Gloucestershire Care Services NHS
NHS Trust

Quality & Performance Report

Trust Board Meeting
27th September 2018

Data for August 2018

Understanding You

Executive Summary

Gloucestershire Care Services NHS Trust

Are Our Services Caring?

- The overall Friends and Family Test response rate in August was **12.2%,** an increase compared to July response rate of **11.2%**. The proportion of patients indicating Likely or Extremely Likely to recommend our services also increased slightly to **92.4%** in August compared to **91.7%** in July.

Are Our Services Safe?

- The nationally reported Safety Thermometer Harm free score remains consistent at **94.9%** during August, against a target of 95%.
- Based on new harms only, the Trust achieved harm-free care of **99.4%** in August, compared to a target of 98%. This was a slight improvement on the July performance of **99.2%**.

Are our Services Effective?

- The Bed Occupancy rate was **91.0%** in August, an increase compared to **90.2%** in July.
- Delayed Transfer of Care (DToC) rate in August was **1.8%,** below the target of <3.5% and a decrease from **2.6%** in July. There were an average of **3** patients delayed per day in August.

Are Our Services Responsive?

- The number of 4 hour breaches in MIIUs have decreased significantly to **71** during August compared to **197** in July and **514** for 2017/18 as a whole. August performance in the '% seen and discharged within 4 hours' measure, at **99.0%,** remains above the 95% target.
- For countywide services, the Musculoskeletal Clinical Assessment and Treatment service (MSKCAT), achieved the 95% target for patients seen within 8 weeks of referral in August at **99.1**%; this demonstrates maintained good performance over the last four months.
- SPCA have maintained good performance of their abandoned call rate measure at **1.2%** in August, which 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 **98.8**%, a slight increase compared to **98.3%** performance in July.

Are Our Services Well Led?

- Mandatory training compliance rate in August was an average of **86.24%**, an improvement compared to the 2017/18 average of **82.63%**.
- National Staff survey results for Qtr. 1 2018/19 indicate that **88.0%** of staff responding would recommend the Trust as a place to receive treatment (target is 67%). **63.0%** of staff indicated that they would be 'Extremely Likely' or 'Likely' to recommend the Trust as a place to work (target is 61%). Both of these measures are showing an improvement against **83%** and **49%** performance respectively in Qtr. 4 of 2017/18.
- Sickness absence (rolling 12 months to August) is **4.73%,** against a local target of <4%; this is consistent performance through the year.
- **80.09%** of all staff Personal Development Reviews were completed by the end of August 2018. For active assignments only, the figure for August is **83.60%.**

NHS Gloucestershire Care Services NHS Trust

Quality and Performance Dashboard (Trustwide)

CQC DOMAIN - ARE SERVICES CARING?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
1	Friends and Family Test Response Rate	N - T	15%	8.3%	13.2%	15.2%	13.8%	11.2%	12.2%								13.1%		
2	% of respondents indicating 'extremely likely' or 'likely' to recommend service	N - R L - I	95%	94.2%	93.5%	92.0%	92.4%	91.7%	92.4%								92.4%		90.1%
3	Number of Compliments	L - R		924	75	76	91	100	113								455		
4	Number of Complaints	N - R		44	3	7	3	2	1								16		
5	Number of Concerns	L - R		391	43	37	52	50	43								225		

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
6	Number of Never Events	N - R		1	0	0	0	0	0								0		
7	Number of Serious Incidents Requiring Investigation (SIRI)	N - R		23	0	1	2	0	1								4		
8	Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		0	0	0	0	0	0								0		
9	Total number of incidents reported	L - R		3,946	352	408	428	457	397								2,042		
10	% incidents resulting in low or no harm	L - R		94.8%	93.2%	97.8%	96.3%	97.4%	94.7%								95.9%		
11	% incidents resulting in moderate harm, severe harm or death	L - R		5.2%	6.8%	2.2%	3.7%	2.6%	5.3%								4.1%		
12	% falls incidents resulting in moderate, severe harm or death	L - R		1.5%	0.0%	1.3%	4.5%	1.5%	0.0%								1.5%		
13	% medication errors resulting in moderate, severe harm or death	L - R		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%								0.0%		
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	1*	16	3	4	1	1	1								10	Y	
15	Number of MRSA bacteraemias	N - R L - C	0	0	0	0	0	0	0								0		
16	Number of MSSA Infections	L - R	0	0	0	0	0	0	0								0		
17	Number of E.Coli Bloodstream Infections	L - R	0	0	0	0	0	0	1								1	Y	
18	Safer Staffing Fill Rate - Community Hospitals	N - R		100.2%	100.5%	99.8%	100.7%	100.2%	99.7%								100.2%		
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	95.0%	87.9%	93.0%	91.0%	94.3%	94.6%								92.2%	Y	
20	Safety Thermometer - % Harm Free	N - R L - C	95%	94.1%	92.8%	91.9%	94.4%	94.9%	94.9%								93.8%	Y	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.0%	97.2%	95.8%	97.8%	99.2%	99.4%								97.9%	Y	96.5%
22	Total number of Acquired pressure ulcers	L - R		652	71	51	50	53	72								297		
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		578	62	46	44	48	62								262		
24	Number of grade 3 Acquired pressure ulcers	L - R		64	7	5	5	5	10								32		
25	Number of grade 4 Acquired pressure ulcers	L - R		10	2	0	1	0	0								3		

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

Quality and Performance Dashboard (Trustwide)

NHS Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES EFFECTIVE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
Community Hospitals																			
26	Re-admission within 30 days of discharge following a non-elective admission	N - R		10.7%	6.6%	9.0%	11.1%	6.2%	8.9%								8.4%		
27	Inpatients - Average Length of Stay	L - R		26.8	28.0	27.2	28.8	24.5	24.3								26.6		27.0
28	Bed Occupancy - Community Hospitals	L - C	92%	96.7%	93.2%	95.1%	91.8%	90.2%	91.0%								92.3%		89.6%
29	% of direct admissions to community hospitals	L - R		25.3%	26.3%	27.4%	21.8%	26.7%	20.1%								24.5%		
30	Delayed Transfers of Care (average number of patients each month)	L - R		11	3	3	2	3	3								3		
31	Bed days lost due to delayed discharge as percentage of total beddays	L - R	<3.5%	5.9%	1.4%	1.0%	1.2%	2.6%	1.8%								1.6%		11.6%
32	Percentage of patients waiting less than 6 weeks from referral for a diagnostic test	N - T	>99%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%		

CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
Minor Injury and Illness Units																			
33	MIIU % seen and discharged within 4 Hours	N - T	95%	99.3%	99.4%	98.8%	98.6%	97.5%	99.0%								99.2%		
34	MIIU Number of breaches of 4 hour target	L - R		514	35	90	106	197	71								499		
35	Total time spent in MIIU less than 4 hours (95th percentile)	L - I	<4hrs	02:53	02:39	02:50	03:15	03:28	02:58								03:02		
36	MIIU - Time to treatment in department (median)	L - I	<60 m	00:26	00:30	00:34	00:35	00:39	00:30								00:34		
37	MIIU - Unplanned re-attendance rate within 7 days	L - C	<5%	2.4%	0.8%	0.8%	0.9%	0.9%	1.3%								0.9%		
38	MIIU - % of patients who left department without being seen	L - C	<5%	2.2%	2.4%	3.6%	3.7%	4.0%	2.9%								3.3%		
Referral to Treatment																			
39	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	84.4%	60.7%	59.5%	57.1%	59.8%	46.8%								56.6%	Y	
40	Podiatry - % treated within 8 Weeks	L - C	95%	92.8%	97.5%	98.4%	98.6%	98.6%	95.6%								97.7%		
41	MSKCAT Service - % treated within 8 Weeks	L - C	95%	57.1%	95.8%	99.7%	100.0%	99.7%	99.1%								98.8%		
42	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	90.7%	91.4%	99.7%	85.7%	90.1%	89.5%								89.5%	Y	
43	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	85.0%	84.3%	84.5%	81.1%	79.6%	86.6%								83.0%	Y	
44	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	82.8%	77.4%	70.1%	76.8%	73.1%	69.3%								73.2%	Y	
45	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	96.2%	94.5%	85.5%	97.6%	87.8%	90.7%								90.5%	Y	
46	Bone Health Service - % treated within 8 Weeks	L - C	95%	99.5%	96.0%	99.5%	99.3%	97.7%	98.8%								98.2%		
47	Contraception Service and Sexual Health- % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%		
48	HIV Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%		

Quality and Performance Dashboard (Trustwide)

Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
49	Psychosexual Service - % treated within 8 Weeks	L - C	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%		
50	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	80%	77.4%	73.4%	63.4%	83.2%	70.7%	66.0%								72.5%	Y	
51	Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	97.7%	93.3%	99.5%	95.6%	95.4%	100.0%								97.1%		
52	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	99.0%	96.9%	99.1%	97.4%	93.2%	80.0%								93.3%	Y	
53	Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	96.6%	97.6%	98.6%	96.4%	98.4%	97.2%								97.5%		
54	MSKCAT Service - % of referrals referred on to secondary care	L - C	<30%	12.4%	13.3%	11.1%	10.3%	12.3%	12.7%								11.9%		
55	MSKCAT Service - Patients referred to secondary care within 2 days of decision to refer onwards	L - C	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%								100.0%		
56	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	L - C	95%	95.9%	84.6%	96.3%	97.6%	96.7%	**								94.4%*	Y	
57	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	88.6%	65.2%	72.7%	44.4%	65.0%	66.6%								63.3%	Y	
58	Stroke ESD - Proportion of patients discharged within 6 weeks	L - C	95%	98.9%	100.0%	96.3%	100.0%	96.3%	95.0%								97.4%		
59	Social Care ICT - % of Referrals resolved at Referral Centres and closed	L - C		45.9%	45.2%	44.8%	47.4%	48.9%	52.0%								47.7%		
60	Newborn Hearing Screening Coverage	N - T	97%	100.0%	100.0%	100.0%	100.0%	GCS no longer delivering NHSP									100.0%		
61	Newborn Hearing Screens completed by 5 weeks (community sites) - Well babies	N - T	97%	99.6%	99.6%	100.0%	100.0%										99.9%		
62	Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R		40,511	3,212	3,309	3,195	3,453	3,293								16,462		
63	SPCA % of calls abandoned	L - C	<5%	2.7%	1.6%	1.6%	1.4%	2.0%	1.2%								1.6%		
64	95% of priority 1 & 2 calls answered within 60 seconds after introductory message finishing	L - C	95%	90.5%	91.7%	95.6%	94.6%	98.3%	98.8%								96.1%		
65	Rapid Response - Number of referrals	L - C	*922	3,726	309	290	319	341	327								1,586		

