University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: 27 September 2018

Time: 11:00 – 13:00

Venue: Conference Room, Trust Headquarters

University Hospitals Bristol
NHS Foundation Trust

BOARD OF DIRECTORS (in Public)

Meeting to be held in Public Thursday 27 September 2018, 11.00 – 13.00
Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
Preliminary Business				
1.	Apologies for absence	Information	Chair	Verbal
2.	Declarations of interest	Information	Chair	Verbal
3.	Patient Story	Assurance	Chief Executive	7
4.	Minutes of the last meeting • **27 July 2018**	Approval	Chair	11
5.	Matters arising and action log	Approval	Chair	27
6.	Chief Executive's Report	Information	Chief Executive	29
Care and Quality				
7.	Review of Major Incident in the Bristol Haematology And Oncology Centre in May 2018	Approval	Chief Executive	35
8.	Quality and Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer; Chief Nurse/Medical Director	57
9.	Quality and Outcomes Committee Chair's Report • August • September	Assurance	Quality and Outcomes Committee Chair	59 To be tabled
10.	Six-Monthly Nurse Staffing Report	Assurance	Chief Nurse	63
11.	Patient Complaints and Experience Reports a) Patient Complaints Q1 Report b) Patient Experience Q1 Report	 Assurance Information	Chief Nurse	 71 115
12.	Evaluation of Patient Safety Programme 2015-2018 and Patient Safety Priorities 2019-	Assurance	Chief Nurse	143

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Workforce				
15.	Revalidation and Medical Appraisal Report	Assurance	Medical Director	265
Strategy and Transformation				
16.	Healthier Together Sustainability and Transformation Partnership Update	Information	Chief Executive	281
Financial Performance				
17.	Finance Report	Information	Director of Finance and Information	297
18.	Finance Committee Chair's Report • August • September	Assurance	Chair of Finance Committee	315 To be tabled
19.	Strategic Capital Programme and Medium Term Financial Plan	Approval	Director of Finance and Information; Director of Strategy and Transformation	317
Governance				
20.	Well-led Review Self-Assessment	Decision	Trust Secretary	345
21.	Governors' Expenses Policy Review	Approval	Trust Secretary	355
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24.	Governors' Log of Communications	Assurance	Chief Executive	394
Concluding Business				

NO.	AGENDA ITEM	PURPOSE	SPONSOR	PAGE NO.
25.	Any Other Urgent Business		Chair	Verbal
26.	Date and time of next meeting • **29 November 2018, 11.00 – 13.00, Trust HQ**		Chair	Verbal

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	3
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 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 chose any which are impacted on / relevant to this paper)			
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 (please select any which are relevant to this paper)							
For Decision	☐	For Assurance	☒	For Approval	☐	For Information	☒

Executive Summary

Purpose

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.

Key issues to note

At this meeting we had intended to share a story from a family member and carer of a patient in their 70s who is receiving care at the Bristol Haematology and Oncology Hospital (BHOC) This was as an alternative to original plans to share a patient support story from the Trust's Volunteer Services.

The story was to have charted a 12 month journey through BHOC from initial diagnosis to on-going care with a particular focus on the emotions and feelings experienced by the family member (the patient's son) as they cared for and provided support to their loved one (the family members father). The story encapsulates the highs and lows, joys and tensions of being a family member with carer responsibilities and sheds light on the value we place on carers and the role they have as partners in care. Unfortunately, at short notice, the family member has had to withdraw from sharing their experience with the Board yet remains committed to doing so at a future meeting. They asked me to extend their apologies and inform you that both they and their loved one are doing well.

Attempts are being made by the Patient Experience and Involvement team to secure an alternative patient story although this is proving difficult. Looking ahead, plans are in place for the Board to receive a patient story from the Teenage and Young Adult Cancer Services in November.

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 act on feedback from patients, staff and our public.	☒	Failure to recruit, train and sustain an engaged and effective workforce.	☐
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.	☐	Failure to comply with targets, statutory duties and functions.	☐

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 Board of Directors Meeting Held in Public
on Friday 27 July 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	Deputy Chief Executive and Chief Operating Officer
Martin Sykes	Non-Executive Director
Jill Youds	Non-Executive Director

In Attendance

Name	Job Title/Position
Sophie Melton Bradley	Deputy Trust Secretary
William Oldfield	Medical Director (Designate)
Kate Parraman	Deputy Director of Finance
Jeanette Jones	Royal College of Nursing Lead, Joint Union Committee
John Kirk	Communications Manager
Alistair Johnstone	Consultant Anaesthetist and Safe Working Hours Guardian
Mark Read	Chaplaincy Team Leader (for item 2)
Lisa Smith	LIASE Support Officer (for item 2)
Mo Phillips	Public Governor
Malcolm Watson	Public Governor
John Rose	Public Governor
Rashid Joomun	Patient Governor
Garry Williams	Patient/Carer Governor
Florene Jordan	Staff Governor
Andy Coles-Driver	Staff Governor
Emma King	Member of the public

Minutes:
Sarah Murch: Membership and Governance Administrator

The Chair opened the Meeting at 11.00

Minute Ref	Item Number	Action

Minute Ref	Item Number	Action
Preliminary Business		
120/07/2018	**1. Welcome and Introductions/Apologies for Absence**	
	The Chair, Jeff Farrar, welcomed everyone to the meeting. Apologies were received from Chief Executive Robert Woolley, Non-Executive Directors Guy Orpen and Steve West, and Non-Executive Director (Honorary) Sue Evans. The Chair informed the Board that a member of the Council of Governors, Hussein Amiri, had recently passed away. He expressed condolences to Hussein's family on behalf of the Board, adding that Hussein had been a positive and inspiring young man who would be sadly missed by Governors and those who had worked with him. He further extended a particular welcome to William Oldfield, the Trust's new Medical Director starting in August. He thanked Mark Callaway for his work as Acting Medical Director over the past year and noted that Mark would now be returning to his role as Deputy Medical Director.	
121/07/2018	**2. Declarations of Interest**	
	There were no declarations of interest.	
122/07/2018	**3. Patient Story**	
	The meeting began with a patient story, introduced by the Chief Nurse, Carolyn Mills. This month's story came from the Trust's Spiritual and Pastoral Care Service, the Annual Report of which was available to Board members on request. Carolyn introduced Mark Read, Chaplaincy Team Leader, who began by informing the Board that in the past year, hospital chaplains had supported over 6000 people in some significant way and performed over 1700 religious rites on request. More than 33% of the people supported did not express any religious belief or faith but they had valued the care that the service had been able to provide. He told the Board the story of one of these families. The story described an encounter between a chaplain and the family of a child at the end of his life. The child, who had an inherited life-limiting and progressive disease, had been brought into Bristol Royal Hospital for Children following a serious accident at home. He did not recover, and his mother was asked to make the decision to withdraw treatment. Following the withdrawal of life support, the child had survived for a further six weeks before eventually passing away. The mother of the child, who was Roman Catholic by religion, had turned to the Chaplaincy service for help. The chaplain had not only supported her spiritual needs, but had also provided invaluable emotional support throughout the entire time - by listening,	

Minute Ref	Item Number	Action
	understanding, compassionate responding, and conversation. He had also played an important role in mediating between the family and Trust staff. Mark's story highlighted that the Trust had a responsibility to support family, carers, and staff through difficult decision-making processes and challenging situations as much as it had a duty of care to the patient, and that the chaplaincy could be central to providing this holistic care. Members of the Board thanked Mark for a moving story and discussed the following: • Garry Williams, Patient/Carer Governor enquired how the Trust communicated stories such as this through the hierarchy of religion and to people practising at a local level. Mark Read responded that while the Trust chaplaincy would not usually be able to share such stories publicly, they worked with local faith leaders and were working on developing stronger links in the community. • Madhu Bhabuta, Non-Executive Director, asked whether the service had needed to call upon a multi-faith team to support the staff in this case. Mark responded that this case had been handled by the Roman Catholic chaplain, but that if the family or staff had required any specific support from any other religions, this would have been facilitated. The Chair thanked Mark Read for attending and he left the meeting. **Members RESOLVED to:** • **Receive** the patient story for information.	
123/07/2018	**4. Minutes of the last meeting**	
	Members reviewed the minutes of the meeting held on 28 June 2018. There were no amendments to the minutes. **Members RESOLVED to:** • **Receive** the minutes of the meeting held on the 28 June 2018 as a true and accurate record.	
124/07/2018	**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: *Chief Nurse Carolyn Mills to provide an update to the Board on Patient Safety Improvement at the end of the programme in September 2018.* **This action would be carried forward to September.** **Min reference** 62/04/18: Quality and Performance Report: *Acting*	

Minute Ref	Item Number	Action
	Medical Director Mark Callaway to update Board on progress with establishing cohorting of the trauma and orthopaedic ward. **Work was in progress and an update would be provided to September Board.** **Min reference** 08/01/18: Quality and Performance Report - *Acting Medical Director to share the annual report on the genomics project with the Board.* **This was an agenda item for today's meeting and the action would be closed on that basis.** **Min reference** 101/06/2018: Patient Story – June 2018**:** *Chief Nurse to liaise with Lucas James to arrange a shadowing session for the Chair with her and her son Kai at an upcoming hospital appointment.* **A session had been organised and the action would be closed.** **Members RESOLVED to:** • **Note** the updates against the action log.	
125/07/2018	**6. Chief Executive's Report**	
	In the absence of the Chief Executive, Mark Smith, Deputy Chief Executive and Chief Operating Officer, presented the report of the Senior Leadership Team to the Board. He provided updates on several further matters including the following: The new Secretary of State for Health, Matt Hancock, had made several announcements in his initial weeks in the role. He had announced a £487m funding package for the NHS predominately for IT modernisation, and an increase in funding over a five year period for the NHS linked to the development of a 10-year strategic plan. He had also announced that he was going to focus on effecting cultural change within the health sector. The NHS Agenda for Change national pay deal had been agreed and would be implemented in August, with significant changes to pay, progression and various allowances backdated to April. Paul Mapson, Director of Finance and Information, added that the pay deal was receiving a mixed reception particularly as it was now emerging that changes to the pension scheme could impact adversely on staff at Band 5 (i.e. the majority of the Trust's nursing staff). Mark Smith referred to UH Bristol's priority for this year on increased productivity and working smarter, and informed the Board that a theatre productivity plan was already bringing dividends and was receiving positive feedback. The Trust's second QI Forum had been held on 10 July 2018. This was a poster-sharing event in which staff members from across the Trust were invited to share the Quality Improvement Projects they had been working on, and this year there had been around 70 entries showcasing	

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	a variety of Quality Improvement work from around the Trust. Among other successes of the month, the Trust had delivered 97% of its CQUIN (Commissioning and Quality Innovation) target, the UH Bristol Library and Knowledge services team had received a Health Education England award for outreach and evidence updates, and the Academic Health Science Network (which included UH Bristol) had received a Health Service Journal patient safety award for its work in embedding early warning scores into clinical practices, which had had a marked impact on mortality. David Armstrong, Non-Executive Director, noted the reference in the Senior Leadership Team report to a 'stakeholder mapping tool' that the Trust intended to use for stakeholder management. He asked that more information about this be provided to Audit Committee. This was agreed. **Action: More information on the stakeholder mapping tool for stakeholder management to be provided to the Audit Committee.** **Members RESOLVED to:** • **Receive** the Chief Executive's Report for assurance.	Director of Strategy and Trans-formation
Care and Quality		
126/07/2018	**7. Board Assurance Framework**	
	The Board received the Board Assurance Framework, the mechanism for reporting risks to the achievement of the Trust's strategic objectives. The Board noted that the format of the Board Assurance Framework was under review, and a new version would be provided to the September Board meeting. David Armstrong, Non-executive Director, welcomed the refresh and called for greater alignment between this document and the Corporate Risk Register and the Trust's strategic plans. **Members RESOLVED to:** • **Receive** the Board Assurance Framework for assurance.	
127/07/2018	**8. Quality and Performance Report**	
	Mark Smith 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. Highlights around Access standards included: • The measure of A&E patients seen in under 4 hours was 92.8% for June. While this did not achieve the 95% national standard, it was above the improvement trajectory target of 90% and the Trust would therefore be eligible for Sustainability and Transformation funding.	

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	• Work was ongoing around increasing capacity and flow modelling and this had been discussed in more detail by the Board at a recent seminar. • The percentage of patients waiting under 18 weeks was 88.6% as at end of June, which did not achieve the national 92% Referral to Treatment (RTT) standard but maintained the improvement trajectory. • The 'on hold' position (patients who had been incorrectly categorised as 'on hold' on the Trust's patient record system) had improved, with numbers being reduced to 1200. New procedures were now in place to stop this issue from reoccurring. • In relation to cancer access targets, performance was recovering following the fire at the Bristol Haematology and Oncology Centre in May, but the Trust was still in discussions with regulators to ensure that focus on this remained. • Through partnership working with Weston Area Health NHS Trust, the Trust was set to gain 50% further capacity for cardiac echo diagnostic tests from next week. Jeff Farrar expressed his gratitude to Mark Smith and his team for their determination and hard work in reducing the number of on-hold patients. Martin Sykes, Non-Executive Director, enquired whether there were any wider lessons to be learnt from this issue, and Mark Smith responded that lessons were already being incorporated into the way in which the Trust recorded patients and dealt with follow-up appointments. In relation to Quality standards, Carolyn Mills, Chief Nurse, informed the Board that the Trust was delivering a sustained performance, though there had been two trust-apportioned MRSA cases in June, which had been examined by the Infection Control committee. Regarding the Workforce metrics in the report, Matt Joint, Director of People, reported that staff sickness rates had been better than expected, agency usage had remained steady, and essential training rates had improved. The e-appraisal system had now been fixed and it was expected that compliance in this area would improve as a result. During the next period, there would be a renewed focus on staff turnover. David Armstrong, Non-Executive Director, sought assurance that the Trust was effectively managing the risks and cultural change agenda presented by new digital systems, such as e-appraisal, electronic prescribing and e-rostering tools. During the following discussion, it was agreed that it would be useful for the Board to be given more information about the oversight and governance of the digital agenda. **Action: The Board to receive an update on the Trust's digital governance arrangements.**	Director of Finance and Informatio

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the Quality and Performance Report for assurance.	n
128/07/2018	**9. Annual Safe Working Hours Guardian Report**	
	Dr Alistair Johnstone, Guardian of Safe Working, introduced the annual mandatory report to the Board on rota gaps (those rotas where there were below optimal numbers of junior medical staff) for junior doctors and dentists across the Trust. Key points to note were: • In common with most NHS Trusts, many of the rotas across the Trust had suffered from intermittent gaps this year due to fluctuations in numbers of deanery trainees, sickness, maternity leave, or failure to attract suitable candidates at interviews. • Rota gaps were a key factor in the morale and wellbeing of junior medical staff as they resulted in the requirement to provide internal cover to ensure the delivery of safe patient care. • Several major projects to address these gaps had been initiated by the Trust in the previous 12 months, particularly the investment of an additional 25 'trust grade' posts from August 2017. The Board was now asked to support a new eRostering system for junior doctors which it was hoped would address some of the issues. Members of the Board thanked Alistair for his well-written report and expressed their appreciation for his pivotal role in the organisation. They discussed the following: • Following an enquiry from Mark Smith, Deputy Chief Executive and Chief Operating Officer, about whether the Trust had an effective strategy in place to attract junior doctors, Mark Callaway, Acting Medical Director, confirmed that the Trust was working on a short, medium and long-term strategy. The Board noted that the shortage of junior doctors was a national problem, but that UH Bristol was well-placed as a teaching hospital, and was also working with its partners in the city on pan-Bristol recruitment. However, they recognised they still needed to do more as a Board to mitigate the recruitment challenges. Madhu Bhabuta, Non-executive Director, suggested that the Trust consider widening its recruitment initiatives beyond Europe to countries such as Kenya or India. • Members of the Board expressed their support for the introduction of the e-rostering system. They also asked Alistair to pass on their appreciation of the efforts being made by junior doctors in the face of the challenges that they faced. It was noted that Jeff Farrar, Trust Chair, was due to attend the Junior Doctors' Forum on 13 September	

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	at which he would emphasise the Board's support. **Members RESOLVED to:** • **Receive** the Annual Safe Working Hours Guardian Report for assurance.	
Organisational and System Strategy and Transformation		
129/07/2018	**10. Mortality and Learning from Deaths Annual Report**	
	Mark Callaway, Acting Medical Director, introduced this item, the purpose of which was to gain Board approval of the annual report into Adult Mortality and Learning from Deaths. Key points to note were: • This was the first annual report of a team that had been set up in April 2017 to review all adult inpatient mortality to enable learning from deaths. The report set out the process by which all deaths were reviewed in UH Bristol, the process of monitoring the outcome and learning from death, and documented the results. • The review had found that the majority of care provided had been good or very good and the proportion of avoidable deaths were lower than expected. • Several themes had been identified from the process. In particular, where there had been care at a lower level than expected, there had often been a slow introduction of the patient onto an end of life pathway. This information had been fed back to the Divisions and would form the basis of a Quality Improvement project. **Members RESOLVED to:** • **Approve** the annual report into Adult Mortality and Learning from Deaths.	
130/07/2018	**11. Clinical Negligence Scheme for Trusts (CNST) Compliance Report**	
	Carolyn Mills, Chief Nurse, introduced this report, which sought the approval of the Board for the Trust's self-assessment of its maternity service against the ten criteria set out by the Clinical Negligence Scheme for Trusts (CNST). Key points highlighted were: • The CNST maternity incentive scheme was part of the Department of Health and Social Care's Maternity Safety Strategy and its aim was to reward Trusts who had taken action to improve maternity safety. • The Trust's self-assessment had concluded that its maternity service was compliant with all ten criteria and that it had robust evidence to demonstrate this. • The Board was asked to note the review of evidence in the report	

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	and approve the self-certification. It was noted that Carolyn Mills as Chief Nurse had already signed off the self-certification on behalf of the Board, and she was therefore seeking retrospective approval. The evidence was now being reviewed by NHS Resolution who would confirm incentives for successful trusts. **Members RESOLVED to:** • **Approve** the Trust's self-assessment of compliance against the criteria for the Clinical Negligence Scheme for Trusts incentive scheme.	
131/07/2018	**12. Quality and Outcomes Committee - Chair's Report**	
	Julian Dennis, Chair of the Quality and Outcomes Committee, introduced the report of the Committee from its meeting on 25 July 2018: Key points to note were: • The Committee had discussed the Quality and Performance Report and were monitoring the Trust's Emergency Department performance and Referral to Treatment times. • The Committee had been pleased to note that last minute cancellations in June had reduced to below 1%, the lowest for some time, as theatre initiatives had been implemented. They had also been very pleased with the decrease in numbers of on-hold patients, particularly as processes were now in place to prevent numbers from increasing again. • The Committee had however expressed concern about high numbers of vacancies among ancillary staff, and were keen to learn how the Trust planned to increase support to this key group of people. • The Committee had also received and discussed the Annual Safe Working Hours Guardian report, the Education Performance report, the Mortality and Learning from Deaths Annual Report, an analysis report on the 2017 national inpatient survey results, and a presentation on staff turnover. **Members RESOLVED** to: • **Receive** the Quality and Outcomes Committee Chair's report for Assurance.	
132/07/2018	**13. Transforming Care Programme Board Report – Q1**	
	Paula Clarke, Director of Strategy and Transformation introduced the quarterly report to update the Board on progress with Trust-wide programmes of work under the Transforming Care programme. Key points to note were:	

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	• The report focussed on the three current priority areas for the programme: Digital Transformation, Working Smarter/Productivity Improvement and the Quality Improvement programme. • Board members' feedback on the new report format was welcomed. Members of the Board discussed the following: • There was positive feedback for the format of the report and the way in which it emphasised the key points. • Jill Youds, Non-Executive Director, questioned how the Trust measured the impact on patients of changes to services, before during and after implementation. Paula Clarke acknowledged that engagement with patients was variable from project to project and the rigour with which it was done could be monitored more closely. Garry Williams, Patient/Carer Governor, asked that any changes to services also take into account the needs of carers. This was noted. • Madhu Bhabuta, Non-Executive Director, noted that during the last quarter the roll out of the eObservations system across adult wards had been completed but she expressed concern about an apparent lack of basic infrastructure, for example Wi-Fi, multiple logins. Paula explained that the work was taking place within existing constraints but improvements to infrastructure were taking place alongside it. **Members RESOLVED to:** • **Receive** the Transforming Care Programme Board Report for assurance.	
Financial Performance		
133/07/2018	**14. Genomics Annual Report**	
	Mark Callaway, Acting Medical Director introduced this report, the purpose of which was to update the Board on the progress of the 100,000 Genomes Project and the achievements of the West of England Genomic Medicine Centre (WE GMC). He highlighted that the project's strategic approach as a multi-provider organisation had been held out as national exemplar. However, with uncertainty about continuing funding, the Board was also being asked to note a potential project closure approach that would facilitate completion of the 100,000 Genomes Project across the WE GMC, and an outline proposal for short term and longer term delivery of legacy work associated with the project. Members of the Board expressed great concern about the lack of assurance that programme funding would continue until there was a clearer national plan for future provision. While uncertainty remained, Executive Directors confirmed that the Trust was making representations and was expecting clarification within the next two	

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	weeks. **Members RESOLVED to:** • **Receive** the Genomics Annual Report for assurance.	
134/07/2018	**15. Q1 Corporate Objectives Update**	
	Paula Clarke, Director of Strategy and Transformation, introduced this report, the purpose of which was to provide an update to the Board on the delivery of the Trust's Corporate Objectives for Quarter 1 as approved in the 2018/19 Operating Plan. The report adopted a new approach which included an overview of all actions completed against the Trust's objectives in Quarter 1 and identification of key milestones for delivery in Quarter 2. The Trust's divisions would be asked to provide assurance on the delivery of their annual objectives in the same format to ensure assurance at all levels in the organisation. Non-Executive Directors welcomed the new approach but asked that consideration be given as to whether the report could also be received at Board Committee level to ensure greater non-executive oversight. It was noted that it was a key Board responsibility to ensure delivery of the business plan, and therefore adequate time would be allocated at Board meetings for the quarterly review of objectives. In addition, the cycles of business for the Committees would be aligned with milestones in the plans to deliver the corporate objectives, so that Committees would receive updates on progress against key action areas throughout the year. **Action: Consideration to be given to whether the quarterly Corporate Objectives updates should be given greater Non-Executive oversight at Board Committee level.** **Members RESOLVED to:** • **Receive** the Q1 Corporate Objectives Update for assurance	Director of Strategy and Trans-formation
135/07/2018	**16. Equality and Diversity Annual Report**	
	Matt Joint, Director of People, introduced this report, the purpose of which was to provide assurance to the Board that the Trust was compliant with the Public Sector Equality Duty. The report provided an update on progress against the Trust's Strategic Equality and Diversity Objectives for 2016-2019 and included information about the range of different initiatives that the Trust had put into place to achieve these. He asked the Board to note that this was the	

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	end of a strategy and that a new one would be more strategically focussed with greater emphasis on outputs rather than initiatives. Members of the Board discussed the following: • Non-Executive Directors noted that the report contained a lot of information but concluded that, while it provided some assurance that the Trust was compliant with its duties, the assurance was not at the level that the Board would expect. • The Chair, Jeff Farrar, noted some key omissions in the report, and particularly highlighted the lack of Board committee oversight. He enquired about the contribution of Divisional Boards to the strategy. Matt Joint explained that the strategy was discussed by an Organisational Development group which included representatives of the divisions, but acknowledged that there was little input from the divisions in objective-setting. • It was agreed that this area required greater scrutiny by the Board and that Equality and Diversity should therefore become a regular item for discussion by the new People Committee. • The Board asked for a change in approach going forward in order to ensure that the Trust's Equality and Diversity strategy was coherent and linked in with divisional objectives. **Members RESOLVED to:** • **Receive** the Equality and Diversity Report for assurance and **note** that the Trust's Equality and Diversity Strategy required significant revision.	
136/07/2018	**17. Research and Innovation Report**	
	Mark Callaway, Acting Medical Director, introduced the quarterly report to the Board on the performance, funding and governance of the Trust's Research and Innovation department. Key issues to note: • The Trust continued to demonstrate good performance in delivering commercial trials to time and target at 67%. • Changes to the reporting requirements from the Department of Health meant that poor performance against the benchmark would no longer incur penalties, but transparency expectations required the Trust to continue to publish the performance data. • A reduction of 10% in the available national Research Capability Funding budget had been reflected in the Trust's allocation • An application had been submitted for Applied Research Collaborations. **Members RESOLVED to:** • **Receive** the Research and Innovation report for assurance.	

Minute Ref	Item Number	Action
137/07/2018	**18. Finance Report**	
	Paul Mapson, Director of Finance and Information, introduced the Finance Report for the first quarter of the financial year. Key issues included the following: • The Board were informed that the Trust's financial position was broadly satisfactory, reporting a surplus of £2.181m, £0.010m favourable to plan. • Financial projection assumed the Trust would lose one quarter's A&E Sustainability and Transformation Funding, but would otherwise achieve forecasts. • Divisional and corporate overspends had been offset by over-performance on income due to additional activity, particularly in the Emergency Department, but not necessarily in the areas that had been expected. This was enabling cost pressures to be accommodated but only for the time being. Focus was therefore on cost pressures particularly in the Divisions of Medicine and Surgery. • It was noted that the HRG4+ funding issue (which related to reimbursements for activity funded by NHS Wales) was still unresolved. This had been reflected in planning for this year. • The Board were asked to note significant slippage on capital. • In relation to the Agenda for Change NHS pay award and the Medical Pay Awards, the funding appeared affordable but that it was difficult to be certain at this stage. Members of the Board discussed the following: • Julian Dennis, Non-Executive Director, expressed concern about the overspend in non-pay in the Surgery and Medicine Division and enquired as to the drivers. Paul Mapson responded that this matter would be explored and a detailed report would be received by the Finance Committee as previously agreed. Non-Executive Directors asked that this report identify gaps in behaviours and systems and an investigation into non-pay controls. Paul added that he was testing performance management in this regard in different areas and it was suggested that perhaps there could be non-executive involvement in this. **Members RESOLVED to:** • **Receive** the Finance Report for information.	
138/07/2018	**19. Capital Investment Policy**	
	Paula Clarke, Director of Strategy and Transformation, asked the Board to approve minor amendments to the Capital Investment Policy. **Members RESOLVED to:** • **Receive** the Capital Investment Policy for approval.	

