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Date	9 July 2020	Agenda item	Bo.7.20.15

PATIENT EXPERIENCE QUARTER 4 AND ANNUAL REPORT

Presented by	Karen Dawber, Chief Nurse	
Author	Karen Bentley, Assistant Chief Nurse Patient Experience	
Lead Director	Karen Dawber, Chief Nurse	
Purpose of the paper	Patient Experience Q4 (Including complaints)	
Key control	This paper is a key control for the strategic objective to provide outstanding Care for patients.	
Action required	To note	
Previously discussed at/ informed by	Patient Experience subcommittee (in part)	
Previously approved at:	**Committee/Group**	**Date**

Key Options, Issues and Risks

This report provides an annual update on the work of the Patient Experience Sub-committee, which includes work undertaken by the central Patient Experience team, Clinical Business Units (CBU) as well as corporate work streams. The report also includes a report of Quarter 4 (Q4) complaints and Patient Advice and Liaison Service (PALS).

Throughout 2019/20 work has continued to embed the Patient Experience Strategy, ensuring that this is a key strand through all patient experience work. Developments have taken place within the Trust to capture and strengthen patient experience and many positive developments and successful stories are contained within.

Now that the team has successfully appointed to the Quality Lead for Patient Experience and the Patient and Public Involvement Officer positions, an exciting year ahead is planned to continue to enhance patient and relative encounters with the Trust. The strategic work plan that has been developed will allow steer and monitor of planned proposed projects which will be overseen by the Patient Experience Sub-committee.

It is requested that the Board of Directors accept the proposed recommendations held within this paper to support improvements to all areas of patient experience within the Trust.

Analysis

Promotion of the Patient Experience Strategy; *Embracing Kindness* remains a key priority to the Chief Nurse team. Plans to further develop the *kindness* work have already started. Extension to the strategy includes various schemes within the Trust which are in the planning stages, which includes *kindness* forming part of the ward accreditation scheme.

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Improvements to National Surveys Care Quality Committee (CQC) results in both the Inpatient and Maternity surveys have been welcomed following a number of key patients experience quality improvements measures that have taken place during 2019-20.

Friends and Family response rates have increased significantly from 13% up 20% this financial year. This is a direct result of ongoing persistence from ward areas to ensure feedback is offered and in a variety of forms including paper and iPad completion electronically.

The Trust has strengthened its position regarding the requirements for the Accessible Information Standard, to include policy and development in all areas of the standard.

Collaboration work has taken place in a number of forms during 2019-20; improvement work in relation to carers has taken place with the West Yorkshire and Harrogate Partnership (West Yorkshire Associate of Acute Trusts, WYAAT). This is in addition to collaborative work with other agencies, both within Health and the voluntary sector to improve patient experience.

Below are the headlines from the analysis of complaints, PALS and compliments:

- Q4 has seen 120 complaints and 445 annually 2019/20.
- PALS contacts remain consistent at (311) during Q4, annually 1383 informal contacts.
- Compliments are now being logged and have increased in number.
- The theme of most complaints is in relation to appropriateness of treatment.
- There have been no complaints graded as High during Q4 and only one annually.
- Learning from complaints is a key priority and evidence of this how captured and reported.

Recommendation

- Support is required from all areas to continue to embrace the PE Strategy.
- Note strategic work plan (Appendix 1).
- Use of QI methodology for tests of change.
- National Survey (CQC) action plans to be developed to steer improvement, led by a designated area lead.
- Ongoing promotion and development of Friends and Family Test data.
- Continue collaboration work with WYAAT to improve collective and consistent improvements.
- Benchmark against other Trusts that are doing well or significantly better in key patient experience areas.
- There is the requirement for a *tight grip* to remain on the handling and processing of complaints to meet timescale in line with policy.
- Learning from complaints to be made transparent for the public.
- Compliments to be captured and celebrations and acknowledgement of these to be developed.

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- Continue to develop creative ways of enhancing patient experience during Covid-19 restrictions.

Risk assessment						
Strategic Objective	**Appetite (G)**					
	Avoid	**Minimal**	**Cautious**	**Open**	**Seek**	**Mature**
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	**Low**		**Moderate**	**High**	**Significant**	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	☐	☐	☐
Is there any other national benchmarking data relevant to the content of this paper?	☐	☐	☐
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	☐	☐	☐

Risk Implications (see section 5 for details)	Yes	No
Corporate Risk register and/or Board Assurance Framework Amendments	☐	☒
Quality implications	☒	☐
Resource implications	☐	☒
Legal/regulatory implications	☒	☐
Diversity and Inclusion implications	☐	☒
Performance implications	☒	☐

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Regulation, Legislation and Compliance relevance
NHS Improvement: (please tick those that are relevant) ☐Risk Assessment Framework ☒Quality Governance Framework ☐Code of Governance ☐Annual Reporting Manual
Care Quality Commission Domain: Caring
Care Quality Commission Fundamental Standard: Person Centred Care
NHS Improvement Effective Use of Resources: Clinical Services
Other (please state):

Relevance to other Board of Director's Committee: (please select all that apply)					
Workforce	Quality	Finance & Performance	Partnerships	Major Projects	Other (please state)
☐	☐	☐	☐	☐	☐

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1 PURPOSE/ AIM

This report provides an annual overview to the Board of Directors on the work that is being undertaken within Bradford Teaching Hospitals NHS Foundation Trust to improve patient experience. The report includes the complaints report for Quarter 4, 2019/20 (Q4). The Patient Experience team and the work streams that sit within this portfolio of work are focussed on supporting the delivery of the Foundation Trust's mission; to provide the highest quality healthcare at all times.

From a governance perspective, work carried out within the Trust in relation to patient experience has continued to be over seen by the Patients Experience Sub-committee. This sub-committee meets on a monthly basis and reviews the strategic patient experience work plan (Appendix 1) to provide on-going assurance that the objectives are being met and that any work required to support and improve patient experience is progressing. In addition to providing this assurance to the Board of Directors, it is recognised that there is a need for effective dissemination down throughout the organisation to all areas within the Trust to ensure patients, friends and family are at the forefront of all that we do. Currently, there is a Patient and Public Voice Representative appointed as a member of the Patient Experience Sub-committee, increasing our accountability and transparency and furthering our ethos of co-working.

This report provides an update on some of the key pieces of work being undertaken in relation to patient experience led by the team, or as part of identified work streams that report to the sub-committee. This includes:

- National CQC Survey updates.
- Friends and Family Test Results.
- Accessible Information Standard.
- PLACE.
- Patient Experience Collaboration.
- West Yorkshire Acute Trust (WYAAT) collaboration work.
- Patient Experience developments during Covid-19.

The work streams which provided their scheduled report to the Patients Experience Sub-committee during Q4 included:

- End of Life Care Group.
- Dementia Steering Group.
- Learning Disability Forum.
- Volunteers services.

Some of the annual developments the Patient Experience team have completed during the year are discussed. Finally, this paper provides an update of the Q4 and annual data for complaints, Patient Advice and Liaison Service (PALS) and compliments received and highlights specific areas of learning that have taken place as a direct result of these.

2 CURRENT POSITION

2.1 National Survey updates

2.1.1 In-Patient Survey 2019

The National In-Patient Survey results for the 2019 survey are due to be released by the CQC on the 3 July 2020. However, the Trust has received preliminary results from Patient Perspective, the Trusts appointed survey contractor, which indicate significant improvements since the 2018 results.

This annual survey is carried out via post to individuals who were inpatients within the Trust between specific dates during the summer of 2019. The surveys are in English, with a covering letter of how to access the survey in different languages. 419 completed surveys were returns giving a 35.3% rate.

The CQC have made changes to the 2020 planned survey data collection to include future electronic methods. Considering Bradford's population demographics having one of the youngest populations in the country, this may result in future improved response rates.

Overall this was a much improved survey results for BTHFT from 2018. The average mean score rating, across all questions, was 71.2 % compared to 68.6% in 2018.

Outcomes are measured nationally and Trusts are noted as being (compared to other Trusts):

- In the top 20%.
- About the same.
- In the bottom 20%.

The 2018 results showed BTHFT to be in the bottom 20% on 34 questions, this is now down to only 4 questions and the Trust has now risen to the "about the same" category in these areas.

Following the disappointing National 2018 Inpatient Survey results, a number of actions were taken. First, to enable patient feedback to be captured in a contemporaneous way via questions on ward iPads, patients were asked during their admission, about questions the Trust had scored in the "bottom 20%" for on the National Survey.

The results received in key questions were reported throughout the year via presentations at the Quality Committee to demonstrate the improvements that had been made in key areas like;

- Reducing noise at night.
- Communication in a way patients understood.
- Privacy and dignity.
- Answering of important questions.

Secondly, to revisit and develop new patient experience initiatives within the CBUs to enhance patient experience. Lots of creative work took place during the year and included the development of:

- *Good night sleep tight* campaign.
- Tea with matron.
- #hellomyname refresh.
- "*Tell me about your care*" badges.
- Communication workshops.

The results received indicate that compared with the 2018 survey, the Trust received a 5% or greater improvement on 12 questions, this is an excellent improvement for the Trust.
What is more rewarding is that these advances directly correlate to patient experience improvement work carried out. An example of this is the question:

- *Were you ever bothered by noise at night from a patient.*

This question showed an 8% improvement and the team feel this is directly attributed to the work that has taken place in wards to reduce noise at night through the *Good night sleep tight campaign*. The use of ear plugs and comfort rounds before bed, noisy shoes and squeaky doors been address, to light reduction and phones to be silence during sleeping hours.

2.1.2 National Maternity Survey 2019

The National Maternity results for the 2019 survey were released in January 2020. This annual survey consists of a postal survey of approximately 50 questions that is sent out to every mother who has had a live birth in February of that year. The survey is in English, with a covering letter of how to access the survey in different languages.

A small maternity team met with Patient Perspective, the Trusts appointed contractor for analysis and formulate actions required for improvement.

A total of 358 surveys were posted to eligible women in Bradford. The response rate was low at **23%** but as noted by Patient Perspective, the national response rate was lower in 2019 than previous years.

Overall this was a much improved survey results for BTHFT from 2018. The average mean score rating, across all questions, was 82 % (78.9% in 2018).

Outcomes are measured nationally and Trusts are noted as being in the top 20%, about the same as other Trusts, or in the bottom 20% of Trusts on the questions asked. BTHFT scored in the **top 20%** of Trusts on **19** questions, two of which were the top scorers in the antenatal sections.

This is a marked improvement from 2018, where BTHFT scored in the top 20% for only 8 questions. Of the questions asked, 3 showed at least a 10% improvement on the 2018 score. 1 question showed a 10% or more worsening of score. This was around delay in discharge postnatal from the maternity wards where BTHFT scored about the same as other Trusts nationally. The remaining questions showed less than 10% change in score since 2018.

Following review of the results, 5 areas of improvement were identified for BTHFT Maternity Services. This work required actions to improve scores on following questions:

- Cleanliness of all areas within the hospital maternity services.
- Women not seeing a midwife as much as would have liked postnatal.
- Being left alone in labour when worried the woman or her partner.
- Skin to skin immediately post birth.
- Timely postnatal discharge from the maternity wards.

Overall results and an action plan was presented to the Patient Experience Subcommittee in February 2020 to provide evidence and a level of assurance that active work was being completed to improve the above actions.

2.2 Friends and Family Test

Table 1 shows the Friends and Family Test (FFT) results for Q4 and the total for 2019-20. The patient experience team has worked closely with the CBUs over the last 12 months to engage staff and patients in order to facilitate completion of the Friends and Family Test.

Many areas have now moved to using electronic resources to facilitate completion of FFT, such as IPads being available in every clinical area, with the exception of AED. Results have been relatively stable across the year. Response rates when compared to 2018/19 have shown improvement from every area across the Trust. The biggest increase is from the day case areas. These response rates have increased by 23% since 2018/2019. The overall response rate for the Trust, from 2018/19 to 2019/20 has increased from 12% to 20% (Table 2).

	Jan-20			Feb-20			Mar-20			Quarter 4 2019-20		
Area	Recommend %	Not Recommend %	Response Rate %*	Recommend %	Not Recommend %	Response rate %*	Recommend %	Not Recommend %	Response rate %*	Recommend %	Not Recommend %	Response rate %*
Wards	92%	5%	46%	93%	6%	42%	92%	6%	20%	93%	5%	37%
A&E	100%	0%	0%	93%	5%	5%	72%	28%	0%	93%	5%	2%
Maternity	96%	2%	29%	100%	0%	34%	95%	5%	4%	98%	1%	22%
Day Case	97%	2%	41%	97%	3%	42%	97%	3%	8%	97%	2%	33%
Outpatients	96%	2%	-	93%	4%	-	0%	0%	-	94%	3%	-
Trust Total	95%	3%	20%	95%	4%	21%	93%	6%	6%	95%	4%	16%

Table 1 Q4 FFT results

	2018-19			2019-20		
Area	Recommend %	Not Recommend %	Response rate %*	Recommend %	Not Recommend %	Response rate %*
Wards	95%	1%	37%	95%	2%	46%
A&E	87%	2%	0%	90%	4%	4%
Maternity	97%	1%	21%	98%	1%	22%
Day Case	98%	1%	13%	98%	1%	36%
Outpatients	96%	2%	-	96%	2%	-
Trust Total	96%	1%	12%	96%	2%	20%

Table 2 Comparisons of 2018/19-2019-20 of response rates.

2.3 Accessible Information Standard

The Accessible Information Standard (AIS) places a requirement on the NHS to develop a specific, consistent approach to identifying, recording, flagging sharing and meeting the information and communications support needs of patients, service users, carers and parents, where this need arises from a disability, impairment or sensory loss. A task and finish group was established during 2019 to review the Trusts current position against compliance and policy was written to support this work. The introduction of the Electronic Patient Record has provided new opportunities to address the requirements of the standard

and work is being progressed in conjunction with Calderdale and Huddersfield NHS Foundation Trust to progress this. Work carried out to date is summarised as below.

2.3.1 Identification of need

Required-: A consistent approach to the identification of patients', service users', carers' and parents' information and communication needs, where they relate to a disability, impairment or sensory loss.

Action taken: Guidance has been finalised for admin and clinical staff. AIS to be included in the training of all new staff that uses EPR.

2.3.2 Recording of needs

Required: A consistent and routine recording of patients', service users', carers' and parents' information and communication needs, where they relate to a disability, impairment or sensory loss, as part of patient / service user records.

Action taken: Additional options have been built into systems that produce electronic letters. These include easy read, font size and braille request.

2.3.3 Flagging of needs

Required: Establishment and use of electronic flags or alerts, or paper-based equivalents, to indicate that an individual has a recorded information and / or communication need, and prompt staff to take appropriate action.

Action: To ensure staff is aware of what they need to do for AIS. This will include training for new staff and raising awareness in existing staff.

2.3.4 Sharing of needs

Required: Inclusion of recorded data about individuals' information and / or communication support needs as part of existing data-sharing processes, and as a routine part of referral, discharge and handover processes.

Action: To ensure staff is aware of any share process.

2.3.5 Meeting of needs

Required: Ensure that the individual receives information in an accessible format and any communication support which they require.

Action: Provide digital and print letters in the patient's preferred format. The new appointed contractor can accommodate the AIS production of letters.

2.4 Patient Lead Assessment of the Care Environment (PLACE)

During the past 12 months there has been a National review of the PLACE programme led by NHS England and NHS Improvement with a steering group working alongside. The purpose of the review was to ensure that PLACE collection remained fit for purpose and

relevant. The generic conclusion confirmed support for PLACE to continue with the following principles remaining:

- Patient led assessments.
- Focus on the environment.
- Organisations run PLACE voluntarily.
- Results inform and drive improvements.

From this National review there were changes to the paperwork in some of the questions asked, training slides and the portal for the submission of data. A revised and extended timetable period of 10 weeks was introduced. The patient experience team led the programme during Q2 and carried out all the necessary assessments.

Due to the extent of the changes to the PLACE programme (questions and scoring system); PLACE scores for 2019 are not comparable with those from previous years.

The Trusts result presents scores in a number of domains which include:

- Cleanliness.
- Food general.
- Ward food.
- Privacy and dignity.
- Disability.

- Organisational facilities.
- Communal areas.
- Dementia.

As a general comparison between other local similar sized Trust BTHFT is marginally above average on 3 domains, on average for 2 and below average on 3 domains.

The regional score for dementia and disability are below the national average; however BTHFT sits at the lower end of this range. A brief analysis of the data providing these dementia score indicates that the reason the Trust scores badly for dementia and disability is generally due to:

- Signage and heights (particularly for toilets).
- Door colours and contrasts.
- Handrails.
- Local artwork on walls.

A paper was presented to the March Quality Committee with an Action Plan. This plan differentiates between what changes can be made at no cost, where changes can be made at a cost to the organisation and will require some capital funding and identifies where

changes are not possible due to the age of the estate or not owned by the Trust. A copy of the Action Plan can be found in Appendix 2.

2.5 Patient Experience Collaboration

A Patient Experience Collaborative (PEC) was established and launched in July 2019, which is a quality improvement project designed to enhance the experience of care across the Trust. This was intended to support the implementation of the Trust's patient experience strategy and improve the experience of care for patients, carers and families. The collaborative approach was designed to support staff across the organisation to enhance the patient experience of care through a series of learning sessions and action periods. The aim was to improve the way information is captured, understood and how patient feedback is acted upon. Work to March 2020 is as follows:

2.5.1 Key outputs:

- Three leaning sessions for staff which included introduction to quality improvement theory, tools and techniques and sharing learning from small test of change. This included patient involvement in the design and running of learning sessions.
- Bespoke patient experience training developed and delivered to Band 2 and 3 clinical and non-clinical support staff.
- Bespoke Quality Improvement training delivered to staff.

2.5.2 Key Successes by speciality

- The Emergency Department tested new ideas to improve the way they interpret and act upon patient feedback from the FFT. This included Staff engagement and rewards using patient stories, blue badge initiative *'Tell me, how was your care today?*' and visual displays for patients and staff. The department demonstrated a significant increase in the number of FFT's completed.
- Urgent and Emergency care - Promoting *'Good night, sleep tight'* initiative' – providing ear plugs/eye masks for all, addressing specific patient feedback with regard to bright lights. Since changes were made there had been no complaints from patients about disturbances at night.
- Urology (ward 14) – Co-developing patient education for the self-administration of Tinzaparin post-operatively at home.
- Orthopaedics - Piloting a new pre-assessment one-stop clinic for patients undergoing elective hip and knee surgery on the Ward 28.
- Respiratory (ward 23) - Providing activities for patients, games, pom-pom making, supported by the Enhanced Care Lead Nurse. Improving the working environment for staff, by creating lots of small changes and encouraging staff awards.

