2gether NHS Foundation Trust

Gloucestershire Care Services NHS Trust

Trust Board

Date of Meeting: 6th June 2019

Report Title: Quality and Performance Report

Agenda reference Number	20/0619
Reason for Being Heard in Confidential Session	N/A
Accountable Executive Director (AED)	Susan Field – Director of Nursing Candace Plouffe, Chief Operating Officer
Presenter (if not AED)	Susan Field – Director of Nursing
Author(s)	Susan Field – Director of Nursing
Board action required	To Discuss, Note and Receive
Previously considered by	Quality and Performance Committee 25th April 2019 (March 2019 data) Executive Team (May 2019)
Appendices	Appendix 1 – Quality and Performance Report April 2019 data

Executive Summary:

This report provides an overview of the Trust's Quality and Performance activities as at April 2019. It is also intended to highlight achievements made and outlines how the Trust is responding to those areas where improvements are either continuing or need to improve further.

Recommendations:

The Board is asked:

- **Discuss**, **Note** and **Receive** the April 2019 Quality and Performance report

Joining up physical and mental health care

Related Trust Objectives	
Risk Implications	Risk issues are clearly identifed within the report
Quality/Equality Impact Assessment (QEIA) Requirements/Implications	No equality implications identified
Financial Implications	Finance implications are clearly referenced in the report
Legal/Regulatory Implications	Legal/Regulatory implications are clearly referenced in the report

Quality and Performance Report

Introduction and Purpose

This report summarises the key highlight and exceptions in the Trusts April 2019 Quality and Performance data.

Background

The Trusts Quality and Performance Committee reviewed March 2019 and full year end performance data at its meeting in April. The attached report format has been reviewed in readiness for the 2019-20 reporting year. This review has involved executive and performance team colleagues and taken into account any learning from last year's reporting arrangements.

Key Areas to Note

This report outlines an improved qualitative approach for reporting against its 2019-20 quality priorities and the national Commissioning for Quality and Innovation (CQUIN) associated with falls prevention and management. In addition to this there is now closer alignment with the quality dashboards that are now being displayed in the Community Hospitals and Minor Injury and Illness Units (page 12 of the report).

Other matters of note include:

- An improving level of compliance with Personal Development Reviews (PDRs)
- Some services continue to be challenging in terms of achieving its 8 week referral to treat targets, most notably adult speech and language, Musculoskeletal (MSK) Physiotherapy, paediatric physiotherapy, occupational therapy and Integrated Community Teams (ICT) physiotherapy service.
- There have been no reported cases of Clostridium Difficile, MRSA.
- There have been no Serious Incidents Requiring Investigation (SIRI) or Never Events declared.

Conclusion and Recommendations

The Trust Board is asked to:

- **Discuss**, **Note** and **Receive** the April 2019 Quality and Performance report

Abbreviations Used in Report

PDRs - Personal Development Reviews
CQUIN – Commissioning for Quality and Innovation
MSK – Musculoskeletal
ICT – Integrated Community Teams
SIRI – Serious Incident Requiring Investigation

Gloucestershire Care Services NHS
NHS Trust

Quality & Performance Report

Trust Board
6th June 2019

Data for April 2019

Understanding you

Executive Summary

NHS Gloucestershire Care Services NHS Trust

Are Our Services Caring?
- Friends and Family Test response rate in April was **17.8%,** a decrease from March **(19.4%)** but above the 2018/19 mean **(14.6%)**.
- The proportion of patients indicating Likely or Extremely Likely to recommend our services increased to **93.4%** in April (Apr-17 – Apr-19 mean **93.0%**).

Are Our Services Safe?
- Safety Thermometer Harm free score was **94.3%** in April, an increase from **92.1%** in March (target 95%), and above the mean **93.95%** (Apr-17 – Apr-19).
- Based on new harms only, the Trust achieved harm-free care of **98.3%** in April, compared to a target of 98%.

Are our Services Effective?
- Bed Occupancy rate was **94.1%** in April, a decrease from **96.5%** in March and slightly below the mean of **94.92%** (Apr-17-Apr-19).

Are Our Services Responsive?
- The number of 4 hour breaches in MIIUs increased to **59** in April from **36** in March. Performance in the '% seen and discharged within 4 hours' measure remains significantly above the 95% target with performance of **99.1%** in April 2019 and a mean of **99.14%** since April 2017.
- Musculoskeletal Advanced Practitioner service (MSKAPS) performance metric for patients to be seen within 2 weeks of referral has been removed in 2019/20. The target had not been achieved since introduction of Electronic Referral System as patients could book appointments outside of the 2 week window. This issue is being experienced nationally by other providers.
- SPCA abandoned call rate measure was **0.9%** in April, a reduction from **1.0%** in March and continues to be below the threshold of <5%. For priority 1 and 2 calls, the percentage of calls answered within 60 seconds is above the 95% target at **97.9%**.
- Referral to Treatment targets continue to prove challenging. Five services are identified from Statistical Process Control charts as continually missing the 95% within 8 weeks target.

Are Our Services Well Led?
- Mandatory training compliance rate in April was **85.79%**.
- Sickness absence (rolling 12 months to march) is **4.89%,** against a local target of <4% and a slight decrease to the level reported in December 2018.
- **76.42 %** of all staff Personal Development Reviews were completed by the end of April 2019 an increase from March (**74.66%)** but below target (95%). For active assignments only, the figure for April is **81.24**%, an increase from March (**79.10%**) and highest since August 2018 but remains below target (95%)**.**

Statistical Process Control (SPC) Charts
- The criteria for exception reporting in this report uses SPC charts to identify where performance falls outside of upper or lower control limits, and is viewed in conjunction with, rather than solely based on, RAG ratings. This report contains a number of SPC charts and is supported by a separate SPC Addendum pack that covers all measures within the Performance Dashboard (pages 15-17).

Data Quality

The Performance Dashboard (pages 15-17) includes a data quality rating for each metric. The basis of this is the 2017/18 Trust Reference Cost report and additional interpretation from Performance and Information team. The methodology incorporates consideration of completeness, validity and reporting methodology of activity recorded within systems used for performance reporting. However this approach does not have a statistical basis to the methodology or RAG rating. The metric rated red is:
- % of terminations carried out within 9 weeks and 6 days of gestation – the current spreadsheet reporting tool used for medical terminations of pregnancy is subject to recording error and the plan is to transition this onto the Clinical System used in Sexual Health. Work has been completed to ensure all data items are available to be collected on dynamic forms, however, connectivity issues are currently being investigated and a Task and Finish Group will commence work in May 2019 to resolve all issues by end of Qtr.2 2019/20.

Month on month change in data quality rating will be indicated with an upwards arrow to show improvement, downwards arrow to show reduction.

Quality Priorities

Quality Priorities for 2019/20 included in this report are based on a mixture of metrics and audits. Where audits or actions are to be reported on a quarterly basis a RAG rating will be applied and updated during the quarter to provide an update of progress towards completion of actions.

Quality Priority | Are Service Safe?

Gloucestershire Care Services NHS Trust

1. Medication Incidents

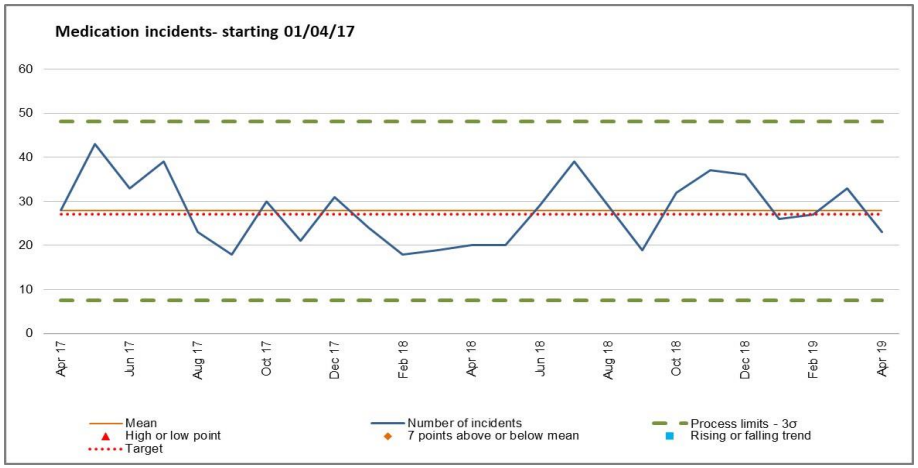
Outcome: Improve the learning from "no-harm" and "low-harm" medication incidents in order to enhance patient safety and quality of care

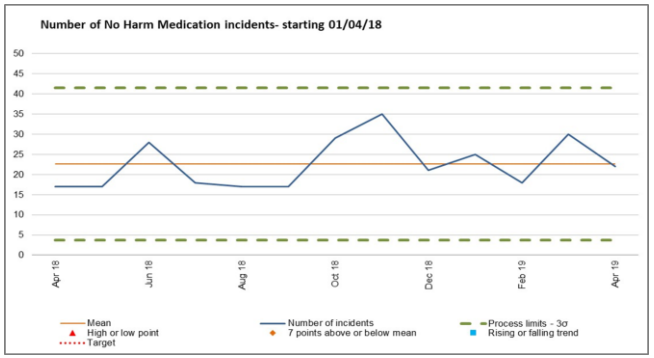
This continuing priority will support:

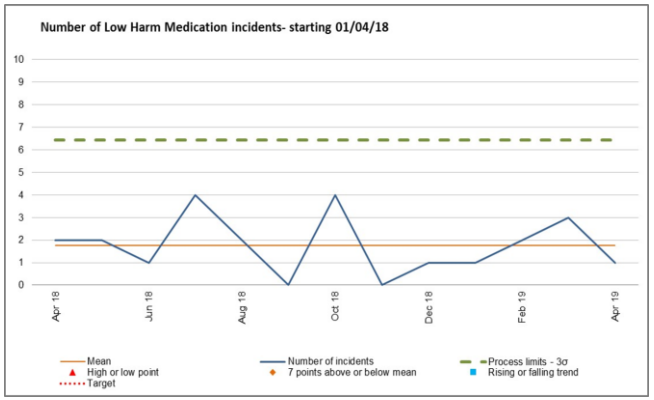
- Identification and theming of factors contributing/causing low and no harm medication incidents
- Recommendations to address identified themes

Quarter 1 action to establish a baseline of quality of reporting of no-harm and low-harm reported medication incidents is on target to be completed within the quarter.

