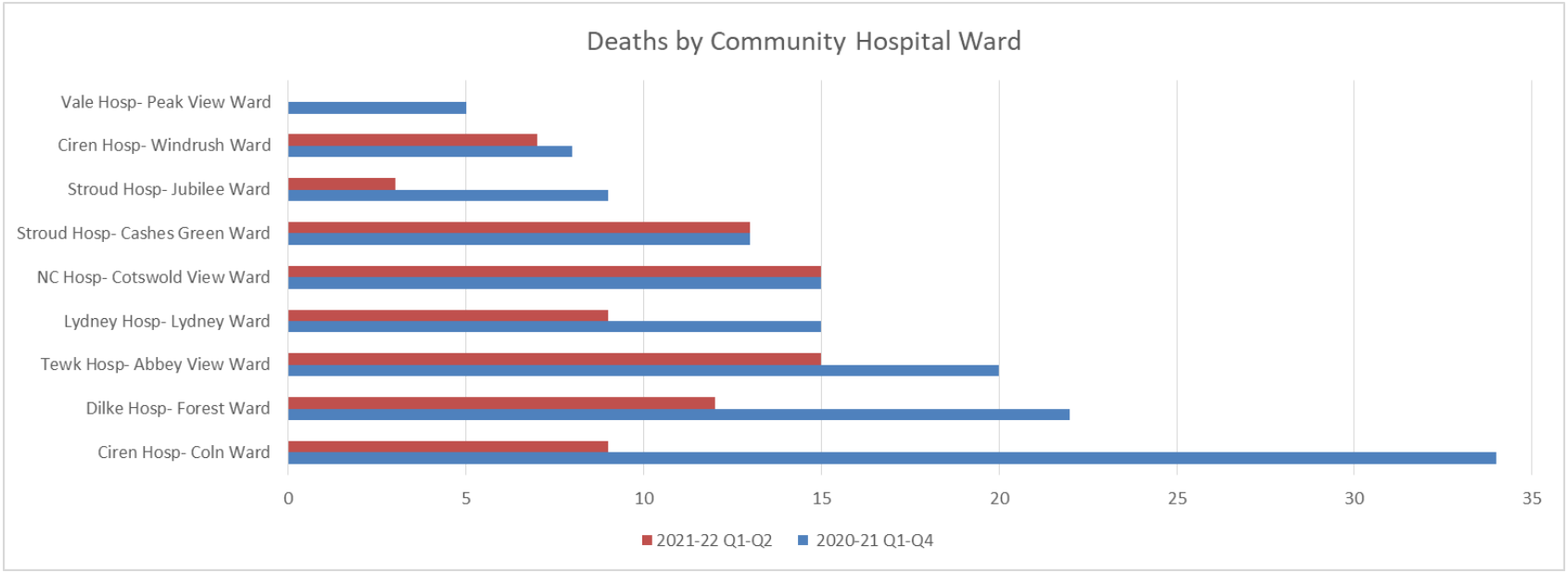
- During 2021-22 Q1-Q2 there were 83 community hospital (CH) inpatient deaths. Deaths per month are shown below with comparison to deaths in 2020-21 Q1-Q4, wherein there were 141 CH deaths in total.



- The increase in deaths seen in April 2020 corresponds to the first wave of the COVID-19 pandemic and the associated expected increase in inpatient deaths at that time.
- No such increase in death rate was seen during the second wave of the pandemic.
- During 2021-22 Q1-Q2, inpatient deaths have displayed a rate in line with pre-COVID-19 pandemic levels.

Community Hospitals
Deaths per Hospital Ward

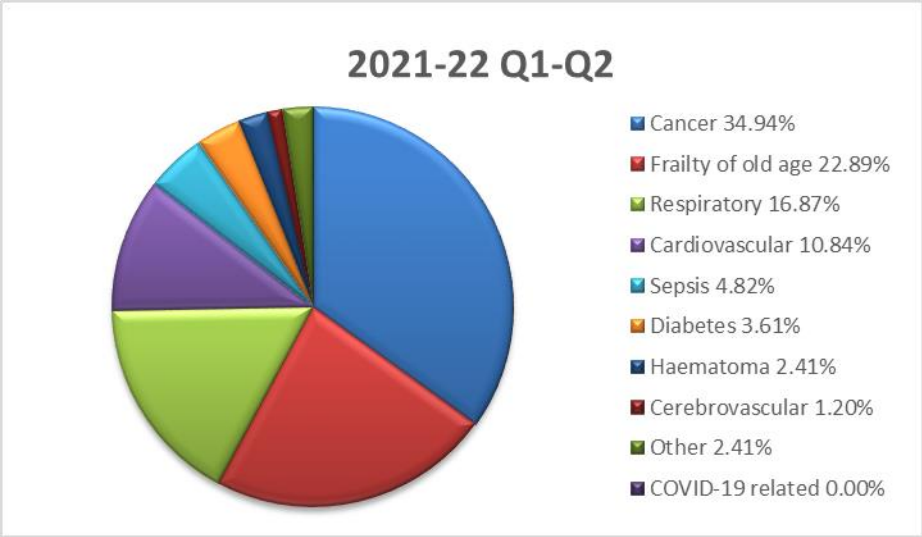
Gloucestershire Health and Care
NHS Foundation Trust

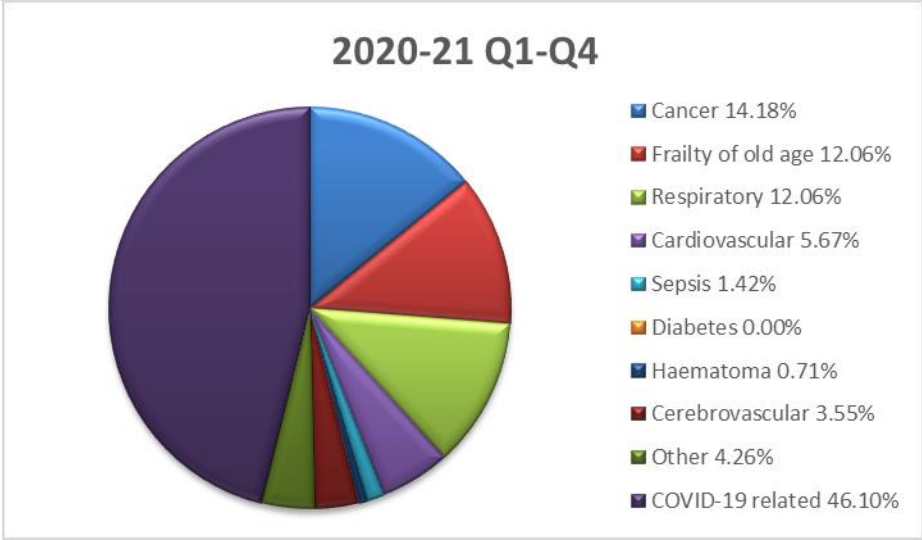


- During 2020-21, Coln Ward, Cirencester Hospital, saw an increase in death rate, due to the COVID-19 pandemic, with lower death rates seen on some of the other CH wards.
- 2021-22 data would show that this skew, due to COVID-19 has abated. Coln Ward's rate of inpatient death has thus decreased and is projected to be in line with pre-pandemic levels.
- Should there be a further COVID-19 wave, projected 2021-22 yearly death rates based on the above 6 monthly figures, are liable to change.

Community Hospitals Causes of Death

Gloucestershire Health and Care
NHS Foundation Trust





- Of the 83 CH inpatient deaths reported during 2021-22 Q1-Q2, cancer has been recorded 29 times as the cause of death, representing the most prevalent cause of death at 34.94%.
- So far during 2021-22, no death has been reported as being COVID-19 related.
- During 2020-21 Q1-Q4, of the 141 CH patient deaths, 65 were reported to be COVID-19 related, representing 46.10% of the total deaths reported last year.
- These 65 deaths include those where COVID-19 was recorded at Part I or Part II MCCD and/or where the patient received a positive test result with 28 days of death.

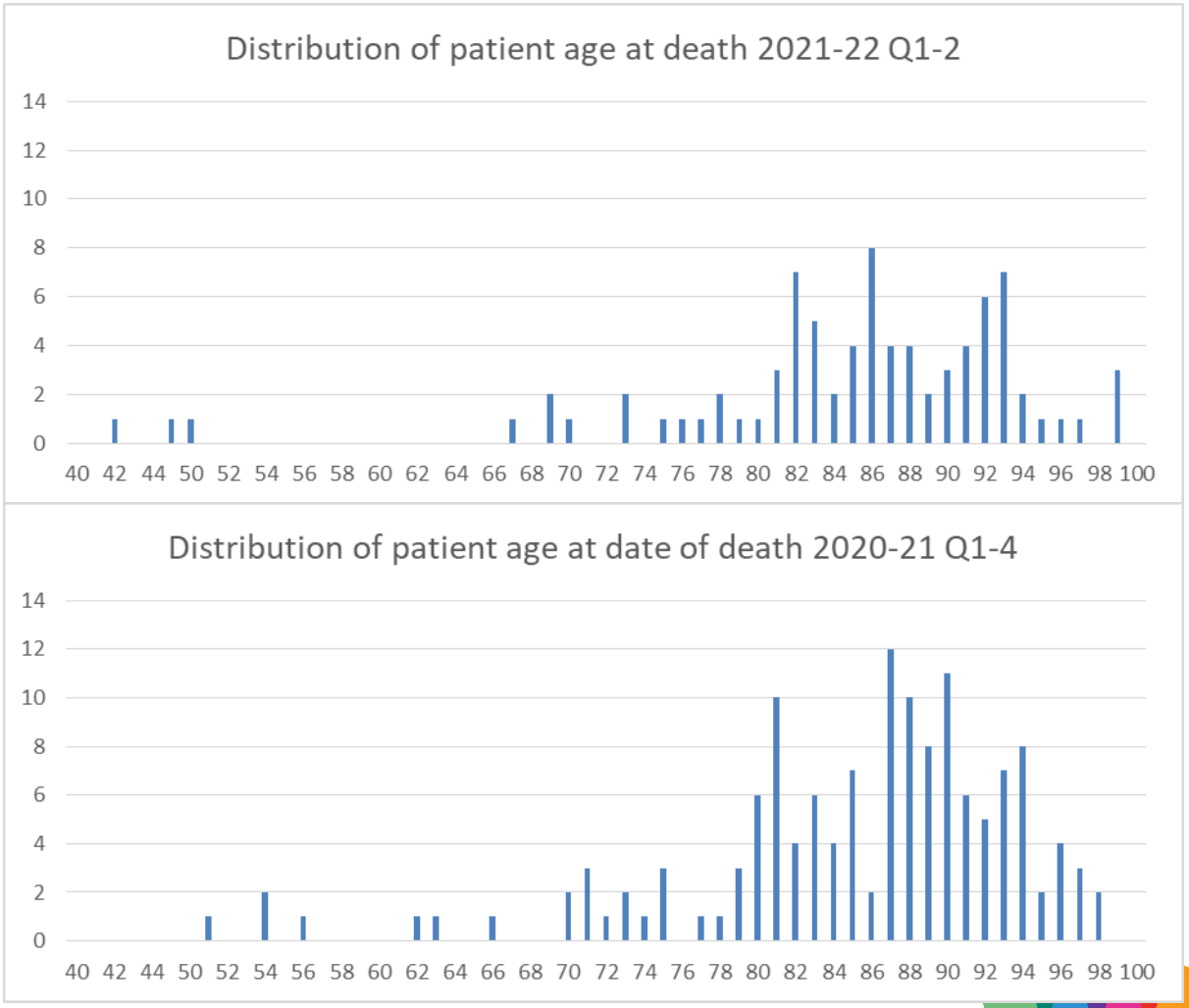
Community Hospitals
Patient Demographics – Age Distribution

Gloucestershire Health and Care
NHS Foundation Trust

The distribution of age at time of death for CH inpatients during 2021-22 Q1-Q2 is following a similar pattern to 2020-21 Q1-Q4.

During 2021-22 Q1-Q2, the youngest inpatient that died was 42 years old and the oldest was 99 years old, with the mean being 84.5 years.

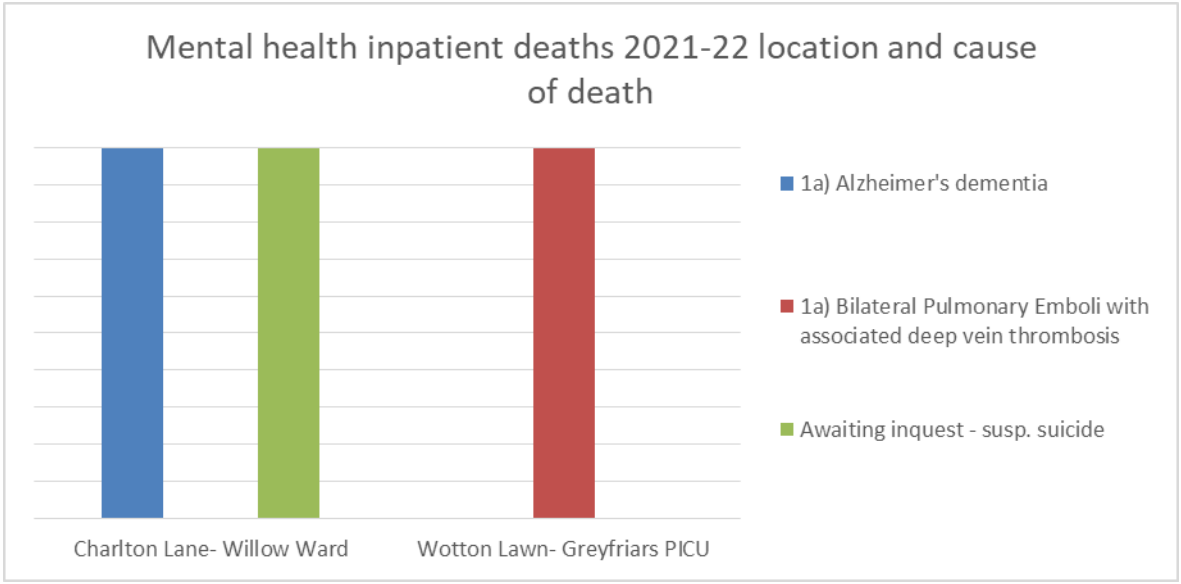
During 2020-21 Q1-Q4, the youngest inpatient that died was 51 years old and the oldest was 98 years old, with the mean being 85 years.



Mental Health Inpatient Units – Death by Ward and Cause of Death 2021-22 Q1-Q2

Gloucestershire Health and Care NHS Foundation Trust

- During 2021-22 Q2, there have been no mental health inpatient deaths. During 2021-22 Q1, there were 3 inpatient deaths, shown opposite.

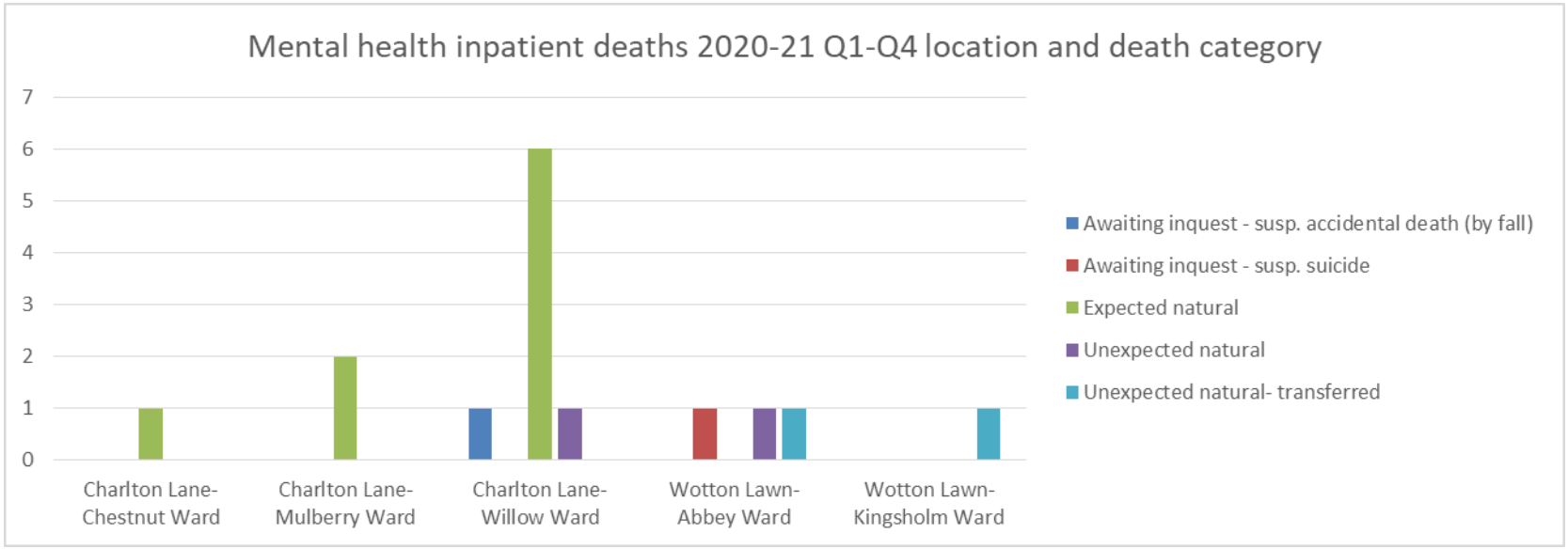


- 2 deaths occurred on Willow Ward, of which one was an expected death of a patient receiving end of life care. The second death is a suspected suicide. A serious incident investigation was commissioned and the Coroner's inquest is awaited.
- 1 death occurred on Greyfriars Ward. It was unexpected and from natural causes.

Mental Health Inpatient Units – Death by Ward and Cause of Death Category 2020-21 Q1-Q4

Gloucestershire Health and Care NHS Foundation Trust

During 2020-21 Q1-Q4, there were 15* mental health inpatient deaths.

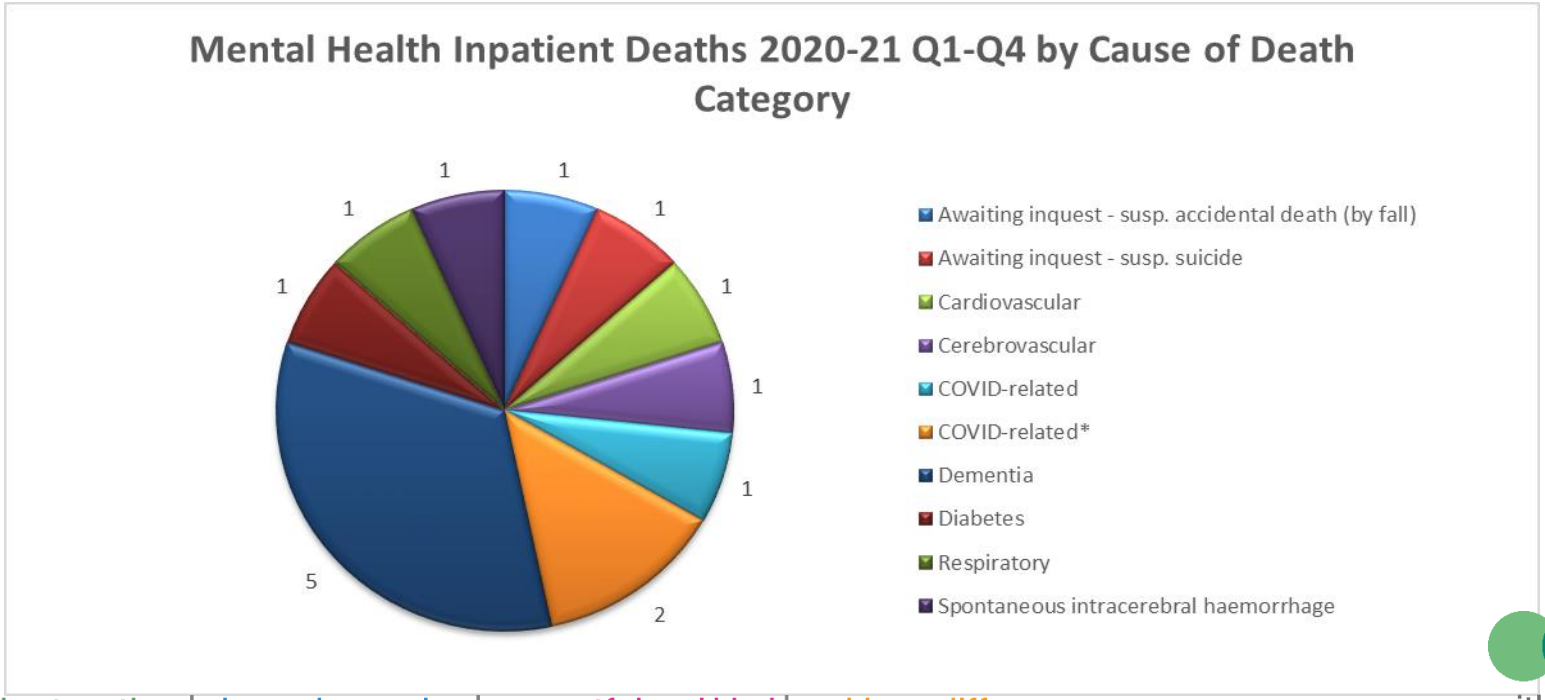


- *NB: 2 of the 15 deaths occurred soon after emergency transfer to the acute setting, labelled above as 'Unexpected natural – transferred'.
- 2 of the patients whose deaths were from a natural but unexpected cause were subject to the Metal Health Act when they died.

Mental Health Inpatient Units – Cause of death category 2020-21 Q1-Q4

Gloucestershire Health and Care NHS Foundation Trust

- Of the 15 inpatient deaths which occurred in 2020-21 Q1-Q4, dementia was proportionally the most prevalent cause of death, representing patients receiving end of life care at Charlton Lane Hospital.
- One patient's death was COVID-19 related and was reported to NHSE/I. *2 earlier deaths were recorded as suspected COVID-19 related without a positive test. At that time, NHSE/I was not collecting such data and did not collect in retrospect.



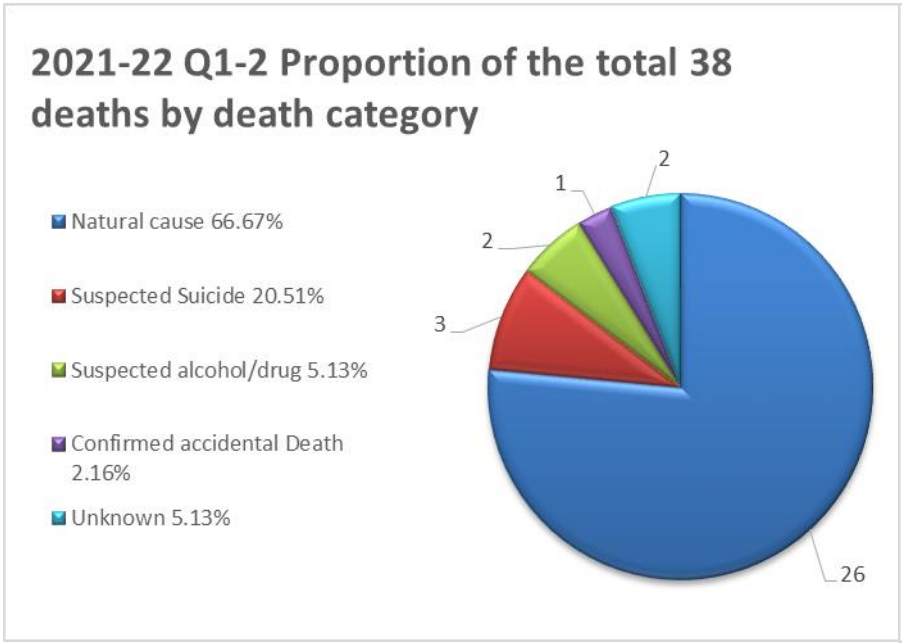
Mental Health Patients

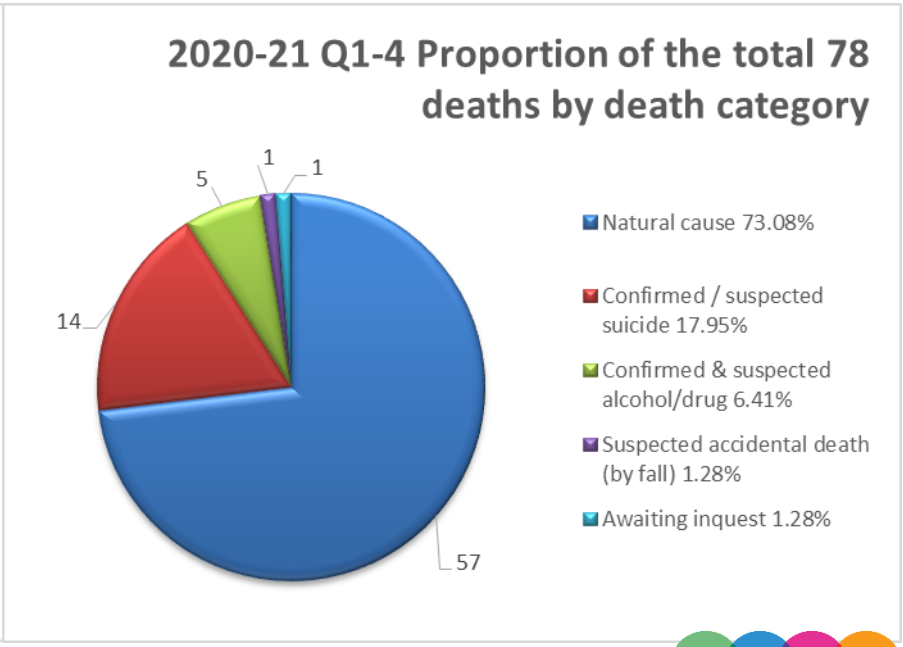
(Excluding those with a primary diagnosis of dementia and those on the MHICT caseload)

Gloucestershire Health and Care
NHS Foundation Trust

Cause of Death Category

- During 2021-22 Q1-Q2, excluding those patients with a primary diagnosis of dementia and in contact with MHICT, there were 35 community mental health patients and 3 mental health inpatients who died, totalling 38 patient deaths. The distribution of the 38 patient deaths by death category is shown below with comparison to 2020-21 Q1-Q4.



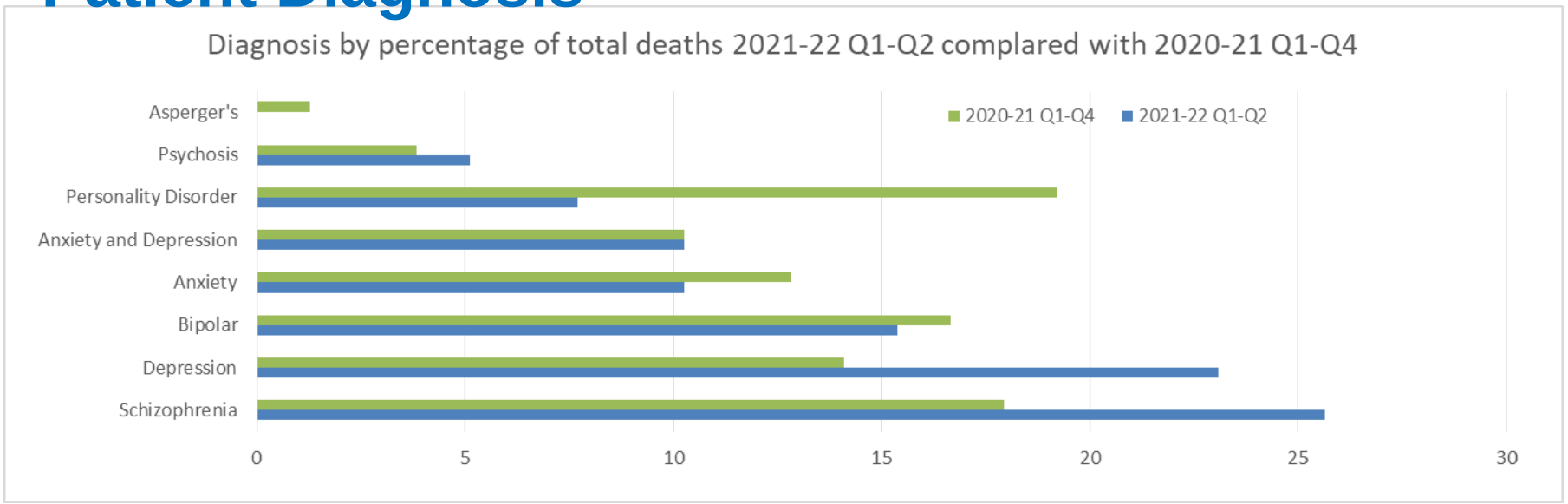


Mental Health Patients

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

Gloucestershire Health and Care
NHS Foundation Trust

Patient Diagnosis



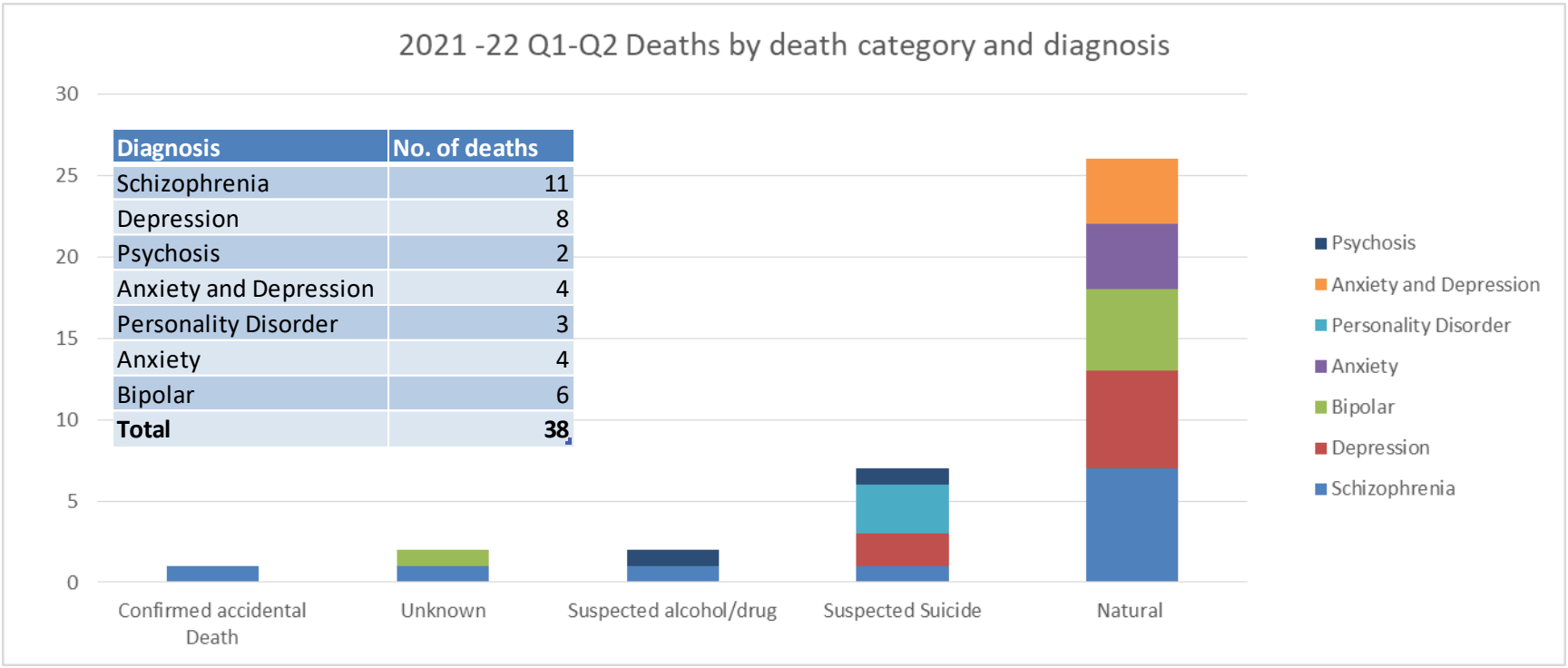
- By the mid-point of 2021-22 Q, there appears to be limited similarity between the percentage by diagnosis of total deaths with that of 2020-21 Q1-Q4 figures.
- During 2020-21 Q1-Q4, personality disorder was the most prevalent diagnosis, whilst during 2021-22 Q-Q2, schizophrenia has been most prevalent.
- Both years show relatively small numbers of deaths of patients with a diagnosis of psychosis, compared to the other diagnoses.

Mental Health Patients

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

Cause of Death Category vs. Diagnosis

Diagnosis	No. of deaths
Schizophrenia	11
Depression	8
Psychosis	2
Anxiety and Depression	4
Personality Disorder	3
Anxiety	4
Bipolar	6
Total	**38**

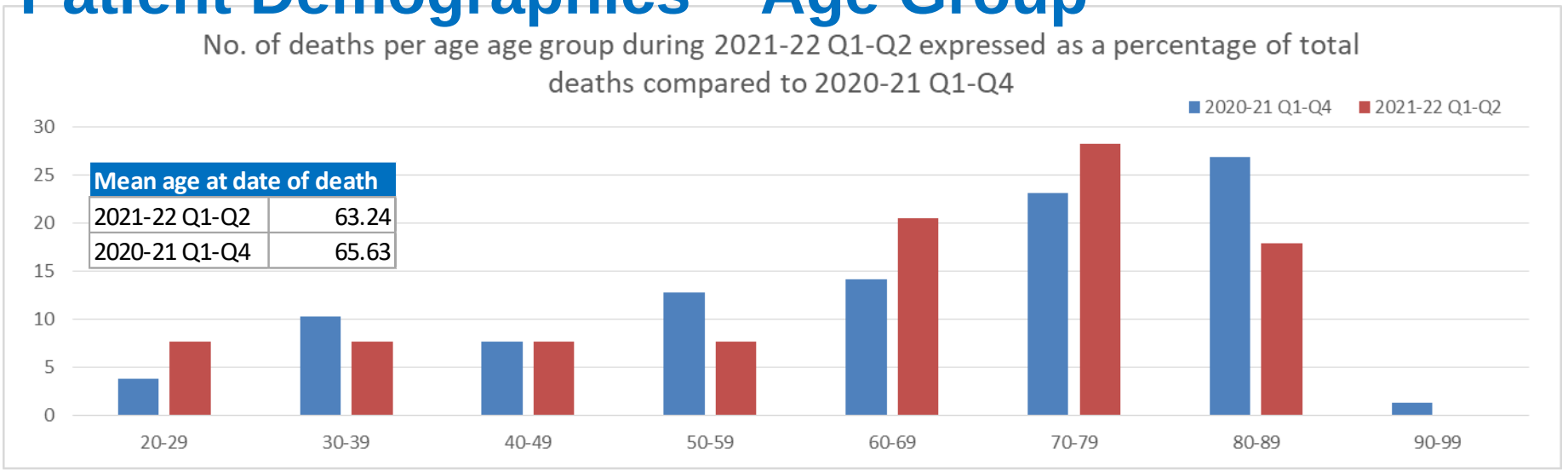


Mental Health Patients

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

Gloucestershire Health and Care
NHS Foundation Trust

Patient Demographics – Age Group



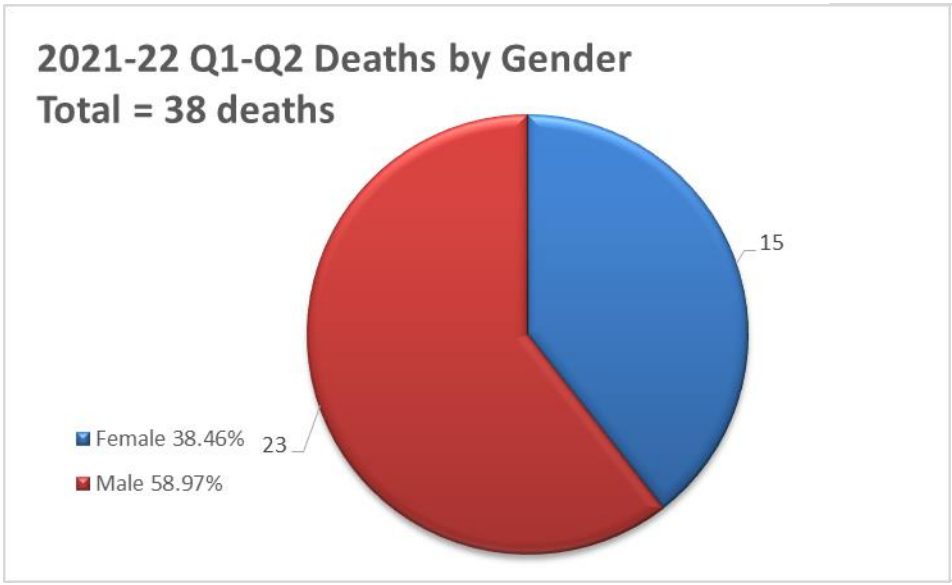
Mean age at date of death	
2021-22 Q1-Q2	63.24
2020-21 Q1-Q4	65.63

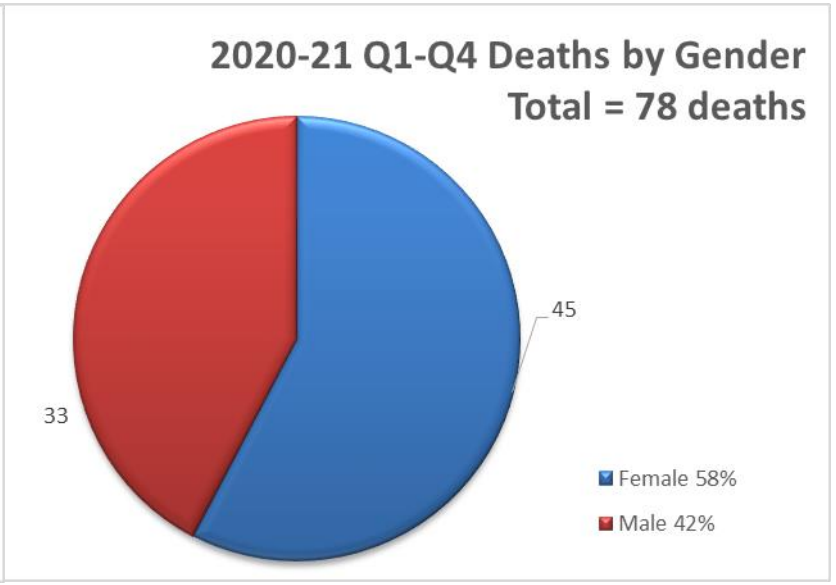
- The distribution of the 38 patient deaths by age group is above. The youngest patient was 20 years old and the oldest was 88 years old.
- The mean age at date of death was 63.24 years of age, which at the mid-point of 2021-22 is younger than the figure for 2020-21 Q1-Q4, which was 65.63 years.
- The relatively young mean age of patients at date of death is consistent with accepted research indicating that people with mental health illness die on average at an earlier age than those without.

Mental Health Patients

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

Patient Demographics - Gender



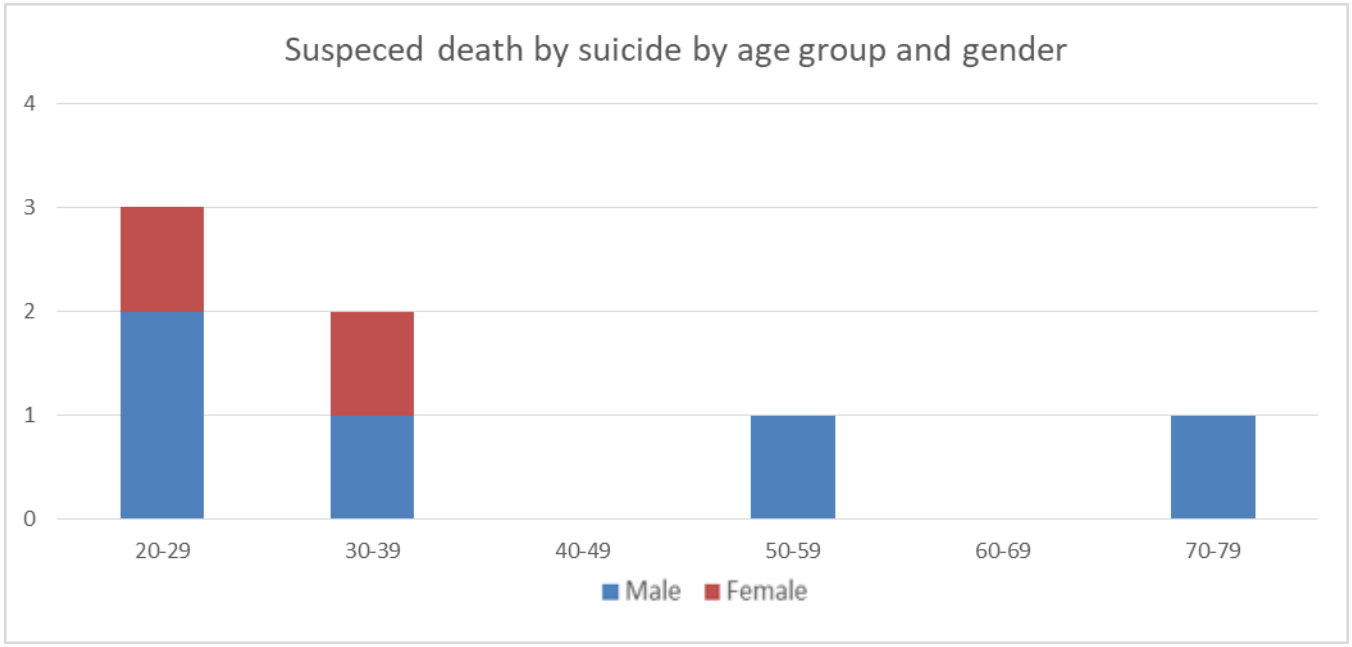


Mental Health Patients

Gloucestershire Health and Care
NHS Foundation Trust

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

Patient Confirmed/Suspected Suicides – Age & Gender



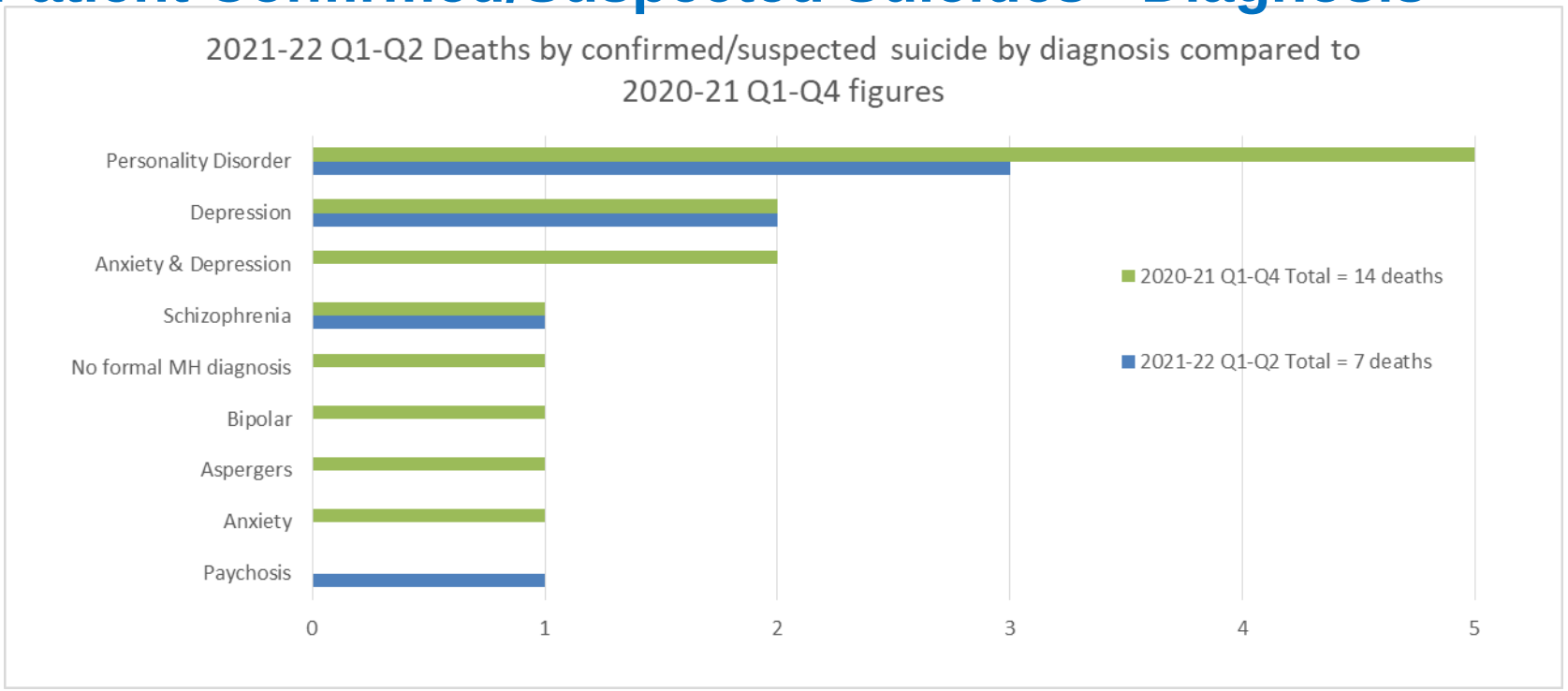
- Of the 38 patient deaths occurring in 2021-22, 7 are suspected deaths by suicide. Distribution by age group and gender is shown above.
- The average age was 38 years.
- Of the 7 suspected deaths by suicide, 5 patients were male and 2 were female.

Mental Health Patients

Gloucestershire Health and Care NHS Foundation Trust

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

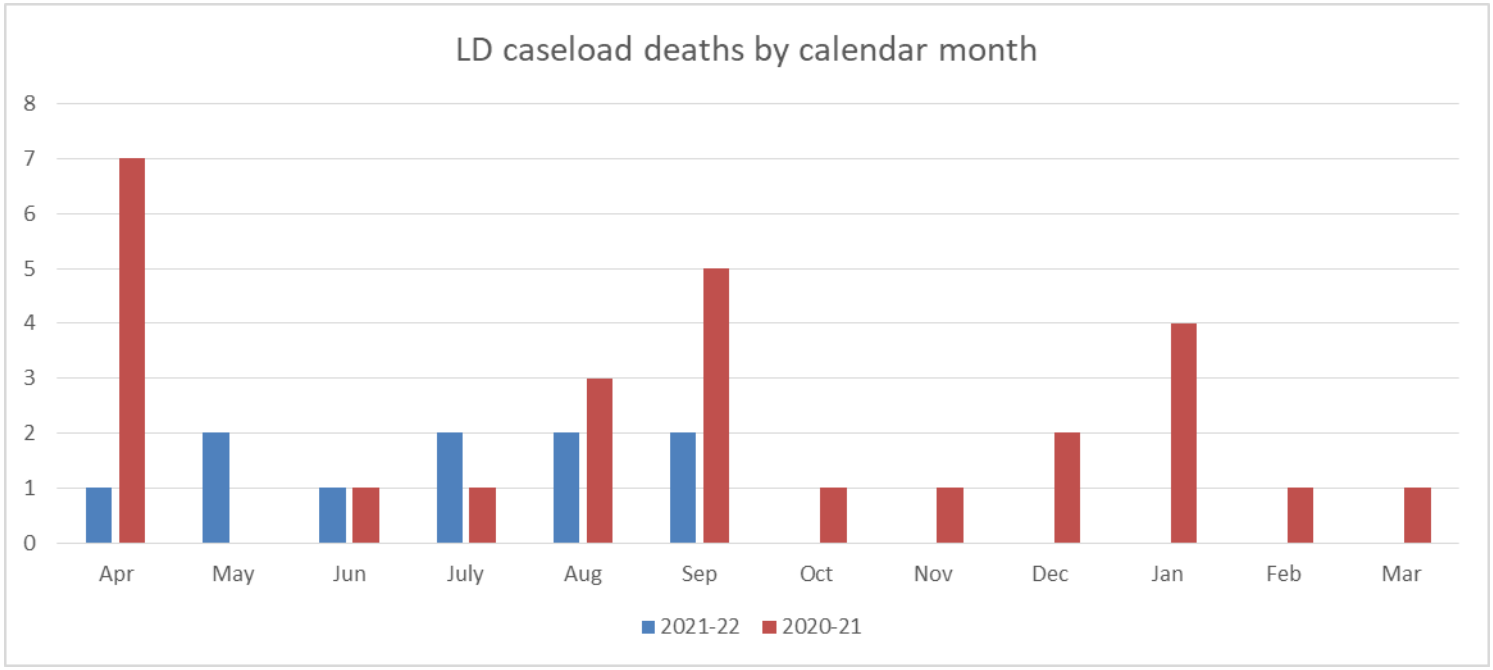
Patient Confirmed/Suspected Suicides - Diagnosis



Of the 7 suspected deaths by suicide, personality disorder is the most prevalent mental health diagnosis. This mirrors the most prevalent mental health diagnosis for deaths by confirmed/suspected suicide in 2020-21 Q1-Q4.

Learning Disability Patients Deaths per Month

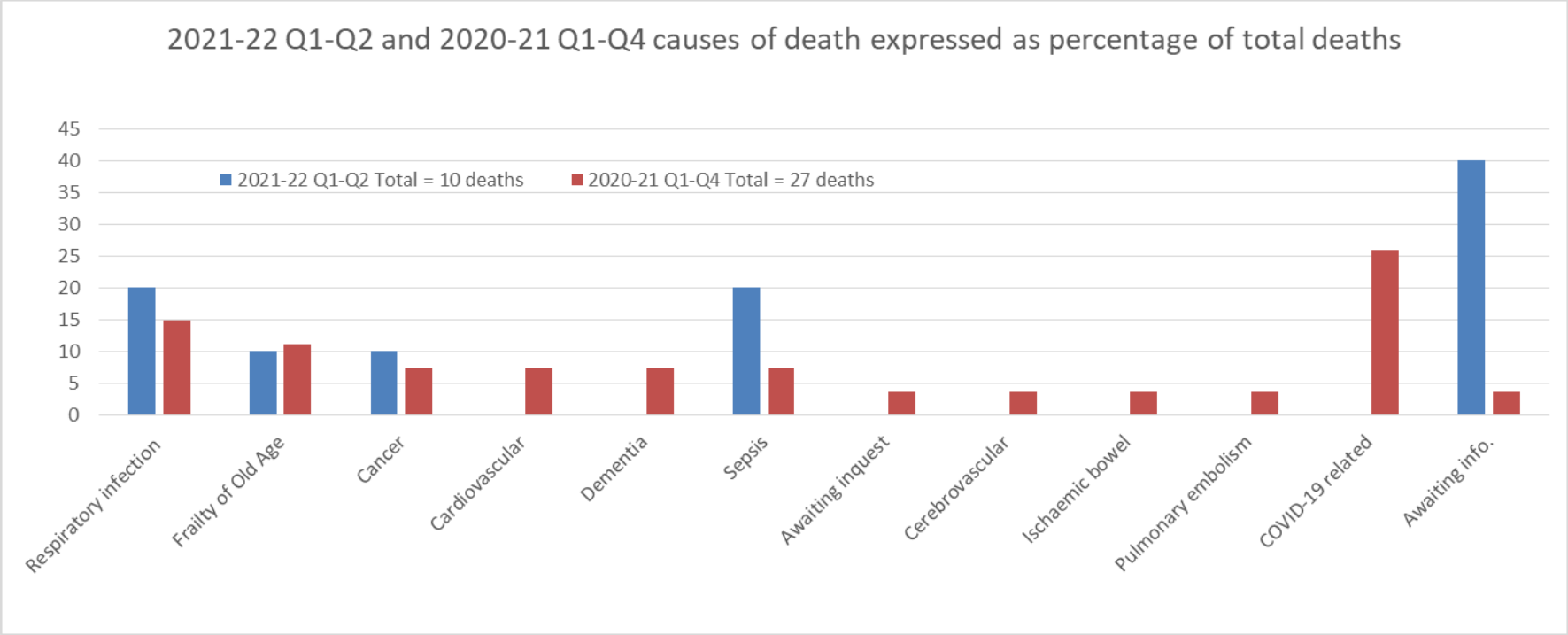
Gloucestershire Health and Care
NHS Foundation Trust



- During 2021-22 Q1-Q2, there were 10 deaths of patients open to trust Learning Disability (LD) caseloads. Deaths per month are shown above with comparison to 2020-21 Q1-Q4 figures, wherein there were 27 LD caseload deaths in total.
- 3 of the LD caseload deaths in Apr 2020 and all 4 in Jan 2021 were COVID-19 related

Learning Disability Patients Cause of Death

Gloucestershire Health and Care
NHS Foundation Trust



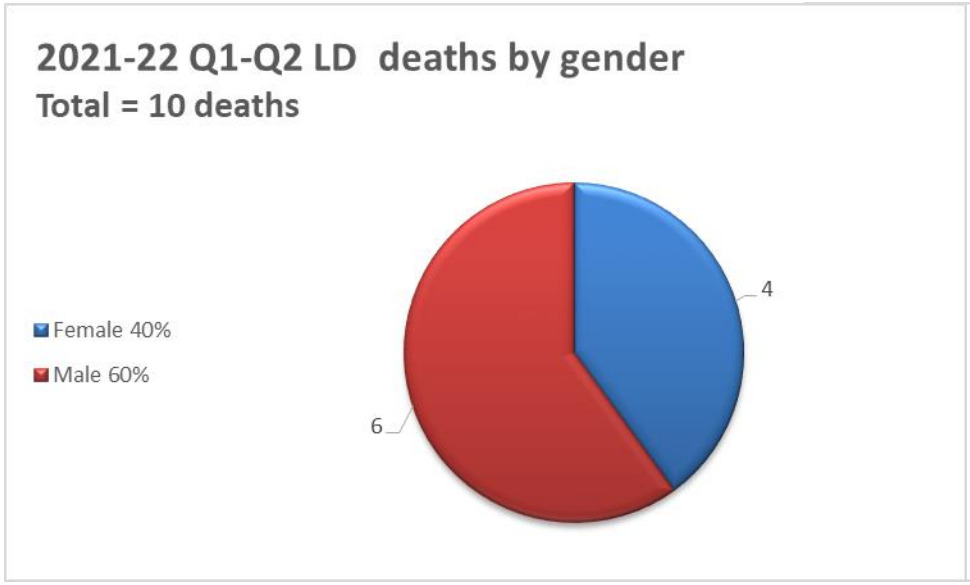
- Of the 10 LD caseload deaths occurring during 2021-22 Q1-Q2, respiratory infections and sepsis are the most prevalent causes of death.
- During 2020-21 Q1-Q4, the most prevalent cause of death was COVID-19-related, followed by other respiratory infections.

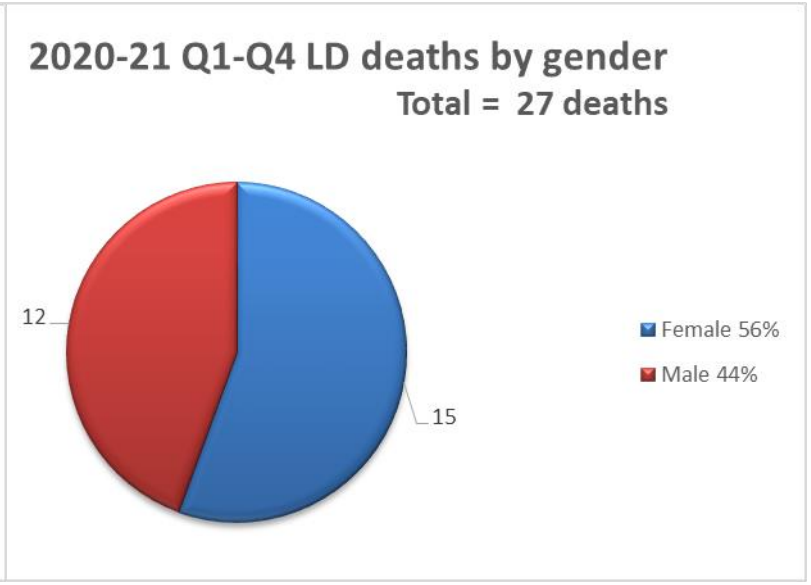
Learning Disability Patients
Patient Demographics - Ethnicity and Gender

Gloucestershire Health and Care
NHS Foundation Trust

- 100 percent of all patient deaths open to LD caseloads during 2021-22 Q1-Q2 and 2020-21 Q1-Q4 were reported to be of white ethnicity.

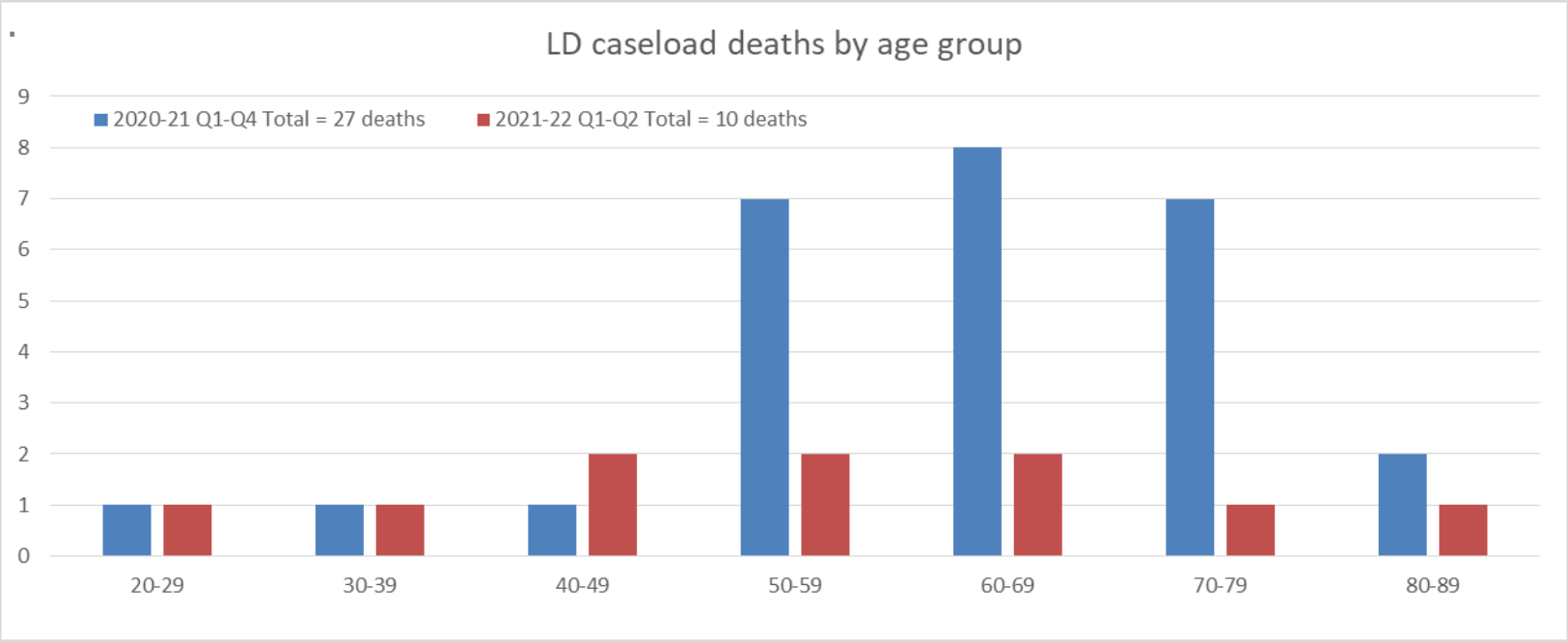
- 2021-22 Q1-Q2 LD caseload deaths by gender with comparison to 2020-21 Q1-Q4 is shown below.





Learning Disability Patients
Patient Demographics - Age Group

Gloucestershire Health and Care
NHS Foundation Trust



- The distribution of the 10 deceased patients open to LD caseloads who died during 2021-22 Q1-Q2 by age group is shown below. The youngest patient was 29 years old and the oldest was 81 years old.
- The mean age at date of death was 56.4 years of age, which so far during 2021-22 is younger than the figure for 2020-22 Q1-Q4, which was 61.9 years of age.

Medical Examiner Input

Medical Examiner (ME) input within community hospitals commenced from 17 May 2021; this section aims to provide an overview of activity against identified Key Performance Indicators (KPIs) key activity and learning during Quarter 2 2020/21.

Feedback from the ME service:

"Overall, the interaction from ward doctors across the entire community hospital sites has been very good. We have not knowingly caused any delays to process and feel that the first few months have gone very well indeed. The ME service team continues to learn and grow in confidence in scrutinising deaths in the community as a result of GHC's commitment to collaborative working ahead of the statutory footing next spring. Thank you!"

Discussion is currently underway to agree the roll out of the ME Service to Charlton Lane Hospital. It is projected that this will go live from 1 December 2021.

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Medical Examiner KPIs

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD
Percentage of deaths generating MCCD resolved with the input of the ME service													
Number		Pilot		18	15	13							46
Percentage		Pilot		100%	100%	100%							100%
Number of times a MCCD is rejected by Registrar and reason this occurs		Pilot		0	0	0							0
Percentage of potential Coroner referrals resolved with the input of the ME service													
Number		Pilot		5	3	1							9
Percentage		Pilot		100%	100%	100%							100%
Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)		Pilot		0	0	0							0

Feedback & Learning from ME Input

Compliments *- Examples received during the quarter. Full details are shared via MRG monthly*

- ***Dilke.*** *Feedback from brother: "Wonderful care and the cause of death was exactly what the family expected.".*
- ***Lydney.*** *Feedback from son: "Care was brilliant, especially last night!"*
- ***Cirencester.*** *Feedback from son in law: Fantastic – perfect care at Cirencester Hospital!*
- ***Stroud.*** *Feedback from daughter: "Amazing care at Stroud – GRH too – but Stroud was beyond excellent. Family and patient were so well cared for. Nurses Sarah, Ayisha and others to be thanked!"*
- ***North Cotswolds Hospital.*** *Feedback from Son: The care was excellent, extraordinary, brilliant, outstanding in fact!! A lovely nurse held Dad's hand until the end as we had not arrived in time…*
- ***Tewkesbury.*** *Feedback from daughter: "Amazed about the care. Felt very supported too. Everyone was so kind and caring."*

Complaints

- *A concern regarding care at Cirencester Hospital were flagged by a family to the ME Service. This is being progressed via the Patient & Carer Experience Team*

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AGENDA ITEM: 11/1121

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 25 November 2021**
PRESENTED BY:	Sonia Pearcey, Freedom To Speak Up Guardian and John Trevains, Director of Nursing, Therapies and Quality
AUTHOR:	Sonia Pearcey, Freedom To Speak Up Guardian
SUBJECT:	**FREEDOM TO SPEAK UP GUARDIAN SIX MONTHLY 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 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

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

Executive summary

This report for Q1 & Q2 2021-22 gives an update from the last report Trust Board report, an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

18 cases were raised in Q1 and 15 in Q2, with a total of 33 cases for the first six months of 2021-22. To note that in 2020-21 120 cases were raised through the Freedom to Speak Up route, an increase of 74% on 2019-20.

In 2020-21 Nurses accounted for the biggest portion (32%) of speaking up cases raised through the Freedom to Speak Up route. For Q1 & Q2 within the Trust Nurses accounted

for 18% followed by Doctors/Dentists at 12% with anonymous reporting through the Work in Confidence portal at 24%.

A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and Great Place to Work. It is a core component in our health and wellbeing offer to colleagues and in our "Strong Voice" commitment to colleagues within our new People Strategy. Since the last reporting period the Quality Strategy has been launched within the organisation to "Develop a just culture which promotes safety through supporting people to speak up".

In July 2021 The National Guardian's Office published the latest Annual Data Report, which analyses the themes and learning from the speaking up data shared by Freedom to Speak Up Guardians, 'The Year of the Pandemic: A Summary of Speaking Up to Freedom to Speak Up Guardians April 2020 - March 2021'

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	No issues identified within this report

Where has this issue been discussed before?
Quality Assurance Group 18/11/2021 JNCF 26 May 2021

Appendices:	N/A

Report authorised by: John Trevains	**Title:** 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 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.

1.3 Celebrate our progress in continuing to raise the bar in embedding our speaking up culture within 2021-22 and beyond.

2. ASSESSMENT OF FTSU CASES

2.1 Speaking up for Q1 & Q2 are detailed in Table 1, which also gives an overall picture of this year compared to 2020-2021. Speaking up for these periods have been received via different routes and all anonymous cases were via the Work in Confidence system. Some colleagues may also have raised more than one concern.

Table 1

Quarter 2020-21	**Number of cases raised**	**Number of cases raised anonymously**
Q1: April - June	42	15
Q2: July - September	23	6
Q3: October - December	25	4
Q4: January - March	30	4
Quarter 2021-22		
Q1: April - June	18	5
Q2: July - September	15	3

2.2 Themes

Updated guidance on mandated data submission came into the effect on 1 April 2021. The following changes were made to include 'Worker safety' has been added as a category (in addition to the existing 'patient safety/quality' and 'bullying and harassment' categories). The term 'detriment' has been replaced with 'disadvantageous and/or demeaning treatment', though the term detriment is still used in brackets to avoid any confusion.

Other themes collected are behaviours, systems/processes, other and ideas for learning and improvement.

Table 2

Quarter	Patient safety/ quality	Bullying and/or harassment	Worker safety	Other behaviours	Systems and/or process	Other	Ideas for learning and improvement
Q1	2	8	1	5	2	0	0
Q2	0	6	0	5	2	2	0

Freedom to Speak Up processes are in place to proactively support patient safety and improve worker experience. Within national reporting, the National Guardian's Office have demonstrated that more issues are raised through Freedom to Speak Up concerning staff experience than patient safety; this is consistent with the GHC experience:

Some examples of speaking up in Q1 & Q2 are:

- Initially raised through Work in Confidence, a colleague wanted support regarding what they described as harassment and micro-aggression that they have experienced a few years. They have accessed BAME coaching which has helped to some extent however their experience is being progressed further with the support of the Freedom to Speak Up Guardian.

- A colleague spoke up about concerns regarding the unprofessional conduct of a team member and they were treating them as another gender, with lack of respect. Support was given to frame a conversation and coaching style phrases to address this and ensure diversity within the team is enhanced.

- A colleague, who wished to remain anonymous, highlighted concerns over patient safety and treatment of both patients and staff. The concerns were raised within the working environment and then to a corporate colleague. After discussion with the Executive Director of Nursing, Therapies & Quality and the Freedom to Speak Up Guardian, it was agreed that a fact-finding report should be undertaken. Confidential staff discussions were held and the report was shared. Feedback was given to the reporter through the Apprenticeship and Widening Access Lead. An action plan has been developed with governance oversight due to team and organisational learning. The feedback from the reporter was positive in the response to speaking up.

Table 3

Quarter	Worker	Manager	*Senior Leader	Not disclosed	Protected characteristic shared
Q1	8	5	0	5	Disability-1 BAME-2
Q2	8	4	0	3	Disability-1

*This category is applied to Board-level or equivalent

Table 4

Professional Group	Q1	Q2	Total
Administration, Clerical & Maintenance/Ancillary	0	3	3
Allied Health Professionals	0	1	1
Ambulance (operational)	0	0	0
Commissioning	0	0	0
Corporate Services	1	1	2
Medical and Dental	3	1	4
Not known	5	3	8
Nursing Assistants or Healthcare Assistants	0	2	2
Other	3	2	5
Public Health	0	0	0
Registered Nurses and Midwives	5	2	7
Social Care	1	0	1

For Q1 & Q2 within the Trust Nurses accounted for 21% of speaking up through the Freedom to Speak Up route followed by Doctors/Dentists at 12% with anonymous reporting through the Work in Confidence portal at 24%. This anonymous reporting figure remains higher than the national figure of 11.7% (2020-21 published data).

Increased engagement continues with our medical and dental workforce, with the Freedom to Speak Up Guardian continuing to present at team meetings and at junior doctor inductions. Within the Speak Up Advocate team there is no medical or dental representation, although with the new champion model review there are interested medical and dental colleagues.

Reflecting on 2020-21 Nurses accounted for the biggest portion (32%) of speaking up cases raised through the Freedom to Speak Up route within the Trust, followed by Allied Health Professionals (17.5%) and corporate colleagues (10%). Not known colleagues (20%) were through the anonymous Work in Confidence portal. When the 'Not known' is considered, this can include an instance when an individual has not disclosed their professional group or when a colleague wishes to remain anonymous.

Work in Confidence

Work in Confidence, an anonymous, secure and independent platform remains another route for colleagues to speak up. Various colleagues are available to offer support through this platform and with the governance oversight by the Freedom to Speak Up Guardian. The Trust's Information Governance Manager/Data Protection Officer is supporting current work to securely enhance the recording of information in case management tool. This platform will enable the Guardian to more easily understand 'reach' across the organisation and identify any groups which may be using the Freedom to Speak up route more frequently, or less frequently, than other groups.

Table 5

Quarter 2021-22	Number of contacts	Category
Q1	5	Bullying and/or harassment-4 Patient safety/quality-1
Q2	3	Bullying and/or harassment-2 Other-1

3. PATIENT SAFETY AND/OR WORKER EXPERIENCE FEEDBACK

Feedback is requested from all colleagues whether they have had a positive experience or not. Some feedback is shared from colleagues as below from Q1 & Q2:

- Thank you so much you've been wonderful!
- The reporter (anonymous) was very grateful to receive the feedback and has expressed their gratitude for the support they've had from the Trust throughout this investigation. They feel happy with the way in which the feedback was handled and confident that the changes will make a difference going forward.
- I would definitely use the Freedom to Speak Up service again. You responded in a kind manner when I didn't know where else to turn. Showing me what else I can get to help me was really helpful.
- Thank you for your time to off load and you helped me to put things into perspective. I will be championing you in my team and would like to able to influence and be a part of the civility programme.

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 the review led by Sir Robert Francis QC, he highlighted that minority staff feel vulnerable when speaking up, as they may feel excluded from larger groups of workers.

Table 6

Quarter	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment (detriment)	Given your experience would you speak up again
Q1	3 (BAME -1)	Yes-8 No- Maybe-2 Don't Know-
Q2	3 (Disability-2)	Yes-7 No- Maybe- Don't Know-

12% of all colleagues who spoke up declared a protected characteristic, disability 6% and BAME 6%. Those colleagues that have indicated that they are suffering detriment who shared a protected characteristic is 50%. Colleagues are further supported through dedicated health and wellbeing resources, reciprocal mentoring, and also sign posted onto to our Equality, Diversity and Inclusion networks.

4. LEARNING AND IMPROVEMENT

4.1 Difference Matters: The Impact of Ethnicity on Speaking Up

Inclusive Freedom to Speak Up is essential for a healthy speak up, listen up and follow up culture. There has been little research into the impact of a person's protected or other characteristics have on speaking up.

The National Guardian's Office commissioned research looking at people's experiences of accessing their Freedom to Speak Up Guardian and whether ethnicity has an impact. Difference Matters: The Impact of Ethnicity on Speaking Up was produced by the equality's charity and Roger Kline OBE.

The research found that black and minority ethnic respondents were six times more likely than white respondents to say that they were more likely to raise a concern with a Guardian of the same ethnicity as themselves. The research explores why this might be, including issues around bias and discrimination.

The research also found that black and minority ethnic workers who did speak up had comparable experiences to white workers. Black and minority ethnic workers who had spoken up also reported that they thought Freedom to Speak Up Guardians had a good understanding of discrimination and bias, were empathetic and had good listening skills.

The research also found awareness among Freedom to Speak Up Guardians of the potential impact of characteristics, and details some examples of the work they were carrying out to improve the speaking up culture for all workers.

Our Trust Freedom Speak Up Guardian was one of a sample of Guardians (18 NHS trusts across England) to be interviewed as part of Phase 2 and Phase 4. For Phase 3 an anonymous online survey was sent to staff working on eight Trust sites. Some highlights from the data at GHC;

- In total 164 responses were from GHC with 87% of responses were from White British colleagues.
- The number of responses was the highest amongst participating Trusts.
- 82.6% of White colleagues were aware of the Freedom to Speak Up Guardian compared to 80.6% of BME colleagues.
- When asked if in the previous four years, was there an issue you could have raised with the Freedom to Speak Up Guardian, 47.4% were White colleagues compared to 56% of BME colleagues.

- Did the issue involve people – staff or patients – being treated differently because of their race, nationality, or ethnicity? All ethnic groups responded no 76.2%, yes 7.9% and not sure 15.9%.

- Respondents were asked if they considered raising the issue with a Freedom to Speak Up Guardian? 40.5% were White colleagues compared to 57% of BME colleagues.

- 73.9% of all respondents strongly agreed or agreed that the Freedom to Speak Up Guardian understood their issue.

- When asked, how would you rate your Freedom to Speak Up Guardian's understanding of discrimination and bias if that seemed relevant, all ethnic groups responded at 54% and 28% not relevant.

- Lastly colleagues were asked, have you considered becoming a Freedom to Speak Up Guardian? All ethnic groups responded yes 74%, if no why with free text comments - too much work, poor experience of Guardians in a past Trust, don't think I have the communication skills, don't know what is expected and happy with the current Guardian.

4.2 Freedom to Speak Up Index (FTSU Index)

Following the last reporting period, The National Guardian's Office published the latest FTSU Index, which uses four questions in the NHS Annual Staff Survey, to understand the impact of Freedom to Speak Up. The FTSU Index, first published in 2019, is a key metric for organisations to monitor their speaking up culture and comparable to other sectors, a score of 70% is perceived as a healthy culture. Within the FTSU Index report 2019, GCS was in the top 10 for most improved out of 220 Trusts nationally.

FTSU Index report	GCS	2gether	GHC	Comparator Trust	National Average
2019	82%	80%			78.1%
2020	84.1%	80.6%			78.7%
2021			82.5%	80.8%	79.2%

The NHS Staff Survey for 2021 has undergone significant changes, in line with the People Plan. As a result, some of the questions which comprised the Freedom to Speak Up Index have been dropped so therefore the index will no longer be published. Last year's survey included a new question asking whether workers feel safe to speak up about anything that concerns them in their organisation. The question remains in this year's survey and is accompanied by a new follow-up question: 'If I spoke up about something that concerned me, I am confident my organisation would address my concern.'

Further local and Trust learning is being incorporated into future plans with feedback and self-reflection with colleagues and teams.

- Work continues to further develop and strengthen the Gloucestershire ICS Guardian network and to gain a greater understanding from a national perspective regarding a future ICS model.

- Signposting colleagues to health and wellbeing resources and where appropriate raise to senior managers.

- Facilitated meetings/mediation to support and address inappropriate behaviours. Referral to OD team to offer wider team coaching and support.

- Civility and respect issues, team dynamics. Civility framework within the Civility Saves Lives programme to tackle some of these issues is being explored. Bullying and Harassment Policy is being reviewed.

- Discussion and coaching to raise the issue with line manager or appropriate person.

- Compassionate leadership and kindness role modelled to ensure a compassionate culture

- Colleagues with the knowledge and skills not feeling they are influencing the direction of travel, team debriefs, listening events and visibility of leaders increased.

- Students need to empowered to speak up through their education route as well as the placement route, so that issues are identified as soon as possible and positive action taken.

- The placement expectations for students needs to be reviewed and confirmed to ensure both registered nurses and students know the expectations moving forward.

5. ACTIONS TAKEN TO IMPROVE THE SPEAKING UP CULTURE ALONGSIDE ASSOCIATED WORK OF THE FREEDOM TO SPEAK UP GUARDIAN

Progress continues to further improve the speaking up culture within the organisation. The following builds upon previous significant work:

- **National Speak Up Month October 2021** - The pandemic has highlighted that speaking up has never been more important for the benefit of colleagues, patients and our service users. Speak Up Month in October is an opportunity to raise awareness of how much we value speaking up in our organisation. The theme of this year's Speak Up Month is Speak Up, Listen Up, Follow Up.

