

North Bristol  
NHS Trust



# Account of the Quality of Clinical Services 2015/2016

*Exceptional healthcare, personally delivered*



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# Statement on the quality of services from the Chief Executive

## Introduction from the Chief Executive

**North Bristol NHS Trust is the largest hospital trust in the South West of England, providing hospital and community healthcare to the residents of Bristol, South Gloucestershire and North Somerset. We are also a specialist regional centre for a number of services including neurosurgery, renal (kidney) medicine, plastics, orthopaedics and major trauma.**

We aim for *'Exceptional healthcare personally delivered'* by providing services of exemplary quality, ensuring no unnecessary waits or delays, providing care in high quality facilities and having well trained and caring staff.



Quality improvement – In 2014, we became one of the first 12 NHS organisations in England to ‘Sign up to Safety’ - a government-led campaign that aims to make the NHS the safest healthcare system in the world. Five core safety pledges were made and a huge amount of work has been done throughout the organisation to support these pledges.

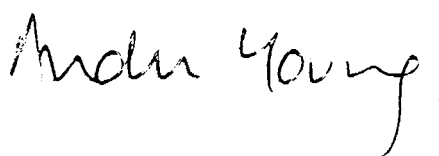
- **Putting safety first** – as part of this pledge our dedicated falls lead has trained over 500 staff, and environmental changes have been made in clinical areas all targeted towards reducing falls. As a result of this focus we have seen a significant decrease in the amount of serious falls.
- **Continually learning** – Our trust has always been at the forefront of patient safety initiatives and the drive and focus of our staff to continually develop and improve how we do things plays a large part in this pledge. We have developed an organisation wide improvement and safety programme and in their inspection report the CQC recognised the positive opportunities provided for continued learning and improvement, as illustrated through outstanding practice in a number of areas, such as dementia care and Major Trauma outcomes.
- **Honesty** – A culture of openness and transparency is something I personally feel strongly about and we can demonstrate this happening in practice across NBT. The CQC observed an effective safety culture with staff taking an honest approach to incident reporting and highlighting that staff felt able to raise any concerns they might have about safety. We are also currently evaluating the results from a detailed staff safety culture survey, which has generated a fantastic response from around 1000 staff. The outcomes will shape further improvements in 2016/17 to support our ambition of becoming one of the safest hospitals in the UK.
- **Collaboration** – Examples of collaborative working include the SHINE project which was initially implemented at University Hospitals Bristol and has since been used to great effect in our Emergency Department. This example of safety improvement has led to reduced incidents relating to recognition of deteriorating patients or delays in care within the ED.
- **Support** - This pledge has seen us focusing on helping staff to understand why things go wrong and how to put them right. The implementation of a safety hub is providing staff with support through dedicated weekly awareness and training sessions. This is facilitated at locations close to clinical teams’ working areas through ‘pop up’ booths that help to make this as widely accessible as possible.

Care Quality Commission inspection – In December 2015, the Care Quality Commission (CQC) carried out a focused re-inspection of services previously rated as ‘requires improvement’ or ‘inadequate’ in November 2014. Whilst our overall rating has remained as ‘requires improvement,’ the CQC has recognised significant safety improvements within urgent and emergency care services with the service improving to a ‘Good’ rating overall. Important improvements were also recognised within our critical care and maternity and gynaecology services, both of which also achieved an overall rating of ‘good.’

I am also extremely pleased that the CQC described the care we are providing to our patients with dementia as ‘an outstanding example of responsiveness’ as well as praising the passion and continual drive for improvement in patient care shown by frontline staff and managers. There is still work to do but I am confident that our continued commitment will enable us to provide quality care that achieves the best possible outcomes for all our patients.

Patient experience – One of our priorities was to improve our patient’s overall experience in hospital and in 2015-16 we have laid the foundations for achieving this consistently. New trust-wide leadership roles in Patient Experience and Quality & Safety Improvement have helped to scope priorities in each area that are engaging the whole organisation more effectively. For example, a new initiative entitled ‘Ask three questions’ aims to empower patients and their families and carers to play a more active role in decisions about their care. By asking the right questions during consultations with their doctors, nurses and therapists, patients can actively consider their options with the support of their healthcare professional

Trust strategy – The Trust Board approved a new strategy at its March 2016 meeting. This will provide clarity of direction over the next five years. It sets out our vision of the future - delivering healthcare, which is of exceptional quality, with excellent clinical outcomes and in an environment that provides an outstanding experience for our patients and staff. We will be sharing this broadly internally and externally to gain further views on how we can successfully take this forward.



**Andrea Young**  
**Chief Executive**  
**North Bristol NHS Trust**

# Review of Services

During 2015/16, the Trust provided a wide range of NHS services. These are listed in Appendix 3.

The Trust reviews data and information related to the quality of these services through regular reports to the Trust Board and the Trust's governance committees. Each clinical service undergoes monthly Executive review in which performance against standards of quality and safety are reviewed. These reviews discuss with clinical teams and managers any areas of concern and also continuous quality improvement. The Trust has therefore reviewed 100% of the data available to them on the quality of care in all its NHS services.

During the year a new Patient Administration System (Lorenzo) was implemented, which went live in November 2015. As with any large scale system implementation, this has disrupted the

collection and quality of information available. This primarily has an impact on operational data, for example that relating to length of stay, bed days, bed occupancy and performance against national waiting time standards. Gradually these issues are being addressed through the post implementation stabilisation process, which is overseen through the IM&T Committee and reported at each Trust Board. Progress is also scrutinised by commissioners and the Trust Development Authority.

If there is any doubt as to the quality of data included within this account this is clearly stated within the relevant section.

The income generated by the NHS services reviewed in 2015/16 represents 100% percent of total income generated from the provision of NHS services by the North Bristol NHS Trust for 2015/16.

# Statement of Directors' responsibilities in respect of the Quality Account 2015/16

**The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).**

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

NB: sign and date in any colour ink except black

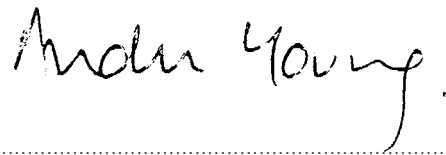
Signatures and dates in final published copy



Signed .....

Date ..... 27 June 2016 .....

**Peter Rilett  
Chairman**



Signed .....

Date ..... 27 June 2016 .....

**Andrea Young  
Chief Executive**



## Section 1 - Priorities for Improvement

Every year the Trust manages a wide range of quality improvement targets and measures set by the Trust Board, Commissioners, NHS England and the Department of Health alongside requirements of specialist national reviews and recommendations from national NHS organisations including NICE, Royal Colleges and Care Quality Commission amongst others.

The targets are included as part of our overall quality strategy under the headings of Patient Safety, Clinical Effectiveness and Patient Experience. The connection between good performance and high quality care and the range of issues that remain priorities for the board include falls, pressure ulcers, nutrition, medicines safety, and infection prevention & control. In addition to all the other quality and safety targets, each year Trusts are asked to choose up to 5 priorities for improvement which are chosen in consultation with patients, public and staff.



## Involving the public in identifying these priorities

We asked our clinical teams to make suggestions for priorities to improve patient care. This list was then discussed with the Trust's Patient Panel and the Patient Experience Group members to obtain their views.

These topics were then compiled into a survey for patient and public consultation which was distributed to the Trust's Foundation Trust members who wish to take part in surveys. Presentations including the shortlist were made to Local Authority Health Scrutiny Committees to seek their views.

Over 180 patients and members of the public completed the survey. The results of the survey were analysed and ranked according to importance as rated by patients and carers. These were discussed by the Trust's Quality Committee to agree the final priorities prior to final approval by the Trust Board.

## Our Priorities for Improvement for 2015/16

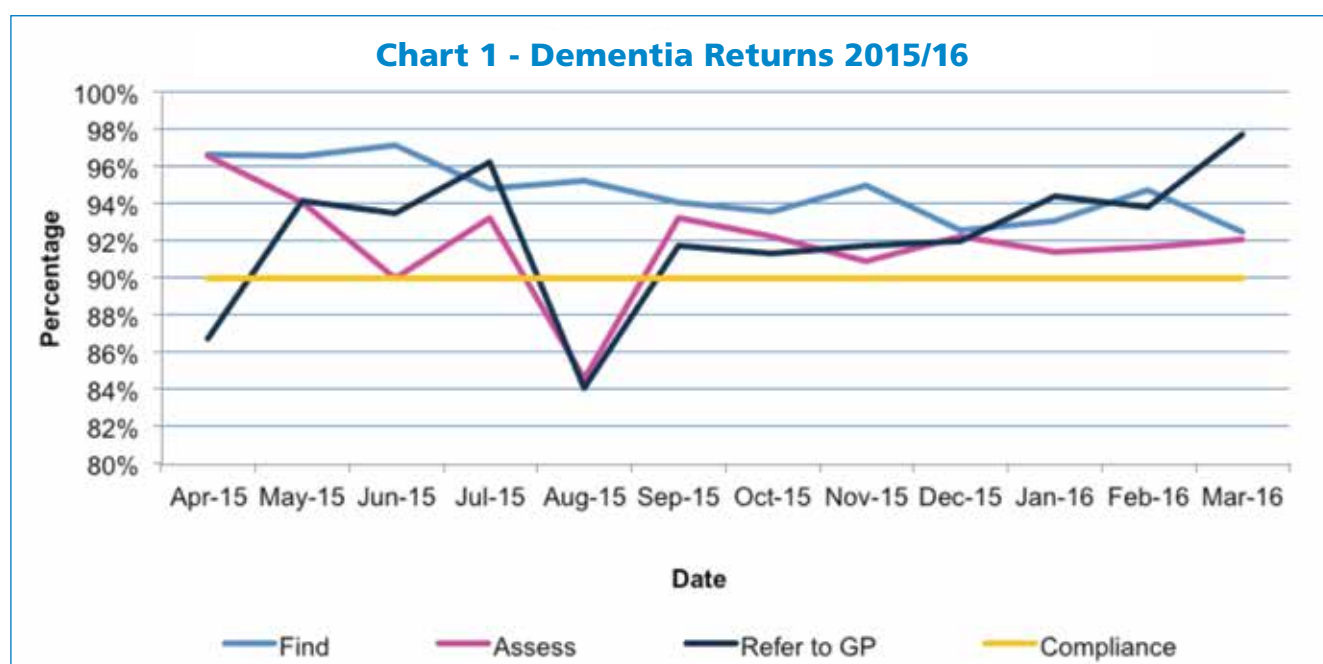
1. Improving care for patients with dementia.
2. Improve our patients' overall experience in hospital.
3. Improving the recognition, diagnosis and treatment of Acute Kidney Injury (AKI).
4. Improving the quality and timeliness of information provided to GP's when patients go home to ensure there is safe handover to primary care.

## How did we get on with these priorities?

### Priority 1: Improving care for patients with dementia

Dementia continues as one of the Trust's priorities led by the dementia team of doctor, matron and trainer. Work to improve the care of people with dementia starts on admission with staff identifying people with dementia and those who have had a decline in their memory. This enables the provision of reasonable adjustments to each person's care using our cognitive impairment care bundle.

There are national incentives to finding, investigating and referring people with unrecognised cognitive decline for diagnosis and as can be seen from chart 1 we have moved forward in this throughout the year exceeding compliance with national standards.



Our Care Bundle for people with cognitive impairment allows an individualised plan to be constructed using evidence based interventions to improve care. It covers a wide range of tools including selection of the best environment for care, medication reviews, promoting nutrition and hydration and supporting people to remain independent. The team are working to make sure that this is embedded as normal care for people with dementia.

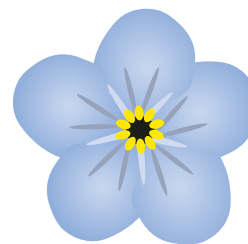
The care plan encourages staff to support carers to be involved as much as they wish, in particular to be present when the person with dementia is eating and drinking. The Trust was one of the first to sign up to “John’s campaign” which also encourages carers/family to remain with the patient as much as they wish. This can include remaining overnight to reassure and care for their loved ones.

Carers are also the focus for the Memory Café which is held every Wednesday in conjunction with the Alzheimer’s Society. Here carers can receive more information and support, be linked into external caring organisations and enjoy tea and biscuits whilst they find out what they wish to know.

The dementia team were pleased to be shortlisted for “Dementia Team of the Year” in the BMJ awards. Whilst we did not win, we received a highly commended certificate for our development of the memory café, now copied in other Trusts.

More recently we have joined with the new “enhanced care” improvement project, linking with occupational therapists to work on providing more meaningful activity for patients on the wards. This has included the provision of “digital reminiscence DTRS” computers to each ward. In ED they have found this to be an excellent tool in engaging with older people who are distressed.

We continue to use twiddlemuffs knitted by numerous groups for us to help calm agitated people and there are activity boxes available to support staff in providing simple activities.



We are not complacent as we still have lots to do to maximise care for people with dementia. Each patient bedroom is now equipped with a clock and whiteboard for communication, and during the year the Elgar wards were refurbished with improved colour and signage to aid way-finding.

Fresh Arts have helped with planning murals to go on the walls and storage for activity equipment. This is still a work in progress with improvement continually being added. Other projects for the coming year include continuing to improve the environment, increasing the breadth of training and improving the identification of people with delirium – another under-recognised group.

*“One of the positive experiences I had with the DTRS was when an elderly chap with dementia was in the department, it was busy, it was loud, and he was distressed, shouting, grabbing and generally agitated.”*

*We decided we would try the DTRS, it was still fairly new and we were all slightly scared of this big machine on wheels that not many of us had gone near yet! We switched it on, found some jazz music, hit the play button and within ten minutes the patient was tapping his feet, wiggling on his bottom and at times pretending to blow the trumpet! It was like watching a person transform in front of us.”*

**RL (ED staff member 2016)**



### Priority 2: Improve our patients’ overall experience in hospital

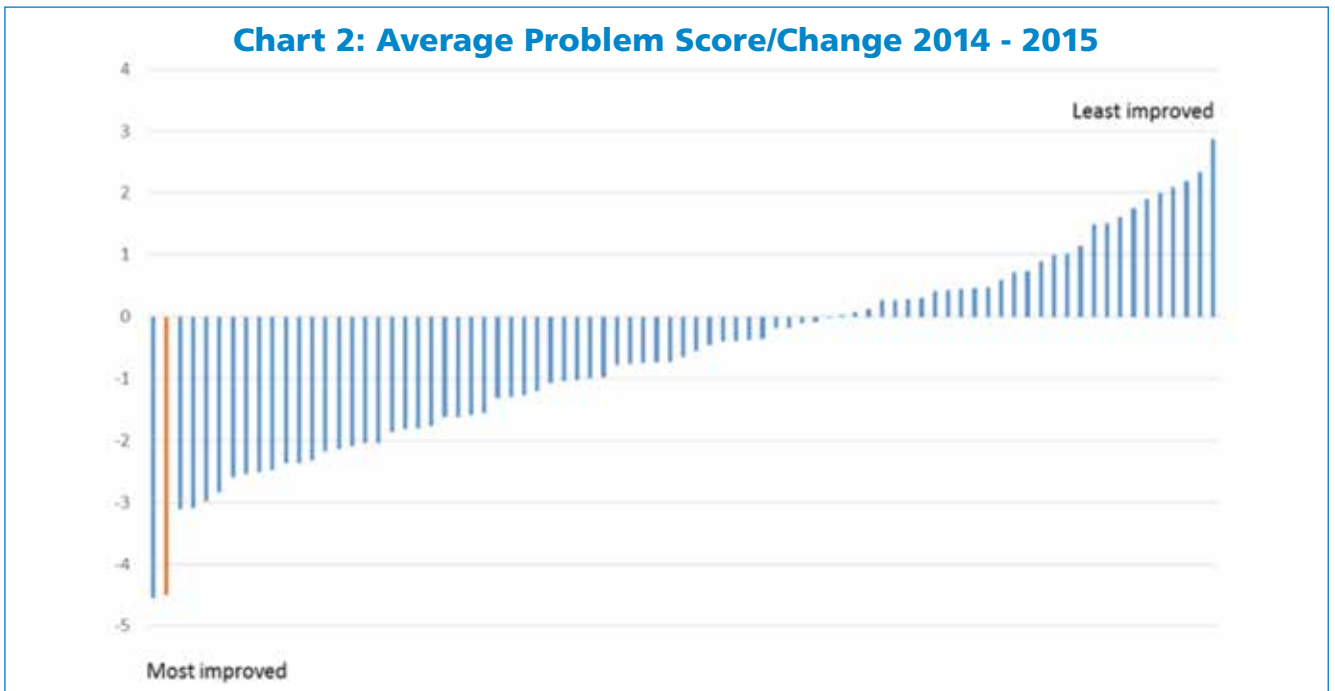
The experience of our patients and carers is at the heart of our work. What patients and carers tell us makes a difference to the services we provide. To help with this work this year we have appointed a Head of Patient Experience to lead this aspect of work.

The experience and satisfaction of our patients is monitored and measured in a range of ways. This includes complaints, concerns and compliments, national surveys, local surveys, the Friends and Family Test, social media and online patient feedback.

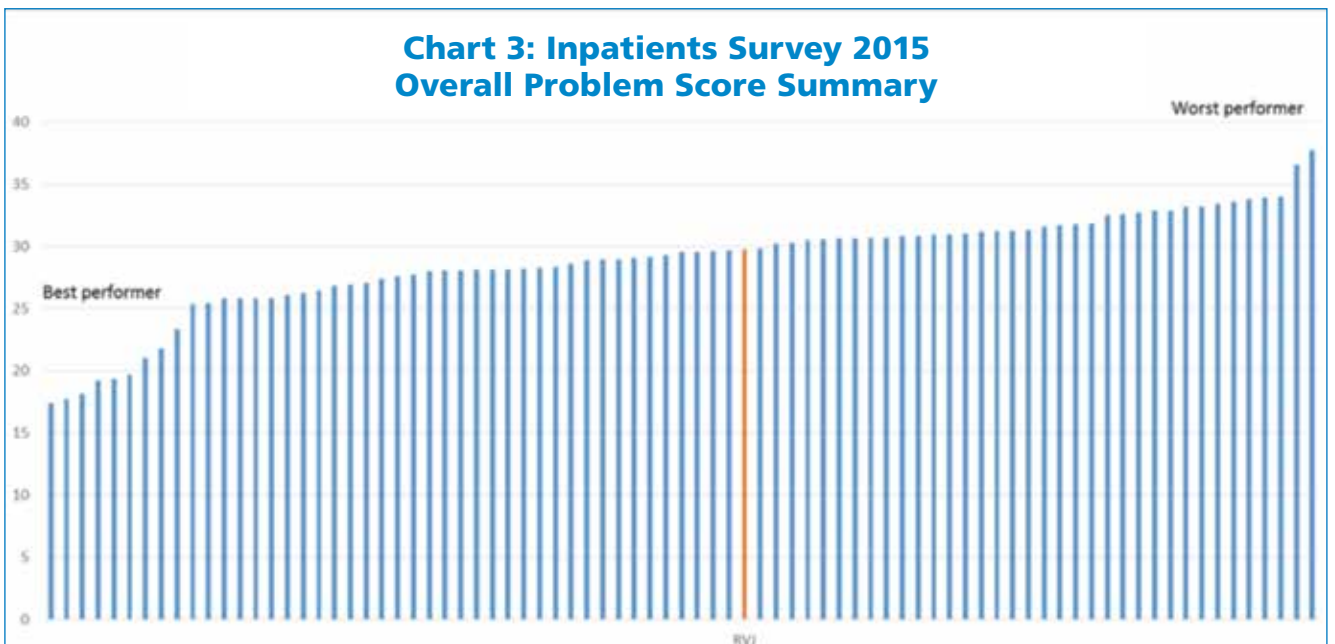
### Inpatient survey (general)

The national patient survey is part of a national survey program. It is run by Picker Europe Ltd on our behalf every year. A random sample of 850 patients who have stayed in our Trust in July 2015 are invited to take part. There was a response rate of 49.9%.

Patients were asked 62 questions about different aspects of their experience. The overall outcomes are summarised below in chart 2 showing that we are the 2nd most improved trust of the 81 who also used Picker Europe Ltd to undertake their survey. In terms of overall outcomes we will continue working hard to move our overall achievement towards the best performers during 2016 (see chart 3).



**Chart 2** - The orange line indicates north Bristol Trust position in relation to improved scores in the National Inpatient Survey compared with 81 other Trusts.



**Chart 3** - the orange line indicates North Bristol Trust position in relation to the 81 trust we were compared with.

The more detailed information shows that we scored significantly worse than last year for 3 questions (below), significantly better in 19 and there was no significant change in 40.

Areas where we scored worse than last year:

- Hospital: patients staying in more than 1 ward shared sleeping accommodation with opposite sex.
- Hospital: patients using bath or shower shared it with the opposite sex.
- Discharge: Staff did not discuss need for further health or social care.

Aspects of care that improved significantly include:

- Patients feeling of being well looked after by staff.
- Having privacy when being examined or treated in the emergency department.
- Involvement in decisions about care and treatment
- Quality and choice of food

### Focus for improvement:

The Trust's inpatient areas are comprised of 75% single rooms to maximise privacy and dignity, including ensuring single sex accommodation. The challenges experienced are relatively small scale in overall terms and primarily related to extreme pressures within the emergency zone where the concentration of patients within the department meant this was unavoidable. All options to minimise this are being considered and we have already eliminated particular issues identified within interventional radiology.

The following aspects of the reported experience of patients have been agreed by Patient Experience Group as the focus for improvement:

- Discharged patients
  - Being told of any danger signals to look for.
  - Family being given enough information.
  - Being involved in decisions about discharge from hospital.
  - Being given enough information to help care after discharge.
  - Consideration being given to the family or home.
  - Information on medications.
  - Discussion of the need for health and social care services.
- Enabling the patient to be more involved in decisions about care & treatment where they wish to - this will link with our progress on empowering patients in shared decision making through 'Ask 3 Questions'
- Finding someone to discuss concerns with.
- Receiving enough emotional support from staff.
- Being told how they would feel after operation or procedure.

These aspects have the highest problem scores and are supported by evidence from other feedback such as complaints and feedback from Healthwatch. We look forward to working with our partners as well as patients and carers to improve these aspects of the patient experience.

## Priority 3: Improving the recognition, diagnosis and treatment of Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) is a sudden and recent reduction in a person's kidney function. In the UK up to 100,000 deaths each year in hospital are associated with AKI and up to 30% could be prevented with the right care and treatment. It is estimated that up to one in five people admitted to hospital as an emergency has AKI and 65% of these start in the community. This year by focusing on 'kidney attack', NBT seeks to reduce harm associated with AKI by 50%. An AKI working group was established in April 2015 to develop and implement an AKI improvement strategy for the trust in line with the national 'Think Kidneys' programme set up by NHS England ([www.thinkkidneys.nhs.uk](http://www.thinkkidneys.nhs.uk)). We are also working in collaboration with clinical teams in other trusts (UHB, Weston, and RUH) to develop a unified strategy in tackling AKI in the area.

### Kidneys for Life: Stop Acute Kidney Injury

#### What we achieved last year (2015/16)

##### 1. Early detection of AKI:

Early diagnosis of AKI enables clinical teams to take appropriate measures to stop the kidney function getting worse and thereby improve patient outcomes. A diagnosis of AKI is made if the patient's kidney function has worsened by more than 50% compared to previous results. As of September 2015, we had implemented an electronic alert in the hospital's laboratory systems to facilitate the early diagnosis. The Laboratory Information Management System (LIMS) will automatically compare patient's kidney function tests during the current admission to previous blood test results and generate a laboratory report on the system if the patient has met the criteria. The alerts are colour coded 'yellow', 'amber' and 'red' to represent the increasing severity of AKI.

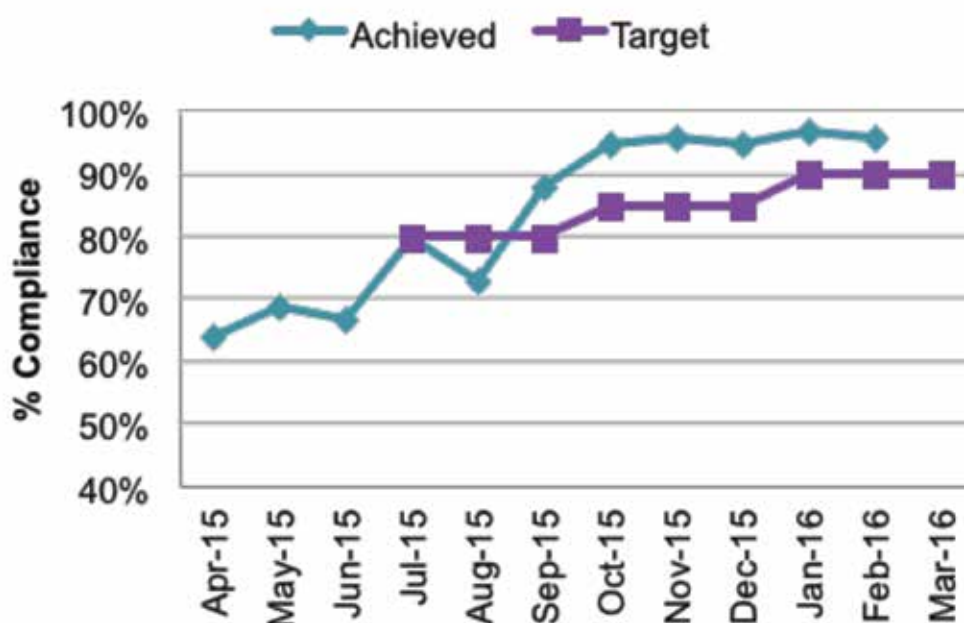
Data on the number of patients who had AKI each month will be sent to UK Renal Registry, commissioned by NHS England to collect and report incidence of AKI across the UK for benchmarking and quality improvement.

##### 2. AKI training programme:

A structured education and training programme on prevention and management of AKI has been rolled out for pharmacists and junior doctors during their induction training. We are in the process of implementing similar sessions for registered nurses and developing an e-learning module to facilitate broader uptake of training.

##### 3. AKI patient information:

There is an urgent need to raise public awareness of AKI. We have developed a patient information leaflet to help patients, their carers and the public understand what kidneys do, how important they are, what they can do to keep their kidneys healthy and reduce their chances of AKI. This will be handed out to patients who have been diagnosed during the hospital admission and to those who are at risk due to their other health problems.

**Chart 4: AKI Discharge Information to GPs**

#### 4. AKI CQUIN:

It is important that GPs are informed at the time of discharge if their patients had developed AKI during their recent hospital admission and what follow up is required in the community to monitor their kidney function. NHS England had established a national CQUIN around this for 2015/16. Our target was to achieve 80% for the 3rd quarter and 90% for the fourth quarter of this year. Our performance for the 3rd quarter has been well above the target at 95% and we are on track to maintain this for the fourth quarter, as set out below within chart 4.

#### Ongoing work (2016/17)

##### 1. AKI Care bundles:

We have developed a care bundle that will be piloted in the Medical Admissions Unit (MAU) with plans to roll it out across the trust. The care bundles incorporate a minimum set of standards of care to be implemented in those who have been diagnosed with AKI. The aim is that these care bundles will raise awareness and understanding of the risk of AKI, improve the care and treatment of patients with AKI and enhance their recovery.

##### 2. AKI Risk assessment tool:

Some patients are predisposed and at a higher risk of developing AKI due to their underlying health problems and the medications they are currently on. We have developed a risk assessment tool and this will be tested in one of the wards. This tool, once finalised, will enable clinical teams to identify patients who are at increased risk of developing AKI so that appropriate interventions can be put in place to minimise the chances.

#### Future Work includes

##### 1. Mini RCA:

It is estimated that 20-30% of AKI is avoidable. We hope to develop a system to undertake root cause analyses for at least the severe forms. This will help us understand the reasons for the AKI and if this could have been prevented and what measures need to be put in place to prevent this happening again.

##### 2. Engagement with primary care:

It is estimated that 65% of the AKI starts in the community and therefore further work needs done to raise awareness amongst health care professionals in the community on prevention and management.

#### Priority 4: Improving the quality and timeliness of information provided to GP's when patients go home to ensure there is safe handover to primary care

A Discharge Summary or Transfer of Care document is a letter written by the doctors and the multi-professional teams caring for a person in hospital. It contains important information about that person's hospital stay including why they came in, what diagnosis was made, what tests they had, what medications they were being discharged on and what changes had been made during their stay. Follow up arrangements and future planning are also documented.

A working group was set up in July 2015 to improve the information included in the discharge summary. Feedback from GP's, patients and relatives, junior doctors completing the form, senior doctors, pharmacists, nursing staff, patient safety representatives and audit results all contributed to this work. A meeting was also held with the University Hospitals Bristol discharge summary lead to ensure consistency across the local health system.

### Key changes made include;

- 1) Moving medications to the bottom of the discharge summary keeping diagnosis at the top (more clinically coherent)
- 2) Include treatment escalation decision discussions
- 3) Bring together the delirium diagnosis and cognitive problems
- 4) Clarity around responsible consultant and team details in case of query
- 5) Elective or emergency admission
- 6) Advice section for patient-encourage patient responsibility for making appointments with GP
- 7) Adding whether the patient had been septic during their stay
- 8) Infection risks
- 9) Clarifying reasons for medication additions and changes and stoppages
- 10) Follow-up arrangements clearly stated
- 11) Increase the proportion of discharge summaries sent electronically

Commissioning for Quality and Innovation (CQUIN) standards for completion were audited for Quarter 2 and 3 through a joint audit with a local GP and we were pleased to exceed targets for accurate completion at rates above 75% in both cases.

Building on this success, we will be progressing further work in 2016-2017, such as;

- 1) Deceased patient summary for GP to help support relatives
- 2) Aiming for electronic summary for all GP's
- 3) Medication education information for discharge
- 4) Pharmacy to check reconciliation system on discharge (aiming for 100% of summaries.)
- 5) Customising discharge summaries for specialities

### Our Priorities for Improvement for 2016/17

We will continue to improve the quality of care for patients as set out in our contract across a wide range of areas. For example - prevention of deterioration, continuing reduction

of pressure ulcers, reducing the number of falls, infection prevention and control, improving nutrition, improve the identification and care for patients with Acute Kidney Injury and the management of catheters or other similar items (e.g. tubes or drains). In addition, through our consultation we have agreed with patients, staff and local Healthwatch organisations to address the following priorities within the Quality Account:

1. Involving patients, family and carers in decisions about care and treatment.
2. Improving the identification and management of sepsis.
3. Improving care for patients with Dementia or delirium.
4. Improving the consistent delivery of care for patients who are nearing their end of life.

### How we will measure progress with these priorities

A clinical lead and supporting reference group will be identified for each priority to drive it forward. Improvement measures will be set and the data will be collected and analysed to track progress.

In addition to the ongoing review at the relevant group, overall progress will be monitored closely by the Trust's Quality Committee chaired by the Medical Director. Its membership includes the Director of Nursing and Director of Operations as well as Clinical Directors, chairs of quality and safety committees and other key staff involved in monitoring or progressing quality and safety priorities.

Reporting on a wide range of quality measures is presented to the Board every month as part of an Integrated Board Report and includes measurements of progress against improvement measures set, shown on a quality dashboard. This report is included in the public session of the Trust Board and is published on the Trust's external website as part of the papers.

In addition, quality measures are reviewed at the Quality Sub Group to South Gloucestershire, Bristol and North Somerset CCGs, the main local commissioners for the Trust's services, plus NHS England who commission specialised services.



