University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 28 June 2018

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

NHS
University Hospitals Bristol
NHS Foundation Trust

Board of Directors (in Public)

Meeting to be held in Public on Thursday 28 June 2018, 11.00 – 13.00
Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
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2.	Declarations of interest	Information	Chair	Verbal
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4.	Minutes of the last meeting • **24 May 2018**	Approval	Chair	5
5.	Matters arising and action log	Approval	Chair	19
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7.	Major Incident in Bristol Haematology and Oncology Centre	Assurance	Deputy Chief Executive and Chief Operating Officer	27
8.	Quality and Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer; Chief Nurse; Director of People	32
9.	Quality and Outcomes Committee Chair's report	Assurance	Quality and Outcomes Committee Chair	Click here
10.	Patient Experience Reports: a) Patient Experience Q4 Report - National Maternity Survey Results Patient Complaints reports: b) Patient Complaints Q4 Report c) Annual Report	Assurance	Chief Nurse	77 105 110 150

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16.	Local Clinical Research Network (LCRN) West of England Annual Plan 2018/19 (hosted body report)	Assurance	Acting Medical Director	220
17.	LCRN, National Institute for Health Research Host Agreement Variation to Contract	Assurance	Acting Medical Director	258
18.	LCRN, West of England Annual Report (hosted body report)	Assurance	Acting Medical Director	260
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20.	Any Other Urgent Business		Chair	Verbal
21.	Date and time of next meeting **27July 2018, Conference Room, THQ**		Chair	Verbal

Cover report to the Public Trust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Patient Story**		
Author	Tony Watkin, Patient and Public Involvement Lead		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

<u>Purpose</u>

Patient stories reveal a great deal about the quality of our services, the opportunities we have for learning, and the effectiveness of systems and processes to manage, improve and assure quality.

The purpose of presenting a patient story to Board members is:

- To set a patient-focussed context for the meeting.
- For Board members to understand the impact of the lived experience for this patient and for Board members to reflect on what the experience reveals about our staff, morale and organisational culture, quality of care and the context in which clinicians work.

<u>Key issues to note</u>

In this story we hear from the mother of a young patient who has a unique unbalanced chromosome translocation. The patient is under the care of several consultants at the Children's Hospital and will shortly commence their transition to adult services. The mother's

story will focus on the care of her son and the family's experiences of relationship building with Consultants. The family are active participants in health care improvement and the story will demonstrate how they have engaged positively in a learning space across providers, contributing effectively to service improvement. By way of illustration, the parent is one of a number of individuals who work voluntarily with Sirona care & health providing opportunities for medical students to visit families in their homes. They work as a parent representative with Bristol Parent Carers and the Carers Support Centre. At UH Bristol, they take an active role in the Disabled Children's Working Group at the Children's Hospital and as a participant in our "patients and doctors as partners in learning" initiative which explores the value of relational care through lived experiences – an initiative that was shortlisted as a finalist in the 2018 Health Education England Star Awards. The patient story is set in the context of National Carers Week, 11-17th June.

Recommendations

Members are asked to:

- **Note** the Patient Story

Intended Audience **(please select any which are relevant to this paper)**									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk **(please choose any which are impacted on / relevant to this paper)**			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☒	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment **(please tick any which are impacted on / relevant to this paper)**							
Quality	☐	Equality	☒	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Minutes of the Public Trust Board Meeting

Held on Thursday 24 May 2018, 11:00-13:00, Conference Room, Trust Headquarters

Present

Board Members

Member Name	Job Title/Position
Jeff Farrar	Chair of the Board
David Armstrong	Non-Executive Director
Madhu Bhabuta	Non-Executive Director (Designate)
Mark Callaway	Acting Medical Director
Paula Clarke	Director of Strategy and Transformation
Julian Dennis	Non-Executive Director
Matt Joint	Director of People
Paul Mapson	Director of Finance and Information
Carolyn Mills	Chief Nurse
John Moore	Non-Executive Director
Mark Smith	Chief Operating Officer and Deputy Chief Executive
Martin Sykes	Non-Executive Director
Steve West	Non-Executive Director
Emma Woollett	Vice-Chair and Non-Executive Director
Robert Woolley	Chief Executive

In Attendance

Name	Job Title/Position
Eric Sanders	Trust Secretary
Anna Farthing	Arts Director
Hannah Allen	Assistant Press Officer
Chris Swonnell	Head of Quality (Patient Experience and Clinical Effectiveness) (Items 1-3 only)
Tony Watkin	Patient and Public Involvement Lead (Items 1-3 only)
Sara Kirby	Corporate Governance Administrator (Items 1-3 only)
Kate Wilson	Bristol Post
Emily Polley	Johnson and Johnson
Garry Williams	Patient/Carer Governor
Mo Phillips	Public Governor
John Rose	Public Governor
Clive Hamilton	Member of the Public

Minutes:

Sarah Murch	Membership and Governance Administrator

The Chair opened the Meeting at 11.00

Minute Ref	Item Number	Action
Preliminary Business		
76/05/2018	**1. Welcome and Introductions/Apologies for Absence**	
	The Chair welcomed everyone to the meeting. He introduced Anna Farthing, the Trust's newly-appointed Arts Director. Apologies for absence were received from Non-Executive Directors Guy Orpen and Jill Youds.	
77/05/2018	**2. Declarations of Interest**	
	Members noted that Madhu Bhabuta had taken on a new directorship. The Register of Business Interests would be updated accordingly. There were no further new declarations of interest.	
78/05/2018	**3. Patient Story**	
	The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills. The story, which took the form of a video, was shared with the Board in the context of Deaf Health Awareness Week (14-20 May 2018). In the video, a profoundly deaf patient talked about the difficulties that he had encountered when accessing services at Bristol Community Health, particularly due to the unavailability of interpreters at the time of his appointments, and how this had made him feel. The video highlighted the needs of deaf patients and the potential for partnership working across the system to ensure that information about patient needs was passed on between different organisations. Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness) explained that at UH Bristol, interpreter services were provided by a company called Sign Solutions. Staff were made aware of patient needs through a flag on the Medway patient administration system and should arrange the appropriate support. There was a renewed emphasis on deaf awareness training among staff, and as part of this a new Patient Inclusion and Diversity group had been set up. In the following discussion, the key points were as follows: • It was clarified that UH Bristol's Medway flag did not feed into the regional Connecting Care system and could not therefore be viewed by others within the health system. At present, patients' requirements also therefore needed to be recorded within the GP system and passed to other organisations through onward referral letters. • John Moore, Non-Executive Director, recalled that patient feedback about Sign Solutions several years ago had highlighted some issues, and asked whether improvements had since been made. Chris Swonnell, explained that regular meetings with patient representatives	

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	had enabled the Trust to identify significant improvements to the service, although there were still occasional challenges in satisfying all patients' specific requests. Carolyn Mills added that the Trust's reporting mechanisms enabled the Trust to monitor the reliability of the interpreters and subcontractors. • David Armstrong, Non-Executive Director enquired whether the volume of patients using the service would make it worthwhile for the Trust to employ interpreters in-house. Robert Woolley, Chief Executive, responded that the multiplicity of locations across the Trust at which interpreting services were required at any one time meant these could more effectively be provided through an on-call contract. • In response to a question from Madhu Bhabuta, Non-executive Director (Designate) about whether the use of ipad technology could remove the need for face-to-face interpreters, Chris Swonnell noted that other Trusts were considering this model and that UH Bristol was exploring whether this could be implemented in some areas. • It was noted that UH Bristol was a partner member of the newly formed Bristol Deaf Heath Partnership in which it was working with a range of other healthcare organisations across the region to improve the experience of deaf patients and others with additional needs. In response to a request from Robert Woolley for more information about how patients were systematically involved in designing the approach, Tony Watkin, Patient and Public Involvement Lead, explained their use of feedback from Healthwatch which had held a number of events engaging with the deaf community. • Garry Williams, Patient/Carer Governor, asked the Board to take in to account the needs of more vulnerable patients who attended hospital frequently and found it easier to have the same interpreter each visit. **Members RESOLVED to:** • **Receive** the patient story.	
79/05/18	**4. Minutes of the last meeting**	
	Members agreed one amendment to the minutes of the meeting held on 26 April 2018: Min reference 65/04/18 (Item 11 – Operational Plan 2018/19) Paul Mapson clarified that the 3.5% savings figure reflected divisional savings. The Trust-wide savings target for 2018/19 was actually 5%. **Members RESOLVED to:** • **Receive** the minutes of the meeting held on the 26 April 2018 as a true and accurate record subject to the above amendment.	

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80/05/18	**5. Matters arising and Action Log**	
	Members received and reviewed the action log. Completed actions were noted and updates against outstanding actions were noted as follows: **Min reference** 62/04/18: Quality and Performance Report: *Acting Medical Director Mark Callaway to update Board on progress with establishing an elderly hip ward* Mark Callaway updated the Board that the aim was to establish a wider resource for all 'silver trauma', (trauma care for elderly patients). This was ongoing and a proposal would come to Board in the near future. **Min reference** 65/04/18: Operating Plan 2018/19: *The final financial position, reflecting the £18.5million control total proposed by NHS Improvement, would be reflected in an updated version of the Operational Plan, which would be circulated to the Board by the Director of Finance and Information, for the Board's approval.* This action would be covered under Item 12. **Min reference** 66/04/18: Transforming Care Programme Board Report – Q4: *Director of Strategy and Transformation to revise the Transforming Care Programme Board Report to reflect Board members' input.* This had been completed. **Min reference** 74/04/18: Any Other Urgent Business: *Deputy Chief Executive and Chief Operating Officer Mark Smith to share the figures on Weston patients referred to UH Bristol's A&E with Public Governor John Rose.* Mark Smith reported that in the last 6 months there had been 1,016 patients (an average of 5.6 per night). 83% of those had been conveyed by ambulance, and 58% were admitted, which represented an average of 3.5 patients per night. **Min reference** 44/03/2018: Quality and Performance Report: *The Acting Medical Director Mark Callaway to update the Board on progress to attract candidates to stroke care at UH Bristol.* Mark Callaway informed the Board that a locum and a substantive post had now been advertised, and also an advanced nurse practitioner post. There was a locum consultant in post until the end of June and it was expected that a substantive post would be filled once this ended. **Min reference** *06/01/18: Chief Executive's Report: Update on the Digital Transformation Programme to come to a future Board meeting.* It was noted that this would be received at the June 2018 meeting. **Min reference** 08/01/18: Quality and Performance Report *Acting Medical Director to share the annual report on the genomics project with the Board.*	

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	Mark Callaway informed the Board that while the genomics project did not produce a formal annual report, he had asked for a report on the current status of the project which would be shared with the Board. **Min reference** 30/02/18: Chief Executive's Report: *Trust Secretariat to Incorporate opportunities for visits to the Sexual Assault Referral service into NED visit planning.* The Board noted that the programme of non-executive visits was currently being reviewed. **Members RESOLVED to:** • **Note** the updates against the action log.	
81/05/18	**6. Chief Executive's Report**	
	Chief Executive Robert Woolley discussed highlights from the Senior Leadership Team Report and updated the Board on several further matters which were not covered in the report, including the following: • **Major incident in Bristol Haematology and Oncology Centre (BHOC)**: Robert Woolley noted the Board's thanks and admiration for the staff who had been involved in the evacuation in BHOC following a fire in the building on 10 May. Patient safety had been a clear priority throughout and staff had moved patients to safety very effectively. No harm to date had been caused to any of the patients involved. The response from all staff across the Trust had been extremely impressive in finding space for the patients and giving other support. He also recorded his gratitude to the Trust's partners in the wider health community who had provided immediate support: all ambulances had been diverted for 24 hours and in subsequent days UH Bristol had received a lot of support from other hospitals. While the majority of services were now restored and BHOC was now once again in a position to operate cancer services, there was a lot of work taking place to rebook patients and monitor their treatment. He provided reassurance that support had been offered to those staff affected, and the Trust had kept regulators and media informed throughout. There would now be a full investigation into all aspects of the incident and the findings would be reported back to the Board. • **UH Bristol Strategy:** In the national context of a potential new funding settlement for NHS and the proposal to develop a new 10 year NHS plan, the Trust's renewal of its strategy would be of particular importance to determine how UH Bristol would be positioned over the next five years. The Trust had sought input from staff, external partners and other stakeholders to inform the Trust's draft strategic objectives.	

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	• **Healthy Weston**: The Clinical Commissioning Group was now anticipating that their work on potential new models of care in Weston would be concluded by the autumn. UH Bristol's partnership with Weston Area Health Trust was still working to good effect. A number of service reviews were now taking place which would be reported back to Board in due course. • On behalf of the Board, Robert congratulated Jeanette Jones, a nurse at the Bristol Royal Infirmary, who had received a national award at the Royal College of Nursing's annual Congress for services to members as an RCN representative. Jeanette was the Trust's lead for Living and Working with Disability, Illness or Impairment (LAWDII), and was the Trust lead steward, president and secretary of the RCN Greater Bristol branch and vice chair of the RCN South West Board. • The Care Quality Commission had published a report on lessons learned from winter pressures. Initiatives at the Bristol Royal Infirmary had been used in two of the case studies: a multi-disciplinary user group looking at frequent attenders in the Emergency Department, and the Trust's arrangements for managing ambulance queues. Questions were invited from the Board. Non-Executive Directors praised the Trust for its response to the BHOC fire and emphasised the importance of the Executive Team's support for the staff involved. Mo Phillips, Public Governor, spoke on behalf of the Council of Governors to voice their admiration for the response of all involved and the evident effectiveness of the Trust's emergency planning procedures. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for assurance.	
82/05/18	**7. Major Incident in BHOC**	
	Mark Smith, Deputy Chief Executive and Chief Operating Officer, introduced this report, which was intended to inform the Board about the fire in the Bristol Haematology and Oncology Centre on 10 May 2018. The report included initial details of the fire and provided assurance on immediate actions taken and the proposed next steps. The key points were: • Staff had ensured that all 53 patients in BHOC had been evacuated to a position of safety. All hospitals had been busy at the time, and staff across the Trust had mobilised to find beds, keep track of all patients and their notes, and ensure patients at highest risk were prioritised.	

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	• Most patients had been kept in the Trust's hospitals, with around five taken to other hospitals. • No patients were harmed during the evacuation and work was now ongoing to ensure that services could be safely and quickly returned to normal. It would however take a considerable amount of work over the coming months to recover the Trust's position. He described the response from staff and the wider system as magnificent. Mark Callaway, Acting Medical Director, added his thanks to the Emergency Services who had worked with the Trust during the night and whose clarity had made decision-making easier. The Chair expressed appreciation for the impressive response to the emergency from all concerned. Anna Farthing, Arts Director, offered to assist with ideas for how the event could be commemorated and learning shared through cultural output. Members asked that learning points arising from the investigation be shared with the wider health system regionally and nationally, and this was agreed. **Members RESOLVED to:** • **Receive** the update on the Major Incident in BHOC for assurance.	
Care and Quality		
83/05/18	**8. Quality and Performance Report**	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive presented the Quality and Performance Report, the purpose of which was for the Board to review the Trust's performance on Quality, Workforce and Access standards. He highlighted the following key points: • An improvement in the Trust's April performance indicated that winter pressures were now finally over, but there was recognition that this winter had been a particularly challenging one for staff. • The percentage of Emergency Department patients seen in under 4 hours was 84% in April with a further improvement to date in May. • The percentage of Referral-to-Treatment (RTT) patients waiting under 18 weeks was 88.2% as at end of April. The Trust was embarking upon productivity measures including a cataract improvement workshop. • The 62 Day Cancer standard for GP referrals had achieved the national target. However, the effects of the BHOC fire and recovery would impact next month's performance, and modelling around capacity and demand planning would need to be undertaken. • The percentage of Diagnostic patients waiting under 6 weeks at end of April was 96.8%, which was lower than the national standard, mainly due to delays in cardiac echo and ultrasound and	

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	staffing gaps in echo sonography. • Last Minute Cancelled (LMC) Operations had improved. • Finally, he advised Board members that the format of the Quality and Performance Report was changing and requested feedback on the proposed new report. Carolyn Mills, Chief Nurse, asked the Board to note that there was a gap in the data in relation to sepsis which would be resolved in next month's report. Performance was back on track in relation to the number of outlying bed days. Current priorities included ensuring that complaints were responded to within the timeframe, as this had not been achieved in April despite a lot of work in this area. Matt Joint, Director of People, noted that due to a change in the reporting approach, performance in relation to essential training metrics appeared to be deteriorating, but work was ongoing to improve this. The Trust had improved its position in relation to agency usage due to increased scrutiny on the issue. Sickness absence rates had decreased. Vacancy rates were still slightly above targets, and turnover was high though similar to other comparators at around 14%, and this would remain an area of focus. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance. • Provide feedback on the new format of the Quality and Performance Report.	All Board members
84/05/18	**9. Learning from Deaths Report**	
	Mark Callaway, Acting Medical Director introduced this report, the purpose of which was to report on the first three quarters' learning from deaths processes. All adult in-patient deaths had been reviewed by the mortality screening nurse. The majority of care provided when reviewed had been good, and one death had been identified as potentially avoidable, which was lower than predicted. Madhu Bhabuta, Non-executive Director (Designate) sought clarification on the one avoidable death, and Mark Callaway explained that this had undergone review in line with the serious incident reporting process and as such would have been received by non-executive directors through their Quality and Outcomes Committee. **Members RESOLVED to:** • **Receive** the Learning from Deaths Report for assurance.	

Minute Ref	Item Number	Action
85/05/18	**10. Quality and Outcomes Committee - Chair's Report**	
	Julian Dennis, Chair of the Quality and Outcomes Committee, introduced the report of his Committee's areas of focus in their May meeting: • The Committee had discussed the Trust's improvement trajectories for access standards and had requested greater assurance to be provided on how these were progressing. • The Committee had reviewed dissatisfied complaints data. • The Committee was maintaining its focus on Essential Training targets. • The Committee had received an update on on-hold patients and had been assured that 77 cases of on-hold patients had been reviewed by the Harm Panel, and no harm had been identified to any of those patients. • The revised format for the Quality and Performance Report was discussed and the Committee had agreed that it would be more useful in highlighting trends. • The Committee had also received the Paediatric Mortality Report and Neo-natal Intensive Care Unit Mortality Report for assurance. • Finally, Julian reported his findings from a recent visit to Hey Groves theatres: he had been particularly impressed with the difference in atmosphere from a previous visit several years ago and supported the changes that had been made in this area. David Armstrong, Non-Executive Director, voiced his appreciation for the inclusion of Non-Executives in the work to redesign the Quality and Performance Report. He added that the Committee had requested greater assurance on the impact of certain key vacancies with effect to quality of care and contracted activity, and had discussed turnover at length. Steve West, Non-executive Director, expressed concerns about future workforce planning given that changes in support for nurse training was likely to result in a significant drop in qualified nurses in a few years' time. With the added impact of the exit of the UK from the European Union, the whole health system was likely to struggle with recruitment. There were already examples of university radiography departments closing down due to lack of demand and the Trust would need to take this into account. Jeff Farrar agreed that non-executive directors needed a forum in which they could participate in strategic discussions around workforce, and that this was currently being reviewed. Martin Sykes, Non-executive Director, expressed concern about the two incidences of grade 3 pressure ulcers reported in April and enquired about the investigation procedure. Carolyn Mills, Chief Nurse, outlined the two cases and added that all incidences of pressure ulcers would be	

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	escalated through the serious incident procedure and reported to the Quality and Outcomes Committee. John Moore, Non-executive Director, noted that a greater level of assurance was required in relation to staff turnover, and requested more information on the proportion of UH Bristol staff who were leaving the NHS entirely, the proportion retiring early, and the proportion going to other organisations. This was agreed. **Members RESOLVED** to: • **Receive** the Quality and Outcomes Committee Chair's report • Receive more information on staff turnover from the Director of People	Director of People
Organisational and System Strategy and Transformation		
86/05/18	**11. Embracing Change, Proud to Care – Our 2025 Vision - Strategy**	
	Paula Clarke, Director of Strategy and Transformation, introduced this item, the purpose of which was to update the Board and seek approval for the Trust's draft strategic priorities and objectives. Since the Board's January meeting, in which they had approved the overall approach for the Trust's five-year strategy, analysis had been undertaken and views sought from staff, external stakeholders, governors, Foundation Trust members and members of public. Board members were reminded that the proposals were still in draft format and that on-going engagement and detailed planning within services would continue to refine the priorities and objectives. The aim at this stage was to seek Board agreement to use these to provide a strategic planning framework for the Trust's Divisions. Members welcomed the document, which they felt presented a pragmatic approach to a complex review across many dimensions. They were pleased that meaningful engagement had taken place. They requested that Paula ensure that the strategy was clearly aligned with the operational plan and the Board Assurance Framework. More detail was requested on the investment that would be required to enable the achievement of the strategy. Chief Executive Robert Woolley confirmed that this would form part of the next phase of the development of strategy. **Members RESOLVED to:** • **Approve** the draft strategic priorities and associated objectives.	
87/05/18	**12. Operational Plan 2018/19**	

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	Paula Clarke, Director of Strategy and Transformation, presented the Trust's Operational Plan 2018/19. The Board had discussed the plan previously at their March and April meetings. This was the final version of the plan which had been submitted to NHS Improvement on 30 April and it was being presented to the Board to formally note. **Members RESOLVED to:** • **Receive** the Operational Plan 2018/19 for information.	
Financial Performance		
88/05/18	**13. Finance Report**	
	Paul Mapson, Director of Finance and Information, introduced the Finance Report, the purpose of which was to inform the Board of the financial position of the Trust for April 2018. Paul noted that while Month One results should be treated with caution, there was an indication that the Trust was around £400k adverse to plan. This was due to the loss of funding due to underperformance of the Emergency Department, and Divisional and Corporate overspends particularly in medical pay. Board members also noted that it was likely that the BHOC fire and recovery plan would affect the financial position in subsequent months. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	
89/05/18	**14. Finance Committee Chair's Report**	
	Martin Sykes, Non-executive Director and Chair of the Finance Committee introduced this report. He highlighted the following key points: • The Committee had briefly reviewed the Annual Accounts and were content that they had reflected the position during the year. • The Committee had received an update on the Trust's productivity programme, which had included ideas for where the Trust should be focussing its efforts on efficiencies. The Chair added that the Trust had reported a surplus at the end of the financial year, which was a remarkable achievement. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's Report – Q4 for assurance.	
90/05/18	**15. Treasury Management Policy**	
	Paul Mapson, Director of Finance and Information, introduced the Treasury Management Policy, which the Board were required to annually	

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	approve. The Finance Committee had agreed minor changes to the policy at their meeting on 26 March, primarily to update terminology. **Members RESOLVED to:** • Note that the Treasury Management Policy remained largely unchanged and **approve** the minor changes.	
Governance		
91/05/18	**16. Emergency Preparedness Annual Report**	
	Mark Smith, Chief Operating Officer and Deputy Chief Executive, presented this report, the purpose of which was to provide assurance on the trust's position in relation to emergency preparedness, resilience and response (EPRR) over the past 12 months. Mark highlighted that the Trust's emergency plans were tested regularly through exercises and incorporated learning from other incidents. The Trust had achieved substantial compliance in the NHS England EPRR annual assurance outcomes programme 2017, with a much improved rating from two years ago. In response from an enquiry from John Moore, Non-Executive Director about how new leaders joining the Trust were trained on the internal procedures, Mark explained that all new starters were shown where to find the business continuity plans that were appropriate for their level and profession. It was agreed that in future this annual review should be received first by the Audit Committee as it was a key governance document. **Members RESOLVED to:** • **Receive** the Emergency Preparedness Annual Report for assurance. • Ensure that the Emergency Preparedness Annual Report was reviewed annually through the Audit Committee**.**	Trust Secretary
92/05/18	**17. General Data Protection Regulation Compliance Update**	
	Eric Sanders, Trust Secretary, introduced this item, the purpose of which was to provide assurance around the Trust's compliance under the new General Data Protection Regulation (GDPR) when it came into force on 25 May 2018. The Board was asked to note the key actions taken to ensure compliance: • The Trust had an Interim Data Protection Officer in place and a permanent appointment had been made and would start in September. • Trust policies and processes had been updated. The Trust's Privacy Notice had been updated and was prominent on the Trust's website. Engagement work was ongoing with staff, and a	

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	management guide had been produced. • New Information Governance training was available at basic and enhanced levels, and a new privacy risk assessment process had been implemented. Eric Sanders advised the Board that more work was needed in several areas: to update Subject Access Request processes, to identify all information assets and their owners, and to update all data processing agreements to reflect GDPR. GDPR compliance would also form part of the internal audit programme for the coming year. Julian Dennis, Non-executive Director, enquired whether the development of the Trust's research programme would be affected by GDPR, and was advised that the Trust's Head of Research and Innovation, Diana Benton, had been involved in implementing the Trust's GDPR programme of work and was satisfied with it. **Members RESOLVED to:** • **Receive** the General Data Protection Regulation Compliance Update for Assurance.	
93/05/18	**18. Audit Committee Chair's Report**	
	Members noted that the Audit Committee Chair's Report had not yet been received and would therefore be circulated post-meeting. **Members RESOLVED to:** • **Receive** the report of the Audit Committee post-meeting.	Trust Secretary
94/05/18	**19. Provider Licence Self-certification 2018**	
	Eric Sanders, Trust Secretary, introduced this item, the purpose of which was for the Board to approve the Trust's self-certifications. He explained that NHS foundation trusts were required to self-certify, on an annual basis, whether or not they have: (1) complied with the conditions of the NHS provider licence; (2) the required resources available if providing commissioner requested services; (3) complied with governance requirements; and (4) have provided Governors with the necessary training. The Board was assured that evidence aligned to each element of the provider licence conditions had been considered by the Audit Committee at their meeting on 20 April. **Members RESOLVED to:** • **Approve** the Trust's provider licence self-certifications.	
95/05/18	**20. Terms of Reference for the Quality and Outcomes Committee**	

Minute Ref	Item Number	Action
	Members received the Terms of Reference for the Quality and Outcomes Committee for approval. These had been agreed at the committee's meeting on 23 May subject to a minor amendment. **Members RESOLVED to:** • **Approve** the Terms of Reference for the Quality and Outcomes Committee. • Receive the Annual Business Cycle for the Quality and Outcomes Committee for **information.**	
Items for Information		
96/05/18	**21. Governors' Log of Communications**	
	• This item was received for **information**.	
Concluding Business		
97/05/18	**22. Any Other Urgent Business**	
	The Chair, Jeff Farrar, asked the Board to note that this was the last meeting for Emma Woollett, Vice-Chair, whose final term of office was due to end on 31 May. He thanked Emma for her enormous contribution to the Trust in the roles of Non-executive Director, Vice-Chair of the Trust, Senior Independent Director and Chair of the Remuneration, Nominations and Appointments Committee. Emma spoke warmly about her time at the Trust, of its ups and downs over the last decade, of her pride in its journey of improvement, and she wished all well for the future. The meeting ended at 12.45pm.	
98/05/18	**23. Date and time of Next Meeting**	
	The date of the next meeting was confirmed as **11.00 – 13.00, 28 June 2018, Conference Room, THQ**	

Chair's Signature: ..... Date: .....

University Hospitals Bristol
NHS Foundation Trust

Public Trust Board of Directors meeting
28 June 2018
Action tracker

Outstanding actions from the meeting held on 24 May 2018					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	85/05/18	**Quality and Outcomes Committee Chair's Report May 2018** A greater level of assurance in relation to staff turnover was requested. The Board would be provided with information on the proportion of staff leaving the NHS entirely, proportion retiring early and the proportion moving on to other organisations.	Director of People	June 2018	**Work in progress** Requested information to be provided to a future Board meeting.
2.	62/04/18	**Quality and Performance Report** Chief Nurse Carolyn Mills to provide an update to the Board on Patient Safety Improvement at the end of the programme in September 2018. Acting Medical Director Mark Callaway to update Board on progress with establishing cohorting of the trauma and orthopaedic ward.	Chief Nurse Acting Medical Director	September 2018 June 2018	**Work in Progress** Update to be provided to the Board in September 2018 **Work in Progress** The Board received an update at the May Board. This was ongoing and a proposal would be provided to a Board meeting in the near future.
3.	08/01/18	**Quality and Performance Report** Acting Medical Director to share the annual report on the genomics project with the Board.	Acting Medical Director	June 2018	**Work in Progress** The Acting Medical Director would circulate the final report to the Board when available.
Closed actions from the meeting held on 24 May 2018					

No.	Minute reference	Detail of action required	Responsible officer	Completion date	Additional comments
1.	65/04/18	**Operating Plan 2018/19** The final financial position, reflecting the £18.5million control total proposed by NHS Improvement, would be reflected in an updated version of the Operational Plan, which would be circulated to the Board by the Director of Finance and Information, for the Board's approval.	Director of Finance and Information and Director of Strategy and Information	May 2018	**Complete** Final Operational Plan circulated for and approved by the Board.
2.	66/04/18	**Transforming Care Programme Board Report – Q4** Director of Strategy and Transformation to revise the Transforming Care Programme Board Report to reflect Board members' input.	Director of Strategy and Transformation	May 2018	**Complete** This was complete.
3.	74/04/18	**Any Other Urgent Business** Deputy Chief Executive and Chief Operating Officer Mark Smith to share the figures on Weston patients referred to UH Bristol's A&E with Public Governor John Rose	Deputy Chief Executive and Chief Operating Officer	May 2018	**Complete** Mark Smith provided the Board with the figured requested. This action was complete.
4.	44/03/18	**Quality and Performance Report** The Acting Medical Director to update the Board on progress to attract candidates to stroke care at UH Bristol.	Acting Medical Director	May 2018	**Complete** Update provided to the Board in May 2018
5.	06/01/2018	**Chief Executive's Report** Update on the Digital Transformation Programme to come to a future Board meeting.	Director of Strategy and Director of Finance and Information	June 2018	**Complete** The Board would receive an Update on the Digital Transformation Programme at a future Board Seminar.
6.	30/02/18	**Chief Executive's Report** Trust Secretariat to incorporate opportunities for	Trust Secretary and	June 2018	**Complete** This action would be

		visits to the Sexual Assault Referral service into NED visit planning.	Deputy Trust Secretary		incorporated into NED visit planning later in the year.

Cover report to the Public Trust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	6
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Chief Executives Report**		
Author	Robert Woolley, Chief Executive		
Executive Lead	Robert Woolley, Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.

Key issues to note

The Board will receive a verbal report on matters of topical importance to the Trust, in addition to the attached report summarising the key business issues considered by the Senior Leadership Team in June 2018.

Recommendations

The Trust Board is recommended to note the key issues addressed by the Senior Leadership

Team in the month and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.

Members are asked to:

- **Note the Report.**

Intended Audience **(please select any which are relevant to this paper)**								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk **(please choose any which are impacted on / relevant to this paper)**			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment **(please tick any which are impacted on / relevant to this paper)**							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications **(please tick any which are impacted on / relevant to this paper)**			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – MAY 2018

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in June 2018

2. QUALITY, PERFORMANCE AND COMPLIANCE

The group **noted** the current position in respect of performance against the NHS Improvement's Oversight Framework.

The group **received** updates on the financial position for 2018/2019.

3. STRATEGY AND BUSINESS PLANNING

The group received an update on marking NHS70 at UH Bristol on 5 July with further activity planned throughout the rest of July and **supported** the plans in place.

The group **received** an update on stage 3 of the Strategic Renewal Programme and the next steps for Divisional teams.

The group **approved** options to expand the bed base in Divisions of Medicine and Surgery to meet the needs of increased demand and to ensure delivery of a robust winter plan for 2018/2019.

4. RISK, FINANCE AND GOVERNANCE

The group **received** an update on the Job Planning Guidance and supported the implementation of the Medical Job Plan Consistency Committee.

The group received and **supported** plans for the implementation of the electronic management of leave and junior doctor rostering.

The group **received** an update on the plain film reporting backlog and supported the actions being taken.

The group **received** a paper outlining the actions and next steps in achieving effective ongoing management and oversight of hosted services at UH Bristol NHS Foundation Trust.

The group **approved** the quarterly complaints and patient experience reports for onward submission to the Quality and Outcomes Committee and Trust Board.

The group **received** the Annual Freedom To Speak Up Report for onward submission to the Trust Board.

The group **received** three Internal Audit Reports with significant assurance in relation to Treasury Management, Payroll and Children's Cardiac Review and one Internal Audit Report with satisfactory assurance in relation to Service Line Reporting.

The group **approved** revised Terms of Reference for the Phase 5 Programme Board.

The group **approved** risk exception reports from Divisions.

Reports from subsidiary management groups were **noted,** including updates on the current position following the transfer of Cellular Pathology to North Bristol NHS and on the Transforming Care Programme.

The group **received** Divisional Management Board minutes for information.

5. RECOMMENDATIONS

The Board is recommended to note the content of this report and to seek further information and assurance as appropriate about those items not covered elsewhere on the Board agenda.

Robert Woolley
Chief Executive
June 2018

Cover report to the Public Trust Board Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	7
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Major Incident in Bristol Haematology and Oncology Centre**		
Author	**Mark Smith, Chief Operating Officer/Deputy Chief Executive**		
Executive Lead	Mark Smith, Chief Operating Officer/Deputy Chief Executive		
Freedom of Information Status		Open	

Strategic Priorities			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

This report provides a summary of the actions taken following the major incident in the Bristol Haematology and Oncology Centre (BHOC) on 10 May 2018.

Key issues to note

A number of actions are underway to investigate the fire, and review the response to the major incident. The Trust is working closely with the Avon Fire and Rescue Service to support their ongoing work. The Trust is also ensuring that patients and staff who have been impacted by the incident are supported and processes are in place to identify whether there has been any harm caused as a result of the incident.

Recommendations

The Board is asked to consider the actions being taken to respond to the major incident.

Members are asked to:

- **Note** the Report.

Intended Audience									
Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☒
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

1. Purpose

1.1. This briefing note is intended to update the board on the issues relating to the fire incident at the Bristol Haematology and Oncology Centre (BHOC). It should be noted that this briefing note is draft since it represents a snapshot in time and will be updated and modified as the results of other reports and lines of enquiry become available.

2. Background

2.1. The Incident affected the BHOC and occurred at 00.55am on the 10 May 2018. The incident was a fire caused by the failure of the low voltage panel (power factor correction unit in the level 1 switch room of the building). The fire was contained within the switch room and destroyed the Low Voltage distribution board. There was extensive smoke "penetration" into the building following the fire.

2.2. As a precaution all other low voltage panels throughout the Trust have been inspected and the Power Factor Correction Units isolated. They will remain isolated until the outcome of further investigations is known.

2.3. Avon Fire and Rescue Services (AFRS) attended the incident and dealt with the fire. A total of 13 appliances were present until the building was fully evacuated. AFRS handed the building back to the Director of Estates and Facilities late afternoon the same day.

2.4. The BHOC provides a range of cancer related services and comprises outpatient services on Levels 1, 2 and 5, support and management services on levels 3, 4 and 8 and Inpatient wards on levels 6 and 7.

2.5. A total of 53 inpatients were in the building at the time of the incident who were safely evacuated to the Bristol Heart Institute (BHI) atrium and then accommodated in other parts of the hospital. No in patients were transferred to offsite locations and there were no reported patient harm incidents due to the immediate evacuation.

2.6. Temporary power was established to 80% of the building via emergency generators later on the same day and this enabled the clean-up operation to commence through a combination of internal staff and external contractors the following day.

2.7. Radiotherapy services resumed on the Linear Accelerators on level 2 extension on the Saturday (2 days after the incident) and outpatient services resumed on Level 5 the following Wednesday (6 days after the incident) with inpatients reoccupying wards on the 21 May 2018.

3. Actions Taken

3.1. Since the incident the following actions have been taken:

BHOC Recovery Board

3.2. The purpose of the BHOC Recovery Board is to oversee the recovery of the physical estate and services following the fire incident on 10 May 2018. It is also overseeing the various project and task groups listed below.

3.3. This group initially met daily but has now reduced that to weekly meetings.

The Investigation

3.4. This will be taken forward as three elements of a single investigation.

A Serious Incident Investigation with agreed Terms of Reference for SI No. 2018/11827:

3.5. Investigation into the management of the major incident called on 10 May 2018 related to a fire in the BHOC

3.6. Lead independent investigator: Sharon Wilson Head of Emergency Preparedness, Resilience and Response NHS England – supported by Simon Steele Resilience Manager UH Bristol

A Serious Incident Investigation with agreed Terms of Reference for SI No. 2018/11827

3.7. Investigation into the management of the BHOC Fire Incident 10 May 2018

3.8. Lead investigator: Andy Headdon – Director of Estates and Facilities

Harm Panel established with the following purpose

3.9. Following the fire at the BHOC the existing harm panel has extended its remit to assess all patients undergoing treatment that was delayed as a result of this event. The harm panel is currently redefining its terms of reference for this group of patients, in line with National Guidance used to assess harm associated with a delay in oncological treatment. A small working party of medical oncologists and radiotherapists has been established to define both the assessment of harm and the most appropriate timeline to review the impact of the individual delays.

BHOC Fire Recovery Project Team

3.10. The purpose of the BHOC Fire Recovery Project Team is to plan and oversee a package of works to ensure the full recovery of the building, services and medical equipment and to meet the requirements of the Trust insurers following the fire incident on 10 May 2018.

Structured Incident Review

3.11. A structured incident review was held on 4 June 2018 to identify good practice and areas for improvement in the response to the evacuation and subsequent major incident. This was facilitated by an external facilitator, Steven Mulvihill Emergency Preparedness Resilience and Response (EPRR) Manager at North Bristol NHS Trust and included representation from all parties to the response. The report is currently being drafted and will be one of the elements that will contribute to the major incident review being conducted by Sharon Wilson, NHS England South West Head of EPRR and Simon Steele, the Trust's Resilience Manager**.**

Staff Debriefs

3.12. There were two debriefs held for staff involved in the evacuation of the BHOC led by two of the Trust's Clinical Psychologists, Jonnie Raynes and Lizzy Banwell. The invite was open to both staff who were working in the BHOC as well as the large number of other members of staff who were involved from across the Trust. The purpose of these was primarily to support staff with facilitated discussion about the events and staffs reaction to them at the time and subsequently. The debriefs were also attended by Simon Steele, Resilience Manager to ensure any lessons identified were captured to feed into the incident reviews. Further support is being coordinated by the Director of People.

AFRS Investigation Response Project Team

3.13. The AFRS Investigation Response Project Team has been established to co-ordinate the Trust response to the investigation being undertaken by Avon Fire and Rescue Service.

3.14. The investigation will be conducted by the AFRS under The Regulatory Reform (Fire Safety) Order 2005, Article 27.

4. Internal Assurance and Governance

4.1. A documentation review has been instigated, to encompass prior inspection reports and internal decision-making around fire prevention since 2009. As part of the assurance process the Trust has commissioned an independent audit through our appointed Authorised Engineer for Fire (company called Capitec) against the 2005 fire regulations, current systems and processes and policies. A report will be presented to the Board.

5. Next Steps

5.1. This recovery process of the BHOC and subsequent investigation and learning from the major incident will need to be effectively managed and coordinated. As the various outputs become available from the investigations updates will be provided to the Audit Committee and Board.

6. Recommendation

6.1. The Board are asked to note the contents of this paper.

Cover report to the Public Trust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	8
Meeting Title	Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Quality and Performance Report**		
Author	James Rabbitts, Head of Performance Reporting Anne Reader, Head of Quality (Patient Safety) Matt Joint, Director of People		
Executive Lead	Overview and Access – Mark Smith, Deputy Chief Executive and Chief Operating Officer Quality – Carolyn Mills, Chief Nurse Workforce – Matt Joint, Director of people		
Freedom of Information Status		Closed	

Strategic Priorities **(please choose any which are impacted on / relevant to this paper)**			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required **(please select any which are relevant to this paper)**							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary
Purpose To review the Trust's performance on Quality, Workforce and Access standards. Key issues to note Please refer to the Executive Summary in the report.

Recommendations
Members are asked to: • **Note** report for Assurance

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26 June 2018		

University Hospitals Bristol NHS
NHS Foundation Trust

Quality and Performance Report

June 2018

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 84.1% for April. This is below the national standard of 85% but is above the Sustainability and Transformation Fund (STF) target of 81%. Recovery against the 62 day GP standard is forecast for August.
- The measure for percentage of A&E patients seen in less than 4 hours was 91.1% for May. This did not achieve the 95% national standard but is above the STF target of 90%. The Children's Hospital has sustained its consistently good performance and exceeded the 95% standard in May, at 96.3%. The Bristol Royal Infirmary performance had risen to 85.6% in May.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 89.1% as at end of May. This did not achieve the national 92% standard. The Sustainability and Transformation Fund (STF) target for this measure has been set at 87% so this was achieved. The Trust was 871 patients away from the national compliance of 92%. Early sight for June is holding at 89%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of May was 97.6%, with 232 patients waiting 6+ weeks. This is lower than the national 99% standard. The maximum allowed breaches to achieve 99% was 97.

Headline Indicators

Performance against Infection cases, patient falls, hospital acquired pressure ulcers and patient experience remain consistently above target.
Fracture Neck of Femur performance for patient seeing an ortho-geriatrician within 72 hours achieved 100% in May, with 48% achieving Best Practice Tariff.

Last Minute Cancelled (LMC) Operations remains above the required threshold of 0.8% of admissions, with 125 such cancellations in May, which equated to1.9% of admissions. Also the 28 day readmission standard of 95% was not achieved in May, with 12 patients not re-admitted within 28 days.

There has been a significant reduction in overdue follow-ups in Outpatients, with divisions undertaking review, validation and actioning of Outpatients who are overdue by more than 12 months. Did Not Attend (DNA) and hospital cancellation rates have shown improvement in May.

Workforce

Percentage agency usage is on target at 0.9%.
Overall vacancies reduced to 5.3% against a target of 5%. Nursing vacancies increased by 16.1 FTE in month to 230.7 (7.2%). Registered nursing contributed to 14.6 FTE of the increase.

Turnover reduced to 14.1% from 14.2% last month. The biggest reduction was seen in unregistered nursing (1.1% percentage points).

Staff Sickness reduced to 3.3% in May against a target of 3.6% with reductions in all Divisions except Surgery and Women's & Children's, where increases of 0.1% were seen. The largest staff group reduction was seen in unregistered nursing.

Essential training held at 89% across the 11 core skills programmes, with 6 of the programmes making individual gains of 1% in the last month.

1.2 OVERVIEW – Single Oversight Framework

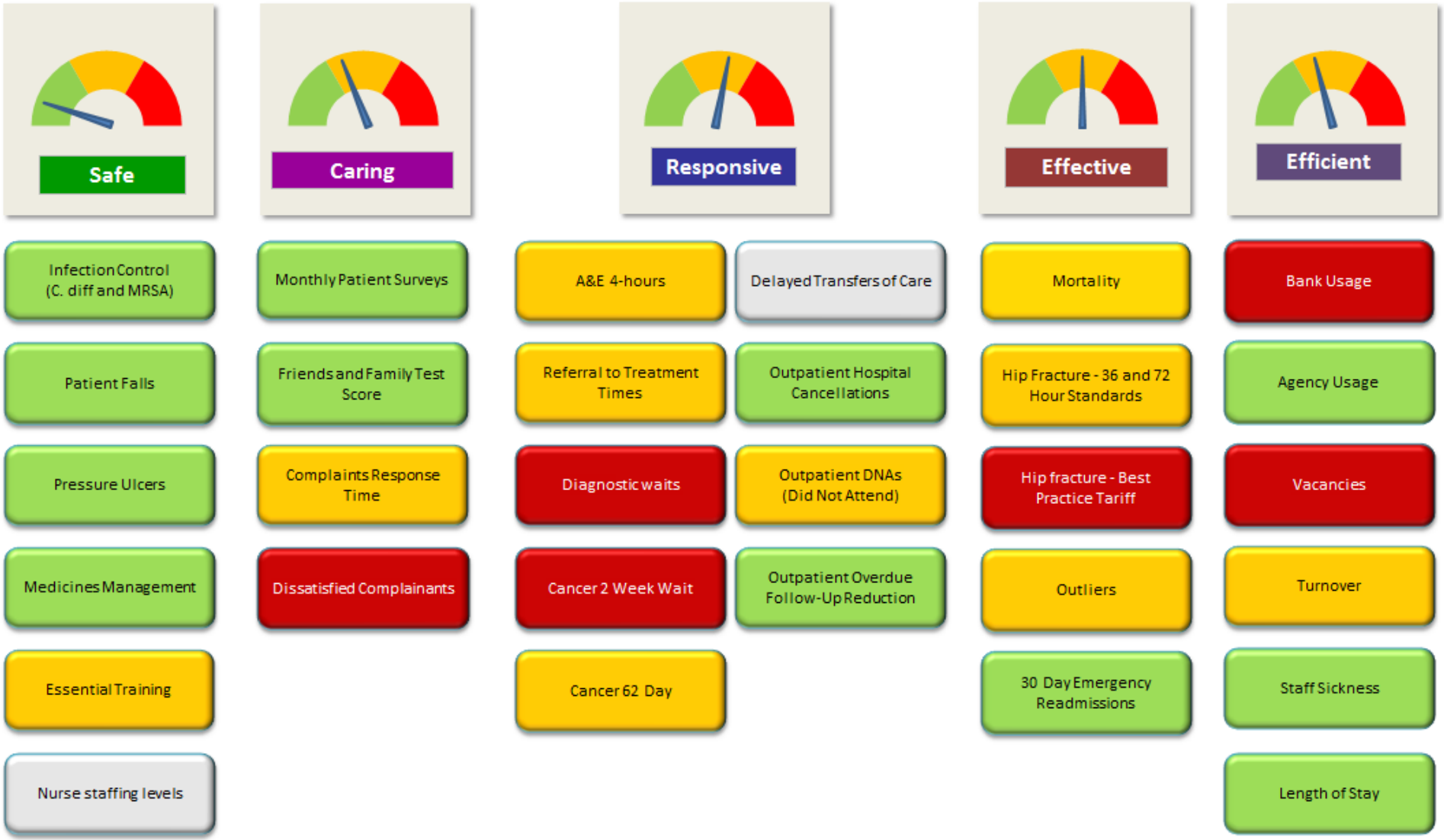
Access Key Performance Indicator		Quarter 3 2017/18			Quarter 4 2017/18			Quarter 1 2018/19		
		Oct 17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
A&E 4-hours	Actual	90.1%	90.3%	85.3%	82.7%	83.2%	78.9%	84.0%	91.1%	
	Trust "Footprint"	92.8%			86.1%					
	STF trajectory	90%	90%	90%	90%	92%	95%	90%	90%	90%
62-day GP cancer	Actual (Monthly)	84.1%	88.6%	82.9%	78.4%	81.3%	87.3%	84.1%		
	Actual (Quarterly)	85.4%			82.4%					
	STF trajectory	82.5%	82.5%	82.5%	82.6%	82.6%	82.6%	81%	83%	83%
Referral to Treatment Time	Actual	90.0%	88.9%	88.3%	88.1%	88.4%	87.0%	88.2%	89.1%	
	STF trajectory	92%	92%	92%	92%	92%	92%	87%	87%	
6-week wait diagnostic	Actual	98.2%	98.3%	97.6%	97.8%	99.2%	98.5%	96.8%	97.6%	
	STF trajectory	99%	99%	99%	99%	99%	99%	99%	99%	99%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

Note on A&E Trust "Footprint":
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres and Minor Injury Units in their region. For UHBristol this was the Bristol, North Somerset and South Gloucestershire (BNSSG) region. The result of this apportionment was carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the STF target for Quarter 3 and 4. The above table shows the Trust achieved the required level, after apportionment, in Quarter 3 but not in Quarter 4.

1.3 OVERVIEW – Key Performance Indicators Summary

Below is a summary of all the Key Performance Indicators reported in Section 2.



1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	Successes	Priorities
ACCESS Emergency	• When the Trust's A&E 4 hour performance is uplifted by the apportionment of local Walk In Centres (as published by NHS England), the Trust achieved 92.8% for Quarter 3 and so achieved the Sustainability & Transformation Funds (STF) target of 90%. Performance without this apportionment was 88.64%. • The Children's Hospital continues to meet the STF trajectory for 4hr performance	• Sustain A&E 4 hour performance particularly at the Bristol Royal Hospital for Children where increased growth in attendances has been seen.
ACCESS Cancer	• Recovery trajectory and national standard for 62 day GP performance were met in March and April, and recovery trajectory for quarter narrowly missed (by 0.06 percentage points). The May trajectory is on track to be met when the impact of the fire is subtracted. • Subsequent chemotherapy and radiotherapy standards and two week wait first appointment standard achieved for the quarter • 62 day GP referred standard achieved in quarter 3, for the first time a quarter has been achieved since 2012. • Impact of oncology centre fire minimised and recovery on track despite the very challenging circumstances	• Minimise surgical cancellations of cancer patients and take actions to recover quickly when cancellations occur. • Recover from the impact of the Bristol Haematology and Oncology Centre fire on performance – radiotherapy service recovery expected to take longer than chemotherapy due to the service depending on finite complex machinery • Recover the 85% standard in August at the latest and maintain this. • Continue work with other providers to reduce late referrals/minimise their impact • Prepare for the changes to performance reporting rules from July 2018 – cancer register has been upgraded and all performance reporting tools, with new systems for communicating about shared patients in development
	Opportunities	**Risks and Threats**
ACCESS Emergency	• Refreshed plan around DTOC in place, with delivery expected from BCC social care in June of changes to care home tendering, re-ablement provision and home care services. • Increasingly embedding Clinical Utilisation Review into patient flow meetings to improve real-time information and action. • Continued delivery against plan and maximise capacity for change across the summer period.	• Q2 performance – particularly evening pressure points in adult services and growth in children's
ACCESS Cancer	• Avoiding cancellation is the single most important high impact action for the Trust to improve and sustain performance against the cancer standards. • A 'virtual PTL' (waiting list meeting) with referring providers is developing with participation from four providers, and the new waiting times allocation rules will be used to gain wider engagement • Incorporation of cancer into a cross-standards performance meeting gives new opportunities to discuss performance issues, particularly those not specific to cancer. Focus is currently on diagnostic tests and 'getting it right first time', and on first appointment timeliness	• Late referrals from other providers continue to impact on achievement of the 62-day GP cancer waiting times standard. The new standards may provide an opportunity to mitigate this but the new rules are complex and this is not yet a certain benefit. There will continue to be a need to work with other providers to improve these pathways • Surgical cancellations are a high risk to achievement of several cancer standards as well as to patient experience and quality. Currently cancellations are at a minimal level, with one surgical service still recovering from the impact of winter pressures and the fire. • Dermatology transfer not taking place until 2019, meaning the Trust's challenging casemix remains an issue

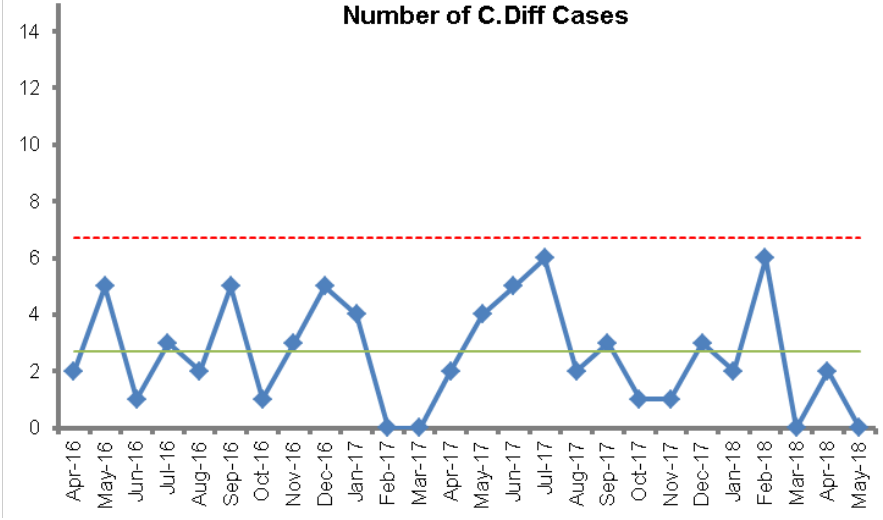
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

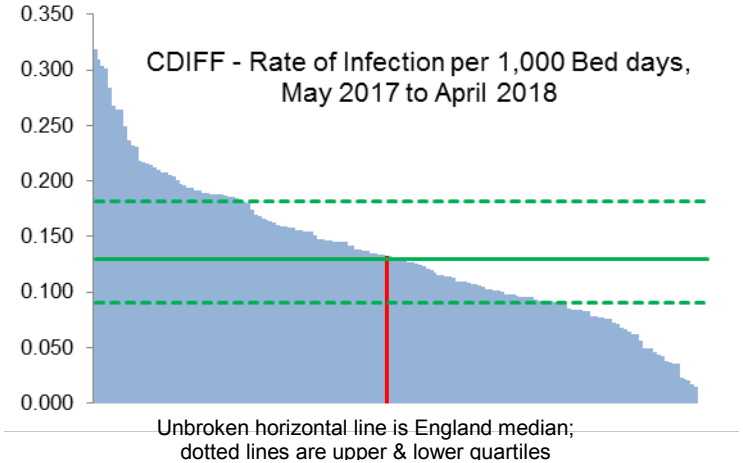
	Successes	Priorities
ACCESS Planned Care	• The Trust is beginning to see reductions in the volume of on hold pathways being added, which is a major step forward. • There are now five on-hold reasons within our Patient Administration System ("Medway PAS") that are selectable at the point of recording the outcome of the patient appointment and a further two on-hold reasons which are system generated. Previously there were 23 selectable on-hold reasons within Medway PAS. • The weekly performance meetings continues with a focus on RTT performance to include patient dated/undated 40+ weeks and waiting list size management, diagnostic 6-week standard, Cancer 2 week wait, 62 and 31 day performance, on-hold status flags in Medway, overdue partial bookings, last minute cancellations and 28-day rebooking and activity against commissioning intentions.	• Continue to hold steady state on Referral To Treatment (RTT) performance with a plan to restore achievement of the 92% Referral to Treatment national standard as an aggregate position at end of August 2018 • The sampling process for all cohorts identified as part of the "on hold "patient pathways, has now been completed, to either full validation, or to the expected standard identified by the IST of 10% of all pathways. Results of this sampling need to be collated and reviewed. • Focus continues on clearing of long waiting breaches and clearing in the Referral to Treatment backlog, particularly in Pediatric Services and Dentistry services. All remaining 52 week waiting patients will be dated and treated in order to achieve) 52 week waiters at the end of July reporting position. • Achieve the 99% standard for Diagnostics waiting times by end of August.
	Opportunities	**Risks and Threats**
ACCESS Planned Care	• The Trust is beginning to see reductions in the volume of on hold pathways being added, which is a major step forward. • There are now five on-hold reasons within our Patient Administration System ("Medway PAS") that are selectable at the point of recording the outcome of the patient appointment and a further two on-hold reasons which are system generated. Previously there were 23 selectable on-hold reasons within Medway PAS. • The weekly performance meetings continues with a focus on RTT performance to include patient dated/undated 40+ weeks and waiting list size management, diagnostic 6-week standard, Cancer 2 week wait, 62 and 31 day performance, on-hold status flags in Medway, overdue partial bookings, last minute cancellations and 28-day rebooking and activity against commissioning intentions.	• Continue to hold steady state on Referral To Treatment (RTT) performance with a plan to restore achievement of the 92% Referral to Treatment national standard as an aggregate position at end of August 2018 • The sampling process for all cohorts identified as part of the "on hold "patient pathways, has now been completed, to either full validation, or to the expected standard identified by the IST of 10% of all pathways. Results of this sampling need to be collated and reviewed. • Focus continues on clearing of long waiting breaches and clearing in the Referral to Treatment backlog, particularly in Pediatric Services and Dentistry services. All remaining 52 week waiting patients will be dated and treated in order to achieve) 52 week waiters at the end of July reporting position. • Issues with capacity planning in Echocardiography resulted in significant breaches (115, 90%), divisional plan for recovery by end of July.

1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	• **Successes**	• **Priorities**
QUALITY	• Sustained delivery of key quality performance metrics	• Improve number of complaints responded to within timeframe to achieve 95% target for this indicator.
WORKFORCE	• Delivery of a series of events during May's 'Diversity week' including a *'See it my way'* workshop with over 25 participants. • Medical recruitment migrated from the Medical HR team to the Resourcing team, to create efficiencies and rigour to service delivery and support an improved customer experience. • Establishment of a new Workplace Wellbeing Advocate Network comprising 40 members representative of each Division	• A medical recruitment microsite is under design and development to mirror the successful approach in nursing, with the aim of increasing the marketing and attraction plans for medical staff.
	Opportunities	**Risks and Threats**
QUALITY	• Continued roll out of digital solutions such as e obs and e prescribing to increase process reliability	• Continued inability to sustain fractured neck of femur best practice tariff to meet 90% targets,
WORKFORCE	• 1 hour '*Resilience to Stress'* workshop available to multi-disciplinary colleagues during Mental Health Awareness Week, complements of Spiral Wellbeing (previously commissioned by the Trust). • Launch of a new Reserve Forces Policy and Trust sign-up to the Armed Forces Covenant which is a commitment to support the reserve forces and their families into employment. • Allocate modules; Medic Online, Medic On-Duty, Locum On-Duty & e-Job Planning have been purchased. Implementation and engagement plans have been drawn together with a planned roll out commencing in General Medicine as an initial pilot area.	• Recruitment challenges with UK Borders Agency approval of Certificates of Sponsorship (visas) for medical staff. • Demand continues to outstrip supply for doctors. Significant work to be undertaken to redesign medical workforce models to create sustainable and efficient services. A range of initiatives are being planned, but the benefits of these may take several years to come into fruition.

Infections – Clostridium Difficile (C.Diff)	
Standards:	Number of Trust Apportioned C.Diff cases to be below the national trajectory of 44 cases for 2018/19. Review of these cases with commissioners' alternate months to identify if there was a "lapse in care".
Performance:	There were zero C.Diff cases in May 2018. The two cases from April 2018 are awaiting review by the CCG in June 2018, so no confirmed "lapse in care" cases this year.
Commentary:	The Trust performed well in this area in 2017/8 and performance in the first two months of 2018/19 is good. There were no Trust apportioned cases of C.Diff in May 2018 therefore we are on target to stay within the national trajectory for our Trust.
Ownership:	Chief Nurse





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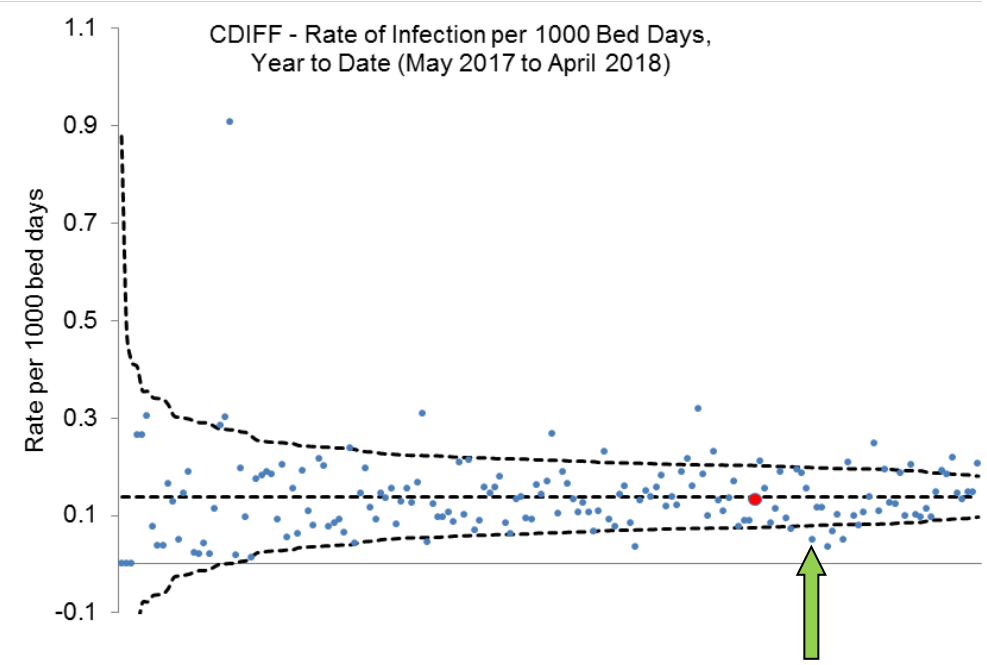
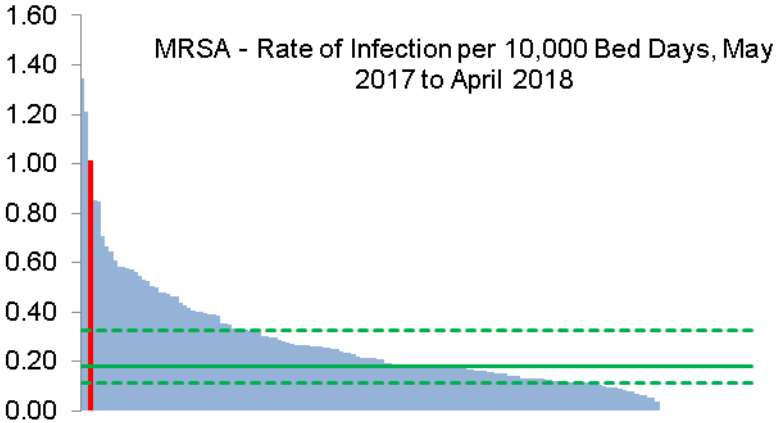


CDIFF Cases	May-18	2018/2019
Medicine	0	0
Specialised Services	0	0
Surgery	0	1
Women's and Children's	0	1
Grand Total	0	2

2.1 PERFORMANCE – Safe Domain

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	One MRSA case in April, none in May
Commentary:	There was one Trust apportioned case of MRSA in April 2018. The Trust has reviewed this case using the Post Infection Review framework and work is underway to implement the learning.
Ownership:	Chief Nurse

MRSA	May-18	2018/2019
Medicine	0	1
Specialised Services	0	0
Surgery	0	0
Women's and Children's	0	0
Grand Total	0	1



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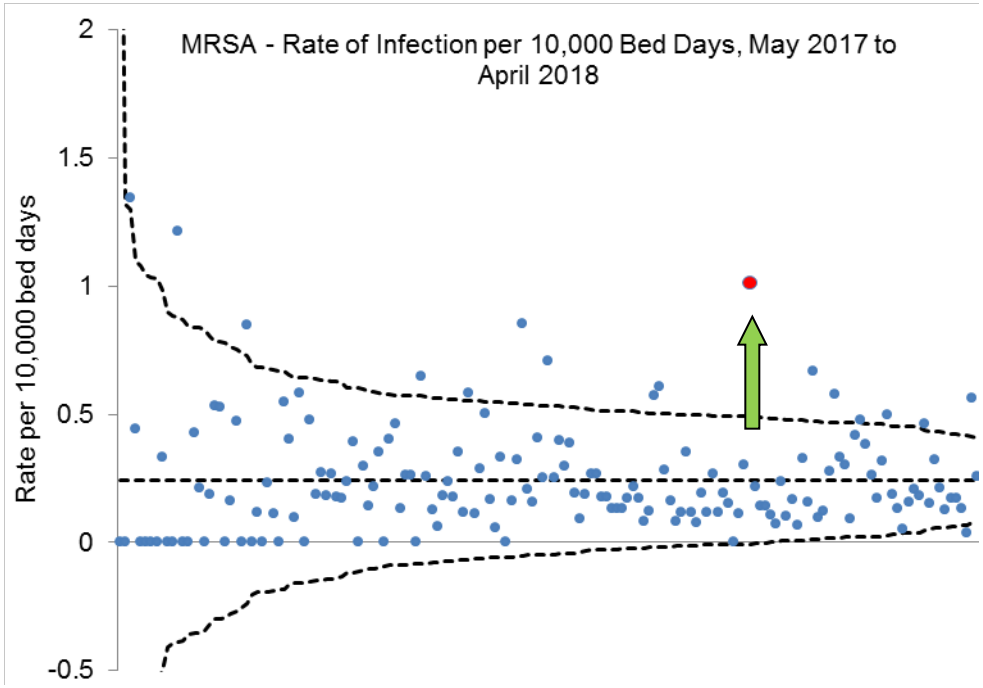
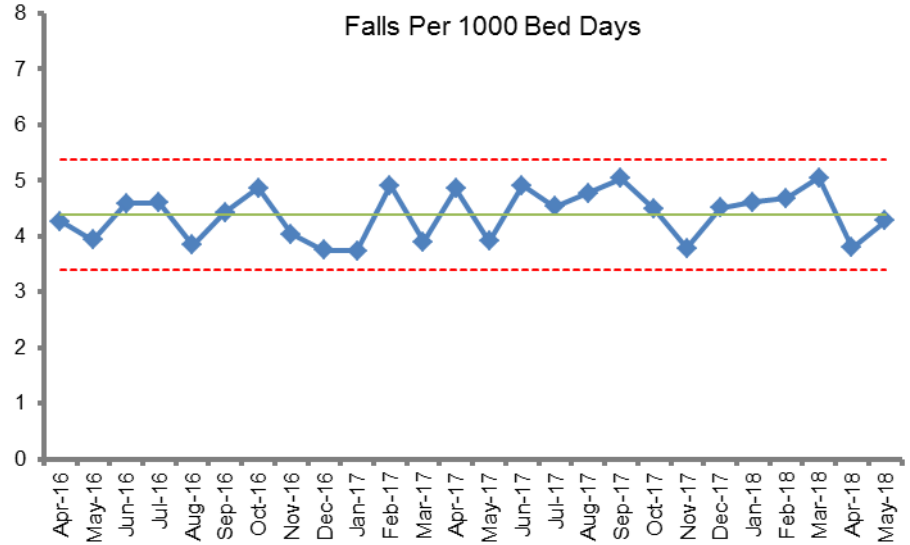
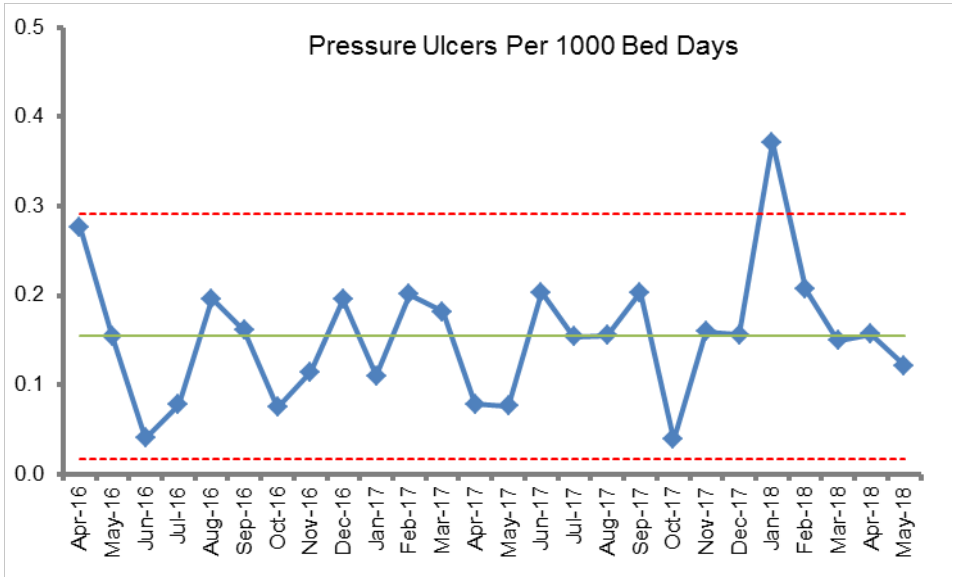


2.1 PERFORMANCE – Safe Domain

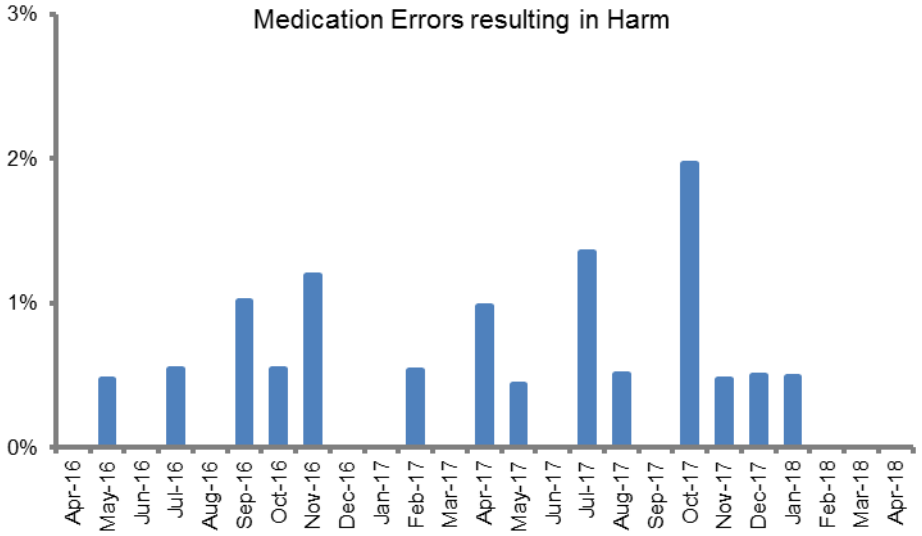
Patient Falls and Pressure Ulcers	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above) Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Falls rate for May was 4.27 per 1,000 beddays. This was 106 Falls with four resulting in harm. Pressure Ulcers rate for May was 0.12 per 1,000 beddays. There were 3 Pressure Ulcers in May, with none at Grades 3 or 4.
Commentary:	• Pressure ulcer performance per 1,000 bed days for May remains green at 0.121 (three new grade 2 pressure ulcers). An improved picture from April at 0.156 per 1,000 bed days. • Pressure ulcer prevention and reduction work will focus on the ambition to reduce pressure ulcers category 1-3 across the organisation by 50% 18/19 – actions to deliver this ambition have been identified within the work plan. • The overall number of falls per 1,000 bed days remains at green. There was however an increase in falls with harm in May, 4 compared to 2 in April. Over the last 3 years the number of falls with harm has reduced. However the aim of the 18/19 work plan is to see this reduce even further by delivering a number of practice and education and training related objectives.
Ownership:	Chief Nurse

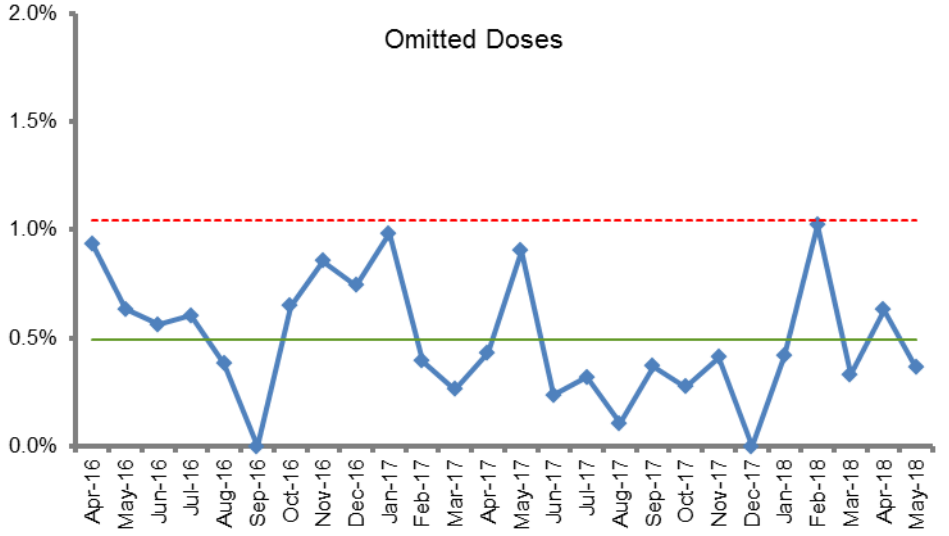




2.1 PERFORMANCE – Safe Domain

Medicines Management	
Standards:	Number of medication errors resulting in harm to be below 0.5%. Of all the patients reviewed in a month, under 0.75% to have had a non-purposeful omitted dose of listed critical medication
Performance:	0% of medication errors in April resulted in harm (zero errors out of 227 cases reviewed). Omitted doses were at 0.36% in May (2 cases out of 551 reviewed).
Ownership:	Medical Director





2.1 PERFORMANCE – Safe Domain

Essential Training	
Standards:	Essential Training measures the percentage of staff compliant with the requirement for core essential training. The target is 90%
Performance:	In May Essential Training overall compliance remained static at 89% compared with the previous month (excluding Child Protection Level 3).
Commentary:	May 2018 compliance for Core Skills (mandatory/statutory) training is holding at 89% overall across the eleven core skills programmes, although six of the eleven programmes made individual gains of 1% in the past month. Compliance for all other Essential Training remains at 92% overall.
Ownership:	Director of People

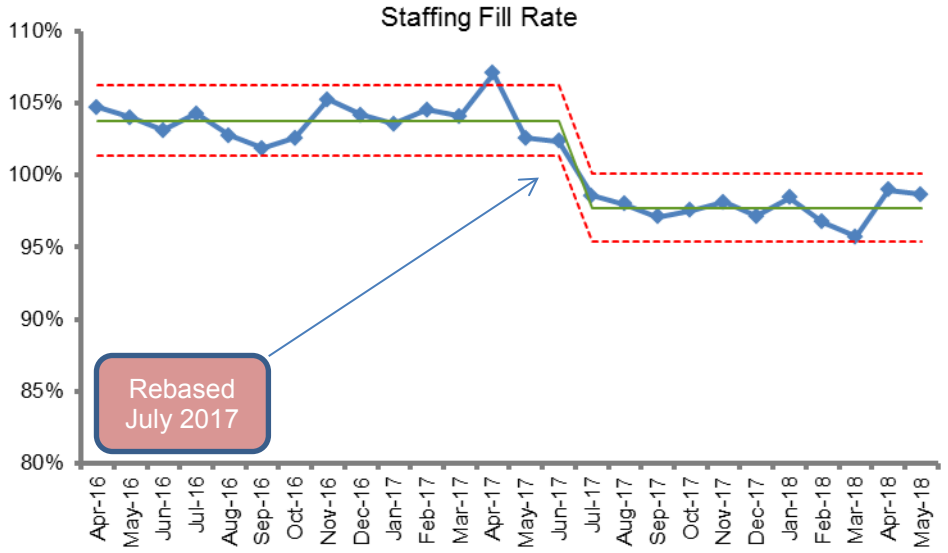
Essential Training	May-18	KPI
UH Bristol NHS Foundation Trust – overall	**89%**	**90%**
Conflict Resolution Training	94%	90%
Equality, Diversity and Human Rights	90%	90%
Fire Safety	88%	90%
Health, Safety and Welfare (formerly Health & Safety)	94%	90%
Infection Prevention & Control	93%	90%
Information Governance	85%	95%
Moving and Handling (formerly Manual Handling)	82%	90%
Preventing Radicalisation	90%	90%
Resuscitation	86%	90%
Safeguarding Adults	90%	90%
Safeguarding Children	90%	90%

2.1 PERFORMANCE – Safe Domain

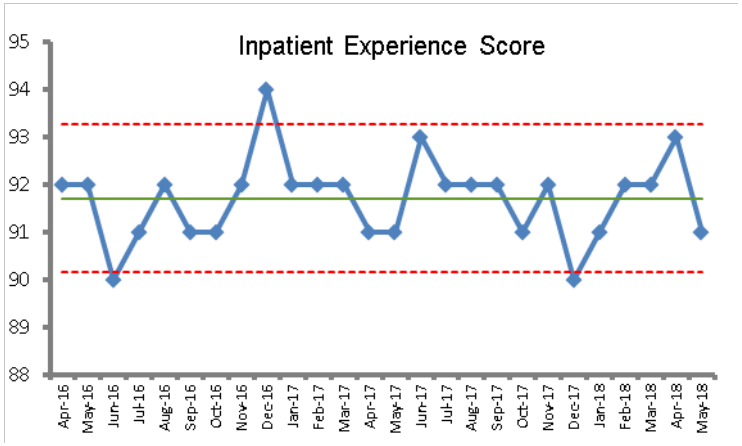
Nursing Staffing Levels	
Standards:	Staffing Fill Rate is the total hours worked divided by total hours planned. A figure over 100% indicates more hours worked than planned. No target agreed
Performance:	May's overall staffing level was at 98.7% (236,287 hours worked against 239,511 planned). Registered Nursing (RN) level was at 95.0% and Nursing Assistant (NA) level was at 107.9%
Commentary:	Overall for the month of May 2018, the trust had 94% cover for RN's on days and 96% RN cover for nights. The unregistered level of 103% for days and 114% for nights reflects the activity seen in May 2018. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night.
Ownership:	Chief Nurse

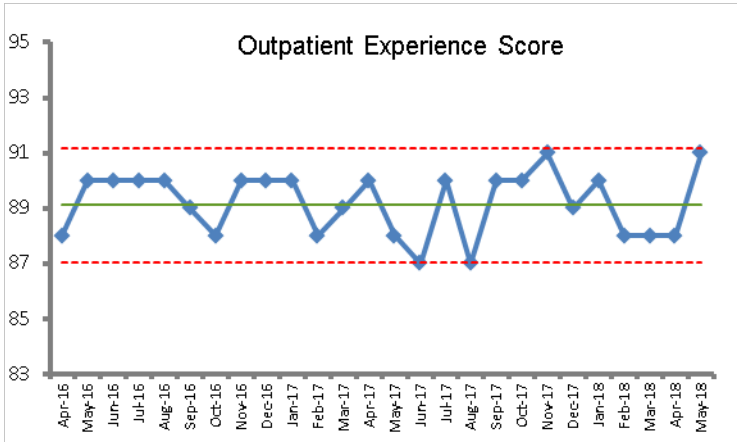
	Day	Night	TOTAL
Registered Nurses	94.2%	96.0%	95.0%
Nursing Assisstant	103.3%	114.4%	107.9%
TOTAL	**96.9%**	**100.9%**	**98.7%**

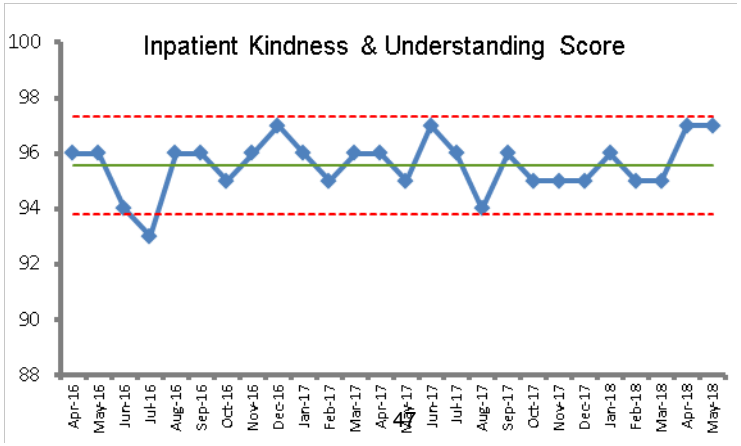
Medicine	107.1%
Surgery	102.3%
Specialised Services	97.7%
Women's and Children's	91.3%



Monthly Patient Survey	
Standards:	For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over.
Performance:	For May 2018, the inpatient score was 91/100, for outpatients it was 91. For the kindness and understanding question it was 97.
Commentary:	The Trust's postal survey programme provides robust patient-reported experience data for inpatient, outpatient and maternity services. The headline measures from these surveys remained above their minimum target levels in June 2018, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse

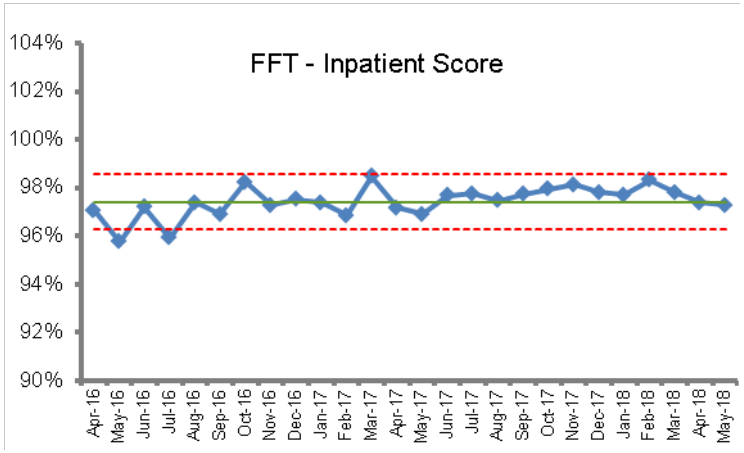


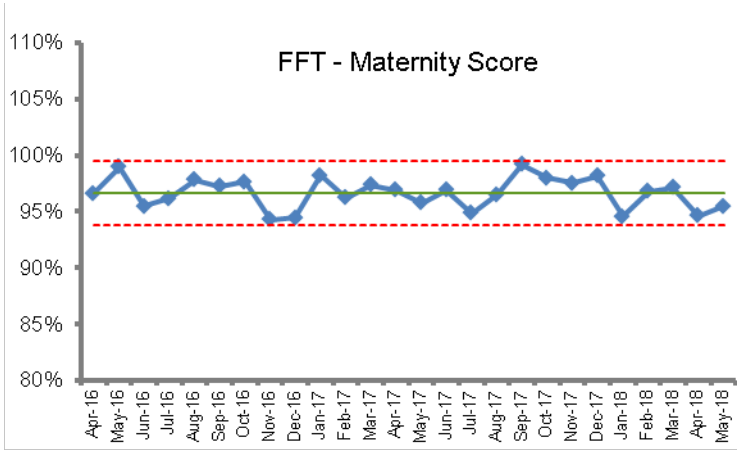


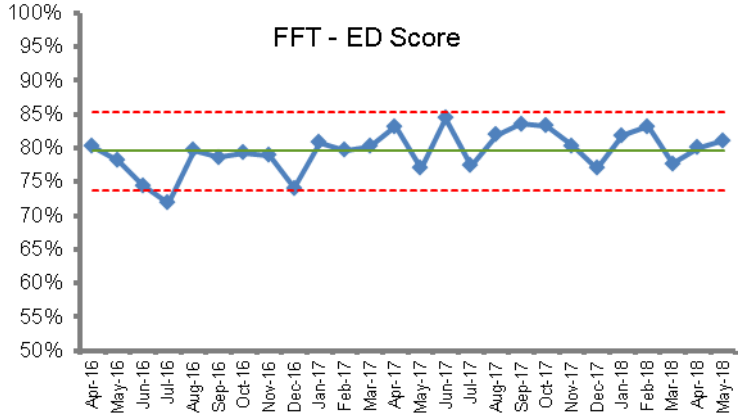


2.2 PERFORMANCE – Caring Domain

Friends and Family Test (FFT) Score	
Standards:	The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 60%.
Performance:	May's FFT score for Inpatient services was 97.3% (2351 out of 2417 surveyed). The ED score was 81.1% (1257 out of 1550 surveyed). The maternity score was 95.5% (170 out of 178 surveyed).
Commentary:	The Trust's scores on the Friends and Family Test were above their target levels.
Ownership:	Chief Nurse



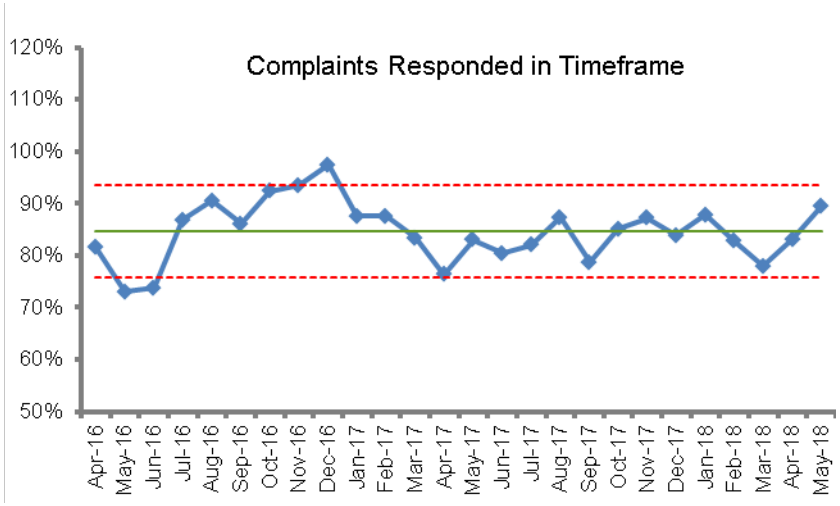


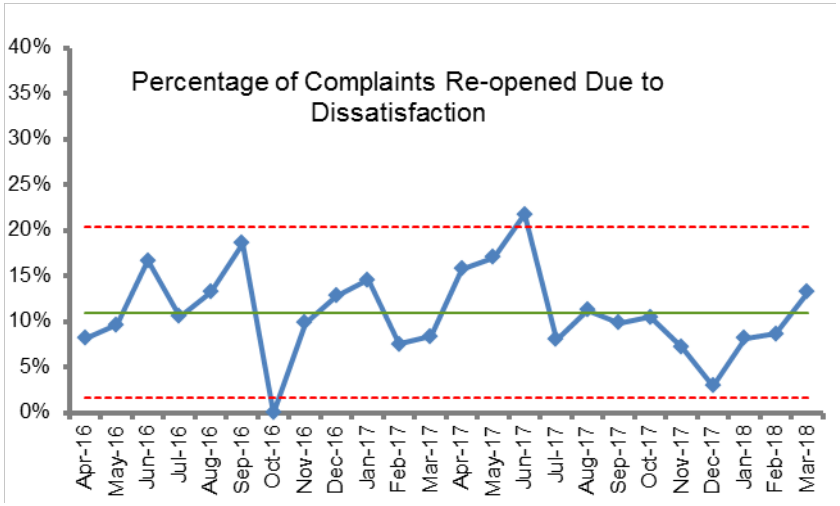


Score		May-18	2018/2019	Score		May-18	2018/2019
Inpatient	MDC	97.6%	96.7%	ED	BCH	84.3%	83.6%
	SHN	97.7%	98.1%		BEH	94.7%	93.1%
	SPS	98.2%	97.4%		BRI	64.2%	65.4%
	WAC	96.6%	96.7%		Total	81.1%	80.6%
	Total		97.4%	Maternity		95.5%	95.0%

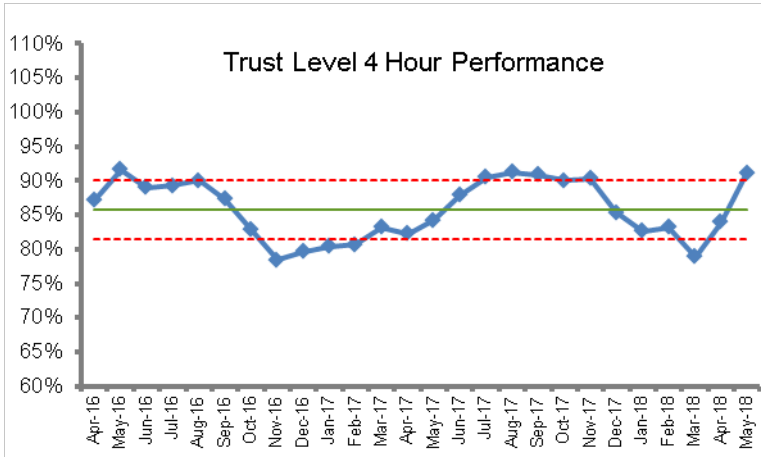
2.2 PERFORMANCE – Caring Domain

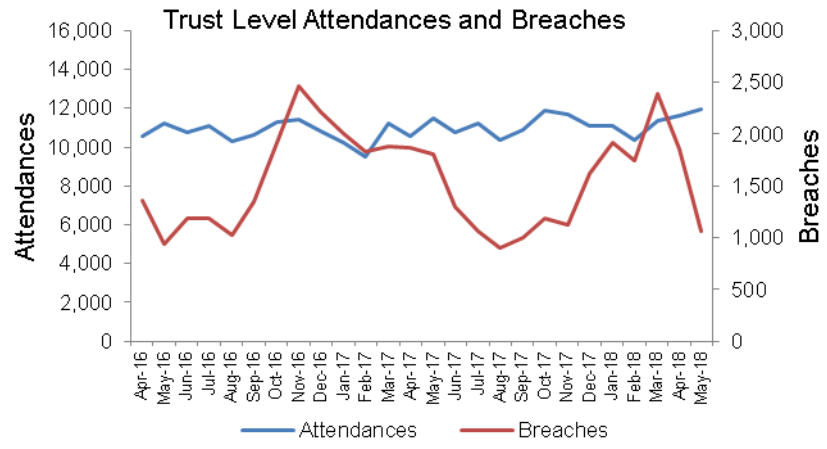
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe. Of all formal complaints responded to, less than 5% should be re-opened because complainant is dissatisfied.
Performance:	In May, 60 out of 67 formal complaints were responded to with timeframe (89.6%) Of the 68 formal complaints responded to in March, 9 resulted in the complainant being dissatisfied with the response (13.2%)
Commentary:	The rate of dissatisfied complaints has now remained below the amber 10% threshold for six consecutive months, suggesting that the Trust's work on getting complaints responses right first time is having a positive impact. The Trust has not achieved 90% for timeliness of complaints responses since December 2016. Divisions have recently agreed to adopt a 'zero tolerance' approach to complaints breaches; supporting achievement of the Trust's 95% target is the key objective for our complaints service in 2018/19.
Ownership:	Chief Nurse

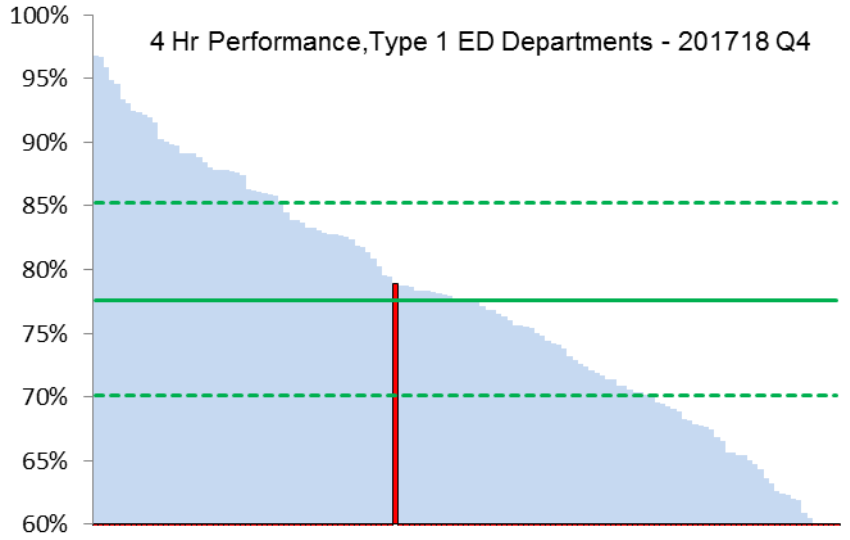




Emergency Department 4 Hour Wait	
Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The standard is that at least 95% of patients should wait under 4 hours. There is also an improvement trajectory being agreed.
Performance:	Trust level performance for May was 91.14% (11940 attendances and 1058 patients waiting over 4 hours).
Commentary:	Significant improvement in performance in both adult and children's services sustained across the month. Detailed analysis in adult ED has refreshed thresholds for escalation to reduce the risk of queuing at peak times, and re-modelling staffing to the peak attendances. Delivery of work streams against the UCSG action plan continues. Children's services highlighted increased growth in attendances outside plan and following discussion at A&E Delivery Board, a system diagnosis is being completed. This needs to be followed with actions to help mitigate this growth across primary and community services.
Ownership:	Chief Operating Officer



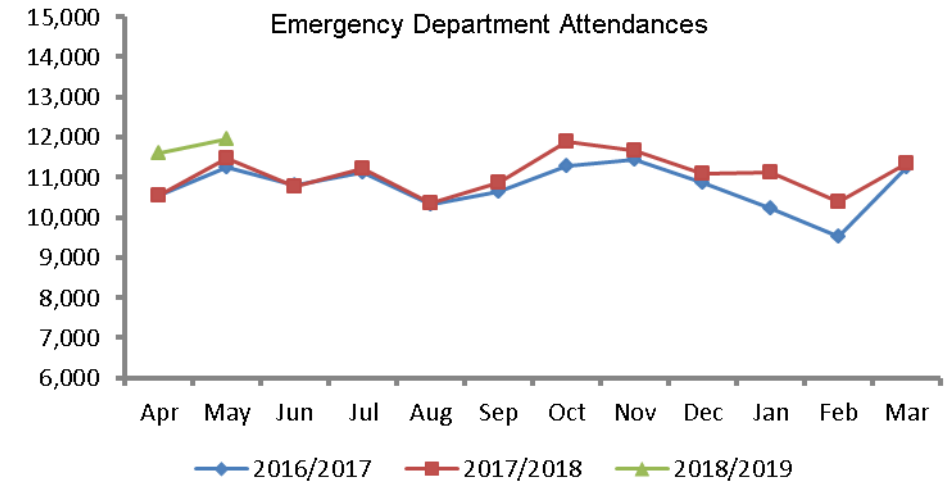


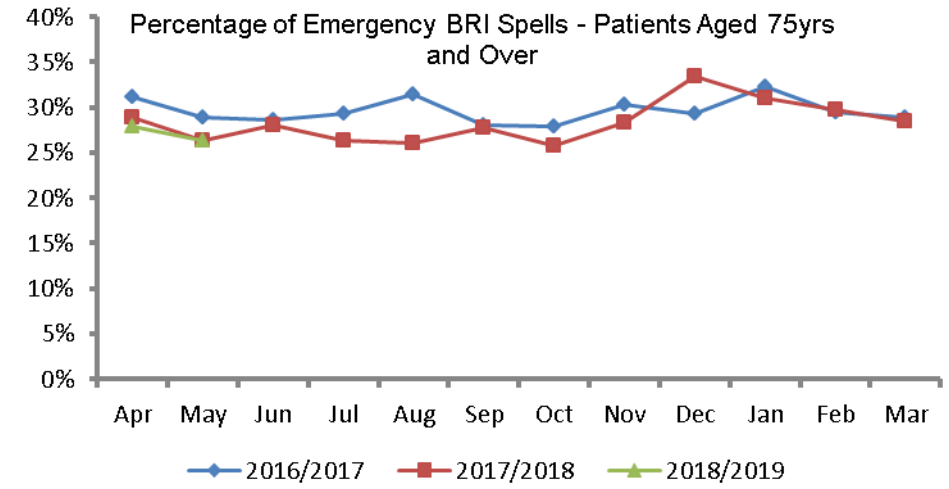


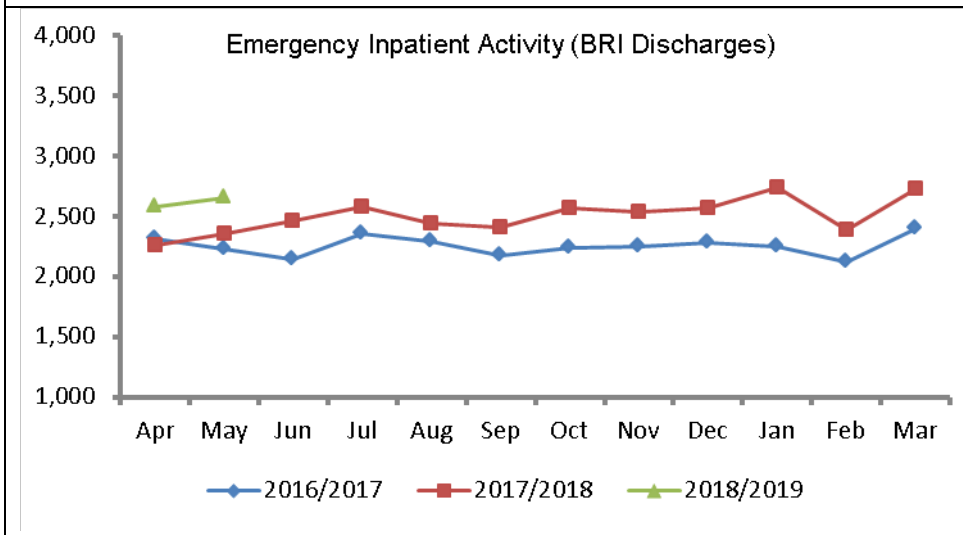
Unbroken horizontal line is England median;
dotted lines are upper & lower quartiles