Minute Ref	Item Number	Action
139/07/2018	**20. Finance Committee Chair's Report**	
	Non-Executive Director and Chair of the Finance Committee Martin Sykes introduced the report which provided a summary of the key issues considered at the Finance Committee meeting of 25 July 2018. He highlighted that the committee had been assured that the Trust was on target for its financial position. They had discussed the Trust overspend in non-pay and in nursing and medical pay at length, and had received information about the priorities and actions of the divisions to improve their financial position on a month-by-month basis. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's Report for assurance.	
Governance		
140/07/2018	**21. Constitution of a People Committee**	
	Sophie Melton Bradley, Deputy Trust Secretary, introduced this item, the purpose of which was to seek Board approval for the Terms of Reference for a new People Committee. Key issues included the following: • The Board had asked that a new committee be constituted as it was felt that none of their existing committees included within their remit sufficient room for scrutiny on workforce issues. • The draft Terms of Reference had previously been circulated to the Board and changes from Executive Directors had been incorporated. • It was intended that the People Committee would hold its first meeting in September 2018. Members of the Board discussed the following: • Jeff Farrar, Trust Chair, endorsed the constitution of the committee and asked the Board to give thought to the business that needed to be on the agenda. The Committee would look at both strategic and operational issues, and would examine in more details items relating to workforce that were currently considered in the Quality and Outcomes Committee and the Finance Committee. • David Armstrong, Non-executive Director noted that he had suggestions for minor amendments to the terms of reference, and it was agreed that these would be considered by the Deputy Trust Secretary. • Malcolm Watson, Public Governor, asked whether staff governor or union representation on the new committee would be useful. Jeff Farrar explained that representation would be invited from staff representatives, but that governor involvement might give rise to	

Minute Ref	Item Number	Action
	governance implications. It was agreed to discuss the matter further at the Council of Governors meeting that afternoon. • In response to a question from Garry Williams, Patient/Carer Governor, about whether the Committee's remit would include volunteer staff, it was clarified that matters relating to volunteers would be included but that governance for the Trust's voluntary services team would still be directed through the Patient Experience Group to the Quality and Outcomes Committee. **Members RESOLVED to:** • **Approve** the constitution of a People Committee and **approve** its terms of reference, subject to minor amendments by the Trust Secretariat.	
141/07/2018	**22. Register of Seals**	
	Sophie Melton Bradley, Deputy Trust Secretary, asked the Board to note a report of all new applications of the Trust Seal since January 2018, reported to Board as required by the Trust's Constitution. **Members RESOLVED to:** **Receive** the Register of Seals for information.	
142/07/2018	**23. Audit Committee Chair's Report**	
	David Armstrong, Chair of the Audit Committee, introduced his committee's report of their meeting of 16 July 2018. He brought the Board's attention to the following key issues: • The committee was supportive of the Trust's work to develop its management of strategic risk in relation to the operational plan and operational risk • One of the committee's priorities in the coming year was to ensure that the Trust was maximising value from internal and external audit activity • As Committee Chair, he was undertaking a stakeholder analysis for the committee to inform its annual business cycle. • The Committee had received a further report to inform them of the investigations that were now underway following the fire in the Bristol Haematology and Oncology Centre. • The Committee had received a hosted activity report on the services hosted by the Trust and how they were managed. More work needed to be done to establish the duration of hosting arrangements and the risks around them, but the committee were assured that the Trust now had a good system of governance in place. **There were no questions. Members RESOLVED to:** • **Receive** the Audit Committee Chair's report for assurance.	

Minute Ref	Item Number	Action
Items for Information		
143/07/2018	**24. Governors' Log of Communications**	
	The purpose of this report was to provide the Board with an update on all questions asked by governors to officers of the Trust through the Governors' Log of Communications. This item was received for **information**.	
Concluding Business		
144/07/2018	**25. Any Other Urgent Business**	
	The Chair, Jeff Farrar, announced the Board's intention to reduce the number of Public Board meetings from ten per year to six on a bi-monthly basis, effective immediately. The reason for this was to give Board members more time for training and development, visits to hospital areas, and Board committees. He emphasised that this was not an attempt to dilute governance and that he would keep its impact under review. There was no further business.	
145/07/2018	**26. Date and time of Next Meeting**	
	The date of the next meeting was confirmed as **11.00 – 13.00, 27 September 2018, Conference Room, Trust HQ, Marlborough Street, Bristol, BS1 3NU.**	

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

University Hospitals Bristol
NHS Foundation Trust

Public Trust Board of Directors meeting
27 September 2018
Action Tracker

Outstanding actions from the meeting held on 27 July 2018					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	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 September 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. - **Update June 2018:** a task and finish plan had been set up across the Medicine, Diagnostics & Therapies and Surgery Divisions. A business plan had been developed and would be reviewed shortly.
2.	127/07/2018	**Quality and Performance Report** The Board to receive an update on the Trust's digital governance arrangements.	Director of Finance and Information	December 2018	**Complete**: It has been agreed with the Chair that an update will be brought to a Board Seminar later this year.

3.	134/07/2018	**Q1 Corporate Objectives Update** Consideration to be given to whether the quarterly Corporate Objectives updates should be given greater Non-Executive oversight at Board Committee level.	Director of Strategy and Transformation		**Update Sept 2018:** Adequate time to be allocated at Board meetings for the quarterly review of the Corporate Objectives. Board Committee Annual Business Cycles to be aligned with milestones in the plans to deliver corporate objective, to ensure Board Committees are receiving updates on progress against key action areas**.**
Closed actions from the meeting held on 27 July 2018					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
	125/07/2018	**Chief Executive's Report** More information on the stakeholder mapping tool for stakeholder management to be provided to the Audit Committee.	Director of Strategy and Transformation	September 2018	**Complete**: Information provided to Audit Committee Chair – action confirmed closed by David Armstrong 6/9/18.

Cover report to the PublicTrust Board Meeting to be held on 27 September 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, 27 September 2018
Report Title	**Chief Executive's 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 of 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 August and September 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)**

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – SEPTEMBER 2018

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in August and September 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.

The group **received** assurances that the on-hold waiting list position had been recovered.

3. STRATEGY AND BUSINESS PLANNING

The group **approved** the business case for the refurbishment of Ward D603 in the Bristol Haematology and Oncology Centre.

The group **approved** the Strategic Outline Case for the Cardiac Services Expansion, and **approved** the supplementary business case to accelerate additional catheter laboratory capacity.

The group **approved** the Divisional Operating Plan for Medicine, acknowledging that this would move into a phase of performance management to recover the financial position.

The group **approved** the major medical programme for 2019-21.

The group **approved** the launch of the 2019/2020 Operating Planning process.

The group **supported** the proposal for the PC and Laptop device replacement programme to start in 2019.

The group **received** an update on the outcome of discussions on the design works to finalise the exact bed base numbers to create additional bed capacity in Medicine and Surgery and to ensure a robust winter plan for 2018/2019.

The group **noted** the Bristol North Somerset and South Gloucestershire Clinical Commissioning Group's decision to move access to NHS funding for Homeopathy Services from 'prior approval' to 'individual funding request' following consultation.

4. RISK, FINANCE AND GOVERNANCE

The group **approved** the Mass Countermeasures Distribution Centre Plan, noting that this plan would be enacted alongside a wider system plan and was supported by local partners such as Avon and Somerset Police, and South West Ambulance Service.

The group **supported** a proposal for establishing a system to monitor and review compliance within the organisation for the management of Non-NICE guidelines.

The group **supported** a proposal for training all consultants involved in the care of adult patients in structured case note mortality review.

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

The group **supported** the Trust's assessment of the NHS England Evidence Based Consultations and the recommendation that no formal response was required due to the low level of inherent risk to the Trust.

The group **received** an update on the Fractured Neck of Femur best practice position and confirmed its support to the Division to take forward next steps.

The group **received** the quarterly update of the Congenital Heart Disease network and **received** their annual plan for 2017/18.

The group **approved** the Corporate Records Retention Policy.

The group **received** an update on the timetable of the implementation of the performance and talent management module of the People Strategy, noting the first key phase will begin in April 2019.

The group **received** an update on work being undertaken around the honorary contract process and sought assurance on the timeline for compliance.

The group **received** an update on the Uninterrupted Power Supply and Theatre review and agreed further work to ensure business continuity plans were in place in clinical areas and next steps to develop the scope of work to create an investment plan.

The group **received** the post project evaluation of the Patient Catering Service Project 2017/2018.

The group **received** five Internal Audit Reports with satisfactory assurance in relation to Well Led Review, Private Patients, Teaching and Learning Strategy – the Quality Assurances of Essential Learning, Delayed Transfers of Care, Carbon Footprint and Clinical Waste Management.

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

The group **received** an update on plans being taken forward in respect of drainage issues in the Bristol Haematology and Oncology Centre.

Reports from subsidiary management groups were **noted,** including an update on the current position following the transfer of Cellular Pathology to North Bristol NHS Trust 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
September 2018

Cover report to the Public Trust Board. Meeting to be held on 27 September 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, 27 September 2018
Report Title	**Review of Major Incident in the Bristol Haematology And Oncology Centre in May 2018**		
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

The attached report describes the findings of investigations into the causes of a fire in the Bristol Haematology and Oncology Centre (BHOC) on 10 May 2018 and into the Trust's emergency response, the action required by the Trust to mitigate the risk of fire in the BHOC and other premises, and the need for any improvements in the governance of fire safety arrangements in the Trust.

Key issues to note

The Trust has fully co-operated with the Avon Fire and Rescue Service (AFRS) which has requested information in line with its statutory responsibility to enforce the Regulatory Reform (Fire Safety) Order 2005 on Trust premises. At the time of writing, no information about the status of the AFRS investigation into the BHOC incident was available.

The Trust itself has undertaken or commissioned a comprehensive set of investigations and reviews into the causes of and response to the incident:

- serious incident investigation undertaken by the Director of Facilities and Estates
- external review of emergency preparedness and response by NHS England
- review of patient harm organised by the Acting Medical Director
- governance review, undertaken by Executive Directors, assisted by the Trust Secretariat and the Director of Estates and Facilities.

The serious incident investigation has shown that:

- The fire was caused by the catastrophic failure of the Power Factor Correction unit in the plant room of the BHOC. This failure could not have been predicted and there is no evidence that a lack of maintenance contributed to the failure.
- The fire detection system worked as expected and there were no major issues regarding access to the plant area concerned.
- The fire compartmentation in the switch room immediately above was compromised due to removal of fire barrier material leading to smoke penetration into the building. It has not been possible to identify who was responsible for this action.
- The lack of power to the building and the spread of smoke lead to a full evacuation of the building.
- Emergency lighting was working but was ineffective due to low levels of illumination and some lamps inoperable which did not support the evacuation process.
- The lack of evacuation chairs severely hindered the evacuation process.
- There was a reported lack of communication between the Trust and AFRS and between Trust staff groups throughout the incident, in particular the issue that AFRS were not aware of the conditions internal to the building affecting the site management team's decision on whether to evacuate the building.
- The access control system did not release doors as expected throughout the building.
- The support from HART [the Hazardous Area Response Team of the Ambulance Service] during the evacuation was commended.
- There is a current fire risk assessment for the building.

The draft findings of the external review of emergency preparedness and response are that:

- The Trust was excellent at mitigating the impacts on patient and their ongoing care.
- All the staff engaged in the response had a single primary focus which was to safeguard patients and ensure their continuity of care. This was borne out by the safe evacuation and transfers of 56 patients to alternative locations within the Trust, with no reports of patient harm.
- Robust plans with regard to psychosocial [sic] support for both patients and staff were put in place and the Trust was able through a complex recovery strategy to have the BHOC and technical equipment contained within it operational in a very short period of time.
- A number of weaknesses in the Trust's systems need addressing, particularly around on-call communications arrangements, clarity and availability of the major incident policy and action cards, adherence to policy and procedures by staff, record-keeping, up-to-date training and professional development and consistency of application of staff welfare plans.

Preliminary findings from the review of patient harm are that:

- There were no significant delays in radiotherapy treatment and no patient harm has been identified as a result of the minor delays that were incurred
- 31% of chemotherapy patients suffered no delay, 32% were treated within 7 days of the planned treatment date, 13% had a maximum of one treatment omitted and the remainder were deferred for clinical reasons, were treated elsewhere or received in-patient treatment.

The review of governance has found that:

- Between 2010 and 2015 a number of important fire improvement schemes were completed by the Trust, which succeeded in delivering full compliance for fire detection and warning systems across the whole of the main precinct.
- Further work was planned but not universally implemented, mainly around compartmentation, fire doors and fire dampers. In particular, the known compartmentation risks in the BHOC were formally deemed a lower priority for remedial work than those in the BRI.
- There were delays in delivering the planned fire improvement works in the BRI.
- The most recent, risk-based assessment of Trust-wide compliance with all aspects of fire safety requirements (undertaken in 2017) puts the Trust at 79% compliance for primary means of escape in clinical buildings, although compartmentation, corridor breaks and fire dampers are identified as priority areas for further work.
- An audit by the Authorising Engineer (Fire), reported in August 2018, notes the absence of ductwork fire dampers in the BHOC.
- The present governance arrangements do not necessarily facilitate comprehensive monitoring of all fire safety requirements and proactive escalation of risks and issues.
- A £4.5 million programme of further improvement works is planned over the next 3 to 5 years, with the detail, scheduling and overall timescale for those works still to be established.

The attached report sets out the findings from the above investigations and reviews in more detail and describes how each will be taken forward. Specific recommendations are made about changes to the governance arrangements relating to fire safety.

The BHOC was appropriately recommissioned prior to re-occupation and necessary maintenance works completed. A programme of remedial works to return the BHOC to its condition before the incident has been approved and will start on 24 September.

Action has been taken across main campus to remove the risk of any further malfunction of PFC units and a range of specific improvement works have been completed, including a number of those recommended in the commissioned reports.

Recommendations

Members are asked to:

- Note the findings of the investigations and reviews conducted to date into the causes of and responses to the incident at the BHOC in May 2018

- Agree that progress against the action plan responding to the recommendations from the **serious incident investigation** should be reported to the Audit Committee.

- Agree that the report and recommendations from the review of **emergency preparedness and response** and resulting action plan should be reported to the Quality and Outcomes Committee.

- Agree that further actions to review **potential patient harm** caused by interruption or delay in treatment should be reported to the Quality and Outcomes Committee.

- Agree the recommendations arising from the **governance review**, including that the Audit Committee receive a six-monthly update on fire compliance and review an Annual Fire Safety Report, prior to consideration by the Board.

- Agree that the delivery of the planned **fire safety improvements programme** be reported to the Finance Committee.

- Agree any further assurance mechanisms required.

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
Risks to the safety of patients, staff and visitors and to compliance with fire safety regulations

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)**
Insert Date	**Insert Date**	**Insert Date**	**Insert Date**	**[Insert committee name and date]**

REVIEW OF MAJOR INCIDENT IN THE BRISTOL HAEMATOLOGY AND ONCOLOGY CENTRE IN MAY 2018

1. INTRODUCTION

The purpose of this report is:

- To describe the findings of investigations into the causes of a fire in the Bristol Haematology and Oncology Centre on 10 May 2018 and into the Trust's emergency response, and the recommendations from those investigations.
- To describe the action already taken by the Trust to mitigate the risk of fire in the Bristol Haematology and Oncology Centre and in the Trust's other premises and to set out the plan for further action.
- To review the governance of fire safety arrangements in the Trust and identify any improvements required.
- To seek the Board's approval for the further recommendations set out in this report.

2. INCIDENT OVERVIEW

This section sets out the Trust's understanding of the incident, at the time of writing.

At approximately 12.50am on Thursday 10 May 2018, a fire was reported in the switch room on level 1 of the Bristol Haematology and Oncology Centre (BHOC).

The fire was contained within the switch room but all electrical power to the building was lost and there was extensive smoke penetration, which led to the evacuation of all staff and 56 patients from inpatient wards on the 6th and 7th floor and temporary closure of the building.

Avon Fire and Rescue Service (AFRS) attended the incident, dealt with the fire and oversaw the evacuation. The AFRS handed the building back to the Trust later the same day.

At approximately 5.00am, the Trust had declared a major incident, which remained in place until 9.00 am on Monday 15 May.

BHOC inpatients were taken to other areas of the Trust as part of the immediate response. Within 24 hours, all were accommodated in other Trust inpatient wards. All affected inpatients were visited by the Head of Nursing in Specialised Services and the Chief Nurse the morning after the incident and offered support through Clinical Psychology services. Booked outpatients were contacted by administrative staff and offered urgent appointments in alternative clinic locations in the Trust.
Temporary power was established to 80% of the building via emergency generators, allowing a clean-up operation to commence through a combination of internal staff and external contractors on 11 May.

A BHOC Recovery Board was established to oversee the recovery of the physical estate and restoration of clinical services. Radiotherapy services resumed on the Linear Accelerators on Level 2 on Saturday 13 May and outpatient services resumed on Level 5 the following Wednesday 17 May, with inpatients reoccupying wards on 21 May.

In support of staff involved in the evacuation, two debriefs were held, led by Clinical Psychologists in the Trust, with an open invitation to affected BHOC staff and others across the Trust. The debriefs allowed staff to review the events through facilitated discussion and share their personal reactions at the time and subsequently. Further staff support has been made available on request.

3. APPROACH TO INVESTIGATION

The Trust has undertaken or commissioned a comprehensive set of investigations and reviews into the causes of and response to the incident. In addition, the Fire Service has requested information in line with its statutory responsibility to enforce the Regulatory Reform (Fire Safety) Order 2005 on Trust premises.

This section describes the various investigations and reviews and their current status. The findings and recommendations are summarised in Section 4.

3.1 External Investigation by Avon Fire and Rescue Service

The Fire Service has powers to ascertain whether the Trust has complied with the provisions of the Regulatory Reform (Fire Safety) Order 2005 and may issue notices of alteration, enforcement or prohibition as a result. The Trust has fully co-operated with the AFRS to support their investigation, including providing documentation and facilitating interviews with staff, where requested.

At the time of writing, no information about the status of the AFRS investigation into the incident on 10 May was available. While it is not anticipated that their factual findings in respect of the cause of the fire and subsequent smoke penetration will differ significantly from those of the Trust's internal investigation, the Board should be aware that the independent investigation by the AFRS may identify additional information and may make recommendations, to which the Trust will need to give full consideration.

The Avon Fire Authority were notified of the incident through routine performance reporting at their meeting on 31 May 2018, where it was written that, "The cause of the fire is thought to be accidental."

3.2 Serious Incident Investigation

A root cause analysis investigation has been undertaken by the Director of Estates and Facilities.

The purpose of the investigation was to establish the facts, both about what happened when the fire started and what happened to the staff and patients in the BHOC in the immediate period thereafter, to identify whether relevant standards, policies, procedures or guidelines were followed and whether gaps occurred in care

or treatment, to establish contributory factors and root causes and to make recommendations for improvement and learning.

The serious incident investigation report was submitted to Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group (CCG) on 31 July 2018. The CCG notified the Trust on 21 August that they had closed the incident following a formal panel review.

The final findings, recommendations and associated action plan from the serious incident investigation are summarised in Section 4.1

3.3 External Review of Emergency Preparedness and Response

The Trust has commissioned an independent review from Sharon Wilson, Head of Emergency Preparedness, Resilience and Response at NHS England (South), in order to maximise learning about the handling of the major incident response.

The objectives of the independent review were:

- To assess the preparedness of the Trust to respond to a major incident.
- To examine the effectiveness of the Trust's major incident and business continuity plans, including the associated standing operating procedures and action cards.
- To explore the effectiveness of the Trust's command, control and communications process during the major incident response phase.
- To examine working relationships, cooperation and interoperability between staff / departments involved in the major incident response phase.
- To identify and share good practice to enhance future preparedness and response.
- To identify any gaps or other opportunities to increase preparedness and strengthen any future response to a major incident.

It is expected that this review will be finalised shortly. The draft findings are summarised in Section 4.2.

3.4 Review of patient harm

The fire and subsequent evacuation caused an interruption to the delivery of both chemotherapy and radiotherapy for patients undergoing oncological treatment. As a result of this interruption and consequent delay in a patient's treatment pathway, potential harm may have been caused.

To assess any potential harm, a Review Panel was convened by the Acting Medical Director, firstly, to determine the best way of assessing potential harm and, secondly, to assess any potential harm that did occur. This panel comprised the Trust Cancer Lead and the Clinical Lead for Oncology.

This review, which reported initially to the BHOC Recovery Board and subsequently to the Clinical Quality Group and Quality and Outcomes Committee, remains active. The interim findings are set in Section 4.3.

3.5 GOVERNANCE REVIEW

Executive Directors, assisted by the Trust Secretariat and the Director of Estates and Facilities, have undertaken a review of fire safety governance in the Trust, to establish whether there were omissions in risk assessment or mitigation which might have been contributory factors in the outbreak of fire or the smoke penetration into the building.

An extensive range of records have been examined as part of the review:

- Annual Fire Safety Reports 2010 – 2015
- Minutes of Trust Health, Safety and Fire Committee meetings 2009 – 2018
- Notes of Estates and Facilities Directorate performance reviews 2009 – 2015
- Minutes of the Capital Programme Steering Group/Capital Prioritisation Group/Trust Capital Group 2010 – 2018
- Risk registers 2010 – 2018
- Minutes of Risk Management Group 2012 -2018
- Minutes of Audit Committee meetings 2010 – 2018
- Minutes of Trust Board meetings 2010 - 2018

Draft findings from this review were considered at the Risk Management Group earlier this month.

By way of context, the fire safety compliance framework and the Trust's internal governance arrangements are summarised below.

The Trust has a legal obligation to achieve compliance with The Regulatory Reform (Fire Safety) Order 2005 and related Firecode. While in practice full compliance can only be achieved over time, the enforcement authority (in this case, Avon Fire and Rescue Service) needs to be satisfied that the Trust has a plan in place to achieve compliance and, in particular, a programme of works that will deliver:

- a functional detection and warning system
- at least 60-minute compartmentation protection for designated fire escape routes.

The Trust's internal governance arrangements relating to fire compliance are as follows:

The Estates and Facilities Directorate, which holds the corporate responsibility for fire safety, reports to the Chief Operating Officer, and is subject to quarterly performance reviews with the Chief Executive and Executive Directors.

A full time fire compliance officer reports directly to the Director of Estates and Facilities and is responsible for applying the NHS Improvement Premises Assurance Model to assess fire safety compliance against the full range of regulatory standards. (This is currently a self-assessment model, but may be made mandatory in future.)

The applied Premises Assurance Model is presented and reviewed monthly at the Estates and Facilities Risk Management meeting with an action plan to improve compliance.

The status of fire safety and related statutory compliance in the Trust is reported to the quarterly Health, Safety and Fire Committee which in turn reports to the Risk Management Group, which is a sub-group of the Senior Leadership Team (the top-level executive management committee in the Trust). The Risk Management Group counts all the Executive Directors as members and is chaired by the Chief Executive.

Until 2011/12, the Department of Health required submission of an Annual Statement of Fire Safety, signed by the Chief Executive.

An internal annual fire safety report was reported to the Trust Board and Senior Leadership Team until 2015.

The route for Trust Board assurance about fire safety risk has been via the Audit Committee, which has considered a number of reports relating to fire safety over the period.

Findings and recommendations from the review of fire safety governance are set out in Section 4.4.

4. FINDINGS AND RECOMMENDATIONS

This section summarises the findings and recommendations (final or draft) from the reviews conducted to date.

4.1 SERIOUS INCIDENT INVESTIGATION

The evidence available to the Trust indicates that the root cause of the fire was a catastrophic failure of the Power Factor Correction (PFC) capacitors within the Low Voltage electrical panel on level 1 of the BHOC building, leading to a localised fire.

In addition, compromised fire compartmentation failed to contain smoke in the switch room area.

The following are the key findings from the investigation:

- The catastrophic failure of the PFC unit could not have been predicted and there is no evidence that a lack of maintenance contributed to the failure.
- The fire detection system worked as expected and there were no major issues regarding access to the plant area concerned.
- AFRS adopted their standard protocol, which was to contain the fire until electrical supplies were made safe.
- AFRS assumed the building compartmentation was not compromised.
- The fire compartmentation in the switch room immediately above was compromised due to removal of fire barrier material leading to smoke penetration into the building. [It has not been possible to identify who was responsible for this action.]

- The lack of power to the building and the spread of smoke lead to a full evacuation of the building.
- Emergency lighting was working but was ineffective due to low levels of illumination and some lamps inoperable which did not support the evacuation process.
- The lack of evacuation chairs severely hindered the evacuation process.
- There was a reported lack of communication between the Trust and AFRS and between Trust staff groups throughout the incident in particular the issue that AFRS were not aware of the conditions internal to the building affecting the site management team's decision on whether to evacuate the building.
- The access control system did not release doors as expected throughout the building.
- The support from HART [the Hazardous Area Response Team of the Ambulance Service] during the evacuation was commended.
- There is a current fire risk assessment for the building.

The key recommendations from the investigation are:

- A full review of the requirement for PFC given the changing nature of the site electrical load.
- A process be developed to ensure that any works undertaken by any persons has not left a breach in fire compartmentation.
- A full review is undertaken across the Trust estate to assess the operational status of emergency lighting.
- A review of the fire strategy across the Trust in particular where buildings have limited in patient accommodation, to ensure that appropriate notification is provided of any fire incident within the building out of normal hours.
- A full review of the Trust estate to assess the need for evacuation equipment and [action to] put such equipment in place, and provide the required training.
- A review of training needs for site management personnel for serious incidents should be considered.

The action plan in response to these recommendations will be presented to the Quality and Outcomes Committee, which will oversee progress. The following actions or improvements have already been implemented in the BHOC or are in the process of being implemented:

- A full building recommissioning exercise was undertaken prior to reoccupation of the building, which included a full fire cause and effect test to ensure that the alarm and alert status is in line with the fire strategy for the building. This test also confirmed that all fire doors released and all dampers closed in line with the strategy.
- Maintenance works have been undertaken on fire doors and emergency lighting.
- All fire doors within the building were checked prior to reoccupation to ensure that any damaged seals were replaced and the doors closed properly. This is part of the routine fire door maintenance schedule carried throughout the rest of the estate.
- Where emergency lights were identified as either not working or giving a low level of illumination these have been replaced.

