NHS
North Bristol
NHS Trust

Account of the Quality of Clinical Services 2016/2017

Exceptional healthcare, personally delivered


League of Friends

Statement on the quality of services from the Chief Executive

North Bristol NHS Trust is a provider of local hospital services and complex specialist care for a large population in the South West of England. Employing over 8,000 highly skilled and caring staff, we aim to deliver excellent clinical outcomes and a great experience for all service users.

Our aim is to provide our patients with best practice, high quality care and treatment that is comparable to the best in the world. As one of the largest hospital trusts in the UK we treat some of the most difficult medical conditions in an increasingly complex patient population. We want to care for our patients in a safe environment and ensure that everyone has an outstanding experience.

As part of a local healthcare system we need to make the most efficient use of resources and work with partners to continuously improve the way we do things as we know this will lead to a better experience for patients and better clinical outcomes.

In 2016, we published our Five Year Strategy which clinicians, staff and patients contributed to and was based on our activity, performance and outcomes.

The strategy, which covers the period from 2016 - 2021, outlined our commitment to being one of the safest trusts in the UK with the ambition of making patients partners in their care. We want to devolve decision-making to empower our frontline staff to lead, a shift which is already starting with the move to creating clinical divisions.

In 2016 we were placed in Financial Special Measures by NHS Improvement. This move challenged us to meet a new finance target which we exceeded for the year with the support of all of our staff. We feel the progress we have made demonstrates our ability to better manage our budgets while continuing to provide high quality patient care so that we can be a sustainable organisation in an increasingly challenging financial climate.

We have seen some successes over the last year:

- **Cancer performance improvements** – with all national standards being met by the end of 2016/17;
- **Embedding safety checks** – within the Emergency Department and sustaining good quality for patients despite pressures around the four-hour performance. We also finished the year above our improvement trajectory and ended March with the most improved performance in the South at 88%;
- **Management of sepsis** – a new sepsis tool is being used in inpatient areas, building on our strong performance in the Emergency Zone, and 1,298 members of staff received training in just 60-days as part of a training initiative;
- **Growing culture of quality improvement**;
- **Sustaining dementia quality work** – with a focus on improving ward environments for people with dementia and growing our network of Dementia Champions across the Trust;
- **We have seen our lowest C-Diff rates ever** – with the number of cases below our trajectory;
- **Sustaining low mortality rates**;
- **CQUIN achievement is the highest ever**;
- **Improving responsiveness to complaints** – and introducing a Lay Review Panel to evaluate quality – in partnership with the Patients Association.

Our challenges have been:

- **MRSA** – where there were six cases;
- **Never Events** – there were five never events during the year, which is too many of these preventable incidents and work has been carried out in response to these;
- **Staff Friends and Family Test** – while the majority of staff would recommend the organisation to friends or family for care or as a place to work, we would like the figures to be higher and are working to improve our engagement with staff; and
- **Pressure Injuries** – while we remain on target to reduce the number of pressure injuries over the three-year period 2015/16 – 2017/18 we have not sustained a reduction of grade 3 and 4 pressure injuries.

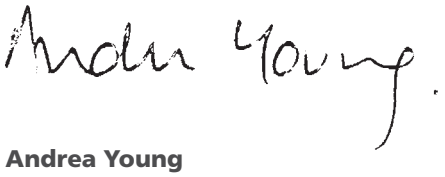
Way Forward

We are pleased with the progress we have made as an organisation over the last year and appreciate the work of our staff in achieving so much improvement. But we know that they and we will continue to drive change so that patient care is the best it possibly can be and that staff can always be proud of what they do. Our ambition is to be one of the safest trusts in the UK and we know there are actions we can take to help us to achieve this.

We know we have more work to do to engage our staff meaningfully in these changes and we intend to focus on this next year so that everyone in the Trust understands just how valuable they are in realising our full potential. The move to five clinical divisions supported by professional services and improved analytics will provide the platform for this culture shift.

We are working to improve the technology we use within the organisation, moving to an electronic data management service where all patient information is available on computers so that we are reducing our reliance on paper records. This work has already started in some clinical areas and is being rolled out across the Trust.

The views of our patients are incredibly important to us and we will continue to use feedback from those who have used our services to shape care improvements.



Andrea Young
Chief Executive
North Bristol NHS Trust

Review of Services

During 2016/17, 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. Clinical Directorates are subject to regular Executive reviews 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.

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 2016/17 represents 100% percent of total income generated from the provision of NHS services by the North Bristol NHS Trust for 2016/17.

Statement of Directors' responsibilities in respect of the Quality Account 2016/17

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

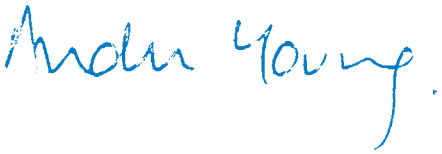
NB: sign and date in any colour ink except black

Signatures and dates in final published copy

Signed .....

Date June 29, 2017

Peter Rilett
Chairman



Signed .....

Date June 29, 2017

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 injuries, nutrition, medicines safety, mortality rates and infection prevention & control. In addition to all the other quality and safety targets, each year Trusts are asked to choose priorities for quality improvement which are chosen in consultation with patients, public and staff.

Our Priorities for Improvement for 2016/17

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 did we get on with these priorities?

Priority 1: Shared Decision Making, 'Ask 3 Questions'

What is 'Ask 3 Questions' about?

As part of a local CQUIN (Commissioning for Quality and Innovation) initiative with Bristol CCG, we have been implementing an initiative called 'Ask 3 Questions' across outpatient and inpatient settings to support shared decision making with patients. In outpatients we started with Rheumatology, Colorectal and Vascular Surgery and then included Bariatrics, Lung Cancer and Hepatology. In inpatient wards we have started with 33b (vascular), 34a (colorectal and medical patients) and 9a (stroke and neck of femur).

What did we do?

Patients attending outpatient appointments were given 'Ask 3 Questions' leaflets and postcards to encourage their involvement in their consultations. A short 'Ask 3 Questions' video was also played in the waiting area to help reinforce the message. Before and during the implementation of 'Ask 3 Questions', patients were asked to complete questionnaires about how involved they felt in decisions about their healthcare. To help embed the initiative in the three original outpatient settings shared decision making and enabling conversation workshops were delivered to the clinical teams and observations of consultations were undertaken to refine practice.

Patients coming onto the three wards were given an Inpatient Discharge Engagement Tool leaflet to support them to make the necessary arrangements needed to leave hospital. In a similar way to outpatients, patients were also asked to complete questionnaires before and during the initiative, to understand how involved they felt in their discharge planning and what impact this initiative had made, if any, to support them with this.

What difference did it make?

In patient discharge:

We received a summary of the results of the reported patient experience before and after the introduction of the A3Q Discharge engagement tool. There was an increase in the number of patients reporting.

- they felt more involved in decisions about their discharge (from 87.2% - 98%)
- being given more notice of discharge (from 88.89% – 93.88%)
- staff taking account of their family/ home situation (increased by 8%)
- staff giving their family / those close to them enough information to help care for them

55% of patients said that they felt the A3Q was very / quite helpful in helping them make plans for leaving hospital.

There are many variables influencing patients' responses but overall this indicates that there was positive impact for patients in using the A3Q Discharge engagement tool

Outpatient experience: Involvement in decisions

A3Q Outpatient summary data summarises the results of the reported patient experience before and after of the introduction of the A3Q Leaflet helping them ask questions about their treatment options, including the pros and cons of these options. Overall there was an increase in the number of patients reporting improvement in:

- Receiving the right amount of information about this condition/ treatment (from 82.7% to 95.5%)
- Being involved in decisions (from 93.9% to 100%)
- The appointment helping them feel they could manage their condition / treatment better (from 81.2% to 88.3%)

Of the respondents 74% reported that the A3Q leaflet was quite/ very helpful in helping them asking question about their condition/ health problem.

There was a decrease in the number of patients reporting that staff asked what was important to them in managing their condition/ health problem indicating the A3Q approach had influenced patients' behaviour more than that of the staff. Whilst training had been given to staff on having this type of conversation it clearly not had sufficient impact. This will be revisited to help embed the approach of having enabling conversations with patients.

What next?

Supported by Trust Board, both parts of this initiative will continue to be rolled out across the Trust at a pace that the available resource allows.

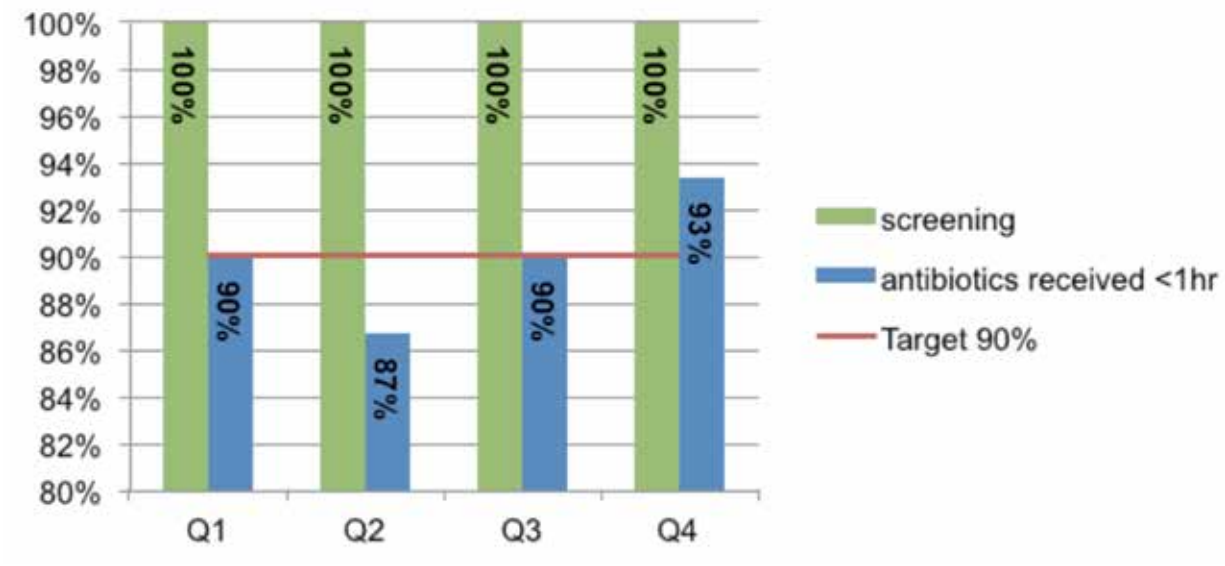
Priority 2: Management of Sepsis

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.

We have a multi-professional Sepsis working group which works on improvements in identification and management throughout the year.

Sepsis CQUIN target achieved for 2016/17



What we achieved

- We trained 1,278 members of staff in 60 days in Sepsis identification and management as part of our 6 for Sepsis Campaign.
- We trained all clinical staff joining the trust in Sepsis management at induction.
- We screened 100% of patients who presented to the Emergency Department who met the screening criteria using our electronic patient triage form.
- We maintained our improvements in antibiotic delivery within 1 hour of entering the Emergency Department at 95%.
- We launched a new Sepsis tool across the trust to enable prompt Sepsis management on inpatient wards.
- 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.

We performed excellently against the 2016/17 CQUIN targets for Sepsis care, which were split into two parts; screening and administering antibiotics, achieving 100% of available financial incentive funding from commissioners.

What we plan to achieve for 2017/18

- Aim to screen more than 90% of inpatients who have deteriorated on the wards and could have new sepsis.
- Improve antibiotic delivery to inpatients with new sepsis to more than 60% in 60 minutes.

Priority 3: Improving care for patients with dementia

Work to improve the care of people with dementia has focused this year on embedding all the changes that have been introduced to improve care over the past few years. There have been several small modifications to our care practices and we have continued to emphasise the importance of the information and support that can be gained from including carers and family members in the care team.

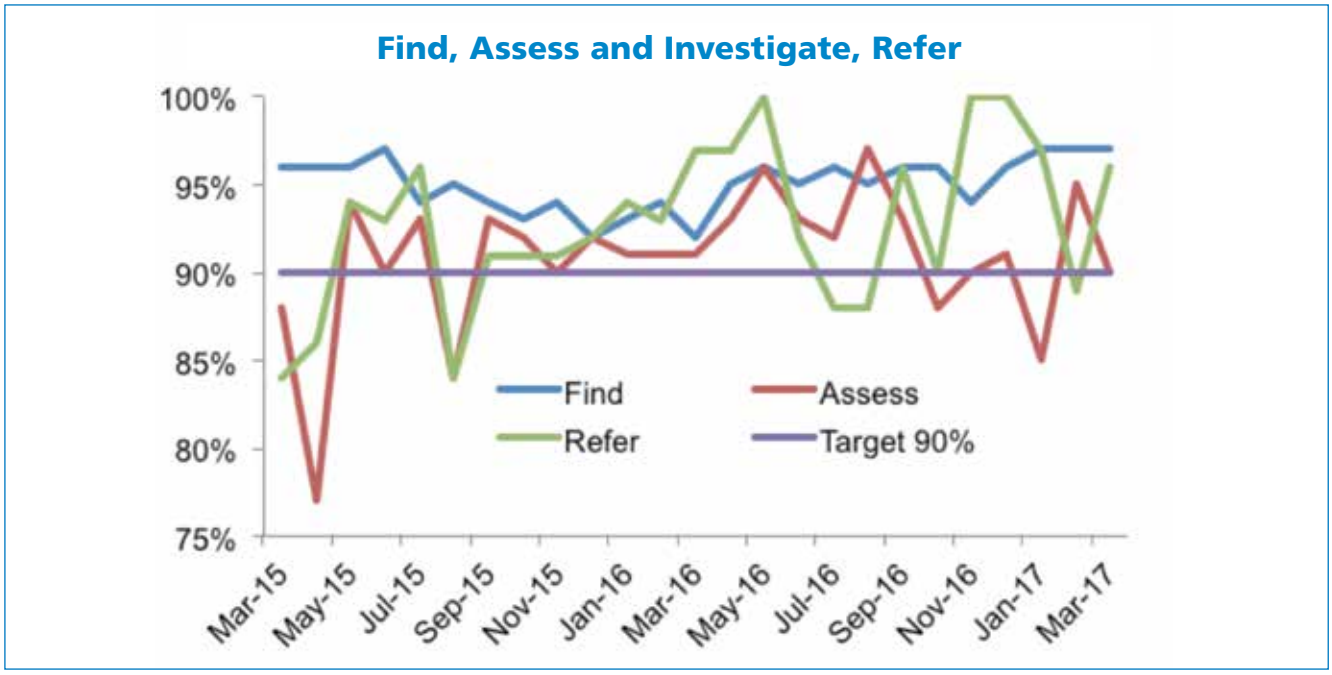
Participation in National Audit

We took part in the third National Audit of Dementia which took several months to collect the required data. The results of the audit, which is collated independently by the Royal College of Psychiatrists, was published late May 2017 and will enable us to compare our care of people with dementia against national benchmarks. The audit included feedback from patients and carers as well as staff who were asked to comment on their training in dementia care provided by NBT. We took part in the original and second National Audit and these were very helpful in identifying areas where we could improve care.

The forget me not symbol reminds all staff that they need to make reasonable adjustments in the care of people who have this identification as they will have some cognitive impairment.

Memory Café

The Memory café held at Gate 28 every Wednesday afternoon continues to go from strength to strength. We have an information stall in the atrium to catch passers-by who can be diverted up to Gate 28 if necessary for more detailed and private conversations. Besides NBT dementia staff and the Alzheimer's Society dementia support workers the café is also supported by volunteers.



Improving the environment for patients with dementia

- Murals were provided in the Complex Care wards to make the environment more stimulating.
- Other departments have made improvements to the care environment for people with cognitive impairment.
- The Emergency Department has arranged for some bays to be redecorated so that they are more dementia friendly and quieter for people with cognitive impairment.
- The Acute Medical Unit has also received some funding from the Friends of Southmead Hospital to install large calendar clocks and displays so that carers can see what aids may be helpful for their relatives.

Dementia Champions

Our network of Dementia Champions continues to grow with over 200 in all areas of the Trust. They are supported by Sharon Parsons, dementia trainer, with regular newsletters and an annual conference and are often able to make novel and innovative changes to care in their areas.

Measuring improvements in care for patients with dementia

We continue to assess and report on a monthly basis the measures of care that were underpinned by nationally agreed quality improvement targets, CQUINS. Throughout 2016/17 we surpassed the 90% target for finding, assessing and referring patients with dementia, with only some slight dips in performance during the challenging winter months.

We all have an important role in helping to achieve better outcomes for patients with dementia and everyone in the chain of patient interaction and intervention has the capacity to make a positive difference. We knew our work was making an impact throughout the organisation when a porter helping an older patient with confusion asked for a "Forget ME Not" sticker for the patient's wristband.

What we plan to achieve for 2017/18

We are developing a dementia dashboard as recommended by the Alzheimer's Society in their publication "Fix Dementia Care" in order to continue to measure and improve care for patients with dementia.

Priority 4: End of Life Care

We provide end of life care for approximately 1,800 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.

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 the national framework Ambitions for Palliative and End of Life Care.

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

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 Care Quality Commission 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.

Our Strategy for End of Life Care

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.

Recent developments in end of life care

- 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.
- Our new paperwork includes information for relatives and carers and 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 (CQUINS) for some of this work.
- Following feedback from hospital and community staff we have conducted a training needs analysis and developed a training programme with the end of life leads for Urology, Care of Elderly and Renal teams to address the team approach to earlier recognition of patients in the last year of life, appropriate treatment escalation planning for these patients and communication of those plans to GPs on discharge. This has been underway since September 2016.
- Since January 2016, we have been delivering introductory end of life training to all our staff.

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 co-ordination of services.

Results of the baseline audits

Specialty Sample size	Does the patient have poor prognostic criteria?	Is there a documented Treatment Escalation Decision?	Is there a DNACPR order in place?	How many patients were discharged?	Has the GP received poor prognostic information?
Cardiology N=57	19 / 57	5 / 19	13 / 19	18 / 19	3 / 18
	33%	26%	68%	94%	17%
Care of the Elderly N = 124	86 / 124	48 / 86	68 / 86	70 1/ 86	32 / 70
	69%	56%	79%	81%	46%
Urology	6 / 26	1 / 6	4 / 6	5 2 / 6	3 / 5
N = 6	23%	17%	67%	83%	60%
Renal	10 / 27	3 / 10	5 / 10	9 2 /10	1 / 10 3
N = 10	37%	30%	50%	90%	10%
Overall	**52%**	**47%**	**74%**	**84%**	**38%**

1. 14 died in hospital, 2 still inpatient 2. 1 died in hospital 3. 3 other patients highlighted for renal supportive care register

In 2016/17 we started a quality improvement project that focusses on improving compassionate and personalised end of life care on the wards. This is based on findings from a large audit of our care. The audit included four specialities, Cardiology, Urology, Renal and Care of the Elderly encompassing over 200 patients. The aim of this audit is to address key parts of caring for dying patients. The development of these plans, including the baseline audit and related training materials has been recognised and we achieved 100% of available financial incentive funding from commissioners for the End of Life Care CQUIN scheme.

What we plan to achieve for 2017/18

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 our 8,000 plus 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 care.
6) Reviewing how we make arrangements for collection of death certificates.
7) Improving our documentation of the end of life care that we deliver.
8) Improving our documentation of decisions about resuscitation.

Our Priorities for Improvement for 2017/18

Involving the public in identifying these priorities

The Trust approved a new strategy for 2016-2021 in March 2016, which in turn set the overall context for developing a framework for quality improvement during the 2016-17 financial year. This prompted us to review our historic approach to setting priorities for the Quality Account whereby we have focused upon four relatively narrow areas in line with the original national guidance. We reflected that this selection did not truly afford greater focus than the many other quality priorities we must respond to as a consequence of the scale and complexity of our services and national policy drivers.

On that basis we asked our clinical teams to make suggestions for priorities to improve patient care taking a wider view of potential subject areas. This long list was then discussed with the Trust's Patient Partnership Group and external Patient Experience Group members to obtain their views.

Our consultation approach posed three questions.

1. Does our way of describing these priorities make them understandable for you?
2. Is there anything you would wish to clarify within these priorities?
3. Is anything missing in your view?

The outcome was strong endorsement for our overall approach with recognition of the need for a more broad-based range of quality improvement priorities. Specific support or suggestions were made for the inclusion of:

- End of Life Care & learning from feedback;
- Ensuring patient views influence ongoing service developments;
- Staff Wellbeing; and
- Ensuring consistency, quality and security of patient records.

Having concluded these discussions, these were taken forward by the Executive Leads for quality, the Director of Nursing and Medical Director for review and approval by the Trust's Quality Committee, the Non-Executive-chaired Quality & Risk Management Committee and finally the Trust Board. Following these reviews, the first two areas suggested above were included.

The other two suggestions are fully supported as very significant organisational priorities as undoubted key enablers of care quality. As such they will both feature within ongoing Trust Board-level reporting and scrutiny. However we consider it important to retain a focus on specific quality outcomes for this purpose within the Quality Account.

How we will measure progress with these priorities?

A clinical lead and supporting working group will be identified for each priority to drive it forward, which will wherever possible utilise existing groups to avoid unnecessary additional meetings and to help join up related area of clinical practice. Improvement measures will be set within the areas outlined above and the data will be collected and analysed to track progress.

Accountability for overall progress will be achieved through the Trust's Quality Committee, chaired by the Medical Director. Its membership includes the Director of Nursing, Deputy Medical Director, Associate Medical Director for Safe Care and divisional Clinical Directors, chairs of quality and safety committees and other key staff involved in monitoring or progressing quality and safety priorities. This committee also includes a representative from the trust's Patient Participation Committee who actively contributes to its agenda.

A wide range of quality measures are reported to the Board every month as part of an Integrated Board Report, which 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, by NHS England who commission specialised services, by the Care Quality Commission who regulate care delivery at the Trust and by NHS Improvement who are the Trust's performance regulators.

Selected Areas of Quality Improvement

Following conclusion of the approach set out above we will address the following priorities within our Quality Account for 2017/18:

Quality Priority	Rationale	Elements we are focusing on
1. Improving Theatre safety	During 2016/17 there were five Never Events within the Trust, three of which were within the theatre environment. Whilst none of these resulted in harm to the patient and represent a very small fraction of operations performed, we are committed to improving safety and the occurrence of these 'near misses' requires further work.	• WHO checklist compliance (a set of defined checks before and after each surgical procedure) • Stop Before You Block audit compliance (to reduce the incidence of inadvertent wrong-sided nerve block during regional anaesthesia) • Human Factors training delivery • Improving the safety climate
2. Reducing Harm from Pressure Injury	We are not satisfied with the progress made during 2016/17 and are therefore focusing additional resource into this area during 2017/18, both internally and also through working with partners across the health system.	Reduction in the numbers of pressure injuries classified as: • Grade 2 • Grade 3 • Grade 4
3. Reduction of infections arising from indwelling devices	We have made good progress in reducing overall infection rates, particularly C-Difficile, but are dissatisfied with the number of MRSA cases seen this year and recognise the need to focus on practice associated with 'indwelling devices' (such as catheters or peripheral lines). We will step up our quality improvement work across the Trust to focus on the human factors and associated practice that is key to driving better outcomes.	Reduction in the number of: 1) MRSA; and 2) MSSA Bacteraemia. Ensuring Aseptic Non Touch Technique (ANTT) policy fully in place and followed when undertaking procedures.
4. Learning from deaths in hospital and improving end of life care	This has been an area of national focus for the past three years and the Trust has maintained its good record of low mortality rates overall, plus developing a good assessment and review tool for all deaths in hospital. Alongside this we have been improving the spread of good end of life care training and support beyond the specialist palliative care team. However, we believe there is much more to learn and act upon to ensure that end of life care is understood and delivered to a high standard in all areas. This is a national priority and we are committed to being an exemplar organisation in this area (as reviewed and awarded externally).	• Ensuring Mortality Screening Reviews are undertaken in line with national policy • Using reviews to inform improvement programme • Ensuring appropriate family involvement • Acting upon poor prognostic indicators and appropriate GP communication • Training delivery of end of life care to clinical staff
5. Improving the care of patients whose condition is at risk of deteriorating	Consistently and effectively preventing, detecting and acting on patient deterioration is a complex issue. Points where the process can fail include: • Scoring observations incorrectly; • Not recognising early signs of deterioration; • not communicating observations causing concern; and • not responding to these appropriately. We have made good progress in a number of areas and aim to build upon this success both internally and across the healthcare system, particularly at points of care handover between healthcare agencies.	• Sepsis screening, treatment & review • Acute Kidney Injury identification & treatment • Effective use of National Early Warning Score (NEWS)
6. Enhancing the way patient feedback is used to influence care and service development	During 2016-17 we have expanded the principles of Shared Decision Making through our 'Ask 3 Questions' CQUIN scheme and introduced a complaints Lay Review Panel to help objectively review the quality of our investigations and responses following a complaint. We have also improved our overall response rates for the Friends & Family Test. However, we want to drive a step change in how we use feedback to influence improvements in care and service design and need to spread this more consistently across the Trust.	• Extending membership of the Patient Participation Committee • Mapping local directorate patient groups and obtaining feedback • Complaints Lay Review Panel outcomes • Friends & Family Test outcomes • Ask 3 Questions / Shared Decision Making

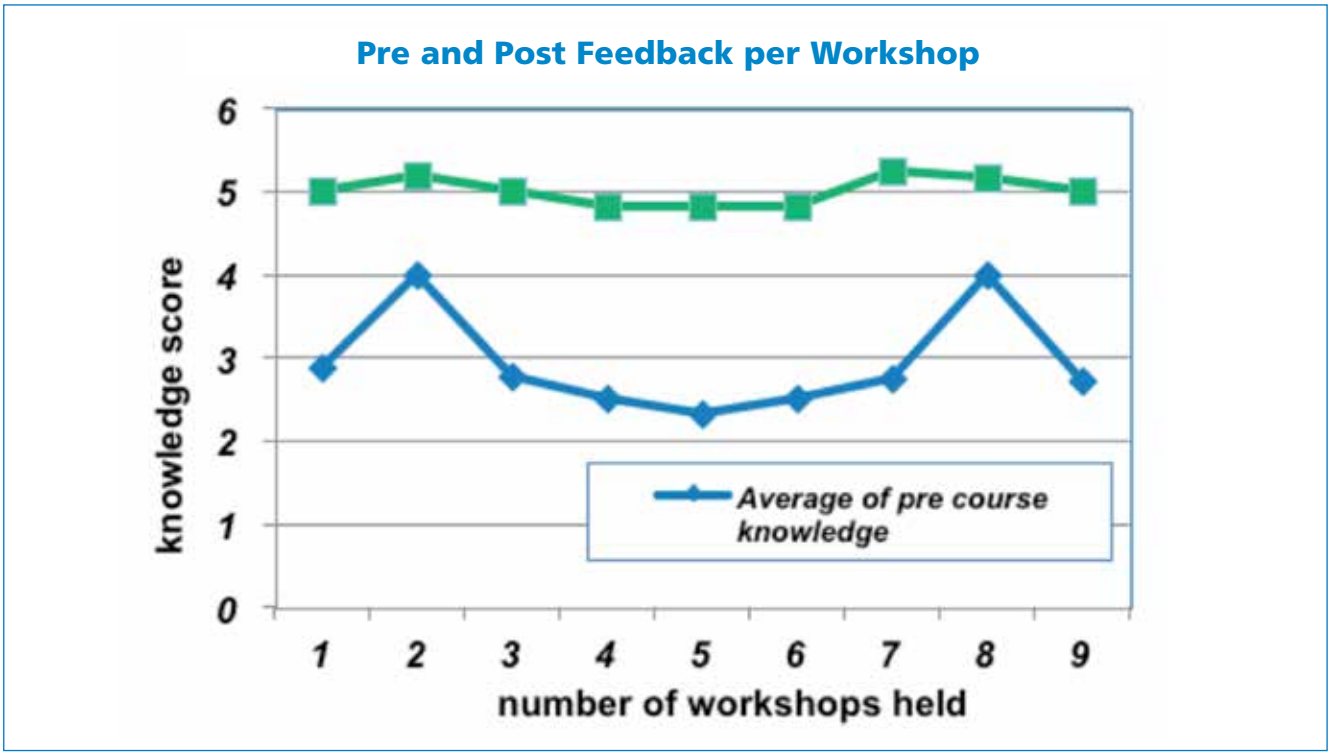
NBT Quality & Sign up to Safety Improvement Programme

Quality Safety Improvement Team (QSIT)

The Quality Safety Improvement Team's (QSIT) 2016/17 programme was developed in conjunction with the national Sign up to Safety campaign to underpin North Bristol's NHS Trust Strategy to become one of the safest trusts in the United Kingdom. The team has undertaken a number of work streams across the Trust to help achieve this.

Quality Improvement capability

Empowering staff to give them the quality improvement (QI) knowledge, skills and confidence they need is essential to translate training into tangible improvements in patient care and services across the organisation. All staff receive QI Awareness training in corporate and clinical induction and monthly three-hour QI sessions are also delivered to existing staff. This has enabled us to reach over 4,000 staff members with this training. We have created a weekly QI "Hub" enabling access to the QI support team to discuss new work, help remove barriers in progessing QI work and help sustain and embed interventions within the organisation. There is also a QI webpage which is under development. Staff have provided very positive feedback from the training provided – as illustrated below.



"Made me feel more confident in change process. I feel inspired to implement my own QI project."

