# 2GETHER NHS FOUNDATION TRUST
## BOARD MEETING
## THURSDAY 30 JULY 2015 AT 10.00AM
## TRUST HEADQUARTERS, RIKENEL, GLOUCESTER
## *AGENDA*

| | | | |
|---|---|---|---|
| 10.00 | 1 | **Apologies** | |
| | 2 | **Declaration of Members Interests** | |
| 10.05 | 3 | **Minutes of the Board meeting held on 28 May 2015** | **PAPER A** |
| | 4 | **Action Points and Matters Arising** | |
| 10.10 | 5 | **Questions from the Public** | |
| **IMPROVING QUALITY** | | | |
| 10.15 | 6 | **Patient Experience Presentation** | **PRESENTATION** |
| 10.45 | 7 | **Non-Executive Audit of Complaints – Q4 2014/15** | **PAPER B** |
| 10.55 | 8 | **Performance Dashboard Report** | **PAPER C** |
| 11.05 | 9 | **Medical Revalidation Annual Report** | **PAPER D** |
| **IMPROVING ENGAGEMENT** | | | |
| 11.15 | 10 | **Chief Executive's Report** | **PAPER E** |
| **11.30am – BREAK** | | | |
| **IMPROVING SUSTAINABILITY** | | | |
| 11.40 | 11 | **Summary Financial Report** | **PAPER F** |
| 11.45 | 12 | **Organisational Development Strategy** | **PAPER G** |
| 11.55 | 13 | **Quarterly Reporting to Monitor – Q1 2015/16** | **PAPER H** |
| 12.05 | 14 | **Board Committee Summaries**<br>• MH Legislation Scrutiny Committee – May and July<br>• Audit Committee – May and July (inc. Annual Report 14/15)<br>• Delivery Committee – May, June and July<br>• Governance Committee – May, June and July<br>• Charitable Funds Committee – July | <br>**PAPER I1**<br>**PAPER I2**<br>**PAPER I3**<br>**PAPER I4**<br>**PAPER I5** |
| **INFORMATION SHARING (TO NOTE ONLY)** | | | |
| 12.25 | 15<br>16<br>17 | Chair's Report<br>Council of Governor Minutes – May 2015<br>Use of the Trust Seal | **PAPER J**<br>**PAPER K**<br>**PAPER L** |
| 12.35 | 18 | **Any Other Business** | |
| 12.40 | 19 | **Date of Next Meeting**<br>Thursday 24 August 2015, Trust HQ, Rikenel, Gloucester | |

## QUESTIONS FROM THE PUBLIC

**Written questions for the Board Meeting**

People who live or work in the county or are affected by the work of the Trust may ask:

- the Chairperson of the Trust Board;
- the Chief Executive of the Trust;
- a Director of the Trust with responsibility; or
- a chairperson of any other Trust Board committee, whose remit covers the subject matter in question;

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

**Notice of questions**

A question under this procedural standing order may be asked in writing to the Chief Executive by 10 a.m. 4 clear working days before the date of the meeting.

**Response**

A written answer will be provided to a written question and will be given to the questioner and to members of the Trust Board before being read out at the meeting by the Chairperson or other Trust Board member to whom it was addressed.

**Additional Questions or Oral Questions without Notice**

A member of the public who has put a written question may, with the consent of the Chairperson, ask an additional oral question on the same subject. The Chairperson may also permit an oral question to be asked at a meeting of the Trust Board without notice having been given.

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

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

**Unless the Chairperson decides otherwise there will not be discussion on any public question.**

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

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

For further information, please contact the Assistant Trust Secretary on 01452 894165

# [2]GETHER NHS FOUNDATION TRUST

## BOARD MEETING
## THE KINDLE CENTRE, HEREFORD
## 28 MAY 2015

**PRESENT**

Ruth FitzJohn, Chair
Shaun Clee, Chief Executive
Marie Crofts, Director of Quality
Martin Freeman, Non-Executive Director
Charlotte Hitchings, Non-Executive Director
Andrew Lee, Director of Finance and Commerce
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of Organisational Development
Jonathan Vickers, Non-Executive Director

**IN ATTENDANCE**

Ron Allen, Tewkesbury Borough Council
Adele Butler, Nurseline Healthcare
Richard Castle, Trust Governor
Gavin Davies, Assistant Director, Communications
Anna Hilditch, Assistant Trust Secretary
Dawn Lewis, Public Governor, Herefordshire
John McIlveen, Trust Secretary
Bren McInerney, Member of the Public
Ian Stead, Healthwatch Herefordshire
Al Thomas, Trust Governor
Eight members of the public including colleagues from local military organisations and charities

## 1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Maggie Deacon, Paul Winterbottom and John Saunders.

1.2 Ruth FitzJohn welcomed people to the meeting, thanking those colleagues from local military charities and organisations who had attended an earlier session on the launch of 2gether's Corporate Covenant. [2]gether was the first MH Trust in the country to sign up, as an organisation to a Corporate Covenant and the Chief Executive had signed this on behalf of the Trust.

## 2. DECLARATIONS OF INTERESTS

2.1 Charlotte Hitchings declared an interest in relation to her involvement in a business being developed by a colleague in the area of leadership and management training in resilience.

## 3. MINUTES OF THE MEETING HELD ON 26 MARCH 2015

3.1 The minutes of the meeting held on 26 March were agreed as a correct record and would be presented to the Trust Chair for sign off.

## 4. MATTERS ARISING AND ACTION POINTS

4.1 The Board reviewed the action points, noting that these were now complete or progressing to plan.

4.2 The Director of Engagement and Integration informed the Board that work was currently taking place to improve the complaints process and it had therefore been agreed that the

quarterly Non-Executive Director audit of complaints report would be delayed until the next meeting, whilst this improvement work was carried out.

4.3 Bren McInerney asked the Board to reconsider the publishing of Trust Board papers on the website before the meeting. Bren had received a set of papers electronically for the meeting; however, he said that he would welcome receiving these earlier to enable him to review them thoroughly before the meetings.

## 5. MILITARY COVENANT

5.1 The Board welcomed Martin Walsh (Royal British Legion), Leslie Hart (Herefordshire Veterans Group) and Penny Jones (Herefordshire County Council) who had kindly agreed to speak about why [2]gether's Corporate Covenant was important to patients who have a military background. He also spoke about the work taking place both locally and nationally to support military veterans and their families with their health and wellbeing.

5.2 Martin Walsh informed the Board that the RBL was there to assist ex-service personnel and their families by offering support with benefits, accommodation and independent allowance. Martin said that the majority of people leaving the forces had a positive experience; however, there was a small percentage that did need some help and support. One of the key problems experienced was access to services. People may attend their GP surgery and get a diagnosis of PTSD but there was no signposting or guidance on where to go next for help. People would often deteriorate and only then seek further help when they have hit rock bottom. Martin said that since the setting up of the Let's Talk service in Herefordshire, there was now somewhere for people to go and once referred to the service, people would be guaranteed to be seen within 28 days. He said that this was seen as an excellent and valuable service.

5.3 Leslie Hart said that she had received many referrals from veterans with MH problems and the Herefordshire Veterans Group was there to offer help, advice and support. She said that many people find it difficult adapting back to "civvie street" once they have left the forces. The group also gave people the opportunity to help each other by giving advice and support.

5.4 Penny Jones was a member of the Civilian Military Task Group which had been set up at Herefordshire County Council. Working in partnership with the RBL and SSAFA a military services helpdesk had been set up 2 days a week where people could call in and have the opportunity to meet with a case worker to get some support. This was a key development in Herefordshire which was proving beneficial.

5.5 The Director of Engagement and Integration said that she was pleased to hear the positive experiences from people who had used the Let's Talk service and made reference to a compliment that had recently been received from the regiment based at South Cerney.

5.6 Colleagues were asked whether there was anything that [2]gether could do to improve services or any enhancements that would be welcomed. Martin Walsh said that he was keen to set up a MH Network involving local health organisations and military groups.

5.7 The Chief Executive said that [2]gether was looking to secure funding from Combat Stress to set up an outreach/military front end service which would be specifically for veterans and would be staffed by people with military experience to help with understanding. Martin Walsh welcomed this idea. He said that there were many private counselling organisations

that had been set up; however, knowing that [2]gethers Let's Talk service was part of the NHS and therefore regulated made a difference.

5.8 Tim Howsen (SSAFA) said that he helped to deliver the military helpdesk in Herefordshire and noted that the volunteers all had military experience. He said that he would welcome the idea of a MH Network and would like to get more involved in ensuring joined up working with charities and local NHS organisations.

5.9 Alan Haddy (RBL) reminded the Board about Reservists. He said that these people experienced the same problems as full time military personnel but they were volunteers and came back to regular jobs. The Director of Organisational Development agreed that educating the family of a Reservist of the key signs to look out for was important. She added that it was an important area to be mindful of as an employer.

5.10 Ruth FitzJohn thanked everyone for their contributions and for what had been an enlightening and productive session.

## 6. SERVICE EXPERIENCE REPORT 2014/15 QUARTER 4

6.1 The Director of Engagement and Integration presented this report which provided assurance that service experience information about Trust activity in Quarter 4 2014/15 has been reviewed in depth, scrutinised for themes and considered for both individual team and general learning across the organisation.

6.2 The Board noted that the level of assurance was high in relation to the organisation having listened to, heard and understood patient and carer experience of [2]gether's services. This was across all domains of feedback including complaints, concerns, comments and compliments. Survey information has also been used to understand service experience. The high level of assurance will be maintained by the rigorous and sustained effort to gain service experience feedback from multiple sources on a continuous basis and by responding swiftly to people particularly where the feedback is of a negative nature.

6.3 The report identified and recommended four broad themes for general learning and implementation throughout the organisation, including:

- Service users and carers benefit from being involved in setting their care plan and receiving a written copy of the care plan
- Information provision needs to be considered by practitioners at each contact with service users and carers as readiness to receive information varies
- Service users require explanations about the medication that is prescribed for them.
- Service users appreciate literature about spirituality / religion being available to them.

6.4 In summary, between 1st January and 31st March 2015 the Trust received 43 complaints. 29 concerns were expressed and the Trust received 34 requests for advice and support. 457 people told us that they were pleased with our service by giving us a compliment. During the quarter 868 people took part in a survey about their experience of the Trust's services and 88% said that they would recommend our service.

6.5 In relation to complaints, the time taken to close complaints had increased during the quarter and this was noted. The Director of Engagement and Integration informed the Board that the level of complexity of complaints being received had increased and these were more multi-faceted. The Chief Executive said that [2]gether was not as good as it could be around negotiating timescales and there was a need to talk to complainants and agree a

mutually agreeable timescale. In relation to enabling a swifter response time to people who complain, several actions were in hand including:

- Discussions with Locality Directors to ensure that complaint investigations are rigorous and undertaken within the allocated timeframe
- Continued effort to recruit to vacancies in the Service Experience Team
- Co-ordination of diaries for final response letter signatures

6.6 The Director of Quality noted that only 66% of people had said that they had received a copy of their care plan. This was a slow yet negative direction of travel and it was suggested that if the Trust was doing this then there may be a need to rethink how it was doing this.

6.7 Charlotte Hitchings made reference to one of the comments received in the report relating to support for self-harm. She said that the Delivery Committee was carrying out work to review incidents of Deliberate self-harm and suggested that the Director of Engagement and Integration liaise with the CYPS Service Director to triangulate the data.

***ACTION: Director of Engagement and Integration to liaise with the CYPS Service Director to triangulate the data around self-harm.***

6.8 The Director of Organisational Development said that she would welcome receiving information about the specific concerns raised in relation to staff attitude to see whether any themes or learning could be drawn out.

***ACTION: Director of Engagement and Integration to provide the Director of OD with the specific concerns raised in the SE Report in relation to staff attitude***

6.9 The Board noted the Service Experience Report, agreeing that this was a very clear and helpful report, and acknowledging the efforts of the Service Experience Team in pulling the report together. The Director of Engagement and Integration informed the Board that she would be carrying out some work to produce a more concise Service Experience Report for future meetings.

## 7. QUALITY REPORT 2014/15

7.1 The Board received the final draft of the Annual Quality Report which summarised the progress made in achieving targets, objectives and initiatives identified, and has been collated following an extensive review of all associated information received from a variety of sources throughout the year.

7.2 The priorities for improvement during 2015/16 have been agreed in consultation with both internal and external stakeholders. These priorities were categorised under the three key dimensions of effectiveness; user experience and safety. The draft quality priorities were reviewed by the Council of Governors at its meeting on 13 March 2015 and they chose one of the indicators for our external auditors to audit as part of the external audit process of the Quality Report.

7.3 The draft Quality Report has been shared with commissioners in Herefordshire and Gloucestershire, and also both Healthwatch organisations and the Health and Community Care Overview and Scrutiny Committees (HCOSCs) in the two counties, in order for them to provide formal feedback which is published as part of the final report. Herefordshire HCOSC has not commented.

7.4 The Board noted the requirement that External Assurance on the Quality Report (provided by Deloittes) must provide a limited assurance report on the content of Quality Reports produced by Foundation Trusts. In providing this assurance, Deloittes have reviewed the draft report for consistency and have also tested the following mandated indicators:

- Minimising delayed transfers of care, (DTOC)
- Admissions to inpatient services has access to crisis resolution home treatment teams
- 48 Hours follow up (local target)

Deloittes have indicated that they anticipate issuing an unmodified opinion in their public report and have identified a number of recommendations following testing of these indicators.

7.5 Formal ratification of the Quality Report 2014/15 took place at the Audit Committee on 26 May and will be included as part of the Trust Annual Report, to be submitted to Monitor by 30 May 2015.

7.6 The Board received the Quality Report and thanked all colleagues for their contributions.

## 8. PERFORMANCE DASHBOARD

8.1 The Board received the Performance Dashboard outturn report for 2014/15. It was noted that this had been scrutinized in detail at the Delivery Committee. Overall performance was good and there had been some particularly welcome achievements during the year, notably the Gloucestershire and Herefordshire IAPT services achieving the 15% access target.

8.2 The Board noted that the CYPS access rate had decreased; however, the Trust had made significant progress in managing long waiters with no one waiting over 18 weeks. This was getting closer to the target of 95% being seen within 12 weeks and it was noted that additional funding had been received from Gloucestershire commissioners to continue to progress this target.

8.3 The Board noted those targets that had not been achieved during the year and was assured that actions were in place to address these for 2015/16.

8.4 Ruth FitzJohn said that she was proud to be part of an organisation that would knowingly miss a target if it was in the best interest of service users. She agreed that this demonstrated an excellent performance in what had once again been a tough year and asked that the Board's thanks be given to all Service Directors and their teams for their efforts.

## 9. CHIEF EXECUTIVE'S REPORT

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

9.2 Richard Layard, Labour peer and programme director of the London School of Economics' Centre for Economic Performance, has written a briefing on what he believes should be the main priorities regarding mental health services in the next five years. He particularly focuses on expansion of access to IAPT, which he argues "costs commissioners nothing" through savings released elsewhere. The Chief Executive agreed to make this briefing available to Board members for information.

***ACTION: Chief Executive to circulate the link for Board members to access the Richard Layard briefing re: the main priorities regarding mental health services in the next five years***

9.3 The Board noted the extensive engagement activities that had taken place during the past month, and received an update on progress with implementing the mobile working initiative. Bren McInerney asked what the impact was of all of the engagement activities. The Chief Executive said that the purpose of carrying out such activities was to ensure that [2]gether could inform, could be informed and could influence. The performance dashboard was a good demonstration of this with the Trust's ability to get out and speak to commissioners about services and the potential need for additional funding.

## 10. ANNUAL MEMBERSHIP REPORT

10.1 This report provided a full analysis of the 2014/15 financial year membership data.

10.2 There were 7369 members of our Trust at the end of the 2014/15 financial year which included 362 new members and 329 people who were removed from the database. It was noted that the majority of people left the Trust due to "no forwarding address" rather than a lack of interest; however, further work on engaging with Members would assist in encouraging people to let us know if they move house. On average, 30 people become members of the Trust every month.

10.3 Trust Membership currently appeals more to women than men, to people aged 65 and to those with self-reported disability. Further tactics will be developed to encourage membership from men, younger people, people from minority ethnic groups and from people who are without disability in order to reflect an accurate representation of the constituents of Gloucestershire and Herefordshire.

10.4 Membership in Herefordshire has seen the largest increase during the year; however, it is still significantly lower than in Gloucestershire. More work was needed to ensure that Trust membership was representative of the population and communities we serve.

10.5 The Board noted that this report focused purely on the statistical data, not engagement. A Governor working group had been set up to look at the key areas of engagement and to progress this area of work.

## 11. SUMMARY FINANCE REPORT

11.1 The Board received the Finance Report that provided information up to the end of April 2015. The month 1 position was a deficit of £75k compared to the planned deficit of £99k and the forecast outturn was a £497k deficit. The Trust had a Continuity of Service Risk Rating of 4.

11.2 The 2015/16 contracts with Gloucestershire CCG, Herefordshire CCG and Worcestershire Joint Commissioning Unit have been signed.

11.3 Budgets were approved by the Board in March for 2015/16 and the Trust submitted its one year Operational Plan to Monitor on the 10th May 2014.

11.4 The Director of Finance and Commerce informed the Board that the Trust had spent £500k on capital expenditure during month 1 which was in line with the Monitor target.

11.5 The Annual Accounts had been received and approved at the Audit Committee meeting on 26 May and the External Auditors had given an unqualified audit opinion on these. The Board asked that their thanks be given to the Trust's Finance team for all of their efforts.

## 12. PROVIDER LICENCE DECLARATIONS

12.1 It is a requirement of the governance condition of the Trust's licence that the Trust submits a Corporate Governance Statement to Monitor within three months of the end of each financial year. The governance condition 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

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

12.3 Monitor also require the Board to make declarations regarding:

a) governance systems and processes in place where the Trust is a member of, or considering taking part in a major joint venture or Academic Health Science Centre (AHSC).
b) the provision of necessary training to Governors, pursuant to Section 151(5) of the Health and Social Care Act 2012.

12.4 Foundation Trusts are also required to make an annual declaration to Monitor regarding their systems for compliance with provider licence conditions (General Condition G6). This declaration is in two parts, with part 1 referring to the financial year just ended, and part 2 referring to continuing to meet the criteria for holding a licence. In respect of part 1 of this declaration the issue of a letter of contravention from the Health and Safety Executive, deeming the Trust to have been in breach of the Health and Safety at Work Act, means that the Trust failed to meet Condition FT4 (5h) of its licence, namely to establish and effectively implement systems and/or processes to ensure compliance with all applicable legal requirements. In respect only of the first part of this declaration, the Board was therefore recommended to declare 'Not Confirmed' and to provide appropriate explanatory information to Monitor as required by the declaration template. Given that issues within the Letter of Contravention have already been addressed through implementation of an action plan arising from the Trust's internal review, the Board was invited to make a declaration of 'Confirmed' in respect of part 2 of this declaration, which refers to forward compliance. The Chief Executive noted that the HSE investigation had not yet concluded. The incident that had taken place at the PICU occurred outside the reporting period but he wanted the Board to be assured that processes were in place to review this, with an external thematic review planned.

12.5 All declarations must be made having regard to the views of Governors, and the Board noted that Governors had been invited to provide comment on this report in advance of the Board meeting and thanks were given to those who had contributed. The issue of Governor Training had been raised, accepting that this be "confirmed" this year with the understanding that more was needed next year.

12.6 The Chief Executive informed the Board that the Executive Team had discussed this report and fully recognised that the Trust was not where it wanted to be in terms of Datix and

incident reporting systems. However, the Governance Committee reviewed this situation regularly and assurance was given that progress was being made.

12.7 The Board accepted and approved the recommendations set out within the report.

## 13. CHANGES TO THE TRUST CONSTITUTION

13.1 This report sets out proposed changes to the Trust Constitution, in particular to the composition of the Council of Governors, as follows:

- The Medical and Nursing Staff Class will be dissolved on 3 October 2017, to be replaced by separate Medical and Nursing Staff Classes
- Minimum membership numbers for these new classes will be introduced on 3 October 2017, set at 50 and 100 respectively
- Provisions in the constitution made redundant once these changes are enacted on 3 October 2017 will be removed
- Public Governor representation for the Stroud constituency will be reduced with immediate effect to 2 Governors, in line with all other local public constituencies
- The Appointed Governor position for the Gloucestershire District and Borough Councils will be removed with immediate effect
- The size of the Council of Governors will reduce from 29 members to 27

13.2 New election rules have been approved by Monitor and are now in force. The new rules enable electronic voting to take place for Governor elections. Changes to the election rules do not qualify as a change to the constitution requiring the agreement of the Board and Council of Governors. The new election rules will therefore be incorporated into the Constitution regardless of the agreement of the changes proposed in this report.

13.3 The Trust does not need to obtain permission from Monitor for these changes to take place to its Constitution. Because the changes do not affect the powers of Governors, there is no requirement to seek approval for these changes at the Annual Members' Meeting.

13.4 These proposals were considered and approved by the Council of Governors at its meeting on 12 May 2015.

13.5 The Board approved the changes to the Constitution and agreed that a copy of the revised Constitution would be sent to Monitor for publication on their website.

***ACTION: Revised Constitution to be sent to Monitor for publication of their website***

## 14. REVIEW OF BOARD COMMITTEE PROCESSES

14.1 Nikki Richardson had been asked to lead on carrying out a review of Trust Board and Committee processes, looking at the relationship between them and reviewing paperwork.

14.2 Nikki informed the Board that she had now attended meetings of all Board committees and had also met with and received feedback from the Committee Chairs. A report was being drafted with her findings which would be presented at the Executive Committee for consideration.

## 15. BOARD COMMITTEE REPORTS – AUDIT COMMITTEE

15.1 The Board received and noted the summary report from the Audit Committee meeting held on 21 April. A special Audit Committee had taken place on 26 May and the Board was asked to note that the Annual Accounts and Annual Report had been approved.

## 16. BOARD COMMITTEE REPORTS – GOVERNANCE COMMITTEE

16.1 Martin Freeman presented the summary report from the Governance Committee meeting that had taken place on 24 April. The Committee had been pleased to note that Herefordshire Children's Services had received notification from the Parliamentary Undersecretary of State for Children and Families that the improvement notice (implemented in 2012) was lifted on 24th March 2015. Martin Freeman informed the Board that the Governance Committee received quarterly updates on Safeguarding which had increased assurance in this important area.

16.2 A verbal report was given from the meeting held on 20 May. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- There had been 7 reported serious incidents in April; however, this increase was felt to be seasonal rather than due to any specific trends.
- Progress had been made on the Homicide action plan but the Committee asked for better real time reporting at future meetings
- A positive report on safe staffing levels was received and the Committee noted the introduction of a new measure around Staff contact time
- The Greenlight Toolkit for MH was received which offered good assurance, with 26 of the 39 measures reported as compliant and 8 making good progress
- A review of the key Governance risks was carried out and assurance received around those 6 risks listed as providing limited assurance.
- The number of NHSLA claims had reduced and subsequently there had been a reduction in the level of the Trust's financial contribution
- The IG Toolkit was received which offered positive assurance
- A CQC Update report was received and the Committee noted the intelligent monitoring information which rated [2]gether overall as "Low risk"

## 17. BOARD COMMITTEE REPORTS - DELIVERY COMMITTEE

17.1 Charlotte Hitchings presented the summary report from the Delivery Committee meeting that had taken place on 25 March. This was noted.

17.2 A verbal report was given from the meeting held on 27 May. A full written report would be presented at the next Board meeting. Key items received and discussed at the meeting included:

- The Committee received the performance dashboard outturn report for 2014/15 and congratulations were given to the teams for an excellent year-end achievement.
- Additional assurance was sought by the Committee around safeguarding and Rapid Tranquilisation training
- Discussions took place around data quality and the impact of this on the ability to correctly monitor data
- The use of agency and bank staff in Herefordshire was discussed and the varying availability of bank staff in Herefordshire

- Assurance was sought on Deliberate Self harm and those people who had been previously discharged from services.
- A report on Autistic Spectrum Services was received which would be shared with Trust Governors for information
- Locality reviews from Countywide and CYPS were received and assurance was provided around year-end overspends which had arisen from sickness, vacancies and an increase in complex needs of service users. In terms of quality and safety, it was noted that [2]gether would overspend if there was a clinical need to do so.
- The Committee received and approved the Heatwave Plan
- A report on the successful RiO implementation was received and it was agreed that the Committee would receive a report in 6 months' time from clinicians on the usability of the system. The Board agreed that the transfer to the new RiO system appeared to have been very smooth and positive.

## 18. BOARD COMMITTEE REPORTS – DEVELOPMENT COMMITTEE

18.1 Jonathan Vickers provided a verbal update from the Development Committee meeting held on 22 May 2015.

18.2 Key items received and discussed at the meeting included:
- A presentation on the implementation of Service Line Reporting
- Capital Expenditure and improved year end spend.
- Review of Trust strategies and progress being made with these

## 19. BOARD COMMITTEE REPORTS – MH LEGISLATION SCRUTINY COMMITTEE

19.1 Martin Freeman provided a verbal update from the MH Legislation Scrutiny Committee meeting held on 22 May 2015. A full written report would be presented at the next Board meeting.

19.2 Key items received and discussed at the meeting included:
- DoLS Applications follow up
- Audit of S17 Leave arrangements
- Policy on the receipt of MH documents
- Human Rights Act

19.3 The Board was also informed of changes to the MH Act Managers with 2 new appointments, 2 reappointments and 2 retirements. The Board expressed their thanks to Anne Robinson and Elke Stratford for their work and contributions over the past 12 years.

## 20. INFORMATION SHARING REPORTS

20.1 The Board received the following reports for information:
- Chair's Report
- Minutes from the Council of Governors meeting held on 12 March 2015

20.2 Ruth FitzJohn informed the Board that she had written to all of the newly elected MPs and Councillors in Gloucestershire and Herefordshire following the recent election. She said that 100 letters had been sent and approximately 10-15 people had come back asking for more information about [2]gether which was encouraging.

## 21. ANY OTHER BUSINESS

21.1 There was no other business.

21.2 Bren McInerney expressed his thanks for the openness of the Board meeting and its Chair. He said that [2]gether had an excellent culture and he welcomed the opportunity to attend meetings and ask questions.

## 22. DATE OF THE NEXT MEETING

22.1 The next Board meeting would take place on Thursday 30 July 2015, at Trust HQ, Rikenel, Gloucester.

**Signed: ……..** **Date: …….**
**Ruth FitzJohn, Chair**

**BOARD MEETING**
**ACTION POINTS**

| Date of Mtg | Item ref | Action | Lead | Date due | Status/Progress |
|---|---|---|---|---|---|
| 26 Mar | 13.4 | Organisational Development Strategy to be reviewed and a final version presented back to the Board in May | Carol Sparks | July | On agenda for July Board meeting |
| 28 May | 6.7 | Director of Engagement and Integration to liaise with the CYPS Service Director to triangulate the data around self-harm. | Jane Melton | | Complete |
| | 6.8 | Director of Engagement and Integration to provide the Director of OD with the specific concerns raised in the SE Report in relation to staff attitude | Jane Melton / Carol Sparks | | Complete |
| | 9.2 | Chief Executive to circulate the link for Board members to access the Richard Layard briefing re: the main priorities regarding mental health services in the next five years | Shaun Clee | June | Complete http://cep.lse.ac.uk/pubs/download/EA035.pdf |
| | 13.5 | Revised Constitution to be sent to Monitor for publication of their website | John McIlveen | June | Complete |

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|---|---|---|---|
| **Agenda Item** | **7** | **Enclosure** | **Paper B** |

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|---|---|
| **Report to:** | 2gether NHS Foundation Trust Board – 30 July 2015 |
| **Author:** | Maggie Deacon, Non-Executive Director |
| **Presented by:** | Maggie Deacon, Non-Executive Director |

**SUBJECT:** **NON EXECUTIVE DIRECTOR AUDIT OF COMPLAINTS – QTR 4 2014/15**

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

**EXECUTIVE SUMMARY**

A Non-Executive Director Audit of Complaints was conducted covering three complaints that had been closed between 1 January and 31 March 2015.

The Board can draw **significant assurance** that a Complaints policy and process are in place. However, on this limited evidence, there is only **low assurance** that the policy and process are being fully implemented and given sufficient priority within localities.

**RECOMMENDATIONS**

The Board is asked to note the report and support the recommendations highlighted in section 3

## 1. INTRODUCTION

1.1 An audit was conducted covering three complaints closed between January and March 2015. The electronic files relating to these complaints were reviewed. An audit checklist was used in order to appraise the quality of the process for handling each complaint and final response to the service user. The complaints were chosen randomly and involved three separate localities of the Trust. It is acknowledged that this audit took place at a particularly difficult time for the Complaints Team, with most members being temporary staff.

## 2. SUMMARY OF FINDINGS

2.1 This was the auditor's first Audit of Complaints. The auditor had not used the previous paper system and commented that it was not possible to make a comparison between the previous paper based system and the current electronic system of storing information about complaints. However, it was noted that moving between complaint records in the electronic system was somewhat

challenging and time consuming. The auditor has received assurance that the new Datix system would improve the functionality of the complaints system.

2.2 It was observed that the majority of files were saved as a Word document, which meant that they could be changed. It was suggested that this could be an issue if there was any legal challenge. Saving final versions of critical documents as PDF files would offer more assurance of rigor.

**2.3 Key Areas of Concern**

2.3.1 Significant delays were seen in all three cases, with the responses sent beyond the performance target agreed with the person who complained. The main causes were:

1. Delay due to length of time taken from first draft response to final response, and the number of drafts created
2. Delay in appointing an investigator – as much as three weeks in a 25 day target.

2.3.2 In two cases the delay was such that three holding letters were sent.

2.3.3 In two cases, there was no indication that the complaint had been closed on the front sheet.

2.3.4 In all three cases, the learning had not been included on the front sheet and no individual had been named as responsible for ensuring learning is translated into practice. However, learning was identified in other parts of the files. The auditor has been advised that further rigor has been introduced through this through the addition of a process of investigation 'sign-off' by Locality Directors.

2.3.5 Oral complaint issues were not stated in the acknowledgement letter for one complaint.

2.3.6 Administration errors were noted in the files, for example, an 'investigation report' had been filed as "Response to complaint" and in one consent form only 50% of it was visible.

**2.4 Key areas of Good Practice**

2.4.1 Each investigation involved discussion with colleagues as well as a review of clinical records

2.4.2 Records of email and face to face conversations were present in each case

2.4.3 The learning folder was completed in each case

2.4.4 Risk Assessment of the impact of the complaint on the Trust was completed in each case

2.4.5 Where consent was needed this was sought and a record of the consent form was present

## 3 RECOMMENDATIONS

That the:

3.1 Implementation of the new Datix system to check ease of moving between records within and between complaints.

3.2 New Datix system to be reviewed to see how far it can flag missing information.

3.3 Locality Directors to be reminded of the importance of adhering to the Complaints policy and underpinning processes.

3.4 Delays in appointing investigators and in approving final letters to complainants, resulting in a succession of ‘holding letters’ needs to be addressed. Mitigating action needs to be taken by responsible managers to enable promised timetables to be kept.

3.5 Deadlines for sign-off of investigations by the Service Director (or delegate) should be in the diary, so that it can be undertaken in a timely way as a priority action to prevent further delays in the system.

3.6 Letters of acknowledgement and investigation findings need to include all areas raised as concerns, particularly where the initial compliant is oral.

3.7 Service Experience Team to review their processes for saving complaint documents in order that critical files, upon which the Trust might rely as evidence, are saved in PDF format. Administration errors need to be addressed.

3.8 That anonymized examples of complaints are important learning tools for active learning within the Trust. They could, for example, form part of a Board Patient Experience session or role play within induction programmes.

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

| | |
|---|---|
| **Report to:** | 2gether NHS Trust Public Board 30th July 2015 |
| **Author:** | Steve Moore, Interim Head of Information Management and Clinical Systems |
| **Presented by:** | Colin Merker, Director of Service Delivery |
| **SUBJECT:** | **Performance Dashboard to the period to the end of May 2015** |

This Report is provided for:

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

**EXECUTIVE SUMMARY:**

Overview

This report is our first report for the new contract period 2015/16. It provides details on our agreed Key Performance Indicators (KPIs) for the period to the end of May 2015.

It is presented as in previous years setting out our KPIs in the categories of:

- Monitor requirements
- Department of Health requirements (including Never Events)
- Gloucestershire CCG contract
- Herefordshire CCG contract
- Herefordshire DASH contract
- CQUINs

There are some 150 KPIs in total which are required to be reported on a monthly, quarterly and/or annual basis. Of these 150 KPIs some 101 are KPIs that were reported throughout the 2014/15 contract period while some 49 are new KPIs introduced for this year.

For May 2015, 103 KPIs are reportable, of these 76 are meeting the required performance threshold, while 23 are not and 4 are not yet available or under review.

For the 23 indicators not achieving the required performance threshold, various work is underway to identify either process, data quality and/or performance issues that need to be addressed so that the necessary performance level can be achieved. Our Delivery Committee oversee the operational delivery of our services and will be seeking the necessary assurances that are required, so that the required level of performance is achieved at the earliest opportunity.

The table below summarises the position as at the end of May 2015 for each of the KPIs within each of the reporting categories.

| Indicators Reported in Month and Levels of Compliance | | | | | | | |
|---|---|---|---|---|---|---|---|
| Indicator Type | Total Measures | Reportable | Not Yet Required | Compliant | Non Compliant | NYA / UR | % non-compliance |
| Monitor Requirements | 13 | 12 | 1 | 10 | 2 | 0 | 17 |
| Never Events | 17 | 17 | 0 | 17 | 0 | 0 | 0 |
| Department of Health | 10 | 9 | 1 | 8 | 1 | 0 | 11 |
| Gloucestershire CCG Contract | 43 | 21 | 22 | 15 | 6 | 0 | 29 |
| Herefordshire CCG Contract | 29 | 27 | 2 | 16 | 10 | 1 | 37 |
| Herefordshire DASH | 20 | 17 | 3 | 10 | 4 | 3 | 24 |
| CQUINS | 18 | 0 | 18 | 0 | 0 | 0 | 0 |
| Overall | 150 | 103 | 47 | 76 | 23 | 4 | 22 |

Within the detailed reports that follow, new key performance indicators for 2015/16 are shown with ID numbers highlighted in blue. Excluding CQUIN measures agreed for this year, there are 31 new performance indicators, 26 are reportable this month, of which 21 are compliant, 4 are non-compliant and 1 is not yet available as there is an on-going query with respect to methodology.

