

Account of the Quality of Clinical Services 2017/2018



Exceptional healthcare, personally delivered



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1.1 Statement on Quality from the Chief Executive



Putting patients first



Recognising the person



Striving for excellence

North Bristol NHS Trust provides general hospital services to the local population as well as complex regional specialist care for the South West in areas including Major Trauma, renal transplant, and urological, skin, brain and breast cancers.

We employ more than 8,000 staff across Southmead and Cossham hospitals and the Bristol Centre for Enablement and care for approximately 700,000 patients a year.

Our aim is to provide high quality safe care to all of our patients with great outcomes comparable to the best in the world.

And every day our incredible staff strive to deliver that ambition.

This year saw the busiest winter on record and while the whole of the country saw increasing demand on hospital services we have seen the number of people requiring inpatient care rise by 9%. Increasingly patients requiring emergency care are frailer and older and this brings its own challenges as many people tend to need additional support to help them leave hospital. This can mean patients spend longer on our wards than is good for them, but also impacts upon our ability to move new patients from our Emergency Zone and can, on occasion, lead to the postponement of operations and procedures.

We know that this winter was difficult for our staff and meant that at times our patients did not benefit from the experience we strive to provide, but I am proud that in spite of the demand for our services we continued to provide exceptional clinical care.

The flow of patients through our hospital is an area that requires continued focus both within North Bristol and with our health and social care partners. We are embarking on a development programme to support our staff in reducing delays in patient care so that they can leave as soon as they are medically fit for discharge of patients and are working with others in the Sustainability and Transformation Partnership on new services that could see more people undergoing treatment closer to their homes.

Our CQC inspection report reflects this progress and whilst overall our ranking remained as Requires Improvement, we were delighted to see eight of our ratings improved, including moving to Outstanding for caring in the End of Life Care category and an overall rating of Good for Outpatients. Our Quality improvement plan will help move us forward in achieving a Good rating across the board.

We were successful in delivering our financial plan last year which enabled the lifting of Financial Special Measures by NHS Improvement in July. Our staff were our greatest asset in restoring financial control, with lots of ideas and positive engagement in tackling waste and making savings without impacting on patient care. We have sustained that financial rigour into 2017 and met our financial outturn position of -£18m this year, and while we need to continue reducing our deficit we have made substantial inroads in the last two years.

We were proud to become the 26th trust nationally to be named a Venous Thromboembolism (VTE) Exemplar Centre this year. Our thanks to Dr Jason Kendall for relentless energy and leadership in this area, which covers VTE prevention, diagnosis and treatment. Good VTE care saves lives and prevents complications.

As you will see in more detail later in this report, our theatres staff have done some great work this year to improve safety practices. There is a positive safety culture in theatres and our teams have shown a real appetite for improvement which has seen an increase in compliance with surgical checklists and audits all of which will contribute to improved patient outcomes and our progress towards being one of the safest hospitals in the country.

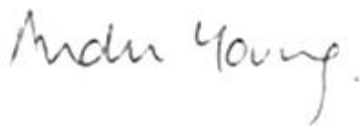
The experience of our patients with cancer has also improved as evidenced by the latest National Cancer Patient Experience Survey. We have improved access to cancer care, increased cancer nurse specialist roles and telephone advice and providing holistic care to patients living with Cancer through the NGS Macmillan Wellbeing Centre.

We know that we have more work to do to ensure all clinical staff are confident in the use of Mental Capacity Assessments and in what circumstances we should apply Deprivation of Liberty Safeguards, and our plans include improving our training.

Caring for our most vulnerable patients is important to us. Our staff are very proud of their work to improve care for people living with dementia. We are committed to doing more for our patients with learning disability and autism. Our transition policy has been in place a year, and will be audited next year, we would also like to ensure we involve parents and families more during transition to acute adult services, we would like to ensure we hear from families and carers and involve community services more.

This will form a key feature of our quality improvement work in 2018/19.

We will be happy to report on progress next year.



Andrea Young
Chief Executive
North Bristol NHS Trust



1.2 Review of Services

During 2017/18, the Trust provided a wide range of NHS services. These are listed in section 8.3.

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 divisions are subject to executive reviews in which performance against standards of quality and safety are reviewed and, in line with the principles of Service Line Management introduced during 2017/18, are responsible for their own internal assurance systems. These reviews discuss with clinical teams and managers any areas of concern, and also seek continuous quality improvement. Through these mechanisms the Trust., therefore, reviews 100% of the data available 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 2017/2018 represents 100% of the total income generated from the provision of NHS services by North Bristol NHS Trust for 2017/18.



1.3 Statement of Director's Responsibilities

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT 2017/18

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

Signed 

Date 15/06/2018

Frank Collins
Chairman

Signed 

Date 15/06/2018

Andrea Young
Chief Executive

2.1 Improving Theatre Safety



Introduction

In 2016/2017 there were three 'never events' in operating theatres. These incidents are ones defined nationally as ones that shouldn't happen. Although never events occurred in a very small percentage of operations we were keen to make this a priority for improvement during 2017/2018 as part of our wider improvement programme.

What did we do?

We really wanted to support improvements in theatre safety culture to enhance and embed a safe, transparent working environment. This aimed to empower our theatre staff so that they feel able to raise concerns and enact change no matter how senior their position.

We introduced swarms which are a way to promptly discuss and investigate an incident, or a potential incident, ensuring that we can learn from that incident, and implement any changes quickly. Swarms encourage staff to be open and honest when discussing incidents in a just culture.

We have implemented a skills matrix which maps staff skills and identifies areas where staff development is needed. This enables us to plan for

safe staff coverage, and empowers staff to request training and development.

The Happy App was introduced to theatres as a way of confidentially capturing the morale of staff and any potential concerns or issues within teams. Senior staff review the comments and respond to staff with a view to remedying any issues.

Human Factors training has been undertaken to support the just culture within the Trust. Human Factors takes into account the emotional impact of events in people's personal lives, and in team dynamics on their work. It encourages staff to consider their role in the team and how they can interact and support others to improve team-working.

Staff take part in simulation and

scenario training to help them practice how they work together in difficult scenarios. It can also be used as an investigative and learning tool to pinpoint where errors might occur, and help staff work out how they would respond. This work has been supported by a donation from the Southmead Hospital Charity's Christmas Cracker Fund which was used to purchase mannequins.

What difference did it make?

The safety culture survey has been undertaken at NBT on a yearly basis using a staff attitudes questionnaire to understand the perceptions and values of staff within the context of safety in the organisation.

The World Health Organisation Surgical Safety Checklist is a

tool to improve safety during surgery. We have been consistently using this tool during 2017/2018 and our improvement interventions over this year have meant that we have exceeded the national target of 95% for the last 4 months.

Our incident reporting has improved which shows staff are more able to recognise

incidents or potential incidents, and are comfortable to highlight these to the appropriate people.

NHS Improvement reviewed our theatres safety programme in May 2017 and reported significant progress since October 2016. NHS Improvement has now encouraged other Trusts to come along and see the work

we do.

We have had no never events involving wrong side nerve blocks since the introduction of audits monitoring our adherence to safe processes. This is part of a national *Stop Before You Block* campaign.

Improvement in Action

During early 2018 we implemented the WHO safer surgery improvement programme to drive an increase in compliance to the WHO Surgical Safety Checklist, and thus improve surgical safety for all our patients.

This programme is being overseen by the Theatre

Board with the main programme being led by the Theatre Management Team.

We are linking with each specialty to ensure that checklists are being undertaken. By targeting improvement at specialty level we are reaching more staff and creating a culture of ownership that would not be

possible at a divisional or Trustwide level.

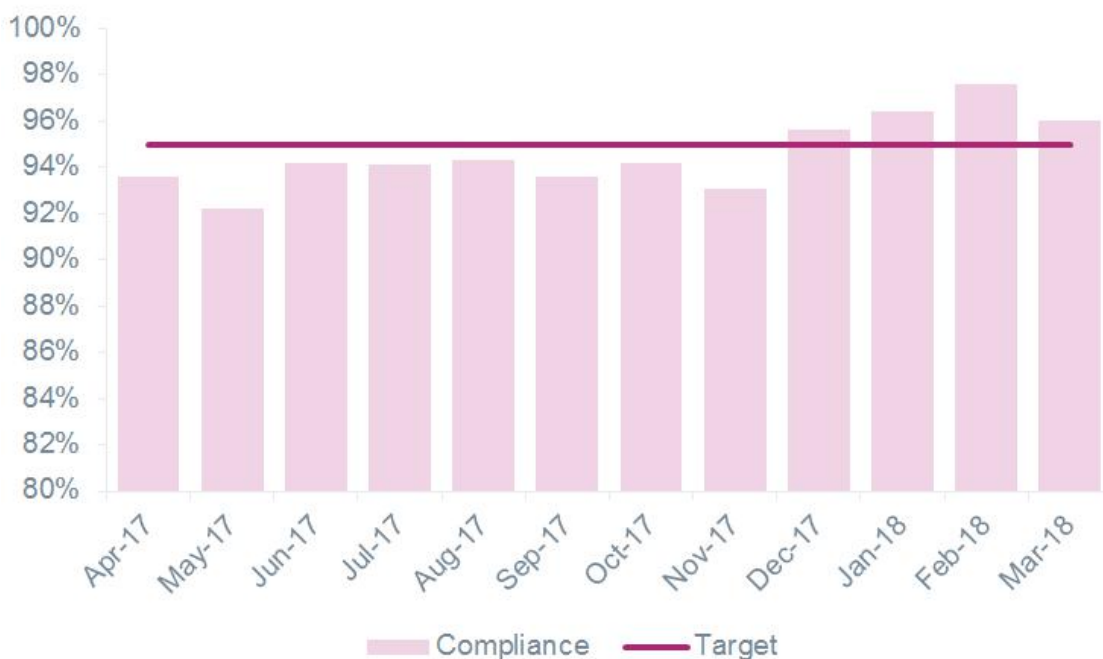
We will continue our work in this area and hope to see further improvements in compliance throughout 2018/19.

Surgical Safety Checklist



Patient Safety
A World Alliance for Safer Health Care

The average compliance with completing the WHO Surgical Safety Checklist over 2017/18 was 95%, this is at the 95% target.



2.2 Reducing Harm from Pressure Injury



Introduction

We have seen pressure injuries reduce by 45% over the last four years, which we are proud of but as an organisation we strive to reduce this further.

We felt we could do more to achieve this ambition and made it a clinical priority for 2017/18, with additional resource made available internally, and working with our partners across Bristol, North Somerset and South Gloucestershire.

What did we do?

A study day was held with representatives from different staff groups including dietitians, therapists, and manual handling, as well as clinical staff who were all encouraged to ask questions and then share their learning with their teams. This gave us the chance to share the SSKIN acronym— Surface, Skin Inspection, Keep Patients Moving, Incontinence/Moisture, Nutrition/Hydration— and remind staff of good practice.

New hybrid mattresses were purchased to ensure patients most at risk of pressure injuries had access to the best preventative care.

New patient information leaflets were produced informing patients about the risks of pressure injury, empowering them with knowledge and

information about their care.

Pressure injury training is now part of our induction programme for new staff, and existing staff can also access this through our online training service.

We have also increased our focus on the ongoing continuity of care of patients after they leave hospital. We've focused on collaborating with our colleagues in community healthcare. This has been supported by a move to the whole of Bristol, North Somerset and South Gloucestershire using the same dressings.

The divisions within the hospital have taken ownership of investigating the cause of pressure injuries in their areas. We use the *swarm* approach which brings together a group of senior staff to conduct an assessment with in a just culture

approach to understand what led to the injury, what could have been done to prevent it, and any learning for the team that can be taken away to prevent it happening again. Previously these *swarms* would have been carried out for the most serious pressure injuries (grades 3 and 4), but they have been extended to grade two as part of our focus on being a pressure injury free organisation.

What difference did it make?

We have had no Grade 4 pressure injuries this year as compared to one in 2016/17 and have seen a reduction in Grade 2 pressure ulcers from 272 (2016/17) to 204 (2017/18). We have seen no pressure injuries in the Rosa Burden Centre during 2017/18.

We have managed to save money by buying equipment as a group of hospitals in the South West and benefitted from free training sessions from the suppliers.

What next?

We have more work to do on Grade 3 pressure injuries. This

is an area we will focus on, as will our commissioners, during 2018/19.

We want to ensure that the strategy group is successful in its aim to reduce and prevent pressure injuries. To this end, we will continue to collaborate with our colleagues in the region .



Improvement in Action

North Bristol NHS Trust has become part of a multi-agency strategy group for Bristol, North Somerset and South Gloucestershire. We have formulated a plan to tackle pressure injuries across the region as a collaborative. This will involve standardised documentation and training

across the region, sharing of information and learning creating an honest, open environment to improve patient care.

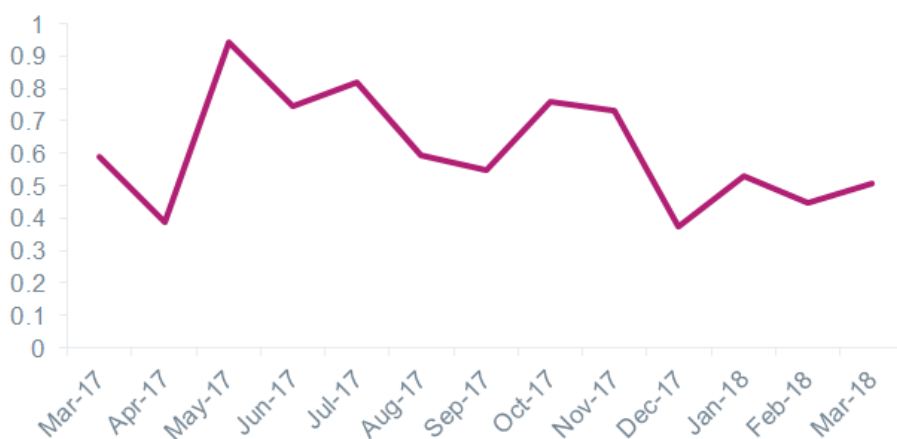
Our main focus is prevention of pressure injury and this involves working with the community and with hospital trusts. We aim to identify best

practice and through standardising frameworks, documentation, and education across the region roll-out best practice to all care settings.

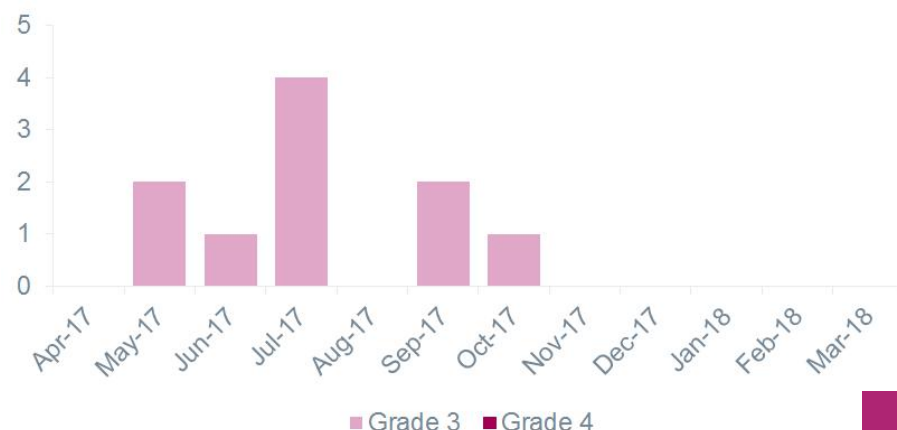
We also want to extend our education to patients and carers to support them in preventing, and managing pressure injuries.

Pressure Injury Rates and Numbers 2017/18

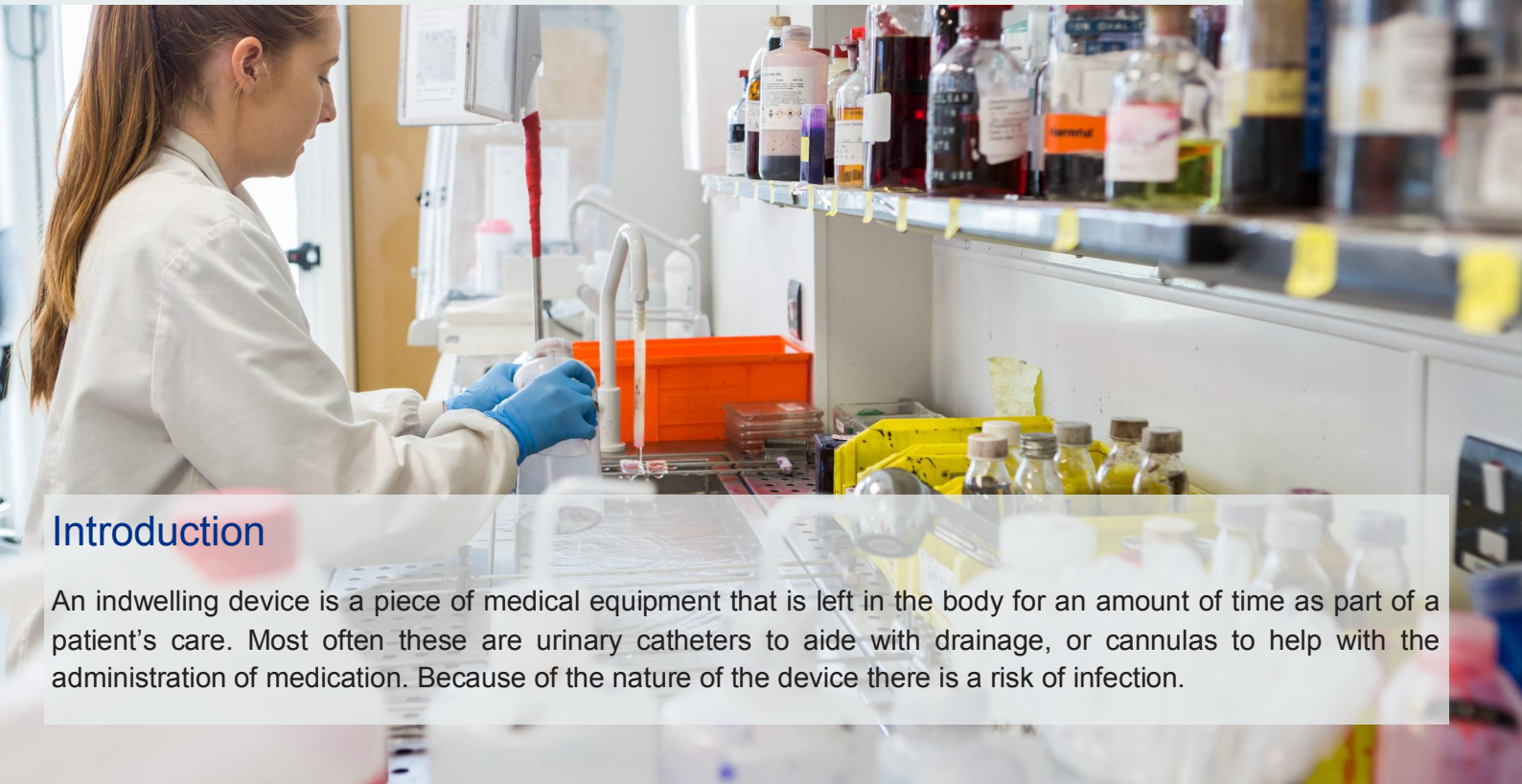
Pressure Injuries Grade 2 and above
- rate per 1000 bed days



Pressure Injuries Grade 3 and Grade 4
- number



2.3 Reduction of Infections Arising from Indwelling Devices



Introduction

An indwelling device is a piece of medical equipment that is left in the body for an amount of time as part of a patient's care. Most often these are urinary catheters to aide with drainage, or cannulas to help with the administration of medication. Because of the nature of the device there is a risk of infection.

What did we do?

We have been involved in a project to improve the quality of our care of patients with peripheral lines. This has been in collaboration with NHS Improvement (NHSI). The project's aim was to design and create a new care plan, and to re-start the Intravenous Access Group. The group has a focus on education, training, policy, and product (i.e. the quality of the dressings we use) and improves how we look after the catheter.

Our infection control team has been working with the whole health economy to reduce a certain type of bacterial infection (gram negative bacterial infection).

We have pioneered the patient passport for urinary catheters,

really involving the patient in their care.

When things do go wrong we make sure that we take learning from them to inform our care going forward and ensure the same thing doesn't happen again. We have used our investigations to directly feed into actions that can be implemented. This constructive learning helps us provide a safer environment for patients.

What difference did it make?

During 2017/18 we identified that our current data capture systems do not differentiate between infections contracted as a result of an indwelling device and those that are not. We recognise that in order to assess the clinical impact of our improvement actions we need

to strengthen our approach. With better data we can evidence our improvement work and gauge which interventions are having a positive effect.

During the year we identified a solution to address this issue and will be implementing a new IT system, Synbiotix, that will allow us to collect and share real time data on levels of care and infection rates from indwelling devices

What next?

We aim to use the Vessel Health Framework to introduce longer lasting lines reducing the risk of infection and increasing patient comfort. The objective is to preserve the line through a combination of correct device selection and insertion techniques followed by daily maintenance.

With the introduction of Synbiotix during the year we will be more actively monitoring our data. This will aid in our improvement work as we will be able to run small tests of change to see how we can affect our outcomes for the better. Having more responsive data will also help us in rolling-out improvements in practice across the Trust as staff will be

able to see the effect of their actions.

Improvement in Action

Reduction of infection from urinary catheters is a national directive, and much like the patient passports developed for medicines, the infection control patient passport focuses on patients taking ownership of their urinary catheters, aiding healthcare professionals across different care settings to provide

continuity of care and reduce rates of infection

The patient passport details the type of catheter, information on how to care for the catheter in hospital and at home, and when the catheter is due for a change.

There are risks when a catheter is left in too long, but

also changing a catheter before it is due to be changed opens up risk of infection.

We want to help patients be a part of their care management and take an active role in their ongoing treatment.

2.4 Improving End of Life Care



Introduction

Every year we care for approximately 1,800 patients at the end of their lives in all areas of our hospital. Good end of life care is about listening to and understanding the wishes of patients and their families, and is the foundation of good care for all patients, whether they are at the end of their lives or not.

In April it was confirmed that we had achieved the national CQUIN target for End of Life Care for 2016/17—the fourth consecutive year. While we have been making strides in the care we provide to patients at the end of their lives we understood there was more to do in improving our processes and embedding them across the Trust, so we made it a continuing priority for 2017/18.

What did we do?

We have introduced our own on-call service to provide staff with specialist palliative care advice rather than relying on an external organisation. Funding has been made available to support this important service since January, and we have been able to provide telephone advice 24 hours a day, seven

days a week. We have ambitions to build on this by working on the roll-out of face-to-face support.

We have worked with the catering team to ensure there is access to food for patients at the end of their lives at all times of day and night. This could be nutritionally specialised meals, soft food for patients with trouble swallowing, or even just a bowl of ice cream to satisfy a craving.

Our Patient Experience and Chaplaincy Services have created a survey for families to understand any areas for improvement.

What difference did it make?

We achieved 'outstanding' in the caring domain from the Care

Quality Commission (CQC) during their 2017 inspection. Feedback from people who used the service and those close to them was "continually positive about the way staff treated people". They found that staff were "highly motivated and inspired to offer care that was kind and promoted people's dignity".

What next?

Having piloted our Purple Butterfly work this year we will be launching this to the rest of the Trust in April 2018.

As part of our CQC action plan we are building on the work we have already done, and developing a system of assurance so that we can demonstrate how patient focused our care is.

The aim is to embed our work across the Trust so that we can make it **sustainable**. This will be supported by real-time audits twice a year to look at key aspects of these new processes.

Continuing to seek the views

of families of those who have died on the quality of care provided at the end of life. These will be reviewed, good practice celebrated and areas for improvement acted upon

Improvement in Action

In response to patient feedback we bid to be part of a project to improve the processes we have in place for people at the end of their lives to ensure there is a more consistent approach to end of life care across the Trust.

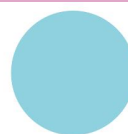
Working with the Point of Care Foundation we launched the Purple Butterfly Project to help empower staff who are not palliative care specialists

to deliver high quality end of life care.

The quality improvement project was launched in December at an event that included the performance of a play—*Homeward Bound*—told from the perspective of a relative to encourage people to think about the care they give from the perspective of the patient and their families.

As part of the project all of our paperwork was updated to help staff provide high quality person-centred care.

Our project was presented in London in February 2018 and won the poster prize.



The
Point of Care
Foundation



2.5 Improving the Care of Patients Whose Condition is at Risk of Deteriorating



Introduction

This year we have focused on three themes to improve our care of patients whose condition is at risk of deteriorating. The first is sepsis, because of the need to be recognised and treated quickly to avoid life changing or life threatening outcomes. Secondly we have focused on the care of patients that rely on insulin, as they are at increased risk during hospitalisation. Lastly we have looked at improving how we calculate and act on the National Early Warning Score (NEWS) that warns health care staff when a patient is deteriorating.

Sepsis

Over recent years we have worked really hard to raise awareness of sepsis and to comprehensively train our staff to recognise the signs. Because of this we have very good front door screening and management, and 90% of antibiotics are delivered within one hour.

We still want to improve on inpatient antibiotic delivery and we have started a Quality Improvement Project to look at why we have delays, and what can be done to improve.

Insulin

In the summer of 2017 we started an Insulin Improvement Group with membership from different professional areas to look at how we ensure patients on insulin receive their

appropriate medication.

We have entered data to the National Diabetes Audit and are undertaking a collaborative Quality Improvement Project to improve care. This involves mapping how we care for patients to find areas where we can improve, and implementing small changes that contribute to overall improvement, with a particular focus on low blood sugar (hypoglycaemia).

We are also exploring giving patients more ownership of their condition when they are in hospital. Often patients are extremely adept at managing their own diabetes and they should be allowed to continue this when inpatients.

Finally, we have undertaken simulation training with feedback from staff indicating that it was extremely useful.

NEWS

Last year we focused on the accuracy of calculating the National Early Warning Score (NEWS) which alerts healthcare professionals to patients whose condition is at risk of deteriorating. Although NEWS was being undertaken consistently we found that the calculations were sometimes incorrect leading to patients being given the wrong scores. We have focused our training on calculating oxygen scoring with 978 staff trained so far.

Although we have improved our accuracy we feel we can do more, so during 2018/19 we will look at implementation of electronic observations and with the release of NEWS 2 we will need to train staff to use the new tool, understand the implementation, and also consider the impact it will have.

% Patients screened for sepsis and % patients given antibiotics within 1 hour of screening

*n/a—For inpatient sepsis the measurement basis was under development during quarters 1 & 2.

	ED		Inpatients	
	Screened	Abx <1 hour	Screened	Abx <1 hour
Quarter 1	100%	90%	n/a*	n/a*
Quarter 2	100%	87%	n/a*	n/a*
Quarter 3	100%	97%	40%	50%
Quarter 4	100%	93%	26%	57%

Improvement in Action

Traditionally when a patient comes into hospital, management of their medication is taken on by the healthcare provider. This can mean that sometimes patients with complex conditions that require a lot of medication, might not receive the level of care we strive for.

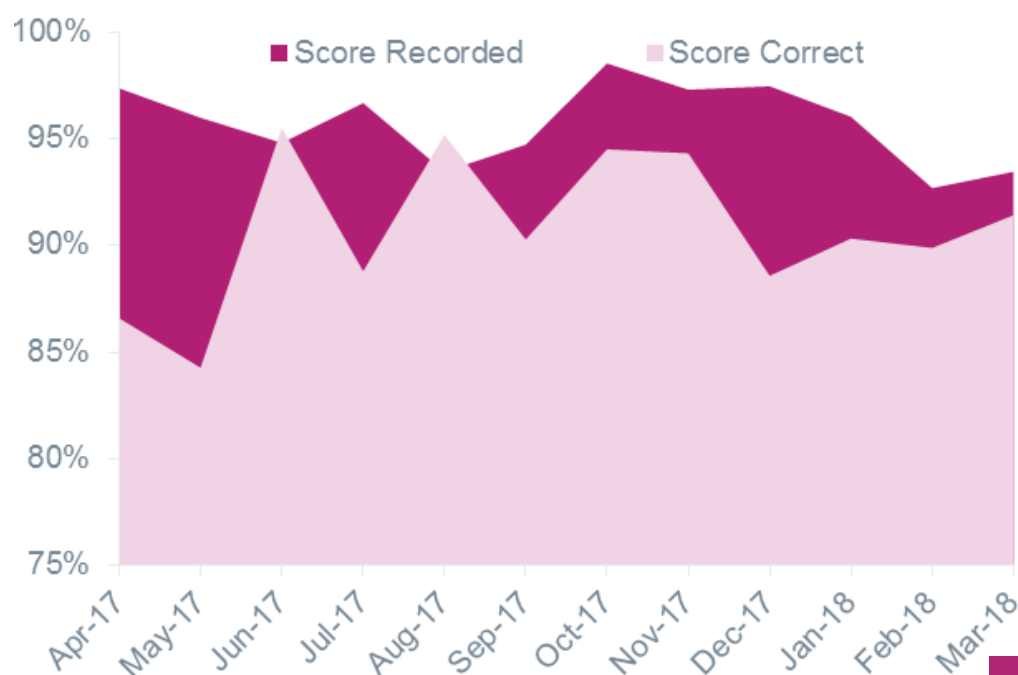
At North Bristol NHS Trust we

have recognised that patients with long term chronic conditions, such as diabetes, are often the best placed people to manage their condition, we call these people expert patients. Because of this we are trialling a new system that encourages patients to retain control of their insulin medication when in hospital.

Although this is not suitable for everyone, for example patients that are seriously ill, for most people it is extremely beneficial for them to manage their diabetes as they would do at home with support from our staff. In turn we hope that this will reduce incidents of missed doses, or attacks of low blood sugar.

National Early Warning Score (NEWS) Recorded and Correct

A monthly audit of NEWS is undertaken at NBT. Average submission to the audit is 284 patients per month.



2.6 Enhancing the Way Patient Feedback is Used to Influence Care and Service Development

Introduction

We encourage feedback from all our patients to better adapt our services to their needs. It's really important when improving an aspect of the service to ensure that we take patients' feedback into account as they are often the experts.

What did we do?

We have begun work to increase the membership of the Patient Partnership Group in order to help ensure that we have the patient voice on key Groups and Committees and also increase the patient presence and influence on the appointment of staff.

The Complaints Lay Review Panel met five times this year. The panel consists of 10 specially trained members.

It is now possible to complete the Friends and Family Test via text message. This eases accessibility for patients. Paper forms are still available in some areas for patients not comfortable with electronic devices.

The Ask 3 Questions initiative that encourages shared

decision-making has evolved to Ask 4 Questions particularly surrounding issues of discharge. It is a tool to help facilitate questions around discharge process and engage patients and their families in decision-making with health and care staff.

A survey was conducted in Maternity Services to gauge patient satisfaction. Regrettably the results were not as positive as we would have liked. However, we saw it as a very valuable learning experience and have driven our efforts towards understanding the root cause of the issues. We are keen to understand why issues are arising, and want to help teams to not only understand the causes of poor practice but the causes of good practice and how to replicate this.

