Trust Board Meeting in Public  
Thursday 27 July 2017  
12.30pm, Seminar Room 5, Learning and Research Centre, Southmead Hospital

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<td>1. Apologies and Declarations of Interest: John Iredale, Robert Mould, Catherine Phillips</td>
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| 4. Action Log and Matters Arising  
  • Impact of Weston ED Closure - KH |
| 5. Chairman’s Business |
| 6. Chief Executive’s Report |

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<td>7. Patient Story <em>(Information)</em></td>
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<td>10. Medical Revalidation and Appraisal Annual Report <em>(Information)</em></td>
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<td>11. Nursing and Midwifery Revalidation Annual Report <em>(Information)</em></td>
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<td>12. Quality Account 2016/17 <em>(Information)</em></td>
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<td>18. Trust Management Team Report <em>(Information)</em></td>
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<td>20. Any Other Business</td>
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21. **Date of Next Meeting**  
Thursday 28 September 2017, 12.30pm, Learning and Research Centre, Southmead Hospital
Minutes of the Trust Board Meeting held in public on 25 May 2017 in Seminar Room 5, Learning and Research Building, Southmead Hospital

Present:

Mr P Rilett  Non-Executive Director  (Chairman)  Ms A Young  Chief Executive
Ms J Davis  Non-Executive Director  Dr C Burton  Medical Director
Mr J Everitt  Non-Executive Director  Mr N Darvill  Director of Informatics
Mr R Mould  Non-Executive Director  Ms J Fergusson  Director of People and Transformation
Dr E Redfern  Non-Executive Director  Ms K Hannam  Director of Operations
                     Mrs S Jones  Director of Nursing
                     Mrs C Phillips  Director of Finance
                     Mr S Wood  Director of Facilities

In Attendance:

Mr S Lightbown  Director of Communications  Mr E Sanders  Trust Secretary
Ms S Radford  Carer's Trust  Mr N Stibbs  Corporate Services Manager

Apologies: Prof J Iredale, Non-Executive Director

Observers: Two CQC staff members, one member of the public and one member of staff.

Action

TB/17/05/01  Patient Story

Sue Jones, Director of Nursing and Quality, introduced Sam Radford who was a member of the Carer’s Trust and had run the Carer’s Liaison Service jointly with University Hospitals Bristol for five years.

Sam Radford presented the story of Mandy Laws who was the carer for her daughter and husband with help from her son in the evenings. Her mother, having previously been fit and well, suffered a fall and was admitted firstly to the Bristol Royal Infirmary. She was referred to Southmead for elective surgery which took place after a twelve week wait. She was sent home within 24 hours of the operation in a swift and poorly organised discharge with none of her family asked if they were prepared, no advice about care and no discussion about the need for any equipment. As a user of the Carer’s Service she was able to navigate some help but had to juggle her new caring commitment for issues such as pain relief with her existing responsibilities. Sam Radford said that Mandy’s daughter was profoundly disabled and Mandy had much experience in both challenging professionals about treatment but also in thanking the NHS for saving her life on a few occasions.

Sue Jones noted that a few simple questions would have elicited the needs of this family and she would pick up the lessons learned. The obvious place for discovering the issues would have been in pre-op. Jaki Davis, Non-Executive Director, questioned the amount of time
between the injury and the operation and Chris Burton, Medical Director, said he had no knowledge of the clinical background so could make no comment about this aspect.

TB/17/05/02 Declarations of Interest
No interests were declared in the papers presented.

TB/17/05/03 Questions from Members of the Public
There were no questions from members of the public.

TB/17/05/04 Minutes of the Trust Board meeting held on 30 March 2017
The minutes were approved as a true and correct record of the meeting subject to amendment of Minute 17/3/09 and the first sentence of the first paragraph to end ‘… poor staff engagement.’

TB/17/05/05 Action Log and Matters Arising
The Trust Board approved the closure of actions as stated on the action log and noted progress as follows:

Action 4 – Simon Wood, Director of Facilities, reported that other suitable options on or near the Royal United Hospital site were currently being explored for a replacement Renal Dialysis Unit. RUH officers would decide on the viability of an alternative site within their trust within the next four weeks. The other option would be a new build. He would provide a report to the Board at the July meeting.

TB/17/05/06 Chairman’s Report
Peter Rilett, Chairman, said that there had been 17 applications for the vacant non-executive director post. Short listing would take place after the General Election.

TB/17/05/07 Chief Executive’s Report
Andrea Young, Chief Executive, referred to her written report and reported, in addition, that with the heightened national state of alert regarding terrorism, staff had been asked to be vigilant and reminded on the actions to move patients quickly in the event of a major incident. Plans for extra staff in theatres and blood supplies had been checked.

She referred to the volunteers celebration and said that the 500 volunteers gave over 50,000 hours of their time to the hospital a year and Simon Wood had taken tea to one volunteer who was unable to leave her home. In addition to the awards in her report there had been a presentation of 20 long service awards.

Referring to the recent consultant appointments, Chris Burton, Medical Director, said that it was pleasing to appoint a good candidate to the histopathology post but there were still a number of vacancies in the specialty on which recruitment was very active.

TB/17/05/08 Integrated Performance Report
Andrea Young, Chief Executive, introduced the monthly Integrated Performance Report (IPR) and highlighted:

- the four hour Accident and Emergency performance had
decreased from March's position to 86.2% due mainly to shortfalls in workforce numbers in the Emergency Department. These were being resolved but a longer term workforce plan was required

- the national target for diagnostic waiting time performance had been narrowly missed due to the continuing issues in endoscopy and an increase in ultrasound breaches
- in March the Trust had again delivered all seven cancer targets
- maternity services continued not to achieve the Friends and Family response rates and some further ideas were required
- the sickness rate had reduced to 4.4% still above the target of 4% submitted to NHS Improvement.

Kate Hannam, Director of Operations, reported that the hospital was extremely busy and there were over 50 medical patients occupying beds outside of medicine’s base because of the volume of admissions. Medical staff were stretched to cover these patients and Chris Burton, Medical Director, noted that there was increased interest from regulatory bodies on 'stranded' patients. Kate Hannam said delayed transfers of care were meeting the national target and other reasons for discharge delays were worsening. The total discharges over Easter had not created enough capacity to cope with the demand after Easter and bed occupancy was still at or over 100%. The aim was to achieve the national target for four hour waits (95%) in the Emergency Department (ED) by the end of the year and over 90% had been achieved in March. John Everitt, Non-Executive Director, questioned whether quality and safety had been compromised and Sue Jones said that a robust dashboard (Shine) was reviewed weekly by the executives and was used daily to direct operations and improve quality at ward level. Chris Burton also noted that quality was being monitored by visits from non-executives, executives and commissioners and further scrutiny came through the Quality and Risk Management Committee (Q&RMC).

Kate Hannam said that the aim for diagnostic services was to achieve a shorter than six week wait and whilst all cancer targets had been met breast cancer services were predicted to be a challenge.

Under Safety, Sue Jones reported that the South Bristol Dialysis Unit had hit the QuESTTT effectiveness and safety tool threshold. Recruitment was in place to fill the workforce shortfall but sickness levels remained an issue and environmental issues were being reviewed which had resulted in a reduction in chair capacity. Chris Burton reported that the hospital acquired Methicillin Resistant and Methicillin Sensitive Staph. Aureus (MRSA) case from April was being referred to third party arbitration and the number of Clostridium Difficile cases was running at less than the national and regional averages.

Sue Jones noted the number complaints and concerns had reduced and the number of overdue responses was down to 25. The establishment of a lay review panel had started well and a ‘Happy App’ was being trialled to improve staff engagement. The Board noted that compliance with the eight essential training subjects was very good although Peter Rilett questioned the declining rate of non-medical appraisals. Jacolyn Fergusson, Director of People and Transformation
North Bristol NHS Trust

said that the system was changing to a window of opportunity from 1 May which should see all appraisals completed by the end of September.

Sue Jones noted that the vacancy factor had reduced in April and nurse recruitment was progressing well. There had been no decrease in ‘A’ level leaver appointments but more effort needed to be put into recruiting more mature staff.

Catherine Phillips, Director of Finance, reported on the financial position and said that the Trust was £100,000 favourable to plan at the end of April with good performance in income and pay offset by poor performance in non-pay. Savings delivery was £800,000 less than planned. This and the level of elective activity were the main concerns.

There was discussion about the negative answer to the compliance statement on plans to achieve all targets. It was agreed to continue to report negatively but to reconsider in two months following a proper understanding of the issues at the workshop in June and the July Board meeting.

The Board note the report and agreed ‘stranded patients’ should be recorded in the IPR.

TB/17/5/09 Nasogastric Tube Safety Alert Actions

Sue Jones, Director of Nursing, presented a report on the actions taken to address a patient safety alert regarding nasogastric tube misplacement. Andrea Young, Chief Executive, said that the Board had considered it at its last meeting in private to comply with the alert’s time constraint. It was reproduced in the public meeting to show staff and the public that the Board acknowledged it and had taken advice from professional staff. A communications plan had been developed to ensure all clinical staff were aware of the procedures.

TB/17/5/10 Financial Recovery Plan Progress Update

Jacolyn Fergusson, Direct of People and Transformation, presented a report that set out the financial, cost improvement, workforce and operational efficiencies achieved in 2016/17. These, and the progress in 2017/18, were largely duplicates of the finance reports to the Board having accepted a control total for the current year of a deficit of £18.8m. To date £29.5m of cost improvements had been identified towards the target of £39.4m. In addition there was an estimated £3.2m worth of pipeline schemes. The next checkpoint meeting with NHS Improvement would be held on 18 June 2017 and the executive’s intention was to plan savings beyond the target and to validate all the schemes.

The Trust Board noted the report.

TB/17/5/11 Capital Planning Report

Simon Wood presented the monthly Capital Planning Report and highlighted the following issues:

- Trust officers were currently going through the Exova report on fire integrity
• Landscaping works at Beaufort house were due to complete by the end of June 2017

• A contractor had been appointed to remove the residual asbestos from Limewalk, Sherston and Brecon buildings starting 1 July 2017

The Board noted the work to evaluate the practicality of vacating Monk’s Park House. Chris Burton, Medical Director, said that a small part of it housed a children’s outpatient department and the Outpatient Work Stream Board would have to consider the implications.

The Trust Board noted the update.

TB/17/5/12 Service Line Management Timeline and Divisional Structure

Jacolyn Fergusson, Director of People and Transformation, presented a report outlining progress towards implementing service line management (SLM) by April 2018. Appointments had been made to all the senior divisional teams, Finance, Human Resources and IM&T business partners had been confirmed and would move into their posts the following week and other corporate support would be confirmed by 1 July 2017. A draft development plan to support the move to SLM had been developed and would be informed by the outputs from the Board development day in May 2017.

Chris Burton, Medical Director, reported that the Neurosciences and Musculo-Skeletal Division would combine under a single director in August or September 2017.

Jaki Davis, Non-Executive Director, reported that the Audit Committee had noted PwC’s forensic report on the financial problems at St George’s Trust in London when it had been implementing SLM and that a report on the learning points from it would be put to the Board in July 2017.

The Trust Board noted the report.

TB/17/5/13 Provider Licence – Self Certification

Eric Sanders, Trust Secretary, reported on a new requirement for NHS Trusts to self-certify themselves against criteria for compliance with the Provider Licence. The requirement had been introduced under directions from the Secretary of State. By 31 May 2017 the Trust had to ‘confirm’ or ‘not confirm’ that it had taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution and by 30 June 2017 that it complied with the required governance arrangements.

Having reviewed evidence and, in particular, the Head of Internal Audit Opinion he recommended the Board respond with ‘confirmed’ for all elements. The Trust Board agreed to the recommendation.

TB/17/5/14 Quality and Risk Management Committee Report

Liz Redfern, Chairman of the Q&RMC, presented the report from the meeting of the Committee held on 18 May 2017. She highlighted:

• a number of issues were identified, through a horizon scanning process, that could affect delivery of the Trust Strategy but it was agreed that a framework was required to provide structure
to the discussion

• the receipt of a presentation by David Gibbs, Severn Pathology Service Manager, of the pathology service and the new Laboratory Information Management System

• that some risks were still not being managed effectively and better alignment was required between the Committee and the Clinical Research Committee (CRC). It was agreed to invite the new chairman of the CRC to a future meeting

• the Committee believed that actions raised by the Coroner at inquests required a mechanism for raising Board awareness and it was agreed to receive a report to every second meeting;

The Committee approved a number of minor amendments to the terms of reference particularly to include the Director of Operations and Director of Informatics as members and recommended them to the Board for adoption.

The Trust Board noted the report and approved the revised Terms of Reference.

TB/17/5/15 Remuneration and Nominations Committee Report

John Everitt, Chairman of the Remuneration and Nominations Committee, presented the report from its meeting held on 27 April 2017. He Highlighted the changes the Committee recommended to its terms of reference.

The Trust Board noted the report and approved the revised terms of reference.

TB/17/5/16 Trust Management Team Report

Andrea Young, Chief Executive, presented the report of the meeting of the Trust Management Team held on 16 May 2017. She highlighted the risks relating to the recent cyber-attack which had affected a number of NHS organisations and the bed capacity to manage forecast demand, particularly for the Winter of 2017/18.

Jaki Davis, Non-Executive Director, questioned how the Trust had avoided the cyber-attack problems and Andrea Young said it had been the updating of technology in recent months which like all updates from manufacturers meant some minor operational disruption when implemented.

The Trust Board noted the report.

TB/17/5/17 Partnership Programme Report

Rob Mould, Non-Executive Director, presented a verbal report from the recent Partnership Programme Board (PPB) meeting. It had discussed the Neonatal Intensive Care Unit, Cardiology, Stroke and Pathology services, the Sustainability and Transformation Partnership (STP) and its work and ownership. The PPB had committed to meeting three times a year.

The Chairman felt that a joint approach to STP was required and Andrea Young, Chief Executive, said that a stronger commissioning
voice was also required.

The Trust Board noted the report.

**TB/17/5/18**  
**Date of Next Meeting**

The next meeting was to be held on Thursday 27 July 2017 at 12.30 pm in Seminar Room 5, Learning and Research Centre, Southmead Hospital.
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<thead>
<tr>
<th>Meeting Date</th>
<th>Minute Ref</th>
<th>Action No.</th>
<th>Action</th>
<th>Owner</th>
<th>Review Date(s)</th>
<th>Status</th>
<th>Info.</th>
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<tbody>
<tr>
<td>30-Mar-17</td>
<td>TB/17/3/05</td>
<td>4</td>
<td>Update on potential move of Bath Dialysis Unit to next Board meeting</td>
<td>SW</td>
<td>25-May-17</td>
<td>C</td>
<td>Verbal update provided under matters arising</td>
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<tr>
<td>29-Sep-16</td>
<td>TB/16/09/06</td>
<td>23</td>
<td>Plan for Service Line Management implementation in 2017/18 to be developed</td>
<td>AY</td>
<td>25-May-17</td>
<td>C</td>
<td>Discussed at May meeting</td>
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<tr>
<td>24-Nov-16</td>
<td>TB/16/11/10</td>
<td>31</td>
<td>FT membership to be engaged in ST Plans</td>
<td>SL</td>
<td>27-Jul-17 &amp; 28-Sep-17</td>
<td>O</td>
<td>Plans to be updated and awaiting governance arrangements</td>
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<td>30-Mar-17</td>
<td>TB/17/3/08</td>
<td>5</td>
<td>Research Strategy to be presented by Director of Research</td>
<td>CB</td>
<td>27-Jul-17</td>
<td>A</td>
<td>Item 13</td>
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<td>30-Mar-17</td>
<td>TB/17/3/18</td>
<td>8</td>
<td>Succession planning to be discussed in detail by Workforce Committee and then Board report for September</td>
<td>AY</td>
<td>28-Sep-17</td>
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<td>25-May-17</td>
<td>TB/17/5/05</td>
<td>9</td>
<td>Full report on plans for Bath Dialysis Unit to Board in July</td>
<td>SW</td>
<td>27-Jul-17</td>
<td>A</td>
<td>Item 15</td>
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<tr>
<td>25-May-17</td>
<td>TB/17/5/08</td>
<td>10</td>
<td>Stranded patients' data to be added to IPR</td>
<td>KH</td>
<td>27-Jul-17</td>
<td>A</td>
<td>Item 8</td>
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<tr>
<td>25-May-17</td>
<td>TB/17/5/09</td>
<td>11</td>
<td>Staff to be informed that Board has seen the actions following professional advice on the Safety Alert regarding the placement of nasogastric tubes</td>
<td>SJ/SL</td>
<td>27-Jul-17</td>
<td>C</td>
<td>Within papers for May meeting and Friday 5</td>
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<tr>
<td>Meeting Date</td>
<td>Minute Ref</td>
<td>No.</td>
<td>Decision</td>
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<td>26/1/17</td>
<td>17/1/11</td>
<td>1</td>
<td>Operational Plan 2017/18 and 2018/19 approved with minor changes regarding e-rostering</td>
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<td>26/1/17</td>
<td>17/1/16</td>
<td>2</td>
<td>Revised Standing Orders approved</td>
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<td>26/1/17</td>
<td>17/1/17</td>
<td>3</td>
<td>Transfer of charitable Toy and Communications Aids Fund to Claremont School and charitable funds in respect of the Riverside Unit to Avon and Wiltshire Mental Health Partnership approved</td>
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<td>30/3/17</td>
<td>17/3/13</td>
<td>4</td>
<td>Sustainable Development Policy adopted</td>
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<td>30/3/17</td>
<td>17/3/16</td>
<td>5</td>
<td>Charity Funds Committee revised terms of reference approved</td>
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<td>30/3/17</td>
<td>17/3/18</td>
<td>6</td>
<td>Annual Cycle of Business approved with two additions</td>
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<td>25/5/17</td>
<td>17/5/13</td>
<td>7</td>
<td>Self-Certification of all provider licence conditions approved</td>
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<td>25/5/17</td>
<td>17/5/14</td>
<td>8</td>
<td>Q&amp;RCMC terms of reference revisions approved</td>
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<td>25/5/17</td>
<td>17/5/15</td>
<td>9</td>
<td>R&amp;NC terms of reference revisions approved</td>
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<tr>
<td>Report to:</td>
<td>Trust Board</td>
<td>Agenda item:</td>
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<td>Date of Meeting:</td>
<td>27 July 2017</td>
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<tr>
<th>Report Title:</th>
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<td>Status:</td>
<td>Information</td>
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<td></td>
<td>X</td>
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<tr>
<td>Prepared by:</td>
<td>Eric Sanders, Trust Secretary</td>
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<tr>
<td>Executive Sponsor (presenting):</td>
<td>Andrea Young, Chief Executive</td>
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<td>Appendices (list if applicable):</td>
<td>None</td>
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**Recommendation:**

The Trust Board is asked to note the content of the report.
1. Purpose

1.1. To present an update on local and national issues impacting on the Trust.

2. Background

2.1. The Trust Board should receive a report from the Chief Executive to each meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks in the health economy, PBR new tariffs etc.).

3. Exit from Financial Special Measures

3.1. NHS Improvement have written to the Trust to confirm that, as of 3 July 2017, the Trust was removed from Financial Special Measures.

3.2. The Trust successfully demonstrated that it had met the exit criteria, having improved the underlying financial position and having accepted the control total for 2017/18.

3.3. It was noted that whilst having exceed the financial plan for 2016/17, the Trust had managed to sustain quality and safety. The Trust was specifically recognised for developing and delivering an effective staff communications campaign which helped to engagement staff in the financial improvement.

3.4. The Trust has been placed into segment 3 of the Single Oversight Framework.

4. National Patient Safety Award

4.1. Healthcare staff from Bristol picked up a prestigious award this month for an initiative to support the adoption of an emergency department checklist tool across all hospitals in the West of England.

4.2. Led by the West of England Academic Health Science Network (AHSN), the Emergency Department Collaborative won the HSJ Patient Safety Award ‘Best Patient Safety Initiative in A&E’.

4.3. Originally piloted at University Hospitals Bristol NHS Foundation Trust in 2014, the West of England AHSN has supported all seven emergency departments in the region (spanning six hospital trusts and the ambulance service) to adopt the emergency department safety checklist to address the shared challenge of ensuring patient safety during periods of crowding.

4.4. The checklist helps to standardise and improve the delivery of basic care in emergency departments, providing a time-based framework of tasks completed for every patient, other than those with minor complaints.

4.5. The judges felt the checklist had already achieved a significant impact on patient safety and, having
already spread across multiple organisations, could see the potential for wider adoption across the country.

5. Latest GMC Survey

5.1. The latest national data released by the General Medical Council shows that junior doctors at NBT are the most satisfied in the region in relation to the quality of education and training they receive.

5.2. The annual survey looks at patient safety, quality of supervision amongst other things and showed that overall satisfaction is above the national average and has been increasing year on year.

6. Domestic Violence Award

6.1. One of our care assistants in Southmead Hospital’s Emergency Department has been presented with an award for her efforts in supporting victims of domestic violence.

6.2. Emergency Care Assistant Rose Lockhart was presented with The Ann Wood Award for her “outstanding contribution to tackling domestic abuse in South Gloucestershire” in acknowledgment of her “determination and dedication” in supporting people who had disclosed that they were victims while in the department.

6.3. The annual award is given out by the South Gloucestershire Partnership Against Domestic Abuse.

6.4. Staff in the Emergency Department received training from domestic violence charity Survive to help them feel more confident in broaching the subject with patients they think might be victims and understanding how they can provide advice about the next steps to take and help with referrals. They also work with Independent Domestic Violence Advisors (IDVA) within the department to support victims of domestic abuse.

7. Non-Executive Director Recruitment

7.1. Tim Gregory was successfully appointed to the Trust Board with effect from 1 July 2017.

7.2. Tim brings a wealth of experience in delivering large scale change having worked in a range of organisations including the Ministry of Defence, Wiltshire Council and Nottinghamshire County Council.

7.3. Tim’s last role in Nottinghamshire was as Corporate Director – Place where he successfully delivered improved customer service through integrated IT system implementation and process redesign.
8. Annual General Meeting (AGM)

8.1. The Trust held its AGM on 20 July 2017 where the annual report and accounts for 2016/17 were presented to the public. Over 40 members of the public and staff attended the event, and heard presentations from the Chairman, Chief Executive, and Director of Finance, on the Trust’s quality, operational and financial performance.

8.2. There were also presentations on Schwarz Rounds and the quality and safety improvements in the Emergency Department.

9. BNSSG Sustainability & Transformation Partnership

9.1. Sir Ron Kerr has been confirmed as the Independent Chair of the Bristol, North Somerset and South Gloucestershire CCG. Ron was most recently the Chief Executive of Guy’s and St. Thomas’s Hospitals NHS FT in London, but also brings a wealth of senior experience over 30 years in both executive and non-executive roles in all parts of the NHS.

9.2. A refresh of the STP is underway, led by Laura Nicholas, STP Programme Director. The refresh will ensure that there is a clear strategic framework in place and concise articulation of the transformational changes planned. The approach will be:

9.2.1. To undertake a rapid review of the 3 current STP work-streams, including scope, progress, resourcing, programme management, and alignment with and impact on current system priorities.

9.2.2. To develop and agree the forward work programme for the rest of 2017/18, including:

- medium-term service improvement / pathway transformation priorities. These are likely to be derived from current work programmes.
- agreed programmes of work for each of the enabling work-streams. In the communications and engagement work stream, this will include establishment of effective patient, public and other stakeholder involvement and engagement mechanisms.
- finalised STP clinical, financial and delivery strategy framework (including a clear case for change) to provide a clear, quantified, evidenced based strategic direction for the partnership
- full implementation of the STP programme architecture.

9.3. The refresh is due to be completed by 26 July 2017, with a report to be presented to the STP Sponsoring Board.
10. NHS Improvement – Interim Chair Appointment

10.1. Richard Douglas, CB, has been appointed interim Chair of NHS Improvement with effect from 21 July 2017. Richard replaces ED Smith who stepped down on 20 July and will be in place until the conclusion of the recruitment process.

10.2. Richard Douglas is the former Director-General of Finance at the Department of Health and has extensive experience of working across Whitehall.

10.3. Richard retired as Director-General (DG) of finance, commercial and the NHS directorate at the Department of Health in April 2015. He was responsible for ensuring that the department properly managed its finances and those of the health service and accounted to parliament. He also had primary responsibility for NHS policy and the government’s relationship with the NHS. He was the department’s sponsor for a number of national arm’s-length bodies, including NHS England, Monitor and the NHS Trust Development Authority.

11. NHSI and NHSE New Leadership Model

11.1. NHS Improvement and NHS England have written to the Trust to confirm that from 1 September 2017 they will be piloting a new leadership model and ways of working in the South.

11.2. Anne Eden will assume the joint responsibilities of both the Regional Director for NHS England and the Executive Regional Managing Director for NHS Improvement for the NHS in the South East and Jennifer Howells will assume the same joint responsibilities for the NHS in the South West.

11.3. The Trust will be discussing this with NHS Improvement to understand the implications on the Trust.

12. International Healthcare Design Award

12.1. Southmead Hospital’s Brunel building has been named the best designed large hospital in the international category of the European Healthcare Design Awards.

12.2. The purpose-built hospital building which opened to patients in May 2014 bringing most services from the old Southmead and Frenchay hospitals together under one roof was the only British hospital to make the shortlist.

12.3. Despite being European awards, the Brunel was also up against competition from the United States and Canada in the category for Healthcare Design buildings over 25,000 square metres.

12.4. The awards celebrate and recognise professional and research excellence in the design of healthcare environments both in Europe and around the world.
12.5. The Brunel building was the result of 9 years of design, planning and construction with North Bristol NHS Trust working with architects BDP and private finance initiative partners Carillion.

13. ICU Coastal Challenge

13.1. Members of staff, ex-patients, family members and colleagues have successfully completed the South West Coastal Path challenge and have raised £25,000 for the Trust’s Intensive Care Unit. Walkers, who completed the route in stages and in their own time, completed the 630 miles in eight weeks, with the start aligned to the fourth anniversary of moving into the Brunel building.

13.2. A cheque for the total raised was presented to the Southmead Hospital Charity by BBC west presenter Will Glennon.

14. Recent Consultant Appointments

14.1. The following consultant appointments have been made since 9 May 2017:

<table>
<thead>
<tr>
<th>Interview Date</th>
<th>Name</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 June 2017</td>
<td>Edward Richfield</td>
<td>Medicine for Older People</td>
</tr>
</tbody>
</table>

15. Recommendations

15.1. The Trust Board is asked to note the content of the report.
**Report to:** Trust Board  
**Agenda item:** 8  
**Date of Meeting:** 27 July 2017

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>Integrated Performance Report (IPR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Lisa Whitlow, Associate Director of Performance and Sustainability</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Executive Team</td>
</tr>
<tr>
<td>Appendices (list if applicable):</td>
<td>IPR</td>
</tr>
</tbody>
</table>

**Recommendation:**

The Trust Board is asked to note the contents of the Integrated Performance Report.

**Executive Summary:**

Details of the Trust's performance against the domains of Access, Safety, Patient Experience, Workforce and Finance are provided on page 2 of the Integrated Performance Report.
North Bristol NHS Trust

INTEGRATED PERFORMANCE REPORT

July 2017 (presenting June 2017 data)
Executive Summary
June 2017

ACCESS
Overall June performance against the four hour target was 79.13%, a 0.34% increase compared to May’s position. The majority of breach reasons were ED attributable, followed by a wait for beds. Volume of ED attendances remains high in comparison to the same period in 2016/17.
The Trust has achieved the agreed recovery trajectory for Referral To Treatment (RTT) incomplete performance for June (87.78% vs trajectory of 86.70%). The waiting list backlog stands at 3722 vs a target of 3812.
The Trust has failed to achieve the national target (1.00%) for diagnostic performance with actual performance of 2.42% in June. There continues to be underperformance against target due to Endoscopy surveillance patients becoming overdue for review in month. In addition, there has been a drop in performance for DEXA Scans. This is due to a prolonged period of staff shortages leading to the growth of a backlog of patients, who are breaching their planned date for a Scan. The Trust has improvement plans in place for both of these areas.
The Trust has delivered 4 of the 7 national cancer targets in May. The 62 day standard was failed in May with performance at 81.46% vs the 85.0% standard. The majority of breaches related to Urology patients for a variety of breaches reasons including, late referrals from other providers, lack of capacity and complex diagnostics. Early indications are that Urology performance has greatly improved in June. There continues to be underperformance against the Two Week Wait urgent GP referrals standard, where there has been demand and capacity imbalance for skin and breast patients in particular.

SAFETY
Nursing staff levels continue to be monitored closely, but one ward triggered the Quality Effectiveness and Safety Trigger Tool (QuESTT) in June. Actions are in place to support the Ward Sister with recruitment to vacancies and sickness management.
Incidence of pressure ulcers decreased in June with 23 reported Grade 2 pressure injuries, 1 reported Grade 3 and none reported at Grade 4. The Trust remains on target to achieve a 50% reduction of pressure injuries over the three year period.
The Trust reported 0 cases of MRSA and 4 cases of C. Difficile in different clinical areas in May.

PATIENT EXPERIENCE
The number of complaints received by the Trust in June has decreased from 48 to 44 in June. Reported concerns decreased from 65 to 58 in June. Friends & Family response rates have seen a decrease in June 2017 in all fours areas. The lowest response rate continues to be within Maternity. The Maternity Team has been consulting with another Trust who uses the same methodology of data collection to see if there is any learning that can be shared to improve the Trust’s performance in future.
NHS Choices ratings for both Southmead Hospital and Cossham Hospital remain at 4/5 stars.

WORKFORCE
The Trust vacancy factor increased from 7.57% in May to 8.14% in June. Targeted actions are in progress to fill posts substantively in specific areas, such as Theatres and Facilities, where there are high levels of vacancies. The in-month turnover rate marginally increased in June to 1.14% which is above the planned rate for the month of 0.90%. The in-month sickness rate has reduced from 4.12% in April to 4.11% in May, but remains above the 3.59% target submitted to NHS Improvement.

FINANCE
The Trust has planned a deficit of £18.7m in line with the agreed control total with NHS Improvement. The financial position for the end of June is £0.3m favourable to plan. As of July 2017, the Trust is no longer in Financial Special Measures. Continued focus on identification of the full savings target required, as well as good contract delivery and management in the first half of the year, will be crucial to ensure delivery of the Trust’s control total.
### Key / Notes

Unless noted on each graph, all data shown is for period up to, and including, 30 June 2017.

All data included is correct at the time of publication. Please note that subsequent validation by clinical teams can alter scores retrospectively.

### Abbreviation Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Glossary</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCS</td>
<td>Core Clinical Services</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Clin Gov</td>
<td>Clinical Governance</td>
</tr>
<tr>
<td>IM&amp;T</td>
<td>Information Management</td>
</tr>
<tr>
<td>Med</td>
<td>Medicine</td>
</tr>
<tr>
<td>MSKN</td>
<td>Musculoskeletal and Neurosciences</td>
</tr>
<tr>
<td>RAP</td>
<td>Remedial Action Plan</td>
</tr>
<tr>
<td>Non-Cons</td>
<td>Non-Consultant</td>
</tr>
<tr>
<td>Ops</td>
<td>Operations</td>
</tr>
<tr>
<td>Renal</td>
<td>Renal Transplant &amp; Outpatients</td>
</tr>
<tr>
<td>ASCR / Surg</td>
<td>ASCR / Surgery</td>
</tr>
<tr>
<td>W&amp;Ch</td>
<td>Women’s &amp; Children’s</td>
</tr>
<tr>
<td>RCA</td>
<td>Root Cause Analysis</td>
</tr>
<tr>
<td>HON</td>
<td>Head of Nursing</td>
</tr>
</tbody>
</table>

### CQC Domain / Report Section

<table>
<thead>
<tr>
<th>CQC Domain / Report Section</th>
<th>Sponsor/s</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness</td>
<td>Director of Operations</td>
<td>4</td>
</tr>
<tr>
<td>Safety &amp; Effectiveness</td>
<td>Medical Director, Director of Nursing, &amp; Director of Facilities</td>
<td>18</td>
</tr>
<tr>
<td>Caring</td>
<td>Director of Nursing</td>
<td>35</td>
</tr>
<tr>
<td>Well Led</td>
<td>Director of People and Transformation &amp; Medical Director</td>
<td>42</td>
</tr>
<tr>
<td>Finance</td>
<td>Director of Finance</td>
<td>53</td>
</tr>
<tr>
<td>Regulatory View</td>
<td>Chief Executive</td>
<td>58</td>
</tr>
</tbody>
</table>
## Overview

### Urgent Care

June’s four hour A&E performance was 79.13%. The majority of breach reasons were ED attributable, followed by a wait for beds. One of the factors in this drop in performance relates to ED workforce shortfalls. This should improve at the beginning of August 2017 when a new rotation of junior doctors commences.

The Delayed Transfers of Care (DToc) rate has met the national standard of 3.5% and continues to improve with actual performance at 2.48%.

### Referral to Treatment (RTT)

In month, the Trust has exceeded Trust RTT trajectory of 86.70%, with actual performance at 87.78%. At the end of June the Trust has seen a further increase in greater than 52 week waiters. The number of patients choosing to wait greater than 52 weeks for their treatment continues to be a challenge. In addition, a number of breaches have been identified due to lack of capacity and following a data quality/validation exercise. Mitigating actions have been put in place to ensure that data quality issues do not cause further breaches. The Trust has narrowly missed the trajectory for Neurosurgery at the end of June by 1 breach. The Epilepsy trajectory has not been met in month, but continues to be on track for clearance of all breaches by the end of Quarter 3 of 2017/18.

### Cancelled Operations

In month, there was one breach of the 28 day re-booking target; the first breach of the year to date.

### Diagnostic Waiting Times

The Trust has failed to achieve the 1.00% target for diagnostic performance in June with actual performance at 2.42%. There continues to be in month underperformance in Endoscopy. June has seen a significant increase in DEXA Scan breaches (5 May vs 70 June), which has adversely impacted the Trust aggregate position.

### Cancer

Cancer performance in May has achieved four of the seven standards. The Trust has failed the 62 day standard in May at 81.46% (Target 85.00%). The majority of breaches related to Urology patients for a variety of breaches reasons including, late referrals from other providers, lack of capacity and complex diagnostics. Early indications are that Urology performance has greatly improved in June. There continues to be underperformance against the Two Week Wait urgent GP referrals standard, where there has been demand and capacity imbalance for skin and breast patients in particular.

### Areas of Concern

The system continues to monitor the effectiveness of all actions being undertaken, with weekly and daily reviews. The main risks identified to the Urgent Care Recovery Plan (UCRP) are as follows:

- **UCRP Risk**: Lack of community capacity and/or pathway delays fail to meet bed savings plans as per the bed model.
- **UCRP Risk**: Length of Stay reductions and bed occupancy targets in the bed model are not met leading to performance issues.
- **UCRP Risk**: Weston Emergency Department shuts due to staffing problems related to sustainability issues. Risk of 10-15 extra medical admissions to NBT overnight. Contingency plans have been agreed across the system including a repatriation protocol.
### Key Operational Standards Dashboard

**June 2017**

<table>
<thead>
<tr>
<th>Access Standard</th>
<th>Performance against National Target</th>
<th>NBT Trajectory</th>
<th>Performance direction of travel from last month</th>
<th>Year end forecast position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Attendances &lt;4 hour standard vs total attendances</td>
<td>95%</td>
<td>79.13%</td>
<td>90.00%</td>
<td>95.00%</td>
</tr>
<tr>
<td>Referral to Treatment % incomplete pathways &lt;18 weeks</td>
<td>92%</td>
<td>87.78%</td>
<td>86.70%</td>
<td>88.03%</td>
</tr>
<tr>
<td>Referral to Treatment 52 Week Waits - Neurosurgery and Epilepsy</td>
<td>0</td>
<td>15</td>
<td>16</td>
<td>0</td>
</tr>
<tr>
<td>Referral to Treatment 52 Week Waits - Other</td>
<td>0</td>
<td>69</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Trust Wide Referral to Treatment Backlog</td>
<td>N/A</td>
<td>3722</td>
<td>3812</td>
<td>3341</td>
</tr>
<tr>
<td>Diagnostic DM01 % waiting more than 6 weeks</td>
<td>1%</td>
<td>2.42%</td>
<td>N/A*</td>
<td>1.00%</td>
</tr>
<tr>
<td>Cancelled Operations Same day - non-clinical reasons</td>
<td>0.8%</td>
<td>1.75%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Cancelled Operations 28 day re-booking breach</td>
<td>0</td>
<td>1</td>
<td>N/A*</td>
<td>N/A*</td>
</tr>
</tbody>
</table>

*Trajectories being set and awaiting internal sign off and agreement with Commissioners.*
Responsiveness
Urgent Care
Board Sponsor: Director of Operations

Overview of Urgent Care
Sustained pressure experienced within both the Emergency Department and the Trust during June resulted in a significant number of patients waiting in excess of the 4 hour target.

Patients experienced delays due to a combination of issues – workforce shortages in particular within the medical grades of ED and also the inability to support patients being transferred within the hospital in a timely way, due to extremely high occupancy levels, limiting timely flow through the hospital.

There were 3 x 12 hour trolley breaches on 27th June which occurred within an hour of one another which reflected the imbalance of capacity available to meet the peaks in demand of patients requiring admission on that day.
Responsiveness
ED performance and Mental Health Breaches
Board Sponsor: Director of Operations

Attendances and Admissions
There is a continuing increase in attendances and emergency admissions compared to the same period in 2016/17.

Mental Health Breaches
June saw increased numbers of mental health attendances in the Emergency Department. The trend for 4 hour breaches for mental health patients has remained relatively constant at 37.9% breaches as a proportion of all mental health attendances in June.

However, the proportion of breaches attributed to mental health delays increased in the month of June, which accounted for 73.2% of the total 4 hour breaches for mental health patients.
Responsiveness
Length of Stay and Discharge
Board Sponsor: Director of Operations

**Length of Stay**
Length of Stay (LoS) over 14 days continues to be a challenge across all divisions. Work continues to provide a focused review of any patient tipping over 7 days and an audit of patients with a LoS between 7 to 14 days across all divisions.

Medically fit for discharge (MFFD) remain high, 315 overall across the Trust (equivalent to 36.63% of the core bed base).

‘Operation Reset’ commencing for 2 weeks from 24th July 2017 aims to focus on patients with delays using local health economy partners to support timely discharge of complex patients and find suitable alternative discharge destinations. The focus will be on supporting the 70 patients who are currently outside of North Bristol Operational Standards (NBOS – agreed metrics for managing patient pathways). In addition, there will be a focus on the top 20 patients with complex discharges for South Gloucestershire and Bristol.
Responsiveness
Length of Stay, Discharge and Emergency Re-admissions
Board Sponsor: Director of Operations

Bed Occupancy / Discharge
Bed Occupancy for June was reported at 98.71% for the month. This level of occupancy exceeds the 95% occupancy set to maintain flow. Bed occupancy remains high and when escalation beds are taken into account, has been greater than 100% beds occupied.

Delayed Transfer of Care (DToC) was at a rate of 2.48% in June, which was a further improvement from the previous level of 2.97%. This remains below the 3.5% national standard.

The system however has signed up to delivering against the NBOS standards which have a further 5% of patients delayed for ongoing care and this remains the focus of our partnership meetings. The main cause of delays against NBOS remains lack of availability of home care packages for Bristol patients and Pathway 2 packages for all partners.

30 day Emergency Re-admissions
Further detailed analysis is being undertaken with our partners to understand if there are any opportunities to avoid patients being readmitted into NBT.
Referral to Treatment All Specialties
Board Sponsor: Director of Operations

The Trust has achieved the RTT trajectory in month with performance of 87.78%. The Trust also achieved the RTT backlog trajectory, reporting 3722 against trajectory of 3812.

Trauma and Orthopaedics, Gastroenterology and Respiratory Medicine at a specialty level failed to meet their planned recovery trajectories in month. Remedial action plans are in place to monitor progress across a number of specialties who are not meeting the constitutional standards.
Responsiveness
Elective Operations
Board Sponsor: Director of Operations

Cancellations
The same day non-clinical cancellation rate was 1.75% vs the national target 0.8%. The majority of cancellations at the last minute (48%) relate to theatre timing issues.

In month there were zero operations cancelled for a subsequent time.

The Theatres Board is overseeing the monthly performance for the Trust cancelled operations with an aim to further reduce cancellations. The Theatres Board is also overseeing a delivery plan to address theatres productivity and to introduce changes to scheduling.

In month, there was one breach of the 28 day re-booking target. This was a General Surgery patient, who was cancelled due to a theatre overrun related to a complex patient. As the planned operation could only be performed by one particular surgeon, the patient was listed for the next available routine slot, which was outside of the 28 day standard.
Referral to Treatment 52 Week Waits

The Trust has narrowly missed the trajectory for Neurosurgery at the end of June by 1 breach. Whilst the Epilepsy trajectory has not been met in month, the service remains on track to clear all >52 week waiters by the end of Quarter 3 of 2017/18.

There were a total of 84 patients waiting over 52 weeks in June:
- 9 Neurosurgery
- 6 Epilepsy
- 69 Others (patient choice; lack of capacity; data quality)

The number of patients choosing to wait greater than 52 weeks for their treatment continues to be a challenge with 30 patients currently choosing to defer their treatment. Root Cause Analyses have been completed for all patients, with dates for patients’ operations being agreed at the earliest opportunity in line with the patient’s choice.

In addition, a number of breaches have been identified due to lack of capacity and following a data quality/validation exercise. Mitigating actions have been put in place to ensure that data quality issues do not cause further breaches.
In June, the Trust underperformed against the diagnostic six week wait standard with performance of 2.42%.

Of the 13 diagnostic tests, four have reported underperformance in June - an increase from the three reporting in May; Colonoscopy, DEXA Scan, Flexible Sigmoidoscopy and Gastroscopy are reporting below the standard this month.

The largest number of breaches were for DEXA Scans (70), which were 66 breaches above threshold for that test type.

The decline in DEXA Scan breaches relates to a prolonged period of staffing shortages leading to a growing backlog of patients who have breached their planned test date. A recovery plan and trajectory have been requested.

DEXA Scan and Endoscopy (Colonoscopy, Flexible Sigmoidoscopy and Gastroscopy) performance is predicted to continue to underachieve.
# Responsiveness

**Cancer Summary Dashboard**

**Board Sponsor:** Director of Operations

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Please note: Monthly positions are provisional and may not match final quarterly position.

<table>
<thead>
<tr>
<th>Access Standard</th>
<th>Performance against National Target</th>
<th>NBT Trajectory</th>
<th>Performance direction of travel from last month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td>National Target</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients seen within 2 weeks of urgent GP referral</td>
<td>93%</td>
<td>89.03%</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients with breast symptoms seen by specialist within 2 weeks</td>
<td>93%</td>
<td>92.80%</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients receiving first treatment within 31 days of cancer diagnosis</td>
<td>96%</td>
<td>96.59%</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients waiting less than 31 days for subsequent surgery</td>
<td>94%</td>
<td>97.09%</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients waiting less than 31 days for subsequent drug treatment</td>
<td>98%</td>
<td>100.00%</td>
<td>N/A</td>
</tr>
<tr>
<td>Patients receiving first treatment within 62 days of urgent GP referral</td>
<td>85%</td>
<td>81.46%</td>
<td>86.50%</td>
</tr>
<tr>
<td>Patients treated within 62 days of screening</td>
<td>90%</td>
<td>96.05%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Responsiveness
Cancer
Board Sponsor: Director of Operations

Cancer
The May 2017 cancer performance for the Trust shows the Trust met four of the seven national waiting time standards.

Whilst there was an improvement from April performance, the Trust failed the Two Week Wait (TWW) standard at 89.03%.

The Trust received 1949 TWW referrals in May, a rise of 138 from the previous month. Of the 1949 referrals there were 215 breaches. 109 of these breaches were in Skin, 48 breaches were in Breast, 28 breaches were in Colorectal and 14 breaches were in Upper GI.