Improve the learning from "no-harm" and "low-harm" incidents	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No-harm medication incidents	Establish a baseline of quality of reporting of no-harm reported medication incidents using quality audits			Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting			Implementation of actions agreed from Qtr. 2			A repeat audit of no-harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved		
Low-harm medication incidents	Establish a baseline of quality of reporting of low-harm reported medication incidents using quality audits			Quality Improvement working group will establish a training needs analysis on baseline data and agree actions required to improve quality of reporting			Implementation of actions agreed from Qtr. 2			A repeat audit of low-harm reported medication incidents will be performed to determine if the aims of the outcome have been achieved		







What actions have been taken to improve performance?

- Work continues to source and develop e-learning, essential for role training to support safe and secure management of medicines for colleagues.
- The SPC chart shows the number of medication incidents to be within control limits (normal variation).

There were 23 medication incidents with GCS responsibility reported in April.

- 1 resulted in low harm
- 22 resulted in no harm

2. Mental Capacity Act

Outcome: Improve the usage of mental capacity assessments in our hospital and community settings to ensure that individuals who lack the ability to make decisions are the focus of any decisions made, or actions taken on their behalf

NHS Gloucestershire Care Services NHS Trust

The underlying philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack the capacity to make specific decisions are the focus of any decisions made, or actions taken, on their behalf. It is a legal requirement to carry out an assessment when a person's capacity is in doubt.

Due to the nature of many of our patients it has been recognised for some time that we need to improve our practice of assessing mental capacity in those where capacity has been in doubt, and this has been confirmed by recent audits. Clinicians cite time constraints, confidence and lack of awareness for reasons for MCA assessments not being completed; myth busting the time capacity issue has been identified as a key challenge as using MCA as a tool earlier in assessments can save considerable time for clinicians later on.

Whilst it is recognised that this is a national problem not unique to this Trust it is felt we can significantly improve on our current performance. A Quality Improvement programme in 2019-20 will address this new programme through increasing availability and targeting of MCA training, campaigns on general awareness, "common scenarios" updates through CORE newsletter and social media and regular audits to establish success and target any further action.

MCA needs to become a "business as usual" exercise, to ensure that the Trust is compliant with legislation and to achieve optimum benefits to our patients and families

Metrics for performance will focus on the completion of the MCA2 and Deprivation of Liberty Safeguards (DoLS) assessments for significant decisions where patients do not have the capacity to consent to being restricted or restrained. General usage of the MCA1 form (where clinicians demonstrate they have considered capacity for day to day decisions) will also be monitored and reported on across the Trust, with baselines for these determined in Qtr. 1. This should provide a general proxy indicator on whether awareness and practice is becoming more embedded.

Clinical Policy CLP 117 Restrictive Intervention Policy (ADULTS) defines:
Any restrictive practice must be reasonable and proportionate to the identified risk. Recognising that circumstances are often complex, it is imperative that all other means of preventative restrictive practice is applied. Any restraint must be for the minimum time. This is determined through an ongoing assessment of the person.

A Supreme Court judgement in March 2014 made reference to the 'acid test'. The acid test is applied to people who lack capacity to be able to give valid consent to care and treatment and

- Are not allowed to leave
- Are under continuous supervision and control

Examples include:

- Patient not allowed to leave the ward (wrist band alarm or locks, sedation)
- One to one supervision
- Bed rails
- High/low bed
- Pressure mats/sensors
- Covert Medication

Mental capacity Act and DoLS operational practice
Reference – 559
Rating – 12

MCA Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Has an MCA2 been completed for restrained or restricted patients in our community hospitals?	Target	15%			30%			60%			90%		
(Baseline from March 2019 audit 11%. Measured from dip test audit mid quarter)	Actual	Audit mid May 2019			Audit mid August 2019			Audit mid November 2019			Audit mid February 2020		
Has a deprivation of Liberty Safeguards application been made for all patients who do not have capacity to consent to being restricted or restrained?	Target	25%			40%			60%			90%		
(Baseline 22% from March 2019 audit)	Actual	Audit mid May 2019			Audit mid August 2019			Audit mid November 2019			Audit mid February 2020		

3. "Better Conversations" and Personalised Care

Outcome: Develop a programme of personalised care planning to enable patients to manage their long term conditions more effectively

NHS Gloucestershire Care Services NHS Trust

Quarter 1 action to establish baseline and set targets is on target to be completed within the quarter.

Personalised care is a priority in the Long Term Plan, with a stated objective that it should become "business as usual across the health and care system". In the ICS workforce strategy the vision is to see this facilitated by a health coaching approach, called "Better Conversations".
The Trust is committed to the wide spread adoption of this new programme in a sustainable way and will be monitoring and reporting upon:

- Evidence of numbers of people completing Better Conversations training
- Evidence of use of supervision to embed and support this approach
- Evidence of this approach in use in Multidisciplinary (MDT)/Network MDT/case management meetings

NHSE have committed to "*consider, develop and test the most appropriate personalised care activity metrics*" including the development of a new Long Term Conditions Patient Recorded Outcomes Measure (PROM).

The patient activation measure (PAM) will be a key tool in these early stages. Patient "activation" describes the knowledge, skills and confidence a person has in managing their own health and care. The concept of patient activation links to all the principles of person-centred care, and enables the delivery of personalised care that supports people to recognise and develop their own strengths and abilities. It underpins an asset-based approach that supports people to develop their capability to manage their own health and care by giving them information they can understand and act on, and providing them with support that is tailored to their needs. By understanding a person's level of knowledge, skills and confidence (or "activation level"), NHS services can support them in the most appropriate way to manage their long term condition.

As this is the first year of the programme much of Qtr. 1 and some of Qtr. 2 will include identifying appropriate patient cohorts by participating services on the basis of local (place based) priorities and contractual requirements, pending the completion of this work, local metrics will continually develop but we aim to be able to measure from early on:

- The number of care planning conversations taking place for the identified cohorts (rising % over time)
- Number of patients completing a Patient Activation Measure (PAM) questionnaire; Number of patients completing a second PAM
- The use of PAM data to tailor interventions to further the personalisation agenda
- Delivery of a quarterly *qualitative* report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning.

The services that will be included to start with will be MacMillan Next Steps, Self Management, Diabetes Education, and part of the ICTs (specifically Complex Care at Home and Berkeley Vale ICT where health coaching training has taken place).

It is noted that both the Trust's and 2G Contracts for 2019-20 include a commitment to work with the GCCG to develop "5 core measurable statements for the ICS personalised care programme that define outcomes for patients and success". This programme will directly feed in to this growing body of work.

Better Conversations and Personalised Care Measures	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Number of care planning conversations taking place for the identified cohorts	Establish baseline and set targets for use in Qtrs. 2 to 4			
Number of patients completing a Patient Activation Measure (PAM) questionnaire	Establish baseline and set targets for use in Qtrs. 2 to 4			
Number of patients completing a second PAM	Establish baseline and set targets for use in Qtrs. 2 to 4			
The use of PAM data to tailor interventions to further the personalisation agenda	Establish baseline and set targets for use in Qtrs. 2 to 4			
Delivery of a quarterly qualitative report detailing ongoing developmental activities and examples of good practice, patient stories and shared learning	Establish baseline and set targets for use in Qtrs. 2 to 4			

4. Catheter Management

Outcome: Commence a Quality Improvement programme to improve the management of catheters in community settings

NHS Gloucestershire Care Services NHS Trust

Quarter 1 action to establish baseline and set targets is on target to be completed within the quarter.

Long term catheters whilst beneficial for some patients are also associated with morbidity. Infections (including sepsis) and other complexities which include anxiety over unpredictability of catheter problems (e.g. sudden blockage), difficulties managing away from home (e.g., taking equipment on holiday), sense of physical restraint, limited clothing choices, interruptions to sleep due to discomfort or pulling, and self-identity issues.

It has been identified that some patients appear to have clinically unnecessary urinary catheters in situ; the above risks and problems can therefore impact on the safety, morbidity and quality of life of these cohorts of patients.