In addition, all PFC units located in other plant rooms have been de-activated.

A range of further fire compliance works has been undertaken across the Trust as well as the completion of some of the actions arising from the commissioned reports. These include:

- Review of evacuation chair requirements across the campus complete and procurement in hand.
- Strobe and beacon lighting installation has been commissioned for priority areas in the BHOC, Children's Hospital, Eye Hospital, Heart Institute, King Edward Building, Dolphin House and St Michael's Hospital .
- Fire door surveys have been completed in the Heart Institute, Eye Hospital, Dental Hospital, Terrell Street Building and King David offices.
- Regular, periodic inspections of plant rooms have started.
- Compartmentation and sub-compartmentation works have been undertaken in specific areas in St Michael's Hospital, the King Edward Building, the Queen's Building and Trust Headquarters.

A programme of remedial works to return the BHOC to its condition before the incident has been approved. Works will start on 24 September and should be completed by the end of January 2019. Each floor of the building has been split into zones and the works package designed to cause as little clinical disruption as possible

In addition, Estates-controlled areas such as plant rooms and ductwork affected by the fire are scheduled to go through similar reinstatement in the coming months. The scope of these works is being finalised.

4.2 Review of Emergency Preparedness and Response

The findings of this review remain in draft form but are not expected to change materially. The review found that:

- The Trust was excellent at mitigating the impacts on patients and their ongoing care.
- All the staff engaged in the response had a single primary focus which was to safeguard patients and ensure their continuity of care. This was borne out by the safe evacuation and transfers of 56 patients to alternative locations within the trust, with no reports of patient harm.
- Robust plans with regard to psychosocial [sic] support for both patients and staff were put in place and the Trust was able through a complex recovery strategy to have the BHOC and technical equipment contained within it operational in a very short period of time.

In addition to a number of examples of best practice, areas of important learning for the Trust are identified, including on-call communications arrangements, clarity and availability of the major incident policy and action cards, adherence to policy and procedures by staff, record-keeping and up-to-date training and professional development.

While the staff welfare plan was mobilised to good effect, the review also identified variability in the arrangements across different areas.

In order to strengthen the Trust's response to future incidents, 31 recommendations for improvement are made. An action plan to address these recommendations will be prepared as soon as the report has been finalised and will be overseen by the Chief Operating Officer/Deputy Chief Executive.

4.3 REVIEW OF PATIENT HARM

Preliminary findings from this review are shown in Table 1, demonstrating that no serious harm resulted from interruption or delay in treatment. It should be noted that these findings may be altered following completion of the Case Review which remains in progress.

There are published guidelines for maximum acceptable delays in proposed Radiotherapy treatment (Royal College of Radiologists), depending on disease type and treatment intention (radical versus palliative):

- Category 1 - treatment must not be delayed by more than 2 days;
- Category 2 - treatment should not be delayed by more than 2 days – no safe minimum established;
- Category 3 - treatment should not be delayed beyond 7 days.

For chemotherapy regimens no evidence exists to quantify the risk associated with treatment delay or omissions, therefore expert opinion is used to assess whether potential harm has occurred.

Specialty	Impact
Radiotherapy Category 1	No patient suffered any delay in treatment.
Radiotherapy Category 2	Breast cancer patients, by missing three attendances in clinical terms, suffered the same effect as a Bank Holiday weekend (where there is a three day gap). Only one patient exceeded the recommendation by one day.
Radiotherapy Category 3	No harm has been identified in any patients.
Chemotherapy	534 patients were affected in the period between the time of the fire and the reopening of the Day Unit: • 31% suffered no delay • 32% were treated within 7 days of the planned treatment date • 13% had one treatment omitted – no patient had more than one treatment omitted. The remaining patients were deferred for clinical reasons, were treated elsewhere or received in-patient treatment

Table 1. Preliminary findings from review of potential patient harm

A number of related actions have been completed, including:

- Individual patient records and plan reviewed by senior clinical staff and prioritised according to clinical judgement.

- All patients contacted.
- Additional capacity created for in-patient treatments.
- Patients remain under active review as appropriate

The main action still in progress is the full review of relevant clinical records. It is anticipated that this review will be complete by October 2018.

4.4 REVIEW OF GOVERNANCE

In the light of the emerging findings from the serious incident investigation, the review of Trust governance has been focused primarily on the assessment and mitigation of infrastructure risks to fire safety over the last 8 years.

An enforcement notice was issued to the Trust in 2009 by the Avon Fire and Rescue Service concerning St Michael's Hospital. Fire safety upgrades at St Michael's Hospital were completed in Spring 2010 and were duly signed off by the Fire Service.

In parallel, a Trust-wide fire safety risk assessment was undertaken by the then Director of Estates and Facilities. Works costs totalling £4m were advised to the Capital Prioritisation Group in March 2010, with the stated intention that the highest risk priority (alarm and detection systems across the main campus) would be addressed in the first year of a phased programme, with the remainder to be sequenced over a total period of up to 4 years on the basis of risk assessment.

In June 2010, an immediate £1m allocation specifically for Trust-wide fire improvements was agreed (with flexibility for further allocations in future). In August 2010, £100k was vired into the Bristol Haematology and Oncology Centre Refresh scheme to allow fire improvements to be undertaken within that project.

Risk number 1603 was raised in August 2010 to cover Trust-wide compliance with fire safety regulations and was assessed as a moderate risk (Moderate x Unlikely = 6), which remained on the Estates and Facilities risk register. (This became Risk 972 on the new Datix system in July 2015). This risk was monitored by the Service Delivery Group, chaired by the then Chief Operating Officer.

The Annual Fire Safety Report for 2010/11 showed that the fire alarm system in the Bristol Haematology and Oncology Centre had been upgraded to Level 1 standard in the course of the year. The Report also identified a series of priorities by building, to be taken forward in the rolling programme of precautionary works. For the Bristol Haematology and Oncology Centre, the following priorities are shown:

- provision of fire breaks in ceiling voids
- provision of fire dampers in ductwork in ceiling voids
- upgrading of fire doors
- removal of waste bins from means of escape corridors
- provision of Evac+Chair and AlbacMat for use in emergency evacuation.

In June 2012, the Director of Estates and Facilities reported to the Capital Programme Steering Group that the Trust-wide installation of a Level 1 fire detection and alarm system was nearing completion but that this had taken longer than the 12

months originally planned. The delay was attributed to the difficulty of “obtaining access to operational areas (a new detector was required in every room larger than $1m^2$)”. He indicated, however, that “some of the other fire compartment work” in the BHOC had been completed as part of the BHOC Refresh project and that, in total, “about 40% by value of the total programme” was now complete.

In terms of immediate priorities, it was recommended by the Director of Estates and Facilities that compartmentation and emergency lighting improvements in the Bristol Royal Infirmary (BRI) should be addressed next, both because the BRI was assessed as presenting a higher safety risk and because of the impracticality of undertaking compartmentation works in the BHOC while a major redevelopment scheme (the BHOC extension, completed in 2014) was in progress. The report by the Director of Estates and Facilities shows the BHOC as an amber risk.

The status of Risk 1603 was reported to the Risk Management Group by the Chief Operating Officer in October 2012 who said that, “Two of the three areas had made progress, which were: 1) Capital; and, 2) Risk Assessment. The third area, Training, had made limited or no progress” at that time but that he “planned to de-escalate the risk, as none of the items in their own right were high risk.”

In November 2012, the Trust Board approved the Medium Term Indicative Capital Programme 2012/13 to 2015/17, which included £1.1m of Refurbishment funding for Approved Fire Improvement Works.

A scheme for compartmentation, replacement fire doors, emergency lighting and ventilation duct dampers in the BRI was duly set against a £1m allocation in the annual capital programme (with a further £300k allocated in 2013/14). The Capital Programme Steering Group was advised that the work was “likely to take a minimum of 12 months and possibly up to 18 (i.e. March 2014)” if the works started as expected in November 2012. It appears that delays were then incurred in specifying detailed design requirements and agreeing the schedule of works. There is an indication of a revised target start date set for June 2013, which was itself put back until December 2013 after tenders exceeded the ring-fenced financial allocation. New tender documents were finally issued in March 2014.

The Board Assurance Framework report in April 2013 suggested a risk of a ‘Pause in Fire Safety Improvements due to capital non-availability’. While normal expenditure approvals would have been required at different stages of the programme, there is no evidence that a capital funding risk materialised and was the genuine cause of the subsequent delays. The Audit Committee were informed in September 2013 that, “2013/14 will see the programme of fire compartmentation in the Queens building implemented. This project was currently being tendered and would start in Q2, though issues around obtaining access to clinical areas might prolong the implementation.”

Analysis of actual recorded spend on fire improvements in this 5 year period shows that it fell from a high of £1.2m total for the 2 years 2009/10 and 2010/11 to £349k in total for the 3 subsequent years, 2011/12 to 2013/14. In January 2014, the Capital Programme Steering Group recorded that fire compliance accounted for an underspend against the annual capital programme, which continued into 2014/15

and beyond. The Financial Resources Report issued to the Trust Board in March 2014 noted slippage of £1.193m against operational capital for Fire Improvements, to be brought forward in 2014/15.

A review of Trust-wide fire risks and further re-specification of the BRI works were apparently undertaken in 2015. An allocation of £774k was made for improvement works in levels 4 and 6 of the BRI Queen's Building. However, further slippage incurred until the Health, Safety and Fire Committee was advised in March 2016 that, "Fire protection upgrades to compartmentation in ceiling voids and fire doors commencing soon on Level 4 and 6, Queens Building. Fire door works taking place on Level 4, BHOC".

At the Trust's request, the South West Audit Consortium, the Trust's internal auditors, undertook a review of fire safety procedures and practice in 2015/16. The audit was given a red assurance rating and assessed as high impact. While it was found that the Trust had a clear and appropriate fire safety framework in place to enable effective fire safety standards to be operated throughout the Trust and an appropriate Fire Safety Policy, Procedures and Guidance document in place that clearly detailed the fire safety arrangements to be followed, and was compliant with the most recent guidance published by HM Government relating to fire safety at healthcare premises, there were weaknesses identified in the operation of fire safety practice which included the lack of a maintenance programme for fire doors and fire dampers, low staff compliance with basic fire safety training and fire evacuation training.

The management response was described by the then Chief Operating Officer to the Trust Board in May 2016, including the recent award of a contract to a new routine maintenance provider, a plan to complete face-to-face training of staff by the end of December 2016, and a risk-based approach to training relevant staff in evacuation, which had already been completed for staff who worked at night.

In late 2016/early 2017, the persistent underspend against the capital allocation was a cause of concern to the Capital Programme Steering Group, which tasked the Director of Estates and Facilities with providing an account of works undertaken to date and a full review of fire safety compliance across the Trust.

This report, dated May 2017, detailed the works completed over the previous 3 years (see Table 2) and indicated that a further risk-based prioritisation had been undertaken in 2016/17 but that "a number of works have slipped further into 2017/18 due to project resourcing issues, predominately staff workload".

A further report in June 2017 provided a written summary of the progress made Trust-wide since 2009:

> "Fire detection has been upgraded to L1 across BHOC, Queens Building, King Edward Building, BEH, BDH and BRCH. L1 installed into any new buildings or upgraded as part of refurbishments in other areas since 2009.

"Compartmentation works have been completed on L5 Queens, KEB levels 3 (part), 4 & 5, BHOC extension & level 7, Queens 8 (part) & 9 and most levels within BEH."

Financial year	Detail	Expenditure
2014/15	BRI Queens Building fire compartmentation compliance surveyed and remedial works commenced on level 5. Compartmentation improvements completed as part of phase 4 schemes in A524, A525 & A528, A522, A518.	£260k
2015/16	BRI Queens level 5 compartmentation works completed	£197k
2016/17	Bristol Heart Institute fire damper remedial works completed. Fire compartmentation improvement works also carried out as part of other capital schemes across the estate.	£283k

Table 2. Summary of completed fire safety works 2014-2017, as reported in May 2017

Following further detailed assessment by a newly formed Fire Improvement Project Team, which was presented in October 2017, funding for fire improvements of £750k a year for 5 years was agreed. In addition, £150k is made available annually for fire precautions and maintenance and for 2018/19 this has been increased by £100k.

A risk based assessment model is used to prioritise fire compliance works. This was approved by the Capital Programme Steering Group and underpins the fire strategy and annual funding allocations through the normal business planning process.

On current projections, this programme, which will provide 60 minute protection on main fire escape routes, will take 5 years to complete. An option to reduce the programme to 3 years will be presented to the Senior Leadership Team in November.

4.4.1 Audit by Authorising Engineer (Fire)

To provide external assurance, an audit of standards of fire safety management had been commissioned from the Trust's Authorising Engineer (Fire) prior to the BHOC incident, although the actual inspection was undertaken in May 2018. The report, published on 14 August 2018, finds that:

- The Trust has a robust fire safety strategy in place, with key personnel who have made considerable improvements and understand the tasks needed in both the physical estate and training of staff over the coming year. It needs to continue to strive toward improving standards of fire safety which provide a safe environment for service users, many of whom are considered vulnerable persons. This should involve ongoing strategic-level oversight and monitoring of the cumulative 'corporate' level risk currently present on the estate.
- The Trust has engaged with the CCG, staff, contractors and Avon Fire and Rescue Service, to discuss the Trust's fire strategy, an approach which has

supported increased fire safety performance (as is clear from this audit and from stakeholder feedback).

- Strong areas of performance include the reduction of unwanted fire signals in the past 6 years, fire safety training, fire compartmentation drawings and the fire team's competency.
- A number of fire systems within UH Bristol require upgrading/replacing, inspecting and maintaining to ensure they work in the way intended. These include both passive fire systems – stopping and fire dampers, and active fire systems - fire alarm and emergency lights.
- Two areas that need attention are (1) detection and smoke dampers within the ventilation system and (2) the current electrical fixed wiring testing and inspection regime.
- With specific reference to the BHOC, the Authorising Engineer records that: "Ductwork was identified without fire dampers installed within the fire compartment lines within Bristol Haematology and Oncology Centre."

The Authorising Engineer (Fire) finds that the current assessed position of the Trust's estate fire safety is that fire safety management is of a broadly reasonable standard, with fire safety training standards the highest witnessed by the Authorising Engineer within the healthcare sector.

There remains a need for further remedial works projects to be funded and implemented. The report notes that the process of allocating resources to improvement works is complex and that it is not feasible to undertake all works required immediately but the £4.5 million planned works over the next five years should improve the built environment to a standard it would be reasonably expected to be at when set against other Trusts of a similar nature, Firecode and legislative requirements.

The Authorising Engineer recommends that the Trust should consider having an independent audit of the risk-based analysis used to prioritise the fire remediation projects, to provide assurance to the Trust that current prioritisation provides the levels of fire safety and protection required during the period of time it will take to complete all the works identified. This audit is currently being commissioned and should report at the end of October 2018.

4.4.2 Governance review: conclusions

This review demonstrates that between 2010 and 2015 a number of important fire improvement schemes were completed by the Trust, which succeeded in delivering full compliance for fire detection and warning systems across the whole of the main precinct.

Fire risk assessments during this period continue to report non-compliance on other elements, mainly around compartmentation, fire doors and fire dampers.

The most recent, risk-based assessment of Trust-wide compliance with all aspects of fire safety requirements puts the Trust at 79% compliance overall, although compartmentation, corridor breaks and fire dampers are identified as priority areas for further work.

It appears that the practical challenges of specifying and delivering the 4-year works programme agreed in 2010 may have been under-estimated, and were exacerbated by capacity constraints within the Estates team, the difficulty of gaining access to functioning patient areas and the complexity of scheduling the various schemes.

The known compartmentation risks in the BHOC were in any case formally deemed a lower priority for remedial work than those in the BRI. The major extension to the BHOC was also given as a reason for deferring complex improvement work in the remainder of the building.

It may be surmised that the initial good progress with fire detection and warning systems, combined with an appreciation of the major improvements being made to the overall condition of the Trust's estate as a result of strategic redevelopment schemes in the BRI, BHOC and BRHC (all Firecode compliant in themselves) diminished the focus on remediation of the remaining, identified compartmentation risks in the BHOC until a new Trust-wide re-assessment was ordered in 2017.

The Serious Incident investigation has found that the catastrophic failure of the PFC unit in the BHOC plant room could not have been predicted and that its impact was aggravated by the exceptional, prior removal of fire barrier material in the plant room. It may be assumed, however, that the absence of ductwork fire dampers noted in the Authorising Engineer's report contributed to the spread of smoke through the building.

In order for the Trust's Fire Policy to be enacted fully, the Trust must not only put appropriate preventive measures in place but also ensure that other works are not allowed to compromise those measures in future. (The serious incident investigation includes a recommendation to this effect.)

The present arrangements, whereby fire compliance is monitored by the Estates and Facilities Divisional Risk Management Group and quarterly in arrears by the Health, Safety and Fire Committee do not necessarily facilitate comprehensive monitoring of all fire safety requirements and proactive escalation of risks and issues.

There is evidence that fire risk assessments were in place (confirmed by the South West Audit Consortium audit in 2015/16) and that the compartmentation risks in the BHOC were deemed by the Director of Estates and Facilities to be lower than those in the BRI (which were duly prioritised for investment by the Trust). Although fire safety improvements were being overseen by Estates and Facilities and by the Health, Safety and Fire Committee, however, and although associated capital spending was monitored by the Capital Programme Steering Group, it is not clear that the potential impact of the identified scheme delays on overall fire safety risk was fully articulated or escalated.

The Authorising Engineer (Fire) records that the Trust can demonstrate communication of significant fire risk to the Board via reports written by the Trust fire safety advisor and that the ability of the Trust fire safety advisor to communicate to senior management and the Board when it is required represents commendable practice.

The Trust Board and Audit Committee may feel, however, that they not have had sufficiently detailed information over the whole period to allow Board members comprehensively to understand and take appropriate assurance about all the various domains of fire safety risk, including infrastructure risks.

4.4.3 Governance review: recommendations

In order to enhance the current governance arrangements, it is proposed to implement the following changes to existing structures and processes:

- The monitoring of fire compliance will move to a standalone Fire Committee, meeting monthly, comprising members from the Estates Department and operational areas and potentially a representative from the Authorising Engineer. The Committee will be chaired by the Director of Estates and Facilities and will develop a cycle of business which ensures that all areas of Fire Compliance receive appropriate scrutiny throughout the year, reporting to the Risk Management Group. This will include but is not limited to:
    - Reviewing the annual fire safety report before onward presentation
    - Reviewing the PPM schedules and their associated outputs
    - Monitoring of fire compliance across the Trust
    - Monitor compliance of contractor's activities with policy and SOPs
    - Review of the AE (Fire) annual audit
    - Review annual fire risk assessments for each building
    - Review of fire related incidents and risks
    - Oversee fire compliance in leased premises and advise on any actions to address identified risk
    - Receive monthly status reports from the Fire Improvement Project Team
- A Fire Improvement Project Team has been established but requires more formal arrangements to be put in place. The Project Team will be chaired by the Assistant Director of Estates- Capital Projects and will report to the Fire Committee, as well as to Trust Capital Group and Capital Programme Steering Group. The project team will monitor progress, mitigate identified risks, direct co-ordination with operational activities to minimise disruption, oversee the programme of works and communications, and will ensure the outcomes of the programmes are delivered.
- The Audit Committee will receive a six-monthly update on fire compliance and will review an Annual Fire Safety Report prior to consideration by the Board.
- A review should be undertaken of fire compliance resources to provide assurance that appropriate capacity and capability is in place.
- External assurance will continue to be provided through the current regime of independent audits provided by the AE (Fire). An annual internal audit will be scheduled to focus on areas of risk as determined by the Fire Committee.
- The Capital Programme Steering Group will be asked to seek more detailed assurance on the implications of delays to capital schemes and to escalate delays to the Senior Leadership Team where there is the possibility of a material change in risk profile.
- These arrangements will be reviewed annually.

5. CONCLUSION AND RECOMMENDATIONS

This report has set out the status and findings of investigations undertaken or commissioned by the Trust following the major incident in the BHOC in May 2018.

The BHOC was appropriately recommissioned prior to re-occupation and necessary maintenance works completed. A programme of remedial works to return the BHOC to its condition before the incident has been approved and will start on 24 September.

Action has been taken across main campus to remove the risk of any further malfunction of PFC units and a range of specific improvement works have been completed, including a number of those recommended in the commissioned reports.

The most recent, risk-based assessment of Trust-wide compliance with all aspects of fire safety requirements (undertaken in 2017) puts the Trust at 79% compliance for primary means of escape in clinical buildings, although compartmentation, corridor breaks and fire dampers are identified as priority areas for further work.

A £4.5 million programme of further improvement works is planned over the next 5 years, with consideration to be given to its potential earlier completion.

The Trust Board is recommended to:

- Note the findings of the investigations and reviews conducted to date into the causes of and responses to the incident at the BHOC in May 2018
- Agree that progress against the action plan responding to the recommendations from the **serious incident investigation** should be reported to the Audit Committee.
- Agree that the report and recommendations from the review of **emergency preparedness and response** and resulting action plan should be reported to the Quality and Outcomes Committee.
- Agree that further actions to review **potential patient harm** caused by interruption or delay in treatment should be reported to the Quality and Outcomes Committee.
- Agree the recommendations arising from the **governance review**, including that the Audit Committee receive a six-monthly update on fire compliance and review an Annual Fire Safety Report, prior to consideration by the Board.
- Agree that the delivery of the planned **fire safety improvements programme** be reported to the Finance Committee.
- Agree any further assurance mechanisms it requires.

Robert Woolley
Chief Executive
19 September 2018

Cover report to the Public Trust Board. Meeting to be held on 27 September 2017 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	**8**
Meeting Title	Public Trust Board	**Meeting Date**	**Thursday, 27 September 2018**
Report Title	**Quality and Performance Report**		
Author	James Rabbitts, Head of Performance Reporting Anne Reader, Head of Quality (Patient Safety) Deborah Tunnell, Associate Director of HR Operations		
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		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 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)**
		25 September 2018		

University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

September 2018

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 85.7 % for July, so the national standard of 85% was achieved. The national standard is on track to be achieved in August, September and the quarter.
- The measure for percentage of A&E patients seen in less than 4 hours was 90.1% for August. This did not achieve the 95% national standard and is below the improvement trajectory target of 91.26%. However, with the addition of Walk-In Centre data (as part of NHS England's "Trust Footprint" publication), UHBristol's A&E performance for August is expected to deliver the trajectory. The Children's Hospital has sustained consistently good performance and exceeded the 95% standard in August, at 97.9%.
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 88.73% as at end of August. This did not achieve the national 92% standard. The improvement trajectory target for this measure has been set at 88.70% so this was achieved. The Trust was 956 patients away from the national compliance of 92%.
- The percentage of Diagnostic patients waiting under 6 weeks at end of August was 97.1%, with 230 patients waiting 6+ weeks. This is lower than the national 99% standard. The maximum allowed breaches to achieve 99% was 80.

Headline Indicators

Infection cases of Clostridium Difficile remain below the trajectory and there were no MRSA cases in August. Performance pressure ulcers and patient experience remain above target. However there was one category 3 pressure ulcer this month. Patient Falls saw an increase in August, with 130 incidents reported, which gives a rate of 5.3 falls per 1,000 beddays. This exceeds the standard of 4.8 falls per 1,000 beddays. The incidents are being reviewed in detail through the Falls Steering Group.

Last Minute Cancelled Operations (LMCs) were at 0.8% of elective activity and equated to 55 cases. There were five breaches of the 28 day standard (LMCs from last month had to be re-admitted within 28 days).

100% of patients with fractured neck of femur were seen by an ortho-geriatrician within 72 hours in August, which is also the sixth consecutive month the 90% requirement for this component of Best Practice Tariff has been achieved.

Workforce

Agency usage increased by 5.2 full time equivalents (FTEs) to 99.4 (1.2%), with the largest increase seen in Specialised Services. Bank usage increased by 16.3 FTE to 449.2 (4.3%), with the largest increase seen in Trust Services.

Turnover increased to 13.80% from 13.79% last month, with decreases across three divisions – Diagnostics and Therapies, Specialised Services, and Surgery. Overall vacancies reduced to 5.4% compared to 6.1% in the previous month.
There were reductions in all but one staff group (Allied Health / Scientific Professions).

Sickness absence reduced from 3.90% to 3.86%, with reductions in four divisions. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, this increased by 3.6% compared with last month. Other Musculoskeletal Problems are the second highest cause of sickness and this reason increased by 9.2% compared with last month. The third highest reason, Gastrointestinal problems reduced by 12.0% compared to the previous month.