The increase in referral rates and failed TWW performance will continue into June 2017. TWW performance is steadily improving from April into June, however ongoing capacity issues in skin will prevent the Trust from achieving the performance standard currently.

The Trust failed the breast non symptomatic screening standard with a performance of 92.75%. There were 5 breaches in total, all due to capacity issues as patients were unable to attend the appointments that were offered on day 14 of their pathway and there was no capacity to offer prior to day 14.
Responsiveness
Cancer
Board Sponsor: Director of Operations

The Trust failed the 62 day national standard for May 2017 with a performance of 81.46% against the 85% target. The Trust is now being measured against the new national breach reallocation policy however there is no system for NHSE to collect this performance data as yet so the Trust declared performance as 80.04% under the former rules.

In May there were 35 patients who breached in total, 24 of which were TWW referrals direct to NBT and 11 of which were tertiary referrals into the Trust from other providers.

Of the 24 breaches that started their pathway at NBT 10 received their first OPA or diagnostic after day seven. Radiology delays impacted on 18 breaches with radiology delays being wholly responsible for 5 breaches.

11 Urology patients were transferred in to the Trust from other providers for treatment in May, 4 of them were received after day 38 of their pathway and not treated within 24 days of receipt. 1 was received prior to day 38 and not treated by day 62 of their pathway. 6 were received after day 38 and treated within 24 days. This enabled the trust to reallocate 3 breaches back to the referring providers for these patients.

NB: The charts show the breakdown of breach reasons for both whole and shared 62 day breaches for the month of March. Breakdown of breach reason may not match total published performance due to time of which data was captured. Data is extracted from a live system.
Responsiveness
Cancer
Board Sponsor: Director of Operations

The Trust passed the 31 day first treatment performance standard with a performance of 96.59%. There were 10 breaches in total; 4 in breast, 2 in skin and 4 in Urology. 2 patients were cancelled on the day of surgery, 1 was an administrative error and 7 were due to elective capacity.

NBT achieved the 31 day subsequent treatment targets in May 2017 for both surgical and drug treatments. The Trust also passed the 62 day screening target with a performance of 96.05%.

The Trust will continue to struggle to meet the TWW performance target through the summer due to increased referrals in skin and consultant capacity. The service will continue to outsource one clinic per week through this period in an attempt to address this issue.
### Section Summary

<table>
<thead>
<tr>
<th>Improvements:</th>
</tr>
</thead>
</table>
| One ward triggered the QuESTT early warning tool, actions are in place to support the ward Sister with recruitment to vacancies, sickness management and to understand the impact on the staffing model following a recent change of use swapping 12 MSK rehab beds for acute medical beds. The rate of agency use has increased in month but remains well below the cap at 3.2%.  
The rate of falls per 1,000 bed days is at the lowest level for 12 months for two consecutive months. |

<table>
<thead>
<tr>
<th>Areas of Concern:</th>
</tr>
</thead>
</table>
| NICU cots have been reduced by 4-6 to meet BAPM and commissioned standards for safe staffing following a case to increase staffing that was not supported by specialist commissioning. The South West Neonatal Network have been informed.  
In July we reported a never event of wrong size implant following a hip replacement. Safety alerts have been issued, a SWARM conducted, and 72 hour report completed. Duty of candour has been followed for the patient and the RCA underway (deadline 25/09/17).  
The rate of serious incidents has stabilised following improvements to our processes. We are now seeing an improvement in low harm and near misses that should be reflected in next months data.  
There was one grade 3 pressure ulcer in month and work to do to improve the numbers of grade 2 pressure ulcers. Following a visit from the Royal United Hospital Bath to share best practice our senior team are planning to adopt their approach of an immersion event to reduce grade 2s, and at back to the floor we have awarded bronze, silver, gold and platinum awards for wards with the greatest number of months since their last grade 2 hospital acquired pressure ulcer. |
<table>
<thead>
<tr>
<th>Standard (target)</th>
<th>June 2017</th>
<th>Quarterly Trend (Q4 2016/17 vs Q1 2017/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Performance against National Target</td>
<td>NBT Trajectory</td>
</tr>
<tr>
<td>Never Event Occurrence by Month</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Safety Thermometer Overall Compliance</td>
<td>-</td>
<td>93.35%</td>
</tr>
<tr>
<td>Malnutrition Screening</td>
<td>90%</td>
<td>89.13%</td>
</tr>
<tr>
<td>Hand Hygiene Compliance (in arrears)</td>
<td>95%</td>
<td>98.00%</td>
</tr>
<tr>
<td>MRSA</td>
<td>0 Internal</td>
<td>1</td>
</tr>
<tr>
<td>C. Difficile</td>
<td>&lt;3.6 Internal</td>
<td>4</td>
</tr>
<tr>
<td>MSSA</td>
<td>&lt;1.6 Internal</td>
<td>1</td>
</tr>
<tr>
<td>Venous Thromboembolism Screening (in arrears)</td>
<td>95.0%</td>
<td>95.01%</td>
</tr>
</tbody>
</table>
QuESTT

In June one of the wards triggered above the threshold of 12 for action. There were 6 wards which did not submit data, each has been individually reviewed and rescored with review by the Heads of Nursing.

Gate 9a Triggered 12:
Reasons: Vacancies, sickness, complaints, and significant demands on the service.

Actions in Place: new staff due to commence in September, Sickness managed in line with policy, Head of Nursing providing support for completion of complaint responses. Staffing levels are being closely monitored in line with safe care live data to ensure appropriate staffing model in place for Specialties.

Safe Care Live (Electronic Acuity tool) is used at the twice daily safe staffing meetings. The acuity of patients is measured three times daily and staff are moved between divisions to ensure safety is maintained where a significant shortfall in required hours is identified. Data for this month shows that all Clinical Divisions have higher acuity than staffing planned. The shortfall is risk assessed across the Trust. Data validation is continuing to ensure consistency of patient assessments by all staff. The Medical Division is working to improve census completion.
Safe Staffing
Nursing Workforce
Board Sponsor: Director of Nursing

Nursing Workforce
There remains an increase in June in over establishment of Health Care Assistants (HCA) with a reduction in the over establishment of Registered Nurses (RN).

MSKN
Increases in HCA to cover Enhanced Care and above plan sickness.

Women and Children’s
Staffing the additional bed capacity which remained open throughout June.

Medicine
Staffing for extra capacity and increase in Enhanced Care requirements for complex patients on 2 wards.

ASCR
High number of vacancies and sickness in Theatres / Medirooms and due to use of Medirooms as bed escalation area.

CCS
Increased use of HCAs in OPD due to sickness.

Actions in place:
RN and HCAs in the pipeline due to start over the next three months to support shortfall. HCAs being trained to provide mental health support role for certain patient groups to reduce dependency on RMNs.

The use of agency staff in June increased to 3.3%, this was due to increased vacancies and to ensure safety within ASCR and NICU.
Southmead Nursing Fill Rate and CHPPD
The overall fill rate for Registered Nurses (RN) on both day and night shifts decreased in June with an increase in both day and night shifts for Care Assistants (CA). CA hours increase are reflective of the enhanced care requirements for patients across the Trust. In June there was continued requirement for staff for additional bed capacity with patients cared for in Medirooms, Interventional Radiology and AMU. CHPPD remains at an overall of 8.1 this includes CHPPD for ICU, NICU and the Birth Suite.

Wards below 80% fill rate are:
NICU: Reduced fill rate for CA Night shifts, NICU staffing is monitored closely alongside cot dependency with RN’s used instead of CA’s if required. To ensure safety is maintained there has been a reduction in the number of cots by 4 -6 dependent on acuity.
ICU: Reduced fill rate for CA Day and Night shifts, with shortfall supported with above100% fill for RN Day shifts. ICU staffing is managed in line with patient dependency, a review of staffing recently has changed the skill mix which provides an increase in RN’s.
8B: Reduced fill rate for CA’s on days, safety was maintained where required by utilising Ward Sister and Matron.
Mendip Birth Suite: Fill rates for all shifts were below 80% when births were reduced, at this time staff were moved to support CDS and other areas within the Unit.
Quantock: Reduced fill rates for Maternity support worker day shifts, staff were moved across the unit to maintain safety.

Cossham Midwifery Fill Rate and CHPPD:
Cossham Birth Suite fill rates have decreased this month across all shifts, this is reflective of a reduced number of Births which have occurred. There was an increase in CHPPD to 50.1 in June.

Table 1

<table>
<thead>
<tr>
<th>June 2017</th>
<th>Day shift</th>
<th>Night Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RN/RM Fill rate</td>
<td>CA Fill rate</td>
</tr>
<tr>
<td>Cossham</td>
<td>92.2%</td>
<td>73.3%</td>
</tr>
<tr>
<td>Southmead</td>
<td>96.4%</td>
<td>114.9%</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>June 2017</th>
<th>Care Hours Per Patient Day (CHPPD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cumulative Pt.census</td>
</tr>
<tr>
<td>Cossham</td>
<td>39</td>
</tr>
<tr>
<td>Southmead</td>
<td>28773</td>
</tr>
</tbody>
</table>

The numbers of hours Registered Nurses (RN) / Registered Midwives (RM) and Care Assistants (CA) / Maternity Care Assistants (MCA), planned and actual, on both day and night shifts are collated manually by each gate/ department every month. This data is uploaded on UNIFY for NHS Choices and also on our Website showing overall Trust position and each individual gate level. The breakdown for each of the ward areas is available on the external webpage.
Maternity Staffing

This report provides information about midwifery staffing and will track occasions when the Central Delivery Suite (CDS) was unable to take admissions and why.

In June 2017 the unit closed on one occasion. This was due to a lack of beds on CDS.

The Midwife to birth ratio was maintained at 1:30 in June and has been a constant since April 2016. The Birth Rate Plus report continues to be used to inform business planning for the future workforce plan, alongside a pilot to change to integrated working between the birth centres and the community.

There were 475 births in June with a normal birth rate of 57.9%. Cossham Birth Centre had 20 births in June and Mendip Birth Centre had 67 births.

78.7% of births were on CDS, with a slight decrease in the total births in birth centre locations from 19.7% to 18.3%.

There was an increase in the Caesarean rate from 27% in May to 29.6% in June.

One to one care in labour was provided for 96.4% of women in our care.
Serious Incidents (SI)

Nine serious incidents were reported to STEIS in June 2017:
- 2 x Surgical Complication
- 2 x Delayed Treatment
- 1 x Delay to Act on Test Results
- 1 x Medication Error
- 1 x Unexpected Death
- 1 x Fall
- 1 x Infection Control

Two serious falls investigated through the SWARM process.

Initial details, including any urgent safety actions identified from immediate learning have been reported to the national reporting system STEIS in line with the 72 hour reporting process and summary information is shared with the Board through the bi-weekly Flash reports.

Trustwide Serious Incidents Rate per 1000 Bed Days: Jul 2016 - Jun 2017

SI & Incident Reporting Rates
Incident reporting has increased slightly to 37 PBD. Serious incidents rate continues to be high at 0.38, but has fallen slightly from May.

Directorates:
- SI Rate by 1000 Bed Days
  - CCS* – 0.37
  - ASCR – 0.31
  - WCH – 0.31
  - Med – 0.28
  - MSKN – 0.16

*CCS Bed Base Intentional Radiology only
Quality & Patient Safety
Additional Safety Measures
Board Sponsor: Director of Nursing

**Incident Reporting Deadlines**
One serious incident breached the reporting deadline.

**Top SI Types in Rolling 12 Months**
Falls remain the most prevalent of reported SI’s, followed by SWARM Falls and Pressure ulcers.

Eight Serious incidents have been submitted to the CCG in June, 1 breaching the 60 working day deadline.

**Central Alerting System (CAS)**
16 New alerts reported, none breaching alert target.

**Data Reporting basis**
The data is based on the date a serious incident is reported to STEIS. Serious incidents are open to being downgraded if the resulting investigation concludes the incident did not directly harm the patient i.e. Trolley breaches. This may mean changes are seen when compared to data contained within prior Months’ reports.

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**Number of Serious Incidents Closed and Open Breaching Deadlines Jul 2016- Jun 2017 by Date Reported to STEIS**

**Top Types of SI reported Jul 2016- Jun 2017 N = 98 by Date Reported (STEIS or SWARM)**

<table>
<thead>
<tr>
<th>Category</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Serious Incidents Closed and Open Breaching Deadlines Jul 2016- Jun 2017 by Date Reported to STEIS</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>CAS Alerts – June 2017</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Patient Safety</td>
<td>4</td>
<td>12</td>
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<td>1</td>
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<tr>
<td>Facilities</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical Devices</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Data Reporting basis</td>
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<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
| The data is based on the date a serious incident is reported to STEIS. Serious incidents are open to being downgraded if the resulting investigation concludes the incident did not directly harm the patient i.e. Trolley breaches. This may mean changes are seen when compared to data contained within prior Months’ reports.
The ‘harm free’ care reporting now includes both overall harm free care and the new harm rates which are reflective of ‘hospital acquired harm’. This shows a decrease to 97.21% for hospital acquired harm which reflected an increase in the number of reported hospital acquired pressure ulcers. One ward saw a significant increase in heel reported injuries, and following this implemented some immediate improvement measures to prevent further occurrences.

**Overall Falls**

There were 150 reported falls in month with 3 major falls included, of which two have been externally reported.

Thematic review has identified the need to review standing and supine blood pressure monitoring which will be considered further at the next Falls Prevention meeting.
Pressure Injury

Pressure injury incidence per 1000 bed days has decreased in June.

**Grade 4:** Nil reported in June.

**Grade 3:** One reported in June occurring within the Medical Division.

Immediate actions following the SWARM: Carrying out all patients’ skin integrity and documentation within the SKIN bundle. Completion and documentation of the intentional rounding tool.

**Grade 2:** 23 reported in June occurring on 21 patients

Further work will begin on a Trust-wide pressure injury reduction emersion event.

The Trust remains on target to achieve a 50% reduction of all pressure injuries over the three year period, in line with the target set at the outset of the national ‘Sign up to Safety’ programme.

VTE Risk Assessment

Timely VTE Risk Assessments above the 95% national standard have continued. The emphasis on broader quality improvement work in relation to cases of Hospital Acquired Thrombosis continues, overseen by the Thrombosis Committee.

The Trust is has applied for VTE exemplar centre status and it is anticipated that the required accreditation visit will be undertaken in the Autumn 2017.
Malnutrition

Malnutrition compliance for June was 89.13%. The improvement and sustainability for Women's Division to ensure that they remain above 90% for Nutritional screening is being led by the Matron working with the Ward Sister with weekly reporting to help drive the improvement with the team.

WHO Checklist Compliance

Measured compliance with the WHO checklist improved to 95.8% in June 2017 from 94.5% in May 2017.

The WHO checklist compliance improvement programme is ongoing and is being overseen by the Theatre Board and work is underway reviewing the WHO safer surgery compliance to ensure we are accurately reporting against all activity.
The work of the NBT Patient Safety Medicines Management team continues.

**Missed Doses**
The percentage of missed doses is within target.

**Incidents**
The Medication Safety Subgroup reviews all drug related incidents from eAIMS and includes division representatives to improve shared learning across the hospital.

**Major / Catastrophic Incidents**
No major / catastrophic incidents were reported in May.

**Themes / Types / High risk drugs**
Common causes of incidents over the past 12 months are shown.
MRSA
There have been no reported cases of MRSA bacteraemia in June. The Trust position remains at 1 in 17/18 and 8 in the past 12 months.

The Trust has been unsuccessful in their appeal to NHS England of the third party arbitration decision for the March Community acquired case and the April case from ICU.

MSSA
There was one reported cases of MSSA bacteraemia in June.

C. Difficile
There have been 4 reported cases in June occurring within different clinical areas. The total number remains below the expected trajectory. The infection prevention & control team and clinical teams continue to investigate each case and review lessons learnt.
In May 2017 the Department of Health published national guidance on the reduction of gram negative blood stream infections. The ambition is set at a 10% reduction across the whole healthcare community for this year with a 50% reduction by 2020. The Trust will commence reporting on the IPR from August 2017. An investigation will occur for each case to establish themes and learning outcomes. There were a total of 7 cases in April, 1 in May and 5 in June.

Hand Hygiene
The Trust Hand Hygiene compliance is meeting the Trust standard.

Norovirus
There was one care of the elderly ward placed under restricted access, in June, due to confirmed Norovirus affecting both patients and staff.

Public Health England (PHE) Benchmarks
Data from the latest published report is shown.
Effectiveness

Mortality

Board Sponsor: Medical Director

**Mortality**

HSMR and SHMI mortality indicators remain below 100 in NBT resulting in fewer observed deaths than would be expected for the case mix. Statistically, mortality at NBT is ‘as expected’.

There were 1643 cases identified to undergo mortality review in the year to March 2017. 1390 of these were “reviewable” cases (e.g. notes were accessible). 51.7% of the total number of cases were reviewed. 61.2% of the “reviewable cases” were reviewed. The reviews by specialty in the 15 months to June 2017 are shown and demonstrate considerable variation in delivery by specialty.

A new mortality review tool called the Structured Case note Review (SCR) has gone live in July after being tested with all specialties. All trust Specialty Mortality Review Leads have been identified and are engaged in the new process. Screening of notes will take place in 4 specialties with a sample taken for full SCR. A policy for Mortality Reviews will go out for consultation this month and be approved at the September Quality Committee.

Data on how many deaths occurred where ‘care delivery problems’ contributed, will be published in the Board report from the end of Q2.

### Specialty Review Completed Number Completion %

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Target: 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephrology</td>
<td>90.0%</td>
</tr>
<tr>
<td>Respiratory Medicine</td>
<td>89.7%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>89.2%</td>
</tr>
<tr>
<td>Urology</td>
<td>84.9%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>78.6%</td>
</tr>
<tr>
<td>Care of the Elderly</td>
<td>75.7%</td>
</tr>
<tr>
<td>Vascular</td>
<td>74.9%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>68.0%</td>
</tr>
<tr>
<td>Haematology</td>
<td>66.0%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>64.7%</td>
</tr>
<tr>
<td>Neurology</td>
<td>60.0%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>52.4%</td>
</tr>
<tr>
<td>ITU</td>
<td>51.7%</td>
</tr>
<tr>
<td>Trauma &amp; Orthopaedics</td>
<td>40.7%</td>
</tr>
<tr>
<td>Stroke</td>
<td>16.3%</td>
</tr>
<tr>
<td>Emergency/Medicine</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

**Trustwide: 51.7%**

### Top 5 most frequent diagnosis group for in-hospital death (rolling 12 months April 2016 - March 2017)

- Pneumonia: 300
- Septicemia (except in labour): 250
- Congestive heart failure: 150
- Chronic obstructive pulmonary: 100
- Acute cerebrovascular disease: 50

### Total Number of Patient Deaths

- Observed (Dr Foster)
- Expected (Dr Foster)
- Observed (Local)

### SHMI - Mortality Ratio - Rolling 12 Months

- Sum of SHMI
- Sum of Low
- Sum of High
2017/18 recruitment has started the year well with NBT achieving the recruitment target.

The Trust is still challenged to meet the 70 day target in initiating studies. This is as a result of external national changes to the metric and the continuing internal issues with pharmacy capacity. A plan is in place to improve performance. It should be noted that our improved Q2 performance is expected to place us inside the top half.

Recruitment to time and target has seen a continued strong performance with over 70% commercial studies meeting the required recruitment target. A recovery plan is in place but it should be noted we are performing well above the national average.

The Trust will host a MHRA GCP regulatory inspection between the 29th August and the 1st September.

The R&I strategy has been finalised and is awaiting Board confirmation.

NBT currently holds 12 NIHR research grants worth £18m. In addition, two NIHR grants worth £700,000 total are under contract negotiation and will become active mid-2017. This includes a grant awarded to Dr Ed Carlton, Consultant, Emergency Medicine, to undertake a trial with the aim of ruling out heart attacks faster and reducing the time these patients spend in hospital.

There are currently 6 charity funded grants in delivery worth a total of £397,071 to NBT including £170k for Ronelle Mouton (Vascular surgery) and two grants worth £73k each for Christy Burden and Stephen O’ Brien (Women and Children’s).
FACILITIES MANAGEMENT
FM Operational Services (FM OPS) Cleaning Performance against the 49 Elements of PAS 5748 v.2014 (Specification for the planning, application, measurement and review of cleanliness in hospitals)
Board Sponsor: The Director of Facilities

Audit scores for cleaning have risen in all areas this month.

Mandatory training compliance for June still exceeds agreed target at 92% and 98% of staff appraisals due have been completed.

Staff engagement has been a key feature of the past 12 months – to increase the frequency of engagement we are now holding regular and local staff meetings alongside wider quarterly staff engagements with the senior management team. All sessions are minuted and followed by regular newsletters.

<table>
<thead>
<tr>
<th>Very High Risk Areas</th>
<th>Include: Augmented Care Wards and areas such as ICU, NICU, AMU, Emergency Department, Renal Dialysis Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Score 98%</td>
<td>Audited Weekly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High Risk Areas</th>
<th>Include: Wards, Inpatient &amp; Outpatient Therapies, Neuro Out Patient Department, Cardiac/Respiratory Outpatient Department, Imaging Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Score 95%</td>
<td>Audited Fortnightly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Significant Areas</th>
<th>Include: Audiology, Plaster rooms, Cotswold Out Patient Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Score 90%</td>
<td>Audited Monthly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Low Risk Areas</th>
<th>Include: Christopher Hancock, Data Centre, Seminar Rooms, Office Areas, Learning and Research Building (non-lab areas)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target Score 80%</td>
<td>Audited Every 13 weeks</td>
</tr>
</tbody>
</table>
### Section Summary

**Improvements & Actions:**

Areas of focus for FFT is to improve the percentage who would recommend through the use of feedback for learning at ward and department level.

Overdue complaints have increased again to 46, directorates are meeting fortnightly with the Director of Nursing to explain and restore their position. Of the 2 reviews already complete medicine expect to be back on track, and Neuro MSK confirming a timeline to restore the MSK position. These actions have been shared with the CCG quality subgroup and will form an improvement plan.

**Trends:**

Response rates continue below the national average for inpatients and maternity.
% Recommend and Experience

Note: NHS England FFT Official stats publish data one month behind current data presented in this IPR.

Inpatient Experience
Percentage of respondents who would recommend the service they have experienced at NBT to a friend and family if they need similar care is 90.80% for June 2017 a decreasing trend since March 2017. Cause not identifiable.

% recommend: In the month of May 2017 NBT was 4% below the National average (96%) at 92%.

Staff attitude remains the highest area of positive and negative reported experience.

Outpatient Experience
93.94% would recommend for June 2017.

% recommend: In the month of May 2017 NBT was 1% above the National average (94%) at 95%.

Staff attitude and waiting times remain the largest number of positive and negative comments indicating the importance of these domains in the experience of patients.
% Recommend and Experience
Emergency Department
June percentage recommend for NBT would recommend is 85.8%.

% recommend: In the month of May 2017 NBT was 1% below the National average (87%) at 86%.

Staff attitude continues to be the largest contributor to positive comments. Whilst waiting time is the largest contributor for negative comments, it is also the second highest in terms of positive comments.

+ve experiences related to caring staff providing a friendly and efficient service.
-ve experiences related to reported rudeness of some staff, not being updated, waiting and not having the outcome expected.

Maternity Department (Birth)
June percentage for NBT would recommend is 92% decrease on previous 3 months data

% recommend: In the month of May 2017 NBT was 2% below the National average (97%) at 95%.

Staff attitude remains the largest positive theme along with implementation of care.
There remains an overall decrease in response rates from Delivery/Birth part of the pathway. In May, NHS FFT stats data showed NBT response rate at 14% with national RR at 23.9%.

NBT June response rate decreased to 13.3% (total discharges = 473/ No. of responses = 63 i.e. 473/63).

Action: awaiting feedback from maternity team following consultation with other trust using same methodology of data collection.

Emergency Department
Response rate continued trend of improving response rates. NBT remain above the South West Regional and National average, dropping slightly in June to 19.2% (5191/998).

Outpatient Department
Response rates remain well above the locally agreed response rate of 6% and continually exceed the Regional and National average response rates. The significant drop from May to 13.6% is noted (44,388/6053).

Review of the integrity of telephone data is being undertaken.

Inpatient Department
Response rate decreased in June to 21.1% (7333/1544) and remains below the required national response rate target. The trend is similar to the average overall National response rate.
Caring
Friends & Family Test - Patient Comments
Board Sponsor: Director of Nursing

Inpatient
“All staff on this ward are amazing - Name the housekeeper fantastic. Discharge could have been handled better in the first instance, lack of information to carer, got better towards the end.”

Outpatients
“I received a letter in the post asking me to phone to book a phone call. I had to wait 2 weeks for a phone call. I was told I would then be sent an appointment. I received another letter asking me to ring to book an appointment. I waited around 20 minutes to speak to someone who said there are no appointments and someone would ring me when one is available. Everyone I spoke to was friendly and helpful, but the system is crazy.”

Maternity
“1 for postnatal and 1 for birthing. Could not fault the midwives and doctors in both the delivery suite and Mendip postnatal ward. Only issue was the lack of facilities to deal with the heat in Mendip! Availability of some fans would make a huge difference in coping during heat waves.”

Inpatient
“Hours sat waiting for a bed, days in hospital waiting for a scan, nurses either not understanding my English or not listening to me, getting woken up because I might be moved, no communication about when I would see the doctor.”

Outpatient
“Main reason for my high score …… was the hard work by staff doctor & nurses finding out the best way to get me back to full fitness”

ED
“Got triaged fairly quickly, but was then sat in a room on my own in increasingly more pain with no updates and no drugs for over 90 minutes; it didn't feel like anyone cared about me apart from the receptionist, who was lovely.”

ED
“Highly efficient service, hugely kind and empathic triage nurse, doctors and X-ray team. Looked after my toddler whilst my baby had an X-ray, impressive and reassuring presence of all the medical professionals encountered. Very clean, good toys available for the children.”
Complaints and Concerns:
The Trust received 44 Complaints & 58 Concerns in June 2017.

Compliments:
Overall increase due to improved provision of information from ASCR.

NHS Complaints National Guideline Targets:
The three day acknowledgement target was met.

Overdue Cases:
The number of overdue Complaints continues to climb, with June’s figure at 46. This was reduced to 40 by the end of the first week in July. ACTION, Director of Nursing and Quality is meeting weekly to secure improvement in order to reach the agreed overall target of < 10 overdue complaint responses / month within the first week of September. This matter will also be addressed in the Divisional Performance Meetings commencing 24Th July.

Final Response Compliance
Of the cases closed in June (to account for late responses), those completed within agreed timescale were 59 (72.84%). The exceptions were:
11.11% (9) were 1 - 10 days overdue.
4.94% (4) were 10 - 20 days overdue.
11.11% (9) were greater than 20 days overdue.
Caring Complaints & Concerns
Board Sponsor: Director of Nursing

Complaint Handling
The top three categories of complaints June 2017 reflect the ongoing trend of clinical care, communication (including staff attitude), delays and cancellations.

All written responses are fed back to the Divisions to inform good practice in responding to complainants.

NHS Choices web-posts continue to show very positive comments. Southmead Hospital has an overall star rating of 4.5 out of five from 242 reviews and Cossham has a rating of 4.5 out of five from 24 reviews.

In June 2017 the star ratings given were:
- 7 x 5 stars
- 3 x 4 Stars
- 1 x 3 Stars
- 1 x 0 stars

The Advice & Complaints team provide feedback comments to each reviewer, usually within a day of receipt.

Ombudsman Cases
There were three new cases for the PHSO for June 2017.

Payment of £350 provided to complainant relating to a significant administrative error relating to communication on diagnosis.
Section Summary

Improvements & Actions:
Staff FFT
The Quarter 1 Staff FFT survey has now closed with a response rate of 16%. Data is now being uploaded so that reports can be produced for each participating area.

Staff Health and Wellbeing
A plan has been drafted with proposals for 2017-18. Funding is currently being identified to fund the initiatives which include extending and increasing the resource for a staff physiotherapist service, continuing the wellbeing courses offered by the psychology team and providing training for managers to support them around mental health and wellbeing of their staff. Such initiatives are expected to support staff staying in work or shortening their sickness absence period.

Junior Doctor Rotas
All junior doctor rotas are now on the Allocate Software eRota system and have been reviewed against the requirement of the new junior doctor contract and compliance confirmed. Initial financial costing is complete and awaiting validation.

SLM Development
The second development centre took place in the week commencing 10th July with 78% of the SLM leadership community attending. The aim of the workshop was to identify barriers that prevented teams from achieving action plans and setting their strategy. Building an understanding of team dynamics and helping delegates understand working preferences and encouraging cross divisional support groups. Working towards an understanding of their team capabilities.

Trends:
• The in month turnover rate remained at 1.1% in June, with the number of leavers increasing by 3 WTE in June when compared with May. The in month turnover for May was slightly above the annual plan submitted to NHSI which was 0.9%

• Agency expenditure continues to be below the level in the annual plan submitted to NHSI.

Areas of Concern:
• Sickness absence reduced from 4.12% in April to 4.11% in May. However, the overall sickness level remains above the target of 3.59%. A deep dive into sickness absence is being presented to the next workforce committee meeting.

• The Trust vacancy factor increased from 7.6% in May to 8.1% in June above the vacancy factor target of 6.1% in the annual plan submitted to NHSI. Targeted actions are in progress to fill substantively high levels of vacancies in specific areas, such as Theatres and Facilities.
## Key Operational Standards Dashboard

**June 2017**

<table>
<thead>
<tr>
<th>Access Standard</th>
<th>Performance against National Target</th>
<th>Performance direction of travel from last month</th>
<th>Quarterly Trend (Q4 2016/17 vs Q1 2017/18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Target</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Agency Expenditure</strong></td>
<td>£582</td>
<td>£498</td>
<td>£2,818 (Q4 2016/17) - £1,405 (Q1 2017/18)</td>
</tr>
<tr>
<td>Month End Vacancy Factor</td>
<td>6.10%</td>
<td>8.14%</td>
<td>9.44% (Q4 2016/17) - 8.26% (Q1 2017/18)</td>
</tr>
<tr>
<td>In Month Turnover</td>
<td>0.90%</td>
<td>1.14%</td>
<td>1.10% (Q4 2016/17) - 1.24% (Q1 2017/18)</td>
</tr>
<tr>
<td>In Month Sickness Absence (In arrears)</td>
<td>3.59%</td>
<td>4.11%</td>
<td>4.88% (Q3 2016/17) - 4.72% (Q4 2016/17)</td>
</tr>
<tr>
<td>Trust Mandatory Training Compliance</td>
<td>85.00%</td>
<td>83.28%</td>
<td>83.09% (Q4 2016/17) - 83.55% (Q1 2017/18)</td>
</tr>
<tr>
<td>Non - Medical Annual Appraisal Compliance</td>
<td>90.00%</td>
<td>57.61%</td>
<td>57.25% (Q4 2016/17) - 58.41% (Q1 2017/18)</td>
</tr>
</tbody>
</table>
Well Led
Workforce Utilisation
Board Sponsor: Director of People & Transformation

**Trust Position**
Worked WTE reduced by 0.1% whereas expenditure reduced by 1% in June 2017 compared with May (excluding the impact of any financial adjustments in either month).

**Temporary Staff**
Bank worked WTE remains high, most significantly for unregistered nurses where bank use represents 44% of the total use in the Trust in June. The bank worked WTE is 75% greater than the number of reported substantive vacancies and funded bank and agency posts.

The increase in expenditure on bank and agency staff was proportionally less than the increase in worked WTE other than for locums where the converse was true.
Well Led  
Workforce Utilisation  
Board Sponsor: Director of People & Transformation

**Bank and Agency**  
Bank use increased in June and continues to be above the expenditure plan submitted to NHSI, whilst agency expenditure remains at a similar level to last month’s usage.

Non Framework has increased in June compared with May which again is predominantly due to high demand in specialist areas such as ICU and NICU and Theatres.

NICU, ICU and Theatres are hotspot areas for temporary staffing use; recruitment plans are being developed that will more effectively fill vacant posts in these areas reducing the reliance on temporary staffing.

Work continues with local Trusts in developing a collaborative approach to agency spend.

We are continuing to recruit Bank Nurses with more than 15+ in the pipeline to start, and recent adverts having attracted 10-15 applications in a 2 week period.

We’re continuing our work in increasing our substantive workforce that are registered with the Bank, to ensure they have freedom to work additional hours in their own areas, or other areas within the Trust.

---

**Bank Expenditure vs Plan**  
Bank Expenditure Plan vs Bank Expenditure Actual

**Agency Expenditure vs Plan**  
Agency Expenditure Plan vs Agency Expenditure Actual

**Agency nursing**  
Agency nursing hours for Bands 5 RMN and Band 5 RN

**Non-framework nursing**  
Non-framework nursing hours for Bands 5 RMN and Band 5 RN
Alignment between ESR and the Trust’s Financial System is a recommendation of the Carter Review. A 95% minimum alignment is required.

Compliance with this metric continues to remain steady; not dropping below 98%.
Vacancy Factor
In June the vacancy factor increased from 7.6% in May to 8.1% in June. The biggest increase is in ancillary band 2 staff, registered nursing and midwifery and unregistered scientific and technical staff.

Nurse Recruitment Open Day
The Trust continues to hold nurse recruitment open days approximately every six weeks. 17 candidates were recruited on the 23rd June. Our next Open Day is planned for the 25th August 2017.

Resourcing Plan
A Trust resourcing plan is currently being developed with the next iteration scheduled for August.
Turnover

A small increase of 3 WTE in the number of leavers maintains turnover at 1.1% in June.

Nursing & Midwifery Registered, Additional Clinical Services, Estates and Ancillary and Administrative and Clerical remain the staff groups with the greatest number of leavers with little change in June when compared with May.
Well Led Sickness
Board Sponsor: Director of People & Transformation

A small reduction in long term sickness and a small increase in short term sickness means that the level of sickness in May remains unchanged.

Anxiety/Stress/Depression remains as the number one reason for long term sickness, increasing in May. The reason Other Musculoskeletal Problems has reduced by 41% from March 2017 to May 2017 (886 FTE days lost to 514 FTE days lost).

The largest increase in short term sickness has been in Anxiety/Stress/Depression and Cough, Cold & Influenza which has seen 40% more FTE days lost in May 17 than the same time last year.

A core focus of the staff health and wellbeing plan is around mental health wellbeing and resilience.
Well Led
Sickness
Board Sponsor: Director of People & Transformation

In Month Sickness Absence by Staff Group

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Variance</th>
<th>Apr-17</th>
<th>May-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Add Prof Scientific and Technic</td>
<td>-1.49%</td>
<td>4.50%</td>
<td>3.01%</td>
</tr>
<tr>
<td>Additional Clinical Services</td>
<td>-0.21%</td>
<td>5.64%</td>
<td>5.43%</td>
</tr>
<tr>
<td>Administrative and Clerical</td>
<td>0.23%</td>
<td>4.46%</td>
<td>4.69%</td>
</tr>
<tr>
<td>Allied Health Professionals</td>
<td>0.20%</td>
<td>2.09%</td>
<td>2.28%</td>
</tr>
<tr>
<td>Estates and Ancillary</td>
<td>-0.41%</td>
<td>6.66%</td>
<td>6.26%</td>
</tr>
<tr>
<td>Healthcare Scientists</td>
<td>-0.10%</td>
<td>3.27%</td>
<td>3.18%</td>
</tr>
<tr>
<td>Nursing and Midwifery Registered</td>
<td>0.27%</td>
<td>3.86%</td>
<td>4.13%</td>
</tr>
<tr>
<td>Medical and Dental</td>
<td>-0.12%</td>
<td>0.87%</td>
<td>0.75%</td>
</tr>
<tr>
<td>Trust</td>
<td>-0.01%</td>
<td>4.12%</td>
<td>4.11%</td>
</tr>
</tbody>
</table>

Rolling 12 Month Sickness Absence

<table>
<thead>
<tr>
<th></th>
<th>Apr-17</th>
<th>May-17</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Absence</td>
<td>4.51%</td>
<td>4.51%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Long Term Sickness Top 5 Reasons (WTE Days) May 2017

- S10 Anxiety/stress/depression/other psychiatric illnesses: 1035.98
- S98 Other known causes - not elsewhere classified: 695.23
- S12 Other musculoskeletal problems: 513.63
- S99 Unknown causes / Not specified: 409.01
- S17 Benign and malignant tumours, cancers: 250.89

Short Term Sickness Top 5 Reasons (WTE Days) May 2017

- S10 Anxiety/stress/depression/other psychiatric illnesses: 653.3
- S98 Other known causes - not elsewhere classified: 513.8
- S13 Cold, Cough, Flu - Influenza: 503.8
- S25 Gastrointestinal problems: 625.7
- S99 Unknown causes / Not specified: 529.1
Well Led
Staff Engagement
Board Sponsor: Director of People & Transformation

Essential Training Actions
Compliance for May remains steady at 83.7%.

New e-learning such as the updated equality and diversity package is about to be launched. Further e-learning developments are being considered with a focus on reducing time away from the workplace where appropriate, along with other bespoke methods of delivering training.

<table>
<thead>
<tr>
<th>Training Topic</th>
<th>Variance</th>
<th>May-17</th>
<th>Jun-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Control</td>
<td>-0.6%</td>
<td>86.4%</td>
<td>85.8%</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>-1.1%</td>
<td>87.6%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Waste</td>
<td>-0.2%</td>
<td>88.9%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Information Governance</td>
<td>0.3%</td>
<td>78.6%</td>
<td>78.9%</td>
</tr>
<tr>
<td>Child Protection</td>
<td>-0.4%</td>
<td>84.8%</td>
<td>84.4%</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>-0.2%</td>
<td>86.7%</td>
<td>86.5%</td>
</tr>
<tr>
<td>Fire</td>
<td>-0.1%</td>
<td>77.9%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Manual Handling</td>
<td>-0.8%</td>
<td>78.4%</td>
<td>77.6%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>-0.4%</strong></td>
<td><strong>83.7%</strong></td>
<td><strong>83.3%</strong></td>
</tr>
</tbody>
</table>
Medical Revalidation Compliance Rate against revalidations due - last 12 months

- Positive: 62%
- Deferral: 35%
- Non-Engagement: 3%

No. of Doctors revalidating: 34

Medical Appraisal

70% of the appraisals that were due between April and June have been completed. Incomplete appraisals are being managed through the Trusts escalation process.

The Trust has currently deferred 35% of all revalidation recommendations due over the past 12 months. The number of recommendations due is low because of the way revalidation was rolled out across the existing workforce by the GMC and the majority in this year are clinical fellows which we know are the most difficult to reach in the national data. The number of doctors going through revalidation will rise again in 2018.

The Trusts first non-engagement recommendation was made to the GMC in May 2017 following an individuals continuous failure to engage with the process and meet agreed deadlines. Consideration of the individuals license to practice is happening through the GMC process.

The 2016/17 annual report on the revalidation process appears in this months board papers for consideration.
## Section Summary

**Summary:**

The Trust has a planned deficit of £18.7m for the year in line with the control total agreed with NHS Improvement.

- At the end of June the Trust is reporting a deficit of £7.3m compared with a planned deficit of £7.6m, £0.3m favourable to plan. Income was £0.6m adverse to plan with pay and non-pay (including financing costs) favourable to plan by £0.2m and £0.7m respectively.
- The main areas of concern relate to the level of elective activity income against planned levels as well as savings delivery which is behind plan. This is despite the fact that the overall financial plan profile reflects a savings profile that is lower in Quarter 1.
- The Trust has ended the month with £12.7m cash after receipt of £3.3m loan financing from the Department of Health to support the ongoing deficit.
- Capital expenditure was £1.2m for the year to date against a plan of £2.5m.
- The Trust is rated red by NHS Improvement (NHSI) as a result of being in Financial Special Measures in June.

## Key areas of concern:

- Continued focus on delivering the full savings required as well as full delivery of planned activity and income for the year will be crucial to ensure delivery of the Trust's control total.
## Assurances

The financial position at the end of June shows a deficit of £7.3m, £0.3m favourable to the planned deficit of £7.6m.

## Key Issues

- Delivery of savings was £1.8m less than the £7.4m required to date.
- Contract income is £0.2m adverse to plan reflecting primarily under-performance in elective inpatient activity. Other income is £0.4m adverse primarily due to lower Research income.
- Pay has a £0.2m favourable variance due to above plan vacancies.
- Non pay is £0.9m favourable to plan with materially lower independent sector and drug usage along with a non-recurrent benefit of £0.6m partially offset by higher consumable costs.

## Actions Planned

Continued focus on identification of the full savings required as well as full delivery of planned activity and income for the year will be crucial to ensure delivery of the Trust's control total.

### Table: Finance Statement of Comprehensive Income

<table>
<thead>
<tr>
<th></th>
<th>Prior year actual to 30 June 2016 £m</th>
<th>Position as at 30 June 2017</th>
<th>Variance (Adverse) / Favourable £m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td>17.18 Plan £m</td>
<td>Actual £m</td>
</tr>
<tr>
<td>Contract Income</td>
<td>111.0</td>
<td>117.0</td>
<td>116.8</td>
</tr>
<tr>
<td>Other Operating Income</td>
<td>17.8</td>
<td>19.2</td>
<td>18.8</td>
</tr>
<tr>
<td>Donations income for capital acquisitions</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Total Income</td>
<td>128.8</td>
<td>136.2</td>
<td>135.6</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td>(84.4)</td>
<td>(83.2)</td>
</tr>
<tr>
<td>Pay</td>
<td>(46.7)</td>
<td>(44.5)</td>
<td>(43.6)</td>
</tr>
<tr>
<td>Non Pay</td>
<td>(1.4)</td>
<td>(1.5)</td>
<td>(1.5)</td>
</tr>
<tr>
<td>PFI Operating Costs</td>
<td>(132.5)</td>
<td>(129.2)</td>
<td>(128.1)</td>
</tr>
<tr>
<td><strong>Earnings before Interest &amp; Depreciation</strong></td>
<td>(3.7)</td>
<td>7.0</td>
<td>7.5</td>
</tr>
<tr>
<td>Depreciation &amp; Amortisation</td>
<td>(5.8)</td>
<td>(6.4)</td>
<td>(6.6)</td>
</tr>
<tr>
<td>PFI Interest</td>
<td>(8.2)</td>
<td>(8.5)</td>
<td>(8.5)</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>(0.0)</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(0.6)</td>
<td>(1.1)</td>
<td>(1.3)</td>
</tr>
<tr>
<td>PDC Dividend</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Other Financing costs</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Impairment</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Operational Retained Surplus / (Deficit)</strong></td>
<td>(18.3)</td>
<td>(9.0)</td>
<td>(8.9)</td>
</tr>
<tr>
<td>STF</td>
<td>(14.2%)</td>
<td>(14.3)</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Add back items excluded for NHS accountability</strong></td>
<td></td>
<td>(7.6)</td>
<td>(7.5)</td>
</tr>
<tr>
<td>Donations income for capital acquisitions</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Depreciation of donated assets</td>
<td>0.2</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Impairment</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Adjusted surplus /(deficit) for NHS accountability</strong></td>
<td>(18.1)</td>
<td>(7.6)</td>
<td>(7.3)</td>
</tr>
</tbody>
</table>
The Trust received new loan financing in June of £3.3m. The total Department of Health borrowing is now £144.9m.

The Trust ended the month with cash of £12.7m, £8.7m higher than plan. The higher balance is required in order to meet contractual payments prior to receipts being received from commissioners in July.

June saw invoiced debtors reduce in month by £20.6m, due to clearance of 2016/17 over-performance invoices.

Concerns & Gaps
The level of payables is reflected in the Better Payment Practice Code (BPPC) performance for the year which is below the required 95% with 76% by volume of payments made within 30 days.

Actions Planned
The focus continues to be on reducing the level of debts and ensuring cash financing is available.