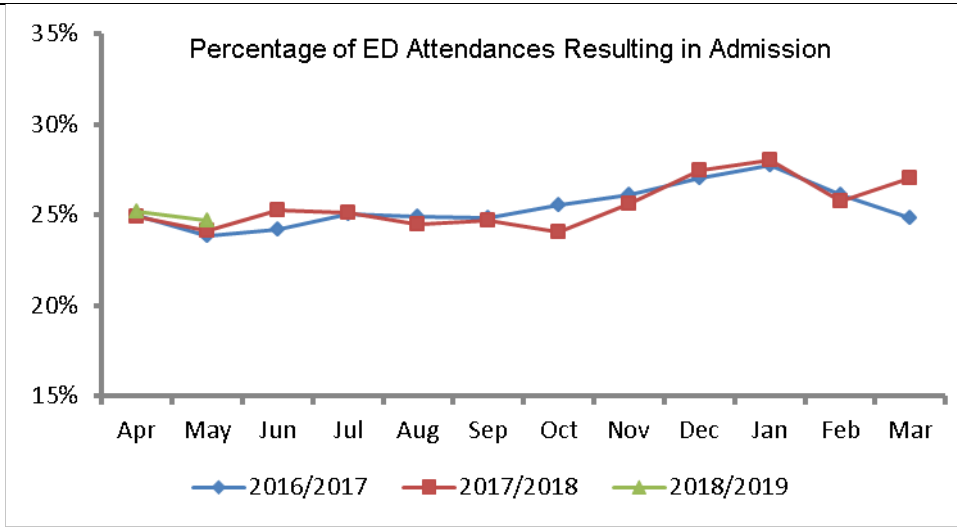
	Attendances		Under 4 Hours		Performance	
	May-18	2018/2019	May-18	2018/2019	May-18	2018/2019
BRI	6061	11990	5186	9569	85.56%	79.81%
Trust	11940	23545	10882	20625	91.14%	87.60%

2.3 PERFORMANCE – Responsive Domain



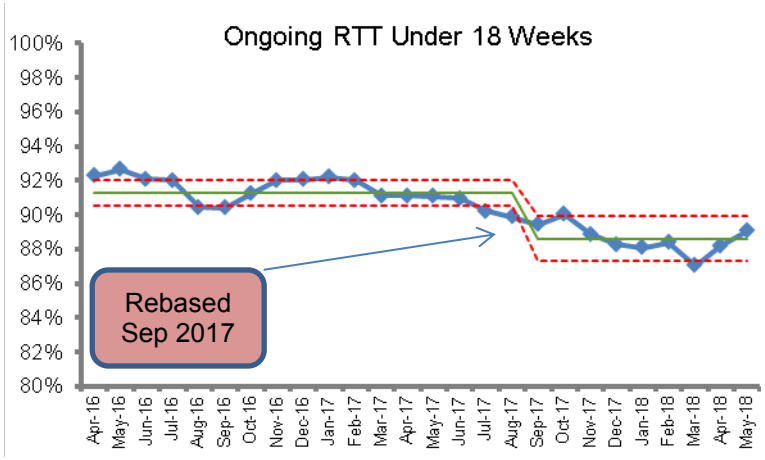


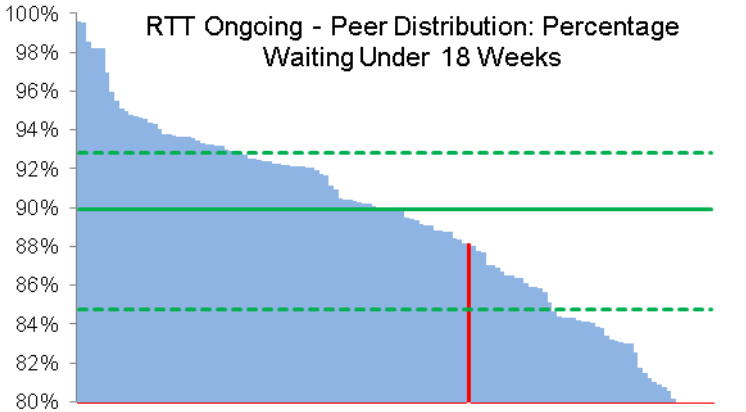




2.3 PERFORMANCE – Responsive Domain

Referral to Treatment (RTT)	
Standards:	At each month-end, we report the number of patients on an ongoing RTT pathway and the percentage that have been waiting less than 18 weeks. The standard is that over 92% of the patients should be waiting under 18 weeks. Also no-one should be waiting 52 weeks or over.
Performance:	At end of May, 89.1% of patients were waiting under 18 week (26,416 out of 29,660 patients). 12 patients were waiting 52+ weeks
Commentary:	The 92% national standard was not met at the end of May, with performance reported at 89.1%. However, this was above the Sustainability and Transformation Fund (STF) recovery target of 87%. In terms of long waiters, there were 12 patients waiting over 52 weeks. Early sight for June is holding at 89%.
Ownership:	Chief Operating Officer



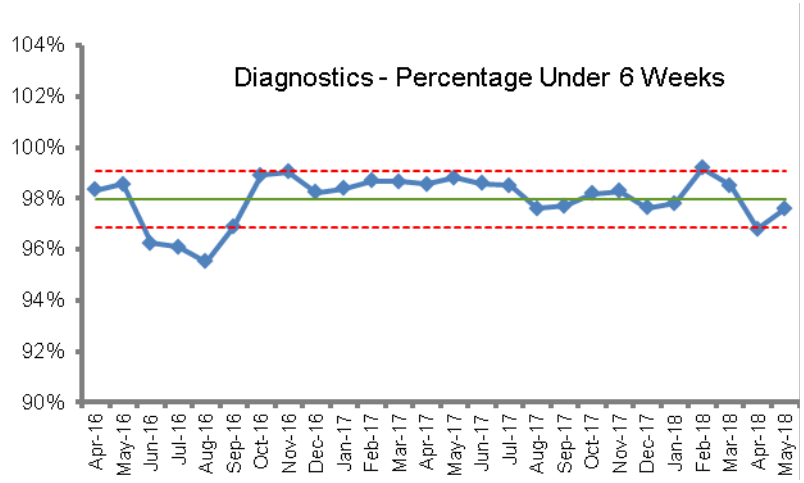


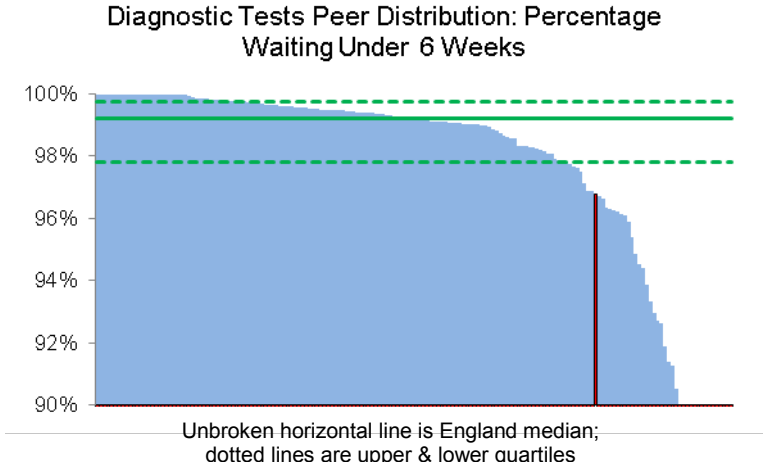
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,034	371	81.8%
Cardiothoracic Surgery	305	53	82.6%
Dermatology	2,436	111	95.4%
ENT	1,977	81	95.9%
Gastroenterology	589	13	97.8%
General Medicine	10	0	100.0%
Geriatric Medicine	57	0	100.0%
Gynaecology	1,183	115	90.3%
Neurology	443	172	61.2%
Ophthalmology	4,116	417	89.9%
Oral Surgery	2,655	243	90.8%
Other (Clinical Genetics)	1,402	160	88.6%
Other (Dental)	2,370	170	92.8%
Other (General Surgery)	1,335	282	78.9%
Other (Haem/Onc)	121	1	99.2%
Other (Medicine)	633	49	92.3%
Other (Other)	515	7	98.6%
Other (Paediatric)	5,389	844	84.3%
Other (Pain Relief)	155	0	100.0%
Other (Thoracic Surgery)	152	43	71.7%
Plastic Surgery	0	0	-
Rheumatology	482	26	94.6%
Thoracic Medicine	600	11	98.2%
Trauma & Orthopaedics	701	75	89.3%
TOTAL	**29,660**	**3,244**	**89.1%**

2.3 PERFORMANCE – Responsive Domain

Diagnostic Waits	
Standards:	Diagnostic tests should be undertaken within a maximum 6 weeks of the request being made. The national standard is for 99% of patients referred for one of the 15 high volume tests to be carried-out within 6 weeks, as measured by waiting times at month-end.
Performance:	At end of May, 97.6% of patients were waiting under 6 weeks (9,471 out of 9,703 patients).
Commentary:	The Trust did not achieve the 99% standard at end of May; it needed a maximum of 97 breaches but actually ended with 232 breaches (135 excess breaches). There was a capacity planning issue in Echocardiography which resulted in 115 breaches for that area. The Trust is now required to deliver 99% by August.
Ownership:	Chief Operating Officer

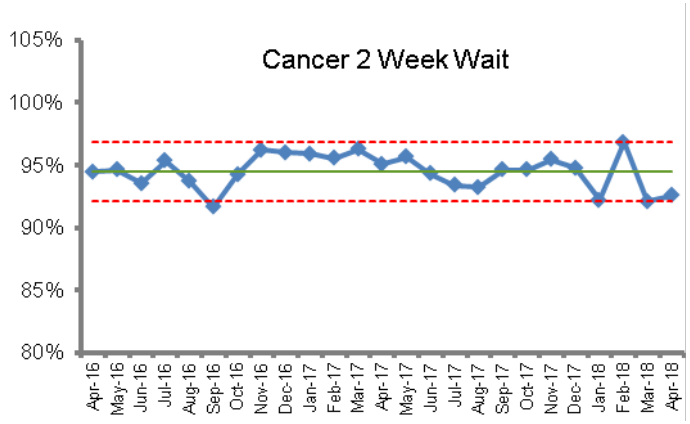


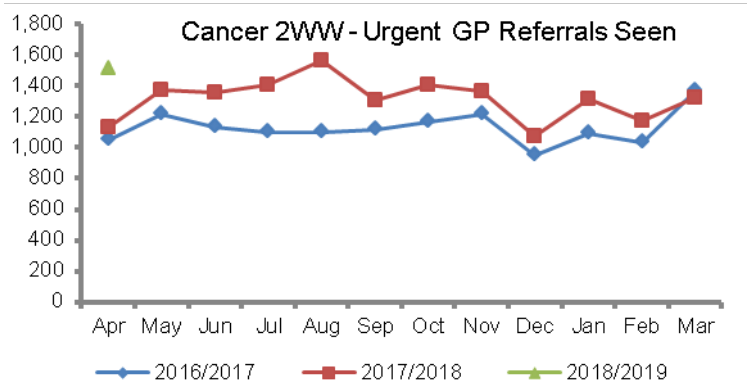


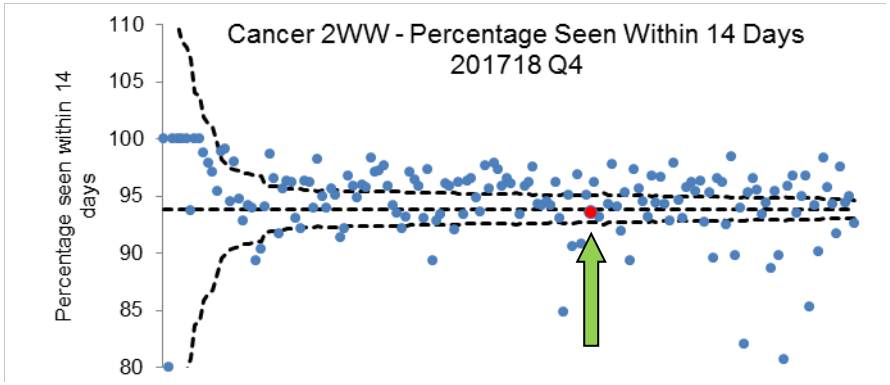
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	1,401	7	1,408	99.5%
Colonoscopy	149	2	151	98.7%
CT	943	7	950	99.3%
Cystoscopy	6	1	7	85.7%
DEXA Scan	404	6	410	98.5%
Echocardiography	993	115	1,108	89.6%
Flexi Sigmoidoscopy	48	0	48	100.0%
Gastroscopy	184	4	188	97.9%
MRI	2,226	64	2,290	97.2%
Neurophysiology	218	0	218	100.0%
Sleep Studies	210	25	235	89.4%
Ultrasound	2,689	1	2,690	100.0%
Grand Total	**9,471**	**232**	**9,703**	**97.6%**

2.3 PERFORMANCE – Responsive Domain

Cancer Waiting Times – 2WW	
Standards:	Urgent GP-referred suspected cancer patients should be seen within 2 weeks of referral. The national standard is that each Trust should achieve at least 93%
Performance:	For April, 92.6% of patients were seen within 2 weeks (1395 out of 1507 patients).
Commentary:	The major oncology centre fire has impacted on the majority of cancer waiting times standards, with recovery against the 62 day GP standard forecast for August. The recovery is currently on track, with the priority being to treat patients in the clinically appropriate timescale. In July 2018 the way in which waiting time performance is allocated between providers is changing, this will affect the Trust's performance figures and the impact is difficult to forecast as the historic data required to do so are not held by the Trust. The underlying actions to improve performance remain unchanged and include minimising surgical cancellations, installation of new scanners and working with other providers to improve shared pathways
Ownership:	Chief Operating Officer



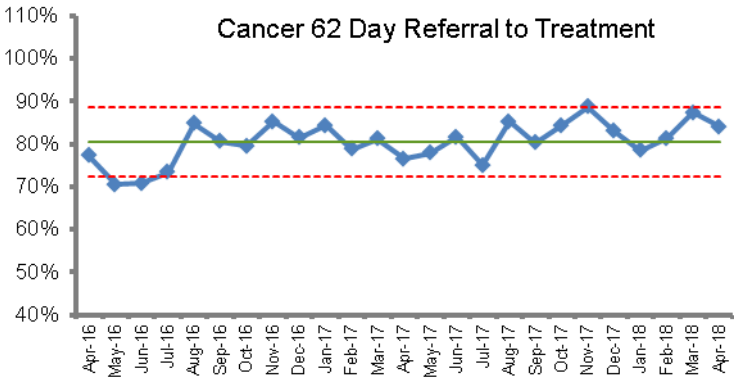


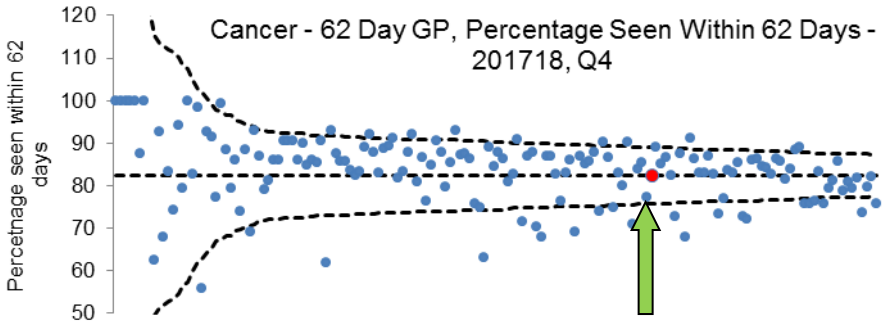


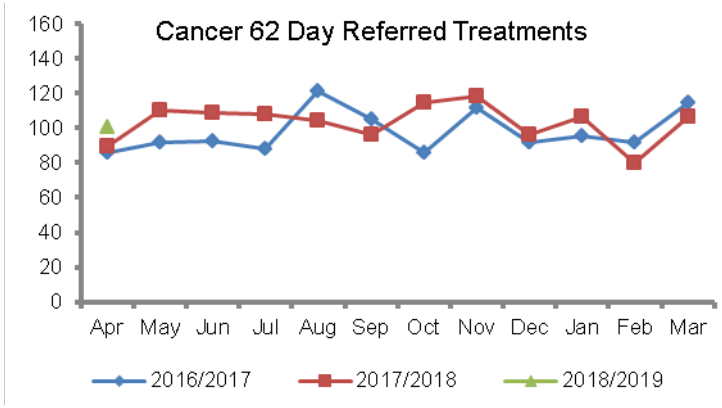
	Cancer 2WW - Apr-18		
Cancer Site	Under 2 Weeks	Total Pathways	Percentage
Other suspected cancer	2	2	100.0%
Suspected children's cancer	12	14	85.7%
Suspected gynaecological cancers	84	93	90.3%
Suspected haematological malignancies excluding ac	12	13	92.3%
Suspected head and neck cancers	388	396	98.0%
Suspected lower gastrointestinal cancers	138	141	97.9%
Suspected lung cancer	33	35	94.3%
Suspected skin cancers	639	718	89.0%
Suspected upper gastrointestinal cancers	87	95	91.6%
Grand Total	1,395	1,507	92.6%

2.3 PERFORMANCE – Responsive Domain

Cancer Waiting Times – 62 Day	
Standards:	Urgent GP-referred suspected cancer patients should start first definitive treatment within 62 days of referral. National standard is that Trusts should achieve at least 85%.
Performance:	For April, 84.1% of patients were seen within 62 days (84.5 out of 100.5 patients).
Commentary:	See Commentary from the 2 Week Wait section above.
Ownership:	Chief Operating Officer



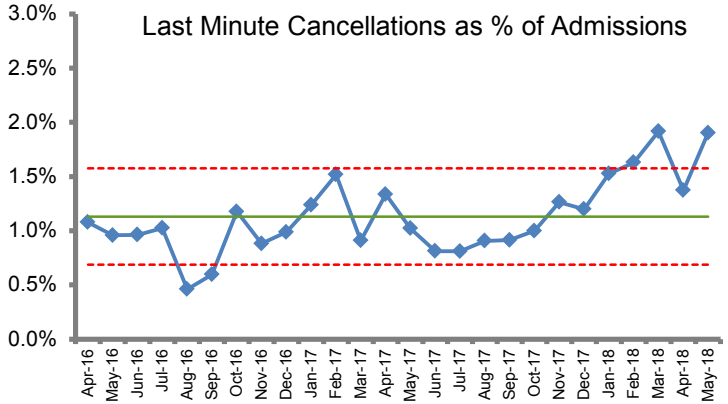


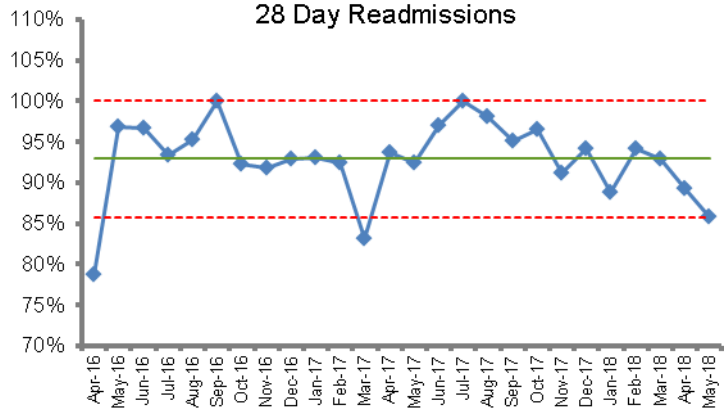


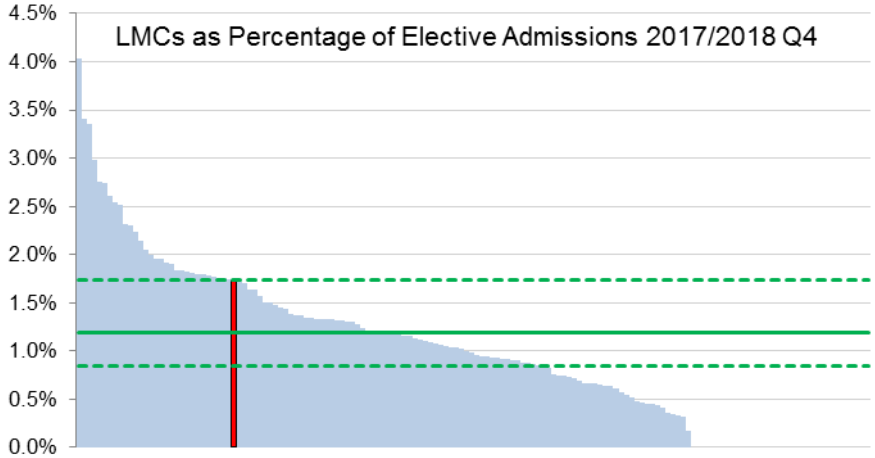
	Cancer 62 Day - Apr-18		
Cancer Site	First Treatment - Within Target	First Treatment - Total	First Treatment - Performance
Breast	2.0	2.0	100.0%
Gynaecological	3.0	5.5	54.5%
Haematological	6.0	6.5	92.3%
Head and Neck	4.5	6.0	75.0%
Lower Gastrointestinal	4.5	5.5	81.8%
Lung	9.0	13.5	66.7%
Other	2.0	2.5	80.0%
Sarcoma	2.0	2.5	80.0%
Skin	48.0	49.0	98.0%
Upper Gastrointestinal	3.0	6.5	46.2%
Urological	0.5	1.0	50.0%
Grand Total	84.5	100.5	84.1%

2.3 PERFORMANCE – Responsive Domain

Last Minute Cancelled Operations	
Standards:	This covers elective admissions that are cancelled on the day of admission by the hospital, for non-clinical reasons. The total number for the month should be less than 0.8% of all elective admissions. Also, 95% of these cancelled patients should be re-admitted within 28 days
Performance:	In May there were 125 cancellations, which was 1.9% of elective admissions. Of the 85 cancelled in April, 73 (85.9%) had been re-admitted within 28 days.
Commentary:	Levels of last minute cancellations remains high. The fire at the Oncology Centre resulted in 53 LMCs on the 10th May.
Ownership:	Chief Operating Officer







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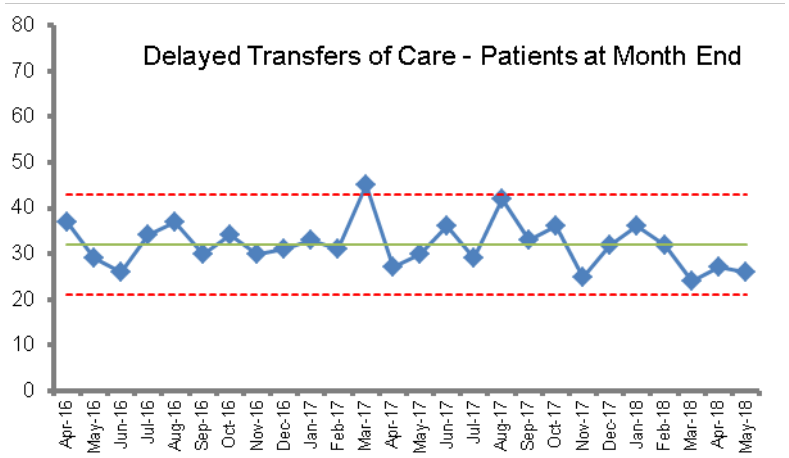
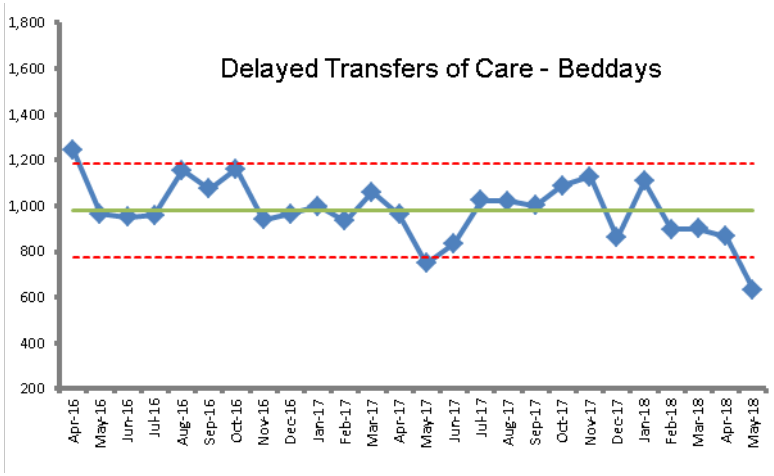
Cancellation Reason	Total
AM list over-ran	6
Booking Error	4
Equipment Failure	2
List Overbooked	2
No Beds Available	24
No HDU Beds	2
No Lab Staff	1
Other clinically complicated Patient in theatre	2
Other Emergency Patient Prioritised	25
Other Non Emergency Patient Prioritised	4
Surgeon Unavailable	13
Technician Not Available	1
Grand Total	86

2.3 PERFORMANCE – Responsive Domain

Delayed Transfers of Care (DToC)	
Standards:	Patients who are medically fit for discharge should wait a "minimal" amount of time in an acute bed.
Performance:	In May there were 26 Delayed Transfer of Care patients as at month-end, and 632 beddays consumed by DToC patients,
Commentary:	Significant improvement seen in month, largely driven by the system response to the major incident. Three key initiatives coming on stream in June with Bristol City Council – changes to the provider care home market procurement processes, improved access to home care providers and increased capacity in re-ablement. Trajectory agreed for improvement of target against actions by December 2018 being linked to our overarching plans for this improvement.
Ownership:	Chief Operating Officer



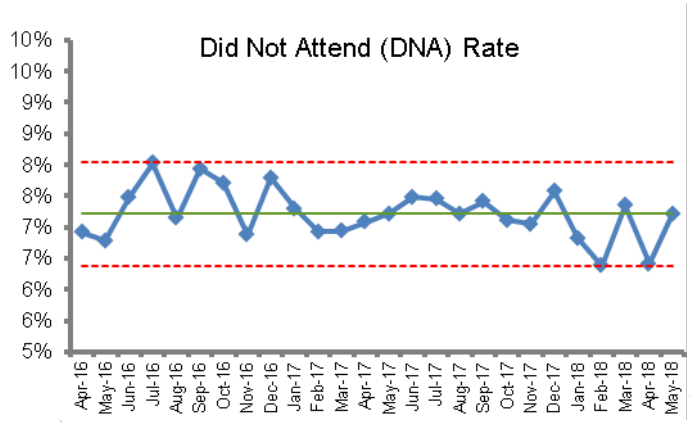


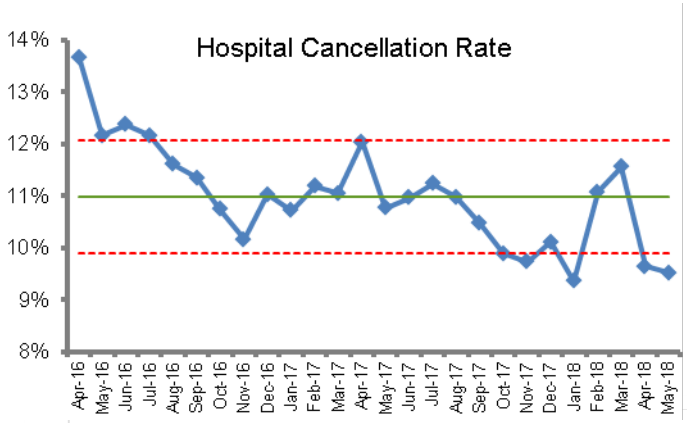
National DTOC Code	National DTOC Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	1	17	0	0
		NHS	2	53	0	1
		Social Care	3	68	0	55
B	Public Funding	Social Care	0	0	0	1
C	Further non acute NHS Care	NHS	1	42	0	0
Di	Care Home Placement	NHS	1	30	1	8
		Social Care	0	33	0	16
Dii	Care Home Placement	NHS	4	83	1	1
		Social Care	1	41	2	14
E	Care package in own home	NHS	1	31	1	8
		Social Care	2	46	2	50
F	Community equipment / adaptions	Both	0	4	0	2
		NHS	0	1	0	2
		Social Care	1	1	1	3
G	Patient or family choice	NHS	0	11	0	0
H	Disputes	NHS	0	1	0	0
I	Housing - patient not covered by NH	NHS	1	9	0	0
Grand Total			18	471	8	161

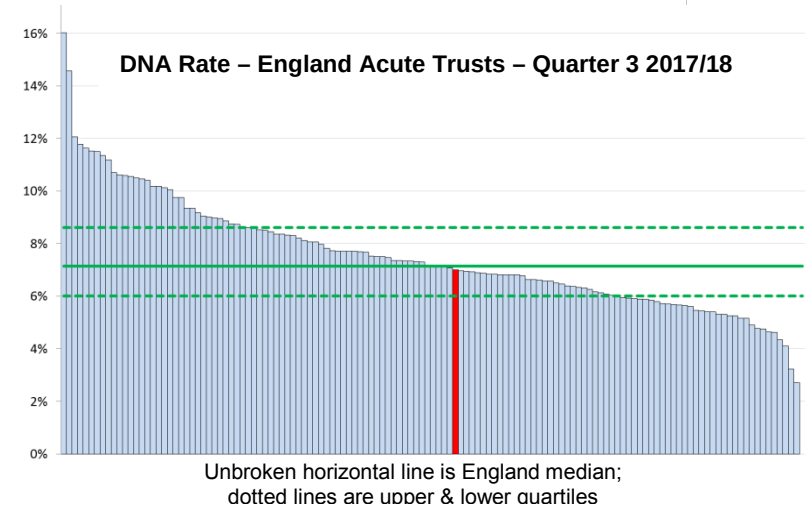
May-18	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	56	35	24	20
Bristol Haematology & Oncology Centre	25	10	5	1
Bristol Royal Infirmary	199	99	63	44
South Bristol Hospital	58	45	37	29
St Michael's Hospital	23	17	16	15
TRUST TOTAL	362	207	145	109
Bristol Royal Infirmary Divisional Breakdown:				
Medicine	113	60	39	24
Specialised Services	40	11	7	7
Surgery, Head & Neck	46	28	17	13

2.3 PERFORMANCE – Responsive Domain

Outpatient Measures	
Standards:	The Did Not Attend (DNA) Rate is the number of outpatient appointments where the patient did not attend, as a percentage of all attendances and DNAs The Hospital Cancellation Rate is the number of outpatient appointments cancelled by the hospital, as a percentage of all outpatient appointments made. The target for DNAs is to be below 5%, with an amber tolerance of between 5% and 10%. For Hospital Cancellations, the target is to be on or below 9.7% with an amber tolerance from 10.7% to 9.7%..
Performance:	In May there were 8952 hospital-cancelled appointments, which was 9.5% of all appointments made. There were 4938 appointments that were DNA'ed, which was 7.2% of all planned attendances.
Commentary:	Good progress has been made through Outpatient Steering Group. The group will now be reviewing specialties where there are improvement opportunities for reducing DNAs and cancellations still further, and new targets will be created. The effect of paper-less GP referrals and the requirement for all these referrals to come through eRS (electronic referral service) is also being monitored.
Ownership:	Chief Operating Officer







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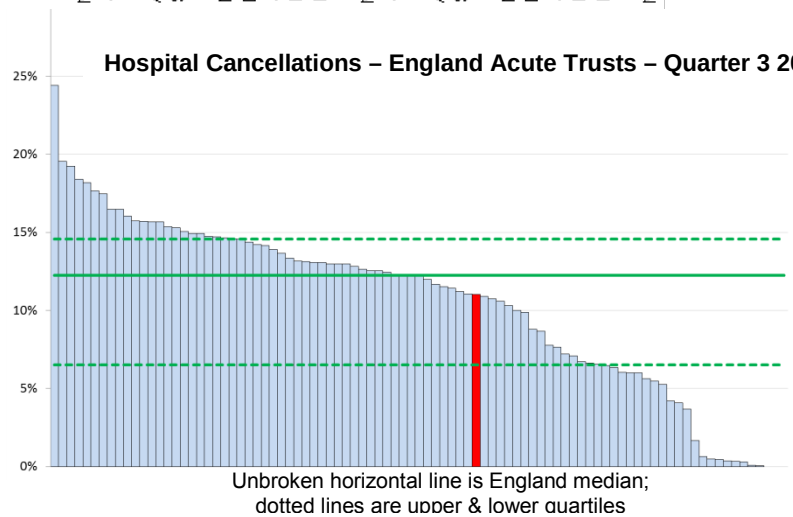

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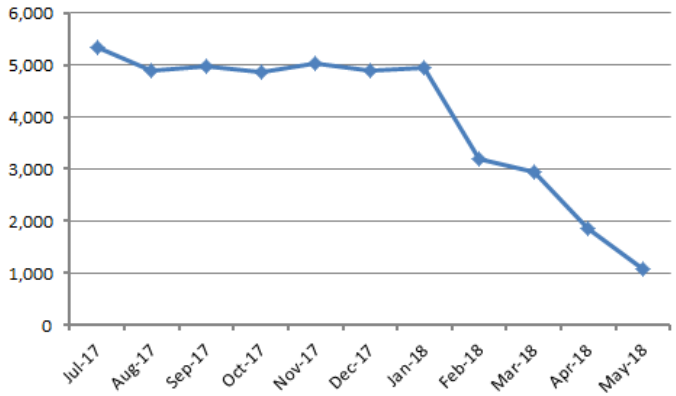
2.3 PERFORMANCE – Responsive Domain

Outpatient – Overdue Follow-Ups	
Standards:	This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can b reported. The current aim is to have no-one more than 12 months overdue
Performance:	As at end of May, number overdue by 12+ months has fallen to 1086.
Commentary:	Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting. The Trust aims to have eliminated the number of 12+ month overdue follow-ups by
Ownership:	Chief Operating Officer

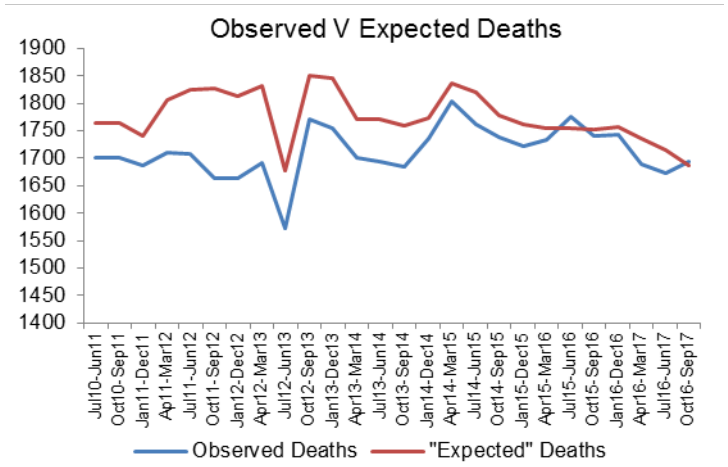
Number of Outpatients Overdue by 12+ Months at Month End

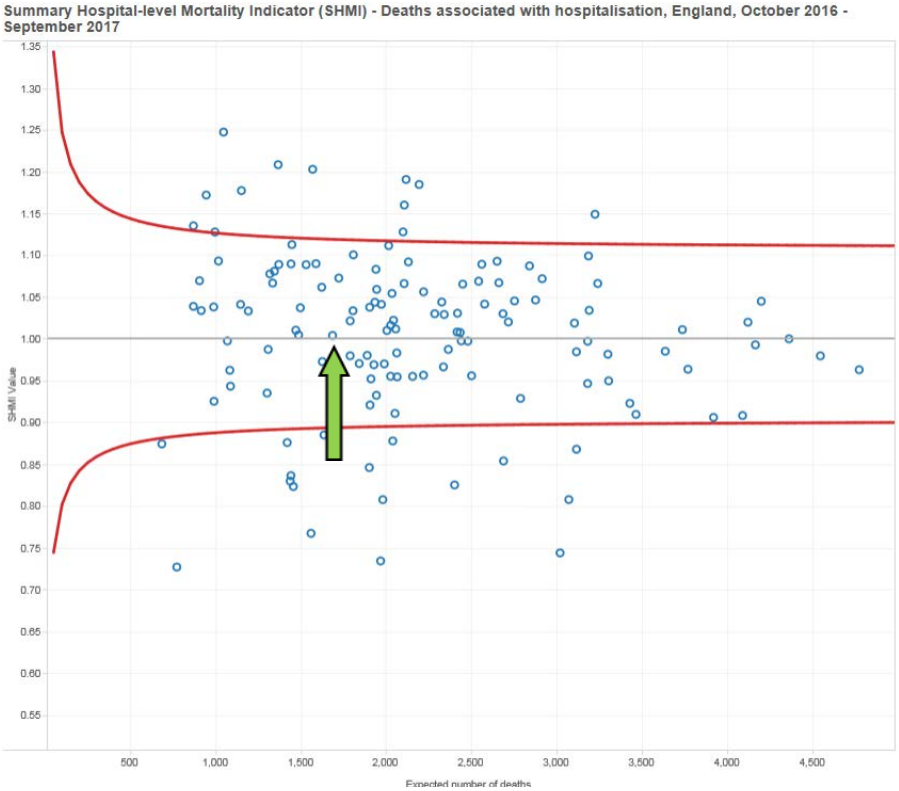
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Diagnostic & Therapy	0	0	0	0	0	0	0	0	0	0	0
Medicine	1,113	1,045	1,111	1,252	1,336	1,276	1,345	1,245	1,105	461	133
Specialised Services	563	432	442	295	353	387	400	367	383	188	206
Surgery	1,200	1,058	1,015	934	947	922	887	717	573	444	221
Women's & Children's	2,451	2,364	2,400	2,381	2,398	2,299	2,330	868	888	756	526
TRUST TOTAL	**5,327**	**4,899**	**4,968**	**4,862**	**5,034**	**4,884**	**4,962**	**3,197**	**2,949**	**1,849**	**1,086**



Mortality - Summary Hospital Mortality Indicator (SHMI)	
Standards:	This is the national measure published by NHS Digital .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Summary Hospital Mortality Indicator (SHMI) covers deaths in-hospital and deaths within 30 days of discharge. It is published quarterly as covers a rolling 12 –month period. Data is published 6 months in arrears.
Performance:	Latest SHMI data is for 12 month period Oct-16 to Sep-17. The SHMI was 100.4 (1693 deaths and 1686.2 "expected")
Commentary:	Although the Trust SHMI is slightly over 100, the Trust is still in the "SHMI As Expected" category. All Trusts are assigned to "Worse Than Expected", "As Expected" or "Better Than Expected". Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

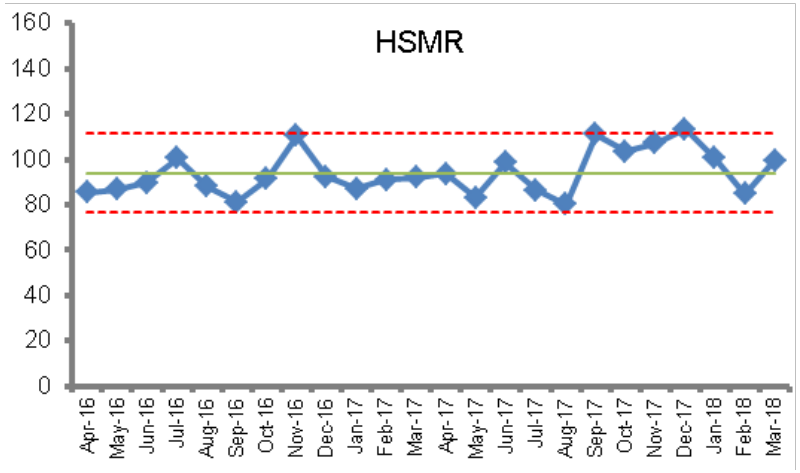
Time Period	Observed Deaths	"Expected" Deaths	SHMI	Banding
Jul15-Jun16	1,775	1,754	101.2	As Expected
Oct15-Sep16	1,741	1,752	99.4	As Expected
Jan16-Dec16	1,743	1,758	99.1	As Expected
Apr16-Mar17	1,690	1,737	97.3	As Expected
Jul16-Jun17	1,674	1,715	97.6	As Expected
Oct16-Sep17	1,693	1,686	100.4	As Expected

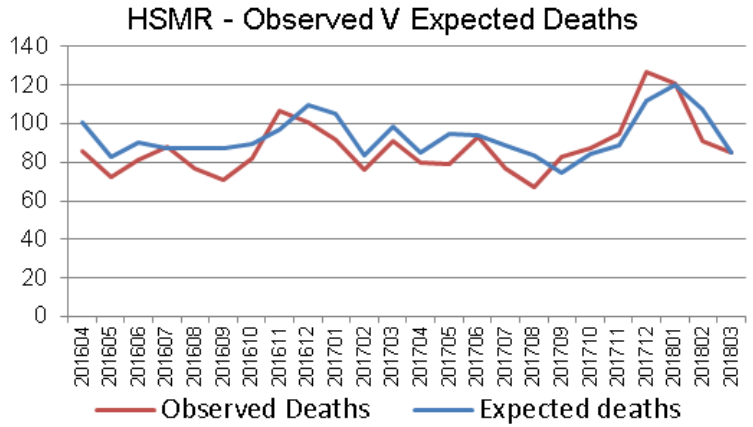




2.4 PERFORMANCE – Effective Domain

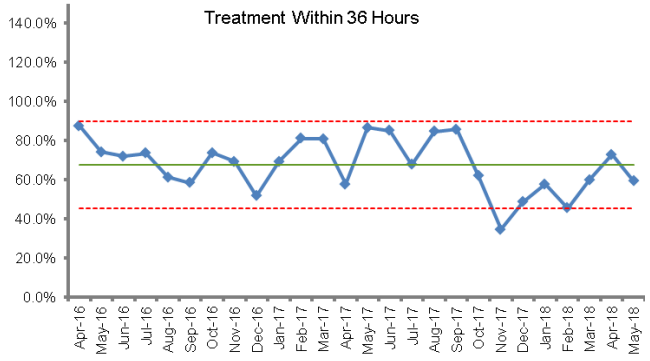
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for March 2018. The HSMR was 99.6 (85 deaths and 85 "expected")
Commentary:	The 12 month rolling HSMR remains below 100. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

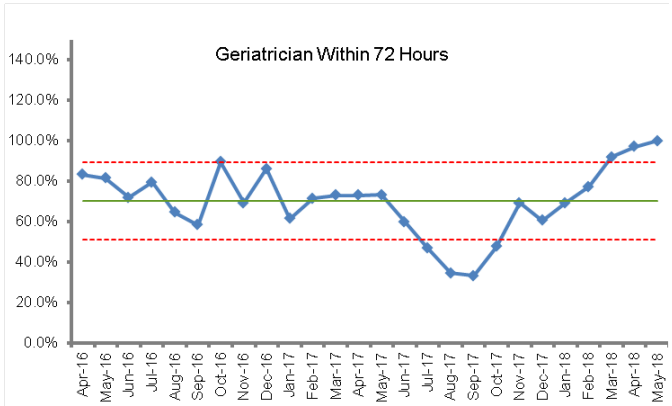


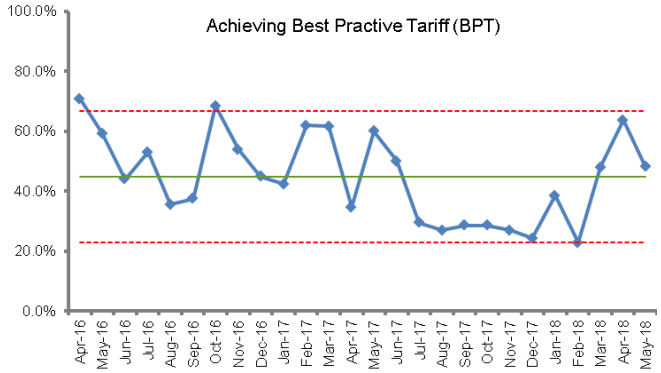


2.4 PERFORMANCE – Effective Domain

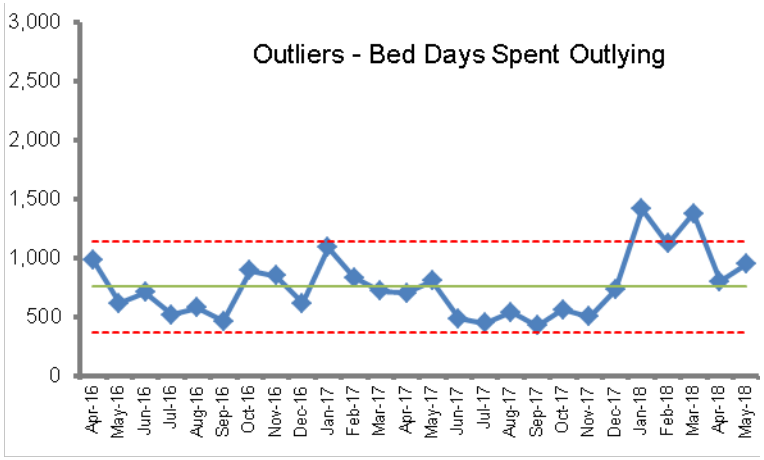
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	Latest data is May, where 27 Fracture NOF patients were admitted. For the 36 hour target, 59% were seen with target. For the 72 hour target, 100% were seen within target 13 patients (48%) achieved all elements of the Best Practice Tariff.
Commentary:	In May, there were 29 patients discharged following an admission for #NOF, and 27 of them were eligible for BPT. 11 of these patients were not operated on in theatre within the required 36 hours. 4 patients were also not reviewed by a Physiotherapist on the day of or the day after surgery. Therefore 14 patients did not qualify for BPT. Further details are provided below: The list below outlines the details of the 11 patients who were not treated in theatre within 36 hours: • One patient was not medically fit for surgery within the 36 hour window, • One patient required a specialist surgeon, • Nine patients were not operated on within the 36 hour timeframe due to other urgent trauma cases being prioritised. Several of these patients were admitted at a similar time. The 4 patients that were not reviewed by a Physiotherapist were because one patient was not well enough for an assessment and the remaining 3 patients were not assessed as we do not currently run a Sunday service.
Ownership:	Medical Director

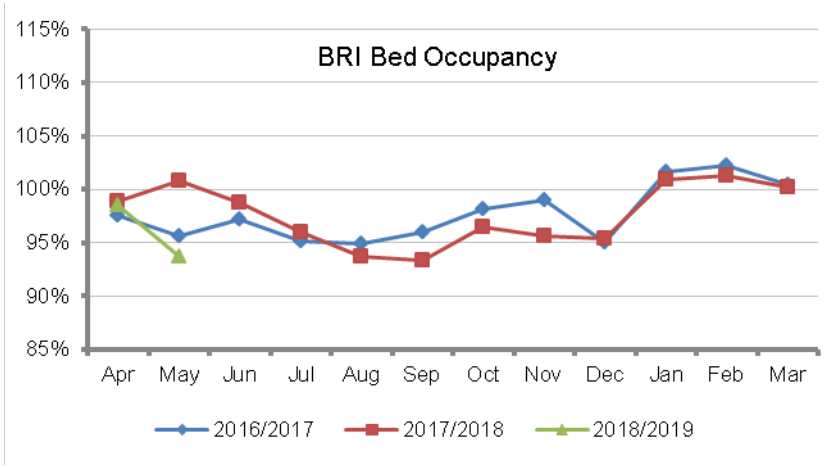


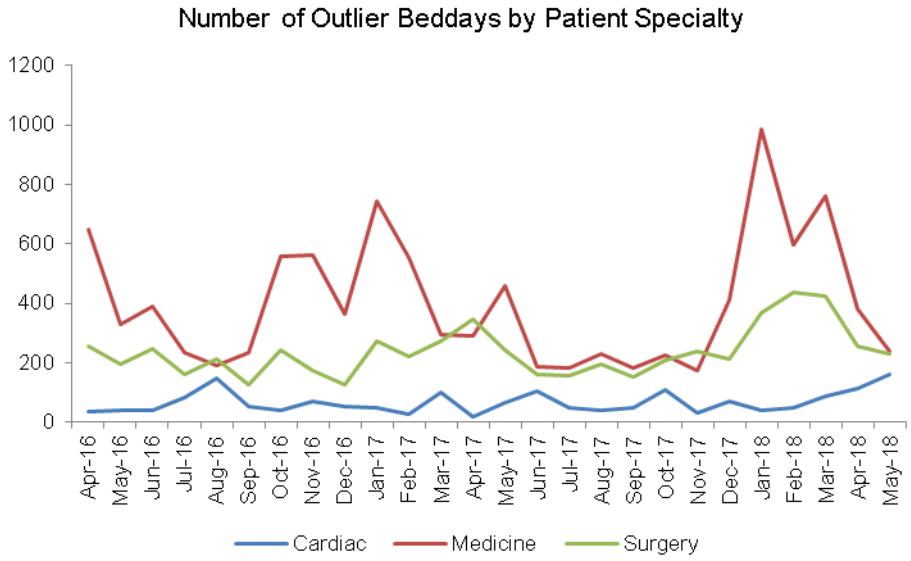




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In May there were 945 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight) Of these 241 were Medicine patients, 469 were Specialised Services patients and 232 were Surgery patients.
Commentary:	Impact of re-locating Oncology Centre patients because of the fire on site caused some increase in outliers. However, there was much improved performance across the month related to winter operational pressures subsiding. Implementation of Clinical Utilisation Review ongoing with a focus on increasing the use of this data at all patient flow meetings, and divisional targets to reduce the number of internal delays.
Ownership:	Chief Operating Officer

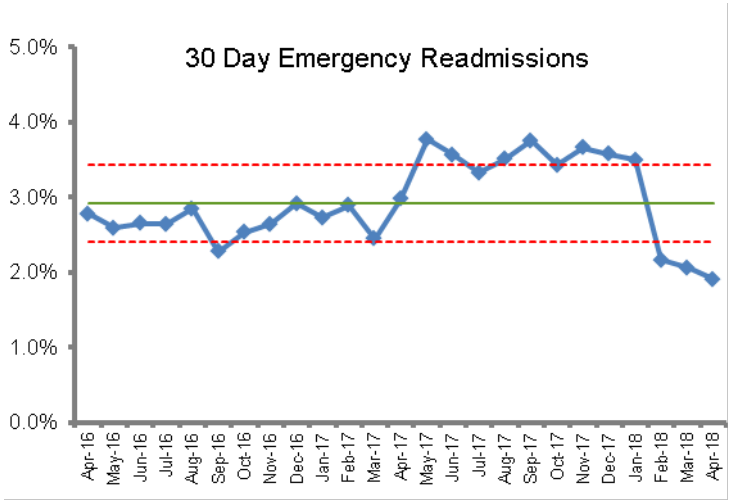






2.4 PERFORMANCE – Effective Domain

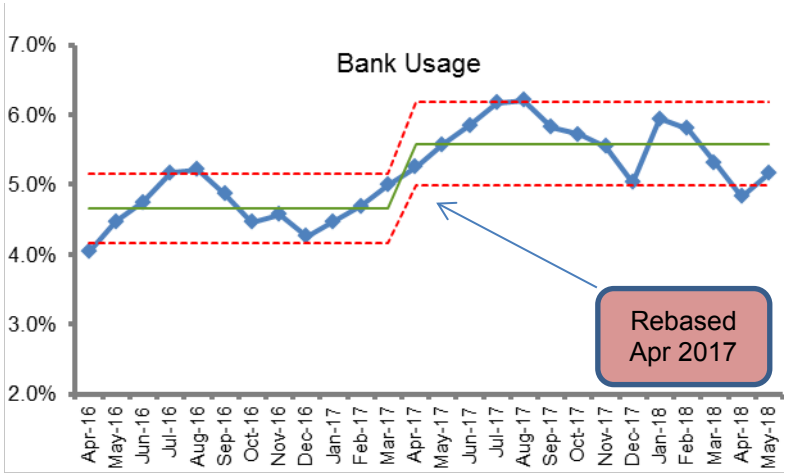
30 Day Emergency Readmissions	
Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain pathways such as Cancer and Maternity. The target for the Trust was to remain below 2014/15 levels of 2.7%.
Performance:	In March, there were 12201 discharges, of which 252 (2.07%) had a re-admission within 30 days.
Ownership:	Chief Operating Officer

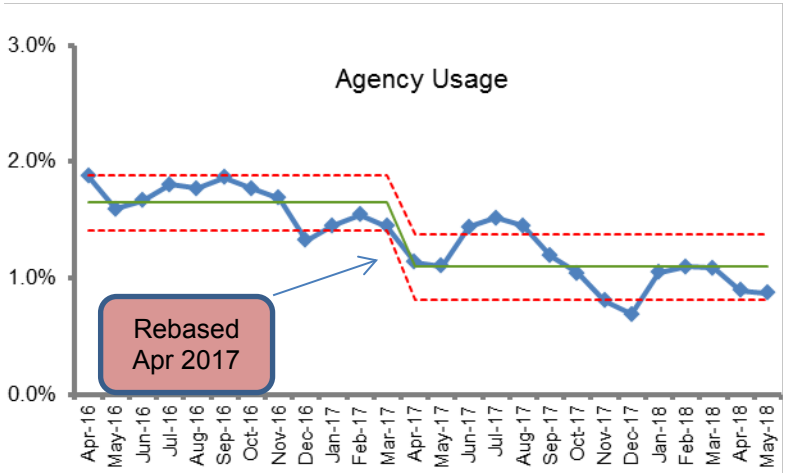


Discharges in April 2018

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	0	31	0.00%
Medicine	112	2,250	4.98%
Specialised Services	11	2,629	0.42%
Surgery	71	3,269	2.17%
Women's and Children's	39	4,050	0.96%
TRUST TOTAL	**233**	**12,229**	**1.91%**

Bank and Agency Usage	
Standards:	Usage is measured as a percentage of total staffing (FTE - full time equivalent) based on aggregated Divisional targets for 2018/19. The red threshold is 10% over the monthly target.
Performance:	In May, total staffing was at 8619 FTE. Of this, 5.1% was Bank (441 fte) and 0.9% was Agency (75.1 fte)
Commentary:	Agency usage reduced by 1.2 FTE, with the largest reduction seen in Women's and Children's, 22.2 FTE compared to 24.2 FTE in the previous month. The largest increase was seen in Surgery, rising to 16.7 FTE from 10.6 FTE the previous month. Bank usage increased by 27.4 FTE, with increases in all divisions and the largest increase for the Nursing & Midwifery staff group (18.5 FTE).
Ownership:	Director of People



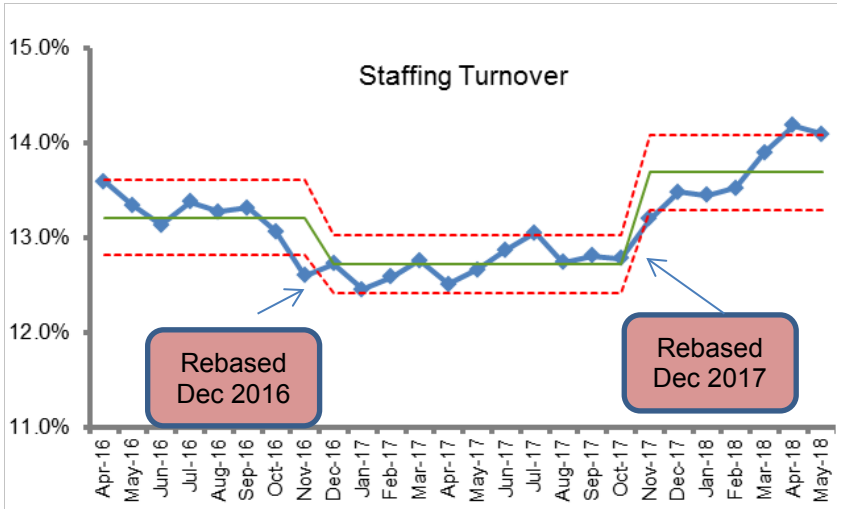


Bank	FTE	Actual %	KPI
UH Bristol NHS Foundation Trust	**440.7**	**5.1%**	**4.4%**
Diagnostics & Therapies	12.0	1.2%	1.4%
Facilities and Estates	48.4	6.5%	6.6%
Medicine	116.2	9.1%	10.9%
Specialised Services	62.9	6.3%	5.4%
Surgery	86.5	4.8%	3.0%
Trust Services	49.0	5.9%	2.9%
Women's & Children's	65.8	3.3%	2.1%

Agency	FTE	Actual %	KPI
UH Bristol NHS Foundation Trust	**75.1**	**0.9%**	**0.9%**
Diagnostics & Therapies	4.1	0.4%	1.1%
Facilities and Estates	3.4	0.5%	0.4%
Medicine	20.7	1.6%	1.9%
Specialised Services	6.3	0.6%	0.9%
Surgery	16.7	0.9%	0.8%
Trust Services	1.7	0.2%	0.3%
Women's & Children's	22.2	1.1%	0.7%

2.5 PERFORMANCE – Efficient Domain

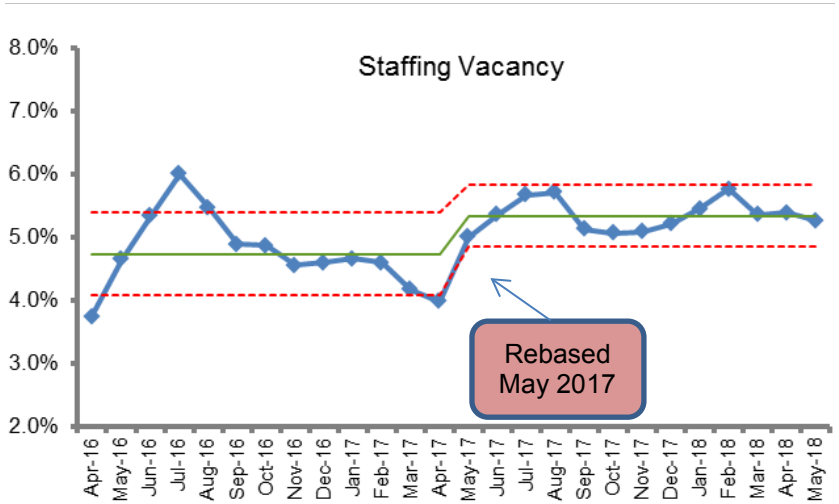
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In May, there had been 982 leavers over the previous 12 months with 6967 FTE staff in post on average over that period; giving a Turnover of 982 / 6967 = 14.1%
Commentary:	Turnover reduced to 14.1% from 14.2% last month, with decreases across 4 divisions - Facilities & Estates (0.5%), Medicine (0.4%), Specialised Services (0.5%), and Trust Services (0.4%). The largest increase in staff group was seen in Add Prof Scientific and Technical (1.2 percentage points), the biggest reduction was unregistered nursing (1.1% percentage points
Ownership:	Director of People



Turnover	May-18	KPI
UH Bristol NHS Foundation Trust	14.1%	13.6%
Diagnostics & Therapies	11.4%	11.6%
Facilities & Estates	18.7%	18.0%
Medicine	14.4%	14.4%
Specialised Services	15.7%	15.1%
Surgery	14.0%	12.6%
Trust Services	16.0%	16.0%
Women's & Children's	12.0%	11.6%

2.5 PERFORMANCE – Efficient Domain

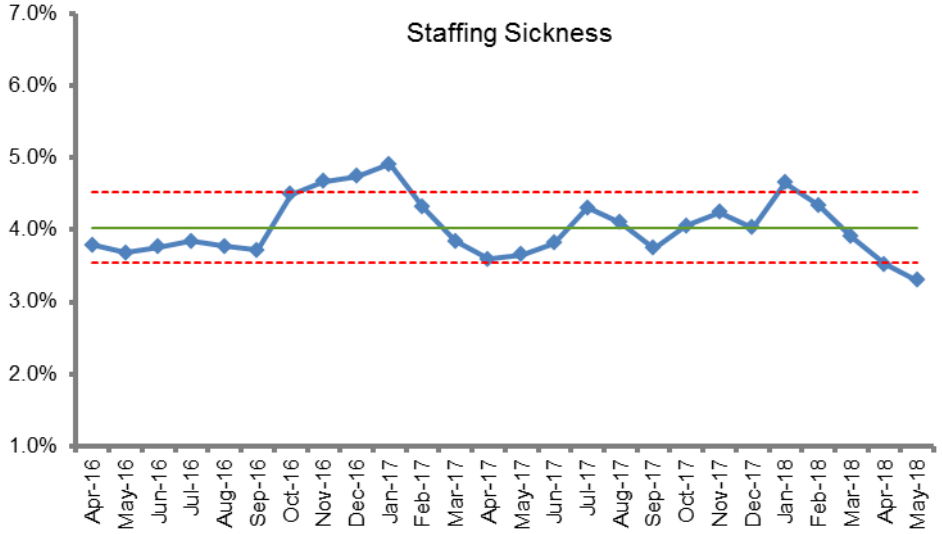
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In May, funded establishment was 8554, with 450 as vacancies (5.3%).
Commentary:	Overall vacancies reduced to 5.3% compared to 5.4% in the previous month. Admin and Clerical / Senior Managers reduced from 106 FTE to 85 FTE. The biggest reduction in this area was seen in Trust Services (excluding Facilities and Estates) where Admin and Clerical / Senior Manager vacancy reduced to 34 FTE from 49 FTE the previous month. The overall nursing vacancy position increased by 16.1 FTE. Registered nursing contributed to 14.6 FTE of the increase. The division of Women's and Children's registered nursing increased to 37.1 FTE from 21.6 FTE the previous month.
Ownership:	Director of People



Vacancy	May-18	KPI
UH Bristol NHS Foundation Trust	5.3%	5.00%
Diagnostics & Therapies	5.6%	5.00%
Medicine	6.1%	5.00%
Specialised Services	7.8%	5.00%
Surgery	5.9%	5.00%
Women's & Children's	0.9%	5.00%
Trust Services	3.9%	5.00%
Facilities & Estates	10.8%	5.00%

2.5 PERFORMANCE – Efficient Domain

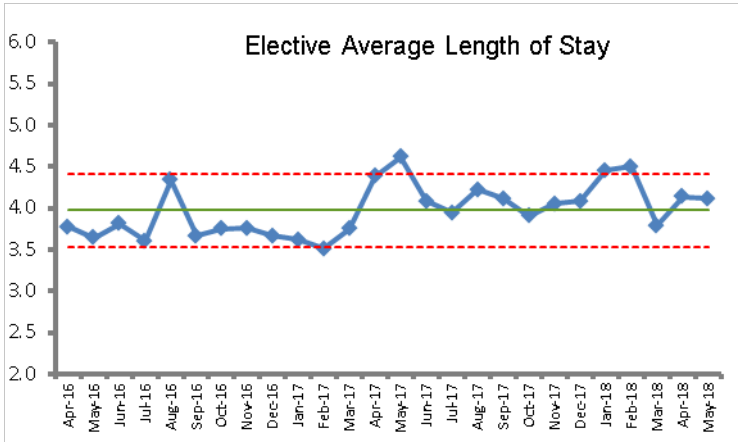
Staff Sickness	
Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In May, total available FTE days were 250404 of which 8258 (3.3%) were lost to staff sickness
Commentary:	Sickness absence reduced from 3.5% to 3.3%, with reductions in all Divisions except for Surgery and Women's and Children's both only increasing by 0.1%. The largest staff group reduction was seen in unregistered nursing. Stress/Anxiety continues to be the cause for the most of amount of sickness, days lost has increased by 5.6% compared with last month
Ownership:	Director of People

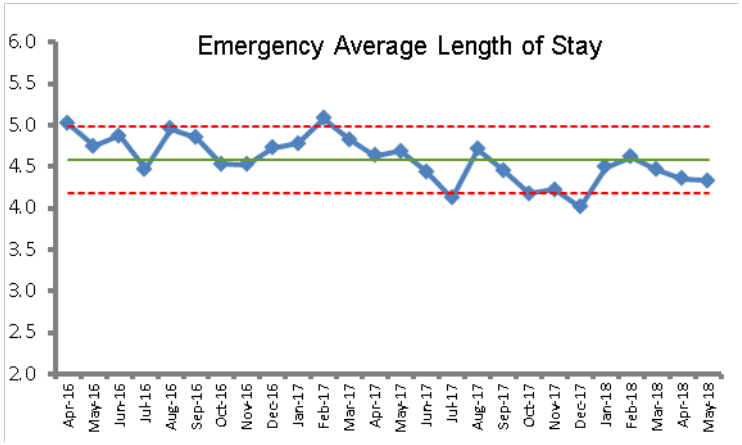


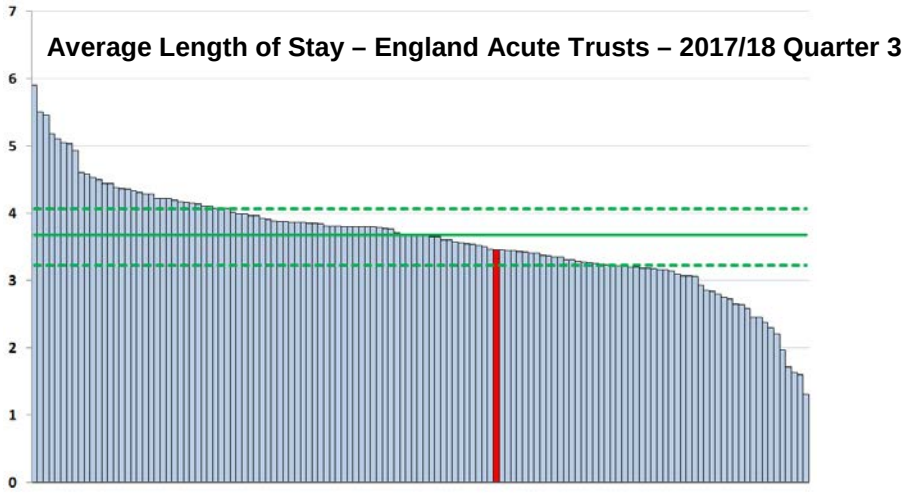
Staff Sickness	May-18	KPI
UH Bristol NHS Foundation Trust	**3.3%**	**3.6%**
Diagnostic & Therapies	2.5%	3.0%
Facilities & Estates	4.6%	6.2%
Medicine	3.6%	3.5%
Specialised Services	2.3%	3.3%
Surgery	3.5%	3.6%
Trust Services (exc Facilities & Estates)	2.2%	2.9%
Women's & Children's	3.7%	3.6%

2.5 PERFORMANCE – Efficient Domain

Average Length of Stay	
Standards:	Average Length of Stay is the number of beddays (1 beddays = 1 bed occupied at 12 midnight) for all inpatients discharged in the month, divided by number of discharges.
Performance:	In May there were 6597 discharges that consumed 25920 beddays, giving an overall average length of stay of 3.93 days.
Ownership:	Chief Operating Officer





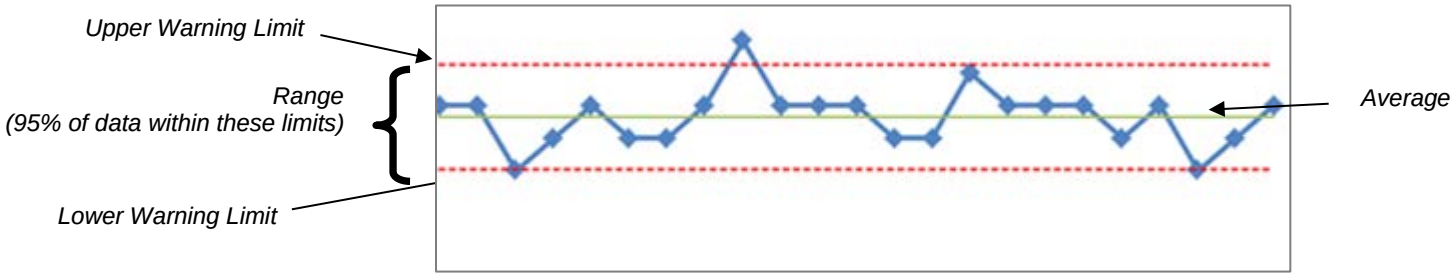


Unbroken horizontal line is England median;
dotted lines are upper & lower quartiles

A1 APPENDIX 1 – Explanation of SPC Charts

In Section 2, some of the metrics are being presented using Statistical Process Control (SPC) charts

An example chart is shown below:



The blue line is the Trust's monthly data and the green solid line is the monthly average for that data. The red dashed lines are called "warning limits" and are derived from the Trust's monthly data and is a measure of the variation present in the data. If the process does not change, then 95% of all future data points will lie between these two limits.

If a process changes, then the limits can be re-calculated and a "step change" will be observed. There are different signals to look for, to identify if a process has changed. Examples would be a run of 7 data points going up/down or 7 data points one side of the average. These step changes should be traceable back to a change in operational practice; they do not occur by chance.

A2 APPENDIX 2 External Views of the Trust

This section provides details of the ratings and scores published by the Care Quality Commission (CQC), NHS Choices website and Monitor. A breakdown of the currently published score is provided, along with details of the scoring system and any changes to the published scores from the previous reported period.

Care Quality Commission

Ratings for the main University Hospitals Bristol NHS Foundation Trust sites (March 2017)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Medicine	Good	Outstanding	Good	Requires improvement	Outstanding	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Outstanding	Good	Outstanding	Outstanding
Critical care	Good	Good	Good	Requires improvement	Good	Good
Maternity & Family Planning	Good	Good	Good	Good	Outstanding	Good
Services for children and young people	Good	Outstanding	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients & Diagnostic Imaging	Good	Not rated	Good	Good	Good	Good
Overall	Good	Outstanding	Good	Requires improvement	Outstanding	**Outstanding**

NHS Choices

Website

The NHS Choices website has a 'Services Near You' page, which lists the nearest hospitals for a location you enter. This page has ratings for hospitals (rather than trusts) based upon a range of data sources.

Site	User ratings	Recommended by staff	Mortality rate (within 30 days)	Food choice & Quality
BCH	5 stars	OK	OK	✓ 98.5%
STM	5 stars	OK	OK	✓ 98.4%
BRI	4 stars	OK	OK	✓ 96.5%
BDH	3 stars	OK	OK	Not available
BEH	4.5 Stars	OK	OK	✓ 91.7%

Stars – maximum 5
OK = Within expected range
✓ = Among the best (top 20%)
! = Among the worst
Please refer to appendix 1 for our site abbreviations.

SAFE, CARING & EFFECTIVE

Topic	ID	Title	Annual 17/18	Annual 18/19 YTD	Monthly Totals Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	4	1	1	0	0	0	0	1	1	1	0	0	1	0	0	2	1	1
	DA02	MSSA Trust Apportioned Cases	25	8	3	0	3	0	5	4	1	2	3	3	3	5	3	10	8	8
	DA03	CDiff Trust Apportioned Cases	35	2	5	6	2	3	1	1	3	2	6	0	2	0	11	5	8	2
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	7	0	1	2	1	1	0	0	0	0	0	0	0	0	4	0	0	0
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	12	2	0	0	0	0	0	1	3	2	6	0	2	0	0	4	8	2
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.6%	97.2%	98.4%	97.2%	97.7%	96.3%	96.4%	97.6%	97.3%	98.4%	98.2%	96.9%	96.8%	97.8%	97%	97.1%	97.8%	97.2%
	DB02	Antibiotic Compliance	86.4%	82.2%	87.4%	87.8%	81.3%	84.4%	85.1%	89.1%	85.4%	85.2%	89.6%	85.3%	82.8%	81.3%	84.3%	86.4%	86.6%	82.2%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	96%	96%	97%	97%	96%	96%	95%	98%	94%	95%	95%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	98%	98%	98%	96%	97%	98%	97%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	97%	97%	97%	97%	96%	97%	96%	93%	96%	96%	96%	95%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	57	13	6	5	3	9	2	4	4	6	2	7	3	10	17	10	15	13
	S02a	Number of Confirmed Serious Incidents	49	-	6	5	3	9	2	3	4	6	2	2	-	-	17	9	10	-
	S02b	Number of Serious Incidents Still Open	5	13	-	-	-	-	-	-	-	-	-	5	3	10	-	-	5	13
	S03	Serious Incidents Reported Within 48 Hours	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	94.7%	100%	83.3%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.2%	87.5%	100%	100%	100%	100%	100%	100%	100%	83.3%	100%	100%	100%	75%	100%	100%	93.3%	87.5%
	S04a	Overdue Exec Commissioned Non-SI Investigations	19	4	2	1	1	2	1	1	3	3	1	1	2	2	4	5	5	4
Never Events	S01	Total Never Events	8	0	2	1	0	0	2	0	0	1	0	1	0	0	1	2	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	15656	2739	1330	1288	1249	1229	1311	1332	1193	1347	1379	1480	1428	1311	3766	3836	4206	2739
	S06b	Patient Safety Incidents Per 1000 Beddays	50.86	54.37	53.99	49.49	48.38	49.91	50.19	52.96	46.38	50.04	57.11	55.29	55.84	52.85	49.25	49.82	54.04	54.37
	S07	Number of Patient Safety Incidents - Severe Harm	92	19	8	6	7	7	4	9	9	10	7	7	6	13	20	22	24	19
Patient Falls	AB01	Falls Per 1,000 Beddays	4.59	4.03	4.91	4.53	4.76	5.04	4.48	3.78	4.51	4.61	4.68	5.04	3.79	4.27	4.77	4.26	4.78	4.03
	AB06a	Total Number of Patient Falls Resulting in Harm	25	6	4	0	0	3	2	2	5	2	0	2	2	4	3	9	4	6
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.162	0.139	0.203	0.154	0.155	0.203	0.038	0.159	0.156	0.372	0.207	0.149	0.156	0.121	0.17	0.117	0.244	0.139
	DE02	Pressure Ulcers - Grade 2	45	5	5	2	4	4	1	4	4	10	5	4	2	3	10	9	19	5
	DE04A	Pressure Ulcers - Grade 3 or 4	5	2	0	2	0	1	0	0	0	0	0	0	2	0	3	0	0	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.4%	98.2%	98.7%	98.8%	97.4%	98.3%	98.4%	98.2%	98%	98%	98.3%	98.3%	98.1%	98.4%	98.2%	98.2%	98.2%	98.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	94.9%	97%	97.4%	94.9%	92.3%	97.1%	94%	92.3%	91.4%	94.4%	97.1%	93.8%	96.1%	94.7%	94.5%	94.1%	94.9%
	N04	Number of Hospital Associated VTEs	42	-	5	4	2	3	6	1	4	9	-	-	-	-	9	11	9	-
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	2	-	1	0	0	0	1	0	0	0	-	-	-	-	0	1	0	-
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	7	-	0	0	0	0	0	0	4	3	-	-	-	-	0	4	3	-
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	92.1%	-	91.5%	96.2%	94.6%	92.6%	91%	95.2%	88.8%	95%	91%	93.7%	-	-	94.5%	91.3%	93%	-
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	89.9%	-	92.2%	-	-	92%	-	-	88.9%	-	-	86.3%	-	-	92%	88.9%	86.3%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.8%	99.8%	99.8%	99.8%	99.9%	99.8%	99.2%	99.8%	100%	99.8%	99.7%	99.9%	99.7%	99.8%	99.6%	99.8%	99.8%

APPENDIX 3 – Trust Scorecards

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	17/18	18/19 YTD	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Medicines	WA01	Medication Incidents Resulting in Harm	0.55%	0%	0%	1.35%	0.51%	0%	1.97%	0.47%	0.5%	0.49%	0%	0%	0%	-	0.64%	0.97%	0.15%	0%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.4%	0.51%	0.24%	0.32%	0.11%	0.37%	0.27%	0.41%	0%	0.42%	1.02%	0.33%	0.63%	0.36%	0.25%	0.24%	0.57%	0.51%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	-	97.9%	97.7%	96.9%	97.7%	97.5%	98.8%	98.3%	98.8%	98.2%	98.2%	-	-	97.4%	98.2%	98.4%	-
	AK04	Safety Thermometer - No New Harms	98.8%	-	98.4%	98.8%	98.2%	98.7%	98.9%	99.1%	99%	99.9%	98.4%	98.5%	-	-	98.6%	99%	98.9%	-
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	96%	-	93%	100%	97%	100%	90%	93%	97%	95%	91%	100%	-	-	99%	94%	95%	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	9.5%	6.7%	8.4%	10.9%	9.7%	9.1%	9.4%	9.1%	8.7%	8.2%	9%	10.2%	8.8%	9.7%	9.2%	8.6%	9.5%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.4%	21.4%	23.3%	22.9%	21.9%	24%	24.2%	24%	20.8%	20.5%	20.9%	21.9%	20.3%	22.4%	22.9%	23%	21.1%	21.4%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11138	1797	944	962	909	983	1024	1010	863	867	814	945	834	963	2854	2897	2626	1797
Staffing Levels	RP01	Staffing Fill Rate - Combined	98.9%	98.8%	102.4%	98.6%	98%	97.1%	97.5%	98.1%	97.2%	98.5%	96.8%	95.7%	99%	98.7%	97.9%	97.6%	97%	98.8%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	99	-	97.6	-	-	100.4	-	-	-	-	-	-	-	-	100.4	-	-	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	96.9	-	98.6	86.4	80.2	111.2	103.6	107.2	113.5	100.6	84.8	99.6	-	-	91.8	108.6	94.9	-
Readmissions	C01	Emergency Readmissions Percentage	3.28%	1.91%	3.57%	3.33%	3.51%	3.76%	3.43%	3.66%	3.57%	3.5%	2.17%	2.07%	1.91%	-	3.53%	3.55%	2.6%	1.91%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	51.1%	-	38.1%	21.1%	50%	16.7%	20%	33.3%	46.7%	64.7%	87%	83.3%	-	-	29.7%	35.5%	79.7%	-
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	77.4%	-	62.5%	66.7%	100%	100%	50%	-	100%	-	100%	50%	-	-	88.9%	75%	75%	-
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	93.3%	-	100%	100%	100%	100%	66.7%	-	75%	-	100%	-	-	-	100%	71.4%	100%	-
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	83.4%	-	78.3%	93.8%	95%	92.9%	91.7%	76%	68%	86%	88%	88%	-	-	94%	75.8%	87.3%	-
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	85.5%	-	77.8%	84.6%	88.2%	100%	94.1%	86.2%	91.7%	90%	74.2%	94.1%	-	-	90%	90%	83.8%	-
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	93.1%	-	100%	100%	100%	100%	88.9%	84%	90.9%	100%	82.1%	100%	-	-	100%	87.7%	91.2%	-
Maternity	G01	Percentage of Low Weight Babies	2.5%	2.6%	0.5%	1.5%	3.3%	3.4%	0.9%	2%	4.6%	3.2%	2%	3.2%	3.2%	2.1%	2.7%	2.5%	2.8%	2.6%
	G01A	Number of Low Weight Babies	119	20	2	6	13	13	4	7	18	13	7	12	12	8	32	29	32	20
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	64.2%	66.7%	85%	67.6%	84.6%	85.7%	61.9%	34.6%	48.5%	57.7%	45.5%	60%	72.7%	59.3%	77.8%	47.5%	54.8%	66.7%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	61.6%	98.3%	60%	47.1%	34.6%	33.3%	47.6%	69.2%	60.6%	69.2%	77.3%	92%	97%	100%	39.5%	60%	79.5%	98.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	34.8%	56.7%	50%	29.4%	26.9%	28.6%	28.6%	26.9%	24.2%	38.5%	22.7%	48%	63.6%	48.1%	28.4%	26.3%	37%	56.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	37.1	45.9	43.8	37.1	53.3	75.9	58.6	64.8	65.7	81.5	48.7	72.7	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	62.6%	58.1%	66.7%	72.9%	61.9%	70%	60.7%	55.6%	60.9%	57.9%	61.3%	54.3%	58.1%	-	68.5%	59.1%	57.4%	58.1%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	85.8%	81.4%	81.8%	83.3%	81%	92.5%	96.4%	83.3%	87%	84.2%	93.5%	80.4%	81.4%	-	85.4%	88.2%	85.2%	81.4%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	54.6%	33.3%	77.3%	27.3%	66.7%	75%	66.7%	70%	42.9%	50%	36.4%	20%	15.4%	54.5%	55.9%	62.9%	34.2%	33.3%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	89.3%	86.2%	89.4%	91.1%	89.9%	93.5%	87.7%	93.7%	87.9%	90.7%	87.3%	86.3%	87.3%	84.8%	91.5%	89.6%	88.2%	86.2%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	96.2%	93.5%	100%	100%	97.7%	97.9%	94%	97.4%	100%	93.8%	86%	96.5%	95%	91.9%	98.6%	96.9%	92%	93.5%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.9%	0%	100%	100%	100%	100%	75%	100%	100%	100%	-	100%	-	0%	100%	87.5%	100%	0%
	AC04	Percentage of Dementia Carers Feeling Supported	60%	-	100%	-	-	-	-	-	-	100%	-	33.3%	-	-	-	-	50%	-
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9098	1745	485	448	537	424	558	499	730	1411	1120	1377	800	945	1409	1787	3908	1745

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Topic	ID	Title	Annual 17/18	Annual 18/19 YTD	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	93	92	92	92	91	92	90	91	92	92	93	91	92	91	92	92
	P01g	Patient Survey - Kindness and Understanding	-	-	97	96	94	96	95	95	95	96	95	95	97	97	95	95	96	97
	P01h	Patient Survey - Outpatient Tracker Score	-	-	87	90	87	90	90	91	89	90	88	88	88	91	89	90	89	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35%	39%	37.4%	35.8%	35.1%	35.3%	39.5%	33.2%	28.4%	34.9%	36.2%	30.3%	40.7%	37.6%	35.4%	33.9%	33.7%	39%
	P03b	Friends and Family Test ED Coverage	17.3%	17.3%	20.9%	17.2%	18.5%	18.3%	17.9%	17.9%	14.6%	17.8%	17.4%	15.2%	17.3%	17.2%	18%	16.9%	16.8%	17.3%
	P03c	Friends and Family Test MAT Coverage	19%	16.5%	21.8%	20%	17.3%	18.3%	21%	12.4%	23.1%	17.5%	17.7%	18.2%	19.8%	13.2%	18.6%	19%	17.8%	16.5%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.7%	97.3%	97.7%	97.7%	97.5%	97.7%	97.9%	98.1%	97.8%	97.7%	98.3%	97.8%	97.4%	97.3%	97.6%	98%	97.9%	97.3%
	P04b	Friends and Family Test Score - ED	81%	80.6%	84.4%	77.4%	81.9%	83.5%	83.3%	80.3%	77%	81.8%	83.2%	77.7%	80.1%	81.1%	81%	80.5%	81%	80.6%
	P04c	Friends and Family Test Score - Maternity	96.9%	95%	96.9%	94.9%	96.5%	99.2%	98%	97.5%	98.1%	94.6%	96.8%	97.1%	94.6%	95.5%	96.8%	98%	96.1%	95%
Patient Complaints	T01	Number of Patient Complaints	1815	306	150	146	146	138	154	155	98	143	121	159	149	157	430	407	423	306
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	83%	87%	80.4%	82%	87.3%	78.7%	85.1%	87.1%	83.8%	87.8%	82.8%	77.9%	83.1%	91%	83%	85.4%	82.3%	87%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	84.1%	78.3%	90%	81.7%	86.9%	83.6%	90%	82.4%	91.8%	82.8%	77.9%	85.9%	82.1%	85.7%	85.4%	83.4%	84.1%
	T04c	Percentage of Responses where Complainant is Dissatisfied	10.68%	-	21.74%	8%	11.27%	9.84%	10.45%	7.14%	2.94%	8.16%	8.62%	13.23%	-	-	9.89%	6.83%	10.29%	-
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.19%	1.65%	0.81%	0.81%	0.91%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.92%	1.37%	1.9%	0.88%	1.15%	1.69%	1.65%
	F01a	Number of Last Minute Cancelled Operations	919	210	54	54	61	58	68	85	71	102	98	121	85	125	173	224	321	210

RESPONSIVE

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	92%	87%	89.6%	88.6%	91%	90.2%	89.9%	89.4%	90%	88.9%	88.3%	88.1%	88.4%	87%	88.2%	89.1%	89.8%	89.1%	87.8%	88.6%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3023	3317	3372	3524	3300	2927	3085	3138	3308	3783	3510	3244	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	209	27	46	30	32	19	10	13	9	1	15	18	15	12	81	32	34	27
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	-	-	193	198	240	182	155	136	158	160	148	164	154	141	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.3%	92.6%	94.3%	93.4%	93.2%	94.6%	94.6%	95.5%	94.8%	92.2%	96.9%	92.1%	92.6%	-	93.7%	95%	93.6%	92.6%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	58.9%	41.3%	62.2%	63.6%	62.4%	59.9%	64.2%	57.6%	54.4%	58.8%	59.6%	54.6%	41.3%	-	62%	59%	57.7%	41.3%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	95.8%	94.4%	95.1%	97%	97.9%	96.9%	95.4%	98.1%	96.7%	92.9%	95.1%	95.8%	94.4%	-	97.3%	96.7%	94.5%	94.4%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.6%	97.6%	98.7%	98.6%	98.6%	98.5%	99.3%	98.7%	98.9%	98.7%	98.6%	98.4%	97.6%	-	98.6%	99%	98.6%	97.6%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	92%	93%	93.2%	91.7%	96.3%	94.7%	95.7%	96.8%	93%	96.6%	87.7%	79.5%	93%	-	94.3%	95.2%	89%	93%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.3%	98.5%	95.9%	93.9%	97.3%	98%	96.4%	96.1%	97.6%	92.9%	97.9%	96.4%	98.5%	-	96.3%	96.6%	95.6%	98.5%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	81.7%	84.1%	81.7%	75%	85.2%	80.2%	84.3%	88.6%	82.9%	78.4%	81.3%	87.3%	84.1%	-	80.1%	85.4%	82.4%	84.1%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	74.8%	66.7%	100%	87.5%	100%	100%	66.7%	76.5%	71.4%	100%	58.3%	28.6%	66.7%	-	96.3%	73.3%	61.5%	66.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	85.4%	79.3%	87%	78.6%	84.8%	90.7%	74.7%	88.5%	85.7%	88.7%	83.9%	90.9%	79.3%	-	84.6%	83%	87.9%	79.3%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	47.5	3	5	8	5	3	3.5	2	4.5	3	2.5	2	3	-	16	10	7.5	3
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.19%	1.65%	0.81%	0.81%	0.91%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.92%	1.37%	1.9%	0.88%	1.15%	1.69%	1.65%
	F01a	Number of Last Minute Cancelled Operations	-	-	919	210	54	54	61	58	68	85	71	102	98	121	85	125	173	224	321	210
	F02	Cancelled Operations Re-admitted Within 28 Days	95%	85%	94.2%	87.9%	97%	100%	98.1%	95.1%	96.6%	91.2%	94.1%	88.7%	94.1%	92.9%	89.3%	85.9%	97.6%	93.8%	92.3%	87.9%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.61%	2.31%	1.82%	1.2%	0.88%	1.73%	1.28%	1.9%	1.38%	1.81%	2.08%	2.31%	2.26%	2.36%	1.26%	1.53%	2.06%	2.31%
	F07a	Number of Admissions Cancelled Day Before	-	-	1244	295	121	80	59	110	87	128	82	121	125	146	140	155	249	297	392	295
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	76.1%	86.2%	77.5%	75%	80.6%	84.8%	73.8%	77.4%	63.8%	80.9%	71.1%	65.2%	86.2%	-	80.2%	70.8%	74.1%	86.2%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.2%	93.1%	90%	87.5%	94.4%	97%	92.9%	93.5%	93.6%	95.7%	97.4%	91.3%	93.1%	-	93.1%	93.3%	95.4%	93.1%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.29%	97.2%	98.58%	98.52%	97.61%	97.7%	98.19%	98.28%	97.62%	97.81%	99.19%	98.51%	96.8%	97.61%	97.94%	98.03%	98.53%	97.2%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	10.7%	9.6%	11%	11.2%	11%	10.5%	9.9%	9.7%	10.1%	9.4%	11.1%	11.6%	9.7%	9.5%	10.9%	9.9%	10.6%	9.6%
	R05	Outpatient DNA Rate	5%	10%	7.2%	6.8%	7.5%	7.4%	7.2%	7.4%	7.1%	7.1%	7.6%	6.8%	6.4%	7.3%	6.4%	7.2%	7.4%	7.2%	6.8%	6.8%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.19	2.03	2.23	2.25	2.26	2.16	2.1	2.15	2.2	2.22	2.17	2.1	2.06	1.99	2.22	2.15	2.16	2.03
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	20.2%	20.1%	21.7%	18.8%	16.8%	15.8%	20.2%	22.3%	20.8%	20.8%	22.6%	14.6%	18.6%	21.5%	17.1%	21.1%	19.4%	20.1%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	-	-	279	40	30	18	31	22	26	17	23	27	23	19	22	18	71	66	69	40
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	103	13	6	11	11	11	10	8	9	9	9	5	5	8	33	27	23	13
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	8466	1047	577	745	647	757	774	854	606	836	715	696	576	471	2149	2234	2247	1047
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	3106	452	259	278	374	243	315	273	255	272	182	204	291	161	895	843	658	452
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	43	46	51	36	46	44	47	53	54	52	59	56	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	11	15	17	22	22	11	13	15	26	17	18	14	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1403	1430	1580	1502	1461	1555	1532	1757	1652	1989	1832	1574	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	419	401	572	515	671	451	479	593	453	501	614	451	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.05	3.97	4.06	3.8	4.37	4.12	3.87	4	3.74	4.15	4.15	3.96	4.01	3.93	4.09	3.87	4.08	3.97
	J04D	Percentage Length of Stay 14+ Days	-	-	6.8%	6.5%	6.7%	6.2%	7%	6.8%	6.8%	6.9%	6%	6.6%	6.9%	7.1%	6.5%	6.4%	6.7%	6.5%	6.9%	6.5%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	226	250	255	237	240	213	243	242	252	238	234	207	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	6.5%	5.2%	4.2%	4.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	4.2%	5.6%	3.3%	6.5%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	34.5%	37.2%	39.5%	50%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	40.9%	48.3%	50.6%	34.5%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	90%	86.48%	87.6%	87.89%	90.53%	91.26%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	90.87%	88.64%	81.54%	87.6%
This is measured against the national standard of 95%																						
ED - Time in Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	-	-	86.48%	87.6%	87.89%	90.53%	91.26%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	90.87%	88.64%	81.54%	87.6%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	78.35%	79.81%	79.01%	85.11%	86.82%	86.53%	84.11%	88.22%	77.24%	71.39%	73.24%	65.06%	73.92%	85.56%	86.14%	83.2%	69.78%	79.81%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	94.89%	95.38%	97.14%	96.62%	96.35%	94.99%	96.34%	91.54%	92.56%	93.91%	94.5%	95.08%	94.45%	96.25%	95.97%	93.42%	94.49%	95.38%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	96.26%	96.24%	97.9%	96.58%	97.04%	96.58%	97.43%	94.21%	98.34%	96.63%	94.35%	92.9%	94.4%	98.11%	96.74%	96.59%	94.62%	96.24%
This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																						
Trolley Waits	B06	ED 12 Hour Trolley Waits	0	1	8	0	0	0	0	0	0	0	5	3	0	0	0	0	0	5	3	0
Time to Initial Assessment	B02c	ED Time to Initial Assessment - Under 15 Minutes (Excludes BCH)	95%	95%	97.9%	95.8%	98.3%	98.5%	99.3%	97.8%	98.8%	98.6%	98.2%	97.6%	96.5%	96.3%	96.8%	94.8%	98.5%	98.5%	96.8%	95.8%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	94.4%	91.1%	92.8%	91.8%	92.6%	90.7%	94.2%	94.8%	99.4%	99.4%	98.4%	93.7%	91.9%	90.2%	91.7%	96.2%	97.2%	91.1%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.2%	51.7%	52.8%	54%	55.4%	54.1%	53.2%	48.4%	51%	54.4%	52.4%	48%	49.5%	53.8%	54.5%	50.8%	51.6%	51.7%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	97.4%	96.6%	97.1%	97.4%	97.3%	97.5%	97.1%	97.8%	98%	98%	97.6%	96.5%	96.5%	96.7%	97.4%	97.6%	97.4%	96.6%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.8%	3%	2.7%	2.7%	1.9%	2.3%	2.9%	3.3%	3.3%	3.1%	2.9%	2.9%	3%	3%	2.3%	3.2%	3%	3%
	B05	ED Left Without Being Seen Rate	5%	5%	1.9%	1.5%	2.5%	2%	2.1%	3.7%	1.1%	1.1%	1%	1%	1.1%	1.5%	1.4%	1.6%	2.6%	1.1%	1.2%	1.5%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	840	123	84	46	54	44	63	63	87	62	59	85	75	48	144	213	206	123
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	6.5%	5.2%	4.2%	4.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	4.2%	5.6%	3.3%	6.5%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	34.5%	37.2%	39.5%	50%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	40.9%	48.3%	50.6%	34.5%

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Trust Board meeting to be held on Thursday 28 June 2018, 10:00 – 12:30 in the Board Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	9
Report Title	Quality and Outcomes Committee Chair's Report		
Author	Julian Dennis, Non- Executive Director		
Executive Lead(s)	Carolyn Mills, Chief Nurse	Robert Woolley, Chief Executive	
Freedom of Information Status	Open		

Reporting Committee	Quality and Outcomes Committee
Chaired by	Julian Dennis, Non-Executive Director
Date of last meeting	26 June 2018

Key risks and issues/matters of concern and any mitigating actions

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 23 May 2018.

Quality and Performance Report
The Committee received the Quality and Performance report from Interim Deputy Chief Operating Officer Shaun Carr on the Quality and Performance Report.

Key points to note included:

- As the Committee were aware, there had been significant changes to the structure of the Quality and Performance Report to improve its usefulness and provide a more considered approach to showing performance trajectory. It was intended to bring this to a Board Seminar for further discussion.
- Performance against the 4 hour ED waiting target had improved post-winter, was 91.1% in May, and was currently at 89.1% in-quarter, so there was a real chance of hitting the quarterly target for STF of 90% (though not the 95% national target). ED staffing remained a concern, and there were challenges to finding cover, even with locums, though options including the use of GPs were being explored
- Performance against the 62-day Cancer standard for GP referrals was 84.1% for April 2018. This was below the national standard of 85%, but above the STF target of 81%. Recovery against the 62 day GP standard was forecast for August 2018. It was noted that the major fire incident at BHOC had impacted particularly on cancer performance.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 89.1% as at the end of May, and 89% as the predicted early position for June, meeting the 87% STF target but not the 92% national standard.
- The percentage of Diagnostic patients waiting under 6 weeks at end of May was 97.6%, and 98% in June, lower than the national 99% standard. The national trajectory was expected to be achieved as per the trajectory from August.

- The Committee noted the launch of a virtual fracture clinic was scheduled for mid-July 2018 (date to be confirmed).
- The Committee were very encouraged to see improvements coming through in the data around performance.

On-hold Patients - Update

The Committee received an update from the Interim Deputy Chief Operating Officer Shaun Carr.

Key points to note included:

- This was progressing well: 16,000 pathways should be closed off soon, and there were currently 28,000 pathways still on the systems out of the original 86,000 on-hold. IST remained satisfied with the Trust's work on this.
- The harm panel had reviewed a significant volume of cases and had not identified any major impacts on individuals from the on-hold issue.
- The aim would be to close off the whole process fully by the end of September 2018.
- A by-product of this area of work was some focus on overdue follow ups: there was now an average waiting time of 14 months, which was much improved and close to the 12 month target.
- There would be an additional review of patients whose appointments had been cancelled due to the BHOC major fire incident.

Serious Incident Report & Root cause Analysis Reports

Key points to note included:

- There were ten new serious incidents reported in May 2018. All timescales and initial duty of candour requirements were met for these incidents.
- The latest root cause analysis reports were received and considered. The Committee noted in particular an RCA related to a serious data breach involving the checking and sending out of a disc containing patient notes. The Committee noted that it was important to make sure both the filing and checking of patient notes was appropriately and realistically managed to help prevent this kind of incident.
- The Committee noted that a number of updates on overdue actions were awaited from the divisions, and asked if updates could come back to the Committee on incidents where actions were overdue and deadline extensions for investigations being granted.

Monthly Nurse Staffing Report

Key points to note included:

- The Committee asked for further information on theatre gaps identified in the report to be brought back to the next meeting.
- There were no risks or concerns to flag from the report**.**

Patient Safety Improvement Programme – Q4 Report

The Committee received the Patient Safety Improvement Programme – Q4 Report, presented by Anne Reader.

Key points to note included:

- The programme would come to the end of its initial three years in summer 2018 when there would be a review of what the Trust's patient safety improvement priorities should be for the next three years.
- Some improvement goals, including adverse event rate, had been achieved, whilst others such as mortality reduction had not.
- The intention was to start planning soon for the next three year programme, including key milestones.

NHS National Staff Survey Report 2017

The Committee received an update on the Trust's response to the NHS National Staff Survey Report 2017 by Director of People Matt Joint.

Key points to note included:

- Areas of focus include increasing the provision of non-mandatory training.
- Appraisal scores remained a concern: the overall quality of appraisals had increased, but numbers of completed appraisals had reduced, largely due to known system issues, which needed to be addressed.
- Scores on motivation and flexibility also needed addressing. The Committee agreed that ensuring strong staff comms, making sure staff saw their successes publicised and celebrated, were very important to staff motivation.
- There was also work to address bullying issues, including engagement with Staffside to work ultimately towards a culture of 'zero tolerance' on bullying.
- The Committee praised the quality of the report, including the narrative provided, and requested to see further information on action planning and outcomes against this work in future.