  Here at GHC we are further promoting our speaking up culture through a refreshed 'Speak Up Champion role' and Freedom to Speak Up e-learning, available on Care to Learn, which is freely available for anyone wherever they work. The third module Follow Up is will be launched during this month, aimed at senior leaders in their role in fostering a culture where people can speak

up and be confident they will be listened to and the action will follow for learning and improvement.

Through enhanced visibility and engagement sessions the Guardian will be encouraging colleagues make a Speak Up Pledge to show how you support speaking up, listening up and following up. Listening and acting upon matters raised means that Freedom to Speak Up will help us to be the best place to work.

- **Freedom to Speak Up Advocate Model** -The National Guardian's Office has published new Guidance for Freedom to Speak Up Guardians on the Development of Freedom to Speak Up Champion and Ambassador Networks.. Engagement sessions continue with current advocates to refresh, raise awareness and promote the value of speaking up. The new guidance is being implemented with current teams in the Forest of Dean Community Hospitals, Charlton Lane Hospital and Wotton Lawn Hospital as our 'Strong Voice' commitment to colleagues within our new People Strategy.

- **Health and Wellbeing Hub** – Speaking Up continues to be integral to the health and wellbeing hub. The voice of colleagues is fundamental to this and learning from speaking up is feedback to the Health and Wellbeing hub to inform priorities.

- **Civility Saves Lives** – Dr Chris Turner joined the Senior Leadership Network in August, to share his experiences of incivility and the impact on patient safety. This session 'When we permit rudeness our patients die unnecessarily' gave colleagues the opportunity to reflect on their own behaviours and the positive differences that we can make at an individual level.

  Next steps include scoping for project management and quality improvement support, with interested teams to pilot the next stage, a follow-on programme is called 'Calling it out with compassion' and was co-created by Dr Chris Turner and Hadas Levy, Manager Health and Wellbeing, the Royal College of Physicians of Ireland. The programme builds upon the work of Gerald Hickson at Vanderbilt University and develops a network of second messengers (someone not involved in the initial incident) who have kind, respectful conversations with staff whose behaviours have left others distressed.

  The evidence is that if staff are given the chance to reflect on the impact their behaviours had on another person then the vast majority will change, almost all on the first intervention and after the 2nd intervention less than 1% repeat the behaviour and need the intervention of an authority figure.

- **Embedding Serious Incident Learning** - Leading on this reflective discussion approach to ensure compassionate leadership and just culture approaches are key.

- **Thrive Leadership Development Programme -** These the Freedom to Speak Up Guardian continues to support the delivery of 'Creating Psychological Safety' alongside Organisational Development Colleagues.

- **Diversity Networks** - The Freedom to Speak Up Guardian is an integral member of the network and offers guidance, support and leadership to the Chair of the Race and Cultural Awareness Network. The NHS People Plan commitment, which referred to a joint training programme for Freedom to Speak Up Guardians and WRES Experts will further support our inclusive speaking up agenda.

- **Reciprocal Mentoring** - Being part of this programme enhances knowledge and understanding of lived experience and is used to shift awareness and action.

- **Co-Chair Regional Network** - The Freedom to Speak Up Guardian continues to Co-Chair the South West Freedom to Speak Up Guardian Regional Network, offering leadership peer support and advice, although has decided to stand down at the end of the year.

- **RePAIR (reducing preregistration attrition improving retention)** - Invited by Health Education England to support this work for the South West in supporting students to speak up. The Impact of Covid19 study completed last July identified that whilst students are aware of how to raise concerns, a significant number were unsure or would not do so.

- **National Guardian's Office Strategic Framework** - In the 5 years since the Freedom to Speak Up Review, much has been achieved. The strategic direction of the National Guardian's Office is to build on those improvements and to ensure that speaking up arrangements work consistently well. There is now a network of over 700 Freedom to Speak Up Guardians supporting nearly 500 organisations. Universal principles for creating a speak up, listen up, follow up culture, and implementing the Freedom to Speak Up Guardian role, will promote consistency and support the development of a more integrated healthcare system. This Strategic Framework also sets out the intention of the National Guardian's Office to obtain greater assurance about speaking up cultures and the quality and consistency of how the Freedom to Speak Up Guardian role is implemented (NGO 2021).

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AGENDA ITEM: 12/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

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

AUTHOR: Stephen Andrews, Deputy Director of Finance

SUBJECT: **FINANCE REPORT FOR PERIOD ENDING 31st OCTOBER 2021**

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 is to:

- **note** the month 7 position
- **approve** the write-off of the debt owed to the Trust by Misco (UK) Ltd for £38,916.30

Executive summary

- The Gloucestershire ICS has been given a funding envelope for the second half of the financial year (H2) which is being spilt between the partners
- The Trust has a H2 plan of break even
- The Trust's position at month 7 is a deficit of £33k
- The Trust is forecasting a H2 position of break even
- The cash balance at month 7 is £56.0m
- Capital expenditure is £3.208m at month 7
- The Trust has spent £1.212m on Covid related revenue costs between April and October
- The Trust is owed £38,916.30 by Misco (UK) Ltd which went into liquidation in 2017. The Trust has received a final dividend from the administrator of the firm and will not receive any further payments. In accordance with SFIs the Trust Board is asked to approve the write-off of the outstanding balance. There is no impact on the I & E position as the Trust has a provision to cover this loss.

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?
• Trust Board – Resources Committee

Appendices:	Finance Report

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

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AGENDA ITEM: 12.1 /1121

Finance Report Month 7

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

Overview

- Gloucestershire ICS has been given an overall funding envelope for the second six months of 21/22
- Negotiations are continuing to finalise the allocation of the envelope to ICS partners
- The Trust has a H2 financial plan of break even
- At month 7 the Trust has a deficit of £33k and a full year forecast position of break even
- The Trust has recorded Covid related expenditure of £1.212m for April to October
- 21/22 Capital plan is £15.493m, spend to month 7 is £3.208m which is £4.0m less than the ytd NHSI plan
- The Better Payment Policy information is 87% by value (95% in October), the national target is 95%
- During the financial year the Trust has paid 73% of invoices by value within 7 days
- Cash at the end of month 7 is £56.0m, a decrease of £3.4m on last month
- The Trust was owed £39,647.28 by Misco (UK) Ltd when it went into administration in 2017. In August 2021 the Trust received from the administrators acting on behalf of the company a cheque for £730.98 being a first and final dividend against our unsecured claim. No further payments will be received.
- In accordance with SFIs the Board is asked to approve the write-off of the balance of £38,916.30. The Trust has a full provision to cover this loss.

Gloucestershire Health and Care
NHS Foundation Trust

GHC Income and Expenditure

Statement of comprehensive income £000	2021/22 Original Plan	2021/22 NHSI H2 plan	2021/22 NHSI H1 & H2 plan	2021/22 NHSI H1 & H2 plan ytd	2021/22 Actual ytd	Variance	2021/22 Full Year Forecast
Operating income from patient care activities	220,598	120,821	234,701	134,017	136,563	2,546	236,646
Other operating income	6,700	3,819	8,253	5,071	4,855	(216)	7,685
Employee expenses	(170,274)	(91,250)	(177,781)	(101,739)	(104,601)	(2,862)	(179,527)
Operating expenses excluding employee expenses	(53,533)	(32,105)	(62,559)	(35,805)	(35,397)	408	(62,312)
PDC dividends payable/refundable	(2,701)	(1,337)	(2,690)	(1,576)	(1,511)	65	(2,612)
Other gains / losses	0	0	0	0	0	0	
Surplus/(deficit) before impairments & transfers	**790**	**(52)**	**(76)**	**(33)**	**(91)**	**(58)**	**(120)**
Remove capital donations/grants I&E impact	100	52	76	33	58	25	120
Surplus/(deficit)	**890**	**0**	**0**	**0**	**(33)**	**(33)**	**0**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	0	**0**	0	0
Revised Surplus/(deficit)	**890**	**0**	**0**	**0**	**(33)**	**(33)**	**0**

Under the system negotiations for H2 the Trust has been issued with £106,326 from the system envelope v £106,485 requested

GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

STATEMENT OF FINANCIAL POSITION (all figures £000)		2020/21	2021/22	2021/22			2021/22
		Actual	Original Plan	H1 & H2 plan ytd	Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	488	488	488	258	(230)	200
	Property, plant and equipment: other	109,796	119,881	113,552	109,231	(4,321)	118,892
	NHS receivables	276	0	0	0	0	0
	Non-NHS receivables	316	0	0	244	244	252
	Total non-current assets	**110,876**	**120,369**	**114,040**	**109,733**	**(4,307)**	**119,344**
Current assets	Inventories	718	418	618	718	100	418
	NHS receivables	6,077	5,877	6,010	7,624	1,614	5,512
	Non-NHS receivables	5,928	5,928	5,928	5,077	(851)	4,698
	Cash and cash equivalents:	52,333	38,340	46,878	55,981	9,103	47,288
	Property held for sale	0	0	0	0	0	0
	Total current assets	**65,056**	**50,563**	**59,434**	**69,400**	**9,966**	**57,916**
Current liabilities	Trade and other payables: capital	(5,108)	(3,108)	(4,441)	(2,456)	1,985	(5,345)
	Trade and other payables: non-capital	(23,762)	(20,262)	(22,595)	(27,608)	(5,013)	(24,493)
	Borrowings	(107)	(107)	(107)	(109)	(2)	(108)
	Provisions	(3,526)	(1,526)	(2,859)	(3,723)	(864)	(2,933)
	Other liabilities: deferred income including contract liabilities	(2,273)	(773)	(1,773)	(4,230)	(2,457)	(3,144)
	Total current liabilities	**(34,776)**	**(25,776)**	**(31,775)**	**(38,126)**	**(6,351)**	**(36,022)**
Non-current liabilities	Borrowings	(1,363)	(1,363)	(1,363)	(1,308)	55	(1,246)
	Provisions	(1,423)	(1,423)	(1,423)	(1,423)	0	(1,423)
	Total net assets employed	**138,370**	**142,370**	**138,913**	**138,276**	**(637)**	**138,569**
Taxpayers Equity	Public dividend capital	126,578	126,578	126,578	126,578	0	126,576
	Revaluation reserve	6,826	6,826	6,826	6,826	0	6,828
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	6,207	10,207	6,750	6,113	(637)	6,406
	Total taxpayers' and others' equity	**138,370**	**142,370**	**138,913**	**138,276**	**(637)**	**138,569**

Trade and other payables non-capital fallen by £4.2m in October as a result of efforts to settle outstanding invoices

Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 20/21		ORIGINAL PLAN 21/22		ACTUAL YTD 21/22		YEAR END FORECAST 21/22	
Cash and cash equivalents at start of period		**37,720**		**52,333**		**52,333**		**52,333**
Cash flows from operating activities								
Operating surplus/(deficit)	(203)		**2,800**		1,745		2,574	
Add back: Depreciation on donated assets	127		0		66		147	
Adjusted Operating surplus/(deficit) per I&E	**(76)**		**2,800**		**1,811**		**2,721**	
Add back: Depreciation on owned assets	8,734		6,500		4,375		7,238	
Add back: Impairment	5,006		0		0		0	
(Increase)/Decrease in inventories	0		300		(0)		300	
(Increase)/Decrease in trade & other receivables	5,722		200		(348)		1,795	
Increase/(Decrease) in provisions	492		(1,500)		198		(593)	
Increase/(Decrease) in trade and other payables	7,758		(1,500)		(31)		(3,346)	
Increase/(Decrease) in other liabilities	(1,409)		0		1,623		871	
Net cash generated from / (used in) operations		**26,227**		**6,800**		**7,628**		**8,985**
Cash flows from investing activities								
Interest received	9		0		8		15	
Purchase of property, plant and equipment	(10,769)		(17,993)		(3,208)		(11,965)	
Sale of Property	0		0		0		0	
Net cash generated used in investing activities		**(10,760)**		**(17,993)**		**(3,200)**		**(11,950)**
Cash flows from financing activities								
PDC Dividend Received	679		**0**		0		0	
PDC Dividend (Paid)	(1,170)		**(2,800)**		(726)		(1,959)	
Finance Lease Rental Payments	(363)		**0**		(54)		(121)	
		(854)		**(2,800)**		**(780)**		**(2,080)**
Cash and cash equivalents at end of period		**52,333**		**38,340**		**55,981**		**47,288**

Covid 1

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has spent £1.2m up to 31st October 2021
- The Trust has received system COVID funding for the in envelope expenditure
- Out of envelope income has been included at £164.9k

For periods up to and including 31/10/2021 (M7)	Original Plan 21/22 (£)	Actual ytd Expenditure (£)	Actual ytd Income (£)	YTD Net (£)	Full Year Net Forecast (£)
Expand NHS Workforce - Medical / Nursing / AHPs	507,832	**254,621**		**254,621**	**363,385**
Remote management of patients	186,000	**108,500**		**108,500**	**186,000**
Existing workforce additional shifts	223,440	**28,488**		**28,488**	**52,416**
Decontamination	82,510	**26,075**		**26,075**	**37,156**
Backfill for higher sickness absence	223,440	**100,475**		**100,475**	**139,270**
Remote working for non patient activites	186,000	**108,500**		**108,500**	**186,000**
National procurement areas	72,000	**0**		**0**	**0**
Other	174,000	**0**		**0**	**0**
COVID-19 virus testing (NHS laboratories)		**420,258**	**(420,258)**	**0**	**0**
TOTAL IN ENVELOPE	**1,655,222**	**1,046,917**	**(420,258)**	**626,659**	**964,228**
Vaccine Program - Local Vaccination Service	0	**68,878**	**(68,878)**	**0**	**0**
Vaccine Program - Lead Employer	0	**72,826**	**(72,826)**	**0**	**0**
Vaccine Program - 12-15s	0	**23,240**	**(23,240)**		
TOTAL OUT OF ENVELOPE	**0**	**164,944**	**(164,944)**	**0**	**0**
Net Expenditure over Income	**1,655,222**	**1,211,861**	**(585,202)**	**626,659**	**964,228**

Capital – Five year Plan

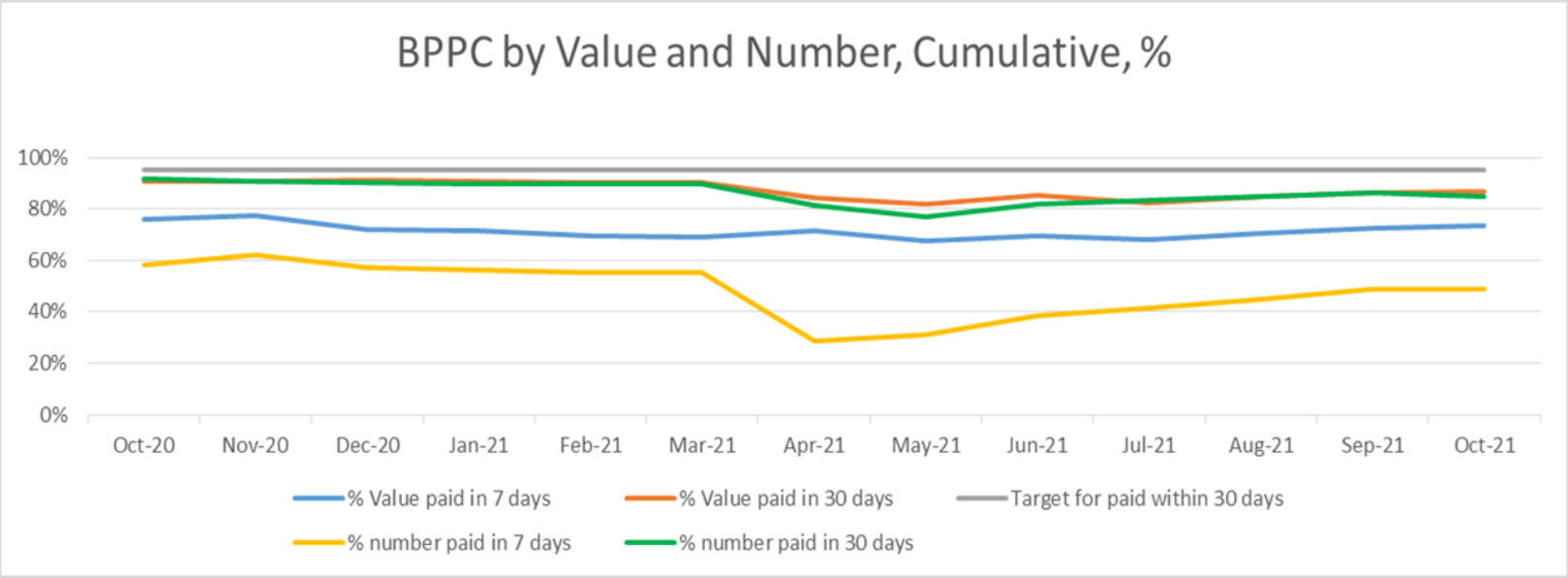
Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Revised Plan	Plan to Date	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan	
£000s	2021/22	2021/22	2021/22	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Land and Buildings									
Buildings	4,692	2,940	947	4,692	2,000	2,500	1,000	1,000	11,192
Backlog Maintenance	3,467	1,340	841	3,467	0	2,876	1,250	1,393	8,986
Urgent Care	750	563	34	750					750
Buildings - Finance Leases							1,500		1,500
LD Assessment & Treatment Unit						2,000			2,000
Cirencester Scheme						5,000			5,000
Medical Equipment	2,282	839	490	2,282	0	130	1,030	1,030	4,472
IT									
IT Device and software upgrade	800	200	(2)	800	0	600	600	600	2,600
IT Infrastructure	1,086	560	251	1,086	996	1,300	1,300	1,300	5,982
Clinical Systems						1,000			1,000
Unallocated	(100)			(100)			2,300	2,300	4,500
Sub Total	**12,977**	**6,442**	**2,561**	**12,977**	**2,996**	**15,406**	**8,980**	**7,623**	**47,982**
Forest of Dean	2,516	1,230	647	2,516	11,500	8,500	0	0	22,516
Total of Original Programme	**15,493**	**7,672**	**3,208**	**15,493**	**14,496**	**23,906**	**8,980**	**7,623**	**70,498**
Disposals					(1,349)	(2,454)	(2,000)	0	(5,803)
Donation - Cirencester Scheme					0	(5,000)	0	**0**	(5,000)
Net CDEL	**15,493**	**7,672**	**3,208**	**15,493**	**13,147**	**16,452**	**6,980**	**7,623**	**59,695**
Anticipated CDEL	**15,493**				**11,493**	**10,993**	**10,993**	**10,993**	**59,965**
CDEL Shortfall (under commitment)	**0**	**7,672**	**3,208**	**15,493**	**1,654**	**5,459**	**(4,013)**	**(3,370)**	**(270)**

There are no Capital Business Cases requiring Board approval in the next 3 months.
Forest of Dean scheme includes prior year spend of £1.4m giving total scheme cost of £23.9m
This programme does not include any mitigations except bringing forward £1.5m of FoD spend, removing £1m from unallocated and deferring £0.5m of buildings schemes into 22/23

Prompt Payment of Suppliers within 30 and 7 days

Better payment practice performance for 2021-22 has improved through the year
The dip in achieving the 95% target will continue whilst the Trust focuses on a continued effort to pay older and problematic invoices.
This requires Budget Holders to regard the prompt paying of invoices as important too as their timings on authorising invoices has a significant impact on these targets.



Risks

Gloucestershire Health and Care
NHS Foundation Trust

Risks to delivery of the Trust's financial position are as set out below:
The risk 'Efficiencies need to be higher than assumed for H2' has been removed
A new risk ' 20/21 efficiency reinstated' has been added to the Risks 22/23

Risks 21/22	21/22 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Differential CIP schemes	124	124	0	2	1	2
Delivering Value Scheme CIPs	618	618	0	4	2	8
Risks 22/23	**22/23 Risks**	**Made up of: Recurring**	**Made up of: Non Recurring**	**Likelihood**	**Impact**	**RISK SCORE**
IFRS 16 revenue impact not fully funded	1,500	1,500	0	4	3	12
Remaining 21/22 CIP made non recurrent, then delivery needs to be	742	742	0	3	2	6
20/21 efficiency reinstated	1,900	1,900	0	4	3	12
Total of all risks	**4,883**	**4,883**	**0**			

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AGENDA ITEM: 13/1121

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 25 November 2021**
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 – including updates on Non-Executive Directors
- Governor activities – including updates on Governors
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

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 – September and October 2021

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

REPORT FROM THE CHAIR

1. 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. BOARD UPDATES

2.1 Non-Executive Director (NED) Update:

- The Council of Governors recently approved a second three-year term for Non-Executive Director Sumita Hutchison.

- The Non-Executive Directors and I continue to meet regularly, and meetings were held on 26th October and 9th November. NED meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive as the Trust continues to juggles pandemic issues – direct and indirect, winter pressures and routine business while still striving to continuously improve the way we operate.

- I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

2.2 Trust Board Meeting:

An **Extra-ordinary meeting of Trust Board** took place on 3rd November to further discuss the new Forest of Dean Community Hospital.

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 high quality care and colleagues' wellbeing. The following sessions have taken place:

7th October – People Participation workshop – a helpful development session as we consider ongoing working with stakeholders
19th October – Board Development Workshop, facilitated by The King's Fund
3rd November – Board Seminar on Well Led - both the CQC Framework and the NHSE/I Developmental Review – which we will be taking forward next year.
3rd November – Board Development session on the ICS Constitution – important updating and reflection session to consider how the ICS and the

constituent members will work together – both jointly and as independent organisations – making best use of resources, times and skills and ensuring appropriate accountabilities were key considerations.

3. GOVERNOR UPDATES

- A meeting of the Membership and Engagement Committee was held on 6th October where we discussed progress with the Membership and Engagement Strategy and how Membership and Engagement can be promoted and supported by the Trust and Council of Governors.

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 13th October along with Trust Secretary / Head of Corporate Governance Lavinia Rowsell, and Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for the Council meeting on 10th November. **Chris Witham** and I also had a one-to-one meeting on 4th November. These sessions are helpful as we work together to further develop the Council of Governors and ensure that the Governors are fully sighted on the work of the Trust and able to provide appropriate challenge, support and input.

- A meeting of the **Nominations and Remuneration** Committee was held on 27th October where matters discussed included NED reappointment; Review of Chair and NED remuneration; Annual NED skills audit; Deputy Lead Governor role and Membership and Election report.

- A meeting of the **Council of Governors** was held on 10th November 2021 where in addition to routine matters, the meeting received an update on Integrated Care System (ICS) Developments from the Chair of the ICS Board, Dame Gill Morgan; an update on the Forest of Dean hospital development plans from the Trust's Director of Strategy and Partnerships, Angela Potter and a holding to account presentation on the Charitable Funds Committee from Chair of the Committee, Non-Executive Director, Sumita Hutchison.

- I had introductory meetings with new Staff Governors **Erin Murray** on 4th November and **Paul Winterbottom** on 11th November.

- **Governor changes**: I would like to record my thanks to Katie Clark, Staff Governor who will step down in December for her 6 year contribution to the Council of Governors. Katie's expertise on training and development and links with colleagues enabled her to provide a wide ranging contribution to the Council, including much appreciated advice on the use of Teams as we transitioned to virtual working. We are currently in election processes for Public Governors from Stroud and the Forest of Dean.

4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in September, I have attended a breadth of national meetings:

- **NHS Providers Community Provider Chairs Network** – 26th October – this was an informal opportunity for Community Provider Chairs to meet virtually to discuss sector priorities.

- **NHS Providers Community Network** – 26th October – I was unavailable to attend this meeting, so was represented by Vice-Chair Graham Russell. Matters discussed included an update from the Care Quality Commission; an update from NHSE/I; and a Strategic Policy Update from NHS Providers.

- **NHS Providers Annual Conference** – 16th and 17th November. This year's event highlighted the work Trusts are doing to deliver integration and explored how to embrace new opportunities across the health and social care system, and create a sustainable NHS fit for the 21st century. Keynote speakers included NHS England Chief Executive Amanda Pritchard who talked about priorities going forward and the Secretary of State for Health and Social Care, Sajid David who shared his priorities and ambitions for the NHS in the future.

- **NHS Confederation NHS Reset Webinars** continue to take place on a regular basis and 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 past months.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits.

5. 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:

- I met with **Mark Yates, Chair of Worcestershire Health and Care NHSFT,** on 6th October to discuss matters of mutual interest.

- I chaired a **Children and Young People's Mental Health Summit on 7th October 2021.** The event was organised by Gloucestershire ICS to further develop our county-wide commitments to better support our young people's mental health. One in eight children and young people already have a diagnosable mental health condition, and research suggests that the pressures created by the Covid-19 pandemic are exacerbating their needs. We know that children and young people from certain demographics are already disproportionately affected by mental health issues, with the pandemic widening these inequalities as well as increasing the overall prevalence. While our children's mental health support services in Gloucestershire deserve enormous credit for responding to the challenges of the pandemic so far, we are unfortunately already seeing an unprecedented and sustained surge in need across the county. There has also been ongoing work to make improvements to support across the county including on line options, support in schools and creative health, as well as further recruitment of staff to services. With demand likely to continue, we cannot afford to lose momentum.

- Along with the Chief Executive and Director of Strategy and Partnerships I attended a meeting of the County Council's **Health Overview and Scrutiny Committee** on 12th October. This meeting primarily focussed on the Gloucestershire NHS Urgent and Emergency Care Winter Sustainability Plan (2021-22) and a performance update about South West Ambulance NHS Foundation Trust (SWAST). The next meeting on 30th November is focussing primarily on matters relating to mental health.

- I attended **Gloucestershire Hospitals NHSFT Annual Members Meeting** on 19th October.

- Following recent interviews, **Mary Hutton** has been appointed as the **Chief Executive Designate of the Gloucestershire Integrated Care Board (ICB)** subject to the new statutory NHS body coming into being on 1st April 2022. The Trust offers congratulations to Mary Hutton on her appointment.

- The Trust's **Annual Informal meeting with Gloucestershire County Council's Health Overview Scrutiny Committee (HOSC**) was held by MS Teams on 28th October. The Chief Executive gave an overview of Trust activities over the last 12 months and presentations were received from Sarah Walters (Deputy Service Director, Urgent Care and Speciality Services) on the Rapid Response service; Justine Hill (Deputy Service Director, Mental Health Specialist Services) and Rosemary Neale (Service Director, Adult Community Mental Health and Learning Disabilities) on Eating Disorders; and Marc Pratt (Team Leader, Intensive Health Outreach Team) on the work of the Learning Disabilities Intensive Health Outreach Team.

  HOSC Members expressed their grateful thanks to colleagues for their very informative updates and presentations. I would also like to put on record my thanks to colleagues for taking the time out of their extremely busy schedules to attend the meeting with HOSC to talk about the important work they undertake for the Trust to help provided a broad understanding of the wide range of GHC's work within the County. It is hoped that next year's meeting can revert back to being held at one of the Trust's clinical services.

- I was invited to attend the **Forest of Dean Health Forum**'s monthly meeting on 2nd November to talk about the role of the Governor and Membership of Trust. It was a lively meeting with an interesting question and answer session.

- The Chief Executive and I had a further meeting with the **Police and Crime Commissioner, Chris Nelson**, and **Deputy, Nick Evans**, on 3rd November where we discussed matters of joint interest and concern.

- Along with the Trust's Non-Executive Directors and the Lead Governor, Chris Witham, I attended a meeting of the **NED and Lay Member Network** on 8th November where we received an update from the Chair of the ICS, Dame Gill

Morgan; discussed the ICS Transition; and received an overview of the System Oversight Framework.

- I am a **Trustee of the Gloucestershire GP Education Trust (GGPET**) and attended their AGM on 10th November.

- **A meeting of the ICS Board** was held on 18th November where a number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported and ensures that we are thinking jointly about the "new normal"

- 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, Dame Gill Morgan.**

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- Annual meetings with the County's MPs continue and the Chief Executive and I met virtually with:

  Mark Harper, MP for the Forest of Dean, on 1st October
  Richard Graham, MP for Gloucester, on 12th November
  Laurence Robertson, MP for Tewkesbury, on 23rd November, and
  Sir Geoffrey Clifton-Brown, MP for Cotswolds, on 24th November.

- The Chief Executive, Director of Partnerships and Strategy and I held a meeting with **Healthwatch Gloucestershire** on 5th October to discuss matters of mutual interest.

- I was invited to visit the **Redwell Centre in Matson** on 20th October. The Redwell Centre provides positive responses and resources to help to combat challenges faced by members of the local community, and utilises the experience and knowledge of the community people to help build support networks and achieve a strong sense of community. I was very impressed with the work undertaken at the Centre and my grateful thanks to Vanessa and her team for an enjoyable and very informative afternoon. I particularly liked the concept of the "Happy Coach" – underlying the importance of wellbeing across all organisations.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- This year's annual awards event, now rebranded as "**Better Care Together Awards**" will be taking place on the evening of Weds 1st December and I was pleased to be asked to chair the judging panel on 14th October. The judging panel was made up of a wide selection of colleagues from across all areas of the Trust.

- I met with **Andy Telford (Deputy Director, Adult Community Services**) on 14th October for a briefing on the Community Mental Health Transformation Programme. Further information can be found in Agenda Item 15 at today's Public Board.

- I continue to attend the Trust's Committees on a rotational basis and attended the **Mental Health Legislation Scrutiny Committee** on 20th October and **Resources Committee** on 2nd November.

- I had an informal discussion with **David Noyes** who will be joining the Trust on 10th January 2022 as Chief Operating Officer.

- **Appointment and Terms of Service Committee (ATOS**) was held on 9th November 2021.

- **Armistice Day (also known as Remembrance Day)** - 11th November.

  To mark the day the Trust held a **virtual Act of Remembrance** via MS Teams, which included a poetry reading by Veterans Champion Simon Shorrick and a two-minute silence at 11am.

  Poppies to Paddington - Veterans Steering Group Lead Jonathan Thomas and Nicola Shilton, the Trust's Partnership and Inclusion Assistant Development Worker, laid a wreath on behalf of the Trust and the NHS at Gloucester Railway Station on Remembrance Day, as part of the Poppies to Paddington initiative.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting when possible with the Chief Executive and the Trust Secretary/Head of Corporate Governance.

  Whilst drop in chats with services and colleagues continue to be mainly virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I have an active presence on social media to fly the GHC flag and highlight great work across the county.

8. 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 September and October 2021.

9. 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 – 31st October 2021

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr. Stephen Alvis	Forest of Dean new hospital Sustainability Workshop Gloucestershire CCG AGM Meeting with Director of HR & OD Meeting with Trust Chair MHAM personal review (4) Non-Executive Directors Meetings (2) Nosocomial Transmission Case Team meeting Quality visit to Homeless Healthcare Centre Senior Leaders Network (2) Team Talk	NHS Chairs Reset Group (2) GGI NHS NED Development Programme webinar (2)	Annual Audit and Assurance Committee evaluation Board Development session Forest of Dean Assurance Committee MHAM Forum MHLSC People Participation Board Workshop Quality Committee Trust AGM Trust Board
Maria Bond (until 30th Sept)	EPRR meeting Meeting with Director of Finance Meeting with Director of Nursing Meeting with Director of Strategy and Partnerships Meeting with Expert by Experience Meeting with Head of Corporate Governance Non-Executive Directors Meetings Quality visit to St Paul's Dental Clinic Reciprocal Mentoring Workshop		Annual Audit and Assurance Committee Evaluation Appointments and Terms of Service Committee Quality Committee Trust AGM Trust Board
Clive Chadhani (from 20th Sept)	Induction visit to Tewkesbury Hospital Induction visit to Vale Hospital Induction visit to Wotton Lawn Hospital Meeting with Head of Integrated Community Teams Meeting with Trust Chair Non-Executive Directors Meeting		Board Development session People Participation Board Workshop Trust AGM Trust Board

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Director of HR&OD Meeting with Director of Nursing Meeting with Director of Strategy and Partnerships Meeting with Head of Corporate Governance Meeting with Head of Counter-Fraud Meeting with Medical Director Meetings with Director of Finance Meetings with Non-Executive Directors		
Steve Brittan	Forest of Dean new hospital Sustainability Workshop Meeting with Director of Finance Meeting with Medical Director Meeting with Non-Executive Director Meeting with Non-Executive Director Meetings with Sustainability Manager (2) Meetings with Trust Chair (2) NHS Non-Executive Directors meetings Quality visit to Telecare Service Quarterly Audit of Complaints	NHS Chairs Reset Group	Annual Audit and Assurance Committee Evaluation ATOS Committee Board Development Forest of Dean Assurance Committee People Participation Board Informal Workshop Trust AGM Trust Board
Marcia Gallagher	Gloucestershire CCG AGM Meeting with Chair and Vice-Chair Meeting with Director of Finance Meeting with Head of Corporate Governance Meeting with NHS England Assistant Director Meetings with Director of Finance (2) Mental Health Act Managers meeting Non-Executive Directors Meetings Pre-meet with Head of Governance Quality visit to Cirencester Mental Health Recovery Team	Forest Health Forum Good Governance Institute Meeting	Annual Audit and Assurance Committee Evaluation Appointments and Terms of Service Committee Board Development session Briefing session with Governors on Annual Report Holding to account session Governors Quality Committee Trust AGM

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Consultant Appointment Committee Meeting with Chair of Resources Committee Meeting with Emily Beardshall (CCG)		
Sumita Hutchison	Better Care Together Awards Judging Panel Member Diversity Network Meeting with Director of Strategy and Partnerships Meeting with Medical Director and Non-Executive Director Meeting with Non-Executive Director Meeting with Staff Governor Non-Executive Directors meetings Quality visit to Perinatal Mental Health Service	Masterclass in wellbeing data South West Health and Wellbeing Guardian meeting	Annual Audit and Assurance Committee Evaluation Board Development session Great Place To Work Committee Mental Health Act Legislation Committee People Participation Board workshop Trust AGM Trust Board
Jan Marriott	Ageing Well Programme Board Housing and Care Workshop ICS Quality Transition Board ICS Quality Transition Programme Board Meeting ref MHLSC agenda Meeting with Associate Director of Quality Assurance and Compliance Meeting with Chair of Quality Committee Meeting with FTSU Guardian Meeting with Non-Executive Director Meeting with Tewkesbury Governor Meeting with Trust Chair Non-Executive Directors meetings Oliver McGowan Project Board Quality Assurance Group Quality visit to Wheelchair Service Reducing Reoffending and Rehabilitation Workshop		Appointments and Terms of Service Committee Board Development session Council of Governors People Participation Board workshop Quality Committee Trust Board

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	ICS Quality Transformation Chairs meeting Meeting with Coproduction Wales and Becky Parish Quality Assurance Group		
Graham Russell	Forest of Dean Hospital Sustainability briefing GHC Housing and Care Workshop ICS Board pre-meet ICS CEO interview discussion group Meeting with Chair and Senior Independent Director Meeting with Director of HR & OD Meeting with Director of HR & OD Meeting with Senior HR Team Meetings with Trust Chair Non-Executive Directors meeting Quality visit to Weavers Croft, Stroud University of Gloucestershire and GHC sustainability workshop	Meeting with Chair of Stroud League of Friends NHS Providers Community Network meeting	Annual Audit and Assurance Committee Evaluation Board Development Council of Governors Forest of Dean Assurance Committee Great Place to Work Committee ICS Board ICS Board/Gloucestershire Health and Wellbeing Board Trust AGM Trust Board

AGENDA ITEM: 14/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

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

Recommendations and decisions required

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

Executive Summary

The report summarises the work led by or participated in by the Chief Executive (CEO) since the last Board meeting. It there paints a picture of the wider ranging involvement and activity of the Trust. As an Executive Team we continue to navigate the continuing pandemic, recovery, and service pressures. Despite the operational pressures we are working to meet the needs of our service users, support staff and to achieve the aims set out in the Trust Strategy.

The paper describes the system pressures which, at this time, are at an all-time high which have inevitably raised concerns about the wellbeing of colleagues and the potential for burnout and fatigue in services across the Trust. The Executive Team have heard and seen the challenges colleagues are facing and are putting plans in place to help support colleagues, especially through the upcoming winter months.

Despite the challenges presented, we continue to push forward to achieve our goals and support the community of Gloucestershire by providing the best possible care, as a Trust, as part of the Integrated Care System (ICS), as part of the region, and as part of the wider NHS.

The report focuses on the work led by the CEO and highlights ongoing joint working, within Gloucestershire, the South-West and more widely, to ensure we are benefitting from best practice that others have developed and highlighting developments we are taking forward. As well as updates on the activity and focus of the CEO, this report provides an update on the initiatives the Executive Team are working on to help support colleagues.

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?

Appendices:	

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

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

1.1 Covid-19 update

At the time of writing this report, the latest Covid data outlines that Gloucestershire currently has a rate of 450 cases per 100,000 population. Colleagues are working hard to continue to plan and implement vaccine delivery, including booster vaccines, school immunisation programmes, and winter flu vaccines.

The gradual reduction in the infection rate is welcome following a peak in Gloucestershire earlier in the month which led to the highest number of Covid admissions into Gloucestershire Hospitals NHS Foundation Trust (GHFT) since February. Admissions into the Gloucestershire virtual Covid ward, where patients receive escalated home monitoring and support, also climbed significantly. Alongside other health and care system partners GHC deployed escalation measures to support our Covid response.

12-15 Vaccination Programme

The young people's mass vaccination programme is in progress. As this report is being written 29 schools have had their vaccination clinics completed and virtually all schools have been scheduled. With the commitments and activities across the system and the high priority of the flu vaccination programme, workforce has been a challenge but the workforce has been identified to complete this programme.

There are c28,000 eligible 12-15 year olds in Gloucestershire. Uptake has been significantly affected by the high infection rate in Gloucestershire which was particularly prevalent in young people. This has led to significant isolation absence in schools and there has to be a significant gap for young people between having Covid and safely taking the vaccine.

Jointly with Gloucestershire County Council, the NHS in the County is embarking on an appropriately targeted publicity campaign to increase take–up.

The core programme is being delivered by the Covid Mass Vaccination team in GHC. The team was established in December 2020 to support the PCNS to deliver the vaccine programme with a focus on those for whom the mainstream vaccination offer was not accessible. This included those who are housebound, those with health needs in cohort 6 (e.g. Mental Health, LD, homeless) and other community groups that required a bespoke offer. Having this established team in place and using the learnings from the Covid vaccination programme to date and the experience of colleagues from the School Age Immunisation team we are able to delivery both the Covid vaccinations in schools and continue with the winter flu annual programme for children.

We continue to expand the workforce and are working in partnership with the GHFT staff bank to pool vaccinator resources to ensure this programme, the Covid booster for those over 50s, and the HSCW boosters can be delivered simultaneously.

Workforce has been a big challenge and no different to any part of the health and social care delivery at present however, helpfully from 1st November NHSE are allowing appropriately trained and supervised non-registered staff to deliver the vaccine to young people.

The key approach for the school programme has been to engage with the head teachers. This started in advance of the official sign off from the government to ensure schools were well briefed and prepared in advance knowing this would be a tight turn around. Schools have been hugely supportive and working in collaboration ensured we have an effective model of delivery, vaccinating up to 500 children in the larger schools per day.

We are maintaining a focus on the safe and effective delivery of the programme, ensuring good planning, time for parents to understand the information and seek support and consent to the vaccination with their young people should they wish to. We and other providers have fed back to the regional and national team that we will not comprise safety of our staff, young people or the school staff or the quality of the service we provide and therefore time frames to complete the programme should be reviewed.

In half-term, Primary Care Networks commenced a programme of supplementing the schools programme by offering a combination of drop-in and booked appointments for 12-15 year olds. This nearly doubled the capacity to deliver the programme. This programme managed by the PCNs has continued since half-term.

Sadly, Anti Vax activity has added additional challenges for schools, vaccination hubs and the vaccination team. However, working in partnership and with the support of GHC security colleagues and the LRF, we have a robust plan in place to assess and manage any risks. I would like to put on record my thanks to the police for their support when needed.

29 out of 73 schools have been completed. Currently 2 school vaccination sessions a day are being carried out with 43 school vaccination sessions confirmed between now and 14/12/2021. By the 21st November 51% of children had been offered a vaccine through the schools programme and many more through PCN sessions.

Vaccination for NHS colleagues

The Department of Health and Social Care has confirmed it will become compulsory for NHS workers in frontline roles to be fully vaccinated from April next year. To ensure colleagues have ease of access to vaccines we have been holding regular drop in vaccination clinics throughout the past month. Further

pop up clinics will be coordinated to provide ample opportunities for colleagues to receive their vaccinations. Additionally, the Working Well team is working closely with colleagues to address any possible implications of the mandatory requirement.

1.2 Wider system pressures

The pressure under which the NHS is working at the moment has received wide coverage in the media both locally and nationally. The combination of the pandemic, particularly the resurgence in recent weeks, supressed demand now turning into referrals and pressures on workforce in all sectors has put our system under relentless pressure.

I will update the Board at the meeting on the current operational situation across our services. I wanted, however, to put on record my gratitude to colleagues across the Trust and the wider system who are currently under unsustainable pressure. I have visited and met many staff in recent weeks and as ever have been impressed by their dedication and commitment. We will continue to work, as a leadership team, to support them in both morale and practical terms – it is our top priority. See section 2 below.

1.3 Internal engagement and developments

The Trust has continued to hold its **Covid-19 briefing calls** for senior and on call managers. The frequency of these meetings is dictated by the level of activity in the Trust and system, and are currently being held twice weekly. These calls provide daily national, regional and local updates and data on the number of Covid-19 positive patients in Gloucestershire hospitals. They also provide an update on the GHC testing team, the 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 regular basis and put in place any actions required.

A virtual **Senior Leadership Network** (SLN) meeting was held on 26th October. This provided an excellent opportunity to update participants on Trust and national developments. The October session featured an informative update and workshop from the project team on the clinical systems vision, followed by a presentation from Cheryl Haswell, **Matron, Forest of Dean Community Hospitals**, on learnings from Speaking Up at the Dilke Community Hospital supported by Sonia Pearcey, **Freedom to Speak Up Guardian**.

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-19 and workforce news, amongst other recent items of interest. The Team Talk sessions help to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team. I led the session held on 13th October which covered Black History month, flu vaccinations, Freedom to Speak Up month, a training update on the CITO Electronic Document

Management System, and healthcare ambassadors' updates; local good news stories and updates were also shared.

Corporate Induction is back to being held fortnightly. Corporate Inductions continue to provide an excellent opportunity for myself and/or the Executive Team to welcome new colleagues into the Trust, introduce our core values, and ensure that everyone feels included. I was pleased to be able to welcome new starters to the Trust on 11th October. It is also good to see an increasing number of new colleagues join the Trust as our recruitment drive ramps up.

I attended the **Board Development** session which took place on 19th October. The key theme of this workshop was *Effective Challenge: Creating Unitary Board Governance.*

On 3rd November two **Board Seminar** sessions were held. The first, covered the *NHS Well-Led Framework: an introduction & self-assessment*. The second was facilitated by ICS colleagues and covered the *ICS Constitution*.

On 20th October I took part in and completed the **Bronze Quality Improvement (QI) training**. This training features a half day introduction to Quality Improvement using the Institute for Healthcare Improvement's Model for improvement with the aim to give participants the knowledge and skills to be able to get involved in QI work within their team and across the Trust. I was keen to undertake this training personally because I strongly believe that QI must be at the heart of our efforts to improve our services and feel that I should be able to talk about it from a position of knowledge.

I attended the **Appointment and Terms of Service Committee** meeting on 9th November for the interim reviews of the Executive Directors performance and remuneration. It is the responsibility of the Chief Executive to complete the interim reviews and reports for the Appointment and Terms of Service Committee. The interim reviews offer a good check-in point to assess progress on objectives for the Executive Team and helps provide encouragement and support in achieving these objectives, as well as an opportunity for any concerns to be raised. The Executive Team individually and collectively have delivered significantly on agreed objectives so far in 2021/22 and I am truly grateful to them all.

Weekly **Executive Director Meetings** continue, where collectively the Executive Team oversee the day-to-day, and longer-term executive management of the Trust. Key agenda items over the past two months have included: clinical service pressures, support for staff (outlined further in section 2.0), the Medical Job Plan Policy, recruitment and retention, learning disability acute pathway review, the operational recovery programme, and the ICS development and transition.

I chair the **Trust Senior Team Meetings** bi-monthly, which were launched in June. The Trust Senior Team is a forum to bring together senior management and clinical leaders to provide advice to the Executive on the direction and operational management of the Trust. The meeting held on 12th October included an update from the Diversity Network Chairs including updates on the

Women's Leadership Network, RCAN, Disability Awareness Network and LGBTQ. Linda Gabaldoni (Head of Leadership and Organisational Development) presented on inclusive succession planning. Julie Goodenough (Service Director, Hospitals) presented on Inpatient Services. There was also a discussion on ICS developments and estates strategies led by Angela Potter (Director of Strategy and Partnerships). The senior team meetings support the Executive in the delivery of the Trust's strategic aims and objectives through a focus on performance, delivery and leadership development.

I provided the Chief Executive's update at the **Non-Executive Directors meeting** on 9th November.

I attended the **Council of Governors** meeting on 10th November.

I led the **Staff Forum** on 24th October. The discussion was centred around the topic of *what more we can do to help, encourage and recognise colleagues at times of increasing pressure?* This is discussed further in section 2.

1.4 Mental Health Focus

My own focus on mental health is local, regional and national to progress the mental health agenda as the wider impacts of the pandemic manifest themselves and as services consider how mental health services can continue through the service recovery process. Throughout these conversations and meetings, it is evident that all colleagues and partners believe in the importance of Mental Health Services and are working tirelessly to ensure the best possible service is given across the Trust. As well as the implications for individual citizens these pressures have an impact on all public services. The aim at the establishment of the Trust to provide joined up services, which consider a service users physical and mental health concerns, continue to be an important strand of this work.

I chaired the **South West Regional Mental Health Programme Board** on 28th October. The Mental Health Programme Board looks to develop, implement and support the long-term plan, ambitions, and South West-wide Mental Health priorities. The October meeting discussed Children and Young Persons (CYP) benchmarking, mental health provider collaboratives, the mental health dashboard across each system, high impact changes, risk register development and the Regional Mental Health Summit.

I chaired the monthly **South West (Regional) Mental Health CEO's** meeting on 15th October and 19th November. This group acts as the overarching governance summit for the regional South West NHS Provider Collaborative and provides an opportunity for CEO colleagues to raise key issues about mental health services across the region and to offer mutual support.

I also held a 2:1 meeting with Melanie Walker (Chief Executive, Devon Partnership Trust, which hosts the collaborative) and Anne Forbes (Programme Director for the collaborative) to discuss the SW Mental Health collaborative governance and leadership.

On 5th November I facilitated the **South West Regional Mental Health Summit** alongside Rachel Pearce (Director of Commissioning NHS England and NHS Improvement – South West) and Justine Faulkner (Programme Director-Mental Health, NHS England and NHS Improvement South West). This session was aimed and re-examining and restating our ambitions with regard to achieving the improvements and investments in Mental Health Services set out in the NHS Long-term Plan. At the session looked at updates from all the regions including priorities, challenges and opportunities, a presentation on the five-year modelling of LTP delivery, followed by a collaborative working discussion on regional ambitions and how these can be achieved. This work will be followed up by a small group from across the region.

The bi-monthly national NHS England **Mental Health Trusts CEO meeting**, chaired by Claire Murdoch continues to take place. Over the last two months these useful sessions provided updates on mental health, learning disabilities and autism and featured presentations on winter vaccinations, digital mental health updates (Smart Foundations assessment), mental health discharge seasonal pressures funding, SHOUT crisis text line (pilot partnership with Trusts) and mental health provider collaboratives.

In Gloucestershire, I now chair the **Community Mental Health Transformation (CMHT) Programme Board**. The CMHT meeting held virtually on 11th November discussed updates from the People Representative Action Board (formerly the People's Participation Board), NHSE updates and submissions, CMHT programme priorities, as well as the CMHT board membership and future arrangements.

I had many informative meetings to discuss Mental Health initiatives across the South West including monthly meetings with **Regional Director of Commissioning, Rachel Pearce**, and a meeting with **Programme Director for New Care Models, Anne Forbes.**

1.5 Tackling Inequalities

I have continued to develop my work as **lead CEO for tackling inequality,** for the Gloucestershire ICS (Integrated Care System). I regularly convene and attend meetings that seek to respond to and in the longer term prevent the systematic inequalities brought to light by the pandemic, as well as the long-standing inequalities which were already recognised. As part of this work, Gloucestershire County Council and the ICS have established an "**inequalities panel**", which I have joined. This is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme. The next meeting for this panel is scheduled for 29th November.

I am a member of the **South West Inequalities Leadership Forum** which is designed to share good practice and monitor progress across the South West NHS Region. The most recent meeting took place on 15th November and discussed Elective Recovery, Core20PLUSS, childhood oral health, as well as developing an approach to population health.

I chair the monthly **Gloucestershire Covid-19 Vaccination Equity Group**, which took place on 10th November. The group discussed next steps and actions needed alongside the booster programme and school aged immunisations to ensure our efforts are equitable and accessible to all.

I am a member of the **SW Equality Diversity and Inclusion Board** and attend monthly meetings that discuss various initiatives focusing on improving the experience of NHS colleagues.

I attended the **Walk In My Shoes (WIMS)** community reverse mentoring programme meeting on 24th November at which we discussed and agreed the approach to putting this programme on a more sustainable longer term basis supported by a local third sector organisation. We hope to make announcement about this in the new year

The **Reciprocal Mentoring for Inclusion in GHC** advisory meeting took place on 18th November. I continue to take part in this programme and have had sessions with both Kizzy Kukreja (Senior Dental Officer) on 18th November and Clare Turner (International Recruitment Project Manager) on 22nd November.

I continue to meet with new **International Nurses** who join the Trust each month. Recently I have had the pleasure of welcoming Shavanna Charles and Chaitra Kuvalekar. We are very privileged as an organisation to have such a diverse workforce and greatly benefit from the knowledge and experiences that international team members bring to the Trust.

I met with Dr Bola Owolabi, Director – Health Inequalities, NHS England & Improvement, on 9th November to discuss the **Better Care Together Programme** – **Mental Illness and Inequalities Event** which is taking place on 9th December. Dr Bola Owolabi kindly agreed to be the keynote speaker for the event.

Equality, Diversity and Inclusion continues to be at the core of how we operate as a Trust and my involvement in the wider agenda helps us achieve our aims in this regard.

1.6 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)** – Deborah Lee and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** - Mary Hutton to keep abreast of any issues facing our partner organisations.

Professor Sarah Scott, Executive Director of Adult Social Care & Public Health and I met on 22 November to discuss a range of operational and strategic challenges common to our organisations and the system.

Dame Gill Morgan, Chair, Gloucestershire ICS, and I met virtually on 18th October. We hold regular meetings every 6 weeks to discuss matters arising across Gloucestershire.

On 18th October I attended the **Gloucestershire Hospitals NHS Foundation Trust AGM**.

The **ICS Board**, **ICS Executive** and **ICS CEO Meetings** continue to take place monthly focusing on system-wide planning and resilience, and provide updates on organisational matters and projects. 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 took part in the **stakeholder panel for the NHS Integrated Care Board CEO interviews** on 21st October. I am delighted to extend my congratulations to Mary Hutton on her successful appointment as the Chief Executive designate of the Gloucestershire Integrated Care Board.

I attended the **ICS Board and workshop** on 18th November which featured a session with Ernst & Young on their report for the ICS Board *Developing the ICS's future approach to commissioning,* a discussion on the Integrated Care Board's constitution and current system pressures including a workforce update.

I took part in the **Delivering Value Workshop** on 4th November. This workshop was facilitated by the Clinical Commissioning Group and focused on the importance of delivering value-based care. Dr Sally Lewis, National Clinical Lead of Value Based and Prudent Healthcare, provided the keynote speech which was both informative and inspiring.

The **Health Overview and Scrutiny (HOSC)** meeting took place on 12th November. Updates were provided and discussed on the South West Ambulance Service, Gloucestershire NHS Urgent and Emergency Care Sustainability Plan, GHFT Estates, GCCG Performance, One Gloucestershire ICS, the GCCG Clinical Chair Annual report, and the HOSC work plan for future meetings.

The Chair and I also facilitated the **annual GHC informal meeting with HOSC** on 28th October which was held virtually. This meeting was a roundtable discussion which provided HOSC members an opportunity to raise any questions they had with members of the Trust. This session also provided updates on a selection of important matters including Rapid Response, Eating Disorders, and the LD Intensive Health Outreach Team (IHOT). This meeting allowed for open dialogue between HOSC members and facilitated a constructive conversation that was well received by all.

The system Gold Health System Strategic Command CEOs (now called the **Executive Review Group**) is now taking place twice weekly on Wednesdays and Fridays due to an increase in system pressures and Covid cases, and as part of the wider **Gloucestershire ICS Covid-19 Response Programme.** This forum has proved essential in overseeing the system response to the Covid-19

pandemic (and continues to do so as we enter the winter season) and in providing a regular liaison point between senior leaders in the NHS and social care system.

I continue to attend the **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. The frequency of these meetings is currently monthly. However, we also held an extraordinary session on 29th October to discuss 12-15 year old vaccinations and the booster programme. The regular monthly meetings provide updates on the Covid-19 situation in Gloucestershire including testing, vaccinations, and case rates as well as updates on the system position, and additional noteworthy information (i.e. winter planning, urgent care pressures, and good news stories).

The Chair and I are in the process of holding our **annual meetings with MPs** to discuss Trust updates, address any concerns and ensure effective cross communication. The Chair and I held meetings as follow:

- 01 October 2021 – Mark Harper
- 12 November 2021 – Richard Graham
- 23 November 2021 – Laurence Robertson
- 24 November 2021 – Sir Geoffrey Clifton-Brown

Additionally, on 22nd October I met individually with Siobhan Baillie to discuss Mental Health and how best to improve our communication with MPs for more open and collaborative working.

On the 3rd November, the Chair and I had a follow-on meeting with the **Police & Crime Commissioner, Chris Nelson** along with his Deputy Nick Evans following our meeting earlier in the year. During this meeting we discussed the **Sexual Assault Referral Service (SARC)**, actions on domestic violence, safeguarding (children and adults), the **Covid vaccination team** and **Mental Health Services.**

I chair the **West of England Patient Safety Collaborative Board** meetings. The latest meeting took place on 6th October. This meeting discussed the national patient safety improvement programme, learning disability and mental health collaboratives, as well as how we can work best to achieve common goals.

I attended the **NHS Providers Annual Conference and Exhibition** on 16th and 17th November. This conference was held virtually again this year due to the current Covid situation. Sessions at the conference included *Levelling up through partnership and collaboration; Speaking truth to power: how leaders can better hear what they need to hear; Are we equal to COVID-19? Tackling the backlog, addressing health inequalities and the wider impact of the pandemic,* and a keynote speech from the Secretary of State for Health and Social Care, Sajid Javid in which he shared his priorities and ambitions for the service moving forward.

I chaired the **Diagnostics Programme Board** on 15th October. This programme board is working on progressing the work of the developed

proposals for local Community Diagnostics Hubs (CDH). These proposals focus on the development and coordination of networked diagnostic services which are equitable and consistent; aiming to get the right patient to the right test, in the right location, in the fewest number of visits (and referrals) and in the shortest amount of time. The aim is to maximise the limited diagnostic capacity through triage, stratification and prioritisation which is personalised and sustainable across Gloucestershire whilst seeking to invest / innovate and expand existing services so that they meet current and future demands.

I have attended many meetings to discuss the **Forest of Dean Hospital** including the Extraordinary Board meeting on 3rd October. More details about the Forest of Dean project can be found in Angela Potter's (Director of Strategy and Partnership) report.

On 14th October I attended the **SW Regional Chief Executives** meeting which featured presentations on Elective Recovery, the Think Big Outpatient Programme, and the Covid Vaccination Programme.

I also attended the **extended SW Regional Chief Executives** meeting held on 20th October. The overall purpose of the extended meeting was to give the Chief Executives an opportunity to highlight and discuss the main challenges facing them with regards to workforce and use this to outline the broader themes to be developed and explored in 2022.

1.7 Service Visits

Since May I have continued to do a number of **service visits** (in person – where this can be done safely). Each day spent in these locations has been a very valuable experience providing substantial insight into colleagues' experiences with their working environment and how they address the challenges presented by the ever-changing circumstances. I value the opportunity to be able to continue to meet with colleagues and patients, and to be on hand to discuss any topics or issues they would like to raise.

On 11th November I was based at **Cirencester Hospital** and was able to meet with the community nursing team to discuss the challenges they are facing, talk through their concerns, and discuss the Trust's plans to manage the challenges for our district and community nurses.

13th October and 2nd November I was based at **Wotton Lawn Hospital.** These days provided opportunities to speak 1:1 with various team members which was very insightful to hear about their experiences throughout the pandemic and how we can support them moving forward.

Over the upcoming months I aim to continue regular service visits (following Covid secure guidance). I greatly see the benefit in having these conversations with colleagues to listen, learn, and work together to help make our Trust a great place to work for all.

2.0 STAFF SUPPORT

Colleagues across the Trust have been working dedicatedly through the pressures resulting from the pandemic. Their hard work and commitments have been and are invaluable to those we serve as a Trust. That being said the pandemic has heighted pressures and stresses on colleagues and this has not gone unnoticed. We have heard from a variety of pathways that colleagues are under pressure and as such, we as an Executive Team have put together a staff support project team to help greater support staff throughout the coming winter months.

This programme is working across directorates to identify areas of improvement and implement changes that will benefit all colleagues. These areas include (but are not limited to) improving recruitment and retention, assessing equitable bank rates and incentives, improved recognition of efforts, aiding in employee health and wellbeing, as well as alleviating various additional pressures for colleagues where possible.

I am continually grateful for the incredible team of staff that provide health and care for the communities of Gloucestershire. I am proud to work with such devoted, innovative, and caring colleagues. Thank you for your hard work and commitment throughout the challenging pandemic and as we navigate into the future to continue to provide the best possible health and care across the Gloucestershire Health and Care NHS Foundation Trust.

3.0 CONCLUSION AND RECOMMENDATIONS

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

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

PRESENTED BY: Angela Potter, Director of Strategy and Partnerships

AUTHOR: Angela Potter, Director of Strategy and Partnerships

SUBJECT: **COMMUNITY MENTAL HEALTH TRANSFORMATION PROGRAMME**

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

This report is provided for:

Decision Endorsement Assurance ☐ Information ☑

The purpose of this report is to:

Provide an update and overview to the Trust Board on the Community Mental Health Transformation Programme.

Recommendations and decisions required

The Board is asked **to note** the contents of this paper.

Executive summary

The Community Mental Health Framework for Adults and Older Adults was released in September 2019 and laid out the core building blocks to develop a more integrated approach for those people who experience a range of long-term severe mental illnesses. It aims to eradicate the historic thresholds for service access for example into eating disorders and services to support those with complex mental health difficulties particularly associated with a diagnosis of personality disorder.

The One Gloucestershire system developed its Community Mental Health Transformation (CMHT) plan in July 2021 which has enabled the opportunity for a fundamentally different approach to developing new integrated services.

This is a system wide change programme and includes not just GHC as a statutory provider of mental health services, but all partners and stakeholders including those services provided by voluntary and third sector providers and within primary care settings. The whole programme is developed with a clear commitment to co-production and full involvement of service users, carers, experts by experience and wider stakeholders.

A Programme Board has been established chaired by Paul Roberts – Chief Executive of GHC which reports into the Integrated Care System Executive. Sitting alongside the programme board is a People's Representative Action Board which is facilitated by our Voluntary Community Sector partners and Inclusion Gloucestershire and chaired by and attended by Experts by Experience and third sector representation.

The programme is designed around a number of workstreams and underpinning drivers as outlined below;

Existing Projects				Service Models		
Physical Health Checks SMI	Eating Disorders	Complex Emotional Needs	Housing & Accommodation	Young Adults	Access and assessment (inc wait times)	Service configuration and workforce
Experience Based Co-Design						
Personalisation						
Health Inequalities						

Fundamentally the focus is on health inequalities; physical health; prevention as well as access to care and treatment; accommodation; employment and social care; all of which are significant determinants of health and wellbeing.

There will be a replacement of the traditional Care Programme Approach to introduce new alternative assessment and care management frameworks creating more individualised programmes of support. There will be a universal 4 week wait target and activity targets will be increased and refreshed.

Risks associated with meeting the Trust's values

Delivery of this programme is core to reducing health inequalities across the county and is in line with the Trust's values and strategic direction

Corporate considerations	
Quality Implications	Failure to deliver some of the key transformation workstreams will continue to impact on the health and well-being of our population
Resource Implications	Funding has been incorporated as appropriate to deliver the GHC elements of the programme.
Equality Implications	The work programme has a focus on reducing health inequalities and reduce the disparity for those who experience serious mental illness

Where has this issue been discussed before?

Appendices:	

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

Community Mental Health Transformation – Update

1. INTRODUCTION

Community mental health services have long played a crucial yet under-recognised role in the delivery of mental health care closer to people's homes and communities. However, it has more recently been recognised that they are in need of fundamental transformation and modernisation in order to deliver the aspirations as set out in the NHS Long Term Plan.

This paper provides an overview of the One Gloucestershire Community Mental Health transformation (CMHT) programme.

2. BACKGROUND AND CONTEXT

The Community Mental Health Framework for Adults and Older Adults was released in September 2019 and laid out the core building blocks to develop a more integrated approach for those people who experience a range of long-term severe mental illnesses. It aims to eradicate the historic thresholds for service access for example into eating disorders and services to support those with complex mental health difficulties particularly associated with a diagnosis of personality disorder.

The One Gloucestershire system developed its Community Mental Health Transformation (CMHT) plan in July 2021 which has enabled the opportunity for a fundamentally different approach to develop new integrated services.

The key is that this programme is not just about GHC as a statutory provider of mental health services, but it is a whole system approach focusing on the services provided by everyone, including those provided by voluntary and third sector providers and within primary care settings. The whole programme is developed with a clear commitment to co-production and full involvement of service users, carers, experts by experience and wider stakeholders.

A Programme Board has been established chaired by Paul Roberts – Chief Executive of GHC which reports into the Integrated Care System Executive. Sitting alongside the programme board is a People's Representative Action Board which is facilitated by our Voluntary Community Sector partners and Inclusion Gloucestershire and chaired by and attended by Experts by Experience and third sector representation.

3. DELIVERY OF THE PROGRAMME

The programme will span over 3 years with full implementation not anticipated until 2023 however, it is built on early implementer work that started in Gloucester City. The approach will radically re-engineer our community mental health services so that each of Gloucestershire's 15 PCNs will have access to a mental health multi-disciplinary/multi-agency team working within it.

By aligning the statutory and third sector service providers we aim to ensure a seamless range of offers is available to support people in not just meeting their mental illness needs but also to support the wider determinants of health through the alignment with roles such as the Social Prescribing Link Workers (SPLW) and the Enabling Active Communities work.

The programme is funded for 3 years to enable the transformation and will then become business as usual with baseline funding for the reshaped services. We are not however, starting from scratch. We have an excellent basis of services to build from for example, our existing dedicated referral centre for mental health services which is already clinically led will be further develop to improve self and VCS access. This is complemented by 24hr access to Crisis services, including self-referral.

The programme is designed around a number of workstreams and underpinning drivers as outlined below;

Existing Projects				Service Models		
Physical Health Checks SMI	Eating Disorders	Complex Emotional Needs	Housing & Accommodation	Young Adults	Access and assessment (inc wait times)	Service configuration and workforce
Experience Based Co-Design						
Personalisation						
Health Inequalities						

Fundamentally the focus is on health inequalities; physical health; prevention as well as access to care and treatment; accommodation; employment and social care; all of which are significant determinants of health and wellbeing.

There will be a replacement of the traditional Care Programme Approach to introduce new alternative assessment and care management frameworks creating more individualised programmes of support. There will be a universal 4 week wait target and activity targets will be increased and refreshed.

Although still very much in its set up phase, a number of phase 1 projects have commenced and some highlights are in the sections below;

<u>Physical Health Checks for people with Serious Mental Illness</u>

The majority of health checks take place in primary care and often require a proactive and targeted approach to maximise every opportunity and interaction with people to support the health checks being completed. Unfortunately, with the impact of Covid and other factors, Gloucestershire is not achieving the desired outcomes or access targets in this area. Whilst, we know there are recording and data quality issues we have recognised that further focused work to support primary care with other targeted approaches is also needed.

Some activities include;

- Recruitment of additional staff within GHC to enable the establishment of a ‘blue box’ scheme (which is essentially point of care testing that can take place in health centres and clinics) with funding through NHS Digital to allow a wider locality offer to be available.
- Continued healthy lifestyle promotion activities and working with Social Prescribing Link Workers (SPLW) to help address the wider inequalities that people with an SMI face.

The inclusion of this measure within national indicators and within the GP's Quality and Outcomes Framework (QOF) will help ensure continued focus on achieving physical health checks.

Eating Disorder Services

As has been reported in recent performance and recovery reports to the Trust Board demand on our eating disorders services is high and is currently outstripping capacity. Further investment into the service is planned as part of service recovery and we will be exploring the development of alternative psychological roles e.g. Clinical Accredited Psychologist (CAP) roles and evaluating this through a pilot within our eating disorders workstream to help offset some of the ongoing workforce challenges in this area.

The CMHT transformation model will focus on ensuring a person centred approach is developed with the ability to move between partners (statutory and voluntary) as an individual's condition and personal needs indicate.

It is recognised that there is much work needed to support eating disorder services not only with the immediate capacity challenges but also to enable wider system wide transformation and additional internal project management resources have been allocated to help provide this focus.

Complex Emotional Needs (CEN) Service

The Health Needs Analysis for Gloucestershire identified the need for a cohesive multi-agency approach to supporting individuals with a personality disorder at all levels of need. In developing our CMHT response several stakeholder events were undertaken to enable public engagement and consultation on the development of a Complex Needs Strategy.

The Complex Emotional Needs Service (CENS) will improve services for people with complex emotional needs across primary, secondary and VCS providers, breaking down barriers and the need for formal diagnosis. We will also look to integrate our physical and mental health Homeless Health Care Teams to further address inequality and disproportionate health outcomes.

The CEN service is looking to be fully recruited to shortly (some of the roles being for those with lived experience) and community of practice based action learning sets are being implemented to share learning and ensure continuous development.

In terms of outcomes we are looking to see a greater emphasis on trauma informed care with training programmes being delivered to GHC staff via the Nelson Trust, one of our VCS partners. We also aim to see a reduction in Out of Area placements by the development of local CEN services. Presently, the CEN work is focused on adults but we recognise the need to consider younger adults and are building this into future work programmes moving forward.

Housing and Accommodation

It is now widely recognised across the inequalities work that poor housing can have detrimental impact on a person's health and well-being and it is a key factor in the inequalities gap. Housing whilst a focused programme in its own

right, will also be a golden thread that runs though many of our transformation discussions and looks to bring a wide range of agencies together to understand what the gaps and challenges are in our current housing provision. Barnwood Trust are taking a pivotal role in the early phase in leading workshops with housing providers to understand wider contributions that this sector can bring in reducing health inequalities, particularly for those with complex mental illness.

Summary

Key aspects of our transformational model will include providing a seamless service for people, moving away from traditional concepts of referral, triage and signposting to allow people to be held and have their needs met through a personalised plan designed and agreed with them and moving within and across the statutory and non-statutory sector. This will remove the current interface between primary and secondary care.

4. STRATEGIC DIRECTION

A further component of the CMHT work is to consider how we enhance the partnership working between the statutory and third sector providers across the county. There is a strong appetite to explore an alliance or collaborative type commissioning model between GHC and the VCS organisations through the development of new contracting routes as well as the addition of new roles, such as mental health navigators for VCS and paid peer support workers.

This work aligns with the development of the ICS and the potential shifts between strategic and operational commissioning and the different role that providers may play as our system matures. It is therefore considered to be a key strategic priority for GHC to help develop a mature and energetic relationship with our partner organisations and to develop commissioning models that enable true and equal partnership approaches across all providers.

In addition, developing an engagement strategy for service users not currently accessing services in seldom heard groups is of strategic importance, to ensure that the profile of patients accessing services in a PCN footprint is representative of its population.

5. CONCLUSION AND NEXT STEPS

The CMHT transformation is an ambitious and exciting 3 year programme of significant change and investment. The Trust is taking a pro-active role in leading many of the strategic components to this transformation programme and has begun to allocate both operational and programme management support. Over the coming months, we expect to see increased granularity around the milestones and targets that each workstream will need to achieve and we will ensure board are updated on a regular basis.

Trust Board are therefore asked to **note** the contents of this report.

Angela Potter
Director of Strategy & Partnerships

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 16/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

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

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

Executive Summary

This paper provides an overview of a range of activity taking place across the Integrated Care System. This update includes:

- Meetings with Health Overview and Scrutiny Committee on the 12th and 28th October
- Overview of the Health and Wellbeing Board meeting
- Gloucestershire's Safeguarding Adults Annual Report
- Race relations commission deep dive activities into workforce and diabetes
- Activity continuing across the six integrated Locality Partnerships
- Update on various engagement activities that have taken place

Risks associated with meeting the Trust's values

None identified.

Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our surveys and include them within future service reviews and developments.
Resource Implications	None specific to the Trust.
Equality Implications	The Trust is actively engaged in wider inequalities work and will build any findings into the Trust service developments moving forward.

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

Appendices:	ICS Accountable Officer Report (HOSC November 2021) ICS Board Minutes *(Available to Board members in the Reading Room)*

Report authorised by:	Title:
Angela Potter	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 (ICS).

1. Health & Well-Being Board

1.1 The Gloucestershire Health and Wellbeing Board (H&WB) met on the 2 Nov 2021 and received an update on the work progressing on the development of the Integrated Care System (ICS) Board and its associated structures since the joint workshop that took place to review the relationship of the ICP and the Health and Wellbeing Boards.

The workshops produced a number of recommendations including;

- that aligning both boards is the preferred option supported by a joint secretariat and suggest potential membership for this and a draft Term of reference to be brought back to H&WB board for future discussion
- Over time the secretariat will provide the 'engine room' for the boards with agenda planning and monitoring functions to support the work.
- Note that the meetings of both boards will be aligned so they will meet on the same day in succession.
- Acknowledge that there should be further clarification about how the voice of Patients/carers/citizens will be represented at the ICP

1.2 HWB Dashboard development

An update was provided on a dashboard being developed to monitor progress against each of the seven HWB priorities. It was agreed this needs to measure how each of these priority areas progress over time, but also that a set some baseline measures are required. The aim is for the dashboard to be a live and accessible tool to provide information on trends and the position against priorities in Gloucestershire which all organisations can then use.

1.3 Child Friendly Gloucestershire: Children and Young People's Wellbeing Coalition – Update Report.

A range of work programmes have now commenced and the Coalition anticipates that, over time, they will increasingly take forward work with partners to ensure that young people have the best possible start in life in the county.

The Coalition Brochure is a key element in embedding a shared appreciation of its role and purpose. A number of major changes to the document have been made since the July Health and Wellbeing Board and the name has been changed from the Child Friendly Coalition to the Gloucestershire Children and Young People's Wellbeing Coalition – this is a more inclusive title and many

young people in the 10 – 25-year age bracket has indicated that they object to being categorised as children

1.4 Gloucestershire Domestic Abuse Strategy 2021 – 2024

The Strategy was shared with the HWB having now been signed off by the Domestic Abuse Local Partnership Board and the Safer Gloucestershire Partnership Board and will be published, alongside the needs' assessment, on the GCC website as well as the 'Glostakeastand' website.

2. HEALTH OVERVIEW & SCRUTINY

The Health Overview & Scrutiny Committee (HoSC) met on the 12 October 2021 and received a detailed presentation from the South West Ambulance Service on their latest performance position and associated delivery challenges. It was acknowledged that all services are facing unprecedented levels of demand and the current situation faced in the emergency departments was significantly impacting on the ability of the ambulance provider to achieve their delivery standards.

Data presented that showed ambulance activity was circa 24.4% higher than a comparable period 2 years ago (August 2019 compared to August 2021). During 2020/21 the Ambulance Trust has also seen an increase in the amount of operational resource time lost as a result of handover delays at acute hospitals in excess of the 15 minute target set for each patient handover. Gloucestershire have introduced a Lead Paramedic Hospital Ambulance Liaison Officer (LP HALO) who acts as a point of contact for SWAST crews and conduit between SWAST and Hospital staff and ongoing support to all agencies is continuing across the system.

GHC also put forward a case to continue to operate the Minor Injury Units on an 8am -8pm basis across all sites rather than extend Lydney and Cirencester and back to an 11pm opening time. On reducing the opening hours in response to Covid, a telephone triage service was developed utilised the redeployed staffing resources. This service has proved extremely beneficial to the overall system as it enables members of the public to ring and speak directly to a member of our nursing staff and receive advice and guidance over the phone and if appropriate, to be allocated a pre-booked appointment to attend one of the MIIU sites. This has both resulted in more people being able to take forward self-care options, but also reduced the amount of time people have to wait as they have a pre-planned attendance time. As we could not extend the opening hours and run the triage service, a case was made to continue with the triage service. This was supported by HOSC until the end of March 2022 as an extension of the temporary service change.

Informal Annual Meeting – The Trust also held its annual informal meeting with members of HOSC on the 28th October 2021. This was an opportunity for the Trust to provide an overview of the Trust's services and detailed presentations and discussions took place on three of the Trust's services – the rapid response

service; the Learning Disability Intensive Health Outreach Team (IHOT); and the eating disorder service.

A further HOSC meeting is scheduled for the 30th November when the Trust will present a detailed overview of the position with regard to mental health services performance and recovery.

3. GLOUCESTERSHIRE CRIMINAL JUSTICE BOARD

Marieanne Bubb-Mcghee and Angela Potter have been invited to join the newly configured Gloucestershire Criminal Justice Board. Chaired by Chris Nelson - Police and Crime Commissioner, this forum will focus on a wide range of cross organisational issues. The inaugural meeting considered which agencies should be involved and suggestions were made to reach out to the Gloucestershire Housing Partnership Board. The meeting discussed the strong links with our community mental health transformation programme and the development of the community forensic services and also considered the domestic abuse needs assessment that had been completed.

All parties commended the involved of GHC into this arena and we will maintain activities links to help strengthen our partnership working across this important agenda.

4. WIDER ICS AND PARTNER UPDATES:

4.1 Gloucester City Race Relations Commission Deep Dives

Workforce

The report reviews the workforce position of the main public sector organisations, (including GHC) across Gloucestershire and the position with regard to the levels of employment from BME populations. It highlights the underrepresentation in both the general workforce and in senior positions within the organisations and highlights that more action can and should be taken to further address the issue of underrepresentation.

This should include how we recruit new starters while also retaining, growing and investing in the diverse talent our organisations already have. A clear list of recommendations will be developed as part of this Deep Dive and we will ensure these are shared and taken forward appropriately.

Diabetes

Data for Gloucestershire shows that the prevalence of diabetes is much higher among ethnic minority groups than in the white population. This is consistent with the national picture where type 2 diabetes is up to six times more likely in people of South Asian descent and up to three times more likely in African and African-Caribbean people.

Conscious of these disparities, the Diabetes Clinical Programme Group identified that ensuring equity of access for people from ethnic minority

communities to diabetes prevention programmes and to services for the management of diabetes is a priority. To support this the Clinical Commissioning Group commissioned ICE Creates Ltd. to undertake behavioral insights research into the motives, barriers and enablers to increasing access to services in the county in early 2021.

The commission then undertook a deep dive into the recommendations for increasing uptake of structured education for type 2 diabetes and attendance at annual checks and how to support this being taken forward across our communities.