## Sign up to Safety' & NBT Quality Faculty

### The Trust Quality and Safety Improvement Team

The Quality and Safety Improvement Team was set up in June 2015. We lead the Safety Programme for North Bristol Trust. The function of the team is to provide direction for safety projects within the programme, ensure they align with patient needs and the overall Trust strategy, and generate commitment from members of staff involved in the safety work. The team consists of a consultant physician who is the associate medical

director for safe care, a senior nurse who is the quality and safety improvement lead and a radiographer who is a quality improvement practitioner. The team has the medical director as the executive lead and report to the Trust's quality committee.

### What are our aims?

Our aim is to make North Bristol NHS Trust a high-reliability organisation with safety at the heart of its culture. We want our staff to be delivering the right care to patients at the right time, even when no-one is looking.



### Building improvement capability in our workforce

The Trust is seeking to build upon previous success in delivering quality improvement projects that deliver real benefits for our patients. Although a number of staff members are engaged in improvement work across the hospital, this work is not always visible to others.

The team have the opportunity to introduce themselves to all new staff at the staff induction days and are able to explain why safety and continuous improvement is so important to patients, carers and families. In 2016 the team have set up quality improvement workshops for all members for staff to attend, (including porters, managers, nurses, doctors, and physiotherapists) with a plan to continue these workshops to build capability in improvement skills and maintain momentum.

Keeping patients safe whilst having a positive experience of care are also the underpinning foundations for the NHS Outcomes Framework and reflect the approaches and measures recommended by the aforementioned resources.

**[www.health.org.uk/publications/the-measurement-and-monitoring-of-safety/](http://www.health.org.uk/publications/the-measurement-and-monitoring-of-safety/)**

### The measurement & monitoring of safety;

#### Safety Hub

A physical Safety Hub has been launched in the Brunel Building to enable staff to learn about improvement science, problem-solve issues with current projects and keep up to date with the ongoing safety work in the Trust. The Hub will also have a portable function so that it can make use of different locations e.g. use of the staff restaurant and the hospital atrium for staff and patients (recognising that staff will not always have the time to be released from clinical areas). The Safety Hub days are advertised and on occasions will include speakers. The Safety Hub captures current projects and will include events, workshops, and conferences. It will act as an informal support unit for any member of staff wanting to learn about improvement science or start up their own project.

## 2015/16 Sign up to Safety Priorities for the Trust and team;

The Quality and Safety Improvement Team support a number of work streams within the Trust and these include:

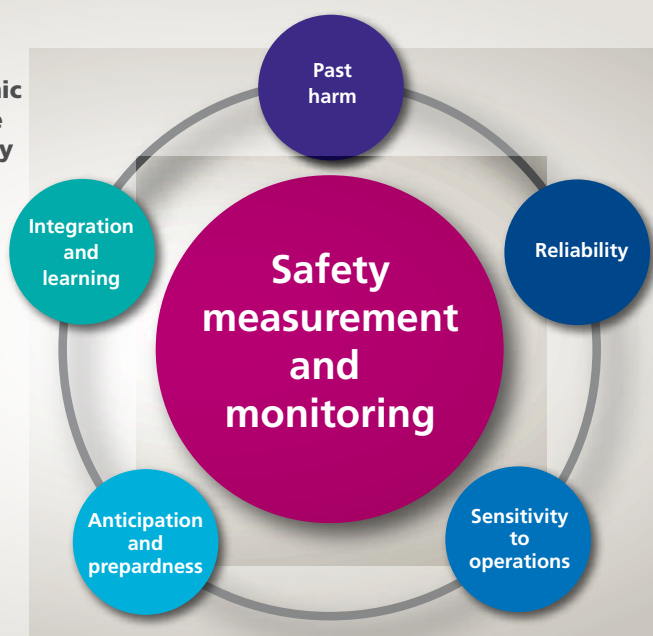
- Reducing Patient Falls
- Preventing Pressure Ulcers
- Sepsis Management
- Acute Kidney injury (AKI) Management
- Safe Medicines
- Prevention of Patient Deterioration
- Continence
- Dementia and Delirium
- Safe Emergency Care
- Discharge of Patient and the Safe Handover of Care
- Safe Operating Theatre

## Organisational Safety Culture

Organisational culture is difficult to define but is vital to address if the ambition to be the 'best in class' is to be achieved.

Organisational culture can be defined as the assumed understandings between the staff of an organisation. It means that they share views on the way staff should work together and treat each other and their patients. We have an ambition to be an organisation with a strong safety culture. At the core of this plan is improving patient care and bringing about a step change in 'how we improve and manage the quality agenda'. The aim is to make quality everyone's business to increase the profile of the work staff currently do in relation to this agenda, bring about a system of total quality management that creates a culture of team working, efficient working practices based on the newest technology, systems based thinking, best evidence and a culture of continuous improvement. This year we will start work in key areas such as Theatres and the Emergency Zone by undertaking a safety survey with staff and developing improvement work streams through the feedback received.

**Fig.1 – Health Foundation: The Measuring and Monitoring of Safety. Drawing together academic evidence and practical experience to produce a framework for safety measurement and monitoring. – Professor Charles Vincent, Susan Burnett, Jane Carthey – April 2013**



## Emergency Department Improvement Work

When inspectors from the Care Quality Commission (CQC) first visited the department in November 2014 – six months after the move from outdated facilities at Frenchay Hospital to the new hospital at Southmead – they had significant concerns around overcrowding, primarily due to issues associated with flow and patients accessing beds in a timely manner.

The Emergency Department was rated as "inadequate" overall; therefore a warning notice was placed on the department when the report was published in February 2015.

Since then there has been a relentless focus on making improvements – so much so that in its latest report, published on 6th April 2016, the CQC has rated the service as "good" overall. The requirements of the warning notice were fully met following a subsequent inspection in October last year.

This reflected a number of positive changes, such as;

- An additional triage nurse on duty for every shift, day and night. This has halved the time people are waiting to be triaged
- Creating more space by moving the seated assessment area into the Acute Medical Unit next door
- Consolidating patient documentation so that the patient record from ambulance to admission to the Emergency Department is all in one place and therefore safer for patients and more efficient for staff
- Changing shift patterns for doctors and consultants – meaning that an additional consultant is on duty in the department during the middle of the day

*As Matron Juliette Hughes says; "What we have proved is that during busy times we can continue to provide safe, excellent care and high quality treatment to patients – even though waiting times may be longer than we would like. It is fantastic for us and our patients to have this recognised by the CQC."*



# What other Organisations say about the Trust

## Care Quality Commission (CQC)

By law all Trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards. NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them. As at 31/03/16, the Trust is registered for all of its regulated activities, without conditions. Without this registration, we would not be allowed to operate.

The Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during the reporting period. The Trust was first inspected by the CQC under its new regime in November 2014. A further inspection was undertaken in December 2015, covering services and domains not rated as either 'good' or 'outstanding' originally.

Following publication of the Care Quality Commission's (CQC) latest reports on 6th April 2016, the CQC Quality Summit was held on 11th April. The first half was chaired by the CQC with a presentation from the Head of Hospitals Inspection,

followed by NBT's response. The CQC's comments about the Trust's progress were glowing; the overall improvement at NBT over the last 12 months was described as "remarkable". In particular the passionate commitment of our frontline staff and managers in delivering high quality care was considered to be "outstanding".

The overall sense was of an organisation that is improving but needs to persist with the challenging issues reflected in the 'must do actions' within the report – namely patient flow and medical records. There is an expectation from CQC and NHS Improvement that our health and social care partners will also contribute to delivering better flow which needs to be incorporated into the final CQC action plan.

The current ratings across NBT services are shown below as at the end of the financial year 2015/16 and the Trust will be submitting an action plan to the CQC by 17th May setting out measures to address those issues, aiming for an overall rating of 'good' within the next 12-18 months.

### Overall Trust Rating

	<b>Safe</b>	<b>Effective</b>	<b>Caring</b>	<b>Responsive</b>	<b>Well-led</b>
Overall trust	Requires improvement	Requires Improvement	Good*	Requires Improvement	Good

*\*Rating from November 2014*

## Southmead Hospital Rating

### Table 2 - Southmead Rating

	Safe	Effective	Caring	Responsive	Well led	Overall rating
Urgent & Emergency Services	Good	Good	Good *	Requires improvement	Good	Good
Medical Care	Requires improvement	Requires improvement	Good *	Requires improvement	Good	Requires improvement
Surgery	Requires improvement	Requires improvement	Good *	Requires improvement	Requires improvement	Requires improvement
Critical care	Good	Good *	Good *	Requires improvement	Good *	Good
Maternity & Gynaecology	Good	Good *	Good *	Good	Good *	Good
Services for Children & Young People	Good*	Good*	Good *	Good*	Good*	Good*
End of life care	Requires improvement	Requires improvement	Good *	Requires improvement	Requires improvement	Requires improvement
Outpatients & Diagnostic Imaging	Requires improvement	N/A	Good *	Requires improvement	Good *	Requires improvement
Overall location	Requires improvement	Requires improvement	Good *	Requires improvement	Requires improvement	Requires improvement

\*Rating from November 2014

## Frenchay Hospital Rating

### Table 3 - Frenchay Rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients	Requires improvement	Not rated	Good *	Requires improvement	Good *	Requires improvement

\*Rating from November 2014

## Cossham Hospital

### Table 4 - Cossham Rating

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity & Gynaecology	Good*	Good*	Outstanding*	Outstanding*	Good*	Outstanding*
Outpatients	Good*	Not rated	Good*	Good*	Good*	Good*

\*Rating from November 2014

## Community CAMHS Rating

Table 5 - CAMHS Rating						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Community CAMHS	Requires improvement	Good *	Good *	Good *	Requires improvement	Requires improvement

*\*Rating from November 2014*

## Child and adolescent mental health wards (Riverside)

Table 6 - Riverside Rating						
	Safe	Effective	Caring	Responsive	Well-led	Overall
CAMHS wards Riverside	Good *	Good *	Good *	Good *	Good *	Good *

*\*Rating from November 2014*

## Community health services for children, young people and families

Table 7 - CYPF Rating						
	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services	Good *	Outstanding*	Outstanding*	Good*	Outstanding*	Outstanding*

*\*Rating from November 2014*

Copies of the full reports for the Trust and each location inspected by the CQC in 2015 are available at;

### Trust-wide Quality Report;

[http://www.cqc.org.uk/sites/default/files/new\\_reports/AAAE8140.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/AAAE8140.pdf)

### Southmead Hospital

[http://www.cqc.org.uk/sites/default/files/new\\_reports/AAAE8141.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/AAAE8141.pdf)

### Specialist Community Mental Health Services (Children & young People)

[http://www.cqc.org.uk/sites/default/files/new\\_reports/AAAE8142.pdf](http://www.cqc.org.uk/sites/default/files/new_reports/AAAE8142.pdf)

## Section 2 - Patient Safety

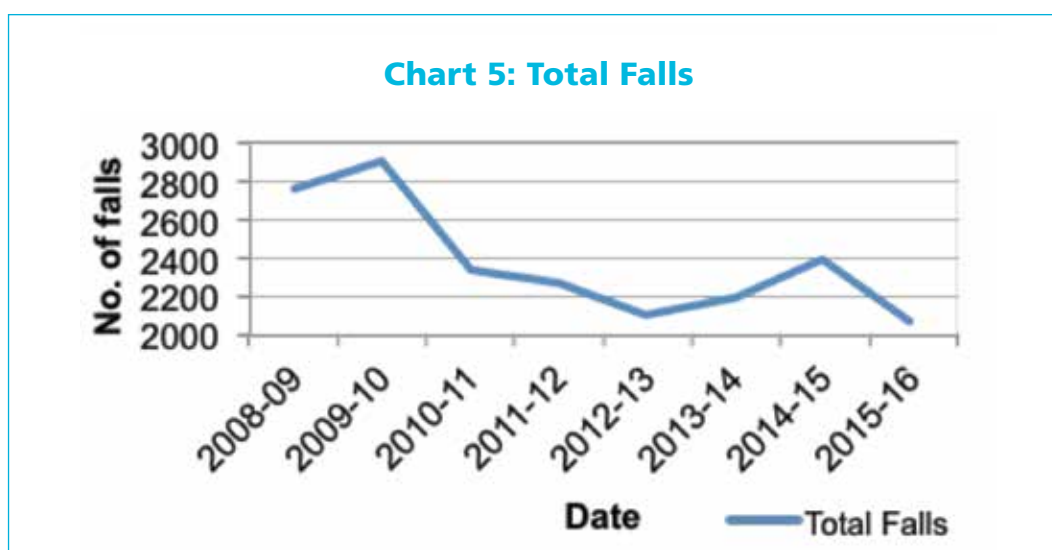
### Reducing Patient Falls

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety Agency (2011) report 'Essential Care After an Inpatient Fall' states that each year around 282,000 patient falls are reported to the NHS England's Patient Safety division from hospitals and mental health units. A significant minority of these falls result in death or in severe or moderate injury.

The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year, therefore falling has an impact on quality of life, health and healthcare costs.

## Falls Prevention Steering Group

The Trust has a Falls Prevention steering group which meets monthly. Membership includes ward nursing representatives, therapists, pharmacy, the training department, dementia and safeguarding teams and the Deputy Director of Nursing.



The total number of falls has reduced over the last 5 years. The number of falls resulting in serious injuries rose in 2014/15 following the move into the new hospital at Southmead but has since reduced.

### What we achieved

Given the majority of Falls resulting in serious injury are in patients with dementia, delirium and cognitive impairment, we started working very closely with the Trust's Enhanced Care Project team, Dementia Team and the Health Education Southwest funded Improving Patient Enablement & Continuity of Care (IPECC) Reablement project.

### Preventative Care

- Daily falls map to ensure patients are cared for in the right location on the ward and can be observed.
- 9am Safety Briefing with doctors, nurses and physiotherapists to highlight who is at risk of falling.
- Project to improve medication review by doctors.
- New Falls Care plan with a focus on delirium, blood pressure, medication and vision.
- New bed rail magnets to ensure bed rails are used for the right patients.
- Falls sensors to alert staff if a patient has moved from the bed or chair.
- Improved tools to enable staff to manage patients' safety after a fall.
- Meaningful Activity Occupational Therapist working with wards to improve the experience of patients with dementia in hospital and reduce falls.

## Environment

- Work due to start to improve all inpatient bathrooms to reduce falls risk.
- Delirium Friendly Acute Medical and Complex Care Assessment Units with dementia-friendly signage, coloured bathroom suite, and clocks.
- Digital Reminiscence equipment now in use on 20 gates including the Emergency Department to help improve experience for patients with cognitive problems.
- Activity boxes for people with dementia (including old photos, colourful materials, etc.).

## Training

A Lead Nurse for falls prevention was employed in September 2015 using NHS England Sign Up to Safety funding. The Lead Nurse has provided face-to-face training for 817 nursing staff in falls prevention over 6 months. Training at Induction has been improved to include training for healthcare assistants and scenario training has been developed. Equipment has been purchased to enable simulation training in falls for junior doctors and multi-professional teams.

## Current Outcomes

There were 2257 falls this year compared to 2391 the previous year (a reduction of 134 falls). The current falls rate is 6.44 per 1000 bed days (compared to a national acute hospital rate of 6.63), which represents a 6% reduction compared to last year. Serious Incident falls have reduced by 20% with 26 serious injury falls (compared to 33 last year).

## Reducing Pressure Ulcers

All people are potentially at risk of developing a pressure ulcer. If these occur they can be debilitating, increase complications to health and can have a serious impact on a person's quality of life. There are national frameworks (NICE) in place requiring healthcare establishments have systems in place to prevent and monitor incidence of pressure ulcers.

At North Bristol the prevention of pressure ulcers is a key priority ensuring the safety and quality of care to all those receiving treatment in our hospital. 2015/16 sees the completion of the Trust's first of three years of sign up to safety for which the reduction of pressure ulcers is one of the objectives with a target to reduce incidence of grades 2-4 by 50% by the end of year 3 (2017/18).

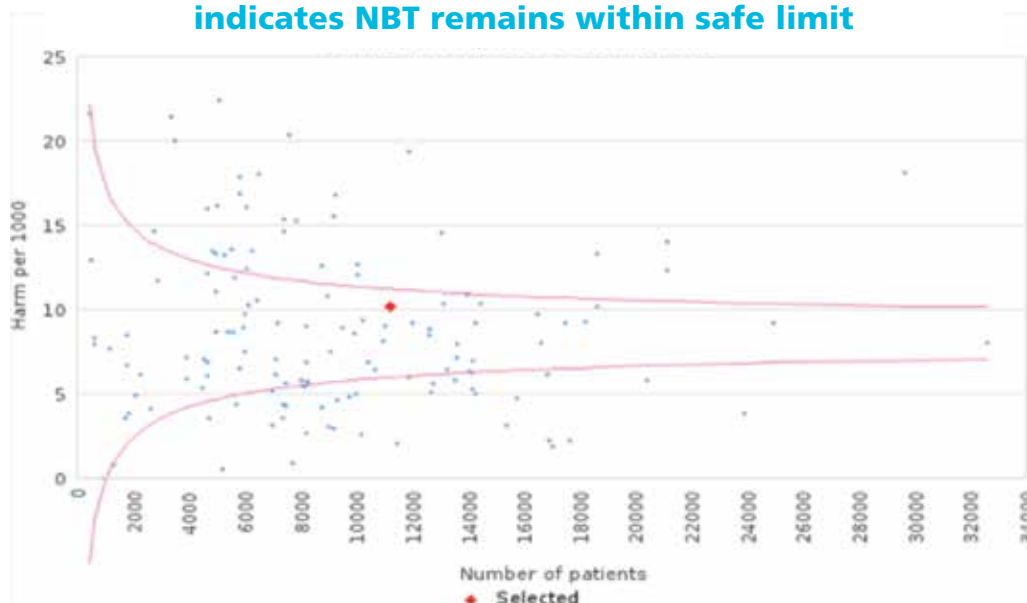
2015/16 has seen a significant improvement on the incidence of pressure ulcers grades 2-4, as shown in the table below, which is a result of continuous focus from work started in 2014/15 and robust review of all grade 3 and 4 pressure ulcers. Key themes are established from each case, which informs the tissue viability team of the educational and training needs for clinical staff. This year's success culminated with a regional study day with presentations by nationally recognised experts, attended by over 150 staff from both the hospital and community settings and the launch of a Pan Avon Dressings Formulary.

The Trust remains focused on continuous reduction to avoidable health care acquired pressure ulcers. Broader work has already commenced with a hospital and quality improvement collaboration to reduce pressure ulcers within the Bristol, North Somerset & South Gloucester health system.

**Table 8 - Pressure Ulcer Guide**

Year	Pressure Ulcer Grade		
	Grade 4	Grade 3	Grade 2
2014/15	6	14	378
2015/16	0	7	326
Total % reduction	100%	50%	14%

**Chart 7 - Funnel plot for pressure ulcer incidence – indicates NBT remains within safe limit**



### Intravenous Fluids Management

In August 2014, NICE published a clinical guideline and quality standard for intravenous (IV) fluid therapy in hospital. This was in response to a number of reports highlighting poor or unsafe care of patients with a requirement for IV fluids. Errors in assessment and management of patients' IV fluid requirements are common (around 20% of patients have complications). The task of assessing and managing patients' IV fluid needs can be left to the most junior and inexperienced staff with little knowledge of patient daily requirements or the composition of common IV fluids.

We developed a Fluids working group with doctors, nurses, pharmacists, dieticians and education staff to review and improve practice.

### What we achieved

- We have developed three levels of e-learning training and competency assessment to target all healthcare professionals including doctors, nurses, dieticians, pharmacists, healthcare assistants and physiotherapists
- In addition, we have delivered practical and simulation sessions in IV fluid management for junior doctors
- We have modified the hospital clinical incident reporting tool to enable easier reporting of incidents related to poor fluid management. A monthly report is reviewed and actioned by the IV fluids lead
- The IV fluids working group is working closely with other working groups in the hospital, particularly Acute Kidney Injury and Sepsis
- A new intravenous fluid prescription chart was implemented
- A new hydration chart has been developed and piloted with a view to improving the documentation of hydration in patients without complex fluid needs
- An advanced fluid management tool has been developed for use in patients with complex IV fluid needs and has shown improvement in fluid recording. We will now be working on the spread of these tools and also test a new hydration risk assessment tool

### Catheters and Continence Management

It is estimated that 1 in 5 people in the UK have trouble with bladder control, and 1 in 10 have trouble with bowel control. Within our hospital between 15 and 20% of our patients will have a catheter inserted in their bladder to drain their urine. Some patients come into the hospital with a catheter and others will have one for a short time as part of their hospital treatment. It is important that catheters are kept very clean and well cared for, to reduce the risk of patients getting infections in their bladders or kidneys.

North Bristol NHS Trust has a good record for catheter care with less than 0.5% of our patients with catheters being diagnosed with a urine infection in 2015/16; however we need to ensure that catheters are only used when necessary and that they are removed as soon as they are no longer needed.

### What we did in 2015/16:

#### Catheter Care Plan

In 2015 we designed, tested and implemented a new Catheter Care Plan to ensure that all patients receive the care that they need to reduce the risk of infection. The care plan includes a new section which reminds the nursing staff to check every shift whether the patient still needs a urinary catheter or whether it can be taken out. The design also helps the nurses to keep track of when the catheter bag is due for changing.

#### Catheter Care Re-launch Week

In April 2015 we held a special week-long event focusing on Catheter Care, with key messages about reducing the risk of infection going to all clinical staff via email and computer reminders. All the Matrons and Ward sisters used their regular walk-rounds to talk to staff about Catheter Care and check that all patients with catheters were receiving safe care.

## On-going Work in 2016/17

### World Continence Week

Our next focus on continence and catheter care will be during World Continence Week, 20th to 26th June 2016, when we will be sharing the latest developments in continence with our teams through publications and special events.

### Policy review

During 2016 we will be reviewing our policies for Bowel Management and Catheter Care as well as developing a new policy for supporting patients to maintain or regain Continence.

### Improving practice

We are working with our colleagues in the community, and with the companies that supply continence equipment to ensure that we select good quality, cost effective products which our patients can use in hospital and in their homes.

## Preventing Deterioration prior to Cardiac Arrest

Cardiac arrests in hospital are rarely a sudden event. There is evidence to show that patients will often present with signs of deterioration prior to suffering a cardiac arrest.

Patients who are deteriorating often show signs and symptoms indicating their worsening state. Early Warning Scores (EWS) calculates a score based on the patient’s key physiological measurements and provides an indicator of how sick a patient is, thus enabling the recognition and escalation of care of patients whose condition is worsening.

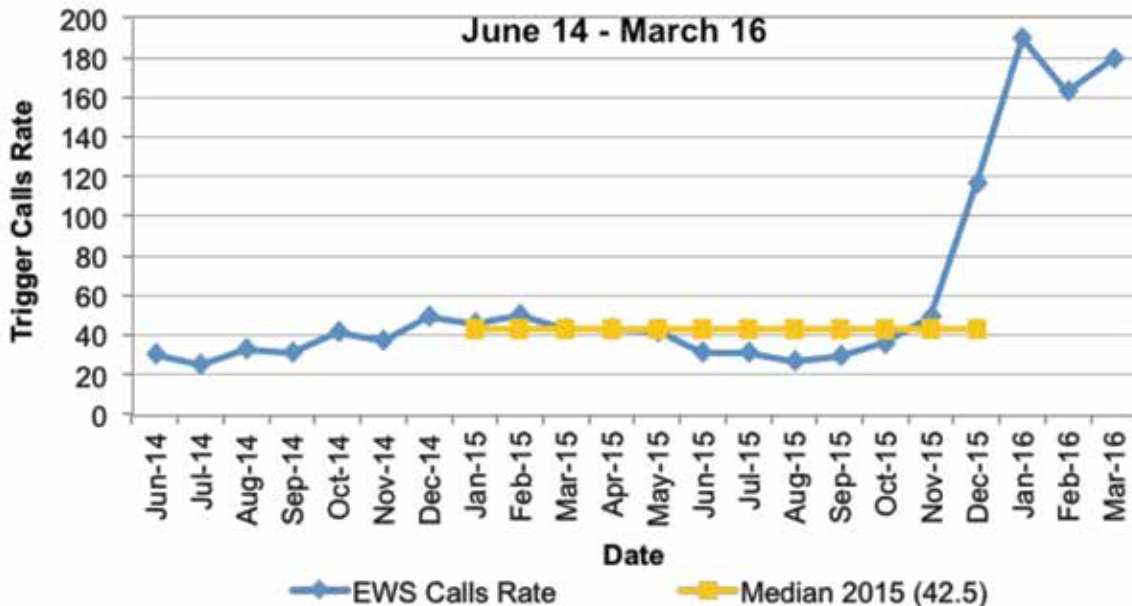
All inpatients within the Trust have their physiological observations (respiratory rate, levels of oxygen, pulse, blood pressure, level of consciousness and temperature) measured and recorded in accordance with the Trust Observations Policy.

This early recognition and management of patient observations may prevent avoidable patient admissions to the Intensive Care Unit (ICU) and help prevent avoidable cardiac arrests and the need for Cardiopulmonary Resuscitation (CPR).

In December the Trust changed the Observation chart to incorporate the nationally validated National Early Warning Score (NEWS), this was undertaken in conjunction with other healthcare providers within the Southwest to support the use of common terminology and help support the patient journey.

As illustrated in chart 8, since the implementation of the NEWS chart there has been a significant increase in the number of patients who have triggered and as a result been escalated for medical review. This is a positive sign, reflecting the successful implementation of the NEWS chart which helps to ensure we identify and act upon patients who are showing signs of deterioration.

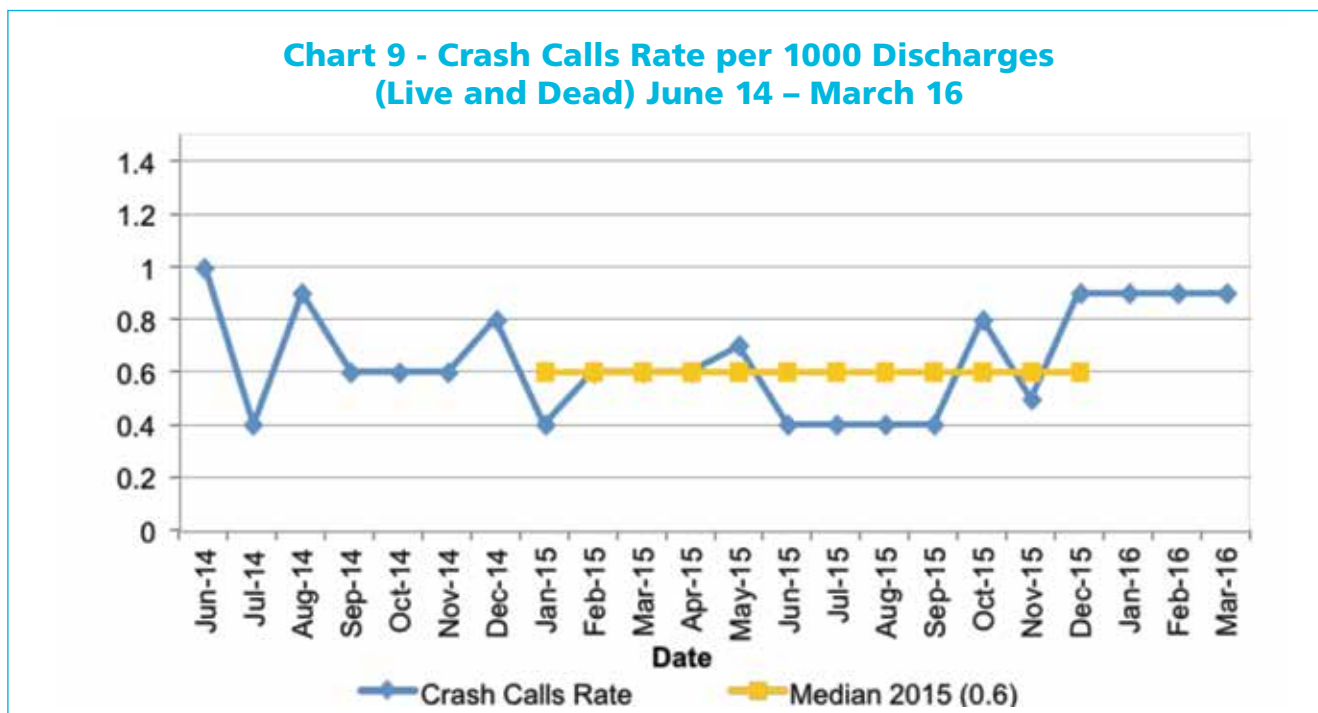
**Chart 8 - EWS Trigger Calls Rate per 1000 Discharges (Live and Dead) June 14 – March 16**



### Cardiac Arrest rates

The Trust’s cardiac arrest rate continues to reduce. Chart 9 shows that the Trust median rate is 0.6 per 1000 discharges, which shows NBT to be much better than the National Average of approximately 1.5 per 1000.





The reduction in the number of cardiac arrests in the Trust over the past 5 years is shown below.

**Table 9 - Reduction in number of cardiac arrests**

2011/12	2012/13	2013/14	2014/15	2015 / 2016
215	163	148	125	103

### Achievements

- Successful implementation of the NEWS chart across the organisation – currently working with the Emergency Department and Neurosciences.
- Successful implementation of a funded project looking at the benefits of In Situ simulation training of our Acute Medical Admissions units in identifying and treating confirmed or suspected sepsis.
- Increased training and awareness of the deteriorating patient through practical assessment, simulation and focused debriefing for all Foundation Doctors and Nursing staff.
- Combined working with the Sepsis Group to integrate sepsis screening with NEWS.
- Continued improvement in the reduction of cardiac arrests.
- Clearer communication from the wards via our switchboard operators to the medical teams.
- Work with GPs and community services to use the NEWS for acutely unwell patients to enable clear handover of patients to the Ambulance Service and Emergency Department.
- Ongoing development and implementation of a structured assessment tool for reviewing unwell patients to improve their management; encourage escalation to senior teams and improve communication to nursing staff.
- Implementation of a joint educational programme for junior doctors and nurses seeing acutely unwell patients using simulation training scenarios.

### Venous Thromboembolism (VTE)

This condition encompasses Deep Venous Thrombosis (DVT), where a blood clot (thrombus) forms in a vein - often the deep veins of the legs - and Pulmonary Embolism (PE) - a blood clot in the lungs.

