

Quality Dashboard 2023/24

Physical Health, Mental Health and Learning Disability Services

Data covering December 2023

This Quality Dashboard reports quality focussed performance, activity, and developments regarding key quality measures and priorities for 2023/24 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is welcomed and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

The Quality Dashboard summary is informed by NHS England's shared single view of quality – which aims to provide high quality, personalised and equitable care for all. The primary drivers in this shared view focus on systems and processes that deliver care that is safe, effective and has a positive experience which is responsive, personalised and caring. We frame our quality reporting in line with this view. This provides an escalation process to ensure we identify and monitor early warning signs and quality risks, helps us monitor the plans we have in place to transform our services and celebrates our successes.

Are our services SAFE?

The business intelligence team have developed a clinical system to automatically report safeguarding referrals to the local authority. The aim is to go live by the end of March 2024 once key new staff are in post within the Safeguarding Team. In line with NHSE Pressure Ulcer (PU) reporting standards we have removed the **acquired** and **inherited** label from the dashboard and are preparing to adopt the new national PU data system to replace the National Safety Thermometer, which supports quality improvement rather than traditional data collection. GHC PU reporting is in line with regional and national community Trusts recognising that a) PU prevention and management is a system issue rather than a single provider issue and b) a significant proportion of GHC patients enter our services with a PU developed outside of the Trusts services. We are looking at the accuracy of coding PU's that are classified as "Developed prior to admission to the Trust" to further validate this. Last month Quality Committee received a deep dive into PU which provided both reassurance and assurance that there is sustained grip and focus on this issue. Berkeley House remains under a period of enhanced surveillance with the ICB in line with National Quality Board requirements, the Trust meet monthly with the ICB to discuss progress, positive feedback has been received from the ICB with regards to our improvements. There were a total of 1112 patient incidents reported in December. 983 were reported as No and Low harm incidents and 129 as Moderate, Severe or Catastrophic incidents. The top four overall categories of incident excluding skin integrity were self-harm, clinical care, falls and medical emergency. 1 serious incident was reported in December. Two After Action Reviews took place in December and learning from these has been shared with clinical teams and governance forum. Good progress continues with restrictive practice reduction in the Trust and an update report was shared at Quality Committee earlier in the month.

Are our services EFFECTIVE?

This month we have provided an overview of CQUIN's that have been agreed with Gloucestershire ICB, with the H1 position being reported via the national portal in line with required timescales. Throughout 2023, there has been a significant increase in MASH activity due to the introduction of the new Police Daily Vulnerability Meeting (PDVM). This is impacting on the team's ability to meet MASH timescales and new appointments have been made to expand the team to absorb the increased activity safely and effectively. **Appendix 2** summarises wider key operational performance data. We note improvement within therapies within all of the six reported measures showing a positive improvement over November data which is attributable to increased oversight and the realisation of recovery plans. Included this month, in summary on slide 3 and in detail at **Appendix 3**, are the slides relating to the Trusts Quality Priorities for improvement which are contained within the Quality Account. The Quality Priorities cover a two-year time frame. All of the priorities support local and national agendas around personalisation, co-production and shared decision making. This month we include a deeper dive on progress for each as at Q3 as we prepare to produce the base data for our Quality Account. Safer staffing data acknowledges the continuing challenges and progress for inpatient teams. There is an improving recruitment position at WLH, there was a trajectory to be fully established at Band 5 level for the entire WLH site by end of November 2023, this target was not met but there has been significant improvement with the current vacancy rate being 6.6 WTE. This month we continue with the exception reporting in relation to Statutory and Mandatory training, where there are 5 or more teams not reaching the threshold for compliance. Access to individual team data is now available to support team managers to identify areas that require support. Essential to Role (E2R) training is now included this month (mainly MH) and more will be included in 2024.

Are our services CARING?

The new complaints management process launched on 1st August 2023 in line with the revised PHSO standards is now firmly embedded within the Trust. The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. We will continue to review the process (including recording/reporting) and monitor feedback from patients/staff. FFT responses reduced this month, however, the percentage of respondents reporting having had a positive experience reached the target of 95%. In December, the number of formal complaints reduced to 5, which is the lowest number since April 2023. 89% of complaints were closed within three months (target 50%) and 100% closed within six months (target 80%). There were no re-opened complaints in December. The Patient Carer Experience Team continues to work with operational colleagues to achieve improved governance/oversight of all feedback received in order to embed learning and recommendations.

CQC Update

We are working on actions arising from the recent CQC inspection visit to Berkeley House. We continue to facilitate monthly meetings with the CQC, ICB and NHSE to update them on improvement plans. We are adopting the new CQC Quality of Life tool for inspecting specialist services for people with a learning disability and autism. This will inform future reporting to the CQC. The actions arising from the Trust wide CQC core inspection are now **100%** complete. All self-assessments have now been completed for those services not inspected in the 2022 programme. Peer reviews are completed and plans in place for CLDT, Recovery and the Crisis Team. The CAHMS Service will be reviewed internally early in 2024.

The National CQUINs applicable to GHC for 2023/24 are tabled in summary below, progress reporting commences at the close of H1 (Q3 for Flu). Agreement reached with commissioners that reporting will be for information purposes only with no financial penalties linked to thresholds.

SUMMARY CQUIN INITIATIVES 2023-2024

CCG Ref	Description	Mental Health	Physical Health	Reporting Process	Status
CCG1	Flu vaccinations for frontline healthcare workers, (70%-90% compliance)	✓	✓	Established process via Immform to continue as per previous years.	Flu and Covid-19 vaccination programme is underway. Clinic locations and times are publicised on the Intranet. Good take up from staff has been evident in these early clinics, targeted work is planned for areas of low uptake. (uptake 15 th Jan 45%).
CCG12	Assessment and documentation of pressure ulcer risk Achieving 70% (min) of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.		✓	Manual Audit. H1 & H2	H1 results show 75% compliance, CQUIN Requirements for H1 have been achieved. Manual audits planned for H2.
CCG13	Assessment, diagnosis and treatment of lower leg wounds Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines.		✓	Suspended	CQUIN suspended due to national challenges with audit tool, work stream incorporated in to 2023-24 by the implementation of the tissue viability quality priority.
CCG14	Malnutrition screening in the community - applicable to inpatients in community settings Achieving 70% (min) of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks.		✓	Manual Audit. H1 & H2	H1 results show 44% compliance, CQUIN requirements for H1 have not been achieved. A review identified the main factor was the timing of the use of the tool rather than results obtained. Remedial actions are under way and we confident of being fully compliant.
CCG15a	Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHS's), having their outcomes measure recorded at least twice. Separately, achieving 10% of adults and older adults accessing select Community Mental Health Services, having their patient-reported outcomes measure (PROM) recorded at least twice.	✓		Routine submission (via MHSDS)	At present paired outcomes are not consistently recorded. As part of the Community Mental Health Transformation work, DIALOG+, which is a self assessment and Patient Rated Outcome Measure (PROM), is being trialled. This will give an opportunity for outcomes to be assessed. Engagement and training is underway. Teams have been informed that the use of the template is now compulsory. The majority of community mental health teams (Recovery, Later Life, MHCT and AOT) have received DIALOG+ training. A further online training date of 10/01/24 has been confirmed for those who were unable to attend previous dates. Further discussion needs to be had with CRHTT to establish a training and roll out plan. Discussion has also started with NTQ in terms of amalgamating the new care planning process and DIALOG+ roll out, due it's overlap.
CCG15b	Routine outcome monitoring in CYP and community perinatal mental health services . Achieving 50% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measure recorded at least twice.	✓		Routine submission (via MHSDS)	Being scoped. This indicator requires further development and input from BI and will be noted as indicator N26 in the next phase of indicators to go live organisationally.
CCG17	Reducing the need for restrictive practice in adult/older adult settings . Achieving 90% of restrictive interventions being recorded in adult and older adult acute mental health, PICU and learning disability and autism inpatient settings with all mandatory and required data fields completed.	✓		Routine submission (via MHSDS)	Being scoped. This indicator requires further development and input from BI and will be noted as indicator N32 in the next phase of indicators to go live organisationally.

Quality Priorities 2023-2025:

A summary of quality priority activity in H1 2023-24 is provided below. This is a 2 year work programme and a definitive compliant/non compliant rating will be issued at the end of Q8.

Progress against plan for each priority is provided in more detail in Appendix 3.

SUMMARY QUALITY PRIORITIES 2023-2025

Priority	Description	Status 23/24
1	<ul style="list-style-type: none"> Tissue Viability (TVN) - with a focus on reducing performance through improvement in the recognition, reporting, and clinical management of chronic wounds. 	No significant barriers to achievement reported. Detail in Appendix 3.
2	<ul style="list-style-type: none"> Dementia Education - with focus on Increase staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire. 	No significant barriers to achievement reported. Detail in Appendix 3.
3	<ul style="list-style-type: none"> Falls prevention – with a focus on reduction in medium to high harm falls within all inpatient environments based on 2021/22 data. 	Community falls workstream being re-evaluated as wider discussions are taking place relating to scoping of data and the validity/accuracy and effectiveness of the data evidenced thus far.
4	<ul style="list-style-type: none"> End of Life Care (EoLC) – with a focus on patient centered decisions, including the extent by which the patient wishes to be involved in the End of Life Care decisions. 	Base line identified, however, a shortfall in training availability means that that the trajectories for staff completing E2R training are not realistic or achievable during the 2 years expected in the End of Life Quality Priority. Further work is planned to refine E2R training – i.e. the number of Masterclasses that are classed as E2R and/or staff groups needs to reduce and/or a different way of delivering the training needs to be introduced in order to achieve delivery within the 2 years.
5	<ul style="list-style-type: none"> Friends and Family Test (FFT) – with a focus of building upon the findings of the 22/23 CQC Adult Community Mental Health Survey action plan. 	No significant barriers to achievement reported. Detail in Appendix 3.
6	<ul style="list-style-type: none"> Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. 	No significant barriers to achievement reported. Detail in Appendix 3.
7	<ul style="list-style-type: none"> Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranquilisation. 	No significant barriers to achievement reported. Detail in Appendix 3.
8	<ul style="list-style-type: none"> Learning disabilities – with a focus on developing a consistent approach to training and delivering <i>trauma informed</i> Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025. 	No significant barriers to achievement reported. Detail in Appendix 3.
9	<ul style="list-style-type: none"> Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan. 	No significant barriers to achievement reported. Detail in Appendix 3.
10	<ul style="list-style-type: none"> Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan. 	No significant barriers to achievement reported. Detail in Appendix 3.
11	<ul style="list-style-type: none"> Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation. 	No significant barriers to achievement reported. Detail in Appendix 3.

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

	Reporting Level	Threshold	2022/23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 YTD	Notes
Number of Friends and Family Test Responses Received	N - R		20,256	2,419	2,699	3,115	2,705	2,877	2,476	2,683	2,356	1,799				23,129	
% of respondents indicating a positive experience of our services	N - T	95%	94%	94%	94%	94%	94%	95%	93%	94%	94%	95%				94%	
Number of compliments received in month	L - R		2081	202	160	256	306	205	205	244	210	181				1,969	
Number of enquiries (other contacts) received in month	L - R		619	44	75	82	87	99	102	116	121	95				821	This includes feedback that may previously have been categorised as a <i>concern</i>
Number of concerns received in month	L - R		692	66	65	48	40	0	0	0	0	0				219	NHS Complaints Standards: feedback is now either an enquiry (other contact) or a complaint.
Number of complaints received in month <i>Includes ALL complaints (closer look complaint / early resolution complaint)</i>	N - R		136	8	13	6	11	35	23	13	8	5				122	
Of complaints received in month, how many were early resolution complaints	L - R			0	0	0	0	33	23	13	7	5				81	
Number of open complaints (not all opened within month) <i>Includes ALL complaints (closer look complaint / early resolution complaint)</i>	L - R			43	39	30	33	50	58	46	36	25					This includes feedback that may previously have been categorised as a <i>concern</i>
Percentage of complaints acknowledged within 3 working days	N - T	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	
Number of complaints closed in month <i>Includes ALL complaints (closer look complaint / early resolution complaint)</i>	L - R			6	17	15	8	18	15	25	18	16				138	
Number of complaints closed within 3 months	L - I			5	9	8	4	13	12	20	16	14				101	We have adjusted our local KPIs in line with the NHS Complaints Standards targets
Number of re-opened complaints (not all opened within month)	L - R			7	5	3	4	4	4	2	0	0					
Number of external reviews (not all opened within month)	L - R			2	4	4	5	6	7	7	4	6					This includes 3 x complaints we have referred to the PHSO to investigate

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

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

Key Highlights:

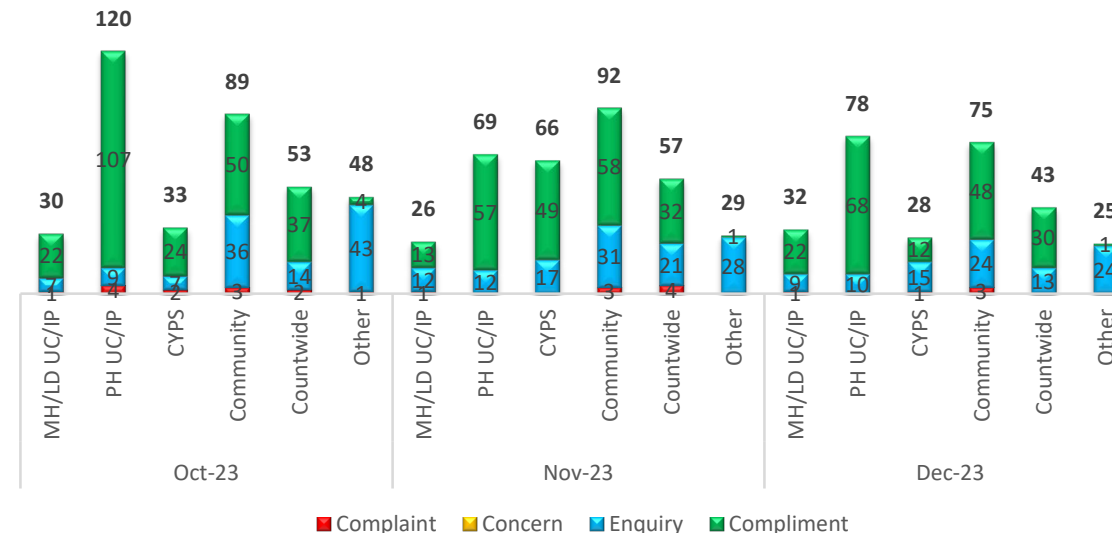
- The new PCET process launched on 1st August 2023 in line with the [NHS Complaints Standards](#).
- The Standards are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. We will continue to review the process (including recording/reporting) and welcome all feedback from patients/staff via experience@ghc.nhs.uk
- Numbers are reported by operational channels/directorates, then by type.
- Directorate level data is shared with SDs, DSDs, P&D leads and NTQ links each month to enable interrogation of service specific feedback; this time is also be used to discuss ongoing investigations and emerging themes/ learning.

This table shows all reported PCET data received this month by type and directorate

It is important to note that this is a snapshot and does not consider footfall/caseloads/acuity of patients.

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	1	Early resolution:	1	9	22
		Closer look:	0		
PH urgent care and inpatient	0	Early resolution:	0	10	68
		Closer look:	0		
CYPS	1	Early resolution:	1	15	12
		Closer look:	0		
PH/MH/LD Community	3	Early resolution:	3	24	48
		Closer look:	0		
Countywide	0	Early resolution:	0	13	30
		Closer look:	0		
Other	0	Early resolution:	0	24	1
		Closer look:	0		
Totals	5	Early resolution:	5	95	181
		Closer look:	0		

Directorate feedback over the past three months



The above graph shows feedback by type and directorate over the past three months.

Whilst there have been several complaints, there have been significantly more compliments across every directorate. Moving forward, we want to start shifting our focus to learning from excellence too.

The new NHS Complaint Standards were implemented in August 2023 – feedback is no longer categorised as a concern, and is instead either a complaint or an enquiry:

- Complaints:** now divided into early resolution complaints (like concerns, except with a formal response) and closer look complaints (like formal complaints)
- Enquiries:** this category now includes feedback that may have previously been categorised as a *concern*

Examples of complaints [as reported] for each directorate:

- MH UC/IP:** care delivery on the ward
- Community:** insensitive and upsetting remarks made by staff; alleged misconduct of a staff member, family report patient was neglected.
- CYPS:** long awaited appointment cancelled when family moved out of county

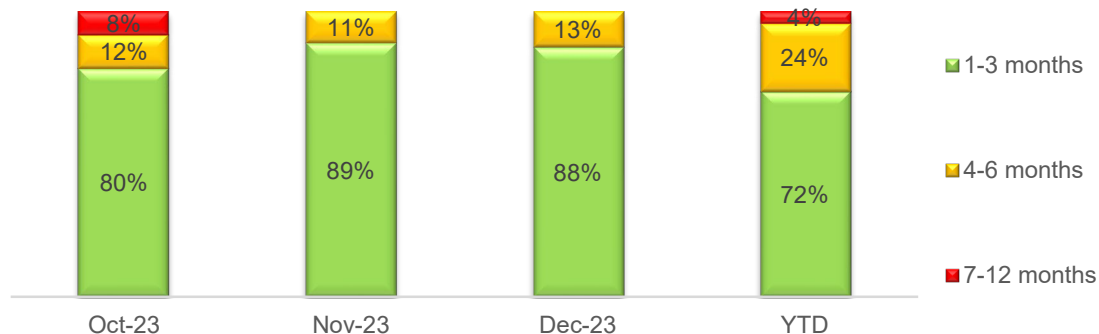
CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The below table shows all COMPLAINTS closed this month by outcome and directorate.
These include closer look and early resolution complaints.

Directorate	Upheld	Partially upheld	Not upheld	Other	Total
MH/LD urgent care, inpatient	0	2	0	0	2
PH urgent care, inpatient	0	1	2	0	3
CYPS	0	0	1	0	1
PH/MH/LD Community	1	1	5	1	8
Countywide	1	0	0	0	1
Other	0	0	0	1	1
Totals	2	4	8	2	16

The below graph shows improvements in the length of time taken to close complaints.

- We have updated our local KPIs in line with the new national targets
- This month, **89%** were closed within three months (target = 50%), **100%** closed within six months (target = 80%)
- YTD, **95%** of complaints have closed within six months (87% for 2022/23)

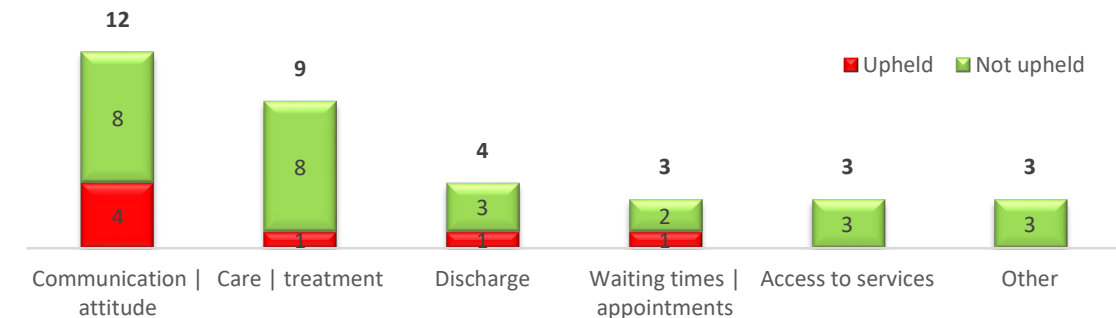


The below table shows upheld COMPLAINT THEMES this month.
These include closer look and early resolution complaints.

Directorate	Upheld themes for complaints closed this month
PH urgent care, inpatient	Communication: Confusion over emergency contact device
MH urgent care, inpatient	Communication: Letters sent to GP and patient were different; relative not informed of patient discharge Discharge: Patient discharged without confirming they had access to basic provisions.
PH/MH/LD Community	Communication: Email not responded to Patient care: Patient left without team assigned to care
Countywide	Referral: Failure to refer

The chart below shows the themes highlighted in all complaints closed over the past month

- Communication or attitude - upheld in **3** directorates
- Care and treatment - upheld in **1** directorate
- Referral - upheld in **1** directorate
- Discharge - upheld in **1** directorate



Due to the implementation of the new complaints standards, we expect an increase in the number of complaints received, and a corresponding increase in the number of complaints upheld/partially upheld (however, we will monitor this over time).