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
66	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R L - T	61%	53.3%			63.0%												
67	Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R L - T	67%	83.0%			88.0%												
68	Mandatory Training	L - I	92%	82.63%	86.30%	85.80%	86.02%	86.39%	86.24%								86.15%	Y	88.5%
69	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	79.91%	84.40%	80.94%	81.41%	80.09%	80.09%								81.39%	Y	82.4%
69a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	N/A	87.40%	85.40%	84.00%	83.63%	83.60%								84.81%	Y	
70	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.63%	4.70%	4.60%	4.66%	4.69%	4.73%								4.68%	Y	4.6%

****Reporting being developed and validated following service switch to referral recording in ERS**
*** Year to date figure is for April to July**

QUALITY PRIORITY | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

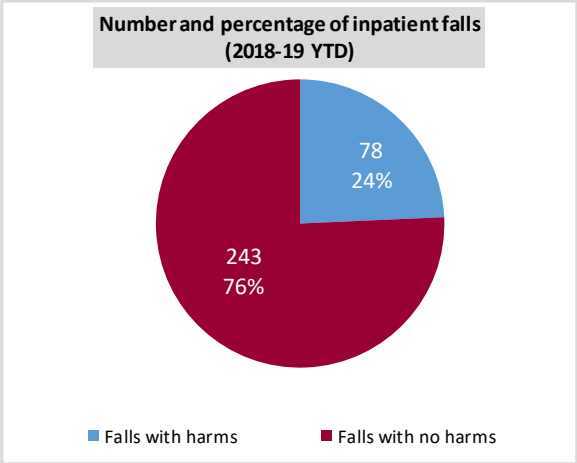
2018/19 Quality Priorities		Quality Domain
1. Falls Prevention and Management	Our aim will be to continue focusing on preventing and managing falls, particularly in areas where falls cause harm.	SAFE
2. Health and Well-being of Colleagues	Our aim is to maintain or reduce colleague sickness and absence, and to continue our work relating to health and wellbeing. We will also aim to achieve a 75% uptake rate of colleagues having their flu vaccinations	CARING
3. End of life Care	Our aim will be to consolidate further our End of Life care developments with the intention of being able to increase the proportion of people who are able to die in their preferred place of choice.	EFFECTIVE
4. Nutrition and Hydration	Our aim is to build on what we have achieved through PLACE with regards to our community hospitals and to include a focus on nutrition and hydration with our wider community services.	WELL-LED
5. Preventing Pressure Ulcers	The prevention of pressure ulcers remains one of our top priorities with regards to patient safety. Our aim will be to continue to monitor the number and incidences of pressure ulcers and to continue to drive our reduction plans forward	SAFE
6. Reducing Medication Errors	Our aim is to improve patient safety and to get a more detailed understanding of our medication errors by improved reporting which will enable further learning to support safer practice.	WELL-LED
7. Deteriorating Patient, Including Sepsis	Our aim will be to support and develop our clinical colleagues in the recognition and early identification of deteriorating patients to include sepsis and other life threating conditions.	RESPONSIVE
8. CQUIN	National Commissioning for Quality and Innovation (CQUIN)	WELL-LED

QUALITY PRIORITY | ARE SERVICES SAFE?

1. Falls Prevention and Management

NHS Gloucestershire Care Services NHS Trust

Hospital	Total Falls				Injurious Falls			
	2018/19 YTD		2017/18 Total		2018/19 YTD		2017/18 Total	
	Number of falls (cumulative)	Falls per 1,000 Occ. Bed Days	Number of falls (cumulative)	Falls per 1,000 Bed Days	Number of injurious falls (cumulative)	Injurious falls per 1,000 Occ. Bed Days	Number of injurious falls (cumulative)	Injurious falls per 1,000 Bed Days
The Vale	61	21.0	68	9.9	8	2.8	12	1.7
North Cotswolds	39	12.1	103	13.2	8	2.5	21	2.7
Tewkesbury	35	12.0	73	12.1	12	4.1	13	2.1
Cirencester	81	11.5	197	11.4	23	3.3	44	2.5
Dilke	41	11.5	131	14.7	9	2.5	40	4.5
Stroud General	45	8.8	120	8.9	17	3.3	32	2.4
Lydney	19	7.1	66	9.7	5	1.9	16	2.3
TOTAL	321	12.0	758	11.3	82	2.9	178	2.6
Expected year end outturn	770				197			



Monthly figures	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Rolling 12 months total
Falls in Community Hospitals (inpatients only)	72	60	62	66	54	59	49	65	79	65	63	49	743

Additional information related to performance

Falls in an inpatient setting

- 76% of all falls reported in the year to date are **without harm.**

Benchmarking

- The Trust is reporting a rate of 11.46 falls per 1,000 occupied bed days (6 month period between Feb-18 to Jul-18) compared to an average of 8.12 falls per 1,000 bed days based on the Trusts within the latest NHS Benchmarking Network monthly indicator report.
- Internal benchmarks have now been set in recognition that the NHS benchmark changes every month and to allow for more accurate reporting of variances across the different community hospitals. The internal benchmarks are 8 falls per 1,000 bed days and 3.5 falls with harm per 1,000 bed days.

What actions have been taken to improve performance?

- The improvement plan is reviewed by the community hospitals Falls Prevention Group on a monthly basis and reported to the Quality Steering Group, and Quality and Performance Committee.
- Total falls per 1,000 occupied bed days are at 12, above the internal benchmark of 8. Please see commentary on pages 8-9.

Performance against trajectory is from the April 2018 Quality Assurance Report
Narrative and performance for the Quality Priorities will be updated quarterly in accordance with availability of updated Quality Assurance Reports

1. Falls Prevention and Management

Additional information related to performance	What actions have been taken to improve performance?
1.1 Compliance with NICE Guidance (CG161)	• The updated multifactorial falls risk assessment which is now on SystmOne is compliant with CG161 which means that all patients have a full assessment of their individual risk factors which might contribute to their risk of falling. A patient's individual risk factors and the actions required to reduce their individual risk are now recorded. This is reviewed on at least a weekly basis and following any falls. • In addition, the post falls "SWARM" (a 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 falling that can be easily and quickly remedied to reduce the risk of future falls. • Qtr. 2 2018/19 – Record keeping audit indicated that the multi-factorial risk assessment was being completed however the quality improvement group plan to audit compliance on some areas that were identified as being amber or red on the record keeping audit and a visual audit of the area around the patients to identify any potential risk factors on the day (e.g. make sure the call bell is within reach, walking aids are within reach etc.) – planned to take place in Qtr. 3. • Qtr. 3 2018/19 – Audit as described above to take place. • Qtr. 4 2018/19 - Results from audit published and action plan to address areas of non-compliance produced.
1.2 Education and Training	• It is proposed for Year 2 of this Quality Priority that the training report is split to show those colleagues who have received falls awareness training (all community hospital inpatient colleagues) and those who have received falls prevention and assessment (FallSafe) training (all qualified nurses and therapists on community hospital inpatient wards). • Target set at 92% compliance in line with statutory and mandatory training for each of the training pathways with a view to increasing from baseline of around 35% compliance in both by 10% each quarter. • Latest Qtr. 2 2018/19 – **40%** of staff have received falls awareness training; **37%** of staff have received FallSafe training. By the end of Qtr. 2 trajectory for training would be **55%.**
1.2.1 Orthostatic Hypotension	• Orthostatic hypotension can increase a patient's risk of falling. Careful assessment is needed so that treatment and management strategies can be implemented. The aim therefore is for 92% of community hospital colleagues to be trained on correct, consistent techniques for taking lying and standing blood pressure. • Accurate training reports are still not being produced due to data not being inputted. Actions are being put into place to correct this. • Qtr. 1 2018/19 – **47.7%** of staff have received training • Latest Qtr. 2 2018/19 – **50%** of staff have received training.

Narrative and performance for the Quality Priorities will be updated quarterly in accordance with availability of updated Quality Assurance Reports

1. Falls Prevention and Management (cont'd)

Additional information related to performance	What actions have been taken to improve performance?
1.3 Reducing Falls with Harm and Reducing Variation	• Analysis has evidenced a variance against the local benchmark for all falls and falls with harm across all the community hospitals. It can be seen that two of the hospitals are within the target of 8 falls per 1,000 occupied bed days, however all hospitals (with the exception of Tewkesbury) are below the benchmark for falls with harm of 3.5 per 1,000 bed days. • The quality improvement group have requested an additional regular report to show the frequency of falls per patient which will show how many patients fall 1, 2, 3 or more times. This will enable us to identify any areas where patients fall multiple times which will increase their risk of receiving an injury • There was previously no clear definition of what a fall is and what a fall with injury is in terms of how incidents are reported and it was felt that this was contributing to the variation in the incidence of falls reported across the inpatient wards. Definitions were agreed and implemented and in May 2018 the community hospital Matrons audited a sample of incident reports to check compliance against the agreed definitions. The results showed that in **97%** of cases the risk grading was reasonable.
1.4 Positive Risk Taking	• Leaflets are in place and there is now a "tick box" on SystmOne so that colleagues can record that the leaflet has been shared with the patient and/or relatives as part of their falls assessment. This will be audited in Qtr. 3 along with the audit of the multi-factorial falls risk assessment on SystmOne.
1.5 #endPJparalysis	• The Trust participated in the national 70 day #EndPJParalysis challenge as part of the celebrations of 70 years of the NHS. Every day for 70 days the wards measured how many patients are up and dressed in their own clothes and had undertaken some sort of activity. • This information was then uploaded onto an app that feeds into a national database to be displayed on a dashboard. The idea being that our community hospital teams can see how they compare with one another and also with other hospitals participating in this national campaign. • It has not yet been possible to access data to gain an update despite contacting the website directly.