Safety Culture

Improved safety and teamwork culture has been associated with a reduction in patient harm within hospitals through various national studies. Building upon previous surveys undertaken within the Trust, a safety culture questionnaire was distributed to staff in February 2016, using a validated review tool. The results were shared with the teams for them to develop ways to improve. The same questionnaire is being used again in 2017 to enable the QSIT to measure staff safety attitudes to their working environment.

One key response to the previous survey has been to introduce Schwartz Rounds into the Trust. Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The purpose of Schwartz Rounds is to understand the challenges and rewards that are intrinsic to providing care, rather than focusing on the clinical aspects of patient care. Schwartz Rounds can help staff feel more supported in their jobs, to give them the time and space to reflect on their roles which they might not otherwise have in their everyday routines. Evidence elsewhere shows that staff who attend Schwartz Rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles. They also help to reduce hierarchies between staff and to focus attention on relational aspects of care. The underlying premise for Schwartz Rounds is that the compassion shown by staff can make all the difference to a patient's experience of care, but that in order to provide compassionate care staff must, in turn, feel supported in their work. Two Schwartz Rounds have taken place this year with good evaluation feedback, some examples of which are shown below.

"Great stories, thought-provoking. Safe forum for reflection. Great to see so many professionals attending and open to reflection."

"Good to hear the open sharing amongst the group. Good learning experience and compare against one's own personal management of difficult situation."

"Really skilful management of a large number of participants and some emotional stories. Felt safe and lots of people spoke - who I've not heard before."

Safe Care Programme

Responding effectively to Serious Incidents in a way that supports staff immediately afterwards and enables rapid learning ahead of the formal Root Cause analysis process has been a key focus in 2016-17. In order to achieve this we have introduced a swarm approach for all serious incidents in the organisation, including 'never events.' This approach entails the QSIT lead and the Deputy Director of Nursing attending the clinical area within two working days to support staff and to identify early learning and implementation of Improvement Actions. Examples of the swarm approach prompting swift action are:

- A safety alert was developed following a serious fall involving wrongly assembled seating;
- Stop Before You Block observational practice changes in theatre; and
- Communication of best practice for management of rigid collars after development of a Grade 3 pressure injury.

Nursing and junior medical staff have used a QI approach for fluid assessment and management with the support of QSIT. A new fluid balance chart has been implemented Trust-wide and wards have seen reductions in the number of patients who develop acute kidney injury when the new chart is used.

Funding from the West of England Academic Health and Science Network (WEAHSN) has supported an emergency care collaborative. As set out in more detail in relation to compliance with Care Quality Commission requirements, an emergency checklist has been shared with all local trusts and has been adapted for the patient mix in each acute hospital. The Emergency Department routinely measures key indicators and shares this information with staff, commissioners and regulators for quality improvement work and assurance. Pain assessment and sepsis management have improved considerably since the checklist was introduced.

Observations of patients' clinical signs are vital when caring for them. We have worked collaboratively with United Hospital Bristol NHS Foundation Trust to design a National Early Warning Score (NEWS) observation chart to record patients' blood pressure, heart rate, temperature etc. This work has also been supported by the WEAHSN, which means that the NEWS is also being rolled out in general practice and the ambulance service and is proving to be a good communication tool to support clinical decisions.

Safe Procedures

QSIT has been working with the Anaesthesia, Surgery and Critical Care Directorate focusing on a range of actions to improve safety within our theatre environment. This has included strengthening the safety culture, identifying and addressing relevant 'human factors' and improving standard operating procedures. Further detail on this is covered within the Never Events section of this Quality Account.

The National Safety Standards for Invasive Procedures (NatSSIPs) is a large piece of work being led by QSIT. This is to ensure that local safety standards are used when carrying out surgical procedures that are not performed in theatres such as insertion of chest drains, endoscopy and radiological procedures. The local standards will align to those used in the theatre environment, for example checking patient consent, site of procedure, equipment required. QSIT is also working with teams on the human factors that can influence communication and decision-making.

What other Organisations say about the Trust

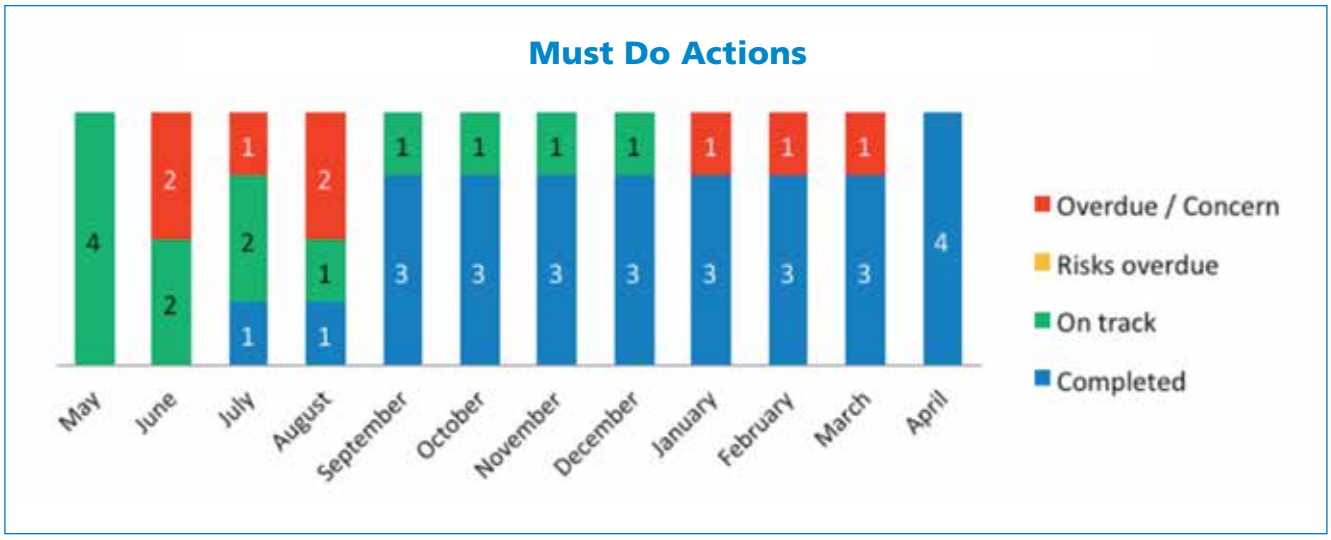
Care Quality Commission (CQC)

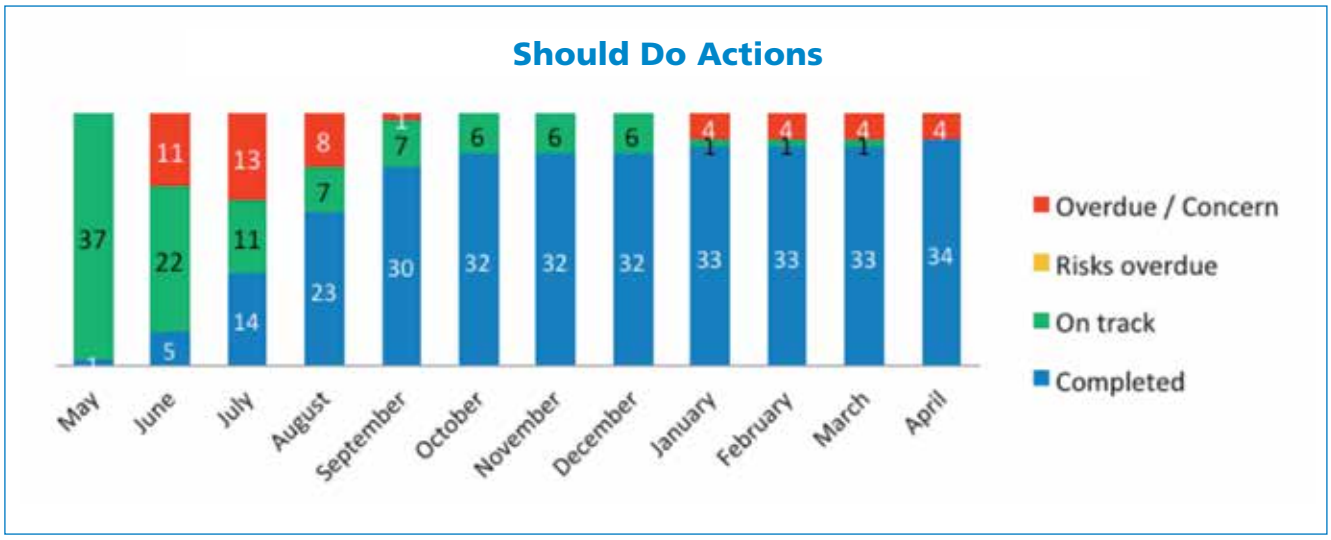
By law all trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards. NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them. As at 31/03/17, the Trust is registered for all of its regulated activities, without any negative conditions attached. 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. As required an Action Plan was submitted to the CQC that set out how the actions they set out within their reports would be delivered. As always their actions were defined as either 'Must Do' or 'Should Do' in nature. Progress against these actions has been tracked during the year as shown below. All 'must do' actions and the majority of 'should do' actions have been completed.

Progress on actions





Additional Independent Assurance 2016

As part of the Trust's annual internal audit plan, our internal auditors, KPMG, undertook a spot check audit in late November 2016. This comprised 'mock' CQC style observational checks across 49 areas of the Trust. The aim was to provide further evidence of improvement or other actions required to deliver the requirements. The executive summary included the observation that "The Trust has made good progress with many areas of its action plan that was put in place to address findings from its last CQC visit." There were 36 areas of good practice set out within the report.

It also identified that insufficient progress has been made in managing the secure and safe storage of medicines and intravenous fluids in some areas. This is being escalated for priority action at ward level across the Trust and an enhanced compliance regime will be introduced to ensure this is delivered robustly and consistently in all areas. Work is also progressing to close down the remaining four 'should do' actions from the 2016 Action Plan.

The current ratings across NBT services are shown below as at the end of the financial year 2016/17.

Overall Trust Rating

Table 1 - Trust Rating

	Safe	Effective	Caring	Responsive	Well-led
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*

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*

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

Southmead Hospital

http://www.cqc.org.uk/sites/default/files/new_reports/AAAE8141.pdf

Section 2 - Patient Safety

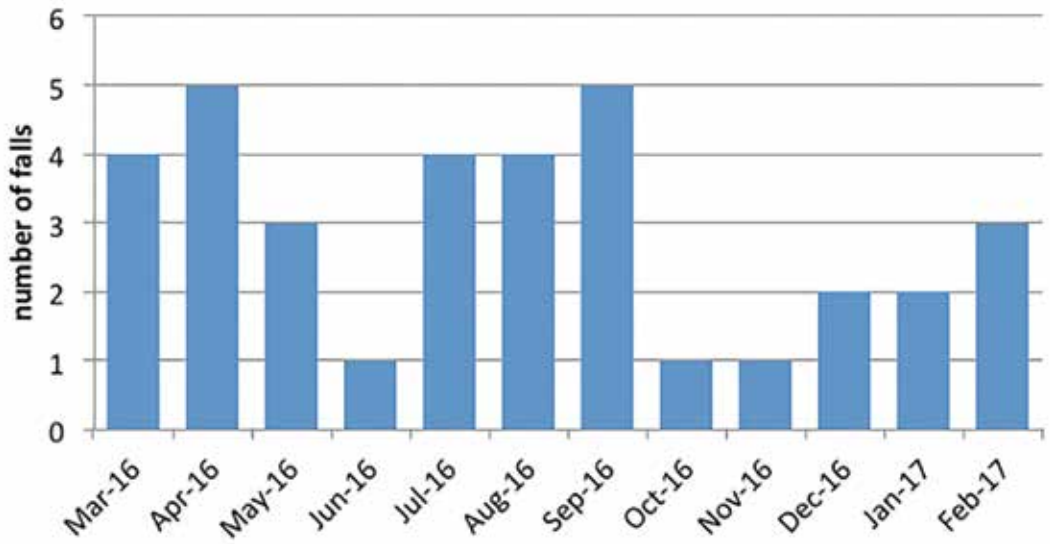
Reducing Patient Falls

A history of falls in the past year is the single most important risk factor for further falls while in hospital. By undertaking an assessment of all people within six hours of admission we are able to determine the level of care required to minimise the risk of falling during the hospital period.

Reports of falls range from people who nearly experience a fall to those who have come to harm and have required further and unexpected hospital treatment as a consequence. With an increasing number of frail and elderly patients the potential for falls is high. In context, we have just over 1,000 beds in use on any given day and there are approximately 200 reported falls per month. There is an average of just under three falls per month that lead to harmful injuries. Looking more widely, our current number of falls is approximately or slightly better than the national average, which demonstrates good progress for us given the added complexity that our hospital has with a relatively high number of single rooms. However, this is not to downplay the impact. We take every case seriously as we know the potential harm and distress this causes patients and their relatives and we continue to seek ways of reducing this risk with some positive results:

- There has been a 10% increase in people at risk of falls being admitted to the hospital; and
- There has been an 8% reduction in falls for winter 2016/17 compared with the corresponding period in 2015/16 despite a slightly higher usage of bed days.

Serious Falls



Living with the risk of falling and being responsible for someone at risk can be frightening and highly stressful. Colleagues in all areas of health and social care are continually assessing people with the risk of falling and seeking to provide services to help reduce the chances of such an event. All staff are now supported to undertake falls prevention training as part of their ongoing learning and development.

We have a Falls Prevention Group that meets every month to plan and learn from falls that have occurred within the hospital and from new information and advice that comes from other areas of the NHS. All wards are represented alongside other professionals such as therapists, pharmacists, trainers and specialists in dementia and safeguarding.

All falls resulting in harm are discussed in detail and plans are put in place and reviewed. We have also started arranging rapid (within 48 hours) swarm meetings on the wards with staff who have responded to a fall. This aims to pick up issues at a much earlier stage before they escalate and could lead to a serious fall. Our Falls Prevention Group also has representatives from our local commissioners who help to check that we are capturing all the information needed to make future plans. These plans are logged and reviewed every month to check for progress.

Reducing Pressure Injuries

The National Institute for Health and Care Excellence (NICE) recommends that services should be commissioned from and co-ordinated across all relevant agencies encompassing the whole pressure injury care pathway. A person-centered, integrated approach to providing services is fundamental to delivering high-quality care to people with pressure injuries and to prevent the development of pressure injuries in people at risk.

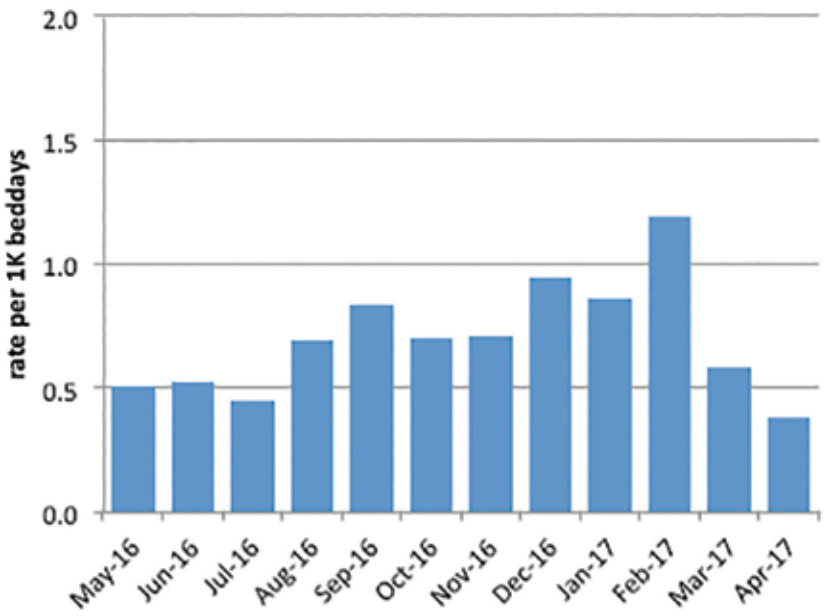
The Sign Up to Safety campaign was developed at NBT collaboratively involving a range of clinical staff and allied health professionals working with Quality Improvement experts and leaders within the organisation. Most importantly it was developed with the support and engagement of the Patient Partnership Committee within NBT and built on our extensive quality improvement learning and experience. NBT was one of the pioneering NHS Organisations for the Safer Patient Initiative (2006 to 2009) and subsequently in the South West Quality Improvement & Patient Safety Programme.

Our goal, over the three-year campaign period is to reduce the instances of pressure injuries within the Trust by 50%, achieving 10% of this reduction within the first year. There was a successful completion of year one of the campaign, achieving an overall 10% pressure injury reduction.

Year 1 of Campaign 2015/16	Pressure Injury Grade		
	Grade 4	Grade 3	Grade 2
Total % reduction	100%	50%	14%
(Number of pressure injuries)	(0)	(6)	(326)

Year 2 of Campaign 2016/17	Pressure Injury Grade		
	Grade 4	Grade 3	Grade 2
Number of pressure injuries	1	10	272

Patients with Grade 2 or above pressure injury
Rate per 1,000 Bed Days



The Trust remains on target to achieve a 50% reduction of pressure injuries over the three year period. However it is acknowledged that during 2016/17 we have not sustained a reduction of grade 3 and 4 pressure injuries, but remain below the rates reported prior to the commencement of this campaign, with a continued drive to improve.

What we plan to achieve for 2017/18

The Pressure Injury Improvement Plan 2017/18 outlines the strategy for delivery during the final year of this campaign. There is commitment from the Trust at all levels to achieve this improvement programme to deliver the required reduction. The Trust is committed to sustaining a continued reduction for all avoidable pressure injuries which occur within our care, and involves a continued collaborative strategy across Bristol, North Somerset and South Gloucestershire (BNSSG) to enable a system-wide impact.

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). 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.

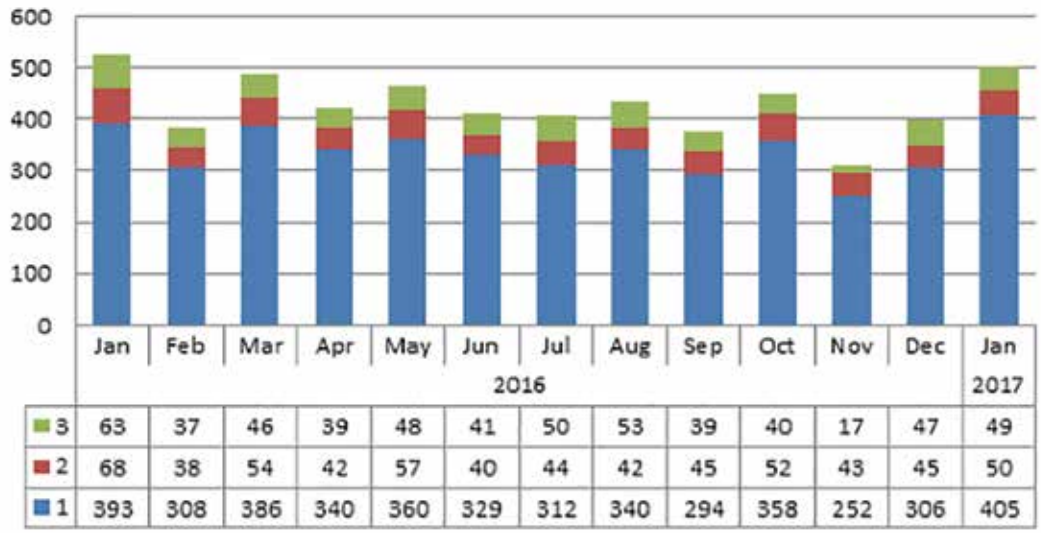
What we achieved last year (2016/17)

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. 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.

We have now used this data to produce an AKI dashboard to monitor trends in the incidence and severity of AKI in each speciality and various clinical areas. This will help us identify areas with higher incidence and target prevention strategies. The AKI dashboard will be discussed regularly in Clinical Governance meetings across all specialities to raise awareness.

Number of AKI alerts by stage and month



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
	2016												2017
3	63	37	46	39	48	41	50	53	39	40	17	47	49
2	68	38	54	42	57	40	44	42	45	52	43	45	50
1	393	308	386	340	360	329	312	340	294	358	252	306	405

AKI training programme

A structured education and training programme on the prevention and management of AKI has been continued for pharmacists and junior doctors during their induction training. An e-learning module for nurses in line with NICE guidelines has been nearly finalised, ready for roll out in summer 2017.

Ongoing work (2017/18)

1. Mini RCA: It is estimated that 20-30% of AKI is avoidable. We are in the process of developing a mini-RCA tool to help clinicians to do a structured case review of severe forms of AKI and those who have progressed to develop AKI in hospital. This will help us understand the reasons for the AKI and to learn lessons and share good practice in the prevention and management of AKI. Ideally we would like to develop this electronically and work is underway to embed this in the new DATRIX system that will be used for incident reporting and management within the trust from October 2017.
2. Engagement with primary care: It is estimated that 65% of AKI starts in the community. We have been liaising with primary care and CCG colleagues to develop an integrated care pathway for managing AKI in the community.
3. AKI alerts for primary care: Currently AKI e-alerts are issued only for those blood tests that are done in secondary care. In line with the Think Kidney programme advice, work is underway to release AKI alerts from primary care blood tests requests. This will enable GPs to diagnose early patients developing AKI in the community and refer them appropriately to secondary care.
4. AKI Care bundles: We have developed a care bundle that is being piloted in the trauma and orthopaedics wards 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.

Preventing deterioration prior to cardiac arrest

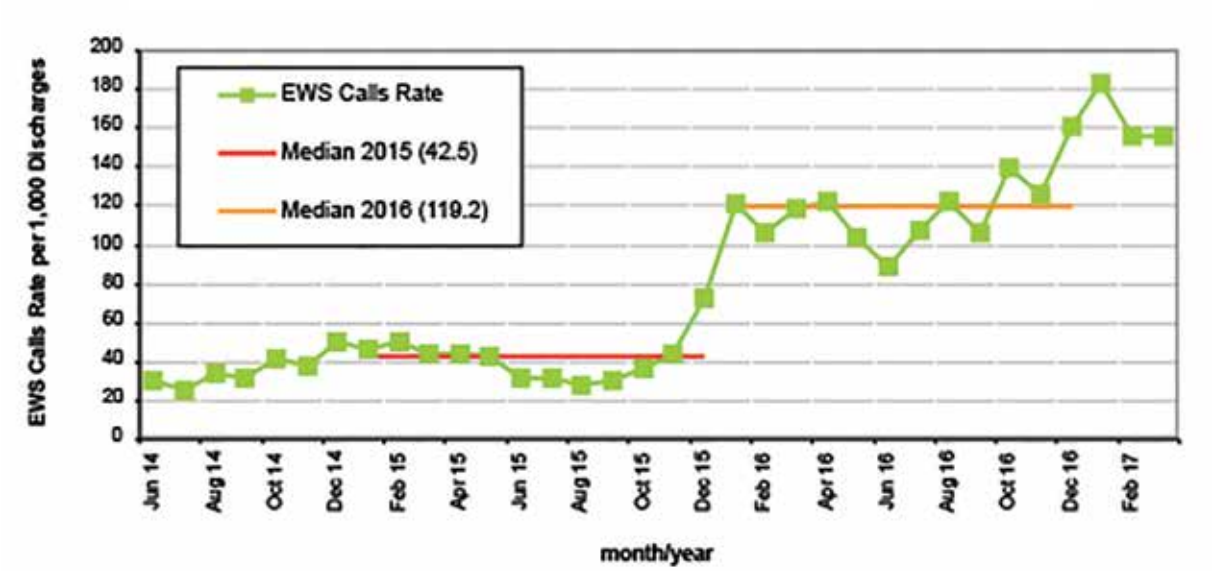
Cardiac arrests in hospital are rarely a sudden event. There is significant evidence to demonstrate that patients will often present with signs of deterioration prior to suffering a cardiac arrest.

National Early Warning Score introduced enabling recognition and escalation of patient care

In December 2015 we introduced the National Early Warning Score (NEWS), working in collaboration with West of England Academic Healthcare Science Network (WEAHSN) and University Hospitals Bristol (UHB). The NEWS 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.

There has been a significant increase in the number of patients who have "triggered" NEWS and as a result been escalated for senior / medical review, as illustrated in the chart below. 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.

NEWS Trigger Calls Rate per 1,000 Discharges
June 2014 – February 2017



NEWS has also been rolled out to the Emergency Department and Neurosciences (with some slight changes). This work has been driven by the Quality and Safety Improvement Team.

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.

As the roll out of NEWS has been undertaken across the region healthcare providers can use common terminology and help support the patient journey.

As already identified within the above chart clinical expertise has seen an increase, evidenced by the number of patients who are receiving lifesaving treatment prior to having a cardiac arrest.

In August 2016, the Trust agreed to change the name of the cardiac arrest team to support the change in clinical practice and to support the empowerment of staff calling for help early. The "Cardiac Arrest Team" became the "Clinical Emergency Team". This change was undertaken following a robust communication plan and awareness tools.

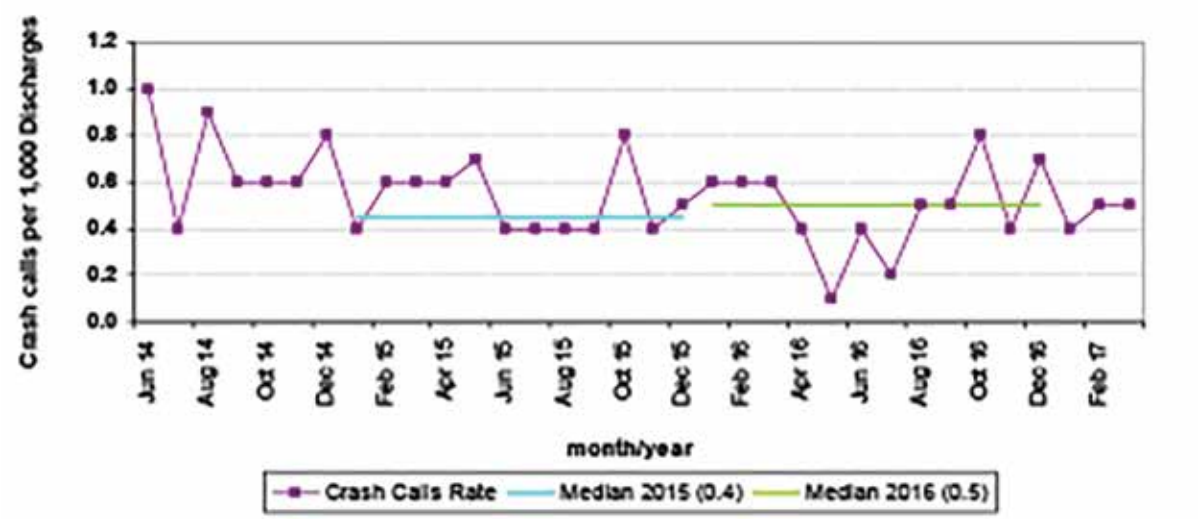
Cardiac Arrest rates

In addition to the increase in deterioration calls we have also seen a decrease in the number of cardiac arrests for the fifth year running. For the purpose of measurement and to ensure consistency we use the National Cardiac Arrest Audit (NCAA) definition of cardiac arrest.

" Any patient who receives chest compressions and an emergency call is made"

In addition to making comparisons against admissions and discharges we have also seen a reduction in the actual number over the past six years from 215 in 2011/12 to 95 in 2016/17.

Crash calls rate per 1,000 discharges, June 2014 to March 2017



The chart shows that the Trust median rate is 0.5 per 1,000 discharges. Whilst this is a minimal increase compared with last year, it remains below the national average.

At Quarter 3 according to the NCAA (non-adjusted for risk) data…

We had the lowest cardiac arrest rate per 1,000 admissions compared to all other participating hospitals

Achievements

- Successful implementation of the NEWS chart across the organisation including the Emergency Department and Neurosciences, working in collaboration with other regional healthcare providers and partners.
- Increased training and awareness of the deteriorating patient through practical assessment, simulation and focused debriefing for all foundation doctors and nursing staff.
- We have also seen an increase in the number of staff receiving and successfully passing Immediate Life Support training which is nationally accredited by the Resuscitation Council (UK).
- Continued improvement in the reduction of cardiac arrests.
- Successful implementation of the Clinical Emergency Team name change.
- Implementation of a joint educational programme using simulation training scenarios for junior doctors and nurses seeing acutely unwell patients.

What we plan to achieve for 2017/18

- Exploring the opportunities to increase training in clinical areas.
- The development and undertaking of a new audit exploring themes around patients who survive a cardiac arrest until discharge.
- Continue to explore options for reducing cardiac arrests within the organisation.