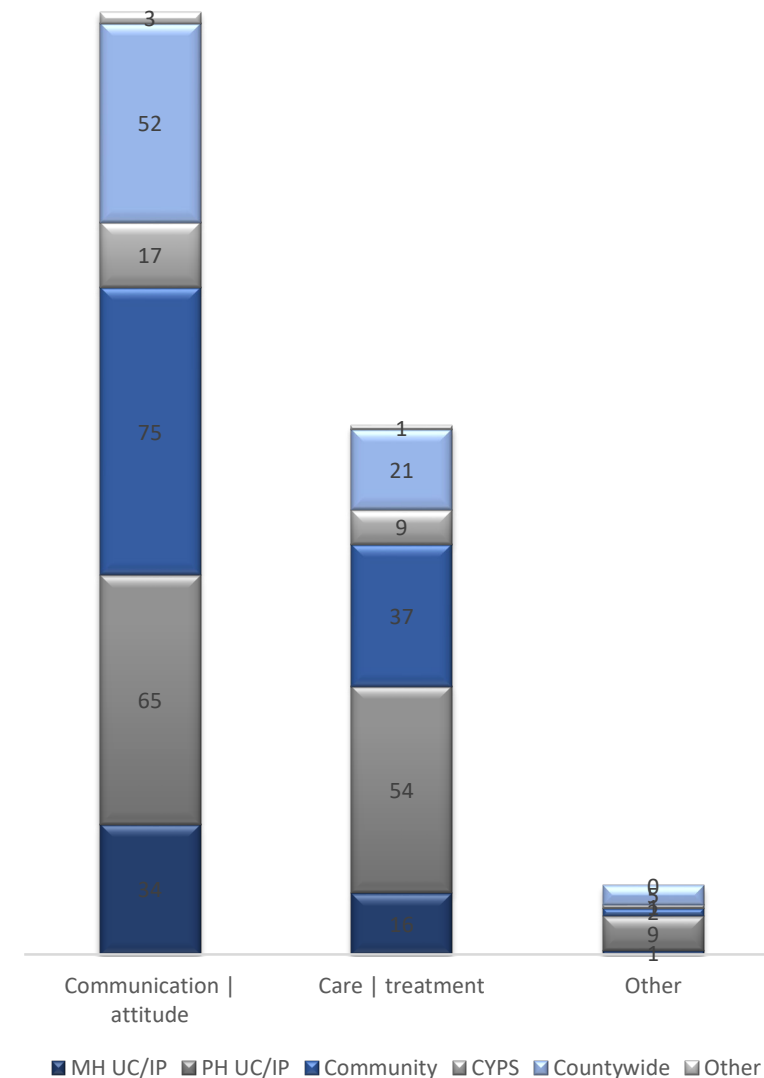
We also anticipate being more responsive through the early resolution process.

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

The table below is a sample of compliments received this month, and the chart opposite shows all COMPLIMENTS received this month by theme and directorate.

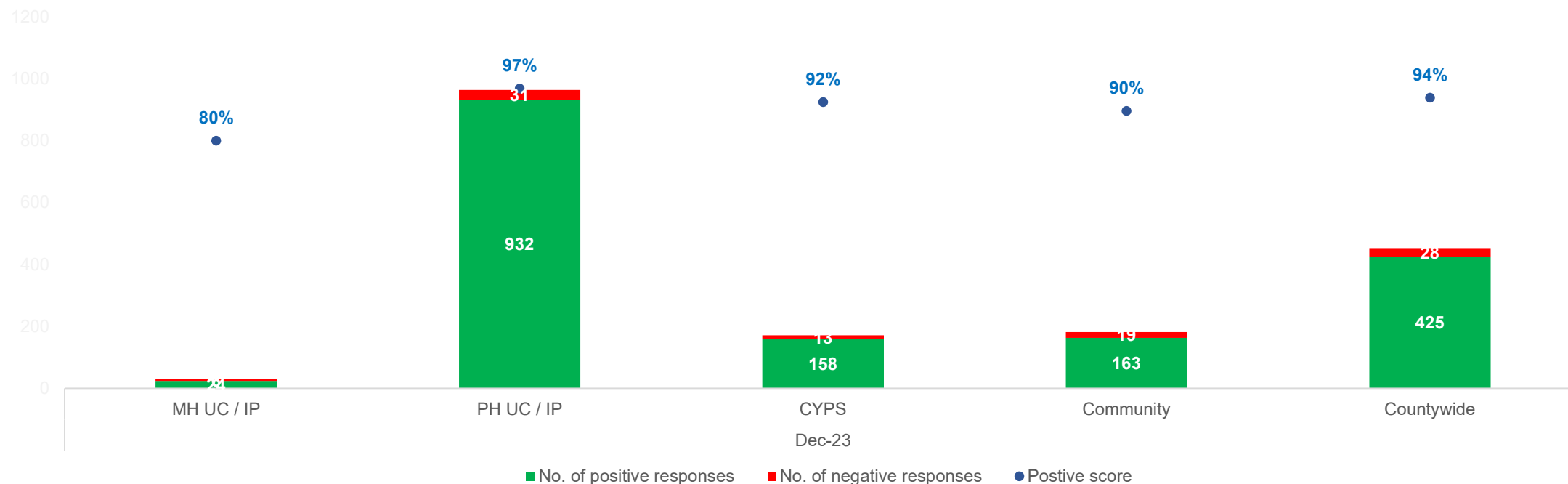
The 181 compliments recorded contained comments that were distributed over **10** different themes. **Some compliments contained more than one theme.** It is very likely that more compliments were received but not recorded, therefore, not reported; this is due to operational challenges in some teams.

Date	ID	Team	Compliment
19/12/2023	12216	ICT Cotswold North DN	Thanks to the Community Nurses for their help and support
04/12/2023	12066	MSK Physio	"Excellent advice. I am a retired physio, so know what I am talking about. My appointment was unhurried and my comments were listened to I was given good advice and appropriate suggestions for the future . I felt happy and confident in my physio"
19/12/2023	12226	CYPS/PH-Childrens Physio	Thank you! And thank you for your notes, we wouldn't have got to this point with ** without your fantastic support, so thank you for everything you've done so far
05/12/2023	12090	Ciren Hosp- Windrush Ward	Thank you card: To all the wonderful staff on Windrush Ward Thank you so much for looking after my dad so wonderfully. Your kindness and understanding has been very much appreciated. You all do such an amazing job and help make a difficult time more manageable. Keep being amazing!
08/12/2023	12161	CRHT Chelt & Tewks	Thumbs up to the reception team at Leckhampton Lodge and the Crisis Team. A patient recently sent a thank you and wrote: "Thank you for your help hearing I was unwell and contacting the team. I was very poorly, the Crisis Team saved my life and kept me out of hospital."
27/12/2023	12295	Charlton Lane- Mulberry Ward	I would like to thank everyone in Mulberry for being so kind and supportive. I am always happy to be in the ward. And I see what the staff do there, and I feel great respect for all. And thank you for the shortbread biscuits, which are one of my favourites, which means they are in no danger of becoming stale. Best wishes for 2024.
29/12/2023	12355	Dilke Hosp- Forest Ward	Thank you to all the kind staff that looked after our Mum Jeanne, for all your care and help over the last few months. It is very comforting knowing that she was so well looked after. Thank you all again.
22/12/2023	12345	CAMHS Core	From parent of young person. Thank you, this is all very helpful- he is doing well so far, sorry I couldn't attend the last session & thanks for everything you've done
06/12/2023	12111	FAES (Falls Assessmt & Ed Svc)	Patient and family attended clinic appointment. They fed back that it had been an excellent service and the assessment had been very thorough.



CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

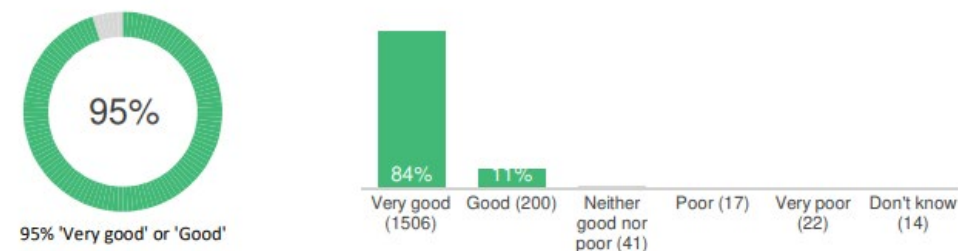
FFT scores by month and directorate



Highlights for this month:

- The overall number of responses was lower than in recent months, but we expect this to be due to the Christmas period.
- The overall positive experience rating has remained at 95%, which is in line with recent months.
- We are continuing to work with services where responses are low to promote a variety of survey methods, such as iPads, QR codes and paper where this is appropriate.
- There were 4 requests for contact via the open FFT question
- A pilot to share feedback through 'You Said, we Did' Board is underway in Q4 as part of the FFT QI project.

Overall experience of our service | December 2023



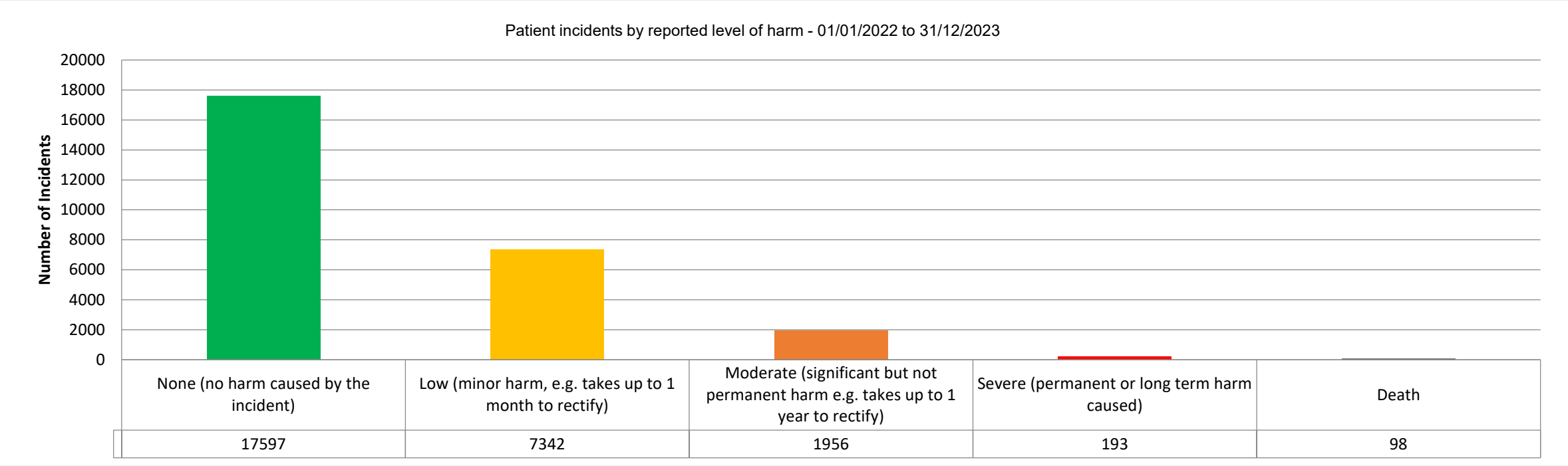
CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	Reporting Level	Threshold	22-23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023-24 YTD	R	Exception Report?	Benchmarking Report
																	A		
																	G		
Number of Never Events	N - T	0	1	0	0	0	0	0	0	0	0	0				0			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	5	2	2	3	3	1	2	1	1				20			N/A
No of overdue SI actions (incomplete by more than 1 month)	L - R		N/A	0	0	0	0	0	0	0	0	0				0			N/A
No of unallocated SI investigations (waiting more than 1 month for allocation).	L - R		0	1	0	1	0	1	0	0	0	0				3			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self-harm or attempted suicide	N - R		5	0	0	0	0	1	0	0	0	0				1			N/A
Number of Learning from Incidents contacts	L - R		9	2	6	4	2	0	10	27	16	23				90			N/A
Total number of Patient Safety Incidents reported	L - R		13029	1057	1111	1317	1237	1329	1208	1413	1194	1112				10978			N/A
Number of incidents reported resulting in low or no harm	L - R		11967	964	1007	1209	1145	1233	1118	1281	1082	983				10022			N/A
Number of incidents reported resulting in moderate harm, severe harm or death	L - R		1062	93	104	108	92	96	90	132	112	129				956			N/A
Total number of patient falls (hospitals and inpatient units) reported as resulting in moderate harm, severe harm or death	L - R		29	1	2	1	0	3	1	0	2	0				10			N/A
Total number of medication errors reported as resulting in moderate harm, severe harm or death	L - R		5	1	0	2	0	1	2	0	3	0				9			N/A
Total number of sexual safety incidents reported	L - R		129	7	5	10	13	13	4	13	3	7				75			N/A
Total number of Rapid Tranquilisations reported	N - R		981	46	30	61	37	71	48	52	38	54				437			N/A

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

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

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data



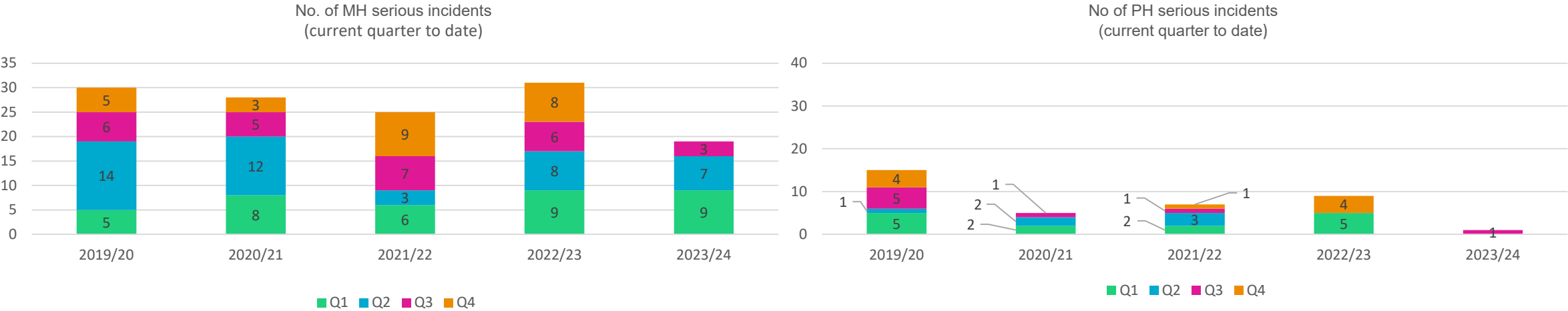
Key highlights:

We have included in this dashboard a summary of patient safety incidents reported over the last 2 years and seek to present data that can identify patterns requiring deeper analysis.

In December there were 1112 patient incidents reported on Datix (82 fewer than November). 983 were reported as No and Low harm incidents (99 fewer than November) and 129 as Moderate or Severe harm or Death (17 more than November). The reduction in reported incidents over Q3 represents a reduction of 24%. This may be a seasonal variation, however, further observation of this data will continue in to Q4.

The PST continues to review incidents in teams with reporting anomalies and shares comprehensive reports with service level Ops and Governance meetings to support the development of insights into patient care. Additionally, to support widening the lens around harm, the PST and PCET meet weekly to describe new issues, complaints and moderate harm incidents. Mortality data and themes also drive the QI process. The legal services team have joined this forum to share learning from claims and other legal processes.

CQC DOMAIN - ARE SERVICES SAFE? – Serious Incidents and Embedded Learning



Key Highlights

1 new mental health serious incident was reported in December 2023 and is being managed as a Care Review.

PST and the ICB have agreed renewed timescales for the submission of a number of SI reports. Good progress has been made and the position will be fully recovered by the end of January 2024.

Two After Action Reviews (AAR) took place in December. These are reported in Datix and shared with the clinical team and governance forums. The AAR reports will form part of the Trusts Duty of Candour response to patients and families.

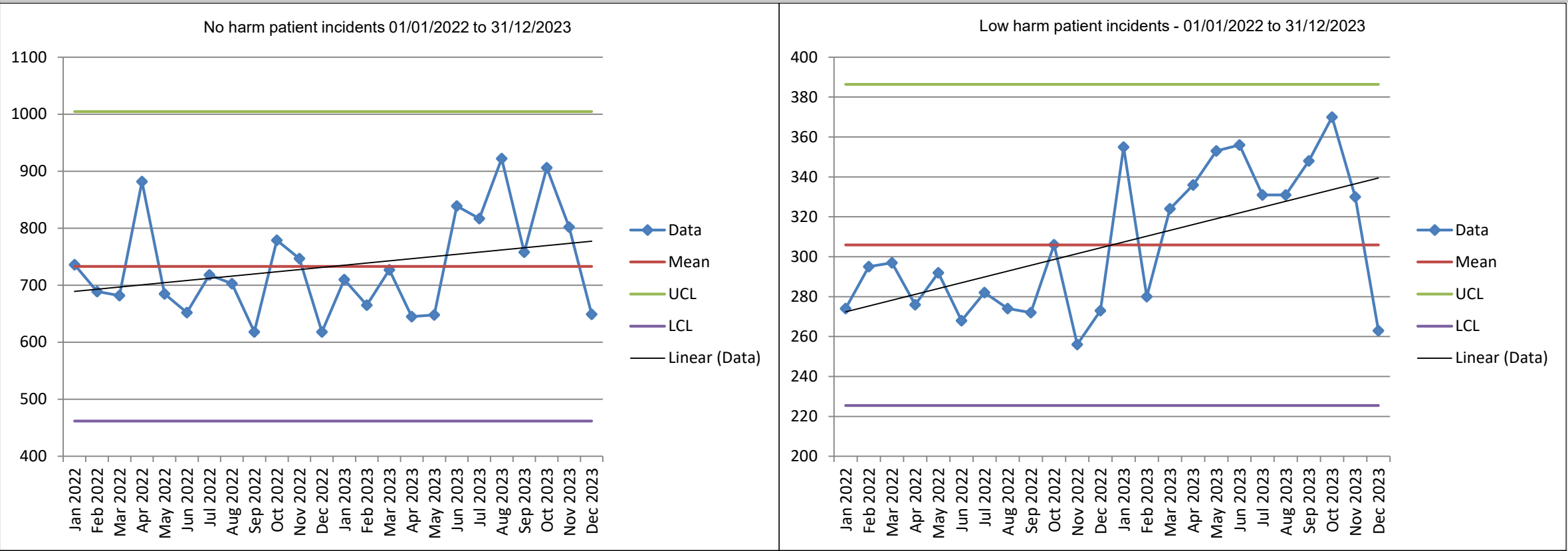
Learning Assurance Activity:

- Learning Assurance attended three Directorate-level meeting in December to raise the profile of learning assurance and share updates on incidents.
- Learning was disseminated via Medical and Dental Staffing Committee meeting, Patient Safety and Quality of Care Noticeboards and the Learning Opportunities Group (weekly).
- Internal review meetings for three clinical incidents, one huddle following a clinical incident.
- We met with the Homeward Assessment Service as they felt that they had learning to share with us. They report their learning on the GHFT Datix system. We now have on-going meetings planned with this team, so that learning can be shared

Ongoing learning assurance was supported through:

- Regular meetings with Matrons at Wotton Lawn and Charlton Lane Hospitals, the Clinical Development Manager and Duty of Candour Lead and Mental Health and Learning Disability Education Team and Physical Health Leads. These support the learning assurance work in the Hospitals
- The homicide action plan working group
- Colleagues in PCET, QI and CQC Quality to share updates (weekly)
- Attendance at the Carers Working Group, the Task and Finish Group on Observations and Engagement, the physical health mortality review group meeting and a meeting with the ICB to discuss current action plans and assurance from actions.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

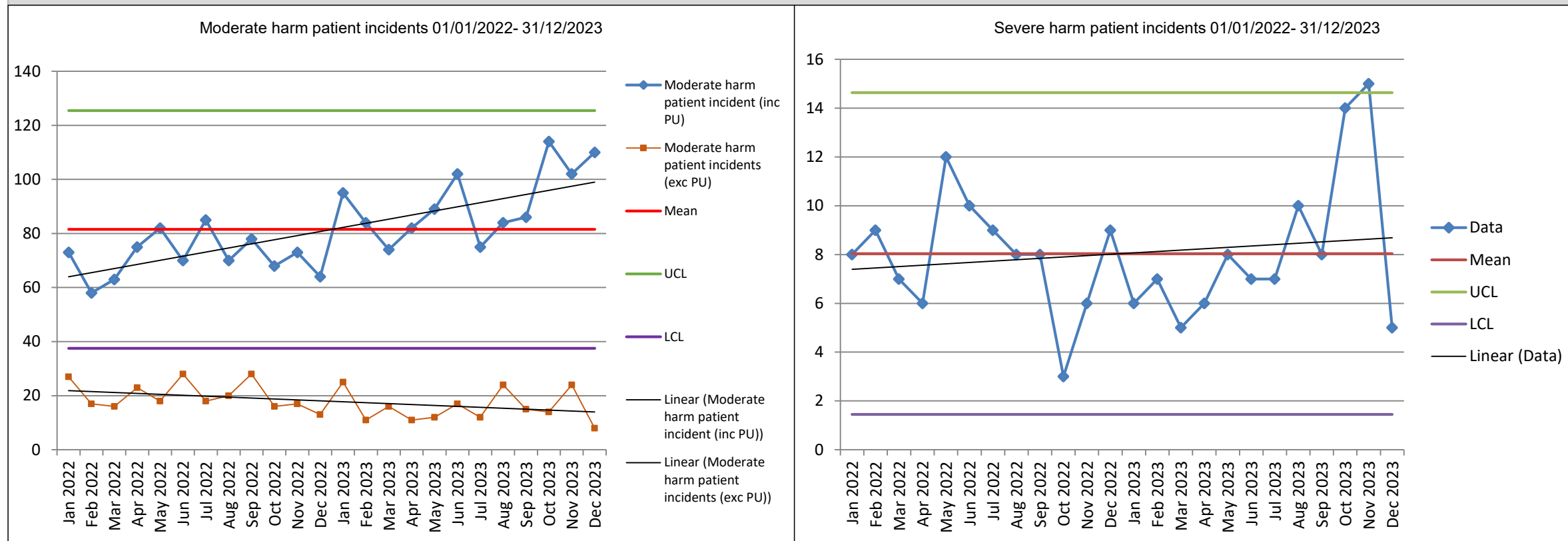


Key Highlights:

- No Harm Incidents** – the increase from May to October can be attributed to no harm restraints at Berkley House, no harm falls at Charlton Lane Hospital and no harm restraints in LD IHOT, who are supporting seasonal Covid-19 and Flu vaccinations
- Low Harm Incidents over time** - The PST continue to support staff to correctly assess and grade incidents. The 8 data points above the mean, since March 2023, are being monitored and were due to an increase in the reporting of skin integrity (including pressure ulcers) and falls incidents.