4.2 Focus on Homelessness and Streetlink

We recognise that housing is a key factor in influencing health and inequalities and to support this agenda all six local Councils, the County Council, the Office of the Police and Crime Commissioner and the NHS Clinical Commissioning Group work together through the countywide Housing Partnership to ensure that everyone in the county has access to a warm and stable home. The Trust is seeking to develop stronger links with the Countywide Housing Partnership to consider how we can continue to support this wider agenda for our population.

As winter approaches, the Partnership is focused on preventing homelessness and ensuring those who do become homeless, have access to the right support as soon as they need it. The Partnership is stepping up efforts to identify and support those who are sleeping on the streets but are asking local residents to help by referring those they see sleeping rough, to Streetlink.

Street Link referrals can be made online, via an app or on the phone and are sent directly to the county's outreach service who can find rough sleepers and support them to access help and accommodation.

A range of support is available in Gloucestershire including Somewhere Safe to Stay Hubs; dedicated support to help address medical care issues including mental health, addiction, and other issues which can be made worse by rough sleeping; and dedicated nurses in the Homeless Healthcare Team and Gloucestershire Hospitals.

Streetlink can be accessed by visiting www.streetlink.org.uk, downloading the Streetlink app or by calling 0300 500 0914.

4.3 Support for Care Leavers

The County Council is launching its new Step Forwards employability programme to support care leavers aged 16 to 25 to find employment, working closely with Gloucestershire's Employment and Skills Hub.

A new dedicated Step Forwards job broker role has been created which will help young people to take their first steps into work, supporting them to gain and sustain employment.

The job broker who will be part of the council's Forwards employability team, will work with young people to explore all available job opportunities to find the

right one for them. Support provided will include one to one help with preparing CVs, interview training and sourcing work placements. Requests for employability support can be made at www.gloucestershire.gov.uk/employment-and-skills-hub

4.4 Fire and Rescue Service Draft Community Risk Management Plan – Public Consultation

Gloucestershire County Council, as the Fire Authority, has a statutory responsibility to produce a Community Risk Management Plan (CRMP). The plan looks at how Gloucestershire Fire and Rescue Service will tackle and mitigate the risks our communities face.

A draft plan has been produced and is out for consultation until the end of November. It contains eight key objectives which cover aspects such as prevention and wider collaboration with other partners. As a key stakeholder in supporting the community, the Trust will consider the plan and respond to the consultation as appropriate.

4.5 Gloucestershire Safeguarding Adults Board Annual Report 2021

The Gloucestershire Safeguarding Adults Board (GSAB) have released their annual report for 2021. It outlines the work undertaken to deliver on the final year of the priorities that were set out in the 3 year strategic plan 2018-2021. In addition, it outlines the consultation work that was undertaken in 2021 to begin the work to develop the next three year plan which included engagement with other Boards and partners including the voluntary and community sector.

The Trust's own work in this area has also been highlighted in the report demonstrating the Trust's ongoing commitment to this agenda.

Gloucestershire Health and Care NHS Foundation Trust (GHC)

- Throughout the pandemic, the Trust safeguarding team has continued to function as a priority service, albeit with adaptations in place to work around restrictions and lockdowns
- Since November 2020, training has resumed using a virtual platform. The feedback for level 3 adult safeguarding has been favourable although some staff find receiving training through virtual platforms challenging.
- The team have continued to support the MARAC information sharing process putting additional resource in when needed

5. INTEGRATED LOCALITY PARTNERSHIPS (ILPS) UPDATES

All ILP's have been receiving an update and overview on Community mental health transformation work from Andy Telford – Operational Lead.

Tewksbury ILP - next meeting scheduled for 14th November and will continue to focus on further exploring the implications of the Garden Town development status and the wider health & wellbeing opportunities.

Two priority project groups continue to progress:

- Brockworth Community-based project where they are exploring a community builder type role to lead on engagement and relationship networking;
- Tewkesbury Town project – progressing Asset mapping and building membership of a steering group to support asset mapping activity – aim to identify what locals perceive to be health & wellbeing promoting services/activity in the local area and to reconnect people & services to local provision following lockdown.

Gloucester City ILP - met on the 14th October: Continued work to explore the impact of housing and the wider determinants of health including aspects such as Fuel Poverty, warmth on prescription and respiratory conditions. High Intensity Users work continues as we understand the data further and those registered within each PCN's.

FOD ILP – met on 20thth October: This was a workshop to review the locality level data and identify new priorities completed: Key areas of interest were highlighted as Substance Abuse; Pre-Diabetes; aging well which if taken forward will be added to the current FOD projects which include: CYP MH & Obesity project & Complex Care @Home pilot.

Cheltenham ILP – met on 8th October; Further analysis has been requested for high intensity users as well as review mortality data to understand if there is a concordance between cause of death and deprivation, which could be a focus of further development work. Each PCN continues to take forward their individual priorities building on the population health management work.

Cotswolds ILP - met on 26th October**;** The frailty, loneliness and Isolation working group has been progressing to the extended cohort to include those who were shielding due to Covid, building on working from Cheltenham in an attempt to develop a Gloucestershire algorhythm to identify those at risk of falls to enable preventative interventions and to re-engage people into community based assets outside their home.

Healthy lifestyles and prevention - South Cotswolds PCN are now trialling a routine approach to identify people who are appropriate for National Diabetes Prevention Programme (NDPP) to increase referral rates and improve coding.

Stroud and Berkley Vale - met on the 21st October: Stroud District Council are working with Social Prescribing Link Worker (SPLW) to develop a “support group” for parents of young people awaiting assessment by eating disorder services. Linking with Eating disorder services to develop an offer that supports developing skills to care and support young people.

Work is ongoing regarding dementia, frailty and carers alongside the carers hub and consideration of a further pilot is taking place along with work to understand what is currently happening within the locality in terms of carers support and non-statutory offers for frailty and carers.

6. FOCUS ON PATIENT, CARER AND ENGAGEMENT

6.1 Carers Survey

Gloucestershire County Council is inviting carers to take part in a national survey to find out more about their vital role. National carers surveys were started in 2012, and take place every two years. The survey is nationwide and organised by the Department of Health and Social Care.

There are more than 63,000 carers in Gloucestershire, providing unpaid support to family members or friends who need help due to a variety of reasons, including age, substance misuse, physical or mental illness and disability.

This survey includes additional questions designed to find out how the pandemic has affected carers and specifically how they feel about areas such as the support they have received from Social Services throughout this time

A random sample of approximately 1000 carers in Gloucestershire will be sent the survey from early October. Responses need to be received by Friday 30 November 2021.

6.2 Children & Young People's Mental Health Awareness Event

The Gloucester Know Your Patch Network are hosting a Children & Young People's Mental Health Awareness event on 24th November at Walls Club, Gloucester between 10am - 12pm.

6.3 Black Minority Ethnic (BME) Mental Health Event

Gloucestershire County Council have released a report focusing on mental health inequalities in our ethnic minority communities and are looking for feedback on the recommendation and any gaps. A meeting has been scheduled for Wednesday 1st December 2021 9.15am – 2.00pm at the Friendship Café, Chequers Bridge Centre, Painswick Road, Gloucester, GL4 6PR. For further information and to book your place, please contact: Haroon Kadodia (Glos County Council): 07714 206201 Haroon.KADODIA@gloucestershire.gov.uk

6.4 Freshers Fairs

The Partnership and Inclusion Team supported a number of fresher's event aimed at new University Students to raise awareness of local NHS services, in particular mental health and sexual health services.

The team had the Clinical Commissioning Group bus and video booth for the Hartpury freshers event. The aim was to get students thinking about what they can do to improve their emotional wellbeing with a focus on:

- Having a video booth to get young people to pledge to do something to help their emotional wellbeing as well as sharing their top tips with their peers.
- Hand write pledges and mindful colouring in to improve emotional wellbeing
- Informed students about the 5 steps to wellbeing and had conversations around what the students are already doing and what else they could do
- Leaflets and info on local services

Regular dialogue is also maintained through the Students Union to replenish GHC leaflet supplies and continue to raise the profile of mental health awareness.

The team also attended the Cirencester College Induction Day and the Royal Agricultural College.

7. ICS ACCOUNTABLE OFFICERS REPORT

ICS Accountable Officers report to HOSC in October in reading room.

8. NEXT STEPS

Trust Board members are asked to note the contents of this update report

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AGENDA ITEM: 17/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

PRESENTED BY: Lavinia Rowsell, Head of Corporate Governance & Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Corporate Governance & Trust Secretary

SUBJECT: **BOARD ASSURANCE FRAMEWORK**

If this report cannot be discussed at a public Board meeting, please explain why.	Not Applicable

This report is provided for:

Decision ☑ Endorsement ☑ Assurance ☐ Information ☐

The purpose of this report is to

To provide assurance on the management of the Trust's strategic risk and provide further information on the risk controls, assurances and mitigating actions relating to *Risk 4 – Recruitment and Retention.*

Recommendations and decisions required

The Board is asked to:

(i) **To receive and consider** the BAF

(ii) **Note** the overarching risk profile for the Trust (page 1 BAF**)**

(iii) **To discuss** *Risk 4 – Recruitment and Retention* which has been updated following and Executive deep dive session and to **agree** the rating for this risk.

(iv) **Note** that from December, oversight of all workforce related risks will move to the Great Place to Work Committee.

Executive summary

Along with the Corporate Risk Register the Board Assurance Framework (BAF) supports the creation of a culture which allows the organisation to anticipate and respond to adverse events, unwelcome trends and significant business and clinical opportunities. It helps to clarify what risks are likely to compromise the trust's strategic and operational objectives and assists the executive team in identifying where to make the most efficient use of their resources in order to improve the quality and safety of care.

The Board Assurance Framework (BAF) for 2021/22 was developed to ensure it reflected the Trust's updated Strategic Aims and Objectives and identified areas of strategic risk so that appropriate controls and mitigations could be put in place.

The BAF is reviewed regularly by Executive owners and the Executive Team and quarterly by Board Governance Committees. Amendments made to the BAF in the last review are highlighted in red.

Risk 4: *Recruitment and Retention*
This risk has received particular focus during the recent round of governance committees given the challenging national picture and how highly workforce risks feature across the services. In response, this risk was the subject of a deep dive by the Executive Team on 16 November 2021 at which, detailed consideration was given to the current status of the risk and any additional controls or mitigating actions that could be put in place. The BAF has been updated to reflect these discussions and additional mitigating actions agreed, including an end to end review of the recruitment process which will be supported by the Quality Improvement Team and report in Q4.

Executive gave detailed consideration to the current risk rating (16) and whether this remained appropriate in light of forthcoming winter pressures. Current and proposed mitigations were discussed including progress with filling vacancies and the additionally resourced new roles within the recruitment team, the introduction of the TRAC recruitment system by Easter 2022, and the proposed recruitment process review. In addition, it was agreed that there was enough mitigation in the system as part of the recovery and surge planning processes to ensure that services were not interrupted. It was recommended that the risk rating should not be increased at the current time but should continue to be closely monitored.

Risks associated with meeting the Trust's values
Refer to the corporate risk register and Board Assurance Framework

Ensuring a BAF is in place which helps to effectively manage Strategic Risks is a core element of the Trust's Risk Management Policy.

Corporate considerations	
Quality Implications	As detailed
Resource Implications	As detailed
Equality Implications	As detailed

Where has this issue been discussed before?

Executive meetings, Governance Meetings (Q3)

Report authorised by:	**Title:**
Lavinia Rowsell	Head of Corporate Governance & Trust Secretary

Strategic Risk Description	Strategic Aim				Strategic Risk No	Risk Type(s)							Lead Committee	Initial Risk Score	Target Risk Score	Risk Score				Executive Lead	Date Last Exec Review	Date Last Comm Review	Issue to be raised (by Exec or Comm) Y/N
	High Quality Care	Better Health	Great Place to Work	Sustainability		Quality/Outcomes	Compliance / Regulatory	Reputational	Innovation	Partnerships / Collaboration	Workforce	Finance Inc. VFM				Qtr 1	Qtr 2	Qtr 3	Qtr 4				
Quality Standards	✓	✓			1	✓	✓	✓					Quality	12	8	8	8	8		DNTQ	Oct 21	Nov 21	N
Research & Innovation	✓	✓	✓		2			✓	✓			✓	Quality	12	6	8	8	8		Med.Dir	Oct 21	Nov 21	N
Excess Demand for Services	✓	✓			3	✓	✓	✓				✓	Resources	16	12	16	16	16		COO	Oct 21	Nov 21	N
Recruitment & Retention	✓	✓	✓		4	✓					✓		Resources	12	8	16	16	16		DHR/OD	Oct 21	Nov 21	Y
Workforce Wellbeing	✓		✓		5	✓					✓		Resources	9	6	9	9	9		DHR/OD	Oct 21	Nov 21	N
Education, L&D		✓	✓		6	✓			✓		✓		Resources	6	4	6	6	6		DHR/OD	Oct 21	Nov 21	N
Culture (Internal)		✓	✓		7			✓					Resources	9	4	6	6	6		DHR/OD	Oct 21	Nov 21	N
Partnership Culture		✓			8	✓		✓		✓			Board	9	6	9	9	9		DSP	Oct 21	Nov 21	N
Resources Targeted at Acute Care	✓	✓			9	✓	✓	✓	✓			✓	Board	16	8	12	8	6		DoF	Oct 21	Nov 21	N
Funding – Nat. Econ. Issues	✓	✓	✓		10				✓	✓		✓	Board	15	10	15	12	8		DoF	Oct 21	Nov 21	N
Sustainability (environment)				✓	11		✓		✓	✓			Resources	12	3	9	9	9		DSP	Oct 21	Nov 21	N

Strategic Risk Description	Strategic Aim				Strategic Risk No	Risk Type(s)							Lead Committee	Initial Risk Score	Target Risk Score	Risk Score				Executive Lead	Date Last Exec Review	Date Last Comm Review	Issue to be raised (by Exec or Comm) Y/N
	High Quality Care	Better Health	Great Place to Work	Sustainability		Quality/Outcomes	Compliance / Regulatory	Reputational	Innovation	Partnerships / Collaboration	Workforce	Finance Inc. VFM				Qtr 1	Qtr 2	Qtr 3	Qtr 4				
NHS Reorganisation	✓	✓	✓		12a	✓	✓	✓	✓	✓	✓	✓	Board					9		DS&P	Oct 21	Nov 21	N
NHS Reorganisation	✓	✓	✓		12b	✓	✓	✓	✓	✓	✓	✓	Board					16		DS&P	Oct 21	Nov 21	N

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="2">High Quality Care

Better Health</td><td>Board Lead:</td><td>John Trevains, Dir NTQ</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>1</td><td>Description:</td><td colspan="2" rowspan="8">Quality Standards:

There is a risk that failure to:

(i) monitor & meet consistent quality standards for care and support;
(ii) address variability across quality standards;
(iii) embed learning when things go wrong;
(iv) ensure continuous learning and improvement,

will result in poorer outcomes for patients / service user and carers and poorer patient safety and experience.</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators: (taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020</td><td colspan="4">• Number of Complaints
• Timeliness of reviews into Concerns
• Patient Safety Incidents
• Friends & Family Test measures
• Safe Staffing Levels
• Embedding learning /Quality Improvement activity reporting</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">Target Score in Place 1st April 2021</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="6">This Risk was on 2019/20 BAF. It was confirmed it remained a key risk for monitoring at Board Strategic Session 14/Jan 2021.</td></tr>
<tr><td colspan="9">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="9">This is a risk that has received ongoing focus during 2019/20 following the merger and has reached target risk score. The potential impact of the Covid pandemic on Quality Standards is regularly considered to ensure quality and standards are maintained. The work of the Quality Committee and their reviews of the Quality Indicators provides ongoing assurance. The development and implementation of the Quality Strategy/Framework over 2021/22, approved by the Board in July 2021, will ensure this risk is effectively managed and continues to be central to our ways of working. The KPIs identified to inform the scoring of this risk are within agreed parameters.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Quality Dashboard	1/10/2019 (part of merger work)	2021/22	To be considered within development of Quality Strategy/Framework	Implementation and embedding of Quality Strategy
2.	Nursing, Therapies and Quality Directorate work aligned to governance framework set within Board memorandum	As above	As above	As above	Trust Quality Strategy/Framework to be embedded
3.	Patient Safety Controls – including Freedom to Speak Up mechanisms	19/03/21	As above	Dir NTQ	Quality Dashboard and patient safety, experience and Freedom to speak up reports consistently produced – to maintain.
4.	Patient Experience Controls	As above	As above	As above	As above
5.	Workforce Controls	19/03/21	As above	Dir NTQ	Ongoing monitoring required to ensure urgent issues such as Covid do not restrict workforce capacity and necessary focus on improvement Safe staffing report in quality dashboard, community services staffing data being included in dashboard for 21/22. Recovery reporting in performance report.

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Reports on Quality Standards/Performance	L2	Rec'd each Mtg	Qual/Res Comm or Board	Satisfactory	KPIs within Monthly reports to be reviewed to ensure measures being used are the most appropriate and timely.
2	Reports on Service User Experience	Includes L3	6 monthly reports	Qual Comm	Limited	Resolving the complaints backlog
3	Internal Audit Report on Freedom to Speak up	L3	Mar 2020	Audit Committee	Satisfactory	Revised policy and reporting process proposed – complete
4	Reports on Freedom to Speak up actions & issues raised	L2	6 monthly Reports	Board	Satisfactory	None highlighted since recommendations within Internal Audit Report implemented.
5	Service Experience Stories to Board	L3	Every other month	Board	Satisfactory	Feedback loop from service user stories built into Quality Committee agenda cycle.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Freedom to Speak Up revised Policy & Reporting process in place – review to ensure required impact achieved.	To be discussed at Board	FSUG	To complete Feb 2022 – in progress
2	KPI Review and Development workshop to be held with Board during 2021/22	Workshop to be set up pre-July 2021	HoCG/DoF	Workshop held July 2021
3	KPI Review to be implemented	High-level milestones agreed to be monitored via resources comm	DoF	In progress
4	Quality Strategy/Framework to be developed & implemented.	Overarching Trust Strategy in place for 2021/22. Quality Strategy to be taken forward 21/22 subject to Covid impacts.	DoNTQ	Approved July 2021
5	Quality mechanism processes KPIs to be kept under review to ensure being undertaken within required timelines.	Quality Committee to Monitor	DoNTQ	Refreshed dashboard being developed for 21/22

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Amjad Uppal, Medical Director</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>2</td><td>Description:</td><td colspan="3" rowspan="7">Research & Innovation
There is a risk that Research and Innovation are not embedded in our ways of working, resulting in failure to develop our local research portfolio to meet our strategic objective to be recognised as a centre of research excellence and failure to identify and implement leading edge practice to inform our care</td><td>Lead Committee</td><td>Quality</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="6">Relevant Key Performance Indicators:
• Number of studies open
• Number of locally-led studies
• Trust R&D Income
• Number of clinical areas research active</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">1/4/20</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>4</td><td>2</td><td>8</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Board Risk Seminar 14th Jan 2021. This risk brings together elements of risks within the prior year BAF relating to Research and Innovation.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)
The Research and Innovation Agenda is an area of increasing focus for the Trust. A Research Champions initiative has been put in place with 7 Research Champions to promote awareness across the Trust, including in areas we have not been traditionally research active. Processes to ensure we can identify individuals to act as Principal Investigators are being developed. The impact of Covid on staff availability to take on these roles whilst balancing additional demands in their main role is being kept under review. The research and innovation strategy is in development.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1.	Staff Engagement - Research Champions in place, staff briefed on Research at induction.	1/4/21	1/10/21	Head of R&D	Support and monitoring for roles to be confirmed. There are 7 Champions so some areas are not supported. More T&D to be put in place post Covid.
2.	Trust membership of Research4Gloucestershire – ICS Group to support collaboration and support.	1/4/21	1/10/21	Head of R&D	-
3.	Clinical Directors for research in place to support embedding research into core Trust activity	1/4/21	-	Med Dir	Research and Innovation Strategy to be completed.
4.	Associate Director of Research links junior doctors & trainees with research activity.	1/4/21	-	Med Dir	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1.	Quarterly Reporting	L1	12/05/21	Research Overview Committee	Satisfactory	Reports to increase focus on changes to practice.
2.	Annual Report on Res & Inn to Qual Comm	L2	Oct 20	Quality Committee	Satisfactory	
3.	Research Champions Feedback	L1	12/05/21	Research Overview Committee	Satisfactory	
4.	Sponsor Reviews – (includes consideration if standards met)	L3	Ongoing	Research Overview Committee	Satisfactory (reported if issues raised)	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Put in place relationships with QI and Audit to improve knowledge of research & evaluation & work together to support local projects	Discussions ongoing to map ways of working and agree processes to support	Head of R&D	**In progress – to complete Mar 2022**
2.	Innovation Lead role to be put in place.	Role being developed	Med Dir	In Progress – to complete Sept 2021
3.	Process to enable research to be built into job plans to ensure staff have dedicated time to work on projects to be developed	To be considered as element Research and Innovation Strategy	Med Dir	Not started – to complete Mar 2022
4.	Research and Innovation Strategy to be developed to pull together Res & Inn. Activities and consider overall impact on care.	Methodology for development to be considered and taken forward	Med Dir	Not Started- to complete Mar 2022
5.	Pilot of Research Champions to be reviewed for impact	Initial 6 months from 1 Oct, extended 6 months with summer review	Exec	Not started – planned for

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care

Better Health</td><td>Board Lead:</td><td>Chief Operating Officer</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>3</td><td>Description:</td><td colspan="3" rowspan="2">Excess Demand for Services

There is a risk of excess demand for services (due in part to a disconnect between social care and health and increasing demand due to widespread Covid impact), which cannot be managed through usual mechanisms, resulting in services no longer meeting the expectations of the commissioners and the people we serve leading to a potential impact on patient wellbeing.

It is recognised that there is an inter relation of this risk and Risk 4 Recruitment and Retention and Risk 5 staff Wellbeing.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report)</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td>1st April 2020</td><td colspan="3" rowspan="5">• Waiting times
• Referral and Access Reports
• Length of Stay
• No. Complaints and Compliments (access related)
• Out of Area Placements</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>3</td><td>4</td><td>12</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="4">1st April 2023</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14 Jan 2021, risks relating to demand incorporated in previous BAF.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)

Demand for our services remains high. The pandemic has led to pent up demand for some services, although most continued to operate during this period, and the impact of long Covid, and the impact on staff wellbeing and retention of working through a pandemic is not yet known. The relationship of Health and social care (and social care funding) remains to be resolved at a national level. To date relationships with Commissioners remain broadly supportive, but we need to ensure clear understanding of the volumes we are dealing with and how we are supporting Health & Care provision across the County. Progress has been made with the Regroup, Reconnect and Recovery programme to recover services from the pandemic and with all services reviewed, service redesign identified where required and extent of known demand. Project being undertaken to resolve data quality issues relating to physical health and the information held in the clinical system to enable an accurate waiting list position across services by end q4. However, greater system intelligence/collaboration is required to understand future demand and how our services may be further impacted by other changes/challenges within the system. Discussions are underway to commission work for accelerated demand and capacity modelling.</td></tr>
</table>

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Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Contract Management Board	Monthly		DoF	
2	ICS Board	Every other month		CEO	
3	Board and Committee Monitoring	Monthly		Board	
4	Business plan – process & monitoring	Annual		CEO/Chair	
5	Relationship GCC and GCCG	Ongoing		CEO/Chair/Board	GCC not formal member ICS

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Performance Report	L2	Monthly	Resources/ Board	Satisfactory	
2	ICS Operating Plan	L2	Annual	Board	Satisfactory	ICS Control Total may impact funds available to meet demand
3	Business Plan monitoring	L2	6 monthly	Board	Satisfactory	Delays in provision guidance business plan & budget mean 6-month review planned.
4	Quality Account – including stakeholder feedback	L2/L3	Annual	Board	Satisfactory	
5	HoSC feedback	L3	Every other month	Chair/CEO/	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Recovery Clinics being undertaken with service leads to understand demand and capacity and determine service lines that need review with Commissioners	Recovery Clinics underway. Impact of a further Covid surge needs to be considered	COO	All clinics completed and plans in place for red RAG rated services – move to amber
2.	Continue work to build capacity and understanding of self-care.	To be built into service reviews & developments. Focus on co-production for service developments to continue	COO DS&P	In progress - Anticipate incremental adoption in conjunction with ILPs in 21/22
3	Continue work to improve joined up working across the county to make best use of Gloucestershire pound	Ongoing work across ICS	Exec	**In progress**
4	Continue relationship building with GCC and County MPs	Regular Exec yearly update to GCC to continue. Regular meetings with MPs to continue.	CEO	**In progress**
5	Continue performance report monitoring & deep dives to focus on patient outcomes.	Established within agenda cycles	COO	**In progress**
6	Project to improve data quality on physical health services in SystmOne to resulting in improved reporting	6 months of data quality clerking obtained through the CSU to support project.	DoF	**In progress – Q1 2022**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great place to work
Better Health
High Quality Care</td><td>Board Lead:</td><td>N Savage D of HR & OD</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>4</td><td>Description:</td><td colspan="3" rowspan="6">Recruitment & Retention

There is a risk that we do not develop a long term and sustainable, cross Gloucestershire solution to recruitment and retention issues resulting in insufficient staff resource.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators: (taken from the Performance Report)

Turnover
Staff Survey
Staff Friends and Family FFT scores - Recommend Trust as Place to Work
Vacant posts</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2022</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14 Jan 2021 and related risk within 2020/21 BAF.</td></tr>
<tr><td colspan="10">Rationale for current score: (What is the justification for the current risk score)
Our Flexible Working Policy was refreshed and reviewed in 2019 and again in 2021, to maximise the opportunities available, particularly for retire and return and to encourage and support retention. Turnover has stabilised over last year (c12%/13%) and staff survey results for 2020 (released March 2021) showed improved satisfaction of the Trust as place to work and in the questions relating to intent to leave or look outside the trust. A long-term recruitment strategy to support required staff levels, recognising age demographic of current staff, is proposed as an area of considerable focus for Our People Strategy. Despite workforce turnover remaining consistent, the volume of recruitment activity has increased significantly since January. This has coincided with vacancies and maternity leave within the recruitment team. Additional resources have been agreed by Executive and new colleagues are in place or due to start by end Dec. TRAC, a new software system to provide faster and more accessible recruitment data will be implemented in Q4. An end to end review of the recruitment process will commence shortly, supported by QI, to report in Q4 with input from colleagues across the Trust.

Specific recruitment and retention initiatives in progress include the Widening Access/Apprenticeship Hub, international recruitment programme with first cohort of 30 RGNs in place, with RMNs in the pipeline; a review of bank pay rates and incentives; a pilot of retention incentives for Wotton Lawn Hospitals RMNs, and the commencement of the new NHS Cadet Scheme. The sustainable staffing oversight group in place.

We continue to work with systems partners on how to tackle the workforce gap and work has commenced on ICS recruitment and retention plan alongside the recruitment process for a new ICS Recruitment and Retention Lead.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1	International Recruitment Programme	22/03/21	1/10/21	Exec	1-year programme – review to see benefits met and option extend
2	Relationships number of universities to build supply New Programmes developed Uni of Glos – LD Nursing, Established RGN, RMN & Physiotherapy Degrees and student placement UoG Three Counties Medical School – local medical supply line	Ongoing	1/7/21	Exec	Lead time for RMN and Learning Disabilities degree training to complete. Sept intake on target for full cohort
3	Retention Lead Appointed	22/03/21	1/5/2021	CEO	Plan, impact & review to be taken forward
4	Recruitment Policy in place to fast track recruitment	22/03/21	1/2/22	Exec	
5	ICS Workforce Steering Group	Ongoing		Exec	ICS recruitment and retention plan
6	Wotton Lawn Task and Finish Group	01/10/21	01/12/21	Exec	Evaluation of pilot of retention incentives
7	Operational Workforce Task Group	17/11/21	01/01/22	Exec	First meeting w.c. 17.11.21

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Monthly Recruitment Activity Reports	L1	Monthly	Exec	Work in progress	Recruitment Strategy to be finalised
2	Staff Survey	L3	Mar 2021	Board	Satisfactory	
3	Retention Data	L2	Ongoing	Resources	Work in progress	
4	Turnover Data	L2	Ongoing	Resources	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete In Progress Delayed Not Started
1	Recruitment Strategy & Action Plan to be put in place (to include consideration of Lead times issue highlighted in gap in controls.	Consultation and engagement commenced	D HR&OD	**In progress** – target complete ~~Oct 21~~ Q4
2	Recruitment & Retention Premium Business case in development for higher vacancy/hard to recruit areas	In progress	D HR&OD	**In progress** – target complete Oct 21
3	Targeted temporary staff bank recruitment and review of bank incentives	Growth plan to be developed and implemented. Revised bank rates approved.	D HR&OD	**In progress** – target complete Oct 21
4	Continue to monitor Temporary staffing supply contracts (To be reviewed annually)	Sustainable Staffing Oversight Group in place. Master Vendor Contract and other agency provider reviews undertaken 2020/21.	D HR&OD	Complete for 2020/21
5	Implementation of TRAC system	Approved for implementation	D HR&OD	**In progress** - Target Q4
6	QI review of recruitment process	Commissioned 17/11/21	D HR&OD	Target Q4

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great Place to Work

High Quality Care</td><td>Board Lead:</td><td>Neil Savage, Director of HR&OD</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>5</td><td>Description:</td><td colspan="3" rowspan="2">Workforce Wellbeing

There is a risk that workforce health and wellbeing is not built into our ways of working, and not prioritised or appropriately resourced, leading to staff burnout, falling levels of retention, staff satisfaction, poor patient care experience and lower productivity.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="3">1st April 2020</td><td colspan="4" rowspan="5">• Staff Survey wellbeing metrics – positive action on HWB, reduction staff working when unwell,
• Pulse survey data
• Sickness Absence KPI</td></tr>
<tr><td colspan="3"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>3</td><td>6</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2022</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14 Jan 2021 and also elements from risks within 2020/21 BAF.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)

There has been a month on month reduction in sickness absence May 2020-July 2021 (with current rate being in target at 3.94%), regular NHS pulse surveys on Health & Wellbeing place the Trust above average, 2020 Staff survey (published Mar 2021) showed 10% improvement on positive action on HWB, reduction in staff working when unwell. Staff survey return has increased but further work is planned to build on this to ensure these measures are informed by even broader cross section of Trust staff. The Health and Wellbeing strategy is being updated with consideration of future sustainable funding arrangements and agreement with the ICS that the Trust will host the system-wide Health and Wellbeing Hub which has received NHSI/E funding. Progress on mitigating actions delayed but on target to reach tolerable risk score.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Health & Wellbeing (HWB) Team in place.	22/03/21	1/4/22	Exec & Board within Business Plan & Budget setting	HWB Strategy to be updated to reflect national framework
2	Health & Wellbeing Communication Plan in place – intranet, website	Ongoing	-	Exec/Board	
3	NED Wellbeing Lead, Exec Wellbeing Lead	22/03/21	-	Board	Role description not finalised.
4	Health & Wellbeing built into budget and business plan	22/03/21	31/3/22	Board	Sustainable core funding
5	Staff Support processes include HWB conversations – management supervisions, 121 meetings and appraisals	22/03/21			Assurance Audit to confirm built and of required quality in to be undertaken if staff survey highlights concerns.
6	Activities: Staff Counselling, MSK self-referral, Health & Hustle, Covid support, signposting Lets Talk Therapies	22/03/21			Covid support does not currently have recurrent funding. Services offered to be reviewed within updated strategy.

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Annual Working Well Assurance Report	L3	February 2021	Resources Committee?	Satisfactory	
2	Internal Audit HR to review compliance with processes	L3	2019	Audit Committee	Satisfactory – following completion follow up issues	
3	Working Well Occupational Health Safe Effective Quality Review (SEQOHS) accreditation & annual assurance process	L3	2020	Exec	Satisfactory	
4	Employee Assistance Programme	L3	Monthly	HR	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	HWB Strategy to be developed to reflect national strategy	Planned for Q1 2021/22	D HR&OD	**In progress** – target complete 1/11/21
2	Face to face counselling times to be reduced	Target 1-2 weeks, has reduced to 3-4 from 5-6	D HR&OD	**In progress** – target complete 1/11/21
3	Long term plan to fund support for Covid to be developed	Plan to be developed over Q1 2021/22	D HR&OD	Not Started
4	Audit of Quality HWB conversations to be undertaken if staff survey indicators raise as issue.	Not highlighted in 2020 Survey	-	Not currently required
5	Working well income generation programme to fund service provision and development.	To be reported on within revised HWB Strategy	D HR&OD	**In progress** – target complete 1/11/21

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great Place to Work

Better Care</td><td>Board Lead:</td><td>Neil Savage, Director of HR&OD</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>6</td><td>Description:</td><td colspan="3" rowspan="2">Education, Learning & Development

There is a risk that Education, Learning and Development are not recognised (and appropriately invested in) as central to improving practice, resulting in care not keeping pace with national developments and staff having reduced levels of satisfaction.</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="6">Relevant Key Performance Indicators:
(taken from the Performance Report)

• Related scores within Staff Survey
• [Set percentage within budget?]
• Statutory and mandatory training compliance
• Staff satisfaction
• Friends and Family Patient Feedback</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td>Tolerable Risk:</td><td>2</td><td>2</td><td>4</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st October 2021</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14/1/21 and related risks within 2020/21 BAF.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)

A new post-merger Learning and Education Strategy needs to be developed. Annual Education, Learning & Development Budgets and CPD expenditure plan and funding in place for 2021/22 and recognised as area of commitment within business planning process. L&D Policy developed and approved by JNCF, approved ICS system bid for improving student placements to HEE. Actions delayed due to staff vacancies.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Education, Learning & development budgets in place.	Mar 21	Mar 22	Board (within Bus Plan)	
2	Processes in place to ensure funding from range of bodies accessed: Apprenticeship Policy & Levy Funding, Health Education England	Mar 21	Mar 22	Board (within Bus Plan)	
3	Continuing Prof. Dev expenditure plan & funding in place	Mar 21	Mar 22	Board (within Bus Plan)	
4	Appraisal & Supervision discussions to identify training needs	Ongoing	Ongoing	Levels by Exec & Board	Need assurance robust conversations – triangulate with staff survey feedback
5	Accessibility and monitoring of completion of training through Care to Learn Platform	Updated 2020	2022	Exec	
6	Clinical Skills programmes/training funded and in place.	Ongoing	2022	L&D Team	Student placement provision limited in 2020/21 due to Covid.
7	Clinical Skills Strategies in place e.g. Dementia T&E Strat.	Ongoing	-	Quality Directorate	
8	Practice & L&D Lead and Teams in place	Ongoing	-	Dir HR&OD and D	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Education & Training Reports	L2	Annual	Workforce Management Group	Satisfactory	Mandatory Training compliance now reported in monthly Performance Dashboard which comes to Resources Committee, but on-going review of 2021/22 dashboard from April onwards.
2	Student Educational Surveys	L3	Quarterly	L&D Team	Satisfactory	
3	Staff Survey (T&D Qus)	L3	Mar 2021	Board	Satisfactory	Levels of staff engagement means whilst results statistically significant not hearing from all staff
4	Staff Survey – rec place to work	L3	Mar 2021	Board	Satisfactory	Ditto

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Learning & Ed Strategy to be put in place	To be taken forward 2021/22. First Draft targeted Nov 2021	D HR&OD	Not Started
2	Student Placement Provision availability in 2020/21 due to Covid means may be greater demand in 2021/22 which will need to be carefully managed.	Assessment of impact and development of plan to respond to be developed.	D HR&OD	**In Progress**
3	Work with ICS Partners to ensure we access HEE Transformation Funds effectively	Ongoing processes in place	D HR&OD	**In Progress**
4	Obtain feedback through alternative means	Consider T&D specific survey	D HR&OD	Not started
5	Overarching T&D Report to be presented to Board Committee	To discuss with Board and agree if required	D HR&OD	Not started

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Great Place to Work

Better Health</td><td>Board Lead:</td><td>Neil Savage, Director of HR&OD</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>7</td><td>Description:</td><td colspan="3" rowspan="6">Culture (Internal)

There is a risk that we fail to deliver our commitment to being a fully inclusive and engaging culture which reduces the attractiveness of the Trust as a place to work resulting in retention and recruitment issues and impacting on our ability to address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020</td><td colspan="4" rowspan="4">• Staff Survey – Rec place to work
• Engagement with Diversity Network, Team Talk, Comms etc
• Diversity levels at Band 8 and above – area of ongoing work
• Diversity Figures through organisation?</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>2</td><td>6</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>2</td><td>4</td><td colspan="4" rowspan="2"></td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">1st April 2022</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar Jan 2021.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The organisation Values & Behaviours work was co-developed, agreed and is now embedded within key policies, reward/award process, recruitment, inductions and appraisals to help ensure the culture reflects Trust and Board commitments. The Speaking Up at Work and Freedom to Speak Up Policies plus the developing Diversity Networks which are used to inform and develop practice provide assurance that the values and behaviours are being lived throughout the organisation. Leadership Development Programme (Thrive) and ICS Flourish Programme (positive action/stepping up programme) in place. Successful summer diversity event held. Equality and Diversity Lead Role appointed.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Co-developed Values & Behaviours organisational values	Mar 2020	Mar 2022	Board	
2	Just culture and appreciative enquiry processes included in performance management & Disciplinary Processes	Mar 2020	-	Executive	
3	Valuing Difference Leadership Strategy in place	2020	2022	Executive	
4	Freedom to Speak Up, Speaking up at work policies	Nov 2020	Nov 2021	Board	
5	Co-production commitment to service design	Ongoing		Board	Impacted by Covid restrictions

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 – Operational L2 – Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Feedback from appraisals and reward award processes	L1	Ongoing	Exec	Satisfactory	
2	Disability Confident Leader Accreditation	L3	Ongoing	Board	Satisfactory	
3	Annual Workforce Race Equality Scheme & Action Plan	L2	July 2020	Board	Satisfactory	
4	Annual Disability Equality Scheme & Action Plan	L2	July 2020	Board	Satisfactory	
5	Patient & Staff Surveys	L3	Mar 2021	Board	Satisfactory	
6	Freedom to Speak Up mechanisms report	L2	Nov 2020	Board	Satisfactory	
7	Diversity Network (sub groups women, LGBTQ+, Disabled, BAME) with Lead NED in place	L2	Ongoing	Board/Exec	Satisfactory	
8	Gender Pay Gap Reporting	L3	Mar 2021	Board	Satisfactory	
9	Work in confidence anonymous reporting in place	L2	Ongoing	Exec	Satisfactory	

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1.	Diversity at senior levels of Trust – Band 8 and above to be developed.	Reverse Mentoring in Place and ongoing	D HR&OD	**In progress**
2	Equality &Diversity Training to be updated.	E&D Training being reviewed 2021/22	D HR&OD	**In progress** – target Dec 21
3	Equality & Managing Diversity Policy to be updated	Being Reviewed with Trade Unions.	D HR&OD	**In progress** – target Dec 21

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="2">Better Health</td><td>Board Lead:</td><td>Angela Potter, Director of Strategy and Partnerships</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>8</td><td>Description:</td><td colspan="2" rowspan="7">Partnership Culture

There is a risk that the Trust is not seen as an inclusive organisation which works actively with its patients, staff and wider community partners resulting in a lack of engagement with the organisation as a partner which impacts on our ability to deliver co-produced, personalised and high-quality services and address inequalities in service delivery (access, experience and outcomes).</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report)</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td>1st April 2020</td><td colspan="4" rowspan="5">• Number of Engagement Partners
• Number of services redesigned using co production
• Number and breadth of services covered by Experts by Experience?
• Staff Diversity data reflects our community
• Patient Diversity Data reflects our community – this is information to be developed going forwards and is not yet routinely in place</td></tr>
<tr><td colspan="2"></td><td>Likelihood | Impact | Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3 | 3 | 9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3 | 3 | 9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2 | 3 | 6</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td>1st April 2022</td><td colspan="4"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="6">Discussion Board Risk Seminar 14/1/21 and elements of risks within BAF 2020/21</td></tr>
<tr><td colspan="9">Rationale for current score:
(What is the justification for the current risk score)
The Trust has a strong commitment to partnership working, co-production and personalised care within its ways of working which was a central tenet within its rationale for merger. The ongoing pandemic during 2020/21 has impacted on our ability to engage face to face with service users, although other mechanisms have maintained contact and there has also been less capacity in the Trust to engage in partnership working, although there has been a higher level of partnership working through the Gloucestershire health sector and community partnership work to support delivery of the Covid vaccine across the county's communities. Better Care Together events on schedule to restart December 2021 focussing on mental illness and inequalities with a programme across 2022 being developed. Board Development session completed in October relating to the People Participation agenda, co-creation engagement workshops taking place and the overarching Involving and Engaging People Plan is due to be presented to the Trust Board in December – this will now align with the new guidance for ICS's around engagement and involvement and the 10 principles on involvement.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Directorate for Strategy and Partnership with engaged team embedded in the communities we serve	Agreed as part merger	-	Board	Better Together events now scheduled to recommence
2	Joint Director with GCCG to support working with GP Network	Agreed as part merger	-	Board	
3	Expert by Experience Programme	20/21	21/22	D S&P	To ensure coverage of physical and mental health and to look at lessons from Covid
4	Governor Membership & Engagement Strategy	31/3/21	31/3/22	Council of Governors/Board	Action Plan to be implemented
5	Walk in My Shoes Programme	Ongoing	-	Exec/Board	To be reviewed for impact

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Friends and Family Test Patient Feedback Report	L2	Monthly (in quality report)	Quality Comm/Board	Satisfactory	
2	Compliments & Complaints Report	L2	Monthly (in quality report)	Quality Comm/Board	Satisfactory	
3	Staff Diversity Data	L2	Annual	Resources	Satisfactory	
4	Patient Diversity Data	L2	Ad hoc		Low	Reporting to be enhanced

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high-level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Better Together Events to recommence.	Agenda planned for commencement in December 21 with focus on mental illness and inequalities. Forward programme for 2022 underway.	D S&P	**In progress** Dec 2021
2	People Participation Strategic Framework to be developed	Engagement workshops and co-production session underway. Board development session completed and plan on track for presentation in December.	D S&P	**In progress** Dec 2021
3	Personalisation of Care to be confirmed element of co-production and service review	Personalisation of Care to be built into co-production and service review. Review of complete work programme and activities paused during covid underway	D S&P	**In progress**
4	Experts by Experience Review	New induction pack being completed. Further EBE recruited and a focus on widening the range of physical and MH inputs has taken place	D S&P	**In progress**
5	Governor Membership & Engagement Action Plan	To be implemented – partners and members to be put in place	H CG&TS	**In Progress**
6	Walk in My Shoes Programme	To be reviewed for impact in July 2021	CEO	Not started
7	Patient Access and Involvement Data to be developed	To be developed and reviewed against health inequalities	D S&P	Not started

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Better Health
High Quality Care</td><td>Board Lead:</td><td>Sandra Betney, Director of Finance</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>9</td><td>Description:</td><td colspan="3" rowspan="6">Resources Targeted at Acute Care

There is a risk that due to demand pressures, the ICS continues to be forced to prioritise acute care demand over Mental Health, Community, Primary Care and Learning Disabilities resulting in under resourcing of non-acute care and restricting the ability to provide joined up care</td><td>Lead Committee</td><td>Board/ Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4" rowspan="5">Relevant Key Performance Indicators:
(taken from the Performance Report)

• % of Glos health pound going to GHC out of ICS total?</td></tr>
<tr><td colspan="2">Date Risk Identified/confirmed</td><td colspan="2">1st April 2020</td></tr>
<tr><td colspan="2"></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>2</td><td>3</td><td>8</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">Target Score in Place 1st April 2022</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Risk identified at Risk Seminar 4th Jan 2021, also an element of risk within 20/21 BAF.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)

Acute services tend to have a higher profile in the media, to be more easily understood by service users and are often have more growth built into funding which can mean that growth in acute services is more easily recognised and reflected in funding allocations than non-acute services. The role non-acute care plays in prevention and supporting service users post-acute care needs to be reflected in funding mechanisms to provide holistic care, which makes best use of the Gloucestershire pound, in the county. Currently the allocations of funding in the ICS remain strongly focused on the acute trust. The joint working in response to the pandemic should help to strengthen understanding of the way acute and non-acute services work most effectively in partnership, but the focus on returning acute services but “normal” needs to be achieved without reducing funding to non-acute services which have also experienced growth in demand, particularly highlighted in relation to mental health within the media, but also the position across services. The H1 system plan delivers a break even position. The reduction in risk rating reflects the position for H1 agreed with system partners to achieve a breakeven position for H1. The funding secured for Mental Health Services, and the Covid funding (which exceeds Covid costs) are currently being treated as non-recurrent. Currently although there is a small surplus on the Trust’s position, the underlying recurrent position is less clear. H2 funding is not yet agreed but the reduction in impact represents the agreement with the CCG that MHS funding will be recurrent and progress on agreeing a contract schedule in readiness for when contracting resumes (22/23). The new financial regime is likely to give longer term planning certainty.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Strong partner within ICS – maintain our voice – Chair and CEO active within ICS Board meetings and planning	Report to each Board	Each Board	Board	
2	Active engagement in ICS groups - maintain our voice	Ongoing	Each Board	Board	
3	Active lead by CEO of a number of ICS groups	Ongoing			Evidence that community care reducing acute demand.
4	ICS Pathway planning	Ongoing	Exec	Board	
5	Active member NHS Providers, Mental Health Bodies and Community Trusts	Ongoing	Each Board	Board	
5	Communications Plan	Annual- within Business Planning	Mar 22	Board	Communication has been impacted by pandemic with greater focus internal comms.
6	Independent Chair of ICS	Annual		ICS	

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Annual Funding allocations	L2	Annual budget	Board	Satisfactory	
2	Interim Allocations to respond to pandemic	L2	Ongoing	Board	Satisfactory	
3	Trust media profile	L1	Reports to CEO weekly	CEO	Satisfactory	Need to reinforce reputation and knowledge of services, service quality and contribution to Glos Health System on ongoing basis
4	Benchmark data across acute, MH, Community services and LD services to demonstrate VfM	L3	Annual- gen Nov	Resources	Satisfactory	Need to work to ensure data which can be drawn out is comparable so that it can be used to support funding case. VFM Strategy in development.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Develop Evidence Base which is able to measure the role that community care plays in keeping people healthy and reducing acute demand.	Trust to put in place measures to enable this to be assessed & to work with ICS to support measurement across the system.	Exec	Not Started
2	Build knowledge base to demonstrate quantifiable results of investment in non-acute services	Trust building knowledge base and to build into communication strategy to improve understanding of impact non-acute care.	DoF	**In progress**
3	Review Communicating Business Plan and Objectives to ensure role Comms plays in maintaining reputation and profile of the Trust recognised by all Teams, with early engagement in service developments.	Comms Plan Objectives set for 2021/22 and to be kept under review to ensure internal and external comms needs balanced.	CEO	**In Progress**
4	Finance Strategy to be considered by Resources 21/22 (potential to include VFM measures and reference costs.	Business Intelligence team members of benchmarking groups to contribute to national guidance, data gathering and information held supports comparability of data. Finance Strategy in development.	DoF	Delayed
5	Ensure Trust's voice is heard within the Gloucestershire ICS pilot for proposed national reorganisation of NHS	CEO and Chair active part of the ongoing discussions to ensure understanding roles of different services built into proposed new structures.	CEO	**In progress**

<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Sandra Betney, Director of Finance</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>10</td><td>Description:</td><td colspan="3" rowspan="6">Funding - National Economic Issues

There is a risk that national economic issues impact on the funding settlement available for healthcare, meaning care is not adequately funded to improve and develop to meet needs, and services do not keep pace with demand and best practice, and the organisation ceases to be sustainable.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4">1st April 2020</td></tr>
<tr><td></td><td colspan="2">Likelihood</td><td>Impact</td><td>Overall</td><td colspan="4" rowspan="4">• NHS Funding Settlement</td></tr>
<tr><td colspan="3">Inherent Risk Score:</td><td>3</td><td>5</td><td>15</td></tr>
<tr><td colspan="3">Current Risk Score:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td colspan="3">Tolerable Risk:</td><td>2</td><td>5</td><td>10</td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2024</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Board Risk Seminar 14th Jan 2021 and elements of existing risks within the 2020/21 BAF.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">The pandemic has impacted on the wider economic health of the country, the potential impact of this has been reflected in proposed pay award levels for NHS Staff which has the potential ability to impact on staff recruitment and retention thus impacting on ability to resource levels of care required. The Trust's ability to directly impact on this risk is limited. The Controls, Assurances and Mitigations from risk 9 also help manage this risk. Based on the H1 efficiency ask, planning for H2 and funding secured, the impact of national economic issues has reduced although there remains uncertainty about recurrent funding.
H2 efficiency lower than anticipated and pay award impact recognised (although not fully funded) so risk likelihood reduced</td></tr>
</table>

	Controls: (What do we currently have in place to control the risk?)	Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Active Member NHS Providers	Ongoing	Each Board	Board	
2	Active member ICS	Ongoing	Each Board	Board	
3	Communication Plan and objective.	Annual – Bus Plan	Mar Board	CEO – ongoing	
4	Business & Financial Planning & Budget Setting processes	Annual & 6 monthly review	Sept Board	Board	These reflect internal processes to support sustainability, which are within the parameters of any funding settlement achieved by both the NHS and the local authority.
5	Financial Management processes including QuIP and CQuin	Monthly	April	Resources & Board	As above

	Sources of Assurance: (How do we know if the things we are doing are having an impact?)	Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Management Accounts	L2	Monthly	Resources/ Board	Satisfactory	
2	Performance Reports	L2	Monthly	Resources/ Board	Satisfactory	
3	Staff recruitment & Retention data	L2	Monthly	Resources/ Board	Satisfactory	
4	Funding allocations achieved with commissioners	L2	Annual – Jan- Mar	Exec/Board	Satisfactory	
5	Updates on relationships – commissioners, GCC, GCCG, MPs, Councillors.	L2	Every other month	Board	Satisfactory	

	Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)	Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Continue to provide information to NHS Providers to demonstrate wider impact of the NHS settlement in keeping individuals able to return to work/self-care.	Ongoing	CEO/DoF	**In progress**
2	Continue to take active role in consideration potential NHS reorganisation to attempt to minimise potential reorganisation costs (financial, time and emotional).	Ongoing	CEO	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">Sustainability</td><td>Board Lead:</td><td>Angela Potter, Director of Strategy and Partnerships</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>11</td><td>Description:</td><td colspan="3" rowspan="7">Sustainability (environment)

There is a risk that the resources and energy required to take forward sustainability in the Trust are diverted or under resourced resulting in failure to progress sustainability into all areas of the Trust's operation impacting on our commitment to be a good citizen and play our part in responding to the Climate Emergency</td><td>Lead Committee</td><td>Resources</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:</td></tr>
<tr><td colspan="3">Date Risk Identified/confirmed</td><td colspan="4" rowspan="5">• Green Plan in Place – Mar 22
• Targets/KPIs to be included in Green Plan [TBC]</td></tr>
<tr><td colspan="3">1st April 2020</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>4</td><td>3</td><td>12</td></tr>
<tr><td>Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td>Tolerable Risk:</td><td>2</td><td>3</td><td>6</td><td colspan="4" rowspan="2"></td></tr>
<tr><td colspan="3">Target Date to Achieve Tolerable Score</td><td colspan="3">March 2023</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">Reflection on Strategic Aims by Executive.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">Sustainability (environment) has been identified as an area of increased focus for the Trust. To date embedding of sustainability has largely been within Estates Management. It has been recognised this now needs to be driven across the Trust's wider operation and the sustainability team built and developed. A Head of Sustainability was appointed in Jan 2021 and a Sustainability Project Manager appointed in August 2021. A Green Plan is being developed to support this work. Green Plan Guidance (A three-year strategy towards net zero) has been issued by NHSE/I with Trust plans required by January 2022 and system-wide plans by end March 2022. Board development session planned for December 2021 and on schedule to reach target date.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		Last Review Date:	Next Review Date:	Reviewed by:	Gaps in Controls: (What additional controls should we seek?)
1	Estates Environment Measures monitoring	Ongoing	Mar 22	Head of Sustainability	Need for a complete baseline dataset
2	Management structure to support sustainability in place – Directorate responsibility DSP and Head of Resources in Place	Nov 2020	-	DSP	Keep under review resources required to achieve impact – dedicated lead in place – will team require future expansion or use of champions
3	Relationships in place to support joint working on this issue	Ongoing	-	DSP	Sustainability action group to be established
4	Commitment to sustainability within Trust Business Plan	Mar 21	Mar 22	Board	
5	Commitment to sustainability within Trust Strategy	Mar 21	Mar 22	Board	Green Plan Signed off by the Board

Sources of Assurance: (How do we know if the things we are doing are having an impact?)		Lines of assurance: L1 - Operational L2 - Board oversight L3 – Independent	Last Received	Received by	Assurance Rating	Gaps in Assurance: (What additional assurances should we seek?)
1	Estates Reporting on environmental measures within annual report	L2 L3	May 21	Board	Satisfactory (audited by External Audit)	Oversight of monitoring has been annual, need to ensure monitoring is more regular at Directorate level.
2	Procurement processes in place which include high level consideration of sustainability	L1	2020	Resources	Satisfactory	Embed sustainability within procurement at all levels.
3	Climate Emergency Reporting at Board level to contextualise this work.	L2	2020	Board	-	Need to ensure annual monitoring of this built into Board reporting to support understanding of context.

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:	Action Owner:	Deadline [revised deadline] Complete / In Progress / Delayed / Not Started
1	Develop baseline green position, and develop and Embed Green Plan.	Head of Sustainability in place. Work ongoing to develop green baseline and then green plan with objectives and measures.	DSP	~~Oct~~ Jan 2022
2	Build partnerships to help us meet our green aspirations.	Work ongoing to identify partners who could help us meet our green aspirations. Development of links with GHT and other system partners including membership of regional green forums.	DSP	**In progress**
3	Embed sustainability considerations into Trust Procurement processes	Work ongoing to further develop sustainability considerations into Trust wide procurement processes – beyond estates procurement	DSP	**In progress**
4	Consider future reporting mechanisms for sustainability to ensure impact is recognised and built upon	Metrics for wider monitoring of sustainability to be considered as part of the green plan development	H of Sustainability	**In progress** – discussions with BI

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Angela Potter Dir S&P</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>12a</td><td>Description:</td><td colspan="3" rowspan="6">NHS Re-organisation
There is a risk that the current NHS re-organisation results in diversion of time and energy, causing instability to colleagues and changes to priorities meaning the organisation is unable to deliver its long-term plan, strategies and organisational priorities, and that medium term plans may also be delayed.

It is recognised that there is an inter relation of this risk and risks 8 – Partnership Culture, Risk 4 Recruitment and Retention and that if risk 12a increases in likelihood that risks 8 and 4 are also likely to increase.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td colspan="2">Date Risk
Identified/confirmed</td><td>1st April 2020</td><td colspan="4" rowspan="4">Tbc</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td colspan="2">Inherent Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Current Risk Score:</td><td>3</td><td>3</td><td>9</td></tr>
<tr><td colspan="2">Tolerable Risk:</td><td>3</td><td>2</td><td>6</td><td colspan="4"></td></tr>
<tr><td colspan="2">Target Date to Achieve Tolerable Score</td><td colspan="3">Target Score in Place 1st April 2022</td><td colspan="4"></td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was recognised as a potential risk when the 2021/22 BAF was developed, as the NHS reorganisation processes have further developed the risk has been reviewed and following Board discussion has been added to the BAF as a Risk requiring full consideration and mitigation</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">As the NHS reorganisation moves forward towards becoming statute and ICSs are developed in readiness to respond to the changes detailed within the current Bill, directors, management and staff within the Gloucestershire health system are required to engage in developing revised ways of working at a time when responding to the Covid-19 pandemic and its wider impact are already stretching capacity and energy.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)		**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	ICS Transition Group and cascade groups established	July	Sept	Boards	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
2	ICS Transition Group Terms of Reference	July	Sept	Board	
3	ICS Executive and Board oversight – GHC Chair & CEO engaged	July	Sept	Board	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
4	GHC Board Reporting mechanisms	Every other month	Sept	Board	Confirm Board cycle maps to ICS decision cycle.
5	GHC Communication Processes	Monthly	Ongoing	Executive	

	Sources of Assurance: (How do we know if the things we are doing are having an impact?)	**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	All Board Strategies to be finalised in line with agreed timeline and agreed metrics in place for effective monitoring
2	Quality, Finance & Workforce Reporting	L2	Monthly	Board/Related Committee	Satisfactory	Exception Reporting in place and any significant changes in performance to be considered to identify if they are being impacted by this risk.
3	Staff Family and Friends Data	L3	Annual (Mar)	Board	Satisfactory	
4	Staff Pulse testing	L3	Qtrly	Board/ Committee	Satisfactory	
5						

	Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)	**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Ensure that performance reporting is considered through this lens to identify if performance is being impacted by this risk and remedial action considered.		DNTQ DHR&OD	
2	Ensure that Strategy achievement progress is considered through this lens to identify if performance is being impacted by this risk and remedial action considered.	Strategic oversight group mapping the organisational programmes of work with the ICS clinical programme groups and ensuring alignment and attendance.	Execs	**In progress** – November 21
3	Develop Relationships further as ICS continues to develop	Exec alignment into each of the ICS Transition workstreams with Director of Strategy & Partnerships taking an overarching co-ordination role. Bi-weekly ICS transition group meetings taking place	Execs	**In progress**

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<table>
<tr><td colspan="3">Strategic Aim:</td><td colspan="3">High Quality Care
Better Health
Great Place to Work</td><td>Board Lead:</td><td>Angela Potter Dir S&P</td><td>Date of review:</td><td>Oct 21</td></tr>
<tr><td>Risk ID:</td><td>12b</td><td>Description:</td><td colspan="3" rowspan="6">NHS Re-organisation
There is a risk that the current NHS reorganisation is not taken forward through effective, constructive and committed partnership working meaning that the opportunities for ensuring the new structure best meets the long-term needs of the Gloucestershire community and the responsibilities of the different partners are not understood and recognised in its operating processes and that planned service transformations are impacted.</td><td>Lead Committee</td><td>Board</td><td>Date of next review:</td><td>Jan 22</td></tr>
<tr><td colspan="3">Risk Rating:
(Consequence x Likelihood):</td><td colspan="4">Relevant Key Performance Indicators:
(taken from the Performance Report/ Quality Dashboard)</td></tr>
<tr><td>Date Risk
Identified/confirmed</td><td colspan="2">1st April 2020</td><td colspan="4">•</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Overall</td></tr>
<tr><td>Inherent Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Current Risk Score:</td><td>4</td><td>4</td><td>16</td></tr>
<tr><td>Tolerable Risk:</td><td>2</td><td>4</td><td>8</td></tr>
<tr><td>Target Date to Achieve Tolerable Score</td><td colspan="3">Target Score in Place 1st April 2022</td></tr>
<tr><td colspan="3">Potential or actual origin of the risk:</td><td colspan="7">This Risk was recognised as a potential risk when the 2021/22 BAF was developed, as the NHS reorganisation processes have further developed the risk has been reviewed and following Board discussion has been added to the BAF as a Risk requiring full consideration and mitigation.</td></tr>
<tr><td colspan="10">Rationale for current score:
(What is the justification for the current risk score)</td></tr>
<tr><td colspan="10">As the NHS reorganisation moves forward towards becoming statute and ICSs are developed in readiness to respond to the changes detailed within the current Bill there is a need to ensure that the proposed ways of working and the development of the new structure best meets the long-term needs of the Gloucestershire community and the responsibilities of the different partners are not understood and recognised in its operating processes. At the moment these processes are at an early stage and the need to build in necessary safeguards without creating onerous processes needs to be recognised, developed and implemented.</td></tr>
</table>

Controls: (What do we currently have in place to control the risk?)			**Last Review Date:**	**Next Review Date:**	**Reviewed by:**	**Gaps in Controls:** (What additional controls should we seek?)
1.	ICS Transition Group and cascade groups established		July	Sept	Boards	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
2	ICS Transition Group Terms of Reference		July	Sept	Board	
3	ICS Executive and Board oversight – GHC Chair & CEO engaged		July	Sept	Board	Ensure Board receives timely reporting and mechanisms in place for 2 way communication between Boards and ICS
4	GHC Board Reporting mechanisms		Every other month	Sept	Board	Confirm Board cycle maps to ICS decision cycle.
5	GHC Communication Processes		Monthly	Ongoing	Executive	
Sources of Assurance: (How do we know if the things we are doing are having an impact?)		**Lines of assurance:** L1 - Operational L2 - Board oversight L3 – Independent	**Last Received**	**Received by**	**Assurance Rating**	**Gaps in Assurance:** (What additional assurances should we seek?)
1	Board Strategy Reporting	L2	Every other month	Board	Satisfactory	All Board Strategies to be finalised in line with agreed timeline and agreed metrics in place for effective monitoring
2	Regular Board Reporting on ICS Development	L2	Every other month	Board	Satisfactory	Ensure effective 2 way communication in place between Boards and ICS

Mitigating actions: (What more should we do to address the gaps in Controls and Assurances?)		**Update since last reviewed (this should be high level actions – the detail of the actions part of regular committee discussions:**	**Action Owner:**	**Deadline** [revised deadline] Complete / In Progress / Delayed / Not Started
1	Identification of key decisions to be made as an ICS and confirmation of how Boards will be engaged agreed.	ICS Transition Plan, Structure and Workstreams identified. Draft milestones/outputs considered by ICS Exec.	CEO/Chair	**In progress**
2	Confirmation of escalation process for ICS decision making.	As above	CEO/Chair	**In progress**
3	Ensure ICS culture and processes reflect its new structure and purpose		CEO/Chair	**In progress**

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RISK MATRIX	LIKELIHOOD				
CONSEQUENCE	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	**15**	**20**	**25**
4 Major	4	8	12	**16**	**20**
3 Moderate	3	6	9	12	**15**
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

KEY:	1 – 3 LOW RISK	4-6 MODERATE RISK	8-12 SIGNIFICANT RISK	15 and over HIGH RISK

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AGENDA ITEM: 18/1121

REPORT TO: **TRUST BOARD PUBLIC SESSION – 25 November 2021**

PRESENTED BY: Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

AUTHOR: Anna Hilditch, Assistant Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL – Q1 AND Q2 2021/22**

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 Quarter 1 & Quarter 2 2021/22 (1st April – 30th September 2021).

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 and lease agreements.

The Board is asked to note that the Trust Seal was not used during the reporting period.

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?
Six monthly reporting to Trust Board

Appendices:	N/A

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance/Trust Secretary

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Wednesday 8 September 2021
Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Chris Witham
	Graham Hewitt	Ruth McShane	Laura Bailey
	Katherine Stratton	Said Hansdot	Mervyn Dawe
	Julie Clatworthy	Sarah Nicholson	Andy Holness

IN ATTENDANCE: Sandra Betney, Director of Finance/Deputy Chief Executive
Marcia Gallagher, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Jan Marriott, Non-Executive Director
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Corporate Governance & Trust Secretary
Graham Russell, Non-Executive Director/Deputy Chair
Neil Savage, Director of HR & OD
Gillian Steels, Trust Secretary Advisor (from Item 10)
John Trevains, Director of Nursing, Therapies and Quality

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from the following Governors: Kizzy Kukreja, Juanita Paris, Dan Brookes, Tracey Thomas, Katie Clark, Rebecca Halifax and Jenny Hincks. Karen Bennett did not attend the meeting.

1.2 Apologies were received from the following Non-Executive Directors: Maria Bond, Steve Alvis, Steve Brittan and Sumita Hutchison. Apologies for the meeting had also been received from Paul Roberts, Chief Executive.

1.3 Ingrid Barker welcomed Andy Holness to his first Council meeting since his appointment as a Public Governor for Tewkesbury on 15th July.

1.4 Ingrid Barker informed the Council that June Hennell, Public Governor for Stroud had sadly tendered her resignation from the Council on 31 August due to ill health. Ingrid had written to June to send her best wishes, and to thank her for her commitment and for sharing her experience, expertise and passion with the Council over the past 2 years.

1.5 It was noted that Maria Bond, Non-Executive Director would be coming to the end of her term of office on 30 September. Sadly, Maria had been unable to attend today's meeting, but the Council expressed its thanks to Maria for her work and commitment to GHC, and its predecessor Trust 2gether over the past 5 years.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 14 July 2021 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 expressed his apologies that he had been unable to attend the previous meeting in July due to personal circumstances; however, he made reference to the presentation that had been received by the Council relating to Out of Area Placements. He said that he would have welcomed a written report, rather than a verbal update as it was difficult to know exactly what had been discussed. From the minutes of the meeting, he said that there were a number of areas that still concerned him and that he felt had not been fully addressed. It was agreed that Mervyn would provide a list of those things that he wished to receive assurance on, to be passed on to James Wright and Leon Meek for action, via Anna Hilditch. **ACTION**

5. CHAIR'S REPORT

5.1 The Council received the Chair's Report, which outlined the key activities of the Trust Chair and Non-Executive Directors up to July 2021. It was noted that this report had also been presented to the Trust Board at its meeting on 29th July.

5.2 As noted earlier in the meeting, Maria Bond's term of office would come to an end on 30 September. The Council of Governors approved the appointment of Clive Chadhani as a Non-Executive Director, and he would be commencing in post on 1 October. Ingrid Barker informed the Council that the NEDs continued to meet monthly, and that these meetings had been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to continuously improve the way we operate. In light of the recent NED changes, and changes in Board Committee membership, it was noted that the NED portfolios would be updated and amended accordingly. Governors would receive the updated NED portfolios once confirmed. **ACTION**

5.3 Ingrid Barker was pleased to announce that the Chair and NED quality visits had now resumed. These visits to Trust sites and services had to be put on hold throughout the pandemic. However, with restrictions now easing a schedule of formal in person visits for the Chair and NEDs was now taking place and the outcomes would be reported to the Board, via the Quality Committee.

5.4 The Council noted that Ingrid Barker had recently been invited to be a Member of the NHS Executive Search Chair and Chief Executive Advisory Board and attended its inaugural meeting on 9th July. In response to a query from Nic Matthews, Ingrid Barker advised that the NHS was not very diverse, and historically there were few senior leaders in the NHS from ethnic minorities or other protected characteristics. The Advisory Board worked to provide development and support to potential applicants from this wider group. Neil Savage informed the Council that GHC had launched a new development programme called Flourish for colleagues on Bands 4-7 and one of the programmes focussed on protected characteristics.

5.5 Ingrid Barker informed the Council that it continued to be a very busy time but that her report demonstrated that some great work was taking place, both within GHC and the wider system.

6. CHIEF EXECUTIVE'S REPORT

6.1 Sandra Betney provided the Council with a verbal update on key news and developments.

6.2 The Trust had successfully appointed a new Chief Operating Officer, David Noyes. David was a very experienced COO and the Trust was looking forward to welcoming him into post early in the new year.

6.3 Some big capital projects had recently been approved by the Board and were due to get underway shortly. These included refurbishment works at Southgate Moorings in Gloucester (Dental Services) and Stroud Hospital MIIU and Jubilee Ward. Sandra Betney informed the Council that the Stroud League of Friends had offered huge support for the Stroud scheme.

6.4 It was noted that Covid measures were still in place across GHC, with Covid Secure environment guidance in place to ensure that our buildings remain secure. Sandra Betney said that GHC wished to be cautious with regard to lifting restrictions to ensure that both patients and staff were safe. She said that this was putting pressure on people as there was a disconnect between work and personal life where more restrictions had been lifted. Discussions were continuing to look at post-Covid working arrangements.

6.5 There remained huge pressures in the system, with an upsurge in demand for services. There was a knock-on impact on system flow with people discharged from the acute trust, into community hospitals with GHC and onwards into the social care system where delays were being seen. An increase in demand for mental health services was highlighted, as well as eating disorder services which could be seen at both GHC and Gloucestershire Hospital's Trust. Sandra Betney said that there was a real focus on recovery currently, with a huge amount of work taking place with operational services at GHC to review each service provided. It was noted that the Trust was also working in a challenging financial environment with funding only agreed for the first 6 months of the year (H1). It was expected that guidance for the latter half of 2021/22 (H2) would be issued at the end of September. A lot of close system working would be taking place.

6.6 Nic Matthews referred to the MH pressures in the system, which had also been highlighted in the Governor Dashboard report and asked for further information about the position at Wotton Lawn. Neil Savage said that the pressures at Wotton Lawn were in the main related to workforce/recruitment challenges and the supply of staff. A Task and Finish Group had been set up and a work plan was in place which had executive oversight. A Mental Health Admission and Discharge pathway group had also been set up to ensure robust monitoring of the flow of patients.

6.7 Graham Hewitt noted the staffing pressures at Wotton Lawn and asked whether GHC had a high turnover rate and how this compared with other Trusts. Neil Savage advised that the Trust's turnover rate remained consistent and was in line with other Trusts such as AWP and Worcestershire. There were hot spots where rates were higher, and these areas were being monitored. Neil Savage advised that this did not link to the current appraisal performance, noting that performance for appraisals and statutory training were slightly below target. Both of these areas were currently in recovery following Covid and recovery plans were in place. Statutory and Mandatory training stood at 89% against a target of 90% so improvements were being seen. The Council was asked to note that a new Board Committee had been set up – the Great Place to Work Committee – and this would focus purely on workforce and our people, with the ambition of supporting GHC to be an outstanding employer.

6.8 Chris Witham noted the generous support that had been offered from the Stroud League of Friends for the Stroud Hospital refurbishment works. He referred to the Governor Dashboard and the summary provided from the last Charitable Funds Committee meeting and suggested that it would be helpful for Governors to gain a better understanding on how Charitable Funds were used, particularly those that had been allocated from NHS Charities Together during Covid. Sandra Betney explained that Charitable Funds were used to purchase things that were classed as "above and beyond" those expected to be funded and provided for out of budgets. This would normally include things such as specialist equipment or garden furniture. It was agreed that it would be helpful to provide further information for Governors on all Charitable Funds and how these were used, and it was suggested that this could be tied in with the next Holding to Account presentation in November, with Sumita Hutchison, Chair of the Charitable Funds Committee being invited. **ACTION**

7. MEMBERSHIP UPDATE REPORT

7.1 The Council received this report which provided an update on Trust membership activity and statistics for the period up to 1 September 2021.

7.2 An overview of Trust membership was presented and included a breakdown of public members by constituency, ethnicity, disability and age profile. The Council was asked to note that public membership data had remained relatively static over the past 12-18 months, with little change in the statistics month on month. As of 1 September 2021, the Trust had 5944 Public members, of which 4991 were in Gloucestershire. Of these public members, 2580 receive communication from the Trust via Email.

7.3 It was noted that the Membership & Engagement Committee had been closely monitoring progress with the Membership & Engagement Strategy action plan at its meetings. Good progress was being made on all actions, with many of these now complete.

7.4 Anna Hilditch advised that managing Covid and the restrictions that have been in place over the past 18 months it had been difficult to carry out our regular engagement events. This was reflected in the earlier observation that public membership had remained static during this time. However, as restrictions start to ease, the Trust is starting to participate in events across the county and a monthly schedule of all planned Trust engagement opportunities was now being produced and shared with Governors. Governors were encouraged to attend these events alongside our Strategy and Partnership Team colleagues to promote Trust membership. An engagement pack had been produced to assist Governors in attending events and engaging with prospective members.

7.5 Graham Hewitt said that he had attended an event at Cirencester College. He said that he had welcomed this opportunity. In terms of feedback for future events, Graham said that the Trust might like to consider improved signage, such as banners at its stands as it had not been clear that this was an NHS stand. He also suggested that it would be helpful for Governors to receive a diagram setting out the NHS organisations in Gloucestershire, and how these fit together. **ACTION**

8. GOVERNOR ENGAGEMENT AND PRE-MEETING REPORT

8.1 Chris Witham, Lead Governor provided some feedback on discussions that had taken place at the Governor pre-meeting. He said that the Governors had welcomed the Governor Dashboard which would be discussed further later in the meeting.

8.2 The Governors had expressed their collective appreciation and thanks to Trust colleagues for all of the work that was taking place. There were a lot of tired people doing some fantastic work, ensuring that the Trust could continue to provide good care and services and this huge effort was recognised by Governors.

9. GOVERNOR DASHBOARD

9.1 As part of the Governors Review and Refresh work that took place in 2020/21, it was agreed that a Dashboard would be produced for Governors. The purpose of this dashboard was to provide a high-level overview on the performance of the Trust through the work of the Board and Committees, with particular focus on the core responsibilities of governors in holding the NEDs to account for the performance of the Board.

9.2 The dashboard provides a high-level snapshot to ensure governors have an ongoing sense of how the Trust is performing. This includes key Trust statistics, the achievement of Trust targets, and a summary of the business discussed at the Board and its Committees. The dashboard was designed to be easy to navigate, at the same time ensuring that Governors are not overwhelmed with data. Information is already available to Governors via public Board papers on the full range of Quality and Performance indicators, so this dashboard was not designed to duplicate this information, simply to highlight some of the key measures that Governors may wish to take assurance from.

9.3 Graham Hewitt said he found the dashboard extremely useful and would help to highlight the key issues for Governors to focus on. With regard to the Quality measures, Graham suggested that an additional measure looking at Complaints and the number resolved within the period might be helpful to include. **ACTION**

9.4 Mervyn Dawe felt that the dashboard was very useful. He asked about the target set for statutory and mandatory training compliance and queried why this target was not set at 100%. Neil Savage advised that the target for training was 90% as the Trust needed to factor in things such as turnover, sickness and maternity leave. As discussed earlier in the meeting, Neil noted that the Trust was still in the recovery phase. The Trust continued to operate under Covid Secure Environment guidelines, and it had not been possible to provide the level and frequency of training as pre-Covid. However, good progress was being made, with compliance at 89% currently.

9.5 Julie Clatworthy said that dashboard was a great development which provided very helpful headlines for Governors. She suggested that it might be helpful to include information in future editions on the Trust's recovery programme and also on vaccination statistics. **ACTION**

9.6 Nic Matthews also welcomed the dashboard, noting that this was really helpful by way of giving Governors a snapshot of performance. He supported the decision not to duplicate information, instead offering signposting to the Quality Dashboard and Performance Report by way of reducing the number of papers received by Governors. Nic Matthews asked whether it might be sensible to develop a tracker to ensure that Governors remained sighted on those longer-term issues which may be identified. **ACTION**

10. HOLDING TO ACCOUNT PRESENTATION

10.1 The Council received a HTA presentation from Marcia Gallagher, Senior Independent Director (SID) and Chair of the Audit & Assurance Committee. The presentation provided Governors with an overview of the purpose of the Committee, the key ways

of working, those things that had worked well and a summary of the areas where development was underway.

10.2 The Audit & Assurance Committee was a statutory committee. The purpose of the Committee is to provide the Board with a means of independent and objective review of financial and corporate governance assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Annual Governance Statement. Marcia had been chairing the Audit & Assurance Committee since 2016 (2gether).

10.3 Marcia Gallagher set out the key role and duties of the Audit Committee. In addition to those roles expected of a Committee Chair, Marcia's role as Audit Chair also included:

- Requirement to act as the key contact point for all auditors (internal and external) if they suspect any impropriety
- Authority to approve waivers outside of formal Committee meetings, where required, and providing appropriate challenge to the Director of Finance on these
- Have the ability as a qualified accountant to ask questions and to seek assurance on more technical financial implications/decisions
- Play a lead role in the evaluation of the External Audit performance

10.4 Mervyn Dawe said that he really appreciated the role played by Marcia Gallagher and Sandra Betney, Director of Finance. He noted that Marcia had the authority to sign waivers outside formal meetings and he asked whether there had ever been a conflict with that and if there was a process to follow if an issue did arise. Marcia Gallagher said that there could be a difference of opinion and she had refused to authorise waivers previously. On these occasions she had met with Sandra Betney to discuss the reasons, and further information/assurance was then sought and provided. Marcia said that it was her prerogative as Chair of the Audit Committee to challenge decisions and to request further work or information if it was felt it was required. Marcia Gallagher informed the Council that she was fortunate to have a very good and effective working relationship with Sandra Betney and it was unlikely that any major conflicts would arise.