Patient Experience Quarterly Report – Q4

Key points to note included:

- There had been continued improvements on Patient Experience feedback, particularly at South Bristol Community Hospital.
- The Trust had hit its 6% target for completion of the Friends and Family Test, collecting a total of 33,000 patient responses.
- It had been flagged in Q3 that patient experience in Ward 528 – Care of Elderly was below what was expected, something which had been followed up on with patient interviews. The ward was now drafting a staff engagement action plan.
- There would now be similar engagement in response to rates in Ward A604, with a possible link to a high staff vacancy rate.
- Rapid response patient feedback system work testing had been successfully completed, and contracts were expected to be signed shortly.

Patient Complaints Quarterly Report – Q4

Key points to note included:

- The complaints rate remained steady at 140-150 complaints per month.
- A zero tolerance approach to breaches had led to improvements in quality, as demonstrated in the report. It was noted that from Q1 onwards more detailed information would be provided in the quarterly reports on the reasons for breaches, and the extent of recorded breaches.

Update and Closure of 'Should do' Action Plan following CQC inspection November 2016.
The Committee received an update on the Action Plan from Head of Quality (Patient Safety and Clinical Effectiveness) Chris Swonnell

Key points to note included:

- This reflected progress against recommended actions from the inspection, rather than mandatory requirements.
- SLT's recommendation was that the plan could be closed, with remaining 'should dos' moving into a business as usual risk-based approach, subject to the Committee's agreement.
- The Committee agreed to close the plan, subject to a short summary coming to the December 2018 meeting to confirm the action plan 'should dos' had been completed as planned.

Reports received for assurance included:

- **Clinical Quality Group Meeting Report**
- **Patient Complaints Annual Report**
- **Never Events National Report**

Matters requiring Committee level consideration and/or approval	
None.	
Matters referred to other Committees	
None.	
Date of next meeting	25 July 2018

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10a
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Quarter 4 Patient Experience and involvement Report**		
Author	Paul Lewis, Patient Experience and Involvement Team Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

To provide the Quality and Outcomes Committee with an update of survey data relating to service-user experiences at UH Bristol and a summary of Patient and Public Involvement activity being carried out at the Trust.

Key issues to note

Patient-reported experience surveys

- All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 4, indicating the continued provision of a high quality experience for our service-users

- South Bristol Community Hospital's headline survey scores increased for the third consecutive quarter. This change coincides with the ongoing work that has been carried out to improve patient experience at the hospital
- In Quarter 4, two wards received relatively low headline survey scores:
    - A528 (care of the elderly): patient and visitor interviews were carried out in response to the relatively low scores for this ward that were previously identified in Quarter 3. The feedback received through these interviews was very positive about the quality of care on ward A528, but the survey scores have continued to be relatively low in Quarter 4. The Matron for the ward is currently drafting a new staff engagement action plan and will incorporate insights from the patient / visitor feedback into this plan.
    - A604 (trauma and orthopaedics): patient interviews will be carried out to further explore these scores and to identify any specific actions that can be carried out to improve patient experience. The scores may relate to a high staff vacancy rate on the ward, with a number of temporary staff in post at present. A recruitment plan is in place to address this.

The Trust has an outpatient Friends and Family Test response rate target of 6%. In Quarter 4 the Trust achieved a response rate of 5.6%, the second consecutive quarter where the target was not met (having been 5.8% in Quarter 3). The Trust is predicted to exceed the 6% target for 2017/18 as a whole (we are awaiting the final release of March 2018 data from NHS England before this can be confirmed). In May 2018, the Patient Experience and Involvement Team extended the SMS (text message) element of this outpatient survey to include attendances at the Bristol Royal Hospital for Children. This methodology significantly increased the number of responses in adult services when it was introduced during 2017/18, and we anticipate a similar effect in children's services. This should therefore boost the overall number of responses to the Trust's outpatient Friends and Family Test, enabling us to exceed the 6% response rate target going forward.

Patient and Public Involvement

Examples of Patient and Public Involvement projects undertaken during Quarter 4 are provided in the Quarterly Report, including:

- The Trust's annual "Quality Counts" event was attended by around 50 people, with a range of external stakeholders represented, including members of the Trust's Involvement Network, Clinical Commissioning Groups, Healthier Together (Sustainable Transformation Plan), and Healthwatch. Feedback and suggestions from the event have informed the Trust's selection of quality objectives for 2018/19.
- Healthcare Change Makers is a patient leadership programme jointly partnered by UH Bristol, North Bristol NHS Trust, Bristol Community Health and the BNSSG Clinical Commissioning Group. The Healthcare Change Makers continue to bring a

patient voice into the Healthier Together partnership. During Quarter 4, they have supported the Healthier Together team in the development of their engagement and communication strategy bringing a particular focus to the issues of accessibility.

Care Quality Commission 2017 National Maternity Survey

The Trust's 2017 national maternity survey results, which were received during Quarter 4, were broadly in line with the national average. However, in the previous survey in 2015 the Trust had been among the very best nationally. UH Bristol's scores did not change significantly over this period, but at a national level the scores did improve. The response from the Trust's maternity service focusses on an extensive improvement programme to improve people's experiences of maternity care across the whole of Bath, Bristol, North Somerset and South Gloucestershire, as well as a number of specific actions that will be taken forward at St Michael's Hospital. This represents a clear ambition to return UH Bristol to its national-leading position in respect of the maternity experience. This is also one of the Trust's quality objectives for 2018/19.

Recommendations

Members are asked to:

- **Note the Report.**

Intended Audience **(please select any which are relevant to this paper)**								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk **(please choose any which are impacted on / relevant to this paper)**			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment **(please tick any which are impacted on / relevant to this paper)**							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26 June 2018		Patient Experience Group (17/5/2018); Senior Leadership Team Committee (20/6/2018)

University Hospitals Bristol
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 4 2017/18

Author: **Paul Lewis, Patient Experience and Involvement Team Manager**

Patient Experience and Involvement Team

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1. Overview of patient-reported experience at UH Bristol: update since the last Quarterly Report

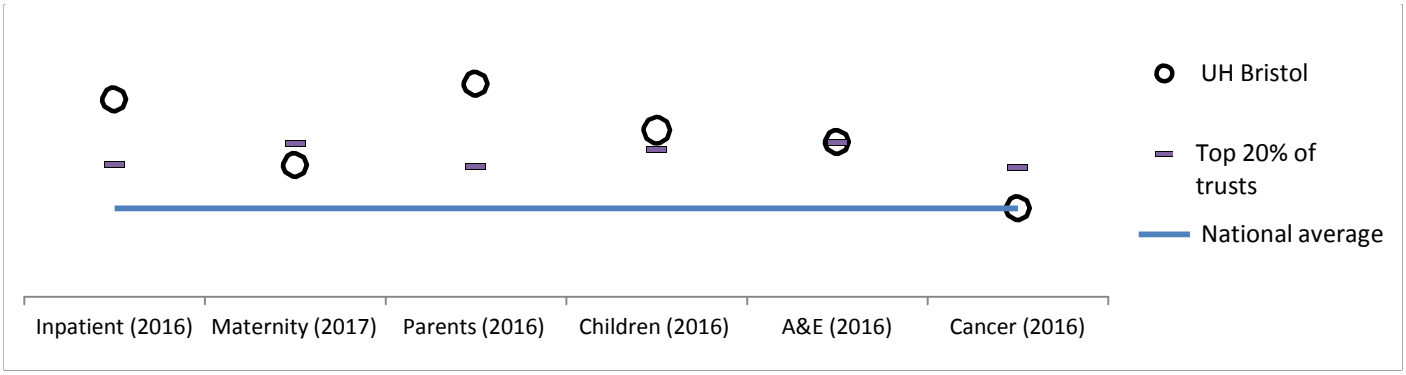
Successes	Priorities
• All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 4, indicating the continued provision of a high quality experience for our service-users • UH Bristol continues to receive positive scores in our local surveys, with 98% of patients rating their care as excellent, very good or good • South Bristol Community Hospital's headline survey scores increased for the third consecutive quarter. This coincides with the ongoing work that has been carried out to improve patient experience at the hospital. • Around 50 people attended the Trust's "Quality Counts" event, with a range of external stakeholders represented including members of the Trust's Involvement Network, Clinical Commissioning Groups, Healthier Together (Sustainable Transformation Plan), and Healthwatch. Feedback and suggestions from the event have informed the Trust's quality objectives for 2018/19.	The Trust's 2017 national maternity survey results, which were received during Quarter 4, were broadly in line with the national average. However, in the previous survey in 2015 the Trust had been among the very best nationally. UH Bristol's scores did not change significantly over this period, but at a national level the scores did improve. A more detailed analysis of these results for the Senior Leadership Team and Quality and Outcomes Committee accompanies the current report. The response from the Trust's maternity service focusses on extensive improvement programme to improve peoples' experiences of maternity care across the whole of Bath, Bristol, North Somerset and South Gloucestershire, as well as a number of specific actions that will be taken forward at St Michael's Hospital. This represents a clear ambition to return UH Bristol to its national-leading position in respect of the maternity experience. This is also one of the Trust's quality objectives for 2018/19.
Opportunities	**Risks & Threats**
A key part of the Trust's Quality Strategy (2016-20) is to ensure that patients know how to give feedback and raise / resolve any issues that they have about their care. The Trust's Patient Experience and Involvement Team has been working with a graphic designer to produce new posters, comment cards and other "marketing" materials that will signpost patients to opportunities to give feedback and raise concerns. The designs are based on UH Bristol's popular inpatient Welcome Guide and these materials will occupy prominent positions around the Trust, including on wards and in outpatient departments. Divisional representatives have been consulted on the design and the drafts are currently being tested with patients. These designs will be finalised in Quarter 1 2018/19, with a roll out that will take place as part of the implementation of the new rapid-time feedback system.	There are two wards that have received relatively low headline survey scores for the last two quarters: A528 (care of the elderly): further analysis and patient interviews have not been able to pin-point the exact reason for these scores. It is however recognised that this ward can be a particularly stressful environment for staff (see page 5 of this report), with the potential for this to impact negatively on patient experience. The Matron for the ward is currently drafting a staff engagement action plan and will incorporate insights from patient feedback into this. A604 (trauma and orthopaedics): patient interviews will be carried out to further explore these scores and identify any specific actions that can be carried out to improve patient experience. The scores may be related to a high staff vacancy rate on the ward, with a number of temporary staff in post at present. A recruitment plan is in place to address this.

2. Patient survey data

2.1 National benchmarks

The national survey programme provides a comparison of patient-reported experience at UH Bristol against all other English NHS hospital trusts. Chart 1 shows that UH Bristol performs in line with or better than the national average in these surveys. At UH Bristol, the results of each national survey, along with improvement actions / learning identified from them, are reviewed by the Trust's Patient Experience Group Quality and Outcomes Committee of the Trust Board.

Chart 1: UH Bristol's hospital based patient-reported experience relative to national benchmarks



During Quarter 4, the Trust received the results of the Care Quality Commission's 2017 national maternity survey. The great majority of the Trust's scores were in line with both the national average and our previous set of results in this survey in 2015[1]. However, at a national level, the survey scores improved over this period. The net result is that the number of UH Bristol scores classed as being "better than the national average" declined from ten to four between 2015 and 2017. This is particularly disappointing as UH Bristol had been identified by the Care Quality Commission as the best performing trust nationally in 2015.

The provision of hospital and community maternity services at UH Bristol is part of a wider network of maternity care that stretches across Bristol, North Somerset, and South Gloucestershire (the "BNSSG" area). This includes GP practices, Commissioning organisations, and providers of hospital care. Truly transformational change needs to occur across these settings to have meaningful impact on the whole maternity experience. A BNSSG Maternity Transformation Plan is currently in development[2] and will focus on improving the following aspects of maternity care over the next two years:

- Integrated information technology across and within service providers, to offer women more choice and joined-up care
- Review of the initial midwifery "booking" appointment to identify opportunities to free up time for more meaningful conversation and a genuinely personalised care plan
- Continuity of carer during the antenatal period, to reduce the number of different midwives women see for their antenatal care
- Improved postnatal hospital care, for example through better infant feeding support, staff training, and a review of the bereavement care pathway
- Improved mental health care during pregnancy or in the first year following birth of the child)

[1] Out of 65 scores, four UH Bristol scores were classed as being better than the national average to a statistically significant degree, with one score classed as being below this benchmark. Two UH Bristol scores changed significantly from 2015 – one increased and one declined to a statistically significant degree.

[2] This is being led by two UH Bristol members of staff who have been seconded to the project.

The maternity team at St Michael's Hospital recognises that staff engagement was a key driver of the Trust's excellent performance in 2015. Therefore, this will be a focus of activity during 2018/19, including:

- Repeating the previous *Patient Experience at Heart* initiative as a collaboration between UH Bristol's maternity service and the Patient Experience and Involvement Team. In a workshop setting, staff at all levels of the service will discuss their experience of working in the department, leading to a recognition of the positive aspects of the service and identifying "blocks" which the management team can address. A series of these workshops will take place during 2018/19.
- Replicating the successful *#conversations* week at the Bristol Royal Hospital for Children, which engaged staff, patients and families in discussions about their experiences of care. An equivalent event will take place at St Michael's Hospital during June 2018

These actions will form the basis of a UH Bristol corporate quality objective focussed on maternity services in 2018/19 – demonstrating the Trust's commitment to restoring its maternity service experience to being among the best in the country.

2.2 Overview of Quarter 4 performance

In Quarter 4, all of the Trust's headline patient-reported experience measures at Trust and Divisional level were above their target levels, indicating that patients continue to report a very positive experience at UH Bristol (Table 1). The Trust's response rate to the outpatient Friends and Family Test was again slightly below target during the Quarter (5.6% against a target of 6%). The sample size for this survey is being increased from Quarter 1 2018/19, which should ensure that the target is met going forward (see Table 2, over, for further information).

Detailed analysis of the survey data, down to ward level, is provided in Section 2.3 of this report. Table 2 (over) identifies scores that were "negative outliers" within this wider dataset and summarises action(s) undertaken in response to them. Further information about the scoring used in this report, along with the methodologies adopted in the Trust's patient experience and involvement programme, can be found in Appendices A and B to this report.

Table 1: Quarter 4 Trust-level patient-reported experience at-a-glance

	Quarter 4	Previous Quarter (Q3)
Inpatient experience tracker score	Green	Green
Inpatient kindness and understanding score	Green	Green
Inpatient Friends and Family Test score	Green	Green
Outpatient experience tracker score	Green	Green
Day case Friends and Family Test score	Green	Green
Emergency Department Friends and Family Test score	Green	Green
Inpatient / day case Friends and Family Test response rate	Green	Green
Outpatient Friends and Family Test response rate	Red	Red
Emergency Department Friends and Family Test response rate	Green	Green

Table 2: Patient survey data exception reports for Quarter 4 (full data can be found in Section 2.3 of this report)

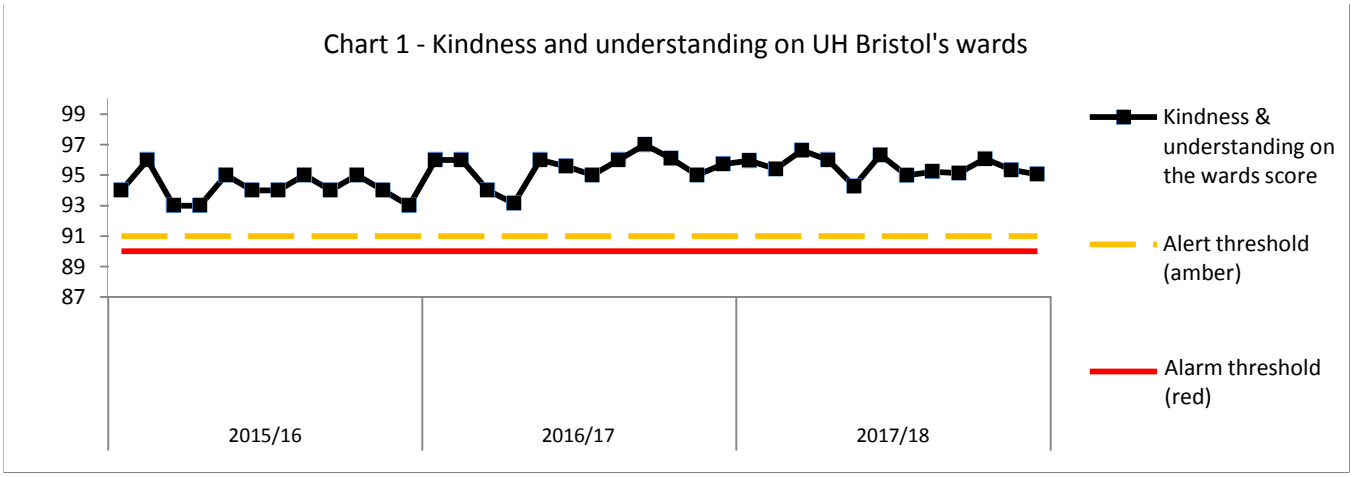
	Description	Response / Actions
1. Survey scores on ward A528 (care of the elderly)	For the second successive quarter, ward A528 had relatively low "kindness and understanding" and "inpatient tracker" survey scores (Charts 18 and 19). Whilst it should be recognised that the majority of feedback for the ward was positive, further analysis of the survey data showed that the ward had the lowest scores on these measures over the course of 2017/18.	In response to the Quarter 3 results, the Trust's volunteer *Face2Face* interview team visited ward A528 to talk to patients and families. In all, 11 people took part in the interviews, and these interviews were complemented by observations made by the interview team. Whilst there were general learning points that have been shared with the Matron / Ward Sister, the feedback was generally very positive and did not offer specific insights into why the survey scores are relatively low. The Matron for A528 is currently developing an action plan aimed at enhancing staff morale and engagement on the ward. It is recognised that this is particularly important because some patients on the ward can display challenging and, at times, physically aggressive behaviour - for example due to dementia and other cognitive disorders. This makes the working environment particularly stressful, which in turn could be negatively affecting patient experience. The Patient Experience and Involvement Team is working with the Head of Nursing and Matron to provide further insights into the survey data, so that these can be incorporated into the action plan. Furthermore, the techniques adopted in the "Patient Experience at Heart" staff workshops, which successfully drove forward improvements in the maternity service, will be discussed with the Matron - so that that can also be incorporated into the improvement work on A528 where possible. A further update will be provided in the next Quarterly Patient Experience and Involvement Report.

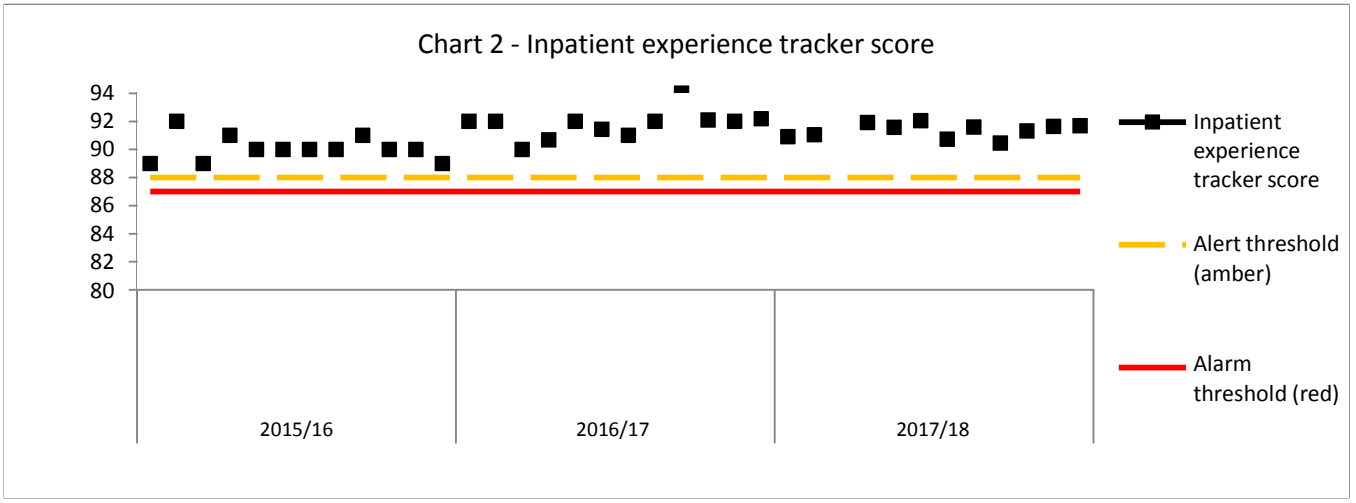
2. Survey scores on A604 (Trauma and Orthopaedics)	Ward A604 had low scores on all of the key survey measures (Charts 18-20). This is the second successive quarter where the ward was a negative outlier in this data. Further analysis of the data has shown a deteriorating trend in the survey scores over the course of the year. Again, it is important to recognise that the feedback is still generally very positive, but clearly the decline in these scores needs to be arrested and reversed.	The Patient Experience and Involvement Team will commission the Trust's *Face2Face* volunteer interview team to visit the ward during Quarter 1 2018/19, to further explore patient and family experiences of care. In addition, a more detailed breakdown of the survey data has been provided to the Head of Nursing, who will discuss this with the new Ward Sister and Matron to raise awareness of this issue and to develop specific improvement actions. An update of this work will be provided in the next Quarterly Patient Experience and Involvement Report. No specific reason can be identified by the Division for the relatively low patient survey scores. There have however been significant staff vacancies on the ward, resulting in high numbers of temporary staff. Plans are in place for additional recruitment and the new staff are likely to commence in post during Quarter 2 (September 2018).
3. Inpatient experience tracker survey score at South Bristol Community Hospital	South Bristol Community Hospital (SBCH) received an inpatient experience tracker score of 86 / 100 against a minimum target of 87 (Chart 15).	This result should be viewed in the context of an improving set of inpatient survey results at SBCH: Quarter 4 was the third successive improvement in the scores over the past year. Furthermore, for the first time in 2017/18, the hospital's scores on the "kindness and understanding" survey measure were above the Trust's target level (again forming part of an ongoing improvement trend). This positive trend is likely to reflect a significant focus on improving these scores by the SBCH management team (this work has been discussed in detail in previous Quarterly Patient Experience and Involvement Reports).
4. Inpatient delays at discharge in the Specialised Services Division	Inpatients reported a relatively high frequency of delays at discharge in Quarter 4, at both the Bristol Heart Institute and the Bristol Haematology and Oncology Centre, compared to the Trust's other hospitals (Table 3).	As noted in the previous Patient Experience and Involvement Report, an Electronic Prescribing system (EMPA) was introduced during Quarter 3, which may initially have slowed down discharges as staff get used to the new system. As EMPA becomes fully embedded into practice, it will improve the efficiency of administering medications at discharge (a key source of patient-reported delays). We would therefore anticipate that the Quarter 1 score for these hospitals will be at least in line with the UH Bristol average.

5. Conveying waiting time information in outpatient clinics at the Bristol Royal Hospital for Children	Relatively few patients / parents reported that they were told about delays in outpatient clinics at the Bristol Royal Hospital for Children (Table 4).	The Bristol Royal Hospital for Children has not been flagged as an outlier on this score previously. Therefore, given the relatively small sample sizes for this survey, some caution is needed in respect of the reliability of this result. However, the Sister in charge of the outpatient departments has been notified and will remind her reception team of the importance of conveying this information to patients.
6. Outpatient waiting times clinics in the Bristol Haematology and Oncology Centre	Analysis of this survey data showed that outpatients reported relatively long waiting times in clinics at the Bristol Haematology and Oncology Centre (Table 4).	The Division of Specialised Services management team recognises the effects of significantly increased demand on patient experience and are working to mitigate this. There is a comprehensive improvement plan in place to support the Trust's response to the National Cancer Patient Experience Survey results, and a number of developments planned or at business case stage that will improve patient flow and experience of cancer services.
7. Communicating key information at discharge in the Division of Medicine	The Division attracts consistently low scores around conveying key information at discharge from hospital (e.g. medication side effects, who to contact with concerns – see Table 3).	The Division of Medicine has a relatively high proportion of patients with complex health and social care needs, so there can be challenges in conveying what can be a large amount of information in a way that patients will understand. The Division is confident that this information is being provided to patients, but it may be possible to increase the prominence of this within the discharge process. The Division is therefore reviewing the discharge check list to include more effective prompts for this information. The revised checklist is currently being trialled until the end of June 2018 and will be evaluated at that point.
8. Outpatient Friends and Family Test response rate	The Trust has an outpatient Friends and Family Test response rate of 6%. In Quarter 4 the Trust achieved a response rate of 5.6%. The Trust primary uses an SMS (text message) survey in this context and the response rate has declined slightly over the course of the year. Overall however, the Trust should exceed the 6% target for 2017/18 (we are awaiting the final release of March 2018 data from NHS England before this can be confirmed).	The effect of a slightly decreasing response rate over time is likely to be due to patients who are repeat attenders in outpatient clinics: this reduces the available sample size over time because we do not send people this survey more than once per month (to avoid over-surveying people), and also because people are unlikely to complete the survey on multiple occasions. In May 2018, the Patient Experience and Involvement Team will extend the SMS survey to include attendances at the Bristol Royal Hospital for Children. This methodology significantly increased the number of responses to the outpatient Friends and Family Test in adult services during 2017/18, and we anticipate a similar effect in children's services. This should therefore boost the overall number of responses to the Trust's outpatient Friends and Family Test, enabling us to exceed the response rate target going forward.

2.3 Full survey data up to and including Quarter 3

This section of the report provides a full breakdown of the headline survey data to ward-level. Caution is needed below Divisional level, as the margin of error becomes larger. At ward-level in particular it is important to look for trends across more than one of the survey measures presented.





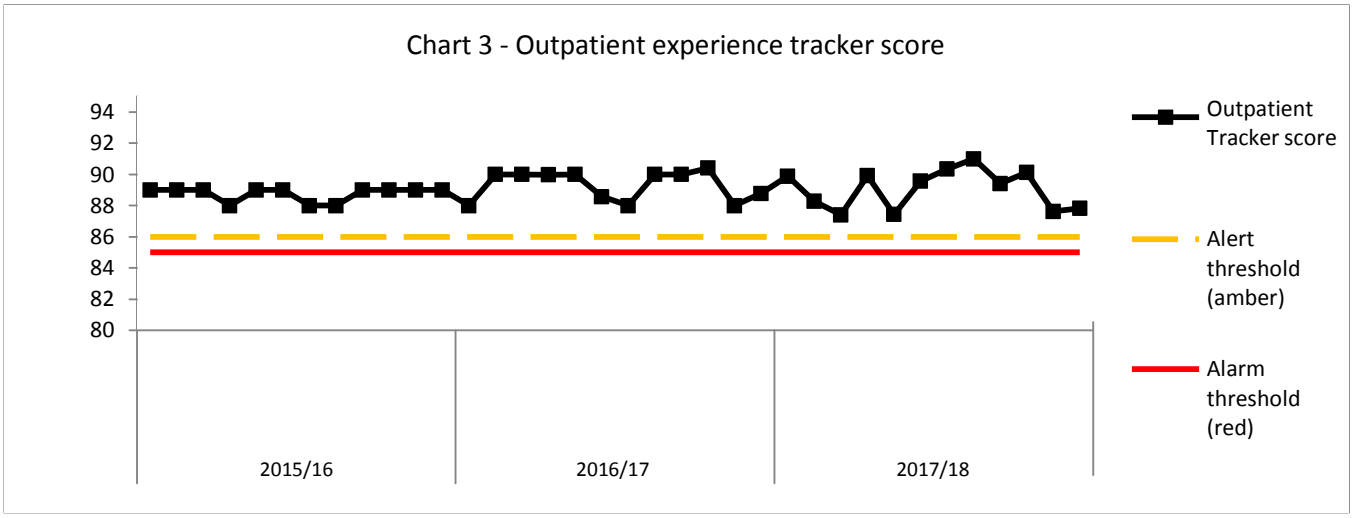


Chart 4 - Friends and Family Test Score - inpatient and day case

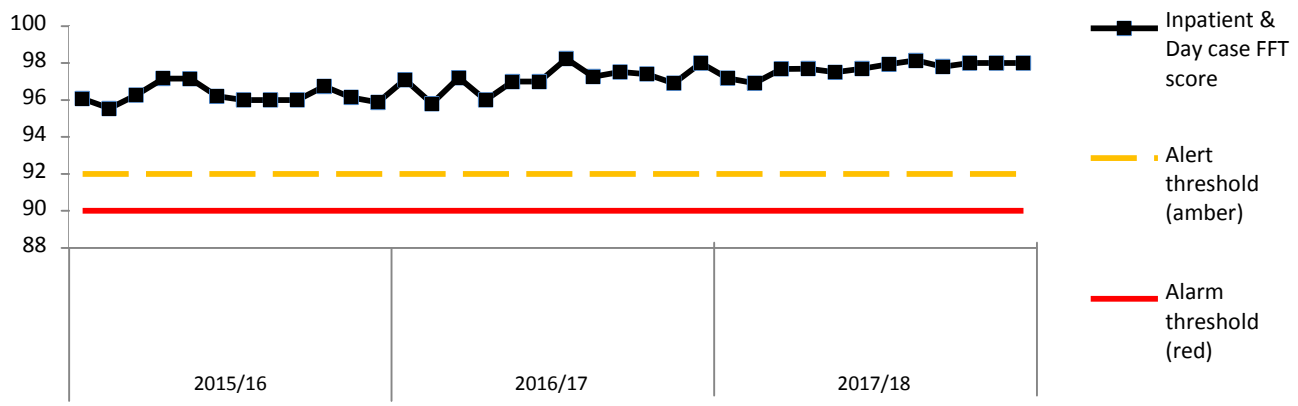


Chart 5 - Friends and Family Test Score - Emergency Departments

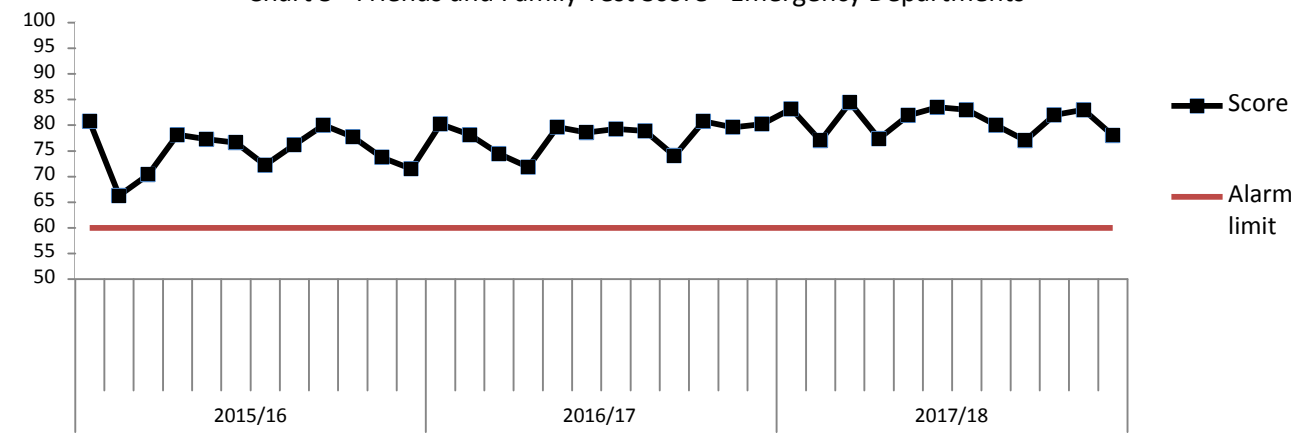


Chart 6 - Friends and Family Test Score - maternity (hospital and community)

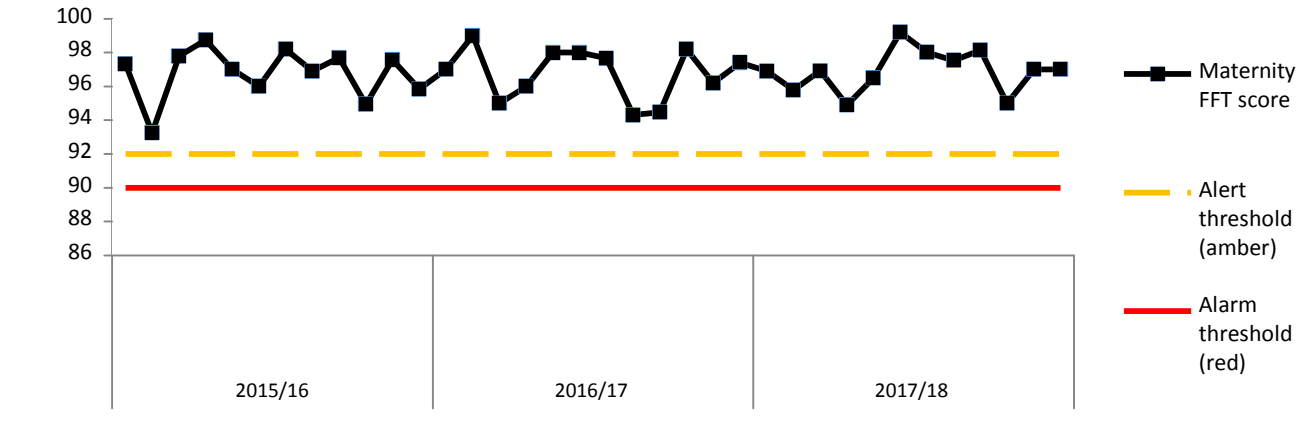


Chart 7: Friends and Family Test Response Rates (inpatient and day case)

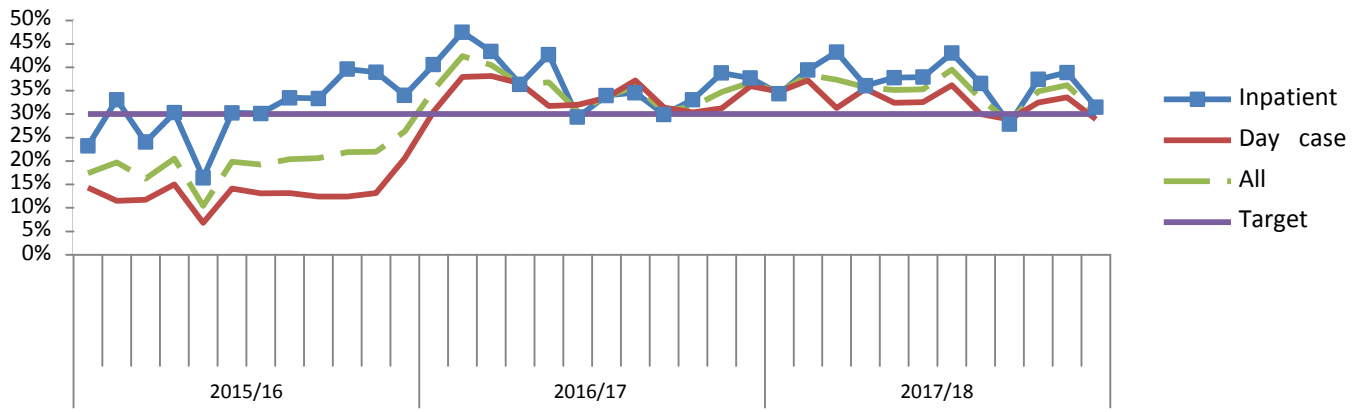


Chart 8: 2015 /16 Friends and Family Test Response Rates (maternity combined)

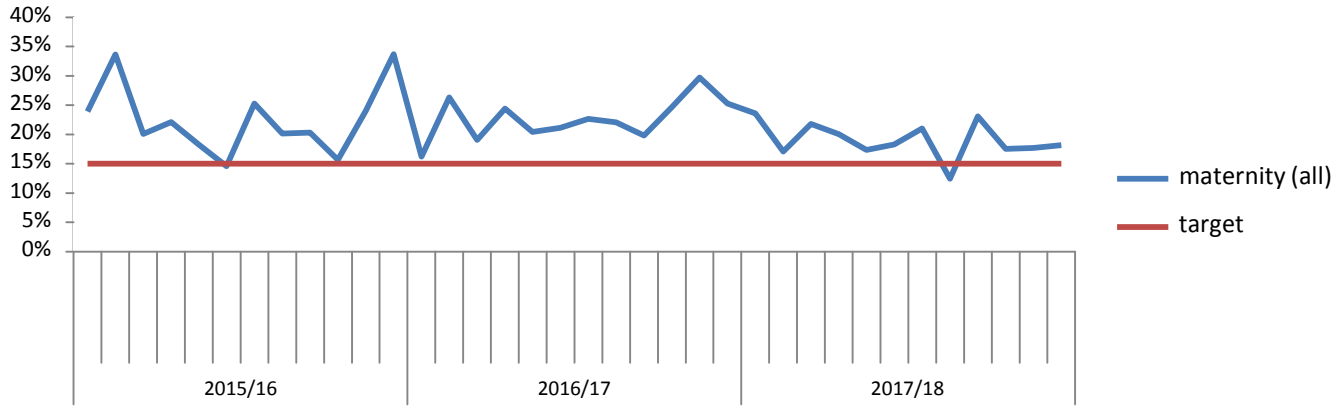


Chart 9: 2015/16 Friends and Family Test Response Rates (Emergency Departments)

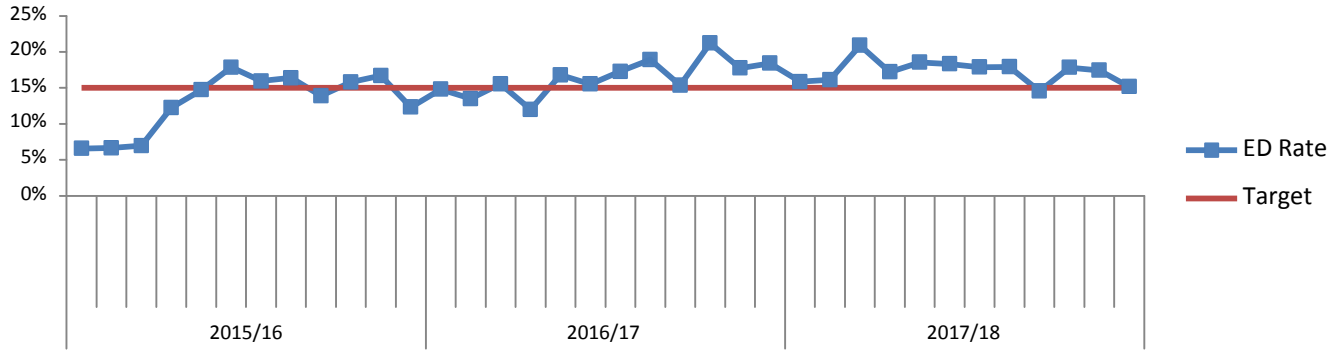
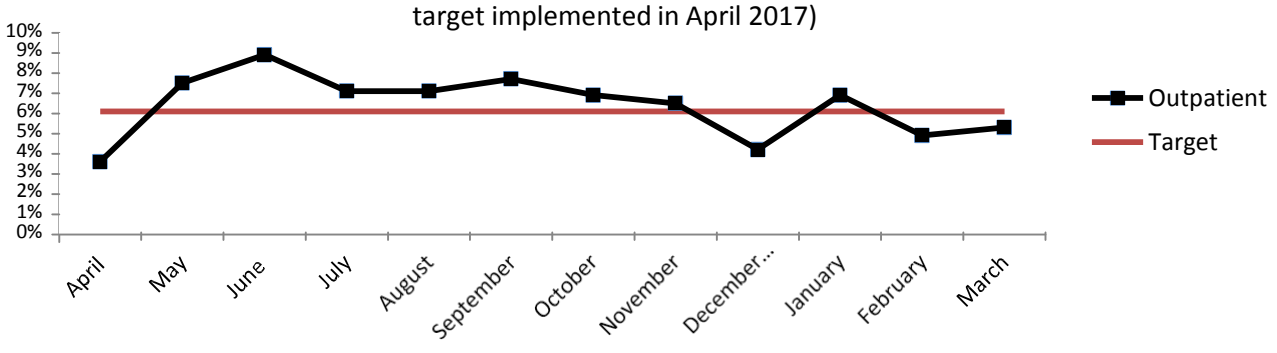
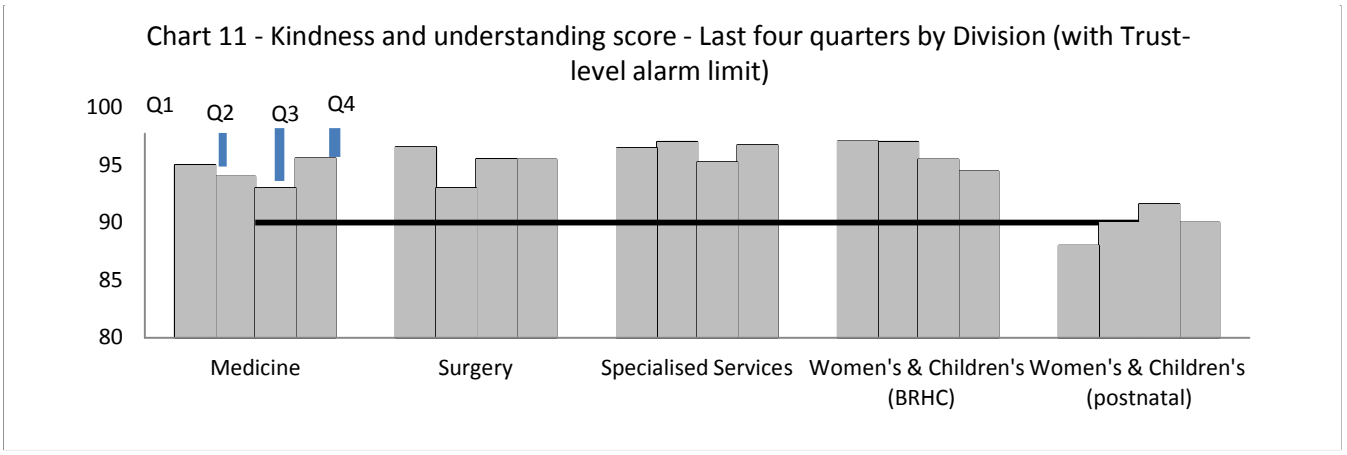
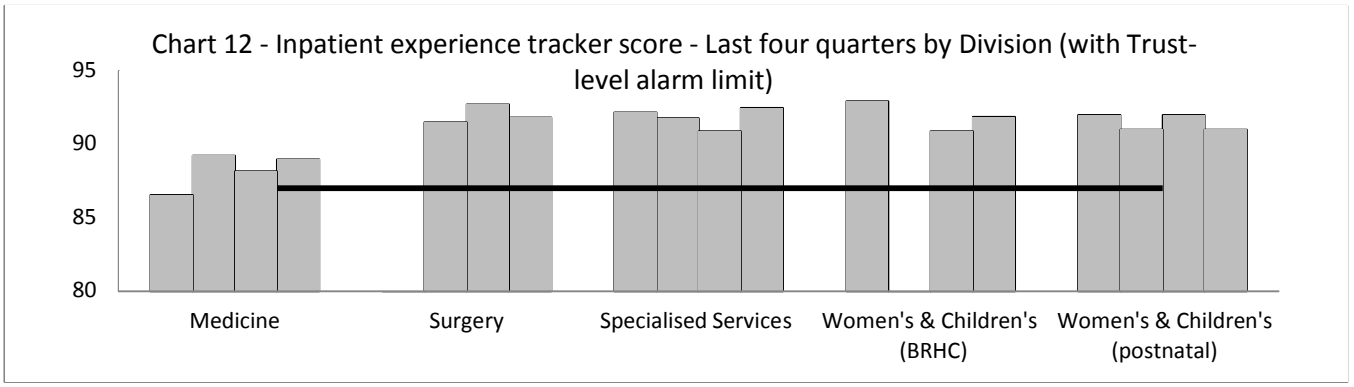


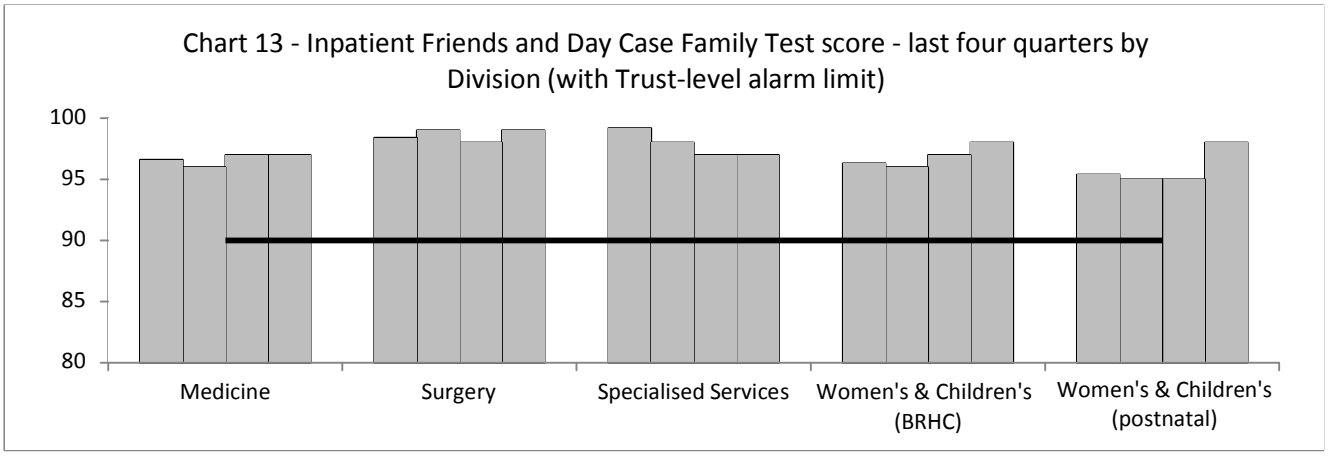
Chart 10: UH Bristol Outpatient Friends and Family Test Response Rates 2017/18 (6% target implemented in April 2017)



2.3.2 Divisional level survey results







2.3.3 Hospital level headline survey results

Key: BRHC (Bristol Royal Hospital for Children), BEH (Bristol Eye Hospital), BHOC (Bristol Haematology and Oncology Centre), BRI (Bristol Royal Infirmary), BHI (Bristol Heart Institute), SBCH (South Bristol Community Hospital), STMH (St Michael's Hospital), BDH (Bristol Dental Hospital)

Chart 14: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

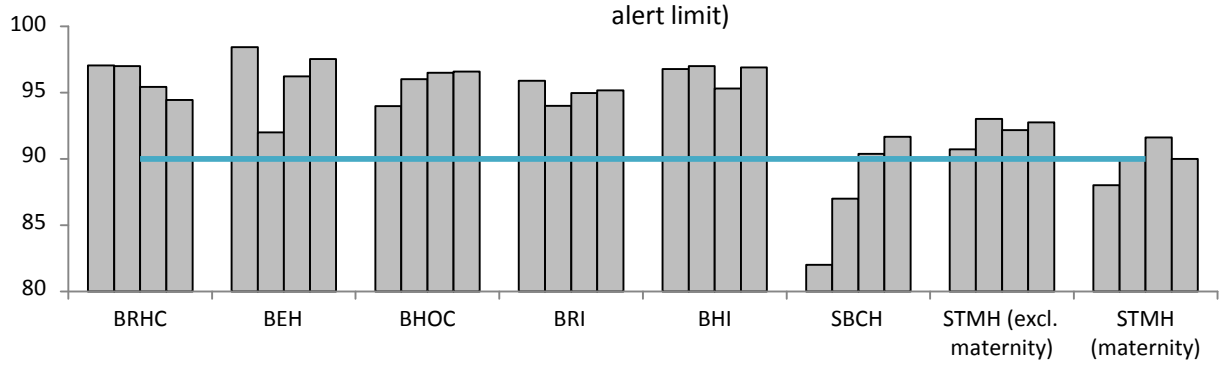


Chart 15: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

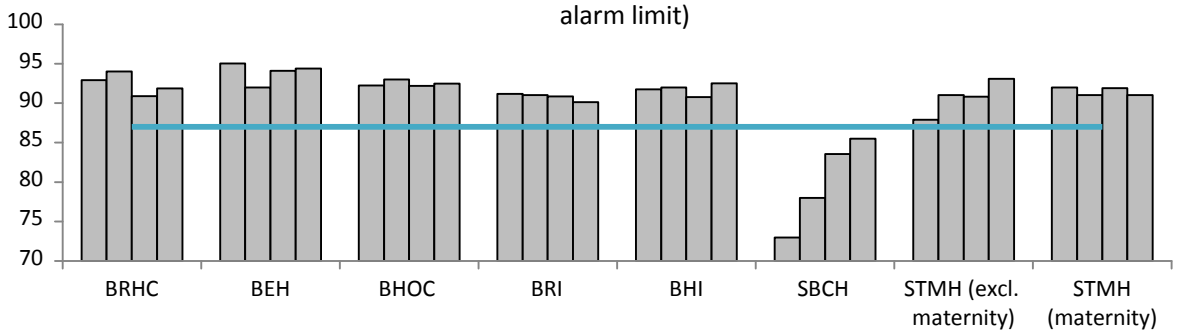


Chart 16: Inpatient and day case Friends and Family Test score (last four quarters; with Trust-level alarm limit)

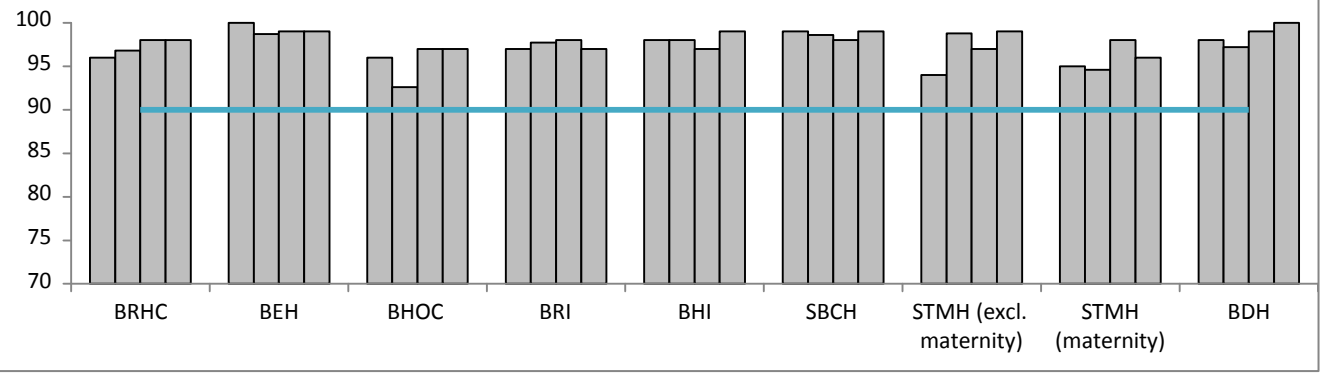
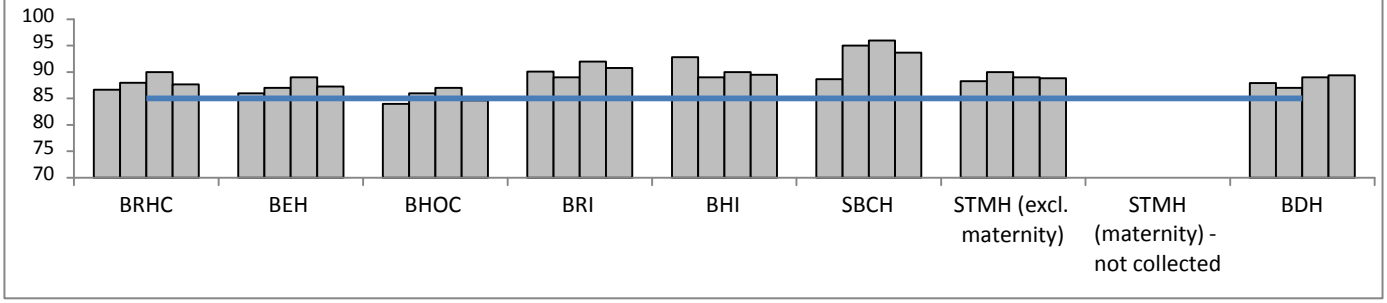


Chart 17: Outpatient experience tracker score by hospital (with Trust-level alarm limit)



2.3.4 Ward level headline inpatient survey results

Chart 18: Kindness and understanding score by inpatient ward

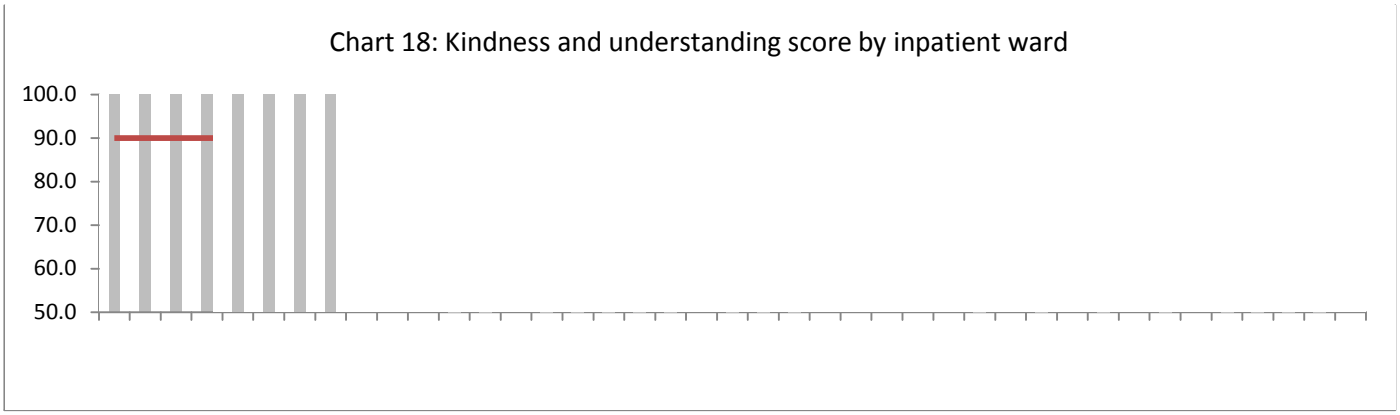


Chart 19: inpatient experience tracker score by inpatient ward

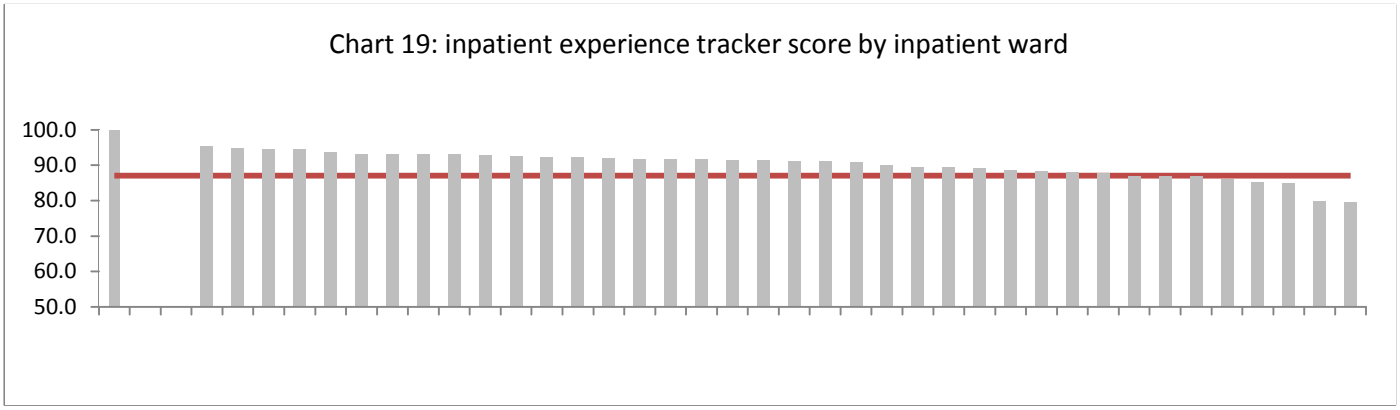


Chart 20: Friends and Family Test score by inpatient ward

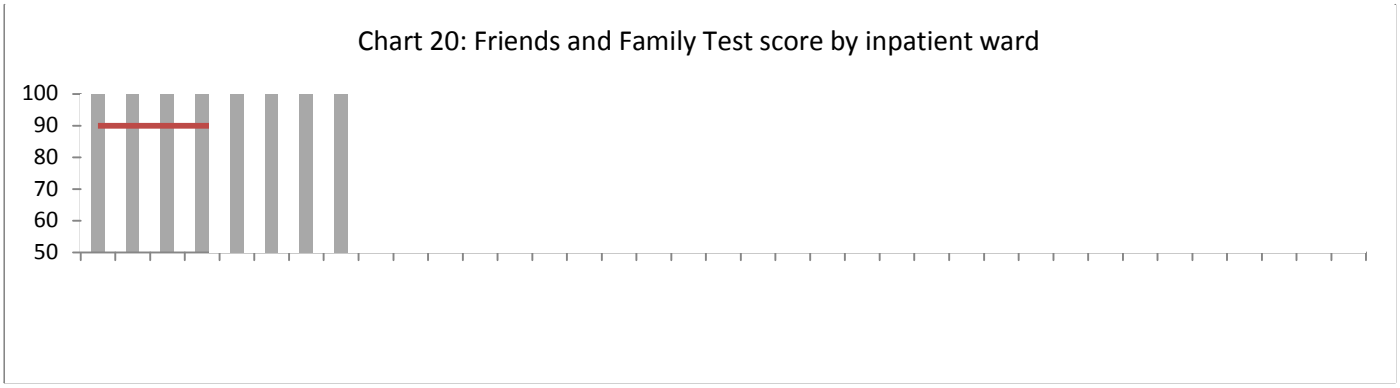


Table 3: Full Quarter 3 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for an explanation of the scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	Specialised Services	Surgery	Women's & Children's	Maternity	TOTAL
Were you given enough privacy when discussing your condition or treatment?	92	94	94	92		**93**
How would you rate the hospital food?	62	58	60	61	52	**60**
Did you get enough help from staff to eat your meals?	85	90	90	78		**87**
In your opinion, how clean was the hospital room or ward that you were in?	94	94	96	93	88	**94**
How clean were the toilets and bathrooms that you used on the ward?	91	90	93	92	81	**91**
Were you ever bothered by noise at night from hospital staff?	84	78	87	83		**83**
Do you feel you were treated with respect and dignity by the staff on the ward?	96	98	97	95	94	**97**
Were you treated with kindness and understanding on the ward?	96	97	95	94	90	**96**
Overall, how would you rate the care you received on the ward?	87	91	90	91	92	**90**
When you had important questions to ask a doctor, did you get answers that you could understand?	87	92	90	90	90	**90**
When you had important questions to ask a nurse, did you get answers that you could understand?	87	92	91	93	92	**91**
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	71	77	76	79	80	**76**
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	82	88	85	91	90	**86**
Were you involved as much as you wanted to be in decisions about your care and treatment?	80	87	86	90	90	**86**
Do you feel that the medical staff had all of the information that they needed in order to care for you?	87	91	90	87		**89**
Did you find someone on the hospital staff to talk to about your worries or fears?	70	79	77	85	81	**78**
Did a member of staff explain why you needed these test(s) in a way you could understand?	84	88	88	94		**88**

(inpatient scores continued)

	Medicine	Specialised Services	Surgery	Women's & Children's	Maternity	**Trust**
Did hospital staff keep you informed about what would happen next in your care during your stay?	81	85	83	88		**85**
Were you told when this would happen?	80	82	80	83		**84**
Before your operation or procedure, did a member of staff explain the risks/benefits in a way you could understand?	80	91	93	95		**92**
Beforehand, did a member of staff explain how you could expect to feel afterwards?	69	76	79	85		**77**
Were staff respectful of any decisions you made about your care and treatment?	92	93	93	94		**94**
During your hospital stay, were you ever asked to give your views on the quality of your care?	24	28	28	33	36	**30**
Do you feel you were kept well informed about your expected date of discharge from hospital?	80	83	83	86		**84**
On the day you left hospital, was your discharge delayed for any reason?	58	45	60	68	64	**61**
Did a member of staff tell you about medication side effects to watch for when you went home?	46	55	66	69		**61**
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	67	82	84	89		**82**

Table 4: Full six-monthly Divisional-level scores (June-December 2017) from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are 12 points or more below the Trust score). Scores are out of 100 unless otherwise stated – please see appendices for an explanation of this scoring mechanism.

	Diagnostic & Therapy	Medicine	Specialised Services	Surgery	Women's & Children's (BRHC)	TOTAL
When you first booked the appointment, were you given a choice of appointment date and time?	86	69	85	67	63	**76**
Was the appointment cancelled and re-arranged by the hospital?	95	95	95	94	98	**95**
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	72	71	63	67	68	**68**
When you arrived at the outpatient department, how would you rate the courtesy of the receptionist?	85	87	86	84	83	**85**
Were you and your child able to find a place to sit in the waiting area?	99	99	97	99	100	**99**
In your opinion, how clean was the outpatient department?	94	96	94	93	91	**94**
How long after the stated appointment time did the appointment start?	89	74	58	75	70	**73**
Were you told how long you would have to wait?	51	48	44	38	23	**42**
Were you told why you had to wait?	63	60	59	64	61	**61**
Did you see a display board in the clinic with waiting time information on it?	42	62	49	36	55	**49**
In your opinion, did he / she have all of the information needed to care for you (e.g. medical records, test results, etc)?	90	96	90	93	90	**92**
Did he / she listen to what you had to say?	95	98	97	96	94	**96**
If you had important questions to ask him / her, did you get answers that you could understand?	93	95	92	91	93	**93**
Did you have enough time to discuss your health or medical problem with him / her?	91	95	93	90	94	**93**
Were you treated with respect and dignity during the outpatient appointment?	98	99	100	97	98	**98**
Overall, how would you rate the care you received during the outpatient appointment?	92	93	93	90	91	**92**
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	85	90	88	91	85	**88**
If you had any tests, did a member of staff explain the results in a way you could understand?	82	83	81	79	77	**80**

2.3.5 Themes arising from free-text comments

At the end of the Trust's postal survey questionnaires, respondents are invited to comment on any aspect of their stay. The themes from these comments are provided in Table 5. By far the most frequent type of feedback is praise for staff. Key improvement themes focus on communication, staff behaviour and waiting times. Although these categories do not directly overlap with the way that the Trust classifies complaints, there are similarities between these issues and themes seen in the complaints data (see accompanying Quarterly Complaints Report).

Table 5: Quarter 4 themes arising from free-text comments in the patient surveys (the comments are taken from the Trust's postal survey programme, unless otherwise stated)[3]

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[4])	Staff	Positive	73%
	Communication/information	Negative	13%
	Food / catering	Negative	11%
Division of Medicine	Staff	Positive	64%
	Food / catering	Negative	14%
	Communication/information	Negative	13%
Division of Surgery	Staff	Positive	75%
	Communication/information	Negative	12%
	Staff	Negative	11%
Division of Specialised Services	Staff	Positive	70%
	Communication/information	Negative	14%
	Food / catering	Negative	13%
Women's and Children's Division (excluding Maternity)	Staff	Positive	80%
	Communication/information	Negative	17%
	Staff	Negative	12%
Maternity	Staff	Positive	65%
	Care during labour and birth	Positive	20%
	Communication/information	Negative	13%
Outpatient Services	Staff	Positive	69%
	Waiting / delays	Negative	9%
	Communication / information	Positive	9%

[3] The percentages shown refer to the number of times a particular theme appears in the free-text comments. As each comment often contains several themes, the percentages in Table 1 add up to more than 100%. "Sentiment" refers to whether a comment theme relates to praise ("positive") or an improvement opportunity ("negative).

[4] The maternity inpatient comments have a slightly different coding scheme to the other areas, and maternity is not part of the outpatient survey due to the large number of highly sensitive outpatient clinics in that area of care.

3. Specific issues raised via the Friends and Family Test in Quarter 4

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 6 provides an overview of activity that has arisen from the relatively small number of negative ratings, where that rating was accompanied by a specific, actionable, comment from the respondent.

Table 6: Divisional response to specific issues raised via the Friends and Family Test in Quarter 3, where respondents stated that they would not recommend UH Bristol and a specific / actionable reason was given.

Division	Area	Comment	Response from ward / department
Medicine	Emergency Department (Bristol Royal Infirmary)	*No water supply for free.*	Water is available on request from the reception desk. However, patients in the department are at different stages of triage and treatment, and ideally patients would not consume food and drink until they have been fully assessed by a clinician.
Women's & Children's	Ward 30 (Bristol Royal Hospital for Children)	*Noisy doors at night, noise from nurses station, phones etc.*	We are sorry that this parent and their child experienced a high level of noise at night. There is going to be a Trust-wide focus on reducing noise and lighting at night during 2018/19, with a range of initiatives that are currently being planned. This will be supported by a "reducing noise at night week", which is likely to take place in September 2018.
	Emergency Department (Bristol Royal Hospital for Children)	*Disappointing that the average waiting time isn't accurate. It stated longest waiting time was 2.21 and we were over 3 hours.* *Hugely frustrating that the vending machine was taken away.*	The Emergency Department Sister has contacted the Trust's Information Management and Technology Department to check that the on-line system is working, as there have been no other reports of inaccuracies. The vending machine was removed several years ago, but there are vending machines located between the BRI and BRHC Emergency Departments. This information is already in the leaflet that is provided to attendees, but the Department leads will also discuss the possibility of putting notices / posters up about this for families: however, it is important to balance this message with an awareness that patients themselves would ideally not eat and drink until they have been fully assessed by a clinician.

Division	Area	Comment	Response from ward / department
Women's & Children's	Postnatal Wards (St Michael's Hospital)	*There was quite a bit of inconsistency around the messaging from the ward staff and NICU staff - ward staff told us for example that our baby would be discharged from NICU much earlier than was in fact the case. Some members of staff also showed a surprising lack of sensitivity to the situation - one midwife in particular upset us hugely by suggesting to my wife that she should have done more to go and visit our baby in NICU even though other members of staff had told her explicitly that she would need to recover more from the c section before moving. On the night our baby was admitted to NICU another member of staff decided to interrogate us about our decision that my wife would not have steroid injections before the birth and implied that this had a bearing on the problems our baby was then facing. This insensitivity, along with the inconsistency of messaging, made a difficult time considerably more so. This was particularly a shame as our experience of the staff in NICU was so positive, particularly the nurse practitioner who originally diagnosed and cared for our son.*	We are very sorry to hear about this lady's experience on the postnatal ward. Unfortunately we aren't able to look into these issues in detail because the comment was provided anonymously. There are however a number of learning opportunities here that we will use as a reminder to our staff, in particular: • Postnatal ward staff should not comment on when babies on the Neonatal Intensive Care Unit (NICU) are going to be discharged, as these babies are not under our care. • Women are encouraged to mobilise to prevent deep vein thrombosis, and when Mum and baby are separated due to baby requiring care in our neonatal unit we do encourage Mum to visit to ensure bonding and establishing feeding. However it is imperative that women in our care can recover from their delivery appropriately and are able to rest. The NICU Matron will ask her nursing staff to ensure that they keep the postnatal ward Midwives up to date with the Baby's condition, when Mum cannot visit the unit during her recovery period. We can only apologise that the there was a lack of compassion and sensitivity from our staff, and the Matron will ensure that staff are reminded of their responsibility to care for both the emotional and physical demands of the women in their care. We are very sorry that this family felt so un-supported by our staff during their stay on level E.

Surgery	Ear, Nose and Throat Outpatient Clinic	*The outpatient ENT clinic at St Michael's none of the chairs face the doors people are called from - difficult for the deaf!*	The department has discussed moving the chairs to a row system but feel this would be less comfortable than the relaxed arrangement in place now. However, the Sister for the area will reassess this based on this feedback. The nurses do call the patients 3 times and will go to reception to check if the patient is checked in. The electronic system notifies the area that the patient is here, so the nurses are thorough when looking for the patients.
	Queen's Day Unit	*Unfortunately had to be moved to Queen's Day Unit. Was not happy as ward very noisy. No TV, not even TV room, lights stay on all night, so very hard to sleep. No shower facilities, so not really suitable for more than 1 day.*	The Queen's Day Unit is a day case area that is only used for inpatient stays during times of extreme escalation. We appreciate that providing a positive patient experience can be challenging in this context, but are very sorry to hear this feedback. The lighting has been fixed so that staff can now dim lights at night. Ear Plugs should be routinely offered to patients staying overnight and our staff will be reminded to do this. The offer of going to nearby ward for a shower is offered to all inpatients where appropriate on a daily basis: we apologise that this did not happen. Staff will be reminded to keep noise levels to a minimum, although this is sometimes difficult due to the number of specialities using the department.
	A609	*On A609 the ward I was in was not cleaned for over two days*	We are sorry to hear that this patient did not have their ward cleaned for two days. The cleanliness levels are regularly audited and the results have been very positive during the year so far. The ward will always respond and contact cleaning services if there are specific cleaning concerns that require immediate attention.
	A604	*The nursing care is very good and housekeepers very friendly. I found the noise at night very difficult. Sometimes that is unavoidable of course but perhaps tones could be quieter and lighting lower whenever possible.*	We are pleased to hear that the patient found our staff to be friendly. The Ward Sister is rostered to work 2 Night Duty shifts on 14th and15th May and will be able to look at the ward routine at night, to take forward changes to reduce unnecessary noise and light.

Specialised Services	Ward D603 (Bristol Haematology and Oncology Centre)	*Ward very hot at times with no window! Staff and care was excellent but found ward depressing-very busy and noisy-cramped and not enough space to move about!*	We are pleased to hear that this patient found our staff and care to be excellent. We do recognise that the ward is in need of refurbishment and are developing a funding application in respect to this. As part of this process, during May 2018, the Trust's *Face2Face* volunteer interview team visited ward D603 to talk to patients and visitors about their experience of the ward environment and to discuss their priorities in respect of its potential refurbishment.
	C705	*Whilst staff were pleasant and caring, the noise level, especially at night, was extremely disturbing. The continuous ringing noise from that I believe was from monitor equipment is not acceptable when seriously ill patients require rest.*	We are very sorry that the noise at night did not allow this patient to get the rest that they needed. The monitoring equipment does have audio alerts that are an important way of ensuring patient safety on the ward. However, we have shared this comment with the Sister in charge of the ward who will remind staff about the importance of minimising un-necessary noise at night.

4. Update on recent and current Patient and Public Involvement (PPI) Activity

4.1 UH Bristol Involvement Network

The UH Bristol Involvement Network connects the Trust to a diverse range of voluntary and community organisations across Bristol. During Quarter 4, we worked with a range of provider organisations and interest groups aligned to the Involvement Network to establish the Bristol Deaf Health Partnership. The Partnership provides a single forum to fosters dialogue; enabling us to work together to understand and improve the experience of Deaf, hard of hearing and deaf blind people across the health community in Bristol. In addition, members of the Involvement Network participated in the Trust's Health Matters event, "Where next for UH Bristol?"

4.2 Face2face interviews

The Trust's Face2face patient interview team consists of Trust and staff volunteers trained and supported to undertake interviews with adult patients in a ward environment. During Quarter 4, the Face2face team held interviews with patients and relatives on Wards 100 and 200 at South Bristol Community Hospital to explore the relational aspects of care. In addition interviews were held in our care of the elderly ward, A528 and C808 to explore the experience of patients with complex needs in terms of comorbidities and social backgrounds many of whom have cognitive impairments and who find the experience of being in hospital frightening. Further interviews were held with patients on ward D603 to explore how the environment on the ward makes them feel as part of an initiative to secure funds to refurbish this ward.

4.3 Local Patient and Public Involvement activity

The UH Bristol Patient Experience Involvement team support a range of staff to carry out patient involvement projects. In collaboration with the Infection Control team, patient focus groups were held with patients who had acquired a line infection. The focus groups explored how information about line infections is shared, the attitudes of patients towards line infections and their approach to self-care. As a result of these discussions patients will work with the team to improve the information available to staff and patients about line infections. In addition, planning continued with colleagues in Specialised Services to deliver Patient and Public Involvement work in both Sickle Cell and Cardiac Surgery care pathways. Current work also includes supporting colleagues in the Division of Women's and Children's Services to plan and deliver *#Conversations* events at St Michaels Hospital and the Bristol Royal Hospital for Children later in the year.

4.4 Healthcare Change Makers

Healthcare Change Makers is a patient leadership programme jointly partnered by UH Bristol, North Bristol NHS Trust, Bristol Community Health and the BNSSG Clinical Commissioning Group. The Healthcare Change Makers continue to bring a patient voice into the Healthier Together partnership. During Quarter 4, they have supported the Healthier Together team in the development of their engagement and communication strategy bringing a particular focus to the issues of accessibility.

4.5 Quarter 4 focus on quality

The Patient Experience and Involvement Team adopt a quarterly theme on which to focus activity. In the last quarter of the year (Quarter 4) this theme is usually built around the Quality Counts event, which supports the Trust's Quality Objective review and setting process[5]. This year the event was a joint venture with the Trust Membership team with a focus on reviewing the Trust's 2017/18 corporate quality objectives, and setting new objectives for 2018/19. Around 50 people attended, with a range of external stakeholders represented at the event, including members of the Trust's Involvement Network, Clinical Commissioning Groups, Healthier Together (Sustainable Transformation Plan), and Healthwatch. Feedback and suggestions from the event have informed the Trust's selection of quality objectives for 2018/19.

[5] Corporate quality objectives set out the Trust's key improvement objectives for the year.

Appendix A – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manage a comprehensive programme of patient feedback and engage activities. If you would like further information about this programme, or if you would like to volunteer to participate in it, please contact Paul Lewis (paul.lewis@uhbristol.nhs.uk) or Tony Watkin (tony.watkin@uhbristol.nhs.uk). The following table provides a description of the core patient experience programme, but the team also supports a large number of local (i.e. staff-led) activities across the Trust.

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before, or just after leaving hospital, all adult inpatients, day case, Emergency Department patients, and maternity service users should be given the chance to state whether they would recommend the care they received to their friends and family and the reason why.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity / outpatient surveys)	These surveys, which each month are sent to a random sample of approximately 2500 patients, parents and women who gave birth at St Michael's Hospital, provide systematic, robust measurement of patient experience across the Trust and down to a ward-level.
	Annual national patient surveys	These surveys are overseen by the Care Quality Commission allow us to benchmark patient experience against other Trusts. The sample sizes are relatively small and so only Trust-level data is available, and there is usually a delay of around 10 months in receiving the benchmark data.
In-depth understanding of patient experience, and Patient and Public Involvement	Face2Face interview programme	Every two months, a team of volunteers is deployed across the Trust to interview inpatients whilst they are in our care. The interview topics are related to issues that arise from the core survey programme, or any other important "topic of the day". The surveys can also be targeted at specific wards (e.g. low scoring areas) if needed.
	The 15 steps challenge	This is a structured "inspection" process, targeted at specific wards, and carried out by a team of volunteers and staff. The process aims to assess the "feel" of a ward from the patient's point of view. Whilst the 15 steps challenge and Face2Face interviews remain stand-alone methodologies, in 2017 they were merged – so that volunteers now carry out the 15 steps challenge whilst in a ward / department to interview patients.
	Involvement Network	UH Bristol has direct links with a range of patient and community groups across the city, who the Trust engages with in various activities / discussions
	Focus groups, workshops and other engagement activities	These approaches are used to gain an in-depth understanding of patient experience. They are often employed to engage with patients and the public in service design, planning and change. The events are held within our hospitals and out in the community.

The methodology for the UH Bristol postal survey changed in April 2016 (inclusive) and so caution is needed in comparing data before and after this point in time. Up until April 2016, the questionnaire had one reminder letter for people who did not respond to the initial mail out. In April we changed the methodology so that the questionnaire had no reminder letters. A larger monthly sample of respondents is now taken to compensate for the lower response rate that the removal of the reminder letter caused (from around 45% to around 30%). This change allowed the data to be reported two weeks after the end of month of discharge, rather than six weeks. It appears to have had a limited effect on the reliability of the results, although at a Trust level they are perhaps marginally more positive following this change (these effects will be reviewed fully later in 2016/17, and the target thresholds adjusted if necessary). The survey remains a highly robust patient experience measure.

Appendix B: survey scoring methodologies

Postal surveys

For survey questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the survey questions have three or more response options. Based on the approach taken by the Care Quality Commission, each one of these response options contributes to the calculation of the score (note the CQC divide the result by ten, to give a score out of ten rather than 100).

As an example: Were you treated with respect and dignity on the ward?

	Weighting	**Responses**	**Score**
Yes, definitely	1	81%	81*100 = 81
Yes, probably	0.5	18%	18*50= 9
No	0	1%	1*0 = 0
Score			*90*

Friends and Family Test Score

The inpatient and day case Friends and Family Test (FFT) is a card given to patients at the point of discharge from hospital. It contains one main question, with space to write in comments: How likely are you to recommend our ward to Friends and Family if they needed similar care or treatment? The score is calculated as the percentage of patients who tick “extremely likely” or “likely”.

The Emergency Department (A&E) FFT is similar in terms of the recommend question and scoring mechanism, but at present UH Bristol operates a mixed card and touchscreen approach to data collection.

2017 National Maternity Survey Briefing Note

1. Purpose of this report

This paper provides an analysis of how University Hospitals Bristol NHS Foundation Trust ("UH Bristol") performed in the Care Quality Commission's 2017 national maternity survey, and sets out a response to the results from the Trust's Women's and Children's Division.

2. Executive summary

- The national maternity survey is part of the Care Quality Commission's national patient survey programme. In total, 130 NHS acute trusts in England participated in this survey in 2017.
- Most UH Bristol scores (46/51) in this survey were in line with the national average. Three scores were classed as being better than average to a statistically significant degree, and one was below this benchmark
- The Trust's survey scores in 2017 were largely unchanged from the previous results in 2015. However, the national average moved in a positive direction over this period. The net result was a reduction in the number of "better than national average" scores achieved by UH Bristol, from ten to four.
- To reflect the Trust's ambition to re-establish its position among the best performers in this survey, a corporate quality objective relating to maternity services has been adopted for 2018/19.
- The improvement plan outlined in the current report involves transformational change across maternity service in Bristol, Bath, North Somerset and South Gloucestershire. The key work streams in this programme are:
    - Integrated information technology across and within service providers, to offer women more choice and joined-up care
    - Review of the initial midwifery "booking" appointment to identify opportunities to free up time for more meaningful conversation and a genuinely personalised care plan
    - Continuity of carer during the antenatal period, to reduce the number of different midwives women see for their antenatal care
    - Improved postnatal hospital care, for example through better infant feeding support, staff training, and a review of the bereavement care pathway
    - Improved mental health care during pregnancy or in the first year following birth of the child)
- This report also outlines a number of UH Bristol specific staff and service-user engagement activities, to identify local improvement opportunities and to promote the delivery of a positive patient experience.

3. Survey methodology

The national maternity survey is part of the Care Quality Commission's national patient survey programme. In total, 130 NHS acute trusts in England participated in this survey in 2017. Women were sent a questionnaire by post if they were aged 16 or over, had a live birth during February 2017, and gave birth in a hospital, maternity unit or at home.

UH Bristol's participation in this survey was co-ordinated by the Trust's Patient Experience and Involvement Team, with support from the Information Management and Technology Department. In total, 366 women were sent a questionnaire about their experiences of UH Bristol's community and hospital maternity services. The Trust received 165 responses: a response rate of 47%[1], which was above the overall national response rate of 37%.

4. Overview of UH Bristol maternity services

UH Bristol provides community midwifery services from 12 bases located across south and central Bristol. All women are under the care of a community midwife during pregnancy and in the first few weeks following the birth of their baby. Women who have more complex needs will have care by a consultant obstetrician as well as a community midwife. UH Bristol also has a central delivery suite, midwifery-led unit, antenatal and postnatal wards located at St Michael's Hospital, where around 400 babies per month are born. A home birth service is also provided.

5. Overview of UH Bristol's 2017 national maternity survey results

Tables 1 and 2 summarise UH Bristol's performance in this survey: it can be seen that most of the Trust's scores were in line with the national average and were similar to our previous results in 2015. However, at a national level, the survey scores improved over this period[2]. The net result is that the number of UH Bristol scores classed as being "better than the national average" declined from ten to four between 2015 and 2017. This is particularly disappointing as UH Bristol had been identified by the Care Quality Commission as the best performing trust nationally in 2015 on this measure.

Table 1: UH Bristol's scores in the national maternity survey against key benchmarks

	Comparison to national average		
	Above (better)	Same	Below
2017 National Maternity Survey (Labour and Birth)	1	18	0
2017 National Maternity Survey (Community Midwifery)	3	28	1

Table 2: UH Bristol's outlier scores in the survey results

Whether women are given a choice of where to give birth	Better than national average
Whether concerns raised by women during birth are taken seriously by midwives	Better than national average
Ensuring that women are given the contact details of their post-natal community midwife	Better than national average
Giving women advice about contraception postnatally	Better than national average
Confidence and trust in postnatal community midwives.	Worse than national average
Being able to move around during birth	Declined since 2015
Respondents saying that their partner could stay on the postnatal ward	Improved since 2015

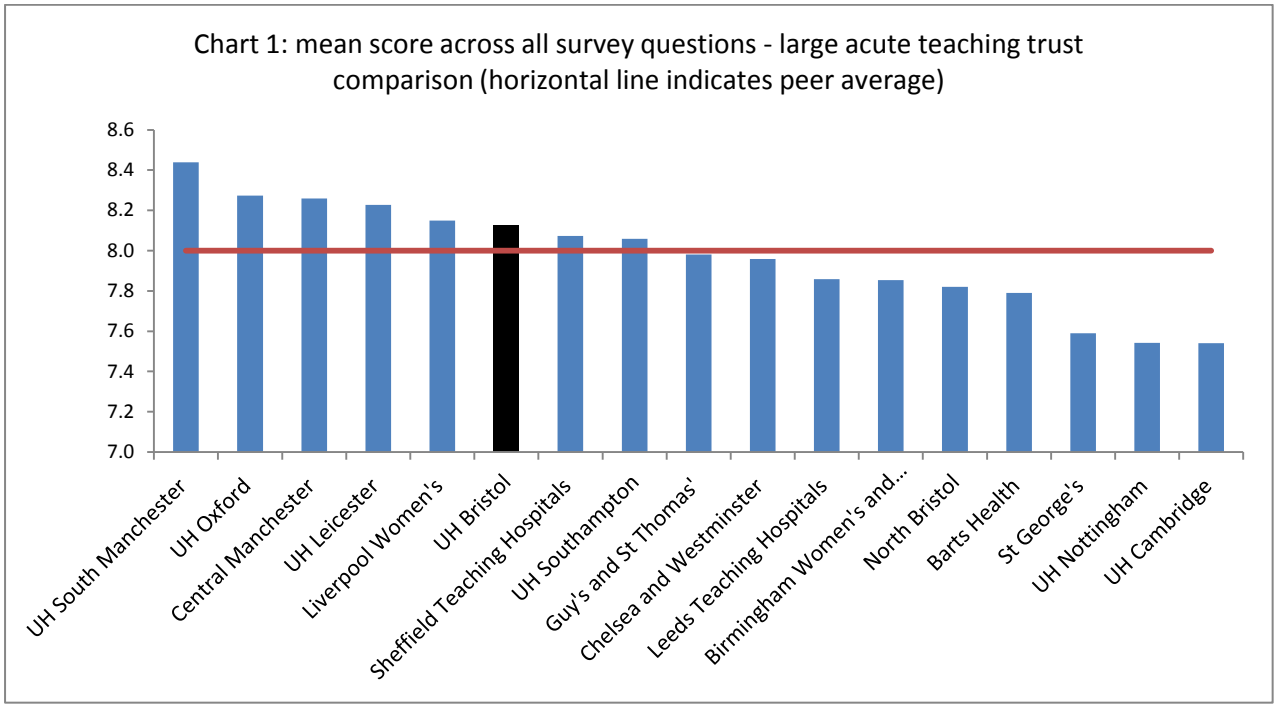
[1] The response rate excludes questionnaires that could not be delivered.
[2] See https://www.cqc.org.uk/publications/surveys/maternity-services-survey-2017

6. Comparison of UH Bristol's performance against local and peer trusts

Table 2 compares UH Bristol's performance against geographically local NHS maternity services. It can be seen that UH Bristol was a mid-performing Trust within this cohort. Chart 1 provides a comparison of UH Bristol's performance against other large acute teaching trusts: UH Bristol was marginally better than average when compared in this way.

Table 2: Comparison of geographical neighbouring trusts

	Number of scores…			
	A. better than national average	B. worse than national average	Difference (A-B)	2015 "score"
Gloucestershire Hospitals NHS Foundation Trust	10	0	+10	+2
Royal United Hospitals Bath NHS Foundation Trust	7	1	+6	+2
Royal Devon and Exeter NHS Foundation Trust	5	0	+5	+2
University Hospitals Bristol NHS Foundation Trust	4	1	+3	+10
Yeovil District Hospital NHS Foundation Trust	2	1	+1	+4
Taunton and Somerset NHS Foundation Trust	1	4	-3	+2
North Bristol NHS Trust	1	4	-3	-1



Analysis: UH Bristol Patient Experience and Involvement Team. See Appendices for full list of peer trust names.

7. Responding to the survey results: transforming the maternity care experience

UH Bristol's performance in the 2017 national maternity survey was in line with both the national average and our previous scores in 2015. However, 2017 represents a disappointing set of results - in particular because the Trust was identified as *the* top performer nationally in 2015 in respect of the number of scores classed as being better than the national average.

To reflect the Trust's ambition to re-establish its position among the best performers in this survey, a Trust corporate quality objective will be put in place from 2018/19[3], with the aim of delivering a transformation of maternity service-user experience.

The provision of hospital and community maternity services at UH Bristol is part of a wider network of maternity care that stretches across Bristol, North Somerset, and South Gloucestershire (the "BNSSG" area). This includes GP practices, commissioning organisations, health visitors, community midwifery / support services, and providers of hospital care. Transformational change needs to occur across these settings to have a significant impact on the whole maternity experience of our service-users.

The BNSSG Maternity Transformation Plan is an ambitious programme of activity with a particular focus on improving the following aspects of maternity care:

- Integrated information technology across and within service providers, to offer women more choice and joined-up care
- Review of the initial midwifery "booking" appointment to identify opportunities to free up time for more meaningful conversation and a genuinely personalised care plan
- Continuity of carer during the antenatal period, to reduce the number of different midwives women see for their antenatal care
- Improved postnatal hospital care, for example through better infant feeding support, staff training, and a review of the bereavement care pathway
- Improved mental health care during pregnancy or in the first year following birth of the child)

The BNSSG Maternity Transformation Plan is being led by two UH Bristol members of staff[4] seconded to the project, in close collaboration with a wide range of organisations across the area. Progress will be monitored through the Post-natal Working Party at St Michael's Hospital, reporting to the quality assurance meeting in the Division of Women's and Children's Services.

In addition, there will be a number of UH Bristol-specific initiatives to support this quality objective during 2018/19:

- Following the success of *#conversations* week at the Bristol Royal Hospital for Children, which engaged staff, patients and families in discussions about their experiences of care, the maternity department and LIAISE[5] service will replicate this event at St Michael's Hospital during the first half of 2018/19.
- *Patient Experience at Heart* is an approach used previously with great success at St Michael's Hospital, which invites staff at all levels of the service and patients to share their respective experiences. The aim is to identify any barriers to providing a high quality service, which the management team can then address. Further workshops will be held during 2018/19 to draw in staff who have joined the hospital since the programme was last run.

[3] Corporate quality objectives are "flag-ship" improvement objectives, set by the Trust in collaboration with external stakeholders and published in UH Bristol's annual Quality Account.
[4] Dr Tim Overton, Consultant Obstetrician; and Emma Grzyb-Yung, Midwife
[5] LIAISE is the 'PALS' service (Patient Advice and Liaison Service) for Bristol Royal Hospital for Children

8. Summary

The Trust's performance in the 2017 national maternity survey was in line with the national average. The national average has moved in a positive direction since 2015, but this improvement was not evident at UH Bristol. The net result was a reduction in the number of "better than national average" scores achieved by the Trust over this period. An ambitious, system-wide transformation of maternity services is being planned, along with local service-user engagement and involvement activities. This improvement activity has been adopted as a corporate quality objective from 2018/19, reflecting UH Bristol's ambition to return to being a top performing trust in this survey.

Appendix A: Care Quality Commission survey scoring

For questions with two response options, the score is calculated in the same was as a percentage (i.e. the percentage of respondents ticking the most favourable response option). However, most of the national survey questions have three or more response options. In the CQC benchmark report, each one of these response options contributes to the calculation of the score.

As an example: Were you treated with kindness and understanding on the postnatal wards?

	Weighting	**Responses**	**Score**
Yes, definitely	1	78%	77*1 = 77
Yes, probably	0.5	19%	19*0.5 = 9.5
No	0	5%	5*0 = 0

The result is then calculated as (77+9.5)/10 = 8.7

Appendix B - list of "peer" trusts included in Chart 1

Barts Health NHS Trust
University Hospitals Bristol NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
St George's University Hospitals NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
Birmingham Women's and Children's NHS Foundation Trust
Chelsea and Westminster Hospital NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Oxford University Hospitals NHS Foundation Trust
North Bristol NHS Trust
Central Manchester University Hospitals NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Nottingham University Hospitals NHS Trust

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10b
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Patient Complaints Report – Q4**		
Authors	Tanya Tofts, Patient Support and Complaints Manager Louise Townsend, Acting Patient Support and Complaints Manager Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

To provide the Board with information about complaints received during the final quarter of 2017/18, the Trust's performance in handling those complaints, and assurance about how Divisions have been responding to any 'hot spots' identified.

Summary of performance in Quarter 4

	Q4	
Total complaints received	**423**	↑
Complaints acknowledged within set timescale	**97.6%**	↓
Complaints responded to within agreed timescale – formal investigation	**82.3%**	↓

Complaints responded to within agreed timescale – informal investigation	**74.7%**	↑
Proportion of complainants dissatisfied with our response (formal investigation)	**8.2%***	

*January data only

In Q4:

- The most common causes for complaint related to 'appointments and admissions' and 'clinical care'.

Improvements in Q4:

- Complaints about 'appointment administration issues', which had previously been flagged as a concern in Q1 and Q2, fell again in Q4.
- Ward A700 received only one complaint in Q4, after receiving eight in Q3.
- Complaints about Radiology, Ward A700 and Sleep Unit fell in Q4.
- Following identification of a data reporting error from the Trust's Datix system, dissatisfied data from February 2017 onwards has been recalculated since the last quarterly report. Revised data shows a reduction in dissatisfied complaints since June 2017.

However:

- Complaints about the 'cancelled/delayed appointments and operations' rose sharply in Q4.
- Complaints about 'appointments and admissions' also rose in Q4, reversing a previous trend of reductions.
- Bristol Dental Hospital continued to receive relatively high levels of complaints in Q4.
- Complaints about Ward A300, Physiotherapy, Upper GI surgery and the Bristol Heart Institute Outpatient Department increased in Q4.

Recommendations

Members are asked to:

- **Note the Report.**

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support	☐	Failure to take an active role in working	☐

transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.		with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment **(please tick any which are impacted on / relevant to this paper)**							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications **(please tick any which are impacted on / relevant to this paper)**			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26 June 2018		Patient Experience Group, Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 4, 2017/2018

(1 January 2018 to 31 March 2018)

Authors: Tanya Tofts, Patient Support and Complaints Manager
Louise Townsend, Deputy Patient Support and Complaints Manager
Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)

Quarter 4 Executive summary and overview

	Q4	
Total complaints received	**423**	↑
Complaints acknowledged within set timescale	**97.6%**	↓
Complaints responded to within agreed timescale – formal investigation	**82.3%**	↓
Complaints responded to within agreed timescale – informal investigation	**74.7%**	↑
Proportion of complainants dissatisfied with our response (formal investigation)	**8.2%***	

*January data only

Successes	**Priorities**
• Complaints about 'appointment administration issues', which had previously been flagged as a concern in Q1 and Q2, fell again in Q4. • Ward A700 received only one complaint in Q4, after receiving eight in Q3. • Complaints about Radiology, Ward A700 and Sleep Unit fell in Q4. • Following identification of a data reporting error from the Trust's Datix system, dissatisfied data from February 2017 onwards has been recalculated since the last quarterly report. Revised data shows a reduction in dissatisfied complaints since June 2017.	• Re-focus on achieving target of sending at least 95% of responses to formal complaints within timescale agreed with complainant. • Re-commence divisional complaints review panels (Women's Services panel will meet in June). • Implement any actions arising from internal audit of learning from complaints (draft report received in Q4).
Opportunities	**Risks & Threats**
• Key actions in the Patient Support and Complaints team's work plan for 2018/19 include: o Establishing twice yearly focus groups with previous complainants o Reviewing the process for risk rating complaints o Finalising and launching complaints toolkit jointly developed with the Patients Association o Commencing reporting of complaints relating to equality themes to the Patient Inclusion and Diversity Group	• Complaints about the 'cancelled/delayed appointments and operations' rose sharply in Q4. • Complaints about 'appointments and admissions' also rose in Q4, reversing a previous trend of reductions. • Bristol Dental Hospital continued to receive relatively high levels of complaints in Q4. • Complaints about Ward A300, Physiotherapy, Upper GI surgery and the Bristol Heart Institute Outpatient Department increased in Q4.

1. Complaints performance – Trust overview

1.1 Total complaints received

The Trust received 423 complaints in quarter 4 (Q4) of 2017/18. The total figure of 423 includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff.

Figure 1 provides a long-term view of complaints received per month. With the notable exception of a special cause variation in April 2017, this graph shows a broadly consistent monthly complaints rate since the summer of 2016.

Figure 1: Number of complaints received

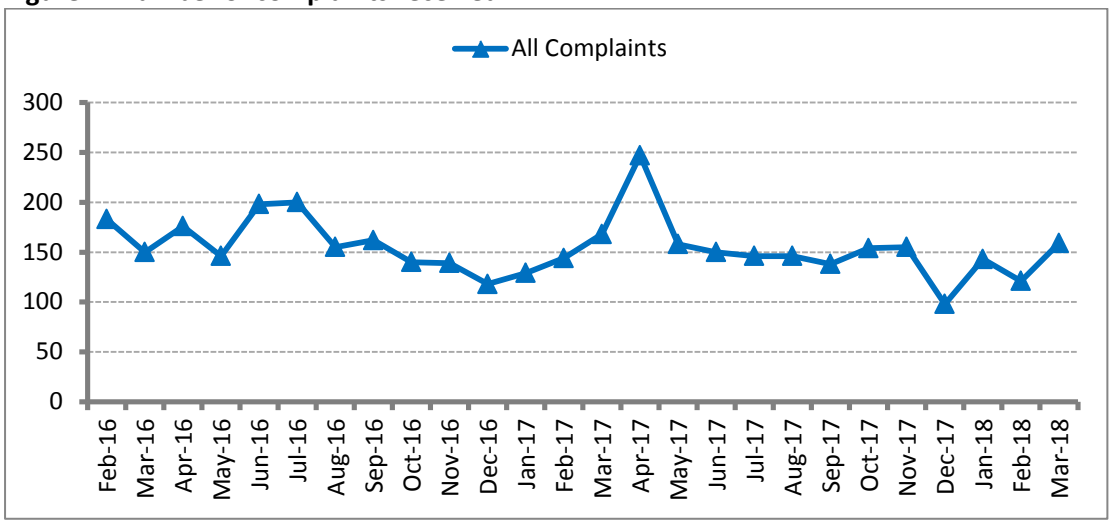
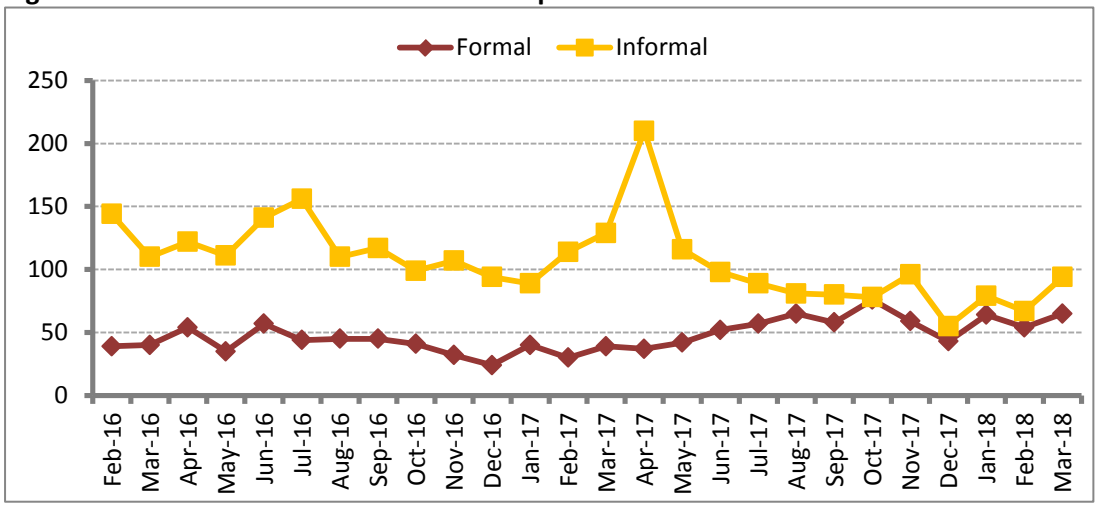


Figure 2 shows complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process, over the same period. We want to be addressing concerns raised as quickly and as close to the point of care as possible, so it is encouraging to see that the proportion of informal complaints, relative to formal complaints, increased at the end of Q4.

