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NHS
Gloucestershire Health and Care
NHS Foundation Trust

Quality Account 2023/24

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Part 1: Statement on Quality from the Chief Executive

Introduction

I am pleased to present Gloucestershire Health and Care NHS Foundation Trust's Quality Account for 2023 to 2024.

It has been a year when we have been embracing opportunities to improve our quality of services for the communities we serve at the same time as responding to circumstances in which rapid improvements have been required.

Our 11 Quality Priorities, which were designed with a 2-year implementation plan carry over to their second year, the timescale was set as such as they are large scale pieces of work which require time to develop and embed. We are proud to say good progress is being made with all 11, as you will see from the report.

Our Quality priorities for 2024/25, you will see outlined, reflect our ambitions set out in our Trust Quality Strategy, and we are committed to ensuring that these are fully implemented within the relevant timescales.

Quality Improvement (QI) is at the heart of what we do as a Trust. Our QI approach continues to mature and expand as does collaborative work in understanding why patients can be subjected to delays within the system, particularly in leaving hospital. These are things that impact upon patients directly and will always be most important to us as a result.

We have also faced challenges during this year, where we have been disappointed that the quality of some services has not been in line with our own standards and those of our regulator the Care Quality Commission. In these circumstances, our focus has been on implementing immediate improvements, in partnership with the wider health and care system. Our overall CQC rating as a Trust remains 'Good'.

There is, of course, always room for improvement and we have been continuing to develop and mature our overall approach to quality improvement. There is also a stringent process for checks and balances and the organisation constantly encourages feedback from our colleagues and the people who use our services. That feedback is used to ensure a continuous cycle of improvement.

I'd like to thank everyone involved in keeping services safe and delivering high quality care throughout the past year – we are very fortunate to have such skilled and dedicated colleagues supporting the people we serve.

If, when reading this report, you would like more information or to get involved in continuing to improve our services, then please contact experience@ghc.nhs.uk.

To the best of my knowledge the information contained in this report is an accurate representation of the year's events.

Kind regards,

Douglas Blair
Chief Executive

Part 2.1: Looking ahead to 2023/24

Quality priorities for improvement 2024/25

The present quality priorities which were agreed in 2023 were designed to be implemented over a two-year period and will continue through to full implementation in 24-25. These indicators were agreed with the Gloucestershire Integrated Care Board (ICB) and further ratified by Governors in March 2024. They cover areas of quality improvement taken from the Quality Strategy and are large pieces of work which take time to develop , implement and embed. We are committed to developing quality priorities that reflect our ambitions within the Trust Quality Strategy. We continue to build on this mandate and our aspirations are central to our total quality management approach, which focuses on the contribution of our people to develop changes in our culture, processes and practice – a philosophy which we apply to the way the whole organisation manages change and decision-making. It is based on the concept that continual improvement towards a quality aim provides better services, increases quality and reduces costs. The Care Quality Commission (CQC) Well Led Inspection in 2022 gave "good" assurance that our governance structures provide a good foundation for growth and are the gateway for our ambitions to be an outstanding provider of healthcare in Gloucestershire. As we enter the second year of those priorities, we acknowledge that the foundation year has demonstrated improvements in all our priority areas. We will be drawing on our experiences and improvements in year and continue to develop and embed these over the next year, which keeps pace with the current Quality Strategy. Our focus with support of our stakeholders is as follows:

- Tissue Viability (TVN) - with a focus on the recognition, reporting and clinical management of chronic wounds using quality improvement methodology and educational resources.
- 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.
- Falls prevention – with a focus on reduction in medium to high harm falls within all inpatient environments based on baseline 2021/22 data.
- 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.
- 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.
- Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services.
- Reducing Restrictive Practice – with a focus on continuing our strategy in line with the Southwest Patient Safety Strategy to include restraint and rapid tranqulisation.
- Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* 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.
- Children's services – with a focus on the implementation of the SEND and alternative provision improvement plan.
- Embedding learning following patient safety incidents – with a focus on the implementation of the Patient Safety Improvement Plan.

- Carers – with a focus on achieving the Triangle of Care Stage 3 accreditation.

We have continued support from our Trust Board and Governors to build on the successes in the foundation year and continue to implement the full ambitions of the 11 Quality Priorities above. This reflects our ongoing focus and shining a light on quality within the organisation and channelling improvements which reflect our Trust values.

Our quality ambitions are always underpinned by the three pillars of quality:

- Always effective – embedding a culture of continuous improvement in all of our services.
- Great experience – making sure everyone's experience is personalised and is consistently the best it can be.
- Consistently safe – people who use and deliver our services consistently receive intervention free from harm and which provides the most benefit.

In addition, and to support a number of national initiatives all of the priorities will have golden threads that support our agendas around personalisation, co-production and shared decision making.

The key performance indicators were agreed in the Quality Contract with the ICB. The Trust will schedule regular performance reviews with the ICB to monitor progress. Internal oversight and scrutiny will be provided via the Quality Committee and the Board.

Part 2.2: Statements relating to the quality of NHS services provided

Review of services

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

Between April 2023 and March 2024, Gloucestershire Health and Care NHS Foundation Trust provided or sub-contracted the following NHS health services.

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

- One Stop Teams providing care to adults with mental health needs and those with a learning disability.
- Minor Injury and Illness Units MIIU's
- Intermediate Care Mental Health Services (Primary Care Mental Health Services and Improving Access to Psychological Therapies – Let's Talk).
- Recovery Teams and Accommodation Teams
- Specialist services including Early Intervention, Mental Health Acute Response Service, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services, Eating Disorders, Intensive Health Outreach Team, and the Learning Disability Intensive Support Service & Reablement
- Inpatient mental health and learning disability care.
- Community services in peoples' homes, community clinics, outpatient departments, community hospitals, schools and GP practices; District nursing, Integrated Community Team, Rapid Response and podiatry etc
- In-reach services into acute hospitals, nursing and residential homes and social care settings.
- Seven community hospitals provide nursing, physiotherapy, re ablement in community settings.
- Health visiting, school nursing and speech and language therapy services for children.

- Other specialist services including sexual health, heart failure, community dentistry, diabetes, intravenous therapy (IV), tissue viability, Wheelchair Assessment and community equipment.

MH & LD Urgent Care and In-Patient Services	PH Urgent care and In-Patient Services	Community PH, MH & LD Services	CYPS Directorate	Countywide Services
Inpatients MH & LD & supporting functions • Wotton Lawn Hospital • Charlton Lane Hospital • MH Inpatient Rehabilitation Laurel House • MH Inpatient Rehabilitation Honeybourne • Montpellier Low Secure Unit • Learning Disabilities Inpatients - Berkeley House • Alexandra Wellbeing House • Crisis Services incl. Mental Health Rapid Response Vehicle (MH RRV) • s136 Maxwell Centre • Mental Health Liaison Team • Criminal Justice Liaison Service • Approved Mental Health Professional (AMPHP) Hub • First Point of Contact Centre • Specialised Community Forensic Team	Inpatients PH & supporting functions • Vale • Tewkesbury + CATU • Stroud • North Cots • Dilke • Lydney • Cirencester Out-patients Depts • Cirencester • North Cots • George Moore Clinic • Fairford • Vale • Tewkesbury • Stroud • Dilke • Lydney Theatre activity (GHFT with GHC staff) • Cirencester + Endoscopy (all GHFT inc staff) • Stroud + Endoscopy • Tewksbury • Minor Injury and Illness Units • Rapid Response and • Intravenous (IV) Therapy Services • Home Assessment Treatment	• Integrated Care Team (ICT) • Assertive Outreach Team (AOT) • Complex Psychological interventions (CPI) Recovery • Later Life • Community Dementia Nurses (+CHST) • Memory Assessment Service • Mental Health ICT – Primary MH Nursing • MHICT (IAPT) • First Contact Practitioner (ARRS) • Eating Disorders • Perinatal • Learning Disability Intensive Support Services (LDISS) and Intensive Home Outreach Team (HOT) • Learning Disabilities Health Facilitation Team • Community Learning Disability Team (CLDT) • Complex Emotional need (CEN) • LD Health Education Team • Gloucestershire Recovery in Psychosis (GRiP) • Integrated Social Care (ISC) • Autistic Spectrum Conditions (ASC) • Attention Deficit-Hyperactivity Disorder (ADHD) • Specialist Treatment and Rehabilitation (STAR) • Individual Placement service (IPS) • Evening and Overnight District Nursing Services	• CAMHS Parenting Support Team • CAMHS LD • CAMHS Interagency Teams (x 3 teams) • CAMHS MHST Young Minds Matter • Core CAMHS and Outreach Paediatric Liaison Team (LTCs) Young Adults (16-25) Team • SCAAT (Social Communication and Autism Assessment Team) - CYPS • CAMHS VCS (x 11 teams) • Children's Community Nursing Team • Children's Complex Care Team • Children's Occupational Therapy Inc. CYPS Home Safety Team • Children's Physiotherapy • CYPS Respiratory Physiotherapy • CYPS Persistent Physical Symptoms (PPS) • Children's Speech and Language Therapy SALT • Immunisation Service • School Nursing Team • Health Visiting Team • Children in Care Team • Wellchild Nurse and Trg	• Long Term Conditions - Heart Failure - Cardiac Rehab - Bone Health - Macmillan - Respiratory – home oxygen - Respiratory – core - Pulmonary Rehab - Adult specialist Respiratory - Diabetes – nursing and education - Long Covid - Dental • Complex Care at Home • Sexual Health – PAS. GUM/HIV • Sexual Health Referral Centre (SARC) • Accommodation • Wheelchair Assessment Service • Integrated Community Equipment Service • Blue Badge • Telecare • Musculoskeletal (MSK) • Musculoskeletal Advanced Practitioner Service (MSKAPS) • First Contact Practitioners (PH) • Lymphoedema • Falls Assessment • Tissue Viability • Homeless healthcare • Complex leg wound/lower limb • Podiatry Services • Speech and Language Therapy Services (SALT) • Early Stroke Discharge (ESD) • *Neurology (Clinical Specialists*

Gloucestershire Health and Care NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income for patient care activities in 2023/24 represents 93.2% of the total income generated by Gloucestershire Health and Care NHS Foundation Trust for 2023/24.

Participation in clinical audits and National Confidential Enquiries

National Clinical Audits

During 2023/24, there were 9 national clinical audits which related to mental health and physical health services provided by Gloucestershire Health and Care NHS Foundation Trust. During this period, Gloucestershire Health and Care NHS Foundation Trust participated in 78% of the national clinical audits.

The national clinical audits that Gloucestershire Health and Care NHS Foundation Trust was eligible for and participated in during 2023/24 are as follows:

Clinical audits	Participated Yes/No	Teams
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	Community Hospital Inpatients and Mental Health Inpatients

National Audit of Cardiac Rehabilitation	Yes	Cardiac Rehabilitation Team
National Audit of Care at the End of Life (NACEL)	Yes	Community Hospital Inpatients
National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis	Yes	GRIP (Early Intervention in Psychosis) Team
National Diabetes Footcare Audit	Yes	Podiatry Service
National Respiratory Audit Programme (NRAP): Pulmonary Rehabilitation Audit	Yes	Pulmonary Rehabilitation Team
Prescribing Observatory for Mental Health (POMH): Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	No	N/A
Prescribing Observatory for Mental Health (POMH): Monitoring of patients prescribed lithium	No	N/A
Sentinel Stroke National Audit Programme (SSNAP)	Yes	The Vale Stroke Unit and Early Supported Discharge Team

Gloucestershire Health and Care NHS Foundation Trust will be participating in the Prescribing Observatory for Mental Health (POMH) Audits in 2024. The aim of POMH is to help clinical services maintain and improve the safety and quality of their prescribing practice, reducing the risks associated with medicines management. Participating in the POMH audits means that the organisation will be able to benchmark its performance against other Trusts.

The reports of national clinical audits are reviewed by the provider when they are published and Gloucestershire Health and Care NHS Foundation Trust acts to improve the quality of healthcare provided where required. An example of this is given below:

Audit title	Details of the audit and the actions that were taken as a result of the audit
National Audit of Inpatient Falls	The National Audit of Inpatient Falls (NAIF) is a national clinical audit run by the Falls and Fragility Fracture Audit Programme (FFFAP) at the Royal College of Physicians. This audit measures compliance against national standards of best practice in reducing the risk of falls in inpatient settings. The audit consists of four Key Performance Indicators (KPIs): KPI 1 – High-quality Multi-factorial Risk Assessment (MFRA) KPI 2 – Check for injury before moving. KPI 3 – Safe lifting equipment used to move the patient from the floor. KPI 4 – Medical assessment within 30 minutes of the fall A Multi-factorial Risk Assessment (MFRA) is recommended for all inpatients aged over 65 years to identify their individual risk factors for falling. This enables the practitioner to refer the patient for effective, targeted interventions, with the aim of reducing falls. In the latest Quarter 4 results, 100% of patients had had a high-quality MFRA, compared to the national average of 30.6%.

Audit title	Details of the audit and the actions that were taken as a result of the audit
	Three out of four KPIs focus on post-fall management. Actions taken after a fall have the potential to influence outcomes and patient experience. In Quarter 4, patients were checked for injury before being moved in 100% of cases, compared to 75.2% nationally. In Quarter 4, there was no evidence that safe lifting equipment had been used to move the patient from the floor (compared to 33.6% of cases nationally). A local Inpatient Falls Audit recently completed in the Trust also identified post-falls management as an area for improvement. Individual ward action plans were developed to improve compliance with post-falls management. A further local re-audit is planned for 2024/25. Both local and national Falls Audit results are reported into the Trust's Falls Group and Improving Care Group.

National Confidential Enquiries

During 2023/24 Gloucestershire Health and Care NHS Foundation Trust participated in two National Confidential Enquiries: The End-of-Life Care Study and the Juvenile Idiopathic Arthritis Study. Once the reports have been published by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD), they will be reviewed, and any actions required to improve the quality of care provided will be taken.

Local clinical audit activity

The reports of 72 local clinical audits were reviewed by Gloucestershire Health and Care NHS Foundation Trust in 2023/24. Below are examples from across the Trust that demonstrate some of the actions taken to improve the quality of healthcare provided by our services:

Audit title	Details of the audit and the actions that were taken as a result of the audit
Audit of Physical Health Monitoring Post-Rapid Tranquillisation	An audit was completed at Wotton Lawn Hospital to ascertain if the physical health monitoring of patients post-Rapid Tranquillisation is in line with the Trust's policy on the use of Rapid Tranquillisation. The aim of Rapid Tranquillisation is to calm a person and reduce the risk of violence and harm by a person with disturbed mental functioning. It is necessary to carefully monitor the patient's physical health after the administration of Rapid Tranquillisation, due to potential complications arising from the Rapid Tranquillisation. A previous audit in 2023 found that physical observations or non-contact observations had been monitored and recorded hourly after 70% of the Rapid Tranquillisations administered over a 3-month period. As a result of the audit findings, all staff were reminded about the policy and process for post-Rapid Tranquillisation physical observations, and this was added as a standing agenda item on all staff meetings on the wards at Wotton Lawn Hospital. The re-audit in January 2024 found that the monitoring and recording of physical observations or non-contact observations had increased significantly to 89%. The 2023 audit found that a de-brief / wellbeing check had been completed following 27% of cases. Following the audit, actions were implemented to ensure that a de-brief was completed with the patient and recorded in Datix and the

Audit title	Details of the audit and the actions that were taken as a result of the audit
	patient electronic record. In the re-audit, de-briefs / wellbeing checks had increased to 70%. Following the latest audit in January 2024, all wards were asked to adopt the post-Rapid Tranquillisation progress note on the electronic patient record, to allow for the prompting and reminding of the required process. This was used regularly on one of the wards at Wotton Lawn Hospital and this good practice was reflected in their audit results. A further re-audit is due to take place in April 2024, reviewing Rapid Tranquillisation administrations from December 2023 to March 2024.
Children's Complex Care Team Risk Assessment Audit	The Children's Complex Care Team provides care to children who are eligible for Continuing Health Care Funding. The care delivered is home-based to enable families to have a break from their caring role. Risk assessments are completed for certain aspects of the team's work, including lone working, and for items of equipment that the team use. The team write and share risk assessments with parent/carers so that they understand the risks that are involved with each clinical task. The risk assessment also identifies practices that are carried out by the team to reduce any risk. All risk assessments should be reviewed every 6 months as a minimum, or sooner if the care needs change. An audit reviewing the team's risk assessments was completed in 2022 and this was repeated in 2023. Due to one area of low compliance identified in the initial audit, it was decided to re-audit after 7 months. In the initial audit, none of the lone working risk assessments had been reviewed within 6 months or when the care had changed. Actions were implemented to address this, with Care Coordinators being reminded of the importance of reviewing all risk assessments every 6 months as a minimum. The findings from the 2023 re-audit showed an improvement in the review of the lone working risk assessments, with 86% of risk assessments having been reviewed within 6 months or when the care had changed. Continued good practice was seen in all other areas of the audit, particularly in the completion, sharing and review of risk assessments for all items of equipment in use. A further re-audit is planned for July 2024 to ensure that the areas of good practice are sustained, and further improvement is seen in the review of the lone working risk assessments.

Participation in clinical research

Research activity in Gloucestershire Health and Care NHS Foundation Trust in 2023/24

The number of patients receiving relevant health services provided or subcontracted by Gloucestershire Health and Care NHS Foundation Trust in 2023/24 that were recruited during that period to participate in National Institute for Health Research Portfolio research approved by a research ethics committee was **244**. No target was set for 2023/24 due changes to the Key Performances Indicators that were changed by the NIHR post the COVID Pandemic.

This participation was across **22** different studies in Mental Health, Dementia and Neurodegenerative Diseases and Children clinical areas. This is an increase on the previous year's total of **161** participants (from 17 studies). The legacy of the COVID-19 pandemic has led to a reduction in recruitment and many other trusts around the country are still seeing lower recruitment in the same

way. The need to find new ways of working to avoid infection risks led to many studies being redesigned to work remotely, and this trend has continued beyond the Pandemic as it can prove more efficient and cost effective. However, it is hoped that this year's activity is an indication that the lasting impacts of COVID on research and development are diminishing.

In 2023/24, the Trust registered and approved **38** studies in the following clinical areas:

- **21** in Mental Health Services
- **3** in Medicines for Children
- **3** in Infectious Diseases (2 related to COVID-19)
- **3** in Workforce related topics
- **2** in Peri-Natal Mental Health
- **1** in Mental Health and Diabetes
- **1** in Dementias and Neurodegenerative Diseases
- **1** in Physiotherapy
- **1** in Diabetes
- **1** in Older People
- **1** in Health Services and Delivery Research

Although there is still a focus on mental health studies, the variety in other studies continues to reflect the growing opportunities for taking part in research. A growing proportion of these studies are being led by local teams and students.

The breakdown of study type included:

- **13** non-commercial portfolio studies
- **6** non-commercial, non-portfolio studies
- **17** academic/student projects
- **1** commercially sponsored study

Of the above studies 15 were evaluations of local services.

The increase in the number of studies approved in 23/24 indicates a general increase in activity especially in relation to local teams and services and we hope to continue to promote this in 24/25 to ensure trust staff are fully supported to undertake research.

More detail of the recruiting studies and the services from which they were recruited is shown in Table 1 below.

GHC Research

<u>Funding</u>

Budgets for 2024/25 have been announced and GHC will receive £261,686 compared to £251,553 for 2023/24. National budgets have not increased significantly, so local budget increases have also been low, with uplifts largely provided to offset some of the increase costs from annual pay awards/incremental increases.

In addition to this, for 2024/25 we are in receipt of £11,187 additional funding for a band 7 Pharmacist to support study delivery at the Fritchie Centre and £25,676 to support two Band 7 Physiotherapists (0.2 WTE each) to support the delivery of two portfolio studies.

We have also been allocated £55,247 to support the management of research in the community and primary care and will be working closely with the research leads in the ICB to finalise how this resource can be used most efficiently and effectively.

We are still waiting for confirmation of any Research Capability Funding allocated to GHC. If we qualify for this payment in 24/25, we would expect it to be around £20 to £25k

Sadly, the funding for the Research Doctor has come to an end and, due to some extended absence and lack of funding, the pilot project has also come to an end.

Research Network

From October 2024, the Local Clinical Research Network (LCRN) West of England will be known as the Southwest Central Research Delivery Network (RDN). While the work of the networks will not change significantly, their main aim still to be to promote and support the development of a wide range of health and social care research across the country, the size of the network will increase slightly.