See Appendix 3 for examples of the work carried out.

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2.6 West Yorkshire and Harrogate Partnership

At the end of 2019 the West Yorkshire and Harrogate Partnership contacted the Partnership Trusts and began to scope what is already available to Carers across the local health service. The project has two schemes, firstly to support carers when the person they care for is attending as an outpatient and is an inpatient. The second part of the scheme is supporting workers within the Trusts who may be carers themselves. BTHFT has linked up and engaged with the scheme and are committed to the unpaid carers' project. The Patient Experience team are in constant contact with the scheme leaders and associated Trusts to work collaboratively. A carers Charted has been written and is ready to be launched and regular Task and Finish meetings have taken place to ensure that the passport is equitable and fair and ensure when launched it is a success. Further meetings and adjustments will be carried out during 2020. Work is also being done by the Patient Experience team to introduce a new patient information booklet that will allow patients to get an understanding of what to expect from a visit or stay at BTHFT. Alongside this a new visitors charter has been written and will be ready to launch in 2020.

2.7 Covid-19 Patient Experience work

2.7.1 Chaplaincy

In response to increased demand due to Covid-19 the patient experience team have worked closely with the Chaplaincy department and have changed the way Chaplaincy operates during the times of increased pressure. The service now operates a 24/7 service and has a chaplain per faith either on site on or call. The biggest faith requirement has been through Muslim Chaplains. As a result the team has employed two male chaplains from the Bradford Council of Mosques on a bank contract and employed a Muslim Chaplain from West Yorkshire police, who can also deliver pastoral care to other religions. The Chaplains have adapted the way they work and visit wards and patients daily and are inclusive of all religions on these daily visits. The Chaplains have also been able to support end of life visits, pastoral care on handing over property and have implemented faith resources for all wards as additional support. This service has been very well received and the team has had a number of positive compliments.

2.7.2 Property management

The Patient Property team was formed in March 2020, as a result of Covid-19, to collect deceased patient's property from wards and store safely to avoid cross contamination on wards and other departments. Since then the team has evolved to helping ensure parcels and property get to patients via collection from relatives at entrances to the Trust. Further to this the team has worked with Chaplaincy to put in a process whereby if a relative comes to collect belongings that they get the emotional and pastoral care required.

2.7.3 Relatives line and *Thinking of You* line

The relatives line was initiated during the Covid-19 pandemic for three primary reasons; to allow clinical staff to focus on direct patient care, enable relative to get up to date information about their loved ones in the absence of them being able to visit in person and to facilitate Covid-19 results. The relative's line is run by qualified nurses who are currently not able to carry out clinical duties. Since launch, the service has received 16,192 calls to date with 94% of calls presented handled, with on average 223 calls per day.

A service evaluation of the relatives line service was conducted (April-May2020) with data collected on over 3000 calls. Feedback was also collated from relatives (via telephone interviews), staff on wards (via interviews) and with operators (via interviews). Key findings from the user feedback include:

- The service was utilised by care home staff in addition to relatives.
- The accessibility of the service was praised. Other agencies reported the value in providing continuity of care, as prior not always aware that patients were being discharged from hospital or of patients' on-going care needs.
- Relatives have said they feel 'cared about and cared for' at a time of heightened anxiety. This service has enabled time to listen and answer questions, explain treatment plans and provide details on on-going care needs for patients post-discharge.
- Able to provide public health guidance re Covid-19 test results and on-going management.

An extensive review of this service has been carried out by the research institute, full details of which can be found in Appendix 2.

Thinking of You (ToY), was initiated to provide a mechanism to relay messages (written and/or video) from relatives to patients in hospital during visiting restrictions. A dedicated email inbox (thinkingofyou@bthft.nhs.uk) went live on 12th April 2020 to receive messages from relatives. Short messages are transcribed onto postcards or a specific template for longer messages, photographs printed and laminated, and these written messages and video messages (via a tablet device) are delivered to patients on wards. Messages are delivered 4-5 times a day at BRI and twice a day to other Trust sites. The service has received 882 messages since launch.

*Family View***,** has been utilised as a NHSE approved mechanism for relatives to video call patients in hospital. Each ward has a tablet device to receive a video call from a relative for a patient and to activate the ward can send a link to the relative in the community for them to activate. This service has also been used to facilitate end of life chaplaincy prayers for patients and is now planned to be used to replace face to face meetings with complainants moving forward during Covid restrictions.

These services have clearly met the information needs of relatives/families whilst visiting has been restricted. The Relatives line evaluation has also demonstrated that the service is meeting an unmet need for relatives by providing a mechanism that enables relatives to 'reach in' to the hospital to meet their information needs in a more responsive way than perhaps traditional methods (telephoning wards and hospital visiting). Both services are currently under review, and are likely to continue, but delivered as one amalgamated and streamlined service managed within the Patient Experience portfolio.

2.8 Patients Experience Subcommittee Work Stream Updates

2.8.1 End of Life Care Group

The end of life care group reported a busy quarter with developments and activity as below:

- The registration for the National Audit for Care at End of Life (NACEL) registration for 2020 has begun.
- Bereavement project in AED commenced January 2020. Relatives of those who have died are invited in approximately 6 weeks following death to meet with healthcare professionals to discuss the care of their relative.
- Shared Memories Event – inaugural adult event was planned for Saturday 28th March 1-3pm in the Listening for Life Centre (cancelled due to Covid).
- Bradford Bereavement conference is planned for the 5th of June (cancelled due to Covid).
- Last Days of Life Documentation for EPR has been developed in collaboration with CTHFT. BTHFT will pilot the documentation which will begin in March 2020.
- End of Life Communication Skills workshops in collaboration with paediatrics & neonates will start in spring 2020.
- Education to support the EPR *Last days of life* documentation due to be rolled out from March 2020.

2.8.2 Dementia Steering Group

The Dementia Steering Group reported that since the appointment of the Lead Nurse for Dementia, developments have taken place in a number of key areas to improve the care that we provide to patients and their families. Key areas of focus include:

- **Dementia Education**

There is an established education programme for dementia, incorporating delirium. Levels one (e-learning), two (for all clinical staff coming into contact with those with dementia) and three (dementia champion) are all able to be booked online through ESR. Data is currently been gathered with Matrons and ward managers to establish those staff who were previously trained and not recorded on ESR to establish overall compliance. There are currently 113 dementia champions across the Trust, up from 56 last year. A PhD Student

has been appointed, who aims to complete research looking into pre-operative assessment for people living with dementia.

Simulation scenarios on dementia and delirium are included in SAFE training.

- **Environmental changes**

Work to create a dementia cubicle in AED is now complete and received positive feedback from patients and relatives, particularly via the PLACE work carried out in the department.

St Luke's Outpatients (Horton Wing) has undergone a dementia friendly review and re-decoration, along with the friends of St Luke's café.

Ward 22/ dialysis unit at BRI/ ward 16/ 5/ all updated, with the input of dementia champions and the estates department ensuring that they are dementia friendly. Again many of recommended changes were highlighted during the Trust participation with PLACE.

- **Re-admission rate**

Previously on the Trusts National Audit of Dementia BTHFT was above national average. During the last report on this (March 2020), we scored below. This is now showing lower than the National average (37% National rate in 2019 when last analysed and 18% as of March 2020 in BTHFT).

- **Advance Care Planning (ACP)**

As part of a regional pilot through NHS E & I, the team participated in educating 40 front line clinical staff to begin ACP conversations and begin documenting ACP's to prevent future unnecessary admissions and ensure people's views were taken into consideration for a time when they might lack capacity. This work is currently on hold due to the COVID-19 pandemic.

- **Delirium**

New delirium resources from NHS Yorkshire and the Humber clinical network entitled "Think Delirium" have been successfully rolled out across the Trust, encouraging medical staff to code a delirium when someone is admitted, this then pulls through to the GP discharge letter, so the GP is informed of a presentation of delirium and can continue to monitor in the community. 66% of relevant discharge letters currently contain this information (national average is 36%, dates as of November 2019).

- **Patient Experience and dementia**

The patient story of *Michael*, was produced and presented to Board in September 2019. Michael shared his experience of living with dementia and being an inpatient within the Trust. Michael raised a number of invaluable points from his experience and enabled the team to develop recommendations. Learning points that have been developed from this

patient story include pre-operative communication for reference during admission, ward location and orientation of dementia patients at admission.

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In May 2019 during dementia awareness week the Dementia Lead Nurse and the Assistant Chief Nurse for patient experience held a patient focus group, to welcome areas for improvement in line with BTHFT Dementia Strategy. Recommendations from this group included, the use of flower magnets, blue wristbands (to symbolise dementia) would be helpful. These are in use in all areas across the Trust. The *forget me not* tool continues to be embedded in all areas across the Trust, with magnets used behind the bed and "This Is Me" documentation increasingly used.

Items on hold until COVID restrictions withdrawn:

- Dementia performance of "don't leave me now" from Brian Daniels for staff to raise dementia profile (due May 2020).
- New simulation course designed to educate staff on common mental health Presentations, Acute Psychiatric Problems in Acute Settings (APPAS).

2.8.3 Learning Disability Forum

There has been an increase in activity in relation to supporting patients with a Learning Disability who have accessed the acute services. This in part is due to the ongoing development work undertaken by the Safeguarding Name Nurse in collaboration with the Health facilitation team from BDCFT. The sharing of information facilitated patient records being flagged to ensure staff is aware of certain diagnosis on admission. As part of the flag, reasonable adjustments have been added to patient's record, to facilitate patient centred care on admission. This development also means that the Trust has more intelligence regarding the number of patients with a learning disability accessing services, which in turn facilitated specific pieces of work to be undertaken.

During the last year, the policy for patients with a Learning disability was re written and the Trust adopted the VIP passport. This was a document already used by patients with a learning disability whilst in the community. It provides staff with information about the person that they themselves may be unable to communicate. By using consistent paperwork as an inpatient or whilst in the community it ensures the individuals needs are highlighted and staff have a clear reference document for meeting those needs.

The second annual national benchmarking data collection was undertake in early 2020, the Trust undertook this, providing specific data from an organisational perspective, obtaining patient feedback and completing staff surveys. The results have not been published due to the Covid-19 pandemic. The data that was not currently captured and the learning from this will be incorporated into the forthcoming years' work plan.

A business case was put forward for a specific Learning Disabilities Lead Nurse. This was successfully recruited to in early 2020. Patient representatives with a Learning Disability assisted the Trust in the recruitment process. This post will continue to work with partner agencies from statutory, voluntary and charitable services to ensure the needs of patients with a learning disability are addressed and our services meet these needs

2.8.4 Voluntary services 2019-20

At the end of the financial year Bradford Teaching Hospitals NHS Foundation Trust had 430 active volunteers which include the Chaplaincy visitors. It is impossible to measure the value and pleasure those individuals bring to the organisation.

In addition to delivering existing services such as Tea Bars, Guides, Patient Support, radio and the ward trolley, Voluntary Services have developed the following roles over the past 12 months.

- **Pets As Therapy** – Successfully introduced a PAT dog onto the paediatric ward and were about to introduce a dog to ICU just as Covid-19 lockdown began. All the relevant documentation has been written and approved for the re-introduction of this valuable service when allowed. Future expansion is planned to develop this service for the Chemotherapy day unit.

- **Partnership work** – The volunteer services works in partnership with a number of local charities and support groups to offer volunteering to a wide range of people from the local community. In the last year the Trust has worked with Horton Housing, offering volunteering to refugees who are in the UK as part of managed migration programmes. This has been a successful project working with the Volunteer Co-ordinator and New Communities Support Workers from the project.

- **Phlebotomy** – At management request there has been the development of a volunteer role within the phlebotomy department. Volunteers support staff to manage patient flow in this busy department and has helped reduce delays and improve patient experience of patients through the department.

- **Research** – Working with colleagues at BIHR a number of volunteers have been recruited to assist on specific research programmes. These include Born in Bradford, respiratory research and neuro physiotherapy. These are bespoke roles that have been developed.

- **Psychology** – Work has begun with colleagues in Psychology to support the recruitment of a small number of volunteers to work in the department. Work had also started to look at working in partnership with Bradford University around the opportunities in psychology.

- **Winter Pressures** – BTHFT was chosen by NHS England to receive some additional funding to support volunteers assisting the Trust during the winter pressure months. Work had begun on this focussing initially around the Discharge lounge in February before being put on hold due to Covid-19.

During the year additional Patient Support volunteers were placed on wards that had not previously had them including Ward 12.

Work had also started with developing the role of Activity Volunteer. Initially this was focussed on Dementia, working closely with the dementia lead to develop the role. However, plans are in place to extend this to working with patients to include Learning Disability and Mental Health following discussions with those colleagues.

2.9 Patient Experience Ongoing Developments.

The strategic patient experience work plan for 2020/21 has been reviewed and updated (Appendix 1). This work plan is reviewed monthly via the Patient Experience Subcommittee.

The team has now successfully appointed to the Quality Lead for Patient Experience position and the successful candidate is Laura Booth, who joined the Trust in November 2019. This new appointment will help the team to deliver on some fantastic planned improvements projects planned for 2020/21.

In addition the Patient and Public Involvement Officer Samina Fayyaz commenced in post in January 2020. This valuable post will facilitate engagement with patient and service users in addition to working with other organisations in both health and the voluntary sector, promoting collaborative working.

Other recent developments carried out include, review and production of new bedside folder information, development of a Patients Charter, production of a cohort of accessible information leaflets to support the changes during Covid-19 to visiting and services in the Trust and ongoing stories from patients made to open Board meetings.

3.0 Complaints

During quarter 4 (Q4), the Patient Experience team have continued to focus on measures to improve the quality and timeliness of responses to complaints by continuing weekly complaints meetings and keeping complaints under constant review via the complaints tracking system. During Q4 the Trust received a total of 120 complaints. This completes the annual total, which stands at 445 for the year. Table 3 below provides the annual breakdown per CBU.

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	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	Total
Planned Care Group	60	44	43	38	185
Unplanned Care Group	57	64	51	78	250
Central	2	1	3	4	10
Total	119	109	97	120	445

Table 3 complaints per quarter and CBU received during 2019/20.

Despite an annual figure of 445 complaints for 2019/20, this figure has dropped significantly from the previous financial year position by 20%. Figure 1 below makes comparisons of this data and demonstrates the reduction from overall 557 during 2018-19 down to 445 for 2019-20.

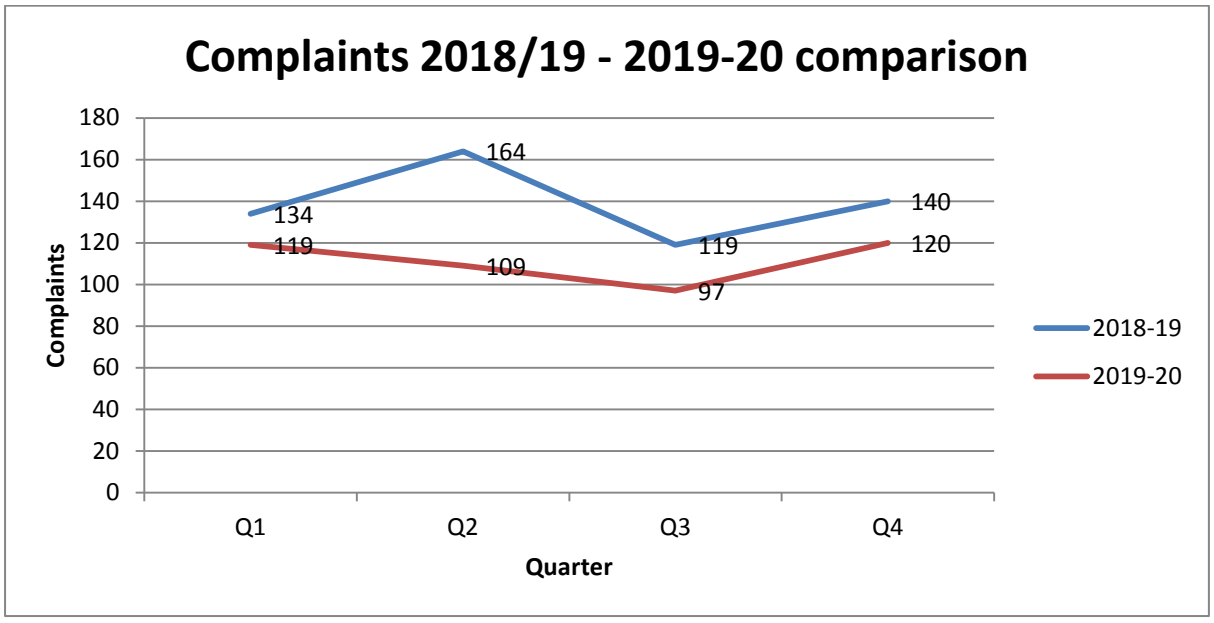

Figure 1 Complaints comparison between 2018/19-2019-20.

The patient experience team believes that this reduction may be as a direct result of some of the positive impacts new patient experience initiatives have had during patient encounters/stay. The promotion of the *good night sleep tight* campaign has had a significant impact on patients sleep and rest and the encouragement to reintroduce communication campaigns and the importance of clear concise communication with patient and families may have helped, as communication issues are often raised within complaints.

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One of the key objectives of the central complaints team was to track and ensure that the Trust minimised the number of complaints that were responded to beyond 6 months from receipt, to fall in line with national recommendations and Trust policy. Figure 2 clearly demonstrates the initial and sustained improvement that has been made in relation to this objective. Rationale for the outliers has generally been as a direct result of complex clinical complaints taking over the 6 months.