Venous Thromboembolism (VTE)

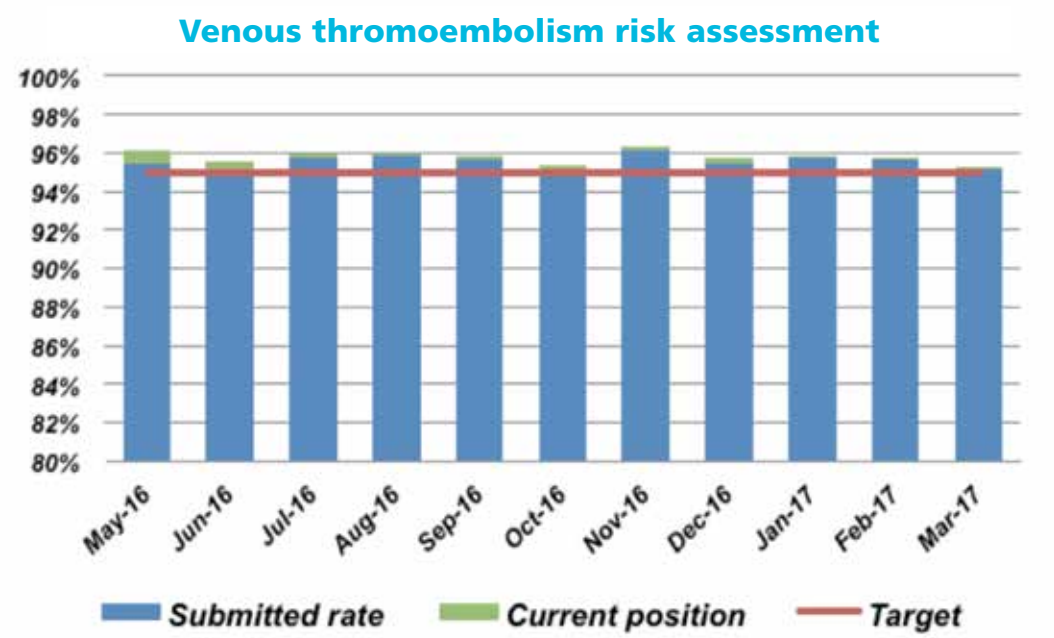
This condition encompasses Deep Venous Thrombosis (DVT), where a blood clot (thrombus) forms in a vein, often the deep veins of the legs, and Pulmonary Embolism (PE) which is a blood clot in the lungs.

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. Additional risk factors in this case include the condition itself and/or procedure for which the patient is admitted.

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

Risk Assessment Compliance	2013/14	2014/15	2015/16	2016/17
	96.95%	95.53%	94.77%	95.78%



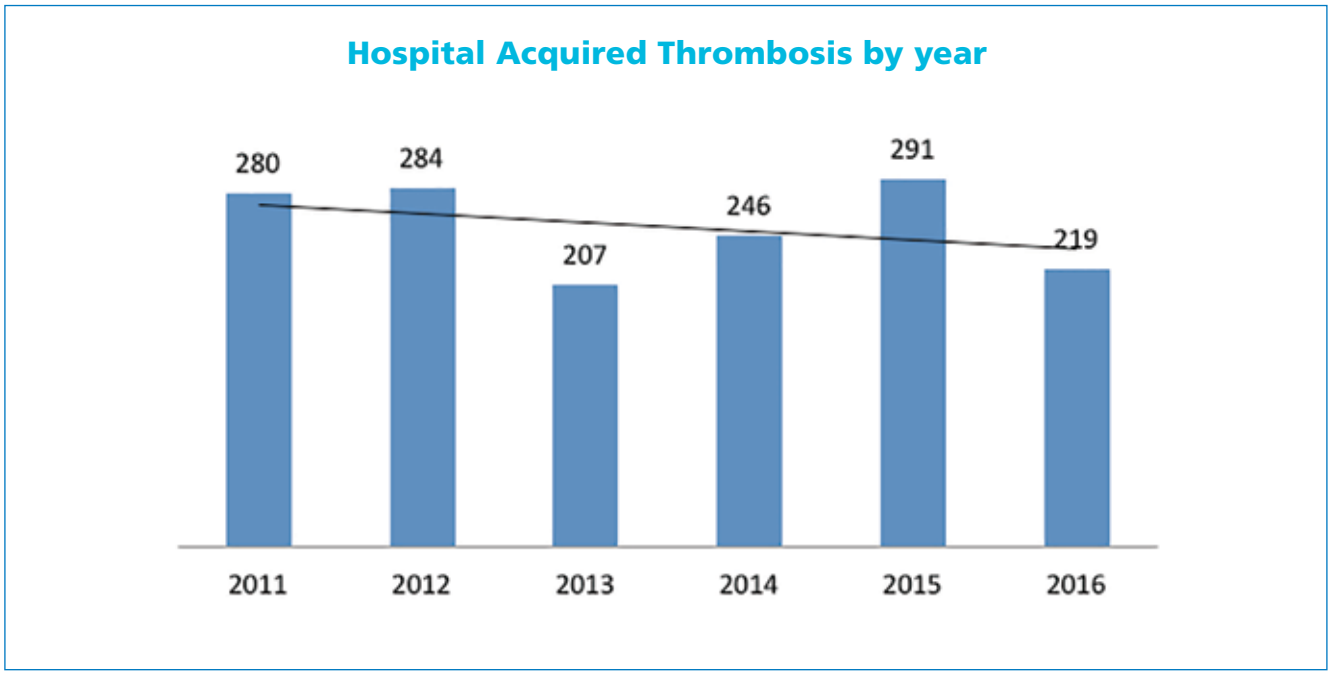
During 2016-17 we successfully addressed recording challenges that had resulted in a dip in recorded risk assessment performance in 2015/16 associated with the implementation of our new Patient Administration System in November 2015. Working with commissioners we were able to demonstrate improvements in our recording of risk assessments and this is now embedded within our electronic recording systems.

Since 2013 VTE training has been mandatory for our clinical staff. We are making good progress in delivering this with more than 85% of our clinical staff now trained.

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 shall aim to increase this towards 100% during 2017. We have introduced a risk assessment in the fracture clinic and thromboprophylaxis (where appropriate) will be given for patients with lower leg fractures who require a plaster cast and can be managed as outpatients. We have developed a bespoke patient leaflet to be given to these patients.

The overall outcome measure that demonstrates the success, or otherwise of these initiatives is the occurrence of Hospital Acquired Thrombosis (HAT). It is notable that the definition of a HAT (diagnosed after 48 hours or within 90 days of admission) does not take into account the individual circumstances of the cause of the thrombosis; many patients with, for example, metastatic disease have a high risk of thrombosis that cannot be prevented, but it will still count as a HAT. There is, therefore, a baseline, below which we will not be able to further reduce incidence of "HAT".

Encouragingly, the chart demonstrates our overall improvement since 2011 and most importantly that, following some disruption around the hospital move in 2014 and associated clinical service changes, we have seen the second lowest number of hospital acquired thrombosis in the past 6 years.



Improvement Plans for 2017/18

In order to further enhance the review and learning from cases of HAT we have agreed the following review processes;

- All preventable HAT will be discussed at the thrombosis committee meetings which are held quarterly
- Details of the events will be gathered by the VTE team and discussed
- The presentations will then be available with the minutes from the meetings
- The database will be updated to indicate that the HAT has been discussed
- Reasons for HAT will be recorded on the database for audit purposes

All of the work referenced above and more broadly in the management of VTE means that the Trust is now applying for VTE Exemplar Centre status. The application has just been submitted to the national Exemplar Centres network hosted by Kings College Hospital and will prompt independent review of our systems, processes and clinical expertise which we believe will endorse our high quality in this area.

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 2016:

- Shortlisted for two national awards;
- Winners of the NBT Exceptional Healthcare awards – Patient Safety team 2016;
- We have presented at two National and one European conference; and
- Our Medicines Reconciliation work has been published in NICE's Quality and Productivity case study collection.

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 three areas:

- Medicines Reconciliation – both on admission and on discharge;
- Missed doses; and
- Warfarin.

Medicines Reconciliation

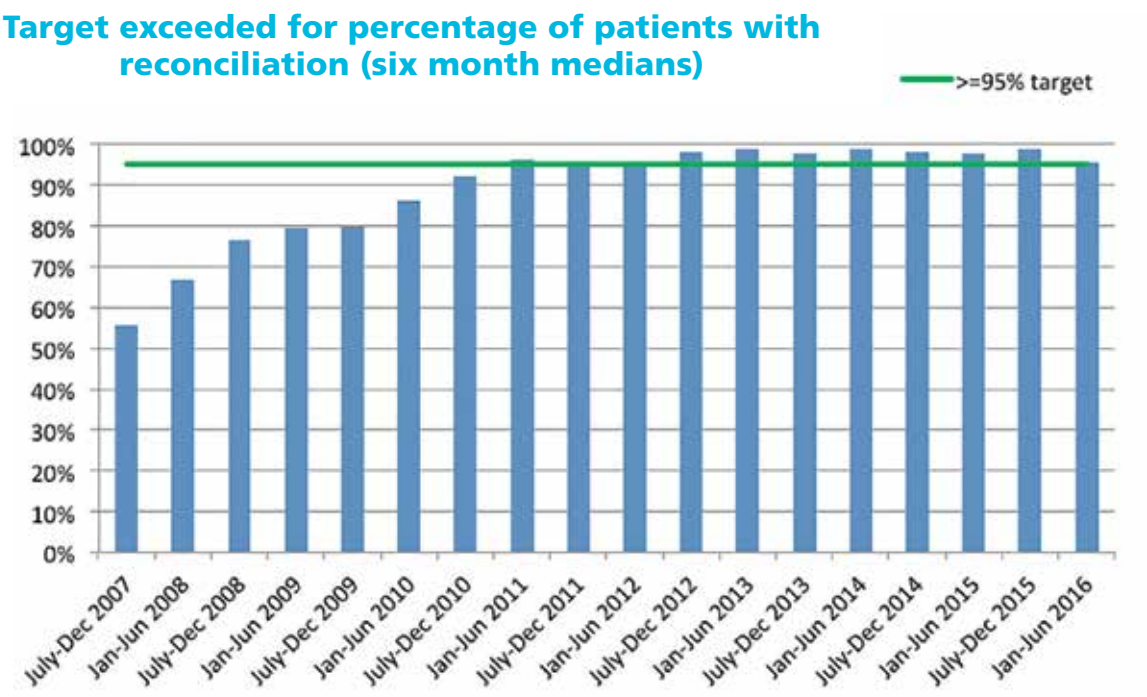
A team of NBT Pharmacists recently attended the Patient Safety Medicines Management Reconciliation Summit to speak about our work. This pharmacy-led project ensures that the medicines being prescribed to a patient on admission are the same as those they have been taking at home. This is an important step in getting patients home quicker and avoiding unnecessary delays or harm. Conversations now take place with patients once they are admitted to ensure we're getting this right and the process is fully embedded across the Trust.

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. The chart below confirms that this is an embedded process.

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 over the last seven years…

We are the best performing trust in England and Wales

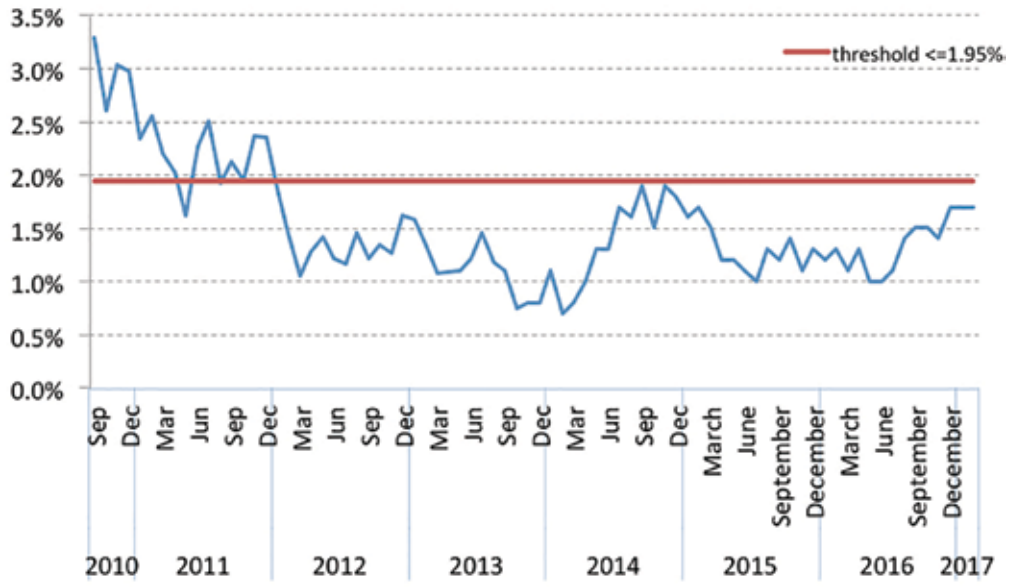
The team has achieved and maintained our target on admission. The next phase is for the medicines management team to focus on the discharge process and work with primary care teams and Community Pharmacists in supporting effective communication during handover and at the time of discharge to ensure that changes on medication initiated in hospital are continued after the patient is discharged.

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.

Good performance consistently below the threshold for percentage of patients with one or more missed doses



Progress to Date

Overall progress on reducing "missed doses" has 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 (May 2014), then started to improve but have worsened during patient flow pressures. We are now monitoring compliance on a monthly basis and targeting wards that breach the target.

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. Our new prescription chart enables these patients to be highlighted.

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 its use.

Progress to Date

Since 2011 we have worked on improvements by monitoring causes of high International Normalised Ratio (INR) levels. INR is a laboratory measurement of how long it takes blood to form a clot. 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

There has been a reduction in the number of our inpatients having an INR greater than 6. 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.

Future work

We plan to feedback findings of mini root cause analyses for inpatient INRs greater than 6 to directorate Clinical Governance leads quarterly. We are also reviewing access to data and to investigate availability of data which separates the clotting screens and the Warfarin INRs over 4.

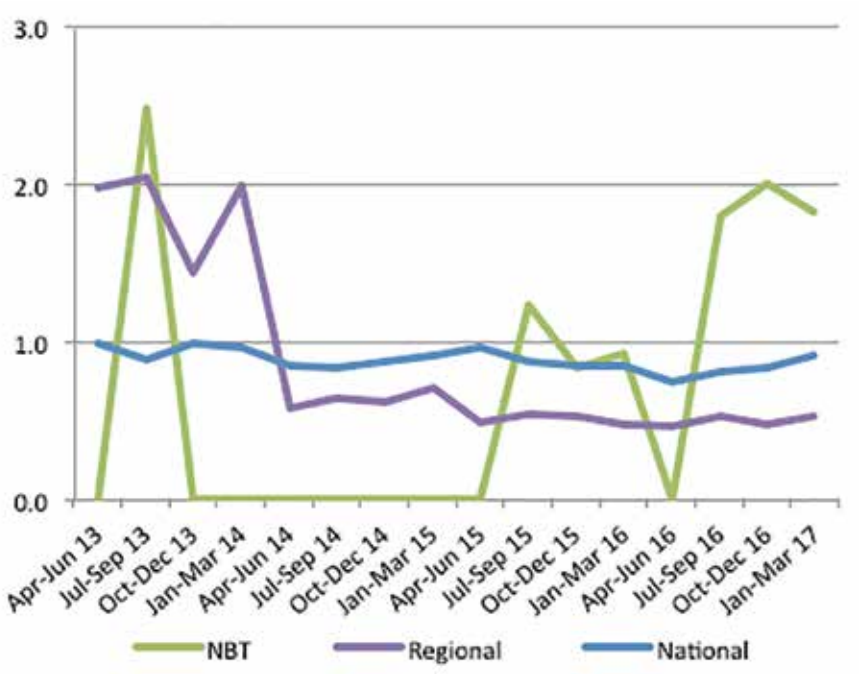
Reducing Harm from Infection

The prevention of healthcare associated infection (HAI) remains a top priority for the public, patients and staff. Avoidable infections are not only potentially devastating for patients and healthcare staff, but consume valuable healthcare resources. Investment in Infection Prevention and Control is therefore both necessary and cost effective.

The Trust recognises its responsibility for minimising the risks of infection and is committed to promoting a culture of risk reduction and safety for patients, visitors and staff. Reduction in healthcare acquired infection (HCAI) remained one of the Trust's key priorities during 2016/17. Proactive prevention and management of infection is a statutory requirement under the Hygiene Code (Department of Health 2015), with the support of NICE quality standards.

MRSA is an ongoing focus in the Infection Prevention and Control annual programme however six cases occurred in 2016-17, which is a poor outcome compared to regional and natural rates, as illustrated below.

Quarterly MRSA cases per 100k bed days

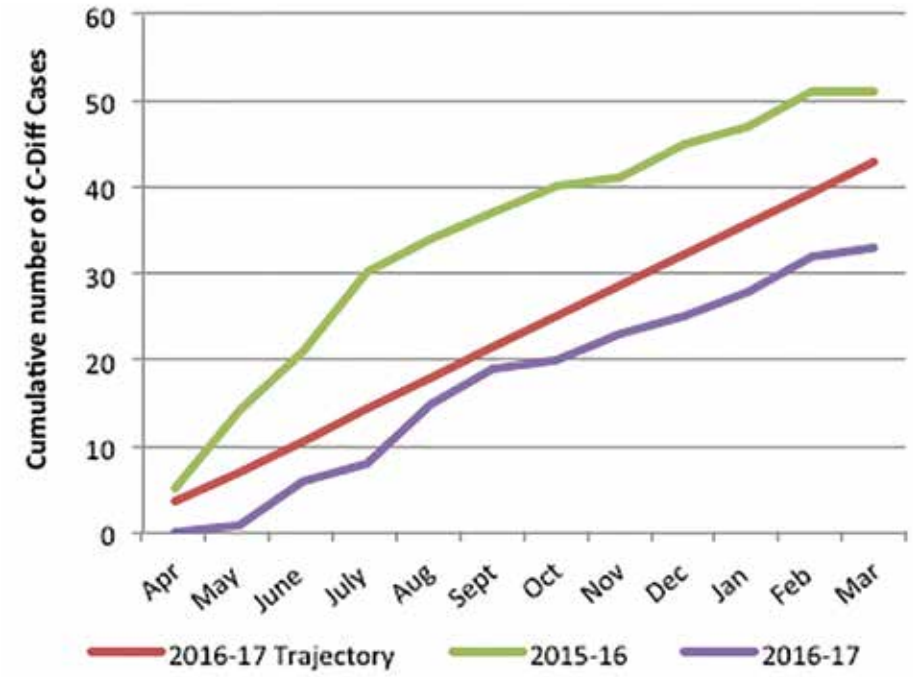


The Trust has instigated a remedial action plan to focus on the underlying root causes of these MRSA bacteraemia cases. This will provide confidence internally as well as assurance to external partners that appropriate actions are being implemented to reduce these risks.

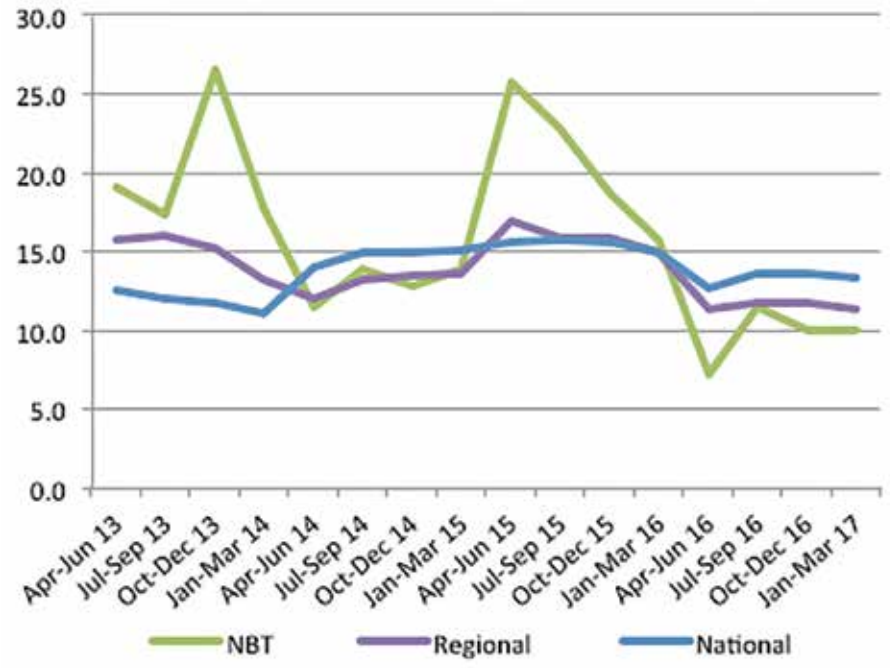
C. difficile infection remains an unpleasant and potentially severe infection that can occur within both the primary and secondary health care setting. The Trust target for 2016/17 remained the same as for 2015/16 and there was a programme of proactive measures to further reduce cases of C diff that has included a focus on cleanliness of the environment and point of care equipment, all of which is supported by our commissioners. Progress is monitored internally through the C diff Steering Group and the Control of Infection Committee.

The outcome of these actions was an encouraging year end figure of 32 cases, below the annual target of 42 and, as illustrated below, a significant improvement compared to both 2014/15 and 2015/16 and in relation to our regional and national peers.

C-Difficile Cases - Trust Attributable - Cumulative Cases



Quarterly C-Difficile case rates per 100k bed days



Screening for, and treating, alcohol-related conditions

Alcohol dependence affects 4% of the adult population in the UK. Nearly 1 in 5 of adults drink alcohol to an extent that pose some risk to their health. It costs the NHS around £3.5 billion a year.

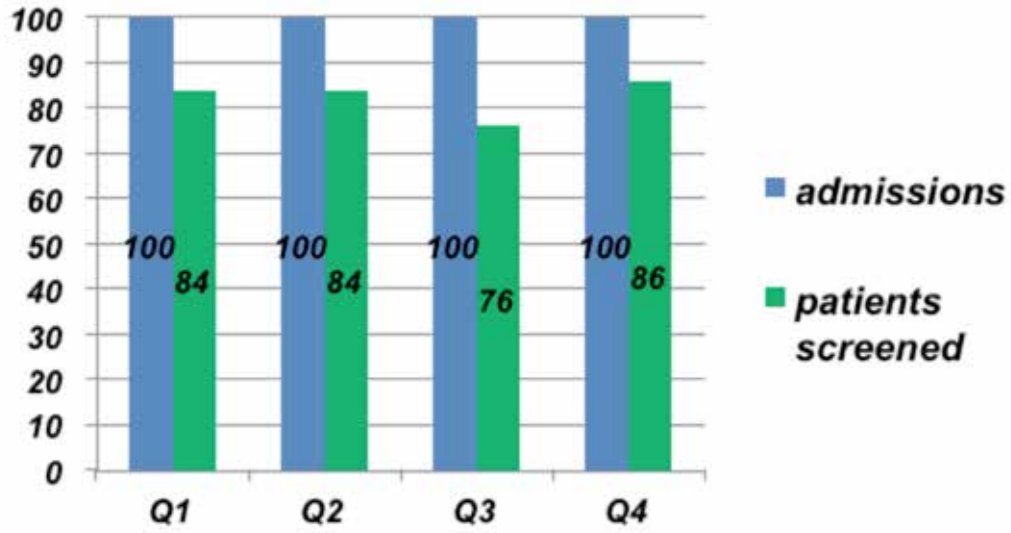
Alcohol-related liver disease is a disease of the young. The average age of death is 57 years. The mortality from liver disease continues to rise whilst deaths from conditions such as heart disease, diabetes and cancer is falling year on year.

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. This is how we're trying to meet the recommendations.

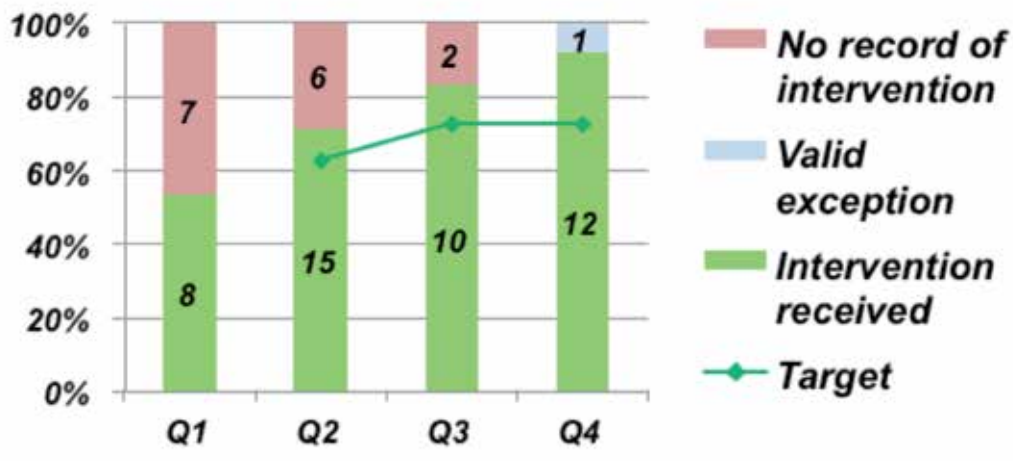
What we achieved in 2016/17

- We have expanded the alcohol specialist nurse (ASN) service from 1.0 WTE nurse to 2.8 WTE nurses and we maintained this service in 2016/17.
- A Bristol-wide strategy was created in 2015 to improve assessment and treatment of alcohol related harm in patients coming to hospital. This includes formally screening more patients attending hospital for alcohol misuse with an evidence-based tool and using personalised detoxification regimes, via an alcohol guideline, which are shown to reduce the length of stay and be safer.
- Any patient who is admitted to the Neurosciences or Medical directorate is now screened for alcohol misuse. The number of people being screened is up to 86% in some areas and we hope this to be 100% by asking everyone about their alcohol use. We hope to extend this screening to all patients being admitted to the Trust in the next 12 months.

Number of patients screened that were Medical Admissions

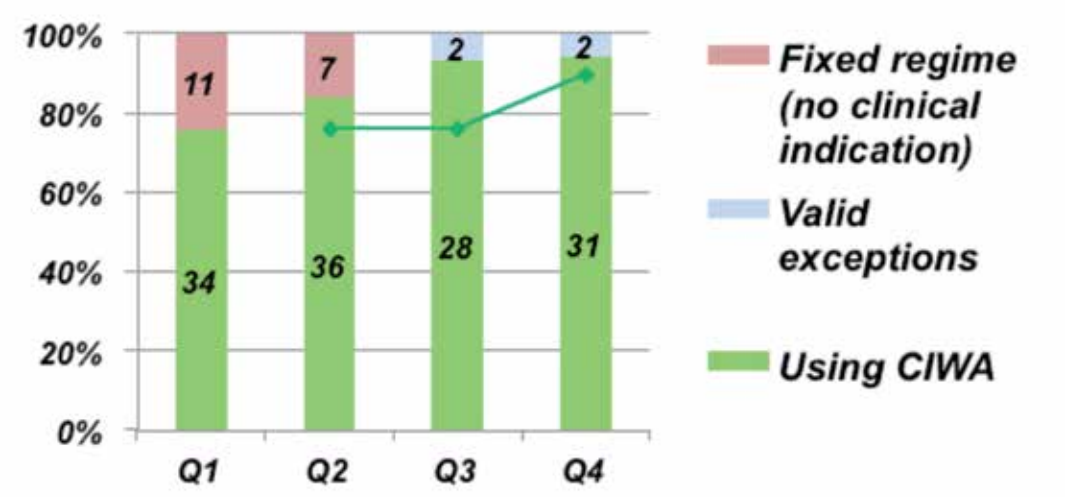


Target exceeded for patients receiving intervention following a positive screening outcome



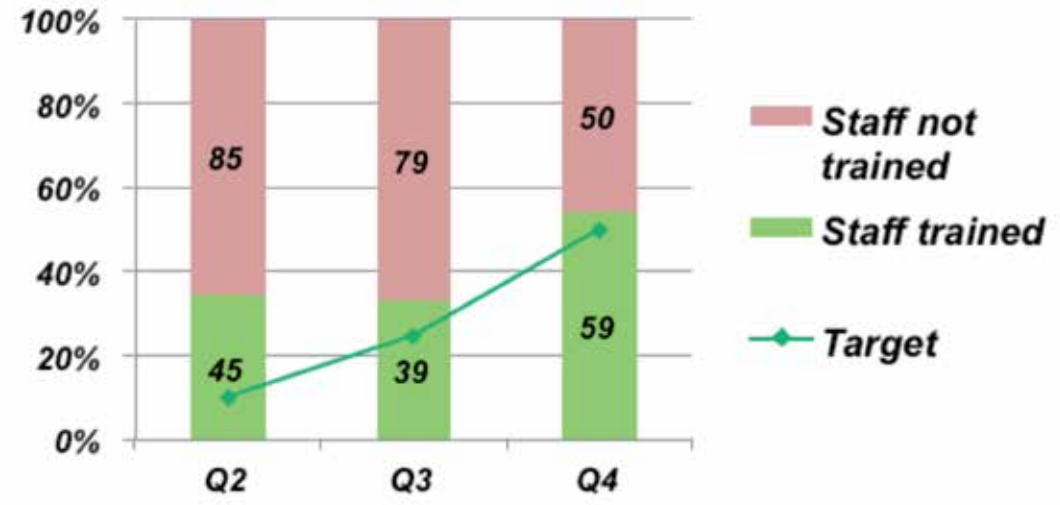
- Currently eight of the nine medical inpatient wards are using the new system of detoxification (CIWA) and hopefully all the wards will be using this system over the next few months. This is being implemented via face to face and online learning modules to medical and nursing staff.

Target exceeded to use CIWA for detoxification



- The management of patients with alcohol related liver disease has also 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.

Target exceeded to deliver staff training



- 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 'liver care bundle' is in use 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.

What we plan to achieve for 2017/18

- We plan to extend screening to all patients being admitted to the Trust over the next 12 months by positively improving the culture and asking everyone about their alcohol use.
- We plan to continue achieving against the intervention and training targets set.
- We expect all patients to have their intervention recorded in the electronic discharge summary that is sent to the primary care physician.

Managing Patient Safety Incidents & 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 proactive 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 and 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.