A high level of incident reporting is positive and patterns observed in these increases will be monitored and reported through services and QAG.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data



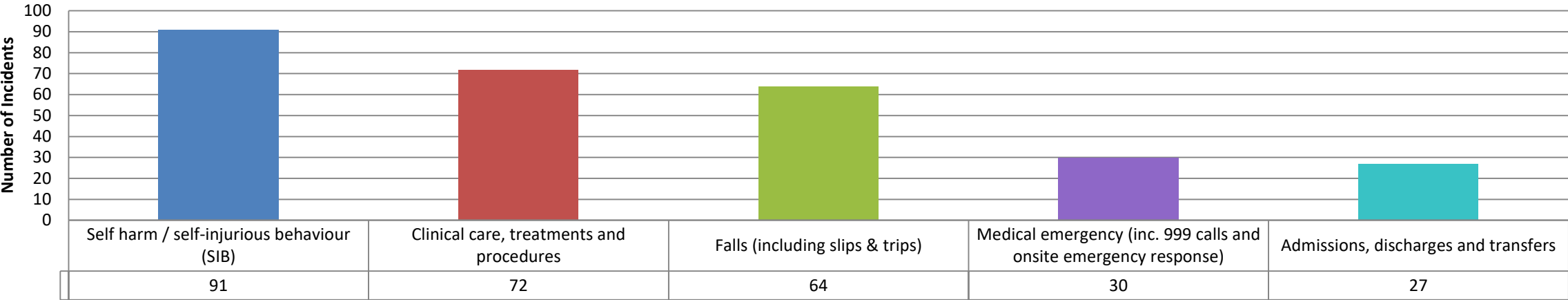
Moderate Harm Incidents over time The picture emerging here, despite the mean not altering at present, is a rise in the number of reported moderate harm incidents. Currently 8 data points emerge on or above the mean. There is an increase in skin integrity and falls incidents and a general reduction in all other moderate harm incidents reported.

The PST monitor these routinely and capture these on a team tracker which are reviewed at regular points in the working week. There are three key factors that are driving an increase in number and severity of pressure ulcers: circulatory changes following Covid-19 infection; deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid-19 infection. The PST have commenced a thematic review of skin integrity incidents across 2 ICT's. The thematic review will report early findings to ICT's and ICG. Importantly, the themes will contribute to an ICS wide Tissue viability workplan, focusing on chronic wounds including pressure ulcers. This countywide approach supports understanding incidence data as prevention and early identification is often outside of the Trusts remit and requires a system approach which is outside the influence of any one organisation.

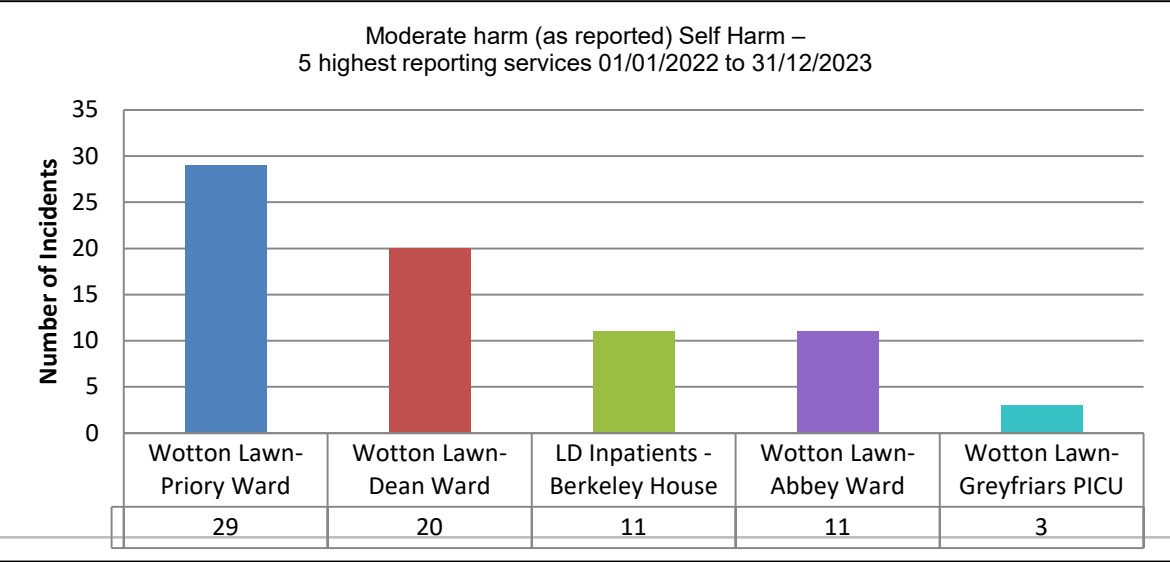
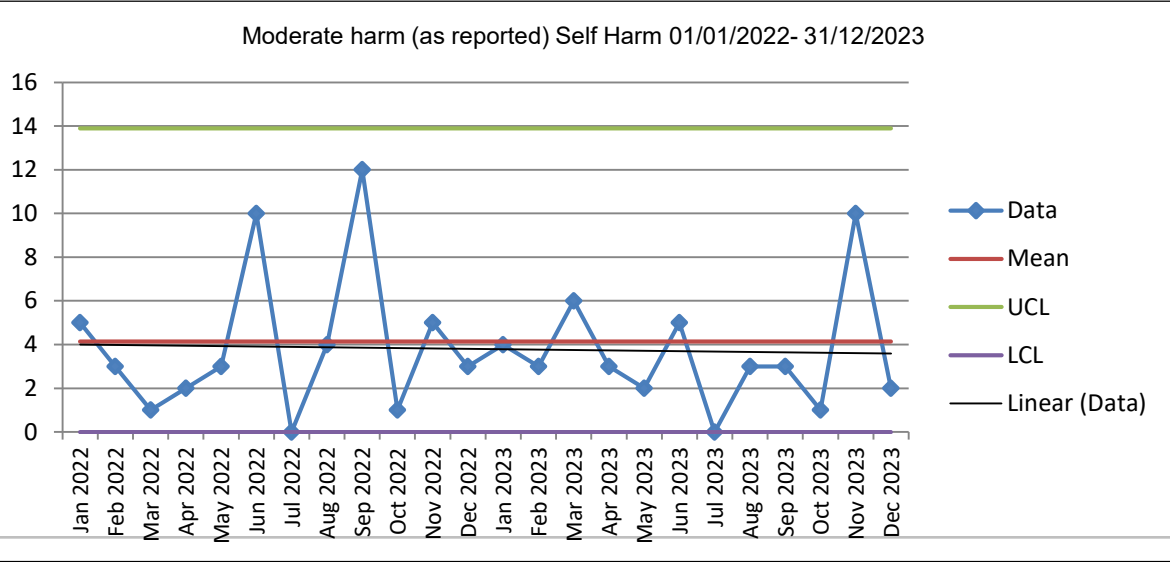
Severe Harm Incidents over time - Following a largely static picture in 2023 there is reported an increase in severe harm pressure ulcer incidents. It is highly likely that these are directly linked to those patients who are approaching end of life and this picture is mirrored regionally and nationally.

CQC DOMAIN - ARE SERVICES SAFE? – Patient Safety Incident Data

Top 5 moderate harm (as reported) patient incident categories (excluding skin integrity) 01/01/2022 to 31/12/2023



Moderate harm patient incidents (excluding skin integrity)
The chart above shows the 5 highest categories of reported moderate harm patient incidents (excluding skin integrity) over 24 months. The charts below provide a breakdown of moderate harm self harm incidents over the same period. Moderate and severe harm self injury and ligatures activity is monitored weekly and is shared with Matrons, Team Managers, Heads of Profession and NTQ. There are 4 SOP's to support the safe management for those that self injure and care plans are assessed against these standards weekly.

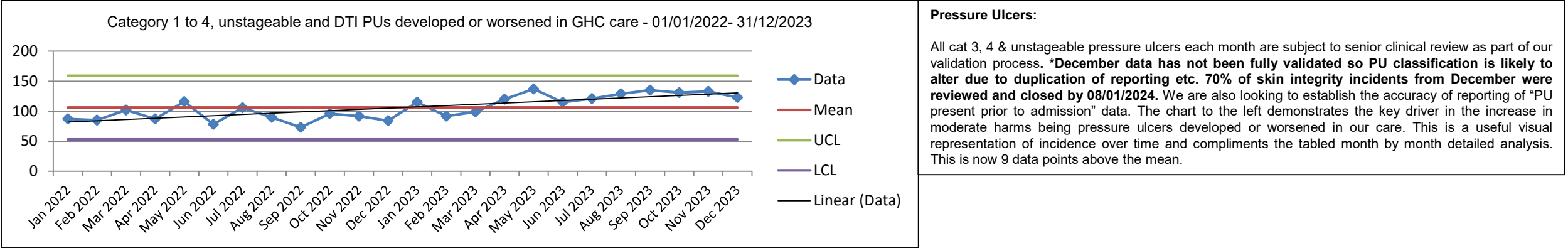


CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

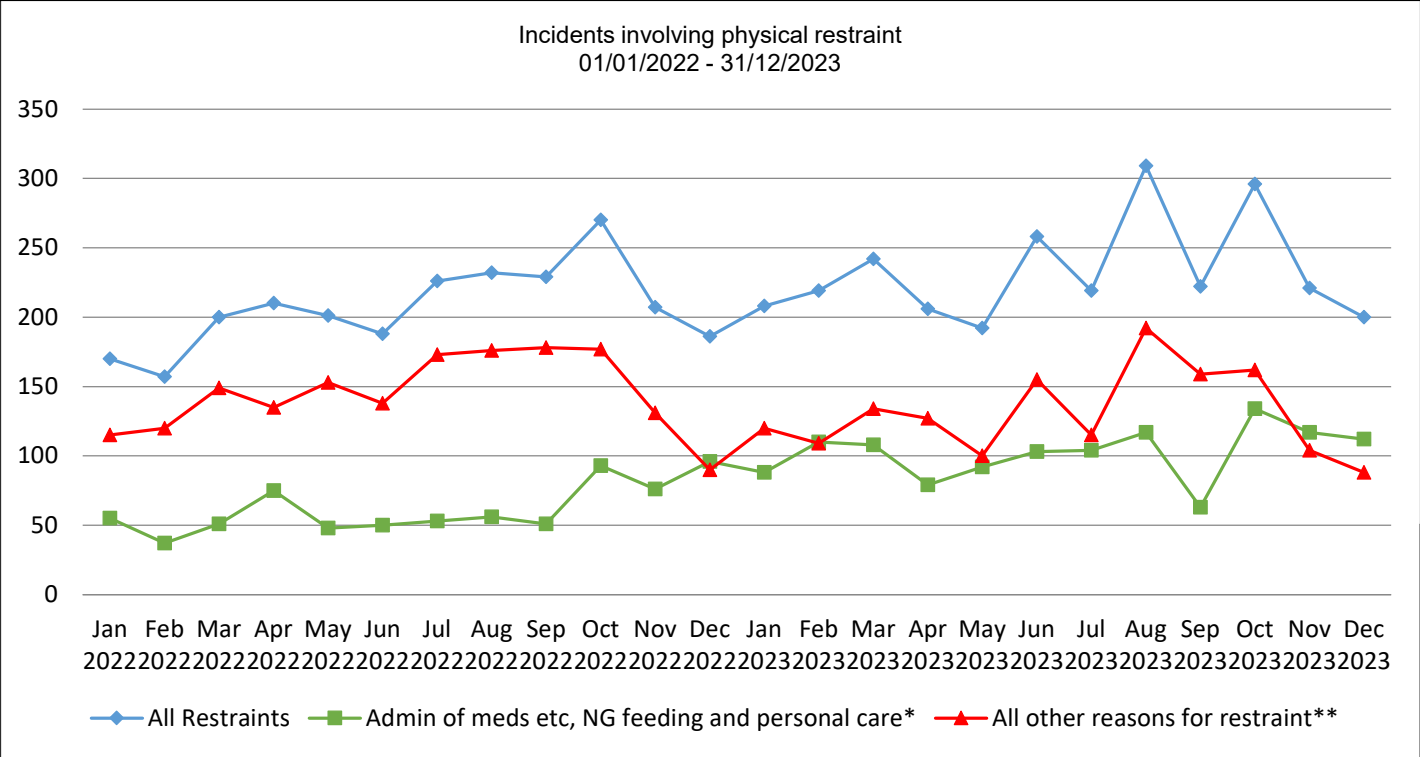
	Reporting Level	Threshold	2022/23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 YTD	R	Exception Report?	Benchmarking Report
																	A		
																	G		
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	98.61	97%	100%	100%	99%	99%	98%	98%	100%	98.9%				99%	G		
Number of HODA Clostridium Difficile Infections (C Diff)	N	16	10	3	0	0	0	2	0	0	0	0				5	G		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0	0	0	0	0	0	0	0	0	0	0				0	N/A		
Number of MRSA Bacteraemia	N	0	0	0	0	0	0	0	0	0	0	0				0	N/A		
PU Data threshold removed therefore no longer RAG rated – in line with revised national guidance.																			
Total number of pressure ulcers developed or worsened within our care.	L - R		1128	120	137	115	121	129	135	131	133	123*				1144			
Number of Category 1 & 2 pressure ulcers developed or worsened within our care.	L - R		735	82	91	73	85	88	92	75	78	62*				726			
Number of Category 3 pressure ulcers developed or worsened within our care.	L - R		33	5	5	3	5	2	2	4	5	4*				35			
Number of Category 4 pressure ulcers developed or worsened within our care.	L - R		18	1	1	1	1	1	1	1	4	3*				14			
Number of unstageable and deep tissue injury (DTI) pressure ulcers developed or worsened within our care.	L - R		342	32	40	38	30	38	40	51	46	54*				369			

ADDITIONAL INFORMATION - Health Care Acquired Infections (HCAI) & Pressure Ulcers (PU)

HCAI: There were 0 post 48-hour Clostridium Difficile in December (C. Diff), and no MRSA infections recorded in December. Note our ICB threshold has been set at 16 for the year.



Incidents involving restraint

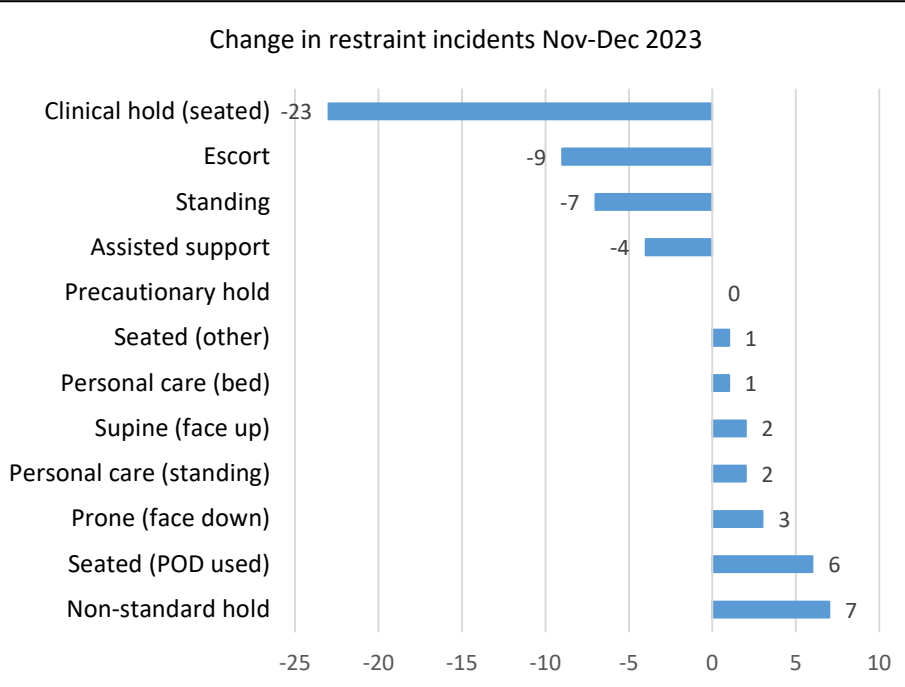
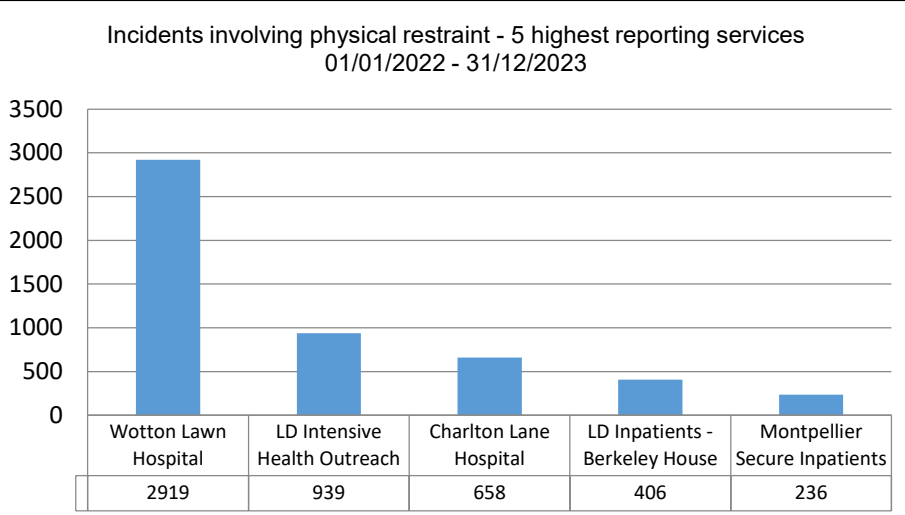


*Lawfully administer medicines or other medical treatment, Facilitate nasogastric (NG) feeding & Facilitate personal care
**Prevent a patient being violent to others, Prevent a patient causing serious intentional harm to themselves, Prevent a patient causing serious physical injury to themselves by accident, Prevent the patient exhibiting extreme and prolonged over-activity, Prevent the patient exhibiting otherwise dangerous behaviour, Undertake a search of the patient's clothing or property to ensure the safety of others, Prevent the patient absconding from lawful custody & Other/Not Known.

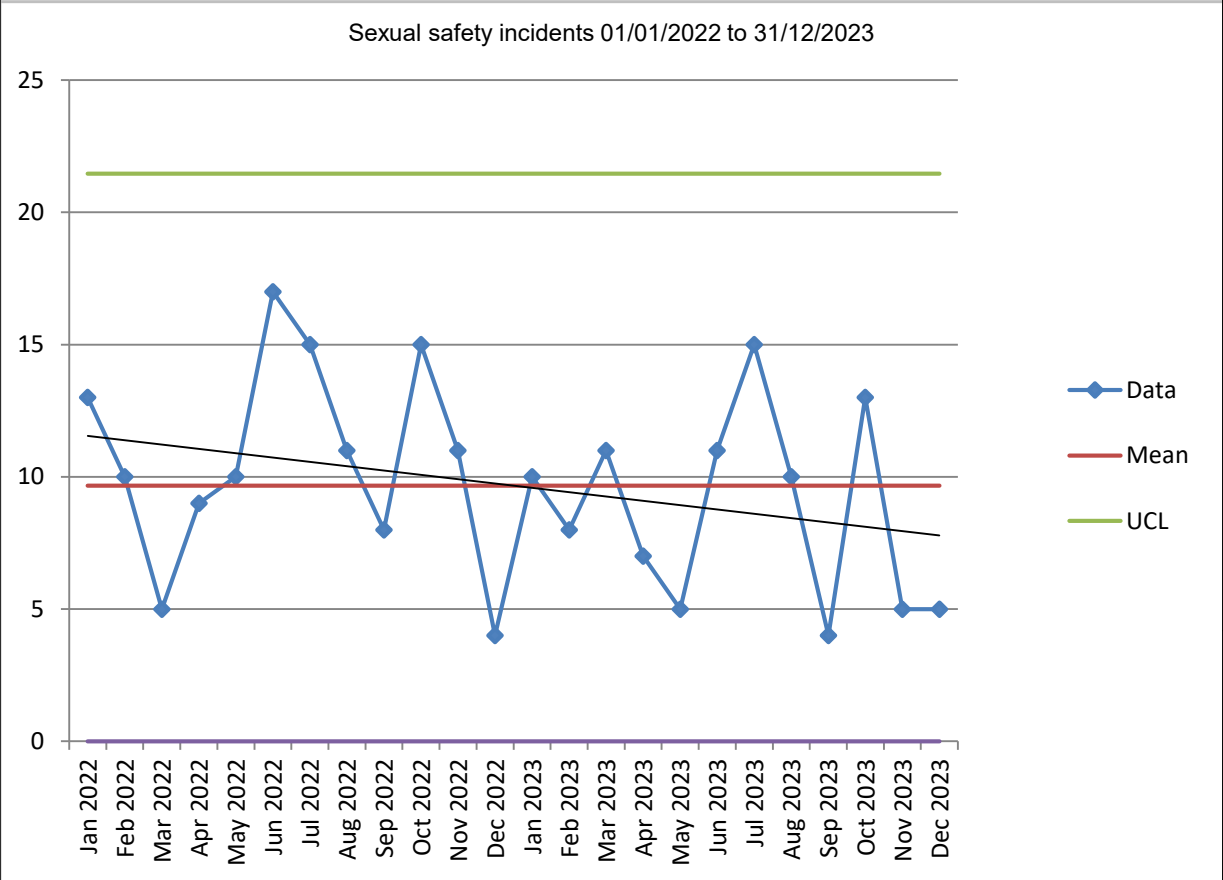
The Positive and Safe meeting continues to review all activity on a monthly basis. A weekly summary is provided to all team managers which gives regular oversight of restraint and ensures managers can take action to support teams. There have been no moderate harm restraint incidents reported in the Trust since April 2020.