### Finance Statement of Financial Position

<table>
<thead>
<tr>
<th>31 March 2017</th>
<th>Statement of Financial Position as at 30th June 2017</th>
<th>Plan £m</th>
<th>Actual £m</th>
<th>Variance above / (below) plan £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Current Assets</td>
<td>Property, Plant and Equipment</td>
<td>513.8</td>
<td>512.8</td>
<td>(1.0)</td>
</tr>
<tr>
<td></td>
<td>Intangible Assets</td>
<td>11.1</td>
<td>15.8</td>
<td>4.8</td>
</tr>
<tr>
<td></td>
<td>Non-current receivables</td>
<td>19.0</td>
<td>20.0</td>
<td>1.0</td>
</tr>
<tr>
<td></td>
<td><strong>Total non-current assets</strong></td>
<td>543.9</td>
<td>548.7</td>
<td>4.8</td>
</tr>
<tr>
<td>Current Assets</td>
<td>Inventories</td>
<td>9.7</td>
<td>10.0</td>
<td>0.3</td>
</tr>
<tr>
<td></td>
<td>Trade and other receivables NHS</td>
<td>31.4</td>
<td>16.4</td>
<td>(15.0)</td>
</tr>
<tr>
<td></td>
<td>Trade and other receivables Non-NHS</td>
<td>30.8</td>
<td>28.8</td>
<td>(1.9)</td>
</tr>
<tr>
<td></td>
<td>Cash and Cash equivalents</td>
<td>4.0</td>
<td>12.7</td>
<td>8.7</td>
</tr>
<tr>
<td></td>
<td><strong>Total current assets</strong></td>
<td>75.9</td>
<td>68.0</td>
<td>(8.0)</td>
</tr>
<tr>
<td></td>
<td>Non-current assets held for sale</td>
<td>0.0</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td><strong>Total assets</strong></td>
<td>619.8</td>
<td>618.0</td>
<td>(1.8)</td>
</tr>
<tr>
<td>Current Liabilities (&lt; 1 Year)</td>
<td>Trade and Other payables - NHS</td>
<td>9.5</td>
<td>12.7</td>
<td>3.2</td>
</tr>
<tr>
<td></td>
<td>Trade and Other payables - Non-NHS</td>
<td>77.7</td>
<td>63.4</td>
<td>(14.4)</td>
</tr>
<tr>
<td></td>
<td>Borrowings</td>
<td>11.5</td>
<td>40.1</td>
<td>28.6</td>
</tr>
<tr>
<td></td>
<td><strong>Total current liabilities</strong></td>
<td>98.7</td>
<td>116.2</td>
<td>17.4</td>
</tr>
<tr>
<td>(51.1)</td>
<td>Net current assets/(liabilities)</td>
<td>(22.8)</td>
<td>(48.2)</td>
<td>(25.4)</td>
</tr>
<tr>
<td>502.8</td>
<td>Total assets less current liabilities</td>
<td>521.1</td>
<td>501.8</td>
<td>19.2</td>
</tr>
<tr>
<td></td>
<td>Trade payables and deferred income</td>
<td>18.5</td>
<td>9.8</td>
<td>(8.7)</td>
</tr>
<tr>
<td></td>
<td>Borrowings</td>
<td>515.9</td>
<td>520.9</td>
<td>5.0</td>
</tr>
<tr>
<td>(21.4)</td>
<td><strong>Total Net Assets</strong></td>
<td>(13.3)</td>
<td>(28.9)</td>
<td>(15.6)</td>
</tr>
<tr>
<td>Capital and Reserves</td>
<td>Public Dividend Capital</td>
<td>241.5</td>
<td>241.7</td>
<td>0.2</td>
</tr>
<tr>
<td></td>
<td>Income and expenditure reserve</td>
<td>(353.8)</td>
<td>(363.5)</td>
<td>(9.6)</td>
</tr>
<tr>
<td></td>
<td>Income and expenditure account - current year</td>
<td>(7.6)</td>
<td>(7.5)</td>
<td>0.1</td>
</tr>
<tr>
<td></td>
<td>Revaluation reserve</td>
<td>106.7</td>
<td>100.4</td>
<td>6.3</td>
</tr>
<tr>
<td>(21.4)</td>
<td><strong>Total Capital and Reserves</strong></td>
<td>(13.3)</td>
<td>(28.9)</td>
<td>(15.6)</td>
</tr>
</tbody>
</table>
The overall financial position was £0.3m favourable against plan at the end of June.

Capital expenditure was £1.2m compared to a plan of £2.5m for the year to date. The plan for the year is £21.8m.

**Assurances and Actions Planned**

- Daily cash monitoring and planning to ensure sufficient cash is available to meet immediate liabilities.
- Cash for our planned deficit for the year to date has been made available to the Trust via the interim working capital facility and DH loan.

**Concerns & Gaps**

The Trust is rated at 4(a score of 1 is the best) in the finance and use of resources metric. This measure relates to the override due to the Trust being in financial special measures, the Trust would have been rated at 3. The Trust exited financial special measures in July.
**Assurances**
£39.6m of efficiencies required for the year have been identified at the end of June, £0.2m above the in year target.

**Concerns & Gaps**
Under-delivery of £1.8m in the first three months against a target of £7.4m.

The graphs show forecast delivery of £39.6m. £26.9m is rated as green or amber.

**Actions Planned**
Continued monitoring of actions required to deliver required savings in 2017/18 and catch up the year to date shortfall.
The Governance Risk Rating (GRR) for ED 4 hour performance continues to be a challenge through 2017/18, actions to improve and sustain this standard are set out earlier in this report. A recovery plan is in place for RTT incompletes and long waiters (please see Key Operational Standards section for commentary). In quarter, monthly cancer figures are provisional therefore, whilst indicative, the figures presented are not necessarily reflective of the Trust’s final position which is finalised 25 working days after the quarter.

We are scoring ourselves against the Single Operating Framework (SOF). This requires that we use the performance indicator methodologies and thresholds provided and a Finance Risk Assessment based upon in year financial delivery.

Board compliance statements – number 4 (going concern) and number 10 (ongoing plans to comply with targets) warrant continued Board consideration in light of the in year financial position (as detailed within the Finance commentary) and ongoing performance challenges as outlined within this IPR. The Trust is committed to tackling these challenges and recovery trajectories are scrutinised on an ongoing basis through the Monthly Integrated Delivery Meetings.

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### CQC reports history (all sites)

<table>
<thead>
<tr>
<th>Regulatory Area</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
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<th>Dec-16</th>
<th>Jan-17</th>
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<th>Apr-17</th>
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<tr>
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<td>Prov. Licence non-compliant statements</td>
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<td>CQC Inspections</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
<td>RI</td>
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<td>RI</td>
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<table>
<thead>
<tr>
<th>Location</th>
<th>Standards Met</th>
<th>Report date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>Requires Improvement</td>
<td>Apr-16</td>
</tr>
<tr>
<td>Child and adolescent mental health wards (Riverside) *</td>
<td>Good</td>
<td>Feb-15</td>
</tr>
<tr>
<td>Specialist community mental health services for children and young people *</td>
<td>Requires Improvement</td>
<td>Apr-16</td>
</tr>
<tr>
<td>Community health services for children, young people and families *</td>
<td>Outstanding</td>
<td>Feb-15</td>
</tr>
<tr>
<td>Southmead Hospital</td>
<td>Requires Improvement</td>
<td>Apr-16</td>
</tr>
<tr>
<td>Cossham Hospital</td>
<td>Good</td>
<td>Feb-15</td>
</tr>
<tr>
<td>Frenchay Hospital</td>
<td>Requires Improvement</td>
<td>Feb-15</td>
</tr>
</tbody>
</table>

* These services are no longer provided by NBT.
<table>
<thead>
<tr>
<th>Ref</th>
<th>Criteria</th>
<th>Comp (Y/N)</th>
<th>Comments where non compliant or at risk of non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>G4</td>
<td>Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)</td>
<td>Yes</td>
<td>A Fit and Proper Person Policy is in place. All Executive and Non-Executive Directors have completed a self assessment and no issues have been identified. Further external assurance checks have been completed on all Executive Directors and no issues have been identified.</td>
</tr>
<tr>
<td>G5</td>
<td>Having regard to monitor Guidance</td>
<td>Yes</td>
<td>The Trust Board has regard to Monitor guidance where this is applicable.</td>
</tr>
<tr>
<td>G7</td>
<td>Registration with the Care Quality Commission</td>
<td>Yes</td>
<td>CQC registration is in place. The Trust received a rating of Requires Improvement from its inspection in November 2014 and again in December 2015. A number of compliance actions were identified, which are being addressed through an action Plan. The Trust Board receives regular updates on the progress of the action plan through the IPR.</td>
</tr>
<tr>
<td>G8</td>
<td>Patient eligibility and selection criteria</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>P1</td>
<td>Recording of information</td>
<td>Yes</td>
<td>A range of measures and controls are in place to provide internal assurance on data quality. Further developments to pull this together into an overall assurance framework are planned through strengthened Information Governance Assurance Group.</td>
</tr>
<tr>
<td>P2</td>
<td>Provision of information</td>
<td>Yes</td>
<td>Information provision to Monitor not yet required as an aspirant Foundation Trust (FT). However, in preparation for this the Trust undertakes to comply with future Monitor requirements.</td>
</tr>
<tr>
<td>P3</td>
<td>Assurance report on submissions to Monitor</td>
<td>Yes</td>
<td>Assurance reports not as yet required by Monitor since NBT is not yet a FT. However, once applicable this will be ensured. Scrutiny and oversight of assurance reports will be provided by Trust's Audit Committee as currently for reports of this nature.</td>
</tr>
<tr>
<td>P4</td>
<td>Compliance with the National Tariff</td>
<td>Yes</td>
<td>NBT complies with national tariff prices. Scrutiny by CCGs, NHS England and NHS Improvement provides external assurance that tariff is being applied correctly.</td>
</tr>
<tr>
<td>P5</td>
<td>Constructive engagement concerning local tariff modifications</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>C1</td>
<td>The right of patients to make choices</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>C2</td>
<td>Competition oversight</td>
<td>Yes</td>
<td>Trust Board has considered the assurances in place and considers them sufficient.</td>
</tr>
<tr>
<td>IC1</td>
<td>Provision of integrated care</td>
<td>Yes</td>
<td>Range of engagement internally and externally. No indication of any actions being taken detrimental to care integration for the delivery of Licence objectives.</td>
</tr>
</tbody>
</table>
### Self-assessed, for submission to NHSI

<table>
<thead>
<tr>
<th>No.</th>
<th>Criteria</th>
<th>Comp (Y/N)</th>
<th>No.</th>
<th>Criteria</th>
<th>Comp (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The Board is satisfied that, to the best of its knowledge and using its own processes and having</td>
<td>Yes</td>
<td>8</td>
<td>The necessary planning, performance, corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the Trust Board are implemented satisfactorily.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.</td>
<td>Yes</td>
<td>9</td>
<td>An Annual Governance Statement is in place, and the Trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (<a href="http://www.hm-treasury.gov.uk">www.hm-treasury.gov.uk</a>).</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and revalidation requirements.</td>
<td>Yes</td>
<td>10</td>
<td>The Trust Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the relevant GRR; and a commitment to comply with all known targets going forwards.</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>The board is satisfied that the Trust shall at all times remain an ongoing concern, as defined by the most up to date accounting standards in force from time to time.</td>
<td>Yes</td>
<td>11</td>
<td>The Trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>The board will ensure that the Trust remains at all times compliant with regard to the NHS Constitution.</td>
<td>Yes</td>
<td>12</td>
<td>The Trust Board will ensure that the Trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the Board of Directors; and that all Trust Board positions are filled, or plans are in place to fill any vacancies.</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner.</td>
<td>Yes</td>
<td>13</td>
<td>The Trust Board is satisfied that all Executive and Non-executive Directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including; setting strategy; monitoring and managing performance and risks; and ensuring management capacity and capability.</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of it occurring and the plans for mitigation of these risks.</td>
<td>Yes</td>
<td>14</td>
<td>The Trust Board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Comment where non-compliant or at risk of non-compliance**

As the Trust has not yet achieved a sustainable position in relation to delivery of the 4 Hour A&E and RTT standards due to a reliance on external system changes/factors, the Trust is unable to confirm compliance with this statement.

**Timescale for compliance:**

Q3 2017/18 – for RTT
Report to: Trust Board

Date of Meeting: July 2017

Report Title: Safe Nurse Staffing – 6 Monthly Assurance Report

Status: Information | Discussion | Assurance | Approval
X | x

Prepared by: Sarah Dodds, Deputy Director of Nursing (Part A)
Gina Augarde Director of Midwifery/ Head of Nursing (Part B)

Executive Sponsor (presenting): Sue Jones, Director of Nursing and Quality

Appendices (list if applicable): Appendix 1

Recommendation:

Part A

The Trust Board is asked to note:
- Assurance regarding current position against the expectations and actions of the updated NQB expectations, NICE guidance and a self-assessment against NHS Improvement recommendations
- Next step requirements to progress a centralised ward level dashboard for quality, staff, patients and carer feedback.
- The plan for the formal annual review of safe staffing for all inpatient ward areas in September / November 2017.

Part B

- There has been a review of staffing across all maternity areas using Birth Rate Plus recommendations and NICE guidance.
- A programme to implement the recommendations of ‘Better Births’ 2016, to include Integration of the community and Birth centres has commenced.
- Full review of staffing in 6 months will take place following implementation of new Acuity tool and embedding of Integration.
# Executive Summary:

Following the Francis report, the National Quality Board (NQB) published guidance\(^1\) that set out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients. This was followed by the NICE guidance ‘Safe staffing for nursing in adult inpatient wards in acute hospital’\(^2\) (July 2014) and ‘Safe midwifery staffing for maternity settings’\(^3\) (Feb 2015).

The Lord Carter Review (2016)\(^4\) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The review described a new nursing workforce metric to be used from May 2016 (Care hours per Patient Day (CHPPD) along with a model hospital dashboard.

The NQB updated and refreshed their expectations in July 2016\(^5\) to ensure safe, effective, caring, and responsive and well led care on a sustainable basis; Trusts will employ the right staff with the right skills in the right place at the right time. In February 2017 an improvement resource was published by NHS Improvement\(^6\) to support nurse staffing in adult inpatient wards and implementation of the NQB expectations.

This report demonstrates the work underway at North Bristol Trust in line with the 3 expectations of the NQB and a self-assessment of NBT against the NHS Improvement recommendations for safe staffing is provided in Appendix 1.

The Maternity report describes the methodology for reviewing midwifery staffing. Birth Rate plus was commissioned in October 2016 and undertook a review, at the time this report showed a requirement for additional Midwives in some care settings, and recommended that a new model of care was implemented called Integration. Subsequent to the report there has been a reduction in the number of births and booked births, therefore the decision has been made to purchase an additional acuity tool to measure acuity more accurately, to implement the integration model and to repeat a safe staffing review in 6 months.

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\(^1\) How to ensure the right people with the right skills are in the right place at the right time, NQB November 2013
\(^2\) https://www.nice.org.uk/guidance/sg1
\(^3\) https://www.nice.org.uk/guidance/ng4
\(^5\) National Quality Board (July 2016) Supporting NHS Providers to deliver the right staff, With the right skills, in the right place at the right time.
1. Purpose
The purpose of this paper is to provide the Board with a 6 monthly report on Nursing and Midwifery staffing and to provide assurance that the Trust has a clear validated process in place for monitoring and ensuring safe staffing in line with current national recommendations.

2. Background
Following the Francis report, the National Quality Board (NQB) published guidance that set out the expectations of commissioners and providers for safe nursing and midwifery staffing, in order to deliver high quality care and the best possible outcomes for patients.

NICE guidance for ‘Safe staffing for nursing in adult inpatient wards in acute hospital (July 2014) and ‘Safe midwifery staffing for maternity settings (Feb 2015) was produced and was recommended to be read alongside that of the NQB guidance.

The Lord Carter Review (2016) highlights the importance of ensuring that workforce and financial plans are consistent in order to optimise delivery of clinical quality and use of resources. The Carter review recommended use of a new metric, Care hours per patient day (CHPPD).

All NHS Trusts are accountable to NHS Improvement and are expected to provide assurance that they are implementing the NQB staffing guidance and that, where there are risks to quality of care due to staffing, actions are taken to minimise the risk. In July 2016 the NQB guidance was refreshed, broadened and re-issued to include the need to focus on safe, sustainable and productive staffing.

In February 2017 an improvement resource was published by NHS Improvement to support nurse staffing in adult inpatient wards. It is aimed at wards that provide overnight care for adult patients in acute hospitals excluding intensive care high dependency, acute admissions and assessment.

This paper will focus on the NQB expectations and assess the Trust’s current approach and achievements against these expectations and a self-assessment of the recommendations of the NHS Improvement resource can be found in Appendix 1.

3. NQB Expectations: a triangulated approach to staffing decisions
The updated NQB expectations support an approach to deciding staffing levels based on patients’ needs, acuity and risks, monitored from ‘ward to board’. This triangulated approach to staffing decisions rather than making judgments based solely on numbers or ratios of staff to patients is supported by the CQC.

<table>
<thead>
<tr>
<th>Expectation 1 Right Staff (workforce Plans)</th>
<th>Expectation 2 Right Skills</th>
<th>Expectation 3 Right place and time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence based workforce planning</td>
<td>Mandatory Training, development and education</td>
<td>Productive working and eliminating waste</td>
</tr>
</tbody>
</table>
Professional Judgement | Working as a Multi professional Team | Efficient deployment and flexibility
---|---|---
Compare staffing with Peers | Recruitment and retention | Efficient employment Minimising agency usage

**Table 1 NQB Updated Expectations (2016)**

### Expectation 1 Right Staff (Workforce Plans)

The methodology used for the nursing establishment reviews at NBT includes analysis of actual staffing alongside other metrics; patient acuity (completed 3 times per day), Professional Judgment, ward quality metrics and national tools available such as the NICE guidance (2014) and evidence based guidance from Royal Colleges. The Trust also compares local staffing with staffing provided by an appropriate peer group within the Model hospital dashboard, recognising that the specific ward design for the Brunel Wards also needs to be appropriately benchmarked.

In line with all Trusts NBT reports monthly Care Hours per Patient Day (CHPPD). Over time, this metric enables a review of staff within a specialty and by comparable ward. CHPPD is calculated by adding the hours of registered nurses and the hours of health care assistants and dividing the total by every 24 hours of inpatient admissions or approximating 24 patient hours by counts of patients at midnight. Total CHPPD for NBT for the past 6 months is provided in Table 1.

### Divisional Changes

In November 2016 to manage the winter bed base plan there was a series of bed moves, with some wards changing speciality. This occurred at the same time as the implementation of the Safe Care live acuity module. In view of these changes it was felt more appropriate to monitor the patient acuity and staffing requirements daily before agreeing any change in funded establishment in the new specialty wards.

In April 2017 the 7 Clinical Directorates moved into 5 Divisions. Bed capacity has remained challenging for all wards and has required additional patients to be cared for on some inpatient wards, when this occurs the matrons assess the level of care required on the wards and if required will request additional staff.

The band 2 and band 3 skill mix within each Division has been reviewed to realign with the role requirements on each ward.

A full staffing review of all inpatient wards is now planned for September to November 2017 in preparation for the new budget setting period.

**Anaesthetics, Surgery, Critical Care and Renal (ASCR) Division**

**Gate 32B Surgical Assessment Unit**

Required fluctuating levels of staffing in order to support the new speciality, continues to be monitored using Safe Care live. No additional approved funding. Full staffing review will occur in the autumn.
Intensive Care Unit
Requirement to increase the unit to 46 Critical Care Beds, the staffing has been reviewed to support this to provide 1:1 Level 3 Care and 1:2 Level 2 care and a skill mix of 90% Registered Nurses / 10% Non-Registered:

29 Registered Nurses and 4 Assistant Practitioners per shift, supported by: 1 Clinical Unit Coordinator and 4 Clinical Support Nurses. In addition there are 3 ancillary support workers per day / 2 per night supporting the delivery of care but not allocated patients.

Medicine Division

Gate 27A
There has been a Divisional review of the staffing levels and in line with a change in acuity the staffing levels have reduced by 1 registered nurse at night.

Gate 27B
There has been a review of the skill mix and the changes enable a Band 6 per shift to provide expert Respiratory HDU care, this was achieved through a Band 5 review replaced with Band 4 posts which reflects the care requirements for the ward.

AMU
In order to manage increased bed capacity requirements the Ambulatory Emergency Care unit at times is required to be opened and staffed overnight, when this occurs additional staff are requested, this is currently not part of the funded establishment.

The additional staffing required at times of surge for both AMU and ED is approved by the Head of Nursing for Medicine along with the Director/Deputy Director of Nursing.

Neuro and Musculoskeletal Division

Gate 9a
With the ward speciality change there has been a requirement at times for increased staffing in line with the Safe Care live results, this ward will be reviewed as part of the autumn safe staffing reviews.

Women's and Children's Division

Cotswold Ward
There has been a fluctuating bed base over the past 6 months with bed capacity increased to support the Trust activity, and at present reduced bed capacity due to estates work. The staffing levels have been assessed using the acuity tool. An approved review of staffing levels will take place in the autumn review of safe staffing.

NICU
An external review of NICU was commissioned by the Director of Nursing in January 2017 which included a review of staffing. This is being reviewed and managed via the Trust Workforce Committee and currently the number of cots has been reduced by 4 in order to ensure that current staffing is safe. 3 times daily an SBAR is completed which manages the staffing requirements in line with acuity of babies.
Core Clinical Division
Interventional Radiology remains unfunded to be opened at the weekends, staff staffing is provided when required to be used for in patients by the use of temporary staff and substantive staff from Medicine and ASCR.

Expectation 2 Right Skills

Mandatory Training, development and education
The Trust is committed to ensuring that clinical staff have the appropriate training and the right competencies to support new models of care. The clinical Induction programme was further reviewed in April 2017 ensuring the relevant level of training provided and where possible this has been completed in the clinical area where the member of staff will be working. The supernumerary guidance for new nurse and midwifery starters is now well embedded to reflect an appropriate timescale for staff to be supernumerary within the workplace.

Working as a Multi Professional Team
The Trust has demonstrated its commitment to investing in new roles and skill mix reviews which enables registered nurses to spend more time to focus on clinical duties and decisions about planning and implementing nursing care. The 2015 Shape of caring report7 recommended changes to education, training and career structures for registered nurses and care staff, in light of this NBT has continued with the development of its workforce in support of this report. Training for Assistant Practitioners is well embedded within NBT and the role is continuing to be developed throughout the hospital.
In April 2017 the Trust as part of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan along with Bath commenced as a pilot site for the National Nursing Associate role training with 13 candidates commencing at NBT.
The NHS Improvement Resource recommends taking account of the wider multidisciplinary team who may or may not be part of the core ward establishment including allied health professionals, advanced clinical practitioners, administrative staff and volunteers. It is recognised that the range of specialist and advanced practitioners at NBT provide expert advice, intervention and support to ward based teams, along with the ‘link nurse’ model which is in place for certain specialties e.g Tissue viability, Diabetes.

The delivery of high quality care depends on strong and clear clinical leadership, and well led and motivated staff. In order for this to be achieved at ward level the sisters are supervisory, this enables them to be visible to patients, staff and visitors and to work alongside staff as role models, monitor performance and deliver training. On occasions they are required in reality to work clinically to support wards when there is a shortfall of last minute nursing staff, the administrative requirements of their role are supported by a ward administrator working across 3 wards.

7 https://hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf
Recruitment and Retention

Over the past 6 months there has been a continued focus in the activity of both Registered and Non Registered Nurse recruitment which has included:

- Open days for Registered Nurses every 6-8 weeks, these are well led by the Divisions and enable the opportunity for staff to be shown around wards and departments and to be interviewed and offered posts on the day.
- Specialist Divisional adverts have continued where required.
- The process for the recruitment of non-registered nurses has been streamlined with support from the Learning and Development department and has enabled high quality and well informed candidates attending the Assessment Centre. This has shown a rapid improvement in quality and an increase in the numbers of non-registered staff in the recruitment pipeline.

Each Division has a detailed understanding of their vacancies and tracks both recruitment and turnover closely to ensure that they are proactively recruiting. Additional recruitment resource is being provided to ASCR given the ongoing use of agency staff in Theatres, Medirooms and Intensive Care setting to support the filling of vacancies and retention of staff.

Retention programmes are now being developed more extensively within each Division and include Divisional rotational posts and a Trust Wide staff engagement plan. The use of the staff engagement ‘happy app’ is being led in Theatres and Medirooms and further training Trust wide is underway for other areas across the Trust.

Following attendance at the NHS Improvement retention Masterclass in June, an action plan is being developed to improve the retention of both Registered and Non registered Nursing and Midwifery staff with learning gained from other Organisations.

Expectation 3: Right place and time

Each month the Trust submits the ward planned and actual staffing levels including Care Hours Per Patient Day (CHPPD) via Unify.

The nursing and midwifery fill rates and CHPPD for Southmead Hospital for the past 6 months can be viewed in Table 1.

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>March</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN Day</td>
<td>95.9%</td>
<td>96.5%</td>
<td>97.8%</td>
<td>97.7%</td>
<td>98.7%</td>
<td>96.4%</td>
</tr>
<tr>
<td>HCA Day</td>
<td>104.9%</td>
<td>104.1%</td>
<td>107.5%</td>
<td>110.4%</td>
<td>113.4%</td>
<td>114.9%</td>
</tr>
<tr>
<td>RN Night</td>
<td>98.6%</td>
<td>96.0%</td>
<td>98.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.7%</td>
</tr>
<tr>
<td>HCA Night</td>
<td>112.8%</td>
<td>110.0%</td>
<td>111.9%</td>
<td>113.4%</td>
<td>117.7%</td>
<td>122.0%</td>
</tr>
<tr>
<td>CHPPD</td>
<td>7.5</td>
<td>7.9</td>
<td>8.2</td>
<td>8.0</td>
<td>8.1</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Table 1 Fill Rates and CHPPD

All wards continue to reach a funded ratio of 1 Registered Nurse: to 8 Patients or less for a day shift, exclusive of the supervisory ward sister. The Night shift is monitored closely depending on the number of patients, can increase on a ward to 1:12.

When there is a shortfall of registered nurses, on occasions unregistered staff are being utilised to ensure safe staffing. In addition the greater than 100% fill rates in HCA numbers are due to the high volume of ‘specials’ utilised to provide enhanced care.
Graph 1 shows the number of safe staffing incidents reported by month, these are all escalated to Heads of Nursing to review with alerts to the Director/ Deputy Director of Nursing when an incident occurs.

**Graph 1 - Total number of staffing levels incidents**

![Graph showing total staffing levels incidents from July 2015 to June 2017]

The highest reporting Divisions are Medicine and Women’s and Children’s Directorate which have corresponded with the decreased fill rates in some of these ward areas. In Medicine when required to maintain safety at times of increased numbers of patients, staff are moved for short periods of time. Safety has been maintained by the inclusion of an escalation process for Neonatal Intensive Care Unit (NICU) which requires senior non ward based staff responding to support at short notice, the use of both Framework and Non Framework agency for NICU and the Matrons covering clinical shifts.

**Productive working and eliminating waste and efficient deployment and flexibility**

To ensure that there is an appropriate system and process in place for the deployment of staff and managing the staffing resources on a day to day basis, the Trust uses the Safe Care live Acuity tool. This has now been in use Trust wide for the past 6 months; it continues to require some validation of data to ensure accuracy. Twice daily safe staffing meetings occur when real time data of actual staffing levels and patient acuity can be viewed and staff redeployed as required.

The Trust also updated the e rostering policy in February 2107 to ensure that it was in line with the NHS Improvement best practice E rostering Guide.

**Efficient employment minimising agency usage**

NBT has clear plans in place and is working towards an ongoing significant reduction in the use of agency nursing staff in line with the NHS Improvement agency rules. Framework and non-framework agency nurse approval is via the Director and Deputy Director of Nursing or on call Executive out of hours. The use of agency Health Care Assistants ceased in July 2016 following strong recruitment to both substantive posts and NBT Extra.

The use of any agency is utilised to ensure patient safety is not compromised by booking in advance following approval for NICU, Theatres / Anaesthetics/ Medirooms and Intensive Care Unit (ICU). Careful control and monitoring of fill rates is maintained by the Heads of Nursing to ensure that there is no negative impact on patient care and safety. All staff are encouraged and supported to complete incident forms if concerns regarding safe staffing are raised. None of the current framework agencies meet the pay cap and in order to further drive down agency costs work across BNSSG is being progressed at an Executive level.
The recruitment of both registered and non-registered nurses to the temporary staffing bank continues and staff are well supported by the Clinical Lead in ensuring support for new starters, revalidation and monitoring and maintaining high professional standards.

Staff feedback
From the review of the staff survey results in 2016 the results from the question:

‘There are enough staff at this organisation for me to do my job properly’

20% of registered nurses either agreed or strongly agreed with this statement.
17% of non-registered nurses either agreed or strongly agreed with this statement.

4. Risks

Although both registered and unregistered nurse recruitment has been substantial over the past 6 months, with a high number of vacancies in certain areas it is still challenging to fill with the current applicants. There is very close working between the nursing, workforce planning, finance and recruitment teams to ensure that data is readily available and risks are regularly reviewed.

- There remains a high use of agency and temporary staff in NICU, ICU and Theatres/Medrooms and at times agencies are unable to fill shifts and therefore a risk assessment with regards to activity has to be made in order to manage staffing safely.

- The Trust undertook a series of ward moves in November 2016 in order to create a Surgical Assessment and Short Stay Unit, a dedicated Major Trauma ward and to provide a plan for the winter management of Acute Medical Beds. The ward establishments in place are managed closely and efficiently using the Acuity tool and will continue for the next few months to ensure that the appropriate staffing levels are achieved. There is a risk that there may be a requirement to increase staffing to support some of these changes if the acuity reflects this.

- The Trust has seen an increase in acute admissions which has required more patients to be cared for on some wards. The current staffing establishments have been funded for the ward bed base in Brunel of 32 beds however there are occasions when this is required to increase to 35 patients. If required to ensure safety an additional member of staff is booked.

- Over the past 6 months NICU has continued to experience high acuity, high agency usage and a number of unfulfilled vacancies which has impacted on some aspects of quality. In view of this, the Director of Nursing commissioned an external review in January 2017 to include an assessment of staffing against the existing British Association of Perinatal Medicine standards. Recommendations from this report were discussed with the Specialist Commissioners who at the current time have not agreed to support the increased funding requirements for staffing. Therefore the decision has been taken to reduce by 4-6 cots depending on acuity in the first instance. This has been communicated to the South West Neonatal Network.
Conclusion

This paper has reviewed North Bristol NHS Trust against the triangulated approach of the NQB expectations (July 2016) for safe staffing, it has demonstrated the outcomes of the actions which have progressed over the past 6 months regarding recruitment and future plans in place to manage vacancies to ensure safe staffing. There has been some ward specialty changes over the past 8 months, ward establishments have been managed closely alongside patient acuity, once the changes are embedded in each ward a full review of staffing levels with take place.

Next Steps

Over the next 6 months in line with the action required from the self-assessment of the NHS Improvement resource- see appendix 1. A ward level dashboard will be progressed to include quality indicators and staff, patient and carer feedback indicators. This is endorsed within the Chief Nursing Officer Strategy (2016)8 ‘Leading Change, Adding Value: a framework for nursing, midwifery and care staff’ with the aim to achieve better outcomes, better patient and staff experience and better use of resources.

A full staffing review of all inpatient wards is planned for September to November 2017.

Recommendations

This report has demonstrated to the Trust Board that 6 monthly assessment of nurse staffing against the triangulated approach to staffing of the NQB expectations has taken place along with a self-assessment against the NHS Improvement recommendations.

The Trust Board is asked to note:

1. Assurance regarding current position against the expectations and actions of the updated NQB expectations, NICE guidance and self-assessment of the NHS Improvement recommendations.

2. Next step requirements to progress a centralised ward level dashboard for quality, staff, patients and carer feedback.

3. The plan for the formal annual review of safe staffing for all inpatient ward areas in September / November 2017.

8 https://www.england.nhs.uk/ourwork/leading-change/
Midwifery Safe Staffing Report

1. **Purpose:**

   A 6 monthly report, to provide the Trust board with a Safe staffing update for the Maternity service at NBT.

2. **Background:**

   In October 2016, North Bristol NHS Trust (NBT), Maternity department, commissioned a review using ‘Birthrate Plus’ to look at current midwifery staffing, and supported this with NICE\(^9\) recognised guidance around safe staffing.

   The Birth Rate plus acuity model and detailed staffing review is the only model recognized by the Royal College of Midwives and NICE who published ‘Safe midwifery staffing for maternity settings’ in February 2015.

   The Birth Rate Plus model uses data from Maternity Units around the UK to allow a validated customized interpretation of staffing needs for individual units.

   The CQC report in March 2016 rated Maternity Services at NBT as Good; an improvement from the previous 2014 rating of requires improvement. This was in direct result of improved investment in staffing and improved ratios from December 2015.

   \(^9\)[https://www.nice.org.uk/guidance/ng4](https://www.nice.org.uk/guidance/ng4)

<table>
<thead>
<tr>
<th>Midwife to Birth Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-15</td>
</tr>
<tr>
<td>1:33</td>
</tr>
<tr>
<td>May-16</td>
</tr>
<tr>
<td>1:30</td>
</tr>
<tr>
<td>Nov-16</td>
</tr>
<tr>
<td>1:30</td>
</tr>
</tbody>
</table>

**Total Births:**

Over the past 2 years there was an ongoing trend of an increased birthrate; however since 2016/17 there has been a changing trend which shows a decrease in births to 6261 a decrease of 2.6% (Table 2). This decrease in birthrate trend is currently continuing. There has however been a change in acuity from a 60:40 low risk to high risk caseload to a caseload mix of 50:50. So whilst this affects the staffing demands as higher acuity requires 1:1 midwifery care for longer, with the reduction in birth bookings there is a not currently a requirement to increase staffing. This will be monitored closely.
Birthrate plus report recommendations\textsuperscript{10}

- Showed a negative variance of 14.86 wte staff (Band 3 – Band 7)
- Integrated working would support reducing this variance to 10 wte
- 85% of staff should be registered midwives - currently the percentage is 70%
- Plan systematic transfer of band 3 staff into the budget for registered midwives to address the differential in percentage of registered to Non registered staff.

Subsequent clinical activity following the report has gone on to show that current staffing models support current activity, and with integration there is no requirement to increase staffing in the next 6 months. Although the requirement to convert band 3 posts into band 5/6 posts with natural wastage is planned and being enacted as posts become vacant.

The expected skill mix ratio should be 85:15 Registered Midwife to maternity support worker, the current average ratio at NBT is 70:30 with 80:20 on Delivery Suite. The midwife to birth ratio has been consistent at 1:30 since December 2015.

\textsuperscript{10}Birthrate Intrapartum Acuity® System (BRIPAS)

This document could be made public under the Freedom of Information Act 2000. Any person identifiable, corporate sensitive information will be exempt and must be discussed under a ‘closed section’ of any meeting.
‘Better Births’ (2016) a National review of Maternity services

This review was used alongside the Birth Rate plus report. A critical element of the review has been acknowledging that the quality and outcomes of maternity care have improved significantly in the last two decades, including a 20% fall in stillbirth and neonatal mortality rates. At the same time maternity services have had to respond to challenges, such as more women giving birth at an older age and the increasing complexity of many women’s health needs. Despite the progress made in recent years, the review identified some instances where maternity services were falling short:

- Women were not always being offered real choice in the services they could access or were told what to do, rather than being given information to make their own decisions.
- Hospital services were frequently operating at 100% capacity while community-based services struggled to survive.
- Whilst women wanted their midwife to be with them from the start, they rarely saw the same professional twice.
- The quality of maternity care varied considerably, there was insufficient collaboration across professional boundaries and staff spent too much time collecting poor-quality data.
- Things go wrong too often and fear of litigation inhibits staff from being open about and learning from mistakes.
- Outcomes on some measures are worse in the UK than for comparable services elsewhere in Europe.

Practice changes are being put in place to reflect the document and the birthrate plus review.

1. Integrated working for midwives working in specific community areas to integrate with the birth centre teams. This will provide improved flexible staffing, enabling the workforce to be moved to areas of need, following the patient through her journey in a responsive way.
2. Integrated working for maternity support workers working in specific community areas to integrate with the birth centre teams. Enabling the support worker also to be moved to areas of need, following the patient through her journey in a responsive way.

Since the report, booking numbers have declined, and a new dynamic staffing tool has been developed and purchased. This will enable 3 times live acuity monitoring which will provide a more accurate assessment of staffing requirements.

Integration has been launched but has yet to embed; based on this the decision has been made by the Divisional Management team to monitor the acuity using the new tool and review again in six months and review in line with the NHS improvement Midwifery resource.

Therefore careful monitoring of growth using the Birthrate plus tool will support the model of staffing required going forward.

The review of community midwifery services has shown a caseload ratio of 1:100 with a 77:23 ratio Registered to Non registered staff. Clerical support was an identified area needing review due to this, the next stage is to review the support worker role, and identify if administration support is more beneficial than maternity support workers.

---

**Staff Development**

There is a formal development programme for transition from Band 6 to 7 and from 7 to 8a. This programme is in place on the delivery suite, in the community setting, and within the ward areas. All Band 5 midwives have a named preceptor and follow a preceptorship package. This was recently increased to 23 months to support the Band 5 staff to complete their competencies, and be supported to fulfil a Band 6 job description.

The Maternity Department train in a multi-professional model, using PROMPT training, developed at Southmead Hospital. The training has supported safe emergency care despite increased acuity in the caseload. There is a robust clinical governance process and the maternity dashboard looking at outcomes is reviewed monthly in the Clinical Governance meeting.

### 3. Summary

A strategic review of staffing across all areas of the Midwifery service, using Birthrate plus, took place in October 2016. It recommended additional staff across band’s 3 to band’s 7, Integrated working, and a change in skill mix.

The report was helpful and relevant at the time, given the working model and number of births. However since then, integrated working has been developed and recently commenced, and the birth booking numbers have reduced.

A new Birthrate plus acuity tool is being purchased to which now includes Antenatal and Postnatal care, and a dynamic responsive data capture of intrapartum care requirements and acuity. This will enable live acuity monitoring which will provide a more accurate assessment of staffing requirements on an hourly basis, and is in line with safer staffing, but designed specifically for maternity services.

Methodology for reviewing staffing and capacity is based on the Birth rate plus tool, NICE guidance and professional judgment, in conjunction with length of stay and bed modelling. 1:1 care in labour has improved in 2017 to 96.9% supporting the decision to keep staffing establishment as it is currently.

### 4. Next Steps:

- Ongoing audit of 1:1 care in labour.
- Use of Birthrate Intrapartum Acuity® System (BRIPAS) to inform staffing requirements in relation to acuity.
- Purchase of a new tool has been approved to include the Antenatal and Postnatal areas.
- Full review of staffing in 6 months following implementation of new tool.
- Continue to promote low risk setting as default birth place for all low risk.

### 5. Recommendations

- Trust Board to note there has been a review of staffing across all maternity areas using Birth Rate Plus recommendations and NICE guidance.
- A programme to implement the recommendations of ‘Better Births’ 2016, to include Integration of the community and Birth centres has commenced.
- Full review of staffing in 6 months will take place following implementation of new Acuity tool and embedding of Integration.
## Appendix 1: Safe, Sustainable and productive staffing – An improvement resource for adult inpatient wards in acute hospitals, Self Assessment

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>NBT Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A systematic approach should be adopted using an evidence-informed decision support tool triangulated with professional judgement and comparison with relevant peers.</td>
<td>In place, use of Model Hospital Dashboard, National tools and Royal Colleges where relevant.</td>
</tr>
<tr>
<td>A strategic staffing review must be undertaken annually or sooner if changes to services are planned.</td>
<td>In place, undertaken 6 monthly with full review annually and at every change to service. To be linked going forward to Budget setting timescales</td>
</tr>
<tr>
<td>Staffing decisions should be taken in the context of the wider registered multi-professional team.</td>
<td>Undertaken where relevant e.g Elgar 2 ward has registered Multi professional team members on the ward</td>
</tr>
<tr>
<td>Consideration of safer staffing requirements and workforce productivity should form an integral part of the operational planning process.</td>
<td>In place</td>
</tr>
<tr>
<td>Action plans to address local recruitment and retention priorities should be in place and subject to regular review.</td>
<td>In place, retention schemes to be further developed with learning gained from NHS Improvement Masterclass</td>
</tr>
<tr>
<td>Flexible employment options and efficient deployment of staff should be maximised across the hospital to limit temporary staff.</td>
<td>Efficient deployment using Safe Care live daily. Controls in place for Agency approval. Employment options to be further explored as part of retention.</td>
</tr>
<tr>
<td>A local dashboard should be in place to assure stakeholders regarding safe and sustainable staffing. The dashboard should include quality indicators to support decision-making.</td>
<td>Staff staffing reported in line with National requirements, staffing decisions based on review of quality indicators. Trust wide dashboard for review required.</td>
</tr>
<tr>
<td>Organisations should ensure they have an appropriate escalation process in case staffing is not delivering the outcomes identified.</td>
<td>Formal staffing reviews include assessment of all metrics and process for escalation to Executive level in place</td>
</tr>
<tr>
<td>All organisations should include a process to determine additional uplift requirements based on the needs of patients and staff.</td>
<td>Uplift/ Headroom levels monitored closely each month, recognition that high numbers of part time staff and specialist areas may require increased study leave.</td>
</tr>
<tr>
<td>All organisations should investigate staffing related incidents, their outcomes on staff and patients and ensure action and feedback</td>
<td>Robust process in place to review and investigate locally all staffing incidents, reviewed monthly at Nursing and Midwifery Leadership group for themes. Staff encouraged to report unsafe staffing and any impact on patients via electronic incident reporting.</td>
</tr>
</tbody>
</table>
Report Title: Medical Revalidation and Appraisal Annual Quality Report

Status:

<table>
<thead>
<tr>
<th>Information</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Approval</th>
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<tr>
<td>✓</td>
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</tr>
</tbody>
</table>

Prepared by: Chris Burton, James Calvert & Nick Standen

Executive Sponsor (presenting): Chris Burton

Appendices (list if applicable): Appendix A (Designated Body Statement of Compliance) to be signed by a member of the Board

Recommendation:

The Board is asked to agree to the statements in appendix A by signing the document so that it can be returned to the NHS higher level Responsible Officer by the deadline of 29th September 2017.

Executive Summary:

North Bristol Trust is the designated body supporting the revalidation and appraisal of 678 doctors (figure at 21st June 2017) in a number of grades. Well established processes are in place to quality assure the appraisal process and to identify doctors who have missed their appraisals. Each directorate has a designated appraisal lead who reports to the Deputy Responsible Officer for Revalidation.

The Trusts appraisal systems were last inspected by NHS England in September 2015 which received an “Excellent” rating in all domains. The next full inspection is due in 2020. A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result.
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1. **Introduction**

Legislation supporting the licencing of doctors (Revalidation) was introduced in April 2013, so is now in its 5th year.

At the 31st March 2017; 661 doctors had a prescribed connection to North Bristol NHS Trust meaning that NBT is the designated body for the purposes of medical revalidation. Each year every doctor must complete an appraisal that meets the GMC requirements. The fourth year of revalidation detailed in this report covers the period from 1st April 2016 - 31st March 2017.

NBT supports appraisal and revalidation for consultants, clinical fellows, specialty doctors, associate specialists and a small number of Trust locums. There are also a further 9 doctors who complete annual appraisals at NBT but maintain a connection to another designated body. Doctors in training grades maintain a connection to their deanery for revalidation.

During the transfer of the Community Child Health Partnership from NBT in April 2016, their medical staff transferred to Sirona. NBT agreed to maintain the appraisal and revalidation service this group for a 12 month term which has now been extended until March 2018.

2. **Purpose of the Paper**

The purpose of this report is to communicate the results of an annual organisational audit of the Trust’s progress with revalidation which cross references the Medical Profession (Responsible Officers) Regulations 2010 (amended 2013) and the GMC (Licence to Practice and Revalidation) Regulations 2012. This will enable the Trust Board to make a statement of compliance (Appendix A) that must be returned to NHS England before the 29th September 2017.