We understand that it is important to highlight the good as well as the bad and focus on sharing and replicating good and exceptional practice across the Trust. Patients are an essential part of doing this; contributing feedback and ideas for us to put into action.

What difference did it make?

As a result of the success of last year's Ask 3 Questions initiative in engaging patients in their care, it has been incorporated in to the new Trust Consent Policy, promoting the expectation of patients to engage and ask questions.

The move to collecting the Friends and Family Test via text message has given us the opportunity to update our contact information for patients.

number of responses we receive, and consequently the amount of information we have to act upon.

What next?

We want to continue to engage patients in their care and how we develop and maintain services in the Trust. We want to continue to extend the membership of the Patient Partnership Group via the

creation of focus groups to provide service specific feedback from our different areas of care.

We want to listen more to our patients and learn more about how to provide a service which delivers the best experience for the patient, their family, and carers.

Improve the use of FFT data in building on good practice and demonstrating improvements

where required across wards and departments

Increase our engagement with voluntary sector organisations and Healthwatch to enable their views and experiences to influence the delivery of care and services – the main focus will be in the outpatient service

Complete the pilot of 'Ask 4 Questions' enabling roll out to other areas

Improvement in Action

At North Bristol NHS Trust we are working to improve, where possible, including patients at the highest level, in the decisions we make around care and service development. Part of this process is ensuring that as many groups or committees as possible include membership of a patient. Patients are also involved in

focus groups with the Trust Chairman.

Patients attending these committees are trained and supported to give an important patient perspective. Their contribution influences decision-making and is welcomed by staff.

In this way we ensure that we consistently and continuously

think about our patients when making decisions and have an open and honest governance process.

Their work outside of these committees has included in the appointment of 3 consultants this year and in the appointment of the Trust Chairman.

Patient Partnership Group

The members of our Patient Partnership Group (PPG) continue their important contribution in helping us provide patient centred care and services through their challenge and influence. The question of "*what does this mean for patients?*" is ever on their lips. Membership of the panel is 8 strong, having decreased over the years mostly due to deteriorating health of the members. We are recruiting new members to join our experienced panel in 2018/19, providing training and support to undertake this vital

work. This year was greatly saddened by the death of Julie Francis, Chair of the PPG, and a very active member of the panel for over 15 years. Her insight, leadership, and challenge is greatly missed by all.

This year our patient partners have given the *Patient Perspective Challenge* to the work of many established governance and development groups across the Trust. These include the Clinical Effectiveness Committee, Patient Safety & Clinical Risk Committee, Quality

Surveillance Group, Medicine Governance Group, Clinical Audit Committee, Complaints Review Panel, and Patient Experience Group, as well as contributing to the appointment of staff.

Once we have increased our members we welcome their input into interviewing patients and undertaking patient surveys, as well as auditing privacy and dignity from a patient perspective, and of their experience of the process of gaining information and giving consent to treatment.

2.7 Our Priorities for Improvement 2018/2019

Introduction

The quality priorities set out below have been set through a review and process of consultation that takes account of;

- NBT Trust Strategy (2016-21)
- NBT Business Plan Priorities 2018/19
- NHS Improvement Planning Guidance 2018/19
- Clinical Divisional Management Team comments
- Patient Participation Committee comments
- External Patient Experience Group member comments
- CQC inspection actions (November 2017 inspection)

Our patient group 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 endorsed our overall approach with recognition of the need for a more broad-based range of quality improvement priorities. These discussions also recognised that any large Trust, such as NBT, has a significant number of quality measures to review and provide confidence on. These continue to be managed and reported openly, even when not included as a quality improvement priority.

Having concluded these discussions, the proposed priorities were taken forward by the Executive Lead 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.

1.

Eliminate delays in hospital to improve patient safety and reduce bed occupancy ('Home is Best')

Why?

A year-on-year increase in both attendances and emergency admissions, coupled with limited external capacity in the community to support patients in their discharge, has continued to place pressure on the Trust's bed capacity.

This has increased the number of patients who are unnecessarily in hospital for more than seven days, and as a result, occupancy levels are frequently in excess of 100% of available bed capacity. This is not helpful for a high quality patient or staff experience.

How?

- Meeting a target bed occupancy 95%, with escalation areas only in use in exceptional periods of demand.
- Delivery of the inpatient elective Service Level Agreement (SLA) in 2018/19 (31st March 2019).
- A reduction in the number of patients with a length of stay greater than seven days by at least 50% in all wards (against a specific baseline to be determined).
- Consistent delivery of daily expected discharges on all wards.
- Reliable Estimated Discharge Dates (EDDs) implemented consistently on all wards.

Why?

We are not satisfied with the progress made during 2017/18, and are therefore focusing additional resource and expertise into this area during 2018/19, both internally, and also through working with partners across the health system.

How?

- Increasing the membership of the Patient Partnership Group, also providing training in order to help them in their role and interactions with staff and the work of the Trust.
- Complaints Lay Review Panel outcomes to be used to shape improved quality of complaint investigation and responses.
- Increased complaint investigation training uptake.
- Reduction in overdue complaints.
- Improved Friends and Family test outcomes (response rates and percentage of patient recommending the service) and also demonstrate the changes made as a results of the feedback
- Improved inpatient survey 'engagement in discharge' score
- Deliver actions for inpatient and maternity surveys.

2.

Enhance the way patient involvement and feedback is used to influence care and service development

3.

Improving end of life care

Why?

We have made good progress in this area, as reflected in our most recently published CQC report, which recognised the good leadership of the improvement work across the Trust, and the outstanding care provided. 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).

How?

- Embedding 'Purple Butterfly' project, and widening roll-out.
- Ensuring appropriate family involvement.
- Acting upon poor prognostic indicators and appropriate GP communication.
- Training delivery of end of life care to clinical staff
- Using feedback from families on their experience and quality of the care of their loved one at the end of their life to improve and to reinforce, and celebrate good practice

4.

Strengthen learning and action by embedding quality governance at specialty, cluster and divisional level

Why?

In 2017/18 we launched the development of Service Line Management to support our strategic aim of being a clinically-led organisation. This focused on the creation of five clinical divisions, developing the leadership teams, and supporting this through a tailored programme.

This transition requires further support for the devolved roles, responsibilities, and supporting processes and systems that help to embed strong quality governance as close to the front line as possible. Some of the building blocks have been established during 2017/18, such as implementing the Datix system to support better management of incidents, complaints, safeguarding cases, inquests claims, and risks, but more work is needed.

How?

- All specialties' governance arrangements reviewed.
- Divisional governance reports established with Business Intelligence (BI) support.
- Deep Dive rotational reviews at Quality Committee.
- Implement Synbiotix (a system that collects audit data) and routine review of ward data and actions.
- Clear linkages between divisional and corporate quality governance structures.
- Achieve CQC 'Good rating' - agreed plan to deliver improvements.

5.

Demonstrate a stronger clinical understanding and application of the Mental Capacity Act and Deprivation of Liberty Safeguards

Why?

The CQC inspection raised some concerns in this area, with 2 'Must Do' actions set within the report.

Currently there is an overreliance upon central specialist team support and there is a training need to empower local teams to operate within the required statutory frameworks, with divisional oversight.

How?

- Trust-wide improvement work with the divisional teams led by the Deputy Director of Nursing and Head of Patient Experience with support from subject specialists.
- Development of e-learning packages, face-to-face training for Heads of Nursing and Matrons, and tailored training in higher risk areas.
- Internal audit in progress focusing on knowledge and awareness in a sample of clinical areas to baseline the gaps and inform training plan.

How will we measure progress with these priorities?

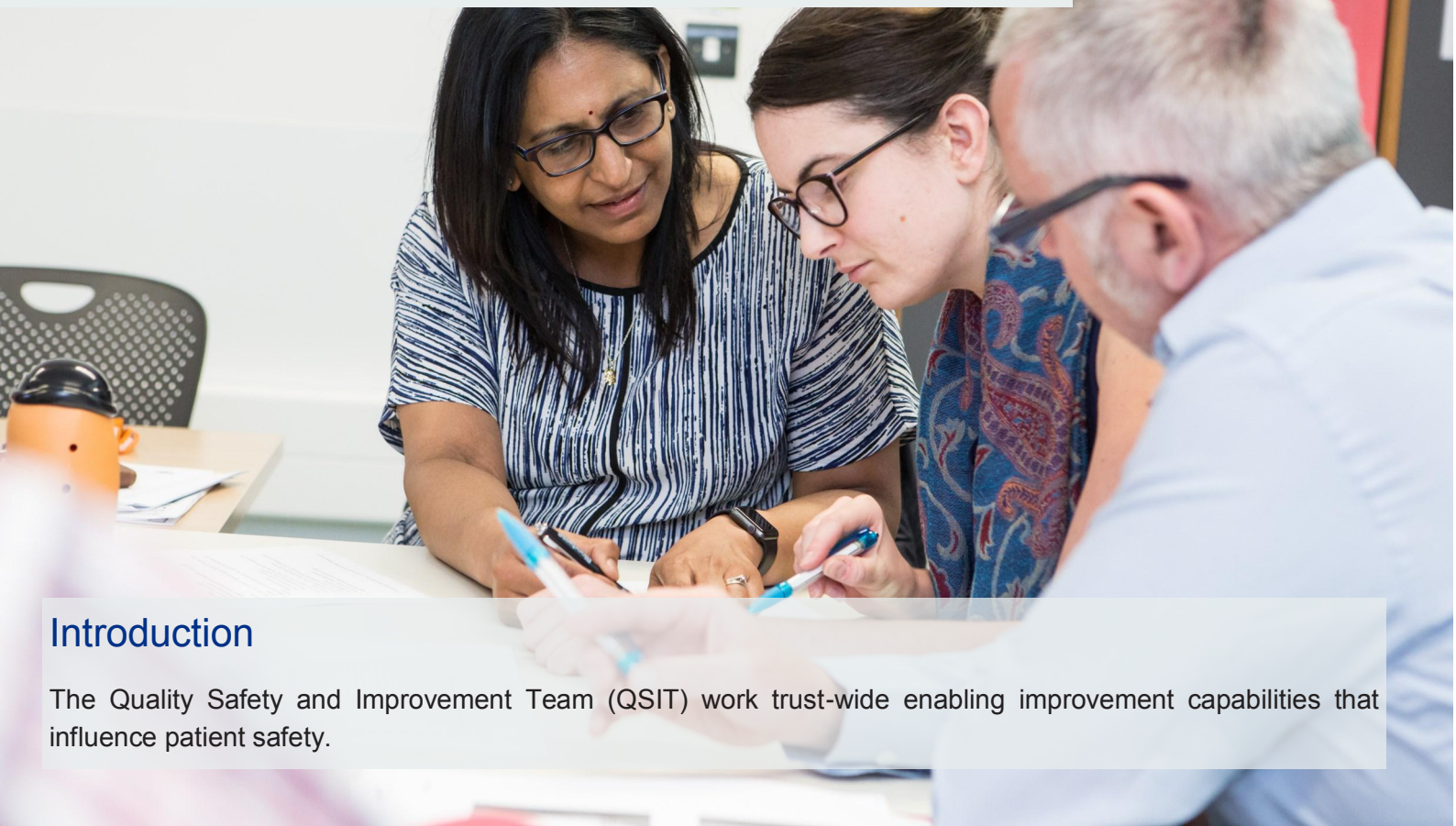
A clinical lead and supporting project or working group will be identified for each priority to drive it forward, which will, wherever possible, utilise existing groups to avoid unnecessary additional meetings, and to help join up related areas of clinical practice. Improvement measures will be set within the areas outlined, and 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, Associate Medical Director for Safe Care and Divisional Clinical Directors, Heads of Nursing, 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 Trust 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 Bristol, North Somerset & South Gloucestershire Clinical Commissioning Groups (CCGs), the local commissioners for the Trust's services; by NHS England who commission specialised services; by the Care Quality Commission (CQC) who regulate care delivery at the Trust, and by NHS Improvement who are the Trust's performance regulators.

2.8 Quality and Safety Improvement



Introduction

The Quality Safety and Improvement Team (QSIT) work trust-wide enabling improvement capabilities that influence patient safety.

QSIT reach out to staff throughout North Bristol NHS Trust, offering Quality Improvement (QI) training, support and resources. QSIT also sit on key patient safety groups such as the Falls Committee, Sepsis, Mortality Reviews and Safe Theatres, facilitating QI work to improve patient safety and care.

What did we do?

We collaborate with external networks including the West of England Academic Health Science Network (WE AHSN) and are members of the 'Q Community' which is a network by the Health Foundation with a focus on improving health and care quality. This keeps us connected with like-minded people and encourages us to bring back new ideas and learning to the trust as well as

providing additional support to existing work streams.

We offer staff interactive QI workshops, providing the knowledge, tools and resources needed to successfully complete a QI project. This year we have trained 146 members of staff through our workshops, as well as an additional 296 staff who have received bespoke sessions within their teams. In addition to this QSIT host a weekly QI hub offering ongoing support to staff working on improvement projects.

We developed and maintain a QI database allowing us to capture trust wide QI activity. The benefits of this have been it allows us to connect teams working on similar ideas, identify common themes and to highlight projects that complement Trust priorities.

What difference did it make?

This year's most successful QI project was completed by our end of life care team in collaboration with QSIT, called The Purple Butterfly Project. The outcomes of this improvement work will empower staff who are not palliative care specialists to deliver high quality end of life care. This project has been shortlisted for a BMJ Award, in the Palliative and Hospice category. A great strength of the development of this project was the patient-centred design through patient shadowing. Also this year, we have seen a 100% increase in the amount of QI projects registered.

This translates to more improvements to the quality of services we provide at NBT.

What next?

We have identified the need for a more collaborative approach when delivering QI training therefore, this year we aim to improve our QI Workshops by aligning our training programmes with QI training

offered in other local hospitals including University Hospitals Bristol NHS Foundation Trust and Gloucestershire Royal Hospital. This will allow us to share QI knowledge with our counterparts in other local NHS Trusts and begin to standardise the QI education we all provide benefiting our colleagues who rotate between NHS organisations.

We also plan to introduce QI

Clinics for staff who have registered a QI project and already have basic QI knowledge but require more bespoke input to progress with their work.

Improvement in Action

We hosted our first Celebrating Quality Improvement Event on 13 April, where we asked teams working on QI projects to design a poster showcasing their work during 2017/18. We had 45 QI projects displayed and invited our colleagues and the public to come along. We also had displays with information on patient safety

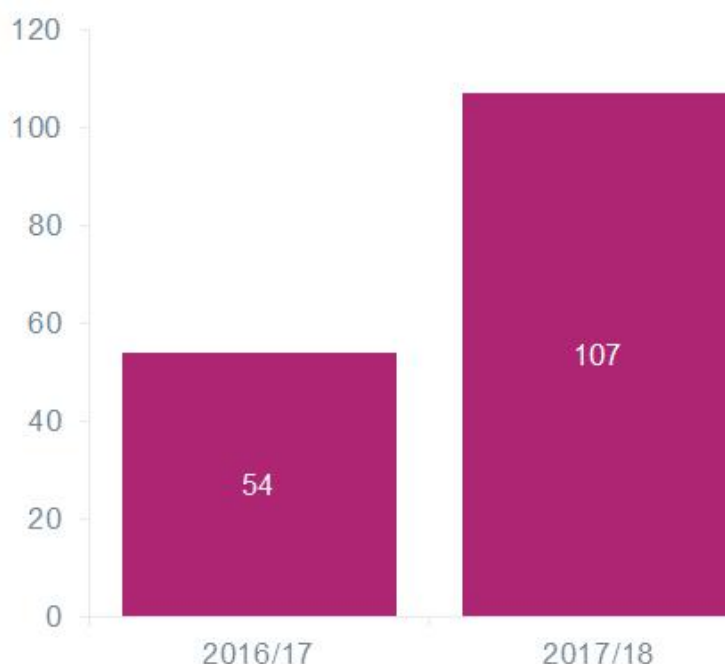
(sepsis awareness). The Medical Director and Director of Nursing, along with public votes chose the first and second best projects along with a third as 'most promising'

The event provided an opportunity for the teams to showcase their fantastic work on improving patient safety

and experience in North Bristol NHS Trust as well as role modelling to colleagues how improvements to the care we deliver can be made in small, simple steps.

Quality Improvement Projects Registered and Staff Trained

Total Quality Improvement Projects Registered 2016/17—2017/18



2.9 What Others Say About Us

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. NHS trusts are registered for each of the regulated activities they provide, at each location they provide them from. As at 31/03/18, the Trust is registered for all of its regulated activities, without any negative conditions attached. 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 in November 2014. A second inspection was undertaken in December 2015 covering services and domains not originally rated as either 'good' or 'outstanding'. During 2017 the CQC changed its inspection process, which principally entailed;

1. Clinical services being inspected on an unannounced basis (30 minutes notice).
2. A planned review of the Trust against the 'Well Led' domain being undertaken, following on from the unannounced inspection.

The Trust was the third in the South West to receive such an inspection. The unannounced inspection commenced on 7 November and the well led review concluded on 29 November. The final reports were published on 8 March 2018.

The Trust's overall 'Requires Improvement' rating was retained but we were pleased that eight individual ratings at Southmead improved to a 'Good' rating, including Outpatients which improved to 'Good' overall. We were also extremely pleased that we sustained a 'Good' rating in Urgent & Emergency services demonstrating the high care standards delivered, even when under significant pressure at our 'front door.' This reflects the dedication of our staff, who the CQC found to be compassionate and caring across the board. For patients at the end of their lives, caring was highlighted as 'Outstanding' and within Surgery both the Effective and Well Led domains improved to 'Good.' The majority of our services are rated as 'Good' for Well Led with positive feedback from patients about their care.

In common with many acute trusts, at peak times we are

often overwhelmed by the number of patients we are seeing, or who we cannot discharge into alternative care settings once they are ready to leave. This is reflected in the 'Inadequate' rating in Medical Care. We are identifying ways of working more effectively with our partners in the community to ensure patients are looked after in the most appropriate place, reducing the need for a stay in hospital.

As required, an Action Plan was submitted to the CQC on 19 April 2018 following Board approval. Progress against these actions will be actively tracked during the year at the Board and in more detail through the Trust's Quality Committee and within clinical divisions. Externally, progress will be monitored by local commissioners and NHS Improvement, as well as through ongoing engagement visits during the year from the CQC.

Overall Trust Rating

Overall Rating	Safe	Effective	Caring	Responsive	Well-Led
Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement

Southmead Hospital Rating

	Overall Rating	Safe	Effective	Caring	Responsive	Well-Led
Urgent & Emergency Services	Good	Good	Good	Good	Requires Improvement	Good
Medical Care	Requires Improvement	Requires Improvement	Requires Improvement	Good	Inadequate	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Good
Critical Care	Good	Good	Good	Good	Requires Improvement	Good
Maternity & Gynaecology	Good	Good	Good	Good	Good	Good
Children & Young People Services	Good	Good	Good	Good	Good	Good
End of Life Care	Requires Improvement	Requires Improvement	Requires Improvement	Outstanding	Good	Good
Outpatients	Good	N/A	Good	Good	Good	Good
Overall Location	Requires Improvement	Requires Improvement	Requires Improvement	Good	Requires Improvement	Good

Cossham Hospital Rating

	Overall Rating	Safe	Effective	Caring	Responsive	Well-Led
Maternity & Gynaecology	Outstanding	Good	Good	Outstanding	Outstanding	Good
Outpatients	Good	Good	N/A	Good	Good	Good
Overall Location	Good	Good	Good	Good	Good	Good

3.1 Reducing Falls



Introduction

We believe that it is unacceptable for any person to fall in hospital and constantly strive to reduce the numbers of people, including relatives and friends, from experiencing this distressing event.

What did we do?

A large proportion of our patients who need to spend an extended period of time in hospital are frail and unsteady on their feet. With this in mind, plans are put in place to minimise the risk of falling whilst in hospital.

One of the ways we do this is to ensure that all people requiring an admission to hospital receive a falls risk assessment that is designed to help identify which patients are of a higher risk of falling and put appropriate plans

in place to help reduce the chance of this happening.

As part of a Quality Improvement (QI) programme for falls prevention, this year we established a process whereby a meeting, called a Swarm, is arranged within 48 hours of a serious fall. This enables staff to discuss what happened, how it happened and why it happened whilst the events are still fresh in their minds. After a falls Swarm, participants decide where improvements can be made to the Trust's falls prevention plan either as part of a QI investigation or if a more in-depth Root Cause Analysis is needed.

All falls resulting in harm are discussed in detail and plans are put in place and reviewed at our monthly Falls Prevention Group. This group has

representatives from our local commissioners who check that we are capturing all the information needed to make effective future plans. These plans are logged and reviewed every month to check progress. All wards are represented alongside other professionals such as therapists, pharmacists, trainers and specialists in dementia and safeguarding.

Colleagues in all areas of health and social care are continually assessing people with a risk of falling and seek to help reduce this as best they can. To help our staff better understand the risk of falls, we have established a training package that includes information on what to do in the event of witnessing a fall and what measures can be taken to reduce the risk of falls.



Falls risk assessment completion for 2017/18

What difference did it make?

On any given day, we can have more than 1,000 people in hospital with approximately seven reports of falls. Of these, the vast majority are harmless with an average of two a month resulting in a harmful consequence and possible increase to their stay in

hospital. The introduction of falls Swarms is helping us improve safety culture within North Bristol NHS Trust as well as ensuring staff feel supported.

What next?

We are planning to undertake a study looking at the numbers of reported falls against the actual numbers of falls. Hospitals with

a smaller gap between actual falls and reported falls are known to have a better culture of openness and learning.

We are also commencing a study to understand any alignment with a person's length-of-stay and the timing of the fall to work to reduce harmful inpatient falls and improve patient safety.

Improvement in Action

We are in the process of extending the falls Swarm process to include people who experience less harmful falls and will then progress to investigating the benefits of holding these meetings within 24 hours for every reported fall. This is currently being piloted on our complex elderly care wards in Elgar House.

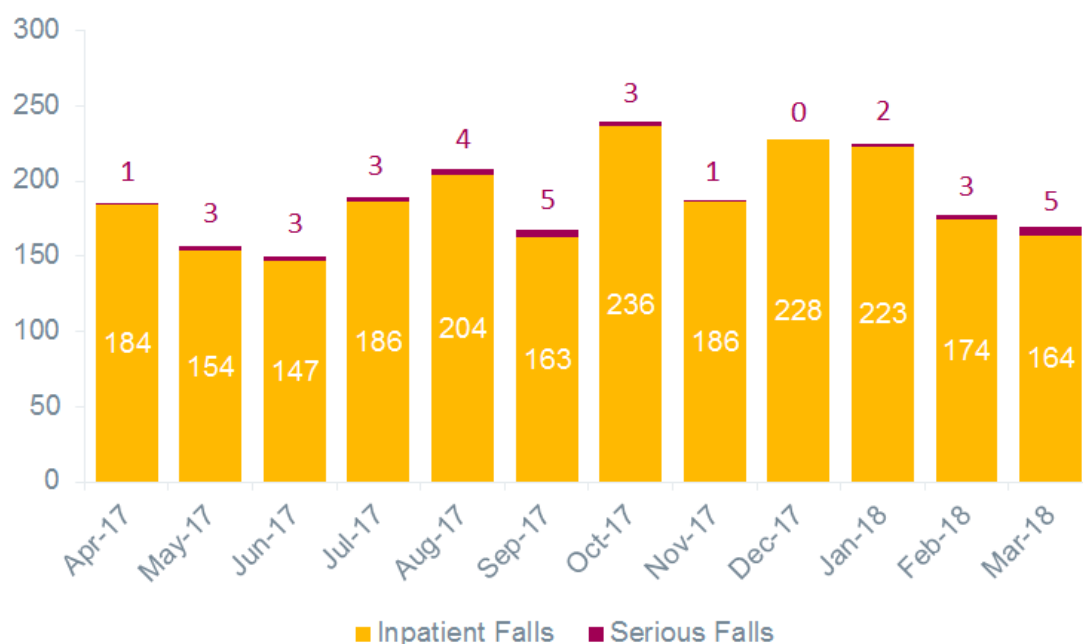
NBT will be participating in the nationwide #EndPJParalysis challenge that will run from 17 April to 26 June to finish in time for the NHS 70th anniversary celebrations. The aim is to achieve one million patient days of people up, dressed and moving in their own clothes, rather than hospital gowns or pyjamas (PJs). The benefits will

include reduced loss of mobility, deconditioning and risk of falls. As well as a reduced length of stay enhancing the wellbeing of patients and staff.



Number of Reported Inpatient Falls

Serious falls data includes Swarm Falls and STEIS Falls



3.2 Reducing Harm from Infection



Introduction

The main hospital acquired infections are Clostridium difficile (C.diff), methicillin-resistant Staphylococcus aureus (MRSA), and methicillin-sensitive Staphylococcus aureus (MSSA). These infections are highly contagious and can be resistant to certain antibiotics. Most often infection is passed from patient to patient in a hospital setting via patient contact, contact with staff, contact with equipment, or where proper sterilisation has not occurred.

What did we do?

We educated staff to be able to identify which patients need screening for MRSA. Through this we ran teaching sessions on encouraging clinicians to sample all patients with a possible infection on admission. We also educated staff to treat the patient as having an infection on sampling. This means that we are not waiting to have an infection confirmed before we are enacting infection control measures such as stricter cleaning and isolation.

To improve sampling we have implemented automated liquid swabs that can be processed without the need for lab staff to manually grow cultures relieving the pressure on the labs.

We worked hard to change the

culture around accessing results. There was often a delay between the swab result being ready and the clinician accessing and then enacting on that result. We educated staff to access results as soon as they are ready. These training improvements were incorporated into the mandatory training and update training to all clinical staff in the Trust.

This training has been rolled out across the Trust but we've also encouraged divisions to take ownership of their infection rates and improvement strategies.

We've implemented the 'right person right place' strategy to reduce movements of infected patients. This means that people with infections should be admitted to the correct ward on

admission. This is problematic due to the pressures on the hospital with high admission rates, but we have been working with the operations team to make this happen.

What difference did it make?

2017/18 has seen the lowest rate of C.diff infections to date with 32 being recorded in the year against a trajectory of 43. Unfortunately this has not been mirrored in our MRSA and MSSA infection rates. We have taken on board how our processes and strategies have affected our C.diff rates and now want to apply them to MRSA and MSSA.

What next?

We want to look at our use of gloves when treating patients. Overuse can actually lead to a rise in infection because people are less aware of what they are touching and can forget to change gloves in-between patients.

As part of encouraging good

hand hygiene for staff and visitors, we have listened to public feedback and we will be standardising the gel dispensers so that they are all wall mounted and in the same place in each room.

We aim to have a more active role in forward and contingency planning in relation to winter. Our objective is to set up a

training programme to give staff the knowledge and confidence to be able to make decisions around infection control in an emergency situation when the infection control team is not available for consultation or input (e.g. out of hours).

Improvement in Action

During 2017/18 we had the lowest rate of Clostridium difficile infection (vomiting and diarrhoea) to date and performing well under our trajectory of 43 cases. This has been due to introducing a new way of working involving reviewing in-depth every case of C. diff and learning from these episodes to prevent the same thing happening again.

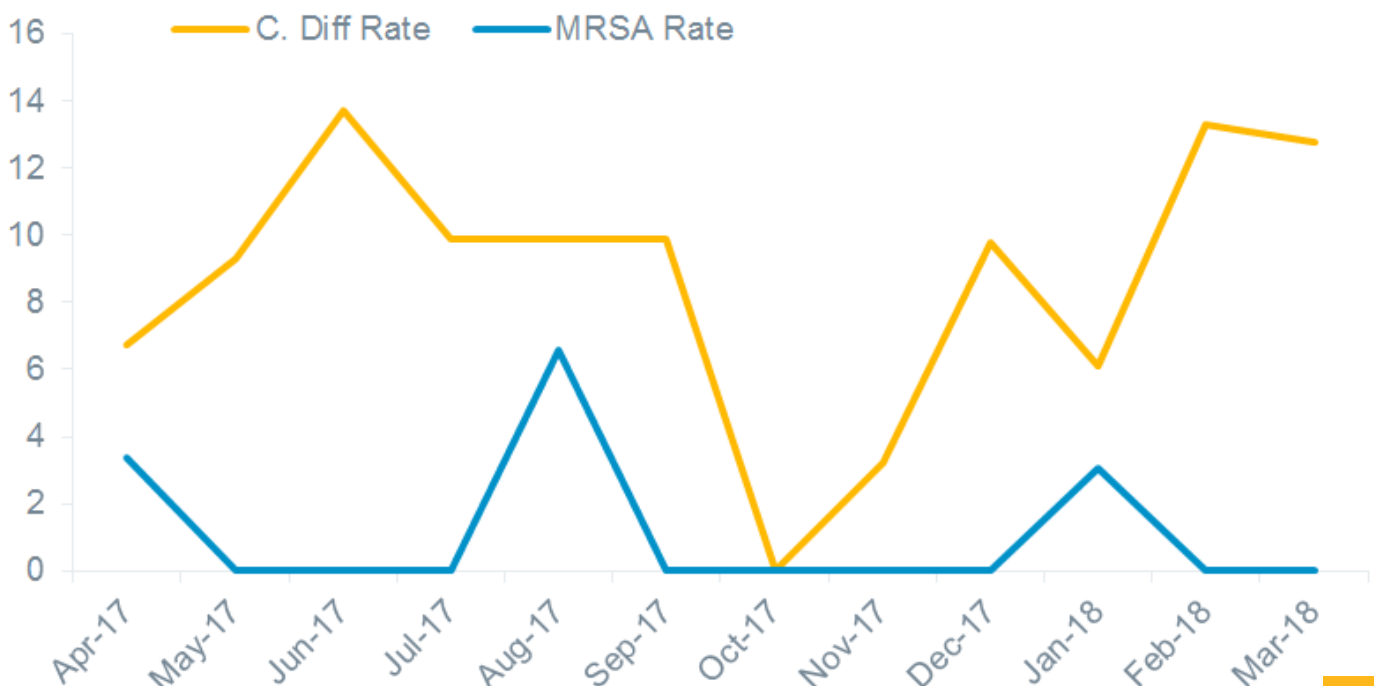
We involve a multi-disciplinary

team consisting of doctors, nurses, pharmacists, cleaners, clinical scientists and members of the Clinical Commissioning Group, to ensure we have input from all areas.