There has been a decrease in the number of incidents involving physical restraint, in particular of clinical hold (seated) restraint. The fluctuation over the last 4 months is mainly due to:

- IHOT facilitate clinical holding to enable phlebotomy and vaccinations; it is projected that the flu and Covid-19 booster vaccination programmes will account for increased interventions into Q4
- Therapeutic interventions to support a female patient requiring NG feeding are more effective in some months than in others
- An overall reduction in the use of Rapid Tranquillisation (RT) in December



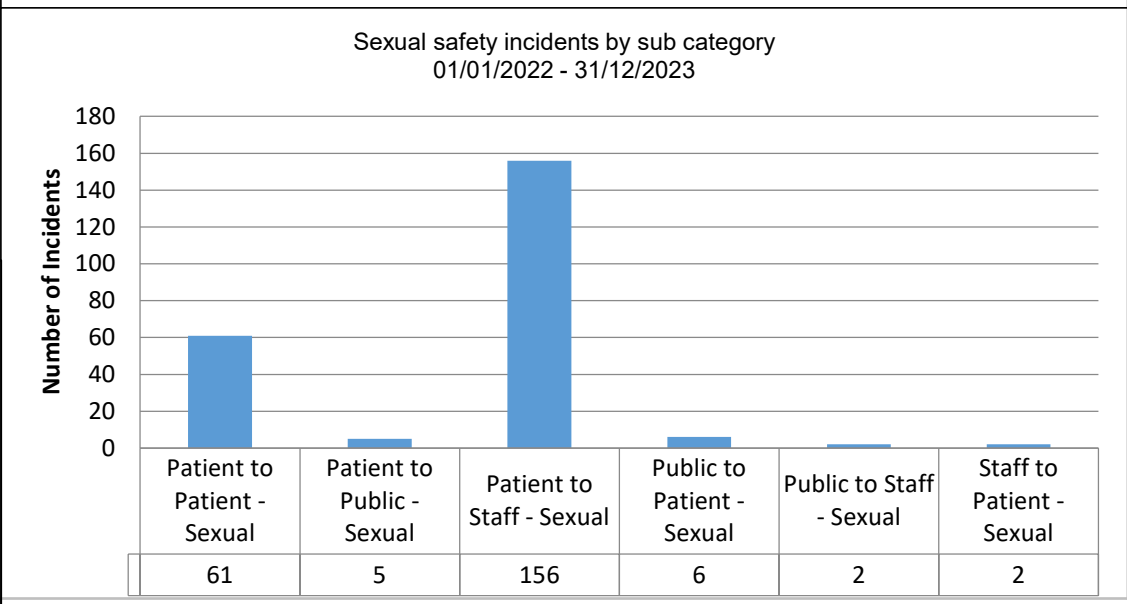
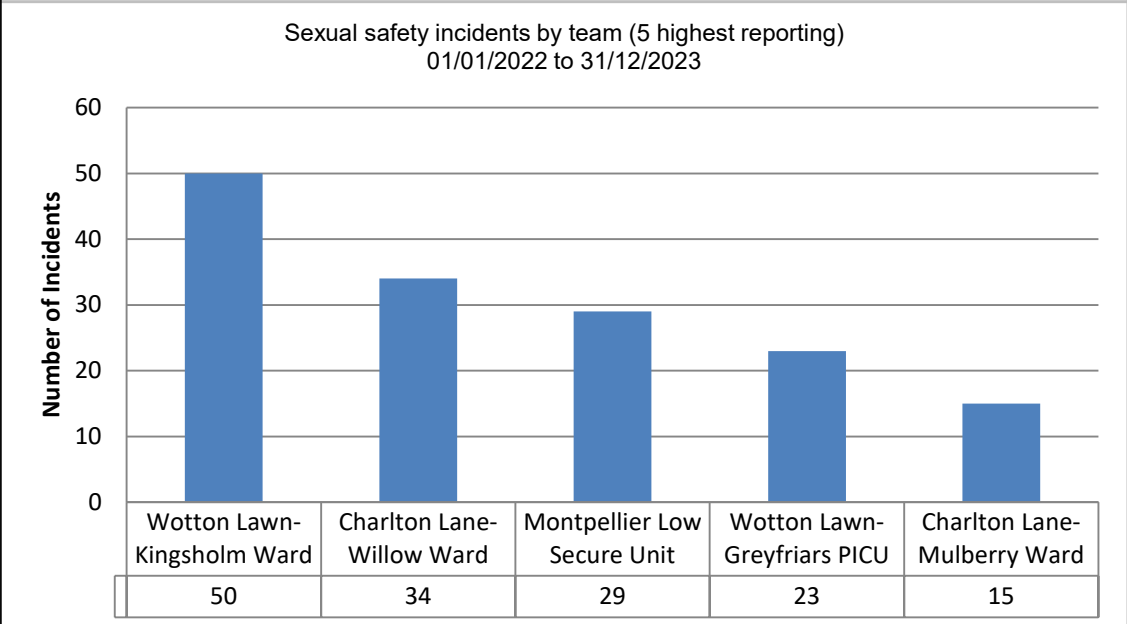
Sexual Safety Incidents



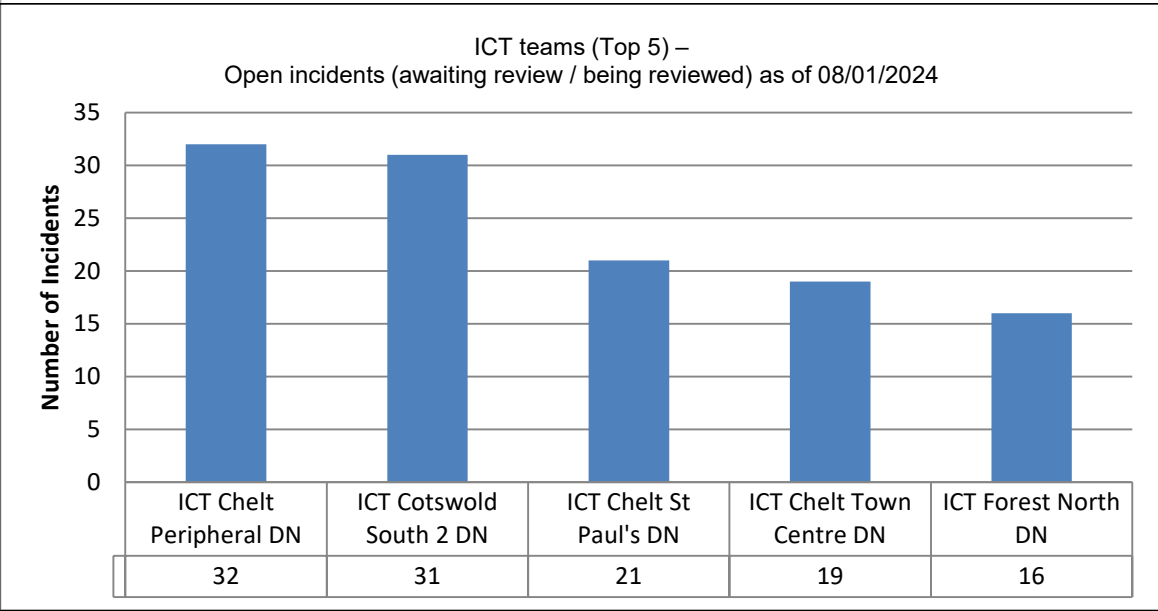
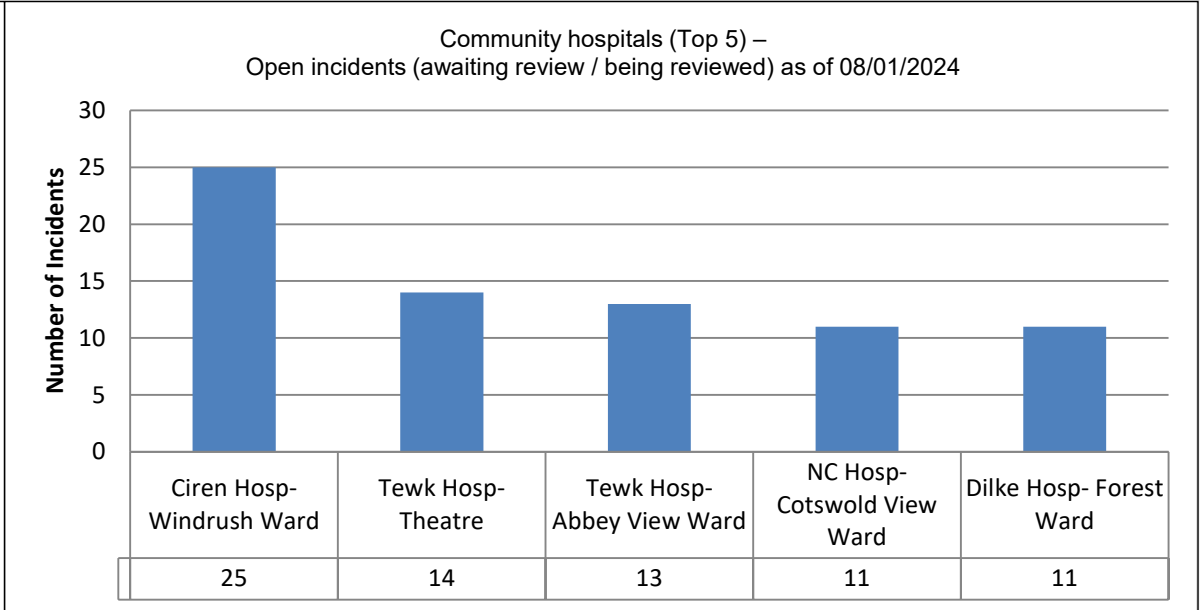
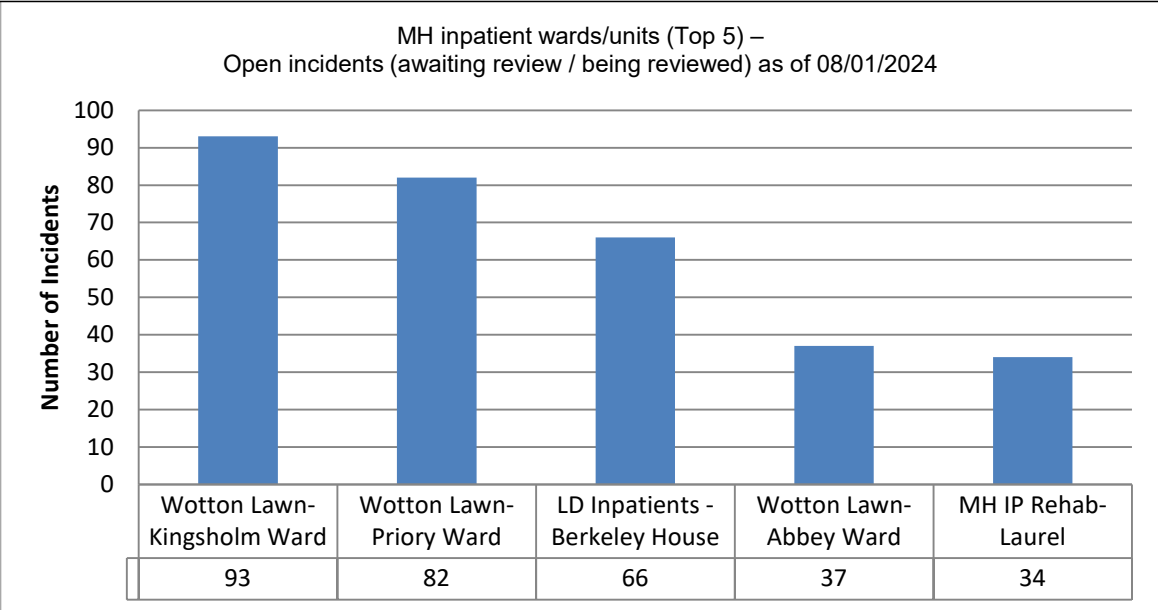
NHS England have developed a toolkit designed to support colleagues to discuss and tackle unwanted, inappropriate and/or harmful sexual behaviour in the workplace. GHC have a local plan, ongoing work continues regarding reducing sexual behaviour harms and incidents and data collection is more robust due to improved sexual safety incident reporting. Policy alignment has taken place to strengthen sexual safety and connect practices.

During November and December 2023, 85% of sexual safety incidents were reported by mental health inpatient services. The majority of incidents reported were patient to staff with the majority being male service user to female colleague. This is being addressed via an OD/HR project to promote the Sexual Safety Charter through the Violence and Harm Reduction workstream. Physical health community teams reported 15% of incidents. A meeting with the Community Nurse Leads took place in December to explore incidents and training. Some community nurses are using the Hollie Guard App on phones supported by the Trust Security team and exploration of Corporate licences for the App is in development.

Dates for 2024 Sexual safety awareness training have been offered to Wotton Lawn Hospital and the Dental Service. Devon Partnership NHS Trust have shared posters /resources that they have used in their organisation which could be adapted within GHC.



Incidents awaiting review and confirmation of level of harm: data priority areas and actions underway



The Datix incident reporting system captures reported incidents and requires managers to review the incident and allocate the correct level of harm.

The number of open incidents, excluding serious incidents, that have yet to be reviewed by Managers has decreased by 2184 since 8 March 2023, **representing a 61.9% decrease in open incidents across the Trust.**

National incident reporting will be changing from NRLS to LFPSE within GHC Datix from 9 January 2024. Any moderate/severe harm or death patient incidents that occurred before 9 January, but remain open at that time, will need to be reported nationally via LFPSE, with the mandatory LFPSE questions completed retrospectively. The Patient Safety Team is, therefore, working with operational services to review and close these where possible before the change to LFPSE in early January. As of 08/01/2024 there are 153 moderate/severe harm or death patient incidents open (awaiting review/being reviewed) on Datix.

CQC DOMAIN - ARE SERVICES SAFE?- Development Slide – Training and Supervision

Service – data as at 09/01/24	Fire Safety	Resus Level 3	PBM/ PMVA	Clozapine	Rapid Tranquilisation	Mental Capacity Act	Clinical Risk Assessment	Observation and Engagement
Cirencester & Fairford Hospital	98%	90.7%	N/A	N/A	N/A	92.8%	N/A	N/A
Dilke Hospital	89.6%	86.6%	N/A	N/A	N/A	100%	N/A	N/A
Lydney Hospital	84.2%	85.2%	N/A	N/A	N/A	97.6%	N/A	N/A
MIIU's	100%	93.2%	N/A	N/A	N/A	86.5%	N/A	N/A
North Cotswold Hospital	85.7%	80.4%	N/A	N/A	N/A	94.5%	N/A	N/A
Stroud Hospital	88.5%	84.2%	N/A	N/A	N/A	90.4%	N/A	N/A
Tewkesbury Hospital	89%	95.4%	N/A	N/A	N/A	97.5%	N/A	N/A
The Vale Hospital	85.4%	90.4%	N/A	N/A	N/A	93.1%	N/A	N/A
Community Physical Health	98.6%	N/A	N/A	N/A	N/A	83.8%	N/A	N/A
AMHP	100%	100%	N/A	N/A	N/A	88.8%	100%	N/A
Charlton lane Hospital	90.1%	93.1%	88.3%	97.4%	96.4%	96%	92.5%	95%
Community Forensics	100%	N/A	N/A	100%	N/A	91.6%	100%	N/A
Criminal Justice Liaison	100%	N/A	N/A	100%	N/A	100%	100%	N/A
Crisis Resolution HT	98.7%	100%	N/A	96%	100%	74%	85.9%	N/A
Honeybourne	83.3%	100%	N/A	100%	N/A	94.7%	77.7%	93.3%
Laurel	78.2%	100%	N/A	100%	N/A	95.8%	84.6%	94.7%
Berkeley House	71.4%	70.7%	82.9%	N/A	88.8%	88.8%	91.6%	79.4%
Psychiatric Liaison	96.7%	N/A	N/A	96.6%	N/A	65%	93.1%	N/A
Wotton Lawn Hospital	76.1%	86.7%	61.4%	93.2%	89%	90.5%	77.4%	84.3%
Community Mental Health	96.1%	100%	N/A	89.6%	N/A	81.2%	89.3%	N/A

Additional information

This is a developmental slide. Statutory and Mandatory training is included on the slide where there are 5 or more teams not reaching the threshold for compliance. Some Essential to Role (E2R) training is now included this month (mainly MH) and more will be included next year when they become E2R on Care2Learn. Prevention and Management of Violence and Aggression (PMVA) compliance rates on one ward at WLH are lower than other wards which is impacting the overall compliance figure. This does not impede the hospitals ability to provide safe management of distress.

Appraisal - The December figure is 87% which is a slight increase on the previous month. **Clinical Supervision** – The December figure is 32.54% Trustwide. There is new guidance for teams to support recording of clinical supervision, with a requirement for 8 sessions per year with no more than 40 days in-between sessions. The current low rate reflects the transition to the new system of recording and reporting.

CQC DOMAIN - ARE SERVICES EFFECTIVE ? – Community Hospital Delayed Patients

Long Length of Stay Patients – Community Hospitals

The information presents a summary of data relating to long length of stay in our Community Hospitals. For assurance, both Operational and Nursing, Therapies and Quality senior colleagues have good visibility of the data and attend appropriate system groups that identifies the impact of a long length of stay together with system meetings that seek to address the challenges. The detrimental effect that a prolonged hospital admission has upon a patient is well evidenced. When a patient is deemed to 'no longer meet the criteria to reside' (nCTR), timely and effective discharge plans should be in place to enable a discharge. Unfortunately due to the flow and capacity challenges across the system, we often see patients delayed. We are keen to ensure our 'super stranded' patients (over 50 days nCTR) have a continued focus and support in escalation with system partner working to expedite their discharge pathway. It is imperative we learn and shape services around the needs of the population, by collecting data and identifying themes of the delays, we can support discharge pathways that meet the needs of the patients, and also target our approach to escalation and requests of support. At system request, the focus is now on over 30 days not meeting the criteria to reside (nCTR).

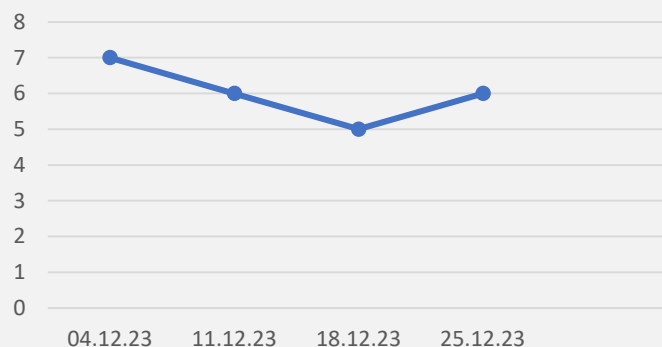
Headline Data - December 2023

- There has been an average of 39 patients that have Not Met the Criteria to Reside (nCTR) in a community hospital in December 2023
- There has been an average of 6 patients in total Not Meeting the Criteria to Reside (nCTR) for over 30 days in December 2023

- Overall, there has been a slight decrease in the number of patients that have not met the Criteria to Reside in a Community Hospital, however the number of patients who have not met the CTR for >30 days has significantly decreased.
- The hybrid model has supported an increase in number of patients discharged into Home first, and also a reduction in delays waiting.
- There has been a slight increase in bed days lost due to delays associated with provision of housing. Currently 1 out the 6 patients who are nCTR >30 days are delayed due to housing (awaiting supported accommodation).

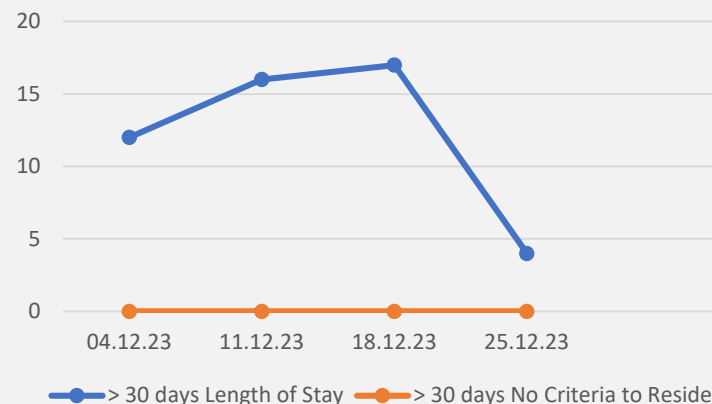


Number of patients not meeting Criteria to Reside for over 30 days in a Community Hospital



Showing the number of patients that do not meet the Criteria to Reside for > 30 days. Date ranges week commencing 04/12/23 – 31/12/23.

Discharges on Pathway 1



Showing the number of patients **discharges** on Pathway 1 who did not meet the criteria to reside for > 30 days. Date range: week commencing 04/12/23 – 31/12/23. Pathway 1 can be defined as discharge home with support from Home first, a self-funding care package or a care package sourced by Social Care.

Discharges on Pathway 3

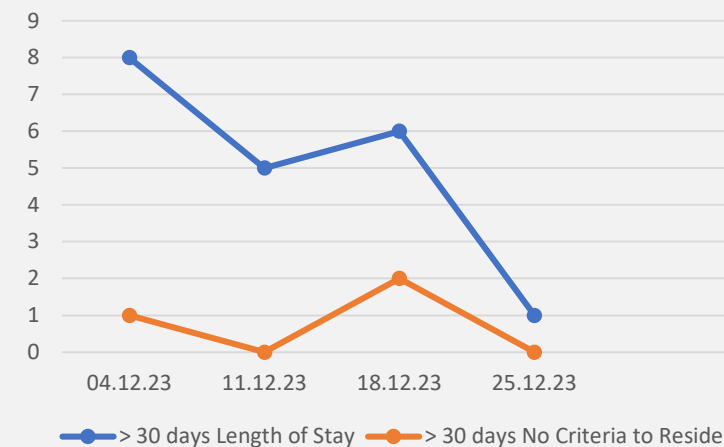


Chart 3 - Showing the number of patients delayed on Pathway 3 for over 30 days. Date range: week commencing 04/12/23 – 31/12/23. Pathway 3 is defined as discharge to a Care home, either funded by the individual or through Social Care funding.