10.5 Mervyn Dawe made reference to government funding for the NHS. Sandra Betney said that no confirmation had been received nationally as to where the 3% pay rise would be funded from; however, Trusts had been advised not to include the impact of this in their accounts as it would be funded centrally. She noted however that it was interesting that the percentage pay rise was the same as the percentage of efficiency savings being request from Trusts.

10.6 Graham Hewitt expressed his thanks to Marcia Gallagher and Sandra Betney for leading the recent Governor session on the Annual Report and Accounts. He said that this briefing had provided good assurance on the Trust's management of the financial accounts.

10.7 The Council noted that the Trust had a good working relationship with KPMG, the current external auditors, who had been with the Trust since the merger in October 2019, and prior to this with the predecessor organisations. Marcia Gallagher advised that an effectiveness review was carried out annually on the external auditors, a process that she led as Chair. Evaluation of the external audit function on a regular basis is considered good practice and is recommended to NHS audit committees in the Healthcare Financial Management Association's NHS Audit Committee Handbook. Benchmarking data gathered last year on external audit fees paid to other NHS Trusts suggested that the fee charged by the external auditors was in line with comparable organisations. Marcia Gallagher advised that this was the last year of the current external audit contract. The market for external audit was complex and the increasing

requirements placed on Auditors by the regulator has had the effect of reducing the available pool of auditors. It is proposed that market exploration will commence in October 2021 with a decision to tender taken by the Council of Governors at its meeting in November 2021 with a view to a new contract commencing in April 2022.

10.8 Marcia Gallagher informed the Council that the Audit Committee received and discussed the internal audit work plan annually. This work plan of audits to be conducted during the year was developed focussing on those areas identified by GHC as requiring improvement or development. The Trust, and the Audit Committee was always looking to strengthen assurance mechanisms.

10.9 The Council of Governors thanked Marcia for her presentation and for providing robust assurance on the role of the Audit & Assurance Committee and the processes in place to ensure organisational compliance.

10.10 It was noted that there had been a number of apologies received for today's meeting so a copy of the recording from this meeting could be made available to anyone who wished to hear the Holding to Account presentation in full.

11. COUNCIL OF GOVERNOR MEMBERSHIP AND ELECTION UPDATE

11.1 The Council received and noted this report which provided an update on changes to the membership of the Council of Governors and an update on progress with Governor elections.

11.2 Mervyn Dawe noted the Public Governor vacancy in Stroud following June Hennell's departure. He asked whether consideration could be given to advertising both Stroud positions at the same time, noting that his term would end in June 2022 and by carrying out the process now it could save the Trust some money. Mervyn was thanked for this useful suggestion, and it was agreed that this would be considered depending on when the election process commenced. **ACTION**

12. GOVERNOR ACTIVITY UPDATE

12.1 There were no further updates provided.

13. ANY OTHER BUSINESS

13.1 Ingrid Barker informed the Council that Gill Morgan, Chair Designate for Gloucestershire ICS would be attending and presenting to Governors at the next meeting in November.

13.2 Mervyn Dawe asked about GHCs involvement around ME care, and also whether there was a team offering transgender support. These questions would be considered further outside the meeting. **ACTION**

14. DATE OF NEXT MEETING

14.1 The next meeting would take place on Wednesday 10 November 2021 at 2.00pm.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
12 May 2021			
9.1	Consideration be given to providing Governors Public Governors with email addresses for correspondence.	Anna Hilditch	**Complete**
8 September 2021			
4.2	Mervyn Dawe would provide a list of those things relating to OAA Placements that he wished to receive further assurance on, to be passed to James Wright and Leon Meek for action, via Anna Hilditch.	Mervyn Dawe	**Complete**
5.2	Governors would receive the updated NED portfolios once confirmed.	Anna Hilditch	**Complete.** See App 1 of Chair's Report.
6.8	Further information to be provided for Governors on Charitable Funds and how these were used. This would be tied in with the next Holding to Account presentation in November, with Sumita Hutchison, Chair of the Charitable Funds Committee being invited.	Anna Hilditch	**Complete.** Charitable Funds presentation and HTA session taking place at November Council meeting
7.5	It would be helpful for Governors to receive a diagram setting out the NHS organisations in Gloucestershire, and how these fit together.	Anna Hilditch	**Ongoing.**
9	**Additions to Governor Dashboard:** • Complaints and the number resolved within the period • Update on Recovery programme • Vaccination statistics	Anna Hilditch	**Complete.** Now included in Governor Dashboard
9.6	Look to develop a tracker alongside the dashboard to ensure that Governors remained sighted on those longer-term issues which may be identified.	Anna Hilditch	Ongoing development
11.2	Consideration would be given to advertising both Stroud Governor positions at the same time, noting that Mervyn's term would end in June 2022 and by carrying out the process now it could save the Trust some money.	Anna Hilditch	**Complete.** See update in Council Membership & Election report on agenda
13.2	Mervyn Dawe asked about GHCs involvement around ME care, and whether there was a team offering transgender support. These questions would be considered further outside the meeting.	Anna Hilditch	**Complete.**

MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE SUMMARY REPORT

DATE OF MEETING 20 October 2021

COMMITTEE GOVERNANCE	• Committee Chair – Sumita Hutchison, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

UPDATE ON THE CONSULTATION ON REFORMS TO THE MHA WHITE PAPER

The Medical Director provided the Committee with a verbal update on the consultation on the reforms to the MHA White Paper. A *Task and Finish Group (Mental Health Operational Group)* had been established in which discussions of the implications of the changes to the MHA were being discussed. There will be specific information on what **additional staff** is needed to meet the requirements from the reforms and the risks arising from the reforms. This information will define the Corporate Risk ID 180. The Committee highlighted the critical need for **operational Support** both on the Committee and within the Mental Health Operational Group.

The Committee was informed that the Royal College of Psychiatrists had issued a press release which called for an investment of approximately £82m in order to make the requested changes successful. There was also the requirement for an additional 349 psychiatrists by 2024/25. A 7% increase in AMHP workforce was also recommended and it was noted that this would include supporting prisons; which the service currently did not do. The likelihood of the Trust recruiting the right levels of staff to meet the requirement of the Mental Health Act reforms is very small.

BLACK LIVES MATTER – GLOUCESTERSHIRE'S MENTAL HEALTH SERVICES

The Committee welcomed David Pugh and Noor Al-Koky to the meeting, who shared a presentation on Black Lives Matter and Gloucestershire's Mental Health Services. They shared some co-produced and relevant recommendations. The committee requested that they return in January and give an **update on progress within this Trust and the wider system** on progress against these recommendations.

COMPLEX EMOTIONAL NEEDS SERVICE PILOT

The Committee welcomed Jo Greenwood, Clinical Development Lead for **Complex Emotional Needs Service** and Jo Tym, Lived Experience Practitioner to the meeting who shared a presentation on the Complex Needs Service. They explained the work they did and the Committee considered it to be in line with **Trust values and strategy; co-produced, multiagency and preventative work**. The service requested a place to work from.

CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register, which provided information and assurance in respect of the following risk for the Committee's oversight.

Risk ID 180 - Mental Health Act Changes

There is a risk that new government legislation will have a significant impact on clinician workloads. This is because a Government review of the mental health act looks like increasing

safeguards for patients and significantly increasing responsible clinician workload. There is a potential impact on provision of clinical services.

The Committee was informed that the risk score for Risk ID 180 (above) had increased to 15. Risk ID 180 would also be received by the Resources Committee – and subsequently the Great Place to Work Committee due to the workforce implications. The detail of the **risk will be amended**, based on the findings from the Mental Health Operational Group.

AMHP UPDATE

The Committee received an update on the AMHP service activity and a downward decline in referrals in the current quarter was highlighted; with a decline of 2.6 in comparison to the previous year. It was reported that 88% of referrals received had led to an assessment; and from these, 200 had led to an admission (out of a total of 332).

The Committee was informed that the majority of the referrals were from the Crisis Resolution and Home Treatment teams, who had made 175 referrals for the quarter. Wotton Lawn Hospital and the Mental Health Liaison Team followed in numbers.

The Committee noted the challenges encountered with under age 18 patients and it was reported that in quarter 1, one under 18 was detained on Maxwell Suite. Due to this, Maxwell Suite was closed to other patients.

The Committee agree the **importance of the MH triage car** and noted the reduction in its operational time as compared to pre-pandemic levels. The Committee agreed that an increase in operational time would impact the s.136 detentions albeit acknowledged a shortage of skilled staff to fulfil this role.

The Committee **noted** the report and assurance provided.

REVIEW OF MHA/MCA/DOLS TRAINING

The Committee received the Review of MHA/ MCA DoLs Training report which provided an update on the training position and the development of training provisions going forward.
The Committee **noted** the current position with training provision and **endorsed** the training proposals presented.

MHAM REAPPOINTMENTS

It was reported that four MHA Managers were due for reappointment. All Managers received a performance review and all were supported for reappointment for a period of 3 years from 1 November 2021. The managers reappointed were:

- Barbara Nurse
- Gill Pyatt
- Anthea Foden
- Libhin Bromley

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the Mental Health Operational Group update
The Committee **received** and **noted** the MHA Policies, Receipt & Scrutiny of MHA Documents and Renewal of Detention & Extension CTO
The Committee **received** a verbal update on the Review of Legal Services
The Committee **received** a verbal update on the Review of Detention Issues & Identification of Lessons Learned & Actions Undertaken

The Committee **received** and **noted** the rolling audit of detained patients and the reminder to them about their rights
The Committee **received** a verbal update on the Review of DoLs Applications

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Endorse** the reappointment of 4 MHAMs
- **Note** the contents of this summary.

DATE OF NEXT MEETING	**19 January 2022**

GREAT PLACE TO WORK COMMITTEE SUMMARY REPORT

DATE OF MEETING 21 October 2021

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 67% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

WELCOME

The Chair commented that the aspirations of the Committee were to be fun, inclusive and engaging. The Committee would be open to everyone and be an honest and open environment to share views and hold discussions.

STAFF STORY - APPRENTICESHIPS

The Committee welcomed Stacey Robinson, Apprenticeship & Widening Access Lead/ICS, Zoe Carter, Apprentice Health Care Assistant and Evie England, Apprentice Learning & Development. Stacey Robinson shared the fantastic news with the Committee that at Gloucestershire's Apprenticeships Awards; the Trust had won five awards, including overall apprentice of the year (See below):

- Gloucestershire apprentice of the year – Zoe Carter
- Apprentice of the Year (Business and Finance) – Evie England
- Apprentice of the Year (Healthcare) – Zoe Carter
- Outstanding contribution to apprenticeships in Gloucestershire – Stacey Robinson
- Over all employer of the year – GHC

Each of the apprentices were invited to speak about their experiences and shared their achievements within the role.
The Trust currently had 173 apprentices, ranging from level 2 up to level 7. There were 26 apprenticeship standards. 88 apprentices had enrolled in 2021, 26 had completed.
The Chair asked that GHC's apprenticeship success be reported back to the Trust Board.

DRAFT TERMS OF REFERENCE

The Committee received the draft Terms of Reference (ToR) for the GPTW Committee and was invited to discuss any inclusions or amendments.
The Committee discussed the inclusion of a governance structure chart highlighting how different management groups would feed in to the Committee. Other amendments were discussed and the Head of Corporate Governance agreed to incorporate.

The Committee **received** and **commented** on the Terms of Reference.

WORKFORCE KPI/METRICS DEVELOPMENT & OPTIONS FOR THE COMMITTEE

The Committee received the Workforce KPI/Metrics Development & Options for the Committee and a demonstration of the dashboard and its functions.

The Chair asked for the inclusion of exception reporting, key trends and benchmarking against other trusts within the county and nationally. Consideration would be given to how the information would be triangulated.

RISK APPROACH

The Committee was informed that the Risk Team had been reviewing the alignment of risks with the GPTW Committee and the Committee would receive the risks for which it held responsibility in the December meeting. The Committee would also receive the Board Assurance Framework at the December meeting.

NATIONAL QUARTERLY PEOPLE SURVEY (NQPS – FORMALLY STAFF FFT) & PULSE SURVEY UPDATE

The Committee received the National Quarterly People Survey (Formally Staff FFT) & People Pulse Survey update. The Committee was informed that overall the Trust was doing well. The Trust had performed better in 6 out of 9 of the questions which were asked.

It was reported the scores for the following questions had remained the same:

- I look forward to going to work
- I am enthusiastic about my job

One score had reduced which was in response to question; *time passes quickly when I am working.*

The Committee **noted** the results of the first 2021 national Quarterly People Survey.
The Committee **noted** the results of the most recent People Pulse Survey, noting that the Health and wellbeing Hub were considering actions to take forward with support from the Executive and Communications.

COMMITMENT – EQUALITY, DIVERSITY & INCLUSION

The Committee received the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) 2021/2022 Action Plan which provided an update on the Trust's progress and duties with regard to its WDES and its WRES for 2021/22.

The Committee **approved** the WDES/WRES Action Plan 2021/22 for publishing on the public website, with the caveat any future amendments would be incorporated.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the draft Committee Work Plan
The Committee **received** the sample agenda for future GPTW Committee meetings.
The Committee **received** and **noted** the People Strategy.
The Committee **received** and **noted** the HR & OD Directorate Organogram.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**13 December 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 22/1121

FOREST OF DEAN ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 26 October 2022

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

OVERVIEW OF THE CURRENT COST PLAN/ DESIGN & TIMELINE UPDATES

The Committee received a presentation on the overview of the current cost plan/design updates and timeline updates. The Committee was assured that the Director of Finance, the Director of Strategy and Partnerships and the Strategic Project Manager regularly met with colleagues at the regional office and that discussions held had helped to clarify their requirements for the full business case.

The Committee was informed of factors influencing the programme and noted delays due minor changes in floor plans, the delay in submission of changes to Mechanical & Engineering requirements (which included changes to the roof designs) and engagement from County Council Highways.

The indictive programme milestones was shared with the Committee and it was reported that planning approval was anticipated to be 4 January 2022. It was noted that the prime risk would be approval from County Highways. A 6-week window had been incorporated in to the plan to allow for delivery of any pre-start conditions set by the District Council.

The Committee was informed that the agreed construction cost plan was £23.9m and noted that this included the £500k contingency previously agreed. The revised cash flow was reported as £1m - 21/22, £12.5m - 22/23 and £8.5m - 23/24. Confidence was expressed that the delivery cost plan would not exceed the approved £23.9m. It was noted that the £500k contingency was still intact and was available to allocate to the project if required. However, once the GMP was set, this contingency could be used for other projects if not required for the Forest scheme. The Committee was assured the GMP had built in contingency to cover any risks.

CDEL & SYSTEM CONVERSATIONS REGARDING CAPITAL

The Committee discussed the implications of CDEL on the project and the Director of Finance reported that in order to agree how CDEL would be assigned, it would firstly need to be agreed by the ICS for the system.

The Committee was informed that a presentation of the mitigating actions to address the CDEL was presented to the ICS Executive.

An Extraordinary Board meeting (Private) would be taking place on 3 November, at which the actions and implications would be discussed in more detail.

BOARD CERTIFICATION STATEMENT

The Committee received the Board Certification Statement, which provided evidence to support the Trust Board in certifying that it had satisfied itself in a number of the key areas of risk as prescribed by NHSE/I in the National Transaction Guidance for Foundation Trusts (November 2017) in relation to the investment in a new hospital for the Forest of Dean. It was agreed that the updates relating to CDEL would be included.

The Committee **considered** the evidence provided, noting that this would be presented at the Extraordinary Trust Board on 3 November for approval and sign off.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the General Risk Register
The Committee **received** and **noted** the Construction Risk Register

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**TBC**

AGENDA ITEM: 23/1121

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 02 November 2021

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 6

The Committee received the Finance Report for month 6, which provided an update on the Trust's financial position. It was noted the Financial Report closed H1 of 2021/22. The Trust had a break-even position at the end of H1. This was in line with the soft close position which was expected by the Trust. The Committee noted that the pay award and the pay arrears were paid in month 6 which was £2.3m pay matched by assumed income. It was reported that the level of risks identified was reduced at the end of 21/22 period. The Committee **noted** the month 6 financial position.

PERFORMANCE REPORT – MONTH 6

The Committee received the Performance Report for month 6 which provided a high-level view of the key performance indicators in exception across the Trust. In relation to Recovery, it was reported that the MacMillan Service had moved into a red rating and that this was due to staffing issues. The Mental Health Complex Psychological Interventions service had moved to amber and the CAMHS Learning Disabilities service has also reduced to amber.
The Committee noted that all of the indicators within the report had been in exception with the previous 12 months.
The Committee **noted** the aligned Performance Dashboard for September 2021.
The Committee **noted** the report as a **significant level of assurance** that the Trust's contract and regulatory performance measures were being met or that appropriate service action plans were being developed to address areas requiring improvement.

ICS H2 PLAN SUBMISSION / FINANCIAL IMPACTS ON GHC

The Committee received the ICS H2 Plan Submission and the Director of Finance reported that the submission of initial plans to NHSI was due by 16 November and the final plan would be submitted on 25 November 2021. The final position of the system had not yet been agreed. The Committee was assured that the plan was being reconciled in the background to reflect the budgets and business plan that had already been agreed. The H2 plan would be aligned with the plan that the Trust already had. Planning guidance was received in September 2021 and was similar to the guidance received for the planning of H1. The 6 key priorities for the delivery of H2 were shared with the Committee and it was noted that they were continued from H1
The draft financial submission was shared and it was noted that this was a system plan and that any surplus' available in H1 would be used in H2 to help to manage the winter demands and elective recovery. The system was expected to break even at the end of the financial year.
The Committee received the Financial Impact of H2 on GHC. The Committee was informed that the System had been given £546m to spend in H2. Each organisation within the System

had projected their income and expenditure for the financial year. From this, H1 spending was deducted and a forecast estimate of what was thought to be required from the £546m was produced. It was reported that the Trust's projected request would be £106m. The Committee was asked to note that the System requirement (at present) was £552m, which meant a gap of £6.6m. As a System, it was believed £3.9m had been identified to bridge the gap, which left £2.6m to find. The Director of Finance commented that she felt by submission the mitigation of the £2.6m would be agreed.

GREEN PLAN DEVELOPMENT

The Committee welcomed James Powell, Head of Sustainability to the meeting who shared a presentation on the Green Plan Development. The Committee was informed that in 2020 the Greener NHS set an ambition to become the world's first healthcare organisation to reach net zero emissions. The two overarching targets in order to achieve net zero carbon emissions were shared with the Committee; these were:

- NHS Carbon Footprint -80% reduction in emissions by 2032 with ambition to be Net zero by 2040
- NHS Carbon Footprint Plus -80% reduction in emissions by 2039 with ambition to be Net zero by 2045

The Committee was informed that the Trust Board would receive the final Green plan for approval in January 2022. This would then be submitted in March 2022 following input from the ICS.

BUSINESS DEVELOPMENT REPORT / SARC TENDER

The Committee was informed that the Trust had been successful in stage 1 of the SARC (Sexual Assault Referral Centre) tender submission and would now move into stage 2, the service assurance process. The winning bidders of the service would be awarded the relevant contracts for each lot to commence 1 October 2022. This would be for a 7-year period. The Committee was informed of the service details and potential partnership working arrangements with First Light. The service would cover both Gloucestershire and Swindon & Wiltshire. If the tender was successful, a Partnership Board would be established with joint membership of GHC and First light.

In terms of finances, it was identified that the largest cost would be the SOE (Sexual Offence Examiner) element. The new accreditation of forensic and legal medicine costs had been included in the finances shared with the Committee. It was noted that this would be a new accreditation in the next 2 years and was estimated to cost £156k to achieve.

The Committee was informed that the full assurance submission would be December 2021 and the contract award would be 28 February 2022. The Committee supported the tender process presented.

EMERGENCY PLANNING ANNUAL REPORT & CORE STANDARDS

The Committee received the Emergency Planning Annual Report and Core Standards which provided an update on the Trust's compliance against the NHSE Core Standards for Emergency Preparedness Resilience and Response for 2021/22.

The Committee was informed of three core standards in which additional assurance was required in order to achieve full compliance for 2022/23. These were:

1. Business Continuity Plan Audit
2. Shelter and Evacuation
3. Lockdown

The Committee **endorsed** the content of the report and the current declared level of assurance provided. The Committee **endorsed** the identified EPRR priorities required for full compliance in 2022/23. This endorsement would be reported to the Trust Board.

SOUTH GATE MOORING LEASE NEGOTIATIONS

The Committee received the Southgate Moorings Lease Negotiations, which sought the support of the Committee in negotiating the extension of the lease at Southgate Moorings; ahead of seeking approval of the Trust Board. The Committee **supported** an extension to the existing Southgate Mooring lease being negotiated in line with the recommendations detailed within the paper.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the Internal business Plan – Q2
The Committee **received** the Estates & Facilities presentation
The Committee **received** and **noted** the Risk Register
The Committee **received** and **noted** the Board Assurance Framework
The Committee **noted** the outcome of the Resources Committee Effectiveness Review
The Committee **reviewed** and **considered** the proposed changes to the Committee's terms of reference.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**23 December 2021**

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 04 November 2021

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD

The Committee received the Quality Dashboard, which provided a summary assurance update on the progress and achievement of quality priorities and indicators across the Trust's physical health, mental health and learning disability services.

The Committee noted that recruitment and retention within key service critical areas remained a significant challenge and was informed that Senior colleagues within NTQ had increased their involvement with OD and operational teams to support the recovery work.

The NTQ team continued to lead the 'learning from nosocomial transmission' project which supported the countywide serious incident for HOPHA and HODHA Covid-19 cases in the Trust's hospitals. The level of scrutiny applied to each case and the compassionate personalised approach to applying duty of candour was noted.

The Committee noted the report included the first Non-Executive Director (NED) Quality Visits report which was well received.

It was reported that a scoping exercise had been undertaken with community teams ensuring that staff presenting at care homes had their vaccination evidence easily available.

The Committee **received, noted** and **discussed** the Quality Dashboard.

HOME FIRST – CLINICAL PRESENTATION

The Committee welcomed Steve Holmes and Victoria McCuaig to the Committee who shared a presentation on Home First, reablement.

The Committee was informed that the strategy was to get people out of hospital and also offering alternative care to avoid admittance into hospital. It was recognised that it was important to identify patients early on in order to provide proactive reablement.

The Committee thanked Steve Holmes and Victoria McCuaig for sharing the presentation and for their work within the service. It was agreed that the presentation would be shared with the Trust Governors.

QUARTERLY PATIENT SAFETY REPORT – Q2

The Committee received the Quarterly Patient Safety Report, which provided a summary of both mental and physical health Patient Safety incidents reported during quarter 2.

It was reported that the number of no and low harm incidents reviewed in quarter 2 had exceeded the Trust's target of 10%, with 15.5% reported for the quarter.
It was reported during quarter 2 the Patient Safety Team convened 14 72-hour Initial Investigation meetings, this included incidents which had gone on to be declared as a SIRIs.
The Committee was informed that 3 mental health incidents and 3 physical health incidents had met the criteria for a Serious Incident Requiring Investigation (SIRI).

The Committee was informed of a clinical investigation which was being completed by a member of the GHC Safeguarding Team following an incident where a letter was written to the parents of a CAHMS patient, disclosing that her colleagues had recently attended a Multi-Agency Risk Assessment Conference (MARAC). It was reported that this was a breach of information as a high-risk perpetrator (the patient's father) should not have found out that a case was being heard at MARAC. It was confirmed that the incident had been reported to the Information Commissioners Office.

It was reported that Physical Health hospitals, and older persons wards including Charlton Lane Hospital, reported higher rates of falls and some skin integrity incidents. Similar divergence was also seen with the Community Teams.

The Committee **noted** the contents of the Quarterly Patient Safety Report.

OTHER ITEMS RECEIVED

The Committee **received** and **noted** the Risk Register
The Committee **received** and **noted** the Board Assurance Framework
The Committee **received** and **noted** the learning from Deaths Report – Q2
The Committee **received** and **noted** the Resuscitation Report
The Committee **received** and **noted** the Quality Assurance Group Summary Report.
The Committee **received** and **noted** the Quality Committee Effectiveness Review
The Committee **reviewed** and **considered** the proposed changes to the Terms of Reference.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**06 January 2022**

AGENDA ITEM: 25/1121

APPOINTMENTS AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT

DATE OF MEETING 9 November 2021

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

EXECUTIVE DIRECTOR INTERIM PERFORMANCE REVIEWS

The Committee received a report setting out the interim performance of the Executive Directors. It was noted that the Chief Executive met with Executive colleagues to carry out a formal review of performance. These reviews focused on progress against agreed annual objectives as well as discussions about any challenges or achievements. This report was received and the Committee was pleased to see the positive progress made to date. Assurance was received that plans were in place to address any areas requiring development/improvement.

EXECUTIVE DIRECTOR REMUNERATION

This report set out a recommendation for pay uplifts for 2 Executive Directors. Detailed analysis had taken place, taking into account recent NHSE/I guidance on Very Senior Managers' pay, national benchmarking and current performance. The Committee approved the recommended uplifts, which would bring both posts in line with similar organisations both regionally and nationally.

SUCCESSION PLANNING

This report provided the Committee with an overview of Executive Director succession planning, highlighting those directorates where there was a need to strengthen the senior team support available on a longer term basis. The Committee noted this report and it was agreed that further work would be carried out to look at the development of role descriptions of Deputy Directors, flexible working opportunities for senior managers and possible secondment opportunities.

OTHER ITEMS RECEIVED

The Committee **received** and **discussed** the ATOS Committee Effectiveness Review

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**18 January 2022**

AGENDA ITEM: 26/1121

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 11 November 2021

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 **noted** progress with the internal audit plan for 2021/2022 and with the implementation of internal audit recommendations. The Committee discussed those areas where actions were overdue, (consultant job planning and HR (recruitment)) and agreed further action/timeline for review.

The Committee received and **noted** the Internal Audit on procurement which received a low risk classification; with two low risk findings and one advisory finding.

EXTERNAL AUDIT – PROGRESS REPORT & TECHNICAL UPDATE

The Committee received the External Audit Progress Report and Technical Update and was informed that confirmation had been received that IFRS 16 would be implemented in the NHS from 1 April 2022. The Committee was assured that workshops had been held with IT, estates and key stakeholders involved and a lease register was being established in preparation for the new requirements. The Committee **noted** the report.

COUNTER FRAUD, BRIBERY & CORRUPTION

The Committee **received** and **noted** the Counter Fraud, Bribery & Corruption Progress Report; noting that there had been two new allegations of fraud since the previous meeting which were being investigated. The Committee considered the final Single Tender Waiver Benchmarking reporting noting that the Trust compared favourable amongst peers. It was agreed that information on single tender waivers would be included in future compliance reports.

A Board Seminar on Counter Fraud would be held on 12 January 2021 with input from Professor Mark Button, Director of the Centre for Counter Fraud Studies at Portsmouth University.

BOARD ASSURANCE FRAMEWORK AND CORPORATE RISK REGISTER

The Committee **considered** the BAF and Risk Register in particular Strategic Risk 4; *Recruitment and Retention.* It was noted that this would be considered further by the Great Place to Work Committee in December. In advance of that the Executive team would undertake a deep dive consideration of the risk, controls and mitigating actions given the challenging national workforce picture.

PROCUREMENT SHARED SERVICES ANNUAL ASSURANCE REPORT

The Committee received the Procurement Shared Services Annual Assurance Report, which provided information and assurance on the service being delivered to the Trust. The Committee

considered the performance of the service against KPIs, developments in the service over the past year and considered value for money.

CONTRACTS – INTERNAL AND EXTERNAL AUDIT

The Committee received an update on future arrangements for the Trust's internal and external audit contracts. An update will be provided to the Board in its private session.

OTHER ITEMS RECEIVED

The Committee:

- **Received** the Finance Compliance Report, noting progress with aged debtors.
- **Received** the **noted** the Audit & Assurance Committee Annual Effectiveness Assessment which had a positive outcome. The terms of reference had been reviewed and no changes were proposed.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**10 February 2022**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING

PUBLIC SESSION

Thursday 27 May 2021

10.00 – 13.00pm

To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/0521	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0521	Declarations of interest	Assurance	**Paper**	Chair
10.05	03/0521	Service User Story Presentation	Assurance	Verbal	DoNQT
10.25	04/0521	Draft Minutes of the meeting held on 31 March 2021 • Response to Public Question received at March Board	Approve Assurance	**Paper**	Chair
	05/0521	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0521	Questions from the Public	Assurance	Verbal	Chair
Strategic Issues					
10.35	07/0521	Report from the Chair	Assurance	**Paper**	Chair
10.40	08/0521	Report from Chief Executive	Assurance	**Paper**	CEO
10.50	09/0521	Organisational Priorities Update	Assurance	**Paper**	CEO
11.00	10/0521	Regroup, Reconnect, Recover	Assurance	**Paper**	Acting COO
11.15	11/0521	Systemwide Update	Assurance	**Paper**	DoSP
11.30	12/0521	System Operating Plan 2021-22	Approve	Verbal	DoF
11.40	13/0521	Digital Strategy 2021-2026	Approve	**Paper**	DoF
11.50am - BREAK – 10 Minutes					
Performance and Patient Experience					
12.00	14/0521	Freedom to Speak Up Report	Assurance	**Paper**	SP/DoNQT
12.10	15/0521	Quality Dashboard Report	Assurance	**Paper**	DoNQT
12.20	16/0521	Patient Safety Report Q4	Assurance	**Paper**	MD
12.30	17/0521	Performance Report	Assurance	**Paper**	DoF
Governance					
12.40	18/0521	Provider Licence Declarations	Approve	**Paper**	HoG
12.45	19/0521	Change to the Constitution	Approve	**Paper**	HoG

TIME	Agenda Item	Title	Purpose		Presenter
12.50	20/0521	Use of the Trust Seal Q3/Q4 2020/21	Assurance	**Paper**	HoG
12.55	21/0521	Council of Governor Minutes – March	Assurance	**Paper**	HoG
Board Committee Summary Assurance Reports (Reporting by Exception)					
	22/0521	FoD Assurance Committee (16 April)	Information	**Paper**	FoD Chair
	23/0521	Mental Health Legislation Scrutiny Committee Summary (21 April)	Endorse	**Paper**	MHLS Chair
	24/0521	Resources Committee Summary (29 April)	Information	**Paper**	Resources Chair
	25/0521	Audit and Assurance Committee (6 May)	Information	**Paper**	Audit Chair
	26/0521	Quality Committee Summary (11 May)	Information	**Paper**	Quality Chair
Closing Business					
13.00	27/0521	Any other business	Note	Verbal	Chair
	28/0521	**Date of Next Meeting** **2021** Thursday 29 July Thursday 30 September Thursday 25 November	Note	Verbal	All

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 04/0521

MINUTES OF THE TRUST BOARD MEETING

Wednesday 31 March 2021

Via Microsoft Teams

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

IN ATTENDANCE:
Sarah Birmingham, Deputy Chief Operating Officer
Dan Brookes, Trust Governor (Public)
Dr Oana Ciobanasu, Consultant (External)
Lauren Edwards, Deputy Director of Quality and Therapies
Graham Hewitt, Trust Governor (Public)
Anna Hilditch, Assistant Trust Secretary
Kizzy Kukreja, Trust Governor (Staff)
Bob Lloyd-Smith, Healthwatch
Kate Nelmes, Head of Communications
Lavinia Rowsell, Head of Governance/Trust Secretary

1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from John Campbell and Helen Goodey.

2. DECLARATIONS OF INTEREST

2.1 The Board received and noted the complete 2020/21 Board Declarations register.

2.2 There were no new declarations of interest.

3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Mrs. Jennifer Downing to the meeting, who was joined by Sophie Belson, Community Nurse with a Specialist Interest in Complex Leg Wounds. Mrs. Downing spoke to the Board about a leg wound that she had developed following an accident at home.

3.2 The Board noted that following Mrs. Downing's accident, she developed an edema and was in Lydney Hospital for 2 weeks. On discharge, she was seen by District Nurses and then referred to the Lydney Complex Leg Wound Team. Treatment was moved from a clinic to the home setting due to Covid and lockdown, noting that Mrs. Downing was shielding.

3.3 It was at the point of referral to the Complex Leg Wound Team that compression therapy was used. Mrs. Downing said that this was uncomfortable; however, it made all the difference. Sophie Belson said that they had now moved to using supported hosiery which meant that when it became uncomfortable, Mrs. Downing could remove it, unlike the compression bandages. It was pleasing to report that the wound was vastly improved.

3.4 Steve Alvis asked whether any other support was required during this period from other agencies such as social services. Mrs. Downing said that her husband was able to help her on a day to day basis; however, she did receive assistance in terms of the provision of walking aids.

3.5 Angela Potter asked Sophie Belson whether there was anything that would help in progressing the service provided by the Complex Leg Wound Team. Sophie said that being able to offer sharp debridement therapy would be a helpful development, and also getting a trust wide message out to colleagues that compression therapy should the first thing to do for leg wounds, not a last resort. John Trevains agreed to pick this up as part of the wound care development programme. **ACTION**

3.6 Mrs. Downing said that she had gone through a period of feeling very down during her treatment; however, she said that she had received great support from the Trust's community services and the Complex Leg Wound nurses. The importance of combining physical and mental health services and having the necessary support available was recognised.

3.7 The Board thanked Mrs. Downing for attending and speaking so openly about her experience. Thanks were also given to Sophie Belson and her team for the tremendous service that they provided. Ingrid Barker said that it was important to hear about personal stories as it really did ground the Board in why we are here.

4. MINUTES OF THE PREVIOUS MEETING HELD ON 28 JANUARY 2021

4.1 The Board received the minutes from the previous meeting held on 28 January 2021. Subject to two minor typos, 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 progressing to plan. There were no further matters arising.

6. QUESTIONS FROM THE PUBLIC

6.1 The Trust had received one question from the public in advance of the Board meeting in relation to the development of the new Forest of Dean Hospital. A verbal response was given at the meeting, as follows:

QUESTION – Can you explain in full detail how the hospitals as you have stated "are no longer fit for purpose", as you have announced on numerous occasions and patients are happy with the facilities? *Louise Penny, Campaigner for HOLD*

RESPONSE

Angela Potter advised that the Trust fully recognised that both existing hospitals were very much loved and valued by the local populations of the Forest of Dean and our staff continue to deliver excellent care within the constraints of the environment that they are working in. However, the Dilke Memorial Hospital and Lydney & District Hospital are both aged hospital sites which present a range of operational and

maintenance challenges, including poor patient flow, asbestos, inability to carry out internal reconfiguration, privacy and dignity issues and compliance with single sex regulations. Angela Potter said that the Trust really wanted to make sure that the facilities and environment available to the Forest population was at the same high standard as the level of care provided.

6.2 A full written response to the question would be provided and this response would expand on those areas highlighted. A copy of the full response would be included for reference with the minutes of this meeting presented at the May Board (Appendix 1).

7. COVID PROGRAMME UPDATE

7.1 This item provided an update to the Board on progress with the ongoing management of Covid.

7.2 Updates were provided around Covid Testing and central stock management.

7.3 During the second covid surge, a commitment was made to continue where possible to maintain all service delivery. Two services were however closed with full system support, the Vale MIIU to enable a PCN vaccination site to be established and Tewkesbury MIIU with staff redeployed to enable Rapid Response to be available. Apart from these system supported closures, no GHC services were closed, with 13 providing a reduced service offer to focus on urgent priority referrals. Reprioritising services enabled the release of staff to support essential services and the enhance offers required to enable effective operational flow.

7.4 Work has commenced to support teams and services to 'Regroup, Reconnect, Recover' as we begin to shape service delivery post the second covid surge in Gloucestershire. This process is underpinned by principles of inclusion and collaboration, considering the needs of all stakeholders and a realistic evaluation of time frames and capacity required to meet increased demands. Each service is producing a plan on a page and has the opportunity for bespoke support via Working Well and the health and wellbeing hub to enable individual and team recovery. Paul Roberts said that recovery was right at the core and a huge amount and work and effort was being put into the recovery agenda.

7.5 GHC continue to contribute to the covid vaccination programme across the county and the programme is operating successfully. Focused work continues to support uptake in the GHC workforce for those in eligible cohorts. Progress has been made in the last 4 weeks as a result of targeted communications, advice and education through Working Well, learning from a staff survey and additional pop-up clinics in areas of lower uptake. Uptake from frontline staff was now at 89% and Ethnic minority staff at 64%. Graham Russell asked for assurance about colleague vaccinations and whether current performance was in line with plan. Sarah Birmingham said that the Trust wanted to achieve higher and continued to promote the vaccinations. Paul Roberts said that there was an equity issue; however, it was important to be mindful that some staff members would not want to receive the vaccination, despite being offered.

7.6 Work was under way in conjunction with PCN colleagues to review the current use of three GHC sites as vaccination centres and explore future options to enable GHC service recovery in a timely manner. The GHC mass vaccination team are also working alongside the vaccine equity group to undertake a deep dive into the data on vaccine uptake for those with a learning disability, severe mental illness and dementia.

7.7 Paul Roberts informed the Board that it had been agreed to stand down the Gold/silver/bronze command with the wider system, with things being incorporated into business as usual going forwards. Jan Marriott said that she had found this to be a

helpful way of getting information agreed and disseminated out into the system rapidly and queried whether this would still be possible once it had been stood down. Paul Roberts said that it was hoped that this level of communication and collaborative working with the system would continue going forwards.

7.8 Sumita Hutchison asked about the learning from Covid and what would be done differently having taken that into account. Sarah Birmingham advised that GHC had introduced Attend Anywhere which had allowed patients to connect with us virtually and this would continue, along with other digital platforms as feedback from patients demonstrated that these were valued. Steve Brittan welcomed this information, in particular the benefits of using technology to support service delivery; and said he was glad to hear that the Trust was going to continue innovative approaches, based on recent experiences. John Trevains added that a huge amount of learning had been captured throughout the Covid pandemic and this was available to staff via the Covid Portal.

8. CHAIR'S REPORT

8.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in January. 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 the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

8.2 The Board noted the content of the Chair's report.

9. CHIEF EXECUTIVE'S REPORT

9.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in January.

9.2 Paul Roberts opened his report by informing the Board that a number of long serving senior colleagues would be leaving the Trust over the coming months. This included Marieanne Bubb-McGhee, Bernie Wood, Sue Heafield, Kathy Campbell and Terry Gibbs. Their huge length of service and commitment to the Trust was acknowledged, and the Board joined Paul in expressing their thanks and good wishes to those concerned.

9.3 The Executive team, on behalf of the Board, is exploring what "business as usual" may look like over the coming months following the Government announcement setting out the roadmap to recovery from Covid. The Board and Executive team have begun to concentrate on a "recovery and refocus" programme balancing:

- Individual recovery - ensuring the Trust continued to focus on the health and wellbeing of colleagues.
- Service recovery – ensuring that there are plans to restore services, accommodate changing demand patterns and to embed innovative practice associated with the pandemic response.
- Refocus on strategic ambitions – increase effort to deliver the strategic ambitions of the organisation, set out when it was formed in October 2019.

9.4 Paul Roberts has continued to develop his work as lead CEO for equality, diversity and inclusion (EDI) for the Gloucestershire ICS. The partnership is developing its approach to the systematic tackling inequality and to co-ordinate its response to the recent

challenges brought to light by the pandemic. The "eight urgent actions" outlined by NHS England in August 2020 provide a useful framework for this work. Sumita Hutchison said that she welcomed this work and asked what would change for GHC as a result of the actions set out. Paul Roberts suggested that outcomes would change and improve, noting that the framework looked at equity as well as equality. This would be embedded into the Trust committee structure, with Board oversight for assurance.

9.5 NHS England recently released its White Paper, Integration and Innovation, working together to improve health and social care for all. The proposals would lead to Integrated Care Systems becoming statutory bodies and a mandate to work more closely with Local Authority and other system partners including the voluntary sector. It was noted that a Board Development session was planned for April for the Board to consider this in more detail.

9.6 In November 2020 Sarah Scott (now Executive Director of Adult Social Care and Public Health) attended the Board to present her annual report. The report focussed on race, health and inequality in the context of Covid. The report discussed six areas of action and response to Covid which were incorporated into eight recommendations for the county. The Board received a brief update on Trust activity in the six themed areas.

9.7 Marcia Gallagher noted that Paul Roberts had been invited to join the SW Imaging Regional Focus Group to steer the development of the national imaging strategy. She asked about commitment to cancers and whether this group had oversight of the workforce and national shortages of radiographers. Paul Roberts advised that the group had not yet met but acknowledged that this was a challenging agenda.

10. INTEGRATED CARE SYSTEM UPDATE

10.1 This paper provided an overview of a range of activity taking place across the Integrated Care System.

10.2 Ongoing dialogue with the Health Overview and Scrutiny Committee took place on 2nd March and sought support to extend the temporary service changes put in place associated with Covid. An extra-ordinary meeting took place on 22nd March to further consider the Fit for the Future proposals.

10.3 The Health and Well Being Board met on 16th March with a focused agenda on health inequalities and the activities taking place across the county to take forward this complex and important agenda.

10.4 The Integrated Locality Partnerships have now also re-commenced some of their activities and started to revisit their priority actions moving forward, taking into account the impact of COVID. Jan Marriott asked about Governor involvement with the ILPs. Angela Potter advised that the Strategy and Partnerships Team had now been aligned to localities and some mapping work would take place to see how links with Trust Governors could best be established. **ACTION**

10.5 Ingrid Barker said that she welcomed the breadth of coverage within this report. It was noted that a set of principles around system working were being developed and these would be shared with the Board in due course.

11. BUSINESS PLANNING 2021/22

11.1 The purpose of this paper was to set out the Business Planning process for 2021/22 and the proposed Business Planning Objectives for operational and corporate teams.

11.2 This report set out the business planning process that was launched in December to support Directorates and Teams in developing their business planning objectives for 2021/22. The business plan is key to the delivery of the Trust Strategy and the business planning structure has been updated and underpinned by our four strategic aims.

11.3 It was noted that the National Planning guidance had been published for 2021/22 for Quarter 1 and further guidance was expected in April for the remainder of the year. The Trust had agreed to continue with a business as usual approach and a business planning refresh is therefore proposed at the 6-month mid-point to allow for further national guidance and in-year changes.

11.4 Sandra Betney informed the Board that producing the business plan had been challenging, however, the Trust had supported colleagues to identify service objectives that were realistic, and she said that there had been amazing engagement from staff.

11.5 The Board noted that the Business Planning process had been shared with Governors at their meeting on 10 March to enable their comments to be taken into account. Sandra Betney advised that a lot of detail sat beneath each of the objectives, including specific measurements for achievement. The Board also noted that the Business Plan had been produced in line with budget setting for 2021/22. System planning was now commencing and updates on this would be presented to the Resources Committee moving forward.

11.6 Maria Bond welcomed this report, noting that it was clear and visually helpful. She queried how many of the identified objectives would be of system benefit, rather than simply a benefit to GHC. Sandra Betney agreed that this would be helpful to see and noted that it was planned to include a review of this as part of the systemwide planning process.

11.7 Graham Russell agreed that this was a good document and like other Board members he supported the “business as usual” approach that had been taken. He queried whether the plan was clear enough about its linkage with the Trust Strategy and whether further reference needed to be included. There was a need to ensure read across and consistency. **ACTION**

11.8 The Board approved the business planning objectives and noted that a formal refresh of these was planned for quarter 2. Thanks were given to the team for producing a very readable and encouraging document, and to Trust colleagues for engaging with the process despite the challenges being faced.

12. BUDGET SETTING 2021/22

12.1 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 set out the level of budgets proposed and how they have been prepared in order to meet this annual obligation under the Standing Financial Instructions.

12.2 It was noted that the budgets proposed in this paper formed the financial governance of the Trust for 21/22. Although national interim funding arrangements will remain in place for the first half of the next financial year these budgets will provide a clear financial framework in which all Trust staff can continue to operate and make financial decisions. It was noted that these budgets also formed the basis of the plans on which the Trust will deliver its business planning objectives and strategic aims for the year ahead.

12.3 Sandra Betney advised that national planning guidance had not yet been issued for 21/22 so the Trust has used the planning assumptions from the NHS Five Year Plan where appropriate e.g. income and pay uplifts. The financial planning assumptions used mean these budgets will deliver a surplus. It is possible that the new financial regime may not encourage, or may even prohibit, surpluses for Foundation Trusts. These budgets will deliver a surplus of £0.790m, which includes delivery of a non-recurrent £600k surplus in order to generate cash for the Forest of Dean Hospital scheme. If the surplus needs to be reduced then the Trust can reduce the level of non-recurring savings, but needs to continue to deliver all recurring savings so that it stays in recurring balance.

12.4 In order to deliver these budgets recurring cost improvement schemes of £3.90m will be required. In addition, £1.600m of non-recurrent savings will need to be found to support non-recurrent expenditure and non-recurrent cost pressures. During budget setting 67% of recurring savings have already been identified.

12.5 A capital expenditure budget of £14.363m is proposed for 2021/22. The disposal of the Holly House site for c.£2m has been moved in 22/23 so there are no capital disposals planned for 21/22. 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, the completion of the ensuite upgrade of the Montpellier Low Secure facility and addressing c.£2.0m of outstanding Condition C&D High or Significant risk backlog maintenance issues.

12.6 Marcia Gallagher thanked Sandra Betney and colleagues for this clear report. She asked whether there was a sense yet of how much additional funding the Trust would receive for Covid and the treatment of long Covid. Sandra Betney advised that this was not yet clear but any funding received would be non-recurrent.

12.7 The Board noted the budget setting process and linkages within business planning and Cost Improvement Programme development processes. The Board approved the revenue and capital budgets for 2021/22 and noted the five-year capital plan. It was noted that a revised capital plan would be presented to the Resources Committee for approval at its April meeting once the allocation of the system envelope had been agreed. The Board also reviewed and noted the risks associated with the proposed budgets for 2021/22.

13. OUR TRUST STRATEGY 2021-2026

13.1 The Board received this report which presented the Trust's five-year strategy for 2021 – 2026 and highlighted the final process of engagement and drafting refinements.

13.2 'Our strategy 2021-2026' is for all our staff, service users, patients, carers and our partners. It seeks to provide clarity on who we are, what is important to us, what we want to achieve and how we will do it. This remains a public facing document, ensuring that everyone can access, understand and contribute to implementing our strategy.

13.3 The Board noted that the strategy was supported by the Annual Business Plan for 2021/22, which articulates the detailed plan for delivering year one of our five-year strategy. Throughout the life of this strategy, subsequent annual plans will provide the specific annual actions and milestones. The Board also noted that the data included within strategy was set at 31 March, to ensure that this was consistent and enabled read across with the Trust's annual report.

13.4 Angela Potter advised that the aim was to communicate the strategy widely with our staff and partners and a communication and engagement strategy was in the process of being developed. Following approval of the strategy the Trust would take forward the

development of a "plan on a page" and an easy read version of the strategy. Work would take place with our senior leaders to support cascading the strategy and build it into their team and individual objectives and plans.

13.5 Jan Marriott made reference to the section highlighting "our journey so far" and asked whether some clear examples of providing integrated care could be included. **ACTION**

13.6 Steve Brittan asked how the Trust was measuring its effectiveness through this strategy and whether there was a need to quantify the benefits. Angela Potter noted that the enabling strategies that sat beneath this overarching strategy would help with specificity and benefits. It was agreed that there was a need to identify top level measures and a Board development session was planned for June to look in more detail at measuring "what matters". Paul Roberts said that measuring outcomes was challenging but this would be kept under review by the Board.

13.7 The Board agreed that the Strategy set out the big picture direction of travel. There would be a need to come back and revisit some specifics, such as outcomes; however, the Strategy was approved, subject to some minor typos and comments received.

14. OUR PEOPLE STRATEGY

14.1 The Board was presented with the draft "Our People Strategy", a subset of the emerging Trust Five-Year Strategy, for consideration, comment and agreement in principle prior to it being formatted for launch.

14.2 Our People Strategy sets out the vision and framework for achieving our goal. It translates the six strategic objectives from the main Trust strategy into six easy to remember "commitments" to deliver our Great Place to Work ambition. These are:

- Model Recruitment & Retention
- Health & Well-being
- Great Culture, Values & Behaviours
- Strong Voice
- Equality, Diversity & Inclusion, and
- Full Potential

14.3 The strategy also included a proposed 'road map' outlining how we intend to approach delivering our goal, aims and commitments, alongside key measures of performance. The Board agreed that this road map was a helpful inclusion.

14.4 The Board noted that once approved, the strategy would be professionally formatted in line with the draft Trust Strategy with infographics.

14.5 It was noted that the draft Our People Strategy had previously been received and discussed by the Resources Committee and feedback had been incorporated into this final draft.

14.6 The Board reviewed and was happy to endorse the final draft Our People Strategy.

15. QUALITY DASHBOARD REPORT

15.1 This report provided an overview of the Trust's quality activities for February 2021. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led. The dashboard also contained the Q3 NED Audit of Complaints and Guardian of Safe Working data.

15.2 John Trevains informed the Board that overall the report demonstrated that some fantastic work was being carried out and high-quality services were being delivered.

However, there was frustration that not all areas had progressed as quickly as had been planned due to the impact on capacity from Covid. The report highlighted those Quality issues for priority development to the Board:

- Work is underway to design the 2021/22 Quality Dashboard, the quality team will be using quality metrics from a wider range of Trust services such as sexual health, dental, complex leg wound and specialist mental health/learning disability services, to commence from April 2021.
- A quality deep dive into the Memory Assessment Service is planned for inclusion in the next Quality Committee Dashboard.
- CPA compliance remains under threshold and a CPA audit has commenced to understand challenges.
- Continued focus and quality improvement work to enhance recovery within the complaint management process following the national pause.
- To support the NHS Long Term Plan to eliminate out of area mental health placements, there is a comprehensive quality improvement plan in place which focuses on governance and leadership, operational practice, and service development.

15.3 Those Quality issues showing positive improvement:

- The number of Category 1 and 2 acquired pressure ulcers has reduced to below threshold and for the first time since September there were no reported Category 4 acquired pressure ulcers in the month of February
- 89% of all GHC staff have now received their first vaccination for Covid-19
- An action plan is being delivered and a monthly exception reporting regime in place for recovering resuscitation and restrictive physical intervention training (PMVA and PBM) compliance.
- The regrouped training strategy for medical emergency training has been well received by frontline staff and found to increase staff confidence in the application of skills following the reduction in face to face training resulting from COVID.

15.4 John Trevains informed the Board that the Trust had secured funding of £250k for international recruitment into community services. The Board was assured that the Trust ensured ethical recruitment practices.

15.5 Steve Alvis had carried out the Quarter 3 NED Audit of Complaints, the results of which had been included within the dashboard. He said that he had been very impressed with the quality and thoroughness of the paperwork, and congratulated the Patient Experience Team on the work they had carried out. John Trevains agreed to pass these thanks to the team. He added that the NED input into the complaints process was really valued.

15.6 Ingrid Barker said that it was pleasing to see the reduction in the reporting of pressure ulcers, and she asked whether this was going to be a sustainable improvement. John Trevains advised that this reduction had primarily been seen within the district nursing team. The improvement work the Trust had introduced was gaining traction and this included education sessions, professional support and integration of policies.

15.7 Ingrid Barker noted that the Trust had 5 complaints in the system which had remained open for over a year. She asked whether it would be possible to include a trajectory in future reports to be able to get a sense for when these were expected to be closed down. **ACTION**

15.8 Ingrid Barker said that it was helpful to see the vacancy data within the dashboard. There were some big gaps within the ICT Teams and she asked if further information

could be included around the impact of these vacancies on quality and continuity of care. John Trevains advised that more detailed analysis of this was planned as part of the continued development of the quality dashboard.

15.9 The Board welcomed this report, noting the developments underway and the good level of assurance provided.

16. LEARNING FROM DEATHS REPORT – QUARTER 3

16.1 The Board received the Learning from Deaths report for quarter 3. During the quarter there were 139 reported GHC patient deaths. None of these patient deaths were judged to be more likely than not to have been due to problems in the care provided by the Trust.

16.2 Marcia Gallagher made reference to 3.4 of the report which stated that "the Trust is continuing its work with regard to installing electronic countermeasures". Given the importance of this work around reducing ligatures, Marcia asked for further assurance around progress and when work was likely to be complete. Amjad Uppal agreed to seek and provide the necessary information to the Board. **ACTION**

17. FINANCE REPORT

17.1 The Board received the month 11 Finance Report for the period ending 28 February 2021.

17.2 There is a Covid interim financial framework for the NHS in place for October to March 2021. The Trust has received additional block contract payments to cover Covid costs, lost income and some new developments but will receive no further top ups. The Trust has spent £3.213m on Covid related revenue costs between April and February.

17.3 The Trust has an interim plan of a deficit of £439k for October to March. The Trust's position at month 11 was a surplus of £145k. The Trust is forecasting a year end surplus of £0.163m. The Trust has decreased its annual leave accrual estimate by £520k to £2.514m

17.4 The revised recurring Cost Improvement Plan (CIP) target for GHC is £3.230m and the amount delivered to date is £3.492m.

17.5 The cash balance at month 11 was £68.8m.

17.6 The Trust has reviewed its balance sheet and released several provisions and proposed a number of asset and debtor write-offs. The Trust has identified 4 HIV drugs invoices to CCGs, dating back to 2014-2017, that required Board approval to be written off. This approval was received.

17.7 Capital expenditure was £5.269m at month 11. The Trust has a revised capital plan for 20/21 of £10.772m. Sandra Betney advised that the Trust had amended the capital programme to increase the Forest of Dean scheme to £20.4m and moved the sale of Holly House back one year to 22/23.

18. PERFORMANCE DASHBOARD

18.1 Sandra Betney presented the Performance Dashboard to the Board for the period February 2021 (Month 11 2020/21). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

18.2 At the end of February, there were 10 mental health key performance thresholds and 16 physical health key performance thresholds that were not met. It was noted that all

bar two of these indicators had been in exception previously within the last 12 months. The two new indicators were '1.05: Delayed Transfers of Care' and '50: Psychosexual Service - % treated within 8 weeks'. 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. It was noted that the 4 Trust wide workforce indicators included within the dashboard remained in exception this month; however, there had been an improvement in the supporting commentary.

18.3 It was noted that the Eating Disorder Service continued to face major performance challenges due to a high number of referrals and high vacancy rate. The Board was assured that the Executive Team continued to closely monitor and review the service challenges.

18.4 The Board was asked to note that there was 1 admission of an under 18 in February. A young person under the care of EI and Crisis services was admitted initially to the Maxwell Suite and then to Wotton Lawn overnight. A Tier 4 placement was found, and the young person transferred the next day.

19. STAFF SURVEY RESULTS 2020

19.1 The purpose of this report was to present the Board with a summary of the 2020 Annual Staff Survey results. This was Gloucestershire Health and Care NHS Foundation Trust's first ever single Staff Survey feedback report, covering data gathered from colleagues during Quarter 3 of 2020/21. It was important to note that the 2020 Survey came at a time when colleagues, the organisation and the wider NHS was significantly impacted by Covid.

19.2 The Board noted that this year's survey was changed from previous years, with a shorter core survey, the addition of Covid questions, and the option for Trusts to have some additional questions.

19.3 The Trust was also now in a new benchmarking category - *"Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts."*

19.4 Neil Savage said that the results presented a performance that the Trust should be proud of given the context of the post-merger period and the pandemic, with many post-merger organisations having historically suffered a notable reduction in staff ratings.

19.5 The Board received the key headlines which included:

- Significantly **improved response rate – 46.3%.**
- **80%** of ratings **improved or remained unchanged**
- Of the **Ten Themes - 7 improved, two were unchanged,** and **one worsened**
- **Highest improvement** rating is an **11% increase** (colleagues reporting that they do not "come to work when feeling unwell in the last 3 months"), with a number of other statistically significant improvements in the order of 5%, 6%, 7%, 8% and 10%
- **10% improvement** on colleagues agreeing the Trust takes **positive action** on **Health and Well-being**
- Colleagues agreeing **senior managers act on staff feedback is up 8%**
- **71%** of colleagues **would recommend** the Trust as a **place to work**
- **79.5%** of colleagues **would recommend** the Trust to **provide care**
- Largest reduced rating is '**During the last 12 months have you felt unwell as a result of work-related stress?'** which is up by 3%

- All the other reduced scores are in the low 1-2% reduced rating range
- The **highest % of improved scores/stayed the same** are in the **line manager** and **health and wellbeing** sections
- **The highest % of the reduced scores** are in the **Your Job** section

19.6 It was noted that the survey results had been discussed widely and the draft staff survey results action plan had been presented to the Executive Team meeting. There would be a further opportunity to review and discuss the Staff Survey results, with a session taking place in May for Board members.

19.7 Sumita Hutchison said that it was excellent to see an increase in a number of the scoring areas, especially as the survey was carried out during Covid. She noted however, that January/February had been an especially hard time for people and queried whether the scores could have been affected had the survey taken place then. Neil Savage said that it was difficult to tell but he offered the Board some assurance that the Trust would be reintroducing quarterly internal surveys which it was hoped would capture this data.

19.8 In relation to staff Health and Wellbeing, Angela Potter reported that the Trust had been successful in receiving £99k from NHS Charities Together which would be used to support the Trust's wellbeing offers to staff.

19.9 The Board received and noted the Staff Survey results report 2020 and was assured that approaches to people management, workforce culture and communications over the past year, since the merger, were paying positive dividends, with generally improving scores, and recognised that in light of new benchmarking the Trust still had much more improvement work to do to become a consistent top quartile performer.

20. GENDER PAY GAP ANNUAL REPORT

20.1 The purpose of this report was to inform the Board on the 2020 gender pay gap within Gloucestershire Health & Care NHS Foundation Trust. The UK Gender Pay Gap legislation requires NHS Trusts to annually publish 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 4 April 2021 and is based on data drawn from 31 March 2020.

20.2 This report contained the statutorily required calculations, presenting the gender pay gap against the six requisite indicators. The Board was asked to note that this was the first joint report for GHC, with the results summarised below considering performance from the legacy Trusts, 2gether and GCS:

- **Mean average gender pay gap**. Women earn less than men by 18.63%. This compares with the 2019 gap of 22% in 2G and 12% gap in GCS.
- **Median average gender pay gap**. Women earn less than men by 7.55%. This compares with a previous 2019 gap of zero in GCS and 14% in 2G.
- **Mean average bonus gender pay gap**. Women are paid less than men by 11.8%. This compares with a previous 2019 gap of 7% in 2G and 71% in GCS.
- **Median average bonus gender pay gap**. Women are paid more than men by 16.67%. The latter figure is impacted by the small number of staff that fall into this category (6 women and 26 men). This compares with a previous 2019 gap in women being paid more than men by 35% in 2G, and by 83% less in GCS.

- **Employee numbers by quartile.** The proportion of men and women (when divided into four groups) ordered from lowest to highest pay shows there are a higher proportion of women in all quartiles and the gap closes with progression toward the upper quartile.

20.3 This data shows a 2020 position whereby the Trust has effectively landed in the middle, between the previously slightly lower pay gap for GCS and the higher 2G gap. It also shows a small widening of the gender pay gap in year when reviewing the average hourly rate, while also showing an improvement on the median average bonus pay for women over 2019.

20.4 The Board noted that the report presented an all too typical position highlighting the scale of challenge and the inherent unfairness in the system within and beyond the Trust. Sustainable improvements will arguably require further changes in legislation, continued application of good practice, such as positive action in recruitment and Clinical Excellence Award marketing and support, alongside changes in education, careers advice, flexible working, management and leadership culture.

20.5 Neil Savage advised that this report had been previously received and scrutinised by the Appointments and Terms of Service Committee, who recommended that the Board endorse the following statement:

"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."

20.6 The Appointments and Terms of Service Committee also asked that the Board consider an additional statement to strengthen the Trust's commitment to closing the gap which also sends a positive message to colleagues and applicants.

"Additionally, the Board is fully committed to working in partnership with colleagues, stakeholder organisations and external agencies to learn from other organisations, apply good practice and to take innovative approaches, including positive action in its action to reduce and remove the gender pay gap."

20.7 The Board agreed that this report clearly demonstrated the degree of challenge and importance being placed on this area of work by the Trust. It was noted that the report would also be presented at the Trust's Women's Network for discussion. The Board supported the recommendations set out and agreed to publish this report and the commitment statements on the Trust website, and via the government website.

21. MEMBERSHIP AND ENGAGEMENT STRATEGY

21.1 The Board received the Membership and Engagement Strategy 2021-2024 for endorsement. The purpose of the Strategy and its related action plan was to build a membership which is engaged and reflects the breadth of the communities the Trust serves.

21.2 It was noted that the Governor's Membership and Engagement Committee had met twice since it was agreed to establish it at the November Council meeting. The Strategy was considered and updated in the light of feedback from the Committee who highlighted the need to clearly communicate the benefits of membership, to target our communications effectively to different audiences and to use partnership working to help spread the message of membership. An Action Plan was developed to put in place some of the key foundations needed to support this strategy and the work on this is

now ongoing. A Partnership Methodology had also been produced to reflect how the Membership and Engagement Strategy plans to work with partners to achieve its aims.

21.3 The Board endorsed the Membership and Engagement Strategy 2021-24, noting that the Council of Governors had received and approved this at their meeting on 10 March.

22. BOARD COMMITTEE STRUCTURE REVIEW AND TERMS OF REFERENCE

22.1 The purpose of this report was to provide a summary of the outcome from the Annual Board Committee evaluation process and set out the proposed next steps.

22.2 The Board noted the key themes identified from the effectiveness reviews, and it was agreed that a wider review be carried out to see how the Board Committee structure, and the interplay and reporting between the Committees could be further developed and strengthened. Discussions would take place with the Committee Chairs and Executive Leads to address the themes identified and propose any revisions to the Committee structure as required to ensure the ongoing effectiveness of the Trust's governance framework. Any changes would be brought to the May Board meeting for approval, with work then taking place to ensure implementation by Quarter 3. Board members supported this approach.

22.3 The Terms of Reference for each of the Board Committees are reviewed annually, with any change recommended to the Trust Board for approval. This year the TOR were reviewed with specific focus on consistency and formatting, in line with the recommendations arising from the Internal Audit on Corporate Governance. In addition to this, a number of changes have been made to membership and attendance at the Committees to take into account the transfer of Herefordshire MH services to Worcestershire in April 2020. The Board was asked to note that the terms of reference for the Board Committees may require further revisions during the year dependent on the outcome of the wider Committee Review, however, it was deemed prudent to have a full set of consistent and up to date terms of reference in place to refer to as part of this review. The Board received and approved the following Terms of Reference:

- Appointments and Terms of Service Committee
- Forest of Dean Assurance Committee (New)
- MH Legislation Scrutiny Committee
- Quality Committee
- Resources Committee

23. BOARD COMMITTEE SUMMARY REPORTS

23.1 Mental Health Legislation Scrutiny Committee

The Board received and noted the summary report from the MHLS Committee meeting held on 20 January 2021.

23.2 Audit and Assurance Committee

The Board received and noted the summary report from the Audit and Assurance Committee meeting held on 11 February 2021. It was noted that a Counter Fraud survey had been sent out and Board members were encouraged to complete this.

23.3 Resources Committee

The Board received and noted the summary report from the Resources Committee meeting held on 25 February 2021.

23.4 Quality Committee

The Board received and noted the summary report from the Quality Committee meeting held on 4 March 2021.

23.5 Appointments and Terms of Service Committee

The Board received and noted the summary report from the ATOS Committee meeting held on 17 March 2021.

23.6 Forest of Dean Assurance Committee

The Board received and noted the summary report from the first FoD Assurance Committee meeting held on 4 March 2021. Two further meetings of the Committee would be scheduled to go through the plans and review the Business Case in advance of it being received by the Board for sign off in May.

24. ANY OTHER BUSINESS

24.1 There was no other business.

25. DATE OF NEXT MEETING

25.1 The next meeting would take place on Thursday 27 May 2021.

Signed: ……..….. **Dated: ……**

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

with you, for you

Agenda Item: 04.1/0521

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19th April 2021

Louise Penny
Via Email

Dear Louise

Many thanks for your further question to the public session of our Trust Board meeting in March 2021. I provided a summary response at the meeting and am pleased to provide a more detailed response below to your question which is as follows:

Can you explain in full detail how the hospitals as you have stated "are no longer fit for purpose", as you have announced on numerous occasions and patients are happy with the facilities?

We fully recognise that both of the existing hospitals are very much loved and valued by the local populations of the Forest of Dean and our staff continue to deliver excellent care within the constraints of the environment that they are working in. However, we do hear from our staff that they struggle to provide efficient and effective care due to these constraints and the inpatient environments particularly presents challenges.

The Dilke Memorial Hospital and Lydney & District Hospital are both aged hospital sites which present a range of operational and maintenance challenges which can be summarised as follows.

<u>The clinical/operational environment challenges include:</u>

- The two community hospitals have grown organically over many years, often reactively to immediate priorities and this has resulted in poor flow around the buildings (this is exemplified by the lack of a single reception in Lydney and the site being split in the middle by a road). The current configuration of the estate means that it is not possible to modify or refurbish the existing estate to bring it up to modern building standards. Any works that we were to undertake would need to meet today's compliance standards and not the standards that the buildings currently comply with.
- On the inpatient wards, bed spaces are small and separated only by curtains which can lead to issues of privacy and dignity: equally, neither hospital has a dedicated dayroom to allow inpatients, as well as friends and families, to eat or spend time together. The available space in the areas would not allow us to suitably re-develop and add in this space.

- A lack of appropriately configured space, particularly storage space, for the equipment needed to provide modern healthcare – the size and amount of equipment has increased considerably since the ward hospitals were first built.

- There are no patients dining or social space on either inpatient wards which is a vital component of patient rehabilitation.

- There is a limited number of single rooms which severely impacts on infection prevention and control regulations, and impacts on the ability to comply with the latest single sex guidelines. Again, the space and configuration of the ward environments do not allow us to reconfigure the space to build in the required en-suite facilities and create an increased proportion of single rooms.

- The single rooms that we do have often don't have en-suite facilities which makes it very challenging to maintain patient dignity, especially for those with overnight support needs.

- Neither hospital benefits from piped oxygen and we rely heavily on gas cylinders which have to be moved around the site. Retrofitting gas supply is problematic and challenging across either of the sites.

- Lydney Hospital in particular struggles to accept Bariatric patients because the accessways are too narrow to accommodate the requisite equipment and outpatient rooms, especially those in the Dilke, are very small, which restricts the types of clinics which can be provided

<u>The Physical Environmental challenges include;</u>

- Due to the age and physical dimensions of both community hospital buildings, it is increasingly challenging, and cost-ineffective, to comply with prevailing Health Technical Memorandums (HTMs), Health Building Notes (HBNs) and other necessary building requirements. Any works undertaken now have to meet the relevant building standards of today and we cannot replace on a like for like basis with what was there historically. This inevitably means that the space needed is often much greater than the space available within the current estate and as I have previously mentioned, the ad-hoc way in which the sites have grown do not lend themselves to good services adjacencies and flow around the site.

- Asbestos is present at the sites meaning that any upgrading and alterations are challenging and potentially prohibitive. Any attempts to remove the asbestos would need to comply with all health and safety requirements and result in site closures etc throughout any periods of works.

- The sites are incredibly inefficient to power (The Dilke relying on Oil heating) which severely hampers our ability to achieve the latest NHS Sustainability targets and for the Dilke in particular, the physical condition of the heating and domestic hot and cold water services means that more winter breakdowns are anticipated, and if severe, these may result in the hospital's services being compromised;

- Maintenance of the heating, lighting and electrical systems requires a disproportionate amount of resource due to the maintaining the heating systems – the replacement parts etc for many of the systems are no longer manufactured and therefore any refurbishment of the existing hospital infrastructure would require the retrofitting of completely new heating and electrical systems. The presence of the asbestos previously mentioned, makes these extremely challenging.

I hope that the above demonstrate that in previous phases of the project considerable thought was put into whether the retention and refurbishment of the two current hospitals was indeed a viable option moving forward. For the reasons outlined above, we do not believe that it is. In addition, one of the other key challenges that was laid out in the case for change was the issue of staffing two sites with a scarce workforce across the Forest. Whilst this is not directly answering your question about why the two hospitals are no longer fit for purpose, it is a key factor in terms of operating a robust and resilient level of service from both sites.

I trust that the above answers your questions but please do not hesitate to contact me should you require any further information.

Yours sincerely

Angela Potter
Director of Strategy and Partnerships

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 05/0521

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 27 May 2021

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
31 March 2021	3.5	The message about the importance of using compression therapy for leg wounds to be picked up as part of the wound care development programme.	John Trevains	May 2021	**Complete** This message has been passed through to Trust wound care leads and quality improvement work streams via H Williams, Dep Director Nursing	
	10.4	Mapping work would take place to see how locality links with Trust Governors could best be established and possible Governor involvement with the ILPs.	Angela Potter	May 2021	**Complete** Locality leads within the Strategy & Partnerships team have been identified and communicated out to relevant Public Governors for links to be made.	
	11.7	Trust Business plan to be clear about its linkage with the Trust Strategy to ensure read across and consistency	Sandra Betney	May 2021	**Complete**	
	13.5	Section of Our Trust Strategy highlighting “our journey so far” to include some clear examples of providing integrated care.	Angela Potter	May 2021	**Complete**	

Meeting Date	Item	Action Description	Assigned to	Target Completion Date	Progress Update	Status
	15.7	A trajectory for open complaints in the system to be included in future QD reports to be able to see the timescales for when these were expected to be closed down.	John Trevains	May 2021	**Progressing to plan/Scheduled** This is being developed as part of the quality improvement work, alongside a new internal quality indicator for 21/22 Complaints Time to Completion.	
	16.2	Amjad Uppal agreed to seek and provide assurance to the Board on progress and target completion dates of the Trust's work to install "electronic countermeasures" given the importance of this work around reducing ligatures.	Amjad Uppal	May 2021	**Progressing to plan/Scheduled** The Trust is currently reviewing options available in the use of an Electronic Patient Observation System in our in-patient units. A business case has been written and it is anticipated that this will be presented to the relevant committees over the next two months for a decision on the next steps.	

with you, for you

NHS
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AGENDA ITEM: 07/0521

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 27 MAY 2021**
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

It is highlighted that as the move out of lockdown continues that the Chair and Non-Executive Directors will be moving back to more face to face visits and quality visits where appropriate.

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:	Page 10 - **Appendix 1** Non-Executive Director – Summary of Activity – 1st March to 30th April 2021

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

REPORT FROM THE CHAIR

1. 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. BOARD

2.1 Non-Executive Director (NED) Update

The Non-Executive Directors and I continue to hold our monthly meetings and virtual meetings were held on 29th April and 18th May. With lockdown restrictions easing, we also enjoyed an informal social gathering in an open air setting on 24th May recognising the importance of building our relationship as a team despite the challenges of remote meetings.

NED meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive at this difficult time and to continuously improve the way we operate.

At the NEDs meeting on **29th April** we received an update on the performance and activities of the Children and Young People's Directorate over the last year. This Directorate provides care through 33 services delivered by over 500 colleagues and the meeting involved updates on the Directorate's working through COVID, including innovations, and longer-term implications; the impact of COVID on the service and subsequent system pressures; and proposals for going forward. My thanks to Hilary Shand (Acting Chief Operating Officer), Sarah Birmingham (Deputy Chief Operating Officer) and Melanie Harrison (Service Director, Children and Young People's Service) for setting time aside to give Board members an informative and very interesting presentation.

Jan Marriott, Non-Executive Director, was agreed for re-appointment at the Council of Governors to serve a further three-year term from 1st Oct 2021 recognising that she is a valued and experienced Non-Executive Director who has the confidence of fellow Directors on the Board and who brings an independent clinical and quality focus to the Board and its Committees.

I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

2.2 **Board Updates:**

Board Strategy:
On 11th May, the Chief Executive and I were proud to launch the **Trust's Strategy for 2021 to 2026**. The Strategy - called '**Better Care Together'** - was developed in partnership with our colleagues, volunteers, people we serve, carers, members, and a wide range of other stakeholders.

It is the Trust's road map for the next five years and through it we pledge to put people at the heart of our services, focusing on personalised care by **asking 'what matters to you?' rather than 'what is the matter with you?'**

The strategy outlines the Trust's **Mission:** ***Enabling People to Live the Best Life They Can***

It also states the Trust's **Vision:** ***Working Together to Provide Outstanding Care***

Four strategic aims have been identified – **High Quality Care, Better Health, Great Place to Work and Sustainability** – each underpinned by measurable, specific goals and objectives.

The full strategy is available on the Trust website and hard copies can be requested via the Comms Team - ghccomms@ghc.nhs.uk.

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:

- **14th April -** facilitated by The King's Fund and focussed on taking stock of where the Trust is one year into the pandemic; looking forward at the national and local policy agendas; developing strategic aims. Taking time for reflection, whilst challenging to schedule at a time when operational challenges remain, was an invaluable use of Board time, helping us ensure our strategic and long-term focus is maintained.

- **15th April** – Reforming the Mental Health Act development session. This session was an opportunity to understand more about the proposed reforms of the Mental Health Act and contribute to the Trust's organisational response to the consultation. We were joined by Experts by Lived Experience, Approved Mental Health Practitioners (AMHPs) and Medical colleagues all of whom have their own experiences and perspectives of the use of the Mental Health Act. This approach reflects our Trust's commitment to co-production – and the insights it provided will be very useful for informing our response to the consultation.

- **4th May –** Deep dive into the Staff Survey Results for 2020. Our results, along with all other NHS organisations have been published nationally and were reported on at the March Board. This was our opportunity to look at variation and trends and consider how we can continue to build on the improved results and improved response rate.

- **18th May –** informal update on progress with plans for the new Forest of Dean community hospital.

Committee changes:
Following the recent annual committee evaluation process and consideration of the outcomes of an internal audit on governance, the Trust's Committee structure has been reviewed in discussion with Board Members and in the context of the Trust's new 5-year strategic framework. The following changes have been agreed:

- That a dedicated **People/Workforce** Committee be established
- That oversight of **performance reporting** remains within the remit of the Resources Committee.
- That the terms of reference for all Committees be reviewed to embed **Equality Diversity and Inclusion** within each Committee's remit with oversight at Board level.

The proposed terms of reference for the People Committee will be presented for approval to the July meeting of the Board for implementation in Quarter 3 2021/2022. The resulting governance structure will be reviewed against the aims of the strategic framework to ensure that there is a governance space for all aims with particular consideration of our work on **Better Health and Place** and **People Participation.** Consideration will also be given to the relationship between the Trust's governance structure and developing plans for changes to the **Integrated Care System**.

Veterans Covenant Healthcare Alliance (VCHA):
I am pleased to announce that the Chief Executive and I recently received a letter from the Patron and Chair of the **Veterans Covenant Healthcare Alliance** (VCHA) advising that as a result of the hard work undertaken by Jonathan Thomas, Sophie Ayre and Andrew Mills in demonstrating the Trust's commitment to the **Armed Forces Covenant,** the Trust has received **Accreditation as a Veteran Aware Hospital** which recognises the Trust's work in identifying and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community.

3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 15th April and 5th May. These sessions are helpful as we work together to further develop the Council of Governors.