The existing 15 LCRNs will become 12 RDNs and the Southwest Central RDN will incorporate the same area as the existing LCRN, but stretch south through Dorset to the south coast as see in Fig 1 below.

Fig 1 – New RDN Boundaries

Research Strategy

A new GHC Research and Innovation Strategy has been agreed by the trust and has been published on the Research Intranet pages HERE. One of the key themes of the strategy is collaboration, and

we will be working closely with the Research4Gloucestershire partners throughout 24/25 to set up systems and process that will support a truly collaborative, system0wide approach to research, development and innovation.

Research4Glouestershire is a consortium of research active organisations within Gloucestershire, including, GHC, Glos ICB, GHT, Uni of Gloucestershire, Social Care, General Practice. We will continue to review this membership and expand it as appropriate.

Table 1 - Studies Recruiting in Gloucestershire Health and Care NHS Foundation Trust – 2023/24				
Short Name	**Managing Specialty**	**Trust Type**	**Project Type**	**Recruitment**
Quantitative MRI in the NHS – Memory Clinics / QMIN-MC	Dementias and Neurodegeneration	Mental Health	Non-commercial portfolio	55
EMPOWER Digital Intervention eHealth RCT	Mental Health	Mental Health	Non-commercial portfolio	40
National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)	Mental Health	Mental Health	Non-commercial portfolio	25
PPiP2 - Prevalence of neuronal cell surface antibodies in patients with psychotic illness	Mental Health	Mental Health	Non-commercial portfolio	18
Understanding anger and aggression: A questionnaire study	Mental Health	Mental Health	Non-commercial portfolio	16
DIAMONDS - Improving diabetes self-management for people with severe mental illness	Mental Health	Mental Health	Non-commercial portfolio	12
Genetic Links to Anxiety and Depression (GLAD)	Mental Health	Mental Health	Non-commercial portfolio	12
Liaison and Diversion Services for Children: A Qualitative Study	Mental Health	Mental Health	Non-commercial portfolio	10
CAMH-Crisis2: Mental health crisis care for children and young peopleV1	Mental Health	Mental Health	Non-commercial portfolio	9
Thoughts about physical activity: questionnaire study	Mental Health	Mental Health	Non-commercial portfolio	7
integrating smoking cessation treatment into online psychological care	Mental Health	Mental Health	Non-commercial portfolio	7
STOP- Successful Treatment of Paranoia	Mental Health	Mental Health	Non-commercial portfolio	5
Trialling an optimised social groups intervention in services to enhance social connectedness and mental Health in vulnerable young people: A feasibility study	Mental Health	Mental Health	Non-commercial portfolio	4
Self-Harm in Eating Disorders	Mental Health	Mental Health	Non-commercial portfolio	4
A multicentre double-blind placebo-controlled randomised trial of SerTRaline for AnxieTy in adults with a diagnosis of Autism (STRATA)	Mental Health	Mental Health	Non-commercial portfolio	4
Stretching programme for ambulant children with cerebral palsy (SPELL)	Children	Mental Health	Non-commercial portfolio	3
OPTIMA RCT- Online Parent Training for The Initial Management of ADHD Referrals: A two-arm parallel randomised controlled trial of a digital parenting intervention implemented on a treatment waitlist.	Mental Health	Mental Health	Non-commercial portfolio	3
FReSH START RCT - Function REplacement in repeated Self-Harm: Standardising Therapeutic Assessment and the Related Therapy (WP4 - Randomised Controlled Trial)	Mental Health	Mental Health	Non-commercial portfolio	3
RCT of group CBT for men with IDD and harmful sexual behaviour	Mental Health	Mental Health	Non-commercial portfolio	2
ADEPP - Antidepressant for the prevention of DEPression following first episode Psychosis trial	Mental Health	Mental Health	Non-commercial portfolio	2
National Centre for Mental Health (NCMH)	Mental Health	Mental Health	Non-commercial portfolio	2
FASTBALL MCI - Fast-Periodic-Visual-Stimulation – a new technique for assessing memory in Alzheimer's disease	Dementias and Neurodegeneration	Mental Health	Non-commercial portfolio	1

Use of the Commissioning for Quality and Innovations (CQUIN) framework

A proportion of Gloucestershire Health and Care NHS Foundation Trust's income is typically informed by achieving quality improvement and innovation goals agreed between Gloucestershire Health and Care NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 23/24 we continued to progress a number of improvement and innovations and were able to make progress in the following areas:

Goal name	Applicable To
Staff Flu Vaccinations for frontline healthcare workers.	Community and Mental Health
Assessment Diagnosis and Treatment of Lower Leg Wounds	Community
Assessment and Documentation of Pressure Ulcer Risk	Community
Achieving 50% of adults and older adults accessing select Community Mental Health Services (CMHS's), having their outcomes measure recorded at least twice.	Mental Health
Routine outcome monitoring in CYP and community perinatal mental health services.	Mental Health
Reducing the need for restrictive practice in adult/older adult settings	Mental Health
Malnutrition Screening	Community

2024/25 CQUIN Goals

CQUIN Schemes nationally paused with the option to undertake locally agreed schemes.

Gloucestershire Health and Care Locally agreed CQUINS

Goal name	Applicable To
None negotiated for 24 -25	NA

Statements from the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care services in England. From April 2010, all NHS trusts have been legally required to register with the CQC. Registration is the licence to operate and to be registered. Providers must, by law, demonstrate compliance with the requirements of the CQC (Registration) Regulations 2009.

Gloucestershire Health and Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Good" overall. The following services make up our statement of purpose as an organisation and we are registered to undertake the following regulated activities:

- Assessment or medical treatment to persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Treatment of disease, disorder or injury.
- Personal care.
- Surgical procedures.
- Family planning services; and
- Termination of pregnancies.

Gloucestershire Health and Care NHS Foundation Trust has one condition on its registration.

Through our internal quality and governance monitoring we declared some quality issues to the CQC which resulted in an unannounced visit in October 2023 of our 'wards for people with learning disability and autism' – Berkeley House. This resulted in a change of rating from this service from 'Good' to 'Requires Improvement' The Trust was issued with a Section 31 notice which required us to take additional actions to improve the care delivery in this service. This has resulted in an intensive programme of work for the service and was supported by our system partners to improve the quality of care and to progress the discharge of the patients from the unit. Improvements have been made and the Trust are now applying to have the notice and restrictions on the registration of this service removed. The removal of the notice was supported by our system partners and commissioners.

During 23/24 the CQC undertook routine Mental Health Act (MHA) visits to a number of our inpatient's units. These visits by the CQC are to assess how we comply with the MHA Code of Practice which sets out clear guidance to our registered medical practitioners, approved clinicians, managers and staff of hospitals on the standards that we are expected to achieve to safeguard those people who use those services.

The CQC will ensure that we can evidence the guiding principles when applying the standards set out in the MHA and when we are making decisions to use the legislation.

There are five guiding principles that should be considered when making any decisions in relation to care, support or treatment provided under the Act:

- Least restrictive option and maximizing independence.
- Empowerment and involvement
- Respect and dignity.
- Purpose and effectiveness, and
- Efficiency and equity

The empowerment and involvement of patients and carers, and dignity and respect are key principles underpinning the MHA and we aim to ensure as an organisation we can evidence our approaches to our regulators.

The following wards were inspected in this account period:

Location	Date
Kindsholm Ward	13 April 2023
Dean Ward	4th April 2023
Montpellier Ward	5th July 2023
Chestnut Ward	21 February 2024

Overall, feedback has been very positive and although there are some areas that we need to improve upon the MHA Inspectors did not raise any immediate concerns in relation to how we apply the MHA. There are were some common themes across a number of our Mental Health inpatient wards and

these included some variation in the completion of T2 & T3's which are the legal forms that relate to prescribed medication and clarity of the information in the Section 17 form which outlines the conditions of how patients use time away from the units, described in the documentation as 'leave'. Where areas of improvement are required each service will complete and Provider Action Statement which outlines in detail the steps required to improve in the areas identified. These plans are monitored with the CQC relationship manager and form part of our routine internal governance arrangements to ensure we can evidence, reassure and assure on the work we need to complete.

During April and May 2022, the Trust underwent a CQC Core and Well-Led inspection which resulted in an overall rating of "GOOD". All actions from this inspection have now been finalised in the account reporting period and the Trusts Quality Team have undertaken a fidelity checking process to ensure that all actions have been embedded in clinical practice areas. Fidelity checking provides a critical evaluation of actions to identify which actions have been fully embedded into practice by providing evidence of any practice change and the impact they had on improving the standard that was identified for development by the CQC. Any actions that do not meet this standard of evaluation will remain open to the clinical area and will be supported by our Quality Team.

Charlton Lane Hospital (CLH) was subject of an independent inspection in March 2022. This was an unannounced inspection as we had informed the CQC of a quality issue. CLH rating was changed to 'requiring improvement 'as a result of this inspection. All actions relating to this inspection have now been completed and fidelity checking has also been carried out which has provided good assurance of adherence to the changes. The Trust has invited the CQC to review the rating noting these improvements.

In May 2023 the Sexual Assault Referral Centre (SARC) was inspected by the CQC. They visited both Hope House and Swindon SARC which is managed by First Light. The inspection found that there was a lack of assurance around the Well-Led aspect of the service and as a result a 'breach' was placed on this domain. First Light had recently partnered with the Trust to deliver this service, joining in October 2022 and we were in a period of transition which was being overseen by the Specialist Commissioning Team. We were in a period of merging our governance process and whilst good progress was being made to align our processes the CQC felt this could have been strengthened. Although a 'breach' in some areas of the Well Led domain were observed as a result of the inspection, the breach didn't trigger a change in the rating of the service as SARC services are evaluated under a different framework. The breach did not impact on the services ability to meet the needs of those requiring services of SARC. The service responded immediately and addressed the breached standards and a further inspection was planned for October 2023. The inspection was postponed by the CQC as the CQC were evaluating other services in the Trust at the time. The re-inspection date has not been set, however, the service remains ready to evidence the changes that were identified in the initial report.

We have a good working relationship with the CQC and we meet with our relationship manager on a regular basis. This includes an opportunity to share our wider developments and quality priorities to demonstrate our approach to continuous improvement.

The CQC have announced changes in the way they will regulate and inspect services as part of their Single Assessment Framework. The aim is to develop a more structured and consistent approach to regulation and have developed six categories where they will collect evidence to inform their rating of services. They will focus on the following areas:

- people's experiences
- feedback from staff and leaders
- observations of care
- feedback from partners
- processes
- outcomes of care.

Inspecting services will be based on an evaluation of risk rather than regular Core and Well-Led Trust wide inspections. Although this can result in a more dynamic inspection routine, there is a risk that some services might not be eligible for inspections for long periods. To cater for this, we continue to deliver an in-house assurance programme to ensure our services are meeting the standards of registration. We have carried out internal Peer Reviews on services that have not been inspected since 2016 and 2018 inspections. These teams were:

- Community Mental Health Recovery Teams
- Community Learning Disability Teams
- Community Later Life Teams
- Crisis Resolution and Home Treatment Team

There are also planned reviews for the first quarter of 2024 of a range of Child and Adolescent Mental Health Service. Outcomes of the visits are typically shared throughout the services to generate opportunities for learning, share good practice and prepare colleagues for external reviews.

The Trusts self-assessment programme has continued and all services scheduled to complete the assessment were completed over the past 12 months. This has not identified any significant quality issues during the last period. Noting the proposed change to the Single Assessment Framework, we have revised our assessment template to reflect the quality statements and approach to regulation and this standard will be applied to all future peer and self-assessment. We plan to start this development in the first quarter of 2024.

Data Quality

Reliable data underpins the effective provision of healthcare services both at a delivery and a management level. It is essential for maximising performance, informing service improvements and creating reliable insight to inform decision making. However, to be of use, data needs to be of high quality, timely, comprehensive, and accurately captured.

Gloucestershire Health and Care NHS Foundation Trust (GHC) submitted data to the following at the required quality maturity levels during 2023/24 (based on latest national position as of December 2023, month 9).

- The patient's valid NHS number was: **99%** for Emergency Care (ECDS); **100**% for Community Services (CSDS), **100%** for Mental Health Services (MHSDS) and **100%** for Improving Access to Psychological Therapies (IAPT). The National data score average for NHS Number was 81.3%.

- The patient's valid General Medical Practice Code (Patient Registration) was: **99%** for Emergency Care (ECDS); **100**% for Community Services (CSDS), **100%** for Mental Health Services (MHSDS) and **100%** Improving Access to Psychological Therapies (IAPT). The National data score average for General Medical Practice Code was 86.1%.

The Data Quality Maturity Index (DQMI) Rates for GHC at the end of 2023 were: MHSDS 96.7%, IAPT 99.7%, CSDS 85.4%, and ECDS 74.2%.

Furthermore, the Trust has achieved the following key improvements during 2023/24 to support our wider business planning objectives:

- Formulation of a Clinical and Corporate Record Quality Working Group with further development of data quality reporting, and Board level DQMI monitoring.

- Developed BI business partnering structure to improve relations and support to operational directorate management and their services.
- Integrated corporate and clinical service level reporting for MH, LD and PH services/ teams.
- Implemented Clinical Supervision monitoring, Community Assessment & Treatment Unit (CATU) reporting, Service experience monitoring, Risk and Incident reporting and Commissioner reporting.
- New data flows for Gloucestershire Integrated Care Board (ICB), Gloucestershire County Council (for Adult Social Care), Patient Level Costing and Information System (PLICS) and for Appraisals.
- Further improvements within equality integration within existing and new reporting tools.
- Completely overhauled domain layout within the corporate Performance Dashboard to improve clarity on internal (ICS Agreed, Specialised and Nationally contracted) and internal (Board focus and Operational) indicators.

Information Governance

Gloucestershire Health and Care NHS Foundation Trust's (GHC) 2022 to 2023 Data Security and Protection Toolkit (DSPT) submission was an overall score of Standards Exceeded and was graded as green. GHC is fully expecting to submit a similarly complaint return in June 2024 for the 23/24-year DSPT submission.

Clinical Coding

Gloucestershire Health and Care NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2023/2024 by the Audit Commission.

Learning from Deaths

During 2023-2024, 693 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died.

This comprised the following number of deaths, which occurred in each quarter of that reporting period:
201 in the first quarter;
205 in the second quarter;
164 in the third quarter;
123 in the fourth quarter.

By 2 April 2024, 61 case record reviews and 17 investigations had been carried out in relation to the 693 deaths included above.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:
21 in the first quarter;
21 in the second quarter;
15 in the third quarter;
21 in the fourth quarter.

0, representing 0.0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

0 representing 0% in the first quarter;

0 representing 0% in the second quarter;
0 representing 0% in the third quarter;
0 representing 0% in the fourth quarter;

These numbers have been estimated using Structured Judgement Review (SJR). For deaths of:

- Mental health patients; the Royal College of Psychiatrists (RCPsych) Mortality Review Tool 2019 is employed;
- Learning disability (LD) patients; a similar Trust-developed SJR tool is 21rganiza which pre-dates the RCPsych tool. This approach has been maintained to allow consistency with the Learning Disability Mortality (death) Review (LeDeR) programme;
- Physical health patients; a range of questions based on SJR tools is being used to assess the standard of care provided to patients that die during an inpatient stay at a community hospital.
- The numbers above do not include open investigations and reviews.

Case record reviews are discussed at Mortality Review Group (MRG) meetings chaired by a Clinical Director and Quality Lead (Mortality, Engagement and Development).

For any deaths meeting Serious Incident or Clinical Incident criteria, a full Comprehensive Investigation was carried out, including Root Cause Analysis.

Learning

The Trust has identified the following learning points in relation to deaths reported in 2023-2024:

Mental Health & Learning Disability Services

- New employees at Charlton Lane Hospital should attend End of Life Masterclass Training to ensure that they are aware of how to access End of Life resources. This is now included in local induction and details of how to access information relating to the syringe driver, the Rapid Response Team and contact details for the Trust's End of Life Lead.

- Where a patient on a community team caseload has a range of significant physical health services comorbidities, the Complex Care at Home Team can provide support on referral for those with one of more of the following – Complex long-term conditions,
  medication management issues Inc. polypharmacy, dementia diagnosis or suspected resulting in worsening physical health conditions, loneliness, bereavement, health related anxiety affecting their ability to self-manage their health and regular hospital admission or at risk of inappropriate unnecessary hospital admission.

- Patients with advanced dementia are at increased risk of falling.

- The multidisciplinary clinical team can consider that transfer to the Emergency Department of a patient for head injury is not in an incapacitious patient's best interests, including in severe frailty or palliative care. This will be a best interests decision made by the multidisciplinary team in consultation with the patient's family.

- Staff must be familiar with the Falls Policy, in particular managing patients with a head injury in line with NICE guidance.

- Antipsychotics (particularly clozapine) have been associated with an increased incidence of pneumonia. Pneumonia is reported as a rare side effect with clozapine (1/1000 to 1/10,000

patients). Pneumonia is associated with inflammation which can potentially increase plasma clozapine levels. An increase in clozapine levels may give rise to an increase in side effects. Aspiration pneumonia can also occur because of hypersalivation with clozapine.

- Mental Capacity Act (MCA) assessments (MCA 2005 s2 and s3) should be clearly documented. The Best Interests checklist (MCA 2005 s4) should be considered for best interest's decisions.

- If informed of the death of a community patient by a 3rd party, await verification of death via the 'status' on RiO (Records system for mental health and learning disability services) before removing a patient from a caseload. A black circle on RiO indicates that the death has been informally recorded either by the Health Records Team or the National Spine, but a death certificate has not been processed. A black diamond on RiO indicates that the death has been formally confirmed by receipt of a death certificate.

Community Hospitals

- Take timely advice from palliative care if refractory symptoms, including constipation, delirium are present.

- Help the helpers – support staff supporting patients with potentially traumatic events.

- To reduce the risk of medication errors, staff must be aware of human factors and ward pressures.

- Read & check prescription charts. Verbalize thought processes while preparing the drug. "This is…". Don't assume the other understands the rational as to why it's being given.

- Palliative Care Service can be contacted 24/ 7 for advice and support if symptom relief is difficult to manage.

- Verbal orders for medication can now be taken over the phone, as per POPAM section 2.1.11 (local Trust Policy) and this guidance has been shared with medical staff.

- Staff must ensure that they are acting lawfully and be familiar with the Mental Capacity Act Code of Practice, and Standard Operating Procedure for Deprivation of Liberty Safeguards. All documentation must be thoroughly completed.

- MCA assessments (MCA 2005 s2 and s3) should be clearly documented. The Best Interests checklist (MCA 2005 s4) should be considered for best interest decisions.

- Each team should appoint a colleague to become an MCA Champion and staff are able improve their knowledge of MCA by attending the weekly online drop-in sessions and discussing cases.

- Ensure monitoring of patients' bowels regularly and review on a daily ward round ensuring patients are prescribed appropriate laxatives. These can be administered covertly if Best Interest guidance is appropriately followed and documented.

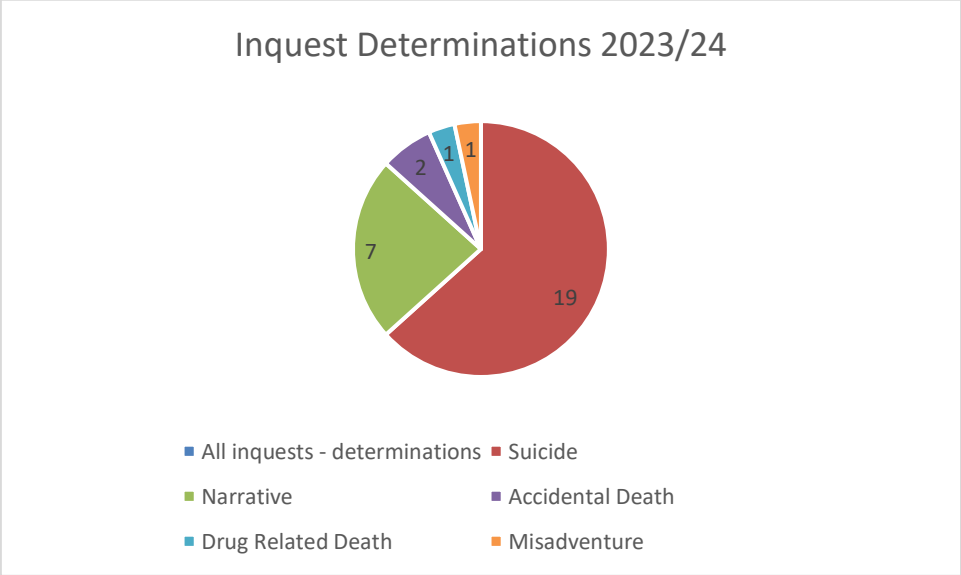
- For patients with identified faecal loading plan, prescribe and administer a suitable bowel management regime.