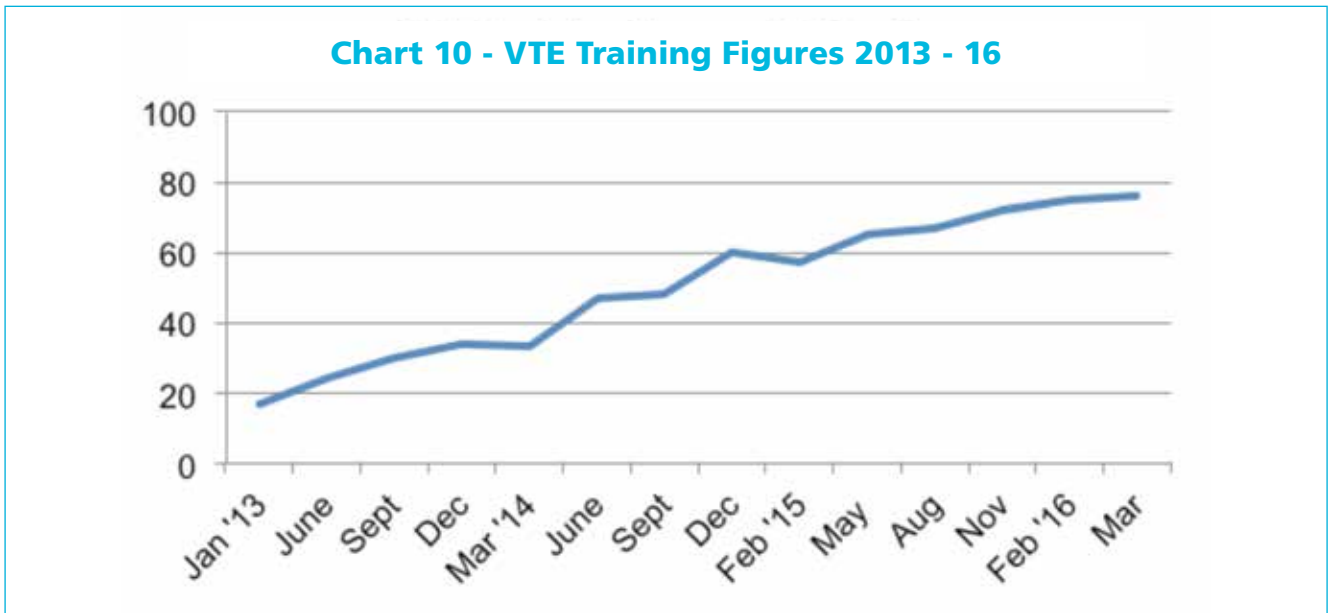
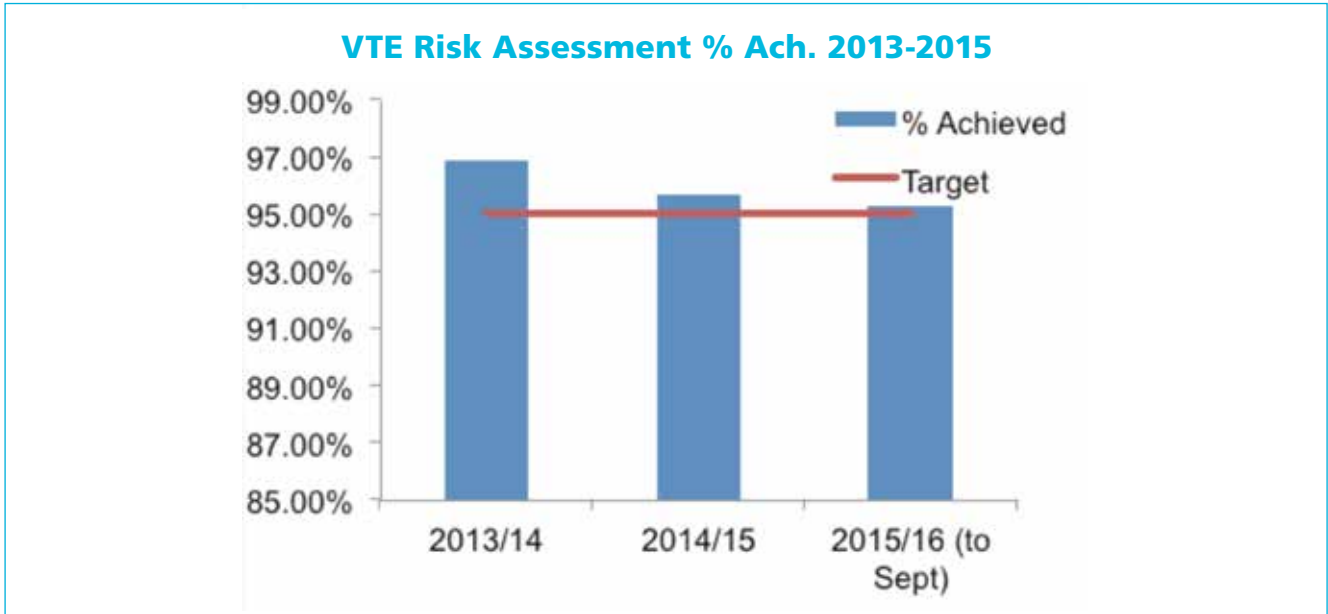
Providing information to both patients and staff on recognising and reducing the risks of VTE is an important factor in our quest to reduce the incidence of VTE. Information leaflets are widely available for patients and carers.

There are many risk factors for the formation of blood clots including advancing age, obesity, previous episodes of VTE, certain co-existing conditions (e.g. cancer) and even long haul flights. VTE can also occur during or after a stay in hospital. Risk factors in this case include the condition and/or procedure for which the patient is admitted.

The national target is to assess at least 95% of patients on admission for their risks of developing VTE and, following this, provide appropriate thromboprophylaxis (measures to reduce the risk of VTE) to at least 90%.

In the first half of 2015/16 (April – September), for which we have reliable data, the average rate of VTE risk assessment was 95.14%.





In the preparation for and post 'Go Live' period since the implementation of our new Patient Administration System, the reliability of data has reduced. For this measure the main impact has arisen from backlogs in the clinical coding of patient notes, including for VTE.

This is being closely managed internally and scrutinised by the Trust's commissioners to ensure coding backlogs are cleared and a true picture obtained of the continued delivery of this standard.

Since 2013 VTE training has been mandatory for all clinical staff. We are making good progress in delivering this (see graph below) with more than 75% of clinical staff having received it.

In order to improve the safety and quality of our practice, we currently perform a root-cause analysis review of the care provided to approximately 50% of patients who develop VTE during or after their stay in hospital. We will increase this to 100% during the 2016-17 financial year.

We will also be introducing risk assessment and thromboprophylaxis (where appropriate) for patients with lower leg fractures who require a plaster cast and can be managed as outpatients.

### Management of Sepsis

Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs. Infections which can give rise to sepsis are common, and include lung infections, urine infections, and infections in wounds or the joints. Sepsis can lead to shock, multiple organ failure and death, especially if not recognised early and treated promptly.

Sepsis accounts for 44,000 deaths annually in the UK and is a medical emergency. Patients with the most severe forms of sepsis are up to five times more likely to die than patients with a heart attack or stroke. Caught early, the outlook is good for the vast majority of patients. Treatment should be started within one hour of sepsis being suspected.

NBT has a sepsis working group who meet monthly to work on improvements in identification and management.

## What we achieved

- We screened 100% of patients who presented to the Emergency Department who needed screening using our electronic patient triage form.
- We improved our antibiotic delivery within 1 hour of entering the emergency department from 50% at the end of September 2015 to 83% at the end of December 2015.
- We are testing a new tool to improve sepsis identification on our surgical and medical wards.
- We have delivered sepsis training to staff in the Acute Medical Unit.
- All patients who are admitted with or develop sepsis whilst in hospital have this information included on their Handover of Care Discharge Summary to improve communication to the GP Practice when they leave hospital.

## Medicines Management

The Trust has an excellent reputation nationally as being at the forefront of improving safety in medicines management.

This commitment to safety and quality improvement is no better illustrated than by the recognition we've received in 2015:

- We have been shortlisted for 3 national awards:
  - "Patient Safety Congress" – Patient Safety Awards (July 2015: Birmingham)
  - "Pharmaceutical Care Awards" (June 2015: London)
  - "I Love My Pharmacist Award" (November 2015)
- We have presented at 2 National and 3 European conferences.
- Our work has been published in:
  - NICE's Local Practice Collection (March 2015)  
**[www.nice.org.uk/savingsandproductivityandlocalpracticeresource](http://www.nice.org.uk/savingsandproductivityandlocalpracticeresource)**

Since 2007 we have made ongoing improvements and as part of our Medicines Quality and Improvement work we continue to remain focused on the following 3 areas;

- Medicines Reconciliation
- Missed doses
- Warfarin

## Medicines Reconciliation

### Why is this important?

Ensuring an accurate record of medications on admission to hospital is important for safe treatment. Reconciliation is a process of confirming the medication that a patient is taking with at least two independent sources of information.

Prescribing errors can result in harm to patients and the aim of this process is to ensure when patients are admitted to hospital that important medicines aren't stopped and that new medicines are prescribed, with a complete knowledge of what a patient is already taking. NBT set a target of 95% for patients admitted to have their medicines reconciled within 24 hours.

### Progress to Date

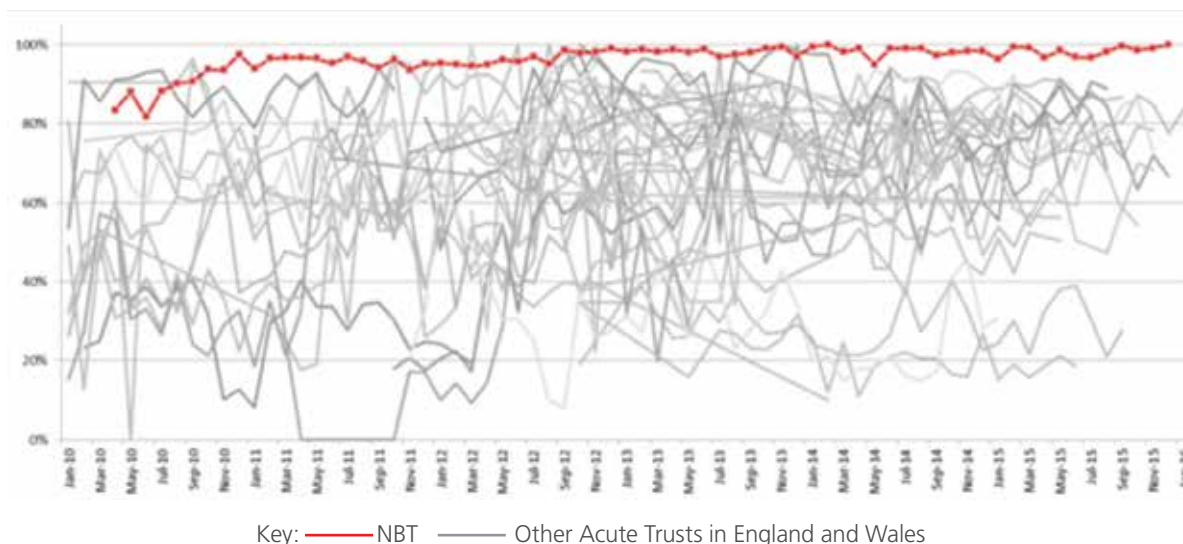
#### QIPP Benchmarking Data: 2010 – 2016

In 2012 our data was submitted to the national "Quality, Innovation, Productivity and Prevention" (QIPP) benchmarking and still shows that NBT is the best performing Trust in England and Wales.

### Future work

Now that the team has achieved and maintained our target, we are continuing to monitor and review results but are now starting to focus on Medicines Reconciliation on discharge and have several discharge work streams.

**Chart 11 - Percentages Medicines Reconciliation on Admission 2010 – Jan 2016**



## Missed Doses

### Why is this important?

Avoiding missed doses is important to ensure a patient’s care is not compromised. Missed doses were highlighted as an issue at the Trust following a review of incident forms.

### Progress to Date

Progress on reducing “missed doses” has generally been shown since 2010. Pharmacists continue to measure missed doses on a daily basis and wards also collect data. Medicines Management Technicians and Pharmacists contribute to investigating incidents and look to remove underlying causes.

Results deteriorated after the move to the new hospital but this is now starting to improve. We are now targeting wards breaching the target on the monthly reports. The team are working closely together to ensure improvements are being made and a new Safety Briefing is being finalised together with an updated flow diagram on how to access drugs and avoid missed doses.

### Future work

We also undertook work on patients with Parkinson’s disease in association with the “Get It on Time” campaign to ensure that these patients do not miss crucial medication. This is now being reviewed to re-highlight to those wards linking in with the testing of the new prescription chart.

## Warfarin Control

### Why is this important?

Warfarin is an anticoagulant and is a high risk medicine that can cause increased risk of bleeding when there is poor control of Warfarin management.

### Progress to Date

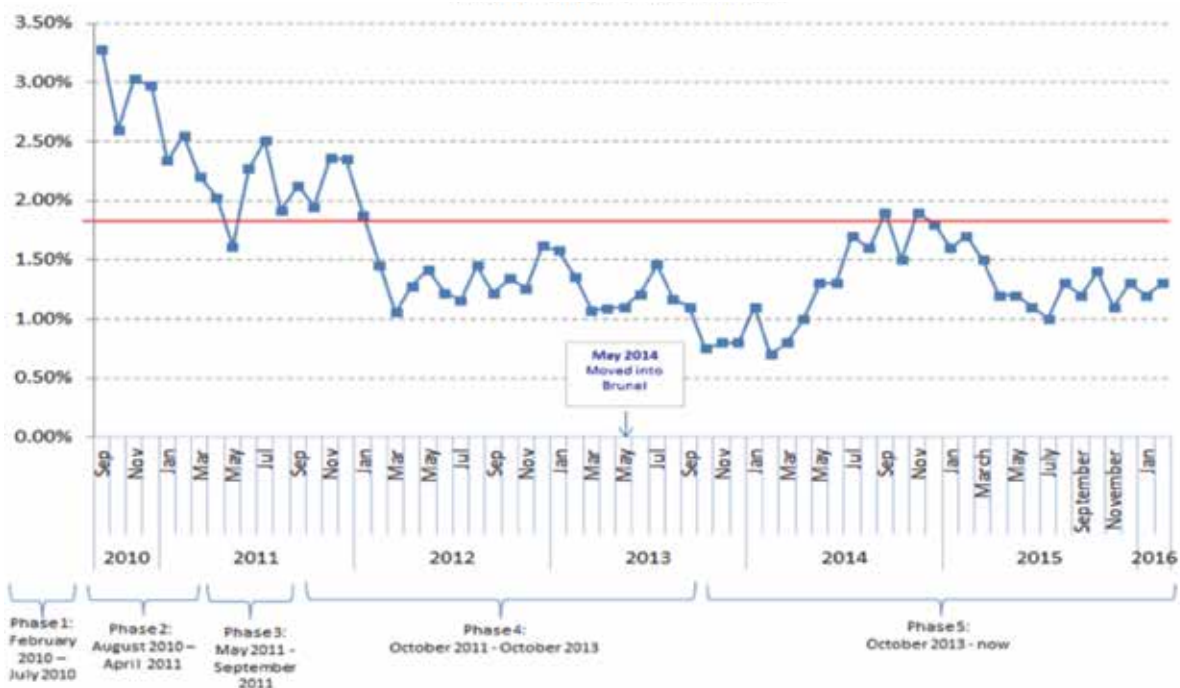
Since 2011 we have worked on improvements by monitoring causes of high International Normalised Ratio (INR) levels. We identified that interacting drugs and inappropriate prescribing were the main causes. We have therefore updated our anticoagulation chart to allow prescribers and pharmacists to more prominently display interacting medications, and made a change to the low dose loading regimen for Warfarin. Key important themes have also been included in a doctors and nurses e-learning package launched in 2014 and 2015 respectively.

### INR greater than 6 for inpatient having INR tests for Warfarin control

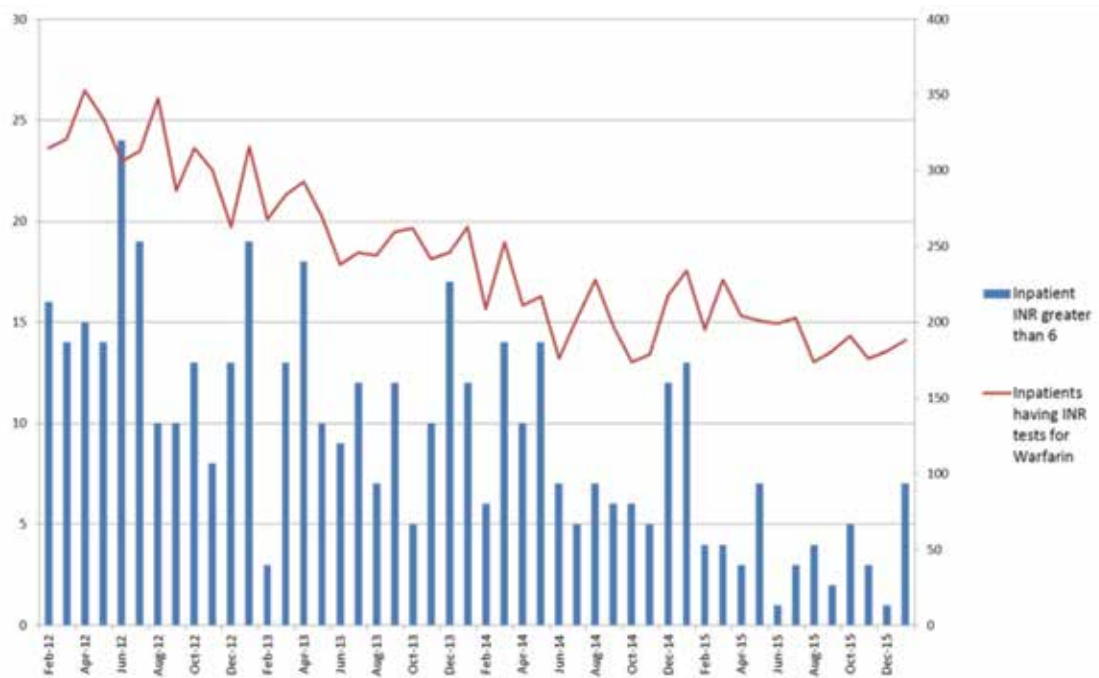
The run chart shows the reduction in the number of NBT inpatients having an INR greater than 6. A medication safety alert for Warfarin was circulated in November 2014 to all clinical staff.

The newer oral anticoagulants Apixaban, Rivaroxaban and Dabigatran are now widely prescribed and constitute a bleeding risk. Patient safety work with these medicines has included a patient information leaflet, Anticoagulation Alert Cards, patient counselling checklists and a Medication Safety Alert in March 2015.

**Chart 12 - Percentage of patients with one or more missed doses across NBT**



**Chart 13 - INR Greater than 6 for inpatient having INR tests for Warfarin control**



**Future work**

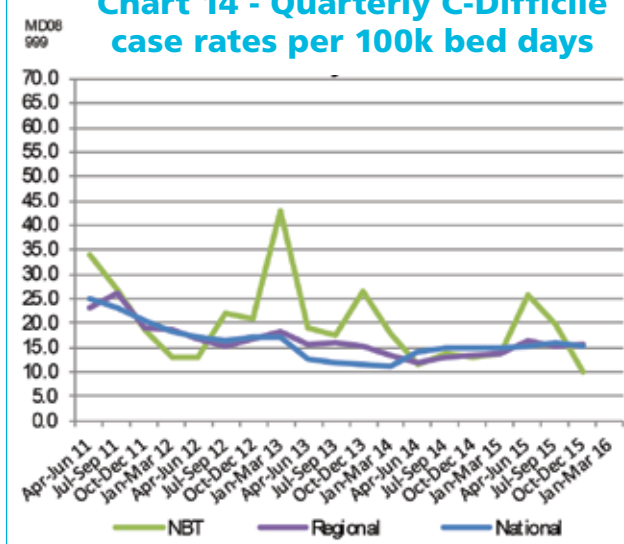
We plan to feedback findings of mini root cause analysis for inpatient INRs greater than 6 to directorate Clinical Governance leads quarterly.

**Reducing Harm from Infection**

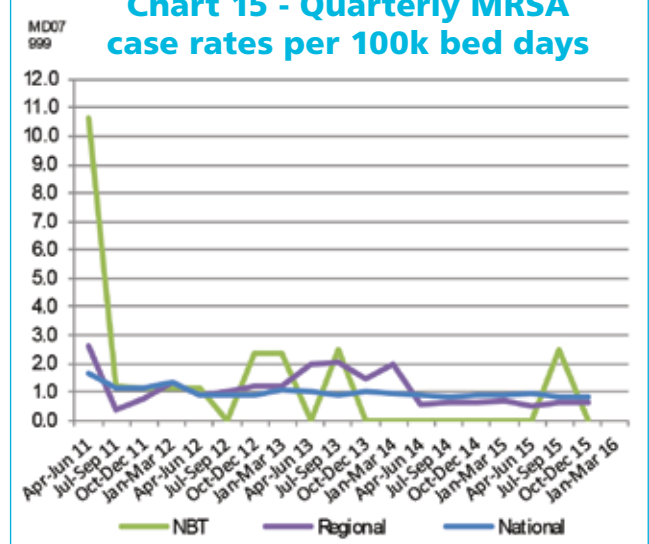
A healthcare-associated infection can occur in any patient receiving care in a healthcare setting, with the potential to delay recovery and affect quality of life. At North Bristol the prevention of healthcare-associated infections remains one of our key priorities ensuring the safety and quality of care to all those receiving treatment in our hospital.

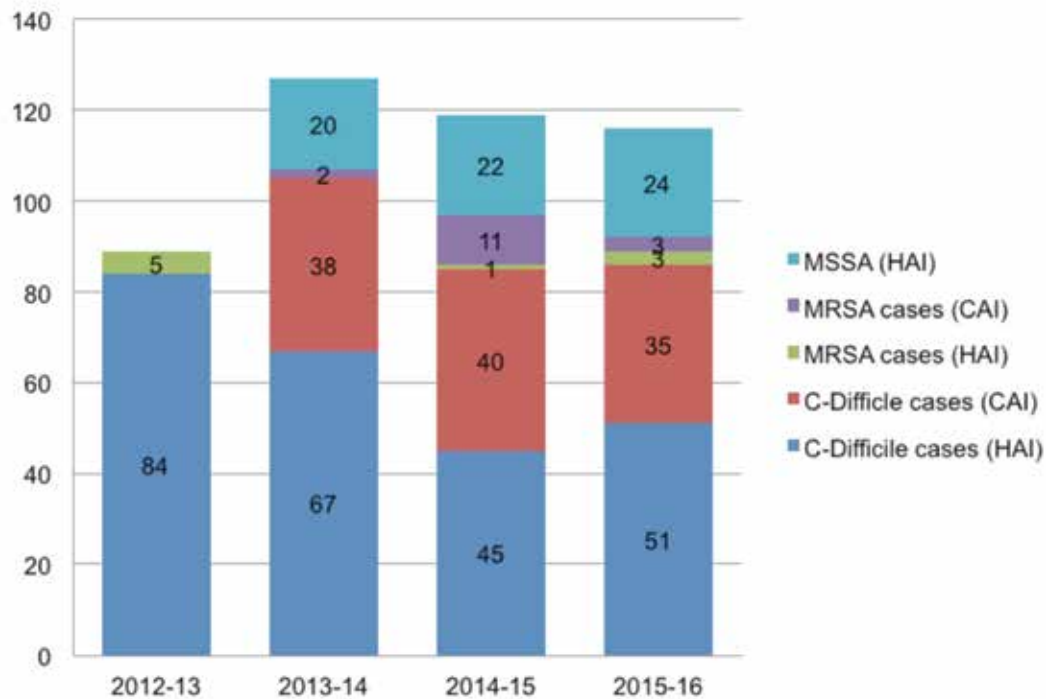
The Trust’s compliance with infection prevention and control standards and rates of infection is monitored against nationally recognised frameworks which include the Hygiene Code (DH, 2008) and the National Institute of Clinical Excellence (NICE). The Trust’s Medical Director holds the position of Director of Infection, Prevention and Control (DIPC) supported by an established infection prevention and control team who are responsible for ensuring the implementation and facilitation of best practice and investigating cases relating to healthcare associated infection, the emphasis that the prevention of infection is the responsibility of every member of staff employed by the Trust with the message that IPC is “everyone’s business”.

**Chart 14 - Quarterly C-Difficile case rates per 100k bed days**



**Chart 15 - Quarterly MRSA case rates per 100k bed days**



**Chart 16 - Infection control Cdiff, MRSA, MSSA**

Having had zero incidence of hospital acquired MRSA bacteraemia since September 2013; it was disappointing to report 3 MRSA Bacteraemia for 2015/16, with the first case occurring in August followed by one each in September and January. Each case was individually investigated to establish the root cause, with actions in place from those lessons learnt. The key areas for improvement were the embedding of recommendations for MRSA patient screening, and the care and management of indwelling devices.

C. Difficile infection (CDI) remains an unpleasant and potentially severe infection that occurs within healthcare especially to those who have had antibiotic treatment. The Trust continues to work very hard at reducing the number of patients acquiring C Difficile whilst in our care. Each year the Trust is set a national target which for 2015/16 was 43 cases. This was significant reduction on the trajectory from the previous year (2014/15) of 79 cases. In addition to the target of 43 cases there has also been national recognition that some cases of CDI are outside the control of the healthcare setting that detected the infection.

An individual investigation takes place to understand if there have been any lapses in the quality of care provided in each case. This process has been in place for several years at NBT, which has had a positive impact in the reduction of incidence. Key themes and actions have centred on the cleanliness of the environment and point of care equipment and early detection through prompt sampling.

In 2015/16, 51 cases of CDI were reported against a target of 43, however only 32 of these were as a result of a lapse in care at the Trust, therefore below the national target.

The Trust will continuously strive for reductions of infection acquired by patients cared for by the Trust.

### Screening for and treating alcohol related conditions

Alcohol dependence affects 4% of the adult population in the UK. Nearly 1 in 4 of adults drinks alcohol at a harmful or potentially harmful level. It costs the NHS around £3.5 billion a year.

Alcohol related liver disease is a disease of the young. The average age of death is 59 years. The mortality from liver disease continues to rise whilst deaths from conditions such as heart disease, diabetes and cancer is falling year on year.

There was a national and confidential enquiry into patients with alcohol related liver disease in 2013 which came up with a number of key recommendations. A working group was created to address these recommendations.

### What we achieved:

We implemented an expansion of the alcohol specialist nurse (ASN) service from 1 nurse to 2.8 WTE nurses. A review of attendances related to alcohol in North Bristol showed that when a patient attended hospital for an alcohol related issue and they were seen by an ASN, the chance of them coming back to hospital was 5% compared to 15% when they didn't see an ASN. The ASN also attends the weekly liver clinic which provides opportunistic intervention for patients who may not wish to engage with community support services.

A Bristol-wide strategy was created in 2015 to improve medical assessment of alcohol related harm. This includes formally screening more patients attending hospital for alcohol misuse with an evidence based tool and using different detoxification regimes to what were used previously, which are shown to reduce the length of stay and be safer.

Currently 10 of the wards are using the new system and the screening tool has been incorporated into the admissions proforma for people admitted into the directorate of Medicine. Since the new proforma has been introduced, the percentage of people being screened for alcohol misuse has increased from 35% to 65% in 6 months. A deficiency has been noted in screening patients over the age of 65 and this will be a focus of improvement in the upcoming months by positively improving the culture of asking everyone about their alcohol use.

A 'liver care bundle' has been created to standardise the approach to patients attending the hospital with liver cirrhosis. This ensures timely investigation and management of this condition with early identification of infections and kidney failure which can be fatal if not identified early in this group of patients.

The management of patients with alcohol related liver disease has been incorporated into a number of teaching programmes for various levels of junior doctors and the identification of alcohol misuse and management has been included into the Trust induction programme which occurs monthly for all new clinical staff.

### Improving Theatre Safety - 5 Steps to Safer Surgery and World Health Organisation (WHO) Checklist

During 2015/16 Team Theatres have been focussed on continuing the work related to Improving Theatre Safety which was identified as a priority in 2014/15.

The 5 steps to Safer Surgery continue to be used for all patients undergoing an invasive procedure in the Operating Theatres and the Interventional Radiology Rooms.

These are listed as:

- STEP 1: TEAM BRIEF
- STEP 2: SIGN IN
- STEP 3: TIME OUT
- STEP 4: SIGN OUT
- STEP 5: TEAM DE-BRIEF

Every member of the team is involved with these 5 steps and is encouraged to speak up if they have any concerns or questions related to the patient and the procedure which is taking place.

This ensures that through effective communication the safety of the patient is maintained - the correct patient is having the correct operation supported by staff with the appropriate experience and skills and that the right equipment is available.

Compliance with the 5 Steps to Safer Surgery and WHO Checklist is measured against a target of 100% with 2015/16 performance achieving 92.6% for WHO and 84.8% for Safer Surgery. This shows a decrease in compliance from 2014/15. This information is taken from an electronic Theatre Information System. In addition, a paper WHO checklist is completed and retained in the patient's notes. In order to improve this position, a daily review of operations where a WHO checklist has not taken place is being completed. This allows for a review of the patient's notes and checking for a checklist. If present this can then be inputted on to the electronic system retrospectively.

Work has commenced to change the way that patients are booked for emergency operations moving from a paper based system to using an electronic system which is already used for the booking of x-rays and laboratory tests. The benefits of this are that will improve safety as patients are booked in using their dedicated hospital number with specific operation details, it will allow for auditing of efficiency of the emergency operating lists to ensure that patients are getting their procedures within an appropriate time scale and that the resource is being used efficiently.

To guarantee that staff have the appropriate skills and experience a formal system for measuring skills and gaps in skills has been introduced within Team Theatres – the 'Skills Matrix'. Alongside this set supernumerary periods have been agreed to support new staff into the Theatre environment allowing them to gain the basic skills required and on which to build.

Additional instruments have been purchased and introduced into the system to make certain that the correct instruments are available, and there has been reduction in the non-conformance with decontamination standards which assures that instruments are safe for use.

A new role is being introduced for the development and delivery of a multi-professional simulation based education projects focussing on human factors training including simulation of emergency situations so that all involved know their roles and are prepared.

### Improving Emergency Laparotomy Care at NBT

NBT has been participating in the National Emergency Laparotomy Audit since 2013, which aims to improve care in this high risk patient group. We collect information on all patients having this emergency surgery including preoperative risk assessment, treatment of sepsis, time to theatre, consultant supervision in theatre, postoperative care, mortality and lengths of stay.

Since September 2015, NBT is one of 30 Trusts in England participating in the Emergency Laparotomy Collaborative (ELC). The ELC is a two-year quality improvement project aimed at improving standards of care and outcomes for patients undergoing emergency laparotomy. We aim to save 1000 lives over the next 2 years.

We have introduced a six-step care bundle to standardise patient care from admission to postoperative stay. This includes:

1. Use of National Early Warning Score (NEWS) and measurement of lactate to identify patients most at risk, and the delivery of prompt resuscitation.
2. Use of a sepsis screening tool to identify septic patients and treatment with Sepsis Six.
3. Surgery within 6 hours of decision to operate.
4. Appropriate goal directed fluid resuscitation in theatre.
5. Postoperative critical care for all patients.
6. Consultant led care throughout.

We have introduced a new theatre booking system for emergency laparotomy cases to ensure the preoperative steps are being completed. We are monitoring our compliance with the introduction of these improvements and give timely feedback on our progress to all the theatre team. We meet regularly with other Trusts to share data and ideas on best practice.