Figure 2: Numbers of formal v informal complaints



[1] Informal complaints are dealt with quickly via direct contact with the appropriate department, whereas formal complaints are dealt with by way of a formal investigation via the Division.

1.2 Complaints responses within agreed timescale

Whenever a complaint is managed through the formal resolution process, the Trust and the complainant agree a timescale within which we will investigate the complaint and write to the complainant with, or arrange a meeting to discuss, our findings. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

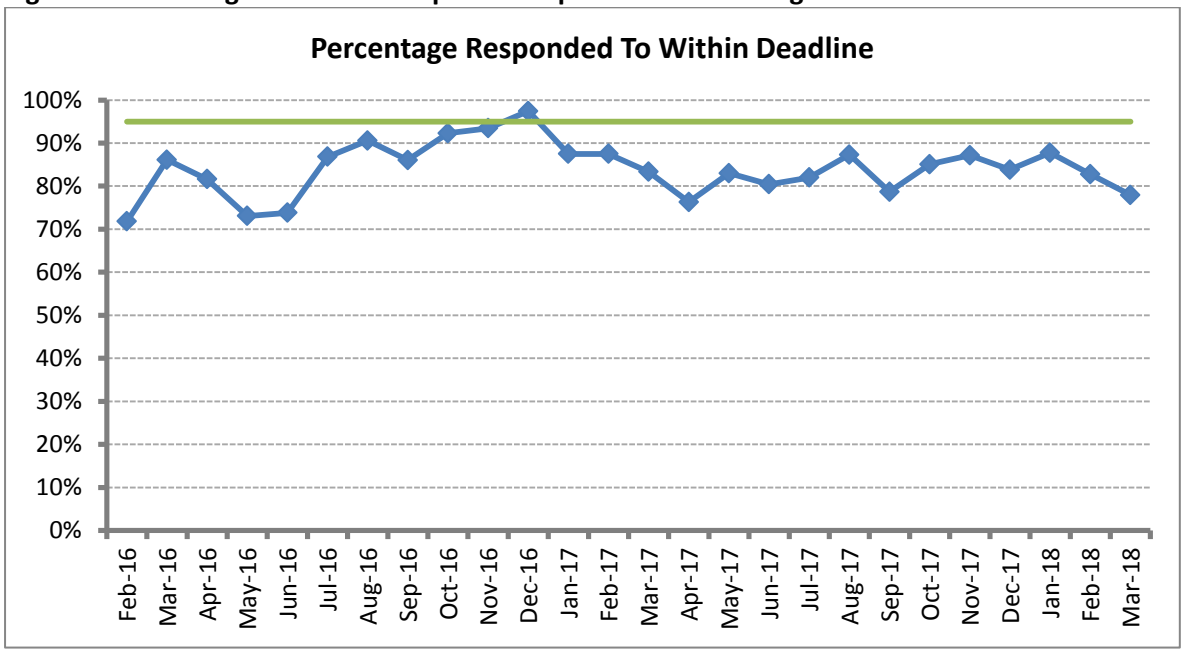
When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

1.2.1 Formal Investigations

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant.

In Q4 of 2017/18, 82.3% of responses were posted within the agreed timescale (compared with 85.4% in Q3). This represents 31 breaches out of the 175 formal complaints which received a response during the quarter[2]. Figure 3 shows the Trust's performance in responding to complaints since February 2016.

Figure 3: Percentage of formal complaints responded to within agreed timescale



1.2.2 Informal Investigations

In Q4 2017/18, the Trust received 240 complaints that were investigated via the informal process. During this period, 178 informal complaints were responded to and 74.7% of these (133 of 178) were resolved within the time agreed with the complainant.

[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.

1.3 Dissatisfied complainants

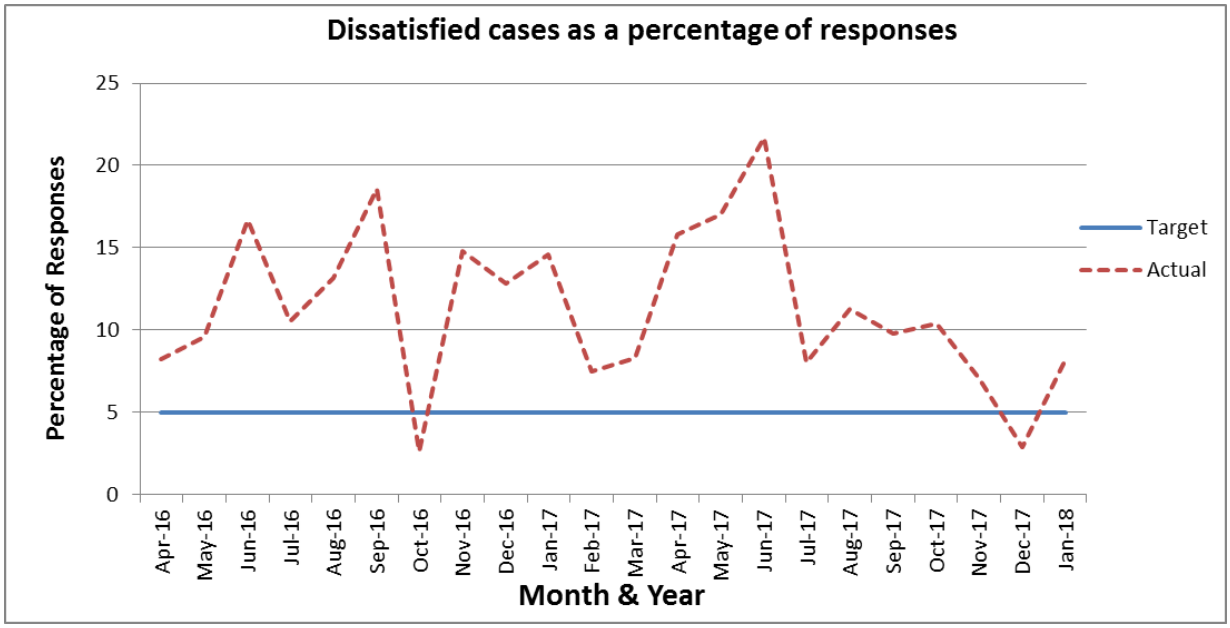
Our target is for less than 5% of complainants to be dissatisfied with our [formal] response to their complaint. This data is reported two months in arrears in order to capture the majority of cases where, having considered the findings of our investigations, complainants tell us they are not happy with our response.

In Q4, by the cut-off point of mid-April 2018 (the point at which dissatisfied data for January was calculated for board reporting), four people who received complaints responses in January had contacted us to say they were dissatisfied. This represents 8.2% of the 49 responses sent out during January.

Figure 4 shows the monthly percentage of complainants who were dissatisfied with aspects of our complaints responses since April 2016.

Important note:
Following identification of a data reporting error from the Trust's Datix system, dissatisfied data from February 2017 onwards has been recalculated. The revised data is reflected in Figure 4, which shows an improving pattern since June 2017.

Figure 4: Dissatisfied cases as a percentage of responses



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 1 provides a breakdown of complaints received in Q4 2017/18 compared to Q3. In Q4, complaints about 'attitude and communication' fell but complaints about 'appointments and admissions' rose.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q4 (2017/18)	Number of complaints received in Q3 (2017/18)
Appointments & Admissions	126 (29.8% of total complaints) ↑	97 (23.8% of total complaints) ↓
Clinical Care	123 (29.2%) ↑	118 (29%) ↓
Attitude & Communication	85 (20.1%) ↓	109 (26.8%) ↑
Facilities & Environment	26 (6.1%) ↑	23 (5.7%) ↑
Information & Support	25 (5.9%) ↓	29 (7.1%) ↑
Discharge/Transfer/Transport	25 (5.9%) ↑	16 (3.9%) ↑
Documentation	9 (2.1%) ↓	10 (2.5%) ↑
Access	4 (0.9%) ↓	5 (1.2%) ↑
Total	**423**	**407**

Each complaint is also assigned to a more specific sub-category, of which there are over 100. Table 2 lists the ten most consistently reported sub-categories, which together accounted for 63% of the complaints received in Q4 (266/423).

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q4 (2017/18)	Q3 (2017/18)	Q2 (2017/18)	Q1 (2017/18)
Clinical care (Medical/Surgical)	52 (1.9% decrease compared to Q3) ↓	53	58	70
Cancelled/delayed appointments and operations	73 (55.3% increase) ↑	47	68	75
Appointment administration issues	23 (20.7% decrease) ↓	29	45	46
Clinical care (Nursing/Midwifery)	27 (35% increase) ↑	20	28	18
Attitude of medical staff	19 (% decrease) =	19	28	29
Failure to answer telephones/failure to respond	11 (38.9% decrease) ↓	18	25	22
Attitude of admin/clerical staff	10 (44.4% decrease) ↓	18	7	4
Communication with patient/relative	19 (11.8% increase) ↑	17	18	15
Discharge arrangements	21 (40% increase) ↑	15	13	10
Attitude of nursing/midwifery staff	11 (22.2% increase) ↑	9	16	3

Figures 5-7 below show complaints received since February 2016 for the top three complaints sub-categories reported in Table 2.

In summary:

- Complaints about the 'cancelled/delayed appointments and operations' rose sharply in Q4 to 73, compared with 47 in Q3.
- Complaints about 'discharge arrangements' rose again to 21 in Q4 compared with 15 in Q3.

- Complaints about clinical care (nursing/midwifery) increased from 20 in Q3 to 27 in Q4.
- Complaints about 'appointment administration issues', which had previously been flagged as a concern in Q1 and Q2, fell again in Q4.

Figure 5: Cancelled or delayed appointments and operations

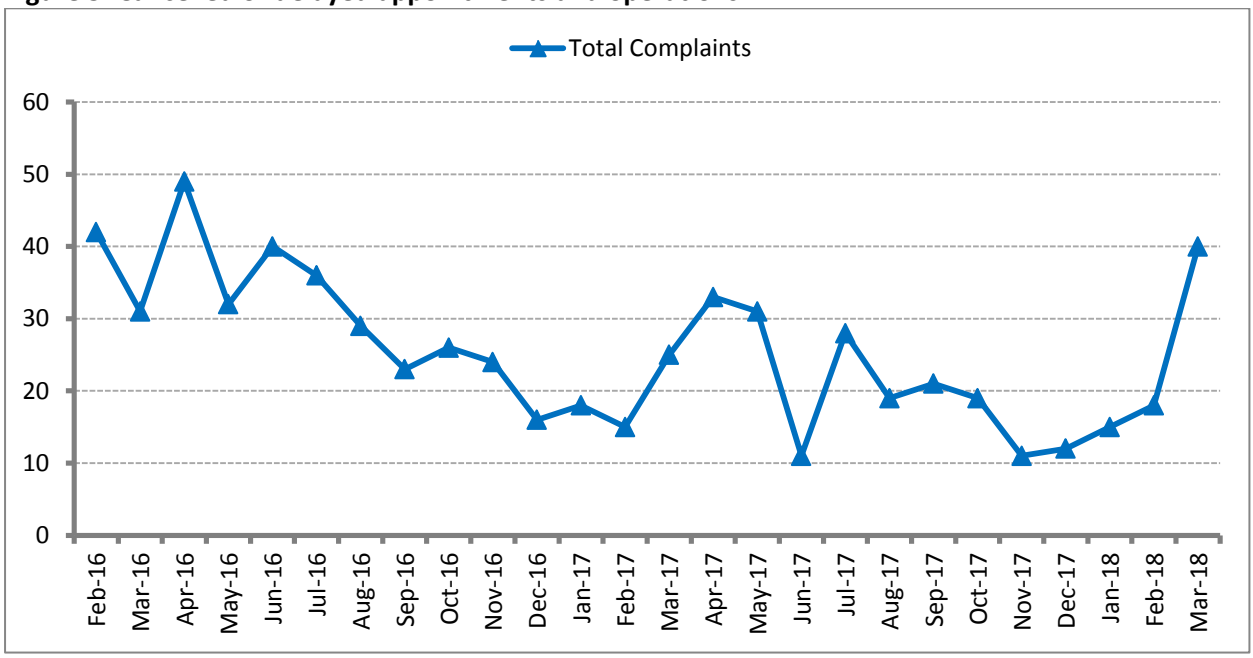


Figure 6: Clinical care – Medical/Surgical

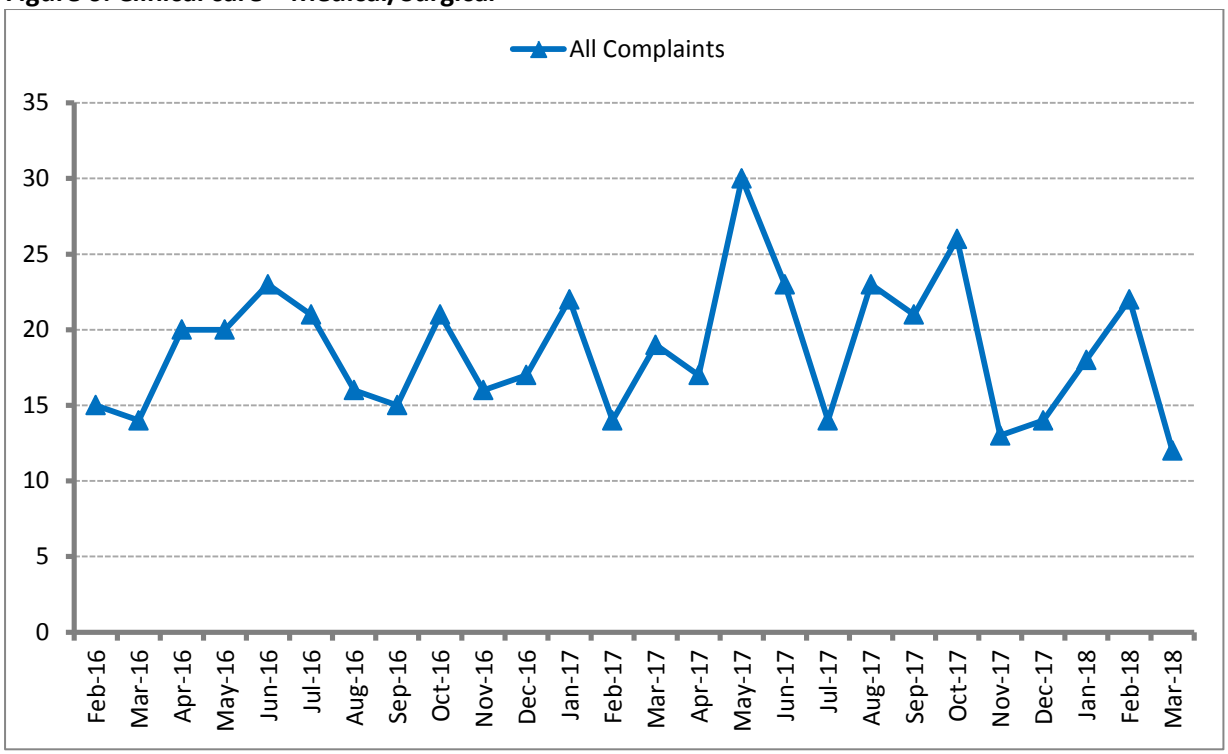


Figure 7: Clinical care – Nursing/Midwifery

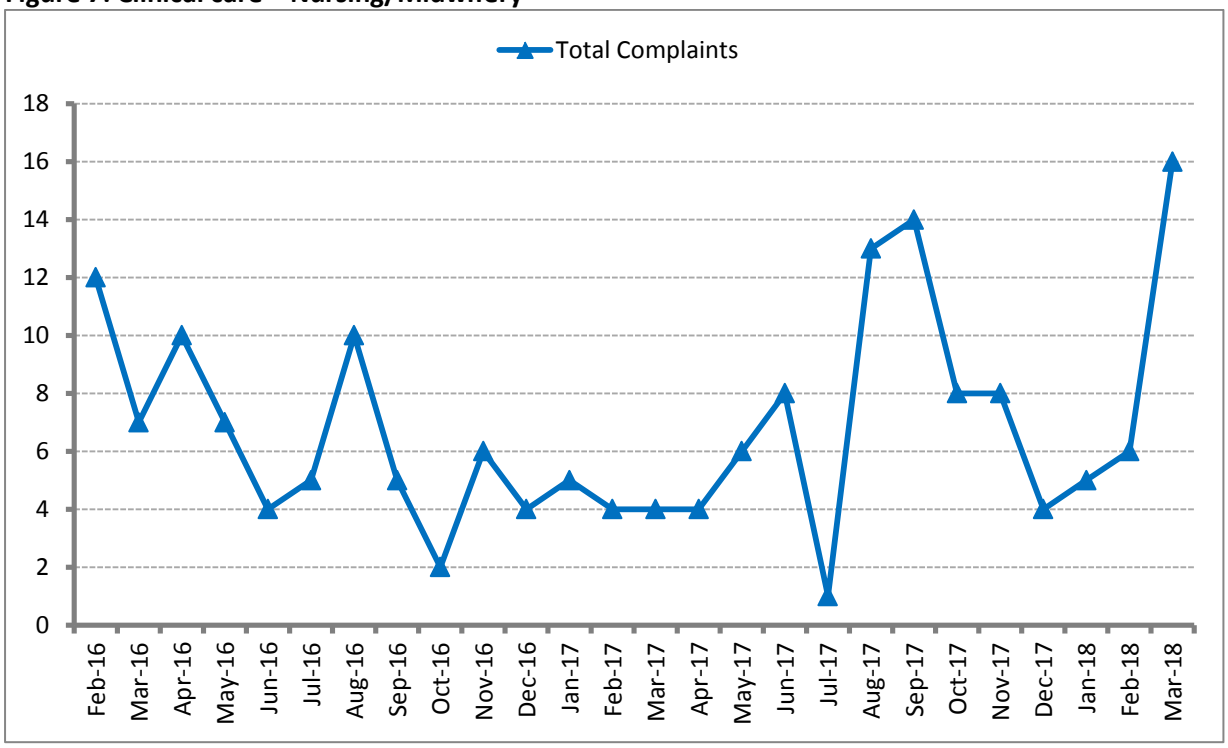
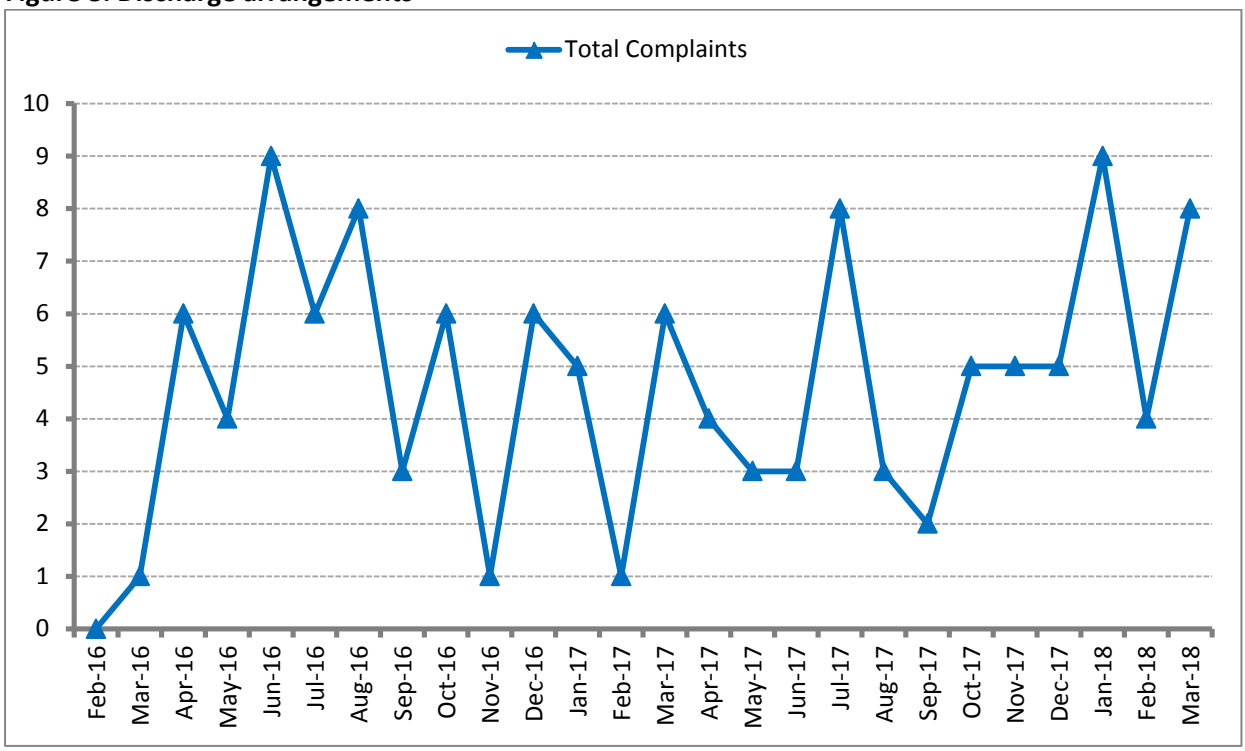


Figure 8: Discharge arrangements



3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q4 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care. Data for the Division of Trust Services is not included in this table but is summarised in section 3.1.6 of the report.

Table 3	**Surgery**	**Medicine**	**Specialised Services**	**Women & Children**	**Diagnostics & Therapies**
Total number of complaints received	158 (151) ↑	101 (94) ↑	55 (57) ↓	69 (56) ↑	20 (23) ↓
Number of complaints about appointments and admissions	71 (53) ↑	16 (11) ↑	16 (16) =	18 (10) ↑	4 (6) ↓
Number of complaints about staff attitude and communication	31 (41) ↓	22 (32) ↓	10 (13) ↓	12 (10) ↑	5 (6) ↓
Number of complaints about clinical care	38 (42) ↓	32 (24) ↑	18 (17) ↑	31 (28) ↑	3 (7) ↓
Area where the most complaints have been received in Q4	Bristol Dental Hospital – 50 (48) Bristol Eye Hospital – 33 (30) Trauma & Orthopaedics – 16 (11) QDU (Endoscopy) – 6 (10) ENT – 12 (9) Upper GI – 10 (5)	Emergency Department (BRI) - 35 (31) Dermatology – 14 (11) Sleep Unit – 2 (6) Unity Sexual Health – 5 (6) Ward A300 – 6 (1) Ward A400 – 6 (4)	BHI (all) – 42 (41) BHI Outpatients - 18 (9) Chemo Day Unit / Outpatients (BHOC) – 7 (8) Ward C604 (CICU) – 4 (3)	Children's ED & Ward 39 (BRHC) – 5 (5) Gynaecology Outpatients (StMH) – 12 (9) Ward 73 – 5 (3) Ward 78 – 6 (4)	Radiology – 7 (16) Physiotherapy – 6 (1)
Notable deteriorations compared to Q3	ENT – 12 (9) Upper GI – 10 (5)	Emergency Department (BRI) - 35 (31) Dermatology – 14 (11) Ward A300 – 6 (1)	BHI Outpatients – 18 (11)	Gynaecology Outpatients (StMH) – 12 (9)	Physiotherapy – 6 (1)
Notable improvements compared to Q3	Ward A700 – 1 (8)	Sleep Unit – 2 (6)	None	None	Radiology – 7 (16)

3.1.1 Division of Surgery

In Q4, the Division of Surgery received slightly more complaints than in the previous quarter. There was an increase in complaints about appointments and admissions (including cancelled or delayed appointments and operations) following a decrease in the previous quarter, with 71 compared to 53 in Q3. The number of complaints about Bristol Dental Hospital (BDH) was essentially unchanged from Q3, increasing by two to 48. Complaints about attitude and communication decreased from 41 in Q3 to 31 in Q4, with a reduction across all staff groups in this category.

Table 4: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2017/18**	**Number and % of complaints received – Q3 2017/18**
Appointments & Admissions	71 (44.9% of total complaints) ↑	53 (35.1% of total complaints) ↓
Clinical Care	38 (24.1%) ↓	42 (27.8%) ↑
Attitude & Communication	31 (19.6%) ↓	41 (27.2%) ↑
Information & Support	3 (1.9%) ↓	6 (4%) ↓
Facilities & Environment	4 (2.5%) ↑	3 (2%) ↑
Access	3 (1.9%) =	3 (2%) =
Discharge/Transfer/ Transport	6 (3.8%) ↑	2 (1.3%) ↓
Documentation	2 (1.3%) ↑	1 (0.7%) =
Total	**158**	**151**

Table 5: Top sub-categories

Category	**Number of complaints received – Q4 2017/18**	**Number of complaints received – Q3 2017/18**
Cancelled or delayed appointments and operations	45 ↑	22 ↓
Appointment administration issues	11 ↓	18 ↓
Clinical care (medical/surgical)	16 ↑	15 ↓
Failure to answer telephones/ failure to respond	4 ↓	10 ↓
Attitude of admin/clerical staff	5 ↓	7 ↑
Attitude of medical staff	7 =	7 ↓
Communication with patient/relative	5 ↓	7 ↑
Clinical care (nursing)	8 ↑	3 ↓
Attitude of nursing staff	2 =	2 ↓
Discharge arrangements	5 ↑	2 ↓

Table 6: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints about Bristol Dental Hospital increased slightly compared with quarter 3; however, BDH continues to receive high levels of complaints. Of the 50 complaints received, 16 were for Adult Restorative Dentistry; nine were received for Child Dental Health; and there were five complaints each for Oral Medicine and the Orthodontics Lab. The majority of complaints received by the Dental Hospital (36) were in respect of 'appointments and admissions', 24 of which were about cancelled/delayed appointments and operations.	BDH has experienced an increase in both formal and informal complaints with regard to cancellations of surgery due to Trust black escalation measures. Complaints are still being received about appointments for restorative dentistry where the service has been restricted, as explained in previous quarterly reports.	The Division continues to monitor all complaints received to identify and take action on any appropriate themes. On a positive note, there has been a reduction in complaints about telephones not being answered. In April 2018, an initiative called #takephonership was launched. This builds on four months of work led by a consultant and general manager to change the culture around answering telephones and to minimise potential pitfalls – such as telephones not working and old letters with incorrect telephone numbers. This initiative has also included drop in sessions for staff to share concerns and ideas.
Within the Division as a whole, complaints regarding 'appointments and admissions' increased from 53 in Q3 to 71 in Q4. Of these 71 complaints, 45 were received in respect of cancelled/delayed appointments and operations. A further 16 complaints were about appointment administration issues, including appointment letters not received and the appointment reminder system.	This reflects the difficulties the Division has experienced whilst the Trust is in black escalation. Elective patients were clinically triaged and proactively managed to accommodate the anticipated increase in emergency admissions. These complaints ranged from appointments being cancelled/ delayed, waiting for appointments and not receiving appointments. These were informal complaints which were resolved within the 10 day timeframe.	The Division has entered a period of implementing extra operating sessions to accommodate the planned reduction in elective activity during the winter months. Informal complaints are tracked on a daily basis, with any themes relating to specific departments being escalated to the general manager.
In Q4, the number of complaints received by the ENT service increased from 9 in Q3 to 12 in Q4. Six of these complaints were about 'appointments and admissions' and five were in respect of 'attitude and communication'.	These complaints relate to appointments rather than admissions. Patients expressed concerns variously about waiting times in clinic, an interpreter not being available and patients	The Division continues to monitor all complaints. Informal complaints are tracked daily by the complaints coordinator to identify any trends that can be actioned promptly to resolve.

	needing to chase appointments. No patterns have been identified and there have been no repeat concerns about individual staff attitude.	
The number of complaints received by the Trauma & Orthopaedics Department increased from 11 in Q3 to 16 in Q4, with seven of these complaints being about 'appointments and admissions'.	There is a very high demand for this service with one of the busiest clinics within the division Complaints about appointments refer to cancelled appointments and waiting times for appointments.	As above.
In Q4, the Division responded to 77 complaints via the informal investigation process. Of these 77 responses, a total of 14 (18%) breached the deadline that had been agreed with the complainant. Of these 14 complaints, six were for Bristol Dental Hospital and five were for Bristol Eye Hospital.	Whilst not being the level of performance we aim for, nonetheless this is a significant improvement on the 32.3% of breaches reported in Q3 (30 from 93 responses).	Informal complaints continue to be tracked by the divisional complaints lead to promote compliance with the 10 day turnaround timescale

Figure 9: Surgery, Head & Neck – formal and informal complaints received

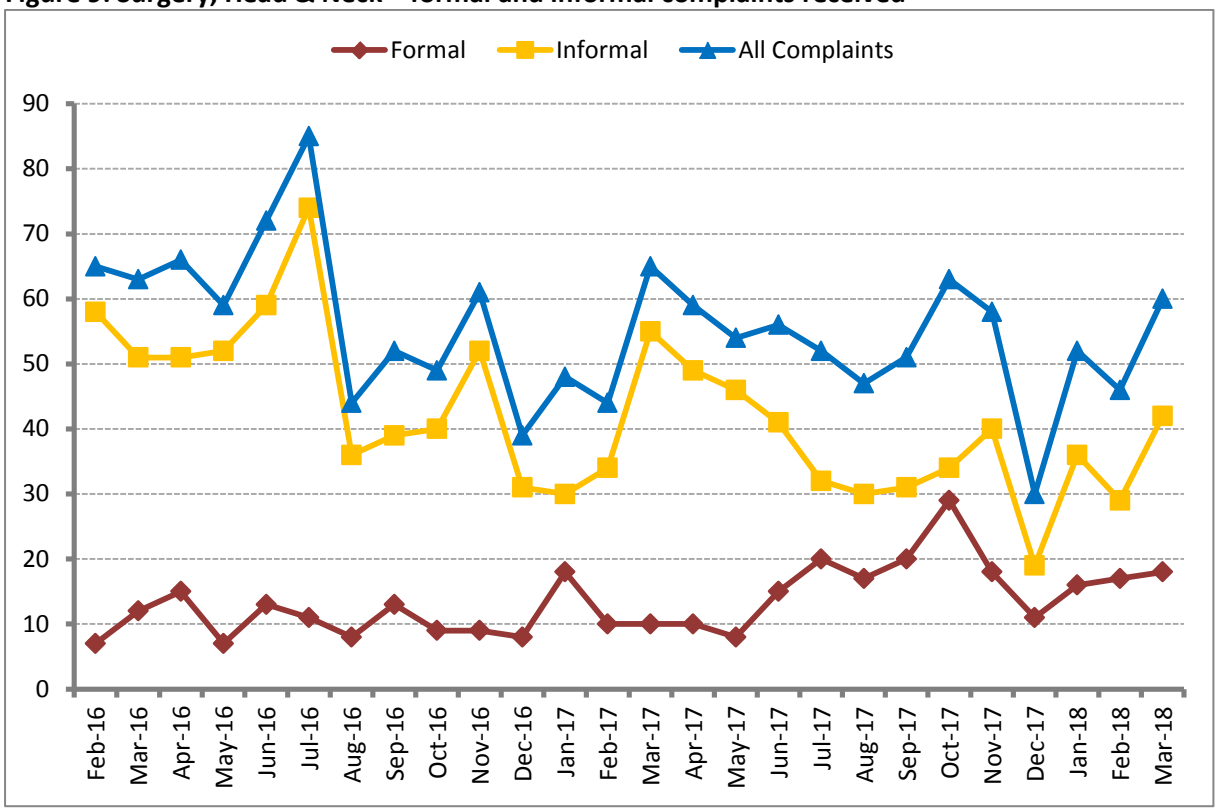


Figure 10: Complaints received by Bristol Dental Hospital

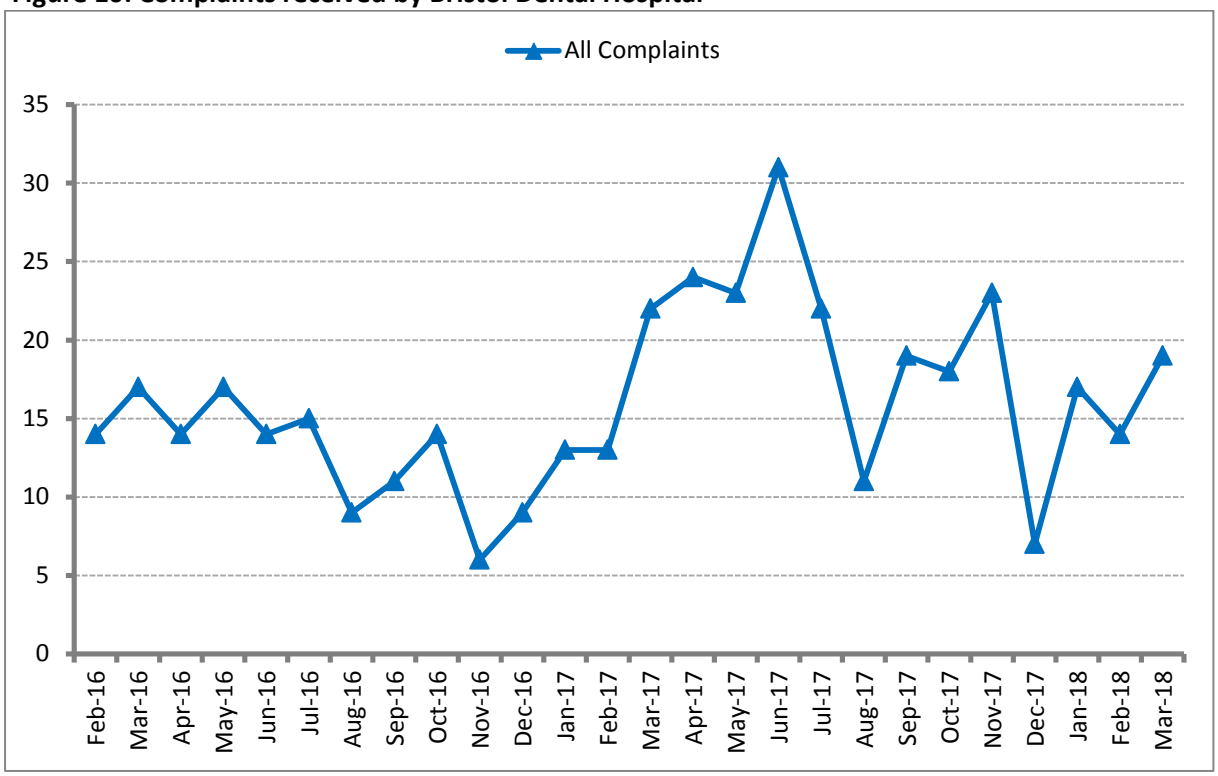
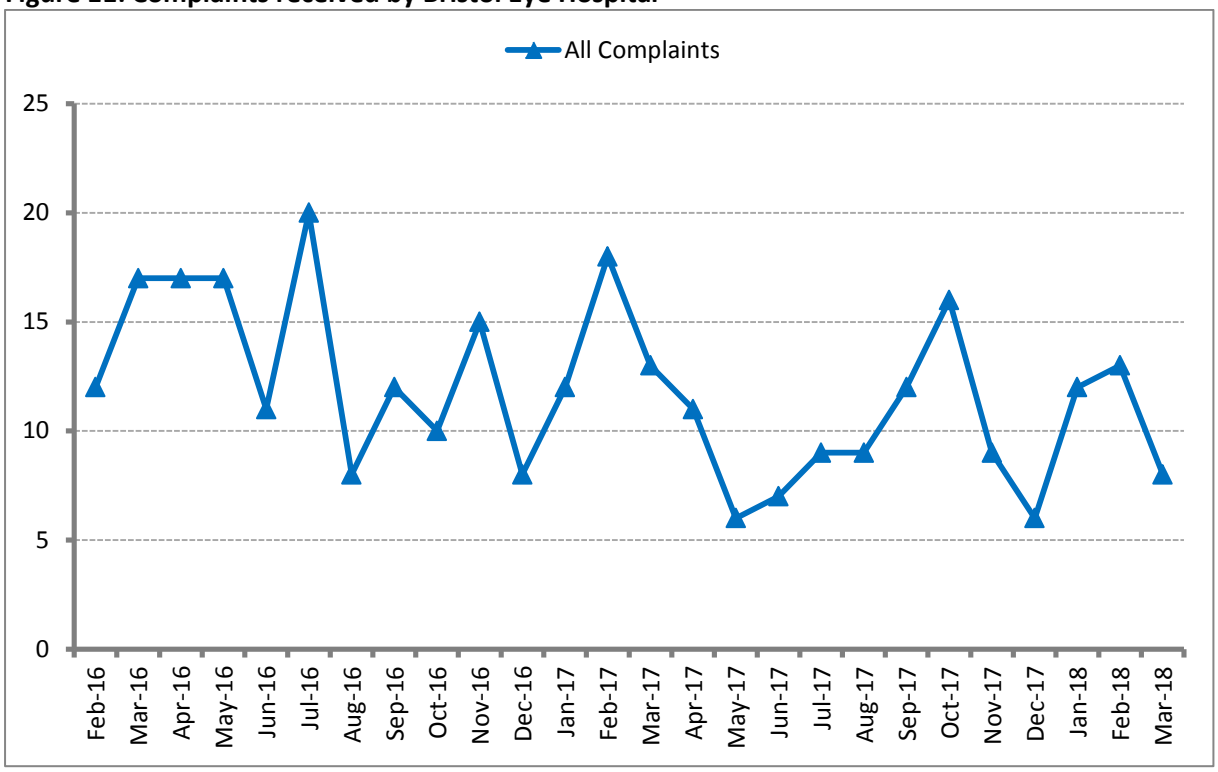


Figure 11: Complaints received by Bristol Eye Hospital



3.1.2 Division of Medicine

In Q4, the Division of Medicine received seven more complaints than in Q3 (101 compared to 94). The largest increase was seen in the category of 'clinical care', with 32 complaints compared with 24 in Q3. There were also smaller increases in complaints about 'discharge/transfer/transport', 'appointments and admissions' and 'information and support'. Complaints about the BRI Emergency Department, Dermatology and Ward A300 all increased in Q4. However, during a very busy quarter for the Emergency Department, only one complaint was received in respect of waiting times in the department. Of the 101 complaints received by the Division, 56 were resolved via a formal investigation and 45 via the informal route. The Division has seen an increase in the number of complaints resolved via the formal route since Q2 of 2017/18, whereas prior to that, it had resolved the majority of its complaints via the informal route.

Table 7: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2017/18**	**Number and % of complaints received – Q3 2017/18**
Attitude & Communication	22 (21.8% of all complaints) ↓	32 (34% of total complaints) ↓
Clinical Care	32 (31.7%) ↑	24 (25.5%) ↓
Discharge/Transfer/ Transport	14 (13.9%) ↑	12 (12.8%) ↑
Appointments & Admissions	16 (15.8%) ↑	11 (11.7%) ↓
Information & Support	8 (7.9%) ↑	6 (6.4%) ↓
Facilities & Environment	7 (6.9%) ↑	4 (4.3%) ↑
Documentation	2 (2%) ↓	3 (3.2%) ↑
Access	0 (0%) ↓	2 (2.1% of total complaints) ↑
Total	**101**	**94**

Table 8: Top sub-categories

Category	Number of complaints received – Q4 2017/18	Number of complaints received – Q3 2017/18
Discharge arrangements	12 ↑	11 ↑
Clinical care (medical/surgical)	15 ↑	11 ↓
Attitude of medical staff	5 ↓	9 ↓
Cancelled or delayed appointments and operations	5↓	6 ↓
Attitude of nursing staff	6 =	6 ↓
Attitude of admin/clerical staff	1 ↓	5 ↑
Clinical care (nursing)	9 ↑	5 ↓
Appointment administration issues	5 ↑	4 ↓
Failure to answer telephones/failure to respond	4 =	4 ↓
Communication with patient/relative	5 ↑	3 ↓

Table 9: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Emergency Department complaints increased slightly in Q4 to 35, compared with 31 in Q3 and 18 in Q2. Of the 35 complaints received, 10 were in respect of 'attitude & communication' and 13 were about clinical care. Of the 10 complaints about attitude & communication, five related to attitude of nursing staff.	The Emergency Department saw an increase in activity and attendances in Q4, with significantly more occasions when there was both crowding and queuing. Despite staff working to provide the care to the highest possible standards, we acknowledge that communication with patients can sometimes be suboptimal at these times.	We continue to thematically review all complaints, looking for patterns of day, time, source, triggers. Work is being undertaken to improve the well-being of staff and support resilience. Work continues to seek workable solutions to improve patient flow through the Emergency Department.
The Division received six complaints about Ward A300 (AMU) during Q4. Three of these complaints were about clinical care and two related to premature discharge.	This level of complaints is within the normal range for AMU. Complaints are balanced by positive patient feedback.	We will continue to review complaints for potential patterns and common themes. .
During Q4, the Division responded to 36 complaints via the informal investigation route. Of these 36 responses, 11 (30.5%) breached the deadline	The process for tracking and monitoring informal complaints investigations requires further embedding in the division.	We will ensure all teams are aware of the process by way of email reminder. Specific support to be provided in Dermatology, where new senior leaders have

agreed with the complainant. Four of these 11 breaches were in respect of complaints received by Dermatology.		been appointed.

Figure 12: Medicine – formal and informal complaints received

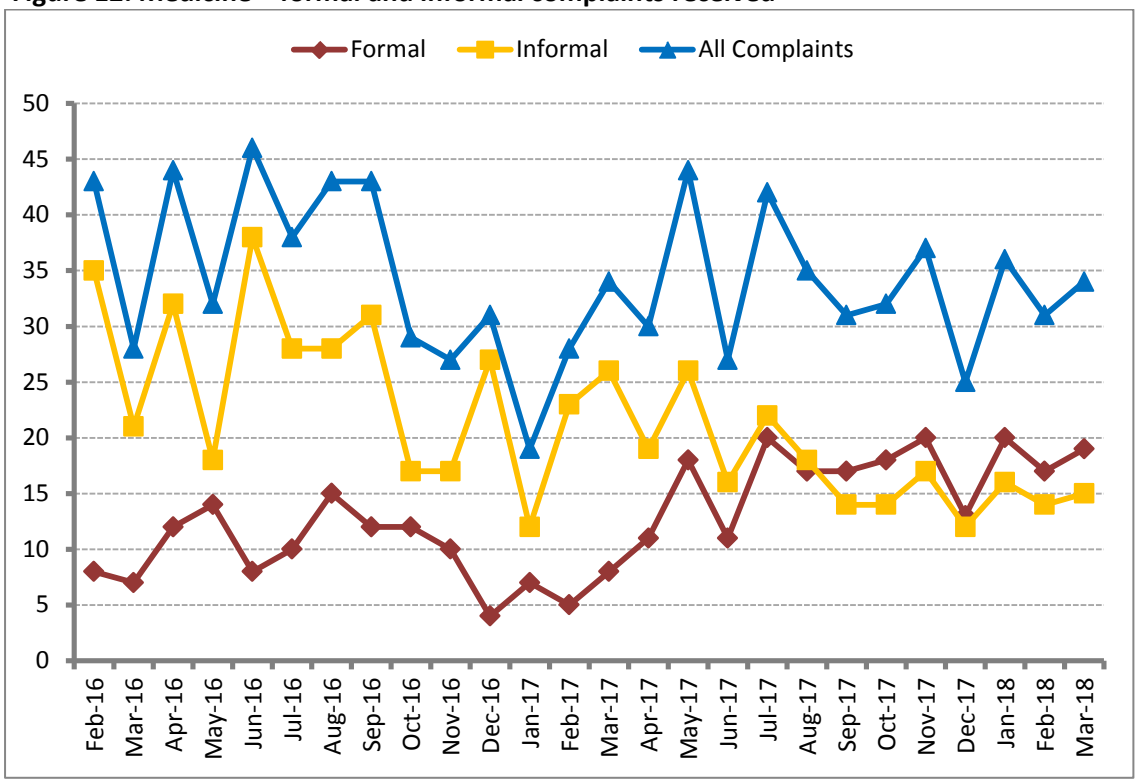
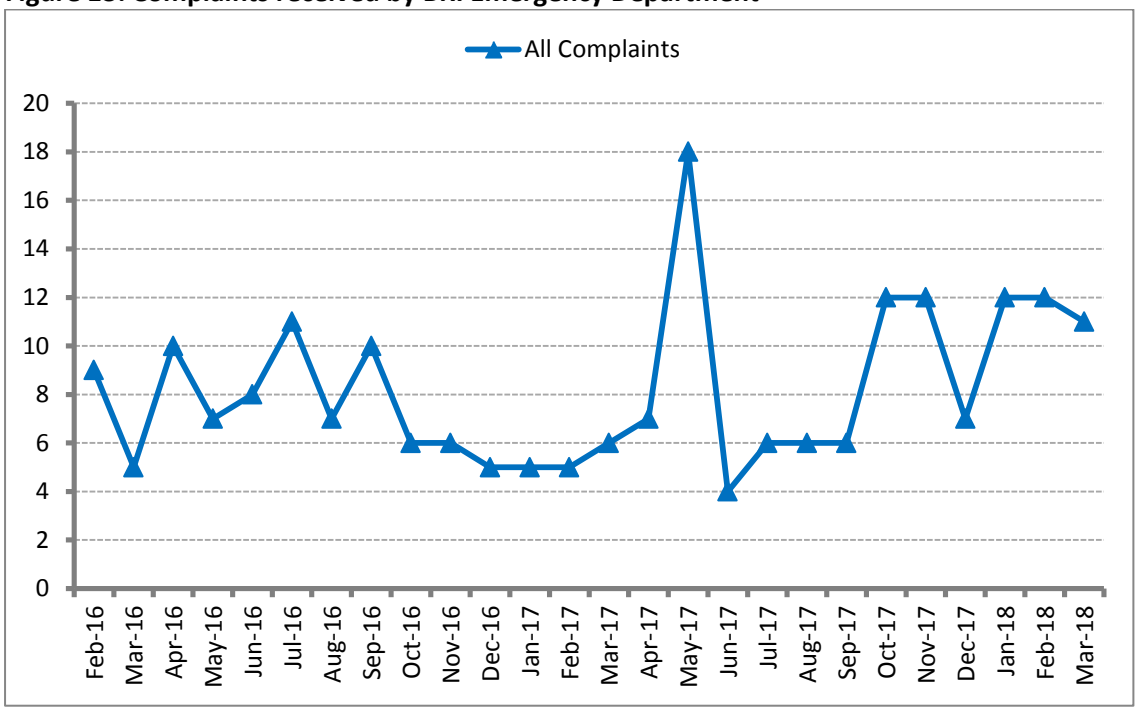


Figure 13: Complaints received by BRI Emergency Department



3.1.3 Division of Specialised Services

In Q4, the Division of Specialised Services received a similar number of complaints to the previous quarter (55 in Q4 compared to 57 in Q3). There were small increases in the number of complaints received in the categories of 'clinical care', 'information and support' and 'discharge/transfer/transport'. The number of complaints received in relation to 'appointments and admissions' remained the same as the previous quarter at 16 complaints. Of the 55 complaints received by the Division in Q4, 23 were investigated via the formal complaints process and 32 were dealt with via the informal process.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q4 2017/18	Number and % of complaints received – Q3 2017/18
Clinical Care	18 (32.7% of all complaints) ↑	17 (29.8% of all complaints) ↑
Appointments & Admissions	16 (29.1%) =	16 (28%) ↓
Attitude & Communication	10 (18.2%) ↓	13 (22.8%) =
Information & Support	6 (10.9%) ↑	5 (8.8%) ↑
Documentation	1 (1.8%) ↓	3 (5.3%) ↑
Facilities & Environment	0 (0%) ↓	2 (3.5%) =
Discharge/Transfer/Transport	4 (7.3%) ↑	1 (1.8%) =
Access	0 (0%) =	0 (0% of total complaints) =
Total	**55**	**57**

Table 11: Top sub-categories

Category	Number of complaints received – Q4 2017/18	Number of complaints received – Q3 2017/18
Cancelled or delayed appointments and operations	10 ↑	8 ↓
Clinical care (medical/surgical)	9 ↑	7 ↑
Appointment administration issues	2 ↓	5 ↓
Clinical care (nursing)	2 ↓	5 ↑
Communication with patient/relative	2 ↓	3 =
Attitude of admin/clerical staff	0 ↓	2 ↑
Attitude of medical staff	3 ↑	1 ↓
Failure to answer telephone/failure to respond	1 =	1 ↓
Attitude of nursing staff	2 ↑	1 =
Discharge arrangements	4 ↑	1 ↑

Table 12: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints received by Bristol Heart Institute Outpatient Departments (including Outpatient Echo) increased from 11 in Q3 to 18 in Q4. Of these 18 complaints, nine were in respect of 'appointments and admissions' (six of which were about delayed appointments).	Two patients who were waiting for an echo were sent appointments but we had an old address. There were issues around patients wanting to cancel procedures but not being sure who to contact. Patients complained about time that they had to wait for an operation whilst on the waiting list.	The patients' information was updated and their appointments were organised immediately. This was resolved with the patients at the time All of the patients on the waiting list are reviewed by the clinical team to ensure that they are prioritised appropriately and kept informed of what is happening.
Bristol Haematology & Oncology Centre received 11 complaints in Q4. Of these 11 complaints, seven were received by the Chemotherapy Day Unit/Outpatients Department, three were for Ward 61 and one was for Area 61 Inpatient). Four of the complaints related to 'appointments and admissions', four were about 'attitude and communication' and three were in respect of 'clinical care'.	These complaints came about for a variety of reasons. The complaints about appointments and beds not being available were all dealt with at the time and happened during a time where there were increased capacity issues, especially around chemotherapy delivery. The attitude and communication complaints were discussed with the staff members involved. One clinical care complaint was in respect of a patient who died on the Teenagers and Young Adults Unit. This was a complex complaint.	The administration team had additional support during this time to answer increased calls from patients who were concerned about appointments for chemotherapy, in order that they could be kept informed. Whenever a complex complaint is received and it is clear that the family are clearly grieving, they are always offered a meeting so that issues can be resolved and the family can be supported during a difficult time.

Figure 14: Specialised Services – formal and informal complaints received

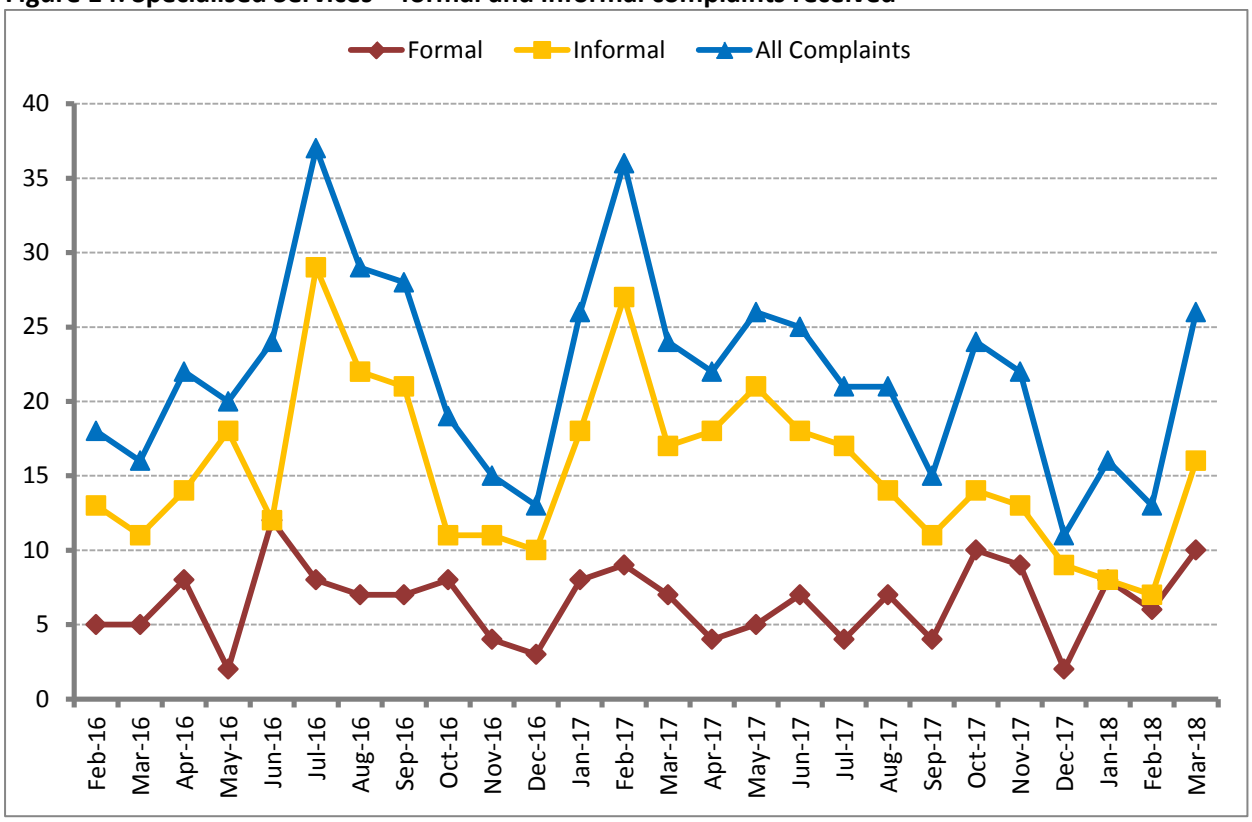


Figure 15: Complaints received by Bristol Heart Institute

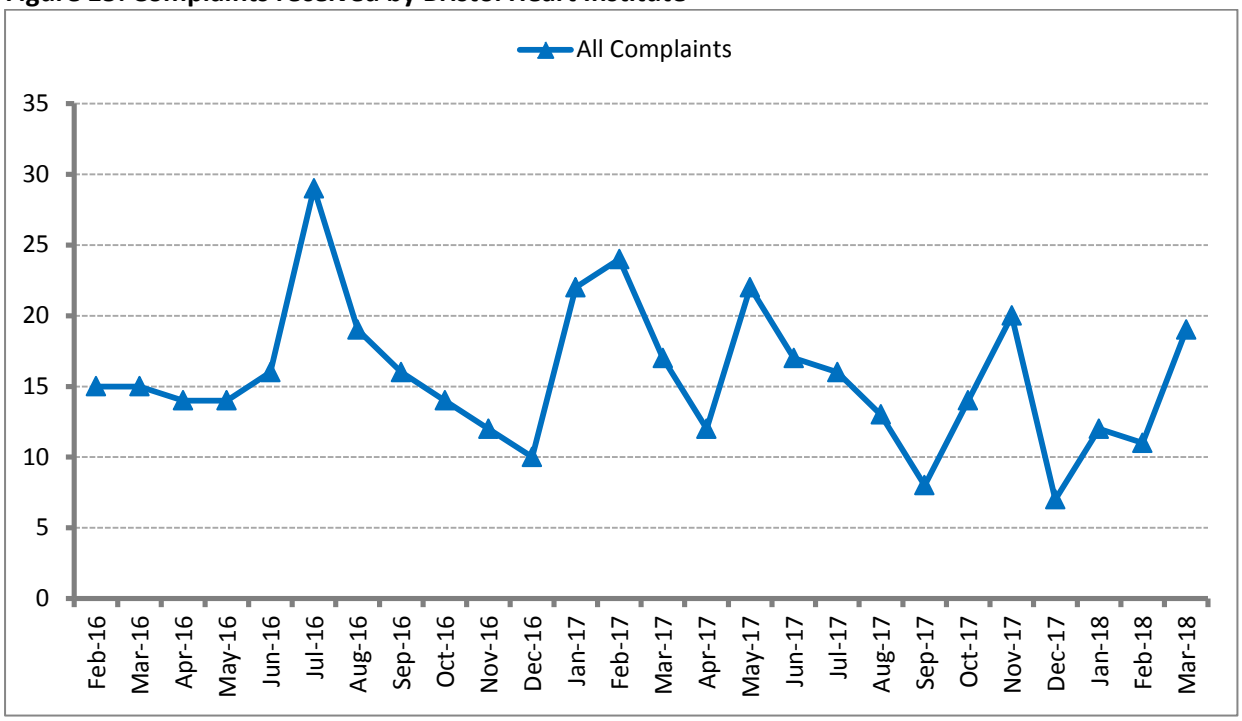


Figure 16: Complaints received by Bristol Heart Institute Outpatients

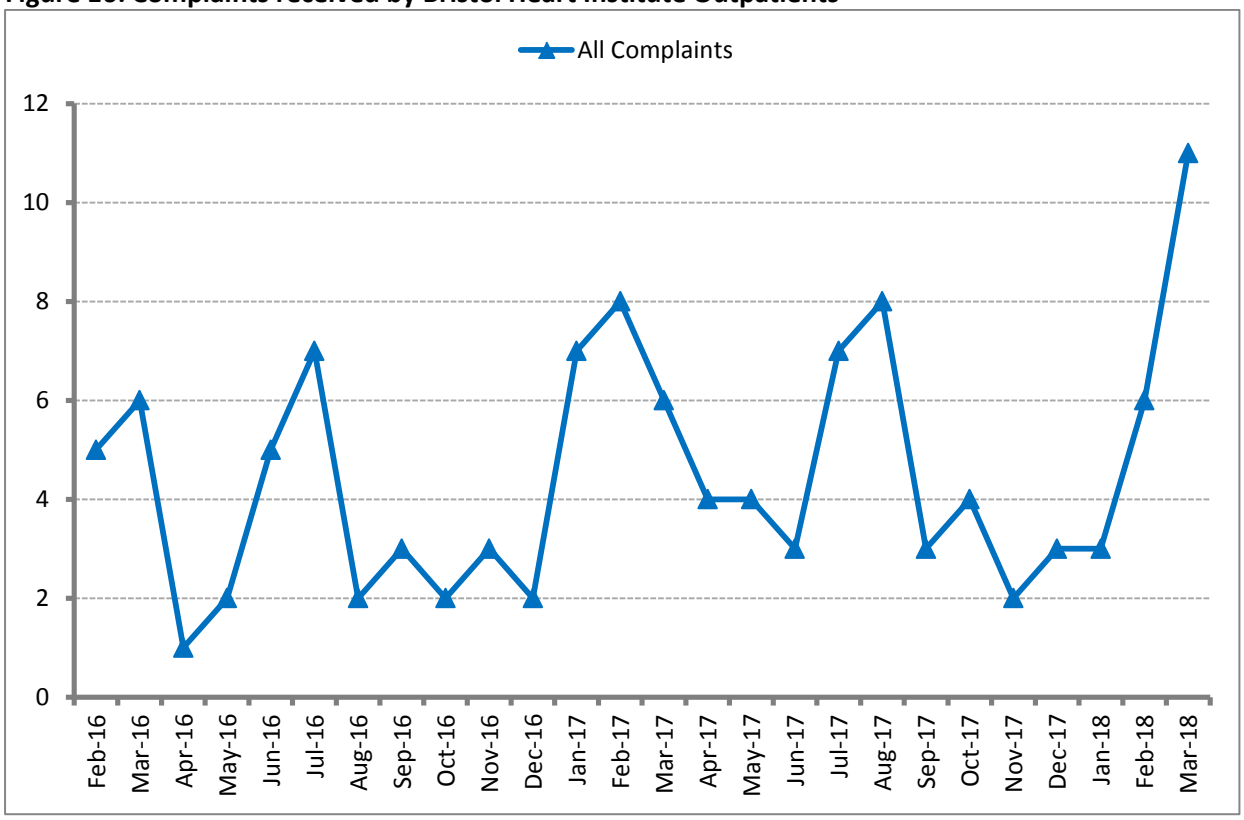
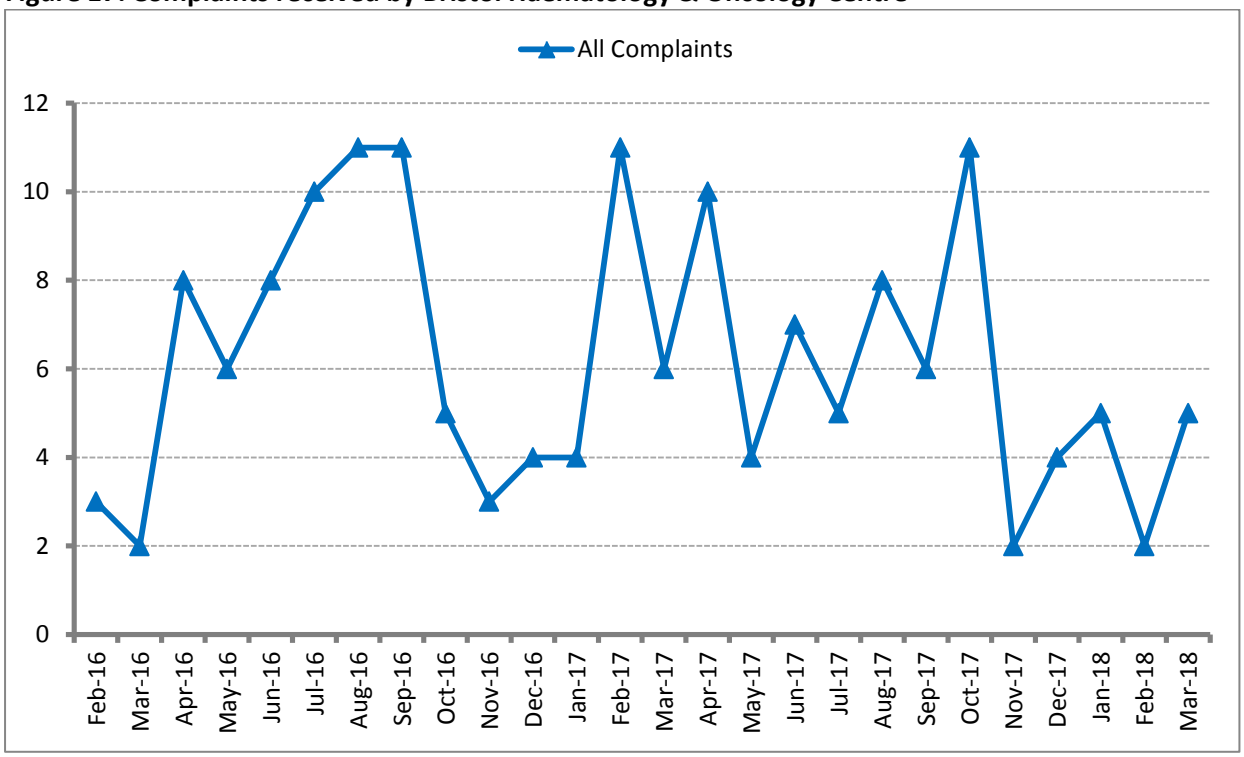


Figure 17: Complaints received by Bristol Haematology & Oncology Centre



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division increased by 23% compared with the previous quarter. The number of complaints about clinical care increased, accounting for just under half of all complaints received by the Division. Women's and Children's Services was the only division where the majority of complaints received in Q4 were resolved via the formal investigation process (45 formal compared to 24 informal).

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q4 2017/18	Number and % of complaints received – Q3 2017/18
Clinical Care	31 (44.9% of total complaints) ↑	28 (50% of total complaints) ↓
Appointments & Admissions	18 (26.1%) ↑	10 (17.9%) ↓
Attitude & Communication	12 (17.4%) ↑	10 (17.9%) ↓
Facilities & Environment	3 (4.3%) =	3 (5.4%) ↑
Information & Support	2 (2.9%) ↓	3 (5.4%) ↓
Discharge/Transfer/Transport	0 (0%) ↓	1 (1.7%) ↑
Documentation	2 (2.9%) ↑	1 (1.7%) =
Access	1 (1.5%) ↑	0 (0%) =
Total	**69**	**56**

Table 14: Top sub-categories

Category	Number of complaints received – Q4 2017/18	Number of complaints received – Q3 2017/18
Clinical care (medical/surgical)	11 ↓	13 ↑
Cancelled or delayed appointments and operations	10 ↑	8 ↓
Clinical care (nursing/midwifery)	8 ↑	7 ↓
Communication with patient/relative	5 ↑	3 ↓
Attitude of admin/clerical staff	1 ↓	2 ↑
Attitude of medical staff	3 ↑	2 ↓
Failure to answer telephones /failure to respond	1 =	1 ↓
Appointment administration issues	3 ↑	1 ↓
Discharge arrangements	1 =	1 ↑
Attitude of nursing/midwifery	1 ↑	0 ↓

Table 15: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Almost half of all complaints received by the Division (31 of 69) in Q4 were in respect of clinical care. Clinical care has been the category with the highest number of complaints for the Division for the last four consecutive quarters. 15 of the complaints about clinical care were received by Bristol Royal Hospital for Children (BRHC) and 16 by St Michael's Hospital (STMH).	**BRHC** Complaints relating to inpatient clinical care have been decreasing from a high in August 2017 to zero in March 2018. However complaints about Outpatients have been increasing. **STMH** Many of the complaints at St. Michaels are because women have not understood what has happened to them in labour and why, or because their expectations of labour are not met. Women also sometimes find that post-natal care does not meet their expectations, having gone from 1 to 1 care in labour to 1 to 8 care from a midwife. This is a national issue. Some complaints received in Q4 also corresponded with reported clinical incidents.	**BRHC** The Matron and Sister for outpatients are aware and investigating potential themes. **STMH** An action plan has been developed in response to the results of the national maternity survey. Ongoing work with the Local Maternity System across BNSSG is focusing on personalised care and post-natal care.
Complaints received by Gynaecology Outpatients increased from 9 in Q3 to 12 in Q4. Six of the 12 complaints were in respect of cancelled/delayed appointments/operations; three were about 'attitude and communication' and three related to 'clinical care'.	**STMH** We have experienced an increase in complaints about delays in the urogynae pathway. This is due to having a single specialist Consultant who has a long waiting list. A pattern of complaints about the attitude of a staff member is being addressed with the individual concerned.	**STMH** A new urogynae pathway will be introduced which will include nurse led clinics for conservative management, freeing up space in the Consultant clinic for complex patients needing surgery. A patient leaflet has been drafted for approval which will assist in managing patient expectations. Specific reflective work undertaken with Consultant. As above with regards to leaflet and expectations.
During Q4, 11 formal complaints responses breached the deadline agreed with the complainant (34.4%). Six of these breaches were in relation to responses from STMH and five were from BRHC.	**BRHC** Three of the breaches were in relation to complex complaints being handed over to a new member of staff. Questions raised by the Chief Nurse also needed to be addressed. **STMH** There have been delays in	**BRHC** We are reviewing the complaints process in the BRHC, with the aim of trialing a new approach that should improve the response rates, and decrease the number of dissatisfied replies. **STMH** This has been brought to the

	receiving responses from medical staff.	attention of the clinical lead who is addressing this and it has been discussed in business meeting in Women's Services.

Figure 18: Women & Children – formal and informal complaints received

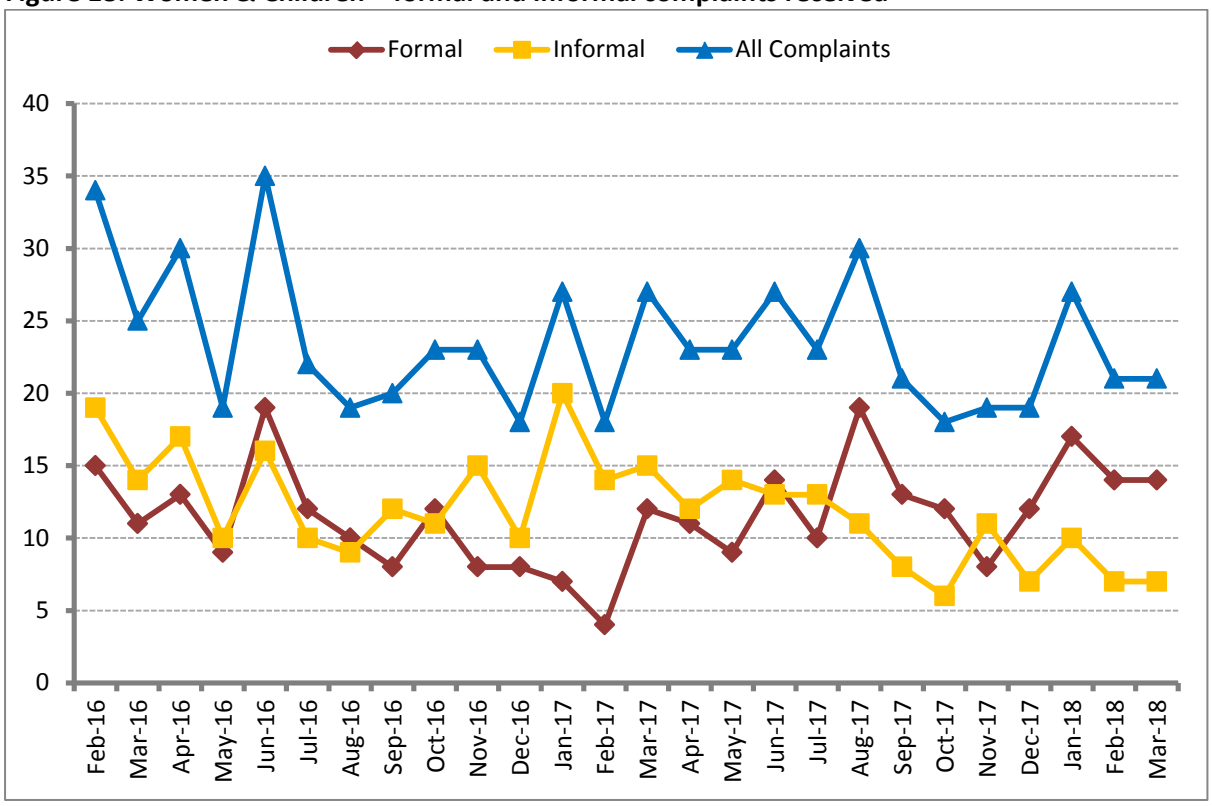


Figure 19: Complaints received by Bristol Royal Hospital for Children

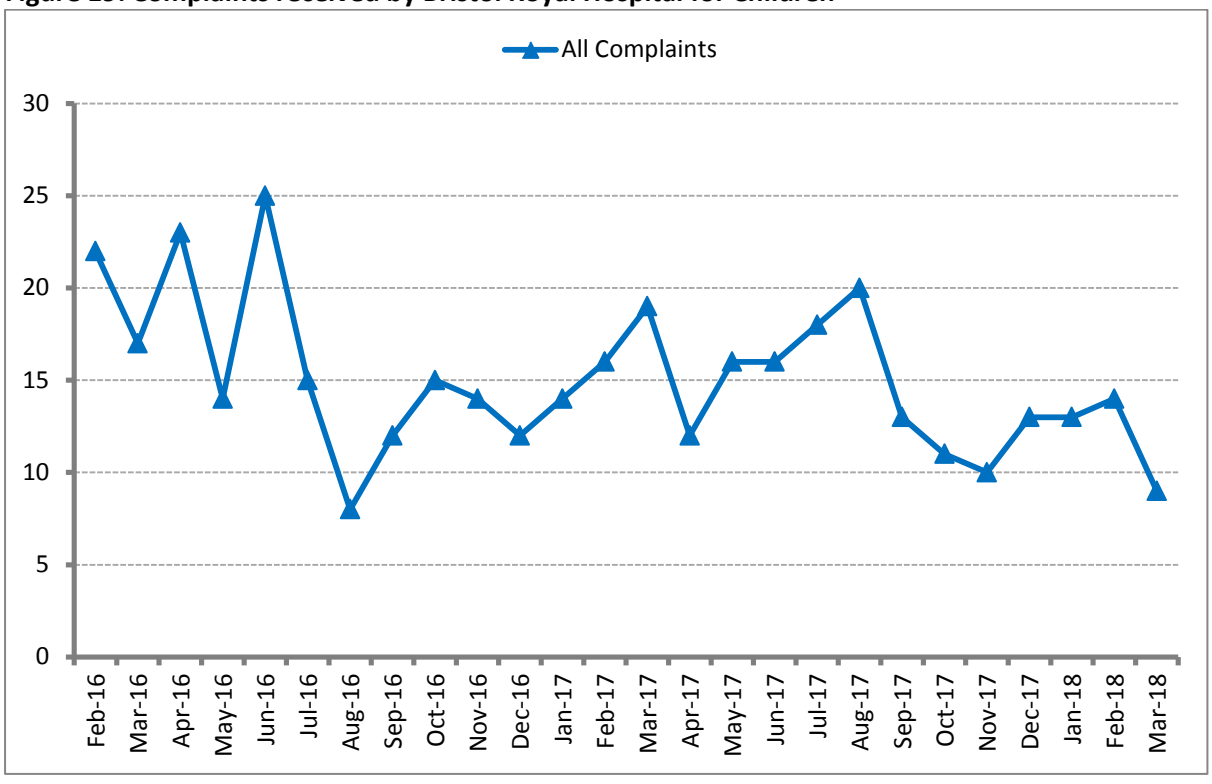
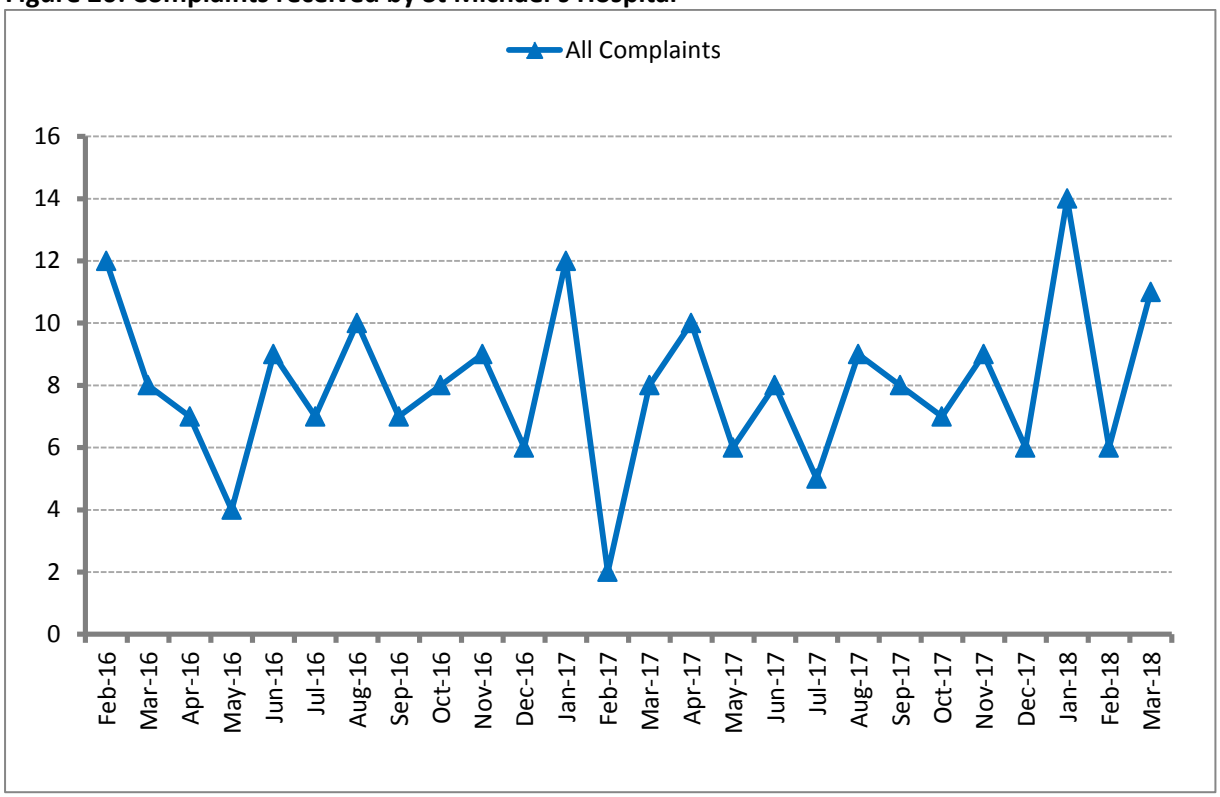


Figure 20: Complaints received by St Michael's Hospital



3.1.5 Division of Diagnostics & Therapies

Complaints received by the Division of Diagnostics and Therapies fell by 30% in Q4 after increasing for three consecutive quarters up to Q3. The majority of complaints received (5) were in respect of 'attitude and communication', closely followed by those about 'appointments & admissions' and clinical care'. The Division dealt with three of the 16 complaints via a formal investigation, with the remaining 13 complaints being resolved informally.

Table 16: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2017/18**	**Number and % of complaints received – Q3 2017/18**
Clinical Care	5 (% of total complaints) ↓	7 (30.4% of total complaints) ↑
Appointments & Admissions	4 (25%) ↓	6 (26.1%) =
Attitude & Communication	6 (%) ↓	6 (26.1%) ↓
Facilities & Environment	4 (%) =	4 (17.4%) ↑
Information & Support	1 (6.3%) ↑	0 (0%) =
Discharge/Transfer/Transport	0 (0%) =	0 (0%) =
Documentation	0 (0%) =	0 (0%) ↓
Access	0 (0%) =	0 (0%)
Total	**20**	**23**

Table 17: Top sub-categories

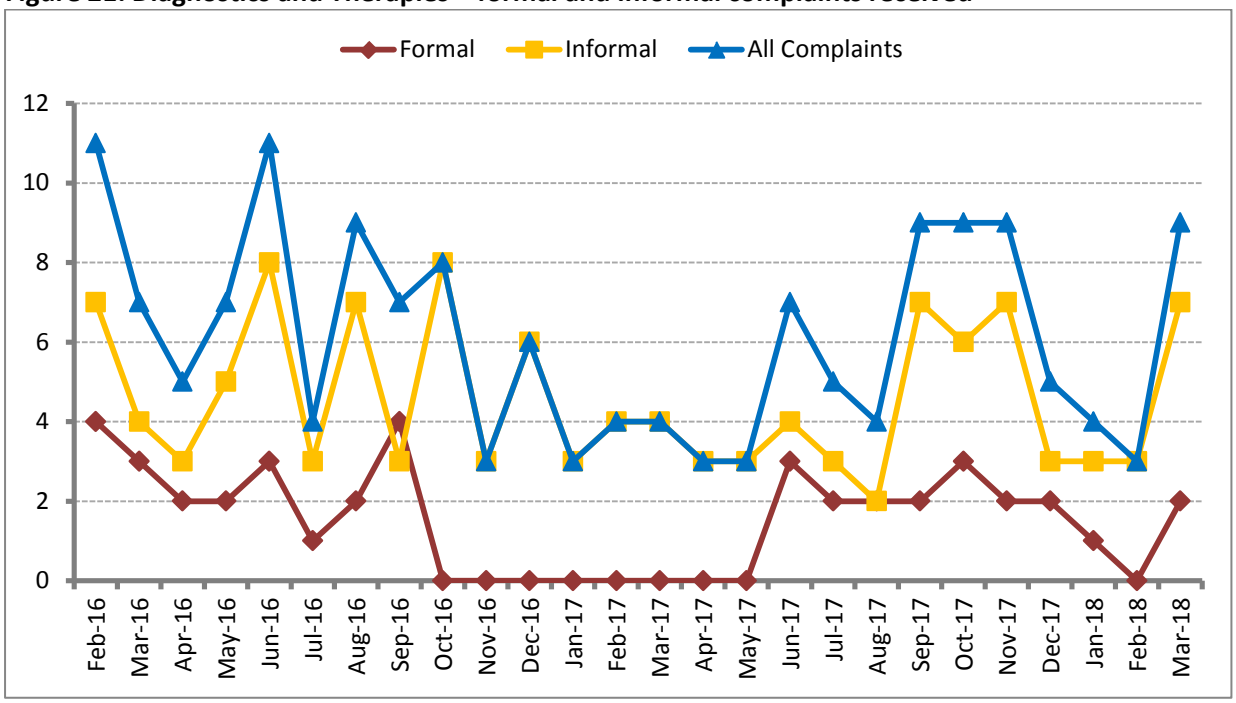
Category	Number of complaints received – Q4 2017/18	Number of complaints received – Q3 2017/18
Cancelled or delayed appointments and operations	3 =	3 ↑
Clinical care (medical/AHPs)	2 =	2 ↑
Failure to answer telephones /failure to respond	1 ↓	2 ↑
Appointment administration issues	1 =	1 ↓
Attitude of medical staff/AHPs	3 ↑	1 =
Communication with patient/relative	1 =	1 =
Clinical care (nursing)	0 =	0 =
Attitude of nursing/midwifery	0 =	0 ↓
Discharge arrangements	0 =	0 =
Attitude of admin/clerical staff	0 =	0 ↓

Table 18: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
The Division received six complaints about Physiotherapy during Q4. Three of these complaints related to appointments and admissions, and one complaint related to clinical care, facilities and environment and attitude and communication.	The majority of complaints relate to patients being unable to contact the physiotherapy department regarding their appointments. This was due to a new team of staff learning processes not logging in to the 'hunt group' for the phones, a lack of phone lines and an incorrect telephone number put on the appointment letters. The clinical care complaint was a patient who had their walking stick removed but they did not understand why and felt it hindered their recovery. The complaint about facilities was regarding the fact that the	All staff now log in to the 'hunt group' from 08:00. Phone reports are monitored on a weekly basis. Periods when phone traffic is busiest have been identified - outgoing calls will be reduced at these times to focus on patients calling in. Admin staff have completed a survey on best phone practice. Letters have been amended with correct telephone number. Explanation of the clinical reasons for the stick being removed provided. Patient stated she now feels having the stick removed aided her overall recovery after all. Staff member spoken to around their communication skills to ensure a clear explanation is provided at the time with future patients. A new contract is in place with the equipment supplier so patients will

	department was unable to reuse equipment such as walking aids and nebulisers.	have unwanted items collected from their homes and they can be reused. Nebulisers can be returned through the patients GP.

Figure 21: Diagnostics and Therapies – formal and informal complaints received



3.1.6 Division of Trust Services

The Division of Trust Services, which includes Facilities & Estates, received 20 complaints in Q4, compared to 26 in Q3[3]. Of the 20 complaints received in Q4, three each were received by the Private & Overseas Patients Team, the Welcome Centre Reception, Medical Records (BRI) and the Outpatients Appointment Centre. The remaining eight complaints were in respect of car parking and hospital transport.

[3] Four complaints for Boots Pharmacy (BRI) were incorrectly recorded under Trust Services and Figure 21 therefore shows a total of 24 complaints for Q4 instead of 20.

Figure 22: Trust Services – formal and informal complaints received

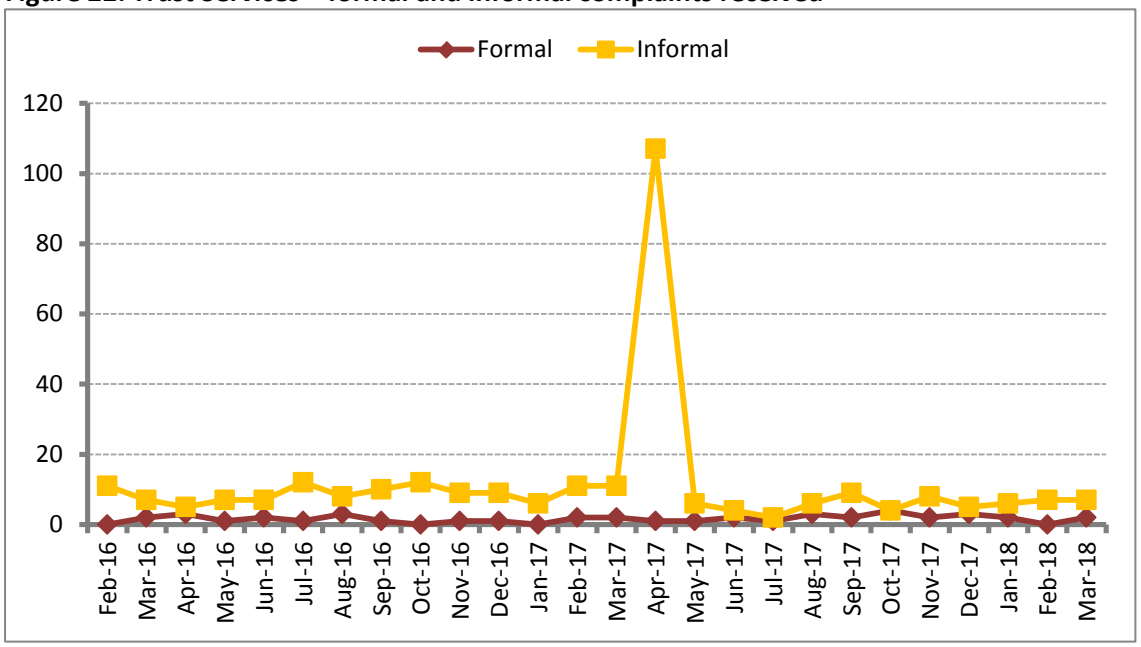
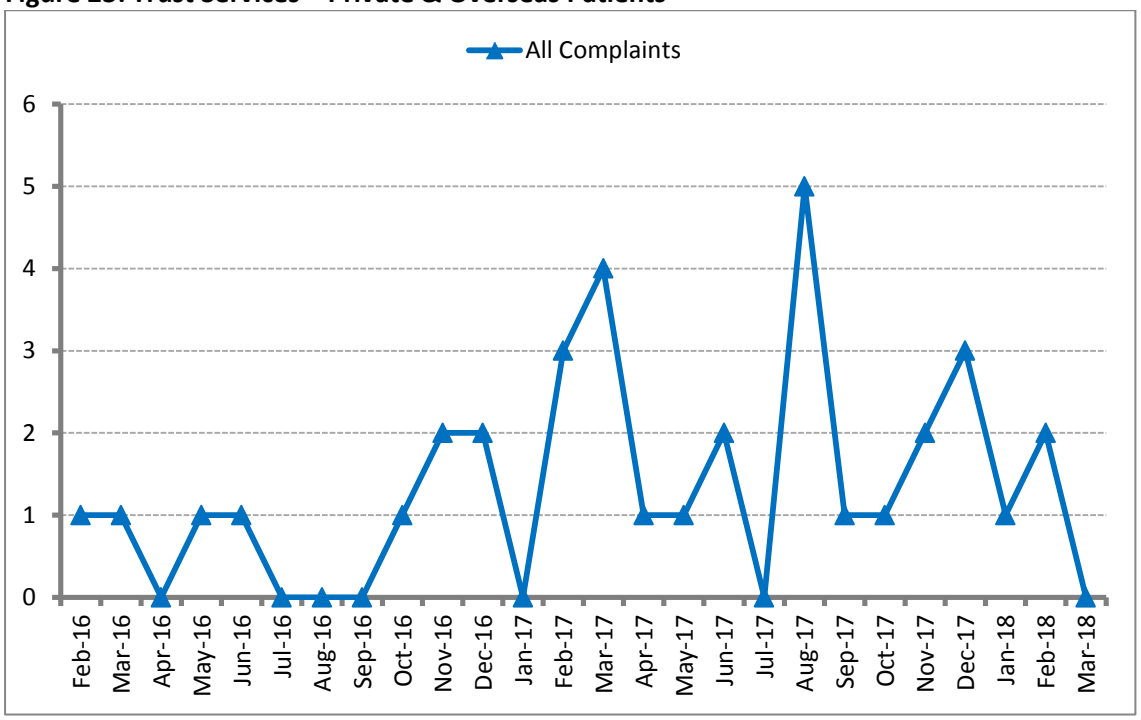


Figure 23: Trust Services – Private & Overseas Patients



3.2 Complaints by hospital site

Of those complaints with an identifiable site, the breakdown by hospital is as follows:

Table 19: Breakdown of complaints by hospital site[4]

Hospital/Site	Number and % of complaints received in Q4 2017/18	Number and % of complaints received in Q3 2017/18
Bristol Royal Infirmary	182 (43% of total complaints) ↑	174 (42.8% of total complaints) ↓
Bristol Dental Hospital	50 (11.8%) ↑	48 (11.8%) ↓
Bristol Heart Institute	42 (9.9%) ↓	44 (10.8%) ↑
Bristol Royal Hospital for Children	37 ↑	36 (8.8%) ↓
St Michael's Hospital	45 ↑	34 (8.4%) ↓
Bristol Eye Hospital	33 ↑	31 (7.5%) ↑
Bristol Haematology & Oncology Centre	12 ↓	17 (4.1%) ↓
South Bristol Community Hospital	12 ↑	10 (2.5%) ↑
Southmead and Weston Hospitals (UH Bristol services)	2 ↓	3 (0.6%) ↑
Trust Headquarters	0 ↓	2 (0.5%) ↑
Trust Car Parks	2 =	2 (0.5%) ↑
Off Trust Premises	0 ↓	1 (0.2%) =
Community Dental Sites (Charlotte Keel)	2 ↑	0 (0%) ↓
Unity Community Sexual Health	4 ↓	6 (1.5%) ↑
TOTAL	**423**	**407**

3.2.1 Breakdown of complaints by inpatient/outpatient/ED status

In order to more clearly identify the number of complaints received by the type of service, Figures 24-28 below show data differentiating between inpatient, outpatient, Emergency Department and other complaints. The category of 'other' includes complaints about non-clinical areas, such as car parking, cashiers, administration departments, etc.

In Q4, 45.2% (*42.3%) of complaints received were about outpatient services, 34.3% (34.4%) related to inpatient care, 9.7% (9.3%) were about emergency patients; and 10.8% (16.3%) were in the category of 'other' (as explained above).

** Q3 percentages are shown in brackets for comparison.*

[4] It should be noted that these figures will not all match complaints by Division as some divisional services take place at other sites. For example, ENT comes under the remit of the Division of Surgery but the clinic is based at St Michael's Hospital.