August 2018 compliance for Core Skills (mandatory/statutory) training reduced to 89% overall across the eleven core skills programmes

1.2 OVERVIEW – Single Oversight Framework

Access Key Performance Indicator		Quarter 1 2018/19			Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19		
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
A&E 4-hours Standard: 95%	Actual	84.0%	91.1%	92.8%	90.3% *	90.1% *							
	"Trust Footprint"	92.05%											
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%	86.0%	85.7%								
	Actual (Quarterly)	84.2%											
	Trajectory (Monthly)	81%	83%	79%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	82.5%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	88.2%	89.1%	88.6%	88.9%	88.7%							
	Trajectory	88%	88%	88.5%	88.5%	88.7%	88.5%	88.5%	88.0%	87.0%	86.0%	87.0%	87.0%
6-week wait diagnostic Standard: 99%	Actual	96.8%	97.6%	97.8%	97.9%	97.1%							
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

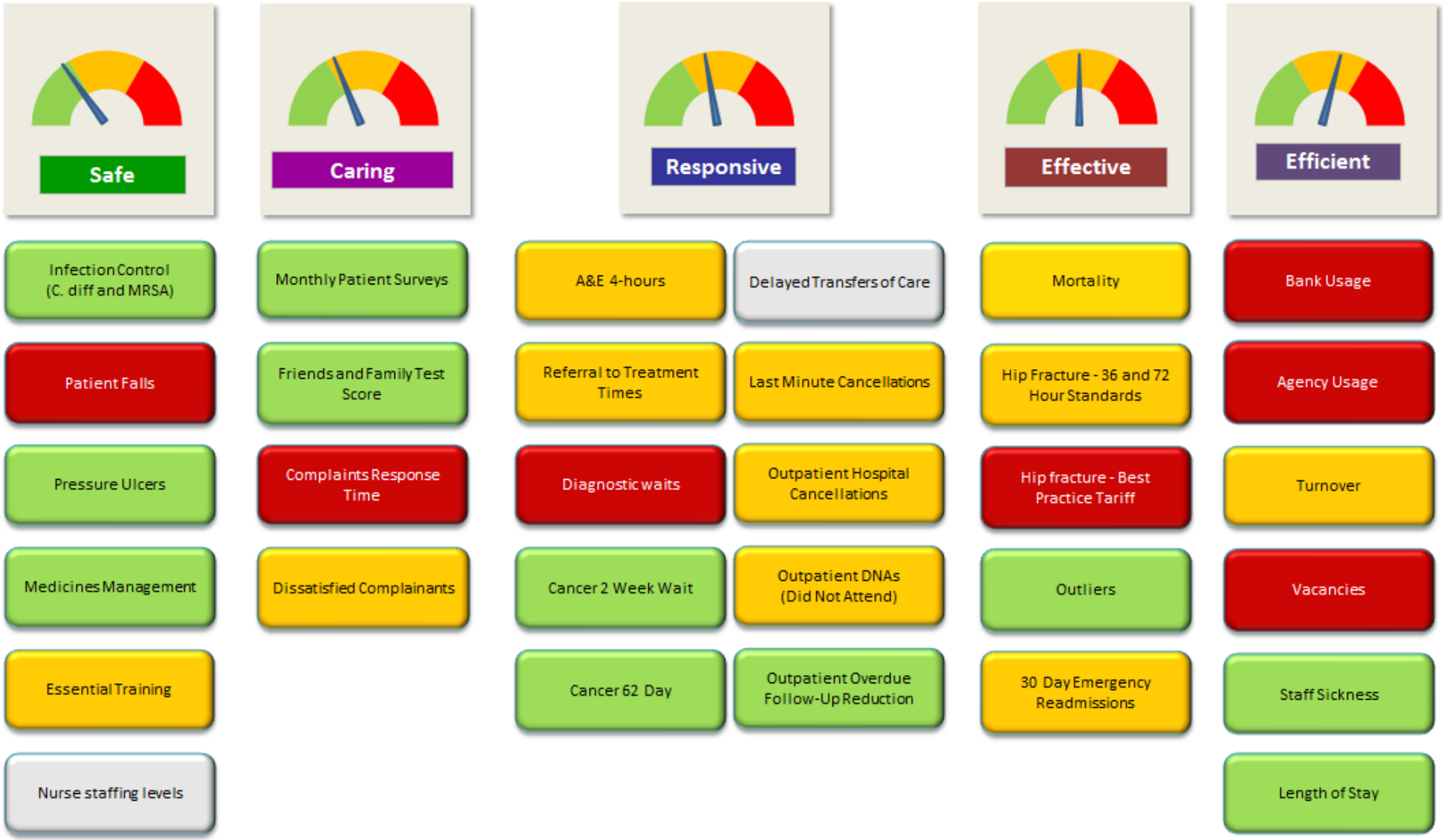
GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

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, Somerset and South Gloucestershire (BNSSSG) 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 recovery trajectory for each quarter.

* With addition of WIC data (as part of NHS England's "Trust Footprint" publications), UHBristol's A&E performance for July and August is expected to deliver the trajectory.

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	• Achieved the 62 day GP national standard in June (86%) and July (85.7%) and on track for August and September and Quarter 2. • Sustained ED 4 hour performance at Children's Hospital (97.9% within 4 hours in August). Improved performance at the Eye Hospital (98.8% in August). • Emergency Department 4 Hour performance with Walk-In Centre activity is expected to deliver the recovery trajectory of 91.26% for August. • Referral To Treatment (RTT) Performance remains above recovery trajectory (88.73% for end of August against target of 88.70%) • Weekly meetings are now in place for each Wednesday to ensure effective winter planning for 2018/19 • Implementation of Surgical Bronze role to support ED and flow commenced from 3rd September. • Sleep Studies and ultrasound breaches of 6 week wait target remain consistently low (4 and 1 breach respectively at end of August).	• Delivery of GP Cancer 62 Day national standard of 85% in each month and quarter. • Ensuring all processes are in place to report against the amended national rules for cancer performance • Recommendations from the Surgical Acute Assembly and Acute Care Assembly to be taken forward, through Urgent Care Steering Group. • Review of radiology reporting in ED underway to implement standards for reporting times • Deliver A&E 4 hour performance trajectory of 90.84% and RTT trajectory of 88.5% in September • Monitoring of patients with a current on-hold status will continue at the weekly performance meeting. Observation of staff working practices in the Trust's Patient Administration System has commenced in September • Work with our commissioners to continue the review of the local patient access policy. The Trust has shared its proposal with commissioners and have committed to reviewing and reporting back by December.
	Opportunities	**Risks and Threats**
ACCESS	• Opportunity to improve cancer performance with new national rules for allocation of performance between providers • Funding awarded to support performance improvement across the local area, with a dedicated role at each BNSSG provider to troubleshoot pathway issues internally and regionally • A business case for additional medical and nursing staffing in Children's ED has been developed and is with the division for sign off • Development of a new escalation and predictor model within adult ED, to better predict potential surges in arrivals. • Pilot launch of Laparoscopic surgery in South Bristol Community Hospital from 10th September 2018 for 3 months. • Launch of Virtual Fracture clinic in June 2018 to improve patient flow and experience through orthopaedic services. Impact to be assessed. • Cataract Services will be piloting 260 patients per month being offered choice of admission date from pre-op	• Rising demand in Dermatology is causing pressures in service delivery (division are reporting an 11% increase in 2018/19 referrals). Commissioners are sighted on this increase, discussions ongoing. • ED attendances are increasing: 5% rise at BRI and 8% rise at BCH (Apr-Aug 2017 vs Apr-Aug 2018) • Volume of predicted breaches of the 6 Week Diagnostic Wait for Echocardiographies remains above tolerance (80 breaches predicted for end of September) and threatens delivery of the 6 week standard, • 52 week breaches did not achieve the target of ZERO for end of August. The Trust reported 7 breaches due to patients exercising choice • Without an agreed patient access policy to support the high level of cancellation/patient choice achieving no long waiting patients would be difficult to achieve. Work is being undertaken, see "Priorities" section.

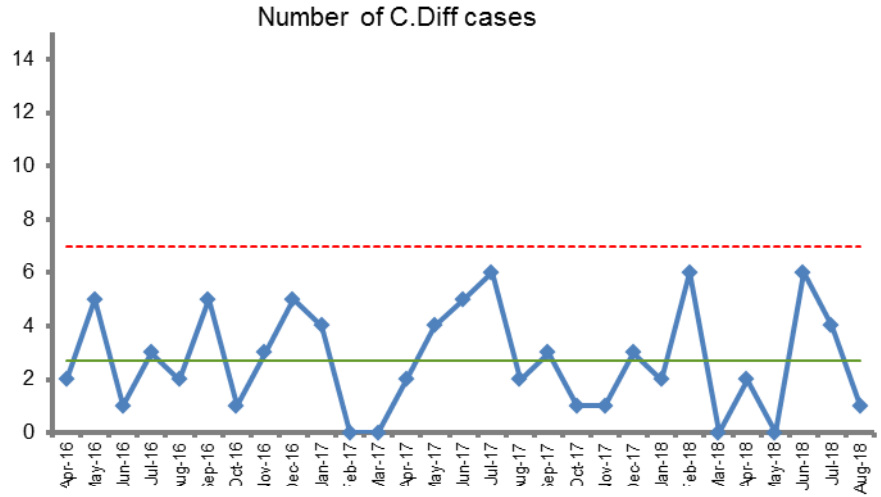
QUALITY AND PERFORMANCE REPORT - COMMENTARIES

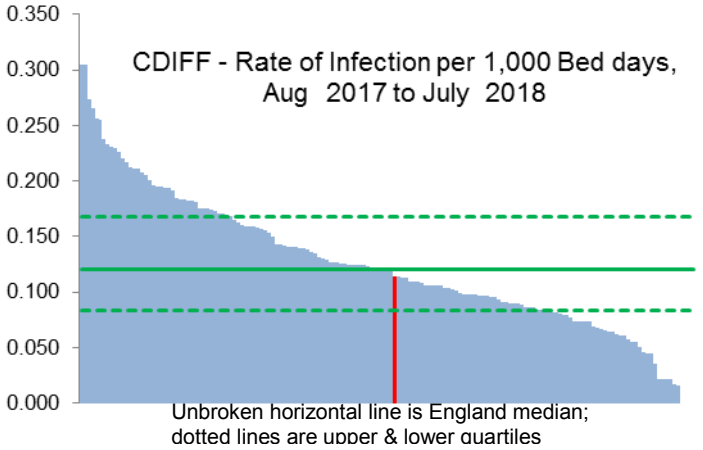
QUALITY	**Successes**	**Priorities**
	• There were zero medication incidents resulting in moderate or above harm in July 2018 • We have sustained 100% of patients with fractured neck of femur being reviewed by an ortho-geriatrician within 72 hours for two consecutive months. • Sepsis data is submitted quarterly to NHS England, but the latest results for July 2018 show 100% achievement for all three indicators for inpatients, and that we achieved the 90% target for screening and antibiotic review in our emergency departments. • Friends and Family Test scores for Inpatients and Maternity services were both in excess of 98% in August	• One potential never event was reported in August involving a broken off tip of a Percutaneous Intravenous Central Catheter (PICC line) guidewire which was retained. This is currently subject to a serious incident investigation the results of which will be reported to the Quality and Outcomes Committee in due course. • There have been four grade 3 pressure ulcers in 2018/19 to date compared with total of five last year, mainly located on patients' heels. Learning from investigations completed to date includes ensuring anti-embolic stockings are removed daily to perform skin checks and instigate further preventative measures if required. • There were five falls resulting in harm in August, three of which caused moderate harm and two of which are serious incidents and are under investigation. Both of the patients involved were mobilising as part of their rehabilitation.
QUALITY	**Opportunities**	**Risks and Threats**
	• Performance in responding to complaints within the timescales agreed with complainants continues to be below the 95% target set by the Trust (83% in August). Details of all breaches are now being discussed at monthly meetings of the Clinical Quality Group. • The proportion of complainants who are dissatisfied with our response to their concerns is in line with external benchmarks but above the Trust's 5% target (9.3% for cases responded to in June). Dissatisfied cases are now reviewed in detail by the Head of Quality (PE/CE) and a nomination Head of Nursing, and learning is shared with Clinical Quality Group on a monthly basis.	• At Month 5, the Trust has reported 17 MSSA cases, compared to 25 cases at the same point in 2017/18. Of 12 MSSA infections reported in Quarter 1, 7 were in cardiac services. Detailed analysis of these cases has identified a need for better compliance with policy in the care of cannulas. This work is being led in the Division of Specialised Services supported by the Trust's Infection Control Team. • The Friends and Family Test response rate for maternity patients has been below the Trust's 15% target four consecutive months. This is being driven by a very low response rate (c.3%) in community services where externally provided administrative support has been withdrawn – solutions are actively being sought.

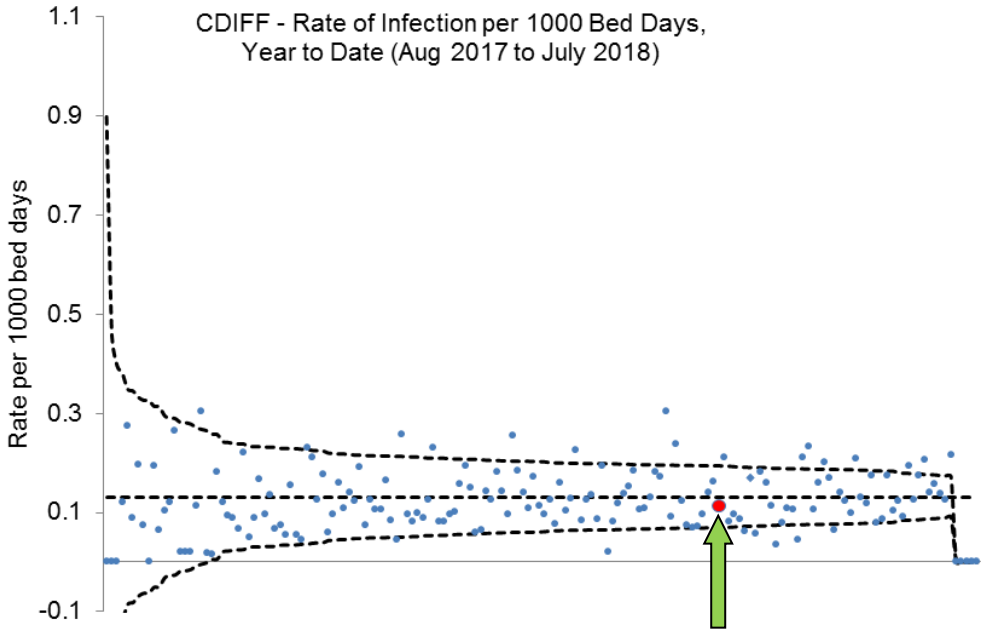
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

	Successes	Priorities
WORKFORCE	• Of the 11 Core Skills, there were two increases – Equality, Diversity & Human Rights increasing to 93% from 92% and Moving and Handling increasing to 83% from 82%. • Compliance for all 'Remaining Essential Training' increased to 94% compared with 93% in the previous month. • A key focus during August was Ancillary recruitment with an assessment centre approach being trialed and subsequently adopted to deliver higher volumes of candidates with lower recruiting manager input, mirroring the success seen with Nursing Assistant recruitment.	• Essential Training - Countdown communications to affected staff continue; the update frequencies for both Resus and Infection Prevention and Control (the clinical version) will change from 2-Yearly and 3-yearly, respectively, to an annual update frequency. This shortened period will become effective on the Portal on 1 January 2019. • To convert sustained achievement of 50% of leavers undertaking exit questionnaires into statistically meaningful turnover data for each division. • To complete a review of the effect of the Supporting Attendance Policy introduced in March, as agreed with Staff Side. • To continue reviewing the way Junior Doctor rotas in General Medicine are managed to enable the successful implementation of rostering & absence management.
	Opportunities	**Risks and Threats**
WORKFORCE	• Further exploration with North Bristol Trust to create an efficient transfer of training records between both Trusts, and determine the level of resources required to achieve this on a large scale, prior to every corporate induction. • To work collaboratively with the 50 wellbeing advocates to strengthen the communication of the wellbeing menu across the organisation. • To work proactively with divisions to drive a compliance increase in appraisal now the system issues have been resolved. • A new approach is being adopted to target final year UWE students who have their last clinical placement at UHB positioning the Trust as the employer of choice. • Head of Medical HR is supporting the national review of the Junior Doctor Contract 2016 as an employer representative. This provides the Trust with the opportunity to influence positive change for both employers and junior medical staff.	• August saw a large intake of approx. 200 new Doctors, which is a contributing factor for a 5% drop in Corpak NG Tube X-Ray Confirmation eLearning. This programme is an immediate mandatory requirement for almost all new doctors. It is expected that compliance for this programme will recover in the coming month, as the new doctors have more time to complete the eLearning. • Sickness is likely to begin increasing as we approach the winter months, particularly colds & flu. • Demand for bank and agency is likely to start increasing as we enter a period of higher sickness and increased acuity. Plans to meet demands are under review. • Complexities of rota and culturally ingrained practices continue to pose difficulties with the pace of implementation for the eRostering project.

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 was one trust apportioned C.Diff cases in August 2018, giving 13 cases year-to-date. This is below the year-to-date trajectory of 15 cases
Commentary:	There was one case of C. Difficile identified in August 2018. One case requires a review with our commissioners before determining if the case will be Trust apportioned. Once reviewed in October, any outstanding appropriate actions will be implemented.
Ownership:	Chief Nurse



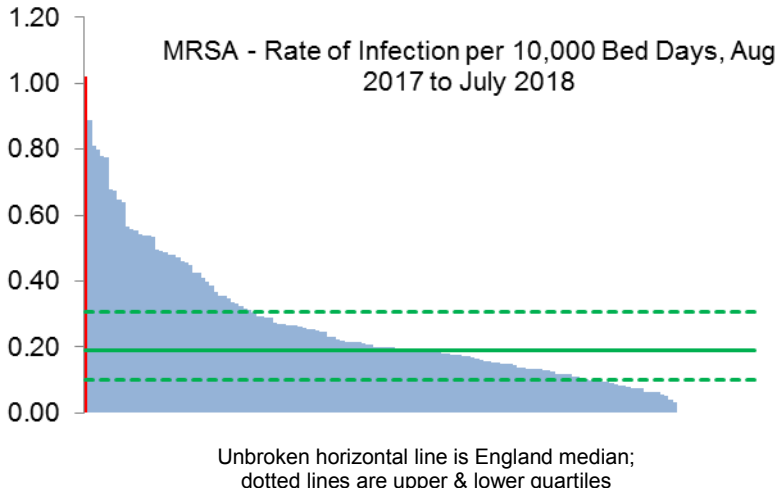




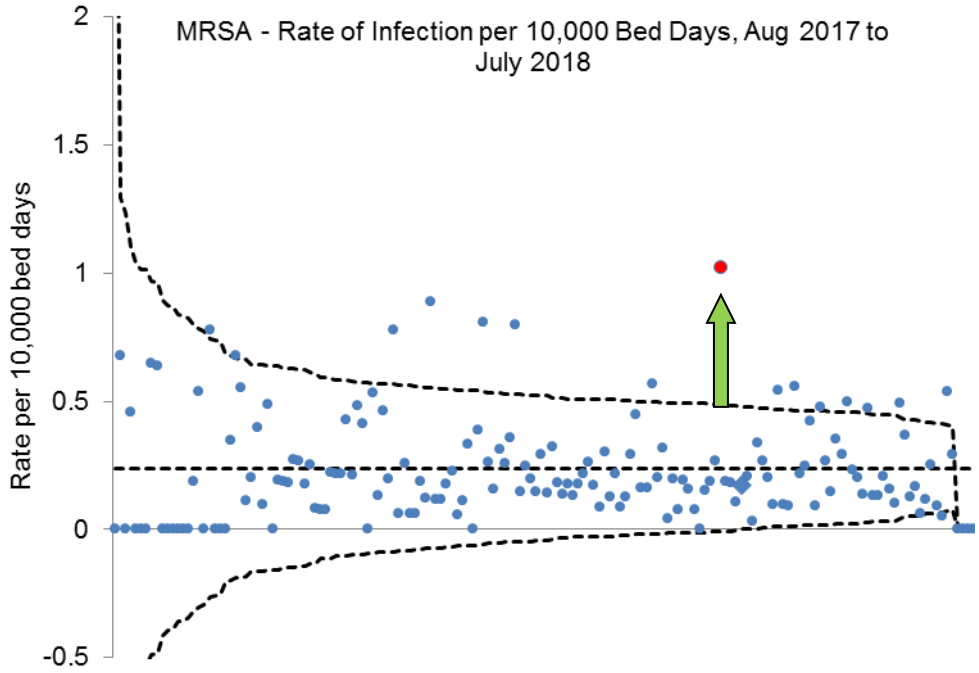
CDIFF Cases	Aug-18	2018/2019
Medicine	0	1
Specialised Services	0	6
Surgery	0	2
Women's and Children's	1	4
Grand Total	1	0

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There were no trust apportioned MRSA cases in August, making three cases year-to-date.
Commentary:	There were no cases attributed to the Trust during August 2018. Ongoing training and reporting mechanisms are continuously being reviewed to ensure any learning is identified and shared accordingly.
Ownership:	Chief Nurse

MRSA	Aug-18	2018/2019
Medicine	0	2
Specialised Services	0	0
Surgery	0	1
Women's and Children's	0	0
Grand Total	0	0

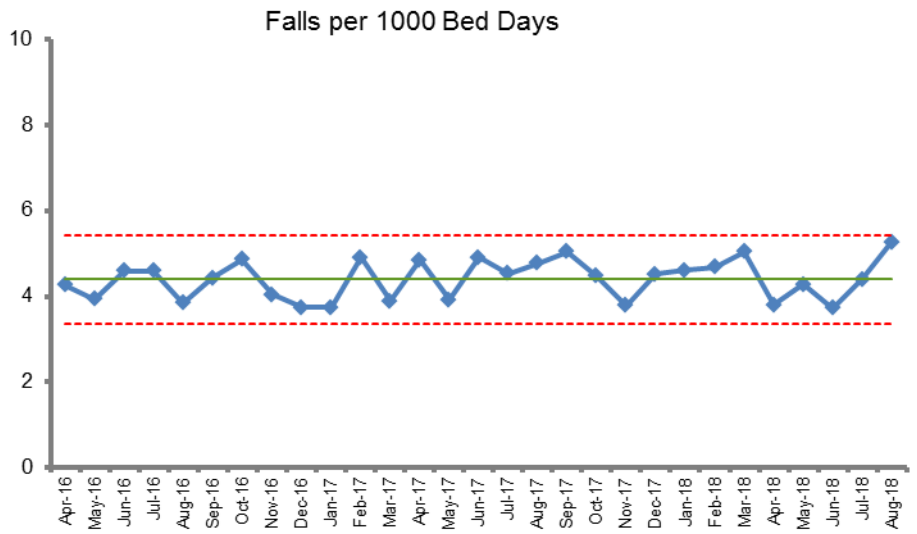


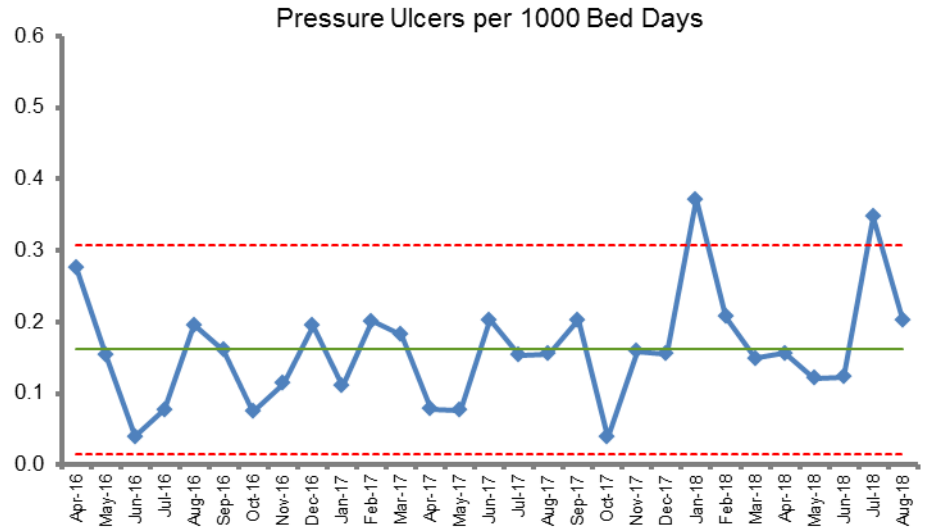
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles



2.1 PERFORMANCE – Safe Domain

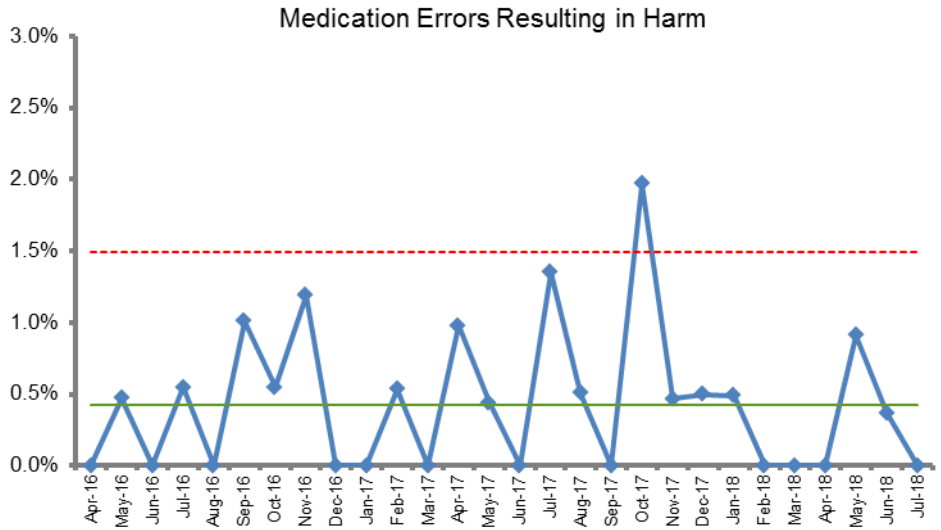
Patient Falls and Pressure Ulcers	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above) Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Falls rate for August was 5.27 per 1,000 beddays. This was 130 Falls with 5 resulting in harm. Pressure Ulcers rate for August was 0.20 per 1,000 beddays. There were five Pressure Ulcers in August, with one at Grades 3, the rest at Grade 2.
Commentary:	There were 130 falls in August which is an increase from the 114 in July, and takes the falls per 1,000 bedday metric to 5.3, which is above the target of 4.8. The August falls data will be reviewed in detail through the Falls Steering Group and learning from these incidents will be shared and cascaded to the relevant divisions, with any recommendations/actions incorporated into the work plan. The Dementia & Falls team continue to link falls awareness into all training sessions to highlight the increased risk of falls when a patient is cognitively impaired. Pressure ulcer performance for August remains green. The overall number of pressure ulcers in August has reduced per 1,000 bed days to 0.20 with one new category 2 pressure ulcer and disappointingly one new category 3 pressure ulcer. Pressure ulcer prevention and reduction work 18/19 focuses on our ambition to reduce pressure ulcers category 1-3 across the organisation, focusing on high reporting areas and delivering a number of practice and training related objectives.
Ownership:	Chief Nurse