### Managing Patient Safety Incidents & Implementing the Duty of Candour

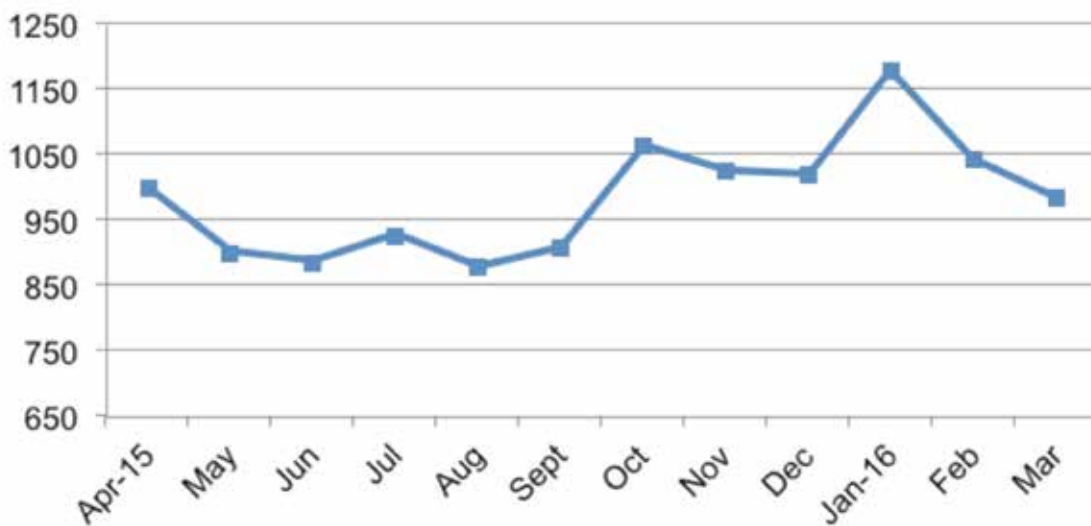
The Trust is committed to minimising the risk of harm to patients in the course of their treatment and care. However, incidents do occur and we aim to adopt a pro-active approach to prevent incidents and learn lessons to improve patient safety. An open and learning culture operates within the Trust and all patient safety incidents are reported to the National Reporting & Learning System (NRLS) and the Care Quality Commission (CQC).

The Trust adheres to the principles of Being Open and Duty of Candour as defined by National Health Service England

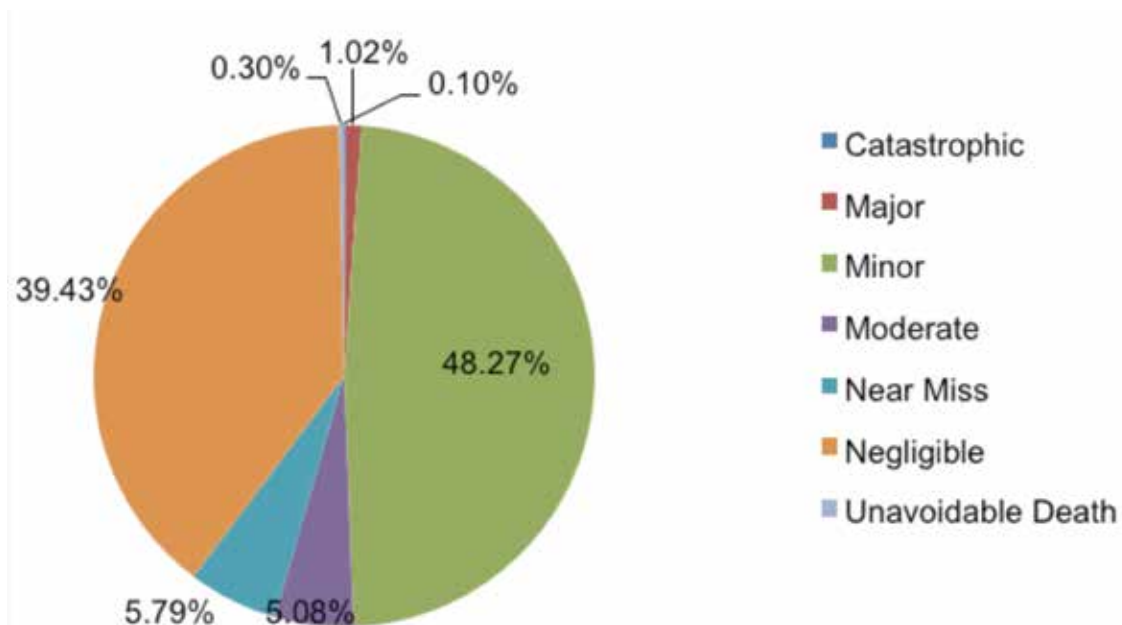
(NHSE). The Duty of Candour ensures incidents resulting in harm of moderate levels or worse are investigated and a structured process followed to ensure the patient, patients’ families or other involved persons are informed throughout the investigation and provided with explanations of the investigation findings.

We have actively promoted staff awareness of the Duty of Candour process since its introduction in April 2015 and guidance is available to all staff on the intranet. Further changes have been introduced with the revised Serious Incident Framework and the Never Event Framework published by NHSE for the 2015/16 financial year which has been reflected in the Root Cause Analysis (RCA) process for Serious Incidents (SI’s).

**Chart 17 - Total Patient Safety Incidents Reported April 2015 to March 2016**



**Chart 18 - Actual Impact April 2015 to March 2016**





**Chart 19 - Trustwide Serious Incidents Rate per 1000 Bed Days: April 2015 – March 2016**



RCA training is delivered on a monthly basis to senior staff to enable ongoing improvements in the quality of SI investigations. Further e-learning packages are being introduced to ensure staff know when and how to report and manage incidents.

All new staff attend an induction programme where patient safety is part of the curriculum, thus introducing them to the principles of a good patient safety culture from the outset.

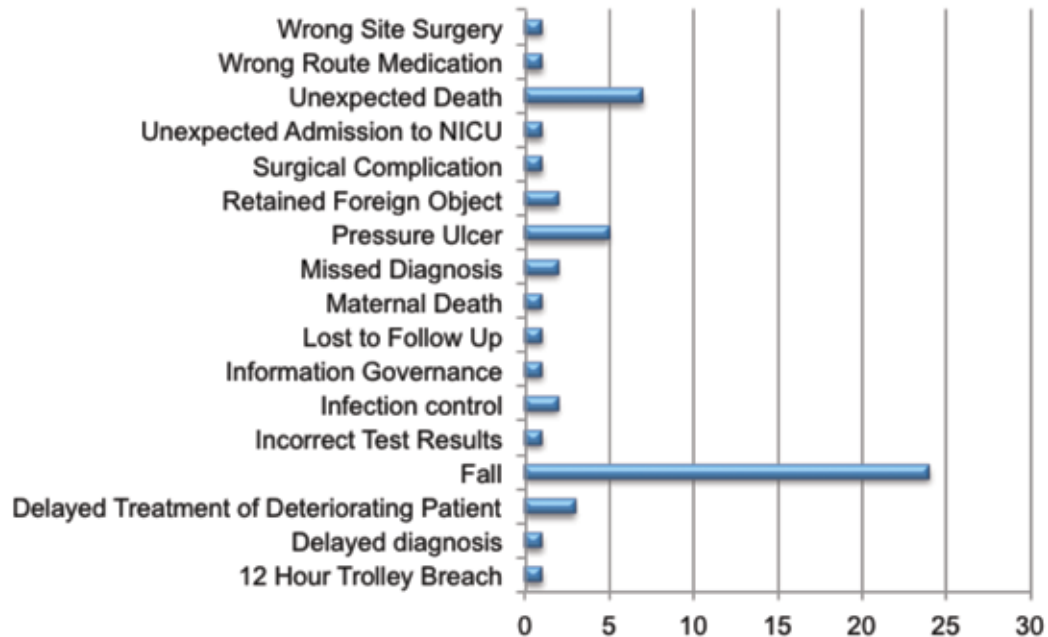
Organisational feedback reports from the NRLS indicated a reduction in the level of reporting from NBT at the lower end of the mid-range of national reporting figures last year. In response to this, an improvement plan is now in progress

to address the issues. This has had a positive effect on the number of incidents reported since September (chart 17).

A high proportion of incidents resulted in either no harm or low harm to patients, which demonstrates a positive approach to incident reporting and a pro-active safety culture (chart 18).

There were 56 SI's investigated from April 2015 to March 2016 (compared to 87 in 2014/15). All of these incidents were thoroughly investigated and an action plan for each incident was implemented. All Root Cause Analysis reports and the implementation of action plans are agreed and monitored by the Trust's Clinical Risk Committee.

**Chart 20 - Incidents – Types of SI's reported April 2015 – March 2016**



## Types of Serious incidents reported to STEIS April 2015 to March 2016

The rate of Serious Incidents reported per bed day across the Trust has varied per month over the past year (chart 19). Of these, the Trust has seen a positive decrease in the number of pressure ulcers occurring in hospital. However, serious falls incidents remain an issue and the Trusts falls group are working hard to address the problem (chart 20).

### Never Events

'Never events' are a particular type of serious incident that are wholly preventable and have the potential to cause serious patient harm. NHS England reference these types of incidents as there is evidence that they have occurred in the past and barriers are now in place to ensure they should not occur in Health Care. These types of incidents are easily recognised and clearly defined as such in the Never Event Policy Framework (NHS England 2015). There were three confirmed never events reported by the Trust in 2015/16, details of which are as follows;

#### 1) Retained Foreign Object

A patient was admitted to Southmead Hospital for an elective High Anterior Resection. During the operation a Wound Protector/Retractor was used.

Three days later the patient became unwell. A CT scan was requested and carried out. This was reported – 'there appears to be a circular prosthesis underlying the ileostomy site'. Later the same day the patient returned to theatre, the wound was reopened and a wound protector/retractor was removed.

At completion of the operation, Consultant surgeon contacted the patient's wife and informed her there was a foreign body which she had removed and the patient was recovering.

The main points identified in the investigation were;

Root Cause:

- The wound protector/retractor was not included in the count and therefore not identified as "missing"
- Although the Swab, Instrument and Needle Count policy states disposable items to be included in the counts, there are a number of items that are not routinely counted. This includes wound protector/retractors as the visual size, including the outer rigid ring and how it was used, meant it would not be able to "slip" into the abdomen

The following learning points have been taken forward:

- At all times Scrub Practitioners must be aware of the location of all swabs, needles, sharps, disposable items, instruments and medical devices
- All items entering the sterile field to be part of the swab, instrument and needle counts
- Theatre senior staff to observe swab and instrument counts carried out, to ensure the quality of these counts
- When enlarging an incision after the wound protector has been placed, surgeons to consider using a larger wound protector

#### 2) Wrong Site Surgery

A patient with progressive myelopathy due to cervical spinal cord compression at C4/5 was admitted for a C4/5 Anterior Cervical Discectomy + fusion + plate.

During the operation the level was checked with the image intensifier and C5/6 was misinterpreted as C4/5. The patient had a fusion at C5/6. This error was recognised when further x-rays were taken before plating. Plating of C5/6 was completed. The correct level, C4/5, was identified and discectomy with fusion and plating was carried out.

The patient and her husband were informed soon after the operation.

Post op x-ray and scans carried out prior to discharge were satisfactory. On discharge, the patient stated her left thumb symptoms are now better, and was discharged the same day having recovered well from the surgery.

It was identified that the radiopaque retractor blade was misinterpreted as the marker for C4/5.

The surgeon confused the intraoperative level marker with the radio opaque blade of the cervical retractor which looks very similar.

The following learning points have been taken forward:

- There is no nationally agreed technique or protocol for confirming the level of surgery.
- There is a risk of confusing artery clips used as surgical level markers with radio opaque retractor blades on an X-ray.
- Further work is underway to monitor current practice and identify the occurrence of this type of incident as a National concern.

#### 3) Wrong Route Medication

A 41 year old gentleman admitted to the Emergency Department with decreased conscious level following illicit drug use.

The patient received a wrong route administration of oral medication via an intravenous cannula. There was no adverse effect on the patient as a result of the incident.

It was identified that a lack of oral syringes within the isolation suite resulted in a breach of oral medication administration policy.

Also, internal escalation status in the hospital resulted in the member of staff lone working in an isolation area whilst night staff supported the Acute Medical Admissions Unit.

The recommendations identified from the investigation were:

- Enteral syringes must be used for oral liquid medication administration
- Medication should not be left unattended
- Distractions should be avoided whilst administering medication
- Safe staffing levels should be maintained at all times within the isolation unit and lone working should be avoided
- Housekeepers to ensure enteral syringes are stocked at all times within the isolation suite. This is included in their daily working schedule
- Review staffing within isolation suite, recommend no further lone working
- Purchase mobile phone to enable easy access to nurse in charge on 27b
- Registered nurse not to administer medications until reassessed as competent
- Registered nurse to complete Managed Learning Environment medicines management online



## Section 3 - Patient Experience

### National Maternity Survey

The national survey of maternity services was published by the Care Quality Commission in December 2015. This survey is undertaken every 2 years. The overall response rate for North Bristol Trust was 53% (the overall national response rate being 41%). Both Cossham Maternity Hospital & Southmead Maternity Hospital were included in the survey.

The survey data was reviewed with other information from patient complaints and the Friends and Family Recommender Test. Whilst there are many compliments and positive comments from our mothers the need to improve communication was noted and action has been taken which includes a training session within a regular study day for midwives, doctors and maternity care assistants on communication, customer care and scenarios of poor communication.



Other areas for improvement from the survey area are as follows:

- Labour and Birth:
  - Ensuring our patients are involved as much as they want to be in decisions about care.
- Postnatal Care:
  - Ensuring mothers have enough information about emotional changes that may be experienced.
  - Ensuring all mothers are always treated with kindness and understanding.
  - Ensuring mothers are able to get help from a member of staff within a reasonable time.
  - Enabling anyone close to the patient to be able to stay as long as possible. N.B. Recliner chairs are now by all postnatal and antenatal beds to enable partners to stay.
- Postnatal carer at home
  - To seek to improve access to breast feeding advice during evenings, nights and at weekends.
- Feeding:
  - Antenatal
- Full discussion of infant feeding during pregnancy.
  - Post Natal
- Receiving consistent advice.
- Receive support and encouragement.
- Full discussion on infant feeding (where not fully discussed during pregnancy).

### Involving our Board in reviewing the quality of Patient Experience

In 2015-16 considerable work was undertaken to improve the existing connections between frontline clinical teams and the Executive and Non-Executive Directors who make up the Trust Board.

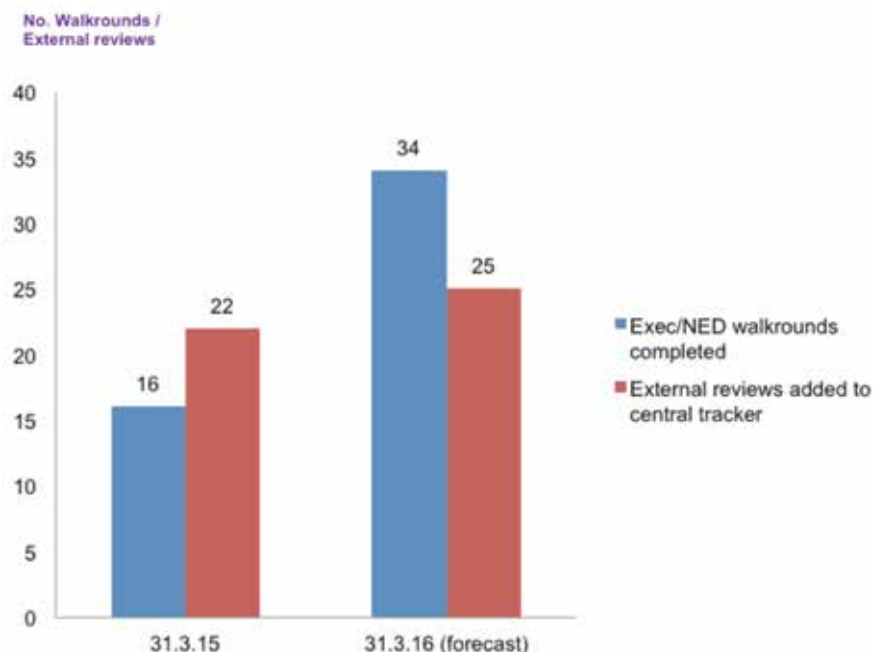
Executive Safety Walkrounds have been a long-standing activity at the Trust, viewed as crucial in connecting the most senior-level managers with staff involved in the frontline delivery of care – enabling them to observe, enquire, speak to patients, and make time to learn about local issues, success stories and innovations, and in doing so take forward key actions and ideas to improve the experience of our patients and staff.

A new walkround programme was initiated this year, which involves an improved feedback form for the wards, an enhanced schedule which now sees each Executive complete at least 6 walkrounds per year across more locations, (this includes our mortuary, discharge lounge, dialysis units and other off-site locations), a ‘Summary of Learning’ report to the Trust’s Quality & Risk Management Committee and - for the first time - a new Non-Executive Director (NED) walkround based on the national 15-Steps Challenge.

The 15-Steps Challenge is a national toolkit produced by patients to help trusts on their continuous improvement journey. It focuses on the patient/relative perspective on first entering a ward or clinical area and the various factors which instil confidence in the quality of care that they will receive. Given the success of this tool among Boards at other Trusts, we decided the 15 Steps to be a good framework to base our new NED walkrounds on – observing areas with a more holistic view, particularly suited to role of the NED within an NHS Trust.



**Chart 21 - Risk/Compliance – Executive Walkrounds and External Review**



Each of our 7 NEDs, including the Trust Chairman, have completed at least one 15-Steps style walkround this year and, due to their success, are now scheduled to complete a further 2 each during 2016-17. The informal format of “coffee and chat” with the Matron and Sister for the ward before the walkround, followed by debrief and discussion of actions at the conclusion of the walkround have been felt positively by both our NEDs and nurse managers.

Our target for 2016-17 is for 62 walkrounds to take place, covering all of our main services and locations, and allowing greater staff contact with our Executive and Non-Executive Team. We aim to continually improve the feedback loop between ward and board, and the sharing of - and ultimately ability to act on - information in both directions.

## Friends and Family Test – Patients

### What is FFT?

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience.

It asks people if they would recommend the service they have used to their family and friends if they ever needed to use it. There are a range of responses available including the opportunity to explain why they have given that response. This commentary is vital to help us make improvements and celebrate that we are doing well.

The opportunity to give feedback should be provide to all patients attending outpatient clinics; those who are inpatients and those attending the emergency department. Maternity services offer the opportunity to their mothers and mums to be at 4 points of their care.

### Response rates:

The overall response rate against the required target by these services is provided in table 10 below, as well as the percentage of patients that would recommend the service to their family and friends. This shows that we have not been able to achieve the required national targets during the year on a consistent basis. Achieving increases in response rates is a key area of focus for 2016/17.

**Table 10: Overall % response rates against required levels and % of respondents recommending the service**

Area	Response Rate			% Recommend	
	Target	NBT	Mths ach.	NBT	National avege.
Inpatients	30%	22%	3	96.2%	95.0%
ED	20%	9%	5	92.9%	87.0%
Outpatients	5%	2%	0	92.9%	92.0%
Maternity	15%	13%	4	95.3%	95.3%

### What did our patients tell us?

The overwhelming feedback is of a really positive experience by patients, emphasising the importance of good communication, kindness, compassion and respect.

Themes from the inpatient comments analysis from the year 2015-16 for both positive and negative aspects are set out in Table 11 opposite.

**Table 11 - Feedback from Inpatient FFT**

Positive experience themes	Number of comments	Negative experience themes	Number of comments
Staff +	7030	Waiting / Delays: -	210
General Quality of Care: +	3830	Food / Catering: -	185
Food / Catering: +	738	Staff: -	165
Facilities: +	604	Facilities: -	135
Cleanliness: +	589	TV: -	126
Information: +	358	Noise: -	90
Environment: +	286	General Quality of Care: -	72
Comfortable: +	157	Staffing levels: -	59
Nursing Care: +	75	Information: -	55
Waiting / Delays: +	72	Environment: -	47
Communication between staff +	51	Communication between staff -	37
Involving family/carers +	26	Parking: -	28
Privacy: +	25	Moving Wards etc: -	25
TV: +	19	Discharge: -	22

## What changed?

The benefit of FFT is that the feedback is about that immediate experience. Whilst it is anonymous, actions can be taken to help improve matters for all patients. Below are some comments that patients gave us and the action that took place.

*"My experience towards the end of my stay was very good, but at the beginning it was very confusing and not easy to feel confident in their care because I kept being told something different and a lot of the nurses and doctors didn't seem to know what was wrong with me. It was much better when I had the same nurse for more than 1 day and 1 night. Communication between the different teams was very bad and clear communication with me was not often very good, which left me nervous and unsure."*

- Action taken: staff reminded of the need to ensure staff are clear what is happening with the patient and any changes are shared with the patients whilst ensuring the patient has understood.

*"Highly specialist neurological team worked their magic and got us the best present for Christmas, my mother's speech back. Areas for improvement, shelf in shower, so soap, shampoo and conditioner does not drop. Some patients cannot reach the floor."*

- Action taken: shelving put into shower facilities.

*"This hospital and staff have provided an amazing and comforting experience. The building and equipment are state-of-the-art and the dedication and team spirit of the staff is self-evident. It is a massive yes from me!"*

Other actions that have taken place across the Trust:  
TVs are now in place across ward areas in the Brunel building. Further work is required to establish TVs across the wards in maternity.

The quality and choice of food and availability throughout the day.

## Feedback from Healthwatch

During 2015-16 we have worked hard to build a positive and responsive relationship with Healthwatch as this provides valuable insight to us. We continue to receive feedback through Healthwatch of Bristol, South Gloucestershire and North Somerset of the experience of members of the public who have used our services. We respond and link this to our patient experience improvement actions, with formal reporting into our Patient Experience Group.

In August and November 2015 Healthwatch Bristol visited our Hospital and sought the views and experiences of those coming to the Brunel Building and from inpatients on a number of wards. The full report of this feedback and the recommendations & actions being taken can be found through the following link to the report

**<http://healthwatchbristol.co.uk/wp-content/uploads/2015/01/Healthwatch-Bristol-visit-to-Southmead-Hospital-November-2015-summary-reportCL.pdf>**

The key aspects of the report are as follows:

- Parking and transport – this remains a challenging issue but will greatly improve with the opening of Brunel Phase 2 and the increased patient and staff car parking this will bring in July 2016.
- The positive attitude of staff and volunteers.
- Information provision and understanding treatment.
- Getting in contact with the right department and people.
- Getting around the hospital – the Atrium ‘buggy’ was greatly valued; signage and way finding could be improved in certain areas.
- Single rooms- enjoyed by some but some older people found them lonely. The TVs have helped considerably.
- Food – quality and choice had improved, more choice for those on special diets was requested and the feedback is greatly valued by the Trust and has strengthened our relationship with Healthwatch.

*“The commentator said that they thought the entrance to the Brunel Building of Southmead Hospital is impressive and they like the internal shuttle buggy service which takes patients to their gate”*

*“The commentator said that they are not happy with the procedure involved with moving patients from different rooms or departments in the middle of the night, without any prior notice or the patient’s family being informed.”*

## Examples of patient comments through Healthwatch

*“Even the consultant pushed me in my wheelchair. I cannot fault the service at Southmead.”*



# NHS Staff Survey and Staff Friends & Family Test

## 2015 National Staff Attitude Survey – Recommendation to Friends and Family

The National Staff Attitude Survey is an annual survey that takes place during Quarter 3 of the financial year. This helps to ensure that the views of staff working in the NHS inform local improvements and provide input into local and national assessments of quality, safety and delivery of the NHS Constitution. All eligible staff in the Trust were invited to complete the survey during September to December 2015. 2636 staff responded, giving a response rate of 30% (compared to 25% the previous year).

Overall some improvements were made in the 2015 survey but we have further to go. We are building on the work we did in 2015 to improve by:

- Identifying the three Trust-wide changes that will make the most difference
- Engaging staff in the Directorates in identifying the key actions that will make the most difference locally

The score below corresponds to the survey questions relating specifically to staff recommendation of the Trust as a place to work or receive treatment. It is correlated from the following questions:

- Care of patients/service users is my organisation's top priority
- I would recommend my organisation as a place to work
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation

The score is from 1 to 5. 1 represents staff unlikely to recommend the Trust and 5 represents those likely to recommend the Trust.

**Table 12 - NHS Staff Survey 2015**

NHS Staff Survey 2015	NBT 2014	NBT 2015	National Average (combined Acute & Community Trusts)
Score out of 5			
Staff recommendation of NBT as a place to work or receive treatment	<b>3.32</b>	<b>3.64</b>	<b>3.71</b>

The table below shows the scores for staff experiencing harassment, bullying or abuse in the last 12 months and staff believing the organisation provides equal opportunities for career progression or promotion.

**Table 13 - NHS Staff Survey 2015**

NHS Staff Survey 2015	NBT 2014	NBT 2015	National Average (combined Acute & Community Trusts)
KF19 - % staff experiencing harassment, bullying or abuse from staff in previous 12 months	<b>26%</b>	<b>26%</b>	<b>24%</b>
KF27 - % staff believing the organisation provides equal opportunities for career progression or promotion for the Workforce Race Equality Standard	<b>86%</b>	<b>85%</b>	<b>87%</b>

These figures do not provide any significant conclusions in themselves; however we are undertaking work in both areas.

With respect to harassment and bullying, it is notable call volumes for the Harassment & Bullying helpline have been declining over the past three years, which may indicate a reduction in concerns. We are not complacent and are currently evaluating options for promoting the Trust's zero tolerance policy more actively.

With respect to equal opportunities, our Trust Equality & Diversity Manager is working closely with our Director of Operations Kate Hanham in her capacity as 'Gender Champion' to promote the Trust's Respect and Dignity Statement. This has been widely distributed, it is on the HR portal on the equality page and is included on the patient information screens in the Brunel and on the equality notice boards.

## Staff Friends & Family Test

In addition to the National Staff Attitude Survey, the Trust runs the Staff Friends and Family Test in Quarters 1, 2 and 4 of the financial year. The two mandatory questions the Trust is required to ask are:

- How likely are you to recommend North Bristol NHS Trust to friends and family if they needed care or treatment?
- How likely are you to recommend North Bristol NHS Trust to friends and family as a place to work?

The results from Quarters 1 and 2 of 2015-16 are shown below. The survey was conducted electronically and sent to all eligible staff. The results from Quarter 4 have not yet been received.

**Table 14 - How likely are you to recommend North Bristol Trust for care or treatment?**

	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Response Rate
Q1	18%	51%	21%	7%	2%	1%	17%
Q2	20%	51%	20%	5%	3%	1%	15%

**Table 15 - How likely are you to recommend North Bristol Trust as a place to work?**

	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Response Rate
Q1	10%	37%	24%	17%	11%	1%	17%
Q2	11%	37%	24%	16%	11%	1%	15%

We are proud that 71% of our staff would recommend us for care or treatment but aim to improve on this, building on the good outcomes that we achieve for patients.

There are two aspects to this:

- Continuing to improve the experience of patients in our Trust as well as the outcomes.
- Ensuring that all our staff, including those who work in non-patient facing roles, understand the progress we are making in achieving those improvements.

In a busy hospital it's easy to lose track of the great care delivered every day, so one of the ways we are addressing this is through celebrating and spreading good practice, for example, through staff induction, iCARE moments awards and the NBT Heroes awards.

## 'Ask 3 Questions' - developing shared decision making

### What is 'Ask 3 Questions' about?

As part of a local CQUIN (Commissioning for Quality and Innovation) initiative with Bristol CCG, NBT is trialling an initiative called 'Ask 3 questions' in three Outpatient specialities (Rheumatology, Colorectal and Vascular Surgery) from 29 February 2016. Patients attending outpatient appointments in these areas were given 'Ask 3 Questions' leaflets and postcards to encourage them to become more involved in understanding their treatment options and making choices that are right for them. Asking the 3 questions helped start the conversation.

### What did we do?

Two short videos were played in the outpatient area to help patients understand the 'Ask 3 Questions' approach and they were also given a postcard that offered more information. This also had additional space for writing any other questions they may have. The clinical lead for this work within the specialities discussed the approach with staff to enable the opportunity for patients to ask questions to be explicit in the consultation.

### 'The three questions are:

1. What are my options?
2. What are the possible benefits and risks of those options?
3. What help do I need to make my decision?

Before and during the implementation of 'Ask 3 Questions', we asked patients several questions relating to their involvement in decision making, its impact on them and whether staff focused on what was important to them.

### What difference did it make?

The survey results proved that the doctors were discussing with patients what was important to them in managing their illness, and as a result of this approach there was strong indication that patients felt better able to manage their condition or illness after using the 'Ask 3 Questions' approach.

### What next?

We are excited by the results and we will continue to roll this out to other outpatient areas over the coming year and monitor its impact. We will also use the principle of 'Ask 3 Questions' to support and empower patients to ask questions whilst they are attending appointments at the hospital.

## Managing Complaints and Sharing Compliments

### Complaints

Each and every complaint or concern received is important to the Trust as they provide an important feedback opportunity, allowing us to reflect on where things have fallen below our expected standards and in turn generating sustained improvements to our service across all aspects for the future. To ensure overall visibility of this important information at the highest level, the Chief Executive takes a 'hands on' interest by reading and signing off all formal complaints.

The overriding complaints challenge for the Trust this year was addressing the backlog of complaints associated with significant environmental and practice changes in moving to the new Brunel Building in May 2014. Common themes of these complaints included concerns about;

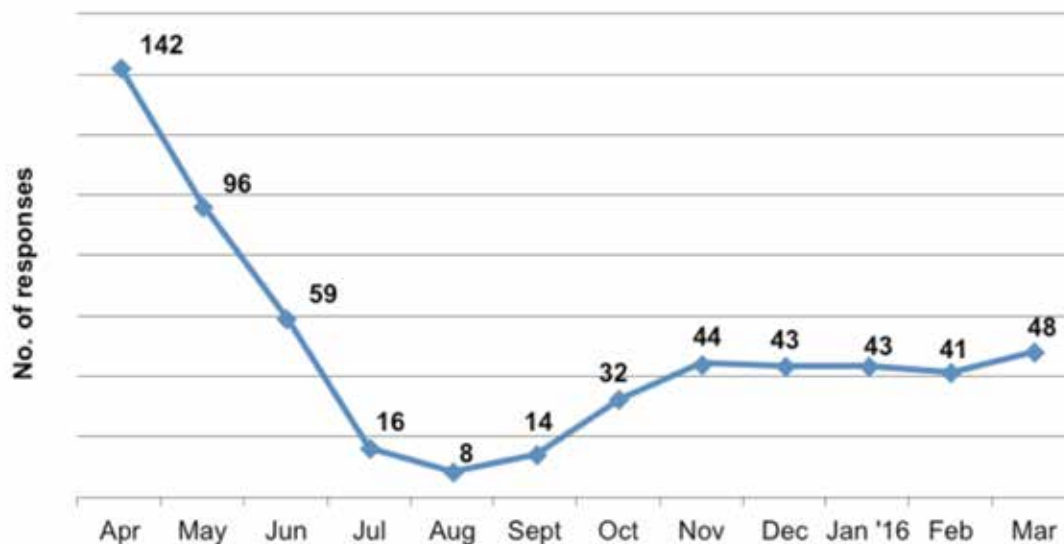
- Shortage of parking
- Crowded and un-coordinated drop-off access to Brunel Building
- Single patient rooms – lack of TV
- Move to system of centralised outpatient administration, and knock-on effect on patient appointments and letters

The graph below clearly illustrates the success the Trust has had this year in reducing the backlog of overdue complaints and in addressing the root of these complaints long term through taking the following actions;

- "Pay on exit parking" introduced.
- The drop-off area in front of the main hospital will continue to be manually policed until all Phase 2 construction is completed in the late spring, which will provide new access roads and more and improved visitor parking with direct access to the Brunel Building.
- TVs provided for patients' in all wards to supplement the improved entertainment options provided by free Wi-Fi.
- Out-patient booking services have continued to be reviewed to ensure a more responsive service.
- Departmental and outpatient clinic letters continue to be revised to improve clarity and ensure the correct contact details are included. This limited any adverse impact of the move to the new Patient Record System.
- New staff parking facilities provided as the Phase 2 construction progressed.