3. **Governance Arrangements (Compliance Statement 1)**

**Revalidation roles at NBT**

The revalidation team at NBT:

- **Responsible Officer (RO):** Dr Chris Burton Medical Director
- **Deputy Responsible Officer & Revalidation Lead for NBT:** Dr James Calvert
- **Revalidation Support Manager (supporting both medical and nursing & midwifery revalidation):**
- **Revalidation Support Administrator (this role was in place until November 2016. The post will not be continued).**

Within each clinical directorate there is an appraisal lead(s) that provides a link between the revalidation team, the directorate management team and the individual doctors. ASCR now have three appraisal leads and Neuro-MSK have two. Core Clinical Services are currently in need of a new lead.

The Trust also provides a lay member who attends an annual revalidation steering group.

**Meetings**

**Medical revalidation steering group**

The revalidation team, directorate appraiser leads and other identified individuals who support the revalidation and appraisal processes meet up to twice per year at the revalidation steering group to discuss current processes and improvements.
Appraisal system

The Trust continues to use the PReP appraisal software for all medical appraisals to ensure compliance and quality assurance. The current licence agreement is due to expire in November 2017. Every doctor has an annual appraisal due date on the Trust’s system. A doctor’s due date will remain the same each year regardless of when the individual last completed the appraisal to ensure that the required 5 annual appraisals take place over the 5 year revalidation cycle.

Reporting of appraisal progress

Two reports are produced simultaneously each monthly by the Revalidation Support Manager:

1. Revalidation appraisal figures report

Issued to the Responsible Officer / Deputy Responsible Officer / Deputy Medical Director / Trust HR Business Partners / Information Management Department

The report highlights the following:

- Number of appraisals that were due by the current point in the appraisal year and % that have been completed
- Number of appraisals in the current appraisal year that are:
  - Completed
  - Missed
  - Due date not yet set (for doctors who joined NBT in the past 2 months)
  - Not due yet

The report also contains the following metrics for the Trust’s Integrated Performance Report:

- Rolling % of doctors, by grade, who are complying with the NHS England requirement to not exceed 15 months since their last appraisal
- Total number of revalidation recommendations made in each of the past 12 months.
  a. No. of positive recommendations
  b. No. of deferrals
  c. No. of non-engagement recommendations

2. Missed appraisal report

This report is issued to Clinical Directors / Directorate Appraiser Leads / Trust HR Business Partners / General Managers

The report is presented by directorate and highlights all the individual doctors who have passed their appraisal due date without a completed appraisal and any reasons given for the delay.
Process of escalation for a missed appraisal

Where an appraisal is delayed and highlighted in the above report there is an escalation process in place as detailed below. This process was updated in September 2016 and agreed by the Joint Local Negotiating Committee (JLNC).

There is a 1 month gap between each stage.

**Stage 1:** Letter to the doctor from the directorate appraiser lead offering support and guidance

**Stage 2:** Letter to the doctor from the Deputy RO requiring action within three weeks

**Stage 3:** Letter to the doctor from the RO requiring actions within three weeks or confirmation of the reasons why this is not possible

**Stage 4:** A meeting is arranged between the doctor and the Deputy RO to identify the reasons for the missed appraisal and the necessary actions required to complete. A form is also issued to the GMC which triggers a non-engagement communication letter to be sent from the GMC instructing the doctor that they must meet the requirements within 8 weeks.

Failure to meet this GMC deadline can result in a non-engagement recommendation being made which will put the doctor’s license to practice at risk.

Maintaining an accurate list of prescribed connections (Compliance Statement 2)

To ensure that the list of doctors with a prescribed connection to North Bristol NHS Trust is accurate, the following processes are in place:

**Doctors joining NBT**

The Medical Personnel team inform the Revalidation Support Manager each month of doctors joining the Trust. The Revalidation Support Manager assesses whether NBT should be the doctor’s designated body as per the GMC guidelines. The doctor is then added to the Trusts designated body via an online database GMC-Connect.

When a doctor joins the Trust; the Revalidation Support Manager issues a request to the individual doctor’s previous designated body to identify the date of the doctor’s most recent appraisal and details of any concerns relating to the individual. Returned forms are inserted into the individuals NBT appraisal portfolio for the doctor to access and any details of concerns are shared with the Trusts RO.

**Doctors leaving NBT**

The Medical Personnel team inform the Revalidation Support Manager when a doctor leaves the Trust. The doctor’s connection to NBT is removed via the online system GMC-Connect.

Sharing Information (Compliance Statement 8)

Information about a doctor’s fitness to practice is requested from the previous designated body when a doctor joins the Trust. The NBT appraisal system expects that a doctor declares their whole scope of work as required by the GMC. This ensures that the revalidation support team and Responsible Officer can identify other places where the doctor works for the purposes of sharing fitness to practice information.
During an appraisal doctors must include information from private practice including a statement of no concerns signed by the private employer. Appraisers do not proceed with the appraisal until this information has been included.

Process of internal assurance

Audit South West completed an audit of the Trusts revalidation and appraisal processes in February 2015 which received an overall green assurance opinion rating and a low impact assessment rating.

Documented in last year’s board report; NHS England conducted a review (independent verification visit) of the Trusts appraisal and revalidation processes in September 2015. The review provided an ‘Excellent’ outcome which meets all core standards. Independent Verification Visits by NHS England will be carried out at least once per revalidation cycle (5 years). The next review at NBT is likely to take place around 2020.

A shorter visit took place by NHS England in February 2017. The NHS England team were happy with the current progress with no recommendations made as a result.

Trust Policy and User Guide

The NBT appraisal and revalidation policy and user guide was updated and signed off by the Joint Local Negotiating Committee (JLNC) in September 2016.

4. 2016/17 Medical Appraisal & AOA Results

2016/17 Appraisal and revalidation performance data (Compliance Statement 5)

The NHS England revalidation framework of quality assurance requires the Trust (as a designated body) to return an Annual Organisational Audit (AOA) to NHS England following the end of the 2016/17 appraisal year.

The AOA was returned in May 2017 and includes the 2016/17 appraisal compliance for all doctors with a prescribed connection to the Trusts designated body at the 31st March 2017.

At the 31st March 2017, the Trust declared that 636 doctors were connected to its designated body. There were two additional groups of doctors completing appraisals at NBT who are not included in the 636 doctors. These are:

- 25 doctors who were Sirona employees (referenced in the introduction in section 1). These 25 doctors were all compliant with an appraisal using the NBT system and the details of this were returned in a separate AOA report by Sirona.

- 9 doctors who completed appraisals at NBT but who hold a prescribed connection to another designated body. These 9 doctors were all compliant with their appraisals and the details of this were returned in a separate AOA report by their designated bodies.

The below details returned to NHS England represent the 636 doctors with a prescribed connection to NBTs designated body highlighted above.
Only doctors with a prescribed connection to the Trusts designated body at the 31st March 2017 are included within this data. The table below shows the number of doctors with a prescribed connection, the number of completed appraisals, the number of approved or incomplete missed appraisals, the number of unapproved or missed appraisals, and the percentage of appraisal completion.

<table>
<thead>
<tr>
<th>Category</th>
<th>No of Doctors with a prescribed connection</th>
<th>Completed Appraisals</th>
<th>Approved or incomplete missed appraisals</th>
<th>Unapproved or missed appraisals</th>
<th>% Appraisal Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants (permanent employed consultant medical staff including honorary contract holders)</td>
<td>399</td>
<td>368</td>
<td>14</td>
<td>17</td>
<td>92%</td>
</tr>
<tr>
<td>Associate Specialists &amp; Specialty Doctors</td>
<td>39</td>
<td>35</td>
<td>1</td>
<td>3</td>
<td>89%</td>
</tr>
<tr>
<td>Temporary and short term contract holders (temporary employed staff including locums who are directly employed, trust doctors and clinical fellows)</td>
<td>191</td>
<td>162</td>
<td>1</td>
<td>28</td>
<td>84%</td>
</tr>
<tr>
<td>Other doctors (recently retired NBT doctors paying for a revalidation service)</td>
<td>7</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>636</td>
<td>572</td>
<td>16</td>
<td>48</td>
<td>89%</td>
</tr>
</tbody>
</table>
The 16 doctors with approved missed appraisals are for long term leave due to maternity or sickness. Other reasons include awaiting the outcome of an incident to discuss at the appraisal, awaiting the outcome of a University appraisal to feed into the NBT appraisal and delays due to unforeseen compassionate leave.

The 48 unapproved missed appraisals are being managed through the Trusts missed appraisal escalation process. 12 remain incomplete at the 30th June 2017. In the last year, 2 doctors not compliant left the trust and were removed from our designated body. A third, clinical fellow grade doctor has recently had a non-engagement recommendation made to the GMC. He is currently appealing the GMC’s decision to remove his licence to practice.

**Previous AOA data**

The below table presents the 2016/17 AOA appraisal compliance compared to previous years.

<table>
<thead>
<tr>
<th>AOA Appraisal Year</th>
<th>No. of prescribed connections</th>
<th>% of appraisals completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>636</td>
<td>89%</td>
</tr>
<tr>
<td>2015/16</td>
<td>636</td>
<td>88%</td>
</tr>
<tr>
<td>2014/15</td>
<td>575</td>
<td>87%</td>
</tr>
<tr>
<td>2013/14</td>
<td>519</td>
<td>87%</td>
</tr>
</tbody>
</table>

**Appraisers (Compliance Statement 3 & 4)**

**New appraiser training:**

The number of appraisers required to support revalidation is monitored within each division based on the number of appraisees. It is based on an appraiser conducting a minimum of five appraisals per year. The time allowance allows for between five and ten appraisals per year and is reimbursed as 0.25 SPA per week.

New appraiser training is provided where a drop in the number of appraisers in a division occurs or the number of appraisees rises. The training is provided by an external company. Two companies have been used over the 2016/17 year. Effective Professional Interactions are used for large group training and Dedici Ltd are used when there is a need to train individuals. The content of both training programmes have been reviewed by the revalidation support team to ensure they meet the GMC requirements and are recognised for CPD.

**Existing appraiser training:**

Existing appraisers are expected to attend a half day update training session each year facilitated by an external training group: Effective Professional Interactions. The training days are supported by the Deputy Responsible Officer and the Revalidation Support Manager.

There were two training days in 2016. Both days consisted in half day sessions providing 4 sessions in total. The next medical appraiser CPD updates are due in June & November 2017. Effective appraiser training is a key part of professional development for medical staff in the trust. Training in recent years has included; supporting doctors in maintaining resilience and different career stages, having difficult conversations, assisting doctors in formulating measurable personal development plans for the year ahead.
Quality assurance of appraisals

The following outlines the areas of quality assurance within the appraisal processes:

Appraisal systems:

- PReP allows the appraisal conversation to be summarised and captured electronically providing an audit trail of each individual step in the process.
- An appraisee is required to make mandatory pre-appraisal probity statements in the system.
- The appraisal inputs are required to be submitted to the appraiser prior to the date of appraisal. This provides the appraiser with sufficient time to review the content and return the form for editing if necessary.
- Information regarding closed complaints, audits, quality improvement projects, Trust MLE training and formal HR concerns are included into the appraisal inputs for every doctor by the Revalidation Support Manager to ensure they are included for discussion with the appraiser. This provides assurance that all elements set out as needing discussion by the GMC during appraisal are included.
- Reports on clinical incidents are currently not being added to the appraisal inputs by the Revalidation Support Manager as a number of the reports generated from the Safeguard system were inaccurate. The introduction of Datix should provide a more accurate reporting process. Doctors are able to still add incidents to their portfolio themselves. The deputy RO is chairing the Datix Implementation Project Board.
- Any information that the Responsible Officer deems appropriate for inclusion into a doctor’s appraisal input is also sent to the Revalidation Support Manager to upload to the system. This is locked in the system with mandatory reflection required. This may include letters of advice sent as a result of disciplinary processes etc.
- 360 feedback is collected through the Edgecumbe Doctor 360 tool which provide anonymous reports meeting GMC guidance for feedback.

For the appraisers:

- Appraisers are required to reflect on their performance as an appraiser during their own appraisal. As part of completing an appraisal, the appraisee is required to complete an online questionnaire about the performance of the appraiser. These feedback results and comments are then anonymised and uploaded into the appraisers portfolio by the Revalidation Support Manager.
- Appraisers will also attend the appraiser half day training days annually which will provide CPD and appraiser networking which will feed into their own appraisals.
- Appraisers are also asked to attend any directorate appraiser meetings which are setup by the directorate appraiser leads.
- During a doctor’s revalidation, the Deputy Responsible Officer reviews all appraisal inputs and outputs for that individual. The quality of the appraisal outputs are assessed and fed back to the appraiser with suggestions for improvement where necessary. The 2016 revalidation Trust policy update includes a new process for any appraisers who are not meeting the expectations of the role.
For the organisation:

- User feedback on the systems in place is gathered during directorate appraiser meetings, steering groups and through the appraiser training days.
- The monthly appraisal compliance reports provide a continuous audit of appraisal compliance. The revalidation team has also complied with every appraisal report required by NHS England to date which is requested four times per year.
- The Trust has processes outside of the appraisals to investigate and manage complaints and incidents as they occur. The outcomes from these are included in appraisals for doctors to reflect on and learn from.
- The Revalidation Support Manager contacts all specialty leads every 6 months to identify any low level concerns for doctors that have not been picked up by the Trusts formal processes. Any concerns received are shared with the RO.
- Two key audits in the past two years from Audit South West and the NHS England Independent Verification Visit

**Security and clinical governance**

The following levels of access have been provided to the users of PReP:

- The PReP e-portfolio is accessed by a unique user name and password
- Responsible Officer and Deputy Responsible Officer has access to all e-portfolios through a user name and password
- The following individuals have access to all individual e-portfolios for the purpose of providing individual system support and help; support to appraisers and to upload centrally produced supporting information:
  - Revalidation Support Manager
  - Medical HR Manager (only in the absence of the Revalidation Support Manager)
- Appraisers only have access their own agreed appraisee portfolios to view appraisal input forms and supporting information and to complete Output forms. Appraisees can change this at any time.

PReP is supplied by Premier IT which is ISO 27001 compliant for Information Security Management. Patient identifiable information is neither allowed nor required to be uploaded to individual's e-portfolios.

5. **Revalidation Recommendations**

The 2016/17 appraisal year (April 2016 - March 2017) saw a significant drop in the number of recommendations due compared to the previous years. It also saw a rise in the percentage of deferral recommendations.
<table>
<thead>
<tr>
<th>Appraisal Year</th>
<th>Revalidations Due</th>
<th>Positive</th>
<th>Deferral</th>
<th>Non-Engagement</th>
<th>% Deferrals Made</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>44</td>
<td>32</td>
<td>12</td>
<td>0</td>
<td>27%</td>
</tr>
<tr>
<td>2015/16</td>
<td>202</td>
<td>172</td>
<td>30</td>
<td>0</td>
<td>15%</td>
</tr>
<tr>
<td>2014/15</td>
<td>189</td>
<td>164</td>
<td>25</td>
<td>0</td>
<td>13%</td>
</tr>
<tr>
<td>2013/14</td>
<td>96</td>
<td>86</td>
<td>10</td>
<td>0</td>
<td>10%</td>
</tr>
</tbody>
</table>

**No. of recommendations**

When revalidation was introduced in 2012, the GMCs intention was that all licenced doctors at the time of its introduction would go through the revalidation process within its first three years. This is why the number of revalidation recommendations due has dropped in the fourth year since its introduction.

**Deferrals**

The percentage of deferrals made in the 2016/17 year has risen. All doctors who were registered with a licence to practice in 2012 went through revalidation within the first three years; the majority of the revalidation recommendations due in the fourth year have been for non-consultant grade doctors.

<table>
<thead>
<tr>
<th>Grade of doctor</th>
<th>No. of deferrals made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>1</td>
</tr>
<tr>
<td>Clinical Fellow</td>
<td>8</td>
</tr>
<tr>
<td>Specialty Doctor/Associate Specialist</td>
<td>2</td>
</tr>
<tr>
<td>Trust Locum Doctor</td>
<td>1</td>
</tr>
</tbody>
</table>

A high number of recommendations due in the fourth year were for clinical fellows. Clinical fellows remain the key target group for the Revalidation Support Team. Many clinical fellows come directly from a recognised training programme where the process of appraisal and revalidation is quite automatic for them through their ARCP reviews. Other clinical fellows come from abroad and are unfamiliar with the requirements and importance for appraisal and revalidation. For these reasons, this group of staff are seemingly slow to prioritise the work needed to be prepared for revalidation which has led to an increase in the percentage of deferral recommendations.

Various methods of communications are in place to advise clinical fellows of their responsibilities for annual appraisal and revalidation. Due to the continuous lack of engagement from this particular staff group, the Revalidation Steering Group has agreed to a new process of delegating appraisers to clinical fellows upon their arrival at the Trust. The appraiser will be able to advise the individual of their responsibilities following the information that the doctor has already received from the Trust. It is hoped that this will reduce the number of clinical fellows with deferred revalidation dates. A deferral is an administrative action taken by the trust to allow a doctor to collect more information for their appraisal. It is not a disciplinary action and has no implications for a doctor’s licence to practice.
The reasons for the deferrals in the last appraisal year are listed below.

<table>
<thead>
<tr>
<th>2016/17 Reasons for Deferrals</th>
<th>Number of Deferrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient evidence within previous appraisals or no previous appraisals completed. Deferral until a further appraisal can be complete.</td>
<td>4</td>
</tr>
<tr>
<td>Failure to complete a full set of 360 colleague and patient feedback including the individual’s reflections on the results.</td>
<td>3</td>
</tr>
<tr>
<td>Failed to complete upcoming appraisal by the revalidation deadline</td>
<td>2</td>
</tr>
<tr>
<td>Unable to complete appraisal and 360 feedback due to maternity leave</td>
<td>1</td>
</tr>
<tr>
<td>Doctor new to NBT - more time needed to engage with the NBT appraisal process. Revalidation date too soon after Trust start date.</td>
<td>2</td>
</tr>
</tbody>
</table>

Non-engagement recommendation

In May 2017 at the start of the 2017/18 appraisal year, the Trusts first non-engagement recommendation was made for a clinical fellow. The recommendation followed a deferral that was made for the individual by NBT in October 2016. The individual was also deferred by their previous Designated Body in August 2015.

The Trusts revalidation support team are confident that the individual was provided with every opportunity to complete the required actions in good time before the non-engagement recommendation was submitted to the GMC. The Trusts revalidation support team made extensive efforts to assist the individual. By the deadline in May 2017, the individual had failed to complete the actions that were agreed following the second deferral in October 2016. The GMC had also written to the individual on multiple occasions.

The individual was provided with an opportunity to explain to the GMC the reasons why they had failed to engage with the process by the May deadline. On the 7th June, the GMC wrote to the Trusts Responsible Officer with their decision to withdraw the individuals licence to practice on the 12th July. The individual has until the 5th July to appeal.

6. Monitoring Performance (Compliance Statement 6)

For the purposes of revalidation the following information is included into each doctor’s appraisal portfolio. The doctor is expected to reflect on the content of all these reports within their appraisal and discuss any outcomes with their appraiser:

a. Complaints (run from the Trusts Safeguard system)

The advice and complaints team maintain a process by which doctors are informed of all incoming and outgoing correspondence concerning complaints with which they are involved. A retrospective report from the preceding 12 months is uploaded to the individual’s e-portfolio eight weeks prior to their appraisal for reflection and discussion at appraisal.

b. Incidents (run from the Trusts Safeguard system) - suspended

The Trust’s eAIMS system contains a process where a doctor can be actively highlighted and an explanation of their involvement in an incident can be detailed. Due to some inaccurate data appearing in the reports, the revalidation support team have suspended adding incident reports into doctor’s portfolios until the new Datix system is implemented.
Doctors must still include information on any incidents they have been involved in by adding this to their own portfolio. The revalidation support team are working with the Datix project team to ensure that this process can be re-introduced with the new system.

c. Clinical audit (produced by the Clinical Audit department)

The Trust’s Clinical Audit department produces a report of all completed, registered clinical audits for each doctor. A retrospective report from the preceding 12 months is uploaded to the individual’s e-portfolio eight weeks prior to their appraisal for reflection and discussion at the appraisal.

d. Quality improvement projects (produced by the Quality & Safety Improvement Team)

The Trust’s Quality Improvement department produces a report of all completed and ongoing registered quality improvement projects for each doctor. A retrospective report from the preceding 12 months is uploaded to the individual’s e-portfolio eight weeks prior to their appraisal for reflection and discussion at the appraisal.

e. Formal fitness to practice concerns (produced by the HR department)

The Trust’s HR department maintains an electronic record of all doctors who are going through a formal management process due to fitness to practice concerns. A retrospective report from the preceding 12 months is uploaded to the individual’s e-portfolio eight weeks prior to their appraisal for reflection and discussion at appraisal. Concerns are only included into an e-portfolio when they are closed or when formal remedial actions have been agreed with the individual.

f. Formal HR concerns - Bristol University

The University of Bristol HR department maintains a record of all formal concerns for doctors employed with the university. Those with honorary contracts with NBT are appraised and revalidated through the Trusts Designated Body. A transfer of information request is sent to the university eight weeks prior to their appraisal and a retrospective report from the preceding 12 months is uploaded to the individual’s e-portfolio for reflection and discussion at the appraisal.

g. Low level fitness to practice concerns; produced in a six monthly report from the individuals clinical manager

Specialty leads are provided with a list of all doctors within their specialty every six months and are asked to make a statement, for each doctor, whether there are any low level fitness to practice concerns (not in a formal management process). Where a concern is identified an exception report is produced where more detail is provided and this is uploaded to the individual’s e-portfolio for reflection and discussion at appraisal. Concerns are only included in an e-portfolio if the specialty lead is able to confirm that the individual has been made aware of the concern.

h. Formal HR concerns - Sirona

Sirona Care & Health HR department maintains a record of all formal concerns for doctors employed with Sirona. NBT Provides an appraisal and revalidation service for these. A transfer of information request is sent to Sirona eight weeks prior to their appraisal and a retrospective report from the preceding 12 months is uploaded to the individual’s e-portfolio for reflection and discussion at the appraisal.
7. **Responding to Concerns and Remediation (Compliance Statement 7)**

The NBT Medical Staff Remediation Policy and User Guide describes the approach of the Trust to the identification, classification and response to the performance issues of members of the medical staff for whom North Bristol Trust is the designated organisation.

Remediation programmes are designed to meet the needs of the individual doctors and as such are not formally laid out in the policy or user guide. The Trust also has methods of responding to complaints and incidents as they occur.

8. **Recruitment and Engagement Background Checks (Compliance Statement 9)**

All pre and post-employment checks at NBT comply with the NHS Employment Check standards which apply to all applications for NHS positions and staff in ongoing NHS employment. The NHS standards are regularly reviewed to ensure ongoing compliance. The relevant regulations with which NBT complies are described below:

All NHS providers are required to be registered with the Care Quality Commission (CQC) and, as part of this registration are required to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

The CQC’s Essential Standards of Quality and Safety outline core standards which must be met, including robust recruitment practices in place. NHS providers should therefore provide evidence of compliance with the NHS Employment Check Standards as part of the CQC’s regulatory framework. The NHS Employment Check Standards are also embedded in the Crown Commercial Service, National Agency Framework Agreement and there are annual audit checks of agencies, to assure compliance with the standards.

9. **Risks, Concerns and Corrective Actions (Compliance Statement 10)**

**Risks and concerns**

- Clinical fellow engagement in appraisal and revalidation needs to be strengthened. Engagement through an allocated appraiser may help to highlight the importance of this process to those clinical fellows who do not take any responsibility for their own appraisal compliance.

**Corrective actions**

- As part of the process of updating the Trust’s revalidation policy, the missed appraisal escalation process has been adapted to include a communication from the GMC where necessary at stage 4. This was discussed and agreed at the LNC.

- Due to some inaccurate data appearing in the clinical incident reports run from the Safeguard system, the revalidation support team have suspended adding incident reports into doctor’s portfolios until the new Datix system is implemented. Doctors must still add the details of incidents that they have been involved in to their appraisal portfolios.
10. Actions Required

The board is asked to accept the report and consider the Statement of Compliance (Appendix A) to decide if there is sufficient assurance for this to be signed and returned to the Trusts Revalidation Support Manager.
Appendix A

Designated Body Statement of Compliance

The board of North Bristol NHS Trust can confirm that

- an AOA has been submitted,
- the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013)
- and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   Comments:

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   Comments:

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   Comments:

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers\(^1\) or equivalent);

   Comments:

5. All licensed medical practitioners\(^2\) either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   Comments:

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners\(^3\) (which includes, but is not limited to, monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues) and ensuring that information about these matters is provided for doctors to include at their appraisal;

   Comments:

---

\(^1\) [http://www.england.nhs.uk/revalidation/ro/app-syst/](http://www.england.nhs.uk/revalidation/ro/app-syst/)

\(^2\) Doctors with a prescribed connection to the designated body on the date of reporting.

---
7. There is a process established for responding to concerns about any licensed medical practitioners’ fitness to practise;

Comments:

8. There is a process for obtaining and sharing information of note about any licensed medical practitioner’s fitness to practise between this organisation’s responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where the licensed medical practitioner works;\(^3\)

Comments:

9. The appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that all licenced medical practitioners have qualifications and experience appropriate to the work performed;

Comments:

10. A development plan is in place that ensures continual improvement and addresses any identified weaknesses or gaps in compliance.

Comments:

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: ____________

Name: ____________ Signed: ____________

Role: ____________

Date: ____________

The paper sets out for assurance to the Trust Board that there is a process in place for ensuring and supporting the revalidation of Nurses and Midwives within North Bristol Trust.
1. **Background**

1.1. Revalidation aims to protect the public, increase public confidence in nurses and midwives and help those on the Nursing and Midwifery Council (NMC) register to meet the standards required of them.

1.2. Revalidation takes place every 3 years and replaces the current post registration education and practice standards (PREP). Under revalidation, registered nurses and midwives must meet the following requirements in the 3 year period since their registration was last renewed:

- Practised for at least 450 hours (900 if dual registered)
- Undertaken at least 35 hours of continuing professional development relevant to their scope of practice as a nurse or midwife (with a minimum of 20 hours being participatory learning).
- Collected 5 pieces of feedback on their practice using feedback from service users, patients, relatives, colleagues and others.
- Written 5 reflective accounts referring to CPD, Practice-related feedback and/or an experience in their practice and how it relates to the code.
- Held a reflective discussion with another NMC registered nurse or midwife.
- Received confirmation for a third party (called a ‘confirmer’) that they have met the revalidation requirements.

1.3. The model of NMC revalidation is very different to the General Medical Council (GMC) revalidation model:

   - It is the responsibility of each nursing and midwifery registrant to fully complete the online application and submit their revalidation to the NMC, (including statements on health and character and indemnity cover).

2. **Purpose**

Revalidation for Nurses and Midwives began in April 2016. The process is mandatory for all Nursing and Midwifery Council registrants in order to maintain an up to date registration.

This paper describes the approach to revalidation from the Trust since its introduction in 2016 and the engagement from staff employed at NBT.

3. **Supporting Revalidation**

3.1. **Revalidation Roles**

Revalidation is currently supported in the Trust by:

- Sarah Dodds - Deputy Director of Nursing
- Nick Standen - Revalidation Support
- Education Department - reviewing CPD and E-Learning

For a fixed term period during the initial 12 months of implementation of revalidation, a Project Manager and Support Administrator were also in place.

*This document could be made public under the Freedom of Information Act 2000. Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.*
3.2. **Support for Staff**

All nurses and midwives at NBT have access to the following support and resources:

- **Intranet** - An intranet page is accessible from the Trusts home page containing all necessary information and links to the NMC.

- **Email** - The email address Revalidation@nbt.nhs.uk provides a dedicated support which is accessed daily by the Revalidation Support Manager. A direct telephone number is also available.

- **MLE e-Learning Module** - An electronic learning module is available via the MLE for staff to access and learn about the revalidation requirements.

- **MLE e-Portfolio** – An electronic portfolio is available to all nurses and midwives via the Trusts MLE system which can be used for preparing and storing revalidation evidence and calculating CPD. The NMC strongly recommend that individuals store their revalidation evidence either in hard copy or on an electronic portfolio. The system also provides timely reminders to individuals as their revalidation submission dates approach.

- **Newsletters** – Newsletters are frequently produced and circulated to all nurses and midwives.

- **Policy** – A Trust revalidation policy and user guide is available. Last updated and approved by the JCNC on the 28th June 2017.

4. **Revalidation Engagement**

4.1. **Tracking Revalidation Dates**

Revalidation dates can be tracked on the Trust ESR payroll system. Each nurse and midwife will have a revalidation renewal date set by the NMC which feeds into ESR. There is no method for tracking whether an individual has submitted their revalidation application to the NMC on time, however the revalidation renewal date is tracked in ESR and an alert is generated if an individual has not revalidated.

4.2. **Reporting**

Each month, the Revalidation Support Manager produces a report from ESR which is circulated to all Heads of Nursing, Matrons, Ward Sisters and General Managers. The report highlights all nurses and midwives in the Trust who are due for revalidation in the following two months.

4.3. **Revalidation Compliance 2016/17**

During the course of the 2016/17 year (April 2016 - March 2017) the ESR system registered that 829 nurses and midwives in the Trust were subject to revalidation.

- 825 nurses and midwives successfully revalidated
- 7 were granted extensions by the NMC
- 4 nurses and midwives failed to revalidate.
3 retired and 1 bank nurse failed to submit their online application in time. The individual was restricted from bank work until she had successfully applied for re-admission to the register with the NMC.

One extension has been granted for a revalidation due in May 2017. The remainder of the revalidation year sees 700 staff approaching revalidation with similar peaks to the 2016/17 year.

<table>
<thead>
<tr>
<th>Month</th>
<th>Successful Revalidation</th>
<th>Failed to Revalidate</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>May</td>
<td>40</td>
<td>0</td>
</tr>
<tr>
<td>June</td>
<td>33</td>
<td>0</td>
</tr>
</tbody>
</table>
Report to: Trust Board  
Date of Meeting: 27 July 2017

Report Title: Quality Account 2016-17

<table>
<thead>
<tr>
<th>Status</th>
<th>Information</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Prepared by: Paul Cresswell, Associate Director of Quality Governance

Executive Sponsor (presenting): Sue Jones, Director of Nursing & Quality

Appendices (list if applicable): A - Quality Account 2016-17

**Recommendation:**

Trust Board is recommended to;
1. Note the final 2016/17 Quality Account published at the end of June.
2. Note the unqualified audit opinion for the Quality Account, which was reviewed at the Audit Committee on 30th May 2017.
1. Purpose

1.1. This report was approved at the Trust Board’s private meeting on 29 June to meet the national deadline for publication by 30 June 2017.

1.2. The copy is reproduced at this meeting with the most recent changes to make it open to public view although it is now on the Trust’s website.

2. Background

2.1 All NHS Trusts are required to produce an Annual Quality Account that complies with the requirements of the Department of Health Quality Account Toolkit 2010-11, which remains the primary guidance. It is supplemented each year by specific guidance from NHS England that sets out mandatory reporting indicators for inclusion.

2.2 The Trust Board reviewed a first draft of the Quality Account at its meeting in April. Changes were made to reflect:

- Feedback from the External Audit process.
- Comments from external stakeholders
- Editing requested at previous board and from subsequent internal reviews to improve the formatting and ease of understanding for readers

3. Updates Since Draft Version

3.1 Changes have been made following review and further proof-reading in conjunction with the Communications Team. These were made to convey the information in a simpler format where possible and to improve the quality of graphics provided to the external publisher. Changes in wording are in red font. Removed charts are crossed through diagonally.

3.2 As required, external stakeholder comments are reported verbatim within the Quality Account, section 7. These are mainly positive, although there are some important learning points, in particular:

- our need to engage in year more effectively with Healthwatch to address some of the points raised and to ensure greater shared understanding and
- to provide clarify about measures of success for our 2017/18 quality priorities.

3.2 The final version was concluded by the mandatory 30th June deadline for external publication on Trust Website and NHS Choices.

4. External Audit

4.1 The external Audit was undertaken and a draft report reviewed at the Trust’s Audit Committee on 30th May 2017.

4.2 The Audit Opinion has been added as Appendix 4 at the end of the Quality Account, and was unqualified.

5. Recommendations

5.1. The Trust Board is recommended to;
• Note the final publication with the changes made in June.
• Note the unqualified audit opinion for the Quality Account, which was reviewed at the Audit Committee on 30th May 2017.
Account of the Quality of Clinical Services 2016/17

Exceptional healthcare, personally delivered
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Account of the Quality of Clinical Services 2016/17
Statement on the quality of services from the Chief Executive

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

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

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

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

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

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

We have seen some successes over the last year:

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

Our challenges have been:

- MRSA – where there were six cases;
- Never Events – there were five never events during the year, which is too many of these preventable incidents and work has been carried out in response to these;
- Staff Friends and Family Test – while the majority of staff would recommend the organisation to friends or family for care or as a place to work, we would like the figures to be higher and are working to improve our engagement with staff; and

1 - Account of the Quality of Clinical Services 2016/17
Pressure Injuries – while we remain on target to reduce the number of pressure injuries over the three-year period 2015/16 – 2017/18 we have not sustained a reduction of grade 3 and 4 pressure injuries.

Way Forward

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

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

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

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

Andrea Young
Chief Executive
North Bristol NHS Trust
Review of Services

During 2016/17, the Trust provided a wide range of NHS services. These are listed in Appendix 3.

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

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

The income generated by the NHS services reviewed in 2016/17 represents 100% percent of total income generated from the provision of NHS services by the North Bristol NHS Trust for 2016/17.
STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT 2016/17

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

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

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

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

By order of the Board

NB: sign and date in any colour ink except black

Signatures and dates in final published copy

Signed............................................................. Date…………29/06/2017………..

Peter Rilett
Chairman

Signed............................................................. Date...........29/06/2017............

Andrea Young
Chief Executive

4 - Account of the Quality of Clinical Services 2016/17
Section 1 – Priorities for Improvement

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

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

Our Priorities for Improvement for 2016/17

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

How did we get on with these priorities?

Priority 1: Shared Decision Making, ‘Ask 3 Questions’

What is ‘Ask 3 Questions’ about?

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

What did we do?

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

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

In patient discharge:

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

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

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

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

Outpatient experience: Involvement in decisions

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

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

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

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

What next?

Supported by Trust Board, both parts of this initiative will continue to be rolled out across the Trust at a pace that the available resource allows.
Priority 2: Management of Sepsis

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

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

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

What we achieved

- We trained 1,278 members of staff in 60 days in Sepsis identification and management as part of our 6 for Sepsis Campaign.
- We trained all clinical staff joining the trust in Sepsis management at induction.
- We screened 100% of patients who presented to the Emergency Department who met the screening criteria using our electronic patient triage form.
- We maintained our improvements in antibiotic delivery within 1 hour of entering the Emergency Department at 95%.
- We launched a new Sepsis tool across the trust to enable prompt Sepsis management on inpatient wards.
- All patients who are admitted with or develop sepsis whilst in hospital have this information included on their Handover of Care Discharge Summary to improve communication to the GP Practice when they leave hospital.

We performed excellently against the 2016/17 CQUIN targets for Sepsis care, which were split into two parts; screening and administering antibiotics, achieving 100% of available financial incentive funding from commissioners.
What we plan to achieve for 2017/18

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

Priority 3: Improving care for patients with dementia

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

Participation in National Audit

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

Memory Café

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

Improving the environment for patients with dementia

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

Dementia Champions

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

Measuring improvements in care for patients with dementia

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

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

What we plan to achieve for 2017/18

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

Priority 4: End of Life Care
We provide end of life care for approximately 1,800 people each year. End of life care is delivered in all areas of the hospital including the medical, surgical and orthopaedic wards, the Emergency Department and the Intensive Care Unit. End of life care is given by doctors, nurses and other health care professionals in each area, often with help from the specialist palliative care team, ward based link nurses, chaplaincy team, pharmacists, Macmillan Wellbeing Centre staff, psychologists, mortuary staff and bereavement services.

We aim to give high quality individualised care and support to people who are nearing the end of their life and also to those close to them. We do this by planning care and services in line with the national framework Ambitions for Palliative and End of Life Care.

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

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

Our Strategy for End of Life Care

We have an End of Life Strategy Group made up of staff working in all areas of the hospital who are involved with caring for people at the end of life. This group plans the priorities for developing and improving end of life care. These are based on gaps identified by audits and national standards, outcomes of complaints and other feedback from patients and carers and areas of concern highlighted by staff.

Recent developments in end of life care

- The introduction of a new way of recording care at the end of life called “Caring for Patients at End of Life”, following the national withdrawal of the Liverpool Care pathway.
• Our new paperwork includes information for relatives and carers and prompts staff to think about all aspects of good end of life care and to make individual care plans for each person and ensure that comfort and symptom control are monitored closely and addressed quickly.

• The development of new forms to help guide doctors and nurses in discussing treatment aims with people when they are very unwell. This is helping to make sure that people understand what is wrong with them and this allows them and their carers to be more involved in planning their treatment and where they would like to be cared for. We have achieved local quality improvement targets (CQUINS) for some of this work.

• Following feedback from hospital and community staff we have conducted a training needs analysis and developed a training programme with the end of life leads for Urology, Care of Elderly and Renal teams to address the team approach to earlier recognition of patients in the last year of life, appropriate treatment escalation planning for these patients and communication of those plans to GPs on discharge. This has been underway since September 2016.

• Since January 2016, we have been delivering introductory end of life training to all our staff.

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

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Sample size</th>
<th>Does the patient have poor prognostic criteria?</th>
<th>Is there a documented Treatment Escalation Decision?</th>
<th>How many patients were discharged?</th>
<th>Has the GP received poor prognostic information?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology N=57</td>
<td></td>
<td>19 / 57</td>
<td>5 / 19</td>
<td>13 / 19</td>
<td>18 / 19</td>
</tr>
<tr>
<td>Care of the Elderly N = 124</td>
<td>86 / 124</td>
<td>48 / 86</td>
<td>68 / 86</td>
<td>70 1 / 86</td>
<td>32 / 70</td>
</tr>
<tr>
<td>Urology N = 6</td>
<td></td>
<td>6 / 26</td>
<td>1 / 6</td>
<td>4 / 6</td>
<td>5 2 / 6</td>
</tr>
<tr>
<td>Renal N = 10</td>
<td></td>
<td>10 / 27</td>
<td>3 / 10</td>
<td>5 / 10</td>
<td>9 2 / 10</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td>52%</td>
<td>47%</td>
<td>74%</td>
<td>84%</td>
</tr>
</tbody>
</table>

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

What we plan to achieve for 2017/18

1) Planning for how we can provide face to face access to specialist palliative care services seven days per week.
2) Continuing with delivery of introductory end of life training for all staff and planning how we can deliver the right level of further training to our 8,000 plus staff.
3) Improving our communication with people about their illness, what to expect, what their preferences are about their treatment and where they would like to be cared for.
4) Improving how we communicate information to GPs and other community staff when people leave hospital.
5) Improving how we collect and act on feedback from people and their carers about end of life care.
6) Reviewing how we make arrangements for collection of death certificates.
7) Improving our documentation of the end of life care that we deliver.
8) Improving our documentation of decisions about resuscitation.
Our Priorities for Improvement for 2017/18

Involving the public in identifying these priorities

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

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

Our consultation approach posed three questions.

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

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

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

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

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

Selected Areas of Quality Improvement

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

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

### How we will measure progress with these priorities?

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

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

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

In addition, quality measures are reviewed at the Quality Sub Group to South Gloucestershire, Bristol and North Somerset CCGs, the main local commissioners for the Trust’s services, by NHS England who commission specialised services, by the Care Quality Commission who regulate care delivery at the Trust and by NHS Improvement who are the Trust’s performance regulators.
Quality Safety Improvement Team (QSIT)

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

Quality Improvement capability

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

Safety Culture

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

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

Safe Care Programme

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

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

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

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

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

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

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

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

**Safe Procedures**

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

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

Care Quality Commission (CQC)

By law all trusts must be registered with the CQC under section 10 of the Health and Social Care Act 2008 - to show they are meeting essential quality standards. NHS Trusts have to be registered for each of the regulated activities they provide at each location from which they provide them. As at 31/03/17, the Trust is registered for all of its regulated activities, without any negative conditions attached. Without this registration we would not be allowed to operate. The Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during the reporting period.

The Trust was first inspected by the CQC under its new regime in November 2014. A further inspection was undertaken in December 2015 covering services and domains not rated as either ‘good’ or ‘outstanding’ originally.

Following publication of the Care Quality Commission’s (CQC) latest reports on 6th April 2016, the CQC Quality Summit was held on 11th April. As required an Action Plan was submitted to the CQC that set out how the actions they set out within their reports would be delivered. As always their actions were defined as either ‘Must Do’ or ‘Should Do’ in nature. Progress against these actions has been tracked during the year as shown below. All ‘must do’ actions and the majority of ‘should do’ actions have been completed.

Progress on actions
Additional Independent Assurance 2016

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

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

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

**Overall Trust Rating**

<table>
<thead>
<tr>
<th>Overall trust</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall trust</td>
<td>Requires improvement</td>
<td>Requires Improvement</td>
<td>Good *</td>
<td>Requires Improvement</td>
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*Rating from November 2014

**Southmead Hospital Rating**

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<thead>
<tr>
<th>Urgent &amp; Emergency Services</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall rating</th>
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<tbody>
<tr>
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<td>Good *</td>
<td>Requires improvement</td>
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<tr>
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<th>Well led</th>
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<th>Well led</th>
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<tbody>
<tr>
<td>Surgery</td>
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<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
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<tbody>
<tr>
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<td>Good *</td>
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<tr>
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<tr>
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<th>Well led</th>
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<td>Good*</td>
<td>Good *</td>
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<td>Requires improvement</td>
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<table>
<thead>
<tr>
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<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall rating</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Good *</td>
<td>Requires improvement</td>
<td>Good *</td>
<td>Requires improvement</td>
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<table>
<thead>
<tr>
<th>Overall location</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall rating</th>
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<tbody>
<tr>
<td>Overall location</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Good *</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
<td>Requires improvement</td>
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*Ratings from November 2014
### Cossham Hospital

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
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<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
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<tbody>
<tr>
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<td>Good*</td>
<td>Outstanding*</td>
<td>Outstanding*</td>
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</table>

*Ratings from November 2014

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

**Trust-wide Quality Report;**

**Southmead Hospital**
Section 2 – Patient Safety

Reducing Patient Falls

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

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

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

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

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

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

Reducing Pressure Injuries

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

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

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

<table>
<thead>
<tr>
<th>Year 1 of Campaign 2015/16</th>
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<tr>
<td></td>
<td>Grade 4</td>
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<tr>
<td>Total % reduction</td>
<td>100%</td>
</tr>
<tr>
<td>(Number of pressure injuries)</td>
<td>(0)</td>
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</table>

<table>
<thead>
<tr>
<th>Year 2 of Campaign 2016/17</th>
<th>Pressure Injury Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grade 4</td>
</tr>
<tr>
<td>Number of pressure injuries</td>
<td>1</td>
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</table>
The Trust remains on target to achieve a 50% reduction of pressure injuries over the three year period. However it is acknowledged that during 2016/17 we have not sustained a reduction of grade 3 and 4 pressure injuries, but remain below the rates reported prior to the commencement of this campaign, with a continued drive to improve.

What we plan to achieve for 2017/18

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

Improving the recognition, diagnosis and treatment of Acute Kidney Injury (AKI)

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

What we achieved last year (2016/17)

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

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

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

Ongoing work (2017/18)

1. Mini RCA: It is estimated that 20-30% of AKI is avoidable. We are in the process of developing a mini-RCA tool to help clinicians to do a structured case review of severe forms of AKI and those who have progressed to develop AKI in hospital. This will help us understand the reasons for the AKI and to learn lessons and share good practice in the prevention and management of AKI. Ideally we would like to develop this electronically and work is underway to embed this in the new DATRIX system that will be used for incident reporting and management within the trust from October 2017.