- I chaired a meeting of the **Nominations and Remuneration Committee** on 28th April.

- **A Staff Governor Session** was held on 6th May. Topics discussed included the Governor role description and how can staff Governors get involved / engage with Members. This was a really enjoyable session with thoughtful and honest contributions from all attendees which we will use to help revise how Staff Governors engage with their members. We have a review session planned for the autumn so that we can reflect on how the planned changes are going.

- A meeting of the **Council of Governors** was held on 12th May. This included a more detailed discussion on the Staff Survey outcomes which had been considered in headline terms at the last meeting and a holding to account session on the Quality Committee. These new sessions are proving invaluable in providing the Council with new opportunities to probe and challenge.

- **Alison Feher**'s Term of Office as a staff governor will end on 31 May and she was thanked for her contribution to the Council over the period she has served. **Dawn Rooke**, Public Governor for the Forest of Dean resigned from her position on 13 April. Our thanks and best wishes have been communicated to Dawn.

4. NATIONAL AND REGIONAL MEETINGS

Since the last meeting of the Trust Board in March, I have attended a breadth of national meetings, all of which considered COVID plus more routine business:

- **NHS Providers Board** – 5th May - where we discussed important policy and national operational issues and current challenges and opportunities. Having served eight years as a Trustee, I will be leaving the NHS Providers Board in June.

- **NHS Confederation NHS Reset Webinars** continue to take place on a regular basis and 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 past months.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits.

- **National Chairs' Advisory Group** – 21st April – this meeting focussed on the efforts to recover the service demand backlog.

- I had an introductory meeting with the newly appointed **CEO of the NHS Confederation**, Matthew Taylor, who takes up his post in early June. The Chair of the Gloucestershire ICS Board will be inviting the new CEO to Gloucestershire as soon as his diary permits.

- I chaired a meeting of the **NHS Providers Remuneration Committee** on 5th May.

- On 18th May I was invited to participate in a **Good Governance Institute** event on **Systems and Funding**.

- The **NHS Providers Annual Governance and Quality Conference** took place from 17th-20th May and I was pleased to be asked to Chair the morning session on Weds 19th May.

5. WORKING WITH OUR PARTNERS

I have continued my regular virtual 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:

- As Chair of the ICS Board Remuneration Committee it is my responsibility to undertake the **annual appraisal for the Independent Chair of the Gloucestershire ICS *(Integrated Care System)* Board**, and this took place on 29th April.

- 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, Dame Gill Morgan.**

- **ICS Boards** were held on 15th April and 20th May. A number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported.

- Following an initial meeting held in February regarding the proposed partnership working with the **University of Gloucestershire**, a **Task and Finish Group** was held on 4th May. Three joint workshops with the University of Gloucestershire are being scheduled over the next few weeks and further updates will be given as this exciting initiative moves forward.

- To further enhance the Trust's work with the University of Gloucestershire, I attended the **Inaugural Civic University Network conference** which took place from 18th – 20th May, and joined several interesting sessions.

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

The Trust was delighted and honoured to receive **HRH The Princess Royal** in the grounds of Wotton Lawn Hospital on Wednesday 21st April. Her Royal Highness had conversations with nurses, allied health professionals, facilities colleagues, emergency response leads and Trust Executive and Non-Executive Directors about their roles and the challenges they have faced over the past 18 months. Colleagues were able to share details of the breadth of their work throughout the pandemic. HRH was particularly interested in hearing about the work of the Trust's COVID

testing team, the vaccinators, the Homeless Healthcare service, facilities and infection control colleagues and hospital and community teams who have worked tirelessly to keep the people of Gloucestershire safe and well throughout what has been an unprecedented and incredibly challenging time.

7. ENGAGING WITH OUR TRUST COLLEAGUES

- I attended a **Reciprocal Mentoring Development update session** on 20th April where we discussed experiences to date, shared learning, identified gaps and discussed next steps.

- I have dedicated a high proportion of my time throughout April preparing for and undertaking the **annual appraisals** for the Trust's seven Non-Executive Directors.

- I have also dedicated time throughout April consulting with ICS partners and colleagues in relation to the **Chief Executive's annual appraisal**, scheduled for the beginning of June.

- Non-Executive and Executive Director **"pairing"** meetings continue to take place and I was pleased to meet with the Director of Strategy and Partnerships, Angela Potter, for an informal open air catch up on 12th May.

- With lockdown restrictions thankfully easing, I plan to **informally visit** as many of the Trust's services across the county as possible in the forthcoming weeks - diary and COVID restrictions permitting. I was pleased to visit the Dilke Hospital in Cinderford on 12th May and Wotton Lawn Hospital in Gloucester on 13th May.

- I attended the **Senior Leaders Network** meeting on 25th May.

- **Formal Quality Visits** in person by myself and the NEDs had to be put on hold throughout the pandemic. However, with restrictions now easing a schedule of formal in person Quality Visits for myself and the Non-Executive Directors is currently being compiled for June onwards and will be reported on at future meetings.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting when possible with the Chief Executive and the Trust Secretary/Head of Corporate Governance.

Whilst drop in chats with services and colleagues need to be virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I have an active presence on social media to fly the GHC flag and highlight great work and issues across the county

8. NED ACTIVITY

The Non-Executive Directors continue to be very active, attending virtual meetings across the Trust and where possible visiting services and they too are looking forward to moving back to more in person meetings.

See **Appendix 1** for the summary of the Non-Executive Directors activity for March and April 2021.

9. CONCLUSION AND RECOMMENDATIONS

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

Appendix 1

Non-Executive Director – Summary of Activity – 1st March to 30th April

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Graham Russell	ICS Board (2) Meeting with Chief Operating Officer Meeting with Trust Chair Staff Forum Meeting with Chair and Senior Independent Director Meeting with Trust Chair for annual appraisal	Visit of HRH The Princess Royal Pre-meet with The King's Fund	Forest of Dean Community Hospital Assurance Committee COVID briefing (2) Council of Governors ATOS Committee Trust Board NEDs meetings (2) Chair's appraisal meeting Board Development with The King's Fund Nomination and Remuneration Committee Resources Committee Board Seminar – Mental Health Act Board briefing: Children & Young People Service
Marcia Gallagher	Meeting with Trust Chair (2) GCCG Audit Committee Meeting with Director of Finance Meeting with Director of Primary Care Meeting with Medical Director Meeting with Director of Nursing, Therapies and Quality Senior Leadership Network (2) Meeting with Trust Chair for annual appraisal Meeting with Counter Fraud Meeting with Trust Chair for Chair appraisal Meeting with Chair and Vice-Chair Meeting with Associate Director of Estates	Digital Webinar Cynapsis GGI Intuition in Resource Allocation GGI Do the Numbers Matter Pre-meet with The King's Fund Visit of HRH The Princess Royal GGI ref Digital and Data Mental Health Act Panel	COVID Briefing (2) Council of Governors Chair's appraisal meeting ATOS Committee Trust Board NEDs (2) Board Development with The King's Fund Board Seminar Mental Health Act Board briefing: Children & Young People Service

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr. Stephen Alvis	Serious Incident Review Investigation Chair Team Talk (2) UCASS Clinical Governance Senior Leadership Network (2) MHA Manager personal development review Meeting with Trust Chair for annual appraisal Meeting with MHAM Member	Breakfast Webinar GGI (2) Good Governance Institute for NEDs (4) NHS Reset Chairs meeting (2) Pre-meet with The King's Fund Consultants CEA meeting GGI NED Development Programme (2)	Ethics Committee Quality Committee COVID briefing (2) Council of Governors ATOS Committee MHAM Forum Trust Board Chair's appraisal meeting NEDs meetings (2) Board Development with The King's Fund Board Seminar Mental Health Act Board briefing: Children & Young People Service
Maria Bond	Post Quality Committee meeting with Governors and Experts by Experience Meeting with Director of HR & OD Senior Leaders Network Meeting with Chair of Audit & Risk Committee Meeting with Director of Nursing, Therapies and Quality Meeting with Trust Chair for annual appraisal	Promoting Mental Health and Wellbeing of BAME staff through COVID and beyond NHS Providers Risk Management Course NHS Reset Chairs Meeting Pre-meet with The King's Fund	Quality Committee Forest of Dean Community Hospital Assurance Committee COVID briefing (2) ATOS Committee Trust Board Council of Governors NEDs meetings (2) Board Development with The King's Fund Board Seminar Mental Health Act Board briefing: Children & Young People Service
Steve Brittan	Meeting with Trust Chair for annual appraisal Meetings with Sustainability Manager (2) Meeting with Senior Independent Director (4) Meeting with Director of Finance (2) Meeting with Trust Chair (2)	Pre-meet with The King's Fund Meeting ref Integrating Data Systems To Divert Patients Away From Emergency Departments Meeting with Richard Graham MP and Trust Colleagues	Forest of Dean Community Hospital Assurance Committee Board Development with The King's Fund Board Seminar Mental Health Act Board briefing: Children & Young People Service COVID briefing (2)

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Director of Strategy and Partnerships Meeting with Chief Executive	One Gloucestershire Digital Workshop Part 1 Meeting with Cinapsis Serious Investigation Review meeting NHS Reset Chairs Meeting	Oxevision Project Group (2) Council of Governors NEDs meetings (2) Trust Board
Jan Marriott	Meeting with NED Meeting with Chair and NED Meeting with Medical Director Meeting with Community Nursing Student Senior Leadership Network Meeting with Executive Director Meeting with Person with Lived Experience Meeting with Governance colleague Meeting with Trust Chair for annual appraisal Attendance at Performance and Ops Team meeting Meeting with Executive Director Meeting with NED	Pre-meet with The King's Fund Oliver McGowan Project Launch MH Operation Group Cheltenham Know Your Patch Good Governance Institute NED network	Quality Committee COVID briefing (2) Trust Board Chair's appraisal meeting NEDs meeting (2) Board Development with The King's Fund Board Seminar Mental Health Act MHLSC Resources Committee Board briefing: Children & Young People Service
Sumita Hutchison	Meeting with Trust Chair for annual appraisal Women's Leadership Meeting Trust staff wellbeing core project team Meeting with Governor Wellbeing Guardian meeting Promoting Mental Health and Wellbeing of BAME Staff, through COVID and beyond Meeting with Director of HR&OD (2) Meeting with NED Meeting with Trust Chair and NED	Pre-meet with The King's Fund NHS Providers Risk Management Training Wellbeing Guardian meeting	Trust Board Quality Committee Ethics Committee Resources Committee COVID briefing Board briefing: Children & Young People Service Board Development with The King's Fund Board Seminar Mental Health Act Council of Governors ATOS Committee NEDs meetings (2)

NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Director of Strategy and Partnerships Meeting with Sustainability Manager (2) Diversity Network meeting Senior Leadership Network		NEDs meeting ref Chair's appraisal

AGENDA ITEM: 08/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

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 Chief Executive and the Executive Directors, alongside many across the Trust and wider NHS, have adapted working practices as part of ongoing response to the Covid-19 pandemic. The impact of this is gradually reducing as the NHS emergency response level changes but the executive directors still maintain two “bubbles” and work in a blended digital and face to face way – formal meetings remain digital in the main.

The Trust continues to make progress on other key projects including the Forest of Dean, significant and welcome Mental Health investments, Covid service recovery (on the agenda today), Equality, Diversity and Inclusion (EDI) initiatives, and following on from the March Board meeting the launch of the new Trust Strategy.

The efforts put in by all colleagues to continue to move services and projects forward, while proficiently responding to the pandemic continues to be extraordinary. I am proud and grateful for the hard work, determination, and motivation of all those working within the Trust as we continue to work towards achieving our goals.

An update on the Trust Strategy is provided as well as updates on the Oliver McGowan Training, new Trust appointments, the Reciprocal Mentoring Programme, and the Local Clinical Excellence Awards.

Risks associated with meeting the Trust's values
None identified

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

Where has this issue been discussed before?
N/A

Appendices:	Report attached

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

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0 CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

1.1 Covid-19

Since the March Trust Board, the organisation has been continuing its exceptional work responding to the pandemic, encouragingly however Covid-19 related infections continue to fall in the community, with Gloucestershire numbers lower than both the South West and the National rates of infection. This is reflected in the reduced mortality rate attributable to Covid-19 in the county. At time of writing there are no Covid-19 positive patients within our inpatient services.

Patient deaths are subject to further Gloucestershire system-wide Covid-19 mortality reviews in line with national guidance. This work is being led by the Trust Medical Director and the NTQ team. Due attention is being paid to communicating with relatives and the duty of candour requirements. Further updates will be provided through the Quality Committee into the Trust Board.

The Trust continues actively to participate in supporting the **Primary Care Network vaccination activities**. Many Trust staff have now received their second vaccination and the organisation continues to promote uptake of vaccination to vulnerable staff groups. The Trust continues to provide “Pillar 1” testing and is providing considerable testing support to enable GHFT elective surgery with pre-op testing rates of above 150 tests per day regularly being delivered at EJC. PPE supplies remain at good levels and the Trust Infection Control Team and Health and Safety Team continue to oversee advice and guidance to ensure our facilities are considered Covid-19 secure.

1.2 Tackling inequalities

I have continued to develop my work as **lead CEO for tackling inequality,** for the Gloucestershire ICS. I regularly convene and attend meetings that seek to respond to and in the longer term prevent the systematic inequalities brought to light by the pandemic, as well as the long-standing inequalities which were already recognised. As part of this work, Gloucestershire County Council and the ICS are establishing an “**inequalities panel**”, which I will join, and is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme.

I am a member of the **South West Inequalities Leadership Forum** which is new and is designed to share good practice and monitor progress across the South West NHS Region.

On 8th April I attended the **Building Trust to Improve Vaccination Uptake** webinar facilitated by Jazzi Chopra-Povall - CNO BAME Lead SW, Acting

Divisional Director of Nursing & Quality, Gloucestershire Hospitals. The webinar discussed vaccination hesitancy, looking at possible causes and responses. The webinar focused on the importance of building trust when addressing this issue and was a very informative session which will feed in to my work as Chair of the **Gloucestershire Covid- 19 Vaccination Equity Group.**

This group, which held weekly meeting in the initial phase is now moving forward with monthly meeting. The purpose of the group is to support equitable uptake of Covid-19 vaccinations across the population of Gloucestershire. The group continues to focus on addressing vaccination inequity and hesitancy within populations where evidence suggests vaccination rates may be lower including traveller communities, boating communities, people with disabilities or long-term illnesses and minority ethnic communities. The group is moving at pace to facilitate efforts that aid in addressing these areas and help to enable vaccination uptake across the county. GHC is playing a central role alongside primary care colleagues by providing a flexible vaccination outreach service.

I am a member of the **SW Equality Diversity and Inclusion Board** and attend monthly meetings that discuss various initiatives focussing on improving the experience of NHS colleagues including: A regional Leading for Inclusion Programme, National EDI Work Programme, and the Interim Workforce Equality and Inclusion Strategy. Each of these projects is working towards greater EDI throughout their respective areas. I look forward to continuing to be a part of these projects that work to address inequality which is a key element of the Trust's newly launched Strategy.

1.3 **Other activities**

I have visited a number of our service centres, in person – where this can be done safely - over the last couple of months. I value the opportunity to hear first-hand how colleagues are experiencing their new ways of working and how they are coping with the ever-changing challenges presented to them. Recently I have based myself at the Stroud General Hospital, Wotton Lawn Hospital, Tewkesbury Hospital and Cirencester Hospital where I was able to meet with colleagues and patients and also be on hand to discuss any topics or issues that they wished to raise.

I would like to thank and congratulate the teams at Stroud General Hospital and Cirencester Hospital for successfully passing the **JAG assessment for the Stroud Endoscopy services**. The JAG accreditation is only awarded to high quality gastrointestinal endoscopy services after a rigorous assessment process. This accreditation is hugely beneficial for our services and highlights the quality of work that these exceptional teams produce.

I have been asked to chair the regional **Mental Health Programme Board** which will be an excellent opportunity to further progress mental health priorities in the Long-Term Plan and this will benefit the Trust's Mental Health agenda by improving our wider connectedness.

Mental Health awareness week took place in May and highlighting the importance of focusing on mental health and connecting to the natural environment, especially important during the unique and challenging circumstances presented by the pandemic.

The Chair and I welcomed Her Royal Highness, The **Princess Royal** on 21st April to the Trust. During the visit to Gloucester, Her Royal Highness had conversations with nurses, allied health professionals, facilities colleagues, emergency response leads, and Trust Executive and Non-Executive Directors about their roles and the challenges they have faced over the past 18 months.

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 as we enter the next phase of the pandemic.

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

Internal focus

A **Board Development Session** was held on 14th April, which was facilitated by the **Kings Fund**, with whom the Trust Board has had a partnership over the last two years. At the seminar Helen McKenna, a Senior Fellow at the Fund who is leading on policy connected with the development of ICSs and Dame Gill Morgan the independent Chair of the Gloucestershire ICS, presented and discussed their perspectives on the latest NHS White Paper and the potential implications for the Trust. The second part focussed on leading the recovery programme and setting priorities for the year.

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 an update on the Launch of the new Trust Strategy and new Trust Leadership Programme. The Team Talk sessions help to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team.

Virtual **Senior Leadership Network** (SLN) meetings were held on 27th April and 25th May. These provided an excellent opportunity to update the SLN on Trust and national developments. The April session featured an informative presentation from Sarah Scott (Director of Public Health, Gloucestershire) on population health management. Neil Savage (Director of HR and Organisational Development) also provided further updates on Recovery and Refocus following on from the March session. Linda Gabaldoni (Head of Leadership and Organisational Development) provided a presentation on the Leadership and Development Programmes (Brilliant Essentials and Leading Better Care Together) which have been developed based on the values of the

Trust and aims to equip our leaders with the tools and techniques to be the best leaders they can be.

Corporate Induction has continued to be run as a weekly virtual event throughout the lockdown period. 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. We expect the use of e-learning to continue where it has been shown to best meet our needs but we are also exploring which types of training and development should return to face to face sessions when it is considered appropriate.

The Trust has continued to hold its **Covid-19 Briefing calls** for senior and on call managers. The frequency of these meetings is dictated by the level of activity in the Trust and system and are currently being held twice weekly. 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. Twice weekly **Oversight Calls** are also being held, led by the Operations Directorate.

I attended the **Non-Executive Director's meeting** on 29th April and provided an informal update. Sandra Betney deputised for me at the meeting on 18th May. This meeting is reported on in more detail in the Chair's report.

I attended a **Council of Governors** meeting on12th May to provide the CEO update on a number of important matters, including an update on Covid-19 and the updated hospital visiting arrangements. This meeting is reported on in more detail in the Chair's report.

I have continued involvement, along with other GHC Directors, in the **Reciprocal Mentoring Scheme** and I attended a workshop on the 20th April which included a constructive discussion on our experiences so far, shared learning, identified gaps and recommended next steps. See 6.0 below.

On 4th May we held an Executive's deep dive session to examine and discuss the results of the **2020 Staff Survey results**. This meeting provided an excellent opportunity to assess the trends and results of the survey and look at how we can make a meaningful impact for our colleagues moving forward.

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. I also continue to have regular meetings with senior officers and Leaders at Gloucestershire County Council, including Sarah Scott, **Executive Director of Adult Social Care and Public Health,** we have reinstated our informal operational informal senior team meetings to share common priorities and issues**.**

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. 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 system **Gold Health System Strategic Command CEOs** call has continued to be in operation until the beginning of April as part of the **Gloucestershire ICS Covid-19 Response Programme**; recently the frequency has reduced frequency to once a week with a focus on executive review of our improvements to system patient flow. 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 and social care system.

I continue to attend the bi-weekly **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. These largely focus on the latest developments in the management of the Covid-19 pandemic including providing updates on vaccination mobilisation and PPE. Elective diagnostics recovery, system flow delivery and primary care updates are also provided at these meetings.

I continue to chair the **ICS Diagnostic Programme Board**, which met on 13th May. The Board is continuing to progress the important work on developing local proposals for potential Community Diagnostic Hubs (CDH). A CDH has been defined nationally as a 'free standing multi-diagnostic facility that is designed to be located away from main 'acute' hospital sites, including on the high street and in retail locations. The service model will be to provide quick and easy access a range of elective diagnostic tests on the same day, supporting earlier diagnosis, greater convenience to patients and the drive to reduce health inequalities. Resources have been made available to regions and we are exploring the viability of such development to complement existing community diagnostic services.

The Chair and I attended the first task and finish group meeting for the **University of Gloucestershire Partnership** on 4th April with other directors, senior clinicians and senior managers. This session discussed the commencement of work on forming a bilateral partnership with the University of Gloucestershire to complement the wider system work, such as Research for Gloucestershire. The task and finish group spoke positively about the potential opportunities of this partnership and looks forward to working together in the coming months to progress this project.

Further system updates are provided later in the agenda.

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, the key meetings have included:

- NHS England's monthly MH (Mental Health) Trusts CEO Meeting, chaired by Claire Murdoch
- Monthly SW Regional Chief Executive meetings, chaired by Elizabeth O'Mahoney; and
- SW MH (Mental Health) CEO's meetings, which I now Chair and which act as the executive leadership group for the MH collaborative.

Additionally, I chaired the virtual **West of England Academic Health Science Network (AHSN) Patient Safety Collaborative Board** meeting on 11th May. The main focus of this meeting was an overview of the five workstreams and the Local Improvement Plan for the West of England's National Patient Safety Improvement Programme. An informative presentation was provided by Noshin Mezies on reducing Health Inequality.

2.0 TRUST STRATEGY

Following our approval at the March Board meeting on 11th May, our new **Trust Strategy** was launched for 2021 to 2026. The strategy – called 'Better Care Together' – was developed in partnership with our colleagues, volunteers, people we serve, carers, members, and a wide range of other stakeholders. It is our road map for the next five years and through it we pledge to put people at the heart of our services, focusing on personalised care by asking 'what matters to you?' rather than 'what is the matter with you?' It describes our Mission: to **Enable People to Live the Best Life They Can and** our Vision: **Working Together to Provide Outstanding Care**. It also details our four strategic aims are – **High Quality Care, Better Health, Great Place to Work and Sustainability** – each underpinned by measurable, specific goals and objectives.

We will be using this framework to shape the ambitions and priorities of the organisation, as an example today we are considering the Digital Strategy for the Trust.

3.0 APPOINTMENTS

I am pleased to announce that following a competitive selection process, Liz Lovett has been appointed to the substantive post of **Matron of Stroud and Vale** community hospitals. Liz has been leading and supporting both hospitals in an acting capacity since June 2020 and will commence this role with immediate effect. She brings a wealth of varied and highly-applicable clinical and leadership experience and knowledge to the position.

Margaret Dalziel has now joined the organisation as **interim Deputy COO** whilst Hilary Shand acts up as interim COO whilst John Campbell is absent.

We also welcome Tania J Hamilton who joins the Trust for the next three months working with our **Diversity Network** and subgroups to help us ensure all our colleagues at GHC have a voice, feel equally valued and supported. Tania has worked in HR and diversity across public, private and non-profit sectors, and is a non-executive Board Trustee for diversity and inclusion with Charity 'Active Gloucestershire'.

4.0 OLIVER MCGOWAN LD AND AUTISM TRAINING

The **Oliver McGowan Mandatory Training** Trial in LD and Autism launched in Gloucestershire on 1st April with over 90 people attending the training on the first day. This training is named after 18-year-old Oliver McGowan, whose tragic death in 2016 highlighted the need for health and social care staff to have better training in learning disabilities and autism. It is part of a national commitment to develop a standardised training package, and GHC was one of four national partners appointed to co-design and co-deliver the training as part of a national pilot. All of the training is fully co-designed and co-delivered with people with a learning disability, autistic people, family carers and people working within learning disability and autism services. When it becomes mandatory across England in 2022 it will make a huge difference to people with a learning disability and autistic people, in accessing the help they need from the NHS and social care in a way that meets their needs effectively. This training is now available for all staff within GHC to register with many training dates available throughout the remainder of the year.

5.0 RECIPROCAL MENTORING UPDATE

Board members will remember that we launched our pilot of the NHS Leadership Academy's Reciprocal Mentoring programme in late November 2019. Since then a number of colleagues have benefited from the programme and, in particular, from their reciprocal mentoring relationship. Some participants have obtained career promotions and some have moved on and left the programme and we are currently seeking additional participants. Nationally, the Leadership Academy are reinitiating the programme with 34 Trusts across England now participating in the programme.

By means of background, reciprocal mentoring has benefits for the both the organisation and individual. As a methodology, it is known to have a positive impact on changing mind sets and influencing real cultural transformation. There is conclusive research from Australia, India, USA and the UK that evidences the benefits reciprocal mentoring can have on organisational diversity, fairness, psychological safety, the representation of protected characteristics across all levels, the bottom line, and the broader workplace culture. National and local data through the Workforce Disability Equality Scheme (WDES), Workforce Race Equality Scheme (WRES), Staff Surveys

and research by Stonewall all evidence there is both real disparity of experience and inequality in the NHS. Reciprocal mentoring can be a game changer for improvement.

Inevitably, COVID has impacted our ability to make the level of progress at the pace we would have liked. **The Leadership Academy paused the programme for much of 2020**, while the Trust itself also temporarily paused much of its training and education activity at the same time. After a soft relaunch earlier this year and the most recent session on 19th May 2021, it would be helpful to schedule a discussion with the Board with a view to gaining an explicit recommitment to growing and developing the programme as part of our strategic ambition of being a Great Place to Work. There is now a timely opportunity to recommit and set our future strategic ambition on our approach to reciprocal mentoring.

The Board has recently agreed a key **People Strategy** objective of being an organisation that takes positive action to create an organisational culture that is welcoming and celebrates inclusivity and diversity and provides a sense of belonging and trust. Reciprocal mentoring is one key component to delivering this objective, alongside our stated commitment to helping colleagues reach their full potential.

The Board is asked to consider a recommitment to developing and growing the scheme. It is also asked to consider its appetite and ambition for a more systemic roll out of further cohorts generally, and, more specifically, offering the scheme to a more diverse groups of colleagues.

An ultimate longer-term vision could be to make reciprocal mentoring available to all colleagues at all levels within the Trust. This would need on-going partnership working with the Leadership Academy, alongside internal planning, resource and time to further develop and fine hone our intended longer-term outcomes and objectives of the programme.

The delivery of this ambition could truly set the organisation apart from others and contribute to tackling our recruitment and retention challenges.

Our intent is to now set up a Programme Management Team to support the programme. Part of its role will be to ensure the whole organisation supports participants taking part (in terms of time release and resources), and also to assist the programme with innovating and experimenting with new ideas and approaches to addressing challenges and make change happen. Places will also be offered in a targeted manner to members of the Diversity Network and its subgroups and colleagues in the CCG.

6.0 LOCAL EXCELLENCE AWARDS

The Trust has now completed the most recent year's round of local **Clinical Excellence Awards CEAs**. In this year's round 34 Consultants were eligible to apply and 8 applications were received. There were no five-year award review applications. Candidates from protected characteristics were particularly

encouraged to apply for this year's round, with buddying being offered, alongside a training programme delivered by the Medical Director.

The Committee included NED and external lay representation, Local Negotiating Committee representation, the Medical Director, the Director of HR and OD, and consultants not eligible to apply this year. There were 13 CEA awards that could have been made for the 2019/20 year, plus 4 carried over from the previous year, On the basis of the applications and their accompanying evidence, alongside the scoring by the panel members, the Committee is recommending making 4 awards of 2 CEAs, and 3 awards of a single CEA. 6 potential awards would therefore be carried forward to 2020/21. A date is now being sought for the Committee's recommendations and reflections from this year's round to be taken to an Appointment and Terms of Service Committee for debate, consideration and approval.

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: 09/0521

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 27 May 2021**
PRESENTED BY:	Paul Roberts, Chief Executive Officer
AUTHOR:	Paul Roberts, Chief Executive Officer
SUBJECT:	**UPDATE ON ORGANISATIONAL PRIORITIES**

Can this subject be discussed at a public Board meeting? If not, explain why	N/A

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

PURPOSE OF REPORT

To remind and update the Board on the short term priorities adopted in 2019 and 2020. To recommit to the balanced approach to delivering Trust priorities in 2021/22.

RECOMMENDATIONS

The Board is asked to:

- **note** the short-term priorities and progress made in 2019 and 2020
- **recommit** to the balanced approach to achieving the Trust's priorities as described in section 4.0 of this paper.

EXECUTIVE SUMMARY

When Gloucestershire Health and Care NHS Foundation Trust was launched in October 2019 following the merger of 2gether and Gloucestershire Care Services it was impossible predict the context in which it was to operate for most of the first twenty months of its existence. This context has clearly had significant implications for the pursuit of the priorities and ambitions identified through the merger process and on operational capacity to deliver priorities beyond the Covid response.

Nevertheless the Board agreed a number of short-term priorities in September 2019 and a larger number in 2020 to ensure that an achievable strategic progress was made. In November 2020 the second wave of Covid had a further and arguably more significant impact on the Trust's capacity to deliver its wider ambitions; again however despite this progress has been made.

This paper describes the short-term priorities agreed in 2019 and 2020 with a brief commentary on progress and sets out the broad approach taken for 2020/21.

Risks associated with meeting the Trust's values
None.

Corporate Considerations	
Quality implications	None directly
Resource implications:	None directly
Equalities implications:	None directly
Risk implications:	Addresses the organisational risks associated with recovering from the Covid Pandemic

Where has this issue been discussed before?
CoG, Board, Executive group and Senior Leadership Network

What wider engagement has there been?
Via Team Talk, Global updates and other media

Appendices:	None

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

UPDATE ON ORGANISATIONAL PRIORITIES

1.0 BACKGROUND

When Gloucestershire Health and Care NHS Foundation Trust was launched in October 2019 following the merger of 2gether and Gloucestershire Care Services it was impossible predict the context in which it was to operate for most of the first twenty months of its existence. This context has clearly had significant implications for the pursuit of the priorities and ambitions identified through the merger process and on operational capacity to deliver priorities beyond the Covid response.

Nevertheless, the Board agreed a number of short-term priorities in September 2019 and a larger number in 2020 to ensure that an achievable strategic progress was made. In November 2020 the second wave of Covid had a further and arguably more significant impact on the Trust's capacity to deliver its wider ambitions; again however despite this, progress has been made.

This paper describes the short-term priorities agreed in 2019 and 2020 with a brief commentary on progress and sets out the approach taken for the coming months.

2.0 HIGH LEVEL PRIORITIES 2019/20

The Board meeting on 26th September 2019 agreed five short-term high-level priorities to be delivered in the early months post-merger and whilst the Trust developed its five-year strategy, below is a brief commentary on progress:

Priority	Progress
Consolidation of the merger	Largely complete although some system integration is still being finalised. Ironically the pandemic has ensured that culturally the organisation has had to come together to deliver appropriate care.
Development of a Trust Strategic Framework	• The Trust Strategic Aims adopted by the Board in March 2020 • Our People Strategy adopted March 2021 • Five-Year Organisational Strategy: Better Care Together adopted March 2021 and launched in May 2021. • Digital Strategy being considered today
Transfer of the Herefordshire mental health and learning disability services	Complete – March 2020
Building blocks of organisational transformation	• ED&I Programme launched July 2020 • Leadership/Management Development Programme launched March 2021

Priority	Progress
Progress on "system" and "place" agenda	Progressing but ongoing – key opportunity with White Paper

3.0 ORGANISATIONAL PRIORITIES 2020/21

At the September 2020 Board meeting following a review of the 2020/21 short-term priorities twenty-three organisational priorities covering each of the Trust's four newly agreed strategic aims were approved for the remainder of 2020/21. It was acknowledged at the time that these priorities were in addition to the Trust's requirement to continue to deliver the Phase 3 NHS Recovery and, even more significant, the response to Covid "Wave 2" which was more demanding than Wave 1. Below is a brief commentary on progress to date:

Strategic Aim	Organisational Priorities	Progress
High quality care	• Further build a strong voice within the ICS	• Good progress, Trust leads some key work streams/programmes
	• Develop and maintain Covid safe environments	• Good compliance and encouraging feedback via the staff survey
	• Develop an effective QI programme	• Many of QI team redeployed during Covid – now making active progress
	• Build sustainable access to digital care platforms	• Used professional and service user feedback to choose and support systems
	• Develop a focussed academic partnership	• Involvement in AHSN reinvigorated and started process of closer partnership with UoG
	• Maximising the impact of the MH Investment Standard	• This has been very challenging with Covid but is receiving significant focus
	• Finalise plans for a hospital in the FoD which provides an excellent and future-proof environment	• A complex project with many challenges but making progress
	• Continued ambitious roll-out of personalised care agenda	• Limited progress, AP will now chair the system programme board to move this forward.

Strategic Aim	Organisational Priorities	Progress
Better health	• Develop a process for routine access to good PHM data and information	• Work ongoing led mainly at ILP level
	• Focus on developing relationship with Gloucester and Cheltenham ILPs with shared priorities which match GHC ambitions	• Although interrupted by Covid, now actively meeting with clear GHC leadership/involvement
	• Develop good data and information on access by high risk communities to our services (a Phase 3 requirement)	• Part of service recovery process – focus on recovering inclusively
	• Participate in PHM programmes in Cheltenham and Gloucester focussed on inequality	• Fully engaged in Cheltenham. Ready to participate as programme rolls out
	• Some further targeted ILP activity focussed inequality in Gloucester linked to Mental Health investments	• Appropriate elements of the MHIS investments are focussed in Gloucester as planned.
Great place to work	• Continued development of recruitment and retention approaches	• There has been a need to focus on temporary staffing and redeployment in Covid. Now more strategic focus, particularly on WL staffing.
	• Further development of H&WB support	• H&WB has been continually reviewed on the hub and good feedback from colleagues
	• A focussed equality, diversity and inclusion programme	• We have developed our diversity networks and our response to Covid with clear ED&I outcomes in mind. Reinvigorating our reciprocal mentoring programme currently
	• Pilot a more radical approach to distributed	• No specific progress but distributed leadership approach

Strategic Aim	Organisational Priorities	Progress
	leadership (self-managed teams for instance)	part of relaunched leadership development programmes.
Sustain-ability	• Develop an estates and "assets" enabling strategy • Develop an environmental sustainability strategy and programme	• In progress (Board workshop in May) • Later in 2021
Generic	• Provide good support for digital technologies • Continue the development of the Trust Strategy and the detailed ambitions and objectives to support it • Finalise the digital strategy specifically for GHC • Targeted "Covid inspired" role out of digital technology	• Generally good support during Covid • Strategy agreed in March 2021 by the Board. Trust Operational Plan builds on it • To Board in May 2021 • As above and in Digital Strategy

4.0 APPROACH TO DELIVERING TRUST PRIORITIES FOR 2021/22

NHS England/Improvement (NHSE/I) published its planning guidance for 2020/21 in March 2021 which built on interim guidance published in December 2020 which focussed on Covid recovery as well as reinforcing the NHS Long Term Plan priorities. The latest guidance set out a division of the financial year in to two halves "H1" and H2". The guidance emphasised system working and the submission date for the Gloucestershire consolidated plan is in early June.

Notwithstanding the unusual circumstances GHC is in a comparatively good planning position having adopted its organisational strategy, people strategy and an annual (not half-year) business plan at the March Board meeting and the Digital Strategy is being considered today. The Board will also be receiving today an update on the service recovery programme for the Trust which will reflect a huge element of the capacity and focus for clinical, service and operational teams throughout the coming year.

Given the above, the Trust has clearly gone some way to re-establishing "normal" planning processes (as was set out in the business plan in March) based on Trust strategic aims, commissioning intentions and national guidance. It is therefore not proposed to adopt short-term priorities as was done in a different context in 2019 and 2020.

It is however worth reinforcing recommitting to the guiding approach that has been discussed informally by the Council of Governors, the Board, the executive team and senior leadership team over the last few months: our commitment to balancing individual recovery, service recovery and our determination to fulfil our strategic ambitions as illustrated below.

5.0 RECOMMENDATIONS

The Board is asked to:

- **NOTE** the short-term priorities and progress made in 2019 and 2020
- **RECOMMIT** to the balanced approach to achieving the Trust's priorities as described in section 4.0 of this paper.

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 10/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

PRESENTED BY: Hilary Shand, Acting Chief Operating Officer

AUTHOR: Sarah Birmingham, Deputy Chief Operating Officer

SUBJECT: **REGROUP, RECONNECT, RECOVER**

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 the Board with an overview of the comprehensive approach to recovery across Gloucestershire Health and Care NHS Foundation Trust following the first and second wave of the Covid-19 pandemic.

Recommendations and decisions required

The Board is asked to:

- **Note** the approach being taken by the Operational Directorate in order to Regroup, Reconnect and Recover.
- **Note** the 4 key areas identified as risk and issues across the organisation with an overview of the mitigation plans

Executive summary

Following the undertaking of recovery clinics across all Operational Directorates, recovery plans have been agreed and formalised that take into account the need to regroup, reconnect and recover.

This has identified 4 major risk/issues across the organisation that may hinder recovery and impact upon the delivery of patient care.

The Directorates have identified mitigation working collaboratively with partners.

Risks associated with meeting the Trust's values
4 key risk have been identified: • Colleagues health and well-being • Demand and capacity • Workforce • Estates

Corporate considerations	
Quality Implications	Clinical risk
Resource Implications	Waiting List
Equality Implications	Access

Where has this issue been discussed before?
• Recovery Clinics • Operational Governance and delivery Forum • Executive Team • Chief Operating Team

Appendices:	Regroup, Reconnect, Recover Presentation

Report authorised by: Margaret Dalziel	**Title:** Interim Deputy Chief Operating Officer

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AGENDA ITEM: **10.1**/0521

Regroup, Reconnect, Recover

Trust Public Board

27 May 2021

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Regroup, Reconnect, Recover
Background

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October to March 2020/21

- During the 2nd Covid -19 wave (October 2020 - March 2021) key GHC services remained open for business and continued to accept referrals, maintain waiting lists and deliver care.
- During this period 18 (out of 90) GHC services were reprioritised to priority level 2, offering a service for urgent and priority patients only whilst continuing to accept referrals, provide triage/advice and wait list maintenance.
- Seasonal winter pressures during this same compounded the challenge of the pandemic.
- Reduction in Covid related operational pressures in March enabled the Operational Teams to start the process of Regroup, Reconnect, Recover.

Regroup, Reconnect, Recover
Organisational Approach

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- **Regroup** - Individual Recovery—putting our people/workforce first
- **Reconnect** - Service & Team Recovery—getting back to a new normal
- **Recover** – Focus on Service Recover and refocus on our aims and on our transformation—why we merged and re-energising our ambitions

Regroup, Reconnect, Recover

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Principles of Recovery Planning

- Staff health and well-being is core
- Wider system partner are considered ensuring we considered the potential impact of recovery decisions.
- Preparation for further Covid waves and impact
- Align with business planning as a core part of 2021/22 priority work
- Incorporating learning from the last 12 months
- Planning seeks and reflects service user feedback.

Regroup, Reconnect, Recover

Gloucestershire Health and Care NHS Foundation Trust

Process

Recovery Clinic for each Operational Directorate held in April 2021 reviewed all services with a focus on:

Workforce and OD

- Health and well being of individuals and teams
- Bespoke welfare support plans for Directorates
- Workforce challenges impacting on resilience and capacity
- Training needs

Demand/Capacity and Business Intelligence

- Demand profile across 20/21
- Forecast demand 21/22
- Patients waiting and waiting lists plans
- Capacity to meet demand
- Forecast demand and capacity and recovery trajectory

Regroup, Reconnect, Recover

Gloucestershire Health and Care
NHS Foundation Trust

Process

Recovery Clinic for each Operational Directorate held in April 2021 reviewed all services with a focus on:

Service Developments and Changes

- Service user experience
- Estates challenges and opportunities for expanded service delivery (Covid secure)
- New ways of working – what's the 'new normal'
- What's the planned new delivery model - face to face, virtual and telephone.

Quality & Risk

- Patient safety
- Staff safety
- Risk, issues and mitigation
- Complaints / themes
- Use of decision making matrix and risk stratification to prioritise and direct care.
- Review of service risks and issues in relation to recovery.

Communications

- Communication with staff and with patients / users

Regroup, Reconnect, Recover

Outcome – Plan on a Page

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Following each recovery clinic, a plan on a page was completed by the Service Director with their teams highlighting key milestones, delivery trajectories, risk, issues, support required and an opportunity for reflective feedback.

SERVICE OVERVIEW: predictions for 'New Normal'

INITIAL RECOVERY PLAN: What will we do?

Milestone	Q1	Q2	Q3	Q4
Workforce				
Operating model				
Service user engagement				
Business planning expectations				

DEMAND AND CAPACITY PLANNING

Recovery trajectory	Q1	Q2	Q3	Q4

NEW NEED/SUPPORT REQUIRED

Support	Q1	Q2	Q3	Q4
Health &Well-being				
Estates				
BI				
Service User Experience				
Training				
IT equipment				
PPE				

RISKS AND ISSUES

REFLECTIVE FEEDBACK

Regroup, Reconnect, Recover

Risk Rated Recovery

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Each service has RAG rated their ability to recover using the descriptors below:

Recovery Descriptor	Risk Rating
Service recovery plan in place to support recovery	**Low Risk**
Service recovery plan in place to support recovery within 12 months. Moderate level of risk Identified which may involve workforce, demand and capacity, estates or service design challenges	**Moderate Risk**
Service recovery plan in place to support recovery to take in excess of 12 months. High level of risk identified which may involve workforce, demand and capacity, estates or service redesign challenges.	**High Risk**

- There is an immediate focus on those services that are High Risk.
- Service Recovery will be regularly reviewed, with those moving to High Risk being prioritised.
- We predict to see an increase in High Risk services in Mental Health over the coming months

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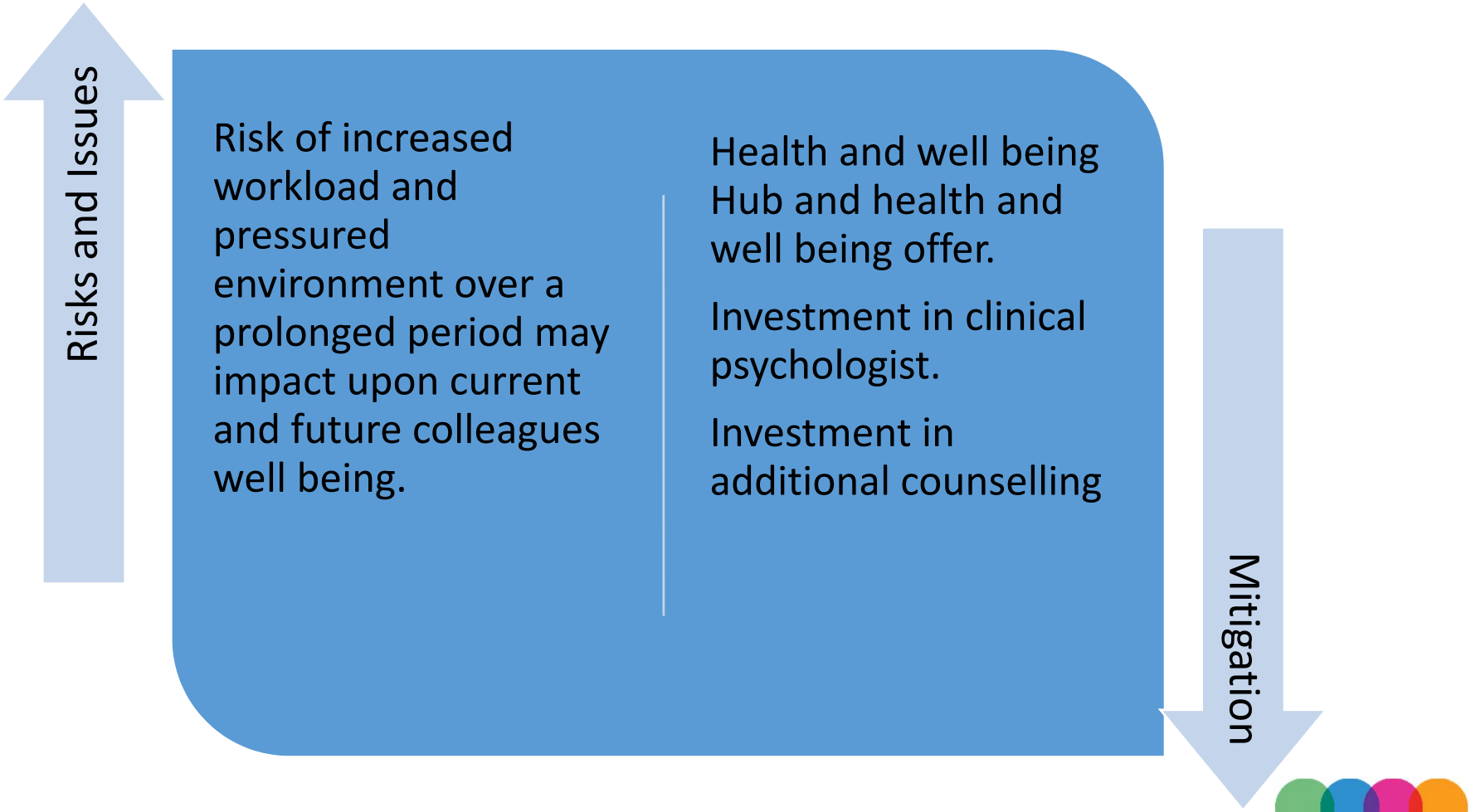
Key Risks, Issues and Mitigation to Recovery:
Colleagues Well-being



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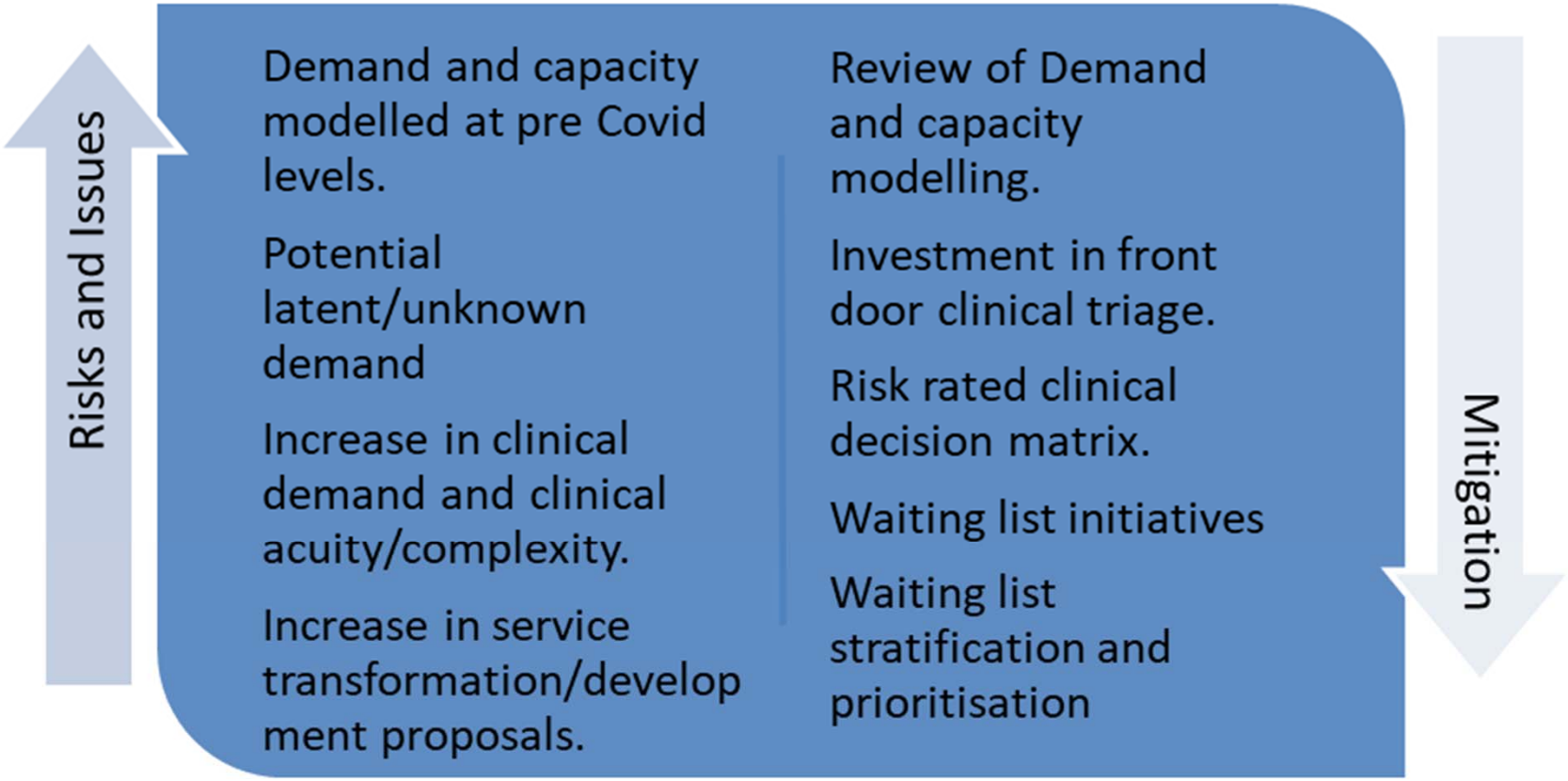
Key Risks, Issues and Mitigation to Recovery:
Demand & Capacity



Regroup, Reconnect, Recover

Waiting List Management

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Measures in place to support safe waiting list management and to mitigate the risk:

- Robust Clinical triage
- Triage supportive conversation
- Prioritisation of urgent and priority needs
- Support/welfare telephone calls - Registered Clinicians where Clinical Risk is discussed, alongside any changes to presentation and a check in with any self-help materials
- Referrals to other services are also actioned if it becomes apparent they would be helpful whilst waiting or if circumstances change (e.g. Early Help, Hospital Education).

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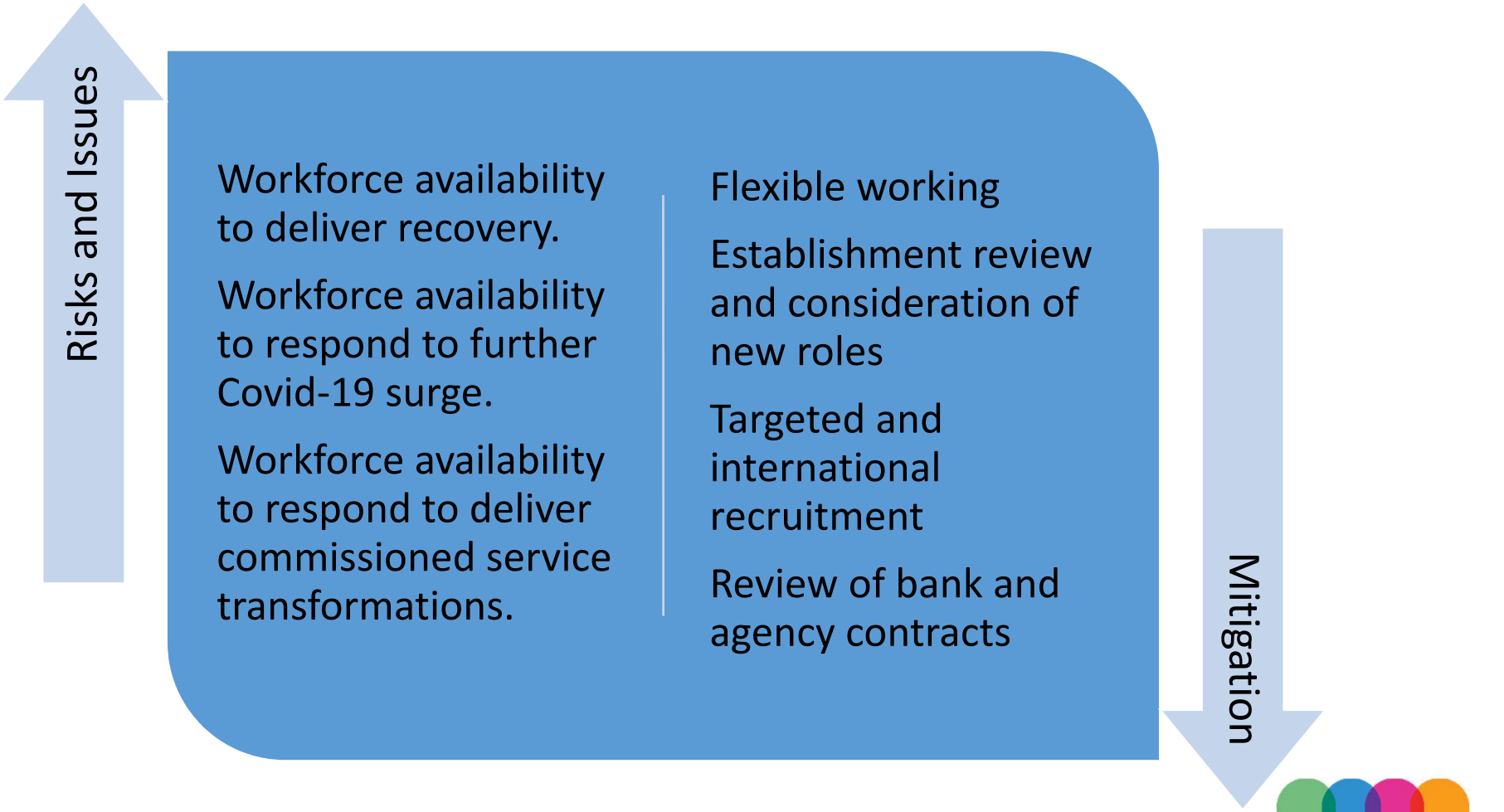
Key Risks, Issues and Mitigation to Recovery:
Workforce



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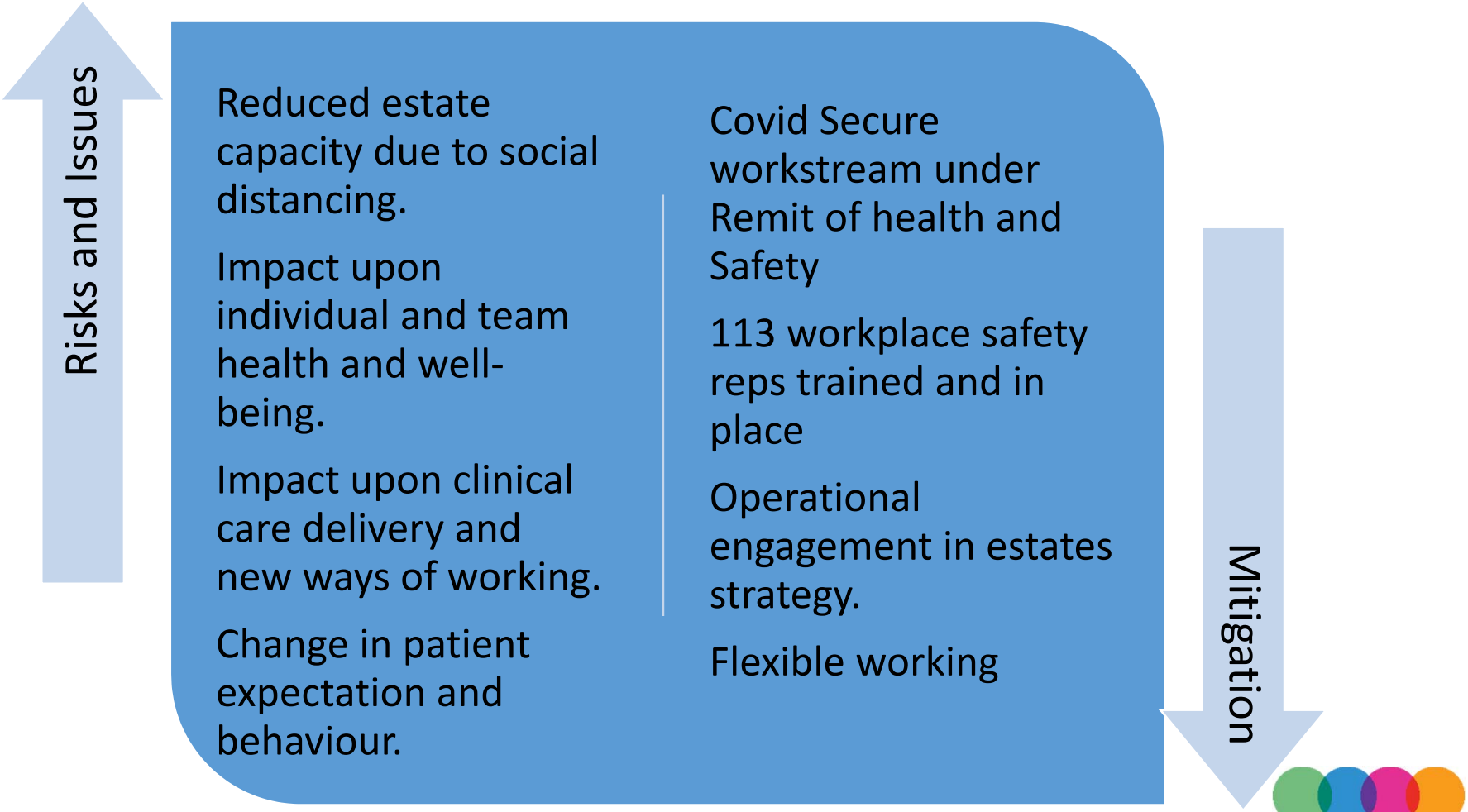
Key Risks, Issues and Mitigation to Recovery:
Estates



Regroup, Reconnect, Recover

Governance & Oversight

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Monthly Operational Recovery Oversight & Task Force Group
Establishment of a the Group to provide support to services and to track recovery. Membership includes colleagues from the Health and well-being Hub, Quality Improvement, Human Resources, Nursing Quality and Therapy, Business intelligence.

Weekly Operational Recovery Drop-in Clinic
Implementation of a drop in clinic available to all services, with Operational and Corporate Services leads.

Monthly Health Inequalities & Waiting Lists Forum
Review of waiting lists and agreed actions to understand service recovery focus needs for BAME communities, deprivation and potential unmet need.

Monthly Operational Governance Reporting
Monthly review and reporting at Directorate and Pan-Directorate Governance Forums.

Quarterly Workshop
Cross Directorate sharing, learning and developmental recovery focussed workshop.

Regroup, Reconnect, Recover

Gloucestershire Health and Care
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Health inequalities & Waiting Lists

Working collaboratively with our system partners we aim to:

- Protect the most vulnerable by connecting with and understand our communities
- Restore inclusivity – enable those with greatest need to access our care
- Support digital enabled care pathways increasing inclusivity and access
- Recover preventative programmes to proactively engage those at greatest risk
- Support mental health across all communities

We have establishes a monthly Health Inequalities and Waiting List Forum to review ethnicity and demographic data across mental and physical health waiting lists.

Regroup, Reconnect, Recover

Health inequalities & Waiting Lists

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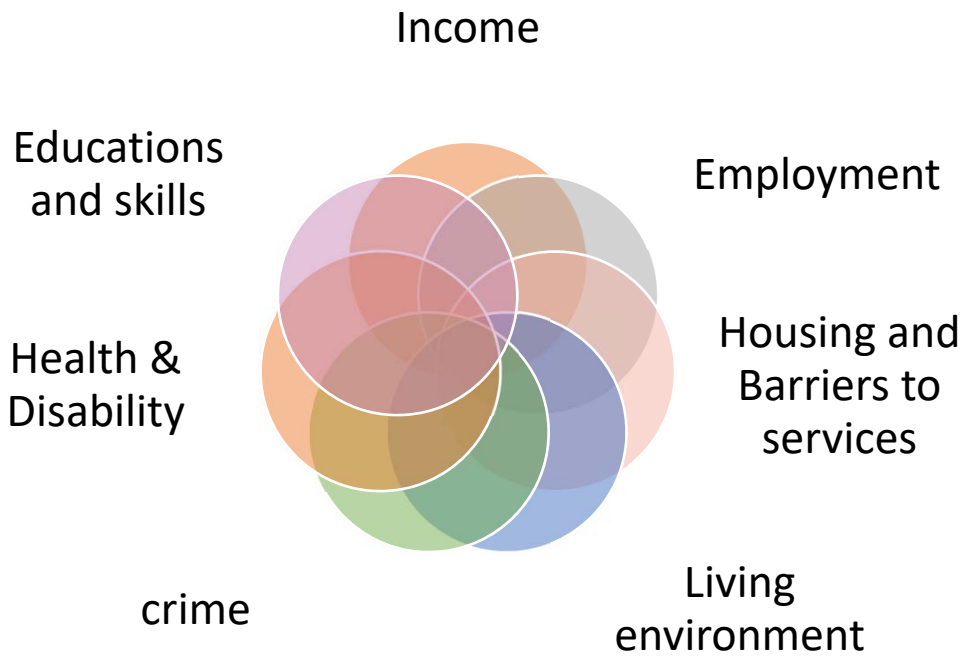
Index of Multiple Deprivation (IMD)

By combining information from the seven domains illustrated we will produce an overall relative measure of deprivation score, the Index of Multiple Deprivation (IMD).



Two additional Supplementary Indices:

- Income deprivation affecting children index
- Income deprivation affecting Older people index.

Regroup, Reconnect, Recover

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Health inequalities & Waiting Lists

Use the Index of Multiple Deprivation (IMD) score for targeting services initially across:

- Children's Mental Health
- Adult Mental Health
- Cardiac
- Pulmonary Rehabilitation
- Diabetes
- Inpatient admissions

Focused recovery of service delivery by taking account of the bottom 20% by IMD and black and minority ethnic populations for patients.

Review black and minority ethnic population access data with CCG to consider patterns between different population groups accessing or not accessing our services.

Regroup, Reconnect, Recover

Next Steps

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Under the Governance of the Operational Recovery Oversight and Task Force, the focus and support for Regroup, Reconnect and Recovery will include:

Regroup

- Confirmation and support of the various offers from internal directorates, including Health and Wellbeing, Quality, Business Intelligence and HR, whilst also promoting what teams offer as BAU.
- High Risk services to receive a personalised support package, with all other services being invited to regular Recovery drop-in Clinics, where support offers can be agreed or tailored to the need.

Reconnect

- Assessment of workforce and estate challenges.
- Communication with staff at all levels, with a focus on recovery and creating an organisational support network.

Recover

- Review of demand and capacity modelling and waiting list trajectory.
- Implementation of waiting list initiatives, supported by Quality Improvement colleagues.
- Continue stratification and prioritisation of wait lists with health inequalities.
- Communications plan to ensure aligned, timely engagement with staff, patients and the system.
- Longer term links with Business plans and wider Strategies, e.g. potential impact of recovery, and aligning recovery support with People Plan priorities.

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AGENDA ITEM: 11/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

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
This paper provides an overview of a range of activity taking place across the Integrated Care System. This update includes:

A number of service developments continue to happen across the county including the launch of the Reducing Re-offending strategic objectives, the Safeguard Adults Board and the Carers Partnership Board's engagement work and the work of the Gloucester City Race Relations Board.

The Integrated Locality Partnerships have now also re-commenced some of their activities and an overview of ongoing activity is included in the report.

Engagement updates, including completion of recent surveys and engagement activities undertaken by partners such as Inclusion Gloucestershire and Healthwatch Gloucestershire, are also included.

The ICS Board Minutes are available in the reading room for further information. There is no Accountable Officer Report available due to the timings of the Health Overview and Scrutiny Committee (HOSC) meeting.

Risks associated with meeting the Trust's values
None

Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our surveys and include them within future service reviews and developments
Resource Implications	None specific to the Trust
Equality Implications	The Trust is actively engaged in the Race Relations work and will build any findings into the Trust service developments moving forward

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

Appendices:	ICS Board Minutes

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

INTEGRATED CARE SYSTEM UPDATE REPORT

1.0 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.

1.1 Health Overview and Scrutiny Committee Activities

HOSC has not met since the last Board and will reconvene once the new cabinet is assembled.

1.2 Wider ICS and Partner updates:

1.2.1 Active Communities Grants

Gloucestershire County Council has launched an 'Active Communities Grant application process' as part of the Tackling Inequalities work run by Sports England. The fund aims to minimise the impact of coronavirus on the activity levels of people from under-represented groups, particularly those groups who are working with lower income households, ethnically diverse groups and disabled people. The funding will help to create safe spaces that build confidence and connections and support people to increase connectivity and resilience.

1.2.2 Safeguarding Adult Board Update

Gloucestershire Safeguarding Adults Board Roadshow had over 500 people attend across its week of activities to promote and develop inclusive plans reflecting the commitment to multi-agency and partnership work across Gloucestershire. The events were held virtually, with a focus on safeguarding during the COVID-19 pandemic and the Voluntary and Community Sectors contribution to keeping people safe during this challenging time. Each day had a specific theme; these were Financial Abuse, Domestic Abuse, Substance Misuse, Mental Health and Disability.

1.2.3 Gloucester City Commission to review Race Relations

A Commission has been set up by Gloucester City Council and is headed by local businessman and social entrepreneur Rupert Walters. Running for a year, it aims to identify areas where it can help to improve the lives and opportunities for those who experience racism and disadvantage because of their colour.

The Commission members are made up of representatives from both major institutions and from BAME communities within the city and will be tasked with putting together a strategy based on the findings of the Commission.

Commissioners are a cross-section of those representing major institutions and BAME communities within the City. Whilst commissioners will draw on their

institutional and personal experiences, they are acting in the interest of the City as a whole. The Trust is represented by the Strategy & Partnerships Directorate.

The work programme has been now agreed by the Commissioners and will consist of seven focused events that will explore or investigate a particular issue, service, or experiences. The evidence provided will be used to inform recommendations in the Commission's final report, to be shared with the city's key organisations and decision makers.

In addition, commissioners are calling for evidence and case studies from individuals and organisations.

The work programme includes:

(1) Health Inequalities – BAME and Mental Health (co-led by Trust rep)
(2) Race inequalities in the criminal justice system with focus on youth justice
(3) Education attainment
(4) Health inequalities – Diabetes (co-led by Trust rep)
(5) BAME workforce representation
(6) Heritage Assets
(7) Housing

1.2.4 Reducing Re-Offending Strategic Objectives Launch

Reducing re-offending and increasing rehabilitation opportunities via better services are key objectives of the County and the Gloucestershire Reducing Re-offending Board is a multi-agency partnership that aims to facilitate and co-ordinate partnership work to help build better strategies for diversion and rehabilitation to achieve these objectives. The Board have released their strategic objectives 2021 this month which include 5 priority delivery groups that they will focus on which include:

- Women in Criminal Justice
- Mental Health
- Accommodation
- Integrated Offender Management
- Proportionality in the Criminal Justice System

As the Trust has just commenced its work through the South West Provider Collaborative on the development of a Forensic Community Liaison pathway the release of this strategy is timely and will inform our work moving forward.

1.3 **Carers Partnership Board**

The Trust plays an active role in the Gloucestershire Carers Partnership Board which aims is to ensure that carers, commissioners, providers and partner agencies work closely together to ensure that Carers are resilient and feel supported to manage their own health and wellbeing whilst also feeling valued and having their voice heard at an individual and strategic level. The

Partnership Board is in the process of developing a new action plan for carers which we anticipate to be released shortly and will help support the Trust's own work to support carers.

1.4 **Integrated Locality Partnerships**

The Trust is actively engaged with all Integrated Locality Partnerships as they re-commence activity following Covid. Below is a number of the key highlights from discussions since the last update;

1.4.1 **Cheltenham ILP** – Met April 2021 and now planning to meet bi-monthly. Population Health Management (PHM) work continues across the Primary Care Networks (PCNs) as much as Covid activities allow. For example, Central PCN have expanded the approach to a further cohort of Children & Young people (CYP), to review progress and linking CYP's into the project. The aim of this PHM aspect is to work with children and young people and their families to build resilience with the view to prevention of future need. They are linking in their CYP Social prescriber, meeting regularly with the Trust's trailblazer workers to prevent duplication.

1.4.2 **Gloucester ILP** – Met April 2021 and intending to meet monthly moving forward. Gloucester City ILP had its first meeting since November 2020 and undertook a detailed review of the impact of Covid and discussed the benefit of having close working relationships throughout the period was noted. The support from the Trust into the vaccination programme was particularly noted and the impact of the Rapid Response teams.

Work has also progressed on the Community Builders project across the City and a map of community builders and social prescribing services in Gloucester City has been produced along with initial work taking place to develop an Engagement Strategy. It was recognised that as this project further develops, there may an opportunity to align this work as a work stream within the Health Equality work.

1.4.3 **Tewkesbury ILP** – A number of Partnership wide task & finish groups have been established with two being led by members from the Trust's Strategy & Partnerships team; one that focuses on work around Healthy Lifestyles and Prevention and one focusing on Mental Health. Both areas of work consider the wider determinants of health and how particularly working age adults and children and young people can access support and services.

1.4.4 **Stroud ILP** – received an update on the Community Dementia work that has been taking place across Stroud & Berkeley Vale by the Trust and the discussions regarding potential roll out and next steps which remain ongoing.

1.4.5 **Cotswolds ILP –** continue to work on priority areas and keen to pick up dialogue regarding new ways of working and ongoing partnership working with the Trust. This will be taken forward as part of a wider system piece of work in conjunction with operational colleagues, the nursing and therapies teams and

supported by myself and Helen Goodey, Director of Primary Care & Locality Development.

1.4.6 **Forest ILP** – Discussions are underway with regard to a timetable to recommence formal ILP activities but priority work areas have continued where possible.

2.0 FOCUS ON PATIENT, CARER AND STAFF FEEDBACK AND ENGAGEMENT

2.1 Healthwatch Gloucestershire has commenced a survey to seek people's views of the CV19 vaccination programme and if there are any aspects of the roll out that could be improved upon. The survey closed on the 3rd May and we will review the findings once they are released.

2.2 Gloucestershire VCS Alliance are exploring the ways in which the VCS sector is providing mental health support in the county by undertaking a survey of the local VCS organisations to understand both the work they are doing and any challenges they may have in undertaking this. The work is being supported by Barnwood Trust who are providing some background work and hosting the survey.

2.3 In May 2021, Inclusion Gloucestershire and Kingfisher Treasure Seekers have released their report relating to the experiences of people from different ethnic backgrounds in accessing services. The report acknowledges some of the ongoing struggles for individuals accessing health services and can be found via Health Inequalities Report | Kingfisher Treasure Seekers (kftseekers.org.uk) *(Board members can access this document in the Reading Room on Diligent).*

2.4 *Heads Up Cheltenham* is a steering group of partners which exists to encourage good mental health and wellbeing across Cheltenham. The first key 'project' was to input in a wellbeing survey #CheltenhamUnmuted which has over 100 respondents and the results will be shared in the new few weeks.

The Trust has been actively engaged in this work through the Partnership and Inclusion Team along with Alex Burrage, Consultant Psychological Therapist who will be part of the official launch of the Campaign.

2.5 In April 2021, Healthwatch Gloucestershire launched a new Young Listeners project to help bring positive change to young people's health and social care services and ensure that you people can directly influence the services they use. They are recruiting volunteer Young Listeners aged 16-24 to find out more about the views on young people on the services they use.

The Trust is also developing a similar strand within its People Participation work and has been commencing work through a number of Young Ambassadors conversations which will help inform the development of a Youth forum for the Trust. Links will continue to be made with Healthwatch Gloucestershire to ensure we learn and support each other as we take forward these pieces of work.

Angela Potter
Director of Strategy & Partnerships

AGENDA ITEM: 13/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

PRESENTED BY: Sandra Betney, Director of Finance & Deputy Chief Executive

AUTHOR: Informatics Team

SUBJECT: **DIGITAL STRATEGY**

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 get endorsement/feedback on the updated Trust Digital strategy to enable a final version to be published. The digital strategy is one of the key enabling strategies supporting the overall strategy work the organisation is pulling together.

Recommendations and decisions required

The Board is asked to:

- **Endorse** the content of the digital strategy.

Executive summary

The digital strategy being presented today is an evolution of work that has taken place since May 19. What started life as the digital framework for the merging organisation has subsequently considered feedback from many stakeholders and the consequences of the Covid Pandemic. This has radically impacted on how NHS organisations and patients think about digital and provided opportunities to move forward in many areas such as remote consultations which has been built into the updated strategy.

The digital strategy has introduced a new digital vision and moved towards a plainer English version removing the technical language that was utilised previously. This alongside the more visual look of the strategy will hopefully support a wider organisational engagement and understanding in the digital strategy and what is trying to be achieved over the next 5 years.

Risks associated with meeting the Trust's values
It is important that the trusts digital strategy reflects the wider strategic vision of the trust to ensure alignment with what the organisation wants to achieve over the next 5 years.

Corporate considerations	
Quality Implications	Implementing the digital strategy should impact on all aspects of the trust and its patients including quality, resource and health inequalities
Resource Implications	Implementing the digital strategy should impact on all aspects of the trust and its patients including quality, resource and health inequalities
Equality Implications	Implementing the digital strategy should impact on all aspects of the trust and its patients including quality, resource and health inequalities

Where has this issue been discussed before?
The new organisational strategy work has been discussed at numerous forums within the organisation. The Digital Strategy and previous iterations have been to the Digital Group, the Resources Committee, a Board workshop and has been part of many engagement sessions both internally and within the wider ICS.

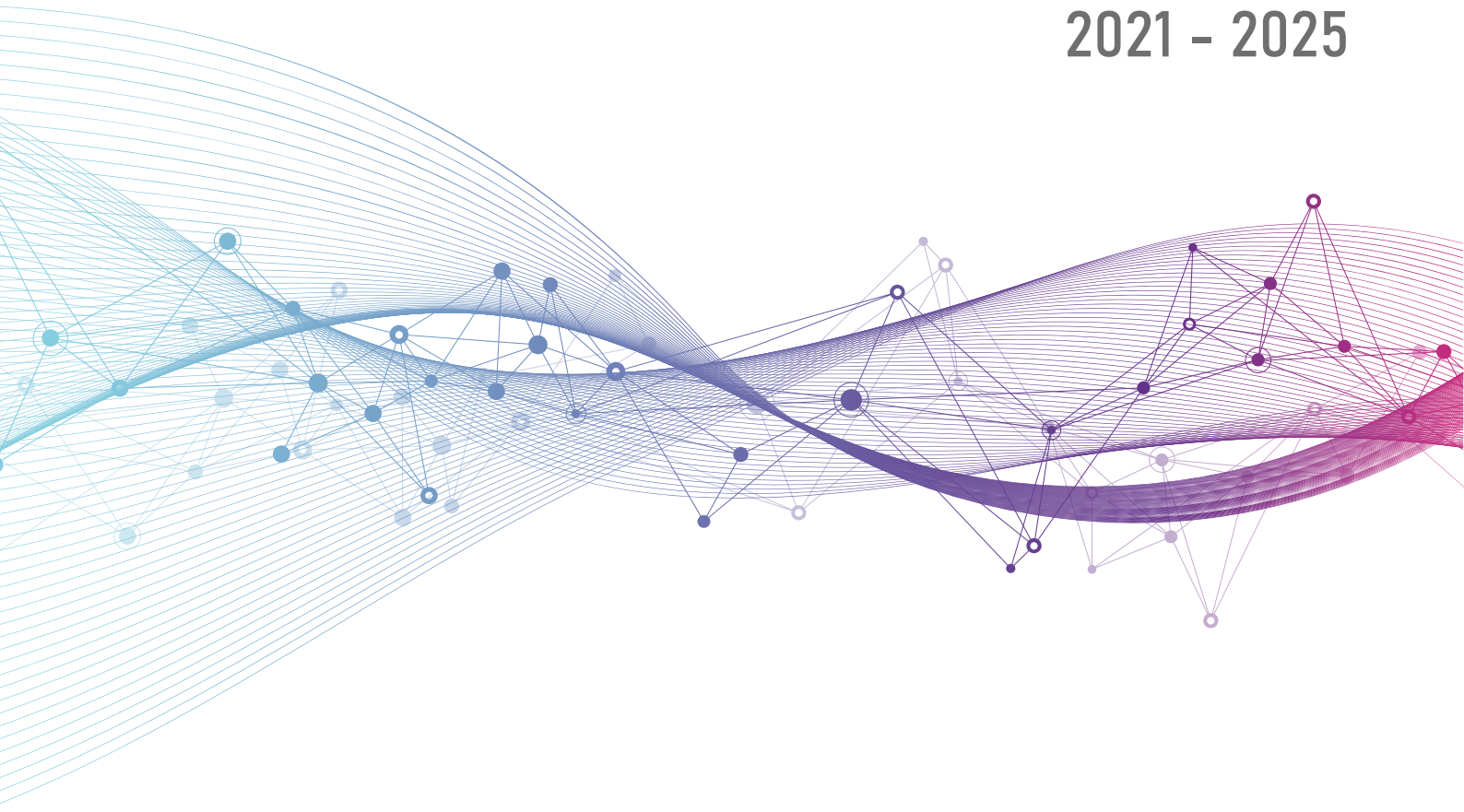
Appendices:	Appendix 1: Digital Strategy

Report authorised by:	**Title:**
Sandra Betney	Director of Finance & Deputy Chief Executive

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Digital Strategy 2021 - 2025



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

Executive Summary

As our society rapidly embraces and adopts technology the NHS cannot stand still. Our Digital Strategy describes our five year plan to achieve our organisation, local and national ambitions for digital transformation, integration and innovation. Improving people's health, well-being and care experiences, through the effective use of data, digital technology and technology-enabled care.