## Summary Exception Reporting

The following 23 key performance thresholds were not met at the **end of May 2015:**

### Monitor Requirements

- 1.04 – Care Programme Approach – formal review within 12 months
- 1.07 – New psychosis (EI) cases per contract

### DOH Requirements

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

### Gloucestershire CCG Contract Measures

- 3.08 – Completion of MHMDS ethnicity coding for inpatients
- 3.09 – Completion of IAPT Minimum Data Set outcome for Service Users
- 3.18 – Care plans within 4 weeks of working diagnosis of Dementia
- 3.21 – Access to psychological therapies – IAPT recovery rate
- 3.29 – Intermediate Care Teams: referral to screening assessment within 14 days
- 3.32 – Children and Young People who enter treatment to have a care coordinator

### Herefordshire CCG Contract Measures

- 5.10 – Completion of IAPT Minimum Data Set outcome for Service Users
- 5.15 – Emergency referrals to CRHT Team seen within 4 hours (8am to 6pm)
- 5.17 – IAPT achieve 15% of patients entering the service against prevalence
- 5.18 – Dementia Diagnosis: number of new inceptors (diagnoses) to achieve 50 per month
- 5.21 – Number on caseload who have not been seen, face-to-face, within 90 days
- 5.22 – Reduce those people readmitted to inpatient care within 30 days of discharge
- 5.26 – Care Programme Approach – formal review within 12 months
- 5.27 – Specialist Memory Clinic: service users to be offered an appointment within 4 weeks
- 5.28 – No children under 18 admitted to adult in-patient wards
- 5.29 – Patients discharged from local rehab within 2 years of admission

**Herefordshire DASH**

- 6.02 – Wait 3 weeks or less for first intervention
- 6.03 – Percentage receiving a Hepatitis B vaccine
- 6.04 – Percentage previously or currently injecting who have been tested
- 6.16 – Number of discharges from Drug Intervention Programme (DIP)

**RECOMMENDATIONS**

The Trust Board are asked to:

- Note the first Performance Dashboard Report for the 2015/16 contract period which covers the period to the end of May 2015.
- Note that there is still work ongoing to review all of the indicators not meeting the required performance threshold, in order to ensure that the process of measurement and data quality is being met and/or performance matters addressed.

| **Corporate Considerations** | |
|---|---|
| *Resource implications*: | The Information Team provides the support to operational services to ensure the robust review of performance data and co-ordination of the Dashboard |
| *Equalities implications:* | Equality information is included as part of performance reporting |
| *Risk implications:* | There is an assessment of risk on areas where performance is not at the required level. |

| **WHICH TRUST KEY STRATEGIC OBJECTIVES DOES THIS PAPER PROGRESS OR CHALLENGE?** | | | |
|---|---|---|---|
| Supporting clinical care | P | Skilled workforce | P |
| Getting the basics right | P | Using better information | P |
| Social inclusion | | Financial efficiency | P |
| Seeking involvement | | Legislation | |

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

| **Where in the Trust has this been discussed before?** | | |
|---|---|---|
| Not applicable. | Date | |

| **What consultation has there been?** | | |
|---|---|---|
| Not applicable. | Date | |

| **Explanation of acronyms used:** | AOT Assertive Outreach Team<br>ASCOF Adult Social Care Outcomes Framework<br>CAMHS Child and Adolescent Mental health Services<br>CPA Care Programme Approach<br>CQUIN Commissioning for Quality and Innovation<br>CRHT Crisis Home Treatment |
|---|---|

| | |
|---|---|
| | CYPS Children and Young People's Services<br>DASH Drug and Alcohol Service Herefordshire<br>HoNoS Health of the Nation Outcome Scale<br>IAPT Improving Access to Psychological Therapies<br>SI Serious Incident<br>YOS Youth Offender's Service |

## 1. CONTEXT

This report sets out the performance Dashboard for the Organisation to the end of May 2015.

1.1.1 The following section of the report now includes:

- An aggregated overview of all indicators in each section with exception reports for non-compliant indicators supported by the relevant Scorecard containing detailed information on all performance measures. These appear in the following sequence.
    - Monitor Requirements
    - Never Events
    - Department of Health requirements
    - NHS Gloucestershire Contract – Schedule 4 Specific Performance Measures
    - NHS Herefordshire Contract – Schedule 4 Specific Performance Measures
    - NHS Gloucestershire CQUINS
    - Low Secure CQUINS
    - NHS Herefordshire CQUINS

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

2.1 The following tables outline the performance in each of the performance categories within the Dashboard as at the end of May 2015. Where indicators have not been met during the reporting period, an explanation is provided relating to the non-achievement of the Performance Threshold and the action being taken to rectify the position for the future.

2.2 Where stated, 'Cumulative Compliance' refers to compliance recorded from the start of the new contract period until the end of May 2015.

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

| | | |
|---|---|---|
|  | = | **Target not met** |
|  | = | **Target met** |
| **NYA** | = | **Not Yet Available from Systems** |
| **NYR** | = | **Not Yet Required by Contract** |
| **UR** | = | **Under Review** |
| **N/A** | = | **Not Applicable** |
| **Baseline** | = | **2015/16 data reporting to inform 2016/17** |

## DASHBOARD CATEGORY - MONITOR REQUIREMENTS

| Monitor Requirements | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 10 | 13 | 13 | 13 |
|  | 0 | 0 | 2 | 2 |
|  | 10 | 12 | 10 | 10 |
| NYA | 0 | 0 | 0 | 0 |
| NYR | 0 | 0 | 0 | 0 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 0 | 1 | 1 | 1 |

## Performance Thresholds not being achieved in Month

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

**1.04: Care Programme Approach – formal review within 12 months**

Our May 2015 performance of 93% is below the performance threshold of 95%. The 7% of cases not meeting the performance threshold represents 82 service users. For these records, no evidence of a review has been recorded. These are currently being followed up as they may have been reviewed while outcomes have not been recorded. This has been an area of data quality concern previously.

**1.07: New psychosis (EI) cases per contract**

This indicator provides an overview of the number of new cases coming into the service. The total number of new cases expected in a year is presented as a monthly average and the actual cases coming into services in a month is compared to this average. The performance on a month by month basis varies as the number of new cases do not present in a linear manner. This measure needs to be reviewed on a monthly and periodical basis so that the notional annual variations can be considered and actions taken where it is believed that the cumulative performance threshold will not be met. During May 2015 neither Gloucestershire nor Herefordshire saw a number of new cases in line with the average. This indicator needs to be kept under ongoing review.

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

This KPI is a new measure and profiles the new waiting time requirements to be achieved by March 2016. The KPI is being reported so that our progress towards consistently achieving this measure can be monitored. On the basis that this KPI has to be met in full by March 2016 if the up until that time if the required performance threshold is not met it will be shown as Amber rather than Red.

**Note:** KPI measures 1.09 and 1.10 - IAPT waiting times, referral to treatment performance thresholds of 6 weeks and 18 weeks are new Monitor performance indicators introduced for 2015/16.

## Cumulative Performance Thresholds Not being Met

**1.04: Care Programme Approach – formal review within 12 months**
As above

**1.07: New psychosis (EI) cases**
As above

## Changes to Previously Reported Figures

None

## Early Warnings

None

# Monitor Requirements

| ID | Performance Measure (PM) | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | |
| 1.01 | Number of MRSA Bacteraemias | PM | 0 | 0 | 0 | 0 | 0 |
| | | Gloucestershire | 0 | 0 | 0 | | 0 |
| | | Herefordshire | 0 | 0 | 0 | | 0 |
| | | Combined Actual | 0 | 0 | 0 | | 0 |
| 1.02 | Number of C Diff cases (day of admission plus 2 days = 72hrs) | PM | 0 | 0 | 0 | 0 | 0 |
| | | Gloucestershire | 2 | 0 | 0 | | 0 |
| | | Herefordshire | 1 | 0 | 0 | | 0 |
| | | Combined Actual | 3 | 0 | 0 | | 0 |
| 1.03 | Care Programme Approach follow up contact within 7 days of discharge | PM | 95% | 95% | 95% | 95% | 95% |
| | | Gloucestershire | 98% | 99% | 99% | | 99% |
| | | Herefordshire | 98% | 100% | 100% | | 100% |
| | | Combined Actual | 98% | 99% | 99% | | 99% |
| 1.04 | Care Programme Approach - formal review within12 months | PM | 95% | 95% | 95% | 95% | 95% |
| | | Gloucestershire | 97% | 96% | 93% | | 94% |
| | | Herefordshire | 97% | 96% | 94% | | 94% |
| | | Combined Actual | 97% | 96% | 93% | | 94% |
| 1.05 | Delayed Discharges (Including Non Health) | PM | 7.5% | 7.5% | 7.5% | 7.5% | 7.5% |
| | | Gloucestershire | 0.8% | 0.0% | 0.8% | | 0.4% |
| | | Herefordshire | 1.3% | 1.8% | 0.0% | | 0.9% |
| | | Combined Actual | 0.9% | 0.5% | 0.6% | | 0.5% |
| 1.06 | Admissions to Adult inpatient services had access to Crisis Resolution Home Treatment Teams | PM | 95% | 95% | 95% | 95% | 95% |
| | | Gloucestershire | 99% | 98% | 100% | | 99% |
| | | Herefordshire | 100% | 100% | 100% | | 100% |
| | | Combined Actual | 99% | 98% | 100% | | 99% |
| 1.07 | New psychosis (EI) cases as per contract | PM | 72 | 6 | 6 | 6 | 12 |
| | | Gloucestershire | 91 | 7 | 5 | | 12 |
| | | PM | 21 | 2 | 2 | 2 | 4 |
| | | Herefordshire | 26 | 2 | 1 | | 3 |
| 1.08 | New psychosis (EI) cases treated wtihin 2 weeks of referral (Target Q4: 50%) | PM | | 50% | 50% | 50% | 50% |
| | | Gloucestershire | | 71% | 40% | | 58% |
| | | Herefordshire | | 0% | 100% | | 33% |
| | | Combined Actual | | 56% | 50% | | 53% |

# Monitor Requirements

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 1.09 | IAPT - Waiting times: Referral to Treatment within 6 weeks (based on discharges) | PM | | 75% | 75% | 75% | 75% |
| | | Gloucestershire | | 90% | 89% | | 90% |
| | | Herefordshire | | 94% | 90% | | 93% |
| | | Combined Actual | | 91% | 89% | | 90% |
| 1.10 | IAPT - Waiting times: Referral to Treatment within 18 weeks (based on discharges) | PM | | 95% | 95% | 95% | 95% |
| | | Gloucestershire | | 100% | 99% | | 99% |
| | | Herefordshire | | 100% | 98% | | 99% |
| | | Combined Actual | | 100% | 99% | | 99% |
| 1.11 | **MENTAL HEALTH MINIMUM DATA SET PART 1 DATA COMPLETENESS: OVERALL** | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 99.7% | 99.7% | 99.7% | | 99.7% |
| | | Herefordshire | 99.8% | 99.8% | 99.8% | | 99.8% |
| | | Combined | 99.7% | 99.7% | 99.7% | | 99.7% |
| 1.11a | Mental Health Minimum Data Set Part 1 Data completeness: DOB | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 100.0% | 100.0% | 100.0% | | 100.0% |
| | | Herefordshire | 100.0% | 100.0% | 100.0% | | 100.0% |
| | | Combined | 100.0% | 100.0% | 100.0% | | 100.0% |
| 1.11b | Mental Health Minimum Data Set Part 1 Data completeness: Gender | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 99.9% | 99.9% | 99.9% | | 99.9% |
| | | Herefordshire | 100.0% | 100.0% | 100.0% | | 100.0% |
| | | Combined | 99.9% | 99.9% | 99.9% | | 99.9% |
| 1.11c | Mental Health Minimum Data Set Part 1 Data completeness: NHS Number | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 99.9% | 99.9% | 99.9% | | 99.9% |
| | | Herefordshire | 99.9% | 100.0% | 100.0% | | 100.0% |
| | | Combined | 99.9% | 99.9% | 99.9% | | 99.9% |
| 1.11d | Mental Health Minimum Data Set Part 1 Data completeness: Organisation code of commissioner | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 99.0% | 98.9% | 98.8% | | 98.9% |
| | | Herefordshire | 99.9% | 99.9% | 99.9% | | 99.9% |
| | | Combined | 99.2% | 99.1% | 99.1% | | 99.1% |
| 1.11e | Mental Health Minimum Data Set Part 1 Data completeness: Postcode | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 99.7% | 99.9% | 99.8% | | 99.9% |
| | | Herefordshire | 99.8% | 99.8% | 99.8% | | 99.8% |
| | | Combined | 99.8% | 99.9% | 99.8% | | 99.8% |
| 1.11f | Mental Health Minimum Data Set Part 1 Data completeness: GP Practice | PM | 97% | 97% | 97% | 97% | 97% |
| | | Gloucestershire | 99.3% | 99.3% | 99.3% | | 99.3% |
| | | Herefordshire | 99.3% | 99.3% | 99.3% | | 99.3% |
| | | Combined | 99.3% | 99.3% | 99.3% | | 99.3% |

# Monitor Requirements

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 1.12 | **MENTAL HEALTH MINIMUM DATA SET PART 2 DATA COMPLETENESS : OVERALL** | PM | 50% | 50% | 50% | 50% | 50% |
| | | Gloucestershire | 98.2% | 98.6% | 98.7% | | 98.6% |
| | | Herefordshire | 95.9% | 97.6% | 97.8% | | 97.7% |
| | | Combined | 97.5% | 98.4% | 98.4% | | 98.4% |
| 1.12a | Mental Health Minimum Data Set Part 2 Data completeness: CPA Employment status last 12 months | PM | 50% | 50% | 50% | 50% | 50% |
| | | Gloucestershire | 97.2% | 98.0% | 98.2% | | 98.1% |
| | | Herefordshire | 94.4% | 97.2% | 97.3% | | 97.2% |
| | | Combined | 96.4% | 97.8% | 97.9% | | 97.8% |
| 1.12b | Mental Health Minimum Data Set Part 2 Data completeness: CPA Accommodation Status in last 12 months | PM | 50% | 50% | 50% | 50% | 50% |
| | | Gloucestershire | 97.7% | 98.4% | 98.3% | | 98.4% |
| | | Herefordshire | 95.5% | 97.6% | 97.8% | | 97.7% |
| | | Combined | 97.1% | 98.2% | 98.2% | | 98.2% |
| 1.12c | Mental Health Minimum Data Set Part 2 Data completeness: CPA HoNOS assessment in last 12 months | PM | 50% | 50% | 50% | 50% | 50% |
| | | Gloucestershire | 99.6% | 99.5% | 99.5% | | 99.5% |
| | | Herefordshire | 97.8% | 97.9% | 98.3% | | 98.1% |
| | | Combined | 99.0% | 99.1% | 99.2% | | 99.1% |
| 1.13 | Learning Disability Services: 6 indicators: identification of people with a LD, provision of information, support to family carers, training for staff, representation of people with LD; audit of practice and publication of findings | PM | 6 | 6 | 6 | 6 | 6 |
| | | Gloucestershire | 6 | 6 | 6 | | 6 |
| | | Herefordshire | 6 | 6 | 6 | | 6 |
| | | Combined | 6 | 6 | 6 | | 6 |

## DASHBOARD CATEGORY – DEPARTMENT OF HEALTH PERFORMANCE

| DoH Performance | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 24 | 27 | 27 | 27 |
| 🔴 | 1 | 1 | 1 | 1 |
| 🟢 | 23 | 25 | 25 | 25 |
| NYA | 0 | 0 | 0 | 0 |
| NYR | 0 | 1 | 1 | 1 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 0 | 0 | 0 | 0 |

## Performance Thresholds not being achieved in Month

**2.21: No children under 18 admitted to adult inpatient wards**
There was 1 admission in Herefordshire, in May. CAMHS recommended that a 17 year old be admitted for safety reasons but there were no age-appropriate beds available at the time. The patient agreed to be admitted to our Stonebow unit and was transferred to an age-appropriate bed out of area after 3 days.

## Cumulative Performance Thresholds Not being Met

**2.21: No children under 18 admitted to adult inpatient wards**
As well as the admission detailed above, there was 1 under 18 admission to Wotton Lawn in April.

## Changes to Previously Reported Figures

None

## Early Warnings

None

# DOH Never Events

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 2 | | | | | | | |
| 2.01 | Wrongly prepared high risk injectable medications | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.02 | Maladministration of potassium containing solutions | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.03 | Wrong route administration of oral/enteral treatment | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.04 | Intravenous administration of epidural medication | PM | | 0 | 0 | 0 | 0 |
| | | Actual | | 0 | 0 | | 0 |
| 2.05 | Maladministration of insulin | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.06 | Overdose of midazolam during conscious sedation | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.07 | Opioid overdose in opioid naive patient | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.08 | Inappropriate administration of daily oral methotrexate | PM | | 0 | 0 | 0 | 0 |
| | | Actual | | 0 | 0 | | 0 |
| 2.09 | Suicide using non collapsible rails | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.10 | Falls from unrestricted windows | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.11 | Entrapment in bedrails | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.12 | Misplaced naso - or oro-gastric tubes | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.13 | Wrong gas administered | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.14 | Failure to monitor and respond to oxygen saturation - conscious sedation | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.15 | Air embolism | PM | | 0 | 0 | 0 | 0 |
| | | Actual | | 0 | 0 | | 0 |
| 2.16 | Severe scalding from water for washing/bathing | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 2.17 | Mis-identification of patients | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |

# DOH Requirements

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 | | Cumulative Compliance |
|---|---|---|---|---|---|---|---|---|
| 2.18 | Mixed Sex Accommodation - Sleeping Accommodation Breaches | PM | 0 | 0 | 0 | 0 | | 0 |
| | | Gloucestershire | 0 | 0 | 0 | | | 0 |
| | | Herefordshire | 0 | 0 | 0 | | | 0 |
| | | Combined | 0 | 0 | 0 | | | 0 |
| 2.19 | Mixed Sex Accommodation - Bathrooms | Gloucestershire | Yes | Yes | Yes | | | Yes |
| | | Herefordshire | Yes | Yes | Yes | | | Yes |
| | | Combined | Yes | Yes | Yes | | | Yes |
| 2.20 | Mixed Sex Accommodation - Women Only Day areas | Gloucestershire | Yes | Yes | Yes | | | Yes |
| | | Herefordshire | Yes | Yes | Yes | | | Yes |
| | | Combined | Yes | Yes | Yes | | | Yes |
| 2.21 | No children under 18 admitted to adult in-patient wards | PM | 0 | 0 | 0 | 0 | | 0 |
| | | Gloucestershire | 9 | 1 | 0 | | | 1 |
| | | Herefordshire | 3 | 0 | 1 | | | 1 |
| | | Combined | 12 | 1 | 1 | | | 2 |
| 2.22 | Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation) | Gloucestershire | Yes | Yes | Yes | | | Yes |
| | | Herefordshire | Yes | Yes | Yes | | | Yes |
| | | Combined | Yes | Yes | Yes | | | Yes |
| 2.23 | Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation) | Gloucestershire | Yes | Yes | Yes | | | Yes |
| | | Herefordshire | Yes | Yes | Yes | | | Yes |

# DOH Requirements

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 2.24 | Serious Incident Reporting (SI) | Glos | 44 | 7 | 1 | | 8 |
| | | Hereford | 4 | 0 | 0 | | 0 |
| 2.25 | SI reported within 48hrs | PM | 100% | 100% | 100% | 100% | 100% |
| | | Gloucestershire | 100% | 100% | 100% | | 100% |
| | | Herefordshire | 100% | n/a | n/a | | n/a |
| 2.26 | SI Initial Report - to CCG within 3 working days | PM | 100% | 100% | 100% | 100% | 100% |
| | | Gloucestershire | 93% | 100% | 100% | | 100% |
| | | Herefordshire | 100% | n/a | n/a | | n/a |
| 2.27 | SI Report Grade 1 - to CCG within 60 working days | PM | 100% | 100% | 100% | 100% | 100% |
| | | Gloucestershire | 100% | NYR | NYR | | NYR |
| | | Herefordshire | 100% | n/a | n/a | | n/a |
| 2.28 | SI Report Grade 2 - to CCG within 26 weeks | PM | 100% | 100% | 100% | 100% | 100% |
| | | Gloucestershire | 100% | 100% | 100% | | 100% |
| | | Herefordshire | 100% | n/a | n/a | | n/a |
| 2.29 | SI Final Reports outstanding but not due | Gloucestershire | 8 | 7 | 1 | | 8 |
| | | Herefordshire | 0 | NYA | NYA | | NYA |

## DASHBOARD CATEGORY – GLOUCESTERSHIRE CCG CONTRACTUAL REQUIREMENTS

| Gloucestershire Contract | | | | |
|---|---|---|---|---|
| | In month compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 59 | 43 | 43 | 43 |
| 🔴 | 7 | 3 | 6 | 3 |
| 🟢 | 27 | 18 | 15 | 18 |
| NYA | 18 | 0 | 0 | 0 |
| NYR | 3 | 21 | 21 | 21 |
| UR | 3 | 0 | 0 | 0 |
| N/A | 1 | 1 | 1 | 1 |

## Performance Thresholds not being achieved in Month

**3.08: Completion of MHMDS ethnicity coding for inpatients**
This is a new indicator for Gloucestershire. Our performance to the end of May has identified issues with data quality that new processes have now been put in place to address.

**3.09: Completion of IAPT Minimum Data Set outcome for Service Users**
The consolidation of IAPT reporting onto our IAPTus system has revealed a number of data quality issues within the data previously reported from RiO. New processes and staff training are being put in place to address this.

**3.18: Care plans within 4 weeks of working diagnosis of Dementia**
The methodology associated with this indicator is under review with commissioners to clarify and agree the point of measurement. In the interim, it has been agreed to continue to report this measure while the review is ongoing.

**3.21: Access to psychological therapies – IAPT recovery rate**
This measure is currently unreliable as the data quality has been affected by the transfer of reporting from RiO to IAPTus. From next month an additional measure of the reliable improvement rate will also be introduced in order that the correlation between reliable improvement and recovery rate can be seen and used to identify underlying performance issues that need to be addressed.

**3.29: Intermediate Care Teams: referral to screening assessment within 14 days**

This measure is taken from IAPTus and now reports the combined performance of the Primary Mental Health Team and IAPT Team. A review of the working practices and data quality is ongoing to understand this shortfall in performance.

**3.32 Children and Young People who enter treatment to have a care coordinator**
The service are reviewing at which point in the pathway a care coordinator is allocated and this should improve the reporting of this measure going forward.

## Cumulative Performance Thresholds Not being Met

**3.09: Completion of IAPT Minimum Data Set outcome for Service Users**
As above

**3.18: Care plans within 4 weeks of working diagnosis of Dementia**
As above

**3.29: Intermediate Care Teams: referral to screening assessment within 14 days**
As above

## Changes to Previously Reported Figures

**3.22: Access to psychological therapies should be improved: No waiters more than referrals.**
This measure has been refined so that it has a reportable threshold. The measure now indicates the number of people waiting for treatment as a % of the new referrals received in month.

## Early Warnings

**3.31: Children should not wait longer than 8 weeks from referral to treatment.**
This performance threshold will continue not to be met until the capacity of the service is increased to meet demand. Additional funding has been agreed with commissioners and an appropriate operational plan has been developed. It is anticipated that this measure won't see appreciable change until the later part of the new contractual period. This area of service delivery is under ongoing scrutiny by the Delvery committee.

**3.32: Children should not wait longer than 10 weeks from referral to treatment.**
As above

# Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| | **A.OPERATIONAL STANDARDS** | | | | | | |
| | **Mixed Sex Accommodation Breaches** | | | | | | |
| 3.01 | Sleeping Accommodation Breach | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| | **Mental health** | | | | | | |
| 3.02 | Care Programme Approach (CPA): Percentage of service users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care | PM | 95% | 95% | 95% | 95% | 95% |
| | | Actual | 98% | 99% | 99% | | 99% |
| | **B. NATIONAL QUALITY REQUIREMENT** | | | | | | |
| 3.03 | Zero tolerance MRSA | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| | | Unavoidable | 0 | 0 | 0 | | 0 |
| 3.04 | Minimise rates of Clostridium difficile | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 2 | 0 | 0 | | 0 |
| | | Unavoidable | 0 | 0 | 0 | | 0 |
| 3.05 | Publication of Formulary | PM | N/A | Report | Report | Report | Report |
| | | Actual | N/A | Compliant | Compliant | | Compliant |
| 3.06 | Duty of candour | PM | N/A | Report | Report | Report | Report |
| | | Actual | N/A | Compliant | Compliant | | Compliant |
| 3.07 | Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, | PM | N/A | 99% | 99% | 99% | 99% |
| | | Actual | N/A | 100% | 100% | | 100% |
| 3.08 | Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users | PM | N/A | 90% | 90% | 90% | 90% |
| | | Actual | N/A | 93% | 88% | | 91% |
| 3.09 | Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users | PM | N/A | 90% | 90% | 90% | 90% |
| | | Actual | N/A | 56% | 58% | | 57% |

# Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| | **C. Local Quality Requirements** | | | | | | |
| | **Domain 1: Preventing People dying prematurely** | | | | | | |
| 3.10 | Increased focus on suicide prevention and reduction in the number of reported suicides in the community and inpatient units | PM | Q4 report | | | | Annual |
| | | Actual | Compliant | | | | NYR |
| 3.11 | To reduce the numbers of patients absconding from inpatient units | PM | | | | Q1 Report | |
| | | Actual | | | | | NYR |
| | **Domain 2: Enhancing the quality of life of people with long-term conditions** | | | | | | |
| 3.12 | IAPT access: 6 week wait referral to treatment (based on discharged patients) | PM | | 50% | 50% | 50% | 50% |
| | | Actual | | 90% | 89% | | 90% |
| 3.13 | IAPT access: 18 week wait referral to treatment (based on discharged patients) | PM | | 60% | 60% | 60% | 60% |
| | | Actual | | 100% | 99% | | 99% |
| 3.14 | 2G bed occupancy for Gloucestershire CCG patients | PM | | TBC | TBC | TBC | TBC |
| | | Actual | | 92% | 90% | | 91% |
| 3.15 | Care Programme Approach: 95% of CPAs should have a record of the mental health worker who is responsible for their care | PM | 95% | 95% | 95% | 95% | 95% |
| | | Actual | 100% | 100% | 100% | | 100% |
| 3.16 | CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months) | PM | 95% | 95% | 95% | 95% | 95% |
| | | Actual | 99% | 97% | 96% | | 96% |
| 3.17 | Assessment of risk: Patients on CPA to have a documented risk assessment | PM | 85% | | | 85% | 85% |
| | | Actual | 97% | | | | NYR |
| 3.18 | Dementia should be diagnosed as early in the illness as possible: 100% of people within the Memory Assessment Service with working diagnosis of dementia to have initial care plan agreed within 4 weeks | PM | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 73% | 60% | 88% | | 74% |

# Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | | Cumulative Compliance |
|---|---|---|---|---|---|---|---|---|
| | **Domain 3: Helping people to recover from episodes of ill-health or following injury** | | | | | | | |
| 3.19 | Percentage of inpatient admissions that have been gatekept by crisis resolution/ home treatment team | PM | 95% | | | 95% | | 95% |
| | | Actual | 99% | | | | | NYR |
| 3.20 | People experiencing first episode psychosis must receive treatments delivered in accordance with NICE guidelines within 2 weeks (Target Q4 51%) | PM | | | | N/A | | N/A |
| | | Actual | | | | | | NYR |
| 3.21 | Access to psychological therapies should be improved (IAPT) (Recovery rate) | PM | 50% | 50% | 50% | 50% | | 50% |
| | | Actual | 52% | 61% | 46% | | | 54% |
| 3.22 | Access to psychological therapies should be improved: No waiters more than referrals | PM | <100% | <100% | <100% | <100% | | <100% |
| | | Actual | 8% | 14% | 10% | | | 12% |
| 3.23 | LD: Care programme Approach (CPA); The percentage of people with learning disabilities in inpatient care on CPA who were followed up within 7 days of discharge | PM | | 95% | 95% | 95% | | 95% |
| | | Actual | | 100% | 100% | | | 100% |
| 3.24 | To ensure patients with dementia receive appropriate care for basic health needs (weight assessment) | PM | | | | | | 95% |
| | | Actual | | | | | | NYR |

# Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | | Cumulative Compliance |
|---|---|---|---|---|---|---|---|---|
| 3.28 | Adults of working age - 100% of MDT assessments to have been completed within 4 weeks (or in the case of a comprehensive assessment commenced within 4 weeks) | PM | 85% | 85% | 85% | 85% | | 85% |
| | | Actual | 91% | 89% | 88% | | | 88% |
| 3.29 | Adults Mental Health Intermediate Care Teams (New Integrated service) Wait times from referral to screening assessment within 14 days of receiving referral | PM | 85% | 85% | 85% | 85% | | 85% |
| | | Actual | 91% | 76% | 82% | | | 79% |
| 3.30 | 100% of all SI's reported within 24 hours | PM | 100% | | | 100% | | 100% |
| | | Actual | Compliant | | | | | NYR |
| 3.31 | Number of children that received support within 24 hours of referral, for crisis home treatment (CYPS) | PM | 95% | | | 95% | | 95% |
| | | Actual | 96% | | | | | NYR |
| | **CYPS** | | | | | | | |
| 3.32 | Children and young people who enter a treatment programme to have a care coordinator - Level 3 Services (CYPS) | PM | 98% | 98% | 98% | 98% | | 98% |
| | | Actual | 99% | 99% | 97% | | | 98% |
| 3.33 | 95% accepted referrals receiving initial appointment within 4 weeks (excludes YOS, substance misuse, inpatient and crisis/home treatment and complex engagement) (CYPS) | PM | 95% | | | 95% | | 95% |
| | | Actual | 89% | | | | | NYR |
| 3.34 | Level 2 and 3 – Referral to treatment within 8 weeks (excludes YOS, inpatient and crisis/home treatment) (CYPS) | PM | 80% | | | 80% | | 80% |
| | | Actual | 65% | | | | | NYR |
| 3.35 | Level 2 and 3 – Referral to treatment within 10 weeks (excludes YOS, inpatient and crisis/home treatment) (CYPS) | PM | 95% | | | 95% | | 95% |
| | | Actual | 72% | | | | | NYR |
| 3.36 | Level 3 YOS Specific – proportion receiving treatment within 10 working days of assessment (CYPS) | PM | 80% | | | 80% | | 80% |
| | | Actual | UR | | | | | NYR |

# Gloucestershire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | | Cumulative Compliance |
|---|---|---|---|---|---|---|---|---|
| | **Vocational Service (Individual Placement and Support)** | | | | | | | |
| 3.37 | 100% of Service Users in vocational services will be supported to formulate their vocational goals through individual plans (IPS) | PM | 98% | | | 98% | | 98% |
| | | Actual | 100% | | | | | NYR |
| 3.38 | The number of people finding paid employment or self-employment against accepted referrals into the service (IPS) | PM | 100% | | | 100% | | 50% |
| | | Actual | 100% | | | | | NYR |
| 3.39 | The number of people retaining employment at 3/6/9/12+ months (IPS) (all clients) | PM | 50% | | | 50% | | 50% |
| | | Actual | 83% | | | | | NYR |
| 3.40 | The number of people supported to retain employment at 3/6/9/12+ months (employed at referral) | PM | 50% | | | 50% | | 50% |
| | | Actual | 48% | | | | | NYR |
| 3.41 | Fidelity to the IPS model | PM | Annual | | | Annual | | Annual |
| | | Actual | Yes | | | | | NYR |
| | **General Quality Requirements** | | | | | | | |
| 3.42 | Complex Psychological Interventions: Wait times: | PM | | | | TBC | | TBC |
| | | Actual | | | | N/A | | NYR |
| 3.43 | GP Practices will have an individual annual (MH) ICT service meeting to review delivery and identify priorities | PM | | | | 100% | | 100% |
| | | Actual | | | | N/A | | NYR |

## DASHBOARD CATEGORY – GLOUCESTERSHIRE SOCIAL CARE

| Gloucestershire Social Care | | | | |
|---|---|---|---|---|
| | In month compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 18 | 15 | 15 | 15 |
|  | 0 | 0 | 0 | 0 |
|  | 1 | 4 | 4 | 4 |
| NYA | 5 | 3 | 3 | 3 |
| NYR | 0 | 2 | 2 | 2 |
| UR | 1 | 0 | 0 | 0 |
| N/A | 11 | 6 | 6 | 6 |

**Performance Thresholds not being achieved in Month**
None

**Cumulative Performance Thresholds Not being Met**
None

**Changes to Previously Reported Figures**
None

**Early Warnings**
None

**Not yet available**
There are currently three indicators that are not yet available:

**4.03 Ensure that reviews of new packages take place within 12 weeks of commencement**
To enable calculation of this indicator, collection of a new data item was required. This field has now been added to the monitoring system and the service will be recording this data, for all new cases, to ensure performance can be reported going forward.

**4.04 – Percentage of people getting long term services, in a residential or community care reviewed / re-assessed in last year.**
Following agreement with Commissioners on how to calculate this indicator, the data required is now being collected and performance will be reported from next month.

**4.07 – Percentage of carers accepting an assessment of need**
This indicator has never been reported as the required information could not be collected on RiO. With the move to the new $^{2}$gether RiO system this information can now be recorded. A programme for implementation and rollout is being developed. We anticipate that this indicator will become available in the later part of the year.

# Gloucestershire Social Services

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 4.01 | Outcome measure reported against each care cluster | PM | TBC | TBC | TBC | TBC | TBC |
| | | Actual | 92% | 93% | 93% | | 93% |
| 4.02 | Delayed transfers of care (DTOC's) from hospital & those which are attributed to adult social care (ASCOF 2C pt 2) | Plan | TBC | TBC | TBC | TBC | TBC |
| | | Actual | 5 | 0 | 0 | | 0 |
| 4.03 | Ensure that reviews of new packages take place within 12 weeks of commencement | PM | 95% | 95% | 95% | 95% | 95% |
| | | Actual | UR | NYA | NYA | | NYA |
| 4.04 | Percentage of people getting long term services, in a residential or community care reviewed/re-assessed in last year | PM | 95% | 95% | 95% | 95% | 95% |
| | | Actual | N/A | NYA | NYA | | NYA |
| 4.05 | Current placements aged 18-64 to residential and nursing care homes per 100,000 population | PM | TBC | TBC | TBC | TBC | TBC |
| | | Actual | 12.32 | 12.96 | 12.96 | | 12.96 |
| 4.06 | Current placements aged 65+ to residential and nursing care homes per 100,000 population | PM | TBC | TBC | TBC | TBC | TBC |
| | | Actual | 21.36 | 21.36 | 21.36 | | 21.36 |
| 4.07 | % of carers accepting an assessment of need | PM | TBC | TBC | TBC | TBC | TBC |
| | | Actual | NYA | NYA | NYA | | NYA |
| 4.08 | Ensure that there are sufficient number of integrated AMHPs to respond to requests for Mental Health Act assessments within working hours/operating times of their host team | PM | Annual | | | | Report |
| | | Actual | NYA | | | | NYR |
| 4.09 | Ensure 18 hours per annum of relevant CPD is available to all AMHPs regardless of substantive employer | PM | 100% | | | | 100% |
| | | Actual | NYA | | | | NYR |
| 4.10 | % of eligible service users with Personal budgets (Self Directed Support) | PM | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 98% | 99% | 98% | | 98% |

# Gloucestershire Social Services

| ID | Performance Measure | | 2014/15 outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | | Cumulative Compliance |
|---|---|---|---|---|---|---|---|---|
| 4.11 | % of eligible service users with Personal Budget receiving Direct Payments (ASCOF 1C pt2) | PM | 15% | 15% | 15% | 15% | | 15% |
| | | Actual | 16% | 20% | 19% | | | 20% |
| 4.12 | Adults subject to CPA in contact with secondary mental health services in settled accommodation (ASCOF 1H) | PM | 80% | 80% | 80% | 80% | | 80% |
| | | Actual | 88% | 87% | 87% | | | 87% |
| 4.13 | Adults not subject to CPA in contact with secondary mental health service in settled accommodation | PM | | TBC | TBC | TBC | | TBC |
| | | Actual | | 92% | 92% | | | 92% |
| 4.14 | Adults subject to CPA receiving secondary mental health service in employment | PM | 13% | 13% | 13% | 13% | | 13% |
| | | Actual | 13% | 14% | 15% | | | 14% |
| 4.15 | Adults not subject to CPA receiving secondary mental health service in employment | PM | | TBC | TBC | TBC | | TBC |
| | | Actual | | 20% | 21% | | | 21% |

## DASHBOARD CATEGORY – HEREFORDSHIRE CCG CONTRACTUAL REQUIREMENTS

| Herefordshire Contract | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 35 | 29 | 29 | 29 |
|  | 9 | 8 | 10 | 9 |
|  | 21 | 18 | 16 | 17 |
| NYA | 3 | 1 | 1 | 1 |
| NYR | 0 | 1 | 1 | 1 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 2 | 1 | 1 | 1 |

## Performance Thresholds not being achieved in Month

**5.10: Completion of IAPT Minimum Data Set outcome for Service Users**
A review of the data recorded within IAPTus has indicated data quality issues. Staff are being briefed and trained to resolve this issue.