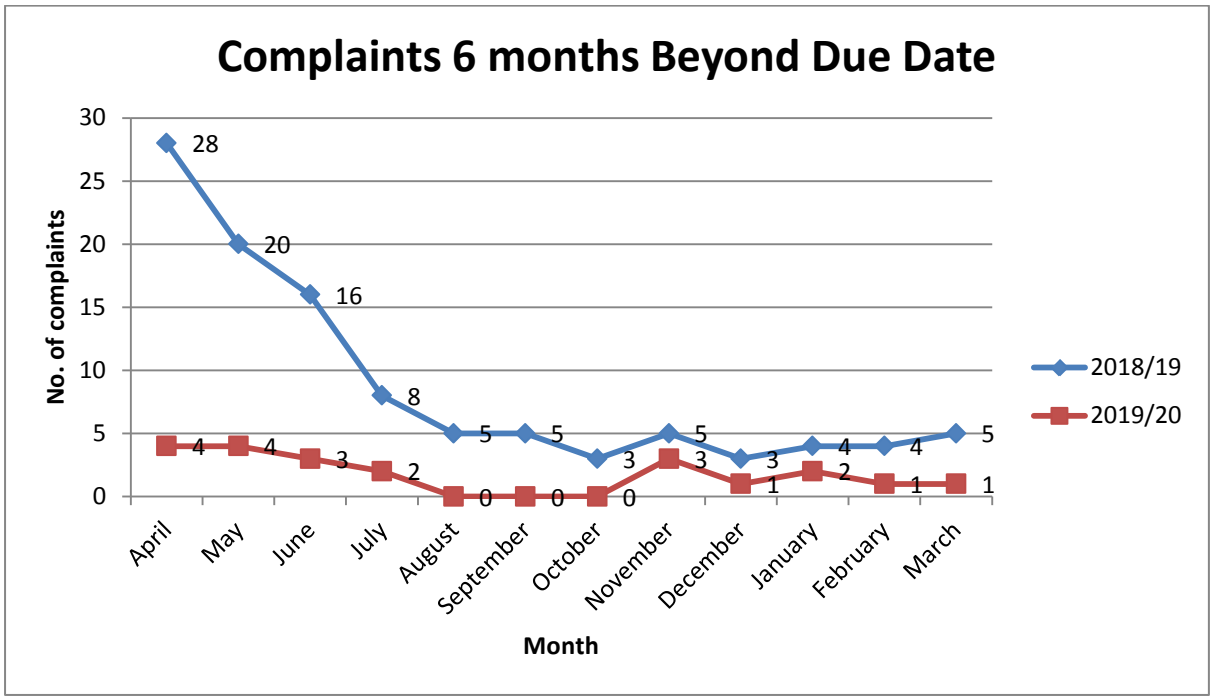

Figure 2 Comparative data representing the number of complaints 6 months beyond review date.

When further analysing the breakdown of complaints received to the Trust during Q4 figure 3, clearly highlights that the Accident and Emergency Department (AED) received the highest number N = 26 (22%). Areas which receive either a significant number or cluster are asked to scrutinise for themes and trends and report this data back into the Patient Experience Subcommittee. On initial review, no significant themes were identified.

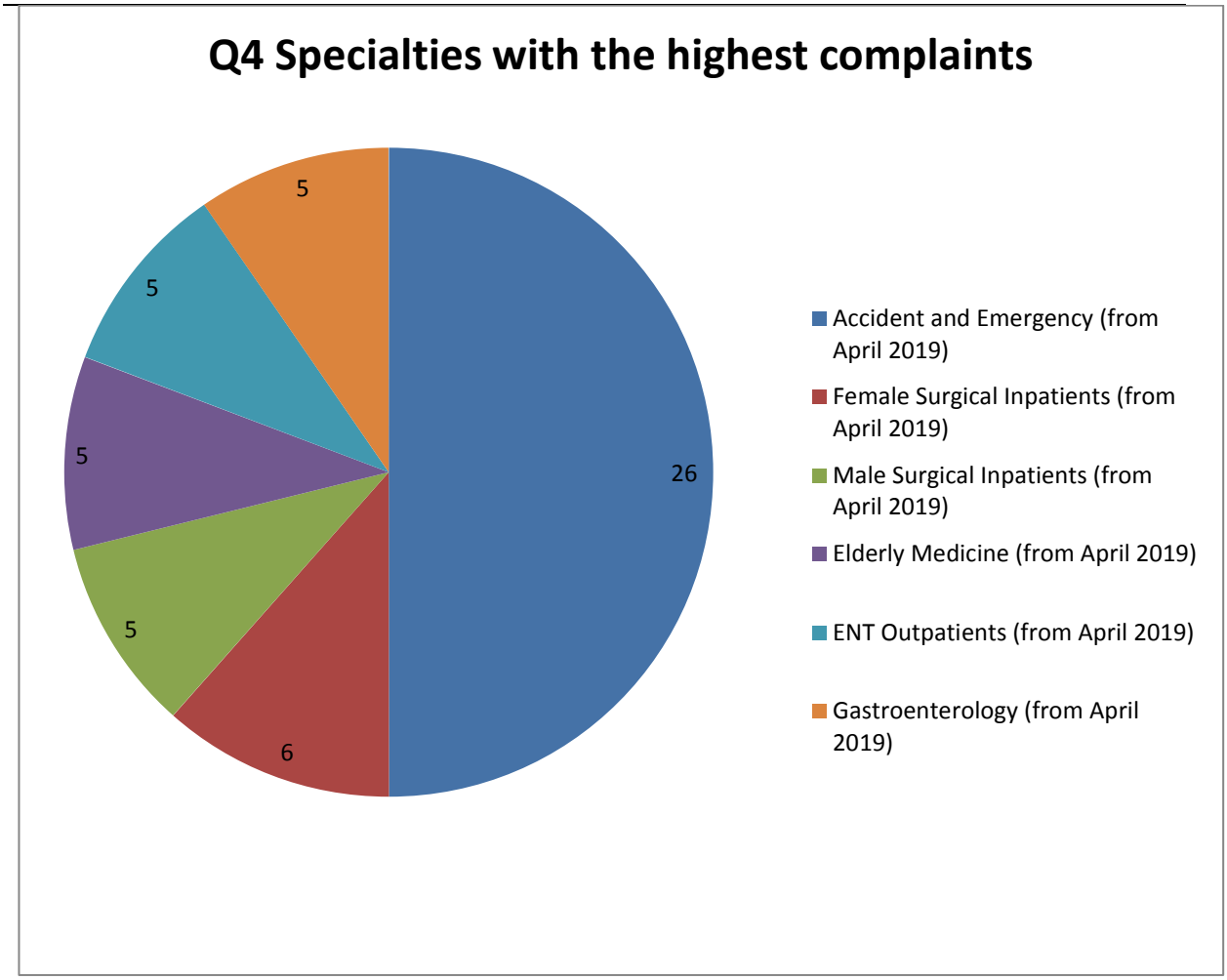

Figure 3 Q4 complaints by speciality.

Of the 445 annual complaints received, Figure 4 demonstrates the annual position of the areas who received the most. AED remain the area that received the highest number overall (N = 94) for the year. Whilst the aim is always to have no complaints, this figure should be considered against the 136,639 attendances the AED department managed during 2019-20.

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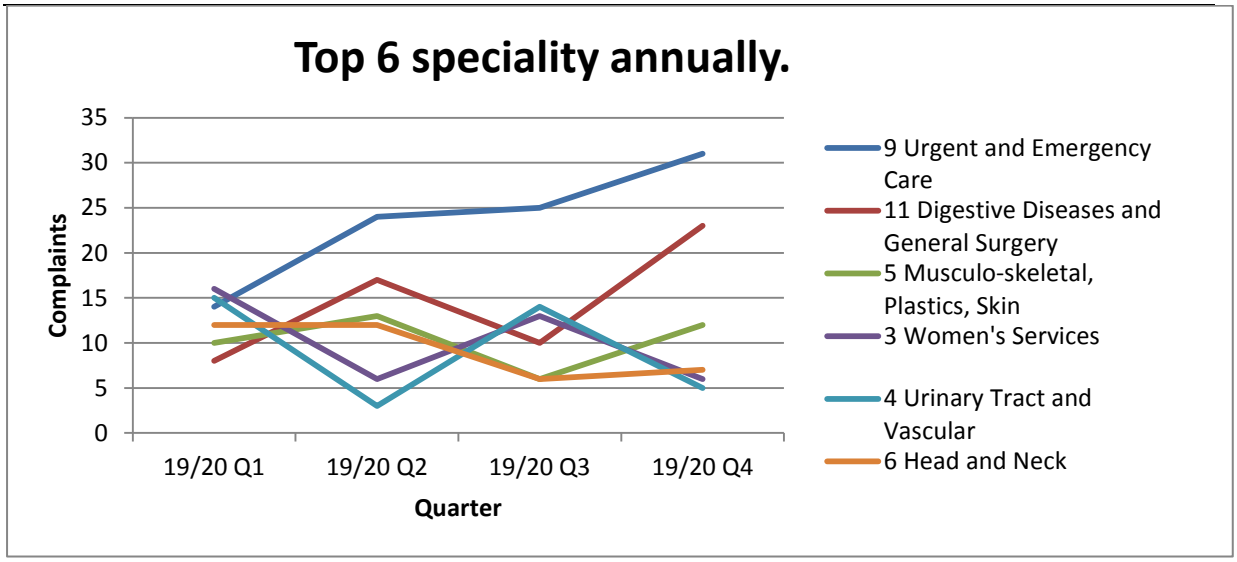

Figure 4 Highest complaints annually 2019-20.

Figure 5 reports the top themes of complaints during Q4. It should be noted that complaints usually contain more than one theme. Triangulation against other sources of data i.e. patient feedback surveys and risk incidents are monitored within the CBU and at performance meetings.

Reporting of themes is monitored at the Patients Experience Subcommittee meeting, along with actions being taken to address issues identified. Reports on complaint themes have also been supplied for departmental quality improvement initiatives, such as ‘deep dives’ and ‘time-out’ sessions to review services. Appropriateness of treatment continues to be the highest category of complaints. This category is currently under review with the risk team to consider ways to extract more specific information within this category to support future targeted work.

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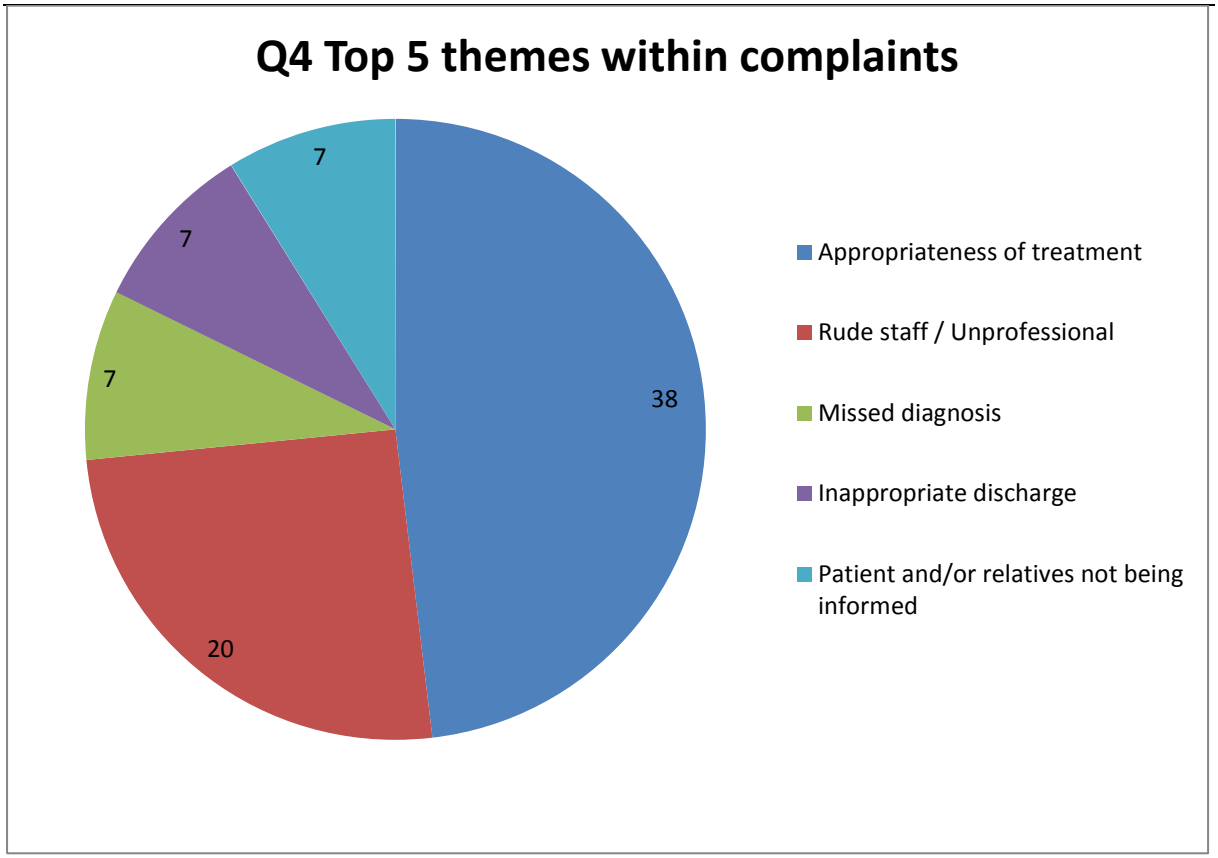

Figure 5 themes of complaints.

When complaints are received and reviewed, they are recorded and graded on the Trust Datix system. There were no complaints received during Quarter 4 graded as extreme or high, which is excellent. There continues to be on-going collaborative work and scrutiny between the risk and complaints team and the daily “Huddle” provides a robust mechanism for testing these results. The remaining grading for Q4 is 26 Moderate and 94 Low (Table 4).

Table 4 Grading of all complaints received during Q4 by CBU.

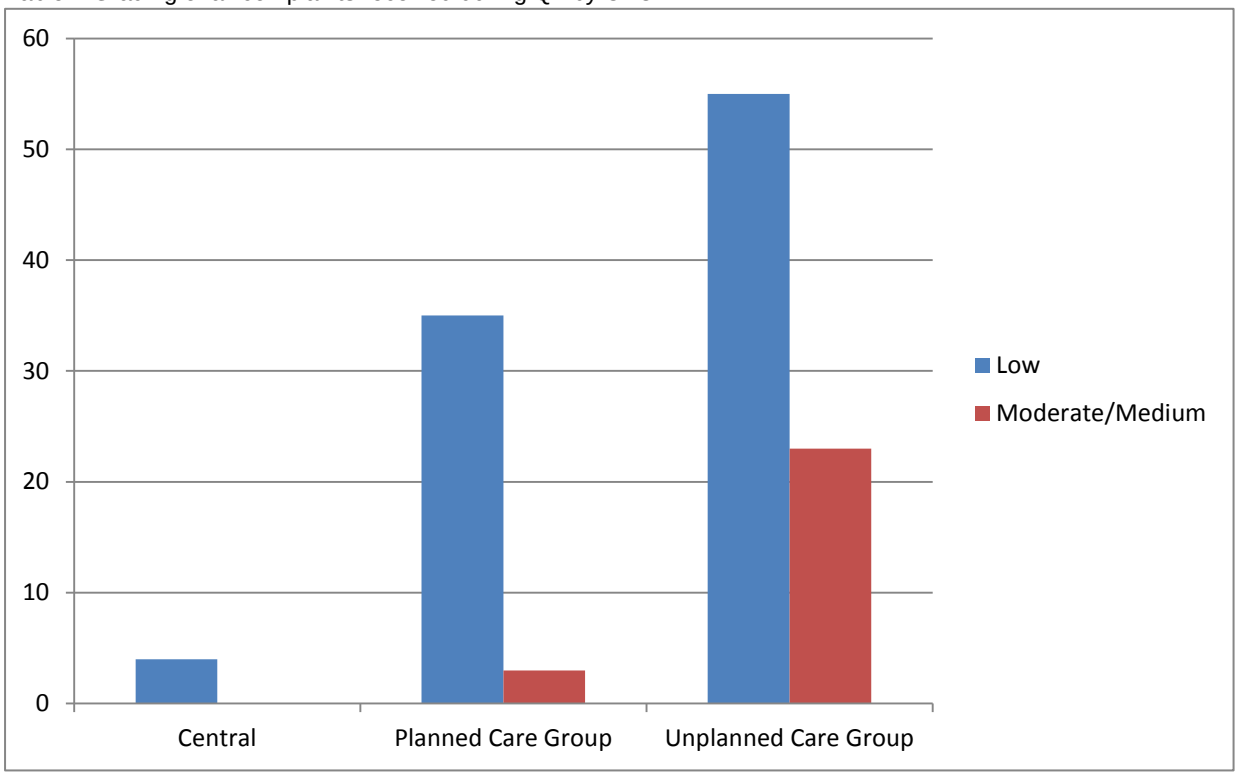

Table 5 provides an annual summary of the grading of the complaints received. The one complaint that was graded as High throughout the year was subject to extreme scrutiny and learning. A paper was presented by the matron for the area to the Patient Experience Subcommittee in September 2019, full evidence of the learning can be seen in the learning from complaints section (3.3.1).

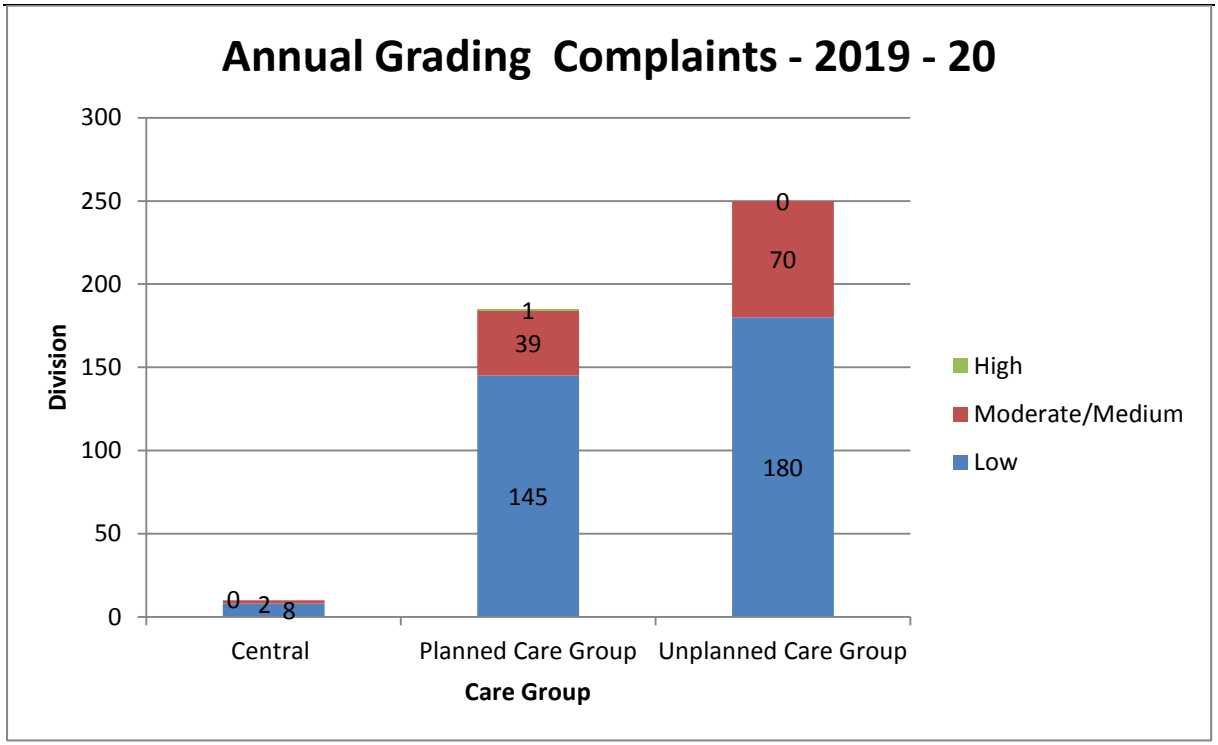

Table 5 annual grading of complaints.