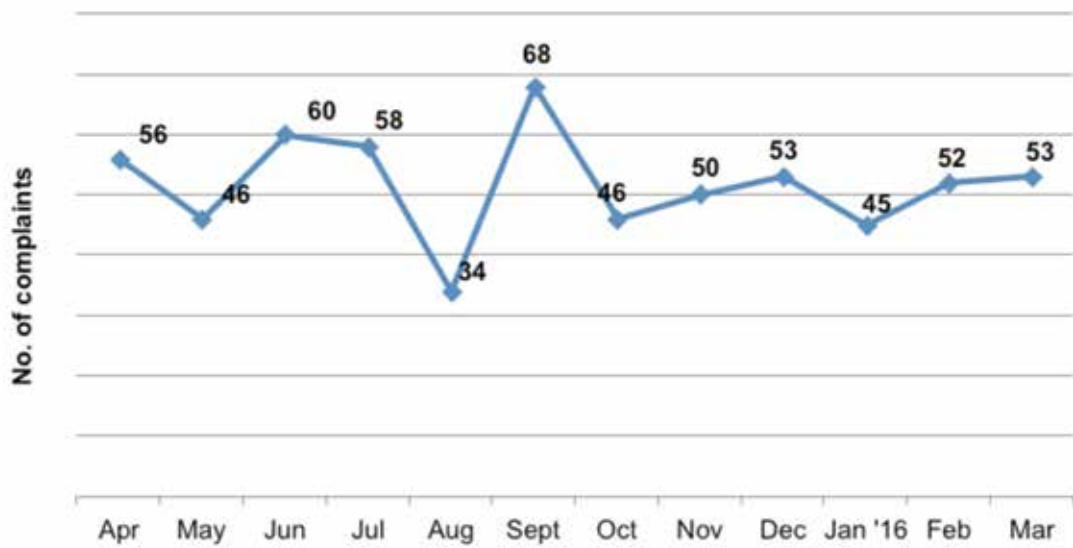
The increase observed in the latter part of the year can be explained in part by the transition to the Trust's new Patient Information System, which went live in December 2015. While the system is now embedding well within the Trust, this proves to be the next challenge in terms of addressing complaints associated with bookings made during, and immediately-post, the changeover of systems.

**Chart 22 - Complaint Responses Overdue 2015/16**



The relatively high number of complaints received during 2014/15 were due to the challenges associated with closing the Frenchay site and moving both hospitals into new accommodation. This has fallen by approximately 17.5% during 2015/16.

**Chart 23 -Total Complaints Received 2015/16**



Prior Years' Comparison

**Table 16 - Complaints**

Year	2012/13	2013/14	2014/15	2015/16
Number of complaints	832	757	1006	821
Rate of Complaints per 1000 patient episodes	2.26	1.3	3.4	4.19

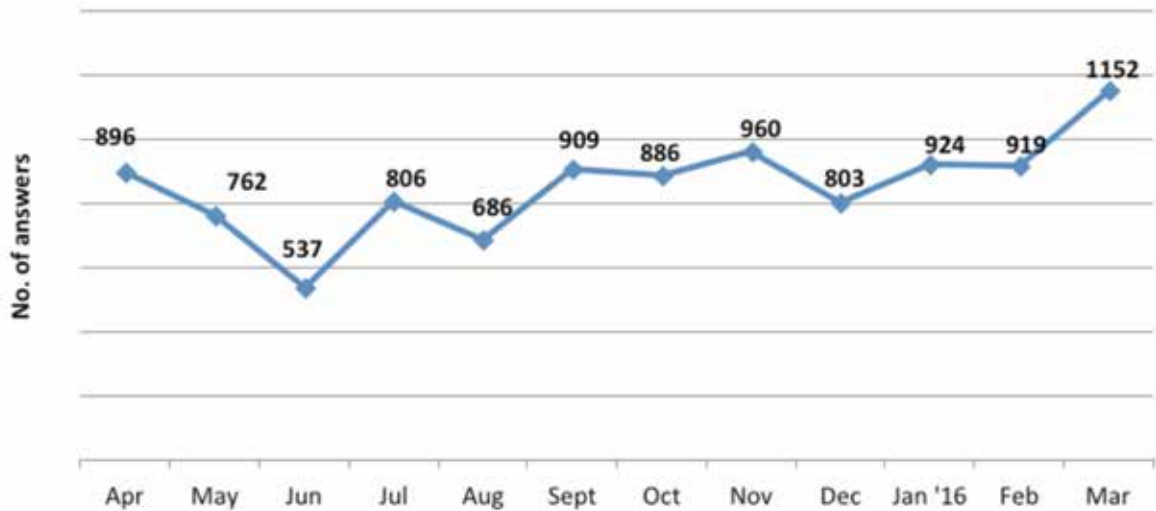
The overall total of cases received by the Trust increased reflecting the pattern of increased complaints across the whole of the NHS and the Trust's particular circumstances of another year of huge change.



### Enquiries & Informal Concerns

The Advice and Complaints Team (ACT) also successfully managed many low level concerns and enquiries outside of the formal complaints process, through a telephone helpline or by meeting patients in person. While these are generally going up in-line with increases experienced across the NHS as a whole, the variation in the numbers broadly reflect the expected seasonal trends.

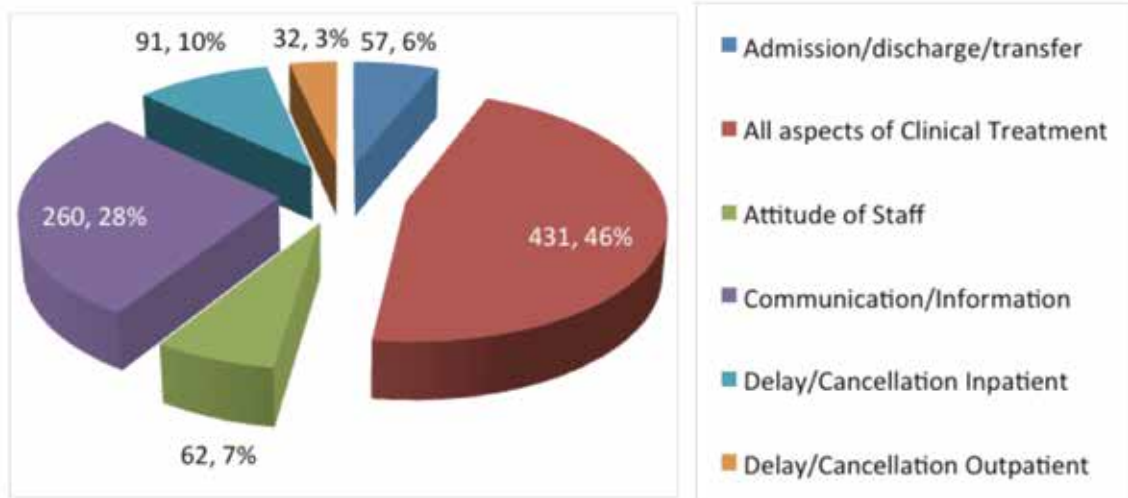
**Chart 24 - Total Enquiries Answered 2015/16**



### Complaint Themes:

The graph below shows a breakdown of the top 6 categories of complaint.

**Chart 25 - Complaint Themes**



## Monitoring and Feedback

In order to continue to take advantage of the learning opportunities for the Trust, robust monitoring has been undertaken within the Complaints Team to provide information and analysis of complaint data. This includes:

- Risk rated Action Plans are created for all complaints to facilitate tracking and recording the lessons learned to help improve services and patient experience
- Monthly feedback to directorates on details of complaint numbers, types, specialties, and graphical analysis of the data. Response times and action plans are also closely monitored along with returned complaints and the reason for the return
- A dashboard of key information is also produced monthly for Trust Board Meetings
- In our iCARE programme, real complaints and compliments are used in training for all existing staff as well as new staff on induction, this helps staff look at care issues from the patient's perspective
- Information about complaints is included in medical staff appraisals

## Complaints Action Plans

Risk rated Action Plans are created for, and supplied to, all complaints by the Complaints Department to facilitate tracking and recording the lessons learned to help improve services and patient experience.

## Parliamentary Health Service Ombudsman (PHSO) Reviews

The Trust's Complaints service and performance was reviewed this year by the Parliamentary Health Service Ombudsman to ensure that good principles of complaints handling are being consistently met. Following completion of their investigations the Ombudsman upheld 2 and partially upheld a further 4 complaints. 8 were found to be not justified. These cases proved a valuable source of information to help further improve the complaints process. Additionally the Patient's Association (which assisted the NHS following the Francis Report) will continue to work with the Trust to advise on improving the complaints process and wider patient experience monitoring.

## Responses following resolved complaints

*"I just wanted to say thank you to everyone for really investigating (my complaint) and that I am very impressed by the thought that went into it and the changes that were implemented."*

### Re a telephone problem resolved...

*"I had my surgery last week- it's just a short email to say thank you for all you did for me and to say that all the staff at Southmead were amazing I couldn't have been taken care of any better. I thought I would let you know as I expect all your emails are complaints."*

## Compliments

Over 4,300 compliments were recorded during 2015/16. These were received in many forms, from telephone messages to thank you cards and emails. Positive feedback is shared with staff and patients to promote and celebrate good practice as well as to boost staff morale. As the strategy of improving patients' experience continues we will be looking at closer links between Patient Experience and ACT involving more systematic ways of inviting, collecting and learning from positive feedback, which is easily overlooked when focusing on the more challenging issues.

A selection of the compliments received (where permission to share was granted) is included below:

Gate/Ward/Department: 33a.  
Hospital: Southmead -  
*"many thanks to all the hard working staff who looked after me on ward 33a. You all made me feel like I got the treatment I needed."*

Gate/Ward/Department: Cossham birth centre.  
Team/Name of staff: Jill, Vanessa, Kathy, and the whole team!! - *"My misses was worried as the date drew nearer. Her first birth wasn't amazing - she had an epidural and a 9 hour labour - but this was so much nicer. Rooms with a view, en suite bathrooms, double bed and first class care! Our baby was born within 16 minutes of being there and was all done on gas and air. The excellent advice and support from the Cossham team and Jill who we caught a little off guard with the quick birth, but she didn't let us down in anyway. Couldn't fault it and was well worth it, if only all birthing units had the care, time and staff that Cossham could give. We would all be a lot happier. All birthing units could learn a good lesson from Cossham and should. A massive thank to you all at Cossham."*

Gate/Ward/Department: 27 - Cardiology. Team/Name of staff: Consultant Dr Walker. Hospital: Southmead -  
*"I was admitted via A&E and underwent tests for Unstable Chest pain. I was recommended for a heart bypass and transferred to the Heart Institute in Bristol. Without the skill and ability of the team at Southmead I may well have suffered a further heart attack. I am now 5 weeks post op and feeling wonderful. They without doubt saved my life and gave me a new much healthier life to boot. I cannot thank them enough. As a patient you can trust them with your life what can one say. THANK YOU."*

Gate/Ward/Department: 35 A&E  
Team/Name of staff: Receptionist that booked me in & Ann triage nurse  
Hospital: Southmead - *"I would like to thank the receptionist who booked me in around 15:30 on Friday 14/8/2015 & Ann the triage nurse who was lovely to me when I got upset during my consultation she made me feel so at ease."*

Team/Name of staff: To all the staff  
Hospital: Southmead. - *"To all the nursing staff on 25A, thank you for looking after me you are all wonderful. It was nice to have staff who care so much about the patients. Thank you again."*

Gate/Ward/Department: Cotswold Clinic.  
Team/Name of staff: Hysteroscopy Team on 16th July 2015 Hospital: Southmead -  
*"Just wanted to say a big thank you to the doctor and nurses who made the experience as pleasant as it possibly could have been. Also to the very kind lady on the phone (Gail?) who tried hard to give me an earlier appointment. Everyone was very kind and supportive. Thank you."*



## Improving Cancer Patient Experience

The National Cancer Patient Experience Survey was sent out to patients earlier in the year by Quality Health. We expect to have the results published in the next few months. The survey did not take place last year.

North Bristol Trust continues to lead nationally on the Living With and Beyond Cancer programme also known nationally as the Recovery Package. This programme is endorsed in Achieving world-class cancer outcomes - A strategy for England 2015-2020. The strategy sets out a proposed new five-year Cancer Strategy for England which recommends accelerating the roll-out of stratified follow up pathways and the "Recovery Package". It states the aim should be that by 2020 every person with cancer will have access to elements of the Recovery Package, and stratified pathways of follow up care. At NBT we have successfully implemented risk stratification and remote monitoring for follow-up in breast, colorectal & prostate services and are redesigning pathways in other cancer sites. We have an active "Living-well" programme supporting cancer patients and their families following treatment. All cancer teams are delivering regular education and information events with the 4 main teams also providing self-management courses. In 2015 we held 30 events with a total of 700 patients attending. In 2016 we have at least 36 Living Well days and 11 courses planned.

Patients are receiving documented holistic assessments and individualised care plans and we are improving the information sent to the GP's in the form of a treatment summary helping primary care support their patients following treatment. We have been successful in achieving a CQUIN for 2015-2016 in providing treatment summaries for over 40% of patients.

In September 2014 we opened our NGS Macmillan Wellbeing Centre on the Southmead site delivering a wide range of activities and providing information, support and advice for cancer patients, families and professionals. The centre has been a huge success and we have had over 1500 people through the doors in the past year. We expect numbers to greatly increase when we become more visible to the public in May 2016. In September 2015 we introduced free complementary therapies for cancer patients supported by therapist volunteers and we now run a regular cancer workshop for qualified therapists following a successful application to the Health Education South West for funding.

The cancer teams continue to work hard in delivering a high standard of patient care whilst looking for innovative ways of making improvements.

## End of Life Care

At North Bristol NHS Trust, we provide end of life care for approximately 1800 people each year. End of life care is delivered in all areas of the hospital including the medical, surgical and orthopaedic wards, the emergency department and the intensive care unit. End of life care is given by doctors, nurses and other health care professionals in each area, often with help from the specialist palliative care team, ward based link nurses, chaplaincy team, pharmacists, Macmillan Wellbeing Centre staff, psychologists, mortuary staff and bereavement services.

At NBT, we aim to give high quality individualised care and support to people who are nearing the end of their life and also to those close to them. We do this by planning care and services in line with national recommendations.

**Ambitions for Palliative and End of Life Care:**  
A national framework for local action 2015-2020

National Palliative and End of Life Care Partnership  
[www.endoflifecareambitions.org.uk](http://www.endoflifecareambitions.org.uk)

- Each person is seen as an individual**  
*I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.*
- Each person gets fair access to care**  
*I live in a society where I get good end of life care regardless of who I am, where I live or the circumstances of my life.*
- Maximising comfort and wellbeing**  
*My care is regularly reviewed and every effort is made for me to have the support, care and treatment that might be needed to help me to be as comfortable and as free from distress as possible.*
- Care is coordinated**  
*I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.*
- All staff are prepared to care**  
*Wherever I am, health and care staff bring empathy, skills and expertise and give me competent, confident and compassionate care.*
- Each community is prepared to help**  
*I live in a community where everybody recognises that we all have a role to play in supporting each other in times of crisis and loss. People are ready, willing and prepared to have conversations about dying and doing well and to support each other in emotional and practical ways.*

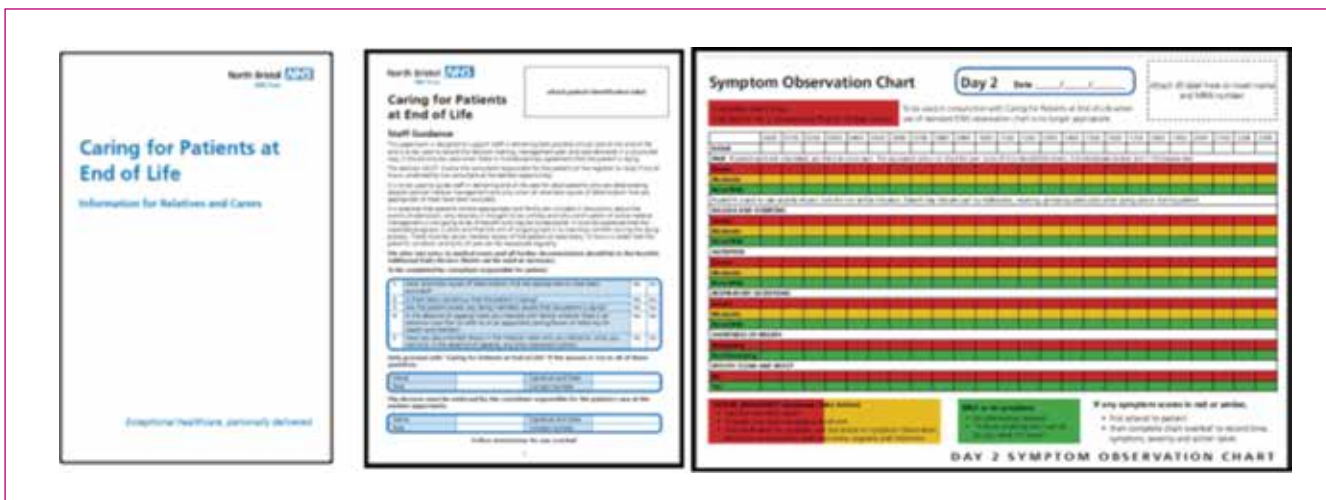
We focus on how we can deliver care with compassion and kindness and maintain dignity and comfort as best we can. In the report issued by the CQC after the last inspection, staff were praised for being caring and the report emphasised that end of life care at NBT was delivered with the aim of meeting the individual needs of people.

At NBT we have an End of Life Strategy Group made up of staff working in all areas of the hospital who are involved with caring for people at the end of life. This group plans the priorities for developing and improving end of life care. These are based on gaps identified by audits and national standards, outcomes of complaints and other feedback from patients and carers and areas of concern highlighted by staff. These are reported quarterly to the Quality and Risk Management Committee and actions are identified for the coming year to address the issues.

Recent developments in end of life care at NBT include;

- The introduction of a new way of recording care at the end of life called "Caring for Patients at End of Life", following the national withdrawal of the Liverpool Care pathway. The new NBT paperwork prompts staff to think about all aspects of good end of life care and to make individual care plans for each person and ensure that comfort and symptom control are monitored closely and addressed quickly.
- The development of new forms to help guide doctors and nurses in discussing treatment aims with people when they are very unwell. This is helping to make sure that people understand what is wrong with them and this allows them and their carers to be more involved in planning their treatment and where they would like to be cared for. We have achieved local quality improvement targets for some of this work.
- Since January 2016, we have been delivering introductory end of life training to all staff at NBT.

There are many aspects of end of life care where we can work to improve the quality of patient care, patient experience, staff skills, knowledge and attitudes and coordination of services.



There are many aspects of end of life care where we can work to improve the quality of patient care, patient experience, staff skills, knowledge and attitudes and coordination of services.

Our priorities for the coming year are;

- 1) Planning for how we can provide face to face access to specialist palliative care services seven days per week.
- 2) Continuing with delivery of introductory end of life training for all staff and planning how we can deliver the right level of further training to over 8,000 staff.
- 3) Improving our communication with people about their illness, what to expect, what their preferences are about their treatment and where they would like to be cared for.
- 4) Improving how we communicate information to GPs and other community staff when people leave hospital.
- 5) Improving how we collect and act on feedback from people and their carers about end of life at NBT.
- 6) Reviewing how we make arrangements for collection of death certificates.
- 7) Improving our documentation of the end of life care that we deliver at NBT.
- 8) Improving our documentation of decisions about resuscitation.

## Carers

Understandably, Patient Carers need dignity and respect during a loved one's hospital stay. Many carers are likely to be relatives of very sick patients and therefore every bit of assistance should be provided in making access to support as easy as possible.

As part of the NBT Carer Support Scheme, Carers providing support while a patient is in hospital are entitled to:

- a complimentary parking permit
- an access card permitting access to the ward as well as access to the staff restaurant on level 5
- Carers conversation
- Referral to Carers liaison Service

As a Trust we have signed up to John's Campaign <http://johnscampaign.org.uk/> (and further work related to engagement with carers will be progressed through the newly formed carer's strategy group that will report to the Patient Experience group.

We have re launched the carers scheme and updated information related to this on the extranet and internet. (There was a picture on twitter to support this yesterday).

## iCARE

It stands for:

- I** take responsibility for:
- C**ommunication that's effective
- A**ttitude that's positive
- R**espect for patients, carers and colleagues
- E**nvironment that's conducive to care.

The Trust uses iCARE to embed our values and provide a vehicle for improved patient and staff experience. Staff are engaged in a practical expression of our values of Putting Patients First, Working Well Together, Recognising the Person and Striving for Excellence. It also embraces other ways of making clear and personal commitments, such as our 'Don't Walk By,' campaign, our 'Patient Experience Improvement Plan', and how to respond when things don't go well, and in maintaining one's own professional and personal standards.

The iCARE sessions are highly participative using real patient feedback and staff experience to gain an understanding of how our values and behaviours can affect the quality of patient and staff experience.

In 2015/16 we have continued to champion iCARE, and to celebrate and raise awareness of good practice through the



iCARE Moments awards campaign. iCARE also became part of the NBT Welcome and induction, and Health Care Support Worker Care Certificate programmes. This means that all new staff on their very first day, are given the insight into the importance of our NBT Values and how we want to work together to support our service users in NBT.

## Safeguarding Vulnerable People

### Safeguarding Children

Children and young people are seen in a range of settings throughout North Bristol NHS Trust such as the Maternity services, Emergency Department, Outpatient clinics and the Nursery. Young people aged between 16 and up to 18 years can be admitted as inpatients and we work closely with other providers as young people transition from children's services to adult health services. Children and young people are also seen indirectly through our contact with parents.

North Bristol NHS Trust has a duty to safeguard and promote the welfare of children and young people who are under 18 years of age. This is achieved in several ways by;

- Ensuring all staff are appropriately trained.
- Having robust governance arrangements.
- Having specialist staff to guide the Trust.
- Maintaining expected standards and responding to inspections.

### Training

North Bristol NHS Trust staff are trained to recognise, understand and report any safeguarding concerns for children. Throughout 2015-2016 the Trust's in-house Safeguarding Children Training Programme offered training at three levels for all staff employed within the organisation and training compliance figures are reported to the Commissioner quarterly. The training is in-line with the requirements of Safeguarding Children and Young people: roles and competences for healthcare staff; Intercollegiate Document (2014) and the Trust's Safeguarding Children Training Policy. High levels of compliance have been evident for the last 4 years. A collaborative approach to delivering level 1 and 2 training for adults and children has been developed.

The Trust aims to achieve 90% compliance with all levels of training.

The Quarter 3 for figure 2015/16 has shown a drop in compliance from Acute Services. This has been identified during the separation of Acute Hospital Staff from Children's Community Health Partnership (CCHP) staff.

**Table 17 - Quarter 3 figure for Acute Staff**

The percentage of staff trained at level 1	89
The percentage of staff trained at level 2	80
The percentage of staff trained at level 3 core	80

A recovery plan is in place and will be monitored by the Safeguarding Committee.

## Governance

2015/16 has seen a strengthening and improvement of the arrangements in place within the Trust to safeguard all patients and the development of a "Think Family" culture. The Trust's Safeguarding Committee arrangements were reviewed in 2015 and are now established with a focus on providing challenge and assurance with regard to the safeguarding arrangements within the Trust for both Adults and Children at the same committee.

Our commissioners receive quarterly reports monitoring the Trust against agreed standards. These standards are assured internally by the Children's Operational Group and the Safeguarding Committee.

## Specialist Staff

We have a team of individuals who are specialist in Children's Safeguarding to provide advice and support to all Staff. The vacancy created by the impending departure of the Children's services for a Named Doctor has been filled. The Named Nurse's post for Safeguarding Children will be vacant in March 2016. A succession plan has been developed with the Director of Nursing to ensure continuity of the service until a substantive post holder can be recruited.

## Inspections

A recent inspection by the CQC was very positive.

*"We saw good evidence of the specialist [Safeguarding Midwives] midwives role in both internal and multi-agency liaison."*

*"Without the Family Nurse Partnership we wouldn't have been as good parents as we are now."*

*"Once 'in service' (then) young people in South Gloucestershire are supported well by CAMH practitioners."*

*"Children and young people who attend ED at Southmead hospital following self-harm, overdose or other risk taking behaviours are safeguarded well."*

Whilst the overall inspection was positive North Bristol NHS Trust had a number of specific actions assigned to it and these have been identified and collated into an action plan, implementation of which is being monitored by the Trust Wide Safeguarding committee and our Commissioners.

## Moving to Pastures New...

The Community Child Health Partnership (CCHP) for Bristol and South Gloucestershire services (including community paediatrics, health visitors, school health nursing and allied health professionals) which has worked within a valued partnership with NBT for the past six years is leaving. In April 2016 NBT will say goodbye to our colleagues in CCHP and welcome three new providers of care.

## Safeguarding Vulnerable Adults

The Safeguarding of vulnerable adults remains a high priority for the Trust. This area of practice requires collaborative working with other health providers, health and social care commissioners and the local authority and the police.

The Trust's Safeguarding Adult Team is made of an Adult Safeguarding Lead (full time) and Specialist Safeguarding Practitioner (part time) supported by a full time administrator. The Team is led by the Head of Patient Experience. The Director of Nursing is the Executive Lead for Adult Safeguarding and chairs the Trust Safeguarding Committee. Adult Safeguarding has its own subcommittee which is chaired by the Head of Patient Experience.

The Trust has maintained its focus on Safeguarding Adults, Mental Capacity Act (including Deprivation of Liberty) training which now includes PREVENT awareness, Domestic Abuse and Violence and Female Genital Mutilation, as well as Human Trafficking awareness. Training is supplied to every member of NBT staff at various levels and is delivered face to face with frontline professionals. This training is refreshed every three years.

April 2015 saw the introduction of the Care Act. Under that Adult Safeguarding moves on to a statutory footing from a policy basis. The Act increased those people who can be classified "as an adult at risk of harm" (this replaces the phrase vulnerable adult) so increases volume and lowers the threshold from significant harm to harm.

The table below shows the growth of referrals from the Trust into the team.

**Table 18 – Growth of referrals**

Year	Q1	Q2	Q3	Q4	Total
2013/14	22	12	42	34	100
2014/15	54	57	105	98	214
2015/16	212	241	163	160*	776

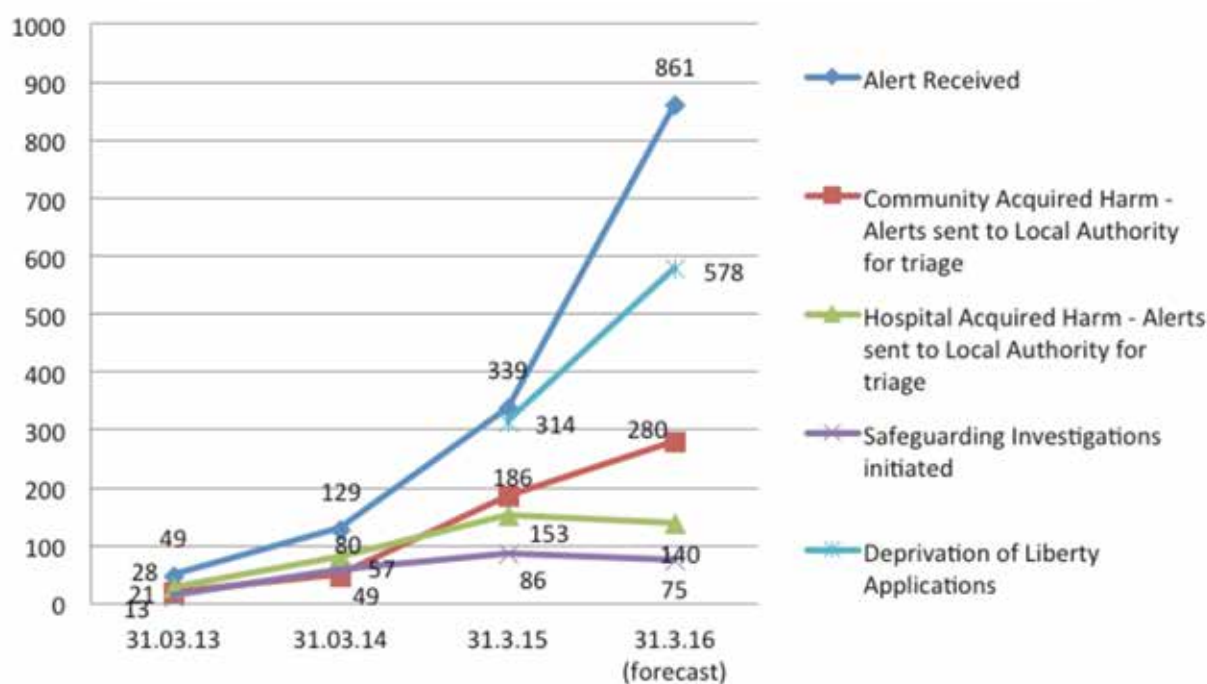
\*Quarter 4 figures compiled before quarter end.

The growth in referrals is explained by the following factors;

- Change in definition and threshold as required by national requirements
- The effect of training – generating greater awareness and therefore more referrals
- Adult Safeguarding Team improved availability for support
- The adding of additional strands to the Adult Safeguarding Agenda i.e. Domestic Abuse and Violence, FGM, Modern Slavery
- Greater need to support practitioners with Mental Capacity Act and Deprivation compliance.

Safeguarding Adults Boards are now a statutory partnership for North Bristol NHS Trust. The Head of Patient Experience sits on the Boards for both Bristol and South Gloucestershire. The Adult Safeguarding Lead sits on sub groups of both boards.

**Chart 26 - Safeguarding Adults**



## Section 4 - Clinical Effectiveness



### Mortality Outcomes - HSMR/SHMI

#### Mortality

The Trust has an excellent record on patient mortality and both internal and external assessments by the CQC and TDA of its performance indicate that it is consistently performing at or better than the national expected levels on a range of measures that are used to monitor and assess mortality.

### Hospital Standardised Mortality Ratio - HSMR

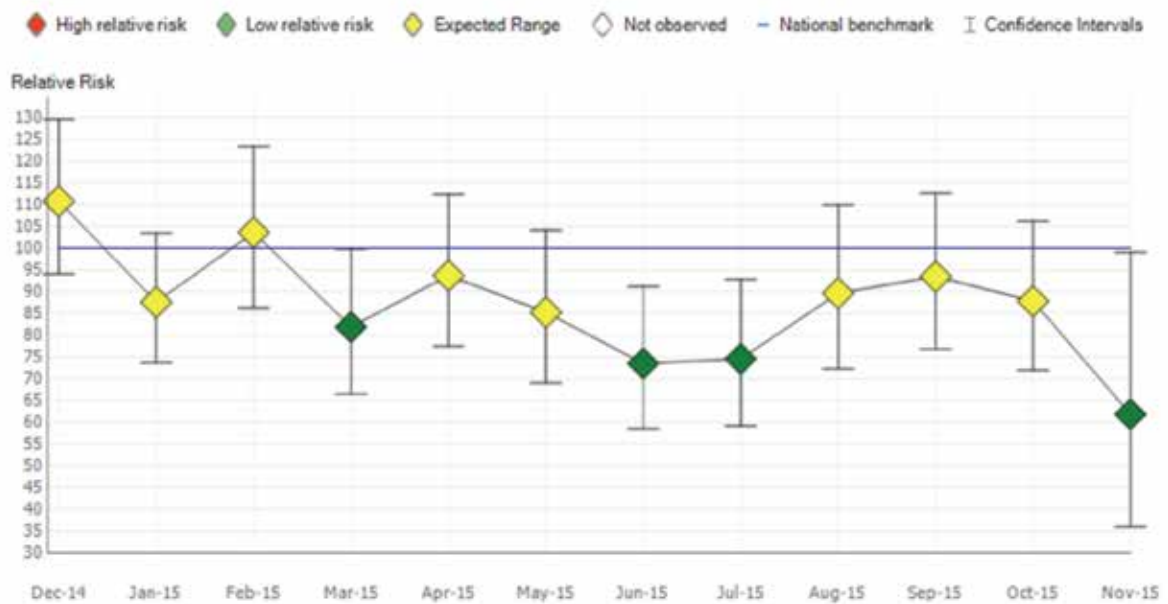
HSMR is a measurement which compares a hospital's actual number of deaths with their predicted number of deaths, taking into account factors such as the age and sex of patients, their diagnosis and whether their admission was planned or an emergency. If a Trust has an HSMR of 100, this means that the number of patient deaths is as expected, based on the seriousness of their condition. If the HSMR is above 100 this means that more people have died than would be expected. In contrast an HSMR below 100 means that fewer die than expected. Chart # below shows that mortality is below expected levels for almost all of the year. There was a rise in December 2014 and February 2015 but it is important to note that the mortality levels still remained within the 'expected range'.