- Be mindful that if patients with cancer are having abdominal symptoms it is important to check calcium levels as they could be suffering from bone metastases causing hypercalcemia.

- Ensure there are several family members contact numbers on the shared care and electronic patient record. Check awareness that the Next of Kin (NOK) is fully understanding the conversations from the teams. Be aware of the potential need to include the other family members as a support for the NOK and be mindful of the post death bereavement process and who will be supporting the NOK.

Coronial Activity

During the reporting period, 30 inquests were heard (not all these deaths occurred during the reporting period) which touched on the deaths of Trust patients. The outcomes of these inquests are shown in the graph below. Based on the outcomes of inquests *suicide prevention* remains a key priority for the Trust.



Two Prevention of Future Deaths Reports were issued to the Trust during 2023/24. Actions taken in response to these to promote learning include:

- Ensuring that referrals to out of county services are followed up via a confirmed email immediately following contact being made (including a copy of the assessment, an outcome of referral made and agreed timeframe for that contact).

- Provision of a simulated choking scenario as part of the Level 3 Resuscitation Training.

- Improved processes for documenting follow up to medical emergencies and any associated risks, and signposting colleagues in emergency services to the exact required location when they arrive on site.

Medical Examiner

The Medical Examiner (ME) service in Gloucestershire provides independent scrutiny of deaths which are not subject to inquest, and an opportunity for the bereaved to raise concerns to a doctor not involved in the care of the deceased person. During 2023/24 all-natural cause deaths occurring in community hospitals and at Charlton Lane Hospital were reviewed by the Medical Examiner service.

Feedback from the Medical Examiner service continues to provide significant assurance that that the care provided to inpatients at the time of their death was of a good standard, that families were appreciative of the ME service input and were happy with the cause of death given, and gladly gave feedback about care when asked. Examples of feedback from families given the ME service about the care provided is shown below.

'Absolutely amazing care by all staff, nurses so gentle and kind'.

'Care was absolutely perfect; staff were so good with my husband and myself too.'

'The empathy care and dignity were incredible. Family blown away by the care'.

'Everyone from kitchen staff to medical team were wonderful.'

'Could not fault the care, staff so busy but fantastic.'

'Cannot thank enough – all staff put their heart into their job'.

'Wonderful care from beginning to end. Superb and respectful'

No complaints or concerns were raised by families to the ME service.

Actions Taken

For all deaths which are investigated as either serious incident or clinician incidents, bespoke action plans are developed. These are progressed by the Patient Safety Team in collaboration with operational staff and identified action owners. Key aspects of these are further explored through the Trust's evolving Embedding Learning process, jointly facilitated by the Patient Safety Team and the Freedom to Speak Up Guardian.

Where there is novel learning following Structured Judgement Reviews at the Mortality Review Groups, *learning on a Page* documents are produced to reflect the learning from individual cases in a succinct and accessible format. These are disseminated throughout the organisation via the operational governance structures and are also presented in the quarterly Learning from Deaths reports. An additional step towards effective dissemination of learning has been the provision of Patient Safety Notice Boards as a measurable step. These provide a large display area for monthly updates and learning points in areas relevant to the clinical setting, including learning summaries from serious and clinical incidents, and mortality reviews.

Findings relating to the local demographic data for community mental health patients (age vs. deprivation) continue to show the correlation between reduced deprivation and living longer and this information is fed into the community mental health team transformation workstream.

Impact of Actions Taken

During 2023-2024, the Trust participated in the National Audit of Care at End of Life (NACEL) Pilot, feedback will inform the development of the tools for the forthcoming year. Assurance regarding provision of End-of-Life care from the revised audit process will therefore be ascertained in the 2024-25 audit cycle.

The CQC inspection carried out in April and May 2022 reviewed community End of Life care and provided the following rating in August 2022. As there has been no further CQC inspection of this area during the reporting period, the rating below remains in effect.

	Safe	Effective	Caring	Responsive	Well-led	
Community end of life care	Good	Good	Outstanding	Good	Good	Good

Previous Reporting Period

By 2 April 2024, 16 case record reviews and 11 investigations completed after 31st March 2023 related to deaths which took place before the start of the reporting period.

1, representing 0.20% of these patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using Structured Judgement Review (SJR). For deaths of:

- Mental health patients; the Royal College of Psychiatrists (RCPsych) Mortality Review Tool 2019 is employed;
- Learning disability (LD) patients; a similar Trust-developed SJR tool is 25rganiza which pre-dates the RCPsych tool. This approach has been maintained to allow consistency with the Learning Disability Mortality (death) Review (LeDeR) programme;
- Physical health patients; a range of questions based on SJR tools is being used to assess the standard of care provided to patients that die during an inpatient stay at a community hospital.

For any deaths meeting Serious Incident or Clinical Incident criteria, a full Comprehensive Investigation was carried out, including Root Cause Analysis.

2, representing 0.40% of the total patient deaths during the period 1 April 2022 – 31 March 2023 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 2.3: Mandated core indicators 2023 – 24

There are several mandated Quality Indicators which organisations providing mental health services are required to report on, and these are detailed below. The comparisons with the national average and both the lowest and highest performing trusts are benchmarked against other mental health service providers.

1. **The percentage of patients aged 0-15years and 16 years and over readmitted to hospital which forms part of the Trust, within 28 days of being discharged from a hospital which forms part of the trust, during the reporting period**

	Quarter 1 2023-24	Quarter 2 2023-24	Quarter 3 2023-24	Quarter 4 2023-24
Gloucestershire Health and Care NHS Foundation Trust 0-15	0%	0%	0%	0%
Gloucestershire Health &Care NHS Foundation Trust16 +	2.76%	3.10%	3.03%	6.72%

Gloucestershire Health and Care NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust does not have child and adolescent inpatient beds.
- Service users with serious mental illness are readmitted to hospital to maximise their safety and promote recovery.
- Service users on Community Treatment Orders (CTOs) can be recalled to hospital if there is deterioration in their presentation.

Gloucestershire Health and Care NHS Foundation Trust has taken the following action to improve this percentage, and so the quality of its services, by:

- Continuing to promote a recovery model for people in contact with services;
- Supporting people at home wherever possible by the Crisis Resolution and Home Treatment Teams.

2. The percentage of staff employed by, or under contract to, the Trust during the reporting period who responded positively to "*If a friend or relative needed treatment I would be happy with the standard of care provided by the Organisation*"

	NHS Staff Survey 2021	NHS Staff Survey 2022	NHS Staff Survey 2023
G H C NHS Foundation Trust	78.6%	72.9%	76.62%
National Average Score	64.9%	62.9% (all NHS trusts) 63.6% (MH, LD, Comm trusts)	64.97% (all NHS trusts) 65.18% (MH, LD, Comm trusts)
Worst Trust Score	45.0%	40.1% (MH, LD, Comm trusts	43.64% (MH, LD, Comm trusts)
Best Trust Score	82.4%	79.6% (MH, LD, Comm trusts	80.42% (MH, LD, Comm trusts)

- The GHC Trust score is less than the previous year, however we remain in the top quartile and well above the national average score which has remained as last year.

Part 3: Looking back: a review of quality during 2022/23

Introduction

Quality Priorities 2023-2025:

In support of our overarching quality ambitions our physical, mental health, learning disability, children's and specialist services undertook the following quality improvement priorities which have been agreed with commissioning bodies and were reported upon at the end of H2. This is to facilitate an ongoing focus on quality for the organisation in order to improve care for the people we seek to serve in Gloucestershire. The priorities are underpinned by the mandate set out in the Quality Strategy and reflect our 3 Pillars of Quality in terms of Effectiveness, Safety and user Experience. This is a 2-year work programme and a definitive rating of success will be issued at the end of Q8.

During the year there has been a tremendous amount of work undertaken in relation to the Quality Priority workstreams with all involved being highly engaged and motivated to demonstrate progress in their areas of practice. A summary of Trust wide progress was presented to the Quality Committee in January and also to Governors at their in March meeting where the reporting timetable for the Quality Account was agreed. This gives Governors and colleagues the opportunity to contribute and shape the priorities workplans for the coming year.

There have been no barriers to completion identified and feedback received has demonstrated that "having the ability to flex the workstreams to make amendments and alterations where required is beneficial as there have been instances where the original work plans have required amendment after the testing cycles" and or the addition of further additional national directives.

SAFE	QUALITY PRIORITIES 2023-2025			
Standard	**Tissue Viability (TVN) - with a focus on the recognition, reporting and clinical management of chronic wounds using quality improvement methodology and educational resources**			
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	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plans	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	Contact companies approved by	Invite community-based clinicians & TVN	Identify a community nurse	Identify if funding is available to

implementation of a wound care app.	NWC strategy and identify the ap most suited to community care	colleagues to review the ap & comment on its application to supporting patient care	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 "	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

Work Stream plan	**Present Position H2**
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.0. 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.

SAFE	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	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plan	Q1	Q2	Q3	Q4
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	Gather baseline training data providing a breakdown across services / teams. Identify training audience and agree training thresholds	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)	Q3 data to be reported to the ICS Dementia Training and Education Strategy Network.
Gloucestershire 5 Step approach. Progress across Community Hospitals.	Scoping	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	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	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.
Patient /Carer Experience To establish and evaluate any themes	Scoping		To meet with Patient Experience Team in order to	Share learning

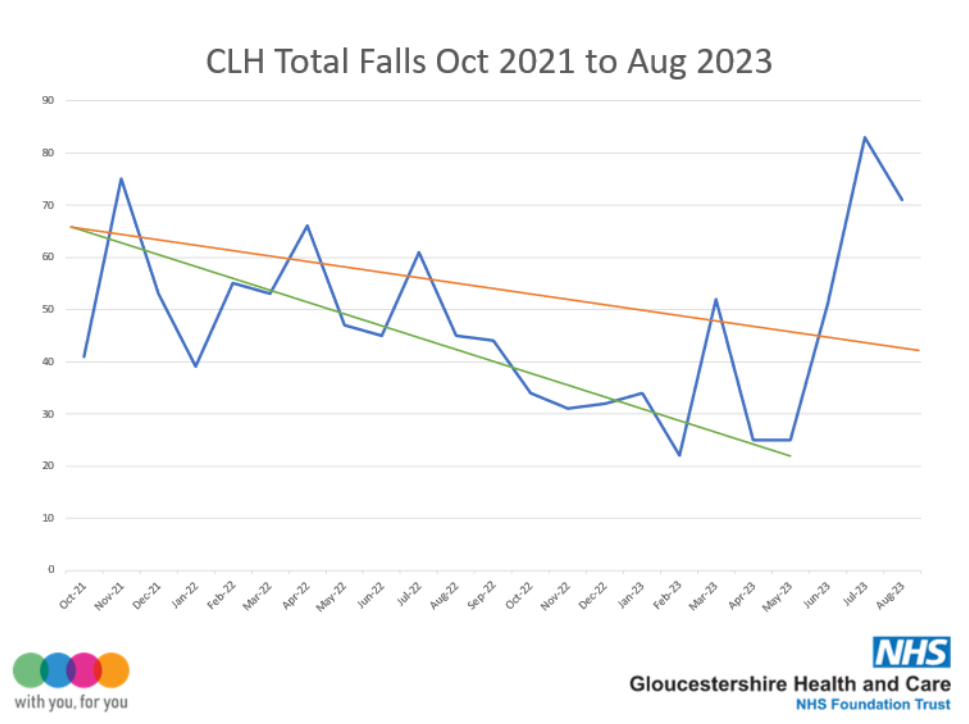
and trends relating to dementia arising from complaints and compliments received via the Patient Experience Team and to ensure learning from these events is shared throughout the organisation.			identify themes and trends from compliments and complaints and begin evaluation. Complete evaluation and report on these findings via Improving Care Group, evaluate how these can feed into workstreams.	
System working with GP practices Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification.	Scoping	Evaluate ARRS team training needs. Develop education session alongside EBE.	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	Develop GP session – (video resource – Webinar)?
Communication Develop comms plan with a profile of workstream to be on current agendas and team meetings.	Scoping			Update Complete comms and add to Bitesize
Work Stream Plan	**Present Position H2**			
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	ICS Dementia Training and Education Quarterly report just under development and will be presented at the next network meeting (2nd May) Building up team of Dementia Link Workers and Dementia Leads on Willow Ward. Charge Nurse on Willow Ward completing her Dementia Care Mapping (DCM) course to support Trust wide DCM plans SSK presenting at GHLL conference in June, to encourage more PHSE teachers to use the dementia resources across the county in schools No current significant increase in GHC colleagues completing Tier 1, 2 or 3 training.			
Gloucestershire 5 Step approach.	This online resource is available on the GCC website. Colleagues across the ICS are directed there to complete. Currently seeking feedback from ICS on the session and how effective this is for colleagues			

Progress across Community Hospitals.	Increase in staff completing Tier 2 and Tier 3 dementia training Currently reviewing the PLACE assessment for the dementia and disability domain and overall % has decreased this year First DCM session took place at Cirencester Community Hospital (5th April) and report currently underway (overall positive).
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.	16 concerns raised to the Trust relating to a person living with dementia between April 2020 – September 2023 have been reviewed. I do not feel this is a true reflection as this was during the Pandemic and some of the concerns raised relate to families not being able to see their relative in hospital and also appointments being cancelled due change in service deliver during that period. Some of the overarching themes relate to poor communication and daily in assessment / input.
System working with GP practices Targeted work within GP practice staff to include ARRS roles around early onset dementia and identification.	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. Gloucestershire Dementia Strategy should be published in January / February 2024. Session for MH ARRS worked booked for quarter 2, particularly around young Onset Dementia. Education session developed and arranged for 15th May (during Dementia Action Week) for primary care facing staff. Targeted comms going out through ICB on Dementia Diagnosis Rate and highlighting need for this to be improved and how we can help.
Communication Develop Comms plan with a profile of workstream to be on current agendas and team meetings.	Ongoing reminders / promotion of dementia training that is available to colleagues across the trust. Dementia Action Week takes place on 13th - 18th May – this year's theme is 'reducing your risk' and we would welcome guests at any of the events that we have planned. **ICS Dementia Action Week, 13th – 19th May - Plans for the week:** **Theme for the week –** Reducing your risk of getting dementia

SAFE	QUALITY PRIORITIES 2023-2025			
Standard	**3 Falls prevention with a focus on reduction in medium to high harm falls.**			
Performance	**Target** – an overall reduction in the number of medium and high harm falls within inpatient units.			
Commentary	• The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion. 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.			
Work Stream Plans	Q1	Q2	Q3	Q4
Community falls - Establish a baseline for falls at home to measure improvements made.	Scoping	Data gathering and process map to be produced.	Review data and depending on results, decide how and if these falls can be reduced.	

Inpatient falls - To produce a countywide Falls Reduction Action Plan for Inpatient Units	Scoping – Decision made to trial at CLH	Roll out Falls reduction plan at CLH	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%	Evaluation and plan of roll out Audit number of falls within inpatient units since introduction of action plan Audit number of staff who have attended Falls awareness training
Falls Policy Revise and refresh policy to meet NICE standards for both Community and Inpatient	Scoping	Draft policy to be produced and circulated to Trust Falls group for comment.	New Trust wide Policy to be ratified by GHC Policy Group. Undertake Roll out Trust wide and implement changes.	Audit compliance with revised policy.
Trust wide Inpatient falls leaflet to be produced.	Scoping	Draft version to be produced and circulated within Falls Group	New Falls Prevention Leaflet to be agreed and circulated to Inpatients Trust wide	Ask for staff/patient feedback on Leaflet, make changes if needed.

Work Stream Plan	**Present Position H2**
Community falls - Establish a baseline for falls at home to measure improvements made.	There were Issues found with data collection regarding 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. This prompted a change in approach and links were made with the Falls Assessment Education Service who provide a "Strong and Steady Service" to evaluate any alternative courses of action and the availability/coverage of the service. Leaflets have been produced and are available to 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
Inpatient falls - To produce a countywide Falls Reduction Action Plan for Inpatient Units.	Successful trial undertaken at CLH with data/presentation available to demonstrate that there were lower numbers of injurious falls evidenced post initiative. On the graph below the data Green Line demonstrates a significant reduction in falls from the initiation of the Falls Action Plan and various service changes between October 2021 and May 2023, the Orange Line demonstrates current trend as a result of increases in falls since May 2023. Although there is a sharp increase in the number of falls since June 2023, when we drill down into the data we can see that: - There continues to be a reduction in injurious falls despite increase in total falls

	-Early data showed multiple patients were falling across all wards -Data shows fewer people are falling, however outliers are pushing the number up -E.g. in July 3 patients made up 71% of falls -Within out review process we focus interventions and changes around these key patients/areas. -In August these 3 patients saw a 71% decrease in their falls, however, other service users were admitted with significant risks increasing the numbers. 
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 now available to inpatient units.

SAFE	QUALITY PRIORITIES 2023-2025
Standard	**End of Life Care (EoLC) – with a focus on patient centered decisions, 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 the identification of additional resource where required.			
Commentary	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plan	Q1	Q2	Q3	Q4
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.	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	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)	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)	Evidence 90% or better attendance at Essential to Role Masterclass sessions Number and or % 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)
Work Stream plan	**Present Position H2**			
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.	H2 – Q4 NACEL Audit 2024 commenced, 20 case notes audited, results due July. H1 - NACEL 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. H2 – Community EoL Audit results poor (53% overall) due to poor documentation. Action Plan with short, medium and long-term plans developed with community nurses. Immediate issue is to improve documentation, and to support, first assessment visits will now be 2 hours. H1 - Community Nursing Care at EoL Audit in October is being analysed currently. 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?" H2 – 24 surveys returned, 18 (75%) responded "As involved as I needed or wanted to be (only 4% wanted to be involved more). H1 – 19 surveys returned, 18 (95%) responded "As involved as I needed or wanted to be" Complaints raised. H2 – 0 complaints. 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. Datix reported. H2 – 107 Datix (excl. falls and skin integrity) Work in Q3 successfully reduced the number of CHC fast-track applications that were declined. SCP review has been moved to 2024/25. 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 and RIO n H2 to better capture personalised care at end of life
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.	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.
To maximise training availability, and ensure the identification of additional resource where required.	30 spaces are available at Masterclass (with the exception of Having Difficult Conversations which is face to face and 15 max). H2 – Q3 – 39% and Q4 – 50% of available Masterclass spaces were taken up. Overall H2 – 45% take-up of Masterclasses. H1 - Q1 – 69% and Q2 – 58% of available Masterclass spaces were taken up. Overall H1 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, Q3 – 70 staff trained, Q4 – 104 staff trained). We are increasing the number of places that can be overbooked for the next run of Masterclasses. Need identified for Difficult Conversations at End-of-Life training for call handlers/ward clerks in hospitals, ICT Referral Centres etc. H2 -2 sessions in October (20 attendees). H1 - 1 session in September (17 attendees). Training aimed at HCA's has been rolled out to Training and Development sisters at Community Hospitals, Charlton Lane Hospital and Professional Leads in ICTs for them to train HCA's in their hospitals/localities. H2 – 55 attendees. H1 - 47 attendees. 2 face to face Masterclasses regarding Dementia in EOL care have been arranged to encourage attendance in addition to 2 MS teams sessions

SAFE	QUALITY PRIORITIES 2023-2025
Standard	**Increasing the visibility of the Friends and Family Test (FFT) feedback to staff and patients and their families.** **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	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plan	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)

Work Stream Plan	**Present Position H2**
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 have been installed in three services in Q4. An evaluation of their success will be undertaken in 6 months' time in the way of feedback analysis.
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. Action: reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet Q4 Update: Website – reviewed to make it simpler and include what people can expect when they call. External links to VCSE providers added.