3.1 PALS (Patient Advocacy and Liaison Service)

The total number of Patient Advice and Liaison Service (PALS) issues continues to remain high with Q4 recording 311 contacts and the annual figure a staggering 1383. Table 6, represents the quarterly figures and Figure 6 makes comparisons to previous years, which seems to have stabilised.

PALS	Q1	Q2	Q3	Q4	Total
2018/19	281	351	367	333	1332
2019/20	338	385	349	311	1383

Table 6 number of PALs contacts per month and year 2019-20.

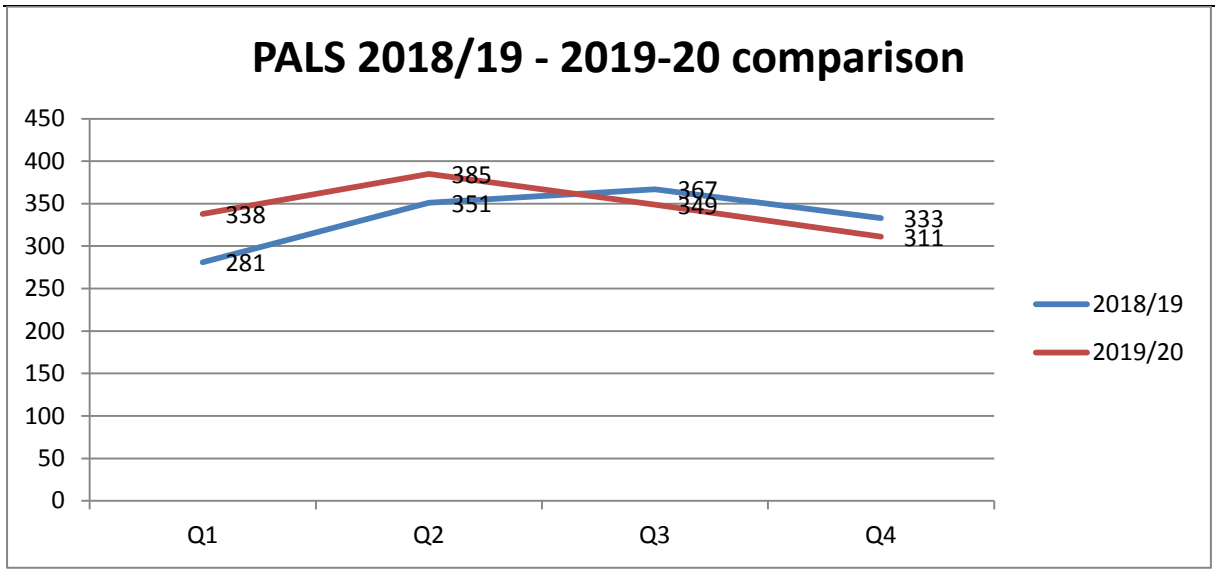

Figure 6 comparisons PALs data

These numbers demonstrates the high volume of activity that the Patient Experience Team are dealing with; in many cases they are resolving at first contact and preventing issues being progressed to formal complaints. PALs issues are dealt with quickly to prevent escalation. At the time of writing this report of the 1383 only 3 remain open.

AED received the highest number of PALs contacts N=27, around 9% overall for quarter 4 (Figure 7).

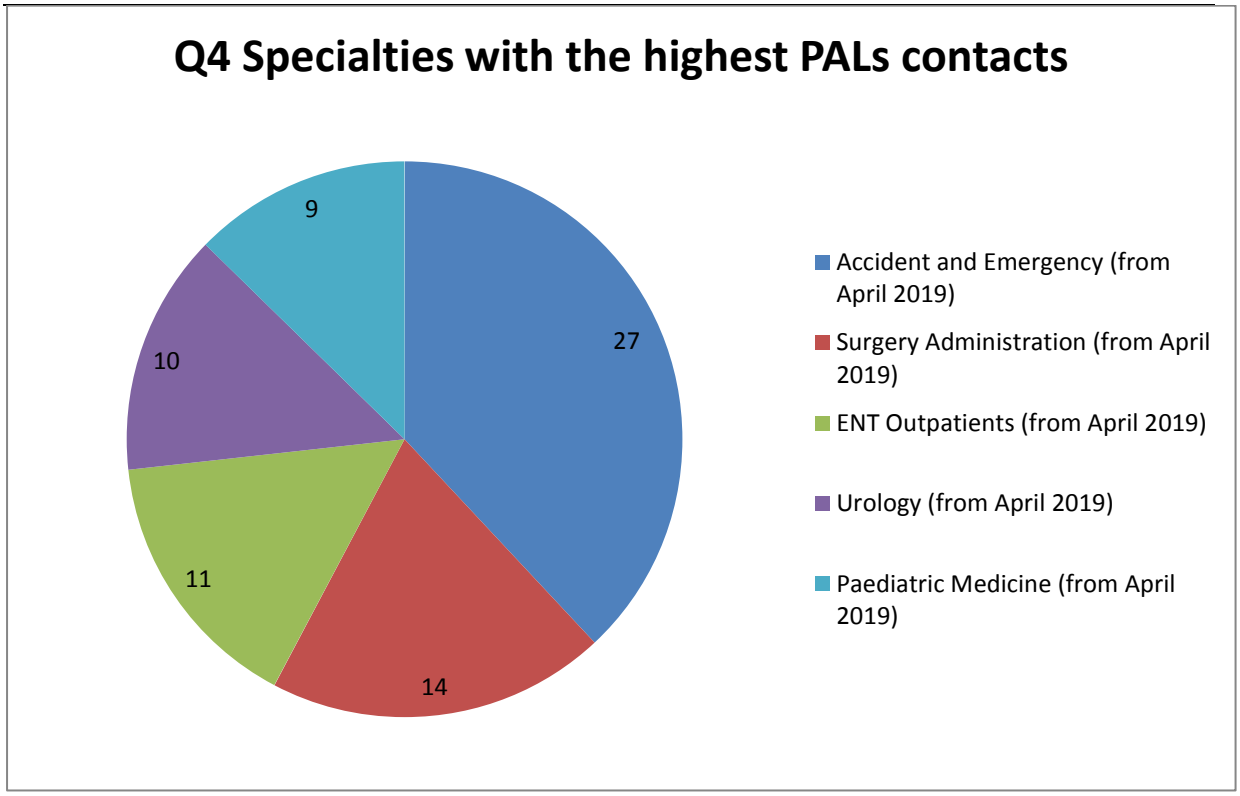

Figure 7 provides a breakdown of the PALS issues, by speciality,

When reviewing the Q4 themes of PALs, Figure 8 provides a breakdown, with appropriateness of treatment being the highest reason for contact.

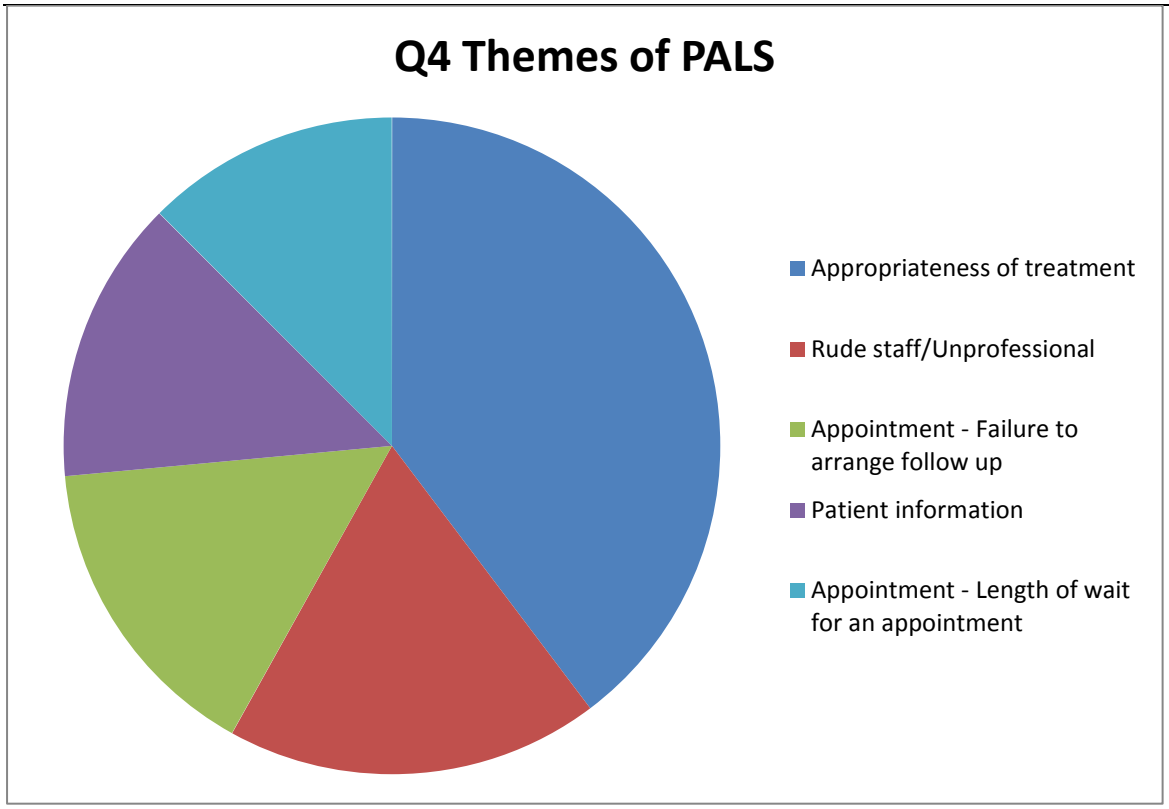

Figure 8 Q4 themes of PALs contacts.

3.2 Compliments

Compliments are simple ways for people to show their appreciation and kindness. At the Trust there are many ways that staff receives compliments, via thank you letters, emails, tweets and cards. Historically within the patient experience reports this valuable data has not been reported or celebrated this valuable praise.

During the past year whilst carrying out a number of patient experience initiatives throughout the Trust, areas and teams have been encouraged to log these compliments on Datix in the same way that a complaint or PALs are logged. There is much work to be done to capture and celebrate this success and plans to strengthen and expand our kindness pledge in the Patient Experience Strategy should help. Figure 9 highlights the increase in the number of compliments received and captured, with Datix reporting 1732 compliments during 2019-20.

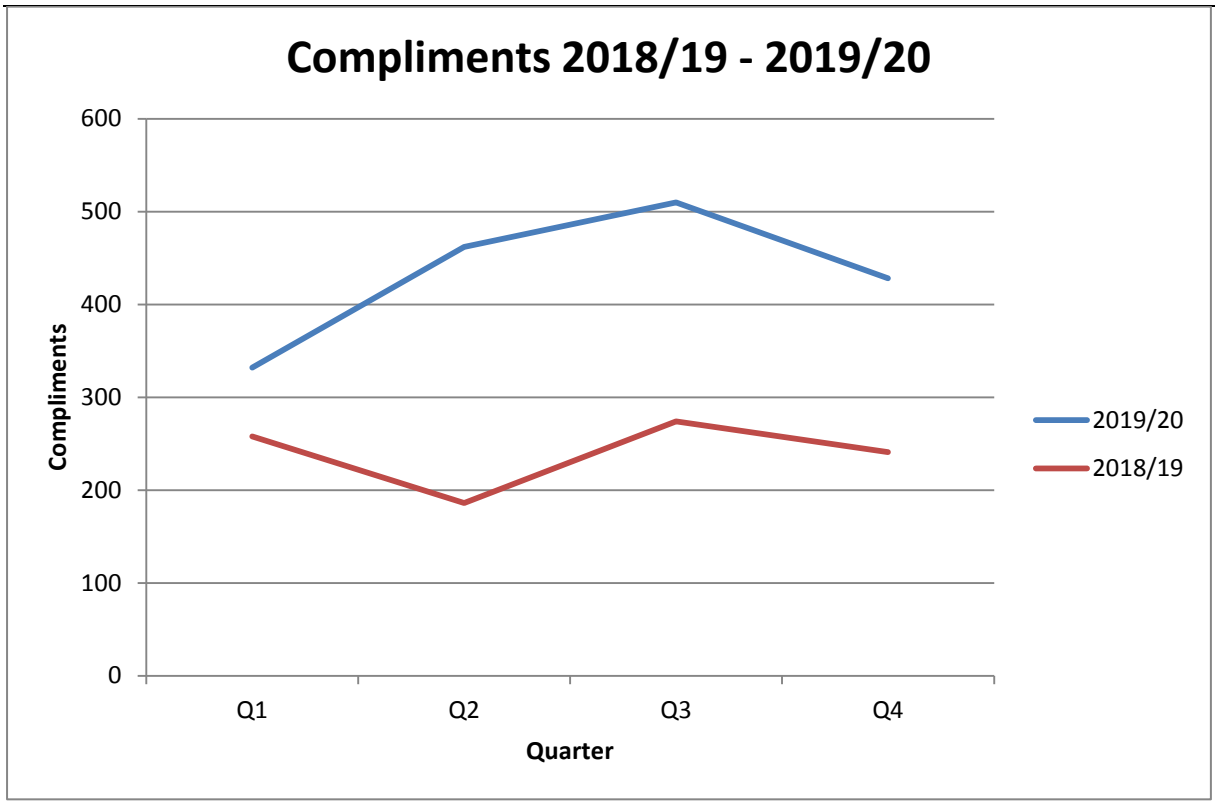

Figure 9 comparison of compliments received.

3.3 Learning from Complaints

During 2019-20 the patient experience team have led in a number of assurance processes to evidence learning from complaints. Actions from complaints are held by each CBU complaints lead to monitor completion. Where themes or clusters of complaints are identified then a request is made for a review and presentation to the following Patient Experience Subcommittee. Work in relation to transparency of learning to the public is planned for the next year to provide evidence to the public of how the organisation has learnt from the complaints received.

3.3.1 Planned Care - Head and Neck Team – High Complaint

Complaint:

- Patient with complex needs was not cared for with recognition of his safeguarding needs (DOLs).
- Concerns were raised regarding nursing care.
- Gaps in knowledge were identified in catheter care.

Action:

- All nursing staff has DOLS and Delirium training.
- All nursing staff now has pressure area care, catheterisation training and management of fluid balanced charts.
- Inspections to the ward by the Patient Experience Team on the 5/3/20 for assurance as a "secret shopper", significant improvements noted in the areas of original concern.

3.3.2 Chief Nurses' Team - Bereavement Team

Complaint:

- Poor communication with a family following an external decision not to honour a bequest request for a body donation, and a body being retained in the mortuary for a long period of time.
- Poor Call Log - of all contact made with family relating to the deceased.

Action:

- The Bereavement team have arranged weekly dialogue with the Mortuary team regarding deceased patient's stays.
- Bereavement office log details of extended stays in the Mortuary, contains current actions and the date of the action.
- Weekly updates documented by both Mortuary team and the Bereavement team.
- The bereavement team have strengthened their documentation process to reflect all their communications.

Leeds Medical School taking the lead responsibility for informing deceased families if they refuse a body donation bequest, they have accepted this responsibility from September 2019 following this complaint.

3.3.3 Planned Care - Women and Children- Moderate Complaint

Complaint:

- Poor support given to a mother who lost a twin baby at 14 weeks gestation. The remaining twin survived.

Action:

- All the maternity team have attended Care and Compassion Workshops.
- Bereavement training has been given to include the management of early gestation pregnancy loss.

- The Maternity team have ensured following this complaint, that all mothers of deceased baby will be given the option of being able to see their baby, regardless of the length of the gestation period.
- The mothers of deceased babies will also have the opportunity to name their deceased baby and discuss the options available for the burial of the deceased baby.

3.3.4 Unplanned Care- Specialist Medicine - Moderate Complaint

Complaint:

- End of life care and support for a patient in hospital linked to pain relief management and lack of support for the spiritual needs of the patient.

Action:

- Ward trained by the Palliative Care Team to better support patients, the keys learning points were to improve pain control for patients linked to out of hours support.
- The Palliative Care Team has ensured the nursing team have been fully trained on the correct escalation of pain relief issues to resolve pain control for patients.
- Additional education providing in relation to End of Life Care to support spiritual needs.

This complaints actions and learning were shared to additional areas for extended learning within the CBU.

3 PROPOSAL

The Patients Experience Team and Chief Nurse Office will continue to develop work to enhance patient and relatives encounters with the Trust. The Strategic Work Plan will allow steer and control of planned projects to be monitored and overseen by the Patient Experience subcommittee. Work will continue to extend kindness commitment made via the Patient Experience Strategy and look at imaginative ways to build this into other established schemes like ward accreditation.

Quality improvement work will continue via the Patient Experience Collaboration work, working collectively with staff in individual areas recommendations from the CQC National surveys will help direct these areas for improvement.

Valuable patient and public collaboration work will be re-established to ensure their voices are heard and influence patient experience projects for the next year ahead.

The overall complaints process and numbers will continue to have ongoing oversight from the central team, to enable challenge, monitoring and tracking to agreed timescales. The Central team will continue to provide support and training and assist with training and complex cases where required. To deliver on this the team will:

- Hold weekly “Grip and Control” complaints meeting between Central and CBU leads to track status of complaints and provide timelines for completion.
- Monthly complaints meetings with Heads of Nursing and Chief Nursing office.
- Lower the threshold for senior escalation where complaints are not progressing.
- Delivery of complaints training to all staff who is investigators to improve quality.
- Buddying and mentorship provided for authors of complaints responses.
- Process reviewed and guidance strengthened for complaints procedure.
- Weekly position reported to Chief Nurse.