Gloucestershire Care Services NHS Trust

2. Colleague Health and Well-being

Additional information related to performance	What actions have been taken to improve performance?
The Trust is committed to providing a healthy and safe working environment to support colleagues in maintaining and enhancing their personal health and wellbeing at work. The Trust also recognises that supporting staff to improve their quality of life is crucial to the delivery of high quality, person centred care across the organisation's health and social care services.	• Health and Hustle continues to grow its membership and has expanded its reach across the ICS, recently recruiting the County Council, GHNHSFT and the City Council. This has increased interest in the Trust and activity is continuing to grow. • The Trust is also working closely with ICS partners in a joint Health and Well-being working group and we are producing guidance for desk based colleagues on posture and stretching exercises. • Bath Spa University is continuing work on the research project into mental health in the workplace and the aims to have a toolkit and app by the end of the Summer. • The fast track physiotherapist service introduced at the start of the 2017/18 financial year continues to be well received and figures indicate that in the last 12 months there has been a decrease in MSK related absence excluding pregnancy related disorders has decreased by 778 FTE days from the previous year, a reduction of **10.7%.** This will be reported as an ongoing measure from next month's report.

NHS Gloucestershire Care Services NHS Trust

3. End of Life Care

Additional information related to performance	What actions have been taken to improve performance?
Leadership	• End of Life Care work plan and quality improvement metrics have been renewed to support outstanding actions from our CQC inspection and to align with countywide and regional work streams such as the Clinical Programmes Group and the ReSPECT roll out.
Quality Metrics	The quality improvement metrics are: **1. Understanding our Performance:** this will be measured by the utilisation and documentation in the SystmOne End of Life Template. This template will help us to understand and communicate patient wishes/choices for their end of life care. 2. Ensuring we have **Skilled and Trained Colleagues** to provide end of life care. Our End of Life Care Training Framework will guide staff to appropriate resources and we will establish a system to clearly see which staff have received training. **3. Mortality Case Reviews**: we are aligning and enhancing the current system to ensure countywide community hospital learning and sharing of best practice happens. We will also identify a process to start reviewing deaths that occur in the community/at home.
Development of the metrics to date	All activity is currently on track, and includes: • Staff to use the new SystmOne EoL template from October 2018. Reporting from this will commence following this go-live. • Booking sessions with all appropriate teams and services to discuss the metrics (including demonstrating the SystmOne template) and update colleagues on all the activity happening countywide. • Identifying gaps in training provision for locally delivered bite size sessions (potentially looking at prognostic indicators and advance care planning discussions/having those difficult but important conversations around ceilings of care). • We have developed a report prototype that is being used at mortality review groups and are currently establishing if this captures all the relevant information in an easy to use format.
Training and Education	The current training framework is a good base to start to understand the development needs of colleagues. There has been a positive response from colleagues who have attended the masterclasses and training programme to date. We will use their evaluations and feedback to identify further educational needs including the bite size sessions described above.

Gloucestershire Care Services NHS Trust

3. End of Life Care (cont'd)

Additional information related to performance	What actions have been taken to improve performance?
National Audit of Care at the End of Life (NACEL)	• The NACEL relative questionnaire/survey ceased at the end of August and the ward teams have returned to sending these out locally. • The NACEL patient records audit has now begun, 41 patients matched the criteria for audit. • The work to date has highlighted that only 50% of patients next of kin/family have their postal address documented on SystmOne which means that we are only able to capture the experience of half of the families affected by a death in one of our Community Hospitals.
ReSPECT (Recommended Summary Plan for Emergency Care and Treatment)	• Gloucestershire CCG is setting up a Task and Finish Group to support the roll out of ReSPECT across the County, this group is expected to start in September 2018 and GCS is represented.
Countywide roll out of the new Shared Care Plan and diamorphine to morphine swap in End of Life Care	• These 2 changes commenced in June 2018 with countywide sessions for colleagues and the development of local Train the Trainers to support the awareness and safe swap over. A pragmatic approach has been agreed and all new patients will follow the new guidance but existing patients will remain on their existing regimes as both systems support quality of care. The swap from diamorphine is due to its cost and reduction in availability, diamorphine and morphine provide equally good pain control.

- The Trust is also developing some resources to support registered practitioners (particularly those caring for life limiting conditions) in having the difficult conversations and documenting the DNACPR decisions but ensuring there is communication and agreement with the patients GP. This will support ACP and early use of the SystmOne template.
- The Trust is reviewing the MIDAS template to ensure it is capturing the right information and at the same time ensuring it is user friendly.
- The Trust is undertaking a completing a gap analysis against the recommendations of the NQB Learning from Deaths, Working with Families (July 2018) document to see where we can improve our work in this area

Gloucestershire Care Services NHS Trust

4. Nutrition and Hydration

What actions have been taken to improve performance?

To meet CQC regulation 14, providers must make sure that people have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so.

Metric 1: To increase the usage of the malnutrition universal screening tool (MUST)

- **80%** of community nursing patients (including complex leg) will have a MUST assessment completed on initial assessment. **Baseline data for 2017/18 = 27.5%.** Data for Qtr. 1 2018/19 is showing **28.0%.**
- **95%** of in-patient patients will have a MUST assessment completed within 24 hours of admission. **Baseline data for 2017/18 = 13.1%.** Data for Qtr. 1 2018/19 is showing **14.8%.** Assessments outside of 24 hours from admission shows 98.8% of patients have the MUST assessment completed. (Note this target is still to be agreed).

Metric 2: To deliver a "Do one more thing" campaign in every ICT locality to promote the uptake of fluids in patients in their homes. Progress to date – This will be led by a newly appointed Clinical Pathways Lead (anticipated start date September 2018).

Metric 3: Proxy measure to metric 2 - To decrease the incidence of CAUTIs possibly associated with dehydration.

- Retrospective records audit planned between summer 2018 and summer 2019. **Progress to date –** This audit will be led by a newly appointed Clinical Pathways Lead (anticipated start date September 2018).

Metric 4: Healthy workforce campaign: Promote the 3Rs campaign in every community hospital and community site.

- Rest – Rehydrate – Refuel. **Progress to date –** The 3Rs was promoted on various posters in sites throughout the Trust during July when there was unseasonably hot weather, this included a Trust-wide screen saver in early July 2018. Further campaigns will be planned for later in the year.

Metric 5: Increase the uptake of MUST training to include the usage of upper arm measurements in the absence of scales in people's homes. Progress to date – Baseline Data - we have established that formal training numbers are very low in terms of the online training **44 members of staff in 2015, 28 in 2016 and 17 in 2017**. The MUST training with upper arm measurements is now also included in preceptorship training which will ensure that newly trained staff are up to date. Efforts to increase the accessibility of training in forms that will help front line colleagues will be actioned when a new clinical pathways lead as been appointed (September 2018).

Metric 6: Staff colleagues are aware of and can apply the International Dysphagia Diet Standard Initiative. Progress to date – The IDDSI is currently a focus for the Trust's Nutrition and Hydration Quality Improvement Group and plans are currently being put in place to increase awareness and deliver training. This is a major commitment for the Trust and the wider system and we are currently liaising with our partners and commissioners to ensure its success.

Metric 7: Leadership: Non-Executive representation of Nutrition and Hydration. Progress to date – We are currently determining whether there is capacity within the NED structure for NED representation for this quality work stream

These metrics are commensurate with the 8 commitments of the Trust's Quality Improvement group nutrition and hydration strategy as well as CQC standard 14, and should provide demonstrable evidence of quality activity and outcomes.

QUALITY PRIORITY | ARE SERVICES SAFE?

5. Preventing Pressure Ulcers

NHS Gloucestershire Care Services NHS Trust

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
CQC DOMAIN - ARE SERVICES SAFE?																			
22	Total number of Acquired pressure ulcers	L - R		652	71	51	50	53	72								297		
23	Total number of grades 1 & 2 Acquired pressure ulcers	L - R		578	62	46	44	48	62								262		
24	Number of grade 3 Acquired pressure ulcers	L - R		64	7	5	5	5	10								32		
25	Number of grade 4 Acquired pressure ulcers	L - R		10	2	0	1	0	0								3		

Avoidable Pressure Ulcers (Community hospitals and community)	Aug-18
Total number of Grades 1&2	16
Number of Grade 3	0
Number of Grade 4	0
Total	**16**

Unavoidable Pressure Ulcers (Community hospitals and community)	Aug-18
Total number of Grades 1&2	46
Number of Grade 3	10
Number of Grade 4	0
Total	**56**

Additional information related to performance

Pressure Ulcers (Pressure Ulcers)

- In August there were 72 acquired pressure ulcers:
  14 were reported in Community Hospitals
  58 were reported in Community Services

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 0.92 in July. The benchmarking figure is 0.35 for Community Hospital settings in July.

Risks (Pressure Ulcers)
Reference – 562
Rating – 16

Risks (Acquired Pressure Ulcers)
Reference – 710
Rating – 9

What actions have been taken to improve performance?

- Pressure ulcer data has been sent to Matrons to set up their own Datix enquiries for review at Clinical Governance
- Waterlow assessment tool will be implemented in community hospitals with SystmOne changes. The tool will replace Braden and will calculate the Waterlow score.
- Daily skin inspection by a Nurse now be in place by all wards this will support the HCAs in their assessment and to ensure the Nurse is accountable.
- The Vale hospital are trialling use of heel balm
- Gap analysis of new pressure ulcer definitions (NHSI) has been completed, There will be changes to Datix for aspects of this.
- Stop the Pressure day is due to take place on Nov 15th. The theme is " What our team have done to reduce pressure ulcers in 2018 "
- Repositioning charts at the bedside in community hospitals has improved and is part of monitoring through spot audits.

Key successes:

Please note: Quarterly figures are taken from an 8 week extract in each quarter. Qtr. 2 2018/19 extract is from 01/07/2018 to 01/09/2018.

- Increase in reporting of moisture lesions from **2%** of all Pressure Ulcers reported in Qtr. 1 2017/8 to **9%** in Qtr. 2 2018/19.
- In Qtr. 2 2018/19 **6.6%** of all Pressure Ulcer incidents reported were entered by non nursing colleagues, up from **4%** in Qtr. 2 2017/18.
- The incidence of acquired and avoidable pressure ulcers is now **16%** compared to **33%** in Qtr. 1 2017/18 baseline.
- The percentage of grade 1 Pressure Ulcers detected is **21%** of all reported Pressure Ulcers in Qtr. 2 2018/19, compared to **13.7%** in the Qtr. 1 2017/18 baseline. This identifies methods of earlier detection and screening are proving effective.

QUALITY PRIORITY | ARE SERVICES SAFE?