### Standardised Hospital Mortality Indicator - SHMI

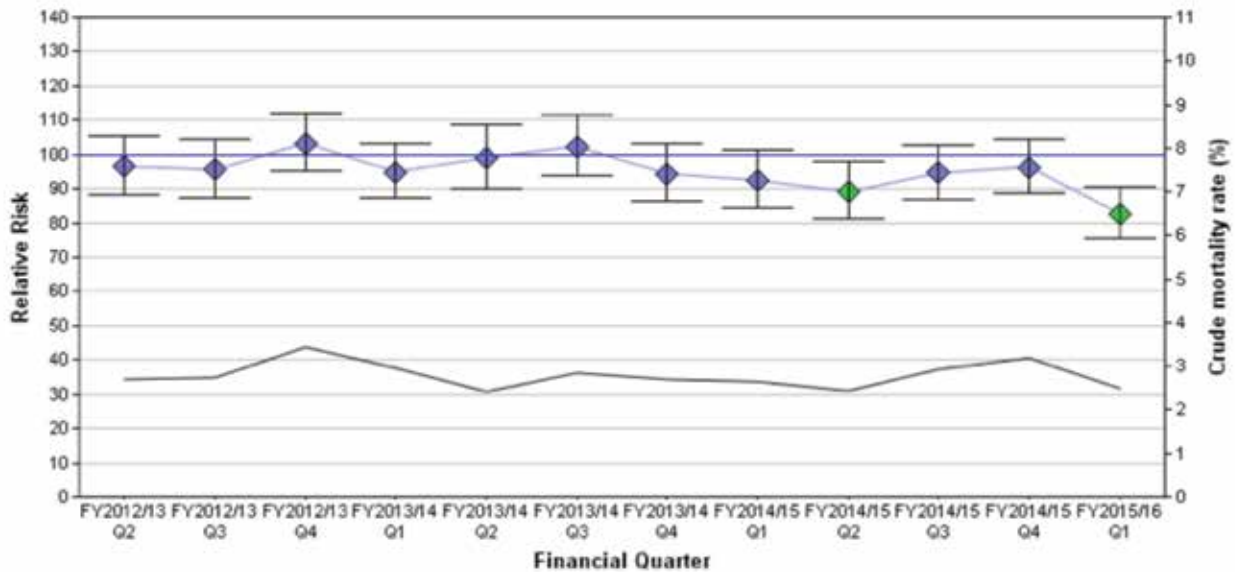
SHMI is the preferred method used to measure and compare patient mortality but is more recently introduced than HSMR. The SHMI includes post-discharge deaths (30 days). The Trust SHMI is also below the Trust national average of 100, which indicates that NBT is performing better than would be expected. The key differences in methodology between HSMR and SHMI indicators are;

- HSMR is a sample of 56 diagnoses where around 85% of hospital deaths occur. HSMR is adjusted for more factors than SHMI, most significantly palliative care, but also other sub groups, such as social deprivation, past history of admissions and source of admission
- SHMI includes all deaths, regardless of whether they were attributable to the hospital. So, for example, if 30 days after being in hospital someone dies (of any cause), it would still be included in SHMI

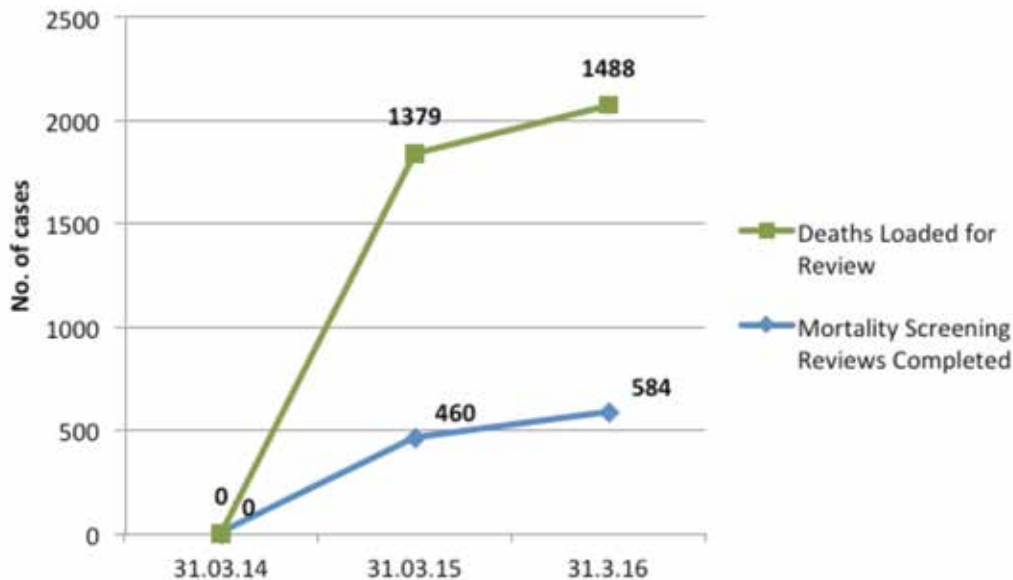
**Chart 27 - HSMR to November 2015. (Source: Dr. Foster)**



**Chart 28 - SHMI trend for all activity across the last available 3 years of data. (Source: Dr. Foster)**



**Chart 29 - Mortality review & QI reporting**



**Safety Review of every patient death**

Whilst the published and independently assessed NBT data outlined in Charts 27, 28 and 29 is reassuring, we are not complacent and continuous improvement is the goal for our longer term quality and safety improvement work. In April 2014 a new system was introduced to support the formal screening and review of all in-patient deaths, and underpin our objectives to prevent avoidable harm and death. This is

undertaken to provide an objective review. To date (Feb 2016) there have been approximately 517 patient deaths which have been reviewed in this way. It is reassuring to note that no cases of avoidable death have been found during these reviews. The information from this Mortality Screening and Review work is compared with other data from the Trust to look for potential learning and improvement opportunities by the Trust’s Quality Surveillance Group.



## Quality of Cancer Services

Within North Bristol Trust there are 11 specific cancer clinical teams who provide support to cancer patients and are additionally supported by a palliative care team and an acute oncology service. Each of these teams has an identified Lead Clinician who works closely with Clinical Nurse Specialists and other supporting staff to deliver services for cancer patients. All cancer clinical teams are monitored against national standards as part of the National Peer Review Programme. Each team's compliance with these "national quality standards"

is monitored through a programme that utilises self-assessment and external validation processes. The self-assessment process at North Bristol Trust is either conducted by the clinical lead as a desk-top exercise or via an internal validation panel (where teams are reviewed and validated by peers within the organisation). Teams are also selected for an external review where professional peers are invited to visit and review teams against their compliance with these standards. In 2015 the following reviews were undertaken and the compliance is noted below:

**Table 19 - Cancer Services**

Assessment type	Disease Site/Peer Review Area	Measures	2015 (% compliance)	Action areas identified
External Validation Visit	Haematology	18	SA – 89% EV - 83%	Serious concern - Inadequate CNS support
	SIHMDS	5	SA – 80% EV - 60%	Serious concern – Regional integrated reporting system
Compulsory National Self-Assessment & Internal Validation	Acute Oncology	5	IV - 60%	Administrative support for service needs review
	- Gen	10	IV – 80%	
	- Inpatient	4	IV – 50%	
	CUP Hospital	3	SA – 66%	Pathway agreed but needs Bristol wide sign off
	Breast	16	IV – 87.5%	Patient information was not up-to-date Pathways were locally developed and not networked
	Skin - Specialist Skin – Immuno	20 1	Desk top – 67% Desk top – 100%	Gloucester patients pathways and procedure numbers to be reviewed
	Urology - Specialist	21	IV - 81%	MDT attendance issues RUH radical prostatectomy review required
Urology - Penile	17	Desk top - 65%	Serious concern - Inadequate clinical support for service	
Nationally Optional Assessment – team assessed via Internal Validation	Brain & CNS – Trust	6	IV – 100%	Serious concern - Neuro-psychology support to the MDT
	Brain – Rehabilitation	18	IV – 80%	
	Brain – Neuroscience MDT	18	IV – 80%	
	Colorectal Colorectal Diagnostic	18 1	IV – 95.5% IV – 100%	No issues identified - letter to confirm attendance measure requested.
Lung	15	IV – 80%	Waiting times for endoscopy and outpatients highlighted	
Sarcoma Trust Sarcoma MDT	8 20	IV – 87.5% IV – 70%	Shared care and network pathways need updating	

**Table 19 - Cancer Services (contd.)**

Assessment type	Disease Site/Peer Review Area	Measures	2015 (% compliance)	Action areas identified
Nationally Optional Assessment – team assessed via self-assessment/desk top	Gynaecology Diagnostic	2	SA – 100%	
	Palliative Care	25	SA – 95%	National measures pose challenges as no network group at present
	Chemotherapy	36	SA – 75%	
Nationally Optional Assessment – team chose not to assess	Brain - Skull Base	18	SA – Not provided	None expected but self-assessment not completed
	Brain - Pituitary	18		
	Onc. Pharm Service	5	SA – Not provided	Self-assessment not completed

(Note SA – self-assessment, IV – Internal Validation and EV – External Validation).

All issues or concerns raised as part of the Peer Review Programme of reviews were included in the clinical teams Work Programme for the year and these were reviewed at the bi-monthly Cancer Committee meeting to monitor progress against actions and escalate issues identified.

## Cancer Performance

As outlined in the national cancer waiting time guidance document the Trust is tasked with delivery national cancer waiting times targets. These targets can be summarised as follows:

Maximum two weeks from:

- Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first outpatient attendance [Operational Standard of 93%].
- Referral of any patient with breast symptoms (where cancer not suspected) to first hospital assessment [Operational Standard of 93%].

Maximum one month (31 days) from:

- Decision to treat to first definitive treatment [Operational Standard of 96%].

- Decision to treat/earliest clinically appropriate date to start of second or subsequent treatment(s) for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is
  - Surgery [Operational Standard of 94%]
  - Drug treatment [Operational Standard of 98%]
  - Radiotherapy [Operational Standard of 94%]

Maximum two months (62 days) from:

- Urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment (62 day classic) [Operational Standard of 85%].
- Urgent referral from a NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment [Operational Standard of 90%].
- Consultant upgrade of urgency of a referral to first treatment [No Operational Standard as yet].
- Maximum one month (31 days) from urgent GP (GMP, GDP or Optometrist) referral to first treatment for acute leukaemia, testicular cancer and children's cancers [No separate Operational Standard – Monitored within 62 day classic].

The Trust has not been able to meet all these targets consistently over the past year and the performance against the key targets that North Bristol is measured against can be summarised below:

<b>Table 20 - Standards</b>						
<b>Standard</b>	<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>	<b>YTD</b>	<b>Total # Patients</b>
Patients seen within <b>2 weeks of an urgent GP referral (93% target)</b>	92.4%	93.5%	94.7%	93.8%	93.6%	<b>20,214</b>
Patients with breast symptoms seen by specialist within 2 weeks <b>(93% target)</b>	99.1%	96.9%	92.8%	94.5%	95.5%	<b>1,166</b>
Patients receiving first treatment <b>within 31 days</b> of cancer diagnosis <b>(96% target)</b>	92.0%	91.5%	93.1%	92.9%	92.3%	<b>3,132</b>
Patients waiting less than 31 days for subsequent surgery <b>(94% target)</b>	91.4%	94.4%	95.3%	94.8%	94.1%	<b>905</b>
Patients waiting less than 31 days for subsequent drug treatment <b>(98% target)</b>	100%	100%	100%	100%	100%	<b>122</b>
Patients receiving first treatment within <b>62 days of urgent GP referral (85% target)</b>	78.4%	81.7%	80.8%	75.2%	79.4%	<b>1,558</b>
Patients treated 62 days of screening <b>(90% target)</b>	93%	86.5%	91.5%	90.8%	90.5%	<b>393</b>
Patients treated within 62 days of consultant upgrades <b>(90% target)</b>	87.8%	98.4%	98.9%	93.5%	95.4%	<b>296</b>

In order to ensure that the impact of failing to meet these measures is fully understood and actioned the Trust undertakes a review of all patients who are not treated within 62 days of their GP referral (patients who breach this national standard).

Cancer patients who breach cancer waiting times targets are reviewed firstly by the core cancer services team to identify potential reasons for the breach and then, as appropriate, by the clinical teams to review reasons, actions and to attempt to ascertain risks for the patients of the breach.

1. The core cancer services team conduct an initial review of the breach and provides a summary of findings and initial reason notes on the cancer register.
2. Breaches are then reviewed by the clinical teams, as appropriate, to clarify and confirm appropriate actions and potential risks to a patient.

The review of risk is based on the clinical judgement of the team reviewing the breach and the primary question posed is whether, based on the final diagnosis of the patient, the delay represented a clinical risk to the patient.

If there is any clinical concern, the directorate teams must conduct an appropriate formal review and follow incident and risk reporting processes of the Trust. For shared pathways the review of the breach focuses on the part of the pathway that sits within the control of NBT and if appropriate timescales were followed in respect of this.

These reviews are essential in informing actions required to improve patient pathways.

In order to facilitate swifter cancer pathways the cancer teams within NBT have worked on reviewing their clinical pathways to identify and attempt to map 'time points' when certain key steps in their pathways should occur. These timed pathways have been developed across the majority of cancer teams within the Trust and support capacity review and ensuring clear expectations across the Trust. The pathways are not expected to be met for all patients as allowance must be made for medical conditions that would alter standard pathways and for pathway delays due to informed patient choice. The Trust continues to monitor its delivery of cancer performance and look at key aspects of the timed pathway to assist in identifying areas for improvement.

## Patient Reported Outcome Measures (PROMs)

All NHS patients having hip or knee replacements, varicose vein surgery, or groin hernia surgery are invited to fill in PROMs questionnaires. When patients go into hospital, they are asked to fill in a short questionnaire before their operation. The NHS

asks patients about their health and quality of life before they have an operation, and about their health and the effectiveness of the operation afterwards. This helps the NHS to measure and improve the quality of its care. NBT is working on new approaches to seek to improve rate of completion by patients of PROMs questionnaire and methods to act upon results.

**Table 21 - Indicates the participation response rates by patients to the questionnaire**

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked
All Procedures	1960	350	17.9%	272
Groin Hernia	398	22	5.5%	15
Hip Replacement	742	152	20.5%	120
Knee Replacement	738	176	23.8%	137
Varicose Vein	82	0	0.0%	0



## Participation in Clinical Audits

### National Clinical Audits Listed for the Quality Account 2015/2016

The National Clinical Audits and National Confidential Enquiries that North Bristol NHS Trust participated in during April 2015 – March 2016 (stated in the DoH list of audits for inclusion in the Quality Account) are as follows:

- 59 National Clinical Audits were listed to be reported in the Quality Account for 2015/2016. This did not include the National Confidential Enquiries.

- During April 2015 – March 2016, 44 of the 59 (75%) national clinical audits covered NHS services that North Bristol NHS Trust provides.
- During April 2015 – March 2016 North Bristol NHS Trust participated in 41 of the 44 (93%) relevant national clinical audits.

The table opposite details the national clinical audits listed on the quality account for 2015/2016. It indicates NBT's eligibility for participation, whether NBT did participate and the case ascertainment figures and percentages for each audit in which NBT participated.

**Table 22 - National Clinical Audits**

National Clinical Audit Title	Eligible to Participate?	Participating?	Case Ascertainment		
			No Submitted	No Expected	%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	456	456	100%
National Adult Bronchiectasis Audit	Yes	Yes	0 <sup>1</sup>	5	
Bowel cancer (NBOCAP)	Yes	Yes	250 <sup>2</sup>	241	103%
Cardiac Rhythm Management (CRM) <sup>3</sup>	Yes	Yes			
Case Mix Programme (CMP)	Yes	Yes	932 <sup>4</sup>	932	100%
Child health clinical outcome review programme	No	N/A			
Chronic Kidney Disease in primary care	No	N/A			
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	No	N/A			
Coronary Angioplasty/National Audit of PCI	Yes	Yes	214	214	100%
Diabetes (Adult)	Yes	Yes			
- Diabetes Foot Care Audit	Yes	Yes		Data not submitted <sup>5</sup>	
- Diabetes in Pregnancy	Yes	Yes	21 <sup>6</sup>	21	100%
- National Diabetes Audit	Yes	Yes			
o Case note review			121	121	100%
o Patient experience			92	N/A	N/A
Diabetes (Paediatric) (NPDA)	No	N/A			
Elective surgery (National PROMs Programme)	Yes				
Emergency Use of Oxygen	Yes	Yes	1 Institution 23 Submissions	1 Institution Avg. 13 Submissions	100%
End of Life Care Audit: Care of the Dying	Yes	Yes	52		
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes	Yes			
- National Hip Fracture Database	Yes	Yes	440	484	91%
- 1st National Audit of Inpatient Falls <sup>7</sup>	Yes	Yes	All falls	All falls	100%
Familial Hypercholesterolaemia	No	N/A			
Inflammatory Bowel Disease (IBD) programme (Round 5)	Yes	Yes	Reporting Sep 16		
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	N/A			
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A			
Lung cancer (NLCA)	Yes	Yes	253 <sup>8</sup>	253	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	1339	1241	108%
National Adult Cardiac Surgery Audit	No	N/A			
National Audit of Intermediate Care	No	N/A			

1. Data collection does not close until 30 September 2016

2. 2015 report (2013/2014 data)

3. Latest report 2013/2014 (published 19th December 2014)

4. As of Quarter 2 2015 (latest quarterly DAR published)

5. Data not submitted as NBT was not made aware by the National Body that the database was open

6. 2014 data submitted for report published November 2015. 21 pregnancies captured – may have been more but women did not consent.

7. Round 1 figures

8. 2015 report on 2014 data

**Table 22 - National Clinical Audits**

National Clinical Audit Title	Eligible to Participate?	Participating?	Case Ascertainment		
National Cardiac Arrest Audit (NCAA)	Yes	Yes	115 <sup>9</sup>	115	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – pulmonary rehabilitation audit	Yes	Yes			
National Comparative Audit of Blood Transfusion programme	Yes	Yes			
- Patient Blood Management in Adults Undergoing Elective, Scheduled Surgery	Yes	Yes	32		
- The Use of Blood in Lower GI Bleeding <sup>10</sup>	Yes	Yes			
National Complicated Diverticulitis Audit (CAD)	Yes	No			
National Emergency Laparotomy Audit (NELA)	Yes	Yes	156	233	67%
National Heart Failure Audit	Yes	Yes	495	495	100%
National Joint Registry (NJR)	Yes	Yes	1625	1625	100%
National Ophthalmology Audit	No	N/A			
National Prostate Cancer Audit	Yes	Yes	96 <sup>12</sup>	186	52%
National Vascular Registry	Yes	Yes			
- AAA Repair <sup>13</sup>	Yes	Yes	37	45	82%
- Carotid Endarterectomy <sup>14</sup>	Yes	Yes	51	48	106%
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	2828 <sup>15</sup>	2828	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	136 <sup>16</sup>	151-200	81-90%
Paediatric Asthma	No	N/A			
Paediatric Intensive Care Audit Network (PICANet)	No	N/A			
Prescribing Observatory for Mental Health (POMH)	No	N/A			
- Will possibly be involved in the element - Prescribing for ADHD in Children	No	N/A			
Renal replacement therapy (Renal Registry)	Yes	Yes	148 (all)	All	100%
RCEM Procedural Sedation in Adults	Yes	Yes	29	50	58%
Pulmonary Hypertension (Pulmonary Hypertension Audit)	No	N/A			
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	114		
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	Not reported	Not reported	90%+
UK Cystic Fibrosis Registry	No	N/A			
UK Parkinson's Audit (previously known as National Parkinson's Audit)	Yes	Yes			
- Speech and Language Therapy	Yes	Yes	20	20	100%
- Patient Management	Yes	Yes	25	25	100%
RCEM Vital signs in Children	Yes	Yes	50	50	100%
RCEM VTE risk in lower limb immobilisation	Yes	Yes	50	50	100%

9. 2014/2015 data from report published April 2015

10. Report to be published end of May 2016

11. Figures as of 17/05/2016 – Data collection to end 1st June 2016

12. Data from 2014 (2015 report)

13. Data from patients diagnosed between 1 January 2012 and 31 December 2014 (2015 report)

14. Procedures done between January and December 2014 (2015 report)

15. 2015 report on 2014 data

16. Patients diagnosed between 1st April 2012 and 31st March 2014 (2015 report)

## Local Clinical Audits

The Clinical Audit Committee (CAC) uses the results from local and national audit to inform the Trust Quality and Safety Strategy and annual quality objectives. The CAC monitors action plan progression as a result of local and national clinical audit activity and highlights to the Trust Quality Committee lack of progression or specific actions which require their intervention. CAC reviews one local audit every 2 months, which equates to 6 over the 12 month period.

## National Clinical Audit Outcomes 2015/2016

### Introduction

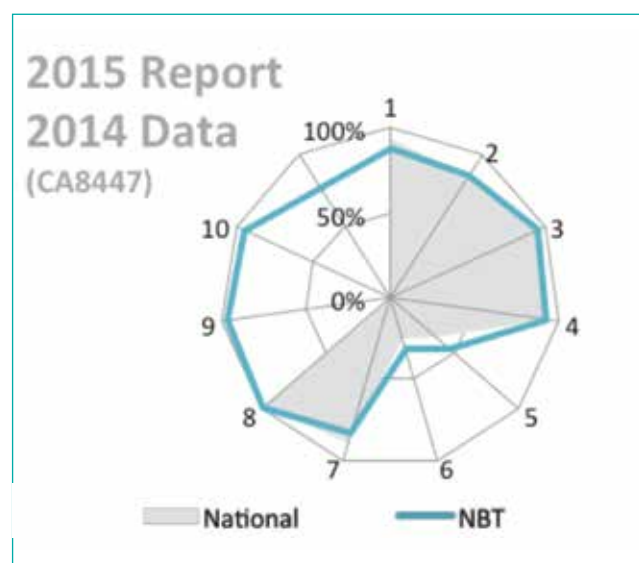
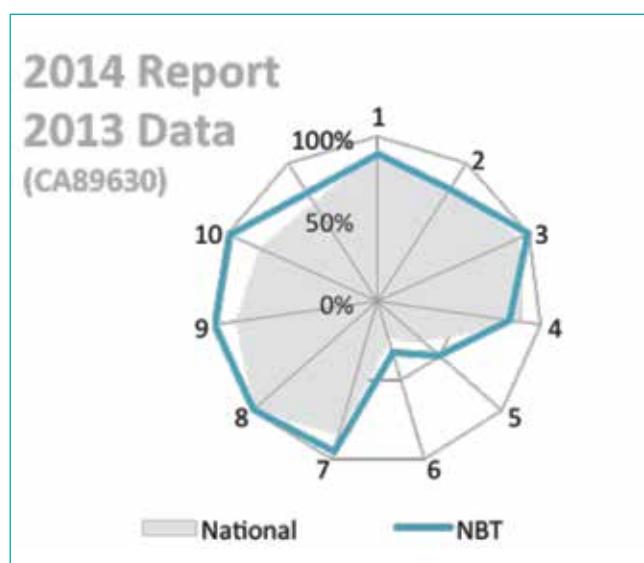
During 2015/2016 the Clinical Audit Committee reviewed and approved reports and initial action plans for 25 National Clinical Audits. 21 out of 25 national clinical audits reviewed were listed on the Quality Account.

Once action plans are approved by the Clinical Audit Committee they are monitored to ensure that progress is being made at 6 month intervals until completion. 29 6, 12 and 18 month action plan updates were reviewed and approved by the Clinical Audit Committee during 2015/2016, 21 of these were National Clinical Audits listed on the Quality Account.

Audits are closed if all actions are completed, or a re-audit report is published and outstanding actions are carried over to the new action plan. In 2015/2016 9 audits were closed.

Below are 3 examples of National Clinical Audits that have had an action plan approved and implemented during 2015/2016 and a subsequent re-audit report has been published. The summaries below outline the outcomes of the earlier reports and the actions implemented to improve results at the re-audit stage. The comparative tables and graphs show areas where improvements have been realised and also those areas that need further work in order to improve outcomes. Action plans will be developed for the re-audit reports and will be appraised by CAC early in 2016/2017.

## National Neonatal Audit Programme (NNAP) 2014 and 2015 (Quality Account)



### 2014 Report Summary

The 2014 audit report indicated several areas of low compliance, however these were broadly in-line with the national average.

### Action Plan and Changes in Practice











A comprehensive action plan was developed carrying over any outstanding elements from the previous report. Work has been carried out to improve data management for NNAP including appointing a new NICU Data Manager. Data migration to more up-to-date systems and data sharing with other departments, training specialists to enter their own data regularly as well

as the production of monthly reports and dashboards gives a more current overview of care. It is noted on the action plan that there are exceptions to NNAP standards and this is where NBT's non-compliance usually falls, however actions are specified to endeavour to improve compliance in all areas.






### 2015 Report Summary

Following implementation of the action plan the 2015 audit report was released. It noted areas of improved compliance with regards to antenatal steroids being given and screening times. Compliance fell on one metric, and this element will be addressed in the new action plan.

**Table 23 - NNAP NBT vs National****Compliance and Improvement Table NBT vs National**

Measure		Report	Site		+/- 5%
No	Name	Year	NBT	National	Improvement
1	Temperature taken within an hour of birth	2014	90%	93%	
		2015	88%	94%	
2	Percentage with any antenatal steroids given	2014	82%	83%	
		2015	96%	85%	
3	Babies with ROP screening	2014	100%	94%	
		2015	96%	97%	
4	Screened on time	2014	80%	87%	
		2015	93%	93%	
5	Feeding with Mother's milk only	2014	49%	36%	
		2015	46%	35%	
6	Feeding with any Mother's milk	2014	32%	23%	
		2015	32%	25%	
7	Consultation with parents within 24 hours of admission	2014	95%	84%	
		2015	83%	89%	
8	Eligible babies receiving neurodevelopment follow-up	2014	100%	99%	
		2015	100%	98%	
9	Blood cultures with results entered <32 weeks	2014	100%	87%	
		2015	97%	Not recorded	
10	Blood cultures with results and clinical signs entered ≥32 weeks	2014	99%	79%	
		2015	95%	Not recorded	

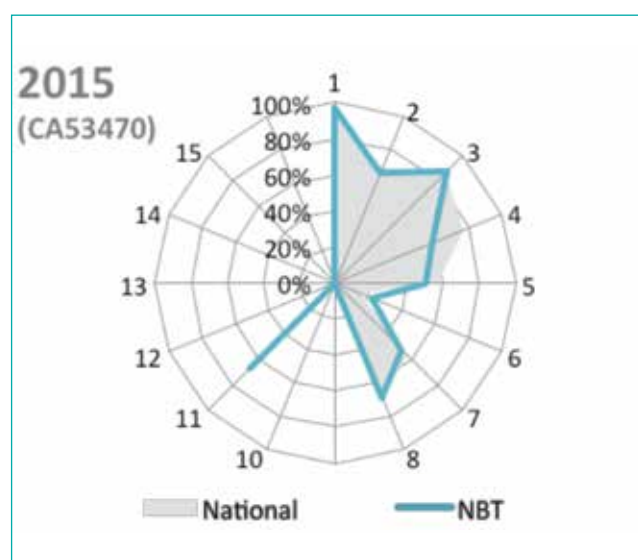
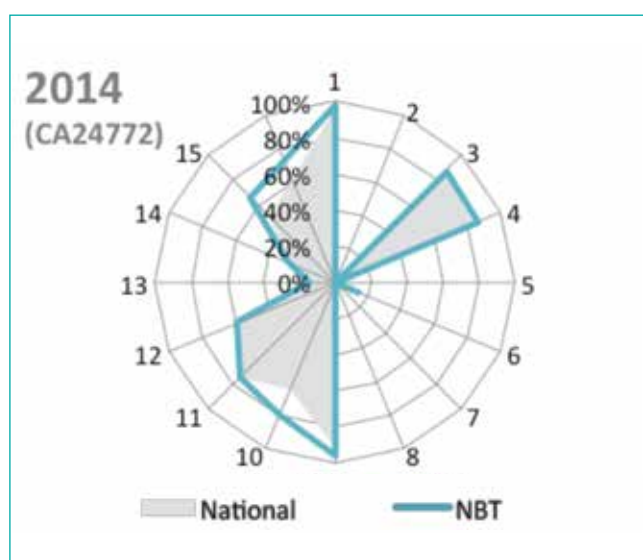
**Key to Tables 23, 24 and 25**

+5% Improvement		-5% Improvement		-5% on National Average	
No change +/- 5%		+5% on National Average			





### National Lung Cancer Audit (NLCA) 2014 and 2015 (Quality Account)



#### 2014 Report Summary

North Bristol supports a good MDT approach to the diagnosis of lung cancer, patients are seen by a specialist nurse who is present at time of diagnosis, receive CT before bronchoscopy and patients are discussed at MDT at a comparably good level when compared to other Trusts in the region. There are potential areas of concern with regards to patients having active treatment, patients with non-small cell lung cancer having surgery and the percentage of patients with small cell cancers receiving chemotherapy.

#### Action Plan and Changes in Practice






The action plan concentrated on the four main areas of concern. Data validation was implemented to ensure data accuracy. Rates of histological confirmation, surgical resection, and chemotherapy were to be reviewed on publication of the 2015 report. Monthly reviews of data uploaded to the NLCA will help to direct changes to improve results. It was highlighted that the crude resection rate should be reviewed

only in the context of the early stage lung cancer resection rate which is a more accurate marker of appropriate case resection (NBT - 66.7% which is the 7th highest rate of all Trusts). The shortfall in the chemotherapy rate is arguably not clinically significant and could be representative of performance status and patient preference. If the chemotherapy rate is lower than the benchmark 70% for the 2015 report further investigation will be carried out.