Figure 24: All patient activity

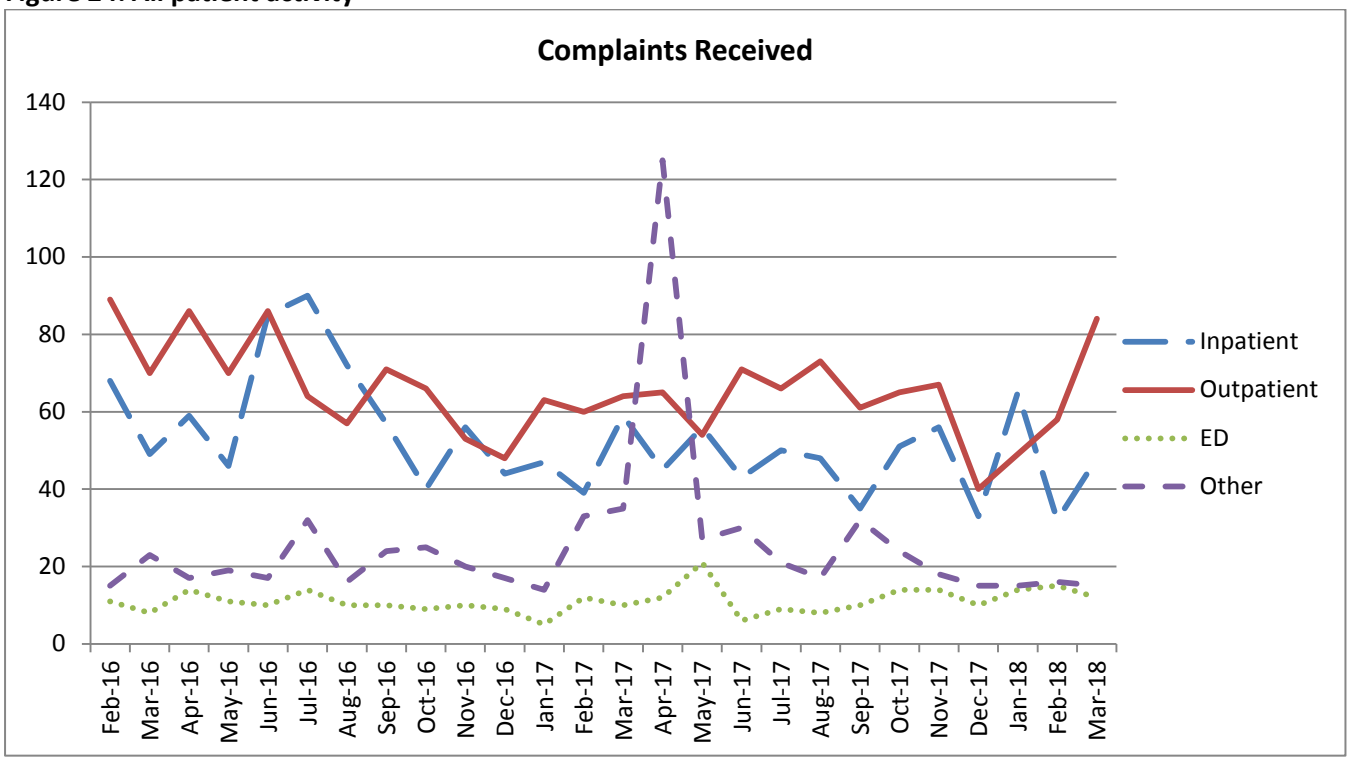


Figure 25: Complaints received from inpatients

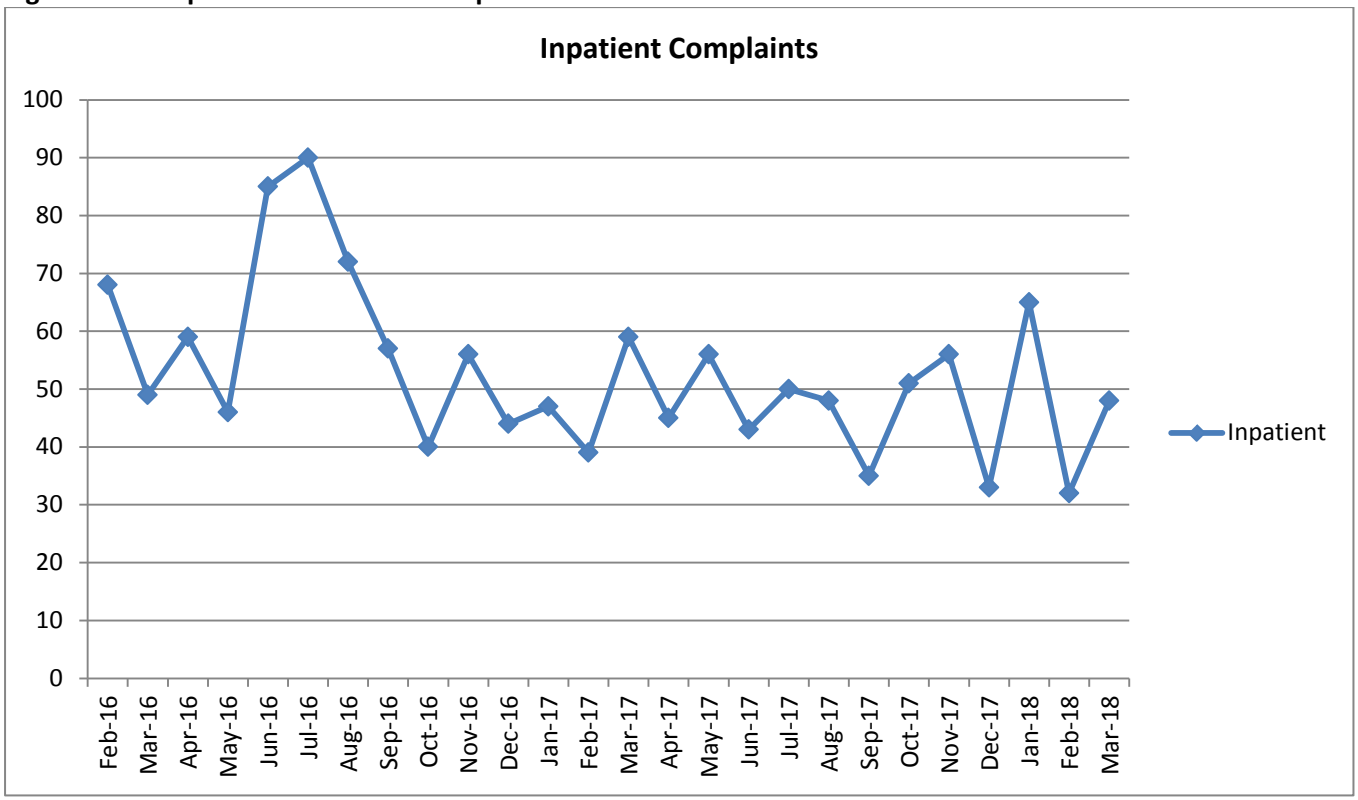


Figure 26: Complaints received from outpatients

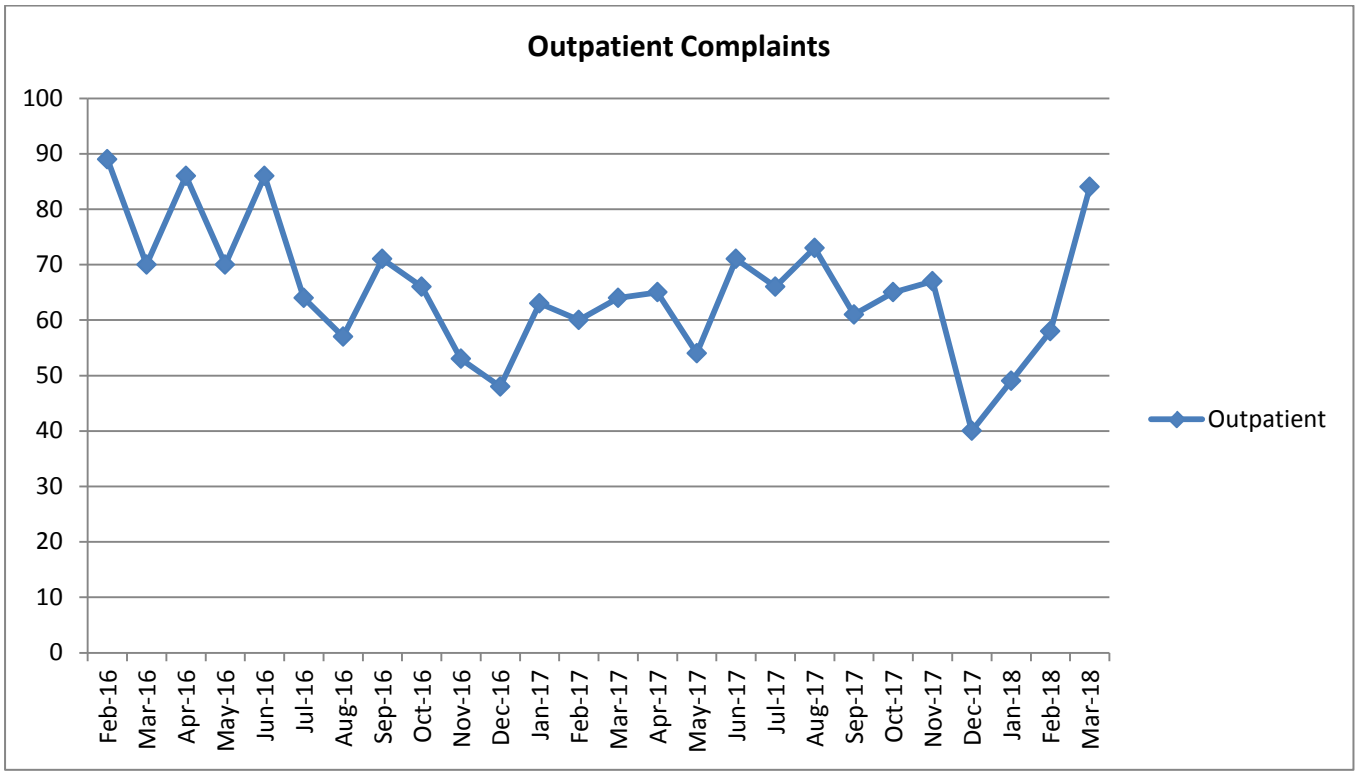


Figure 27: Complaints received from emergency department patients

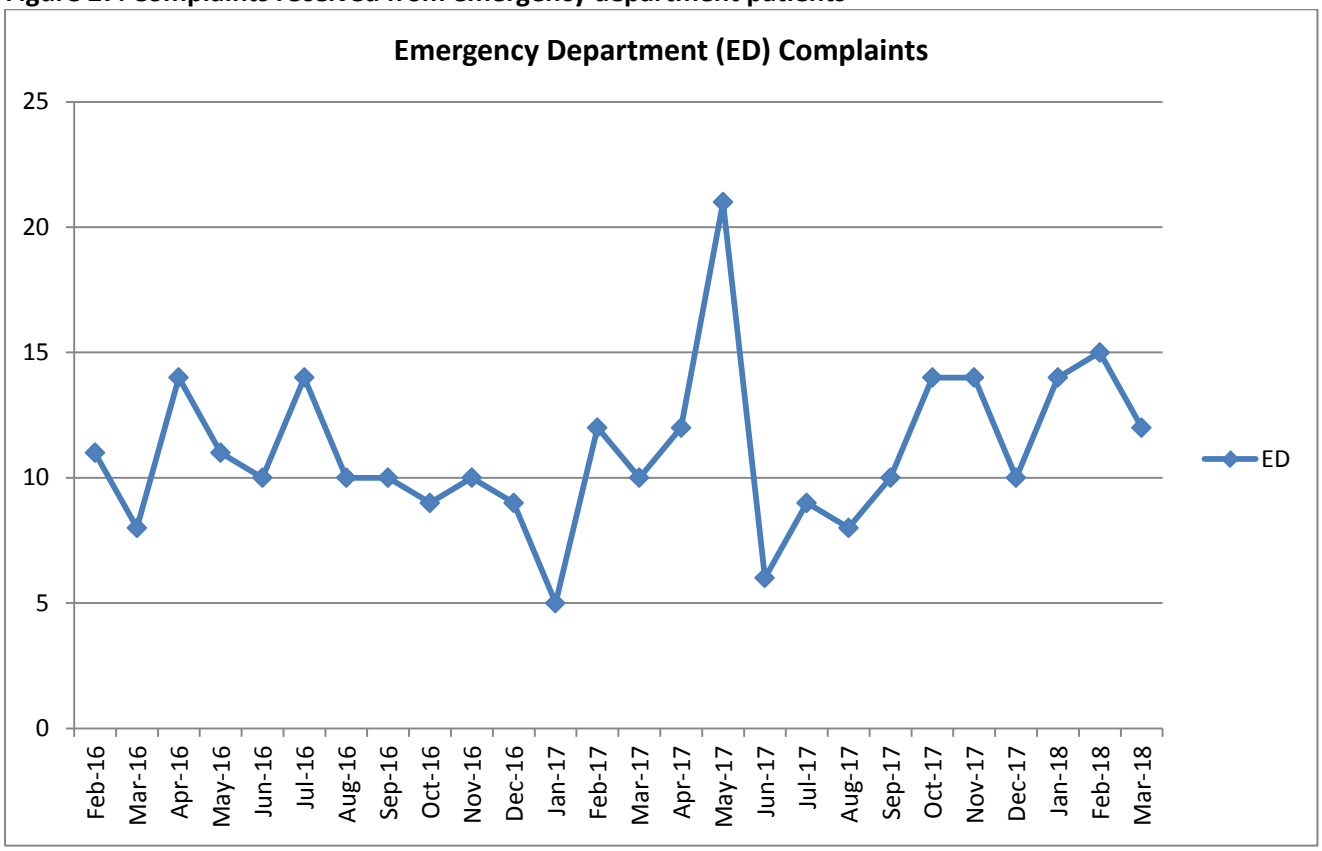


Figure 28: Complaints received from other patients (not inpatient, outpatient or emergency patients)

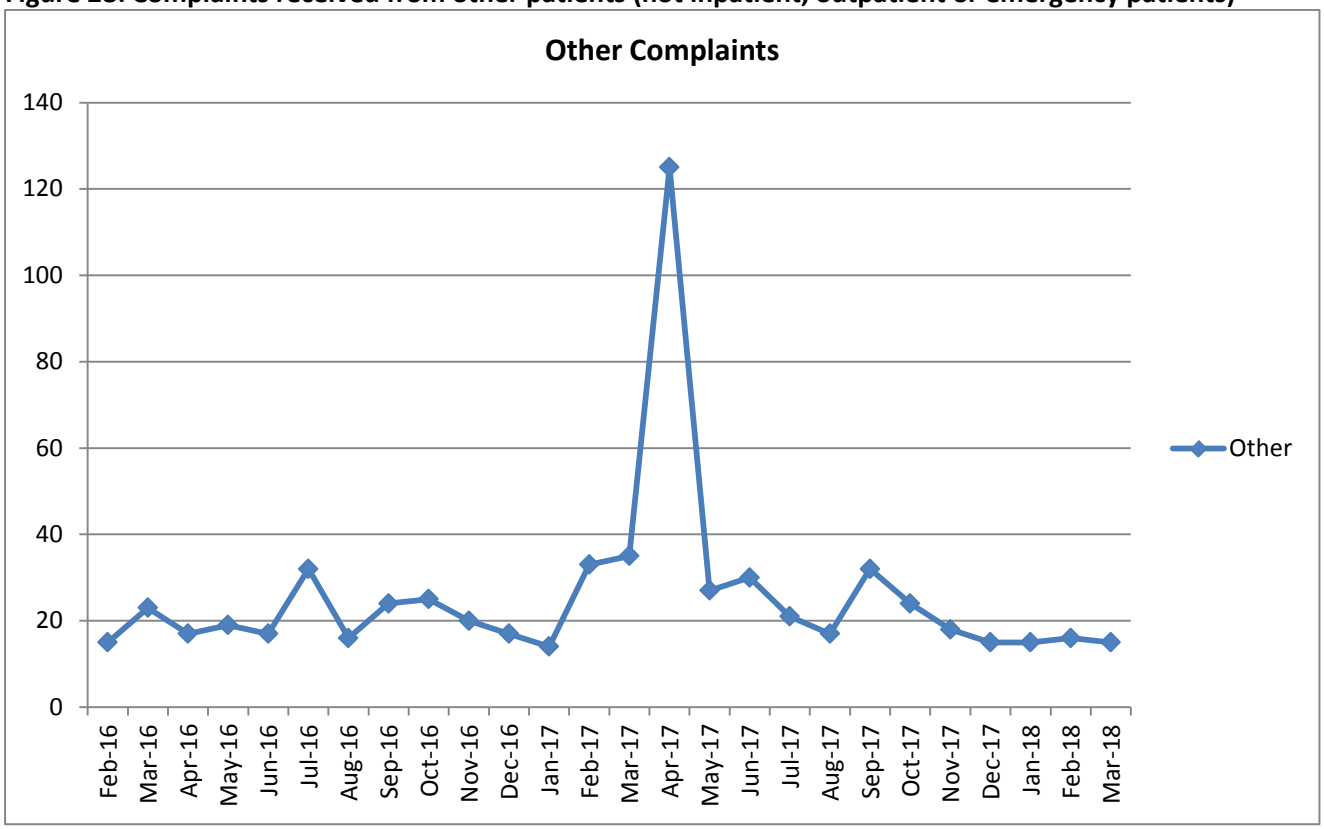


Table 20: Breakdown of Area Type

Complaints	**Area Type**				
Month	**ED**	**Inpatient**	**Outpatient**	**Other**	**Grand Total**
May-16	11	46	70	19	146
Jun-16	10	85	86	17	198
Jul-16	14	90	64	32	200
Aug-16	10	72	57	16	155
Sep-16	10	57	71	24	162
Oct-16	9	40	66	25	140
Nov-16	10	56	53	20	139
Dec-16	9	44	48	17	118
Jan-17	5	47	63	14	129
Feb-17	12	39	60	33	144
Mar-17	10	59	64	35	168
Apr-17	12	45	65	125	247
May-17	21	56	54	27	158
Jun-17	6	43	71	30	150
Jul-17	9	50	66	21	146
Aug-17	8	48	73	17	146
Sep-17	10	35	61	32	138
Oct-17	14	51	65	24	154
Nov-17	14	56	67	18	155

Dec-17	10	33	40	15	98
Jan-18	14	65	49	15	143
Feb-18	15	32	58	16	121
Mar-18	12	48	84	15	159
Grand Total	**255**	**1197**	**1455**	**607**	**3514**

3.3 Complaints responded to within agreed timescale

All Divisions reported breaches in Q4, totalling 31, which is a slight increase on the 30 breaches recorded in Q3. The largest percentage of breaches reported was by the Division of Trust Services (42.8% of all responses).

Table 21: Breakdown of breached deadlines

Division	Q4 (2017/18)	Q3 (2017/18)	Q2 (2017/18)	Q1 (2017/18)
Surgery	5 (9.2%)	9 (10.8%)	8 (14.3%)	6 (14.6%)
Women & Children	11 (34.4%)	9 (25.7%)	15 (38.5%)	6 (18.2%)
Trust Services	6 (42.8%)	5 (62.5%)	5 (45.5%)	2 (50%)
Medicine	6 (11.8%)	4 (8%)	5 (11.1%)	6 (22.2%)
Specialised Services	2 (10.5%)	3 (12.5%)	3 (12%)	6 (24%)
Diagnostics & Therapies	1 (20%)	0 (0%)	0 (0%)	0 (0%)
All	**31 breaches**	**30 breaches**	**36 breaches**	**26 breaches**

(So, as an example, there were 11 breaches of timescale in the Division of Women's & Children's Services in Q4, which constituted 34.4*% of the complaint responses which were sent out by that division in Q4*.)

Breaches of timescale were caused either by late receipt of draft responses from Divisions which did not allow adequate time for Executive review and sign-off; delays in processing by the Patient Support and Complaints Team; delays during the sign-off process itself; and/or responses being returned for amendment following Executive review.

Table 21 shows a breakdown of where the delays occurred in Q4. The Divisions were responsible for 22 of the breaches, five were caused by delays in the Patient Support & Complaints Team and four breaches were attributable to delays during Executive sign-off. The reason for the delays caused by the Patient Support & Complaints Team was a period of sickness when the team did not have any administrative cover and as a result some responses were late being taken to Trust Headquarters for signing.

Table 22: Reason for delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	All
Division	0	3	1	11	0	6	21
Patient Support & Complaints Team	1	3	1	0	0	0	5
Executives/sign-off	4	0	0	0	1	0	5
All	**5**	**6**	**2**	**11**	**1**	**6**	**31**

3.4 Outcome of formal complaints

In Q4 we responded to 175 formal complaints[5]. Tables 23 and 24 below show a breakdown, by Division, of how many cases were upheld, partly upheld or not upheld in Q4 of 2017/18 and Q3 of 2017/18 respectively.

Table 23: Outcome of formal complaints – Q4 2017/18

	Upheld	Partly Upheld	Not Upheld
Surgery	10 (18.5%)	28 (51.9%)	16 (29.6%)
Medicine	13 (25.5%)	26 (51%)	12 (23.5%)
Specialised Services	8 (42.1%)	8 (42.1%)	3 (15.8%)
Women & Children	11 (34.4%)	17 (53.1%)	4 (12.5%)
Diagnostics & Therapies	1 (20%)	3 (60%)	1 (20%)
Trust Services	5 (35.7%)	3 (21.4%)	6 (42.9%)
Total	**48 (27.4%)**	**85 (48.6%)**	**42 (24%)**

Table 24: Outcome of formal complaints – Q3 2017/18

	Upheld	Partly Upheld	Not Upheld
Surgery	15 (19.8%)	40 (52.6%)	21 (27.6%)
Medicine	14 (27.5%)	25 (49%)	12 (23.5%)
Specialised Services	10 (38.5%)	13 (50%)	3 (11.5%)
Women & Children	12 (35.3%)	20 (58.8%)	2 (5.9%)
Diagnostics & Therapies	2 (22.2%)	5 (55.6%)	2 (22.2%)
Trust Services	3 (33.3%)	3 (33.3%)	3 (33.3%)
Total	**56 (27.3%)**	**106 (51.7%)**	**43 (21%)**

4. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with help and support. The team also acknowledged 30 compliments received during Q4 and shared these with the staff involved and their Divisional teams.

Table 25 below shows a breakdown of the 165 requests for advice, information and support dealt with by the team in Q4.

Table 25: Enquiries by category

Category	Enquiries in Q4 2017/18
Information about patient	43
Hospital information request	41
Clinical information request	14
Signposting	14
Medical records requested	7
Appointments administration issues	7
Patient choice information	5
Appointment enquiries	5
Travel arrangements	4

[5] Note: this is different to the number of formal complaints we *received* in the quarter

Clinical care	4
Accommodation enquiry	4
Communication	4
Personal property	3
Expenses claim	2
Emotional support	2
Freedom of information request	2
Aids and appliances	1
Transfer arrangements	1
Wayfinding	1
Support with access	1
Total	**165**

In addition to the enquiries detailed above, in Q4 the Patient Support and Complaints team recorded 117 enquiries that did not proceed. This is where someone contacts the department to make a complaint or enquiry but does not leave enough information to enable the team to carry out an investigation, or they subsequently decide that they no longer wish to proceed with the complaint. Including complaints, requests for information or advice, requests for support, compliments and cases that did not proceed, the Patient Support and Complaints Team dealt with a total of 741 separate enquiries in Q4 2017/18, compared with 710 in Q3.

5. Acknowledgement of complaints by the Patient Support and Complaints Team

The NHS Complaints Procedure (2009) states that complaints must be acknowledged within three working days. This is also a requirement of the NHS Constitution. The Trust's own policy states that complaints made in writing (including emails) will be acknowledged within three working days and that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q4, 251 complaints were received in writing (email, letter or complaint form) and 172 were received verbally (31 in person via drop-in service and 112 by telephone). Of the 423 complaints received in Q4, 97.6% (413 out of the 423 received) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written).

The Patient Support & Complaints Manager has reviewed the 10 cases that were not acknowledged within timescale and all 10 occurred when the team were experiencing high levels of sickness and were without administrative cover for a short period. As a result, some administrative work unfortunately fell slightly behind.

6. PHSO cases

During Q4, the Trust was advised of four new Parliamentary and Health Service Ombudsman (PHSO) interest in specific complaints. During the same period, three existing cases remain ongoing. Two cases were closed during Q4, one of which was partly upheld and one was not upheld

Table 26: Complaints opened by the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
8854	CP	AP	10/07/2017 [01/02/2018]	BRHC	Paediatric Rheumatology	Women & Children
Copies of complaint file and medical records sent to PHSO 27/02/2018. Received written confirmation of the scope of the PHSO's investigation on 28/03/2018 and this was shared with the Division. Currently awaiting PHSO's draft report.						
7407	JW-S	LS	20/04/2017 [31/01/2018]	BHI	Cardiology	Specialised Services
Copies of complaint file and medical records sent to PHSO 13/02/2018. Received PHSO's draft report 24/04/2018 confirming that they have upheld the complaint. Currently awaiting divisional comments on draft report, to be sent as a formal response from the Trust – due with PHSO by 11/05/2018.						
6693	CL	SL	16/03/2017 [01/02/2018]	BRI	Ward A700	Surgery
Copies of complaints file and medical records sent to PHSO 26/02/2018. Further information requested by PHSO 25/04/2018 – currently awaiting a response from the division.						
695	BG	N/A	04/03/2016 [12/03/2018]	BEH and BRI	BEH ED and BRI Radiology	Surgery and Diagnostics & Therapies
Copies of complaint file and medical records sent to PHSO 26/03/2018. Currently awaiting further contact from the PHSO.						

Table 28: Complaints ongoing with the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
679	LH		02/03/2016 [09/05/2017]	BEH	Outpatients	Surgery
Received PHSO's draft report on 04/04/2018 partly upholding the complaint and making recommendations. On 09/04/2018, we responded accepting the findings and the recommendations. Currently awaiting the PHSO's final report.						

Table 29: Complaints formally closed by with the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
1380	SD	DD	26/04/2016 [23/08/2017]	STMH	Ear, Nose & Throat	Surgery
On 25/02/2018, the Trust received the PHSO's final report confirming that they have not upheld the complaint. This was shared with the division.						

3438	SC	SC	26/04/2016 [23/08/2017]	STMH	Fetal Medicine Unit	Women & Children
PHSO decided to partly uphold the complaint and recommended that we write to the patient to apologise for the failings identified in their report and for the impact these failings had on her. On 21/02/2018, the PHSO confirmed that they were satisfied that the Trust had complied with all of their recommendations.						

7. Complaint Survey

Since February 2017, the team has been sending out complaint surveys to all complainants six weeks after their complaint was resolved and closed. Prior to this, surveys had been issued retrospectively on an annual basis; this meant that for some complainants, a year had passed since they had made their complaint and many struggled to recall the details.

The survey responses are now monitored on a regular basis and one improvement has already been made to the way that the Patient Support & Complaints team work as a direct result of the responses received. Respondents told us that they were not always made aware of SEAP and other independent advocacy services. The team now ensures that all complainants (not just those making a formal complaint) are provided with details of these advocacy services.

Table 28 below shows data from responses received during Q4, compared with those received in previous quarters – Q4 data is based on 29 responses received.

Table 28: Complaints Survey Data

Survey Measure/Question	Q4 2017/18	Q3 2017/18	Q2 2017/18	Q1 2017/18
Respondents who confirmed that a timescale had been agreed with them by which we would respond to their complaint.	73.4%	83%	71.1%	73.9%
Respondents who felt that the Trust would do things differently as a result of their complaint.	21.3%	20%	37.2%	23.4%
Respondents who found out how to make a complaint from one of our leaflets or posters.	8.8%	5.6%	14.3%	6.7%
Respondents who confirmed we had told them about independent advocacy services.	32%	37%	31.1%	34%
Respondents who confirmed that our complaints process made it easy for them to make a complaint.	65.5%	64.3%	73.9%	63%
Respondents who felt satisfied or very satisfied with how their complaint was handled.	63.2%	66.1%	67.4%	58.7%
Respondents who said they did not receive their response within the agreed timescale.	26.0%	28.6%	20.5%	21.3%
Respondents who felt that they were always treated with dignity and respect by the Patient Support & Complaints Team.	77.4%	91.1%	100%	85.1%
Respondents who felt that their complaint was taken seriously when they first raised	79.1%	83.9%	78.3%	74.5%

their concerns.				
Respondents who did not feel that the Patient Support & Complaints Team kept them updated on progress often enough about the progress of their complaint.	25.2%	20.4%	23.9%	31.9%
Respondents who received the outcome of our investigation into their complaint by way of a face-to-face meeting.	3.2%	1.8%	6.8%	2.3%
Respondents who said that our response address all of the issues that they had raised.	53.7%	62.3%	44.4%	50%

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	10c
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Patient Complaints - Annual Report**		
Author	Louise Townsend, Acting Patient Support and Complaints Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

To provide an overview of complaints activity during the year 2017/18.

Key issues to note

- 1,817 complaints were received by the Trust in the year 2017/2018, averaging 151 per month. Of these, 674 were managed through the formal investigation process and 1,143 through the informal investigation process. This compares with a total of 1,874 complaints received in 2016/2017, a decrease of 3.1%.
- In addition, the Patient Support and Complaints Team dealt with 701 other enquiries, including compliments, requests for support and requests for information and advice; this represents a 13.9% decrease on the 814 enquiries dealt with in 2016/2017.
- In 2017/18, the Trust had 11 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). Six cases were not upheld and one was partly upheld; the remaining four cases are still being considered by the Ombudsman (as of 8 May 2018). Three cases referred to the PHSO in 2016/17 were ongoing at the time of last year's

annual report; two were subsequently partly upheld and one case was not upheld.

- 83.0% of formal complaints were responded to within the agreed timescale, a decrease compared to the 86.1% achieved in 2016/17.
- At the time of writing the report, 9.7% complainants had expressed dissatisfaction with complaints responses sent out during 2017/18 (11% at the same point in 2017).
- Developments in 2017/18 included the introduction of a new Executive-led complaints review panel to identify learning and share good practice in complaints handling.

Recommendations

Members are asked to:

- **Note the Report.**

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐

Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
		26 June 2018		Patient Experience Group, Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

ANNUAL COMPLAINTS REPORT 2017/2018

Author: Louise Townsend, Deputy Patient Support and Complaints Manager - May 2018

Contents

Executive Summary

In accordance with NHS Complaints Regulations (2009), this report sets out a detailed analysis of the number and nature of complaints received by University Hospitals Bristol NHS Foundation Trust (UH Bristol) in 2017/2018. The report also records other support provided by the Trust's Patient Support and Complaints Team[1] during the year.

In summary:

- 1,817 complaints were received by the Trust in the year 2017/2018, averaging 151 per month. Of these, 674 were managed through the formal investigation process and 1,143 through the informal investigation process. This compares with a total of 1,874 complaints received in 2016/2017, a decrease of 3.1%.

- In addition, the Patient Support and Complaints Team dealt with 701 other enquiries, including compliments, requests for support and requests for information and advice; this represents a 13.9% decrease on the 814 enquiries dealt with in 2016/2017.

- In 2017/18, the Trust had 11 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). Six cases were not upheld and one was partly upheld; the remaining four cases are still being considered by the Ombudsman (as of 8 May 2018). Three cases referred to the PHSO in 2016/17 were ongoing at the time of last year's annual report; two were subsequently partly upheld and one case was not upheld.

- 83.0% of formal complaints were responded to within the agreed timescale, a decrease compared to the 86.1% achieved in 2016/17.

- At the time of writing, 9.7% complainants have expressed dissatisfaction with complaints responses sent out during 2017/18. This compares with 11.8% dissatisfied complaints received in 2016/17.

- Developments in 2017/18 included the introduction of a new Executive-led complaints review panel to identify learning and share good practice in complaints handling.

[1] i.e. UH Bristol's integrated 'PALS' and complaints team

1. Accountability for complaints management

The Board of Directors has corporate responsibility for the quality of care and the management and monitoring of complaints. The Chief Executive delegates responsibility for the management of complaints to the Chief Nurse.

The Trust's Patient Support and Complaints Manager is responsible for ensuring that:

- All complaints are fully investigated in a manner appropriate to the seriousness and complexity of the complaint, in line with the complainants wishes;
- All formal complaints receive a comprehensive written response from the Chief Executive or his nominated deputy or a local resolution meeting with a senior clinician and senior member of the divisional management team;
- Complaints are resolved within the timescale agreed with each complainant at a local level wherever possible;
- Where a timescale cannot be met, an explanation is provided and an extension agreed with the complainant; and
- When a complainant requests a review by the Parliamentary and Health Service Ombudsman, all enquiries received from the Ombudsman's office are responded to in a prompt, co-operative and open manner.

The Patient Support and Complaints Manager line manages a team which consists of one full time Band 6 Deputy Manager, one full-time and four part-time complaints officers/caseworkers (Band 5) and three part-time administrators (Band 3). The total team resource, including the manager, is currently 7.64 WTE.

2. Complaints reporting

Each month, the Patient Support and Complaints Manager reports the following information to the Trust Board:

- Total number of complaints received
- Percentage of complaints responded to within the agreed timescale
- Percentage of cases where the complainant is dissatisfied with the original response

In addition, the following information is reported to the Patient Experience Group, which meets every three months:

- Validated complaints data for the Trust as a whole and also for each Division
- Quarterly Complaints Report, identifying themes and trends
- Annual Complaints Report (which is also received by the Board).

The Quarterly Complaints Report provides an overview of the numbers and types of complaints received, including any trends or themes that may have arisen, including analysis by Division and information about how the Trust is responding. The Quarterly Complaints Report is also reported to the Trust Board and published on the Trust's web site.

3. Total complaints received in 2017/2018

The total number of complaints received during the year was 1,817, a decrease of 3.1% on the 1,875 complaints received the previous year. Of these, 674 (37%) were managed through the formal investigation process and 1,143 through the informal investigation process; this compares with 487 (26%) complaints managed formally in 2016/17 and 1,388 managed informally. Understanding possible reasons for this apparent shift towards formal resolution – breaking the pattern of the previous two years – will form part of the Trust's complaints work plan for 2018/19. We want to be addressing concerns raised as quickly and as close to the point of care as possible.

A formal complaint is classed as one where an investigation by the Division is required in order to respond to the complaint. A senior manager is appointed to carry out the investigation and gather statements from the appropriate staff. These statements are then used as the basis for either a written response to, or a meeting with, the complainant (or sometimes a telephone call from the manager). The method of feedback is agreed with the complainant and is their choice. The Trust's target is that this process should take no more than 30 working days in total.

An informal complaint is one where the issues raised can usually be addressed quickly by means of an investigation by the divisional management team and a telephone call to the complainant.

Figure 1 provides a long-term view of complaints received per month that were dealt with via the formal investigation process compared to those dealt with via the informal investigation process, over the same period. The figures below do not include informal concerns which are dealt with directly by staff in our Divisions. The spike in complaints in April 2017 related to a one-off event: a story about security officers' uniforms which drew attention from local and national media at the time.

Figure 1 – Numbers of formal v informal complaints

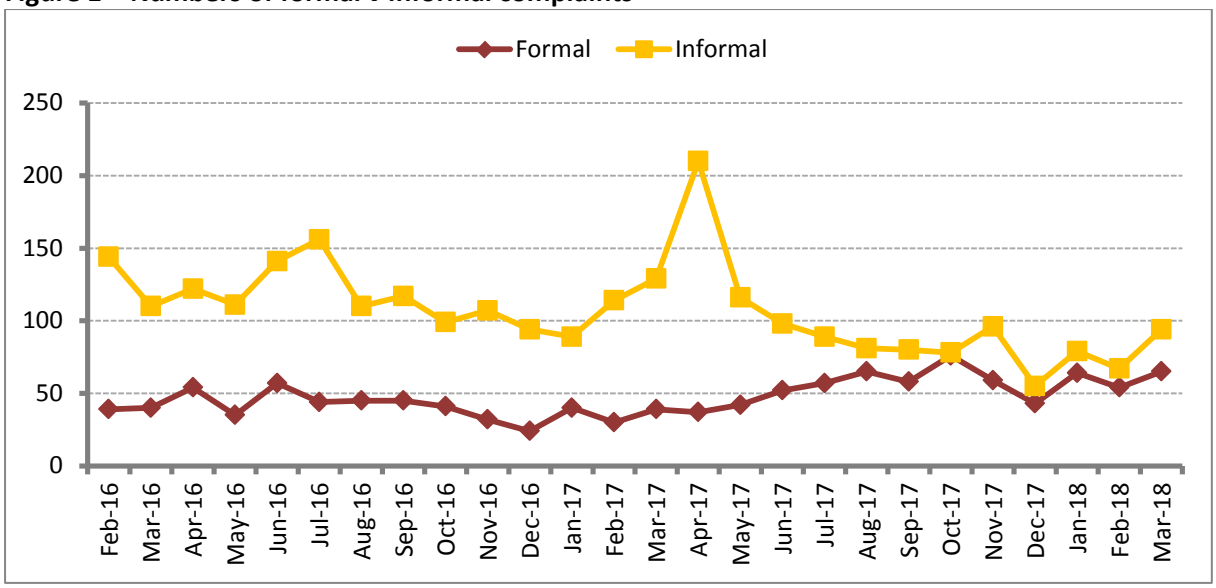


Table 1 below shows the number of complaints received by each of the Trust's clinical divisions compared with the previous year. Directional arrows indicate change compared to the previous financial year.

Table 1 - Breakdown of complaints by Division

Division	Informal Complaints 2017/2018	Informal Complaints 2016/2017	Formal Complaints 2017/2018	Formal Complaints 2016/2017	Divisional Total 2017/18	Divisional Total 2016/17
Surgery	429 ↓	553 ↓	199 ↑	127 ↓	628 ↓	680 ↓
Medicine	203 ↓	301 ↑	202 ↑	122 ↓	405 ↓	423 ↑
Specialised Services	166 ↓	209 ↑	77 ↓	84 ↑	243 ↓	293 ↑
Women and Children	119 ↓	156 ↑	154 ↑	121 ↓	273 ↓	277 ↓
Diagnostics and Therapies	59 ↑	56 =	19 ↑	15 ↓	78 ↑	71 ↓
Trust Services (including Facilities & Estates)	167 ↑	113 ↑	23 ↑	18 ↓	190 ↑	133 ↑
TOTAL	**1143** ↓	**1388** ↑	**674** ↑	**487** ↓	**1817** ↓	**1877** ↓

Table 1 shows an increase in formal complaints received by all clinical Divisions, with the exception of the Division of Specialised Services and a decrease in informal complaints received by all clinical Divisions, with the exception of Diagnostics and Therapies and Trust Services.

4. Complaint themes

The Trust records all complaints under one or more of eight high-level reporting themes, depending upon the nature and complexity of the complaint. This data helps us to identify whether any trends or themes are developing when matched against hospital sites, departments, clinics and wards.

Table 2 and Figure 2 show complaints received by theme, compared to 2016/17 and 2015/16.

Table 2 - Complaint themes – Trust totals

Complaint Theme	Total Complaints 2017/18	Total Complaints 2016/17	Total Complaints 2015/16
Access	12 ↓	16 ↓	40 ↓
Appointments and Admissions	519 ↓	589 ↓	661 ↑
Attitude and Communication	492 ↑	454 ↓	552 ↑
Clinical Care	491 ↑	490 ↑	469 ↓
Facilities and Environment	82 ↓	89 ↓	99 ↓
Discharge/Transfer/Transport	73 ↓	89	Not available (new reporting category)
Documentation	31 ↑	12	Not available (new reporting category)
Information and Support	116 ↓	136 ↑	120 ↑
TOTAL	**1817**	**1875** ↓	**1941** ↑

In 2017/18, five of the previous eight main complaints themes saw a decrease when compared with the previous year. Complaints about 'Appointments and Admissions' fell for the second consecutive year. However complaints about 'Attitude and Communication' increased by 8.3%, having fallen the previous year. The largest sub-category within 'Attitude and Communication' was 'Attitude of Medical Staff' (95 complaints). The Associate Medical Director (AMD) oversees a system to monitor

complaints where individual doctors or surgeons are cited; staff are interviewed by the AMD or Medical Director if patterns of repeated behaviour are identified which give cause for concern.

5. Performance in responding to complaints

In addition to monitoring the volume of complaints received, the Trust also measures its performance in responding to complainants within agreed timescales, and the number of complainants who are dissatisfied with responses.

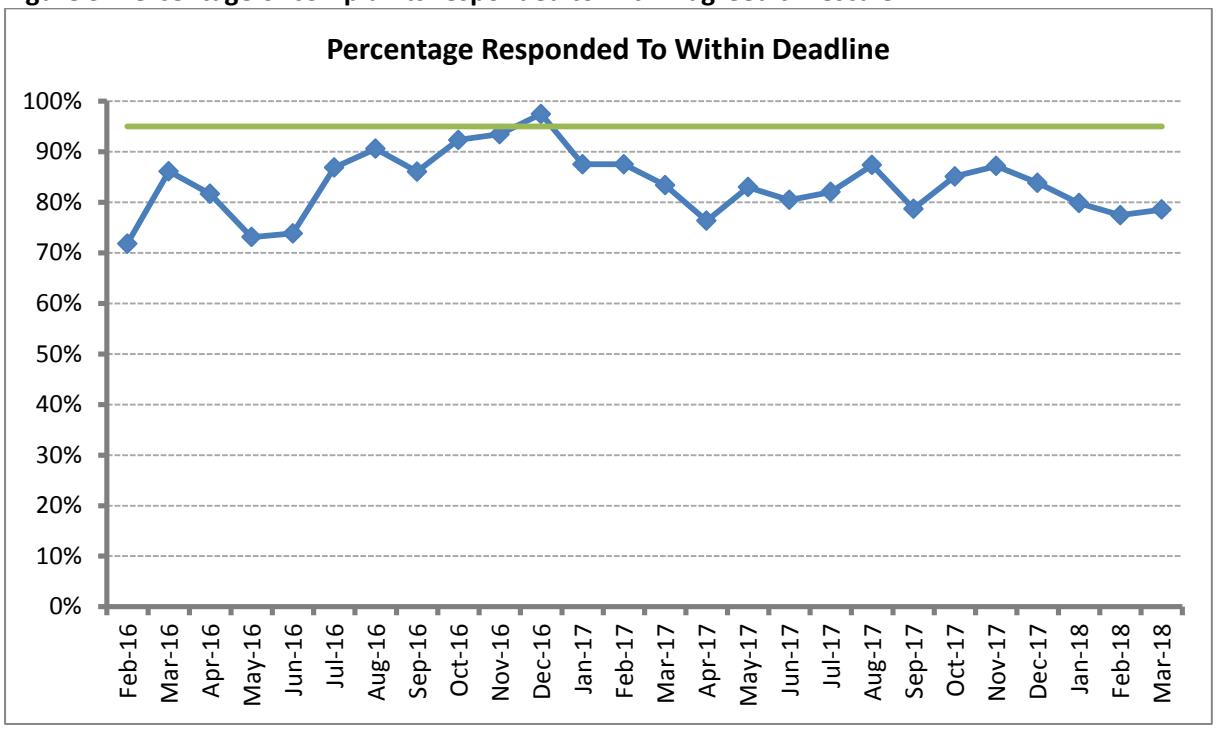
5.1 Percentage of complaints responded to within timescale

The Trust's expectation is that all complaints will be acknowledged within two working days for telephone enquiries and within three working days for written enquiries. The complainant's concerns are confirmed and the most appropriate way in which to address their complaint is agreed. A realistic timescale in which the complaint is to be resolved is agreed, based on the complexity of the complaint whilst responding in a timely manner.

The time limit for making a complaint, as laid down in the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, is currently 12 months after the date on which the subject of the complaint occurred or the date on which the matter came to the attention of the complainant. These regulations and guidance from the Parliamentary and Health Service Ombudsman indicate that the Trust must investigate a complaint 'in a manner appropriate to resolve it speedily and efficiently and keep the complainant informed.' When a response is not possible within the agreed timescale, the Trust must inform the complainant of the reason for the delay and agree a new date by which the response will be sent.

The Trust captures data about the numbers of complaints responded to within the agreed timescale. The Trust's performance target continues to be 95% compliance. Over the course of the year 2017/18, 83.0% of responses were responded to within the agreed timescale, a decrease compared to the 86.1% achieved in 2016/17, although better than the 75.2% achieved in 2015/16. This is a disappointing outcome; achieving sustained improvement will be a priority in 2018/19.

Figure 3. Percentage of complaints responded to within agreed timescale



5.2 Numbers of complainants who are dissatisfied with our response

The Trust also measures performance in respect of the number of complainants who are dissatisfied with the response provided to their complaint due to the original investigation being incomplete or inaccurate (which we differentiate from follow-up enquiries where a complainant raises additional questions).

At the time of writing, 9.7% of complainants have expressed dissatisfaction with complaints responses sent out during 2017/18. This compares with 11.8% measured at the corresponding point in time for 2016/17. Informal benchmarking against other NHS trusts indicates that a dissatisfaction rate of 8-12% is typical. Nonetheless, our aspiration is for nobody to be unhappy with the quality of our original response.

6. Parliamentary and Health Service Ombudsman (PHSO)

If a complainant is unhappy with the way in which their complaint has been dealt with by the Trust and feels that local resolution of their complaint has not been satisfactory, they have the option of asking the PHSO to carry out an independent review of their complaint.

In 2017/18, the Trust had 11 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO). Six cases were not upheld and one was partly upheld; the remaining four cases are still being considered by the Ombudsman (as of 8 May 2018). Three cases referred to the PHSO in 2016/17 were ongoing at the time of last year's annual report; subsequently, two were partly upheld and one case was not upheld.

7. Information, advice and support

In addition to managing complaints, the Patient Support and Complaints Team also deal with information, advice and support requests. The total number of enquiries received during 2017/18 is shown below, together with the numbers from 2016/17 and 2015/16 for comparative purposes:

Table 3:

Type of enquiry	**Total Number 2017/18**	**Total Number 2016/17**	**Total Number 2015/16**
Request for advice / information/support	576	524	399
Compliments	125	290	200
Total	**701**	**814**	**599**

Many service users will contact the team for reasons other than complaints. This may be about:

- Services which the Trust provides
- Signposting to other local or voluntary services
- Outpatient clinic appointments (patients may occasionally ask a member of the team to attend with them)
- Liaison for carers and patients who have additional support needs and complex health problems
- Communication with patients' healthcare teams to facilitate both parties being able to work together in the future.
- Assisting families who arrive in Bristol with a patient but do not live locally and require local orientation and signposting to further help about finding somewhere to stay.

Examples of typical enquiries about advice and information include:

- ‘What is the waiting time for xxx procedure?’
- ‘Who do I contact to discuss xxx?’
- ‘Can I have my treatment at a different hospital/location?’
- ‘Is it true that my operation has been cancelled due to cost cuts?’
- ‘I’m having an operation soon, who do I speak to about some concerns/questions that I have?’
- ‘I need a letter from my consultant in order that I can get my driving licence back.’
- ‘How do I make a complaint about my GP?’
- ‘My transport hasn’t arrived and I’m going to miss my appointment. Who do I contact?’
- ‘I’m on the ward and I need to know the password for the Wi-Fi.’
- ‘I was an inpatient last week and lost my glasses. What do I need to do?’

Examples of typical enquiries about support include:

- ‘I would like someone to come to my outpatient appointment with me for support.’
- ‘I’ve arranged to meet with my consultant, would you be able to come with me?’
- ‘I need to arrange for a translator/interpreter to be available at my mother’s appointment, can you help?’
- ‘Are you able to help me get hold of my consultant’s secretary?’
- ‘Who do I need to contact to arrange hospital transport?’

8. Looking back and ahead

UH Bristol continues to be proactive in its management of complaints and enquiries, recognising that the way we respond to concerns is part of our commitment to excellence in customer service and acknowledging that all complaints are a valuable source of learning.

In 2017/18, for example:

- We introduced a new Executive-led complaints review panel. The purpose of the panel is to look back at specific complaints cases, through the lens of the panel’s two lay members, to identify any ways in which the Trust’s handling of these complaints could have been improved, and to share this learning with our clinical Divisions.
- We undertook a significant piece of work with the Patients Association which has resulted in the development of a complaints ‘toolkit’ for staff. The toolkit includes guidance to help staff to think about ways of developing objectivity when seeking to resolve complaints and, where appropriate, for obtaining independent views. We will be introducing the toolkit in the second quarter of 2018/19; the Patients Association are considering options for making this resource available to a wider NHS audience.
- We made improvements to facilities in the Patient Support and Complaints Team office to create a new reception desk and improve the visibility of the service in the Bristol Royal Infirmary Welcome Centre.
- We supported an NHS Improvement review of complaints handling at another NHS Trust

Looking ahead to 2018/19, our focus will be on ensuring that we significantly improve performance in responding to complaints within the timescale agreed with complainants. In effect, we will be adopting a ‘zero tolerance’ approach to breaches.

Our detailed complaints work plan for 2018/19 is available upon request.

Cover report to the Public Trust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	11
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Safeguarding Annual Report**		
Author	Carol Sawkins, Safeguarding Lead Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☐

Executive Summary

Purpose

The purpose of this annual report is to provide assurance to the Trust Board Members that the Trust is fulfilling its statutory responsibilities to safeguard adults, children and young people.

The report provides an overview of key safeguarding activity, achievements, risks and mitigations in place across all areas of service delivery for adults and children.

Recommendations

Members are asked to: **Note the Report.**

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☒	Regulators	☒	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☒	Failure to comply with targets, statutory duties and functions.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☒
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☒	Equality	☐	Legal	☒	Workforce	☒

Impact Upon Corporate Risk
• No impact on corporate risk. • There are three corporate risks related to safeguarding adults and children, these are detailed in the annual report.

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

University Hospitals Bristol NHS
NHS Foundation Trust

Safeguarding Annual Report

(Adult & Children)

April 2017 – March 2018

Index

1. Introduction

Welcome to the Safeguarding Children and Adults Annual Report. This report provides University Hospitals Bristol Trust Board, Bristol Clinical Commissioning Group and Local Safeguarding Boards with assurance that the Trust has continued over the last year to fulfil its statutory responsibilities to safeguard the welfare of children and adults across all areas of service delivery.

The Trust safeguarding agenda continues to be underpinned by the Trust values aiming to ensure that a culture exists where safeguarding is everyone's business and areas for learning and improvement are continually identified. The summary and conclusion of this report describes the key priorities and areas identified for development for safeguarding in 2018/19.

2. Summary of current arrangements for Safeguarding within University Hospitals Bristol NHS Foundation Trust (UHBristol)

The Trust safeguarding arrangements, for both adults and children are underpinned by the Named Professionals (Doctor, Nurse and Midwife), plus a team of experienced safeguarding nurses and administration staff.

Key governance arrangements comply with the statutory requirements of Section 11 of the Children Act 2004, including:

- UHBristol Trust Board holds ultimate accountability for ensuring that safeguarding responsibilities for both children and adults are met with the Chief Nurse as Executive Lead for Safeguarding.
- A team of experienced safeguarding professionals, including the Named Professionals, provide expert advice, support and supervision to practitioners across all areas of the Trust.
- Safeguarding performance is monitored by the Trust Safeguarding Steering Group, chaired by the Chief Nurse and supported by senior representation from all Divisions.
- The Steering Group in the last year has reported to the Clinical Quality Group which in turn reports to the Quality and Outcomes Committee, the quality sub-committee of the Trust Board.
- The Trust has two operational groups: one for Children's Safeguarding and one for Adult Safeguarding, these meet alternative months and report to the Safeguarding Steering Group and are responsible for the operational delivery of safeguarding across the Trust and delivery of an annual audit programme.

3. Safeguarding Assurance including Performance Monitoring and Audit

The Trust's compliance with statutory safeguarding arrangements for children are defined within Section 11 of the Children Act 2004 is monitored by the Local Safeguarding Children Boards. The Trust was subject to BSCB review of compliance in 2017 in the Section 11 areas of interagency working and information sharing. The Trust was judged as compliant with these areas supporting our self-assessment submission.

4. Safeguarding and Care Quality Commission (CQC) Regulation 13

The Trust has self-assessed as having maintained compliance with CQC Regulation 13 'Protecting Service users from abuse' during this reporting period. Ensuring that those who use the Trust services are safeguarded and that staff are suitably skilled and supported, demonstrating safeguarding leadership and commitment at all levels of the organisation and being fully engaged in local accountability and assurance structures.

The Lead Nurse for Safeguarding is accountable for compliance with regulation 13, reporting regularly to the safeguarding operational groups, the Safeguarding Steering Group, and bi annually to the Clinical Quality Group (CQG).

5. Safeguarding Risks

The Safeguarding Steering Group and the Operational Groups maintain oversight of all safeguarding Corporate, Divisional and Departmental High risks entered onto Datix. There are three risks relating to safeguarding on the corporate risk register. These risks remain unchanged from the previous year's report, including the associated risk rating

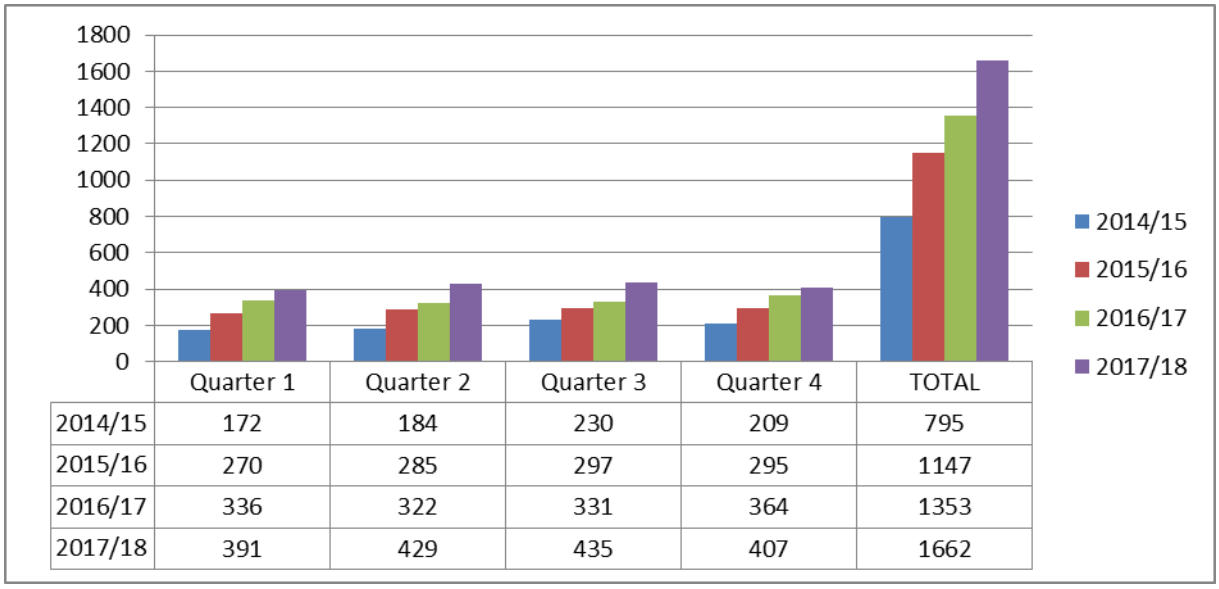
Table 1: Summary of Corporate Safeguarding Risks

Risk No	Summary of Risk	Current Risk Rating & Controls	Current Position and Key mitigating actions	Owners of Risk / Monitoring Group
856 **Corporate**	Risk that the emotional and Mental Health needs of children and young people admitted to the Children's Hospital (for mental health reasons only), may not be fully met as the Hospital is not a provider of mental health services.	Risk Rating 12 Controls Inadequate / High Risk	This is an ongoing risk with a number of children and young people being admitted to the BRCH as a place of safety who do not require treatment for any physical health reasons. Actions to mitigate this risk taken in the last year include: • Provision of some liaison psychiatry resource for the BRCH via AWP mental health trust, • BRCH psychology service providing additional support in specific situations, • Establishment of an improved system for collecting mental health activity data in the Children's ED. Further investment in the AWP mental health trust paediatric liaison service was agreed for 2017/18 which allowed the service to develop and expand provision for inpatients.	Children's Governance & Mental Health Operational Group, Safeguarding Steering Group.
921 **Corporate**	Risk of not achieving 90% compliance for all Essential Training, which includes safeguarding training.	Risk Rating 12 Controls Adequate / High Risk	If rates of compliance with Essential Training are not met and sustained, then staff may not have the skills, knowledge and experience to deliver effective care and treatment and maintain a safe working environment. This Risk is also reflected in W & C Division – Risk no **1046 (Risk Rating 12 – High Risk).**	Executive Lead - Director of Workforce & Organisational Development. Safeguarding Steering Group
1595 **Corporate**	Risk that if patients suffering from mental health disorders spend prolonged time in ED their condition could deteriorate. Patients affected are those detained under S 136 (Mental Health Act)	Risk Rating 16 Controls Inadequate / Very High Risk	This risk primarily relates to patients suffering from mental health disorders having a prolonged stay in ED. Patients affected include those detained under Section 136 (Mental Health Act), due to the lack of available facilities locally and nationally. There are controls in place and good partnership working with AWP colleagues. The key ongoing action is: A project with partner agencies led by AWP mental health trust and Bristol CCG to review Section 136 provision across the city and agree a sustainable model to meet currently unmet demand. (See Section 15.2)	Mental Health Operational Groups. Safeguarding Steering Group

6. Safeguarding Children Activity Data

This reporting period has seen an increase (22%) in the number of contacts from practitioners across the Trust to the Safeguarding Team for advice and support, (See Table two).

Table 2 : Number of Contacts for advice recived (per quarter per year)



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2014/15	172	184	230	209	795
2015/16	270	285	297	295	1147
2016/17	336	322	331	364	1353
2017/18	391	429	435	407	1662

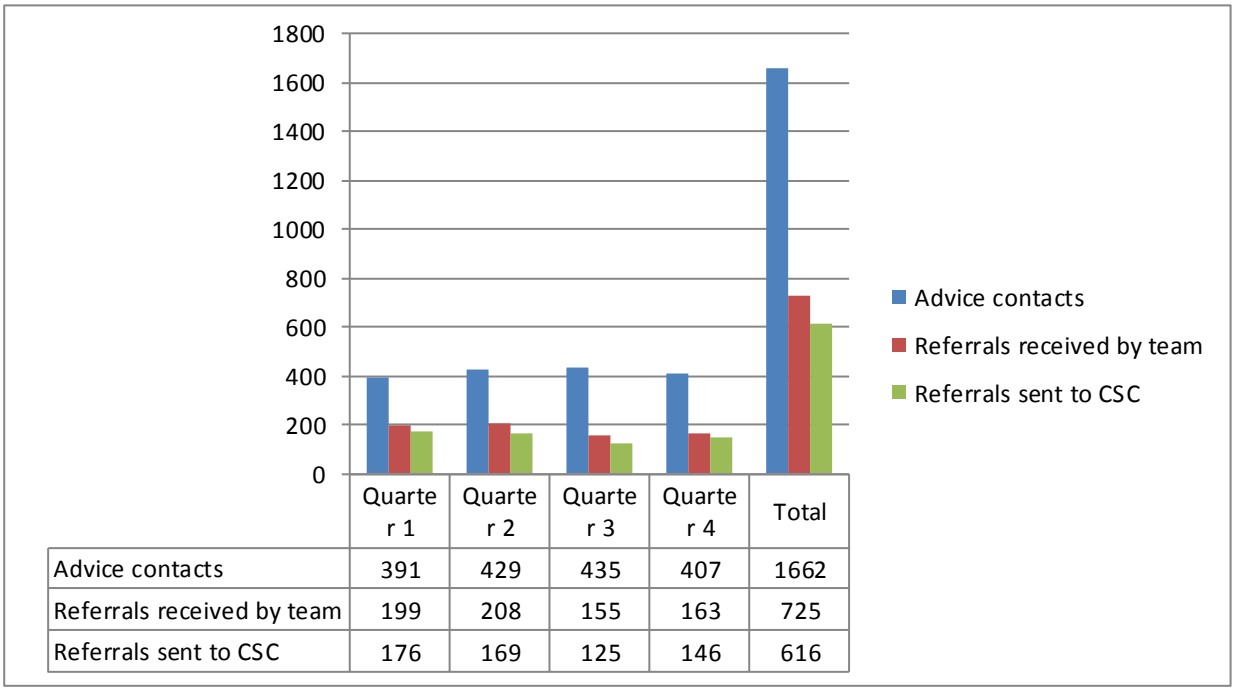
Approximately 20-25% of the advice contacts result in a referral to the relevant Local Authority Children's Social Care Team. (Detailed in Table 2).

All safeguarding children's referrals (Request for Help forms) are sent to the safeguarding team prior to sending onwards to the relevant Local Authority Children's Social Care. This allows for a process of quality assurance to ensure all referrals include sufficient details, clearly articulate the level of risk and are in line with the local Thresholds Guidance. This process also allows safeguarding activity data to be monitored and evaluated robustly by the Child Protection Operational Group (CPOG)

The number of onward referrals to Children's Social Care has remained relatively stable, despite the increase in contacts to the safeguarding team. (Table 3) Contacts and referrals 'screened out' are highlighted to the child's Primary Health Care Team or other appropriate services for ongoing support and monitoring.

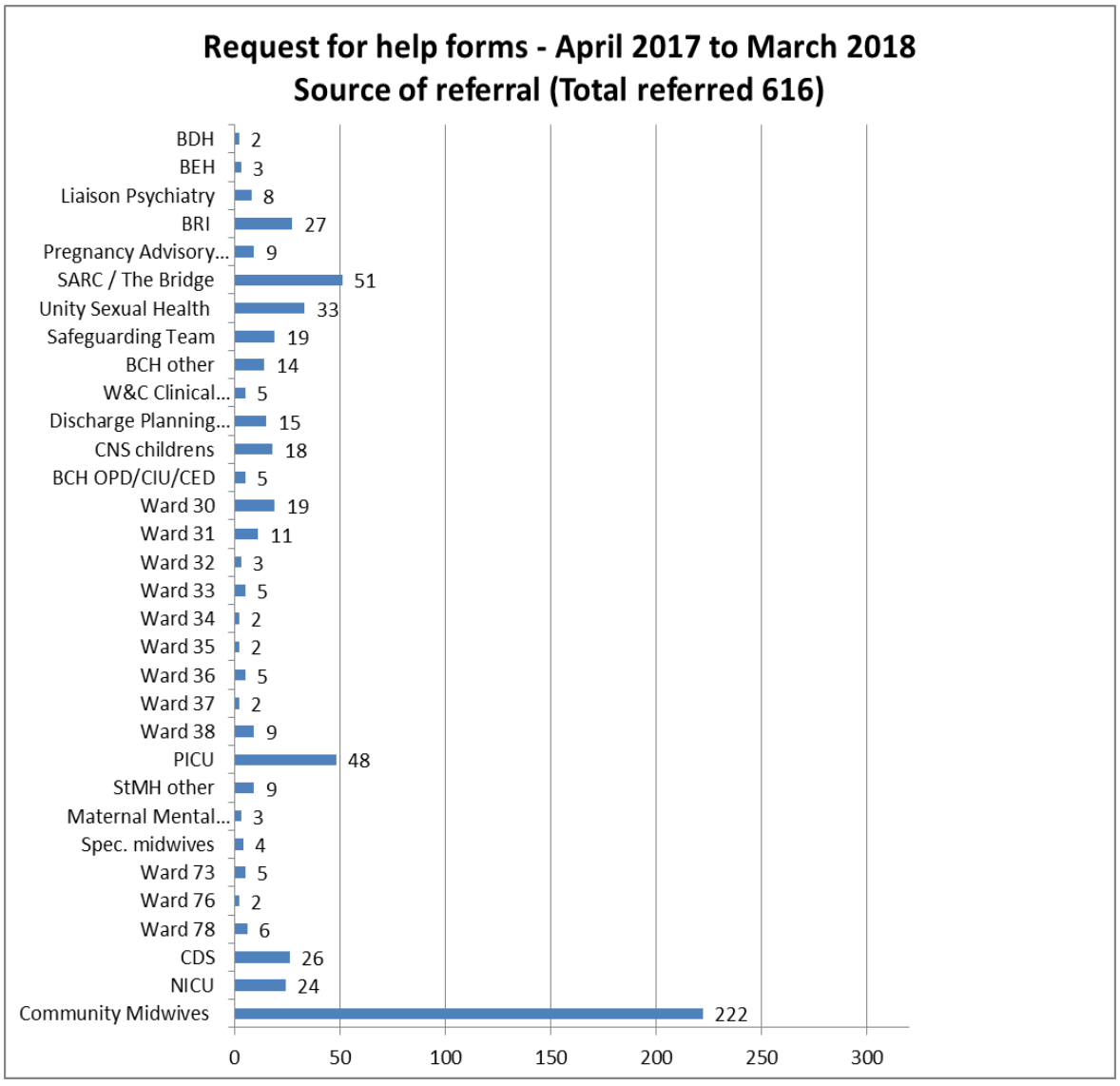
During this reporting period a total of 725 referrals were received by the safeguarding team; of which 109 did not meet a safeguarding threshold. In these cases feedback will be given to the referrer which may be sign posted to other services. (See table three)

Table 3 : Number of Contacts/referrals screened prior to sending to Local Authority



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Advice contacts	391	429	435	407	1662
Referrals received by team	199	208	155	163	725
Referrals sent to CSC	176	169	125	146	616

Table 4: Safeguarding Referrals by ward/department



Safeguarding referrals received in the last year are summarised below. The greatest number of referrals continues to be made from the Women's and Children's Division, as would be expected. (See Section 7)

The new Unity Sexual health service made a total of 33 referrals to Children's Social Care during this reporting period, a reflection of the robust Safeguarding (See Section 11)

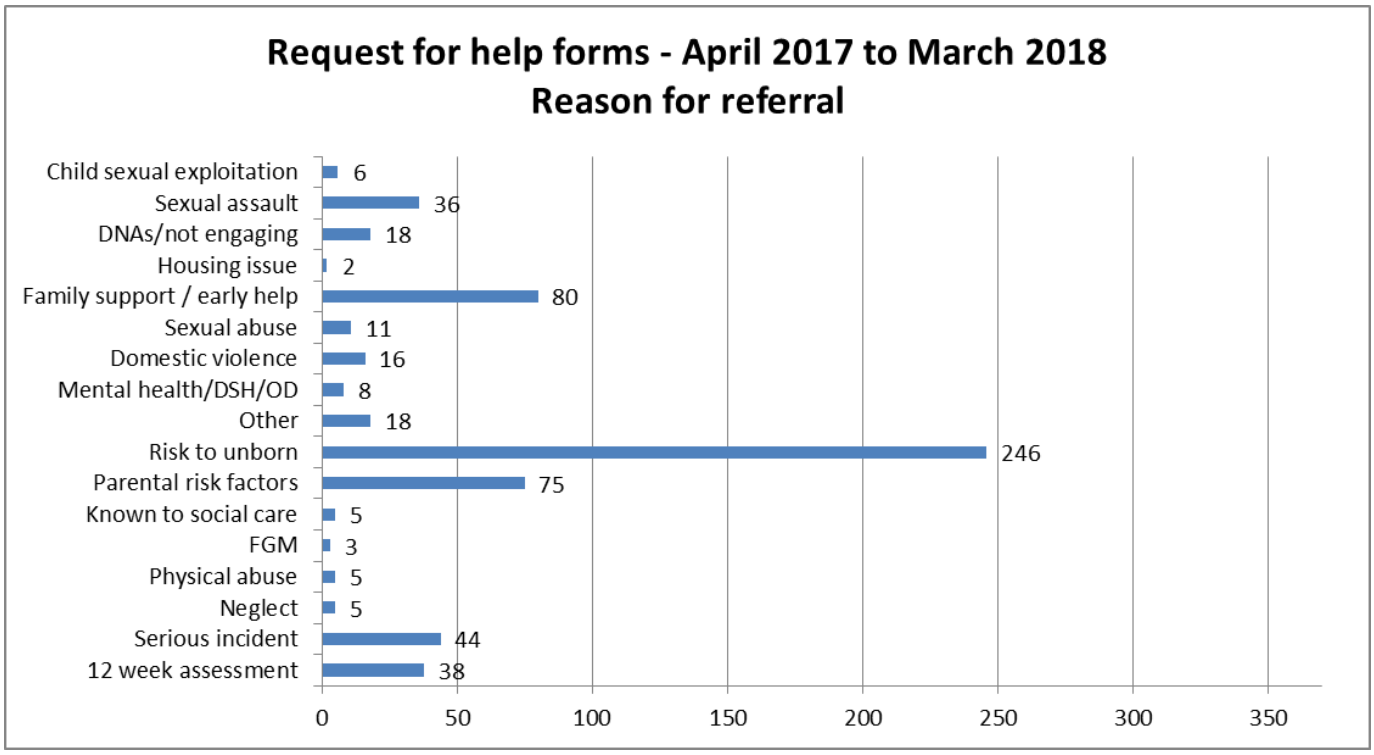
Table 5: Emergency Department Safeguarding Referrals / Information Sharing

The number of information sharing notification and referrals made by practitioners in the Trust's Emergency Departments to Children's Social Care has remained broadly in line with previous years (See table five)

	2014/15	2015/16	2016/17	2017/18
Children's Emergency Department	1362	1494	1326	1248
Adults Emergency Department (BRI)	593	486	616	779

The weekly Emergency Department safeguarding meeting, in which all referrals are discussed and reviewed, has continued during this reporting period. This process assists in monitoring the quality and appropriateness of referrals with feedback (referral outcomes) from Children's Social Care shared at the meeting.

Table 6: Reason for safeguarding referral



The range of concerns and reasons for referrals being completed remains broadly in line with previous reports (see table six)

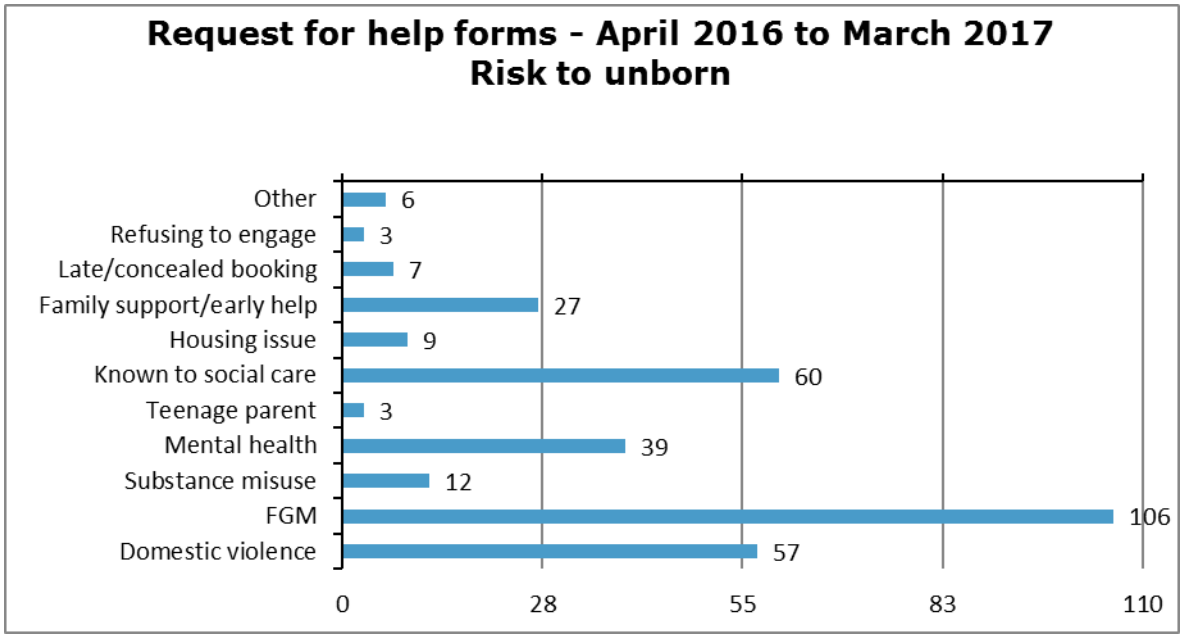
7. Safeguarding, Midwifery and the Unborn Baby

A significant number of safeguarding referrals continues to be made by the Community Midwifery Team and includes an increasing number of challenging and complex cases (See table 6). In response to the level of midwifery safeguarding activity and complexity, additional resources have been secured during this reporting period, and a new Midwifery Safeguarding Nurse has been appointed.

The post is jointly funded by Weston and UHBristol midwifery services as women may receive antenatal care in Weston and deliver at St Michalis hospital, particular when there is a complex social situation. The post holder works across both midwifery sites, providing a robust and cohesive safeguarding service, as well as providing midwives with advice, support and supervision. The post holder works closely with the Safeguarding Nursing Team.

Referrals for unborn babies are made due to concerns about potential parental risk factors, (incorporated into table seven below), which may result in occasions where babies have to be removed from their mothers following a multi- agency safeguarding process.

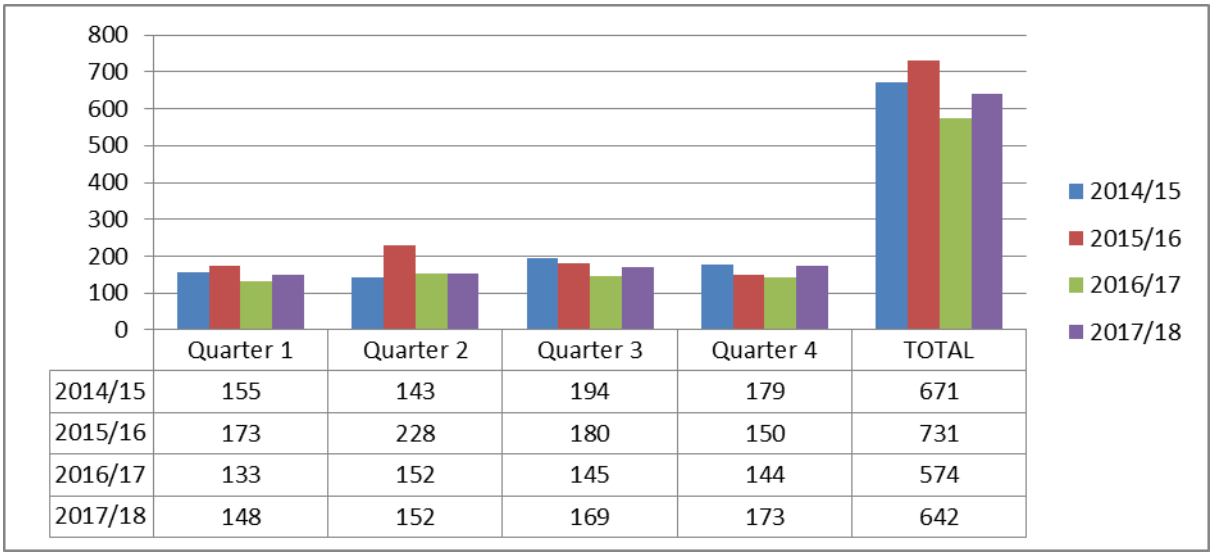
Table 7: Reason for safeguarding referral for unborn babies



8. Safeguarding Adults Activity Data

The safeguarding adult's activity data, in the main, has remained consistent with previous reports. The total number of concerns raised for safeguarding adults remains broadly consistent with previous year's data (See table eight below).

Table 8: Number of Referrals Received

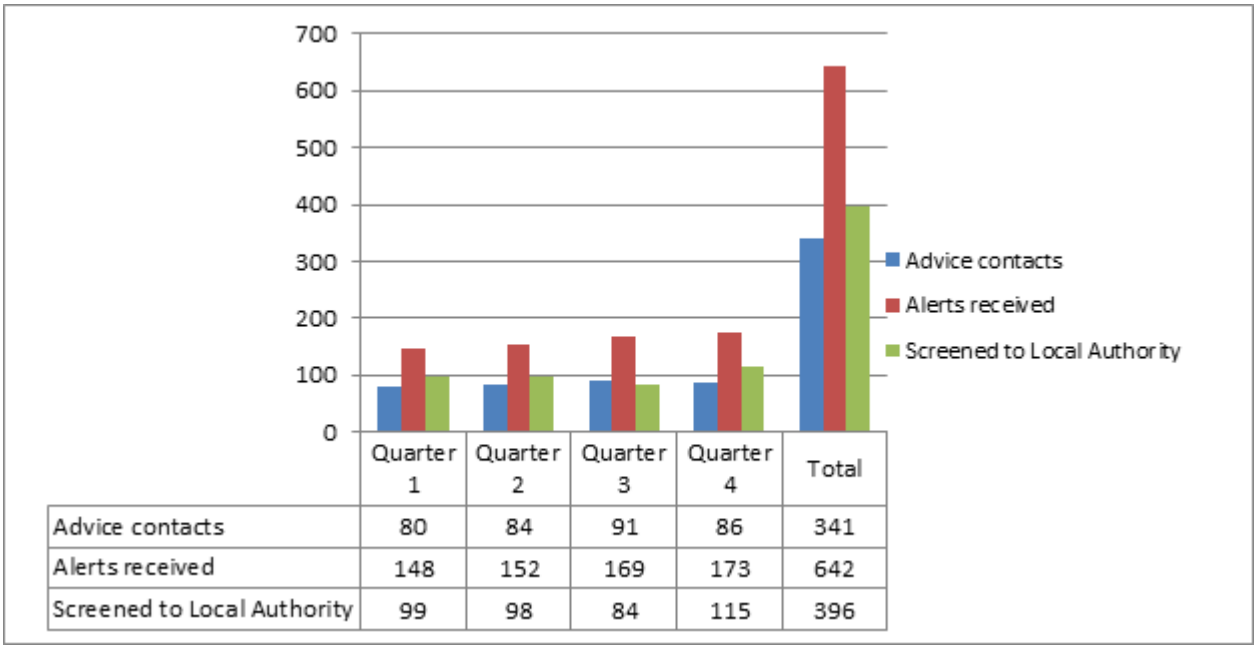


	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2014/15	155	143	194	179	671
2015/16	173	228	180	150	731
2016/17	133	152	145	144	574
2017/18	148	152	169	173	642

The rise in referrals in 2015/16 coincides with the implementation of the Care Act 2014, particularly Q2 which would reflect the impact of the training delivered around the practical application of the principles of the Care Act 2014.

The figures have since become more consistent as the Care Act principles become embedded in practice and following the initial spike in referrals, the rate subsequently has been in line with previous years.

Table 9: Number of Contacts / Referrals screened prior to sending to Local Authority



	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Advice contacts	80	84	91	86	341
Alerts received	148	152	169	173	642
Screened to Local Authority	99	98	84	115	396

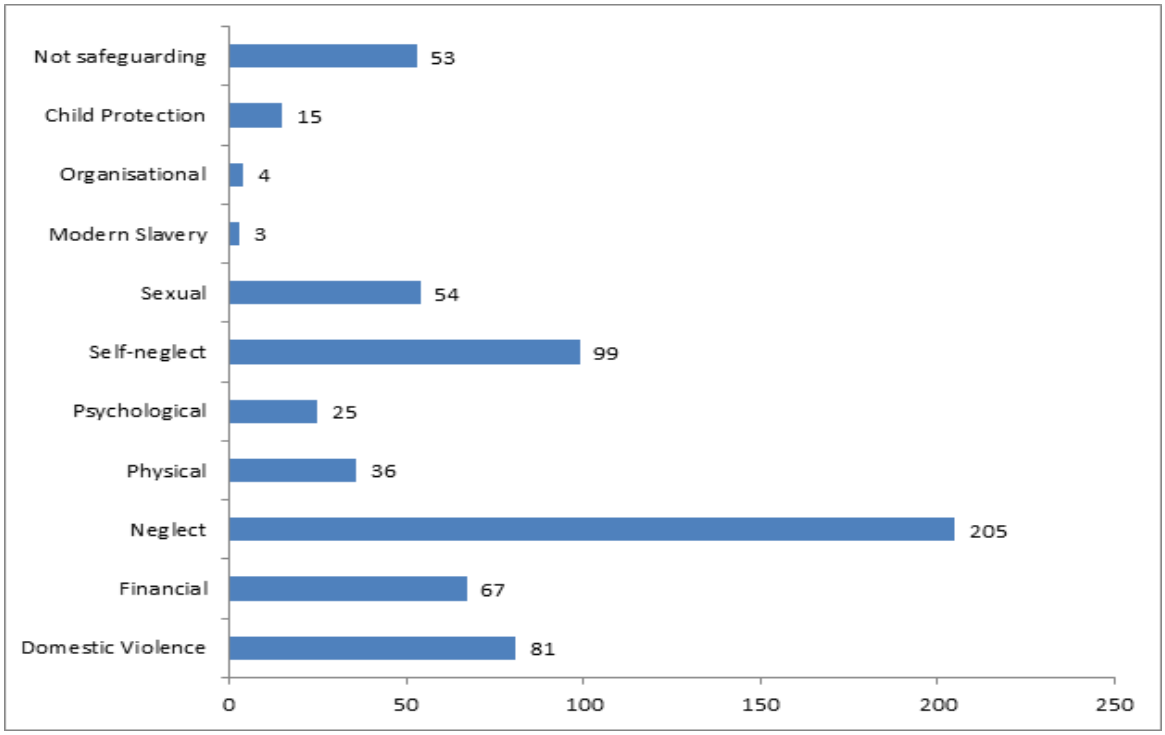
The Safeguarding Nursing team continues to review and filter all referrals in line with the Threshold Guidance produced by Bristol City Council, underpinned by the Care Act 2014. Overall 62% of alerts received during this reporting period have met the agreed threshold for referring onwards to the Local

Authority for a safeguarding investigation. Alerts not meeting the threshold have been redirected to other appropriate services, such as housing, after careful risk assessment.

The Safeguarding nursing team continues to record the number of requests for advice and support from staff across the Trust. Contacts in relation to adults includes advice sought in relation to queries about the implementation of the Mental Capacity Act and Deprivation of Liberty Safeguards (See 8.3)

A significant number of these calls relate to questions around the practical application of the Mental Capacity Act and demonstrate an increasing awareness of the circumstances when the legislation needs to be adhered to. The calls also provide an opportunity to give staff feedback in relation to improving the quality of safeguarding referrals and to support staff developing their knowledge about the use of the Mental Capacity Act and the Best Interest Decision making process

Table 10: Category of referrals



The Trust has made three referrals under the category of Modern Slavery this year, in comparison to six the previous year. Whilst this number remains small, the concerns have been identified appropriately and promptly as a result of the inclusion of Modern Slavery training into Safeguarding training. The referrals were responded to promptly by the Police and interventions commenced.

There has been a progressive drop in Safeguarding referrals in the category of Domestic Abuse during this reporting period from 100 to 81. This may be the result of staff making more referrals directly to the hospital Independent Domestic and Sexual Violence Advisor (IDSVA) service as their awareness of this service increases.

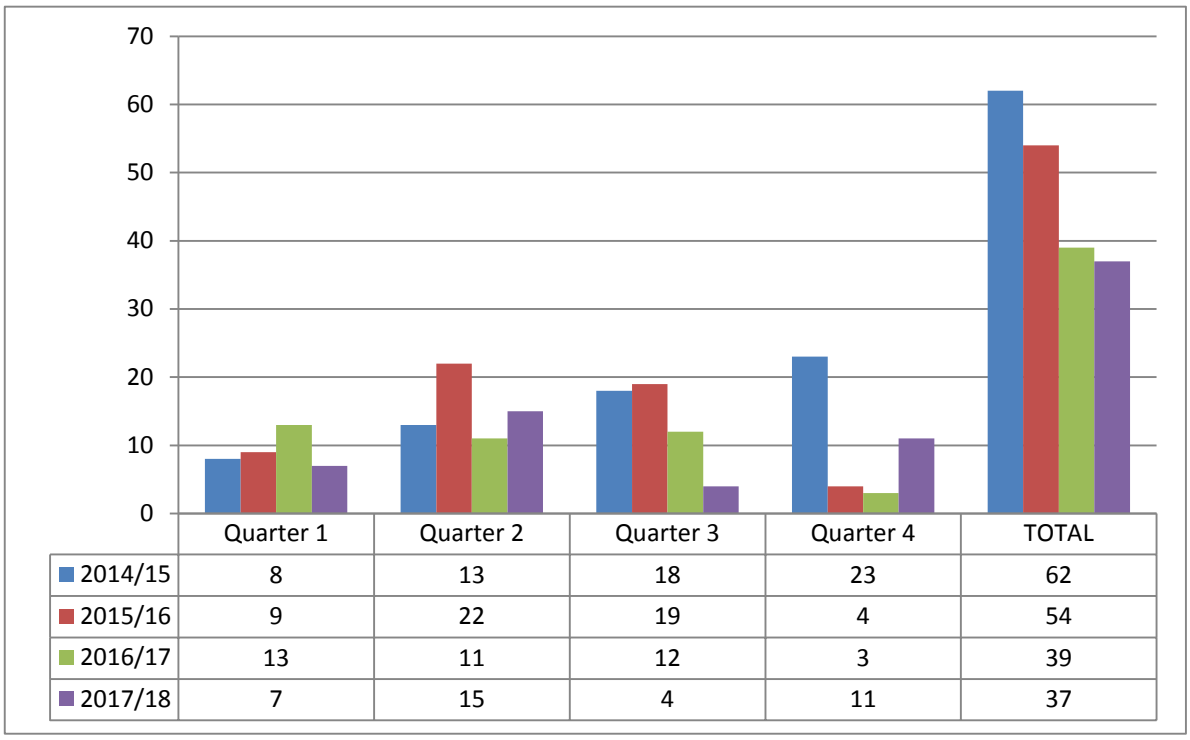
Staff may also be more confident in their understanding of safeguarding thresholds i.e. that a safeguarding referral may not be required in cases in which the patient has no other care and support needs that would meet the threshold for a full safeguarding investigation. (See 12.2 for further details of the IDSVA Service this year)

The volume of referrals made under the category of self-neglect continues to increase which is a challenge which is reflected nationally, particularly in relation to agreement of a safe threshold for intervention in these often complex cases. As a result of these challenges Bristol Safeguarding Adults Board produced a Multi-Agency Guidance on Self –neglect in March 2017.

8.1. Internal Safeguarding Alerts

A Safeguarding Internal Alert is raised if it is thought that the Trust may have caused harm through the omission or provision of care to a patient. This is underpinned by Trust's responsibility to be open and transparent in line with the Duty of Candor. Alerts may be raised by practitioners within the Trust or by other agencies or individuals who may have a concern about the care a patient has received.

Table 11: Internal Safeguarding Alerts Received Per Quarter



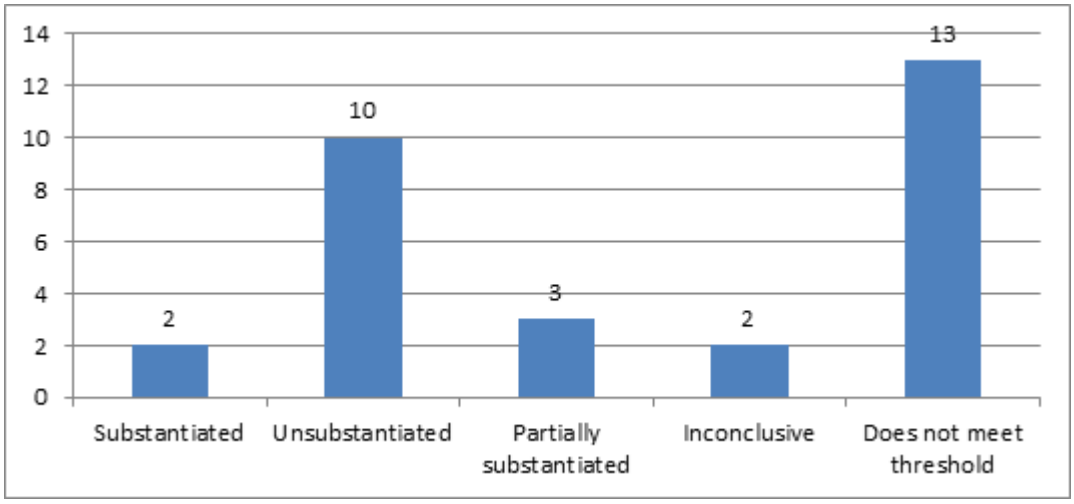
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	TOTAL
2014/15	8	13	18	23	62
2015/16	9	22	19	4	54
2016/17	13	11	12	3	39
2017/18	7	15	4	11	37

Table eleven demonstrates the year on year downward trend in the total number of internal alerts for the fourth consecutive year.

This downward trend is likely to be continuing as a result of the comprehensive review and screening process undertaken by the Safeguarding Team, in consultation with the Divisional Patient Safety teams. It facilitates early identification of pivotal points of concern which are then discussed with the Local Authority to establish an early decision as to whether a Safeguarding referral is triggered or whether a local response is sufficient.

The numbers of internal alerts, outcomes, emerging themes or concerns, are monitored closely by the Safeguarding Team, Divisional Patient Safety Teams and the Adult Operational Group with regular reports submitted to the Safeguarding Steering Group. Learning outcomes are incorporated into staff training updates.

Table 12: Outcome of internal Safeguarding investigations



Of the internal cases this year, two (5%) were closed as Substantiated, in comparison to twelve (30%) in the previous reporting period. Some of the outcomes relate to internal alerts raised during 2016/17 so further comparison between reporting periods is not meaningful. The proportional decrease, however, is significant and is likely to reflect the work undertaken to improve documentation around pressure area management and hospital discharge communication, recognising that there is further room for improvement going forward.

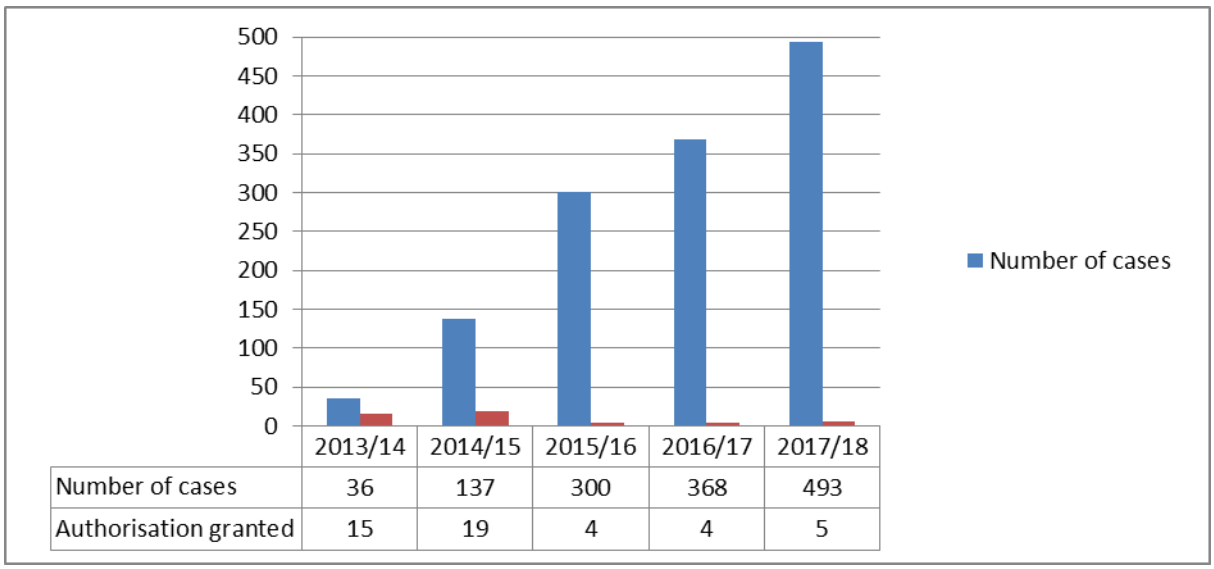
Of the two cases closed as Substantiated, one related to the development of grade 3 pressures sore as a result of nasal tubing in a critically ill patient; the second case related to a patient who was discharged home from the Emergency Department with a cannula insitu. Whilst this represents a decrease, from four similar incidents reported in the previous year, this remains an area of concern for the Trust. Further work, to which the Safeguarding Nursing team will contribute, is planned in the next reporting period to examine any incidents relating to patient discharge in more detail.

Of the cases closed as partially substantiated during this reporting period, there has been learning identified around documentation of skin condition on arrival to hospital, documentation of mobility assessments made prior to discharge from ED to the Discharge lounge and learning around documentation of the care provided to patients exhibiting challenging behaviour.

8.2 Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS), within the Mental Capacity Act, provides a protective legal framework for those vulnerable / at risk people who are deprived of their liberty. The Supreme Court judgment in March 2014 continues to have a significant impact on frontline practice and the increase in the number of DoLS applications (See table fifteen below).

Table 13: Deprivation of Liberty Safeguards (DoLS)



	2013/14	2014/15	2015/16	2016/17	2017/18
Number of cases	36	137	300	368	493
Authorisation granted	15	19	4	4	5

The volume of DOLS applications has increased this year by 34% Of the 493 DoLS applications made to the Local Authority; only 5 resulted in progression to an ongoing Standard authorisation. The Trust continues to care for and detain these patients, as it is in their best interests to do so, following the least restrictive option. This stance mirrors the current position of NHS Trusts both locally and nationally.

9 Safeguarding Supervision (adults and children)

A Trust wide Safeguarding Supervision Policy is in place to support staff in accessing the model of supervision most appropriate to their role and responsibility.

A key objective for the safeguarding team during this reporting period has been to increase capacity to provide staff with safeguarding supervision, and to progress this objective, a specialist supervision course was commissioned in September 2017. Sixteen senior staff from key staff groups, in adult and children's services, completed the course and are now able to provide safeguarding supervision

To support the new and existing safeguarding supervisors in their role and to strengthen the existing arrangements, a Safeguarding Supervisors Forum has been implemented.

10. Safeguarding Children and Adult Training

The provision and delivery of both children and adults safeguarding training remains a key priority, ensuring that all staff are provided with the appropriate training for their role and responsibilities. The Trust performance standard is 90% compliance with all levels of safeguarding training.

10.1 Level 1 and 2 Training Compliance

Safeguarding Level 1 and 2 training for both children and adults is incorporated into corporate clinical and non-clinical induction and update training. Compliance is detailed in table fourteen below.

Table 14: Level 1 and 2 Safeguarding Training Compliance

	March 2017	March 2018
Level 1 Safeguarding Adults	90%	92%
Level 1 Safeguarding Children	91%	93%
Level 2 Safeguarding Adults	91%	86%
Level 2 Safeguarding Children	90%	91%

10.2 Level 3 Core and Specialist Training (Children)

All staff who work regularly with children, young people or the unborn baby must complete Level 3 Core training as a minimum, (approximately 1,600 staff). Staff in a more senior role must complete the more advanced level of Level 3 Specialist training (approximately 370 staff)., which includes staff such as; Paediatric Consultants and Matrons, Community Midwives and Paediatric Specialist Nurses who are expected to undertake a lead role in safeguarding situations. The focus in the last year has been to improve the Trust's compliance with Level 3 Specialist training.

The Trust safeguarding Training Matrix states that staff in the Level 3 Core target audience must complete training within six months of starting employment and Specialist target audience completed within twelve months.

The Trust training data reporting system is currently unable to routinely exclude new starters from the overall compliance data. To improve the accuracy of the reporting a more detailed analysis was completed in March 18 which resulted an end of year compliance of 82% for core and. 87% for specialist.

Table 15: Level 3 Safeguarding Children Training Compliance

	March 2017	March 2018	March 2018 (Excluding new starters)
Level 3 Safeguarding Children (Core)	78%	79%	82%
Level 3 Safeguarding Children (Specialist)	74%	83%	87%

Non-compliance with the training target remains on the Trust Corporate Risk Register (Datix Number 921) monitored robustly through the Trust's governance arrangements including the Safeguarding Steering Groups and both Operational Groups.

10.3 Level 3 Safeguarding Training Compliance (Adult)

Significant progress has also been achieved with Level 3 safeguarding adults training and the required target has now been reached (90.5%).

Table 16: Level 3 Safeguarding Adult Training Compliance

	March 2017	March 2018
Level 3 Safeguarding Adults	78%	90.5%

10.4. Prevent, including training

The Counter-Terrorism and Security Act requires that specified bodies, including health, have a legal duty to, "have due regard to the need to prevent people from being drawn into terrorism". As part of these statutory requirements, underpinned by the NHS Commissioning Standards, the Trust is required to train staff so they know what PREVENT is and how to escalate concerns regarding people who may be at risk of radicalisation.

Safeguarding training incorporates the required level of PREVENT /WRAP according to staff role and level of responsibility. Compliance is reported as part of the Trust monthly Essential Training report

Table 17: Prevent/ WRAP Training Compliance

	March 2017	March 2018
Prevent training	65%	90%
WRAP training	47%	68%

The compliance target for both PREVENT and WRAP training is 90%. Work towards achieving the WRAP target will continue in the next reporting period , incorporated as part of the objectives to improve Level 3 safeguarding children's training. The Trust is required to have a dedicated PREVENT lead, which has been incorporated within the remit of the Safeguarding Lead Nurse. The Trust made one referral during this reporting period which did not meet the Threshold for further action (the Channel Panel) as was redirected to another support service.

11. Serious Case Reviews, Serious Adult Reviews and Domestic Homicide Reviews

Serious Case Reviews (SCR) for children and Serious Adult Reviews (SAR) are undertaken as part of a statutory multi-agency investigation process:

- following the death or serious harm of a child or an adult (with care and support needs),
- as the result of abuse or neglect,
- and there have been concerns about the way in which agencies have worked together and lessons can be learnt.

Domestic Homicide Reviews (DHR), are conducted following the death of an individual over the age of 16 years of age as a result of violence within a relationship, either from a partner of another member of the household they live in. Six requested for DHR information have been actioned during this reporting period; no DHR reports have yet been published.

During this reporting period the following local case reviews have been published:

Table 18: Case Reviews published 2017/18

Serious Case Review	Safeguarding Adults Reviews
Neglect of a Baby	Melissa
Becky	Christopher
Aya	Mate Crime Thematic Review
Baby L	
ZBM	

UHBristol services/teams were directly involved in four of the cases. Learning and associated actions resulting from these SCR / SAR s is included and monitored via the safeguarding work and audit plans Key actions include:

- Practitioners must clearly articulate the risk when making a safeguarding referral.
- Risks relating to premature and / or multiple births should be clearly understood across all agencies, including clarity about additional needs
- Practitioners should consider the risks for all types of Domestic Abuse, including non- intimate partner violence , such as between adult siblings
- There is a need to engage with the fathers of unborn babies.
- To ensure staff have access to supervision (see section 9)
- To ensure that appropriate staff are trained in the Mental Capacity Act

12. Unity Sexual health

In April 2017 Bristol Sexual Health was awarded a five year contract to provide Integrated contraception and sexual health services across Bristol, North Somerset and South Gloucestershire (BNSSG) and became Unity Sexual Health (Unity). Unity works with a number of partners: British Pregnancy Advisory Service (BPAS); Brook; The Eddystone Trust; Marie Stopes International (MSI); North Bristol NHS Trust; Terrence Higgins Trust; Weston Area Health NHS Trust (Weston Integrated Sexual Health – WISH).

Unity Sexual Health includes a strategic group, which is accountable for safeguarding activity. Safeguarding arrangements are aligned to the overall Trust safeguarding and risk management arrangements.

13. Safeguarding and Domestic Violence

The need to protect both children, including the unborn baby, and adults from the risks and consequences of domestic abuse, remains a key priority for the safeguarding teams. The prevalence, characteristics and the associated risks for both adults and children are highlighted through safeguarding training and specialist in house Domestic Abuse training.

The Trust continues to be represented at Multi Agency Risk Assessment Conference (MARAC) where referrals have been made by UHBristol practitioners.

The Safeguarding nursing team continues to have close links with the hospital and community IDSVA services and this ensures that services are delivered to patients in the most appropriate location and promotes early discharge from hospital to community IDSVA support.

13.1 Independent Domestic and Sexual Violence Advisor (IDSVA) Service

The Bristol Royal Infirmary is one of twenty five hospitals in the UK to have a team of Independent Domestic and Sexual Violence Advisors (IDSVA). This is now well established in the seventh year of service.

Table 19: Key Activity in the last twelve months

Service Activity	2016/17	2017/18
Number of patients aged 16 and above referred following disclosure of DVA	265	323
Numbers of patients referred who receive advice and safety planning from an advisor	175 engaged	240 engaged
Number of patients referred who are not high risk on DASH Risk assessment	58%	70%
Number of referrals signposted onto generic or specialist services	N/A	240

Education to front line staff across the Trust to recognise high risk presentations and indicators such as, strangulation, sexual violence or recent separation from the perpetrator remains a key part of the work of the IDSVAs.

14. Safeguarding Resourcing Group

The purpose of the Safeguarding Resourcing Group is to ensure that the Trust's safeguarding duties for both adults and children relating to all resourcing matters are fully considered. The group reports to the Safeguarding Steering Group.

Key Activity in the last twelve months

- The level of criminal record check required for the different types of substantive roles within the Trust was further reviewed in light of the new eligibility tool created by the Disclosure and Barring Service (DBS).
- Volunteer compliance with safeguarding training continues to be formally reported to the Safeguarding Lead via the Group. There have been no concerns reported. More rigorous reporting has been established for the compliance with safeguarding training for Bank-only staff.
- Further changes have been made to the Trust's protocol for approving appointments where there is an adverse disclosure to ensure it remains fit for purpose and there is ongoing rigour, consistency and governance.
- Input continues into operationalising the Trust's Standard Operating Procedure for the employment of 16 -17 year olds working as an apprentice.
- Finalisation and formal ratification of the Trust's DBS and Safe Handling of Information Policy
- Transfer of Locum recruitment to Resourcing, creating rigour to the pre-employment checking process

- Developing a local orientation checklist for nurse agency staff to ensure temporary agency workers are appropriately familiarised with the environment and relevant procedures and policies to work safely on Trust premises

- Strengthened controls and governance around specialist non-clinical agency workers and off-payroll contractors were implemented in response to the new Intermediaries Legislation in April 2017

- Review of requirements against new national guidance for Disclosure and Barring checks for non-clinical Bank appointments to ensure appropriate levels of checks are undertaken.

- A Self-Assessment against national DBS Standards was undertaken and received well by the Disclosure and Barring Service

15. Report summary and objectives for 2018/19

The safeguarding agenda for both children and adults is constantly changing and it is essential that the Trust continues to develop a proactive approach to ensure that safeguarding practice remains up to date and in line with new guidance and best practice.

Safeguarding remains a key priority for the Trust and this annual report summarises the key safeguarding activities, developments and achievements in this reporting period. The report aims to provide assurance that the Trust is fulfilling its statutory safeguarding duties and responsibilities and is thereby fulfilling its contractual duty to safeguard children and adults.

Whilst there have been many achievements over the last twelve months there are also many areas in which further work is required. Key objectives for the next twelve months include continuing to focus on improving compliance with Level 3 Safeguarding Children's Training and development of the safeguarding supervision arrangements. For adult safeguarding, key areas of focus will include the focus on raising staff awareness of the Mental Capacity Act and ensuring that front line practice is in line with major legislative changes. This will be particularly important in relation to the anticipated changes in the Deprivation of Liberty Safeguards Legislation.

Full details of the aims and objectives of both safeguarding teams going forward are detailed in the work and audit plans for 2018/19 available on request.

Cover report to the Board Meeting in Public to be held on 28 June 2018 from 11:00 – 13:00 in the Conference Room, Trust HQ

		Agenda Item	12
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Freedom to Speak Up – Annual Report 2017/18**		
Author	Eric Sanders, Freedom to Speak UP Guardian		
Executive Lead	Matt Joint, Director of People		
Freedom of Information Status		Open	

Strategic Priorities			
Strategic Priority 1: We will consistently deliver high quality individual care, delivered with compassion services.	☒	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required							
For Decision	☐	For Assurance	☒	For Approval	☒	For Information	☐

Executive Summary

<u>Purpose</u>

The annual report outlines the work of the Freedom to Speak Up (FTSU) Guardian over the year 2017/18, and presents the outcome of an assessment against the self-review tool developed by the FTSU National Guardian's Office.