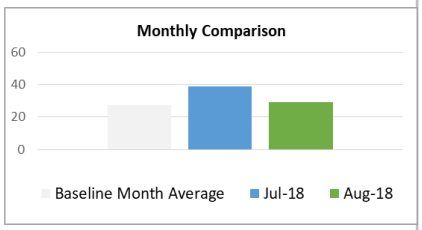
NHS Gloucestershire Care Services NHS Trust

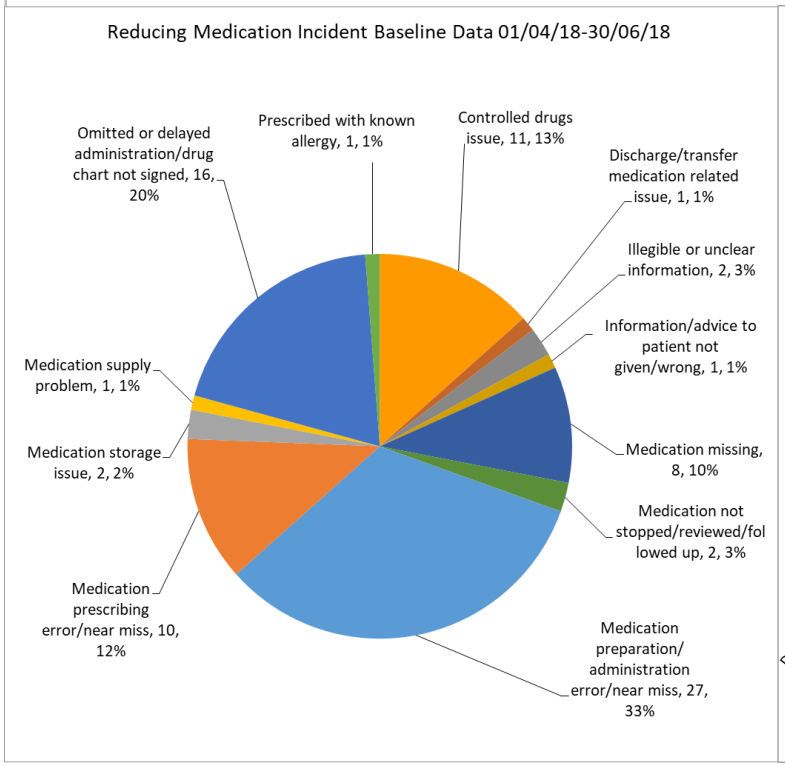
6. Reducing Medication Errors

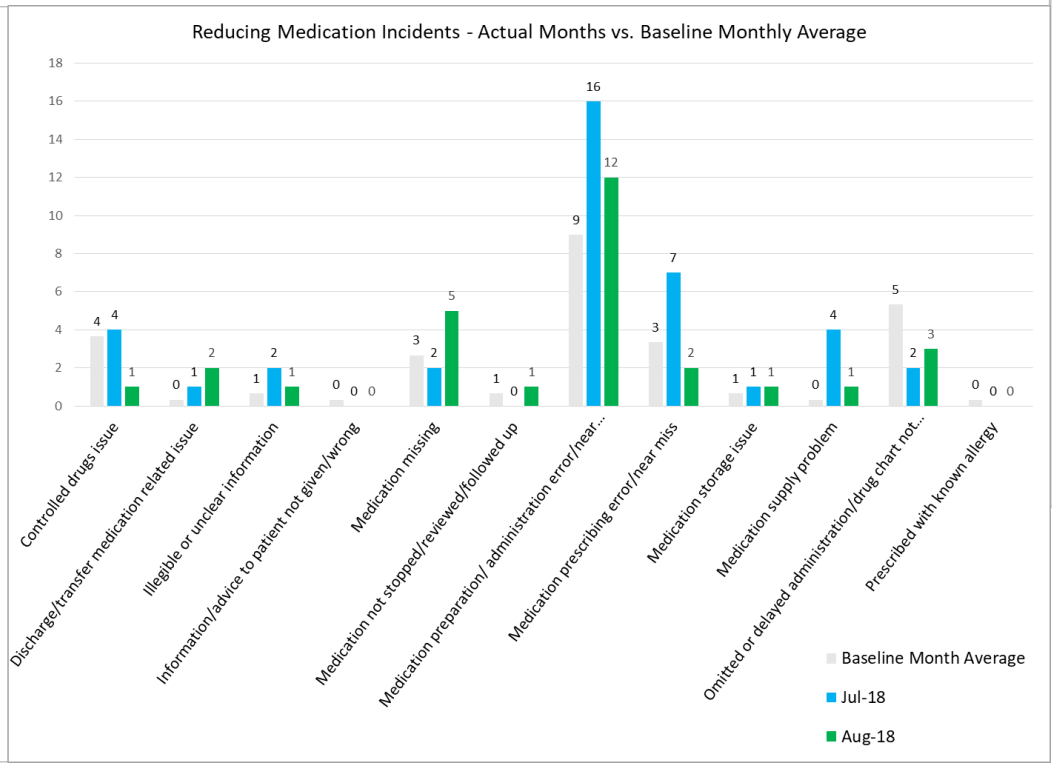
What actions have been taken to improve performance?

- Medication errors and the harm caused by them are a worldwide problem and they are the second highest area of reporting across GCS. In March 2017, the World Health Organisation (WHO) launched its third Global Patient Safety Challenge: Medication without Harm. The aim of this Challenge is to reduce severe avoidable medication-related harm globally by 50% in the next 5 years. The Challenge focused on three priority areas of medication safety that most affect patients; these three areas are high-risk situations, polypharmacy and transitions of care. Each area is associated with a substantial burden of harm and therefore, if appropriately managed, could reduce the risk of harm to many patients.

- **Action completed:** Datix reporting categories reviewed and changes proposed.
- **Action completed :** Medication incidents agenda item on GCS Medical Forum.
- **Action completed :** Community insulin chart launched 1st July 2018.
- **Action underway:** Review of medication training programme.
- **Action underway:** Review of medication Error Management policy.







Please note: Narrative comparing Qtr. 2 data with the Qtr. 1 baseline will be included in the November Quality and Performance report

Gloucestershire Care Services NHS Trust

7. Deteriorating Patient, Including Sepsis

What actions have been taken to improve performance?

Improvements in early detection, escalation, treatment and reporting of deteriorating patients are a new quality and safety priority for the Trust this year. The National Early Warning Score ((NEWS, and now updated NEWS2) is a shared common language to quickly identify deteriorating patients. This supports clinicians to quickly identify and communicate deterioration across acute, community and primary care settings. Early detection of deterioration can aid treatment of suspected sepsis and improve patient health outcomes.

Policy & awareness for clinical colleagues

- Milestone Achieved - The Adult Policy for the deteriorating patient has been completed, ratified and uploaded onto the intranet. Engagement is currently underway across patient facing services to promote awareness of deterioration and escalation principles.
- New Outcome Measure 1: Paediatric deteriorating patient review and agreement on policy. PEWS – Paediatric Early Warning Score: Update review of current guidance completed and assembled. Task & finish group of clinicians identified to lead the review of these, RCN standards & UK sepsis trust guidance. The completed work will be included in an overarching deteriorating patient policy. Baseline compliance audit for PEWS in MIIU's at planning stage with identified lead. MIIU will be auditing PEWS following their NEWS audit.
- Outcome Measure 2:- Deteriorating Patient (Adult) policy roll out and awareness training for all patient facing staff: Update: Awareness & level 1 training (both recordable on ESR with agreed profiles) available through Training and Development Sisters/Rapid Response in Community Hospitals. Following agreement from the Head of ICTs awareness training in ICT localities has commenced with 22 community nurses attending the first session in Stroud this month.
- Outcome Measure 3 - All appropriate patients will have a NEWS score recorded on admission to community hospital or caseload as a baseline. Update: Final report Community Hospital NEWS audit showing an improvements across all measurements. The NEWS audit tool for ICT localities & Rapid Response is complete and awaiting data review of records. A MIIU audit lead has been identified.
- Outcome measure 3 – Will also incorporate the following milestone: Revised National Early Warning Score (NEWS2) upgrade. Test and learn period completed in Rapid Response. Feedback recommendations: Risks to be reviewed (unnecessary escalation and patients assigned to scale 2 without medical review). Risk would be reduced by staged rollout accompanied by training support (already in place with Training and Development Sisters/Rapid Response). Introduction discussed with Head of community nursing, to be agreed by the Medical Director. SystmOne template built, NEWS2 paperwork finalised. Suggested introduction for Community Hospitals in November.

Sepsis

- Outcome Measure 4 – All patients who are identified as being at risk of SEPSIS (using NEWS/Sepsis risk stratification tool data from SystmOne) are managed/escalated appropriately on the sepsis pathway (see deteriorating patient policy). Update: Work to allocate read codes completed. Use of template agreed by Rapid Response and IV clinical leads and currently being used. Performance and Information team are reviewing the data from the template and this will be reported in the next Quality and Performance report.

EXCEPTION REPORT | ARE SERVICES SAFE?