This document explains how we will work towards our Digital priorities to achieve our vision:

To become a fully digital Trust.

Our vision means that we intend to integrate digital solutions into every interaction to improve the quality and experience of care. We have identified five strategic aims that will help us in our journey:

Empower people; Enable clinicians; Integrate systems; Revolutionise information; Build the future.

Our vision is not just about IT systems and equipment, it is about developing a digital culture within the Trust. Gaining a collective understanding and mindset where we confidently use information and digital solutions to improve care experiences and aid decision making; contribute to how we can operate responsibly as an anchor institution in Gloucestershire; add value and increase efficiency; and effectively transform services to make the most of digital and techonological innovation. Coproduction and collaboration are key to how we will achieve our vision, working with the population we serve, services that deliver and support care, local partners and NHS Digital.

This journey will include:

- Increasing access for people using services, enable people to self manage and interact with the NHS more effectively from their own homes.
- Ensuring personalised care approach programmes and resources are integrated into clinical systems.
- Making sure people have options so that they are not digitally excluded and support personalised care
- Building a digitally skilled workforce with the right technology, training and infrastructure in place to support planning, digitalise processes and improve mobile working.
- Ensuring that technology and information is available in the right place, for the right person, at the right time and on the right device.
- Collaborating with Gloucestershire's Integrated Care System partners to build a robust digital infrastructure capable of supporting joined-up accessible health records and data sharing.
- Revolutionising data and information consumption to enhance quality improvement, research and evidence based practice as well as support complex modelling, cost reduction and decision making.
- Transforming and integrating infrastructure and technology ensuring they are fit for the future reflected by increasing our digital maturity index

Introduction

The NHS policy, 'The future of healthcare: our vision for digital, data and technology in health and care' (2017) outlines specific ambitions for NHS organisations to support health and care provision. To quote the highly regarded Wachter report "… **the one thing the NHS cannot afford to do is remain a largely non-digital system. It is time to get on with IT**".

This Digital Strategy is our response to that challenge.

This strategy does not sit is isolation but as one of six integrated enabling strategies for Gloucestershire Health and Care NHS Foundation Trust (GHC) first five year plan 'Our Strategy for the Future' 2021-2026.

As a new organisation formed in October 2019 from two high performing NHS Trusts, our digital transformation and ambitions build on the strengths of our legacy trusts. Our merger programme dominated our attention during 2019 in bringing together a number of diverse information systems. This included both clinical and non-clinical systems ensuring we provided colleagues with access to relevant information and technology from any location and at any time in all of our services.

This digital strategy encompasses a much broader scope and set of ambitions that will explain how we will contribute towards our mission:

Enabling people to live the best life they can

And how we will work towards achieving over arching vision:

Working together to provide outstanding care

The GHC Information Technology (IT), Clinical Systems and Business Intelligence (BI) teams are the key enablers working together to making our ambitions a reality. Collaboration with Gloucestershire's Integrated Care Sytem partners and NHS Digital national team will be essential to achieving our organisational and local delivery ambitions ensuring our health and care system is collectively fit for the future.

Our road to embracing digital will see us remove digital friction, implement enabling technologies, ensure technology is aligned to roles, and enable high quality data at the point of care. Additionally we will improve digitisation of interactions for people using services, and the automation of related processes, enabling data sharing across the system. Finally we will reflect our growing wealth of data back to decision-makers at all levels of the Trust through compelling self-serve Business Intelligence.

Where we are... and where we want to be

2019

- Merger
- Integration of Trust systems

2020

- EPMA roll out in mental health services
- Office 2010 replacement
- Total mobile project progressed
- BI system integration progressed
- Covid response
- Rapid roll out of virtual consualtations and MS Teams
- Mobile access infrastructure upgrades

2021

- CAMHS online PHR portal launch
- Digital inclusion project launch
- Community mental health clinical system review
- E-Obs roll out in mental health services
- Integrated rostering roll out

2022

- Implement further use of enhanced medical equipment
- Progress clinical system review recommendations
- ICS information sharing in place

2023

- Digital skills and training programme roll out
- ICS system optimisation of real time monitoring to support clinical decision making

2024

- Further develop artifical intelligence to enable proactive use of data
- GHC fully cloud transitioned

Case Study

Berkeley House: First inpatient facility using e-prescribing enables high quality care and sustainability

Simon Eddy
Developing Advance Nurse Practitioner for Learning Disabilities and Autism

"We've only had e-prescribing a few weeks and need to iron out a few challenges from poor wifi signal but we can already see the significant benefits e-prescribing brings to both staff and patients. No more rewriting charts, interpreting handwriting, storing mountains of paper medical charts and needless trips to the GP for a signature. It is also easier to report, analyse and review medicinal history.

The advantages are clear - safer prescribing, quicker implementation of medicinal treatment, reduced time spent on admin and reduced costs."

Berkeley House is a learning disability assessment and treatment inpatient unit for adults with learning disabilities and autism.

Case Study

Rapid expansion of remote working kept people safe and made sure services could maintain care through lockdown

Hannah Borne
Speech and Language Therapist

"Video consultations have benefitted our patients in a number of ways. Many of our less mobile patients have commented on the convenience of being able to access therapy from within their own homes instead of travelling to clinics. Others said that virtual appointments are less stressful. People also reported they can fit appointments more easily in to their working day."

What people said about using video consultations:

"Easy to access on the internet. My therapist was really helpful and had lots of patience with me."

"All connections work well today and I appreciate the continued support."

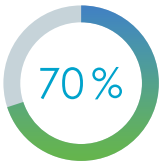
"As a clinically at risk person, I have benefitted from being able to work safely from home."

Learning from our Covid response

The impact of the Covid-19 pandemic has changed the landscape of delivery across our health care services. This has resulted in an accelerated transition to virtual consultations and digital approaches to communication and service delivery.

The speed and agility of the digital response to the pandemic has raised the expectation of leaders and staff highlighting the continued importance of digital capability and infrastructure.

Across Gloucestershire we use a shared network which includes primary care and acute sites/services enabling colleagues and partners to securely and safely share information with each other as well as offering the opportunity to work across.



3,320 colleagues using portable devices

From 0 to 18,396 virtual meetings held

15 new WiFi hotspots created in car parks

From 0 to 55 services using Attend Anywhere with over 1,000 appointments per week

30,000 support calls - 98.9% closed first time. Average of 14 seconds response rate to calls

6 new consultation pods installed

The bigger picture and national drivers for change

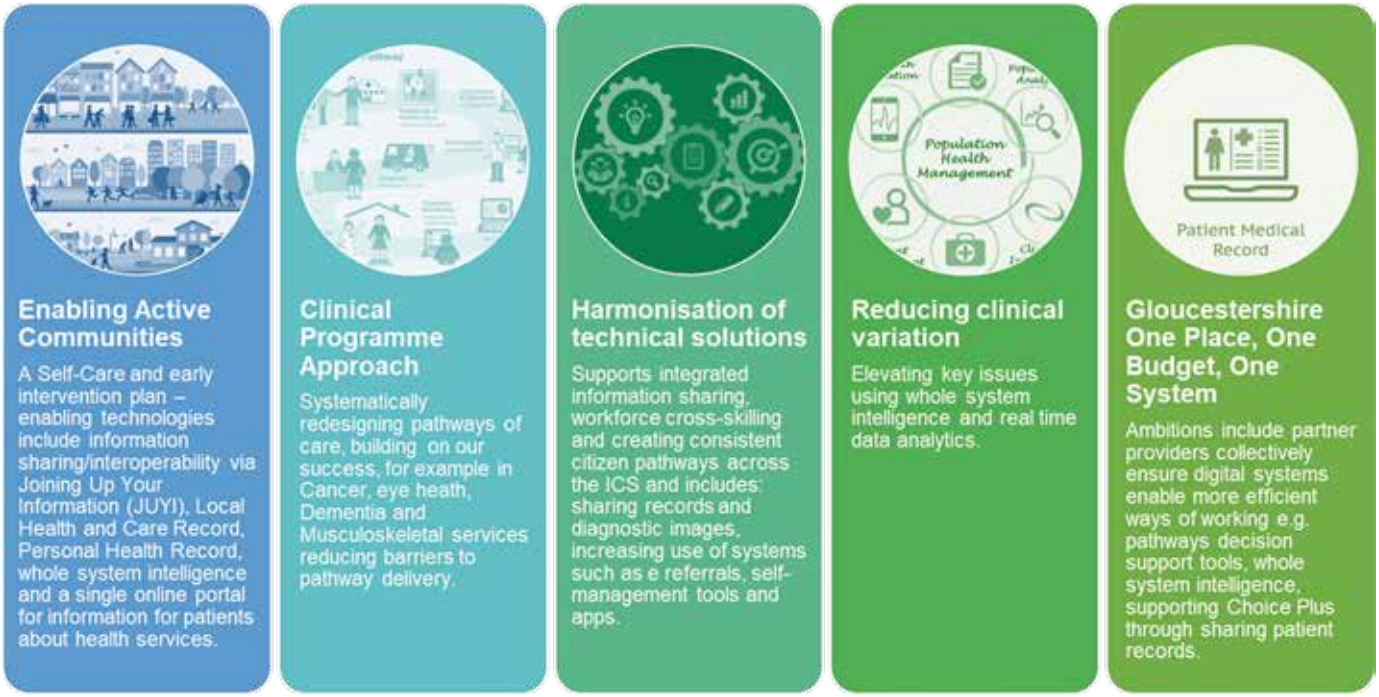
Across Gloucestershire we use a shared network which includes primary care and acute sites/services enabling colleagues and partners to securely and safely share information with each other as well as offering the opportunity to work across.

Fundamental to this strategy is recognition that the people of Gloucestershire's health and care journey goes beyond interactions with GHC as a local anchor institution. Innovation and integration of our digital approach with Gloucestershire Integrated Care System (ICS) projects is key to delivering joined up care and improving health outcomes. To this end, our priorities align with the ICS vision and aims:

ICS vision: *To empower people to manage their own health and to be able to quickly access high quality person-centred care within their localities.*

ICS aims include: *to give more capabilities to people to self-manage and co-create care, to improve health outcomes and reduce bureaucracy across the system.*

Key ICS digital initiatives and projects which we are involved with include:



There are also a number of National catalysts to help our journey over the next five years, including:

- The NHS Long term Plan and national launch of Local Digital Roadmaps.
- The publication of the Wachter Review on using health information technology to improve care
- The appointment of a Senior Clinician-led Digital Team at NHS England.
- The development of NHS Digital and NHS X the national agencies for digital transformation and their retained health and social care brief
- A heightened level of focus on the digitisation of the NHS Institute for Innovation and Improvement (NHSI) services by supporting and driving the Digital Maturity Programme through the investment in the Global Development Exemplar (GDE).

Case Study

Let's Talk: Better health, high quality care and sustainability can come through the use of data and analytics: enabling complex modelling, forecasting, continuous improvement and resource targeting

Alex Burrage
IAPT Clinical Lead

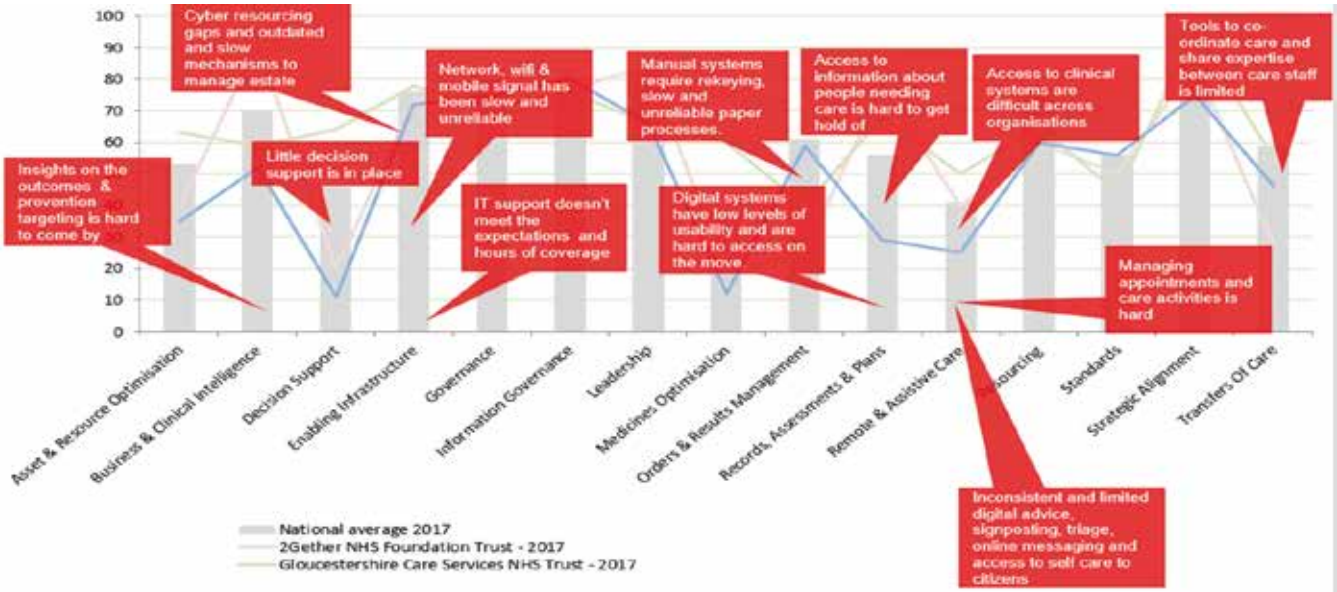
Let's Talk, our Improving Access to Psychological Therapies (IAPT) service, use business intelligence yo transform services and monitor the impact of care.

Alex said: "Forming a close working relationship with the Business Information team has been crucial to the development of our IAPT service. Information supports change, ongoing review and reporting. We can understand what's working well and have the tools to undertake further development."

Key challenges for our digital strategy

Assessment of our digital maturity helps us understand areas for development and identify priorities. There is an added complexity in working with a dual focus: managing our own Trust's transformation plans and as an ICS partner aligning multiple programmes of work challenges ahead. By increasing our digital maturity we can assure improvement benefits our population and ensure alignment with our system partners.

Our digital maturity challenges:



Digital change will be transformation-led with projects and priorities aligned with Trust objectives and wider system transformation initiatives. The complexity of step by step changes will be managed through a structured project framework. We will co-design digital advances with people receving and providing services to ensure solutions are fit for purpose, using data and people stories to measure success and sustainability.

GHC's key challenges and actions we take to support delivery of our Digital Strategy are summarised in the table below:

Challenge	Mitigations
Engagement of staff in the ownership of the digital agenda	Using digital champions in the organisation
	Creation of digital forum, innovation group and other networks
	Better access to meaningful data and insights
	Access to central IT support for local digital projects
Funding limitations	Complete benefits analysis of digital solutions to support funding for additional resources as required
	Identify where there are gaps in resources to support priority planning
	Accessing central government funds and ICS wide project funds for digital projects
Technical system barriers	In-house IT function to provide expertise on technical systems
	Adhering to standardised use of external IT systems to minimise customisations that have a high degree of support reliance
	Alignment with ICS wide system development
	Agile system design for future interoperability assurance
Skills and human resource limitations	Accessing the wider public sector and higher education sector to learn from others or to use external skills that work not for profit
	Foster partnership working with other analytical teams in the ICS
	Work as an ICS to identify key skill gaps and collectively fund resources in this area
	Work smarter across the ICS to deliver projects and programmes learning from others and supporting implementations with the same project teams

Our ICS shared key risk is not progressing our digital ambitions and just sticking to a traditional & siloed way of IT delivery. This would negatively impact delivering at scale objectives such as increased self-care and personalised care; improved joined-up working; and use of Population Health Management approaches to support health and care planning. Lack of resources and funding for digital solutions is a key challenge for both GHC and the ICS. The digital teams will address these challenges with prioritisation and robust benefit analysis.

The challenge is to arrive at a comparable level of digital integration to avoid disjointed or incomplete information. To mitigate against this Gloucestershire has adopted the Global Digital Exemplar Model. This enables organisations to make changes at a pace matching business demands.

Challenge	Mitigation
Insufficent resources to support system wide development	Identify where there are gaps in resources to support priority planning
	Agree ICS digital workstream goals and develop 'road maps' to articulate how different organisations can achieve these.
Multi-organisation digital alignment and system interoperability	Global Digital Exemplar model - blueprinting and fast following: progressing with ready teams, learn and adapting.
	Collaborative study and review to enable adaptation for system wide scale-up plans.
	ICS technology platform managed by unified technology teams·

How will we know our digital ambitions benefit the people we serve?

Coproduction and collaboration are key to how we will achieve our Trust's strategic aims and our digital ambitions. We have completed an analysis of our digital aims to assess how they support the Trust's overarching strategic aims:

Before and during digital strategy development, we undertook and were involved in a series of engagement, co-design and participation events with people who use ourt services, colleagues and system partners. Our goal was to make sure we understood what benefits or important outcomes our colleagues and people who use our services wanted to experience through improved digital technology.

As part of our ICS digital group we used this information to create a series of problems and outcomes so that we can easily see the link between what we are doing and the benefits people will expereince. We will continue to assess and adjust our action plans over time through consultation.

In 2020...
As a GP I don't know who in the practice is at greatest risk of developing a chronic disease so I can help.

In 2024...
As a GP I can see which patients have the greatest risk factors in my PCN and the social segment they are in. I work with a virtual multidisciplinary team to develop an appropriate menu of interventions, which I then agree a plan with the patients, tracked via an online consultation and digital diary.

In 2020...
As a multidisciplinary team, we can't get video conferencing to work. This means that there is less collaborative working and joint decision making is delayed until we can find time to meet in person.

In 2024...
As a multidisciplinary team, we now meet virtually with ongoing messaging episode alerts and task assignment based on what's happening to the people we are caring for together. We don't have to wait for meetings to act and can set up ad-hoc video calls, where we share images, investigations and update the same shared care plan.

In 2019...
As someone being diagnosed with a suspected long-term condition, I don't know what the next steps are, what I can do now to help myself and how long I'll need to wait. This creates anxiety, feelings of powerlessness and causes me to put plans on hold.

In 2024...
As someone being diagnosed with a suspected long-term condition, I use the NHS App to triage to an appropriate set of local servoces to support me, including online options. I also can see a status of test results and a record of previous consultations.

Our GHC Digital Approach and Aspirations

Our Digital Vision: To become a fully digital Trust.

Improving our patients' health and wellbeing and their care experience, through the effective use of data, digital technology and technology-enabled care with collaboration at our core. This means that we will ensure information is available in the right place, for the right person, at the right time and on the right device.

To deliver our vision we have identified five strategic aims that align with the NHS Digital Transformation Program and GHC's strategic intentions. Against each of our aims, we have identified over arching goals, a number of objectives and measures of success.

DIGITAL GHC

Empower people: Provide convenient access to services and health information for people to self manage and support personalised care.

Enable clinicans: Build a digitally skilled workforce with the right technology training and infrastructure in place to deliver efficient, high quality, responsive and innovative services.

Integrate systems: Work in collaboration with partners to improve system wide health and care transformation to improve planning and delivery of services through the greater use of shared data.

Revolutionise information: Delivering secure, robust and reliable data analytics that can be easily and rapidly accessed across the organisation and health care system.

Build the future: Provide convenient access to services and health information for people to self manage and support personalised care.

All our digital aims, objectives and planning decisions align with our Trust values and are grounded in the principles developed by National Voices and the NHS Empowering Patients and Communities Board:

User Need	Privacy & Security	Interoperability & Openness	Inclusion
Every service must be designed around user needs whether the needs of the public, service usersm carers, clinicans or other staff.	It is critical that we maintain public trust in how we hold, share and use data.	We develop our technology so that data and clinical systems are built to enable safe sharing of information between clinicans, teams and partners in our ICS system.	We will design services created in partnership with citizens and communities with a focus on equality and narrowing inequalities.

Digital Strategic Aim One: **Empower People**

Provide convenient access to services and health information so that people can self manage, access services more easily and contribute to personalised care.

Our goals over the next 5 years are to ensure that:	Objectives and actions
• People will be able to access and maintain their own health records, manage their illness, record physical observations and contribute to recovery plans. • People will consistently be able to choose how they communicate with health care professionals, book appointments and have options in how appointments are conducted – virtual video, telephone or face to face. • All data sharing, new technologies and digitally-enabled models of care improve people experience of care, keep personal information safe and promote equality. • People are able to participate and contribute to designing digital solutions.	• Develop a secure patient portal, provide digital tools and advice that helps people better manage their health and conditions at home or convenient place. • Support digital implementation of the comprehensive model of personalised care. • Expand our range of digitally enabled models of care building on our Covid19 experiences: e.g. improving video consultations options; self-care digital therapies; and digital linking of health monitoring equipment. • Prepare our systems for E-referrals and E-booking technologies. • Develop, review & implement Trust and system wide digital inclusion programme supporting technology in people homes and training packages to suit people's needs (NHS App, 'widening digital participation' and 'digital smarties' programmes). • Develop and test 'digital front door' access solutions starting with children's mental health services to enable expansion to other services. • Align with the trusts people participation plan to ensure representation in appropriate digital projects.

Key areas of work over the next 12 months:

- Digitally enabled self care
- Learning from our Covid-19 response and produce a detailed review to develop a long term strategy of video conferencing.
- Review and develop options for an integrated electronic appointment booking system.
- Review and develop an integrated approach to 'digital inclusion' learning from peoples expereinces during the Covid-19 pandemic.

Measures of Success

- Periodic reviews (audit, internal assurance visits, peer reviews, user satisfaction surveys, feedback from colleagues and partners) to monitor the impact digital transformation is having on care delivery.
- Measure against specific project success criteria as agreed with partners and people who use our services.

Digital Strategic Aim Two: **Enable Clinicans**

Build a digitally skilled workforce with the right technology, training and infrastructure in place to deliver efficient, high quality, responsive and innovative services.

Our goals over the next 5 years are to ensure that:	Objectives and actions
• Colleagues can communicate effectively with each other and across organisations in order to share information and decision making. • Colleagues can consistently and safely access information when they need it, where ever they are - right place, right information, right time and right device. • Colleagues have the essential skills to make the best use of digital transformation and information. • People can easily engage with Digital services to get support for projects, innovations & developments.	• Provide appropriate technology, build infrastructure and develop training packages involving the people that will be using them. • Collaborate with service improvement champions to digitalise processes and support smarter working using appropriate technology e.g reducing the need for paper, save time, increase efficiency and data security. • Support clinical and corporate service colleagues use information wisely to enhance decision making, monitor performance and progress, improve services, contributing to research and evidence-based practice. • Building our digital culture by placing technology as a key founding element of excellent and safe health care. • Increase the number and spread of clinical and operational staff who are directly engaged in digital transformation • Support the formal development of clinical and digital leadership through regularly enrolling people in the NHS Digital Academy. • Develop and improve digital front door enabling colleagues to request project support and explore improvements and innovation.

Key areas of work over the next 12 months:

• Ensure a consistent user setup of hardware and software for all staff across the trust
• Invest in digital skills and training to improve competency and capability of our workforce both through recruitment, retention and ongoing skills development.
• Further embed the use of collaboration tools to support clinicians working effectively within the Trust but also within the wider ICS.
• To increase the number and spread of clinical and operational staff who are directly engaged in digital transformation

Measures of Success

• Relevant measures in the Staff Survey
• Evidence of digital coproduction and co-design in service transformation
• Digital Literacy and Leadership programmes are available and used across the Trust

Digital Strategic Aim Three: **Integrate Systems**

Work in collaboration with partners to improve system wide health and care transformation planning and delivery of services through the greater use of shared data and joined up clinical systems.

Our goals over the next 5 years are to ensure that:	Objectives and actions

• People are able to reliably and consistently receive effective health and care interventions in the place that is most convenient for them.
• People involved in providing and receiving care can access and contribute to shared multi-disciplinary and multi-agency clinical records, decision making and care plans at the right time, remotely and in a usable format.
• People are supported and enabled to manage their care effectively where they live, maximizing independence and minimizing risk.
• All business processes, standards, systems and technology are supported with a robust infrastructure to enable cross boundary working.
	• All clinical systems will be reviewed in 2021 and a new Clinical Systems Vision will be agreed and shared by the end of 2021/2022
	• Integrate data from mulitiple cinical systems across the Trust enabling full representation of activity and performance in one view.
	• Continue our programme to rationalise corporate and clinical systems ensuring alignment with national standards by 2022/23
	• Rationalize, develop and harmonise technology and infrastructure to join up information and interoperability between multiple organisations effectively, safely and securely, including:
	  ○ E-rostering and E-Job planning systems.
	  ○ Electronic patient records
	• Provide technology and develop training packages to suit people's needs.
	• Work with Ambulance services to ensure Mental Health Crisis plans are available through the National Record Locator by 23/24.
	• Ensure local implementation of the child protection sharing solution as part of the national delivery by 2022/23

Key areas of work over the next 12 months:

• Develop, align and rationalise GHC corporate and clinical systems.
• Explore and agree technical design decisions to enable system partners operational systems to align and enable interoperability.
• Integrate from multiple systems and enable data presentation.

Measures of Success

• An improvement in the Trust's Digital Maturity Index position
• 360 surveys on Trust influence and reputation in digital services
• Pooled or collective arrangements in place for cross-organisation digital services.
• Development of new partnership arrangements with new organisations e.g. Gloucestershire University

Digital Strategic Aim Four: **Revolutionise Information**

Delivering secure, robust and reliable data analytics that can be easily and rapidly accessed across the organisation and health care system.

Our goals over the next 5 years are to ensure that:	Objectives
• Colleagues and system partners have access to reliable, robust data and information. • Colleagues can confidently use powerful data interrogation self-service tools and compelling dashboards to effectively support decision making, drive change, improvement and target resources. • People can be assured that increases in data use and sharing consistently maintains legal and regulatory compliance with cyber security and information management standards.	• Ensure digital technology and infrastructure is in place to enable data collection, interpretation and presentation simply and intelligently through Business Intelligence (BI) Analytics tool. • Expand implementation of BI Analytics tool enabling reports, dashboards and alerts to be viewable on all devices. • Increase professionalised informatics accreditation and achievement of professional analyst standards. • Collaborate with teams to digitalise processes and upgrade technology to minimises the burden of data collection. • Continue to develop predictive analytics capable of modeling and forecasting future capacity, demand and performance. • Develop systems that are interoperable enabling safe open access across system platforms. • Work with the wider health community to support the safe, lawful and secure utilisation of population health data to inform future delivery and present a single patient pathway across all organisations.

Key areas of work over the next 12 months:

• Roll out of real time, point of contact performance and activity monitoring dashboards.

Measures of Success

• All systems information available through the trusts data warehouse and BI system
• Data quality improvements
• Population Health solution in place across the ICS

Digital Strategic Aim Five: **Build the Future**

Develop our digital infrastructure and systems so that they are fit for the future - digitise processes, contribute to clinical research, evidence based-practice, life sciences and support our Trust's sustainability ambitions.

Our goals over the next 5 years are to ensure that:	Objectives
• Our digital maturity index increases to HIMSS stage 7 or an equivalent measure. • Support the NHS vision that internet first should be the direction of travel offering improved flexibility, connectivity and a reduction in costs. • New systems are, where appropriate, cloud hosted, web based and browser agnostic in line with the vision presented in The Future of Healthcare. • Provide digital solutions that support different approaches to recruitment.	• Transform and consolidate GHC clinical systems, modernising our network, aligning devices and technology. • Develop and test technological advances as they emerge. • Investigate and develop transition of local systems to the cloud as part of local server infrastructure refresh plans by FY 24/25. • Investigate and embrace the use of artificial intelligence capable of supporting a shift from reactive and retrospective analytical approaches to a proactive use of data. • Investigate and review automation opportunities across the trust to remove repetitive manual tasks both for clinicians and corporate staff. • Work within our ICS to support the development of population health management systems.

Key areas of work over the next 12 months:

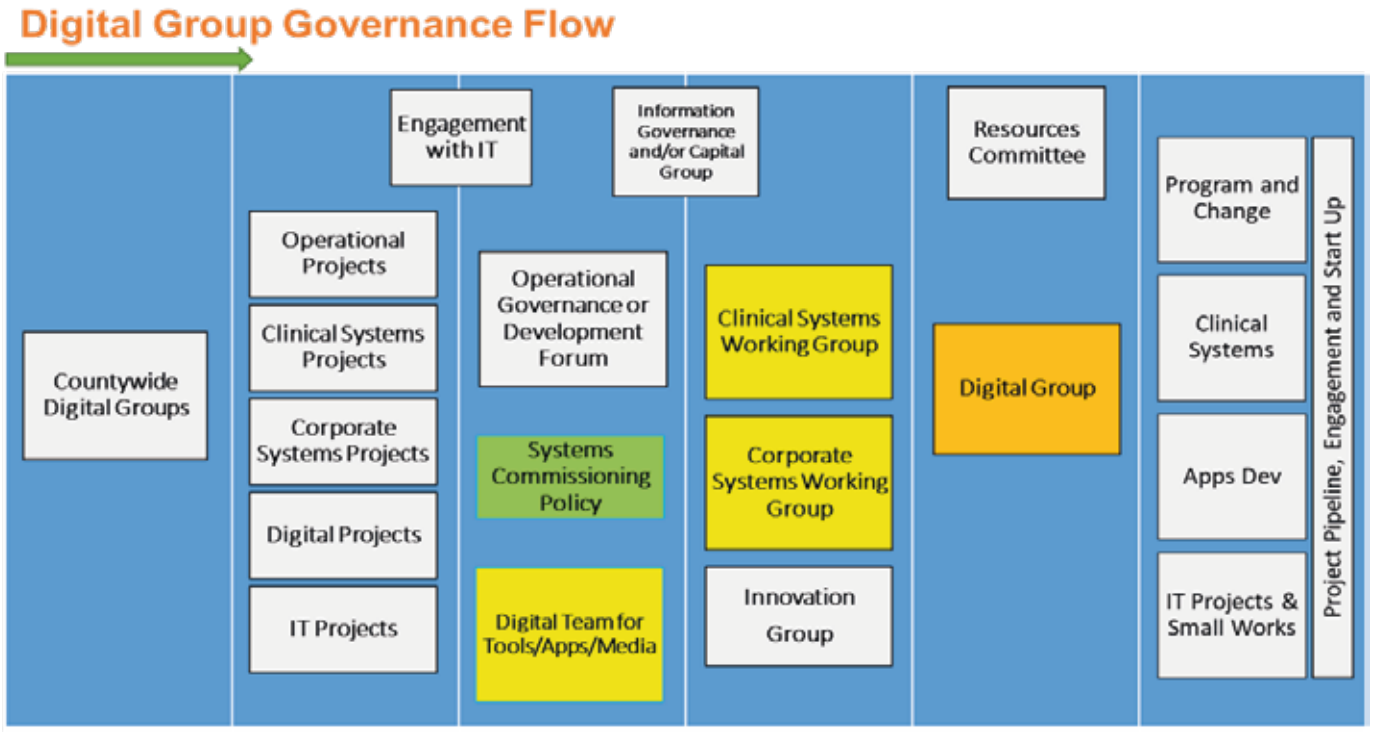
- Progress digital and technological innovation and improvement projects including: electronic prescribing and medicines management roll-out to all services; electronic paper free correspondence across all our services;
- Progress with the ICS implementation of a population health management solution
- Work with the ICS to finilise the information sharing roadmap for Gloucestershire for the next 5 years

Measures of Success

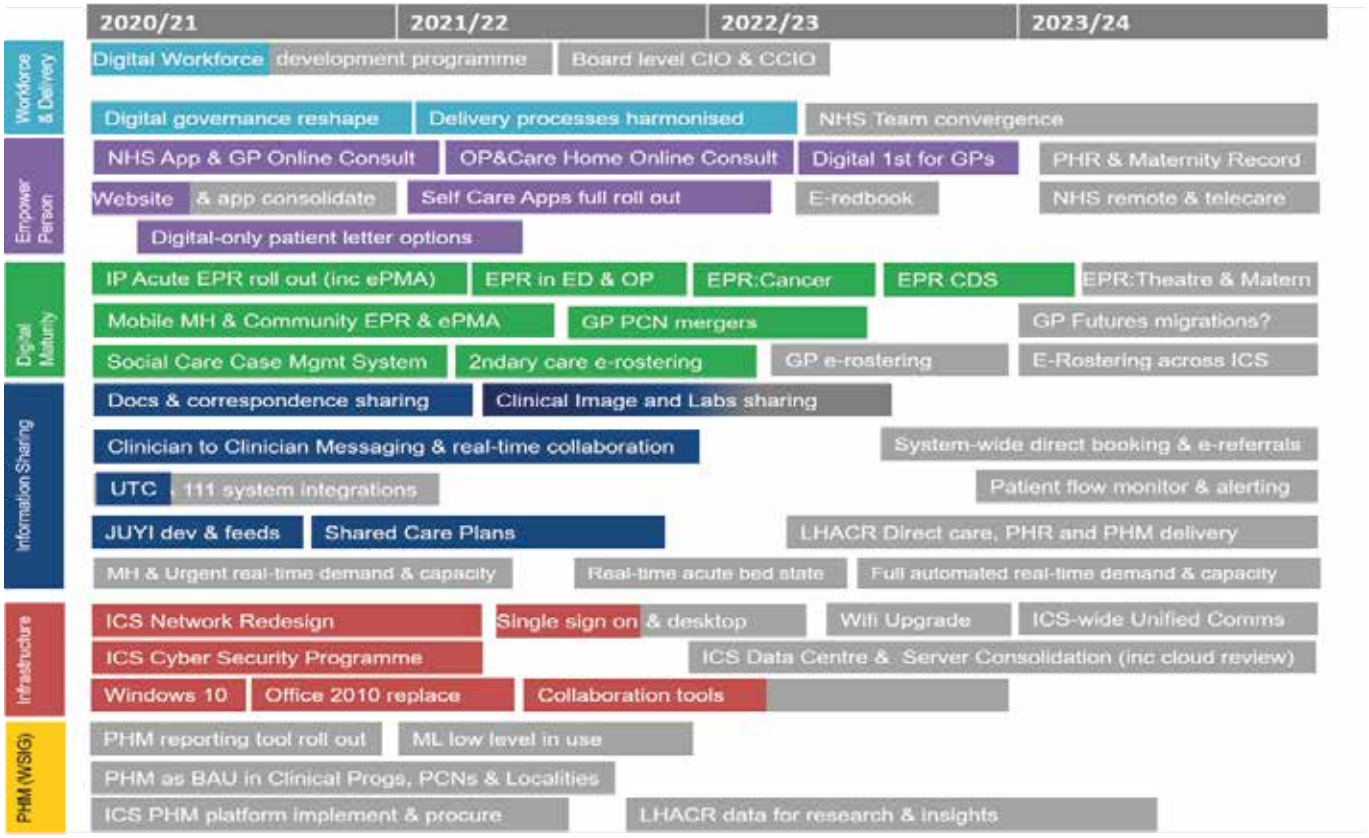
- Periodic reviews using difference mechanisms such as audit, internal assurance visits and peer reviews
- An improvement in the Trust's Digital Maturity Index position
- Case studies of impact of digital transformation

Delivery and Governance

Scrutiny and oversight of progress of our Digital Strategy and priorities will happen on various levels within the governance and assurance structures of both our Trust and ICS. In order to launch this strategy it was scrutenised by our Finance and Resource Committee before approval by our board of directors.



With such a large complex plan over the next 5 years there are a number of interdependencies and support required both with within GHC and within the wider ICS. This translates into a programme of work, such as the one below, that will be updated yearly based on requirements and developing priorities.



It will be operationally managed via the Digital Group who will receive an update every 6 months to ensure work is progressing as required, the governance flow of all digital projects is illustrated on the previous page.

Conclusion

By pursuing our vision, we will build solutions where we put the citizen at the centre of solutions we provide. We will act with the interest of the local health economy in everything we do and ensure collaboration is built into our digital solutions from the outset rather than added as an afterthought. Collaboration will not stop at technology as we will share our resources and learning to ensure that as a community we are not re-inventing solutions.

We will accelerate our digital transformation by assimilating existing best practice solutions into our organisation. As a Trust we will learn from implementations elsewhere in the NHS and beyond, recognising that others also have the skills and ability to create transformational solutions which we can assimilate into our operations.

Executing our strategy means quality, safety and patient experience will improve by using our digital solutions to create an environment in which the right information is available to staff at the right time. By listening and co-designing solutions with all stakeholders, we will provide innovative, intuitive and vastly improved ways for people to interact with the NHS.

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AGENDA ITEM: 14/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

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

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

Executive summary

This report for Q3 & Q4 2020-21 gives an update from the last report Trust Board report, an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

25 cases were raised in Q3 and 30 in Q4, with a total of 120 cases for 2020-21, an increase of 74% on 2019-20.

In 2020-21 nurses accounted for the biggest portion (32%) of speaking up cases raised through the Freedom to Speak Up route.

That a positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and

Great Place to Work. It is a core component in our health and wellbeing offer to colleagues and in our "Strong Voice" commitment to colleagues within our new People Strategy.

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?
JNCF 26 May 2021

Appendices:	N/A

Report authorised by: Sonia Pearcey & John Trevains	**Title:** 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.

1.3 Celebrate our progress in continuing to raise the bar in embedding our speaking up culture within 2020-21 and beyond.

2. ASSESSMENT OF FTSU CASES

2.1 Speaking up for Q3 & Q4 are detailed in Table 1, which also gives an overall picture of the year. Speaking up for these periods have been received via different routes and all anonymous cases were via the Work in Confidence system. Some colleagues may also have raised more than one concern.

Table 1

Quarter 2020-21	Number of cases raised	Number of cases raised anonymously
Q1: April - June	42	15
Q2: July - September	23	6
Q3: October - December	25	4
Q4: January - March	30	4

The combined Trusts (legacy 2gether and Gloucestershire Care Services) data for the number of colleagues speaking up in 2019/20 was 69 cases. In 2020/21, 120 cases of speaking up shows a marked increase of 74%.

Data reconciliation for the year 2020-21 by the National Guardian Office has been delayed due to the pandemic and will close 12 May 2021. A verbal update maybe available at the time of the Trust Board Session to include highlights regarding national and regional variations, professional groups and themes.

2.2 Themes

The Tables 2,3 & 4 below are further mandated data that is submitted to the National Guardian Office. Further updated Guidance for Freedom to Speak Up Guardians Recording Cases and Reporting Data came into effect for

cases raised from 1 April 2021 (Q1 2021-22) and in summary the following changes have been made:

- 'Worker safety' has been added as a category (in addition to the existing 'patient safety/quality' and 'bullying and harassment' categories).
- The term 'detriment' has been replaced with 'disadvantageous and/or demeaning treatment', though the term detriment is still used in brackets to avoid any confusion.
- The definitions for various categories have been updated for added clarity.
- A section has been added on how the data submitted by FTSU Guardians to the NGO is used for sharing and learning.

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	7	10	5	8	10	2
Q2	6	7	5	1	3	1
Q3	5	6	8	3	3	0
Q4	4	10	6	8	2	0

Some examples of speaking up in Q3 & Q4 are:

- Initially raised through Work in Confidence, concerns were raised by a colleague 'to report bad practice from staff towards a patient'. The colleague had already raised with the team regarding their inappropriate behaviour, in their negative language towards a patient. Support was requested from the Head of Nursing by the Freedom to Speak Up Guardian. Following conversations with the team, a risk assessment was put in place, discharge planning is underway and feedback is that the intervention has made a positive difference to the patient. Feedback will be shared with the team.

- A colleague spoke up about concerns regarding the unprofessional conduct of a team member and how this may impact staff and patient safety. Support was given to structure the conversation with their manager, which was positive and the colleague was 'happy with the outcome of this meeting and felt listened to'. They were thanked at the time by their manager.

- Colleagues spoke up to the Freedom to Speak Up Guardian regarding allegations of bullying and harassment within two separate teams. At the time of reporting two investigations have been commissioned in accordance with the Trust's Disciplinary Policy. Ongoing support is continuing for all of

these colleagues by the Freedom to Speak Up Guardian and other health and wellbeing resources.

Table 3

Quarter	Worker	Manager	Senior Leader	Not disclosed	Protected characteristic shared
Q1	17	10	0	15	Disability-1 BAME-1
Q2	12	5	0	6	BAME-2
Q3	12	9	0	4	LGBTQ+-1 BAME-1 Disability-1
Q4	17	9	0	4	BAME-4 Disability-1 Pregnancy-1

Table 4

Professional Group	Q1	Q2	Q3	Q4
Allied Health Professionals	5	2	8	6
Medical and Dental	2	0	0	0
Ambulance (operational)	0	0	0	0
Public Health	0	0	0	1
Commissioning	0	0	0	
Registered Nurses and Midwives	12	9	7	10
Nursing Assistants or Healthcare Assistants	0	3	1	0
Social Care	0	1	1	1
Administration, Clerical & Maintenance/Ancillary	4	1	0	2
Corporate Services	4	1	2	5
Other	0	0	4	4
Not known	15	6	2	1

Table 4 shows that over 2020-21 nurses accounted for the biggest portion (32%) of speaking up cases raised through the Freedom to Speak Up route, followed by Allied Health Professionals (17.5%) and corporate colleagues (10%). Not known colleagues (20%) were through the anonymous Work in Confidence route. This figure remains higher than the national figure of 13% (2019-20 published data).

Engagement has been increased with our medical and dental workforce, with the Freedom to Speak Up Guardian presenting at team meetings, presence at

junior doctor inductions, junior doctor forums and most recently the senior medical committee. Within the Freedom to Speak Up Advocate team there is no medical or dental representation, although with increased presence as described above, and increased support from the Medical Director, Guardian of Safe Working and Medical Education Manager there is confidence that this will increase in 2021-22.

When the 'Not known' is considered, this can include an instance when an individual has not disclosed their professional group or when a colleague wishes to remain anonymous.

Work in Confidence

Work in Confidence, an anonymous, secure and independent platform remains another route for colleagues to speak up. Various colleagues are available to offer support through this platform and with oversight by the Freedom to Speak Up Guardian. The Trust's Information Governance Manager/Data Protection Officer is supporting current work to potentially use the case management system to record all interactions through the speaking up route. Table 5 below shows speaking up through this route:

Table 5

Quarter	Number of contacts	Category
Q1	15	Bullying & Harassment-2 Ideas for learning and improvement-2 Other -9
Q2	6	Patient safety concerns-3 Ideas for learning and improvement-1 Other-2
Q3	4	Bullying & Harassment-1 Cultural-1 Inappropriate behaviours-1 Other-1
Q4	5	Patient safety concerns-1(face to face contact made with consent regarding this case) Bullying & Harassment-2 Other-1 Cultural (unprofessional behaviours)-1

3. PATIENT SAFETY AND/OR WORKER EXPERIENCE FEEDBACK

Feedback is requested from all colleagues and the challenge is obtaining feedback from colleagues whether they have had a positive experience or not. This has been recognised also across other Guardian networks. Some feedback is shared from colleagues as below from Q3 & Q4:

- I was very happy with your approach and the way you responded and also your colleague. Your colleague then spoke with senior management of the

unit and then suggested if I could speak with them as well, however I didn't feel as this would help. The reason why I used this service was to stay anonymous and I didn't want the unit to know that it was me who raised the concern to protect my future working relationship with them. So, given my experience I would speak up again as my action did partly improve the situation for my patient. Thank you for all your support.

- No further support I need thank you - you've been wonderful!

- I would definitely use the Freedom to Speak Up service again. I found the service was very easily accessed at my workplace and at home. I received a reply very promptly and the advice I received was appropriate, easily actioned and helped resolve my immediate concerns. However, I am not so confident I would raise a concern in my workplace again as it has had a huge negative impact on my mental health. Although I felt I was listened too on the whole for a long time I received no feedback or witnessed no evidence that any action was being taken to protect myself, my colleagues or patients. This has had a negative effect on my trust in the senior management in my workplace. It really would depend on the seriousness of any future situation.

- Thank you for your reply. It's reassuring to hear that the badges were part of a wider strategy and it's good to hear there has been an investment in staff wellbeing. I did appreciate the thank you day we were given. I realise this would have been at great financial cost to the trust but the gesture did mean something. I think it's generally probably difficult to try and please everyone, so the group are doing a good job.

- I feel that I am being treated as a number and want to be in the future part of the decision making regarding my safety. Thank you for your time to off load and you helped me to put things into perspective and move forwards.

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. With in he reviews led by Sir Robert Francis QC, he highlighted that minority staff feel vulnerable when speaking up, as they may feel excluded from larger groups of workers. Data set out in these reviews also showed that minority staff groups are more likely to suffer detriment for having spoken up.

Detriment, described as disadvantageous and/or demeaning treatment as a result of speaking up is recorded. The below data in table 6 highlights the number of cases where an individual felt that they have suffered detriment as a result of speaking up.

Table 6

Quarter	Number of cases where people indicate that they are suffering detriment	Given your experience would you speak up again

Q1	3	Yes-24 No Maybe-2 Don't Know-1
Q2	1	Yes-10 No Maybe-1 Don't Know
Q3	2	Yes-11 No Maybe-1 Don't Know
Q4	6	Yes-13 No Maybe-3 Don't Know

11% of colleagues who spoke up declared a protected characteristic, disability 2.5%, pregnancy <1%, LGBTQ+ <1% and BAME 7%. Those colleagues that have indicated that they are suffering detriment who shared a protected characteristic, is 25%. Colleagues are further supported through dedicated health and wellbeing resources, reciprocal mentoring, and also sign posted onto to our Equality, Diversity and Inclusion networks.

The noted increase in Q4, colleagues felt that they had suffered detriment through speaking up due to changes in working practices, and bullying and harassment experienced by a more senior colleague.

4. LEARNING AND IMPROVEMENT

In March 2021, The National Guardian's Office published its Annual Report for 2020 and laid it before parliament, highlighting the progress which has been made in Freedom to Speak Up in health and the impact of the pandemic on speaking up.

The same month, the Freedom to Speak Up Guardian survey report was published. The fourth annual survey report found that Guardians believe the speak up culture in the NHS is improving. With in the South West some specific regional highlights are as below and as a regional network we are engaging in some proactive work to further improve these findings:

- In the South West 81% gather feedback on their performance as a Freedom to Speak Up Guardian
- 46% of respondents have no ring-fenced time to carry out their role – this is the highest of all regions
- 89% of respondents said they were part of a Freedom to Speak Up Network and in the South West 68% of respondents believed representation of diverse groups was improving in their network, the highest region in the country

- 92% of respondents had direct access to their CEO and 89% to their Non-Executive direct who has speaking up as part of their portfolio
- 84% felt valued by senior leaders but only 62% felt valued by middle managers, with over 90% of respondents felt valued by workers in their organisations
- Only 44% of Freedom to Speak Up Guardians felt people did not suffer detriment for speaking up and only 38% of respondents felt action taken in response to reports of detriment was improving
- 74% of respondents in the South West felt their organisation was actively tackling barriers to speaking up
- Less than 70% of workers had Freedom to Speak Up training available to them, with only 23% of workers had sufficient time to undertake training, according to survey respondents. The survey was sent out before the launch of the new eLearning modules
- 75% felt their organisation had a positive culture of speaking up, one of the highest performing regions and 83% of respondents believe the FTSU Guardian role is making a difference.

Further local and Trust learning is being incorporated into future plans with feedback and self-reflection with colleagues and teams. Some further learning below:

- Work continues to further develop and strengthen the Gloucestershire ICS Guardian network and to gain a greater understanding from a national perspective regarding a future ICS model.
- Review of exit interview process with the retention team, with the Freedom to Speak Up Guardian being invited to newly commenced retention clinics
- Lessons learnt from redeployment to include information when able to return to 'home' team and being listened to when concerns raised regarding scope of practice in a new/redeployed role
- Signposting colleagues to health and wellbeing resources and where appropriate raise to senior managers
- Management facilitated meetings/mediation to support and address inappropriate behaviours. Referral to OD team to offer wider team coaching and support
- Discussion and coaching to raise the issue with line manager or appropriate person
- Enhanced communications to enable colleagues to access health and wellbeing support in relation to speaking up
- Compassionate leadership and kindness role modelled to ensure a compassionate culture
- Colleagues with the knowledge and skills not feeling they are influencing the direction of travel, team debriefs, listening events and visibility of leaders increased
- Refreshed risk assessment and Infection control guidance to support a patient within our services to be able to live more independently
- 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. Four stories are currently being developed with colleagues' consent.

4.1 Freedom to Speak Up Index (FTSU Index)

The National Guardian's Office will shortly be publishing the latest FTSU Index, which uses four questions in the NHS Annual Staff Survey, to understand the impact of Freedom to Speak Up. This year the questions are numbered 16a, 16b, 17a and 17b. This is a metric for NHS Trusts asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident

The FTSU Index, first published in 2019, is a key metric for organisations to monitor their speaking up culture. The index has risen nationally from 75.5% in 2015 to 78.1% in 2019. Comparable to other sectors, a score of 70% is perceived as a healthy culture. It is also recognised that organisations with higher Freedom to Speak Up scores are associated with higher performing organisations as rated by the Care Quality Commission (NGO 2020).

Within the FTSU Index report 2019, GCS was in the top 10 for most improved out of 220 Trusts nationally, while 2gether, like GCS faired favourably in the top third of the overall table. The 2020 report GCS was 11th overall which is a testament in itself at the time of a merger, with the South West as the most improved region.

FTSU Index report	GCS	2gether	GHC	National Average
2019	82%	80%		78.1%
2020	84.1%	80.6%		78.7%
2021(unpublished)			82.5%	78.7%

Reflecting on the data from 2020 an anticipated index score for 2021 (unpublished) of 82.5%. This score remains higher than our comparators (80.2% 2020) and illustrates a strong performance going forward as a newly merged Trust.

Question 18f, I feel safe to speak up about anything that concerns me in this organisation, is a new question in the NHS Staff Survey (GHC 68.3% and the national all NHS organisation average of 65.6% with 68.7% for MH, LD and community trusts). Freedom to Speak Up is about more than the ability to raise concerns about patient safety. It is about being able to speak up about anything which gets in the way of doing a great job, whether that's an idea for improvement, ways of working, or behaviours (H Hughes 2021). The responses to this question show a very strong positive correlation with the Freedom to Speak Up Index.

5. ACTIONS TAKEN TO IMPROVE THE SPEAKING UP CULTURE ALONGSIDE ASSOCIATED WORK OF THE FREEDOM TO SPEAK UP GUARDIAN

Progress 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:

- **Health and Wellbeing Hub** - The health and wellbeing hub, which has broad representation across the Trust, has been meeting regularly since the start of the pandemic to oversee, develop and plan appropriate support. The voice of colleagues is fundamental to this and learning from speaking up is feedback to the Health and Wellbeing hub to inform priorities.

- **Ethnicity Research** - As a Trust we were invited in April 2021 to participate in a survey being conducted on behalf of the National Guardian's Office to explore barriers to speaking up in a sample of NHS Trusts. This survey is being hosted by brap, an equalities charity transforming the way we think and do equality (www.brap.org.uk). Brap are working with Roger Kline OBE. (author of The Snowy White Peaks of the NHS). Initial data is not published as yet although there are many positive responses also with learning identified moving forwards.

- **National Strategy** - The National Guardian's Office shortly will publish their five-year strategy post the consultation which has ended. The strategy is based on the learning from the past four years following on from the introduction of the Freedom to Speak Up Guardian role. The strategy has four pillars: Workers, Freedom to Speak Up Guardians, Leaders and Managers and the Healthcare System as a whole. Once this is published in line with the NHS People Plan, this will link in with both our local Trust strategy and the new People Strategy and plans moving forwards.

- **Freedom to Speak Up Training** - The national Freedom to Speak Up e-learning modules are hosted on our Care to Learn platform and are free to access for all. These set out what speaking up is and its importance in creating an environment in which people are supported to deliver their best. The first module – Speak Up – is for everyone. The second module, Listen Up, for managers, builds upon the first and focuses on listening and understanding the barriers to speaking up. A final module, Follow Up, for senior leaders will be launched later in the year to support the development of Freedom to Speak Up as part of the strategic vision for organisations. Both these modules will be part of our new leadership development programmes.

- **Leadership Development Programmes –** With in these the Freedom to Speak Up Guardian will be supporting the delivery of the following workshops: 1. Creating a Compassionate Culture 2. Strategies for inclusion 3. Creating Psychological Safety.

- **Diversity Networks** - The Freedom to Speak Up Guardian is an integral member of the network and offers guidance, support and leadership to the co-chairs. Work continues alongside others to improve and support our

colleague's employee experience and more recently with the Equality, Diversity and Inclusion consultant.

- **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. Initial scoping with Dr Chris Turner has commenced.

- **Embedding Serious Incident Learning** - Leading on this reflective discussion approach to ensure compassionate leadership and just culture approaches are key. Utilising Kirkpatrick's (2016) evaluation model has informed our proposed approach to promoting embedding learning and evaluation that this has taken place. These discussions occur 2-3 weeks post the completion the investigation and report publication. The Trust has also commenced a pilot of just and learning culture e-learning that will further support speaking up.

- **Freedom to Speak Up Advocate Model** – Monthly drop in and update sessions continue for advocates to offer some time to further support speak up in their teams. The National Guardian's Office has published new Guidance for Freedom to Speak Up Guardians on the Development of Freedom to Speak Up Champion and Ambassador Networks. The guidance sets out principles for the development and support of Freedom to Speak Up Champion/Ambassador networks. Engagement sessions have commenced with current advocates to refresh, raise awareness and promote the value of speaking up.

- **Engagement Sessions –** These continue at team meetings, presence at junior doctor inductions, junior doctor forums and most recently the senior medical committee. Our Regional Liaison Adviser for General Medical Council is keen to explore supportive sessions for doctors in line with the Civility Saves Lives programme of work. Other sessions have included time with the new international nurses, preceptorship cohort and student nurses from the University of Gloucestershire.

- **Reciprocal Mentoring** – Being part of this programme enhances knowledge and understanding of lived experience and is used to shift awareness and action. The ethos aligns with objectives around equality, diversity and inclusion and the speaking up agenda.

- **Team and Individual Coaching** – Alongside the Organisational development team to support teams to speak up and have a psychologically safe space. Individual coaching is on request for senior leaders in the organisation.

- **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.

- **Work in Confidence** – As primary administrator, keep abreast of the system changes and conversations that occur through this system, so colleagues get timely and supportive responses. 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.

- **Operational On Call** – Supporting the safety of colleagues and increases the visibility of the Freedom to speak Up Guardian role.

- **Co-Chair Regional Network** – The Freedom to Speak Up Guardian continues to Co-Chair the South West Freedom to Speak Up Guardian Regional Network, offering leadership peer support and advice. This network is excellent for support and sharing good practice.

- **Freedom to Speak Up Conference** – In April 2021 the Freedom to Speak Up Guardian presented to colleagues at Avon & Wiltshire Mental Health Partnership NHS Trust as the keynote speaker – 'Driving a thriving speaking up culture through a merger'.

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AGENDA ITEM: 15/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD –April 2021 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 GHC Board members 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

Board members are asked to:

- **Receive, note** and **discuss** the April 2021 Quality Dashboard

Executive summary

This report provides an overview of the Trust's quality activities for April 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forum for assurance.

Quality issues for priority development

- Continued focus on complaints recovery plan including a redesign of complaint pathway management and delivery of a new internal quality indicator for 21/22 regarding time to completion of complaints.
- Continued NTQ led focus on the prevention, identification and management of Pressure Ulcers building upon the lessons learnt from recent quality improvement work. This now includes targeted support and education into Community Hospitals.
- Appraisal rates have a slow recovery rate and additional work is being undertaken. Ongoing focus on recovery of mandatory training rates with particular attention on resuscitation and restrictive practices. Additional scrutiny of the effectiveness of

the planned activity recovery work will be required via Quality governance structures.

- Significant pressures on mental health beds for both children and adults is noted and requiring additional support and management to address. The Director of Nursing, Therapies and Qualities (NTQ) has commenced additional work with Commissioners on this matter.
- Ongoing workforce vacancy pressures are noted with particular attention required for in-patient mental health areas. The Director of Human Resources & Organisational Development is leading work on the matter. The NTQ team are leading work on international recruitment solutions.

Quality issues showing positive improvement

- CPA recovery work has enabled further progress against the target with a 1.7% increase in month with the overall validated performance figure being 94.1% (0.9% from target).
- Greater understanding and identification of services requiring support with PU management as detailed within the dashboard. Early indicators are positive that this is an improving area
- There is ongoing improvement in staff Covid-19 vaccination rates with good progress made on closing the gap for BAME colleagues (67%)
- 149 compliments received regarding care provided by the Trust in April –above monthly average
- International Recruitment: 25 new physical health nursing colleagues are in the process of joining the Trust. 3 new mental health nursing colleagues are joining with additional recruitment underway in this area. The Trust has received additional funding to be part of a national project to develop direct entry into community services for international recruits.

Are Our Services Caring?

The Board are asked to note that 11 complaints were received in April which is an increase of 1 when compared to the previous month. Actions associated with the complaint's recovery plan continue with the number of complaints open for 7-12 + months reducing again this month. April saw 2 WTE quality assurance posts successfully recruited to. Whilst FFT levels of satisfaction have slightly dropped by 2% below the 95% target at the 20/21 outturn it should be noted that this is still an improvement upon the 2019/20 outturn. The Q4 2020/21 NED Audit of Complaints has been completed and notwithstanding the improvements in response times required, assurance is available that demonstrates the Trust is investigating complaints appropriately.

Are Our Services Safe?

Good assurance can be provided that shows incident reporting rates are consistent with established averages and we continue to see the percentage of patient safety incidents meeting moderate, severe and death thresholds drop below 8%. Greater detail is provided in this month's dashboard regarding ongoing developments to improve pressure ulcer management. There were no new cases of Covid-19 detected across Trust inpatient units in GHC in April. As of 20/05/21, 86% of patient facing GHC staff have received their first

vaccination for C-19 and 73% have received their second. The figure for BAME colleagues vaccinated has risen in to 67%.

Are Our Services Effective?

Board are asked to note the continued and ongoing critical role that the Trust is playing in system-wide patient flow, in particular this month the Community Hospital sub-acute offer has been strengthened. Accepting a higher acuity of patients has resulted in improved bed capacity with system partners. The number of occupied bed days for inappropriate out of area Mental Health placements in April was 82 days which relates to 6 patients. There has been a significant surge in demand for inpatient beds in month and the levels of acuity and dependency has resulted in a shortage of bed availability.

Are Our Services Responsive?

Good assurance is available regarding adherence to national PHE admission guidance in order to minimise the risk of nosocomial transmission, whilst supporting an increased demand for Community Hospital beds. Following agreement at the Health Overview and Scrutiny Committee Tewkesbury MIIU reopened on the 1st April 2021. CPA compliance increased on the previous month's figure by 1.7%

Are our Services Well Led?

Overall statutory and mandatory training compliance has improved this month to 87.9%. Due to C-19 disruption, Resuscitation and Restrictive Physical Intervention training continues to be an area of focus. There is monthly exception reporting in place for recovering training compliance. Appraisal compliance is now 71.2% against a target of 90%. There is continued emphasis on appraisal completion over the coming months, including the re-introduction of appraisal training. Sickness absence levels remain above the Trust target of 4.00% when a rolling average is applied. However, it is planned to use an additional indicator in future to highlight the monthly snapshot figures which will enable specific triggers and trends to be identified and explored. Staff health and wellbeing remains a priority, Working Well have seen an 83% increase in staff requesting counselling (136 in 19/20 up to 249 in 20/21).

Risks associated with meeting the Trust's values

Specific initiatives or targets that are not being achieved are highlighted in the Dashboard. Key quality and safety risks are included 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?
Quality Assurance Group and monthly reports to Quality Committee

Appendices:	Quality Dashboard Report

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

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AGENDA ITEM: 15.1/0521

Quality Dashboard 2020/21

Physical Health, Mental Health and Learning Disability Services

Data covering April 2021

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

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. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

Are our services CARING?

Eleven complaints were received in April which is 1 more than the previous month though comparable to year on year data. The number of complaints open for 7-12 + months continues to reduce in line with the recovery plan and temporary reallocation of resources. . 8 of the 11 complaints received in April 2021 were acknowledged within the 3-day target timeframe. Of the 3 that breached, all received an immediate automated acknowledgement of receipt and were followed up with an individual acknowledgment The Q4 2020/21 NED Audit of Complaints has been completed and concluded that overall there is good assurance on quality of complaint resolution and compassionate response letters in line with Trust values, but that delays in finalising the closure of complaints, in part due to C-19 related disruption, remains a NTQ priority to recover. Additional permanent recruitment to the team has taken place and process improvement work is ongoing. This month FFT levels of satisfaction reduced below the 95% threshold falling 2% points on 20/21 outturn but are still improved when compared against 2019/20 outturn

Are our services SAFE?

Incident reporting rates are consistent with established averages and we continue to see the percentage of patient safety incidents meeting moderate, severe and death thresholds drop below 8%. There are currently 9 active SIRIs. Greater detail is provided is provided this month regarding ongoing developments to improve pressure ulcer management and there are indicators of improvement in this area. We are pleased to report that zero C-19 deaths were reported by GHC inpatient services during March. There were no new cases of C-19 detected in GHC in April . Stocks of PPE remain good and the Trust is fully assured on future supply of all stock items via national supply routes**.** An executive led ICS review has been established to ensure GHC reports and responds to hospital onset probable and definite C-19 infections) and C-19 hospital deaths in line with statutory requirements and regional NHSE/I guidance. Further updates will be provided to the Quality Committee. As of 20/05/21, 86% of patient facing GHC staff have received their first vaccination for C-19 and 73% have received their second. The figure for BAME colleagues vaccinated has risen in to 67%. Systems are in place to vaccinate all eligible inpatients and vulnerable service users.

Are our services EFFECTIVE?

GHC has a critical role in system-wide patient flow and have taken proactive measures to increase their sub-acute offer enabling our Community Hospitals to accept a higher acuity of patients resulting in improved bed capacity with system partners. The Demand and Capacity team has been strengthened to ensure that 'Home First' is considered the first option for patients moving across the system. GHC are active participants of the One Gloucestershire 90 day improvement plan focussing on; refining the processes between the Trust and Adult Social Care, admission avoidance and strengthening reablement offers to support early discharge. Early Intervention and IAPT services continue to perform above threshold. The National Childhood Measurement Programme has recommenced and progress is being made towards achieving targets of 95% of children measured by the end of the academic year - Cumulative target (July 2021). The occupied bed days for inappropriate out of area Mental Health placements in April was 82 days which relates to 6 patients. There has been a significant surge in demand for inpatient beds in month with increased levels of acuity and dependency observed amongst service users which has has resulted in a shortage of bed availability, this is reflected regionally and nationally. Dashboard development work by the NTQ directorate is creating new outcome measure data reporting for inclusion in future dashboards in partnership with clinical services.

Are our services RESPONSIVE?

Good assurance remans in place demonstrating adherence to national PHE admission guidance in order to minimise the risk of nosocomial transmission, whilst supporting an increased demand for Community Hospital beds. Following agreement at the Health Overview and Scrutiny Committee Tewkesbury MIIU reopened on the 1st April 2021 and it is planned that the Vale MIIU will re-open on mid August 2021 with Dilke remaining closed . CPA compliance increased marginally on the previous month's figure by 1.7%. In line with system partners and an easing of national lockdown requirements our inpatient units have enabled increased visiting, recognising the importance of human contact to patients whilst maintaining appropriate measures to keep everyone safe.

Are our services WELL LED?

Overall statutory and mandatory training compliance has improved this month to 87.9%. Due to C-19 disruption, Resuscitation and Restrictive Physical Intervention training continues to be an area of focus. There is monthly exception reporting in place for recovering training compliance. Resuscitation training is improving there is a recovery plan in place to achieve compliance in the next 3 months. Appraisal compliance is now 71.2% against a target of 90%. There is continued emphasis on appraisal completion over the coming months, including the re-introduction of appraisal training. Sickness absence levels remain above the Trust target of 4.00% when a rolling average is applied. However it is planned to use an additional indicator in future to highlight the monthly snapshot figures which will enable specific triggers and trends to be identified and explored. Staff health and wellbeing remains a priority and outside rest areas are being explored to enable staff to take their breaks in the fresh air, based on feedback from our clinical teams. Working Well have seen an 83% increase in staff requesting counselling (136 in 19/20 up to 249 in 20/21). Registered Nurse international recruitment continues and up to 25 new registered nurses will join our Community Hospitals in by June subject to travel restrictions. Pastoral support for our international nurses a bespoke adaptation program, RMN specialist International recruitment is being led by NTQ. NTQ was awarded additional funding to be part of limited national project to develop direct entry to district nursing for international recruits.

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	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A	Exception Report?	Benchmarking Report
No of C-19 Inpatient Deaths reported to CPNS		N-R		66	0												0			N/A
Total number of deaths reported as C-19 related.		L-R		161	0												0			N/A
No of Patients tested at least once		N-R		2004	281												281			N/A
No of Patients tested C-19 positive or were admitted already positive		N-R		322	0												0			N/A
No of Patients discharged from hospital post C-19		N-R		271	9												9			N/A
Community onset (positive specimen <2 days after admission to the Trust)		N-R		30	0												0			N/A
Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)		N-R		6	0												0			N/A
Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)		N-R		10	0												0			N/A
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust		N-R		27	0												0			N/A
No of staff and household contacts tested		N-R		3123	65												65			N/A
No of staff/household contacts with confirmed C-19		L-R		323	0												0			N/A
No of staff self-isolating: new episodes in month		L-R			34															N/A
No of staff returning to work during month		L-R			29															N/A
No staff GHC who received Covid-19 vaccine first dose				4046	17												17			

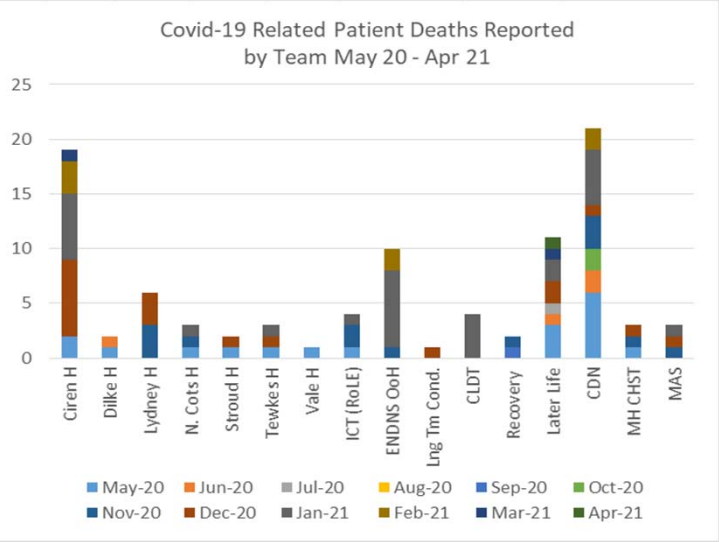
Additional Information

Patient Reporting

The number of Covid-19 (C-19) related inpatient deaths has continued to fall in Apr 21, with zero inpatient death meeting criteria for national reporting to CPNS. The number of community patient deaths reported as C-19 related has also fallen, both corresponding to the downward curve of the second peak of the pandemic. C-19 related patient deaths since May 20 by team/hospital site are shown in the chart opposite, previous year data being included for comparison. A review has been established to ensure GHC reports and responds to hospital onset probable and definite Covid-19 infections (HOPHA/HODHA) and Covid-19 hospital deaths in line with statutory requirements and regional NHSE/I guidance. One Gloucestershire NHS partners have agreed to declare a countywide serious incident for HOPHA and HODHA Covid-19. Trust's will undertake their own organisation specific investigations and produce individual investigation reports, with learning to be brought together in a countywide action plan. Duty of candour will be applied where appropriate. GHCNHSFT will review nosocomial cases from 1st July 2020 (when updated PHE guidance recommended routine in-patient swabbing following admission).

Patient Testing

A large reduction in the number of positive patient results was again seen in April, which is in line with the national dataset. As agreed with ICS Bronze IPC cell, and in line with PHE guidance GHC undertakes inpatient testing on days 1,3,5,7 and 10 and every subsequent 5th day of a patient's admission. This exceeds the national recommendation but is a local enhancement to improve system-wide surveillance. A second IPC-led audit to monitor swabbing compliance has provided good assurance across the Trust that this practice is embedded.



COVID-19 - KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

GHC inpatients and priority groups

- Rolling weekly programme in place to provide first and second doses for eligible new admissions to Community Hospitals, learning disability and mental health units.
- Robust Standard Operating Procedure developed to enable administration of AZ different second dose if not able to provide Pfizer.
- Work continues in partnership with IHOT, GPs and GHC roving team to provide bespoke reasonable adjustments to those with complex needs
- Scoping work underway to identify additional support requirements for SMI cohort to ensure effective uptake.
- Continue to work with ICS vaccine equity group to explore uptake in key groups including the development of a bespoke clinic in a low stimulus environment for those with additional support needs.

GHC staff

- 83 % "frontline" workforce received first vaccine; 66% BAME colleagues received first vaccine. 30/04/2021 – Percentage reduction from previous month due to growth workforce baseline number attributable to data quality re temporary staffing colleagues
- Vaccine uptake data is monitored weekly and submitted to NHSE/I every 14 days
- Workstream in place led by Working Well to enhance uptake that includes staff conversations to compassionately address vaccine hesitancy
- Proactive and targeted communication in place
- **As of 20/05/21, 86% of patient facing GHC staff have received their first vaccination for C-19 and 73% have received their second. The figure for BAME colleagues vaccinated has risen in to 67%.**

Validated Data as of 30-4-2021

ROLE	TOTAL NUMBER April 2021	1ST VACCINE (up to 30/04/21)	%	2nd VACCINE (up to 30/04/21)	%
All doctors/dentists	128	110	86	90	70.3
All qualified nurses, including students	1467	1213	83	988	67.3
All other professional qualified staff	776	658	85	560	72.2
Support to clinical staff	1710	1395	82	1071	62.6
TOTAL GHC CLINICAL STAFF	**4081**	3372	83	2709	66.4
NHS infrastructure staff	526	345	66	308	58.6
TOTAL GHC WORKFORCE	4607	3717	81	3017	65.5

Supporting the Primary Care Network public programme in GHC

- Housebound and care home vaccination continues in collaboration with PCNs; first and second doses.
- GHC Roving team well established, with a bank of 36 vaccinators
- IHOT team supporting learning disability shared care environments.
- GHC bank vaccinators available to support PCN clinic staffing at short notice to prevent cancellations

CQC DOMAIN - KEEPING PEOPLE SAFE – SPOTLIGHT ON DUTY OF CANDOUR

Since November 2019, a Duty of Candour (DoC) clinical compliance and quality assurance review has been undertaken on a quarterly basis. Commissioned by the Director of Nursing, Therapies and Quality the he purpose of this is twofold. Firstly, it provides assurance to the Trust that it is compliant with Regulation 20: DoC (Care Quality Commission, CQC, 2015 & 2021) in all cases where DoC applies. Secondly, it reviews all clinical incidents of reported and confirmed "moderate harm" and above to ensure that there are no omissions in the application of DoC.

The table below highlights the number of incidents that have been scrutinised for Quarters 1 and 2 of 2020/2021. The compliance and assurance review for Quarter 4 is currently underway. This has now been broken down into three categories, namely: Serious Incidents Requiring Investigation (SIRIs), incidents that required further investigation in the form of a Root Cause Analysis (RCA) Clinical Investigation, and incidents that were either reported and/or confirmed as causing "moderate harm" where the Trust had been deemed to be the responsible organisation. The review for this period provided significant assurance that the Trust had correctly identified incidents where DoC applied

Quarter 2020/21	SIRIs	RCAs	Moderate Harm	Total Number of Incidents
Quarter 1	12	10	13	35
Quarter 2	13	19	8	40
Quarter 3	9	14	7	30
Quarter 4				
Total no of Incidents	34	43	28	105

The findings from the outset of this piece of work have been shared through formal reports presented to the Regulatory Compliance Group and the Improving Care Group. As a result of the reviews, it is evident that the profile of DoC needs to be raised throughout the Trust. Therefore, the following measures have been taken:

1. Working in collaboration with the Patient Safety Team to ensure that the Datix incident reporting form captures all elements of the DoC regulatory requirements.
2. Review and update of the Trust's "Being Open – Duty of Candour" Policy to reflect national guidance and evidence based practice.
3. Informative and engaging DoC teaching sessions delivered to colleagues undertaking the preceptorship programme and the care certificate.
4. Circulation of the "Saying sorry" leaflet published by NHS Resolution (2017) to support and empower operational colleagues to adopt an open and transparent approach with patients and their families in accordance with the CQCs Regulation 20: DoC guidance.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

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

No		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
	Number of Friends and Family Test Responses Received	N - T		11990	1786												1786			
	% of respondents indicating a positive experience of our services	N - R	95%	94%	92%												92%			
	Number of Compliments	L - R		1478	149												149			
	Number of Concerns	L - R		390	41												41			
	Concerns escalated to a formal complaint			14	1												1			
	Number of Complaints	N - R		83	11												11			
	Number of open complaints (not all opened within month)				76															
	Percentage of complaints acknowledged within 3 working days		100%	96%	73%												73%			
	Number agreeing investigation issues with complainant				15															
	Number of complaints awaiting investigation				4															
	Number of complaints under investigation				10															
	Number of Final Response Letters being drafted				44															
	Number of Final Response Letters awaiting Exec sign-off				3															
	Number of complaints closed				7															
	Number of re-opened complaints (not all opened within month)				5															
	Current external reviews				4															

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

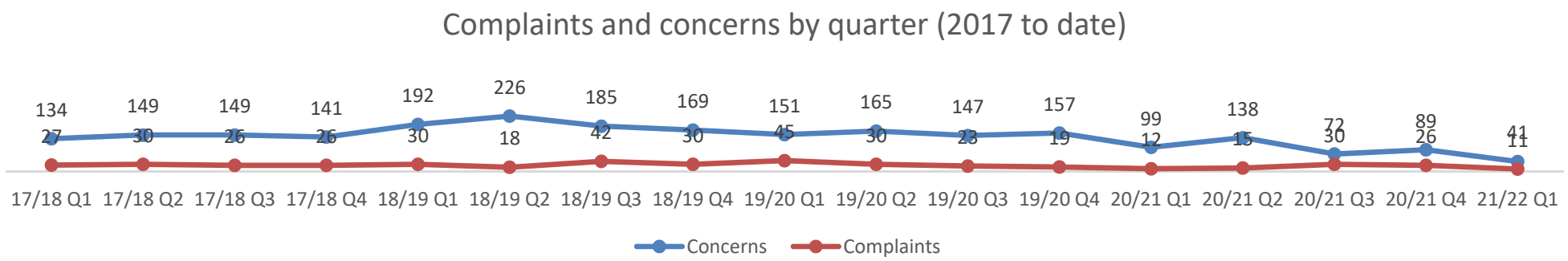
RAG Key: R – Red, A – Amber, G - Green

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

Complaints, concerns and compliments

- The average number of complaints received in April over the past four years is **10**. In April, 2021 we received **11 complaints**.
- In April 2021, **7** complaints were closed: **1** was withdrawn, **3** were partly upheld, and **3** were not upheld
- **41** concerns were raised in April 2021, which is higher than the monthly average of 32 concerns during 2020/21.
- **149** compliments were received in April 2021, which is more than the monthly average of 123 during 2020/21.