	Leaflet – reviewed to make it simple and clearer and changed some of the language. Q4 report on progress to Board. **Talking Therapies:** ensuring talking therapies is explained in an understandable way and service users are involved in decision making. Action: reviewing patient information regarding access to the service through a review of the Service specific website and patient information leaflet Q4 Update: Website – reviewed and updated to reflect the feedback provided by the survey group the Leaflet has been reviewed and alterations made in the way in which the service was explained, including a more comprehensive description of what it has to offer.
Next steps:	To share initial findings of 2023 survey in Q4. limited information provided to board in Q4, as results under embargo until 18 April 2024

SAFE	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. Progress will be measured through the implementation of 4 key elements			
Commentary	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plan	Q1	Q2	Q3	Q4
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
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%
Reduce Blanket Restrictions		Agree template for identifying restrictions	Pilot draft template on identified ward.	Evaluate Pilot and agree process for spread.
Develop Post Restraint Debrief Process		Map out current practice	Establish potential options and framework for debrief	Pilot draft model on identified ward

Work Stream plan	Present Position H2
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 were due 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). This, however, was not able to be progressed as the ward needed to focus on embedding the Self Harm Pathway. During Q1 2024/25 the team will consider the overlap between embedding the Self Harm Pathway and restraint reduction and establish if these can complement each other from a safety and quality perspective. Greyfriars PICU identified as next ward to engage with the project and 'set up' meeting held on 15/01/2024. Blanket restriction template confirmed as fit for purpose during Q4 2023/24 so will be utilised by Greyfriars throughout 2024/25.
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, more detailed development was required to actively progress phase 2 of the KPI portfolio development process. This did not occur during Q4 and BI are not progressing. Interrogation of the Datix System (post LFPSE configuration) did establish compliance data relating to mandatory data fields as follows: • 2443 restrictive intervention incidents 2023/24 took place in MH/LD units (including S136 suite). • MHS505 data was not fully completed on 685 of 2443 incidents, giving us a compliance percentage of **71.96%** The primary reason for non-compliance with MHS505 is failure to record whether post incident reviews took place (not recorded on 661 of 685 records where data for MHS505 not fully completed) • MHS515 data was not fully completed on 573 of 2443 incidents, giving us a compliance percentage of **76.54%** The primary reason for non-compliance with MHS515 was onset and offset times not being completed (not recorded on 535 of 573 records where data for MHS515 not fully completed) These aspects of non-compliance will be a priority during 2024/25.
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 was evaluated during Q4 and the form was approved as being fit for purpose. Greyfriars PICU will focus on reduction of blanket restrictions as their restraint reduction project during 2024/25. Other wards will commence establishing a log of blanket restrictions in place.
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). A

	Standard Operating Procedure remains in the process of development ahead of being piloted. It is envisaged that this will be ready to trial by Q2 2024/25.

SAFE	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	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion. The National Confidential Inquiry into Suicide & Safety in Mental Health (NCISH) identifies 10 key elements for safer care of patients.  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.			
Work Stream Plans	Q1	Q2	Q3	Q4
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.
Work Stream plan	**Present Position H2**			

Implementation of the NCISH self-audit Toolkit for mental health services.	Self-assessment against the 10 key elements of the suicide prevention toolkit was completed during 2023/24. GHC has the majority of systems and processes in place and the recommended operational configuration. The areas for focus in 2024/25 include staff turnover, family involvement in learning lessons, and multi-agency working by CAMHS health and social care, specialist drug and alcohol services and services for self-harm. 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.

SAFE	QUALITY PRIORITIES 2023-2025			
Standard	**Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* 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	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plans	Q1	Q2	Q3	Q4
Develop training matrix to identify the baseline no of staff who require a consistent approach to training.	Scoping	Establish and report upon the identified staff numbers who require training at team level. Develop training plan		
Develop a bespoke Trauma Informed Positive Behaviour Support Training Pack (TIPBSTP) to form core foundation of the delivery of this programme.	Scoping	Collaboratively produce training pack.	Training pack to be available	
Deliver Trauma Informed Positive Behaviour Support Training to ALL staff working in learning disability services			Pilot training pack	Commence delivery of training
Work Stream plan	**Present Position H2**			

Matrix and Training Pack/day	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. We have run one training session and now have dates booked until March 2025 this includes over 50 staff from both community and inpatient settings, 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. Work is currently ongoing regarding the identification / development of an evaluation tool to monitor the impact this training will hopefully have on practice.

SAFE	QUALITY PRIORITIES 2023-2025			
Standard	**Learning disabilities – with a focus on developing a consistent approach to training and delivering *trauma informed* 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. 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 its impact.**			
Commentary	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plan	Q1	Q2	Q3	Q4
Tier One of The Oliver McGowan Mandatory Training package co-designed by GHC, Inclusion Gloucestershire and Family Partnership	Re-commence delivery of T1 webinars ICB to lead on training needs analysis	ICB to lead on developing work plan for rollout of the training Review T2 materials and	Pilot T2 locally T1 webinars available	T1 webinars and T2 training available across the Trust & ICB

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.		train trainers for T2. T1 webinars available		
Develop measures to assess impact of training		Report upon levels of training achieved H2	Collaboratively Identify and document measures to assess direct and indirect outcomes from training that can be shared.	Establish and report upon the effectiveness of Oliver McGowan Mandatory Training.
Work Stream plan	**Present Position H2**			
Tier One Training	Tier 1 Webinars, facilitated by Inclusion Gloucestershire (IG), are now available to staff across Gloucestershire for staff working in both health and social care. The capacity of IG to deliver training is restricted by the number of Experts with Lived Experience available to help co-deliver the Webinars, but IG continues to recruit and train people so numbers are increasing. They have also recruited a Training Co-Ordinator who is overseeing this training which is helping to improve the booking procedures. There are currently 8 webinars being delivered each month, with 30 places available on each course, although there are often a number of people who do not attend the training. Work is still underway to assess the total number of staff across the ICS who need training for Tier 1 and to ensure all organisations have fair access to the finite number of places available.			
Roll Out	GHC has trained nine facilitating trainers (mostly staff from within GHC learning disability services) as well as appointing a half-time, fixed term trainer dedicated to Tier 2 delivery. Tier 2 training sessions started in March 2024 and dates are currently planned through to August 2024. There are currently two Tier 2 training days being offer each month although the hope is to be able to increase this to one every month, when possible. We are still awaiting guidance from the national steering group with regard to how the training will be evaluated at a national level. However, we are conducting local evaluation and the feedback has been encouraging. Positives include : Informative and engaging content: Personal experiences and interactive sessions appreciated: Knowledgeable and well-delivered by facilitators. Areas for Improvement: Length and repetition led to loss of concentration for some: Need for more tailored content based on prior			

	experience: More interactive activities, especially in the afternoon: Examples more relevant across different settings. Here's just one quote: "I really like this training because it's not just theory we get videos in between and group discussions. It's really nice."

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	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion.			
Work Stream Plans	Q1	Q2	Q3	Q4
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	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 CST to build recording capability within the clinical systems.	Work with BI to ensure data flows through the data warehouse and performanc e reports and dashboards can be developed.	To have robust reporting capability that demonstrates activity, demand and compliance against statutory EHCP timeframes.
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	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.	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 and Training Team to develop EHCP Contents Awareness Training that is informed by the outcome of the audits.	To have a SEND Training Assurance Framework ratified by CYPS Governance forums by April 2024

Disabled Children SEND Basic Awareness E-Learning Level 1 and Level 2.				
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	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 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.	SEND Leads to join Future Me Glos forums to work alongside young people.	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
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	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.	All CYPS PH services to be using the EHCP portal by the end of Q1.	CAMHS and LD Services to prepare to use the EHCP portal – set up, training sessions and testing.	For all CYPS Services will be using the EHCP portal
Work Stream plan	**Present Position H2**			
Digital Reporting Q4 System Update	<u>Visibility of SEND:</u> • EHCP High Priority Reminders are now being added to SystmOne for all children and young people with a new confirmed EHCP. The SOP for this has been agreed at governance forums. **Next steps:** Review reporting for new process. Once reporting has been quality			

	assured, work will commence to share the SOP with all CYPS staff so EHCP reminders can be added to all records of CYPs with an EHCP. This will inform demand and capacity planning, evaluation of referral trends and distribution of SEND across the services. • The Health Visitors continue to use the Purple Square icon for children with SEN. This is reportable and is shared with GCC. This figure informs resource planning in early years. • There are no options for these to be used on RiO. **Next steps**: The CAMHS/ LD SEND Lead will pick up discussion with Clinical Systems about options available on this system. <u>SEND Performance:</u> • SEND activity on SystmOne and on RiO cannot be reported upon within specialist services because it is included in holistic delivery and not able to be differentiated. • There is no way of reporting via the clinical systems whether EHCP assessments are completed and returned within statutory timeframes. **Next Steps:** The EHCP Portal is now in use across all agencies and it is hoped that this will provide rich data around assessment timelines. It is noted, however, that there are still issues with this platform and it is not yet fit for purpose. • New SEND Advisor roles are being established in the School Nursing Service. They will provide assessment and recommendations for CYPs not known to specialist health services as part of the EHCP assessment process. **Next Steps:** When this service is operational, there will be record and reporting for SEND assessment timeliness, as well as activity. <u>SEND Demand:</u> • EHCP demand is captured manually across CYPS and provides an indication of demand trends. • Tribunal demand is provided by the GHC legal team – there has been a significant increase in EHCP tribunals over the last 2 years. This reflects the national picture. RAG at end of Yr. 1 - Amber - some elements have progressed, but further development is required across all areas to provide a satisfactory position.
<u>Training</u> Q4 Update	<u>GHC SEND Training:</u> • SEND Basic Awareness Training Level 1 - 62% compliance across CYPS. • SEND Basic Awareness Training Level 2 - 77% compliance across CYPS. It is worth noting that is ongoing data quality issues with the compliance reporting, with many staff groups reporting completion of the training, but this is not pulling through on the reporting system. The training team continue to support with reporting as CYPS strive towards improved compliance across the directorate. **Next Steps:** Establish reporting for adult services supporting young adults with SEND, including CLDT. • SEND Leads in GHC attend external training provided by the wider system, Council for Disabled Children and SEND Networks. <u>GHC EHCP Training:</u> • The EHCP handbook has not been produced yet due to operational pressures in all areas, but CYPS have now commissioned a SEND Handbook to be produced - as part of this there will be EHCP information and action cards for all staff. It is anticipated that this handbook will be completed by end Q2 24/25. • Once the handbook is available the SEND Leads for PH and MH/ LD Services will launch and share it across the CYPS directorate and offer 'SEND Training Clinics' for staff.

	GHC Tribunal Training: The GHC Legal Team offer tribunal readiness and information training to leads and managers who may be required to attend hearings. RAG – Green for year one. A whole SEND Training Assurance Framework has not yet been established, but with the fundamental training offers are now in place across CYPS, so there is opportunity to produce this in year 2.
Feedback Q4 update.	Service Users/ Experts: • SEND Leads are working with the Engagement Officer for Future Me Glos at the County Council - they are attending some forums with young people with SEND to capture their voice and hear their thoughts and contributions. • **Next Steps**: SEND Leads hope to work with Experts by Experience to audit the quality of EHCPs health assessment and reports in 24/25. System Partners: • The Head of Service for CYPs Learning Disabilities attends and supports the Preparing for Adulthood working group. • The partnership's Preparing for Adulthood strategy is now outdated and requires review – this will be driven by the ICB. It was noted though that data to inform the review of the strategy is limited across all areas. GHC: • A CYPS Directorate PfA group has been established and will plans to work in work in partnership with the ICB to review the PfA strategy. The group also recognises that there is a requirement for GHC to review its internal transition processes, tools and outcomes for service users – this is a large-scale piece of work and may require additional resource to complete alongside other SEND priorities. • The Transition of Care Policy requires review.
EHCP Portal Q4 Update	CYPS Physical Health Services all use the EHCP Portal. However, there have been numerous and ongoing issues with the Portal itself, which have hindered uptake. Health services are still receiving paper and electronic referrals, as well as portal referrals. GHC have produced a SBAR which was shared with the ICB and EHCP Portal team outlining the ongoing issues so these can be addressed. Due to the ongoing portal issues, CAMHS and LD services have been advised by the ICB DCO not to start using the portal until these have been resolved.

SAFE	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.

Commentary	The work is planned over a 2-year timeline therefore a compliant/non-compliant rating is not applicable this year. Excellent progress has been made and there are no known barriers to completion. Commentary: The approach of the PSIRF seeks to shift our response away from individuals and root cause analysis to exploring and understanding systemic issues. 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.			
Work Stream Plan	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.	Scoping	Fidelity testing template , process and tracker to be developed.	Review of results and learning	
Work Stream plan	**Present Position H2**			
LAF Framework, Incidents Policy and Fidelity Testing	The Learning Assurance Team has continued to explore channels for dissemination of learning and this is now done via various means, such as learning videos, sharing of information on the Patient Safety and Quality			

	noticeboards, via the Patient Safety Bulletin 'Insight', site visits alongside the Quality Managers, monthly Quality meetings with hospital matrons, attendance at governance / directorate meetings, monthly meetings with the ICB and joint working meetings. Monthly slides are now produced for each directorate which summarise incidents and the sharing of learning. We have also started developing safety actions with clinical teams following 'After Action Reviews' (AAR's). Fidelity Testing is now imbedded in quality Culture and occurring on a routine basis with positive feedback received.
Civility Saves Lives	Ongoing workstream, highlights in H2 include webinars from external prominent speakers which were well attended and received

SAFE	QUALITY PRIORITIES 2023-2025			
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 2024/2			
Commentary	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.			
Work Stream Plan	Q1	Q2	Q3	Q4
Mission and Vison 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	Scoping	Development of a matrix map to begin detailing the Trusts	Continuing progressing the matrix detailing all teams self-	Work to finalise the self-assessments within all MH & LD teams and to have

compliance status with level 2 requirements by using a self-assessment methodology.		current position with teams self-assessment within the Triangle of Care covering all Mental Health, Learning Disability Community and Inpatient teams	assessment compliance with Triangle of Care	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
Work Stream plan	**Present Position H2**			
Update H2	ToC 2-star status has been granted for our Mental Health inpatient and community teams plus crisis teams. All these teams need onward annual review of their Self-assessment and annual reporting. This is scrutinised by the Carers Trust to ensure progressive implementation of ToC across our MH teams and recommendations are made to continue best practice. The journey for physical heath is in its infancy but when we have introduced this across all PH sites (the 2-year plan) and they are conducting their self-assessments, then we will have all Trust teams on board. We will then be in the position where we can formally apply for 3rd. and final star status to be granted. Again, the Carers Trust will scrutinise the overall report submitted (based upon all the individual teams reporting), review the findings and make recommendations accordingly			

Quality Dashboard Highlights

The Trust Quality Dashboard 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.

The dashboard forms a key role in our Quality Management System and informs a number of quality forums and committees within the Trust governance structures as well as a vehicle to inform our ongoing quality relationship with our Commissioners, System Partners and our Regulators. It includes a range of information across all of our services and has a core reporting element which is linked to our Quality Strategy and the priorities that we set on an annual basis.

The dashboard provides a monthly overview of our activity and focuses on the following core areas:

- Patient and Carer Experiences & Non-Executive Director audits – provides an overview of Compliments, Complaints, Concerns, FFT and progress on the team's activity.
- Patient Safety – provides an overview of clinical incidents in month and a detailed breakdown on the levels of harm and progress on how we embed learning. It also includes our work around Closed Cultures and eliminating the risk of patient abuse.
- Quality Priorities & CQUINs – provides an overview on the quarterly milestones and progress on the areas of development.
- Length of stay – provides an overview on the length of stay in our inpatient's services in Mental Health and Community Hospitals. It looks at trends and barriers to discharge.

- Closed Culture - The CQC closed culture-related work applies to services that can be described as locked environments or areas where open access is restricted. Alongside these areas, services that deliver care to people that have communication or significant cognitive challenges are also considered at risk of becoming a closed culture. We have identified the following settings in the Trust as *potentially* having a raised risk of a closed culture; these are the focus of increased monitoring and support to eliminate this risk.

- Quality Improvement Hub – provides an overview of the various projects being undertaken and an overview on staff training for quality improvement methodologies.
- Safeguarding – provides an overview of all safeguarding activity within the Trust and our relationship with the local authority.
- Trust wide Physical Health Focus – provides an overview on infections rates, tissue viability, fall and end of life pathways.
- Safer Staffing – provides an overview of our safety staffing numbers, vacancies across our clinical services and recruitment of healthcare professionals.
- Operational Hotspots – provides an overview on those services that have highlighted an enhanced need for surveillance. This could include waiting list data, treatment times, vacancy and statutory and mandatory training data.
- Non-Executive Director (NED) Quality Visits – provides an overview and feedback from the multiples visits our NEDs complete with services over the year.

The quality account has provided updates for all of these core areas during 2023 & 24.

Outreach Vaccination Team (OVT)

The Outreach Vaccination and Health Team (OHVT) support the national immunisation programme by offering vaccinations including Covid and Flu to the people of Gloucestershire in four core areas of activity:

- Community based pop-up sessions are arranged in areas with low vaccine uptake and underserved communities offering Covid and sessional flu vaccines (there were 74 vaccination sessions held including; inpatients, housebound, venues supporting the homeless, food banks, community centers, warm spaces, sports clubs, libraries, village halls, students as well as health and social care staff). During these sessions 4219 Covid and 2420 Flu vaccines were administered by the team.

- Support the national call for Making Every Contact Count (MECC) in which public facing staff engage with patients, service users and members of the public as an opportunity to support and encourage or consider behavior change such as stopping smoking to improve individual people's health and wellbeing. The OVHT offer health care advice including blood pressure checks, sign-post people to free local services and partner organisations at community pop-up vaccination and MECC sessions. There were 91 MECC sessions offered, with 1698 blood pressure checks completed and from this 276 people were referred on for specialist/ primary care review.

- Unfortunately, in the UK and locally, we are starting to see a decline in routine childhood immunisation uptake including Measles, Mumps and Rubella (MMR). The OVHT has supported an NHS project to increase MMR uptake in 17-30-years-olds across Gloucestershire. In response to National alert to support preparedness for the management of suspected or confirmed measles cases in health care settings, the OHVT held a number of work-placed sessions offering health care staff who had incomplete MMR vaccination status the opportunity to receive a vaccination. The OVHT are also collaborating with systems partners to plan a local pathway for Post Exposure Prophylaxis for people with an incomplete MMR vaccination status who have been identified as being a close contact with a positive measles case.

- The OVHT continue to work jointly with system partners to support offering routine immunisations to asylum seekers in the county such as MMR and diphtheria/tetanus and polio.

The Outreach Vaccination and Health Team tirelessly champion vaccination uptake and outreach within Gloucestershire through ongoing engagement with community leaders/networks and partner organisations and seek innovative ways to expand their reach.

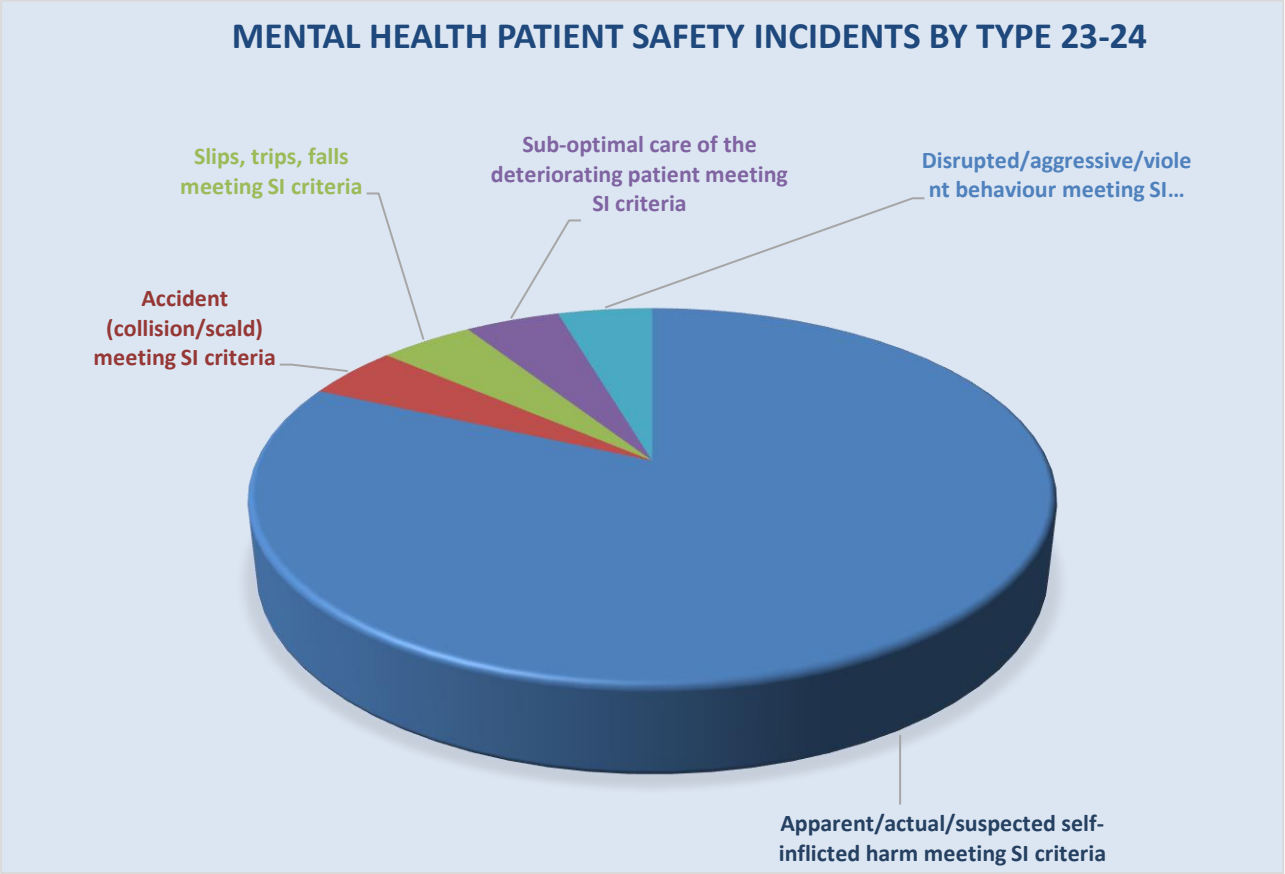
Patient Safety incidents

Mental Health Services

By the end of 2023/24, **22** Patient Safety Incidents (PSI's) were reported by the Trust. The classification of these incidents reported are shown below.