A new Quality Improvement (QI) programme has been established that will focus on improving catheter management in our community settings. The following performance metrics have been proposed that will measure its success. The baseline metrics in order to compare and set subsequent performance across Qtrs. 2, 3 and 4 will be established in Qtr. 1; part of the current activities involve changing some configurations in SystmOne (S1) to capture this activity effectively, this work is currently underway:

•To reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.
•The To reduce the number of (clinically unnecessary) urinary catheters inserted or retained in the community setting.

Catheter Management metrics	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
Reduce the amount of community nursing contacts to patients between planned routine catheter changes to manage catheter associated problems.	Establish baseline and set targets for use in Qtrs. 2 to 4			
Reduce the number of (clinically unnecessary) urinary catheters inserted in the community setting.	Establish baseline and set targets for use in Qtrs. 2 to 4			

Actions completed:

A measure has been added into SystmOne to allow us to identify if contacts were planned or unscheduled. This will allow us to extract data – but it means we do not have enough data to establish a baseline at this time.

We have undertaken a catheter challenge in Community Nursing and will review this work in Qtrs. 2 & 3 to look at all caseloads again.

The Catheter Quality Improvement group are focusing on education provision and a recognition the current offer is not accessible enough (currently run through GHFT) and there will be a locally created and delivered offer created.
Linked to this, the education provision will include: urinary catheter assessment & management training, urinary catheter care (for unregistered colleagues), bowel assessment & management and primary continence assessment. Each session will be separate and will be accessed on ESR. We are working with the Lead Specialist Nurse to create these offers.
In addition the group is looking at a new device called Farco-Fill which is in early stage use nationally. This is being done alongside GHFT Urology consultants and is being used for some patients with regular catheter problems to trial use and review efficacy.

5. Wound Care

Outcome: Increase the quality of wound assessments and management countywide in order to reduce clinical variation and improve wound healing rates

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This priority builds on the 2017-2019 CQUIN which was put in place nationally following UK studies that identified inconsistencies in the assessment and management of wounds and the opportunities to improve both efficiency of working and patient outcomes.

There are two principle reasons why wound assessment has been targeted:
1. a need to improve the quality and consistency of care delivered, and
2. a need to reduce the cost burden of wounds. Clinical practice and wound outcomes should ultimately improve.

The Trust has been working to improve wound care as per the 2017-19 CQUIN, performance from Qtr. 4 of year 2 of the CQUIN is known and is used below as a baseline for the Quality Improvement project is currently being established as part of Qtr. 1 activity. The proposed metrics therefore are:

- To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry service or Inpatient settings from baseline.

- To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.

Wound Care Metrics		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
To increase the number of patients who receive a fully compliant assessment (to the "leading change adding value" clinical assessment domains of the 2017-19 wound assessment CQUIN) on admission to Community Nursing caseloads, Complex Leg wound services, Podiatry Service or Inpatient Settings from baseline.	Target	**20%** (based on Q4 Year 2 of the CQUIN)			**30%**			**40%**			**60%** by the end of Year 1 of the QI project. Metrics to be reviewed again if project goes in to Year 2		
	Actual	Audit available end June 2019			Audit available end September 2019			Audit available end December 2019			Audit available end March 2019		
To increase the number of patients who have received a full wound assessment according to the "leading change adding value" Clinical Assessment domains of the 2017-19 wound assessment CQUIN AND whose wounds have healed within 4 weeks.	Target	**55%**			**60%**			**65%**			**70%**		
	Actual	Audit available end June 2019			Audit available end September 2019			Audit available end December 2019			Audit available end March 2019		

6. Pressure Ulcers

Outcome: Build on our success of reducing pressure ulcers by working with the NHSI Stop the Pressure Collaborative framework. This will focus on specific community programmes to reduce pressure ulcers

NHS Gloucestershire Care Services NHS Trust

The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Despite great strides in the past 2 years our aim will be to continue to monitor the number and incidence of pressure ulcers and to continue to drive our reduction plans forward. Our proposed metrics for measuring performance therefore are:

1. Pressure ulcers will continue to reduce across our patient facing services where our span of influence can have an impact.
2. Quality improvement methodology will continue and be targeted in areas of high incidence to understand the issues, focus on those areas and showcase improvement. The PDSA cycle will report quarterly on these areas and will include a qualitative report.

Plans also include working collaboratively with GHFT or care homes where specific incidences or themes demonstrate the potential for system wide learning. Qualitative reporting will also include case studies where pressure ulcers have been managed and healed, following the patient journey and taking in to account other factors such as nutrition and hydration.

Pressure Ulcers		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acquired Pressure Ulcers will continue to reduce across patient facing services where our span of influence can have an impact	Target		**8%** (2018-19 Q4 baseline 8.9%)		**7%**			**6%**			**5%**		
(Number of avoidable acquired pressure ulcers / total pressure ulcers)	Actual		Audit available end June 2019		Audit available end September 2019			Audit available end December 2019			Audit available end March 2019		

Preventing Pressure Ulcers update:

- In April there were 79 acquired pressure ulcers: 8 in Community Hospitals, 71 in Community Services. NHS Improvement's Tissue Viability Nurse Specialist has visited the Trust and provided excellent feedback for our Quality Improvement PDSA cycle to address #stopthepressure.
- As expected the mid point data has shown improved reporting in the 2 Gloucester teams, no moisture lesions (which corroborates the trajectory in Q3 for countywide data).
- This is linked to better care and recognition of the risk of developing moisture lesions and the holistic assessments undertaken following education for clinical staff.
- Positive and enthusiastic feedback from the clinical colleagues taking part in the project has been inspiring.
- A final audit was completed in April and a report and celebration to share with the teams and locality.
- QSIR project to replicate on a larger locality scale in the planning phase and will include analysis and feedback from this first cycle.

Risks (Pressure Ulcers)
Reference – 562 - Rating – 12

- Definition of Acquired pressure ulcers from NHS improvement (July 2018) and NRLS (March 2019) as detailed in the gap analysis report for Q&P (July 2018): A pressure ulcer that has occurred whilst the patient has been receiving care and that the pressure ulcer was not present at admission.

Benchmarking: In the 'Rate of new grade 2,3,4 avoidable pressure ulcers acquired in a Community Hospital setting per 1,000 occupied bed days' the Trust submitted a figure of 1.35 in March. The benchmarking figure is 0.28 for Community Hospital settings.

7. Nutrition and Hydration

Outcome: Increase the use of nutrition and hydration assessments in all appropriate settings in order for patient's to be optimally nourished and hydrated

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This continues to be a focus of achievement for another year as the Trust was not assured that significant progress was being made on this aspect of nutrition and hydration, particularly when attempting to evidence the activity from SystmOne.
The quality improvement group will also be adopting Quality Improvement methodology and the proposed metrics include:

- Patients will have a baseline MUST on admission to wards or clinical caseloads (the maximum time frame is 72 hours for in-patient settings or 2 visits for Integrated Community Teams - ICTs).
- An audit approach to measure performance will be used until more reliable reporting can be assured from SystmOne.
- Qualitative, quarterly reporting will also be included as part of the Quality Improvement approach (using a PDSA methodology). This will focus on reviewing samples of patients where MUST scores have triggered the need for interventions to establish whether patients are being managed appropriately and to a high quality. This will include all aspects of the patient's care such as food charts, supplements, referrals to dieticians and impacts on other aspects of care such as the prevention or healing of pressure ulcers.

Hydration will also be included, with retrospective analysis of some patients who have delirium or confusion to determine whether dehydration was a cause, in order to possibly inform future work streams and performance measures.

Nutrition and Hydration metrics 2019/20 (performance from audit data)						
Service area	Baseline		Q1	Q2	Q3	Q4
ICTs	December 2018 audit 66%	Target	65%	70%	75%	95%
		Actual	Audit end June 2019	Audit end September 2019	Audit end December 2019	Audit end March 2019
Community Hospitals	March 2019 audit 80%	Target	80%	85%	90%	95%
		Actual	Audit end June 2019	Audit end September 2019	Audit end December 2019	Audit end March 2019

8. End of Life Care

Our aim will be to embed as "business as usual" with dedicated leadership.

End of Life Care improvements will continue to be reported during 2019/20

- Rationale for documenting prescribed hypnotic or anxiolytic medications

End of life Care	Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Percentage of patients who have End of Life care recorded on SystmOne EoL template	48.6%	48.0%											
Number of patients who have End of Life care recorded on SystmOne EoL template	n/a	72											
Number of patients who died in the month	n/a	150											

Actions completed:

- ReSPECT: GCS and 2gt are working closely together to support the countywide roll out of ReSPECT. There is a suggested implementation date of August 2019 and next steps are to design educational resources for colleagues.
- National Audit of Care at End of Life (NACEL): GCS has now registered for round 2 of the national NACEL audit, data collection opens in June 2019.
- Mortality Reviews (Stroud Community): The community mortality review pilot is slowly progressing, the data collection tool has been adapted to support community information. We are working with clinical systems to resolve the issue where ICTs do not have access to clinical information recorded on Rapid Response and Evening District Nursing Service systems.
- Mortality Reviews (Homeless Health Care): An initial meeting has been held, with the following actions identified - establish a support system for the nurses following the death of a patient (emotionally/psychologically) particularly for sudden deaths, and to understand how the lack of housing can affect the quality of care at the end of life and to identify best practice for this patient group.