#### 2015 Report Summary

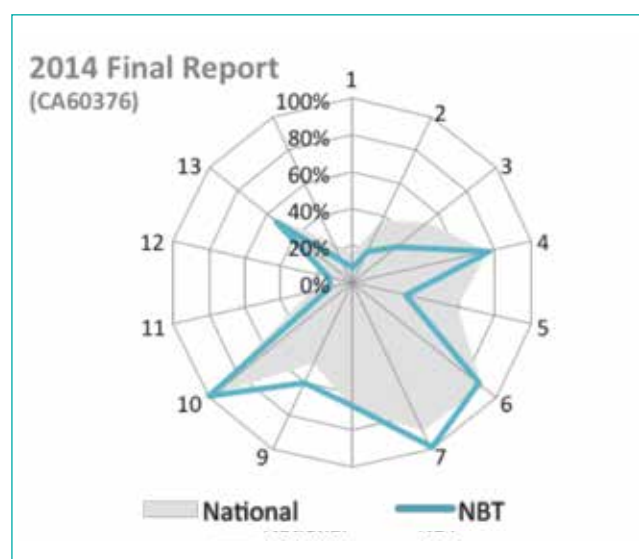
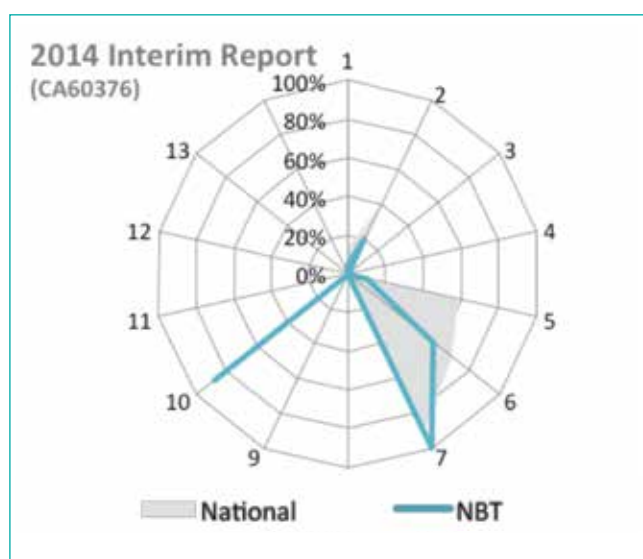
The 2015 report demonstrates improvement in the percentage of NSCLC patients having surgery, and NBT is now above the national average for this metric. Unfortunately this is somewhat marred by a lower percentage being reported for patients seen by a nurse specialist and patients having a histological diagnosis. The action plan for the 2015 report will focus on these areas. Out of the 9 metrics reported in 2015 NBT was above or comparable to the national average on 7 of these.

**Table 24 - Lung cancer NBT vs National****Compliance and Improvement Table NBT vs National**

Measure		Report	Site		+/- 5%
No	Name	Year	NBT	National	Improvement
1	Discussed at MDT	2014	99%	95%	
		2015	98%	94%	
2	Pathological diagnosis	2014	Not recorded	Not recorded	N/A
		2015	66%	69%	
3	NSCLC specified rate	2014	87%	88%	
		2015	88%	88%	
4	Patients seen by nurse specialist	2014	86%	84%	
		2015	59%	78%	
5	Anticancer treatment	2014	Not recorded	Not recorded	N/A
		2015	51%	58%	
6	NSCLC having surgery	2014	14%	17%	
		2015	23%	15%	
7	NSCLC stage IIIB/IV and PS 0-1 having chemotherapy	2014	Not recorded	Not recorded	N/A
		2015	53%	57%	
8	SCLC patients having chemotherapy	2014	Not recorded	Not recorded	N/A
		2015	69%	68%	
9	Patients receiving CT before bronchoscopy	2014	97%	91%	N/A
		2015	Not recorded	Not recorded	
10	Nurse specialist present at diagnosis	2014	80%	65%	N/A
		2015	Not recorded	Not recorded	
11	Histological diagnosis	2014	75%	75%	
		2015	66%	69%	
12	Having active treatment	2014	59%	60%	N/A
		2015	Not recorded	Not recorded	
13	Receiving surgery (all cases)	2014	15%	15%	N/A
		2015	Not recorded	Not recorded	
14	Receiving radiotherapy	2014	29%	28%	N/A
		2015	Not recorded	Not recorded	
15	NSCLC Stage IA, IB, IIA or IIB having surgery (patients first seen 2011-2013)	2014	67%	52%	N/A
		2015	Not recorded	Not recorded	



## National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis 2014 (EIA) (Quality Account)



### Interim Report Summary

NBT did not reach the expected standard for a number of the quality indicators reported by the National Audit. Areas to be targeted for improvement included referral times and patients being seen within 3 weeks. There was a short fall in the number of patients receiving educational support and the treatment target set for Rheumatoid Arthritis at base line was also falling short of the national average. There were areas where NBT was better than the national average such as patients having access to urgent advice, and 100% of patients had their treatment target agreed at base line.

### Action Plan and Changes in Practice







The referral times (only 5% referred within 3 days) were highlighted by the national clinical audit body (British Society for Rheumatology) and a response was returned in December 2015 confirming the data and outlining the action plans in

place to address the issue. A new referral guideline is being developed in conjunction with the referral booking team and consultants, it is hoped that more stringent referral guidelines can be added for GPs in order to ensure that EIA patients are seen promptly. Actions that have already been implemented include education of GPs as to the national standards for referral, meetings and education with coding to ensure errors do not skew the data, and education sessions are in place with OTs and Physios for people with EIA and patients are now offered this session on day of diagnosis.

### Full Report Summary

The full report has since been published for this audit and it shows improvement or no significant change in all comparable areas. NBT has work to do to improve compliance to the standard and the action plan will be developed in response to this to ensure continued improvement and will be reviewed at Clinical Audit Committee by July 2016.

**Table 25 – Compliance and improvement****Compliance and Improvement Table NBT vs National**

Measure		Report	Site		+/- 5%
No	Name		NBT	National	Improvement
1	Patients referred within 3 days	Interim	5%	14%	
		Final	8%	17%	
2	Patients seen within 3 weeks	Interim	20%	41%	
		Final	19%	38%	
3	Patients commencing SMARD <6 weeks	Interim	Not recorded	Not recorded	N/A
		Final	31%	53%	
4	Treated with steroids at working diagnosis	Interim	Not recorded	Not recorded	N/A
		Final	77%	76%	
5	Patient received educational support	Interim	10%	59%	
		Final	30%	59%	
6	Treatment target set for RA at BL	Interim	57%	69%	
		Final	89%	91%	
7	Treatment target agreed with the patient for RA at BL	Interim	100%	91%	
		Final	100%	90%	
8	Treatment target set at FU	Interim	Not recorded	Not recorded	N/A
		Final	68%	69%	
9	Treatment target achieved at FU	Interim	Not recorded	Not recorded	N/A
		Final	61%	49%	
10	Patients have access to urgent advice	Interim	88%	78%	
		Final	100%	99%	
11	Remission	Interim	Not recorded	Not recorded	N/A
		Final	13%	24%	
12	Low disease activity	Interim	Not recorded	Not recorded	N/A
		Final	13%	10%	
13	Reduction in DAS score by at least 1.2	Interim	Not recorded	Not recorded	N/A
		Final	53%	62%	

The table below details the national confidential enquiries listed on the quality account for 2015/2016. It indicates NBT's eligibility for participation, whether NBT did participate and the case ascertainment figures and percentages for each audit in which NBT participated.

**Table 26 - National Confidential Enquiries**

National Confidential Enquiry Title	Eligible to Participate?	Participating?	Case Ascertainment		
			No Submitted	No Expected	%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	6261	6261	100%
Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes			
- Acute Pancreatitis	Yes	Yes	10	10	100%
- Mental Health in General Hospitals Study	Yes	Yes	5	5	100%
- Sepsis	Yes	Yes	5	5	100%
- Gastrointestinal Haemorrhage	Yes	Yes	6	6	100%
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	N/A			

## NICE Quality Standards

NICE quality standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of health of care. They are derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE. They are developed independently by NICE, in collaboration with health and social care professionals, their partners and service users.

Quality standards cover a broad range of topics (healthcare, social care and public health) and are relevant to a variety of different audiences, which will vary across the topics. Audiences will include commissioners of health, public health and social care; staff working in primary care and local authorities; social care provider organisations; public health staff; people working in hospitals; people working in the community and the users of services and their carers.

NICE quality standards enable:

1. Health, public health and social care practitioners to make decisions about care based on the latest evidence and best practice.
2. People receiving health and social care services, their families and carers and the public to find information about the quality of services and care they should expect from their health and social care provider.
3. Service providers to quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide.
4. Commissioners to be confident that the services they are purchasing are high quality and cost effective and focused on driving up quality.

Quality standards consider all areas of care, from public health to healthcare and social care. Evidence relating to effectiveness and cost effectiveness, people's experience of using services, safety issues, equality and cost impact are considered during development.

Although some standards are area-specific, there will often be significant overlap across areas and this is considered during development of the standard. Where appropriate, complementary referrals are combined and developed as a fully integrated quality standard.

## How quality standards are managed

Within NBT all Quality Standards are assessed for their applicability to NBT and its services and patients. A 'Gap Analysis' is completed by the NBT Lead for the Standard and the Clinical Team or Teams linked to the Standards. As an outcome of the Gap Analysis an Action plan is developed to address any possible gaps that may exist. The whole system and process is managed by the Quality Improvement & Clinical Audit Team on behalf of the Clinical Effectiveness Committee.

To date 116 Quality Standards have been released by NICE and of these some 94 apply the Trust with more than 61 Gap analyses' completed during 2015/16.

## Research

We are committed to research and innovation that improves our patients health outcomes and their experience of our services.

We had 531 active research studies this year with 3617 patients recruited and a further 4190 patients seen as part of ongoing research projects. Recruitment was 29% higher than last year and demonstrates North Bristol NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. This year we have carried out research in more clinical areas than ever before with 44 departments across all clinical directorates running research studies. 30% of patients recruited to research in 2015/16 are from the Trusts 6 major specialities.

Strong internal relationships and a commitment to delivering research have made us one of the fastest Trusts in the country to set up new research studies. Patients have had the opportunity to participate in 89% of studies within 70 days of us receiving a request to open a new study.

This year has been notable for new partnerships in research. NBT is leading the way for research to be delivered at all the major maternity units in the west of England by building new

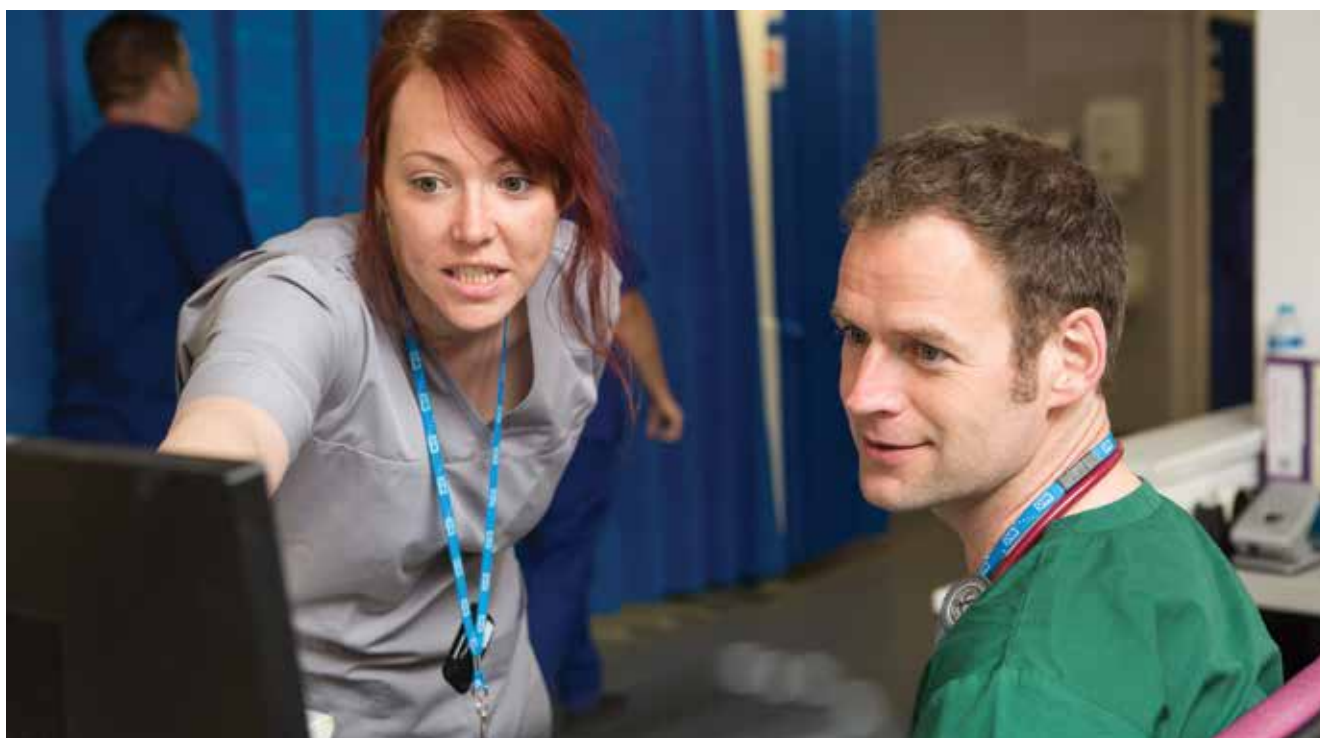
relationships and sharing new ways of working together. 778 women have participated in the IMOX maternity trial at NBT with a total of 1386 participating across the region. NBT is also working with a number of leading life science companies to improve health and answer key questions about dementia, diabetes, Musculoskeletal and cancer.

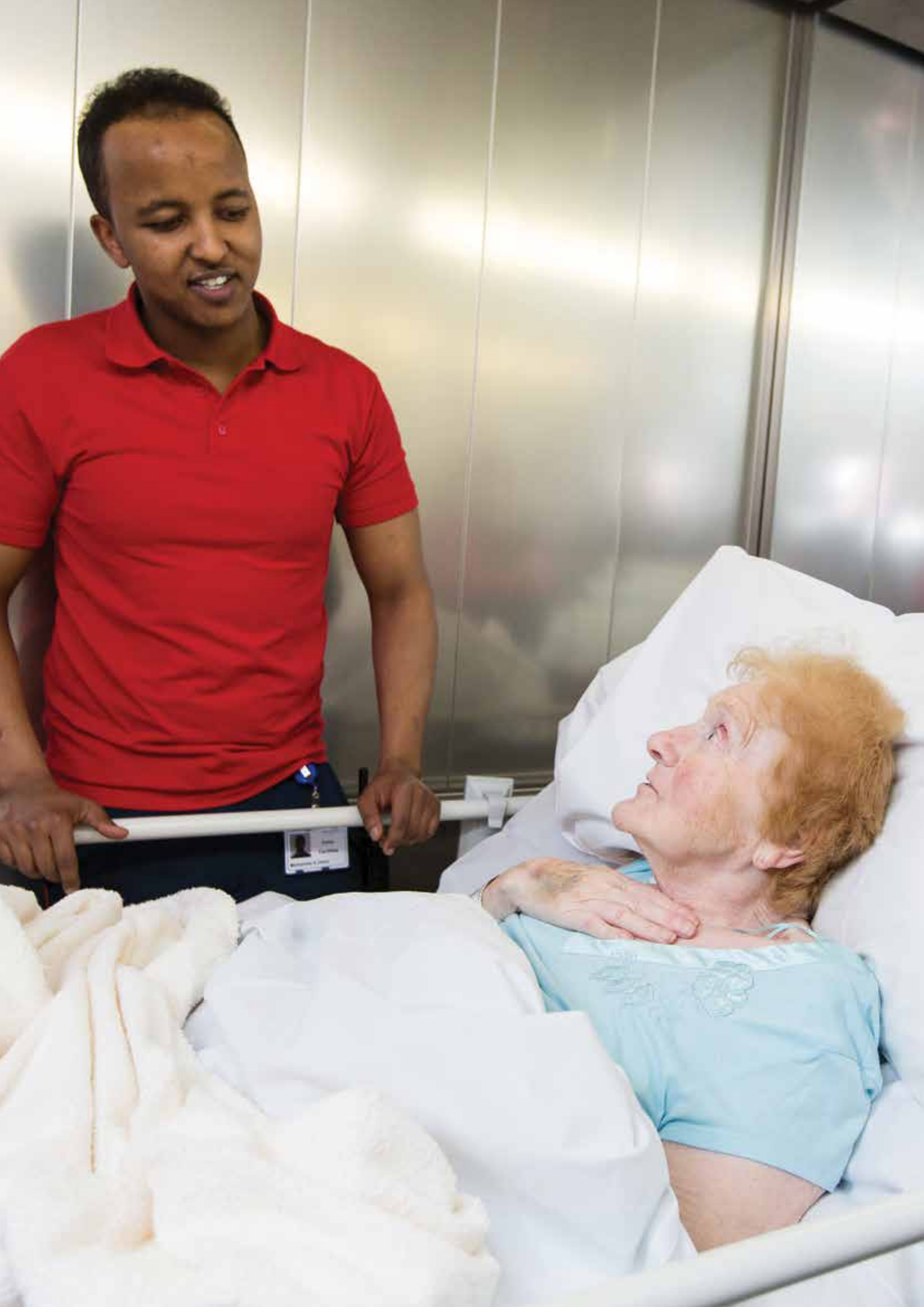
NBT remains a leader in health research that aims to answer important clinical questions. We are currently managing £24.5 million grants awarded to deliver new programmes of research. NBT has attained significant success with our musculoskeletal, urology and microbiological grant development and delivery.

Patients and members of the public are a key part of shaping how we do research. They have helped make decisions on what research to fund through our charitable fund scheme Springboard and have sat on our panels reviewing tender bids for services we use. This year we have created a patient magazine that has been distributed across the whole region to showcase the research we do and the experience of patients who take part.

In December 2015 NBT announced that we had partnered with University Hospitals Bristol, RUH and Gloucester to become one of 13 NHS Genomic Medicine Centres (GMC), in a major national initiative (the 100,000 Genome Project) that aims to transform diagnosis and treatment for patients with cancer and rare diseases. NBT will contribute approximately 600 genomes to the project annually which should enable the development of new and better predictive and diagnostic tests for diseases, and allow drugs and other treatments to be tailored precisely to the individual patient.

The Trust is working collaboratively across the geographical area with primary and secondary care providers to ensure all patients have equal access to research, highlighting research as a treatment option and empowering patients to request and require access to research studies.





## Section 5 - Operational Standards and Data Quality



### Emergency Department

North Bristol NHS Trust's Board has a commitment to sustain a performance of 95% of patients not waiting longer than four hours in its A&E departments from arrival to admission, transfer or discharge.

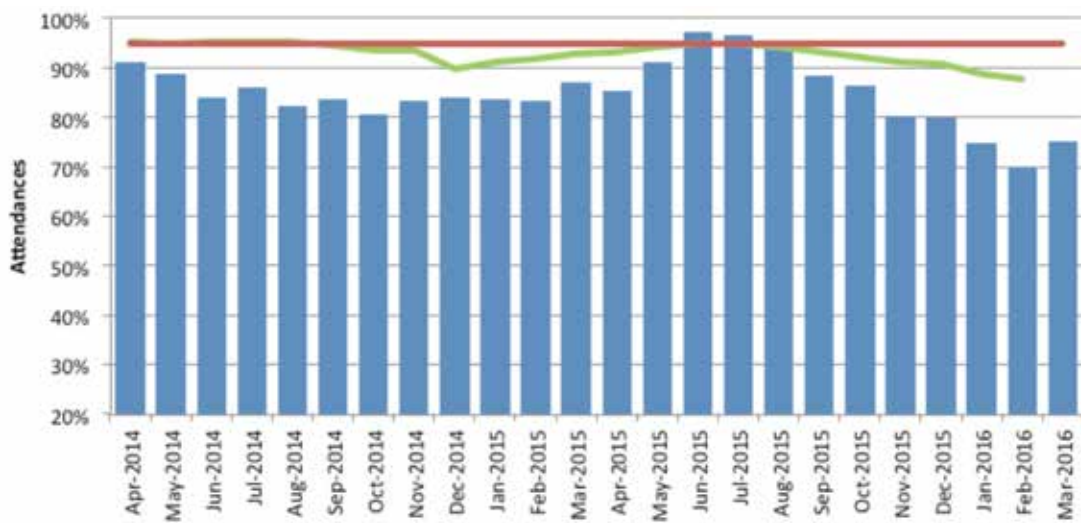
NBT has not been able to sustain the 4 hour A&E performance target but did achieve of this standard during Jun-15, Jul-15 and Aug-15. Over the last year patient safety, privacy and dignity have been the focus of significant change and improvement in the emergency zone, ensuring consistent safe practice.



Bed occupancy within the Trust is high, resulting in restricted flow of patients through and out of the hospital; and the Bristol and North Somerset system has agreed to an action plan aimed to improve and sustain the performance in 2016/17. Key actions include;

- Early discharge preparation and documentation within NBT;
- Stronger board-rounds with a pivotal role for the integrated discharge member;
- Simple common referral pathways for discharge;
- Clarity of capacity and flow for discharge; and
- Production of and use of a trusted leaving hospital patient database.

**Chart 30 - Urgent Care – Waits in Under 4 Hours vs. Total Attendance**

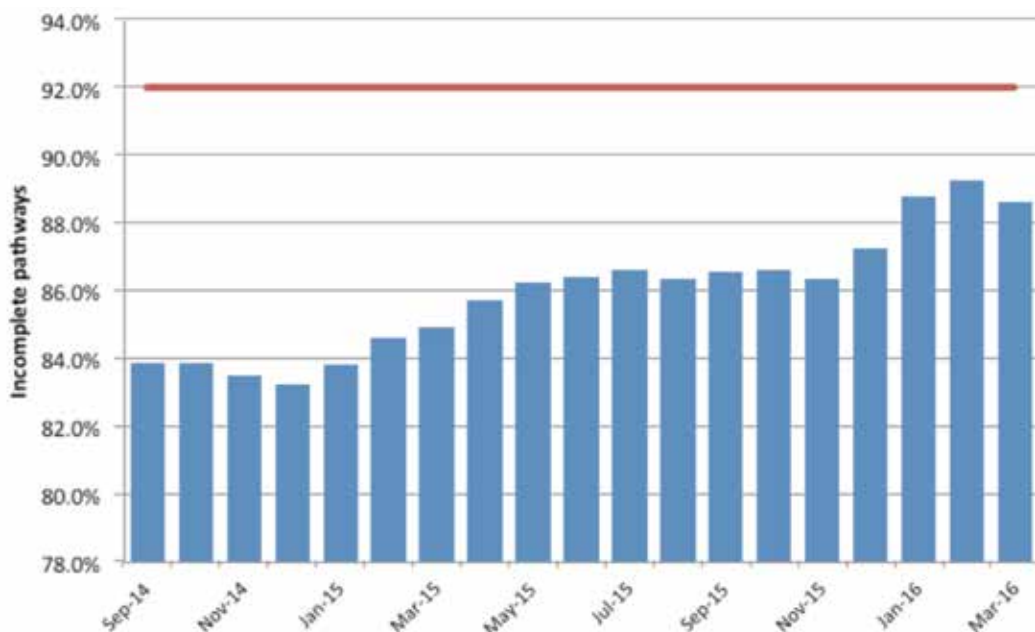


**Referral to Treatment**

As part of the NHS Constitution NBT recognises the patient’s legal right to start a non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.

Throughout the year NBT has seen a steadily improving position against this performance standard, and continues to have agreed improvement profiles in place with the system to remove all long waiters (waits in excess of 52 weeks) and then move towards sustainable delivery of this target.

**Chart 31 - Percentage of Incomplete Pathways**



## Long waiting specialties

The Trust Board for North Bristol NHS Trust is absolutely committed to the zero tolerance of >52 week waiters on an RTT incomplete pathway. These long waiters are seen in the orthopaedic and neurosciences service for spinal related patients, as well as those on a specialised epilepsy care pathway. NBT is partaking in the South West Network Spinal Transformation Project to look at the spinal pathway across the local health system to ensure that the service will have an achievable and deliverable capacity and demand for all providers and parts of the pathway prior to reopening.

## Clinical Review whilst on waiting list

During the year the Trust's Quality Committee has reviewed and signed off an approach to ensuring that all patients waiting for a longer than the ideally identified time for treatment undergo a clinical review. This clinical review varies in nature depending upon the specialty in question but the common requirement is that senior clinicians ensure that patients do not experience additional harm due to their waiting time. During 2016/17 this approach will be enhanced through more formalised assurance measurement and reporting both internally and externally to commissioners.

## Improving the discharge of patients from hospital

We discharge many patients each day to a variety of settings. Whilst for many patients this is a positive experience, we recognised that for some the experience could be improved. We also wanted to reduce the numbers of patients who no longer needed acute hospital care but were still delayed in hospital waiting for ongoing care services.

Many staff also feedback that the systems and processes for discharge were complicated to follow and difficult to understand. We have therefore spent time developing and implementing a series of changes and improvements:

**Discharge to assess** – We worked with external health and social care partners to establish three different pathways (home with support, community rehabilitation, and long term care), aimed at discharging patients once they no longer need acute hospital care – right care, right place, right time.

**Integrated Discharge Service** – We have built a service comprising health and social care partners, all working from the same location to support and deliver safe and timely discharge for patients with complex needs. This expert team works with patients and families from the earliest possible stage in their hospital stay to determine their ongoing care needs and the most appropriate discharge pathway. This service is still in its early stages so there will be further review and development.

**Discharge Lounge** – We have opened an area on the ground floor overlooking pleasant gardens, designed to house patients who are waiting to go home that day. This enables their bed to be vacated early to enable any new admissions to have prompt access to a hospital bed at a time when they are acutely ill.

**Care Home CQUIN** – This has been agreed with commissioners and the care home sector as a set of standards designed to improve the experience of care home residents who are admitted to hospital, as well as improving the discharge of this vulnerable patient group into the care home sector. We have changed our discharge checklist to reflect the new standards and have also implemented an audit programme to measure how we are doing.

There have been many other related developments during the course of year, and this has resulted in reducing length of hospital stay for many patients, an increase in community support for both health and social care, and improved patient satisfaction with the care around discharge planning and their actual hospital discharge. Some of the above work is being nationally recognised as good practice, and we will continue to improve patient experience around discharge and drive efforts to discharge patients in a timely way to improve bed availability for acutely ill patients.



## Data Quality

### Hospital Episode Statistics

The Trust submits a wealth of information and monitoring data centrally to our commissioners and the Department of Health. The accuracy of this data is of vital importance to the Trust and the NHS to ensure high quality clinical care and accurate financial reimbursement.

Our data quality reporting, controls and feedback mechanisms are routinely audited and help us monitor and maintain high quality data.

We submitted records during 2015/16 to the Secondary Users' Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. Within this data we are expected to include a valid NHS number and the General Medical Practice (GMP) Code and report this within each year's quality account. This information is presented below.

**Table 27 - HES**

M9	2013/14		2014/15		2015/16	
	NHS no.	GMP code	NHS No.	GMP code	NHS No.	GMP code
Admitted Patient Care	99.4%	100.00%	99.5%	100.00%	99.5%	98.20%
Out Patients	98.6%	99.90%	98.4%	99.80%	98.7%	99.80%
A&E	97.8%	100.00%	97.4%	100.00%	97.4%	100.00%

The percentage of records in the published data which included patient's valid NHS number remains consistent in each of the three domains.

The completeness for inclusion of the GMP within Admitted Patient Care has suffered since the Lorenzo go-live which occurred in mid-November 2015. Prior to that, in October 2015, we were reporting 100% for the year to date. The issue within Lorenzo is being resolved but won't be complete in time for our 'closure' of 2015/16 data as the national HES refresh will be made ahead of this.

The fix will prevent under reporting of this in 16/17 and we will also retrospectively fix our own Admitted Patient Care dataset for 2015/16.

### Clinical coding error rate

Accurate clinical coding is now widely recognised by the NHS as being an essential element for benchmarking Trusts

performance against peers nationally, recouping accurate income from commissioners through Payment by Results (PbR), and it provides the ability to understand the Trusts own clinical activity in areas such as mortality statistics, audit and many other crucial areas.

During 2015-16 the clinical coding department participated in the Trusts Monitor reference Cost audit, although this did not involve an audit of the actual coded data.

As part of the Trusts internal rolling clinical coding plan of audit the department did conduct several audits throughout the financial year, including the mandatory Information Governance (IG) audit, which examines general coding accuracy in the departments selected areas.

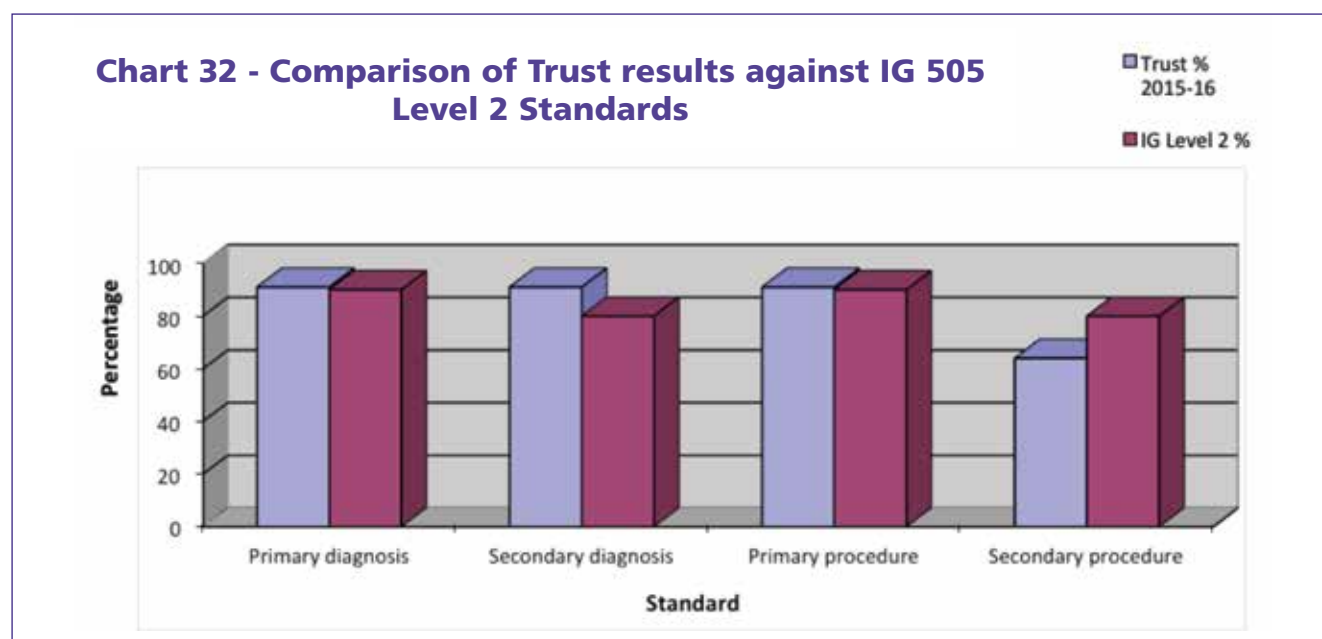
The approved auditors examined 200 FCE's (Finished Consultant Episodes) in total. The focus of the audit was 100FCE's for Vascular Surgery and 100 FCE's for Endoscopy, the results were as follows:

**Table 28 – FCE's**

Correct primary diagnosis %	Correct secondary diagnosis %	Correct primary procedure %	Correct secondary procedure %
91	91	91	64

The Trust achieved Information Governance Level 2 standards in all but secondary procedure coding.

Below is a comparison of the Trusts results against Information Governance 505 level 2 attainment standards.