18 Apparent/actual/suspected self-inflicted harm meeting SI criteria
1 Accident (collision/scald) meeting SI criteria

1 Slips, trips, falls meeting SI criteria
1 Sub-optimal care of the deteriorating patient meeting SI criteria
1 Disrupted/aggressive/violent behaviour meeting SI criteria



All Patient Safety Incidents were investigated by a dedicated team of clinicians, all of whom have completed two days of formal training.

18 incidents related to self-inflicted injury and do refer to suspected and attempted suicide incidents. 17 such incidents resulted in the patient's death. We had one incident of an Accident (collision/scald) meeting SI criteria, one Slips, trips, falls meeting SI criteria, one Sub-optimal care of the deteriorating patient meeting SI criteria and one incident of Disrupted/aggressive/violent behaviour meeting SI criteria.

The service has seven dedicated Family Liaison Practitioners in place, comprising both clinical and non-clinical colleagues. Each member of our team has attending PABBS training, Cruse bereavement by suicide webinar and Trauma informed response facilitated by Nelson's Trust. The Family Liaison Service is currently supporting eleven families. The service has a Standard Operating Procedure (SOP) in place to serve as a comprehensive guide for our team members. Additionally, we have curated a range of resources to support our team in their voluntary role. We are currently reviewing how we can capture feedback from those families who have been supported. Our Family Liaison Services places a strong emphasis on the wellbeing and self-care of our members. We meet monthly incorporating regular wellbeing sessions facilitated by the Wellbeing line Psychologist. Both of which are invaluable moving forward. We are forging links within our community, including collaborations with where we share our processes and experiences. Our engagement with Sunflowers, a bereavement support charity based in Gloucestershire has provided invaluable insights, with the founder sharing personal experiences related to the Trust's review process.

The Trust continues to share copies of our investigation reports regarding suspected suicides with the Coroner in Gloucestershire to assist with the Coronial investigations.

Physical Health Services

For 2023/24, the Trust reported **0** Patient Safety Incidents **(**PSI's) .

However, as a Trust we undertook two thematic reviews

Skin Integrity
As the population ages the number of older people living in care settings or being cared for at home is increasing, therefore so does the frequency of reported skin integrity incidents. The Patient Safety Team (PST) have commenced a thematic review of skin integrity incidents across 2 integrated Care teams (ICT's) and this work will involve a broad range of experts, exploration of data and the discovery of the experience of colleagues delivering care. There are three key factors that are driving an increase in number and severity of pressure ulcers; circulatory changes following Covid infection, deconditioning of patients who live at home and have become more socially isolated and physical immobility during and following Covid infection. The thematic review will report early findings to ICT's and through ICG to support the commencement of learning or improvement prior to the final report being prepared.

Urethral Erosions
The second thematic review is being undertaken in relation to urethral erosions associated with catheters. Several incidents reported in ICT's are being reviewed to understand common links, themes or issues. It will seek to understand key barriers or facilitators to safety and help the organisation to make sense of the safety concerns at different parts of the system and with different aspects of variability.

My Care Plan

My Care Plan aims to capture the personalised care and conversations between the person, their key worker and all GHC health professionals involved in their care. It should identify what is important to the person, their skills and strengths, the areas of their life they would like support with, and the collaboratively agreed goals and actions. My Care Plan should reflect the person's thoughts, feelings and concepts in their own words, and is therefore unique to each person.

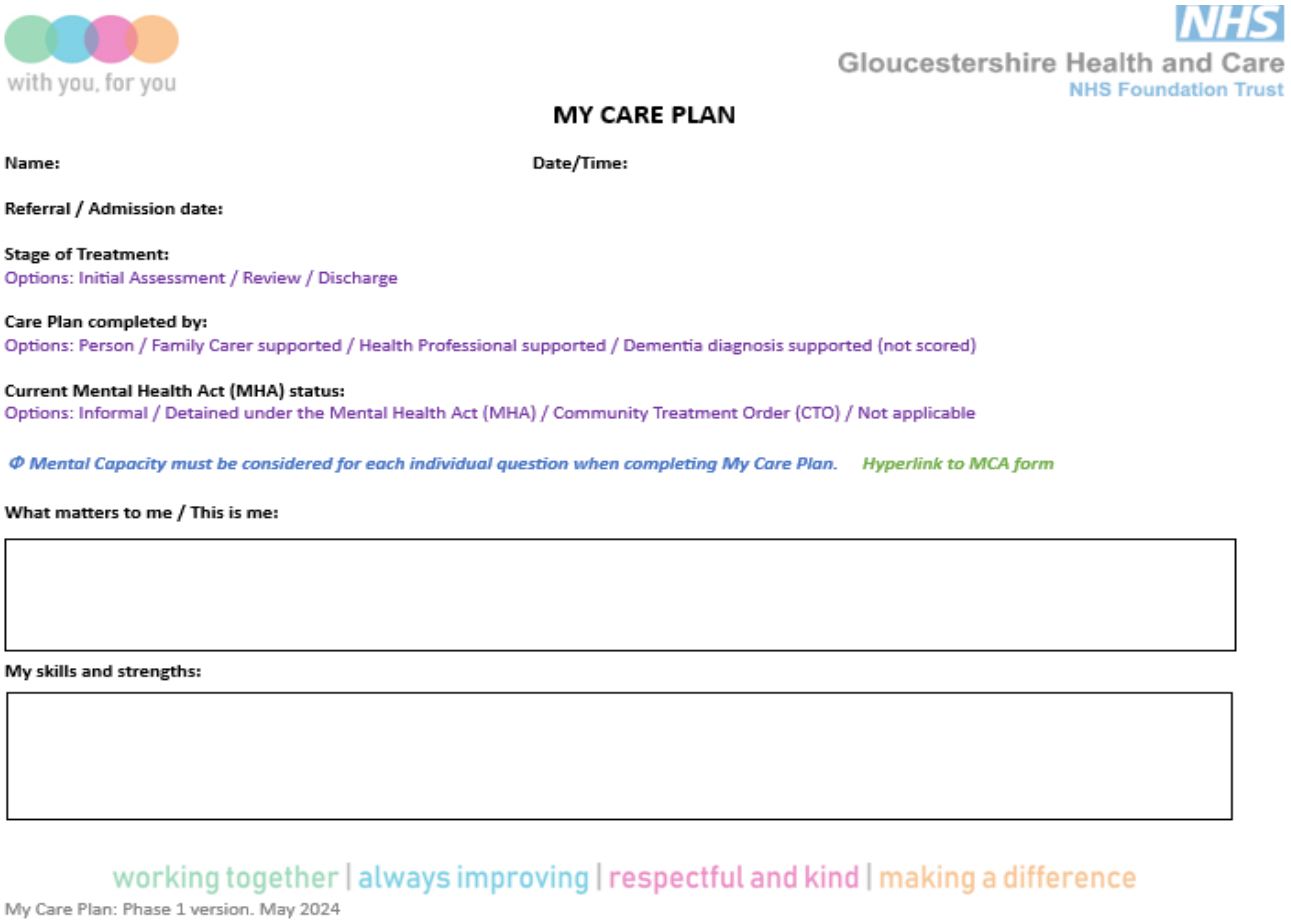
My Care Plan is based on Dialog which is a scale of 11 questions to help support open therapeutic conversations aiming to address all areas of quality of life. The person can choose to rate their satisfaction and whether they would like help in each area. Dialog has been widely implemented in the NHS and across several other countries, and provides a score for subjective quality of life and treatment satisfaction. Dialog is based on quality of life research, concepts of patient-centred communication and solution focused therapy.

Staff working across GHC mental health services are keen to change the way in which we care plan. Several internal closely related workstreams were reviewed including Dialog and the personalised care agenda including 'What Matters to Me' and 'Me at My Best'. Key stakeholders were consulted including experts with lived experience, service users and carers, staff across inpatient and community MH teams, specific working groups and specialists. Really valuable feedback and challenge helped shape the new care plan and prepare for the changes ahead.

Frontline staff are being supported throughout the transition to My Care Plan through the development of a new e-learning, workbook, quick guide and dedicated intranet page with multiple resources. Face to Face support is also being offered at each site and via MS Teams, with solution focused conversation training also in development.

My Care Plan will enable more meaningful and purposeful care planning that reflects the high standard of personalised care that is provided by our mental health teams. This will benefit all those involved in the care and treatment, including the person themselves, their family and carers (where appropriate) and staff.

My Care Plan is being introduced across GHC mental health services in a phased roll out starting on May 13th 2024. Phase 1 includes mental health inpatients (except Berkeley House), Recovery, AOT and Crisis teams, and the Young Adult Service.


with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

MY CARE PLAN

Name: **Date/Time:**

Referral / Admission date:

Stage of Treatment:
Options: Initial Assessment / Review / Discharge

Care Plan completed by:
Options: Person / Family Carer supported / Health Professional supported / Dementia diagnosis supported (not scored)

Current Mental Health Act (MHA) status:
Options: Informal / Detained under the Mental Health Act (MHA) / Community Treatment Order (CTO) / Not applicable

Φ Mental Capacity must be considered for each individual question when completing My Care Plan. *Hyperlink to MCA form*

What matters to me / This is me:

My skills and strengths:

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

My Care Plan: Phase 1 version. May 2024

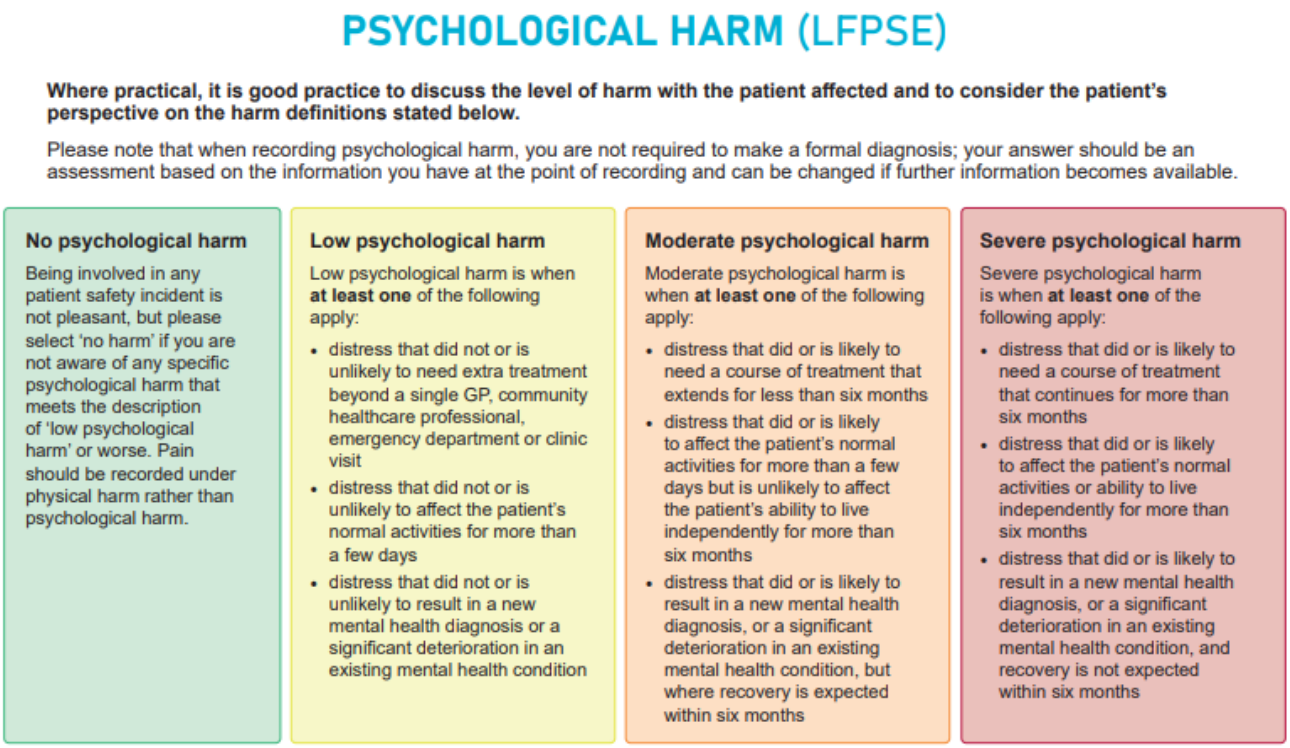
LFPSE: learning From Patient Safety Events

LFPSE is a new single national NHS service for the recording and analysis of patient safety events that occur in healthcare. LFPSE is a major upgrade and replaces the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS). It introduces improved capabilities for the analysis of patient safety events and enables better use of the latest technology, such as machine learning, to create outputs that offer a greater depth of insight and learning that are more relevant to the current NHS environment. GHC transitioned across to LFPSE on Datix on the 9th of January 2024.

A new key feature of LFPSE is that for each patient safety incident a harm grading must be attributed to both physical and psychological harm at the point of reporting on Datix. When the incident is reviewed by the Datix Handler, an 'Overall Severity' harm grading is required. This places equal importance on both the psychological and physical impact on the patient who has been involved in the incident.

For many years, staff have graded patient harm related to incidents and the introduction of grading psychological harm has raised many questions and does pose some challenges, particularly in some clinical specialities within GHC. The requirement to consider the grading of psychological harm is a positive move forwards in understanding the patient experience, and involving and engaging with our patients following incidents – a key part of PSIRF (Patient Safety Incident Response Framework).

The Trust Datix Manager has been actively involved at national level throughout the introduction of LFPSE, with national level feedback also provided by our Head of Psychological Services and DoC Lead. A GHC working group has been established to review the psychological harm data to understand how staff are grading harm in this domain and to identify themes and trends. The information gathered will identify learning and areas for development and improvement, which will be used both internally and fed back at a national level to NHSE.



Duty of Candour

Duty of Candour (DoC) is an essential part of a positive, open and safe culture within the organisation. Service users have a right to be informed about all elements of their care and treatment, and as a provider we have a responsibility to be open and honest with those in our care. DoC is closely linked to a 'just culture' is part of the wider commitment to safety, learning and improvement.

Professional DoC is an individual health and care professional's responsibility and is regulated by the healthcare professional bodies, for example the NMC, GMC and HCPC. Regulation 20 DoC is the Trust's statutory responsibility and is regulated by the CQC.

Regulation 20: Duty of Candour applies to 'notifiable safety incidents' (NSI). These are incidents that cause a moderate or severe harm, or death, and where something unintended or unexpected has happened during GHC care or treatment. If a notifiable safety incident is identified, the specific verbal and written notification requirements of Regulation 20 DoC must be met in a timely manner. One of the key elements of this is a meaningful apology with the use of the word 'sorry'.

Staff training continues, face to face where possible, with a focus on staff support, engagement and discussion. There are often new and interesting scenarios raised by staff that promote healthy debate and enable further learning. Emphasis is placed on staff wellbeing following incidents, and that saying sorry does not admit fault or liability, but is the first step in learning from what has happened.

Some incident types and clinical specialities present complexities regarding DoC responsibilities. Specific incidents are discussed with the DoC Lead who works collaboratively with the Patient Safety, Patient Carer and Experience, and Legal teams. Multiple DoC resources and 'real life' GHC case

examples have been collated that more accurately reflect the type and complexity of incidents experienced within the Trust to support staff awareness, reasoning and compliance.

The Trust needs to be able to demonstrate compliance with Regulation 20 DoC. The DoC Lead and Patient Safety Team work closely together to identify notifiable safety incidents through Datix reporting, and to support staff to fulfil DoC requirements. The DoC Lead keeps an ongoing quarterly detailed record of all notifiable safety incidents and compliance with Regulation 20 requirements using evidence from clinical, Datix and patient safety records. Retrospective quarterly assurance reviews are submitted to the Quality and Regulatory Compliance Group. Moving forwards, DoC assurance will be demonstrated through an annual audit and collaborative work is underway support this.

With the introduction of the Patient Safety Incident Response Framework (PSIRF) and Learn from Patient Safety Events (LFPSE), work has focused on ensuring Regulation 20 DoC has been embedded into these new processes.

The table below provides an example summary of Regulation 20 DoC activity: Quarter 1 2023-24:

NSI Summary Q1 23-24: N = 26	Mental Health Inpatient / Urgent Care	CYPS	Community	Physical Health Inpatient / Urgent Care	Countywide	Total
Death / SIRI (9)	2 suspected suicide: CRHTT 1 Accidents: CLH 1 Fall:CLH 1 Medical emergency: CLH		4 suspected suicide: Recovery, MHICT			9
Confirmed Severe (1)					1 Clinical care: Dental	1
Confirmed Moderate (9)	1 Fall: CLH 1 Clinical care: CLH 1 Self harm: WLH		1 Medication: ICT	4 Falls: CoHo 1 Medical emergency: CoHo		9
Skin Integrity Severe (1)				1 Catheter injury: ICT		1
Skin Integrity Moderate (6) (sample of 20 only)			3 Unstageable: ICT 1 Cat 4: ICT	1 DTI: CoHo 1 Unstageable: CoHo		6
Covid-19 (0)						0
Total	8	0	9	8	1	26

Physical health care in mental health settings

GHC employs a small team of nurses/HCAs to improve the physical healthcare of patients with mental health (MH) and learning disabilities (LD) within Gloucestershire. We have Physical Health Nurses working within our Older and Working Age Adult inpatient units, and provide weekly support for Berkeley House. This year we have also been fortunate to have secured funding for a Treating Tobacco Dependency Service (TTDS) for people within MH inpatient settings. This means we have had three new members of staff join our team.

The TTDS team was set up in January 2024 and to coincide with National No Smoking Day, we re introduced a Smoke Free environment within our Inpatient settings. We had done this preciously, but relaxed the rules in the pandemic, but now patients and staff must leave Trust property if they wish to smoke. The positive side to the roll out this time, is that the TTDS team have been on hand to provide advice and treatment for people wishing to smoke or support abstinence or reduction from smoking whilst they are in hospital.

We have had great feedback from staff and patients alike, and are pleased to say that we already have eight patients (and two staff members) on quit attempts.

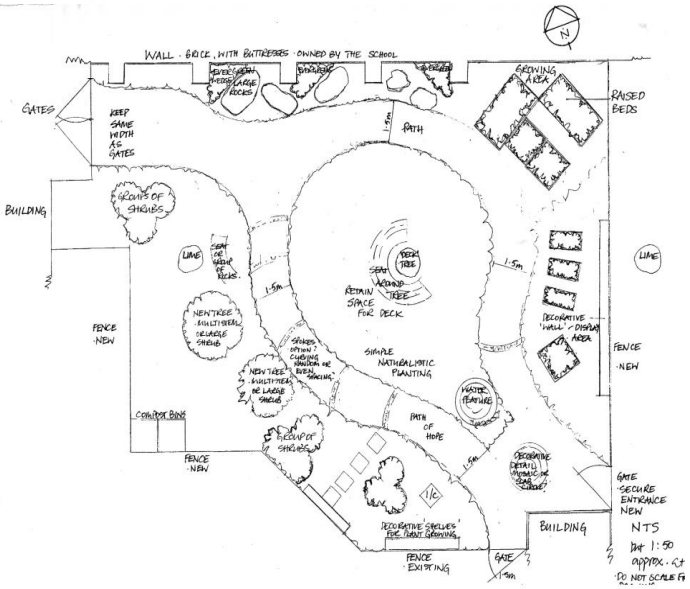
We continue to offer Annual Physical Health Checks for people both in hospital and the community for people with a Severe and Enduring Mental Illness (SMI). Regular audits mean we are continuing

to offer the majority of our patients a full cardiometabolic health check and have been working hard to ensure we have good interventions to offer service users who may need them. We now have six Healthcare Assistants based within the Recovery Teams in the Community and can now offer to help screen patients with SMI in primary care and not necessarily known to us in GHC. The ICB recently commissioned a new Service Provider within Gloucestershire to replace the Healthy Lifestyles service and we look forward to working with the new provider to ensure people with SMI or LD have access to services.