Finally the teams will look at ways of celebrating success and compliments received to ensure teams and individuals are recognised for the kindness and compassion they share daily.

4 RECOMMENDATIONS

- Support is required from all areas to continue to embrace the PE Strategy.
- Use of QI methodology for tests of change.
- National Survey (CQC) action plans to be developed to steer improvement, led by a designated area lead.
- Ongoing promotion and development of FFT data.
- Continue collaboration work with WYAT to improve collective and consistent improvements.
- Benchmark against other Trusts that are doing well or significantly better in key PE areas.
- There is the requirement for a *tight grip* to remain on the handling and processing of complaints to enable the trajectory to continue.
- Learning from complaints to be made transparent for the public.
- Compliments to be captured and celebrations and acknowledgement of these to be developed.
- Continue to develop creative ways of enhancing patient experience during Covid-19 restrictions.

5 Appendices

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Appendix 1 Patient Experience Strategic Work Plan

Patient Experience Strategic Work Plan

Patient Experience Work Plan		Date initiated	August 2019	Date of update	June 2020
Accountability		Responsibility			
Lead	Oversight/governance structure	Lead	Work-stream/operational group		
Karen Bentley	Patient's Experience Sub-Committee	Laura Booth	Complaints Operational Group		
Laura Booth	Quality Lead Patient Experience	Samina Fayyaz	Patient Engagement		
		Jackie Loach	Nutrition steering Group		
		Liz Price	End of Life Group		
		Sarah Turner/Caroline Carass	Learning Disability/Enhanced Care		
		Roshanne Fox	Dementia		
		Helen Sutcliffe	CPAG		
		Gill Hollingsworth	Cancer Board		
		Karen Bentley	PLACE Steering Group		

Aim	Objective No	Objective	Expected Outcome	Assurance Mechanism	Review date
Strengthen and Improve Patient Experience at BTHFT	1	Complaints	Ensure all complaints are responded to within policy guidance and timescales Reduce timescales for dealing with complaints. Gain assurance that complaints are leading to learning and improvement.	Complaints Steering Group. Quarterly/Annual Reports Feedback from the CBU to PE sub-committee how learning from complaints has been achieved	Monthly review during 2020/21
	2	Implementation of the Patient Experience Improvement Framework	Enable BTHFT to establish how well PE is embedded within the organisation and identify key areas of work to be development via self-assessment against the recognised key themes. Leadership, Organisational Culture, Compassionate Care, Safe Staffing levels and consistent incident reporting and learning lessons.	Develop metric for collecting data to enable measurement tracking and driving quality improvement in relation to PE	December 2021
	3	PLACE	Deliver a PLACE assessment programme for the Trust	Production of Action plan following national result release. PLACE steering group to monitor actions. Produce a paper to Quality committee with progress and results update.	September 2020
	4	Patient Engagement	Assurance that we are engaging with patients and	Quarterly patient experience report	September

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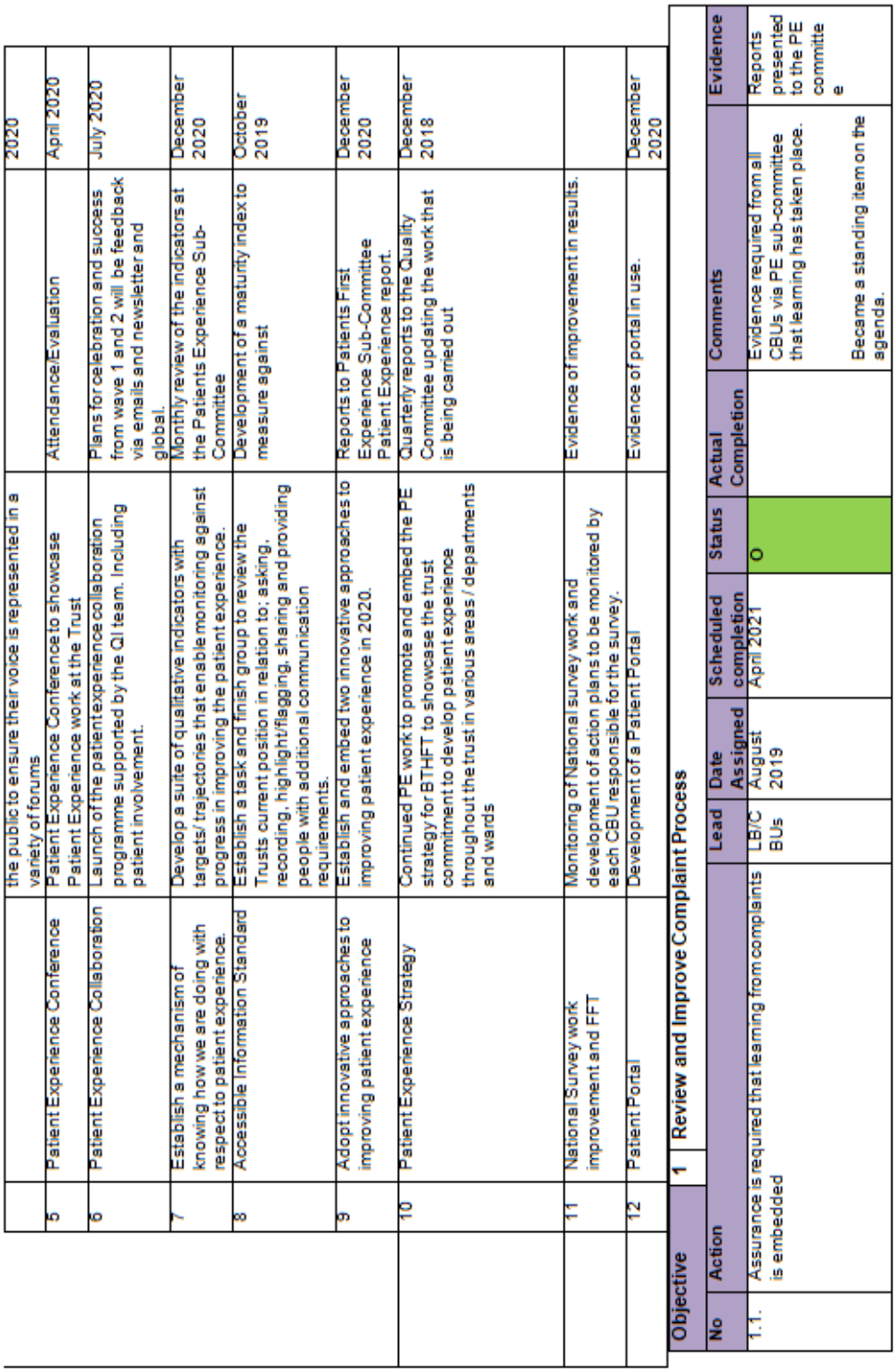

			the public to ensure their voice is represented in a variety of forums								2020	
	5	Patient Experience Conference	Patient Experience Conference to showcase Patient Experience work at the Trust							Attendance/Evaluation	April 2020	
	6	Patient Experience Collaboration	Launch of the patient experience collaboration programme supported by the QI team. Including patient involvement.							Plans for celebration and success from wave 1 and 2 will be feedback via emails and newsletter and global.	July 2020	
	7	Establish a mechanism of knowing how we are doing with respect to patient experience.	Develop a suite of qualitative indicators with targets/ trajectories that enable monitoring against progress in improving the patient experience.							Monthly review of the indicators at the Patients Experience Sub-Committee	December 2020	
	8	Accessible Information Standard	Establish a task and finish group to review the Trusts current position in relation to; asking, recording, highlight/flagging, sharing and providing people with additional communication requirements.							Development of a maturity index to measure against	October 2019	
	9	Adopt innovative approaches to improving patient experience	Establish and embed two innovative approaches to improving patient experience in 2020.							Reports to Patients First Experience Sub-Committee Patient Experience report.	December 2020	
	10	Patient Experience Strategy	Continued PE work to promote and embed the PE strategy for BTHFT to showcase the trust commitment to develop patient experience throughout the trust in various areas / departments and wards							Quarterly reports to the Quality Committee updating the work that is being carried out	December 2018	
	11	National Survey work improvement and FFT	Monitoring of National survey work and development of action plans to be monitored by each CBU responsible for the survey.							Evidence of improvement in results.		
	12	Patient Portal	Development of a Patient Portal							Evidence of portal in use.	December 2020	
Objective		**1**	**Review and Improve Complaint Process**									
No	**Action**			**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**			**Evidence**
1.1.	Assurance is required that learning from complaints is embedded			LB/C BUs	August 2019	April 2021	G		Evidence required from all CBUs via PE sub-committee that learning has taken place. Became a standing item on the agenda.			Reports presented to the PE committee

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Objective	1	Review and Improve Complaint Process							
No	Action		Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
1.2	Assurance that complaints are responded to in the required timescales as per policy and within national guidelines.		LB	August 2019	Dec 2021			Trials of auditing action plans from complaints were started in February 2020 across the Trust. Plans to continue this process and evaluate the benefits of audit will continue during 2020. Evidence for the public is required regarding learning that has taken place. Work required during 2020/21 to develop and strengthen for transparency. Regular huddles have been started for the patient experience team, allowing the team to identify any areas of concern, improvement and where further support is required. Ongoing weekly and monthly meetings with CBU complaints leads and AHNs for complaints to track and monitor complaints. Escalation of delays. Weekly complaints position sent to CEO and CN. Development of KPIs and ongoing monitor of performance.	

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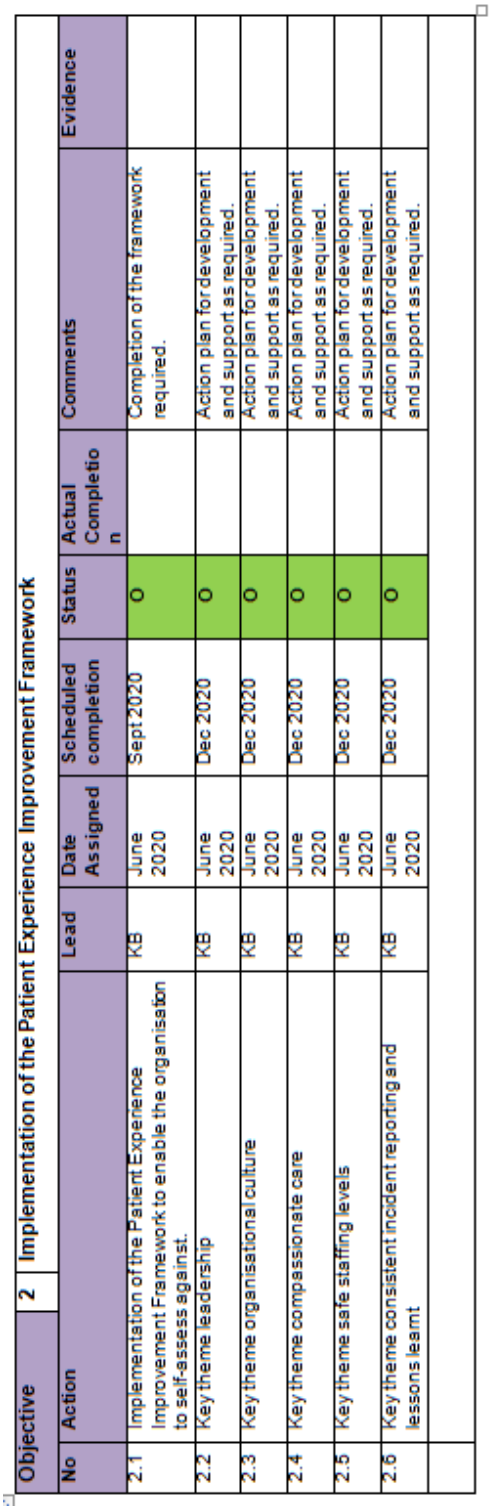

Objective	2	Implementation of the Patient Experience Improvement Framework							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
2.1	Implementation of the Patient Experience Improvement Framework to enable the organisation to self-assess against.	KB	June 2020	Sept 2020	O		Completion of the framework required.	
2.2	Key theme leadership	KB	June 2020	Dec 2020	O		Action plan for development and support as required.	
2.3	Key theme organisational culture	KB	June 2020	Dec 2020	O		Action plan for development and support as required.	
2.4	Key theme compassionate care	KB	June 2020	Dec 2020	O		Action plan for development and support as required.	
2.5	Key theme safe staffing levels	KB	June 2020	Dec 2020	O		Action plan for development and support as required.	
2.6	Key theme consistent incident reporting and lessons learnt	KB	June 2020	Dec 2020	O		Action plan for development and support as required.	

Objective	3	PLACE						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
3.1	Organise, facilitate and arrange the required PLACE assessment to be carried out as required to follow the new 2019 programme	KB/SE	Sept 2019	Nov 2019	C		Full PLACE programme completed November 2019.	Meeting minutes and schedules
3.2	Production of action plan following national results release	KB/SE	Jan 20	Sept 2020	C		Production of action plan and paper to the quality committee will be produced. PLACE steering group to be set up to monitor any actions and improvements required.	Paper sent to the March QC
3.3	PLACE steering group to monitor actions of the PLACE action plan.	KB	March 2020	Sept 2020	O		On hold due to covid-19 as of June 2020	

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Objective	4	Patient Engagement						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
4.1	Increase the number & diversity of individuals & community groups actively involved in FFT and other feedback mechanisms including patient stories and patient experience collaboration work	SF	June 2020	On-going	G		Patient involvement with the launch and wave 1 of the patient experience collaboration has taken place.	
4.2	Scope current position in relation to patient engagement and involvement with external groups	SF	June 2020		G		Patient engagement work plan in place. Includes	
4.3	Ensure an overview of activity is captured of surveys and work streams taking place within the organisation to enable further work in relation to any key action fed back from patients can be identified..	SF	June 2020		G			
4.4	Develop an 'Engagement Toolkit' for use by all staff and departments. Launch toolkit will facilitated training sessions and support for departments to run engagement events	SF	Sept 2020	April 2021	G			

Objective	5	Patient Experience Conference						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
5.1	Confirm Speakers and Stallholders	KB/LB	June2020	June 2021	G		Outline plan to be presented to Patients Experience Sub-Committee (covid pending). Consider virtual conference options.	

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5.2	Produce final program and publicise to attract attendees	KB/PE Team	Dec2020	Jan 2020	O			
5.3	Evaluation report to Patient's Experience	KB	Aug 2020	June 2020	O			

Objective	6	Patient Experience Collaborative							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
6.1	Establish and launch a patient experience collaboration to improve quality and enhance experience of care.	KB/LT	March 2019	June 2020	C		Patient experience collaborative wave 1 has now been launched.	Projected complete d and presented to PE commitee.
6.2	Learning events to be established to gather and share learning from co designed projects.	KB/LT	July 2019	Nov 2019	C		Wave 1 learning project scheduled for October 2019.	Learning event taken place.
6.3	Ensure sustainability of collaboration events and involve public to quantify	KB/LT	July 2019	Sept 2020	O		Revisit QI projects to verify sustainability	

Objective	7	Establish a mechanism of knowing how we are doing with respect to patient experience.							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
7.1	Establish a task and finish group to oversee the process, ensuring appropriate stakeholder involvement.	KB/LB	August 2020	April 2021	O		Work to be carried out with partners and CCGs to look at Grassroots data.	

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									Regular meetings with Health Watch to carry out joint work streams and PPE.
7.2	Review the range of metrics available and assess suitability in terms of appropriateness of measuring patient / experience engagement, ease of data capture, ability to report on a monthly basis.	KB	August 2020	April 2021	O				New reports are generated weekly around complaints, PALS and compliments. This report goes to QOUC and is reviewed by the panel.
7.3	Agree appropriate metrics and mechanism of reporting	KB	August 2020	April 2021	O				

Objective	8	Accessible Information Standard							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
8.1	Develop a task and finish group to take forward the implementation of the AIS work within the trust.	KB/S S/AD	June 2019	Sept 2020	O		A task and finish group is in place and mapping work has been carried out. The trusts position against: asking, recording, highlighting and flagging, sharing and providing people with additional communication needs ins currently in place.	
8.2	Development of an action plan against the 5 AIS standards to be developed	KB/S S/AD	Nov 2019	Sept 2020	O		Action plan to be monitored in terms of progress at the task and finish group and fed back into PE subcommittee for	

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assurance.

Objective	9	Adopt innovative approaches to improving patient experience							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
9.1	Identify innovative approach to patient experience through a range of opportunities, including a review of what other organisations have done..	KB/LB	February 2019	December 2020	C		Visits to other local organisations have taken place and shared learning is being carried out. Chaplaincy service has been reviewed and a temporary service has been implemented to cover a 24 hour period. Religious specific packs have been made and given to patients with positive feedback and ward resources have been strengthened. A new Patient Property team has been put in place to aid patients receiving items of comfort from their families and for bereaved families to collect patient property in a safe and caring matter.	SOP in place.
9.2	Agree 2 innovative initiatives for 2020/21	KB/LB	May 2020	December 2020			BTHFT have linked up with WYAAT and are formulating a new Carers passport and Carers charter to enable carers accessing the Trust the best possible experience whilst feeling involved and supported. Additional to this a Carer toolkit is being tested for use at BTHFT via WYAAT. Work has begun on creating a new information pack for	

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								people coming in as inpatients and for relatives and carers which will make coming into hospital easier in terms of knowing what to expect.
9.3	Improve social media use for PE initiatives. Review the way compliments are received and collated	KB/L B	June 2020 June 2020	Dec 2020	O			Improve use of twitter, update of the intra/internet site for PE. Compliments are now being captured and reported to celebrate the positive thanks staff receive.

Objective	10	Patient Experience strategy							
No	Action		Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
10.1	To create and develop a PE strategy. To create this there is a requirement to discuss with staff, family and friends what matters to them in terms of patient experience. We will all provide the best possible experience by embracing a spirit of kindness		KD / SS / KB	August 2018	December 2018	C	December 2018	The PE strategy (Embracing kindness) has been developed. At Bradford Teaching Hospitals, we believe that by embracing, supporting and promoting kindness we will provide outstanding patient care and an outstanding experience for all those involved with our services.	18102502_Patient xperience_Strategy
10.2	Continued promotion of PE Strategy and embedding		KD / SS / KB	August 2019	December 2020	C		Tea trolley round to promote PE Strategy to individual ward areas Feedback Friday and tea trolleys taken place 2019 to promote the PE strategy (Sept 2019)	Launched at the leadership forum, EMT and NMDF

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10.3	Phase 2 of the Patient Experience Strategy to extend kindness.	KB/LB	June 2020	June 2021	O		Consider kindness accreditation, via the ward scheme and through a series of trust wide events to include e learning packs, conscious kindness.	Paper to the EMT June 2020 for consideration.