2. Engagement with primary care: It is estimated that 65% of the AKI starts in the community. We have been liaising with primary care and CCG colleagues to develop an integrated care pathway for managing AKI in the community.

3. AKI alerts for primary care: Currently AKI e-alerts are issued only for those blood tests that are done in secondary care. In line with the Think Kidney programme advice, work is underway to release AKI alerts from primary care blood tests requests. This will enable GPs to diagnose early patients developing AKI in the community and refer them appropriately to secondary care.

4. AKI Care bundles: We have developed a care bundle that is being piloted in the trauma and orthopaedics wards with plans to roll it out across the Trust. The care bundles incorporate a minimum set of standards of care to be implemented in those who have been diagnosed with AKI. The aim is that these care bundles will raise awareness and understanding of the risk of AKI, improve the care and treatment of patients with AKI and enhance their recovery.

Preventing deterioration prior to cardiac arrest

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

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

In December 2015 we introduced the National Early Warning Score (NEWS), working in collaboration with West of England Academic Healthcare Science Network (WEAHSN) and University Hospitals Bristol (UHB). The NEWS calculates a score based on the patient’s key physiological measurements and provides an indicator of how sick a patient is, thus enabling the recognition and escalation of care of patients whose condition is worsening.

There has been a significant increase in the number of patients who have “triggered” NEWS and as a result been escalated for senior / medical review, as illustrated in the chart below. This is a positive sign, reflecting the successful implementation of the NEWS chart which helps to ensure we identify and act upon patients who are showing signs of deterioration.
NEWS has also been rolled out to the Emergency Department and Neurosciences (with some slight changes). This work has been driven by the Quality and Safety Improvement Team.

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

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

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

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

**Cardiac Arrest rates**

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

“Any patient who receives chest compressions and an emergency call is made"
Crash calls rate per 1,000 discharges, June 2014 to March 2017

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

At Quarter 3 according to the NCAA (non-adjusted for risk) data the Trust had the lowest cardiac arrest rate per 1000 admissions compared to all other participating hospitals.

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

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<tbody>
<tr>
<td>Number</td>
<td>215</td>
<td>163</td>
<td>148</td>
<td>125</td>
<td>103</td>
<td>95</td>
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</table>

Achievements

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

What we plan to achieve for 2017/18

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

Venous Thromboembolism (VTE)

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

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

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

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

<table>
<thead>
<tr>
<th>Risk Assessment Compliance</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
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<tr>
<td></td>
<td>96.95%</td>
<td>95.53%</td>
<td>94.77%</td>
<td>95.78%</td>
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During 2016-17 we successfully addressed recording challenges that had resulted in a dip in recorded risk assessment performance in 2015/16 associated with the implementation of our new Patient Administration System in November 2015. Working with commissioners we were able to demonstrate improvements in our recording of risk assessments and this is now embedded within our electronic recording systems.

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

In order to improve the safety and quality of our practice, we currently perform a root-cause analysis review of the care provided to approximately 50% of patients who develop VTE during or after their stay in hospital. We shall aim to increase this towards 100% during 2017. We have introduced a risk assessment in the fracture clinic and thromboprophylaxis (where appropriate) will be given for patients with lower leg fractures who require a plaster cast and can be managed as outpatients. We have developed a bespoke patient leaflet to be given to these patients.

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

29 - Account of the Quality of Clinical Services 2016/17
Encouragingly, the chart demonstrates our overall improvement since 2011 and most importantly that, following some disruption around the hospital move in 2014 and associated clinical service changes, we have seen the second lowest number of hospital acquired thrombosis in the past 6 years.

![Hospital Acquired Thrombosis by year](image)

**Improvement Plans for 2017/18**

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

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

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

**Medicines Management**

The Trust has an excellent reputation nationally as being at the forefront of improving safety in medicines management. This commitment to safety and quality improvement is no better illustrated than by the recognition we’ve received in 2016:

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

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

- Medicines Reconciliation – both on admission and on discharge;
Medicines Reconciliation

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

Why is this important?

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

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

Progress to Date

![Target exceeded for percentage of patients with reconciliation (six month medians)](image-url)
The team has achieved and maintained our target on admission. The next phase is for the medicines management team to focus on the discharge process and work with primary care teams and Community Pharmacists in supporting effective communication during handover and at the time of discharge to ensure that changes on medication initiated in hospital are continued after the patient is discharged.

**Missed Doses**

*Why is this important?*

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

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

Results deteriorated after the move to the new hospital (May 2014), then started to improve but have worsened during patient flow pressures. We are now monitoring compliance on a monthly basis and targeting wards that breach the target.

We also undertook work on patients with Parkinson’s disease in association with the “Get It on Time” campaign to ensure that these patients do not miss crucial medication. Our new prescription chart enables these patients to be highlighted.

Warfarin Control

Why is this important?

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

Progress to Date

Since 2011 we have worked on improvements by monitoring causes of high International Normalised Ratio (INR) levels. INR is a laboratory measurement of how long it takes blood to form a clot. We identified that interacting drugs and inappropriate prescribing were the main causes. We have therefore updated our anticoagulation chart to allow prescribers and pharmacists to more prominently display interacting medications, and made a change to the low dose loading regimen for Warfarin. Key important themes have also been included in a doctors and nurses e-learning package launched in 2014 and 2015 respectively.
INR greater than 6 for inpatient having INR tests for Warfarin control

There has been a reduction in the number of our inpatients having an INR greater than 6. The newer oral anticoagulants Apixaban, Rivaroxaban and Dabigatran are now widely prescribed and constitute a bleeding risk. Patient safety work with these medicines has included a patient information leaflet, Anticoagulation Alert Cards, patient counselling checklists and a Medication Safety Alert in March 2015.

Future work

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

Reducing Harm from Infection

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

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

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

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

C. difficile infection remains an unpleasant and potentially severe infection that can occur within both the primary and secondary health care setting. The Trust target for 2016/17 remained the same as for 2015/16 and there was a programme of proactive measures to further reduce cases of C diff that has included a focus on cleanliness of the environment and point of care equipment, all of which is supported by our commissioners. Progress is monitored internally through the C diff Steering Group and the Control of Infection Committee.
The outcome of these actions was an encouraging year end figure of 32 cases, below the annual target of 42 and, as illustrated below, a significant improvement compared to both 2014/15 and 2015/16 and in relation to our regional and national peers.

Screening for, and treating, alcohol-related conditions

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

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

There was a national and confidential enquiry into patients with alcohol-related liver disease in 2013 which came up with a number of key recommendations. This is how we’re trying to meet the recommendations.

What we achieved in 2016/17

- We have expanded the alcohol specialist nurse (ASN) service from 1.0 WTE nurse to 2.8 WTE nurses and we maintained this service in 2016/17.

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

- Any patient who is admitted to the Neurosciences or Medical directorate is now screened for alcohol misuse. The number of people being screened is up to 86% in some areas and we wish hope this to be 100% by positively improving the culture of asking everyone about their alcohol use. We hope to extend this screening to all patients being admitted to the Trust in the next 12 months.
Currently eight of the nine medical inpatient wards are using the new system of detoxification (CIWA) and hopefully all the wards will be using this system over the next few months. This is being implemented via face to face and online learning modules to medical and nursing staff.
The management of patients with alcohol related liver disease has also been incorporated into a number of teaching programmes for various levels of junior doctors and the identification of alcohol misuse and management has been included into the Trust induction programme which occurs monthly for all new clinical staff.

The ASN also attends the weekly liver clinic which provides opportunistic intervention for patients who may not wish to engage with community support services.

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

What we plan to achieve for 2017/18

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

Managing Patient Safety Incidents & Duty of Candour

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

The Trust adheres to the principles of Being Open and Duty of Candour as defined by National Health Service England (NHSE). The Duty of Candour ensures incidents resulting in harm of moderate levels or worse are investigated and a structured process followed to ensure the patient, patients’ families or other involved persons are informed throughout the investigation and provided with explanations of the investigation findings.

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

**Reported Patient Safety Incidents**

Organisational feedback reports from the NRLS indicated that NBT is at the lower end of the national reporting figures last year, however, incident reporting is increasing overall. In response to this, an improvement plan is now in progress to address the issues. This has had a positive effect on the number of incidents reported since September 2016.

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

![Total Reported Patient Safety Incidents](image)

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

![Actual impact of patient safety incidents](image)

**Serious Incidents and Never Events**
There were 86 **serious incidents** investigated from April 2016 to March 2017 (compared with 56 in 2015/16). All of these incidents were thoroughly investigated and an action plan implemented to ensure wider learning. All Root Cause Analysis reports and the implementation of action plans are agreed and monitored by the Trust’s Patient Safety and Clinical Risk Committee.

**Serious incidents reported April 2016 to March 2017**

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

Of the 86 reported serious incidents, the Trust has seen an increase in the number of pressure injuries occurring in hospital. **However**, serious falls incidents remain an issue and the Trust’s Falls Group are working hard to address the problem with the implementation of a Trust-wide action plan.
Never Events

‘Never events’ are a particular type of serious incident that are wholly preventable and have the potential to cause serious patient harm. NHS England reference these types of incidents as there is evidence that they have occurred in the past and barriers are now in place to ensure they should not occur in health care. These types of incidents are easily recognised and clearly defined as such in the Never Event Policy Framework (NHS England 2015). We reported five confirmed never events in 2016/17, details of which are as follows;

| Never Event Type                      | Numbers | Study
|---------------------------------------|---------|---
| Unintended damage to organ            | 3       | ▲
| Surgical complication                 | 2       | ▲
| Retained foreign object               | 1       | ▲
| Delayed treatment of deteriorating patient | 2     | ▼
| Equipment failure                     | 1       | ▲
| Missed diagnosis                      | 3       | ▲
| Medication error                      | 3       | ▲
| Other                                 | n/a     | 6

### Wrong Site Surgery – Wrong Site Nerve Block

**Brief Description**

A patient had a right side fascia-ilica nerve block when he should have had a left fascia-ilica nerve block.

**Root Cause**

Failure to carry out the “STOP BEFORE YOU BLOCK” confirmation check of the consent form and surgical site marking prior to block insertion due to staff distractions, student supervision and time pressure in a busy theatre list.

**Learning Points**

- There is no robust mechanism in place to ensure that the “stop before you block” moment is done by the anaesthetic team prior to needle insertion.
- WHO check lists are not completed in the presence of all staff involved in the operation.
- Anaesthetic assistants are under pressure to provide equipment and drugs for pending theatre list so not focussed on current patient whilst ordering for the next.
- If there is more than one anaesthetic trainee or student in theatre, it is not possible for the consultant anaesthetist to directly supervise both at the same time when preparing a patient for surgery.
- Surgical markings are not always sited in an area visible to anaesthetist when administering blocks, particularly in lower limb surgery.

### Wrong Site Surgery – Wrong Site Nerve Block

**Brief Description**

The patient had a left femoral nerve block when she should have had a right femoral nerve block.

**Root Cause**

There was no “STOP BEFORE YOU BLOCK” confirmation check of the consent form and surgical site marking prior to block insertion due to distractions from equipment and time pressures to restart the list when an inpatient bed became available.

**Learning Points**

- WHO Sign In procedures are not always completed in the presence of all staff involved in the operation. There is no robust mechanism in place to ensure that the anaesthetic team carry out a “stop before you block” moment prior to needle insertion.
- Surgical markings are not always sited in an area visible to anaesthetist when administering blocks, particularly in lower limb surgery.
- The current mechanism to confirm the availability of inpatient beds prior to surgery is variable and time consuming for the theatre team.

### Surgical Complication

**Brief Description**

The patient was an elective admission for a right total knee replacement for osteoarthritis. During the operation left-sided femoral, and tibial base plate components were implanted rather than right-sided components.

The following day, the data entry clerk when inputting details of the implant components into the National Joint Registry (NJR), noted the wrong side implants had been implanted.
and informed the consultant surgeon who met and explained to the patient this had not been identified despite multiple checks in theatre.

**Root Cause**

Staff were not complying with the Standard Operating Procedure (SOP) checking process for surgical implants and there was a culture of assuming a company representative is an expert in circulating practice, including obtaining and opening implants.

**Learning Points**

- Implant required should be agreed at the Team Briefing, including type, laterality and potential sizes.
- There should be a surgical pause prior to implantation to verbally communicate type, size, laterality, expiry date and description of implant.
- Staff were not complying with the SOP checking process for surgical implants and there was a culture of assuming a company representative is an expert in circulating practice, including obtaining and opening implants.

### Retained Foreign Object

**Brief Description**

The patient was taken to maternity theatre for a manual removal of placenta following a normal birth and for suturing of a second degree tear. The first procedure was undertaken by an ST1 doctor, supervised by an ST3 doctor. An ST3 doctor was also present for the perineal repair. The ST1 and ST3 doctors undertook the swab count prior to the procedures. The ST3 doctor was called away before the post procedure swab count took place; the pre and post-suturing swab count was recorded as correct on the maternity electronic patient record and in the manual removal of placenta proforma but neither swab count is signed. Subsequently (a few days later) a vaginal swab was found in situ by community midwife following complaint of soreness from the patient.

**Root Cause**

Untaped swab inserted  
Swabs were not counted post-procedure  
Suturing proforma not completed

**Learning Points**

- Untaped swabs inserted  
- Swab counts not performed post procedure  
- Documentation of swab checks not completed  
- Peri operative record of care not fit for manual removal of placenta and perineal repair.

### Misplaced NG Tube

**Brief Description**

A naso-gastric tube was misplaced and the X-ray taken to confirm the position was misinterpreted. As a result the NG feed commenced and went directly to the lung and the patient developed a chemical pneumonitis.

**Root Cause**

Despite following the protocol the radiograph obtained was not of high quality but was deemed adequate by the radiology registrar on duty. Her opinion at the time was that the tube had passed down the oesophagus to the stomach and was therefore safe for feeding.

**Learning Points**

- Reporting of NG tube chest X-rays as safe to feed should only happen when the reporting radiologist is 100% certain that the tube tip is in the correct position.
- These examinations are difficult to interpret as these are often very sick patients. If there is any doubt in interpreting the radiograph the advice should be not to proceed with feeding.

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

In addition, following the three Never Events within theatres, the Trust participated in a collaborative review with NHS Improvement on 21 October, which made a number of recommendations to support the improvement work already underway. A range of actions are in place, which include strengthening the

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safety culture, identifying and addressing relevant ‘human factors’ and improving standard operating procedures.

These actions are being supported by the Trust’s Quality Improvement Team, working with the ASCC Directorate, with progress managed operationally through the Theatre Programme Board. The Trust’s commissioners are overseeing this through the Quality Sub Group and a further review with NHS Improvement was planned for May 2017 to provide assurance on the improvements made.
Section 3 – Patient Experience

Involvement of Patients and the Public

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

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

The experiences of our patients and carers

The experience of our patients and carers is at the heart of our work. What patients and carers tell us makes a difference to the services we provide.

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

Inpatient survey (general)

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

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

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

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

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

Areas scoring highly were:

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

Focus for improvement

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

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Acting upon Healthwatch Feedback

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

Involving our Board in reviewing the quality of Patient Experience

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

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

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

Our Non-Executive Director (NED) walkrounds are based on the national 15-Steps Challenge, which is a national toolkit produced by patients to help trusts on their continuous improvement journey. It focuses on the patient/relative perspective on first entering a ward or clinical area and the various factors which instil confidence in the quality of care that they will receive. It guides the observation of areas holistically and from a non-specialist perspective, which is therefore particularly suited to role of the NED within an NHS Trust.

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

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

Friends and Family Test, Patients

**What is the Friends and Family Test?**

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

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

**Response rates**

The overall response rate against the required target by these services is provided in the table below, as well as the percentage of patients that would recommend the service to their family and friends. This shows that we have not been able to achieve the required national targets during the year on a consistent basis. To address this, improving the quality of patient data to address this has been a priority over the last few months. As a result we are beginning to see an improvement in response rates.
<table>
<thead>
<tr>
<th>Area</th>
<th>Target</th>
<th>NBT Average</th>
<th>National Response rate (average)</th>
<th>No. of months that target achieved</th>
<th>NBT</th>
<th>National average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>30%</td>
<td>25%</td>
<td>24.3%</td>
<td>0</td>
<td>92%</td>
<td>96%</td>
</tr>
<tr>
<td>ED</td>
<td>20%</td>
<td>16%</td>
<td>12.3%</td>
<td>2</td>
<td>86%</td>
<td>87%</td>
</tr>
<tr>
<td>Outpatients</td>
<td>5%</td>
<td>15%</td>
<td>Not set</td>
<td>10</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>Maternity (Birth)</td>
<td>15%</td>
<td>24%</td>
<td>23%</td>
<td>10</td>
<td>92%</td>
<td>97%</td>
</tr>
</tbody>
</table>

**What did our patients tell us?**

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

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

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

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

**What changed?**

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

**Ambulatory Emergency Care**

Within our Ambulatory Emergency Care; a patient service that sits in Acute Medical Admissions, action has been taken to improve the patient pathway, based on feedback received from FFT. Patients felt that waiting times for this service were too long, especially if they were first seen in the Emergency Department. Whilst it was difficult to reduce waiting times in this service because of the investigatory process many patients have to undergo, staff were keen to address patients’ concerns. The first action taken was to ensure that all patients were given a full explanation of what to expect from the service and were then kept informed along their pathway. GP and consultant rotas were also adjusted to give better coverage during the busier times for this service. As a result of these actions taken, patients’ experiences of using the service have improved.
Maternity (birth)
Based on feedback given by a woman using the maternity services, which related to the way she felt she was treated during her pregnancy because of her age and size, a training video was developed to share her experiences. During the filming the woman also offered solutions about how the service could be more respectful whilst maintaining the safety of her and her baby. This video was shown on this year’s intrapartum study day, which all doctors and midwives attend.

Ward 28a (patients with complex care needs)
A patient fed back that they were very impressed with the high standard of care they had received from the Healthcare Support Workers on the ward. To ensure this high standard of care continued, the ward manager fed this back to her team, which had a very positive impact all round.

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

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

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

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

“My visit was handled with cheerful, positive professionalism. Despite a potentially stressful time I was put at ease by the ongoing, clear communication throughout.”
(Outpatient)
NHS Staff Survey and Staff Friends and Family Test

2016 National Staff Attitude Survey – Recommendation to Friends and Family

The National Staff Attitude Survey is an annual survey that takes place during Quarter 3 of the financial year. This helps to ensure that the views of staff working in the NHS inform local improvements and provide input into local and national assessments of quality, safety and delivery of the NHS Constitution. This year a sample of eligible staff in the Trust were invited to complete the survey during September to December 2016. 1,250 staff were invited to participate. 401 staff responded, giving a response rate of 32% (compared to 30% the previous year).

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

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

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

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>NHS Staff Survey 2016</th>
<th>NBT 2016</th>
<th>NBT 2015</th>
<th>National Average (Acute Trusts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff recommendation of NBT as a place to work or receive treatment</td>
<td>3.62</td>
<td>3.64</td>
<td>3.77</td>
</tr>
</tbody>
</table>

"Well my score is marked down because my previous appointment was cancelled without my knowledge. Not very customer friendly!" (Outpatient)
The table below shows the scores for staff experiencing harassment, bullying or abuse in the last 12 months and staff believing the organisation provides equal opportunities for career progression or promotion.

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

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

With respect to equal opportunities, our Trust Equality and Diversity Manager is working closely with our Director of Operations, Kate Hannam, in her capacity as ‘Gender Champion’ to promote the Trust’s Respect and Dignity Statement. This has been widely distributed; it is on the HR portal on the equality page and is included on the patient information screens in the Brunel building and on the equality notice boards. Both the helpline and Respect and Dignity policy are promoted in the monthly equality newsletter and included in all face to face equality training i.e. induction for all new staff, consultants, domestics and porters.

**Staff Friends and Family Test**

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

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

The results from Quarters 1 and 2 of 2016-17 are shown below. The survey was conducted electronically and sent to all eligible staff. The results from Quarter 4 have not yet been received.

<table>
<thead>
<tr>
<th></th>
<th>Extremely Likely</th>
<th>Likely</th>
<th>Neither Likely nor Unlikely</th>
<th>Unlikely</th>
<th>Extremely Unlikely</th>
<th>Don’t Know</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>23%</td>
<td>51%</td>
<td>17%</td>
<td>6%</td>
<td>2%</td>
<td>1%</td>
<td>18%</td>
</tr>
<tr>
<td>Q2</td>
<td>23%</td>
<td>53%</td>
<td>15%</td>
<td>5%</td>
<td>2%</td>
<td>2%</td>
<td>15%</td>
</tr>
</tbody>
</table>
We are proud that 76% of our staff would recommend us for care or treatment but aim to improve on the experience of staff, building on the good outcomes that we achieve for patients.

There are two primary aspects to this:

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

Managing Complaints and Sharing Compliments

Complaints

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

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

There are two key measures for NHS Complaints:

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

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

Activity levels

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

The three highest categories of formal complaints were:

- All aspects of Clinical Care 220
- Lack of Communication 207
- Attitude of Staff 68

The three highest categories of concerns were:

- Lack of Communication 235
- All aspects of Clinical Care 178
- Delay / Cancellation Outpatient 90
Enquiries and Informal concerns

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

Lessons learned

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

NHS Choices website feedback

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

Improving communication

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

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

Service improvements delivered in 2016/17

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

Ombudsman Referrals

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

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

Compliments
9,065 compliments were received during 2016/17; a significant increase on the previous year’s figure (6,761).
Improving Cancer Patient Experience

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

New survey reporting methodology

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

Survey results included in NHS England cancer dashboard

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

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

Questions which scored outside expected range for hospitals of a similar size (positively or negatively)

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

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

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

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

Carers

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

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

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

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

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

- An agreement to allow carers to register up to two cars for complementary parking has been a welcome addition to the carers’ scheme; this was part of the relaunch on 1st February 2017
- During February 2017 there were 173 carers registered for the scheme; 134 had requested parking;
- Over 25 wards and departments have offered this scheme to carers; and
- It is anticipated that we will be able to use the data collected for future reporting and improvements.

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

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Safeguarding Vulnerable People

Safeguarding Children

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

<table>
<thead>
<tr>
<th>Group</th>
<th>No. of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients/day cases (16 – 17 year olds)</td>
<td>861</td>
</tr>
<tr>
<td>Emergency Department (0 – 17 years)</td>
<td>9,979</td>
</tr>
</tbody>
</table>

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

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

Challenges during 2016-17

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

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

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

Training

Our staff are trained to recognise, understand and report safeguarding concerns for children and young people. All training is delivered in line with the requirements set out in the document Safeguarding children and young people: Roles and competences for health care staff. Intercollegiate Document. 3rd Edition. March 2014. The required standard set by our commissioners is that 90% of staff requiring a particular level attend the relevant training. The attained levels are shown below.
<table>
<thead>
<tr>
<th>Training level</th>
<th>Compliant Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2016/17 Quarterly Range</td>
</tr>
<tr>
<td>Level 1</td>
<td>80 – 86%</td>
</tr>
<tr>
<td>Level 2</td>
<td>82 – 88%</td>
</tr>
<tr>
<td>Level 3</td>
<td>69 – 81%</td>
</tr>
</tbody>
</table>

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

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

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

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

**Governance**

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

**Safeguarding Vulnerable Adults**

**Introduction**

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

The Trust has maintained its focus on safeguarding adults, mental capacity act (including Deprivation of Liberty) training which now includes PREVENT awareness, domestic abuse and violence and female genital mutilation, as well as human trafficking awareness. Training is provided to all NBT staff and for frontline professionals training, is delivered face-to-face. Our staff is required to attend update training every three years.

We are now a year on from the implementation of the Care Act which moved adult safeguarding from an objective set by government by policy to an objective governed by statutory law.
The chart below shows the growth of referrals from the Trust into the team. A referral is better described as a contact that can lead to a number of outcomes and interventions.

![Growth of Safeguarding Adult Referrals](image)

The growth in referrals is explained by the following factors:

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

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

**Safeguarding Adults**

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

![Referral types: Hospital or Community Acquired Harm](image)

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

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

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

Deprivation of Liberty Safeguards (DoLS)

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

Once an application is made the Local Authority is required to assess whether the legal grounds are met within seven days. During 2016/17, none of the DoLS applications made by our staff were assessed or authorised within the legal timeframes, nor at the time of the patient’s discharge. However the local authorities are actively addressing the resource required for full assessment to be made in a timely manner.
Section 4 – Clinical Effectiveness

Mortality Outcomes - HSMR/SHMI

Mortality

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

Hospital Standardised Mortality Ratio - HSMR

HSMR is a measurement which compares a hospital’s actual number of deaths with their predicted number of deaths, taking into account factors such as the age and sex of patients, their diagnosis and whether their admission was planned or an emergency. If a Trust has an HSMR of 100, this means that the number of patient deaths is as expected, based on the seriousness of their condition. If the HSMR is above 100 this means that more people have died than would be expected. In contrast an HSMR below 100 means that fewer die than expected. The chart below shows that mortality is below expected levels for almost all of the year. There was a rise in October and November 2016 but it is important to note that the mortality levels still remained within the ‘expected range’.

Standardised Hospital Mortality Indicator - SHMI

SHMI is the preferred method used to measure and compare patient mortality but is more recently introduced than HSMR. The SHMI includes post-discharge deaths (30 days). The Trust SHMI is also below the Trust national average of 100, which indicates that we are performing better than would be expected and have been for a number of years.

The key differences in methodology between HSMR and SHMI indicators are:

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

Source: Dr Foster
Safety Review of every patient death

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

In April 2014 a new mortality review system was introduced to support the formal screening and review of all in-patient deaths, and underpin our objectives to prevent avoidable harm and death. It supports our existing Clinical Risk and Serious Incident review and reporting systems and aims to ensure that all in-patient deaths are investigated.

In 2016/17 a total of 734 mortality reviews were completed on in-patient deaths. This represents 55% of deaths and does not include those deaths that have been reviewed as part of our serious incident work. This is a slight reduction on last year's completion and this reflects the need to prioritise clinical activity in the current demanding time for the NHS as a whole. The information from this mortality review work is compared with other data from the Trust to look for potential learning and improvement opportunities by the Trust’s Quality Surveillance Group.

Quality of Cancer Services

We have 11 specific cancer clinical teams who provide support to cancer patients and are additionally supported by a palliative care team and an acute oncology service. Each of these teams has an identified Lead Clinician who works closely with Clinical Nurse Specialists and other supporting staff to deliver services for cancer patients. All cancer clinical teams are monitored against national standards as part of the National Peer Review Programme now known as Quality Surveillance Programme. Each team’s compliance with these national quality standards is monitored through a programme that utilises self-declaration, internal validation and external validation processes. In 2016 the following reviews were undertaken and the compliance is noted below.
<table>
<thead>
<tr>
<th>Disease Site / Peer Review Area</th>
<th>Review Measures</th>
<th>2016 (% compliance)</th>
<th>Action areas identified</th>
</tr>
</thead>
</table>
| **Urology**                     | 21              | SD – 76.2%, PR – 66.7% | • NICE guidance requires complex urological cancer surgery to be performed by a specialist urology MDT; it's currently being undertaken by Royal United Hospitals Bath NHS Foundation Trust. The Trust is in discussions with the commissioners to explore growing their surgical robotic capacity.  
• All the team’s documentation and data needs to be reviewed and validated, to ensure reflection of the service.  
• IT issues relating to the 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.  
• The team needs to audit the referral numbers of high risk non muscle invasive bladder cancer and prostate cancers from Royal United Hospitals Bath NHS Foundation Trust. |
| CUP Hospital                    | 3               | SD – 100%, PR – 100% | Awaiting actions from assessment |
| Breast                          | 5               | IV – 100%            | Awaiting actions from assessment |
| Skin - Adult                    | 6               | SD – 100%, IV – 100% | No actions identified |
| **Urology - Penile**            | 6               | SD – 100%            | • Currently there is only a single clinician offering this service and additional consultant support is required to meet demand moving forward. A business case will be written to obtain funding for this post.  
• Replacement equipment required as service agreement is coming to an end (Robot). Business case has been submitted and approved and we are awaiting an update on funding. |
| Brain & CNS                     | 22              | SD – 92%             | Awaiting actions from assessment |
| Colorectal                      | 8               | SD – 100%            | No actions Identified |
| Lung                            | 7               | SD – 86%, IV – 73%   | • No named cover for Palliative Care representative nor MDT Co-ordinator.  
• 54.9% of meetings were not quorate. 5 missing attendance for a consultant surgeon and 20 from a representative of the specialist palliative care team. |
| Sarcoma                         | 6               | SD – 83%             | Awaiting actions from assessment |
| Gynaecology                     | 7               | SD – 83%             | Awaiting actions from assessment |
| Palliative Care                 | 25              | SA – 95%             | • National measures pose challenges as no network group at present |
| Chemotherapy                    | 36              | SA – 75%             | Awaiting actions from assessment |
| Oncology Pharm Service          | 5               | SA – Not provided, self-assessment not completed | |

Key: SA – Self Assessment, SD – Self Declaration, IV – Internal Validation and PR – External Peer Review
There was a change to the assessment process in 2016 which stated that services were no longer required to perform an internal validation, and there was a vast reduction in measures to report against from 2015. We will continue to perform internal validations based on the quality of self-declaration submissions.

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

Cancer Performance

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

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

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

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

The Trust undertakes a review of all patients who are not treated within 62 days of their GP referral (patients who breach the national standard) to enable learning and to identify issues within pathways that require resolution. This has been a vital element of the improvement of cancer systems at the Trust, as there has been an increase in referrals of nearly 10% from the previous year.
Cancer patients who breach cancer waiting times targets are reviewed firstly by the core cancer services team to identify potential reasons for the breach and then, as appropriate, by the clinical teams to review reasons, actions and to attempt to ascertain risks for the patient of the breach.

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

**What we plan to achieve for 2017/18**

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

**Patient Reported Outcome Measures (PROMs)**

All NHS patients having hip or knee replacements, varicose vein surgery, or groin hernia surgery are invited to fill in PROMs questionnaires. When patients go into hospital, they are asked to fill in a short questionnaire before their operation. The NHS asks patients about their health and quality of life before they have an operation (pre-op questionnaire) and about their health and the effectiveness of the operation afterwards (post-op questionnaire). The post op questionnaire is sent direct to the patients' home address. For hip and knee procedures the process can be up to nine months after the procedure. For groin hernia and varicose vein, the process can be up to three months after the procedure. To ascertain whether there has been a health gain, a pre-op questionnaire and a post-op questionnaire must be returned. This helps the NHS to measure and improve the quality of care. We are working on new approaches to seek to improve the rate of completion by patients of PROMs questionnaire and methods to act upon results.

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

<table>
<thead>
<tr>
<th></th>
<th>Eligible hospital procedures</th>
<th>Pre-operative questionnaires completed</th>
<th>Participation Rate</th>
<th>Pre-operative questionnaires linked</th>
<th>Linkage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All Procedures</strong></td>
<td>1,053</td>
<td>489</td>
<td>46.4%</td>
<td>372</td>
<td>76.1%</td>
</tr>
<tr>
<td><strong>Groin Hernia</strong></td>
<td>181</td>
<td>62</td>
<td>34.3%</td>
<td>33</td>
<td>53.2%</td>
</tr>
<tr>
<td><strong>Hip Replacement</strong></td>
<td>422</td>
<td>212</td>
<td>50.2%</td>
<td>184</td>
<td>86.8%</td>
</tr>
<tr>
<td><strong>Knee Replacement</strong></td>
<td>386</td>
<td>202</td>
<td>52.3%</td>
<td>147</td>
<td>72.8%</td>
</tr>
<tr>
<td><strong>Varicose Vein</strong></td>
<td>64</td>
<td>13</td>
<td>20.3%</td>
<td>8</td>
<td>61.5%</td>
</tr>
</tbody>
</table>
### Participation in Clinical Audits

**NHS England Quality Accounts List 2016/17**

**NBT Case Ascertainment**

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

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

<table>
<thead>
<tr>
<th>National Clinical Audit and Clinical Outcome Review Programmes</th>
<th>Host Organisation</th>
<th>NBT Eligible</th>
<th>NBT Participating</th>
<th>Case Ascertainment</th>
<th>Report Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Myocardial Infarction National Audit Programme (MINAP)</td>
<td>National Institute for Cardiovascular Outcomes (NICOR)</td>
<td>Y</td>
<td>Y</td>
<td>522/529 (98.7%)</td>
<td>2016/2017(^1)</td>
</tr>
<tr>
<td>2 Adult Asthma Audit</td>
<td>British Thoracic Society (BTS)</td>
<td>Y</td>
<td>Y</td>
<td>41/20 (205%)</td>
<td>2016</td>
</tr>
<tr>
<td>3 Adult Cardiac Surgery</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>4 Asthma (paediatric and adult) Care in Emergency Departments</td>
<td>Royal College of Emergency Medicine</td>
<td>Y</td>
<td>Y</td>
<td>50/50 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>5 Bowel Cancer (NBOCAP)</td>
<td>Royal College of Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>233/235 (99%)</td>
<td>2016</td>
</tr>
<tr>
<td>6 Cardiac Rhythm Management (CRM)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Case Mix Programme (CMP)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>Y</td>
<td>Y</td>
<td>100% Q3 2016/2017</td>
<td></td>
</tr>
<tr>
<td>8 Child Health Clinical Outcome Review Programme</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9 Chronic Kidney Disease in Primary Care</td>
<td>Informatica Systems Ltd</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>10 Congenital Heart Disease (CHD)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>11 Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Y</td>
<td>Y</td>
<td>216/216 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>12 Diabetes (Paediatric) (NPDA)</td>
<td>Health and Social Care Information Centre (HSCIC)</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>13 Elective Surgery (National PROMs Programme)</td>
<td>Health and Social Care Information Centre (HSCIC)</td>
<td>Y</td>
<td>Y</td>
<td>489/1053 (46.4%)</td>
<td>Apr-Sep 2016</td>
</tr>
<tr>
<td>14 Endocrine and Thyroid National Audit</td>
<td>British Association of Endocrine and Thyroid Surgeons</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>15 Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Royal College of Physicians</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fracture Liaison Service Database (FLS-DB)</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- National Hip Fracture Database (NHFD)</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Head and Neck Cancer Audit</td>
<td>Saving Faces – The Facial Surgery Research Foundation</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>17 Inflammatory Bowel Disease (IBD) Programme</td>
<td>British Society of Gastroenterology/Royal College of Physicians</td>
<td>Y</td>
<td>Y</td>
<td>60(^2)</td>
<td>2016</td>
</tr>
<tr>
<td>- Biological Therapy Audit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 Learning Disability Mortality Review Programme (LeDeR Programme)</td>
<td>University of Bristol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Major Trauma Audit</td>
<td>Trauma Audit and Research Network (TARN)</td>
<td>Y</td>
<td>Y</td>
<td>1462/1370 (+100%)</td>
<td>2016</td>
</tr>
<tr>
<td>20 Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

66 - Account of the Quality of Clinical Services 2016/17
<table>
<thead>
<tr>
<th>National Clinical Audit and Clinical Outcome Review Programmes</th>
<th>Host Organisation</th>
<th>NBT Eligible</th>
<th>NBT Participating</th>
<th>Case Ascertainment</th>
<th>Report Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 Medical and Surgical Clinical Outcome Review Programme</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>Y</td>
<td>Y</td>
<td>5/5 (100%)</td>
<td>2017</td>
</tr>
<tr>
<td>- Mental Health</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>10/10 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>- Acute Pancreatitis</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>2/2 (100%)</td>
<td>N/A</td>
</tr>
<tr>
<td>- Acute Non Invasive Ventilation</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>6/6 (100%)</td>
<td>N/A</td>
</tr>
<tr>
<td>- Chronic Neurodisability</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>No data entered yet</td>
<td>N/A</td>
</tr>
<tr>
<td>- Cancer in Children, Teens and Young Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 Mental Health Clinical Outcome Review Programme</td>
<td>National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester</td>
<td>N</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>23 National Audit of Dementia</td>
<td>Royal College of Psychiatrists</td>
<td>Y</td>
<td>Y</td>
<td>Not available</td>
<td>N/A</td>
</tr>
<tr>
<td>24 National Audit of Pulmonary Hypertension</td>
<td>Health and Social Care Information Centre (HSCIC)</td>
<td>N</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>25 National Cardiac Arrest Audit (NCAA)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme</td>
<td>Royal College of Physicians</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Secondary care Audit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>194/1133 (17.1%)4</td>
<td>2017</td>
</tr>
<tr>
<td>- Pulmonary Rehabilitation Audit</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>455</td>
<td>2017</td>
</tr>
<tr>
<td>27 National Comparative Audit of Blood Transfusion</td>
<td>NHS Blood and Transplant</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Audit of Patient Blood Management in Scheduled Surgery</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>32/45 (71%)</td>
<td>20155</td>
</tr>
<tr>
<td>28 National Diabetes Audit – Adults</td>
<td>Health &amp; Social Care Information Centre (HSCIC)</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Case Note Review</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>137/137 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>- Patient Experience</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>96/137 (70.1%)</td>
<td>2016</td>
</tr>
<tr>
<td>29 National Emergency Laparotomy Audit (NELA)</td>
<td>The Royal College of Anaesthetists</td>
<td>Y</td>
<td>Y</td>
<td>216/216 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>30 National Heart Failure Audit</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR)</td>
<td>Y</td>
<td>Y</td>
<td>403/464 (86.9%)</td>
<td>2016/20177</td>
</tr>
<tr>
<td>31 National Joint Registry (NJR)</td>
<td>Healthcare Quality Improvement Partnership</td>
<td>Y</td>
<td>Y</td>
<td>1138/1624 (90%)</td>
<td>2016</td>
</tr>
<tr>
<td>32 National Lung Cancer Audit (NLCA)</td>
<td>Royal College of Physicians</td>
<td>Y</td>
<td>Y</td>
<td>267/267 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>33 National Neurosurgery Audit Programme</td>
<td>Society of British Neurological Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>Information not currently available</td>
<td></td>
</tr>
<tr>
<td>34 National Ophthalmology Audit</td>
<td>Royal College of Ophthalmologists</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>35 National Prostate Cancer Audit</td>
<td>Royal College of Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>1512/1425 (+100%)</td>
<td>2016</td>
</tr>
<tr>
<td>36 National Vascular Registry</td>
<td>Royal College of Surgeons</td>
<td>Y</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Carotid Endarterectomy</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>125/124 (+100%)</td>
<td>2016</td>
</tr>
<tr>
<td>- Elective Infra-Renal AAA Repair</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>83/85 (97.6%)</td>
<td>2016</td>
</tr>
<tr>
<td>- Repair of Ruptured AAA</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>376</td>
<td>2016</td>
</tr>
<tr>
<td>- Repair of Complex AAA</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>206</td>
<td>2016</td>
</tr>
<tr>
<td>- Lower Limb Revascularisation</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>35710</td>
<td>2016</td>
</tr>
<tr>
<td>- Major Lower Limb Amputation</td>
<td></td>
<td>Y</td>
<td>Y</td>
<td>12411</td>
<td>2016</td>
</tr>
<tr>
<td>37 National Neonatal Audit Programme</td>
<td>Royal College of Paediatrics and Child Health</td>
<td>Y</td>
<td>Y</td>
<td>3080/3080 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>38 Nephrectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>555/860 (64.5%)</td>
<td>201612</td>
</tr>
<tr>
<td>39 Oesophago-Gastric Cancer (NAGOCC)</td>
<td>Royal College of Surgeons</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>40 Paediatric Intensive Care (PICANet)</td>
<td>University of Leeds</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>41 Paediatric Pneumonia</td>
<td>British Thoracic Society</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>42 Percutaneous Nephrolithotomy (PCNL)</td>
<td>British Association of Urological Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>108/108 (100%)</td>
<td>201613</td>
</tr>
</tbody>
</table>

67 - Account of the Quality of Clinical Services 2016/17
<table>
<thead>
<tr>
<th>National Clinical Audit and Clinical Outcome Review Programmes</th>
<th>Host Organisation</th>
<th>NBT Eligible</th>
<th>NBT Participating</th>
<th>Case Ascertainment</th>
<th>Report Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>43 Prescribing Observatory for Mental Health (POMH-Uk)</td>
<td>Royal College of Psychiatrists</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>44 Radical Prostatectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>468/705 (66.4%)</td>
<td>2016</td>
</tr>
<tr>
<td>45 Renal Replacement Therapy (Renal Registry)</td>
<td>UK Renal Registry</td>
<td>Y</td>
<td>Y</td>
<td>148/148 (100%)</td>
<td>2015</td>
</tr>
<tr>
<td>46 Rheumatoid and Early Inflammatory Arthritis</td>
<td>Northgate</td>
<td>Y</td>
<td>Y</td>
<td>491</td>
<td>2016</td>
</tr>
<tr>
<td>47 Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Royal College of Physicians</td>
<td>Y</td>
<td>Y</td>
<td>232 (Band A17)</td>
<td>2016</td>
</tr>
<tr>
<td>48 Severe Sepsis and Septic Shock – Care in Urgent Care Units</td>
<td>Royal College of Emergency Medicine</td>
<td>Y</td>
<td>Y</td>
<td>50/50 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>49 Specialist Rehabilitation for Patients with Complex Needs</td>
<td>London North West Healthcare NHS Trust</td>
<td>Y</td>
<td>Y</td>
<td>963/963 (100%)</td>
<td>2016</td>
</tr>
<tr>
<td>50 Stress Urinary Incontinence Audit</td>
<td>British Association of Urological Surgeons</td>
<td>Y</td>
<td>Y</td>
<td>8619</td>
<td>2016</td>
</tr>
<tr>
<td>51 UK Cystic Fibrosis Registry</td>
<td>Cystic Fibrosis Trust</td>
<td>N</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

Local Clinical Audits

The Clinical Audit Committee (CAC) uses the results from local and national audit to inform the Trust Quality and Safety Strategy and annual quality objectives. The progression of local clinical audits, their reporting and subsequent completion of actions is a specialty/directorate responsibility, with oversight through the CAC, which includes directorate representatives. The requirements for local clinical audit design, completion, reporting and action are clearly set out within the Trust’s Clinical Audit Policy. The CAC monitors action plan progression as a result of local and national clinical audit activity and highlights to the Trust Quality Committee lack of progression or specific actions which require their intervention. In order to provide an overall randomised quality control check, CAC reviews one local audit every two months as a ‘deep dive,’ which equates to six over the 12 month period. 169 new audits were started in 2016/17 and 129 reports and action plans were reviewed and marked as completed by Quality Assurance and Clinical Audit staff based upon submissions provided by specialty teams.

National Clinical Audit Outcomes 2016/17

Introduction

During 2016/17 the Clinical Audit Committee reviewed and approved reports and initial action plans for 24 National Clinical Audits. 19 out of 24 national clinical audits reviewed were listed on the Quality Account.
Once action plans are approved by the Clinical Audit Committee they are monitored to ensure that progress is being made at six month intervals until completion. 29 six, 12 and 18-month action plan updates were reviewed and approved by the Clinical Audit Committee during 2016/17, 23 of these were National Clinical Audits listed on the Quality Account.

Audits are closed if all actions are completed, or a re-audit report is published and outstanding actions are carried over to the new action plan. In 2015/16 16 audits were closed.

Below are three examples of National Clinical Audits that have had an action plan approved and implemented during 2016/17 and a subsequent re-audit report has been published. The summaries below outline the outcomes of the earlier reports and the actions implemented to improve results at the re-audit stage. The comparative tables and graphs show areas where improvements have been realised and also those areas that need further work in order to improve outcomes. Action plans will be developed for the re-audit reports and will be appraised by CAC early in 2017/18.