There was a noted increase in errors in secondary procedure coding in part due to omission of or incorrect site codes being recorded. A change in national standards now means that site codes can be consistently audited, which was not the case for many years. Feedback and any necessary training have and will continue to be given to the coding team.

All other areas examined met or exceeded requirements showing continued high standards of coded data that compares well nationally with our peers

The department has conducted other audits throughout the financial year, an example of one such audit was the Haematology/Oncology audit, in this audit all four examined areas achieved over 93 per cent, and this again reflects the high standards to which the department operates.

Throughout the financial year the department has continued to encourage closer working relations with clinicians and directorates, including work with the Neuropsychiatry team, Orthopaedic consultants- specifically in relation to pelvic work, the Plastic Surgery team, the Women and Children's team and many others.

Clinicians have also continued to be widely involved and engaged in the Clinical Coding Validation service, with a number of new consultants asking to be registered for the service. This demonstrates the services continued value.

The department have had a number of new staff join them throughout the financial year and been committed to developing the individual's skills, as well as the team as whole. The new starters have been supported throughout this process by the Deputy Head of Coding, the Clinical Coding Trainer/Auditor and the Clinical Coding Team Managers.

The department introduced new data quality reports that helped improve the recording and capture of clinical information in a coded format. They also continued with the use of data quality

reports already in place which had proved themselves in prior years as essential to continue to monitor and improve data quality.

The department's internal programme of audit, clinical coding validation service, clinician engagement and variety of data quality reports continue to ensure the coding department has a robust internal programme of audit to guarantee accurately coded clinical data.

### Information Governance Toolkit attainment levels

The IG Toolkit is now in its 13th year (v13). Evidence is required to be uploaded to support the self-assessment across 45 requirements.

There are two possible grades:

- Satisfactory (green); level 2 achieved on all 45 requirements
- Not Satisfactory (red); level 2 not achieved on all requirements

The purpose of the IG toolkit is to drive improvement. All organisations are expected to achieve level 2 in all requirements in accordance with the NHS Operating Framework (informatics planning 2011/2012).

North Bristol NHS Trust IG Toolkit assessment report overall score for 2015/2016 (v13) is 65%, graded red.

There are improvement plans in place detailing the evidence needed for each requirement, which will allow the Trust to clearly identify where improvement has been made and or there are gaps in compliance. The improvement plans will be reviewed through the Trust governance processes throughout the 2016/17 financial year.

The Trust has recently received the final report for an internal audit, which concluded that the overall system for compiling the IG evidence and score is sound and this includes effective ongoing governance arrangements.



# Section 6 - Engagement and Consultation

## Quality Priorities

To find out which topics matter the most to the Trust's stakeholders when selecting the Quality Priorities for 2016-17, the Trust undertook a programme of engagement with its members, staff, Local Authority Health Overview and Scrutiny Committees, the Trust's own Patient Panel and others. This has included the following schedule of meetings, targeted discussions and specific presentations about the Quality Account;



- Review with Trust Patient Panel – February 2016
- Review with Patient Experience Group – February 2016
- Discussion with Healthwatch – February 2016
- Presentation/Discussion at Quality Committee – March 2016
- Presentation to Bristol City Council People Scrutiny Commission – April 2016
- Presentation to North Somerset Council Health Overview & Scrutiny Panel – April 2016
- Supply of presentation for South Gloucestershire Public Health and Health Scrutiny Committee – April 2016

The Trust also undertook an on-line survey of the Trust's members and clinical leads and management teams to ascertain views on the priority topics for the year ahead, which received 198 responses and identified the four priorities for 2016-17.

The draft Quality Account was circulated for comment in the period 29th April 2016 – 28th May 2016.

A list of the organisations who were sent the document as part of the consultation is shown below.

### External Comments

The following organisations were invited to comment on the draft of the Quality Account:

- NHS South Gloucestershire Clinical Commissioning Group
- NHS Bristol Clinical Commissioning Group
- NHS North Somerset Clinical Commissioning Group
- North Bristol Trust - Patient Panel
- Bristol Healthwatch
- South Gloucestershire Healthwatch
- North Somerset Healthwatch
- South Gloucestershire - Public Health Scrutiny Committee
- Bristol - People Scrutiny Commission
- North Somerset - Health Overview & Scrutiny Panel

## Commentary from the North Somerset Health Overview & Scrutiny Panel



### Response to the North Bristol NHS Trust (NBT) Quality Account 2015/16

### QA Presented by Sue Jones (Director of Nursing & Quality) and Paul Cresswell (Associate Director of Quality Governance)

**In its response to the Trust's 2014/15 Quality Account (QA) last year, Members acknowledged the significant challenges associated with the move to the new hospital at Southmead and noted the impacts on services provided to patients. The Panel is pleased to see the significant progress made by the Trust this year, evidenced by the much improved CQC compliance and ratings from recent inspections and clear improvements in patient feedback.**

#### Performance against 2015/16 Priorities

The Panel especially welcomes the work undertaken by the Trust in improving care for patients with dementia noting its excellent performance in finding, investigating and referring people with unrecognised cognitive decline (exceeding compliance with national standards).

Members also recognise the Trust's focus on patient safety as evidenced by its "Sign up to Safety" priorities with specific programmes delivering significant improvements in a number of key areas including reducing patient falls, pressure ulcers, and acute kidney injury (amongst others).

Furthermore, Members are encouraged by the Trust's performance against its priority to "improve our patients' overall experience in hospital", noting its improved

performance in the 2015 National Inpatient Survey and Friends and Families Test results.

#### 2016/17 Priorities

The Panel supports the Trust's 4 key QA priorities for 2016/17: involving patients, families and carers in decisions about their care and treatment; dementia and delirium care management; improving end of life care; and improving the identification and management of Sepsis – together with the continuing focus on the "sign up to safety" priorities.

Roz Willis  
Chairman, Health Overview & Scrutiny Panel  
North Somerset Council

# North Bristol NHS Trust Quality Account 2015/16

## Response from South Gloucestershire, Bristol and North Somerset CCG

**NHS**  
South Gloucestershire  
Clinical Commissioning Group

**NHS**  
Bristol Clinical Commissioning Group

**NHS**  
North Somerset  
Clinical Commissioning Group

**The CCGs welcome the opportunity to respond to NBT's quality account for 2015/16. We felt the document is a very good read and provides an honest representation of quality within the Trust detailing the positives and also where things are not going so well and targets that haven't been achieved. We particularly liked the staff and patient comments throughout the report.**

As acknowledged in the recent Care Quality Commission (CQC) report the positive improvement in quality within the Emergency Department is commendable, specifically with regards to patient's safety, privacy and dignity. We also recognise the improvements made in critical care, maternity and gynaecology services.

The Trust has shown an increased focus on reducing the number of inpatient falls and pressures ulcers, which they have achieved and we note the plans within their 'Sign up to Safety' pledges to continue to focus on these areas going forward. Of particular note, is the Trust not having any grade 4 pressure ulcers in 2015/16 and a reduction of 50% grade 3 pressure ulcers.

It was disappointing to note the Trust did not achieve either of the infection control constitutional standards, reporting three MRSA cases and 51 Clostridium Difficile infections (CDI) in 2015/16. In addition it was also noted that of the 51 CDI cases, 32 were classed as avoidable with little details on actions to reduce this number going forward.

It is encouraging to see the quality improvement work on timely discharge communication and the changes that have been made to the discharge summary from having completed the quarterly audits with the Trust in 2015/16. It is good to see this work continuing to be rolled out to other specialties during 2016/17.

The Trust has demonstrated how they have reduced the number of overdue complaints and steps taken to address common complaint themes. However, we acknowledge that in the latter part of 2015/16 the number of overdue complaints has increased again. The CCGs are actively working with the Trust to address this increase in a sustainable way. The response rates for the patient feedback via the Family and Friends Test is also noted to be below the target rate in all four areas (Inpatients, Emergency Department, Maternity and Outpatients) for the majority of months in 2015/16, however, we note the Trust has recently implemented a new system to capture patient experience and the response rates are likely to increase.

During 2015/16, the CCGs have actively worked with the Trust to help achieve the 95% compliance for Venous Thrombosis Embolism (VTE) risk assessment national target. We note the backlog of clinical coding prevented the Trust from achieving the target in the latter part of year and the Trust is now looking an alternative way to capture VTE risk assessment on admission to hospital.

The Trust details the notable work they have done against their four quality priorities for 2015/16 however, it is not clear if they have fully achieved these. The four quality priorities for 2016/17 have been listed and whilst we can see the alignment with national and local CQUINs 2016/17, we would have liked to have seen more detail describing what success looks like for these priority areas.

NBT have demonstrated areas of good quality improvement and the CCGs look forward to working with the Trust in 2016/17. During the year, we want to use the opportunity to focus on those areas where standards fell below an acceptable level and the actions needed to improve quality of care for patients.

**Anne Morris**  
Director of Nursing and Quality  
South Gloucestershire CCG

**Alison Moon**  
Transformation and Quality Director  
Bristol CCG

**Bridget James**  
Head of Quality  
Bristol CCG

**Jacqui Chidgey-Clark**  
Chief Nurse  
North Somerset CCG

May 2015



# Commentary from Bristol Healthwatch & South Gloucestershire Healthwatch

## Healthwatch Bristol and Healthwatch South

## Gloucestershire reply to the North Bristol NHS Trust (NBT) Account of the Quality of Clinical Services 2015/16



Healthwatch Bristol and Healthwatch South Gloucestershire acknowledge that following the Care Quality Commission inspection in December 2015 the trust remains as 'requires improvement' but were pleased to note that within urgent and emergency care services the rating acknowledged the improvement in service and is now rated 'good'. Healthwatch wonders whether the implementation of the Patient Administration system (Lorenzo) the disruption in the collection and quality of information has impacted on patients. Healthwatch has continually heard that data is not always available at their appointments. Healthwatch welcomes the work of the trust on dementia and were pleased to hear that this work is acknowledged in being shortlisted for 'Dementia Team of the Year'.

Healthwatch have been disappointed to read that areas that scored worse than last year included patients staying on a ward with shared sleeping accommodation, with bath and shower facilities with the opposite sex. It was also unacceptable for staff not to have discussed the need for further health or social care around discharge, all patients need a discharge plan and Healthwatch would like to see this as a trust priority that is acted on to make improvements during the year. Healthwatch recognise the aspects of care that have significantly improved as patients tell us that they are well cared for by staff. Healthwatch wonders whether the quality improvement workshops as part of building improvement capability in the workforce are mandatory?

Healthwatch read with interest the outcomes on the rate of falls, and the reduction can be attributed to the face to face training for 817 nursing staff. Healthwatch would like all staff to be aware of falls and hope that following the Sign up to Safety funding from NHS England this training by Lead nurses can continue.

NBT set a target of 95% for patients admitted to have their medicines reconciled within 24 hours, Healthwatch believe this should be 100% and also encourage the trust to look at the prescription of medicines, making sure the patient and / or their carer/family have written information of what has been prescribed and how medicines should be taken. Some patients tell us they are not given enough information about prescribed medicines on discharge.

Healthwatch were disappointed to read that there were 51 cases of C. Difficile infection (CDI) and with almost a third bought in from outside the hospital. Healthwatch would like to work with NBT to raise awareness with the public about this unpleasant

and potentially severe infection. Healthwatch accept the reduction of safety incidents this year, and how staff awareness has been actively promoted but Healthwatch feels all staff need to be aware of their Duty of Candour this should be mandatory as not all staff will read the guidance on the intranet.

Healthwatch read with interest the themes patient tell NBT and we recognise that a lot of this mirrors what Healthwatch hear from children, young people and adults. There were only 28 negative experience themes on parking and Healthwatch hear a great deal more about the issues of car parking at Southmead hospital and the concern people have over the proposed car parking charges at Cossham hospital.

Healthwatch read the staff survey feedback and were saddened to read that there has been no change in the 26% of staff experiencing harassment, bullying or abuse from staff. Healthwatch would like to hear in the coming year what the trust intends to do to address this.

The fall in complaints this year, Healthwatch would like to know the breakdown of low level concern themes and whether these match the complaints themes? Healthwatch would also like to see the comparison to compliments received last year and the breakdown of compliment themes in future quality accounts. Healthwatch were disappointed to read that the Trust has not been able to meet all the targets in cancer performance and in trying to fully understand the delays the trust is reviewing all patients who are not treated within the 62 days of their GP referral. Healthwatch look forward to hearing if the trust can identify ways to address this in the coming year. Healthwatch read with concern that the trust has been unable to meet the 95% target of 4 hours for patients in A&E and read with interest the key actions for 2016/17. Healthwatch would like some clarification on who the integrated discharge member will be as they appear to be key in addressing the issue.

As part of the CQUINS where income is conditional on achieving quality improvement Healthwatch look forward to hearing the outcomes particularly for CAMHS as Healthwatch is looking at the transformation of children and young people's mental health services.

Healthwatch noted that the quality account as a public document has no information printed about how people can access the document in other accessible formats, with the introduction of the Accessible Information Standard coming in this year Healthwatch recommend that this is something to be considered for the next quality account.

# Commentary from North Somerset Healthwatch



## Response to North Bristol NHS Trust Quality Account 2016

### **Healthwatch North Somerset is pleased to have the opportunity to comment on the draft North Bristol NHS Trust Quality Account for 2016.**

Healthwatch North Somerset acknowledges the Quality Account for North Bristol NHS Trust 2015/2016 and note the good progress on the Priorities for Improvement. We welcome the Trusts commitment to continue building on achievements on those Priorities alongside the four Priorities for Improvement identified for 2016/2017 – we would welcome however clarity on how the progress each of the Priorities will be measured and against which criteria these measurements will be assessed.

We commend and note the improvements the Trust has made over the past year and the commitment to address the numerous CQC 'requires improvement' ratings. We note that 'Caring' is rated as good or outstanding throughout the Trust.

The Trust is to be congratulated for the ratings given to the Community Health Services for children and young people and families and Cossham Hospital.

It is disappointing that there has been a decrease in compliance with the 5 Steps to Safer Surgery aspects of improving theatre safety but we note the statement regarding a decrease in non-conformance with decontamination standards – although figures for this were not included in the Account.

It is encouraging to see Early warning score rise in trigger calls rates so deterioration of condition is being observed early.

We note the level of serious incidents reported and the comment about serious falls remaining an issue. The graph relating to Serious Incidents is partially incomplete.

There is concern regarding the quality standard for intravenous fluid therapy statement that states 'The task of assessing and managing patients IV fluids can be left to the most junior and inexperienced staff with little knowledge of patient daily requirements or the composition of common IV fluids'. We seek assurance that this is not the case.

The evaluation of patient experience is central to the functions of Healthwatch. Healthwatch North Somerset provides feedback of patient experiences to the Trust each month and have a representative on the Patient Experience Group. Engagement by the Trust with so many stakeholders including Healthwatch is to be congratulated.

The level of Friends and Family Test responses were significantly lower than the national benchmark. However, we note the feedback themes and the high level of positive feedback compared to negative feedback. We commend the steps taken by the Trust to focus on the patient experience through the development of a walk around programme - '15-Step Challenge'.

The increase in number of complaints in 2015/2016 compared to previous years is noted and we acknowledge the steps taken to reduce the backlog of complaints and the actions being undertaken to analyse the data. We also acknowledge the high number of compliments received.

The figure relating to staff experiencing harassment, bullying or abuse from staff is of concern. We are reassured that there is a commitment to actively promote the Trust's zero tolerance policy. We also note that 71% of staff would recommend the Trust as a place to work.

The Ask 3 Questions trial appears to be a positive step in empowering patients to manage and understand their own conditions and choices.

We acknowledge the data referring to Quality of Cancer Services and note that the national target of Patients receiving first treatment within 62 days of urgent GP referral was breached in each quarter. We seek reassurance that robust measures will be put in place to ensure this target is met.

We recognise the number of clinical audits and clinical research the Trust has participated in which provide an effective mechanism for clinical governance for improving the quality of care patients receive.

We are unable to fully comment on the mandatory indicators as the data is not complete. However we note from the figures shown that the Trust in many instances performs below national averages. Clarity on these would be welcomed.

There is a contents page and appendices but no glossary of terms and many acronyms are used. Not all of the charts are easily accessible or understandable. Combined, these make the Quality Account difficult to understand for the lay reader.

This response was completed with the support of Healthwatch North Somerset Volunteers.

# Commentary from the South Gloucestershire Public Health Scrutiny Committee



## Health Scrutiny Committee's comments on the North Bristol NHS Trust (NBT) Quality Account 2015/16

### The Health Scrutiny Committee received NBT's Quality Account on 8 June and the following points were covered:

- Ongoing car parking issues at Southmead Hospital - the opening of the phase 2 multi-storey car park, adjacent to the new Brunel Building, in July 2016 was welcomed by members.
- Pathology Services – members praised the new pathology laboratory on the Southmead site, which they visited earlier this year. They felt that it would attract top quality staff and students, and were, therefore, concerned that an appointment had still not been made to the Pathology Clinical Lead post. In response NBT stated that they were currently in discussion with one perspective candidate.
- The Trust had recruited new Executive and Non-executive Directors and restructured its Quality Governance Team.
- Significant improvement had been made following the CQC inspection last year, with the Emergency Department moving from inadequate to good.
- Improvements had been made in terms of hospital acquired infections.
- Progress had been made in terms of patient falls and the management of serious falls had improved.
- Issues raised in the inpatient survey around continuity of care – NBT acknowledged that work was needed to improve on this.
- Learning from mistakes and staff not feeling able to report issues – this came out in a staff survey. NBT stated that it was aware of the issue and is now looking to procure a new reporting system, and it is working with staff on safety.
- Complaints – concern about the number of outstanding complaints at the end of the year, response times and what learning takes place. NBT acknowledged the issues and reported that process and cultural changes are being put in place. The Director of Nursing is now responsible for complaint handling and is looking at what further support is needed within directorates to ensure processes are robust. They are also going to let complainants know, at the beginning of the process, how long their complaint will take to address and are introducing more early resolution meetings.
- Increase in safeguarding alerts – this was felt to be due to greater staff knowledge, a higher number of elderly patients and a more open learning culture.
- Reliance on agency staff – this had reduced following a large recruitment campaign and a recent cohort of Spanish nurses joining NBT.
- End of life care and supporting carers – a similar service existed across the city of Bristol, including access to the hospital canteen for meals and free parking. NBT was putting in place the provision of camp beds for carers to use and would also consider the 'carers box' scheme provided by some other providers.

Councillor Toby Savage  
Chair,  
Health Scrutiny Committee

Councillor Sue Hope  
Lead Member,  
Health Scrutiny Committee

Councillor Ian Scott  
Lead Member,  
Health Scrutiny Committee

# Commentary from the Bristol People Scrutiny Commission



**The Bristol City Council People Scrutiny Commission holds the statutory health function for Bristol Council. The Commission received a presentation on the 8th June and Members were satisfied with the contents of the North Bristol NHS Trust - Account of the Quality of Clinical Services 2015/16.**



**Section 7 -  
Appendices**

## Appendix 2 2015/16 CQUINS

A proportion of North Bristol NHS Trust's income in 2015-16 was conditional

on achieving quality improvement and innovation goals agreed between North Bristol NHS Trust and local Clinical Commissioning Groups or NHS England for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2015-16 and for the following 12 month period are available electronically at

<https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf>

<b>Appendix 2 2015/16 CQUINS</b>		
<b>Title</b>	<b>National &amp; Local CQUINS (CCG contracted)</b>	<b>Outcome</b>
Acute Kidney Injury	Acute Kidney Injury - Discharge information	Green
Sepsis	Sepsis Screening at admission	Green
	Sepsis Antibiotic Administration	Green
Dementia Care	Find, Assess/Investigate, Refer/Inform (FAIRI)	Yellow
	Staff Training	Yellow
	Supporting Carers	Yellow
Urgent Care	Reducing Avoidable Admissions	Yellow
	Reduction in alcohol dependence & related emergency admissions	Yellow
Patient Discharge	Discharge summaries - timeliness and completion	Green
	Care homes - Prevention of admission and timely discharge	Green
	Discharge to assess pathways and Integrated Discharge Hub' (IDH)	Yellow
Cancer Care	Reducing late inter-provider cancer referrals	Green
	Cancer survivorship	Green
End of Life Care	End of Life - prognostic indicators & training	Green
Patient Experience	Patient Self-care -ask 3 questions	Yellow
Patient Safety	Organisational safety culture review	Green
Safeguarding Adults	Making safeguarding personal for people with Learning Disabilities	Red
<b>Specialised CQUINS (NHS England contracted)</b>		
Clinical Utilisation	Implementing Clinical Utilisation review	Yellow
HIV monitoring	Reducing unnecessary CD4 monitoring	Yellow
Vascular Surgery	Improving outcomes for major lower limb amputation	Yellow
Critical Care	Rehabilitation assessment before critical care discharge	Yellow
	Reduce delayed discharges from Intensive Care Unit to wards	Yellow
Neurology	Emergency care plans for patients with a long term neurological condition	Green
CAMHS	CAMHS Tier 4 - Carer and family engagement	Green
NICU	Hypothermia	Red
Orthopaedics	Orthopaedics - Developing network	Green

Good Achievement - 80%+	Green
Partial achievement - 40%-79%	Yellow
Poor achievement- <40%	Red

### Appendix 1 – Mandatory Indicators Table

Mandatory indicator	NBT 2015/16	National average 2015/16	National best 2015/16	National worst 2015/16	NBT 2014/15	Comment
Venous thromboembolism risk assessment	93.5% Apr 15 - Dec15	95.7% Apr-Dec15	100% Apr-Dec15	80.6% Apr-Dec14	97%	The Trust considers that this data is as described as there is a close focus on VTE risk assessment performance due to challenges raised around the operational delays in coding of clinical notes that are causing this to fall below the national standard of 95%. This issue has been exacerbated by the stabilisation required following the new Patient Administration system 'go live' in November 2015. From clinical audits it is clear that actual clinical practice does achieve the required 95% standard but the coding lag means this is not reported in time for national data collection.  The Trust will continue to ensure our patients are risk assessed for VTE on admission and is working on improving VTE prevention as detailed in the report. Work to improve the operational factors that will improve the reported percentage is being managed through an agreed Action Plan with commissioners, which is overseen internally through the Quality Committee and externally through the CCG Quality Sub Group.
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)	14.95 Apr 15 – Mar 16	15.3 Apr15-Jan16	0 Apr15-Jan16	63.4 Apr15-Jan16	14.2 Apr14 – Mar 15	The Trust considers that this data is as described for the following reasons: rate is as described as the latest available on the HSCIC website and is validated closely on a case by case basis by the Trust's Infection Control Team.  The Trust will act to improve this percentage, and so the quality of its services by continuing to focus on a range of improvement actions to reduce C.Difficile infection through as outlined in this report.
Rate of patient safety incidents reported per 1,000 bed days	28.95 Apr15-Sep15	38.23 Apr15-Sep15	117[1] Apr15-Sep15	15.90 Apr15-Sep15	30.9 Apr14-Sep14	The Trust considers that this data is as described as it is supplied by the National Reporting & Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year.  The Trust will act to improve this rate, and so the quality of its services by continuing to review incident data to encourage open and transparent reporting and to identify improvements to practice and learning.
Percentage of patient safety incidents resulting in severe harm or death	0.53% Apr15-Sep15	0.42% Apr15-Sep15	0% Apr15-Sep15	2.92% Apr15-Sep15	0.40% Apr 14- Sep 14	The Trust considers that this data is as described as it is supplied by the National Reporting & Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year.  The Trust will act to improve this percentage, and so the quality of its services by continuing to review all Serious Incidents through Root Cause Analysis investigation and actions to identify lessons and improvements to practice.

Responsiveness to inpatients' personal needs	Comparative data for 2014/15 (2013/14 in brackets): NBT score 63.8 (76.5); England overall 68.9 (68.7); low 59.1 (54.4); high 86.1 (84.2). Comparative data for 2015/16 will not be available from the Health & Social Care Information Centre until August 2016.	69% 2015 Staff Survey Oct 14 – Sep 15	75.0% 2015 Staff Survey Oct 14 – Sep 15	86.1% 2015 Staff Survey Oct 14 – Sep 15	55.4% 2015 Staff Survey Oct 14 – Sep 15	51.9% 2014 Staff Survey Apr 14 – Mar 15	The Trust considers that this data is as described for the following reasons as this rate is as described as is the latest as available on the HSCIC website. The Trust will act to improve this percentage, and so the quality of its services by continuing to collect feedback from patients, carers and relatives through a range of different sources co-ordinated by the Head of Patient Experience and utilising the Patient Panel and Experience Group as outlined in this report.
Percentage of staff who would be happy with standard of care provided if a friend or relative needed treatment	69% 2015 Staff Survey Oct 14 – Sep 15	75.0% 2015 Staff Survey Oct 14 – Sep 15	86.1% 2015 Staff Survey Oct 14 – Sep 15	55.4% 2015 Staff Survey Oct 14 – Sep 15	51.9% 2014 Staff Survey Apr 14 – Mar 15	The Trust considers that this data is as described as it is directly extracted from National Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions. The Trust will act to improve this percentage, and so the quality of its services by revitalising the approach taken to patient feedback to broaden its range and target improvement actions rapidly to address themes. This includes improvements in relation to the management of incidents and feedback on actions taken.	
Summary Hospital-level Mortality Indicator (SHMI) value and banding	90.2 Oct 14 – Sep 15	100 Oct 14 – Sep 15	73.78 Oct 14 – Sep 15	114.72 Oct 14 – Sep 15	91.89 Apr 14 – Mar 15	The Trust considers that this data is as described as it is directly extracted from the Dr Foster system and analysed through the Trust's Quality Surveillance Group, the medical Director and within specialities. The rate is also consistent with historic trends. The Trust will act to improve this percentage, and so the quality of its services by continuing with the approach detailed in this account to improve quality and safety. The Trust does not specifically target a reduction in mortality but has more robust processes in place for monitoring mortality including the ongoing review of all Hospital deaths. It is important to note that palliative care coding has no effect on SHMI.	
Percentage of patient deaths with speciality code of 'Palliative medicine' or diagnosis code of 'Palliative care'	26.14% Oct 14 – Sep 15 (latest available)	26.6% Jul13 – Jun14	0.2%	53.5%	29.04% Jul13 – Jun14	These figures are all taken from the HSCIC website, however the sample size is too small to be published nationally. The Trust considers that this data is as described as it is obtained directly from the national PROMs information site. The Trust will act to improve this percentage, and so the quality of its services by analysing the outcome scores and continuing to focus on participation rates for the preoperative questionnaires.	
Patient Reported Outcome Measures – No. of patients reporting an improved score; Hip Replacement Primary EQ-VAS	Apr-Sep 2015 NBT score 87% (national average 76.81%)	Hip Replacement Primary EQ 5D Apr- Sep 2015 NBT score 81.22% (national average 80.52%)	Knee Replacement Primary EQ-VAS Apr- Sep 2015 NBT score 81% (national average 73.04%)	Knee Replacement Primary EQ 5D Apr- Sep 2015 NBT score 71.26% (national average 75.22%)	Varicose Veins, Groin Hernia and Hip Replacement Revision No information available for 2015/16	The Trust considers that this data is as described as it is obtained directly from the national Information Centre site. Nationally comparative data is not available. The Trust will act to improve this percentage in relation to its bi-monthly review with clinical directorates of its own monitoring data within the Performance Assurance Framework. This will identify adverse trends and agree actions to reduce unplanned readmissions.	
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: NBT score 10.2%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for 2012/13, 2013/14 or 2014/15 from the Health & Social Care Information Centre.	Emergency readmissions within 28 days of discharge: age 16 or over Comparative data for 2011/12: NBT score 10.9%; England average 11.4%; low 0%; high 17.1%. Comparative data is not currently available for 2012/13, 2013/14 or 2014/15 from the Health & Social Care Information Centre.					The Trust considers that this data is as described as it is obtained directly from the national Information Centre site. Nationally comparative data is not available. The Trust will act to improve this percentage in relation to its bi-monthly review with clinical directorates of its own monitoring data within the Performance Assurance Framework. This will identify adverse trends and agree actions to reduce unplanned readmissions.

**Appendix 3 List of Services provided by NBT as at 31st March 2016**

Directorate	Specialities	Directorate	Specialities
Medical Directorate	A&E Care of the Elderly Medical Day Care General (Acute) Medicine Cardiology Dermatology Clinical Haematology Respiratory Medicine Palliative Care Clinical Immunology HIV/AIDS Service Oncology Clinical Psychology GI Services (Medicine) Diabetes & Endocrinology Mental Health Liaison	Renal & Outpatients Directorate	Hospital Services Renal Medicine Renal Surgery Transplantation Surgery Hospital Haemodialysis Community Renal Services Home Haemodialysis Peritoneal Dialysis Satellite Haemodialysis Renal Technical, Diagnostic & Treatment Services Outpatient Clinics Day Case Suite Minor Operations and Procedures Theatre
Musculoskeletal Directorate	Orthopaedics Trauma Services Rheumatology Paediatric Rheumatology Orthotics Disablement Services	Women's and Children's Directorate	Gynaecology Fertility Services Integrated Maternity Services Neonatal Intensive Care Unit (NICU) General Paediatrics incl. Outpatients Peri-operative Acute Care Unit School Nurses Community Paediatrics Children's Speech Therapy Child & Adolescent Mental Health Family Therapy Psychotherapy Children's Occupational Therapy Child Psychology Riverside Unit
Surgical Directorate	General (Acute) Surgery Vascular Surgery Breast Services Urology Plastics and Burns Surgery GI Services Surgery Endoscopy Pigmented Lesion Clinic Audiology Orthodontics	Neurosciences Directorate	Neurology Neurosurgery Neurophysiology Neuropathology Neuropsychiatry Neuropsychology Frenchay Centre for Brain Injury Rehabilitation (FCBIR) Head Injury Therapy Unit (HITU) Ophthalmology Stroke Service
Core Clinical Services Directorate	Anaesthetics ITU HDU Theatres Clinical Equipment Services Pain Management Back Pain Services Resuscitation Training Day Case Unit Pathology Genetics Clinical Biochemistry Dietetics Outpatient Facilities Management	Cellular Pathology Haematology Immunology Microbiology Pharmaceutical Services Radiology Medical/Radiation Physics Regional Quality Control Lab Infection Control Phlebotomy Medical Illustration Adult Speech Therapy Occupational Therapy Physiotherapy and associated Musculo-skeletal rehabilitation	



## Appendix 4 Auditor's Opinion

### Independent Auditor's Limited Assurance Report to the Directors of North Bristol NHS Trust on the Annual Quality Account

We are required to perform an independent assurance engagement in respect of North Bristol NHS Trust's Quality Account for the year ended 31 March 2016 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

#### Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following indicators:

- Friends and Family Test – Patient Element
- Percentage of reported patient safety incidents resulting in severe harm or death

We refer to these two indicators collectively as "the indicators".

#### Respective responsibilities of directors and auditors

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by DH in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2015 to May 2016;
- papers relating to quality reported to the Board over the period April 2015 to May 2016;
- feedback from the Commissioners dated May and June 2016;
- feedback from Local Healthwatch dated May and June 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 2015/16;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated May 2015;
- the latest national staff survey dated March 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2016;
- the annual governance statement dated 02 June 2016; and
- the Care Quality Commission's Intelligent Monitoring Report dated May 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of North Bristol NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and North Bristol NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

### **Assurance work performed**

We conducted this limited assurance engagement under the terms of the guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by North Bristol NHS Trust.

### Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

*Grant Thornton UK LLP*

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Date 22/6/16.

If you require a summary of this information  
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