CQC DOMAIN - ARE SERVICES Effective? – Mental Health Hospital Delayed Patients

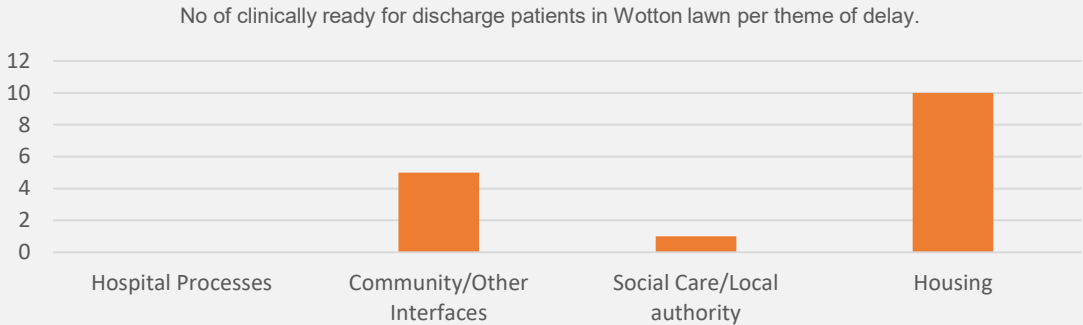
Long Length of Stay Patients- MH Hospitals.

Clinically Ready for Discharge, formally known as DTOC, is the new terminology for reporting delays in MH since January 2023. “Clinically Ready” does not indicate complete recovery, it is the point at which a person could be safely assessed, cared for and treated at home or in a less restrictive setting. Being “Clinically Ready for Discharge” (CRfD) is an indication that a person could continue their recovery outside of a hospital setting – with adequate support/services in place.

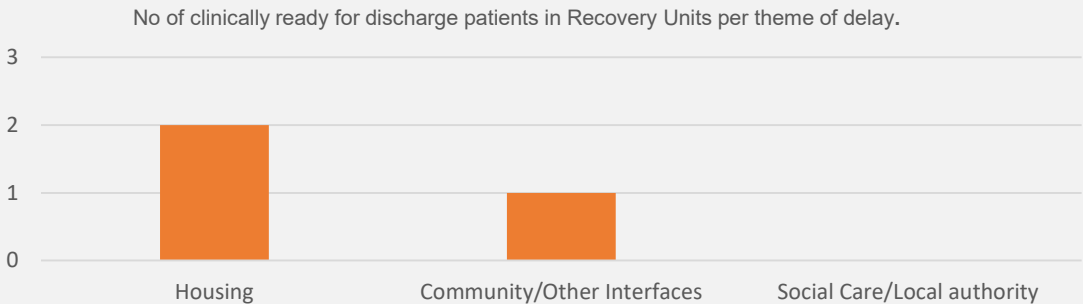
For reporting and descriptive purposes four high level sub-categories have been developed and these categories describe the reasons that a persons discharge is delayed.

- Hospital Processes - defined as any process that is the responsibility of the inpatient service that is related to the delay.
- Community/other interfaces – defined as any team or service (excluding social care/local authority or housing partners) that are responsible for/related to the delay.
- Social Care/Local Authority – defined as any factors that are due to social care provision or are the responsibility of social care/local authority partners, related to the delay.
- Housing /accommodation – defined as any factors that are due to housing provision or are the responsibility of housing partners/teams, related to the delay.

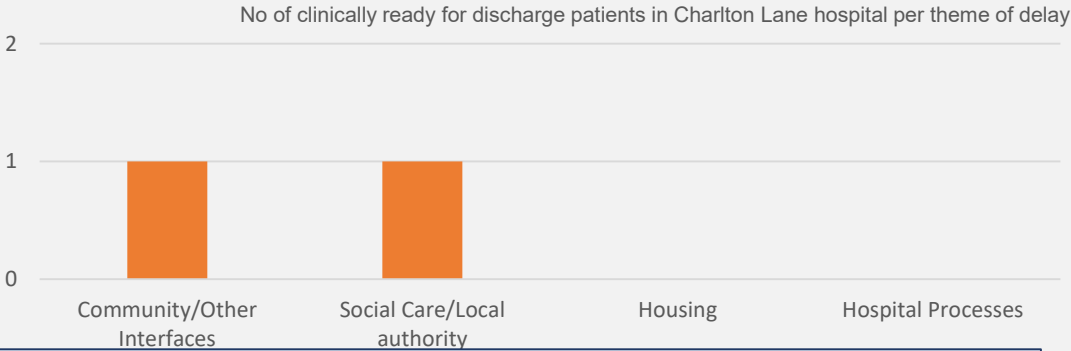
Headline Data - December 2023: Total of patients across WLH, CLH, Recovery, LD = 22 WLH = 16 CLH = 2 Recovery Units = 3 Learning Disability = 1



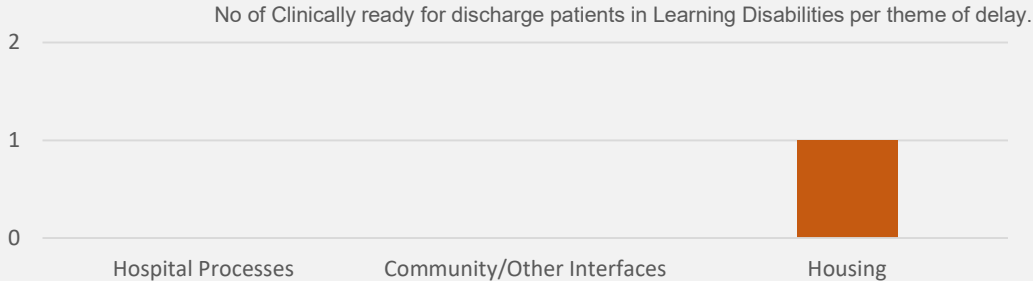
Themes related to delays:-
Community/Other Interfaces – lack of specialist health care provision.
Social Care/Local Authority – lack of Social care provision to support assessment/discharge
Housing – homelessness, lack of appropriate supported accommodation



Themes related to delays:-
Community/Other Interfaces – awaiting public funding, await outcome of legal requirements e.g. awaiting mental capacity assessment



Themes related to delays:-
Hospital Processes – patient/family choice regarding care home placement
Community/Other Interfaces – awaiting care home placement (under care of hospital social work team)
Social Care/Local Authority – Awaiting care home through brokerage



Themes related to delays:-
Lack of appropriate housing



- The Quality Improvement Hub is a dedicated Trust team of subject matter experts whose primary aim is to provide leadership to the organisation in the field of improvement science. The team seek to support the experts – the people who use our services and those that deliver them, to understand problems identified and the associated data, find change ideas, test them out at small scale, upscale as appropriate and make them sustainable using proven methodology.
- This update provides a brief overview of the Trust QI training programme- with its intention to ensure that a QI approach is embedded across the whole organisation by;
 - Providing a complete range of training packages that demonstrate learning outcomes in alignment with the Kirkpatrick Evaluation Framework
 - It also shows the active QI projects recorded on Life QI- the system the trust utilises to capture and share QI activity.

1. New improvement opportunity/concept/idea

- National mandate
- New service bid
- GHC Strategic priority
- ICS/CCG mandate
- Colleagues
- Service users/Carers
- Quality Issue

2. Improvement idea scoping

- What is it
- Why are we doing it
- What are the benefits/risks
- Is the problem clear, understood and agreed
- Is there data

3. Improvement idea initiated

- Stakeholder mapping
- Tools to understand the problem
- Baseline data
- Early team tasks
- Life QI

4. Improvement idea testing – e.g.: PDSAs

- Using the Model for Improvement to test change ideas
- Data to show towards progress and inform next steps

5. Improvement idea sustained & implemented

- Evidence of sustained improvement through data
- Ongoing quality control & assurance agreed

- = QUITT - reducing inpatient smoking in MH
- = (s) Homeward Assessment Team and ICT pathway
- =(s) Retire and return HR project

- ↑ (s) Psychological Services Research
- ↑ s) Standardised approach to medical equipment - thermometers
- = Smartcard use for RIO by bank and agency workers MH and LD inpatients
- = Staff retention - itchy feet
- = Improving Access & Delivery of Family Interventions with Psychosis & bi-polar within the Early Interventions Team
- = Toilet training - improving outcomes for children
- = Improving the number of patients receiving their depots in primary care
- = Ensuring meaningful appraisals and assuring completion levels
- = Increasing number of sustainability champions
- = Reducing restrictive practice in Dean Ward, WLH
- = Reducing restrictive practice in Greyfriars, WLH
- = Reducing School Nursing waiting list for primary school aged children
- = CYPS Public Health Liaison Nursing
- ↑ (s) CYPS SLT Selective Mutism Project

- = Sexual health specimen mis-labelling
- = (s) Leadership opportunities for AHP students
- = Reducing medication errors in CLH
- = Health checks for those with SMI
- = CYPS physio service flow
- = (s) Improve communication and liaison between maternity service and health visiting service
- = Patchwork project Infection Prevention Control
- = Increasing the time between incidents of severe constipation needing a proactive response in CLH
- = Improving access to ECT in WLH and community
- = Developing a FCP Occupational therapist in Primary Care
- = Inappropriate referrals into therapies (OT) from care homes
- ↑ School nursing mental health pathway and resources
- ↓ Reducing delayed transfer of care - MH LoS
- ↑(s) CYPS SLT waiting list

- =(s) Paired ROMs compliance – CAMHS
- = (s) How do we provide services for lung cancer patients
- = (s) Creating a sustainable placement offer for AHP Students in GHC
- = (s) Improving mouthcare standards in inpatient areas
- = Optimising flow in community hospitals
- = (s) Increasing the use of FFT feedback in our organisation
- = (s) MUST Completion (Dilke) (Nutritional pathways)
- = Single handed personalised care approach
- = (s) Length of time on core CAMHS caseload
- = School nursing duty system
- = Improving standard of observations on Abbey Ward, WLH
- = Improving standard of observations on Dean Ward, WLH
- = Improving standard of observations on Kingsholm Ward, WLH
- = Antipsychotic monitoring CAMHS
- = Substance misuse in CAMHS


- = Improving standard of observations on Priory Ward, WLH

Directorate	No of Projects
Countywide	4
MH Hospitals and UC	14
PH Hospitals and UC	3
Adult MH/PH/LD Community	7
CYPs	13
Corporate	8
Total: 49	


Key:
+ new to tracker
= no movement
↑ moved forwards
↓ moved backwards
*Restarted
(s) Silver project

Training data December 2023:
26 Silver – 0.4% workforce
623 Bronze -13.5% workforce
678 Pocket QI – 14.7% workforce

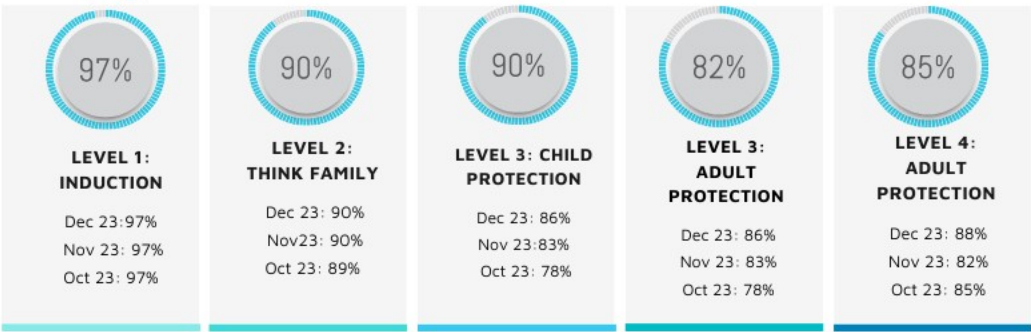
Supervision

 **Childrens: Group Supervision Compliance** **61%**

Integrated Group Supervision Sessions: 68
One to One Supervision Sessions: 8

 **Adults Group Supervision Sessions** **5**

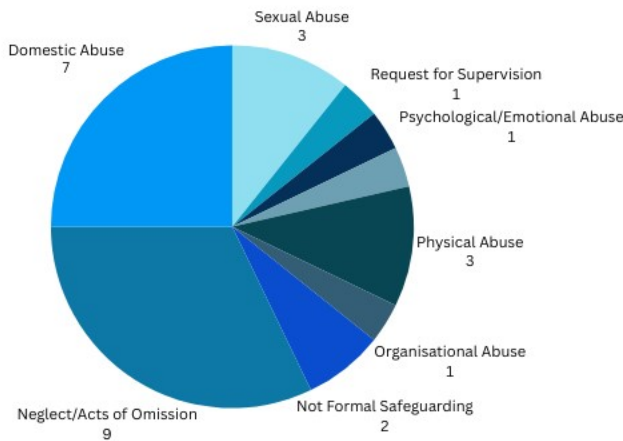
Training



Referrals and Advice Line



Referral Themes



Summary information

The Safeguarding Dashboard provides assurance that:

- Safeguarding activity is a Trust priority function that is closely monitored
- Safeguarding is being delivered as per the requirements of the Gloucestershire

Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation. Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements in place to ensure that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.

The Safeguarding Dashboard is presented in 3 sections:

- Safeguarding Children Activity
- Safeguarding Adults Activity
- Safeguarding Training Compliance and Safeguarding Supervision

Summary

Highlights

- The new safeguarding team structure is now in place, the recently appointed Head of Safeguarding commenced employment on 18th December.
- There are now 3 new band 6 nurses who have started in MASH, and 1 new B4 admin about to start to support us with the MASH expansion and undertaking the new process of coordinating the strategy meetings for all of health within Gloucestershire and completing research.
- An internal recruitment process is underway to fill a B7 post within the adult Safeguarding Team, the is due to an existing member of the team undertaking 12 month secondment. It is hoped the post will be filled in January.

Challenges/Risks

- The design of the Safeguarding template is progressing well and the safeguarding adults team have been shown the adult template and piloting to be commenced soon. The children's template is slightly behind by about a month. The templates original completion date was end of November 2023 but work is progressing with Clinical Systems to enable a BI solution to report the number of safeguarding referrals made to the Local Authority and the number of safeguarding escalations.

CQC DOMAIN - ARE SERVICES SAFE										
Safe Staffing Inpatient data December – 2023										
Ward Name	Code 1		Code 2		Code 3		Code 4		Code 5	
	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	Exceptions	Hours	
Dean	35	4	7.5	1	0	0	0	0	0	0
Abbey	207.5	24	40	4	0	0	0	0	0	0
Priory	57.5	7	0	0	0	0	0	0	0	0
Kingsholm	0	0	20	2	0	0	0	0	0	0
Montpellier	7.5	1	45	5	0	0	0	0	0	0
Greyfriars	40	5	0	0	0	0	0	0	0	0
Willow	0	0	7.5	1	0	0	0	0	0	0
Chestnut	7.5	1	22.5	3	0	0	0	0	0	0
Mulberry	0	0	10	1	0	0	0	0	0	0
Laurel	75	10	120	16	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	52.5	7	167.5	16	0	0	15	1	0	0
Total In Hours/Exceptions	482.5	59	440	49	0	0	15	1	0	0

The Director of NTQ reviews safe staffing reports every month ahead of submission to NHSE, this acts as a rolling review of safe staffing and is informing a detailed Trustwide safe staffing review in line with NHSE guidance, this will be reported on in February 2024 We have cross referenced highest exceptions with patient safety and experience data. Abbey ward have reported the highest code 1 exception levels, followed by Laurel House. The Matrons report no adverse impact on care delivery or patient experience. Code 1 exceptions at Laurel House were attributable to HCA vacancies on early and late shifts. Code 2 exceptions at Berkeley were attributable to all shifts (RN and HCA). The Code 4 at Berkeley House was coded as such as a patient was unable to engage in activity off the unit due to the lower staff number on duty. In the context of our CQC action plan, this has been noted and mitigating structures put into place.

Mental Health & LD				Physical Health			
Ward	Average Fill Rate %	Sickness %	Vacancy %	Ward	Average Fill Rate %	Sickness %	Vacancy %
Dean Ward	108.71%	8.9	-1.2	Coln (Cirencester)	106.37%	5.9	14.9
Abbey Ward	100.28%	4.1	6.5	Windrush (Cirencester)	106.64%	5.8	16.3
Priory Ward	153.55%	9.4	5.2	The Dilke	98.99%	6.2	18.8
Kingsholm Ward	116.82%	14.4	7.9	Lydney	88.60%	6.5	20.2
Montpellier	98.63%	6.1	18.6	North Cotswolds	101.46%	7.6	10.2
PICU Greyfriars Ward	104.17%	13.5	20.9	Cashes Green (Stroud)	100.71%	4.5	15.4
Willow Ward	102.91%	8.9	6.2	Jubilee (Stroud)	97.90%	6.7	10.9
Chestnut Ward	100.79%	16.1	1.4	Abbey View (Tewkesbury)	112.21%	5.3	0.5
Mulberry Ward	105.75%	3.0	6.0	Peak View (Vale)	92.03%	5.3	22.7
Laurel House	102.42%	2.5	0.8	PHH Totals Avg (Dec 23)	100.55%	6.4	12.4
Honeybourne Unit	102.13%	8.7	2.1	Previous Month Totals	101.16%	6.7	12.1
Berkeley House	98.61%	7.7	30.0				
MHH Totals Avg (Dec 2023)	103.58%	8.1	11.1				
Previous Month Totals	104.33%	6.9	10.7				

NHSE Zero HCSW Vacancy Commitment Inc. bank – 3 month report		Cost Centre	FTE Budgeted	FTE Actual	FTE Variance
		Grand Total	608.63	506.94	-101.69
Oct	99.99	327 E11850 LD Inpatients - Berkeley House	49	32	-17
		327 B11200 Ciren Hosp- Windrush Ward	17.06	9.07	-7.99
		327 B11201 Ciren Hosp- Coln Ward	20.16	13.2	-6.96
Nov	98.21	327 E11802 Vale Hosp- Peak View Ward	18.63	12.63	-6
		327 C11505 Lydney Hosp- Lydney Ward	17	12.13	-4.87
Dec	101.69	327 G12308 Children Complex Care	11.59	6.92	-4.67
		327 D11602 Wotton Lawn- Dean Ward	12.5	8.4	-4.1

NHSE Zero HCSW Vacancy Commitment: The workstream continues with 5 main strands, Attraction, Innovative Recruitment, Learning and Development, Recognition and Value and Retention. There are 31 people in recruitment pipeline and in December there were 5 new recruits and 7 leavers. The table opposite is a breakdown of the current HCSW vacancy hotspots.

IR/Recruitment: 8 International Educated Nurses (IEN) are in the pipeline for 2024. 89 international colleagues have been recruited (from Jan 2021). 2 IEN's have received promotion to band 6, showing their dedication and professionalism. Our IEN council met on 15th November. The IEN Guidebook is now available for staff to view and encompasses much useful and insightful information.

Appendix One

Safeguarding Information - December 2023

Summary Trust Safeguarding Data

Summary information:

The Safeguarding Dashboard provides assurance that:

- Safeguarding activity is a Trust priority function that is closely monitored
- Safeguarding is being delivered as per the requirements of the Gloucestershire Safeguarding Adults Board (GSAB), the Safeguarding Children Partnership (GSCP), commissioning expectations, and national guidance and legislation.

Safeguarding children and adults is a key element of the assessment and care management processes for staff. There are arrangements in place to ensure that staff are appropriately trained, supervised and supported in their safeguarding related work. The Trust's Safeguarding Group monitors safeguarding activity and reports quarterly into the Quality Assurance Group.

The Safeguarding Dashboard is presented in 3 sections:

1. Safeguarding Children Activity
2. Safeguarding Adults Activity
3. Safeguarding Training Compliance and Safeguarding Supervision

Highlights:

- The new Safeguarding Management structure is now in place with the recently appointed Head of Safeguarding having commenced employment on 18 December 2023.
- There are now 3 new band 6 nurses who have started in MASH, and 1 new B4 admin about to start, to support us with the MASH expansion and undertake the new process of coordinating the strategy meetings for all of health within Gloucestershire and completing research.
- An internal recruitment process is underway to fill a B7 post within the adult Safeguarding Team, this is due to an existing member of the team undertaking 12 month secondment. It is hoped the post will be filled in January.

Challenges/risks:

- The design of the Safeguarding template is progressing well and the safeguarding adults team have been shown the adult template and piloting to be commenced soon. The children's template is slightly behind by about a month. The templates original completion date was end of November 2023 but work is progressing with Clinical Systems to enable a BI solution to report the number of safeguarding referrals made to the Local Authority and the number of safeguarding escalations.