**5.15: Urgent / Emergency referrals to CRHT Team seen within 4 hours (8am to 6pm)**
This is a new measure for this contract period. We have referred this measure back to commissioners as it has become apparent that the definition and methodology needs to be reviewed.

**5.16: Number of people moving to recovery with IAPT service intervention**
A review of the data recorded within IAPTus has indicated data quality issues. Staff are being briefed and trained to resolve this. The review has also indicated that this measure may need to be considered on a quarterly rather than monthly basis because of fluctuations in the patient numbers completing treatment that affects the calculation of this measure.
As from next month we will also be reporting the reliable improvement rate in order to provide a data quality check for the recovery rate indicator.

**5.17: IAPT achieve 15% of patients entering the service against prevalence**
The service is not meeting the requirement for the number of people entering treatment. A review of clinical processes and activity reporting to the team is being undertaken to identify remedial actions required.

**5.18: Dementia Diagnosis: number of new inceptors to achieve 50 per month**

This indicator is being reviewed with commissioners to agree the definition and point of measurement, as at the current time it records patients with a diagnosis rather than patients entering assessment. A review of the patient flows and information recording for the complete Dementia Care Pathway is also being undertaken to inform a potential revision to these measures.

**5.21: Number on caseload not seen, face-to-face, within 90 days**
This is a new indicator for this contract period. The indicator is intended to identify people whose care may need to be managed in a different way. The service users not seen face to face within 90 days will all be reviewed to ensure they are being managed appropriately or whether they should be discharged from the service.

**5.22: Reduce those people readmitted to inpatient care within 30 days of discharge**
This is a new indicator for the 2015/16 contract period. The indicator is being reviewed with commissioners in order to confirm its definition. The intent is to provide a measure around the quality of care provided by our inpatient services, measured through the number of people re-admitted within 30 days of discharge. The measure will either indicate a requirement to improve on our 2014/15 performance or to be below the Mental Health National average as identified through the NHS benchmarking information.

**5.26: Care Programme Approach – formal review within 12 months**
Herefordshire reached 94% of formal reviews against a performance threshold of 95%. The number of cases not meeting the performance threshold is 17. For these records, no evidence of a review has been recorded. These are currently being followed up as they may have been reviewed while outcomes have not been recorded. This has been an area of data quality concern previously.

**5.27: Specialist Memory Clinic: all service users to be offered an appointment within 4 weeks of referral**
This indicator was not meeting its performance threshold at the end of 2014/15 and the service has introduced a remedial action plan to address matters. The implementation of the plan continues and a data quality review is also being undertaken to ensure that the appropriate point of measurement is consistently being followed.

**5.28: No children under 18 admitted to adult in-patient wards**
There was 1 admission in Herefordshire, in May. CAMHS recommended that a 17 year old be admitted for safety reasons but there were no age-appropriate beds available at the time. The patient agreed to be admitted to our Stonebow unit and was transferred to an age-appropriate bed out of area after 3 days.

**5.29: Patients discharged from local rehab within 2 years of admission**
This indicator was not meeting its performance threshold at the end of the 2014/15 contract period, as 3 patients had lengths of stay beyond the 24 months indicator. All 3 cases were the subject of ongoing review as their discharge arrangements had been affected by a number of external factors. 2 of the patients have now been successfully discharged and the service is having to progress a new package of care for the 3rd as their original discharge arrangements have now been identified as undeliverable.

## Cumulative Performance Thresholds Not being Met

**5.10: Completion of IAPT Minimum Data Set outcome for Service Users**
As above

**5.15: Emergency referrals to CRHT Team seen within 4 hours (8am to 6pm)**
As above

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

**5.18: Dementia Diagnosis: number of new inceptors (diagnoses) to achieve 50 per month**
As above

**5.21: Number on caseload who have not been seen, face-to-face, within 90 days**
As above

**5.27: Specialist Memory Clinic: all service users to be offered an appointment within 4 weeks of referral**
As above

**5.28: No children under 18 admitted to adult in-patient wards**
As above

**5.29: Patients discharged from local rehab within 2 years of admission**
As above

## Changes to Previously Reported Figures

**5.25: Access to psychological therapies should be improved: No waiters more than referrals.**
This measure has been refined so that it now has a reportable threshold. The measure now indicates the number of people waiting for treatment as a % of the new referrals received in month.

## Early Warnings

None

### Not yet available

There is one indicator that is not yet available:

**5.19: 100% of people within the memory assessment service with a working diagnosis of dementia to have an initial care plan agreed within 4 weeks of diagnosis or discharge from memory service.**
This is a new indicator. The methodology associated with this indicator is under review to clarify and agree the point of measurement.

# Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 5.01 | Sleeping Accommodation Breach | PM | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| 5.02 | Care Programme Approach: Percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric inpatient care | Plan | 95% | 95% | 95% | 95% | 95% |
| | | Actual | 98% | 100% | 100% | | 100% |
| 5.03 | Zero tolerance MRSA | Plan | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| | | Unavoidable | 0 | 0 | 0 | | 0 |
| 5.04 | Minimise rates of Clostridium difficile | Plan | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 1 | 0 | 0 | | 0 |
| | | Unavoidable | 0 | 0 | 0 | | 0 |
| 5.05 | VTE risk assessment: all inpatients to undergo risk assessment for VTE | Plan | 95% | 95% | 95% | 95% | 95% |
| | | Actual | 99% | 100% | 100% | | 100% |
| 5.06 | Publication of Formulary (on provider's website) | Plan | Report | Report | Report | Report | Report |
| | | Actual | Compliant | Compliant | Compliant | | Compliant |
| 5.07 | Duty of candour: Avoidable events which cause "significant harm" are reported to patient with agreement and written action plan | Plan | Report | Report | Report | Report | Report |
| | | Actual | Compliant | Compliant | Compliant | | Compliant |

# Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 5.08 | Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS | Plan | 99% | 99% | 99% | 99% | 99% |
| | | Actual | 100% | 100% | 100% | | 100% |
| 5.09 | Completion of Mental Health Minimum Data Set ethnicity coding for all detained and informal Service Users | Plan | 90% | 90% | 90% | 90% | 90% |
| | | Actual | 98% | 96% | 96% | | 96% |
| 5.10 | Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users | Plan | 90% | 90% | 90% | 90% | 90% |
| | | Actual | 90% | 83% | 85% | | 84% |
| 5.11 | IAPT access: 6 week wait referral to treatment (based on discharged patients) | Plan | | 50% | 50% | 50% | 50% |
| | | Actual | | 95% | 93% | | 94% |
| 5.12 | IAPT access: 18 week wait referral to treatment (based on discharged patients) | Plan | | 60% | 60% | 60% | 60% |
| | | Actual | | 100% | 99% | | 99% |
| 5.13 | Treatment within 2 weeks for people experiencing a first episode of psychosis (Target Q4 = 50%) | Plan | | N/A | N/A | N/A | N/A |
| | | Actual | | 0% | 100% | | 33% |
| 5.14 | Elimination of avoidable pressure ulcers - category 2, 3 and 4 | Plan | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 0 | 0 | 0 | | 0 |
| | | Unavoidable | 4 | 0 | 0 | | 0 |
| 5.15 | Urgent/emergency referrals to Crisis Resolution Home Treatment Team seen within 4 hours of referral (8am-6pm) | Plan | | 98% | 98% | 98% | 98% |
| | | Actual | | 30% | 59% | | 47% |
| 5.16 | Number of people moving to recovery with IAPT service intervention. | Plan | 50% | 50% | 50% | 50% | 50% |
| | | Actual | 48% | 39% | 56% | | 44% |
| 5.17 | IAPT achieve 15% of patients entering the service against prevalence *(Annual Target of 2178)* | Plan | 2,186 | 182 | 363 | 545 | 363 |
| | | Actual | 1,748 | 163 | 289 | | 289 |

# Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | | Cumulative Compliance |
|---|---|---|---|---|---|---|---|---|
| 5.18 | Dementia Diagnosis - number of new inceptors (diagnoses) to achieve 50 per month | Plan | | 50 | 50 | 50 | | 100 |
| | | Actual | | 26 | 19 | | | 45 |
| 5.19 | 100% of people within the memory assessment service with a working diagnosis of dementia to have an initial care plan agreed within 4 weeks of diagnosis or discharge from memory service | Plan | | 100% | 100% | 100% | | 100% |
| | | Actual | | NYA | NYA | | | NYA |
| 5.20 | Delayed transfers of care to be maintained at a minimum level | Plan | 5% | 5% | 5% | 5% | | 5% |
| | | Actual | 1.3% | 1.8% | 0.0% | | | 0.9% |
| 5.21 | Number of service users on the caseload who have not been seen (face to face) within the previous 90 days (Recovery Service) | Plan | | 0 | 0 | 0 | | 0 |
| | | Actual | | 105 | 115 | | | 220 |
| | | Denominator | | 759 | 761 | | | 1,520 |
| | | % of caseload | | 14% | 15% | | | 14% |
| 5.22 | Reduce those people readmitted to inpatient care within 30 days following discharge. | Plan | NA | <6% | <6% | <6% | | <6% |
| | | Actual | 17 | 0% | 10% | | | 5% |
| 5.23 | Service users receiving home treatments by the Crisis Home Treatment Team *(Annual target of 285)* | Plan | | 23 | 47 | 72 | | 47 |
| | | Actual | | 24 | 47 | | | 47 |

# Herefordshire CCG Contract - Schedule 4 Specific Performance Measures

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| 5.24 | IAPT high intensity (HI) service user contacts on current caseload *(Annual target of 350. Monthly trajectory to be confirmed)* | Plan | | | | | Annual |
| | | Actual | | | | | NYR |
| 5.25 | Access to psychological therapies should be improved - the number of patients that have waited longer than 28 days from referral for an assessment should not exceed the number of referrals in that month | Plan | | <100% | <100% | <100% | <100% |
| | | Actual | | 9% | 3% | | 6% |
| 5.26 | CPA Review - % of people having had a formal care program approach review within 12 months | Plan | | 95% | 95% | 95% | 95% |
| | | Actual | | 96% | 94% | | 95% |
| 5.27 | Waiting times - Specialist Memory Clinic: 100% of service users are offered a first appointment within 4 weeks of referral | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 48% | 87% | 81% | | 85% |
| 5.28 | No people aged under 18 admitted to adult inpatient wards | Plan | 0 | 0 | 0 | 0 | 0 |
| | | Actual | 3 | 0 | 1 | | 1 |
| 5.29 | Patients are to be discharged from local rehab within 2 years of admission (Oak House). Based on patients on ward at end of month. | Plan | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 77% | 70% | 67% | | 68% |
| | | No. of patients | 3 | 3 | 3 | 3 | 3 |

## DASHBOARD CATEGORY – HEREFORDSHIRE DASH

| Herefordshire DASH | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 20 | 20 | 20 | 20 |
|  | 3 | 5 | 4 | 4 |
|  | 11 | 12 | 10 | 13 |
| NYA | 3 | 0 | 3 | 0 |
| NYR | 0 | 0 | 0 | 0 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 3 | 3 | 3 | 3 |

## Performance Thresholds not being achieved in Month

**6.02: Wait 3 weeks or less for first intervention**
**6.03: Percentage receiving a Hepatitis B vaccine**
**6.04: Percentage previously or currently injecting who have been tested for Hepatitis C**
**6.16: Number of discharges from Drug Intervention Programme (DIP)**

## Cumulative Performance Thresholds Not being Met

**6.02: Wait 3 weeks or less for first intervention**
**6.03: Percentage receiving a Hepatitis B vaccine**
**6.04: Percentage previously or currently injecting who have been tested for Hepatitis C**
**6.16: Number of discharges from Drug Intervention Programme (DIP)**

## Changes to Previously Reported Figures

None

## Early Warnings

None

# Herefordshire DASH

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| **New Treatment Episodes** | | | | | | | |
| 6.01 | Care plans completed for new treatment episodes | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 100% | 100% | 100% | | 100% |
| 6.02 | Wait 3 weeks or less for first intervention | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 99.6% | 92% | 87% | | 90% |
| 6.03 | Percentage receiving a Hepatitis B vaccine (of those offered and accepted) | Plan | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 78% | 77% | 66% | | 72% |
| 6.04 | Percentage previously or currently injecting who have been tested for Hepatitis C | Plan | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 75% | 76% | 73% | | 75% |
| **Successful Completions** | | | | | | | |
| 6.05 | Planned discharges/total clients last 12 months | Plan | 15% | 15% | 15% | 15% | 15% |
| | | Actual | 17% | 17% | 16% | | 17% |
| 6.06 | Numbers discharged | Plan | 150 | 150 | 150 | 150 | 150 |
| | | Actual | 183 | 187 | 189 | | 189 |
| 6.07 | Of those discharged - percentage planned | Plan | 50% | 50% | 50% | 50% | 50% |
| | | Actual | 61% | 59% | 58% | | 59% |
| **[2]gether Contract Report** | | | | | | | |
| 6.08 | Numbers in effective treatment | Plan | 460 | 460 | 460 | 460 | 460 |
| | | Actual | 460 | 455 | 460 | | 460 |
| 6.09 | Service Users receiving general healthcare assessment | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 100% | 100% | 100% | | 100% |
| 6.10 | Service Users offered Hepatitis B vaccination | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 100% | 100% | 100% | | 100% |
| 6.11 | Previous or current injectors to be offered Hepatitis testing | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 100% | 100% | 100% | | 100% |

# Herefordshire DASH

| ID | Performance Measure | | 2014/15 Outturn | April-2015 | May-2015 | June-2015 / Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|---|---|
| **Drug Intervention Programme** | | | | | | | |
| **6.12** | Numbers in treatment in month (DIP) | Plan | NA | NA | NA | NA | NA |
| | | Actual | 223 | 57 | 54 | | 111 |
| **6.13** | New Drug Intervention Programme (DIP) interventions | Plan | 50 | 5 | 5 | 5 | 10 |
| | | Actual | 66 | 10 | 5 | | 15 |
| **6.14** | Referrals from prison | Plan | NA | NA | NA | NA | NA |
| | | Actual | 13 | 1 | 2 | | 1 |
| **6.15** | Prison referrals seen within 3 weeks | Plan | 100% | 100% | 100% | 100% | 100% |
| | | Actual | 100% | 100% | 100% | | 100% |
| **6.16** | Number of discharges from Drug Intervention Programme (DIP) | Plan | 50 | 5 | 5 | 5 | 10 |
| | | Actual | 31 | 4 | 4 | | 8 |
| **6.17** | Of DIP discharges - percentage planned | Plan | NA | NA | NA | NA | NA |
| | | Actual | 26% | 50% | 25% | | 38% |
| **TOPS Completion (Source: NTA Monthly Reports)** | | | | | | | |
| **6.18** | Percentage start TOP completed within guidance time | Plan | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 90% | 91% | NYA | | 91% |
| **6.19** | Percentage discharge TOP completed within guidance time | Plan | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 86% | 96% | NYA | | 96% |
| **6.20** | Percentage review TOP completed within guidance time | Plan | 80% | 80% | 80% | 80% | 80% |
| | | Actual | 90% | 100% | NYA | | 100% |

## DASHBOARD CATEGORY – GLOUCESTERSHIRE CQUINS

| Gloucestershire CQUINS | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 8 | 8 | 7 | 7 |
|  | 0 | 0 | 0 | 0 |
|  | 8 | 0 | 0 | 0 |
| NYA | 0 | 0 | 0 | 0 |
| NYR | 0 | 7 | 7 | 7 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 0 | 0 | 0 | 0 |

**Performance Thresholds not being achieved in Month**
None

**Cumulative Performance Thresholds Not being Met**
None

**Changes to Previously Reported Figures**
None

**Early Warnings**
None

# Gloucestershire CQUINS

| ID | Performance Measure | | 2014/15 Outturn | Quarter 1 | | Cumulative Compliance |
|---|---|---|---|---|---|---|
| | **National CQUINs** | | | | | |
| | **CQUIN 1** | | | | | |
| **7.01** | Acute Kidney Injury - EWS score within 12 hours (Charlton Lane) | PM | | Report | | Report |
| | | Actual | | | | NYR |
| | **CQUIN 2** | | | | | |
| **7.02a** | Improving physical healthcare: Cardio Metabolic Assessment for patients with schizophrenia | PM | 4th Qtr | Report | | Report |
| | | Actual | Awarded | | | NYR |
| **7.02b** | Improving physical healthcare: Communication with GPS | PM | 4th Qtr | Report | | Report |
| | | Actual | Awarded | | | NYR |
| | **CQUIN 3** | | | | | |
| **7.03** | Identification and Assessment of Delirium | PM | | Report | | Report |
| | | Actual | | | | NYR |
| | **Local CQUINs** | | | | | |
| | **CQUIN 4** | | | | | |
| **7.04** | Triangle of Care | PM | | Report | | Report |
| | | Actual | | | | NYR |
| | **CQUIN 5** | | | | | |
| **7.05** | Transition from Young People's Service to Adult Mental Health Services | PM | | Report | | Report |
| | | Actual | | | | NYR |
| | **CQUIN 6** | | | | | |
| **7.06** | Perinatal Mental Health | PM | | Report | | Report |
| | | Actual | | | | NYR |

## DASHBOARD CATEGORY – LOW SECURE CQUINS

| Low Secure CQUINS | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 5 | 5 | 5 | 5 |
|  | 0 | 0 | 0 | 0 |
|  | 5 | 0 | 0 | 0 |
| NYA | 0 | 0 | 0 | 0 |
| NYR | 0 | 5 | 5 | 5 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 0 | 0 | 0 | 0 |

**Performance Thresholds not being achieved in Month**
None

**Cumulative Performance Thresholds Not being Met**
None

**Changes to Previously Reported Figures**
None

**Early Warnings**
None

# Low Secure CQUINS

| ID | Performance Measure | | 2014/15 Outturn | Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|
| | **National CQUINs** | | | | |
| | **CQUIN 1** | | | | |
| 8.01a | Improving physical healthcare: Cardio Metabolic Assessment for patients with schizophrenia | PM | 4th Qtr | Report | Report |
| | | Actual | Compliant | | NYR |
| 8.02 | Improving physical healthcare: Communication with GPS | PM | | Report | Report |
| | | Actual | | | NYR |
| | **Local CQUINs** | | | | |
| | **CQUIN 2** | | | | |
| 8.02 | Supporting service users to stop smoking | PM | | Report | Report |
| | | Actual | | | NYR |
| | **CQUIN 3** | | | | |
| 8.03 | Active engagement programme - Risk assessment secure unit and staff | PM | 4th Qtr | Report | Report |
| | | Actual | Compliant | | NYR |
| | **CQUIN 4** | | | | |
| 8.04 | Mental Health carer involvement strategies | PM | 4th Qtr | Report | Report |
| | | Actual | Awarded | | NYR |

## DASHBOARD CATEGORY – HEREFORDSHIRE CQUINS

| Herefordshire CQUINS | | | | |
|---|---|---|---|---|
| | In month Compliance | | | Cumulative Compliance |
| | Mar | Apr | May | |
| Total Measures | 10 | 10 | 6 | 6 |
|  | 3 | 0 | 0 | 0 |
|  | 7 | 0 | 0 | 0 |
| NYA | 0 | 0 | 0 | 0 |
| NYR | 0 | 6 | 6 | 6 |
| UR | 0 | 0 | 0 | 0 |
| N/A | 0 | 0 | 0 | 0 |

**Performance Thresholds not being achieved in Month**
None

**Cumulative Performance Thresholds Not being Met**
None

**Changes to Previously Reported Figures**

**Early Warnings**
None

# Herefordshire CQUINS

| ID | Performance Measure | | 2014/15 Outturn | Quarter 1 | Cumulative Compliance |
|---|---|---|---|---|---|
| | **National CQUINs** | | | | |
| | **CQUIN 1** | | | | |
| 9.01a | Improving physical healthcare: Cardio Metabolic Assessment for patients with schizophrenia | PM | 4th Qtr | Report | Report |
| | | Actual | Awarded | | NYR |
| 9.01b | Improving physical healthcare: Communication with GPS | PM | 4th Qtr | Report | Report |
| | | Actual | Compliant | | NYR |
| | **CQUIN 2** | | | | |
| 9.02 | Urgent and Emergency Care: Development of an adult personalised discharge care plan | PM | | Report | Report |
| | | Actual | | | NYR |
| | **CQUIN 3** | | | | |
| 9.03 | Urgent and Emergency Care: Improvement in Crisis Contingency Planning | PM | | Report | Report |
| | | Actual | | | NYR |
| | **Local CQUINs** | | | | |
| | **CQUIN 4** | | | | |
| 9.04 | Development of Personality Disorder consultation | PM | | Report | Report |
| | | Actual | | | NYR |
| | **CQUIN 5** | | | | |
| 9.05 | IAPT vulnerable service users | PM | | Report | Report |
| | | Actual | | | NYR |

**Agenda item 9** **Enclosure Paper D**

| | |
|---|---|
| **Report to:** | Trust Board, 30th July 2015 |
| **Author:** | Dr Paul Winterbottom, Medical Director & Dr Barnaby Major, Chair, Medical Appraisal Committee |
| **Presented by:** | Dr Paul Winterbottom, Medical Director |
| **SUBJECT:** | **Medical Appraisal Annual Report** |

**This Report is provided for:**

Decision **Endorsement** **Assurance** **To Note**

## EXECUTIVE SUMMARY


- Medical Appraisal has been instituted within 2gether NHSFT aligned with national policy.
- Investment in SARD JV and transfer to that system is supporting effective monitoring, recording and review of the quantity, quality and uptake of appraisal.
- 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 2015 demonstrate that at that time 89.5% of Doctors had a currently valid appraisal. 3.9% non-compliant are explained by exclusion criteria such as long term sick leave. There are 6.6% who at that point were classified as being non-engaged. A further review of these cases suggests that they are accounted for by short term delays and all those doctors have since completed an annual appraisal.
- 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.
- Medical Appraisal and Revalidation whilst being proportionately resourced and supported in 2gether NHSFT has a significant cost associated with the support and engagement that is inescapable.
- To note Appendix A that indicates the current compliance rates.


## RECOMMENDATIONS

1) That the Trust Board accept and endorse the Medical Appraisal Annual Report and:
   - Recognise the progress that has been made 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 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.

2) That the Board agrees the content and submission of the Statement of Compliance to NHS England (**Appendix B**).

| **Corporate Considerations** | |
|---|---|
| *Quality implications:* | Appraisal contributes to patient safety. |
| *Resource implications*: | Continuing use of administrative and managerial time with clinician input to revalidation process. |
| *Equalities implications:* | The annual appraisal monitoring process addresses equalities issues. This process is a particular issue for people on part time contracts. |
| *Risk implications:* | There are significant risks both to quality, safety and reputation of failure to implement Revalidation and annual appraisal effectively. |

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

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

| **Reviewed by:** | | |
|---|---|---|
| Dr Paul Winterbottom, Medical Director | Date | 22nd July 2015 |

| **Where in the Trust has this been discussed before?** | | |
|---|---|---|
| Medical Appraisal Committee | Date | 6th July 2015 |
| Governance Committee | Date | 17th July 2015 |

| What consultation has there been? | | |
|---|---|---|
| Medical Appraisal Committee | Date | 6th July 2015 |
| Governance Committee | Date | 17th July 2015 |

| Explanation of acronyms used: | SARD - Strengthened Appraisal & Revalidation Database<br>MAC – Medical Appraisal Committee |
|---|---|

## 1. CONTEXT

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.

# Annual Medical Appraisal Board Report

| | |
|---|---|
| **Appraisal year:** | **1st April 2014 – 31st March 2015** |
| **Author:** | **Dr Barnaby Major (Chair of Medical Appraisal Committee)**<br><br>***On behalf of Medical Appraisal Committee*** |
| **Prepared for:** | **Trust Board via Trust Governance Committee** |

## 1. Executive summary

Of the 76 doctors requiring appraisal during the last year 68 (89.5%) were compliant as at 1st April 2015. This is a significant improvement on compliance compared to the previous year (75% as at 1st April 2014).

When the Medical Appraisal Committee was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors were engaging in standardised medical appraisal. This year the focus has been on improving and assuring the quality of medical appraisals and the systems in place to support this process. Progress has been made in all areas identified in the Terms of Reference for the Medical Appraisal Committee.

## 2. Purpose of the Paper

The purpose of this paper is to report on the state of medical appraisal to the Trust Board over the preceding appraisal year. It is also to report on further progress made towards developing 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 it's 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

appraisal over a five year period is a crucial factor in enabling the Responsible Officer to make a positive affirmation of fitness to practice to the GMC.

## 4. Governance Arrangements

The Trust Medical Appraisal Committee (MAC) was set up during 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the trust; to develop robust systems for the recruitment, training, support & 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, a separate chair, the director of medical education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical & sub-specialism spread of consultants within the Trust) and at least 1 SAS doctor representative (there are currently 2; to represent both counties).

The MAC convenes quarterly. A recent away day was held to discuss the results of a quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee have reviewed the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

During the last year the MAC produced a final version of the Trust appraisal policy (plus an easily digestible executive summary for circulation to all affected doctors); introduced the use of formal appraisee feedback forms after every appraisal (and systems to formally review and also benchmark this against other similar organisations); formalised processes to manage non-compliance or non-engagement; further developed local appraiser refresher training to update it and align it with Trust policy; developed systems to monitor appraiser training compliance, and systems to conduct performance review (and provide formal feedback to appraisers); and completed a quality assurance audit of completed appraisals.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced during 2013 and training made available for all users. All appraisals during the last appraisal year, and now also job planning, have been completed and documented using this software package. Use of SARD JV has contributed significantly to the process of compliance monitoring and hence the overall improvement in compliance rates.

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.

Priorities for the MAC for the next year include further engaging and supporting the medical appraiser workforce; developing an IT system to support the collection of data to inform medical appraisal; and further improving the quality of completed appraisals.

## 5. Medical Appraisal

### a. Appraisal and Revalidation Performance Data

Of the 76 doctors requiring appraisal during the last year 68 (89.5%) were compliant as at 1st April 2015. Sub-group numbers were insufficient in order to conduct any meaningful statistical analysis; 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 (except possibly overall compliance being lower in Herefordshire compared to Gloucestershire).

Of the 8 doctors which were non-compliant 3 (37.5%) had reasons (1 returning from long term sickness and 2 being new starters). Of the 5 (62.5%) without reasons; 4 were overdue by 1 month and 1 overdue by 2 months (and all were due to restricted availability on the part of the appraiser or appraisee).

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.

For further details see appendix A.

### b. Appraisers

There are currently 38 trained medical appraisers within the employed consultant body. All consultants and SAS doctors were 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 majority of trained appraisers are not currently conducting regular appraisals (for example 14 potential appraisers on SARD conducted no appraisals within the last year; and a further 7 only 1 appraisal within the last year). This number of active qualified appraisers within the Trust is not sustainable in future; the MAC have set minimum numbers of appraisals required to be carried out in a 2 year period in order to ensure that those qualified and active undertake sufficient appraisals to maintain their skills. Those who have conducted no appraisals during the last year are in the process of being reminded of this standard and asked whether they want to be removed from the list of current active appraisers.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom 2gether has a prescribed connection. Some appraisals are

undertaken for colleagues working outside 2gether, in retirement or within other roles such as the Deanery.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. It is planned that SAS doctors will be recruited to become trained and practising appraisers.

Appraiser refresher training was provided within the Trust in October 2014. The training was delivered by a recognised leader in the field. Following that the training was reviewed and further developed to bring it in line with Trust policy and use of SARD JV. It is also proposed to develop peer support and review as a more integral part of the refresher training provided.

**c. Quality Assurance**

As Responsible Officer the Medical Director is required to individually review all completed appraisals for both completion and quality (see Appendix B). The MAC have also developed an additional set of assurance processes which are being introduced.

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role will take place within existing cpd peer groups, as part of appraisers' own appraisals and via support offered from members of the MAC itself.

Appraisee feedback forms are now automatically generated by SARD JV and sent to individual appraisees after all completed appraisals. Once completed these are screened by the medical director's office and then reviewed quarterly at MAC meetings. Summarised (anonymised) feedback covering the entire appraisal year is circulated to all appraisers. Summarised feedback has also been benchmarked against feedback collated from other similar organisations (and has been considered comparable).

The Medical Director's office automatically populate 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.

A quality assurance audit was recently conducted by all members of the MAC; 10% of completed appraisal summaries were randomly audited for completeness and quality. Consent was sought from individual appraisees. The standardised quality assurance audit tool provided by NHS England was used as the standard (Appendix B). Results were discussed at an away day and an action plan subsequently developed; including circulation of key learning points to all appraisers (and incorporation of these into further refresher training provided); agreement to use a different data collection tool (one developed within and favoured by the regional network specifically for this purpose) for next years audit; and a plan to provide individualised feedback to appraisers in relation to specific cases audited from next year onwards. A separate audit report has been completed. The audit will be repeated annually.

## d. 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 have administrative access to SARD portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

## e. Clinical Governance

Work is ongoing to develop a standardised minimum dataset of clinical and performance related data which individual doctors can use to benchmark themselves and their services against similar individuals/services to inform appraisal. Not as much progress has been during the last year as had been hoped for; however this has primarily been due to limited capacity of the IT department to prioritise this work. In due course it is planned that a tool will be developed in order to extract appraisal reports from Sharepoint automatically for this purpose. Work is ongoing in this area and considerable progress has been made recently. It is expected that this resource will be available second quarter 2016.

As stated, the Medical Director's office automatically populate 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 have set an expectation of 2 completed multi-source feedback exercises within each 5 year revalidation cycle. This is greater than the national minimum standard 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.

## 6. Revalidation Recommendations

In the last year 20 revalidation recommendations were completed; of which 19 (95%) were completed on time. 14 of the 20 (70%) were positive recommendations; 3 were recommended for deferral within 2014/15; 2 for deferral within 2015/16 and 1 was a non-engagement recommendation.

The deferrals made within the year have been 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. The one non-engagement recommendation was in relation to a doctor close to retirement who did not want to complete the revalidation process; it was therefore by mutual agreement with the doctor that this was the only way to formally record a recommendation.

The current process for revalidation recommendations are made by the Responsible Officer was recently reviewed by the MAC; it was agreed that sufficient checks and assurances are already in place.

See appendix C for further details.

## 7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at the 2gether NHS Foundation Trust; they are in line with the Trust's Pre-Employment Checks Policy. 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

All pre-employment checks for substantive doctors are completed before employment is started.

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 Exercise
- 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.

One doctor is 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 improved significantly during the last year. This is likely to be largely due to increased engagement on behalf of doctors and also due to the 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 being non-compliant is recorded, combined with the limited range of exceptions, mean that the rolling compliance rates vary from month to month without appraisal uptake having altered markedly.

Exceptions this year are accounted for by long term sickness, recruitment and delay in appraisal meetings due to lack of availability of either appraiser or appraisee.

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 is having an impact on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health in the future.

Recruits from outside the UK have not been taking part in this process and thus for the first year of any practice will not have undertaken appraisal whilst they are collecting data. This group provide a further exception for periods.

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 has been finalised and disseminated alongside an easily digestible executive summary; this will be reviewed again and updated in 2016 by the MAC. Priorities for the MAC for the next year include further engaging and supporting

the medical appraiser workforce; developing an IT system to support the collection of data to inform medical appraisal; and further improving the quality of completed appraisals.

The MAC will investigate individual cases where appraisal has not been 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 an annual appraisal will not be eligible for routine pay progression or local clinical excellence awards; ²gether NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo an 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 progress that has been made in the support provided to Appraisal and Revalidation within 2gether NHSFT through the use of SARD JV and the engagement of clinicians in this.
- Recognise the work that has been undertaken and is 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 snap shot compliance figures do not reflect the annual uptake of appraisal but are primarily a function of the way in which data is collected. In any year the expected outturn will be 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.