9. The Deteriorating Patient

Outcome: Continue to train and support front line colleagues to recognise and manage deteriorating patients to ensure that they are managed quickly and effectively

Gloucestershire Care Services NHS Trust

This remains a quality priority because, similarly to nutrition and hydration, the Trust was not able to effectively evidence from SystmOne that National Early Warning Scores (NEWS) were being recorded at baseline assessments. However, from incident data of deteriorating patients, we were assured that NEWS was being used appropriately and that the practice is embedded.

Until recently this was determined to be one of the highest clinical risks that the Trust was carrying and as such this is reflected on the corporate risk register. Recent in-patient clinical audits however have demonstrated reasonable levels of appropriate practice (with room for improvement), however ICT audits have demonstrated a longer path to achieve this.
Therefore based on this, the proposed metrics are:

- All patients admitted onto Trust caseloads (community and in-patients) will have their NEWS recorded as a baseline.
- Qualitative retrospective dip (snap shot) audits will be undertaken to establish whether rapidly deteriorating patients have been identified and escalated appropriately within the service they are being managed (according to the Trust policy action cards).

For some this will include looking to see whether there were any blocks to colleagues identifying early that the patient was deteriorating and at risk of sepsis and from here identify key issues that may be used to develop further measures for improvement. For example, this may be clinical practice such as the frequency of observations once a NEWS has raised above a certain threshold for a patient – or around ensuring the NEWS scale 2 is used is for patients who have COPD with a clinically diagnosed O2 deficit and therefore need prescribed O2 at an lower rate (88-92).

NEWS Recording Targets 2019/20 (performance from audit data)						
Service area	**Baseline**		**Q1**	**Q2**	**Q3**	**Q4**
Community Hospital In-patients	March 2019 audit 89%	Target	89%	91%	93%	95%
		Actual	Audit end June 2019	Audit end September 2019	Audit end December 2019	Audit end March 2019
ICTs	March 2019 audit 33%	Target	33%	40%	50%	60%
		Actual	Audit end June 2019	Audit end September 2019	Audit end December 2019	Audit end March 2019

Actions completed:

Quality Improvement work has already commenced with North Cotswold Community Nurses using a PDSA approach to understand why the recording of NEWS is low.

The benefit of using a PDSA approach is that colleagues have self identified this issue as miscommunication and feel empowered to correct this. The mid point data will be audited at the end of Qtr. 1.

10. Falls Prevention and Management

Our aim will be to embed as "business as usual" with dedicated leadership.

Gloucestershire Care Services NHS Trust

The Trust will be participating in a national CQUIN associated with falls and especially with regards to:

- Lying and standing blood pressures
- Post fall SWARM to be completed
- Mobility Assessments
- Rationale for documenting prescribed hypnotic or anxiolytic medications

Falls Prevention and Management	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	YTD RAG
Falls awareness training (Community hospital inpatient colleagues)	92%	65.8%												R
Falls Prevention and Assessment training (FallSafe)(all qualified nurses and therapists on Community hospital inpatient wards)	92%	37.8%												R
Community hospital colleagues to be trained on correct, consistent techniques for taking lying and standing blood pressure	92%	62.2%												R

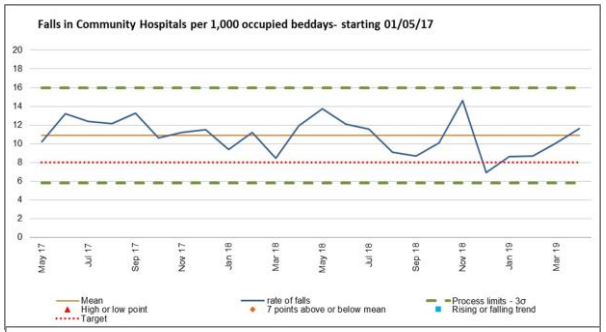
Actions completed:

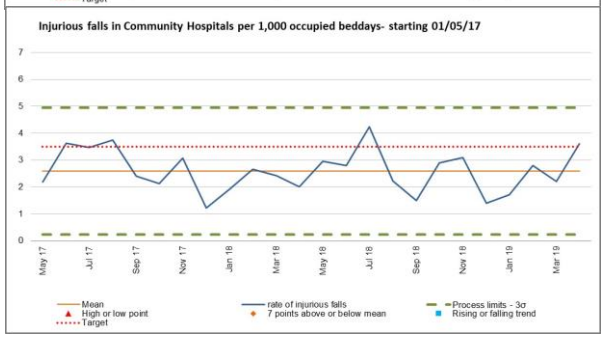
- The updated multifactorial falls risk assessment on SystmOne is compliant with CG161. All patients have a full assessment of their individual risk factors which might contribute to their risk of falling. This is reviewed weekly and following any falls.
- The post falls "SWARM" (rapid multidisciplinary assessment), is now used in all inpatient wards which allows colleagues to quickly review the patient and the environment to ascertain whether there were any contributory factors to the patient and to reduce the risk of future falls.
- GCS have registered to participate in the National Audit of Inpatient Falls – this will enable us to benchmark with other organisations.

- Target set at 92% compliance in line with statutory and mandatory training for each of the training pathways.
- It has not always been possible to get accurate reporting of training due to instances where local records are not being updated in ESR. It is suggested that training compliance is not used as a quality measure for falls prevention in future – other measures could include % of falls assessments completed within 48 hours.

- Frequency of falls per patient report demonstrates that the number of patients falling once is significantly higher than the number of patients falling multiple times. This gives an indication about how effective our post falls interventions are in reducing the risk of further falls.

- Positive Risk taking leaflets are available, there is a "tick box" on SystmOne to record that the leaflet has been shared as part of the falls assessment.

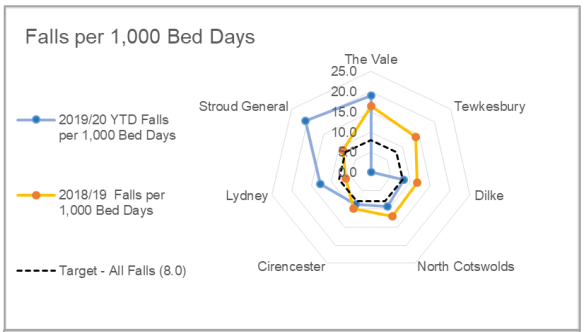


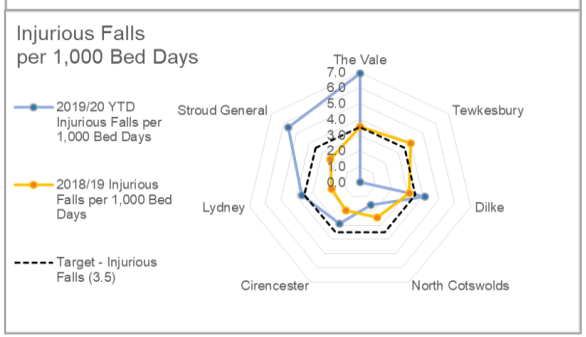


The SPC charts show all falls and injurious falls to be within control limits and close to the mean.

The internal target of 8 falls per 1,000 occupied bed days is close to the lower control limit and below the mean, and only achieved in December 2018.

68.8% of all falls reported in the year to date are **without harm.**





Radar charts show 2019/20 total falls and injurious falls per 1,000 bed days and compared to target.

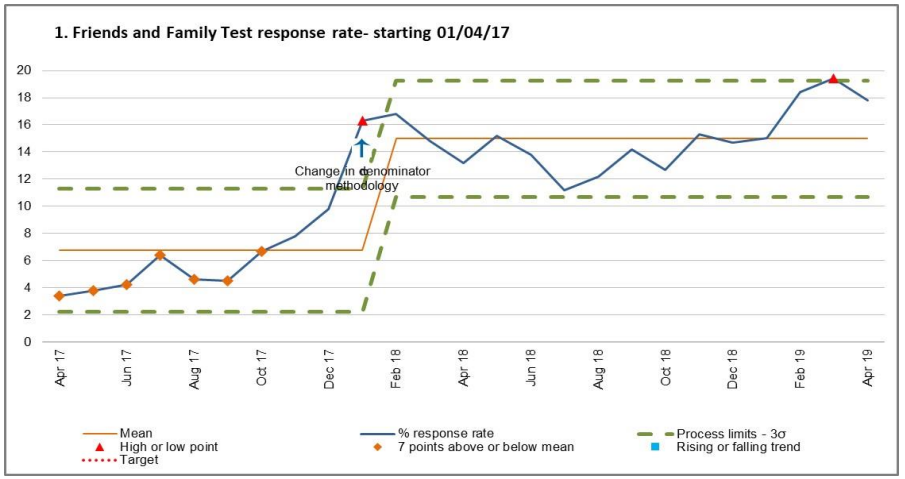
Stroud and Vale are significantly outside of target in 2019/20.