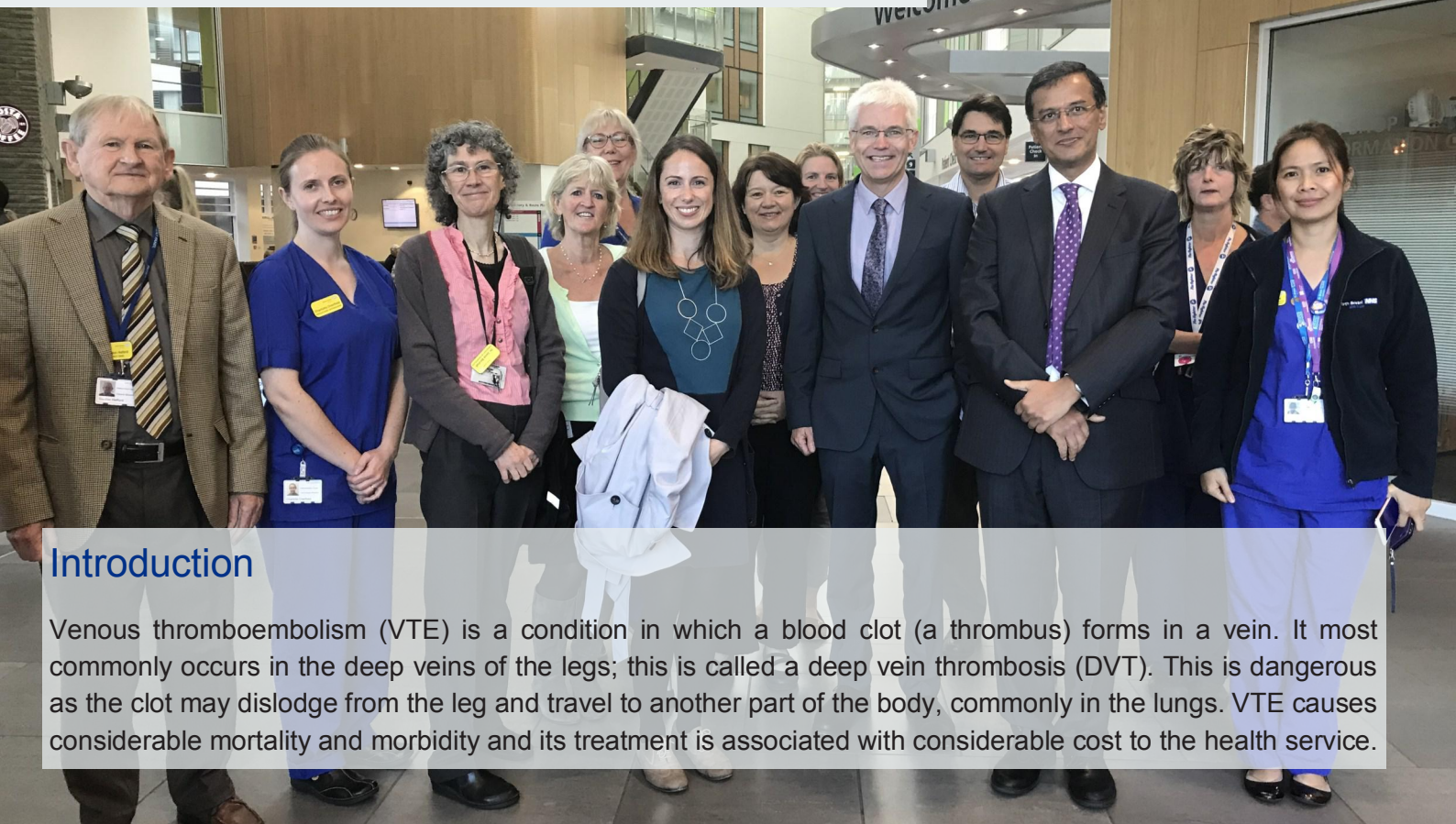
Actions that we have put into place following these reviews have been sharing learning via the infection control newsletter which highlights themes, and reviewing the

antimicrobial and cleaning policies. Part of this was to introduce a simple cleaning scale of red, amber, green to denote how thorough the cleaning needed to be; providing clarity of communication between the clinical team and the cleaning team while preserving the patient's confidentiality surrounding their illness.

MRSA and C.Difficile Infection Rates per 100 000 Bed Days 2017/18



3.3 Venous Thromboembolism (VTE)



Introduction

Venous thromboembolism (VTE) is a condition in which a blood clot (a thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called a deep vein thrombosis (DVT). This is dangerous as the clot may dislodge from the leg and travel to another part of the body, commonly in the lungs. VTE causes considerable mortality and morbidity and its treatment is associated with considerable cost to the health service.

A significant proportion of VTE events are related to a recent hospital admission and are potentially preventable. The risk of developing VTE depends on the condition and/or procedure for which the patient is admitted, and on any predisposing risk factors.

What did we do?

We have followed recommendations by the National Institute for Health and Clinical Excellence (NICE) and introduced risk assessment for patients on admission to identify those at increased risk of VTE. Our target is to risk assess 95% of patients and provide appropriate thromboprophylaxis (measures to reduce the risk of developing VTE) to at least 90% of patients. Monitoring of this via a rolling continuous audit has shown that we are

consistently achieving these targets.

In order to learn from the cases where a thrombus has occurred in hospital, we aim to perform a root cause analysis (RCA) on as many identified cases as possible. A root cause analysis is an investigation which aims to find the underlying causes of an incident and then addresses those issues to prevent it happening again. We performed an RCA on 66% of cases in 2017/18, identified several learning themes, and have implemented changes to improve practice.

What difference did it make?

After several years of



VTE Exemplar Centres
Providing leadership in thrombosis care

sustained work improving VTE processes of care by the Thrombosis Committee, we applied for National VTE Exemplar status; a visiting delegation from Kings College London (VTE Exemplar Lead Centre) formally assessed NBT and awarded us VTE Exemplar status, one of only 27 trusts at the current time to have this status. We are very proud of this award which can give our patients great confidence in VTE prevention at the Trust.

What next?

We are planning to build on this award and continue to sharpen our processes for VTE prevention and case

identification in order to further improve our care and to keep the incidence of hospital acquired VTE as low as possible.

also to achieve our target of formally training 95% of our clinical staff in methods of VTE prevention.

We will focus on giving patients high-quality information in relation to VTE prevention, and

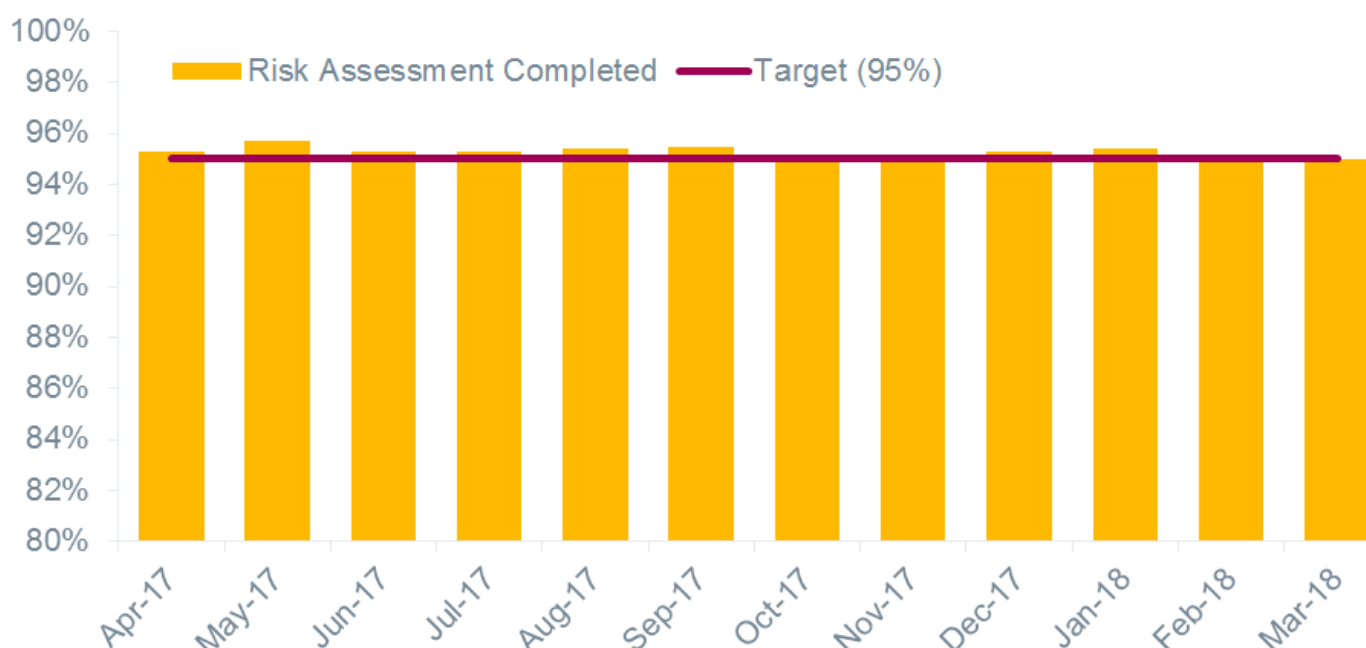
Improvement in Action

A team from King's College London (the first VTE Exemplar Centre) led by Professor Roopen Arya (National Lead, VTE Exemplar Network) has awarded NBT Exemplar status for our work in VTE. We are one of only 27 trusts in the country to have been awarded this status and it is the culmination of 10 years of work since the NBT Thrombosis Committee, chaired by Dr Jason Kendall, was formed.

The recognition evidences high quality performance in VTE prevention, diagnosis and treatment and Professor Roopen commended our work. Effective management of VTE saves lives, supports speedy recovery and prevents complications. It is a significant step forward in NBT's ambition to be one of the safest hospitals in England.



VTE Risk Assessment Completion



3.4 Medicines Management

Introduction

Pharmacy at NBT is responsible for ensuring that all patients receive their correct medication, on time, and in the form that is appropriate for their care. This includes medications given during their inpatient stay, as well as the medications they are sent home with. Pharmacy also manages any medications patients bring in to hospital with them.

What did we do?

During 2017/18 we received national recognition for our work in supporting rheumatology patients with their medication. This included a cost-saving exercise and the development of a new patient pathway so that their medication is managed in the same way across the region. This work has helped to ensure patients are receiving appropriate medication, but also saves the NHS money. Because the good practice has been shared across the region this ensures that all patients benefit.

This year we introduced an electronic prescribing system for chemotherapy. This makes the prescribing of chemotherapy much safer for our patients,; since it is automated there is less chance of human error.

We have really focused on reducing our waste, not only for the environmental benefits, but for the financial benefits as well. This has included reviewing and improving the way medicines are stored on the wards. With the development of the role of Pharmacy Assistants in clinical teams we have more of a presence on the wards to manage patients' drugs and check they are being stored correctly.

We have also directed extra manpower to sort through medicines that have historically been kept on the wards for long periods of time. Any medicines that are suitable for reuse are returned and sent to wards that need them, instead of being disposed of.

Our work with pre-operation assessment clinics means that we see patients before they

come into hospital for their operations and consider any potential issues they might encounter with stopping their regular medication, or starting a new one. By seeing them before their procedures we are able to ensure patients' drug charts are written up before they come into hospital so they do not miss any doses.

We continue to deliver prescriptions for take-home medications to the Emergency Department within one hour. Although the time for take home medications is around two hours for the rest of the organisation this is due to the increased number of patients we are seeing throughout the Trust, and we are working to improve this.

What next?

Over the next year we aim to have completed the full roll out of the Chemocare system to maximise the safety benefits it provides to the prescribing of chemotherapy.

We are also looking forward to the replacement of the HP Pharmacy computer system (now 30 years old) with a modern system with greater functionality.

We will be bidding for available

national funding to implement full Electronic Prescribing and Medicines Administration (EPMA) within the Trust.

We will continue to engage with colleagues and organisations across Bristol, North Somerset, and South Gloucestershire with the Sustainable Transformation Plan (STP) projects such as Polypharmacy, Compliance devices and Pharmaoutcomes.

Finally, we will continue our ongoing review of the services we provide to the Trust to ensure that the Pharmacy Department continues to provide a timely, safe and efficient service to our patients. In particular we are hoping to increase our presence at ward level at the weekends, and to develop medicines governance processes and strategy to further improve the safe and effective use of medicines within NBT.

Improvement in Action

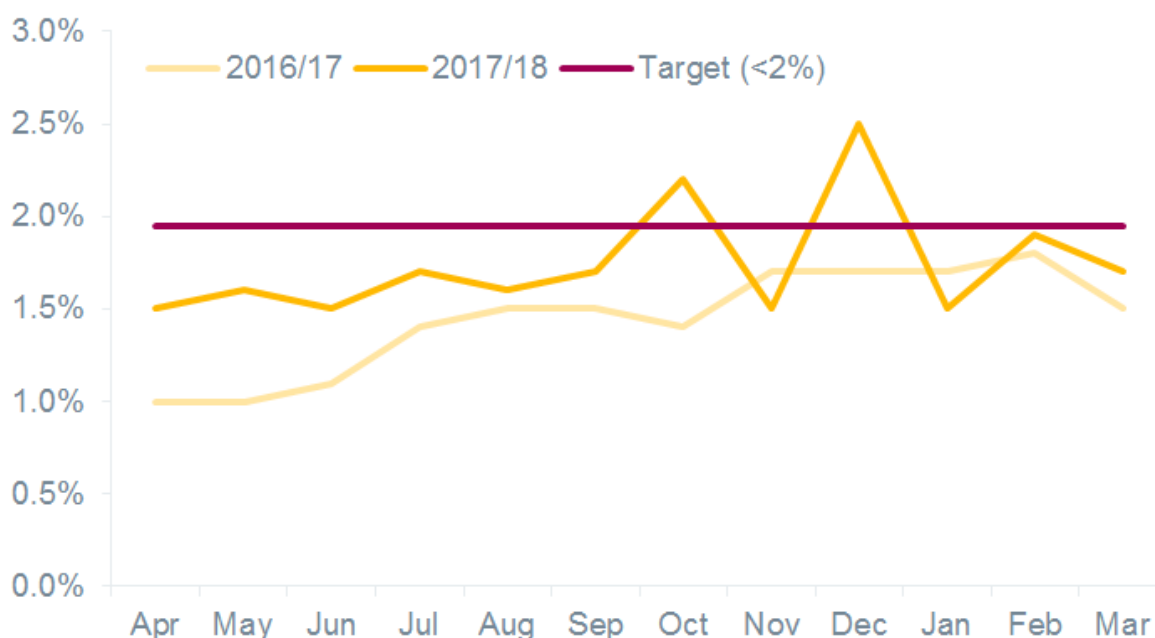
The increase in hospital admissions in the winter is a national problem, and to support the additional pressure on NBT the pharmacy extended its service at the weekends. This was done entirely through pharmacy staff volunteering their time at weekends. It

meant that we could provide medicines for patients to take home, meaning people could be discharged easier on weekends, freeing up beds for incoming patients.

These services were extended through the winter until January.

We also worked with a provider of pill boxes (dosette boxes) to extend their service to the weekends to enable patients to have their medication sorted and organised to help them take the right medication at the right times at home.

Percentage of Patients with One or More Missed Dose of a Prescribed Medication



3.5 Screening for and Treating Alcohol Related Conditions



Introduction

It is thought that a quarter of adults in England drink a dangerous or harmful amount of alcohol. The most recent evidence from 2009 states that 15,000 deaths are thought to have been in some part because of drinking alcohol (NICE, 2012).

Finding out who is drinking at harmful or dangerous levels helps us to give the right information, help and support to patients to make informed choices about their health. In the Trust we use a 3 question screening test to see which patients would benefit from information, or help, around their alcohol use. This is called Audit C.

Audit C also helps us find people who may be drinking dependently so that we can manage their detoxification, reduce the risk of brain damage from alcohol by giving injections of vitamins whilst they are in hospital, and continuing prescriptions of vitamins on discharge. We also make sure GPs know who we have seen so they can continue to support patients when they are discharged.

What did we do?

We have put Audit C into all of our Trust medical proformas so all patients are asked these 3 questions by the doctor who first sees them in hospital. After the 3 questions the patients are given a score and we have a clear pathway for treatment or intervention depending on their level.

We have implemented a training programme for doctors to make them aware how important alcohol screening is, and a training pack for all staff on how to manage alcohol withdrawal.

We have also made a range of health promotion leaflets for patients to empower them to take control of their condition.

What difference did it make?

We have been monitoring the uptake of alcohol screening for medical admissions. We found that 86% of patients were asked about their drinking. All of the patients who had a positive score on their Audit C questions got appropriate information and/or support in line with the pathway.

846 doctors have completed the online training, and, since its launch in September 2017, 414 staff members have finished online alcohol withdrawal training.

Now that we are looking closely for alcohol use, we have seen a large increase in the number of people the alcohol team are being asked to see. This has increased from 1,423 patients in

2016/2017 to 1,827 patients in 2017/2018.

What next?

Our forward plan is to carry on training staff to give brief interventions to patients who are drinking at dangerous levels so that the alcohol team can focus on more complex patients and those patients being seen via outpatient

clinics.

The team has more referrals than it can see so increasing the capacity of the team is very important. One way the team could support patients on discharge is to set up a Self-Management and Recovery Training (SMART) support group in the Trust.

We will continue to work Trustwide to reduce the impact

of alcohol on patients' health, and to use all opportunities to talk about safe alcohol drinking and improving health.

Improvement in Action

Every quarter the Alcohol Team hold an Alcohol Awareness event in the main hospital atrium. Each event focuses on a different theme. Past themes have included 'Dry January' and 'Supporting Families'.

The events are open to all, both members of the public and staff, and to those

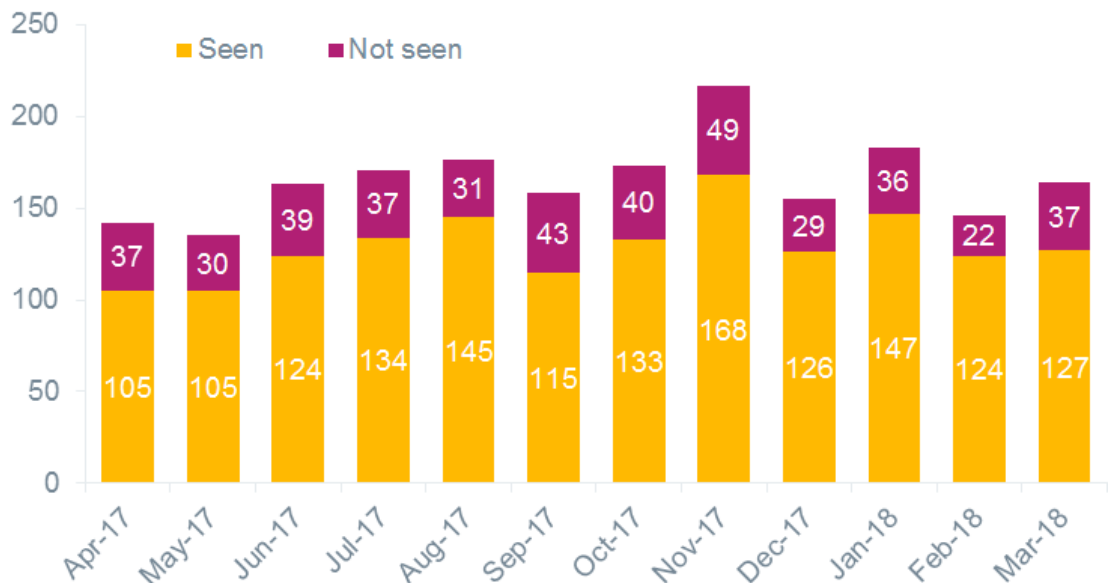
concerned about their drinking, or a loved one's drinking.

The aim is to raise awareness around harmful or potentially harmful levels of drinking, and to encourage conversations between patients and staff, as well as patients and their families and loved ones. Already these events have

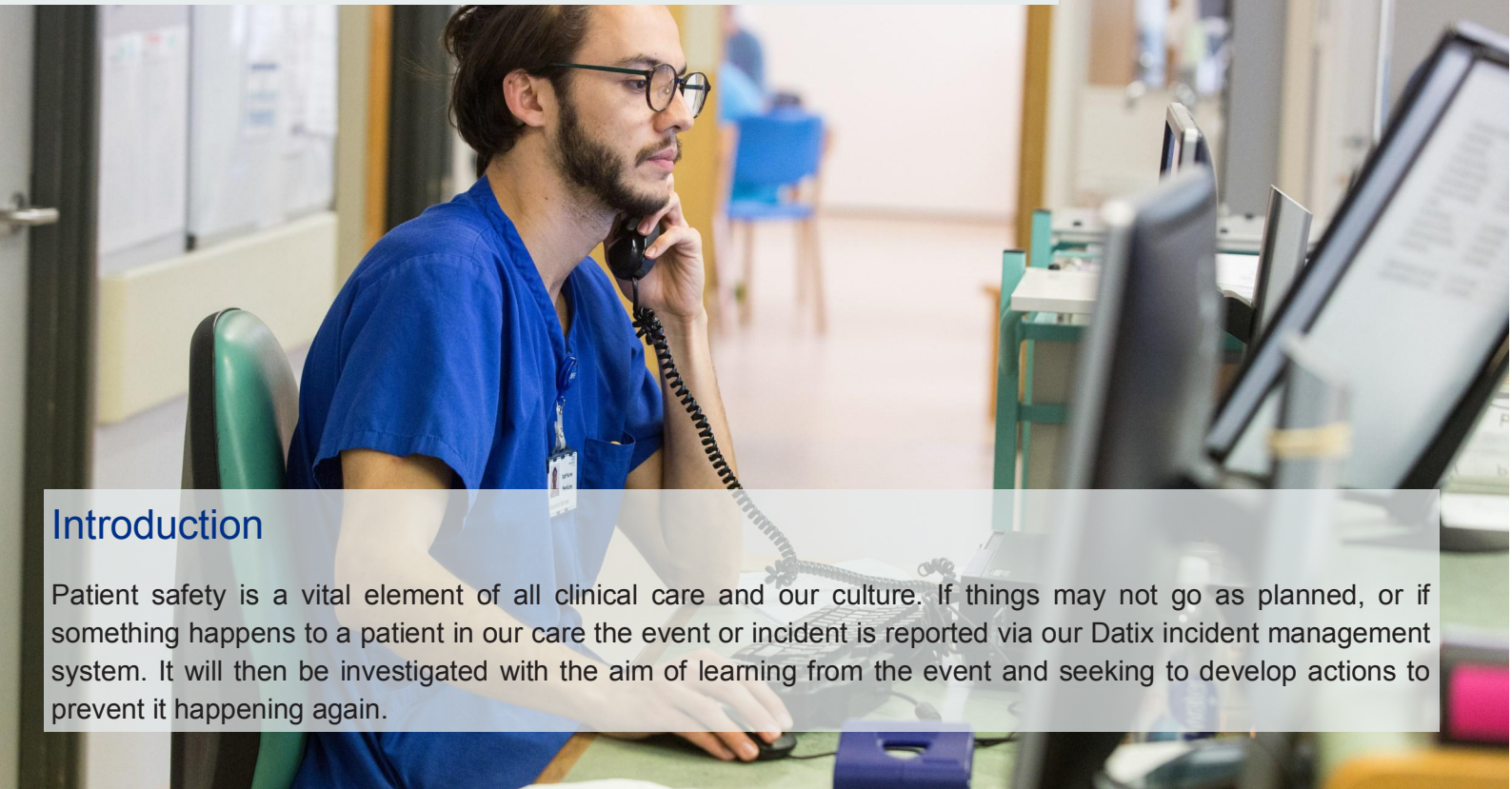
yielded positive results, with some patients saying it gave them the boost to cut down on their levels of drinking.

Number of Referrals to the Alcohol Liaison Service 2017/18

Number of referrals seen and not seen before the patient left hospital for 2017/18



3.6 Managing Patient Safety Incidents and Duty of Candour



Introduction

Patient safety is a vital element of all clinical care and our culture. If things may not go as planned, or if something happens to a patient in our care the event or incident is reported via our Datix incident management system. It will then be investigated with the aim of learning from the event and seeking to develop actions to prevent it happening again.

The patient will also receive an apology if appropriate, and this is part of our 'being open' approach. In some circumstances a detailed investigation may be required and we have a requirement to tell patients and update them on the investigation's progress and outcome. This is our 'Duty of Candour'.

This openness and investigations are all important elements in our aims to protect our patients and maintain our high quality clinical standards.

What did we do?

During the year the following actions have been implemented:

Weekly Executive Incident Review—this provides thematic oversight and a point of escalation/decision making for

declaring serious incidents for external reporting.

Weekly Clinical Risk Committee Working Group—Central team and divisional risk leads working together to improve the systems, processes and relationships that engender more effective and timely serious incident reporting and actions. This includes a forward look at incident investigation completion dates and the sharing of ideas, and clear allocation of responsibilities for complex/joint investigations.

What difference did it make?

It is exciting to see the increase in incident reporting across the Trust. This increase reflects the growing awareness of staff around reporting incidents regardless of any harm taking

place. It also reflects the introduction of Datix and similar reporting through the new system.

It is well understood that organisation with a good safety culture have high reporting levels and greater staff engagement in reporting any incidents they witness.

It is pleasing to note that the bulk of incidents reported had had no harm for patients and less than 1% of incidents resulted in serious harm. NBT continues to work hard to learn from all of these incidents and to introduce changes and improvement to enhance the safety and quality of care we offer.

What next?

Late 2018 will see new national guidance on serious incident

investigation being launched and the Trust is gearing its processes, tools and systems up ready for their introduction.

Specific work will include: Training Development—Root Cause Analysis (Incident Investigation) training is being reviewed and updated. NBT want to develop a team of in-house experts who can help clinical teams in their investigations. This is being addressed initially through the

commissioning of an onsite ‘train the trainer’ day, available to two staff within each clinical division plus five centrally in July 2018.

Electronic Training Packages—will be developed in house drawing upon existing expertise and national guidance. These will help underpin wider staff awareness and training needs.

Policy Updates—the serious incident, incident reporting and being open policies have been reviewed taking account of all of the above, and updated versions approved. The next key area of work is the update of the Duty of Candour Policy.

Commissioner Engagement—A more proactive approach with the commissioners has been developed to ensure that the quality of investigations is of a higher standard.

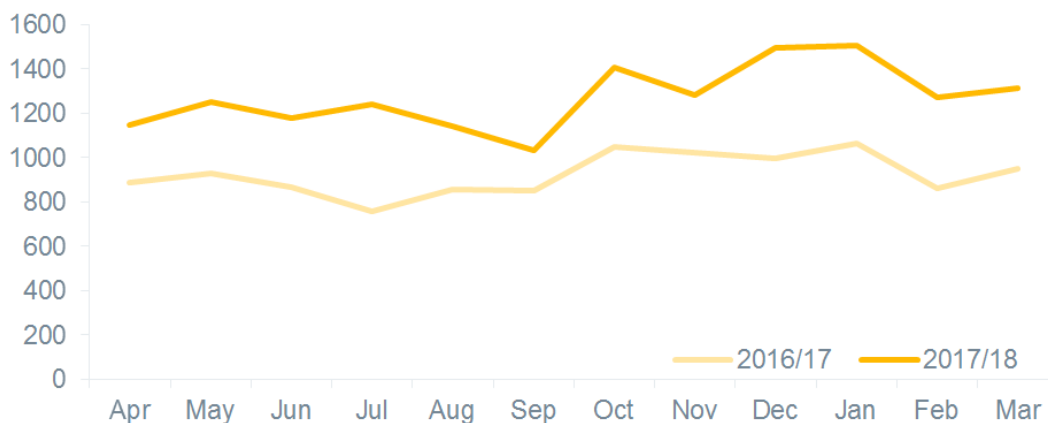
Improvement in Action

During 2017/18 a new reporting system—Datix—was introduced. This has required a complete review of the incident reporting policy and process to ensure that the system reflects, and is able to report upon, the key process measures and track actions.

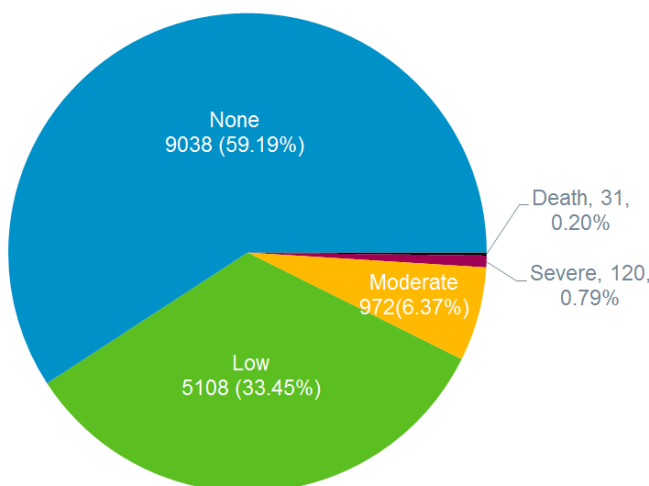
This is already driving increased overall incident reporting since the system is a lot easier to use, and greater transparency of how the key steps in the process are progressed. Examples of this include a review of incidents within 48 hours by the risk

manager for that area, better processes around the declaration of potential serious incidents and improved scrutiny of root cause analysis reporting (the method used to investigate serious incidents).

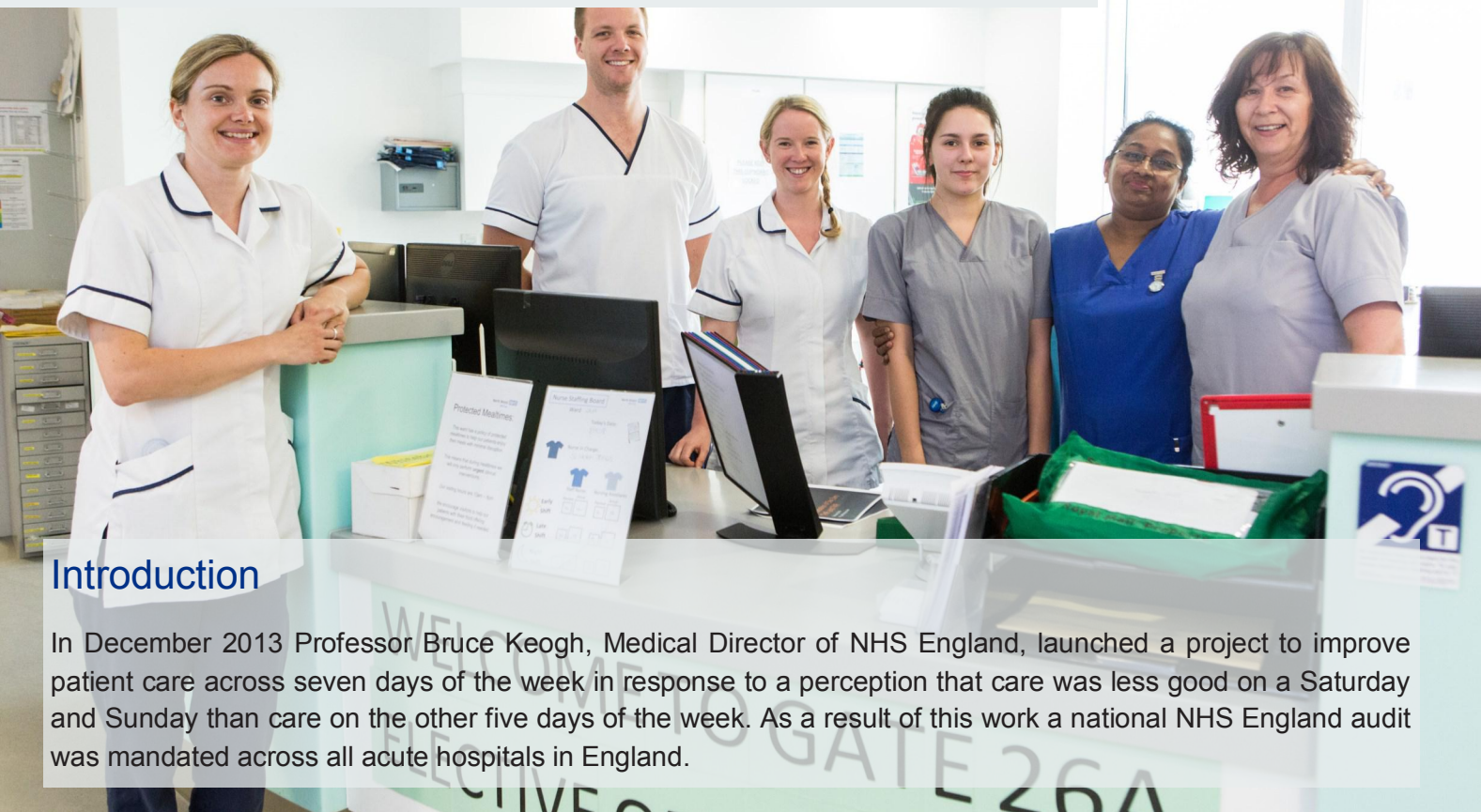
Total Reported Patient Safety Incidents 2016/17 Vs. 2017/18



Severity of Patient Safety Incidents, April 17 to March 18



3.7 Seven Day Working—National Standards



Introduction

In December 2013 Professor Bruce Keogh, Medical Director of NHS England, launched a project to improve patient care across seven days of the week in response to a perception that care was less good on a Saturday and Sunday than care on the other five days of the week. As a result of this work a national NHS England audit was mandated across all acute hospitals in England.