**Annual Report Appendix A**

## Audit of all missed or incomplete appraisals

| **Doctor factors (total)** | **8** |
|---|---|
| Maternity leave during the majority of the ‘appraisal due window’ | 0 |
| Sickness absence during the majority of the ‘appraisal due window’ | 2 |
| Prolonged leave during the majority of the ‘appraisal due window’ | 0 |
| Suspension during the majority of the ‘appraisal due window’ | 0 |
| New starter within 3 month of appraisal due date | 0 |
| New starter more than 3 months from appraisal due date | 2 |
| Postponed due to incomplete portfolio/insufficient supporting information | 0 |
| Appraisal outputs not signed off by doctor within 28 days | 0 |
| Lack of time of doctor | 0 |
| Lack of engagement of doctor | 0 |
| Other doctor factors | |
| - Compassionate Leave | 1 |
| **Appraiser factors** | |
| Unplanned absence of appraiser | 3 |
| Appraisal outputs not signed off by appraiser within 28 days | 0 |
| Lack of time of appraiser | 0 |
| Other appraiser factors (describe) | 0 |
| (describe) | |
| **Organisational factors** | |
| Administration or management factors | 0 |
| Failure of electronic information systems | 0 |
| Insufficient numbers of trained appraisers | 0 |
| Other organisational factors (describe) | 0 |

**Annual Report Appendix B**

## Quality assurance audit of appraisal inputs and outputs

| | | |
|---|---|---|
| Total number of appraisals completed | | **68** |
| | Number of appraisal portfolios sampled (to demonstrate adequate sample size) | Number of the sampled appraisal portfolios deemed to be acceptable against standards |
| Appraisal inputs | Number audited | Number acceptable |
| Scope of work: Has a full scope of practice been described? | **7** | **6 (86%)** |
| Continuing Professional Development (CPD): Is CPD compliant with GMC requirements? | **7** | **7 (100%)** |
| Quality improvement activity: Is quality improvement activity compliant with GMC requirements? | **7** | **6 (86%)** |
| Review of complaints: Have all complaints been included? | **7** | **7 (100%)** |
| Review of significant events/clinical incidents/SUIs: Have all significant events/clinical incidents/SUIs been included? | **7** | **7 (100%)** |
| Is there sufficient supporting information from all the doctor's roles and places of work? | **7** | **2 (29%)** |
| Is the portfolio sufficiently complete for the stage of the revalidation cycle (year 1 to year 4)?<br>Explanatory note:<br>For example | | |
| • Has a patient and colleague feedback exercise been completed by year 3? | **7** | **7 (100%)** |
| • Is the portfolio complete after the appraisal which precedes the revalidation recommendation (year 5)? | **7** | **4 (57%)** |
| • Have all types of supporting information been included? | **7** | **5 (71%)** |
| Appraisal Outputs | | |
| Appraisal Summary | **7** | **7 (100%)** |
| Appraiser Statements | **7** | **7 (100%)** |
| Personal Development Plan (PDP) | **7** | **6 (86%)** |

**Annual Report Appendix C**

## Audit of revalidation recommendations

| **Revalidation recommendations between 1 April 2014 to 31 March 2015** | |
|---|---|
| Recommendations completed on time (within the GMC recommendation window) | 19 |
| Late recommendations (completed, but after the GMC recommendation window closed) | 1 |
| Missed recommendations (not completed) | 0 |
| TOTAL | 20 |
| Primary reason for all late/missed recommendations<br>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 | 1 |
| TOTAL [sum of (late) + (missed)] | 1 |

**Annual Report Appendix D**

## Audit of concerns about a doctor's practice

| Concerns about a doctor's practice | High level[1] | Medium level[2] | Low level[2] | Total |
|---|---|---|---|---|
| Number of doctors with concerns about their practice in the last 12 months<br>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 | 2 | 0 | 9 | 11 |
| Capability concerns (as the primary category) in the last 12 months | 1 | 0 | 0 | 1 |
| Conduct concerns (as the primary category) in the last 12 months | 0 | 0 | 6 | 6 |
| Health concerns (as the primary category) in the last 12 months | 1 | 0 | 3 | 4 |
| **Remediation/Reskilling/Retraining/Rehabilitation** | | | | |
| Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2015 who have undergone formal remediation between 1 April 2014 and 31 March 2015<br>*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*<br>*A doctor should be included here if they were undergoing remediation at any point during the year* | | | | 1 |
| Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff) | | | | 1 |
| 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 |
| Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical | | | | 0 |

[1] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

| | |
|---|---|
| research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies | |
| 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 | 1 |
| **Other Actions/Interventions** | |
| Local Actions: | |
| Number of doctors who were suspended/excluded from practice between 1 April and 31 March:<br>Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included | 0 |
| Duration of suspension:<br>Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included<br>Less than 1 week<br>1 week to 1 month<br>1 – 3 months<br>3 - 6 months<br>6 - 12 months | n/a |
| Number of doctors who have had local restrictions placed on their practice in the last 12 months? | 0 |
| GMC Actions:<br>Number of doctors who: | |
| Were referred by the designated body to the GMC between 1 April and 31 March | 1 |
| Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March | 1 |
| Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March | 0 |
| 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: | 0 |
| Number of doctors about whom the National Clinical Advisory Service (NCAS) has been contacted between 1 April and 31 March for advice or for assessment | 0 |
| Number of NCAS assessments performed | 0 |

**Annual Report Appendix E**

## 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 | 4 |
| Temporary employed doctors | 2 |
| Locums brought in to the designated body through a locum agency | 35 |
| Locums brought in to the designated body through 'Staff Bank' arrangements | 0 |
| Doctors on Performers Lists | 0 |
| Other<br>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 | 0 |

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 investigations | Disclosure and Barring Service (DBS) | 2 recent references | Name of last responsible officer | Reference from last responsible officer | Language competency | Local conditions or undertakings | Qualification check | Revalidation due date | Appraisal due date | Appraisal outputs | Unresolved performance concerns |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Permanent employed doctors | 4 | 4 | 0 | | | 4 | 4 | 1 | 1 | | | 4 | | | | |
| Temporary employed doctors | 2 | 2 | | | | 2 | 2 | 1 | 1 | | | 2 | | | | |
| Locums brought in to the designated body through a locum agency | 35 | 35 | | | | 35 | 35 | | | | | 35 | | | | |

| | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Locums brought in to the designated body through 'Staff Bank' arrangements | | | | | | | | | | | | | | | | |
| Doctors on Performers Lists | | | | | | | | | | | | | | | | |
| Other<br>(independent contractors, practising privileges, members, registrants, etc) | | | | | | | | | | | | | | | | |
| Total | 41 | 41 | | | | 41 | 41 | | | | | 41 | | | | |

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

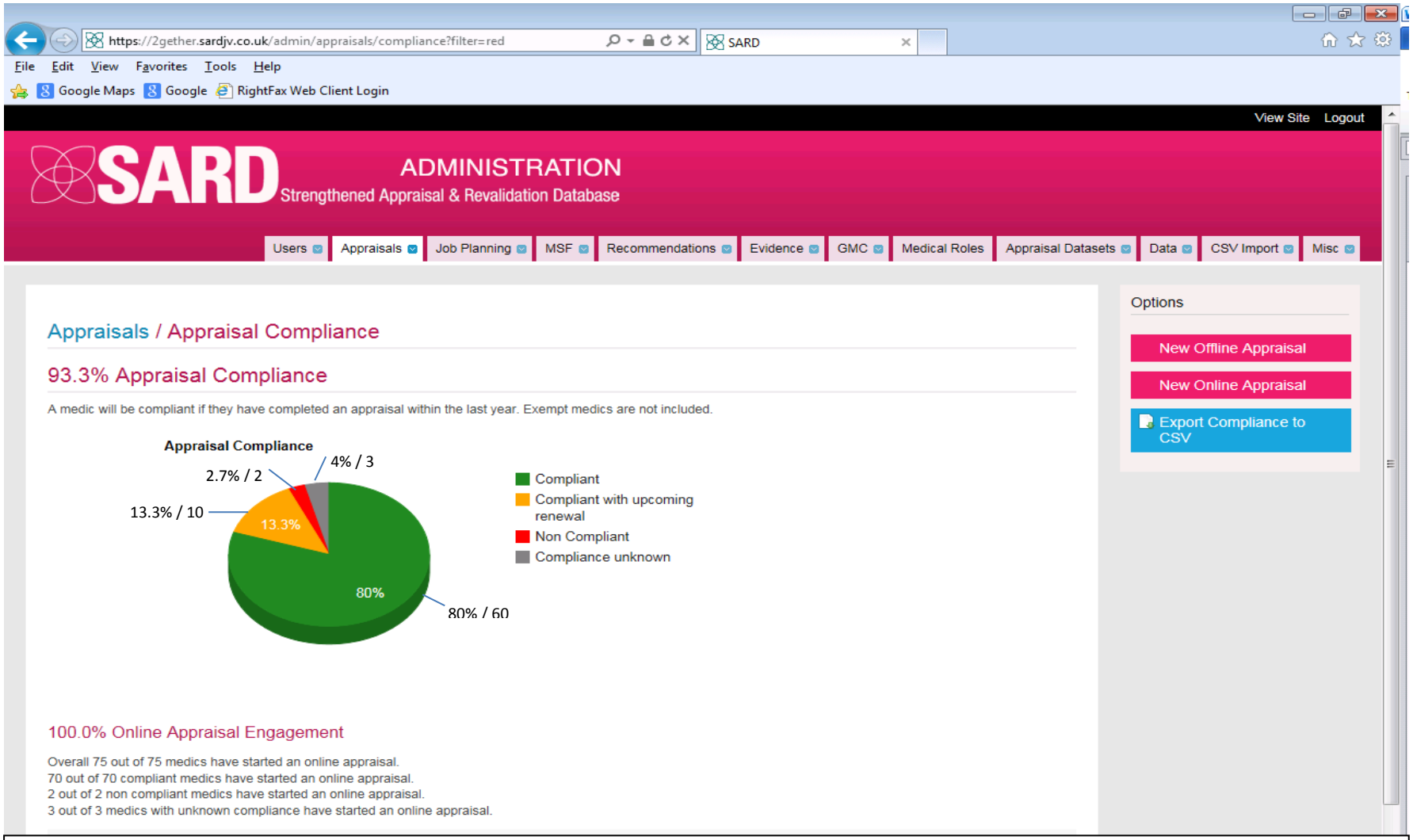
Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

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 | | | | | |
| Medicine | | | | | |
| Psychiatry | 8 | 792 | 230 | 407 | 1429 |
| Obstetrics/Gynaecology | | | | | |
| Accident and Emergency | | | | | |
| Anaesthetics | | | | | |
| Radiology | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Pathology | | | | | |
| Other | | | | | |
| Total in designated body (This 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 | 35 | 31 | 35 | | 1 |
| 3 days to one week | | 4 | | 2 | |
| 1 week to 1 month | | | | 4 | |
| 1-3 months | | | | 3 | |
| 3-6 months | | | | | |
| 6-12 months | | | | | |
| More than 12 months | | | | | |
| Total | 35 | 35 | 35 | 9 | 1 |

**Appendix A**




**SARD does not show doctors that are currently classed as exempt from appraisal due to maternity, long term sick etc. of which there are 4 doctors (in the graph above these are included in the non compliant and compliance unknown categories). This reduces the total non-compliant figure to 1.3% / 1 doctor and increases the total compliance figure to 98.5% / 74 doctors.**

**Figures as of 21st July 2015**

Appendix B

# A Framework of Quality Assurance for Responsible Officers and Revalidation

## Annex E - Statement of Compliance

Version 4, April 2014

**NHS England INFORMATION READER BOX**

| **Directorate** | | |
|---|---|---|
| **Medical** | Operations | Patients and Information |
| Nursing | Policy | Commissioning Development |
| Finance | Human Resources | |

| **Publications Gateway Reference:** | **01142** |
|---|---|
| **Document Purpose** | Guidance |
| **Document Name** | A Framework of Quality Assurance for Responsible Officers and Revalidation, **Annex E - Statement of Compliance** |
| **Author** | NHS England, Medical Revalidation Programme |
| **Publication Date** | 4 April 2014 |
| **Target Audience** | All Responsible Officers in England |
| **Additional Circulation List** | Foundation Trust CEs , NHS England Regional Directors, Medical Appraisal Leads, CEs of Designated Bodies in England, NHS England Area Directors, NHS Trust Board Chairs, Directors of HR, NHS Trust CEs, All NHS England Employees |
| **Description** | The Framework of Quality Assurance (FQA) provides an overview of the elements defined in the Responsible Officer Regulations, along with a series of processes to support Responsible Officers and their Designated Bodies in providing the required assurance that they are discharging their respective statutory responsibilities. |
| **Cross Reference** | The Medical Profession (Responsible Officers) Regulations, 2010 (as amended 2013) and the GMC (Licence to Practise and Revalidation) Regulations 2012 |
| **Superseded Docs** (if applicable) | Replaces the Revalidation Support Team (RST) Organisational Readiness Self-Assessment (ORSA) process |
| **Action Required** | Designated Bodies to receive annual board reports on the implementation of revalidation and submit an annual statement of compliance to their higher level responsible officers (ROCR approval applied for). |
| **Timings / Deadline** | **From April 2014** |
| **Contact Details for further information** | england.revalidation-pmo@nhs.net<br>http:// www.england.nhs.net/revalidation/ |

**Document Status**

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet

## Annex E – Statement of Compliance

### Designated Body Statement of Compliance

The Board of 2gether NHS Foundation Trust as carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments: Yes

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments: Yes

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments: Yes

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   Comments: Yes.

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments: Yes

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   Comments: Yes

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   Comments: Yes

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

| Comments: Yes |
|---|

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

| Comments: Yes |
|---|

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

| Comments: Yes |
|---|

Signed on behalf of the designated body

Name: Ruth FitzJohn Signed: _ _ _ _ _ _ _ _ _ _ _

Chair, 2gether NHS Foundation Trust

Date: 30th July 2015

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

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

**Report to:** 2gether NHS Foundation Trust Board on 30th July 2015
**Author:** Shaun Clee – Chief Executive
**Presented by:** Shaun Clee – Chief Executive

**SUBJECT:** **Chief Executives Report**

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

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

**EXECUTIVE SUMMARY**
This paper provides the Board with:

1. An update on key national communications via the NHS England NHS News
2. A summary of key progress against organisational major projects

**RECOMMENDATIONS**

The Board is asked to note the contents of this report

| **Corporate Considerations** | |
|---|---|
| *Quality implications:* | |
| *Resource implications*: | |
| *Equalities implications:* | |
| *Risk implications:* | |

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

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

| Reviewed by: | | |
|---|---|---|
| Executive Team | Date | |

| Where in the Trust has this been discussed before? | | |
|---|---|---|
| CEO | Date | |

| What consultation has there been? | | |
|---|---|---|
| N/A | Date | |

| Explanation of acronyms used: | |
|---|---|

## 1. CONTEXT

## 1.1 National Context

### 1.1.1 - Health and social care leaders set out proposals to transform NHS services and improve health outcomes using technology and data

Health and social care leaders from the National Information Board (NIB) have unveiled proposals to make technology work harder and faster for patients and increase transparency across more services. The NIB is seeking wider views on the proposals, set out in a series of eight roadmaps, at four regional listening events running from 15 to 28 July. Events are aimed at local commissioners, managers, NHS chief information officers, social services, local government and voluntary/community providers. Please email NIBframework@dh.gsi.gov.uk for more information.

### 1.1.2 - Child and Adolescent Mental Health Services (CAMHS) and Schools Link Pilot Scheme

NHS England and the Department for Education have invited proposals from CCGs, working with partners, to apply to become one of 15 pilot sites to improve mental health services for children and young people. The pilot schemes will test the impact of joint training of linked staff in school settings and local NHS funded CAMHS to improve care and ensure timely, appropriate referrals. Expressions of interest need to be submitted by 31 July 2015. The learning will inform the potential for a national roll-out next year.

### 1.1.3 - NHS drive for action to tackle trans inequalities

NHS England is leading a collective drive to improve the experience of transgender and non-binary people when accessing health and care services. Partners from across the health and social care system together with patients will come together on 30 June to establish a commitment to tackle a series of serious issues faced by these patients.

### 1.1.4 - More information on future vanguards

The New Care Models team are holding a series of events for organisations interested in expressing an interest in the latest vanguard opportunities. Potential applicants for urgent and emergency care can attend clinics on 1 July (London) or 2 July (Leeds), with 15 minute slots available either for face to face or telephone sessions on the application and selection process. Professor Keith Willett, National Director for Acute Care, NHS England, and Clinical Lead for the Urgent and Emergency Care Review will also be holding two webinars on 2 July at 9am and 4:30pm. The closing date for applications is 9am on 15 July 2015. Hospitals interested in registering an expression of interest to work on collaborative ways of redesigning acute care for patients can find out more information at the event on 7 July (London) or 8 July (Leeds). The deadline for submitting expressions of interest is Friday 31 July 2015. For further information please email england.newcaremodels@nhs.net

### 1.1.5 - Urgent and emergency care vanguards - applicants update

Revised guidance for aspiring urgent and emergency care vanguards has been issued to support strong applications. All vanguards will be expected to take part in developing and using a new, standard approach to modelling demand, capacity and activity. Efficiencies in care delivery will need to be made in line with the objectives of the Five Year Forward View. The deadline for applications is 9am 15 July 2015. For further information please contact the new care models team: england.newcaremodels@nhs.net or tel: 07747 795677.

### 1.1.6 - New approach to the winter health campaign

For the first time, NHS England, Public Health England, the Department of Health, the NHS Trust Development Agency and Monitor are joining up our winter health campaigns. In previous years, there have been separate campaigns to address the challenges of winter. This year, we are developing one focused behaviour change programme to help the public know what they need to do to keep well over the winter months. There will be further information on the NHS England website as the campaign develops

### 1.1.7 - Update on Child and Adolescent Mental Health Services (CAMHS)

Taking place in Cambridge on 17 July 2015, this is an opportunity to hear from Kathryn Pugh, the National Child and Adolescent Mental Health Programme Manager for NHS England, about recent developments in CAMHS commissioning guidance. Attendees will also hear from colleagues in the East Midlands who have

undertaken a large scoping of current provision of CAMHS services and have some insightful observations to share.

## 1.2 Delivering our Three Strategic Priorities

### 1.2.1 Continuously Improving Quality

### 1.2.2 Building Engagement

**Internal Engagement**

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| 01/05/15 | The Director of HR and OD chaired the Workforce & OD Sub Committee |
| 01/05/15 | The Medical Director attended the Medical Staff Committee |
| 01/05/15 | The Director of Quality visited LD/LDISS, Stonehouse |
| 06/05/15 | The Director of Quality attended CPD for LD Nurses Day, Dowtys |
| 06/05/15 | The Director of Finance participated as a panel member at the Project Manager interviews |
| 07/05/15 | The Chief Executive presented a ROSCA to Les Copestake at Charlton Lane Hospital |
| 07/05/15 | The Director of Quality chaired Patient Safety Improvement Meeting |
| 07/05/15 | The Director of Quality attended the Nursing Professional Advisory Committee |
| 08/05/15 | The Director of Engagement and Integration conducted a patient safety visit with Sally Ashton to Chestnut Ward and Willow Ward, Charlton Lane Hospital |
| 11/05/15 | The Chief Executive welcomed new colleagues at Corporate Induction |
| 11/05/15 | The Director of Finance was the Executive Lead at the Corporate Induction Lunch |
| 11/05/15 | The Director of Engagement and Integration attended the Corporate Induction lunch in Collingwood House |
| 11/05/15 | The Director of Engagement and Integration chaired the Learning Disability Care Practice Development Project Board, in Rikenel |
| 12/05/15 | The Chief Executive hosted Team Talk |
| 12/05/15 | The Chief Executive attended Council of Governors |
| 12/05/15 | The Director of Service Delivery hosted Gloucester Team Talk with the Chief Executive |
| 12/05/15 | The Director of Service Delivery attended Council of Governors meeting |
| 12/05/15 | The Director of HR and OD chaired the Occupational Health & Safety Sub Committee |
| 12/05/15 | The Director of HR and OD hosted Team Talk, Hereford |
| 12/05/15 | The Medical Director attended the Governors Meeting & Presentation |

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| 12/05/15 | The Director of Engagement and Integration attended the Council of Governors |
| 12/05/15 | The Director of Quality chaired the Quality Improvement Meeting |
| 13/05/15 | The Director of Quality attended the LD Big Health Check Open Day at Walls Social Club |
| 13/05/15 | The Director of Service Delivery attended a Board Visit to CYPS Gloucester/Forest of Dean team |
| 13/05/15 | The Director of Finance attended a Gloucestershire CCG & 2g NHS Foundation Trust Contract Board meeting |
| 18/05/15 | The Medical Director attended the CME Presentation to Doctors – Learning from Serious Incidents |
| 19/05/15 | The Director of Service Delivery undertook a Patient Safety Visit to Oak House, Hereford |
| 19/05/15 | The Director of Engagement and Integration attended a Review of the Governance Committee |
| 19/05/15 | The Director of Finance and Martin Pound met with Paul Gray, Finance Manager Lead for CACD, and Strategic Finance at Gloucestershire County Council to discuss Community Care Forecast Expenditure |
| 20/05/15 | The Director of Quality attended Development Meeting |
| 20/05/15 | The Director of Service Delivery Trust attended Development Committee |
| 20/05/15 | The Director of Engagement and Integration presented an item in the Trust's Development Committee, in Rikenel |
| 21/05/15 | The Director of Service Delivery Trust attended MH Legislation Scrutiny Committee |
| 21/05/15 | The Director of Finance attended the Herefordshire CCG & 2gether Contract Board |
| 21/05/15 | The Director of Finance attended a Finance Meeting with Jill Sinclair and Jon Ursell |
| 22/05/15 | The Director of Service Delivery attended Patient Safety Visit to Hereford Crisis Team |
| 22/05/15 | The Director of Engagement and Integration attended the Trust's Governance Committee, in Rikenel |
| 22/05/15 | The Director of Quality attended Governance Committee Meeting |
| 26/05/15 | The Chief Executive met with Governor Colleagues |
| 26/05/15 | The Director of Finance officially welcomed the IT team to his Directorate and followed up with 15 minute 121's with each team member |
| 27/05/15 | The Chief Executive visited the Memory Service and Early Intervention team at Widemarsh Street in Hereford |
| 27/05/15 | The Director of Service Delivery attended Trust Delivery Committee |
| 27/05/15 | The Director of Quality attended Delivery Committee Meeting |
| 27/05/15 | The Director of Quality visited Charlton Lane Hospital |
| 28/05/15 | The Director of Service Delivery attended Trust Board |

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| 28/05/15 | The Chief Executive attended the Appointments and Terms of Service Committee meeting |
| 28/05/15 | The Chief Executive attended the Trust Board meeting |
| 28/05/15 | The Director of Quality attended Board Meeting |
| 28/05/15 | The Director of Finance attended the 2gether NHSFT Board Meeting in Hereford |
| 28/05/15 | The Director of Engagement and Integration attended the Trust Board Meeting in Herefordshire |
| 29/05/15 | The Director of Engagement and Integration attended the North Forum Locality Meeting in Charlton Lane Hospital |
| 01/06/15 | The Director of HR and OD delivered Organisational Development session as part of the Medical Education Programme |
| 02/06/15 | The Director of HR and OD chaired Workforce & Organisational Development Sub Committee |
| 02/06/15 | The Director of Finance attended a 2gether SLR Project Board Meeting |
| 02/06/15 | The Director of Engagement and Integration attended a visit with Ruth Kyne to Charlton Lane Hospital |
| 05/06/15 | The Medical Director attended Medical Staffing Committee |
| 09/06/15 | The Chief Executive visited the Cirencester Memorial Centre |
| 09/06/15 | The Director of Finance chaired the 2gether IM&T Strategy Group Meeting |
| 11/06/15 | The Chief Executive visited wards at Charlton Lane Hospital |
| 16/06/15 | The Director of Finance hosted a Directorate Away Day for all staff members from Finance & Commerce, Estates and Facilities and IT |
| 18/06/15 | The Director of Finance attended the Herefordshire and 2gether Contract Board and Quality Meeting |
| 18/06/15 | The Director of Engagement and Integration attended a Board Visit with Chris David to CYPS, Acorn House |
| 22/06/15 | The Director of Finance was the Executive Lead at the Corporate Induction Lunch |
| 23/06/15 | The Chief Executive attended a board visit to CAMHS in Hereford |
| 23/06/15 | The Director of Finance attended Development Committee |
| 23/06/15 | The Director of Finance attended a ROSCA review meeting |
| 24/06/15 | The Director of Finance chaired the Staff Engagement Working Group Meeting |
| 25/06/15 | The Director of Finance attended the 2gether NHSFT Board Meeting |
| 25/06/15 | The Director of Engagement and Integration attended Board at Rikenel |
| 25/06/15 | The Chief Executive attended Trust Board followed by a joint Board and Governor Engagement event |
| 25/06/15 | The Director of Finance attended a Joint Board and Governor Engagement event |
| 29 - 30/06/15 | The Chief Executive Chaired a Executive Leadership Development Time Out event in Ross on Wye |

29 - 30/06/15 The Director of Engagement and Integration attended Executive Leadership Development Time Out event in Ross on Wye

29-30/06/15 The Director of Finance attended a two day Executive Away Day event at The Leadership Trust

**Board Stakeholder Engagement**

01/05/15 The Chief Executive met with system leaders regarding the Transformation in Herefordshire

01/05/15 The Director of HR and OD met with Andrew Christaki, RCN Regional Officer

05/05/15 The Director of Engagement and Integration attended the Mental Health Partnership Board, Sanger House

05/05/15 The Director of Service Delivery attended Glos CCG Mental Health Partnership Board

05/05/15 The Director of Engagement and Integration facilitated a meeting with Gloucestershire Media

06/05/15 The Chief Executive met with system leaders regarding planning the trajectory of the work associated with the community Mental Health Integration

06/05/15 The Director of HR and OD attended the Gloucestershire Constabulary GOLD/Strategic Awareness event

07/05/15 The Director of Service Delivery attended Worcestershire Mental Health & Wellbeing Market Engagement event

07/05/15 The Director of Finance attended a Board Visit to the South Intermediate Care Team in Stroud, with Julie White

07/05/15 The Director of Engagement and Integration attended a meeting with Police and Crime Commissioner for Gloucestershire, and the Deputy Chief Executive, at the Office of the Police and Crime Commissioner for Gloucestershire

08/05/15 The Director of Engagement and Integration attended an introductory meeting with the Interim Director for Public Health, Gloucestershire County Council,

11/05/15 The Director of Finance attended the IT Partnership Board meeting

11/05/15 The Director of Engagement and Integration attended the Inauguration of the Mayor for Cheltenham, in Cheltenham Town Hall

11/05/15 The Director of Service Delivery attended Countywide IT Partnership Board

12/05/15 The Chief Executive attended the Gloucestershire HSCOSC

12/05/15 The Director of Quality attended the Council of Governors meeting.

12/05/15 The Director of Engagement and Integration attended the Gloucestershire Health and Social Care Overview Scrutiny Committee, in Shire Hall

12/05/15 The Medical Director met with Gloucestershire CCG Chief Clinical Information Officer

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| 12/05/15 | The Director of Service Delivery attended Glos CCG System Resilience Group |
| 13/05/15 | The Medical Director attended the Learning Disability Big Health Check Open Day |
| 13/05/15 | The Director of Engagement and Integration attended meeting with the Chief Executive of Salters Hill Charity, in Rikenel |
| 13/05/15 | The Director of Engagement and Integration attended the launch of 'Involve Gloucestershire' in the Cheltenham Racecourse |
| 14/05/15 | The Medical Director attended the South West Clinical Senate Meeting |
| 14/05/15 | The Director of Finance was invited by Helen Simpson, Director of Finance, Gloucestershire Hospitals NHS Foundation Trust to sit on the interview panel for Interim Head of Shared Services Secondment interviews |
| 14/05/15 | The Director of Service Delivery attended Glos CCG Mental Health Clinical Programme Group |
| 15/05/15 | The Director of Engagement and Integration attended meeting with Charlotte Hitchings, and Claire Mould, Chief Executive, of OPENhouse, Stroud, |
| 19/05/15 | The Chief Executive presented at the Herefordshire Council Induction for new Councillors |
| 19/05/15 | The Director of Engagement and Integration co-chaired the Tackling Stigma Subgroup Meeting, Gloucestershire Clinical Commissioning Group |
| 21/05/15 | The Director of Engagement and Integration attended a meeting with the Associate Director R&D / Deputy Director SW RDS, Gloucester Research Consortium in Rikenel |
| 21/05/15 | The Director of Service Delivery attended Herefordshire Contact Board |
| 21/05/15 | The Director of Quality attended the Gloucestershire Safeguarding Adults Board |
| 21/05/15 | The Director of Quality attended the Gloucestershire Safeguarding Children's Board |
| 22/05/15 | The Director of Engagement and Integration attended a meeting with officers of Stonham Home Group at Rikenel |
| 26/05/15 | The Chief Executive met with Springfield Mind |
| 26/05/15 | The Chief Executive attended the Gloucestershire Strategic Forum |
| 26/05/15 | The Director of Finance attended Audit Committee Meeting |
| 27/05/15 | The Chief Executive met with Ernst and young regarding the Herefordshire Transformation |
| 27/05/15 | The Director of Engagement and Integration chaired a meeting for the Trust's research and development budget with the Chief Operating Officer, CRN West of England and the Associate Director R&D / Deputy Director SW RDS, |
| 30/05/15 | The Director of Engagement and Integration represented the Trust at an event with the Bishop of Hereford at St Peters Church in Hereford. |

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| 04/06/15 | The Medical Director attended an Inquest in Gloucester |
| 05/06/15 | The Medical Director hosted a Patient Relative Meeting |
| 08/06/15 | The Chief Executive sat on the interviewing panel for the Director of Adult and Wellbeing post in Herefordshire Council |
| 08/06/15 | The Medical Director attended an Inquest in Hereford |
| 09/06/15 | The Chief Executive attended the West of England AHSN's Leaders Seminar |
| 09/06/15 | The Director of Finance attended the IT Partnership Board meeting |
| 09/06/15 | The Director of Engagement and Integration attended a Herefordshire HSCOSC Meeting in Shire Hall, Hereford |
| 09/06/15 | The Director of Engagement and Integration attended Team Talk in Monkmoor, Hereford |
| 10/06/15 | The Director of Engagement and Integration attended CRN: West of England Partnership Group in Swindon |
| 10/06/15 | The Director of Finance attended a Patient Safety Visit to Gloucester AOT Team based in Albion Chambers with Michael Blackburn |
| 10/06/15 | The Medical Director attended a Board Visit to West Intermediate Care Team, Denmark Road |
| 12/06/15 | The Chief Executive sat on the interviewing panel for the Academy Dean of Gloucestershire University |
| 12/06/15 | The Medical Director attended South West Royal College of Psychiatry Executive Committee |
| 15/06/15 | The Chief Executive hosted interviews for the Strategic Partnership Proposal |
| 15/06/15 | The Chief Executive attended the Transformation Board meeting in Herefordshire |
| 16/06/15 | The Medical Director attended the Clinical Priorities Forum |
| 16/06/15 | The Director of Engagement and Integration attended a Herefordshire IAPT Team Meeting in Hereford |
| 16/06/15 | The Director of Engagement and Integration attended NHS Reference Group in Sanger House |
| 18/06/15 | The Director of Engagement and Integration attended a Research Consortium meeting in Gloucester |
| 18/06/15 | The Director of Engagement and Integration attended Healthwatch AGM |
| 22/06/15 | The Chief Executive attended a presentation on the Well Led Framework with Jay Bevington of Deloitte's |
| 22/06/15 | The Chief Executive met with colleagues from PWC |
| 22/06/15 | The Director of Finance attended a presentation on the Well Led Framework with Jay Bevington of Deloitte's |
| 22/06/15 | The Director of Finance attended a meeting with Marcus Robinson of PwC |
| 23/06/15 | The Chief Executive met with new Councillors in Herefordshire |

24/06/15 The Chief Executive participated in the April Q4 Monitor Finance and Quality call

24/06/15 The Director of Finance participated in the April Q4 Monitor Finance and Quality call

26/06/15 The Director of HR and OD met with Dr Mike Seeley – Gloucestershire Hospitals NHS Foundation Trust to discuss Occupational Health Partnership Opportunities

**Board National Engagement**

01/05/15 The Director of Engagement and Integration conducted a telephone meeting with Time To Change

08/05/15 The Director of Engagement and Integration conducted a telephone meeting with Time To Change

12/05/15 The Director of Finance attended HFMA FT Finance Directors' Forum in London

14/05/15 The Chief Executive chaired the SW Mental Health Collaborative Liaison Meeting

14/05/15 The Director of Quality attended the Nursing Senate Meeting at University of Worcester

15/05/15 The Chief Executive met with the Health and Safety Executive

19/05/15 The Chief Executive attended the NHS Confederation Board to Board meeting

22/05/15 The Chief Executive attended the NHS Confederation roundtable meeting with Simon Stevens

03 – 05/06/15 The Director of Engagement and Integration attended a NHS Confederation in Liverpool

04/06/15 The Director of HR and OD attended the Board Level Overview for Staffing Toolkit National Rollout Programme

10/06/15 The Chief Executive attended the HFMA CEO Forum

11/06/15 The Chief Executive met with Chris Hopson, Chair of the NHS Providers

11/06/15 The Director of Engagement and Integration attended the Time to Change Mental Health Professionals Working Group in London

16/06/15 The Chief Executive attended the Health Education South West Governing Body meeting

18/06/15 The Chief Executive attended the Influencing Mental Health Task Force Event

22/06/15 The Director of Engagement and Integration attended Members of Young Parliament Meeting in Gloucester

23/06/15 The Director of Engagement and Integration attended NHS England Chief Allied Health Professions Officers Conference 2015 at The Kia Oval

### 1.2.3 Ensuring Sustainable Services

**Major Project Update – June 2015**

**Mobile Working Technology**

Establishing the foundations for IT Transformation is and remains the key focus of Phase 1 of Mobile Working. The month of June saw numerous critical elements coming together to pave the way for deployments in Phase 2, from the autumn. These critical elements are as follows:

*Early Adopter Pilots – Stroud & the South Locality*

The first 40 of the new mobile computers were deployed to the early-adopter champions across the South Locality at the start of June. These early-adopter deployments also incorporated:

- Deployment of new Wi-Fi services at key South Locality bases;
- A much-improved system for connecting mobile computers, used in remote Wi-Fi locations, to the Trust's new '2gether network'; and
- The first users to receive *NHSmail* prior to a Trust-wide rollout during the summer.

Although a number of initial teething troubles were incurred, the new technology is working well and a number of critical lessons have been learnt with *NHSmail* that have mitigated a number of risks. Credit must go to Community Services Manager Jonathan Thomas, his Team Managers, and the Champion early-adopters in his teams for the commitment and constructive feedback they have all dedicated to the pilot projects to date. These contributions have been critical to refining the technical configurations prior to wider rollout across the Trust. Feedback from the South is also helping to clarify a number of areas of Trust Policy that need to be reappraised and refreshed prior to wider deployment of mobile working. The project's Policy Working Party, with the full support of the Executive Committee will complete this important work before the pilot phase is fully concluded.

*NHSmail*

Full rollout of *NHSmail* is a key component of the mobile working strategy:

- It overcomes a key communication barrier between Gloucestershire and Herefordshire staff, currently using separate and disconnected email and calendar systems;
- It is a fully-supported national resource, aligned with our Gloucestershire health partners, and mandated by the IT Partnership Board;
- Current IT infrastructure supporting the GLOS email and calendar system is old, out of support and is an operational risk to the Trust; and

- An upgrade to NHSmail in 2016 will provide a wide range of new communication resources that will fully support the vision and aims of effective mobile working for clinical and non-clinical staff.

The risks associated with deployment of NHSmail that have been discussed at IM&T Strategy Group and at the Mobile Working Project Board, and mitigations put in place. Findings from other Trusts suggest that migration of *NHSmail* will incur some transitional inconvenience, but this can be minimised through a well-coordinated, intensive migration over a short time frame. This approach forms the essence of our preferred strategy. A report outlining the Trust's deployment approach was received at the Executive Committee on Monday 22nd June.

**July Update -** Migration from GLOS mail to NHSmail is another key aspect of the fundamental infrastructure being provided in Phase 1. During May and June the project listened to the advice of numerous senior stakeholders and partners and formulated an intensive, locally-owned migration strategy from July to September. A number of important lessons were learned from the migration of the first 40 users in Stroud, and the resultant deployment plan gained Executive Committee approval on 22nd June. 14 temporary contractors were then recruited and inducted, and the Trust-wide migration began in earnest on 13th July.

Approx. 300 staff were successfully migrated in this first week while the new deployment team were brought up-to-speed. Momentum should increase as the migration team becomes fully established. Although the migration contains a number of risks and will generate some unavoidable transitional inconvenience, it is considered this deployment will remain on track for completion by early September as planned.

**Digital Transcription Speech Recognition (DTSR)**

The planning phase of DTSR continues to progress to plan. The technical infrastructure needed to host the speech recognition systems is built and undergoing end-stage testing. Relations with *Big Hand* are strong, and their commitment to 2gether's project is clear. *Big Hand* is working closely with the Trust to develop innovative ways to support our communications and engagement strategy. The pilot teams will commence use of the DTSR system from August; scripts for dictation training are being prepared. This project will involve fundamental changes to the interplay between clinical service delivery and supporting administration. Whilst processes in the pilot teams are being mapped in detail, it is imperative that agreement on the model for clinical administration delivery across the Trust, and the resultant strategies for management-of-change, both keep pace with the deployment of the technology.

# Major Project Update – July 2015

## Herefordshire Estate

The expiry of the lease on Monkmoor Court at the end of June 2015 provides an opportunity to rationalise our accommodation in Herefordshire. This project's objective is to establish a new HQ in Herefordshire in Benet House and the Link building at Belmont.

Financial assurances exist between Herefordshire CCG and 2g. Lease terms are in place between NHS Property and Belmont Trust and arrangements are well advanced with sub-leases from NHS Property to WVT and 2gether. Some minor structural changes, refurbishment and decoration are required to Belmont, and a main contractor has been appointed. Consultation with our staff continues to ensure there is engagement throughout the relocation process. The project team is working to complete the logistics of staff moves from Monkmoor Court, which is a priority, Widemarsh Street, 62 Etnam Street, The Knoll and 27a St Owen St.

Relocation planning has provided to maintain appropriate telephony and IT to all sites and the project is due to deliver November 2015.

## Crisis Resolution Model

The model for the extended crisis service, initially called the Mental Health Acute Response Service (MHARS) is progressing toward full agreement with Commissioners and other partners.

The objective is to ensure that this new service is widely available to those in urgent need of mental health care through a range of referral routes, including self-referral. This will increase the possibility of early intervention, reduce the number of people being admitted to hospital for their own safety and greatly reduce the number of people being detained on mental health grounds.

The model aims to reduce pressure on the blue light services and existing mental health services, in addition to releasing hospital beds. To facilitate this change in delivery of the service an additional 23 staff are being recruited to support this 24hr, 365days a year service which should be fully operational in February 2016.

## CQC Inspection

Following the announcement of the dates of the CQC Inspection (26th to 30th October), the intensity of the preparation work has increased. Whilst the Trust consider the inspection to be a positive influence and one from which learning will emerge, time is being spent by staff to ensure that the evidence of the work done by the Trust is readily available for the inspectors. Events are being held to inform staff of the inspection process and discussions are being held with trusts that have already been inspected to understand how the inspect works in practice and what

can be done to help the CQC. Similarly, work is being done on the logistics of the visit, which could involve o considerable number of inspectors, and advice is being sought from Trust staff who have also acted as specialist CQC inspectors on the inspections of other trusts. Every effort is being made to reduce the levels of anxiety likely to be felt by the staff and to present “business as usual” to the inspectors.