<u>Key issues to note</u>

The Board should note:

- 13 cases were reported to the FTSU Guardian during the year. All have been investigated and responses provided to the members of staff raising the concerns.
- Significant action has taken place during the year to setup a network of Advocates to support the FTSU Guardian.
- New publicity material has been designed, printed and distributed across the organisation.

- The self-review has highlighted the need for a clearer strategy to help direct the FTSU programme of work, coupled with improve awareness reasoning, better capturing of learning form concerns raised and reviews into the quality of investigations.
- A set of objectives for 2018/19 have been developed to focus on the learning from the outcomes of the self-review

Recommendations

Members are asked to:

- **Receive the Freedom to Speak Up Annual Report 2017/18**
- **Approve the Self-Review tool assessment**
- **Support the objectives for 2018/19 and note that a report to the Board will be presented every six months**

Intended Audience									
Board/Committee Members	☒	Regulators	☒	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk			
Failure to maintain the quality of patient services.	☒	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
None identified

Resource Implications			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				Senior Leadership Team – 20 June 2018

1. Purpose

1.1. To present an overview of the work of the Freedom to Speak Up (FTSU) Guardian and Advocates over the year including high level details of the number of cases raised, a thematic analysis and any learning from the cases.

2. Background

2.1. The report by Sir Robert Francis, Freedom to Speak Up; An Independent review into creating an open and honest reporting culture in the NHS (2015) highlighted 20 Key Principles for NHS organisations to implement, which included an emphasis on creating a culture of safety, raising concerns, culture free from bullying, visible leadership and valuing staff.

2.2. In addition, the review introduced the role of the Freedom to Speak Guardian to act as an;

> Independent and impartial source of advice to staff, with access to anyone in the organisation including the CEO, or if necessary outside the organisation. They can ensure that the primary focus is on the safety issue; that the case is handled appropriately, investigated promptly and case addressed; and that there are no repercussions for the person who raised it.

2.3. UH Bristol is committed to implementing the recommendations of the Francis Report 2015 and embedding a strong culture throughout the Trust.

3. Key Actions Completed During 2017/18

3.1. The Trust has taken the following steps:

- A FTSU Guardian has been appointed. This is the Trust Secretary
- The FTSU Guardian has undertaken the mandatory national training
- A new Freedom to Speak Up Policy was approved in December 2017 and will be subject to annual review to ensure it is meeting the objectives of FTSU
- A network of FTSU Advocates has been setup. There are currently 17 Advocates who support the FTSU Guardian, and are there to promote the FTSU agenda and be available to advise staff at a local level
- The Director of People is the Executive lead for FTSU and the Senior Independent Director is the Non-Executive lead
- New publicity material in the form of banners, posters, coasters, and leaflets have been developed and circulated to Advocates. The design and print costs were kindly funded by the Trust's charity Above and Beyond.
- Regular FTSU Advocate meetings have been held to provide support and training and to ensure consistency in messaging
- All concerns raised have been investigated, staff raising concerns have been supported and outcomes communicated back to them.

4. Challenges Identified During 2017/18

4.1. During the year there was a change of Trust Secretary and therefore progress slowed during the period of transition (December 2017 to March 2018), although the Advocates continued to be present and promoted the FTSU message. The new Guardian is in the progress of relaunching the FTSU agenda, working closely with the Director of People.

4.2. The numbers of cases raised remains fairly low although the numbers of cases reported benchmarks with equivalent sized organisations. Further work is required to promote the FTSU message and this will be built into objectives for 2018/19.

5. Summary of Cases Raised During 2017/18

5.1. During 2017/18 there were 13 cases raised to the FTSU Guardian. These are categorised and reported to the National Guardian's Office as follows:

Quarter	Total number of cases raised	Number of cases raised anonymously	Cases related to Patient Safety	Cases related to behaviours
Q1	3	0	1	0
Q2	3	3	0	3
Q3	4	1	1	3
Q4	3	0	0	0

5.2. No one who raised a concern subsequently reported suffering a detriment as a result of speaking up.

5.3. The two cases where patient safety issues were identified were immediately raised to the Chief Nurse and Acting Medical Director and investigations undertaken by the Head of Nursing for the Division. In one case the Safeguarding Team were also involved and an investigation by them was also undertaken. In both cases additional training and support were identified to support non-recurrence of the issues.

5.4. The number of cases reported remained static quarter on quarter.

5.5. A thematic analysis of the cases shows the following:

- Cases were raised from across the Trust
- More cases were raised in the Surgery and Estates than other divisions
- The majority of cases raised related to the behaviours of managers and colleagues, with the next highest theme relating to the consistent application of HR policy

5.6. Further work is required to enhance the data collection so that further analysis can be undertaken, for example to understand the characteristics of people speaking up (professional background, protected characteristics).

6. National Staff Survey Results 2017

6.1. The national staff survey includes indicators which directly link to the FTSU programme. Whilst the 2017 results show some improvement, there is still further work to do to ensure that all staff feel able to raise concerns and have confidence in the Trust's response:

		Your Trust in 2017	Average (median) for acute trusts	Your Trust in 2016
	Raising concerns about unsafe clinical practice			
Q13a	% saying if they were concerned about unsafe clinical practice they would know how to report it	93	95	92
	% agreeing / strongly agreeing with the following statements:			
Q13b	"I would feel secure raising concerns about unsafe clinical practice"	67	69	66
Q13c	"I am confident that the organisation would address my concern"	57	57	56

7. National Guidance and Self-Review Tool

7.1. The National Guardian published guidance in early May 2018 which sets out the expectations on boards in relation to FTSU. The guidance aims to help boards to create a culture responsive to feedback and focused on learning and continual improvement. The guidance was shared with the Board of UH Bristol following its publication.

7.2. The guidance is accompanied by a self-review tool. This is to support the principle that regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

7.3. The Care Quality Commission (CQC) assesses a Trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. The guidance is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3.

7.4. Boards are advised to complete the self-review tool and develop an improvement action plan as this will help Trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the Trust's speaking up culture is.

7.5. The self-review has been drafted by the Guardian in conjunction with the Director of People and Senior Independent Director. A summary of the outcome is described below, with the full assessment attached in Appendix 1.

- The Trust is fully or partially compliant with the majority of the recommendations
- Further work is required to describe the Trust's FTSU strategy and ensure this is aligned with the overarching Trust strategy and other enabling strategies such as Workforce and Quality
- More regular reports are required to the Board, with the minimum suggestion being every six months
- There needs to be greater awareness of FTSU at all levels of the organisation, particularly senior management
- The Trust needs to undertake a review of the quality of investigations
- There needs to be further sharing of learning from cases across the organisation.

7.6. The actions to address the identified gaps have been captured in the objectives for 2018/19 and will be monitored though the year and via the reports to the Board.

8. Objectives 2018/19

8.1. Based on the review of cases during 2017/18 and the outcome of the self review, further work is required in a number of areas to enhance the Trust's approach to FTSU. These have been translated into the following objectives for 2018/19:

1. Development of a FTSU strategy, aligned to the Trust, Workforce and Quality Strategies
2. Greater awareness of FTSU across all staff groups and delivery locations
3. Enhanced data collection when cases are raised and follow up with those raising concerns about the adequacy of the process and support provided
4. Learning from FTSU to be shared and incorporated into the new leadership and management development programmes
5. Improved lessons learnt process to include dissemination via management and the FTSU Advocates
6. Enhancements to the FTSU Advocates network through improved training and development, opportunities for sharing and of shaping ideas and approaches, and an increase in the number of advocates including ensuring coverage in all areas such as South Bristol Community Hospital
7. Ensuring alignment of FTSU with other channels for raising concerns such as the Happy App, bullying and harassment champions, equality and diversity champions, patient safety culture survey and friends and family test survey.
8. Six monthly reporting to the Board on FTSU case and learning

9. Recommendations

9.1. The Board is asked to:

- Note the FTSU annual report 2017/18
- Consider the outcome of the self-review tool and note the actions identified
- Support the objectives for 2018/19

Eric Sanders
Freedom to Speak Up Guardian
June 2018

National Guardian
Freedom to Speak Up

NHS
University Hospitals Bristol
NHS Foundation Trust

Freedom to Speak Up self-review

June 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Partially	Continued awareness raising at SLT and wider leadership community	New guidance has been shared with a specific action for those required to read the guidance
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Partially	More regular reports on FTSU issues	FTSU six monthly reports
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Partially	Include examples and learning from FTSU into the new leadership programmes	Leadership Development Programme and associated reports
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Partially	See above re awareness raising	
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	None	Development of an FTSU strategy	
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Fully	Keep under regular review	FTSU Policy
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian)and it aligns with existing guidance from the National Guardian.	None	Development of an FTSU strategy	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	Partially	More regular reports on FTSU issues	FTSU six monthly reports
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Partially	Continued awareness raising at SLT and wider leadership community	FTSU six monthly reports
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Fully		Quality and Performance Report, Quality Report, CQC Inspection Report, Quality Improvement Programme
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Fully	N/A	Happy App, FFT, Staff Survey, Back to the Floor, "You Said, We Did", incident reporting
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Partially	Continued awareness raising at SLT and wider leadership community	
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Partially	Include examples and learning from FTSU into the new leadership programmes	Leadership Development Programme and associated reports
The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Partially	Improved awareness of the FTSU programme Guardian, advocates and	New publicity materials developed and shared across the organisation.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		policy	
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Fully	N/A	Director of People Senior Independent Director
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Fully	N/A	Regular 1-1s
Other senior leaders support the FTSU Guardian as required.	Fully	N/A	There have been no issues accessing individuals for support and advice.
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Fully	N/A	Data available if required
The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Fully	N/A	There have been no issues accessing individuals for support and advice.
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partially	Improved awareness of the FTSU programme Guardian, advocates and	New publicity materials developed and shared across the organisation.

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		policy	
Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Partially	Further work required to understand if there is an issues and how to increase awareness in these groups	Advocates have been recruited from a range of backgrounds and staff are encouraged to contact any advocate
Speak up issues that raise immediate patient safety concerns are quickly escalated	N/A	N/A	None raised to date with current guardian however issues would be raised immediately with the Chief Nurse and Medical Director
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	N/A	Follow up with staff who have raised concerns to ensure there has been no adverse impact from speaking up	
Lessons learnt are shared widely both within relevant service areas and across the trust	None	Lessons learnt are not fully captured through the process	FTSU six monthly reports
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	None	Consider an audit of investigations	FTSU six monthly reports
FTSU policies and procedures are reviewed and improved using feedback from workers	Fully	Policy to be reviewed in December 2018 after 12 months of being live	FTSU Policy
The board receives a report, at least every six months, from the FTSU Guardian.	Fully	N/A	FTSU six monthly reports

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Leaders engage with all relevant stakeholders			
A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	None	Development of an FTSU strategy	
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	None	Consideration to be given to how any themes could be shared	
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Fully	N/A	FTSU six monthly reports in public
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Fully	N/A	Annual Report 2017/18
Reviews and audits are shared externally to support improvement elsewhere.	N/A	N/A	None required to date.
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Fully	N/A	There is full engagement with the regional network and National Guardian's Office
Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Fully	N/A	This is encouraged
Senior leaders request external improvement support when required.	N/A	`N/A	Not required to date but there is awareness that this can be requested if

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
			required.
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Partially	Learning to be capture more systematically so that it can be shared through the management and advocate networks	
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Fully	N/A	The Guardian is buddied with another Guardian and has links to the local and national network.
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Fully	N/A	New guidance is shared with leads as required
Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Fully	N/A	Learning from incidents, internal and external reviews, surveys and other feedback is a corner stone to the Trust and Quality Strategy
The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	None	Development of an FTSU strategy	

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Fully	Policy to be reviewed in December 2018 after 12 months of being live	FTSU Policy
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	None	Consider an audit of investigations	FTSU six monthly reports
Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	None	Include in the six monthly FTSU reports	
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Fully	N/A	The Trust Secretary is the FTSU Guardian and is appointed by the CEO and Chair
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Fully	N/A	FTSU Policy
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Fully	N/A	Annual Report 2017/18

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Fully	N/A	There is full engagement with the regional network and National Guardian's Office
Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Fully	N/A	Regular 1-1s
Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Fully	N/A	Guidance issued to names roles in Trust for review.
Overseeing the creation of the FTSU vision and strategy.	None	Development of an FTSU strategy	
Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Fully	N/A	
Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Fully	N/A	The Guardian has time allocated to undertake the role

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Ensuring that a sample of speaking up cases have been quality assured.	None	Consider an audit of investigations and include outcome in the FTSU reports	
Conducting an annual review of the strategy, policy and process.	Partially	Development of an FTSU strategy	FTSU Policy
Operationalising the learning derived from speaking up issues.	Partially	Learning to be capture more systematically so that it can be shared through the management and advocate networks	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Fully		All allegations are promptly investigated
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	None	Mechanism for assurance to be developed alongside the strategy	
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Fully	N/A	Guidance issued to names roles in Trust for review.
Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Partially	Initial implementation was monitored but a process for follow up assurance is needed	NED lead and subsequently the Board were briefed on initial policy and process implementation
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused	Fully	N/A	QOC and Board pay close attention to staff feedback

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
on learning and continual improvement.			mechanisms and governor feedback and raise challenges regularly
Role-modelling high standards of conduct around FTSU.	None	Increased scrutiny and profile from the NED lead on FTSU	
Acting as an alternative source of advice and support for the FTSU Guardian.	Partially	Regular 121s to be set up between NED lead and new FTSU Guardian	The NED lead met with the previous FTSU Guardian on a regular basis to discuss issues
Overseeing speaking up concerns regarding board members.	N/A this year		
Human resource and organisational development directors			
Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Fully	N/A	The Guardian has a dedicated point of contact in HR
Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Fully	N/A	There is full engagement from HR to support investigations and dissemination of learning
Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Fully	N/A	The first question asked when a concern is raised is whether there is a patient safety issue. Where there is, these are flagged immediately to the

Self review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
			Medical Director and Chief Nurse.
Medical director and director of nursing			
Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Fully	N/A	Both the Chief Nurse and Medical Director are supportive and available to provide advice
Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Fully	N/A	2 cases were raised during the year relating to patient safety concerns and these were dealt with appropriately and immediately.
Ensuring learning is operationalised within the teams and departments that they oversee.	Fully	N/A	Learning is cascaded through the Divisions via the Heads of Nursing.

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	13
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Finance Report**		
Author	Kate Parraman, Deputy Director of Finance		
Executive Lead	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☐
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☐

Executive Summary

Purpose:

To inform the Finance Committee of the financial position of the Trust for May

Key issues to note:

- The Operational Plan for the year is a surplus of £18.480m excluding technical items. This includes £15.480m of Provider Sustainability Funding (PSF). The Operational Plan to May is a surplus of £1.446m excluding technical items.

- The Trust is reporting a surplus of £1.455m, £0.009m favourable to plan. This is due to :
  - Divisional and Corporate overspends of £0.421m
  - Corporate share of income over performance £0.066m
  - Release of Corporate Reserves £0.343m
  - Financing underspend of £0.021m

Recommendations
Members are asked to: Note the contents of this report

Intended Audience (please select any which are relevant to this paper)									
Board/Committee Members	☐	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
Risk 951 – Risk of the loss of S&T funding due to the failure to achieve the “core” control total from quarter 2.

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
	26 June 2018			

Report of the Finance Director

Section 1 – Executive Summary

	2018/19 Annual Plan £m	Income / (Expenditure) Plan to date £m	Income / (Expenditure) Actual to date £m	Variance Favourable /(Adverse) £m
Corporate Income	615.148	101.359	101.425	0.066
Divisions & Corporate Services	(565.627)	(95.170)	(95.591)	(0.421)
Financing	(35.592)	(5.948)	(5.927)	0.021
Reserves	(10.929)	(0.343)	-	0.343
Surplus/(deficit) excl PSF	**3.000**	**(0.102)**	**(0.093)**	**0.009**
PSF Core Funding	10.836	1.084	1.084	-
PSF Performance Funding	4.644	0.464	0.464	-
Surplus/(deficit) incl PSF	**18.480**	**1.446**	**1.455**	**0.009**

The new financial year requires significant funding allocations to Divisions to establish the budgets, including activity contracts, cost pressures and other operating plan adjustments. The allocation of this funding to individual budget lines necessarily spans the first two months of the year therefore the subjective reporting is still under development and will be reviewed for quarter 1/ month 3 projections.

- The Operational Plan for the year is a surplus of £18.480m excluding technical items. This includes £15.480m of Provider Sustainability Funding (PSF).
- The Operational Plan requirement to May is a surplus of £1.446m excluding technical items.
- The Trust is reporting a surplus of £1.455m, £0.009m favourable to plan. This is due to :
  - Divisional and Corporate overspends of £0.421m, offset by
  - Corporate share of income over performance £0.066m
  - Release of Corporate Reserves of £0.343m
  - Financing underspends of £0.021m
- The Clinical Divisional deficit in May is £0.532m, compared to an Operating Plan trajectory of £0.686m. This is primarily due to medical pay (£0.322m) and nursing pay (£0.271m).
- PSF core funding is shown as achieved for month one and two. The Trust is reporting a £0.009m favourable variance against core control total.
- PSF performance funding has been achieved for month two. ED performance was 91.14% against a target of 90.00% including Walk in Centre data. ED performance is expected to meet the quarter one cumulative target.

Year to Date Position

Section 2 – Division and Corporate Services Performance

Performance by Division and Corporate Service Area:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 30 April £m	May £m	To 31 May £m	To 31 May £m	Var £m
Diagnostic & Therapies	0.012	0.059	0.071	0.026	0.045
Medicine	(0.071)	(0.074)	(0.145)	(0.150)	0.005
Specialised Services	(0.176)	0.241	0.065	(0.132)	0.197
Surgery	(0.075)	(0.116)	(0.191)	(0.141)	(0.050)
Women's & Children's	(0.145)	(0.187)	(0.332)	(0.289)	(0.043)
Estates & Facilities	0.003	(0.009)	(0.006)	0.013	(0.019)
Trust Services	(0.008)	(0.002)	(0.010)	-	(0.010)
Other Corporate Services	0.018	0.109	0.127	-	0.127
Total	**(0.442)**	**0.021**	**(0.421)**	**(0.673)**	**0.252**

- Division and Corporate Services adverse variance year to date was £0.421m in May. This compares with the Operating Plan trajectory of an adverse variance of £0.673m, this favourable position compared to operating plan is due primarily to contract income performance being better than expected.

- Diagnostic and Therapies – a favourable variance of £0.071m slightly ahead of the Operating Plan trajectory. This is mainly driven by clinical staffing vacancies and income from activities which offsets a non pay overspend.

- Medicine – an adverse variance of £0.145m in line with the Operating Plan trajectory. Pay was £0.207m adverse in month, of which £0.102m related to medical and £0.110m to nursing, both pay overspends reflect the costs of temporary cover and increases due to clinical need. Income from activities was £0.257m favourable.

- Specialised Services – a favourable variance of £0.065m, £0.197m favourable to Operating Plan trajectory predominately due to a £0.305m favourable position on income from activities. Cardiology was £0.479m favourable in the month and Haematology £0.038m favourable, this was offset by adverse variance in the BHOC specialities following the fire.

- Surgery – an adverse variance of £0.191m year to date which is adverse to Operating Plan trajectory. Adverse variances on pay, £0.324m and non-pay, £0.483m are partially offset by a favourable position on income from activities of £0.622m.

- Women's & Children's – an adverse variance of £0.332m year to date, which is slightly adverse to Operating Plan trajectory. Pay is £0.672m adverse of which £0.321m related to medical pay and £0.246m nursing. Non pay was £0.174m favourable reflecting in part funding yet to be allocated.

Section 2 – Division and Corporate Services Performance continued

Performance by subjective heading:

	Monthly Average 2017/18	2017/18 Outturn £m	April 2018 £m	May 2018 £m	2018/19 To date £m
Nursing & midwifery pay	(0.328)	(3.941)	(0.248)	(0.315)	(0.563)
Medical & dental pay	(0.353)	(4.233)	(0.358)	(0.322)	(0.680)
Other pay	0.076	0.912	0.120	0.060	0.180
Non-pay	(0.388)	(4.655)	0.002	(0.728)	(0.727)
Income from operations	(0.003)	(0.030)	(0.069)	(0.000)	(0.069)
Income from activities	0.396	4.753	0.111	1.327	1.438
Total	**(0.600)**	**(7.195)**	**(0.442)**	**0.022**	**(0.421)**

The allocation of new year funding to individual budget lines continues through to the end of quarter 1 and therefore the subjective level detailed variances remain a work in progress.

- Nursing pay overspend remains at a similar level to April with a £0.315m adverse variance in May. The Divisions of Medicine and Surgery showed a worsening variance compared to April whereas Women's and Children's improved.
- Medical and dental pay variances have improved very slightly but remain a concern at £0.322m adverse in May compared to £0.358m adverse in April. The position reflects a worsening adverse variance in Women's and Children's and Medicine Divisions due to increased expenditure.
- There is a significant adverse non pay variance in May of £0.728m especially in the Surgery Division. This is described in more detail in section 3 but the most significant overspends are activity linked and to some extent offset by the favourable income position.
- Income from Operations is breakeven in the month.
- Income from Activities showed a significant favourable variance of £1.327m in May. Approximately £0.770m reflects an update to the April position following reviews of the activity coding. In addition a number of areas showed over performance against plan in the month such as Cardiology and various surgical specialities.

Section 3 – Subjective Analysis Detail

a) Nursing (including ODP) and Midwifery Pay

Favourable/ (Adverse)	January 2018 £m	February 2018 £m	March 2018 £m	2017/18 Outturn £m	April 2018 £m	May 2018 £m	2018/19 To date £m
Substantive	0.854	0.903	0.940	10.046	0.775	0.830	1.605
Bank	(0.716)	(0.690)	(0.876)	(7.997)	(0.595)	(0.723)	(1.318)
Agency	(0.421)	(0.409)	(0.510)	(5.988)	(0.428)	(0.422)	(0.850)
Total	**(0.283)**	**(0.196)**	**(0.446)**	**(3.939)**	**(0.248)**	**(0.315)**	**(0.563)**

- Nursing pay variance was £0.315m adverse in the month which is 0.067m worse than April.
- Lost time percentages increased from 124% in April to 126% in May.
- Medicine and Surgery Divisions worsened their overspend compared to April. Although agency costs remained broadly static, bank costs have increased in month, both Divisions had increases in lost time and enhanced observation costs.
- Enhanced observation costs increased from £0.146m in April to £0.170m in May, with a particular increase seen in Surgery (£0.029m).

b) Medical and Dental Pay

Favourable/ (Adverse)	January 2018 £m	February 2018 £m	March 2018 £m	2017/18 Outturn £m	April 2018 £m	May 2018 £m	2018/19 To date £m
Consultant							
substantive	0.065	(0.134)	0.317	0.768	0.062	0.152	0.214
additional hours	(0.182)	(0.178)	(0.187)	(2.143)	(0.163)	(0.200)	(0.363)
locum	(0.114)	(0.140)	(0.158)	(0.736)	(0.112)	(0.096)	(0.208)
agency	0.005	(0.006)	(0.041)	(0.190)	0.004	(0.013)	(0.009)
Other Medical							
substantive	0.138	0.096	0.306	0.932	0.100	0.160	0.260
additional hours	(0.123)	(0.181)	(0.146)	(1.575)	(0.133)	(0.150)	(0.283)
Jr Dr exception	0.000	0.000	0.000	(0.007)	(0.001)	(0.001)	(0.002)
locum	(0.075)	(0.077)	(0.097)	(1.059)	(0.096)	(0.140)	(0.238)
agency	0.023	(0.003)	(0.203)	(0.224)	(0.017)	(0.034)	(0.051)
Total	**(0.263)**	**(0.623)**	**(0.221)**	**(4.927)**	**(0.358)**	**(0.322)**	**(0.680)**

- The adverse variance in May of £0.322m is a slight improvement on the April position, although there continues to be significant costs of additional hours payments and locum cover. Women's and Children's and Medicine's variance on medical staffing continue to worsen whilst surgery improved slightly and Specialised was close to a breakeven position. Cost pressures for maternity leave and sickness cover remain a significant issue across the Trust.

Section 3 – Subjective Analysis Detail continued

c) Non pay

Favourable/ (Adverse)	January 2018 £m	February 2018 £m	March 2018 £m	2017/18 Outturn £m	April 2018 £m	May 2018 £m	2018/19 To date £m
Blood	(0.086)	0.031	(0.058)	(0.248)	(0.055)	(0.029)	(0.084)
Clinical supplies & services	(0.185)	0.032	(0.083)	(0.950)	(0.007)	(0.190)	(0.197)
Drugs	(0.115)	(0.179)	(0.212)	(0.961)	0.037	(0.123)	(0.086)
Establishment	(0.079)	0.037	(0.010)	(0.166)	(0.010)	(0.003)	(0.013)
General supplies & services	(0.024)	0.019	(0.005)	0.007	0.044	(0.004)	0.040
Outsourcing	(0.039)	(0.054)	(0.026)	(1.117)	(0.072)	0.022	(0.050)
Premises	(0.064)	0.054	(0.124)	(0.067)	0.034	0.002	0.036
Services from other bodies	(0.120)	(0.136)	(0.068)	(1.031)	(0.042)	(0.139)	(0.181)
Research	(0.100)	0.040	(0.016)	0.034	0.008	(0.029)	0.037
Other non-pay expenditure	(0.007)	(0.472)	(0.076)	(1.526)	0.065	(0.293)	(0.228)
Tranche 1 Winter Funding	0.457	0.457	0.456	1.370	-	-	-
Total inc CIP	**(0.343)**	**(0.171)**	**(0.222)**	**(4.655)**	**0.002**	**(0.729)**	**(0.727)**

- The non-pay position worsened significantly in month with an adverse variance of £0.729m.
- Drugs and clinical supplies expenditure has increased significantly in particular in Surgery Division. This reflects both current clinical activity levels and suspected restocking supplies in theatres. Further work is being undertaken to fully understand the position of clinical supplies in Surgery Division, this work will be supported by the introduction of the managed inventory system in due course.
- The worsening variance on Services from Other Bodies reflects in part billing related to April now processed and doesn't represent a worsening in expenditure trend from the last quarter.
- The increased adverse variance on other expenditure is due to allocation of Divisional budgets in May from this to other subjective lines as the budgets continue to be reviewed at this level of detail.

Section 4 – Clinical and Contract Income

Contract income by work type: (further detail at agenda item 2.2)

	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based:			
Accident & Emergency	3.115	3.290	0.175
Bone Marrow Transplants	1.306	1.193	(0.113)
Critical Care Beddays	7.317	7.299	(0.018)
Day Cases	6.492	6.628	0.136
Elective Inpatients	9.343	9.375	0.032
Emergency Inpatients	15.840	17.140	1.300
Excess Beddays	0.919	1.051	0.132
Non-Elective Inpatients	5.376	4.994	(0.382)
Other	15.478	15.530	0.052
Outpatients	13.274	13.754	0.480
Total Activity Based	**78.459**	**80.225**	**1.795**
Contract Penalties	(0.169)	(0.609)	(0.439)
Contract Rewards	1.661	1.673	0.012
Pass through payments	15.699	14.501	(1.198)
S&T Funding	1.548	1.548	-
2018/19 Total	**97.198**	**97.368**	**0.169**

Following the Trust's receipt of £1.33m from NHS Improvement in respect of losses on HRG4+ related to Wales in 2017/18, £1.53m has been planned for and assumed in 2018/19.

- Activity based income was £1.695m favourable in May, leading to a £1.795m favourable position year to date. A significant proportion of this; £0.725m related to a recalculation of income earned for uncoded spells in April.

- Emergency activity was above plan by £1.226m in May, of which £0.544m related to the April adjustment.

- Inpatient performance was £0.269m above plan, leaving the year to date position £0.350m adverse; the adverse variance is predominantly within Surgery (£0.270m) and Women's and Children's (£0.280m) with the major offsetting favourable variance in Specialised Division (£0.130m).

  Bone Marrow Transplant moved from £0.109m favourable in April to a year to date position of £0.113m adverse, this is mainly due to procedures in Specialised Division.

- Given the Trust has accepted the control total, national core penalties do not apply. Other penalties do apply and the Trust has received penalties of £0.609m year to date, £0.439m greater than planned.

- CQUIN reporting will commence at the end of quarter one.

- Income relating to pass through payments was £0.848m below plan in May, taking the cumulative variance to £1.198m adverse, of this £0.606m relates to drugs, predominately Hepatology.

Section 5 – Savings Programme

Analysis by work streams: (further detail at agenda item 2.4)

	2018/19 Annual Plan £m	Year to date Plan £m	Actual £m	Variance fav/(adv) £m
AHP productivity	0.779	0.130	0.133	0.003
Diagnostic Testing	0.156	-	-	-
Estates & Facilities	0.746	0.152	0.147	(0.005)
Healthcare Scientists Productivity	0.120	0.024	0.025	0.001
Income, Fines, External	2.290	0.352	0.312	(0.041)
Medical Pay	0.625	0.048	0.048	-
Medicines	0.751	0.121	0.075	(0.046)
Nursing Pay	1.061	0.167	0.131	(0.036)
Other / Corporate	7.874	1.312	1.312	-
Productivity	3.268	0.392	0.427	0.035
Non-Pay	5.019	0.768	0.800	0.032
HR Pay and Productivity	0.097	0.016	0.015	(0.002)
Trust Services	0.653	0.109	0.108	(0.002)
Blood	0.046	0.004	-	(0.004)
Unidentified	1.991	0.332	-	(0.332)
Total	25.474	3.928	3.532	(0.396)

Analysis by Division:

	2018/19 Annual Plan £m	Year to date Plan £m	Actual £m	Variance fav/(adv) £m
Diagnostics & Therapies	1.934	0.274	0.278	0.004
Medicine	2.858	0.512	0.335	(0.177)
Specialised Services	2.727	0.404	0.398	(0.007)
Surgery	3.521	0.508	0.438	(0.070)
Women's and Children's	4.869	0.605	0.467	(0.137)
Facilities and Estates	0.976	0.176	0.180	0.004
Finance	0.186	0.034	0.032	(0.002)
Human Resources	0.126	0.021	0.023	0.001
IM&T	0.201	0.039	0.033	(0.006)
Trust HQ	0.203	0.042	0.036	(0.006)
Corporate	7.874	1.312	1.312	-
Total	25.474	3.928	3.532	(0.396)

- The savings requirement for 2018/19 is £25.474m. The Trust has achieved savings of £3.532m against a plan of £3.928m.
- Medicine is £0.177m behind plan, primarily due to unidentified savings.
- Women's and Children's is £0.137m behind plan of which £0.028m is within nursing pay and £0.082m unidentified.
- The Trust is forecast to make savings of £23.812m by year end, an underachievement against plan of £1.662m (94%).

Section 6 – Use of Resources Rating

The Trust's Use of Resources Rating is summarised below:

		Year to date	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		24.7	26.4
Metric Rating	20%	1	1
Capital servicing capacity			
Metric Result – times		3.5	3.6
Metric Rating	20%	1	1
Income & expenditure margin			
Metric Result		1.28%	1.28%
Metric Rating	20%	1	1
Distance from financial plan			
Metric Result		0.0%	(0.01)%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		56.1%	43.88%
Metric Rating	20%	1	1
Overall URR (unrounded)		**1**	**1.2**
Overall URR (rounded)		**1**	**1**
Overall URR (subject to override)		**1**	**1**

- The Trust's Use of Resources Rating for the period to 31st May 2018 is 1 against a plan of 1.

- The Trust is reporting a favourable variance against the control total of £0.009m. The Trust has assumed full achievement of quarter one ED performance. The year to date Provider Sustainability Funding (PSF) assumed for ED performance is £0.464m and Core PSF assumed is £1.084m.

Section 7 – Capital Programme

The Trust's sources and application of capital funding is summarised below:

2018/19 Annual Plan £m	Subjective Heading	Year to Date		
		Internal Plan £m	Actual £m	Variance £m
	Sources of Funding			
1.600	PDC	-	-	-
3.189	Borrowings			
3.000	Donations - cash	0.144	0.027	(0.117)
	Donations – direct	-	-	-
	Cash:			
24.338	Depreciation	3.950	3.946	(0.004)
14.962	Cash balances	(1.505)	(1.659)	(0.154)
47.089	**Total Funding**	2.589	2.314	(0.275)
	Application/Expenditure			
(11.618)	Strategic Schemes	(0.134)	(0.103)	0.031
(17.619)	Medical Equipment	(0.741)	(0.852)	(0.111)
(16.173)	Operational Capital	(0.864)	(0.332)	0.532
(7.711)	Information Technology	(0.589)	(0.845)	(0.256)
(2.367)	Estates Replacement	(0.261)	(0.182)	0.079
(55.488)	**Gross Expenditure**	**(2.589)**	**(2.314)**	**0.275**
8.399	In-year Slippage			
(47.089)	**Net Expenditure**	**(2.589)**	**(2.314)**	**0.275**

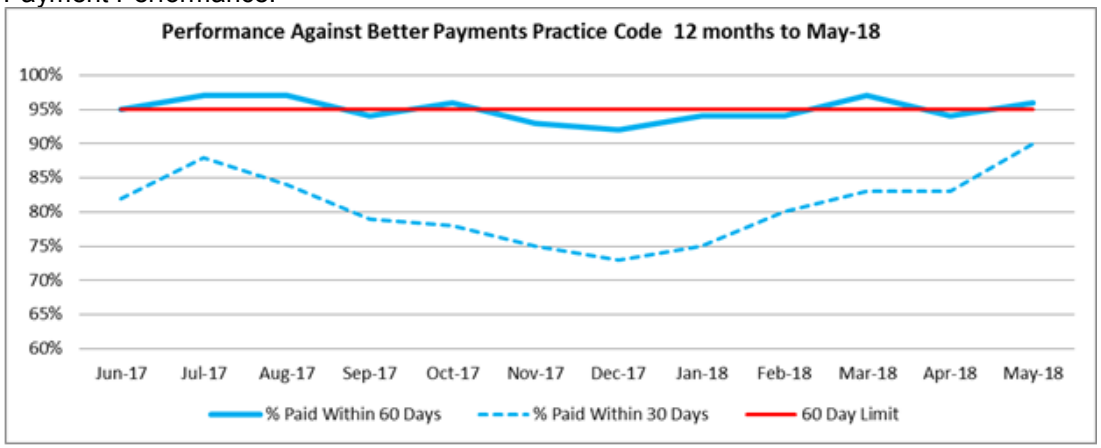
- The Trust has developed a detailed internal profiled plan which reflects expenditure monthly profiles provided through the Trust Capital Group.
- Capital expenditure was £2.314m to the end of May against an internal plan of £2.589m, £2.314m behind plan.
- Operational Capital is behind plan by £0.532m and Medical Equipment, and Information Technology are ahead of plan by £0.111m and £0.256m respectively.
- The operational capital slippage reflects timing delays on active schemes and an anticipated underspend on a prior year scheme which has now completed.
- Medical Equipment expenditure was £0.456m in month as a number of schemes delivered earlier than profiled.
- The IM&T variance relates to unfunded VAT of £0.265m. The Capita Programme Finance Manager is meeting with the Trust's VAT advisors to confirm the VAT recovery position on IT schemes.

Section 8 – Statement of Financial Position and Cashflow

Statement of Financial Position: (further information is at agenda item 4.1)

	Plan as at 31 May £m	Actual as at 31 May £m	Variance £m
Inventories	12.890	13.082	0.192
Receivables	25.002	33.025	8.023
Accrued Income	21.750	20.757	(0.993)
Debt Provision	(10.112)	(9.712)	0.400
Cash	88.974	78.472	(10.502)
Other assets	3.333	4.986	1.653
Total Current Assets	141.837	140.610	(1.227)
Payables	(41.027)	(33.900)	7.127
Accruals	(28.306)	(33.392)	(5.086)
Borrowings	(6.170)	(6.168)	0.002
Deferred Income	(6.481)	(5.149)	1.332
Other Liabilities	(2.770)	(2.755)	0.015
Total Current Liabilities	(84.754)	(81.364)	3.390
Net Current Assets/(Liabilities)	**57.083**	**59.246**	**2.163**

Payment Performance:



- Net current assets as at 31 May 2018 were £59.246m, £2.163m higher than the Operational Plan. Current assets and liabilities are lower than plan by £1.227m and £3.390m respectively.
- Inventories were £13.082m, £0.192m higher than plan.
- Receivables are £8.023m higher than plan due to the estimated 2017/18 quarter four invoices being credited and re-issued in June, a month behind the plan.
- The Trust's cash and cash equivalents balance at 31 May 2018 was £78.472m, which was £10.502m lower than the Operating Plan. The variance is the net effect of higher operating surplus, higher than planned receivables balance, slippage on the capital programme and higher opening balance.
- The total value of debtors was £34.022m, (£24.336m SLA and £9.686m non-SLA). This represents a decrease in the month of £3.883m (SLA decrease of £4.344m and non-SLA increase of £0.461m). Debts over 60 days old have increased by £12.572m to £26.950m, (increase in SLA of £11.452m and non-SLA of £1.120m). The SLA increase relates to the estimated invoices for 2017/18 month 12 which will be credited in June and re-issued with actual activity.
- In May, 96% of invoices were paid within the 60 day target set by the Prompt Payments Code and 90% were paid within the 30 day target set by the Better Payment Practice Code.

Section 9 – Risk

A separate report detailing Financial Risk has been submitted for the Committee in June.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Board of Directors meeting to be held in public on Thursday 28 June 2018 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	14
Meeting Title	Finance Committee		
Report Title	Chair's Report of the Finance Committee		
Author	Eric Sanders, Trust Secretary		
Executive Lead(s)	Paul Mapson, Director of Finance and Information		
Freedom of Information Status		Open	

Reporting Committee	Finance Committee
Chaired by	Martin Sykes, Non-Executive Director
Lead Executive Director (s)	Paul Mapson, Director of Finance and Information
Date of last meeting	26 June 2018

Summary of key matters considered by the Committee and any related decisions made.

This report provides a summary of the key issues considered at the Finance Committee on 26 June 2018.

Financial Risks

The proposed changes to financial risks, were considered in light of the new financial year and operating plan for 2018/19. The risk relating to delivery of the financial strategy and its interconnectivity with the medium term financial plan, which was due to come to the Board in July, was noted. The Committee supported the proposed changes which would now be considered by the Senior Leadership Team.

Finance Directors Report – Month 2 (May 2018)

The Director of Finance highlighted that the Trust's financial position was on trajectory and on plan year to date. The divisional positon was £420k adverse to trajectory but increased activity had supported the overall position. This increased activity included specialised services where the BHOC major incident had occurred. The increase was predominantly in emergency activity. There had been an increase in pay costs and work was underway to ensure that existing controls were still being applied. The slippage in the capital spend remained significant, and a review of the trajectory would be undertaken later in the year.

Contract Income and Activity Reports

Income was noted as £600k higher than plan and Sustainability and Transformation Funding was higher than plan due to an improvement in the Emergency Department performance in the previous month which was above the forecast level. The Committee noted that there had been corrections in predicting uncoded activity and more confidence in the predictions going forward.

Detailed Divisional Financial Reports

The Committee discussed the divisional financial positons and focused on the Medicine

division and the issues around use of agency staffing. Of particular concern were the increasing requirements for agency staff to support the care of patients with mental health conditions. This issue had been escalated and conversations were planned with commissioners.

Savings Programme

The overall programme was £400k behind plan, with Medicine and Women's and Children furthest behind plan. An improved methodology was now in place to measure productivity gains particularly around outpatients, theatres and patient flow. Further work was required on medical staff savings and medicines. The level of non-recurrent savings was discussed and whether this was sustainable, which the Committee felt it was following advice from the Director of Finance.

Capital Income and Expenditure Report

Capital expenditure to date was £2.314m compared to an internal plan of £2.589m. The key variances were in Operational Capital, Medical Equipment and Information Technology. An internal plan and profile were being developed to support overall delivery. The risks to divisions of delays in the capital programme were discussed and the process for mitigating this was highlighted and was noted as owned by the Operational Capital Group.

Statement of Financial Position

The current financial positon of the Trust was presented. A change to the Standing Financial Instructions was proposed following a treasury management audit. The Committee discussed the change and were supportive in principle but asked for a view from external audit and benchmarking with other similar Trusts prior to making a decision and making a recommendation to the Board of Directors. The Committee recognised that all write offs would be reported to the Audit Committee.

Capital Investment Policy

The revised policy was discussed. The Committee requested further detail on the changes and a change to the Committee roles and responsibilities was proposed and supported. The Committee agreed to review in July before presentation to the Board of Directors for approval.

The Committee noted the following reports:

- Month 2 NHS Improvement Submission
- Reference Cost Methodology

Key risks and issues/matters of concern and any mitigating actions	
None identified.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	25 July 2018

Cover report to the Public Trust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Agenda Item	15

Meeting Title	Public Trust Board
Report Title	**Audit Committee Chair's Report**
Author	Eric Sanders, Trust Secretary
Executive Lead	Robert Woolley, Chief Executive
Freedom of Information Status	Open

Reporting Committee	Audit Committee
Chaired by	David Armstrong, Non-Executive Director
Date of last meeting	23 May 2018

Summary of key matters considered by the Committee and any related decisions made.

This report provides a summary of the key issues considered at the Audit Committee meeting of 23 May 2018.

Annual Report and Accounts:

a) Head of Internal Audit Opinion

- A significant assurance opinion was provided by the internal auditors.

b) Significant Estimates

- A description of the estimates used to inform the accounts was presented. The Committee were reminded that the estimates were part of the accounting policies which they had previously approved and there were no changes from the estimates used in 2016/17. External audit had reviewed the reasonableness of the estimates and had found no issues. There were four significant estimates used related to the valuation of assets, impairment of assets, depreciation and month 12 income from activities

c) Finance Director's report on the Annual Accounts (including Accounting Policies)

- The Committee agreed the inclusion in the accounting policies of the process for managing uncoded activity at month 12 and approved the Accounting Policies.
- The Committee recommended approval of the Annual Accounts 2017/18 to the Board of Directors.

d) TACs Summarisation Schedules

- The Committee noted that the Trust Accounts Consolidation (TAC) Summarisation Schedules complied with the requirements of the regulator and were internally consistent with the Trusts annual accounts which had been subject to external audit.

e) Annual Report (including Annual Governance Statement)

- The Committee considered the draft Annual Report, noting that it included all of the mandatory requirements had been included in the document. Robert Woolley, Chief Executive, as Accounting Officer confirmed that all appropriate advice had been taken

to construct the report and that all assumptions, where necessary, were taken appropriately and there was no information not supplied to auditors that should have been.

- The Committee asked that the sections of the report which were less time restricted were presented for review earlier in the process, and this was agreed.

f) Auditor's Report with regards to the Audit of the Financial Statements (including the Management Letter of Representation)

- The External Auditors, PwC, presented their report on the annual accounts, the Value for Money conclusion and the opinion on the Quality Report. At the time of the Committee meeting, a number of areas of work were still being completed but they were confident that these would be completed to allow for signing in advance of the deadline.
- The auditors highlighted the receipt of sustainability and transformation funding received at the year end.
- There were no issues to report in relation to the identified audit risks.
- In relation to the Value for Money conclusion, the auditors had reviewed the Trust's financial and operational performance, and information from regulators. No issues had been identified, but there had been a failure to deliver a number of key operational targets. The auditors advised that they would review performance on a quarterly basis ahead of next year's audit.

Quality:

g) Quality Report

- The Committee received the statutory report developed in line with guidance from NHS Improvement. It was noted that the report had been reviewed by a number of groups in advance of the Audit Committee including the Senior Leadership Team, Clinical Quality Group and Quality and Outcomes Committee.
- The Committee recommend approval of the Annual Quality Report 2017/18 to the Board of Directors.

h) Auditor's External Assurance Report on the Quality Report (*External Auditor*)

- The external auditors presented their report on the Quality Report and confirmed that there were three areas of testing – whether the content was in line with the requirements from NHS Improvement, whether the report was consistent with the annual report, their knowledge about the organisation and information from other stakeholders, and finally the results of testing of a sample of indicators.
- In relation to the first two areas of the review no concerns had been raised.
- In relation to the testing of a sample of indicators, two had been mandated by NHS Improvement (Referral to Treatment (RTT) and A&E 4 hours) and one had been selected locally by the governors. The testing of the RTT indicator had identified eight issues which had impacted on the limited assurance report resulting in a disclaimed opinion for this indicator. It was acknowledged that a new live reporting system had been implemented half way through the year, and all issues had been identified prior to implementation of this new system. As there were no issues identified following the introduction of the new system, PwC reported no significant concerns. The testing of the A&E 4 Hour indicator had not identified any issues.
- The testing of the locally selected indicator (Non-purposeful Omitted Doses of the Listed Critical Medication) identified a number of issues, including the process, availability of data and the change to using an electronic prescribing system during the year. As such PwC were unable to substantively test the local indicator. The Committee noted that the indicator had been devised as a quality improvement

indicator and not as an operational performance indicator. The implementation of the e-prescribing tool would support review in future years. **Clinical Audit Quarterly Report** The Committee received the end of year update on progress against the plan of clinical audit activity, facilitated by the Clinical Audit & Effectiveness Team during the 2017/18 financial year, and an outline of the plan of clinical audit activity 2018/19.	
Key risks and issues/matters of concern and any mitigating actions	
There were no further risks or issues identified other than those highlighted above.	
Matters requiring Committee level consideration and/or approval	
None identified.	
Matters referred to other Committees	
None identified.	
Date of next meeting	15 July 2018

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	16
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**West Of England: Clinical Research Network (CRN) Annual Plan 2018 (hosted body report)**		
Author	Dr Stephen Falk- Clinical Director, Dr Kyla Thomas- Clinical Director Designate and Dr Sue Taylor- Chief Operating Officer		
Executive Lead	Mark Callaway, Acting Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☒	For Information	☐

Executive Summary

Purpose

The CRN West Of England secured a network budget increase of 1.6% for 2018/19 based on a number of variables, one of them being a continued increase in the percentage of commercial and non commercial studies closed having recruited to time and target. This was 76% for commercial studies, which is above the national average, and 74% for non commercial studies. The Annual Plan submitted to the Board for approval builds on the successes of 2017/18. The plan has been developed in collaboration with the network's partners and stakeholders. All partner organisations and Clinical Research Specialty Leads submitted a business plan and met with the leadership team to discuss the successes and challenges of 2017/18 and agree the priorities for 2018/19.

Key issues to note

The Plan has been approved in principle by the Clinical Research Network Coordinating Centre (CRNCC) in May 2018. An LCRN performance review of progress against the plan for Q1 will be completed on the 12 July 2018 with the CRNCC. LCRN Performance Review Meetings are held twice a year and provide an opportunity for the CRNCC Executive and Senior Leadership of each LCRN to meet and discuss network performance against the Annual Plan/Annual Report, achievements, challenges and contract compliance. This meeting will be attended by Dr Stephen Falk, Clinical Director, Dr Kyla Thomas, Clinical Director Designate and Dr Sue Taylor, Chief Operating Officer.

Recommendations

Members are asked to:

- **Approve** the Report.

Intended Audience **(please select any which are relevant to this paper)**									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk **(please choose any which are impacted on / relevant to this paper)**			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment **(please tick any which are impacted on / relevant to this paper)**							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

NHS
National Institute for Health Research

Clinical Research Network
West of England

Annual Delivery Plan 2018/19

Date of submission: 16/03/2018
Submitted by: Dr Sue Taylor, COO

Host Organisation Approval	
Confirmation that this Annual Plan has been reviewed and agreed by the LCRN Partnership Group:	No
Date of the LCRN Partnership Group meeting at which this Annual Plan was agreed:	06/06/18
Confirmation that this Annual Plan has been reviewed and approved by the LCRN Host Organisation Board:	No
Date of the LCRN Host Organisation Board meeting at which this Annual Plan was (or will be) approved:	28/06/18
If this plan has not been approved by the LCRN Host Organisation Board at the time of submission to CRNCC, then the LCRN Host Organisation Nominated Executive Director should provide that confirmation by email to the CRNCC once the Board has approved the Plan	

Section 1: Compliance with the Performance and Operating Framework

Please confirm, at this point in time do you anticipate the Host Organisation and LCRN Partners being able to deliver the LCRN in full compliance with the Performance and Operating Framework 2018-19?	**Yes**
If you have answered 'no' to this question, please identify below the specific areas/clauses of the POF which are of concern by selecting the appropriate boxes, provide a brief explanation of the reasons for non-compliance. Any area of non-compliance must be mitigated by the inclusion of a Key Project in Section 2 of this Annual Plan in order to achieve compliance. Include a cross-reference to the Key Project ID.	

POF area	**Yes**	**As indicated below**
Part A: Context		
3. Working Principles	Yes	
Part B: Performance Framework		
2. LCRN Performance Indicators		
2.1 High Level Objectives	Yes	**HLO 2A, 2B, 4, 5A and 5B for key deliverables to meet the target. See Key Projects section 2.**
2.2 Specialty Objectives	No	**We believe the following specialty objectives are not achievable due to factors out of partners and the networks**
2.3 LCRN Operating Framework Indicators	Yes	**3.1 No identified lead for Metabolic & Endocrine**
2.4 Initiating and Delivering Clinical Research Indicators	Yes	
2.5 LCRN Partner Satisfaction Survey Indicators	Yes	
2.6 LCRN Customer Satisfaction Indicators	Yes	
2.7 LCRN Patient Experience Indicators	Yes	
3. Performance Management Processes	Yes	
Part C: Operating Framework		
2. Governance and Management	Yes	
3. Financial Management	Yes	
4. CRN Specialties	Yes	
5. Research Delivery	Yes	**The existing Study Support Service process will be optimised during the next financial year to ensure maximum value**
6. Information and Knowledge	Yes	
7. Stakeholder Engagement and Communications	Yes	**Further investment within the communication team will be undertaken in 2018-19 to ensure the LCRN can align its**
8. Organisational Development	Yes	**Supra Regional Working, (please see key projects)**
9. Business Development and Marketing	Yes	

Ref	Key project	Outcome	Lead	Milestone	Milestone date
1. Governance and Management					
2.1.1	**Rotational Induction for Clinical Director Designate to National CRN Coordinating centre LCRN Liaison meetings**	As part of the Clinical Director Designate induction plan, in preparation for April 2019 handover, the CD Designate will attend the National CRN Coordinating Centre LCRN Liaison meetings on a rotational basis with the current Clincal Director	Dr Kyla Thomas	1. The CDD to have attended 40% attendance for National CRN Coordinating Centre/LCRN Liaison meetings in keeping with current PA allocation (2 PAs)	Q4
2.1.2	**Named Deputy Chief Operating Officer identified**	Nurse Consultant (seconded) will formally deputise on behalf of the Chief Operating Officer	Paula Tacchi	N/A	Q1
2.1.3	**Category B LCRN Partner flow down contract templates used to contract with all Category B LCRN Partners**	Supraregional approach to partner B contracts, with an external legal practice being approached to provide assurance of the contracts to partner B organisations	Supra Regional Approach	1. To have identified an external legal firm and agreed a standardised approach supra regionally, with CRN Wessex, CRN Thames Valley & South Midlands and CRN South West Peninsula	Q1
2.1.4	**Name and contact details for the individual within the LCRN Host Organisation with specialist knowledge of information governance who is available to respond to queries raised relating to LCRN-funded activities:**	Joe Ellis Information Governance Officer Joe.Ellis@UHBristol.nhs.uk 0117 342 3701			
2. Financial Management					
2.2.1	Section 5				
3. High Level Objectives					
2.3.1	**Extend support for health and social care research taking place in non-NHS settings.** Following the recent change to the portfolio inclusion criteria the Clinical Director Designate (a Consultant in Public Health) is leading plans to: • Scope open eligible studies which may benefit from the network support • Engage with local relevant academic departments / Chief Investigators to ensure CRN support is considered during study set up • Coordinate support for governance and applications in non-NHS settings (via the primary care embedded study support service) • Explore how to best to resource new areas e.g.upskilling existing Research Support Team and submission of a development bid to support a role which promotes further engagement with Local Authorities and Public Health England	Improve HLO1	Clinical Director Designate, Chief Operating Officer, Research Delivery Managers, Study Support Lead and Nurse Consultant	1. Scoping and engagement work is continuing from Q4 17-18. 2. Support for governance and applications in non-NHS settings will continue as currently and will be reconfigured as new national guidance is issued and in the service review (Ref 2.5.1 below) 3. Workforce training needs will be assessed on a per-study basis	Q1 Q3-4 Q1-4
2.3.2	**Expand use of Research Support Teams (Primary Care and Mental Health / Dementia)** **In order to better support research delivery across organisational boundaries and manage peaks in activity there will be a focus on expanding the use of the Research Support Teams. Skill sharing between the previously independent teams will also be explored.**	Improve HLO1	Nurse Consultant and Division 4 RDM	1. Map opportunities throughout year where teams can support peaks in activity (i.e. meet capacity demands for short duration / high recruitment studies e.g. vaccine studies) 2. Identify areas / studies where teams can more efficiently work together. 3. Develop areas where 'Research Practitioner' roles can support activity in Primary Care	Q1 Q1-2 Q1-4
2.3.3	**Staff skill mix / structure reviews** **Lead staff reviews in 2 Partner Organisations identified as being outliers regarding cost per ABF (to run in parallel with LCRN-wide staff review- Ref 8.2)**	Improve HLO1 (via increased return on investment within specified POs)	Nurse Consultant	1. Initial scoping 2. Consultation (where necessary) and implementation	Q1 Q2-4

2.3.4	**Implementation of recommended actions from LCRN Review Project** **In Q3 17-18 a Project was commissioned to investigate why the West of England CRN was falling behind on recruitment in comparison to other LCRNs. The report from the project is due at the end of Q4. Recommended actions from the report are expected to be implemented throughout 2018-19.**	Improve HLO1	All core team members where appropriate	1. Decision by Senior Leadership team as to which recommended actions to take forward (i.e. based on feasibility, available resource and potential impact etc.) 2. Planning and implementation of relevant future projects which will facilitate increased delivery.	Q1 Q2-4
2.3.5	**Root cause analysis of all commercial studies which do not achieve RTT** **To provide insight into future potential areas of improvement all commercial studies closing within secondary sites failing to meet RTT will be categorised and narrative recorded to explain why RTT was missed.**	Improve HLO2a in secondary care	IOM	1. Finalise categories and build drop-down / text field within EDGE to record reasons for not achieving RTT. 2. Monitor collection of data within POs 3. Analyse results and provide recommendations for Annual Plan 19/20	Q1Q1-Q4Q4
2.3.6	**Commercial Community of Practice** **Primary Care: To improve engagement with primary care commercial research delivery. A Primary Care Community of Practice group was established in Q4 2017-18. The group provides an opportunity for PCOs to share best practice on recruitment / feasibilities for commercial studies. 14 PCOs were represented at the first meeting and feedback indicated an interest to continue the group (i.e. teleconferences and face to face meetings).** **Secondary Care: Monthly teleconferences with PO R&Ds to facilitate flow of information from CRN CC to PO, share best practice, and identify areas for collaborative working across the network. For 2018-19, the group will explore the concept of network-wide feasibility.** **For both primary and secondary care, the LCRN is able to facilitate conversations and relationship building between POs/PCOs and sponsors through these community of practice**	Improve HLO2a in primary care	IOM	1. A development bid will be submitted to the LCRN Executive Group to fund a session of Primary Care Research Nurse time to continue to lead the project. 2. Teleconferences and face to face meetings will be facilitated by the IOM / Senior Portfolio Facilitator	Q1 Q1-4
2.3.7	**RTT Incentive Scheme** **Mirroring the national finance model, a local incentive scheme will be set up to reward achievement of RTT (including PCO and POs).**	Improve HLO2	IOM	1. Finalise structure for scheme (engaging with R&D Management Group and gaining approval from Executive Group) 2. A development bid will be submitted to the LCRN Executive Group to ring fence funding for RTT awards in primary and secondary care 3. Promote scheme with partner organisations and primary care organisations.	Q1-2 Q2-Q4
2.3.8	**Locally celebrate achievement of RTT** **Congratulatory letters, from the CD / COO, will be sent to PIs / Research Teams achieving RTT in commercial studies.**	Improve HLO2	IOM and Communications Lead	1. Letters will produced quarterly and articles throughout year	Q1-Q4
2.3.9	**Scoping best practice to achieve HLO4 and HLO5** To better understand how to improve HLO4 and HLO5 the Study Support Service Lead will contact locally and nationally high performing centres to learn of practices/ processes which may be applicable to sites within region.	Improve HLO4 and HLO5	Study Support Service Lead	1. Investigate local practices in locally high performing sites/teams along with practices in the 3 top performing LCRNs 2. Disseminate findings via R&D Management Group Meeting and monthly Study Support Service teleconference 3. Action plan any activities requiring implementation on a regional level	Q1 Q2 Q2-4
2.3.10	**Improving HLO6** The proportion of general practices recruiting to NIHR studies in 2017-18 was 96 out of 286. However, many practices are merging to cover larger population groups which will reduce the proportion of practices recruiting to NIHR studies. The availability of studies on the portfolio for primary care has also reduced substantially. The focus for 2018-19 will be to ensure that GPs are offered and supported to deliver any studies available to the region to ensure maximum engagement and to ensure that research is embeded into the new landscape.	Improving HLO6 for primary care	Nurse Consultant, Senior Research Officer for Primary Care and GP Champions	1. Shortage of Studies - advertising campaign/clearer systematic links with researchers 2. Future proofing the RSI scheme - to encourage research at scale and variation in research sites based on the successful North West Thames Model 3 Flexible Team development - cross-covering with MHT to eventual merge	Q1-4
4. LCRN Specialty Activities					

2.4.1	Specialty Lead Vacancy Intentional vacancy in Metabolic & Endocrine will continue in 2018-19. Role has been previously advertised without any applications. RDM will attend the National Specialty meetings.	Connection between LCRN and National Specialty group / cluster offices will be maintained by RDMs in the abscence of appointed CRSLs in Metabolic & Endocrine.	RDMs	1. Meetings will be attended throughout the year	Q1-4
2.4.2	**Induction for new Division 2 Lead** Plan to induct new Divisional 2 Le	To equip the new Divisional Lead with the necessery knowledge and information to perform the role	Division 2 RDM	1. Focussed sessions (CPMS, national / local funding models, local structure etc.) 2. Ongoing support provided by Division 2 RDM and relevant portfolio facilitator	Q1 Q1-4
2.4.3	**CRSL Review** All CRSLs are being asked to complete a survey at the end of Q4 17/18. The survey has a number of objectives: - To understand their training needs. - To assess their contribution to CRN business. - To re-affirm their responsibilities as a CRSL. CRSLs will also attend a mid-year progress meeting with their DL	- All CRSLs need the necessary knowledge and skills to perform their role both on a local and national level. - The CRSL role requires that individuals are committed to improving local participation in their specialty (where possible), and meeting their local and national responsibilities. - The survey is expected to highlight any areas requiring refreshing for 18/19.	CD, CDD and DLs	1. Surveys reviewed and feedback provided (including any areas requiring attention). 2. Action plans drawn up for any training needs identified. 3. Progress assessed at mid-year meetings. 4. Where needed, CRSL posts will be re-advertised	Q1 Q1 Q2 Q4
5. Research Delivery					
2.5.1	The core LCRN Study Support Service will continue to work closely with NHS Partners to deliver an efficient service. The aim for 2018-19 is to increase the numbers of core staff within the LCRN who are able to support the service by developing the portfolio facilitators through in house training to support local and practical application of the service. A review of the SSS will also take place with our Partners to ensure we are providing value for money, with a move to a centralised approach for oversight of service support costs.	To consistently deliver the local elements of the CRN's Study Support Service within West of England	Study Support Service Lead	Key Deliverables: 1.Review the primary and community research management and support and make recommendations for future provision of the service. 2. Continue with the early contact and engagement. 3. Provide study recommendations and risk assessments to other LCRNs. 4. Focus efforts on local community. 5. Review the matrix of responsibilities for the study support service for commercial, non-commercial and multi centred studies with all stakeholders with a mid-year evaluation to ensure it is effective service and make recommendations for future provision of the service. 6. Workshop with partner organisations and core team to identify and develop tools and materials to support them to deliver the service. 7. Work with the supra regional group to ensure continuous improvement of the service.	 Q3-4 Q1-4 Q1-4 Q1-4 Q2-4 Q2-4 Q1-4
2.5.2	**Coordinated working between Study Support Service and Industry**	To ensure consistent delivery of the Study Support Service for commercial research	IOM and Industry SPoC	1. Work closely with Industry Single Point of Contact, RDMs and Portfolio Facilitators to support commercial research and promote Study Support Service to customers. 2. Activities as described in 2.5.1.	Q1-4 Q1-4
2.5.3	**Accurate Minimum Data Set data** **Monthly reports are distributed to highlight missing data (and discrepancies between LPMS and CPMS within POs). The Portfolio Facilitators meet monthly with POs to understand and correct data. Sponsors are chased if recruitment isn't uploaded onto CPMS with an escalation pathway for non-compliance. Recently rolled out primary care report (where PCOs can check their performance data) to continue in 2018-19.**	Provision of near time Minimum Data Set data items	RDMs and BI Manager	1. Monthly reports from LPMS (EDGE) will continue to be shared with Partner Organisations R&D to identify missing data points and data quality issues within EDGE . 2. Ongoing data quality checks on Capacity and Capability data 3. HLO performance tabled at monthly R&D Management meeting. 4. Provide support to Partner Organisations who are not meeting the HLO requirements. 5. LCRN BIU to deliver CPMS/LPMS training to sites on request.	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4
2.5.4	Prioritisation of dementia research Development of the newly formed 'Mental Health and Dementia Research Support Team' (a regional team managed directly by the core team and therefore better able to work across boundaries) will continue in 18/19. Work will focus on: -Better connecting primary care sites (i.e. acting as PICs) with established research units. -Developing rater skills with the team and other delivery teams within region (including the Primary Care Research Support Team who can provide reciprocal cover). -Expanding research (along with the Primary Care Research Support Team) into local non-NHS settings (i.e. care homes).	Increase recruitment into dementia studies, particularly by working across traditional boundaries	Division 4 RDM	1. Formal 'launch' of the 'Mental Health and Dementia Research Support Team', and generation of promotional material to explain how the team can support studies. 2. Increase with 2 new organisations within region and demonstrate work linking multiple organsiations 3. Develop a programme to increase provision of rater training opportunties across LCRN 4. Collaborate with neighbouring LCRNs on projects	Q1 Q4 Q2 Q4

2.5.5	**Promotion of the use of Join Dementia Research (JDR)** **CRN West of England is engaging with an NIHR exemplar initiative 'Embedding Research In Care (ERICA)' which aims to sustainably embed / promote JDR within the wider NHS. Plan to test and evaluate projects before national launch.**	Increase number of people registering with JDR	Division 4 RDM	1. Establish Project Plan Board consisting of members interested in dementia (trusts, CCGs, AHSNs, Universities) 2. Formulate early project programme (determine scope of work and plan programme of work i.e. initiating 'quick win' projects and longer term objectives). 3. Deliver on project plan	Q1 Q1 Q2-4
2.5.6	**To facilitate collaborative working across primary and secondary care** To increase recruitment via PIC activity, open communication and collaborative ways of working across primary and secondary care will be developed. Lessons learnt from diabetes and dementia projects will be rolled out to other areas.	-Increase in PIC activity across primary and secondary care -Commercial research delivered across diverse healthcare settings	IOM and Primary Care Team	1. Inviting PO R&Ds to meet with PCOs within each locality will strengthen links between these organisations. Speciality focused events such as the Diabetes Regional Events held in April and September 2017 and the Dementia Outreach Project managed by the RICE centre will continue into 2018-19 and include representation from the LCRN to promote this joined up way of working. 2. Explore how we can utilise primary care and mental health peripatetic teams to expand industry offer into non-NHS settings such as community providers/care homes (linked to projects 2.3.1 and 2.3.2)	Q1-4 Q2-4
6. Information and Knowledge					
2.6.1	**Greater utilisation of ODP** Due to delays in research activity being uploaded to CPMS, performance reporting in West of England has typically represented LPMS research activity. Performance report generation has therefore focussed on the use of Excel / Access. With the advent of research activity being exchanged between LPMS / CPMS, there is a need to update the skillset with the core team to better manipulate charts etc. within ODP.	Make better use of ODP program to represent research activity, leading to greater insights into local performance/areas requiring attention. A particular focus will be increasing the use of Statistical Process Control charts.	BI Workstream Lead and BI Manager	1. All staff members who routinely generate reports to undergo ODP training 2. Link with teams within Supra Network who edit ODP for peer support and to develop joint projects. 3. Continue to provide ODP user courses for delivery teams (target to re-visit all major trusts and expand training to primary care teams). 4. Explore potential for digitalising ODP training materials e.g. through webinar system.	Q1 Q1-2
2.6.2	**Development of staff management tool** Due to plans to remove staff names from the to the CRN Finance Tool, a new process will need to be developed to provide adequate oversight of resource deployment with Partner Organisations.	Continuation of ability of Partner Organisations to provide assurance that CRN funding is being appropriately spent.	COO and BI Manager	1. A solution on a Supra regional level will be explored initially. 2. Work with local Data Protection Lead to assure PO's that the LCRN is compliant with GDPR.	Q1 Q1-2
2.6.3	**Extend use of LPMS in Primary Care setting** While the roll out of EDGE into CRN West of England Partner organisations has been completed, there has been limited implementation of the system in the primary care setting. CRN West of England will scope how LPMSs are being implemented in primary care by other LCRNs, exploring GP Practices' reception and engagement with their LPMS and evaluating the training and support needs of the practices. A project plan will be written to deliver an initial EDGE rollout phase to volunteer GP Practices in financial year 2019-20.	To plan for rollout of EDGE to General Practice in 2019-20.	BI Workstream Lead and BI Manager	1. Explore LPMS implementation in primary care with counterparts in other LCRNs and establish whether GP Practices are managing their own instances of their LPMS 2. Establish the feasibility of EDGE being implemented at the GP Practice level within CRN West of England 3. If feasibility is confirmed, identify GP Practices who will be early adopters of EDGE for initial rollout phase in 2019-20 4. Produce project plan for rollout phase in 2019-20	Q1-2 Q2-3 Q2-3 Q3-4
2.6.4	**To contribute to the planning and delivery of national BI initiatives** **BI Manager or nominated deputy will attend all meetings of national working groups including but not limited to the INSIGHT group, Virtual Business Intelligence Unit and ODP Developers. BI Manager or nominated deputy will also attend and contribute to national teleconferences including but not limited to CRN EDGE LPMS group, and vBIU ODP Developers**	To forward the national Information and Knowledge agenda whilst developing local skillset.	BI Workstream Lead, BI Manager and Portfolio Facilitators	1. Aim to have representation at all national meetings related to Information and Knowledge	Q1-4
2.6.5	**Community of Practice for BI** **BI Manager will lead the re-establishment of a community of 'EDGE Champions' in each PO and meet quarterly with an expanded remit to cover the use of all our business intelligence platforms (i.e. the Open Data Platform (ODP) and LCRN produced reports) and surrounding procedures (e.g. Study Change Log). The group will input into procedures, share best practice and ensure new developments are cascaded to POs.**	Better understanding and use of all features of BI tools (ODP, EDGE,local processes) leading to more efficient working.	BI Manager	Root cause analysis of all commercial studies which do not achieve RTT To provide insight into future potential areas of improvement all commercial studies closing within secondary sites failing to meet RTT will be categorised and narrative recorded to explain why RTT was missed.	Q1 Q2-4
7. Stakeholder Engagement and Communications					

2.7.1	**Delivery of LCRN PPIE Inititives** CRN West of England will collaborate with POs and People in Health in the West of England (PHWE), to coordinate the delivery of PPIE activity across the LCRN.	Deliver CRN PPIE initiatives locally	PPIE Workstream Lead	1. The LCRN will appoint a communications assistant in Q1, the post holder will assist in delivering the LCRN PPIE strategy. 2. The LCRN will continue to fund P/T administration post in PHWE, to facilitate the delivery of the Patient Research Experience Survey and Patient Research Ambassador Inititive across the PHWE PPIE network .	Q1 Q1-4
2.7.2	**Patient Research Experience Survey (PRES)** In partnership with POs and delivery teams across the network, the LCRN will coordinate the design,delivery and reporting of the 2018-19 Patient Research Experience Survey.	2018-19 PRES designed delivered across all partner organisations	PPIE Workstream Lead	1. PRES working group, which includes representatives from all POs, LCRN public contributors, LCRN PPIE lead and communications manager, will meet in Q1. 2. the group will review results and report on 2017-18 survey. The report will be shared with all POs, recommendations will inform opportunities for learning and improvement for the LCRN and POs, to improve patient experiences. 3. The working group will design and plan delivery of the 2018-19 survey.There will be a focus on the delivery strategy for 2018-19 PRES, with the aim of increasing the number of respondents across the network. CRN LCRN had 307 respondents in 2016-17, this increased to 332 in 2017-18 using a similar delivery startegy. In 2018-19 new startegies to increase uptake will be explored, this will include a digitalised approach and utilising PRAs embededed in POs. 4. This work will be carried out in collaboration with all POs; the working group will explore a digital strategy in an attempt to increase the response rate. Local Patient Research Ambassadors will be included in the delivery strategy of the PRES 2018-19, utilising PRAs within POs to promote and raise awareness of the PRES and the importance of recording research participants experience in research	Q1-4
2.7.3	**Young Persons Patient Research Experience Survey (PRES)** •In partnership with a local young persons advisory group, the LCRN will coordinate the design, planning, delivery and reporting of a young persons survey in 2018-19. •The LCRN PPIE Lead will facilitate contact with YPAG groups across the supra network, in an effort to create one collaborative YPAG group across the supra network region, with an aim to work on a young persons PRES which could be utilised across the the Supra network.	2018-19 Young persons PRES designed delivered in the region Two young people from each network in the Supra regional network will be identified to create a working group for a Supra regional young persons PRES	PPIE Workstream Lead	1. Local Young Person Advisory Group (YPAG) will design a PRES for their age groups in 2018-19. 2. Two members of the YPAG group will lead this project in 2018-19.	Q1
2.7.4	**Patient Research Ambassador Initiative (PRAI)** **In 2017-18 the LCRN in collaboration with PHWE launched the PRAI throught its extensive PPIE network. At present there are a small number of PRAs locally. In 2018-19 the LCRN in collaboration with current PRAs and PPIE leads across the network will undertake a project to define the role locally and embed PRAI leads into POs**	Definition of PRA role locally, PRAI strategy for 2018-19	PPIE Workstream Lead	1. LCRN PPIE lead will facilitate a workshop in Q1-2 to define the role of the PRA locally. PPIE leads from POs, local Universities, partner organisations from PHWE, public contributors will be invited to the workshop. 2. An outcome will be a PRAI strategy for the LCRN, which will include the identification of a PRAI lead from POs and other stakeholders across the network. 3. This work will be undertaken while communicating with PPIE leads across the Supra Network, in an attempt to standardise the PRAI across the four networks.This will build on discussions and communication platforms which arose from the Supra Network event in Sept. 2017	Q1-2
2.7.5	**Evidencing inclusion and diversity** In line with the Patient and Public Reach Framework . The LCRN and PPIE partner across the network will pilot a system to record and share the range of PPIE activities that is happening locally (Register of LCRN PPIE Activities).	A report recording the reach and contact with patient and public groups across the LCRN.	PPIE Workstream Lead	1. The LCRN PPIE lead and LCRN communications manager will coordinate a scoping exercise across PHWE organisations and their PPIE registers, which include 700+ patients and members of the public. The aim will be to better understand and map inclusion and diversity across the PPIE network in the LCRN.	Q2-3
2.7.6	**Pilot of National Standards for Public Involvement** PHWE (PPIE Leads from all organisation and public contributors) held a workshop in 2017, to discuss the draft National Standards for Public Involvement document. The outcome was a collaborative written response to the standards consultation. PHWE have submitted an expression of interest to be a test bed site for piloting of the national standards in 2018	LCRN and PPIE partners will be successful in their bid to be involved in the national pilot of the public involvement standards	PPIE Workstream Lead	1. PHWE will submit an expression of interest to be involved in the national pilot of the standards,putting the standards to practical use in their own working environment and sharing what they learn.	Q1-4

2.7.8	**Stakeholder Engagement and Communications** **A review of the operational aspect of the communications plan will take place in 2018 in order to renew and refresh communication goals and objectives in order to ensure value for money.** **This will coincide with an increased investment in the communication team**	To deliver the items as set out in the Communications Contract Support Document	Communications Manager	1. An RDM has been assigned as Communications Lead to oversee the communications strategy and line manage the Communications Manager. There will be further investment, manifest as additional communications support, in order to meet the requirements of the POF, NIHR strategies and the LCRN Communications Plan 2018-19. 2. A working group, led by the Communications Manager and PPIE Lead will be set up and operational in Q1 to create a Communication Plan that will asssist delivery of the LCRN Annual Plan 2018-19. 3. In accordance with the POF, a ring-fenced budget of c.£5k will be provided for planned communications and JDR activities, with monthly updates provided to the Finance Team. 4. The communications Manager will work in partnership with PPIE Lead to deliver Stakeholder Engagement and Communications function. 5. The Communication function will be developed to : -Contribute to and support national CRN and NIHR campaigns and initiatives such as Join Dementia Research (JDR) and the UK Clinical Trials Gateway (UKCTG). -Maintain microsite with up-to-date and relevant information. -Further communications activities supporting LCRN research delivery such as specialty specific promotional materials and support of speciality specific engagement events. -Work with supra-regional partners on areas of common activity -Build on existing links with other NIHR infrastructure via the local networks Communications group which includes representation from WEAHSN, CLAHRC West, Bristol Health Partners and local HEI's. 6. Build on existing links with the NIHR funded research infrastructure group for NIHR Managers West of England, Clinical Trials Units, CLAHRC, Biomedical Research Centre and Schools for Public Health and Primary Care Research to increase our cross working and collaboration.	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4 Q1-4
2.7.9	**NHS Engagement Strategy**	Development and implementation of a plan to deliver the NHS Engagement Strategy	Communications Lead	RDM assigned as Communication Lead to: Develop further a high quality and responsive relationships with key stakeholders and partners. To ensure stakeholders have easy access to the information they need in a way they would choose to access it and ensure the LCRN develops and communicates its broad engagement across the health and social care system nationally, regionally and locally. -Improve awareness and understanding of the work and impact of the LCRN. -Measures of success are shared and understood.	Q1 Q1-4
2.7.10	**Improving Access to Digital Technology. There are currently barriers in place which prevent full and effective use of NIHR communication tools and technology. There will be a focus on identifying and working to resolve them to enable the LCRN to increase effectiveness in delivery of core business**	Removal of barriers currently in place to enable increased effectiveness of use of NIHR and other digital communication tools	CI Workstream Lead and Communications Manager	1. Identification of ability of LCRN funded staff to access NIHR Hub, digital and social media and barriers currently in place a) within the core LCRN and b) within Partner Organisations. 2. Scoping work to identify other LCRN's who have encountered these barriers and how they overcame them. 3. Make recommendations on how to overcome these barriers. 4. Aim to implement recommendations.	Q1-4
2.7.11	**Improving effectiveness of EOI Process. A process exists to ensure relevant PO's and health professionals are kept informed of relevant opportunities to get involved in portfolio studies, however some issues have been identified and it is suspected the conversion rate of EOI's to actual studies in the LCRN is not as high as it could be. The process will be reviewed in 2018-19 to identify and implement recommendations for improvement/**	Improve communication and transparency throughout the entire process. Improve stakeholder engagement and satisfaction. Improve conversation rate from EOI to new studies in the LCRN.	CI Workstream Lead	1. Assess baseline stakeholder satisfaction, request suggestions for improvement, request feedback on potential items to mechanisms to improve process. 2. Process map the entire process with relevant internal and external stakeholders. 3. Identify barriers and areas of duplication. 4. Remove areas of duplication and make recommendations to overcome barriers. Implement new streamlined process 5. Assess stakeholder satisfaction post new process.	Q1-4
8. Organisational Development					

2.8.1	Workforce - PI Development PI training materials are available for trusts to use as appropriate. We will refine these to provide specific resources to enable the (1) development of (Nurse, Midwife, Allied Health Professional) NMAHP PIs in both Primary and Secondary Care and (2) provision of Industry focussed resources for use in Primary Care.	Implementation of (1) PI training program for NMAHP PIs in Primary and Secondary Care; (2) Industry focussed PI training for Primary Care practices and an increase in the number of commercial PIs	Nurse Consultant	1. PI training materials distributed across the partner organisations for their adaption and delivery to meet local needs. 2. Adapted for specific audiences to include: Development of the NMAHP PI workforce in Primary and Secondary Care; Focus on Industry active practices in Primary Care. 3. Implementation of these training materials with a minimum of one session per audience. 4. Include commercial focus for specialty specific PI training.	Q1-Q4
2.8.2	**Workforce review** Using new template to map the workforce, needs and development within the LCRN and across the partner organisations.	Completion of workforce review which will enable the development of a long term workforce development plan which is responsive to local needs	Nurse Consultant	1. Research Infrastructure Workforce Committee utilised to support gathering the information needed to complete the review.	Q1 - Q2
2.8.3	**Wellbeing Plan** For 2018-19 there will be a focus on Wellbeing activities within the LCRN core team. These will be overseen by the wellbeing lead and expect to be supported by volunteer 'wellbeing warriors'.	Development and implementation of a Wellbeing program of activities for staff within the LCRN core team	Nurse Consultant	1. Identification of 'wellbeing warriors' from within the LCRN core team. 2. Wellbeing activities will be prioritised and agreed. 3. Monthly wellbeing focus sessions included in the staff meeting schedule. 4. Quarterly focus on specific trust policies which support both managers and individual staff to enable wellbeing at work.	Q1-Q4
2.8.4	**Improving skills and confidence in use of digital tools and technology**	LCRN core and funded staff have improved skills and confidence in the use of digital tools and technology.	CI Workstream Lead, Nurse Consultant and Communications Manager	1. Assess baseline confidence and skill level of staff in using digital tools and technology. 2. Identify areas where increased skills and confidence and required. 3. Identify best intervention mechanisms to improve each skill 4. Implement interventions. 5. Assess confidence and skill level after intervention.	Q1-4
2.8.5	**Improving awareness, knowledge & continuous improvement skills of LCRN staff**	LCRN core and funded staff have access to materials to increase their continuous improvement skills, knowledge and awareness.	CI Workstream Lead	1. Work with the NC to review what current awareness, skills and knowledge is present and review training and development needs. 2. Identify what other organisations (PO's, AHSN, BHP, CLAHRC West, HEIs) are offering in terms of CI skills and development. 3. Work with Communications Manager to ensure that all relevant staff have knowledge about how to access appropriate materials to improve their skills, knowledge and awareness as appropriate.	Q1-4
2.8.6	**Exploring scope for digitalising development materials and processes.** **The aim for 2018-19 will be to streamline and automate some processes involved with the learning and development programme. The LCRN will also explore whether there is potential for development of some digital based services such a local induction webinar for LCRN funded staff.**	Recommendations are made to digitalise materials and processes in learning and development where appropriate	CI Workstream Lead and Nurse Consultant	1. Review current learning and development materials format and processes. 2. Scope other LCRN's to identify which have become more digitalised. 3. Assess which materials and processes within CRN West of England have potential to adopt these processes. Make recommendations for implementation within the LCRN e.g. webinar for local induction of LCRN funded staff.	Q1-4
2.8.7	**To implement the Improvement and Innovation review proposals**	Implementation of the Innovation and Improvement Framework via key projects which support the CI workstream via other workstreams.	COO and RDMs	The LCRN has a culture of Continuous Performance Improvement therefore all key projects also support the CI workstream.	Q1-4
2.8.8	**Increase supra-regional working**	To increase collaboration across neighbouring LCRNs, share best practice and reduce duplication.	COO and each Workstream Lead	1. All work streams will participate in supra regional meetings. 2. The meetings will have a common structure and framework and will identify shared work stream priorities. They will also: 2.1 Meet face to face twice a year. 2.2 Report outcomes of meetings to quarterly COO meeting. 2.3 Work to a common Terms of Reference.	Q1-4
9. Business Development and Marketing					
2.9.1	**Support locally led commercial research** **Meet with the local AHSN and SMEs to supplement the flow of national commercial research by promoting home-grown industry research**	LCRN/SME partnership	IOM	1. Meet with WEAHSN and local SMEs to increase proportion of locally lead NIHR commercial studies on the local portfolio. 2. Collaborative working with the local AHSN and CLARHC on the Innovation Exchange model for the Accelerated Access Review.	Q3-4 Q1-4
2.9.2	**Support national business development initiatives** **Work with local Investigators to develop a strategic plan to support the national interests of Biosimilars studies. The challenge to delivering on this priority will be the availability of studies on the Portfolio.**	Increase in Biosimilar research activity	IOM and Communications Lead	1. Work with the Communication Lead to raise awareness of Biosimilars in order to increase the LCRN support for biosimilars in 2018-19. 2. Success measured through an increase in the number of patients with greater clinical experience with biosimilar compounds.	Q2-4

2.9.3	**To promote the LCRN industry agenda** Develop our external-facing industry processes so the network is seen as an attractive place to bring new studies and ensuring our offer delivers to and beyond expectations of the life sciences industry	Increase the number of commercial studies delivered within LCRN	IOM	1. Industry workstream lead to meet with sponsors on a strategic level regarding coordinated work with performance and pipeline throughout year, initially focussing on those with the largest number of trials within the LCRN. 2. Collaboration with Communications Lead for communication materials to promote LCRN industry offer to POs/PCOs. Industry Workstream Lead to attend specialty specific regional events to promote the Life Sciences Industry Strategy. 3. Industry Workstream Lead to conduct a scoping exercise with three high performing LCRNs for industry to understand best practice and identify industry processes to be considered for adaptation and adoption in the West of England.	Q1-2 Q1-4 Q3-4
2.9.4	**Ensure the provision of NIHR CRN Study Support Service offer for Industry Costing Template validation process**	Ensure Industry Costing Template validation within 3 working days	IOM and Industry SPoC	1. Industry Workstream Lead and Industry SPoC (managed by Senior PF) to provide an efficient and standardised Industry Costing Template Validation service to life science companies to reduce queries and duplication from participating POs	Q1-4

Section 3: High Level Objectives Targets		
HLO	**LCRN Target**	**CRNCC Target**
1	21905	To be populated by CRNCC.
7	550	To be populated by CRNCC.