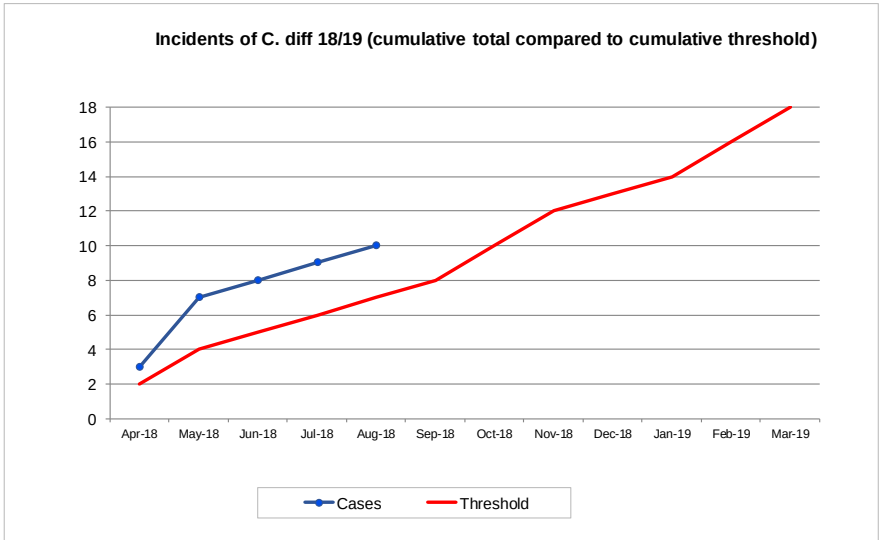
NHS Gloucestershire Care Services NHS Trust

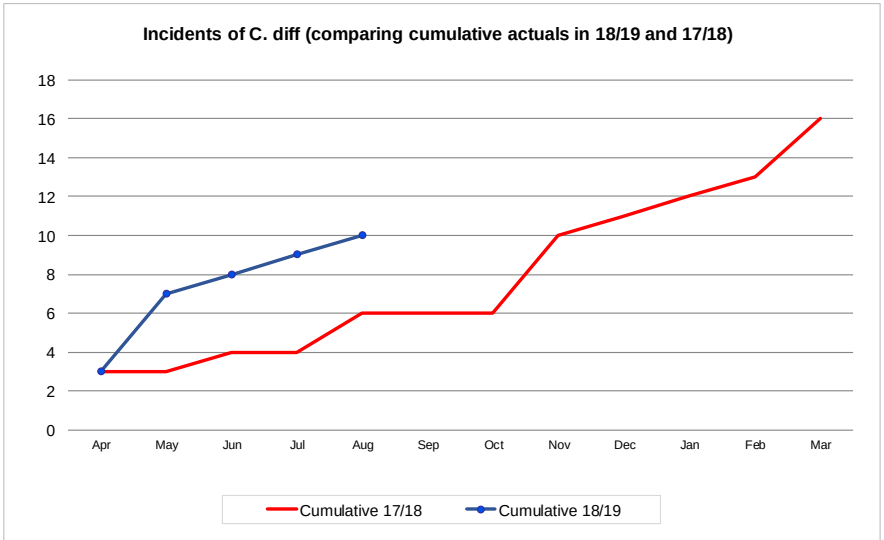
Infection Control

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
14	Number of post 48 hour Clostridium Difficile Infections	N - R L - C	1*	16	3	4	1	1	1								10	Y	
17	Number of E.Coli Bloodstream Infections	L - R	0	0	0	0	0	0	1								1	Y	
19	VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	95.0%	87.9%	93.0%	91.0%	94.3%	94.6%								92.2%	Y	

	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	2018/19
Clostridium Difficile Cases	16	3	4	1	1	1								10
Avoidable cases in GCS care	1	0	0	0	0	1								1
Unavoidable cases in GCS care	15	3	4	1	1	0								9
Norovirus Outbreaks	9	0	1	0	0	0								1





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

EXCEPTION REPORT | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

• Additional information related to performance	What actions have been taken to improve performance?
There has been one C. Difficile toxin positive case to report for August 2018: The patient was admitted to North Cotswold Hospital. The patient suffered symptoms and a sample was sent but no abnormality detected; although later diagnosed as Clostridium difficile toxin positive. This case will be reviewed at the next Clostridium Difficile Infection (CDI) Appeals Panel, organised by GCCG and assigned as either a 'lapse in care' or 'no lapse in care' case. The appeals panel have adopted the Public Health England criteria for deciding if a lapse in care or not has occurred which sets the standard of accountability higher than the previous categorisation of avoidable or unavoidable.	• The patient had a sample taken that was negative prior to the transfer taking place so good practice followed here. • The Ribotype – 18, is the first Ribotype 18 that has been diagnosed for GCSNHST so there is no link to any previous case.
• In the 'Number of Incidences of post 48 hour C.Difficile per 1,000 occupied bed days' measure, 15 of the 18 Trusts in the Network submitted figures for July. GCS submitted a rate of 0.18 per 1000 occupied bed days, 1 other Trust submitted a reported rate of 0.11. The remaining 13 Trusts submitted a rate of 0. • The 6 month average Benchmarking figure across all submissions by Trusts in the Network was 0.07 cases per 1,000 occupied bed days. For GCS the 6 month average is 0.39.	
There has been one E.Coli Bloodstream Infection case to report for August 2018: The Patient was diagnosed whilst at GHNHSFT upon emergency transfer from a GCSNHST inpatient unit. This case will not be recorded/assigned by GHNHSFT as a Pre 48 hour gram negative blood stream infection. The IP&C team are undertaking an investigation using the Public Health England (PHE) Post Incident Review (PIR) process and a report will follow soon as this has been completed.	
Norovirus There have been no Norovirus outbreaks to report during August 2018	

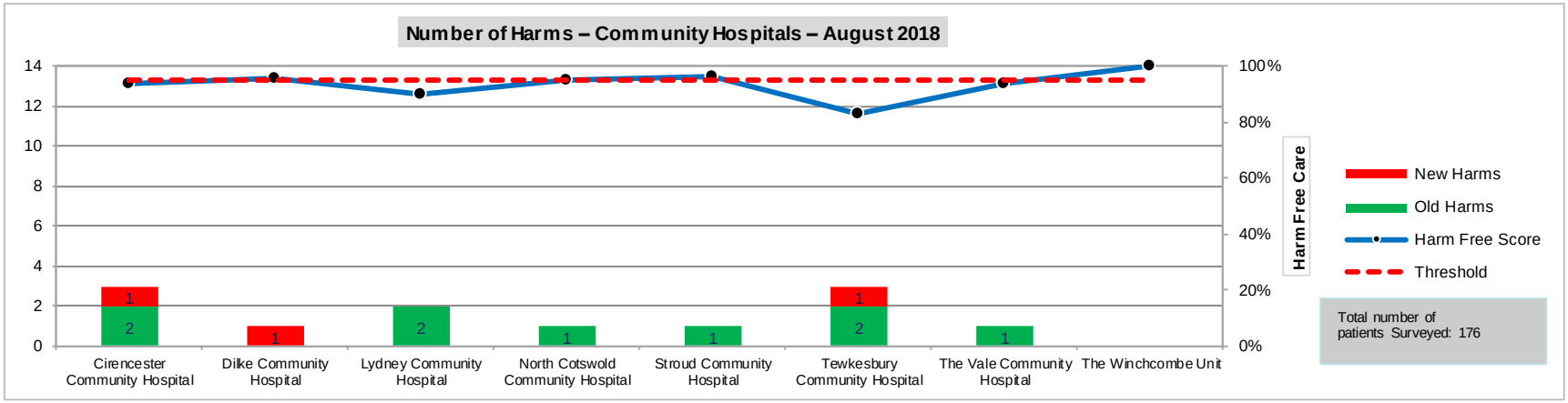
EXCEPTION REPORT | ARE SERVICES SAFE?

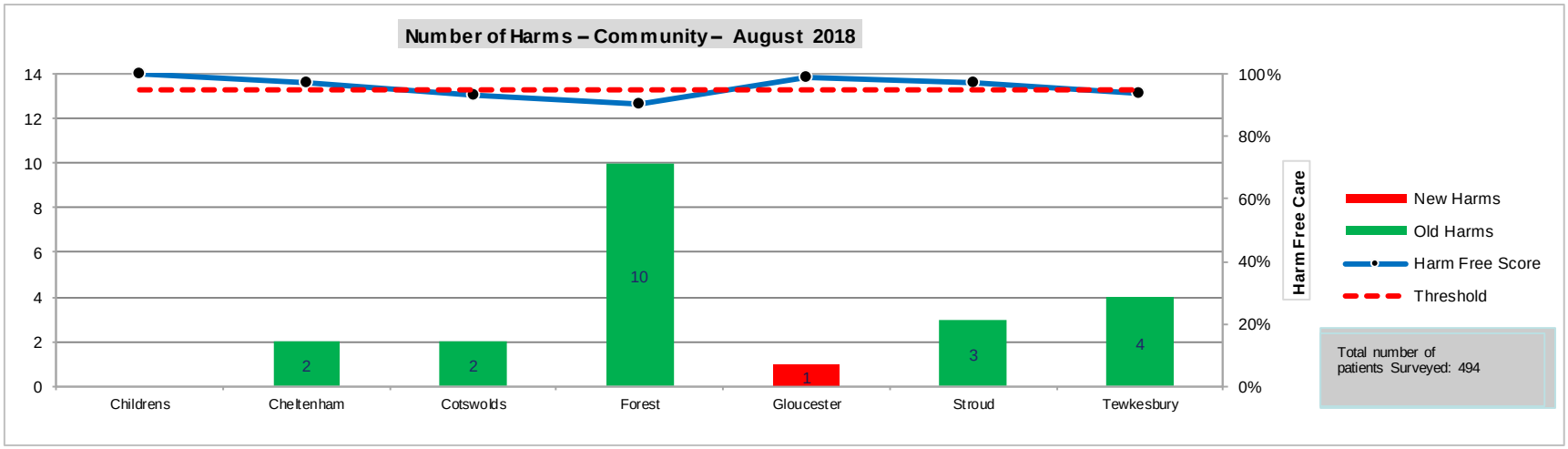
Safety Thermometer (Page 1 of 3)

Gloucestershire Care Services NHS Trust

CQC DOMAIN - ARE SERVICES SAFE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
20	Safety Thermometer - % Harm Free	N - R L - C	95%	94.1%	92.8%	91.9%	94.4%	94.9%	94.9%								93.8%	Y	
21	Safety Thermometer - % Harm Free (New Harms only)	L - I	98%	98.0%	97.2%	95.8%	97.8%	99.2%	99.4%								97.9%	Y	96.5%

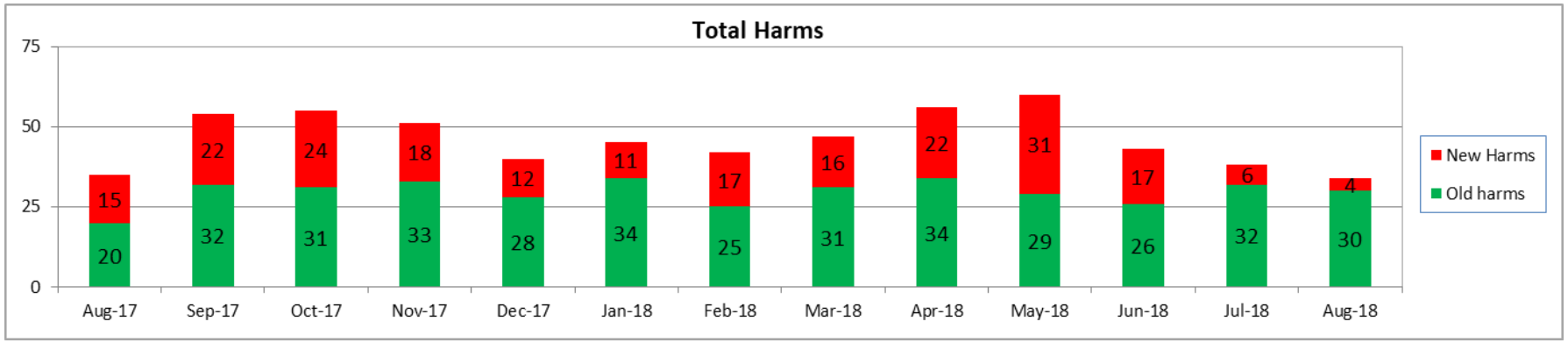




EXCEPTION REPORT | ARE SERVICES SAFE?