This biannual audit reviews the care of a random sample of the patients who are admitted as emergencies during a defined week in spring and autumn. It looks in particular at the most important and relevant four of the original ten clinical standards. These four are:

- Standard 2: time to first consultant review
- Standard 5: access to diagnostics
- Standard 6: access to consultant led interventions
- Standard 8: access to twice daily review for patients with high dependency needs.

What did we do?

NBT has carried out a seven day services review now on five occasions: March 2016,

September 2016, April 2017, September 2017 and April 2018. The next audit will take place in April 2018 and NBT will audit the care of patients during the week 11-18 April.

The audit team at NBT, together with the clinical teams, have continued to improve our data collection to be sure we really understand the service and care we are offering patients. Our results have shown that care of patients across the week at NBT is consistent and this is reflected in our outcomes being as good for patients who come in to the hospital over the weekend as it is for patients who come in during the week. As a consequence of these results NBT is regarded as an exemplar site but we have further to go in making sure our data collection is as accurate as possible. For our next review we

are strengthening clinical input so we know our results will be as accurate as possible.

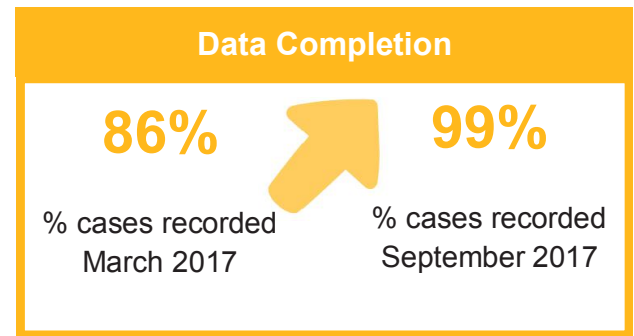
Through medical job planning and supporting junior doctor rotas we continue to work towards being a truly seven day hospital.

What difference did it make?

The results from the September 2017 audit were less good for twice daily review (standard 8) than before, and less good than we had hoped they would be. As a result, we are increasing our engagement with senior doctors across the hospital so they understand the audit is taking place, what it means for patients and how they can help and support accurate data collection.

What next?

We continue to work with senior doctors and nurses as well as with our colleagues in the governance and audit team to improve our collection of data. Once more of our patients' information is collected electronically we expect this to be easier and more accurate.



Improvement in Action

During 2017/18 we have continued to place an emphasis on embedding the data collection for this project into the specialties.

Previously during the first iterations of this audit data was collected centrally and it was difficult to maintain a complete data set due to the challenges associated with

tracking patients through the hospital.

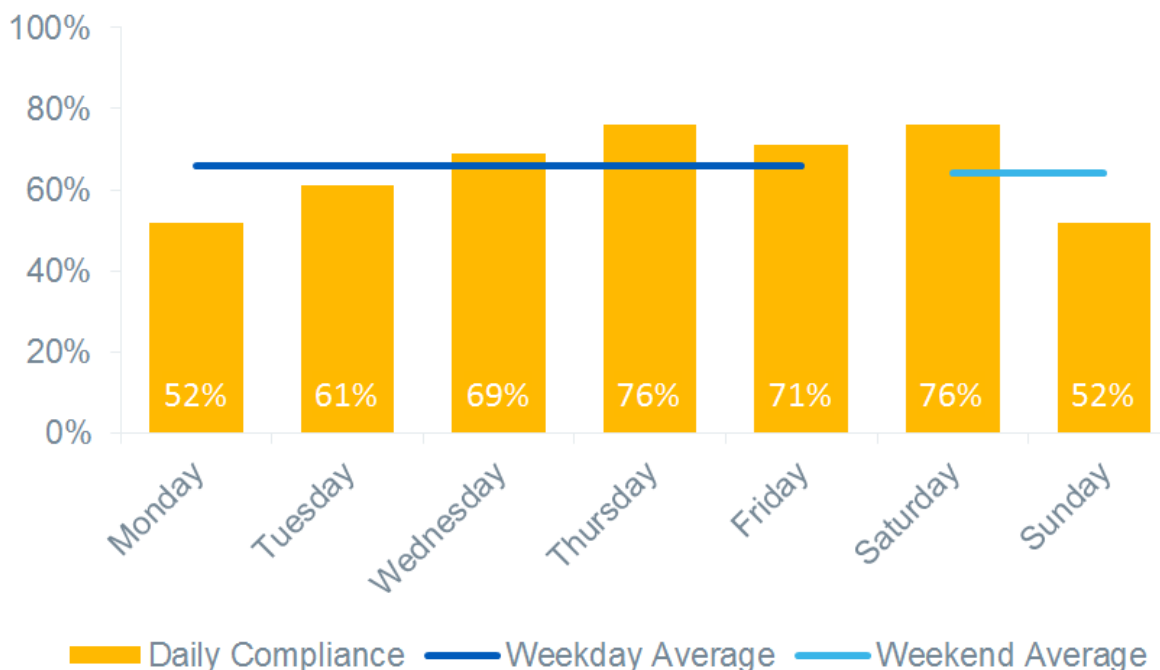
We can achieve a more complete dataset if patients' data is entered prospectively, however this means ensuring that specialty staff have the time, resources and support to be able to take on this task on top of their daily duties without compromising patient care.

We rolled-out a Trustwide training programme to educate staff on data entry, tracking patients, and the information required for the audit.

We put in place divisional coordinators to champion the audit and disseminate information among the specialties.

Patients Receiving a Consultant Review within 14 hours of Admission

Compliance to Clinical Standard 2: All emergency admissions must be seen, and have a thorough clinical assessment by a suitable consultant within 14hrs from the time of admission to hospital



4.1 Involvement of Patients and the Public



Introduction

Patients and the wider public are an integral part of the Southmead Hospital community. Without the input, contribution, and volunteering of our community it would be impossible to provide the standard of care that we do, or improve on our services without the insight from our patient experts and community members.

What did we do?

During 2017/18 we worked to link with the Deaf community. We recognised that we weren't as inclusive or as helpful as we could be for those patients or families who are members of the Deaf community. We endeavoured to improve our services and access to them. This involved planning for the provision of British Sign Language interpreters and flags on the hospital computer system to ensure that Deaf patients have the correct support arranged.

We have been involved in setting up the Healthcare Change Makers forum in conjunction with Bristol

Community Health and University Hospitals Bristol NHS Foundation Trust. The Healthcare Change Makers are specially trained members of the public whose insight is invaluable when planning change to improve healthcare. They also review and scrutinise proposed changes from a patient perspective, ensuring that healthcare decisions aren't just made by professionals but really take into account the patient voice.

We are very privileged to have such dedicated volunteers supporting us. They contribute so much to the patient experience through the incredible work they do.

What difference did you make?

With the help of patients and the public there have been some great achievements during the last year that really improve the care we offer to our patients.

Pets as Therapy (PAT) has been a welcome addition to North Bristol NHS Trust. A group of volunteer therapy dogs, and their owners, regularly visit wards in Southmead Hospital and Elgar House to lift the spirits of patients and aid recovery. They work well with dementia patients as they can stimulate memories, and can be a great comfort in



end of life situations.

The Southmead Hospital League of Friends celebrated its 40th anniversary in 2017.



The League of Friends volunteers run a coffee shop in the Brunel building and all proceeds go towards the hospital. In 2017 this meant the purchasing of a new birthing pool for the Mendip Birth Centre. The benefits of a water birth include relaxation, pain relief, less use of drugs and a quicker labour. The suite was named after two of the

founders of the League of Friends, the late Norman and Margaret Goldsworthy in honour of the charity's contribution. The new birthing pool was added to the suite to help improve the birth experience for more women in the midwife-led birth centre at Southmead Hospital

Also in February 2018 the League of Friends provided the

Improvement in Action

A new surgical robot was purchased for the Urology Department in January 2018 by Southmead Hospital Charity. This is a replacement for the original robot, which was acquired by the Trust in 2009 to treat men with prostate cancer, and has seen Southmead Hospital become a Centre of Excellence for robotic surgery. Southmead

Hospital Charity launched its Prostate Cancer Care Appeal in 2016 to fund two new robots for the department so that more men can benefit from robotic surgery to remove their prostate, which is less invasive than traditional open surgery. Fundraising continues for the second robot with Southmead Hospital Charity hoping to raise a



further £750,000 over the coming year. It is hoped that two new surgical robots will enable the Urological Department to expand surgery to benefit patients with other types of cancers.

funding for a new bariatric ambulance to transfer patients around the site that require extra support. The ambulance will also transport women in labour from the maternity unit to the emergency theatre.

With thanks to their donors the Southmead Hospital Charity were able to buy a supply of 46 wheelchairs for use across the hospital. This will help staff to move patients around easier.

We are always grateful for the charitable donations we

receive from members of the public and patients. It is inspiring to see the lengths people will go to, including running marathons, and climbing mountains to raise money for the hospital.

One such former patient Mr Martin Ashmore raised £1,300 for the Intensive Care Unit during 2017 by organising a raffle with local business owners in Hanham, and Mr Andrew Griffiths ran the Bristol half marathon in September for the League of Friends raising £200.

The Bristol Sands charity raised over £14,000 for the refurbishment of the bereavement suite at the maternity unit. This is a dedicated space for women

whose babies are lost either before, during, or shortly after birth so that they can give birth to their baby and spend time with them.

What next?

We have plans to continue engaging with the community to provide better care, tailored to our patients' needs.

One of the things we are hoping to expand next year is training professionals who have close contact with their clients' skin such as body piercers, acupuncturists and massage therapists to learn about the signs of skin cancer at free information sessions in the hope they can advise their clients to see their GP if they notice a mole is suspicious.



4.2 Involving Our Board in Staff and Patient Experience



Introduction

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



Putting patients first



Recognising the person



Striving for excellence



Working well together

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 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). 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.

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.

What did we do?

During 2017-18 a concerted effort has been made to increase the commitment to these walkrounds, recognising that board visibility and understanding of how both frontline clinical services and also back office support services are delivered. This is reflected in the increased overall numbers.



These walkrounds have taken place across a range of services including maternity services, our head injury therapy unit, theatres, interventional radiology, The Emergency Department, pathology services, catering services, mortuary, portering, breast care, informatics, the Enablement Centre and many more specialties and inpatient areas.

What difference did it make?

There has been a substantial increase in the overall numbers of executive and non-executive walkrounds when compared with previous years. This also means that both execs and non-exec's are able to see a wider-range of working within the hospital.

What next?

We will review the way the walkrounds are conducted during 2018/19 to evaluate the benefits for board members and staff receiving the visits, which will in turn inform the ongoing approach.

Improvement in Action

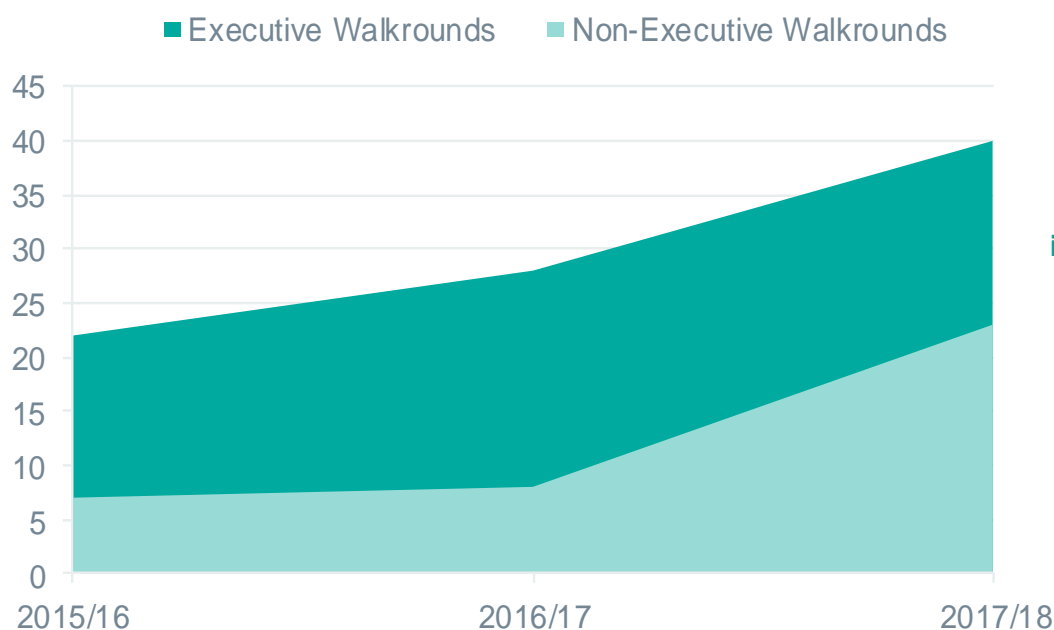
The importance of the walkrounds was highlighted during a recent visit to the Emergency Department. A Non-Executive walkround was scheduled off the back of a particularly challenging 48 hours in the Department and it allowed the Service Leads to provide valuable feedback on where improvements could be made within the

Department, and how to plan and prevent these circumstances from happening in the future.

It was identified during this walkround, that there aren't any formal processes in place for staff to debrief and reflect after a particularly difficult period within their Department. This was noted

as an action and fed-back to the Trust Executive Team who have agreed the necessity of a process that will allow Teams to reflect on what worked well and how to improve and learn during times of immense pressure. This is being actioned through the QRMC and will be a valuable process when it is in place.

Numbers of Executive and Non-Executive Walkrounds 2015/16—2017/18



4.3 Staff Survey Questions



Introduction

The Annual Staff Survey measures how our staff feel about the experience they have while at work. This is important to patient care because there is a well established link between quality of care, and how staff feel about their work: the better the staff experience, the better the patient experience.

The staff survey asks a range of questions that we can use to identify areas of potential improvement, and good practice, both at the Trust-wide and divisional levels. We can then target changes to improve things for staff, and ultimately improve the patient experience.

What did we do?

Last year we identified two areas of priority: staff engagement and staff health and wellbeing.

Staff Engagement

This is a vital measurement in the survey it tells us about our staff's commitment to making the Trust a great place to work and be cared for. Over the last 12 months we have made more opportunities to encourage staff to have their say and to listen to them. This includes creating "Time to Talk" sessions where senior managers take part in frontline team meetings; undertaken a large scale Winter Review listening exercise; and continued the roll out of our "Happy App" across the hospital.

Staff Health and Wellbeing

We have introduced a range of wellbeing initiatives this year, including Schwartz Rounds (a

confidential space where staff from all areas of the Trust can come together to reflect on the emotional impact that our work has upon us)

Physio Direct (direct access to physio telephone consultation and treatment to help staff remain in work)

Mindfulness drop in sessions

Improve your sleep courses

Mood and food groups (enabling healthy eating)

Mental Health First Aid training (run by Mind)

What difference did it make?

Survey Response Rate

3703 staff took part in the 2017 survey. This is a response rate of 46%, above average for acute trusts in England. This is a very positive sign: that staff wish to have their say and are

willing and empowered to take the time to do so.

Survey Findings

Overall the survey shows a similar picture to last year, but with some pockets of improvement. An increasing number of staff said they are proud of the work they do at NBT. Where we fell short, the gap has closed between our results and those in other trusts. Staff engagement levels increased very slightly, in the context of what has been a very challenging year. However, there was a clear message about increasing stress in the workplace and more support being required.

What next?

We have looked at the Trust's results and identified five priority areas of action:

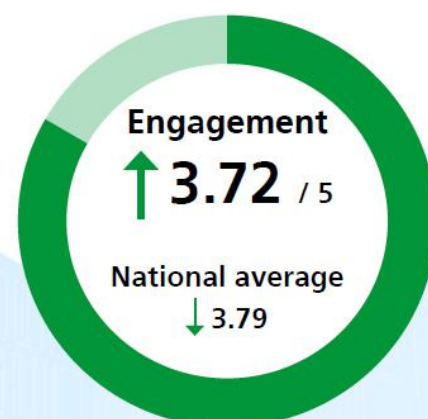
Staff Health and Wellbeing This continues to be a priority from last year. We are committed to maintaining the programmes that we have in place, and will be introducing new interventions and ensuring that all areas of our workforce are aware of and can access the wide range of support that we have in place.

Communications and Engagement This also continues to be a priority from last year. We will look at how we can be innovative, for example with greater use of Happy App. We will ensure that staff feel valued by the Trust for the work they do, say thank you more, and improve communication from senior managers.

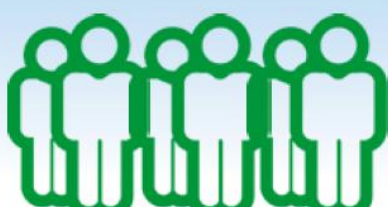
Management and Leadership Development Whilst the majority of scores relating to managers increased positively this year, staff said that there is more we need to do to support managers in their development. We are introducing new development programmes for Matrons, Assistant General Managers, and Specialty Leads. We will be adding to these later this year, by introducing a new set of programmes particularly for middle and first line managers.

Mandatory Training Mandatory and Statutory Training is the basic training that staff need to do their jobs. We are beginning a review of this, working with our partners in other local acute trusts. We are regularly monitoring our completion rates and we are making this training more available and easier to access.

Workload and Resources This is clearly a challenging time for acute Trusts such as ours, and NBT's mix of complex regional specialties and increasing demand mean that we have had significant challenges this year in providing safe care. This will not be an easy or simple fix but we are determined to face this challenge head-on. We asked staff what they think we can do to plan for a better winter next year, and have put actions in place to address this. We are just launching a major programme to improve Patient Flow through the hospital improving the patient experience and making sure they spend less time in hospital and more time at home. To help with this there will be an intensive investment in staff to put them in control of the way they care for patients.



Strengths



We are proud of the standard of care we provide

"If a friend or relative needed treatment I would be happy with the quality of care we deliver"

↑ 6% since 2016
 from 65% to 71%

NBT is a safe, respectful and inclusive place to work

In 11 questions about violence, bullying and discrimination

+ 5 = 4 - 2
 we're better we're the same we're lower
 ...than the national average

4.4 Friends and Family Test



Introduction

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.

We collect this data in a variety of ways, mainly through SMS texting or interactive voice messaging. We do also use some FFT survey cards

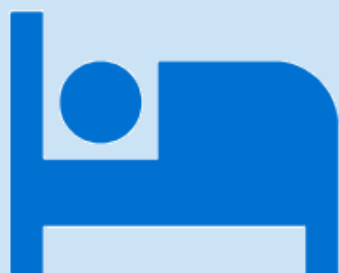
throughout the hospital in areas where patients would prefer to use this method to provide their feedback. The survey is completely anonymous and provides patients with choice to opt out of doing the survey.

Response Rate

Our response rate fell below the nation targets for a number of reasons. Firstly due to the automated nature of the survey, staff stopped inviting patients to give feedback. Secondly, survey fatigue protection was extended to manage the budget spend assigned to FFT. This is a system to prevent patients becoming disgruntled by being surveyed too frequently. Also, a large number of feedback opportunities could not be sent due to missing or incorrect patient telephone numbers being streamed to the managed service provider.

What next?

We will begin by celebrating International Patient Experience Week (April 2018) with a focus on improving the use of FFT feedback to celebrate excellent experiences of care improvement wherever we can. We will be helping staff improve the use of the near time feedback in use of the system, skills, engagement and improvements over the coming year. As well as maximising the use of the FFT system to enable auto alerts, improved use of reports to drive actions and change. Promote the feedback opportunity to patients through a number of different channels patients use to feedback. We also plan to publish a Standard Operating Procedure laying out clear processes, expectations and responsibilities in relation to the FFT survey.

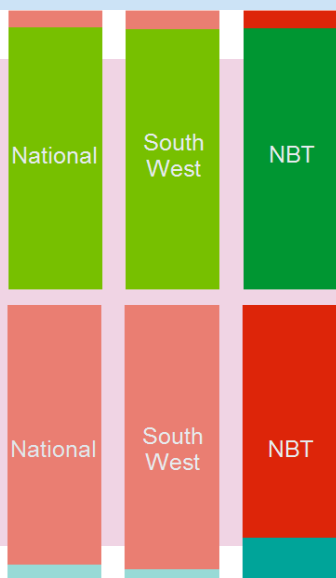


92% of our **inpatients** would recommend us to friends and family.

This is compared with 96% in the region, and 96% nationally.

Our response rate is at **20%**.

This is compared with 21% in the region, and 25% nationally.



94% of our **outpatients** would recommend us to friends and family.

This is compared with 93% in the region, and 94% nationally.

Our response rate is at **16%**.

This is compared with 4% in the region, and 6% nationally.

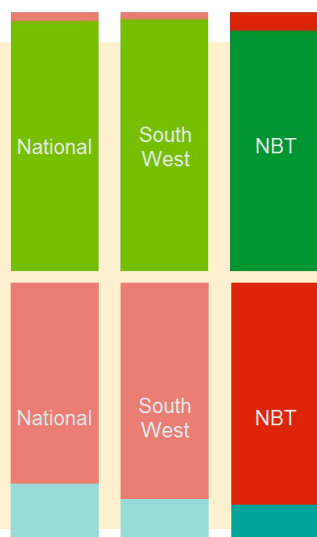
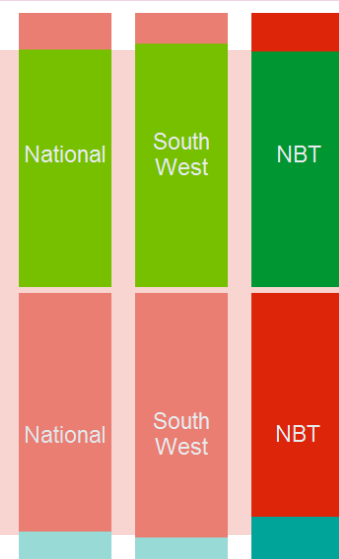


86% of our **emergency department attendances** would recommend us to friends and family.

This is compared with 89% in the region, and 86% nationally.

Our response rate is at **18%**.

This is compared with 11% in the region, and 13% nationally.



93% of our **maternity patients** would recommend us to friends and family.

This is compared with 97% in the region, and 96% nationally.

Our response rate is at **15%**.

This is compared with 17% in the region, and 23% nationally.



4.5 Managing Complaints

Complaints

Overall the number of formal complaints reduced by approximately 9% in 2017/18, from the figure recorded last year (2016/17), which also saw a reduction in the number of complaints on 2015/2016 when many issues arose from the still ongoing redevelopment of Southmead.

In 2016/17 the numbers of complaints where response timeframes were not met also fell significantly on 2015/16's performance; however in the last six months of 2017/18, this figure started to rise again due to the operational demands the Divisions experienced. Eradicating all overdue cases remains an important Trust objective and there is plan in place to do so. The Trust and CCG target of no more than 10 complaints overdue at the end of the month was met in the month of February 2018 and this rose slightly in March to sixteen.

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 August. The average overall compliance was 99.83%. During the year, ten cases remained unresolved over six months, which is an increase from four the previous year.

Activity levels

	2016/17	2017/18		Top 5 complaint themes	
Compliments	9,065	9,440	↗	1 All aspects of clinical treatment	42%
Complaints	654	592	↘	2 Communication	24%
Concerns	1,394	800	↘	3 Attitude of staff	8%
Enquiries	7,059	8,878	↗	4 Admission/discharge and transfer	5%
Response Time (within timescale)	77%	67%	↘	5 Delay/cancellation of Outpatient episode	4%
Local Resolution Meetings	86	96	↗		

Response timeframes

The Trust Board is committed to meeting the timeframe for responding to complaints outlined in its policy and the Clinical Commissioning Group performance target of no more than 10 overdue responses to complaints per month. The Complaints Team provide support to divisions to manage overdue complaints.

Number of Overdue Complaints 2017/18



Local Resolution Meetings

The number of local resolution meetings undertaken within the year were 96 which has increased from 86 in 2016/17. We encourage divisions 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 divisions to record and feedback lessons learned, which is then included as part of the response letter.

NHS Choices website feedback 4.5 out of 5

We respond to all postings and encourage people to contact us to address poor experience.

Audit of complaints by the Complaints Lay Review panel

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 anonymised complaints. This process allows patient representatives, who have been trained in reviewing these complaints against the *Patient Association Good Practice Standards for NHS Complaints Handling (2013)*, to give feedback for incorporation into the ongoing complaints improvement plan.

The panel continue to meet every two months and from their reviews, a number of recommendations were made, these include:

- Ensure there is early verbal/personal contact with the complainants agreeing the timescale

- Provide a named contact for the complainant

- Ensure the outcome wanted by the complainant is identified and managed accordingly

- Provide an update if there is likely to be a delay, providing another date and not leaving the timeframe open

- Ensure actions/next steps are clear in very letter

These recommendations will be incorporated into the review and update of the complaints policy and procedure which will be undertaken in 2018/19.

Service improvements implemented in 2017/18

During the year the Trust implemented a new Risk Management Software system (Datix) which contains a module to record patient feedback. This new system will improve the communication between staff when managing a complaint, as well as improving the systematic follow up and completion of actions following a complaints and enable key themes from concerns, complaints and compliments.

Improvement in Action

Following a meeting with a patient, a different pregnancy letter was created advising patients to undertake a repeat test the following day, alongside changes to how a negative test is communicated to patients in the ward environment to ensure privacy

and compassion at this difficult time

Following investigation of an complaint where a patient attended the fracture clinic on a weekend it was identified that staff are not necessarily aware of the process when dealing with patients who

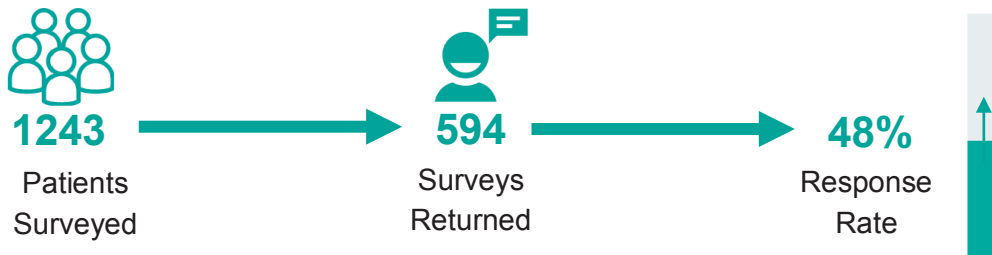
cancel their appointments in fracture clinic. In the future staff will ask the patient concerned to attend the next fracture clinic, usually the following day, due to the nature of the injuries these patients need to be seen within a fixed time frame

4.6 Responsiveness to Personal Needs— National Patient Survey Results in 2017/2018

Every year the NHS is required to participate in national surveys run by the Care Quality Commission (CQC). During 2017 national surveys were carried out with our Maternity Services users who delivered their babies in February 2017 and our inpatients during July 2017.




National Inpatient Survey

We received feedback from the 2017 survey in January 2018.





Results






The survey showed that we had improved in the following areas:

-  Providing information about a patient's condition or treatment in the A&E department
-  Waiting times to get a bed on the ward
-  Involving patients in decisions about care and treatment

The survey showed that we had significantly worse scores in the following area:

-  Being asked to give views on quality of care
-  Discharge delayed on the day

The survey showed that we had **significantly** improved in the following areas:

-  Giving patients enough privacy when being examined or treated in A&E
-  Ensuring patients are not bothered by noise at night from other patients on the wards
-  Increasing confidence and trust in doctors
-  Patients having enough privacy when discussing care or treatment
-  Patients being well looked after by non-clinical hospital staff

What we are doing to improve

We reviewed our results and created actions to improve in the areas that were identified to us through a working group of patients and staff.

We are creating resources to help frontline managers to understand the 'pulse' of their patients'

experiences and using the data from the Friends and Family Test (FFT) to drive and direct quality improvement projects by bringing continuous quality improvement methodology to patient experience feedback.




National Maternity Survey

We received feedback from the 2017 survey in September 2017.





Results

The survey showed that we had **significantly** improved in the following areas:

-  Involving partners enough during labour and birth
-  Involving mothers enough in decisions about care during labour and birth
-  Being able to have somebody close to stay as long as mothers wanted whilst in the postnatal ward

The survey showed that we had significantly worse scores in the following area:

-  Patients seeing their preferred midwife most of the time during antenatal care
-  Mothers being given enough information about their own recovery after the birth

What we are doing to improve

Maternity services have developed an action plan to address the issues highlighted by our patients, and to address other aspects of care that we think we could do better.

We've started by developing a Maternity App to provide information for expectant and new mothers. We hope this will make information a lot more easily accessible. We've made sure to include information for both baby and mother.

Focus Areas for Improvement

Antenatal care:

- Improving the opportunity to see the same midwife whenever possible
- Discussion of infant feeding during pregnancy

Post-natal care

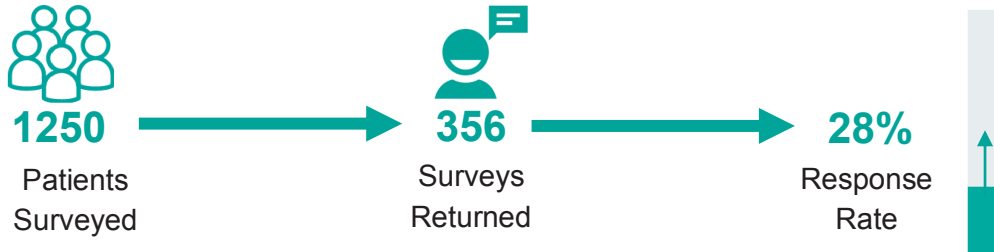
- Receiving consistent help and advice on breast feeding
- Encouragement and support for breast feeding
- Provision of information about emotional changes that may be experienced and recovery after the birth
- Being treated with kindness and respect
- Receiving help from staff within the reasonable time
- Having someone close to them to stay with them as long as possible

This improvement work is integrated into the improvement programme relating to Better Births: Improving Outcomes of Maternity Services in England. A five year forward view for maternity care 2015, NHS England.