Work on the eagerly anticipated 'The Sanctuary Garden' within Wotton Lawn Hospital which will be a female only safe space to provide a peaceful and calming environment for ladies to receive both physical and mental healthcare has continued. Since last year, we have managed to raise another £26500 towards making our plans a reality! We are hoping for work to begin in the Autumn. We have in the meantime commissioned a mosaic wall art piece from Art Shape, who are a MH charity in Gloucester who attended weekly for three months to work with service users and staff to produce a 'Wreath of Seasons 'for the garden

We continue to offer a bespoke service for improving physical healthcare to patients who find it difficult to access traditional physical health services provided by the NHS. Whether this be providing hands on care at home, health screening outside of the usual setting or being a patient's advocate to enable reasonable adjustments to be made to attend mainstream services, we aim to provide parity of esteem for all our patients.

Shown below is the artists impression of The Sanctuary Garden and also photos of staff and patients working at helping to create a mosaic which will be installed into the garden as well as an existing view and architect plans.



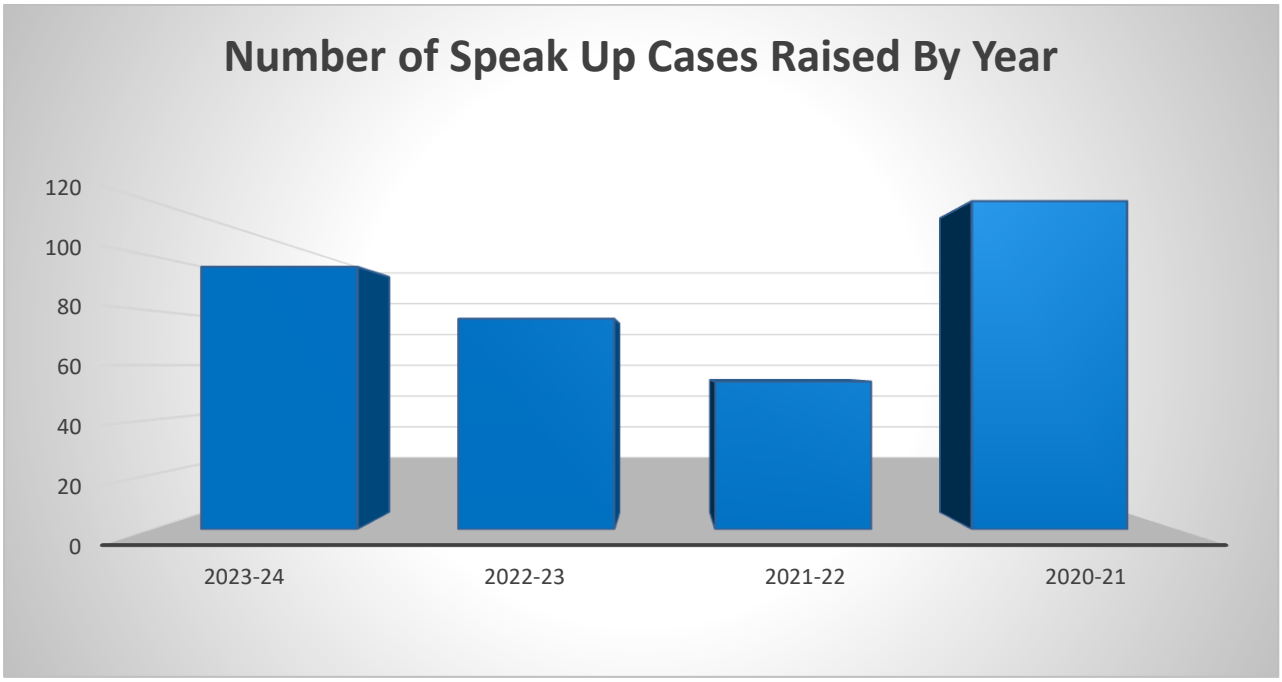
Freedom to Speak Up

The Trust continues to invest full-time in the Ambassador for Cultural Change, a unique role which incorporates the Freedom to Speak Up Guardian. The Guardian operates independently, impartially, and objectively on all matters relating to speaking up in the workplace, taking a highly visible leadership role in promoting the culture of speaking up, including trust and confidence in the processes themselves and promoting learning and improvement. The wider remit is to play a key role in promoting a culture of transparency and safety and she also has a key role in assisting the Trust in protecting staff from suffering detriment through speaking up.

The Freedom to Speak Up Guardian is supported by a network of Champions. This is a voluntary role through which colleagues can apply to support Freedom to Speak Up through involvement in promoting the service and acting as a local representative in their area. Champions do not handle cases but are able to signpost to the Guardian for further support. Refreshing the network in 2023 has attracted more colleagues to a network which now has ninety colleagues and is growing. The

commitment by the Freedom to Speak Up Guardian is to ensure that our champions receive ongoing support and development through sharing successes, challenges, best practice and learning.

There have been 96 speak up cases raised to the Freedom to Speak Up Guardian in 2023-24. There is a notable increase for this year of 25% compared to 2022-23. Previous years data is 77 cases in 2022-23, compared to 54 cases 2021-22, 120 cases in 2020-21 and 60 in 2019-20.



Just over two-fifths of cases, nearly half (42%) included an element of colleague safety or wellbeing and 23% with an element of inappropriate behaviours and attitudes (other than bullying and harassment). Patient safety/quality at 14.5% with bullying and harassment reduced at 12.5%.

The Freedom to Speak Up Guardian role is part of a much bigger picture, supporting our organisational culture to make 'Freedom to Speak Up for Everyone'. We use opportunities to reflect on local and national reports these and capture learning. Within the Trust the new Freedom to Speak Up policy has been implemented and the Guidance for Boards reflection tool highlights continuous improvement. Our processes are aligned to the NHSE/I guidance and the National Guardian's Office embedded in the NHS Contract. A positive speaking up culture within our workforce will ensure that patient safety matters are heard and that colleagues are supported.

A positive speaking up culture is reflected nationally in the People Plan and People Promise, and locally in our strategic commitments to High Quality Care and being a Great Place to Work. It is a core component in our health and wellbeing offer, in our 'Strong Voice' commitment to colleagues. This was reflected in most recent audit, July 2023, BDO our external auditors report concluded a substantial opinion across both the design and effectiveness of the controls in place. Overall, the Trust has a robust Freedom to Speak Up service in place. Responses to concerns raised are timely and effective, and there are several proactive measures in place to address barriers and promote a positive speaking up culture across the Trust.

The Freedom to Speak Up Guardian continues to deliver bespoke sessions on 'Speaking Up in a Culture of Civility and Respect' which reflects on speaking up and the link to patient safety. Alongside organisational development colleagues within our Thrive programme 'Creating Psychological Safety' continues to be delivered with the messaging linked to speaking up and Civility Saves Lives.

Feedback continues to be positive from colleagues who have accessed the Freedom to Speak Up service and this is reflected in the NHS Staff Survey 2023 where we rate favourably nationally and against our comparators.

Learning from speaking up is fundamental to an open and honest culture and through continued work with our leaners. The results of the 2023 National Education and Training Survey (NETS) are once again positive. Proactive work to continue the drive for a positive speaking up culture continues within local universities.

Other options available to colleagues within the Trust include:

Freedom to Speak Up APP is available as a safe, anonymous or confidential application to enable colleagues to enter into a conversation to obtain further advice and support. This in-house application went live on the 30th October 2023 in place of the previous externally funded Work in Confidence. Thirteen colleagues have spoken up to the Freedom to Speak Up Guardian via the new in-house application with three who have chosen to remain anonymous.

Direct to Douglas is a confidential application to share with our Chief Executive any issues colleagues think he should be aware of or ask for a response to something they are concerned about. There are also opportunities to make suggestions for improvement.

Staffing in adult and older adult community mental health services

The major change this year has been the mandatory change of service name; from *NHS Let's Talk* to *NHS Talking Therapies*. This was a centrally led innovation from NHSE to improve access figures and increase the numbers of individuals accessing therapy. Unfortunately, the national change did not include a mass media campaign so we have continued, in Gloucestershire, to invest heavily in marketing our service. This has paid dividends and as we moved into the last quarter of last financial year we began to hit our adjusted targets. We also achieved our other KPIs including a good Recovery rate and manageable waiting lists.

We received notification in March 2024 that NHSE are changing the KPIs for NHS talking Therapies; Access will no longer be a target but instead concentration will be on Recovery and waiting lists. No figures have yet been issued (mid-April 2024) so we are not clear on our local targets but we did, with the support of Trust Executives decide to move our March/April 2024 focus to concentrating on our Waiting Lists rather than chasing Access only for people to wait. This will better place us for the new reporting matrices which will focus on recovery and attended appointments.

We have continued to invest in our staff and to build our service offer; including that to minority groups, we continue to offer both remote and face to face therapy and are actively looking at how we can offer support to older adults.

Finally, we have been concentrating significant time on our NHS Talking Therapies can develop their offer for the CMHT Transformation agenda.

NHSI indicators 2023/2024

		National Threshold	2021-2022 Actual	2022-2023 Actual	2023-2024 Actual
1	Early Intervention in psychosis EIP: people experiencing a first episode of psychosis	50%		69.2%	

	treated with a NICE-approved care package within two weeks of referral		80.95		76.9%
2	Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered routinely in the following service areas: -inpatient wards -community mental health services (people on CPA)	 NA NA	 68% 28%	 68% 70.7%	 77% 81%
3	Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database) Waiting time to begin treatment (from IAPT minimum dataset - treated within 6 weeks of referral - treated within 18 weeks of referral	 50% 75% 95%	 52.9% 99.6% 99.9%	 50.5% 99.6% 99.9%	 52% 99.6% 99.9%
4	Admissions to adult facilities of patients under 16 years old.	NA	1	0	0

The table below reports out of area placements for adult mental health services and this year we are pleased to report that there has been a significant decrease of over 60% on last year's figure which was 963. All out of area placements are monitored by a range of teams to ensure our patients are receiving services which are safe, effective and provide a good experience. Use of out of area placements (typically within the private sector) refers to a situation where a patient is admitted to an inpatient unit outside of their local area because no appropriate bed is available locally. However out of area providers may also have limited capacity or decline to accept a patient when referred.

The aim of the trust is always to eliminate all out of area placements (OAPs) in mental health services for adults in acute care in lieu of local capacity, however in exceptional circumstances use can be operationalised to reduce the risk of harm, ensuring we provide care that has a clear benefit and improve outcomes and is patient centred and in partnership with the patient and their family.
A *'Use of Mental Health Out of Area Beds: In and Out of Hours Protocol'* has been implemented.
To support more local capacity being readily available the Trust has developed a Wotton Lawn Length of stay programme focusing on Mental Health Hospital Flow with community colleagues and system partners. Regular Multi-agency Discharge Events (MADE) are held regularly across working age, older age and recovery units to both enable actions to support patients being discharged but also collating barriers to discharge themes to focus efforts and development to take forward. All of these schemes maturing and being used have contributed to the reduction of use of out of area placements due to capacity.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Year
Average Bed Days	0	0	62	81	48	50	70	33	24	5	2	0	375

Enabling people to have positive experiences of NHS services which meet their needs and expectations is a key national strategic goal and is an underpinning core value of Gloucestershire Health and Care NHS Foundation trust.

The Care Quality Commission (CQC) requires that all providers of NHS mental health services in England undertake an annual survey of patient feedback. For the 2023 survey, Gloucestershire Health and Care NHS Foundation commissioned Quality Health to carry out this work. The CQC makes comparison with 53 English NHS mental health care provider's results of the same survey and the results are published on the CQC website. The CQC requires that all providers of NHS mental health services in England undertake an annual survey of patients in their care.

The CQC will use results from the survey to build an understanding of the risk and quality of services and those who organise care across an area. Where survey findings provide evidence of a change to the level of risk or quality in a service, provider or system, CQC will use the results alongside other sources of people's experience data to inform targeted assessment activities.

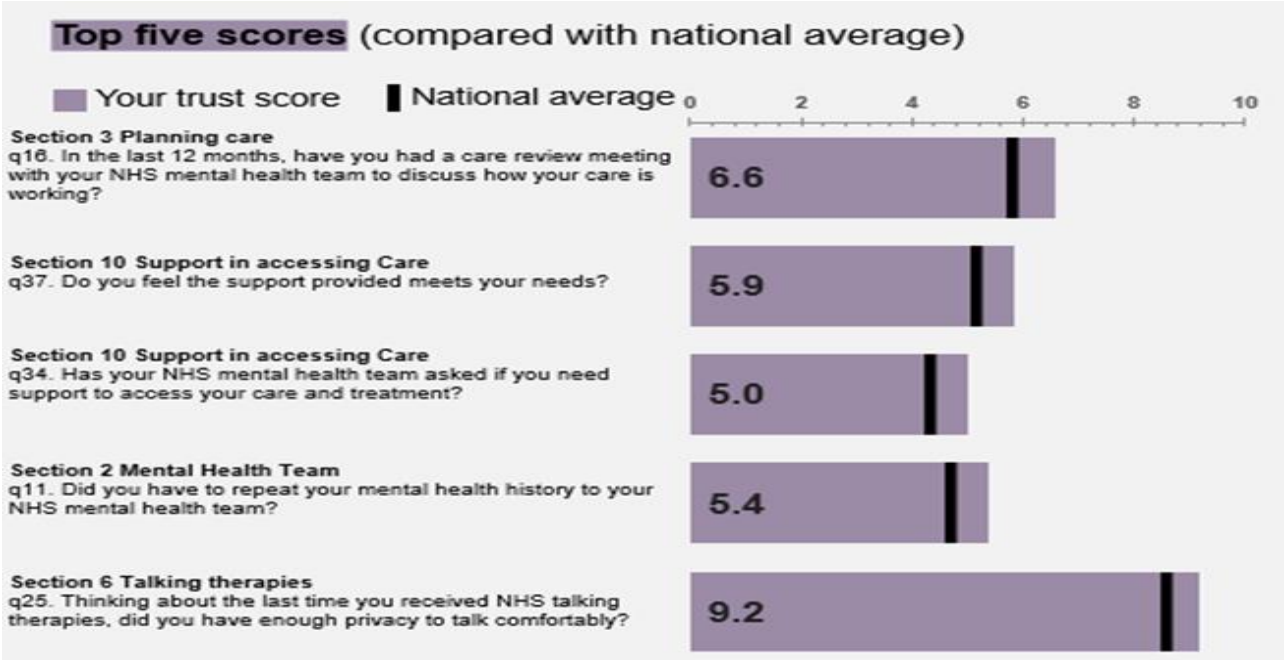
Due to a number of changes made to the 2023 survey and a change of methodology, it is not possible to compare the Trust results with previous years, however benchmark comparison with other trusts have been undertaken.

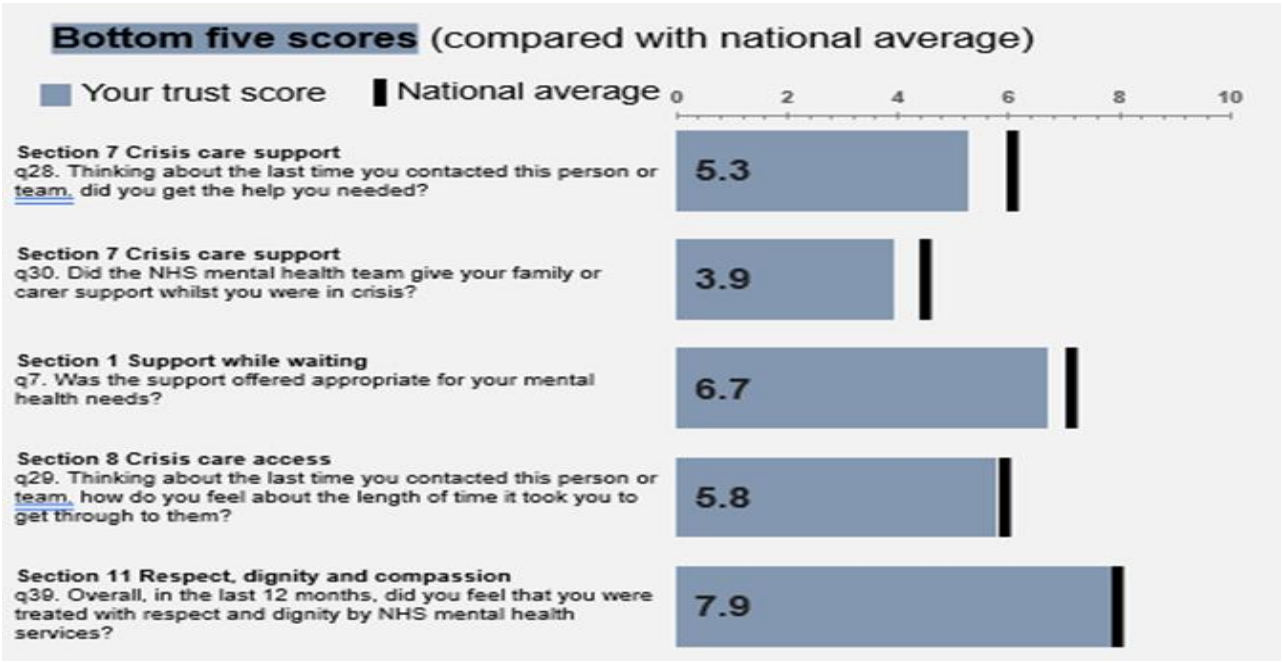
The Trust scores in comparison with other trusts is detailed below:

Survey Domain	Score	Rating
Support while waiting	6.6	Same
Mental Health Team	6.5	Better
Planning Care	6.7	Somewhat Better
Involvement in Care	6.1	Same
Medication	7.4	Somewhat Better
Talking Therapies	9.2	Much Better
Crisis Care Support	4.6	Same
Crisis Care access	7.0	Same
Support with other areas of life	3.7	Same
Support with accessing care	5.4	Somewhat Better
Respect, dignity and compassion	8.0	Same
Overall experience	7.0	Same
Feedback	3.0	Same

The Trust's response rate was 26% (315 responses). This is above the national average of 20%. However, both the Trust's and the national response rates have decreased from the 2022 survey (Trust 29%, national average 21%).

The Trust performed about the same compared with other trusts in 25 of the 33 questions and somewhat better (3), better (4) or much better (1) than expected in the remaining 8 questions. The Trust did not score worse than expected compared with other Trusts in any of the survey questions.

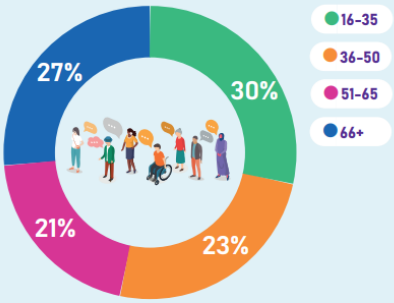




National Survey 2023 – Community Mental Health Trusts

This slide is included to help you interpret responses and to provide information about the population of service users who took part in the survey.

Age



Ethnicity

White	94%
Asian / Asian British	2%
Black / Black British	0%
Multiple ethnic groups	2%
Arab / Other ethnic groups	0%
Not known	3%

Religion

Christian	48%
No religion	39%
Other	4%
Muslim	1%
Buddhist	1%
Hindu	0%
Jewish	0%
Sikh	0%
Prefer not to say	6%

Long term conditions

91% of service users have physical or mental health condition or illness that has lasted or is expected to last for 12 months or more.

Number of long - term conditions reported:

1	36%
2+	64%

Sex

At birth were you registered as...

Female	64%
Male	35%
Intersex	0%
Prefer not to say	1%

2% of service users said their gender is different from the sex they were registered with at birth.