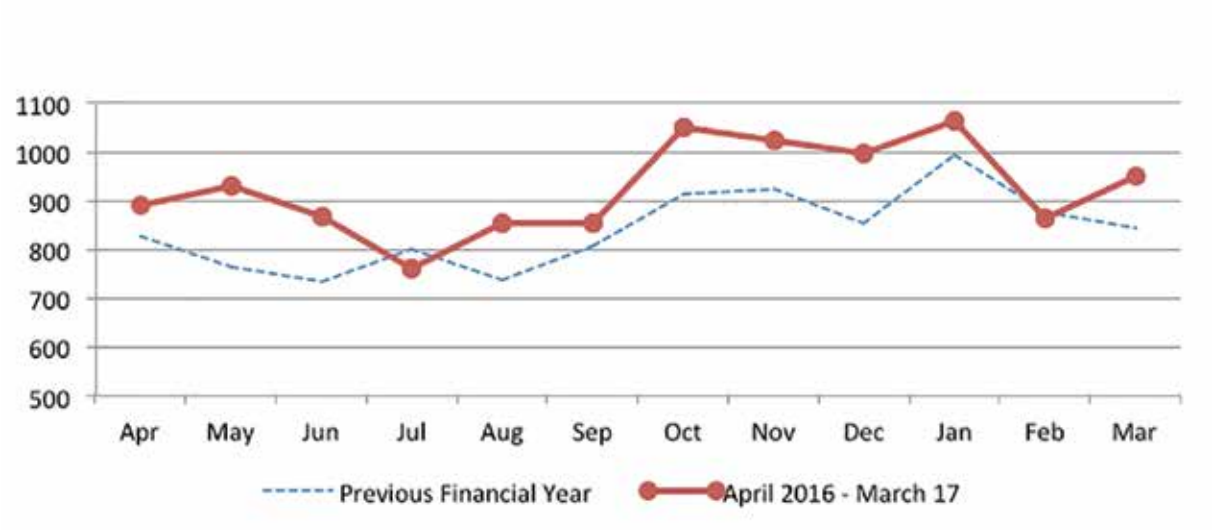
We have actively promoted staff awareness of the Duty of Candour process since its introduction in April 2015 and guidance is available to all staff on the intranet. All new staff attend an induction programme where patient safety is part of the curriculum, thus introducing them to the principles of a good patient safety culture from the outset. During 2017-18 we will implement a new Patient Safety IT system; part of this will include reviewing all business processes that relate to the way our staff work in practice, as well as how they use the system. Improving the current approach to the completion and recording of Duty of Candour is within the scope of this project, which intends to deliver the 'live' system in the autumn of 2017.

Reported Patient Safety Incidents

Organisational feedback reports from the NRLS indicated that NBT is at the lower end of the national reporting figures last year, however, incident reporting is increasing overall. 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 2016.

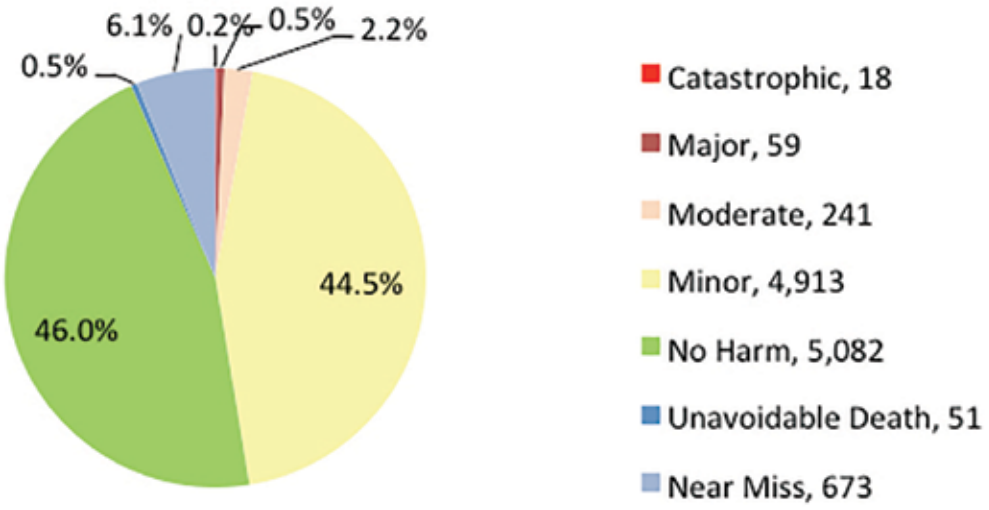
Overall reporting of patient safety incidents has increased over April 2016 to March 2017, with only July 2016 and February 2017 showing decreased reporting when compared with the previous year's figures. Reporting on average showed a 10% increase month on month.

Total Reported Patient Safety Incidents



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.

Actual impact of patient safety incidents April 2016 - March 2017



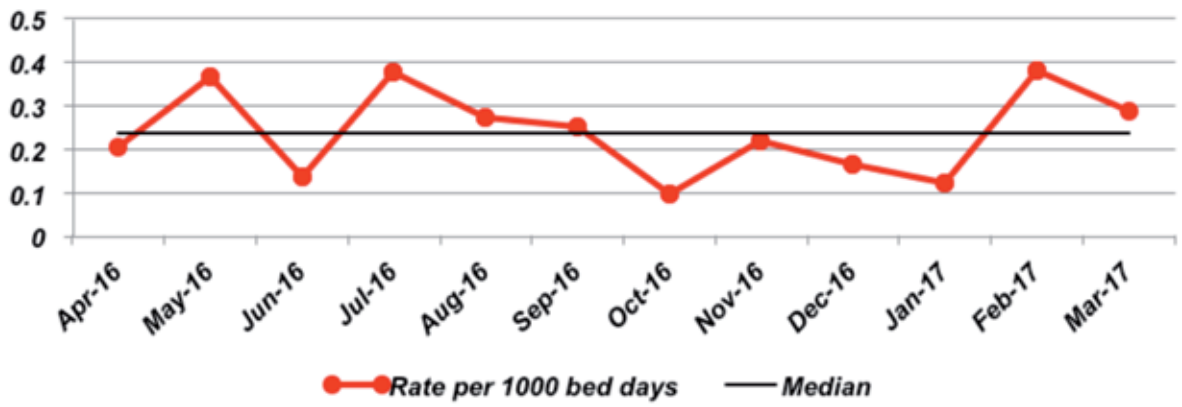
Serious Incidents and Never Events

There were 86 serious incidents investigated from April 2016 to March 2017 (compared with 56 in 2015/16). All of these incidents were thoroughly investigated and an action plan implemented to ensure wider learning. All Root Cause Analysis reports and the implementation of action plans are agreed and monitored by the Trust's Patient Safety and Clinical Risk Committee.

Serious incidents reported April 2016 to March 2017

The rate of serious incidents reported per bed day across the Trust has varied per month over the past year.

Trustwide Serious Incidents Rate per 1,000 bed days: April 2016 - March 2017



Of the 86 reported serious incidents, the Trust has seen an increase in the number of pressure injuries occurring in hospital. Serious falls incidents remain an issue and the Trust's Falls Group are working hard to address the problem with the implementation of a Trust-wide action plan.

Serious Incident Type			
Financial Year	**2016/17**	**2015/16**	**Total**
Serious Fall	**33**	24	
Fall (STEIS)	**23**	24	▼
Fall (swarm)	**10**	n/a	-
Tissue Viability/Infection Control	**12**	7	
Pressure injury	**11**	5	▲
Infection control	**1**	2	▼
Never Events	**5**	3	
Wrong site surgery	**2**	1	▲
Retained foreign object	**1**	1	▶
Misplaced NG tube	**1**	0	▲
Surgical complication	**1**	0	▲
Wrong route medication	**0**	1	▼
Serious Clinical Incident	**36**	22	
Unexpected death	**10**	7	▲
Delayed treatment	**4**	0	▲
Incorrect test results	**4**	1	▲
Lost to follow up	**3**	1	▲
Unintended damage to organ	**3**	0	▲
Surgical complication	**2**	1	▲
Retained foreign object	**1**	1	▶
Delayed treatment of deteriorating patient	**2**	3	▼
Equipment failure	**1**	0	▲
Missed diagnosis	**3**	2	▲
Medication error	**3**	0	▲
Other	**n/a**	6	-

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). We reported five confirmed never events in 2016/17, details of which are as follows;

Wrong Site Surgery – Wrong Site Nerve Block	
Brief Description	A patient had a right side fascia-iliaca nerve block when he should have had a left fascia-iliaca nerve block.
Root Cause	Failure to carry out the "STOP BEFORE YOU BLOCK" confirmation check of the consent form and surgical site marking prior to block insertion due to staff distractions, student supervision and time pressure in a busy theatre list.
Learning Points	• There is no robust mechanism in place to ensure that the "stop before you block" moment is done by the anaesthetic team prior to needle insertion. • WHO check lists are not completed in the presence of all staff involved in the operation. • Anaesthetic assistants are under pressure to provide equipment and drugs for pending theatre list so not focussed on current patient whilst ordering for the next. • If there is more than one anaesthetic trainee or student in theatre, it is not possible for the consultant anaesthetist to directly supervise both at the same time when preparing a patient for surgery. • Surgical markings are not always sited in an area visible to anaesthetist when administering blocks, particularly in lower limb surgery.

Wrong Site Surgery – Wrong Site Nerve Block	
Brief Description	The patient had a left femoral nerve block when she should have had a right femoral nerve block.
Root Cause	There was no "STOP BEFORE YOU BLOCK" confirmation check of the consent form and surgical site marking prior to block insertion due to distractions from equipment and time pressures to restart the list when an inpatient bed became available.
Learning Points	• WHO Sign In procedures are not always completed in the presence of all staff involved in the operation. There is no robust mechanism in place to ensure that the anaesthetic team carry out a "stop before you block" moment prior to needle insertion. • Surgical markings are not always sited in an area visible to anaesthetist when administering blocks, particularly in lower limb surgery. • The current mechanism to confirm the availability of inpatient beds prior to surgery is variable and time consuming for the theatre team.

Surgical Complication	
Brief Description	The patient was an elective admission for a right total knee replacement for osteoarthritis. During the operation left-sided femoral, and tibial base plate components were implanted rather than right-sided components. The following day, the data entry clerk when inputting details of the implant components into the National Joint Registry (NJR), noted the wrong side implants had been implanted and informed the consultant surgeon who met and explained to the patient this had not been identified despite multiple checks in theatre.
Root Cause	Staff were not complying with the Standard Operating Procedure (SOP) checking process for surgical implants and there was a culture of assuming a company representative is an expert in circulating practice, including obtaining and opening implants.
Learning Points	• Implant required should be agreed at the Team Briefing, including type, laterality and potential sizes. • There should be a surgical pause prior to implantation to verbally communicate type, size, laterality, expiry date and description of implant. • Staff were not complying with the SOP checking process for surgical implants and there was a culture of assuming a company representative is an expert in circulating practice, including obtaining and opening implants.

Retained Foreign Object	
Brief Description	The patient was taken to maternity theatre for a manual removal of placenta following a normal birth and for suturing of a second degree tear. The first procedure was undertaken by an ST1 doctor, supervised by an ST3 doctor. An ST3 doctor was also present for the perineal repair. The ST1 and ST3 doctors undertook the swab count prior to the procedures. The ST3 doctor was called away before the post procedure swab count took place; the pre and post-suturing swab count was recorded as correct on the maternity electronic patient record and in the manual removal of placenta proforma but neither swab count is signed. Subsequently (a few days later) a vaginal swab was found in situ by community midwife following complaint of soreness from the patient.
Root Cause	Untaped swab inserted Swabs were not counted post-procedure Suturing proforma not completed
Learning Points	• Untaped swabs inserted • Swab counts not performed post procedure • Documentation of swab checks not completed • Peri operative record of care not fit for manual removal of placenta and perineal repair.

Misplaced NG Tube	
Brief Description	A naso-gastric tube was misplaced and the X-ray taken to confirm the position was misinterpreted. As a result the NG feed commenced and went directly to the lung and the patient developed a chemical pneumonitis.
Root Cause	Despite following the protocol the radiograph obtained was not of high quality but was deemed adequate by the radiology registrar on duty. Her opinion at the time was that the tube had passed down the oesophagus to the stomach and was therefore safe for feeding.
Learning Points	• Reporting of NG tube chest X-rays as safe to feed should only happen when the reporting radiologist is 100% certain that the tube tip is in the correct position. • These examinations are difficult to interpret as these are often very sick patients. If there is any doubt in interpreting the radiograph the advice should be not to proceed with feeding.

As for all serious incidents, a Root Cause Analysis (RCA) report was undertaken for each of the five Never Events, which was scrutinised and approved by the Trust's Patient Safety and Clinical Risk Committee. An RCA report is a detailed investigation of the circumstances, causal factors and actions required to minimise the risk of this happening again. Actions are monitored for completion through this route.

In addition, following the three Never Events within theatres, the Trust participated in a collaborative review with NHS Improvement on 21 October, which made a number of recommendations to support the improvement work already underway. A range of actions are in place, which include strengthening the safety culture, identifying and addressing relevant 'human factors' and improving standard operating procedures.

These actions are being supported by the Trust's Quality Improvement Team, working with the ASCC Directorate, with progress managed operationally through the Theatre Programme Board. The Trust's commissioners are overseeing this through the Quality Sub Group and a further review with NHS Improvement was planned for May 2017 to provide assurance on the improvements made.

Section 3 - Patient Experience

Involvement of Patients and the Public

Enabling the active contribution by patients / carers in the work of the Trust is vital to helping us provide services that are centred on the needs of our patients. Our current Patient Partners make a significant contribution to this work. They are active participants in the work of many committees such as Medicines Management, Clinical Effectiveness Committee, Patient Safety & Clinical Risk Committee, Quality Committee and Patient Experience Group bringing the patient's voice and contributing ideas for improvement. They are also active in a number of audit projects. Their contribution is greatly valued. Ongoing recruitment is essential.

This year has seen the development of the Bristol Healthcare Change Maker Forum (HCCMF) that has been developed through collaborative working between NBT, UHB and BCH, and the recruited forum participants themselves. Their role is to bring 'an influential patient voice into the shaping of Bristol, North Somerset and South Gloucestershire Health & Social Care and wellbeing services'.

The experiences of our patients and carers

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.

Our understanding of the experiences and satisfaction of our patients and carers comes from many sources of information such as day to day conversations, complaints, concerns and compliments, national surveys, local surveys, the Friends and Family Test, social media and online patient feedback.

Inpatient survey (general)

The inpatient survey is part of the Care Quality Commission's annual NHS National Survey programme. It is run by Picker Europe Ltd on our behalf. Random samples of 1,250 patients who were inpatients in July 2016 were invited to take part. There was a response rate of 46% a slight decrease from 2015 (50%).

Patients were asked 62 questions about different aspects of their experience. Compared with the 2015 survey there have been **two areas of significant improvement**. These are:

- Discharge: told who to contact if worried after leaving hospital; and
- Discharge: Who to contact if worried after leaving hospital .

There have been **three areas where the reported experience significantly worsened**. These are:

- Emergency Department: not enough information about condition / treatment;
- Waiting: Too long for a bed on ward; and
- Care: involvement in decisions on care.

Areas scoring highly were:

- room / ward was very/ fairly clean - 99%;
- toilets very / fairly clean - 98%; and
- always had enough privacy when being examined / treated - 92%.

Focus for improvement

From reviewing the survey results in full with staff, patient representatives and members of Healthwatch we are focusing on aspects that are important to patients and those that had higher problem scores. The agreed areas for improvement relate to increasing confidence in staff, improving patient involvement in decisions and continuing the work in relation to discharge experience. Detailed actions are being developed with staff and patients.

Compared with 83 other trusts in England using Picker to undertake their Inpatient Survey 2016…

We are in the 37th position for overall problem score

83rd being the worst, 1st being the best

Acting upon Healthwatch Feedback

Healthwatch of Bristol, South Gloucestershire and North Somerset continue to provide feedback four times a year. This helps us to monitor the reported experience of our patient and carers. The key priority this year relates to improving the experiences and access to appointments and services of those who are deaf. This will continue as an important aspect of our work in partnership with representatives of the deaf community.

Involving our Board in reviewing the quality of Patient Experience

The practice of walking round clinical areas, asking questions, talking to patients, making observations, and checking local and patient records, is a fundamental internal assessment of our core values.

Putting patients first | Recognising the person | Striving for excellence | Working well together

In 2016/17 it has been particularly important to sustain connections between frontline clinical teams and the Executive and Non-Executive Directors who make up the Trust Board, reinforcing the focus on quality of care alongside the financial challenges that have faced the organisation.

Safety walkrounds have been a long-standing activity at the Trust, connecting the most senior-level managers with staff involved in the frontline delivery of care. Through observations and enquiries with both staff, patients and families they facilitate learning about local issues, provide examples of success stories and flag key actions and ideas to improve the experience of our patients and staff. Each Executive completes a number of walkrounds across the full breadth of locations across the Trust (this includes our mortuary, discharge lounge, dialysis units and off-site locations) and feedback notes are taken and actions recorded for follow up.

Our Non-Executive Director (NED) walkrounds are based on the national 15-Steps Challenge, which 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. It guides the observation of areas holistically and from a non-specialist perspective, which is therefore particularly suited to role of the NED within an NHS Trust.

Oversight of completion and outcomes from both executive and non-executive director walkrounds is provided within a 'Summary of Learning' report to the Trust's Quality and Risk Management Committee at each of their bi-monthly meetings. During 2016-17 a total of 28 executive and eight non-executive walkrounds were undertaken, producing lots of rich descriptive information and intelligence on both staff and patient experience. These walkrounds have taken place across a range of services including maternity services, our head injury therapy unit, theatres, interventional radiology, pathology services, breast care and many more specialties and inpatient areas.

We aim to review the way these are conducted during 2017/18 to improve the ownership within each Divisional Management Team for the walkrounds undertaken and the completion of identified improvement actions. We also propose to increase the number of walkrounds. A proposal covering these areas was reviewed at the May 2017 Quality and Risk Management Committee.

Friends and Family Test, Patients

What is the Friends and Family Test?

The Friends and Family Test (FFT) is an important feedback tool that supports people using our services at North Bristol NHS Trust and any other NHS services, to give us real-time feedback of their experiences.

It asks people if they would recommend the service they have used to their family and friends, should they ever need to use it too. It also gives people an opportunity to explain why they have given their response. The commentary given is critical in helping us to make improvements to the care we provide and to honour what we are doing well. All patients, whether they are attending an outpatient appointment, have an inpatient stay on our wards, attend the Emergency Department or use our Maternity Services, have an opportunity to give us feedback about their care.

Response rates

The overall response rate against the required target by these services is provided in the table 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. To address this, improving the quality of patient data has been a priority over the last few months. As a result we are beginning to see an improvement in response rates.

Area	Response Rate April 2016 - March 2017				% Recommend April 2016 - March 2017	
	Target	NBT Average	National Response rate (average)	No. of months that target achieved	NBT	National average
Inpatients	30%	25%	24.3%	0	92%	96%
ED	20%	16%	12.3%	2	86%	87%
Outpatients	5%	15%	Not set	10	92%	93%
Maternity						
(Birth)	15%	24%	23%	10	92%	97%

What did our patients tell us?

Of the feedback received, the majority of patients have reported receiving a…

…really positive experience, emphasising the importance of good communication, kindness, compassion and respect all aspects of a positive and caring attitude.

Top themes from all patient areas have been extracted from comments analysis from 2016-17, for both positive and negative aspects. These are set out in the table below:

Positive experience themes	Number of comments	Negative experience themes	Number of comments
Staff	25,544	Waiting times	1,929
Clinical treatment	10,894	Staff	1,275
Waiting times	10,598	Communication	1,150
Care	10,588	Clinical treatment	907
Environment	4,476	Environment	651
Communication	4,059	Care	332
Catering	784	Discharge	149
Discharge	314	Catering	119
Staffing levels	189	Staffing levels	88

What changed?

The benefit of FFT is that the feedback is about immediate experience. Whilst it is anonymous, actions can be taken to help improve matters for all patients. Below are some actions taken based on feedback we received from our patients.

Ambulatory Emergency Care

Within our Ambulatory Emergency Care; a patient service that sits in Acute Medical Admissions, action has been taken to improve the patient pathway, based on feedback received from FFT. Patients felt that waiting times for this service were too long, especially if they were first seen in the Emergency Department. Whilst it was difficult to reduce waiting times in this service because of the investigatory process many patients have to undergo, staff were keen to address patients' concerns. The first action taken was to ensure that all patients were given a full explanation of what to expect from the service and were then kept informed along their pathway. GP and consultant rotas were also adjusted to give better coverage during the busier times for this service. As a result of these actions taken, patients' experiences of using the service have improved.

Maternity (birth)

Based on feedback given by a woman using the maternity services, which related to the way she felt she was treated during her pregnancy because of her age and size, a training video was developed to share her experiences. During the filming the woman also offered solutions about how the service could be more respectful whilst maintaining the safety of her and her baby. This video was shown on this year's intra partum study day, which all doctors and midwives attend.

Ward 28a (patients with complex care needs)

A patient fed back that they were very impressed with the high standard of care they had received from the Healthcare Support Workers on the ward. To ensure this high standard of care continued, the ward manager fed this back to her team, which had a very positive impact all round.

"No information about what I was waiting for unless I asked. Terrible logistics. I came in for a blood test, but it was 4hours before I had the blood taken and then had to wait another hour for the result."
(ED patient)

"The attention and professionalism of the team in Resus was outstanding and very reassuring. Cannot praise highly enough."
(ED patient)

"The staff were fantastic; sensitive, reassuring and competent. I was given great care and consideration. Staff obviously kept very busy but I did not feel they rushed me - gave me care and attention I needed."
(Maternity patient)

"The staff is really caring, friendly and with clear intention to do their best irrespective of the patients race/colour/ethnic origin, which is really good. Doctors and nurses are well trained, professional and knowledgeable enough to deal with any sort of complications. Even though I had to wait a bit longer than expected, they knew that my life was not under risk, so they are good at prioritizing the work. The doctor was exceptionally good and made sure she was confident about my health before asking me to leave. I felt every penny that I pay as tax is worth it and it is helping people in need. I thank you everyone."(Inpatient)

"I felt that there was a lot of miscommunication, not everyone appeared to know about some things I talked about. At times I found it stressful. However the physio and IT were really helpful which helped with my recovery." (Inpatient)

"My visit was handled with cheerful, positive professionalism. Despite a potentially stressful time I was put at ease by the ongoing, clear communication throughout."(Outpatient)

"Well my score is marked down because my previous appointment was cancelled without my knowledge. Not very customer friendly!"
(Outpatient)

NHS Staff Survey and Staff Friends and Family Test

2016 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. This year a sample of eligible staff in the Trust were invited to complete the survey during September to December 2016. 1,250 staff were invited to participate. 401 staff responded, giving a response rate of 32% (compared to 30% the previous year).

When looking at combined positive responses (e.g. a combination of 'strongly agree' and 'agree' or 'very satisfied' and 'satisfied'), compared to last year there were:

- 34 positive changes;
- 8 no changes; and
- 27 negative changes.

For 2017, the Workforce Committee and Trust Board have agreed that our corporate focus should be on:

- Improving communication and engagement; and
- Improving the health and wellbeing of our staff.

Work has already started in these areas and we are aiming to build on this work over the coming year. Some investment has been made to provide more support to staff in the following areas:

- Fast-track physiotherapy;
- Wellbeing courses to focus on positive health and wellbeing including sleep, mood, work / life balance, resilience and energy management (run by members of the Trust's psychology team); and
- Schwartz rounds – a multi-disciplinary forum designed for staff to come together once a month to discuss and reflect on the non-clinical aspects of caring for patients, i.e. the emotional and social challenges associated with their jobs.

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; and
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

NHS Staff Survey 2016	NBT 2016	NBT 2015	National Average (Acute Trusts)
		Score out of 5	
Staff recommendation of NBT as a place to work or receive treatment	3.62	3.64	3.77

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.

NHS Staff Survey 2016	NBT 2016	NBT 2015	National Average (Acute Trusts)
KF26 - % staff experiencing harassment, bullying or abuse from staff in previous 12 months	26%	26%	25%
KF21 - % staff believing the organisation provides equal opportunities for career progression or promotion for the Workforce Race Equality Standard	85%	85%	87%

With respect to harassment and bullying, it is notable that call volumes for the Harassment and Bullying helpline have been declining over the past few years, which may indicate a reduction in concerns. The Trades Unions are however dealing with cases they receive so staff may not wish to use the helpline. We are not complacent and are currently evaluating options for promoting the Trust's zero tolerance policy more actively. New advisers were recruited and trained in 2016.

With respect to equal opportunities, our Trust Equality and Diversity Manager is working closely with our Director of Operations, Kate Hannam, 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, the patient information screens in the Brunel building and on the equality notice boards. Both the helpline and Respect and Dignity policy are promoted in the monthly equality newsletter and included in all face to face equality training i.e. induction for all new staff, consultants, domestics and porters.

Staff Friends and 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 2016-17 are shown below. The survey was conducted electronically and sent to all eligible staff. The results from Quarter 4 have not yet been received.

	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Response Rate
Q1	23%	51%	17%	6%	2%	1%	18%
Q2	23%	53%	15%	5%	2%	2%	15%

	Extremely Likely	Likely	Neither Likely nor Unlikely	Unlikely	Extremely Unlikely	Don't Know	Response Rate
Q1	14%	42%	22%	14%	7%	2%	18%
Q2	12%	37%	22%	15%	14%	1%	16%

We are proud that 76% of our staff would recommend us for care or treatment but aim to improve on the experience of staff, building on the good outcomes that we achieve for patients.

There are two primary aspects to this:

- Continuing to improve the experience of patients in our Trust as well as the outcomes; and
- Ensuring that all our staff, including those who work in non-patient facing roles, understand the progress we are making in achieving those improvements. This will form part of the work we undertake to improve communication and engagement with staff.

Managing Complaints and Sharing Compliments

Complaints

Overall the numbers of formal complaints reduced by approximately 17.5% in 2016/17, from the figure recorded last year when many issues arose from the still ongoing redevelopment of Southmead.

The numbers of complaints where response timeframes were not met also fell significantly; at best there were only eight cases in June 2016. Since this time the number has again increased to approximately 40 cases, due to the work pressures directorates are experiencing. Eradicating all overdue cases remains an important Trust objective and there is plan in place to do so.

There are two key measures for NHS Complaints:

- to acknowledge all complaints with three working days; and
- to conclude all cases within six months.

During the year the acknowledgement target was achieved in every month except April, September and October. The average overall compliance was 99.85%. During the year, four cases remained unresolved within six months, these were cleared in June 2016 and there have been no subsequent long-standing cases.

Activity levels

The Trust received 654 formal complaints; 167 less than last year. 1,394 concerns were also raised and acted on an increase of 598 over 2015/16. These figures reflect the increase of low-level worries and anxieties related to the ongoing site redevelopment and also the interruption to the smooth scheduling of appointments that resulted from the changeover process to a new Patient Access System (Lorenzo). In general, the stabilisation of services delivered from within the Brunel Building contributed in some extent to the reduction in formal complaints.

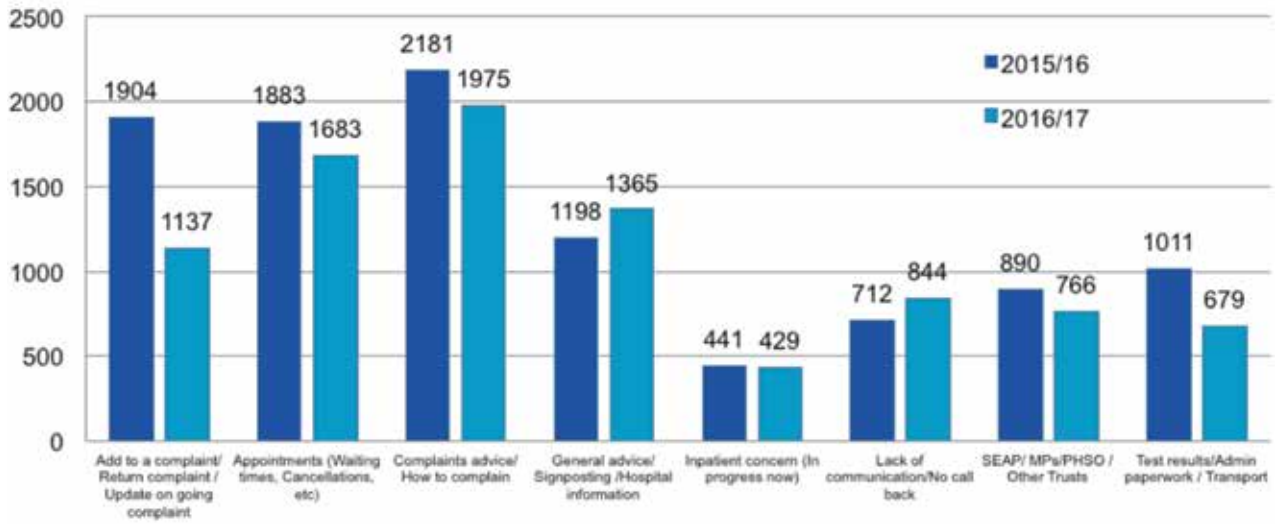
The three highest categories of formal complaints were:
The three highest categories of concerns were:

- All aspects of Clinical Care **220**
- Lack of Communication **207**
- Attitude of Staff **68**
- Lack of Communication **235**
- All aspects of Clinical Care **178**
- Delay / Cancellation Outpatient **90**

Enquiries and Informal concerns

The Advice and Complaints Team (ACT) successfully managed many low-level concerns and enquiries outside of the formal complaints process, through a telephone helpline or by meeting patients in person. These fell overall during the year from 10,220 to 8,878.