4.6 Responsiveness to Personal Needs— National Patient Survey Results in 2017/2018

National Emergency Department Survey

We received feedback from the 2016 survey in 2017.



Results

The survey showed the following positive aspects of care:

- 87% rated care as 7 or more out of 10
- 87% felt they were treated with respect and dignity 'always'
- 85% always had confidence and trust in their doctors
- 99% said hospital rooms/wards were very or fairly clean
- 89% said they always had enough privacy when being examined or treated

The survey showed that compared to the 2014 survey, our Trust is:

Significantly **better** on 14 questions

Significantly **worse** on 0 questions

What we are doing to improve

Although our results were very positive for the 2016 Emergency Department survey we didn't want to be complacent. We created an action plan and enacted some improvements in order to improve our care further.

Although we are constantly looking to reduce our waiting times in the Emergency Department this is a wider issue within the NHS. What we could do was to improve the patient experience of

waiting. We want to make sure that patients are kept informed, their concerns are acknowledged and their levels of distress and anxiety are acknowledged and they are reassured.

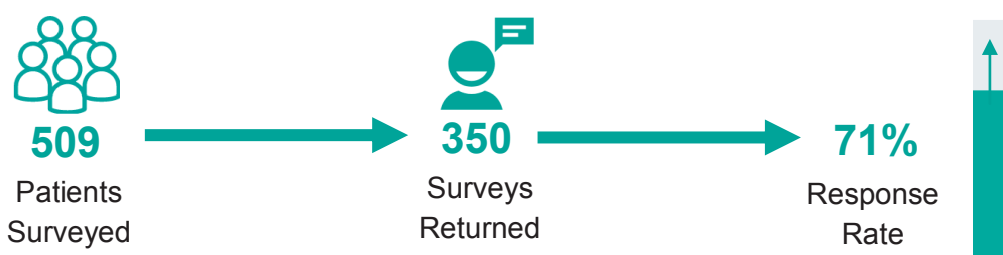
Part of this is ensuring we let patients know when their test results will be returned and how we will let them know. It's also important that as healthcare professionals we introduce ourselves to the patient and explain

our role (for example many patients expect to see a doctor, but this is not always the most appropriate professional to see).

We really want patients to play an active role in their care so we aim to never talk in front of them as if they are not there. We are also developing a guide to the Emergency Department for patients about what to expect for use in the department and on the website.

National Cancer Survey

We received feedback from the 2017 survey in September 2017.



Results

The survey showed following positive aspects of care:

- 👍 82% said that they were definitely involved as much as they wanted to be in decisions about their care
- 👍 94% said that they were given the name of a Clinical Nurse Specialist who would support them through their treatment
- 👍 84% said that it had been 'quite easy' or 'very easy' to contact their Clinical Nurse Specialist
- 👍 87% said that, overall they were always treated with dignity and respect while they were in hospital
- 👍 92% said that hospital staff told them who to contact if they were worried about their condition

Asked to rate their care on a scale of zero (very poor) to 10 (very good) respondents gave an average rating of 8.7



Teams now have a joint telephone to ensure patients can contact their Clinical Nurse Specialist. We are continuing to increase number of patients receiving a holistic needs assessment care plan giving patients an opportunity to identify any concerns they may have about a wide range of issues.

An area for improvement identified in the survey is

providing patients with opportunities to discuss worries or fears. We have introduced Cancer Support Workers to address this.

NBT has been successful in a bid to NHS England for transformation funding to help us improve the care and support we give for people living with and beyond cancer both in hospital and across the community. We have also received

funding from Macmillan Cancer Support to help us improve the psychological and physical needs of patients and address some of the issues associated with the long term consequences of cancer and treatments.

Both these programmes of work will involve evaluating the benefits and positive outcomes of the services.

What we are doing to improve

4.7 Improving Cancer Patient Experience



Introduction

We provide cancer services to a population of 500,000. We diagnose approximately 3,300 new cases of cancer and treat approximately 5,000 new and recurrent cancers each year, making it one of the largest cancer centres in the South West.

What did we do?

We ended 2016/17 meeting all but one of our cancer standards – two-week wait - however for much of this year we have maintained good performance in this area. We did see a slight deterioration in cancer waiting times in the final quarter of 2017/18 due to the pressures on our services during the busy winter months and a rise in demand. This year we have been invited to share our learning and present work at regional events for the Cancer Pathways Improvement Collaborative across the South West. The collaborative is an opportunity to share learning and present the improvement work we have been doing to deliver improvement systems to improve cancer waiting times.

We have seen continued success with the two-week wait for our Upper Gastrointestinal (GI) pathway that enables GPs to book a test or clinic appointment for patients with suspected upper GI cancer straight away. This reduces the time it takes for patients to undergo tests and receive their results and is being recognised as good practice by NHS Improvement and NHS England.

We are taking the lead for the region's implementation of the new prostate cancer pathway, for which we cover the whole of the South West. This has been supported by Southmead Hospital Charity's Prostate Cancer Care Appeal, which has purchased one new surgical robot, and continues to fundraise for a second, which will help us meet the demand for the service.

What difference did it make?

The National Cancer Patient Experience Survey showed that the experience of patients with cancer using our services improved compared to last year's results. This demonstrates that the improvements we have made, not only in cancer pathways but also in terms of our holistic support through the NGS Macmillan Wellbeing Centre and the recovery packages we provide, have improved the experience for our patients.



What next?

We will continue to work with our colleagues across the South West and strive to

maintain and improve our Cancer pathways on behalf of our patients and ensure they are referred to us and seen as quickly as possible.

Improvement in Action

The Bristol Sarcoma Service (BSS) cares for soft tissue sarcoma patients in Bristol and the surrounding region. The BSS is based across both North Bristol NHS Trust and University Hospitals Bristol.

Sarah Baker, from Bath, was diagnosed with sarcoma in May 2016.

Following an MRI scan, Sarah had a biopsy at Royal United Hospitals on her left calf, which was swollen and uncomfortable. This revealed

a malignant tumour that was deep in Sarah's calf, and extremely close to the main nerve that gives sensation to the sole of the foot.

After receiving 25 sessions of radiotherapy at the Bristol Haematology & Oncology Centre, Sarah came to Southmead Hospital in September 2016 to have an excision and plastic surgery on her calf.

After the successful surgery, Sarah has now been cancer-

free for a year. She will need to return to Southmead Hospital every three months for X-rays or CT scans, and receive MRI scans every six months for the next four years. Sarah will be receiving further reconstructive surgery over the next year.



National Cancer Patient Experience Survey Quick Stats



93%

of respondents said they were told who to contact if they were worried about their condition or treatment after leaving hospital.

94%

were given the name of a Clinical Nurse Specialist to support them through their treatment, above the national average.

93%

were given enough privacy when discussing their condition or treatment, above the national average.

4.8 Dementia Care

Introduction

The care of people with dementia is a growing concern in healthcare. As the age of the general population rises there are going to be more patients in hospital who require specialised care due to being affected by dementia or delirium. Dementia is an umbrella term that covers a range of chronic progressive disorders that affect the brain causing symptoms of memory problems, information processing and communication. Delirium is an acute decline in cognitive ability or behaviour which is often related to an underlying illness such as infection, and is more common in people with dementia.

What did we do?

To improve the care of patients with dementia and delirium at NBT we implemented a number of measures. To help identify those patients that require specialised care we trialled a new tool for delirium assessment added to the medical admissions proforma which increased the number of people who were recognised with delirium in the Acute Medical Unit (AMU).

We realised that the system in place to request assessments for dementia was cumbersome and time consuming, so we updated it to be a much simpler system with all assessments able to be requested at the click of a button.

We want to support patients with delirium, and their families

and carers as well. This year we developed a new leaflet on delirium aimed at the patient, and their families. Multiple leaflets can lead to confusion so we wanted one leaflet that would be applicable all and cover the information required. The leaflet was trialled and approved by patients, and will be rolled-out after the next print-run.

The results from the 2016 National Audit of Dementia were released during 2017 and we wanted to make sure we were meeting all the standards.

We understood changes were needed to improve the nutritional intake of our patients and we implemented three things to improve this:

1. A separate dessert trolley in Elgar House to encourage patients to eat a pudding.

2. Piloting a special drinking cup to improve fluid intake. The cup lights up and makes sounds to remind patients to drink. It also has recording function so that relatives can record themselves encouraging the patient to drink.

3. Although NBT does have a range of additional finger foods available at all times of the day for patients with dementia, there was little awareness of the need for this among staff. We continued an awareness campaign to inform staff of this service.

What difference did it make?

The 4th round of the National Audit of Dementia is taking place during 2018 and results

will be available in early 2019. We hope to see an improvement in our results across a number of areas. Until the national audit results are published we will be monitoring our compliance with standards internally via a monthly quality assurance report and an annual dementia dashboard.

What next?

After the results from the 3rd

round of the National Audit of Dementia were published we put together a plan to improve our service. Firstly we are focusing on the priority issues as outlined by the audit..

Whilst all employees of NBT receive training in dementia care we have plans to roll out more advanced training sessions for staff on how to improve specific areas of care. We are looking at ways to

improve support for staff outside normal working hours. We are also looking at ways to improve our documentation both internally and throughout the discharge process to GPs and community care services.

Improve our engagement with patients in our improvement work through partnership with Alzheimer's Society.

Improvement in Action

As part of their improvement work, the Dementia Team, in conjunction with the Neurosciences staff have piloted the Enhanced Care and Meaningful Activity Programme to enrich the lives of people with delirium or dementia.

The programme works around the premise that every

interaction should be meaningful and meaningful interactions should add up to at least one hour a day. This is a huge task as around 40% of all admissions are patients with cognitive impairment.

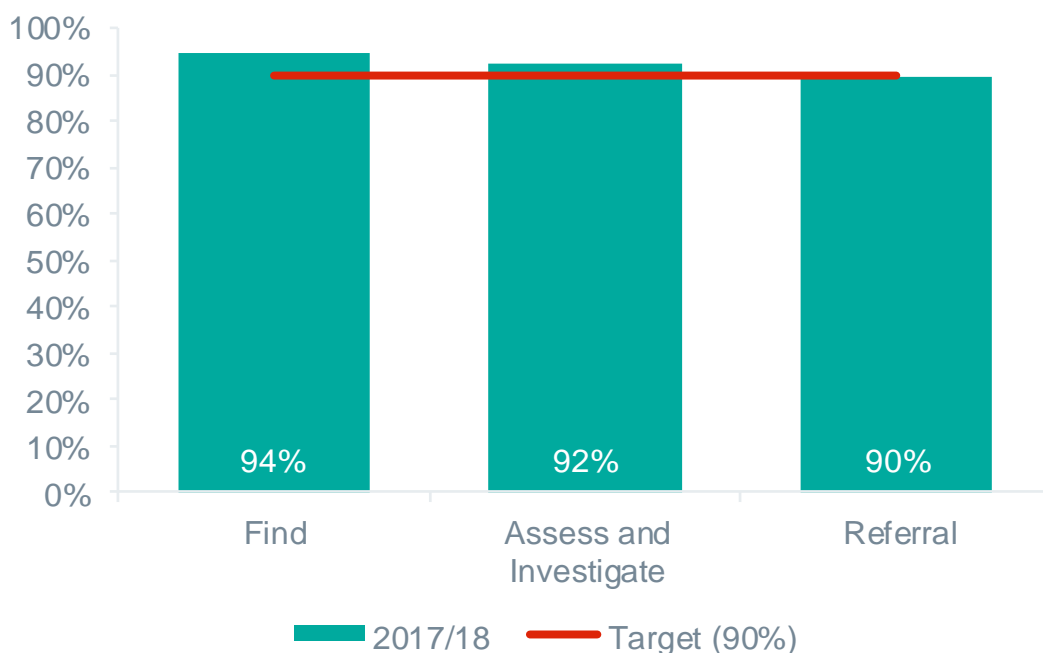
Meaningful interactions mean those where the patient is actively engaged in conversation or an activity

such as dominos, cards, enjoying music, or interacting with electronic entertainment.

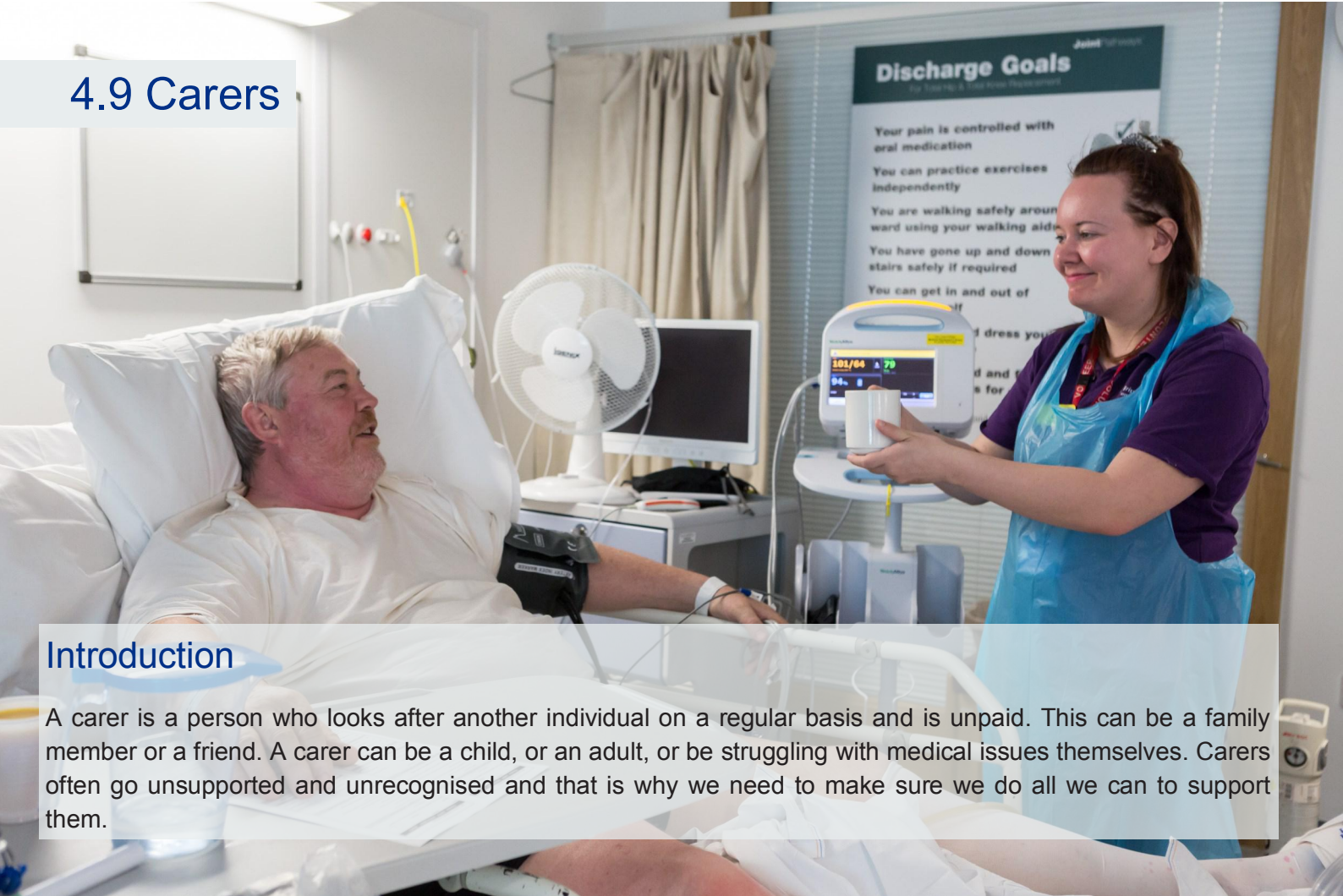
Much of this work is about changing attitudes towards patients with confusion, but also making sure there is time for these meaningful interactions to occur as they can be highly beneficial to the patient.

Compliance with Dementia Quality Assurance Audit (2017/18)

Compliance with **FAIR**—
Find
 (dementia finding question)
Assess and Investigate
 (full assessment during stay)
Referral
 (referred to their GPs for further assessment)



4.9 Carers



Introduction

A carer is a person who looks after another individual on a regular basis and is unpaid. This can be a family member or a friend. A carer can be a child, or an adult, or be struggling with medical issues themselves. Carers often go unsupported and unrecognised and that is why we need to make sure we do all we can to support them.

What did we do?

Through our feedback mechanisms we responded to the carers' request to understand the discharge processes and how they can become more involved to ensure a smooth transition from hospital to home.

We purchased fold down beds in keeping with our commitment to John's Campaign (a national campaign to ensure carers are welcomed in hospital) to ensure that patients' carers can stay with them during their hospital stay. These beds were funded by the League of Friends—a volunteer charity organisation within the hospital.

We have continued to develop the carers' scheme and have signed a charter with University Hospitals Bristol NHS

Foundation Trust that recognises the important role carers play within our hospitals.

We have focused on jointly working with other hospitals in our area, particularly, University Hospitals Bristol NHS Foundation Trust. This is to enable us to provide a united service for carers.

Within our own hospital we recognise many staff have carer commitments that are not always visible. We are working to set up a staff forum to develop a support mechanism to increase awareness for carers and managers of carers as employees. We have flexible working approaches that are available, enabling staff who are carers to remain in work, meeting caring needs, wherever possible.

What difference did it make?

We hope that the work we are doing has made our hospital more welcoming to carers. Our work to develop the carer's scheme includes free parking for carers limiting the financial burden of being in hospital, and access to the staff restaurant to be able to have hot meals.

What next?

The focus of our aims over the next year is to promote the needs of young carers and how we can meet them. We also want to look at ways of identifying young carers as they can often go overlooked and underappreciated.

We will develop a Carers Policy in order to promote the expectation of a consistent

approach to working in partnership with carers and patients.

To further our work during 2017/18 with expanding and developing the carers support scheme we want to continue to improve throughout 2018/19 raising awareness among both

carers and staff of the available support we offer.

In conjunction with this we want to continue to raise awareness of carers who are staff.

Finally we want to further develop and facilitate feedback

opportunities for carers on their experience at North Bristol NHS Trust. In doing so, we will be able to plan improvement work that will have a positive impact on carers, targeting those areas that are the most helpful.

Improvement in Action

As part of the improvement work following the National Audit of Dementia report published in July 2017 we are implementing a number of actions to support carers of dementia sufferers.

The National Audit included a carer's questionnaire which

provided invaluable information.

We are implementing unrestricted visiting times for identified carers and working on raising staff and carer awareness of this.

To help involve carers in the patient's care we are

continuing to train staff using our carers awareness scheme to educate staff to ask carers about what care they prefer to be involved with on the ward.

To help improve discharge and transition to home we are aiming to give carers or families at least 24 hours notice of discharge.

4.10 Safeguarding Vulnerable Adults



Introduction

The Adult Safeguarding Team intervenes when a member of staff raises safeguarding concerns for a patient. Contact can be for a number of reasons e.g. alerting harm (whether acquired in hospital or in the community), human trafficking, modern slavery, domestic abuse and patients that fall under the Mental Capacity Act or the Mental Health Act, and can include referrals under the government's Prevent strategy to counter terrorism.

What did we do?

We continue to train staff to increase their knowledge and understanding of vulnerability factors that affect our patient and staff. We also give them practical advice on how to apply this knowledge in their day-to-day practice.

In order for cases to be reviewed and screened by the Local Authority alerts must reach the statutory threshold in section 42 of the Care Act (2015). The Safeguarding Team deliberately apply a lower threshold, and although we expect that not all the cases will be screened by the Local Authority it ensures those that do need to be reviewed are reviewed. This is an effective marker that NBT is open and transparent around the harm that is caused within our own services.

NBT has invested in Specialist Safeguarding Practitioners. These specially trained staff members enable more work to be undertaken at screening stage. These experienced staff members are more likely to spot safeguarding issues and raise alerts. Specialist Safeguarding Practitioners are also able to make a judgement on a higher proportion of alerts and appropriately manage the alerts to address harm.

We are continuing to apply Deprivation of Liberty Authorisations for patients who cannot consent to stay in hospital for their treatment. This is where the Trust consents for procedures on behalf of a patient that does not have the capacity to do so, and who has no close relatives to consent on their behalf. We take this

responsibility very seriously and the Local Authority consider patients resident within NBT to be safe in comparison to other care settings. Because of this we rarely need to ask for support for Deprivation of Liberty Authorisations.

What difference did it make?

There has been a continued increase in the number of alerts received by the Safeguarding Team. This is a testament to staff's increased knowledge and awareness of safeguarding issues, and represents the growth of safeguarding as a distinct area of work for the Trust.

During 2017/18 there has been an increase in the number of harms reported as acquired in

the community. This shows that staff are more aware of the issues of vulnerability that occur in the community, and are alerting those issues when they come across them.

Due to the investment in Specialist Safeguarding Practitioners the amount of alerts screened by the Local Authority under Section 42 inquiry has dropped

dramatically. This releases pressure on the Local Authority and instils confidence in our referral and escalation criteria.

The rate of Deprivation of Liberty Authorisations has increased when compared to last year.

What next?

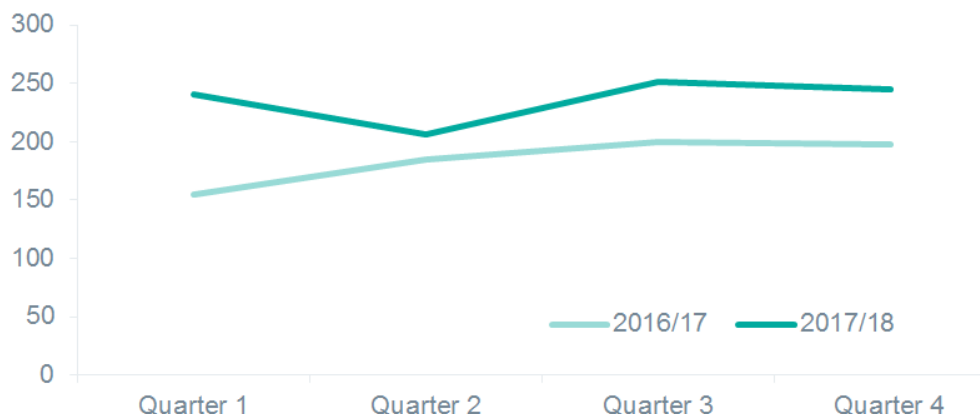
Next year we will have a big

focus on training staff on the practical application of the mental capacity assessment and the applications for Deprivation of Liberty Authorisations.

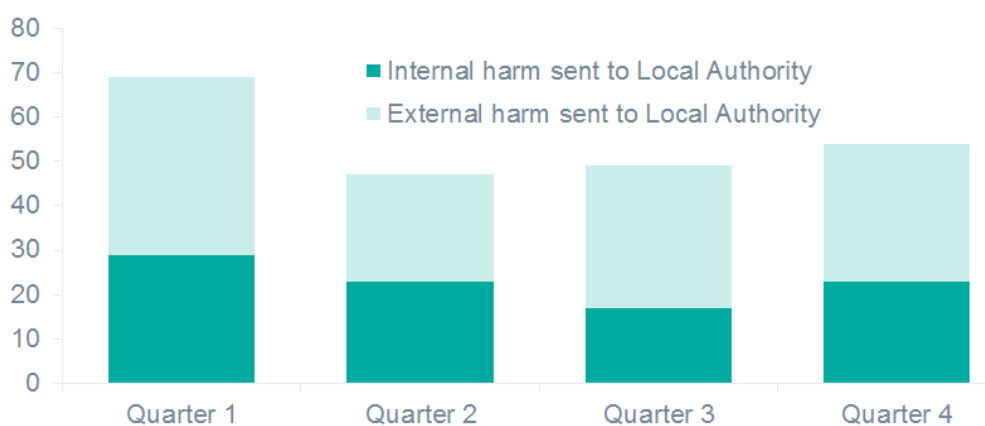
We will be undertaking a comprehensive clinical audit programme to assess how well we work.

Deprivation of Liberty Authorisations, Internal and External Harm, and Alerts

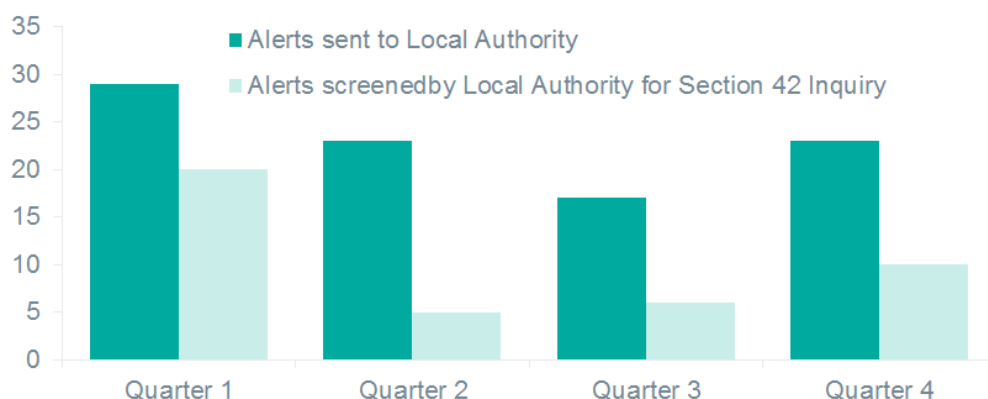
Deprivation of Liberty Authorisations received by the NBT Safeguarding Team 2016/17 vs. 2017/18



Internal and external harm sent to the local authority during 2017/18



Alerts sent to the local authority and alerts that were screened for section 42 inquiry



4.11 Safeguarding Children



Introduction

Safeguarding children is about protecting children from maltreatment, prevention of impairment of their health and development, and contributing to ensuring that all children grow up in circumstances consistent with the provision of safe and effective care which includes taking actions to enable all children to have the best outcomes.

We promote the well being of children who are our patients and those who are the family members of our adult patients.

As a health provider organisation we have opportunities to engage with children and their families as they use our services and to notice where offers of early help for families and children may prevent harm and contribute to better outcomes. We do this in partnership with families through assessment, care planning, and sharing of information with partner agencies and referral to appropriate services.

This matters to patients as adverse experiences in childhood can have lifelong consequences for the individual, their families, and wider society.

What did we do?

We closely monitored the numbers of children who use our service to ensure proactive oversight of admissions into the inpatient bed base by the safeguarding team to support ward staff caring for 16 and 17 year olds.

We included the Bristol Safeguarding Children Board training package for writing good referrals into the level 3 training. This runs as an initial full day course with update courses running internally.

In line with the Trust's paper-free ambition we have worked towards establishing a secure and paper-free approach to referring concerns and sharing information with Children's Social Care, GPs, and Health Visitors/School Nurses via email

from the Emergency Department.

To ensure key questions are asked when a child is admitted we have developed new electronic forms for our computer system that prompt the admitting staff member to gather this information. For example we capture whether families have had social worker involvement.

What difference did it make?

It is important we have a clear idea of the numbers of children using our services to enable services to develop and respond to the needs of children and their families. Regular oversight of admissions to the inpatient bed base by the safeguarding team can contribute to timely information

sharing for children and families, and support live learning and training for staff on wards who are not trained at level 3. For children who are on child protection plans or are *Looked After Children* good quality liaison between agencies improves their patient experience, and ensures safety and prevention of further harm through robust multidisciplinary child focused working.

We know that good quality referrals with the right information at the right time improves outcomes for children. We continue to work with ED staff to write from the perspective of the child, even

when the child isn't present, and to advocate for them and raise concerns about abuse and neglect. We are developing processes for quality assurance and are responding to concerns raised about referrals promptly.

Secure electronic transfer of information and referrals is integral to modern day health practice. NBT regularly has to share information with different local authorities, primary health care providers, and social enterprises. There is a challenge to develop a system that works across all recipients without creating a huge

administration task for busy healthcare practitioners.

What next?

For the coming year we plan to add the Bristol Safeguarding Children Board referral writing package into the Emergency Department training day to improve the quality of our referrals to Children and Young Peoples Services.

We also want to adapt our hospital computer system so it is capable of running the Child Protection Information System within the Emergency Department.