GHC - Safeguarding Dashboard 2023/24 Children's Safeguarding Data

	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3	Additional Information
SAFEGUARDING ACTIVITY							
Advice Line Calls	181	166	77	79	52	208	The number of children's calls reduced in December, this may be due to bank holidays and practitioners having time off.
Multi-Agency Request for Service Forms submitted to MASH	55	61	25	17	14	56	The Local Authority are unable to provide referral data and current GHC clinical systems are unable to accurately capture referral figures. This is a documented risk – Risk 298. An action plan is underway to address this. Practitioners are currently asked to inform the safeguarding team about any referrals that they have made to the local authority. The numbers of referrals that we have been informed about has dropped in December, this may be due to the bank holidays and leave, or that practitioners need to be reminded about the safeguarding notifications mailbox.
Number of Safeguarding Escalations	3	4	1	2	0	3	This information is currently obtained from our Safeguarding Advice Line data. It does not give an accurate picture of the number of escalations made to partner agencies. Further work is underway with Clinical Systems/Business Intelligence Teams to accurately identify the number of escalations made to partner agencies. The updated Working Together to Safeguarding Children 2023 discusses the importance of challenge from all agencies.
CHILD DEATH NOTIFICATIONS							
Expected	3	6	4	3	1	8	Expected deaths are infants with known life limiting conditions or cases of extreme neonatal prematurity.
Unexpected	6	0	1	1	0	2	Gloucestershire Child Death Overview Process is followed for each unexpected death.
RAPID REVIEWS/LCSPR'S							
Number of Serious Incident notifications made by LA	1	1	0	1	1	2	One Serious Incident Notifications submitted to the National Safeguarding Review Panel by the LA in December.
Number of Rapid Reviews attended	1	0	1	0	1	2	1 multi-agency rapid review undertaken in December.
Number of LCSPR's in progress	1	1	1	1	1	3	1 Gloucestershire LCSPR's is now completed. This was due to be published in December however it as been delayed until January
MASH HEALTH TEAM ACTIVITY							
Children researched/info shared	2,126	2,940	1,439	1,535	1,202	4,176	Reduction in children researched for December is due to the Christmas break and schools being closed.
Adults researched/info shared	319	182	102	102	47	251	Number of adults researched in December has significantly dropped due to the Christmas break.
MASH strategy meetings attended	68	115	20	40	31	91	The number of strategy meeting attended dropped in December. In early January, 3 new B6 have started in MASH, with a new admin due to start soon. This will enable the new process of the MASH expansion to be supported whilst they undertake the coordinating and health research for all strategy meeting across Gloucestershire for health. The new process started at the start of January 2024.
Demographic information sharing	684	980	221	196	147	564	MASH health are frequently asked for demographic data from multiagency partners - this is due to referral data quality and incomplete data.
AUDITS							
Single Agency	3	1	1	1	1	3	The annual GHC safeguarding children's audit is currently underway with an aim to get it published by April 2024.
Multi-Agency sub group activity	3	0	0	0	2	2	Participating in an audit with the LA and the ICB around the CP-IS and its efficiency, and also the Annual Section 11 self assessment audit (Children's Act 2004) as requested by GSCP.
UNDER 18'S ADMISSIONS							
Number of under 18's admitted to Adult MH Wards	1	0	0	0	0	0	0 children admitted in December.
Number of under 18's assessed under S.136 of the MHA 83/07	7	1	1	0	2	3	2 children assessed in December.
OTHER WORKSTREAMS							
Allegations management – number of referrals to/from the LADO	6	1	0	0	1	1	1 referral made to the LADO in December.

GHC - Safeguarding Dashboard 2023/24 Adults safeguarding Data							
	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3	Additional Information
SAFEGUARDING ACTIVITY							
Contacts to GHC advice Line	200	231	105	100	54	259	Calls to the GHC advice line re. adult safeguarding enquiries - may or may not proceed to a referral to the Local Authority. Continued good use of the Advice Line.
Safeguarding Referrals made to GCC	24	38	13	15	6	34	This data is obtained from the Safeguarding Team Notifications Inbox. Work is underway with Clinical Systems and Business Intelligence to identify mechanisms across our clinical systems which capture this data accurately.
MH/LD Household Member Form Compliance	56%	57%	56%	56%	56%	56%	Linked to Risk 107 – recording of household members. Household & Family form completion (MH/ LD Current caseload) – added as new 2023/24 Performance indicator - Threshold: 100%
CASE REVIEWS							
New Safeguarding Adult Reviews/Domestic Homicide Reviews	1	0	0	1	0	1	0 new reviews in December.
Number of Reviews ongoing	15	15	13	12	13	38	Consistently high number of safeguarding reviews relating to adults (DHR's DARDR's and SARs). Several reviews are in the final stages of sign off.
Action Plans Ongoing	7	7	7	7	7	21	This includes single and multi agency action plans
MAPPA							
Level 2 Meetings Held	15	15	*	*	*	17	Data reported quarterly.
Level 2 Meetings Attended	15	15	*	*	*	17	Data reported quarterly.
Level 3 Meetings Held	6	5	*	*	*	5	Data reported quarterly.
Level 3 Meetings Attended	6	4	*	*	*	4	Data reported quarterly.
PREVENT							
Number of Prevent Referrals Made	0	0	1	0	0	1	0 Prevent concern raised with the police.
Information requests received & completed from Police/Channel	4	8	3	5	11	19	100% response to all police and channel panel information sharing requests, supportive effective planning and decision making.
MARAC							
Families screened/researched	408	435	167	160	110	437	Continued high level of MARAC activity. Minor variation in month.
No.of children open to MH Services	57	36	6	12	6	24	Number of children open to mental health service highlights the emotional impact of domestic abuse on children. Expected minor variation in month.
No.of victims open to MH Services	76	49	20	27	15	62	Highlights the link between the impact of domestic abuse on victims mental health. Expected minor variation in month.
No.of perpetrators open to MH Services	55	61	20	28	12	60	Identifies the number of perpetrators open to MH services. Expected minor variation in month.
Un-uploaded MARAC Action Plans	59	43	0	118	129	129	This increase is due to illness in the admin team – no clinical risk is present as a patients record has a flag applied to it immediately a MARAC is received and the information is available to all services involved. This metric represents an administrative task rather than actual safeguarding practice. The ICB are exploring funding for this currently non funded administrative function for both GHC and GHFT.
DOLS - No. of referrals for standard authorisation from:							
Mental Health Services Total	12	9	1	3	4	8	Continued pattern of DOLS applications
Mental Health Services Authorised	5	5	0	1	0	1	3 awaiting assessment and 1 closed (patient died).
Physical Health Services Total	39	40	23	22	15	60	Physical health urgent applications (not requiring LA authorisation)
Physical Health Services Authorised	0	0	0	0	0	0	13 awaiting assessment and 2 closed (1 discharged and 1 died).
AUDITS							
Single Agency - Safeguarding Related	1	1	1	0	0	1	
Multi Agency Sub - Group Related	1	1	0	1	0	1	
OTHER WORKSTREAMS							
Allegations management - use of PiPoT guidance	3	3	0	1	1	2	1 new allegation in relating to a member of GHC staff in December.

GHC - Safeguarding Dashboard 2023/24 Training and Supervision Data							
	Q1	Q2	Oct-23	Nov-23	Dec-23	Q3	Additional Information
TRAINING							
Level 1 – Induction	96%	97%	97%	97%	97%	97%	Consistent month on month compliance level
Level 2 – Think Family	91%	91%	89%	90%	90%	90%	Overall a minor variation in month
Level 3 – Multi-Agency Child Protection	88%	87%	89%	90%	91%	90%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3 Adult Protection	84%	79%	78%	83%	86%	82%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 4 Adult Protection	75%	81%	85%	82%	88%	85%	Overall a minor variation in month. Training compliance review being undertaken to identify specific Teams to target to improve compliance.
PREVENT:							
Level 1	98%	98%	95%	99%	99%	98%	Continued high level of compliance with Level 1 Prevent Training
Level 2	84%	86%	89%	92%	92%	91%	Training compliance review being undertaken to identify specific Teams to target to improve compliance.
Level 3	92%	97%	98%	98%	98%	98%	Improving picture of compliance with Level 3 PREVENT training
MENTAL CAPACITY ACT:							
Level 1	90%	92%	94%	95%	95%	95%	New item to the dashboard. Level 1 MCA training is an online package, mandatory for all clinical staff who work with adults.
Level 2	66%	56%	48%	53%	56%	52%	New item to dashboard. During the Covid 19 Pandemic, Level 2 MCA training was put on hold. Training recommenced in July 2022.
Bespoke MCA Training	*	24	12	12	7	31	4 x Mental Capacity/Best Interest Bespoke sessions 2x LPA Bespoke sessions and 1x Level 2 MCA training.
SAFEGUARDING SUPERVISION							
CHILDREN:							
Group Supervision Sessions	67	66	27	26	15	68	Clinical staff working with children need to attend this supervision, 3 x per year. 5 x sessions are delivered per week. Attendance at sessions is excellent, with a maximum of 8 participants per session. Feedback is sought and captured following every session via a Snap Survey – feedback helps to shape future sessions.
Group Supervision Compliance	55%	61%	63%	63%	56%	61%	In April 22 Safeguarding Group Supervision was added as an 'essential to role requirement' on staff Care to Learn Training Profiles. Operational line managers are responsible for monitoring individual staff member compliance. A piece of work is underway to breakdown compliance at team level for targeted work to address low compliance rates. Alongside this a scoping activity is underway to consider developing a new model of Safeguarding Supervision, development will include consultation with operational teams and a review of the different supervision needs of the target audience.
One to One Supervision Sessions	6	4	4	1	3	8	121 Supervision is available to all upon request. The uptake for 121 supervision is poor. Practitioners are made aware of this facility in their Group supervision sessions, in training and on the advice line.
ADULTS:							
Group Supervision Sessions	4	5	2	2	1	5	A new offer/model of Adult Safeguarding Supervision has been developed to address poor attendance and engagement with supervision. This is now beginning to be rolled out across teams and localities
Number of Staff who attended Supervision	5	12	3	15	1	19	
One to One Supervision Sessions	2	0	0	0	0	0	121 Supervision is available to all upon request.

Appendix Two

Trust Operational Data Extract – December 2023

Additional information:

The information provided in the following slides is a snap shot of activity data that was created to monitor performance whilst the Operational Governance Structures were being redesigned. The information supporting the activity data is detailed in the BI Performance Dashboard that has visibility throughout the organisation. Currently the larger data set reports though:

- PFIG & Directorate Governance meetings on a monthly basis
- Business Intelligence Management Group - monthly which reports onward into the Resources Committee
- Pan Ops Directorate who escalate issues from individual Directorates which reports into QAG & Quality Committee.

In future iterations of the dashboard, the Operational Data Extract will be stood down, however, all reporting will channel through the operational governance route and an overview of data will be provided within the QAG paper to the Quality committee. This will reduce the duplication of data and the commitments on operational teams. The dashboard will focus on quality themes from services and give an overview on any enhanced surveillance in place to oversee quality in areas that have higher risk or emerging themes. The dashboard will focus on quality themes from services and give an overview on any enhanced surveillance in place to oversee quality in areas that have higher risk or emerging themes.

CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2022/23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 YTD	R A G	Exception Report	Benchmarking Report
Referral to Treatment physical health																				
	Podiatry - % treated within 8 Weeks	L - C	95%	42.67%	47%	43%	41%	46%	44%	61%	56%	56%	60%				49%	R		
	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	63.93%	78%	68%	65%	80%	80%	76%	78%	81%	81%				74%	R		
	ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	72.81%	78%	78%	80%	75%	77%	72%	73%	76%	81%				78%	R		
	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	50.59%	45%	41%	43%	39%	32%	20%	24%	37%	37%				38%	R		
	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	90.16%	89%	89%	85%	81%	63%	64%	75%	76%	83%				79%	R		
	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	14.35%	11%	13%	8%	32%	14%	10%	6%	9%	23.9%				18%	R		
Wheelchair Services																				
	Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	83.24%	86%	85%	90%	81%	96%	96%	97%	92%	87%				90%	G		
	Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	84.66%	94.0%	83.0%	94%	100%	84%	100%	95%	93%	95%				93%	G		
Mental Health Services (CPA and Eating Disorders)																				
	CPA Follow up contact within 72 hours of discharge. %	N - T	95%	95%	90%	98%	93%	96%	93%	100%	98%	95%	97%				96%	G		
	Adolescent Eating Disorder - routine referral to NICE treatment start within 4 weeks %		95%	46.95 %	30%	30%	67%	75%	72%	79%	52%	47%	85%				60%	R		
	Adolescent Eating Disorder - Urgent referral to NICE treatment start within 1 week %		95%	45.1%	87%	100%	82%	83%	100%	100%	100%	100%	89%				81%	R		
	Eating disorders - Wait time for adult assessments will be 4 weeks %		95%	47.04%	37%	53%	85%	84%	87%	78%	81%	76%	71%				72%	R		
	Eating disorders - Wait time for adult psychological interventions will be 16 weeks %	N - T	95%	68.96%	85%	100%	100%	96%	85%	86%	78%	87.0%	88.2%				93%	A		

Additional information

Therapies: Improvements are being seen in all categories monitored above which is due to the continued increased oversight and initiatives being in place.

Podiatry: The 8 week RTT is 59.2% with 323 out of 795 referrals seen outside 8 weeks. The waiting list is currently showing as 1850, compared to 2404 6 months ago, and this is the lowest it has been for 12 months. Although the situation has improved there is still a significant vacancy rate within the team (December was 11.1% compared to 23.3% in July) and the service is continuing with skill mixing and rotations while recruitment is underway. The main waits are still with the MSK element of the service mainly due to the number of referrals but also sickness from within this particular team. Extra clinics were suspended over Christmas period but will start again in January and the offer of overtime remains. Work is under way to assess the impact of the proposed threshold move from 8 to 18 weeks.

Paediatric Occupational Therapy: December performance was 23.9% compared to a threshold of 95%, with 35 out of 46 referrals seen outside of the 8-week target timeframe. The waiting list for first contact at the end of December was 524, compared to 566 6 months ago. It is recognised that the 8 week referral to treatment target is too ambitious and unattainable with current and changing demands on therapy services. Following approval at BIMG, the KPI will be split into urgent (4 weeks) and routine (18 weeks). The proposal is to replace the KPI from 1st January. The monthly performance and administration of the proposed replacement KPIs continues to be monitored in the meantime. Exceptions are largely due to the service tackling backlogs - this pattern will continue whilst the service continues to tackle the longest waits. Backlog clearance initiatives and focussed recovery work is reducing overall wait times. Currently, the longest waits in the service are: Telephone advice – under a week (improved by 4 months); Clinic appointments - 7 months (same as last month); Home/school appointments - 9 months (same as last month).

Wheelchair Services: The clinical team is now fully established and the service had met target for both indicators since September, however, narrowly missed this month by 3%. It is expected that a positive trajectory will continue in the coming year. The compliance rate for equipment delivered within 18 weeks of referral is at 90% for December.

Eating Disorders: Adolescent RR to NICE treatment within 4 weeks shows 2 non-compliant cases out of 13 in December. Challenges remain and the service continues to offer assessments to patients that have been waiting for an extended period based on a clinical decision of non-urgency. The waiting list has reduced to 36 in December from 38 in November. **Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week:** There was 1 non-compliant case reported in December out of 9. The non-compliant case was treated within 8 days. The service has faced challenges with contacting patients, parents, and families within the time frame due to not responding to calls. As the service is run during week hours, it restricts the opportunity to contact patients, parents, or families. The service has previously offered out of hours calls by bank staff but has been careful not to do this in case the patient is presenting with complexity or risk. Going forward, each patient will be placed onto a handover sheet where the team will seek to contact each patient/parent/carer to provide guidance following the referral. The number of adolescents recorded as urgent and waiting for treatment has reduced to 22 in December from 25 in November. The service has adopted a new triage process, and all new patients receive an initial call within 24-72 hours of the service receiving the referral.

Quality Dashboard																		Gloucestershire Health and Care NHS Foundation Trust		
CQC DOMAIN - ARE SERVICES EFFECTIVE?																				
		Reporting Level	Threshold	2022/23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 YTD	<div>R</div> <div>A</div> <div>G</div>	Exception Report?	Benchmarking Report
Community Hospitals																				
Bed Occupancy - Community Hospitals		L - C	92%*	97%	97%	98%	97%	96%	95%	98%	98%	98%	97%				97%			
* Indicates optimum occupancy to enable flow																				
Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral		N - T	60%	69.2%	60.0%	67%	100%	87%	100%	75%	74%	75%	50%				50%	A		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																				
Inpatient Wards		N - T	95%	68%	72%	63%	69%	71%	72%	80%	66%	69%	79%				66%	R		
Community		N - T	90%	70.2%	76%	9.0%	25%	31%	41%	87%	66%	69%	68%				68%	R		
Improving access to psychological therapies (IAPT): Proportion of people completing treatment who move to recovery (from IAPT database). Waiting time to begin treatment (from IAPT minimum dataset)		N - T	50%	52.1%	51%	51%	57%	53%	54%	52%	54%	54%	51.1%				51.1%	G		
Admissions to MH adult facility of patient under 16yrs		N - R		0	0	0	0	0	0	0	0	0	0				0	N/A		
Inappropriate out of area placements for adult mental health services		N - R	* Bed Days	950*	0	0	5	7	6	3	5	2	2				30	G		
Children's Services – Immunisations				2021/22 Outturn	Academic Year 2022/23 - Target 90% of all 2 immunisations by end of academic year (July 2023) and new cohort 1st immunisations					Academic Year 2023/24 .										
HPV Immunisation coverage for girls aged 12/13 years old (Target for all 2 immunisations to be completed) HPV 2 begins March 2024		N - T	90%*	79.1%	12%	70%	80%	85%	90%								90%	A		
					43.3%	69%	70%	71%	73%								73%			
Childrens Services - National Childhood Measurement Programme				2021/22 Academic Year	Academic Year 2022/23 - Target 95% of children measured by end of academic year - Cumulative target (July 2023)					Academic Year 2023/24.										
Percentage of children in Reception Year with height and weight recorded		N - T	95%*	57.0%	65%	85.0%	95%	95%	95%			10%	15%				18.9%	G		
					82.5%	91.9.3%	96.9.9%	97.1.1%	97.1.1%			12.4%	18.9.9%							
Percentage of children in Year 6 with height and weight recorded		N - T	95%*	96.1%	75%	87%	95.0%	95%	95%			20.0%	25%				30.1%	G		
					89.7.7%	94.0.0%	96.4.4%	96.6%	96.6.6%			20.8.8%	30.1.1%							
Additional Information																				
<p>OOA: This month as last we are reporting 2 OOA placements, the stable position is indicative of the work being undertaken to increase patient flow. All patients are monitored by the Bed Management Team through a virtual ward approach.</p> <p>EIP: There was 1 non-compliant case reported in December. The care coordinator was allocated within 7 days however, the patient required hospital admission the day after referral. During the admission, the patient was too unwell to be seen by the service and for part of the patient's hospital treatment they were placed out of area. The patient has now been seen by the service.</p> <p>Children's Services: NCMP Both indicators are showing a robust commencement position with outcomes above target and an ambition to continue this position.</p> <p>Cardio-metabolic assessment – April's data was the year end position and is reset from May which then impacts on its comparative position against the previous month. Following the small improvement last month we see a significant 10 percentage points increase in the inpatient compliance rate this month. Focus on these rates will continue with input from Matrons and Team leaders in order to attain the 90% target.</p> <p>HPV: quality team monitoring and engaging with team to support activity returning to planned performance</p>																				

Additional KPIs - Physical Health

		Reporting Level	Threshold	2022/23 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2023/24 YTD	R	Exception Report?	Benchmarking Report
																		A		
																		G		
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)			52%*	73.9%	62.0%	83.0%	93%	95%	95%			10%	18%				10%	G	N	
					85%	94%	98%	99%	99%			12%	14%				14%			
Number of Antenatal visits carried out				505	56	54	62	66	67	71	85	79	44				583	NA	NA	
Percentage of live births that receive a face to face, telephone or video NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%		93.53%	92%	92%	95%	95%	95%	94%	94%	94%	94%				94%	A	Y	
Percentage of children who received a face to face, telephone or video 6-8 weeks review.		95%		93.1%	96%	96%	96%	97%	96%	96%	97%	95%	95%				96%	G	Y	
Percentage of children who received a 9-12 month review by the time they turned 12 months.		90%		81.5%	81%	85%	89%	89%	89%	87%	87%	89%	88%				88.0%	A	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		90%		90.25%	92%	91%	92%	92%	91%	94%	93%	92%	92%				93%	G	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		90%		81.06%	90%	89%	92%	93%	90%	87%	89%	89%	92%				92%	G	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%		53.73%	55%	59%	57%	56%	54%	53%	57%	54%	54%				54%	A	Y	
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%		82.1%	78%	87%	83%	83%	79%	80%	81%	81%	79%				79%	A	Y	

Additional Information

Health Visiting:

- **NBV and Child reviews:** December performance (NBV – 7-14 days) - was marginally below threshold at 94% with 34 out of 530 infants not being seen within timeframe. Exceptions were due to 14 babies being in NICU, 6 due to parental choice to be seen outside of timeframe, 3 due to hospital re-admission, and 3 due to staffing. The remainder were due to no access (with an appointment now booked) and system record errors where the babies had been seen. Readmission is unusual and may indicate ward pressures and babies being discharged too early. Parental requests to delay visits is likely linked to the Christmas period.
- **% of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks:** December performance was slightly reduced compared to November with a drop of 2%, showing 79% against a threshold of 80%. It is envisaged that this indicator will return to target and that this will be sustained going forward.
- **% of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence):** December performance was 54%, with 242 out of 621 infants recorded as totally or partially breastfed. The Midwifery Service continues to be understaffed, which impacts on the specialist feeding service/tongue tie service waiting lists. Infant Feeding Lead Health Visitor has set up weekly meetings to address needs identified with plans to improve feeding status and has been invited to Post Natal Care Pathway meetings with the Midwifery service. Infant Feeding Assessment Clinics have been introduced as Pilots in the targeted areas of Gloucester and The forest of Dean. Early intervention is key as attrition rates are highest between 0 and 2 weeks.