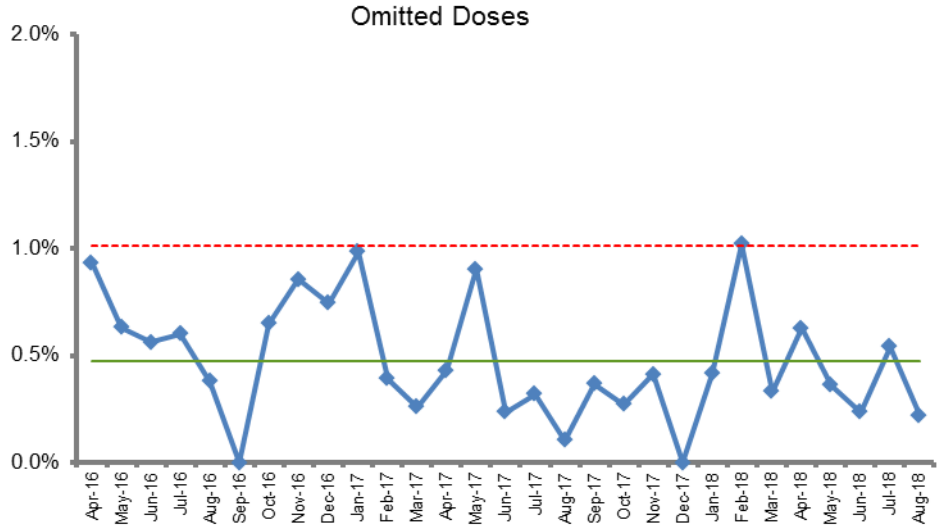




2.1 PERFORMANCE – Safe Domain

Medicines Management	
Standards:	Number of medication errors resulting in harm to be below 0.5%. Note this measure is a month in arrears. 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 July resulted in harm (0 errors out of 286 cases reviewed). Omitted doses were at 0.22% in August (2 cases out of 902 reviewed).
Commentary:	The performance for omitted doses of critical medication has improved since last month. The number of patients reviewed as part of the measure increased from 554 to 902, and the number of patients experiencing missed doses reduced from 3 (0.54%) to 2 (0.22%). As numbers of patients affected are relatively small this improvement may be due to normal variation than a sustained improvement.
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 August Essential Training overall compliance reduced to 89% compared with 90% in the previous month (excluding Child Protection Level 3).
Commentary:	August 2018 compliance for Core Skills (mandatory/statutory) training reduced to 89% overall across the eleven core skills programmes. There were 3 reductions – Fire Safety reducing to 86% from 87%, Infection Prevention and Control reducing to 93% from 94%, and Safeguarding Children reducing to 89% from 90%. There were also two increases – Equality, Diversity and Human Rights increasing to 93% from 92% and Moving and Handling increasing to 83% from 82%. Compliance for all other Essential Training increased to 94% compared with 93% in the previous month.
Ownership:	Director of People

Essential Training	Aug-18	KPI
Conflict Resolution Training	95%	90%
Equality, Diversity and Human Rights	93%	90%
Fire Safety	86%	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)	83%	90%
Preventing Radicalisation	91%	90%
Resuscitation	87%	90%
Safeguarding Adults	90%	90%
Safeguarding Children	89%	90%

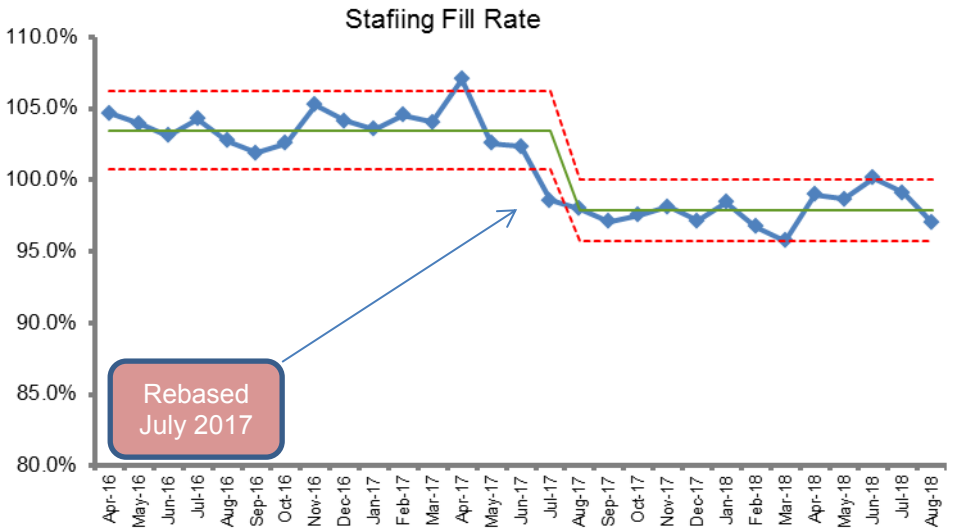
Essential Training	Aug-18	KPI
UHBristol NHS Foundation Trust	**89%**	**90%**
Diagnostics & Therapies	89%	90%
Facilities & Estates	89%	90%
Medicine	89%	90%
Specialised Services	90%	90%
Surgery	89%	90%
Trust Services	91%	90%
Women's & Children's	89%	90%

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:	August's overall staffing level was at 97.0% (231,721 hours worked against 238,900 planned). Registered Nursing (RN) level was at 92.1% and Nursing Assistant (NA) level was at 109.5 %
Commentary:	Overall for the month of August 2018, the Trust had 91% cover for registered nurses on days and 93% registered nurse cover for nights. The unregistered nursing level of 104% for days and 117% for nights reflects the activity seen in August 2018. This was due primarily to nursing assistants specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night
Ownership:	Chief Nurse

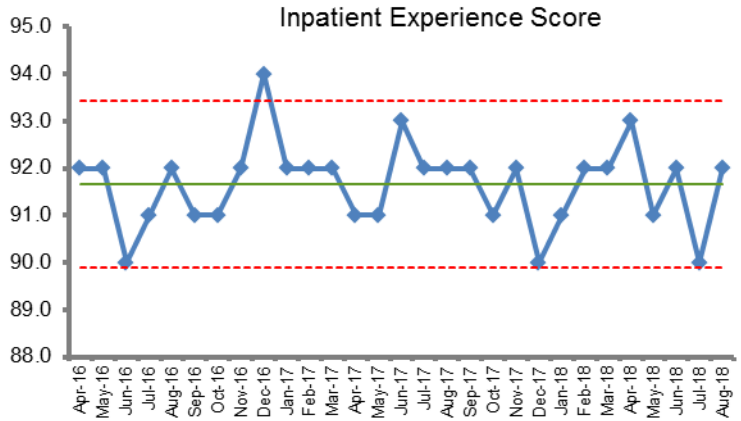
	Day	Night	TOTAL
Registered Nurses	91.5%	92.9%	92.1%
Nursing Assistants	103.9%	117.2%	109.5%
TOTAL	**95.2%**	**99.3%**	**97.0%**

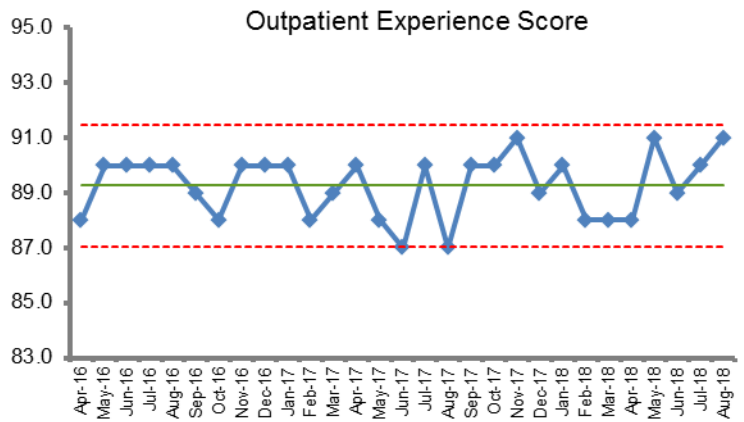
Medicine	108.4%
Specialised Services	98.2%
Surgery	98.5%
Women's and Children's	87.6%
TOTAL	**97.0%**

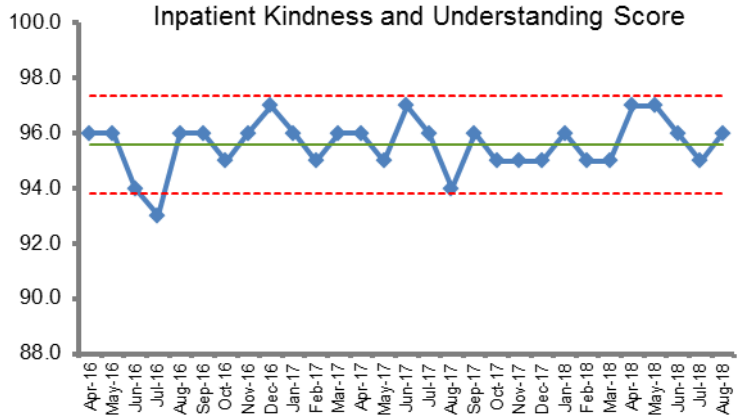


2.2 PERFORMANCE – Caring Domain

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 August 2018, the inpatient score was 92/100, for outpatients it was 91. For the kindness and understanding question it was 96.
Commentary:	The headline measures from these surveys remained above their minimum target levels in August 2018, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse

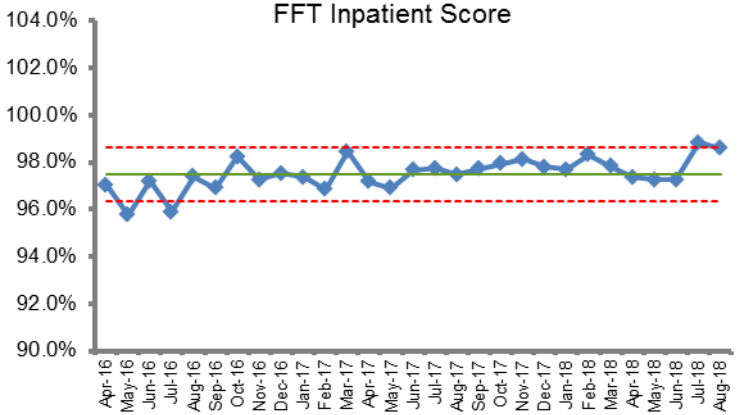


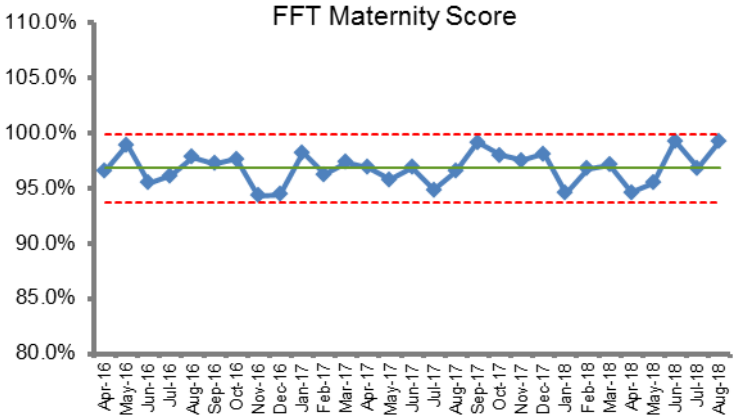


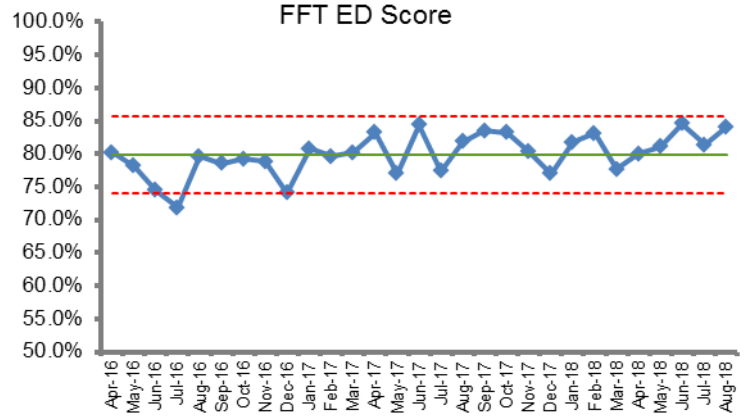


2.2 PERFORMANCE – Caring Domain

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:	August's FFT score for Inpatient services was 98.6% (2184 out of 2215 surveyed). The ED score was 84.1% (1188 out of 1413 surveyed). The maternity score was 99.3% (135 out of 136 surveyed).
Commentary:	The Trust's scores on the Friends and Family Test were above their target levels in August 2018.
Ownership:	Chief Nurse



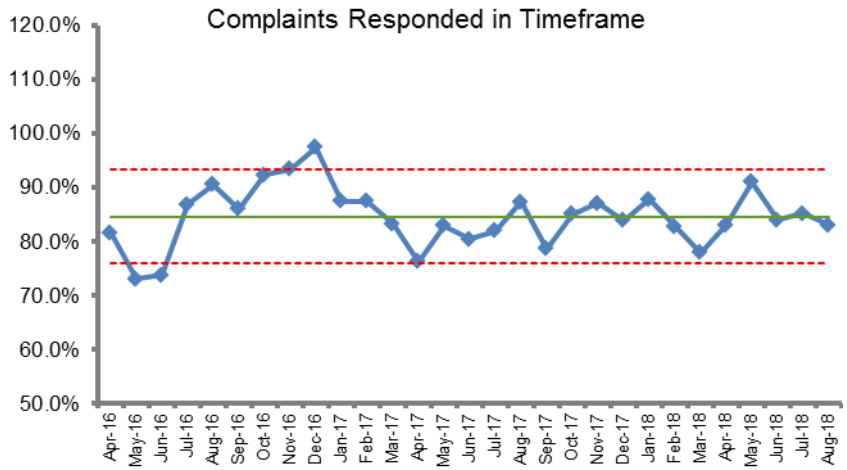


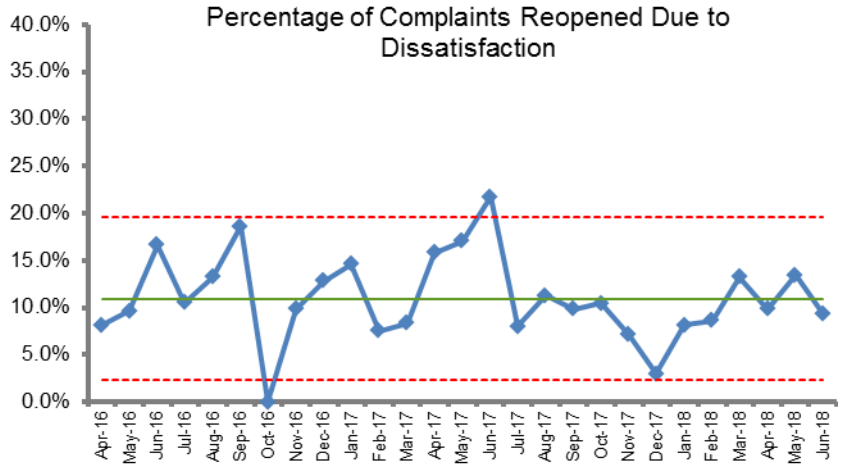


	Response Rate		Score	
	Aug-18	2018/2019	Aug-18	2018/2019
Inpatients				
Medicine	29.2%	37.0%	98.0%	97.2%
Surgery	36.5%	36.3%	98.7%	98.3%
Specialised Services	40.2%	35.2%	99.0%	97.4%
Women's and Children's	36.6%	37.3%	98.7%	98.0%
TOTAL	**35.4%**	**36.5%**	**98.6%**	**97.9%**
Emergency Department				
Bristol Royal Infirmary	12.1%	11.8%	67.3%	66.6%
Children's Hospital	22.4%	21.1%	89.9%	86.0%
Eye Hospital	22.1%	23.7%	95.4%	92.9%
TOTAL	**17.4%**	**17.5%**	**84.1%**	**82.2%**
Maternity				
TOTAL	**9.8%**	**13.6%**	**99.3%**	**96.7%**

2.2 PERFORMANCE – Caring Domain

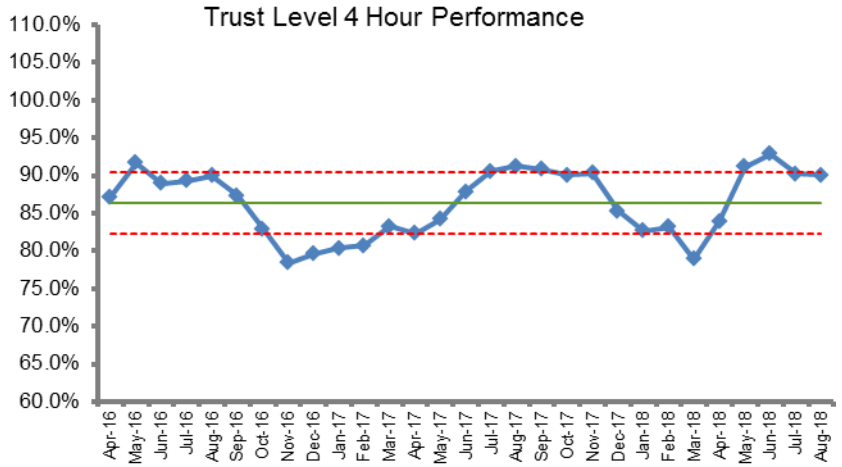
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe. Of all formal complaints responded to, less than 5% should be re-opened because complainant is dissatisfied.
Performance:	In August, 44 out of 53 formal complaints were responded to with timeframe (83.0%) Of the 75 formal complaints responded to in June, 7 resulted in the complainant being dissatisfied with the response (9.3%)
Commentary:	The rate of dissatisfied complaints decreased to 9.3% in June compared to 14.9% in May, having remained below the amber 10% threshold for seven consecutive months prior to the 12.7% reported for April. This represents seven cases from the 75 responses sent out in June. In response to the reported increases in April and May, monthly systematic review of dissatisfied cases has been reintroduced – cases are now reviewed for learning by the Head of Quality (Patient Experience and Clinical Effectiveness) and a Head of Nursing. Retrospective review of April's cases identified two complaints which have subsequently been recoded as not dissatisfied – the revised figure for April is therefore 9.86% (amber). Points of learning from the remaining dissatisfied cases will be shared with Divisions via Clinical Quality Group in October. The Trust's performance in responding to complaints via formal resolution within a timescale agreed with the complainant was 83% in June. This represents 9 breaches of the standard. Since August, Clinical Quality Group has been receiving a monthly report providing details of all breaches and causes to identify learning.
Ownership:	Chief Nurse

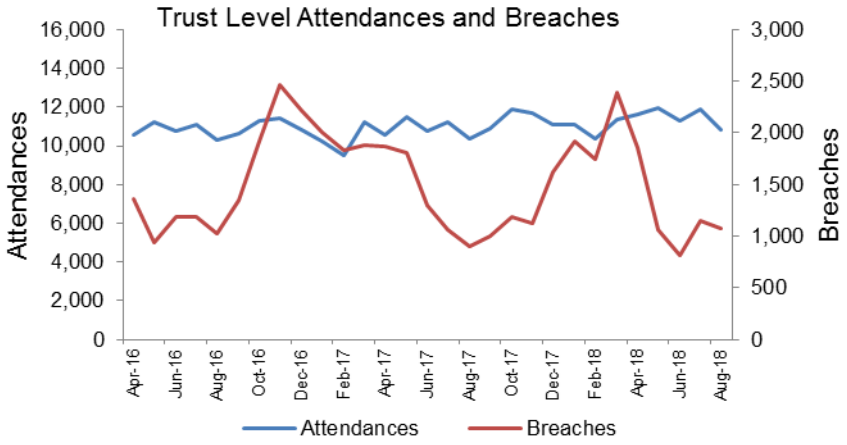


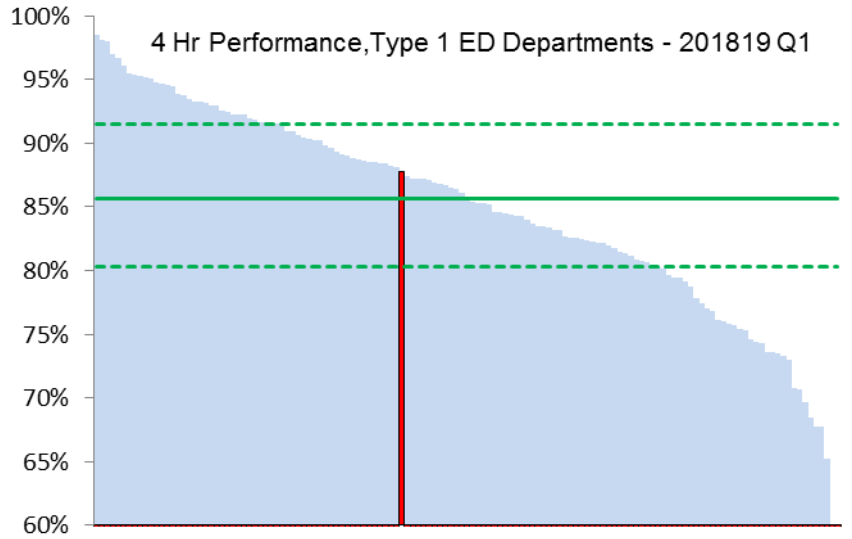


2.3 PERFORMANCE – Responsive Domain

Emergency Department 4 Hour Wait	
Standards:	Measured as length of time spent in the Emergency Department from arrival to departure/admission. The national standard is that at least 95% of patients should wait under 4 hours. The Trust's improvement trajectory is 90.53% for July
Performance:	Trust level performance for August was 90.07% (10862 attendances and 1079 patients waiting over 4 hours).
Commentary:	Performance at the Children's Hospital remained above 95% in August, with 97.9% performance. This is alongside a 8% rise in attendances (Apr-Aug 2018 vs Apr-Aug 2017). The Bristol Royal Infirmary achieved 83.4% in August. With the addition of local Walk-In Centre (WIC) data, Trust performance is expected to deliver the recovery trajectory of 91.26% in August.
Ownership:	Chief Operating Officer

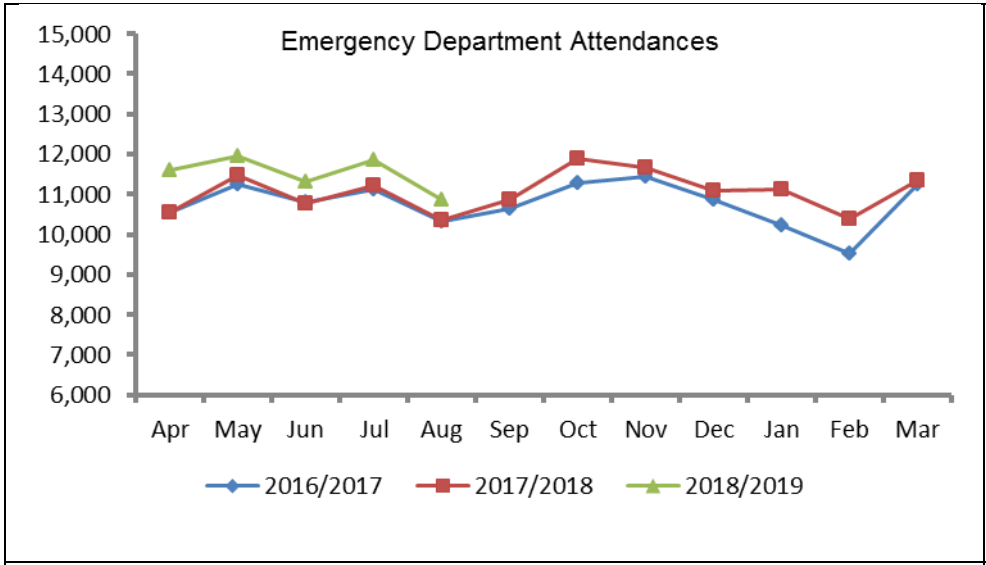


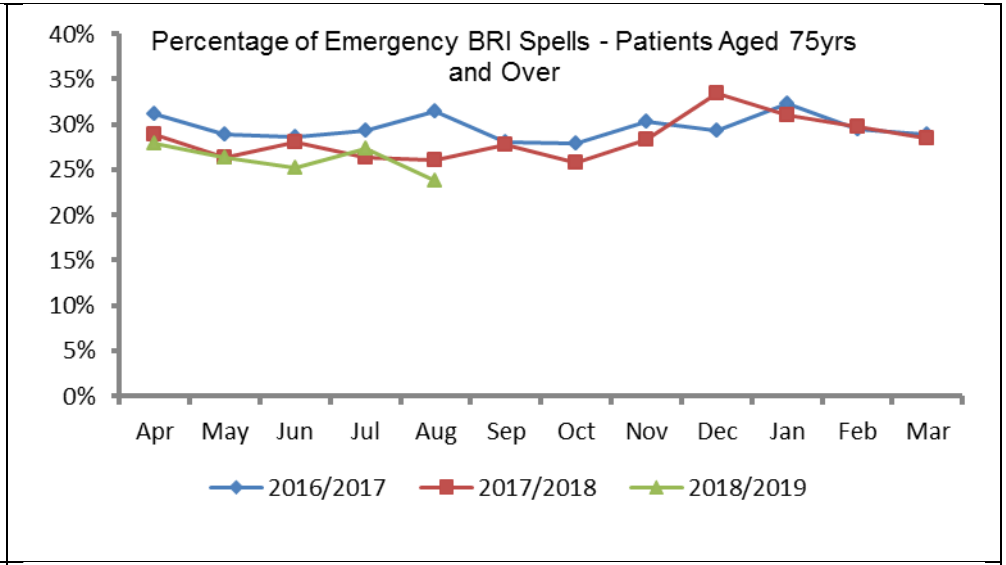


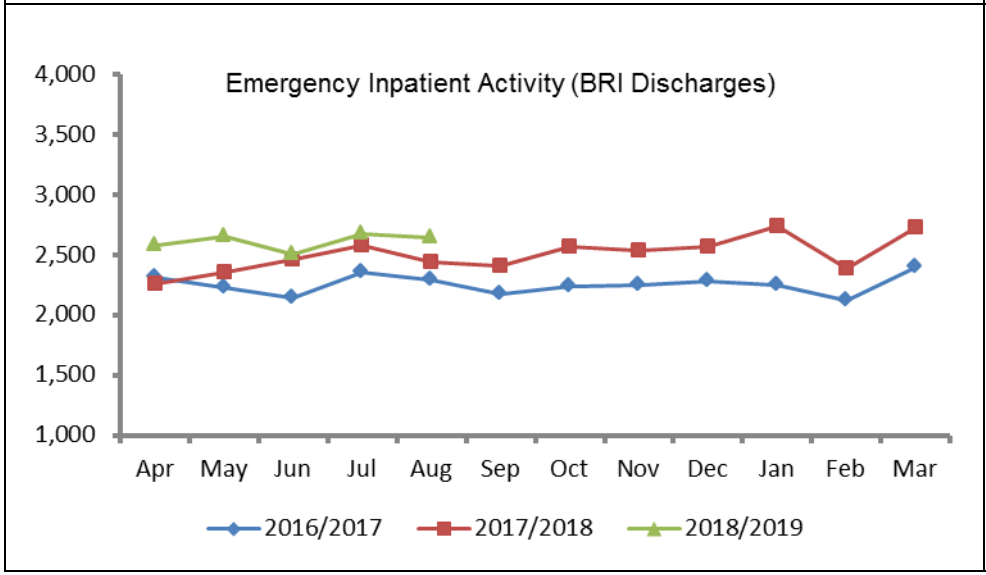


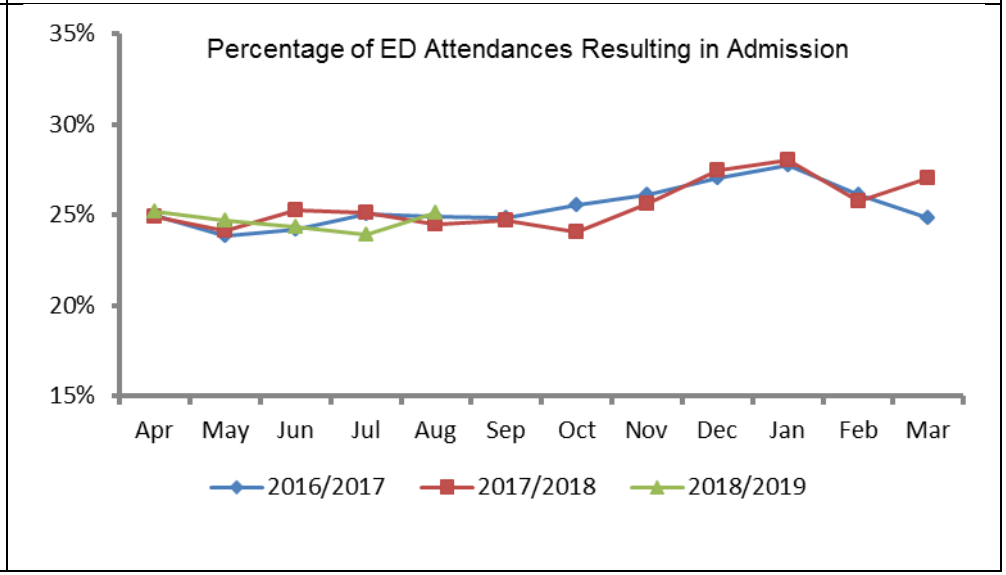
Unbroken horizontal line is England median;
dotted lines are upper & lower quartiles