Enquiries received 2015 - 2017



Lessons learned

The number of local resolution meetings undertaken reduced from 99 to 86. Whilst this is a slight reduction, the figure still reflects how directorates are seeking to resolve more cases through interactive dialogue, which generally provides an improved patient experience and outcome. For all cases an action plan is raised inviting directorates to record and feedback lessons learned, which is then included as part of the response letter. Additionally, from the local resolution meetings, the agreed actions are discussed with the complainants, recorded in writing and are then tracked until completed. The complainants are notified of the date the actions were completed and can be provided with evidence if appropriate. An example of a lesson learned was that the process for communicating with patients and families from the deaf community was changed in response to feedback about a lack of understanding of their needs.

NHS Choices website feedback

As the redevelopment of the Southmead site moved towards completion, and the services delivered continued to evolve to take advantage of the improved facilities, the overall star rating of North Bristol NHS Trust on the NHS Choices Website increased from 3.5 to 4 stars midway through the year.

Improving communication

A part of the Trust's desire to improve the complaints process, a pilot of identifying a named contact for all complaints was undertaken in the Medical Directorate. The appointed individual contacted the complainant to agree the investigation criteria and date of response. In most cases this direct contact was welcomed and allowed for the early resolution of the complaint, saving overall resources and giving a good experience to the person raising the complaint. This model will be rolled out across all the directorates during the forthcoming year.

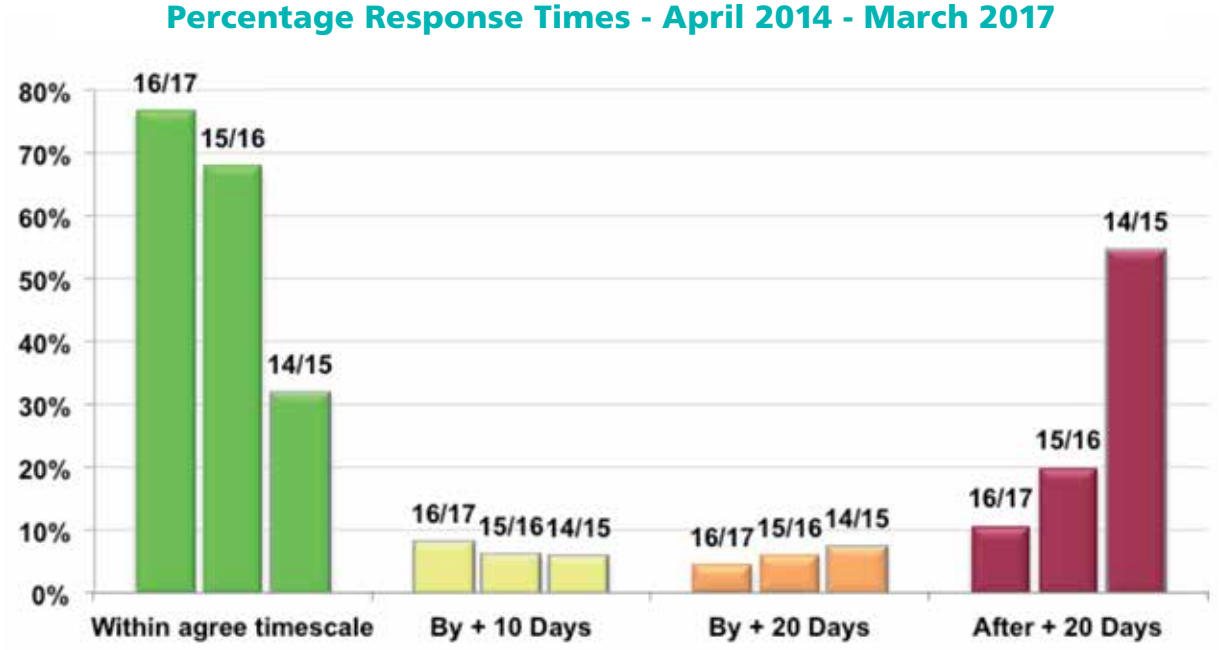
Audit of patient complaints review panels

To provide quality checks of the complaints process from an independent source (in addition to the Clinical Commissioning Group), we have worked with the Patients Association to develop an anonymised audit process that allows real-time feedback on a random sample of the previous quarter's complaints. This process allows patient representatives, who have been trained in reviewing anonymised complaints against the Patient Association Good Practice Standards for NHS Complaints Handling (2013), to give real-time feedback for incorporation into the ongoing complaints improvement plan.

Service improvements delivered in 2016/17

- The overall response times achieved for all cases (complaints and concerns) continued to improve (see chart below).
- The database was amended to ensure the recorded reasons for complaints used the Patient Feedback criteria to provide more consistent reporting.
- The Patients Complaint Review Panel influenced several aspects of the complaint process. These included the following:
  - The need for a named contact to be provided to the complainant on every occasion;
  - The need to ensure that the person making the complaint understands the process; and
  - That the named person clarifies what the complainant wants to achieve through the complaint.
- NHS Choices feedback is tracked and recorded on the complaints database to provide analysis for the Patient Experience Group.
- Training is delivered to complaint investigators in collaboration with the Patients Association.
- Test of change is used to evaluate named clinical directorate contacts to improve complainants overall experience. This model will be adopted as the standard by all directorates over the forthcoming year.

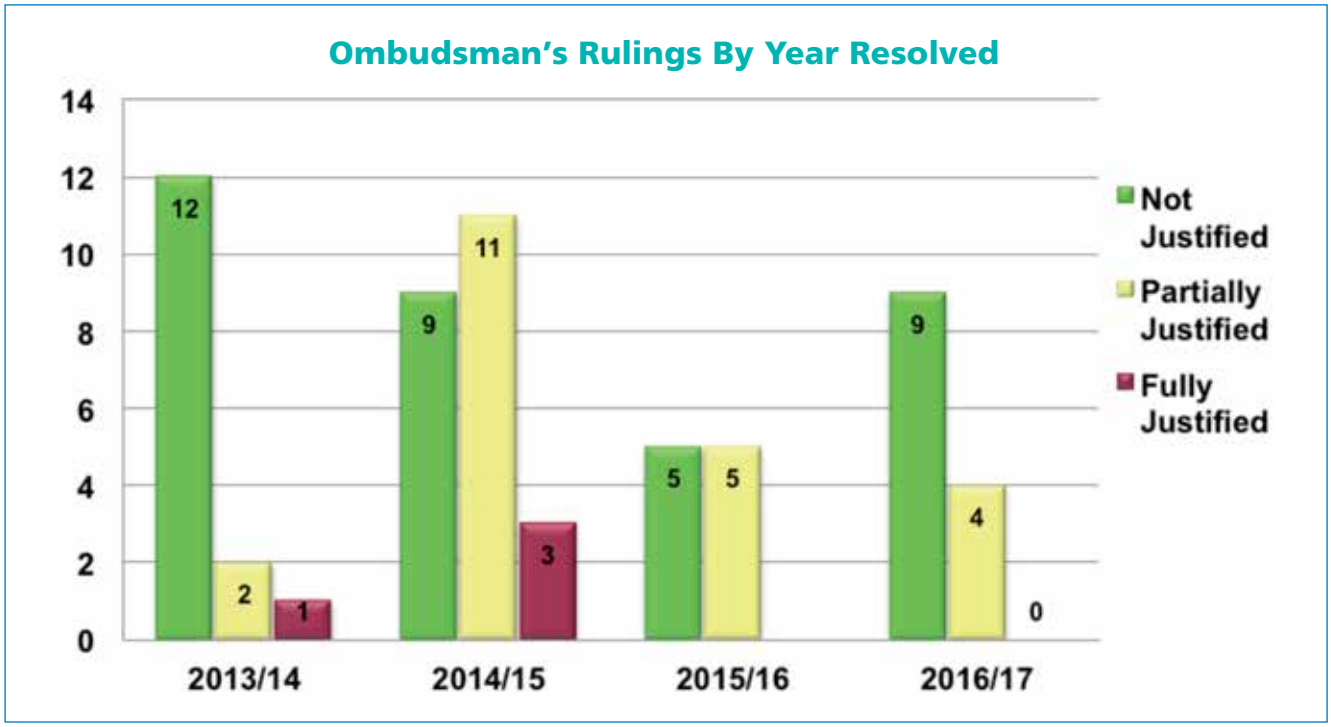
Percentage Response Times - April 2014 - March 2017



Ombudsman Referrals

If after attempts at local resolution the complainant remains dissatisfied, they may request the Parliamentary Health Service Ombudsman (PHSO) to consider their case. The relative rulings from the PHSO over the last three years are shown in the chart below. During 2016/17, the Trust is aware of 18 complainants who contacted the Ombudsman where they subsequently decided to review the actions of the Trust and call for the complaints file. Of these five cases have been closed by the Ombudsman and no complaints were wholly upheld, four were found to be partly justified and nine dismissed. The Trust was asked to extend apologies for all the partially justified cases and to pay compensation in two cases amounting to a total of £900 in respect of cases concluded in 2016/17.

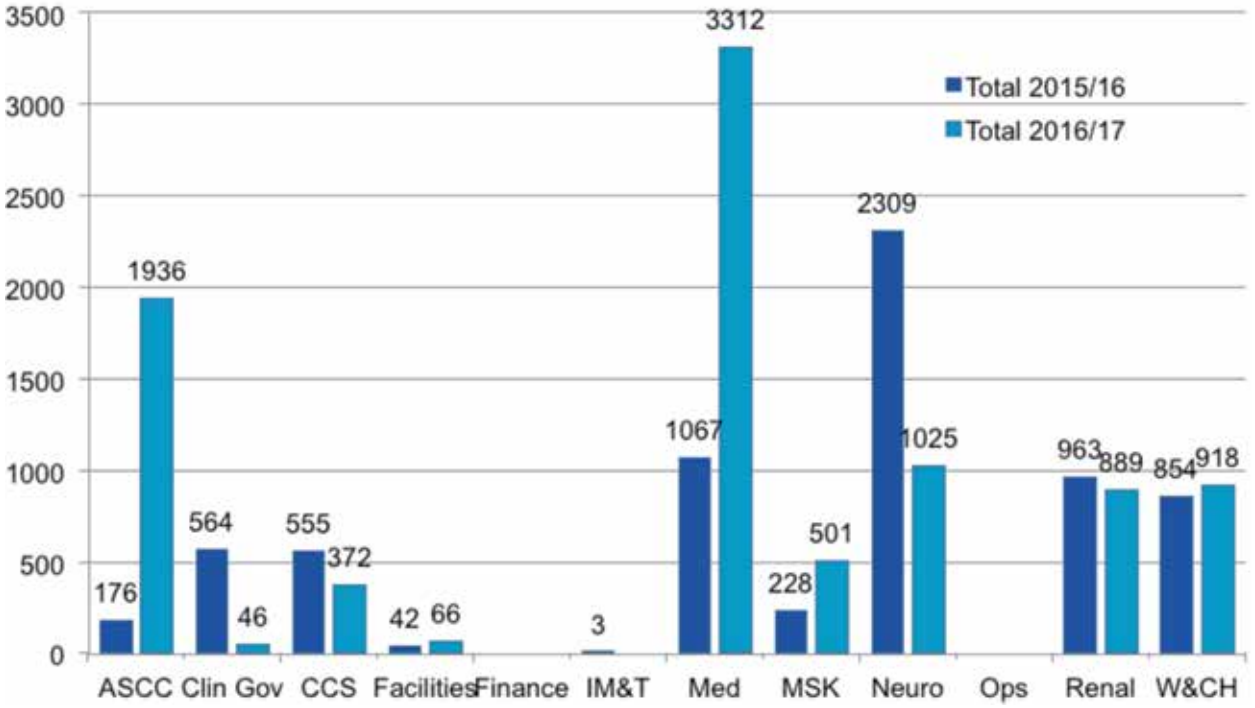
For partially or fully justified rulings the Trust produce an action plan to record any new points of learning, or to illustrate any learning already actioned. These are shared with both the Ombudsman and the complainant. On occasion this will also be followed by regular updates until the identified actions can be shown to have been completed.



Compliments

9,065 compliments were received during 2016/17; a significant increase on the previous year's figure (6,761).

Compliments - Total by Directorate 2015/16 and 2016/17



Improving Cancer Patient Experience

The Trust takes part in the annual national cancer patient experience survey (NCPES) for all patients who received a cancer diagnosis at NBT in 2015. Results of the 2016 national cancer patient experience survey are expected to be published in August 2017.

New survey reporting methodology

For the 2015 survey, the CQC standard for reporting comparative performance has been adopted, based on calculation of expected ranges. Hospital trusts are flagged as outliers only if there is statistical evidence that their scores deviate (positively or negatively) from the range of scores that would be expected for a trust of the same size. Site-specific results were reported only for breast, colorectal, prostate, haematological, skin and urological cancers. The results of tumour groups with less than 20 respondents were not reported. As a result of changes in the format and methodology of the NCPES comparisons with previous years should be treated with caution.

Survey results included in NHS England cancer dashboard

Rate of care on a scale of 0 (very poor) to 10 (very good) – **NBT 8.6** (8.7 national)

- **76% NBT** (78% national) reported they were definitely involved as much as they wanted in decisions about care and treatment
- **93% NBT** (90% national) reported that they were given the name of a Clinical Nurse Specialist (CNS) who would support them through their treatment
- **83% NBT** (87% national) reported that it had been 'quite easy' or 'very easy' to contact their CNS
- **84% NBT** (87% national) reported that, overall, they were always treated with dignity and respect while they were in hospital
- **92% NBT** (94% national) reported that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital

Questions which scored outside expected range for hospitals of a similar size

(positively or negatively)

Question	Number of respondents for this Trust	2015 percentage NBT	Lower limit of expected range	Upper limit of expected range	National Average Score
Support for people with cancer					
Q.20 Hospital staff gave information about support groups	340	88	78	88	83
Operations					
Q.26 Staff explained how operation had gone in understandable way	293	69	78	82	78
Hospital care as an inpatient					
Q.34 Always given enough privacy when discussing condition or treatment	279	90	81	89	85
Hospital care as a day patient / outpatient					
Q.42 Doctor had the right notes and other documentation with them	376	93	94	98	96
Q.47 Beforehand patient had all information needed about chemotherapy treatment	134	78	78	90	84
Q.48 Patient given understandable information about whether chemotherapy was working	121	59	60	76	68
Your overall NHS care					
Q.56 Overall the administration of the care was very good / good	453	84	86	92	89

Following the publication of the results in August 2016 we completed an action plan to improve on areas where the results were below the expected national range. The key areas identified for improvement were:

- Ensuring patients are involved in decision making and provided with clear information and advice on the nature, possible risks and outcomes prior to and following their operation;
- Ensuring patients are provided with clear information and key contact details on discharge from hospital;
- Improve the accessibility for patients to their named Clinical Nurse Specialist at key stages in their pathway;
- Improving the effectiveness of partnership working with UHBristol regarding the provision of patient information about chemotherapy and radiotherapy treatment and its impact on individual patients; and
- Continuing improvements in all aspects of the administration of care at NBT including access to patients notes at consultations across the Trust.

Further areas identified to improve the quality and experience of cancer patients were:

- Improve care planning with patients by ensuring all patient pathways include a personalised care planning appointment at all key stages with the key worker / CNS;
- Improve communication and liaison with community services by developing a standardised treatment summary to be sent in a timely fashion electronically to GPs for all patients;
- Promote the information, advice and support services available at the Macmillan Wellbeing Centre to ward staff for both inpatients and outpatients;
- Increase the number of health and wellbeing education sessions enabling all patients access at key stages in their pathway;
- Promote the Macmillan Citizens Advice Service available at the Macmillan Wellbeing Centre to support patients with financial and back-to-work advice; and
- Work with ward staff to improve the information given to patients regarding social and health support services in the community.

Carers

North Bristol NHS Trust is committed to including and supporting carers as partners in the delivery of safe, effective quality care in the hospital setting. This is endorsed by the new logo that will be jointly used by us and UHBristol.

Building on our established Joint Carers Charter and our Carer Support Scheme over the next few months we will develop a Carers Strategy.

We continue to grow strong links with our partners particularly at the Carers Support Centre.

- In October to December 2016 there were 110 referrals from 18 different wards, compared to 61 referrals across 17 wards at the same time in the previous year.
- There has been an 18% increase in referrals to the service.
- The liaison workers attend the Memory Café weekly in the Brunel building and have now initiated a surgery for carers in Elgar House fortnightly.
- We created a video to support young carers and launched another video on Carers Awareness Day to draw attention to the support needed by young carers.

NBT received feedback from a carer at the memory café regarding the carers' scheme that was very positive. She had fully utilised the options for hot food and complementary parking. Monitoring of the scheme has become a possibility now as the application process became electronic from the February 2017 with the assistance of the travel, parking and security team:

- An agreement to allow carers to register up to two cars for complementary parking has been a welcome addition to the carers' scheme;
- During February 2017 there were 173 carers registered for the scheme; 134 had requested parking;
- Over 25 wards and departments have offered this scheme to carers; and
- It is anticipated that we will be able to use the data collected for future reporting and improvements.

Awareness raising will continue throughout the year, and the web pages will be updated to reflect the progress that is made.

Safeguarding Vulnerable People

Safeguarding Children

Children (those under age 18 years of age) are seen in a range of settings throughout the Trust. These include Maternity services, Emergency Department (ED), outpatient clinics and the nursery. Young people aged between 16 years and up to 18 can also be admitted as inpatients. We work closely with providers of children's services as young people make their transition to Adult Health Services. It is also important to remember that children and young people are seen indirectly through our contact with their parents. In safeguarding children and young people it is the 'Think Family' approach that is important in safeguarding the wellbeing of children and young people.

Group	No. of patients	
	2015/16	2016/17
Inpatients/day cases (16 – 17 year olds)	861	682
Emergency Department (0 – 17 years)	9,979	9,435

We have a responsibility to safeguard and promote the wellbeing of children and young people as well as adults at risk of abuse or neglect in the NHS. In practice this is achieved in a number of ways:

- Ensuring all staff are provided with relevant training;
- Having specialist staff to guide and advise us;
- Maintaining the required standards;
- Demonstrating learning and application from Serious Case Reviews; and
- Participating in the Local Authority Safeguarding Children and Adult Boards.

Challenges during 2016-17

In April 2016 the Community and Child Health Partnership (CCHP) for Bristol and South Gloucestershire parted company from NBT to be managed by other providers, which meant that the experienced support provided by CCHP disappeared. Whilst this was a planned move, this significant change did provide operational challenges to the service due to staff turnover, although it also offered an opportunity to think differently about how the service could be delivered.

The Named Nurse post became vacant, which required the appointment of an interim Named Nurse for five months, following which the Maternity Safeguarding Specialist Midwife provided support until the appointment of a permanent Named Nurse. A new Head of Safeguarding post was appointed in January 2017, which incorporated the Named Nurse responsibilities. This overarching post enables a joined-up approach to the whole of safeguarding across the Trust, using resources and expertise to the maximum effect.

There have been some practical challenges ensuring the efficient referral process of children to the local Authority Safeguarding Services from the Emergency Department, due to changes in the process within the local authority. We found a temporary solution, this being very reliant on time-consuming manual processes. A permanent IT solution is being pursued with urgency and this will be monitored closely until fully resolved.

Training

Our staff are trained to recognise, understand and report safeguarding concerns for children and young people. All training is delivered in line with the requirements set out in the document Safeguarding children and young people: Roles and competences for health care staff .Intercollegiate Document. 3rd Edition. March 2014. The required standard set by our commissioners is that 90% of staff requiring a particular level attend the relevant training. The attained levels are shown below.

Training level	Compliant Staff	
	2016/17 Quarterly Range	Average 2016/17
Level 1	80 – 86%	83%
Level 2	82 – 88%	84%
Level 3	69 – 81%	80%

The lowest level of compliance was seen in Quarter 3 (October – December 2016); 69%, which was driven by a number of factors. These included:

- Capacity of the central team to deliver all the training; and
- Incomplete recording of medical staff training and of the in-department training in the Emergency Department.

In order to improve training compliance and reporting the following is being undertaken:

- Review of recording within and reporting from the 'Managed Learning Environment' (MLE) with the manager of this service;
- Clarity of what training is being delivered, when it is being delivered, who it is being delivered to and by whom within ED and maternity services is delivering it; and
- A training needs analysis is being undertaken which includes;
  - Review of types of learning (e-Learning / case reviews / face to face training etc.)
  - Accessibility and recording of training.

Governance

The revised governance arrangements set up in 2015/16 are working well with the Safeguarding Committee, bringing challenge and seeking assurance on all elements of safeguarding children and adults. This has enabled the identification of issues and remedial actions set out above to be progressed during the year with the involvement of internal and external parties and appropriate scrutiny of progress made. As the revised team structure embeds during 2017/18 we will accelerate our improvement plans in conjunction with our external partners and anticipate this delivering a more efficient and systematic approach.

Safeguarding Vulnerable Adults

Introduction

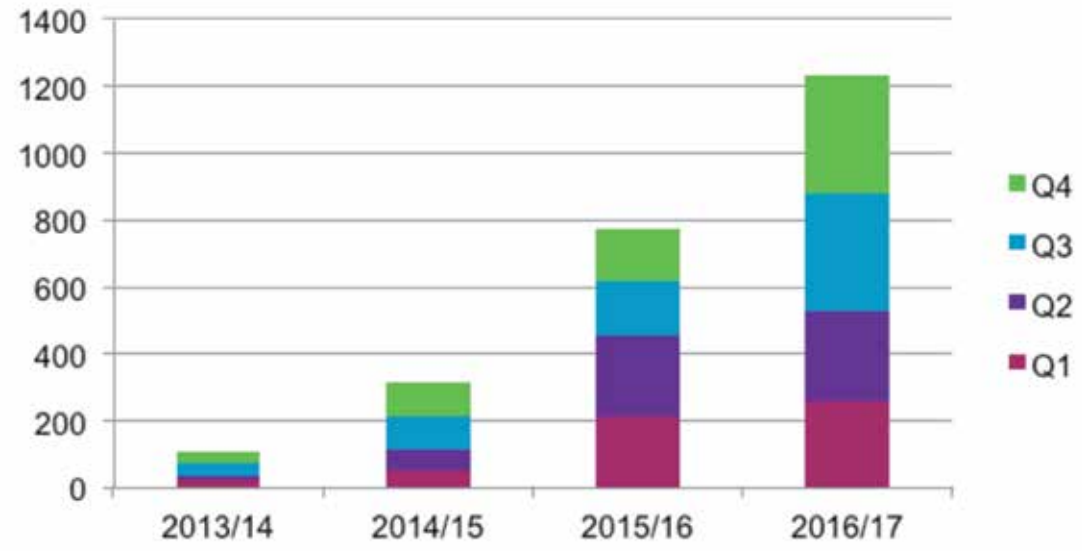
The safeguarding of adults at risk remains a high priority for us. This area of statutory practice requires collaborative working with other health providers, health and social care commissioners and the local authority and the police. The Director of Nursing is the Executive Lead for Adult Safeguarding and chairs the Trust Safeguarding Committee. Adult Safeguarding has its own operational group which is chaired by the Head of Patient Experience. The safeguarding team provides the operational expertise and oversight to support frontline staff in fulfilling their safeguarding responsibilities.

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 provided to all NBT staff and for frontline professionals training, is delivered face-to-face. Our staff is required to attend update training every three years.

We are now a year on from the implementation of the Care Act which moved adult safeguarding from an objective set by government by policy to an objective governed by statutory law.

The chart below shows the growth of referrals from the Trust into the team. A referral is better described as a contact that can lead to a number of outcomes and interventions.

Growth of Safeguarding Adult Referrals



The growth in referrals is explained by the following factors:

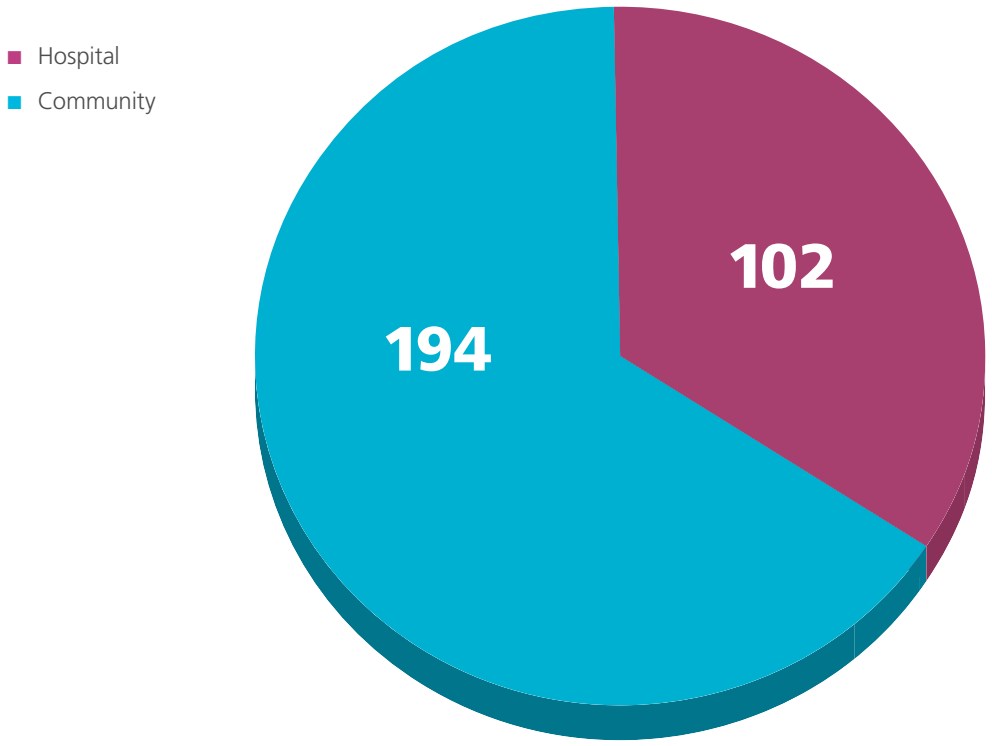
- Change in definition and threshold as required by national requirements;
- The effect of training - generating greater awareness and therefore more referrals;
- Adult Safeguarding Team improved availability for support;
- The adding of additional strands to the Adult Safeguarding Agenda i.e. domestic abuse and violence, FGM, modern slavery; and
- Greater need to support practitioners with Mental Capacity Act and Deprivation of Liberty 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.

Safeguarding Adults

Our frontline staff alert using the incident reporting system where patients may have come to harm. The safeguarding team however will take an alert no matter how it is sent; email, phone or face-to-face contact. Alerts from the Complaints and Clinical Risk teams are also considered by the team for safeguarding actions.

Referrral types: Hospital or Community Acquired Harm

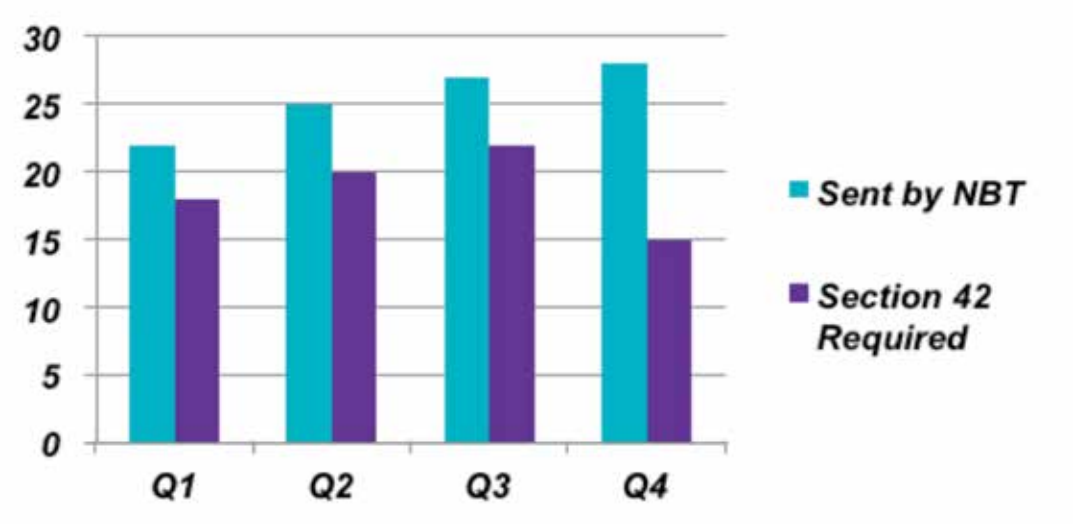


We separate adult safeguarding referrals into two distinct types; community acquired harm and hospital acquired harm. The chart (left) demonstrates the separation between these two types of activity.