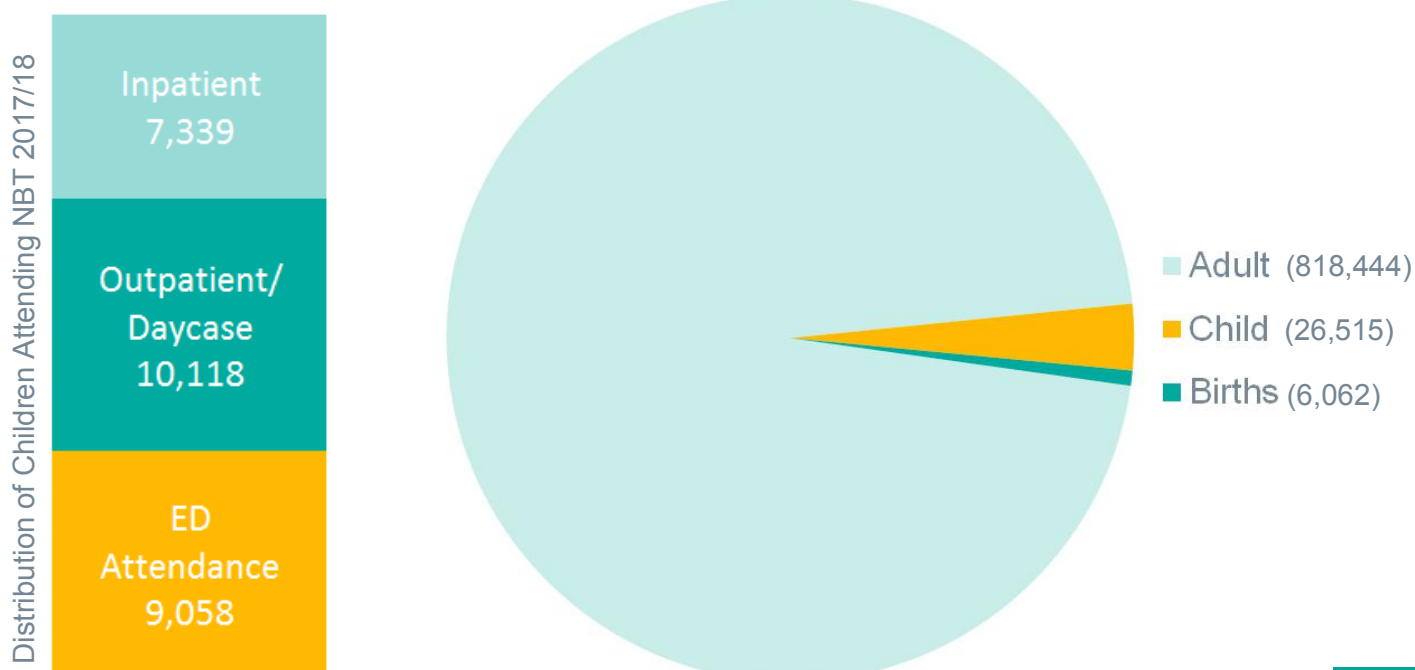
Improvement in Action

A new computer system called Datix has been introduced into the Trust. This system logs and reports on incidents, safeguarding and

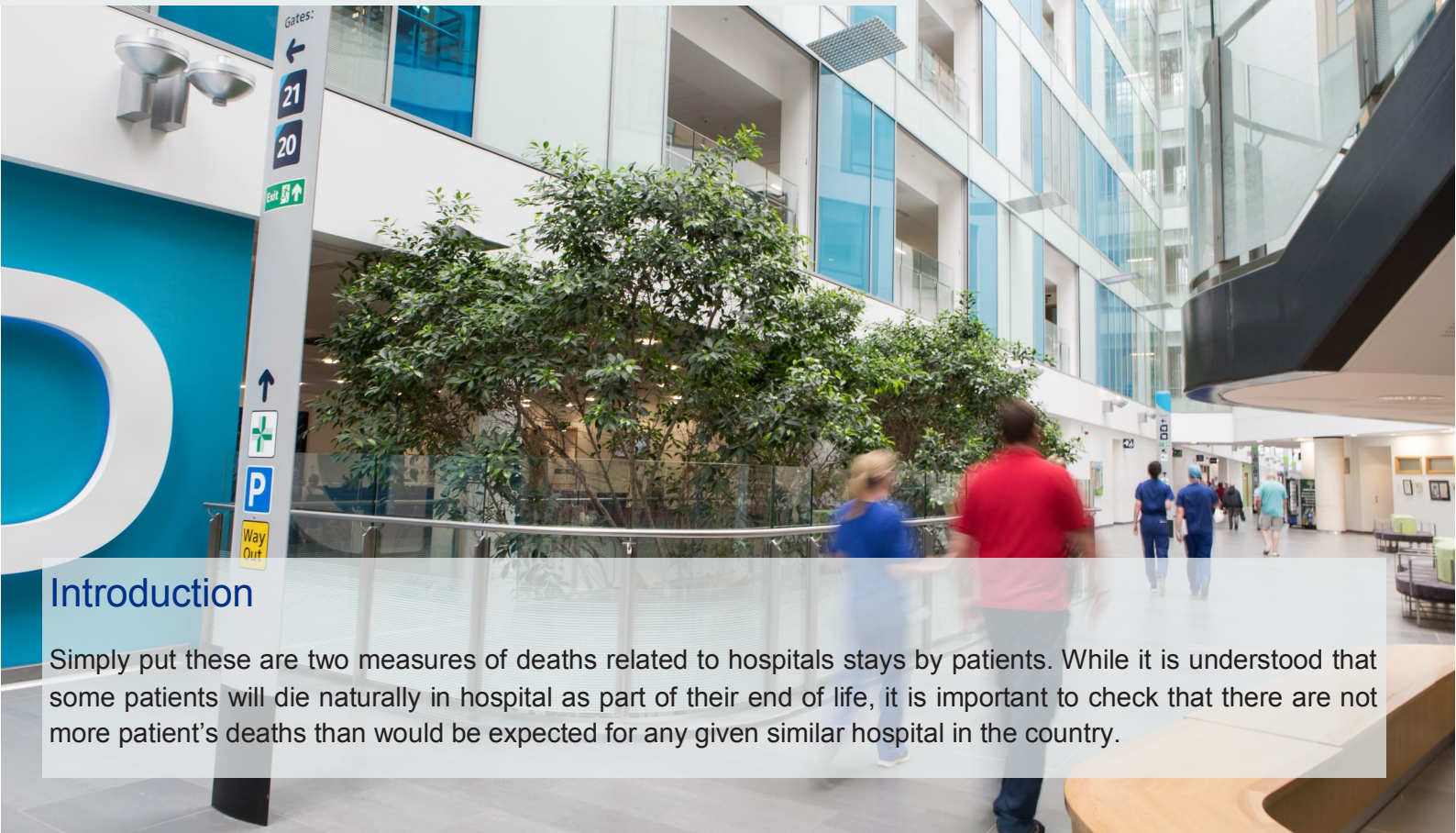
complaints. Although newly implemented we are developing exciting new ways of reporting our data with a focus on monitoring trends

and frequently asked questions that help us analyse where additional support and training for staff is required.

Patients Attending North Bristol NHS Trust 2017/18



5.1 Mortality Outcomes



Introduction

Simply put these are two measures of deaths related to hospitals stays by patients. While it is understood that some patients will die naturally in hospital as part of their end of life, it is important to check that there are not more patient's deaths than would be expected for any given similar hospital in the country.

Both these measures allow comparison and indicated if there are more deaths than would be expected.

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.

What did we do?

NBT has a long history of low mortality as reported by HSMR and SHMI results. Indeed it has some of the lowest mortality rates in the country. Nevertheless NBT monitor and review its in-patient deaths to see what learning we might get from these events and to ensure that we are giving the best possible care. The Trust

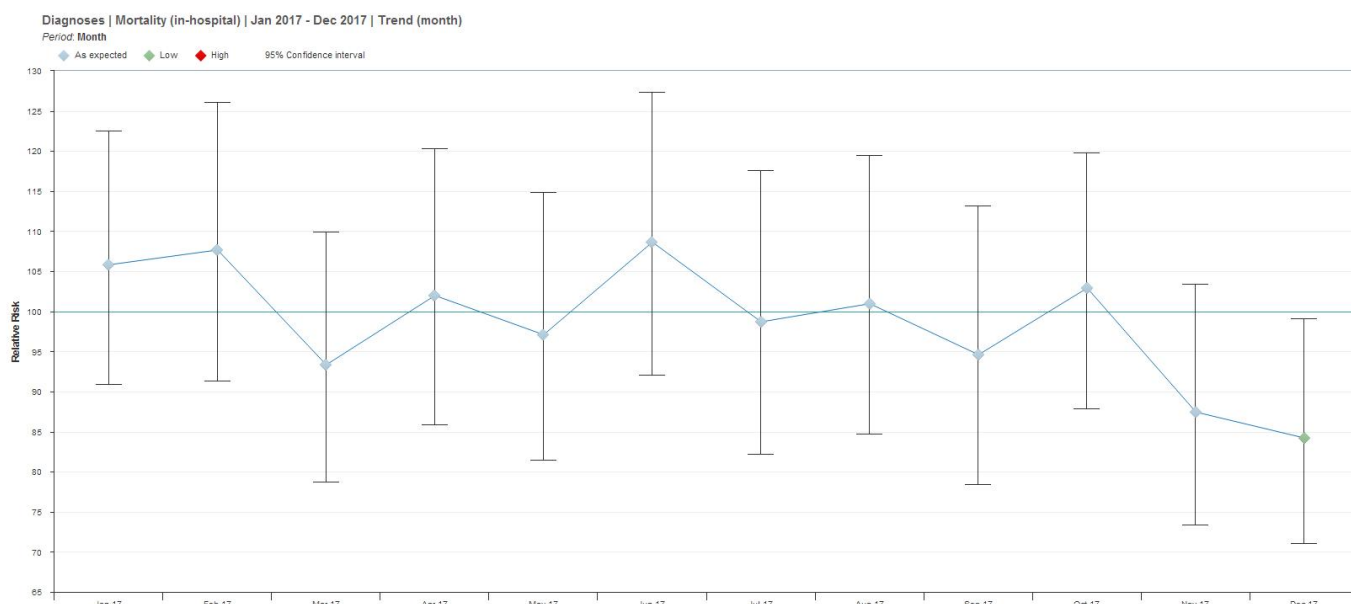
has also an excellent 'End of Life' team who support the final days of many of our patients and their families at this difficult time.

hospitals in the United Kingdom.

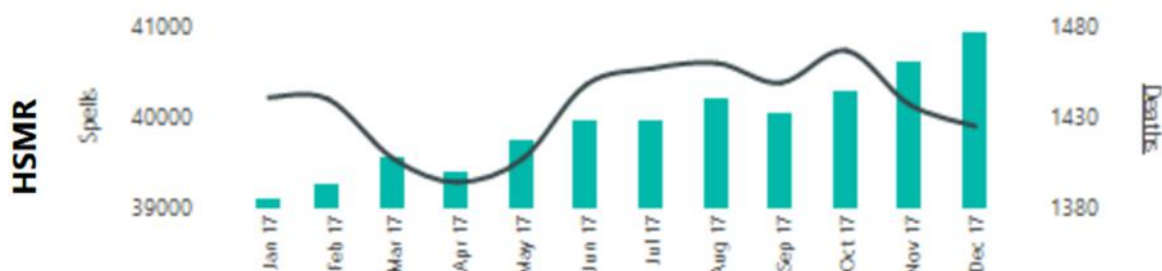
What difference did it make?

NBT will continue in its Mortality Review work and aims to work towards being one of the safety and best

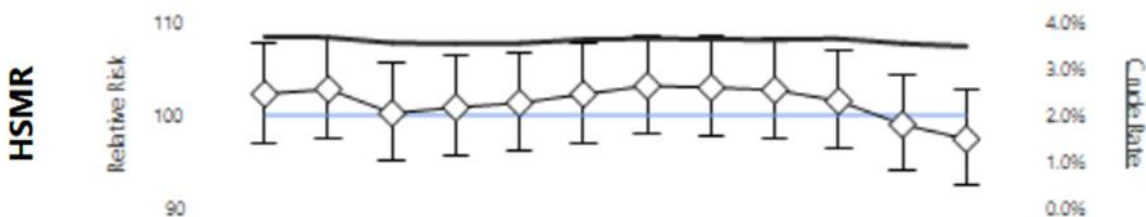
Mortality Summary for 12 Months January 2017—December 2017



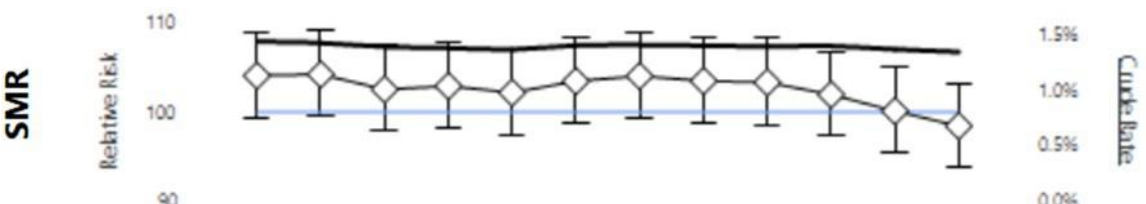
HSMR
Spells vs Deaths



HSMR
Relative Risk vs Crude Rate



SMR
Relative Risk vs Crude Rate



5.2 Learning from Patient Deaths



Introduction

At NBT we have endeavoured to undertake a mortality review on all deceased patients since 2014. We developed a bespoke electronic tool to facilitate this and have reported our findings to the Quality and Risk Management Committee and Quality Committee. Reports are available in real-time for clinicians to review.

What did we do?

We collaborated with the West of England Academic Health Science Network (AHSN) to improve how we review deaths at NBT. The network is a collaborative of five acute trusts, GPs, patients and the public. We share learning around the process for the review of deaths and communicate when patients' care is across settings. It is an open and honest group whose purpose is to improve patient care across all care settings.

The Bereavement Team is starting a survey for deceased patients' families to learn how to improve the quality of care. In this way it is hoped we can not only improve the care of our patients, but also better support families whose relatives are dying, and also, after their

deaths.

We are working with the Learning Disability community provider team (the healthcare provider that looks after patients with learning disabilities in the community) so that *all* learning disabilities patients (who are known formally to the trust) have their deaths reviewed.

What difference did it make?

We reviewed 64% of all deaths from 1st April—31st December 2017. We found that the care was rated as 'good' or 'excellent' for 84% of patients whose deaths were reviewed. We highlighted 4 cases (1%) where a further review was recommended as there was a possibility poor care could have contributed to the patients' death.

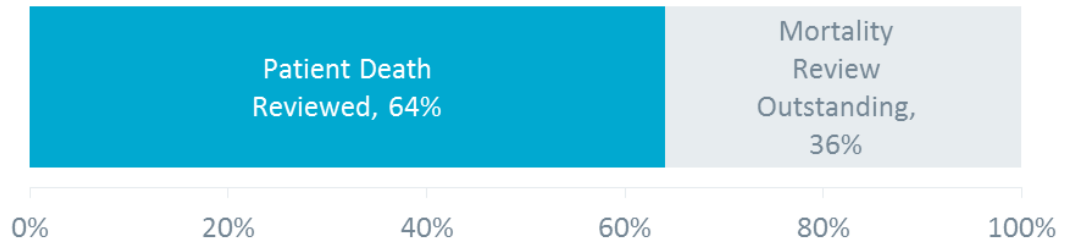
We also looked at harm to patients and found that there was no harm in 65% of the deaths reviewed where a problem with the care was identified.

What next?

We really want to harness the information we gather during the mortality review process and put changes into action. The way this will happen is to investigate and report on themes identified through mortality reviews. Specialties have requested that key themes around deterioration of the patient, escalation to a more intensive care setting and good early discussions with families about end of life care be reported to help identify key areas to target for improvement. We would then link our Quality Improvement Programme to these themes.

Patient Deaths Reviewed April—December 2017

Patient death review includes:
 Full mortality review
 Screened and excluded
 Other review (incident investigation, inquest, safeguarding, external)



In line with Trust Policy clinicians have three months to conduct a mortality review from the time of the patient's death. As such this data is only available 3 months in arrears

Improvement in Action

During 2017/18 concerns were raised over the provision of VTE prophylaxis on a particular ward. VTE prophylaxis is the prescribing of blood thinners to a patient when they enter hospital in order to prevent a blood clot. Blood clots are more likely to occur when a person is not moving, and hence, all

inpatients should be assessed for their likelihood of developing a blood clot, and prophylaxis should be prescribed appropriately.

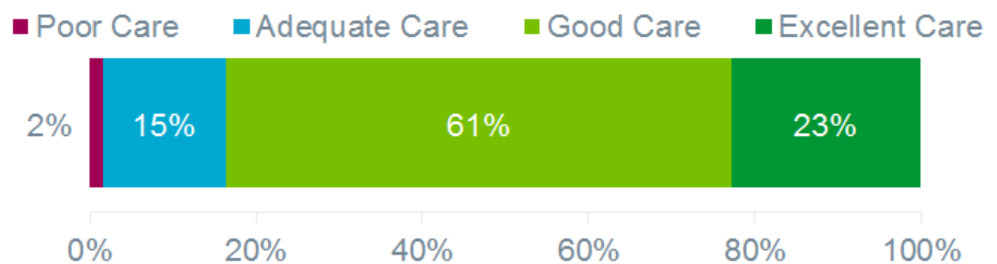
The Trust was alerted to the issue via a combination of mortality reviews and incident investigation reports. It was clear something needed to be done to ensure that VTE

prophylaxis was being prescribed to all patients that needed it.

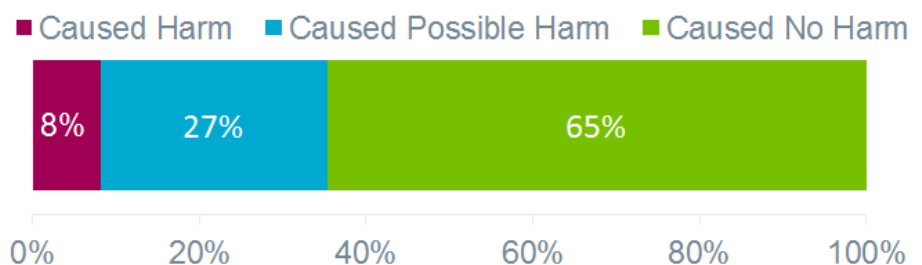
We implemented a process to check whether VTE prophylaxis had been prescribed to those in need and, if found not to be prescribed, to quickly rectify this issue.

Care and Harm 2017/18

Quality of care for all deaths reviewed 2017/18



Where a problem with care was identified, whether harm was caused—all deaths reviewed 2017/18



5.3 Quality of Cancer Services

Cancer Multidisciplinary Team (MDT) Performance

	Q1	Q2	Q3	Q4	
Patient seen within 2 weeks of urgent GP referral	89.0%	91.5%	94.8%	89.0%	
Patients with breast symptoms seen by specialist within 2 weeks	90.4%	95.2%	96.9%	81.9%	
Patients receiving first treatment within 31 days of cancer diagnosis	95.8%	97.8%	97.2%	97.0%	
Patients waiting less than 31 days for subsequent surgery	96.9%	95.9%	85.6%	93.9%	
Patients waiting less than 31 days for subsequent drug treatment	100.0%	100.0%	100.0%	100.0%	
Patients receiving first treatment within 62 days of urgent GP referral	84.2%	87.9%	86.3%	82.2%	
Patients treated within 62 days of screening	97.7%	96.5%	87.5%	91.9%	

Cancer Performance

The Trust has continued to make improvements to cancer pathways over the year to enable cancer performance to meet targets consistently. The Trust has struggled to maintain Two Week Wait (TWW) performance due to further increases in referral numbers.

The 62 day target has been consistently met throughout the first three quarters of the year. The last quarter has been challenging but the Trust is still predicting to meet this standard for the year. 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.

The Trust is involved with all of the pathway improvement projects being coordinated by the SWAG Cancer Alliance and are implementing significant changes to the

Lung, Colorectal and Prostate pathways which will both reduce waiting times and improve patient experience. Prostate and Kidney patients that are transferred in later than the ideal specified timeframes from other providers remain one of the largest sources of cancer breaches at the Trust. The Trust undertakes a review of all patients who are not treated within 62 days of their GP referral 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 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. The Trust will be undertaking harm reviews for all patients that are treated beyond 104 days following referral and this will be managed and audited through the Trust incident and risk system.

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.

What next?

We plan to implement a new breach reallocation policy for the 2018/2019 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. All timed pathways at the Trust will be reviewed to meet any new guidance alongside core clinical services to ensure

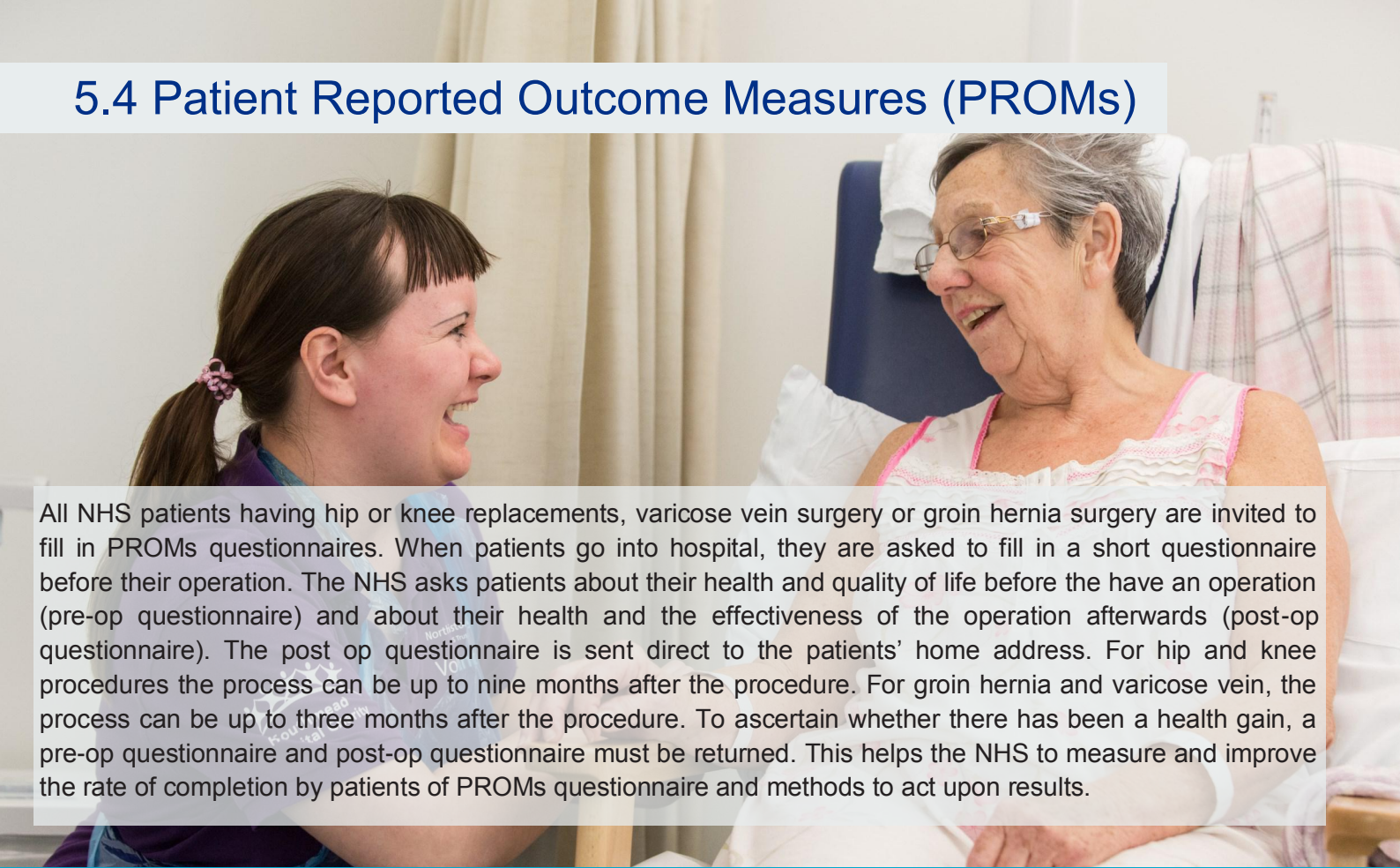
any patients being transferred to UHB from NBT are done so by day 38.

The Trust will continue to implement the best practice pathways for Lung and Prostate and will lead the regional review of the Prostate pathway to ensure consistency for all patients across the region.

Cancer Peer Reviews

Peer Review Area	Review Measures	2017 (%compliance)	Action areas identified
Urology	19	SD – 100%	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. IT issues relating to the videoconferencing equipment needs to be resolved. The Trust needs to ensure sustainability of the urology service including surgical, theatre capacity and supranetwork teams are suitably resourced so capacity can be met. Recruitment of additional prostate consultant following death of current consultant.
CUP Hospital	7	SD – 86%	Facility to maintain a quorate MDT across two sites.
Breast	6	SD – 100%	Review of MDT processes to reduce demands on MDT and members
Skin - Adult	6	SD – 100%	No actions identified
Urology - Penile	9	SD – 89%	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. Lack of annual audit due to resource constraints
Brain & CNS	23	SD – 93%	No actions identified
Colorectal	8	SD – 100%	No actions Identified
Lung	7	SD – 100%	Outpatient capacity review Complex diagnostic pathways can lead to delays – implement NOLCP Review Oncology capacity with BHOC Recruitment of Cancer Support Worker
Sarcoma	7	SD – 100%	No actions identified
Gynaecology	7	SD – 100%	Greater resource for MDT Lead at NBT
Palliative Care	25	SD – 95% SD – 92%	National measures pose challenges as no network group at present Development of treatment algorithms Implementation of e-prescribing
Chemotherapy	26	PR – 1 serious risk identified	Recruitment of dedicated Lead Pharmacist in progress to address serious risk identified.
Acute Oncology	16	SD – 81%	No actions identified
Pancreatic	6	SD – 100%	No actions identified
Urology – Testic-	9	SD – 100%	Greater cover for MDT at UHB through job planning
Haemato-	7	SD – 100%	Video conferencing facility with UHB
Skull Based	12	SD – 92% PR – 1 serious risk identified	Action to address serious risk: This is the requirement for procurement of essential surgical equipment including operating microscopes and facial nerve monitors. Nerve monitors request raised 12/3/18. Business Case is being

5.4 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 post-op questionnaire must be returned. This helps the NHS to measure and improve the rate of completion by patients of PROMs questionnaire and methods to act upon results.

5.5 NICE Quality Standards

Introduction

NICE quality standards are a concise set of statements designed to improve quality within a particular area of health and social care. They cover areas where there is variation in care and include information on how to measure progress.

What did we do?

Although NICE Quality Standards are not mandatory, they are a useful tool that help plan and deliver services to provide the best possible care.

Within North Bristol Trust (NBT) all Quality Standards are assessed for their applicability to the Trust and its services and patients. A 'Gap Analysis' is completed by the NBT Lead for the Standard and the Clinical Team linked to the Standard. 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 Patient Safety and Assurance Service on behalf of the Clinical Effectiveness Committee (CEC).

To date 162 Quality Standards have been published by NICE of which 123 apply to the NBT. Currently, 90% have been reviewed with action plans generated and reported to Trust Clinical Effectiveness Committee.

What difference did it make?

Complying with NICE Quality Standards increase awareness amongst clinicians and through robust reporting methods any gaps in practice can be highlighted and escalated to Trust Board committees for peer review and agreed action.

It is important to review clinical practices to ensure that we are always delivering quality care and services.

What next?

We will continue to provide expert support to the Clinical Effectiveness Committee, Divisional Management Teams and NICE Leads ensuring the delivery and monitoring of an effective NICE Quality Standard programme. As well as this we will actively promote and monitor, in partnership with the NICE leads, the

implementation of change and re-audit activities, ensuring written reports, Gap Analysis and action plans are produced for all applicable NICE Quality Standards. We will also continue to monitor existing published standards and review newly published standards, linking these to NICE pathways, clinical guidelines and Public Health guidelines.

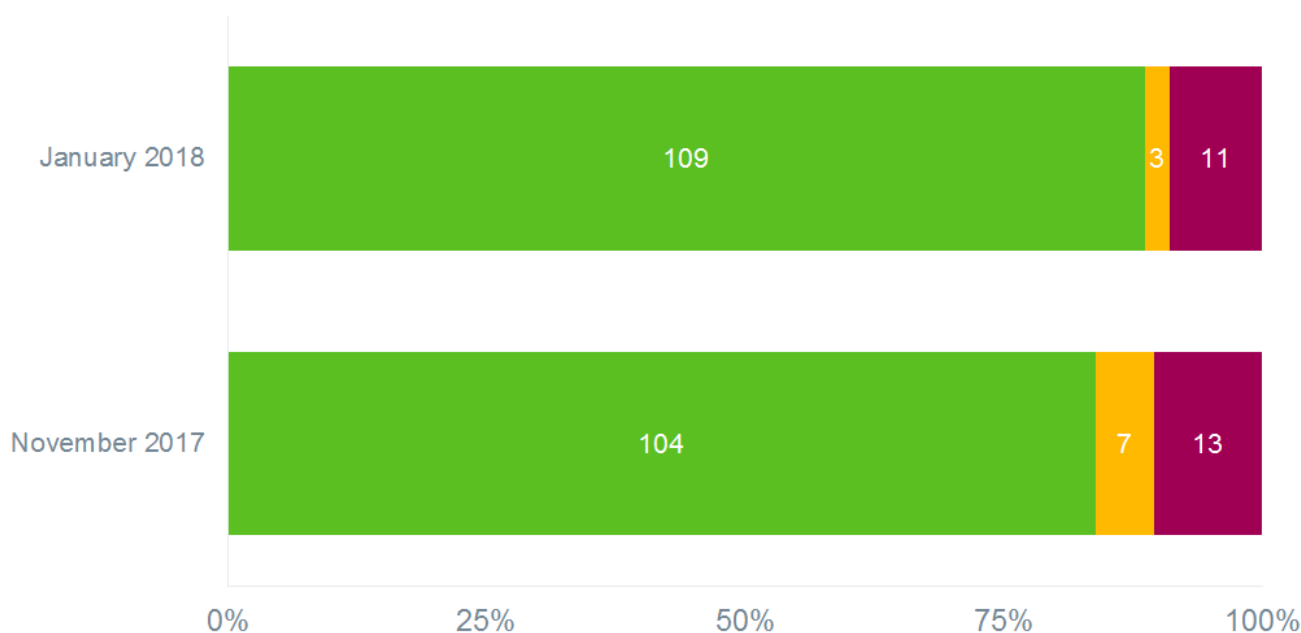
As a result of reviewing relevant Quality Standards within North Bristol NHS Trust we have made a number of improvements to our services.

Improvement in Action

Quality Standard (QS)	QS81 Inflammatory Bowel Disease (IBD)	QS17 Lung Cancer
Recommendation	People receiving drug treatment for IBD should be monitored for adverse effects.	Offer patients with lung cancer a Holistic Needs Assessment (HNA) at each stage of care that informs their care plan and need for referral to specialist services.
What did we do?	We have opened an Immunomodulatory monitoring clinic with a Gastrointestinal Pharmacist led virtual monitoring clinic for patients who start on immunomodulatory therapy for IBD.	Funding was secured and successful recruitment of a dedicated support worker was achieved. The support worker is on hand to discuss the HNA and provide advice and support when planning patients care.

NICE guidance approval status

■ Approved by CEC ■ Awaiting CEC approval ■ Requires initial clinical review



5.6 Participation in Clinical Audits



Introduction

Clinical audits undertaken in the Trust help us to gauge how well we are adhering to guidelines, both local and national. These audit projects can be local within the Trust, or national projects where hospitals from all around the country contribute data. The most important part of the clinical audit process is the action planning stage where we look at how we can improve our compliance. The effectiveness of the interventions is then tested by re-auditing.

What did we do?

During 2017/18 the Patient Safety, Assurance and Audit Service (PSAAS) at NBT registered 201 projects and 126 projects were completed.

When projects are finished the PSAAS reviews the report and action plan, and makes sure that the recommendations address all of the issues highlighted by the audit.

234 actions arising out of clinical audits were completed last year.

Some of the most resource dependent audits are those reportable to the Quality Account. These are national clinical audits that the Department of Health strongly advises hospitals to participate in. These large audits can

require a huge amount of staff time. The good thing about national audits is the chance to see how we compare to other hospitals around the country.

Often, improvement work can also be shared and there are national initiatives to work towards. In 2017/18 we participated in 36 national audits reportable to the Quality Account, the table in appendix 8.3 lists these audits.

What difference did it make?

All national audits are reviewed by the Clinical Audit Committee at NBT. The Committee also reviews the progress of actions arising from National Audits on a six-monthly basis until complete. In 2017/18 the Clinical Audit Committee

reviewed and approved the action plans for 17 national audits, it also reviewed the progress of a further 17 action plans and closed 9 projects since all improvement work had been completed.

During 2017/18 we undertook improvement work around asthma following the BTS National Asthma Audit. This included implementing a new care bundle and personalised asthma management plan for all asthma patients. We saw improvement in how we use the care bundle especially on discharge, and ensuring patients have a community review. We know we still aren't doing this as well as we could, but we have plans to train staff and recruit a new nurse specialist.

Improvement in Action

National Emergency Laparotomy Audit

The National Emergency Laparotomy Audit is a large ongoing project that collects and reports on patients undergoing emergency laparotomy (a surgical operation to find the cause of severe abdominal pain).

During 2017/18 the Emergency Laparotomy team collaborated with the Care of the Elderly team to ensure that all emergency laparotomy patients over the age of 70 had involvement and care from the Care of the Elderly team.