	Attendances		Under 4 Hours		Performance	
	Aug-18	2018/2019	Aug-18	2018/2019	Aug-18	2018/2019
BRI	5977	29957	4983	24966	83.37%	83.34%
Trust	10862	57576	9783	51613	90.07%	89.64%


Emergency Department Attendances
15,000
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2016/2017
2017/2018
2018/2019

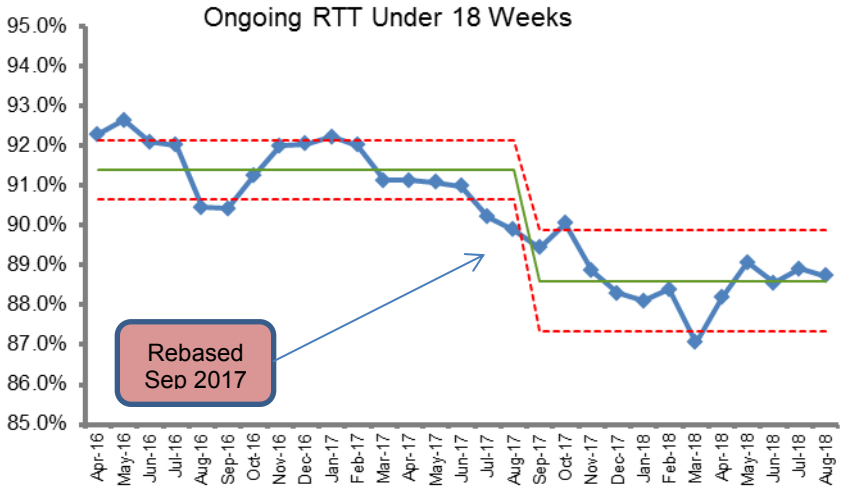

Percentage of Emergency BRI Spells - Patients Aged 75yrs and Over
40%
35%
30%
25%
20%
15%
10%
5%
0%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2016/2017
2017/2018
2018/2019

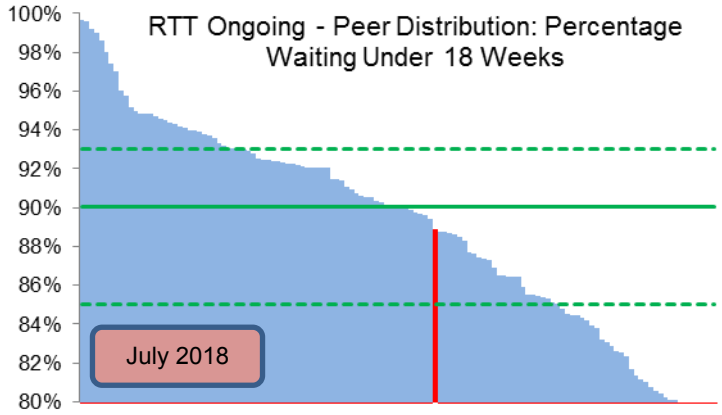

Emergency Inpatient Activity (BRI Discharges)
4,000
3,500
3,000
2,500
2,000
1,500
1,000
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2016/2017
2017/2018
2018/2019


Percentage of ED Attendances Resulting in Admission
35%
30%
25%
20%
15%
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar
2016/2017
2017/2018
2018/2019

2.3 PERFORMANCE – Responsive Domain

Referral to Treatment (RTT)	
Standards:	At each month-end, the Trust reports the number of patients on an ongoing RTT pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. The Trust's improvement trajectory has been set at 88.5% for end of July. In addition, no-one should be waiting 52 weeks or over.
Performance:	At end of August, 88.73% of patients were waiting under 18 week (25,890 out of 29,180 patients). 7 patients were waiting 52+ weeks
Commentary:	The 92% national standard was not met at the end of August; however, this was above the recovery trajectory target of 88.70%. September is on track to deliver the 88.5% recovery trajectory. There were 7 patients waiting 52+ weeks at end of August due to patients exercising choice.
Ownership:	Chief Operating Officer



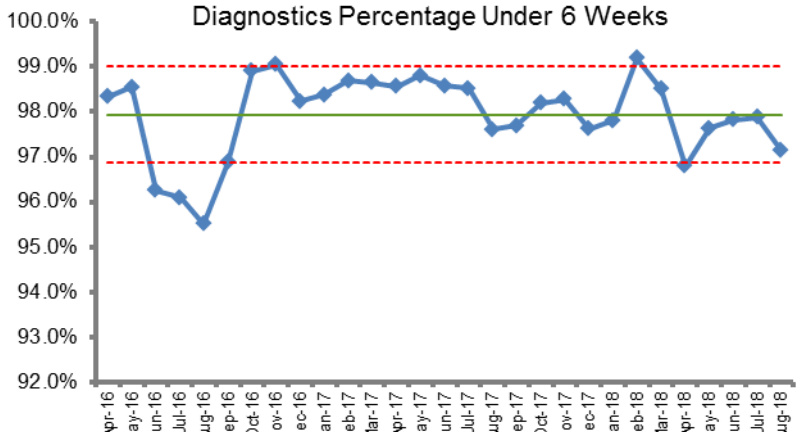


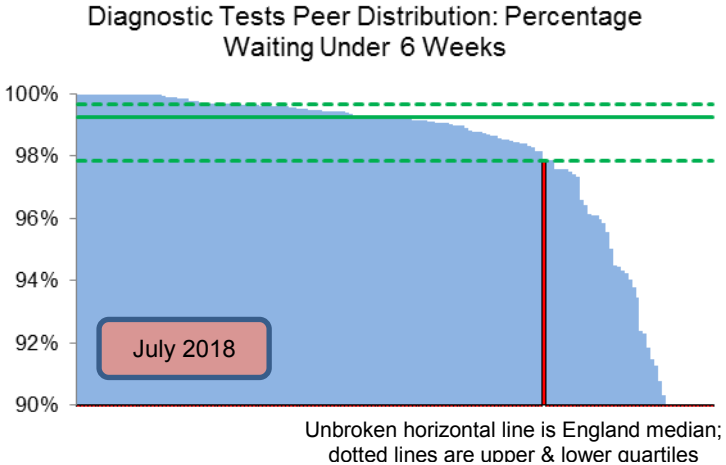
Ongoing Pathways at Aug-18

RTT CCG Specialty	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,114	326	84.6%
Cardiothoracic Surgery	300	58	80.7%
Dermatology	2,554	189	92.6%
ENT	2,166	71	96.7%
Gastroenterology	834	6	99.3%
General Medicine	6	0	100.0%
Geriatric Medicine	56	0	100.0%
Gynaecology	1,270	132	89.6%
Neurology	326	100	69.3%
Ophthalmology	4,162	364	91.3%
Oral Surgery	2,744	373	86.4%
Other (Clinical Genetics)	1,215	186	84.7%
Other (Dental)	1,825	121	93.4%
Other (General Surgery)	1,459	243	83.3%
Other (Haem/Onc)	181	4	97.8%
Other (Medicine)	658	31	95.3%
Other (Other)	355	2	99.4%
Other (Paediatric)	4,950	931	81.2%
Other (Pain Relief)	132	1	99.2%
Other (Thoracic Surgery)	84	7	91.7%
Rheumatology	520	43	91.7%
Thoracic Medicine	387	7	98.2%
Trauma & Orthopaedics	881	95	89.2%
Urology	1	0	100.0%
Grand Total	29,180	3,290	88.7%

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

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. The Trust's improvement trajectory was set at no more than 140 breaches at end of July, which would equate to performance of approximately 98% (depending on total list size).
Performance:	At end of August, 97.1% of patients were waiting under 6 weeks (7,795 out of 8,025 patients). There were 230 breaches of the 6-week standard.
Commentary:	The Trust did not achieve the 99% national standard at end of August and was 150 patients above the maximum number needed to achieve 99% The areas carrying the largest volume of breaches are Paediatric MRI (33 breaches) and Echocardiography (161 breaches).
Ownership:	Chief Operating Officer





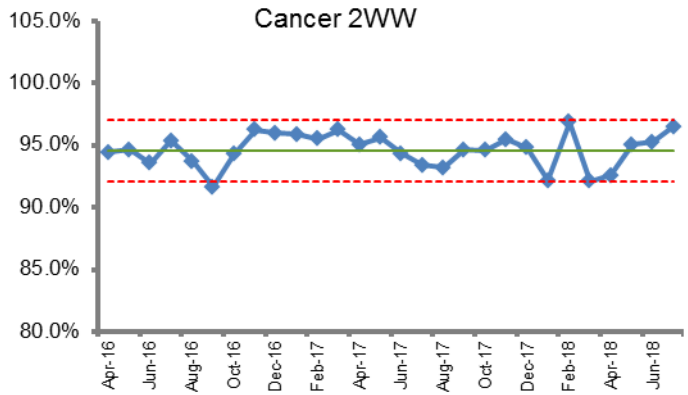
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

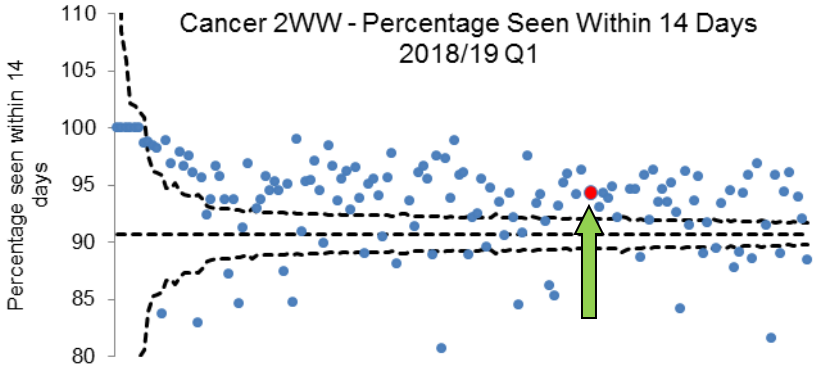
Diagnostic Tests Waiting List at Aug-18

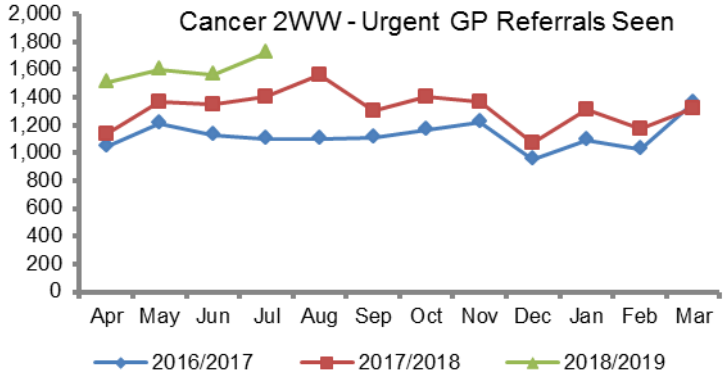
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	903	0	903	100.0%
Colonoscopy	157	23	180	87.2%
CT	798	0	798	100.0%
Cystoscopy	3	3	6	50.0%
DEXA Scan	331	0	331	100.0%
Echocardiography	822	161	983	83.6%
Flexi Sigmoidoscopy	46	1	47	97.9%
Gastroscopy	172	3	175	98.3%
MRI	1,736	34	1,770	98.1%
Neurophysiology	203	0	203	100.0%
Sleep Studies	113	4	117	96.6%
Ultrasound	2,511	1	2,512	100.0%
Grand Total	**7,795**	**230**	**8,025**	**97.1%**

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 July, 96.5% of patients were seen within 2 weeks (1657 out of 1717 patients). Quarter 1 overall achieved 94.3%. Both the month and quarter-have achieved the national standard of 93%.
Commentary:	The standard was achieved in quarter 1 2018/19 and is on track to be achieved in quarter 2.
Ownership:	Chief Operating Officer



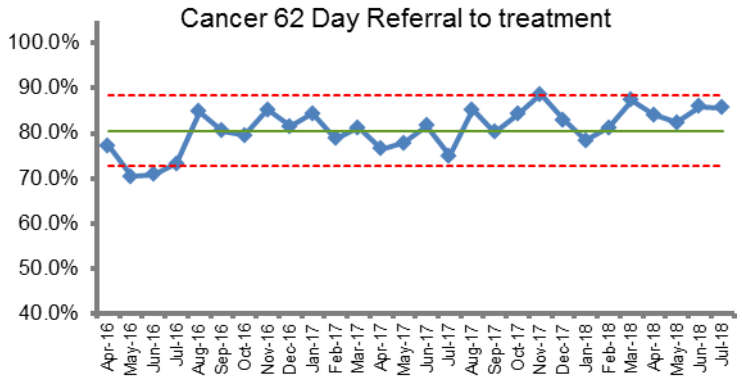


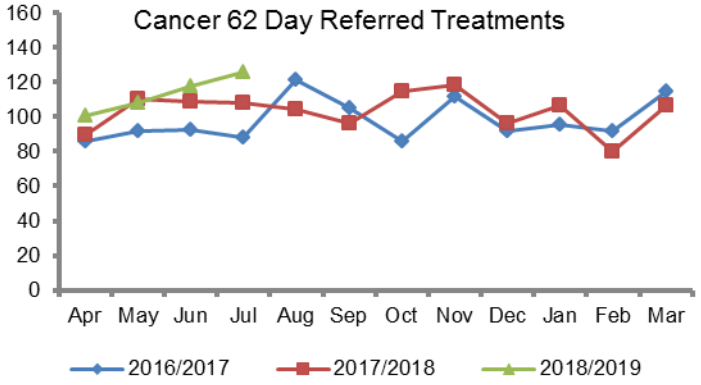


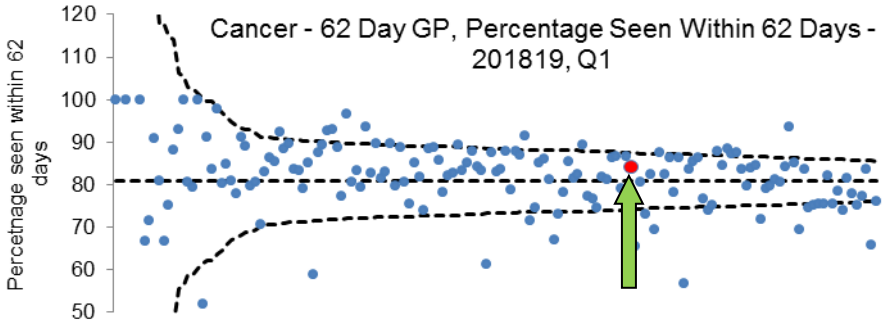
	Cancer 2WW - Jul-18		
Cancer Site	Under 2 Weeks	Total Pathways	Percentage
Other suspected cancer	1	1	100.0%
Suspected children's cancer	24	26	92.3%
Suspected gynaecological cancers	91	98	92.9%
Suspected haematological malignancies excluding ac	15	16	93.8%
Suspected head and neck cancers	345	352	98.0%
Suspected lower gastrointestinal cancers	174	178	97.8%
Suspected lung cancer	29	29	100.0%
Suspected skin cancers	892	928	96.1%
Suspected upper gastrointestinal cancers	86	89	96.6%
Grand Total	1,657	1,717	96.5%

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%. The improvement trajectory is 83% for May and 82.5% for Quarter 1.
Performance:	For July, 85.7% of patients were seen within 62 days (107.5 out of 125.5 patients). Quarter 1-finished at 84.2%.
Commentary:	The national standard was achieved in June and July and is on track to be achieved in August, September and the quarter.
Ownership:	Chief Operating Officer

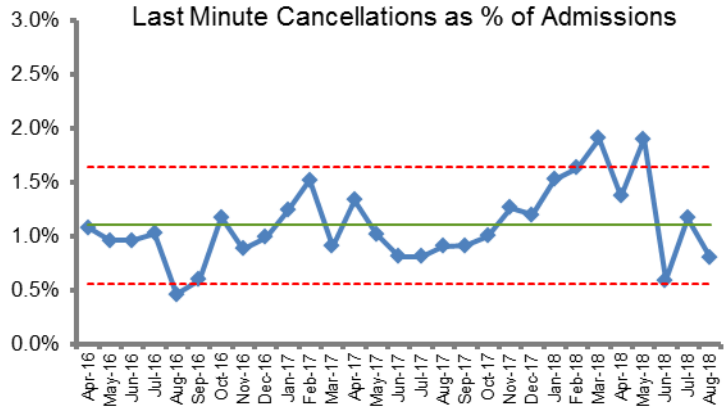


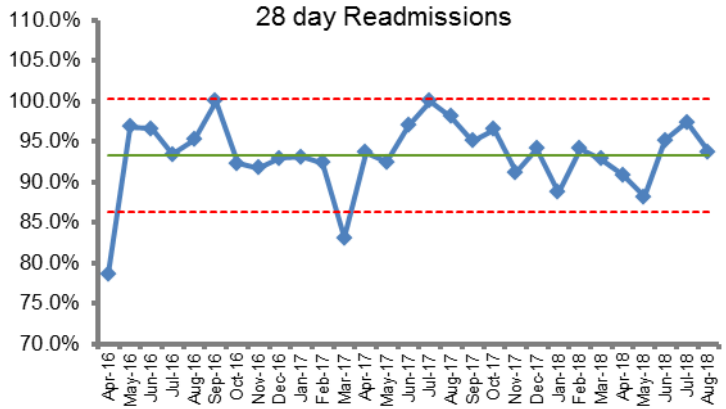


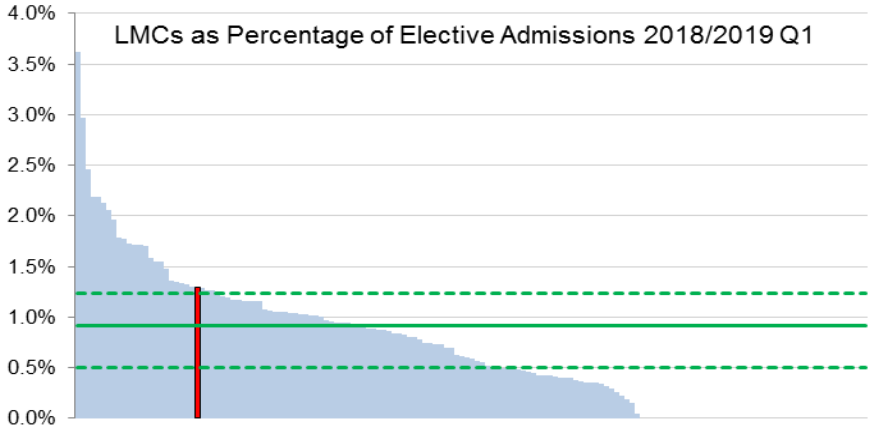


	Cancer 62 Day - Jul-18		
Cancer Site	First Treatment - Within Target	First Treatment - Total	First Treatment - Performance
Acute leukaemia	1.0	1.0	100.0%
Breast	2.5	2.5	100.0%
Gynaecological	5.0	7.5	66.7%
Haematological	4.5	5.5	81.8%
Head and Neck	9.5	12.0	79.2%
Lower Gastrointestinal	6.0	8.0	75.0%
Lung	13.0	18.5	70.3%
Sarcoma	2.5	2.5	100.0%
Skin	57.0	58.5	97.4%
Upper Gastrointestinal	6.0	7.0	85.7%
Urological	0.5	1.5	33.3%
Grand Total	107.5	125.5	85.7%

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 August there were 55 last minute cancellations, which was 0.8% of elective admissions. Of the 80 cancelled in July, 75 (93.8%) had been re-admitted within 28 days.
Commentary:	August saw a reduction in the number of last minute cancellations, compared to July. There were 11 in General Surgery and 9 in Ophthalmology The most common reason was "Other Emergency Patient Prioritised" (9 cancellations). Five of July's last minute cancellation patients were not re-admitted within 28 days, so the 95% was not achieved
Ownership:	Chief Operating Officer





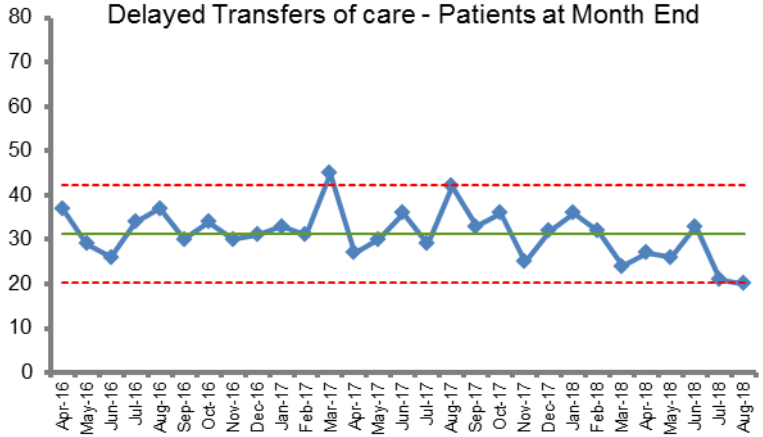


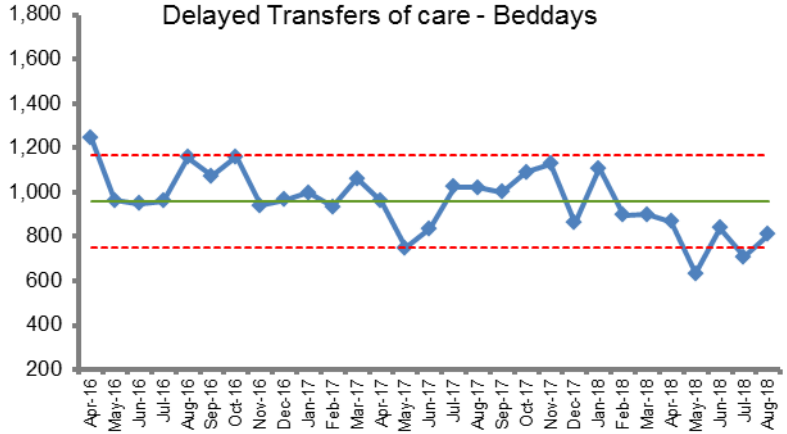
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

Cancellation Reason	Total
Other Emergency Patient Prioritised	9
Surgeon Unavailable	8
Equipment Failure	8
AM list over-ran	5
Theatre Repairs required	5
Surgeon Taken Ill	4
Booking Error	3
Other clinically complicated Patient in theatre	3
Anaesthetist Unavailable	2
List Overbooked	2
No Lab Staff	2
List did not start on time	1
No Theatre Staff	1
No Beds Available	1
PAS-only Error	1
Grand Total	**55**

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 August there were 20 Delayed Transfer of Care patients as at month-end, and 811 beddays consumed by DToC patients,
Commentary:	There were 9 DToCs at South Bristol Hospital and 11 in the Bristol Royal Infirmary. 284 of the beddays were on A528 and A605.
Ownership:	Chief Operating Officer