Appendix Three

Organisational Quality Priorities – 2023/25

QUALITY PRIORITIES 2023-2025

Standard	Tissue Viability (TVN) - with a focus on reducing through improvement, the recognition, reporting, and clinical management of chronic wounds.				
Performance	Target – To include recognition of the importance of prevention which has received wide coverage within clinical areas and to align workstreams with the national Wound Care Strategy.				
Commentary	Work Stream	Q1	Q2	Q3	Q4
	Implementation of the National Wound Care Strategy (2 year initiative)	Link with TVN colleagues across nearby Community Trusts: Oxford & Bristol	Review learning content on NWCS platform	Scope strategy requirements	Set SMART objectives and achievable timelines
	Refresh and evaluate the delivery of training education and support available.	Meet with TVN colleagues, noting current vacancy in CLWS/TVN Professional Lead role will delay progress.	HOP & Operational Lead for Wound and lower limb services to map current education offer from GHC. Identify any gaps; produce an action plan.	Allocate identified gaps in training to clinical specialists to progress. (Professional Lead role commencing mid Oct.)	Update Care to learn with new training. Ensure colleagues are aware of complete TV training offer using professional & operational managerial cascade routes. Publicise using the Trust's weekly communications update: Indigo.
	Evaluate and produce business case for the implementation of a wound care app.	Contact companies approved by NWC strategy and identify the ap most suited to community care	Invite community based clinicians & TVN colleagues to review the ap & comment on its application to supporting patient care.	Identify a community nurse team to trial the use of the ap. Request a quote from the company. Identify business planning colleagues to progress on a "go no go basis "	Identify if funding is available to proceed on a go no go basis.
	Evaluate and strengthen links with dietetic services other services both within GHC and across the system to improve holistic support to patients..	Identify colleagues within GHC	Meet with colleagues and invite comment on the production of improvement and collaboration work.	Participate in systemwide approach to wound care strategy led by ICB.	In partnership with system colleagues scope how to strengthen links to support improved patient care and outcomes
Lead NF					

QUALITY PRIORITIES 2023-2025

Standard	Tissue Viability (TVN) - with a focus on reducing through improvement, the recognition, reporting, and clinical management of chronic wounds.	
Performance	Target – To include recognition of the importance of prevention which has received wide coverage within clinical areas and to align workstreams with the national Wound Care Strategy.	
	Work Stream	Q3 update
Commentary	Implementation of the National Wound Care Strategy (2 year initiative)	Links with TVN colleagues across Gloucestershire (GHFT) and nearby Community Trusts have been established: (Oxford and Bristol). Across Gloucestershire colleagues from acute, community and commissioning are meeting regularly. TVN's and ICT Clinical Nursing leads are also sighted on this strategy which will continue to be shared across the Trust. Review of the latest guidance/standards published on the NWCSP website has been completed. Links to the NWCSP videos and training/learning resources have been shared and key messages fed back to clinicians.
	Refresh and evaluate the delivery of training education and support available.	A successful appointment to the Professional Lead for Tissue Viability was made in October. Discussion and initial agreement has been reached with colleagues to scope a countywide role out of a standardised risk assessment for pressure Ulcers (Purpose T). Resources to support organisations to do this is expected to be included with the NWCSP this year. A blended model of training is being formulated encompassing both Face to Face training and Webinars with the Face to Face offers being made available all around the county at multiple locations, (not just in centralised training facilities) to enable more staff to be able to attend.. Training materials are being developed and current material reviewed in line with the National Wound Care Strategy Programme.
	Evaluate and produce business case for the implementation of a wound care app.	Evaluation of Aps has taken place and the most suitable one has been identified as Healthy I.O. which been presented to and reviewed by clinicians. Colleagues from operations are in discussion with the company with next steps to prepare a business case and undertake trial when/if suitable funding is secured.
	Evaluate and strengthen links with dietetic services other services both within GHC and across the system to improve holistic support to patients..	Links have been established and colleagues from Dietetics have been approached to be involved and actively contribute to training offers, materials and policy, Colleagues have been invited to system meetings initially focused on inpatient CQUIN requirements around pressure ulcers. These meetings will be the vehicle to discuss and agree NWCSP implementation moving towards true system working.
Lead NF		

QUALITY PRIORITIES 2023-2025

Standard	Dementia Education - with focus on Increasing staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.				
Performance	Target – To achieve all elements of each quarter by the end of year 2.				
Commentary	Work Stream Plans	Q1	Q2	Q3	Q4
	<ul style="list-style-type: none"> Training Establish the baseline for T1, T2 and T3 dementia training and Undertake evaluation of future requirements. Plan and facilitate the implementation of Essential to Role Training at Charlton Lane Hospital, including plan profile and journey updates. 	Scoping	<ul style="list-style-type: none"> Gather baseline training data providing a breakdown across services / teams. Identify training audience and agree training thresholds 	<ul style="list-style-type: none"> Q3 training data will be reported at the next ICS Dementia Training and Education Strategy Network (1st Feb) Dementia Lead Lou from Tewkesbury COHO won an award at NHSE SWIPC Awards (CARE document) 	<ul style="list-style-type: none"> Q3 data to be reported to the ICS Dementia Training and Education Strategy Network.
	<ul style="list-style-type: none"> Gloucestershire 5 Step approach. Progress across Community Hospitals. 	Scoping	<ul style="list-style-type: none"> Establish network with Training and Development Sisters across Community Hospital's and aim to share and evidence distribution of training resources. Add to GCC Dementia Education website for use across ICS. Develop training targets 	<ul style="list-style-type: none"> Report training uptake of GHC staff via Care2Learn. Train the Trainer delivered to T&D Sisters across COHO with plan and support in place by DET 	<ul style="list-style-type: none"> Ensure training module is uploaded to Care2Learn. Report training uptake of GHC staff via Care2learn. Report upon how many GHC staff the Training and Development Sisters have trained.
	<ul style="list-style-type: none"> Patient /Carer Experience To establish and evaluate any themes and trends relating to dementia arising from complaints and compliments received via the Patient Experience Team and to ensure learning from these events is shared throughout the organisation. 	Scoping		<ul style="list-style-type: none"> To meet with Patient Experience Team in order to identify themes and trends from compliments and complaints and begin evaluation. Complete evaluation and report on these findings via Improving Care Group, evaluate how these can feed into workstreams . 	<ul style="list-style-type: none"> Share learning
	<ul style="list-style-type: none"> System working with GP practices Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification. 	Scoping	<ul style="list-style-type: none"> Evaluate ARRS team training needs. Develop education session along side EBE. 	<ul style="list-style-type: none"> Finalise education session with EBE and deliver with EBE. Consider session for social prescribers (non-GHC colleagues). Discuss best way to engage with GP's 	<ul style="list-style-type: none"> Develop GP session – (video resource – Webinar)?
	<ul style="list-style-type: none"> Communication Develop Comms plan with a profile of workstream to be on current agendas and team meetings 	Scoping	<ul style="list-style-type: none"> NA 	<ul style="list-style-type: none"> NA 	<ul style="list-style-type: none"> Update Complete comms and add to Bitesize
Lead	SSK				

QUALITY PRIORITIES 2023-2025

Standard	Dementia Education - with focus on Increasing staff awareness of dementia through training and education, to improve the care and support that is delivered to people living with dementia and their supporters across Gloucestershire.		
Performance	Target – To achieve all elements of each quarter by the end of year 2.		
Commentary	Workstream	Detail Q3 Update	Next Steps
	<ul style="list-style-type: none"> Training Establish the baseline for T1, T2 and T3 dementia training and Undertake evaluation of future requirements. Plan and facilitate the implementation of Essential to Role Training at Charlton Lane Hospital, including plan profile and journey updates. 	<p>Dementia Training and Education data for Q3 will be presented at the next ICS DTES network meeting. ICS Dementia training priorities for 24 / 25 as an ICS under review currently and will be agreed at the next ICS DTES meeting.</p> <p>Matron / Ward Managers have agreed that dementia T1 and T2 training is essential for role for clinical staff working across the wards, have seen an increase in staff completing this over Q2 and Q3 and some staff from Willow Ward also doing T3 training (2 completed in Q3 and 2 booked on for Q4)</p> <p>Conversations with GHLL to try and get more schools / colleges using the dementia resources in Q4 / Q1 2024 in prep for Dementia Action Week.</p>	
	<ul style="list-style-type: none"> Gloucestershire 5 Step approach. Progress across Community Hospitals. 	<p>Delay in getting this course up loaded to Care 2 Learn. This will be completed first part of Q4. It is accessible on GCC dementia platform and staff are being directed there in the interim.</p> <p>Train the Trainer session held for Training and Development Sisters across COHO and lead allocated for ongoing support. 2 TD sisters also completed T3 dementia course and plan for another TD sister to complete the course in Q4.</p>	
	<ul style="list-style-type: none"> Patient /Carer Experience To establish and evaluate any themes and trends relating to dementia arising from complaints and compliments received via the Patient Experience Team and to ensure learning from these events is shared throughout the organisation. 	<p>Met with Patient Experience Team and they have produced a spreadsheet of specific dementia related concerns / complaints received. This is just under review and themes will be shared in Q4.</p>	
	<ul style="list-style-type: none"> System working with GP practices Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification. 	<p>Primary Care Dementia Education Event currently in planning stage, will include local and national speakers. Plan to arrange and deliver dementia awareness sessions for the MH ARRS workers across surgeries, specifically focused on YOD.</p> <p>Gloucestershire Dementia Strategy should be published in January / February 2024.</p>	
	<ul style="list-style-type: none"> Communication Develop Comms plan with a profile of workstream to be on current agendas and team meetings 	<p>Ongoing reminders / promotion of dementia training that is available to colleagues as I network across the trust.</p>	
Lead			

SAFE : QUALITY PRIORITIES 2023-2025

Standard	3 Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data .
Performance	Target – an overall reduction in the number of medium and high harm falls within inpatient units.
Commentary	<ul style="list-style-type: none"> The Trust wide Falls group ensures consistency of practice, and strong focus on evidence based falls prevention in all areas of GHC. The group is looking to produce and implement a framework with the ambition of: A reduction in the number, and impact of falls in both community and inpatient settings, (hence widening the reach of the indicator) Improving both staff and patient awareness of falls risks, Reduce the variation of practice in falls prevention. The focus is to promote a culture in which falls prevention, risk assessments and interventions are everybody's business.
Lead	HW

Workstream - Plans	Q1	Q2	Q3	Q4
<p>Community falls Establish a baseline for falls at home to measure improvements made.</p> <p>Inpatient Falls To produce a countywide Falls Reduction Action Plan for Inpatient Units</p>	<p>Scoping</p> <p>Scoping –Decision made to trial at CLH</p>	<p>Data gathering and process map to be produced.</p> <p>Roll out Falls reduction plan at CLH</p>	<p>Review data and depending on results, decide how and if these falls can be reduced</p> <p>Review data and plan. Share best practice with CoHo's to implement where appropriate Introduce an inpatient Falls Reduction Awareness Training programme for Inpatient Staff. Target 80%</p>	<p>Evaluation and plan of roll out</p> <p>Audit number of falls within inpatient units since introduction of action plan</p> <p>Audit number of staff who have attended Falls awareness training</p>
<p>Falls Policy Revise and refresh policy to meet NICE standards for both Community and Inpatient</p>	<p>Scoping</p>	<p>Draft policy to be produced and circulated to Trust Falls group for comment.</p>	<p>New Trust wide Policy to be ratified by GHC Policy Group. Undertake Roll out Trust wide and implement changes.</p>	<p>Audit compliance with revised policy.</p>
<p>Trust wide Inpatient falls leaflet to be produced.</p>	<p>Scoping</p>	<p>Draft version to be produced and circulated within Falls Group</p>	<p>New Falls Prevention Leaflet to be agreed and circulated to Inpatients Trust wide</p>	<p>Ask for staff/patient feedback on Leaflet, make changes if needed</p>

SAFE : QUALITY PRIORITIES 2023-2025

Standard	3 Falls prevention with a focus on reduction in medium to high harm falls based on 2021/22 data .	
Performance	Target – an overall reduction in the number of medium and high harm falls within inpatient units.	
Commentary	<ul style="list-style-type: none">• The Trust wide Falls group ensures consistency of practice, and strong focus on evidence based falls prevention in all areas of GHC. The group is looking to produce and implement a framework with the ambition of:• A reduction in the number, and impact of falls in both community and inpatient settings, (hence widening the reach of the indicator)• Improving both staff and patient awareness of falls risks,• Reduce the variation of practice in falls prevention.• The focus is to promote a culture in which falls prevention, risk assessments and interventions are everybody's business.	
Lead	HW	
Workstream - Plans	Quarter 3 update	
Community falls Establish a baseline for falls at home to measure improvements made. Inpatient Falls To produce a countywide Falls Reduction Action Plan for Inpatient Units	<p>Issues found with data collection with regard to falls at home as it is known that the majority of these type of falls are unrecorded and unknown to the Trust . The data may be held by ED or Ambulance Services (if they were in attendance) with regards to injurious falls, however, the majority of non injurious falls at home will not be recorded . Links are being made with the Falls Assessment Education Service to evaluate any alternative courses of action and the availability/coverage of the service.</p> <p>Successful trial undertaken at CLH with data/presentation available to demonstrate that there were lower numbers of injurious falls evidenced post initiative.</p>	
Falls Policy Revise and refresh policy to meet NICE standards for both Community and Inpatient	Falls policy has been refreshed and ratified and is compliant with NICE guidelines.	
Trust wide Inpatient falls leaflet to be produced.	Leaflet has been produced and is available to inpatient units – looking at a wider distribution to include community and doctors surgeries .with the ambition of reaching out to members of the community who may have experienced falls at home but are unknown to services.	

SAFE : QUALITY PRIORITIES 2023-2025

Standard	End of Life Care (EoLC) – with a focus on patient centered decision, including the extent by which the patient, their carers and families, wish to be involved in the End of Life Care decisions.				
Performance	Target – To be fully assured that patients, their carers and families, are being involved as much as they want to be in end of life care decisions. To be fully assured that all appropriate staff are identified and have received essential to role training with systems in place for ongoing compliance and monitoring of training provision. To maximise training availability, and ensure identification of additional resource where required.				
	Quality Priority Plan	Q1	Q2	Q3	Q4
Commentary	<p>GHC EoLC priorities align with NICE Quality Standards for care at the end of life and NHSE personalised care approach. Our aim is to enable all our staff to be compassionate, confident and competent in delivering personalised end of life care in our hospitals and in the community.</p>	<ul style="list-style-type: none"> Identify training needs baseline across the organisation – (Essential to Role) including which staff are trained to what level. Identify targets Devise training plan Audits to evidence personalised care 	<ul style="list-style-type: none"> Evidence 90% or better attendance at Essential to Role Masterclass sessions Identify the number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys) 	<ul style="list-style-type: none"> Evidence 90% or better attendance at Essential to Role Masterclass sessions NICE QS144 (Care of Dying Adults in Last Few Days of Life) Audit on care at end of life for community and in-patients Identify number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys) 	<ul style="list-style-type: none"> Evidence 90% or better attendance at Essential to Role Masterclass sessions Number/% of instances where care was/was not personalised (identified through Datix, concerns, compliments, case reviews, bereavement surveys) Undertake review of documentation (Shared Care Plan for Expected Last Few Days of Life/S1 template)
Lead	DW				

<p>To be fully assured that patients, their carers and families, are being involved as much as they want to be in end of life care decisions.</p>	<p>National Care at End of Life 2023 Pilot Audit in Sept 2023 (20 case notes reviewed). Evidence of good compliance that patients, their carers and families are being involved in end of life care decisions as much as they wanted to be.</p> <p>Community Nursing Care at End of Life Audit in October is being analysed currently.</p> <p>Community Hospital Bereavement Surveys to next of kin ask “During the last few days, how involved were you with the decisions about their care and treatment?” H1 – 19 surveys returned, 18 (95%) responded “As involved as I needed or wanted to be”</p> <p>Complaints raised. H1 – 3 complaints. For a patient who died in the community there was a learning point around ensuring next of kin are as informed about care and decisions as the patient.</p> <p>Datix reported. H1 – 98 Datix (excl. falls and skin integrity). Communication and lack of accurate documentation about care at end of life are a common theme. There will be a review of Shared Care Plan and templates used to document end of life care on S1 in H2 to better capture personalised care at end of life</p>	<p>Next steps - To re evaluate the training needs baseline and match to available resource/increase resource.</p>
<p>To Be fully assured that all appropriate staff are identified and have received essential to role training with systems in place for ongoing compliance and monitoring of training provision.</p>	<p>A training needs baseline has been identified and 13 Masterclasses have been assigned as Essential to Role for certain staff groups. Work undertaken has shown that the trajectories for staff completing E2R training are not realistic or achievable during the 2 years expected in the End of Life Quality Priority. Further work is required to refine what is E2R and the End of Life Lead is looking at what the mandatory end of life training offer is in other NHS Trusts. The number of Masterclasses that are classed as E2R and/or staff groups needs to reduce and/or a different way of delivering the training needs to be introduced in order to deliver within the 2 years.</p>	
<p>To maximise training availability, and ensure identification of additional resource where required.</p>	<p>30 spaces are available at Masterclass (with the exception of Having Difficult Conversations which is face to face and 15 max). Q1 – 69% and Q2 – 58% of available Masterclass spaces were taken up. Overall 64% take-up of Masterclasses. We allow these sessions to be overbooked on C2L as there are always No Shows on the day. (In total, Q1 – 125 staff, Q2 – 95 staff trained). We are increasing the number of places that can be overbooked for the next run of Masterclasses.</p> <p>Need identified for Difficult Conversations at End of Life training for call handlers/ward clerks in hospitals, ICT Referral Centres etc. 1 session in September (17 attendees), 2 further sessions planned October.</p> <p>Training aimed at HCA's has been rolled out to Training and Development sisters at Community Hospitals, Charlton Lane Hospital and Professional Leads in ICT's for them to train HCA's in their hospitals/localities. 47 attendees in H1.</p>	

QUALITY PRIORITIES 2023-2025

Standard	1. Increasing the visibility of the Friends and Family Test (FFT) feedback to staff and patients and their families 2. Embedding the actions of the 2022 CQC Adult Community Mental Health Survey action plan				
Performance	Target To deliver greater value for the data collected through patient surveys and demonstrate increased awareness of patient and carer feedback				
Commentary	Work Stream	Q1	Q2	Q3	Q4
	Silver QI FFT project	Complete Silver QI training / Project scoping/ Development	Work with services to implement agreed changes and scoping further developments within remit of project. Draft FFT toolkit with QI project group	DELAYED: Finalise FFT toolkit and distribute to services – undertake implementation training with services where required (delayed to Q4) Progress work on the FFT toolkit	Finalise FFT toolkit and distribute to services – undertake implementation training with services where required Evaluate project success and potential further development
	CQC Community MH Survey Action Plan	Agree actions from 2022 MH Community Survey	Work with services to implement agreed actions	DELAYED: Evaluate action outcomes Interim update on 2022 survey actions	Evaluate action outcomes and share final report on 2022 survey/actions Report on 2023 MH Community Survey and develop action plan (Q1 2024/25)
Lead	KB				
Action	Update Q3				Next steps : <ul style="list-style-type: none">To install FFT feedback boards in pilot sites in Q4To provide full update on 2022 MH Community Survey action plan in Q4To share initial findings of 2023 survey in Q4
Silver QI project	Community services are now using a variety of methods for collecting FFT responses, including electronic, paper and QR codes. This has resulted in an increased number of responses across most areas. Staff are encouraging patients to complete the FFT using these new methods. The project team have considered different options on how to share the outcomes more widely with staff and patients through the use of feedback boards in clinical settings and social media. New ‘You said, we did’ feedback boards to be trialled in three services in Q4.				
CQC Community MH Survey Action Plan 2022	We asked both the services how we could best help the address the action areas and both agreed that a review of the information currently provided to patients via leaflets and websites would be a helpful start. Crisis Care: ensuring people have access to crisis care at the time of need and they receive the help they need when contacting the Crisis Team. <u>Action:</u> reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet <u>Q3 Update:</u> Website – reviewed to make it simpler and include what people can expect when they call. External links to VCSE providers added. COMPLETE. Leaflet – reviewed to make it simple and clearer and changed some of the language. Currently with comms for final sign off. IN PROGRESS. Talking Therapies: ensuring talking therapies is explained in an understandable way and service users are involved in decision making. <u>Action:</u> reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet <u>Q3 Update:</u> Website – reviewed and updated to reflect the feedback provided by the survey group. COMPLETE. Leaflet – reviewed and changed the way in which the service was explained, including what it has to offer. IN PROGRESS.				