Objective	11	National CQC Survey programme							
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
11.1	For each of the National CQC surveys a lead should be identified and an action plan be developed	KB/CBU lead	June 2020		O		Programme of surveys for 2020/21 has now been released.	
11.2	Survey action plans to timetabled into PE subcommittee for assurance monitoring	KB/CBU lead	August 2019		O		Survey action plans have been presented to the PE subcommittee. This is an ongoing work requirement year on year for ongoing improvements following survey results review.	

Objective	12	PE portal						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence
12.1	Development work for patient portal	KP	August 2019	August 2010	O		KP to update PE subcommittee on the progress work regarding patient portal.	

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Status:	
O	Open
OC	Open and compromised
C	Closed
OD	Overdue

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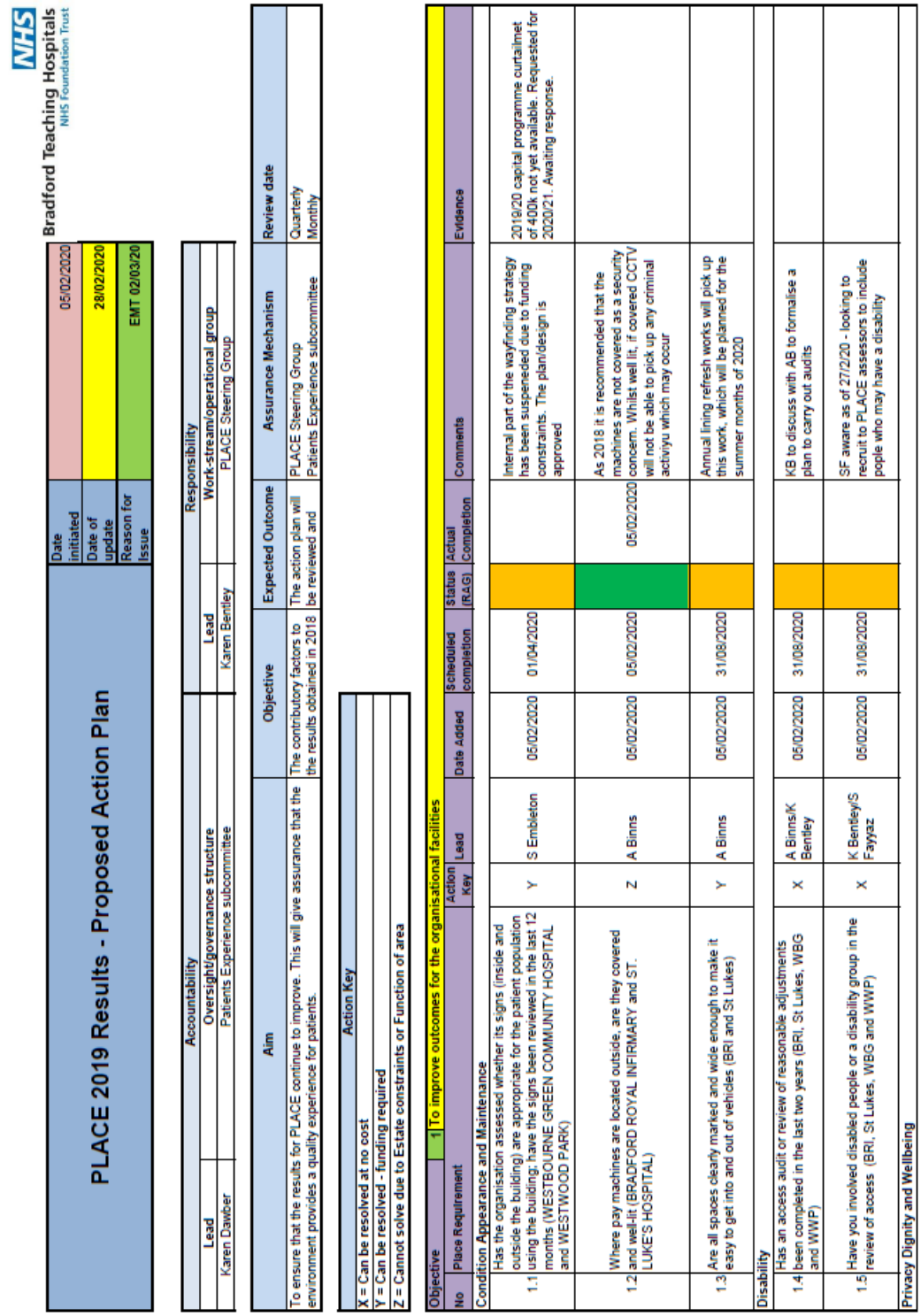
Appendix 2 PLACE Action Plan



Bradford Teaching Hospitals
NHS Foundation Trust

PLACE 2019 Results - Proposed Action Plan

	Date initiated	05/02/2020
	Date of update	28/02/2020
	Reason for issue	EMT 02/03/20

Accountability	
Lead	Oversight/governance structure
Karen Dawber	Patients Experience subcommittee

Responsibility	
Lead	Work-stream/operational group
Karen Bentley	PLACE Steering Group

Aim	Objective	Expected Outcome	Assurance Mechanism	Review date
To ensure that the results for PLACE continue to improve. This will give assurance that the environment provides a quality experience for patients.	The contributory factors to the results obtained in 2018	The action plan will be reviewed and	PLACE Steering Group Patients Experience subcommittee	Quarterly Monthly

Action Key
X = Can be resolved at no cost
Y = Can be resolved - funding required
Z = Cannot solve due to Estate constraints or Function of area

Objective	1	To improve outcomes for the organisational facilities								
No		Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidance
Condition Appearance and Maintenance										
1.1		Has the organisation assessed whether its signs (inside and outside the building) are appropriate for the patient population using the building; have the signs been reviewed in the last 12 months (WESTBOURNE GREEN COMMUNITY HOSPITAL and WESTWOOD PARK)	Y	S Embleton	05/02/2020	01/04/2020			Internal part of the wayfinding strategy has been suspended due to funding constraints. The plan/design is approved	2019/20 capital programme curtailmet of 400k not yet available. Requested for 2020/21. Awaiting response.
1.2		Where pay machines are located outside, are they covered and well-lit (BRADFORD ROYAL INFIRMARY and ST. LUKE'S HOSPITAL)	Z	A Binns	05/02/2020	05/02/2020		05/02/2020	As 2018 it is recommended that the machines are not covered as a security concern. Whilst well lit, if covered CCTV will not be able to pick up any criminal activiyu which may occur	
1.3		Are all spaces clearly marked and wide enough to make it easy to get into and out of vehicles (BRI and St Lukes)	Y	A Binns	05/02/2020	31/08/2020			Annual lining refresh works will pick up this work, which will be planned for the summer months of 2020	
Disability										
1.4		Has an access audit or review of reasonable adjustments been completed in the last two years (BRI, St Lukes, WBG and WWP)	X	A Binns/K Bentley	05/02/2020	31/08/2020			KB to discuss with AB to formalise a plan to carry out audits	
1.5		Have you involved disabled people or a disability group in the review of access (BRI, St Lukes, WBG and WWP)	X	K Bentley/S Fayyaz	05/02/2020	31/08/2020			SF aware as of 27/2/20 - looking to recruit to PLACE assessors to include pople who may have a disability	
Privacy Dignity and Wellbeing										

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1.6	Are a variety of payment options available such as debit / credit card, cash or payment via an app (BRI and St Lukes)	Y	A Binns	05/02/2020				Pemding approval of the car parking strategy inc dunding requirement to enable this to be completed	capital programme 2020/21
1.7	Are parents, relatives, guardians or carers able to access meals / snacks within the building at all times of the day and night (St Lukes, WBG, WWP)	Y	C Keasey	05/02/2020					
1.8	Are there accessible areas for washing and toilet facilities available for parents, relatives, guardians or carers that stay overnight (they do not have to be on the ward directly) (St Lukes, WBG WWP)	Y	I Rashid	05/02/2020					
1.9	Are there area(s)/room(s) designated exclusively for use as family/visiting (St Lukes, WWP)	Y	I Rashid	05/02/2020					
1.10	If No above, are there area(s)/room(s) not designated exclusively for family use but available for use as such (St Lukes)	Y	S Embleton	05/02/2020					
1.11	Is internet access (WiFi) available in public areas (WBG)	Y	S Pearson	06/02/2020	31/08/2020			SP to investigate with landlord (Community Health Partnerships)	
1.12	Is payment by Pay on Exit (i.e. only the actual parking time used is paid for) (BRI, ST Lukes)	Y	A Binns	05/02/2020	TBC			Pemding approval of the car parking strategy inc dunding requirement to enable this to be completed	capital programme 2020/21
1.13	Is there a multi-faith/prayer room available (WWP)	Y	M Arshad/I Rashid	05/02/2020	31/08/2020			IR to discuss with Landlord (NHSPS) to determine if a room can be allocated for this purpose	
1.14	Is there a quiet room available (St Lukes)	X	I Rashid	05/02/2020	31/08/2020			IR to identify a room within the clinical spaces of the Acute Wards where this could be provided	
Privacy, Dignity and Wellbeing I Disability									
1.15	Does the organisation have a travel plan in place which includes accessibility and is the plan reviewed regularly (BRI, St Lukes, WWP, WBG)	Y	C Wilson	05/02/2020	31/08/2020			CW to provide evidence and/or action intentions	
1.16	Is a Changing Places toilet available within the organisation (St Lukes, WBG WWP)		S Embleton	05/02/2020	31/08/2020			Matched funding obtained from DoH&SC to develop Changing Place at SLH. WBG & WWP are down to landlords to provide. If Trust insists, we	

Objective	2	To improve the outcome for organisational food acute							
No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidence
2.1	24-hour services (St Lukes)	Y	C Keasey	25/02/2020	01/09/2020			Vending machines that provides hot meals can be procured, but as this is unlikely to make money, it will come with a rental costs	
2.2	Hot options for dinner: non-special diet patients (St Lukes, WBG, WWP)	X	C Keasey	25/02/2020	01/10/2020			Issue due to providing a finger food only menu. Menus for dementia patients and patients at SLH to be reviewed with nursing staff to consider whether these should be changed	

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2.3	Is the organisation fully compliant with the British Dietetic Association's Nutrition and Hydration Digest (BRI, WBG, WWP)	Y	C Keasey	25/02/2020	01/10/2020				Menus can't be fully assessed as there isn't sufficient dietetic resource available. Business case being produced to request funding to provide		
2.4	Patients choose their dinner at the point of service or one meal ahead	Z	C Keasey	25/02/2020	01/10/2020				Due to the catering receipt and distribution unit being based at SLH, the lead time from ordering to meal delivery is increased. This could only be reduced if the unit was moved to BRI site		
2.5											

Objective	3	To improve outcomes for ward food service								
No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status	Actual Completion	Comments	Evidence	
Food										
3.1	If appropriate, were patients provided with napkins with their meal ((BR)	X	C Keasey/ (ward to order)	25/02/2020	01/03/2020			If napkins are available then the WHA will ensure immediately that these are provided to patients	Ward managers to be informed to ensure all involved with meal service are aware	
3.2	Were the patients' areas clearly readied for the meal service - e.g. all unnecessary items removed from the table top and the table top cleaned where necessary (BRI)	X	K Bentley	25/02/2020				Ward managers to ensure space is made for meals to be eaten.	SOP to be developed by CNT?	
Food | Dementia										
3.3	Is there a separate area, away from the bed-side, where patients can take their meals if they choose to do so (WD 17,27,28)	Y	S Embleton	25/02/2020	31/08/2020			Lack of suitable dining facilities on wards due to configuration and demand for beds and other ancillary ward accommodation	The wards surveyed (17/27 &28) do not have any designated dining area or day room. If one is to be developed it will result in loss of beds. EMT decision to reduce bed base to meet this PLACE objective.	
Food | Dementia | Disability										
3.4	Are packaged foods opened and placed on a plate for patients identified with having difficulty opening packages (BRI, St Lukes) (wd 27, F5)	X	C Keasy/R Fox	25/02/2020	01/05/2020			The forget me not tool for people with dementia highlights what areas people may need asssistance. This requires using across the Trust, dementia lead to provide spotlight audits.	First spotlight audit to be completed 28/02/2020.	

Objective	4	To improve outcomes for food quality								
No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidence	
Food										
4.1	If appropriate, were patients provided with napkins with their meal (BRI)	X	C Keasey/ (ward to order)	25/02/2020	01/03/2020			If napkins are available then the WHA will ensure immediately that these are provided to patients	Ward managers to be informed to ensure all involved with meal service are aware	
4.2	Were the patients' areas clearly readied for the meal service - e.g. all unnecessary items removed from the table top and the table top cleaned where necessary (wd 27,28)(BRI)	X	K Bentley	25/02/2020				Ward managers to ensure space is made for meals to be eaten.	SOP to be developed by CNT?	
Food Dementia Disability										

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4.3	Are packaged foods opened and placed on a plate for patients identified with having difficulty opening packages (BRI and St Lukes) wd 27 F5.	X	C Keasy/R Fox	26/02/2020	01/05/2020				The forget me not tool for people with dementia highlights what areas people may need asssistance. This requires using across the Trust, dementia lead to provide spotlight audits.	First spotlight audit to be completed 28/02/2020.
Food Dementia											
4.4	Is there a separate area, away from the bed-side, where patients can take their meals if they choose to do so (BRI)	Y	S Embleton	26/02/2020	31/08/2020				Lack of suitable dining facilities on wards due to configuration and demand for beds and other ancillary ward accommodation	If dining areas aras are to be developed on wards it will result in loss of beds. EMT decision to reduce bed base to meet this PLACE objective.

Objective	5	To improve outcomes for ward acute								
No	Place Requirement		Action Key	Lead	Date Added	Scheduled completion	Status (R,A,G)	Actual Completion	Comments	Evidence
Cleanliness										
5.1	Floors (Westwood Park Ward) Fail		X	Imran	25/02/2020	31/03/2020			IR to raise concern with CHP	Spot check and cleaning schedule
5.2	Surfaces - High (M3) Fail		X	K Snape	25/02/2020	25/02/2020			Issue dealt with immediately and monitored by supervisor	
Dementia										
5.3	Are all toilet / bathroom / shower room door signs consistent (Ward 27 - No)		Y	S Hunter	25/02/2020	01/06/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund
5.4	Are all toilet / bathroom / shower room doors in a single distinctive colour (Ward 17, 24, 27, F8, F5 and Weswood Park) - No)		Y	S Hunter / I Rashid	25/02/2020	01/06/2020			Surveys to be conducted and priority areas (dementia care) to be completed in-house on redecoration programme. Community Propoerties to be approched to follow suit	estates to fund "owned" priority areas
5.5	Are there points of interest such as artwork on the walls e.g. familiar local sights (Ward 17, 27 and Weswood Park - No)		Y	S Hunter / R Fox	25/02/2020	01/06/2020			To contact specialist suppliers or artwork to provide quotes for points of interest similar to elderly care wards.	Various suppliers.... FIND Memory, Deko Graphics, Wright Sign Service
5.6	Can signs to the toilet be seen from all patient areas and are they clearly identifiable (Ward 24, 27, 28, F5 and F6 - No)		Y	S Embleton	25/02/2020	01/06/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund
5.7	Has colour been used effectively to enhance patients orientation / co-ordination e.g. doors and bays painted in a different colour (Ward 17, 24 and 27 - No)		Y	S Embleton	25/02/2020	01/06/2020			Surveys to be conducted and priority areas (dementia care) to be completed in-house on redecoration programme	estates to fund priority areas
Dementia Disability										
5.8	Are all staff specific signs (e.g. sluice / treatment room) out of general eyesight level (Ward 12, 17, 24, 27, 28, 7, F5, F6 and Weswood Park Ward - No)		Y	S Hunter	25/02/2020	01/06/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund
5.9	Are pictures and text fixed to the toilet / bathroom / shower room doors (Ward 24 and F6 - No)		Y	S Hunter / I Rashid	25/02/2020	01/06/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund

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5.10	Are signs fixed at a height that makes viewing easy (Ward 28 - No)	Y	S Hunter	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund
5.11	Are taps clearly marked as hot/cold e.g. by using red and blue colours (Ward 12 and WWP - No)	Y	S Hunter / I Rashid	25/02/2020	01/08/2020			Surveys to be conducted and priority areas (dementia care) to be completed	estates to fund priority areas
5.12	Are there handrails in corridors where appropriate (Ward 12, 17, 24, 27, 28, 4, 7, M3, F6 and F5 - No)	Y	S Hunter / I Rashid	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to handrail provision	wards to fund
5.13	Is flooring consistent, matt, non-reflective, non-patterned, not slippery (Ward 17, 24, 27, 28, F5 - No)	Y	S Hunter / I Rashid	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to acute ward floors	estates to fund priority areas
5.14	Is it possible to adjust the light levels by using dimmer switches or one on / one off system (Ward 12, 27, Westwood Park - No)	Y	S Hunter / I Rashid	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to lighting provision	wards to fund
5.15	Is the correct day and date displayed and clearly visible in all patient areas (Ward 12, 17, 24, 27, 28 and 7 - No)	X	Matrons / Ward Managers & Sisters	25/02/2020	01/08/2020			Should any clocks display inaccurate dfata, wards to report to Estates so this can be rectified	matrons are to inform all wards. Sam Dawe, Sonya Telley, Amanda Hardaker
5.16	Is there a large, accurate and silent (approx. 18 inch/45cm diameter) clock clearly visible in all patient areas (Ward 12, 17, 24, 27, 28 and 7 - No)	Y	S Hunter	25/02/2020	01/08/2020			resurvey to be conducted and wards given quotes for improvements to clock provision	wards to fund
	Privacy Dignity and Wellbeing								
5.17	Are plug sockets available available for patients to charge mobile phones / devices (Ward Birth Centre, M3 - No)	N	S Embleton	25/02/2020	01/08/2020			Patients are not encouraged to charge phones unless equipment is PAT Tested. Evidence of cheap /quality chargers being cause of electrical faults and socket fires	guildance required from Trust Fire Officer to close out this action.
5.18	Are toilets and bathrooms for single-sex use and do they have appropriate signs (Ward 27 - No)	Y	S Embleton	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund
5.19	Are wards designed so that no patient needs to pass through an area of the opposite sex in order to access toilets, bathrooms or to leave the ward (Ward 27 - No)	Y	S Embleton	25/02/2020	01/08/2020			survey to be conducted to check this result. If correct corrective action to be identified	wards to fund
5.20	Do all patients have a place where they can lock away their personal belongings (Ward 27, 17, F6, F5 and Westwood Park - No)	Y	K Bentley/L Booth	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to locker provision	wards to fund
5.21	Do all patients have access to a telephone for incoming and outgoing calls (Birth Centre, 32 and 7 - No)	Y	S Pearson	25/02/2020	01/08/2020			survey to check on payphone provisdion or SOP for patients to use an alternative phone	Informatics to provide advice