**Mobile Working sustainability**

*Clinical Systems Development Roadmap*

Now that 2gether RiO is live, local configuration is now underway under the direction of the *Change Control Board*. There have already been a number of upgrades to simplify use the system and further requirements around information on carers has been identified as the next priority area.

The wider clinical systems strategy, encompassing further customisations and potential use of middleware is an area that the Clinical Systems Development Lead will continue to progress in the next month. This review will also cover future roadmaps for other Trust clinical systems, including: *IAPTuS*, *Commit*, and *CamhsWeb*.

The 2gether IT Team have commenced some initial dialogue with three vendors providing customised forms-based access into clinical information systems. A layer of customised forms above the RiO application may provide a cost-effective alternative to customising *2gether RiO* and may allow use of a wider range of mobile computing devices.

This work was originally scoped out of the mobile working project in autumn 2014 on the basis of initial and ongoing costs and the assumption that the Trust would pursue a full customisation journey with *Servelec*. However, since autumn ‘14 the following have become apparent:

- The only mobile working device found during extensive device trials to work well directly with the RiO platform is the Toughbook, but these are very expensive per unit;
- Customisation of 2gether RiO is possible, but is likely to be expensive;
- The Digital Transcription and Speech recognition solution may also provide a vehicle for direct updating of RiO; and
- The cost of alternative solutions to customisation appears to have become cheaper in the last six months, with vendors offering substantial discounts on set up and annual recurrent costs.

A full options appraisal, that precedes full business case and involves all strands of IM&T as well as clinical and operational input, is now an essential activity for the project in Q2. This would allow the Trust to make an informed decision after which an appropriate business case and procurement plan will need to be developed.

*[2]gether Network Infrastructure across the Two Counties*

The mobile working solution is enabled through a new network infrastructure called the '2gether network'. This brings together all the necessary connectivity to allow staff instant access to the resources they need whenever they connect to the Trust via an office base or an external Wi-Fi connection. A further advantage of the [2]gether network will be seamless connectivity for staff working across both Gloucestershire and Herefordshire. Integration of the new network in Herefordshire requires some configuration work from Hoople. This has been delayed and discussions continue over costs quoted by Hoople for this work - the next Wave of mobile working devices for 40 Herefordshire staff cannot take place until this infrastructure is in place.

*Staff Culture & Management-of-Change – Mobile Working Policy Group*

A Mobile Working Policy Group has been formed and met for the first time on 26th June. The project team had pre-identified 8 key themes for this Group, which were agreed at the first meeting. These objectives are:

1. General principles and guidance re managing staff and working in the mobile working environment;
2. Identifying and addressing staff IT skills needs;
3. Management of Change and Staff-side contribution;
4. Trust Policy review and refresh;
5. Managing the culture shift;
6. Harmonisation of Trust Estates strategy with IT transformation;
7. Impact on Recruitment, Appraisals and core HR processes; and
8. Address other implications – e.g. pool cars.

The first deliverable from this Group has been a set of General Principles for mobile working for which executive endorsement is now being sought prior to distribution to the clinical workforce.

**Agenda item 11** **Enclosure No** **Paper F**

**Report to:** 2gether NHS Foundation Trust Board 30th July 2015
**Author:** Stephen Andrews, Deputy Director of Finance
**Presented by:** Andrew Lee, Director of Finance & Commerce

**SUBJECT:** **Finance report for period ending 30th June 2015**

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

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

## EXECUTIVE SUMMARY

- The month 3 position is a deficit of £122k compared to the planned deficit of £125k.
- The month 3 forecast outturn is a £495k deficit just below the plan of £500k.
- The Trust has a Continuity of Service Risk Rating of 4 and expects it to remain so into 2016/17.
- The 2015/16 contracts with Gloucestershire CCG, Herefordshire CCG and Worcestershire Joint Commissioning Unit have been signed.
- Work is starting on the detailed savings programme for 2016/17.
- The Trust has sent a response to Monitor's consultation on changes to the Risk Assessment Framework.

## RECOMMENDATIONS

It is recommended that the Board:

- note the month 3 position
- note the reasons for variances from budget
- confirms to Monitor that the Trust will have a Continuity of Service Risk Rating of at least 3 for the next 12 months.

| **Corporate Considerations** | |
|---|---|
| *Quality implications:* | None identified |
| *Resource implications*: | Identified in the report |

| | |
|---|---|
| *Equalities implications:* | None |
| *Risk implications:* | Identified in the report |

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

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

| **Reviewed by:** Andrew Lee, Director of Finance and Commerce | | |
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| | Date | 14th July 2015 |

| **Where in the Trust has this been discussed before?** | | |
|---|---|---|
| | Date | |

| **What consultation has there been?** | | |
|---|---|---|
| | Date | |

| **Explanation of acronyms used:** | See footnotes |
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## 1. CONTEXT

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

## 2. EXECUTIVE SUMMARY

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

| **Indicator** | **Measure** |  | |
|---|---|---|---|
| Year End I&E | Monitor Continuity of Service Risk Rating | 4 | Planned COS Risk rating of at least 3 |
| Income | FOT vs FT Plan | 100.1% | |
| Operating Expenditure | FOT vs FT Plan | 100.1% | |
| Cash | Number of creditor days | 63 | Balance of £26.6m (including investments) which equates to 63 creditor days. £11.2m of this cash is committed to fund the Trust's capital programme to improve facilities for patients over the next 4 years. |
| PSPP | %age of invoices paid within 30 days | 97.0% | 86% paid in 10 days |
| Capital Income | Monthly vs FT Plan | 113.6% | |
| Capital Expenditure | Monthly vs FT Plan | 96.3% | £1,994k expenditure. |

The parameters for the traffic light dashboard are detailed below:

| INDICATOR | RED  | AMBER  | GREEN  |
|---|---|---|---|
| Monitor FOT Financial Risk Rating | <2.5 | 2.5 - 3 | >3 |
| INCOME FOT vs FT Plan | <99% | 99% - 100% | >100% |
| Expenditure FOT vs FT Plan | >100% | 99% - 100% | <99% |
| CASH | <=50 days | 51-60 | >60 days |
| Public Sector Payment Policy - YTD | <80% | 80% - 95% | >95% |
| Capital Income - Monthly vs FT Plan | <90% | 91% - 100% | >100% |
| Capital Expenditure - Monthly vs FT P | >115% or <85% | 110% - 115% or 85% to 89% | 90% to 109% |

- The financial position of the Trust at month 3 is a deficit of £122k which is £3k better than the plan.
- Income is £465k under recovered against budget and operational expenditure is £446k under spent, and non-operational items are £22k under spent.

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

| Trust Summary | Annual Budget £000 | Budget to Date £000 | Actuals to Date £000 | Variance to Date £000 | Year End Forecast £000 | Year End Variance £000 |
|---|---|---|---|---|---|---|
| Cheltenham & N Cots Locality | (5,041) | (1,264) | (1,217) | 47 | (5,057) | (16) |
| Stroud & S Cots Locality | (4,755) | (1,194) | (1,151) | 43 | (4,680) | 75 |
| Gloucester & Forest Locality | (4,508) | (1,128) | (1,157) | (30) | (4,560) | (52) |
| Entry Level | (5,188) | (1,297) | (1,287) | 10 | (5,205) | (17) |
| Countywide | (31,951) | (7,988) | (7,999) | (11) | (32,133) | (182) |
| Children & Young People's Service | (4,652) | (1,163) | (1,164) | (1) | (4,681) | (29) |
| Medical | (13,798) | (3,450) | (3,441) | 8 | (13,906) | (108) |
| Board | (1,329) | (354) | (307) | 47 | (1,328) | 1 |
| Internal Customer Services | (1,440) | (360) | (241) | 119 | (1,439) | 1 |
| Finance & Commerce | (6,289) | (1,530) | (1,584) | (54) | (6,410) | (121) |
| HR & Organisational Development | (3,012) | (780) | (689) | 92 | (3,008) | 4 |
| Quality & Performance | (2,445) | (631) | (553) | 78 | (2,442) | 3 |
| Engagement & Integration | (1,390) | (347) | (329) | 18 | (1,407) | (17) |
| Operations Directorate | (1,292) | (323) | (279) | 44 | (1,273) | 19 |
| Herefordshire Services | (13,241) | (3,324) | (3,455) | (131) | (13,305) | (64) |
| Other (incl. provisional / savings / dep'n / P | (5,370) | (1,302) | (1,112) | 190 | (4,872) | 498 |
| Income | 105,203 | 26,310 | 25,844 | (466) | 105,209 | 6 |
| **TOTAL** | **(497)** | **(125)** | **(122)** | **3** | **(495)** | **2** |

The key points are summarised below;

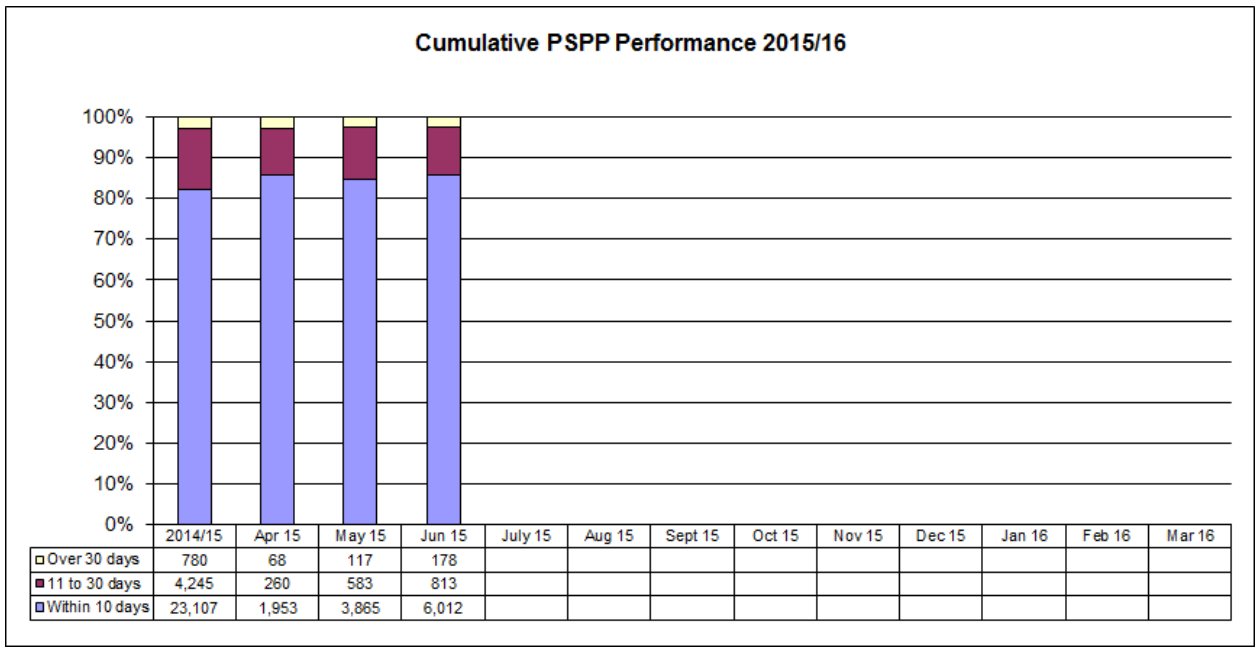
In month

- Income was under recovered as a number of developments have not yet commenced. This was matched by reduced expenditure within Other expenditure budgets.
- Herefordshire was over spent due to agency costs to cover specialling costs on Mortimer ward and sickness in the Crisis team.
- ICS is under spent due to lower than anticipated costs to date within the Information Department and RiO team.

Forecast Outturn

- Finance is forecasting an over spend due to the mobile working project whilst the split of the budget is agreed.
- Countywide is forecast to be over spent predominantly due to bank and agency costs across inpatient units. The management team is investigating the reasons behind this over spend. The forecast overspend fell by £54k in month 3.
- Medical forecast worsened by £11k in the month but a number of actions are in progress and are expected to bring this forecast down.

The cumulative Public Sector Payment Policy (PSPP) performance up to month 3 is 86% of invoices paid in 10 days and 97% paid in 30 days. The Trust has consistently ensured that it pays the majority of its suppliers promptly. The cumulative performance to date is depicted in the chart below and compared with last year's position:




| | 2014/15 | Apr 15 | May 15 | Jun 15 | July 15 | Aug 15 | Sept 15 | Oct 15 | Nov 15 | Dec 15 | Jan 16 | Feb 16 | Mar 16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Over 30 days | 780 | 68 | 117 | 178 | | | | | | | | | |
| 11 to 30 days | 4,245 | 260 | 583 | 813 | | | | | | | | | |
| Within 10 days | 23,107 | 1,953 | 3,865 | 6,012 | | | | | | | | | |

**Agenda item 12** **Enclosure Paper G**

**Report to:** Trust Board - 30th July 2015
**Author:** Carol Sparks – Director of Organisational Development
**Presented by:** Carol Sparks – Director of Organisational Development

**SUBJECT:** **Organisational Development Strategy**

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

## EXECUTIVE SUMMARY

The Organisational Development Strategy was identified and agreed by the Board in 2014 as being one of its enabling strategies. It was first presented to the Board in March 2015, and subsequently to the Council of Governors. The version presented to Board today takes into account the feedback received.

## RISKS

If the Organisational Strategy is not sufficiently visionary, key opportunities may be lost or not recognised resulting in the Trust, its services and staff, not being sufficiently agile to continue to deliver high quality services in the face of emerging challenges.

## ASSURANCES

The content of the strategy has been aligned to the Trust's purpose 'Making Life Better' and the three strategic objectives:

- Improve Quality – safety, outcomes and experience
- Engagement – increase internal and external engagement
- Sustainability – ensure we are sustainable, an effective partner, employer and advocate.

A range of documents, both national and local have been used to inform the content to ensure consistency of messages. The content has been kept simple and the format or design is similar to that of the Staff Charter, the Carers' Charter and the Service Users' Charter, to reinforce messages and consistency.

The Organisational Development Strategy is underpinned by an implementation plan (not attached) which has been endorsed by the Development Committee.

The Organisational Development Strategy sets out a direction of travel, based on the Trust's values, which provides flexibility for the future, in language which can be understood and delivered by leaders and which staff can see put into practice, and recognises the impact of Commissioner intentions and national strategy as at 2015.

There has been significant consultation on the content, format and language of the strategy.

**FURTHER ACTIONS**

Once endorsed by the Board the strategy will be shared with colleagues, and progress with the implementation will be monitored by Delivery Committee.

**RECOMMENDATION**

The Board is invited to endorse the Organisational Development Strategy.

| **Corporate Considerations** | |
|---|---|
| *Quality implications:* | A flexible skilled and engaged workforce will be better motivated to deliver quality care in innovative ways. |
| *Resource implications*: | The implementation plan will in the main be a summary of existing plans and actions which are already resourced. Other actions will be costed as needed and are likely to be delivered from within existing team resources. |
| *Equalities implications:* | Workforce data and the staff profile (including data on protected characteristics) have been taken into account in developing the strategy and will influence the implementation plan. |
| *Risk implications:* | Without a flexible, skilled and motivated workforce and leadership, working in flexible structures, the Trust risks being unable to adapt and respond to external challenge and change. |

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

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

| Where in the Trust has this been discussed before? | | |
|---|---|---|
| Workforce and Organisational Development Committee | Date | 5th March 2015 |
| Executive Committee | | 9th March 2015 |
| Health and Social Care Professional Group | | 10th March 2015 |
| Joint Negotiation and Consultative Committee | | 11th March 2015 |
| Development Committee | | 18th March 2015 |
| Board | | 26th March 2015 |
| Council of Governors | | 12th May 2015 |

| What consultation has there been? | | |
|---|---|---|
| As above | Date | |

| Explanation of acronyms used: | None |
|---|---|

## 1. CONTEXT

1.1 The Organisational Development Strategy is one of a range of enabling strategies that the Trust is developing to help it become flexible, adaptable, efficient and thereby fit for the future, as well as able to continue to deliver safe services in a safe working environment. A range of internal and external strategies and documents have been taken into account in writing this Organisational Development Strategy. External drivers are:

- Francis Report
- Keogh Report
- Berwick Reports
- Dalton Review (December 2014)
- NHS Five Year Forward View (October 2014)
- Workforce Planning in the NHS (April 2015)
- The national 'Speak Out Safely' campaign
- The NHS Constitution
- The Public Health Responsibility Deal
- 'The Talent for Care – A National Strategic Framework'
- The British Psychological Society Strategic Plan 2015-2020
- Existing contracts with Commissioners in Herefordshire and Gloucestershire

Internal drivers are:

- 'Compassion in Practice: Nursing, Midwifery and Care Staff – Our vision and strategy' (December 2012)
- Membership Strategy
- The Trust's Strategic Plan 2014 / 2019

- Commercial Strategy 2015-20
- Corporate Strategy 2014-19
- The Trust's Nursing Strategy 2014 / 2017
- The Trust's Partnership Strategy 2015 / 2018
- The Trust's Health and Wellbeing Strategy 2014 /2017
- Our Staff Charter, Service Users' Charter and Carers' Charter
- Our Investors in People (IiP) action plan.

1.2 The Monitor 'Strategy Development Toolkit' was used to ensure the Organisational Development Strategy met Monitor's expectations that the Trust through its workforce, structure and leadership will be able to meet the challenges of delivering quality care, adopting new technologies and remain sustainable. The 'toolkit' describes a strategy as '*a set of choices and principles designed to help an organisation achieve long-term goals. It will influence how resources are allocated and how staff prioritise their time*.' The Development Committee is invited to offer their feedback as to whether this Strategy and how it is written meets this description.

1.3 One of the challenges for any strategy is to keep the messages simple and clear yet with sufficient detail to inform an implementation plan which will have clear measures of success. The layout and format of this strategy has been designed to give three key messages at each stage around a theoretical framework and align the content to our three key strategic objectives. These statements have then been translated into actions that the Trust will take and differences that Commissioners, staff, volunteers, leaders, governors and members will see. This is consistent with the format used in our Staff Charter, Service Users' Charter and Carers' Charter.

1.4 Finally the 'Strategy on a Page' (appendix 4) uses the template from the Monitor 'Strategy Development Toolkit' and therefore does not attempt to 'reinvent the wheel'.

## 2. DOES THE STRATEGY MEET THE TRUST'S NEED?

2.1 The Monitor "Strategy development toolkit" recommends a whole range of questions which may enable a Board to "test" whether a strategy is fit for purpose. Whilst the questions have been developed to be used with an overarching 'organisation' strategy, a number of those questions are relevant to this Organisational Development Strategy. These questions with answers were provided to the Trust Board in March 2015, and have therefore not been replicated in this paper. The challenge from the Board in March was whether the strategy was sufficiently clear in describing its purpose and intentions, or whether it was sufficiently visionary.

2.2 Feedback from the Council of Governors in May 2015 in summary challenged the length of the document, its structure, content, whether the strategy adequately responded to key external drivers and gave sufficient thought to Commission intentions and strategies.

2.3 All of the feedback from Board and the Council of Governors has been considered in this re-write of the Strategy. The Strategy itself is now contained in five pages, with our activity which feeds into an implementation plan forming the appendices. The 'Strategy on a Page' at appendix 4 remains largely unchanged as does the internal communication map at appendix 3.

2.4 It should be noted that the descriptions of what people will see as we deliver on the Strategy, does not imply that as an organisation none of the activities are taking place at the moment. The intention is to provide a focus on particular attitudes, behaviours, and activity as the key drivers of developing agility, flexibility and adaptability in staff, our services and our organisation.

## 3 SUMMARY

3.1 The Organisational Development Strategy is aligned to national and local drivers, is consistent with a range of documents, uses simple, clear language and is intended to be easily understood by anyone who reads it. The implementation plan has not been attached however this will be a summary of existing action plans and there has been separate consultation on each of these.

## 4 RECOMMENDATION

4.1 The Board is invited to endorse the Organisational Development Strategy.

# Organisational Development Strategy

# 2015 – 2018

# Organisational Development Strategy 2015 - 2018

Change in the NHS has and will continue to be a constant. The Trust, in common with all organisations involved in health service provision, must transform to meet the changes, and consequently must develop a flexible, adaptive and agile organisation. The key to being flexible, adaptive and agile is to ensure staff have the right skills, training and approach to change, supported by leadership, processes, structures, terms and conditions, and technology to enable them to deliver first-class services.

An Organisational Development Strategy ensures we can continue to deliver high quality services in a climate of reducing NHS resources and increasing competition for the delivery of health care. The Strategy provides tools and a focus so that staff and the organisational shape remain fit for the future.

This strategy lays out our view of and approach to organisational development, and how we will, over the next three years (2015-18), create the fundamentals to enable the organisation and staff to adapt and benefit from change. Once those fundamentals are in place, subsequent strategies will detail specific changes based upon the Trust's direction and also the emerging transformational changes required within the wider NHS.

## Organisational Development – our definition

*It is a systematic plan, working within a clear set of values, to achieve the Trust's aims by improving the effectiveness and performance of individuals, teams and the organisation.*

## Organisational Development Strategy – values and priorities

**Our Trust Values**

**S**eeing from a service user's perspective
**E**xcelling and Improving
**R**esponsive
**V**aluing and Respectful
**I**nclusive, open and honest
**C**an do
**E**fficient, effective, economic and equitable

### Values

The shape and focus of an organisation is determined by the values it adopts, which in turn determines not only the type of services it will deliver, but also sets its culture. The Trust has an established set of values and these will underpin the development of this organisation.

### Priorities

**Quality : Engagement : Sustainability**

The Trust's three key priorities remain central to the development of all strategic plans and transformation.

## Internal Drivers of Change

The Organisational Development Strategy is one of a range of 'enabling strategies' that help the Trust become flexible, adaptable, agile, efficient, fit for the future, and able to continue to deliver safe services in a safe working environment. A number of internal and external strategies and documents influence this Organisational Development Strategy:

- Commercial Strategy 2015-20
- Corporate Strategy 2014-19
- Strategic Plan 2014 / 2019
- Nursing Strategy 2014 / 2017
- Partnership Strategy 2015 / 2018
- Health and Wellbeing Strategy 2014 /2017
- Staff Charter
- Investors in People action plan

- Compassion in Practice: Nursing, Midwifery and Care Staff – Our vision and strategy' (December 2012)

## External Drivers of Organisational Change

This strategy must take into account relevant legislation and specifically the Health and Safety at Work Act, the Equality Act 2010, and all employment legislation, and the emerging intentions of the commissioners – particularly as they react to financial pressures and the implications of the Health and Social Care Act. External drivers which have been considered include:

- The national 'Speak Out Safely' campaign
- The NHS Constitution
- The Public Health Responsibility Deal
- The Talent for Care – A National Strategic Framework
- Monitor 'Strategy Development Toolkit'
- Commissioner intentions as described in current contracts.

However, a number of critically important national reports have recently been produced that challenge the NHS approach to quality of care and future financial pressures:

- Francis Report
- Keogh Report
- Berwick reports
- Dalton Review (December 2014)
- NHS Five Year Forward View (October 2014)
- Workforce Planning in the NHS (April 2015)

These reviews and reports provide explicit recommendations on the pressures facing the NHS and the organisational changes required to address them.

The Dalton Review clearly sets out the financial horizon for the NHS: *"The medium term outlook is equally challenging and NHS England has predicted that without reform and efficiency improvement by 2021 the NHS will have a funding shortfall in the region of £30 billion."*

It further describes seven organisational forms that would be appropriate, and emphasises it is a local decision to identify the form that provides best fit *"…..establishing models and systems of care which meet the needs of individuals and communities is essential, and it is crucial for local leaders to determine what will work best for their locality. It is for provider organisations and their leadership, governance, structures and workforce to deliver the required transformational change"*.

The review sees a range of factors that are a risk to standards of clinical services. Including *"….. a blend of leadership, cultural and workforce factors, with internal systems being misaligned and unable to meet the service and financial plans of the organisation*", and urges "*The time is right for providers to examine their service portfolios, clinical models of care and be clear on the supporting organisational forms that are needed to ensure these are fit for the next five years and beyond to meet the changing needs and expectations of patients".*

The Berwick Report ('A promise to learn – a commitment to act') encourages trusts to *"….focus on the culture you want to nurture"*, in particular one devoted to *"…..continual learning and improvement of patient care, top to bottom and end to end."* It is unsurprising that the first of the report's ten recommendations is that "*The NHS should continually and forever reduce patient harm by embracing wholeheartedly the ethic of learning".*

Our Trust must, in addition to making decisions on its future form, develop the organisation's fundamental skills and processes to enable the Trust, staff and those

engaged in delivering its services to become sufficiently agile to rise to future challenges and change.

Lastly, our Commissioners both current and future will influence the nature of the services we provide. Therefore our Organisational Development Strategy will need to be sufficiently flexible to address changing commissioning intentions and to also influence those intentions so that we are part of an agreed vision of the future.

## Aims of the strategy

This organisational development strategy acknowledges the recommendations and appraisals in those national reports, and consequently aims to provide the fundamental skills and processes to enable the Trust, staff and those engaged in delivering its services to become sufficiently agile to rise to future challenges and change.

This strategy has two main aims:

1. Identify and align staff skills, knowledge, behaviours, attitudes to face future challenges
2. Align our processes and procedures to deliver the required skills and knowledge

**Aim 1**

Over the next three years, and delivered through a set of implementation plans which describe in detail a set of actions and outputs, we will:

i. Identify the skills and knowledge our staff will require
ii. Support staff to work flexibly, be adaptable and demonstrate Trust values
iii. Decide how staff will be supported to meet the Trust aim of 'Making Life Better'
iv. Ensure we maximise local flexibility of terms and conditions to improve the agility of the organisation.

**Aim 2**

Through a set of implementation plans which describe in detail a set of actions and outputs, we will align our processes and procedures to deliver the required skills and knowledge by:

i. Effective recruitment and talent management
ii. Providing learning to support modern ways of working
iii. Internal review and challenge
iv. Creating an environment where staff wish to work
v. Introducing flexible and adaptable structures and 'fit for purpose' procedures

These aims will support the delivery of the organisational structure, chosen by the Trust, that will enable it to face the future challenges and opportunities.

A summary of the strategy and the 11 implementation action areas can be found in Appendices 1 and 2.

## Involvement

The strategy and implementation plans will evolve through extensive involvement (achieving 'through' rather than 'doing to' people) and applies to:

- all staff - substantive, short term or agency contracts
- all those who contribute to the Trust aim of 'Making Life Better' - volunteers, students, Governors, and members.

## Change through Organisational Development Strategy

Our strategy aims to help individuals, teams and the Trust work with different partners, work differently and more flexibly, have the appropriate skills, tools and knowledge to work in a changing environment, and be more creative about what we do and how we do it.

## Measuring, Monitoring and Reporting

The implementation plans contain discrete actions, and the percentage of actions delivered will be regularly reported.

Staff and user surveys will provide qualitative data to indicate the level of user and carer satisfaction, and staff feeling of well-being and developmental investment.

The strategy is supported with an enabling annual work plan that is overseen by the Trust's Workforce and Organisational Development Committee. This work plan summarises actions that have been agreed or will be agreed to support the Trust's Health and Wellbeing Strategy, Investors in People accreditation, annual NHS Staff Attitude Survey and the annual Training Plan.

Updates from the Workforce and Organisational Development Committee are provided to the Executive Committee and the Trust's Delivery Committee. In addition progress on the plan will be reported at least annually to the Trust's Delivery Committee.

## Consultation

Consultation on the strategy has taken place with the Trust's Staff Side representatives through the Joint Negotiation and Consultation Committee, with staff more generally through the Workforce and Organisational Development Committee and its Working Groups, and with Service Directors and Heads of Professions.

The strategy has been equality impact assessed using the Trust's agreed template and processes.

## Internal Communication Map

This strategy and its underpinning implementation plan also need to be supported by consistent, regular and appropriate communication plus feedback mechanisms, and appropriate staff support. Appendix 3 describes our 'communication map' although the list is not exhaustive.

**APPENDIX 1**

# OUR STRATEGY IN SUMMARY

| External environment | | | | | |
|---|---|---|---|---|---|
| **National**<br><br>Francis, Keogh, Berwick Reports<br>Dalton Review<br>Five Year Forward View | **Financial, economic, legislative and political landscape** | **Partner Organisations** | **Regulators**<br><br>Care Quality Commission<br>Monitor<br>Health and Safety Executive | **Learning and Education**<br><br>Health Education England<br>Deaneries<br>NHS Leadership Academy | **Demographics**<br><br>Patient expectations<br>Patient numbers<br>Social demographics |

| | Our three strategic objectives | | |
|---|---|---|---|
| | **Quality**<br>We will: | **Engagement**<br>We will: | **Sustainability**<br>We will: |
| Mission | **"Making life better"** | | |
| Strategy | Have a comprehensive range of strategies which describe our direction of travel, and describe the quality of our services in a way that makes sense to our service users and carers and those who are influential in delivering and commissioning our services. | | Explore how we might deliver our services through different types of employers |
| Leadership | Have leaders who understand and enhance their team's performance, and the performance of others. | Have visible and approachable leaders who inspire others, lead by example and communicate well. | Have leaders with the skills to understand the impact of change, manage change and support others through change. |
| Culture | Promote an organisational culture that is consistent with all of our Charters and embraces diversity. | Have open and transparent processes for those who use or deliver our services to raise concerns and get feedback. | Ensure we safeguard the safety of everyone who delivers our services and give equal importance to staff safety and patient safety. |
| Performance | Have agreed roles and responsibilities for everyone who delivers our services, which are understood by our services users, carers and commissioners | Support staff to embrace new technologies and new ways of working, and we will develop new roles for volunteers which meet service need | Provide and have access to quality data to understand our staffing and resourcing challenges and address these. |

**APPENDIX 1**

| | Our three strategic objectives | | |
|---|---|---|---|
| | **Quality**<br>**We will:** | **Engagement**<br>**We will:** | **Sustainability**<br>**We will:** |
| Structure | Have an organisational structure that is fit for purpose agile and responsive to change. | Have a strong voice for clinicians on our Trust Board | Have the right processes in place to change our organisational shape to meet future demands. |
| Management practices | Work with Commissioners to develop new roles to meet new and changing services. | Continuously consult with staff and their representatives on what we do and how we do it, and engage through our Governors with our membership to influence our future. | Have the right management practices to support mobile working / technology. |
| Systems | Have safe and effective working practices and effective governance. | Use national and local feedback processes so staff can share their views and we can respond to concerns raised. | Have HR policies and terms and conditions that are fit for purpose and flexible. |
| Motivation and engagement | Enable staff to engage with stakeholders to improve services and reduce barriers to access. | Recognise and reward the contribution of staff & volunteers who improve our services. | Have leaders who understand the benefits of, encourage, support and implement innovation. |
| Tasks and individual skills / abilities | Ensure staff have access to an annual appraisal and appropriate supervision | Involve staff, volunteers, Governors, Members and others in influencing how they support the delivery of our services, drawing on their talents, strengths and insights. | Ensure that all those who help deliver our services have access to the training, development and support they need to fulfil their duties. |
| Individual needs and values | Support the physical and mental health and wellbeing of our staff | Support the retention of staff, reduce recruitment barriers and encourage a diverse workforce including offering work experience to specific groups | Ensure the employment of staff to meet short term needs is fair, effective, efficient, economical |
| Work climate and environment | Strive to be a place where our staff want to work and feel safe to work | Ensure staff are included in decisions which affect them or service users and carers | Ensure staff have the resources to work effectively and efficiently. |

## Mission

**Our leaders, staff, volunteers, governors and members will**

**Continue to promote our aim of "Making life better"**

## Strategy

**The Trust will:**

**Everyone who helps us deliver our services, use or commission our services, or has an interest in our services will:**

Have a comprehensive range of strategies which describe our direction of travel, and describe the quality of our services in a way that makes sense to our service users and carers and those who are influential in delivering and commissioning our services.

*See simple and clear explanations about our plans on the Trust intranet and website.*


Explore how we might deliver our services through different types of employers.

*Be involved and informed about how the Trust might deliver services, and the impact this may have on them and others.*

## Leadership

| **We will:** | **Staff will:** |
|---|---|
| Have leaders who understand and enhance their team's performance, and the performance of others. | *Have access to internal and external opportunities for leadership and development* |
| Have visible and approachable leaders who inspire others, lead by example and communicate well. | *See Executive and Non-Executive Directors at team meetings and on Patient Safety visits* |
|  | |
| Have leaders with the skills to understand the impact of change, manage change and support others through change. | *Be able to use a range of tools including 'Flightgate' to help them prepare for and work through change, supported by their managers* |

## Organisational Culture

| **We will:** | **Staff, volunteers, and leaders will:** |
|---|---|
| Promote an organisational culture that is consistent with our Trust values, Staff Charter, Carers' Charter and Service Users' Charter and that embraces diversity. | *Be recruited and promoted using our "values based recruitment" tools, and 'Experts by Experience' will be involved as appropriate* |
| Have open and transparent processes for those who use or deliver our services to raise concerns and get feedback. | *Be supported when raising complaints, queries or concerns* |
|  | |
| Ensure we safeguard the safety of everyone who delivers our services and give equal importance to staff safety and patient safety. | *Know the right measures are in place to keep staff, volunteers, patients and others safe, and supported by the right processes* |

## Individual and Organisational Performance

| **We will:** | **Everyone who helps us deliver our services will:** |
|---|---|

Have agreed roles and responsibilities for everyone who delivers our services, which are understood by our service users, carers and commissioners.

*Have a rewarding role which makes a difference to service users, carers and our communities*

Support staff to embrace new technologies and new ways of working, and we will develop new roles for volunteers which meet service need.

*Have access to the right training and development to help them excel*

Provide and have access to quality data to understand our staffing and resourcing challenges and address these.

**Our staff and commissioners will:**

*See clear workforce plans using accurate information which will inform our recruitment, retention, succession planning and talent management*

## Structure

**We will:**

**Staff will:**

Have an organisational structure that is fit for purpose, agile and responsive to change.

*Be able to work in teams with clear lines of accountability that supports service delivery*


Have a strong voice for clinicians on our Trust Board and in our decision making.

*See our Heads of Professions and Medical Leaders involved in developing our business plans*

Have the right processes in place to change our organisational shape to meet future demands.

*See that we have clear management of change processes and communication which reduces uncertainty when change occurs*

## Management Practices

| We will: | Everyone who delivers our services will: |
|---|---|
| Work with Commissioners to develop new roles and new ways of working to meet new and changing services. | *Be supported to develop the right skills to work in different ways, and work collaboratively alongside apprentices, volunteers and others* |
| Continuously consult with staff and their representatives on what we do and how we do it, and engage through our Governors with our membership to influence our future.  | *Understand how they can be involved in influencing our service development using their experience in the process* |
| Have the right management practices to support mobile working and mobile technology. | *See how mobile working / technology will improve the care they provide and help them work more effectively* |

## Systems

| We will: | Staff will: |
|---|---|
| Have safe and effective working practices and effective governance.   | *Have access to Health & Safety Representatives and know that issues can and will be escalated to the Board's Governance Committee* |
| Use national and local feedback processes so staff can share their views and we can respond to concerns raised. | *Be kept up to date with results from the Staff Survey, Staff Family & Friends Test and other surveys and know what actions the Trust is taking to address issues raised* |
| Have HR policies and terms and conditions that are fit for purpose and flexible. | *Know that leaders and Staff Side Representatives have been involved in changes to policies and terms and conditions* |

## Motivation and Engagement

**We will:**

Enable staff to engage with stakeholders to improve services and reduce barriers to access.

Recognise and reward the contribution of staff and volunteers who improve our services.

ROSCAs

Have leaders who understand the benefits of, encourage, support and implement innovation.