QUALITY PRIORITIES 2023-2025

Standard	Suicide Prevention – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.									
Performance	Target – To Reduce Restrictive Interventions within Mental Health & Learning Disability Inpatient Services.									
Commentary	Progress will be measured through the implementation of 4 key elements									
		Priority	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	
	1.	MHC Project Reducing the incidence of reactive restrictive practice in inpatient mental health and learning disability services by 10% by March 2025	Refresh project objectives & support for participating wards	Engage with hospital/unit managers. Identify participating wards & establish new baseline.	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts. Extend Project to March 2025	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts	Wards/units to run PDSA Cycles Data collection ongoing. Monitor impact via SPC charts
	2.	CQUIN 17 Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	Business Intelligence to develop the event lines that can be used to monitor the records reportable as Restrictive Interventions in the MHSDS.	Report on compliance, establish baseline & promote improvements in reporting where identified.	Monitor compliance – target 90%	IMPLEMENT NEXT PHASE OF CQUIN – details awaited				
	3.	Reduce Blanket Restrictions	Agree template for identifying restrictions	Pilot draft template on identified ward.	Evaluate Pilot and agree process for spread.	Implement template across all wards WLH	Implement trust wide across relevant sites	Trust wide register of blanket restrictions to be established	Embed ongoing review of blanket restrictions throughout relevant GHC sites	
	4.	Develop Post Restraint Debrief Process	Map out current practice	Establish potential options and framework for debrief	Pilot draft model on identified ward	Evaluate Pilot	Draft Standard Operating Procedure (SOP) and consult	Approve & Implement SOP	Embed SOP in practice	

QUALITY PRIORITIES 2023-2025

Standard		Suicide Prevention – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.					
Performance		Target – To Reduce Restrictive Interventions within Mental Health & Learning Disability Inpatient Services.					
Commentary		Progress will be measured through the implementation of 4 key elements Quarter 3 Updates					
		1.	MHC Project Reducing the incidence of reactive restrictive practice in inpatient mental health and learning disability services by 10% by March 2025	Dean Ward identified as initial pilot site. Baseline data for Q1 & Q2 2023/24 unplanned restrictive interventions and rapid tranquillisation established including incidents by days of week, time of day, type of intervention, reason for intervention. Ward away day held in November 2023 supported by GHC QI Team, data reviewed and initial ideas for PDSA cycles discussed. Kata Boards to be used as visual reference and Life QI run charts set up. PDSA cycles to run from January 2024 with a focus on provision of therapeutic engagement/activity at the times of day where the most unplanned restrictive interventions occur (evenings). Greyfriars PICU identified as next ward to engage with the project and 'set up' meeting fixed for 15/01/2024.			
		2.	CQUIN 17 Achieving 90% of restrictive interventions in adult and older adult inpatient mental health settings recorded with all mandatory and required data fields completed.	BI have established an indicator within the Performance Dashboard to broadly monitor this (N31 – Event ID 1073), however, further more detailed development is required which is actively in phase 2 of the KPI portfolio development process. It is projected that this process will become automated within the financial year.			
		3.	Reduce Blanket Restrictions	Montpellier Unit have piloted the blanket restrictions template during Q3 focusing on identification of 2 restrictions. 1) Relating to items that patients have 'in possession' e.g. razors/lighters etc which must be returned for secure storage after use and 2) the unit garden being closed between midnight and 06:30hrs. These were piloted with input from service users. Feedback from use of the forms is currently being collated and will be evaluated during Q4 prior to wider use across the hospital site in 2024/25.			
		4.	Develop Post Restraint Debrief Process	Current practice, regarding both patient and staff debrief and support mechanisms, has been mapped out. Following an incident three broad elements have been identified. 1) Ward based support (includes access to the individual MDT professions, managerial and clinical supervision, and handovers). 2) Support external to the ward (includes advocacy, PALS, PCET, matron, investigative processes, Working Well, Freedom to Speak Up, Let's Talk and Behaviour Support and Training Team). 3) Reporting and recording (RiO, Datix and investigative process where indicated). This information will be used to create a simple Standard Operating Procedure which is projected to be ready to pilot by the end of January 2024.			

QUALITY PRIORITIES 2023-2025

Standard	Suicide Prevention– with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.							
Performance	Target – To Improve The Safety Of Mental Health Services Through Implementing Measures Known to Reduce Patient Suicide							
Commentary	<p>The National Confidential Inquiry into Suicide & Safety In Mental Health (NCISH) identifies 10 key elements for safer care of patients</p> <div>  <ul style="list-style-type: none"> NCISH have produced a toolkit (revised March 23) intended to be used as a basis for annual self-assessment by mental health care providers. NCISH Resources (manchester.ac.uk) The Trust will review its practice and performance against each element of the self-assessment toolkit and implement improvements where there is an identified need. This activity will be supported by findings from ongoing activity such as ligature audits, the clinical audit programme, KPIs and feedback from service users, carers and families. </div>							
	Priority	Q2 23/24	Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
	5. Suicide Prevention Implementation of the NCISH self-audit Toolkit for mental health services.	Identify Leads for each of the 10 key elements for safer care	Leads to complete the self-audit	Develop and implement action plan where improvements have been identified.	Establish compliance with action plans.	Annual cycle of re-audit against the toolkit to recommence.	Develop and implement action plan where improvements have been identified.	Establish compliance with action plans.
Update Q3 progress								
Implementation of the NCISH self-audit Toolkit for mental health services.	<p>Self-assessment against the 10 key elements of the suicide prevention toolkit was largely completed during Q3, however, self-assessments are awaited regarding <i>Safer prescribing, Monitoring for depression and Children & Young People</i>. Reassuringly, for the completed returns received, GHC has the majority of systems and processes in place and the recommended operational configuration. Early findings indicate that areas for focus include staff turnover and family involvement in learning lessons. These areas will be reviewed, together with any additional areas for focus, once the outstanding self- assessments are received and action plans developed to implement improvements throughout Q4. The Safety Scorecard compiled by NCISH in November 2023 identified that the suicide rate for people in contact with GHC secondary mental health services was 3.72 (per 10,000 people under mental health care) compared to the national median of 4.83. This benchmark can be viewed positively notwithstanding our aspiration to achieve the lowest possible rate.</p>							

QUALITY PRIORITIES 2023-2025

Standard	Learning disabilities – with a focus on developing a consistent approach to training and delivering <i>trauma informed</i> Positive Behavioral Support (PBS) Plans in line with National Learning Disability Improvement Standards. This includes training all learning disability staff in PBS by April 2025.				
Performance	Target – To train all GHC Learning Disability staff in PBS by April 2025.				
Commentary	Workstream Plans	Q1	Q2	Q3	Q4
	<ul style="list-style-type: none"> Develop training matrix to identify the baseline no of staff who require a consistent approach to training. 	<ul style="list-style-type: none"> Scoping 	<ul style="list-style-type: none"> Establish and report upon the identified staff numbers who require training at team level. Develop training plan 		
	<ul style="list-style-type: none"> Develop a bespoke Trauma Informed Positive Behaviour Support Training Pack (TIPBSTP) to form core foundation of the delivery of this programme. 	<ul style="list-style-type: none"> Scoping 	<ul style="list-style-type: none"> Collaboratively produce training pack. 	<ul style="list-style-type: none"> Training pack to be available . 	
	<ul style="list-style-type: none"> Deliver Trauma Informed Positive Behaviour Support Training to ALL staff working in learning disability services 			<ul style="list-style-type: none"> Pilot training pack 	<ul style="list-style-type: none"> Commence delivery of training
Lead KA					
Q3 Progress Update					
Matrix and Training Pack/day		<p>A comprehensive training pack is now available, having been piloted both internally and externally with a group of local Positive Behaviour Support (PBS) practitioners. The training day will cover an introduction to PBS and the role that staff within our different services play in promoting and delivering the approach. It will also provide an overview of trauma informed care, sharing both the evidence base and also the principles that underpin trauma informed practice. It will end by bringing the two together, encouraging staff to fully embed trauma informed approaches within all of their PBS work.</p> <p>We have dates set to start the training in February, offering mixed sessions across the community teams to encourage multi-disciplinary discussion and networking across teams. There are smaller, more focussed, training days for staff working at Berkeley House to allow time for more patient-specific discussion in order to increase awareness of the unique needs of each individual. The Berkeley House training days will initially target staff who have not yet received formal PBS training and the community days will be open access, with the aim of reaching all staff across all services.</p> <p>Work is currently ongoing regarding the identification / development of an evaluation tool to monitor the impact this training will hopefully have on practice.</p>			

QUALITY PRIORITIES 2023-2025

Narrative	The KPI will be further enhanced by the continuation of the separate Oliver McGowan Training with the ambition that all staff will have an increased awareness of the unique needs of people with a learning disability and autistic people, with a focus on reasonable adjustments, diagnostic overshadowing and tackling health inequalities with the baseline from 22-23 being evaluated and increases delivered.				
Performance	Target – To continuing the roll out of the Oliver McGowan Mandatory Training in Learning Disabilities and Autism across the Trust and monitoring it's impact.				
Commentary	Workstream Plans	Q1	Q2	Q3	Q4
	<ul style="list-style-type: none">Tier One of The Oliver McGowan Mandatory Training package co-designed by GHC, Inclusion Gloucestershire and Family Partnership Solutions in Gloucestershire was chosen last year to be the national training package to be s rolled out nationally.Plan further roll out organisationally at tier 1 and 2 with the ambition of improving last years figures of 82.15% T1 and 355 members of staff T2.	<ul style="list-style-type: none">Re-commence delivery of T1 webinarsICB to lead on training needs analysis	<ul style="list-style-type: none">ICB to lead on developing work plan for rollout of the trainingReview T2 materials and train trainers for T2.T1 webinars available	<ul style="list-style-type: none">Pilot T2 locallyT1 webinars available	<ul style="list-style-type: none">T1 webinars and T2 training available across the Trust & ICB
	<ul style="list-style-type: none">Develop measures to assess impact of training		Report upon levels of training achieved H2	<ul style="list-style-type: none">Collaboratively Identify and document measures to assess direct and indirect outcomes from training that can be shared.	<ul style="list-style-type: none">Establish and report upon the effectiveness of Oliver McGowan Mandatory Training.
Lead					
Quarter 3 Update					
Tier One Training	Tier 1 Webinars, facilitated by Inclusion Gloucestershire IG), are now available to staff in GHC. These are also being made available to staff across the ICS, including Gloucestershire Hospitals Trust, Primary Care and Social Care staff. The capacity of IG to deliver training is restricted by the number of Experts with Lived Experience available to help co-deliver the Webinars, so many of the available sessions are fully booked. IG are taking steps to recruit more trainers to help overcome this issue. Work is underway to assess the total number of staff across the ICS who need training, including the numbers for Tier 1 and Tier 2.				
Roll Out	We have now successfully trained nine facilitating trainers (mostly staff from within GHC learning disability services) for the Tier Two sessions and have dates set in January and February to run two separate Train the Trainer course for experts by lived experienced, one for those with a learning disability and one for autistic facilitators. We have also successfully recruited someone into the lead facilitator role within GHC and Inclusion Gloucestershire have advertised for more experts by lived experience, with the recruitment process being ongoing. There are plans in place to run at least one Tier Two training day per month from March. We are awaiting guidance from the national steering group with regard to how the training will be evaluated; if it transpires that this is likely to focus more on content that the impact of the training then we will look to identify / develop an evaluation tool to monitor the impact this training will hopefully have on practice.				

SAFE : QUALITY PRIORITIES 2023-2025

Standard	Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.				
Performance	Target – To improve the outcomes and experiences of children with SEND by developing system relationships and the knowledge and skills of healthcare staff supporting these children and their families.				
Commentary	Quality Priority Plan	Q1	Q2	Q3	Q4
	<p>Digital reporting Implement performance reporting of SEND related data to inform service provision by reviewing the SystmOne modules and RiO data capturing capabilities by 1st October 2023</p> <p>Training Develop a SEND Training Assurance Framework by 1st April 2024 to enhance knowledge and understanding of the SEND process focusing on inclusion co-production, participation, engagement, personalisation and advocacy. This will include CPD opportunities for all patient facing staff in CYPS to complete the Council for Disabled Children SEND Basic Awareness E-Learning Level 1 and Level 2.</p> <p>Feedback Complete survey of CYP who have transitioned to adult care in order to improve the experiences of young people and inform future practice. This will include 3 patient cohorts (MH/PH and LD) and their carer/family's.</p> <p>Electronic EHCP Portal For all new referrals received through the electronic portal to be actioned electronically in the portal by 1st August 2023 in CYPS Physical health services, and by 1st January 2024 for CYPS Mental Health Services.</p>	<ul style="list-style-type: none"> Take a proposal/request paper to the relevant clinical system working group, highlighting the needs and the recording/ reporting capabilities required. To have an agreed plan to develop digital reporting for SEND. Work with the Learning & Development Team to get SEND Basic Awareness Training Levels 1 & 2 added to Care2Learn. Early adopters in CYPS leadership to start completing training to ensure it works. Scope engagement opportunities with service users and young people with SEND to better understand needs, hear their voices and coproduce development work. SEND Leads to work with the Portal development team to get health services set up on the new platform. Offer teaching and training for CYPS staff on how to use the portal. 	<ul style="list-style-type: none"> Work with CST to build recording capability within the clinical systems. For all CYPS staff to have completed Level 1 & 2 SEND Basic Awareness Training on Care2Learn. This training is delivered by the Council for Disabled Children (CDC). SEND Leads to engage with the Engagement Officer for Future Me Gloucestershire (GCC). SEND Leads to join the ICB-led Transition to Adulthood group that is reviewing transition processes, tools and frameworks across health services and the wider system. All CYPS PH services to be using the EHCP portal by the end of Q1. 	<ul style="list-style-type: none"> Work with BI to ensure data flows through the data warehouse and performance reports and dashboards can be developed. SEND Leads and Training Team to develop EHCP Contents Awareness Training that is informed by the outcome of the audits. SEND Leads to join Future Me Glos forums to work alongside young people. CAMHS and LD Services to prepare to use the EHCP portal – set up, training sessions and testing. 	<ul style="list-style-type: none"> To have robust reporting capability that demonstrates activity, demand and compliance against statutory EHCP timeframes. To have a SEND Training Assurance Framework ratified by CYPS Governance forums by April 2024. Work with Communications team to develop transition surveys that can be shared with parent/ carers and young people to understand their experience and quality of transition. Work with the Young Adults Team and Adult services to share this survey with young people and families who have recently transitioned from children's services to adulthood. For all CYPS Services will be using the EHCP portal.

Q3 System Update	<p>On Monday 27th November 2023, GCC received formal notification of the local area SEND inspection. This is a whole area inspection that will consider children and young people with SEND from all of our children and young adults services. The inspection takes place over 3 weeks.</p> <p>Aims:</p> <ul style="list-style-type: none"> Ofsted and CQC inspectors will provide independent, external evaluation of the effectiveness of the local area partnership's arrangements for children and young people with SEND. Where appropriate, they will recommend what the local area partnership should do to improve the arrangements. <p>Update:</p> <p>During the course of the inspection, CQC inspectors met with relevant health professionals supporting SEND activity in their areas. SEND case studies were selected and case tracking, and pen portraits, were completed with all agencies and staff supporting those children/ young people/ young adults. Inspectors also met with SEND leads and health professionals across CYPs services to understand the experiences of children/ young people with SEND, accessing health services in Gloucestershire.</p> <p>In preparation for the inspection, children's services submitted SEND self-evaluation frameworks, SEND case studies, service overviews and supporting evidence. These were all be reviewed as part of the inspection.</p> <p>An initial inspection feedback session will take place on 15th December 2023.</p>
SEND & Inclusion Local Area Partnership (SILAP) Improvement Plan	<p>The Improvement Plan sets out the priorities and activities that will drive the delivery and improvement of Inclusion, SEND and Alternative Provision services across Gloucestershire.</p> <p>The plan brings together priorities from across the local system including, Education, Health, Care and the voice of children and young people and families.</p> <p>The vision and scope of the Improvement Plan is agreed and governed by the SEND and Inclusion Local Area Partnership (SILAP or 'The Partnership'). The implementation of the Improvement Plan is managed by the SILAP Operational Group, through a series of project and task and finish groups.</p> <p>Aim</p> <p>To improve outcomes for children and young people with SEND through the co-production and delivery of high-quality local services that are available at the right time across education, social care and health.</p> <p>Priorities</p> <ol style="list-style-type: none"> Developing inclusive communities and local education system. Ensuring children and young people with SEND are able to access the right support at the right time. Delivering better value in SEND programme.
Next Steps	<ol style="list-style-type: none"> Learning from the SEND Inspection <ul style="list-style-type: none"> Outcomes and recommendations will inform development and improvement work. A focus on quality <ul style="list-style-type: none"> Using rich data and meaningful outcomes to evaluate the quality of care experienced by children/ young people with SEND. Establishing a quality assurance framework to improve the quality of health advice, recommendations and reports for Education, Health and Care Plans. A spotlight on children's mental health <ul style="list-style-type: none"> Focused support on the SEND agenda within Core CAMHS and children's specialist mental health services Supporting children's mental health professionals to develop knowledge, skills and confidence working with children with SEND Review and develop the SEND processes and practice within Core CAMHS CYPS Strategic Framework <ul style="list-style-type: none"> Ensure that SEND features strongly within the CYPS strategic framework Consider children with SEND within the context of health inequalities Fidelity of staff SEND pledges

QUALITY PRIORITIES 2023-2025

Standard	Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Incident Response Framework				
Performance	Target – To develop a framework which details how the trust will support the development of clear, measurable actions from areas for improvement, how we will schedule longer-term monitoring, define markers of benefit for patients/service users, families and carers and disseminate learning across services and professions.				
<p>Commentary: The approach of the PSIRF seeks to shift our response away from individuals and root cause analysis to exploring and understanding systemic issues.</p> <p>There will be renewed focus upon the impact of and the part that psychological safety plays in learning from incidents in enabling staff to speak up, participate and learn.</p>	Workstream Actions	Q1	Q2	Q3	Q4
	Review Incident Reporting Policy	Scoping	Policy draft	Policy published on Intranet	
	Development and Implementation of Learning Assurance Framework	Scoping	Draft Framework to be produced which details how the trust will support the development of clear, measurable actions from areas for improvement, how we will schedule longer-term monitoring, define markers of benefit for patients/service users, families and carers and disseminate learning across services and professions.	The framework will be completed and agreed in Q3 .	Implementation of framework
	Fidelity Testing	Scoping	Fidelity testing template , process and tracker to be developed.	Review of results and learning	
	Civility saves lives.	This is an Ongoing workstream: Harm from disrespect has been identified as a key element in patient safety efforts and fostering a culture of civility and respect within our Trust further supports the delivery of our values and behaviours. Civility and respect sit behind a positive workplace culture and our Trust values. Civility describes a behaviour: treating someone politely or with courtesy. Respect involves valuing other people's experience and feelings. The two are closely linked, as people show their respect for someone by acting with civility. In health and care, civility and respect involve supporting, valuing and respecting each other for what we do and showing kindness, compassion and professionalism towards our colleagues, patients and service users. It also means ensuring that people are civil in their digital communications, avoiding sharp, harsh or insulting comments on email or social media. Civility saves lives is intended to be entwined into all that we do and we have a four module course available on C2L which we aim to report uptake of over the 2 years.			
Lead PBM and SP					
Q2 Update					
LAF Framework and Incidents Policy and fidelity Testing Fidelity Testing:		The Learning and Improvement Framework was shared through the Quality Assurance Group in December. This supports our approach which we have outlined in our changes in PSIRP. We have begun testing with the support of the Clinical Development Managers. We are also utilising the tool to benchmark against National Prevention of Future Death Notices and will report back into QAG in March.			
Civility Saves Lives		Ongoing workstream, highlights in Q2 include webinars from external prominent speakers which were well attended and received			

Quality Dashboard



Gloucestershire Health and Care
NHS Foundation Trust

Standard	Carers – with a focus on achieving and maintaining the Triangle of Care Stage 3 accreditation.
Performance	Target – To revalidate the organisational Stage 2 accreditation in 2023/24 and then achieve Stage 3 accreditation in 2024/25.
Commentary	<ul style="list-style-type: none"> As a Trust we need to feel confident that the principles held within the Triangle of Care mirror our Organisational values and beliefs, and should be undertaken and embraced by teams as part of their core activities forming business as usual. Prior to merger, 2gether NHS Foundation Trust was accredited at Level 2 having established Triangle of Care within both the Mental Health inpatient and community teams, and therefore prior to undertaking assessment enabling our journey to Level 3 to progress we are required to demonstrate that the merged organisation retains and can evidence competency with each requirement of the accreditation.
Lead	CN

Workstream	Q1	Q2	Q3	Q4
Mission and vision Develop and launch an Organisational plan that communicates the mission and vision of the project.	Scoping	Work to re-engage connections with all Mental Health and Learning Disability Community and Inpatient teams, to review their position within the Triangle of Care Self Assessments and develop plans to progress RAG ratings as a result	Work continuing to re-engage remainder of all Mental Health and Learning Disability Community and Inpatient teams who have yet to review their position with Triangle of Care Self Assessments and to define their progress accordingly	Work to finalise engagement with the remaining teams within Mental Health and Learning Disability Community and Inpatient teams who have yet to undertake or complete a review of their position with Triangle of Care Self Assessments
Mapping Develop a map of all teams and establish their current compliance status with level 2 requirements by using a self assessment methodology.	Scoping	Development of a matrix map to begin detailing the Trusts current position with teams self assessment within the Triangle of Care covering all Mental Health, Learning Disability Community and Inpatient teams	Continuing progressing the matrix detailing all teams self assessment compliance with Triangle of Care	Work to finalise the self assessments within all MH & LD teams and to have this detailed within the matrix thus providing clear and succinct position within all MH & LD inpatient and community teams
Engagement Engage with stakeholders	Scoping	Engagement with teams and carer champions to work towards completion of the Triangle of Care self assessment. Carer Ambassador undertakes work alongside to support teams	To continue process and encourage Team Managers and Carer Champions to advance any remedial work required to positively progress the RAG ratings within the Self assessment	Trust is assured that 80% of its MH and LD teams (both community and inpatient) are complaint with the Triangle of Care Self assessment process and teams remain positively engaged to continue to make progress within their RAG ratings
Planning Develop plan on a page and project control methodology.	Scoping	Team Managers and Carer Champions are enabled to become positively engaged within this process	Evidence that Team Managers and Carer Champions are enabled to become constructively engaged with the Carer Ambassador to positively progress the Triangle of Care self assessment	Teams are able to successfully take ownership of their onward progression within the Triangle of Care self assessment process

Update Q3

Plans and engagement work are progressing with the workstream being positively viewed by teams. Work continues to introduce and embed the processes of Triangle of Care across all MH teams. There are some outlying teams yet to complete and some sticking points requiring perseverance and patience of clinically pressured teams.

There is now support in the form of a Triangle of Care Practitioner who has very recently been appointed on the bank at 15 hours per week to begin engagement with the many CAMHS teams.

The overall work continues at pace where it can with additional work streams being picked up along the way that also feed into the eventual and hopefully successful embedding of an improved culture that we will be able to see an improved engagement with families and carers.

We are well on the way to the predicted target in Q4 but having additional messages and some pressure from a senior level at this point will support staff and teams to engage in this process.