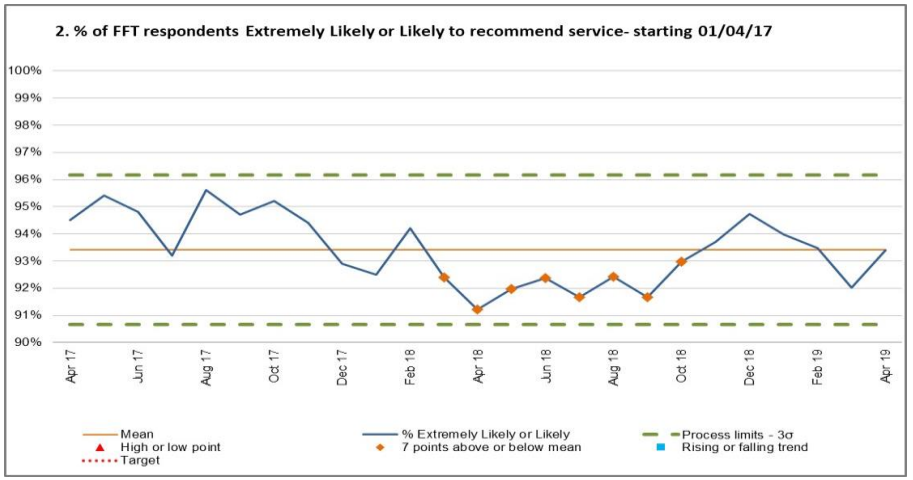
Quality | Are Services Caring?

Patient Experience

Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES CARING?																			
		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.8%												17.8%	No - within SPC limits	G ↑	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%												93.4%	No - within SPC limits	G ↑	91.2%
3	Number of Compliments	L - R	1,317	1,317	124												124		G	
4	Number of Complaints	N - R	42	42	6												6		G	
5	Number of Concerns	L - R	485	485	40												40		G	





Additional information related to performance	What actions have been taken to improve performance?
SPC chart for response rate shows a steady increase in rate since July 2018. The percentage of FFT respondents recommending our services had increased steadily since July 2018 following a lengthy period of decline. This has reduced since December 2018 but shown an increase in April.	• The overall increase in the response rate is mainly due to increased responses from the MIIUs and Children's Services where the response rates in April exceeded the 20% expected response rate. • The change in MIIUs has ben sustained following the short version of the FFT questionnaires. • The increase in the Children's Services response rate is mainly due to a high number of responses from the Children's Immunisation Team.

Note: there is no formal benchmark for the level of extremely likely/likely response to the Friends and Family test, but the average from NHS Benchmarking Network for March is 91.2%.

SPC charts have also been created for Concerns, Complaints and Compliments. These charts show the following:
Concerns – Number of Concerns within normal variation since April 2017.
Complaints – Number of Complaints within normal variation with the exception of high point in November 2018 which is above Upper Control Limit.
Compliments – Number of Compliments shows a sequence of 10 points above the mean from July 2018 to April 2019.

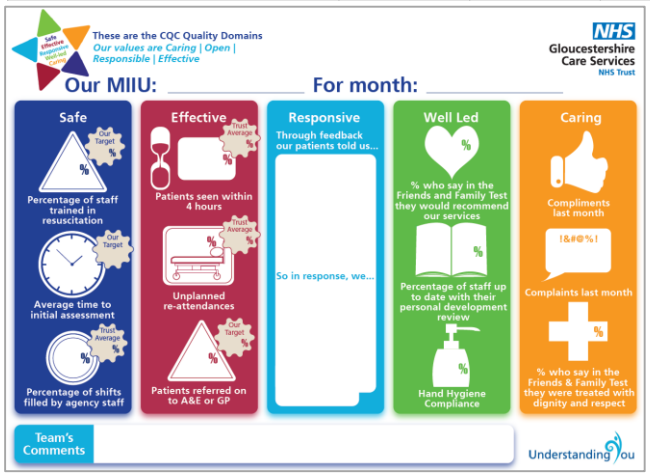
Quality | Are Services Caring?

Quality Dashboards

NHS Gloucestershire Care Services NHS Trust

Community Hospital inpatient and Minor Injury and Illness units Quality dashboards

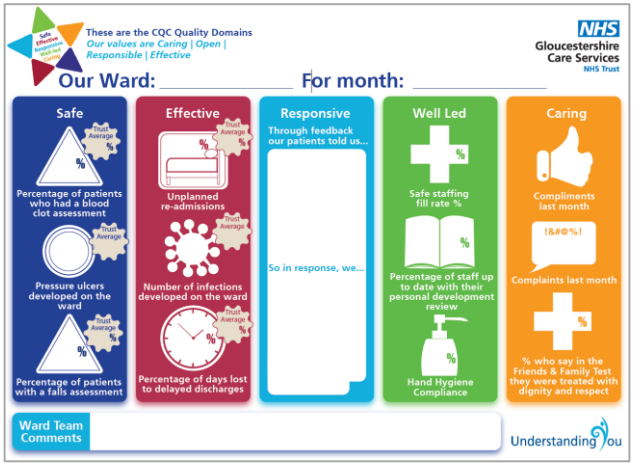
April-2019	Safe	Safe	Safe	Effective	Effective	Effective	Well Led	Well Led	Well Led	Caring	Caring	Caring
Community Hospital Inpatients	% Patients - Blood Clot (VTE) Assessment	Pressure Ulcers Developed (Acquired)	% Patients - Falls Assessment	% Unplanned Re-admissions (CoHo 30 Days)	Number of Infections	% Days lost to Delayed Discharges	% Safe Staffing fill rate	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average	97.4%	1	60.5%	9.5%	0.0	1.5%						
Cirencester - Coln Ward	100.0%	0	86.2%	13.8%	0	0.0%	99.9%	88.6%	100.0%	4	0	90.0%
Cirencester - Windrush Ward	100.0%	1	22.2%	16.7%	0	0.9%	99.2%	68.8%	90.0%	0	0	84.0%
Dilke - Forest Ward	100.0%	2	86.7%	6.7%	0	9.2%	102.5%	92.0%	70.0%	8	0	100.0%
Lydney	100.0%	1	50.0%	4.5%	0	2.9%	100.6%	76.9%	100.0%	8	0	84.0%
North Cots - Cotswold View Ward	95.8%	1	39.1%	4.3%	0	0.0%	104.7%	72.5%	100.0%	0	0	83.0%
Stroud - Cashes Green Ward/Roman Ward	100.0%	0	40.0%	0.0%	0	0.0%	109.4%	63.2%	100.0%	0	0	Not available
Stroud - Jubilee Ward	100.0%	0	55.6%	11.1%	0	0.0%	97.8%	55.2%	100.0%	0	0	100.0%
Tewkesbury - Abbey View Ward	100.0%	3	100.0%	28.6%	0	0.0%	104.2%	85.7%	100.0%	0	1	100.0%
Vale	100.0%	0	50.0%	6.3%	0	0.0%	99.4%	68.3%	100.0%	1	0	86.0%
Winchcombe	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	0	Not available
MIIUs	% Staff Trained in Resuscitation (Target: 92%)	Average Time to Initial Assessment (Target: 15 min)	% of shifts filled by agency staff	% Patients seen within 4 hours	% Unplanned Reattendances	% Referred on to A&E or GP (Target: 4.4%)	% Who say in the FFT they would recommend our services	% Staff up to date PDR	% Hand Hygiene Compliance	Compliments	Complaints	% in FFT say treated with Dignity & Respect
Trust Average			5.4%	99.1%	1.4%							
Cirencester MIIU	88.9%	11	3.9%	99.3%	1.5%	Not available	95.6%	90.5%	100.0%	3	0	97.0%
Dilke MIIU	72.7%	15	5.7%	98.1%	0.9%	Not available	92.3%	46.2%	100.0%	1	0	94.0%
Lydney MIIU	75.0%	15	5.7%	97.9%	1.9%	Not available	96.1%	55.6%	100.0%	0	0	98.0%
NCH MIIU	100.0%	9	0.0%	100.0%	1.1%	Not available	97.6%	70.0%	100.0%	0	0	98.0%
Stroud MIIU	100.0%	11	14.2%	99.2%	1.0%	Not available	93.7%	83.3%	100.0%	0	0	95.0%
Tewkesbury MIIU	84.6%	8	0.0%	99.4%	2.1%	Not available	89.4%	76.9%	100.0%	0	0	92.0%
Vale MIIU	55.6%	9	8.1%	90.2%	1.2%	Not available	96.0%	57.1%	100.0%	0	0	96.0%



The Trust compiles a quality dashboard covering the Community Hospital Inpatient and Minor Injury and Illness units, updated on a monthly basis and displayed within each of the units.

The dashboard includes measures from the Safe, Effective, Well Lead and Caring domains.

The table above illustrates the data for April 2019 and compares each of the units with the Trust average. The data is copied onto posters which are visible in public areas (examples shown on this slide).



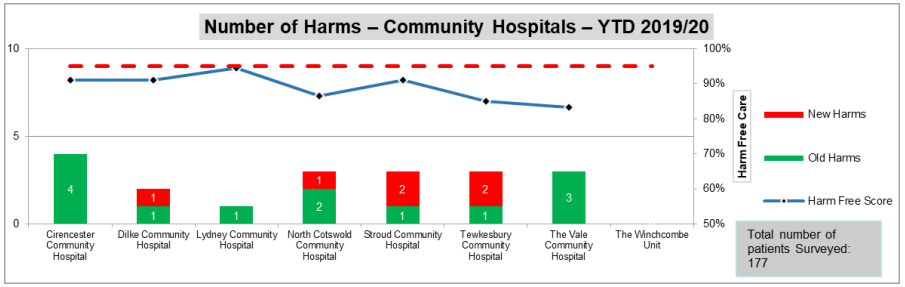
Exception Report | Are Services Safe?