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

#### Year 1 (CA10052)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of cases reviewed by a consultant surgeon within 14 hours of emergency admission to hospital</td>
<td>64%</td>
<td>54%</td>
</tr>
<tr>
<td>Proportion of patients who had a CT scan performed before emergency laparotomy</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
<td>Proportion of patients who had a CT scan performed and reported by a consultant radiologist before emergency laparotomy</td>
<td>72%</td>
<td>69%</td>
</tr>
<tr>
<td>Proportion of patients who had risk documented preoperatively</td>
<td>78%</td>
<td>66%</td>
</tr>
<tr>
<td>Proportion of cases where interval from decision to operate (or time of booking) to arrival in theatre was appropriate to documented operative urgency (for cases with urgency &lt;18 hours)</td>
<td>80%</td>
<td>82%</td>
</tr>
<tr>
<td>Proportion of patients reviewed by a consultant surgeon AND a consultant anaesthetist before emergency laparotomy if pre-operative P-POSSUM mortality risk ≥5%</td>
<td>53%</td>
<td>60%</td>
</tr>
<tr>
<td>Proportion of patients reviewed by either a consultant surgeon, or a consultant anaesthetist (or both) before emergency laparotomy if pre-operative P-POSSUM mortality risk ≥5%</td>
<td>92%</td>
<td>92%</td>
</tr>
<tr>
<td>Proportion of patients for whom surgery was directly supervised by a consultant surgeon and a consultant anaesthetist if pre-operative P-POSSUM mortality risk ≥5%</td>
<td>58%</td>
<td>66%</td>
</tr>
</tbody>
</table>

#### Year 2 (CA10053)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of cases reviewed by a consultant surgeon within 14 hours of emergency admission to hospital</td>
<td>64%</td>
<td>54%</td>
</tr>
<tr>
<td>Proportion of patients who had a CT scan performed before emergency laparotomy</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
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<td>58%</td>
<td>66%</td>
</tr>
</tbody>
</table>

### Compliance and Improvement Table NBT vs National

<table>
<thead>
<tr>
<th>N°</th>
<th>Name</th>
<th>Year</th>
<th>Site</th>
<th>+/- 5% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Proportion of cases reviewed by a consultant surgeon within 14 hours of emergency admission to hospital</td>
<td>2015 (1)</td>
<td>64%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>63%</td>
<td>N/A</td>
</tr>
<tr>
<td>2</td>
<td>Proportion of patients who had a CT scan performed before emergency laparotomy</td>
<td>2015 (1)</td>
<td>Not recorded</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>83%</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>Proportion of patients who had a CT scan performed and reported by a consultant radiologist before emergency laparotomy</td>
<td>2015 (1)</td>
<td>72%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>68%</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>Proportion of patients who had risk documented preoperatively</td>
<td>2015 (1)</td>
<td>78%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>79%</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>Proportion of cases where interval from decision to operate (or time of booking) to arrival in theatre was appropriate to documented operative urgency (for cases with urgency &lt;18 hours)</td>
<td>2015 (1)</td>
<td>80%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>85%</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>Proportion of patients reviewed by a consultant surgeon AND a consultant anaesthetist before emergency laparotomy if pre-operative P-POSSUM mortality risk ≥5%</td>
<td>2015 (1)</td>
<td>53%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>60%</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>Proportion of patients reviewed by either a consultant surgeon, or a consultant anaesthetist (or both) before emergency laparotomy if pre-operative P-POSSUM mortality risk ≥5%</td>
<td>2015 (1)</td>
<td>92%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>89%</td>
<td>N/A</td>
</tr>
<tr>
<td>8</td>
<td>Proportion of patients for whom surgery was directly supervised by a consultant surgeon and a consultant anaesthetist if pre-operative P-POSSUM mortality risk ≥5%</td>
<td>2015 (1)</td>
<td>58%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>75%</td>
<td>N/A</td>
</tr>
<tr>
<td>No</td>
<td>Name</td>
<td>Year</td>
<td>Site</td>
<td>+/- 5% Improvement</td>
</tr>
<tr>
<td>----</td>
<td>-----------------------------------------------------------------------</td>
<td>---------------</td>
<td>---------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>9</td>
<td>Proportion of patients for whom surgery was directly supervised by <em>either</em> a consultant surgeon, <em>or</em> a consultant anaesthetist (or both) if preoperative P-POSSUM mortality risk ≥5%</td>
<td>2015 (1)</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>96%</td>
<td>89%</td>
</tr>
<tr>
<td>10</td>
<td>Proportion of all patients admitted directly to a critical care unit following emergency laparotomy</td>
<td>2015 (1)</td>
<td>52%</td>
<td>60%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>47%</td>
<td>62%</td>
</tr>
<tr>
<td>11</td>
<td>Proportion of patients with post-operative P-POSSUM mortality risk of &gt;10% who were transferred directly to a critical care unit from theatre</td>
<td>2015 (1)</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>90%</td>
<td>85%</td>
</tr>
<tr>
<td>12</td>
<td>Proportion of patients over the age of 70 who were assessed by an elderly medicine specialist after surgery</td>
<td>2015 (1)</td>
<td>29%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>13%</td>
<td>10%</td>
</tr>
<tr>
<td>13</td>
<td>Proportion of patients who did not return to theatre following their initial laparotomy</td>
<td>2015 (1)</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>84%</td>
<td>92%</td>
</tr>
<tr>
<td>14</td>
<td>Proportion of patients without an unplanned critical care admission from the ward &lt;7 days after their initial laparotomy</td>
<td>2015 (1)</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>15</td>
<td>Proportion of submitted cases that did not have any ineligibility of surgical procedure(s) performed</td>
<td>2015 (1)</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>16</td>
<td>Proportion of included cases where both time of decision to operate and time of booking for theatre were submitted</td>
<td>2015 (1)</td>
<td>84%</td>
<td>88%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td>17</td>
<td>Proportion of submitted cases with no missing preoperative or postoperative POSSUM fields</td>
<td>2015 (1)</td>
<td>98%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>96%</td>
<td>Not recorded</td>
</tr>
<tr>
<td>18</td>
<td>Proportion of submitted cases not missing both preoperative or postoperative POSSUM fields (cases submitting at least a preoperative or postoperative POSSUM score)</td>
<td>2015 (1)</td>
<td>Not recorded</td>
<td>Not recorded</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2016 (2)</td>
<td>100%</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

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

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

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

[Diagram showing ICU utilization rates for NBT and National in 2014/15 and 2015/16]
<table>
<thead>
<tr>
<th>N°</th>
<th>Name</th>
<th>Year</th>
<th>Site NBT</th>
<th>Site National</th>
<th>+/- 5% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Non-high risk sepsis admissions (from within the same hospital)</td>
<td>2014/15</td>
<td>94%</td>
<td>87%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>88%</td>
<td>88%</td>
<td>!</td>
</tr>
<tr>
<td>2</td>
<td>Patients without unit-acquired infections in blood</td>
<td>2014/15</td>
<td>98%</td>
<td>98%</td>
<td>≈</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>97%</td>
<td>99%</td>
<td>≈</td>
</tr>
<tr>
<td>3</td>
<td>Discharges within normal hours (not out of hours) 7am-10pm to another ward within the hospital</td>
<td>2014/15</td>
<td>99%</td>
<td>97%</td>
<td>≈</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>99%</td>
<td>98%</td>
<td>≈</td>
</tr>
<tr>
<td>4</td>
<td>Bed days of care provided for critical care unit survivors not exceeding 8 hours after the reported time fully ready for discharge (% of available bed days)</td>
<td>2014/15</td>
<td>91%</td>
<td>95%</td>
<td>≈</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>95%</td>
<td>95%</td>
<td>≈</td>
</tr>
<tr>
<td>5</td>
<td>Patients not having a non-clinical transfer (out)</td>
<td>2014/15</td>
<td>100%</td>
<td>99%</td>
<td>≈</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>100%</td>
<td>100%</td>
<td>≈</td>
</tr>
<tr>
<td>6</td>
<td>% of readmissions within 48 hours that were planned</td>
<td>2014/15</td>
<td>99%</td>
<td>99%</td>
<td>≈</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015/16</td>
<td>99%</td>
<td>99%</td>
<td>≈</td>
</tr>
</tbody>
</table>

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

The CAC approved the action plan which largely seeks to maintain our high level of compliance. The action plan also acknowledges the extensive work being completed within the Trust by the Sepsis Working Group and various Quality Improvement Initiatives. Work around sepsis is being monitored by the Sepsis CQUIN which reports quarterly.
National Inpatient Diabetes Audit 2015

Compliance and Improvement Table NBT vs National

<table>
<thead>
<tr>
<th>№</th>
<th>Name</th>
<th>Year</th>
<th>Site</th>
<th>+/- 5% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>% Visited by specialist diabetes team</td>
<td>2013</td>
<td>34%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>34%</td>
<td>36%</td>
</tr>
<tr>
<td>2</td>
<td>% Free from medication errors</td>
<td>2013</td>
<td>55%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>63%</td>
<td>62%</td>
</tr>
<tr>
<td>3</td>
<td>% Free from prescription errors</td>
<td>2013</td>
<td>69%</td>
<td>78%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>73%</td>
<td>78%</td>
</tr>
<tr>
<td>4</td>
<td>% Free from management errors</td>
<td>2013</td>
<td>74%</td>
<td>78%</td>
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<tr>
<td></td>
<td></td>
<td>2015</td>
<td>83%</td>
<td>76%</td>
</tr>
<tr>
<td>5</td>
<td>% Free from insulin errors</td>
<td>2013</td>
<td>69%</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>79%</td>
<td>78%</td>
</tr>
<tr>
<td>6</td>
<td>% Admitted without foot disease</td>
<td>2013</td>
<td>90%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>84%</td>
<td>91%</td>
</tr>
<tr>
<td>7</td>
<td>% Seen by the MDFT within 24 hours</td>
<td>2013</td>
<td>21%</td>
<td>9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>94%</td>
<td>58%</td>
</tr>
<tr>
<td>8</td>
<td>% Foot risk assessment within 24 hours</td>
<td>2013</td>
<td>19%</td>
<td>38%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>31%</td>
<td>28%</td>
</tr>
<tr>
<td>9</td>
<td>% Foot risk assessment during stay</td>
<td>2013</td>
<td>25%</td>
<td>44%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>35%</td>
<td>33%</td>
</tr>
<tr>
<td>10</td>
<td>% Without severe hypo</td>
<td>2013</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>86%</td>
<td>90%</td>
</tr>
</tbody>
</table>

+5% Improvement  No change  -5% Improvement  +5% on National Average  -5% on National Average
### Compliance and Improvement Table NBT vs National

<table>
<thead>
<tr>
<th>Nº</th>
<th>Name</th>
<th>Year</th>
<th>Site</th>
<th>+/- 5% Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>% Without minor hypo</td>
<td>2013</td>
<td>81%</td>
<td>59%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>76%</td>
<td>80%</td>
</tr>
<tr>
<td>12</td>
<td>% With suitably timed meals</td>
<td>2013</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>61%</td>
<td>63%</td>
</tr>
<tr>
<td>13</td>
<td>% With suitable choice at meal time</td>
<td>2013</td>
<td>57%</td>
<td>63%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>61%</td>
<td>54%</td>
</tr>
<tr>
<td>14</td>
<td>Staff knowledge – answered queries</td>
<td>2013</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>84%</td>
<td>82%</td>
</tr>
<tr>
<td>15</td>
<td>Overall patient satisfaction</td>
<td>2013</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>89%</td>
<td>84%</td>
</tr>
<tr>
<td>16</td>
<td>Patients able to take control of diabetes care</td>
<td>2013</td>
<td>57%</td>
<td>55%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>55%</td>
<td>59%</td>
</tr>
<tr>
<td>17</td>
<td>Staff aware of patients’ diabetes</td>
<td>2013</td>
<td>71%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>88%</td>
<td>84%</td>
</tr>
<tr>
<td>18</td>
<td>All or most staff know enough about diabetes</td>
<td>2013</td>
<td>57%</td>
<td>67%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>62%</td>
<td>66%</td>
</tr>
<tr>
<td>19</td>
<td>Patients with appropriate insulin infusion</td>
<td>2013</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>100%</td>
<td>94%</td>
</tr>
<tr>
<td>20</td>
<td>Average diabetes specialist nursing hours per week per patient</td>
<td>2013</td>
<td>1.2 hours</td>
<td>1.6 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>1.1 hours</td>
<td>1.6 hours</td>
</tr>
<tr>
<td>21</td>
<td>Average consultant hours per week per patient</td>
<td>2013</td>
<td>0.6 hours</td>
<td>0.8 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>1.2 hours</td>
<td>0.7 hours</td>
</tr>
<tr>
<td>22</td>
<td>Average dietician hours per week per patient</td>
<td>2013</td>
<td>0.4 hours</td>
<td>0.5 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>0.0 hours</td>
<td>0.5 hours</td>
</tr>
<tr>
<td>23</td>
<td>Average podiatrist hours per week per patient</td>
<td>2013</td>
<td>0.4 hours</td>
<td>0.5 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>0.0 hours</td>
<td>0.5 hours</td>
</tr>
<tr>
<td>24</td>
<td>Average diabetes specialist pharmacist hour per week per patient</td>
<td>2013</td>
<td>0.0 hours</td>
<td>0.0 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2015</td>
<td>0.0 hours</td>
<td>0.0 hours</td>
</tr>
</tbody>
</table>

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

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

### NICE Quality Standards

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

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

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NICE quality standards enable:

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

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

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

**How quality standards are managed**

All Quality Standards are assessed for their applicability to NBT and its services and patients. A ‘Gap Analysis’ is completed by the NBT Lead for the Standard and the Clinical Team or Teams linked to the standards. As an outcome of the gap analysis an action plan is developed to address any possible gaps that may exist. The whole system and process is managed by the Quality Assurance and Clinical Audit Team on behalf of the Clinical Effectiveness Committee.

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

**Research**

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

There were 591 active research studies this year with 3,736 patients recruited and a further 3,478 patients seen as part of ongoing research projects. Recruitment has remained strong despite the financial and clinical pressures departments are experiencing, demonstrating our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Research continues to be delivered in over 40 departments demonstrating the breadth as well as the depth of the research commitment within the Trust; every clinical directorate delivers research.
Strong internal relationships and a commitment to delivering research have made us one of the fastest trusts in the country to set up new research studies. Patients have had the opportunity to participate in 82% of studies within 70 days of us receiving a request to open a new study.

This year has been notable for building regional partnerships in research. NBT has also brought together maternity units across the West of England to enable a greater number of people access to research. Over the last two years 1,631 women have participated in the IMOX maternity trial at NBT with a total of 3336 participating across the region. NBT is also working with a number of leading life science companies to improve health and answer key questions about dementia, diabetes, maternity, musculoskeletal conditions and cancer.

NBT remains a leader in health research that aims to answer important clinical questions. We are currently managing £30 million grants awarded to deliver new programmes of research. NBT has attained significant success with our renal, breast care, urology and musculoskeletal grant development and delivery.
Patients and members of the public are a key part of shaping how we do research. They have helped make decisions on what research to fund through our charitable fund scheme, Springboard, and have sat on our panels reviewing tender bids for services we use. This year they have also helped to design and shape our new research strategy, which will launch early next year, and provide direction for research across the next five years.

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

The Trust is working collaboratively across the geographical area with primary and secondary care providers to ensure all patients have equal access to research. We are leading the way on patient referrals across the region to enable patients’ access to a greater range of research. We are highlighting research as a treatment option and empowering patients to request and require access to research studies.
Emergency Department

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

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

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

Ensuring Safe Care

Given the factors highlighted above, the emergency department (ED) experiences peaks of activity where it is much more of a challenge to ensure that patients are seen, treated and, if necessary, admitted to the hospital in a safe manner, even where waits are longer than we would like. In light of that, the Trust has since embedded use of the ‘SHINE’ patient checklist, which provides a practical, easy to use summary of key observations and actions for patients within ED. This has been recognised by our regulators, the Care Quality Commission and NHS Improvement, as good practice and has been supported in its development by the West of England Academic Health Science Network (AHSN). The results are shown 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.
We recognise the patient’s legal right within the NHS Constitution to start a non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral; unless they choose to wait longer or it is clinically appropriate that they wait longer.

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

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

Clinical Review whilst on waiting list

During the year, the Trust’s Quality Committee has continued to receive assurance updates from clinical specialities confirming that all patients waiting for longer than the nationally agreed waiting times for treatment to undergo a clinical review. This clinical review varies in nature depending upon the specialty in question but the common requirement is that senior clinicians ensure that patients do not experience additional harm due to their waiting time.
Cancer Waiting Times

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

Improving the discharge of patients from hospital

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

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

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

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

Integrated Discharge Service (IDS) – the service has now been in place for over a year and the partnership model has progressed further with improved systems and processes implemented to develop more efficient and effective discharge pathways. The health and social care professionals work closely with patients and carers to ensure early assessment of needs and ensure discharge plans are developed as soon as possible, to support patients to leave the hospital as soon as they are able to. There continues 80 - Account of the Quality of Clinical Services 2016/17
to be further development of the IDS to ensure key performance indicators are developed to reduce unnecessary delays in transfer of care, and to support the development of the D2A pathways across BNSSG partners.

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

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

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

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

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

**Improving the quality and timeliness of information provided to GPs when patients go home** - a Discharge Summary or Transfer of Care document is a letter written by the doctors and the multi-professional teams caring for a person in hospital. It contains important information about that person's hospital stay, including why they came in, what diagnosis was made, what tests they had, what medications they are being discharged on and what changes had been made during their stay. Follow-up arrangements and future planning are also documented. During 2016/17 we have continued to develop the quality and timeliness of discharge summaries being completed and sent electronically to GPs. This work has been undertaken and audited in collaboration with the Clinical Commissioning Group and a local GP to provide immediate feedback and action to be taken; we have achieved 100% of the related CQUIN.

**Data Quality**

**Hospital Episode Statistics**

The Trust submits a wealth of information and monitoring data centrally to our commissioners and the Department of Health. The accuracy of this data is of vital importance to the Trust and the NHS to ensure high-quality clinical care and accurate financial reimbursement. Our data quality reporting, controls and feedback mechanisms are routinely audited and help us monitor and maintain high-quality data. We submitted records during 2016/17 to the Secondary Users’ Service for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data. Within this data we are expected to include a valid NHS number and the General Medical Practice (GMP) Code and report this within each year’s quality account. This information is presented below:
During the year we have introduced within the Information Management Team the role of ‘Data Quality Marshalls’ whose work with clinical teams role is to find out why things aren’t reporting as they should be to ensure information entered in clinical systems is as accurate as possible. This approach is bearing fruit as the percentage of records has improved in each of the three domains and, with the sole exception of the NHS number completeness for outpatient data, is better than the national average.

**Clinical Coding Error Rate**

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

**Audit**

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

**IG (505) Clinical Coding Audit – November 2016**

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

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

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

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

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<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
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<tr>
<td></td>
<td>NHS No.</td>
<td>GMP code</td>
<td>NHS No.</td>
</tr>
<tr>
<td>Admitted Patient Care</td>
<td>99.5%</td>
<td>100%</td>
<td>99.5%</td>
</tr>
<tr>
<td>Out Patients</td>
<td>98.4%</td>
<td>99.8%</td>
<td>98.7%</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>97.4%</td>
<td>100%</td>
<td>97.4%</td>
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Overall, we obtained Level 2 against the IG 505 toolkit requirement, which is the national requirement.

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

Further Improvements Planned in 2017/18

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

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

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

The IG Toolkit is now in its 14th year (v14). Evidence is required to be uploaded to support the self-assessment across 45 requirements.

There are two possible grades:

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

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

The Trust's IG toolkit assessment report overall score for 2016/17 (v14) is 73%, graded green. The Trust recently received the final report for an internal audit, which concluded that the overall system for compiling the IG evidence and score is sound, and this includes effective ongoing governance arrangements.

There are improvement plans in place detailing the evidence needed for each requirement, which will allow the Trust to clearly identify where improvement has been made and if there are gaps in compliance. The improvement plans will be reviewed through the Trust governance processes throughout the 2017/18 financial year.
Quality Priorities

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

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

Our consultation approach posed three questions:

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

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

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

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

Specifically this included:

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

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

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

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

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

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

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

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

Subject: NBT Quality Assurance Statement 2016/17

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

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

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

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

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

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

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

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

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Commentary from North Bristol NHS Trust’s Patient Participation Committee

I have read in detail the Quality Report and have some specific comments and more general feedback. Overall I think it is a good piece of work and obviously took a huge amount of time and effort to cover such a broad range of areas.

Under ‘Way Forward,’ paragraph 2, the move to five clinical divisions, I believe there could have been some explanation of why this has been decided and what exactly the benefits of this will be to both patients, staff and the Trust? It would also be helpful in future within the serious incidents and Never Events section if Patient Partnership involvement was mentioned.”

Christine Fowler
Chair, Patient Partnership Committee

Commentary from Bristol Healthwatch & South Gloucestershire Healthwatch

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

23 May 2017

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

Priority Improvements for 2016/17

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

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

Healthwatch look forward to seeing the results of the third national audit of dementia that NBT have taken part in due in May 2017 and the comparison of care of people with dementia against national benchmarks. Healthwatch is interested to hear how the trust intends to ensure that delirium is to be prevented, identified and treated in Older People with dementia? It is positive to hear that the Memory café is going from strength to strength.
Healthwatch read with interest about the quality improvement project that focuses on improving compassionate and personalised delivery of end of life care on the wards. It was good to see the plans for 2017/18 particularly the plan detailing how NBT will improve documentation of the end of life care being delivered.

**Priorities for 2017/18**

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

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

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

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

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

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

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

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

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

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

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

It is disappointing to read that NBT has not been able to meet the 4 hour A&E performance standard in 2016/17. Healthwatch appreciate the Trust’s board commitment to sustain a performance of 95% of patients not waiting longer than four hours from arrival to admission, transfer or discharge and would like to see the trust meet and possibly succeed the 4 hour A&E performance standard during 2017/18.
Healthwatch has undertaken work on hearing from the public about hospital discharge in the last two years and welcome the opening of the ground floor discharge lounge. We also appreciate the work undertaken and the training and support for staff to evaluate whether a patient will be safe between visits on the Discharge to Access Pathway 1 to be able to go home.

**Commentary from the South Gloucestershire Council Public Health Scrutiny Committee**

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

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

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

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

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

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

Councillor Marian Lewis  
Chair, Health Scrutiny Committee

Councillor Sue Hope  
Lead Member, Health Scrutiny Committee

Councillor Ian Scott  
Lead Member, Health Scrutiny Committee

**Commentary from the Bristol Council People Scrutiny Commission**

No commentary received.

**Commentary from the North Somerset Council Health Overview & Scrutiny Panel**

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

Members noted the following accomplishments in particular:

- meeting Cancer Standards and RTT, Diagnostic and ED improvement trajectories;
- expansion of the Quality Improvement and Safety Culture Programme;
- 80% achievement of CQUIN targets;
- steady improvements in the patient falls rate;
- significant on-going reductions in pressure injuries; and
- the establishment of a Quality Hub to support the Theatre Quality Improvement Programme.

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

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

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

Roz Willis
Chairman, Health Overview & Scrutiny Panel
North Somerset Council
## Appendix 1 Mandatory Indicators Table - Data provided by the Health and Social Care Information Centre

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<tbody>
<tr>
<td>Venous thromboembolism risk assessment</td>
<td>95.54% Apr 16 – Mar 17</td>
<td>95.6% Apr-Dec16</td>
<td>100% Apr-Dec16</td>
<td>72.1% Apr-Dec16</td>
<td>93.5% Apr 16 – Mar 17</td>
<td>The Trust considers that this data is as described as there is a close focus on VTE risk assessment performance due to challenges raised around the operational delays in coding of clinical notes that had in 2015-16 caused this to fall below the national standard of 95%. Significant improvements have been made and sustained during 2016/17, overseen internally through the Quality Committee and externally through the CCG Quality Sub Group. The related Contract Performance Notice was lifted during the 2016/17 year following conclusion of the related Remedial Action plan.</td>
</tr>
<tr>
<td><em>Clostridium difficile</em> rate per 100,000 bed days (patients aged 2 or over)</td>
<td>9.94 Apr 16 – Mar 17</td>
<td>15.3 Apr15-Jan16</td>
<td>0 Apr15-Jan16</td>
<td>63.4 Apr15-Jan16</td>
<td>14.95 Apr 16 – Mar 17</td>
<td>The Trust considers that this data is as described for the following reasons: rate is as described in the official HCAI Data Tool provided by Public Health England and is validated closely on a case by case basis by the Trust's Infection Control Team. The Trust will act to improve this percentage, and so the quality of its services by continuing to focus on a range of improvement actions to reduce C. Difficile infection through as outlined in this report.</td>
</tr>
<tr>
<td>Rate of patient safety incidents reported per 1,000 bed days</td>
<td>30.98 Apr16-Sep16</td>
<td>40.77 Apr16-Sep16</td>
<td>71.81 Apr16-Sep16</td>
<td>21.21 Apr16-Sep16</td>
<td>28.85 Apr15-Sep15</td>
<td>The Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year and reported to the Board. The Trust will act to improve this rate, and so the quality of its services by continuing to review incident data to encourage open and transparent reporting and to identify improvements to practice and learning.</td>
</tr>
<tr>
<td>---------------------</td>
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<td>---------</td>
</tr>
<tr>
<td><strong>Percentage of patient safety incidents resulting in severe harm or death</strong></td>
<td>0.66% Apr16-Sep16</td>
<td>0.37% Apr16-Sep16</td>
<td>0% Apr16-Sep16</td>
<td>1.7% Apr16-Sep16</td>
<td>0.53% Apr 15-Sep 15</td>
<td>The Trust considers that this data is as described as it is supplied by the National Reporting and Learning System (NRLS) and is consistent with internal data reviewed on a monthly basis during the year and reported to the Board. The Trust will act to improve this rate, and so the quality of its services by continuing to review incident data to encourage open and transparent reporting and to identify improvements to practice and learning.</td>
</tr>
<tr>
<td><strong>Responsiveness to inpatients' personal needs</strong></td>
<td>Comparative data for 2015/16 (2014/15 in brackets): NBT score 69.4 (64.6); England overall 69.6 (68.9); low 58.9 (59.1); high 86.2 (86.1).</td>
<td>Comparative data for 2015/16 will not be available from the Health &amp; Social Care Information Centre until August 2016.</td>
<td>The Trust considers that this data is as described for the following reasons as this rate is as described as is the latest as available on the HSCIC website. The Trust will act to improve this percentage, and so the quality of its services by continuing to collect feedback from patients, carers and relatives through a range of different sources co-ordinated by the Head of Patient Experience and utilising the Patient Panel and Experience Group as outlined in this report.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of staff who would be happy with standard of care provided if a friend or relative needed treatment</strong></td>
<td>65%</td>
<td>70.0% 2016 Staff Survey</td>
<td>85% 2015 Staff Survey</td>
<td>49% 2015 Staff Survey</td>
<td>64% 2015 Staff Survey</td>
<td>The Trust considers that this data is as described as it is directly extracted from National Survey data and the trend variation from previous year is consistent with internal surveys intended to inform ongoing improvement actions. The Trust will act to improve this percentage, and so the quality of its services by revitalising the approach taken to patient feedback to broaden its range and target improvement actions rapidly to address themes. This includes improvements in relation to the management of incidents and feedback on actions taken.</td>
</tr>
<tr>
<td>Summary Hospital-level Mortality Indicator (SHMI) value and banding</td>
<td>93.04 Oct 15 – Sep 16</td>
<td>100 Oct 15 – Sep 16</td>
<td>68.97 Oct 15 – Sep 16</td>
<td>116.39 Oct 15 – Sep 16</td>
<td>90.47 Apr 15 – Mar 16</td>
<td>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</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------</td>
<td>--------------------------</td>
<td>-----------------------</td>
<td>------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'</td>
<td>26.14% Oct 14 – Sep 15 (latest available)</td>
<td>26.6%</td>
<td>0.2%</td>
<td>53.5%</td>
<td>29.04% Jul 13 – Jun 14</td>
<td>Quality Surveillance Group, the medical Director and within specialties. The rate is also consistent with historic trends. The Trust will act to improve this percentage, and so the quality of its services by continuing with the approach detailed in this account to improve quality and safety. The Trust does not specifically target a reduction in mortality but has more robust processes in place for monitoring mortality including the ongoing review of all hospital deaths. It is important to note that palliative care coding has no effect on SHMI and national data comparisons are no longer provided, therefore the last ones published are shown in this table.</td>
</tr>
</tbody>
</table>

**Patient Reported Outcome Measures – No. of patients reporting an improved score:**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Replacement Primary EQ-VAS</td>
<td>Apr-Sep 16 NBT score 87% (national average 65.10%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>These figures are all taken from the HSCIC website, however the sample size is too small to be published nationally.</td>
</tr>
<tr>
<td>Hip Replacement Primary EQ 5D</td>
<td>Apr-Sep 16 NBT score 81.22% (national average 85.60%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Knee Replacement Primary EQ-VAS</td>
<td>Apr-Sep 16 NBT score 81% (national average 54.50%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee Replacement Primary EQ 5D</td>
<td>Apr-Sep 16 NBT score 71.26% (national average 77.50%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicose Veins, Groin Hernia and Hip Replacement Revision</td>
<td>No information available for 2015/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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% | | | | | | The Trust considers that this data is as described as it is obtained directly from the national Information Centre site. Nationally comparative data is not available. The Trust will act to improve this percentage in relation to its bi-monthly review with clinical directorates of its own monitoring data within the Performance Assurance Framework. This will identify adverse trends and agree actions to reduce unplanned readmissions. |

**Same 2011/12 comparative data as national data not updated since November 2011**

| Comparative data is not currently available for 2012/13, 2013/14 or 2014/15 from the Health & Social Care Information Centre. | | | | | | |

**Emergency readmissions within 28 days of discharge: age 16 or over**

| Comparative data for 2011/12: NBT score 10.9%; England average 11.4%; low 0%; high 17.1%. Comparative data is not currently available for 2012/13, 2013/14 or 2014/15 from the Health & Social Care Information Centre. | | | | | | The Trust considers that this data is as described as it is obtained directly from the national Information Centre site. Nationally comparative data is not available. The Trust will act to improve this percentage in relation to its bi-monthly review with clinical directorates of its own monitoring data within the Performance Assurance Framework. This will identify adverse trends and agree actions to reduce unplanned readmissions. |
Appendix 2 2016/17 CQUINS

A proportion of our income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between North Bristol NHS Trust and local Clinical Commissioning Groups or NHS England for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.


<table>
<thead>
<tr>
<th>Title</th>
<th>National &amp; Local CQUINS (CCG contracted)</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health &amp; Wellbeing Initiatives</td>
<td>For staff - increasing physical activity, mental health support services and improving physio access for people with Musculo-skeletal issues</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improving the health of the food offered on Trust premises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improving the uptake of flu vaccinations for frontline clinical staff</td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td>Sepsis Screening &amp; Treatment – Emergency Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sepsis Screening &amp; Treatment – Non Emergency Admissions</td>
<td></td>
</tr>
<tr>
<td>Antibiotics consumption</td>
<td>Reduction in antibiotic consumption per 1,000 admissions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Empiric review of antibiotic prescriptions</td>
<td></td>
</tr>
<tr>
<td>Physical Health</td>
<td>Frailty identification &amp; care planning</td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Reduction in alcohol dependence &amp; related emergency admissions</td>
<td></td>
</tr>
<tr>
<td>Patient Discharge</td>
<td>Discharge summaries - timeliness and completion</td>
<td></td>
</tr>
<tr>
<td>End of Life Care</td>
<td>End of Life - prognostic indicators &amp; training</td>
<td></td>
</tr>
<tr>
<td>Cancer Care</td>
<td>Reducing late inter-provider cancer referrals</td>
<td></td>
</tr>
<tr>
<td>Patient Experience</td>
<td>Patient Self-care – ‘Ask 3 questions’</td>
<td></td>
</tr>
<tr>
<td>Patient Safety</td>
<td>Organisational safety culture review</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Specialised CQUINS (NHS England contracted)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Armed Forces</td>
<td>Review &amp; Revision of Provider Waiting List /Access Policy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff Awareness of the Armed Forces Covenant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Making the Armed Forces Covenant Operational</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Embedding the Armed Forces Covenant</td>
<td></td>
</tr>
<tr>
<td>Breast Screening</td>
<td>Programme Uptake</td>
<td></td>
</tr>
<tr>
<td>Clinical Utilisation Review</td>
<td>Local Learning pilot of clinical decision-making software to assess future implementation options</td>
<td></td>
</tr>
<tr>
<td>(CUR)</td>
<td>Local Learning pilot of clinical decision-making software to assess future implementation options</td>
<td></td>
</tr>
<tr>
<td>Critical Care</td>
<td>ICU Discharge</td>
<td></td>
</tr>
<tr>
<td>Spinal Surgery</td>
<td>Development of Spinal Surgery Networks</td>
<td></td>
</tr>
<tr>
<td>Implementation of Blueteq for Devices</td>
<td>Implementation of Blueteq for Devices</td>
<td></td>
</tr>
<tr>
<td>Vascular services</td>
<td>Quality improvement programme for outcomes of major lower limb amputation</td>
<td></td>
</tr>
<tr>
<td>Stroke Services</td>
<td>Pathway Review</td>
<td></td>
</tr>
</tbody>
</table>

| Good Achievement - 80%+       |                                                                                                        |         |
| Partial achievement - 40%-79% |                                                                                                        |         |
| Poor achievement - <40%       |                                                                                                        |         |
### Appendix 3 List of Services provided by North Bristol NHS Trust as at 31 March 2017

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Specialities</th>
<th>Directorate</th>
<th>Specialities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Directorate</td>
<td>Emergency Medicine, Care of the Elderly, Medical Day Care, General (Acute) Medicine, Cardiology, Clinical Haematology, Respiratory Medicine, Palliative Care, Clinical Immunology, HIV/AIDS Service / Infectious Diseases, Acute Oncology, Clinical Psychology, Diabetes &amp; Endocrinology, Gastroenterology, Mental Health Liaison</td>
<td>Renal &amp; Outpatients Directorate</td>
<td>Hospital Services, Renal Medicine, Renal Surgery, Transplantation Surgery, Hospital Haemodialysis, Community Renal Services, Home Haemodialysis, Peritoneal Dialysis, Satellite Haemodialysis, Renal Technical, Diagnostic &amp; Treatment Services, Outpatient Clinics, Day Case Suite, Minor Operations and Procedures Theatre</td>
</tr>
<tr>
<td>Musculoskeletal Directorate</td>
<td>Orthopaedics, Trauma Services, Rheumatology, Orthotics, Disablement Services, Bristol Re-ablement Service</td>
<td>Women’s and Children’s Directorate</td>
<td>Gynaecology, Fertility Services, Integrated Maternity Services, Neonatal Intensive Care Unit, General Paediatrics incl. Outpatients</td>
</tr>
<tr>
<td>Core Clinical Services Directorate</td>
<td>Clinical Equipment Services, Severn Pathology: Genetics, Clinical Biochemistry, Cellular Pathology (incl. Mortuary), Haematology, Immunology, Infection sciences, Phlebotomy</td>
<td>Therapy Services: Nutrition &amp; Dietetics, Speech and Language Therapy, Occupational Therapy, Physiotherapy, Pharmacy Services incl. Regional Quality Control Laboratory, Imaging Services, Medical Illustration</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4 Auditor's Opinion

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

We are required to perform an independent assurance engagement in respect of North Bristol NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicators:

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

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

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

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

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

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

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

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2014-15 issued by the Department of Health in March 2015 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.
Independent Auditor’s Limited Assurance Report to the Directors of North Bristol NHS Trust on the Annual Quality Account

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

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

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

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

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

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

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017

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

[Signature]
Grant Thornton UK LLP
Hartwell House
55-61 Victoria Street
Bristol
BS1 6FT

22 June 2017
Report to: Trust Board  
Agenda item: 13
Date of Meeting: Thursday 27 July 2017

<table>
<thead>
<tr>
<th>Report Title:</th>
<th>First annual review of implementation of the Trust strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Prepared by:</td>
<td>Chris Burton, Deputy Chief Executive</td>
</tr>
<tr>
<td>Executive Sponsor (presenting):</td>
<td>Chris Burton, Deputy Chief Executive</td>
</tr>
</tbody>
</table>
| Appendices (list if applicable): | Appendix 1 – Strategy on a Page  
Appendix 2 – Delivery of Year 1 Actions |

Recommendation:

The Board is asked to note the review of implementation of its strategy in the first year

Executive Summary:
1. **Purpose**
   1.1. This paper is to update the Board on the implementation of the Trust strategy and inform the board of the plans for 2017/18.

2. **Background**
   2.1. In July 2017 the Board approved a 5 year strategy to realise the ambition to provide Exceptional Healthcare Personally delivered.
   2.2. The Strategy built upon the organisations values of:
   - Putting patients first
   - Working well together
   - Recognising the person
   - Striving for excellence
   2.3. The Trusts vision states:
   
   We will realise the great potential of our organisation by empowering our skilled and caring staff to deliver high-quality, financially sustainable services in state-of-the-art facilities. Clinical outcomes will be excellent and with a spirit of openness and candour, we will ensure an outstanding experience for our patients.

   2.4. Eight themes were described to define the work the Trust would undertake to deliver this vision:
   i. Change how we deliver services
   ii. Be one of the safest trusts in the UK
   iii. Treat patients as partners in their care
   iv. Create and exceptional workforce for the future
   v. Devolve decision making and empower frontline staff to lead
   vi. Maximise the use of technology
   vii. Enhance patient care through research
   viii. Play our part in delivering a successful health & care system

The strategy on a page is shown in appendix 1. The full strategic document can be found at: Trust strategy web page

This document could be made public under the Freedom of Information Act 2000.
Any person identifiable, corporate sensitive information will be exempt and must be discussed under a ‘closed section’ of any meeting.
3. Year one actions

3.1. At the time of agreement of the strategy a number of specific actions were described for the first year. An analysis of delivery of these actions is shown in appendix 2.

3.2. The break down of delivery of the actions is shown in table 1 below.

<table>
<thead>
<tr>
<th>Strategic theme</th>
<th>Green actions</th>
<th>Amber actions</th>
<th>Red actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Services</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2 Safety</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>3 Experience</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4 Workforce</td>
<td>2</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>5 SLM</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>6 Technology</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>7 Research</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>8 System</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>23</td>
<td>6</td>
</tr>
</tbody>
</table>

3.3. Work is taking place in almost all areas for action but the majority have not yet reached full implementation.

4. Activities against strategic themes

4.1. Change how we deliver services. One month following board approval of the strategy the Trust entered financial special measures. The focus of the management teams became provision of more efficient and cost effective services. Clinically led transformation board were set up for Length of Stay, Operating Theatres and Outpatients. A Programme Management Office was created to support the change programmes and to delivery of cost improvement programmes.

The Trust has remained under significant operational pressure with increasing emergency demand and elective demand greater than our capacity in a number of areas. Despite the significant work on effective utilisation of beds the growth in demand has resulted in need to use escalation capacity throughout winter and spring. The Trust Management Team are focussed on next steps to address this pressure on bed capacity. The primary measure of effectiveness of the bed management plan is the 4 hour emergency target against which performance was challenged throughout the year.

This document could be made public under the Freedom of Information Act 2000.
Any person identifiable, corporate sensitive information will be exempt and must be discussed under a 'closed section' of any meeting.
There was continued progress through the year on Referral to Treatment trajectories with significant reduction in waits over 52 weeks and improved delivery to cancer waiting time targets.

The Trust takes part in the 6 monthly NHSEngland 7 day services audits and these show good availability of diagnostics over 7 days and good availability of consultant staff for urgent care. The gaps are in availability of senior medical staff for decision making for all patients receiving ward care over weekends. The Trust has benchmarked well for meeting standards in comparison to other hospitals.

**4.2. Be one of the safest Trusts in the UK.** A significant safety improvement programme was delivered lead by Associate Medical Director Seema Srivastava and Trust Safety lead Lorraine Motuel. CQUINS were delivered for work on managing sepsis and for work on safety culture. The ED Shine checklist was implemented with support from the WEAHSN and this work received an HSJ award. The national Early Warning Score was implemented across all clinical areas.

The Trust is involved in an Emergency Laparotomy collaborative and all patients over 70 undergoing this procedure had comprehensive geriatric assessment introduced. Work continues on good fluid management and reducing incidence of acute kidney injury. Standard operating procedures have been reviewed for procedures outside the operating theatre environment in addition to the work on human factors and safety within theatres.

Delivery of services against the NICE quality standards was undertaken with actions being developed in the small number of areas where there were gaps in delivery.

A new approach to managing serious incidents was introduced involving ‘swarms’ which allow staff to openly discuss what happened with senior leadership to enable evidence to be gathered whilst the incident is fresh in people minds and ensure that staff receive the support they need.

**4.3. Treat patients as partners in their care.** There has been focus on better management of complaints. Training has been provided to key members of staff and there has been improvement in the quality of responses. Local resolution meetings continue to be used to resolve the more significant complaints and concerns. The number of complaints with delayed response has reduced but it has proved difficult to sustain the improvement and so the process of complaint management is being reviewed.

Friends and Family test responses have been changed to allow for electronic feedback and this has increased the response rates.

Assurance that the duty of candour is carried out appropriately is in place for all significant incidents.

Improvements in relation to procedures for ensuring safeguarding of adults and children and compliance with the Mental Capacity Act have been implemented.

*This document could be made public under the Freedom of Information Act 2000.*

*Any person identifiable, corporate sensitive information will be exempt and must be discussed under a ‘closed section’ of any meeting.*
We achieve the CQUIN payment for use of the ‘ask three questions’ tool which empowers patients to ask about the care they are receiving.

4.4. Create an Exceptional Workforce for the Future

Deputy Director of workforce has created more capacity to deliver the workforce change programmes.

Mid-level and Senior leadership programmes are in place. Management skills development is also in place.

Focus on managing absence has seen some benefit but we still have higher sickness absence than benchmark Trusts.

Workforce controls resulting from financial constraints have been effective and improved the capability for workforce planning. There has been significant reduction on reliance on temporary staffing. This will need further development over future years. Robust job planning for medical staff has been introduced with divisional clinical leads supported by the deputy Medical Director. Medical staff extra contractual payments and absence management policies have also been updated.

The Trust has commenced the implementation of the new Junior Doctors contract and has a guardian of safe working hours in place who works closely with the Director of Medical Education and has presented at the Workforce committee. The Trust has improved its rating on overall quality of training of junior doctors to be the best in the South West.

A number of interventions have been introduced to support the health and well being of staff including resilience sessions and ‘Schwarz’ rounds. These enabled the Trust to achieve the related CQUIN. Staff stories are brought to the board.

North Bristol Trust is the lead employer for Nursing Associates in the second national cohort and is a successful apprenticeship provider. A nursing, midwifery and therapies strategy has been launched.

4.5. Devolve decision making and empower frontline staff to lead.

Directorates have been reconfigured to 5 divisions. There is an implementation plan including organisational development for SLM that has been agreed with the board. Leadership programmes are in place for senior leaders. Plans are in development for improving specialty leadership. A performance management framework has been agreed for oversight and support of divisions.

Corporate functions have been reviewed and change proposals to ensure that they provide appropriate support to clinical divisions are under consultation.

A governance framework for good management of clinical divisions is in the process of implementation.

The board has held development sessions jointly with Clinical Directors.
4.6. Maximise the use of technology

Work in IM&T has focussed on:

- Strengthening the IM&T team
- Ensuring resilience of the infrastructure
- Stabilising the Lorenzo system
- Developing plans for Electronic Document Management
- Developing plan for Electronic clinical noting
- Improving availability of data and information
- Achieving an appropriate information governance standard

4.7. Enhance patient care through research

During the year there has been a 3% increase in recruitment of patients to clinical trials. New research profiles have been developed in vascular surgery and stroke. Work is under way to raise patient awareness of available research and joint work with UH Bristol is to ensure that patients have access to research that is only available on one or other of the two sites. Data is now being collected on Friends and Family related to the experience in the clinical research facility.