**Staff will:**

*Have information about patient feedback surveys, patient complaints and compliments to inform what they do and how they do it, thereby improving patient care*

*Be able to nominate colleagues and volunteers with whom they work for recognition of their contribution*

*Be invited to take part in 'Innovation Days' and there will be opportunities for staff to be trained in improvement methodologies*

## Tasks and individual skills / abilities

**We will:**

Ensure staff have access to an annual appraisal and appropriate supervision.


Involve staff, volunteers, Governors, Members and others in influencing how they support the delivery of our services, drawing on their talents, strengths and insights.

Ensure that all those who help deliver our services have access to the training, development and support that they need to fulfil their duties.

**Staff will:**

*Have access to a meaningful appraisal that recognises their past achievements and sets out a clear direction for the coming year*

**Everyone who delivers our services will:**

*Be able to make choices about their roles, careers or employment which balance service need work and their personal life*

*Know how to access training and that their training meets statutory requirements as a minimum*

## Individual Needs and Values

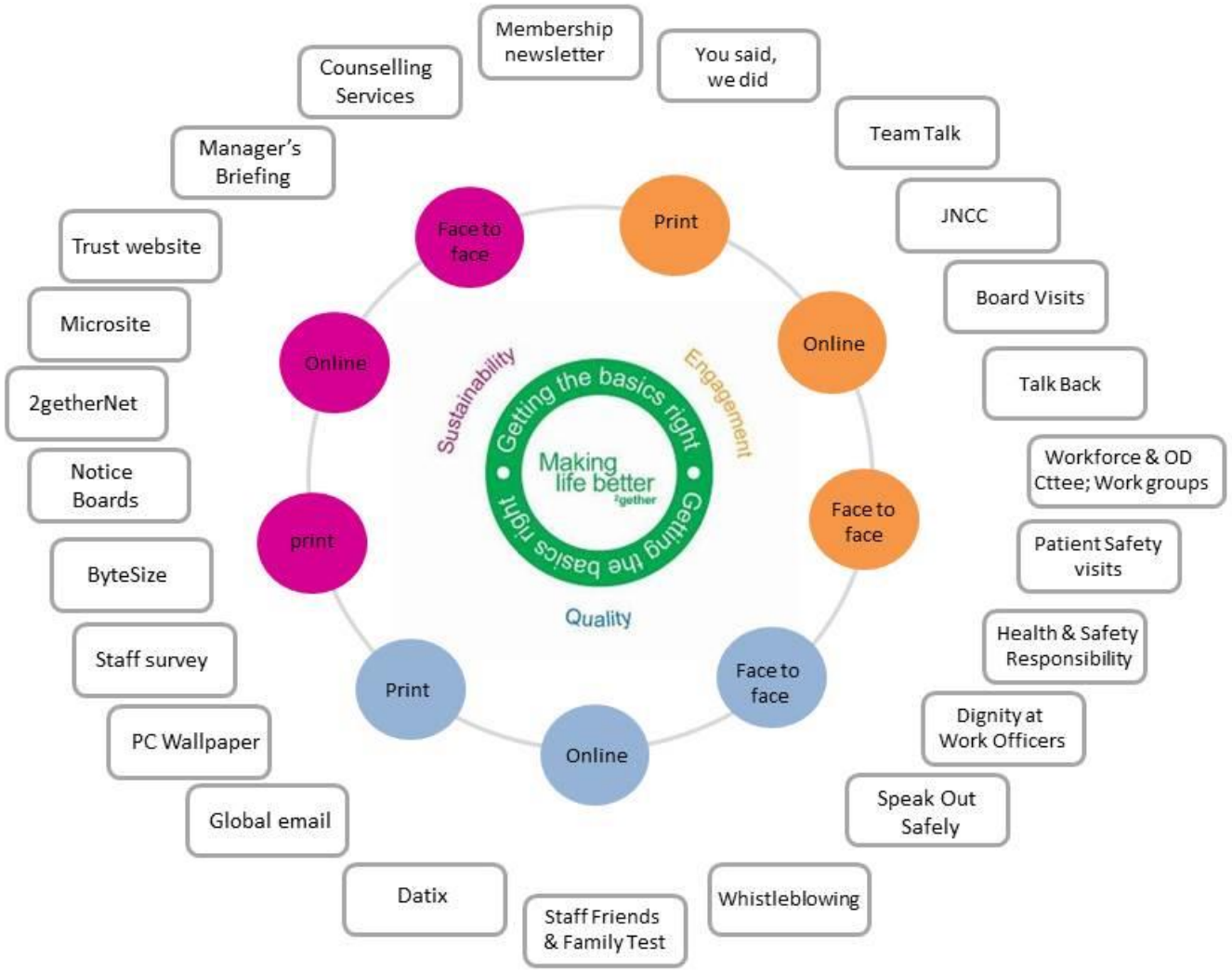
| We will: | Staff will: |
|---|---|
| Support the physical and mental health and wellbeing of our staff. | *Have access to clear information about how to access support, and health and wellbeing benefits for them and their families* |
| Support the retention of staff, reduce recruitment barriers and encourage a diverse workforce including offering work experience to specific groups. | *Be encouraged to use their diverse experiences to benefit service users and carers* |
| Ensure the employment of staff to meet short term needs is fair, effective, efficient, economical. | *Be employed on a variety of different types of contracts, which will support personal choices as well as meeting service need* |

## Work Climate and Environment

| We will: | Staff will: |
|---|---|
| Strive to be a place where our staff want to work and feel safe to work. | *Be encouraged to find ways to improve their work environment and safeguard themselves, their colleagues, service users and carers* |
| Ensure staff are included in decisions which affect them or service users and carers. | *Be asked to contribute constructively to workplace contributions and give honest feedback* |
| Ensure staff have the resources to work effectively and efficiently. | *Be encouraged to maximise opportunities for team working, to utilise resources and improve access to services* |

# Internal Communications Map

**APPENDIX 3**



**APPENDIX 4**

# [2]GETHER NHS FOUNDATION TRUST
# OUR ORGANISATIONAL DEVELOPMENT STRATEGY ON A PAGE
# 2015 – 2018

## What is Organisational Development?

It is a systematic plan, working within a clear set of values, to achieve the Trust's aims by improving the effectiveness and performance of individuals, teams and the organisation.

## Why do we need an Organisational Development Strategy?

An Organisational Development Strategy ensures we can continue to deliver high quality services in a climate of reducing NHS resources and increasing competition for the delivery of health services. The Strategy provides tools and a focus so that staff and the organisational shape remain fit for the future.

## What is the aim of our Organisational Development Strategy?

We know that our services face significant challenges in the coming years, whether that be how we provide services, the cost of services or who provides them. Our Organisational Development Strategy describes the skills and knowledge our staff will require, how they need to work, the options we have as to our organisational structure and how together we will achieve our aim of 'Making Life Better'. Our strategy will describe how we will improve, align and maintain our capability through: effective recruitment and talent management; internal review and challenge leading to renewal; in an environment where staff wish to work; and with flexible and adaptable structures and 'fit for purpose' procedures.

## Who is included in our Organisational Development Strategy?

Our strategy applies to all staff - substantive, short term or agency contracts - and includes, where applicable, our volunteers, students, Governors, members, and those who contribute to the our Trust aim of 'Making Life Better'.

## How will our Organisational Development Strategy change us?

Our strategy will help individuals, teams and the Trust to work with different partners, work differently and more flexibly, be more agile and adaptable to future changes, have the appropriate skills, tools and knowledge to work in a changing environment, and be more creative about what we do, how we do it and when we do it.

## When will our Organisational Development Strategy be delivered?

The strategy covers 2015 – 2018. It will be delivered incrementally year on year through a range of action plans, many of which already exist including some within other enabling strategies and supporting action plans. Our action plans will be flexible to meet any new internal and external challenges.

## How will we know if we have delivered our Organisational Development Strategy?

We will continue to deliver quality services that our commissioners want to purchase, partners want to engage with, our service users and carers want to use, and our staff recommend. Our staff will want to work for us and would recommend us as an employer of choice.

**Agenda Item** **14** **Enclosure** **Paper I1**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE:** Mental Health Legislation Scrutiny Committee

**DATE OF COMMITTEE MEETING:** 20 May 2015

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### AUDIT OF SECTION 17 LEAVE ARANGEMENTS

**SUMMARY**

- Audit of Trust Compliance with section 17 of the Mental Health Act, , using eight indicators. This covers the provision of leave for in-patients
- Previous audit March 2014 – figures in brackets
- Overall compliance 76% (71%) – Herefordshire 80% better than Gloucestershire 75%
- Four indicators improved and four worsened
- Of particular concern was that only 44% (14%) of patients were reported as being given a copy of the Section 17 leave form

**RISKS**

- If reasons for section 17 leave are not recorded, discussed by the MDT and shared with the patient, there is a risk that the neither staff nor patient will fully understand the purpose of the leave in the overall care plan nor the rationale for using section 17 leave rather than a CTO

**ASSURANCE**

- Improving but **limited** assurance

**FURTHER ACTION**

- The Committee concluded that the issue needed to be addressed across the whole in-patient management structure of the Trust and not just through the medical structure
- An action plan to improve compliance with Section 17 would be requested from the in-patient Service leads for Gloucestershire and Herefordshire

### REVIEW OF DOLS APPLICATIONS

**SUMMARY**

- The Committee has commissioned a regular update on actions within the Trust following the issue of its MCA and DoLs Policy
- Legal advice is that all incapacitated people needing admission to Mental Health hospitals must be detained under either the Mental Health Act or a DoLs
- The proposals to be able to use DoLs where appropriate to support admissions to inpatient services within the Trust challenges establish working practices and needs to be closely supported
- A recent check on Willow Ward showed only one informal patient
- Two DoLs applications have been made, which were refused
- These applications are to be followed up to understand the basis of the decisions and disseminate learning through the Trust

**RISKS**

- If the MHA, MCA and DoLs provisions are not correctly applied, the Trust could be detaining a patient unlawfully

**ASSURANCE**

- **Significant** assurance that this issue is being carefully monitored and learning disseminated

**POLICY FOR RECEIPT AND SCRUTINY OF MENTAL HEALTH ACT DOCUMENTS**

**SUMMARY**

- The new MHA Code of Practice requires an update to this policy in respect of guidance to be taken after a detention is deemed to be invalid.
- Previous practice had been for the Head of Health Records to advise on this
- It was agreed that, in future, if a detention was deemed to be invalid and a fresh application was not sought, a panel of Mental Health Act Managers would be convened to formally discharge the patient

**RISKS**

- If a formal process is not in place, then the Trust cannot prove that it has acted in accordance with the 2015 MHA Code of Practice and therefore lawfully

**ASSURANCE**

- **Significant** level of assurance that the new Code of Practice is being carefully reviewed and, where necessary, changes made to Trust policy and practice

**MONITORING OF PROVISION OF PATIENT'S RIGHTS**

**SUMMARY**

- Section 132 of the MHA requires that a detained patient should be informed both orally and in writing, of their legal position and rights.
- Chapter 2 of the 2015 Code of Practice sets out the specific information which must be provided to detained patients and those on a CTO
- Patients should be informed on admission and from time to time thereafter. Trust policy is a reminder weekly for patients subject to Section 2, three weekly fo patients subject to Section 3 and Forensic sections and two-monthly for patients subject to Community Treatment Orders
- A review of the % of patients whose Rights reminders were up to date indicated a recorded compliance of 42-50% in Gloucestershire and 30-62% in Herefordshire

**RISKS**

- If patients/carers are unaware of their rights, they are unable to exercise them and the Trust could act unlawfully without the patient/carer being aware

**ASSURANCE**

- The data provided was not in a form which readily enabled the Committee to gain a thorough understanding of where within the Trust there is significant assurance and where there is need for action to improve compliance

**FURTHER ACTION**

- Inpatient Service leads would be asked to provide clearer information about each unit's compliance with this requirement and action being taken where it is inadequate

**RECEIPT AND SCRUTINY POLICY**

**SUMMARY**

- Audit of a random selection of AMHP applications for admission and medical recommendation forms, to ensure compliance with Trust Policy
- 20 records reviewed representing 14% of applications between January and March 2015
- No errors identified

**RISKS**

- **If** AMHP application for admission or medical recommendation form is not completed correctly, the Trust may be acting illegally in detaining a patient

**ASSURANCE**

- The audit provided **significant** assurance

**MENTAL HEALTH ACT MANAGERS' POLICY**

**SUMMARY**

- This policy required updating as a result of the 2015 MHA Code of Practice
- Additional guidance provided in respect of the discharge powers of Hospital Managers and the necessity for them to be assured as to the capacity of patients appearing before a MHA Managers'

Review Hearing to understand the range of issues pertinent to their detention, treatment and discharge
- The Mental Health Act Managers' Forum had requested that the Trust templates for completion by RCs, nurses and social care professionals should be appended to the Policy, as an aide memoire for MHAMs.

**RISKS**
- If MHAMs do not act in accordance with the MHA Code of Practice they could be acting unlawfully on behalf of the Hospital Managers

**ASSURANCE**
- The Committee received **significant** assurance from the care with which the Trust's Mental Health Act Managers' Code of Practice had been updated to comply with the 2015 MHA Code of Practice and the fact that these updates would be the subject of training for and discussion with Mental Health Act Managers.

**FURTHER ACTION**
- The Committee noted that the template reports for Responsible Clinicians did not include the requirement to clearly state, in the conclusion of their reports to Mental Health Act Managers' review hearings, the reasons why a patient should be detained in accordance with the relevant statutory criteria, as is stated in report templates for other professions. It was reported that RCs do not always conclude their reports in this way and so it was agreed that the templates for RCs would be amended to accord with those of other professions

**CARE PLAN FOLDERS**

**SUMMARY**
- Care plan folders have been introduced to address the issue raised by CQC MHA Commissioner visits, that some patients reported not having copies of their care plans
- Purpose designed folders have been tested in both counties
- While Gloucestershire reported good results, Herefordshire had found problems with the folders and suggested an alternative solution

**RISKS**
- If patients do not have a safe place to keep their care plan and other key information, it is easy for them to be lost and harder for the patient/carer to engage in care planning discussions.
- The Trust can be rightly criticised by the CQC for not having an effective process in place to enable patient copies of information to be secure

**ASSURANCE**
- The Committee received **significant** assurance that solutions are being sought and tested for effectiveness

**FURTHER ACTION**
- The Committee requested that the inpatient services leads, consider the different experience in the two counties and seek to find a common solution, although if this is not possible, then the important point is that a folder of some sort is in place for every patient

**HUMAN RIGHTS ISSUES**

**SUMMARY**
- The Committee's Terms of Reference include the Human Rights Act (HRA)
- The Committee had commissioned a report to clarify its responsibilities under this Act and the European Convention on Human Rights (ECHR)
- Checks with other Mental Health Trusts had identified that this area of scrutiny is underdeveloped, although Trusts had been prosecuted
- Mechanisms in place for monitoring compliance with the MHA, MCA and DoLs were felt to meet the Committees obligations under the HRA and ECHR
- The paper posed a number of questions which would need to be addressed in order to assure the Board that the Trust is complaint with HRA and ECHR

**RISKS**
- If the Trust cannot demonstrate compliance with HRA and ECHR, then it may be acting unlawfully

**ASSURANCE**
- There is significant assurance that an analysis has been undertaken to understand the requirements of HRA and ECHR, however it was felt that a further step to identify evidence

against the key areas would be helpful

**FURTHER ACTION**

- A checklist will be produced indicating the key questions and the evidence of compliance. This will identify any areas where evidence is missing or partial

**REPORTS OF ISSUES ARRISING AT MHA MANAGER REVIEW HEARINGS**

**SUMMARY**

- MHA Managers had raised three issues arising from recent hearings
- Reports and actions taken were reported to the Committee and will be reported to the Mental Health Act Managers' Forum

**RISKS**

- If MHA Managers raise issues of concern from hearings, then they may have identified areas of poor practice or where the Trust is acting illegally

**ASSURANCE**

- Reports from MHA Manager Reviews are taken up with relevant staff and action taken where deemed necessary. This is reported back to the MHA Managers' Forum before being closed.

**REPORT FROM MENTAL HEALTH ACT MANAGERS' FORUM**

**SUMMARY**

- MHAs have raised concerns as to the impact of changes to the provision of social care in Herefordshire
- A discussion of the changes and any reported evidence of impact would be taken to the next MHA Managers' Forum

**RISKS**

- Possible risk that as social care staff in Herefordshire are no longer part of the Trust, this may affect the timeliness and helpfulness of their reports to MHA Manager Review hearings and whether they attend, and this will adversely impact on the patient

**ASSURANCE**

- **Significant** assurance that the possible risk is being monitored to identify if it is crystallising in practice

**FURTHER REPORTS COMMISSIONED BY THE COMMITTEE**

- National and local work being undertaken to ensure access to CAMHS Tier 4 beds
- Review of discharges by Tribunals and Mental Health Act Managers to identify learning and agree necessary actions
- A number of CQC MHA Commissioner visits have identified issues around recording of care plans. A report on recording performance by unit and constraints on recording was commissioned
- Assurance that policy on Seclusion, De-escalation and Segregation can be applied across the Trust in practice

**ACTIONS REQUIRED BY THE BOARD**

The Board is asked to:

- Note the papers received and action taken
- The level of assurance provided by each paper

**Agenda Item** **14** **Enclosure** **Paper I2**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Audit Committee**

**DATE OF COMMITTEE MEETING: 26 May 2015**

### KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

**Counter Fraud Annual Report and Action Plan**
The Committee received and noted the Counter Fraud Annual Report 2014/15 that encompassed standards required by NHS Protect. The Committee was pleased to note that the Trust's 'Prevent and Deter' work had been assessed as Green, an improvement on the Amber rating in 2013/14. The Committee received the 2015/16 action plan and noted that proactive work referenced in the plan would be identified by the end of June 2015.

**Quality Report Assurance Report**
The Committee received and noted the assurance report on the Quality Report 2014/15, which gave an unmodified opinion. The external auditors concluded the Quality Report was in line with Monitor's guidance; and not inconsistent with the information specified by Monitor. The performance indicators mandated by Monitor and the indicator selected by Governors were tested and no significant issues were found, although some minor improvements had been identified around the need for clear and complete records. The Committee noted that compliance figures for Delayed Transfer of Care and Access to Crisis Team had mistakenly been assigned a Red rating, when this should have been Green; this error was agreed and would be amended.

**Quality Report 2014/15**
The Committee received the Quality Report, and noted a number of minor typographical errors which were corrected during the meeting. The Committee took account of the External Auditor's review of the Quality Report, and the amendments outlined above, and approved the signature of the 2014/15 Quality Report.

**Letter of Representation**
The Committee approved the signing of the Letter of Representation.

**Statement of Chief Executive's Responsibilities**
The Committee reviewed the Statement of Chief Executive's responsibilities and approved this for signature by the Chief Executive.

**Annual Governance Statement**
The Committee received the draft Annual Governance Statement (AGS) which is drawn up by the Chief Executive, as Accounting Officer. The statement reviews the Trust's system of internal controls and forms part of the Trust's Annual Report. The Committee approved the AGS for signature by the Chief Executive.

**Post Balance Sheet Report**
The Committee discussed and approved a disclosure in the 2014/15 annual accounts regarding the Trust's Substance Misuse services in Herefordshire.

**External Audit Report on the Financial Statement**
The Committee noted that Deloitte intended to issue an unmodified audit opinion in respect of the 2014/15 accounts, with no matters to report in respect of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources, or in respect of the Annual Governance Statement. The Committee noted that the audit had resulted in only 1 minor adjustment regarding fixed assets with nil Net Book Values. There had been no inconsistencies between the financial statements and the Foundation Trust Consolidation Schedules, no significant uncorrected misstatements and no disclosure deficiencies with the accounts.

**Statutory Accounts 2014/15**
The Committee received the Statutory Accounts for the year ending 31 March 2015 for approval on behalf of the Board. Some minor additional changes had been made to the Accounts since the distribution of the papers for this meeting, and those changes were set out on a paper tabled at the meeting. All amendments had been signed off by the Auditor. The Committee noted that some members of the Committee had not been able to review the Accounts electronically before the meeting, due to a formatting error. With the exception of Jonathan Vickers, who had not been able to review the Accounts for the reason above, the Committee approved the Statutory Accounts on behalf of the Board.

**Annual Report 2014/15 – Including Remuneration Report**
The Committee received the Annual Report 2014/15 and Remuneration Report prior to submission of these documents to Monitor. The Committee approved the contents of the Annual Report, subject to a correction in the Waste data table for Herefordshire, and an amendment to take account of the Committee's earlier discussion on Post balance Sheet events. The Remuneration Report was then signed by the Chief Executive.

**ACTIONS REQUIRED BY THE BOARD**

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

**SUMMARY PREPARED BY: Maggie Deacon ROLE: Committee Chair**

**DATE: 26 May 2015**

**Agenda Item** **14** **Enclosure** **Paper I2**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Audit Committee**

**DATE OF COMMITTEE MEETING: 21 July 2015**

**KEY POINTS TO DRAW TO THE BOARD'S ATTENTION**

**Internal Audit Plan 2015/16**

The Committee received the draft Internal Audit plan for 2015/16 and noted a number of changes made to the plan following discussions at the last meeting of the Committee. Two reviews (Board/Committee Effectiveness and Multi-Speciality Community Providers) had been deferred with a further four reviews being added to the programme, covering Cost Improvement Plans (CIPs), Hoople, Procurement and Herefordshire Community Services. The Committee noted that a review of Data Quality was not currently included in the plan although this had been discussed at the previous meeting; the Committee asked that this review be included in the programme, and that the overall number of audit days be increased if necessary to accommodate this.

The Committee discussed the most appropriate timing for the audit of Incident Reporting scheduled for Q3. The Committee requested that if the implementation of new Datix models during 2015 means that it would be some time before full assurance can be given, an interim audit of progress be undertaken to offer assurance on progress.

The Committee noted that a number of reviews took place on a 2-3 year cycle, and asked that future reports indicate when the last such review took place so that the Committee could be assured that infrequent reviews were not overlooked.

The Committee approved the Internal Audit Plan subject to the inclusion of a Data Quality audit.

**Medical Budget Report**

The Committee received a report on the medical budget which had recently been centralized to provide greater transparency in terms of financial information and to control overspends which were due in large part to agency costs and increased drugs costs. The Committee noted that the medical budget had not been increased this year, and every effort was being made to manage within the existing establishment. However the budget is forecast to overspend this year, albeit by a significantly reduced amount compared to previous years.

The Committee noted a number of actions to alleviate historical overspends in the budget. These included measures such as employing a floating locum consultant, and the implementation of a medical staff bank, to reduce costs incurred in covering vacancies and sickness. Within the Children & Young People's Service, long term locums had been put in place to provide continuity of care and thus mitigate in part the risks to quality and safety of ongoing substantive recruitment difficulties. Further possible actions included the introduction of non-medical prescribing posts in CYPS to reduce the burden of prescription-related follow up appointments. This would make posts more attractive to prospective applicants and together

with a Trust presence at recruitment fairs would improve recruitment opportunities. The Trust's CIP included savings against drugs costs, and savings would be taken from this budget once the first quarter spend was confirmed. The drugs budget would be subject to further scrutiny throughout the year to identify any potential further savings, and the Committee asked that clinical input be obtained as part of that process.

The Committee supported the actions proposed in the report but asked that the Executive Committee examine the issue further with a view to drawing up a systematic and time-bound action plan for the actions proposed in the medical budget report. This action plan should also address the issue of clinical input into savings on the drugs budget, and should also include savings made possible by the introduction of mobile working technology for medical staff. The Committee asked that a further report, including that action plan, be presented at its next meeting in October.

**Data Quality Report**
The Committee received a report on data quality and the processes in place to improve data quality across the organisation, but particularly in terms of performance reporting. Recent changes had been made to processes, a new Data Quality policy had been issued in 2013, and Service Directors now received a situation report 7 days before month end which enabled them to proactively review and correct any data errors before reports were formally compiled and submitted. This made the process more focussed and proactive.

The Committee noted this report which was helpful for summarising the process and steps planned for providing quality data within the Trust. However, the Committee felt it did not provide assurance that issues around data quality were being addressed or that existing processes were being properly implemented and were embedded within the Trust, and the Committee reiterated its view that an Internal Audit on data quality was required in order to provide a more complete view. The Committee discussed where the matter should sit in terms of accountability (and ownership), and which Committee should receive progress reports on the quality of data, and the Director of Quality agreed to take the matter to the Executive Committee.

**Standing Financial Instructions**
The Committee received an updated set of Standing Financial Instructions which had been updated and reformatted to improve readability and to take account of recently agreed financial delegation limits. The Committee noted that a small number of typographical errors had come to light which would be corrected. The Committee approved the SFIs subject to a small number of amendments including a reference to 'current EU procurement limits' rather than the actual monetary figure, the inclusion of a definition of 'significant' in terms of the circumstances under which the Chief Executive may vire expenditure between revenue and capital budgets, and the requirement to report annually to the Committee on waivers of formal tender processes.

**Risk Management**
The Committee reviewed the Corporate Risk Register and the Board Assurance Framework, and noted the current level of risk and mitigating actions in place. The Committee requested that assurances listed in future BAF reports be verified with Committee chairs before the report was issued.

**Audit Committee Annual Report**
The Committee received the Annual Report which gave an overview of the Committee's work in the last financial year, in sections reflecting 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, in support of the Annual Governance Statement.The

Committee endorsed the conclusion of the Annual Report that the Committee's work during 2014/15 had led it to conclude that the Trust's governance and internal control systems are in the main sound, reliable and robust.

The Committee's Annual Report is attached to this summary for the Board to note.

**Audit Committee Effectiveness Self-Assessment**
The Committee received the results of its annual effectiveness self-assessment. The self-assessment was conducted using the pro forma in the Audit Committee handbook.

The self-assessment showed that the Committee believes it has been largely effective in discharging its responsibilities. Positive assurance related particularly to the resources available to the Committee and the expertise of its members, oversight of internal and external audit and counter fraud, and the Committee's role in reviewing and approving annual accounts and disclosure statements.

The self-assessment highlighted a small number of areas for improvement, and the Committee requested that the Trust Secretary and Director of Finance meet with the chair of the Audit Committee to draw up an action plan in respect of these areas for improvement.

**Terms of Reference**
The Committee received the annual review of its terms of reference and agreed minor formatting changes. There were no substantive changes to the terms of reference.

**ACTIONS REQUIRED BY THE BOARD**

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

**SUMMARY PREPARED BY: Jonathan Vickers ROLE: Deputy Committee Chair**

**DATE: 21 July 2015**

# 2gether NHS Foundation Trust

# Audit Committee Annual Report 2014/15

## 1 Introduction

1.1 The Audit Committee was established in its current form under Board delegation in late 2010 following a review of Board Committee structures. Its terms of reference are aligned with the Audit Committee Handbook, published by HFMA and the Department of Health.

1.2 All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair. A number of officers are in regular attendance in accordance with the Committee's Terms of Reference. These include the Director of Finance & Commerce, the Trust Secretary, Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers attended at the request of the Committee. After each meeting of the Committee, the Audit Committee Chair provides a summary report of the Committee's deliberations and decisions to the next Board meeting.

1.3 The Committee met 5 times during the period 1 April 2014 to 31 March 2015, 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.

1.4 Attendance by members at the Committee during the period was as follows:

| | 22/04/2014 | 27/05/2014 | 26/08/2014 | 18/11/2014 | 23/02/2015 |
|---|---|---|---|---|---|
| John Saunders (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ |
| Charlotte Hitchings | | | ✓ | ✓ | ✓ |
| Martin Freeman | ✓ | ✓ | ✓ | | ✓ |
| Jonathan Vickers | ✓ | | ✓ | ✓ | ✓ |
| Jo Newton[1] | ✓ | ✓ | | | |
| Maggie Deacon | | | ✓ | | ✓ |

1.5 The following officers were in attendance at the Committee during the period:

| | 22/04/2014 | 27/05/2014 | 26/08/2014 | 18/11/2014 | 23/02/2015 |
|---|---|---|---|---|---|
| Andrew Lee, Director of Finance & Commerce[2] | | ✓ | ✓ | ✓ | |
| Sallie Cheung, Local Counter Fraud Specialist | | | ✓ | ✓ | |
| Lisa Evans, Board Committee Secretary | ✓ | ✓ | | ✓ | ✓ |
| Trish Jay, Director of Quality | ✓ | ✓ | ✓ | ✓ | ✓ |
| John McIlveen, Trust Secretary | ✓ | | ✓ | ✓ | ✓ |
| Peter Stephenson, PWC | ✓ | | ✓ | | |
| Michelle Hopton, Deloitte | | ✓ | ✓ | ✓ | |
| Ian Howse, Deloitte | ✓ | | ✓ | | ✓ |
| Gordon Benson, Asst Director of Governance | | | | | ✓ |
| Gavin Davies, Deputy Director of Commerce | | ✓ | | | |
| Alan Bourne-Jones, Risk Manager | | | | ✓ | |

[1] Joanna Newton left the Trust on 31 October 2014

[2] As Interim Director of Finance & Commerce until 3 November 2014

| | | | | | |
|---|---|---|---|---|---|
| Shaun Clee, Chief Executive | ✓ | ✓ | | | |
| Ruth FitzJohn, Trust Chair[3] | | | | ✓ | |
| Tanya Hartley, Asst Director of Finance | | | | | ✓ |
| Stephen Andrews, Deputy Director of Finance | ✓ | ✓ | | | ✓ |
| Anna Hilditch, Asst Trust Secretary | | ✓ | ✓ | | |
| Sam Maunder, Deloitte | ✓ | ✓ | | | |
| Lynn Pamment, PWC | | ✓ | | ✓ | ✓ |
| Gavin Davies, Asst Director of Commerce | | ✓ | | | |
| James Pring, PWC | | | ✓ | ✓ | |
| Natalie Tarr, PWC | | | | ✓ | ✓ |
| Roger Wilson, Governor | | | | | ✓ |
| Alan Thomas, Governor | | | | | ✓ |

## 2 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, together with 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 has maintained a continued focus on Incident Reporting systems following a 'Critical Risk' finding which resulted in an overall Head of Internal Audit Opinion for 2013/14 that *'there is considerable risk that the system will fail to meet management's objectives for the areas that we have assessed as critical or high risk. Significant improvements are required to improve the adequacy and / or effectiveness of governance, risk management and control in these areas.'* At the Committee's request, follow-up audits were conducted at various points through the 2014/15 reporting period to assess progress and provide assurance against the action plan drawn up to mitigate this risk. While some progress was noted at the end of the reporting period, this was sufficient only to produce a Head of Internal Audit Opinion of 'Improvement Required' for 2014/15. The Committee intends to continue to focus on this issue throughout the current year.

2.6 The Committee reviewed the Board Assurance Framework at regular intervals, and the adequacy of the assurances given. In line with new arrangements agreed in 2013/14, the Committee also reviewed the Corporate Risk Register at each meeting, and

[3] The Trust Chair is not a member of the Audit Committee, but may attend a meeting of the Committee by invitation

received summary reports from other Board Committees in order to provide challenge and receive assurance that strategic and corporate risks assigned to those Committees are being adequately monitored.

2.7 The Committee reviewed the Annual Governance Statement which forms part of the Trust's Annual report and sets out the systems and processes for internal control.

2.8 The Committee reviewed the Register of Directors' Interests, and the Register of Gifts and Hospitality.

2.9 The Committee discussed and approved a revised Business Conduct, Gifts and Hospitality Policy.

2.10 The Committee reviewed and endorsed the arrangements for conducting a Well-led Framework for Governance review of the Trust.

2.11 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. The Committee believes that while adequate systems for risk management are in place, continued management focus is required to ensure that risk management continues to be embedded within the trust and in particular to address outstanding issues concerning Incident Reporting systems.

**2.12 Internal Audit**

2.13 In completing its work, the Committee places considerable reliance on the work of Internal Auditors. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes and during the year the Committee:

- Reviewed and approved the internal audit plan for 2014/15
- Considered the findings of internal audit in relation to work on the following issues
    - Contracts & commissioning
    - Registration Authority Processes
    - Estates Shared Service
    - Payment By results
    - HR – e-expenses
    - Incident Reporting – Follow-up
    - ICT - Hoople
    - Stakeholder Engagement
    - Cost Improvement Programmes
    - Asset Management
    - Financial Ledger
    - Debtors
    - Procurement and Creditors
    - Information Governance
    - Risk Management

2.14 These audits produced a total of 30 findings (a reduction from 55 findings the previous year) in respect of which 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. A number of these audits were undertaken at the Committee's request in order to examine areas where known areas of risk exist.

**2.15 External Audit**

- The Committee received and noted the final audit in respect of the 2013/14 Financial Accounts and the 2013/14 Quality Report, and approved the Financial Accounts and the Quality Report on behalf of the Trust Board.
- The Committee reviewed and agreed the external audit plan for 2014/15.
- 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.
- The Committee also received regular Sector Development Reports which proved a useful source of intelligence on key national issues and developments.

2.16 The Committee discussed the performance of the External Auditor at its August 2014 meeting, and recommended to the Council of Governors that the External Auditor's contract be extended for a further two years. This recommendation was subsequently accepted by the Council of Governors.

**2.17 Private Meeting with the Auditors**

2.18 The Committee met privately with both internal and external auditors prior to the Audit Committee meeting in November 2014. 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, and has considered any governance implications for the Trust. For example, the Committee considered at its August and November 2014 meetings arrangements for mitigating risks posed by single points of expertise within the Trust. The Committee also received a report which provided assurance regarding the numbers of clinical and non-clinical claims against the Trust.

2.21 The Committee received regular Counter Fraud updates, received and approved the Counter Fraud Policy for 2014/15, and also received the Counter Fraud Annual Report for 2013-14. The Counter Fraud Service completed 95 days of activity during 2014/15, fewer than the planned 145 days. However, the NHS Protect self review tool provided assurance that the Trust has a robust and effective Counter Fraud Service, with the overall level of risk being rated as 'Green' against an Amber rating for 2013/14. The Committee expects the level of Counter Fraud activity to meet the planned level of 145 days during 2015/16 in order to reduce fraud and corruption to an absolute minimum.

2.22 The Counter Fraud Service completed a self-assessment tool in 2014 which was submitted to NHS Protect and reported to the August 2014 meeting of the Committee. The self-assessment rated the Trust as Amber overall, and there were no further quality assessment recommendations from NHS Protect arising from this self-assessment.

**2.23 Management**

2.24 The Committee has challenged the assurance process when appropriate, and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. The Committee has, for example, requested and received:

- further assurance regarding document controls for Capital Review Group papers;

- further assurance on mitigation in place in respect of single points of expertise;
- further assurance on the risk of medicines resale fraud;
- further assurance on the Governance Committee's review of Datix Incident Reporting issues

2.25 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.

**2.26 Financial Reporting**

2.27 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.

2.28 The Committee received the Trust's Going Concern report at its April 2014 meeting, and reviewed the 2013/14 financial statements and annual report at the May 2014 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.29 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 Other Matters

3.1 The Committee agreed a process for a representative of the Council of Governors to attend Audit Committee meetings in order to provide assurance to the Council. Governor attendance began at the February 2015 meeting.

## 4 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. This report gives an overview of the work of the Committee in the last financial year, which has enabled the Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

Maggie Deacon
Chair, Audit Committee

**Agenda Item** **14** **Enclosure** **Paper I3**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Delivery Committee**

**DATE OF COMMITTEE MEETING: 27 May 2015**

**KEY POINTS TO DRAW TO THE BOARD'S ATTENTION**

**PERFORMANCE DASHBOARD REPORT**

The Committee reviewed the Performance Dashboard which provided the outturn for 2014/15.

During the 2014/15 contract period services continued to experience an increase in referrals. Despite this, Trust compliance with national performance measures had been excellent with only three indicators not achieving compliance. Of these three measures two had a threshold of zero. The three performance measures where the Trust did not achieve compliance are as follows:

- Number of C.diff cases: 3 cases in the year, 2 in Gloucestershire and 1 in Herefordshire
- No under18 admissions to an adult ward: 12 in total, 9 in Gloucestershire and 3 in Herefordshire
- Initial SI Report to Clinical Commissioning Groups (CCGs) within 3 working days where the 100% performance threshold was not met in April and September.