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5.22	Do patients have access to television (either personal or in communal areas) (Birth Centre - No)	Y	H Ackroyd	25/02/2020	01/06/2020				When Birth Centre designed, televisions were specifically declined for all rooms. A day room "could" be provided but this may be at the cost of a birth room	Dept management to review and advise
5.23	If the bath/shower on the ward is visible when the door is open, is the privacy of patients protected when using the bath or shower rooms i.e. lockable door or privacy curtains (Ward 17, 27 and F5 - No)	Y	S Hunter	25/02/2020	01/06/2020				survey to be K111+K107conducted and wards given quotes for improvements to privacy and dignity	wards to fund
5.24	Is internet access (WiFi) available on the ward (Ward F5 - No)	Y	S Pearson	25/02/2020	01/06/2020				Survey required to test access points	survey results to be provided to ward manager to close out
5.25	Is there a separate treatment room on the ward for minor procedures/wound dressing (or are all rooms on ward single occupancy) (Ward 17, 27, 28, F5, F6 and Westwood Park - No)	Y	S Hunter	25/02/2020	01/06/2020				Survey and discussion with all failed ward management on their specific requirements	Configuration of ward may not allow for a dedicated Treatment Room. Some wards may not require one.
5.26	Is TV access provided free of charge (Birth Centre, 12, 27, 28, 32, 4 and M3 - No)	Y	S Pearson	25/02/2020	25/02/2020			26/02/2020	current contract with Hospedia procludes free TV on the identified wards	cannot remove installations whilst contract is in place without authorisation. Tehre would be a cost to this and to install "free" tv's.
Privacy, Dignity and Wellbeing I Dementia										
5.27	Are any chairs arranged in such a way that is appropriate for patient use (Ward 17 - No)	X	S Embleton	25/02/2020	25/02/2020			26/02/2020	This was deemed an "on the day" assessment. The ward corrected this following the visit	closed, as chairs are movable equipment they are moved around as required.
5.28	Is it furnished and decorated so as to provide an appropriate environment and to encourage its use (Ward 17 - No)	Y	S Hunter	25/02/2020	01/06/2020				Survey required to see where improvements could be made	Estates to fund on rolling programme
5.29	Is there a day room, social/communal area or playroom on the ward (Birth Centre, 24, 27, 28, 4, 7 and F5)	Y	S Hunter / I Rashid	25/02/2020	01/06/2020				Survey and discussion with all failed ward management on their specific requirements	Configuration of ward may not allow for a dedicated Social/Communal or play room. Some wards may not require one.
Privacy, Dignity and Wellbeing I Dementia I Disability										
5.31	Does seating provide for the range of patient needs (Ward 12, M3, F6 - No)	Y	S Hunter / I Rashid	25/02/2020	01/06/2020				Survey and discussion with all failed ward management on their specific requirements	Rukeya Miah, Alison Powell, Amanda Hardaker
5.32	Is there at least one generally available toilet big enough to allow space for a wheelchair and carer (including staff) to assist when the door is closed (Ward 17 - No)	Y	S Hunter	25/02/2020	01/06/2020				Survey required to see where improvements could be made	wards to fund
Unscored										
5.33	Are all rooms on the ward for single occupancy and with en-suite bath/ shower and toilet facilities (Ward 12, 17, 24, 27, 28, 32, 4, M3, F6, F5, Westwood Park - No)Ward	Z	S Embleton	25/02/2020	25/02/2020			26/02/2020	Impossible ask. None of our wards are fully single room with en suite.	
5.34	Based on your first impressions on entering the ward, how happy / confident are you that A good level of patient care and experience will be deliverede within the environement e.g. does the ward appear bright, clean and welcoming (Ward F6 - No)	X	Matron/Ward manager F6						Matron to investigate why this scored as a fail. Could be various reasons. Develop action plan with ward sister and engage with Estates for any environmental improvements that may be required	Ward to fund any costs assiciated unless repairs / maintenance issues

Objective 6 To improve outcomes for Accident & Emergency

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No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidence
Dementia									
6.1	Are there points of interest such as artwork on the walls e.g. familiar local sights - No	Y	R Fox	25/02/2020	01/06/2020			To contact specialist suppliers or artwork to provide quotes for points of interest similar to elderly care wards.	Various suppliers.... FIND Memory, Deko Graphics, Wright Sign Service
6.2	Can signs to the toilets be seen from all areas and are they clearly identifiable - No	Y	S Hunter	25/02/2020	01/06/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund
Dementia | Disability									
6.4	Does seating in reception/waiting areas provide for the range of patient needs - No (A&E DEPT)	Y	S Embleton/E Clinton	25/02/2020	31/08/2020			high back chairs required for all waiting areas	dept to fund
6.5	Is the correct day and date displayed and clearly visible in all patient areas - No (A&E DEPT)	Y	S Embleton/E Clinton	25/02/2020	31/08/2020			Survey required to check clock provision in all patient areas	dept to fund
6.6	Is there a large, accurate and silent (approx. 18 inch/45cm diameter) clock clearly visible in all patient areas - No	Y	S Embleton	25/02/2020	31/08/2020			as above	dept to fund

Objective	7 To improve outcomes for communal areas								
No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidence
Condition Appearance and Maintenance | Dementia | Disability									
7.1	Do all control buttons in lifts include braille and tactile or raised surface buttons (St Lukes - No)	Y	S Embleton	25/02/2020	01/06/2020			refurbishment required to controls buttons in lifts and additional signage	estates to fund
Dementia									
7.3	Are all toilet doors in a single distinctive colour (Westbourne Green - No)	Y	I Rashid	25/02/2020	01/06/2020			Survey required to check all toilet doors in all patient areas	NHSPS to advise if willing to complete FOC
7.4	Can signs to the toilets be seen from all areas and are they clearly identifiable (St Lukes - No)	Y	I Rashid	25/02/2020	01/06/2020			Survey required to check signage provision in all patient areas	ward / dept to fund
Dementia | Disability									
7.5	Are pictures and text fixed to the toilet door (WBG - No)	Y	I Rashid	25/02/2020	01/06/2020			Survey required to check all toilet doors in all patient areas	ward / dept to fund
7.6	Are there handrails in corridors where appropriate (BRI - No)	Y	S Hunter	25/02/2020	01/06/2020			Surveys completed in 2017 but all allocated funding was spent	await decision on capital funding for 2020/21
7.7	Are wheelchairs available in the entrances for patients to use as required (WBG - N0)	X	I Rashid	25/02/2020	01/06/2020			IR to engage with Brenda Mosley to review requirements	ward / dept to fund if no wheelchairs are available
7.8	Do all external steps have high visibility nosing on treads and risers (WBG - No)	Y	J Hornby	25/02/2020	01/06/2020			Survey required to identify area of non-compliance with building regulations	estates to fund
7.9	Do all internal stairs have high visibility nosing on treads and risers (BRI - No)	Y	J Hornby	25/02/2020	01/06/2020			Survey required to identify area of non-compliance with building regulations	estates to fund
7.10	Does seating in reception/waiting areas provide for the range of patient needs? (WBG and WWP - No)	Y	I Rashid	25/02/2020	01/06/2020			IR to engage with Brenda Mosley to review requirements	ward / dept to fund
7.11	Has colour been used effectively to enhance patients orientation / co-ordination e.g. doors and bays painted in a different colour (BRI - No)	X	S Hunter	25/02/2020	01/06/2020			Surveys to be conducted and priority areas (dementia care) to be completed in-house on redecoration programme	estates to fund priority areas

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Privacy, Dignity and Wellbeing I Dementia I Disability										
7.13	Do all lifts have audible and visual announcements for notifying floor levels (St Lukes - No)	Y	S Embleton	25/02/2020	01/08/2020			quote required from lift supplier to rectify issues	estates to fund

Objective	8	To improve outcomes for external areas							
No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidence
Condition Appearance and Maintenance I Disability									
8.1	Are signs visible (e.g. not obstructed by overgrown trees or other obstructions) and clean (Westbourne Green - No)	X	I Rashid	25/02/2020	01/08/2020			IR to discuss with CHP to rectify	may need trust to contribute to cost
Privacy, Dignity and Wellbeing									
8.2	Is there a safe and secure outside space e.g. garden, courtyard or terrace for patients (Westbourne Green - No)	Y	I Rashid	25/02/2020	01/08/2020			IR to discuss with CHP to see what can be done to improve	may need trust to contribute to cost
Privacy, Dignity and Wellbeing I Disability									
8.3	Is there sufficient seating for patients leading up to the building entrance area within the organisation's ground (Bradford Royal Infirmary - No)	Y	S Embleton	25/02/2020	01/08/2020			subject to capital funding being allocated in 2020/21	

Objective	9	To improve outcomes for outpatient departments							
No	Place Requirement	Action Key	Lead	Date Added	Scheduled completion	Status (RAG)	Actual Completion	Comments	Evidence
Cleanliness									
9.1	Doors and frames (ENT BRI, Fail)	Y	K Snape	25/02/2020	01/08/2020			Previously requested funding to keep on top of area. The area has since be cleaned by deep clean teams, however, this will continue to be an issues that additional cleaning hours required within this area.	
9.2	Floors (ENT BRI - Fail)	Y	K Snape	25/02/2020	01/08/2020				
9.3	Surfaces - high (ENT BRI - Fail)	Y	K Snape	25/02/2020	01/08/2020				
9.4	Surfaces - low/visible (incl. fire extinguishers) (ENT BRI - Fail)	Y	K Snape	25/02/2020	01/08/2020				
9.5	TV/entertainment equipment (ENT BRI - Fail)	Y	K Snape	25/02/2020	01/08/2020				
9.6	Ventilation/air-conditioning grilles (visible) (ENT BRI - Fail)	Y	K Snape	25/02/2020	01/08/2020				
Dementia									
9.7	Are all toilet doors in a single distinctive colour (Gastro Unit and Radiology - No)	Y	S Hunter	25/02/2020	01/08/2020			Surveys to be conducted - to be completed in-house on redecoration programme	estates to fund priority areas
9.8	Are there points of interest such as artwork on the walls e.g. familiar local sights (ENT BRI, Gastro Unit and Plaster Room - No)	Y	R Fox	25/02/2020	01/08/2020			To contact specialist suppliers or artwork to provide quotes for points of interest similar to elderly care wards.	Various suppliers.... FIND Memory, Deko Graphics, Wright Sign Service
9.9	Are there toilets in the area for public use (Plaster Room - No)	Z	S Embleton	25/02/2020	25/02/2020		28/02/2020	No toilets are possible in the plaster room, however toilets are nearby in Ortho OPD	No further work
9.1	Are toilet seats, flush handles and rails in a colour that contrasts with the toilet/bathroom walls and floor (Pennine Suite - No)	Y	I Rashid	25/02/2020	01/08/2020			Survey to be completed to determine extent of non-compliance	

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9.11	Can signs to the toilets be seen from all areas and are they clearly identifiable (ENT BRI and Pennine Suite - No)	Y	S Hunter / I Rashid	25/02/2020	01/08/2020			survey to be conducted and wards given quotes for improvements to their signage	wards to fund	
9.12	When you walk on the floor does it create minimal noise (ENT BRI, Gastro Unit, Radiology, Westwood Park Outpatients)	Y	S Hunter / I Rashid	25/02/2020	01/08/2020			This will require all floors to be replaced with acoustic vinyl which is a significant cost	note: where acoustic vinyl floors are installed it causes issues for portering staff in pusing beds and trolleys	
Dementia I Disability										
9.12	Are all staff specific signs (e.g. sluice / treatment room) out of general eyesight level (ENT BRI and Gastro Unit - No)		S Hunter	25/02/2020	01/08/2020			survey to be completed and options discussed with area Matron	to be funded by dept	
9.13	Are signs fixed at a height that makes viewing easy (Physiotherapy Unit - No)		S Hunter	25/02/2020	01/08/2020			survey to be completed and options discussed with area Matron	to be funded by dept	
9.14	Are there handrails in corridors where appropriate (ENT BRI, Gastro Unit, Pennine Suite, Radiology and Westwood Park Outpatients - No)		S Hunter	25/02/2020	01/08/2020			Surveys completed in 2017 but all allocated funding was spent	await decision on capital funding for 2020/21	
9.15	Does seating in reception/waiting areas provide for the range of patient needs (Gastro, Plaster Room Radiology - No)		area Matron	25/02/2020	01/08/2020			Ward to purchase range of seating from IPROC	to be funded by dept	
9.16	Has colour been used effectively to enhance patients orientation / co-ordination e.g. doors and bays painted in a different colour (ENT BRI, Gastro Unit, Pennine Suite and Radiology - No)		S Embleton	25/02/2020	01/08/2020			Surveys to be conducted - to be completed in-house on redecoration programme	estates to fund priority areas	
9.17	Is flooring consistent, matt, non-reflective, non-patterned, not slippery (ENT BRI, Pennine Suite and Radiology - No)		S Embleton	25/02/2020	01/08/2020			This will require all floors to be replaced which is a significant cost	await decision on capital funding for 2020/21	
9.18	Is the correct day and date displayed and clearly visible in all patient areas (ENT BRI, Pennine Suite, Physiotherapy Department, Plaster Room, Radiology - No)		Area Matron	25/02/2020	01/08/2020			Surveys to be conducted - to be completed in-house on redecoration programme	estates to fund priority areas	
9.19	Is the flooring in a colour that contrasts with the walls and furniture (Gastro Unit, Pennine Suite, Physiotherapy Department, Plaster Room and Radiology - No)		S Embleton	25/02/2020	01/08/2020			This will require all floors to be replaced which is a significant cost	await decision on capital funding for 2020/21	
9.20	Is the flooring in a colour that contrasts with the walls and furniture (Gastro Unit, Pennine Suite, physiotherapy Department and Radiology - No)		S Embleton	25/02/2020	01/08/2020			This will require all floors to be replaced which is a significant cost	await decision on capital funding for 2020/21	
9.21	Is there a large, accurate and silent (approx. 18 inch/45cm diameter) clock clearly visible in all patient areas (Gastro Unit, Pennine Suite - No)		Area Matron	25/02/2020	01/08/2020			Ward to purchase dementia friendly clocks from IPROC	to be funded by dept	
Privacy, Dignity and Wellbeing										
9.22	Are appropriate measures in place to ensure privacy and dignity for patients at reception desks and at self-service check-in kiosks / screens (Radiology, No)		S Embleton/ area Matron	25/02/2020	01/08/2020			explore to see if improvements can be made to queueing systems	to be funded by dept	
9.23	Changing and waiting facilities (Gastro Unit, Pennine Suite and Radiology - No)		S Embleton/ area Matron	25/02/2020	01/08/2020			explore if a room is available for this purpose. if so obtain any quotes necessary to complete	to be funded by dept	

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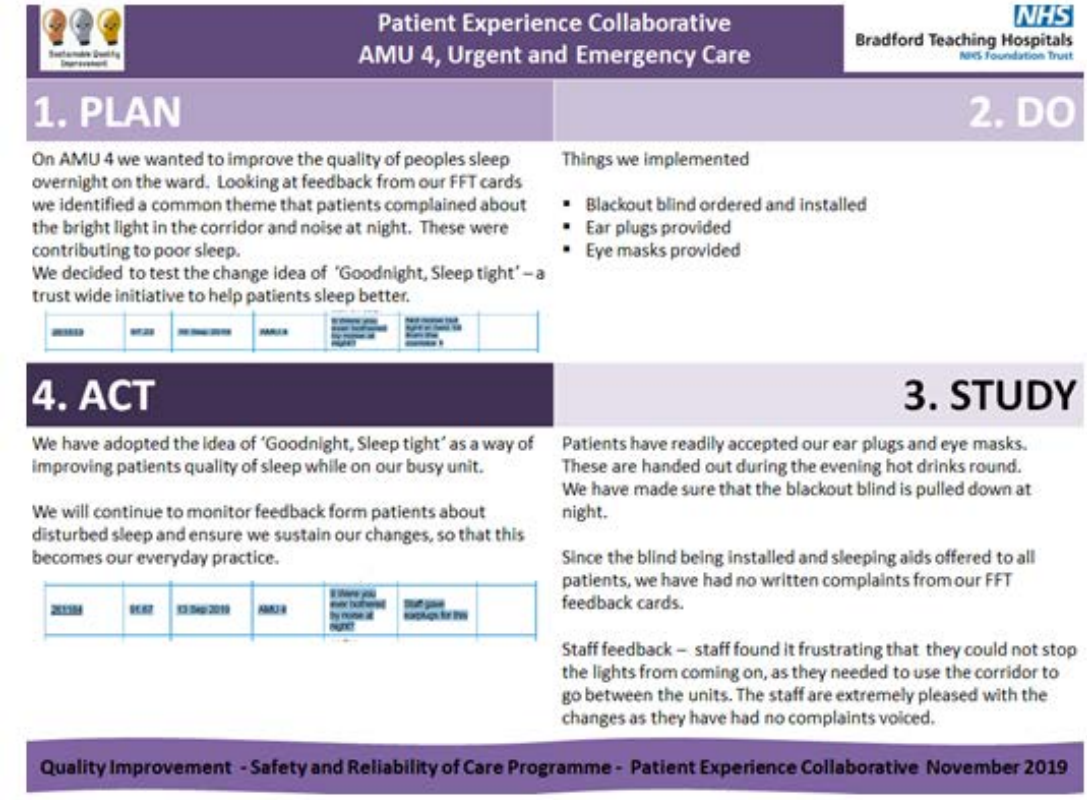
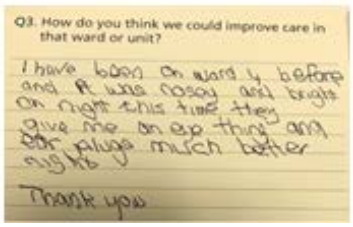
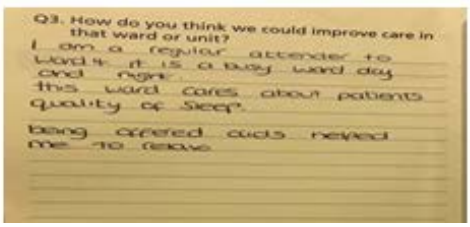
Appendix 3 Patient Experience Collaboration work







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The Patient Experience Collaborative
Improving the Experience of Care

Our mission at BTHFT is to provide the highest quality of care at all times and to provide the best possible experience of care by **embracing a spirit of kindness.**

We have said that we will do this by:

- **Being kind and treating others as we would want our loved ones treated**
- **Introducing ourselves by our first name and explain what we do**
- **Making eye contact, using open body language and smiling**
- **Valuing patients' time**
- **Always communicating with patients in way that is honest, easy to understand and kind**

As a Trust, we want to keep making care better and safer and we use quality improvement tools to help us and we have a team to help you! From February to July 2020 the **Quality Improvement team** are working with lots of different teams to make the experience of care better for patients.