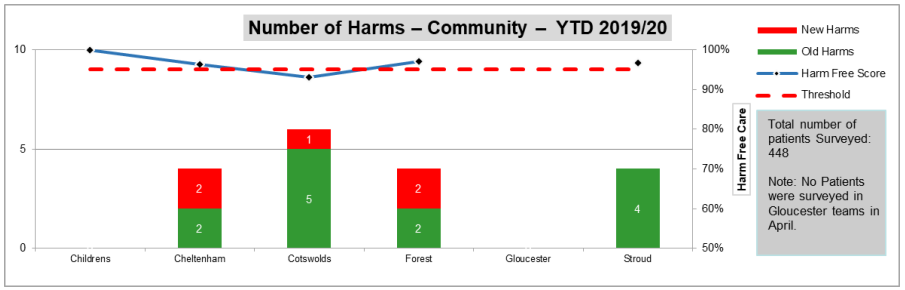
Safety Thermometer (Page 1 of 2)

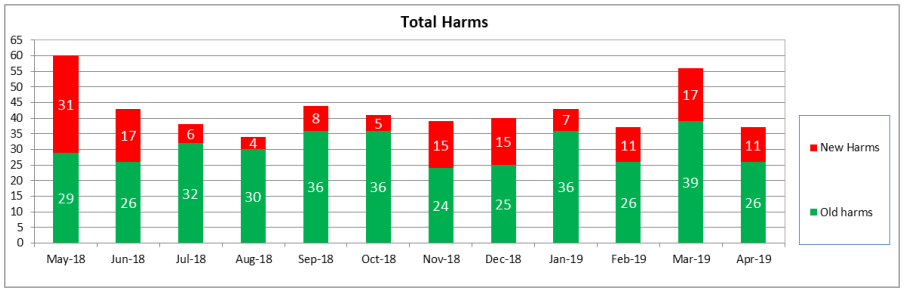
Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%												94.3%	R	Pgs. 13-14	A ↓	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%												98.3%	G		A ↓	96.9%







Additional information related to performance

- 636 patient episodes of care were surveyed for the April Safety Thermometer census, 600 patients' care was harm free.
- Harm Free Care score was **94.3%** (target 95%). 5 more patients with harm free care would have achieved the target.

- Based on new harms only, harm free care was **98.3%** in April, internal target 98%.
- Community Hospital inpatient harm free care **89.3%** in April. New harms only, **96.6%**.
- Community Nursing harm free care was **96.2%** in April. New harms only, **98.9%**.

- 37 harms were reported in April, of which 11 were new harms.

- **1.7%** of all patients surveyed had a new harm (April) compared to 1.9% of patients in 2019/20.

What actions have been taken to improve performance?

- Whilst the Trust's new-harms score remains favourably above the national benchmark, the overall score remains lower than the 95% target due to the skew of high number of old harms. Most of these are not within the Trust's direct control e.g. pressure ulcers that have developed before patients have entered our care. This highlights the need for stronger system working by all ICS partners.
- A Quality Improvement project is currently underway to build on the success of reducing pressure ulcers over the past year which will align with our quality priorities for 2019-20.
- The Trust is still expecting new national guidance on Safety Thermometer categories which will support systemising the census process.
- Pressure ulcers remain the main cause of old and new harms, however the reduction of pressure ulcers that have occurred in our care aligns with the harm free scores for new harms only.
- There were no Safety Thermometer returns for Gloucester Community teams for April due to operational capacity; this has now been addressed and returns are being completed for May.

Benchmarking

- In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 97.5% in March. The benchmark is 96.9% for March.

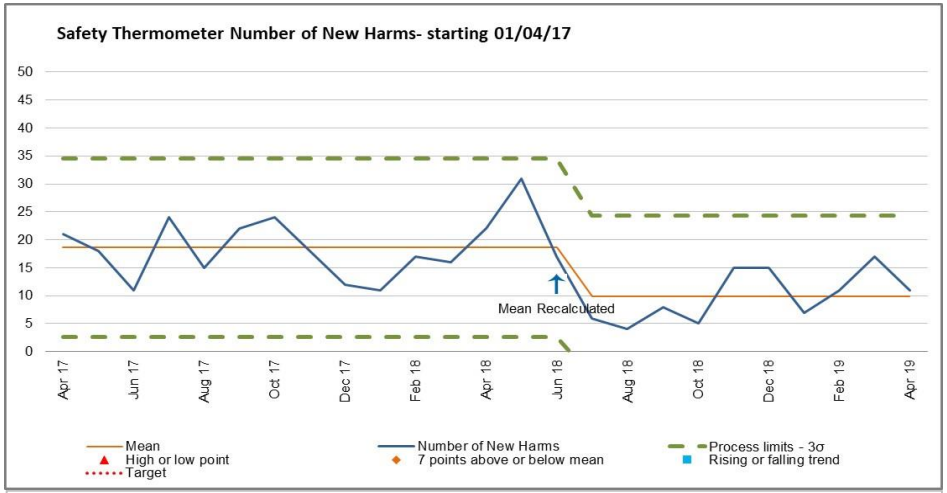
Risks
Pressure Ulcers
Reference – 562
Rating – 12

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

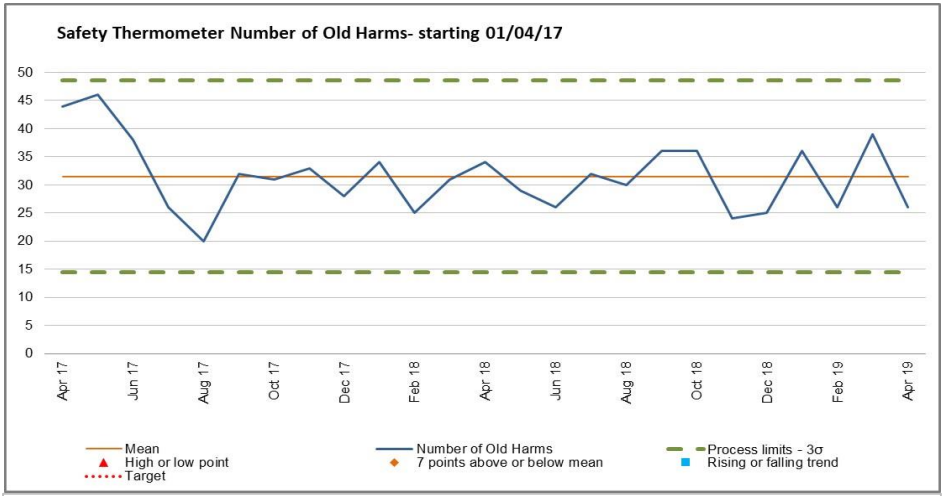
Exception Report | Are Services Safe?

Safety Thermometer (Page 2 of 2)

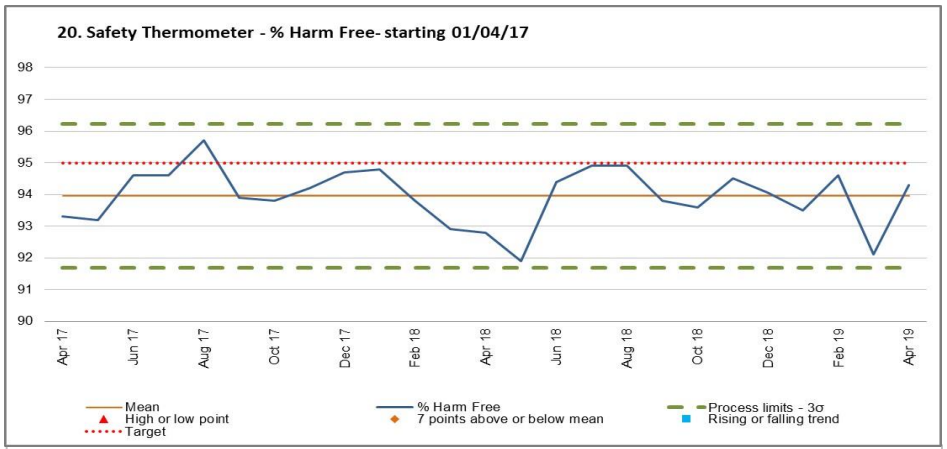
Gloucestershire Care Services NHS Trust



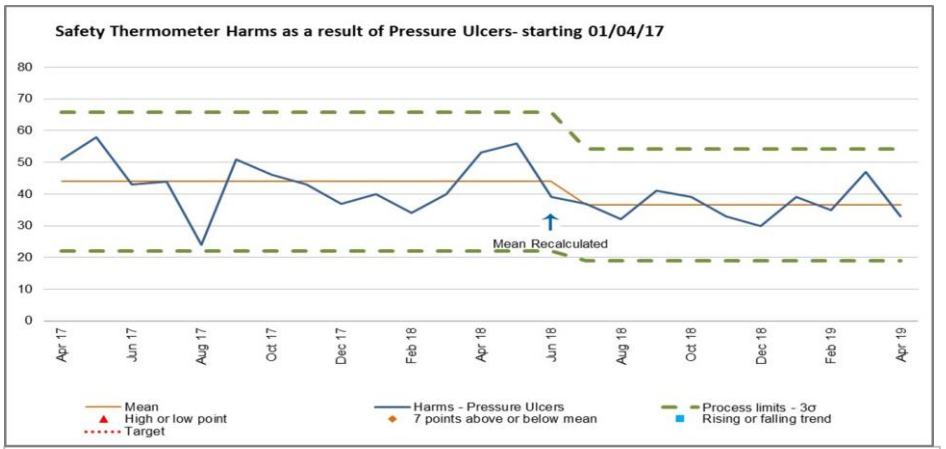
There has been a reduction in New Harms since a peak in May 2018. Mean recalculated from June 2018 following reduction in trend, although this is increasing.