National Survey 2023 – Community Mental Health Trusts

Each domain includes a number of questions. These are each compared to other trusts using this key:

Much better | Better | Somewhat better | Same

Support while waiting	6.6/10
Mental Health team	6.5/10
Planning care	6.7/10
Involvement in care	6.1/10
Medication	7.4/10
Talking Therapies	9.2/10
Crisis Care support	4.6/10
Crisis Care access	7.0/10
Support with other areas of life	3.7/10
Support with accessing care	5.4/10
Respect, dignity and compassion	8.0/10
Overall experience	7.0/10
Feedback	3.0/10

Top five scores (compared with national average)

Section 3. Planning care 6.6/10

Q16. In the last 12 months, have you had a care review meeting with your NHS mental health team to discuss how your care is working?

Section 10. Support in accessing Care 5.9/10

Q37. Do you feel the support provided meets your needs?

Section 10. Support in accessing Care 5.0/10

Q34. Has your NHS mental health team asked if you need support to access your care and treatment?

Section 2. Mental Health Team 5.4/10

Q11. Did you have to repeat your mental health history to your mental health team?

Section 6. Talking Therapies 9.2/10

Q25. Thinking about the last time you recieved NHS talking therapies, did you have enough privacy to talk comfortably?

Bottom five scores (compared with national average)

Section 7. Crisis care support 5.3/10

Q28. Thinking about the last time you contacted this person or team, did you get the help you needed.

Section 7. Crisis care support 3.9/10

Q30. Did the NHS menat health team give your family or carer support whilst you were in crisis?

Section 1. Support while waiting 6.7/10

Q7. Was the support offered appropriate for your mental health needs?

Section 8. Crisis care access 5.8/10

Q20. Thinking about the last time you contacted this person or team, how do you feel about the length of time it took you to get through to them?

Section 11. Respect, dignity and compassion 7.9/10

Q38. Overall, in the last 12 months did you feel that you were treated with, respect and dignity by the NHS mental health services?

Annual NHS Staff Survey 2023

The Trust participates in the annual NHS Staff Survey, supplementing this with a quarterly People Pulse Survey and additional ad hoc surveys. While colleagues also have a breadth of routes to feed back their views and experiences of work, the Staff Survey provides the most in-depth and comprehensive analysis of how colleagues view the Trust as an employer and as a provider of care.

The most recent results present a further improved position in terms of how colleagues rate the Trust over last year. The Trust also compared very positively against Southwest provider trusts and also mental health, learning disabilities and community peers. Within the region, the Trust's overall ratings were ranked 1st= amongst all NHS provider trusts. This mirrored last year's ratings. Additionally, across England, the Trust was rated 5th best mental health, learning disabilities and community employing trust.

The key headlines from the Trust's 2023 Staff Survey results for substantive colleagues are:

- Response rate increased to 58% compared with 55% (2022) and 53% (2021). This compares with the average national NHS response rate of 48%.
- Improvements in Friends & Family Test (Place to Work & Place to Receive Treatment) - both 10% above benchmark comparator average at 73.39% and 76.62% respectively.
- Improved ratings across all Seven People Promise themes, 6 above average , one – We Work Flexibly – average .
- In Staff Engagement & Morale themes, results improved from 2022 & remained above both benchmark sector & NHS averages.
- Compared with 2022, circa 60% questions have improved ratings, 39% have worsened & 1% remained the same.
- Decreases in the number of colleagues thinking about leaving or looking for another job in next 12 months.
- Increases in colleagues feeling they have the both the opportunity and can access learning and development activity.
- Increases on positive scores on majority of questions relating to immediate line manager support/relationship.
- Increase in ratings that colleagues feel supported to develop their potential.

Colleagues' ratings of how the Trust performs against the 7 People Promise Themes and two supplemental Themes, is outlined below.

Theme	National Benchmarking Group Average	2023 GHC score
We are compassionate & inclusive	7.58	7.73
We are recognised & rewarded	6.41	6.54
Each have voice that counts	7.01	7.11
We are safe and healthy	6.38	6.51
We are always learning	5.93	6.05
We work flexibly	6.84	6.84
We are a team	7.18	7.23
Staff Engagement	7.11	7.27
Morale	6.17	6.38

While the improved progress has been hard won, there are still some hot spot teams and areas in terms of both responses & ratings. Mental Health inpatients, discrimination, appraisal effectiveness & pay satisfaction are particular hot spots which the Trust is taking action to improve on.

Historically the Staff Survey was only issued to substantive colleagues and excluded Bank workers. For the 2022 Staff Survey all NHS organisations were provided with a voluntary option to run an

additional survey for Bank Only workers. The Trust took this option and ran its first ever survey for bank staff then. For 2023, the Survey has become mandated for all trusts.

For the bank worker colleague results, key Trust headlines include:

- a response rate of 22% just below the 23.4% rate for 2022. At the time of writing, no national comparison data was available.
- Six of out of seven People Promise themes improved scores and one dipped slightly (Voice)
- In the supplemental Staff Engagement & Morale themes, both results improved from 2022
- Bank colleagues rated the Trust higher than substantive staff in three out of seven People Promise themes as well as for Engagement & Staff Morale
- Increase in the number of bank colleagues who feel valued by their line manager, recognition of the positive impact the appointment of a Clinical Support Manager for Temporary Staffing has had in supporting bank workers.
- Bank colleagues rated the Friends and Family Tests to receive treatment at 73.6% & as a place to work at 73%.

Our priorities

Whilst the Staff Survey results for 2023 are positive and reflect generally improved rating, we continue to recognise that are differences between directorate/service and professional group scores as well as thematic elements to address with room for much more improvement.

The focus on improving during 2024/2025 is on four areas:

- Anti-discrimination (particularly harassment and violence at work from patients): Results illustrate an increase in the number of incidents staff are subjected to from patients & families. Discrimination on the grounds of ethnicity is a hot spot with a 9% increase over last year. We also see that Bank colleagues score higher in comparison to substantive staff with regard to experiencing harassment. We have begun a programme or work relating to this, launching our new Anti-discrimination Abuse Road Map, toolkit, resources, workshops and video earlier in March 2024.
- Flexible working: We will be looking to find out what we could do to progress from average to top quartile in our working flexibly scores. The appointment of our new People Promise Manager will support this.
- Health and Wellbeing: We are continuing to identify themes & hot spots across our services areas / teams & planning to take further targeted action.
- Internationally Educated Nurses: Responses suggest we need to better understand the often-different experiences of our IEN workforce and we have started working with our IEN Council on these issues. This is particularly to help support our top Trust priorities of Recruitment and Retention.

PLACE Assessments

The PLACE Assessments were completed between September and November 2023.This is the second set of assessments that have taken place for the organisation as Gloucestershire Health and Care. It should be noted that the assessments must be viewed as an opportunity to improve where points have been lost. Comparisons by site and by year are not encouraged as the criteria and areas assessed can change and so comparisons may be misleading.

Exception reports have been circulated to all Matrons and Site Managers with the Facilities Mangers copied in. An organisational action plan has been drawn up and updates will go to the Improving Care Group which meets monthly.

There has been a specific task and finish group set up to look at improvements that can be made in the Dementia and Accessibility domain.

Gloucestershire Health and Care NHS Foundation Trust - 2023 Results								
Site Name	**Cleanliness**	**Food Overall**	**Organisational Food**	**Ward Food**	**Privacy, Dignity and Wellbeing**	**Condition Appearance and Maintenance**	**Dementia**	**Disability**
Berkeley House	100.00	94.54	90.45	100.00	89.74	98.33		83.82
Charlton Lane Hospital	100.00	95.56	91.67	100.00	96.51	98.70	89.31	85.78
Cirencester Hospital	100.00	92.05	87.59	97.44	93.33	99.35	70.22	66.50
Dilke Hospital	100.00	93.03	87.59	98.04	87.72	97.88	79.35	80.13
Honeybourne Hospital	100.00	95.97	92.19	100.00	90.70	96.67		85.42
Laurel House	100.00	94.84	90.97	100.00	92.86	96.67		87.50
Lydney Hospital	100.00	82.65	87.59	78.00	88.46	99.17	66.51	70.35
North Cots Hospital	99.35	94.05	87.59	100.00	91.80	99.01	84.53	82.87
Stroud Hospital	100.00	89.71	89.18	90.20	85.96	98.77	71.88	72.89
Tewkesbury Hospital	100.00	92.97	87.59	100.00	94.23	99.18	68.81	67.65
Vale Hospital	100.00	85.66	88.65	82.05	94.23	99.18	74.77	73.56
Wotton Lawn Hospital	99.70	95.48	92.19	100.00	96.83	99.32		86.41
	Cleanliness	**Food Overall**	**Organisational Food**	**Ward Food**	**Privacy, Dignity and Wellbeing**	**Condition Appearance and Maintenance**	**Dementia**	**Disability**
Organisational Average	**99.89%**	**92.79%**	**89.78%**	**96.39%**	**93.18%**	**98.85%**	**76.61%**	**78.97%**
National Average	**98.10%**	**90.90%**	**91.20%**	**91.00%**	**87.50%**	**95.90%**	**82.50%**	**84.30%**
Upper quartile	99.80%	95.80%	95.40%	98.70%	95.20%	99.20%	93.20%	92.70%
Lower quartile	98.10%	89.60%	88.50%	89.80%	85.00%	94.60%	79.90%	80.20%
Lowest	56.10%	72.60%	67.40%	55.20%	13.60%	9.60%	31.70%	30.00%
Highest	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Median	99.30%	93.10%	92.20%	95.30%	90.60%	97.50%	87.20%	87.10%

Key

Above National Average	
In Upper Quartile	
Below National Average	
In Lower Quartile	

Quality Improvement

Quality Improvement - In December 2023 the QI Strategic Implementation Plan was published which set out four commitments to build on the:

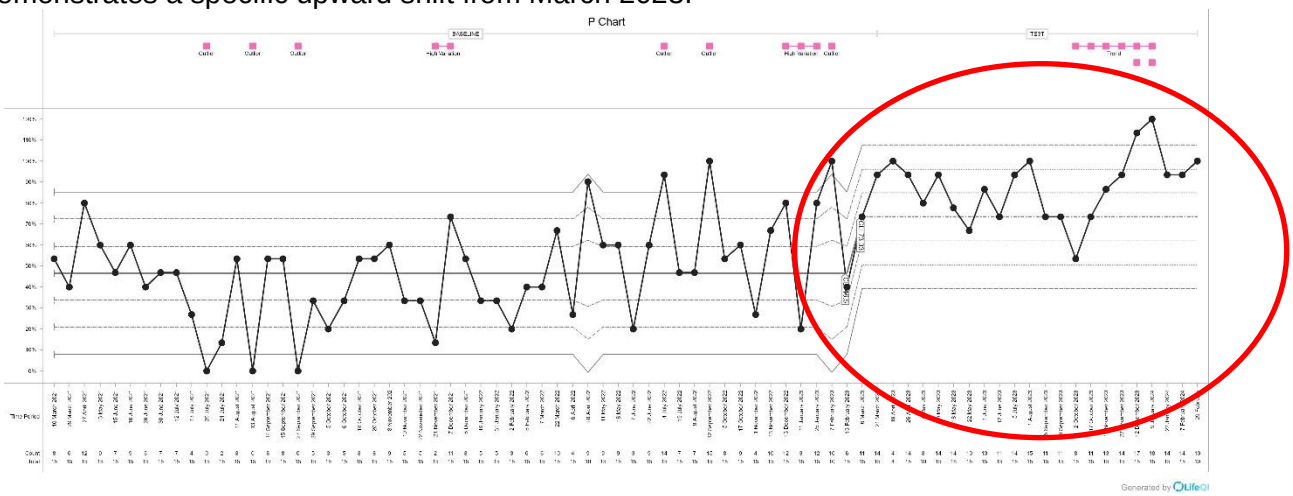
1) Improvement Culture.
2) Improvement Capabilities.
3) Alignment of trust and system priorities with QI initiatives and QI initiatives with trust and system priorities.
4) Foundations for improvement including: the use of data, co-production and a consistent problem-solving approach.

We have supported and developed a QI training programme that consists of bronze level, building confidence in using QI tools and a Silver level, building confidence to lead QI work. This year the QI hub is developing a Gold level, building confidence to coach QI work. This is due to commence in June 2024.

To date, the Trust has 12% (n=547) of current staff trained in Bronze and 1% (n=28) trained in silver level QI.

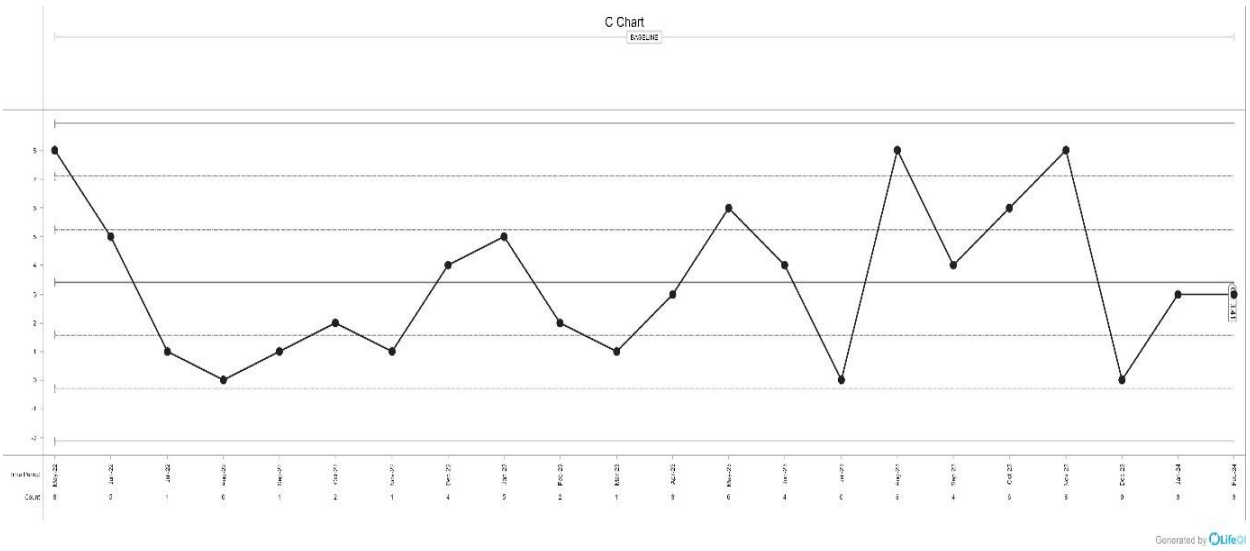
The number of individuals booking onto bronze training has increased over time and for some sessions, where the capacity is 15 places, there has been a wait list created.

Below is a chart from March 2021 that demonstrates the number of individuals that attend training compared to number of spaces available. Back in 2021 the numbers were low, and this led to sessions being cancelled. This chart **(for referencing only)** shows a marked change and reflects the increasing number of individuals attending bronze training year on year. The red circle demonstrates a specific upward shift from March 2023.



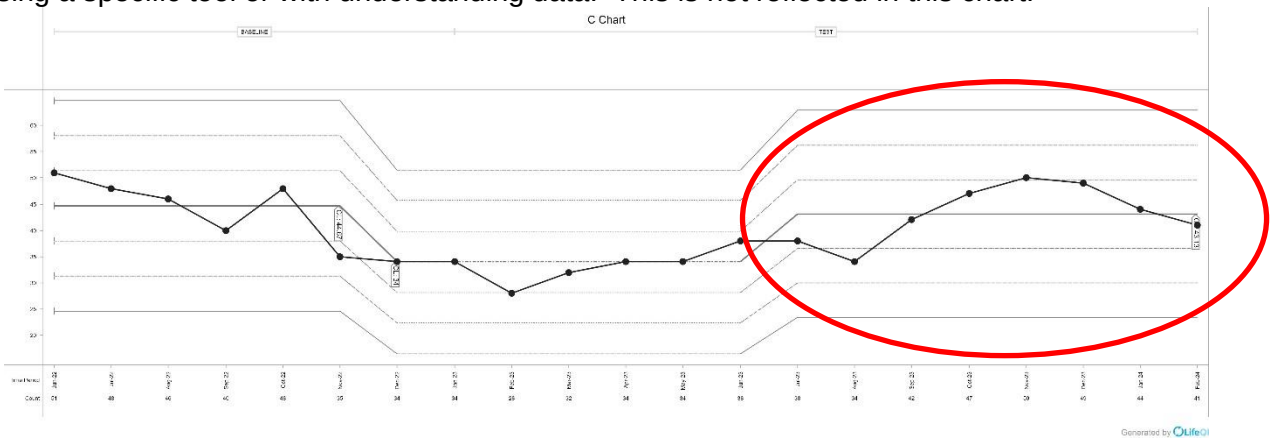
The Silver training has now been delivered over 4 cohorts equating to 28 individuals since 2021. Cohort 5 is currently being delivered with an additional 7 individuals. For cohort 6 due to start in June 2024, there are now 29 people waiting.

The chart below demonstrates the number of new projects initiated monthly since May 2022. These are projects that have been scoped by the QI hub and agreement made to support them. In August and November 2023, the hub saw the greatest number of projects initiated which was 8. The last time this number was this high was back in May 2022, as seen in the chart. There is a theory that this may be due to when staff have the time to initiative QI work however, this has not been tested or evidenced. This chart **(for referencing only)** shows there is variability in the work initiated over time.



The QI hub supports a number of QI projects within the trust and maintain a tracker of these. There is an acknowledgement that there will be projects that the QI hub is not aware of where individuals and teams do not require the support of the hub. This report highlights those projects that the QI hub is actively supporting.

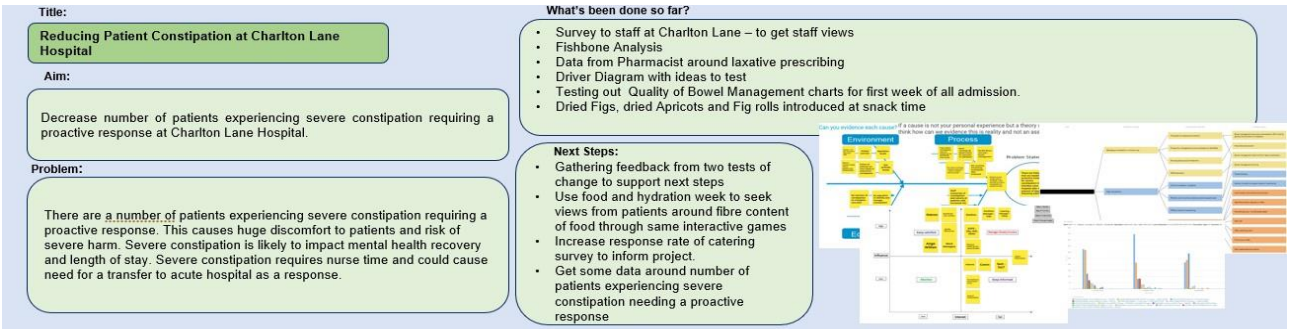
The next chart **(for referencing only)** demonstrates the number of projects supported per month by the QI hub. These are current projects that are open. There are also several projects that are on hold. In addition, there are pieces of work where the QI hub support individuals or teams with using a specific tool or with understanding data. This is not reflected in this chart.



This chart shows active projects from June 2022 to February 2024. The number of active projects reduced in December 2022 when the QI hub introduced an MDT to ensure effective progress and closure of work as appropriate.
From June 2023 there has been an upward shift in the number of active projects being supported by the QI hub. This is highlighted by the red circle. This shows an increase in the average number of active projects from **34** to **43**.

A Case Study:

The below reflects a specific piece of work supported by the QI hub that demonstrates the importance of providing staff with the time, permission, and improvement skills to collaboratively work together on improving an area of work that they are passionate about and adds value to the quality of patient care and experience. The work describes improving the number of patients experiencing severe constipation at Charlton Lane Hospital. Staff are currently testing quality of bowel management charts for the first week of admissions and dried figs and apricots at snack time.



The reflections from this work are that an increasing number of staff are keen and willing to be part of the project as it progresses. The response rate to the survey that the project team put out was high and there was fantastic qualitative feedback which has been used to further inform the fishbone (cause and effect diagram) and change ideas detailed on the driver diagram. This work

demonstrates the way that QI can ensure work that adds value to staff and patients is realised and taken forward.
We have produced the AHP Strategy which is informed by the quality agenda. This sets out our ambitions of the next 3 years and links with a number of parallel themes and ambitions in the Quality Strategy.

In December 2023, colleagues from across Community Hospitals came together to celebrate a broad range of projects that have been initiated throughout the year. The purpose of the event was to create a space to reflect, share, learn and celebrate all of the work happening across our services, and to recognise the passion and innovation that has been driven by teams. The event recognised the broad range of improvement work that had been happening across Community Hospitals, some of which had been supported by the QI Hub, and some that was driven locally by colleagues and their passion for service development. The event was attended by colleagues from across Community Hospital teams, including inpatients, ambulatory care, medical, nursing, therapy and ACP colleagues with fantastic feedback received.