NHS Gloucestershire Care Services NHS Trust

Safety Thermometer (Page 2 of 3)



Additional information related to performance	What actions have been taken to improve performance?
Safety Thermometer: • 666 patient episodes of care were surveyed for the August Safety Thermometer census, out of which 632 patients' care was harm free. The Trust's Harm Free Care score was therefore **94.9%**, missing the target of 95% by 0.11%. 1 more harm free Patient would have achieved the 95% target. Based on new harms only, Harm Free Care in August was **99.4**% compared to an internal target of 98%. • The Community Hospital inpatient harm free care performance was **93.0%** in August. Based on new harms only, the inpatient performance was **98.3%** in August. • Community Nursing harm free care performance was **95.6%** in August. Based on new harms only, Community Nursing harm free care was **99.8%** in August. 34 harms were reported in August, of which 4 were new harms. In August, **0.6%** of all patients surveyed had a new harm. In 2017/18, 205 new harms were reported, representing 2.0% of all patients surveyed for safety thermometer in 2017/18.	• Whilst performance for new harms is better than the national benchmark actions continue to improve performance. The Clinical Governance team (PaCE Directorate) are supporting operational services in the validation of harms for each census. • Further exploratory work is being undertaken with the Performance team and PaCE to determine whether the census can by systemised/automated, taking in to account new national pressure ulcer read codes and classifications. **Risks** Reference – 562 Rating – 16

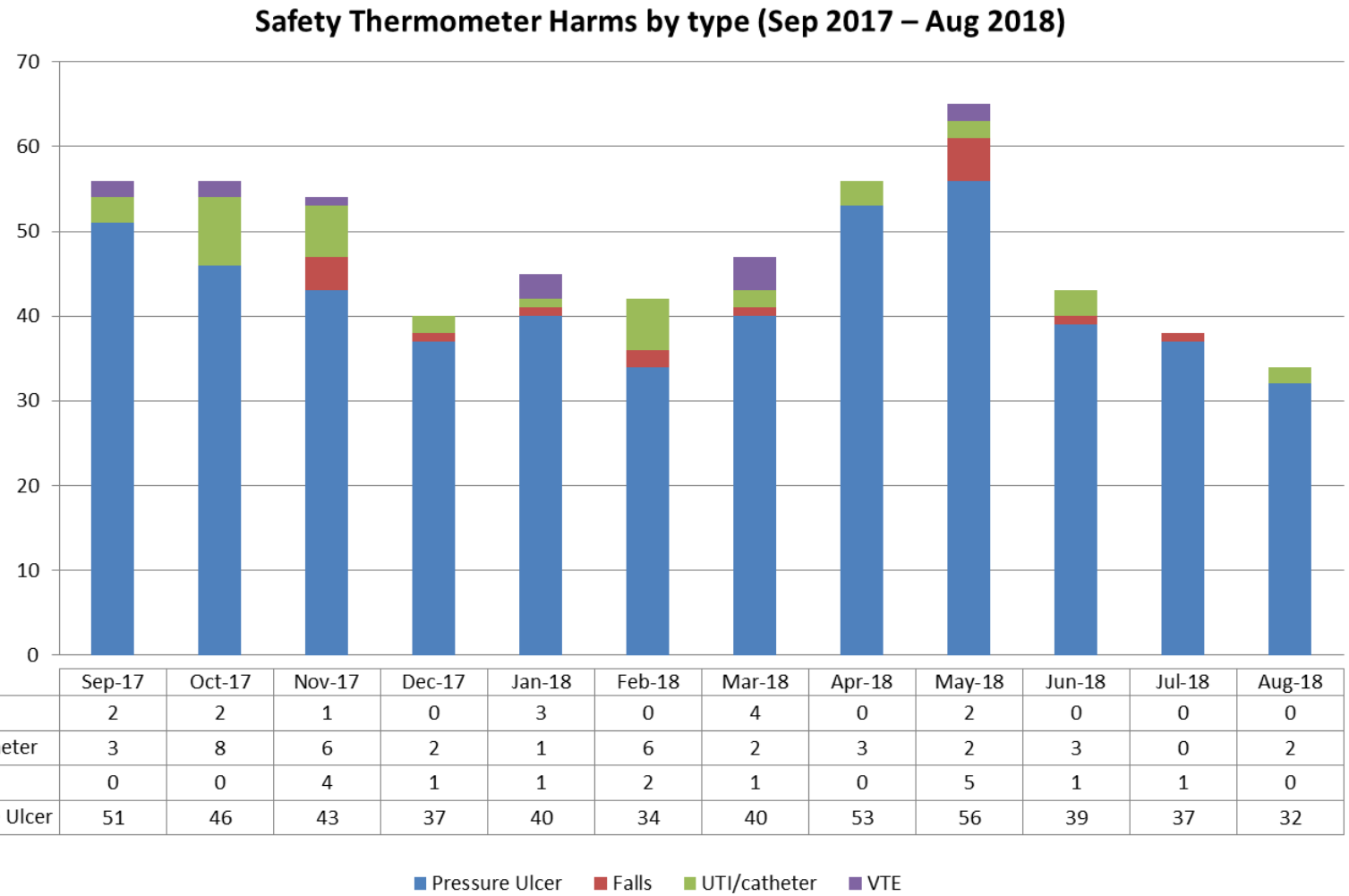
Benchmarking

- In the 'Safety Thermometer – Percentage of 'Harm Free Care (New Harms Only)' measure, the Trust submitted a figure of 99.2% in July. The benchmarking figure is 96.5% for July.

EXCEPTION REPORT | ARE SERVICES SAFE?

Safety Thermometer (Page 3 of 3)

Gloucestershire Care Services NHS Trust



	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
VTE	2	2	1	0	3	0	4	0	2	0	0	0
UTI/catheter	3	8	6	2	1	6	2	3	2	3	0	2
Falls	0	0	4	1	1	2	1	0	5	1	1	0
Pressure Ulcer	51	46	43	37	40	34	40	53	56	39	37	32

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services NHS Trust

8 Week Referral to Treatment (RTT) Measures

CQC DOMAIN - ARE SERVICES RESPONSIVE?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
39	Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	84.4%	60.7%	59.5%	57.1%	59.8%	46.8%								56.6%	Y	
42	MSK Physiotherapy - % treated within 8 Weeks	L - C	95%	90.7%	91.4%	99.7%	85.7%	90.1%	89.5%								89.5%	Y	
43	ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	85.0%	84.3%	84.5%	81.1%	79.6%	86.6%								83.0%	Y	
44	Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	82.8%	77.4%	70.1%	76.8%	73.1%	69.3%								73.2%	Y	
45	Diabetes Nursing - % treated within 8 Weeks	L - C	95%	96.2%	94.5%	85.5%	97.6%	87.8%	90.7%								90.5%	Y	
52	Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	99.0%	96.9%	99.1%	97.4%	93.2%	80.0%								93.3%	Y	

Referral to Treatment – comparison between local 8 week standard and 18 week target (August 2018)

	8 week RTT target	% seen within 8 weeks	Number seen within 8 weeks	Number seen above 8 weeks	18 week RTT target	% seen within 18 weeks	Number seen within 18 weeks	Number seen above 18 weeks	Median RTT in days
Speech and Language Therapy	95%	46.80%	37	42	92%	87.30%	69	10	58
MSK Physiotherapy	95%	89.50%	1290	152	92%	100.00%	1442	0	23
ICT Physiotherapy	95%	86.60%	305	47	92%	96.30%	336	13	12
Occupational Therapy Services	95%	69.30%	303	134	92%	97.00%	424	13	27
Diabetes Nursing	95%	90.70%	39	4	92%	100%	43	0	29
Paediatric Physiotherapy	95%	80.00%	256	64	92%	100%	320	0	16

Other Access measures not included in 8-week RTT table above

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
50	Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation	L - C	80%	77.4%	73.4%	63.4%	83.2%	70.7%	66.0%								72.5%	Y	
56	MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks	L - C	95%	95.9%	84.6%	96.3%	97.6%	96.7%	**								94.4%*	Y	
57	Stroke ESD - Proportion of new patients assessed within 2 days of notification	L - C	95%	88.6%	65.2%	72.7%	44.4%	65.0%	66.6%								63.3%	Y	

****Reporting being developed and validated following service switch to referral recording in ERS**

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services

Additional information related to performance	What actions have been taken to improve performance?
Adult Speech and Language Therapy (% treated within 8 weeks) • Performance was **46.8%** in August compared to 59.8% in July (target is 95%). • 42 out of 79 patients were seen outside the 8 week threshold. • Performance against the 18 week target was 87.3% (10 out of 79 patients were seen outside the 18 week threshold) • Profile of breaches in August (number and percentage): **Wait band** / **Patients** / **%** 8-9 / 9 / 21.43% 9-10 / 4 / 9.52% 10-18 / 19 / 45.24% 18+ / 10 / 23.81%	Amendments made to the SystmOne module to clearly separate GCS and GHNHSFT activity. This went live in July, however reporting has not been updated. Performance and Service Improvement Manager working to understand impact on KPI performance. Audit to be undertaken on 10 patients who waited over 18 weeks to be seen. Further vacancies in service have arisen. Service transformation workshop planned for 3rd October.
MSK Physiotherapy (% treated within 8 weeks) • Performance was **89.5%** in August compared to 90.1% in July (target is 95%). • 152 out of 1442 patients were seen outside the 8 week threshold. • Performance against the 18 week target was 100% (0 out of 1442 patients were seen outside the18 week threshold) • Profile of breaches in August (number and percentage): **Wait band** / **Patients** / **%** 8-9 / 71 / 46.71% 9-10 / 42 / 27.63% 10-18 / 39 / 25.66% 18+ / 0 / 0.00%	Decrease in patients seen in August due to summer holidays (both staff and patient availability). Audit to be undertaken of 39 patients who waited 10-18 weeks to be seen. DNAs and cancellations remain an issue. Demand and capacity modelling training undertaken by MSK band 7 and service lead working with Performance to undertake demand and capacity modelling for the service. Output from the model will be available in October.
Adult ICT Physiotherapy (% treated within 8 weeks) • Performance was **86.6%** in August, compared to 79.6% in July (target is 95%). • 47 out of 349 patients were seen outside the 8 week threshold in August. • Performance against the 18 week target was 96.3% (13 out of 349 patients were seen outside the18 week threshold) • Profile of breaches in August (number and percentage): **Wait band** / **Patients** / **%** 8-9 / 12 / 25.53% 9-10 / 2 / 4.26% 10-18 / 20 / 42.55% 18+ / 13 / 27.66%	Improvement in performance by 7% points. Audit to be undertaken on 13 patients who waited longer than 18 weeks to be seen. Demand and capacity modelling undertaken highlighting where localities pressures lie, and identifying improvement opportunities, however recruitment remains an issue.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services NHS Trust