Old Harms are on or close to mean since September 2017 and within control limits.



Safety Thermometer Harm Free Care within normal variation. However target consistently missed.



There has been a gradually reducing trend over the period for harms that are Pressure Ulcers. Mean recalculated from July 2018 following a reduction in trend.

SPC Charts have been reviewed for other harms:

- VTE harms fluctuate above and below the mean – but remain within control limits and are very low numbers.
- UTI / Catheter harms show a steady reduction over the period.
- Falls resulting in harm fluctuate above and below the mean – but remain within control limits and are very low numbers.

Performance Dashboard

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
1	Friends and Family Test Response Rate	N - T	15%	14.5%	17.8%												17.8%		No - within SPC limits	G ↑	
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	92.7%	93.4%												93.4%		No - within SPC limits	G ↑	91.2%
3	Number of Compliments	L - R	1,317	1,317	124												124			G	
4	Number of Complaints	N - R	42	42	6												6			G	
5	Number of Concerns	L - R	485	485	40												40			G	

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
6	Number of Never Events	N - R		0	0												0			G	
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		11	0												0			G	
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0												0			G	
9	Total number of incidents reported	L - R		4,443	398												398			G	
10	% incidents resulting in low or no harm	L - R		96.4%	97.2%												97.2%			G	
11	% incidents resulting in moderate harm, severe harm or death	L - R		3.6%	2.8%												2.8%			G	
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.8%	3.1%												3.1%			G	
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%												0.0%			G	
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	2*	15	0												0	G		G	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0												0	G		G	
16	Number of MSSA Infections	L - R	0	0	0												0			G	
17	Number of E.Coli Bloodstream Infections	L - R	0	2	0												0			G	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	102.0%												102.0%			G	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	96.9%	99.5%												99.5%	G		G	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	93.7%	94.3%												94.3%	R	Pgs. 13-14	A ↓	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.1%	98.3%												98.3%	G		A ↓	96.9%
22	Total number of Acquired pressure ulcers	L - R		728	79												79			G	
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		671	74												74			G	
24	Number of grade 3 Acquired pressure ulcers	L - R		52	5												5			G	
25	Number of grade 4 Acquired pressure ulcers	L - R		5	0												0			G	

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

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

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

Performance Dashboard

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																					
Community Hospitals																					
26	Re-admission within 30 days of discharge following a non-elective admission**	N - R		8.2%	9.5%												9.5%			G	
27	Inpatients - Average Length of Stay	L - R		27.7	30.5												30.5			G	26.4
28	Bed Occupancy - Community Hospitals	L - C	92%	93.6%	94.1%												94.1%	A		A	91.9%
29	% of direct admissions to community hospitals	L - R		19.3%	18.9%												18.9%			G	
30	Delayed Transfers of Care (average number of patients each month)	L - R		2	2												2			A	
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	1.4%	1.5%												1.5%	G		A	9.9%
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
Minor Injury and Illness Units																					
32	MIIU % seen and discharged within 4 Hours	N - T	95%	99.0%	99.1%												99.1%	G		G	
33	MIIU Number of breaches of 4 hour target	L - R		828	59												59			G	
34	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:58	03:07												03:07	G		G	
35	MIIU - Time to treatment in department (median)	L - I	<60 m	00:34	00:34												00:34	G		G	
36	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	0.9%	0.4%												0.4%	G		G	
37	MIIU - % of patients who left department without being seen	L - C	<5%	3.9%	4.3%												4.3%	G		A	
38	Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:20	00:14												00:14	G		A	
39	Trolley waits in the MIU must not be longer than 12 hours	N - T	< 12 hrs	0	0												0	G		G	
Referral to Treatment																					
40	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	55.8%	69.4%												69.4%	R	Pg. 19	A	
41	Podiatry - % treated within 8 Weeks	L - C	95%	97.2%	88.8%												88.8%	R		A	
42	MSKAPS Service - % treated within 8 Weeks	L - C	95%	96.5%	92.4%												92.4%	A		A	
43	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	89.7%	80.4%												80.4%	R	Pg. 19	G	
44	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	82.8%	81.0%												81.0%	R	Pg. 19	A	
45	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	75.5%	82.6%												82.6%	R	Pg. 19	A	
46	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	93.5%	100.0%												100.0%	G		A	
47	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.1%	99.4%												99.4%	G		A	
48	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	99.9%	100.0%												100.0%			G	
49	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%												100.0%	G		G	
50	Psychosexual Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%												100.0%			G	
51	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	70%	77.6%	81.1%												81.1%	G		R	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.5%	90.9%												90.9%	A		G	
53	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	91.9%	87.2%												87.2%	R	Pg. 19	G	
54	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	95.7%	97.9%												97.9%	G		A	

** I.e. Admission to a GCS hospital within 30 days of the end of a previous GCS hospital spell.

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

Performance Dashboard

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
55	MSKAPS Service - % of referrals referred on to secondary care	L - C	<30%	15.9%	3.8%												3.8%	G		A	
56	MSKAPS Service - Patients referred to secondary care within 2 days of decision to refer onwards	L - C	100%	100.0%	100.0%												100.0%	G		A	
58	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	84.3%	100.0%												100.0%	R	No - Post Sep. Trend	A	
59	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	97.0%	97.1%												97.1%	G		A	
60	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C	**	48.8%	46.8%												46.8%			A	
63	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		39,348	2,975												2,975			G	
64	SPCA % of calls abandoned	L - C	<5%	1.4%	0.9%												0.9%	G		G	
65	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	97.2%	97.9%												97.9%	G		G	
66	Rapid Response - Number of referrals	L - C	*304	3,905	346												346	G		A	
72	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N - T	>99%	100.0%	100.0%												100.0%	G		G	
Cancelled operations																					
73	No urgent operation should be cancelled for a second time	N - T	0	0	0												0	G		G	
74	Number of patients who have had operations cancelled for non-clinical reasons that have not been offered another binding date within 28 days	N - T	0	0	0												0	G		G	
CQC DOMAIN - ARE SERVICES WELL LED?																					
		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
75	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	58.5%																G	
76	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	84.6%																G	
77	Mandatory Training	L - I	92%	85.90%	85.8%												85.8%	A	Pg. 21	A ↓	89.0%
78	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	77.1%	76.4%												76.4%	R	Pg. 20	A	86.5%
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	81.4%	81.2%												81.2%	R	Pg. 20	A	
79	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.8%	4.9%												4.9%	A	Pg. 21	A ↓	4.7%
80	SUS+ (Secondary Uses Service) Data Quality Reporting - Available One month in arrears	N-R		98.9%													TBC			G	

* Threshold is for April

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

Exception Report | Are Services Responsive?

NHS Gloucestershire Care Services NHS Trust

8 Week Referral to Treatment (RTT) Measures

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
CQC DOMAIN - ARE SERVICES EFFECTIVE?																					
CQC DOMAIN - ARE SERVICES RESPONSIVE?																					
Referral to Treatment																					
40	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	55.8%	69.4%												69.4%	R	Pg. 19	A	
43	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	89.7%	80.4%												80.4%	R	Pg. 19	G	
44	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	82.8%	81.0%												81.0%	R	Pg. 19	A	
45	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	75.5%	82.6%												82.6%	R	Pg. 19	A	
53	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	91.9%	87.2%												87.2%	R	Pg. 19	G	

Referral to Treatment – comparison between local 8 week standard and 18 week target

	8 week RTT target	% seen within 8 weeks	RAG	Number seen within 8 weeks	Number seen above 8 weeks	18 week RTT target	% seen within 18 weeks	RAG	Number seen within 18 weeks	Number seen above 18 weeks	Median RTT in days
Speech and Language Therapy	95%	69.4%	R	34	15	92%	98.0%	G	48	1	45
MSK Physiotherapy	95%	80.4%	R	1135	277	92%	99.9%	G	1410	2	35
ICT Physiotherapy	95%	81.0%	R	281	66	92%	100.0%	G	347	0	18
Occupational Therapy Services	95%	82.6%	R	389	82	92%	99.8%	G	470	1	14
Paediatric Physiotherapy	95%	87.2%	R	306	45	92%	100.0%	G	351	0	12

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

Exception Report | Are Services Responsive?