The team makes a judgment as to whether the event is likely to need a safeguarding inquiry under Section 42 of the Care Act 2015. Section 42 means that the Local Authority (often referred to as Adult Services, Adult Social Services, or Social Work teams) must:

- Make enquiries, or cause others to do so; and
- An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

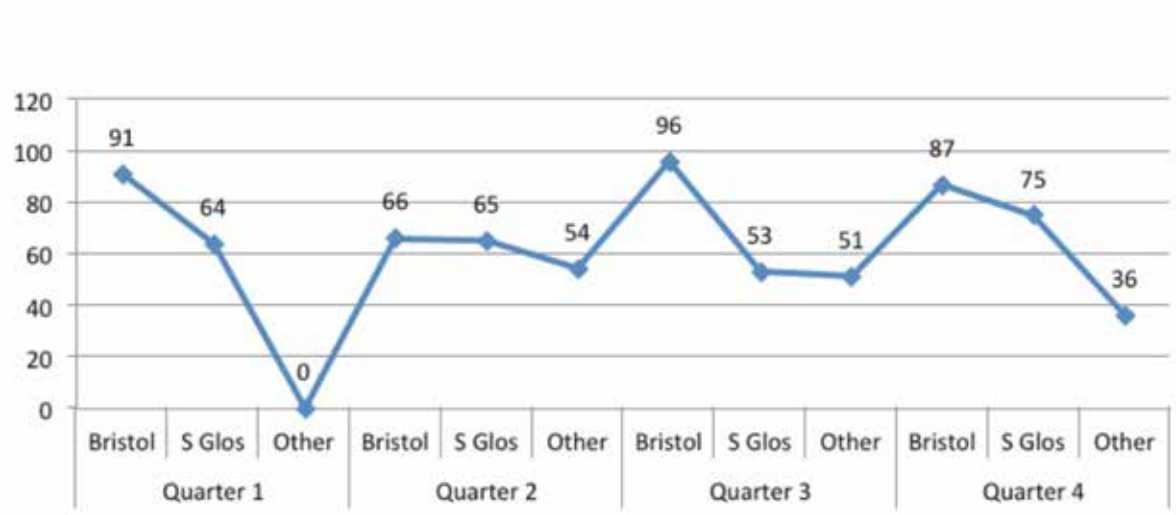
Deprivation of Liberty Safeguards (DoLS)



Deprivation of Liberty Safeguards (DoLS)

When a patient is admitted into our service, if they cannot consent to be with us, the law requires a DoLS authorisation to be completed. The following chart demonstrates how many DoLS applications we make.

Number of DoLS applications made by our staff



Once an application is made the Local Authority is required to assess whether the legal grounds are met within seven days. During 2016/17, none of the DoLs applications made by our staff were assessed or authorised within the legal timeframes, nor at the time of the patient's discharge. However the local authorities are actively addressing the resource required for full assessment to be made in a timely manner.

Section 4 - Clinical Effectiveness

Mortality Outcomes - HSMR/SHMI

Mortality

The Trust continues to have an excellent record on patient mortality. 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

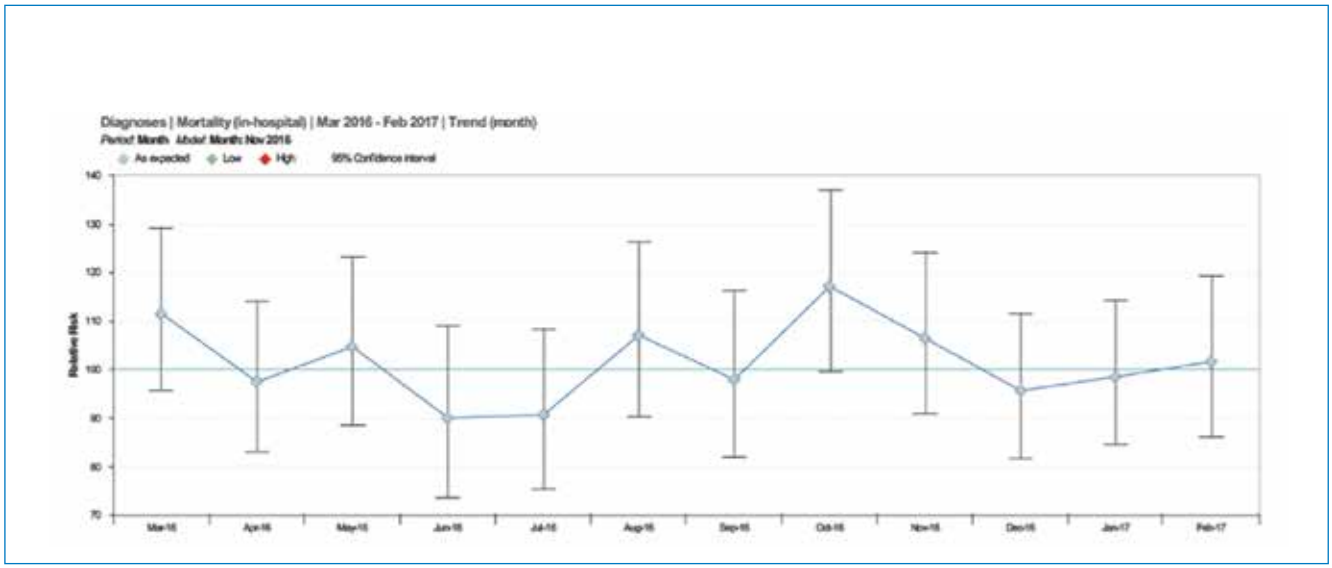
HSMR is a measurement which compares a hospital's actual number of deaths with their predicted number of deaths, taking into account factors such as the age and sex of patients, their diagnosis and whether their admission was planned or an emergency. If a Trust has an HSMR of 100, this means that the 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. The chart below shows that mortality is below expected levels for almost all of the year. There was a rise in October and November 2016 but it is important to note that the mortality levels still remained within the 'expected range'.

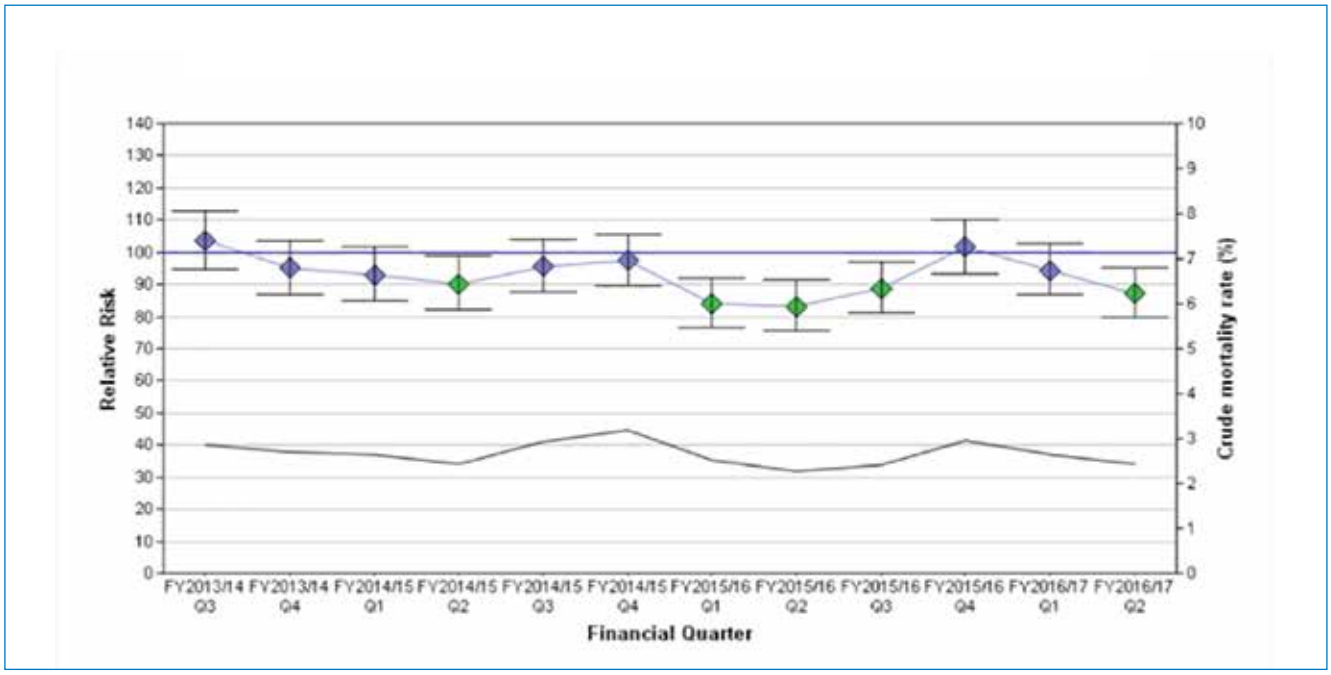
Standardised Hospital Mortality Indicator - SHMI

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 we are performing better than would be expected and have been for a number of years.

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; and
- 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.





Safety Review of every patient death

We have been at the forefront of introducing a formal review of all patient deaths. It has pioneered the introduction of a formal review tool and has supported clinicians in this important learning process. Whilst the published and independently assessed NBT data outlined in the charts is very reassuring, we are not complacent and thus reviewing all in-patient deaths is part of the goal for our longer-term quality and safety improvement work.

In April 2014 a new mortality review 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. It supports our existing Clinical Risk and Serious Incident review and reporting systems and aims to ensure that all in-patient deaths are investigated.

In 2016/17 a total of 734 mortality reviews were completed on in-patient deaths. This represents 55% of deaths and does not include those deaths that have been reviewed as part of our serious incident work. This is a slight reduction on last year's completion and this reflects the need to prioritise clinical activity in the current demanding time for the NHS as a whole. The information from this mortality 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

We have 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 now known as Quality Surveillance Programme. Each team's compliance with these national quality standards is monitored through a programme that utilises self-declaration, internal validation and external validation processes. In 2016 the following reviews were undertaken and the compliance is noted opposite.

There was a change to the assessment process in 2016 which stated that services were no longer required to perform an internal validation, and there was a vast reduction in measures to report against from 2015. We will continue to perform internal validations based on the quality of self-declaration submissions.

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 quarterly Cancer Committee meeting to monitor progress against actions and escalate issues identified.

Cancer Performance

As outlined in the national cancer waiting time guidance document we are tasked with delivering national cancer waiting times targets.

We have made significant improvements to cancer performance over the year in an aim to meet targets consistently. Cancer performance in January showed substantial improvement with the Trust delivering on all seven of the seven national targets. The Trust exceeded the 62-day standard in January, ranking first for 62-day performance in the South West region and second in the South region. This marks a significant achievement for the Trust and demonstrates a significant improvement in waiting times for patients on cancer pathways. The quarterly position has also exceeded the 62-day standard for Quarter 3 2016/17. Performance against the key targets that we are measured against is summarised below.

Standard patients	Target	Q1	Q2	Q3	Q4	YTD	Total no. of patients
Patients seen within 2 weeks of an urgent GP referral	93%	93.8%	89.8%	91.2%	93.5%	92.0%	21,690
Patients with breast symptoms seen by specialist within 2 weeks	93%	94.1%	96.0%	91.8%	95.7%	94.4%	766
Patients receiving first treatment within 31 days of cancer diagnosis	96%	96.4%	96.9%	98.2%	98.5%	97.4%	3,048
Patients waiting less than 31 days for subsequent surgery	94%	96.6%	98.2%	99.3%	95.7%	97.5%	1,020
Patients waiting less than 31 days for subsequent drug treatment	98%	100%	100%	100%	100%	100%	95
Patients receiving first treatment within 62 days of urgent GP referral	85%	83.4%	83.4%	85.9%	87.9%	85.1%	1,629
Patients treated 62 days of screening	90%	85.7%	90.0%	97.0%	94.6%	91.4%	325
Patients treated within 62 days of consultant upgrades	90%	94.4%	91.2%	98.5%	96.2%	95.3%	552

Disease Site / Peer Review Area	Review Measures	2016 (% compliance)	Action areas identified
Urology	21	SD – 76.2%, PR – 66.7%	• NICE guidance requires complex urological cancer surgery to be performed by a specialist urology MDT; it's currently being undertaken by Royal United Hospitals Bath NHS Foundation Trust. The Trust is in discussions with the commissioners to explore growing their surgical robotic capacity. • All the team's documentation and data needs to be reviewed and validated, to ensure reflection of the service. • IT issues relating to the video conferencing equipment needs to be resolved. • The Trust needs to ensure sustainability of the urology service including surgical, theatre capacity and supra network teams are suitably resourced so capacity can be met. • The team needs to audit the referral numbers of high risk non muscle invasive bladder cancer and prostate cancers from Royal United Hospitals Bath NHS Foundation Trust.
CUP Hospital	3	SD – 100%, PR – 100%	Awaiting actions from assessment
Breast	5	IV – 100%	Awaiting actions from assessment
Skin - Adult	6	SD – 100%, IV – 100%	No actions identified
Urology - Penile	6	SD – 100%	• Currently there is only a single clinician offering this service and additional consultant support is required to meet demand moving forward. A business case will be written to obtain funding for this post. • Replacement equipment required as service agreement is coming to an end (Robot). Business case has been submitted and approved and we are awaiting an update on funding.
Brain & CNS	22	SD – 92%	Awaiting actions from assessment
Colorectal	8	SD – 100%	No actions Identified
Lung	7	SD – 86%, IV – 73%	• No named cover for Palliative Care representative nor MDT Co-ordinator. • 54.9% of meetings were not quorate. 5 missing attendance for a consultant surgeon and 20 from a representative of the specialist palliative care team.
Sarcoma	6	SD – 83%	Awaiting actions from assessment
Gynaecology	7	SD – 83%	Awaiting actions from assessment
Palliative Care	25	SA – 95%	• National measures pose challenges as no network group at present.
Chemotherapy	36	SA – 75%	Awaiting actions from assessment
Oncology Pharm Service	5	SA – Not provided, self-assessment not completed	

Key: SA – Self Assessment, SD – Self Declaration, IV – Internal Validation and PR – External Peer Review

Significant improvements have been made to patient pathways for those that are both referred directly to us and are treated by us, and also those patients who are transferred in or out of the Trust for treatment. There have also been significant improvements to the patient-tracking processes employed by Cancer Services and the joint working between Cancer Services and the individual specialities which has enabled a more proactive approach to managing patients along their pathways, and identifying and resolving potential breaches.

The Trust undertakes a review of all patients who are not treated within 62 days of their GP referral (patients who breach the national standard) to enable learning and to identify issues within pathways that require resolution. This has been a vital element of the improvement of cancer systems at the Trust, as there has been an increase in referrals of nearly 10% from the previous year.

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 patient of the breach.

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.

What we plan to achieve for 2017/18

We plan to implement a new breach reallocation policy for the 2017/2018 cancer performance year which will require all patients being treated by a different provider than the one which received the original referral to have transferred the patient to the treating provider by day 38 of the pathway. This policy will make the reporting of cancer performance fairer for tertiary providers and should have a positive impact for the Trust, particularly in urology. All timed pathways at the Trust have been reviewed to meet the new guidance alongside core clinical services to ensure any patients being transferred to UHB from NBT are done so by day 38 and cancer performance is not negatively impacted.

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 (pre-op questionnaire) and about their health and the effectiveness of the operation afterwards (post-op questionnaire). The post op questionnaire is sent direct to the patients' home address. For hip and knee procedures the process can be up to nine months after the procedure. For groin hernia and varicose vein, the process can be up to three months after the procedure. To ascertain whether there has been a health gain, a pre-op questionnaire and a post-op questionnaire must be returned. This helps the NHS to measure and improve the quality of care. We are working on new approaches to seek to improve the rate of completion by patients of PROMs questionnaire and methods to act upon results.

There is no data for 2016/17 as of yet, as there is always a significant time lag with PROMs, however, we can report preliminary findings for April to September 2016, although these may change as more questionnaires are returned.

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	1,053	489	46.4%	372	76.1%
Groin Hernia	181	62	34.3%	33	53.2%
Hip Replacement	422	212	50.2%	184	86.8%
Knee Replacement	386	202	52.3%	147	72.8%
Varicose Vein	64	13	20.3%	8	61.5%

Participation in Clinical Audits

NHS England Quality Accounts List 2016/17

NBT Case Ascertainment

The table below lists the National Clinical Audits and Clinical Outcome Review programmes which NHS England advises Trusts to prioritise for participation and inclusion in their Quality Accounts for 2016/17.

For 2016/17 51 national audits are listed on the Quality Account. NBT is eligible to participate in 36 (71%) and in practice all of these were completed as required, as set out below (audits in light grey are those not applicable to the Trust, shown for completeness).

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Report Year
1	Myocardial Infarction National Audit Programme (MINAP)	National Institute for Cardiovascular Outcomes (NICOR)	Y	Y	522/529 (98.7%)	2016/ 2017[1]
2	Adult Asthma Audit	British Thoracic Society (BTS)	Y	Y	41/20 (205%)	2016
3	Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	N	N/A	N/A	N/A
4	Asthma (paediatric and adult) Care in Emergency Departments	Royal College of Emergency Medicine	Y	Y	50/50 (100%)	2016
5	Bowel Cancer (NBOCAP)	Royal College of Surgeons	Y	Y	233/235 (99%)	2016
6	Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Y	Y		
7	Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Y	Y	100%	Q3 2016/ 2017
8	Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	N	N/A	N/A	N/A
9	Chronic Kidney Disease in Primary Care	Informatica Systems Ltd	N	N/A	N/A	N/A
10	Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	N	N/A	N/A	N/A
11	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Y	Y	216/216 (100%)	2016
12	Diabetes (Paediatric) (NPDA)	Health and Social Care Information Centre (HSCIC)	N	N/A	N/A	N/A
13	Elective Surgery (National PROMs Programme)	Health and Social Care Information Centre (HSCIC)	Y	Y	489/1053 (46.4%)	Apr-Sep 2016
14	Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	N	N/A	N/A	N/A
15	Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database (FLS-DB) - National Hip Fracture Database (NHFD)	Royal College of Physicians	Y Y Y	Y Y Y	1st report published in Spring 2017 521/566 (92.1%)	N/A 2016
16	Head and Neck Cancer Audit	Saving Faces – The Facial Surgery Research Foundation	N	N/A	N/A	N/A

	National Clinical Audit and Clinical Outcome Review Programmes	Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Report Year
17	Inflammatory Bowel Disease (IBD) Programme	British Society of Gastroenterology/Royal College of Physicians	Y	Y		2016
	-Biological Therapy Audit		Y	Y	60[2]	
18	Learning Disability Mortality Review Programme (LeDeR Programme)	University of Bristol				
19	Major Trauma Audit	Trauma Audit and Research Network (TARN)	Y	Y	1462/1370 (+100%)	2016
20	Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Y	Y		
21	Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Y	Y		
	- Mental Health		Y	Y	5/5 (100%)	2017
	- Acute Pancreatitis		Y	Y	10/10 (100%)	2016
	- Acute Non Invasive Ventilation		Y	Y	2/2 (100%)	N/A
	- Chronic Neurodisability		Y	Y	6/6 (100%)	N/A
	- Cancer in Children, Teens and Young Adults		Y	Y	No data entered yet[3]	N/A
22	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	N	N/A	N/A	N/A
23	National Audit of Dementia	Royal College of Psychiatrists	Y	Y	Not available	N/A
24	National Audit of Pulmonary Hypertension	Health and Social Care Information Centre (HSCIC)	N	N/A	N/A	N/A
25	National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Y	Y		
26	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Royal College of Physicians	Y	Y		
	- Secondary care Audit		Y	Y	194/1133 (17.1%)[4]	2017
	- Pulmonary Rehabilitation Audit		Y	Y	45[5]	2017
27	National Comparative Audit of Blood Transfusion	NHS Blood and Transplant	Y	Y		
	- Audit of Patient Blood Management in Scheduled Surgery		Y	Y	32/45 (71%)	2015[6]
28	National Diabetes Audit – Adults	Health & Social Care Information Centre (HSCIC)	Y	Y		
	- Case Note Review		Y	Y	137/137 (100%)	2016
	- Patient Experience		Y	Y	96/137 (70.1%)	2016
29	National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Y	Y	216/216 (100%)	2016
30	National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Y	Y	403/464 (86.9%)	2016/ 2017[7]
31	National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	Y	Y	1138/1624 (90%)	2016
32	National Lung Cancer Audit (NLCA)	Royal College of Physicians	Y	Y	267/267 (100%)	2016

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Report Year
33	National Neurosurgery Audit Programme	Society of British Neurological Surgeons	Y	Y	Information not currently available	
34	National Ophthalmology Audit	Royal College of Ophthalmologists	N	N/A	N/A	N/A
35	National Prostate Cancer Audit	Royal College of Surgeons	Y	Y	1512/1425 (+100%)	2016
36	National Vascular Registry	Royal College of Surgeons	Y	Y		
	Carotid Endarterectomy		Y	Y	125/124 (+100%)	
	Elective Infra-Renal AAA Repair		Y	Y	83/85 (97.6%)	
	Repair of Ruptured AAA		Y	Y	37[8]	
	Repair of Complex AAA		Y	Y	20[9]	
	Lower Limb Revascularisation		Y	Y	357[10]	
	Major Lower Limb Amputation		Y	Y	124[11]	
37	National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health	Y	Y	3080/3080 (100%)	2016
38	Nephrectomy Audit	British Association of Urological Surgeons	Y	Y	555/860 (64.5%)	2016[12]
39	Oesophago-Gastric Cancer (NAOGC)	Royal College of Surgeons	N	N/A	N/A	N/A
40	Paediatric Intensive Care (PICANet)	University of Leeds	N	N/A	N/A	N/A
41	Paediatric Pneumonia	British Thoracic Society	N	N/A	N/A	N/A
42	Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons	Y	Y	108/108 (100%)	2016[13]
43	Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	N	N/A	N/A	N/A
44	Radical Prostatectomy Audit	British Association of Urological Surgeons	Y	Y	468/705 (66.4%)	2016[14]
45	Renal Replacement Therapy (Renal Registry)	UK Renal Registry	Y	Y	148/148 (100%)	2015[15]
46	Rheumatoid and Early Inflammatory Arthritis	Northgate	Y	Y	49[16]	2016
47	Sentinel Stroke National Audit Programme (SSNAP)	Royal College of Physicians	Y	Y	232 (Band A[17])	2016
48	Severe Sepsis and Septic Shock – Care in Emergency Departments	Royal College of Emergency Medicine	Y	Y	50/50 (100%)	2016[18]
49	Specialist Rehabilitation for Patients with Complex Needs	London North West Healthcare NHS Trust	Y	Y	963/963 (100%)	2016
50	Stress Urinary Incontinence Audit	British Association of Urological Surgeons	Y	Y	86[19]	2016[20]
51	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	N	N/A	N/A	N/A

1 2016/2017 year to date (25/04/2017) – Data collection deadline is May 2017
2 Denominator not available
3 Data collection only opened recently for this project and NBT is in the data collection stage before submitting to NCEPOD
4 As of 17/04/2017
5 As of 19/04/2017 – Denominator not available
6 2016 not yet available
7 2016/2017 year to date (25/04/2017) – Data collection deadline is May 2017
8 Denominator not available
9 Denominator not available
10 Denominator not available
11 Denominator not available
12 Data from 2013-2015 combined
13 Data from 2014-2015 combined
14 Data from 2014-2015 combined
15 Data from 2016 not yet available
16 Denominator not available
17 Denominator not available, SSNAP rates case ascertainment from A-E, A is the highest level of case ascertainment
18 2016/2017 data not yet available, data from Aug-Nov 2016
19 Denominator not available
20 Data from 2014-2015 combined

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 progression of local clinical audits, their reporting and subsequent completion of actions is a speciality/directorate responsibility, with oversight through the CAC, which includes directorate representatives. The requirements for local clinical audit design, completion, reporting and action are clearly set out within the Trust's Clinical Audit Policy. 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. In order to provide an overall randomised quality control check, CAC reviews one local audit every two months as a 'deep dive,' which equates to six over the 12 month period. 169 new audits were started in 2016/17 and 129 reports and action plans were reviewed and marked as completed by Quality Assurance and Clinical Audit staff based upon submissions provided by specialty teams.

National Clinical Audit Outcomes 2016/17

Introduction

During 2016/17 the Clinical Audit Committee reviewed and approved reports and initial action plans for 24 National Clinical Audits. 19 out of 24 national clinical audits reviewed were listed on the Quality Account.

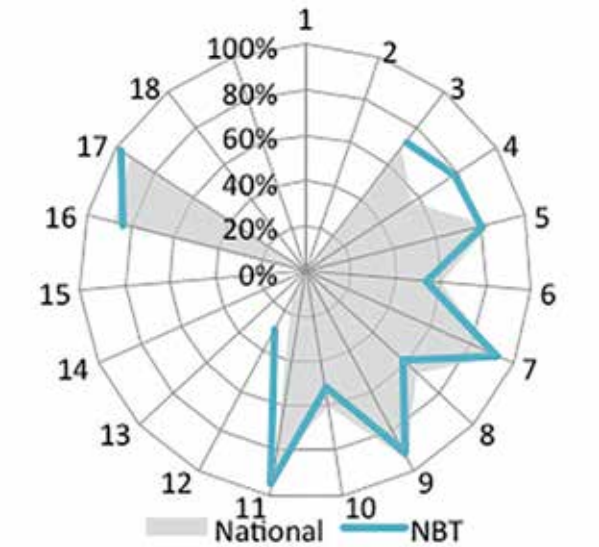
Once action plans are approved by the Clinical Audit Committee they are monitored to ensure that progress is being made at six month intervals until completion. 29 six, 12 and 18-month action plan updates were reviewed and approved by the Clinical Audit Committee during 2016/17, 23 of these were National 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 2015/16 16 audits were closed.

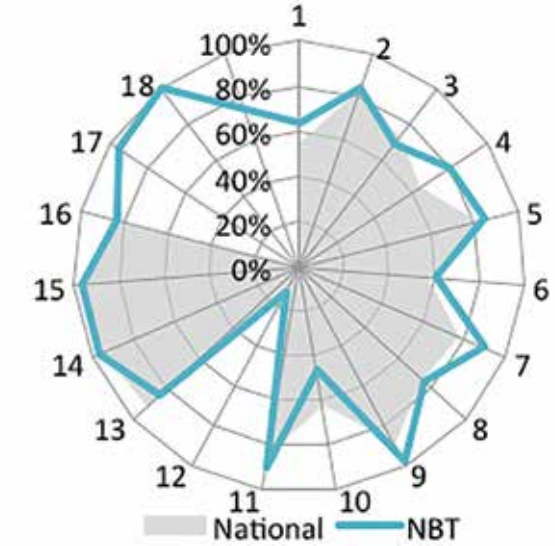
Below are three examples of National Clinical Audits that have had an action plan approved and implemented during 2016/17 and a subsequent re-audit report has been published. The summaries below outline the outcomes of the earlier reports and the actions implemented to improve results at the re-audit 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 2017/18.

National Emergency Laparotomy Audit (NELA) Year 2 (2016)

Year 1 (CA10052)



Year 2 (CA10053)



Compliance and Improvement Table NBT vs National					
Measure		Year	Site		+/- 5% Improvement
No	Name		NBT	National	
1	Proportion of cases reviewed by a consultant surgeon within 14 hours of emergency admission to hospital	2015 (1)	64%	54%	=
		2016 (2)	63%	55%	
2	Proportion of patients who had a CT scan performed before emergency laparotomy	2015 (1)	Not recorded	Not recorded	N/A
		2016 (2)	83%	83%	
3	Proportion of patients who had a CT scan performed and reported by a consultant radiologist before emergency laparotomy	2015 (1)	72%	69%	=
		2016 (2)	68%	72%	
4	Proportion of patients who had risk documented preoperatively	2015 (1)	78%	56%	=
		2016 (2)	79%	64%	
5	Proportion of cases where interval from decision to operate (or time of booking) to arrival in theatre was appropriate to documented operative urgency (for cases with urgency <18 hours)	2015 (1)	80%	84%	✓
		2016 (2)	85%	82%	
6	Proportion of patients reviewed by a consultant surgeon AND a consultant anaesthetist before emergency laparotomy if pre-operative P-POSSUM mortality risk ≥5%	2015 (1)	53%	60%	✓
		2016 (2)	60%	57%	
7	Proportion of patients reviewed by either a consultant surgeon, or a consultant anaesthetist (or both) before emergency laparotomy if pre-operative P-POSSUM mortality risk ≥5%	2015 (1)	92%	92%	=
		2016 (2)	89%	77%	
8	Proportion of patients for whom surgery was directly supervised by a consultant surgeon and a consultant anaesthetist if pre-operative P-POSSUM mortality risk ≥5%	2015 (1)	58%	66%	✓
		2016 (2)	75%	74%	
9	Proportion of patients for whom surgery was directly supervised by either a consultant surgeon, or a consultant anaesthetist (or both) if pre0operative P-POSSUM mortality risk ≥5%	2015 (1)	91%	94%	✓
		2016 (2)	98%	89%	
10	Proportion of all patients admitted directly to a critical care unit following emergency laparotomy	2015 (1)	52%	60%	i
		2016 (2)	47%	62%	
11	Proportion of patients with post-operative P-POSSUM mortality risk of >10% who were transferred directly to a critical care unit from theatre	2015 (1)	95%	87%	i
		2016 (2)	90%	85%	
12	Proportion of patients over the age of 70 who were assessed by an elderly medicine specialist after surgery	2015 (1)	29%	13%	i
		2016 (2)	13%	10%	
13	Proportion of patients who did not return to theatre following their initial laparotomy	2015 (1)	Not recorded	Not recorded	N/A
		2016 (2)	84%	92%	
14	Proportion of patients without an unplanned critical care admission from the ward <7 days after their initial laparotomy	2015 (1)	Not recorded	Not recorded	N/A
		2016 (2)	97%	96%	
15	Proportion of submitted cases that did not have any ineligibility of surgical procedure(s) performed	2015 (1)	Not recorded	Not recorded	N/A
		2016 (2)	97%	97%	
16	Proportion of included cases where both time of decision to operate and time of booking for theatre were submitted	2015 (1)	84%	88%	=
		2016 (2)	84%	86%	
17	Proportion of submitted cases with no missing preoperative or postoperative POSSUM fields	2015 (1)	98%	93%	=
		2016 (2)	96%	Not recorded	
18	Proportion of submitted cases not missing both preoperative or postoperative POSSUM fields (cases submitting at least a preoperative or postoperative POSSUM score)	2015 (1)	Not recorded	Not recorded	N/A

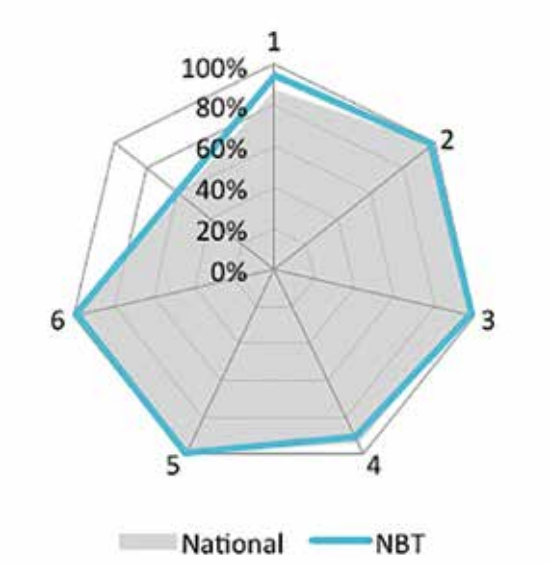
✓ +5% Improvement | = No change +/- 5% | i -5% Improvement | +5% on National Average | -5% on National Average

The CAC reviewed the NELA 2016 audit and action plan in January 2017 and noted that we were performing at or above the national average on all but three of the metrics reported. We only picked up one red flag on the report with 13% of eligible patients being reviewed by an elderly medicine specialist, although this is in line with the national average. In comparison to the previous year's data we improved compliance or remained the same on 10 out of 13 comparable metrics.