What can I do ?

1. Talk about your work with colleagues

- When do you feel you have you made a difference at work?
- What stops you doing you job safely?
- What ideas do you have to make things better?

2. Get involved and see what difference you can make!

- We all play a vital part in the patient journey – join the movement to improve!

Work as One 10-14th Feb 2020

We have been talking about things we could do to improve the experience of care.
Equipment issues have been a key topic.

Focus on CHAIRS -

We think that there is lots of time spent looking for chairs. This adds to delays to patient care - being moved to the right place for tests, or moving to and from wards and departments. It is frustrating for the portering team, when time could be spent doing other things.

Next steps: Measuring to understand what we are doing now (20/02/20 to 4/3/20)

- Number of minutes each day/week porters spend looking for chairs for patients
- Number of steps/miles porters spend walking each week
- Number of jobs requiring a chair

Clinical areas taking part so far…

Care Group	Clinical Business Unit	Ward Dept.	Speciality
Planned care	Urinary Tract and Vascular	14	Urology
	Muscolo-Skeletal, Plastics and Skin	27	Orthopaedics
	Muscolo-Skeletal, Plastics and Skin	28	Orthopaedics
Unplanned care	Specialist Medicine	23	Respiratory
	Elderly and Immediate care	6	Stroke
	Elderly and Immediate care	31	Elderly care
	Elderly and Immediate care	3	Elderly care
	Elderly and Immediate care	F5/F6	Elderly care
	Urgent and Emergency care	1	AMU
	Urgent and Emergency care	4	AMU
	Urgent and Emergency care	ED	Emergency care
	Estates and Facilities		

The Quality Improvement team

Want to find out more! Get in touch with the QI Team:

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18/02/2020 LT

Appendix 4 Relatives line evaluation paper

Evaluation Summary: Relatives' Line Service 2020

Natasha Hardicre (Senior Research Fellow) & Angela Grange (Head of Nursing, Research & Innovation)

June 2020

Introduction

In response to the COVID-19 global pandemic and increasing number of cases within the UK, in March 2020 the UK government announced a nationwide lockdown to restrict non-essential movement and assembly of people not residing in the same households. As part of the NHS' response, BTHFT placed restrictions on visiting to protect patients, staff, volunteers and visitors. On 24th March 2020 routine visiting was stopped, with the following exceptions: one parent or appropriate adult can be with a child at any given time; a birthing partner can accompany a woman in labour; if patients are receiving end-of-life care in all areas; and for patients with a significant cognitive impairment (e.g. learning disability, dementia); and relatives collecting patients at discharge. Facilitated visits to ICU patients were also commenced in April 2020.

In order to facilitate communication for relatives no longer able to visit, three new services were introduced into the Trust: *Family View*, a system through which families can see and speak to loved ones remotely; *Thinking of You*, an electronic in-box for families and friends to send goodwill messages and videos to be played to patients; and a *Relatives' Line*, enabling people to phone between 8am-10pm for a daily update about inpatient relatives from a member of the clinical team, or to pass on a message.

An evaluation of the Relatives' Line (RL) was conducted for 29 days between 24th April and 22nd May 2020, approximately three weeks after the RL service started.

Background

Three key needs drove service change:

1. Ward staff need time to treat patients; answering calls from relatives takes time away from direct patient care.
2. People need information about their relatives in hospital, especially whilst visiting hours are banned or restricted.
3. People (outpatients and relatives or caregivers of patients) need timely access to COVID-19 test results and guidance.

Throughout the evaluation, the RL service comprised a dedicated telephone line in operation seven days a week between 8am and 10pm. The RL was manned by qualified healthcare practitioners (nurses and operating department practitioners (ODPs)), working in a dedicated call centre facility in the Wolfson Centre for Applied Health Research on the Bradford Royal Infirmary site. Service users were able to call the RL service to obtain information about a patient's condition; relatives' line operators (RLOs) accessed information about the patient via their electronic patient record (EPR).

At the start of the evaluation 43 nurses/ODPs staffed the service (22 x Band 5, 16 x Band 6, 5 x Band 7), reducing down to 38 staff by the time the evaluation ended (19 x Band 5, 15 x Band 6, 4 x Band 7). Staff working on the line had varied skill mix and nursing/ODP experience (medicine, surgery, paediatrics). The RLOs were assigned to the RL because they were unable to work on wards owing to underlying health conditions, pregnancy, or other occupational health issues.

Service Development and Implementation

Service development and implementation were driven by major changes in the wider service and by the resources available. Consequently, development and implementation of the RL were iterative and the

service evolved over time. Nonetheless there appeared to be two key goals that were central to initial and ongoing decision-making:

Goal 1: **Divert calls from ward staff to ease workload**
Goal 2: **Provide information to relatives of inpatients about patient condition and wellbeing and COVID-19 test results (when relevant).**

Key evaluation questions:

- Does the service reduce calls to wards?
- Does the service meet the information and communication needs of relevant stakeholders?
- How satisfied are relevant stakeholders with the service?

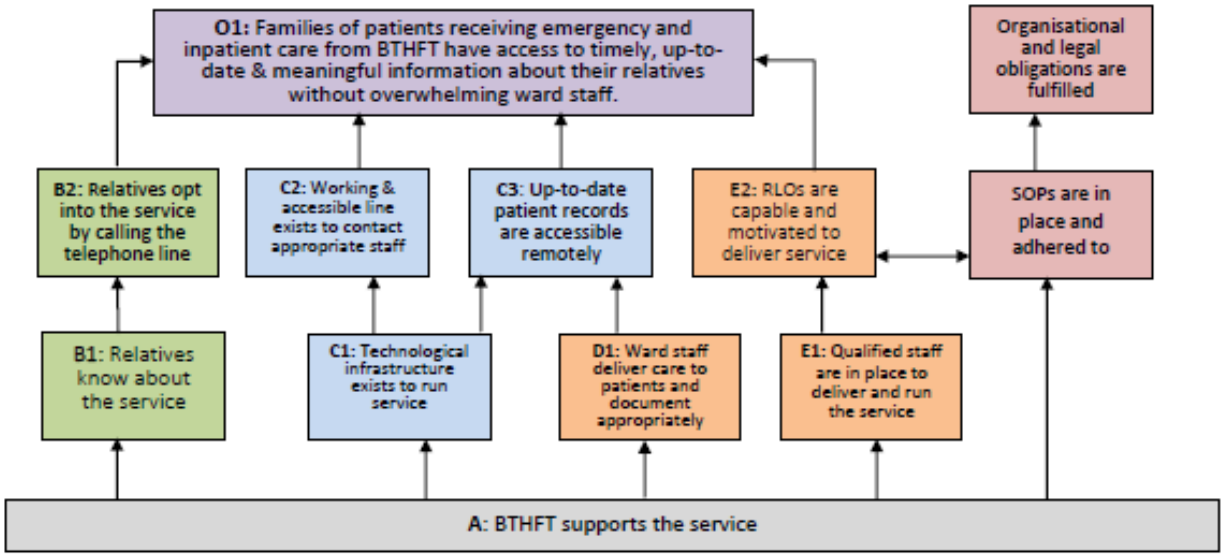
Evaluation activities comprised:

- Analysis of routinely collected service use data from the Trust clinical informatics service
- Analysis of data collected between 24/04/20-10/05/20 by RLOs through call-monitoring logs (n=3408 logs).
- Telephone interviews with relatives (n=15).
- Interviews with RLOs (n=18).
- Feedback from ward teams (n=4).

Evaluation Findings

The Outcomes Chain (see Figure 1) below shows an initial programme theory for the RL service. It was generated as part of the evaluation as a means of illustrating the multiple factors that may contribute to a chain of effects, which result in both intended and unintended outcomes. Each box represents an outcome to be achieved for the service to be delivered successfully; as there are multiple means of achieving outcomes, activities remain unspecified in the diagram. Activities undertaken to operationalize the service are outlined below, alongside evaluation findings.

Figure 1: Relatives Line Outcome Chain



Programme Activities and Outcomes

A: BTHFT agreed to staff the RL and provide necessary funding to make the service operational. Feedback from RLOs and those implementing the service reported that the Trust was very responsive to the need for the service and providing the resources necessary to implement it.

B1: The service was publicised through the BTHFT website and social media channels. Information about the line was also given to relatives by departments and wards. Feedback from relatives suggested that information about the line, including the number to call, was accessible.
B2: The service use data during the evaluation period and from service start date to evaluation end date is presented (Table 1). Data indicates that relatives *have* chosen to opt in to the service. Data captured through call monitoring forms also suggest that other individuals and organisations have also used the service. This includes: patients, home care providers, care home staff, district and community nurses/matrons, GPs, electronic monitoring service, chaplaincy service, hospital staff, insurance provider, EMS representatives, and other health, social and third sector care/service providers.

Table 1. RL service use data for evaluation and service start to evaluation end date

24/04/20 - 22/05/20	Calls Presented	Calls Handled	Calls Abandoned
Total	6916	6555	361
Average (daily)	238	226	12
02/04/20 – 22/05/20			
Total	11783	10997	786
Average (daily)	231	216	15

C1&C2: Technological infrastructure required to deliver the service consists of telephone lines and appropriate software capable of supporting multiple calls, including placing callers in a queue when necessary; and networked computers to provide RLOs access to electronic patient records. Feedback from RLOs suggests that there were very few problems with the technological infrastructure and service users reported excellent experiences of using the service. Users considered the RL very accessible – many users reported *always* being able to get through on the day they called. Relatives who had waited in a queue or had experienced technical issues (e.g. calls cutting out) said that issues only happened seldomly and they did not find these to be problematic because they considered the service itself so valuable. Service users also reported that the RL is far more accessible than usual ways of contacting wards via telephone. Problems frequently encountered prior to the RL include: calls not being answered, calls answered but phone is put straight down, engaged phone lines, unable to speak to someone who can provide information, calls not returned when requested.
C3: The widespread use of EPR across the Trust facilitated the implementation of this service because it enabled patient records to be accessed by staff outside the wards. The RLOs who were normally ward-based had few problems working on EPR as this was part of their usual work. However, some RLOs were less familiar with the EPR system and this posed an additional challenge initially because they were less confident navigating the system to access relevant information and document the call on the patient's record. Additional support was provided to these RLOs. Where departments used different IT systems (e.g. ICU) and RLOs did not have access to this, information provision was more difficult. During the evaluation, ICU opted to manage information and communication between their department and patient's relatives themselves – this was driven by the nature of critical care work and the systems they used to document patient care. The RLOs felt that this was a sensible change to the RL service.

D1: Although the evaluation did not assess or evaluate the care delivered by ward staff, it is a necessary factor for the RL service to work – care can only be reported to relatives if it is delivered and then reported appropriately. One of the main issues faced by the RLOs was the documentation available on EPR. Documentation was frequently scant, missing, or very delayed. This made it very difficult to provide feedback to relatives when they called. On occasions, relatives had to call multiple times a day to get an update because of delays to documentation or RLOs had to call the ward to actively seek information on relatives' behalf; this increased service demand and RLO workload. Interestingly, having been exposed to

what they consider to be poor documentation practices, RLOs who normally work on wards said that their experience of working on the RL would change the way they document on EPR. Widespread use of abbreviations and acronyms was problematic for RLOs who were not familiar with them. Use of abbreviations and acronyms was not consistent between departments.

E1: The RL was staffed by qualified BTHFT staff who were temporarily redeployed to the RL because they were not able to work in their usual services.
E2: RLOs received an initial induction to the service and SOPs were made available to them. Daily huddles were introduced to provide up-to-date information regarding service changes and safeguarding issues they needed to be aware of. Most RLOs felt prepared to work on the line, however, some were apprehensive because the work is different to their usual patient-facing role. Some of the common issues encountered were lack of familiarity navigating EPR, getting used to communicating via the telephone, uncertainty about how much information to share with relatives and how to document calls most effectively on EPR. All the RLOs said they felt extremely well-supported by senior leadership, shift supervisors and other RLOs. The skill mix of the team was beneficial because they were able to ask each other for help understanding patient records for conditions they were unfamiliar with. Most of the RLOs experienced feelings of guilt when they first started on the RL – they felt that they should be working on the frontline with their colleagues. However, after a short time of working on the RL, they viewed their role as extremely valuable and professionally satisfying. They felt they were fulfilling a vital need of relatives, not only in meeting information and communication needs, but also in supporting anxious and distressed relatives. Many of the RLOs reported developing relationships with relatives through repeated contact. This was beneficial in meeting relatives' needs and resolving issues effectively.

O1: The RL service has been extremely well-received. Relatives were grateful to be able to get information about their relatives whilst visiting was not possible. Most information requested was about whether patients have eaten/drunk/slept and mobilised. However, a large proportion of relatives wanted information about test results and treatment plans. Other callers (e.g. service providers) requested information about patient location and discharge plans. Some callers wanted detailed clinical information. For RLOs, choosing what information to share was influenced by caller knowledge, safeguarding requirements, and available documentation. RLOs frequently had to call the wards to request additional information to feed back to relatives. The RLOs also contacted the wards to request that someone contact the family directly. The RLOs provided a much-needed brokering and advocacy role to relatives. People reported feeling cared about, cared for, and receiving meaningful information. Many people said that this service was more effective at meeting their information and communication needs than normal contact with the hospital, even when visiting is allowed. This is because the service was accessible and the RLOs had time to spend explaining information to them in ways that were understandable and meaningful. During a telephone interview, one relative (whose husband has been admitted to hospital multiple times over the past ten years) said that speaking to the RLOs was the first time she had felt like someone had taken the time to explain her husband's condition and tests to her in lay-language. She also reported that although ward staff frequently offer to answer questions, they are often so busy that it has never felt like a meaningful offer. She was extremely grateful for the RL service and said that unlike communicating with ward staff, she never felt like a nuisance when she called the RL.

As can be seen from the service use data, the provision of this service diverted a potentially overwhelming number of calls away from wards. The RLOs were able to manage most information giving and escalated only those necessary. In this respect it operated as a type of 'telephone triage' system. In general, wards felt the provision of the RL was extremely helpful in managing ongoing information provision to relatives. They reported that it reduced their call volumes significantly. The A&E department also found it beneficial to be able to direct relatives, who were unable to accompany patients in the department, to the RL for updates on patient condition and location within the hospital. However, wards that normally communicate regularly with relatives (e.g. acute care for older people and ICU) preferred to maintain their usual communication practices and opted to co-ordinate information provision with relatives as a ward team. Nonetheless, some relatives of patients on these wards still continued to call the RL because their desire for information exceeded that proactively given by these wards.

Conclusions

Evaluation of the Relatives Line shows that the new service, although developed and implemented rapidly and in very challenging circumstances, delivered a high quality provision that is consistent with Trust Values and has added value to the organisation and the community it serves.

- **We care**

Relatives reported feeling cared for by the hospital, both in finding a way to meet ongoing information needs in difficult times, and also in providing a service where they could be listened to and communicated with in meaningful ways. Many relatives reported feeling anxious about having a family member in hospital, even when this was unconnected with COVID-19. However, the RL has been described as a reassuring and supportive service. One service user said that she felt that

"The hospital was considering your feelings [as a relative] as well as looking after the patients" (Patient's Daughter)

- **We value people**

Both RLOs and users of the service said that the RL provides a valuable person-centred service. The RLOs were praised highly by service users, for the information they provided but above all for their manner and care. People said that they felt valued and

"What I like [about the RL] is the personal touch... I think it's wonderful" (Patient's Spouse)

"They went out of their way to get the information for me... Nothing [about the service] could be improved – it's been spot on" (Patient's Son)

The RLOs also reported feeling valuable and valued because they were providing a service which met such an important need. They felt that that their role was an important contribution to the pandemic response and were grateful to be able to help in a meaningful way.

- **We are one team, striving for excellence**

The success of RL service was made possible through existing joined up working practices and EPR. Although there is still some improvement to be made to documentation practices across the hospital, taking a 'one team' approach and having good lines of communication between wards and the RL was beneficial. The RLOs were able to communicate with wards more effectively than relatives outside the hospital are and were able to get the right information quickly by relaying necessary information to ward staff and asking relevant questions. Many relatives said that the service from the RL was much better than when they have rung or visited the ward in the past.

An unexpected outcome of the service was the way in which it enables external (health and social care) service providers to 'reach in' to the Trust in a timely way. In this respect it facilitated working as 'one team' *across care transitions* and enabled more seamless integration with other services post-discharge. A home care organisation said that they had found the service extremely useful. They normally struggle to contact the hospital but need to do so regularly to find out discharge plans of their clients. Because this service was accessible, it enabled them to access up to date information about a patient who had been discharged home without the ward restarting the care package. They were able to restart home care and avoid missed contact. This has positive safety implications.

"It's hard not having normal communication or being able to see anybody. But I have to say, I think you've got it right with this." (Patient's Daughter)

Meeting Title	Board of Directors		
Date	9 July 2020	Agenda item	Bo.7.20.15

Recommendations / Proposed Models

The RL service evaluated is a centralised model (represented below). Alternative models achieving the same outcomes would also be possible. A potential localised model is also shown for comparison.

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