NHS Gloucestershire Care Services NHS Trust

Additional information related to performance	
Adult Speech and Language Therapy (95% to be treated within 8 weeks) • Performance was **69.4%** in April compared to 80.0% in March. • 15 out of 49 patients were seen outside the 8 week threshold. • 18 week target performance was 98.0% (1 out of 49 patients seen outside the 18 week threshold)	• Active recruitment campaign in place, however in the last round there were no applicants for our community lead post and as a result the vacancies continue to impact on recovery. • Service transformation workshops are underway with the team to redesign service delivery model to support improved access. • Agreed a joint Commissioner and Provider led service review to support transformation of this service across the whole system. See operational exception report for further detail.
MSK Physiotherapy (95% to be treated within 8 weeks) • Performance was **80.4%** in April, compared to 88.6% in March. • 277 out of 1,412 patients were seen outside the 8 week threshold. • 18 week target performance was 99.9% (2 out of 1,412 patients seen outside the 18 week threshold)	• Initial demand and capacity analysis shows the service has insufficient capacity (if fully staffed) for the demand, which has grown over the last 2 years. • A review of the increase in demand against forecasted changes anticipated with the implementation of the integrated MSK service is underway to determine if aligned. • Additional clinical resource has been agreed as part of demographic growth. • A further national demand and capacity tool is now being undertaken to model options and their impacts. It is expected that initial options will be presented to the Q&P sub-committee at the end of June. See operational exception report for further detail.
Adult Integrated Community Teams (ICT) **Adult ICT Physiotherapy (95% to be treated within 8 weeks)** • Performance was **81.0%** in April, compared to 80.2% in March. • 66 out of 347 patients were seen outside the 8 week threshold. • 18 week target performance was 100%.	• Detailed improvement plans are in place, and overseen by the Operational lead in conjunction with the Community service manager. See operational exception report for further detail.
Adult ICT Occupational Therapy (95% to be treated within 8 weeks) • Performance was **82.6%** in April compared to 85.3% in March. • 82 out of 471 patients were seen outside the 8 week threshold. • 18 week target performance was 99.8% (1 out of 471 patients seen outside the18 week threshold).	• Detailed improvement plans are in place, and overseen by the Operational lead in conjunction with the Community service manager. See operational exception report for further detail.
Paediatric Physiotherapy (95% to be treated within 8 weeks) • Performance was **87.2%** in April compared to 92.8% in March. • 45 out of 351 patients were seen outside the 8 week threshold. • 18 week target performance was 100%.	• Recruitment to some posts and to fixed term contracts has been successful to cover high levels of maternity leave. Staff and therefore capacity are now coming on line over the next 8 weeks which will improve performance. See operational exception report for further detail.

Exception Report | Are Services Well Led?

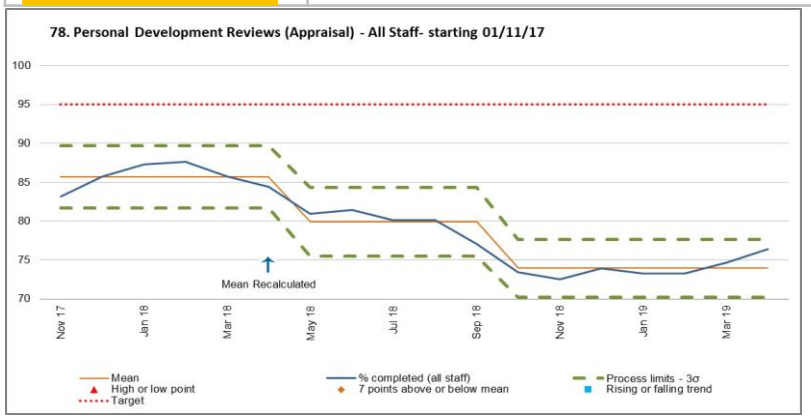
Workforce / HR page 1 of 2

NHS Gloucestershire Care Services NHS Trust

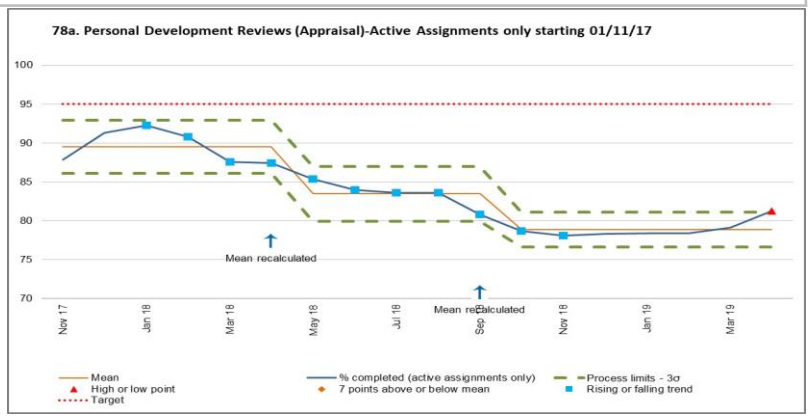
CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2018/19 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 YTD	RAG	Exception Report?	DQ Rating	Benchmarking Report Mar Figure
75	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	58.5%																G	
76	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	84.6%																G	
77	Mandatory Training	L - I	92%	85.90%	85.8%												85.8%	A	Pg. 21	A ↓	89.0%
78	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	77.1%	76.4%												76.4%	R	Pg. 20	A	86.5%
78a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	81.4%	81.2%												81.2%	R	Pg. 20	A	
79	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.8%	4.9%												4.9%	A	Pg. 21	A ↓	4.7%

Additional information related to performance	What actions have been taken to improve performance?
Staff Engagement **Risks (Recruitment/ Retention)** Reference – 609 Rating – 12	• Resources Committee is overseeing action plans which align to the wider resources Organisational Development agenda. • The annual NHS staff survey results are now known and the Trust. Localised actions are being developed in response. • Further cohorts of staff attending the ICS Leadership development, Culture, Values and Behaviours group for the 5 elements for successful leadership programme have been agreed funded through the SWLA and HEE. The provider has now been agreed and launched in April. • The Transition Programme board OD and culture work-stream is developing support for colleagues during times of change, the merger process and beyond. • Valuing your involvement engagement sessions have been carried out throughout March and April involving over 631 colleagues in developing the new Trust values. Sessions feedback has offered significant assurance that participants (1) felt engaged in developing values (2) felt confident that their views had been heard (3) felt motivated to carry positive messages about the merger, (4) would recommend the sessions to others. • Wider colleague engagement activities including Team Talk, The Core and Senior leadership network.
Staff with completed Personal Development Reviews (PDRs) **Risks (PDR)** Reference – 643 Rating – 9	• Currently trialling a new PDR process for Bank Staff and Estates and Facilities and sharing best practice phasing PDRs throughout the year. • Supervision tree templates have been produced for ICT's, Community Hospitals, Estates and Facilities. • Developing PDR for colleagues returning to work following a period of sickness, maternity leave, secondments etc. • Revised PDR paperwork for bank, staff who are retiring/leaving and lower banded posts has been piloted and tested and are now being published on the intranet for wider use.



Personal Development reviews (active assignments and all staff) within control limits, mean has been recalculated twice to track reducing trend. Target has not been achieved.



Exception Report | Are Services Well Led?

Workforce / HR page 2 of 2

NHS Gloucestershire Care Services NHS Trust

Additional information related to performance	What actions have been taken to improve performance?
Sickness absence Latest performance 4.89% %. SPC chart shows sickness absence stabilising since January following rising trend of 9 points. Target has not been achieved. **Benchmarking** In the 'Sickness absence rate (Short and Long Term)' measure, the Trust submitted a figure of 54.5% in March. The benchmarking figure is 4.7% for March.	• Actions taken to date include review of policy, guidance and letter templates and workshops offered by HR, HR Advisors being primarily assigned to business areas. • Discussion at the Performance and Finance meetings and an HR business partner model implemented to offer consistency and local intelligence for each area. • Health and Well Being agenda adopted by the Trust to promote healthy lifestyles. • Introduction of business intelligence on ESR for all managers to review workforce metrics. • New joint policy being developed with 2gt. **Risks (Staff Sickness)** Reference – 633 Rating – 9 In line with a national 10-year trend, sickness rates are increasing despite increased focus by the Trust and with a significant increase in the number of sickness cases being reviewed by managers with HR.

Health and Well-being of Colleagues	18/19 Q4 Baseline	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Uptake rate of frontline colleagues having flu vaccinations		Starting October 2019 - Target 80%											
MSK Related 2018/19 Quarterly days Absence (FTE excluding pregnancy)	1,515												
MSK Related 2017/18 Quarterly days Absence (FTE excluding pregnancy)	1,792												
Difference in Days MSK Related Absence (FTE excluding pregnancy) 18/19 to 19/20	-277												

Mandatory Training Latest performance 85.80%. SPC chart shows this to be within normal variation (except Apr-17, May-17, Nov-17) however target has not been achieved at any point. 13 out of 22 measures have increased in performance in April compared to March, although not all are above the 92% target. **Risks (Mandatory training Compliance - CQC)** Reference – 858 Rating – 9	• Corporate and Mandatory Training Leads continue to work to address hotspots of low compliance. Attendance at Resus L2 training has improved as a result of this work • Facilitated E-Learning Workshops are available to be booked in 2019 to support learners, there is 1 per month for the remainder of the year. • Additional training venues for Resus Level 2 Training have been available from June 2019 • Plans to amalgamate Corporate Induction with 2gether have been delivered. The first merged event was successfully delivered on May 13th. • Reports are available via BIRTIE updated on a weekly basis.