There has been a restriction in the capacity in pharmacy to deliver clinical trials support because of lack of physical capacity. There is a plan to expand capacity but this has been delayed by 12 months which has restricted access to some trials.

The Bio Medical Research centre was awarded to University Hospitals of Bristol with work in collaboration with NBT and the University of Bristol.

A draft strategy will be presented to the board in July 2017 and if approved will be launched in August 2017.

4.8. Play our part in delivering a successful health system

The Trust has been working with partners over the past 12 months on development of the BNSSG Sustainability and Transformation programme. Andrea Young is the SRO for the Acute Care Collaboration work stream.

The Trust continues to discuss service improvements through a formal partnership agreement with University Hospitals of Bristol FT and undertook a board to board meeting with UH Bristol in December 2016.
The Trust executive and clinical leadership have supported the work being undertaken by the North Somerset Sustainability board on the future models of care in Weston super Mare.

The Director of Operations and Director of Nursing work closely with partners on managing urgent care.

The Trust has appointed a GP liaison manager to enhance work with primary care.

Trust teams are contributing to the work to support improvement to the commissioners financial position.

NBT led deployment of a new laboratory information management system across BNSSG and bath and welcomed Public Health England into the new pathology building at Southmead hospital.

5. **Strategy support infrastructure**

The post of Associate Director for strategy which reports to the deputy CEO has been vacant throughout the year which has slowed the pace of development of sub-strategies. A quality strategy, research strategy and estate strategy are expected in the next 12 months in addition to further work to develop strategies at division and service level.

It has been agreed to bring together the strategy and business planning functions and a new post of Associate Director of Strategy and Planning was appointed to in July 2017. This will ensure increased pace in strategy development and further improvement in business planning for 2018/19.

6. **17/18 objectives**

6.1. The themes described in the Trust strategy have been mapped across to the Trust business plan for 17/18 to ensure continued implementation.

6.2. The Trust Management Team agreed the following priorities from within the corporate objectives related to strategic implementation:

1. Improve patients access to care by meeting the 95% 4 hour target for emergency care, the national cancer targets and elective waiting time trajectories

   Make better use of our estate to help reduce the cost of care.

   Deliver the financial plan to achieve an improved year end deficit of £18 million

2. Meet CQC ‘good’ standard for safe care as a minimum in all areas

   80% of staff recommend us as a place for care for friends and relatives in the staff FFT

3. Increase the score for the national inpatient survey question ‘were you engaged as much as you wanted to be in decisions about your discharge?’

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95% of patients recommend us for care and treatment in the inpatient FFT

4. Increase the overall engagement score in the staff survey (from 3.71 to 3.81)
   Improve scores achieved in the staff survey in the health and wellbeing categories to be better than the average of all Trusts.

5. Parameters for devolved decisions to the divisions are defined and understood
   Planned programme of development support to senior management teams of Divisions delivered

6. Information for decision making (from data entry to reporting) is agreed to be high quality and accessible by users
   An increased proportion of Trust documents (clinical and non-clinical) are managed electronically

7. The number of patients taking part in clinical trials is maintained or increased

8. High quality efficient service models for North Somerset hospital care, urgent care, stroke orthopaedics and pathology are agreed with partners
   Our contribution to restore financial balance to the BNSSG health system has been agreed with partners

7. Summary
   Since approval of the board strategy there has been significant work in all eight strategic themes. The themes have formed the basis for the Trust business plan and for the setting of corporate and Executive objectives for 17/18
   The appointment of the Associate Director of Strategy and Business Planning will enable additional work to create sub-strategies and clinical service strategies that will support delivery of the overall strategy and clarify the actions to front-line staff. This individual will also enable the work required to support success of the BNSSG STP and accelerate changes developed through partnership with UH Bristol.
   The board are asked to note the review and progress in year 1.
   For reference the agreed ambitions for 2020/21 are given in appendix 3.

Chris Burton
Medical Director and Deputy CEO
July 2017

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Our strategy for 2016-2021

Our Vision
We will realise the great potential of our organisation by empowering our skilled and caring staff to deliver high-quality, financially sustainable services in state-of-the-art facilities. Clinical outcomes will be excellent and with a spirit of openness and candour, we will ensure an outstanding experience for our patients.

Strategic themes
- Change how we deliver services
- Devolve decision making and empower frontline staff to lead
- Be one of the safest trusts in the UK
- Maximise the use of technology
- Treat patients as partners in their care
- Enhance patient care through research
- Create an exceptional workforce for the future
- Play our part in delivering a successful health & care system

Our values
- Putting patients first
- Working well together
- Recognising the person
- Striving for excellence

Providing local hospital services & complex specialist care
## Appendix 2 – Deliver of year 1 actions

<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Action</th>
<th>Delivery RAG</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change how we deliver services</td>
<td>Minimise delays to inpatient care with timely discharge or transfer when appropriate</td>
<td>Red</td>
<td>Reduced delayed transfers (DTOC), Discharge to assess implemented. Significant delays remain.</td>
</tr>
<tr>
<td></td>
<td>Improve the efficiency of outpatients, theatres and bed use to speed up access to care and maximise effective use of resources.</td>
<td>Yellow</td>
<td>Programmes being established and some delivery in place e.g. increased theatre cases per day, most performance trajectories in delivery.</td>
</tr>
<tr>
<td></td>
<td>Develop and embed the Trust’s service improvement methodology</td>
<td>Yellow</td>
<td>QI methodology established but not clearly articulated for all service improvements.</td>
</tr>
<tr>
<td></td>
<td>Begin work with GPs and community providers so that patients with long term and complex conditions feel supported but hospital attendances are minimised</td>
<td>Red</td>
<td>Minimal work progressed due to concerns about capacity to deliver in primary/community care. Work stream in STP.</td>
</tr>
<tr>
<td>Be one of the safest Trusts in the UK</td>
<td>Ensure infection control processes, including monitoring and reporting are exemplary</td>
<td>Yellow</td>
<td>Good Cdiff performance but disappointing number of MRSA bacteraemia. Improvement plans in place.</td>
</tr>
<tr>
<td></td>
<td>Review learning from every patient death and be transparent in our investigations</td>
<td>Yellow</td>
<td>Currently partial delivery and policy being progressed to national timescale</td>
</tr>
<tr>
<td></td>
<td>Ensure that at least 80% of annual Commissioning for Quality and Innovation (CQUIN) programmes are delivered</td>
<td>Green</td>
<td>Delivered</td>
</tr>
<tr>
<td></td>
<td>Deliver priorities in the annual quality account and Sign up to Safety commitments</td>
<td>Green</td>
<td>Delivered</td>
</tr>
<tr>
<td></td>
<td>Meet all local contractual requirements of quality of care</td>
<td>Green</td>
<td>VTE RAP delivered, theatre safety and MRSA RAP in place with positive progress</td>
</tr>
<tr>
<td></td>
<td>Develop a suite of outcome metrics relevant to all specialties</td>
<td>Yellow</td>
<td>Not delivered - some data in Quality Account. Teams have engaged with Getting it Right First Time data.</td>
</tr>
<tr>
<td>Patients as partners in their care</td>
<td>Embed partnership working between the Trust and patients by ensuring patient and public involvement in an increasing number of our activities</td>
<td>No clear increase in PPI</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>Improve timeliness, transparency and quality of responses to complaints</td>
<td>Training delivered. Some improvements in timeliness but not yet sustained. Improved quality of responses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Act on information from patient surveys including the Friends and Family tests</td>
<td>17/18 objectives include improvements in survey results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve involvement of patients, their families and carers in discharge planning and ongoing decisions</td>
<td>Objective for 17/18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the number of patients with end of life care in their chosen location</td>
<td>End of life projects in NBT and health community but not yet delivered outcome</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use the ‘ask three questions’ CQUIN improvement model so that patients get the information they need</td>
<td>CQUIN delivered</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Exceptional workforce**

<table>
<thead>
<tr>
<th>Management skills development in place and impacting positively on delivery</th>
<th>Mid level and senior leadership programmes in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate management of sickness and other absence</td>
<td>Sickness absence remains above benchmark but evidence of some improvement.</td>
</tr>
<tr>
<td>Workforce planning capabilities are enhanced and rigorous</td>
<td>Work in progress not yet delivered</td>
</tr>
<tr>
<td>Minimise the use of temporary staff</td>
<td>Good impact of workforce controls on temporary staff</td>
</tr>
<tr>
<td>All teams upholding the highest professional standards</td>
<td>Evidence of action, needs further spread</td>
</tr>
<tr>
<td>Improve staff engagement, health and wellbeing</td>
<td>Plans in place for 17/18</td>
</tr>
<tr>
<td>Deliver the staff wellbeing CQUIN goals</td>
<td>Delivered</td>
</tr>
</tbody>
</table>

**Devolve decision making**

<table>
<thead>
<tr>
<th>Develop a detailed implementation plan for clinically led, service line management as agreed by the Board. Actions to commence within 16/17 with completion during 2017/18.</th>
<th>Plan in place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and enable clinical leader capability, addressing gaps in current skill sets</td>
<td>Leadership programmes in place at senior level. Further work needed next layer down</td>
</tr>
<tr>
<td>Align corporate functions to support and enhance clinical directorate success</td>
<td>Work being progressed with exec team</td>
</tr>
<tr>
<td>Technology</td>
<td>Stabilise the existing patient record system (Lorenzo)</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Develop and implement service line reporting</td>
</tr>
<tr>
<td></td>
<td>Implement electronic document management</td>
</tr>
<tr>
<td></td>
<td>Agree and deliver a suite of management information</td>
</tr>
<tr>
<td></td>
<td>reports and support staff to understand and interpret</td>
</tr>
<tr>
<td></td>
<td>the data being presented</td>
</tr>
<tr>
<td>Research</td>
<td>Broaden our research portfolio to offer more of our</td>
</tr>
<tr>
<td></td>
<td>patients the opportunity to participate in research</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop a five year research strategy for the Trust</td>
</tr>
<tr>
<td></td>
<td>Invest in our research workforce and facilities to</td>
</tr>
<tr>
<td></td>
<td>increase our ability to deliver the research of the</td>
</tr>
<tr>
<td></td>
<td>future</td>
</tr>
<tr>
<td></td>
<td>Increase patient satisfaction with our services</td>
</tr>
<tr>
<td></td>
<td>Make research more visible to patients and visitors</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Successful</td>
<td>Work with partners to develop and start to implement</td>
</tr>
<tr>
<td>health system</td>
<td>the Bristol, North Somerset and South Gloucestershire</td>
</tr>
<tr>
<td></td>
<td>Sustainability and Transformation Plan</td>
</tr>
<tr>
<td></td>
<td>Work with partners to design and implement plans that</td>
</tr>
<tr>
<td></td>
<td>ensure the sustainability of Weston General Hospital</td>
</tr>
<tr>
<td></td>
<td>Prioritise improvements to patient flow through our</td>
</tr>
<tr>
<td></td>
<td>hospitals, working with key stakeholders and partners</td>
</tr>
<tr>
<td></td>
<td>across the health and care system to ensure patients</td>
</tr>
<tr>
<td></td>
<td>are only admitted when necessary and are discharged as</td>
</tr>
<tr>
<td></td>
<td>soon as possible</td>
</tr>
<tr>
<td></td>
<td>Minimise delays in transfers of patients to other</td>
</tr>
<tr>
<td></td>
<td>health care providers through building effective</td>
</tr>
<tr>
<td></td>
<td>provider networks</td>
</tr>
</tbody>
</table>
## Appendix 3 – Strategic ambitions for 2020/21

<table>
<thead>
<tr>
<th>20/21 ambition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Have achieved the highest level of rating from regulators</td>
</tr>
<tr>
<td></td>
<td>Deliver services that meet all NHS constitution and national cancer minimum standards</td>
</tr>
<tr>
<td></td>
<td>Deliver operational performance standards to which other trusts aspire</td>
</tr>
<tr>
<td></td>
<td>Deliver best practice emergency care seven days a week</td>
</tr>
<tr>
<td></td>
<td>Have specialist services that meet best practice guidelines for access to care</td>
</tr>
<tr>
<td></td>
<td>Rapidly repatriate specialist patients to referring hospitals and health communities in the best interests of the patient</td>
</tr>
<tr>
<td></td>
<td>Have maximised the use of the hospital infrastructure efficiently across the week</td>
</tr>
<tr>
<td></td>
<td>Have diagnostic services that support a growing number of providers to deliver personalised care and ensure that patients receive the best care, first time and in the most appropriate setting, away from hospital when possible</td>
</tr>
<tr>
<td></td>
<td>Use service line costing so the Trust understands how much each of its services cost and ensure costs do not exceed tariff income</td>
</tr>
<tr>
<td></td>
<td>Have eliminated the financial deficit, offering a portfolio of services that deliver a financially sustainable organisation</td>
</tr>
<tr>
<td>2</td>
<td>Have built a reputation for excellence with outcomes that match the best in the world</td>
</tr>
<tr>
<td></td>
<td>Have a culture of continuous learning and transparent investigations that seek to avoid patient harm as a result of errors in care</td>
</tr>
<tr>
<td></td>
<td>Reduce harm events to a minimum level that is best in class amongst UK hospitals</td>
</tr>
<tr>
<td></td>
<td>Have developed services that are all providing good outcomes of care in comparison to benchmarks and with measurably exceptional care in at least 10 specialties</td>
</tr>
<tr>
<td></td>
<td>Deliver services that meet patient needs seven days a week</td>
</tr>
<tr>
<td></td>
<td>Deliver care in an appropriate, well equipped and clean environment</td>
</tr>
<tr>
<td></td>
<td>Offer rapid access to best in class diagnostic services that meet or exceed all regulatory and professional standards</td>
</tr>
<tr>
<td></td>
<td>Be a centre of excellence for quality and service improvement methodologies</td>
</tr>
<tr>
<td></td>
<td>Have reduced complexity of care by standardising patient pathways</td>
</tr>
<tr>
<td></td>
<td>Have developed team working that manages the complexity of individual patient needs and ensures that high quality handover between teams (inside and outside the Trust), enabling seamless care</td>
</tr>
<tr>
<td></td>
<td>Publish quality and outcome measures to ensure relentless focus of the organisation on delivery of the Trust vision</td>
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</tr>
<tr>
<td>3</td>
<td>Have expert service user involvement in all major change projects and developments</td>
</tr>
<tr>
<td></td>
<td>Have patient held care plans in place, including self-care advice where relevant</td>
</tr>
<tr>
<td></td>
<td>Have clear written information to support patient consent for all procedures</td>
</tr>
<tr>
<td></td>
<td>Have end of life care provided in the setting of choice for patients and families with 24/7 access to expert support</td>
</tr>
<tr>
<td></td>
<td>Reduce follow up outpatient appointments to those where the only option for good care is a face-to-face meeting in the hospital</td>
</tr>
<tr>
<td></td>
<td>Release outpatient capacity to provide rapid access for patients who need it urgently</td>
</tr>
<tr>
<td></td>
<td>Respect patients’ knowledge of the needs of their own long term conditions wherever they are cared for in the Trust</td>
</tr>
<tr>
<td></td>
<td>Have tailored care to meet the needs of patients with cognitive impairment, mental health issues or learning disabilities, maximising the opportunity for these individuals to understand and contribute to decisions about their health</td>
</tr>
<tr>
<td></td>
<td>A patient experience programme that listens to patients, carers and staff and learns from their experiences</td>
</tr>
<tr>
<td></td>
<td>Seek patient feedback and respond promptly to complaints. Teams will develop the services they offer in response to what patients tell them</td>
</tr>
<tr>
<td></td>
<td>Have services that the people who use them rate them highly and recommend them to others</td>
</tr>
<tr>
<td>4</td>
<td>Have staff who are all appropriately trained, motivated and well led have all the skills required to deliver safe care</td>
</tr>
<tr>
<td></td>
<td>Give all staff the opportunity for a greater say in the future of the organisation so that they can effect and take responsibility for making things happen</td>
</tr>
<tr>
<td></td>
<td>Create a culture of upholding the values and standards of behaviour set by the Trust</td>
</tr>
<tr>
<td></td>
<td>Have strong partnerships with the universities and Deanery to support training of health care professionals fit for the future</td>
</tr>
<tr>
<td></td>
<td>Have reliable staffing to full establishment</td>
</tr>
<tr>
<td></td>
<td>Show that our staff are proud of the place they work and what they achieve</td>
</tr>
<tr>
<td>5</td>
<td>Hold directorates accountable for delivery of quality care and for managing performance within available resources through effective service line management</td>
</tr>
<tr>
<td></td>
<td>Have clinicians with the time and skills required to lead the organisation and develop succession plans for their roles</td>
</tr>
<tr>
<td></td>
<td>Demonstrate seamless patient care pathways through directorates working together</td>
</tr>
<tr>
<td></td>
<td>Have clinical leaders focused on collectively delivering the strategic vision of the Trust as well as the success of their own areas of responsibility</td>
</tr>
<tr>
<td></td>
<td>Have clinical leaders who drive the future success of the organisation as well as current performance</td>
</tr>
<tr>
<td></td>
<td>Have management teams and corporate functions skilled in supporting clinical leaders to be successful in their roles</td>
</tr>
<tr>
<td></td>
<td>Have clinicians who are the key decision makers, playing an integral role in shaping clinical services of the future</td>
</tr>
<tr>
<td>6</td>
<td>Have electronic systems that ensure all the information required for individual patient care is always available to staff in a format that supports their work flow</td>
</tr>
<tr>
<td>7</td>
<td>Improve and integrate research access across the region providing our community the maximum research opportunities possible</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8</td>
<td>Be a part of a successful and sustainable health and care system</td>
</tr>
</tbody>
</table>

| Have sufficient hardware devices and resilient IT services in the clinical environment to support use of the electronic patient record |
| Put in place systems that enable connectivity across the health community allowing rapid exchange of information to support care wherever patients are located |
| Use technology to support use of our clinical expertise in caring for patients at a distance such as virtual clinic consultations and advice and guidance for GPs |
| Have systems that are accessible to patients to help them understand their own data and support self-care |
| Enable leaders to understand how the Trust functions, with real time information, business intelligence and large scale analysis to support future development |
| Routinely support demand and capacity analysis and service line reporting |
| Demonstrate that population data such as the Joint Strategic Needs Assessments is incorporated into future planning |
| Have data capture systems that support service improvement methodologies including rapid cycle tests of change and key performance indicators |

7. Improve and integrate research access across the region providing our community the maximum research opportunities possible

| Increase in the research income of the Trust |
| Have patients who are integral partners in designing and directing our research |
| Demonstrate academic excellence (publications and grant income) across our research strengths |
| Have in place systems to support rapid adoption of new evidence based practice and research outcomes with direct patient benefit |
| Have research embedded in clinical services delivering improvements in service delivery and patient outcomes |
| Be leaders in research policy and process to improve research outcomes |

8. Be a part of a successful and sustainable health and care system

| Have developed networks with other providers that ensure patients are managed in the right place at the right time to meet their needs |
| Have built strong relationships with all primary, community and secondary care providers to maximise the effectiveness of care and the patient experience |
| Be working with partners to ensure that patients are only admitted to hospital care if it is in their best interests, using advice and guidance from experts to support community care where possible |
| Be working with partners to ensure that rehabilitation, enablement and social care are accessed rapidly and in the most appropriate location to meet patient need, including those with specialised needs |
| Have embraced opportunities to partner with other organisations to deliver care in more effective ways; be they NHS, commercial or third sector |
| Continuously develop new ways to deliver services, designed for and by the people who use them, working with partners to develop the whole health and care system |
Executive Summary:

A Trust-wide research strategy is required to provide transition from the expired research strategy enabling delivery of the NBT Strategy 2016-2021.

Research active organisations like NBT deliver better outcomes for patients. We are already one of the top 30 research active trusts in the UK and we aspire to become a world leading research facility, delivering high quality research of direct patient benefit.

This document sets out the 5 year strategy for research at NBT
Research Strategy
2017-2022
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Our Vision
To improve patient health through world-class research.

Our Mission
To lead ground-breaking research and work with our partners to improve the health of the nation. Embed a culture of research excellence throughout the Trust delivered by a highly skilled knowledgeable workforce. Make research everyone’s business.

Research at North Bristol NHS Trust
North Bristol NHS Trust (NBT) is a centre of excellence for health care in the southwest and one of the largest hospital trusts in the UK. We treat some of the most complex conditions and are proud of the specialist services that we provide.

Enhancing patient care through research is one of NBT’s key strategic themes. A research-active culture can bring a host of benefits for patients, clinicians and the NHS. Research drives innovation, enables better and more cost-effective treatments and creates opportunities for staff and patients.

There is now clear evidence across a range of conditions that research activity in acute English NHS Trusts is associated with better outcomes, lower mortality and with considerable cost savings.

At NBT we benefit from being part of a vibrant and ambitious Bristol-wide strategic health research and innovation partnership, which enables better co-ordination of research, innovation and resources. NBT Works with our strategic partners in patient groups; academia; NHS; industry to identify the most important research questions to be addressed and the most effective ways to answer those questions.

Our Research & Innovation department is well-established and comprises a multidisciplinary infrastructure that supports a broad range of research activity across very many clinical areas of the Trust.
NBT’s vision and values are central to the way we work

Research is integral to the delivery of the Trust’s vision ‘to realise the great potential of our organisation by our skilled and caring staff delivering innovative, high quality services in state of the art facilities. This will ensure excellent clinical outcomes and an outstanding experience for our patients.’

This research strategy has been developed for the period 2017-2022 to provide focus and clarity of direction for the organisation and its stakeholders. It sets out our future strategic research aims that will ensure the Trust vision is realised. In addition, running through the core of all that we do at NBT are ‘Our Values’:

<table>
<thead>
<tr>
<th>Putting patients first</th>
<th>Working well together</th>
<th>Recognising the person</th>
<th>Striving for excellence</th>
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<tr>
<td>Understanding the impact of every role on patient care, even if you’re not in direct contact</td>
<td>Engaging with colleagues and patients to proactively resolve issues</td>
<td>Making staff and patients feel valued and worth your time</td>
<td>Continuously reviewing what we do, to seek new ideas for improvement</td>
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<td>Taking the time to listen and care</td>
<td>Demonstrating commitment to shared objectives</td>
<td>Looking everyone in the eye, acknowledging them, recognising they are people</td>
<td>Demonstrating commitment to continuous learning and development</td>
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<td>Protecting patient confidentiality, privacy and dignity</td>
<td>Including and consulting others when making decisions that affect them</td>
<td>Appreciating differences and the strength that diversity can bring</td>
<td>Celebrating efforts and successes</td>
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<td>Being open and transparent when things go wrong</td>
<td>Offering encouragement and feedback to others</td>
<td>Helping the patient understand their condition, involving them in decision making</td>
<td>Recognising your own limitations, using mistakes as learning opportunities and remaining resilient when facing challenges</td>
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<td>Intervening when others have not, speaking up when necessary</td>
<td>Becoming trusted and respected by staff and patients</td>
<td>Taking a holistic approach to care</td>
<td>Going the extra mile to make a difference to patients and staff, even if this is indirectly</td>
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The aims of the NBT Research strategy 2017-2022 are:

<table>
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<tr>
<th>Aim 1</th>
<th>Empower patients as partners in high quality research</th>
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<tr>
<td>➢ Enable more people to engage in public and patient involvement (PPI) Activities</td>
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<tr>
<td>➢ Provide more research opportunities for our patients</td>
<td></td>
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<tr>
<td>➢ Deliver research that is important to and prioritised by patients</td>
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<tr>
<td>➢ Improve patient safety and care by demonstrating and implementing research outcomes</td>
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<th>Aim 2</th>
<th>Support and nurture a sustainable workforce with the skills to deliver world class research</th>
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<tr>
<td>➢ Continue to develop our efficient workforce, valuing and effectively utilising the individual team skills and experience</td>
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<td>➢ Develop career pathways for research staff</td>
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<td>➢ Building upon the skills of our workforce and volunteers</td>
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<td>➢ Develop the future workforce</td>
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<th>Aim 3</th>
<th>Research will be visible in all aspects of the day to day business of the Trust</th>
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<td>➢ Increase patient awareness of research</td>
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<td>➢ Increase awareness of research impact and underpinning evidence</td>
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<tr>
<td>➢ Embed research in the care pathway of NBT services</td>
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<td>➢ Deliver research that improves our services</td>
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<th>Aim 4</th>
<th>We will work with our regional partners to strategically and operationally align our research with our clinical services and needs of the community</th>
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<tr>
<td>➢ Focus on and foster our priority areas of research where we are, or have the potential to be, world-leading</td>
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<td>➢ Develop our profile as experts in research management, governance and delivery</td>
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<tr>
<td>➢ Increase partnership working to maximise our research potential</td>
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<tr>
<td>➢ Develop our profile as experts in research management, governance and delivery</td>
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<tr>
<td>➢ Provide state-of-the-art research facilities</td>
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Research Aims and Objectives

Aim 1: Empower patients as partners in high quality research

Objective 1.1: Enable more people to engage in public and patient involvement (PPI) activities

— We will maximise opportunities for PPI in research, by raising awareness through our ‘Take Part Be Involved’ in research campaign.
— We will work with our researchers to broaden the scope and impact of PPI within the Trust.
— We will extend our PPI work out into the community to diversify and broaden representation.
— We will work with our healthcare partners to share best practice in PPI to further develop and streamline processes across the region.
— We will support the professional development of our PPI partners through the sourcing of appropriate training and the development of PPI career pathways.

Objective 1.2: Provide more research opportunities for our patients

— We will further develop our portfolio of studies from observational to complex interventional research to provide a range of research opportunities to patients.
— We will provide cross-organisational regional opportunities to participate in research studies contributing to equity of access to research.

Objective 1.3 Deliver research that is important to and prioritised by patients

— We will provide support and specialist advice on patient and public involvement in research at all stages of study development and delivery.
— We will engage patients, the local community, patient groups and national charities to inform our research portfolio.

Objective 1.4 Improve patient safety and care by demonstrating and implementing research outcomes

— We will work with our PPI partners to disseminate research findings in accessible and innovative ways that will maximise engagement from patient groups and provide awareness to the general public.
Aim 2: Support and nurture a sustainable workforce with the skills to deliver world class research

Objective 2.1: Continue to develop our efficient workforce, valuing and effectively utilising the individual team skills and experience

— We will provide a flexible research workforce that can deliver all aspects of our research portfolio. To support this we will further utilise and analyse our existing workforce metrics.
— We will introduce a Trust value based recruitment process to attract and retain the highest calibre of candidates in line with the trust values.
— We shall review our workforce skill mix on an ongoing basis to ensure it supports the effective delivery of our research portfolio.
— We will capture the broader skills and experience of our staff, to create a “knowledge bank” to be used for the wider benefit of the department whilst also valuing the individual’s expertise.
— We will continue to work with the internationally recognised “Investors in People” organisation to support our ambition of delivering world class research.
— We shall introduce an electronic rota system across our research workforce, to improve efficiency, oversight, productivity and contribute to staff well-being.

Objective 2.2: Develop career pathways for research staff

— We shall develop a meaningful learning and development strategy that supports career pathways for medics, nurses, midwives, AHPs and biomedical scientists.
— Leading from this we will ensure career pathways are actively established and managed for all research staff.
— We shall support volunteers to contribute to the development of research and support existing programmes of work.

Objective 2.3: Building upon the skills of our workforce and volunteers

— We will provide training programmes to equip our staff and volunteers to contribute to the achievement of our strategic goals and their agreed personal development.
— We will help our staff by identifying and accessing the most appropriate funding, academic mentorship and training opportunities, to support their career development and progression.
— We shall provide a tool to help measure training and development needs across the infrastructure, providing a consistent approach to recognising competence across the research workforce.
— We will work with our partners to provide cross disciplinary training across the region and to enable sharing of best practice.
— We will establish a formal induction for new research staff and staff new to Management & Leadership roles.

Objective 2.4: Develop the future workforce

— We will aim to provide protected time and access to start-up funds for staff who are, or have the potential to be, research-active.
— We will identify and support emerging talent and provide academic mentorship and training.
— We will ensure established research teams have clear succession plans in place for key posts and that those identified individuals have the necessary support.
— Increase oversight and monitoring of Research training across the workforce to ensure equity of access, and streamlining of processes utilising NBT’s resources.
Aim 3: Research will be visible in the day to day business of the Trust

Objective 3.1: Increase patient awareness of research

— We will actively increase public awareness of research through external and internal ‘Take Part Be Involved in Research’ communication campaigns.

Objective 3.2: Increase awareness of research impact and underpinning evidence

— We will collect and publicise research impact and outcome data.
— We will communicate with staff and patients to demonstrate the links between research evidence and practice.
— We will work with Directorate teams to raise awareness to their staff, of the value and contribution research makes to practice.
— We will communicate research performance information to Directorates.
— We will ensure that our communications is appropriately targeted and accessible.

Objective 3.3: Embed research in the care pathway of NBT services

— We will actively engage with clinical directors across the Trust to embed research into patient care pathways.
— We will strive to expand awareness of the value of evidenced based practice across all clinical areas.
— We will aim to ensure that no patient group treated at NBT will be excluded from the research portfolio of the Trust.
— We will ensure equitability of access to the Trust’s research portfolio.

Objective 3.4: Deliver research that improves our services

— We will work with clinical teams to focus research in areas of strategic and clinical priority
— We will work with our partners to ensure that our cutting-edge research is rapidly translated through into measurable improvements in patient outcomes, experiences, safety and potentially cost-effectiveness
— We will support staff to challenge conventional practice, and facilitate the dialogue between academics and clinicians which will lead to research that identifies best practice and delivers a step-change in clinical performance at NBT
— Increasing research income through focusing our research on areas which are of strategic importance and likely to have most impact on our services and the wider NHS.
Aim 4: Work with our regional partners to strategically and operationally align our research with our clinical services and needs of the community

Objective 4.1: Focus on and foster our priority areas of research where we are, or have the potential to be, world-leading

— We will identify our strengths and work with our regional partners (see page 17 glossary below) to build critical mass in world-class translational and applied health services research.
— We will implement internal funding calls available to all Trust staff, for small grants and dedicated research time in order to generate the evidence for new research proposals.
— We will provide skilled support for grant applications; navigation of regulatory and approval processes and delivery of studies.
— We will work with our partners to ensure research findings are made widely available and provide support implementation/route to adoption plans.
— We will collect and report research impact and outcome data to demonstrate improvements to care.
— We will broaden and diversify our research portfolio by focusing on under-represented areas such as non-clinician led research.

Objective 4.2: Build on our reputation to make us the collaborator and centre of choice

— We will develop a communication strategy to improve our visibility
— We will work with our partners to maximise our research collaboration across the region.
— We will support our researchers to build networks and collaborations.

Objective 4.3: Increase partnership working to maximise our research potential

— We will align our research themes to include the priority areas of our regional partners as appropriate.
— We will generate critical mass by aiming for closer integration across the partnerships by aligning our research infrastructure and investment priorities.
— We will establish agreements with our regional partners to ensure efficient and seamless working, maximising research productivity and income, and removing bottlenecks and delays at project start-up.
Objective 4.4: Develop our profile as experts in research management, governance and delivery

— We will maintain a suite of advice, guidance and policies for public use.
— We will build upon our training and staff development offerings across the region and nationally.
— We will participate in national work streams placing NBT at the forefront of developments.

Objective 4.5: Provide state-of-the art research facilities

— We will maximise use and income generating activities in the Clinical research Centre to support reinvestment.
— We will work with regional partners to develop shared research facilities and infrastructure.
— We will ensure the right balance of integration of research within clinical services by embedding Research facilities and teams in clinical departments as appropriate.
Delivering the Research Strategy

The success of our strategy will be through the delivery of our four strategic Aims. Each strategic aim will rely on the continued successful relationships with our stakeholders.

Through our collaboration with our academic partners, University of Bristol and the University of the West of England, we are able to explore innovative approaches to provision of care and delivery of research. NBT’s continued successful relationship with the NIHR; MRC; West of England CRN and various charitable organisations will help ensure both the investment in staff development and research delivery.

The Department of Health’s commitment to expanding access to clinical research for all patients helps ensure the continued our collaboration with the NIHR core funded infrastructure, Bristol Randomised Trials Collaboration; Collaboration for Leadership in Applied Health Research and Care West etc. ensuring patients can access to the most up to date care.

A detailed implementation plan which will include actions against individuals/teams and time-lines for delivery, will be developed by R&I and approved by the Trust’s Research and Innovation Group following approval of the Strategy.

Performance and progress in achieving our delivery plan will be kept under review by the Research and Innovation Group and Trust Board. We will publish our performance in key areas, including the set-up and delivery of interventional clinical research trials on our Trust website. We will publish an annual report detailing progress against the Strategy.

The funding for the implementation of the strategy will be secured through ambitious large-scale research proposals to external funders, annual research support allocations and by efficient use and leverage of existing Trust resources (in 16/17, the Trust will receive £9m income for research).

Strategic investment by the Southmead Hospital Charity Research Fund will continue to play a critical role and the improved delivery of clinical trials will enable the Trust to secure additional funding from the Life Sciences industry. R&I is a key part of the Trust’s overall strategy and will contribute to the Trust’s financial success.

We recognise that the research landscape changes rapidly and that the R&I strategy needs to be flexible and adaptive, responding rapidly to new opportunities. This strategy and the implementation plan will be subject to regular review, in partnership with patients, carers, clinicians and managers, at the Trust Board, the Research and Innovation Group and the R&I Senior Management Team.

Year One Priorities

This aims and objectives in this strategy set out an ambitious agenda for research over the next five years. The focus for the first year will be to:
— **Broaden** our research portfolio to offer more of our patients the opportunity to participate in research.

— **Develop** a five year detailed research implementation plan for the Trust.

— **Invest** in our workforce and facilities to increase our ability to deliver the research of the future.

— **Increase** patient satisfaction with our research portfolio and activities.

— **Make** research more visible and accessible to patients and visitors.
Supporting information

National Context

The government provides almost £1 billion research funding per year to support and grow the life science industry in the UK securing our place as a global leader (Strategy for UK life sciences: one year on, Department of Health (DH), 2012: Increasing research and innovation in health and social care, DH: 2013).

There have been a number of national drivers specific to healthcare research and innovation within the NHS aimed at ensuring the NHS is fully engaged in high quality research that will benefit patients and the economy.

The NHS constitution has a commitment to the promotion and conduct of research to improve the health and care of the population. “Research is a core part of the NHS. Research enables the NHS to improve the current and future health of the people it serves. The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them" (Handbook to the NHS Constitution, January 2009).

The NIHR was established in 2006 by the Department of Health to transform research in the NHS. NIHR aims to maintain a health research system in which the NHS supports outstanding individuals working in world class facilities, conducting leading edge research focussed on the needs of patients. NIHR works in partnership with many sectors including academic, charities and industry.

From April 2014, the NIHR structure is divided into 15 local Clinical Research Networks (CRN) across England which will deliver studies across all therapy areas. The geographical boundaries of the Networks correlate with those of the AHSNs.

NHS England published their strategic vision for the NHS in 2014; 5 year forward view. Within this document they state that “research is vital in providing the evidence we need to transform services and improve outcomes” alongside a commitment to accelerate adoption of new and innovative treatments and ways of delivering care.

Following on from the 5 year forward view the Accelerated Access Review sets out an ambitious framework to make the UK a world-leader in healthcare innovation, with an NHS that embraces the new drugs and technologies that patients need by accelerating research, innovation and adoption.

The development of the Health Research Authority has streamlined regulation processes for clinical research. National research benchmarks focus on increasing patient access to research, improving the UKs position in global industry research and streamlining the research lifecycle to enable faster more efficient delivery of research.

The NHS established 15 Academic Health Science Networks (AHSN) in April 2014. Their goal is to improve patient and population health outcomes by bringing together local NHS, university and industry partners to accelerate the spread of innovative, evidence-based care.
Sustainability and Transformation Plans (STP) covering the whole of England (broken down into 44 geographical regions) were published in 2016. Public and staff consultations are planned and/or underway for the BNSSG STP bid (https://www.bristolccg.nhs.uk/library/sustainability-and-transformation-plan-documents/).

The focus of the BNSSG STP is on a step-change in the way services are delivered and integrated and are coordinated through three core transformation portfolios and a range of enabling programmes (Digital, Estates and Workforce):

— Prevention, Early Intervention and Self-Care
— Integrated Primary and Community Care
— Acute Care Collaboration

Local Context
Keeping the people who use our services at the heart of what we do, we benefit from being part of a vibrant and ambitious Bristol-wide strategic health Research and Innovation partnership. This partnership enables better co-ordination of research, innovation and resources.

Bristol Health Partners (BHP) was formally launched in May 2012. The aims of BHP are to generate significant health gain and improvements in service delivery by integrating, promoting and developing Bristol's strengths in health services, research, innovation and education. The way BHP is delivering these aims is by the formation of Health Integration Teams (HITs). HITs include commissioners, public health and NHS specialists working with world-class applied health scientists and members of the public to develop NHS-relevant research programmes and drive service developments to improve health, well-being and healthcare delivery. Patient and public involvement (PPI) are essential to all aspects of HIT structure and function and that the methodologies used must include evaluation. The strengths of BHP and its HITs have directly led onto the award of an NIHR Collaboration for Leadership in Applied Health Research and Care for the West of England (CLAHRC west) that is focused on research targeted at chronic diseases and public health interventions. The CLAHRC west will substantially increase the scale and pace of research into practice and implementation of the novel applied health research findings that the HITs generate. This will in turn strengthen our strategic relationships.

The research and implementation themes of BHP and CLAHRC West dovetail with the stated aims and objectives of the West of England AHSN (WEAHSN) of the need for robust research to inform and accelerate the adoption and diffusion of evidence of best care.

The CRN West of England (CRN WE) helps to increase the opportunities for patients across the region to take part in clinical research ensure that studies are carried out efficiently and support the Government’s Strategy for UK Life Sciences by improving the environment for commercial contract clinical research.

The recent award of the NIHR Bristol Biomedical Research Centre (BRC) brings together healthcare and academic organisations across Bristol to focus on the development of new, ground-breaking treatments, diagnostics, prevention and care for patients in a wide range of diseases. Key themes addressed through the award include: - Cardiovascular disease,
Nutrition, diet and lifestyle, Reproductive and perinatal mental health, Surgical innovation and Mental health.

Consistent with the very substantial increase in the breadth and depth of research undertaken at NBT and across Bristol Health Partners, an extensive portfolio of research projects and trials have already resulted in findings and outcomes that been implemented into routine clinical care that is provided across the City.

An update to the NBT research strategy is therefore timely and emphasises the importance of focusing on working with regional partners to align our research and clinical service strengths.
References


W.O. Bennett, J.H. Bird, S.A. Burrows, P.R. Counter, V.M. Reddy  


**Glossary**

**West of England Academic Health Sciences Network (WEAHSN)** is a network of providers of NHS care across the West of England working with Universities, industry, NHS commissioners and a wide range of partners (http://www.weahsn.org.uk/). The vision of the WEAHSN is to be a vibrant and diverse network of partners committed to equality and excellence.

**Bristol Health Partners (BHP)** is a strategic collaboration between the city's three NHS trusts, three clinical commissioning groups, two universities and its local authority. It’s mission is to generate significant health gain and improvements in service delivery in Bristol by integrating, promoting and developing Bristol's strengths in health services, research, innovation and education.

**The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West (NIHR CLAHRC West)** brings together universities, local authorities, NHS hospital trusts, clinical commissioning groups, patients and members of the public, and third sector organisations to focus on research to improve health and healthcare for local people. Their ethos is to focus on research and Implementation that is, equitable and fair, appropriate and sustainable.

**The NIHR Clinical Research Network West of England**, helps to increase the opportunities for patients to take part in clinical research, ensure that studies are carried out efficiently, and support the Government’s Strategy for UK Life Sciences by improving the environment for commercial contract clinical research.

They provide the local NHS with the support and facilities it needs to carry out research and seeks to demonstrate how the NHS is an attractive option for commercial pharmaceutical, biotech and medical technology companies looking to carry out industry-sponsored research.

**Regional Partners** includes but is not limited to the member organisations of BHP, West of England AHSN, CRN and CLAHRC West. In time, a wider partnership across the west will be formally established, ensuring even closer collaborative working across BHP, CLAHRC West, LCRN and the WEAHSN.

**Research Capability Funding (RCF)** is a quality-driven funding stream allocated annually by the NIHR to all research-active NHS trusts that allows for local discretion and management of people to support and develop patient and people driven research. It is allocated in proportion to the total amount of other NIHR income received by that organisation, and on the number of NIHR Senior Investigators associated with the organisation.

**Research Design Service (RDS)** is part of the National Health for Research (NIHR). The RDS exists to provide help for people preparing research proposals for submission to open, national, peer reviewed funding competitions for applied health or social care research.

**Translational and Applied Health Services Research** leads to benefits in the care provided for patients and encompasses a range of activities that include research going: (a) from bench to bedside, where theories emerging from pre-clinical experimentation are tested on
patients – first in small-scale studies and then through formal research evaluations in large numbers of patients, covering acceptability, clinical effectiveness and cost-effectiveness, and (b) from clinical efficacy to health improvements, whereby a better understanding and then evaluation of health services results in an improvement in outcomes.