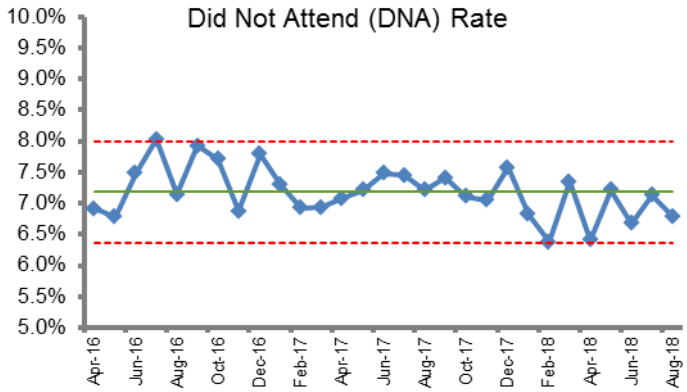
Month	Aug-18					
National DTOC Code	National DTOC Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	1	19	0	8
		NHS	0	18	0	19
		Social Care	1	125	2	62
C	Further non acute NHS Care	NHS	1	31	0	0
Di	Care Home Placement	NHS	0	6	0	1
		Social Care	2	72	1	27
Dii	Care Home Placement	NHS	3	47	1	12
		Social Care	1	50	0	3
E	Care package in own home	NHS	0	46	1	16
		Social Care	2	106	2	33
F	Community equipment / adaptions	NHS	0	8	0	0
		Social Care	0	19	1	9
G	Patient or family choice	NHS	0	31	1	35
H	Disputes	NHS	0	6	0	0
		Social Care	0	1	0	0
I	Housing - patient not covered by NH	NHS	0	1	0	0
Grand Total			11	586	9	225

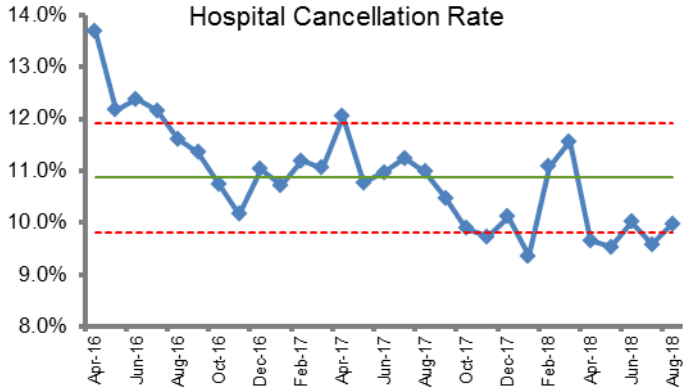
Length of Stay of Inpatients at month-end

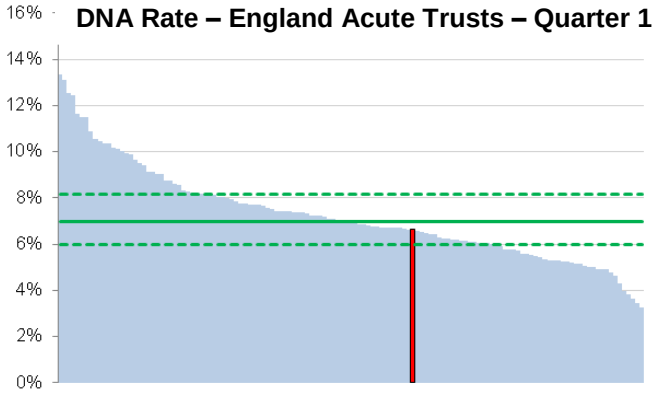
Aug-18	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	57	33	29	23
Bristol Haematology & Oncology Centre	24	11	8	4
Bristol Royal Infirmary	194	107	62	45
South Bristol Hospital	59	49	41	29
St Michael's Hospital	21	11	10	10
TRUST TOTAL	357	211	150	111
Bristol Royal Infirmary Divisional Breakdown:				
Medicine	109	66	42	31
Specialised Services	37	15	9	5
Surgery, Head & Neck	48	26	11	9

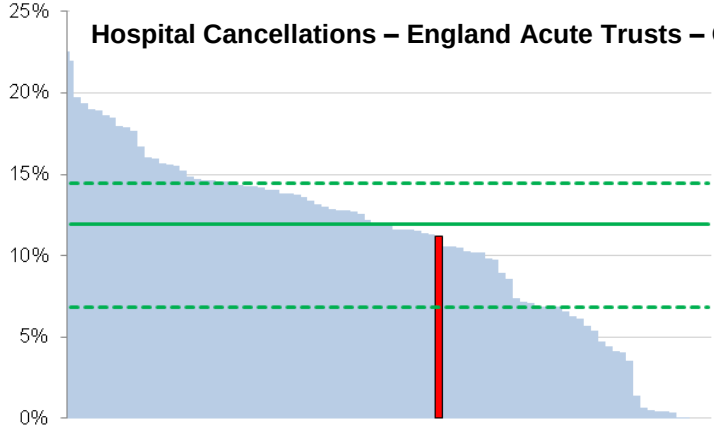
2.3 PERFORMANCE – Responsive Domain

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 August there were 8820 hospital-cancelled appointments, which was 10.0% of all appointments made. There were 4313 appointments that were DNA'ed, which was 6.8% of all planned attendances.
Commentary:	Speciality level DNA targets reviewed monthly at Outpatient Steering Group (OSG). The need to manage GP referrals through e-RS and setting polling ranges to match waiting times may impact on hospital cancellations.
Ownership:	Chief Operating Officer









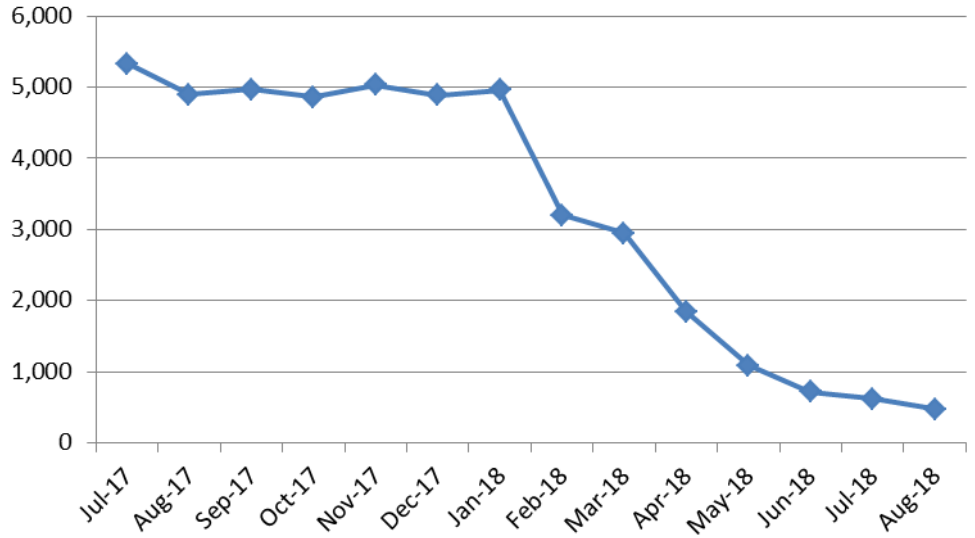
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

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 August, number overdue by 12+ months has fallen to 476.
Commentary:	Significant progress has been made by the divisions, through regular weekly review at the Wednesday performance meeting..
Ownership:	Chief Operating Officer

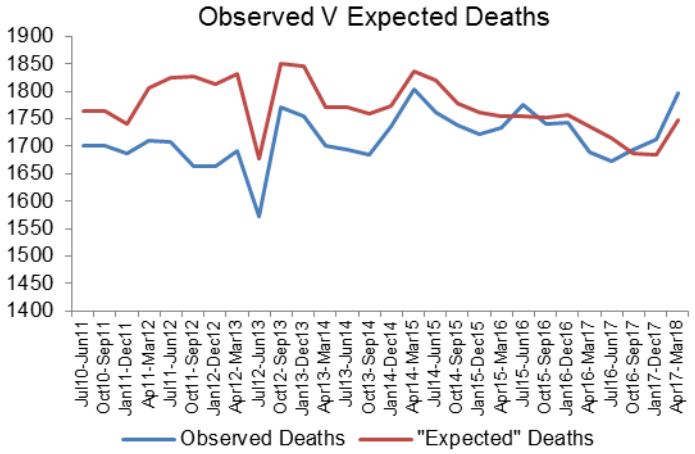
Number of Outpatients Overdue by 12+ Months as at Month End

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Diagnostics and Therapies	0	0	0	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	23	5	7
Specialised Services	563	432	442	295	353	387	400	367	383	188	206	214	208	95
Surgery	1,200	1,058	1,015	934	947	922	887	717	573	444	221	92	17	3
Women's and Children's	2,451	2,364	2,400	2,381	2,398	2,299	2,330	868	888	756	526	387	387	371
TRUST TOTAL	**5,327**	**4,899**	**4,968**	**4,862**	**5,034**	**4,884**	**4,962**	**3,197**	**2,949**	**1,849**	**1,086**	**716**	**617**	**476**

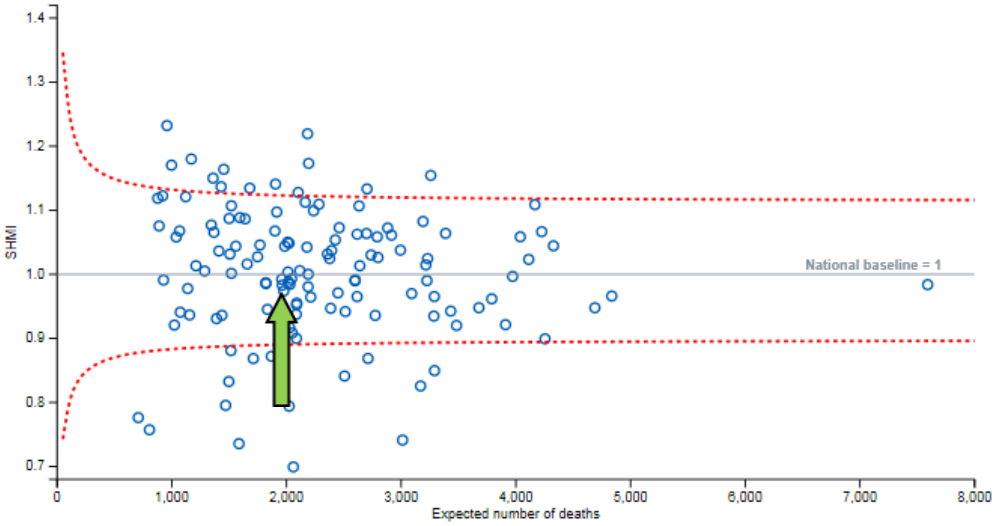


Mortality - Summary Hospital Mortality Indicator (SHMI)	
Standards:	This is the national measure published by NHS Digital .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Summary Hospital Mortality Indicator (SHMI) covers deaths in-hospital and deaths within 30 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 April 2017 to March-2018. The SHMI was 102.7 (1796 deaths and 1748 "expected").
Commentary:	Although the Trust SHMI is 102.7 but is still in the "SHMI As Expected" category and statistically there are insufficient data points to determine any trend. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

Timeframe	Banding	Observed Deaths	"Expected" Deaths	SHMI
Jul15-Jun16	As Expected	1775	1754.3478	101.18
Oct15-Sep16	As Expected	1741	1752.0551	99.37
Jan16-Dec16	As Expected	1743	1758.3667	99.13
Apr16-Mar17	As Expected	1690	1736.8023	97.31
Jul16-Jun17	As Expected	1674	1714.451	97.64
Oct16-Sep17	As Expected	1693	1686.2059	100.40
Jan17-Dec17	As Expected	1712	1683.682	101.68
Apr17-Mar18	As Expected	1796	1748.1723	102.74

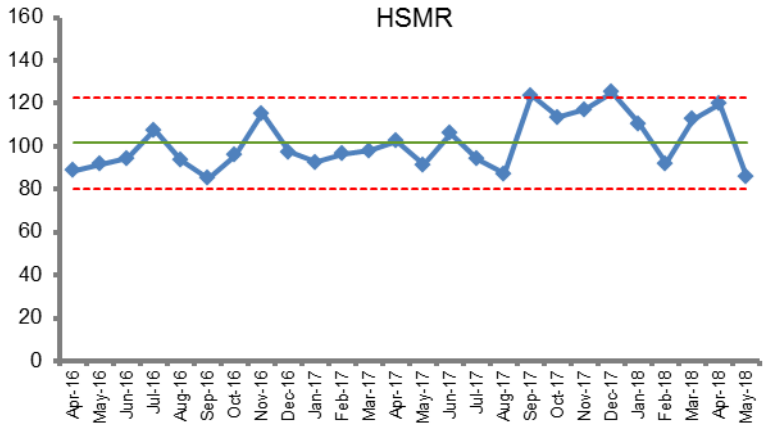


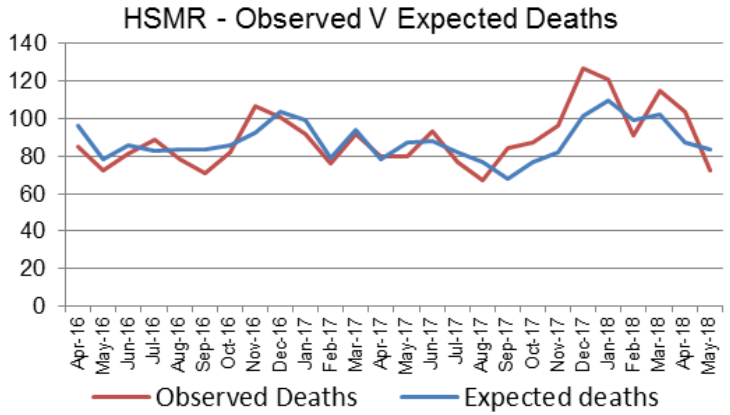
April 2017 to March 2018



2.4 PERFORMANCE – Effective Domain

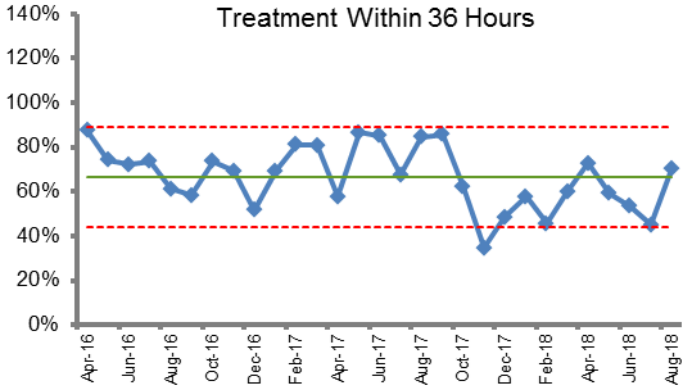
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for May 2018. The HSMR was 85.8 (72 deaths and 84 "expected")
Commentary:	The 12 month rolling HSMR to May 2018 has reverted to below 100 at 85.8 which is close to the lower control limit of 80. Mortality alerts and outliers continue to be monitored through the Quality Intelligence Group, chaired by the Medical Director.
Ownership:	Medical Director

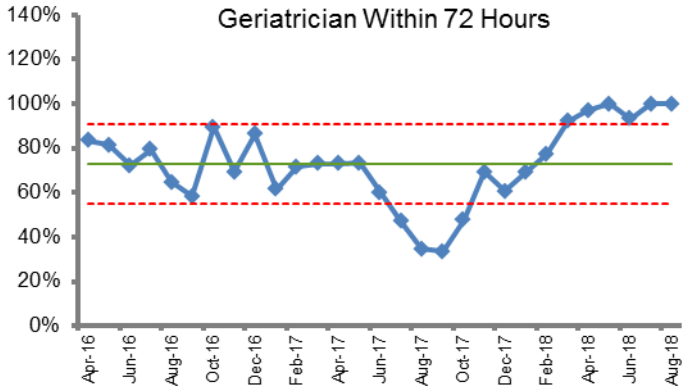


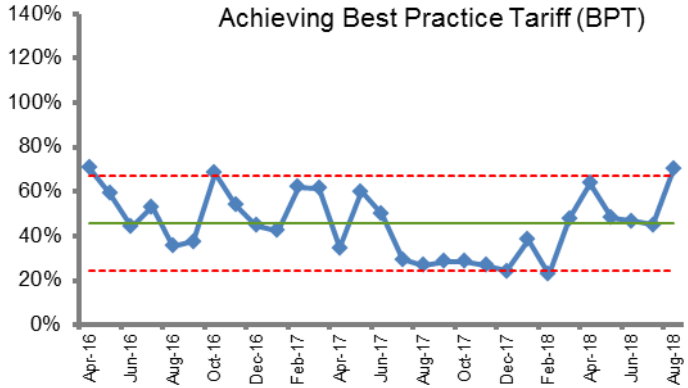


2.4 PERFORMANCE – Effective Domain

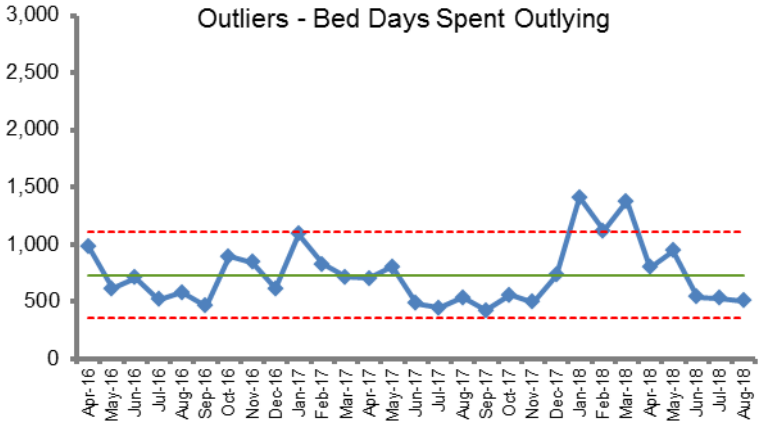
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	Latest data is August, where 20 Fracture NOF patients were admitted. For the 36 hour target, 65% were seen with target. For the 72 hour target, 100% were seen within target 13 patients (65%) achieved all elements of the Best Practice Tariff.
Commentary:	In August, there were 22 patients discharged following an admission for fracture neck of femur, and 20 of them were eligible for Best Practice Tariff. Six of these patients were not operated on in theatre within the required 36 hours. One patient was also not reviewed by a Physiotherapist on the day of or the day after surgery. Therefore 6 patients did not qualify for BPT. Further details are provided below: The list below outlines the details of the 6 patients who were not treated in theatre within 36 hours: • One patient experienced a delay in diagnosing their injury, • Four patients were not operated on within the 36 hour timeframe due to other urgent trauma cases being prioritised, • One patient was not medically fit to have their surgery within the required timeframe The one patient that was not reviewed by a Physiotherapist was due not the fact that we do not currently run a Sunday service.
Ownership:	Medical Director

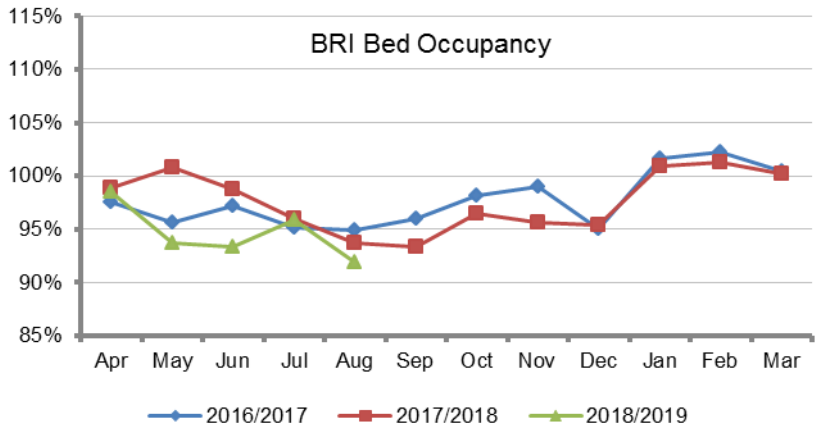


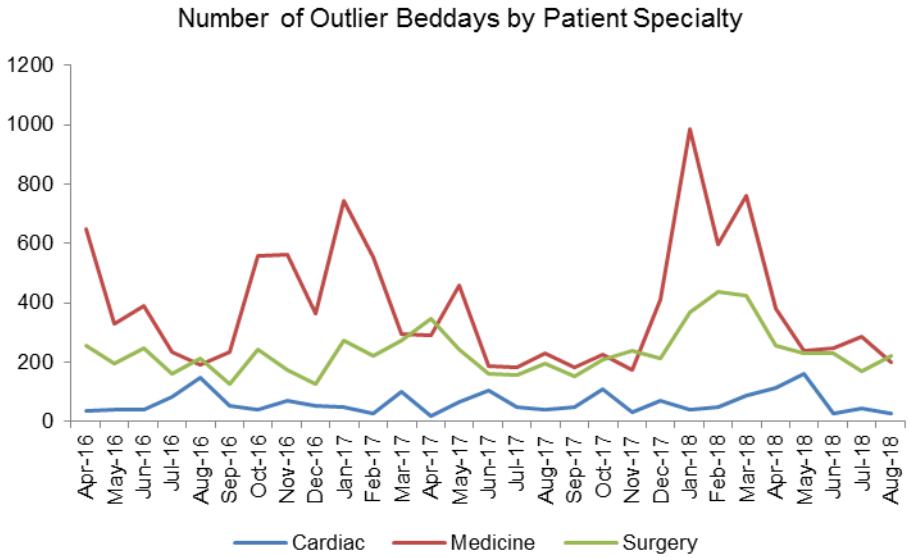




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In August there were 507 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary:	The August target of no more than 563 beddays was achieved. Of all the outlying beddays 202 were Medicine patients, 59 were Specialised Services patients and 227 were Surgery patients. There were only 39 beddays spent outlying overnight on escalation wards.
Ownership:	Chief Operating Officer

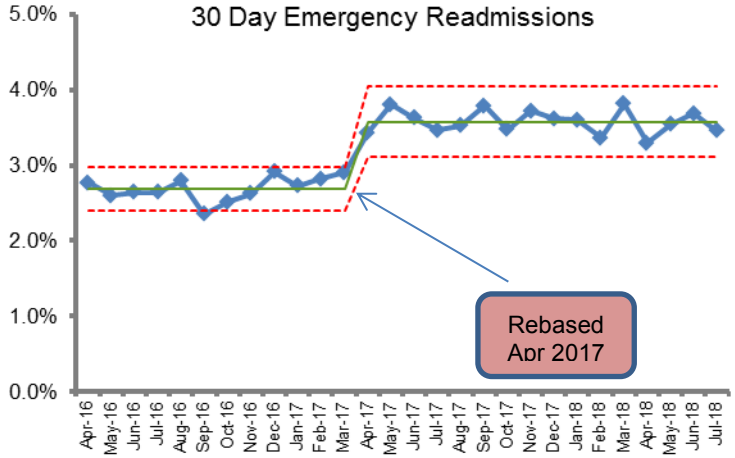






2.4 PERFORMANCE – Effective Domain

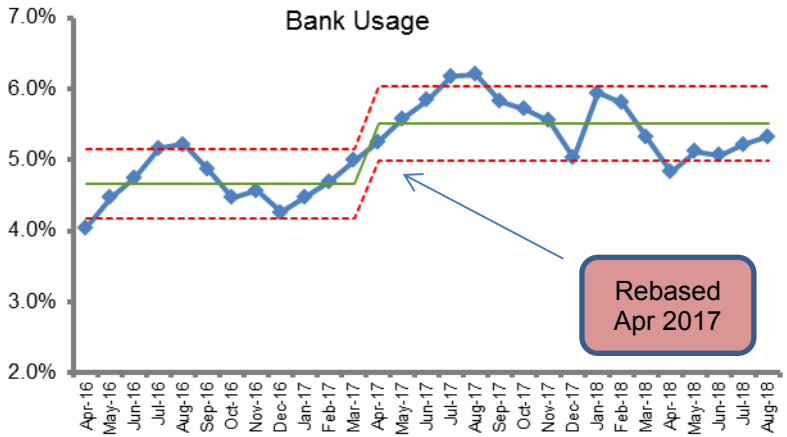
30 Day Emergency Readmissions	
Standards:	This reports on patients who are re-admitted as an emergency to the Trust within 30 days of being discharged. This can be in an unrelated specialty; it purely looks to see if there was a readmission. This uses Payment By Results (PbR) rules, which excludes certain pathways such as Cancer and Maternity. The target for the Trust is to remain below 2017/18 total of 3.62%, with a 10% amber tolerance down to 3.26%.
Performance:	In July, there were 12839 discharges, of which 444 (3.46%) had an emergency re-admission within 30 days.
Commentary:	9% of Medicine division discharges were re-admitted within 30 days as an emergency, 4% from Surgery and 1.3% from Specialised Services.
Ownership:	Chief Operating Officer

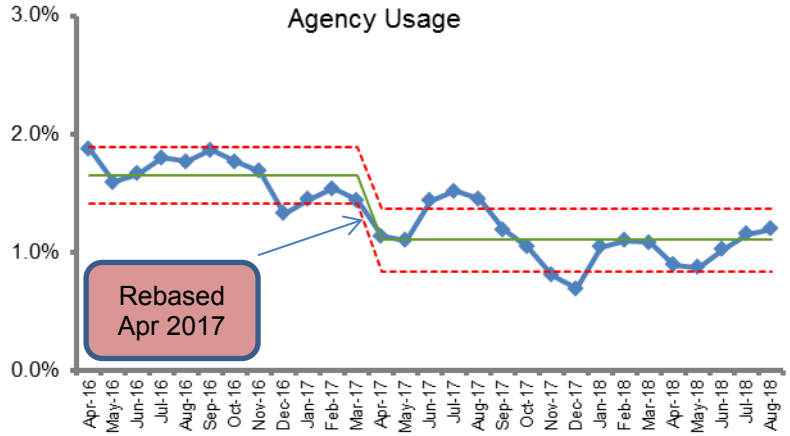


Discharges in July 2018

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	3	32	9.38%
Medicine	223	2,442	9.13%
Specialised Services	36	2,681	1.34%
Surgery	141	3,551	3.97%
Women's and Children's	39	4,126	0.95%
TRUST TOTAL	**444**	**12,839**	**3.46%**

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 August, total staffing was at 8736 FTE. Of this, 5.3% was Bank (465 FTE) and 1.2% was Agency (104.6 FTE)
Commentary:	**Agency usage** increased by 5.2 FTE, with the largest increase seen in Specialised Services with 18.1 FTE compared to 13.8 FTE in the previous month. The largest reduction was seen in Women's and Children's, decreasing to 25.9 FTE from 27.6 FTE the previous month. The largest staff group increase was within Health Professionals increasing to 15.8 FTE from 9.5 FTE in the previous month. **Bank usage** increased by 16.3 FTE, with the largest increase seen in Trust Services; 35.7 FTE compared to 28.3 FTE in the previous month. The largest reduction was seen in Specialised Services, decreasing to 68.9 FTE from 74.8 FTE the previous month. The largest staff group increase was within Admin & Clerical increasing to 101.4 FTE from 89.6 FTE in the previous month.
Ownership:	Director of People