The full year outturn was 93% of performance targets achieved. The majority of performance measures where the Trust did not achieve the required performance threshold were with local commissioners' contractual requirements. Where non-compliance in earlier months highlighted issues within a service, performance had largely improved through the overview and scrutiny of the Delivery Committee.

The Committee reviewed the explanations for negative variances in performance from external targets provided in the Board report. The Committee sought further assurance that training in Herefordshire for adult and child safeguarding and rapid tranquilliser was being carried out and requested an exceptions report on these two areas.

The Committee also discussed the non-compliant HR indicators, appraisals and Statutory & Mandatory training, in particular the issue of data quality, requesting that the June HR Assurance reports include solutions to this particular issue.

**LOCALITY EXCEPTIONS REPORTS**

The Committee received the Locality Exception Reports. The Committee noted that action was being taken to improve the ability of Herefordshire to utilise bank staff rather than use agencies. It was agreed that these measures should be applied across the Trust.

**CYPS REPORTS**
The Committee received the monthly report on the CYPS Waiting List. The longest waiters were now 17 weeks which was a huge improvement. However, the work done to reduce the long term waiting list was continuing to have an impact on 8 and 10 weeks referral to treatment performance in the short term. The team was looking specifically at whether cases were being discharged quickly enough.

The Committee received a quarterly report on children and young people's self-harm and asked for further assurance in the next report on cases previously discharged or on the waiting list with CYPS.

**CQUIN IMPLEMENTATION PLAN**
The CQUIN Plan was reviewed and noted by the Committee. CQUINS had been agreed with the three commissioning bodies for the 2015/16 financial year and the report detailed the financial value allocated to each part of the individual CQUIN. The Committee recognised the hard work and effort that had been put into achieving the 2014/15 targets, some of which had been very challenging.

**COMMUNITY CARE BUDGET**
The Committee received a report on the Community Care budget. Expenditure had reduced by £190k during 2014/15. The Trust had committed to savings of £230k and so had absorbed £40k of these costs. There had been a huge step forward with the Community Care Budget and the Trust was working with Commissioners to establish a realistic forecast for 2015/16.

The Committee requested a further report on the Community Care Budget at the September meeting, and this would include the current financial position and actions to reduce expenditure further.

**AUTISTIC SPECTRUM SERVICE UPDATE**
The Committee received an update on performance and issues relating to the Autism Spectrum Condition (ASC) Assessment Service. The service was experiencing demand significantly higher than anticipated, resulting in a waiting list. The commissioner had allocated an additional resource of £100k for the service and work was underway to understand how this would be best utilised. The focus would initially be on completing assessments for those who had waited longest. The service would then strive to meet the national target of 3 months from referral to diagnosis. The Committee felt this was a very helpful report and recommended it be provided to Governors.

**LOCALITY REVIEWS**
The Committee received Locality Reviews for Countywide Services and CYPS.

The Countywide review provided assurance on the reasons for over spends last year, including sickness and difficulties in recruiting plus the impact of the serious incident at Montpellier.

The CYPS review focused on developments to the service and ensuring that the Committee was aware of ongoing issues with tier 4 beds and recruitment of clinicians.

**TRUST HEATWAVE PLAN**
The Committee received and approved the Trust Heatwave Plan, developed in accordance with NHS England planning. The Committee will receive an update at the next meeting to give assurance on the availability of cool rooms at inpatient facilities.

**PROGRESS WITH OPEN RIO IMPLEMENTATION**

The Committee received the final report on the implementation of Open RiO which was now live. The Committee noted the success of the project in delivering effectively on time and congratulated the team. The Committee asked for a report in 6 months on lessons learned throughout the project and feedback from clinicians on the use of the system, including any issues and how they are being resolved.

**ACTIONS REQUIRED BY THE BOARD**

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

**SUMMARY PREPARED BY:** Charlotte Hitchings **ROLE:** Committee Chair

**DATE:** 27 May 2015

**Agenda Item** **14** **Enclosure** **Paper I3**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Delivery Committee**

**DATE OF COMMITTEE MEETING: 24 June 2015**

### KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

**Performance Dashboard**

The Committee reviewed the Performance Dashboard for the first two months of 2015/16. The Committee noted the performance, as reported to the June Board: out of 103 key performance indicators (KPIs) reportable in May 2015, 76 were meeting the required performance threshold, 23 were not and 4 were not yet available or under review.

The Committee discussed issues with data quality affecting accurate reporting on some KPIs. After the Dashboard was produced further investigation had shown that some KPIs reported as non-compliant were actually compliant. The incorrect reporting was due to the way some teams had interpreted the indicators and were recording/measuring performance, particularly for new indicators, or to late entries on RiO. For example, the Monitor Care Programme Approach indicator, reported as non compliant in the Dashboard, was actually compliant and was shown as non compliant as a result of late data entry; and the Herefordshire Specialist Memory Clinic waiting time for first appointment indicator was shown as non compliant as a result of a misunderstanding of how performance should be measured. The Committee requested a update at the next meeting on actions being taken to ensure operational teams understand what is being measured and how they should input data for this and to ensure data quality through timely reporting. The Committee stressed the need for these issues to be urgently addressed so that areas where remedial action was needed to improve performance could be accurately identified and assurance given that actions were in place to achieve this improvement.

The Committee also requested, where possible, timings and trajectories for improved performance for non compliant indicators to show the impact of remedial actions.

**Locality Exceptions Reports**

The Committee received the Locality Exception Reports.

Gloucestershire Localities

- An agency tracker tool had been introduced to better monitor agency spend.
- Sickness rates had reduced as a result of active management of long term sickness.
- A Complaints sign off procedure had been introduced to ensure Directors were better sighted on learning from complaints.
- The Locality Governance and Delivery Committees for Gloucestershire and Countywide had been amalgamated; this would ensure less duplication of work and a better use of managers' time.

Countywide

- The Locality remained overspent. The continued high levels of clinical need, particularly in Charlton Lane had been recognised and additional funding had been agreed with

commissioners to support increased acuity.
- Pathways were being looked at including measures to avoid admission where possible and clinically advisable and the potential for provision of assessments in service users' own homes.
- Community Care Budget expenditure was continuing to reduce.
- Work continued with commissioners to review service specifications.

Herefordshire

- The Locality was currently overspent. Cost pressures remained in pay due to the high usage of agency staff in the Crisis Team and Mortimer ward.
- Changes were being made to enable recruitment directly into Bank as part of an approach to reduce agency spend. A recruitment fair had been held and number of bank health care assistants had been found.

CYPS

- A potential loss of income was reported which related to delays in claiming out of county and SLA income.
- There were continued challenges with the recruitment of clinical staff.
- The continued underperformance against contractual targets (level 3 services) continued to be monitored and performance improved. Referral to initial assessment remained at 95% within 4 weeks.
- The longest waiter was now 16 weeks with 1 exception at 18 weeks. The Committee noted that 15 people had been removed from the waiting list since it was last reported.

**Finance Report**

The Committee were advised of and agreed a new format for reporting financial performance for the service localities. Each month the Committee will receive more detailed reports from the Service Directors, one month in arrears. The existing Finance Report will continue to go to Board, reporting the most up to date information.

**Emergency Planning and Business Continuity Half Yearly Update**

The Committee received a report that provided assurance that the following policies and plans had been reviewed and updated: the Heatwave Plan, the Fuel Shortage Plan, the Business Continuity Planning Policy and the Pandemic Flu Plan. The Committee congratulated the Assistant Director of Operations and the service delivery teams on achieving 54.7% flu vaccinations of front line staff across the Trust and the successful maintenance of service during two periods of industrial action. The Committee was pleased to hear from Service Directors that team work and cooperation was strong between operations and the on call and emergency planning teams, with twice yearly joint events being held to test plans and policies.

**Update on Progress with Glos Dementia Waiting Times**

The Committee received an update on Dementia service waiting times, in particular in relation to the following KPI which has been non compliant for some time: 100% of people with a diagnosis of dementia to have an initial care plan agreed within 4 weeks.

The Committee received and endorsed a plan to change the way measurement of this indicator is recorded, with the agreement of the commissioner and on the advice of clinicians. This new approach will be trialled to ensure data can be captured and measured effectively. The service also intends to carry out a waiting list initiative to address the historic waiting list the service inherited, seeking to support this through a bid for winter pressures funds. The service was also seeking approval from the Director of Service Delivery to recruit over establishment to ensure resourcing to achieve the waiting list reductions.

**Technology and Clinical Services Strategies**
The Committee noted these two Strategies, which had been approved by the Development Committee, and requested a report from the Director of Service Delivery at the next meeting explaining how implementation of the different work streams will be reported for assurance, including the owners for each work stream. The Committee also noted that the IT Strategy Implementation Plan was still outstanding and requested that this be provided to the Committee at the next meeting.

**Local Security Management Specialist Half Yearly Report**
The Committee received and approved the Local Security Management Specialist Half Yearly Report which included information on incidents involving violence and aggression towards staff. This prompted a discussion about the reporting of health and safety (H&S) incidents and the need for greater assurance on accountability, understanding of responsibilities, assurance inspections are being carried out in accordance with Policy and plans to ensure Datix is made fit for purpose. The Committee agreed the Governance Committee should be provided with a thorough report on the measures being put in place to provide assurance on H&S management and reporting. The Committee also requested that the amended H&S Policy presented to the Committee be circulated to Service Directors to ensure they were clear about accountability and responsibilities for H&S at an operational level.

**Carbon Reduction Strategy and Sustainability Report**
The Committee received the Carbon Reduction Strategy and Sustainability Report and congratulated the team on progress made so far towards Trust targets. With some assumptions about electricity, the report calculated that the Trust has achieved a 25% reduction in carbon this year against a 10% target.

**Annual Assurance Statements: Equalities and Health and Wellbeing**
The Committee received these two Annual Assurance statements which described the actions taken in 2014/15 to ensure the Trust complies with its Equalities responsibilities and to promote the health and wellbeing of staff. The Committee noted the positive approach and asked for both reports to be brought back to the Committee with information on the impact of actions taken during the year and plans for the coming year to provide assurance that the measures and approaches being taken are producing results and plans are in place to address any identified gaps between the Trust's aspirations and achievements in these two important areas.

**Statutory and Mandatory Training and Appraisal Compliance Update**
The Committee received a verbal update on Statutory and Mandatory Training and Appraisal compliance. The plan to address data quality issues previously identified was twofold: (1) to introduce a manual recording system as soon as possible and provide reports on these two indicators quarterly, starting in August, including an amber warning to give teams four months' notice of a requirement to improve. The Committee was assured that this will be an auditable system and will build on information already collected by teams; (2) to source a front end training report function for our Electronic Staff Records (ESR) system, or a replacement training report function for ESR, to support self-service reporting. This was presented as a solution for 2016; however the Committee requested that progress on this be accelerated if possible.

**ACTIONS REQUIRED BY THE BOARD**

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

**SUMMARY PREPARED BY: Charlotte Hitchings ROLE: Committee Chair**
**DATE: 24 June 2015**

**Agenda Item** **14** **Enclosure** **Paper I4**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Governance Committee**

**DATE OF COMMITTEE MEETINGS: 22 May 2015**

**Governance Committee Review**

Members of the Committee are reviewing the current working of the Committee to ensure fitness for purpose, compliance with terms of reference, assurance for the board, and efficiency of process. Initial steps include:

- Review of those papers essential for review by the Committee and links to the Board
- Review of the levels of accountability at Locality level and Sub-Committees of Governance Committee
- Review of work-plan in terms of frequency of papers considered
- Agenda structure – consideration of moving to Care Quality Commission domains as revised structure
- Risks- work continues across Board Committees to ensure efficiency of risk identification, clear ownership, and mitigation. A meeting to be held between Directors of Audit and Governance Committee to review progress.
- The writing of reports – authors to be encouraged to ensure Executive Summaries are clear, with identification of risks, defined level of assurance and mitigation, and recommendations for improvement.
- Locality Governance Reports – introduction of a short template including risks, concerns and positive developments.
- Attendees of the Committee were invited to share thoughts on the working of the Committee to the Committee members.

**Locality Governance Committee Briefings**

Points raised included:

a) Gloucestershire Locality:
   - Concerns expressed regarding the recording of conversations between GPs and Trust clinicians of patient care. Action to be taken to clarify process.
   - The Locality is awaiting feedback from the Health and Safety Audit undertaken earlier in the year. Action to be taken to correct this.
   - The Committee noted that consideration is being given to the merger of resources for Gloucestershire Countywide and Localities in respect of Locality meetings. The first joint Governance meeting had taken place. Further details waited.

b) Gloucestershire Countywide
   - No recent meeting.

c) Herefordshire
   - A new day-care model for therapy services to commence 1st June 2015. Recruitment of staff had taken place as this had been an issue

- Meetings taking place with Wye Valley Trust (WVT) regarding treatment of patients with mental health problems.
- The committee noted ongoing work regarding the governance of PICU pathways for Herefordshire patients. To feedback at next meeting of the Governance Committee.

d) Children and Young Peoples Service
   - 3 Children's' and Young People Services Consultant vacancies have been advertised but not appointed to. The posts will be re-advertised, but the Committee were assured that the Trust has high quality locums and continuity of care was being offered.

**Patient Safety / Serious Incident (SI) Update**

Points to note include:

- There has been a significant rise in the Serious Incident rate during April 2015. This was unexpected. 7 new SIs were reported in April 2015. 6 of these occurred within Countywide Services and 5 of those within inpatient hospitals.
- There have been no Never Events occurring within the Trust Services during April.
- The Committee was assured that no common themes have been identified within the 7 incidents occurring during April. The Committee will continue to review SIs on a monthly basis.
- The Committee were informed that all staff have been alerted to the historical trend of increased incidents during May/June together with actions to be taken with a view to prevention.
- An increase in tissue viability incidents has been reported. All were considered to be unavoidable but learning had been taken from these incidents.
- The Committee were informed of progress regarding 2 SIs occurring on Greyfriars (which had been reported at April Governance Committee)and the actions planned by Executives noted. Further information to be brought back to Governance Committee next month
- Concern was noted regarding the failure to progress work to resolve issues of entry and egress at the Stonebow unit. Actions were agreed to follow this up with update report to the next Governance Committee.

**Homicide 2014 Update**

The Governance Committee reviewed the Action Plan regarding the Montpellier Unit Homicide. The Action plan is reviewed monthly by the Medical Director and Director of Quality and reported to Governance Committee for assurance. The last Action Plan meeting had been held on 24th April.

Points to note include:

a) Of the 37 actions currently included in the plan:
   - 10 (8 previously) are complete with Full Assurance (Evidence of appropriate approved documentation available, or changes to the physical environment complete)
   - 21 ( 18 previously) have Significant Assurance (demonstrable evidence that action is underway, is complete pending approval or production of final document, or pending delivery of staff training)
   - 2 (12 previously) have Limited Assurance (Plans to complete the action underway but no physical evidence to support this, incomplete plans available or not action taken to date.)

- The committee noted a further review of progress is planned in the near future.

b) The Committee was assured that meetings regarding the search policies were taking place to identify best practice and to adhere to Health and Safety Executive and Care Quality Commission requirements.
c) Chair and Vice-Chair of the Committee noted the time delay in providing assurance due to the timing of the Action Plan meeting soon after the Governance Committee. The Director of Quality and Medical Director to consider how reporting to the Non-Executive directors could be shortened.
d) Slippage of some timescales was noted within the Action Plan. This was referred to the Action Plan meetings for consideration of increased assurance.

**Safe Staffing Levels**
The Committee received a paper outlining staffing levels for March 2015
Assurance received included:

- All wards have been displaying and collating core planned staffing levels against actual staffing levels from the beginning of February 2014
- The Trust's specific exception reporting has been published on the Trust website since February 2014.

Summary for April 2015 shows:

- One Code 3 was reported on a single shift by Mulberry Ward on the basis that the staffing compliment and skill mix could not meet all the needs of the patient at the time. The Director of Quality is reviewing this report in greater detail which may include a review of staffing levels using a validated tool if appropriate
- 96.08% of the hours exactly complied with the planned staffing levels.
- 3.73% of the hours during April had a lower staff mix than the planned staffing levels, however staffing numbers were compliant.
- 0.18% of the hours during April had a lower number of staff on duty than the planned levels, however this met the needs of the patients on the ward at the time.

A concern was raised regarding the level of sickness at the Stonebow Unit, the need for the use of Agency Staff and the level of competence of those staff. Further information was requested by the Committee with feedback at the next meeting.
The Committee noted the compliance and approved the information for publication on the Trust website.

**Patient Experience Quarterly Report**
The Committee agreed four broad themes for general learning and implementation throughout the organisation:

- Service users and carers benefit from being involved in setting their care plan and receiving a written copy of the care plan.
- Information provision needed to be considered by practitioners at each contact with service users and carers as readiness to receive information varied.
- Service users require explanations about the medication that is prescribed for them.
- Service users appreciate literature about spirituality/religion being available to them.

Points raised in discussion included:

- Response time to people who make a complaint needs to improve. The following actions to be taken
    - Discussion with Locality directors to ensure complaint investigations are rigorous and undertaken within the recommended timeframe.

    - Continued effort to recruit to vacancies in the Service Experience Team
    - A review of process for receiving and signing off complaints within localities
- Further clarification requested on the process for dealing with concerns.

The Committee agreed the report for presentation to the Board.

**Greenlight Toolkit**

Green Light for Metal Health is a framework and self-audit toolkit for improving mental health support services for people with learning disabilities. The Committee was given a report on compliance with the toolkit in Herefordshire, and an update of the action plan for Gloucestershire. A high level of assurance was received in relation to the organisation achieving the requirements of the recommendations in Herefordshire. 26 of the 39 domains were rated green, 8 amber and none red. The other 5 domains related to commissioner responsibilities and cannot be reported from within the Trust.

The responsibility for undertaking the audit and facilitating the Team Self-Assessment Programme has until now rested with the Social Inclusion Team. Agreement was reached by the Committee that this becomes the responsibility of the localities in future.

**Risk Management**

The Committee reviewed the risks allocated to the Governance Committee. 29 risks are allocated to the Committee of which 6 are noted to be of limited assurance. These include:

- Crisis Contingency / Relapse plans
- Violence and Aggression
- Incident reporting and Management System (DATIX)
- Security Reporting Investigation System
- Medical Equipment
- Fire Prevention Training

Actions to mitigate these requests were noted and an update of outstanding issues requested for the next meeting.

**NHS Litigation Authority Claims Annual Report**

Significant assurance was noted in:

- At the end of the 2014/15 financial year there were a total of 10 open claims (6 clinical negligence scheme and 4 Risk Pooling Scheme for Trusts) which is a net decrease of 4.
- The claims are generally managed and processed in an effective manner.
- Positive benchmarking information in respect of the number of claims received compared with other trusts in our member category.

The Committee also noted the reduction in NHS Litigation Authority Scheme contributions as a result of the claim experience.

The Committee noted 2 delayed claims and the actions being taken to investigate these.

**Care Quality Commission (CQC) Compliance Annual Report**

The CQCs Intelligent Monitoring Statements was issued in draft on 28th April 2015 and showed 2 items at risk from a total of 72 risk indicators. It was noted that the information maintained the Trusts overall low risk rating.One of the identified risks relates to the death of a patient following injury or self-harm within 3 days of admission, the second to the occupancy ratio looking at the average number of available and occupied beds open overnight. The Committee noted the work to actively manage the occupancy rates.The Committee was updated on the work of the Trust in preparation for a CQC visit. Concerns were expressed about the number of actions slipping against timeline and a report requested on these for the next meeting. The date for this CQC visit to the Trust was not confirmed at the time of the meeting.

**Quality Report**
The most up to date draft of the developing Quality Report for 2014/15 was reviewed by the Committee. Further work is required to complete the report prior to Trust sign off by the Audit Committee and Trust Board.
Feedback from stakeholders on the Quality Report were noted and assurance given to the Committee that these would be considered in the preparation of the next report.

**Information Governance (IG) Annual Report**
The report outlined the Trust's performance on Information governance issues during 2014-15. Points to note:

- The Trust achieved at least level 2 in all domains of the Version 12 IG Toolkit.
- 40 information governance incidents were reported within the Trust during the year, a slight decrease from 43 the previous year. No serious incidents regarding IG were identified for reporting via the Information Governance Toolkit protocol.
- 206 Freedom of Information requests were received during the year, an increase from 164 in the previous year. A publication scheme is available on the Trust website. The plan to update this was noted.
- Overall compliance with IG refresher training remains below target. Compliance recorded as 67% compared to 61% in the previous year.

Significant assurance regarding IG was noted by this report.

**Medical Profession Update Report**
Doctors continue to submit appraisals via the Strengthened Appraisal & Revaluation Database Joint Venture scheme with 98.7% on line engagement.
2 cases are currently open to the General Medical council.

**Remediation Policy**
The Committee noted that the Policy on the Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners had been updated and agreed by the Medical Director.

**Clinical audit Programme**
Significant assurance was received regarding the development and delivery of the Trust Audit plan. The Committee discussed the follow up of audits in which poor performance was recorded and noted the process of feedback to Localities of audit findings.

**Clinical Policies**
The Committee received and noted an update on the Care Practice policies being monitored, reviewed, consulted upon and ratified.
It was reported that there were 2 Care Practice Policies ratified since the last report. These are:

- Policy on detained patients to whom the sex offenders act 1997 act applies. (Biennial review)
- Policy for incidents involving hostage taking within inpatient settings. ( Biennial review)

**ACTIONS REQUIRED BY THE BOARD**
The Board is asked to note the content of this report.

**SUMMARY PREPARED BY: Martin Freeman ROLE: Committee Chair**
**DATE: 22 May 2015**

**Agenda Item** **14** **Enclosure** **Paper I4**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Governance Committee**

**DATE OF COMMITTEE MEETINGS: 19 June 2015**

**Patient Safety/Serious Incident (SI) Update**
The Committee received an overview and analysis of serious incident reporting to commissioners and high level monthly trend analysis, including Never Events. The Committee was assured that the significant rise in the SI rate during April 2015 had not continued during May. There was 1 new SI reported in Gloucestershire and none in Herefordshire during May 2015. No Never Events had occurred within Trust services during the month.

The Committee noted that the Lessons Learned documents had not yet been completed for all reviews this month due to the need to respond to the unexpected rise in the reporting rate in April. The SI rate per 1000 caseload was 0.34 for April 2015. The rate for May was 0.05. The Committee reviewed the current format of the report and offered suggestions for minor revision and improved clarity.

The Committee requested information is included in the Locality briefing reports to state how the information was received and analysed within the localities.

**Homicide 2014 Investigation and Action Plan Update**
Dr Winterbottom reported that although the internal review was now complete the Trust was still unable to share the information publically at this time due to the ongoing Health and Safety Executive investigation.

Marie Crofts reported that the Trust's Search Policy had been revised and was to be shared with the Health and Safety Executive and the Care Quality Commission (CQC) who would confirm if it addressed their requirements, although the HSE have advised they can give a view rather than definitive confirmation. The Committee was offered good assurance that actions was being undertake and appropriate training to implement the new policy in place.

The Committee noted that the next Homicide Action Plan meeting would take place on 24 June. It was noted that the date when actions were added was not included on the action plan, it was agreed that this would be added in future. It was also agreed that where an action was multi-stranded, each of the specific actions would be made clear with its own timescales and leads.

**Review of Being Open Policy**
The Committee approved the Trust's "Being Open Policy" which had been revised to ensure that the requirements of CQC Regulation 20: Duty of Candour had been included. The Committee was assured that the Trust Being Open/Duty of Candour Policy had been reviewed by Trust Solicitors, Bevan Brittan, to ensure that the CQC requirements were explicit and clear within the document. Further consultation with Service & Clinical Directors had occurred and

following discussion at the February 2015 Governance Committee, the policy had made managers responsibilities regarding the Duty of Candour explicit. A flowchart had also been included.
The Committee was supportive of the Being Open Policy; however, further assurance was requested to ensure that the policy was implemented and embedded consistently across the Trust. The quality team was asked to provide a report to the next meeting of the Governance Committee on how the Policy was being embedded across the Trust.

**Safe Staffing Levels**
The Committee was assured that all wards had been displaying and collating core planned staffing levels against actual staffing levels from the beginning of February 2014. The Trust's specific exception reporting had been published on the Trust website since February 2014. The national requirements for reporting staffing levels had been adhered to since its inception in June 2014 following the National Quality Board (NQB) mandate through the Chief Nursing Officer (CNO).

The Committee noted the overall summary for May 2015:

- 96.34% of the hours exactly complied with the planned staffing levels.
- 3.47% of the hours during May had a lower staff skill mix than the planned staffing levels, however the staffing numbers were compliant
- 0.19% of the hours during May had a lower number of staff on duty than the planned levels; however this met the needs of the patients on the ward at the time.

For future developments the Committee agreed to consider:

- The use of bank and agency staff and impact on quality
- Consideration of staffing levels within Community teams

The Governance Committee noted the compliance with planned staffing levels for May 2015 and the significant assurance this gave the Committee. The Committee also noted that the staffing levels were uploaded to both the national 'Unify' system; NHS Choices and the Trust website as nationally mandated.

**Saville Report Update**
The Director of Quality reported that the action plan had been completed and returned to Monitor earlier in the week. This would continue to be monitored by the Safeguarding Committee.

**Management Processes for physical intervention training**.
This paper reported that the Trust had in place a number of processes associated with physical intervention and physical intervention training in respect of exemption from training related to health matters. A review had identified a number of gaps in assurance relating to the management and recording processes. This created a discrepancy between the local record and the central ESR record as reported via the HR Dashboard. 54 people were currently unable to undertake the training due to health problems but only 22 had been referred to Working Well.

A number of further actions were therefore agreed to address these identified gaps in process. Additional concern was expressed regarding the need for equality and whether any reasonable adjustments could be made. Colin Merker and Carol Sparks would be asked to discuss how members of staff who were unable to undertake breakaway training were managed and update the Committee at the next meeting.

**Staff Incidents – Quarterly Report**
This report summarised the incidents to staff, visitors and 'others' extracted from the Trust's DATIX Risk Management System for Quarter Four ending 31st March 2015 and included analysis of those incidents which had been 'closed' by line managers. In previous reports, these incidents were classified as 'fully approved'.

The Committee noted that following receipt of the recent PwC audit report on the quality of incidents recorded on DATIX, a health check was undertaken. The report was received week commencing 1st June and Marie Crofts confirmed that a presentation by DATIX was made to the Executive Committee on the 8th June. A number of recommendations were made and were being considered to improve the functionality of the system, the quality of the data and the usefulness for the Trust.

The Committee raised a number of concerns concerning this report for which further assurance was requested. These included:

- The role of the Site Responsible Officer
- Current status of Health and Safety Audits
- Clarity on future DATIX proposals, time line for implementation and measurement of progress
- Appropriate identification of issues, level of assurance and actions to mitigate risk within the report.
- Clarity regarding lines of accountability

The Committee requested this paper reviewed and be brought back to the next meeting of the Governance Committee for further consideration and assessment of assurance. The Committee agreed that this report provided only limited assurance at this time.

**Library Service Annual Report**
The Committee received a summary of library service activity for the year 2014 – 2015. The report provided assurance around 2gether's compliance with the NHS Library Quality Assurance Framework, which was a requirement of the Learning & Development Agreement which the Trust had signed up to and which ensured continued funding for the library service. This included progress in respect of:

- Refurbishment of Wotton Lawn Library
- Development of the Digital Library
- Providing information to support patient care
- Contributing to sustainable development
- The development of services for service users

The Committee noted that the assessment of the Trust using the NHS Library Quality Assurance Framework (LQAF) achieved 94% compliance against a standard of 90%. Significant assurance is provided by this result.

The Committee noted however that there is difficulty accessing library provision in Herefordshire as there was still no physical library there. It was agreed that Paul Winterbottom and the Medical Education Director would provide the Committee with a report of library services in Herefordshire and current fitness for purpose.

**Care Quality Commission (CQC) Compliance Update**
It was reported to the Committee that the CQC would be undertaking an inspection of Trust services during the week beginning Monday 26 October. Fortnightly meetings were taking place to ensure preparedness in line with Quality Improvements across the organisation. The

Committee noted that the CQC would be considering the Trust services against the themes of Safe, Effective, Responsive, Well-led and Caring. Regular updates on this revised approach to managing both preparing for the inspection and ensuring the Trust progressed with quality improvements will be brought to Governance Committee.

**Care Practice Policies**

Five Care Practice policies were available for ratification this month. These included

- Policy on Electro-Convulsive therapy at Stonebow Hospital
- Policy on oxygen use
- Policy on responding to carers concerns regarding Community treatment
- Policy on using bedrails
- Policy on the management of active substance misuse

The Committee was assured that Care Practice Policies were being monitored, reviewed, consulted upon and ratified. These reports updated the Committee on the work being conducted to stream line and reduce the total number of Care Practice Polices.

**Locality Governance Committee briefings**

Areas discussed included:

a) Children and Young Peoples Service Briefing

- Transitions CQUIN: the Committee noted the concern regarding the provision of accommodation for teens not living at home. Discussions are taking place with Social Care.
- The Committee noted that Mary Holba and Dr Rosemary Richards had attended a Ready Steady Go event looking at transitioning to adult services. Commissioners were keen for this initiative to be implemented nationally.

b) Gloucestershire Localities Briefing

- The locality reported concerns regarding Health and Safety audits and the role of Site Responsible Officers – these points were discussed in the Staff Incidents discussion as reported above.
- The Committee noted that this was the last meeting where Gloucestershire and Countywide would meet separately as they were now moving to joint meetings.
- Concerns had been raised regarding responses to complaints being returned to the complaints department without proper management sign-off. However, a new complaints investigation checklist was now in place to guide people through the process.

c) Hereford Locality briefing

- A successful recruitment fair had been held, with a wide and varied attendance.
- The Committee had agreed that 2 additional items were to be added to the locality risk register. These were:
  - The difficulty in securing fire safety training sessions
  - Provision of Clinical Supervision within inpatients settings. This will be considered at the next NPAG meeting.
- Update on the Section 75, Social Care Issues and the actions being taken to mitigate these concerns were provided. Issues relating to the Social Care provision in Herefordshire will continue to be monitored each month by means of the Locality Governance Committee briefing.

d) Gloucestershire Countywide Locality Briefing

- The first of the recent PICU serious incidents had now been reviewed.
- The Learning Disability staff “at risk” status has now being removed.
- The Honeybourne kitchen assessment action plan was now in place.

**Expert Reference Group Exception Reports**

a) Learning Disability Expert Reference Group

- The Committee noted that there was no clarity about the CLDT review and this was a significant concern. PW and MC to raise at the Gloucestershire CCG CQRF.

b) Substance Misuse Expert Reference Group

- The Dual Diagnosis Policy in Gloucestershire had been updated and issued.
- The form for Turning Point staff to make referrals into the Trust had been revised.
- Concerns regarding the lack of a needle exchange programme for YPSMS would be escalated to commissioners.
- The Committee noted that 2gether would not be retendering for the Herefordshire Substance misuse service. Dr Williams reported on the importance of ensuring that the appropriate transfer arrangements are in place.

c) Forensic and Complex Care Expert Reference Group

- Herefordshire staff are now involved in this ERG.
- A consultation was taking place regarding whether there was a safe environment for potentially violent and aggressive these patients to be seen. This is an issue for both counties. The Committee agreed that the Estates Service would be asked to provide a report on safe facilities with availability of 2 exits.

d) Physical Health Expert Reference Group

- The ECG Policy is being developed. There are currently no ECG machines in LD units. Dr Williams confirmed that this would be discussed with Dr Scheepers.
- Some difficulty in locating Trust Policies had been noted.

e) Functional Expert Reference Group

- Consideration is being given to the Training Department arranging Borderline Personality Disorder Training.
- Perinatal work was under resourced and needed additional funding. CCGs were aware of this and work was on going into this area.

**ACTIONS REQUIRED BY THE BOARD**

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

**SUMMARY PREPARED BY: Martin Freeman** **ROLE: Committee Chair**

**DATE: 13 July 2015**

**Agenda Item** **14** **Enclosure** **Paper I5**

## BOARD COMMITTEE SUMMARY SHEET

**NAME OF COMMITTEE: Charitable Funds Committee**

**DATE OF COMMITTEE MEETING: 21 July 2015**

**KEY POINTS TO DRAW TO THE BOARD'S ATTENTION**

**Charitable Fund Accounts and Annual Trustee Report 2014/15**
The Committee received the final Annual Report of the Trustees and Charitable Fund Annual Accounts for the financial year ending 31 March 2015. The Committee noted that the Balance Sheet for Charitable Funds stood at £241k at the end of the financial year. The Committee noted that as income during the reporting year had been below £25k, no audit was required and consequently no Letter of Representation was required.

The Trustee report outlined significant expenditure during the reporting year, which included £75k in respect of the Recovery College. The Committee noted that the Gloucestershire CCG was now providing that funding on an ongoing basis Recovery College.

The Committee requested an amendment to the section regarding staff welfare expenditure to explain this expenditure more clearly, and asked that future Annual reports make greater use of plain English, particularly in explaining the purpose of individual funds

The Committee approved the signing of the Annual Report and Accounts for the year ending 31 March 2015.

**Financial position**
The Committee received the financial activities statement which showed the total balance of charitable funds at £102,381.08 as of 30 June 2015. The Committee noted a number of delegated approvals for charitable funds expenditure below £5,000, and also noted donations to the funds during the period. The Committee noted a number of outstanding commitments and received assurance that these were being progressed. The Committee noted planned commitments for the rest of the year which included £110k in respect of the Trust's contribution to the dementia research centre.

The Committee discussed the Staff Bursary and the need to ensure that staff are aware of the fund and the uses to which it might be put, and requested that the Deputy Director of Finance liaise with the Director of Quality and the Communications Team to raise the profile of this fund through the internal newsletter and other channels.

**Countywide Funds**
The Committee received a presentation from Les Trewin, Service Director, outlining charitable funds expenditure in the Countywide locality. A number of successful initiatives had been made possible through the commitment of Charitable Funds. These included a Big Health Check Day

held on 13th May, Circle dancing and Music in Hospitals at Charlton Lane, the construction of a Garden Shelter at Charlton Lane, and the purchase of a rotivator for the Montpellier Unit. All of these developments had been positively received and were beneficial in encouraging inclusion, engagement and physical activity in patients. Future plans included a further Big Health Check Day, a series of drama-themed workshops at Charlton Lane, and a 'Special Olympic' for Learning Disability service users.

**Committee Terms of Reference**
The Committee reviewed its terms of reference and made one minor change to improve readability. No substantive changes were made to the terms of reference.

**ACTIONS REQUIRED BY THE BOARD**

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

**SUMMARY PREPARED BY: Nikki Richardson ROLE: Committee Chair**

**DATE: 21 July 2015**

**Agenda Item 15** **Enclosure Paper J**

**TO:** **[2]gether NHS Foundation Trust Board**

**FROM:** **Ruth FitzJohn, Chair**

**DATE:** **30 July 2015**

**SUBJECT:** **CHAIR'S REPORT**

## 1. PURPOSE

This report sets out the key activities of the Trust Chair and Non-Executive Directors for the period 17 May – 17 July 2015.

This report is for information only.