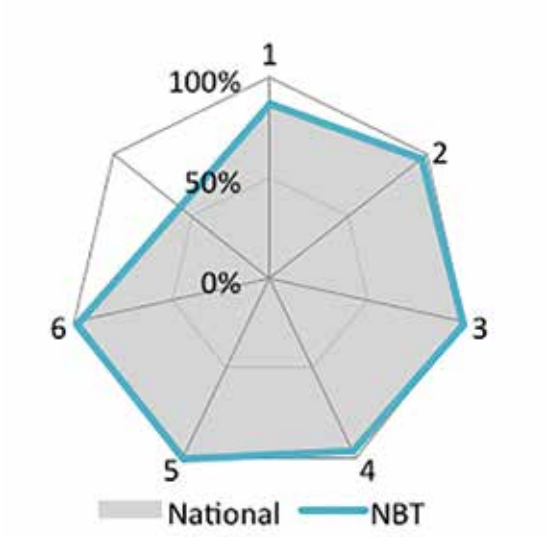
The CAC felt that the action plan adequately addressed issues outlined in the report and are monitoring the progress. Funding has been secured for an elderly care liaison service that will ensure all our patients over the age of 70 are seen by an elderly care specialist. The provision of emergency theatres at weekends is under review and should be improved by the introduction of an electronic booking system.

Intensive Care National Audit and Research Centre (ICNARC) – Case Mix Programme 2015/16

2014/15 (CA433)



2015/16 (CA77892)



Compliance and Improvement Table NBT vs National

Measure No	Measure Name	Year	Site NBT	Site National	+/- 5% Improvement
1	Non-high risk sepsis admissions (from within the same hospital)	2014/15	94%	87%	ℹ
		2015/16	88%	88%	
2	Patients without unit-acquired infections in blood	2014/15	98%	98%	=
		2015/16	97%	99%	
3	Discharges within normal hours (not out of hours) 7am-10pm to another ward within the hospital	2014/15	99%	97%	=
		2015/16	99%	98%	
4	Bed days of care provided for critical care unit survivors not exceeding 8 hours after the reported time fully ready for discharge (% of available bed days)	2014/15	91%	95%	=
		2015/16	95%	95%	
5	Patients not having a non-clinical transfer (out)	2014/15	100%	99%	=
		2015/16	100%	100%	
6	% of readmissions within 48 hours that were planned	2014/15	99%	99%	=
		2015/16	99%	99%	

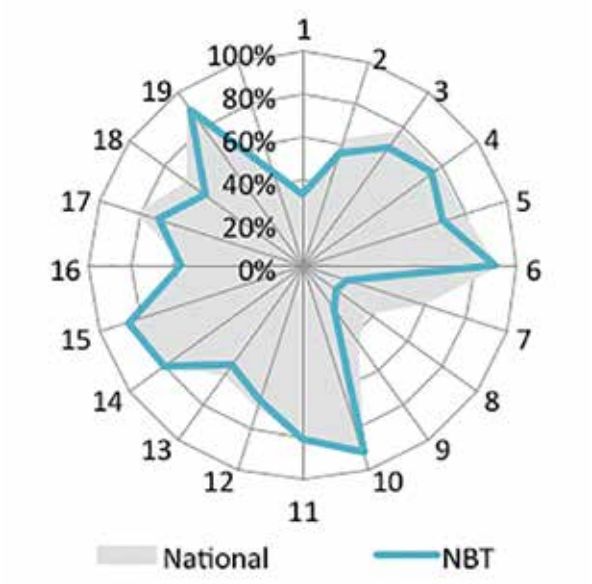
✓ +5% Improvement = No change +/- 5% ℹ -5% Improvement +5% on National Average -5% on National Average

The ICNARC Case Mix Programme 2015/16 Quality Report was reviewed and approved by the CAC in November 2016. We remain consistently in line with the national average since 2014/15 with most metrics above 95% compliance. The only potential issue highlighted by the report was an increase in the number of high-risk sepsis admissions to ITU from within the hospital; however this figure is in-line with the national average.

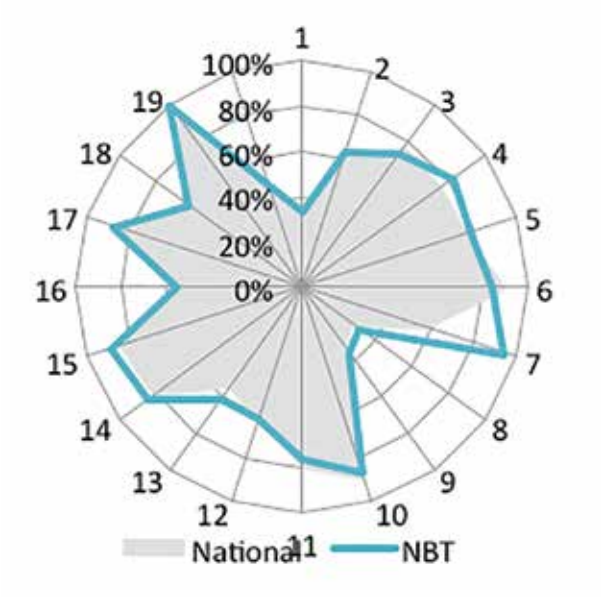
The CAC approved the action plan which largely seeks to maintain our high level of compliance. The action plan also acknowledges the extensive work being completed within the Trust by the Sepsis Working Group and various Quality Improvement Initiatives. Work around sepsis is being monitored by the Sepsis CQUIN which reports quarterly.

National Inpatient Diabetes Audit 2015

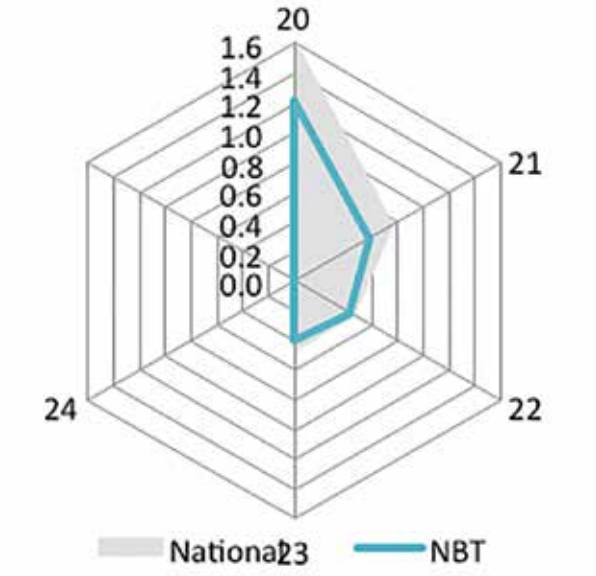
2013 (CA12611)



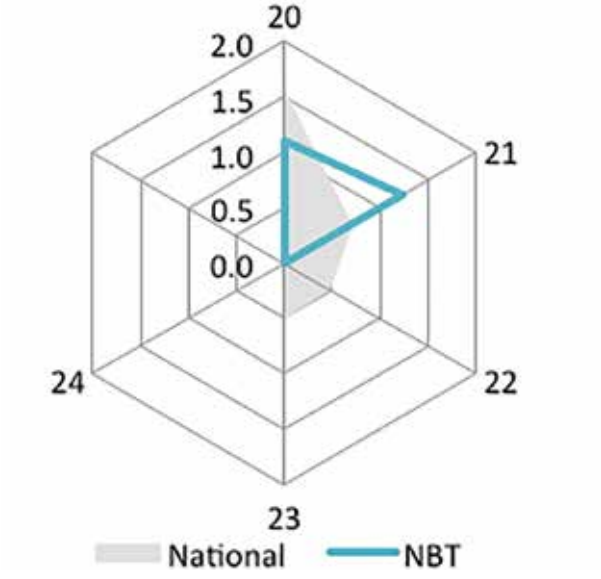
2015 (CA12612)



2013 (CA12611)



2015 (CA12612)



The National Inpatient Diabetes Audit 2015 was reviewed and approved by the CAC in July 2016. 16 out of 19 comparable metrics show that we have improved since 2013. Work has been undertaken to improve rates of foot disease in the Bristol area with the introduction of the 'Touch Toes' screening test to identify at risk patients, a foot risk assessment has also been added to the admission clerking proforma with Doppler machines readily available. Collaboration with the Tissue Viability Team is planned to increase awareness and to undertake a joint launch of a revised skin bundle.

The organisational component of the national clinical audit reviewed staffing levels. The drop in staffing levels is a reflection on funding cuts to NHS organisations and the necessity to streamline services. Business cases are underway to seek recruitment to specialist diabetes roles and additional training for staff will be incorporated as part of appraisal.

Compliance and Improvement Table NBT vs National					
Measure		Year	Site		+/- 5% Improvement
No	Name		NBT	National	
1	% Visited by specialist diabetes team	2013	34%	34%	=
		2015	34%	36%	
2	% Free from medication errors	2013	55%	63%	✓
		2015	63%	62%	
3	% Free from prescription errors	2013	69%	78%	=
		2015	73%	78%	
4	% Free from management errors	2013	74%	78%	✓
		2015	83%	76%	
5	% Free from insulin errors	2013	69%	79%	✓
		2015	79%	78%	
6	% Admitted without foot disease	2013	90%	91%	i
		2015	84%	91%	
7	% Seen by the MDFT within 24 hours	2013	21%	59%	✓
		2015	94%	58%	
8	% Foot risk assessment within 24 hours	2013	19%	38%	✓
		2015	31%	28%	
9	% Foot risk assessment during stay	2013	25%	44%	✓
		2015	35%	33%	
10	% Without severe hypo	2013	92%	91%	✓
		2015	86%	90%	
11	% Without minor hypo	2013	81%	59%	i
		2015	76%	80%	
12	% With suitably timed meals	2013	65%	70%	=
		2015	61%	63%	
13	% With suitable choice at meal time	2013	57%	63%	=
		2015	61%	54%	
14	Staff knowledge – answered queries	2013	80%	80%	=
		2015	84%	82%	
15	Overall patient satisfaction	2013	86%	86%	=
		2015	89%	84%	
16	Patients able to take control of diabetes care	2013	57%	55%	=
		2015	55%	59%	
17	Staff aware of patients' diabetes	2013	71%	82%	✓
		2015	88%	84%	
18	All or most staff know enough about diabetes	2013	57%	67%	✓
		2015	62%	66%	
19	Patients with appropriate insulin infusion	2013	90%	94%	✓
		2015	100%	94%	
20	Average diabetes specialist nursing hours per week per patient	2013	1.2 hours	1.6 hours	N/A
		2015	1.1 hours	1.6 hours	
21	Average consultant hours per week per patient	2013	0.6 hours	0.8 hours	N/A
		2015	1.2 hours	0.7 hours	
22	Average dietician hours per week per patient	2013	0.4 hours	0.5 hours	N/A
		2015	0.0 hours	0.5 hours	
23	Average podiatrist hours per week per patient	2013	0.4 hours	0.5 hours	N/A
		2015	0.0 hours	0.5 hours	
24	Average diabetes specialist pharmacist hour per week per patient	2013	0.0 hours	0.0 hours	N/A
		2015	0.0 hours	0.0 hours	

NICE Quality Standards

NICE quality standards are concise sets of prioritised statements designed to drive measurable quality improvements within a particular area of healthcare. 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:

- Health, public health and social care practitioners to make decisions about care based on the latest evidence and best practice;
- 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;
- Service providers to quickly and easily examine the performance of their organisation and assess improvement in standards of care they provide; and
- Commissioners to be confident that the services they are purchasing are high quality and cost-effective and focused on driving 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

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 Assurance and Clinical Audit Team on behalf of the Clinical Effectiveness Committee.

To date 148 Quality Standards have been released by NICE and of these 113 apply to the Trust with 107 (95%) gap analyses' completed during 2016/17.

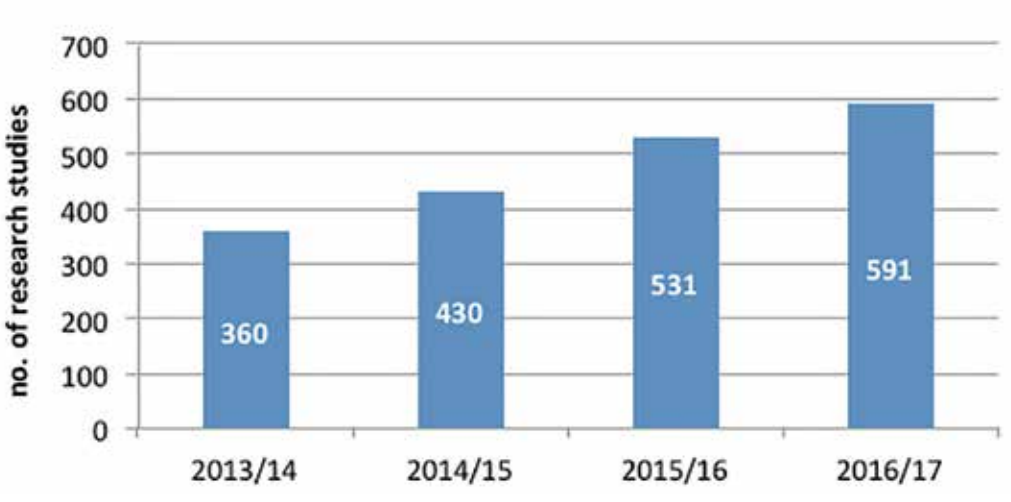
Research

The Trust is committed to research and innovation that improves our patients' health and their experience of our services.

There were 591 active research studies this year with 3,736 patients recruited and a further 3,478 patients seen as part of ongoing research projects. Recruitment has remained strong despite the financial and clinical pressures departments are experiencing, demonstrating our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Research continues to be delivered in over 40 departments demonstrating the breadth as well as the depth of the research commitment within the Trust; every clinical directorate delivers research.

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 82% of studies within 70 days of us receiving a request to open a new study.

Increase in the number of research studies that patients have access to



This year has been notable for building regional partnerships in research. NBT has also brought together maternity units across the West of England to enable a greater number of people access to research. Over the last two years 1,631 women have participated in the IMOX maternity trial at NBT with a total of 3,336 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, maternity, musculoskeletal conditions and cancer.

NBT remains a leader in health research that aims to answer important clinical questions. We are currently managing £30 million grants awarded to deliver new programmes of research. NBT has attained significant success with our renal, breast care, urology and musculoskeletal 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 Southmead Hospital Charity research fund, and have sat on our panels reviewing tender bids for services we use. This year they have also helped to design and shape our new research strategy, which will launch early next year, and provide direction for research across the next five years.

We were part of a Bristol-wide bid led by University Hospitals Bristol NHS Foundation Trust and the University of Bristol to host a £21 million Biomedical Research Centre which will host the development of new, ground-breaking treatments, diagnostics, prevention and care for patients in a wide range of diseases like cancer and dementia. Key themes addressed through the award include cardiovascular disease, nutrition, diet and lifestyle, reproductive and perinatal mental health, surgical innovation and mental health.

The Trust is working collaboratively across the geographical area with primary and secondary care providers to ensure all patients have equal access to research. We are leading the way on patient referrals across the region to enable patients' access to a greater range of research. We are 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

We have a commitment to sustain a performance of 95% of patients not waiting longer than four hours in the emergency department from arrival to admission, transfer or discharge.

We have not been able to meet the 4-hour performance standard in 2016/17, but have seen an improved performance position in comparison with Quarter 3, 2015/16. During the last year national performance has deteriorated reflecting the pressures on emergency department services nationwide, which has been mirrored locally.

Bed occupancy within the Trust is high and is driven predominantly by higher than planned numbers of long-stay patients. This has resulted in restricted flow of patients through and out of the hospital. The Trust is focused on reducing length of stay, where clinically appropriate, to improve patient flow and emergency department waiting times. A dedicated Length of Stay Board launched an improvement programme in 2016/17, targeting reductions in length of stay by expediting patient discharge.

Urgent Care waits in under 4 hours vs Total Attendances

Ensuring Safe Care

Given the factors highlighted above, the emergency department (ED) experiences peaks of activity where it is much more of a challenge to ensure that patients are seen, treated and, if necessary, admitted to the hospital in a safe manner, even where waits are longer than we would like. In light of that, the Trust has since embedded use of the 'SHINE' patient checklist, which provides a practical, easy to use summary of key observations and actions for patients within ED. This has been recognised by our regulators, the Care Quality Commission and NHS Improvement, as good practice and has been supported in its development by the West of England Academic Health Science Network (AHSN). The results are shown on the next page and provide good levels of confidence in the way we manage key safety requirements, such as pain management, infection, nutrition, sepsis, stroke observations and fractured neck of femur (#NOF).

The areas flagging as red relate to the challenges with patient flow outlined above and are therefore subject to the same causal factors.

	Month 1 [03/16]	Month 2 [04/16]	Month 3 [05/16]	Month 4 [06/16]	Month 5 [07/16	Month 6 [08/16	Month 7 [09/16	Month 8 [10/16]	Month 9 [11/16]	Month 10 [12/16]	Month 11 [01/17]	Month 12 [02/17]
NEWS												
NEWScore Recorded on admission to ED**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Obs												
Hourly Obs	N/A	N/A	60%	70%	70%	66%	69%	76%	73%	75%	71%	74%
Pain												
Pain Score documented at triage**	100%	100%	97%	99%	98%	100%	100%	100%	100%	100%	100%	100%
Analgesia administered at Triage (if appropriate)**	80%	81%	94%	100%	88%	100%	100%	100%	100%	100%	100%	100%
Pain reassessed in an hour	49%	67%	62%	85%	83%	80%	82%	88%	85%	86%	82%	84%
Communication												
NOK documented	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Transfer / Discharge												
Good to go @ 2.5 hours***	43%	49%	45%	40%	35%	36%	34%	40%	41%	37%	49%	55%
obs < 60 mins prior to discharge	47%	60%	63%	65%	68%	61%	66%	66%	64%	65%	70%	72%
Infection Prevention												
Cannula CP	84%	91%	89%	93%	94%	93%	94%	96%	95%	96%	97%	94%
Dignity & Nutrition												
Gown	97%	86%	93%	97%	95%	100%	98%	98%	99%	97%	98%	96%
Refreshments offered within 2 hours of admission (if not NBM)	31%	42%	53%	61%	60%	68%	71%	77%	75%	76%	71%	70%
Mental Health Risk Assessment												
RAM completed	100%	95%	90%	95%	100%	91%	100%	100%	100%	100%	100%	100%
Chest Pain												
ECG done & reviewed within 30 minutes	N/A	N/A	75%	83%	92%	88%	92%	95%	95%	90%	96%	97%
Obs on arrival	96%	79%	87%	100%	81%	93%	94%	93%	95%	100%	100%	97%
Stroke												
Hourly neuro obs	50%	77%	67%	61%	71%	83%	78%	88%	89%	100%	100%	100%
Transfer to stroke unit, 3.5 hours	88%	73%	75%	82%	71%	67%	67%	50%	56%	50%	57%	50%
Stroke - CT within 1st Hour	100%	92%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
#NOF												
Pain score on arrival	100%	100%	83%	100%	83%	100%	100%	100%	100%	89%	100%	100%
Analgesia, 20 minutes	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
X ray within 60 minutes	N/A	N/A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pathway Commenced	100%	100%	100%	100%	83%	100%	100%	100%	86%	100%	100%	100%
Admission, 2 hours	0%	7%	0%	25%	0%	25%	20%	20%	29%	22%	17%	17%
Sepsis												
Rx < 1 hour	100%	93%	86%	80%	80%	100%	100%	100%	100%	100%	90%	100%
Pathway Commenced	100%	100%	100%	80%	100%	100%	100%	100%	86%	89%	100%	100%

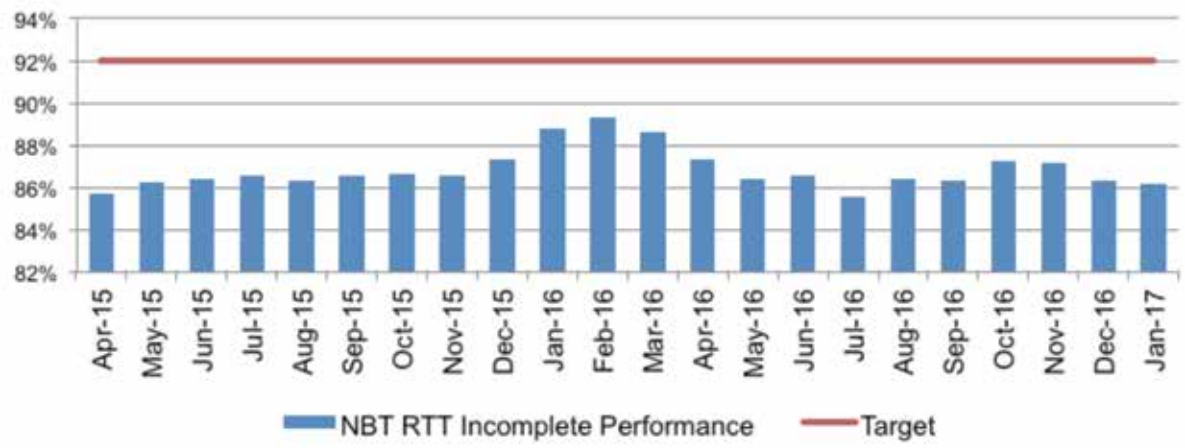
** Score/response recorded electronically *** Convenience sample. Not representative of

Referral to Treatment

We recognise the patient's legal right within the NHS Constitution 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.

In 2016/17, we saw an improved position overall when compared with 2015/16. The Trust continues to work towards delivery of improvement plans and trajectories to move towards sustainable delivery of the Referral to Treatment standard and remove all long waiters (waits in excess of 52 weeks).

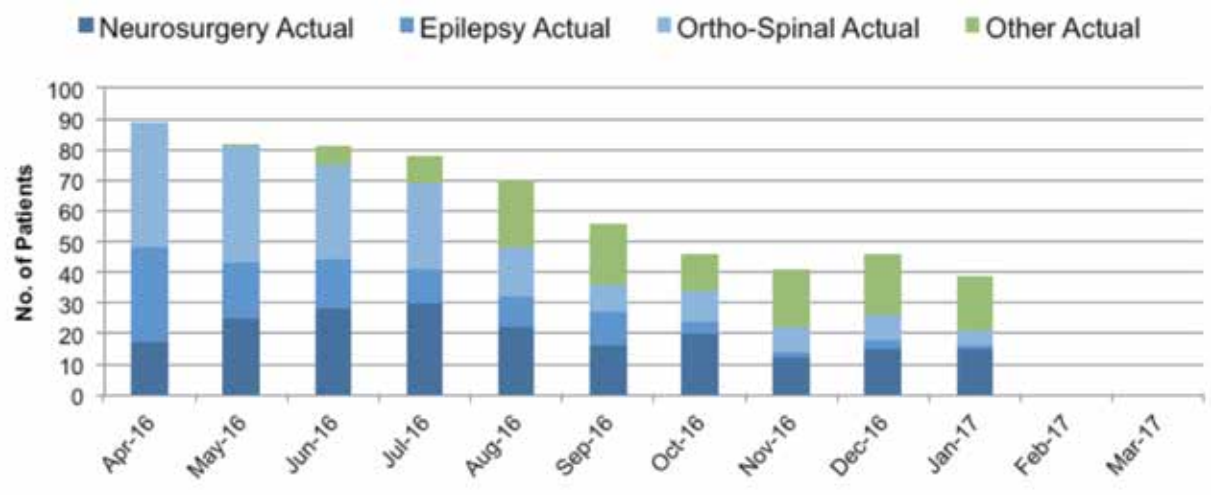
Percentage of Incomplete Pathways <18weeks



Long waiting specialties

Our Trust Board is absolutely committed to the zero tolerance of >52 week waiters on a Referral to Treatment incomplete pathway. Continued effort towards the reduction of long waiters is evident from the decreasing trend experienced in 2016/17, with an overall reduction of greater than 50% since April 2016. This success can be attributed to the implementation of improvement plans targeting long waiting patients in the Orthopaedic Spinal and Neurosurgery services, as well as those on a specialised Epilepsy Care pathway. The Trust recognises a slight increase in long waiters outside of this patient cohort, which has resulted from changes to Referral to Treatment guidance, relating to patients choosing to wait longer for their treatment. Every effort is made to continue the careful monitoring of these patients.

52 Week Waits



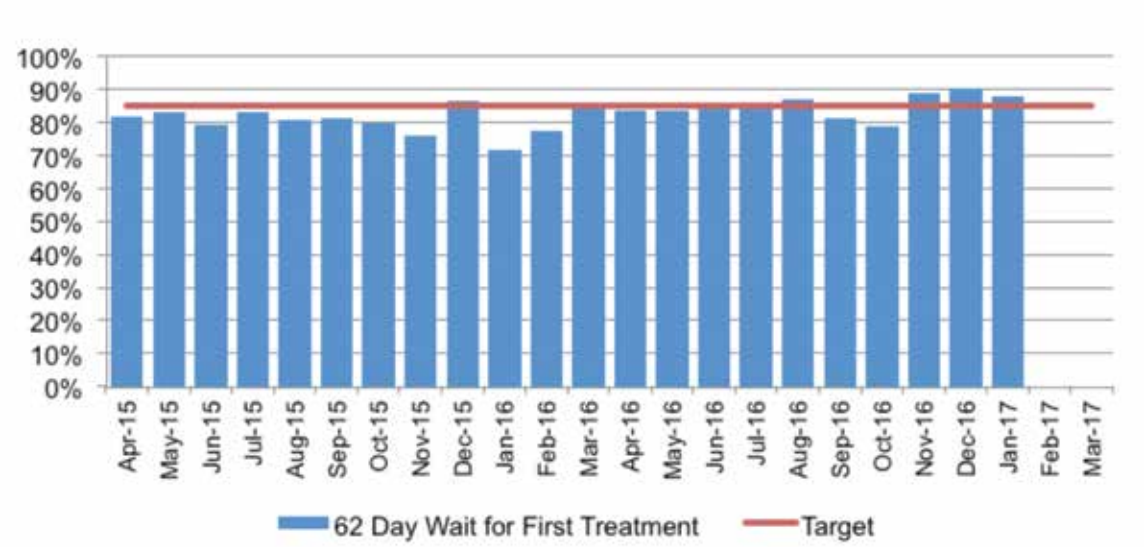
Clinical Review whilst on waiting list

During the year, the Trust's Quality Committee has continued to receive assurance updates from clinical specialities confirming that all patients waiting for longer than the nationally agreed waiting times for treatment to 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.

Cancer Waiting Times

The Trust is dedicated to the improvement of cancer waiting times to support timely diagnosis and better outcomes for patients. Delivery of the 62-day cancer waiting time standard has been a focus for the Trust in 2016/17 in an effort to improve first treatment waiting times for patients on cancer pathways. Targeted improvement plans and continued dedication has supported a substantial year-on-year improvement against this standard throughout 2016/17. The Trust has consistently exceeded the 85% target as of November 2016, demonstrating successful recovery and sustainable delivery of this standard.

62 Day Waiting Times for First Treatment Operational Standard



Improving the discharge of patients from hospital

We discharge many patients each day to a variety of settings, and for the majority this is a positive experience. However, we continue to strive to improve the process of discharge, working closely with partners to reduce the length of time patients stay in hospital when they no longer need acute care services. We aim to ensure that all patients are able to receive the right care, in the right place, at the right time.

Following feedback from staff that there are still complicated systems to negotiate when trying to organise a complex discharge, we have initiated further developments to improve the process, working with partners to ensure there is a shared approach.

Home First – there has been a consistent message for all ward staff to ensure that for all patients the first discharge consideration is to return home. This may be with no care, a restart of an existing care package, return to a care home or home on Discharge to Assess Pathway 1 with the close support of the community health and social care teams. The ward teams have had training and support to be able to evaluate whether a patient will be safe between visits and therefore is able to go home.