Section 4: Specialty Objectives					
Ref	**Specialty**	**Local activities to achieve the national objective**	**Timescale**		
1	**Ageing**	-CRSL due to return from maternity leave in May, initial focus will be on induction to CRN, role and local portfolio of ageing studies (currently 1 study) -All ageing studies open to new sites will be assessed for suitability at local sites and approaches made to potential PIs, including those early in their career. -Explore potential for recruiting across geriatrics as ageing is one of RUH's priority research areas. -Explore potential for increasing collaborations with RICE and Designability to enable further activity within this area.	Q1-2		
2	**Anaesthesia, Perioperative Medicine and Pain Management**	The LCRN has an actively recruiting Trainee Network (Severn Trainee Anaesthesia Research-STAR). -CRSL to continue to meet with STAR Committee a minimum of three times a year and monthly with the STAR trainee lead to review portfolio and share best practice. -Encourage participation in and support recruitment to trainee-led studies such as SWeAT (CPMD ID: 32193), DALES and ATOMIC (CPMS IDs: TBC) to deliver RTT. -Encourage trainee involvement in consultant-led studies such as FLO-ELA (CPMS ID: 33869) and PQIP (CPMS ID: 34612) to increase training and research experience of trainees and deliver RTT. -CRSL to support and supervise trainee led funding applications to at least one national grant e.g. VASGBI trainee development grants and NIAA grants. -CRSL and RDM to work on supporting studies to open at all five eligible POs (GRH, GWH, NBT, RUH and UHB) to maintain and increase research opportunities	Q1-4 Q1-4 Q1-4 Q1-4 Q1-4		
3	**Cancer**	-RDM will build on collaboration with a well-established network through South West Cancer Alliance providing a forum for the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) network, using the SWAG network to raise awareness of new portfolio studies. - RDM will attend Speciality group meetings, with a standing research agenda item to report SSG performance across the network, launch new studies across the network, encourage network wide target setting and intra network referrals into trials. - Subspecialty leads (SSL) are the SWAG research leads, all SSGs meetings (Biannual) will be used as an opportunity for RDM and SSLs to review the subspecialty performance and identify suitable studies from the national portfolio to open at sites in the LCRN. - LCRN will continue engagement with 100,000 Genomes project, staff from inception have been integrated into the relevant research teams recruiting in cancer pathways. There will be trust steering group meetings to explore further areas of growth across different specialities. RDM will engage with the steering group, to support increased recruitment of cancer patients to the project across the region. - GWH cancer research delivery team has undergone restructure, this has affected recruitment to cancer trials at GWH, recruitment to a number of studies suspended, no new studies opened 2017-18. CRSL, RDM and PF will support GWH to reopen suspended studies and explore areas where there is capacity to open new studies in 2018-19. - LCRN workforce development lead and RDM will work with R&D, research delivery team and cancer PI's at GWH , to review skill mix and capacity within the team, a measure of success will be new cancer studies opened and recruiting in 2018-19. - GWH is within CRN LCRN, however the cancer clinical referral pathway is towards CRN Thames Valley & South Midlands, this presents some challenges in the delivery of cancer research at GWH. RDM will meet with CRN Thames Valley cancer RDM, to explore collaboration between both networks, in relation to supporting and growing the cancer portfolio at GWH. - Building on the success of last years collaboration with CRN South West Peninsula, running a colorectal research study day. RDM and CRSL will explore running another study day in collaboration with CRN South West Peninsula, in a chosen subspecialty, to engage with clinicians, trainees and research delivery teams across both networks, raising awareness of current studies and highlighting opportunities for new studies, or collaboration opportunities in the chosen area. We will encourage members to join and contribute to CSG. Specific Area for focus 2018-19: - Palliative Care and Supportive Services, RDM, CRSL, LCRN Primary care lead will meet , to explore opportunities for growth in the this areas. Links will be developed with local hospices, to identify training needs and capacity to delivery Palliative Care and Supportive Services research across the network. - RDM will liaise with Sue Ryder Hospice in Gloucestershire ,learn from their success in this area. Best practice can be shared to other hospices in the region. Liaise with CRN Kent, Surrey and Sussex and CRN Yorkshire and Humber, to share intelligence in this area of research, both networks have a strong portfolio in this area.	Q1-4 Q1-4 Q1-4 Q1 Q1-4 Q1-2 Q1 Q1-2		
4	**Cardiovascular Disease**	-CRSL and RDM to gather information from R&Ds and launch survey to identify cardiac surgery staff within POs and non-NHS organisations. -In collaboration with Workforce Lead, arrange PI Masterclass training sessions with the aim to increase research activity within CVD surgery teams. A key challenge will be establishing new links and increasing engagement from cardiovascular surgery staff in NIHR Portfolio research in addition to research from BRC. -Establish a process for regional referrals for cardiac surgery studies to increase recruitment and develop collaborative ways of working.	Q1 Q2-4 Q1-4		
5	**Children**	Target 90%. Baseline 6 of 9 Trusts (67%). Two of the other three trusts provide CAMHS services and not general medical care therefore any children recruited through CAMHS are likely to go into MH badged studies. GCS not currently recruiting into children's studies (previously non-recruiting PO). Baseline 86% if CAMHS population excluded from metric. Also multiple studies recruiting children in primary care setting. -Continue to routinely examine and review the portfolio for suitable studies to open in sites not currently recruiting children. -Explore the potential for developing collaboration with primary care and community settings to recruit children to studies -GCS and 2gether will be one organisation by the end of 2018-2019. Continue to engage with both organisations around studies that recruit children, assessing feasibility for local delivery. -Continue to review studies allocated to other specialities that recruit children to assess feasibility for opening in CRN West of England sites.	Q1-4 Q1-4 Q1-4 Q1-4		

6	**Critical Care**	-Maintain current level of five ICUs (100%) recruiting into studies on the NIHR CRN Portfolio (GRH, GWH, NBT, RUH and UHB) to maintain research opportunities. -Build on success of Critical Care meetings in 2017-18 and hold another event in Q3/4 to promote and generate research. -Explore possibility of opening up invitation to anaesthesia and injuries and emergency specialty colleagues to share best practice and increase collaborative working. -Use Critical Care event and newly formed 'Critical Care Research Group' as a platform to encourage and develop at least one successful grant submission from the South West to NIHR by March 2020. -Liaise with relevant R&D about potential applications. -Develop promotional materials to showcase specialty.	Q1-4Q3-4Q2-4Q1-4Q2-4Q1-4		
7	**Dementias and Neurodegeneration**	-Scoping work to identify local early career researchers though a local health integration team (HIT) initiative. This will be carried out via the new local Dementia Researcher website as part of the HIT workplan. -Identified individuals will be invited to join a local community of early career researchers using platforms such as the Dementia Researcher Website or g+. -Plan to hold an event for community to provide an opportunity to: raise profile of dementia & neurodegeneration research / network with peers / share best practice and learn from more experienced PIs within the region (using the PI masterclass materials) -Build on existing centres with successful research portfolios e.g. RICE.	Q1 Q2-3 Q3-4		
8	**Dermatology**	-Currently no nurse PIs in post. However reconfiguration to a regionally based service offers significant opportunities for 2018-19.-CRSL and RDM to identify su	Q1-4 Q1-4 Q2-3		
9	**Diabetes**	Continue to improve and develop primary-secondary care collaboration in the delivery of Diabetes research through the role of the Diabetes Project lead by: -Continuing to develop the regional meetings bringing together all stakeholders. -Building COPs across primary and secondary care through improved communication. -Sharing best practice across research sites, by leading COPs. -Feedback and involvement of the PPI group to shape the development of the project. -Support for sites when completing expressions of interest. -Engaging industry with research teams, raising the profile of diabetes research within the region, through the development of promotional material of research conducted in our region.	Q1-4		
10	**Ear, Nose and Throat**	-Advertise, identify and appoint a local NIHR specialty trainee lead for ENT, hearing and balance research.-CRSL and RDM provide support to trainee lead to ec	Q1-4Q1-4Q1-4		
11	**Gastroenterology**	-Identify and appoint a new CRSL for the specialty. -Identify studies on the portfolio where patients could be referred from primary care. -Identify and collaborate with two primary care practices in Gloucestershire to increase referrals from primary care.	Q2-3 Q1-4 Q2-4		
12	**Genetics**	-Continue to ensure all early career researchers have exposure to NIHR portfolio research via existing mechanisms, assessing baseline in April 2018 and progress at March 2019 -Work with relevant 100K Genome project staff to identify ways to support this project appropriately in LCRN recruiting sites	Q1-4 Q1-3		
13	**Haematology**	-Continue to ensure involvement of all trainees in NIHR portfolio research via existing mechanisms. -Continue to pursue formalisation of agreement with Severn Deanery to include research as part of training programme.	Q1-4 Q2-4		
14	**Health Services Research**	-The LCRN has 6 secondary care sites and all have taken part in HSDR portfolio research in the last 2 years. In addition there were 40 GP sites who engaged in HSDR as well as 2gether (community mental health). -The aim is to recruit new non-secondary care sites, where appropriate, as this will depend on the specific study by more active engagement with the primary care team at the CRN or other portfolio facilitators.	Q1-4		
15	**Hepatology**	Currently recruiting to the portfolio in the disease areas of Cirrhosis and NASH. -Continue to work on engaging with relevant individuals and teams throughout the region. -Organise and host an event “Raising the profile of hepatology research” to bring involved and interested individuals together to increase collaboration within the region.	Q1-4 Q3-4		
16	**Infection**	-No current named champion in post. -Agree remit of role of champion for sexually transmitted infection. -Advertise, identify and appoint suitable candidate. CRSL has already identified a suitable candidate to approach but advert will go out across the LCRN. -CRSL and RDM to orientate and provide support to champion to equip them with knowledge to grow research in the LCRN. -CRSL and champion to develop plan for growing research in the LCRN. -CRSL and RDM to work on developing the portfolio to increase research opportunities. -Consider holding a stakeholder engagement event locally or adding LCRN to agenda of a pre-existing meeting/event.	Q1 Q1-4 Q1-4 Q1-4 Q1-4 Q3-4		
17	**Injuries and Emergencies**	-LCRN actively involved in pre-hospital studies. National emergencies lead has a particular research interest in this area and is based in our network -CRSL and RDM meeting at least once and build links with both CRN South West Peninsula and the Ambulance Trust (based in CRN South West Peninsula and responsible for services in CRN West of England) to agree future collaboration. -Supporting the three POs outside of Bristol (GRH, GWH and RUH) to develop their research portfolio to increase research opportunities and encourage participation as appropriate new studies come online.	Q1-2 Q1-4		

18	**Mental Health**	-RDM and CRSL to continue work with the 2 CAMHS Champions to site new studies within region. -Where appropriate, the Regional Mental Health and Dementia Team will assist with set up and delivery. New reinvigorated academic unit in Bristol should start to develop and recruit to home grown studies. Move to regionally based team should exploit strong recruitment growth in Gloucestershire.			
19	**Metabolic and Endocrine Disorders**	This objective will be met through the diabetes workforce due to an inability to recruit to this post	Q1-4		
20	**Musculoskeletal Disorders**	-Advertise, identify, appoint and support Orthopaedic Champion role. There is a strong academic department in this area. -In 2017-18 Q4, PIs for Musculoskeletal Disorder NIHR Portfolio studies within the region were invited to apply for the Co-Lead role of Clinical Research Specialty Lead in Musculoskeletal Disorders. Once appointed, we will be inducting and supporting this person in their role	Q1-2 Q1-4		
21	**Neurological Disorders**	-CRSL role currently out to advert and expectation is that post will be filled in Q1 2018-19. Remit of successful applicant will be mentoring junior researchers -Initial focus will be on induction to CRN, role and local portfolio of ageing studies (currently 7 studies) -All neurological disorder studies open to new sites will be assessed for suitability at local sites and approaches made to potential PIs, including those early in their career -Scoping work will be carried out with higher recruiting regions (in terms of both number of studies and recruitment) to understand best practice to improve performance in West of England	Q1 Q1-2 Q1-4 Q2-4		
22	**Ophthalmology**	-Continue to build Ophthalmology community of practice to encourage and support increased participation in NIHR Portfolio studies. To develop this community, we will identify and invite other interested researchers within the region in order to improve access of research to patients of organisations providing eye services. -Tracking patients across organisations as services move (i.e UHB to WAHT) to help to build stronger links for research within the region.	Q1-4 Q1-4		
23	**Oral and dental health**	-To work with the NIHR CRN CC National Dental lead based within region with the aim of developing a plan to engage the dental workforce community in research following clarity around the JLA priority setting partnership .	Q1-4		
24	**Primary Care**	-Severn Deanery have agreed to support the research champion posts -GP ST3 research champion scholarship programme 2 posts will be advertised on the deanery website	Q1-4		
25	**Public Health**	-Production of a LCRN England Public Health Partnership Research work plan. -At least two LA PH departments in LCRN with a clinical academic appointment/number of appointees. -Number of LA PH departments in LCRN with an internal research function/ formal relationship with the university. -Develop existing relationships with local SPHR to encourage enrolment of PH studies on to the LCRN portfolio.	Q1-4 Q1-4 Q1-4 Q1-4		
26	**Renal Disorders**	Currently six open commercial studies with 5 different PIs, (growth of two over last year). -Identify current PIs with no commercial activity in the last three years from the NIHR CRN Portfolio to identify additional potential new commercial PIs. -There is potential to continue growth and development of renal portfolio in GHFT, including commercial studies. Assess all commercial studies requesting expressions of interest within Gloucestershire for feasibility. -Organise and host an event “Raising the profile of renal research” to bring involved and interested individuals together to increase collaboration within the region and develop our regional profile for renal commercial research.	 Q1-2 Q1-4 Q2-4		
27	**Reproductive Health and Childbirth**	Objective A: 83% (5/6) acute NHS Trusts providing maternity services are currently recruiting into RH&C studies. The non-recruiting site essentially now has only a small midwife led unit therefore aim to maintain this at 83%. -Continue to support COP of senior midwives who collaborate effectively to ensure all sites are informed of pipeline studies, assess feasibility of potential new studies and troubleshoot difficulties with open studies. -Identify all potential studies allocated to specialities outside RH&C to assess feasibility for delivery by RH&C teams. -Explore potential for increasing activity in other sub-specialities including neonatal, gynaecology & fertility. -Continue to grow links with regions outside CRN West of England via the RH&C champions & co-speciality lead to try and attract more studies to the region at an earlier stage of development -Explore potential to increase links with commercial companies on both RH&C portfolio and and cross-speciality studies e.g. gestational diabetes. Objective B (Recruitment within the LCRN geography as a proportion of infant mortality data for that region) Awaiting clarification from Coordinating Centre	Q1-4 Q1-4 Q1-4 Q2-4 Q1-4 Q3-4 TBC		
28	**Respiratory Disorders**	-Encourage participation in and support recruitment to rare diseases studies such as TILT (CPMS ID: 34338), ASSESS-meso (CPMS ID: 33514), RAMPP (CMS ID: 19214) and Hi-SPEC (CPMS ID: 31533). -Establish a respiratory nurse community of practice to share knowledge and best practice. -CRSL and RDM to work on developing the portfolio outside of NBT to increase research opportunities especially RUH which has a research active specialist Pulmonary Hypertension service (one of only 5 outside London) and will be involved in a number of collaborative projects in 2018-19.	Q1-4 Q2-3 Q1-4		
29	**Stroke**	-CRSL and RDM to launch survey to identify greater details about local plans for stroke research and some of the barriers/facilitators for conducting RCTs. -Continue our cross-regional working by identifying key projects/models from other LCRNs which could be adopted and adapted for the West of England. -Hold a stroke research event with speakers from RCT study teams to promote and educate local PIs and stroke research teams about why and how to offer their patients RCTs. The main challenge will be the availability of stroke RCTs on the Portfolio. Also a focus on RCT recruitment will need to be balanced against recruitment to higher recruiting studies for contribution to HLO1.	Q1 Q1-4 Q4		

30	**Surgery**	-The success of Bristol BRC bid including a surgical innovation theme, presents significant opportunities for the LCRN. At least one large local NIHR trial will open across the network in 2018 . -RDM will attend BRC surgical team monthly meetings, to ensure a close working relationship with the group and the LCRN. The LCRN will offer network support where possible, to facilitate BRC trials opening in other sites across the network, increasing recruitment into surgical trials across the LCRN. -CRSL, RDM and PF will meet face to face every quarter, to review local and national surgical portfolios. With focus on local performance, horizon scanning the national portfolio for opportunities across all 15 surgical sub-specialties. Local opportunities and barriers will be discussed and an action plans put in place to address these opportunities and barriers locally. -2017/18 No surgical trials were open in GWH or WAHT. CRSL and RDM will develop surgical team engagement across these POs, through face to face meetings with potential PIs and delivery teams. -CRSL identified a colorectal trial, PPAC2 (CPMS 35187). CRSL and RDM will engage with colorectal surgical teams at GWH, WAHT and GRH to identify potential PIs,teams across the network will be encouraged to open this trial where possible. -CRSL and RDM will support current PIs across the network.Opportunities for non medic PIs will be explored across the surgical teams in the LCRN. Potential non-medic PI's will be identified across the network, PF will identify appropriate studies for identified non-medic PIs. -CRSL is an active PI, currently developing an NIHR proposal. The LCRN will actively support this development by linking the CRSL with a successful CI in the region, this collaboration will work on the proposal in 2018. The planned outcome is the development of the CRSL into an active CI in the region. -PF will raise awareness of future and current research opportunities across all 15 subspecialties, via email contact with the sub specialty champions and surgical delivery teams across the network. The model currently in place across the SWAG SSG network, will be replicated across the surgical research community. Specific Areas of focus 2018-19: -Plastic and Hand surgery, little or no activity in this area currently, RDM and CRSL will engage with plastic surgeons across the network, to appoint a SSL in this area. The SSL, CRSL and RDM will review the national portfolio with the aim to opening at least one study in this area 2018-19. -The appointment of a new clinical Professor of Vascular Surgery in the region presents an opportunity to establish a community of practise for this subspecialty.CRSL, RDM, will meet with the Professor of Vascular Surgery, to look at network wide approach to building the portfolio and mapping links locally and nationally. This community of practice could then be the model of best practice across other sub specialties in the region.	Q1-4 Q1-4 Q1-4 Q2-3 Q1-4		

Cell: B3
Comment: Increase early career researcher involvement in NIHR CRN Portfolio research

Cell: B4
Comment: Increase the number of NIHR CRN Portfolio studies led by trainees as Chief Investigator or co-Chief Investigator

Cell: B5
Comment: Increase patient access to Cancer research studies across the breadth of the Cancer subspecialties (Brain, Breast, Colorectal, Children and Young People, Gynae, Head & Neck, Haematology, Lung, Sarcoma, Skin, Supportive & Palliative Care and Psychosocial Oncology, Upper GI, and Urology)

Cell: B6
Comment: Develop the research workforce in cardiovascular surgery

Cell: B7
Comment: Increase NHS participation in Children's studies on the NIHR CRN Portfolio

Cell: B8
Comment: Increase intensive care units' participation in NIHR CRN Portfolio studies

Cell: B9
Comment: Increase early career researcher involvement in NIHR CRN Portfolio research

Cell: B10
Comment: Develop the Dermatology Principal Investigator (PI) workforce

Cell: B11
Comment: Improve primary-secondary care collaboration in the delivery of Diabetes research

Cell: B12
Comment: Increase trainee involvement in NIHR CRN Portfolio research

Cell: B13
Comment: Improve recruitment to NIHR CRN Gastroenterology studies

Cell: B14
Comment: Increase early career researcher involvement in NIHR CRN Portfolio research

Cell: B15
Comment: Establish links with the relevant professional organisations to encourage and support trainee involvement in NIHR CRN Portfolio studies

Cell: B16
Comment: Increase the number of recruitment sites for NIHR CRN Portfolio studies funded by the Health Services and Delivery Research programme

Cell: B17
Comment: Increase access for patients to Hepatology studies on the NIHR CRN Portfolio

Cell: B18
Comment: Develop research infrastructure (including staff capacity) in the NHS to support clinical research

Cell: B19
Comment: Increase participation in pre-hospital studies via Ambulance Trusts

Cell: B20
Comment: Increase participation in Mental Health studies involving children and young people

Cell: B21
Comment: Understand and develop the research workforce that work in Metabolic and Endocrine-led studies

Cell: B22
Comment: Increase engagement of orthopaedic champions to support the delivery of Musculoskeletal Disorders studies on the NIHR CRN Portfolio

Cell: B23
Comment: Increase early career researcher involvement in NIHR CRN Portfolio research

Cell: B24
Comment: Increase NHS participation in Ophthalmology studies on the NIHR CRN Portfolio

Cell: B25
Comment: To develop the Oral and Dental research workforce in order to meet the demands of the expected growth in the portfolio following the JLA Priority Setting Partnership

Cell: B26
Comment: Increase engagement of GP registrars and First Five GPs with NIHR CRN Portfolio research

Cell: B27
Comment: Develop research infrastructure (including staff capacity and working with local authorities) to support research in Public Health

Cell: B28
Comment: Increase the number of 'new' Principal Investigators (PIs) engaged in commercial Renal Disorders studies on the NIHR CRN Portfolio

Cell: B29
Comment: Increase the proportion of NHS Trusts recruiting into Reproductive Health and Childbirth studies on the NIHR CRN Portfolio

Cell: B30
Comment: Increase access for patients to Respiratory Disorders studies on the NIHR CRN Portfolio

Cell: B31
Comment: CRN recruitment to Stroke RCTs should be at least 8% of the 2017/18 Sentinel Stroke National Audit Programme (SSNAP)-recorded hospital admissions

Cell: B32
Comment: Increase patient access to Surgery research studies on the NIHR CRN Portfolio across the breadth of the surgical subspecialties

Section 5: Financial Management

5.1	Please provide details of the plans that you anticipate impacting on the allocation of LCRN funding			
5.2	In respect of the LCRN 2018-19 local funding model, please complete the following table* by entering the proportion of LCRN funding (%) within the funding elements detailed. If there are any other elements to			
Funding Element		**Examples**	**Description of model**	**% of Total CRN Funding Budget 2018-19 Budget**
Host Top sliced element		Core Leadership team, Host Support costs, LCRN Centralised	Includes Core CRN and Host Support	12.40%
Block Allocations		Primary care, Clinical support services (i.e. pharmacy)	Includes Primary Care & Mental Health, but excludes Clinical Support Services as included ir	10.80%
Activity Based		Recruitment HLO 1, number of studies	Reflects allocations to POs which is predominantly calculated by ABF	73.70%
Historic allocations		PO funding previously agreed		0.00%
Performance Based		HLO performance, Green Shoots funding	Includes dementia, diabetes & training	0.70%
Population Based		Adjustments for NHS population needs		0.00%
Project Based		Study start up		%
Contingency / Strategic funds		Funds held centrally to meet emerging priorities during the year	Includes development & contingency fund and 18-19 transition fund	2.40%
Cap and Collar		Please provide your upper and lower limits if applicable		10% CAP
			With two POs being treated as an exception and receiving a 22% and 34% reduction in 2018-	10% COLLAR
Other funding allocations				%
Comments				
*Notes	1. It is assumed that the Local Funding Model is net of any National Top Slice as these are pass through costs 2. If the funding element category is not applicable to your Local Funding Model, please enter 0% 3. The percentages (%) entered in the table should equate to 100%			
5.3	If the 2018-19 local funding model methodology has changed since 2017-18 please give a brief		The cap and collar has been increased from 5% to 10%, with two exceptions detailed above.	
5.4	Please confirm whether monitoring visits will be taking place over the course of 2018-19. If yes,		None required	
5.5	What are the key financial risks and mitigations for 2018-19?		Filling & retaining all CRN Core posts during 2018-19. The mitigation would be to monitor and allocate any CRN Core underspend at the end of each quarter	
5.6	Please provide details of any planned audit of the LCRN Host Organisation in 2018-19		Meeting with Host Audit to discuss planned Audit for 2018-19	

Section 6: Appendices		
Ref no	**Title**	**Link**
6.1	Business Development and Marketing Profile	https://docs.google.com/document/d/1zPDoRF7qDTF3zAoCs9xkCriEPKGxmNdGzDChZJooVD8/edit
6.2	Risk and Issues Log	https://docs.google.com/spreadsheets/d/1EhWlzc_ZGgPQBAMq_PEpulXJ4By15LTxe-35usqGgA8/edit#gid=1070235198

Section 7. Glossary

Abbreviation	Definition
2gether	2gether NHS Foundation Trust
ABF	Activity based funding
AHSN	Academic Health Science Network
BHP	Bristol Health Partners
BI	Business Intelligence
BIU	Business Intelligence Unit
BRC	Biomedical Research Centre
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group(s)
CD	Clinical Director
CDD	Clinical Director Designate
CI	Chief Investigator
CI	Continuous Improvement
CLAHRC West	Collaboration for Leadership in Applied Health Research and Care West
COP	Community of Practice
CPMS	Central Portfolio Management System
CRN	Clinical Research Network
CRSL	Clinical Research Specialty Lead(s)
CSG	Clinical Studies Group
CVD	Cardiovascular disease
DH	Department of Health
DL	Divisional Lead(s)
EOI	Expressions of interest
GCS	Gloucestershire Care Services
GDPR	General Data Protection Regulation
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GRH	Gloucestershire Royal Hospital
GWH	Great Western Hospitals NHS Foundation Trust
HEI	Health Education Institute
HLO	High Level Objective(s)
HSDR	Health Services Delivery Research
IOM	Industry Operations Manager
JDR	Join Dementia Research
JLA	James Lind Alliance
LA PH	Local Authority Public Health
LCRN	Local Clinical Research Network
LPMS	Local Portfolio Management System
MH	Mental Health
MHT	Mental Health team
NASH	Non-alcoholic steatohepatitis
NBT	North Bristol NHS Trust
NC	Nurse Consultant
NIHR	National Institute for Health Research
NIHR CRN	National Institute for Health Research Clinical Research Network
NMAHP	Nurse, Midwife, Allied Health Professional
ODP	Open Data Platform
PCO	Primary Care Organisation
PF	Portfolio Facilitator(s)
PHWE	People in Health West of England

PI	Principal Investigator
PIC	Patient Identification Centre
PO	Partner Organisation(s)
POF	Performance and Operating Framework
PRA	Patient Research Ambassador
PRAI	Patient Research Ambassador Initiative
PRES	Patient Research Experience Survey
PPIE	Patient, Public Involvement and Engagement
R&D	Research and Development
RCTs	Randomised Controlled Trial
RDM	Research Delivery Manager(s)
RICE	Research Institute for the Care of Older People
RH&C	Reproductive Health and Childbirth
RSI	Research Site Initiative
RTT	Recruitment to Time and Target
RUH	Royal United Hospitals Bath NHS Foundation Trust
SPoC	Single Point of Contact
SSG	Site Specific Groups
SSL	Subspecialty Lead(s)
SSS	Study Support Service
STAR	Severn Trainee Anaesthesia Research Group
SWAG	Somerset, Wiltshire, Avon and Gloucestershire
UHB	University Hospitals Bristol NHS Foundation Trust
WAHT	Weston Area Health NHS Trust
WEAHSN	West of England Academic Health Science Network
YPAG	Young Persons' Advisory Group

Risks and Issues register 2018/19
SCORING:

	IMPACT				
PROBABILITY	**Insignificant (1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Highly Likely (5)	5	10	15	20	25
Likely (4)	4	8	12	16	20
Possible (3)	3	6	9	12	15
Unlikely (2)	2	4	6	8	10
Highly Unlikely (1)	1	2	3	4	5

1-5 GREEN = LOW*
6-11 YELLOW = MEDIUM
12-19 AMBER = HIGH
20-25 RED = EXTREME

Risks with a scoring of 12 and above should be monitored and escalated

Issues log scoring

NB
Risks are things that might happen
Issues are things that have happened

The Issue Log is based on a 5 x 5 matrix
Scores of 1-7 are green (insignificant), 8-12 are amber (moderate) and 13-25 are red (severe) - see matrix below

Issues are each scored from 1 to 5 on proximity and impact
priority: how important is this to the success of the project? 1 is not important, 5 is crucial
impact: what effect will this issue have? 1 is insignificant impact, 5 is major impact

	1	**2**	**3**	**4**	**5**
1	1	2	3	4	5
2	2	4	6	8	10
3	3	6	9	12	15
4	4	8	12	16	20
5	5	10	15	20	25

LCRN Guidance on completion of the Risks and Issues Template can be found within LCRN Contract Support Document PM/035

Please provide details for the process of escalation of Risks and Issues and who they are escalated to

		Low 1-5	Medium 6-11	High 12-19	Extreme 20-25
1	**The processes of escalation**	1. All risks on the Risk Register are discussed and reviewed weekly at the Senior Management meeting. 2. Risks and issues categories are reviewed with input from COO and CD and escalated as decribed in section 2. 3. The Risk register is tabled at the CDLs, R&D and OMG meetings.			
2	**Who are the risks escalated to?**	Scores of >1-5 will be managed by the RDM/Work stream Lead.	Scores of >6-11 will be escalated and managed by Clinical Director and Chief Operating Officer.	Scores of >12-19 will be escalated to the Executive Group/Partnership Group.	Scores of >20-25 will be escalated to NIHR CRN CC.
3	**Is the Risk register submitted to an LCRN board for review? If yes, which board**	1. The Risk Register is submitted to the host Trust Board as part of Annual Delivery Plan and Annual Delivery Report cycle and monthly/quarterly to LCRN Executive Group and LCRN Partnership Group meeting.			

CRN West of England Risk Register-all open risks transferred to new Risk Register format for Annual Plan on 26/02/2018.

The LCRN are aware that only risks of 6 and above need to be recorded on this Risk Register however it is used to record all LCRN risks.

	PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)							
category(Project/Workstream/Spec	Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)	Trend (since last reviewed)
N/a	RR-044 (was R	Performance	Feb 2018	CD/COO	Example CRN West Of England will not deliver against HLO targets for 2017/18, specifically HLO 2 (recruitment to time and target) and HLO 4 (time taken to achieve study set up in the NHS) Cause: Incomplete data and historical impact on HLOs of a number of studies Effect: Reputational loss with research community and performance incentive reduction	3	4	12	April 2018	1. Regular review by CD/COO to review risks and mitigating activities around HLO performance each quarter, prioritising closing studies and set up times 2. Existing local mitigations included in LCRN annual business plan 3. Quarterly performance data for HLOs Standing agenda at key meetings 4. Regular review by NSLs to provide clinical expertise to delivery to improve delivery to time and target 5.Defined plan of action for study closure review and intelligence gathering for effective delivery of future studies	CD/COO	All - ongoing	2	4	8	Open	Static
N/a	RR-045(was R	Reputational	Feb 2018	COO	Study delays due to issues in identifying funding sources/routes for Excess Treatment Costs, leading to frustrations amongst local CI/PIs. Cause: Clarity around ETCs Effect: Reputational risk; delays in initiating studies	4	3	12	April 2018	1. Policy to be agreed to reinstate previous 'pot' arrangement which operated across the network. 2. Highlight issues to CRNCC	COO	1. Ongoing 2. Complete	2	3	6	Open	Static
N/a	RR-046(was R	Information	Feb 2018	COO	CPMS/LPMS integration, not fully established and benefits from additional functionality realised in the time frame required. Cause: Aligning datasets between the two systems	4	5	20	April 2018	1. LPMS working group weekly implementation 2. Part of the working group to work toward contractual management of providers to ensure deliverables met to timelines.	COO	1. Ongoing 2. Ongoing	3	5	15	Open	Static
N/a	RR-047(was R	Services	Feb 2018	CD/COO/IOMs	BREXIT may adversely impact development and delivery. Cause: BREXIT (uncertainty of post- brexit research delivery environment) Effects: International funders may be reluctant to invest in clinical research in the UK. International stakeholders and NIHR staff/associates may choose or be required to leave the UK (visa etc). Relationships and the ability to do business with international organisations may be hindered.	4	4	16	March 2019	1. Maintain review of emerging and developing situation 2. Invest heavily in current relationships with international stakeholders and provide appropriate reassurances	CD/IOMs	All - ongoing	3	4	12	Open	Static
N/a	RR-048(was R	Services	Feb 2018	BI Lead/COO	Cyber crime attacks on the wider research ecosystem (NHS Trusts and other stakeholders) Cause: Cyber crime amongst LCRN NHS trusts Effect: Impact on business continuity of the LCRN and NHS trusts.	5	4	20	Ongoing	1. Review the Business Continuity plans with Senior Management Team to include impact of Cyber crime on the Ecosystems partners and the potential impact on CRN business continuity. 2. Implement measures to allow alternative means of working for such scenarios.	BI Lead/COO	1. Ongoing2. Ongo	3	4	12	Open	Static
N/a	RR-049(was R	Information	Feb 2018	COO/Workforce Development Manager	Staff Retention of good staff due to high cost of living and low unemployment in the region. High proportion of staff from Europe relating to the Brexit risk. Cause: Low unemployment in the region / finding good calibre staff Effect: Demotivating for existing staff due to work pressures / ineffective career planning	5	3	15	May 2018	1. Re-advertise roles as necessary. Advertise more widely than the NHS if required to improve quality of candidates applying for roles. 2. Work with Host trust on retention policies/enhancements	COO/Workforce Development Manager	Ongoing	2	3	6	Open	Static
Business Intelligence	RR-040	Performance	2017	RDM/BI Workstream Lead	There is a risk to data quality due to the LCRN not having access to anonymised data at patient level on LPMS. Cause: LCRN is prevented from undertaking direct comparison between data held by CPMS and data held by LPMS. Effect: Data quality is threatened if the LCRN is prevented from undertaking direct comparison between data held by CPMS and data held by LPMS.	4	2	8	March 2019	1. LPMS provider aware. 2. Raised with NIHR CRN CC at national teleconference.	BI Manager	Open	4	1	4	Open	Static
LCRN Wide	RR-042	Legal	2017	COO	There is a risk that processing staff names may mean non-compliance with GDPR, not processing them will affect workforce planning and LCRN core business . Cause: Changes to legislation. Effect: The NIHR/LCRN may incur financial penalties for non-compliance.	5	4	20	May 2018	1. COO sought advice from host data protection officer. Advice has reduced the risk. 2. Completing national CRN CC response to DH	COO	Open	1	1	1	Open	Static
LCRN Wide	RR-043	Financial	2017	COO	There is a risk that due to the delay in confirmation of variation of contract from DHSC, the LCRN will not be able to maximise recruitment to vacant posts. Cause: This will restrict the LCRNs operational capacity and capability to support research in the region. Effect: This increases the likelihood of a significant underspend.	4	4	16	March 2019	1.Escalated to CRN CC2. Awaiting variation to contract	COO	Open	4	4	16	Open	Increased

CRN West of England Issues Register-all open issues transferred to new Risk Register format for Annual Plan on 26/02/2018.

Date Last Reviewed and by: Dr Sue Taylor, Date : 26/02/2018

LCRN category(P	Issue ID	Issue Type	Date Raised	Owner	Description	Severity(previously impa	Priority	Total Rating	RAG	Actions	Action Owners	Action status	Issue status
N/a	IR-036(wa	Tendency for networks to concentrate multi-site studies within own geography	02/2018	COO/DCOO	Raise with RDMs/IOMs and CRNCC. Raise at national strategy meetings	1	2	3	GREEN	1. Await direction from NIHR CRN CC.	COO/DCOO	In progress	Open
Business Intelligence	IR-012	The quality of data on EDGE from some partner organisations is improving very slowly or not at all, compromising internal reporting from the database and ultimately the ability to report data directly to CPMS and will impact on network income		SRDM	Compromising internal reporting and impact on network income	3	2	6	GREEN	1. Portfolio facilitators to visit sites and help with discrepancies.2. Monthly data discrepanc	BI Manager	All in progress	Open
Metabolic and end	IR-018	No CRSL in post.		COO/CD	Unable to deliver the National objective for this specialty	3	3	9	AMBER	1. Use the diabetes workforce to cover this role.	COO/CD	In progress	Open
Study Support Ser	IR-022	Changes to Study Support Service implementation SOPs by NIHR CRNCC impacts on our ability to roll out the service according to the national timescales.		SSS Workstream Lead	Impacts on the CRN ability to roll out the service according to the national timescales.	3	3	9	AMBER	1. Set a new LCRN implementation date of 01/08/2016. 2. Request tracked changes version of NIHR CRN: CC SOPs to identify changes. 3. Agree to support SSS informally until 01/08/2016. 4. Explore with NIHR CRN: CC way to deliver SSS that fits with integrated model whilst still meeting metrics. 5. Discussed impact of changes with NIHR CRN: CC and agreed a stronger 'voice' for our LCRN on the Change Management Group, with changes made based on the needs of the service and not individual preference. 6. Work with neighbouring LCRNs to develop local materials and tools that reflect our integrated/devolved model.	SSS Workstream Lea	In progress	Open
Cancer	IR-023	Cancer activity is subject to reduction in resource		D1 RDM	Partner organisations prioritise funding to other clinical areas which will result in a fall in the number of patients who can be offered the opportunity to participate in cancer research and difficulty reaching RTT and specialty objectives.	4	2	8	AMBER	1. Ensure partners understand the importance of the cancer research activity from a local and national perspective through effective communications with CEOs, finance directors and budget holders. 2. Investigate models of shared care for research learning from successful shared care in paediatric oncology 3. Demonstrate economies of scale regarding rare cancer research. 13/02/17 - some cancer research teams have decreased in WTE. Recruitment to cancer studies has decreased in 2016-17	D1 RDM	In progress	Open
Study Support Ser	IR-027	There is a risk to the set up and delivery of research if the SSS is not implemented consistently across the network. The Study Support Service was launched nationally in July 2016. In December 2016 the service was 'renewed and refreshed'. The national Study Support Service team are constantly changing the process and these changes are resource intensive and impact on our ability to deliver a responsive, consistent service.		SSS Workstream Lead	Impacts on the CRN ability to roll out the service according to the national timescales.	2	2	4	GREEN	1. Work with Partner Organisations to deliver SSS. 2. Produce clear SOPs to support implementation 3. Provide support to RMG staff to deliver the service 4. Deliver Implementation workshops to explain SOPs and clarify best working practices. 5. Develop responsibility matrices for single site, multi-centre and commercial studies to describe roles and responsibilities. From 2017 onwards, we will have a renewed focus on the local and practical application of the SSS providing support and advice where they are gaps to ensure comprehensive coverage. We will focus on supporting Partner Organisations and researchers locally. Plan 1. Focus efforts on the local research community. 2. Continue with Early Contact and Engagement 3. Provide study recommendations and risk assessment to other LCRNs 4. Assess and provide Partner Organisations R and D with practical support for SSS such as: a. Eligibility criteria b. Costings c. Signposting 5. Workshops with Partner Organisations to identify and develop tools and materials to support them 6. Work with neighbouring LCRNs to provide a responsive service 7. Provide feedback loop for LCRN community to aid service improvement Outcomes 1. Partner Organisations who are experts share learning. 2. Researchers are supported. 3. Joint working across neighbouring LCRNs.	SSS Workstream Lea	In progress	Open
LCRN wide	IR-028	Non compliance of Performance and Operating Framework, specifically HLO2 a and b for 2017-18		COO	Failure to engage with local performance management approaches within the CRN in relation to achievement of the NIHR CRN objectives	3	3	9	AMBER	1. Raised as an issue at OMG. 2. To escalate to Executive Group for to advise on compliai	COO	In progress	Open
Business Intelligen	IR-029	Substantial loss of income		COO	There is a discrepancy between recruitment data being reported to EDGE and recruitment data being reported to Central Portfolio Management System(CPMS). Recruitment data that is not reported to CPMS will not be included in national funding formulae and therefore represents lost income of a substantial amount (£188k to date) to the network.	3	3	9	AMBER	Will be raised as an issue at OMG (19/06) to escalate to Partnership Group.Monthly update	COO	In progress	Open
Mental Health	IR-031	Recruitment decline for both specialties.Unable to meet target for HLO7. Inequity of access for patients to mental health and dementia studies.		SRDM	Current lack of activity for the mental health and dementia portfolio	3	3	9	AMBER	1. Skill mix review undertaken in collaboration with AWP. 2. Recommendations for the CRN flexible mental health and dementia team to be accountable to the CRN for workload to ensure equity across the region and support for studies both for set up and delivery. 3. AWP working closely with the Senior RDM and COO to facilitate this change with the team. 4. AWP's budget is under review given drop in activity.	SRDM	In progress	Open
Critical care	IR-032	Failure to deliver reserch opportunities to patients.		D6 RDM	Shortage of research nurses at NBT for Critical Care/Anaesthesia limits their ability to take on new studies	2	3	6	GREEN	1. Encourage contingency bids to support shortfall. 2. Liaise with CRSL and R&D dept.	D6 RDM	In progress	Open
ENT	IR-033	Shortage of ENT studies in the pipeline.		D6 RDM	Failure to deliver research opportunities to patients. Loss of development opportunities for ENT research in the region.	2	3	6	GREEN	1. Work with CRSL to identify opportunities to exploit.2. Explored opportunities for collabor	D6 RDM	In progress	Open
LCRN wide	IR-035	Reduction in Recruitment leading to an effect on financial stability		COO	Concerns over the West of England's future funding relating to recruitment. This was raised at Executive Management Group	4	4	16	RED	1. Project Lead to be invited to attend the EMG meeting on 5 February to provide an update on progress with National Recruitment analysis. Action 60: The Group requested a standing item be added to the EMG agenda – RDM's to provide detailed input regarding mitigation of recruitment figures.	COO	In progress	Open
Reproductive Health & Childbirth	IR-036	Lack of pipeline of intrapartum studies for birth delivery staff	12/03/2018	D3 RDM	Concerns over West of England's ability to retain IMOX staff in post post-IMOX (and the resultant momentum and infrastrucure within intrapartum research in smaller sites.	4	3	12	AMBER	1. Continue to support Community of Practice (COP) of senior midwives who collaborate effectively to ensure all sites are informed of pipeline studies, assess feasibility of potential new studies and troubleshoot difficulties with open studies. 2. Identify all potential studies allocated to specialities outside RH&C to assess feasibility for delivery by RH&C teams. 3. Explore potential for increasing activity in other sub-specialities including neonatal, gynaecology & fertility 4. Continue to grow links with regions outside CRN WE via the RH&C champions & co-speciality lead to try and attract more studies to the region at an earlier stage of development	D3 RDM	In progress	Open

Closed Risks 2017/18															
PRE-RESPONSE (INHERENT)									POST RESPONSE (RESIDUAL)						
Risk ID	Primary category	Date raised	Risk Owner	Risk Description (to include cause/event, and effect)	Probability	Impact	Value (PxI)	Proximity	Response Actions	Action owner(s)	Action status	Probability	Impact	Value (PxI)	Risk status (open or closed date)
Please note: Closed risks are recorded on the Risk Register. The Risk Register is filtered to show only current risks.															

	Impact				
	1	2	3	4	5
	Very Low	Low	Medium	High	Very High
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

RISK RATING (SCORE)

Low (1-6)	Acceptable risk requiring no immediate action. Review annually.
Moderate (8-12)	Risk may be worth accepting with monitoring. Continue to monitor with action planned within six months. Place on risk register.
High (15-20)	Must manage and monitor risks. Action planned within three month. Review at monthly intervals. Place on risk register.
Extreme (25)	Extensive management essential. Action planned and implemented ASAP. Review weekly. Place on risk register.

RISK TREND
Static
Increasing
Decreasing

1	**CRN West of England**	
2	**LCRN profile lead**	
	Name: **Email address:** **Contact telephone number(s):**	Hannah Williams / Andrew Voisey industry.westengland@nihr.ac.uk 0117 3421375
3	**Study set up (maximum 100 words)**	
	The Industry specific point of contact for all enquiries, expressions of interest and support requests is industry.westengland@nihr.ac.uk. Information received is sent between RDMs, Trust R&D departments, Primary Care Organisations, investigators and relevant partners. Study set up is managed within the Trusts R&Ds and the use of LPMS in CRN West of England means we have a proactive and efficient management of study set up for R&Ds and RDMs. Primary Care Organisations work closely with CCG R&Ds and CRN West of England for study set up. All Trusts and Primary Care Organisations in the region advocate the use of the standard NIHR Industry costing template for study set up and study costs. As part of our Study Support Service which encompasses the industry team, we provide an efficient and standardised Industry Costing Template Validation service to life science companies. Clinical Research Specialty Leads are funded to help drive the research and advise on specific patient cohorts, studies which are compatible with practice and suitable investigators/sites within the region.	

4	**Patient populations**
	A: Specific patient cohorts (maximum 100 words)
	The CRN West of England (LCRN) region has a highly diverse population of 2.4 million. It has a large urban centre in Bristol and predominantly rural areas in South Gloucestershire, North Somerset. The Bristol population has a higher than the national average percentage of young people and 16% of the population is black and minority ethnic. Conversely, the populations of Bath, Gloucestershire and North Somerset have higher than national average percentage of older people. The Avon Longitudinal Study of Parents and Children is a world-leading birth cohort study providing a resource for factors that affect a person's health and development.
	B: Consent for approach cohorts (maximum 100 words)
	The LCRN is a top recruiter in England for Join Dementia Research. This was facilitated by a Join Dementia Research Officer, working with colleagues to promote it in secondary and primary care settings. Avon and Wiltshire Mental Health Partnership NHS Trust's 'Everyone Included' initiative is an opt-out approach to informing patients about research opportunities. Reach West is a list of people living in the West of England who are interested in taking part in health research. By signing up, people have agreed to allow access to their details in order to identify relevant research projects in which they can participate.
5	**Infrastructure**
	A: Specialist research facilities (maximum 100 words)
	● Bristol Biomedical Research Centre was awarded £21 million (2017-2023). The key research themes are: cardiovascular disease, nutrition, diet and lifestyle, reproductive and perinatal mental health, surgical innovation and mental health. ● Clinical Trials and Evaluation Unit based in University of Bristol. ● Clinical Research and Imaging Centre, Bristol is a state-of-the-art research and imaging centre. ● Cobalt Health, Cheltenham is a medical charity scanning centre at the forefront of diagnostic imaging (PET Scanner).

- Research Institute for the Care of Older People (RICE) carries out research into ageing and dementia.
- West of England NHS Genomic Medicine Centre.

B: Specialist Trusts (maximum 100 words)

- Royal United Hospitals Bath now includes the former 'Royal National Hospital for Rheumatic Diseases', a national specialist rehabilitation and rheumatology hospital.
- North Bristol NHS Trust
    - Institute of Neurosciences
    - Richard Bright Renal Service
    - Major Trauma Centre
    - Bristol Urological Institute
- University Hospitals Bristol Foundation Trust
    - Bristol Eye Hospital
    - Bristol Haematology and Oncology Centre
    - Bristol Heart Institute
    - Bristol Royal Hospital for Children
- Avon and Wiltshire Mental Health Partnership NHS Trust
- 2gether NHS Foundation Trust (Mental Health)
- Gloucester Care Services NHS Trust provides health and social care services.

C: Research sites (maximum 100 words)

All Partner Organisations in the LCRN are commercially research active. Regional Monthly 'R&D Management group' (comprising Senior CRN Managers and R&D Managers) and quarterly 'Research Infrastructure Workforce Steering Group' (comprising Senior Research Delivery staff) meetings are held to coordinate and share best practice about research delivery across the region.

Our Intrapartum Research Group has forged collaborative relationships across maternity units in the region.

Kingshill Research Centre in Swindon is a commercial clinical trial centre renowned for its work. It was involved in the original clinical trials for all current licensed drugs for Alzheimer's disease, including Aricept.

D: Community research infrastructure (maximum 100 words)

	CRN West of England has one of the most successful and comprehensive primary care network with high levels of engagement from all 7 CCGs serving a population of over 1 million patients. All research active GP Practices are RCGP Research Ready accredited. There are five collaborations yielding large and diverse patient populations and a cluster of commercially-focused GP investigators with a list size of over 85,000 patients. Our team consists of three GP champions, a flexible peripatetic team of Research Nurses and Clinical Studies Officers, and Research Officers working closely with sites to provide support with study set up. A commercial community of practice has been established for peer support and to promote collaborative ways of working and troubleshooting. Primary care also frequently supports secondary care, acting as PIC sites for commercial studies across a number of specialties, most recently in diabetes and mental health. Currently there is a development project underway to identify and engage non-NHS providers of NHS services to raise awareness of and promote the support the CRN can provide.
6	**LCRN Relationships**
	A: Customers (funders of research) maximum 100 words
	UH Bristol is a Partner Site with IQVIA, a leading global Contract Research Organisation (CRO). IQVIA Partner Sites form part of the company's Prime and Partner Site Network and are selected based on their competitive performance in terms of Study Setup times, patient recruitment and high quality, as well as a cultural fit that places the patient at the centre of all activities. Doctors from the Bath Area Research Organisation Network (BARONET) are the first UK primary care network to partner with Pfizer's INSPIRE (Investigator Networks, Site Partnerships and Infrastructure for Research Excellence) research programme.
	B: Other (maximum 100 words)
	● The universities within the CRN West of England region are: ○ University of Bristol ○ University of the West of England ○ University of Bath ○ University of Gloucestershire ● The LCRN and West of England AHSN are jointly funding a new role to build relationships with local SMEs. ● Bristol Health Partners (BHP) is a collaboration between the city's NHS trusts, CCGs, universities and the local authority. BHP Health Integration Teams (HITs) tackle health priorities by harnessing the best research, innovation, care and education to improve people's health.

	● People in Health West of England (PHWE) comprises BHP, the LCRN, CLAHRC West and West of England AHSN, and is supported by the University of the West of England. It involves the public in research and evidence- based innovation.
7	**Development opportunities, plans and ideas (maximum 200 words)**
	Regionally, our highest performing commercially active specialties are diabetes, cardiovascular, dementia, ophthalmology and children. Development areas include: **Diabetes** ● This three year development project, led by a Senior Research Nurse, looks to ensure equity of access to research for all diabetic patients by adopting a region wide approach to recruitment to diabetes studies, encompassing primary, secondary care settings and other qualified providers. ● This has expanded the regional diabetes knowledge base to allow 'joined-up' thinking around how and where to recruit patients. The intention is that this will also encourage cross referral of research patients to other trials within the region. ● Diabetic patient cohort interested in taking part in further studies established. ● Commercial Diabetes event planned for 9 April 2018 with pharmaceutical companies aims to raise the profile of the CRN West of England with commercial sponsors. **Dementia** A dementia project focusing on increasing dementia research within primary care, residential care and supported accommodations settings. **Primary Care** ● Contributing to national and local IT solutions in Primary Care including the creation of standardised primary care database searches as part of study set up. **Biosimilars** Engagement of the clinical community to support uptake and delivery of biosimilar clinical trials.
8	**Any other information (maximum 200 words)**
	● The STAR (Severn Trainee Anaesthetic Research) Group is a successful trainee research network and has completed ten multi-

	centre audits and led and coordinated regional recruitment. ● Bristol Eye Hospital has a large and increasing portfolio of commercial trials for retinal and other conditions. Professor Andrew Dick collaborates with researchers at the National Eye Institute, USA. ● Professor Adam Finn, Professor of Paediatrics at the University of Bristol and lead of the Bristol Children's Vaccine Centre supports clinical trials of vaccines and medicines in children. He is part of the Bristol NIHR Health Protection Research Unit (HPRU) in Evaluation of Interventions, one of two cross-cutting units in England. ● Professor Roy Jones is Director of the Research Institute for the Care of Older People (RICE), an internationally renowned dementia research and treatment centre conducting studies for major pharmaceutical and Contract Research Organisations since 1985. ● Severnside Alliance for Translational Research (SARTRE) is a partnership between the Universities of Cardiff and Bristol. They translate research into clinical science and practice, and provide a focal point for interactions with the Bio-Pharmaceutical industry.

Cover report to the Public Trust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	17
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Department of Health and Social Care / NIHR LCRN Host Organisation Agreement Variation No 004**		
Author	Dr Stephen Falk- Clinical Director,		
Executive Lead	Mark Callaway, Acting Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

To inform the Board of the extension to the hosting arrangement contract and issue of flow down contracts to NHS partner organisations within the West of England region.

Key issues to note

Continuation of existing hosting arrangements with updated Performance and Operating Framework for the network. The contract has been reviewed and amended in multiple sections fundamentally to improve clarity and consistency. The responsibility to the Host organisation for the network is largely unchanged.

Recommendations

The Chief Executive Robert Woolley signed the Host agreement on the 25 May 2018 to

continue to Host the Clinical Research Network West of England until 2022.

Members are asked to:

- **Note** the report for information

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	18
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**West of England Local Clinical Research Network Annual Report (hosted body report)**		
Author	Dr Stephen Falk- Clinical Director, Dr Kyla Thomas- Clinical Director Designate, Dr Sue Taylor- Chief Operating Officer		
Executive Lead	Mark Callaway, Acting Medical Director		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☒
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☒	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☒
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☒	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☒		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☒	For Information	☐

Executive Summary

Purpose

The Clinical Research Network: West of England Annual Report 2017/18 is submitted to the Trust Board for approval.

Key issues to note

Please refer to the Executive Summary in the report.

The report is awaiting approval by the National Institute for Health Research (NIHR), Clinical Research Network Coordinating Centre (CRNCC). An LCRN performance review will be held with the CRNCC on the 12 July 2018. LCRN Performance Review Meetings are held twice a year and provide an opportunity for the CRNCC Executive and Senior Leadership of each LCRN to meet and discuss network performance against the Annual Plan and Annual Report,

including achievements, challenges and contract compliance. This meeting will be attended by Dr Stephen Falk, Clinical Director, Dr Kyla Thomas, Clinical Director Designate and Dr Sue Taylor, Chief Operating Officer. Key issues to note None impacting on the host organisation namely UHBristol NHS Foundation Trust
Recommendations
Members are asked to: • **Approve** the Report.

Intended Audience **(please select any which are relevant to this paper)**									
Board/Committee Members	☒	Regulators	☐	Governors	☐	Staff	☐	Public	☒

Board Assurance Framework Risk **(please choose any which are impacted on / relevant to this paper)**			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☐
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment **(please tick any which are impacted on / relevant to this paper)**							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk

Resource Implications **(please tick any which are impacted on / relevant to this paper)**			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

Clinical Research Network
Locality

National Institute for Health Research

Annual Report 2017/18

Date of submission: 11/05/2018
Submitted by: Dr Sue Taylor, COO

2017/18 LCRN Annual Reporting Requirements
Link to Requirements for LCRN Annual Delivery Reports 2017/18

Contents

Host Organisation Approval	
Confirmation that this Annual Report has been reviewed and agreed by the LCRN Partnership Group:	Yes
Date of the LCRN Partnership Group meeting at which this Annual Report was agreed:	06/06/18
Confirmation that this Annual Report has been reviewed and approved by the LCRN Host Organisation Board:	No
Date of the LCRN Host Organisation Board meeting at which this Annual Report was (or will be) approved:	2018-06-28
If this Report has not been approved by the LCRN Host Organisation Board at the time of submission to the CRNCC, then the LCRN Host Organisation Nominated Executive Director should provide that confirmation by email to the CRNCC once the Board has approved the Report	

Section 1. Compliance with the Performance and Operating Framework 2017/18

Please confirm that the Host Organisation and all LCRN Partner organisations operated in full compliance with the CRN Performance and Operating Framework 2017/18: If you have answered no, provide a commentary that highlights the specific clauses of non- or partial compliance. Please explain the reasons for non- or partial compliance and the progress of actions taken to address this:		**Yes**
Part A: Performance Framework		
1. LCRN Performance Indicators		
1.1 NIHR CRN High Level Objectives (HLOs)	Yes	Please see Key Projects for details.
1.2 Clinical Research Specialty Objectives	No	Please see Key section 4.2 for details.
1.3 CRN Improvement Objectives	Yes	
1.4 LCRN Operating Framework Indicators	Yes	
1.5 Initiating and Delivering Clinical Research Indicators	Yes	
1.6 Satisfaction Survey Indicators	Yes	
1.7 LCRN Patient Experience Indicators	Yes	
2. Performance Management Processes	Yes	
Part B: Operating Framework		
1. Principles		
2. Governance and Management (including Financial Management)	Yes	
2.1 Category B LCRN Partner flow down contracts	No	Please see appendix 3.
3. CRN Specialties	No	Please see section 4 (19A)
4. Research Delivery	Yes	
5. Information and Knowledge	Yes	
6. Stakeholder Engagement and Communications	Yes	
7. Organisational Development	Yes	
8. Business Development and Marketing	Yes	

Section 2. Executive Summary

Please complete the Table below, entering key performance highlights and successes from 2017/18 from your report, against headings 1-9. Note: When printed this section should be no longer than 2 sides of A4.

1	**Host Organisation**	The Host Organisation has continued to fulfil its responsibilities as a Local Clinical Research Network (LCRN) host in line with the DHSC/LCRN Host Organisation agreement. University Hospitals Bristol NHS Foundation Trust met all the requirements in the performance and operating framework in terms of LCRN structure, management roles and governance arrangements. In October 2017 a Clinical Director Designate who is a Consultant Senior Lecturer in Public Health Medicine was appointed at 2 PAs as part of the succession planning process for the Clinical Director role. This appointment will ensure a smooth transition period for this key clinical leadership role within the network. The LCRN Executive Group has continued to meet on a monthly basis chaired by the Host Organisation interim Medical Director, attended by the Host Finance lead and more recently the Senior Human Resource Lead on an as required basis. The LCRN Clinical Director and Chief Operating Officer are also in attendance as well as two partner organisation R&D Directors. All relevant reports are reviewed at the Host Board meetings with either the Clinical Director or the Chief Operating Officer in attendance. There has continued to be a strong relationship between the CRN West of England and the Host Organisation. Regular meetings, the ability to escalate where needed and Host support has been key to successful performance.
2	**Governance and LCRN Management Arrangements**	The LCRN has met the requirements of the Performance and Operating Framework in terms of LCRN Structure, management role and governance arrangements. Operational Management Group meetings have continued on a monthly basis with representation from Research Delivery Managers (RDMs), R&D Management, Host Finance and Chaired by the Chief Operating Officer. The Clinical Research Divisional Leads meetings have continued monthly and are chaired by the Clinical Director or Clinical Director Designate. Partner organisations have submitted annual operational business plans to support performance management and to inform monthly meetings between RDMs/Locality leads and Research Management. The LCRN has delivered a financial break even for 2017/18 and maintained robust financial governance systems and processes. The appointed Chair for the Partnership Group has increased engagement and attendance.
3	**Business Development and Marketing**	LCRN Business and Development profile has been refreshed for marketing purposes by the national Business Development Team. An assistant RDM was appointed in Q4 supporting Industry Leadership within the LCRN and working with the Life Sciences Industry. The network has promoted the continued importance of the industry agenda to our Partner Organisations and supported the national Biosimilars campaign. This has been through the Primary Care Commercial Community of Practice group and monthly Industry Community telecons for secondary care. Biosimilar research has also been communicated to our Partner Organisations and Primary Care Organisations via LCRN newsletters and website.The LCRN has continued to work with the AHSN and CLAHRC to explore collaboratively, the set up of an innovation exchange and how this mapped on to Sustainability and Transformation Plans . Restructure in AHSN meant that this work had been delayed. Collaborative working on taking the project forward is now re-established for 2018/19.
4	**Information and Knowledge**	Local Portfolio Management System (LPMS) is operational and fully embedded in all partner organisations with the exception of primary care. Minimum data set as agreed by CRNCC has been adopted with all LPMS data points provided to CRNCC timelines. A developed analysis and benchmarking of activities from ODP and financial data has been established in order to improve operational delivery and value for money. A responsive help desk function provided by the Business Intelligence team is in place to support all users in relation to systems provided for NIHR CRN (Hub/ODP/LPMS), supported by face to face training.
5	**Specialty highlights**	Recruited to 29/30 CRN specialties, an improvement on 2016/17 where there was no recruitment to the Oral and Dental health and Public Health specialties. Recruited the first participants to a study from a General Dental Practice in the LCRN. Third highest recruiting LCRN to Ophthalmology specialty. In the top 5 LCRNs for recruitment per million population to Injuries and Emergencies and Stroke specialties. Partner organisations achieved three global first patients to commercial studies: • University Hospitals Bristol NHS Foundation Trust achieved a global first patient in an acute Graft vs Host Disease study (CPMS ID 30732) in the Cancer specialty. • Great Western Hospitals NHS Foundation Trust achieved a global first patient in a heart failure study (CPMS ID 33958) in the Cardiovascular diseases specialty. • Oldfield Surgery achieved a global first patient in a lipid-modifying therapy use study (CPMS ID 34509) in the Metabolic and Endocrine Disorders specialty. Partner organisations achieved a further eight European and UK first patients to commercial studies.
6	**Research delivery**	Join Dementia Research Register, West of England achieved the 3rd highest number of registrants at 2204 people on JDR Delivered the NIHR CRN Study Support Service in accordance with adapted devolved model rather than centralised. CRNCC SOPs and guidance documents. HRA meeting held in June 2017 to discuss challenges and agree solutions to study delays with partner organisations. Recruitment to time and target for commercial research (HLO2a) has improved to 78% from 63% in 2016/17. HLO2B non commercial research has achieved 73% of the national target of 80%

7	**Stakeholder Engagement and Communications**	Increased visibility of the LCRN within the local community and wider audiences using a range of online and offline communication channels, including increasing relevant Twitter followers by 143% (from 450 to 850) due to increased activity, better communications with relevant colleagues in POs and Primary Care. Patient impact and involvement in research stories used in collaboration with Specialty teams eg. Diabetes to create offline materials (posters, leaflets and pull-ups using local case examples) for promotion of research opportunities. The LCRN Continued to deliver a strong programme of patient involvement engagement through collaborative working with the People in Health West of England initiative. A collaborative communications teams approach established with Bristol Health Partners, CLAHRC West, WEAHSN and the Universities. The LCRN currently has seven Patient Research Ambassador Initiatives registered nationally.
8	**Workforce Learning and Organisational Development**	The LCRN promoted a culture of modern workplace learning, including awareness of NIHR National Learning Directory e-learning Programmes, Resources and Communities. The LCRN trained 474 delegates on courses (including Introduction to GCP, GCP Refresher, Valid Informed Consent, Fundamentals of Clinical Research). The LCRN Delivered a well attended "We are Research" event to bring together and support nursing and allied health professional research delivery staff across the region in March 2018. All core team staff taken through the Quality Improvement Academy Bronze Programme in February 2018. A culture of improvement and innovation was promoted through workshop activities with the Clinical Research Specialty Leads in September 2017 and with the R&D directors and managers in January 2018 (Growth and Sustainability event). The outcomes of these meetings informed the development of the LCRN Annual Plan 2018/19. R&I management group : met monthly meetings to work collaboratively to achieve the national high level objectives. A Supra-Regional 'Information and Knowledge / Business Intelligence' working group was created at the Supra-Regional Event (with members attending from WoE, SWP, Wessex and TVSM) held in September 2017. Informal discussions (i.e. sharing best practice) took place at the event and after. A more formal approach (including joint reporting on initiatives to COOs) is planned for 2018/19.
9	**National Contributions**	The Network has contributed to all National Campaigns. RDMs, Nurse Consultant and Communication Lead attend and are engaged in national work stream meetings and divisional meetings. National Initiatives the LCRN have been involved with are: CI supported Accelerating Digital Communications-ICTD league table reporting. PPIE- supported two key national projects PRES report and Patient Research Ambassador Register. Workforce Development: Integrated Workforce. BI Lead part of the national EDGE-CPMS operational working group. Local app developed to encourage self service. Industry Engagement- Senior RDM on Industry working group. Study Support Service launch after national refresh.

Section 3. Key Projects

Please provide an update on all projects outlined in the 2017/18 Annual Plan, inserting additional rows as needed. Please also include any other relevant new projects started, in development or set-up.

RAG Information:

The RAG ratings are automated. Please select Complete, Green, Amber or Red from the drop-down menu in column E and the colour will update automatically.

Complete (C)	Milestone complete
Red (R)	The specified deliverable was not delivered by the Milestone Date
Amber (A)	There is a risk that the specified deliverable will not be delivered by the Milestone Date
Green (G)	On target to deliver the specified deliverable by the Milestone Date

Ref	Key Project	Milestone	RAG	Commentary
3.1. Governance and Management				
3.1.1	The Host organisation has continued to fulfill its responsibilities in line with the DH/LCRN Host agreement	**Complete (C)**	Complete	
3.1.2	Clinical Director Designate appointed in October 2017 to ensure succession planning for the CD role	**Complete (C)**	Complete	
3.2. Financial Management				
3.2.1	Regional NIHR Local Funding Model Review Group	**Complete (C)**	Complete	A robust review of the LCRN funding model was undertaken between June 2017- November 2017 involving representation from secondary care, primary care, finance, RDMs and Clinical Divisional Leads and GP Champion. The review recommended financial principles on which to base future funding allocations to partner organisations.
3.2.2				
3.3. High Level Objectives 2A, 2B, HLO4/5 3.3.1-3.3.4 and HLO6 C 3.3.5				
3.3.1	The network recruited 21,559 patients in 2017/18 less than its original 21,905 target. This was partly due to the decrease in available primary care portfolio studies. In previous years the LCRN had also seen a number of high recruiting studies to non NHS sites, which did not occur this year.	Amber	Amber	RDM Locality leads worked closely with partner organisations early identification of new studies. 5 Portfolio Facilitators were actively involved in searching the portfolio for studies available to open locally. Communities of practice lead by the CRSLs continued to grow to maximise. Improved communication channels with delivery teams within partner organisations. Q4 LCRN commissioned work to explore improving recruitment to portfolio studies as comparison to other LCRNs across England. Findings to be presented to the LCRN Executive Group in 2018/19.
3.3.3	Monthly reporting established between R&D Management and LCRN to reconcile discrepancies between CPMS and LPMS	Green	Green	Embedded in core LCRN Business
3.3.4	Primary Care Commercial Community of Practice group and monthly Industry Community telecons for secondary care established to discuss challenges and share best practice about sponsor engagement, commercial portfolio work and other commercially relevant activities. An assistant RDM appointed in Q4 with a lead role for Industry portfolio to lead and initiate changes to improve RTT.	Green	Green	Embedded in Core LCRN Business
3.3.5	Monthly reporting process between R&D Partners established for recruit to time and target for all relevant HLOs. Locality Leads/RDMs worked closely with identified Partner Organisations to ensure a collaborative approach to performance management.	Green	Green	Embedded in Core LCRN Business

3.3.6	Monthly Reporting process between R&D Partners/PCOs established for recruit to time and target for all relevant HLOs. Locality Leads/RDMs worked closely with identified Partner Organisations to ensure a collaborative approach to performance management.	Green	Green	Embedded on Core LCRN Business (I&I)
3.3.6	**HLO 6C** A reduction in the available studies in the primary care portfolio has seen the percentage of GP practices recruiting to studies falling from 65% 2016/17 to 42% this year	Red (R)	Red	A comparative evaluation of recruitment to the national picture confirms that it is lack of studies available on the portfolio rather than engagement by GPs with in the LCRN. 42% of our GPs are engaged in research. In comparison to the national recruitment of 32% the local recruitment has delivered against the number of available studies on the portfolio.
3.4. Research Delivery				
3.4.1	National CRNCC projects delivered locally include: Supported Accelerating Digital	Amber	Amber	The vast majority of work LCRN work is undertaken on the google Hub, enabling multiple user editing simultaneously. This is now business as usual. A microsite for monthly performance reports (RTT, Highlight report etc) has been developed and a link is emailed out to key stakeholders on a monthly basis when updated. This has reduced the number of requests for adhoc reports by the BI team, increasing capacity within the team. Monthly review of portfolio performance, monthly liaison with Partner Organisations via locality links to reduce discrepancies and site specific studies. All internal meetings are paperless.
3.4.2	Review of local performance commissioned by the LCRN as a comparison to all LCRNs across England to learn lessons from exemplar practice and to increase performance	Complete	Complete	Report to be presented the LCRN Executive Group April 2018 with limitations and recommendations. (see 3.3.1)
3.4.3	Review of the primary care and research management support service in collaboration with APCRC and BRD and GRH	Green	Green	Primary care review of service support service completed evaluating commissioned services for primary care within CCGs and community. Review of report acknowledged that the current collaborations facilitated value for money for primary care but there were some overlap in matrices of responsibilities which were reviewed following consultation. This work will continue 2018/19
3.5. Information and Knowledge				
3.5.1	Continue refining how and to whom we present our data promoting 'self-service', avoiding duplication and working to improve data accuracy. Mid year review for locally reporting outputs to ensure they are continuing to meet the needs of local stakeholders.	Complete	Complete	Following the last major refresh of LCRN reporting we have continuously improved the reports through minor changes (I&I)
3.5.2	Development of reporting within our neighbouring LCRNs (SWP, Wessex and TVSM) to assess: - Whether there is best practice to be shared - Whether there are economies of scale with coordinated working across the wider region (i.e. app development) - Whether there are specialist skills present in some LCRNs where, rather than replicate in each LCRN, joint working arrangements are made (i.e. either 'in-kind' or more formally with financial agreements) i.e. infographics/maps.	Green	Green	A Supra-Regional 'Information and Knowledge / Business Intelligence' working group was created at the Supra-Regional Event (with members attending from WoE, SWP, Wessex and TVSM) held in September 2017. Informal discussions (i.e. sharing best practice) took place at the event and after. A more formal approach (including joint reporting on initiatives to COOs) is planned for 2018/19. (I&I)

3.5.3	Recruitment activity being attributed to a single PO on CPMS for regional projects involving staff from multiple POs at a single site has been a barrier to collaborative working. To prevent this in future, the BI manager will monitor the attribution of recruitment to studies of this nature to ensure reporting accurately reflects the recruitment activity undertaken by staff from each PO.	Complete	Complete	We have devised a process to label studies on EDGE to deal with this situation.
	Key developments relating to local and national systems and processes, including: - How the network has supported the integration of CPMS/LPMS. - Developments relating to the access and use of the Google Hub. - Improvement projects relating to the development of new or existing processes and systems. - New developments relating to the processing and visualisation of performance and other data through the Open Data Platform and other systems.			Re integration of CPMS / LPMS Please see 3.3.3, 3.3.5 and 3.3.6. The BI Manager has attended the fortnightly CRN-EDGE-LPMS teleconference where issues around CPMS/LPMS integration are regularly discussed and solutions to issues are proposed and tested; the group was closely involved in the successful implementation of the GetStudy and HRA Capacity and Capability interfaces in 2017/18. CRN West of England has actively engaged with Partner Organisations to ensure that they are using the new functionality in the LPMS to that will allow the data exchange between CPMS and LPMS; written training materials have been provided and the CRN BI team is available to visit sites to deliver this training on request. Re google hub access and use, please see 3.4.1 and 3.8.2. There are plans in 2018/19 to survey core staff and partner organisations to identify the key issues around access and use of the hub and make recommendations to improve access, skill level and confidence with the hub across the region. Re systems and processes please see 3.2.1, 3.3.5, 3.3.6, 3.4.1, 3.4.3, 3.5.1, 3.5.3, 3.8.2 Re Processing and visualisation of date see 3.5.2. The CRN West of England ODP application was refreshed in 2017/18, however there were no major new developments. A more extensive redesign of the ODP application is planned for 2018/19, including incorporation of LPMS data.
3.6. Stakeholder Engagement and Communications				
3.6.1	West of England Helix Project, innovation to innovation exchange	Green (G)	Green	Continued to work with the AHSN and CLAHRC to explore collaboratively, the set up an innovation exchange and how this mapped on to STPs. Restructure in AHSN meant that this work had been delayed. Collaborative working on taking the project forward is now re-established
3.6.2	Supra- Regional Working between West of England, South West Peninsula, Thames Valley and Wessex	Green (G)	Green	Supra- regional working successful but to continue working collaboratively, a standardised approach to meetings and outcome reporting was recommended by the COOs.The expectation was that individual work streams would meet bi-annually face to face and other meetings as required by telecom/webinar and provide a progress/outcome report to the COOs by specified dates. The work streams would work to a common terms of reference personalised to the individual groups. This approach was finalised in Q4. (I&I)
3.6.3	LCRN Communications Plan 2017/18 v 1.0 set out the planned communication and engagement activity to ensure compliance with the POF	Green (G)	Green	Further investment of 1.6 wte communication assistants was agreed and advertised Q4.
			Green	In total six patient stories were created, some of these are on hold until study progresses and will be used in 2018/19. The patient story that was created: https://www.nihr.ac.uk/news/mel-reynolds-from-bristol-says-they-said-if-i-wasnt-on-the-diabetes-trial-i-wouldnt-be-here-now-it-would-have-been-too-late/6238 and appeared in the Bristol Post: https://www.bristolpost.co.uk/news/bristol-news/clinical-trial-saves-life-bristol-62031 The couple were also interviewed for BBC Radio Bristol as part of our International Clinical Trials Day 2017 coverage.
3.6.4	Increase the number of participants recruited into NIHR CRN portfolio studies by promoting benefits of participation		Green	
			Green	
			Green	
			Green	

			Green	A 'thank you for taking part in research' postcard has been designed and approved by R&D Managers in POS and signed off by Coordinating Centre for Research Teams to give to research participants with a prompt to contact the Communications Department with their experience stories. Greater use of film interviews has been made which will be shared via Social Media and with clinical colleagues at events in 2018/19. Increased contact with relevant colleagues and better relationships with colleagues in POs will ensure a greater number of Patient Stories for 2018/19.
3.6.5	Tweet at least one patient story per calendar month and direct to full story in CRN magazine.		Green	Overall, the Twitter audience was increased from 450 followers to 850, with activity being particularly increased by followers in key specialties (such as Critical Care). Posts of other LCRN patient stories were retweeted, along with key NIHR and Co-ordinating Centre messages and messages from POs.
3.6.6	Publicise ten research success stories via CRN communications, general media, specialist press and online/social media.	Green	Green	Success stories were publicised via monthly newsletter, both quarterly in e-magazine format (typeset in house:
			Green	https://www.nihr.ac.uk/nihr-in-your-area/west-of-england/documents/CRN%20West%20of%20England%20newsletter%20SUMMER%20vF.pdf)
			Green	and monthly in e-newsletter format
			Green	https://mailchi.mp/nihr/interested-in-clinical-research-this-is-for-you-549293
			Green	It was decided that the electronic newsletters were better value for money and provided better measurability of success. The latest newsletter had a 19% open rate and 11% click through rate, with an increased monthly open rate. Key stories from these were promoted via Twitter and with attempted media sell-in where appropriate.
3.6.7	Communications Lead to produce a film dispelling ten research myths for use on Network organisation websites and for talks/ presentations for patient/public audiences.	Green	Green	A PowerPoint presentation dispelling research myths and showcasing local people who have taken part in research was created for research active primary care sites and accessed via the Primary Care newsletter Q4. This presentation was developed by incorporating positive patient feedback from the PRES. This was accessed by 5 GP practices, and others have requested an animated format.
3.6.8	Create a communications engagement plan for primary care.	Complete	Complete	This was completed, working with the Primary Care team to assess what Communications were necessary dependent on their strategic aims. A flyer for the RSI event was produced to distribute at the three events to advertise the Primary Care Team offer. This has been revised and expanded for 2018/19. The existing contacts list was segmented into Primary Care and Secondary Care contacts and utilised to send a dedicated Primary Care e-newsletter, with an open rate of 23% and a clickthrough rate of 12%. Overhauled and updated Primary Care Google site to better reflect new branding and LCRN strategic aims. The aim for 2018/19 is to increase this engagement.
3.6.9	Share 8 positive stories or research updates with relevant health condition charities for onward promotion.	Amber	Amber	Charity collaborations were not achieved in this year's activity. Internal discussions with RDMs about which charities to target which will inform clearer collaboration in 2018/19, if it matches overall strategic aims.
3.6.10	CRN West of England to jointly host public dementia research event with Alzheimer's Research UK.	Amber	Amber	Continued liaison with Join Dementia Research (JDR) Officer has shown a clear workforce emphasis in JDR activity this year. Retweeting key Central JDR messaging has been in place throughout the year. Broadcasting of JDR activity when applicable (such as publicising a stall at Bath Christmas market) is complete, along with suggesting a partnership with the Diabetes team to share the space. Plans for 2018/19 to work with JDR Ambassadors and charities are in place and the Communications team will help to support this.
3.6.11	Communications Lead to support research active organisations to improve research content on websites. Link to UK clinical trials gateway.	Green	Green	Links have been strengthened between PO communications teams and LCRN Communications Manager which will be built upon in 2018/19. An example of this is work around the promotion of International Clinical Trials Day with POs:
			Green	https://spark.adobe.com/page/IFfLSKZuNmkxa/
			Green	Links on all promotional material went to UK Clinical Trials Gateway. Further promotion was advised against by Coordinating Centre as UK Clinical Trial Gateway website was being redeveloped throughout Q3/Q4 of 2017/18.
3.6.12	Increase the proportion of studies in NIHR CRN Portfolio delivering recruitment on time and to target.	Green	Green	Good news stories about top-recruiting or well recruiting sites, with interviews with site teams where possible, have been broadcast via newsletters and social media. A film interview with a clinical colleague in SWP about the benefits of pump funding was created and edited to be broadcast to Clinical Leads and Senior Colleagues (R&D managers and directors) at the 'Growth and Sustainability' event in January 2017. It was added to the main NIHR YouTube channel for wider dissemination. Increased internal communication about these stories continues. Ideas of how to greater increase external RTT communications will be put into place in 2018/19.

3.6.13	Celebration of sites and teams achieving RTT and Global/European/UK Firsts	Green	Green	News of three Global firsts, one European first and seven UK Firsts were reported in newsletters, In 2018/19 these achievements will be further celebrated by certificates (designed in-house) and letters for RTT. Partner organisations achieved three global first patients to commercial studies: • University Hospitals Bristol NHS Foundation Trust achieved a global first patient in an acute Graft vs Host Disease study (CPMS ID 30732) in the Cancer specialty. • Great Western Hospitals NHS Foundation Trust achieved a global first patient in a heart failure study (CPMS ID 33958) in the Cardiovascular diseases specialty. • Oldfield Surgery achieved a global first patient in a lipid-modifying therapy use study (CPMS ID 34509) in the Metabolic and Endocrine Disorders specialty. Partner organisations achieved a further eight European and UK first patients to commercial studies.
3.6.14	Establish a process to trigger contact by Communications Lead with CIs. Evidence recommendations to CIs & evaluate with survey of CIs.	Amber	Amber	Stakeholder mapping and stakeholder journey mapping has started, to be continued in 2018/19 Communications manager has worked with RDM's PF's and CRSLs to produce local infographics for key specialties showing the key benefits of bringing research to the West of England region. These are currently complete for Mental Health, DeNDRoN and Critical Care. More specialities will be added in 2018/19.
3.6.15	Support Diabetes specialty team to promote Research in region	Green	Green	Worked with Senior Research Nurse and patient panel to design and produce posters and leaflets detailing research opportunities in the West of England for distribution to all POs and Primary Care sites. Continue to advise on Social Media possibilities, to provide supporting events media (eg. pull ups) and disseminate stories of events via Social Media channels and to try and sell-in to local press.
3.6.16	Increase coherency and accuracy of LCRN website and online presence	Green	Green	Continue to work with Coordinating centre to ensure LCRN web presence is relevant and up-to-date. Have created digital imagery for use in Eventbrite to better facilitate LCRN events and promote via Social Media and internal lists to relevant contacts.
3.6.17	Support NIHR Communications Strategy objectives 2015-2020 Participate in design & delivery of NIHR communications campaigns & planning.	Green	Green	Attended and contributed regularly to the national communications meetings in London to the virtual Communications team via G+ , sharing best practice and resources.
3.6.18	Protect Network reputation by adhering to brand identity guidance and communications policies & procedures.	Green	Green	Ensured all communications produced adhered to brand guidelines and were signed off by Coordinating Centre prior to distribution. Shared links to relevant new templates and acted as guardian within team and with POs. Designed and produced new materials for team use at events, such as pull-up banners.
3.6.19	Inform the Co-ordinating Centre of planned communications activity & manage any risks.	Green	Green	Regular contact with central communications link officer for CRN West of England. Regularly took part in monthly teleconferences and the quarterly national face to face communications meetings, plus regular catch ups with the assigned Coordinating Centre Communications Manager link.
3.6.21	Patient Research Experience Survey (PRES) 2016/17	Complete	Complete	There were 306 respondents to the 2016/17 survey, from a range of specialities across the network. LCRN PRES report published July 2017. A working group of representatives from the LCRN, all POs and public contributors met in Aug. 2017, to discuss implementation of the report recommendations. A workshop was held at the design and delivery of the 2017/18 survey, based on learning and key recommendations from the report. In line with continuous improvement, the working group agreed key changes to be made to 2017/18 survey. • Reduction from 24Qs to 15Qs • Focused questions related to recommendations from 2016/17 report • Questions comms and age demographic, to better inform delivery in the future 2017/18 PRES was presented at a Young Persons Advisory Group meeting, the outcome was that this group will begin a project to design and plan delivery of a young person specific PRES 2018/19.

3.6.22	Patient Research Ambassador Initiative	Green	Green	The LCRN currently has seven PRAIs registered nationally. The Initiative was soft launched via the communication team in 2017. However , due to capacity issues there has not yet been a wider launch across the network, or a launch event. PPIE lead is working with PPIE partners in People in Health West of England (PHWE), to define the role locally, once this is finalised in 2018, there will be a planned launch across the Network. The added resources to the communications team will assist growing the initiative further in the LCRN(Reference 3.6.
3.6.23	Expression of interest submitted to be a 'Test Bed' pilot site for the introductory phase of the National Standards for Public Involvement in Research.	Complete	Complete	The WoE PPIE network People in Health West, of which the LCRN in a partner organisation submitted an expression of interest to be a pilot site for the introductory phase of the National Standards for Public Involvement in Research. Although we were not selected to be a site , developing the application was a useful project for the PHWE collaboration, and evidenced how as a PPIE network , we were able to work well together on such an application, as a group we plan to look at further collaborative projects in 2018/19
	Workforce, Learning & Organisational Development			
3.7.1	LCRN has in place a senior leader with identified responsibility for the wellbeing of all LCRN funded staff	Green (G)	Green	Nurse Consultant post named as the Wellbeing Lead for the LCRN. In Q4 backfill to this post was increased from 0.2wte to 1.0wte to ensure delivery of the workforce learning and organisational development agenda. During this time the Wellbeing plan has been developed in collaboration with members of the Research Workforce Steering Committee (representations from senior nurses, allied health professionals within partner organisations) Chaired by the NC.
3.7.2	LCRN has an active programme of activities that engage the wider workforce to promote clinical research as an integral part of health care for all	Green (G)	Green	Robust training offer continued Q1-4 GCP online and face to face, Valid Informed Consent, Next Steps in Clinical Research and Let's Talk Trials In Q1, 4 sets of additional training were made available. PI Research Awareness, PI research essentials, The PI role: Leadership and PI Masterclass delivered by Research Nurses or PI s in 3 POs. Soft launch of the Integrated Workforce Framework has been completed to enable research competencies to be embedded into appraisals and support the development of changing career pathways In Q4 a professional Nursing and AHP event/workshop was delivered by LCRN NC/RDMS to increase workforce engagement with LCRN HLOs which was evaluated positively and attended by 113 and will be repeated in 2018/19 In Q4 a strategic event was held for R&D Management, R&D Directors and any key stakeholders to inform the annual planning for the network. CRNCC supported the event through a facilitator Stephanie Carson and presenter Stephen Lock
3.8.2	**Continuous Improvement Initiatives not covered elsewhere in the report**			
	Industry functions to be closely integrated into all core team roles to build speciality level central intelligence.	Complete	Complete	Portfolio facilitators now responsible for distribution and receival of Expression of Interests for new studies for their relevant studies in collaboration with the relevant RDMs. This has enabled a more streamlined service for our stakeholders and the building of better relationships between speciality relevant stakeholders and their relevant PF and RDM.
	Development of our external facing industry processes to improve attractiveness of LCRN to companies.	Amber	Amber	Capacity issues within the team mean that this has now been rescheduled to 2018/19. Assistant RDM with a responsibility of supporting externally facing industry processes appointed Q4.
	Performing a Root Cause Analysis for each study that has closed without achieving RTT, identifying lessons learned and using these to feed into improvement of current and existing studies.	Green (G)	Green	Partner Organisations are performing a Route Cause Analysis for relevant studies. Discussions about how best to efficiently transfer this information into EDGE continue and a system for doing so will be finalised in 2018/19.
	Work with the RIWC to identify a Continuous Improvement champion in each PO and pull together a local Continuous Improvement champions group	Amber	Amber	Due to capacity issues this will take place in Q1 of 2018/19. Chair of the RIWC is the NC whose backfill increased from 0.2wte to 1.0wte Q4.
	Ensure ‘Tools for teams’ developed by national Continuous Improvement leads are accessible and promoted to core team and POs.	Complete	Complete	All core team members have completed the NHS Quality Improvement Bronze programme and two staff members are currently enrolled within the Silver Programme. These programmes include the "Tools for Teams". POs have access to their trust specific QI programmes.

	All core team meetings are paperless with papers projected onto screen. Minutes are typed directly onto the drive so only need amendment later.	Green (G)	Green	All core team meetings are now paperless with papers projected onto screen. 50% of core meetings now have minutes orations typed directly onto the drive. A turnover in administration staff and an admin review have delayed the full implementation of minutes being typed directly onto the screen.
	Further expansion and development of external workspaces on the drive for all key meetings.	Complete	Complete	External sections of the drive have been expanded and further developed. Papers for these meetings and other relevant documents are put directly onto the drive so these meetings are now paperless. This has improved both version control and reduced impact on stationary resource.
	Explore the potential to automate manual processes associated with network training courses e.g. distribution of paperwork, delegate feedback and certificate distribution.	Green (G)	Green	This initiative is in progress and will be completed in 2018/19
3.9. Other local innovations and initiatives				
3.9.1	LCRN Development Fund Dementia project agreed in	Green (G)	Green	Final evaluation of the project will be in October 2018/19
3.9.2	LCRN Development Diabetes Project (3 year project) agreed in 2016/17 with the aim of improving equity of access to research for patients with diabetes. To identify key research champions. Map diabetes across primary and secondary care. Improve communication and collaboration within our region. Increase the number of study participants to available studies on the portfolio.Regional referral of patients into research studies. Active PPIE group driving the development of the project. Additional support for potential sites. Project lead involved with the STP development for diabetes to ensure research forms part of the pathway. Regional meeting broadening the industry invites .	Green (G)	Green	Final evaluation of the project will be in October 2018/19

Section 4. CRN Clinical Research Specialties

4.1. Please provide a report on performance against individual Clinical Research Specialty Objectives.
Please (a) enter the actions to achieve the objectives from your 2017/18 Annual Plan, adding any additional actions taken as appropriate [column C]. Please comment on your network's performance and impact against your planned contributions in 2017/18 [column D].

Ref	Specialty Objective	LCRN actions to achieve objective	Performance against plan
1	Ageing	1. RDM and PF to contact all relevant research teams to map service provision across CRN West of England in Q1. 2. PF to circulate to this group quarterly a full list of studies for which Ageing is either managing or supporting specialty. 3. New national pipeline studies are likely to become available to sites in Q4. CRSL will provide details from the NSG. 4. The one study with ageing as the managing specialty open and recruiting in 2016-17 is LACE: 18290, due to close in 2018. PF to monitor RTT and discuss with site team.	The specialty objective has been met. There is an established and keen regional Specialist Registrar Network: The Severn Trainee Anaesthetic Research (STAR) group (http://anaesthesiaresearch.org/). It has grown into a very successful trainee research network as well as a forum for research opportunities and networking. There are dedicated trainees at all six PO's willing to take part in research. The CRSL met with the STAR group three times this year and monthly with the STAR trainee lead (Dr Alex Looseley) to review the portfolio and share best practice. Trainee network has a representative (Dr Kate Reeve) at RAFT the national umbrella group for trainee research networks. 1. The SWeAT study (CPMS ID: 32193) is STAR led and six out of six (100%) eligible POs (GRH, GWH, NBT, RUH, UHB and WAHT) recruited to this study. This locally-led project was funded by the National Institute for Academic Anaesthesia/AAGBI. All the eligible POs in LCRN took part with 151 participants and total of 397 participants nationally. There was excellent collaboration with CRN South West Peninsula and Wales to recruit a total of 397 across the three regions. 2. The SNAP-2 study (also known as the Epidemiology of Critical Care provision after Surgery (EpiCCS) CPMS ID: 31913) is the second Sprint National Anaesthesia Project, and is STAR led. Six out of six (100%) eligible POs (GRH, GWH, NBT, RUH, UHB and WAHT) recruited to this study. 3. In 2017-18, three out of six (50%) eligible POs (GWH, RUH and UHB) participated in FLO-ELA (CPMS ID: 33869). 4. Covered by 1 and 2 above. 5. RDM joined POMCTN for further information about the organisation and potential studies. 6. No studies were challenged in 2017-18. 7. CRSL has encouraged membership of POMCTN. Unfortunately, membership details are confidential. 8. NIHR CRN Specialty Group and the National Institute of Academic Anaesthesia contributed to "NIHR 20-year future look" report published by RAND in 2017. The LCRN CRSL commented on the report findings: "Initial observation is that whilst implicit in some of the comments about the research environment, there is not much explicit reference to the training/research pathway or Athena Swan agendas, particularly in the summary text. Where this is mentioned (Section 5.2.1 on Page 48), it is pleasing that commentary from the Specialty Group is included and this reflects much of the group discussions over the last couple of years." Other activities include: -CRSL is on the Executive Committee of BSTC (Bristol Surgical Trials Centre) which meets three times a year. This is a great platform to discuss collaborative trials and improve communication between specialties with regards to

2A	Anaesthesia, Perioperative Medicine and Pain Management	The LCRN already has an actively recruiting Specialist Registrar Network: STAR, which benefits Severn Deanery NHS Trusts. The LCRN will support and encourage their involvement in NIHR CRN Portfolio studies by: 1. Supporting the STAR led SWeAT study in six eligible POs (data collection started on 22 February 2017 at GRH, GWH, NBT, RUH, UHB and WAHT). 2. Supporting the STAR led SNAP-2 study from March 2017 at GRH, GWH, NBT, RUH, WAHT and UHB. 3. A minimum of three sites participating in the FLO-ELA study. Although FLO-ELA will be consultant-led, the LCRN will encourage participation of trainees to further broaden their experience with NIHR CRN studies. 4. CRSL continuing to meet with anaesthetists in POs to agree how to work together via STAR and the UK POMCTN meeting. 5. CRSL using the UK POMCTN to identify a minimum of two eligible studies. 6. CRSL encouraging a minimum of two research active consultants at NBT, RUH and UHB and a minimum of one at GRH, GWH and WAHT to register with the UK POMCTN (www.pomctn.org). 7. CRSL and RDM challenging all appropriate studies with NIHR CRN that are inaccurately categorised to other specialties. 8. CRSL submitting and discussing the Specialty Group's guidance for Annual Review of Competence Progression (ARCP) panels for trainees undertaking research placements with Severn PGME School of Anaesthesia.	The specialty objective has been met. There is an established and keen regional Specialist Registrar Network: The Severn Trainee Anaesthetic Research (STAR) group (http://anaesthesiaresearch.org/). It has grown into a very successful trainee research network as well as a forum for research opportunities and networking. There are dedicated trainees at all six PO's willing to take part in research. The CRSL met with the STAR group three times this year and monthly with the STAR trainee lead (Dr Alex Looseley) to review the portfolio and share best practice. Trainee network has a representative (Dr Kate Reeve) at RAFT the national umbrella group for trainee research networks. 1. The SWeAT study (CPMS ID: 32193) is STAR led and six out of six (100%) eligible POs (GRH, GWH, NBT, RUH, UHB and WAHT) recruited to this study. This locally-led project was funded by the National Institute for Academic Anaesthesia/AAGBI. All the eligible POs in LCRN took part with 151 participants and total of 397 participants nationally. There was excellent collaboration with CRN South West Peninsula and Wales to recruit a total of 397 across the three regions. 2. The SNAP-2 study (also known as the Epidemiology of Critical Care provision after Surgery (EpiCCS) CPMS ID: 31913) is the second Sprint National Anaesthesia Project, and is STAR led. Six out of six (100%) eligible POs (GRH, GWH, NBT, RUH, UHB and WAHT) recruited to this study. 3. In 2017-18, three out of six (50%) eligible POs (GWH, RUH and UHB) participated in FLO-ELA (CPMS ID: 33869). 4. Covered by 1 and 2 above. 5. RDM joined POMCTN for further information about the organisation and potential studies. 6. No studies were challenged in 2017-18. 7. CRSL has encouraged membership of POMCTN. Unfortunately, membership details are confidential. 8. NIHR CRN Specialty Group and the National Institute of Academic Anaesthesia contributed to "NIHR 20-year future look" report published by RAND in 2017. The LCRN CRSL commented on the report findings: "Initial observation is that whilst implicit in some of the comments about the research environment, there is not much explicit reference to the training/research pathway or Athena Swan agendas, particularly in the summary text. Where this is mentioned (Section 5.2.1 on Page 48), it is pleasing that commentary from the Specialty Group is included and this reflects much of the group discussions over the last couple of years." Other activities include: -CRSL is on the Executive Committee of BSTC (Bristol Surgical Trials Centre) which meets three times a year. This is a great platform to discuss collaborative trials and improve communication between specialties with regards to
2B	Anaesthesia, Perioperative Medicine and Pain Management	As above.	As above.
3	Cancer	1. Study set up times for commercial studies at some sites need to improve in 2017-18. RDM will organise meeting/workshop with research teams where this has been highlighted as a problem to agree fast track process and monitor start up times. Sites will be asked to provide feedback on site selection dates and start up to the industry team. All commercial studies will report set up within timelines agreed with the sponsor by March 2018. 2. RDM and PF will continue to support the SSLs at each tumour site specific group by preparing a recruitment and pipeline report. The RDM and PF will meet with each SSL six monthly prior to each SSG to discuss national and local issues and solutions and review action plans. 3. PF will prepare quarterly network portfolio lists (studies in set up and open to recruitment) for each SSL that will be distributed to cancer research teams at all sites to raise awareness of the whole network portfolio and encourage intra-network referrals to other sites. This will enable patients to have the opportunity to participate in research, even if the study is not open at their local hospital. Templates will be confirmed in Q1 and include studies for which cancer is the supporting specialty. 4.RDM, SSLs and IOM will agree a process in Q1 with R&D teams to enable EOIs to consider the whole network population for the recruitment forecast to improve chances of site selection. Studies suitable for this model would include commercial studies and those concerned with rare conditions. SSLs, RDM and PF will actively promote this way of working through the quarterly portfolio list/report, SSGs and Cancer Team Leads group. We will expect to see an increase in the number studies selected for sites in the network as a result. Currently there are 39 commercial studies open. This is 14% of the local cancer portfolio. The objective for 2017-18 is to achieve 18-20% by March 2018. 5. RDM and PF will confirm dates for quarterly meetings/teleconferences for the cancer research team leads to communicate and agree plans and enable the leads to motivate, share issues and best practice enabling network wide solutions. Information around performance and objectives will be cascaded to cancer research teams via this route. 6.T he GMC project lead and clinical lead invited to attend Q1 Cancer research team leads group to agree collaborative working at all participating sites and showcase NBT model. PF to work with GMC project lead to agree system of monitoring research activity from collaborative model. Teams will be asked to report successes in recruitment via this model by end of Q2.	The specialty objective has been met. 11 of 13 cancer subspecialties achieved on-target recruitment in 2017-18. 1. UHB commercial manager and Bristol Haematology and Oncology Centre (BHOC) CTU senior management team have worked on a process to improve HLO4 , for commercial studies. Process now in place to focus on commercial study set up. RDM organised a cancer team leads meeting on the 17/10/2017, representatives from teams across the network were present. UHB commercial research manager and BHOC manager presented their model to other teams in the network, the aim was to share best practice, in an attempt to improve HLO4 metric across the cancer portfolio, particularly focused on commercial studies. Further work is planned in 2018/19, to focus on HLO4 in this area. 2. RDM attending site specific group meetings, for all 13 tumour site specific group, utilising the research agenda slot to report on subspecialty performance, including pipeline report now being shared at these meetings and uploaded to the website for Somerset Wiltshire Avon and Gloucestershire cancer alliance access. There is a Plan for the research agenda slot to be used as a launch or relaunch portfolio studies across the network, this is in progress and being presented at the site specific group meetings. Intra network referral is actively promoted by RDM and SSL at each SSG meeting attended. 3. A list of studies (Open and in set up, across the network), is now presented and discussed during the site specific group meetings, RDM utilises this presentation to explain the value of intra network referral. PI's are now invited to give a brief presentation of any studies they would like to promote across the network, this has been useful in the Breast SSG, it is intended that this initiative can be rolled out across the other SSG over the next cycle of meetings. 4. RDM, IOM, and BI manager met in Q1, to plan this initiative, it was decided that it was necessary to promote this way of working with the clinicians firstly, to ensure engagement, as a whole network approach to target setting is reliant on clinician engagement with intra network referrals. This has been actively promoted to the SSGs through the SSLs and the RDM. Currently there are 44 commercial studies open. This is now 16.7% of the local cancer portfolio, showing an increase from 2016/17. 5. RDM and PF have met face to face with cancer teams through the year, to review the portfolio, feedback from national meetings, discuss both national and local issues and best practice. A community of practice meeting was hosted by the LCRN , where there was a workshop on HLO4 (refer to point 1.) 6. GMC project lead presented at cancer leads meeting, held in Q3. Five of the six acute trusts across the network

4	Cardiovascular Disease	1. CRSL, RDM and PF to create community of practice comprised of active investigators and research teams from the existing portfolio. The group will map service provision, review the portfolio and performance locally and nationally, share best practice and expect intra-network referral of patients to sites where studies are open. 2. Initial discussions have been held with the CRN West of England Primary Care team as to how to work most effectively and efficiently with existing systems for GPs to search their databases and contact potentially suitable patients for trials at the specialist centre.	The specialty objective has not been met. The type of study each of our 2 main Cardiovascular Disease research sites within West of England is capable of delivering is very different with little cross over (i.e. specialist centre vs. district general). Therefore the metric was difficult to meet. The 2016-17 baseline for number of studies recruiting at >1 site in the West of England was 6 studies (national average: 15). A 50% reduction over the year means the 2017-18 figure is 3 studies (national average: 17) 1. Delivery teams recruiting to Cardiovascular Disease studies were contacted regarding creating a community of practice in Q1. Due to the above issue of sites having no cross over in studies (and therefore less opportunity to share best practice) it was felt a community of practice between sites would not be suitable. 2. The concept of developing feeder sites to our large specialist centre is being realised with the OMACS study (CPMS: 35331), where we have worked with the CI to change the single centre study into a multicentre study, although this has been with secondary sites. We have also worked with the CI for the ATRIUM study (CPMS: 33800) to adapt it so it can be delivered in primary care.
5	Children	Maintain the current position as a minimum but also: ● To broaden the range of children's portfolio studies undertaken within UHB, expanding into opportunity areas including neurology and pain management. Aim to open at least one study in both areas. ● To engage with all feasible children's portfolio studies in order to increase participation at sites outside UHB ● Explore potential for opening studies that recruit children within GCS. ○ Identify which services GCS provide. ○ Attend GCS R&D group (or other relevant meeting within GCS). ○ Engage with relevant staff within GCS about opening new studies. ○ Examine existing portfolio within the network for suitable studies to open at GCS. ○ Review all studies open to new sites for feasibility of opening within GCS. ● Examine the portfolio to identify areas where increased collaboration with primary care could take place especially for studies running outside UHB (tertiary centre).	This speciality objective has not been met. 6/7 (86%) of trusts providing children's services recruited to children's portfolio studies. The remaining trust (GCS) has only recently become research active. The LCRN has maintained the current level but not met the national speciality objective. There are also multiple studies recruiting children in other specialities, particularly within primary care. The range of children's studies undertaken at UHB have been expanded into the area of pain management with the opening of MAGPIE. There has also been expansion into the area of DMD / Neuromuscular disorders and into commercial cancer studies. Feasible children's portfolio studies are assessed for potential for recruitment from sites outside UHB. Currently of the 67 studies across 88 sites 58 (66%) are running in UHB with the remaining 30 being split across 5 sites. The highest number of WoE led studies are in the Children's portfolio. The LCRN has continued to explore the potential for opening studies that recruit children within GCS. Regular attendance at the GCS R&D Group and engaging with relevant staff via that group about potential new studies. On an ongoing basis the LCRN continues to examine the existing portfolio for suitable studies to open within GCS. Initial exploration of areas for increased collaboration with primary care has started but will be developed further in 2018/19 100% of paediatric ED nursing staff are now GCP trained and the Eclipse trial (deferred consent) has been successfully completed; recruiting over target. This study has already improved practice due to universal buy in to standardisation of approach to seizures.

6	Critical Care	The CRN West of England will increase the proportion of intensive care units recruiting into studies on the NIHR CRN Portfolio by: 1.Maintaining the current level of six ICUs (100%) recruiting into studies on the NIHR CRN Portfolio. 2. CRSL and RDM holding one LCRN Critical Care regional meeting to promote and facilitate research and share best practice between research active staff in our POs. 3. CRSL identifying a designated lead for critical care studies in each ITU. 4. CRSL and RDM focusing on developing the NIHR CRN research portfolio in GRH, RUH and WAHT. Current portfolio and pipeline for 2017-18 is centred on GWH, NBT and UHB as sites for PARAMEDIC 2, CENTER-TBI UK, Adrenal and AWARE III studies. 5. Exploring the potential of other models and ways of working from other LCRNs to address challenges.	The specialty objective has been met. 1. The LCRN has maintained five out of five (100%) eligible ITUs participating in NIHR CRN Portfolio studies (GRH, GWH, NBT, RUH and UHB). WAHT is no longer an eligible recruiting site as from 04/07/2017 the A&E Dept.at WAHT is closed between 10 pm and 8 am. This has affected the ability to deliver NIHR CRN Portfolio studies at this site. The LCRN had one commercial study recruiting on the NIHR Portfolio and this was open at UHB. 2. The LCRN has held two regional Critical Care meetings to promote and facilitate research and share best practice between research active staff in the POs. Both events have included members from outside of the region. 2.1. 22 September 2017 event First critical care regional meeting held on 22/09/2017 with 10 attendees. As a result of the discussion, the multidisciplinary research group agreed a five-year strategy: “to work together to develop at least one successful grant application in critical care research” to increase research in the region and agreed to meet twice a year thereafter. 2.2. 16 March 2018 event Second critical care regional meeting was held on 22/09/2017 with XX attendees. Various research proposals at different stages presented to take forward as a group. 3. The LCRN has identified a lead for critical care studies in each ITU and compiled a list. CRSL has had individual conversations with ICUs in the region about how they can increase recruitment 4. CRSL and RDM focused on developing the NIHR CRN research portfolio in GWH, RUH and WAHT. The 65 study (CPMS ID: 34223) is open at these three sites. RDM and PF assisted PO to negotiate a smaller target for Point Of Care Testing For Sepsis (CPMS ID: 33352) where the target was originally 200. 5. Feedback received from other LCRNs about other models and ways of working. The pros and cons of each approach was discussed informally at our first regional event on 22/09/2017. The potential for a business case submission to LCRN to support other models of working was also discussed. Other activities include: -To promoting the visibility of the LCRN and encourage and recognise achievements in research, the LCRN sponsored a prize for junior researchers at the Society of Intensive Care of the West of England (SICOWE) Annual Meeting on 8-9/02/2018.
7	Dementias and Neurodegeneration	1. LCRN JDR performance overall will increase by an additional 200 registrants and specifically with people with dementia by an additional 50 during 2017-18. 2. JDR function will align with PPIE and Communications work streams within the LCRN to promote JDR at all events and within all communications.(I&I) 3. Promotion of JDR will become a ‘business as usual’ function for the LCRN Primary Care team and the division 4 peripatetic team. 4. BDWS will actively promote JDR and report back to their bimonthly research group on this activity. Expect 30-50 new JDR registrants with dementia on JDR from Bristol. 5. Dementia clinical services will be targeted by the JDR lead to encourage them to promote JDR to patients at the early stages of their care. (I&I) 6. The two LCRN development fund dementia projects (agreed in 2016-17) aim to increase access to research for patients in primary care settings. Evidence of them actively promoting JDR will be reported at end of Q2. 7. The LCRN is a pilot site for national projects involving a mail out to all dementia patients on the Clevedon medical practice register promoting JDR. The national team will report back on this in Q2. 8. JDR named lead to continue collaboration with Bristol Dementia Health Integration Team to develop promotional materials that showcase dementia research in the region. Materials circulated by Q2. 9. All GP practices will be asked to display JDR materials. JDR lead to disseminate through the LCRN primary care team and run a survey monkey to ascertain uptake in Q3. 10. All research sites will be asked by way of an online survey to report on their usage of JDR to identify study participants to the leadership group in July 2017.	This objective is measured nationally. 1. Due to a break between JDR Project Officers being appointed we did not achieve the increase in registrants. The largest initiative delivered (GP mail outs, see below) will contribute registrants to 2018/19 totals. 2. Following a staff review, it was decided to combine PPIE with our general admin team. The JDR Project Officer has attended the following events: Tasks 3, 4, 5, 6, 9 & 10 were not progressed due the break in JDR Project Officer cover. 7. This pilot was rolled out to 3 other practices and involved 12,000 invitation letters being sent out. 8. Contact with Bristol Dementia HIT has continued throughout culminating in project to be delivered in 2018/19 (further details included in 2018/19 Annual Plan). The 504 target for HLO7 was missed by 33 participants (471 patients recruited) however a significant achievement has been setting up and running a number of studies in the Bristol Dementia Wellbeing Service (BDWS) which has previously been inactive in research. The 22 patients recruited in BDWS in 17-18 formally register against CRN SWP, however were facilitated by CRN WoE staff.

8	Dermatology	The LCRN will increase the number of nurse PIs by: 1. CRSL and RDM circulating call for nurses interested in dermatology research. 2. CRSL and RDM establishing a 'dermatology nurse interest group' to develop interest in dermatology research. 3. From this group, explore the potential for developing a 'buddying system' for more experienced staff to share their knowledge with those who are less experienced in research. 4. Identifying non-medical PI models in other LCRNs. 5. CRSL building links with primary care organisations to identify interested practitioners to facilitate recruitment. 6. Identifying a minimum of three dermatology department nurses to undertake GCP training with a view to a minimum of one acting as PI on a suitable study. 7. CRSL and RDM focusing on developing the NIHR CRN research portfolio where appropriate for the patient pathway. 8. CRSL meeting with a minimum of one consultant per research active PO per year.	The specialty objective has not been met. The CRSL met with a research nurse in WAHT who agreed to act as non-medical PI. The LCRN has also identified one other nurse who has expressed an interest in becoming a PI should the right study requiring non-medical PIs be added onto NIHR CRN Portfolio for the dermatology specialty. 1. A call for nurses interested in dermatology research was circulated as part of the research event promotion for 16/11/2017. An expression of interest about becoming a nurse PI was sent out to the newly formed 'Dermatology Research Group'. The LCRN has received interest from 2 nurses to become PIs should the right study come along. 2. From the event, the LCRN determined 2 nurses were interested in dermatology research. 3. From the event, 1 person has been identified who is interested in a 'buddying system'. 4. This offering will form part of a much more structured work package planned for 2018-19. 5. Primary care colleagues invited to dermatology event. 6. From the event, the LCRN has identified 2 nurses who are willing to act as PIs once the right study is available. The CRSL and RDM have also discussed strategies to keep these members of staff interested if a study is not immediately available. This will include creating a network, signposting to relevant training and providing shadowing opportunities as part of a package (see point 3 above). 7. CRSL and RDM met regularly to review the NIHR CRN Portfolio. 8. CRSL and RDM decided a better way of managing time and meeting individuals was to do this through the Dermatology Research event held in 16/11/2017. The CRSL chaired the first regional dermatology meeting held on 16/11/2017 with 24 attendees including trials coordinators, research nurses, academic GPs and senior and junior doctors. The invitation was extended to primary care colleagues to increase collaboration. The meeting provided an opportunity to provide training on the Eczema Area and Severity Index (EASI) score, a tool used to measure the extent and severity of atopic eczema, hear from Keynote Speaker Kim Thomas, Professor of Applied Dermatology Research at University of Nottingham and a session for registrars to present their research ideas. 8 consultants attended dermatology meeting. The group also discussed establishing a 'dermatology nurse interest group', developing a 'buddying system' and identifying non-medical PIs. The group agreed to meet twice a year and another meeting is scheduled for June 2018. This will be held on a rotational basis at a PO. Other activities include: -The LCRN has also developed closer links with PIs from other sites (RUH) and encouraged attendance at the first Skin@Bath Network Symposium on 13-14/12/2017. This was a joint event with University of Bath.
9A	Diabetes	The LCRN will increase Primary Care recruitment into Diabetes studies by: 1. Building upon collaboration between secondary/primary care identifying key players (GPs and nurses) in primary care and building and mapping the relationships. 2. Building a profile of each research site to enable studies to be more focused. 3. Identifying new studies and supporting community and secondary care sites with set up. 4. Setting up meetings between secondary and primary care – such as practice nurse teaching. 5. Listening and responding to the PPI group. 6. Identifying training needs for staff. 7. Building a profile of disease prevalence 8. Identifying research opportunities that span primary and secondary care thus strengthening networks and supporting skill development. 9. Target 10% increase from 2016-17 patients recruited within community.	The national specialty objective has not been met. 16 patients were recruited from community sites in 2017/18, compared to 24 patients in baseline 2016/17. The local objectives have been met through continuation of the local Diabetes Project, these include the PPI group actively taking part in the development of leaflets and meetings between Primary and Secondary care delivered.
9B	Diabetes	Target 5% increase for community sites.	The national specialty objective has not been met. Three sites participated in studies relating to the prevention of diabetes and its complications in 2017/18, compared to four sites in baseline 2016/17. However, the Diabetes Project has increased primary and secondary care engagement across the region.