**Trust Research Staff or “Researchers”** are used throughout this document to encompass all clinical researchers and includes the following professional groups: Medical, Nursing, Midwifery, AHPs, Clinical Scientists and Pharmacists.
## Appendices

### Appendix 1: SWOT analysis

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<th>Strengths</th>
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<tr>
<td>• Centrally managed flexible responsive workforce - ability to cover changes in research focus, funding fluctuations and staffing. Provides varied expertise, sustainable band mix and quality</td>
<td>• Increased number of clinical academics at NBT - increased grant application submissions and income</td>
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<td>• Representation on national groups – early information, early action, ability to direct change/decisions, cross organisation working, good reputation</td>
<td>• Attract and retain high quality clinical staff to NBT – offering opportunities to deliver complex research at the cutting edge of medicine, research explicit in adverts and JDs, strategic research funding for key new appointments</td>
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<td>• Purpose made facilities – clinical research centre, improved reputation, better for patients</td>
<td>• Influence over national and regional decisions – proactive approach to changes, protection and improvement of NBT position</td>
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<td>• High level of patient involvement and engagement – we are delivering what the local community think is important</td>
<td>• Focus research on clinical strengths in NBT and network – follow disease incidence, match research to clinical strategies, more cross organisation working, build strength and reputation</td>
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<td>• High success rate for grant applications – higher than the national funding rate, improved reputation, increased funding, ability to deliver research aligned to local priorities</td>
<td>• Investors in people – increased staff engagement, improved reputation, more attractive to staff, improved training and development, publicity is key</td>
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<td>• Strong performance in commercial research – provides income and overheads to increase research capacity and capability.</td>
<td>• Trend towards personalised medicine research – increase in patient access to novel therapies, Genomics medicine centre projects</td>
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<td>• Non-NHS service providers – work with private hospitals and social enterprises to recruit patients</td>
<td>• Clinical Research Centre – opportunity for increased out of hours commercial consultancy use</td>
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<td>• Engagement: interaction with clinical management and wider organisation, research in clinical business plans, R&amp;I plans aligned with wider strategy</td>
<td>• Health research Authority (HRA) service changes – increased capacity to set up research, better target setting improving performance</td>
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<td>• Large programme of staff development/engagement – investors in people award focussing on development of people, shared values, vision and goals, wider engagement around decisions, performance management/metrics and senior staff appointments, soft side of team management</td>
<td>• Strong performance in commercial research – Increasing this activity directly increases</td>
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<td>• Increase health services research – focus on clinical need, pathway redesign, link to evaluation, impact and service improvement</td>
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<td>• Research engagement - management and clinicians, focus on important outcomes, everyone works together, stakeholder decision making which includes patients</td>
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<th>Weaknesses</th>
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<td>• Clinically research is still not considered ‘core’ business in many areas – majority of clinical areas do not fully integrate research with standard clinical care, research is sometimes seen as “someone else’s job”</td>
<td>• Huge pressure on clinical teams and financial position of NBT - limits ability to maintain and expand research, risk of decreased activity and income, risk of not meeting national research priorities and performance metrics</td>
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<tr>
<td>• Difficult to measure service impact – hard to capture impacts that have direct relevance to service managers</td>
<td>• Attitude that research is not core business - limits ability to expand and increase research, limits patients ability to be involved and access innovative treatment options, potential for conflict over resources, risk of not meeting national research priorities and performance metrics</td>
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<tr>
<td>• Low Visibility: - can be difficult to interact with clinical directorates at a management level and on the ground</td>
<td>• Core clinical staffing, facilities and resource pressures – essential for research delivery, investment and engagement are required to maintain research activity and income.</td>
</tr>
<tr>
<td>• Research portfolio is matched to clinician interest – not always aligned with clinical priorities or disease incidence, service delivery research is limited at NBT</td>
<td>• Funding provided to deliver research is not recognised on the ground – research seen as unfunded activity and is not prioritised</td>
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<td>• Regional working - Work closely with some partner organisations but not enough effective cross working across the whole partnership</td>
<td>• Implementation - Need better ways to link research to translation/impact, otherwise research may become an expensive way to achieve little of relevance to patient care</td>
</tr>
<tr>
<td>• Priorities – conflicting stakeholder priorities, funding restricts direction, too great a focus on metrics</td>
<td></td>
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</tbody>
</table>
## Appendix 2: PESTLE analysis

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>ISSUES</th>
</tr>
</thead>
</table>
| **POLITICAL**  | • NHS Operating Framework – commitment to double the number of patients recruited into trials  
• Government/DH driven performance management – frequent changes  
• HRA -impact of new guidance and process  
• CRN new systems and processes  
• CCG decision making – pathway moves, remove/add treatments  
• NHS England – guidelines on commissioning and research, Excess Treatment Costs  
• NBT decisions - service changes, service transfers, staffing models/policies  
• Changing national health priorities  
• Patient choice                                                                                                                                 |
| **ECONOMIC**   | • DH, NHSE, CRN and LCRN –annual change in finance model, central top slice, penalties  
• LCRN – varied funding model, activity driven allocation  
• CCG – ETC and treatment funding changes  
• NHS national funding cuts and savings  
• NBT funding cuts and savings, financial position, service changes, spend policies                                                                                                                                 |
| **SOCIAL**     | • Patient interest and perception of research  
• Patient input to designing services and research  
• Perception of NBT –CQC, finance position, press,  
• Staff perception of research  
• Developing litigation culture  
• A more health literate public driving demands and concerns about healthcare and research  
• Ageing population and consequent demands upon healthcare providers  
• Significantly changing local demographic notably in context of ethnicity profile  
• Diverse deprivation profile and resulting impacts on health of local population                                                                                                                                 |
| **TECHNOLOGICAL** | • Advancements in technology leading to new practice and improved life expectancy  
• Pharmaceutical progress and reliance upon NHS for adoption and spread  
• IM&T System development and requirements  
• Linkage of data from a variety of routine sources (e.g. HES, primary care, etc)                                                                                                                                 |
| **LEGAL**      | • EU clinical trials regulations – Impact of Brexit  
• Legal framework for regulation of clinical trials of investigational medicinal products – creates a large burden and slows the productivity of research  
• Very significant increase in litigation claims across NHS                                                                                                                                 |
| **ENVIRONMENTAL** | • Centre of excellence for health care in the South West region in a number of fields as well as one of the largest hospital trusts in the UK  
• Research is one of NBT’s strategic themes  
• New state of the art hospital and research facilities, Pathology & Genetics Laboratory in one place  
• Dedicated Clinical Research Centre  
• Close links with our universities and support undergraduate and postgraduate education and work placements across many professions.  |
Appendix 1: Engagement plan

BACKGROUND

The current North Bristol NHS Trust (NBT) Research Strategy expires at the end of 2016. The new strategy will set out the vision for research at North Bristol NHS Trust and will feed into the NBT five year strategy 2016-2021 that is also under review. To ensure that we develop an underpinning research strategy that cements NBT at the forefront of UK research, R&I sought ideas from the Trust’s research community and external stakeholders to help shape what research should look like over the next five years.

ENGAGEMENT PLAN

<table>
<thead>
<tr>
<th>Audience</th>
<th>Plan</th>
<th>Supporting channels</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ R&amp;I Department</td>
<td>1) Workshops, survey, electronic/paper response slips, website and drop in sessions to</td>
<td>NBT Message of Day</td>
<td>R&amp;I Senior management team, supported by Sharon Nolan (Communications)</td>
</tr>
<tr>
<td>▪ all NBT staff (message of the day and bulletin)</td>
<td>identify key themes, ideas, future focus and risks</td>
<td>NBT bulletin</td>
<td></td>
</tr>
<tr>
<td>▪ NBT Clinical Directors and General managers</td>
<td>2) First Draft : Wide Consultation</td>
<td>R&amp;I bulletin</td>
<td></td>
</tr>
<tr>
<td>▪ all NBT research active staff</td>
<td>To gain views and feedback of our draft strategy</td>
<td>R&amp;I Managers Checklist</td>
<td></td>
</tr>
<tr>
<td>▪ all external researchers conducting research at NBT</td>
<td>3) Detailed discussion of first draft at NBT Research &amp; Innovation Group</td>
<td>Blanket email</td>
<td></td>
</tr>
<tr>
<td>▪ internal and external staff/people on our “interested in research”</td>
<td>4) Final draft : Internal review</td>
<td>All R&amp;I infrastructure mtgs</td>
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</tr>
<tr>
<td>contact list</td>
<td>Approval from Research and innovation for draft to go to formal consultation</td>
<td>Bristol Health Partners website</td>
<td></td>
</tr>
<tr>
<td>▪ West of England LCRN and all partner organisations</td>
<td>5) Final Draft: formal consultation</td>
<td>People In Health Website and Newsflash</td>
<td></td>
</tr>
<tr>
<td>▪ University of Bristol and UWE</td>
<td>To gain final internal and external feedback (details in Appendix 2)</td>
<td>LCRN Newsletter</td>
<td></td>
</tr>
<tr>
<td>▪ Patient Panel</td>
<td></td>
<td>Survey Monkey</td>
<td></td>
</tr>
<tr>
<td>▪ Wider patients and public through People in Health West and Bristol</td>
<td></td>
<td>Reply boxes</td>
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<tr>
<td>Health partners</td>
<td></td>
<td>Drop-in Sessions</td>
<td></td>
</tr>
<tr>
<td>▪ Research Innovation Group</td>
<td></td>
<td>Strategy Roadshow</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Overview of final consultation responses

CLINICAL ACADEMICS, INTERNAL & EXTERNAL RESEARCH STAKEHOLDERS

Firstly, I think it’s important that you mention explicitly in the document who your major research partners are. Remember that this document may end up in quite wide circulation and it will be useful not only for the Trust but for those partners. Specifically, I would refer to the University of Bristol and the University of West of England. In addition, I would mention funders. Particularly the NIHR, but you could also mention the MRC. I though the visions, mission and research background statements were all excellent and if anything, would be inclined to bring the statement on the evidence of trust performance being enhanced in the presence of research activity to the fore, perhaps by having it as the first sentence.

I think it is important that the research strategy acknowledges the value of core funded institutions (often jointly run with universities) including the BRC, IEU and the CLAHRC. Again, the reason for mentioning these is that they are both important and, particularly with NIHR funding, this document may well reach the desks of key individuals who would expect to see these investments recognised.

Overall, and to my mind appropriately, the meat of NBTs research strategy relates to empowering and capacity building. I would agree with you that these are important; our staff are highly effective at identifying cogent research questions and challenges in a manner that organise actions are poor at doing. Similarly, developments in patient care are usually and vitally developed by those close to the activity as opposed to at an institutional level. I wonder whether at an early stage in the document there needs to be an explicit statement that the emphasis in empowerment and capacity building is to allow this kind of research leadership to flourish and to develop a workforce who are equipped to bring in funding to deliver the R&D mission. Particularly from external funding agencies such as those mentioned earlier.

Secondly, and I state this as DoH appointed Chair of the NIHR research careers oversight committee. NIHR are currently reviewing their research
careers support and structure. I think a few sentences on explicit support for medics, AHP’s and in particular nurses and midwives to develop their careers would be valuable. It sends the right signal to the relevant constituencies. Additionally, and assuming that this document will reach desks of NIHR staff, it is an important signal to give out.

Finally, I would suggest some form of linkage between objective 4.1 and objective 4.3. Across our respective organisations and UWE there are enormous areas of strength and we will all benefit from aligning our research themes. None of us have the luxury of being able to be all things to all people.

I hope all of this helps. I do think that it reads well and has significant clarity to it.

Final thought. We do intermittently discuss new models of care and I wonder whether you might actually have a final sentence stating that a function of NBTs research strategy will be to horizon scan with partners to identify the research necessary to develop new models of care and enhancing activities to trial novel drugs, treatment, devices and mechanism of patients monitoring to offer our patients the most up to date care available.

I think this looks great. One thing that occurs is that much of our research in dementia will focus on presymptomatic treatment in people who appear healthy – I understand there are analogies in other disease states. I know there has been some resistance in the past to consider studies in “healthy” participants at risk of a condition – or at least it has been debated. It might be nice to have a point that would suggest a priority for timely intervention when good quality of life can be retained. To my mind this is encompassed in the primary goal to ensure “excellent clinical outcomes”, but I wondered if there was any scope to emphasise it more explicitly.

I wondered if there should be a little more focus on some specific areas? I know we would not want to exclude any areas or patients - but the fact is that we are not going to compete (say) with the Bristol Heart Institute at UHB for cardiac research. There are various other areas where we just to not seek to be pre-eminent. But there are areas that we are known for,
not just nationally but internationally, and I think the document should reflect this, shouldn't it? Orthopaedics is an obvious area, and there is the BUI also - and (obviously!) the Brain Centre and the neurosciences. There are probably others.

When each of these is striving to be successful - and in many cases achieving this, shouldn't we stress that success? Put the other way round, wouldn't it appear slightly unappreciative of these groups' efforts for them not even to be mentioned?

Realise this is a strategy document and not operational policy but as clearly indicated in your SWOT analysis, key challenges to translating this vision into reality are recognition/value/resourcing of research for the interested coal face clinician + DMTs to ring fence resource to enable research.

In my view, the current R&I practice of dealing with money linked to research PAs and ETC does not align with this draft strategy / is not fit for purpose given the current reality of NHS/research funding. Current practice is too opaque and does not allow either the clinician or the DMT to prioritise & value research. There needs to be a debate on how R&I receives and then dispenses funds so there is much more transparency on money flows associated with research PAs and ETC. Other trusts who are successful in attracting grants have different ways of doing things – so there are other ways to skin this cat and it would be great if we did not lose the opportunity to update practice in light of a different NHS/research climate. Without this re-think, I think we will struggle to deliver on the very appropriate & laudable visions of the strategy.

The strategy looks great and is to be commended as it is written in plain English and appears actually achievable, which is not to be underestimated in documents such as this. I think it is very relevant for NBT and motivational to achieve an improved research culture here.

Given my current circumstance I am glad to see the objective to “Develop career pathways for research staff”. I think this is absolutely key as there is definitely a ceiling in NBT at the moment. I admit this is probably predominantly from the academic perspective but brief discussions have highlighted that there are also few, if any, nurse consultants within the

| Renal |
| Realise this is a strategy document and not operational policy but as clearly indicated in your SWOT analysis, key challenges to translating this vision into reality are recognition/value/resourcing of research for the interested coal face clinician + DMTs to ring fence resource to enable research. |

| Urology (UoB) |
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| Urology (UoB) |
| Given my current circumstance I am glad to see the objective to “Develop career pathways for research staff”. I think this is absolutely key as there is definitely a ceiling in NBT at the moment. I admit this is probably predominantly from the academic perspective but brief discussions have highlighted that there are also few, if any, nurse consultants within the |
trust, which could fit very well with research. With appropriate pathways, we could enable the retention of highly skilled researchers with vast experience who are well placed to drive more and more high calibre research within NBT that is directly of benefit to patients and the trust.

It just seems that such a great vision for the trust is in danger of being unachievable if everything we put into making this future happen flows out at the top end as NBT can’t retain them with an appropriate career structure.

**EXTERNAL : Feedback on Public Facing ‘Strategy at a glance’**

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have read the 4 pages and agree that they are the ones to include but I do question some of the language/words used on page 12. I envisage some folk switching off completely and thinking &quot;what are they trying to say&quot;</td>
<td>Public member</td>
</tr>
<tr>
<td>I think NBT needs to make much more prominent in this document that it has a close working relationship particularly with UWE and Bristol University – and it may be that some of the goals of the policy ought to include ways to strengthen these bilateral ties, rather than just appearing to see the collaboration through the prism of WEAHSN, BHP, NIHR, CRN, or CLAHRCWest</td>
<td>Public member</td>
</tr>
<tr>
<td>Yes, it became a little more clear universities were included toward the end of the document, where you fleshed it out that BHP and WEAHSN were collaborations involving the universities, but, if only from a PR point of view, I think NBT needs to make much more prominent in this document that it has a close working relationship particularly with UWE and Bristol University – and it may be that some of the goals of the policy ought to include ways to strengthen these bilateral ties, rather than just appearing to see the collaboration through the prism of WEAHSN, BHP, NIHR, CRN, or CLAHRCWest.</td>
<td>Public member</td>
</tr>
<tr>
<td>I have had a really good look at this and am really impressed and pleased with the content. It seems that you have taken on board my feeling that we need to really sell ourselves to the public and make them aware of the excellent work that you all do.</td>
<td>Public Member</td>
</tr>
<tr>
<td>I agree with your proposal on which pages to include as part, if not all, of the public offering. As part of this I would make it clear that it is supported by a very much more detailed working set of documents to be published on the web site</td>
<td>Public Member</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Re: a public version,</strong> it is correct that pages 3, 4, 5, &amp; 12 are particularly clear, crisp and well-worded. I think it would be good if any public version contained a link to the more detailed version, so that members of the public were able to delve deeper, if they wanted. That way, you avoid the accusation or actuality that you are dumbing down for the public.</td>
<td>Public Member</td>
</tr>
</tbody>
</table>
### Report to:
The Trust Board

### Agenda item:
15

### Date of Meeting:
27 July 2017

### Report Title:
Update on Renal Dialysis Services at RUH, Bath

### Status:
<table>
<thead>
<tr>
<th>Information</th>
<th>Discussion</th>
<th>Assurance</th>
<th>Approval</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

### Prepared by:
- Tricia Down
- Jo Anyon

### Executive Sponsor (presenting):
Simon Wood, Director of Facilities

### Appendices (list if applicable):
None

### Recommendation:
The Trust Board is asked to:
- Note that the preferred option of the AWP building at Hillview Lodge is the only option that will deliver in time and in budget.
- Agree that the Trust’s team can progress with agreeing heads of terms with AWP for use of the facility.
1. Purpose

1.1. This report provides an update to the Trust Board regarding the issue of the Trust being asked to vacate the existing renal dialysis unit at the RUH to allow them to redevelop the area.

2. Background

2.1. The Bath Renal Satellite Unit (BRSU) is a 16 station unit, located on the Royal United Hospital (RUH) site and in use since 1995. It is currently located in a 1940s building in the middle of the site that has been designated for demolition in May 2019 in order to make way for a new Cancer Centre. The service is owned and run by North Bristol NHS Trust (NBT).

2.2. Due to its location, NBT was asked to vacate the renal dialysis premises at the RUH. The Outline Business Case was approved by the Trust Board in June 2016.

2.3. Discussions were initially productive with the offer of a new location on which to build the replacement facilities but with high charges for use of the space (including compensating for the loss of public parking income). In addition, the RUH was not prepared to assist with any capital to support the relocation. Over time, the RUH withdrew its offer of land and advised the Trust that it must vacate by August 2018. This timescale has changed on numerous occasions with the latest date being advised as May 2019.

2.4. When the potential opportunity to use RUH land fell away, the NBT project team embarked on a process of identifying other land in the appropriate catchment area through the use of an agent. The National Renal Association sets out guidelines recommending that patients do not have to travel more than 25 miles, or 30 minutes to their appointments. The BRSU currently has 72 patients from within this area receiving treatment there, and another 15 who are having to travel to other units for dialysis due to lack of capacity in the BRSU. This was used as a basis for the land search although areas outside this catchment were also investigated.

3. Renal – site search

3.1. The brief for the property agents was to seek land/property to develop/refurbish on a site, within the Bath area and a 5 mile radius. 2 surveys were completed in 2014 and 2017. All options were considered including office/Industrial refurbs, greenfield/brownfield new build sites and freehold/long leasehold/leasehold opportunities.

3.2. In the 2017 search, 3 locations were identified that met the search criteria plus the RUH car park site that had initially been identified. All options received a technical appraisal. An option appraisal identified
a preferred location which would also be potentially lower cost and shortest programme time. This was the leasing to NBT of part of an Avon & Wiltshire Mental Health Partnership (AWP) property located on the RUH site called Hillview Lodge. This building was considered suitable for refurbishment and could adequately accommodate the clinical service requirements.

3.3. Hillview Lodge also offered advantages it terms of obviating the need for a consultation to take place on the relocation of the service away from the RUH which would have implications for patients as well as the Trust’s ability to meet the RUH timescales for site vacation.

3.4. An assessment of the land and property options which was undertaken with the renal clinical team is available on request.

3.5. Discussions with AWP have been held regarding the use of part of their building and we now have confirmation that they will lease part of the building to us. The proposal supports AWP’s better use of estate (Lord Carter etc), the need for AWP to retain Hillview Lodge for some of their services and supports NBT and RUH programme and cost goals. The experience and pathway for renal patients will not need to change and the RUH has confirmed that it will continue to allow NBT to use the current number of car parking spaces for drop off and patient parking.

3.6. Now that the Trust has confirmation from AWP, a revised business case will be developed and presented to the NBT Trust Board for approval. Following positive feedback from AWP, the Trust has re-engaged the design team to start the design development process for the refurbishment of Hillview Lodge. High level cost proposals from AWP have been reviewed and are well within the envelope currently paid to the RUH.

3.7. The Trust is now required to enter into Heads of Terms with AWP and agree the service payments to be made.

4. Commissioner Engagement

4.1. The satellite dialysis service is specialist service, commissioned by NHS England (NHSE). Engagement with NHSE started in March 2017 and they have attended subsequent project team meetings.

4.2. They have been receptive to the issues that NBT are facing and have discussed ways that they could support NBT. They have acknowledged that NBT could give notice on the service which would mean that NHSE have to find a new provider. They also understand that if the service were to move off the RUH site, this could involve a public consultation.
5. Project Plan

5.1. As the preferred option of Hillview Lodge involves a refurbishment of an existing building, the previous design for a new build is not suitable. Therefore the programme has been reissued starting from the initial design development.

5.2. The indicative timescales for a refurbishment are significantly shorter than that for a new build and are shown below.

<table>
<thead>
<tr>
<th>Action</th>
<th>Start</th>
<th>Finish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline design development</td>
<td>26/07/17</td>
<td>06/10/17</td>
</tr>
<tr>
<td>OBC submitted to Trust Board</td>
<td></td>
<td>30/11/17</td>
</tr>
<tr>
<td>Detailed design development</td>
<td>07/12/17</td>
<td>07/03/18</td>
</tr>
<tr>
<td>Planning process</td>
<td>04/01/18</td>
<td>28/03/18</td>
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<td>Tender process</td>
<td>08/03/18</td>
<td>02/05/18</td>
</tr>
<tr>
<td>FBC submitted to Trust Board</td>
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<td>End of May 2018</td>
</tr>
<tr>
<td>Contract awarded</td>
<td></td>
<td>Beginning of June 2018</td>
</tr>
<tr>
<td>Construction period and handover</td>
<td>07/06/19</td>
<td>12/02/19</td>
</tr>
<tr>
<td>Commissioning and occupation</td>
<td>13/02/19</td>
<td>13/03/19</td>
</tr>
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</table>

6. Summary

- The Bath Renal Satellite Unit on the RUH site has been asked to vacate their current building by May 2019
- The original offer of a carpark by the RUH as a site for the relocation of the service has now been withdrawn.
- A property search identified Hillview Lodge, an AWP property on the RUH site as a potential location for the service
- This is the preferred option, as it is the only option that will meet the RUH timescales, and fulfil the National Standards for travel time for dialysis patients.
- The new programme for the preferred option for Hillview Lodge shows completion and occupation by BRSU in March 2019.

7. Recommendations

7.1. The Board is asked to:

- Note that the preferred option of the AWP building at Hillview Lodge is the only option that will deliver in time and in budget
• Agree that the Trust’s team can progress with agreeing heads of terms with AWP for use of the facility.
## Report to:
Trust Board

## Agenda item:
16

## Date of Meeting:
27 July 2017

### Report Title:
Capital Planning Update

### Status:
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<th></th>
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### Prepared by:
Martin Warren, Estate Development Manager

### Executive Sponsor (presenting):
Simon Wood, Director of Facilities

### Appendices (list if applicable):
Capital Planning Report

### Recommendation:
The Trust Board is asked to note the position on each principal issue and the actions being taken to address them

### Executive Summary:
See following report.
1. Purpose & background

1.1 The attached report updates on progress and issues in relation to matters being managed by the Sustainable Health & Capital Planning Team.

2. PFI Phase 1

2.1 The key risks and challenges are set out on the attached report under Phase 1 Compliance Issues which are reviewed and managed at regular meetings with Carillion and THC.

3. PFI Construction Works

3.1 Some of the Phase 2 defects in relation to the MSCP are still stalled. A further meeting was held this month with THC and Carillion to try and engender some commitment to make progress.

3.2 The demolition programme has been delayed due to delays in the removal of asbestos in Limewalk Sherston and Brecon buildings but the current asbestos removal is on programme.

3.3 Completion of the PFI construction works are consequently delayed to May 2018 and final tree planting in November 2018.

4. Capital Projects

4.1 The greatest challenge within these projects is all the work to decide how best to deal with all occupants of Monks Park House and establishing when the building can be emptied.

5. Recommendations

5.1 The Trust Board is asked to note the current position and actions.
**Capital Planning Report**

19 July 2017

**Capital Projects**

- **Thornbury & Frenchay Lands including HSCC development:** Sirona have appointed architects to undertake planning for both sites. It is anticipated that Planning Approval could be achieved by late Autumn. The Trust has commissioned open market valuations of the sites.

- **Bath Renal Satellite Unit:** Property search complete and preferred option identified. Negotiations with relevant stakeholders continue, as well as engagement with NHSE.

- **Monks Park House:** Work continues to evaluate the practicalities of clearing the building and the timescales involved.

- **Brunel Gate 24:** Works to increase minor ops capacity. Work progressing to reduce programme. User group design groups set up to review design.

- **Brunel ICU garden:** Variation Enquiry issued and costs to produce design received.

- **Beaufort House:** Landscaping works are progressing. There has been some delay relating to the roof tiles but this is resolved. The north wall has cleaned up well and works are due to complete in August.

- **Frenchay:** Works to provide new drainage to Beckspool Building at Frenchay has been included within this programme and is back from tender. The tenders have been reviewed and a programme and design developed to enable existing infrastructure and the Beckspool Building to function during the works. This will also permit Redrow to connect their drainage in the area to the same system. These additional works will now be recosted by the bidders and following review a contract placed with the successful contractor.

- **Frenchay Public Open Space:** Registration as Village Green has been completed and Transfer to Winterbourne Parish Council is being progressed but is dependent on the completion of the S106 works by the developer due by end November.

- **Frenchay Park House Completion delayed pending resolution with SGC of inconsistency between latest stable block planning consent and S106 agreement. Completion in August is the aim.**

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**Estate Capital Replacement Programme**

**Overall programme:** There are 17 schemes prioritised for 2017/18. The majority of the schemes are of relatively low value, apart from the water safety and associated works in the Women’s sector.

**Phases 2 & 3 of the Water Safety works in Women’s Sector** progresses and the decant of Quantock Ward and the DAU were carried out and work in those areas is nearing completion. The adjoining corridor, which is an essential through route, is kept available although there is an amount of pipe work which has to pass through this area. These areas will be re-occupied after deep cleaning and works in Percy Phillips commence at the start of August. Costs have been approved to carry out extensive improvement works in the ward at the same time as the water pipework is changed. There is close collaboration between Women’s Health Management, the Project Team and contractor.

**Central Delivery Suite:** Improvement works to upgrade areas such as the kitchen, sluices, bathrooms and other areas. The planning for this has commenced so that it can be progressed when the main water safety works are complete to minimise disruption to Women’s Health at a manageable level. Another area of work is in connection with improvements to the air conditioning systems in the individual birthing rooms in CDS. It has been decided that the work required is too extensive to be fully implemented in the current programme. We plan to undertake design this year and undertake the works along with other improvements to the rooms at the same time next year.

**Elgar House:** This scheme plans to replace the water storage tanks this year.

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**PFI Construction Works Progress**

**Brunel MSCP:** The Trust is still waiting for costs and agreement on works to make the layout and operation of the car park more efficient.

**Limewalk, Sherston & Brecon buildings:** asbestos remedial delays. The removal works in Brecon are complete. All remaining works should complete in early August.

**PFI Completion** The effect of the asbestos removal delay has already pushed the completion of the PFI construction works to May 2018 and the tree planting until November 2018.

**Condition of Grounds and Gardens:** The quality of the planted areas is still being addressed by CSL & CCL. Several remediation strategies have commenced. BDP have also been commissioned to review the specification of some areas and the relevant maintenance strategies.

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**Top task types to Carillion helpdesk June 2017**

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<thead>
<tr>
<th>Issue</th>
<th>Next Action</th>
<th>Action Required</th>
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</thead>
<tbody>
<tr>
<td>Nurse Call</td>
<td>CCL</td>
<td>NBT has received the Exova Report and meeting held with all Parties. Carillion to finalise action plan to close out Exova recommendations</td>
<td>G</td>
</tr>
<tr>
<td>Sink-R&amp;M</td>
<td>CCL</td>
<td>Increase the ventilation rates in the sterile preparation room: Risks reviewed and highlighted on risk register. Review Aug-17</td>
<td>A</td>
</tr>
<tr>
<td>Powered Doors-R&amp;M</td>
<td>CSL</td>
<td>Carillion have developed process to integrate with Helpdesk. Op Protocol for SP21 being finalised. Aiming for Aug-17 launch.</td>
<td>A</td>
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<tr>
<td>AGV R&amp;M</td>
<td>CSL</td>
<td>ICU works completion due Nov 17. Remaining 4 bed bays being planned with Ops.</td>
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<tr>
<td>Fittings-R&amp;M</td>
<td>CSL</td>
<td>Schedule of roles and responsibilities and frequencies have been agreed. Planning and timescales are currently being prepared. Aiming for end of Sept-17</td>
<td>A</td>
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<tr>
<td>Lighting-R&amp;M</td>
<td>CSL</td>
<td>Timescales for completion are Dec-17. The primary focus is PET/CT which is due for completion in July-17. A working group is reviewing the wider impact for upgrade of electrical circuits to accommodate the humidifiers. This will affect other areas aside from Imaging areas and needs to be fully considered. This is a key risk to be managed.</td>
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**Brunel Compliance Issues**

- **Fire Integrity:** NBT has received the Exova Report and meeting held with all Parties. Carillion to finalise action plan to close out Exova recommendations.  
- **Critical Care & Theatre Ventilation:** Increase the ventilation rates in the sterile preparation room: Risks reviewed and highlighted on risk register. Review Aug-17.  
- **SP21 Works arising from Statutory Inspections:** Carillion have developed process to integrate with Helpdesk. Op Protocol for SP21 being finalised. Aiming for Aug-17 launch.  
- **Flexible Duct Replacement:** ICU works completion due Nov 17. Remaining 4 bed bays being planned with Ops.  
- **Window and Atrium Cleaning:** Schedule of roles and responsibilities and frequencies have been agreed. Planning and timescales are currently being prepared. Aiming for end of Sept-17.  
- **Humidification of Imaging areas:** Timescales for completion are Dec-17. The primary focus is PET/CT which is due for completion in July-17. A working group is reviewing the wider impact for upgrade of electrical circuits to accommodate the humidifiers. This will affect other areas aside from Imaging areas and needs to be fully considered. This is a key risk to be managed.

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**Capital Projects**

- **Thornbury & Frenchay Lands including HSCC development:** Sirona have appointed architects to undertake planning for both sites. It is anticipated that Planning Approval could be achieved by late Autumn. The Trust has commissioned open market valuations of the sites.

- **Bath Renal Satellite Unit:** Property search complete and preferred option identified. Negotiations with relevant stakeholders continue, as well as engagement with NHSE.

- **Monks Park House:** Work continues to evaluate the practicalities of clearing the building and the timescales involved.

- **Brunel Gate 24:** works to increase minor ops capacity. Work progressing to reduce programme. User group design groups set up to review design.

- **Brunel ICU garden:** Variation Enquiry issued and costs to produce design received.

- **Beaufort House:** Landscaping works are progressing. There has been some delay relating to the roof tiles but this is resolved. The north wall has cleaned up well and works are due to complete in August.

- **Frenchay:** Works to provide new drainage to Beckspool Building at Frenchay has been included within this programme and is back from tender. The tenders have been reviewed and a programme and design developed to enable existing infrastructure and the Beckspool Building to function during the works. This will also permit Redrow to connect their drainage in the area to the same system. These additional works will now be recosted by the bidders and following review a contract placed with the successful contractor.

- **Frenchay Public Open Space:** Registration as Village Green has been completed and Transfer to Winterbourne Parish Council is being progressed but is dependent on the completion of the S106 works by the developer due by end November.

- **Frenchay Park House:** Completion delayed pending resolution with SGC of inconsistency between latest stable block planning consent and S106 agreement. Completion in August is the aim.
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<th>Report to:</th>
<th>Trust Board</th>
<th>Agenda item:</th>
<th>17</th>
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<tr>
<td>Date of Meeting:</td>
<td>27 July 2017</td>
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<thead>
<tr>
<th>Report Title:</th>
<th>Quality &amp; Risk Management Committee Report</th>
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<tr>
<th>Prepared by:</th>
<th>Nick Stibbs, Corporate Services Manager</th>
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| Executive Sponsor (presenting): | Liz Redfern, Non-Executive Director |

| Appendices (list if applicable): | |

**Recommendation:**

The Trust Board is asked to note the discussions of the Committee meeting held on 20 July 2017.
1. Purpose
   1.1. To present an update from the Committee following its meeting held on 20 July 2017.

2. Background
   2.1. As a formal Committee of the Trust Board, the Committee is required to report after each meeting to highlight the key discussions, risks identified, decision taken and future business. The following report provides this update to the Trust Board.

3. Business Undertaken
   Patient Safety Risk Assessment
   3.1. The Committee received a record of the activity in the Emergency Department (ED) and the hospital overall for the year to date and was joined by the deputy director of nursing, a matron and a ward sister. It was noted that attendances at the ED had increased by over 6%, the numbers of admissions to the hospital had risen by just under 6% and bed occupancy had averaged over 102%.

   3.2. This had led partly to a number of handovers from ambulance staff to ED staff taking longer than 15 minutes and ED performance against the four hour target falling to 81%. The bed occupancy rate meant that on average there were 12 patients overall occupying a fifth bed in a four bed bay of many wards each day. In addition, there was an average of 43 medical patients located on wards outside of their specialty.

   3.3. Bed occupancy was also affected by an increase in delays in patients waiting to leave hospital including those waiting repatriation from specialist services.

   3.4. To ensure continued safety and quality the Committee heard that daily monitoring was undertaken by a senior nurse and operational leadership team and advanced planning was used to try to ensure the right patient was placed in any fifth bed on admission and/or was likely to be discharged the following day. Extra care was taken to keep the four/five bed bays clean and tidy, incident reporting was checked every day and, if necessary, an extra health care assistant could be deployed. Where there were any concerns about safety a senior nurse site manager was called in to assess the situation.

   3.5. As a further action ward staff in surgery were trying to reintroduce enhanced recovery standards and expectations. All risk assessments were done on the basis that the fifth bed was being used on a temporary basis although there was now recognition that this capacity was being continually used.

   3.6. It was noted that there were complaints about the use of the fifth bed but these were normally dealt with by the ward staff and patients appeared to understand that the hospital was under pressure.

   3.7. The Medical Director noted that there were small indications from the collection of data that the
quality of care was being impacted and the executives and management team were considering longer term actions to ameliorate the position.

Risk Management Assurance

3.8. The Committee was joined by the Chairman of the Clinical Risk Committee (CRC) who discussed some of the shortcomings of the present system of review of clinical incidents and the actions that had been taken to date.

3.9. He felt root cause analyses tended to look at the actions of staff rather than the processes used by the Trust and solutions appeared to major on the education and training of staff rather than improving the patient pathway. There was data available that was now being better used by the CRC but there were some consultant staff who continued to maintain their clinical independence in fiercely supporting their individual patients and not looking at the whole service.

3.10. CRC moderated the risks that were brought to it and the system was maturing slowly. There was a tendency for silo working by the different clinical committees that looked at safety and quality data.

3.11. Q&RMC noted that the new divisional management teams had been given templates for their governance structures that included an emphasis on risk management and clinical governance.

3.12. The Committee also received a report outlining progress on the implementation of a new system that brought together recording of incidents, complaints, compliments, claims, inquests, safeguarding and risks. The system was designed to make the input of data easier, allow triangulation of information for the same patient and increase the ease with which incidents could be reported and the timeliness of responses.

Musculo-Skeletal Outcomes

3.13. The Committee was pleased to receive a presentation from Nick Howells, Consultant Orthopaedic Surgeon on the use of data from the PROMS (Patient Reported Outcome Measures). This was a measure that took into account the quality of life after an orthopaedic operation rather than just the clinical outcome and had been in existence for nearly 15 years.

3.14. In addition a National Joint Registry was based at Southmead which monitored in real time the outcomes achieved by brands of prosthesis, hospital and surgeon and highlighted where these fell below an expected performance in order to allow prompt investigation and to support follow-up action.

3.15. PROMS had a formalised process for informing trusts where there were indications that outcomes appeared to be below an expected degree of success but the whole system was a positive process. It was noted that patients tended to ask
about the chances of success of an operation rather that the risk of a poor outcome that PROMS highlighted.

Quality Performance

3.16. The quality section from the June 2017 Integrated Performance Report (IPR) was reviewed. The rate of falls was reducing but it was noted that work was required on reducing pressure ulcers and advice had been taken from Royal United Hospital representatives who had visited Southmead to learn about other quality aspects. The national Model Hospital Dashboard was currently showing a deterioration in the overall performance on harm which the clinical executives were exploring further to understand more fully.

Never Events

3.17. An update on action plans to address identified Never Events and Serious Incidents was discussed and progress noted. There was a particular increase in delayed treatments on which the committee asked for a report at its next meeting

CQC Regime

3.18. A description of the new regime of unannounced inspections by the Care Quality Commission was noted and the actions being taken to achieve a good rating outlined.

3.19. The Committee agreed that whilst good progress had been made in some areas, some risks were still not being managed as effectively as required and better alignment was required between the Committee and the Clinical Risk Committee (CRC). The new chair of the CRC would be invited to a future meeting to align conversations about risk.

Deprivation of Liberty Safeguards

3.20. The Committee received a report of a spot check audit of the Deprivation of Liberty (DoLS) process and implementation. No ward was completely compliant with all aspects of the processes involved. There appeared to be good awareness about patients who lacked mental capacity but the actions required when this had been established were not consistently being followed. An action plan was noted with ongoing monitoring by matrons’ monthly walkrounds. The Committee agreed that a focussed repeat audit should take place and they would receive the outcome in 4 months time.

4. Key Risks Identified and Impact

4.1. In addition to the specific risks covered in the risk management report the Committee noted the risks related to pressures in the hospital and the actions being taken, risks on the implementation of the Datix System and future cyber attacks.
5. **Key Decisions**  
5.1. To receive a further audit on Deprivation of Liberty Safeguards.

6. **Exceptions and Challenges**  
6.1. There were no exceptions or challenges identified.

7. **Governance and Other Business**  
7.1. The deep dive forward plan was discussed and it was agreed to bring forward the review of medical records to the next meeting ahead of the expected inspection by the CQC, have a deep dive on ED safety and patient experience in November and discuss clinical audit in January 2018.

8. **Future Business**  
8.1. The Committee will, at its next meeting:  
   - Review a deep dive on medical records  
   - Review progress to address actions stemming from Never Events particularly regarding delayed treatments

9. **Recommendations**  
9.1. The Trust Board is asked to note the discussions of the Committee meeting held on 20 May 2017.
Report to: Trust Board  
Agenda item: 18

Date of Meeting: 27 July 2017

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<th>Trust Management Team Report</th>
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<tr>
<td>Prepared by:</td>
<td>Eric Sanders, Trust Secretary</td>
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<tr>
<td>Executive Sponsor (presenting):</td>
<td>Andrea Young, Chief Executive</td>
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<tr>
<td>Appendices (list if applicable):</td>
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Recommendation:
The Trust Board is asked to note the content of this report.
1. Purpose
   1.1. To present an update on the business transacted by the Trust Management Team (TMT) at its meeting held on 18 July 2017.

2. Background
   2.1. The Trust Management Team is the key delivery group in the Trust and consists of the Executive Directors, Clinical Directors and Divisional Managers.
   2.2. It is good practice that all Committees which report to the Trust Board should report after each meeting.

3. Business Undertaken
   3.1. The TMT focused its attention on the following areas:
   
   **CQC New Regime**
   3.2. The Management Team received an update on the new CQC inspection regime due to be implemented over the next few months and how divisions were expected to prepare.
   3.3. A framework for divisional self-assessment was shared and discussed, alongside early work to test compliance across service lines. It was noted that getting an accurate service line perspective was more difficult due to the cross divisional nature of the CQC’s definition.
   3.4. The outputs of the self-assessments would be considered by TMT and an executive review panel.

   **Bed Capacity and Length of Stay**
   3.5. Following work considered at previous meetings, options to address the potential shortfall of beds over Winter 2017/18 were discussed.
   3.6. It was noted that a range of options would be required including driving improved length of stay, productivity and efficiency improvements, and sourcing additional bed capacity. It was agreed that a target of achieving 95\% bed occupancy would create sufficient capacity to manage forecast demand. A longer term target of achieving 92\% was also discussed and agreed which would meet national guidance.
   3.7. Divisions were asked to identify the 2-3 key actions to reduce length of stay and release beds within 2 weeks. Further corporate actions would be taken forward to support delivery of the overall occupancy target.

   **Performance Management Framework**
   3.8. A revised performance management framework was presented to align with the strategic direction of the Trust and implementation of Service Line Management.
   3.9. The framework was based on the principle of lighter touch oversight when performance was
within expected levels; with more enhanced scrutiny when performance was off plan.

4. Key Risks Identified and Impact
   4.1. TMT recognised and discussed risks relating to:
   • the delivery of the Trust's cost improvement programme and achievement of income targets
   • potential insufficient bed capacity which would impact on the delivery of planned elective care and to manage the forecast increase in demand over Winter
   • delivery of an improved CQC rating based on current and forecast activity levels

5. Key Decisions

6. Exceptions and Challenges
   6.1. There were no exceptions or challenges.

7. Governance and Other Business
   7.1. The TMT received an update on the BNSSG Sustainability & Transformation Partnership and on the outputs from the last Service Line Management development day held on 13 July 2017.

8. Future Business
   8.1. The TMT will be focusing on the following areas over the next three months:
   • Bed capacity plans
   • Delivery of the business plan and cost improvement targets
   • Reviewing implementation of the new divisional governance model

9. Recommendations
   9.1. The Trust Board is asked to note the update provided on the work of the TMT
Report from West of England Academic Health Science Network Board, 21 June 2017

1. Purpose

This is the fifteenth quarterly report for the Boards of the member organisations of the West of England Academic Health Science Network.

Board papers are posted on our website www.weahsn.net for information.

2. Highlights from Quarter One 2017/18

- Improving Care of People with Atrial Fibrillation in Bristol – results are in from Bristol Clinical Commissioning Groups (CCGs) “Don’t Wait to Anticoagulate” project which included all 47 GP practices; reviewed over 700 patients at risk of stroke and changed or started medication for over 200 people. They have prevented at least six strokes and saved £140,000 in this year alone. Their work will have longer term benefits. This project has benefitted from the learning with Gloucestershire CCG in 2016/17 which has been evaluated by University of the West of England (UWE).

- We held a Clinical Evidence Fellows Showcase morning on 13 June which attracted representatives from all seven CCGs and included presentations from the GP Clinical Evidence Fellows who have sessional contracts with all our CCGs to support the development of evidence informed commissioning. Read the report here: http://www.weahsn.net/wp-content/uploads/Show-me-the-evidence-web-single-pages.pdf

- Diabetes Digital Coach Test Bed: we have recruited 700 people to pilot Apps which will be part of our integrated diabetes self-management platform. We will be recruiting people with diabetes to use the platform from September. To help us answer the question “What if people with diabetes could use a variety tools to help them self-manage their condition and put them more in control of their own care?” Watch the film: https://www.diabetesdigitalcoach.org/latest-news/ddcanimation

- Thought Leadership on Digital – on 22 May we brokered a B&NES, Swindon and Wiltshire Sustainability and Transformation Partnerships (STP) event for senior leaders and subject matter experts to review and challenge their progress on digital with the Corsham Institute. This offer is open to all three STPs.

- Healthcare Innovation Programme – our third “boot camp” for innovators concluded on Friday 19 May. This four day course puts entrepreneurs
(clinical, companies, universities) who have a great idea through intensive business case development and tests their propositions with potential funders, customers and subject specialists.

3. **Annual Report**


“2016/17 in numbers” is attached to this report.

4. **Health Service Journal Patient Safety Awards**

West of England AHSN has won a HSJ Patient Safety award for adoption and spread of the Emergency Department Safety checklist. This is a credit to all our acute Trusts and South West Ambulance Service NHS Foundation Trust (SWAST) who are the members of our ED collaborative. Together we are improving the safety of 140,000 people who attend the Emergency Departments in the West of England each year.

We were also proud to be shortlisted with Gloucestershire Care Services NHS Trust for their work on National Early Warning Scores (NEWS) in Nursing Homes and with SWAST for transforming care by using NEWS as part of their Electronic patient Record.

It was announced by NHS Improvement at Patient Safety Congress that the National Quality Board has decided that the NEWS will be used throughout England. In the West of England we are using NEWS on a pan system basis with all health service commissioners and providers actively involved alongside many partners soon as the GP out of hours providers. We are the only area of England to have systematically adopted NEWS.

**Attachment:** 2016/17 Year in Numbers
The year in numbers 2016-17

95% of people receiving quality improvement support said they have found this valuable

93% of people who received patient safety or support to spread and adopt innovation feel this was valuable

1,203 patients in the West of England have benefited as a result of the Emergency Laparotomy Collaborative in the last year

93,219 people had their NEWScore calculated at triage into one of our emergency departments

4,000 Dosette box referrals have been made through our Medicines Safety Project

554,489 people had their NEWScore recorded by the South Western Ambulance Service on an Electronic Patient Care Record (ePCR)

3,162 staff have received Human Factors training

4,000 Dosette box referrals have been made through our Medicines Safety Project

127 patient safety and quality improvement projects from across the West of England are now on the Life System

142 commissioners attended our evidence and evaluation workshops

52 entrepreneurs in the West of England have been supported to develop new healthcare solutions and services through our Healthcare Innovation Programme (HIP), run in partnership with SETsquared

142 commissioners attended our evidence and evaluation workshops

10 GP Clinical Evidence Fellows are working with all 7 of our CCGs

3,730 people from across our health and care communities have benefited from West of England Academy learning events and programmes

573 entrepreneurs and companies have come to us for business advice at connection events this year

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142 commissioners attended our evidence and evaluation workshops

14 active members from across the West of England healthcare community are in our Chief Clinical Information Officers Network

£13.5 million in funding has been attracted to date into the West of England with our help for the development of innovative healthcare technologies and solutions

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333 primary care staff have completed the SCORE culture survey about their practices

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