The chart below summarises the number of complaints and concerns received by quarter since 2017/18. This offers assurance that services are not receiving a significant increase in complaints in 2021/22. The impact of Covid-19 (national pause, redeployment, services in recovery), PCET staffing challenges, and a cluster of complaints received in November and December 2020, have all contributed to the current increase in complaint response times.



Assurance regarding complaint management

- Each complaint is triaged to check for any immediate actions required. Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- Trend analysis of the recent increase in complaints shows indicative themes* associated with Mental Health Act application and care, treatment and communication at Wotton Lawn. Integrated Care Teams received complaints regarding tissue viability, End of Life care and communication. Recovery Teams received complaints about care and treatment, discharges, referrals and communication.
- The number of complaints open for 7-12 months is reducing in number due to recovery work that is in progress.
- The Non-Executive Director Audit of complaints for quarter 4 2020/21 is complete and detailed in the following slides .

**As these are the themes from open complaints, investigations have not been completed and so it has not been identified whether these issues will be upheld/not upheld.*

Satisfaction with complaints/concern processes

- **5** active re-opened complaints
- **26** concerns were closed in April 2021, of which **1** was escalated to a complaint

External review

- There are currently **4** complaints with the PHSO for external review; these are complaints from 2016, 2017, 2019, and 2020.

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

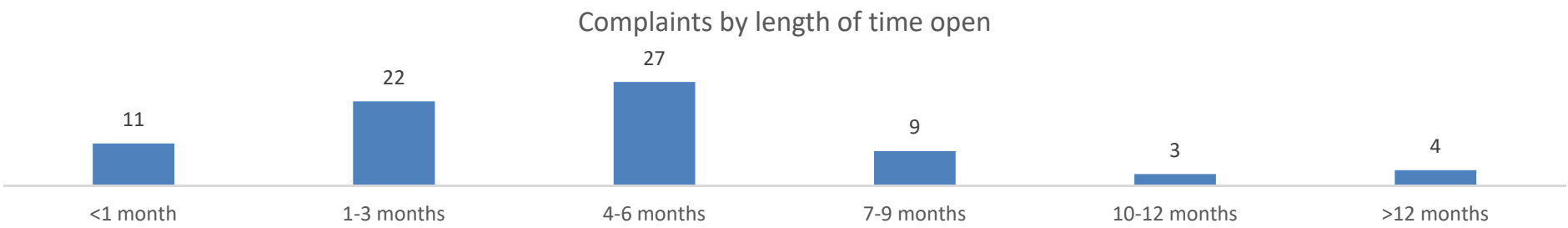
Complaints management timescales

- **8** of the **11** complaints received in April 2021 were acknowledged within the 3-day target timeframe. Of the 3 that breached, all received an immediate automated acknowledgement of receipt and were then followed up with an individual acknowledgment (2 within four days, 1 within 5 days).

- Of the **76** open complaints, **11** do not have agreed response times. Of these:
  - **3** have been delayed due to Covid-19; complaints were received either during or very close to the national pause period. As a result, completion dates were not set and complainants were advised that their concerns would be progressed as soon as possible. These cases are being revisited to agree completion dates and resolve
  - **4** are in the early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set.
  - **4** are complaints being managed by other NHS organisations, for which we are providing input/comments

- Of the **65** complaints with agreed response dates:
  - **22** are within the agreed timeframe
  - **43** have exceeded the initially agreed timeframes, and of these:
    - **2** responses were due during the national pause
    - **41** responses were due following the end of the pause – there are a range of reasons for these delays including:
      - Agreeing issues for investigation with complainants
      - Delays in the investigation process (e.g. allocating investigators, timeliness of investigation report, and availability of staff for interviews)
      - Delays in the drafting and review of final responses (e.g. capacity, quality of investigation, availability of staff to review draft responses)
    - Work is ongoing to address delays in the complaints process in order to minimise them where possible
    - All complainants who have been waiting extended periods of time are offered personalised review meetings to discuss their complaint on completion of the process. This has shown good results in helping to resolve issues to the persons satisfaction

The chart below shows the timeframes for all open complaints. The PCET are focusing on completing investigations for those open for the longest period. A weekly meeting provides high-level oversight of the complaints tracker. Fortnightly updates to the Director of NTQ are in place and regular briefings to the Board and Quality Committee provide assurance regarding focus on recovery.



Additional resources have been allocated to increase capacity of the team and 2 experienced new colleagues have been recruited to the team. Following completion of a detailed quality improvement informed analysis NTQ will be changing the Trusts complaints process and policy to enable it to be more reflexive to need. This will include the introduction of early resolution meetings ahead of final responses and streaming of specific complaints to subject matter experts earlier in the process i.e. End of Life or District Nursing. It is estimated that it will take up to 6 months to recover the performance position to the desired standard. To support pace and monitoring of recovery a complaints responsiveness performance indicator has been established as a Trust Quality Priority of the 2021/22 quality schedule.

ADDENDUM TO QUALITY DASHBOARD

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q4 2020/21

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 auditor
- The Patient and Carer Experience Team completes section 1 of the audit tool and provide 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 2020/21audit indicates overall there is good assurance on quality of complaint resolution and compassionate response letters in line with Trust values, but that delays in finalising the closure of complaints, in part due to C-19 related disruption, remains a NTQ priority to recover
- For one complaint, additional learning was identified in via the audit and this feedback will be shared with the team
- Delays in responses have been noted and work continues to address the backlog of complaints. Waiting times are monitored via the monthly Quality Dashboard.

FUTURE AUDITS

- The Trust Secretary's office will continue to allocate the audits to NED colleagues
- An ongoing programme for NED audit of complaints has been established
- Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS

- To note the contents of the report
- To continue to recover the complaints backlog at pace
- To note the assurances provided regarding the Trust's management of complaints

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q4 2020/21					
	Time scale of response	**Quality of investigation**	**Accessibility, style and tone of letter**	**Learning actions identified**	**Comments**
Complaint 1 • Delayed transport from GHT and contracted Covid • Key broke in lock when Integrated Care Team members were leaving the property	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate	**FULL ASSURANCE** • Learning identified and shared	• Response co-ordinated by GHC, involving GCC
Complaint 2 • Family did not feel involved in decisions regarding medication and care recommendations	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate	**FULL ASSURANCE** • Learning identified and shared	
Complaint 3 • Screening assessment completed but referral not sent to the Autism Spectrum Conditions assessment service	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues identified but not addressed. Need to ensure patient voice/concern is heard	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic	**LIMITED ASSURANCE** • Additional learning identified (variability in screening results; the system (including GP) responding to patient concerns)	• 1st and 3rd screening assessment met referral threshold, 2nd did not. • Referral acknowledgement process introduced prior to complaint being received

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

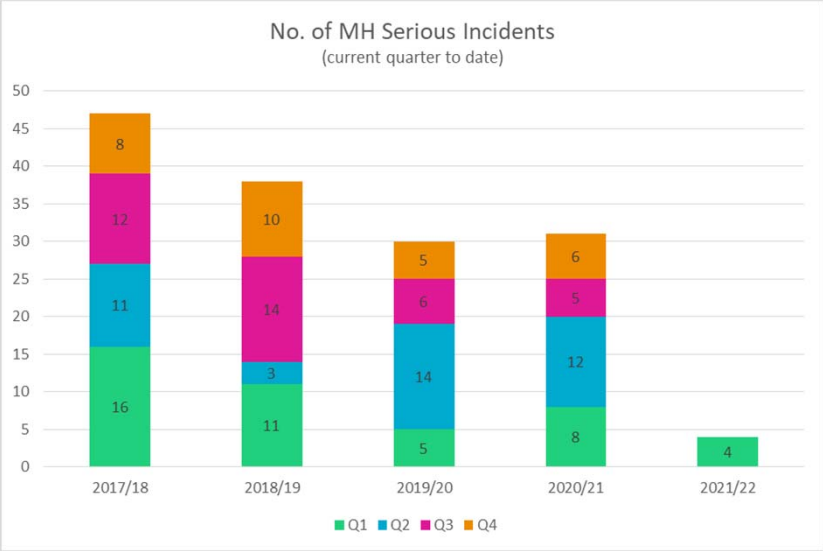
		Reporting Level	Threshold	20-21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021-22 YTD	R / A / G	Exception Report?	Benchmarking Report
	Number of Never Events	N - T	0	0	0												0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	4												4			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		1	1												1			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		3	0												0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		2	0												0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		15	3												3			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		10	0												0			N/A
	Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		0	0												0			N/A
	Total number of Patient Safety Incidents reported	L - R		12474	986												986			N/A
	% incidents resulting in low or no harm	L - R		93.41%	92.90%												92.90%			N/A
	% incidents resulting in moderate harm, severe harm or death	L - R		6.59%	7.10%												7.10%			N/A
	% falls incidents resulting in moderate, severe harm or death	L - R		2.75%	1.10%												1.10%			N/A
	% medication errors resulting in moderate, severe harm or death	L - R		0.83%	1.79%												0.00%			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	0	0	0	0	0			N/A

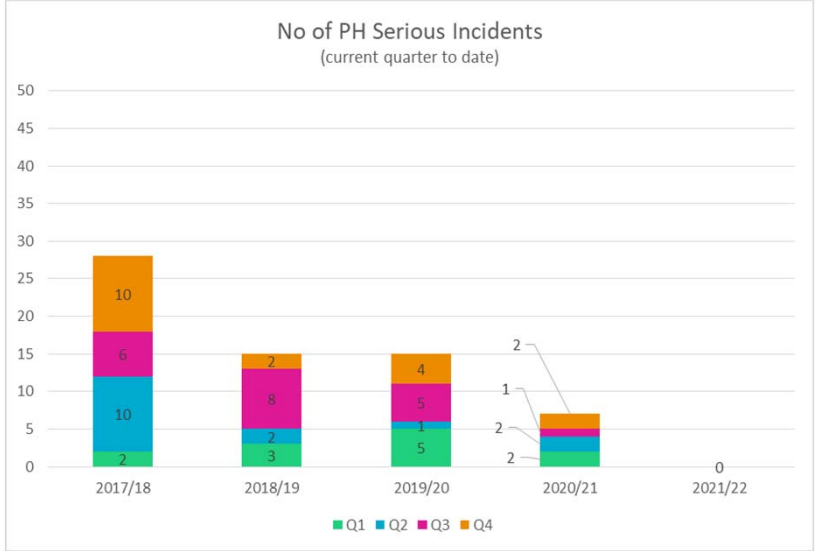
N - T	National measure/standard with target	L - I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L - R	Locally reported (no target/threshold) agreed
L - C	Locally contracted measure (target/threshold agreed with GCCG)	N - R/L - C	Measure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

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

CQC DOMAIN - ARE SERVICES SAFE? – additional information

Four SIRIs were declared in April 2021, one suspected suicide within the Cirencester Recovery Team (mental health services), one medication incident at Wotton Lawn (mental health), and one physical health incident relating to missed/delayed diagnosis at MIiU following a fall at home. All incidents were escalated in line with SIRI reporting requirements. The Patient Safety Team continue to monitor 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 Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues.





Two SIRI final reports, a working age mental health unexpected inpatient death and an older persons inpatient incident involving anticoagulation were completed and submitted to Gloucestershire CCG in April 2021. Incident/s on a Page (IoaP) are drafted and will be disseminated for discussion throughout the Trust to promote learning. All IoaP documents are uploaded to the Trust intranet.

There remain 9 active SIRIs to the end of April 2021.

Regarding all patient safety incidents:

- The total number of patient safety incidents reported decreased from March 2021 (1230) to April 2021 (986), however remained higher than April 2020 (688).
- The percentage of patient safety incidents resulting in moderate or severe harm and death increased from March 2021 (6.34%) to April 2021 (7.10%), however the number of such incidents fell from March 2021 (79) to April 2021 (70).
- The percentage of falls resulting in moderate and above levels of harm increased from March 2021 (0.98%) to April 2021 (1.10%).
- The percentage of medication incidents resulting in moderate and above levels of harm increased from March 2021 (0%) to April 2021 (1.79%). This was a result of one medication incident in April 2021, which has been declared a SIRI and provisionally recorded as moderate harm, pending completion of the investigation.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97%	97.3%												97.3%	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	797	84												84	R		
	Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	698	75												75	R		
	Number of Category 3 Acquired pressure ulcers	L - R	0	70	8												8	R		
	Number of Category 4 Acquired pressure ulcers	L - R	0	29	1												1	R		

ADDITIONAL INFORMATION - PRESSURE ULCERS (PU)

Objectively this months data and activity is showing an improving picture in terms of progress made to address this important area of Trust quality. This is reflected in improvement in Cat 4 pressure ulcers but also the active work with teams in terms of improving practice to meet significant rising demand in pressure area care requests from primary care

The April data shows a **decrease** in the most severe category 4 pressure ulcers from last month. The data is suggestive of an i**ncrease** in the overall number of PU that have worsened under our care although additional scrutiny and data cleansing is yet to be applied to these findings as it is expected that this is a data quality issue. This work commences at the beginning of May and will include working with the Datix team to restructure the reporting template as colleagues have commented that the current template can be confusing and leads to miscoding of PU.

Following the success of the Gloucester QI PU plan the Forest & TNS QI PU approach is currently in the 'do' stage of the PDSA cycle. The Clinical Pathways Lead (CPL) and Quality Manager have met with the Community Managers from Gloucester and Forest & TNS, to review and complete the stakeholder map and ensure full engagement from operational colleagues. Data from these areas from the past year is being used as a baseline for improvement.

Further to the success of the 'Datix dashboard oversight' described for the improvement plans in Gloucester and Forest & TNS, the CPL has recommended that those Datix dashboards and reports specific to inpatient services should be considered for governance and assurance across all our inpatient services, using a QI approach. Operational teams are currently considering this with a decision to be reached following presentation of the QI project described above.

The CPL has continued to host educational webinars highlighting PU categorisation and encouraging an interactive approach from participants and active feedback. Recent attendance at a national conference has expanded networks and evidenced the national increase in incidence and severity of PU's and outlined national work to support reporting , management & education.

The 20 minute open invite for a focussed District Nurse discussion on safe and effective pressure area assessment, monitoring and management will be repeated in June following requests from colleagues. The focus is will continue to be sharing the national and local themes observed in relation to PU incidence and severity, encouraging debate and involvement in improvement.

Pressure ulcer QI virtual groups (PUQIG) commenced in May.The new Trust wide policy which has been reviewed and ratified by the policy group and covers all services.

The CPL has now been repatriated full time following redeployment into District Nursing during the Covid-19 response and has been able to review and present the PU data that facilitates future targeted intervention.

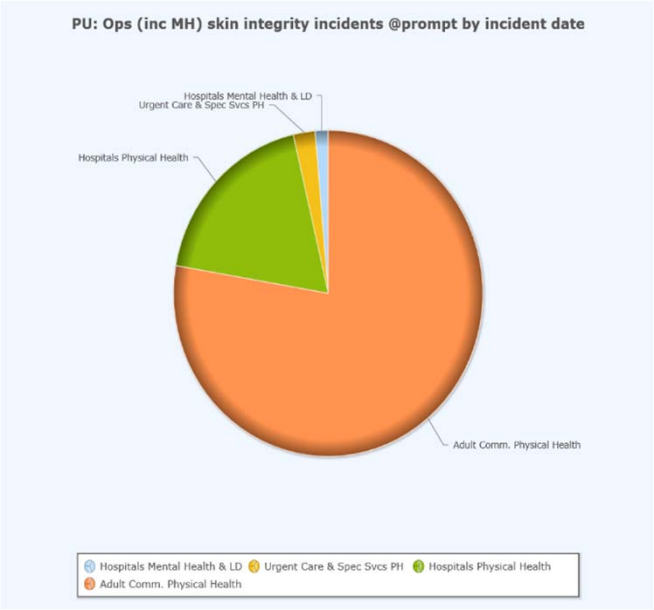
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure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

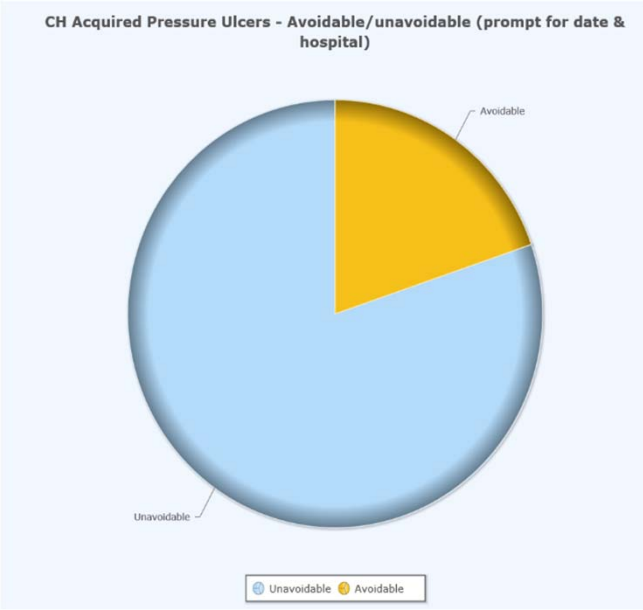
RAG Key: R – Red, A – Amber, G - Green

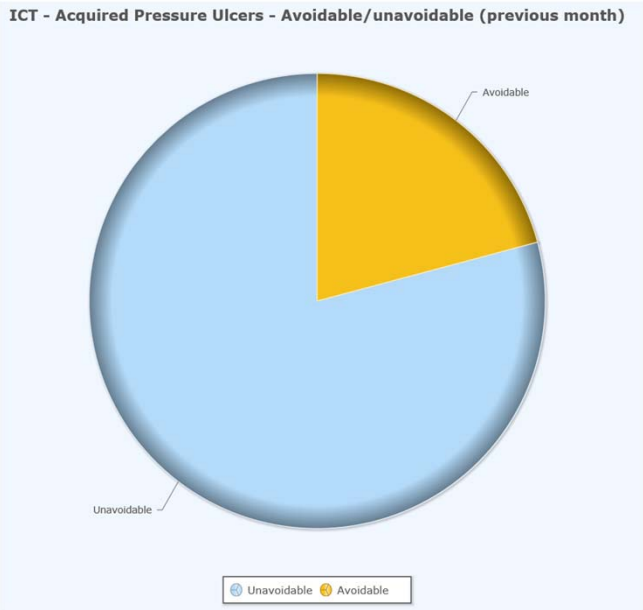
Quality Dashboard

Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus
Pressure Ulcers – April 2021 Additional Information







Pie chart showing skin integrity incident reports per service.

- Skin Integrity which includes (but is not exclusively) pressure ulcers reported by service in April 2021
- Adult community PH 171
- Community Hospitals PH 41
- Urgent Care & specialist services PH 5
- MH & LD Hospitals 3

Pie chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals

Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed*** as being unavoidable or avoidable because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)

- 61 were reported as being unavoidable.
- 15 were reported as being avoidable.

Pie chart showing data reported in ICT's

- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). ***Reviewed by handlers*** as being unavoidable or avoidable. These decisions may have been made because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.) Reasons for these decisions are included in the datix report.
- 38 were reported as unavoidable
- 10 were reported as avoidable

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

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

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Community Hospitals																				
Bed Occupancy - Community Hospitals		L - C	92%	tbc	93.2%												93.2%	R		90.4%
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%	86.4%	100%												100%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered **Re-audit being developed**																				
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%	52.9%	53.9%												53.9%	G		
Admissions to adult facility of patient under 16yrs		N - R		1	0												0	N/A		
Inappropriate out of area placements for adult mental health services		N - R	Occupied bed days	1742	30												30	G		
Children's Services – Immunisations				2020/21 Academic Year																
HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)		N - T	90%*	11.9%	44.4%												44.4%			
Childrens Services - National Childhood Measurement Programme				2020/21 Academic Year	Academic Year 2020/21 - Target 95% of children measured by end of academic year - Cumulative target (July 2021)					Academic Year 2021/22										
Percentage of children in Reception Year with height and weight recorded		N - T	95%*	21.9%	35.9%												35.9%	G		
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	0%	9.0%												9%	G		

Additional Information

Children's Services
National Childhood Measurement Programme reporting has recommenced in March, in line with schools reopening. Although the performance level is low, clinical activity is scaling up and the nationally supported agreement is to complete 10% NCMP for Reception and Year 6 by the end of the current academic year. The GHC School Nursing service has committed to providing system partners with data to support development of the local obesity strategy and we have scheduled to complete all reception year children and 10% of year 6, along with vison screen for all reception children within this timeframe. Analysing NCMP data provides us with an opportunity to further identify our most vulnerable children . This in turn acts as a catalyst that enables interventions to help reduce health inequalities which is a business priority for CYPS in 21/22. The service is currently planning its recovery following the pandemic and is working with commissioners in April/May to agree key indicators for 21/22.

Bed Occupancy
Occupancy levels within Community Hospitals are sustained at expected levels given the pressure within the One Gloucestershire system and are above threshold.

Length of stay (bed days)
The occupied bed days for inappropriate out of area Mental Health placements in April was 82 days which relates to 6 patients (1 x PICU beds and 6 x acute admission beds). There has been a significant surge in demand for inpatient beds in month and the levels of acuity and dependency has resulted in a shortage of bed availability, this picture is mirrored regionally and nationally.

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

Minor Injury and Illness Units

		Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R / A / G	Exception Report?	Benchmarking Report Feb Figure
	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	0:14	0.14												.14	G		
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	96.0%	96.6%												96.6%	G		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	89.8%	97.0%												97.0%	G		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	93%	96.1%												96.1%	G		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	94,8%	97.2%												97.2%	G		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	96.0%	99.2%												99.2%	G		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	97.8%%	95.7%												95.7%	G		
	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	28960	3101												3101	R		
Mental Health Services																				
	CPA Review within 12 Months	N - T	95%	91.8%	94.1%												94.1%	R		
	Admissions to hospital gate kept by CRHTT	N - T	95%	99.5%	95.2%												95.2%	G		

Additional information

MIIUs

- Dilke remains closed due to Covid-19 secure restrictions
- Vale remains closed and will open Mid August due to delays in PCN vax team moving to new base.
- Tewkesbury re-opened on 1st April 2021
- All open units operating 8am-8pm
- Telephone Triage is offered to anyone who calls their local unit so they can be directed to the right place at the earliest point; this includes the closed units as telephones are linked

ICTs

- ICT's begin the year exceeding the required targets with expectation to continue this trend .

Mental health

- CPA compliance increased compared to the previous month's figure of 92.4% and reflects the recovery work the community teams are engaged in. There are 63 CPAs outstanding, which shows an improvement on last months figure of 80 , the majority of these are held within the Recovery Teams. The locality teams are supporting teams to recover the compliance rates, however this is being approached incrementally to reflect the workforce and capacity challenges in the teams.

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Quality Dashboard

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Additional KPIs - Physical Health

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)		95%*	93.1%	35%												35%	G	Y	
Number of Antenatal visits carried out			530	47												47	R		
Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	94.1%	93.4%												93.4%	A	Y	
Percentage of children who received a 6-8 weeks review.		95%	95.9%	98.3%												98.3%	G		
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	72.6%	74.0%												74.0%	R	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	83. 7%	83.9%												83.9%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	72.5%	72.0%												72.0%	R	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	56.0%	61.3%												61.3%	A		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81. 3%	81.7%												81.7%	G		
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	970	No Data															
Number of positive Chlamydia screens		169	632																
Average Number of Community Hospital Beds Open		196	174,9	186.0												186.0	R		
Average Number of Community Hospital Beds Closed		0	1.1	10.0												10.0	R		

Additional Information

Health Visiting (HV): The team are working to improve the uptake of assessments across all age groups. Joint work with commissioners trialling new approaches to uptake have been agreed and are now deployed. As restrictions reduce in line with the national roadmap the service will re-scope community buildings in order to offer more F2F (Face to Face) contacts. Where clinicians are concerned about families, safeguarding protocols are initiated.

New Birth Visiting (NBV) :In the month of April there were 14 babies in NICU against a usual monthly average of 4-5. Contact is made with NICU nurses and parents to arrange home visits once a baby is discharged. This has reduced performance to below the target due to measures out of our control . During the pandemic, there were some parents who requested to delay a F2F offer of a NBV to reduce footfall in their homes. The HVs have offered contacts virtually and/or by phone at the parent's preference. Parents are now more confident with allowing HVs in the home and this month there were 9 F2F NBVs in the home undertaken where as previously they had delayed this part of the contact.

Percentage of children who received a 9-12-month review by the time they turned 12 months. The parents of all children within this age group were offered the opportunity to receive a 9 -12mth and 2year review. These figures show an increase from last month. For all children classified as 'Universal ', virtual appointments via Attend Anywhere are being offered for developmental reviews. 37% of these exceptions declined this contact and 15% did not attend their appointment.

Percentage of children who received a 2-2.5-year review by 2.5 years 50% of parents have declined this contact and the DNA rate is 22% which is a reduction on last month's 30% DNA rate. All UP (Universal Plus) and UPP (Universal Partnership Plus) are seen F2F in the home setting for a full family health needs assessment. As lockdown eases and estate space allows, the service will be returning the 2-year ASQ (Ages & Stages Questionnaire) to face to face with an additional intervention called Early Language Identification Measure (ELIM) to use alongside ASQ. The virtual offer has not increased rates of acceptance of the developmental review as was anticipated. All universal 2-year olds will be offered a F2F in a setting from June. Lists of children that are due to have a developmental review will be shared with the Community Nursery Nurses and where a family can be identified as previously non-engaging a home visit will be offered. If a parent declines an ASQ, they will be offered a telephone /AA (Attend Anywhere) appointment with a CNN (Community Nursery Nurse) to discuss key public health messages which aims to support the parent in ensuring that their child has key skills for school or be able to be referred/signposted to other agencies to gain early support.

CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	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%	85.8%	87.5%												87.5%	A		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	70.4%	71.2%												71.2%	R		
Sickness absence average % rolling rate - 12 months	L - I	<4%	4.80%	4.3%												4.3%	A		
Sickness absence % monthly rate	L-T	<4%	TBC	3.55%												3.55%	G		

Additional information

Mandatory training, appraisal and absence

The initial pause on statutory/mandatory training was lifted in July 2020 but was reinstated with the second lockdown in November to support frontline service provision. Overall compliance is at 87.5%. Due to C-19 disruption, Resuscitation and Restrictive Physical Intervention training continues to be an area of focus. Resuscitation training is improving there is a recovery plan in place to achieve compliance in the next 3 months There is an exception reporting regime in place for recovering resuscitation and restrictive physical intervention training (PMVA and PBM) compliance, reporting monthly to QAG.

Appraisal

The Trust has set a target to achieve a 90% appraisal completion rate. Appraisal rates are beginning to increase and have risen to 71.2%. This in part is due to redeployment coming to an end and a return to business as usual. Line managers are regularly reminded of the importance of carrying out appraisals and in particular the important role they play in supporting colleagues to feel valued, maintain and improve performance. The indicator selected this year has been altered to pick out the appraisal data relating to Active Assignments only. The workforce information team continue to support managers in how to update appraisals on ESR.

Sickness Absence

Sickness absence levels remain above the Trust target of 4.00% when a rolling average is applied. However it is planned to use an additional indicator in future to highlight the monthly snapshot figures which will enable specific triggers and trends to be identified and explored.

Staff Health and Wellbeing

The health and wellbeing hub, which has broad representation and membership from across the Trust, has been meeting regularly since the start of the pandemic to oversee, develop and plan appropriate H&W support. The actions have included:

- Regular H&W newsletters, with the aim to further promote health and wellbeing choices. Examples are ‘You said, we did’, a feature on ‘Time for you’ and Sleep.
- Introduction of staff financial benefit scheme.
- Improved H&W intranet pages.
- Some charitable funds being allocated to support the improvement of outside spaces with benches and tables and outdoor shelter.
- Linking with conversations about what support would be helpful for colleagues experiencing long Covid-19.
- Increased counselling and psychological support.
- Involvement in a WHO film documenting the experience of health care staff through the pandemic and the impact on psychological wellbeing.
- Cascade of the national support available from NHSE.
- Links to and close working with Speaking Up.

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CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Mental Health Inpatient – April 2021

	Code 1		Code 2		Code 3		Code 4		Code 5	
Ward Name	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions
Dean	7.5	1	0	0	0	0	0	0	0	0
Abbey	120	16	0	0	0	0	0	0	0	0
Priory	260	32	0	0	0	0	0	0	0	0
Kingsholm	30	4	0	0	0	0	0	0	0	0
Montpellier	17.5	2	70	8	0	0	0	0	0	0
Greyfriars	0	0	362.5	46	0	0	0	0	0	0
Willow	0	0	22.5	3	0	0	0	0	0	0
Chestnut	15	2	0	0	0	0	0	0	0	0
Mulberry	15	2	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	52.5	6	30	4	0	0	0	0	0	0
Total In Hours/Exceptions	517.5	65	492.5	62	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
Dean Ward	179.22%
Abbey Ward	148.94%
Priory Ward	120.00%
Kingsholm Ward	104.67%
Montpellier	99.67%
PICU Greyfriars Ward	132.36%
Willow Ward	109.46%
Chestnut Ward	100.74%
Mulberry Ward	114.72%
Laurel House	100.56%
Honeybourne Unit	100.28%
Berkeley House	106.94%
Totals (March 2021)	118.13%
Previous Month Totals	116.14%

PHYSICAL HEALTH	
Ward	Average Fill Rate
Coln (Cirencester)	120.41%
Windrush (Cirencester)	111.74%
The Dilke	112.13%
Lydney	100.26%
North Cotswolds	122.69%
Cashes Green (Stroud)	107.31%
Jubilee (Stroud)	100.00%
Abbey View (Tewkesbury)	93.46%
Peak View (Vale)	146.33%
Totals (March 2021)	108.50%
Previous Month Totals	110.81%

Staffing data not available due to the Ledger Merger project and year end reporting .As a result, it is not possible this month to report in-post and vacancy data, or apportion Bank/agency use.

Mental Health and Learning Disability Inpatients

- An International Recruitment project is currently underway. 3 x RMNs have been appointed for Wotton Lawn however Covid-19 continues to cause disruption to planned start dates. RMN specialist International recruitment is being led by NTQ
- There are currently 8 x 12wk agency contracts in place in Wotton Lawn.
- An agency Guaranteed Volume Contract is in place in Wotton Lawn. Work continues to increase this contract by 100% at Wotton Lawn to meet current 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.

Physical Health

- The Trust continues to work to homogenise safe staffing reporting methods across the organisation.
- An International Recruitment project is underway and a more detailed slide will be provided in next months dashboard.
- Up to 25 new registered nurses will join our Community Hospitals in by June subject to travel restrictions

Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN – ARE SERVICES WELL-LED? Focus on - Integrated Care Team (ICT) Staffing (OT= Occupational Therapy; PT= Physiotherapy)

Nursing	Cheltenham				Cotswolds				Forest & TNS				Gloucester				Stroud				Total			
	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3
Total Est	10	29.83	8.18	10.46	9	22	6.32	6.73	10	30.23	6.93	8.45	10	38.55	8.32	10.69	9.5	28.8	6.6	7.08	48.50	149.41	36.35	43.41
Total in post	10.1	22.26	6.86	10.24	7.6	18.09	5.3	6.1	9.0	26.3	5.4	4.75	9.33	34.74	7.1	13.55	9.5	28.5	4	8.9	45.53	129.89	28.66	43.54
	1%	-25%	-16%	2%	-16%	-18%	-16%	-9%	-10%	-13%	-22%	-44%	-6.7%	-10%	-15%	27%	0%	-1%	-39%	26%	-6%	-13%	-21%	.3%
																			VACANCIES		2.97	19.52	7.69	-0.13	30.05

OT	Cheltenham				Cotswolds				Forest & TNS				Gloucester				Stroud				Total			
	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3
Total Establishment	5.70	6.20	1.00	3.43	3.40	4.40	1.70	2.60	3.70	3.70	1.80	2.80	5.50	5.10	2.40	3.40	4.20	4.20	2.10	3.10	22.50	23.60	9.00	15.33
Total In Post	7.18	3.00	1.00	2.80	3.20	3.93	0.82	1.80	4.07	2.60	1.00	3.52	5.70	3.40	0.00	3.50	4.20	3.68	1.00	4.05	24.35	16.61	3.82	15.67
Total Vacancies	26%	-52%	0%	-18%	-6%	-11%	-52%	-31%	10%	-30%	-44%	26%	4%	-33%	-100%	3%	0%	-12%	-52%	31%	8%	-30%	-58%	2%
																			VACANCIES		-1.85	6.99	5.18	-0.34	9.98

PT	Cheltenham				Cotswolds				Forest & TNS				Gloucester				Stroud				Total			
	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3	B6	B5	B4	B3
Total Establishment	3.50	3.00	0.00	2.70	4.03	2.80	0.00	4.21	3.50	2.00	1.69	0.60	5.00	2.80	0.00	3.92	3.60	2.18	0.00	2.12	19.63	12.78	1.69	13.55
Total In Post	3.60	0.00	0.00	2.70	4.33	2.00	0.00	4.21	3.82	2.00	1.69	0.60	4.20	2.00	0.80	2.00	4.00	1.00	0.00	2.31	19.95	7.00	2.49	11.82
Total Vacancies	3%	-100%	0%	0%	7%	-29%	0%	0%	9%	0%	0%	0%	-16%	-29%	80%	-49%	11%	-54%	0%	9%	2%	-45%	47%	-12%
																			VACANCIES		0.08	5.78	-0.80	2.73	7.79

Additional information

The NTQ team continue to progress development work to provide additional safe staffing type data for Trust services. Work is in progress to triangulate the impacts of staffing levels, increased demand, and changes in tasks requested with potential impacts on quality. There is no nationally mandated guidance for community safe staffing levels.

Nursing

There have been national and local historic challenges recruiting, particularly at Band 5 level but there has been good responses to recent recruitments and there has been an increase in successful Nurse recruitment from last month with additions to the Forest and Gloucester Teams now in post. The Trust supports development of Band 4 Nursing Associate roles and this has resulted in further successful recruitment. The Trust is continuing to develop a recruitment pathway into community roles as part of our International Recruitment project and has been successful in becoming one of 6 national pilots in partnership with NHSE/I and the Queens Nursing Institute. GHC remain committed to the development of the Specialist Practitioner Qualification (SPQ) for District Nursing. There are 5.0 wte nurses presently in training and the recruitment processes for the 2021/22 intake has commenced. The Professional Development Team continues to support new staff in developing competencies and confidence alongside wider professional support to maintain quality of care.

Therapy

There are challenges to Band 5 recruitment, with vacancies across the county. Recruitment for the new physiotherapy rotational posts has been successful and there will be new graduates joining in the Summer of 2021. Physiotherapy Trainee Assistant Practitioners are due to complete their apprenticeship in May 2021 and will then be eligible to apply for a Physiotherapy Assistant Practitioner Post - these are the first within GHC.

There is a future workforce pipeline with the local BSc undergraduate Physiotherapy programme and the pre-registration MSc programme being delivered by the University of Gloucestershire. There have been significant recent challenges in placing all undergraduate students across the ICS but it is important that these student placements continue to be supported by the ICTs to support future recruitment.

CQC DOMAIN – ARE SERVICES WELL LED? - Quarter 4 - Guardian of Safe Working Report 2020/21

PURPOSE

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed 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. 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. 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.

Reporting time period January 2021 – March 2021	**Guardian of Safe Working Hours: Dr Sally Morgan**
Number of doctors in training (all on 2016 contract)	In January 2021 there were 38 doctors in training posts and 37 in post in Feb- March 2021 • 12 higher trainees were in post in Jan – March 2021 • 6 CT3 were in post in Jan – March 2021. • 4 CT2 in post in Jan 2021 and 2 were in post in Feb and March 2021 • 2 CT1s were in post in January 2021 and 3 were in post in Feb and March 2021. • 5 GP trainees were in post in Jan – March 2021 • 5 FY2s were in post in Jan – March 2021 • 4 FY1s were in post in Feb and March 2021. • FY doctors rotated posts in December 2021
Exceptions in this period	• **22 on call shifts covered** by our own junior staff acting as locums due to sickness. • **0 exception reports in this time period:** • **There was a Junior Doctors forum held via Microsoft Teams on 10th March 2021.**

with you, for you

Gloucestershire Health and Care
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AGENDA ITEM: 16/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

PRESENTED BY: Dr Amjad Uppal – Medical Director

AUTHORS: Paul Ryder - Patient Safety Manager, Nicola Mills - Clinical Incident and Learning Manager, Ian Main - Associate Director of Patient Safety & Learning

SUBJECT: **QUARTER 4 2020/21 PATIENT SAFETY REPORT (INCLUDING SIRIS)**

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

This report is provided for:

Decision ☐ Endorsement ☐ Assurance ☑ Information ☑

The purpose of this report is to:

This report provides the Board with high level information with regard to patient safety incidents reported through the Trust's Datix Incident Reporting System. Analysis and comments are provided where appropriate.

Recommendations and decisions required

The Board is asked to:

1. **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 4 2020/21 (1st January to 31st March 2021).
- A summary of the prevalence of patient safety incidents by categories including level of investigation.

- Provision of data for Mental Health and Learning Disability Hospitals, Physical Health Community Hospitals, MIIUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the Patient Safety Team (PST) will examine in further detail a different category reporting a significant number of incidents. Q4 2020/21 will look at pressure damage in community ICTs and the developing "PUQs Project".
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q3 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental and physical health patient safety incidents.
-

Risks associated with meeting the Trust's values

Effective systems must be in place to manage all patient safety incidents and reduce risk.

Corporate considerations	
Quality Implications	Increased numbers of reported incidents is seen to indicate and open and transparent reporting culture.
Resource Implications	Quarterly reporting and analysis is resource and labour intensive.
Equality Implications	None.

Where has this issue been discussed before?

This presentation was discussed at the Quality Assurance Group on 23rd April 2021 and Trust Quality Committee on 11th May 2021.

Appendices:	PowerPoint presentation (slide deck) Q4 2020/21 PSR

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

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AGENDA ITEM: **16.1**/0521

Q4 Patient Safety Report 2020/21

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

Q4 PSR 2020/21

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This report provides the Group with:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 4 2020/21 (1 January to 31 March 2021).
- A summary of the prevalence of patient safety incidents by categories including levels of investigation where relevant.
- Provision of data for Mental Health and Learning Disability Hospitals, Physical Health Community Hospitals, MIIUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the Patient Safety Team (PST) will examine in further detail a different category reporting a significant number of incidents. Q4 2020/21 will look at pressure damage in community ICTs and the developing “PUQs Project”.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q4 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental health and physical health patient safety incidents.

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Summary of all Patient Safety Incidents reported in 2020/21

	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)	Yearly Total (%)
No Harm	1469 (57.5)	2148 (65.5)	2104 (62.7)	2072 (63.0)	7785 (62.4)
Low Harm	889 (34.8)	963(29.4)	1018 (30.3)	990 (30.1)	3858 (30.9)
Moderate Harm	164 (6.4)	130 (4.0)	198 (5.9)	188 (5.7)	680 (5.5)
Severe Harm	23 (0.9)	23 (0.7)	27 (0.8)	30 (0.9)	103 (0.8)
Death	12 (0.4)	15 (0.5)	8 (0.24)	8 (0.24)	43 (0.3)
Total	2557	3279	3355	3288	12479

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Number of No and Low Harm Incidents Reviewed - 2020/21

	Q1 (%)	Q2 (%)	Q3 (%)	Q4 (%)	Yearly Total (%)
No Harm	1469	2148	2104	2072	7793
Low Harm	889	963	1018	990	3860
Total	2358	3111	3122	3062	11653
Reviewed (%)	9.5	5.9	9.6	12.2	

The Patient Safety Team aim to review 10% of the No and Low Harm Patient Safety Incidents. This has not always been achieved, particularly in Q2 due to redeployment of some of the team due to Covid-19, the recovery plan of SIRIs and competing workstreams, such as completing SIRI investigations. Significant progress has been achieved during Q3 and Q4.

Q4 PSR 2020/21

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No harm and low harm incidents

Of the 2072 no harm incidents, and the 990 low harm incidents, the Patient Safety Team aimed to review a blind sample of 10% (306 incidents in Q4). This target was set during the reconfiguration of the Patient Safety Team following merger in October 2019 and due to the impact of Covid work the team have not previously met this target. In Q4 a total of 373 low and no harm incidents were reviewed (12.2%).

Results of sample reviewed

One no harm incident reviewed by the PST resulted in a comprehensive SIRI investigation given the Near Miss nature of the incident (Fragmin incident detailed on slide 20).

Q4 PSR 2020/21

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Never Events, Serious Incidents and other reportable incidents

	Q1	Q2	Q3	Q4	Yearly Total
Never Events	0	0	0	0	0
Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Serious Incidents	10	14	6	8	38

Q4 Sub 'Serious Incident' Incidents (moderate and above harm)

During Q4 the Patient Safety Team convened 19 Initial Investigation meetings (including incidents that have gone on to be declared as a SIRI which are featured on slides 20 and 21).

5 mental health incidents and 1 physical health incident met the criteria for a SIRI. One physical health incident (HODHA Covid) has been managed as a Clinical Incident needing additional comprehensive investigation and will conclude in line with CCQ timeframes.

Local learning from these incidents, including evidence of good practice, will be shared via Incidents on a Page following the internal reviews.

Detailed analysis of high frequency incidents

Service provision has seen further disruption due to another national lockdown as a result of the Covid-19 pandemic, however Q4 does demonstrate more established incident reporting trends.

The high frequency incidents within Mental Health inpatient continue to 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 (54.2%).

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High Level Analysis of Mental Health Inpatient Incidents - By Financial Quarter

Top 10 Categories Reported	Deliberate Self-Harm			Physical Intervention			Falls			AWOL			Violence & Aggression			Medication			Accidents			MERT			Clinical Care			Suicide Attempts		
	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4
Wotton Lawn Hospital	381	309	426	228	264	204	16	24	18	40	55	72	53	25	40	13	10	20	2	4	2	39	10	4	6	8	5	10	16	7
Berkeley House	271	280	251	164	127	83	7	6	1	0	0	0	0	0	0	2	2	2	7	13	6	1	2	1	1	0	3	0	0	0
Wotton Lawn - Greyfriars PICU	4	16	27	109	83	50	1	1	1	3	10	18	34	6	5	0	6	5	0	3	0	0	8	2	0	5	1	0	0	10
Charlton Lane Hospital (functional)	4	1	0	17	1	20	29	11	26	0	0	0	1	0	1	11	5	11	7	5	6	2	3	3	46	3	4	1	0	0
Charlton Lane Hospital (organic)	1	4	3	22	37	17	62	141	51	1	2	1	16	8	7	0	8	3	4	2	1	4	6	3	12	5	0	0	2	0
Laurel House & Honeybourne	0	0	0	0	0	0	0	2	1	2	3	4	3	0	3	4	2	2	1	1	0	0	0	1	1	0	0	0	0	1
Montpellier Low Secure Unit	1	0	0	0	0	0	0	0	1	4	0	1	0	0	1	0	1	1	2	1	0	1	0	1	0	0	0	0	0	0
Total	662	610	707	540	512	374	115	185	99	50	70	96	107	39	57	30	34	44	23	29	15	47	29	15	66	21	13	11	18	18

Incident reporting is of a similar order within the Top Ten categories reported, and differences are representative of the changing inpatient population. For example, during Q4, 9 of the 10 suicide attempts at Greyfriars PICU relate to the same patient. The uplift in falls at Charlton Lane Hospital in Q3 relates to a small cohort of patients who were particularly confused and wandering within Willow Ward.

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High Level Analysis of Physical Health Inpatient Incidents – by Financial Quarter

Top 10 Categories Reported	Falls			Skin Integrity			Admissions, Discharges & Transfers			Accidents			Clinical Care			Medication			Infection Control			MERT			Comms & Handover			Equipment & medical devices		
	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4
Cirencester Hospital	11	26	25	34	23	26	4	4	0	4	4	0	3	2	5	3	4	2	3	7	3	0	0	0	1	6	0	0	0	0
Dilke Hospital	34	31	31	13	9	9	3	2	0	4	5	2	2	2	0	5	2	4	3	2	1	2	2	1	0	1	0	0	0	0
Lydney Hospital	15	18	26	17	10	18	0	1	3	1	2	0	1	3	4	6	1	5	0	2	0	0	2	2	1	0	0	1	2	0
North Cots Hospital	11	19	17	4	10	13	0	1	1	0	1	0	0	2	0	0	1	1	0	1	0	1	0	0	1	0	4	1	1	0
Stroud Hospital	20	52	29	39	38	30	12	14	7	6	4	3	4	7	3	6	4	1	0	1	1	9	9	5	3	0	7	0	1	0
Tewkesbury Hospital	12	20	40	12	21	11	1	1	3	2	0	1	1	1	2	2	2	2	0	1	0	1	0	0	2	0	1	0	1	1
The Vale Hospital	27	29	22	11	14	13	1	6	1	3	9	5	2	5	7	5	5	6	0	2	0	0	0	1	1	0	0	0	1	1
Total	130	195	190	130	125	120	21	29	15	20	25	11	13	22	21	27	19	21	6	16	5	13	13	9	9	7	12	2	6	2

Incident reporting is of a similar order and differences are representative of the changing inpatient population.

The prevalence of falls at Stroud hospital in Q3 is notable and continues to be monitored.

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High Level Analysis of Community Mental Health Incidents – by Financial Quarter

Top 10 Categories Reported	Info Governance			Clinical Care			Deliberate Self-Harm			Medication			Appointments & follow up			Admission, discharge & transfer			Death/ SIRI			Communication			PMVA/ PBM			Suicide attempts		
	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4
AMHP	0	0	0	0	5	1	0	0	0	0	0	0	0	0	0	0	5	1	0	0	0	0	0	0	0	0	0	0	0	0
AOT	0	0	0	0	1	0	1	0	1	0	2	3	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
CYPS/CAMHS LD, T2, T3	1	1	2	0	5	2	1	0	4	0	0	0	0	5	2	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
CLDT	0	1	0	1	0	0	0	1	1	2	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
CPI	0	0	1	1	1	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
CRHTT	0	0	0	0	6	3	0	4	2	0	2	1	0	1	1	0	2	1	0	1	1	0	1	3	0	2	0	0	1	0
Eating Disorders	0	0	0	0	1	2	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	3	1	0	0	0	0	0	0
Later Life	0	0	0	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	0	0	0	0	1	0	0
MHICT	0	0	6	3	0	1	2	0	0	0	0	0	2	0	1	0	1	2	0	1	0	0	0	0	0	0	0	0	1	0
Memory Assessment	0	1	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	0	0
MH Liaison	0	0	1	0	2	1	0	4	1	0	0	1	0	2	1	0	2	0	0	1	1	0	5	0	0	0	0	0	2	2
Recovery	0	0	0	4	1	0	3	0	1	1	2	3	0	1	1	0	2	1	0	1	2	0	2	1	0	0	0	2	1	1
Specialist Services	0	1	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Total	1	4	11	10	22	11	8	10	10	3	7	9	2	9	6	0	13	6	0	5	5	0	13	6	0	3	0	3	5	3

Mental Health community teams clearly report far fewer patient safety incidents than their inpatient colleagues (n=64 for Q4). There is limited analysis available from this data.

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High Level Analysis of Community Physical Health Teams Incidents (not ICT/DN) – by Financial Quarter

Top 10 Categories Reported	Diagnosis, Imaging & Testing			Clinical Care			Skin Integrity			Communication			Info Governance			Medication			MERT			Equipment			Admissions, discharges & transfers			Appointments, follow up & referrals		
	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4
Complex Care at Home	0	0	0	1	1	2	0	6	13	0	1	0	0	0	2	1	3	2	0	0	0	0	1	1	0	0	2	0	0	0
Complex Leg (CLWS)	0	0	0	1	1	4	3	2	6	1	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	1	1	0	0	0
CYPS/PH Community Specialist	0	0	1	2	9	1	1	2	2	3	3	3	5	3	4	2	5	6	0	0	0	11	12	5	1	5	0	1	3	0
CYPS/PH Public Health Nursing	0	0	0	0	6	0	0	0	0	2	5	7	0	3	5	0	6	0	0	0	0	0	0	1	1	3	2	1	4	4
Dental & Sexual Health	16	13	5	7	9	8	0	0	0	2	5	7	9	10	3	8	8	5	0	0	1	5	1	2	0	0	0	2	0	1
Intravenous Therapy Team	0	1	0	1	3	0	0	0	0	0	0	0	1	0	0	0	0	2	0	0	0	1	0	0	0	0	1	0	0	0
Long Term Conditions	0	1	0	0	0	2	0	0	0	0	1	0	0	2	3	0	3	3	0	0	0	0	0	0	0	0	1	1	0	0
MIiUs	1	0	30	0	0	9	0	0	0	0	0	3	0	0	0	0	0	1	0	0	14	0	0	0	0	0	3	1	0	4
Rapid Response	0	0	0	1	1	5	3	6	4	0	0	0	0	1	0	2	1	1	0	0	0	2	0	0	0	1	0	0	1	2
Spec Therapy & Equip Services	0	0	0	0	2	1	0	0	1	0	0	0	0	1	3	0	0	0	0	0	0	0	3	1	0	0	0	0	0	1
Tissue Viability	0	0	0	1	1	3	0	3	1	0	0	0	1	0	0	0	0	0	0	0	0	5	1	2	0	4	2	0	0	0
Total	17	15	36	14	33	35	7	19	27	8	15	20	16	20	20	13	26	20	0	0	15	25	18	13	2	14	12	6	8	12

There is a notable upturn in reporting of Diagnosis, Imaging and Testing within MiiUs during Q4. All 30 incidents report no harm and describe a sub-category of Wrong Diagnosis, or Delayed Diagnosis. The Patient Safety Team is currently completing a deep dive report of Diagnostic Imaging at MiiUs to give us a better understanding of the issues.

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High Level Analysis of Community Physical Health Teams Incidents for ICT/DN – by Financial Quarter

Top 10 Categories Reported	Falls			Clinical Care			Skin Integrity			Communication			Info Governance			Medication			MERT			Equipment			Admissions, discharges & transfers			Appointments, follow up & referrals		
	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4	Q2	Q3	Q4
Out of Hours DN	0	1	0	0	9	5	0	7	7	0	1	2	0	0	2	0	5	10	0	0	0	0	0	0	0	0	1	0	0	5
Chelt Peripheral DN	0	0	0	0	2	2	0	13	19	0	2	0	0	0	2	0	2	1	0	0	0	0	1	1	0	0	2	0	1	0
Chelt St Paul's DN	0	4	0	0	3	2	0	38	24	0	2	1	0	0	0	0	5	7	0	0	0	0	2	1	0	2	3	0	2	0
Chelt Town Centre DN	0	2	0	0	4	9	0	29	46	0	3	3	0	0	0	0	4	4	0	0	0	0	1	1	0	3	0	0	1	1
Cotswold North DN	0	0	1	3	7	3	13	16	24	1	0	0	0	0	0	3	2	3	0	0	0	1	1	0	2	7	3	5	0	0
Cotswold South 1 DN	0	1	1	4	3	4	34	42	55	0	0	1	0	1	0	3	3	7	0	0	0	3	5	4	3	1	2	0	3	2
Cotswold South 2 DN	0	0	0	0	0	1	22	20	24	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Forest North DN	0	0	0	2	6	0	32	49	62	1	1	1	0	0	0	0	1	3	0	0	0	1	0	2	0	0	2	0	4	2
Forest South DN	0	1	0	2	3	3	33	30	27	3	0	0	1	0	0	1	2	4	0	0	0	0	4	1	1	2	2	5	2	1
Glos Asp & Stbridge DN	0	0	0	3	2	2	24	26	16	1	1	4	0	0	0	5	5	7	0	0	0	2	1	0	0	1	3	1	1	3
Glos HQR DN	0	0	0	1	3	1	32	36	25	1	0	2	0	0	0	3	8	7	0	0	0	1	0	0	0	2	2	0	2	0
Glos Inner City DN	0	0	0	1	3	3	13	22	25	0	1	1	0	0	0	0	2	2	0	0	0	1	2	1	2	5	3	1	1	0
Glos North South DN	0	0	0	5	7	1	39	34	44	1	3	0	0	1	0	1	6	4	0	0	0	2	1	5	2	0	2	1	1	1
Stroud BerkeleyVale DN	0	0	0	2	0	1	9	20	30	0	0	0	0	0	0	4	0	2	0	0	0	0	5	0	1	2	0	0	0	0
Stroud Cotswolds DN	0	0	1	0	2	2	21	27	18	1	1	1	1	0	0	0	1	6	0	0	0	1	1	1	1	1	2	2	1	0
Stroud SevernHealth DN	0	0	1	3	1	1	12	12	7	1	0	2	0	0	0	5	2	0	0	0	0	0	0	1	0	0	1	0	0	0
TWNS DN	0	1	1	9	9	2	63	71	59	1	1	0	1	1	0	8	11	12	0	0	0	3	5	1	3	5	2	6	3	0
Total	0	10	5	35	64	42	347	492	512	11	16	18	3	3	4	33	60	79	0	0	0	15	29	19	15	31	30	21	22	15

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High Level Analysis of Community Physical Health Teams Incidents for ICT/DN – by Financial Quarter

The consistently high volume of Skin Integrity incidents reported within the District Nursing Service is clear to see.

A report is being prepared by Belle Hyslop, PST Clinical Incident Lead and Investigator, detailing the Pressure Ulcer Questions (PUQ) Review Process. A brief overview is provided on the following slides for this Q4 Patient Safety Report.

Moderate and above Pressure Ulcer (PUs) Review Process by PST

Context: In mid-2019 the number of reported GHC acquired Category 3 and 4 PUs doubled in number over a 3 month period. In early 2020 there was a 48% increase in the reported level of harm compared to the same period in 2019 (graph on next slide). This change in reporting coincided with reduced capacity within the PST to review incidents due to redeployment for COVID response.

Hypothesis: We have seen an approximate increase of 20% of patients referred to our service with an inherited ulcer. The majority of the reported PUs were likely to have developed despite good care and were therefore unavoidable.

Plan: We needed to develop a process to systematically assess all Cat 3 + PUs to determine the likelihood that the wound was unavoidable and develop, using QI techniques.

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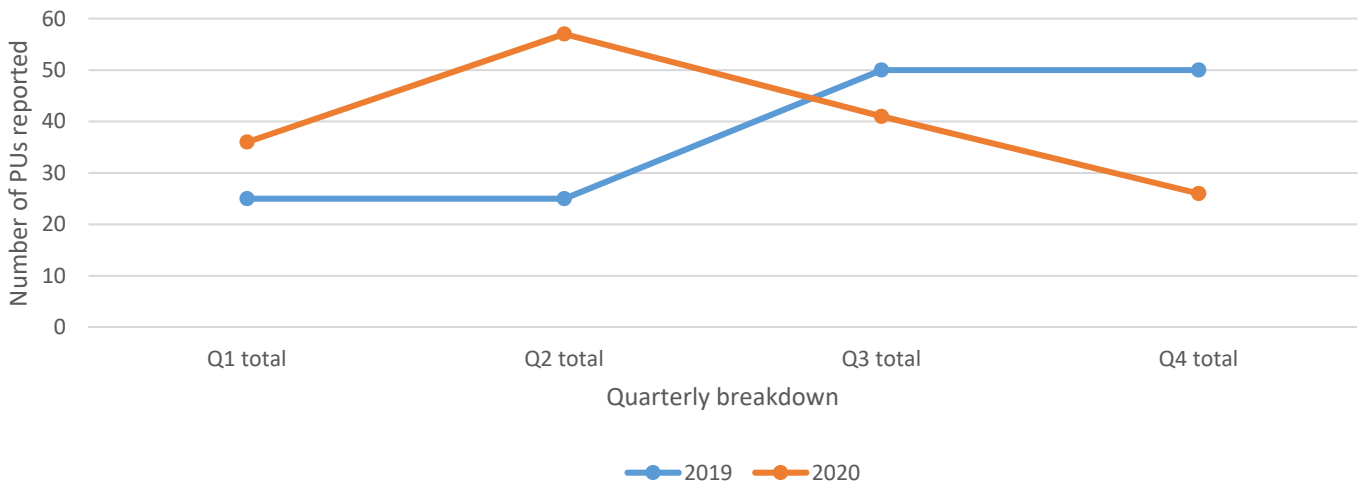
Moderate and above Pressure Ulcer (PUs) Review Process by PST

The majority of moderate and above harm reported to the Patient Safety Team are related to Pressure Ulcers of Category 3, 4 or unstageable, predominantly in adult community nursing.

GHC Acquired PUs Category 3+ 2019/2020 comparison



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Moderate and above Pressure Ulcer (PUs) Review Process by PST

Outcome:

1. Category 3+ PUs across all localities are being investigated by handlers using a Pressure Ulcer Questionnaire (PUQs). These are returned to PST who review and either Finally Approve the decisions, or escalate for further investigation.
2. A monthly snapshot of PUQs is pending, sent to locality Community Managers and District Nurse Professional Leads ensuring regular senior oversight – there was limited assurance of this before the PUQs Review Process.
3. The success of Development Plans to ensure moderate harm PUs are reviewed within 1 month is evident in Gloucester, FOD and latterly Cotswolds teams.
4. 2 localities have reached the point where all the moderate PUs are being actively investigated. This has not been the case since late 2017.

Q4 Physical Health SIRIs reported

1. **27 February 2021 – Missed fractures to the L1, L2 and L3 at Stroud MIiU** – patient attended following falling backwards onto some furniture, sustaining injuries to both hands and her back. Patient had past medical history of Hypertension and Osteoporosis. Patient was reviewed by Senior Emergency Nurse Practitioner who identified that 'hand and wrist injury' was the presenting complaint. X-ray referral made for wrists and hand and concluded her assessment and diagnosed a fractured distal radius. Patient was discharged. No assessment to her back was made.

Q4 Mental Health SIRIs reported

1. **17 December 2020 (declared 6 January 2021) – unwitnessed fall and fracture** of an 82 year old female patient on Willow Ward, Charlton Lane Hospital.
2. **6 January 2021 – suspected suicide (fall from motorway bridge)** 70 year old female patient open to Older Persons Community Mental Health Team
3. **28 January 2021 – Fragmin incident** 59 year old female patient on Mulberry Ward was administered an approximate dose of Fragmin following a suspected PE.
4. **27 February 2021 – attempted suicide** Gloucester Recovery Team, 30 year old female patient jumped from 1st floor window at home address. Significant injuries to leg, elbow and complex fractures to heels.
5. **23 March 2020 – attempted suicide** a 51 year old male patient who had been discharged from Kingsholm Ward that day took an overdose. Needed respiratory care in Department of Critical Care (DCC).

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Q4 Mental Health Clinical Incidents

1. There were no Mental Health clinical incident investigations required during Quarter 4 2020/21.

Q4 Physical Health Clinical Incidents

1. **29 January 2021 – 4 patients acquired Covid-19 while an in-patient at Tewkesbury Community Hospital** Hospital-Onset Definite Healthcare Associated (HODHA) which needed to be understood. (ongoing)
2. **11 February 2021 – an investigation was required following a complaint raised to the PCET regarding End of Life Care** provided to a community patient under the care of Cotswold ICT Team. The issues raised are regarding anticipatory medication and appropriate equipment provision.

Developments within the Patient Safety Team

- Patient Safety Team is being notified of **all** mental health and physical health patient safety incidents categorised as moderate and above. A process is established to review a random sample of 10% no harm, low harm and near misses reported on the Datix system has gathered pace in recent months and the 10% target was met in Q4.
- Duty of Candour has transferred to the Patient Safety Team. Initial disclosure letters (or condolence letters following suspected suicide incidents) provide an apology that the incident occurred, describe the process of investigation, offer supportive contact, and the opportunity for relatives to be involved with the investigation process. Final summary letters are provided particularly where disclosure of the final report is not appropriate, or not required by the family.
- The process for the cascade of learning from incidents continues to be developed by the Associate Director of Patient Safety & Learning.
- Nickki Mills has been appointed as the Clinical Incident & Learning Manager

with you, for you

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AGENDA ITEM: 17/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

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

AUTHOR: Chris Woon, Associate Director of Business Intelligence

SUBJECT: **COMBINED PERFORMANCE DASHBOARD APRIL 2021 (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 performance dashboard report provides a high-level view of key performance indicators (KPIs) in exception across the organisation.

Performance covers the period to the end of April (Month 1 of 2021/22). It is of note that performance period remains aligned to our operational priority to recover services from the pandemic and support developments for the year ahead.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service leads will more fully account for 2021/22 performance indicators in exception through Service Recovery Action Plans (SRAP) updates. Example of this include CYPS and Eating Disorders.

Recommendations and decisions required

- The Board are asked to:
- **Note** the aligned Performance Dashboard Report for April 2021/22.
- **Acknowledge** the ongoing impact of the pandemic on operational performance.
- **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 pandemic response & operational planning.

Executive summary

As shown within the spark charts, all of the indicators within this period have been in exception within the last 12 months, with the exception of *3.49 Perinatal: Routine referral to assessment within 2 weeks*.

Mental Health & Learning Disability Services (National & Local)
The Board's attention is requested to review the 8 key performance thresholds listed in the dashboard (with associated narrative) that were not met for the period. Of note is that Eating Disorder (ED) Services account for three indicators and two are within Children and Young Person Services (CYPS). The ED service continues to face major performance challenges due to a high number of referrals and high vacancy rate which is further outlined within the narrative. The perinatal exception is similarly due to a higher referral rate, staff sickness and the eased induction of new staff. Recovery is however expected within the month through bank staffing support.

As noted within narrative and where applicable, Statistical Process Control (SPC) limits have now been applied for the first time to exception monitoring within Mental Health services.

Physical Community Health Services (National & Local)
Attention is drawn to the 13 key performance thresholds listed in the dashboard (with associated narrative) that were not met for the period. Within these, six are within CYPS and two within Wheelchair Services. It is of note that; '*82: Proportion of eligible children who receive vision screens at or around school entry*' still has an interim, academic year-end target applied because the new academic year has begun but a cumulative delivery trajectory has not been agreed. Conversely in year trajectory targets have now been agreed for 31b and 31d.

Trust Wide Services
There are currently 4 workforce performance indicators in exception this month that apply across the Trust.

A manually produced visualisation presenting additional workforce *activity* indicators has been prototyped, however further tactical conversations need to be held in developing this presentation with data source owners to ensure reader value. Additionally, further data metrics such as Pulse survey results, annual leave consumption and agency usage needs to be incorporated. An early working draft is to be presented to Resources Committee in June 2021. Once issues are satisfied, an automated process can be deployed later in the year which will provide more granular analysis of demographics, professions and areas of work.

Non-exception reporting
It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy '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 briefing paper outlining a proposal to manage 'proxy' indicators for 2021/22 is in final draft awaiting comments from Nursing, Quality and Therapies (NQT) Directorate. It will be presented at the next Resources Committee in June 2021.

Risks associated with meeting the Trust's values
Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Service Recovery Action Plan (SRAP) which outlines appropriate risk and mitigation will be commissioned and monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
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 been discussed before?
BIMG 20/05/2021

Appendices	None

Report authorised by: Sandra Betney	Title: Director of Finance

Gloucestershire Health and Care NHS Foundation Trust

Snapshot Month
April

Performance Dashboard Report & BI Update

Aligned for the period to the end April 2021 (month 1)

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 escalation and senior oversight. Additionally, confirmed data quality or administrative 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, and where appropriate, and in response to significant, ongoing and wide-reaching performance issues; an operational Service Recovery Action Plan (SRAP) which outlines appropriate risk and mitigation will be commissioned and monitored through BIMG. For example, specific updates were provided by operational services in Quarter 4 for two areas with consistent performance challenges; Children and Young People's Services (CYPS) and Eating Disorder Services.

Business Intelligence Update
In spite of high demands, Business Intelligence services continue to deliver key infrastructure development tasks to date and ensured the continuity of business critical reports during the period.

The following high profile tasks continue to be the focus;

- The first Workforce (ESR) and Finance (Integra) reports are being shared with consumers for final validation. This will continue through Q1 as more data becomes available through extracts (e.g. appraisal and full Centros data load).
- Datix data validation is continuing so that this can also be automated into dynamic, regular reporting for both the corporate dashboard and service level needs in 21/22.
- Service level recovery and operational planning is being supported and prioritised wherever possible through robust business partnering
- A comprehensive discovery exercise is being finalised which is evaluating the scale of the existing Community Health (PH) data source adjustments required (primarily to support data quality monitoring) in new environment. This project is called *'SystemOne Simplicity; Improving accuracy, consistency and quality assurance'.*
- Further stakeholder feedback from the Draft Performance Management Framework has been collated and will inform the development of a second draft within Q1.
- The first prototype visualisation of the Workforce Activity Summary has been drafted and is seeking internal feedback. Further items such a Health & Wellbeing Pulse Survey Response Rates, Staff Friends and Family Tests, Cumulative Trust Annual Leave Consumption and Agency utilisation will be incorporated in future iterations. Once an outline is finalised the prototype will progress to development and will offer further automated granulation. This is being presented at the Resources Committee in June 2021.

The following tasks continue to be 'in the development pipeline' in line with the service's 2021/22 Business Plan;

- Dashboard visualisation capability further developed to include; automated benchmarking observation, SRAP alerts and data quality alerts (2021/22).
- Internal service KPI review (2021/22 Q1/Q2)
- BI Infrastructure Development; Further development of the data warehousing infrastructure and technical solutions to ensure robst and reliable BI (2021/22 Q2)
- Core Reporting Delivery; To further develop our established BI reporting and ensure efficient use of information to inform decision making (2021/22 Q3)
- Maintain Data Warehouse; Further develop and maintain efficient data warehouse that maximised data waulity and raised analytical productivity and efficiency (2021/22 Q4)
- Delivering System Data Flows; Introduce new data sources into data warehouse and futher develop existing flows in line with Trust Strategy (2021/22 Q4)
- Legacy Reporting Migration; To conclude legacy reporting requirements (2021/22 Q4)
- Progressive Insight Delivery; To develop next level BI reporting needs and integrate information for cohesive insight (2021/22 Q4)

PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO ADAPT TO BUSINESS DEMANDS, SPECIFICALLY REGARDING THE PANDEMIC RESPONSE AND RECOVERY.

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

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health - National Requirements Gloucestershire

		APRIL	21/22	
1.04	Care Programme Approach - formal review within12 months	93.4% (95.0%)	93.4% (95.0%)	

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
Performance for April is 93.4% (63 cases) against a performance threshold of 95% and is below SPC control limits. Most cases are within the Recovery service (38).

All community services are experiencing a high volume of acuity impacting teams' capacity to carry out non-urgent clinical activities, this is particularly prominent in Recovery Services. All CSM's and Team managers are reviewing CPAs weekly and planning, where capacity allows, balancing the team's wellbeing in managing the considerable pressure from high levels of acuity and complexity and increased distress of carers. Directorate leads are supporting services to achieve this objective whilst maintaining service stability.

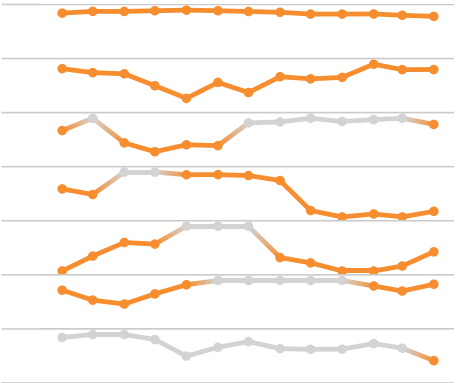
Performance Dashboard: *Mental Health & Learning Disability - Local Contract (Including Social Care)*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract

		APRIL	21/22
3.14	Children and young people who enter a treatment programme to have a care-coordinator - (Level 3 services) (CYPS)	85.4% / 98.0%	85.4% / 98.0%
3.25	% of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded	53.8% / 100.0%	53.8% / 100.0%
3.33	CPI: Assessment to Treatment within 16 weeks	87.5% / 90.0%	87.5% / 90.0%
3.35	Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks	12.5% / 95.0%	12.5% / 95.0%
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	42.8% / 95.0%	42.8% / 95.0%
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	92.3% / 95.0%	92.3% / 95.0%
3.49	Perinatal: Routine referral to assessment within 2 weeks	47.0% / 50.0%	47.0% / 50.0%



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

3.14: Children and young people who enter treatment to have a care coordinator
April is reported at 85.4% against a performance threshold of 98% and is below SPC control limits.

The methodology for this indicator (agreed with commissioners) presumes that treatment begins at the 2nd attended appointment and that it is appropriate to allocate a care coordinator at this point.

The service is redesigning their care pathway to support young people on the waiting list and have introduced extra telephone/video contacts to provide support. These extra contacts then trigger the 2nd contact, however it is not yet the right stage at which to allocate a care coordinator.

The service is waiting for the national team to share the new waiting time criteria and following this the service will map their developing care pathways and then agree methodology with Commissioners. There has been no indication of when this is expected.

3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded
April is reported at 53.8% against a local performance threshold of 100%.

A consistent performance level continues to be maintained. A review of the reporting structure for this indicator continues with Commissioners while we are waiting for the National Team to share their new reporting requirements. A ROMs action plan, monitored quarterly by CAMHS ODGF, is in place. There has been no indication of when this is expected.

3.33: CPI: Assessment to treatment within 16 weeks
April performance is reported at 87.5% against a performance threshold of 90% and is below SPC Chart control limits. There were 4 non-compliant cases in April. To note; 3.32: CPI: Referral to assessment within 4 weeks is reported at 88.5% against a performance threshold of 90% for April but is within normal SPC variation. However, this may be contributing to this pathway deficiency.

CPI teams are running with a high level of vacancies impacting the service's capacity to fulfil contractual requirements. There are ongoing recruitment plans in place, but it remains a challenge to fill these, and it is not expected that any will be filled within the next 8 weeks.

Teams have increased therapist hours to allow extra slots for assessments and are scoping staffing options for Clinical Associates with Psychology.

3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks
April performance is reported at 12.5% against a performance threshold of 95%. There were 7 non-compliant cases in April.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week
April performance is reported at 42.8% against a performance threshold of 95%. There were 4 non-compliant cases in April.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks
April performance is reported at 92.3% against a 95% performance threshold. There was 1 non-compliant case reported in April.

Note on 3.35, 3.37 & 3.40 – Eating Disorders waiting times
The service continues to recruit to the current vacancies with successful candidates due to take up posts over the coming months. The service is expecting to be at, or very near, full establishment by July 2021.

The current wait profile for the service at the end of April indicates that 76.1% (262) of all patients waiting for assessment, are waiting over 4 weeks and waiting times will continue to increase until newly recruited staff are fully in post.

Demand remains high overall with a 24% increase in referrals during 2020/21 compared to 2019/20 and a significant increase in urgent referrals for under 18s (28% in 2020/21 compared to 17% in 2020/21) and this is continuing with 38.7% of referrals received in April being flagged as urgent. The main impact of this referral increase appears to be the detrimental effect that the pandemic, lockdown and school closures have had on CYP's wellbeing and mental health. This is validated by the replication in demand across other teams treating CYP.

Day treatment has been closed temporarily and staff capacity used to accommodate the increase in urgent referrals. Day treatment is likely to remain closed until at least September 2021. The service is accepting routine referrals, which are being triaged and placed on a waiting list, however, assessment and treatment will continue to be paused until July 2021 which will impact on future reported waiting times and has led to several referrals being expedited due to the patients deteriorating condition.

A Digital provider service has been explored and deemed not feasible, therefore other options are being considered such as redeployment of therapists from other directorates and/or over-recruiting of band 4 psychology graduates who can provide treatment interventions.

An action plan is available and reviewed weekly and full capacity mapping work is being undertaken as even if team were at full establishment they would not be able to meet current demand and undertake all the different treatment strands/ functions that were previously offered. Due to performance levels, further scrutiny of planning intentions for adolescent ED is expected from NHSI in the coming months.

3.49: Perinatal: Routine Referral to assessment within 2 weeks
April performance is reported at 47.0% against a performance threshold of 50% and is below SPC Chart control limits. There are 18 non-compliant cases in April.

There are several factors that have led to performance being below the expected threshold: A high number of referrals in April (34% higher than the 20/21 monthly average), staff sickness and new members of staff still working under supervision.

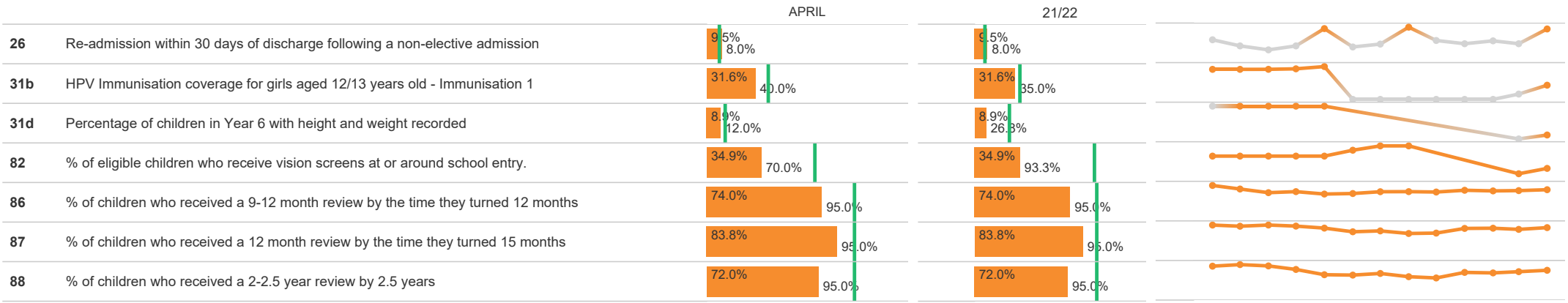
The service expects to be compliant next month as they have requested bank staff to cover the sickness period and new staff will start to take on assessments during May.

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.

26: Re-admission within 30 days of discharge following a non-elective admission
The readmission rate for Community Hospitals in April is 9.5% (14 patients). In the majority of cases the patients' medical condition deteriorated, whilst at the Community Hospital and they required transfer back to the acute trust, to meet their acute care needs. A small number of patients were discharged from Community Hospitals and then readmitted via GHFT, after a small period at home.

31b: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 1
31.6% of the estimated cohort of children eligible for HPV 1st dose in the 2020/21 academic year have been immunised. This is cumulative performance up to April 2021 against the cumulative target of 40% at this stage of the programme. The trajectory aims to reach 90% by the end of the programme in August 2021. This trajectory has just been agreed and if performance hasn't recovered by M2, a plan of action will be expected.