Additional information related to performance	What actions have been taken to improve performance?
Adult ICT Occupational Therapy (% treated within 8 weeks) • Performance was **69.3% in August** compared to 73.1% in July (target is 95%). 134 out of 437 patients were seen outside the 8 week threshold in August. • Performance against the 18 week target was 97.0% (13 out of 437 patients seen outside the18 week threshold) • Profile of breaches in August (number and percentage): **Wait band** / **Patients** / **%** 8-9 / 18 / 13.43% 9-10 / 13 / 9.70% 10-18 / 90 / 67.16% 18+ / 13 / 9.70%	Continued loss of OT staff as a result of OT review impacting on ability to meet target. Demand and capacity analysis undertaken and meeting with commissioners to ask for a review of service KPIs given the level of transformation.
Diabetes Nursing service (% treated within 8 weeks) • Performance was **90.7%** in August compared to 87.8% in July. 4 out of 43 patients were seen outside the 8 week threshold. • Performance against the 18 week target is 100%. • Profile of breaches in August (number and percentage): **Wait band** / **Patients** / **%** 8-9 / 1 / 25.00% 9-10 / 0 / 0.00% 10-18 / 3 / 75.00% 18+ / 0 / 0.00%	4 patients seen outside target, which tips service into non-achievement due to small cohort of patients. All breaches were due to dietetic capacity however service has been training a nutritionist to increase capacity. This capacity is in place for September.
Paediatric Physiotherapy (% treated within 8 weeks) • Performance was **80.0%** in August compared to 93.2% in July. 64 out of 320 patients were seen outside the 8 week threshold. • Performance against the 18 week target is 100%. • Profile of breaches in August (number and percentage): **Wait band** / **Patients** / **%** 8-9 / 17 / 26.56% 9-10 / 12 / 18.75% 10-18 / 35 / 54.69% 18+ / 0 / 0.00%	The service currently has 4 colleagues on maternity leave which is having a significant impact on capacity. Fixed term posts were appointed but before they commenced in post all were offered permanent jobs elsewhere. The service is continuing to try and recruit.

EXCEPTION REPORT | ARE SERVICES RESPONSIVE?

NHS Gloucestershire Care Services NHS Trust

Additional information related to performance	What actions have been taken to improve performance?
Sexual Health - % of terminations carried out within 9 weeks and 6 days of gestation • Performance was **66.0%** in August compared to 71.4% in July. • 72.5% of terminations this year have been provided within the 9 week 6 day target.	Service transformation work continues to improve initial assessment process and utilisation of medical versus surgical pathways. Team looking to run waiting list initiatives. Analysis of August data shows that 28 of the 50 women proceeding to a MVA/STOP procedure presented at over 9 weeks 2 days gestation making the target unachievable 56% of the time.
MSKCAT Service - wait from referral for urgent patients to be seen not to exceed 2 weeks • The MSKCAT service has made the transition to using the ERS system to record referrals.	Performance YTD is 94.4%, 0.6% off target. Service has been meeting target since May. Report development and validation is in progress and 2018/19 figures will be updated retrospectively when this is completed.
Stroke ESD (% of new patients assessed within 2 days of notification) • The reported performance in August was **66.6%** compared to 65.0% in July against a target of 95%, with a YTD figure of 63.3%.	Service reportedly saw 10 out of 15 patients within target. One of these is a data error that we cannot correct due to patient being discharged, therefore service actually saw 11 out of 15 patients within target. Manual reporting and checking still required due to reporting from SystmOne still not being in place. Colleagues attended high complexity model demand and capacity training event in London and will be using tool to model ESD. NHSI keen to work with us as a community provider to develop the tool.

EXCEPTION REPORT | ARE SERVICES WELL LED?

NHS Gloucestershire Care Services NHS Trust

Workforce / HR (Page 1 of 4)

CQC DOMAIN - ARE SERVICES WELL LED?

		Reporting Level	Threshold	2017/18 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2018/19 YTD	Exception Report?	Benchmarking Report Jul Figure
68	Mandatory Training	L - I	92%	82.63%	86.30%	85.80%	86.02%	86.39%	86.24%								86.15%	Y	88.5%
69	% of Staff with completed Personal Development Reviews (Appraisal)	L - I	95%	79.91%	84.40%	80.94%	81.41%	80.09%	80.09%								81.39%	Y	82.4%
69a	% of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only	L - I	95%	N/A	87.40%	85.40%	84.00%	83.63%	83.60%								84.81%	Y	
70	Sickness absence average % rolling rate - 12 months	L - I	<4%	4.63%	4.70%	4.60%	4.66%	4.69%	4.73%								4.68%	Y	4.6%

Additional information related to performance	What actions have been taken to improve performance?
Staff FFT In Qtr. 1 of 2018/19, **63%** of staff would recommend the Trust as a place to work (target is 61%) and **88%** would recommend the Trust as a place to receive treatment (target is 67%).	• The Trusts Workforce & OD Committee is overseeing action plans to improve this further. These plans will continue align to the wider Organisational Development agendas. **Risks (Recruitment/ Retention)** Reference – 609 Rating – 16 **Risks (Staff FFT)** Reference – 622 Rating – 12
Staff with completed Personal Development Reviews (PDRs) • **80.09%** of Personal Development Reviews were completed by the end of August 2018, the same as July. For active assignments, performance was **83.60% in August**, comparable to the Active Assignments performance of 83.63% in July. **Risks (PDR)** Reference – 643 Rating – 9	• The Trust is working with colleagues to proactively monitor both their own training and PDR compliance levels with through Electronic Staff Record (ESR). Self-service functionality has been launched to allow managers to submit details of completed PDRs via ESR. • This is a recognised priority for the Executive Team. A variety of initiatives are being explored to assist teams with improving PDR completion rates. HR are working with service leads on how to overcome barriers which may be leading to non compliance. For example, in some areas we are aware conversations happen but the recording process is affecting the level of reported compliance. In particular we are working through where staff have multiple contracts. • A new PDR form has been developed and was launched in July. All the relevant PDR documentation has been updated on the intranet. • Weekly Appraisal and Mandatory training data is now available via the Trust's Business Intelligence Tool BIRTIE
Sickness absence • The rolling 12 months performance was **4.73%** in August, above target of <4.0%, and a slight increase from July. **Benchmarking** • In the 'Sickness absence rate (Short and Long Term)' measure, the Trust submitted a figure of 4.7% in July. The benchmarking figure is 4.6% for July. **Risks (sickness absence)** Reference – 633 Rating – 12	• This remains a priority for the Executive and operations teams. A variety of initiatives are being explored to assist teams with reducing sickness absence rates. • Actions taken to date include review of policy, guidance and letter templates and workshops offered by HR, dedicated HR support in Community Hospitals and ICTs, • Discussion at the Performance and Finance meetings and an HR business partner model implemented to offer consistency and local intelligence for each area. • Review of actions above to be completed to assess the impact on sickness levels. • Health and Well Being agenda adopted by the Trust to promote healthy lifestyles. • Employee assistance programmes include Care first and Working Well. • In house fast track musculoskeletal service in place. • Introduction of business intelligence on ESR for all managers to review workforce metrics. • Rostering system in all areas to assist with record keeping. • Flu vaccination programme in planning and peer vaccinators being nominated to assist the roll out of the scheme

EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Mandatory Training (Page 2 of 4)

NHS Gloucestershire Care Services NHS Trust

Additional information related to performance

Mandatory Training

- Average August performance was **86.24%** with 6 measures above the 92% target:

Mandatory Training Courses	Target	Jul-18	Aug-18	Change
Safeguarding Level 1	92%	**96.54%**	**95.61%**	**-0.93%**
Safeguarding Children - Level 1	92%	**96.10%**	**95.18%**	**-0.92%**
PREVENT Awareness	92%	**94.41%**	**93.96%**	**-0.45%**
Infection Prevention and Control - Level 1	92%	**93.06%**	**93.19%**	**+0.13%**
Health, Safety and Welfare	92%	**93.93%**	**93.10%**	**-0.83%**
Equality, Diversity and Human Rights	92%	**93.22%**	**92.83%**	**-0.39%**

- **7** out of 21 measures have increased in performance in August compared to July:

Mandatory Training Courses	Target	Jul-18	Aug-18	Change
Resuscitation - Level 3 - Adult Immediate Life Support	92%	**72.58%**	**75.58%**	**+3.00%**
Safeguarding Children - Level 3	92%	**82.51%**	**84.93%**	**+2.42%**
Resuscitation - Level 2 - Paediatric Basic Life Support	92%	**85.41%**	**87.30%**	**+1.89%**
Moving and Handling - Level 2	92%	**65.39%**	**66.56%**	**+1.17%**
PREVENT WRAP - No Renewal	92%	**88.26%**	**89.09%**	**+0.83%**
NHS Conflict Resolution - 3 Years Elearning	92%	**90.23%**	**90.98%**	**+0.75%**
Infection Prevention and Control - Level 1	92%	**93.06%**	**93.19%**	**+0.13%**