Discharge to Assess (D2A) – if the evaluation is that a patient will not be safe between visits staff are able to refer for Pathway 2 or 3. These are beds that are available in the community where the patient may receive ongoing rehabilitation (P2), or if no goals are identified, will be able to transfer to a care home bed (P3) whilst their long term care needs are assessed.

Integrated Discharge Service (IDS) – the service has now been in place for over a year and the partnership model has progressed further with improved systems and processes implemented to develop more efficient and effective discharge pathways. The health and social care professionals work closely with patients and carers to ensure early assessment of needs and ensure discharge plans are developed as soon as possible, to support patients to leave the hospital as soon as they are able to. There continues to be further development of the IDS to ensure key performance indicators are developed to reduce unnecessary delays in transfer of care, and to support the development of the D2A pathways across BNSSG partners.

Single Referral Form - we have worked through this year to develop a single referral form that will be used within Lorenzo (the patient record system). This will be used to electronically refer patients for discharge to health and social care community teams, care homes and other providers. This is now being initiated in the Trust and we will continue the roll out and evaluation through the year.

Managing Expectations Protocol - we have recognised there are times where patients or relatives may not want to leave the hospital, even when a suitable alternative has been made available. This can lead to significant delays in discharge. We have led the re-design of the Managing Expectations Protocol with colleagues in neighbouring acute and community services to ensure there is a consistent message for patients and relatives that a hospital bed is not an appropriate place for someone to stay where there are alternative options available. Further training will be rolled out to our staff over the year.

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 is 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 reduced the length of hospital stay for many patients, and improved patient satisfaction with care around discharge planning and their actual hospital discharge. Some of the above work is being nationally recognised as good practice. 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.

Improving the quality and timeliness of information provided to GPs when patients go home - 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 are being discharged on and what changes had been made during their stay. Follow-up arrangements and future planning are also documented. During 2016/17 we have continued to develop the quality and timeliness of discharge summaries being completed and sent electronically to GPs. This work has been undertaken and audited in collaboration with the Clinical Commissioning Group and a local GP to provide immediate feedback and action to be taken; we have achieved 100% of the related CQUIN.

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 2016/17 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:

M9	2014/15		2015/16		2016/17	
	NHS No.	GMP code	NHS No.	GMP code	NHS No.	GMP code
Admitted Patient Care	99.5%	100%	99.5%	98.2%	99.6%	100%
Out Patients	98.4%	99.8%	98.7%	99.8%	99.2%	100%
A&E	97.4%	100%	97.4%	100%	98.2%	99.9%

During the year we have introduced within the Information Management Team the role of 'Data Quality Marshalls' whose role is to ensure information entered in clinical systems is as accurate as possible. The percentage of records has improved in each of the three domains and, with the sole exception of the NHS number completeness for outpatient data, is better than the national average.

Clinical Coding Error Rate

Accurate clinical coding is widely recognised by the NHS as being an essential element for benchmarking Trust's performance against peers nationally and recouping accurate income from commissioners through National Tariff. It also provides the ability to understand the Trust's own clinical activity in areas such as mortality statistics, audit and other performance areas. Further, the introduction of Health Care Resource Grouper (HRG) 4+ in 2017/18 relies on further granularity and accuracy of code assignment, in order to gain appropriate tariff and remuneration for activity undertaken by healthcare providers.

Audit

During 2016/17 the Clinical Coding Department undertook its internal rolling clinical coding plan, which included several audits throughout the financial year. The internal audit plan included the mandatory Information Governance (IG) audit, which examines general coding accuracy in the department's selected areas. The areas of audit chosen were predicated on previous audit findings and areas of coding not recently audited.

IG (505) Clinical Coding Audit – November 2016

The Department's NHS Digital Approved Auditor examined 200 FCE's (Finished Consultant Episodes).

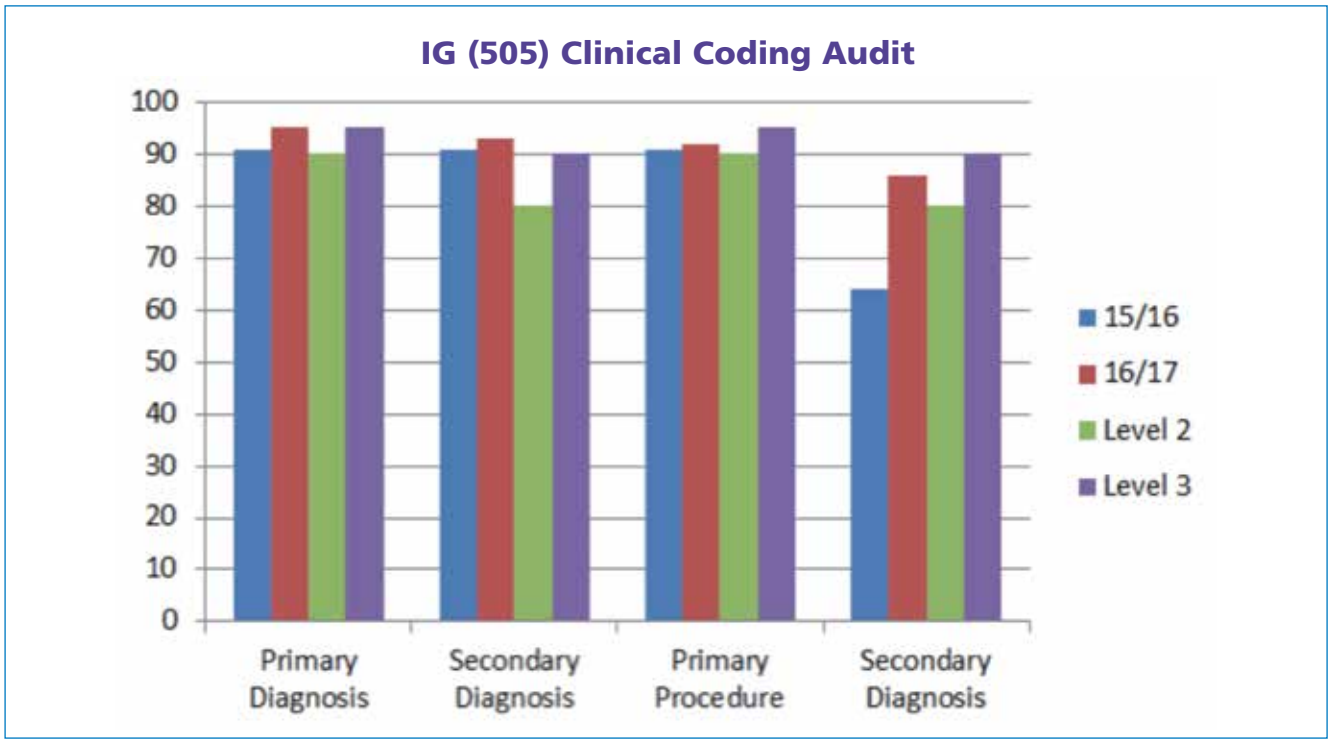
The following areas were selected for the scope of the audit:

- Stroke patients – 50 FCE's;
- Cardiology - 50 FCE's; and
- Short Stay Emergency Surgery and Medicine.

The table below compares Trust's audit findings against the IG 505 attainment standards in 2015/16 and 2016/17.

IG 505 toolkit requirement	Level 2	Level 3	Our Performance
primary diagnosis	>=90%	>=95%	95.0%
secondary diagnosis	>=80%	>=90%	93.0%
primary procedure	>=90%	>=95%	91.8%
secondary procedure	>=80%	>=90%	85.9%

Overall, we obtained Level 2 against the IG 505 toolkit requirement, which is the national requirement.



Accuracy levels were maintained from the previous year's 2015/16 IG audit, with a noted improvement in errors observed in secondary procedure coding: 2016/17 (85.9%) vs 2015/16 (64%).

Further Improvements Planned in 2017/18

The department is reviewing its options to recruit to vacancies, aiming to overcome the local challenges in recruiting qualified coders. The department has a number of trainee clinical coders in place at varying stages of experience. In 2017/18 the department will be reviewing its approach to supporting trainee clinical coders, in order to progress them to becoming qualified clinical coders.

Clinicians continue to be involved and engaged in the clinical coding validation service, through weekly coding validation reports issued to all consultants across the Trust. In 2017 the department will be reviewing how it engages with clinicians, to improve their opportunity in reviewing their coded data and benchmark against expected coding and tariffs.

In 2017/18 the department will be further reviewing how it engages with both clinical and operational teams, to optimise the accuracy of the Trust's clinical coded data and associated income.

Information Governance Toolkit attainment levels

The IG Toolkit is now in its 14th year (v14). 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; and
- 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).

The Trust's IG toolkit assessment report overall score for 2016/17 (v14) is 73%, graded green. The Trust 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.

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 if there are gaps in compliance. The improvement plans will be reviewed through the Trust governance processes throughout the 2017/18 financial year.

Section 6 - Engagement and Consultation

Quality Priorities

The Trust approved a new strategy for 2016-2021 in March 2016, which in turn set the overall context for developing a framework for quality improvement during the 2016/17 financial year. This prompted us to review our historic approach to setting priorities for the Quality Account whereby we have focused upon four relatively narrow areas in line with the original national guidance. We reflected that this selection did not truly afford greater focus than the many other quality priorities we must respond to as a consequence of the scale and complexity of our services and national policy drivers.

On that basis we asked our clinical teams to make suggestions for priorities to improve patient care taking a wider view of potential subject areas. This long list was then discussed with the Trust's Patient Partnership Group and external Patient Experience Group members to obtain their views.

Our consultation approach posed three questions:

- Does our way of describing these priorities make them understandable for you?
- Is there anything you would wish to clarify within these priorities?
- Is anything missing in your view?

The outcome was strong endorsement for our overall approach with recognition of the need for a more broad-based range of quality improvement priorities. Specific support or suggestions were made for the inclusion of:

- End of life care and learning from feedback;
- Ensuring patient views influence ongoing service developments;
- Staff wellbeing; and
- Ensuring consistency, quality and security of patient records.

Having concluded these discussions, these were taken forward by the Executive Leads for quality, the Director of Nursing and Medical Director for review and approval by the Trust's Quality Committee, the Non-Executive chaired Quality and Risk Management Committee and finally the Trust Board.

Specifically this included:

- Discussion at Clinical Governance Directorate Management Team – 10 February 2017;
- Quality Account Working Group review – 27 February 2017;
- Patient review at Patient Participation Committee and external members of Patient Experience Group – 9 March 2017;
- Quality Committee consultation – 14 March 2017;
- Quality & Risk Management Committee review – 23 March 2017; and
- Trust Board review 28 April 2017.

Following these reviews, the first two areas suggested above were included.

The other two suggestions are fully supported as very significant organisational priorities and as undoubted key enablers of care quality. As such they will both feature within ongoing Trust Board level reporting and scrutiny. However, we consider it important to retain a focus on specific quality outcomes for this purpose within the Quality Account.

The draft Quality Account was circulated for comment in the period 2 May 2017 – 31 May 2017.

A list of the organisations that 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 NHS Trust Patient Partnership Committee
- Bristol Healthwatch
- South Gloucestershire Healthwatch
- North Somerset Healthwatch
- South Gloucestershire Public Health Scrutiny Committee
- Bristol - People Scrutiny Commission
- North Somerset Health Overview and Scrutiny Panel

NHS
Bristol, North Somerset and South Gloucestershire
Clinical Commissioning Groups

Commentary from Bristol, North Somerset & South Gloucestershire Clinical Commissioning Groups

Subject: NBT Quality Assurance Statement 2016/17

The commissioners welcome the opportunity to respond to NBT's quality account for 2016/17. The document provides an honest representation of quality within the Trust detailing the positive aspects, where things are not going so well and targets that haven't been achieved.

The Trust has shown an increased focus on the management of sepsis, and implemented several actions in order to improve patient outcomes in this area, with 100% of Emergency Department patients being screened for sepsis using the electronic patient triage form.

We acknowledge the work that has been undertaken in the area of Quality Improvement and Safety Culture and the additional resource and training that has been established to embed this with staff. It is encouraging to see the quality improvement work on preventing deterioration prior to cardiac arrest and the significant impact that this has had on patient outcomes.

The Trust has demonstrated how they have reduced the number of inpatient falls and the total number of pressure ulcers, it is however noted that the number of Grade 3 and 4 pressure ulcers has increased from 2015/16 rates. The work regarding early detection of patients with Acute Kidney Injury is also notable.

We note the improvements with regard to the number of Clostridium Difficile Infections (CDI) and the year end position of 32 cases being below the annual target. It was however disappointing to note that six MRSA cases were reported during the year, which was an increase from 2015/16, with little information provided how this will be reduced for 2017/18.

We were pleased to note that the alternative way of capturing VTE risk assessment on admission to hospital, has had a significant impact on compliance with the 95% national target for Venous Thrombosis Embolism (VTE) risk assessments

The Trust details the notable work they have done against their four quality priorities for 2016/17 however, it is not clear if they have fully achieved these. The six quality priorities for 2017/18 have been listed, however we would have liked to have seen clarity regarding what success looks like for these priority areas.

It is clear that NBT have demonstrated areas of good quality improvement and the commissioners look forward to working with the Trust in 2017/18.

Kind regards
Yours sincerely

Anne Morris
Director of Nursing and Quality

Commentary from Bristol Healthwatch & South Gloucestershire Healthwatch

Healthwatch South Gloucestershire and Healthwatch Bristol combined response to North Bristol NHS Trust Quality Account 2016/2017

23 May 2017

Healthwatch South Gloucestershire and Healthwatch Bristol agreed that North Bristol NHS Trust (NBT) performance against their 2015/2016 quality priorities have improved. Healthwatch welcomes the success particularly the growing culture of quality improvement. NBT have acknowledged the challenges it has faced this year particularly the MRSA and 'never event' cases.

Priority Improvements for 2016/17

Healthwatch were pleased to hear of the introduction of the A3Q Discharge engagement tool for patients attending outpatients and the 74% reported response that the A3Q discharge leaflet is making. It would be useful for Healthwatch to know the numerical numbers i.e. 74% of how many as a baseline. Healthwatch will keep a watching brief on how this is rolled out across the Trust and acknowledges that this will be at a pace that the available resource allows.

Healthwatch read with interest about the management of sepsis and the aim to screen 90% of inpatients on wards of patients who have deteriorated and may have sepsis.

Healthwatch look forward to seeing the results of the third national audit of dementia that NBT have taken part in due in May 2017 and the comparison of care of people with dementia against national benchmarks. Healthwatch is interested to hear how the trust intends to ensure that delirium is to be prevented, identified and treated in Older People with dementia? It is positive to hear that the Memory café is going from strength to strength.

Healthwatch read with interest about the quality improvement project that focuses on improving compassionate and personalised delivery of end of life care on the wards. It was good to see the plans for 2017/18 particularly the plan detailing how NBT will improve documentation of the end of life care being delivered.

Priorities for 2017/18

Healthwatch would welcome the opportunity to work with the trust throughout the coming year and to be kept updated on how the trust is achieving in implementing the six priorities agreed following consultation with the Patient Partnership Group and external Patient Experience Group.

Healthwatch acknowledge the Care Quality Commission ratings and the need for improvement in Safe, effective and responsive domains.

Healthwatch would like to see a reduction in the number of patient falls per month. We appreciate that there has been an increase in the number of people at risk of falls being admitted to the hospital and welcome the 8% reduction in falls for winter 2016/17 recorded.

Reducing pressure injuries in grade 3 and Grade 4 will be an area of interest for Healthwatch to follow in the coming year.

Under medicines management, Healthwatch note the 85% target for patients admitted to have their medicines reconciled within 24 hours and will watch with interest to see if the target is achieved in 2017/18.

Healthwatch has noted the poor outcome of 6 cases of MRSA this year and is pleased that there has been significant improvement in C. difficile infection compared to previous years. Healthwatch look forward to hearing how this can be achieved in 2017/18.

Healthwatch were very disappointed in the increase to 86 serious incidents recorded for the year. Healthwatch volunteers attended an NBT complaints review panel and found the experience was not very personal. Healthwatch volunteers also received no feedback following the panel on how the complaints process had fed back to patients. Of particular concern this year were the 5 'never events' recorded, two of which were wrong site surgery and one a misplaced NG tube. This was particularly disappointing as NBT had won a national award 'Changing Culture' in the Patient Safety category for the work done to prevent the NG tube events in 2011.

Healthwatch welcomes the collaborative working between other trusts on the development of pan Bristol Healthcare Change Maker Forum and the acknowledgement of the trust acting on feedback from Healthwatch.

Healthwatch were glad to read that the trust aims to improve on the experience of staff recommending the trust for care or treatment. The reduced number of formal complaints is also acknowledged and Healthwatch look forward to seeing the pilot of a named contact for all complaints being rolled out across all directorates during the coming year. Healthwatch congratulates the trust on the significant increase in compliments received this year. A Carers Strategy is to be developed by the trust showing trust commitment to including and supporting carers as partners in the delivery of quality care as endorsed by the two new logos to be used jointly with UHB.

Healthwatch were pleased to read that the trust has been at the forefront in introducing a formal review of all patient deaths and noted that 55% of deaths had mortality reviews completed for the in patient deaths last year and these reviews will be the basis of learning and improvement opportunities for the coming year.

Healthwatch acknowledges that the trust has made significant improvements to cancer performance over the year and all but one target has been succeeded. The 62 day cancer waiting time standard has been a focus for the trust in 2015/16 and Healthwatch congratulates the trust on consistently exceeding the 85% target in this standard.

It is disappointing to read that NBT has not been able to meet the 4 hour A&E performance standard in 2016 /17. Healthwatch appreciate the Trust's board commitment to sustain a performance of 95% of patients not waiting longer than four hours from arrival to admission, transfer or discharge and would like to see the trust meet and possibly succeed the 4 hour A&E performance standard during 2017 /18.

Healthwatch has undertaken work on hearing from the public about hospital discharge in the last two years and welcome the opening of the ground floor discharge lounge. We also appreciate the work undertaken and the training and support for staff to evaluate whether a patient will be safe between visits on the Discharge to Access Pathway 1 to be able to go home.

Commentary from the South Gloucestershire Council Public Health Scrutiny Committee

Health Scrutiny Committee's comments on the North Bristol NHS Trust's Account of the Quality of Clinical Services 2016/17

It was not possible for the North Bristol Trust to formally present its Quality Account to the Committee because of meeting restrictions in the run up to the local West of England Mayor election and the 2017 General Election. However, the Committee Chair and Lead Members received the Quality Account by email and these comments are based on the Committee's engagement with the North Bristol Trust during 2016/17.

The Committee received a presentation on the System Flow Partnership, which is working to improve the flow of patients through the urgent care system in South Gloucestershire. The item was a joint presentation by the North Bristol Trust, the local CCG and Sirona care and health. The Committee was pleased to learn of the progress that had been made since October 2015, but was disappointed that there had still been a deterioration in the ED four hour waiting time standard. Members acknowledged the factors that affected this, which included high levels of bed occupancy, weekend attendance and problems with the computer processing system in ED, and would consider further scrutiny during 2017/18.

The North Bristol Trust presented its 2015 CQC Inspection Report. The Committee congratulated the Trust on the improvements that had been made since the previous inspection in 2014 and stated that it hoped the Trust would continue to make further improvement in the areas identified by the CQC.

On two occasions in 2016/17 the Committee scrutinised End of Life Care arrangements in South Gloucestershire, to which the North Bristol Trust provided a valuable contribution and was able to satisfactorily answer members' questions. A further update report is scheduled for 2017/18.

Finally, the Committee received the North Bristol Trust Strategy 2016-2021 and provided a number of comments for the Trust's consideration.

Councillor Marian Lewis
Chair, Health Scrutiny Committee

Councillor Sue Hope
Lead Member, Health Scrutiny Committee

Councillor Ian Scott
Lead Member, Health Scrutiny Committee

Commentary from the Bristol Council People Scrutiny Commission

No commentary received.

Commentary from the North Somerset Council Health Overview & Scrutiny Panel

Response to North Bristol NHS Trust Quality Account 2016/17

Quality Account Presented by Sue Jones, Director of Nursing & Quality

Overall the Health Overview and Scrutiny Panel were very encouraged by the Trust's achievements against its 2016/17 Quality Account priorities and by its performance generally over the year (recognising that recent CQC inspections have reported that actions arising from the 2015 "requires improvement" inspection have all been delivered).

Members noted the following accomplishments in particular:

- Meeting Cancer Standards and RTT, Diagnostic and Emergency Department improvement trajectories;
- Expansion of the Quality Improvement and Safety Culture Programme;
- 80% achievement of CQUIN targets;
- Steady improvements in the patient falls rate;
- Significant on-going reductions in pressure injuries; and
- The establishment of a Quality Hub to support the Theatre Quality Improvement Programme.

Members also felt that the Trust's embedded use of the "SHINE" patient checklist in the Emergency Department was particularly noteworthy as good practice, providing an effective tool for assessing, managing and providing assurance on the quality and safety of Emergency Department services.

The Panel raised concerns in last year's Quality Account response about the Trust's lack of engagement with Healthwatch North Somerset and were pleased to note that this had now been largely addressed.

In conclusion, the Panel felt that the Trust had made good progress against its 2016-17 priorities and that the priority areas identified for 2017/18 were appropriately targeted.

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

Section 7 - Appendices

Appendix 1 - 2016/17 CQUINS

A proportion of our income in 2016/17 was conditional upon 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 2016/17 and for the following 12 month period are available electronically at **https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf**

Title	National & Local CQUINs (CCG contracted)	Outcome
Health & Wellbeing Initiatives	For staff - increasing physical activity, mental health support services and improving physio access for people with Musculo-skeletal issues	
	Improving the health of the food offered on Trust premises	
	Improving the uptake of flu vaccinations for frontline clinical staff	
Sepsis	Sepsis Screening & Treatment – Emergency Care	
	Sepsis Screening & Treatment – Non Emergency Admissions	
Antibiotics consumption	Reduction in antibiotic consumption per 1,000 admissions	
	Empiric review of antibiotic prescriptions	
Physical Health	Frailty identification & care planning	
Urgent Care	Reduction in alcohol dependence & related emergency admissions	
Patient Discharge	Discharge summaries - timeliness and completion	
End of Life Care	End of Life - prognostic indicators & training	
Cancer Care	Reducing late inter-provider cancer referrals	
Patient Experience	Patient Self-care –'Ask 3 questions'	
Patient Safety	Organisational safety culture review	
Title	**Specialised CQUINs (NHS England contracted)**	
Armed Forces	Review & Revision of Provider Waiting List /Access Policy	
	Staff Awareness of the Armed Forces Covenant	
	Making the Armed Forces Covenant Operational	
	Embedding the Armed Forces Covenant	
Breast Screening	Programme Uptake	
Clinical Utilisation Review (CUR)	Local Learning pilot of clinical decision-making software to assess future implementation options	
Critical Care	ICU Discharge	
Spinal Surgery	Development of Spinal Surgery Networks	
Implementation of Blueteq for Devices	Implementation of Blueteq for Devices	
Vascular services	Quality improvement programme for outcomes of major lower limb amputation	
Stroke Services	Pathway Review	

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

Appendix 2 - Mandatory Indicators Table - Data provided by the Health and Social Care Information Centre

Mandatory indicator	NBT 2016/17	National average 2016/17	National best 2016/17	National worst 2016/17	NBT 2015/16	Comment
Venous thromboembolism risk assessment	95.54% Apr 16 – Mar 17	95.6% Apr-Dec16	100% Apr-Dec16	72.1% Apr-Dec16	93.5%	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 had in 2015-16 caused this to fall below the national standard of 95%. Significant improvements have been made and sustained during 2016/17, overseen internally through the Quality Committee and externally through the CCG Quality Sub Group. The related Contract Performance Notice was lifted during the 2016/17 year following conclusion of the related Remedial Action plan.
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)	9.94 Apr 16 – Mar 17	15.3 Apr15-Jan16	0 Apr15-Jan16	63.4 Apr15-Jan16	14.95 Apr 16 – Mar 17	The Trust considers that this data is as described for the following reasons: rate is as described in the official HCAI Data Tool provided by Public Health England 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	30.98 Apr16-Sep16	40.77 Apr16-Sep16	71.81 Apr16-Sep16	21.21 Apr16-Sep16	28.85 Apr15-Sep15	The Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year and reported to the Board. 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	0.66% Apr16-Sep16	0.37% Apr16-Sep16	0% Apr16-Sep16	1.7% Apr16-Sep16	0.53% Apr 15-Sep 15	The Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year and reported to the Board. 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.
Responsiveness to inpatients' personal needs	Comparative data for 2015/16 (2014/15 in brackets): NBT score 69.4 (64.6); England overall 69.6 (68.9); low 58.9 (59.1); high 86.2 (86.1). Comparative data for 2015/16 will not be available from the Health & Social Care Information Centre until August 2016.					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 **For 2016/17 NBT is no longer in the acute and community group, just acute trust comparator.**	65% 2016 Staff Survey	70.0% 2016 Staff Survey	85% 2015 Staff Survey	49% 2015 Staff Survey	64% 2015 Staff Survey	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	93.04 Oct 15 – Sep 16	100 Oct 15 – Sep 16	68.97 Oct 15 – Sep 16	116.39 Oct 15 – Sep 16	90.47 Apr 15 – Mar 16	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 specialties. 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 and national data comparisons are no longer provided, therefore the last ones published are shown in this table.
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'	26.14% Oct 14 – Sep15 (latest available)	26.6%	0.2%	53.5%	29.04% Jul13 – Jun14	
Patient Reported Outcome Measures – No. of patients reporting an improved score;						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.
Hip Replacement Primary EQ-VAS	Apr-Sep 16 NBT score 87% (national average 65.10%)					
Hip Replacement Primary EQ 5D	Apr-Sep 16 NBT score 81.22% (national average 85.60%)					
Knee Replacement Primary EQ-VAS	Apr-Sep 16 NBT score 81% (national average 54.50%)					
Knee Replacement Primary EQ 5D	Apr-Sep 16 NBT score 71.26% (national average 77.50%)					
Varicose Veins, Groin Hernia and Hip Replacement Revision	No information available for 2015/16					
Emergency readmissions within 28 days of discharge: age 0-15 Same 2011/12 comparative data as national data not updated since November 2011	Comparative data for 2011/12: NBT 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.					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 16 or over Same 2011/12 comparative data as national data not updated since November 2011	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.					

Appendix 3 - Services provided by North Bristol NHS Trust as at 31 March 2017

Directorate	Specialities	Directorate	Specialities
Medical Directorate	Emergency Medicine Care of the Elderly Medical Day Care General (Acute) Medicine Cardiology Clinical Haematology Respiratory Medicine Palliative Care Clinical Immunology HIV/AIDS Service / Infectious Diseases Acute Oncology Clinical Psychology Diabetes & Endocrinology Gastroenterology 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 Orthotics Disablement Services Bristol Re-ablement Service	Women's and Children's Directorate	Gynaecology Fertility Services Integrated Maternity Services Neonatal Intensive Care Unit General Paediatrics incl. Outpatients
Anaesthesia, Surgery and Critical Care Directorate	Anaesthetics ITU HDU Theatres General (Acute) Surgery Vascular Surgery Breast Services Urology GI Services Surgery Endoscopy Bariatric Surgery Plastics Surgery Burns Dermatology Pigmented Lesion Clinic Acute Pain Chronic Pain	Neurosciences Directorate	Neurology Neurosurgery Neurophysiology Neuropathology Neuropsychiatry Neuropsychology Neurorehabilitation Head Injury Therapy Unit (HITU) Stroke Service
Core Clinical Services Directorate	Clinical Equipment Services Severn Pathology: • Genetics • Clinical Biochemistry • Cellular Pathology (incl. Mortuary) • Haematology • Immunology • Infection sciences • Phlebotomy	Therapy Services: • Nutrition & Dietetics • Speech and Language Therapy • Occupational Therapy • Physiotherapy Pharmacy Services incl. Regional Quality Control Laboratory Imaging Services Medical Illustration	

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 2017 ("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 2017 subject to limited assurance consist of the following indicators:

- Rate of Clostridium difficile infections ("CDIs") per 100,000 bed days for patients aged two or more on the date the specimen was taken during the reporting period.
- The percentage of patients who were admitted to hospital and who were risk assessed for Venous thromboembolism (VTE) during the reporting period.

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 the Department of Health 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 2016 to 25/05/2017;
- papers relating to quality reported to the Board over the period April 2016 to 25/05/2017;
- feedback from South Gloucestershire Clinical Commissioning Group dated 02/06/2017;
- feedback from Local Healthwatch dated 23/05/2017;
- feedback from South Gloucestershire Health and Scrutiny Committee received 31/05/2017;
- feedback from North Somerset Health Overview and Scrutiny Committee dated 04/05/2017;
- feedback from Patient Partnership Committee dated 04/06/2017;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 19/04/2017;
- the latest local inpatient survey dated February 2017;
- the latest national staff survey dated 2016;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 30/05/2017;
- the annual governance statement dated 30/05/2017;
- the results of the Payment by Results coding review dated November 2016; and
- the Care Quality Commission inspection report dated 06/04/2016;

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;
- 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.

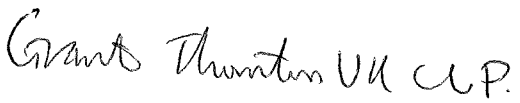
The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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 2017

- 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.



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22 June 2017


Brunel

North Bristol
NHS Trust

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