31d: Percentage of children in Year 6 with height and weight recorded
Height and weight measurements for Year 6 children has now commenced following a delay to the programme. 9% of children in this cohort have a height and weight recorded (64 out of 715). The cumulative target this month is 12%. This cohort (715) has been reduced following advice from Public Health England to take a 10% sample of the total cohort, in Gloucestershire this includes 28 schools. This trajectory has just been agreed and if performance hasn't recovered by M2, a plan of action will be expected.

82: Proportion of eligible children who receive vision screens at or around school entry
35.0% of eligible reception year children in the 2020/21 academic year have received a vision screen. This is a cumulative estimate based on previous academic year cohort. The programme recommenced in March 2021. The service is yet to establish a trajectory for the whole academic year so we can measure delivery against targets. It will be available next month.

86: Percentage of children who received a 9-12 month review by the time they turned 12 months.
74.0% of eligible children received the 9-12 month visit by a health visitor in April 2021 compared to a target of 95%. 336 out of 454 reviews were completed within the target timeframe 9-12 months. This is within SPC Chart control limits based on 2018/19 data.

Of those not taking up an appointment, 37% declined and 15% DNA their first appointment and have been rebooked. The parents of all children within this cohort were offered the opportunity to receive a 9 -12month review.

87: Percentage of children who received a 12 month review by the time they turned 15 months.
83.9% of eligible children received the 9-12 month visit (by 15 months) by a health visitor in April, compared to a target of 95%. 406 out of 484 reviews were completed within the target timeframe of 15 months. This is below SPC Chart control limits based on 2018/19 data.

745 catch-up developmental reviews were completed now parents feel more comfortable. The number of appointments declined decreased this month from 38.5% in March to 17% in April.

88: Percentage of children who received a 2-2.5 year review by 2.5 years.
72.0% of eligible children received the 2-2.5 year mandated contact by a health visitor in April, compared to a target of 95%. 407 out of 565 reviews were completed within the target timeframe of 2-2.5 years. This is below SPC Chart control limits based on 2018/19 data.

Additional Comments for 86, 87 & 88
The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

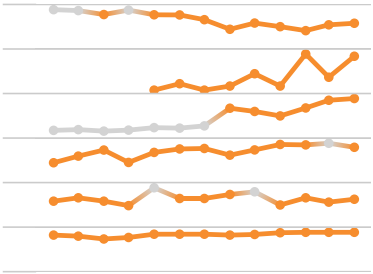
Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Physical Health - Local Requirements

		APRIL	21/22
40	Adult Speech and Language Therapy - % treated within 8 Weeks	66.1% 95.0%	66.1% 95.0%
47	Bone Health Service - % treated within 8 Weeks	75.0% 95.0%	75.0% 95.0%
64	SPCA % of calls abandoned	14.8% 5.0%	14.8% 5.0%
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	82.7% 90.0%	82.7% 90.0%
69	Wheelchair Service: Under 18s: New referrals assessed within 8 weeks	71.4% 90.0%	71.4% 90.0%
95	Average Number of Community Hospital Beds Open	94.8% 100.0%	94.8% 100.0%



40. Adult Speech and Language Therapy - % treated within 8 Weeks
April compliance was 66.1% compared to a target of 95%. 42 out of 127 patients seen in April were seen outside the 8 week target of time from referral to first contact.

April's data shows an improvement in 8 week RTT performance and an encouraging, correlating, trend in the reduction of patients waiting over 8 weeks for their first appointment. It is expected that RTT performance to drop next month as we run specialist clinics for those longer waits but after that much improved performance.

The service remains challenged by vacancy, very hard to recruit to community posts, and maternity leave; both of which we are covering with a locum although recognise that this is not a financially viable model for the year ahead so are seeking recruitment support for innovative models to seek colleagues to join the team.

47: Bone Health Service - % treated within 8 Weeks
3 out of 12 Face to Face contacts in April missed the 8-week threshold. This is 75% compliance against a 95.0% threshold. This is below the lower control limit of 98%. This performance was however impacted by the current inability to include telephone contacts within the methodology.

The service has now caught up with the waiting list caused by additional demand due to the pandemic. The service responded to additional demand by changing their current working practices. Letters to patients are now giving them the option to attend a video/telephone appointment alongside face to face contacts.

The Business Intelligence team is currently working with the service to define and capture clinically significant telephone contacts within the RTT pathway, however this is proving to be a more complex piece of work than was initially anticipated due to the structure of the physical health dataset.

64. SPCA % of calls abandoned
461 out of 3,101 calls received by the SPCA team in April were abandoned. This is 14.9% of the total number of calls received compared to a threshold of 5.0%. This is above the SPC chart upper control limit based on 2018-19 figures.

SPCA has been handling daytime Dental calls since November 2020 due to Covid 19 pandemic which closed most of the dental centres. Historically these calls were handled by dental staff and receptionists in Southgate Moorings. An audit last month confirmed that this continues to impact SPCA call handling pick up times and abandonment KPIs.

A review is ongoing and service leads are looking at staffing numbers and call alignment. Due to service management changes, this review is yet to be concluded. The team are also trialling different processes such as dedicated dental handlers to find improvement. Additional factors include staffing issues with the SPCA service down 2.0 WTE on clinical staff. Due to service management changes, a recruitment process is yet to commence.

This indicator has raised a performance concern regarding dental service monitoring, within which there are no contractual KPIs. The triage service has grown due to the pandemic and this has been raised with Commissioners who are looking at this as a wider regional urgent dental care need project. A business case has been submitted to the commissioners requesting an increase in funding for the number of call handlers in this service and an internal dashboard to monitor performance will also need to be developed to support the service as we advance.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks
5 out of 29 new adults referrals were assessed outside of the 8 week threshold in April. Performance is 82.7% and below the target of 90%.

69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks
5 out 7 (71.4%) of new under 18 referrals were assessed within 8 weeks in April. This is below the target of 90%.

Additional Commentary for 67 & 69
The Wheelchair Service continues to collaborate with the Business Intelligence team to address data quality issues, and has in place a robust plan to establish further quality checks to verify and further improve this dataset. This work is reflected in the improved performance data.

The monthly performance figures now show:

- January to April has seen a reduction in routine assessments from previous months (due to redeployment and long term sickness in the team). Urgent referral assessments are higher in April than the 12 month average of 10 per month.

- 100% performance for the adult and under 18 'urgent referral to assessment' KPI, with the exception of June, January and February, where the target was missed by only by only one exception per month. 12 month performance is above the 95% target at 97.6%.

- Under 18 referral to handover is above target at 100% for April.

- Numbers waiting for assessment have increased slightly in April in line with a 50% increase in referrals during March and April compared to January and February, though longer waiters have decreased.

- Total numbers waiting for handover have remained level since January, following a reduction towards the end of 2020, though the number of longer waiters (9-18 weeks) has steadily reduced since the start of 2021.

A fluctuating trajectory for 'routine referral to assessment' and 'referral to handover' KPI's remains which is an area of focus. Starting with under 18's we expect to then take the learning and apply to adults. This will be a much larger piece of work, reflected by the waiting profiles which we believe are mainly historic artefacts from the data migration from BEST, an external audit is in progress that will support this.

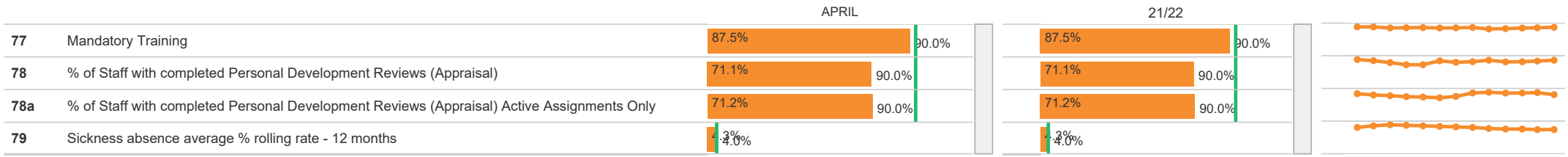
95: Average Number of Community Hospital Beds Open
The average number of beds open in Community Hospitals was 186 in April (compared to the traditional bed stock of 196 beds) and is below SPC Chart lower control limits. This is due to the currently reduced bed base (188) as a result of social distancing on the wards in the wake of the Covid-19 pandemic.

Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

KPI Breakdown

Trust Wide Requirements



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

77: Mandatory Training
Performance was 87.5% in April, below the target of 90%. The average compliance over the past 6 months is 85.3. Performance is below the SPC chart lower control limit based on 2018/19 data. Since December 2020, the mandatory training figures now include Bank Staff, who had previously been excluded from the calculation. This is a positive recovery given that much statutory and mandatory training was temporarily paused in 2020 due to the emergency response to the pandemic, alongside COVID secure requirements which impacted provision.
There are some topics and/or service areas where figures remain lower than required and work is continuing to ensure any deficits are rectified in a timely manner. Current prioritised focus is on resuscitation, physical intervention and information governance training. Further work to help improve training compliance for Bank Staff has also commenced and it is anticipated that this should start to result in improvements across a number of training topics soon.

78: % of Staff with completed Personal Development Reviews (Appraisal)
Performance in April was 71.2% compared to a target of 90%. There is continued focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data. This is a reasonable recovery given that staff appraisals were also temporarily paused in 2020 due to the emergency response to the pandemic.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only.
Performance in April was 71.2% compared to a target of 90%. There is increasing focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data.

For KPIs 78 and 78a
Appraisal Training through Brilliant Essentials has recently been made more readily available, and there is promotion to regularly encourage completion of ESR. Global reminders were also sent out in April reminding colleagues of the importance of recovering their completion of their appraisals alongside signposting to the Trust policy, guidance and documentation. As part of the agenda the new Trust Senior Team meeting on the 18th May colleagues will be reminded of the need to complete appraisals and record on ESR.

79: Sickness absence average % rolling rate - 12 months
Performance presented in April reflects the rolling 12 months sickness absence rate to the end of March. This is due to the way that data is currently managed within the Electronic Staff Record (ESR) system. Performance up to the end of March is 4.3% compared to a threshold of 4.0%.This represents a further month-on-month improvement for each of the past 10 months. Performance is below SPC chart normal variation based on 2018/19 data.

The Operations Directorate has remained at 4.55% this month. However, within Operations the highest levels of sickness absence are in Hospitals at 6.21%, which is slightly up from 6.20% last month.

The Finance Directorate has remained at 4.40% this month. Within Finance; 'Estates & Facilities' were at 5.75% in February, but sickness absence levels have risen slightly to 5.76% for March 20201. Sickness levels within the Finance Team itself have remained at 6.69%.

Working Well alongside the HR Managers assigned to the service areas are continuing to support line managers on all aspects of the operation of the Supporting Attendance Policy, helping to maintain consistency in its application.

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 18/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

PRESENTED BY: Lavinia Rowsell, Head of Governance/Trust Secretary

AUTHOR: Lavinia Rowsell, Head of Governance/Trust Secretary

SUBJECT: **PROVIDER LICENCE – SELF-CERTIFICATION APPROVALS**

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

The purpose of this report is to:

To provide the Board with the information and assurances required to enable it to make the required annual self-certification regarding compliance with the conditions of its provider licence and the systems and processes for ensuring such compliance.

Recommendations and decisions required

The Board is asked to:

a) Have **regard** to feedback received from Governors in respect of these declarations

b) **Agree** to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

c) **Agree** to make a declaration of **'Confirmed'** in relation to the Governor training declaration.

d) **Agree** to make a declaration of **'Confirmed'** by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

e) **Agree** to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

Executive summary

In order to comply with NHSE/I regulatory requirements, the Board is required to make a number of declarations each year regarding compliance with the Trust's provider licence and the systems and processes for ensuring such compliance.

1. Corporate Governance Statement

It is a requirement of the governance condition of the Trust's licence that the Board signs off a Corporate Governance Statement within three months of the end of each financial year.

The Corporate Governance Statement requires the Trust Board to confirm:

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

In making its Corporate Governance Statement declaration, the Board can rely on a range of evidence which is summarised in **Appendix 1** of this report. The Board is asked to confirm **compliance at the date of the statement** and **forward compliance**, for each section of the Corporate Governance Statement.

2. Training of Governors

The Board is required to make a declaration regarding the provision of necessary training to Governors. The Governor Review and Refresh Programme undertaken during the year has produced a number of outputs intended to support Governors to undertake their role. Governors have undertaken two bespoke training sessions with GovernWell and new members of Council have received a detailed induction. The Board is therefore recommended to make a declaration of '**Confirmed'** in respect of the provision of Governor training.

3. Compliance with Licence conditions

Foundation Trusts are also required to make an annual declaration that they have their systems and processes for compliance with provider licence conditions (General Condition G6). **Appendix 2** provides evidence which the Board may rely on to make this declaration. The Board is invited to make a declaration of '**Confirmed'** in respect of both parts of this declaration.

The Board's declarations must be made *having regard to the views of Governors.* The appendices to this Board report were provided to Governors at its meeting on 12 May. The Governors noted the report and no concerns were raised in respect of systems and processes for compliance with licence conditions.

Risks associated with meeting the Trust's values

Regulatory risk the Trusts fails to make the required declarations with in the prescribed timescales and/or makes and false declaration.

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
These declarations are considered on an annual basis. The process involves the Executive, Council of Governors and Board.

Appendices:	**Appendix 1:** Corporate Governance Declaration - Evidence **Appendix 2:** Provider Licence conditions - Overview and Additional Evidence

Report authorised by: Executive Team	4 May 2021

PROVIDER LICENCE SELF ASSESSMENT – 2020/2021

REPORT TO THE BOARD

1.0 INTRODUCTION

1.1 The provider licence requires the Board to make a series of annual declarations to confirm the Trust's compliance with the licence conditions, and also to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance.

1.2 The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

1.3 A further declaration, in relation to the continued availability of resources to provide 'Commissioner Required Services' is not applicable to the Trust as it has not been formally designated by its commissioners as providing such services.

1.4 Declarations must be made by the Board, having regard to the views of Governors.

2.0 CORPORATE GOVERNANCE STATEMENT

2.1 Condition FT4 is about the systems and processes in place to ensure good governance and requires to the Trust to self-certify that this is in place. This includes compliance with the condition at the date of the statement and forward compliance for the current financial year.

2.2 The governance condition of the licence concerns the Trust's internal systems and processes. Hence, the reference to risks within the Corporate Governance declaration relate to risks to those systems and processes, rather than wider risks to the achievement of the Trust's objectives. Where a statement in the declaration indicates a risk to compliance with the governance condition of the Trust's provider licence, NHS I will consider whether any actions or other assurances are required at the time of the declaration, or whether it is more appropriate to maintain a watching brief.

2.3 The Board has during the course of the year received a number of documents which provide evidence of compliance. **Appendix 1** provides a summary of the available evidence to support the Board in making its declaration.

2.4 The Board is required to consider risks to compliance with the Trust's licence conditions, and set out mitigating actions taken to address those risks. The

licence conditions are primarily concerned with the establishment of systems and processes to maintain compliance, and as such there are no obvious risks to the maintenance of such systems and processes.

2.5 In March 2020, in response to Covid-19 the Board agreed revised interim governance arrangements to ensure that, resources were focused on necessary clinical and operational matters to enable safe and sustainable service delivery. These revised interim arrangements reflected guidance from NHSE and NHSI.

2.6 Accordingly, the Board is recommended to make a declaration of **'Confirmed'** in respect of compliance at the time of the declaration, and in respect of forward compliance for the current year.

3. GOVERNOR TRAINING DECLARATION

3.1 Additionally, the Board is required to make a declaration that it has provided Governors with the necessary training, pursuant to Section 151 (5) of the Health and Social Care Act 2012, to enable Governors to fulfil their roles. The Act does not specify the nature or content of training to be provided.

3.2 A number of training opportunities provided by external organisations are made available to Governors. Over the past year, Governors have participated in two bespoke training sessions provided by NHS providers on the Role of Governors and Holding to Account. Governors also receive a local induction, and have opportunities to learn about the work of the Trust through a series of induction meetings and presentations. Access to Trust services and site visits have been more limited due to the Covid pandemic. Over the last year a detailed handbook and induction session has been put in place for governors and an ongoing training plan developed. Governors have taken part in development sessions on aspects of the Trust, for example Strategy Development.

3.3 The Board is therefore recommended to make a declaration of **'Confirmed'** in that it is satisfied that the Trust has provided the necessary training to Governors to ensure they are equipped with the skills and knowledge they need to undertake their role.

4. GENERAL CONDITION G6 – SYSTEMS FOR COMPLIANCE WITH LICENCE CONDITIONS

4.1 General Condition 6 requires that the Trust takes necessary precautions against the risk of failure to comply with the conditions of its licence, any requirements imposed by the NHS Acts, and the requirement to have regard to the NHS Constitution in providing health care services for the purpose of the NHS.

4.2 The licence condition states that the steps the Trust must take should include:

'*the establishment and implementation of processes and systems to identify risks and guard against their occurrence*', and

'regular review of whether those processes and systems have been implemented and of their effectiveness'.

4.3 The declaration asks the Board having reviewed the evidence, to confirm (or otherwise) by the due date of 31 May that:

'*Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that,* ***in the Financial Year most recently ended****, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.'*

4.4 An overview of the provider licence conditions is given at **Appendix 2**. Much of the evidence given in support of the Corporate Governance Statement (listed at **Appendix 1)** may also be relied upon by the Board in order to make the declaration regarding the processes and systems in place to comply with the Trust's licence conditions and general obligations.

4.5 The Board is therefore recommended to respond '**Confirmed'** in respect of the declaration above.

4.6 The Trust is required to publish its G6 declaration by 30 June. As the minutes of this meeting will not be approved by that date, a template provided by NHS Improvement will be used to publish the declaration on the Trust website.

5. HAVING REGARD TO THE VIEWS OF GOVERNORS

5.1 The Board is required to make the above declarations "having regard to the views of Governors". Governor views should be expressed in the context of the Council's statutory duty to hold the NEDs to account for the performance of the Board. This means that Governors should comment on the robustness of the assurance process undertaken in deciding these declarations. A separate report was made available to Governors providing assurance regarding the process for the Board to make these declarations. The appendices to this report have also been made available to Governors alongside the summary assurance report and no concerns were raised in respect of the systems and processes for compliance.

5.2 The Board is therefore asked to have regard to the views of Governors regarding these declarations.

6. RECOMMENDATIONS

6.1 The Board is asked to:

f) Have **regard** to feedback received from Governors in respect of these declarations

g) **Agree** to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.

h) **Agree** to make a declaration of **'Confirmed'** in relation to the Governor training declaration.

i) **Agree** to make a declaration of **'Confirmed'** by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended

j) **Agree** to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

APPENDICES

Appendix 1: Corporate Governance Declaration - Evidence

Appendix 2: Provider Licence conditions - Overview and Additional Evidence

APPENDIX 1 - Corporate Governance Declaration – Evidence

AGENDA ITEM: 18.1/0521

GOVERNANCE STATEMENT	EVIDENCE FOR CURRENT COMPLIANCE		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 • Engagement programme with stakeholders • Scheduled Board meetings including public meetings • Committee structure and Committee meeting programme • Performance dashboards to Resources Committee and Board • Quality monitoring and reporting to Quality Committee • CCG observers at Quality Committee • Quality Report and indicators • Financial reporting monthly to Board/Resources Committee • Financial control systems in place • Information Governance function and reporting • Risk management framework and governance reporting • Assignment of key risks to relevant governance Committees • Regular update and review of risk register • Datix incident reporting system • Council of Governors statutory roles in holding NEDs to account • Patient safety reports to Board and Quality Committee • Patient Stories agenda item at public Board meetings • Meeting evaluation at each Board meeting • Whistleblowing and other organisational policies and procedures in place (including Freedom to Speak Up Guardian) • External audit and internal audit programme	No unmitigated risks identified	Confirmed

	• Clinical audit programme • Compliance with FT Code of Governance • Trust Constitution • Trust vision and values • Annual Governance Statement • Mandatory disclosures in Annual Report • Statutory and mandatory training • Corporate induction for all new starters • Fit and proper person test for Board and Governors • Revised Conflicts of Interests and Risk Management Policies • Statutory registers in place • Single Oversight Framework segmentation of 1 at end 2020/21 • Positive CQC inspection report • Revised interim governance arrangements to respond to Covid-19 signed off by the Board and alignment to NHSE and NHSI guidance		
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 regular item at Board and appropriate Committees • External Auditor Sector development report • NHS I Bulletins received by Exec Directors and Trust Secretary • Annual Reporting Manual guidance • Compliance with FT Code of Governance confirmed in Annual Report • Legal bulletins and updates received by Trust Secretariat Team and disseminated as appropriate	No unmitigated risks identified	Confirmed

The Board is satisfied that GHC NHS Foundation Trust implements effective board and committee structures	• Annual Committee effectiveness review • Committee membership focused to reflect skills – based on skills identified during appointment process • Strong clinical presence on Board • Committee summary reports to Board • Locality Governance structures • Sub-committees mapped	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust implements clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees	• Constitution sets out Board responsibilities • Committee duties aligned to core Board responsibilities • Committee Terms of Reference reviewed annually and substantive changes approved by the Board • Committee agenda planners reviewed regularly • Scheme of Delegation in place setting out delegated responsibilities and powers reserved to Board and reviewed • Revised Standing Financial Instructions in place and reviewed	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust implements clear reporting lines and accountabilities throughout its organisation	• Clear Executive portfolios • Defined management and committee structure • Chief Executive is Accounting Officer • Director of Nursing, Therapies and Quality & Medical Director 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, Whistleblowing, Health and Safety, Safeguarding, Equality and Diversity etc • Lead Executive for each Committee	No unmitigated risks identified	Confirmed

	• Assignment of organisational risks to appropriate Committees • Committees are accountable and report regularly to the Board • Staff appraisals and objectives processes in place		
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively	• Going concern report to Audit and Assurance 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 to Board/Quality Committee • Quality reports to Board/Quality Committee • Outcomes reporting • Clinical audit programme • Internal audit programme • External auditor in place • CQC registration • Single Oversight Framework segment 1 rating • Service/business planning process	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to provide timely and effective scrutiny and oversight	• Executive meetings • NED oversight on Board and Committees • Board and Committee agenda planners • Monthly performance dashboards and exception reports • Executive Engagement processes • Board visits (site visits limited due to Covid) • CQC compliance reports to Quality Committee	No unmitigated risks identified	Confirmed

	• Overall control total achieved • Cost Improvement Programme		
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 Board/Resources Committee • Safety/quality oversight by Quality Committee • CQC/Mental Health Act compliance reports • CQC inspection report • Medical/nursing revalidation programmes • Mental Health Legislation Scrutiny Committee oversight • Executive engagement processes with staff to ensure connection in place with front line staff • Paul's Open Door • Freedom to Speak Up Guardian and advocates • Board visits (site visits limited due to Covid) • Clinical audit programme • Statutory and mandatory training requirements • Clinical policies • PLACE visits • Mental Health Act/Mental Capacity Act policies • Mental Health Act Managers in place • Quality Report • Regulatory inspection reports/action planning • Inquest reports/action planning • Quality Impact Assessments for efficiency and transformation proposals • QIAs reviewed by Medical Director & Director of Nursing, Therapies and Quality • Staff Survey action plan	No unmitigated risks identified	Confirmed

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 • Counter Fraud Service and annual action plan • Resources Committee oversight of development opportunities and business cases • Tender submission procedures • Governor approval process for significant transactions • NHSR Clinical Negligence Scheme for Trusts • NHSR Risk Pooling Scheme for Trusts • Annual financial plan approved by Board before the start of the year • Agency staffing controls	No unmitigated risks identified	Confirmed
The Board is satisfied that GHC NHS Foundation Trust effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up to date	• 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	No unmitigated risks identified	Confirmed

information for Board and Committee decision-making	• Data quality policy • Data quality requirement in Information Governance Toolkit • Finance and performance reporting aligned to Board/Committee cycle • Chief Executive's Reports to Board		
The Board is satisfied that 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 and Assurance Committees and Board • Board Assurance Map review by Executive Committee, Audit Committee and Board • Internal audit programme • Clinical audit programme • Risk consideration as standing Committee agenda item • Incident Reporting policy and culture • Whistleblowing policy and procedure – Freedom to Speak Up • Paul's Open Door • Quality Impact Assessments process	No unmitigated risks identified	Confirmed
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 • Development processes involves service users and Governors, e.g. strategic development sessions • Plans aligned to commissioners' stated intentions • Resources Committee oversight • Executive oversight • Governor involvement on business plan • monitoring reports to Resources Committee • Performance reports • Finance reports • Annual Quality report – external consultation	No unmitigated risks identified	Confirmed

	• External auditors report on Quality report – process suspended for 2019/20 in line with guidance from NHSE and NHSI		
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 and 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 • Information Governance policies and procedures • Clinical policies and procedures • Mental Health Legislation Scrutiny Committee and MHA Managers • Fit and proper person tests • FT Code of Governance compliance reports	No unmitigated risks identified.	Confirmed
The Board is satisfied that systems and processes in place ensure that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided	• Medical Director and Director of Nursing and Therapies and Quality and are clinicians • Non-Executive Director engagement and review provides rigorous quality challenge – a number of Non-Executive Directors are clinicians or have experience as Non-Executives at other NHS Trusts to inform their challenge • Associate NED in place with clinical specialism • To respond to the Covid-19 pandemic, the Trust put in place a 'programme approach' with Executive Directors also having specific responsibilities within the programme. This ensured the maintenance of focus on quality of care. The use of existing expertise and recognised key leads ensured that processes could be activated swiftly without disruption to clinical operation.	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 framework under development • Quality Report is key element of organisational vision and values • Quality Report defines key quality themes for the coming year • Evaluation of each Board meeting	No unmitigated risks identified	Confirmed
The Board is satisfied that systems and processes in place ensure the collection of accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Resources Committee/Board • Performance Exception reports to Board • 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 considers accurate, comprehensive, timely and up to date information on quality of care	• Monthly performance dashboard to Resources Committee • Performance Exception reports to Board • Regular update reports on Quality Report • Regular Patient Safety report to Board • 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 considers as appropriate views and information from these sources	• Quality Report consultation • Update reports on Quality Report shared with stakeholders including Clinical Commissioning Groups, Health Watch and Overview and Scrutiny Committee, and feedback encouraged • Engagement & Communication processes • Patient survey • Staff Survey • Complaints and Comments process • Patient and Staff Friends & Family Tests	No unmitigated risks identified	Confirmed

	• Patient Story is regular agenda item at public Board meetings • Stakeholder Engagement Events (limited due to Covid) • 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		
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 Leads • Service Leads • Heads of Profession • Lead Nurses • Board Committee and sub-committee structure	No unmitigated risks identified	Confirmed
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 compliance with the Conditions of this Licence.	• Board recruitment processes • Governor appointment of Non-Exec Directors • Appointment & Terms of Service Committee for Executive recruitment • Budgeted establishment • Delegated recruitment processes • Recruitment and selection policy • Appraisal and revalidation policies • Ward staffing levels information	No unmitigated risks identified	Confirmed
Supporting Information: The following mitigations were put in force to maintain good governance and oversight during the response to Covid – 19 pandemic and enable confirmation to be given that there are no unmitigated risks.			

In March 2020, in response to Covid-19 the Board agreed revised interim governance arrangements to ensure that resources were focused on necessary clinical and operational matters to enable safe and sustainable service delivery. These revised interim arrangements reflected guidance from NHSE and NHSI. Board Committees, other than the Audit and Assurance Committee were temporarily suspended, with individual work plans reviewed to ensure all issues to be considered were reviewed and either postponed or identified for alternative governance processes as set out below, and any urgent Committee business considered directly by the Board. This included:

- The establishment of a short-life **Board Assurance Committee** focussing on the impact of the exceptional measures being taken in response to the Covid 19 pandemic
- The establishment of an Ethics Group to support executive directors who are making decisions that have complex ethical considerations

The Board continued to ensure open and transparent operation by continuing to operate public Board meetings, which were conducted virtually. The Council of Governors has also moved to remote meeting processes and a newsletter introduced to ensure governors are regularly updated.

Normal governance arrangements resumed in July 2020. The governance arrangements were reviewed again in November 2020 in response to the second wave of the pandemic and minor adjustments agreed.

APPENDIX 2 - PROVIDER LICENCE CONDITIONS – OVERVIEW AND ADDITIONAL EVIDENCE

	Licence Condition	Condition summary	Evidence for compliance
General Conditions			
G1	Provision of Information	Provision of information to NHS I	Operating plan Strategic plan submission Ad hoc submissions to NHS I via portal
G2	Publication of information	Publish information as directed by NHS I	Information on website e.g. Board profiles
G3	Payment of fees to Monitor	Pay fees to NHS I as required	Not applicable - no fees requested to date
G4	Fit and Proper Persons	Not to appoint unfit persons as Directors or Governors	Exclusion criteria in constitution for Directors and Governors Directors' recruitment procedures Governor election rules *'Fit & Proper Persons: Directors'* test incorporated into Board recruitment Annual FFPT declarations by Board/Governors
G5	NHS I guidance	Have regard to NHS I guidance	Code of Governance compliance Single Oversight Framework compliance
G6	Systems for compliance with licence conditions	Have systems in place to comply with licence conditions	Outlined in the appendices to this report – Annex 1
G7	CQC registration	Be registered with the CQC	CQC registration in place
G8	Patient eligibility & selection criteria	Set and apply transparent criteria to determine who can receive health care	Commissioner service specifications
G9	Application of Section 5 – Continuity of Services	States that the Continuity of Services conditions apply where commissioner-requested services are provided	Not applicable
Pricing			
P1	Recording of Information	Record pricing information if required by NHS I	Not required to date.
P2	Provision of Information	Provide information to NHS I	Provision of information via portal
P3	Assurance report on submissions to NHS I	Provide an assurance report re Condition P2 if required by NHS I	Not required to date

	Licence Condition	Condition summary	Evidence for compliance
P4	Compliance with the National Tariff	Comply with national tariff	There is no national tariff in place for community and mental health contract, where tariffs apply for other areas these are complied with as demonstrated through reports to commissioners.
P5	Constructive engagement re local tariff modifications	Engage with local commissioners re tariff modifications	Agreements in place with Gloucestershire CCG re price tariff. Regular monthly meetings take place where performance reports are presented and discussed.
Choice & competition			
C1	Patients' right of choice	Patient notified of choice of provider	Not applicable to Mental health Services In place other services as required. During Covid-19 any limitations on Patients' right of choice were in line with NHSE and NHSI direction
C2	Competition oversight	Not to restrict or distort competition	Legal advice obtained where appropriate when bidding for services/entering partnerships.
Integrated care			
IC1	Provision of integrated care	Not to act detrimentally to the provision of integrated care	Collaborative working within the One Gloucestershire system Participant in two provider collaborative – Thames Valley and Southwest Member of all ILP and on Personalised Care Board.
Continuity of services			
CoS1	Continuing provision of Commissioner Requested Services	Continue to provide CRS as specified except in certain circumstances eg with Commissioner agreement	Not applicable as Trust does not provide Commissioner Requested Services
CoS2	Restriction on the disposal of assets	Not to dispose of any asset without written consent from NHS I	No assets disposed of that provide Commissioner Requested Services
CoS3	Standards of corporate governance and financial management	Apply suitable systems of corporate and financial governance	See evidence in Appendix 1 of this report

	Licence Condition	Condition summary	Evidence for compliance
CoS4	Undertaking from the ultimate controller	Undertaking from any parent company not to cause a breach of the provider licence	Not applicable
CoS5	Risk pool levy	To pay a risk pool levy to NHS I	Not applicable
CoS6	Cooperation in the event of financial stress	To co-operate with the NHS I and others in the event of financial stress	Not applicable
CoS7	Availability of resources	Ensure and certify the availability of financial, physical and human resources for the next 12 months	Not applicable as Trust does not provide Commissioner Requested Services
NHS Foundation Trust Conditions			
FT1	Information to update the register of Ft's	Provision of certain documents to NHS I	Provision of annual accounts and annual report Provision of current version of the constitution Updates regarding relevant Board and Lead Governor changes
FT2	Payment to NHS I in respect of registration and related costs	Payment of a licence fee to NHS I	Not applicable
FT3	Provision of information to advisory panel	Provision of any information requested by an advisory panel	Not applicable – no information requested
FT4	NHS FT governance arrangements	Apply and certify appropriate systems and processes for good corporate governance	Internal Audit reports Head of Internal Audit opinion External Audit

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 19/0521

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 27 May 2021**
PRESENTED BY:	Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
AUTHOR:	Anna Hilditch, Assistant 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:

Present a proposed revision to the Constitution.

Recommendations and Decisions Required:

The Board is asked to **APPROVE** the amendment to the Trust Constitution as presented within 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. The revised composition and subsequent change to the constitution was approved at the November Council of Governor and Board meetings.

The **Medical, Dental and Nursing** staff constituency reduced from 4 posts to 3 and this took effect from 1 January 2021.

There is a provision within our constitution which states that of the 3 seats within the Medical, Dental & Nursing staff class – 1 must be reserved for a nurse, 1 for a doctor and 1 for a doctor or dentist.

This specific provision about reserved seats was not updated at the time to accurately reflect the revised composition and meant that the Trust could only ever have 1 nurse representative on the Council. A small amendment to our constitution is therefore suggested, marked in red as follows:

1.3 ……. 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, a dentist or a nurse.

The approval of the revised Constitution is a two-stage process which requires
(i) approval of the Council of Governors and,
(ii) the Board

The revised Constitution will then be updated to the Trust's website and to NHSEI.

The Council of Governors supported this revision at their meeting on 12 May, for onward presentation to the Board for approval.

Risks associated with meeting the Trust's values
None

Corporate considerations	
Quality Implications	None
Resource Implications	None
Equality Implications	None

Where has this issue been discussed before?
Council of Governor meetings

Appendices:	N/A

Report authorised by:	**Title:**
Lavinia Rowsell	Head of Corporate Governance/Trust Secretary

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 20/0521

REPORT TO: **TRUST BOARD PUBLIC SESSION – 27 May 2021**

PRESENTED BY: Lavinia Rowsell, Head of Corporate Governance/Trust Secretary

AUTHOR: Anna Hilditch, Deputy Trust Secretary

SUBJECT: **USE OF THE TRUST SEAL – Q3 & Q4 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 October 2020 – 31 March 2021 (Q3 & Q4 2020/21).

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 4 times since the last Quarter 2 report to the Board on the 28 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?

Appendices:	Page 3 Appendix 1: Register of Seals (Oct 2020 – March 2021)

Report authorised by: Lavinia Rowsell	**Title:** Head of Corporate Governance/Trust Secretary

APPENDIX 1

Gloucestershire Health and Care NHS Foundation Trust
Register of Seals Q3-Q4 (October 2020 – March 2021)

Seal No.	Date of Sealing	Document Description	No. of Copies	Document Signatory (1)	Document Signatory (2)	Attested by	Attested Date
15/2020	14/10/2020	**Merger of Trust Charities – GHC and 2G**	1	Paul Roberts CEO	Angela Potter Director of Strategy and Partnerships	Lavinia Rowsell Trust Secretary	14/10/2020
16/2020	24/12/2020	Remediation Agreement between Gloucestershire Care Services NHS Trust and Southern Electric Power Distribution PLC. Remediation works by SEPD Plc to remove contamination caused by SEPD equipment.	1	Sandra Betney Director of Finance	John Trevains Director of Nursing, Quality and Therapies	Louise Moss Deputy Head of Corporate Governance	20/12/2020
17/2021	04/02/2021	Form of Agreement between GHCNHST and Speller Metcalfe Malvern Ltd Montpellier refurbishment – **Wotton Lawn Hospital**, GL1 3WL.	1	Neil Savage Director of HR & OD	John Trevains Director of Nursing, Quality and Therapies	Lavinia Rowsell Trust Secretary	04/02/2021
18/2021	29/03/2021	Short contract between GHCNHST and Speller Metcalfe Malvern Ltd Anti-ligature works: window replacement and door alarm system installation at **Wotton Hall Hospital GL1 3WL** commencing 5th April for 24 weeks.	1	Paul Roberts CEO	John Trevains Director of Nursing, Quality and Therapies	Lavinia Rowsell Trust Secretary	29/03/2021

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST
COUNCIL OF GOVERNORS MEETING

Wednesday 10 March 2021
Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Sarah Nicholson	Katie Clark
	Brian Robinson	Jo Smith	Mervyn Dawe	Julie Clatworthy
	Dan Brookes	Chris Witham	Graham Hewitt	Tracey Thomas
	Ruth McShane	June Hennell	Jenny Hincks	Said Hansdot
	Juanita Paris	Anneka Newman	Laura Bailey	

IN ATTENDANCE: Graham Russell, Non-Executive Director/Deputy Chair
Marcia Gallagher, Non-Executive Director
Maria Bond, Non-Executive Director
Steve Alvis, Non-Executive Director
Steve Brittan, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Paul Roberts, Chief Executive
Neil Savage, Director of HR & OD
Lavinia Rowsell, Head of Corporate Governance & Trust Secretary
Anna Hilditch, Assistant Trust Secretary
Gillian Steels, Trust Secretary Advisor
Kate Nelmes, Head of Communications
Lauren Edwards, Deputy Director of Therapies and Quality (Item 12)
Sandra Betney, Director of Finance (From Item 10)
Lisa Proctor, Associate Director of Contracts and Planning (Item 13)

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Karen Bennett, Alison Feher, Anne Roberts, Kizzy Kukreja, Dawn Rooke and Katherine Stratton.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meetings held on 19 November 2020 and 21 January 2021 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.

5. CHAIR'S REPORT

5.1 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 28 January meeting and was

presented to the Council for information and reference. This report and its content were noted.

6. CHIEF EXECUTIVE'S REPORT

6.1 Paul Roberts, Chief Executive presented a verbal report to the Council.

Covid

6.2 The peak from the second wave of Covid was on 18 January and it was noted that this had been far more intense than the first wave. There had been 148 admissions to the acute hospital in the first wave, with 240 admissions recorded during the second. Paul Roberts reported that the death rates had been lower during the second wave, however, there had been longer admissions. The position was improving but the pressure was still on.

6.3 GHC runs 94 services and all services continued to operate during wave 2, with the use of digital interface. Some services were scaled back during that time as staff were redeployed into those services directly responding to Covid. Innovation and the use of technology had come to the fore and the Trust would continue some of this practice going forward.

6.4 It was noted that GHC continued to provide the "Pillar 1" testing service for Gloucestershire. The service could test up to 100 people a day, and included GHC staff and family members, and other local NHS and Social Care organisations. A service was also provided for elective patients.

6.5 GHC had been very involved in the mass vaccination programme, with the Trust's focus being on frontline staff and supporting the Primary Care Networks (PCN) to vaccinate patients. GHC had also focused on the homeless and rough sleepers, as it was important to ensure equitable access to all communities. To date, 80% of all frontline Trust staff had been vaccinated, which equated to 70% of all staff. The aim was to achieve over 90% and messages to staff continued to be sent out regularly inviting eligible colleagues to attend for vaccination.

6.6 The next step would be the focus on recovery, which had already commenced. Paul Roberts said it was important to get the balance of recovery right and this was being looked at within 3 key themes: Individual Recovery, Service & Team Recovery and a Refocus on Ambitions and Transformation.

6.7 Chris Witham asked whether there were any key challenges that had been identified as part of the Covid recovery planning. Paul Roberts said that staffing was a real challenge. There had been Inpatient and Community nursing shortages before Covid hit, and the Trust had been able to adapt with different working models during Covid, but there was a real need to review the staffing models as demand for services was increasing.

6.8 Said Hansdot joined colleagues in thanking the Trust and staff for the huge amount of work that had been carried out to continue running quality services during Covid. He referred to the earlier point about making vaccinations available to all communities and asked whether there were any specific groups that had been identified where more work was needed to promote the vaccinations. Paul Roberts said that a number of communities had been identified and the Trust and its partners were working closely with community and faith leaders to get specific communications out, as well as setting up roving vaccination clinics to make access available to as many people as possible.

6.9 Brian Robinson noted that we were coming out of the second wave of Covid, and it was likely that a third wave would hit. He asked whether planning for future waves and longer term was taking place. Paul Roberts assured the Governors that the Trust's recovery plan had been developed in a Covid secure way, with the possibility of future waves taken into account. He said that this would hold the Trust in good stead and would ensure the Trust could adapt quickly.

6.10 Brian Robinson referenced the proposed 1% pay uplift for NHS staff and asked how it was felt that this would sit with Trust colleagues given the existing challenge of addressing nursing staff shortages. Paul Roberts said that on a personal level he felt that this could affect the morale of lower paid staff who had worked tirelessly through the Covid pandemic. He also had some concerns on how this would impact on future recruitment which the Trust needed to be mindful of. Governors also expressed their concerns around this proposed pay uplift.

Staff Survey 2020

6.11 Paul Roberts said that the staff survey was a significant measure for GHC of what we do, with the Trust's key focus on staff health and wellbeing. This was the first survey carried out as a combined Trust, following the merger in 2019. The Council noted that the results from the National Staff Survey would be published tomorrow, and unfortunately the results were embargoed until that time. However, Paul Roberts presented some headlines to the Council, noting that the response rate had increased and that 80% of the ratings had improved or stayed the same. There had been a 10% improvement in the rating for "The Trust takes positive action around staff health and wellbeing" which was excellent, and there had also been an increase in the measures for staff recommending GHC as a place to work and place to receive treatment. Overall, the results were very positive, which following a merger and taking place during Covid was excellent.

6.12 The full results would be made available to Governors and would include the one-page infographic. A full presentation of the results was scheduled for the next Council meeting taking place in May.

6.13 Chris Witham said that Governors were looking forward to seeing the staff survey results and added that it was pleasing to hear that there had been improvement in the scores considering the very testing year that staff had experienced.

Forest of Dean Hospital Consultation

6.14 Paul Roberts advised that the Trust had received the feedback from the formal FoD Hospital consultation process at the January Board meeting and will be proceeding with the proposals. Work will continue on the finer details, with the Full Business Case being presented to the May Board for approval.

6.15 Brian Robinson said that there were some concerns in Lydney about the removal of a primary health hub in the south of the Forest. Paul Roberts advised that proper dialogue had taken place with people in the Forest of Dean and the CCG had been leading on this, with a series of engagements events planned. It was acknowledged that it would be difficult to please everyone but it was hoped that the new state of the art hospital in Cinderford would be a fantastic facility for the whole Forest population.

7. MEMBERSHIP AND ENGAGEMENT STRATEGY

7.1 The Council received the Membership and Engagement Strategy 2021-2024 for approval. The purpose of the Strategy and its related action plan was to build a membership which is engaged and reflects the breadth of the communities the Trust serves.

7.2 It was noted that the Membership and Engagement Committee had met twice since it was agreed to establish it at the November Council of Governors meeting. The Strategy was considered and updated in the light of feedback from the Committee who highlighted the need to clearly communicate the benefits of membership, to target our communications effectively to different audiences and to use partnership working to help spread the message of membership. An Action Plan was developed to put in place some of the key foundations needed to support this strategy and the work on this is now ongoing. A Partnership Methodology had also been produced to reflect how the Membership and Engagement Strategy plans to work with partners to achieve its aims.

7.3 Ruth McShane said that there was a lot of work taking place and exciting ideas were being generated from the strategy. She added that it was excellent to see practice from other Trusts being considered such as the Young People's Council in Bristol.

7.4 It was noted that a briefing session for Staff Governors was in the process of being arranged and the date would be circulated to all staff Governors once confirmed.

7.5 Ingrid Barker expressed her thanks to all those who had attended the Membership and Engagement Committee meetings and had contributed to the development of the strategy.

7.6 The Council of Governors approved the Membership and Engagement Strategy 2021-24, for onward endorsement by the Trust Board at their meeting on 31 March.

8. MEMBERSHIP AND ENGAGEMENT COMMITTEE – TERMS OF REFERENCE

8.1 The Council received the Terms of Reference for the newly established Membership and Engagement Committee. These were approved.

9. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

9.1 Chris Witham, Lead Governor presented this report to the Council, summarising the key business conducted at the meeting of the Nominations and Remuneration Committee held on 24 February. It was noted that this was the first meeting that Chris had attended in his role as Lead Governor and he provided strong assurance to the Council that the Committee ensured best practice that was in line with national guidance.

9.2 The Committee received a report which set out the process of recruitment for a Non-Executive Director. Over the next 24 months, two NEDS will have completed their second term on the Board. In order to inform future NED recruitment, a skills audit was undertaken of the current NEDs, including the Chair. The purpose of the audit was to identify the skills currently on the Board and, what if any, gaps exist, or will be created when individual NEDs retire. Maria Bond's agreed term of office would be completed on 30 September 2021, thus creating a vacancy on the Board for a 7th NED. Marcia Gallagher's second term of office would conclude on 30 September 2022, and in the absence of another Non-Executive Member of the Board with an appropriate financial qualification and/or experience to take on the role of Chair of the Audit and Assurance Committee, it was agreed that the forthcoming round of NED recruitment focus on succession planning in this area. The Committee endorsed the generic role description and person specification for the NEDs, including the specific requirements for this round of recruitment to seek the necessary financial experience. It was planned that recruitment would commence on 11 March, with a recommendation for appointment being presented to the Council of Governors at its 8 September meeting. The Council of Governors supported this direction of travel.

9.3 The Committee received and endorsed the process and proposed timelines for the 2020/21 Chair and Non-Executive Director appraisals, noting that these would be carried out using nationally set guidance.

9.4 The Committee received the Terms of Reference for the Nominations and Remuneration Committee, noting that the content of these remained largely the same as those previously approved by the Committee, and the Council of Governors in November 2019. However, the TOR had been reformatted and reordered to ensure that they were consistent with those of the other governance Committees within the Trust. The Council of Governors received and approved the TOR.

9.5 The Committee also received an update on the upcoming round of Governor elections.

10. GOVERNOR ROLE IN HOLDING TO ACCOUNT – PROPOSED PROCESS

10.1 The purpose of this report was to provide an update on the Trust's proposals for Governors to carry out their statutory duty of "Holding the NEDs to account for the performance of the Board".

10.2 As part of the Council of Governor Review and Refresh work, focus has been placed on developing effective methods for the Governors to carry out one of their key statutory duties - Holding the non-executive directors to account for the performance of the board. The Council of Governors' primary means of holding NEDs to account is through:

- Receiving the annual report and accounts
- Receiving the quality report
- Receiving performance appraisal information for the Chair and NEDs
- Receiving in-year information updates from the Directors

10.3 In 2015, the Trust introduced a pilot of Governor observation at the Board Committees. However, the Trust has reconsidered national guidance from NHS Providers who have been clear that opening Board committee meetings to Governors is not deemed as good practice. The Trust is aware that Governor observation at the Board Committees has reduced over recent years, with only 3 Governors actively carrying out this role.

10.4 In looking at alternative and more effective ways for Governors to collectively hold the NEDs to account, the outcome of the Review and Refresh work has proposed a number of ways of doing this moving forward to include Holding to Account Presentations at Council Meetings, the development of a Dashboard Report and Locality NED/Governor Links. More work would also be carried out to look at how links could be made for the NEDs with the Staff Governors.

10.5 In light of this it was proposed that from the 1 April 2021, the Governor role in Holding NEDs to account is delivered via the activities set out above and that the current practice of governor observation on Board committees ceases. A review of the holding to account process will be carried out in a year's time to see whether the proposed activities have been successful.

10.6 Nic Matthews said that he welcomed this report and the planned approach. He said that as a current Board Committee observer he did not feel that this effectively covered the HTA role and therefore welcomed this being revisited.

10.7 June Hennell said that she had found attending the Committee meetings very interesting and informative and it had enabled her to gain a greater understanding of the work of the Trust. She said that she had appreciated the opportunity to do this.

10.8 The Council of Governors endorsed this report and supported the proposed HTA activities going forward.

10.9 Ruth McShane asked whether there was any information available about what the Board discussed at their private session meetings. Ingrid Barker said that the Trust always reviewed its agenda to ensure that as many items as possible could be presented at a public meeting; however, some items would need to be taken privately if they were, for example, politically sensitive, HR related or contain patient identifiable information.

11. HOLDING TO ACCOUNT SESSION

11.1 The Council received the first HTA presentation from Graham Russell, NED and Vice Chair. Graham is the Chair of the Resources Committee and his presentation provided Governors with an overview of the purpose of the Committee, the key-ways of working, those things that had worked well and a summary of the areas where development was underway.

11.2 Chris Witham said that the Trust had placed high importance on ensuring that there was a focus on staff and being a great employer. He asked how the line of sight to the patient was considered. Graham Russell advised that service user engagement was vital. The Trust Board always received a service user presentation at the start of its Board meeting which was an excellent way of reminding the Board of what was important and to ensure that the focus was on the patient. In terms of Board Committee oversight, Graham Russell advised that the Quality Committee had a remit to focus on service user involvement, however, some elements of engagement were considered at the Resources Committee.

11.3 Graham Hewitt noted that the Resources Committee had a very wide remit, with only 6 meetings annually. He picked up on an earlier point about the Committee now receiving more focussed reports at its meeting and he asked how Graham Russell as Chair, and the other Committee members could be assured that these shorter, focussed reports covered the significant issues and that nothing of significance was being omitted. Graham Russell used the Trust's Finance Report as an example. He said that the report had been developed over time, so members had seen the previous versions and had been consulted on the revisions being made. The reports had evolved alongside Committee input, not independently.

11.4 June Hennell asked whether the Resources Committee was the Trust's key assurance Committee. Graham Russell said that all of the Board Committees had an important role in providing assurance to the Trust Board, not just the Resources Committee. However, the Resources Committee did provide good assurance around finance and performance.

11.5 Mervyn Dawe asked whether Graham Russell had ever felt worried or not listened to as Chair of the Committee, or whether there had been any conflicts. Graham said that there had been occasions where he had been worried about a certain issue, but he would seek out guidance from the lead Executive as soon as possible to ensure that this did not require escalation. He said that there had not been any conflicts arising in his memory, only good and constructive challenge by the NEDs to the Executives.

11.6 Nic Matthews referred to "The Committee would be better if….." slide within the presentation and confirmed that this felt like an accurate summary from his time as an observer at the Resources Committee.

11.7 Sarah Nicholson first thanked Graham for his presentation and supported this new way of HTA. She asked about Covid expenditure and whether this additional spend would impact on future service delivery and development. Graham Russell advised that the Resources Committee received and scrutinised the Finance Report at each of its meetings, and this report provided good assurance around Covid costs. He said that the Trust would use the experience of Covid to learn and reconfigure how things are done. The aim of this was not to save money, but to do things in a better and more effective way. A huge amount had been learned through the Covid experience, including a lot of good and innovative practice and this would be taken on board as part of developing our services going forward.

11.8 The Council thanked Graham Russell for his presentation which had been informative and helpful. Governor feedback on the format of the session was welcomed.

12. CQC NATIONAL COMMUNITY MENTAL HEALTH USER SURVEY RESULTS

12.1 The purpose of this report was to summarise the results of the 2020 CQC National Community Mental Health survey. These results provide assurance of the quality of adult community mental health services delivered by GHC.

12.2 In 2019, Quality Health was commissioned by GHC to undertake the 2020 Survey, which is a requirement of the Care Quality Commission. Within the results report, the CQC makes comparison with 55 English NHS mental health care providers' results of the same survey. It was noted that the full results were published on the CQC website. A summary of the key points was as follows:

- The Trust's results are 'better' than the expected range for 13 of the 28 questions (45%) and 'about the same' as other Trusts for the remaining 15 questions (54%) These results represent a further improvement on our results from last years' service user feedback (Better = 38%, about the same = 62%)
- The Trust is categorised as performing 'better' than the majority of other mental health Trusts in 8 of the 11 domains (73%) (last year: 7 out of 11, 64%)
- The scores for feedback are disappointing, although are 'about the same' as other Trusts (the highest score in England was only 3.5). This will continue to be a significant area of focus for development, with the work being led by the Patient and Carer Experience Team.
- An action plan will be co-developed with senior operational and clinical leaders and seeking input from Experts by Experience.
- An infographic has been produced to support effective dissemination of findings to colleagues and local stakeholders.

12.3 The Council received and welcomed this report, which demonstrated that the Trust was performing well. The report did identify some challenges but offered significant assurance that the Trust's strategic focus and dedicated activity to deliver best service experience was having a positive effect over time. Assurance was also received that the results of the survey would be used to identify the key areas of focus for practice development activity over the next 12 months.

12.4 Given the limited time available at the meeting, it was suggested that a small working group meeting would be helpful for Governors to discuss the results in more detail. This was supported and a date would be sought and circulated. **ACTION**

13. BUSINESS PLANNING 2021/22

13.1 The purpose of this paper was to set out the Business Planning approach for 2021/22 to ensure the Council of Governors were appropriately involved in the process and have an opportunity to give views for Board consideration.

13.2 The business plan is key to the delivery of the Trust Strategy and the business planning structure is underpinned by the agreed strategic aims linked to each business planning objective. Directorates and Teams are currently developing their business planning objectives as part of the initial stages of the business planning process for 2021/22.

13.3 The Council was asked to note that the business planning process had been slightly delayed for 2021/22 due to Covid. The aim was for the business plan to be finalised in line with our original planning timescales and presented to the Trust Board for approval at the end of March 2021.

13.4 The National Planning guidance had been published for 2021/22 for Quarter 1 and further guidance was expected in April for the remainder of the year. A business planning refresh is therefore proposed at the 6-month mid-point to allow for further national guidance and in-year changes.

13.5 Lisa Proctor informed the Governors that producing the business plan had been challenging, however, the Trust was supporting colleagues to identify service objectives that were realistic. Graham Hewitt acknowledged that this was a difficult time to be developing the business plan and he therefore fully supported the proposal for a 6-month review and refresh. He asked whether there had been any impact on the quality of the objectives being identified this year. Sandra Betney informed the Governors that colleagues could update their objectives as and when they needed to via the Trust's online portal. This meant that people were not required to finalise everything before the end of March. However, there was a need to ensure that business planning was tied in with budget setting so there may be some issues identified when reconciling plans versus budget at the mid-year point.

13.6 Sarah Nicholson informed the Council that she felt that carrying out business planning at this time had actually focussed people and from her perspective it had been quite well received by colleagues.

14. GOVERNOR ACTIVITY UPDATES

14.1 Chris Witham said that he had spoken to Becca Shute, Assistant to the Chief Operating Officer about the Trust's vaccination programme to get a better understanding of activity taking place locally. He said that the energy and enthusiasm of colleagues for what was being delivered was exemplary and there was some excellent work being carried out. An update on this had been shared with the Governors at the pre-meeting.

14.2 Mervyn Dawe noted that the Governors had a received a briefing note on the current position with Out of Area Placements. He said that this briefing did not cover the specific areas that he had previously requested assurance about. Mervyn would send a further email to Anna Hilditch setting out those issues that he would welcome being addressed. **ACTION**

15. ANY OTHER BUSINESS

15.1 Governors were asked to note that due to Covid, there was no longer a requirement to carry out an external audit of the Trust's Quality Report for 2020/21. Governors would normally receive a set of key indicators within the Quality Report and select a local indicator to be audited. It was planned that this process would resume for 2021/22.

16. DATE OF NEXT MEETING

16.1 The next meeting would take place on Wednesday 12 May 2021 at 10.00am.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
10 March 2021			
12.4	A small working group meeting for Governors to discuss the MH Service user survey results in more detail to be arranged.	Anna Hilditch / Lauren Edwards	Complete. Session held on 22 April 2021
14.2	Mervyn Dawe to email specific points requiring assurance around Out of Area placements to Anna Hilditch, for action.	Mervyn Dawe / Anna Hilditch	Complete

AGENDA ITEM: 24

FOREST OF DEAN ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 16 APRIL 2021

COMMITTEE GOVERNANCE	• Committee Chair – Steve Brittan, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

DESIGN & CONSTRUCTION UPDATE

The Committee received the Design and Construction presentation which provided a visual representation of the changes made to the redesign. Changes included the change to a two-storey option.

The Committee was informed of the progress which had been made since the previous meeting on the site abnormals identified: mine workings, highways, ecology and storm and foul water discharge.

The Committee noted the CCTV showed culvert in poor state. This was identified as a risk. It was noted this was owned by Severn Trent and had been added to the risk register; noting that there may be the requirement for improvement works to be carried out.

The Committee was informed of other activities which had been progressed and carried out, including the background noise assessment and the development of an ecological mitigation timeline.

COMMITTEE DISCUSSION

The Director of Strategy and Partnerships informed the Committee the current design incorporated a central court yard and a key aspect of this from both an operational and clinical perspective, was that it would maximise natural light in to 90% – 95% of the building and all clinical rooms which would be occupied on a frequent basis. The Committee was asked for consideration to be given to potentially filling in the court yard space enabling a solid building instead. This would result in a greater use of space on the floor plan, but all rooms not necessarily receiving natural light.

The Committee was informed of the option of flipping the current floor plans to reduce the risk around stairways and lifts; noting that this would potentially locate inpatients on the first floor and thus creating challenges to being able to directly access external gardens. This was noted to have been one of the key drivers (from the consultation and the workforce) to include.

Andrew Paterson, Strategic Project Manager provided detail on the economic business case and explained there would be the requirement by NHSEI to run the Capital Investment model which would produce the value for money at completion. This would set the benefits against the costs defined by the economic model.

SUMMARY & CONCLUSION

The Committee agreed that the full business case for the project would not be received by the Trust Board scheduled for 27th May 2021. The Trust Board would receive an 'approval to proceed' report on the project to outline the approvals needed to proceed with the next phase of the scheme.

The Committee agreed the following information should be provided to continue to provide assurance to the Board:

- That the formal Value for Money assessments required for the Full Business Case would deliver an acceptable outcome that would pass scrutiny
- Confirmation of the forward financial capital "affordability" envelope, taking into account future constraints as far as could currently be understood within the ICS, and the Trust's up-to-date financial position
- A well-qualified project build cost budget, taking into account the risks described above, that is clearly within the capital affordability envelope

OTHER ITEMS RECEIVED BY THE COMMITEE

The Committee received and noted the **Risk Register.**
The Committee received the **Critical Path timeline** and noted the time constraints recorded.
The Committee received the **FoD Programme Board update report.**

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**23 June 2021**

MHLS COMMITTEE SUMMARY REPORT

DATE OF MEETING 21 APRIL 2021

COMMITTEE GOVERNANCE	• Committee Chair – Jan Marriott, Non-Executive Director • Attendance (membership) – 75% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

PROPOSED RESPONSE TO CONSULTATION ON WHITE PAPER ON REFORMS TO THE MENTAL HEALTH ACT

The Committee received the proposed response to the consultation on the white paper on reforms to the MHA 1983. The response included feedback which had been received from Focus Groups, Service Users, mental health workforce and Trust Board members. The Committee discussed the responses set out in the paper and commented on the key themes identified, which included Guiding Principles, Detention criteria, therapeutic benefit and substantial risk, Access to tribunals, Advance choice and care treatment plans, Nominated person, Advocacy and People with a learning disability or autism.

The comments received would be incorporated into the Trust response for submission. The Committee expressed thanks to Becca Shute for her work in producing the Trust's response to the MHA White Paper.

REVIEW OF DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) APPLICATIONS UPDATE

The Committee received a verbal update on the Review of DoLS Applications and it was reported that countywide Gloucestershire County Council currently had 1350 cases to assess. From April to December 2020 Mental Health had 23 applications for DoLS, of the 23, 21 were granted. This showed a significant increase in the applications for DoLS in mental health services. It was reported Physical Health Services, Community Hospitals had received 64 applications over a 9-month period, none of which were authorised. This was expected and would be due to patients moving on before being assessed by the local authority. The Committee was assured that patients who were awaiting DoLS application assessments would continue to receive treatment in the patient's best interests under an urgent DoLS.

POLICIES FOR REVIEW AND RATIFICATION

The Committee received the Mental Health Act Information policy and was informed that the policy assured patient's rights were given within relevant timeframes; noting section 2 was weekly, section 3 was 3 weekly and CTOs were 2 monthly. The Committee noted there were no proposed changes to the policy. The Committee ratified the Mental Health Act Information policy.

The Committee received the Receipt, Scrutiny and Rectification of MHA Documents policy and the proposed changes. The proposed changes provided greater clarity on how section 15 would apply to medical recommendations; in particular, joint recommendations. Section 15(1) of the Mental Health Act would allow for the rectification within 14 days of an incorrect or defective recommendation. Whereas section 15(2), does not allow for the provision of a fresh joint recommendation if it was to be insufficient to warrant detention. The Committee approved the proposed changes and ratified the policy.

The Committee received the Renewal of Detention and Extension of CTO policy and was informed of key changes within the policy. The Committee agreed the policy would be re-issued without the inclusion of the use of video examinations. This would then be re-issued if required.

MENTAL HEALTH ACT POLICIES (MHLS MONITORING)

The Committee received the Mental Health Act Information Policy for monitoring, and was informed of an internal audit of the recording on RiO of verbal provision and reminders to patients subject to the MHA of information about their rights. It was agreed a discussion of further compliance to reduce the risk would be discussed in the meeting. The Committee noted the limited assurance provided by the audit and the ongoing actions being taken by the Mental Health Operational Group.

The Committee received the Policy for Receipt and Scrutiny of Mental Health Act documents for monitoring, informing the Committee of an audit which had been completed of AMHP applications for admission and medical recommendations selected at random. It was reported that no errors were found during the audit. The Committee noted the significant assurance provided by the audit.

ANNUAL AMHP SERVICE REPORT

The Committee received the Annual AMHP Service Report providing an outline of the AMHP activity service for the year 2020/2021. The report highlighted a significant increase of 50% in referrals received in the peak of summer 2020 compared to the previous year. The increase was partly thought to be due to the NHS Guidance around working with mental health and learning disabilities in Covid. The lack of access to community resources was reported to be a problem with many referrals going straight to mental health assessments.

The majority of individuals assessed were in the age bracket 18-30 years. There had been an increase by approximately 5% of admissions in under 18s. In contrast, fewer assesments had been received for over 70s. Those individuals recorded on RIO as identifying themselves as Black ethnicity made up 4.7% of all assessments whereas people identifying as Asian made up just 1.1%. However for 11% of assessments or 148 people, “unknown ethnicity” was recorded.

The report identified the majority of assessments during 2021 were of female patients. In previous years this had been fairly equally divided between males and females. The Committee was informed of a report published 17th March 2021 by OpenDemocracy stating the Women had been disproportionately affected by soaring MHA detentions during Covid particularly the use of section 2 detentions. An FOI reported that GHC had seen a 48% increase in the average monthly numbers of women detained between March and December 2020. Other NHS Trusts (Solent, Cornwall, Northampton) also reported a rise of female detentions by more than a quarter. The Committee noted the assurance provided.

MHA MANAGER REAPPOINTMENT

The Committee was informed of the reappointment of MHA Manager Ivars Reynolds. The reappointment was made via the normal reappointment process of completion of self-assessment forms and two peer review forms, followed by a personal development review with Steve Alvis, Non-Executive Director. The Board would be asked to endorse the reappointment until 31st March 2024.

OTHER ITEMS RECEIVED BY THE COMMITTEE

- The Committee received the Mental Health Operational Group update.
- The Committee was informed that there were no risks on the Corporate Risk Register for oversight by the MHLS Committee.
- A verbal update was provided on Approach to Peer Support Workers.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Endorse** the reappointment of MHAM Ivars Reynolds until 31st March 2024.

DATE OF NEXT MEETING	**21 July 2021**

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 24/0521

RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 29 APRIL 2021

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director • Attendance (membership) – 100% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 12

The Committee received the Finance Report for month 12. In regards to the capital position within the report it was noted that the Trust had spent £10.7m at year end, which was £3k below plan. The Committee agreed that this was an outstanding position considering the challenges faced during the year and thanks were expressed to finance colleagues, as well as those colleagues in IT and Estates who had ensured that the Trust was able to spend its capital envelope.

The Committee congratulated Director of Finance Sandra Betney, Deputy Director of Finance Stephen Andrews and the wider finance team on their outstanding performance. This had been an exceptional year with huge challenges. The achievement of CIPs, hitting the capital plan target and a favourable year-end financial position had been no mean feat. It was acknowledged the performance was also a reflection of the hard work of operational colleagues.

PERFORMANCE DASHBOARD – MONTH 12

The Committee received the Performance Report for month 12 and was informed that all but one of the indicators included in the report had been seen in exception within the past year.
The new indicator was highlighted in the report *Supported Discharge (ESD) – Proportion of new patients assessed within 2 days of notification*. The Committee was informed the indicator was last in exception in October 2019. It was reported the exception related to data quality issues with reporting.

The threshold *Single Point of Clinical Access (SPCA) % calls abandoned* was brought to the Committee's attention; it was reported the threshold challenge directly related to the inclusion of dental within the service management of the area. This resulted in the threshold being breached. It was reported the service had tried to differentiate between routine call abandonment rates and also the dental calls rates and concluded it was specifically relating to dental. This exposed an issue with the dental performance and discussions regarding building a performance dashboard specifically for dental services were ongoing with colleagues.

The Committee noted the Performance Dashboard and the assurance provided.

CAPITAL PLAN 2021/22

The Committee received the Capital Programme 2021/22 report and noted the proposed Capital Plan for the next five years and how Backlog Maintenance would be addressed within the plan.

The Trust has agreed its share of the ICS System Capital envelope for 21/22. It was reported the Trust has a capital envelope of £15.993m for 21/22. This envelope included £5m for the Forest of Dean Hospital new build scheme. The Committee noted that there was a risk that the Trust may not be able to spend all of the £15.993m capital envelope in 21/22, and any slippage would then count against the capital envelope in the following year and reduce the level of funding for new schemes.

The Director of Finance asked for the Committee's consideration to explore the brokerage and then to use it to offset any delays in the FoD Scheme expenditure. It was noted this would be dependent on the Board approving the FoD Business Case when received. The Director of Finance reported the amount allocated to the FoD Scheme remained at £20.4m; however, following additional cash and balance sheet modelling it was noted this could be increased to £25m, dependent on Board approval of the budget.

The proposed capital plan included significant expenditure in Backlog Maintenance. In building this plan the Capital Management Group had considered the significant backlog maintenance issues identified in the recent 6 facet surveys completed across the Trust's estate. This plan addresses all outstanding Condition C & D High or Significant risk backlog maintenance issues in 2021/22.

The Committee noted that no land and building disposals were planned for 21/22. These have been pushed back to 22/23 and 23/24. They have been valued in the plan at Net Book Value rather than Disposal value as per the latest capital guidance.

The Committee approved the capital budgets for 2021/22 and approved in principle the five-year capital plan.

FOREST OF DEAN PROGRESS REPORT

The Committee received a verbal update on progress of the FoD Hospital Development and the Committee was informed that the latest figures received anticipated a current build cost of £23.7m. This posed a challenge, noting the last affordability position approved by the Trust Board was £20.4m
The Director of Strategy and Partnerships informed the Committee of the change in the design of the hospital to a two-storey build. The Committee was informed of work taking place to assess different creative solutions to reduce the cost, including some design changes. A level of compromise was expected which involved issues with inpatient access and decreased natural light. The high-level scrutiny involved in the design was noted. It was reported that a Value for money (VFM) assessment had been completed.

OTHER ITEMS RECEIVED BY THE COMMITTEE

- The Committee received a report and supporting presentation on **System Operational Planning 2021/22.**
- The Committee received the **Digital Strategy** and this was endorsed prior to submission to the May Trust Board.
- The Committee received and considered the updated **Board Assurance Framework.**
- The Committee received the **Risk Register** and noted the information and assurance provided.
- The Committee received the **HR Policies and Procedures update** informing the Committee of the review and amendments made to the Flexible Working Policy and Procedure.

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**24 June 2021**

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 25/0521

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 06 MAY 2021

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

PROGRESS REPORT: The Committee received and noted the Internal Audit progress report.

MANAGING RISK IN THE NHS REPORT: The Committee received the *Managing Risk in the NHS* report from the Trust's Internal Auditors and it was agreed that it would be reviewed against the Trust's Board Assurance Framework.

INTERNAL AUDIT REPORTS: The Committee received the following Internal Audit reports:

Internal Audit	Risk rating
Performance Management	Medium
ESR/ Payroll Alignment	Medium
IT Problem Solving	Medium
Risk Management	Low
System Working	Advisory

AUDIT PLAN 2021/2022: The Committee received a verbal update on the progress of the development of the Internal Audit Plan. This would be received at the next Audit & Assurance Committee meeting.

INTERNAL AUDIT ANNUAL REPORT & HEAD OF INTERNAL AUDIT OPINION (2020/2021) – DRAFT: The Committee was informed that the Internal Audit Annual Report and Head of Internal Audit Opinion would be received at the next meeting of the Audit and Assurance Committee.

EXTERNAL AUDIT

PROGRESS REPORT & TECHNICAL UPDATE: The Committee received an update on recent and planned external audit activities. The Committee was informed that the interim audit had been completed and the final audit had commenced. The findings would be brought to the next meeting of the Committee.

COUNTER FRAUD, BRIBERY & CORRUPTION

PROGRESS REPORT: The Committee received the Counter Fraud, Bribery and Corruption Progress Report. It was brought to the Committee's attention the NHS CFA requires all NHS providers to sustain their compliance with the standards for countering fraud, bribery and corruption. The new standards for the year were implemented in January 2021. For 2020/2021, the Annual Self Review Tool (SRT) (the mechanism used to annual report compliance against the standards) has been replaced by the Counter Fraud Functional Standard Return (CFFSR). Despite all activity for the year being devised and undertaken in accordance with the previous standards, the CFFSR must be based on the new standards which have a greater level as specificity. This will result in an increase in red and amber ratings for the Trust in certain areas. The NHS CFA has acknowledged that this will be a base line

measurement only, and there will be an increase in red and amber ratings. The counter fraud workplan for 2021/2022 identifies the work required for the Trust to meet the new requirements.

The Committee was informed that the total days of agreed activity had increased from 200 to 295 days for the 2021/20022.

It was reported there had been four fraud allegations since the beginning of the financial year which were ongoing. It was highlighted that three of the allegations related to working when reported sick. HR had been notified.

The draft annual report for 2020/21 and the work plan for 2021/2022 were noted.

DRAFT ANNUAL REPORT

The Committee received the draft Annual Report and noted that the report had been prepared in line with the NHS Foundation Trust Annual Reporting Manual for 2020/21. The Committee discussed the draft report and proposed minor amendments. The Committee noted the update and provided feedback for consideration with particular focus on the Annual Governance Statement, Compliance with the NHS Foundation Trust Code of Governance and the Accountability Section.

DRAFT ANNUAL ACCOUNTS (INCLUDING ACCOUNTING POLICY REPORT)

The Committee received the Draft Annual Accounts which showed the draft position of the final accounts for 2020/21. The Committee:

- Received the draft Accounts
- Approved the updates to the Accounting Policies
- Endorsed the Trust's assessment of Going Concern and associated disclosures and recommended statements
- Noted the reconciliation from the management reported position to the Accounts

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance report which provided an update on actions taken under delegated powers since the last meeting of the Committee. The Director of Finance reported debtors had decreased by £44k since month 9. It was noted the Better Payment Policy information demonstrated close to the 95% required target. The Committee was advised of one breach of SFIs.

LESSONS LEARNED – LIGATURE REMOVEAL PROJECT WOTTON LAWN

The Committee received and considered the Lessons Learned Report on the Ligature Removal project at Wotton Lawn.

GOVERNANCE COMPLIANCE REPORT

The Committee received the Governance Compliance Report providing assurance on the progress and achievement with meeting the required standards for registers, held and maintained in line with statutory requirements and good practice.

OTHER ITEMS RECEIVED BY THE COMMITTEE

- The Committee received and noted the **Board Assurance Framework (BAF)**
- The Board received and noted the **Corporate Risk Register**

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**26 MAY 2021**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 26/0521

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 11 MAY 2021

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive Director • Attendance (membership) – 71% • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD

The Committee received the Quality Dashboard and it was highlighted that the Trust was identified by the Health Service Journal (HSJ) as being within the top six highest scoring NHS Trusts based upon the Staff Friends and Family Test (FFT) within the Annual Staff Survey. The Committee requested a breakdown of the FFT results by team or service for the next meeting to seek assurance that the results are representative of the whole Trust.

The Committee was pleased to note the reduction in Covid 19 inpatient deaths reported in the dashboard. Work would take place to streamline the dashboard with a view to moving the reporting of Covid vaccinations and infection rates to "business as usual".

The Committee received a deep dive focus on Pressure Ulcers which offered an excellent level of assurance of the work and developments taking place.

There was continued focus and quality improvement work taking place to enhance recovery within the complaint management process, which included the development of a new internal quality indicator for 21/22 regarding time to completion of complaints. It was noted that 100% of complaints received in March were acknowledged within the three-day time frame. The committee requested further information to track progress on resolving complaints for the next meeting, whilst acknowledging that it could take 6 months to recover from the COVID disruption.

The Committee received, noted and discussed the contents of the report.

PATIENT SAFETY & EXPERIENCE REPORT

The Committee received the Patient Safety and Experience Report informing the Committee of the details of Serious Incidents Requiring Investigation (SIRIs) declared and submitted, information on the number of complaints, concerns and compliments received and an overview of medical alerts received and their current action status.
The Committee noted:

- There were 3 SIRIs declared in March 2021
- There are currently 11 active SIRIs in investigation. All investigations are on target for submission within the NHS framework timeframes
- The PCET received 10 formal complaints in March 2021
- There are currently 72 open complaints. 4 complaints are under review with the PHSO
- A total of 1,596 FFT responses were received; 94% reported a positive experience
- 2 Learning from Patient Experience notices (LfPE) were shared via the Trust's Quality intranet pages and governance meetings.
- The PCET remain in recovery following the national suspension of investigating complaints to support Trusts' responses to the Covid pandemic.

CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register and it was reported that there were 13 corporate risks, all of which had been reviewed by their designated risk owners. There had been one reduction to risk *ID92 Covid-19 - Litigation - Clinical Covid-19 - Litigation - Employer Liability Claims*.
The Committee was informed that one new risk had been added to the register relating to *Patient record Document Storage.* The Committee noted the information and assurance provided.

QUALITY ASSURANCE GROUP SUMMARY REPORT

The Committee sought assurance that the right resources were being put into place to tackle issues in the Eating Disorders Service. Recovery work was underway and demand and capacity mapping for the service was being reviewed, with discussions having taken place with system partners and the CCG regarding accessing additional funding for the service. The Committee received assurance that all patients who were on waiting lists for additional time were contacted on a monthly basis to understand developments of their wellbeing and whether they were deteriorating. A lot of work was being developed as part of the waiting list initiative and ensuring patients were offered additional support and access whilst awaiting treatment. The Committee agreed that the issue of referrals and demand and capacity for both the CAMHS and eating disorder service should be escalated to the Trust Board.

RESUSCITATION TRAINING COMPLIANCE REPORT – QUARTER 4

The Committee received the Resuscitation Training Compliance Report for quarter 4, providing an update on the delivery of Resuscitation Services for the year 2020/21. The Committee noted that good progress with training compliance had been made since the report had been written and assured the Committee that this remained a key action area. The Committee acknowledged the huge efforts from training and operational team colleagues in recovering this position.
The Committee reviewed the report and the level of assurance provided.
The Committee endorsed the proposal for standardising and harmonising the work streams.

OTHER ITEMS RECEIVED BY THE COMMITTEE

The Committee received a **clinical presentation on Quality Improvement.**
The Committee **received, reviewed** and **noted** the information relating to quarterly patient safety incident reporting.
The Committee received the **Board Assurance Framework.**
The Committee received an update on the **Quality Strategy.**
The Committee received and noted the **draft Quality Account.**
The Committee received and noted the **Safeguarding update.**

ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	**01 July 2021**