Risks
(Mandatory training)
Reference – 634
Rating – 9

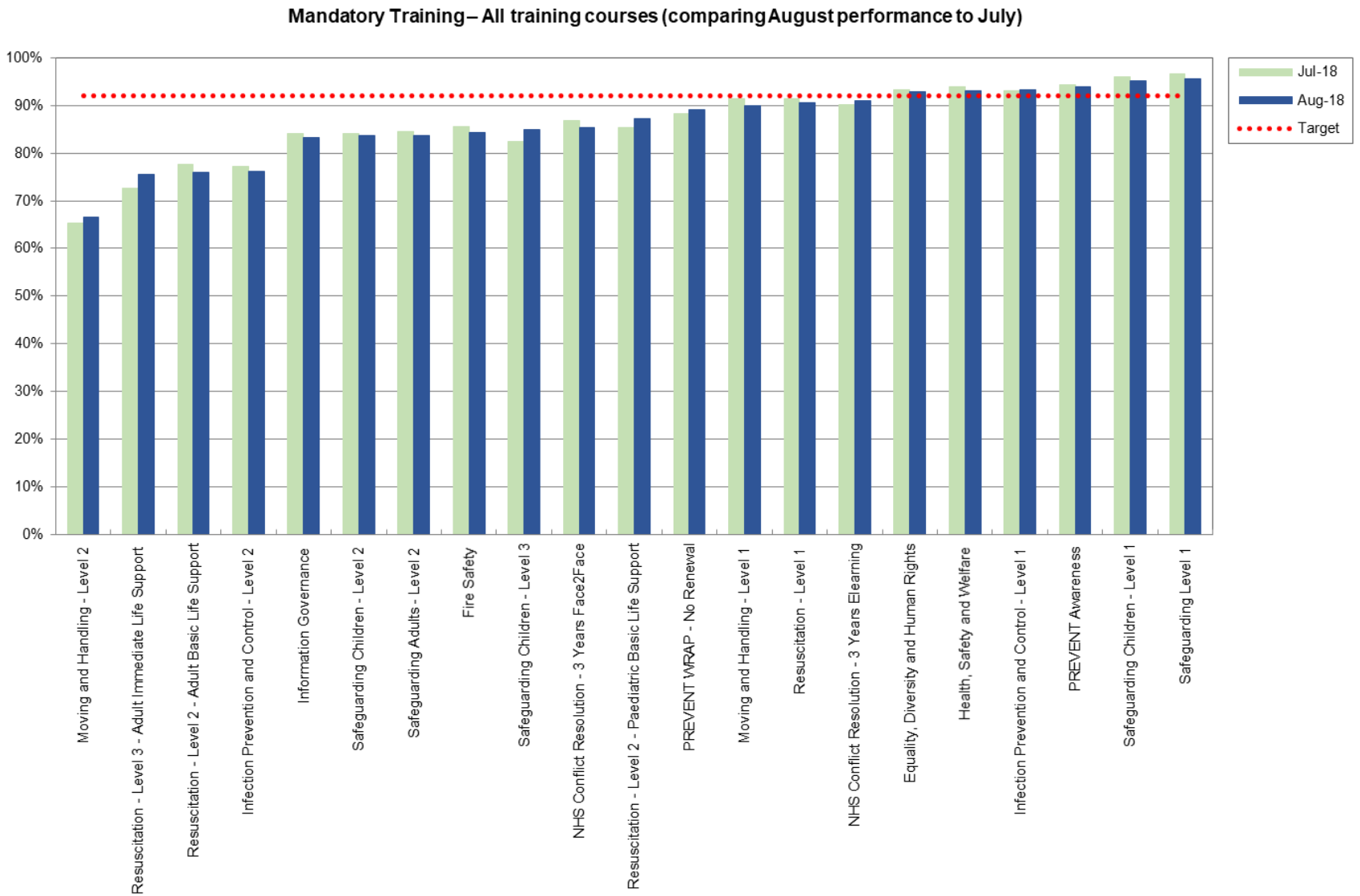
What actions have been taken to improve performance?

- Training review dates are sent to heads of service monthly to inform and support release of necessary capacity to allow colleagues to undertake training.
- Action plans for every subject area below 92% can be informed by the monthly report that is now sent.
- Executive oversight has increased for Resuscitation, Moving and Handling, Information Governance Mandatory training, with a weekly update on compliance.
- The Learning and Development Team have reviewed capacity and sessions have been scheduled for all of 2019.
- Facilitated E-Learning Workshops are delivered around the county in seven locations to support learners with IT, ESR and learning issues in their place of work.
- There is a potential risk that Moving and Handling compliance will reduce further as a result of the relocation of training facilities from the Independent Living Centre (ILC) in Cheltenham to Cirencester Hospital. Plans are being developed to mitigate for this and move the compliance to 92%.
- Overall, compliance remains below the Trust's target rate of 92%.
- Weekly Mandatory training data is now available via the Trust's Business Intelligence Tool BIRTIE

EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Mandatory Training (Page 3 of 4)

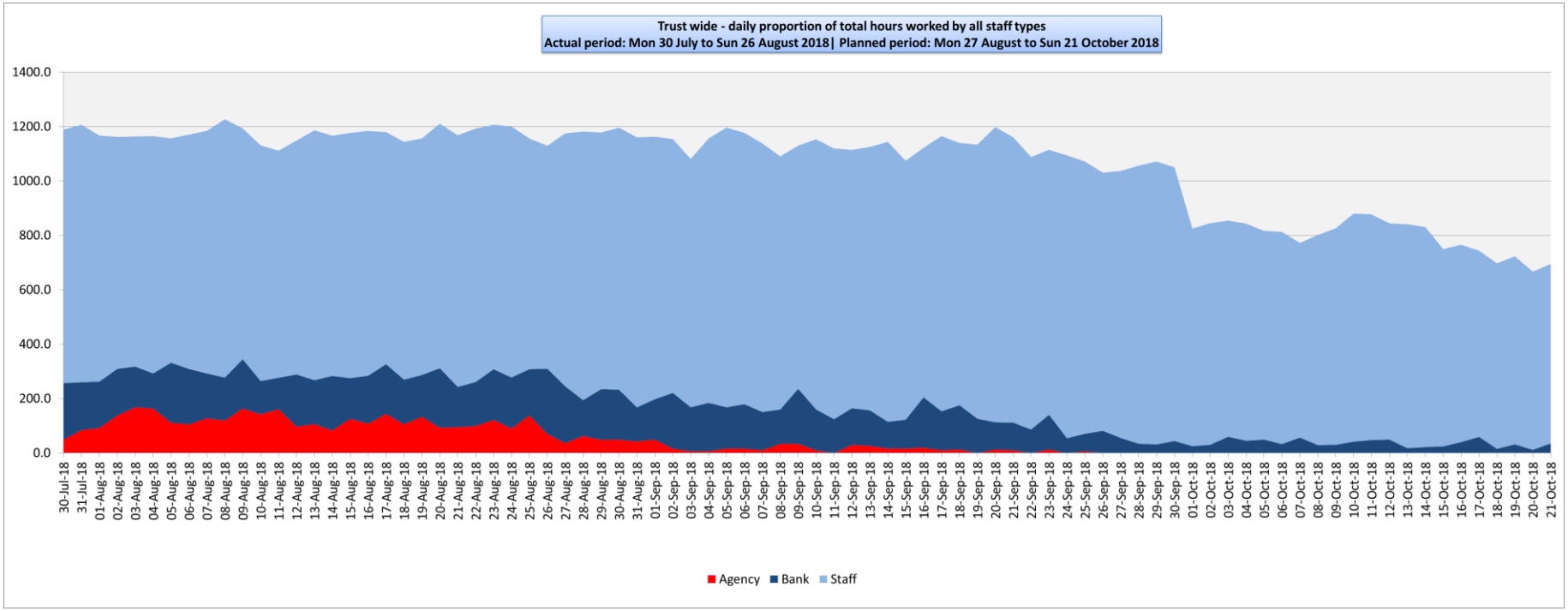
NHS Gloucestershire Care Services NHS Trust

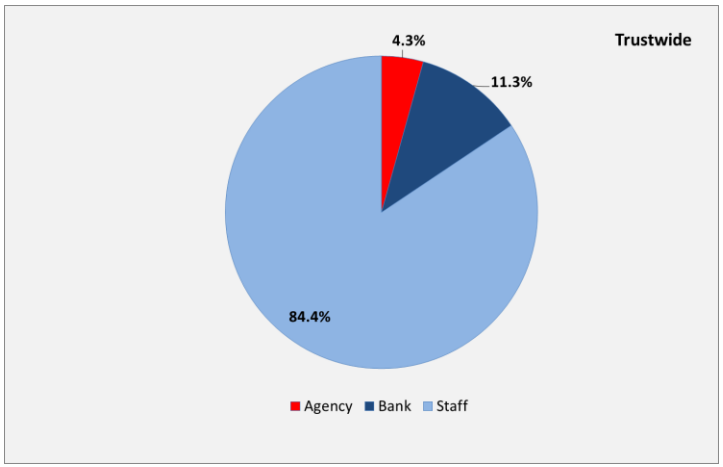


EXCEPTION REPORT | ARE SERVICES WELL LED?

Workforce / HR – Agency Usage (Page 4 of 4)

NHS Gloucestershire Care Services NHS Trust





- The graphs are based on data extracted at the end of **June**, thereby showing actual figures up to the end of that month and planned figures from that point onwards.
- The data is taken from rota information in E-Roster.
- Other information made available to the Trust on a monthly basis includes:
  - Reasons for agency usage
  - Which agencies have been used
  - Agency usage as a percentage of total hours worked, by Hospital ward
  - Of Bank hours, percentages of HCA or RCN
- Workforce definitions:
  - Agency means staff sourced from a private agency with associated cost
  - Bank means sourced through the Trust's internal bank staff
  - Staff means staff directly contracted to Trust and in the establishment of that hospital/ward

Benchmarking

- In the '% Spend on Agency Staff' measure, the Trust submitted a figure of 2.2% in July. The benchmarking figure is 4.2% for July.

Dashboard Key:

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

Report Content:

- The report is constructed on an exception basis, i.e. narrative and improvement actions will only be given against measures that are missing the agreed target.
- Performance against all measures are shown in the Performance Dashboard on pages 4-6; those that are included in the report are indicated by a 'Y' in the 'Exception Report?' column. This will happen under the following circumstances:
  - Current reporting month is red
  - Current and previous consecutive reporting months are amber
  - YTD is amber or red regardless of current reporting month performance