10	Ear, Nose and Throat	The LCRN will develop research infrastructure (including staff capacity) in the NHS to support clinical research by: 1. Maintaining current CRSL as audiology champion. 2. Focusing on maintaining the NIHR CRN research portfolio in this specialty at five sites. 3. CRSL identifying areas that may need support in liaison with the CRSL and POs. 4. CRSL meeting once a year with audiology teams at each of the five sites that have the potential to recruit to ENT studies to increase awareness about the LCRN and ENT portfolio. 5. CRSL providing support and mentoring for new PIs as appropriate. 6. CRSL, RDM and PF sharing best practice and learning from established sites such as GRH and UHB (where both sites have exceeded targets for EARN 30709). 7. CRSL and RDM meeting with neurology and children's CRSLs (in the first instance) to explore opportunities for collaboration.	The specialty objective has been met. A named audiology champion is in post. 1. Dr Amanda Hall is the LCRN's named audiology champion. She is the existing CRSL for ENT and an audiologist by profession. This post was confirmed with CRSL on 22/06/2017. Amanda Hall and Anne Schilder developed a role description that described different levels of activity for the post. It was circulated to other LCRNs for use in local discussions about identifying a champion and the support they could provide. 2. The ENT portfolio is very small. The LCRN has had 3 NIHR CRN Portfolio studies open at 3 sites in 2017-18. All three of these studies recruited to time and target. 3. CRSL has worked collaboratively with POs to develop the portfolio. One indicator of successful engagement by the CRSL is that an ENT surgeon who has not previously been involved in NIHR CRN Portfolio studies has taken on the role of PI for the Genetics of Cholesteatoma study (CPMS ID: 31548). 4. CRSL has met with teams at sites but this is dependent on an active ENT portfolio. 5. CRSL is happy to provide support to potential new PIs. See 3 above. 6. The LCRN were using a research event scheduled for January 2018 as a forum for sharing best practice, promoting partnership working and raising the profile of audiology and ENT research. Unfortunately the event had to be postponed because key speakers were unavailable. The event has been rescheduled for Q1-2 in 2018-19 and it is intended that staff from GRH and UHB are invited to present. CRSL also distributed an email 'newsletter' to her local ENT/Audiology contacts to update them on ENT research in the region. 7. CRSL and RDM met with CRSL for children's specialty on 21/11/2017 to explore possible collaborations with the children's speciality. Advice offered on how to increase opportunities for research. The intention was to do the same with neurology, but we had no neurology lead in post. The CRSL is already working collaboratively by supporting the Newborn Hearing Screening and the risk of SIDS (Oasis) study (CPMS ID: 30694) which is assigned to the children's specialty. CRSL provided expertise on the audiology measures and data collection. This work will continue into 2018/19 as the data collection is completed and analysis is carried out. Other activities include: -CRSL co-led a research workshop at the British Society of Audiology conference in September 2017 to promote NIHR CRN and discuss how audiologists can become PIs on NIHR CRN Portfolio studies. -CRSL is part of the newly formed national group of Audiology champions and developing a national presence including planning a separate national meeting later this year and writing an article for professional newsletters. -CRSL worked with other LCRN specialty leads to identify audiology champions for their areas.
11	Gastroenterology	The LCRN aims to recruit 178 patients in 2017-18 (an increase of 37). Local objective to grow the speciality regionally: ● Identify and appoint a new CRSL for the speciality. ● Assess baseline infrastructure in POs i.e. what capacity is there to deliver and where via: ○ Identification of active and recently active PIs via the portfolio ○ CRSL and RDM to meet with relevant clinical teams across the region ● Open at least one new study with a nurse PI by: ○ Identifying potential nurse PIs during meetings with clinical teams (detailed above) ○ Identifying suitable potential studies through 'studies open to new sites' process detailed above, with particular focus on IBD studies. ○ Matching the potential studies with potential nurse PIs and supporting them through the process with the relevant training ● Explore the potential to increase collaboration with primary care and if there is potential ensure this takes place in at least one study. Development and expansion of Community of Practice (COP) to increase collaboration across the region and enhance capacity to deliver. ● Assess the current baseline for existing COP which exists within speciality. ● Identify key stakeholders of COP. ● Set up monthly teleconference to discuss portfolio. ● Host two face to face meetings of COP annually.	This speciality objective has been met. The LCRN has increased recruitment from 199 in 2016/17 to 259 in 2017/18. 100% of non-commercial studies and 75% of commercial studies closed in green. Recruitment activity has occurred in 5/6 of the acute trusts and within the primary care setting. The LCRN will endeavour to recruit a new CRSL in 2018/19, the existing role-holder will remain in post until a new CRSL is recruited. The portfolio has been reviewed for studies with potential for a nurse PI and potential nurse PI's within the region have been explored. Currently the opportunity for either remains limited particular due to capacity due to clinical pressures in this area. The potential to increase collaboration with primary care will be explored in 2018/19 initially within Gloucestershire where the current CRSL is based. The plans to develop a regional COP have been included in the annual plan for 2018/19
12	Genetics	Still awaiting clarification from the Coordinating Centre on what is classed as early career researcher and whether this is limited only to clinical geneticists or includes non-clinical. ● Clarify what is meant by early career researcher in the LCRN. ● Assess local baseline of early career researcher involvement: ○ Identify number of individuals ○ Identify nature of involvement of those individuals. ● Ensure all early career researchers have exposure to NIHR portfolio research either via an existing forum or by hosting a meeting specifically about NIHR portfolio research for early career researchers to: ○ Provide information about the NIHR ○ Provide information about portfolio research ○ Provide information about the type of involvement they could have ○ Provide information about training opportunities to support that involvement. ● Assess numbers involved and type of involvement at end of 2017-18 to measure the increase and make recommendations for next steps. ● Continue to monitor RTT for portfolio studies to ensure any impact by 100,000 Genome project is identified early via monthly meetings with CRSL.	This speciality objective has been met. There is good general exposure and involvement of early career researchers in NIHR portfolio research including 2 as PI's on portfolio studies. This is up from 1 in 2016/17 to meet the national objective. The total pool of early career researcher s is 5. The aim is to increase this further in 2018/19. With the addition of the 100K Genome Project to the portfolio, recruitment has increased from 377 in 2016/17 to 536 in 2017/18. There has also been an increase in the number of portfolio studies within the region with recruitment from 8/9 trusts and from primary care

13	Haematology	All trainees are already involved with NIHR portfolio research. Assess baseline level of type of involvement. ● Formalise agreement with Severn Deanery to include research as part of training programme. ● Ensure trainees have access to: ○ Information about the NIHR ○ Information about portfolio research ○ Provide information about network training opportunities to support that involvement. ● Assess level of type of involvement following inclusion of research as part of training programme ● Support improvement to RTT on commercial and non-commercial studies via: ○ regular review of RTT report ○ regular meetings with CRSL lead ○ close liaison with trusts & / or delivery teams regarding data discrepancies and improvement action plans for Red and Amber studies ● Increased targeted funding for 2017 to pump prime resource in UHB expects to result in a higher number of commercial trials open, which will increase income and allow portfolio to develop.	This speciality objective has been met. There are already good links with the relevant professional organisations to encourage and support trainee involvement and all trainees continue to be routinely involved with NIHR portfolio research. Discussions to formalise this arrangement have started and will continue into 2018/19. All trainees have access to information about the NIHR, portfolio research and network training opportunities to support involvement. Improvement to RTT of closed studies (34% to 70%) is supported by regular review of the RTT report, meetings with the CRSL and close liaison with relevant trust staff re discrepancies and Red / Amber studies. There has been an expansion of the trials portfolio from non-malignant haematology service at UHBristol including a local investigator led CTIMP. A local research steering group has been established within the main Haematology centre at UHBristol to ensure a formal and transparent process for consideration and progression of new studies. To counteract increasingly poor regional availability of senior clinical staff to lead on clinical research three individuals have been appointed to regional and national leadership roles 1) Newly appointed Haematology Consultant at RUH, Bath has taken on local research lead for Haematology within Bath. 2) A paediatric haemophilia specialist represents the LCRN on a new national working group for non-medical AHP's for haematology aimed at developing new investigator led research with non-medic leadership and 3) A haematology SpR in the Severn Training Deanery is one of 3 founding members of the national haematology HaemSTAR group (https://www.nihr.ac.uk/nihr-in-your-area/haematology/haemstars.htm) . The SpR is also local co-PI for two active studies and has active role developing research interest in her more junior colleagues via her HaemSTAR role.
14A	Health Services Research	A: 1. Professor Yoav Ben-Shlomo is the CRSL for the health services specialty and is actively reviewing all portfolio studies with the PF on a monthly basis. 2.Building on the success of (APACHE), the CRSL will continue to build relationships with PIs and CIs working on health services research in the region 3.The CRSL will use his working knowledge of potential PIs should there be new studies in the pipeline.	The specialty objective has been met The local objectives have been met. A: 1.Yoav Ben-Shlomo is the CRSL for HSDR and is actively reviewing all portfolio studies with the portfolio facilitator on a monthly basis. 2. CRSL has good working relationships with many PIs working on Health services studies in the region 3.CRSL therefore has working knowledge of potential PIs when new studies open to new sites come up
14B	Health Services Research	B: 1. Continue to nurture relationships with University of Bristol and University of Bath so that any health services studies that are eligible for NIHR CRN support apply for inclusion on the Portfolio. 2. Continue to support health services research in primary care settings.	The specialty objective has been met with studies identified by the CRSL The local objectives have been met. B: 1.We continue with our successful relationship with the University of Bath and University of Bristol to ensure suitable eligible studies are on the Portfolio 2. We will continue working with CI's in the region and aim to focus on new studies in the pipeline where CRN WoE are the lead LCRN. Continue to develop flexible research teams that are able to deliver studies in a range of settings to reflect the variability of the Health services research portfolio.
15	Hepatology	Baseline: Currently recruiting into studies in two of the five main subspecialty areas. Objective: Increase this to at least three of the main subspeciality areas. Local objective to grow the speciality regionally: ● Identify and appoint a new CRSL for the speciality. ● Assess baseline infrastructure in POs i.e. what capacity is there to deliver and where via: ○ Identification of active and recently active PIs via the portfolio ○ CRSL and RDM to meet with relevant clinical teams across the region ● Development and expansion of COP to increase collaboration across the region and enhance capacity to deliver. ○ Assess the current baseline for existing COP which exists within speciality. ○ Identify key stakeholders of COP. ○ Set up monthly teleconference to discuss portfolio with key stakeholders. ○ Host two face to face meetings of COP annually.	The specialty objective has been met. The LCRN recruited participants into four of the five main subspecialty areas and recruited a total of 44 participants into NIHR CRN Portfolio studies across 11 studies in FY1718. A new CRSL was appointed into post and has been making links nationally as well as successfully opening and delivering to her first two commercial studies with additional commercial studies in the pipeline. Overall RTT for open studies reaching green status for RTT from March 17 to March 18 has increased by 16%, from 47% open studies reaching RTT in March 17 to 63% open studies reaching RTT in March 18. There has also been an increase in the number of studies. The CRSL has set up a local liver research forum to increase and review research activity within her own trust. Development and expansion of a regional COP will be prioritised for this speciality in 2018/19.

16	Infection	The LCRN will increase participation to infection studies on the NIHR CRN Portfolio by 22% and recruit 220* participants in 2017-18 by: 1. CRSL and RDM focusing on developing the NIHR CRN research portfolio in GRH, GWH, RUH and WAHT where appropriate for the patient pathway as the current portfolio and pipeline for 2017-18 is centred on NBT and UHB. *Based on recruitment figures of 180 from 2016-17 where 196 is the current total recruitment. The current main specialty pipeline for 2017-18 gives an approximate target of 290 participants. This estimate assumes not all studies will achieve RTT, 75% of this is 217, 80% is 232.	The specialty objective has been met. The LCRN recruited 591 participants into infection studies on the NIHR CRN Portfolio in 2017-18. This is an increase of 55% from 2016-17 (managing studies only). Recruited 591/220 participants to date (managing studies only). Recruited 1125/220 participants to date (managing and supporting studies). 1. CRSL and RDM have supported recruitment activity at five sites (GCS, GWH, NBT, UHB and WAHT). There has been an improvement in communication and liaison between LCRN and some research sites e.g. NBT Infection and Immunity, Unity Sexual Health Clinic. Other activities include: -CRSL and RDM discussed requirement for additional resource with UHB in the form of funded practitioner time for Safetxt (CPMS ID: 20710). This improved recruitment activity and resulted in the study meeting target, albeit a reduced one, down from 200 to 120 participants. -RDM also sought advice from other LCRNs about how to improve recruitment for Safetxt (CPMS ID: 20710). The feedback was very valuable and UHB were grateful for the additional information. -CRSL and RDM supported Jane Nicholls and facilitated adoption of Challenges and Opportunities of PrEP CHOP (CPMS ID: 36757) onto the NIHR CRN Portfolio. -Promoted a number of new studies within Microbiology/Infectious Disease community, leading to some Expressions of Interest, e.g. INFE 37120. -CRSL engaged with local study leads (Drs M Gompels, P Horner and H Wheeler). -CRSL provided one expert review of proposed commercial study for Portfolio Applications Team.
17	Injuries and Emergencies	The LCRN will increase recruitment via Ambulance Trusts to two or more pre-hospital care studies on the NIHR CRN Portfolio, led by Injuries and Emergencies by: 1. Identifying a minimum of two pre-hospital collaborators and networks to engage with through the LCRN. 2. CRSL supporting the development of new studies in the early phase of design and set up to create a pipeline of studies in this area. 3. CRSL and RDM meeting and building links with both CRN South West Peninsula and the Ambulance Trust (based in CRN South West Peninsula and responsible for services in CRN West of England) to agree future collaboration. 4. Supporting the four POs outside of Bristol (GRH, GWH, RUH and WAHT) to develop their research portfolio e.g. AIRWAYS-2 and HALT-IT and encourage participation as appropriate new studies come online. 5. CRSL, RDM and PF sharing best practice and learning from NBT where both CRASH-3 and WHiTE Study have exceeded their recruitment target to support other sites.	The specialty objective has been met. The LCRN has increased participation in pre-hospital studies via Ambulance Trust by 5.5% in 2017-18. This is an increase/decrease in activity from 2016-17 where 1141 participants were recruited in 2017-18 versus 1081 participants in 2016-17. 1.RDM explored how to engage further with and best support pre-hospital collaborators. See point 3. 2. Advice on study feasibility, design and implementation given to research groups based in ED, Trauma and Mental Health to support study development via face-to-face meetings and email by CRSL and RDM. CRSL identifying appropriate developing multicentre studies through NSG and national groups that would be suitable for sites in our region. 3. The RDM contacted CRN SWP for advice on collaborating across the neighbouring LCRNs CRN SWP have strong links with the ambulance trust team and meet with them on a regular basis. The LCRN hope to contribute to this meeting to provide a cohesive cross LCRN boundary service. 4. The CRSL has provided support to sites to develop their research portfolio and studies are open at all six eligible POs. 5. Best practice has been shared verbally via CRSL, RDM and PF especially around Novel use of TXA to reduce the need for nasal packing in epistaxis (CPMS ID: 33607) study. Other activities include: -CRSL has advise a number of groups (e.g. ED, Trauma, Mental Health) on study design and implementation. This has helped with funding applications, portfolio adoption and successful implementation. -CRSL has been active in early identification of studies appropriate for the LCRN sites and helped advise on which sites may be the best for recruitment, flagged issues with possible misidentification of sites and flagged resources for site identification (e.g. hip fracture trials, epistaxis trials, burns trials). -CRSL is chair of the DRAFFT2 (CPMS ID: 31693) Trial Steering Committee (TSC) and the AIM (Ankle Injury Management CPMS ID: 8400) TSC. He is also a member of the PIPS (Patella Instability Physiotherapy or Surgery CPMS ID: 32507) TSC. -RDM is a member of the LoDeD study Trial Management Group (CPMS ID: 37566).
18	Mental Health	1. CRSL and CAMHS Champion will meet with service providers in CAMHS, Primary Care, Learning Disabilities and Autism services with a view to opening and recruiting to at least one new study aimed at the 16 and under age group by Q3. 2. CRSL will appoint a second CAMHS Champion to provide wider geographical support. 3. PF will use ODP Specialty app to monitor 16 and under studies' performance and liaise with the national cluster team regarding new studies to bring to the LCRN. 4. Studies in schools are common locally and often mental health related. Investigators will be encouraged to discuss their studies with the CRN as early as possible to ensure the study is eligible to apply to the NIHR Portfolio so that recruitment can be recognised.	This specialty objective has not been met. 1. Initial meetings between CRSL and CAMHS Champions were held to discuss promoting studies in services treating people 16 and under, however a lack of suitable studies (see below) prevented building on these meetings. 2. A second CAMHS Champion was appointed however as mentioned above, a lack of suitable studies has resulted in these roles lacking focus. 3. All mental health studies recruiting participants aged 16 or under and listed on CPMS as 'open to new sites' (14) were contacted to enquire whether they would accept a new site and none were. This has resulted in a limited scope to improve this metric. 4. Contact has been made with local Investigators performing studies in schools to advice as to the support the CRN can offer was given. Other activities: We continue to develop a staffing model (i.e. a centralised 'deployable' team) to work regionally to support Mental Health research opportunities as they arise.

19A	Metabolic and Endocrine Disorders	1. Identify 'caretaker' CRSL until a substantive appointment can be made 2. Meet with Bristol Nutrition BRC to identify and agree future areas for collaboration. 3. CRSL to attend regional NET MDT once per year.	The specialty objective has been met. 22 participants were recruited into studies of rare metabolic/endocrine disease on the NIHR CRN Portfolio in 2017/18, compared to 5 patients in baseline 2016/17 (340% increase). The local objectives have not been met. A CRSL has not been identified in the three attempts to recruit to this role
19B	Metabolic and Endocrine Disorders		The specialty objective has been met. 23 participants were recruited into studies of obesity on the NIHR CRN Portfolio in 2017/18, compared to 3 patients in baseline 2016/17 (667% increase).
20A	Musculoskeletal Disorders	1. A Clinical Research Specialty Co-Lead from a medical background will be appointed to support the current CRSL (with a therapist background). This arrangement will work well to support the current portfolio of medical trials (i.e. biologics in rheumatic conditions) and non-medical trials (i.e. of different therapy protocols) within the region. 2. Enquiries will be made through POs for individuals potentially interested in the Orthopaedic Champion role. 3. Initial discussions have been held with the LCRN primary care team as to how to best work with existing systems for GPs to search their databases and contact potentially suitable patients for trials at the specialist centre. 4. A project (as part of the local STP) to map all AHP leads in the region has recently completed, this provides starting point (and importantly an extensive contact list) to tap into an existing local community to promote clinical research and share best practice. Where possible, an agenda item/information stall/local performance about clinical research will be included in future meetings/events.	This specialty objective has not been met. 1 & 2. The Clinical Research Specialty Co-Lead (funded) and Orthopaedic Champion (unfunded) posts were advertised and promoted by the CRSL but no appointments were made. 3. No studies were identified to use this methodology. 4. This task has been delayed due to delays with the STP project.
20B	Musculoskeletal Disorders	See above	This specialty objective has been met. The number of participants recruited into orthopaedic studies on the NIHR CRN Portfolio has increased by 53% since 2016-17 which exceeds the 10% target.
21	Neurological Disorders	1. RDM and PF to create community of practice comprising of active investigators in all subspecialties - epilepsy, multiple sclerosis, headache, neuro-muscular disease, neurological infections such as encephalitis and the normal development of the nervous system; and research teams from the existing portfolio. The group will map service provision, review the portfolio and performance locally and nationally, share best practice and expect intra network referral of patients to sites where studies are open. Group to meet by Q3. The meeting notes will reflect this activity and RTT will improve from 50% to 80% by Q4. 2. CD to appoint a CRSL by Q3. 3. CRSL and RDM to look at clinicians who work in specialty areas that cross over with neurological disorders as a supported site e.g. genetics, surgery. Non-medic options to be considered. 4. PF to monitor and report on all studies where neurological disorders is the managing and supporting specialty. Include this in the monthly reports to RDM.	This specialty objective has not been met. Due to staffing issues within the core team, and the inability to attract a CRSL appointment, neurology wasn't prioritised in 17/18 in West of England. A CRSL was appointed in Q4 and planning has begun to re-focus on neurology in 2018/19.
22A	Ophthalmology	1. Particular focus will be on areas with potential for high recruitment such as dry eye and glaucoma (drops, rather than surgery). Potential PIs have been identified in these areas. 2. RDM and PF to create community of practice comprising research teams from ophthalmic research active sites.	This specialty objective has been met. The LCRN has 4 trusts providing services, two of which are strong in ophthalmology research. Recruitment at The Bristol Eye Hospital is ranked fourth highest nationally. Gloucestershire Hospitals has worked collaboratively with The Bristol Eye Hospital with the Predict-Cat study, and continues to attract and deliver to time and target on a high number of retinal commercial trials. Clinical engagement has failed at one local site. 1. 75% (3/4) of the acute NHS Trusts in the West of England that provide eye services are recruiting into Ophthalmology studies on the NIHR CRN Portfolio. 2. The RDM and PF hold monthly teleconferences with Ophthalmology Research Managers from 2 POs to discuss new studies and share best practice for recruitment and RTT which have been well attended and provided a community of practice within ophthalmology.
22B	Ophthalmology	See above	811 patients were recruited by 6 primary schools to the The CVI Project study (CPMS 33759).
23A	Oral and dental health	1. CRSL and RDM to meet with National Lead to formulate an action plan to meet both objectives	This specialty objective has been met. Professor Peter Robinson is the National Oral and Dental Lead, local CRSL and Dean of the Bristol Dental school. He has encouraged Post Graduate Deans and Heads of School to promote research and GCP; worked with the PG Dean to encourage GCP across the South West. Contact has been made between the Bristol Dental School Clinical Trials Unit and the LCRN. There has been recruitment to a portfolio study. the NIHR has been promoted at numerous meetings.
23B	Oral and dental health		This specialty objective might have been met. Dentists do not have an email address which allows tracking of their locality. We know that dentists within the LCRN have undertaken the online Dental GCP training, but are unable to quantify the number.
24	Primary Care	1. The CRN West of England will actively engage with the Severn GP Deanery and with local GP educators to ensure this initiative receives the support and encouragement it will need. 2. Active participation of the Academic Primary Care centres will be pivotal. 3. Contractual possibilities are recommended for 2 years, with sufficient allowance for travel within the CRN area. 4. CRN core primary care team will continue to work closely and flexibly with GP practices acting as a direct point of contact to support the delivery of research.	This specialty objective has not been met The local objectives have been met The Deanery will appoint 2 GP scholars starting in August 2018, at ST3 level. Ideally the registrars will be attached to an RSI practice (Research Site Initiative - i.e. already funded to undertake research). The LCRN has identified a source of funding for these posts. A draft programme has been developed by the clinical divisional lead. The Severn Deanery have agreed to support 2 research champion scholarship posts in the next academic year. The Deanery will display information about the scholarship on their website to attract potential candidates. The CRN core primary care team continue to work closely and flexibly with GP practices.

25A	Public Health		This specialty objective has been met. The Clinical Director Designate was appointed October 1st 2017. Dr Thomas is also a Consultant in Public Health in South Gloucestershire Council and Clinical Lecturer in Public Health at the University and has started to focus on the public health agenda with the CRSL lead to explore how the CRN can place research in the greatest need , profiling disease evidence and weakness in populations of health.
25B	Public Health	1. Evaluate the pilot Clinical Scientist position at consultant level between with University of Bristol and South Gloucestershire Council Public Health. 2. Involvement in the Director led academic Public Health training programme review in the South West. 3. Adding collaborative research to the West of England Public Health Partnership as a work stream. 4. To explore Public Health agenda with the CRSL and how the CRN can place research in the greatest need, profiling disease evidence and weakness in populations of health. 5. Articulate the CRN offer to academics at local universities. 6. Enroll one study onto the CRN Portfolio. 7. Identify academic registrar to join the CRN Public Health National Specialty Group. 8. Explore with the Association of Directors of Public Health and the Faculty of Public Health their relationship with the CRN. 9. Maintain a good relationship with University of Bristol and lead on more studies	This specialty objectives have been met. The relationship with the West of England PH Partnership is developing into a wider piece of work focusing on infrastructure development and culture change in local authorities and universities. We have applied for funding and hope to appoint 1.0 FTE to work across the West of England this year. CRN West of England have recruited 60 participants to Public Health studies in 2017/18.
26	Renal Disorders	Baseline: Currently three open commercial studies with three different PIs (all at NBT). ● 14 requests for EOs have been sent out to POs in 2016-17, 6 positive responses have been received resulting in 3 site selections. ● Three commercial studies in the pipeline, two with PIs new to commercial research/not commercially active in last three years therefore the national objective is achievable. In addition: ● Identify current PIs with no commercial activity in the last three year from the NIHR CRN Portfolio to identify additional potential new commercial PIs. ● Assess baseline infrastructure in POs ie what capacity is there to deliver and where via: ○ Identification of active and recently active PIs via the Portfolio ○ CRSL & RDM to meet with relevant clinical teams across the region ● Development and expansion of COP to increase collaboration across the region and enhance capacity to deliver. ○ Assess the current baseline for existing COP which exists within speciality. ○ Identify key stakeholders of COP ○ Set up monthly teleconference to discuss portfolio with key stakeholders. ○ Host two face to face meetings of COP annually. ● Through the activities detailed above, define and develop our regional profile for renal commercial research, exploring potential to maximise our attractiveness to commercial companies e.g. cross referrals, enhanced collaboration. ● Work with IOM to raise our profile to suitable companies.	This speciality objective has been met locally with the opening of two new commercial studies with two new PI's. Recruitment to commercial studies has doubled and recruitment overall far surpassed the target with 350 patients being recruited against a target of 134. This is also an increase on 16/17. The renal portfolio within GHFT has expanded with 4 new studies opening in 2017/18 and another 2 in set up. There were an additional 8 renal studies opened in CRN WE in 2017/18. Development of a community of practice will be prioritised in 2018/19
27	Reproductive Health and Childbirth	Baseline for national objective: currently six of our acute NHS Trusts provide maternity services and 100% of these are currently recruiting into Reproductive Health & Childbirth studies on the Portfolio. Objective: To ensure this remains at 70% as a minimum. With the exception of multiple studies closing to recruitment early it is expected that this measure will remain well above the required 70%. Local objective to grow the speciality regionally: ● Assess baseline infrastructure in POs i.e. what capacity is there to deliver and where via: ○ Identification of active and recently active PIs via the Portfolio ○ CRSL and RDM to meet with relevant clinical teams across the region ● Expansion of portfolio by: ○ Early pregnancy assessment clinic study opening in GRH with non-medical PI. ● Define and develop the role of the LCRN lead research midwives in the LCRN. ● Development and expansion of COP to increase collaboration across the region and enhance capacity to deliver. ○ Assess the current baseline for existing COP which exists via IMox. ○ Identify additional key members to join COP. ○ Host an initial meeting of senior research midwives (or appropriate representative) from each organisation. ○ Set up monthly teleconference to discuss portfolio with key stakeholders. ○ Host two face to face meetings of COP annually. ● RUH planning to put CRN funding into nurse time to support gynaecology aiming to increase the number of studies from two to four although it is is unclear whether these studies will sit under surgery or the reproductive health and childbirth speciality.	The speciality objective has been met. Six of the LCRN acute trusts provide maternity services and 83% of these are recruiting into studies on the RH&C portfolio. The one remaining trust is referring patients to RH&C studies running elsewhere. The CRSL role continues to be held as a joint post between an obstetrician and midwife. The midwife Co-CRSL has spent time meeting with local teams across the region. Two midwives job-share the Reproductive Health Champion Role (previously midwife champion). The RDM, Midwife Co-CRSL & RH Champions meet on a monthly basis. The RC Champions are actively involved with the national RH champion forum and have forged links with other LCRNs with the aim of bringing portfolio opportunities into the region at an earlier stage. This relationship has already resulted in additional sites being selected in CRN WE. The Senior Midwives COP has been further developed and expanded by the midwife co-CRSL and now includes representation from senior midwives across 5/6 of the trusts providing maternity services. This group meet face to face on a monthly basis to share good practice, problem solve issues with portfolio studies and discuss potential new studies. This group organised and ran a region wide event "Raising the profile of Research in Reproductive Health & Childbirth" attended by over 40 staff (primarily midwives) from across the region to great success. The portfolio has expanded outside the LCRN traditional sub-speciality strength areas with 111 patients being recruited to VESPA, an early pregnancy assessment study with a Nurse Consultant PI.

28	Respiratory Disorders	The LCRN will recruit participants into NIHR CRN Portfolio studies in at least three of the four main respiratory disease areas by: 1. CRSL and RDM focusing on developing the NIHR CRN Research Portfolio where appropriate for the patient pathway. 2. When the outcome of the academic application is known, CRSL and RDM to agree how the LCRN can best work to support and enhance the expanded model for respiratory research. For example, a development bid to jointly fund an academic/CRN post (with measurable outcomes). 3. Build closer links between primary care sites (where the patients are seen/based) and specialist centres (who have the capability to run demanding trials) by identifying a minimum of five practice nurses in primary care. 4. Use links with identified specialist, community and practice nurses to develop a referral model for eligible patients.	The specialty objective has been met. The LCRN recruited 345 participants into NIHR CRN Portfolio studies in 2017-18 and recruited participants into NIHR CRN Portfolio studies into at least three of the four main respiratory disease areas. These are as follows: -Asthma-15 participants.(name studies with CPMS ID) -COPD-19 participants.(name studies with CPMS ID) -Bronchiectasis-0 participants. -Rare diseases (e.g. pulmonary hypertension, cystic fibrosis, lymphangioleomyomatosis, pulmonary alveolar proteinosis)-10 participants (A prospective observational cohort study examining the natural history of mesothelioma, exploring potential biomarkers and factors that may predict outcome, as well as providing a resource for future trials within a cohort. TILT Cohort study - CPMS ID: 33514). Any mesothelioma study that is on the respiratory portfolio eg TILT and ASSESS-meso would meet this criteria as a rare study In addition, RAMPP and HiSPEC also meet the criteria for rare diseases 1. The CRSL and RDM have focussed on growing the portfolio where appropriate for the patient pathway and targeting sites that may yield the greatest recruitment opportunities. Most of the respiratory portfolio is based at NBT and UHB. GRH, GWH and RUH undertake respiratory activity but the portfolio is smaller. 2. CRSL and RDM drafted an application for development funding for 2018-19 for additional resource for respiratory to support the region. 3. This work was not started due to capacity issues. This will be undertaken in 2018-19. 4. As for point 3 above. Other activities include: -RDM attended the Industry Respiratory day on 28/06/2017 to learn more about the opportunities to develop the industry portfolio. -CRSL presented at a NBT Open day on 22/02/2018. -Two studies were rebadged from cancer to respiratory specialty: the TILT study (CPMS ID: 34338) and the Pleural effusion biomarker study (CPMS ID: 8960). This study has already resulted in 5 peer review publications.
29	Stroke	1. New stroke-specific research nurse starting at NBT in April 2017 (previously covered by generic Research Nurse) provides opportunity to develop hyper-acute portfolio there. Staffing model utilises share research/clinical roles to fully 'embed' research into routine clinical care. Following an induction period the possibility of applying for Hyper-acute Stroke Research Centre (HSRC) status will be explored, looking at costs (i.e. increased staffing - possibly from a central development bid) vs benefit (increased recruitment). Plan to discuss experiences and approaches with existing and particularly newly appointed HSRCs. 2. Plan to build engagement with all stroke patient pathway providers within the LCRN so patients can be recruited/followed-up at these points. Stroke CRSL is the national Rehabilitation Lead and will be developing relations at national level and this will be mirrored at local level.	This specialty objective has not been met. The data shows the recruitment as a % of SSNAP-recorded admissions is 2%. The challenge is there are no high-recruitment RCTs available on the Portfolio. 1. Due to delays in building up a portfolio of hyper-acute stroke research Studies at NBT, plans to formally apply to be a Hyper-acute Stroke Research Centre have been put on hold. 2. Stroke service providers were scoped and contact made. When a suitable study becomes available, those leads will be explored.

30A	Surgery	1. CRSL to appoint to the seven vacant SSL roles. Look to other specialties and subspecialties where overlap is evident e.g. Head and Neck, Orthopaedics, Plastics. 2. CRSL, RDM and PF meet with SSLs twice a year either individually or as a group, reviewing the Portfolio (national and local) and performance and communication channels with investigators across the LCRN. Intra-network referral of patients will be expected and measured. CRSL, RDM and PF to communicate with this community through a bimonthly update/circular that includes a list of studies across the LCRN with contact details and eligibility criteria. 3. RDM/PF will create a community of practice with surgical research teams across the LCRN who will meet twice a year to discuss issues, barriers, new studies and share best practice. 4. PF to provide monthly report to RDM and CRSL regarding new studies in all the managing specialty areas associated with surgery. 5. Open and recruit to at least one study each from the Plastics and Hand, Hepatobiliary and Head and Neck portfolio. No studies have been opened for Plastics and Hand, Hepatobiliary and Head and Neck surgery. 6. CRSL, RDM and PF to meet with new Vascular Surgery Professor with the aim of establishing a community of practice for this subspecialty across the LCRN. Active sites include GRH and NBT. Staff working on this subspecialty will be visited or invited to an event during Q2 to look at a network wide approach to building the portfolio and mapping clinical links locally and nationall	The specialty objective has not been met. 11 surgery subspecialties were recruited into in 2017-18. 1. RDM, CRSL and divisional lead identified potential candidates through the year, however, there has been no uptake for these vacant voluntary roles. 2. RDM & PF have met with surgical research teams across the network through the year, to review local portfolio performance and horizon scan the national portfolio, across all 15 subspecialties, for potential areas of growth. Three large recruiting studies closed within the network in 2016/17, this has had a significant effect on our local portfolio numbers.The RDM and CRSL met to review the portfolio, areas for focus were identified, such as two sites that have not opened any surgical trail in 2017/18, these will remain focus for 2018/19. There are currently 19 studies open (Surgery managing specialty) to recruitment, across 4/6 acute trusts within the network. The surgical portfolio has grown in 2017/18 with 8 new studies opening. 3. The community of practice is being facilitated by the RDM and PF, through regular contact and engagement with local teams. Due to capacity issues within the core team, there has not been a face to face meeting of a surgical community of practice in 2017/18. The objectives of the meetings (discuss issues, barriers, new studies and share best practice) have been carried out through regular face to face and email contact with the RDM and PF with delivery teams across the network. 4. At present new studies are identified by PF, CRSL and RDM, they are communicated out to potential PIs and delivery team leads via LCRN processes. It is planned to explore using the model currently in place across the SWAG SSG network and replicate this across the surgical research community, to raise awareness of studies open across the network, to facilitate intra-network referrals. 5. No studies were been identified or opened in these specific subspecialties in 2017/18. These areas will continue to be a focus for 2018/19 and have been added to the annual plan. 6. Bristol BRC launched in 2017/18 including a surgical innovation theme. This has presented significant opportunity for the WoE. RDM presented to the BRC surgical theme monthly meeting, to begin developing close working relationships with the group, which includes the new Professor of Vascular Surgery. At least one large local NIHR trial is to open across the network in 2018/19.This area will continue to be a focus in 2018/19.
30B	Surgery	Please refer to 30A, for LCRN actions to achieve objective	The specialty objective has been met. At least 1 patient/100,000 population was recruited into 10 of the surgical subspecialties in 2017-18. Please refer to 30A , for performance against plan
4.2 (Optional)	Please provide a brief summary of overall performance against the Clinical Research Specialty Objectives. Commentary should focus on key achievements, impacts and key challenges and how the challenges have been mitigated/progress against mitigation activities.	The LCRN has met 16/30 clinical specialty objectives, and partially met a further two (Musculoskeletal disorders and Surgery). Three clinical specialty objectives are measured nationally (Dementias and neurodegeneration, Gastroenterology and Infectious diseases and microbiology).	

Cell: B4
Comment: Objective: Each LCRN to have an Ageing Local Specialty Lead who demonstrates leadership in their region and can provide examples of leadership of initiatives aimed at increasing recruitment and research capacity in their regions
Measure: Named Local Specialty Lead in Ageing
Target: 15 LCRNs

Cell: B5
Comment: Objective: Establish links with the Royal College of Anaesthetists' Specialist Registrar networks to encourage and support their involvement in recruitment into NIHR CRN Portfolio studies
Measure: Identification of Specialist Registrar Networks in the LCRN
Target: 15 LCRNs

Cell: B6
Comment: Objective: Establish links with the Royal College of Anaesthetists' Specialist Registrar networks to encourage and support their involvement in recruitment into NIHR CRN Portfolio studies
Measure: Number of LCRNs where Specialist Registrar Networks are recruiting into NIHR CRN Portfolio studies
Target: 15 LCRNs

Cell: B7
Comment: Objective: Increase patient access to Cancer research studies across the breadth of the Cancer subspecialties
Measure: Number of LCRNs achieving on-target recruitment into at least 8 of the 13 Cancer subspecialties, where "on-target" means either improving recruitment by 10% from 2016/17 or meeting the following recruitment targets per 100,000 population served:
a) Brain: 0.2
b) Breast: 8
c) Colorectal: 3
d) Children & Young People: 3
e) Gynae: 3
f) Head & Neck: 1
g) Haematology: 7
h) Lung: 4
i) Sarcoma: 0.1
j) Skin: 0.2
k) Supportive & Palliative Care & Psychosocial Oncology: 3
l) Upper GI: 3
m) Urology: 8
Target: 15 LCRNs

Cell: B8
Comment: Objective: Improve patient access to Cardiovascular Disease studies on the NIHR CRN Portfolio
Measure: Number of Cardiovascular studies on the NIHR CRN Portfolio recruiting from >1 site within that LCRN
Target: 10% increase on national average

Cell: B9
Comment: Objective: Increase NHS participation in Children's studies on the NIHR CRN Portfolio
Measure: Proportion of NHS Trusts recruiting into Children's studies on the NIHR CRN Portfolio
Target: 90%

Cell: B10
Comment: Objective: Increase intensive care units participation in NIHR CRN Portfolio studies
Measure: Proportion of intensive care units recruiting into studies on the NIHR CRN Portfolio
Target: 80%

Cell: B11
Comment: Objective: Optimise the use of "Join Dementia Research" to support recruitment into Dementia studies on the NIHR CRN Portfolio
Measure: The proportion of people recruited to Dementia studies on the NIHR CRN Portfolio who were identified via "Join Dementia Research"
Target: 10%

Cell: B12
Comment: Objective: Develop the Dermatology Principal Investigator (PI) workforce
Measure: Number of Nurse PIs for new Dermatology studies entering the NIHR CRN Portfolio
Target: 1 new Nurse PI per LCRN

Cell: B13
Comment: Objective: Increase primary care recruitment into Diabetes led and supported studies on the NIHR CRN Portfolio
Measure A: Increase the number of patients recruited by community services into Diabetes led and supported studies on the NIHR CRN Portfolio
Target: 10% increase from 2016/17

Cell: B14
Comment: Objective: Increase primary care recruitment into Diabetes led and supported studies on the NIHR CRN Portfolio
Measure B: Increase the number of community sites participating in studies relating to the prevention of diabetes and its complications
Target: 5% increase from 2016/17
Target: 15 LCRNs

Cell: B15
Comment: Objective: Develop research infrastructure (including staff capacity) in the NHS to support clinical research
Measure: Named audiology champion in each LCRN
Target: 15 LCRNs

Cell: B16
Comment: Objective: Increase the number of patients recruited into Gastroenterology studies on the NIHR CRN Portfolio
Measure: Number of participants recruited into Gastroenterology studies on the NIHR CRN Portfolio
Target: 21,500

Cell: B17
Comment: Objective: Increase early career researcher involvement in NIHR CRN Portfolio research
Measure: Number of LCRNs that have evidenced increased early career research involvement in NIHR CRN Portfolio research
Target: 14 LCRNs

Cell: B18
Comment: Objective: Establish links with the relevant professional organisations to encourage and support trainee involvement in NIHR CRN Portfolio studies
Measure: Number of LCRNs that have evidenced increased trainee involvement in NIHR CRN Portfolio research
Target: 15 LCRNs

Cell: B19
Comment: Objective: Develop research infrastructure (including staff capacity) in the NHS to support clinical research in Health Services Research
Measure A: Number of LCRNs with a lead for Health Services Research
Target: 15 LCRNs

Cell: B20
Comment: Objective: Develop research infrastructure (including staff capacity) in the NHS to support clinical research in Health Services Research
B: Identification of Health Service Research studies on the NIHR CRN Portfolio where the research has had an impact on clinical service delivery (impact case studies)

Cell: B21
Comment: Objective: Increase access for patients to Hepatology studies on the NIHR CRN Portfolio
Measure: Number of LCRNs recruiting participants into NIHR CRN Portfolio studies in at least three of the five main subspecialty areas (viral hepatitis, immune-mediated liver disease, transplant, non-alcoholic fatty liver disease, alcohol)
Target: 15 LCRNs

Cell: B22
Comment: Objective: Increase participation in Infection studies on the NIHR CRN Portfolio
Measure: Number of participants recruited into Infection studies on the NIHR CRN Portfolio
Target: 21,500

Cell: B23
Comment: Objective: Increase participation in pre-hospital studies via Ambulance Trusts
Measure: Recruitment via Ambulance Trusts to two or more prehospital care studies on the NIHR CRN Portfolio, led by Injuries and Emergencies, in each LCRN
Target: 15 LCRNs

Cell: B24
Comment: Objective: Increase participation in Mental Health studies involving children and young people
Measure: Increase the number of studies recruiting participants aged 16 years or under
Target: 5% increase from 2016/17

Cell: B25
Comment: Understand and develop the research workforce that work in Metabolic and Endocrine-led studies

Cell: B26
Comment: Objective: Increase participation in studies on the NIHR CRN Portfolio relating to areas defined to be of national priority
Measure: B: Increase the number of participants recruited into studies of obesity on the NIHR CRN Portfolio metabolic/endocrine disease on the NIHR CRN Portfolio
Target: 10% increase from 2016/17

Cell: B27
Comment: Objective: Increase engagement of orthopaedic champions to support the delivery of Musculoskeletal Disorders studies on the NIHR CRN Portfolio
Measure A: Named orthopaedic champion identified in each LCRN

Target: 15 LCRNs

Cell: B28
Comment: Objective: Increase engagement of orthopaedic champions to support the delivery of
Musculoskeletal Disorders studies on the NIHR CRN Portfolio
Measure B: Increase the number of participants recruited into orthopaedic studies on the NIHR CRN Portfolio
Target: 10% increase from 2016/17

Cell: B29
Comment: Objective: Increase the level of early career researcher involvement in NIHR CRN Portfolio research
Measure: Number of LCRNs that have evidenced increased early
career research involvement in NIHR CRN Portfolio research
Target: 15 LCRNs

Cell: B30
Comment: Objective: Increase NHS participation in Ophthalmology studies on the NIHR CRN Portfolio
Measure A: Proportion of acute NHS Trusts that provide eye
services recruiting into Ophthalmology studies on the
NIHR CRN Portfolio
Target: 70%

Cell: B31
Comment: Objective: Increase NHS participation in Ophthalmology studies on the NIHR CRN Portfolio
Measure B: The number of community based sites recruiting to Ophthalmology studies on the NIHR CRN Portfolio
Target: Establish baseline data (to inform 2018/19 objective)

Cell: B32
Comment: Objective: To increase research awareness in the dental community and increase the research-trained workforce
Measure A: LCRNs to work with their Local Postgraduate Dental Deaneries to promote research awareness and training in their postgraduate dental communities
Target: 15 LCRNs

Cell: B33
Comment: Objective: To increase research awareness in the dental community and increase the research-trained workforce
Measure: B: Increase the uptake of dental practitioners completing the NIHR online Dental GCP training course
Target: 10 dental practitioners per LCRN

Cell: B34
Comment: Objective: Increase engagement of GP registrars and First Five GPs with NIHR CRN Portfolio research
Measure: LCRNs to identify and fund a minimum of two named individuals in a GP registrar/First Five nurturing role to undertake Research Champion activities
Target: 15 LCRNs

Cell: B35
Comment: Objective: Develop research infrastructure (including staff capacity and working with local authorities) to support research in Public Health
Measure A: Number of LCRNs with a lead for Public Health
Target: 15 LCRNs

Cell: B36
Comment: Objective: Develop research infrastructure (including staff capacity and working with local authorities) to support
research in Public Health
Measure: B: Number of LCRNs recruiting to at least one study on the NIHR CRN Portfolio led by Public Health
Target: 15 LCRNs

Cell: B37
Comment: Objective: Increase the number of 'new' Principal Investigators (PIs) engaged in commercial Renal Disorders studies on the NIHR CRN Portfolio
Measure: Number of LCRNs with at least 2 ‘New’ PIs (defined as researchers who have not engaged as PI in any commercial study in the last 3 years)
Target: 15 LCRNs

Cell: B38
Comment: Objective: Increase the proportion of NHS Trusts recruiting into Reproductive Health and Childbirth studies on the NIHR CRN Portfolio
Measure: Proportion of acute NHS Trusts, which provide maternity services, recruiting into Reproductive Health and Childbirth studies on the NIHR CRN Portfolio
Target: 70%

Cell: B39
Comment: Objective: Increase access for patients to Respiratory Disorders studies on the NIHR CRN Portfolio
Measure: Number of LCRNs recruiting participants into NIHR CRN Portfolio studies in at least three of the four main respiratory disease areas (asthma, COPD, bronchiectasis, rare diseases (e.g. pulmonary hypertension, cystic fibrosis, lymphangioleomyomatosis, pulmonary alveolar proteinosis)
Target: 15 LCRNs

Cell: B40
Comment: Objective: CRN recruitment to Stroke RCTs should be at least 8% of the 2016/17 Sentinel Stroke National Audit Programme (SSNAP)-recorded hospital admissions
Measure: CRN recruitment as a % of SSNAP-recorded admissions
Target: 8%

Cell: B41
Comment: Objective: Increase patient access to Surgery research studies on the NIHR CRN Portfolio across the breadth of the surgical subspecialties
Measure A: Number of LCRNs recruiting into at least 12 of the 14 surgical subspecialties (breast, cardiac, colorectal,
general, head & neck, hepatobiliary, neurosurgery, orthopaedics, plastics and hand, transplant, trauma, upper GI, urology, vascular)
Target: 15 LCRNs

Cell: B42
Comment: Objective: Increase patient access to Surgery research studies on the NIHR CRN Portfolio across the breadth of the surgical subspecialties
Measure: B: Number of LCRNs recruiting at least 1 patient/100,000 population into at least 6 of the 14 surgical subspecialties (see above)
Target: 15 LCRNs

Section 5. Development and Improvement Objectives 2017/18		
5.1.	Please describe your activities and impact against the following objective: a) promote equality of access ensuring, wherever possible, that patients have parity of opportunity to participate in research	Please refer to key projects 3.9.1
5.2.	Please describe your activities and impact against the following objective: b) demonstrate a "one Network" approach to delivery	Collaborative working across the NIHR infrastructure in West of England was established to identify key theme areas to develop programmes in areas that cut across the NIHR Bristol centres. This group includes the managers and chief operating officers of the CLAHRC West, The Biomedical Research Centre, CRN: West of England, NIHR School for Primary Care Research, School for Public Health. Key priorities for collaborative work programmes will be agreed in 2018/19

Section 6. Operating Framework Compliance Indicators

Please provide the information requested in column C.		Commentary
1.1	**Domain**: Governance and Management **Indicator**: Internal audit in respect of LCRN funding managed by the LCRN Host Organisation, undertaken at least once every three years and which meets the minimum scope requirements specified by the National CRN Coordinating Centre **Assessment Approach**: Monitoring of audit reports provided by the LCRN Host Organisation to the National CRN Coordinating Centre	Internal Audit in respect of LCRN Funding completed in 2015, next due 2018/19
1.2	**Domain**: Governance and Management **Indicator**: Internal audit in respect of LCRN funding managed by each Category A Partner Organisation, undertaken at least once every five years and which meets the minimum scope requirements specified by the National CRN Coordinating Centre **Assessment Approach**: Monitoring of audit reports provided by the LCRN Category A Partners to the National CRN Coordinating Centre	The LCRN has not raised this with partner organisations and will discuss with the LCRN Host an intended approach to review summaries of internal audits with partner organisations for 2018/19.
1.3	**Domain**: Governance and Management **Indicator**: Deliver robust financial management using appropriate tools and guidance **Assessment Approach:** Monitoring by the National CRN Coordinating Centre of percentage variance (allocation vs expenditure) quarterly and year-end (target is 0%); Monitoring by the National CRN Coordinating Centre of proportion of financial returns completed to the required standard and on time (target is 100%); Monitoring of financial management via LCRN financial health check	
1.4	**Domain**: Governance and Management **Indicator**: Distribute LCRN funding equitably on the basis of NHS support requirements **Assessment Approach**: Comparison by the National CRN Coordinating Centre of annual LCRN Partner funding allocations and NHS Support requirements	Annual Contingency and Development Funding bidding process made available in 2017/18. Out of 46 applications in total 35 were agreed (76%)
1.5	**Domain**: Governance and Management **Indicator**: LCRN Host Organisation and LCRN Category A Partners submit an NHS Information Governance Toolkit annual assessment to NHS Digital and attain Level 2 or Level 3 **Assessment Approach**: Analysis of information on the NHS Digital Information Governance Toolkit website which provides open access to attainment levels for all submitting organisations	Host organisation attainment Information Governance Toolkit score, attainment level 2

1.6	**Domain**: Governance and Management **Indicator**: LCRN provides reports and other documents as requested by the National CRN Coordinating Centre **Assessment Approach:** Monitoring of provision of documents requested by the National CRN Coordinating Centre	
1.7	**Domain**: Governance and Management **Indicator**: LCRN CD and/or COO attend all CC/LCRN Liaison meetings **Assessment Approach:** Attendance registers for CC/LCRN Liaison meetings	Annual leave coincided with some of the meetings therefore, the CD attended 38% and the COO 60%. Updates from the Liasion meetings were provided by a COO in a neighbouring CRN for the meetings not attended. There has only been 1.0 wte backfill for the Deputy COO post within the last month of Q4 therefore sending a deputy has only been possible for 1 meeting between Q1-3
2.1	**Domain**: CRN Specialties **Indicator**: LCRN has an identified Lead for each CRN Specialty **Assessment Approach:** The LCRN Host Organisation shall: (1) Provide the National CRN Coordinating Centre with access to a list of Local CRN Specialty Leads, which includes each individual's start/end dates and contact information (2) Notify the National CRN Coordinating Centre if there are changes within the financial year (3) Provide a narrative to justify intentional vacancies or the expected timeframe to fill vacancies	The Clinical Research Specialty Co-Lead (funded) and Orthopaedic Champion (unfunded) posts were advertised and promoted by the CRSL but no appointments were made. A Clinical Research Specialty Lead for Metabolic and Endocrine has not been identified in the three attempts to recruit to this role
2.2	**Domain**: CRN Specialties **Indicator**: Each LCRN Local Specialty Lead attends at least 2/3 of National Specialty Group meetings **Assessment Approach:** Attendance registers for National Specialty Group meetings	
2.3	**Domain**: CRN Specialties **Indicator**: Each LCRN provides evidence of support provided to their Local Specialty Leads (LSLs) to enable them to undertake national activities in respect of commercial early feedback and non-commercial adoption **Assessment Approach:** Evidence of support provided in LCRN Annual Plan and Report	The LCRN completed a Specialty Leads survey (including identifiying training needs) in Q4 2018/19. The surveys will be reviewed in Q1 2018-19 and support provided where required.

3.1	**Domain**: Research Delivery **Indicator**: Each LCRN delivers local elements of the Study Support Service as specified by the National CRN Coordinating Centre **Assessment Approach:** Monitor completion rates for study delivery assessment for each study where the LCRN is assigned as the Lead LCRN / Monitor effective set-up through the upload of the study start-up document into CPMS study records for each study where the LCRN is assigned as the Lead LCRN	The LCRN operates an integrated model for the SSS with our POs. National SOPs are re-written and circulated for local implementation. A SSS teleconference is held monthly with POs. Regular data quality checks are undertaken and addressed. Overall the LCRN SSS performance is 96.30% (ODP 08/05/2018). For each SSS offering, performance is as follows: Early Contact and Engagement: 44.44% Optimising Delivery: 96.30% Effective Study Set-up: 14.81% Performance Monitoring: 12.96% The number of study delivery assessments completed: 13 (ODP 08/05/2018) The number of study start up documents uploaded into CPMS: 8 (ODP 08/05/2018) An internal audit of theLCRN SSS revealed areas for attention. This remedial work is ongoing and will continue in 2018-19 with the help of the new SSS Facilitator who started in December 2017.

3.2	**Domain**: Research Delivery **Indicator**: LCRN provides site level set-up data as specified by the National CRN Coordinating Centre **Assessment Approach:** Analysis of percentage of LCRN sites taking longer than 40 days from "date site selected" to "date site confirmed" from LPMS/CPMS held data. (HLO 4)	Overall, 37% of LCRN sites took longer than 40 days from "date site selected" to "date site confirmed" in 2017-18 (HLO Dashboard ODP, HLO4 raw data sheets). In total, data points for 119 instances of study set-up were sent to the CRN Coordinating Centre for sites in CRN West of England in 2017/18. In two Partner Organisations (2gether NHS Foundation Trust and Avon and Wiltshire Mental Health Partnership NHS Trust), 100% of studies completed set up in less than 40 days. Four Partner Organisations completed set up in less than 40 days for between 63% and 73% of their studies. Royal United Hospitals Bath NHS Foundation Trust and Gloucestershire Hospitals NHS Foundation Trust are outliers, having achieved set up in less than 40 days for 43% and 17% of their studies respectively. GHT now have weekly meetings with delivery team and RM&G staff to ensure progress in capacity and capability checks and earlier engagement with delivery teams to clearly identify potential delays in set-up so that they can be dealt with sooner. They are also ensuring there is clearer communication with the wider team around timelines to improve this metric in 2018/19. Study median time to NHS set up at all CRN West of England sites is 35 days. In terms of data completeness: Avon and Wiltshire Mental Health Partnership NHS Trust and Great Western Hospitals NHS Foundation Trust report 90%+ of the minimum data expected.
4.1	**Domain**: Information and Knowledge **Indicator**: LCRN provides LPMS data points, to timelines, as specified by the National CRN Coordinating Centre **Assessment Approach:** Analysis of percentage of missing data points from each region at the point of annual reporting data cut from CPMS/LPMS held data	

4.2	**Domain**: Information and Knowledge **Indicator**: LCRN provides support for ongoing provision of an LPMS solution **Assessment Approach:** Review of budget line for provision of an LPMS in LCRN annual financial plan	
4.3	**Domain**: Information and Knowledge **Indicator**: Each LCRN has a nominated representative in attendance at all national CRN Virtual Business Intelligence meetings **Assessment Approach:** Attendance registers for national CRN Virtual Business Intelligence meetings	0/2. National meetings only restarted in late Q3 17/18, and the Business Intelligence Manager has been on a period of extended leave during Q4. Due to staff changes, no suitably experienced deputy was available to attend.
5.1	**Domain**: Stakeholder Engagement and Communications **Indicator**: LCRN has an experienced and dedicated communications function **Assessment Approach:** Individual's name and contact details provided to National CRN Coordinating Centre / Non-pay budget line for communications identified in LCRN Annual Plan	Two additional communications assistants posts at 1.6 wte were agreed and advertised in Q4 to ensure delivery of the communications strategy.
5.2	**Domain**: Stakeholder Engagement and Communications **Indicator**: Each LCRN has a defined approach to communications and action plan aligned with the national communications strategy **Assessment Approach:** Review and monitoring of LCRN Annual Plan / Review of outcomes as reported within LCRN Annual Report	see 3.6
5.3	**Domain**: Stakeholder Engagement and Communications **Indicator**: The LCRN has in place a senior leader with experience and identified responsibility for PPIE **Assessment Approach:** Individual's name and contact details provided to National CRN Coordinating Centre	One of the RDMs has a PPIE workstream responsibility.Within their role, they have responsibility to deliver national strategies locally , such as PRES and PRAI. The RDM represents the LCRN in the local PPIE network People in Health West of England (PHWE)
5.4	**Domain**: Stakeholder Engagement and Communications **Indicator**: The LCRN records metrics of research opportunities offered to patients **Assessment Approach:** The LCRN will hold information on its reach with patients and the public (metrics may include local website usage, leaflet distribution, social media reach etc) / Evidence of local patient evaluation system / Progress discussed at national PPIE meetings and reported in LCRN Annual Report	

5.5	**Domain**: Stakeholder Engagement and Communications **Indicator**: The LCRN has collaborative PPIE workplans across CRN and partners with measurable outcomes for delivery of learning resources **Assessment Approach:** LCRN Annual Plan includes PPIE workplan with clear outcomes, milestones and measurable targets / Non-pay budget line for PPIE and WTE for PPIE role(s) identified in LCRN Annual Plan / Progress reported in LCRN Annual Report	Please see 3.6.21 / 3.6.22 / 3.6.23
5.6	**Domain**: Stakeholder Engagement and Communications **Indicator**: Each LCRN delivers the Patient Research Ambassadors (PRAs) project **Assessment Approach:** Review and monitoring of LCRN Annual Plan / Review of outcomes as reported within LCRN Annual Report	Please see 3.6.22
6.1	**Domain**: Workforce, Learning and Organisational Development **Indicator**: The LCRN has in place a senior leader with identified responsibility for the wellbeing of all LCRN-funded staff **Assessment Approach:** Individual's name and contact details provided to National CRN Coordinating Centre / Development of an approach to workplace wellbeing aligned with CRNCC, to include a wellbeing framework and action plan	Please see 3.7.1
6.2	**Domain**: Workforce, Learning and Organisational Development **Indicator**: Each LCRN has an agreed programme of activities that engage the wider workforce to promote clinical research as an integral part of healthcare for all **Assessment Approach:** Evidence of programme of activities provided in LCRN Annual Plan and Report / Monitoring effective approaches shared by Workforce Development Leads at national meetings	Please see 3.7.2
6.3	**Domain**: Workforce, Learning and Organisational Development **Indicator**: The LCRN has a defined approach to developing a culture of Continuous Improvement (Innovation and Improvement) supported by an action plan aligned to local and national initiatives and performance metrics **Assessment Approach:** Evidence of programme of activities provided in LCRN Annual Plan and Report / Monitoring effective approaches shared by Continuous Improvement Leads at national meetings	One of the RDMs has responsibility for leading on the Continuous Improvement workstream. The LCRN embeds the culture of CI throughout all LCRN activities and as such the majority of key projects are embedded within other workstreams. Please see 3.8.2 for CI projects falling outside of other workstreams. Progress of all improvement activities is monitored via the monthly highlight report process at SMT. The CI lead attends and contributes to national CI meetings.
7.1	**Domain**: Business Development and Marketing **Indicator**: Each LCRN has a completed business development and marketing Profile using the template provided by the National CRN Coordinating Centre **Assessment Approach:** Profile template submitted as part of LCRN Annual Plan / Contact details provided for assigned LCRN Profile lead in LCRN Annual Plan	

7.2	**Domain**: Business Development and Marketing **Indicator**: The LCRN has an action plan for promoting the industry agenda aligned with the national business development strategy **Assessment Approach:** Review and monitoring of LCRN Annual Plan / Review of outcomes as reported within LCRN Annual Report	The West of England 'Industry processes' are distributed amongst the Divisional Teams (i.e. RDMs and Portfolio Facilitators). This results in clear communications pathways for sponsors and delivery teams. The IOM (who is also an RDM) links in with the National Industry / Business Development team to escalate / cascade issues of national importance.

Section 7. Non-Supported Non-Commercial Studies

7.1. Please provide a list of any studies that your LCRN has decided not to support, or has been unable to support, in the 2017/18 financial year, where the study had no feasibility concerns but the study was not supported for other reasons, e.g. funding constraints or study not meeting value for money metric. See Eligibility Criteria for NIHR Clinical Research Network Support; https://www.nihr.ac.uk/funding-and-support/documents/study-support-service/Eligibility/Eligibility-Criteria-for-NIHR-Clinical-Research-Network-Support.pdf

CPMS Study ID	Study Title	Priority Category	Name of the LCRN Partner(s) that did not support the study	Reason(s) for non-support
16675	FLAIR	Medium priority study	Great Western Hospitals NHS Foundation Trust and North Bristol NHS Trust	Supported by NBT originally and over recruited to target. NBT were notified the sponsor had submitted a substantial amendment. The amendment introduces some additional treatment arms which incur significant excess treatment costs which the trust would find very difficult to meet. Great Western, as above were unable to to implement the substantial amendment, similar reasons to above , and could no longer support the study.

8. Glossary

2gether	2gether NHS Foundation Trust
AMTC	Adult Major Trauma Centre
ARCP	Annual Review of Competence Progression
AWP	Avon and Wiltshire Mental Health Partnership NHS Trust
BDWS	Bristol Dementia Wellbeing Service
BHI	Bristol Heart Institute
BI	Business Intelligence
BHOC	Bristol Haematology and Oncology Centre
BRU	Biomedical Research Unit
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group(s)
CD	Clinical Director
CF	Cystic Fibrosis
CI	Chief Investigator
CI	Continuous Improvement
COP	Community of Practice
COPD	Chronic Obstructive Pulmonary Disease
CPMS	Central Portfolio Management System
CRL	Clinical Research Leader(s)
CRN	Clinical Research Network
CRNCC	Clinical Research Network Coordinating Centre
CRO	Clinical Research Organisation
CRSL	Clinical Research Specialty Lead(s)
CRST	Clinical Research Nursing Support Team
DeNDRoN	Dementias and neurodegeneration specialty
DH	Department of Health and Social Care
DHSC	Department of Health and Social Care
EOI	Expressions of interest
ETC	Excess Treatment Costs
GCP	Good Clinical Practice
GCS	Gloucestershire Care Services
GRH	Gloucestershire Hospitals NHS Foundation Trust
GWH	Great Western Hospitals NHS Foundation Trust
HLO	High Level Objective(s)
HRA	Health Research Authority
HSRC	Hyper-acute Stroke Research Centre(s)
I&I	Innovation and Improvement (Continuous Improvement)
IOM	Industry Operations Manager
IVF	In vitro fertilisation
JDR	Join Dementia Research
LCRN	Local Clinical Research Network

LPMS	Local Portfolio Management System
LSL	Local Specialty Lead
MHRA CTA	Medicines and Healthcare products Regulatory Agency Clinical Trial Authorisation
MTC	Major Trauma Centre(s)
NBT	North Bristol NHS Trust
NC	Nurse Consultant
NIHR	National Institute of Health Research*
NIHR CRN	National Institute of Health Research Clinical Research Network*
ODP	Open Data Platform
OMG	Operational Management Group
PCPS	Palliative Care, Psychosocial and Survivorship
PF	Portfolio Facilitator(s)
PHWE	People in Health West of England
PI	Principal Investigator
PIC	Patient Identification Centre
PO	Partner Organisation(s)
POF	Performance and Operating Framework
POMCTN	UK Peri-operative Clinical Trials Network
PRA	Patient Research Ambassador
PPIE	Patient and Public Involvement and Engagement
R&D	Research and Development
RDM	Research Delivery Manager(s)
RICE	Research Institute for the Care of Older People
RIWC	Research Infrastructure and Workforce Committee
RNHRD	Royal National Hospital for Rheumatic Diseases (now part of RUH)
RSI	Research Sites Initiative
RTT	Recruitment to Time and Target
RUH	Royal United Hospitals Bath NHS Foundation Trust
SPA	Specialty Programmed Activities
SPOC	Single Point of Contact
SSG	Site Specific Groups
SSL	Subspecialty Lead(s)
SSNAP	Sentinel Stroke National Audit Programme
SSS	Study Support Service
STAR	Severn Trainee Anaesthesia Research Group
SWAG	Somerset, Wiltshire, Avon and Gloucestershire
SWPORMG	South West Paediatric Oncology Research Management Group
TYA	Teenagers and Young Adults
UHB	University Hospitals Bristol NHS Foundation Trust
WAHT	Weston Area Health NHS Trust
WEAHSN	West of England Academic Health Science Network
WFD	Workforce Development
* LCRN uses 'for' usually but NIHR CRNCC templates suggests using 'of'.	

9. Appendices

Appendix number	Title	Link
Appendix 1	LCRN Fact Sheet 2017/18	
Appendix 2	Finance Section for the LCRN Fact Sheet 2017/18	
Appendix 3	LCRN Category B Providers 2017/18	
Appendix 4	Feedback from Clinical Priority setting workshop	

National Institute for Health Research

CRN West of England Fact Sheet (May 2018 Issue)

Table 1. Key Personnel			
1.1	Host Organisation	University Hospitals Bristol NHS Foundation Trust	
	Role	**Name**	**With effect from**
1.2	Host Organisation Chief Executive Officer	Mr Robert Woolley	*September 2010*
1.3	Host Nominated Executive Director	Dr Sean O'Kelly	*April 2014*
1.4	Partnership Board Chair	Deborah Lee	*December 2016*
1.5	CRN West of England CD	Dr Stephen Falk	*April 2014*
1.5	CRN West of England CD Designate	Dr Kyla Thomas	*October 2017*
1.6	CRN West of England COO	Dr Sue Taylor	*April 2017*

Table 2. LCRN Key Information (2017/18)		
2.1	LCRN Population	2,444,831
2.2	Number of NHS Provider Trusts	9
2.3	Number of Category A Providers (including Host Organisation)	9
2.4	Number of GP Practices	280
2.5	Recruitment per 1000 population	11.08
2.6	Academic Health Science Network	West of England

Table 3. Other NIHR Infrastructure	
Early Translational Research	• NIHR Bristol Cardiovascular Biomedical Research Unit • NIHR Bristol Nutrition Biomedical Research Unit
Clinical Research	•

Evaluation and Adoption	• NIHR CLAHRC West
Public Health Safety and Improvement	• NIHR Health Protection Research Unit in Evaluation of Interventions
MedTech Devices	

Table 4. HLO Performance

	HLO	2014/15	2015/16	2016/17	2017/18
4.1	HLO 1	28,050	20,740	26,801	
4.2	HLO 2a	47%	47%	63%	
4.3	HLO 2b	64%	76%	80%	
4.4	HLO 4	87%	94%	60%	
4.5	HLO 5a	40%	33%	25%	
4.6	HLO 5b	33%	35%	20%	
4.7	HLO 6a	93%	100%	100%	
4.8	HLO 6b	78%	78%	78%	
4.9	HLO 6c	68%	60%	68%	
4.10	HLO 7	601	889	536	

Table 5. Analysis of Recruiting Studies

	Year	Total no. of studies		Commercial	Non-commercial	Interventional	Observational	Interventional and Observational	No of recruiting studies (>1 LCRN)	No of recruiting studies (1 LCRN)
5.1	**2014/15**	664		146	518	340	301	23	620	44
5.2	**2015/16**	684		148	536	341	310	33	610	74
5.3	**2016/17**	648		161	487	334	279	35	599	49
5.4	**2017/18**									

Table 6. Category A Providers (including Host Organisation)

	Provider	Sector	Date of last audit	Date of next audit
6.1	2gether NHS Foundation Trust	Mental Health		
6.2	Avon and Wiltshire Mental Health Partnership NHS Trust	Mental Health		
6.3	Gloucestershire Hospitals NHS Foundation Trust	Acute		
6.4	Gloucestershire Care Services NHS Trust	Care		
6.5	Great Western Hospitals NHS Foundation Tru	Acute		
6.6	North Bristol NHS Trust	Acute		
6.7	Royal United Hospital Bath NHS Foundation T	Acute		
6.8	University Hospitals Bristol NHS Foundation Trust	Acute		
6.9	Weston Area Health NHS Trust	Acute		

Table 7. Local Clinical Research Specialty Leads

ID	Specialty	Name	With effect from	No of PAs	LCRN funded
7.1	Ageing	Dr Emily Henderson	*September 2016*	*0.5*	*Yes*
7.2	Anaesthesia, Perioperative Medicine and Pain Management	Dr Ronelle Moulton	*June 2015*	*0.5*	*Yes*
7.3	Cancer	Prof Hugh Barr	*April 2014*	*1*	*Yes*
7.3a	Cancer Subspecialty Lead (Brain)	Dr Christopher Herbert	*April 2014*	*0*	*No*
7.3b	Cancer Subspecialty Lead (Breast)	Dr Mark Beresford Mr Zenon Rayter	*April 2014*	*0*	*No*
7.3c	Cancer Subspecialty Lead (Colorectal)	Dr Stephen Falk	*April 2014*	*0*	*No*
7.3d	Cancer Subspecialty Lead (Children and Young People)	Dr Helen Rees	*April 2014*	*0*	*No*
7.3e	Cancer Subspecialty Lead (Gynae)	Dr Rebecca Bowen	*April 2014*	*0*	*No*

7.3f	Cancer Subspecialty Lead (Head & Neck)	Prof Steve Thomas	*April 2014*	*0*	*No*
7.3g	Cancer Subspecialty Lead (Haematology)	Dr Lisa Lowery Dr Sally Moore	*April 2014*	*0*	*No*
7.3h	Cancer Subspecialty Lead (Lung)	Dr Ashley Cox	*April 2014*	*0*	*No*
7.3i	Cancer Subspecialty Lead (Sarcoma)	Dr Adam Dangoor	*April 2014*	*0*	*No*
7.3j	Cancer Subspecialty Lead (Skin)	Dr Christopher Herbert	*April 2014*	*0*	*No*
7.3k	Cancer Subspecialty Lead (Supportive and Palliative Care and Psychosocial Oncology)	Prof Karen Forbes	*April 2014*	*0*	*No*
7.3l	Cancer Subspecialty Lead (Upper GI)	Dr Sharath Gangadhara	*January 2017*	*0*	*No*
7.3m	Cancer Subspecialty Lead (Urology)	Dr Amit Bahl	*April 2014*	*0*	*No*
7.4	Cardiovascular Disease	Dr Paul Foley	*December 2014*	*0.5*	*Yes*
7.5	Children	Prof Adam Finn	*April 2014*	*1*	*Yes*
7.6	Critical Care	Dr Matthew Thomas	*October 2016*	*0.5*	*Yes*
7.7	Dementias and neurodegeneration	Prof Roy Jones Dr Tarun Kuruvilla	*April 2014*	*0.5 x2*	*Yes*
7.8	Dermatology	Dr Debbie Shipley	*April 2015*	*0.5*	*Yes*
7.9	Diabetes	Dr Andrew Johnson	*April 2015*	*0.5*	*Yes*
7.10	Ear, nose and throat	Dr Amanda Hall	*December 2014*	*0.1 WTE*	*Yes*
7.11	Gastroenterology	Prof Hugh Barr	*April 2014*	*0.5*	*Yes*
7.12	Genetics	Dr Alan Donaldson	*December 2014*	*0.5*	*Yes*
7.13	Haematology	Dr Andrew Mumford	*December 2014*	*0.5*	*Yes*
7.14	Health Services Research	Prof Yoav Ben-Shlomo	*January 2016*	*0.5*	*Yes*

7.15	Hepatology	Dr Coral Hollywood	*April 2017*	*0.5*	*Yes*
7.16	Infection	Dr Peter Muir	*April 2015*	*0.1*	*Yes*
7.17	Injuries and Emergencies	Dr Michael Whitehouse	*November 2016*	*0.5*	*Yes*
7.18	Mental Health	Dr Jonathan Evans	*April 2014*	*1*	*Yes*
7.19	Metabolic and Endocrine Disorders	Vacancy			*No*
7.20	Musculoskeletal disorders	Dr Sandi Derham	*December 2014*	*0.1 WTE*	*Yes*
7.21	Neurological Disorders	Appointment in progress	March 2018	0.5	*Yes*
7.22	Ophthalmology	Dr Clare Bailey	*April 2015*	*0.1*	*Yes*
7.23	Oral and dental health	Prof Tony Ireland	*December 2014*	*0.1*	*Yes*
7.24	Primary care	Dr Tony Crockett	*April 2014*	*0.5*	*Yes*
7.25	Public health	Prof Mark Pietroni	*January 2016*	*0.5*	*Yes*
7.26	Renal Disorders	Dr Albert Power	*December 2014*	*0.5*	*Yes*
7.27	Reproductive Health and Childbirth	Dr Tim Draycott Mrs Sara Burnard	*December 2014*	*0.5 and 0.1 wte*	*Yes*
7.28	Respiratory Disorders	Dr Nick Maskell	*December 2014*	*0.5*	*Yes*
7.29	Stroke	Dr Philip Clatworthy	*July 2015*	*0.5*	*Yes*
7.30	Surgery	Miss Kathryn McCarthy	*April 2015*	*0.5*	*Yes*

FINANCE SECTION OF 2017/18 Annual Factsheet

CRN	West of England

Input cell

Table 1. LCRN Funding				
Year	Initial Allocation (1)	(Underspends) (2)	Redistribution / (Underspend) (3)	Final Expenditure (4)
2014/15	£13,830,878	-£335,000	-£335,000	£13,495,878
2015/16	£13,112,308	£0	£0	£13,112,308
2016/17	£12,812,418	£0	£0	£12,812,418
2017/18	£12,404,521	£0	£674	£12,405,195

Note (1) Initial core funding allocation including RCF excluding national top-sliced.
Note (2) Underspends declared in the Financial year, not necessarily when the underspend was recovered.
Note (3) Redistribution of additional funding less underspends recovered and reported in the financial year.
Note (4) Initial Allocation + Redistribution/ (Underspends) = Final Expenditure, i.e. the final expenditure for the Financial Year, taking into account redistribution and underspends impacting the year.

Table 2. Sector Spend									
Year	Acute	Ambulance	Care / Mental Health	Primary care	Corporate Support services costs and Leadership and Management	Other	Total (1)	This column should equal zero - if not please correct table 2	Commentary
2014/15	£9,699,143	£0	£714,291	£1,192,928	£1,598,638	£290,878	£13,495,878	£0	Other = RCF
2015/16	£9,024,119	£0	£804,593	£990,409	£1,725,629	£567,558	£13,112,308	£0	Other = RCF
2016/17	£9,006,503	£0	£1,000,851	£937,310	£1,867,754		£12,812,418	£0	
2017/18	£9,048,723	£0	£857,452	£808,371	£1,690,649		£12,405,195	£0	

Note (1) The total should equal that of the Final Expenditure column in Table 1' LCRN Funding'
Note (2) Corporate support service costs and Leadership and Management should include costs as per the 18/19 POF definitions under 2.5, 2.8 and 2.9 respectively
Note (3) The expectation is that "Other" will have minimal costs but please provide a commentary on what may have been included

Table 3. Contract Type Spend					
Year	Category A Partners (1)	Category B Partners	Host Corporate Support Services / LCRN Leadership and Management	Total (2)	This column should equal zero - if not please correct table 3
2014/15	£10,704,312	£1,192,928	£1,598,638	£13,495,878	£0
2015/16	£10,396,270	£990,409	£1,725,629	£13,112,308	£0
2016/17	£10,007,354	£937,310	£1,867,754	£12,812,418	£0
2017/18	£9,906,175	£808,371	£1,690,649	£12,405,195	£0

Note (1) Category A Partners should include the Host Organisation spend on Research Delivery
Note (2) The total should equal the total column in Table 2 "Sector Spend".

Table 4. LCRN Cost Per Weighted Recruit by Financial Year/ Sector (1)								
Year	Acute	Ambulance	Care / Mental Health	Primary care	Corporate Support services costs and Leadership and Management (2)	Other (2)	Aggregate (3)	If an error message appears, please correct table 4
2014/15	£149.31	n/a	£117.17	£32.92	n/a	n/a	£107.65	The weighted recruitment used in the CPWR calculations (columns B-G) do not tie up with the total weighted recruitment, please correct
2015/16	£154.77	n/a	£178.84	£37.06	n/a	n/a	£116.59	The weighted recruitment used in the CPWR calculations (columns B-G) do not tie up with the total weighted recruitment, please correct
2016/17	£128.13	n/a	£228.19	£48.41	n/a	n/a	£95.65	The weighted recruitment used in the CPWR calculations (columns B-G) do not tie up with the total weighted recruitment, please correct
2017/18	£132.12	n/a	£99.78	£50.79	n/a	n/a	£129.69	There is an error with the CPWR calculation, please correct

Note (1) Excludes participants recruited to commercial studies. Expenditure excludes national Top-sliced funding. Weightings applied to the recruitment data should be based on
Note (2) If recruitment is not attributed to the 'Corporate Support service costs and Leadership and Management' and 'other' categories, please state 'n/a' in the table above. Do not re-apportion the expenditure to the 'Acute', 'Ambulance', 'Care/Mental Health', or 'Primary Care' sector categories.
Note (3) The Aggregate CPWR should include the total expenditure as reported in Tables 2 and 3 divided by the total weighted recruitment (excluding commercial)

Table 5. Weighted Recruitment data- For info only								
	Acute	Ambulance	Care / Mental Health	Primary care	Corporate Support services costs and	Other (2)	Aggregate (3)	equal zero - if not
2014/15 Check	64,958	-	6,096	36,239	-	-	125,365	- 18,072
2015/16 Check	58,306	-	4,499	26,721	-	-	112,468	- 22,942
2016/17 Check	70,291	-	4,386	19,360	-	-	133,945	- 39,908
2017/18 Check	68,491	-	8,593	15,915	-	-	95,649	- 2,650

Table 6. Total weighted recruitment data by LCRN (for info only)								
LCRN	**FY 14/15 Total Recruitment (Excludes Commercial)**	**FY 14/15 Total non commercial Weighted Recruitment**	**FY 15/16 Total Recruitment (Excludes Non-NHS and Commercial)**	**FY 2015/16 Total Weighted Recruitment**	**FY 16/17 Total Recruitment (Excludes Non-NHS and Commercial)**	**FY 2016/17 Total Weighted Recruitment**	**FY 17/18 Total Recruitment (Excludes Non-NHS and Commercial)**	**FY 2017/18 Total Weighted Recruitment**
East Midlands							TBC	TBC
Eastern							TBC	TBC
Greater Manchester							TBC	TBC
Kent, Surrey and Sussex							TBC	TBC
North East and North Cumbria							TBC	TBC
North Thames							TBC	TBC
North West Coast							TBC	TBC
North West London							TBC	TBC
South London							TBC	TBC
South West Peninsula							TBC	TBC
Thames Valley and South Midlands							TBC	TBC
Wessex							TBC	TBC
West Midlands							TBC	TBC
West of England	26,500	125,365	18,853	112,468	25,325	133,945	TBC	95,649
Yorkshire and Humber							TBC	TBC
Grand Total	**583,568**	**2,549,589**	**571,257**	**2,716,079**	**631,991**	**2,769,051**	TBC	TBC

Appendix 3. LCRN Category B Providers 2017/18			
Name of Provider	**Type of Provider**	**Category B contract**	
Adcroft Surgery	General Practice	No	Agreement in place
Air Balloon Surgery	General Practice	No	Agreement in place
Beechwood Medical Practice	General Practice	No	Agreement in place
Bradford Road Medical Centre	General Practice	No	Agreement in place
Brockworth Surgery	General Practice	No	Agreement in place
Cadbury Heath Health Centre	General Practice	No	Agreement in place
Cedars Surgery	General Practice	No	Agreement in place
Charlotte Keel Health Centre	General Practice	No	Agreement in place
Chew Medical Practice	General Practice	No	Agreement in place
Chipping Campden Surgery	General Practice	No	Agreement in place
Chipping Surgery	General Practice	No	Agreement in place
Churchdown Surgery	General Practice	No	Agreement in place
Clevedon Medical Centre	General Practice	No	Agreement in place
Close Farm Surgery	General Practice	No	Agreement in place
Combe Down Surgery	General Practice	No	Agreement in place
Concord Medical Centre	General Practice	No	Agreement in place
Cotswold Medical Practice	General Practice	No	Agreement in place
Courtside Surgery	General Practice	No	Agreement in place
Dr. Andrew, Edwards, Hayes & Cleary (formally Yorkley Health Centre)	General Practice	No	Agreement in place
Eastville Medical Practice	General Practice	No	Agreement in place
Eldene Surgery	General Practice	No	Agreement in place
Elm Hayes Surgery	General Practice	No	Agreement in place
Elm Tree Surgery	General Practice	No	Agreement in place
Fallodon Way Medical Centre	General Practice	No	Agreement in place
Frome Valley Medical Centre	General Practice	No	Agreement in place
Gloucester Road Medical Centre	General Practice	No	Agreement in place
Grange Road Surgery	General Practice	No	Agreement in place
Greenway Community Practice	General Practice	No	Agreement in place
Hanham Health Centre	General Practice	No	Agreement in place
Harbourside Family Practice	General Practice	No	Agreement in place
Hartwood Healthcare	General Practice	No	Agreement in place
Hathaway Medical Centre	General Practice	No	Agreement in place
Helios Medical Centre	General Practice	No	Agreement in place
Hope House Surgery	General Practice	No	Agreement in place
Horfield Health Centre	General Practice	No	Agreement in place
Hucclecote Surgery	General Practice	No	Agreement in place
Kingswood Health Centre	General Practice	No	Agreement in place
Lansdowne Surgery	General Practice	No	Agreement in place
Leckhampton Surgery	General Practice	No	Agreement in place
London Road Medical Practice	General Practice	No	Agreement in place
Malago Surgery	General Practice	No	Agreement in place

Mann Cottage Surgery	General Practice	No	Agreement in place
Market Lavington Surgery	General Practice	No	Agreement in place
Mendip Vale Medical Practice	General Practice	No	Agreement in place
Minchinhampton Surgery	General Practice	No	Agreement in place
Monks Park Surgery	General Practice	No	Agreement in place
Montpelier Health Centre	General Practice	No	Agreement in place
Mythe Medical Practice	General Practice	No	Agreement in place
New Court Surgery (Wiltshire)	General Practice	No	Agreement in place
Nightingale Valley Practice	General Practice	No	Agreement in place
North Swindon Practice (Home Ground Surgery)	General Practice	No	Agreement in place
Oldfield Surgery	General Practice	No	Agreement in place
Patford House Surgery	General Practice	No	Agreement in place
Pembroke Road Surgery	General Practice	No	Agreement in place
Phoenix Surgery (Cirencester)	General Practice	No	Agreement in place
Pilning Surgery	General Practice	No	Agreement in place
Pioneer Medical Group	General Practice	No	Agreement in place
Portishead Medical Group	General Practice	No	Agreement in place
Portland Practice	General Practice	No	Agreement in place
Price's Mill Surgery	General Practice	No	Agreement in place
Regent Street Practice	General Practice	No	Agreement in place
Rendcomb Surgery	General Practice	No	Agreement in place
Ridge Green Medical Centre	General Practice	No	Agreement in place
Ridgeway View Family Practice	General Practice	No	Agreement in place
Riverbank Medical Centre	General Practice	No	Agreement in place
Rowden Medical Partnership	General Practice	No	Agreement in place
Sea Mills Surgery	General Practice	No	Agreement in place
Seven Posts Surgery	General Practice	No	Agreement in place
Shirehampton Group Practice	General Practice	No	Agreement in place
Southville Surgery	General Practice	No	Agreement in place
St Augustine's Surgery	General Practice	No	Agreement in place
St Chad's Surgery	General Practice	No	Agreement in place
St George Health Centre	General Practice	No	Agreement in place
Stoke Gifford Medical Centre	General Practice	No	Agreement in place
Stow Surgery	General Practice	No	Agreement in place
Streamside Surgery	General Practice	No	Agreement in place
Students' Health Service	General Practice	No	Agreement in place
Sunnyside Surgery	General Practice	No	Agreement in place
The Avenue Surgery (Cirencester)	General Practice	No	Agreement in place
The Family Practice - Western College	General Practice	No	Agreement in place
The Fishponds Family Practice	General Practice	No	Agreement in place
The Health Centre Bradford On Avon	General Practice	No	Agreement in place
The High Street Medical Centre	General Practice	No	Agreement in place
The Lennard Surgery	General Practice	No	Agreement in place
Thornbury Health Centre - Burney(Dr W J Foubister and Partners)	General Practice	No	Agreement in place
Tolsey Surgery	General Practice	No	Agreement in place
Tyntesfield Medical Group	General Practice	No	Agreement in place
Wedmore Practice	General Practice	No	Agreement in place

Wellspring Surgery	General Practice	No	Agreement in place
West Walk Surgery	General Practice	No	Agreement in place
Westbury Group Practice (White Horse Surgery)	General Practice	No	Agreement in place
Westbury On Trym Primary Care Centre	General Practice	No	Agreement in place
Whiteladies Medical Group	General Practice	No	Agreement in place
Winchcombe Medical Centre	General Practice	No	Agreement in place
Winscombe and Banwell Family Practice	General Practice	No	Agreement in place
Yorkleigh Surgery	General Practice	No	Agreement in place

Clinical Research Network
West of England

NHS
National Institute for Health Research

Agenda
Clinical Priority Setting Event
Friday 15 September 2017, 12:00 – 16:00
Venue: Holiday Inn Bristol City Centre, Bond Street, Bristol BS1 3LE.

Chair: Dr Steve Falk **Notes: James Scott**

Feedback:

Workshop 1

How can the network structure best facilitate clinical leadership in order to improve research delivery?

What are our priority areas?

- It would be helpful for contributors to be informed early regarding any upcoming studies and if the recruitment process could be made more accessible.
- It would be positive to focus on the successful areas of study – to analyse what makes a study work and to share best practice.
- A link to RDS to support process between initial contact and recruitment. Recognition and signposting.
- Build a Public Health portfolio to recognise movement of research from secondary to primary care (e.g. diabetes)
- NIHR should take a lead on how study is implemented pre-grant and be more supportive of a preventative rather than disease based model.
- Joint speciality posts worked well – medic and non-medics working on a study.
- Monthly telecons were productive in providing clinical leads with a regional overview.
- Succession planning – providing training and support for younger staff to take on workloads.
- Promote network wide referrals by building connections with other trusts and establishing communication between clinicians.
- Clinical leads could promote CRN to community therapists working in public health.
- Encourage working across boundaries to include recruitment from local authorities and care homes and housing organisations.

Workshop 2

What areas of the network would you invest money in?

- Non NHS settings – support to develop research and recruit, advice on how to be added to the portfolio.
- A training bursary, for example to support a PI progressing to a CI.
- Revamp GCP training to have more relevance for primary care, enabling public health consultants to work in universities and vice versa.
- Research collaborations – an umbrella organisation or super centre to cover research by any provider to increase productivity.
- Grow primary care, public health, community centres.
- Improve digital platform, connecting networks and including study prompts for clinicians.
- Home grown research and CI development.
- Social Media to support recruitment and boost marketing.
- Early career training.
- Patient ambassadors and GP champions.

Cover report to the PublicTrust Board. Meeting to be held on 28 June 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 28 June 2018
Report Title	**Governors' Log of Communications**		
Author	Kate Hanlon, Membership Engagement Manager		
Executive Lead	Jeff Farrar, Chair		
Freedom of Information Status		Open	

Strategic Priorities (please choose any which are impacted on / relevant to this paper)			
Strategic Priority 1 :We will consistently deliver high quality individual care, delivered with compassion.	☐	Strategic Priority 5: We will provide leadership to the networks we are part of, for the benefit of the region and people we serve.	☐
Strategic Priority 2: We will ensure a safe, friendly and modern environment for our patients and our staff.	☐	Strategic Priority 6: We will ensure we are financially sustainable to safeguard the quality of our services for the future and that our strategic direction supports this goal.	☐
Strategic Priority 3: We will strive to employ the best staff and help all our staff fulfil their individual potential .	☐	Strategic Priority 7: We will ensure we are soundly governed and are compliant with the requirements of NHS Improvement.	☒
Strategic Priority 4: We will deliver pioneering and efficient practice, putting ourselves at the leading edge of research, innovation and transformation	☐		☐

Action/Decision Required (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☐

Executive Summary

Purpose: The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications and subsequent responses added or modified since the previous Board.

The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust. The log is distributed to all Board members, including Non-executive Directors when new items are received and when new responses have been provided.

Recommendations

Members are asked to:

- **Note the Report.**

Intended Audience (please select any which are relevant to this paper)								
Board/Committee Members	☐	Regulators	☐	Governors	☒	Staff	☒	Public	☒

Board Assurance Framework Risk (please choose any which are impacted on / relevant to this paper)			
Failure to maintain the quality of patient services.	☐	Failure to develop and maintain the Trust estate.	☐
Failure to recruit, train and sustain an engaged and effective workforce.	☐	Failure to comply with targets, statutory duties and functions.	☒
Failure to enable and support transformation and innovation, to embed research and teaching into the care we provide, and develop new treatments for the benefit of patients and the NHS.	☐	Failure to take an active role in working with our partners to lead and shape our joint strategy and delivery plans, based on the principles of sustainability, transformation and partnership working.	☐
Failure to maintain financial sustainability.	☐		

Corporate Impact Assessment (please tick any which are impacted on / relevant to this paper)							
Quality	☐	Equality	☐	Legal	☐	Workforce	☐

Impact Upon Corporate Risk
N/A

Resource Implications (please tick any which are impacted on / relevant to this paper)			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐

Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**

ID	Governor Name		
203	John Rose	***Theme*** Single point failure	***Source:*** Project Focus Group

Query **25/05/2018**

The recent fire at the Bristol Haematology and Oncology Centre has been dealt with in an exemplary manner, but it shows how vulnerable any business can be to an accident or single point failure. Does the Trust have an operational risk assessment of all its assets recognising the likelihood and effect of single point failures of buildings, departments, power supplies, steam supplies, heating, cooling and ventilation systems, and have mitigating actions been identified and agreed? In addition, are all emergency and life safety systems regularly and effectively tested and reviewed.

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 08/06/2018

Response **13/06/2018**

We have business continuity plans for all key departments and areas of the Trust. These include any patient facing department as well as any other key services provided by the Trust. These plans contain risk assessments as well as a prioritisation of the functions performed by each service. Additionally there is a focus on the response to impacts of incidents affecting premises, staffing, utilities and resources for each area. Within this process single points of failure are highlighted with mitigating actions put in place. Any high risks will also have an additional action plan as part of the plans. Estates and IM&T also hold plans for key systems which are relied upon across the Trust.

Alongside the business continuity plans MEMO also hold a database of all equipment which requires UPS backup and these are maintained between themselves and estates.

Status: *Awaiting Governor Response*

ID	Governor Name				
202	Malcolm Watson	***Theme*** Histopathology		***Source:***	From Constituency/ Members

Query **08/05/2018**

There was recent publicity about a former nurse who is terminally ill with cancer after her histopathology samples were negative when examined by Severn Pathology. This is a centralised service which UH Bristol also uses. Is there assurance that everything is being done now to reduce this risk by having sufficiently trained staff and double reporting (peer review) as recommended by the 2010 Mishcon enquiry?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 15/05/2018

Response **16/05/2018**

The commencement of Severn Pathology saw the establishment of specialist teams of Consultant Pathologists who work in a limited number of specialisms rather than the more generalist approach that was practiced previously. This system allows individuals to build up expertise within those fields and was always a key aim of the merging of the services. The concentration of expertise into teams also facilitates a better approach to double-reporting which has been implemented fully and according to the policy developed for Severn Pathology.

Due to a national shortage of suitable applicants, there remain some gaps in total numbers of Consultant staff which mean that some teams have fewer members than would be optimal. However, with the exception of Paediatric / Perinatal Pathology (PPP), all teams have sufficient numbers to be able to maintain a sufficiently high level of expertise and the numbers to support double-reporting. For PPP, there is support from system-specific teams reporting adult pathology and from PP pathologists in other centres to maintain a safe service. A second pathologist in this field will come in to post in August 2018.

Status: *Awaiting Governor Response*

ID	Governor Name				
201	Pauline Beddoes	***Theme*** Clinic letters		***Source:*** Governor Direct	

Query **08/05/2018**

Patients who have hospital clinic appointments are often advised to have further tests, e.g. blood tests, or are prescribed new medication or changed dosages of existing drugs. The letters are then typed by the secretaries, but unfortunately these take days or even weeks to be sent to the patient's GP.

I understand that other Trusts are providing official forms outlining medication changes at the time of the appointment which patients can then bring into the surgery and the GP can action the changes. The official letter can then be sent later, as it usually is. Are there any plans to implement a similar process at UH Bristol?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/05/2018

Response **09/05/2018**

There are national standards for letter turnaround currently being implemented that will reduce the turnaround time to 7 days. There are no plans to make any changes at present. If it is an urgent prescription change the consultant should give the patient an outpatient prescription before they leave the appointment.

Status: *Re-opened*

ID	Governor Name				
200	John Rose	***Theme*** Management consultants		***Source:***	From Constituency/ Members

Query **03/05/2018**

Bristol University, in collaboration with others, has been evaluating the benefit of employing consultants in NHS organisations. The study, 'The impact of management consultants on public service efficiency', came to the conclusion that, overall, the employment of external consultants resulted in inefficiency rather than the expected improvements in efficiency. Is the Trust acting on the suggested policy actions and what conclusions has it come to in relation to its future use of external consultants?

Division: Trust-wide ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:*** 14/05/2018

Response **09/05/2018**

The Trust approach is first and foremost to seek to resource all activities internally. Consultancy is defined as the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. In general we would only consider use of external consultancy where we do not have the appropriate capability or expertise; where we specifically need independent advice; or where the capacity required to complete a necessary piece of work within a defined timescale, is not feasible to achieve internally.

The study referred to was completed by Warwick University based on analysis of 'consulting services' expenditure from the Annual Reports of acute care hospital trusts in England for four years (2009/10 to 2012/13). Using pooled time series regression analysis, the study looked at the relationship between this spending and the efficiency of each hospital trust over time. The assessment was not of the efficiency or impact of the individual projects for which the consultancy had been secured. Nonetheless, we continue to scrutinize any proposal for expenditure with external consultants very closely and have maintained low levels of such spend. In 2016/17 our spend on external consultancy was £615, 000 (0.09% of total income) and in 2017/18 this was £373,000 (0.06% of total income).

Status: *Awaiting Governor Response*

ID	Governor Name				
199	Garry Williams	***Theme*** Food sales		***Source:*** Governor Direct	

Query **24/04/2018**

The Journal of the Royal Society for Public Health ('Perspectives in Public Health') January 2018 vol. 138 no. 1 p. 5 carries a brief article commenting on the decision of Public Health England to forbid the sale of 'super-size' chocolate bars and regulate the sale of snacks, pre-packaged meals and sandwiches and some drinks, sold in hospital shops, canteens and vending machines.

May governors please be told whether the cafes and shops in UH Bristol's hospitals/premises need to comply with NHS England's directives in relation to calories, saturated fat, added sugar and other. If outlets on UH Bristol premises are not subject to this oversight and regulation, should the fact be made clear to patients using on-site facilities; and does the Trust have a policy aimed at making it more likely that these outlets will accept the NHS England standards for hospital shops, canteens and vending machines?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 03/05/2018

Response **22/05/2018**

All cafes and retail outlets across the Trust are subject to NHS England's directive in relation to calories, saturated fat, added sugar and other. Our Corporate Retail Partners (RVS, Medirest/Costa; WH Smith and M&S; Boots) have signed up directly with NHS England to confirm their commitment and plan to meet the 3-Year CQUIN Indicator 1b in relation to Healthy Eating. Boots' contract is currently under negotiation which includes a requirement for them to meet the CQUIN indicator. All current vending suppliers to the Trust have also signed up to and are meeting this commitment and our Trust-run café outlets and vending are 100% compliant with the current targets.

The Trust has been successful in achieving the Gold Standard of the Bristol Eating Better Award scheme both at the Bristol Heart Institute café and St Michael's Hospital café, a free award scheme publicising food businesses that are taking action to offer food that is healthier and more environmentally friendly. The Trust has also achieved the 'Sugar Smart' Award and is therefore able to use labelling and advertising in relation to this achievement where appropriate to inform patients, visitors and staff of the Trust's commitment. In addition, our Corporate Retail Partners have their own marketing materials in place in relation to informing staff patients and visitors of the changes offering.

Moving forward, all contracts in relation to vending and retail food outlets serving patients, visitors and staff will contain the requirement for suppliers to meet the National CQUIN requirements for Healthy Eating. The retail outlets currently run by RVS will be operated by the in house Facilities team from October 2018. The Trust is going out to tender imminently for a supplier to provide vending services to the Trust.

Status: *Assigned to Executive Lead*

ID	Governor Name				
198	John Rose	***Theme*** Patient safety		***Source:*** Governor Direct	

Query **14/03/2018**

Recent media coverage seems to suggest that surgeons (and doctors) can carry out procedures with only themselves aware of their histories of success or otherwise. What processes are in place to monitor the effectiveness and safety of medical and surgical activities at UH Bristol?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 28/03/2018

Response **11/04/2018**

We have a system for proactively monitoring our quality intelligence data for any potential outlier alerts which need further investigation. Where a potential alert is identified this is reviewed to see if it is statistically significant, that coding and mode of admission data is accurate and, if both, then a clinical review of the care of the patients which comprise the alert is undertaken. Where possible we triangulate the information with other data sources if they are available to us, such as national clinical audits, serious incident investigations, mortality review process. Occasionally we receive outlier alerts from third parties such as the CQC who may use slightly different datasets and statistical methodology. Increasingly when this occurs we are finding that we are already aware of a similar outlier alert which has already been investigated and, if relevant, improvement actions are in place or is being investigated.

Update 03/05/18: The quality intelligence data in the original reply refers to Hospital Episode Statistics data derived from clinical coding of every single patient's inpatient treatment as recorded in the clinical notes. This is reviewed in a number of ways to identify any outlier alerts and themes which can be drilled down into further detail, including to individual consultants. This includes such things and complications, misadventures, surgical site infections, readmissions, mortality. Alerts are reviewed and investigated further via an agreed standard operating procedure, including a review of individual patients if indicated, and reported into the Trust's Quality Intelligence Group chaired by the Medical Director.

With regard to the data in the quality dashboard, this comes from a wide range of internal and external sources e.g. NHS Digital (Summary Hospital Mortality Indicator) and local monitoring systems e.g. observational handwashing audits.

Status: *Awaiting Governor Response*