Project Name	Overview	Learning / Outcomes / Success
End of Life	Project stemmed from feedback received following an EOL patient at North Cotswolds Hospital The team worked to review and improve EOL processes. They worked with the surrounding community to off bereavement services to people in the hospital to help prepare and support people through the process. Time was also spent to support learning for staff.	The project shows our capability to really listen and understand that when someone is dying their relatives don't know what they can do, i.e. hold hand, sit on the bed, etc. it helped place a focus on how we support relatives and their needs during a loved one's EOL.
Phagenesis	Course that the SALT team attended to learn about a tool to stimulate cords giving an opportunity to make a better outcome for the patients through innovation.	Improved swallow timing. Improved airway safety. Improve diet and nutritional independence.
Botulinum toxin injections	Learning undertaken to be able to administer BoTN for the treatment of focal spasticity following stroke. Treatment with Botulinum toxin type A is recognised as common practice as a management option for focal spasticity resulting from upper motor neurone syndrome (e.g. stroke) and is recommended by the Royal College of Physicians (RCP).	Better care for patients. These injections can help to treat conditions following a stroke and help to relieve pain
Macular degeneration society support group	Recognising limitations for people experiencing Macular degeneration, how we can support them by bringing them together. The support group gives patients the opportunity to share experiences, discuss together how these impact on their life and for supporting family members. There are speakers who attend and talk on new research, new treatments and the possibilities for future.	Always improving – the support group offers a safe space for people to share their experiences and learn from others in the group. Guest speakers attend to share new research, treatment and possibilities for the future. Colleagues attending the sessions listen and learn about new ways to help support.

Improving Medication Rounds	Improved drug rounds on the inpatient ward through QI methodology	Improves efficiency and cost as well as time taken to give drugs, better patient outcomes because not having to be disturbed often, improved time to care by nursing team, enabling holistic care
Improving Mouthcare	Standardising mouth care products, improving knowledge and empowering staff through training and education to understand the importance of providing mouth care in a safe and compassionate way, and the impact this has on improving patients' overall health and wellbeing. Established Mouthcare champions to help support raising profile and importance of mouthcare. Pathway development for patients post discharge. Project being rolled out to the community in collaboration with community leads and IPC team.	Personalised care approach. Standardisation of products and production of product guide including poster and action cards. eLearning creation to support staff confidence. Journey shared across OneGlos.
CARE Tool	Developed to support a person living with dementia while they are in our care. It helps with communication, approach, resources and looks at the environment. It gives information on all of those topics and the most effective way to support that individual. Understanding the person and how we can help them in real time and understanding them, using prompts that may help that person when they are in our care.	Culture change on the ward to support person centred care and used alongside the Life Tree on the ward. Winner of the NHS England South West Integrated personalised care award in the category 'Seeing Me' Lucinda Williams awarded the Cavell Nursing award.

Electronic Data Management System (EDMS).

To date, the project team have completed scanning and quality checking the trust's historical paper mental health records. The team have also processed around 60% of the trust's physical health records and are working through additional learning disabilities service records, which were identified later on in the project.

At the beginning of March 2024, the trust's scanned historical paper mental health records were made available to RiO users. Data from the first months following go-live shows the system is being well utilised by the trust's mental health teams. We are seeing a significantly higher number of click-throughs to scanned records from RiO, when compared to requests for paper records prior to the go-live date. Initial feedback from end users has been positive. The project team are in the process of designing a survey to build on this feedback, in order to inform future changes and developments to the system.

The next step for the project is to make scanned historical mental and physical health records available to both RiO and SystmOne users. The project team are currently working with the system suppliers to define requirements for a development to the CITO system, which needs to be in place prior to the go-live for SystmOne users. This is required in order to maintain the current information governance controls we have in place for the RiO and SystmOne clinical systems. The system

suppliers have indicated that this will be in place by October 2024 at the latest but is likely to be delivered earlier than this.

The original business case for the EDMS project was created in March 2021, which included integration with JUYI, MESH, full migration of documents from RiO and SystmOne, including letter template functionality and storage of video files. There have been many changes since then (Clinical Systems Vision Programme, JUYI, etc.). We now have a better understanding of the technical limitations of core systems and need to ascertain the willingness of system suppliers to work with us to develop solutions to key issues. A working group has been set up, with membership from Clinical Systems, IT, BI and the system suppliers to work through issues relating to technical architecture. This group will report back to project board, with recommendations of how to approach these challenges, in order to realise the most benefits for the trust as it is in 2024.

Fidelity Testing

As an organisation we have enhanced and further developed the process of Fidelity Testing during this year to test the fidelity of completed actions and this now forms an embedded core function of the quality directorate. The aim of the fidelity testing is to employ a standardised system to review individual actions following assurance being submitted indicating that actions and recommendations have been completed through various sources of learning.

The actions will have been identified through a number of different areas (although not limited to):

- Clinical Audit
- NICE Guidance
- CQC/PAS Action plans
- CQC Self-Assessment/Peer Review
- Clinical Incidents
- Serious Incidents/Patient Safety Incident Reviews
- PCET Upheld Actions

Process

Six months after an action has been closed down the reviewer will revisit the original action plan and engage in a range of tests to ensure the learning from the action has been embedded. The testing may involve a review of policy, standard operation procedures, healthcare records, ward team visits, interviewing staff and patients where relevant to the action. The fidelity test will be a collaborative process and ideally be undertaken with at least one member of the originating team.

The standard template below has been developed to help evidence the embedded learning outputs. This a blend of ideas from Len Bowers Safe wards, NICHE feedback and builds on current Trust governance structures. The reviewer will need to provide additional evidence of the embedded nature of the action. Each recommendation has the original score and our current assessment based on the programme of work thus providing organisational assurance that action have been implemented and then embedded where required.

Rating System is set out below:

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

0 None of the identified actions have been initiated
1 All actions have an action owner, have commenced and assurance criteria agreed and documented
2 Review of the actions provides evidence that actions identified have significantly progressed and there is evidence to support this
3 Actions have been completed but have not been tested within the clinical environment
4 Actions have been completed and tested; evidence has been provided to give assurance that actions are embedded into clinical practice.
5 This Action can only be completed after actions have been evaluated within clinical practice for a sustained period of between 6 -12 months or as identified by the Quality Assurance team. Clinical audit should be used where appropriate. Following the completion of the rating score 5 the action will be closed.

The outcomes of the test are shared with the clinical teams and feature as part of any arranged local governance meetings. In addition, we share the outputs of this assurance work with the CQC as part of our routine monitoring arrangements.

Even better if…

Over the next 12 months we need to embed Fidelity Testing more routinely into practice areas. The pilot areas have embraced the process and recognise its value in ensuring that actions we set from our activity are meaningful and it has challenged those clinicians to consider how we can evidence the ways in which practice has changed and is then embedded. The Clinical development managers (CDM's) are out in practice areas working alongside clinicians and we need to maximise their time to develop our conversation around quality, controls and assurance processes as this will develop our maturity as an organisation.

Health Inequalities

There are many initiatives across our learning disability services aimed at tackling the health in equalities that we know many people with learning disabilities face. Here are just a few examples:

Our Health Facilitator chairs a multi-agency group looking at how Annual Health checks are run across the county for people with a learning disability; the work of this group has included introducing a pre-health check questionnaire, which has recently been reviewed and is now inline with clinical recording systems used by most GPs across the county, as well promoting access to the learning disability register and ensuring that people are invited to / attend for their health checks. Through this group we have also worked closely with the ICB to support surgeries over the past few years who have been struggling to complete their health checks and work conducted by a specialist learning disability nurse to facilitate this has had a big impact. More recently there has been agreement for a learning disability screening practitioner to work within the Trust to actively promote

access to cancer screenings for people with a learning disability across the county (this post will sit within Angela Willan's team, Nursing Projects - Mental Health and Learning Disabilities).

Clinicians from the GHC learning disability service are actively involved in the LeDeR review process and findings from these reviews produce learning for all involved in the care of people with learning disabilities; local and national learning is shared across our service and more widely. In response to these findings, there is a greater focus on healthy lifestyles and healthy eating, and we are currently working in partnership with Inclusion Gloucestershire to review people's experiences of accessing weight management services with the aim of informing the development of more useful / accessible resources.

One of our biggest and most popular initiatives aimed at health inequalities that people will hopefully already be aware of is the Big Health Day, held every year at Plock Court in Gloucester, where health and social care providers (both statutory and voluntary) come together to offer over 120 information stalls alongside interactive and inclusive sports and other attractions. This year is the 16th Big Health Day event, and it takes place on Friday June 14th.

Guardian of safe working

The Trust has a Consultant and Guardian of Safe Working Hours who provides the Trust Board with quarterly reports about the Trust's performance on junior doctors' rotas and rest periods. These quarterly Board reports summarise all exception reports, work schedule reviews and rota gaps, and provide assurance on compliance with safe working hours by both the Trust and doctors in approved training programmes. The purpose of the regular reports is to give assurance to the Board that doctors in training are safely rostered and that their working hours are in compliance with the Terms and Conditions of Service.

A summary of exception reporting and rota gaps for the year 1st April 2023 to 31st March 2024 is shown below.

Date	No. of reports	Resolutions
April 2023 to June 2023	8	8 – TOIL agreed.
July 2023 to September 2023	9	8 – Additional payment 1 – Penalty action
October 2023 to December 2023	6	3 – Additional payment. 2 – TOIL 1 – Work schedule Review
January 2023 to March 2024	4	3 – TOIL 1 – Payment

Equality , Diversity and Inclusion

Whilst we have had EDI on the agenda for many years, we found that over the last year as a Trust, we have experienced an increase in reported racist incidents. As part of a series of measures we are taking to address these incidents, we are taking this opportunity to raise awareness about the range of support we have in place for colleagues who have experienced racism at work.

Our People Strategy sets out our pledge as an organisation to support our colleagues to be free from bullying or discrimination at work.

Whilst racist incidents are a key focus of the strategy, we are also working to address the wider incidents of hate crime, including homophobic and sexist abuse; whether this is from patient-to-colleague or colleague-to-colleague.

To enable colleagues to more easily access support, we have co-produced an **Equality, Diversity and Inclusion Incident Roadmap** which is aimed at visually representing the range of support that we have in place for those colleagues who have experienced, or may experience and witness, abuse - as EDI Lead Tania Hamilton explains:

"We have felt an increase in the number of racist incidents reported within our Trust and we listened to the views that not all our processes and support around abuse are easy to find. This Roadmap aims to help with that. Nothing is new in this Roadmap, it merely aims to simplify, highlight and raise awareness about the existing support that is currently available in an accessible, at-a-glance image. The image is supplemented by a more comprehensive guidance document with links to relevant support, policies and contacts".

Statement from Healthwatch Gloucestershire

Thank you for sharing the Quality Accounts for Gloucestershire Health and Care Foundation Trust for 2023/24.
As the Trust enters its second year of moving toward achieving the priorities set in 2022/23, we are pleased to see the positive progress being made as a result of the work being carried out by it's staff. We also commend the Trust for its continued emphasis on co-production with these priorities in an effort to put patients and carers at the heart of decision making and steps taken to try to address health inequalities.
As such, we welcome the phased roll out of the "My Care Plan" across mental health services, which lets service users express in their own words what is important to them, and the strong focus on learning from patient safety incidents and Freedom to Speak Up, which provides opportunities for patient and staff voices to be heard and acted upon.
Healthwatch Gloucestershire acknowledges the commitment to making such priorities a two year project to reflect the in depth work being done.
We note the acknowledgement by the CEO that there have been instances where standards were not always as high as expected as highlighted in the CQC inspection report on Berkeley House, but recognise that urgent improvements were implemented and this is being monitored.
Healthwatch Gloucestershire values the collaborative relationship we have with the Trust, particularly through one of our Board members having a seat on the Council of Governors, which enables us to share public feedback and provide insight. Over the past year, the Trust have welcomed our findings and recommendations in response to our independent volunteer visits to Wotton Lawn Hospital and two community Minor Injury and Illness Units to understand what it is like to be a patient using their services.
We congratulate the Gloucestershire Health and Care Foundation Trust on their accomplishments during the period and look forward to continuing to work together.

Gloucestershire Health Overview and Scrutiny Committee response to Gloucestershire Health and Care NHS Foundation Trust's Quality Accounts 2023/24.Please see below a statement from Cllr Andrew Gravells, Chair of the Gloucestershire Health Overview and Scrutiny Committee, in response to the request to comment on the Gloucestershire Health and Care NHS Foundation Trust Quality Account 2023/24.

Thank you for your invitation to comment on the Gloucestershire Health and Care NHS Foundation Trust Quality Account 2023/2024.

In what has again been a challenging year, I can confirm that the Gloucestershire Health Overview and Scrutiny Committee will continue to support the Trust when considering the issues and concerns that impact on the delivery of services provided by Gloucestershire Health and Care. As in previous years, the Gloucestershire Health Overview and Scrutiny Committee value and appreciate the skills and attributes of the men and women employed by the Trust, helping them to deliver a broad range of services, often in difficult circumstances. In particular, the Committee has looked at issues around Mental Health, and CAMHS.

We are pleased to have this opportunity to pay tribute to the work of Ingrid Barker, Trust Chair, who has now left the Trust and who has worked with HOSC closely and courteously over recent years. We wish Ingrid well in her new role.

Kind regards

Cllr Andrew Gravells (Chair)
Health Overview & Scrutiny Overview and Committee

NHS Gloucestershire response to Gloucestershire Health and Care NHS Foundation Trust's Quality Account 2023/24.Please see below a statement from Marie Crofts, Chief Nursing Officer NHS Gloucestershire in response to the request to comment on the Gloucestershire Health and Care NHS Foundation Trust Quality Account 2023/24.

I appreciate the opportunity to review and respond to Gloucestershire Health & Care Quality Account for 2023/24. The Integrated Care Board acknowledges the commitment and efforts demonstrated in delivering quality and care within all of their services.

We recognise achievements in the 11 quality priorities aligning with their Quality Strategy and the continued work to fully implement and embed these improvements over the next year, and as described developing changes in culture, processes and practice.

The ICB notes the compliance with national and local audits, and the subsequent actions taken demonstrating the commitment to continuously improving the quality of healthcare provided by Gloucestershire Health and Care.

It is pleasing to see that research is an important part of the work that Gloucestershire Health and Care are undertaking, working with the Research4Gloucestershire partners on innovation and best practice for the citizens of Gloucestershire in collaborative, systemwide approach.

We appreciate the openness and transparency of the trust when improvements have been required and we commend the strong commitment of the staff to improve quality for their service users. The good working relationships with the CQC and the ICB have supported a structured and sustainable approach to improving the quality of these services.

We look forward to continued collaboration and support in driving quality improvements.

Annex 2: Statement of Directors' responsibilities in respect of the Quality Account

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

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality Accounts (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality account.

In preparing the quality account, Directors are required to take steps to satisfy themselves that:

- the content of the quality account meets the requirements set out in the *NHS foundation trust annual reporting manual 2020/21* and supporting guidance *Detailed requirements for quality reports 2019/20*

- the content of the quality account is not inconsistent with internal and external sources of information including:

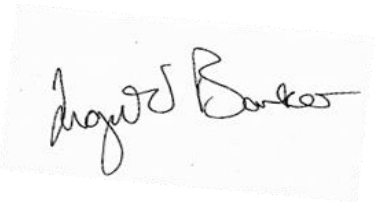
  - Board minutes and papers for the period April 2023 to March 2024
  - papers relating to quality reported to the Board over the period April 2023 - March 2024
  - feedback from Commissioners dated June 2024
  - feedback from local Healthwatch organisations dated June 2024
  - feedback from overview and scrutiny committees dated June 2024

- the Trust's complaints report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2024
- the 2020 CQC national patient survey dated 2023
- the 2020 national NHS staff survey dated March 2024
- CQC inspection reports .

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

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

By order of the Board



Ingrid Barker
Chair **Date: 28/06/2024**

Douglas Blair
Chief Executive **Date: 28/06/2024**

Annex 3: Glossary

BMI	Body Mass Index
CCG	Clinical Commissioning Group
CPA	Care Programme Approach: a system of delivering community service to those with mental illness
CQC	Care Quality Commission – the Government body that regulates the quality of services from all providers of NHS care.
CQUIN	Commissioning for Quality & Innovation: this is a way of incentivising NHS organisations by making part of their payments dependent on achieving specific quality goals and targets
CYPS	Children and Young Peoples Service
DATIX	This is the risk management software the Trust uses to report and analyse incidents, complaints and claims as well as documenting the risk register.

ECG	An electrocardiogram (ECG) is a test that is used to check the heart's rhythm and electrical activity.
GHC	Gloucestershire Health and Care NHS Foundation Trust
GRiP	Gloucestershire Recovery in Psychosis (GriP) is ^{2}gether's specialist early intervention team working with people aged 14-35 who have first episode psychosis.
HoNOS	Health of the Nation Outcome Scales – this is the most widely used routine Measure of clinical outcome used by English mental health services.
ICS	Integrated Care System. NHS Partnerships with local councils and others which take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.
IAPT	Improving Access to Psychological Therapies
Information Governance (IG) Toolkit	The IG Toolkit is an online system that allows NHS organisations and partners to assess themselves against a list of 45 Department of Health Information Governance policies and standards.
LeDer	Learning Disabilities Mortality Review. It is a national programme aimed at making improvements to the lives of people with learning disabilities
MCA	Mental Capacity Act
MHMDS	The Mental Health Minimum Data Set is a series of key personal information that should be recorded on the records of every service user
NHSI	NHSI is the independent regulator of NHS foundation trusts. They are independent of central government and directly accountable to Parliament.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant
MUST	The Malnutrition Universal Screening Tool is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.
NHS	The National Health Service refers to one or more of the four publicly funded healthcare systems within the United Kingdom. The systems are primarily funded through general taxation rather than requiring private insurance payments. The services provide a comprehensive range of health services, the vast majority of which are free at the point of use for residents of the United Kingdom.
NICE	The National Institute for Health and Care Excellence (previously National Institute for Health and Clinical Excellence) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

NIHR	The National Institute for Health Research supports a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.
NPSA	The National Patient Safety Agency is a body that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
PAM	Patient Activation Measure: This is a tool to measure a patient's skill, knowledge and confidence to manage their long-term conditions.
PBM	Positive Behaviour Management
PHSO	Parliamentary Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PLACE	Patient-Led Assessments of the Care Environment
PROM	Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective.
PMVA	Prevention and Management of Violence and Aggression
ReSPECT	This is a plan created through a conversation between a patient and a healthcare professional which includes their personal priorities for care, particularly for those people who are likely to be nearing the end of their lives.
RiO	This is the name of the electronic system for recording service user care notes and related information within the Trust's mental health services.
ROMs	Routine Outcome Monitoring (ROMs)
SIRI	Serious Incident Requiring Investigation, previously known as a "Serious Untoward Incident". A serious incident is essentially an incident that occurred resulting in serious harm, avoidable death, abuse or serious damage to the reputation of the trust or NHS. In the context of the Quality Account, we use the standard definition of a Serious Incident given by the NPSA
SMI	Serious mental illness
SJR	Structured judgement reviews. A process to effectively review the care received by patients who have died
SystmOne	This is the name of the electronic system for recording service user care notes and related information within the Trust's physical health services.
VTE	Venous thromboembolism is a potentially fatal condition caused when a blood clot (thrombus) forms in a vein. In certain circumstances it is known as Deep Vein Thrombosis.

Annex 4: How to contact us

About this report

If you have any questions or comments concerning the contents of this report or have any other questions about the Trust and how it operates, please write to:

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Gloucester Business Park
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Gloucester
GL3 4AW

Telephone: 0300 421 8100 Email: GHCComms@ghc.nhs.uk

Other comments, concerns, complaints and compliments

Your views and suggestions are important us. They help us to improve the services we provide.

You can give us feedback about our services by:

- Speaking to a member of staff directly;
- Telephoning us on 0300 421 8313;
- Completing our Online Feedback Form at www.ghc.nhs.uk
- Completing our Comment, Concern, Complaint, Compliment Leaflet, available from any of our Trust sites;
- Using one of the feedback screens at selected Trust sites
- Contacting the Patient & Carer Experience Team at experience@ghc.nhs.uk
- Writing to the appropriate service manager or the Trust's Chief Executive

Alternative formats

If you would like a copy of this report in a different format please telephone us on 0300 421 7146.