We have moved from 5% of over 70s being reviewed by an elderly care specialist to 55%. This is well above the national average of 28%. Over the coming year we aim to

improve on this further, and the recruitment of more elderly care specialists should make this possible.

Myocardial Ischaemia National Audit Programme

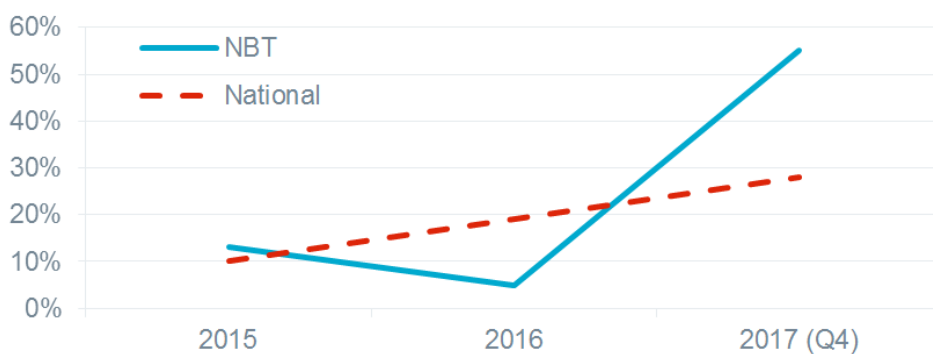
Sometimes the value of National Clinical Audit can be hard to see—there is a lot of input, but not much output. One of the true success stories at North Bristol NHS Trust of a national audit having a real impact on clinical care is the Myocardial Ischaemia National Audit Programme (MINAP).

This audit is so successful at NBT because of investment by the Trust to ensure we have a specialised team of cardiology audit nurses to manage and interpret the data, and to lead on

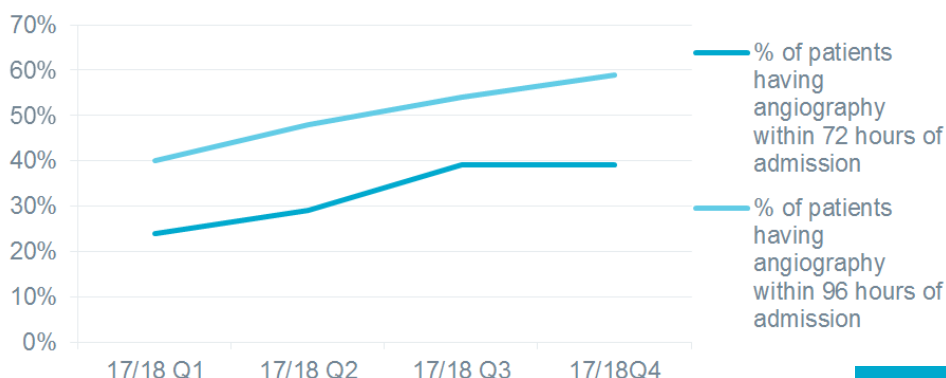
improvement work. Because of this we are able to demonstrate change, and this ensures clinicians ‘buy in’ to the improvement work.

One of our main focuses during 2017/18 and onwards is to improve the percentage of patients having angiography within 72 and 96 hours of admission. Our rates have steadily been improving throughout 2017/18 due to improvement work undertaken throughout the year. We initially conducted a review to understand why patients were not receiving an angiography within the required time and, having pinpointed issues with weekends and our lab provision we are looking at ways to address these. We have prioritised patients that are unstable to ensure the most critical patients receive timely and safe treatment.

Percentage of Patients Over the Age of 70 Assessed by an Elderly Medicine Specialist After Surgery
2015—Quarter 4 2017
North Bristol NHS Trust vs. National Average



Percentage of Patients Having an Angiography within 72/96 Hours of Admission
Quarter 1 2017/18—Quarter 4 2017/18



5.7 Research



Introduction

Each year more than 6,000 patients take part in research at North Bristol NHS Trust with more than 300 research staff delivering over 400 studies each year. We are dedicated to research that improves our patients' health and their experience of our services, with research delivered in more than 40 departments.

What did we do?

This year we launched our new five-year Research strategy, setting out how we will enhance patient care by offering more people the chance to participate in research.

We involved patients and the public in the development of our strategy, which has made a more patient-friendly document.

Our four main aims are: to empower patients in research; support and nurture our workforce; make research visible in day to day activity and work with our regional partners to improve healthcare.

Over the last year we have received more grant submissions than ever before with increasing numbers of our staff leading and designing research to answer important clinical questions. We have involved patients and the public when designing these studies to ensure they are relevant.

We are 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 patient's access to a greater range of research. We are highlighting research as a treatment option and empowering patients to request access to research studies.

What difference did it make?

In the past year we have been awarded major new research grants in areas including the Emergency Department, Urology and Orthopaedic Trauma surgery.

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

Research Strategy 2017-2022



What next?

Next year, with continued grant successes, we aim to support more Nurses, Midwives and Allied Health Professionals to design and lead research. This will provide additional career development opportunities for our staff as well as

encouraging those staff working closely with patients to drive research and improve patient care. With the launch this year of the £21 million Bristol Biomedical Research Centre led by University Hospitals Bristol NHS Foundation trust and the University of Bristol we expect

to see increased working with our partner organisations across the region. This centre 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.

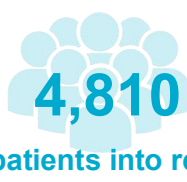
Improvement in Action

A selection of research studies published and implemented from 2016 onwards

Research Study	Outcome
A review of rotational forceps vs manual rotation and direct forceps	The rate of vaginal births was significantly higher with rotational forceps than with manual rotation followed by direct forceps. This informed the national Royal College of Obstetricians and Gynaecologists operative birth training programme (ROBUST) which is now available nationally.
Investigation after Stillbirth to Inform and Guide Healthcare Training	This informed the new National Bereavement Care Pathway and is informing the update of national stillbirth guidelines.
Systematic Reviews of Stillbirth Research (including for the Lancet Ending Preventable Stillbirth Series 2016)	This informed the new National Bereavement Care Pathway and is informing the update of national stillbirth guidelines. It has also informed a global consensus meeting underpinning key guideline updates.
A comprehensive physiotherapy intervention for benign joint hypermobility syndrome	This work was referenced in the updated International Guidelines for Physical Treatment of People with Joint Hypermobility Syndrome/Hypermobile Ehlers Danlos Syndrome.
Identifying Deteriorating Patients Through Multidisciplinary Team Training	A short multidisciplinary training intervention can improve recognition of the deteriorating patient using the EWS (Early Warning Score). This has now been implemented locally and included in the international PROMPT training program.
Evaluation of EWS (Early Warning Score) as a marker of severity and prognosis in adult patients with gram-negative bacteraemia	This study demonstrated that EWS can be used in blood stream infections to improve patient outcomes and has been implemented broadly across the NHS.
Prophylactic radiotherapy for the prevention of procedure-tract metastases after surgical and large-bore pleural procedures in malignant pleural mesothelioma (SMART)	Published in Lancet oncology it led us and the rest of the country to stop using prophylactic radiotherapy in cases of mesothelioma. The BTS (British Thoracic Society) guidelines on mesothelioma are about to be published and used this paper as grade A evidence not to give this treatment anymore. This will inform care across the world implementing the change as widely as possible.
Development of the International Consultation on Incontinence Modular Questionnaires (ICIQ) for pelvic problems	Implemented in NICE (National Institute of Health and Care Excellence) guidance and in use across several specialties nationally. ICHOM (International Consortium for Health Outcomes Measurement) guidelines have just been published recommending use of the ICIQ as part of a standard set of core outcome measures for over active bladder globally.
Use of cement in hip replacements	Following implementation of research findings the proportion of older patients receiving cemented hip replacements has increased from 40% (2013) to 92% (2017) saving £170,000 per year in NBT alone due to decreased failure and revision rates.



New research studies opened



New patients into research studies approved by the research ethics service



Existing participants in research

6.1 Access to Clinical Services

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 embedded the 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 below 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.

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
NEWS												
NEWScore recorded on admission to ED	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Obs												
Hourly Obs	79%	79%	79%	80%	81%	100%	98%	99%	95%	88%	96%	97%
Pain												
Pain scored documented at triage	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%
Analgesia administered at triage (if appropriate)	100%	96%	100%	100%	100%	100%	95%	97%	97%	99%	99%	99%
Pain reassessed in an hour	82%	83%	80%	82%	80%	89%	88%	84%	76%	77%	90%	91%
Communication												
NOK documentation	100%	100%	100%	100%	100%	100%	96%	99%	100%	97%	98%	99%
Transfer / Discharge												
Good to go @ 2.5hours	60%	61%	50%	56%	57%	96%	84%	82%	66%	60%	72%	70%
Obs <60mins prior to discharge	76%	77%	76%	77%	78%	100%	99%	98%	91%	86%	97%	96%
Infection Prevention												
Cannula CP	98%	98%	97%	95%	97%	100%	100%	99%	100%	98%	100%	100%
Dignity & Nutrition												
Gown	98%	99%	97%	99%	97%	100%	100%	99%	100%	100%	100%	100%
Refreshments offered within 2 hours of admission	64%	65%	67%	74%	77%	100%	99%	99%	96%	91%	98%	93%
Mental Health Risk Assessment												
RAM completed	100%	100%	100%	100%	100%	100%	98%	99%	100%	94%	100%	99%
Chest Pain												
ECG done & reviewed within 30mins	99%	98%	9%	98%	97%	100%	100%	100%	100%	100%	100%	100%
Obs on arrival	96%	97%	96%	98%	95%	100%	100%	100%	100%	100%	100%	100%
Stroke												
Hourly neuro obs	88%	83%	100%	100%	100%	100%	96%	100%	100%	86%	90%	98%
Transfer to stroke unit, 3.5 hours	50%	50%	50%	40%	33%	97%	95%	68%	28%	76%	70%	90%
Stroke CT within 1st hour	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%
#NOF												
Pain score on arrival	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Analgesia, 20 mins	100%	100%	100%	100%	100%	98%	92%	55%	18%	53%	33%	67%
X ray within 60 mins	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pathway commenced	100%	100%	100%	80%	100%	96%	91%	92%	60%	55%	72%	87%
Admission, 2 hours	25%	0%	0%	0%	0%	73%	33%	24%	0%	20%	12%	9%
Sepsis												
Rx < 1hour	100%	100%	100%	100%	92%	80%	79%	49%	42%	50%	63%	44%
Pathway commenced	100%	86%	90%	91%	92%	80%	88%	67%	82%	48%	96%	72%

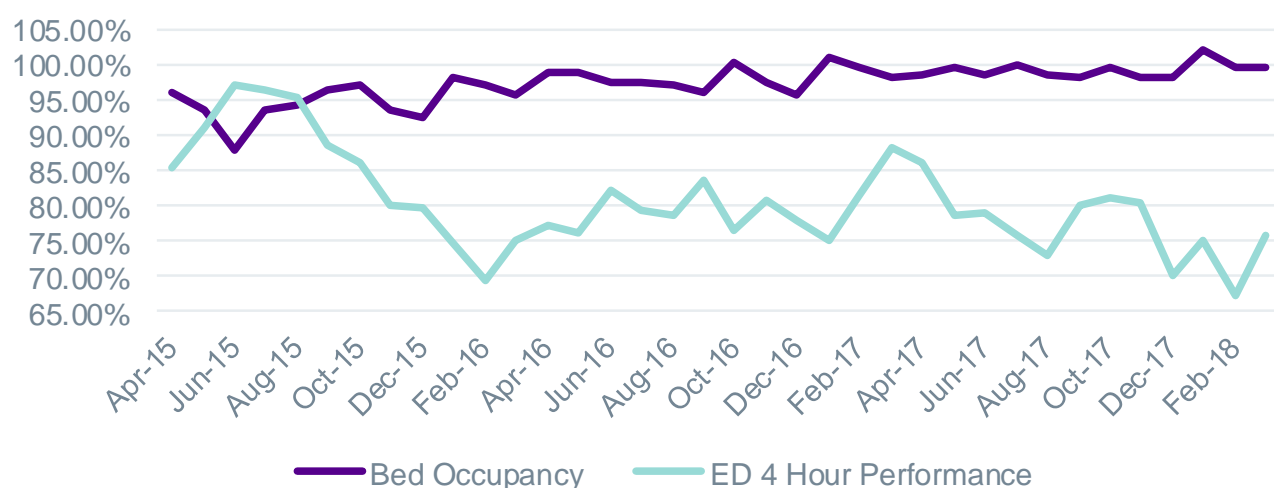
Emergency Department

2017/18 has been a challenging year for performance against the 4-hour A&E standard with performance for the full year of 77% in comparison to 80% in 2016/17.

The Trust has experienced high levels of growth in both patient attendances and emergency admissions. Maintaining patient flow has been difficult and has led to the Trust occupying greater than its core bed base on the majority of days in the year. The greatest area of growth has been in major patient attendances (5%) and there has been a smaller reduction in minor patient attendances (-2%). This means the hospital has seen a greater number of patients who are more unwell.

In addition to the patients who attend the Emergency Department, there is a high number of patients (1697 in March 2018) who are directly admitted into other areas of the hospital including: Ambulatory Care Unit; Medical Assessment Unit; Surgical Assessment Unit; Hot Clinics; and directly to Wards.

Bed Occupancy vs ED 4 Hour Performance



Having such consistently high levels of bed occupancy has reduced the flexibility to bed patients in a timely way leading to breaches of the 4-hour standard. In addition, the increased volume of patients through the Emergency Department has led to longer waits for initial assessment leading to subsequent breaches of the standard.

Another factor in the reduced flow of patients within the hospital has been the sustained high levels of patients exceeding the North Bristol Operational Standards and Delayed Transfer of Care Standards. This has the impact of increasing patients' length of stay and reducing the timeliness of their discharge from hospital.

The Trust has been delivering an Improvement Plan across the year in conjunction with system partners. Key actions delivered have been: additional medical and ENP staffing in the Emergency Department; implementation of a communication and engagement plan focussed on a 'no delays' culture and 'home first' principle for patients at NBT; introduction of a Frailty Team in the Emergency Department; development of Divisional schemes focussed on reducing the number of patients who stay in hospital >7-days; and working with Commissioners to secure additional Discharge to Assess (D2A) pathways and additional Community Rehabilitation beds, freeing up capacity within Elgar House.

The Trust continues to focus on the delivery of its internal Improvement Plan in 2018/19; working with system partners; and has invested in a 16-week improvement programme with PwC called 'Perform', which aims to improve patient flow through the hospital, by embedding new tools and techniques at a ward level.

6.1 Access to Clinical Services

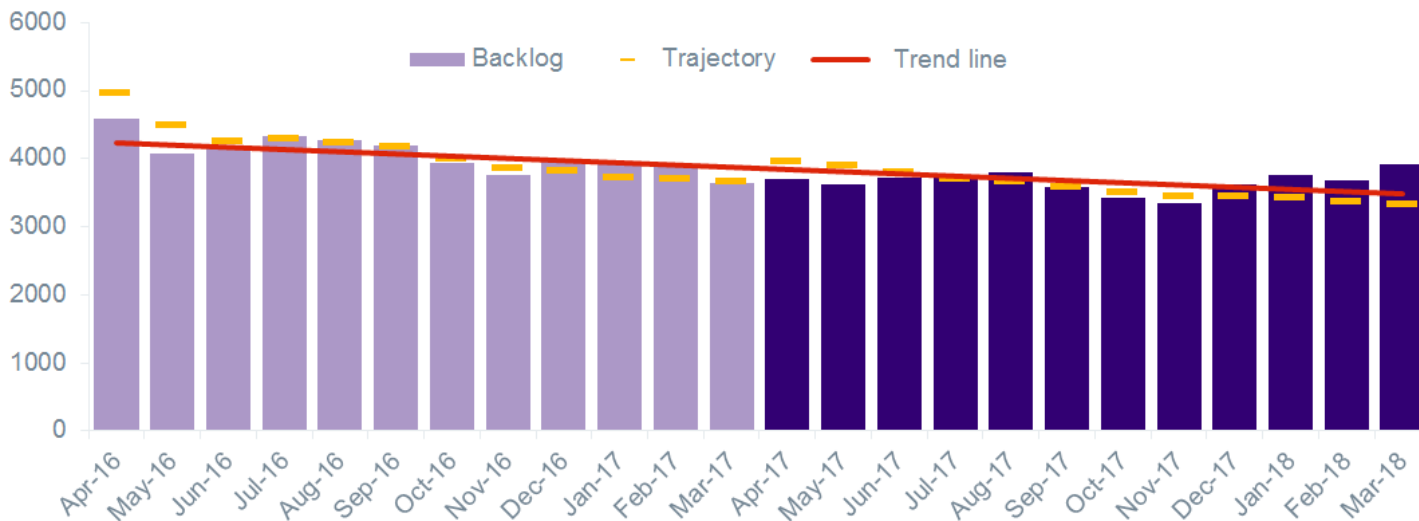
Clinical Validation

In specialties where there is a demand and capacity imbalance the Trust has a policy to clinically validate any long waiting patients (>35 weeks) to ensure their treatment can be expedited if clinically required. In addition, should any patients wait >52 weeks for their treatment a mini root cause analysis is carried out to understand the reason for the long wait and provide assurance that the patient experienced no harm as a result of the long wait. This process also provides valuable information to understand reasons for these breaches and ways in which timeliness of pathways can be improved.

Referral to Treatment

The Trust recognises 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 2017/18, we saw a reduction in the number of patients waiting over 18 weeks for treatment compared with 2016/17.



During the winter period, there was a decline in performance against the 92% national standard and against recovery trajectory. This, in the main, was due to the need to cancel non-emergency elective operations to allow more urgent cases to be treated.

Specialities who are not achieving their trajectory are required to submit a Remedial Action Plan detailing reasons for underperformance, mitigating actions to be taken and timeframes by when they will recover their performance.

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).

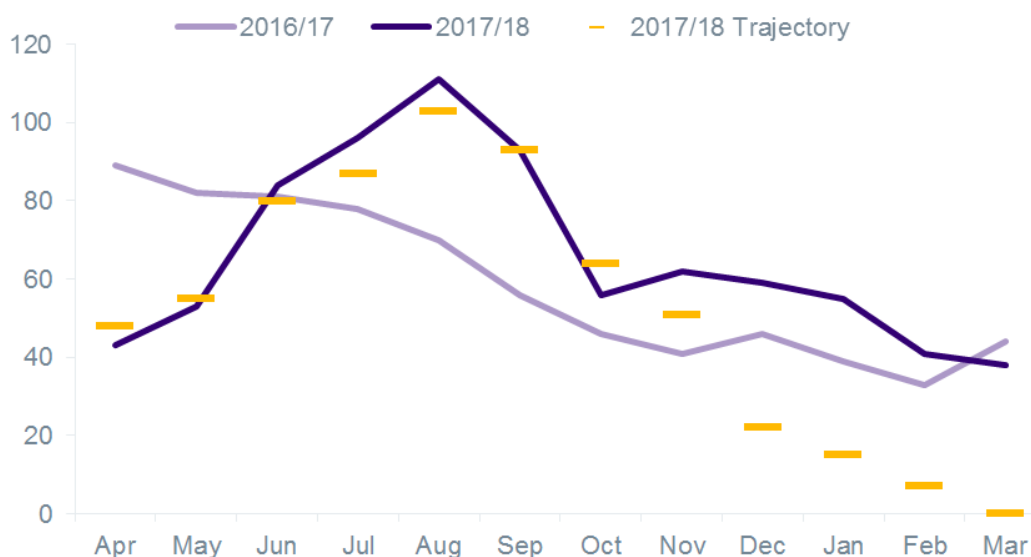
Long Waiting Specialities

The Trust Board is absolutely committed to the zero tolerance of >52 week waiters on a Referral to Treatment incomplete pathway.

Whilst there has been a peak in long waiters during the summer months of 2017/18, the underlying capacity issues have been addressed and there is now a steady decline in the total number of patients waiting in excess of 52 weeks for their treatment.

Root Cause Analyses are completed for all patients breaching 52 weeks wait for treatment to ensure there has been no harm to these patients as a result of the long wait. Dates for patients' operations are agreed at the earliest opportunity and in line with the patient's choice.

Trust Total
52 Week Wait
2017/18 Vs.
2016/17 and
2017/18
trajectory



Plans are in place to continue this improvement into 2018/19.

6.2 Improving the Discharge of Patients from Hospital

The majority of patients in our care are discharged home safely and effectively as soon as they no longer require a hospital bed. However, for patients with more complex needs, they may need additional support for discharge. We recognise that we need to work with partners, patients and their families to ensure that we plan how to make a safe discharge as soon as possible.

Home First

Planning for a patient discharge starts from admission to ensure that there is the earliest opportunity to plan and prevent somebody remaining in hospital when they no longer require medical care. We know that being in a bed leads to decompensation for frail older people and therefore being able to return home is always the preferred option.

If they are safe between visits, we can ensure they are discharged home with any identified support, including;

- ◆ Discharge to Assess Pathway 1
- ◆ Red Cross Home Support
- ◆ Community support such as District Nursing
- ◆ Family support

Key requirements

In order to assess whether the patient is safe between visits, we will check that they can access key requirements:

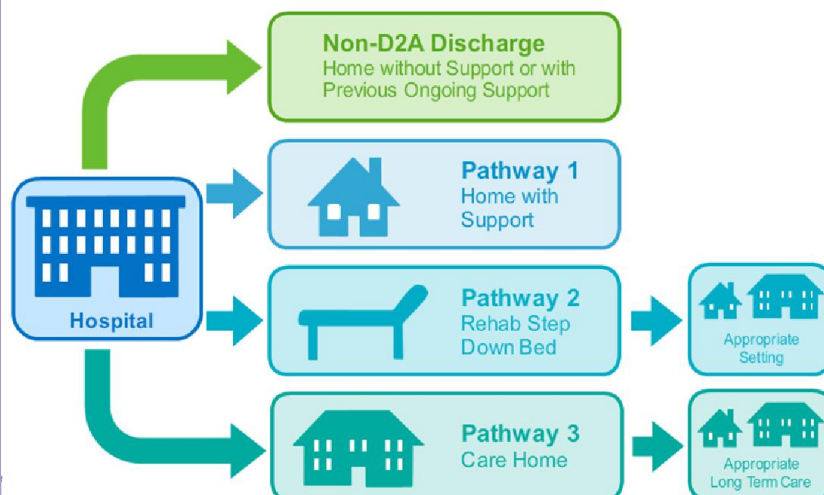
- 1 Access drink**
- 2 Access medication & food**
- 3 Access toileting**
- 4 Wash & dress**
- 5 Call for help**



Discharge to Assess (D2A)

There are a number of options for patients to be supported in the community.

These are options for further assessment and review for the individual in the community and will give further recovery and support available to ensure that they can return to the most appropriate location when they have recovered.



Single Referral Form

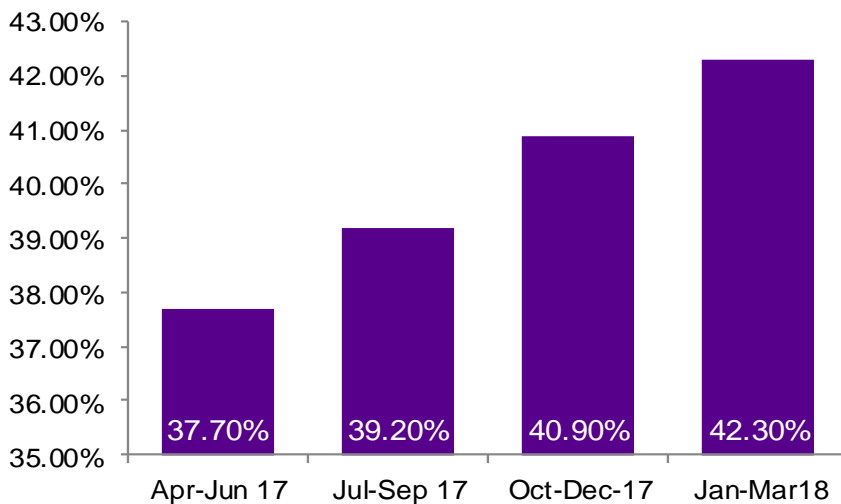
We are continuing to develop the Single Referral Form, leading the way in developing a document that uses the Electronic Patient Record to provide a single source of information that is accurate and trusted. This will help us develop a trusted assessment role between the Trust and community providers to smooth discharge planning.

★ We achieved our Discharge CQUIN

As part of the system review of how we support more people to return home, we have been working with community providers to ensure there are robust discharge plans that work together to promote early return home.

Non Pathway 1 Patients Discharged Home between 3 and 7 Days

(With Los over 2 days)



As a result, we have improved the percentage of people aged over 65 with an unplanned admission who do go home within 3-7 days from 37.7% to 42.3%. This reflects the improvement in decision making and the increase in access to pathway 1 services that have been a focus for the Trust this year.

Managing Expectations Protocol

We have recognised that 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. We use clear information as shown here:

It may be that your long term needs are best met by a permanent placement in a care home; if this is the case our team will work closely with you to plan this. You will have the full support of our team to find a suitable care home as soon as possible, if there are no vacancies at your first choice of care home, you will be placed in alternative accommodation until the home of your choice becomes available. Please work with the team to enable this to happen as quickly as possible to help your recovery.



6.3 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 Payment System. 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.

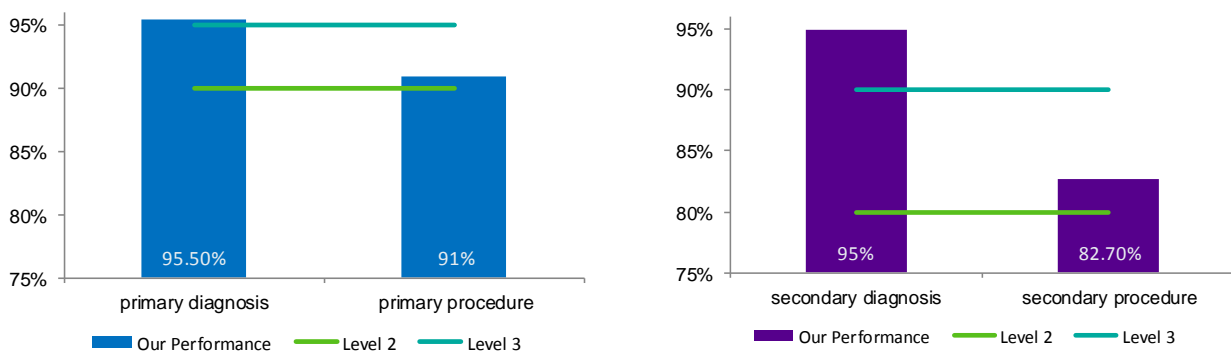
Audit

During 2017/18 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 determined on previous audit findings and areas of coding not recently audited.

IG (505) Clinical Coding Audit December 2017

The Department's NHS Digital Approved Auditors examined 200 CE's (Consultant Episodes). 50 Neurosurgery CE's, 50 Respiratory Medicine CE's and 100 Renal CE's.

The table below compares Trust's audit findings in financial year 2017/18 against the IG 505 attainment standards.



Future Improvements

The department is still reviewing its options to recruit to vacancies, aiming to overcome the local challenges in recruiting qualified coders. This is still proving difficult but plans are in place to address this further during 2018. The department has a number of trainee clinical coders in place at varying stages of experience. Throughout 2017/18 three of our current coders have successfully passed the exam to obtain National Clinical Coding

Qualification status which is excellent progress for them personally as well as for the department. Two coders are to re-sit this year as they were very near misses, and hope to achieve this in 2018.

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 2018 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. The Clinical Coding Divisional Leads already attend more clinical/managerial meetings throughout the Trust since coding department restructure in 2017. This has helped to engage with staff to promote the importance of clinical coding data and associated income and allows hospital staff to have a named contact within our department to raise any queries with.

6.4 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	2015/16		2016/17		2017/18	
	NHS No.	GMP code	NHS No.	GMP code	NHS No.	GMP code
Admitted Patient Care	99.5%	98.2%	99.6%	100%	99.6%	99.4%
Out Patients	98.7%	99.8%	99.2%	100%	99.8%	98.2%
A&E	97.4%	100%	98.2%	99.9%	98.3%	98.0%

6.5 Information Governance Toolkit Attainment Levels

The Information Governance Toolkit is an online system which allows the Trust to assess itself, or be assessed against, information governance policies and standards. It also allows number of the public to view participating organisations' Information Governance Toolkit assessments

For the Trust to be marked as satisfactory level 2 or above should be achieved on **all** 45 requirements.

Our achievement for 2017/18 is as follows:

Assessment	Total Requirements	Level 2	Level 3	Overall Score	Grade
Version 14.1 (2017/18)	45	40	5	70%	Satisfactory

Improvement in Action

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 2018/19 financial year.

The improvement plans in place will also assist in the work already underway implementing the new General Data Protection Regulations (GDPR) which will be active from 25th May 2018.

7.1 Setting Our Quality Priorities—Consultation

The process for review and decision of our quality priorities is set out in section 2.7. Specifically this consultation included:

- Initial discussion at Clinical Governance Divisional Management Team—15th December 2017.
- Patient review at Patient Participation Committee—20th December 2017 and 25th February 2018
- Quality Committee initial review—9th January 2018.
- Quality Committee consultation—6th March 2018
- Healthwatch—w/c 26th March 2017
- Quality & Risk Management Committee review—29th March 2018
- Trust Board approval—26th April 2018

7.2 External Comments on Quality Account

The draft Quality Account was circulated for comment in the period 2nd May 2018—31st May 2018.

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

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

- Bristol North Somerset South Gloucestershire Clinical Commissioning Groups
- North Bristol Trust—Patient Partnership Group
- 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

North Bristol Trust Patient Partnership Group

The other members of the Patient Partnership and I are pleased to see the latest Quality Account. The Quality Account is in a format which is both pleasing to the eye whilst giving the important information in a way that is easy to understand.

The past year has been a huge challenge for NBT and the NHS as a whole, both financially and with patient flow. This has had a massive effect on the experience of patients. As a result this has caused a strain on staff and the hospital. Much work has been done to address these issues and much work continues to go on. NBT is not unique in this situation

I am pleased to report that the members of the Partnership continue to take part, support and give constructive suggestions and criticism, where necessary, as members of the main Committees and Clinical Groups. We are proud to be a part of these. We continue to assist in Consultant interview focus groups, which, as patients and carers, we feel is a valuable thing for all concerned.

Our voices continue to be heard and respected, resulting in affecting change in patient safety, care and Trust policies. Our work in assisting with the Audit process has declined due to pressures within the Trust but we feel confident that these will restart later in the year. A lot of work has been done on complaints resulting in a Complaints Review Panel in conjunction with the Patient Association. This has been a positive learning tool and in the coming year I feel a real improvement will happen with positive results.

It is an honour to contribute alongside such hard working, dedicated and caring staff. Their passion to affect change is inspirational and we feel privileged to be at their side. Even at the most difficult of times it never ceases to amaze us at their resilience.

We have always been treated with respect and appreciate the opportunity that the Trust continues to afford us in these roles.