## 2. CHAIR'S KEY ACTIVITIES

- Chairing two Board meetings
- Chairing a Council of Governors meeting
- Chairing two Appointments and Terms of Service Committee meetings
- Attending the Gloucestershire Health and Care Overview and Scrutiny Committee at Shire Hall
- Attending the Gloucestershire Strategic Forum in Brockworth
- Attending the Wye Valley NHS Trust Annual General Meeting in Hereford
- Hosting a memorial event at Wotton Lawn
- Meeting with the Chair of Wye Valley NHS Trust
- Meeting twice with Gloucestershire Police in Gloucester to discuss the Aston Project
- Meeting with a Herefordshire Councillor
- Meeting with the Chair of Gloucestershire's Health and Care Overview Scrutiny Committee for Gloucestershire at Charlton Lane

- Meeting with a Gloucestershire County Council health and housing Programme Director
- Hosting a drop in session for Governors
- Hosting a joint tea party with Gloucestershire Police Chief Constable for Gloucestershire decision makers and influencers in Gloucester
- Attending the NHS Confederation Conference for three days in Liverpool
- Participating in a Mental Health Managers Review at Wotton Lawn
- Preparing and presenting at Gloucestershire's Academic Programme for doctors at Redwood Education Centre
- Planning and delivering an event for a ²gether NHSFT Emerging Women Leaders Group in Hereford
- Responding to many contacts from Councillors from Herefordshire and Gloucestershire since the elections
- Together with GP Trustees, meeting with the Medical Education/Facilities Manager at the Sandford Education Centre in Cheltenham
- Together with the Chief Executive, meeting with the Chief Executive of NHS Providers in Rikenel and Charlton Lane
- Attending a lecture by Bishop James Jones at the University of Gloucestershire in Cheltenham
- Attending the beginning of the Finance Directorate team's away day
- Visiting the Later Life team, participating in visits and team meetings at Weavers Croft in Stroud
- Participating in an Executive Director's appraisal
- Attending Queen's Birthday event at the request of the Allied Rapid Reaction Corps at Imjin Barracks
- Attending a Board visit to the CAMHS team in Hereford
- Meeting with the newly elected Councillor and Chair of Health Overview and Scrutiny Committee for Herefordshire
- Visiting the Veterans Association in Herefordshire
- Visiting the Hereford Academy
- Attending a Ramadan ifkar at the invitation of local Moslem women in Gloucester
- Participating in a Board and Council engagement strategy workshop

- Working with the Chief Executive to consider a Board and Council joint development programme

- Being interviewed as part of the Board and Council joint development programme

- Participating in an interview with Deloittes as part of the Well Led Board external governance review

- Meeting with the Trust Secretary, Director of Engagement and Integration and Chief Executive ensuring Governor requested actions are in hand

- Attending a Joint Board and Council of Governors engagement strategy workshop

- Participating in a structured discussion with an independent facilitator regarding Development Programme

- Meeting with the Lead Governor

- Meeting with a Staff Governor at their request

- Meeting with a Public Governor at their request

- Meeting with the Deputy Chair to discuss a complaint

- Additional regular background activities include:
    - attending and planning for smaller ad hoc or informal meetings
    - dealing with letters and e-mails
    - reading many background papers and other documents.

## 3. NON-EXECUTIVE DIRECTORS' ACTIVITIES

**Maggie Deacon**

Since her last report Maggie Deacon has;

- Prepared for and Chairing a Mental Health Legislation Scrutiny Committee
- Attending a Development Committee meeting
- Prepared for and Chaired an Audit Committee meeting
- Attending a Mental Health Act Managers review Hearing Panel
- Attending a meeting regarding Risk process
- Attending two interviews with potential third sector strategic partners

**Martin Freeman**

Since his last report Martin Freeman has;

- Attended 2 Appointments and Terms of Service Committee meetings
- Attended a Board meeting in Hereford
- Met with the Director of Quality regarding Governance programme
- Prepared for and chaired 2 Governance Committees
- Prepared for and attended the Delivery Committee
- Met with the Director of Quality, Risk Manager and two other Non-Executive Directors to review risk recording and management process across the Board and Board Committees
- Attended three Serious incident reviews

- Attended 2 Mental Health Act Managers Appeal Hearing
- Met with the Trust Secretary and Lead Governor to consider Governors responses to complaints and concerns that they may come to their attention.
- Attended the June Board Meeting
- Participated in a Joint Board and Governors development session
- Attended an NED informal meeting
- Met with representatives of Deloittes External Auditors regarding Well Led Review
- Prepared for and chaired the Mental Health Legislation Scrutiny Committee
- Attended meetings of the Audit, Charitable Funds and New Highways Committees
- Met with Nikki Richardson, Marie Crofts and Jane Melton to review the workings of Governance Committee
- Met with the NHS England validation of Medical Profession Revalidaton team
- Participated in a facilitated meeting with board members regarding the role of Governors
- Attended a Council of Governors Meeting
- Chaired an interview panel for the appointment of a Consultant Psychiatrist

**Charlotte Hitchings**

Since her last report Charlotte Hitchings has;

- Prepared for and attended the May Board meeting
- Prepared for and chaired the June Delivery Committee
- Prepared for and attended the June Development Committee
- Attended the NHS Confederation Conference in Liverpool
- Attended the South West Academic Health Science Network regional meeting in Swindon
- Completed a questionnaire providing feedback on the Trust's Serious Incident Review process
- Attended Healthwatch Gloucestershire's Annual General Meeting
- Participated in a meeting with members of Gloucestershire's Young Parliament with the Director of Engagement and Integration.
- Prepared for and attended the June Board meeting
- Prepared for and chaired the July Delivery Committee
- Prepared for and attended the July Audit Committee
- Prepared for and attended the July Charitable Funds Committee
- Prepared for and attended the July New Highway Charity Trustee Board meeting
- Prepared for an attended the July Council of Governors meeting
- Attended a meeting of the Appointments and Terms of Service Committee
- Undertaken a desk top review for the Chair
- Participated in a Serious Incident Review
- Chaired a 'Chair's Lunch' with NEDs
- Participated in a Gloucestershire Strategic Forum workshop
- Met with Tim Melling as part of the Board and Council of Governors joint development programme
- Completed a questionnaire as part of the Well Led Governance Review
- Attended a meeting with Deloitte as part of the Well Led Governance Review

**Jonathan Vickers**

Since his last report Jonathan Vickers has;

- prepared for and attended 2 board meetings and Appointments and TOS Committees
- Sat on a MHAM panel

- Prepared for and chaired a meeting of the Development Committee
- Held e-mail conversations with colleagues on various topics
- prepared for and chaired a dismissal appeal hearing
- met senior clinical staff at Wotton Lawn
- attended an informal NED's meeting
- attended a meeting with Deloittes on the well-led boards review
- prepared for and attended a meeting of the council of governors
- prepared for and chaired a meeting of the audit committee
- prepared for and attended a meeting of the Charitable Funds Committee
- prepared for and attended a meeting of the Mental Health Legislation Scrutiny Committee

**Nikki Richardson**

Since her last report, Nikki has;

- Attended a Charlton Lane Vintage Tea Party
- Prepared for and attended an Internal Review
- Attended a MHA Managers Induction
- Met to discuss the Governance Committee
- Attended a Herefordshire HOSC
- Attended a MHA Managers review
- Attended a Gloucestershire Healthwatch AGM
- Prepared for and attended a Governance Committee
- Prepared for and attended a Development Committee
- Prepared for and attended 2 Delivery Committees
- NED meeting with the Chair
- Prepared for and attended 2 Appointments and Terms of Service Committees
- Prepared for and attended a Board meeting
- Prepared and produced a report on the review of Board Committees
- Prepared for and attended a Charitable Funds Committee
- Prepared for and attended a New Highways Committee
- Prepared for and attended the Audit Committee
- Met with Deloittes re Well Led Governance review
- Attended the tea party at The Cavern, Gloucester
- Participated in a MHA Managers Hearing observation

## 4. OTHER MATTERS TO REPORT

The Council of Governors has elected Richard Castle as Lead Governor. We thank Richard for accepting this role, and also Rod Whiteley as he steps down as Lead Governor.

# [2]GETHER NHS FOUNDATION TRUST

## COUNCIL OF GOVERNORS MEETING
## TUESDAY 12 MAY 2015
## BUSINESS CONTINUITY ROOM, RIKENEL, GLOUCESTER

| | | | |
|---|---|---|---|
| **PRESENT**: | Ruth FitzJohn (Chair) | Dawn Lewis | Rod Whiteley |
| | Paul Grimer | Vic Godding | Amjad Uppal |
| | Adrian Wilcox | Pat Ayres | Richard Castle |
| | Alan Thomas | Gillian Hayes | Helen Miller |
| | Mandy Nelson | Rob Blagden | Jodie Townsend |

**IN ATTENDANCE:** Shaun Clee, Chief Executive
Marie Crofts, Director of Quality
Maggie Deacon, Non-Executive Director
Martin Freeman, Non-Executive Director
Anna Hilditch, Assistant Trust Secretary
Charlotte Hitchings, Non-Executive Director
John McIlveen, Trust Secretary
Jane Melton, Director of Engagement and Integration
Colin Merker, Director of Service Delivery
Nikki Richardson, Non-Executive Director
Carol Sparks, Director of OD (Items 9 - 10)
Paul Winterbottom, Medical Director
Member of the Public

## 1. WELCOMES AND APOLOGIES

1.1 Apologies for the meeting were received from Roger Wilson, Paul Toleman, Diane Topham and Hazel Braund. Elaine Davies did not attend the meeting.

## 2. DECLARATION OF INTERESTS

2.1 There were no changes to the declaration of interests. Governors were asked to complete and return a signed copy of the Annual Governance Declaration. Those Governors not present at the meeting would be sent a copy of the form for completion.

***ACTION: Annual Governance Declaration form to be emailed to those Governors not present at the meeting for completion.***

## 3. NOTES OF THE COUNCIL MEETING HELD ON 12 MARCH 2015

3.1 The minutes of the Council meeting held on 12 March were agreed as a correct record.

## 4. MATTERS ARISING AND ACTION POINTS

4.1 The Council reviewed the actions arising from the previous meeting. The majority of actions had been completed, or were progressing to plan.

4.2 Paul Winterbottom had produced a briefing for Governors on mental health conditions and the treatment and care pathways available for people with these conditions within 2gether. This was tabled and a copy would also be uploaded onto the Governor portal.

4.3 Governors were still being sought to become members of the Nominations & Remuneration Committee. Due to a recent Public Governor resignation, the Committees' membership had now reduced to 2 Public Governors and 1 Staff Governor. This was an important Governor committee and people were asked to notify Anna Hilditch if they wished to participate. Rod Whiteley expressed his interest in becoming a member of the committee, once his term as Lead Governor had come to an end.

4.4 Rod Whiteley said that he had looked at the Trust's Complaints Leaflet on the website and Governor portal. The same leaflet had now been uploaded as per the action from the previous meeting; however, he noted that the incorrect telephone numbers were still included. He had also looked at the Children's Complaints Leaflet which was also out of date. Jane Melton thanked Rod for bringing this to her attention and agreed to rectify this as soon as possible.

***ACTION: Jane Melton to review the Trust's Complaints leaflets and ensure that these were consistent and up to date on the Trust website***

4.5 Shaun Clee informed the Governors that the final Monitor Operational Plan had now been submitted to Monitor. The final plan would be uploaded to the Governor portal for information.

4.6 Rod Whiteley noted the amendment that had been proposed to the minutes from the January meeting at 11.1 with regard to the Psychiatric Liaison Team. He said that the proposed amendment did not accurately reflect what had been said at the meeting and he felt that after requesting the amendment twice, it was not good enough that the minute was still incorrect. Rod said that he was disappointed that the Trust had not accurately captured what he as a Trust Governor had said. He added that the issue he had raised originally in relation to his personal experience of patients not being given the opportunity to access the psychiatric liaison at Cheltenham General Hospital had not been addressed. Rod Whiteley informed the Council that he had felt it necessary to raise these concerns with the CQC and had duly done so. Ruth FitzJohn thanked Rod for making the Trust aware of this action and asked if he would be willing to share his correspondence to the CQC with her for information. Rod agreed to share this.

***ACTION: Rod Whiteley to share his specific concerns, as raised with the CQC, with Ruth FitzJohn for information***

4.7 In terms of the Holding NEDs to Account section of the meetings, Richard Castle advised that the Governors had discussed the schedule for this and suggested that Ruth FitzJohn be held to account as Trust Chair at the next Council meeting and Nikki Richardson at the following meeting. The agenda planner would be updated accordingly.

***ACTION: Governor agenda planner to be updated to include Ruth FitzJohn and Nikki Richardson for the Holding NEDs to Account sessions.***

## 5. PSYCHOLOGICAL THERAPY SERVICES – PRESENTATION

5.1 The Council welcomed Jon Cash, Trust Advisor for Psychology, Damian Gardner and Gill Yardley who were in attendance to provide the Council with an overview of the Trust's Psychological Therapy services, which included positive examples of recent interventions and group work.

5.2 The Council asked about the use of volunteers and charitable groups in Psychological Therapy Services. Jon Cash said that the Trust was using Experts by Experience more frequently to seek their comments and feedback on services. Jodie Townsend asked whether the councillors employed by 2gether were volunteers or members of staff. Jon Cash said that a very small number were volunteers, with the majority made up of predominantly paid staff. Jon said that the ability to supervise people and provide oversight of work in psychological services was key and this was more effective when working within a solid organisational structure with appropriate governance and quality standards in place.

5.3 Richard Castle noted the reference to 'exploring further benefits' of the service and asked for an example. Jon Cash said that the Psychological Therapies service would be continuing its group work and more focussed interventions such as reviewing young people and incidents of self-harm would be introduced. The input of Psychological Therapy services into a review of frequent acute hospital attenders was another possible intervention.

5.4 The Council thanked Jon and colleagues for the presentation. A copy of the presentation would be uploaded onto the Governor portal for future reference and information.

***ACTION: PTS Presentation to be added to the Governor portal***

## 6. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

***The Chair and Non-Executive Directors left the meeting at this point***

6.1 Richard Castle presented the Council with a report summarising the discussions that had taken place at the Nominations and Remuneration Committee meeting held on 5 May.

6.2 Charlotte Hitchings, Senior Independent Director/Deputy Chair had been in attendance and had presented the outcome report from the Chair's appraisal process. Overall it had been a strong performance by the Chair, as testified to by the positive feedback she had received for her appraisal. The Committee received assurance that areas for development had been built into objectives for 2015/16. The Committee was pleased to note that eleven Governors had provided a response to the questionnaire, in comparison to only 6 responses received last year. An increase in Board member responses had also been seen. Thanks were expressed to those Governors who had assisted in

developing a revised appraisal questionnaire and to Charlotte Hitchings for carrying out the appraisal and providing such a comprehensive report.

6.3 Ruth FitzJohn, Trust Chair had presented the outcome report from the Non-Executive Directors' appraisal process. Appraisals were completed for Charlotte Hitchings, Martin Freeman, Jonathan Vickers, John Saunders and Maggie Deacon. Nikki Richardson's term of office only began on 1 February 2015 and so did not fall into this 2014/15 review process. Objectives for 2015/16 were agreed with all NEDs, except John Saunders who was just about to begin a planned period of compassionate leave. The Committee noted that all five appraised NEDs had made valuable contributions to the Trust and were performing well at Board, as Committee Chairs and across their broader roles. There were no performance issues to be raised with the Nomination and Remuneration Committee or with the Council of Governors. The Committee received assurance from the Chair that the Trust was in competent hands and was content that any development points would be picked up and managed appropriately through the setting of annual objectives and meetings with the Trust Chair.

6.4 The Committee was also asked to consider the Chair and NED remuneration. Richard Castle said that the 2015/16 national position on pay was complex in so much as staff would receive differential pay depending on their banding (grade) and where they were on their banding. In reviewing the detail of the national arrangements, the Trust identified that a small group of staff would receive no pay award in 2015/16 and would lose the 1% that was afforded in 2014/15 i.e. be materially worse off. The Trust took the decision that in line with Trust values, there should be negotiations with Staff Side to offer a one off 'stand still' payment for that group of staff to ensure their pay remained the same in 2015/16 as it was in 2014/15. Therefore in summary the minimum position is that staff in 2gether will at the very least receive the same pay in 2015/16 as they did in 2014/15. The Committee considered the recommendation of applying this principle of ensuring that the remuneration for Non-Executive Directors remained at the same level for 2015/16 as it was in 2014/15. After discussion and clarification, it was agreed that the Non-Executive Directors, including the Trust Chair, would receive the 1% cost of living increase to ensure that remuneration would remain at the 2014/15 level for 2015/16. This local pay award was for one year only and was end dated 31 March 2016. The Committee agreed that it was sensible to remain consistent with national pay award dates and the locally agreed pay award.

6.5 The Council of Governors endorsed the decision of the Committee that the Chair and Non-Executive Directors would receive the 1% cost of living increase for 2015/16, with an end date of 31 March 2016. The Council was pleased to note the positive outcome from the appraisals.

6.6 Gillian Hayes noted the Governor involvement in the Chair's appraisal process and queried whether it would be appropriate for the Governors to also participate in the Non-Executive Director appraisals in future years. It was agreed that this would be picked up as an item for discussion at the next Nominations and Remuneration Committee meeting.

***ACTION: Nominations and Remuneration Committee to discuss the involvement of Governors in the NED appraisal process in future years, as well as the Chair***

***The Chair and Non-Executive Directors returned to the meeting at this point***

## 7. ATTENDANCE RECORD OF TRUST GOVERNORS

***Mandy Nelson and Rob Blagden left the meeting at this point***

7.1 John McIlveen presented a paper highlighting the attendance record of 2 Governors. John informed the Council that the Constitution requires that where a Governor fails to attend three consecutive meetings of the Council, the Council may terminate that Governors' tenure unless it is satisfied that the absence was due to a reasonable cause, and that the Governor will be able to start attending meetings within a reasonable timeframe.

7.2 Mandy Nelson was elected as a Public Governor for the Tewkesbury constituency in July 2013. Mandy's last attendance at a Council of Governors meeting was in September 2014, and she sent apologies for the subsequent three meetings. Mandy has been in contact with the Trust and has explained that her absence has been due to pressure of work. She has indicated that she would like to remain on the Council of Governors and was present at today's meeting. On Mandy's behalf, Gillian Hayes provided a supporting statement, noting that Mandy was very keen to remain an active member of the Council and attend meetings and working groups where possible. The attendance at meetings during the working day was proving difficult with her new employer.

7.3 Rob Blagden was elected as a Staff Governor in the Management, Admin & Other class in June 2014. His last attendance at a Council of Governors meeting was in September 2014. Rob has been in contact with the Trust to explain that his absence has been due to long term illness. Rob is now on a phased return to work and was present at today's meeting. Rob attended the Nomination & Remuneration Committee meeting on 5 May.

7.4 The Council was happy to accept the separate assurances provided regarding Mandy Nelson and Rob Blagden's future attendance, and agreed that their tenure as Trust Governors not be terminated.

7.5 Richard Castle made the observation that some of the Council of Governor meetings were better attended than others and asked what thought the Trust was giving to encouraging or motivating Governors to attend meetings, and on a wider point, what it was doing to encourage people to stand as Governors. Ruth FitzJohn said that a meeting had taken place earlier in the day where discussions had taken place about the forthcoming Governor elections and how these posts would be communicated and people encouraged to nominate themselves. The Council was assured that this was an area where the need for further work had been identified.

***Mandy Nelson and Rob Blagden returned to the meeting at this point***

## 8. LEAD GOVERNOR NOMINATION PROCESS

8.1 The Council was informed that no nominations for the role of Lead Governor had been received as at the deadline of 22 April. This was an important role and Governors were asked to reconsider putting themselves forward.

8.2 Richard Castle said that this had been discussed at the Governor pre-meeting and he had offered to put himself forward for nomination as the Lead Governor. The Governors had also discussed the nomination of a Deputy Lead Governor.

8.3 It was agreed that as this was a formal role as set out by Monitor, the Trust would need to follow the appropriate nomination process. It was agreed that nomination forms would be circulated out to all Governors again for parity – to ensure that those not present at the meeting also had the opportunity - with a deadline of 22 May for returns. It was agreed that it would be helpful to have a new Lead Governor in place in time for the next Council meeting in July. Richard Castle was thanked for volunteering and encouraged to complete the nomination form once received.

***ACTION: Lead Governor nomination forms to be recirculated to all Governors and nominations sought by 22 May***

## 9. CHANGES TO THE CONSTITUTION AND COUNCIL OF GOVERNORS

9.1 This report set out proposed changes to the Trust Constitution, in particular to the composition of the Council of Governors. Additional changes to the Constitution are proposed in order to recognise new requirements such as the Fit and Proper Person: Directors regulation, to provide further clarity where there is ambiguity in the provisions of the constitution, to update the content to reflect new external references, and to rectify some typographical errors. John McIlveen noted that this report and the proposed changes had been received by the Council in November.

9.2 A number of further questions and queries were raised about the proposed changes set out in the report:

- 24.1 – reference had changed to “the Trust”. Rod Whiteley asked that it be made clear and a definition be added that “the Trust” referred to the Board and Council of Governors.
- Rod Whiteley asked that a check be carried out in relation to the consistency of wording between the revised Constitution and the “Act” around the length of term of Trust Governors.
- The spelling of the “LD Partnership Board” throughout the report would be checked

9.3 The Council of Governors agreed the following recommendations set out in the report, as follows:

- Agree to the dissolution of the current Medical and Nursing Staff class and the creation of separate Staff classes for Medical staff (1 Governor) and Nursing staff (2 Governors) with effect from 3 October 2017.

- Agree to implement the revised minimum membership for Medical and Nursing Staff classes with effect from 3 October 2017
- Agree to the removal, after 3 October 2017, of provisions made redundant by these changes
- Agree to the removal of the Appointed Governor position for Gloucestershire District/Borough Councils, with immediate effect
- Agree to the reduction to 2 for Governor positions in the Stroud constituency with immediate effect
- Note the incorporation of the revised Election Rules into the Constitution.

9.4 The Council of Governors asked that other revisions discussed be presented in a further draft document at a future meeting

***ACTION: John McIlveen to produce a further draft of the constitution incorporating revisions discussed but not agreed, to be presented at a future meeting.***

## 10. ORGANISATIONAL DEVELOPMENT STRATEGY

10.1 Carol Sparks was in attendance to present the draft Organisational Development Strategy to the Council. She reported that the Strategy had been identified and agreed by the Board in 2014 as being one of its enabling strategies and it used the Burke Litwin model of organisational development to provide a framework. The content of the strategy had been aligned to the Trust's three strategic objectives and it was felt that the Strategy set out a direction of travel, based on the Trust's values, which provided flexibility for the future, in language which could be understood and delivered by leaders and which staff could see put into practice.

10.2 The Council noted that the Monitor 'Strategy Development Toolkit' had been used to ensure that the strategy met Monitor's expectations that the Trust through its workforce, structure and leadership would be able to meet the challenges of delivering quality care, adopting new technologies and remain sustainable. A large range of documents, both national and local had been used to inform the content to ensure consistency of messages. The content had been kept simple and the format was similar to that of the Staff Charter; again to reinforce messages and consistency.

10.3 Carol reported that the Organisational Development Strategy would be underpinned by an implementation plan which would in the main summarise existing action plans. The draft OD Strategy had been shared widely throughout the Trust for comment, including with the JNCC, Heads of Professions, the Trust Board and the Development Committee. All comments that had been received had been incorporated into the draft.

10.4 The Council largely welcomed the document and agreed that the format used, which was in line with Monitor guidance, was clear and easy to read. However, Rod Whiteley said that he had not found the document clear at all and he agreed to provide feedback directly to Carol Sparks on the specific areas requiring attention.

***ACTION: Rod Whiteley to provide feedback directly to Carol Sparks on those specific areas within the OD Strategy requiring attention.***

10.5 One addition was suggested to include reference to the Strategy review date within the main text, of February 2018.

## 11. GOVERNOR STEERING GROUP UPDATE

11.1 There was no update from the Governor Steering Group.

## 12. NON EXECUTIVE ASSURANCE ON THE ROLE OF THE MHLS COMMITTEE

12.1 The Council welcomed Maggie Deacon, Non-Executive Director and Chair of the Mental Health Legislation Scrutiny Committee. Maggie had been invited to attend the meeting to provide Governors with assurance about how she, as Chair of the MHLS Committee, holds services to account and gathers a range of assurances to assure the Board that the Trust is operating within the law and to the standards required of [2]gether as a Mental Health and Learning Disabilities Service Provider.

12.2 Maggie Deacon advised that the MHLS Committee holds to account any employee who is responsible for the production of policies, systems and procedures, and their implementation into practice, to ensure compliance with the law, regulations and Codes of Practice. In this case the law being the Mental Health Act, the Mental Capacity Act and the Human Rights Act. Attendance at the Committee includes all professions and administrative areas carrying these responsibilities and where services cross organisational boundaries e.g. social care, representatives from the relevant organisations attend the meetings and report on these key areas.

12.3 Maggie said that the Committee had delegated power to consider, comment upon and amend draft policies which were brought to it, either because of external factors (e.g. a new National Code of Practice or a report from a visit by Mental Health Commissioners) or because of internal factors (e.g. an agreed cycle of review of the policy in practice). In making its decisions the Committee considers the extent of consultation with internal and external parties in drafting or amending a policy. Once the Committee has approved the policy it is put into practice and noted by the Board through the Committee summary. Maggie informed the Council that the Committee provides a summary of key business to the Board after each meeting, pointing out where the Committee is assured and where it is not assured, and in the latter case, what action is being taken. Minutes are also provided to the Audit Committee which scrutinises risk across the organisation. Areas where there is limited or no assurance are also flagged in the Board Assurance Framework.

12.4 Maggie Deacon advised that it was important to remember that the scrutiny role of the Committee was no different to that of the other Board Committees, in that we are seeking assurance that the rhetoric, i.e. what we say, is in fact what we do. Maggie said that she had held various managerial roles in the public sector and as a non-executive of other Boards; she had learnt how to ask questions and had the experience to request specific information to get to

the heart of issues. The Council was informed that Maggie had undertaken training to better understand the Mental Health Act and the new Code of Practice, and the Mental Capacity Act and had received the necessary training to carry out the role of Mental Health Act Manager. In relation to the scrutiny function, it was noted that the Trust's auditors provided briefing and training sessions around risk and assurance which support this.

12.5 Since becoming Chair of the Committee, Maggie had put in place a number of changes to the way in which the Committee functions e.g. early circulation of the Action List after each Committee meeting, the change of name to emphasise recognition of the full range of the Committee's Terms of Reference, trend lines in our KPIs and an annual benchmarking report.

12.6 Rod Whiteley said that he felt encouraged by Maggie's approach to Chairing the Committee but he queried whether the Committee really drilled down to patient level or whether it was simply there to check tick boxes. Maggie said that it was the role of the Committee to provide assurance to the Board that clinical and operational managers were acting appropriately and addressing the recommendations arising from external visits or audits. Shaun Clee said that the MHLS Committee's prime function was to ensure that the Trust was appropriately discharging its powers in relation to the MHA and MCA legally and in line with the Code of Practice.

12.7 Richard Castle noted Maggie Deacon's reference to the role of the NED "going beyond what is actually required" and asked whether this was felt to be sensible given the likely cuts and financial restraints facing NHS Trusts. Maggie Deacon said that there were limited resources; however, it was felt that the MHLS Committee was an extremely valuable Committee and would therefore continue as long as it was deemed to be important in providing assurance.

12.8 The Council thanked Maggie for her presentation, and noted the assurance provided.

## 13. ANNUAL MEMBERSHIP REPORT

13.1 Jane Melton provided the Council with a full analysis of the 2014/15 financial year membership data.

13.2 It was noted that there were 7369 members at the end of the 2014/15 financial year. 362 new members joined the Trust during the year and 329 members were removed from the database. On average, 30 people become members of the Trust every month. Trust Membership currently appeals more to women than men, to people aged 65 and over, and to those with self-reported disability. Further tactics need to be developed to encourage membership from males, younger people, people from minority ethnic groups and from people who are without a disability in order to reflect an accurate representation of the constituents of Gloucestershire and Herefordshire. Membership in Herefordshire is significantly lower than in Gloucestershire; with Gloucester City having the largest proportion of Trust members.

13.3 Mandy Nelson said that she would like to see a comparison of Public Members vs Trust Service Users, rather than the general population statistics as this would be more meaningful. She also said that she wanted to see more about engagement with members and what the Trust was doing to improve this. It was important to have members, but it was more important to have engaged members.

13.4 Al Thomas noted that it was part of the Governor role to represent members and he queried how constituents could get in touch with Governors directly. It was noted that there was a generic email address that had been set up and publicised for members to use if they wished to contact their Governor. The email inbox was monitored by Anna Hilditch who would notify Governors if any correspondence was received. It was agreed that this process was appropriate; however, Governors asked whether it would be possible to publicise the contact details again to ensure that this was clear for people.

***ACTION: Contact details for Trust Governors, including generic email address to be publicised to all members in the next Membership newsletter and clearly on the Trust website***

13.5 Dawn Lewis thanked the Trust for circulating information to the Governors about some events that had been planned for Mental Health Awareness Week. However, this had been sent out on Monday morning and one of the events was taking place later that day. Dawn said that Governors were keen to participate in Trust events and therefore asked that notification of such events be communicated well in advance to enable attendance. The Trust was missing a trick in not liaising with Governors around attendance at Trust events. Jane Melton noted the concern raised and agreed to take this back to her team for action.

***ACTION: Jane Melton to discuss the publicising of Trust events with members of her team to ensure that Governors are notified and invited to attend in good time***

13.6 Gillian Hayes suggested that it would be helpful to reconvene the Membership Working Group to add some emphasis on this. This was agreed and Mandy Nelson, Rob Blagden, Adrian Wilcox and Rod Whiteley volunteered to participate.

***ACTION: Membership Working Group to be reconvened to add more focus on progressing membership engagement***

## 14. GOVERNOR ACTIVITY

14.1 Al Thomas had attended an NHS Providers Event in London and he reported that this had been an excellent event.

14.2 Rod Whiteley had attended a Mental Health Strategy Group meeting and noted that a number of concerns had been raised about the Trust's Carers Charter and the implementation of this. Rod Whiteley agreed to pass the details of this

meeting on to Jane Melton to enable her to investigate what these concerns may have related to.

***ACTION: Rod Whiteley to pass the details on to Jane Melton of the MH Strategy meeting he had attended where he said that concerns had been raised about the Trust's Carer Charter***

14.3 Dawn Lewis had attended a meeting about the Crisis Care Concordat and had been invited to speak at the Royal College of Psychiatrists International Congress in Birmingham.

## 15. ANY OTHER BUSINESS

15.1 The Council was informed that the formal decision had been made not to respond to the tender for Drug and Alcohol Services in Herefordshire (DASH). This was a disappointing decision; however, on assessing the tender it was not felt that 2gether could offer the quality of services that it would wish to within the financial envelope being offered. It was noted that Herefordshire partners and commissioners had been informed of 2gether's decision. Staff in the DASH service were being supported and would transfer to the new supplier of the service from December 2015. Thanks were given to DASH staff for their commitment to the service during this unsettling period.

15.2 Shaun Clee advised that 2gether had submitted an expression of interest to work with Time to Change, as one of two mental health trusts nationally who will during 2015/16 undertake work on attitudes towards mental health within the mental health workforce. Our expression of interest was successful and this work will dovetail into our overall organisational development programme, aligned to our values and strategic objectives.

## 16. DATE OF NEXT MEETING

| Business Continuity Room, Trust HQ, Rikenel | | |
|---|---|---|
| **Date** | **Governor Pre-meeting** | **Council Meeting** |
| Thursday 16 July | 9.30 – 10.30am | 10.30 - 12.30pm |
| Tuesday 15 September | 4.30 – 5.30pm | 5.30 – 7.30pm |
| Thursday 12 November | 2.00 – 3.00pm | 3.00 – 5.00pm |

# Council of Governors
# Action Points

| Item | Action | Lead | Progress |
|---|---|---|---|
| **11 November 2014** | | | |
| 11.5 | Gavin Davies to work with the Governors from the relevant constituencies to organise a future schedule of Membership engagement events for 2015. | Gavin Davies | Ongoing |
| **22 January 2015** | | | |
| 4.6 | Colin Merker to organise a presentation for a future Council meeting on the Trust's community services | Colin Merker | Scheduled for the July Council |
| 5.7 | Governors wishing to become members of the Nominations & Remuneration Committee should notify Anna Hilditch. | ALL Governors | |
| **12 May 2015** | | | |
| 2.1 | Annual Governance Declaration form to be emailed to those Governors not present at the meeting for completion. | Anna Hilditch | Complete |
| 4.4 | Jane Melton to review the Trust's Complaints leaflets and ensure that these were consistent and up to date on the Trust website | Jane Melton | The Communication Team and the Service Experience Department have offered assurance that the Trust's Complaints leaflets are updated |
| 4.6 | Rod Whiteley to share his specific concerns, as raised with the CQC, with Ruth FitzJohn for information | Rod Whiteley | Complete |
| 4.7 | Governor agenda planner to be updated to include Ruth FitzJohn in September and Nikki Richardson in November for the Holding NEDs to Account sessions. | Anna Hilditch | Complete |
| 5.4 | PTS Presentation to be added to the Governor portal | Anna Hilditch | Complete |
| 6.6 | Nominations and Remuneration Committee to discuss the involvement of Governors in the NED appraisal process in future years, as well as the Chair | Anna Hilditch | Complete. Scheduled for next N&R Committee agenda |
| 8.3 | Lead Governor nomination forms to be recirculated to all Governors and nominations sought by 22 May | Anna Hilditch | Complete |
| 9.4 | John McIlveen to produce a further draft of the constitution incorporating the revisions discussed but not agreed, to be presented at a future meeting. | John McIlveen | Amendments to be presented as part of the scheduled review of constitution |
| 10.4 | Rod Whiteley to provide feedback directly to Carol Sparks on those specific areas within the OD Strategy requiring attention. | Rod Whiteley | Complete. Feedback received and acknowledged |
| 13.4 | Contact details for Trust Governors, including generic email address to be publicised to all members in the next Membership newsletter and clearly on the Trust website | Jane Melton / Gavin Davies | Gavin Davies has offered assurance that this will be undertaken in the next Trust newsletter |

| | | | |
|---|---|---|---|
| 13.5 | Jane Melton to discuss the publicising of Trust events with members of her team to ensure that Governors are notified and invited to attend in good time | Jane Melton | The Trust's Communication Team and the Social Inclusion Team are preparing a document with all the current events. This will evolve over the year and Governors will be notified of events as soon as possible during the year |
| 13.6 | Membership Working Group to be reconvened to add more focus on progressing membership engagement | Jane Melton / Gavin Davies | Gavin Davies is progressing this action |
| 14.2 | Rod Whiteley to pass the details on to Jane Melton of the MH Strategy meeting he had attended where he said that concerns had been raised about the Trust's Carer Charter | Rod Whiteley / Jane Melton | Assurance has been received that the individual who communicated concerns is directly involved in the Trusts Triangle of Care development work and is providing a very valuable contribution. |

**Agenda Item** **17** **Enclosure** **Paper L**

**TO:** **[2]gether NHS Foundation Trust Board**

**FROM:** **John McIlveen, Trust Secretary**

**DATE:** **30 July 2015**

**SUBJECT:** **USE OF THE TRUST SEAL**

## PURPOSE

To present the Board with a report on the use of the Trust Seal for the period January to June 2015 (Quarter 4 2014/15 and Q1 2015/16).

## SUMMARY OF KEY POINTS

Section 10.3 of the Trust's Standing Orders requires that use of the Trust Seal is reported to the Board on a quarterly basis.

*"10.3 Register of Sealing - The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document. Use of the seal will be reported to the Board quarterly."*

During the last 2 quarters, the Seal was used once, as follows:

- **5 March 2015**
  Amendment to transfer of 2 parcels of land to [2]gether from the Secretary of State at Holly House and Field View
  Signed: Andrew Lee, Director of Finance & Commerce & Carol Sparks, Director of Organisational Development

## RECOMMENDATIONS

The Board is asked to note the use of the Trust seal for the period January to June 2015 (Quarter 4 2014/15 and Q1 2015/16).