Christine Fowler
Chair of Patient Partnership Group



Healthwatch South Gloucestershire and Healthwatch Bristol combined response to North Bristol NHS Trust Quality Account 2017/2018

Feedback on the priorities for 2017/ 2018

Healthwatch read with interest that NHS Improvement now encourage other NHS Trusts to view the work the Trust does in the theatre safety programme and look forward to hearing about further improvements.

It was good to read that the Trust has had no Grade 4 pressure injuries during the year and more work will take place on Grade 3 pressure injuries as part of a plan to tackle pressure injuries across the region collaboratively.

Healthwatch welcome the improvement by the infection control team to reduce bacterial infection and differentiate between infections contracted as a result of an indwelling device.

It was really heartening to read that the Trust has achieved 'outstanding' and as part of Improving End of Life Care the 'Purple Butterfly' pilot will be launched to the rest of the Trust.

Awareness of sepsis and staff training to recognise the signs is invaluable. Healthwatch applaud the Trusts ambition to improve on inpatient antibiotic delivery. The recognition by the Trust that patients with diabetes are often 'people expert patients' and best placed to retain control of their insulin is welcomed by Healthwatch.

7.2 External Comments on Quality Account

Healthwatch are very keen to work with the Trust to increase engagement with voluntary sector organisations and the focus on outpatient services.

Priorities for Improvement 2018/2019

Priority One: To eliminate delays in hospital to improve patient safety and reduce bed occupancy (Home is Best)

Healthwatch are aware of the Trust's bed capacity and welcome the priorities to address this issue.

Priority Two: Enhance the patient involvement and feedback is used to influence care and service development

Healthwatch applaud the Trust on the work begun to increase the membership of the Patient Participation Group and the creation of focus groups to provide service specific feedback from different areas of care. Healthwatch look forward to seeing this priority develop over the coming year.

Priority Three: Improving End of Life Care

Healthwatch look forward to hearing how the Trust embeds the 'Purple Butterfly' project and ensures appropriate family involvement at end of life care.

Priority Four: Strengthen learning and action by embedding quality governance at speciality, cluster and divisional level

Following the launch of Service Line Management last year, Healthwatch will follow how the planned priorities work to enable the Trust to achieve a 'Good' CQC rating.

Priority Five: Demonstrate a stronger clinical understanding and application of the Mental Capacity Act and Deprivation of Liberty Safeguards

Healthwatch welcome the Trust wide improvement work led by the Deputy Director of Nursing and Head of Patient Experience in training local teams to operate within the statutory frameworks around mental health.

Quality and Safety Improvement:

Healthwatch are keen to hear more about the collaborative approach when delivering Quality Improvement training and the planned Quality Improvement clinics for staff.

Reducing Falls:

Healthwatch welcome staff training with information on what to do in the event of witnessing a fall and what measures to be taken to reduce the risk of falls.

Reducing Harm from Infection:

Healthwatch were pleased to read that in 2017/18 the Trust has seen the lowest rate of C.diff infections to date and welcome the process and strategy being applied to address MRSA and MSSA in the coming year.

Venous Thromboembolism (VTE):

It is good to read that the Trust has introduced risk assessment with a target of 95% for patients at risk of VTE. Healthwatch read with interest that the Trust is only one of 27 trusts to have the VTE Exemplar Status.

Medicines Management:

It was heart warming to read that the pharmacy extended its service at weekends through staff volunteering to cover during the winter pressure. Healthwatch would like to hear the results of the ongoing review of Trust services and how this relates to pharmacy services and the planned ward level presence at weekends.

Screening for and Treating Alcohol Related Conditions:

Healthwatch were pleased to read 86% of patients were asked about their drinking and patients that required it got appropriate information and support. Healthwatch also noted that 846 doctors have completed online training since the launch in September 2017.

Managing Patient Safety Incidents and Duty of Candour:

Healthwatch look forward to seeing how the Trust develops its processes and systems for the launch of the national guidance on serious incidents later in the year.

Involvement of Patients and the Public:

Healthwatch noted the Trusts work with the Deaf community and the involvement with Healthcare Change Makers and were pleased to see the introduction of Pets as Therapy in Elgar wards working with patients with dementia. Healthwatch also applaud the planned awareness training with other professionals to learn about the signs of skin cancer next year.

Staff Survey Questions:

Healthwatch would welcome the Trust sharing information on the Workforce Race Equality Standard within the Quality Account as it would be useful to view the staff views on harassment and bullying.

Friends and Family Test (FFT):

Celebrating International Patient Experience Week with a focus on improving the use of the FFT feedback is noted and Healthwatch will look forward to viewing the Standard Operating Procedure for FFT being published by the Trust.

Managing complaints:

Healthwatch read with interest the drop in the number of formal complaints, it was disappointing that there is an increase to 10 in unresolved cases over the six month period.

Improving Cancer Patient Experience:

Healthwatch were disappointed to read of a slight deterioration in cancer waiting times in the final quarter of 2017/2018, but are aware of the pressures over the winter months and the rise in demand.

Dementia Care:

Healthwatch welcomed the awareness campaign with staff to ensure they know that patients can have a range of food available at all times.

Carers:

Healthwatch were pleased to read that the focus over the next year will be on young carers.

Healthwatch South Gloucestershire and Healthwatch Bristol agreed that North Bristol NHS Trust (NBT) performance against their 2017/2018 quality priorities have improved.

7.2 External Comments on Quality Account

Health Overview and Scrutiny Panel (Quality Account Sub Committee)



Overall the Health Overview and Scrutiny Panel were encouraged by the Trust's achievements against its 2017/18 Quality Account priorities, and particularly noted the outstanding rating awarded by the CQC Inspection Team to the End of Life Care.

Members noted the following accomplishments in particular:

- The Trust has successfully exited Financial Special Measures;
- The improvement in hospital acquired infections;
- Patient Feedback shows more compliments and fewer complaints; and
- Steady improvements in on-going reduction in pressure injuries

Members felt there could be more engagement with the Trust and would like to see representatives at one or more of the scheduled meetings in order to give on-going current progress reports. They felt that this was particularly important in order to monitor any impact that the closure of the Emergency Department of Weston Hospital has had.

The panel were interested in the MacMillan Centre and would like to take up the invitation of an inspection visit.

In conclusion, the Panel felt that the Trust had made good progress against its 2017/18 priorities and that the priority areas identified for 2018/19 were appropriately targeted.

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

Bristol City Council People Scrutiny Commission



The Bristol City Council People Scrutiny Commission holds the statutory health scrutiny function for Bristol City Council. The Commission received a presentation on the 8th May and Members were satisfied with the contents of the North Bristol NHS Trust Quality Account.

However, Members noted that there needed to be some consistency in ensuring that the anagrams and abbreviations within the report were explained, in order to be accessible to the public.

Members commended the hard work required to successfully lift the organisation out of Financial Special Measures as well as commending the following projects and initiatives:

- The Purple Butterfly project and the good progress made to improve the experience of end of life care for patients and families.
- The Perform project and 'home is best' policy, an example of really good work to ensure that patients spend less time in hospital and more time at home.
- Infection control and the strategy to reduce hospital-acquired infections by reducing the movements of infected patients

- The digital information resource available to the public as well as the flexibility and accessibility presented by the online training service for staff
- That a policy of openness and increased incident reporting was being encouraged
- The investment in initiatives to promote staff wellbeing
- It was positive that the Care Quality Commission annual inspection had broadened access to a wider group of staff

Members raised concern about the following:

- The rises in demand for unplanned care and the impact on levels of bed occupancy
- The trend for staff turnover

Members requested further information about how the organisation is addressing medical care issues, rated as 'inadequate' by the CQC.

Bristol, North Somerset and South Gloucestershire CCG's Statement on North Bristol Trust's Quality Account 2017/18



This statement on the North Bristol Trust (NBT) Quality Account 2017/18 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes NBT's Quality Account, which provides a comprehensive reflection on the quality performance during 2017/18. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

BNSSG CCG noted the achievement against the six quality priorities undertaken by the Trust in 2017/18 although as noted last year it is not clear if these were fully achieved. The CCG acknowledges the work put in place for these priorities particularly in relation to the work undertaken to address Never Events in operating theatres and is pleased to note the plans to continue much of this work into 2018/19.

The CCG supports the chosen areas for quality improvement for 2018/19, especially the inclusion of an objective that works across the health system to improve patient care and experience and are pleased to note that success for these objectives has been identified.

BNSSG CCG notes the excellent quality improvement work relating to end of life care and venous thromboembolism (VTE) and commends the Trust on being awarded exemplar status by the VTE Exemplar Lead Centre.

Within the quality account NBT has demonstrated continued good progress in reducing the number of inpatient falls, reducing infections related to indwelling devices and improving theatre safety culture. We welcome the progress achieved in reducing pressure injuries and the continued focus required in 2018/19 to reduce Grade 3 Pressure injuries.

The Trust achieved compliance with the C Difficile target ending under the trajectory of 43 cases, however, as noted in the 2016/17 statement by South Gloucestershire CCG, BNSSG CCG again would have welcomed more detail in relation to the Trust's MRSA and MSSA performance this year and the Trust's plans to improve on this for 2018/19.

The CCG welcomes the work undertaken to safeguard vulnerable adults and children however would have welcomed inclusion of learning from the two safeguarding children reviews the Trust has been involved in, as well as engagement with the Joint Targeted Area Inspection into Neglect and the associated learning from the thematic review of neglect.

7.2 External Comments on Quality Account

BNSSG CCG notes the improvement in performance regarding the NHS national survey results and the ongoing patient experience work within the Trust. We would encourage the Trust to include more patient stories, such as the one for Cancer services, in the annual quality account to highlight the patient experience work they are undertaking.

Following the CQC inspection in November 2017, the Trust retains the overall “Requires Improvement” rating however the CCG acknowledges the work undertaken to improve individual domain ratings and the improvements within the Urgent & Emergency Care Services. The CCG will continue to monitor progress against the required actions through our quality meetings with the Trust.

Going forward BNSSG CCG will continue to work closely with the Trust in areas which need either further improvement or development. These include:

- Closer working with primary care and community partners to help support the reduction in incidences of healthcare associated infections, namely MRSA, C. Difficile Infection, and E coli bacteraemia.
- Improvement in performance to address actions identified through the CQC inspection.
- Focused work to review themes and embed learning arising from Serious Incidents and Never Events to improve patient safety.

BNSSG CCG acknowledges the good work within the Trust and the quality account clearly demonstrates this. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust 2018/19 to deliver those improvements.



Anne Morris
Director of Nursing & Quality



8.1 Mandatory Indicators

	Mandatory indicator	Period	NBT	National average	National best	National worst
23	Venous thromboembolism (VTE) risk assessment	Apr 17 - Dec 17	95.35%	95.19%	100.00%	77.52%
	<i>Cumulative averages for Q1, Q2, Q3 exclude Acute Trusts which did not submit data for all quarters (RMZ, RTE & RWH)</i>	Apr 16 - Dec 16	95.54%	95.6%	100%	72.1%
	The Trust considers that this data is as described as there is a continued close focus on VTE risk assessment performance given that it is a board reported quality metric within the Integrated Performance Report. It is also regularly scrutinised through the Thrombosis Committee as part of the wider reviews undertaken of Hospital Acquired Thrombosis and related Root Cause Analyses (mini RCAs). In 2017 the effectiveness of this work was recognised by the awarding of VTE Exemplar Status to the Trust, as referenced in the main bod of this Quality Account.					
24	Clostridium difficile rate per 100,000 bed days (patients aged 2 or over) - Trust apportioned cases only	2016/17	9.9	13.2	0.0	82.7
		2015/16	15.8	14.9	0.0	67.2
The Trust considers that this data is as described as it is directly extracted from Public Health England National Statistics and the trend variation from previous year is consistent with internal data intended to inform ongoing improvement actions.						
25	Rate of patient safety incidents reported per 1,000 bed days	2017/18	34.05	42.8	111.69	23.47
		2016/17	30.98	40.77	71.81	21.21
	Percentage of patient safety incidents resulting in severe harm or death	2017/18	0.8%	0.4%	0.1%	2.0%
		2016/17	0.7%	0.4%	0%	1.7%
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 increase the overall rate of reporting, which is a sign of a positive safety culture, whilst also acting upon lessons learned to identify improvements to practice and we would expect this to reduce the proportion of severe harm or death related incidents over time.						
20	Responsiveness to inpatients' personal needs	2016/17	69.2	68.1	85.2	60.0
	Comparative data for 2017/18 will not be available from the Health & Social Care Information Centre until August 2018.	2015/16	69.4	69.6	86.2	58.9
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.						
21	Percentage of staff who would be happy with standard of care provided if a friend or relative needed treatment	2017	71%	70%	86%	47%
	*Data compared to Acute Trusts	2016	65%	70%	85%	49%
The Trust considers that this data is as described as it is directly extracted from National Inpatient Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions.						
12	Summary Hospital-level Mortality Indicator (SHMI) value and banding	Jul 16 - Jun 17	98.45	100.00	72.61	122.77
		Oct 15 - Sep 16	93.04	100.00	68.97	116.39
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, by the Medical Director and within specialties. The rate is also consistent with historic trends and the Trust's understanding of the increased acuity of patients being seen within different specialties.						

	Mandatory indicator	Period	NBT	National average	National best	National worst
	Patient Reported Outcome Measures – No. of patients reporting an improved score;					
	Hip Replacement Primary EQ-VAS	Apr 16 - Mar 17	NBT score 66.8%	(national average 67.2%)		
	Hip Replacement Primary EQ 5D	Apr 16 - Mar 17	NBT score 85.9%	(national average 89.1%)		
18	Knee Replacement Primary EQ-VAS	Apr 16 - Sep 16	NBT score 81%	(national average 54.50%)		
	Knee Replacement Primary EQ 5D	Apr 16 - Mar 17	NBT score 76.2%	(national average 81.1%)		
	Varicose Veins, Groin Hernia	Apr 16 - Sep 16	NBT score 71.26%	(national average 77.50%)		
	Not applicable to NBT					
	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					
19	Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: NBT 10.2%; England average 10.0%; low 0%; high 47.6%.				
	Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12: NBT score 10.9%; England average 11.4%; low 0%; high 17.1%.				
	Comparative data since November 2011 is not currently available from the Health & Social Care Information Centre.					

8.2 CQUIN Achievement 2017/18

A proportion of our income in 2017/18 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 2017/18 and for the following 12 month period are available electronically at <https://www.england.nhs.uk/wp-content/uploads/2018/04/cquin-guidance-2018-19.pdf>

Title	National & Local CQUINs (CCG contracted)	Outcome
Health & Wellbeing Initiatives	For staff - 5% improvement in 2 out of 3 staff survey health & wellbeing questions	
	Improving the health of the food offered on Trust premises	
	Improving the uptake of flu vaccinations for frontline clinical staff	
Sepsis	Sepsis Screening – Emergency & Non- Emergency Care	
	Sepsis Treatment – Emergency & Non- Emergency Care	
Antibiotics consumption	Reduction in antibiotic consumption per 1,000 admissions	
	Empiric review of antibiotic prescriptions	
Improved Mental Health Services in A&E	Joint working with mental health sector for care planning for frequent attenders	
Advice & Guidance	Implement advice & guidance to GPs for agreed specialties	
eReferrals	Implementation of 90% Outpatient referrals through eReferrals	
Supporting Proactive & Safe Discharge	Increasing patients discharge <7 days. New Emergency Care Data set	
Title	Specialised CQUINs (NHS England contracted)	
Armed Forces	Embedding the Armed Forces Covenant	
Abdominal Aortic Aneurysm (AAA) Screening	Improving Uptake – communications and promotion	
Clinical Utilisation Review (CUR)	CUR Completion of 2016/17 Pilot	
Spinal Surgery Network	Spinal surgery: networks, data, Multi-Disciplinary Team (MDT) oversight	
MS Monoclonal Antibodies MDT	Setting up Multiple Sclerosis(MS) Multi Disciplinary Team (MDT) meeting to discuss patients going on Monoclonal Antibodies therapy	
Medicines Optimisation	Hospital Pharmacy Transformation and Medicines Optimisation	
Nationally Standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT)	Implementation of nationally standardised doses of SACT	
Enhanced Supportive Care	Patients with advanced Hepatocellular cancer and/or advanced liver disease are offered early referral to a Supportive Care Team	

Good Achievement - 80%+

Partial achievement - 40%-79%

Poor achievement- <40%

8.3 List of Services Provided by NBT

Medicine	Emergency Medicine Acute Medicine Care of the Elderly Respiratory Cardiology Gastroenterology Infectious disease Diabetes / Endocrinology	Acute Oncology Mental Health Liaison Palliative Care Haematology HIV Immunology Clinical Psychology Endoscopy
Anaesthesia, Surgery, Critical Care and Renal (ASCR)	Theatres Intensive Care Unit (ICU) Anaesthetics and acute pain Urology Transplant Renal Services – hospital and community	Vascular Network Plastics and Burns Dermatology General surgery (including GI and bariatric) Breast screening and symptomatic services
Neurosciences & Musculoskeletal (NMSK)	Elective orthopaedics Trauma Major trauma Bristol Centre for Enablement Rheumatology Neurosurgery Spinal Service	Neurology Stroke Service Neurophysiology Neuropsychiatry Neuropsychology Neuropathology Chronic pain
Women & Children's Health	Maternity Services Gynaecology Neonatal Intensive Care Unit (NICU)	Fertility Services General Paediatrics incl. Outpatients
Core Clinical Services	<p>Therapy Services:</p> Nutrition & Dietetics Speech and Language Therapy Occupational Therapy Physiotherapy	Outpatients Services Imaging Services Clinical Equipment Services Medical Photography & Illustration Pharmacy Services (incl. Regional Quality Control Laboratory)
	<p>Severn Pathology:</p> Genetics Clinical Biochemistry Cellular Pathology (incl. Mortuary) Phlebotomy Immunology Hematology Infection sciences	

8.4 National Clinical Audits Reportable In the Quality Account

During 2017/18 41 national clinical audits and 3 national confidential enquiries covered NHS services that NBT provides. During that period NBT participated in 95% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that NBT was eligible to participate in during 2017/18, and the national clinical audits and national confidential enquiries that NBT participated in, and for which data collection was completed during 2017/18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 17 national clinical audits were reviewed by the provider in 2017/18 and NBT intends to take the following actions to improve the quality of healthcare provided:

An action plan is developed and monitored for each individual project by the project leads with oversight from the Clinical Audit Committee.

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	538/538 (100%)	2017/18
2	Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	N	N/A	N/A	N/A
3	BAUS Urology Audits: Cystectomy	British Association of Urological Surgeons	Y	Y	231/269 (85.8%)	2017
4	BAUS Urology Audits: Nephrectomy	British Association of Urological Surgeons	Y	Y	561/634 (88.5%)	2017
5	BAUS Urology Audits: Percutaneous Nephrolithotomy	British Association of Urological Surgeons	Y	Y	178/169 (+100%)	2017
6	BAUS Urology Audits: Prostatectomy	British Association of Urological Surgeons	Y	Y	763/1010 (75.5%)	2017
7	BAUS Urology Audits: Urethroplasty	British Association of Urological Surgeons	Y	N ¹	N/A	N/A
8	BAUS Urology Audits: Female Stress Urinary Incontinence	British Association of Urological Surgeons	Y	Y	121/149 (81.2%)	2017
9	National Bowel Cancer Audit (NBOCAP)	Royal College of Surgeons	Y	Y	264/234 (+100%)	2017
10	Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	Y	Y	141/141 (100%)	2015/16
11	Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Y	Y	2222/2222 (100%)	2016/17
12	Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	N	N/A	N/A	N/A
13	Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	N	N/A	N/A	N/A
14	Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	Y	Y	291/291 (100%)	2017/18
15	Diabetes (Paediatric) (NPDA)	Health and Social Care Information Centre (HSCIC)	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
16	Elective Surgery (National PROMs Programme)	Health and Social Care Information Centre (HSCIC)	Y	Y	Participation: 921/2132 (43.2%) Issued: 838/921 (91.0%) Returns: 568/838 (67.8%)	2016/17
17	Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons	Y	N ²	N/A	N/A
18	Falls and Fragility Fractures Audit Programme (FFFAP) Fracture Liaison Service Database (FLS-DB) National Hip Fracture Database (NHFD) 2 nd National Audit of Inpatient Falls	Royal College of Physicians	Y	Y		
			Y	Y	2162/2560 (84.4%)	2017
			Y	Y	513/565 (90.8%)	2017
			Y	Y	30/30 (100%)	2017
19	Head and Neck Cancer Audit (HANA)	Saving Faces – The Facial Surgery Research Foundation	N	N/A	N/A	N/A
20	Inflammatory Bowel Disease (IBD) Registry	British Society of Gastroenterology/Royal College of Physicians	Y	N ³	N/A	N/A
21	Learning Disability Mortality Review Programme (LeDeR Programme)	University of Bristol	Y	Y	17/19 (89.5%)	2017/18
22	Major Trauma Audit	Trauma Audit and Research Network (TARN)	Y	Y	1125/1103 (+100%)	2017/18
23	Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Y	Y	35/35 (100%)	2017/18
24	Medical and Surgical Clinical Outcome Review Programme Cerebral Palsy Young People's Mental Health Cancer Care in Children, Teens & Young Adults Acute Heart Failure Diabetes – Perioperative Care	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Y	Y		
			N	N/A	N/A	N/A
			N	N/A	N/A	N/A
			N	N/A	N/A	N/A
			Y	Y	4/4 (100%)	2017/18
			Y	Y	7/7 (100%)	2017/18
25	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	N	N/A	N/A	N/A
26	National Audit of Anxiety and Depression	HQIP	N	N/A	N/A	N/A
27	National Audit of Breast Cancer in Older Patients (NABCOP)	Clinical Effectiveness Unit, The Royal College of Surgeons of England	N	N/A	N/A	N/A
28	National Audit of Dementia Clinical Audit Staff Questionnaire Carer Questionnaire	Royal College of Psychiatrists	Y	Y		
			Y	Y	50/50 (100%)	2016/17
			Y	Y	215/20 (+100%)	2016/17
			Y	Y	30/10 (+100%)	2016/17
29	National Audit of Intermediate Care (NAIC)	NHS Benchmarking Network	N	N/A	N/A	N/A
30	National Audit of Psychosis	Royal College of Psychiatrists	N	N/A	N/A	N/A

8.4 National Clinical Audits Reportable In the Quality Account

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Report Year
31	National Audit of Pulmonary Hypertension	NHS Digital	N	N/A	N/A	N/A
32	National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	N	N/A	N/A	N/A
33	National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	Y	Y	251/251 (100%)	2013-2016 ⁴
34	National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Y	Y	86/86 (100%)	2017/18
35	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Royal College of Physicians	Y	Y	759/759 (100%) 44/46 (96%)	2017 2017
	Secondary care audit Pulmonary Rehabilitation Audit		Y Y	Y Y		
36	National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology	Y	N/A ⁵	N/A	N/A
37	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West Healthcare NHS Trust	Y	Y	127/127 (100%)	2017
38	National Comparative Audit of Blood Transfusion	NHS Blood and Transplant	Y	Y	23/23 (100%) 40/40 (100%) 31/31 (100%)	2017 2017 2016
	Re-Audit of Red Cell & Platelet transfusion in adult haematology patients		Y	Y		
	TACO Audit		Y	Y		
	Re-audit of Patient Blood Management in Scheduled Surgery		Y	Y		
39	National Diabetes Audit – Adults	NHS Digital	Y	Y	87/88 (99%) 142/142 (100%) N/A 81 ⁶	2017 2017 N/A 2016
	National Diabetes Foot Care Audit		Y	Y		
	National Diabetes Inpatient Audit (NaDIA)		Y	Y		
	National Core Diabetes Audit		N	N/A		
	National Pregnancy in Diabetes Audit		Y	Y		
40	National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Y	Y	213/242 (88%)	2017
41	National End of Life Care Audit	HQIP	Y	N/A ⁷	N/A	N/A
42	National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Y	Y	578/578 (100%)	2017/18
43	National Joint Registry (NJR)	Healthcare Quality Improvement Partnership	Y	Y	1103/1622 (68%)	2017

¹The consultant performing these procedures works part-time at NBT, their main practice being at Weston General Hospital. Owing to administrative/time constraints they were not able to submit the Southmead data to BAUS but this will be added in the future.

²There is not the administrative capacity to submit data to this audit.

³Data was not submitted by NBT as the necessary internal database was not updated in time. Update is now underway and NBT will be starting to submit data.

⁴Data not yet published for 2017, figures shown are for the most recent reporting period (2013-2016)

National Clinical Audit and Clinical Outcome Review Programmes		Host Organisation	NBT Eligible	NBT Participating	Case Ascertainment	Report Year
44	National Lung Cancer Audit (NLCA)	Royal College of Physicians	Y	Y	303/303 (100%)	2017
45	National Maternity and Perinatal Audit	Royal College of Obstetricians and Gynaecologists	Y	Y	100% ⁸	2017
46	National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Royal College of Paediatrics and Child Health	Y	Y	100% ⁹	2017
47	National Ophthalmology Audit	Royal College of Ophthalmologists	N	N/A	N/A	N/A
48	National Vascular Registry	Royal College of Surgeons	Y	Y		
	Carotid Endarterectomy		Y	Y	117/117 (100%)	2017
	Elective Infra-Renal AAA Repair		Y	Y	75/75 (100%)	2017
	Lower Limb Angioplasty/ Stent		Y	Y	31/31 (100%)	2017
	Lower Limb Bypass		Y	Y	517/517 (100%)	2017
	Lower Limb Amputation		Y	Y	210/210 (100%)	2017
49	Neurosurgical National Audit Programme	Society of British Neurological Surgeons	Y	Y	9159/9159 (100%)	2016
50	Oesophago-Gastric Cancer (NAOGC)	Royal College of Surgeons of England	N	N/A	N/A	N/A
51	Paediatric Intensive Care (PICANet)	University of Leeds	N	N/A	N/A	N/A
52	Pain in Children	Royal College of Emergency Medicine	Y	Y	51/50 (+100%)	2017
53	Fractured Neck of Femur (care in emergency departments)	Royal College of Emergency Medicine	Y	Y	50/50 (100%)	2017
54	Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	N	N/A	N/A	N/A
55	Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine	Y	Y	51/50 (+100%)	2017
56	Prostate Cancer	Royal College of Surgeons of England	Y	Y	Overall Not reported ¹⁰ Prostatectomy: 270/270 (100%)	2017
57	Sentinel Stroke National Audit Programme (SSNAP)	Royal College of Physicians	Y	Y	274 (+90%)	2017/18
58	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Serious Hazards of Transfusion	Y	Y	64/64 (100%)	2016
59	UK Parkinson's Audit	Parkinson's UK	Y	Y		
	Speech and Language Therapy		Y	Y	11/10 (+100%)	2017
	Elderly Care & Neurology		Y	Y	21/20 (+100%)	2017

⁵This audit was not open for data entry during 2017/2018 but is still being listed on the Quality Account

⁶It is not possible to calculate case ascertainment for this audit as no record is kept of how many women did not consent (see NPID Methodology Paper, pg. 4: https://digital.nhs.uk/media/33162/National-Pregnancy-in-Diabetes-Report-2016-Methodology-Paper/default/National_Pregnancy_in_Diabetes_Report_2016_Methodology_Paper)

⁷Data was not collected during 2017/2018

⁸Data pulled from existing database, individual trusts were not responsible for uploading

⁹Data pulled from existing database, individual trusts were not responsible for uploading

¹⁰Case ascertainment data is only reported for Wales

8.5 Review of Deaths

In line with national guidance we implemented a new Learning from Deaths policy for all deaths from 1st April 2017. This changed the way we review deaths and capture our data. Therefore this data covers all reviews from this date.

27.1 During 2017/18 1,974 of NBT's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

463 in the first quarter
416 in the second quarter
504 in the third quarter
591 in the fourth quarter

27.2 By 12/04/2018, 994 case record reviews and 19 investigations have been carried out in relations to 1,974 of the deaths included in item 27.1. In 0 cases a death was subjected to both a case record review and an investigation.¹

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

343 in the first quarter
279 in the second quarter
246 in the third quarter
148 in the fourth quarter

27.3 4 representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

1 representing 0.2% for the first quarter
1 representing 0.2% for the second quarter
2 representing 0.4% for the third quarter
0 representing 0% for the fourth quarter

These numbers have been estimated using the 3 point score for problems with care (no problems, problems that did not attribute to death and problems that potentially attributed to death which need further investigation. Reviewers apply their own clinical judgement to assess this.

27.4 See section 5.2 pages 67 - 68

27.5 See section 5.2 pages 67 - 68

27.6 See section 5.2 pages 67 - 68

27.7 116 case note reviews and investigations completed after 31/03/2017 which related to deaths which took place before the start of the reporting period.

27.8 Sections 27.8 and 27.9 refer to the document from the previous reporting period. This is the first reporting period where this information is mandatory for inclusion and therefore there is no relevant

27.9 document for the previous reporting period to extract the denominators for this metric.

¹ This is because where a death is covered by another investigation the mortality review request is withdrawn from the system

8.6 Auditors Opinion



Independent Practitioner's Limited Assurance Report to the Board of Directors of North Bristol NHS Trust on the Quality Account

We have been engaged by the Board of Directors of North Bristol NHS Trust to perform an independent assurance engagement in respect of North Bristol NHS Trust's Quality Account for the year ended 31 March 2018 ("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, as subsequently amended in 2011, 2012, 2017 and 2018 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE)
- Rate of clostridium difficile infections

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

Respective responsibilities of the directors and Practitioner

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and NHS Improvement 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 and NHS Improvement guidance.

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

8.6 Auditors Opinion

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 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 2017 to May 2018;
- Papers relating to quality reported to the Board over the period April 2017 to May 2018;
- Feedback from commissioners dated 06/06/2018
- Feedback from local Healthwatch organisations dated 24/05/2018;
- Feedback from the North Somerset Council Health Overview and Scrutiny Panel dated 02/05/2018;
- Feedback from the Bristol City Council People Scrutiny Commission dated 31/05/2018;
- Feedback from the Patient Partnership Group dated 09/06/2018;
- The national patient survey dated January 2018;
- The national staff survey dated 13/12/2017
- The head of Internal Audit’s annual opinion over the Trust’s control environment dated May 2018;
- The annual governance statement dated 24/05/2018; and
- The Care Quality Commission’s inspection report dated 08/03/2018.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for 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, except 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;
- Limited testing, on a selective basis, of the data used to calculate the indicators tested against 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 that can result in materially different measurements and can affect 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 of these criteria, 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 and NHS Improvement. 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 limited assurance work has not included governance over quality or non-mandated indicators which have been determined locally by North Bristol NHS Trust.

8.6 Auditors Opinion

Our audit work on the financial statements of North Bristol NHS Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as North Bristol NHS Trust's external auditors. Our audit reports on the financial statements are made solely to North Bristol NHS Trust's directors, as a body, in accordance with the Local Audit and Accountability Act 2014. Our audit work is undertaken so that we might state to North Bristol NHS Trust's directors those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of North Bristol NHS Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such directors as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than North Bristol NHS Trust and North Bristol NHS Trust's directors as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, **nothing has come to our attention that causes us to believe that**, for the year ended 31 March 2018

- 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 identified as having been subject to limited assurance have not reasonable stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Bristol

14 June 2018



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