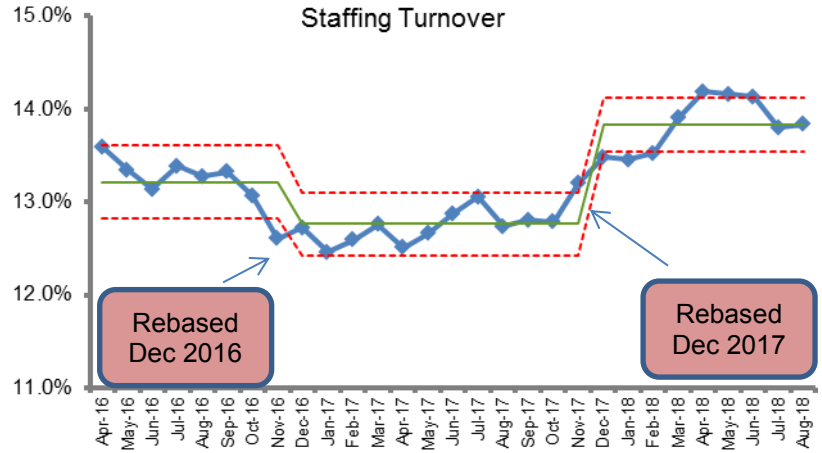


Bank	FTE	Actual %	KPI
UHBristol NHS Foundation Trust	**449.15**	**5.3%**	**4.3%**
Diagnostics & Therapies	12.7	1.3%	1.7%
Facilities and Estates	47.9	7.1%	6.5%
Medicine	133.2	10.6%	11.1%
Specialised Services	74.8	6.7%	5.5%
Surgery	86.3	5.0%	2.4%
Trust Services	28.3	4.2%	3.1%
Women's & Children's	66.0	3.3%	1.6%

Agency	FTE	Actual %	KPI
UHBristol NHS Foundation Trust	**99.4**	**1.2%**	**0.9%**
Diagnostics & Therapies	3.7	0.6%	1.4%
Facilities and Estates	1.8	0.3%	0.7%
Medicine	31.6	2.3%	1.6%
Specialised Services	13.8	1.8%	0.9%
Surgery	16.4	0.88%	0.77%
Trust Services	4.6	0.7%	0.4%
Women's & Children's	27.6	1.3%	0.6%

2.5 PERFORMANCE – Efficient Domain

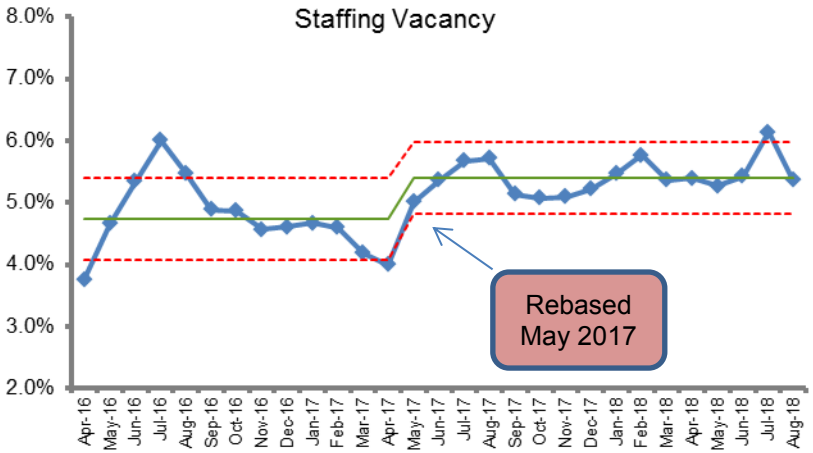
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In August, there had been 963 leavers over the previous 12 months with 6978 FTE staff in post on average over that period; giving a Turnover of 963 / 6978 = 13.8%
Commentary:	Turnover increased to 13.80% from 13.79% last month, with decreases across three divisions – Diagnostics and Therapies, Specialised Services, and Surgery. The largest divisional reduction was seen within Diagnostics and Therapies reducing to 10.6% from 11.0% the previous month. The largest divisional increase was seen within Medicine increasing to 15.1% from 14.6% the previous month. The biggest reduction in staff group was seen within Add Prof Scientific and Technic (0.7 percentage points). The largest increase in staff group was seen within Additional Clinical Services (0.7 percentage points).
Ownership:	Director of People



Turnover	Aug-18	KPI
UH Bristol NHS Foundation Trust	**13.8%**	**13.2%**
Diagnostics & Therapies	10.6%	*11.7%*
Facilities & Estates	18.1%	*17.0%*
Medicine	15.1%	*14.3%*
Specialised Services	15.0%	*14.4%*
Surgery	13.6%	*12.4%*
Trust Services	15.2%	*14.9%*
Women's & Children's	12.2%	*11.2%*

2.5 PERFORMANCE – Efficient Domain

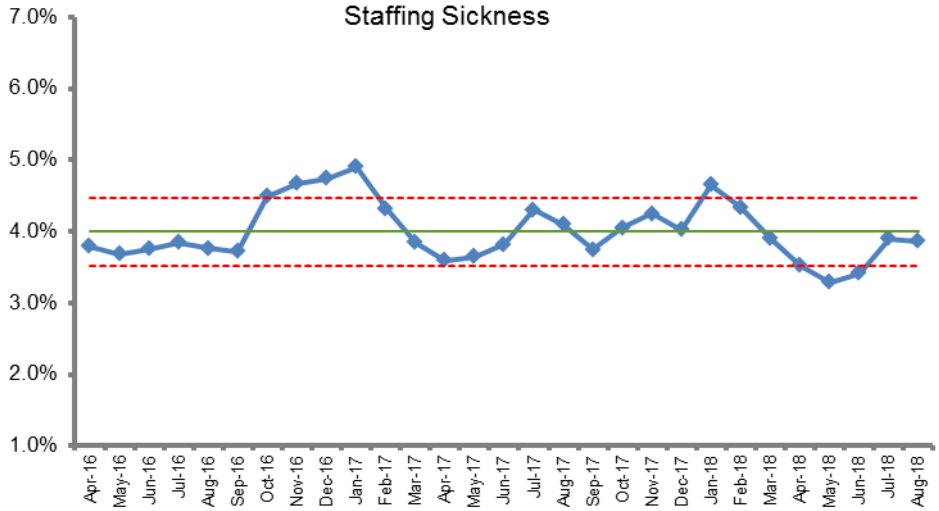
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In August, funded establishment was 8629, with 462 as vacancies (5.4%).
Commentary:	Overall vacancies reduced to 5.4% compared to 6.1% in the previous month. There were reductions in all but one staff group (Allied Health / Scientific Professions). Trust Services had the largest Divisional reduction to 18.6 FTE from 40.6 FTE the previous month. The overall Medical staff group vacancy position reduced to -12.9 FTE from 23.5 FTE the previous month meaning it is now over established. The biggest Divisional reduction in this staff group was seen within Women's and Children's where Medical vacancies reduced to -23.6 FTE from -12.5 FTE the previous month.
Ownership:	Director of People



Vacancy	Aug-18	KPI
UHBristol NHS Foundation Trust	**5.4%**	**5.0%**
Diagnostics & Therapies	4.8%	5.0%
Medicine	6.5%	5.0%
Specialised Services	6.5%	5.0%
Surgery	6.0%	5.0%
Women's & Children's	3.1%	5.0%
Trust Services	2.3%	5.0%
Facilities & Estates	10.0%	5.0%

2.5 PERFORMANCE – Efficient Domain

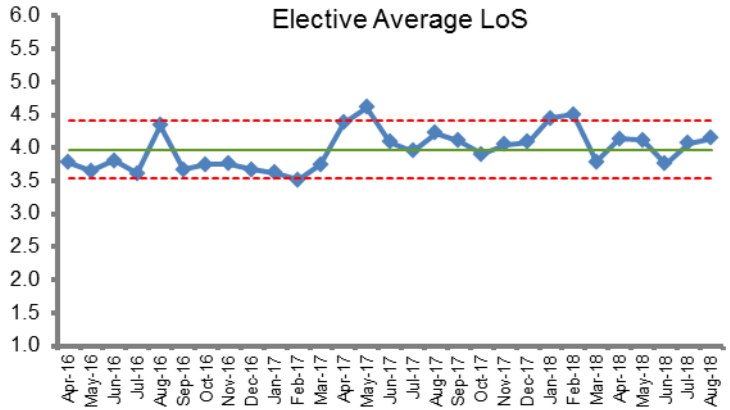
Staff Sickness	
Standards:	Staff sickness is measured as a percentage of available Full Time Equivalents (FTEs) absent, based on aggregated Divisional targets for 2018/19. The red threshold is 0.5% over the monthly target.
Performance:	In August, total available FTE days were 252154 of which 9730 (3.9%) were lost to staff sickness
Commentary:	Sickness absence reduced from 3.90% to 3.86%, with reductions in four divisions. The largest divisional reduction was seen in Women's and Children's reducing to 3.7% from 4.0% the previous month, Facilities and Estates saw the largest increase to 6.5% from 6.1% the previous month. The largest staff group increase was seen in Estates and Ancillary, rising to 6.8% from 6.1% the previous month. The largest staff group reduction was seen within Nursing and Midwifery Unregistered reducing to 7.0% from 7.8% the previous month. Stress/Anxiety continues to be the cause for the most of amount of sickness days lost, this increased by 3.6% compared with last month. Other Musculoskeletal Problems are the second highest cause of sickness and this reason increased by 9.2% compared with last month. The third highest reason, Gastrointestinal problems reduced by 12.0% compared to the previous month.
Ownership:	Director of People

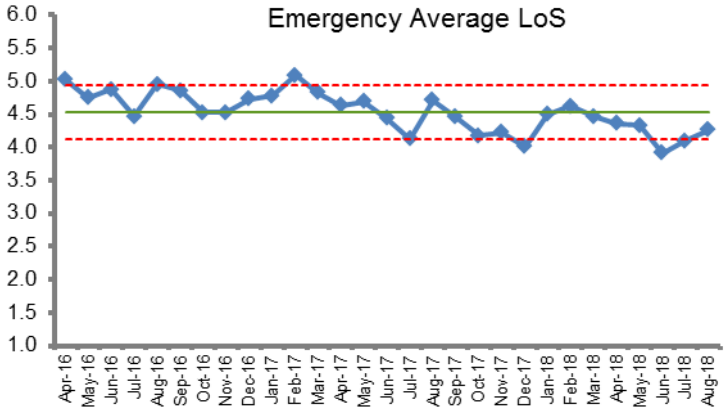


Staff Sickness	Aug-18	KPI
UH Bristol NHS Foundation Trust	**3.86%**	**3.89%**
Diagnostic & Therapies	2.7%	3.0%
Facilities & Estates	6.5%	6.4%
Medicine	4.8%	5.0%
Specialised Services	3.3%	3.5%
Surgery	3.8%	3.6%
Trust Services (exc Facilities & Estates)	2.723%	2.721%
Women's & Children's	3.7%	3.6%

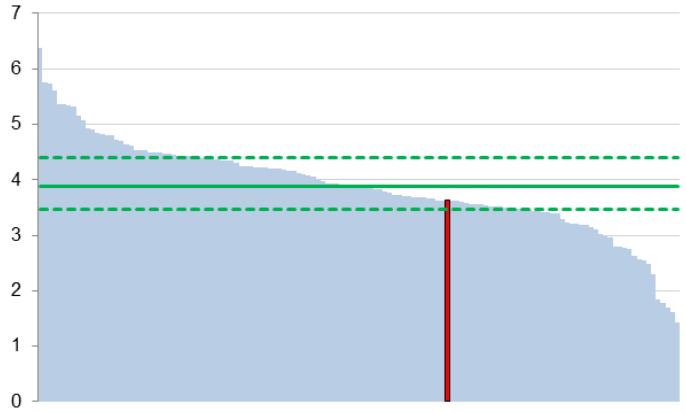
2.5 PERFORMANCE – Efficient Domain

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 August there were 6371 discharges that consumed 24,999 beddays, giving an overall average length of stay of 3.92 days.
Ownership:	Chief Operating Officer

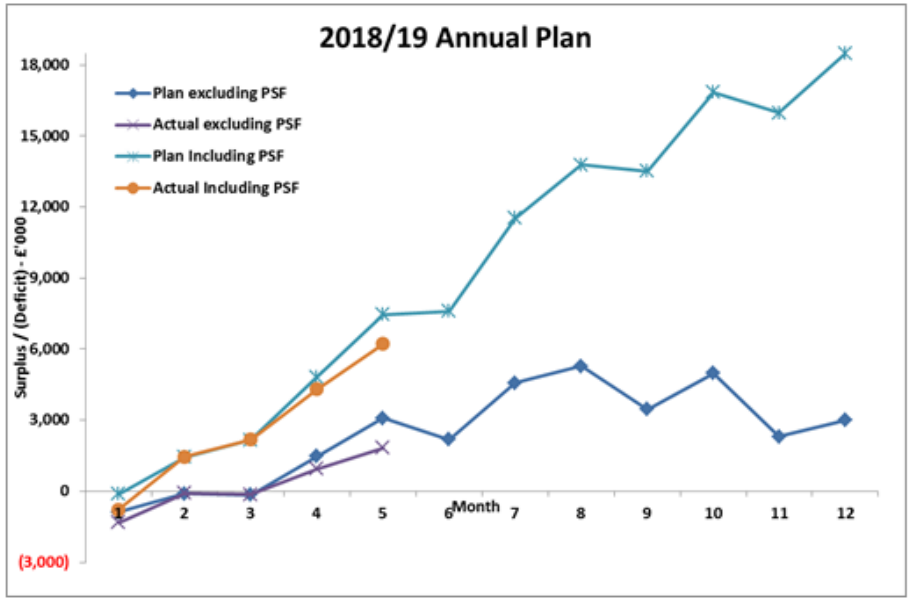


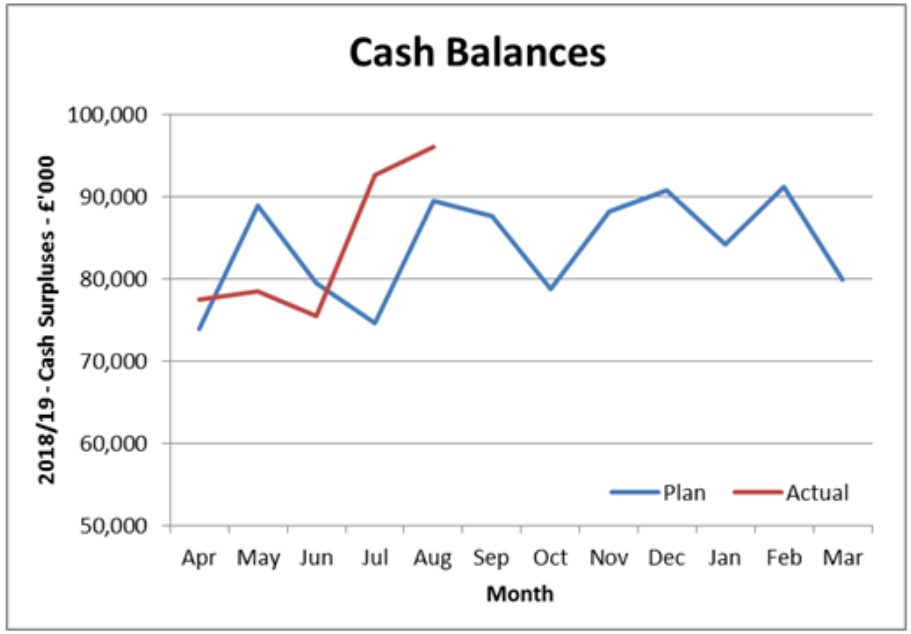


Average Length of Stay – England Acute Trusts – 2018/19 Quarter 1



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

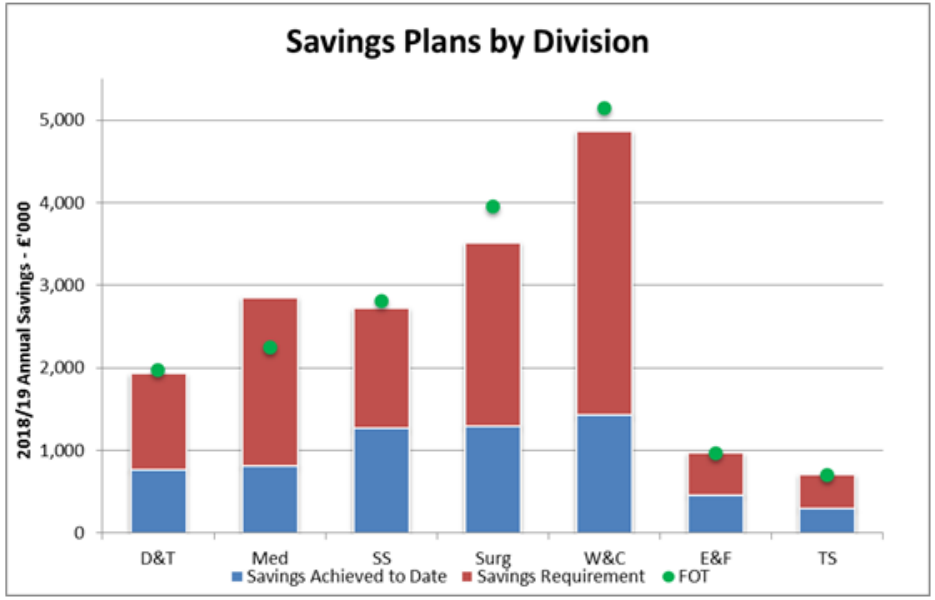




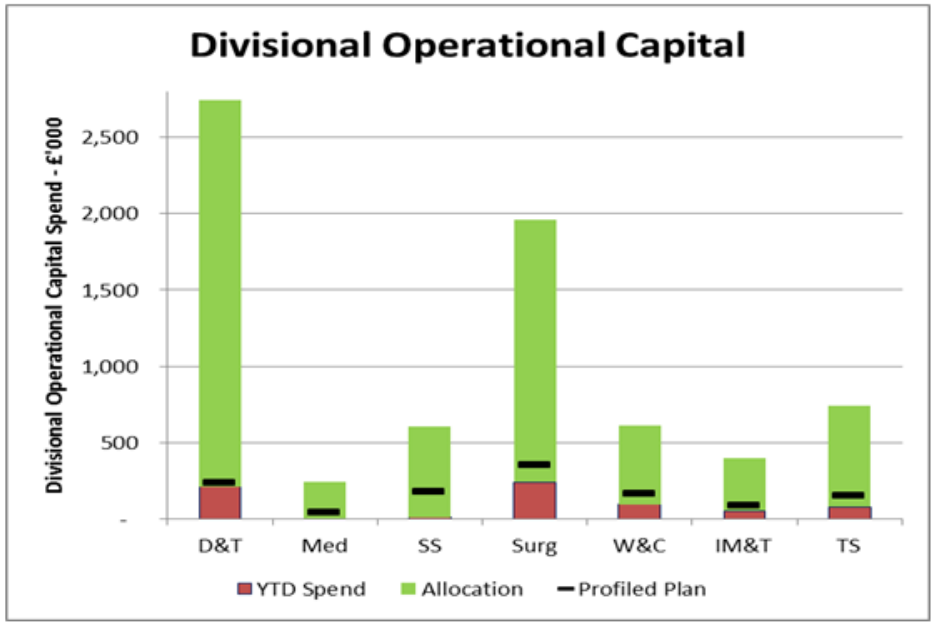
Actual Spend - £'000							
Agency	In Month					Plan for Year	Straight Line Projection
	Apr	May	Jun	Jul	Aug		
Nursing & Midwifery	448	443	515	549	618	**3,277**	**6,175**
Medical							
Consultants	17	25	14	71	61	**184**	**451**
Other Medical	17	35	54	71	24	**276**	**482**
Other	31	85	73	126	188	**1,701**	**1,207**
Total	**513**	**588**	**656**	**817**	**891**	**5,438**	**8,316**

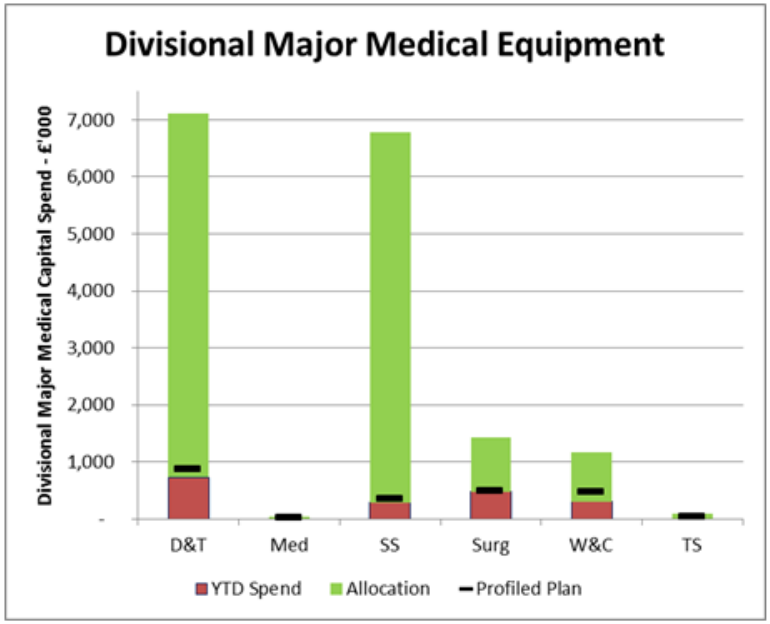
YTD Variance to Budget Surplus/(Deficit) - £'000					
Division	Apr	May	Jun	Jul	Aug
Diagnostics & Therapies	12	71	156	161	160
Medicine	(72)	(145)	(449)	(844)	(1,285)
Specialised Services	(175)	65	335	275	204
Surgery	(75)	(191)	(651)	(995)	(1,436)
Women's & Children's	(145)	(332)	(78)	(121)	(617)
Estates & facilities	3	(6)	(18)	16	28
Trust Services	(8)	(10)	(18)	(18)	(36)
Other Corporate Services	18	127	152	246	162
Total	**(442)**	**(421)**	**(571)**	**(1,280)**	**(2,820)**

Variance to Budget Surplus/(Deficit) - £'000						
Subjective Heading	In Month					YTD
	Apr	May	Jun	Jul	Aug	Total
Nursing & Midwifery Pay	(256)	(329)	(430)	(338)	(288)	**(1,641)**
Medical & Dental Pay	(358)	(322)	(353)	(340)	(395)	**(1,768)**
Other Pay	128	74	126	260	80	**668**
Non Pay	2	(728)	(361)	(475)	(464)	**(2,026)**
Income from Operations	(69)	-	42	75	17	**65**
Income from Activities	111	1,327	825	109	(490)	**1,882**
Total	**(442)**	**22**	**(151)**	**(709)**	**(1,540)**	**(2,820)**



2018/19 Capital Programme			Year To Date		
Operational Plan	Subjective Heading	Internal Plan	Internal Plan	Actual spend	Variance (over) /under
£'000		£'000	£'000	£'000	£'000
	Sources of Funding				
1,600	PDC	1,600			
3,189	Loan	3,189			
3,000	Donations	3,000	714	629	(85)
	Cash:				
24,338	Depreciation	24,338	9,904	9,734	(170)
14,962	Cash balances	15,100	(2,509)	(3,302)	(793)
47,089	**Total Funding**	**47,227**	**8,109**	**7,061**	**(1,048)**
	Application/Expenditure				
(11,618)	Strategic Schemes	(10,565)	(294)	(125)	169
(17,620)	Medical Equipment	(17,697)	(2,230)	(1,836)	394
(16,415)	Operational Capital	(15,705)	(2,437)	(1,979)	458
(7,468)	Information Technology	(7,716)	(2,577)	(2,596)	(19)
(2,367)	Estates Replacement	(2,309)	(571)	(525)	46
(55,488)	**Gross Expenditure**	**(53,992)**	**(8,109)**	**(7,061)**	**1,048**
8,399	In-Year Slippage	23,992			
(47,089)	**Net Expenditure**	**(30,000)**	**(8,109)**	**(7,061)**	**1,048**

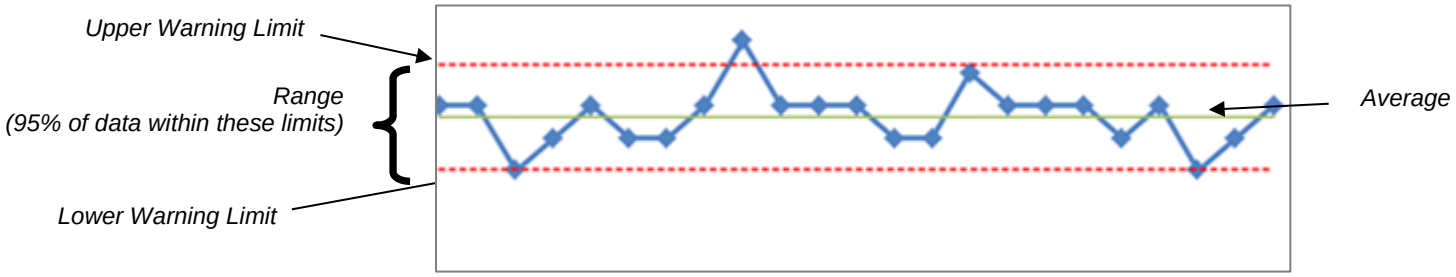




A1 APPENDIX 1 – Explanation of SPC Charts

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 Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	4	3	0	0	1	1	1	0	0	1	0	2	0	0	0	2	1	3
	DA02	MSSA Trust Apportioned Cases	25	17	0	5	4	1	2	3	3	3	5	4	2	3	3	10	8	12
	DA03	CDiff Trust Apportioned Cases	35	13	3	1	1	3	2	6	0	2	0	6	4	1	11	5	8	8
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	7	2	1	0	0	0	0	0	0	1	0	0	1	0	4	0	0	1
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	12	5	0	0	1	3	2	6	0	0	0	1	3	1	0	4	8	1
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97.6%	97.3%	96.3%	96.4%	97.6%	97.3%	98.4%	98.2%	96.9%	96.8%	97.8%	97.4%	97.7%	97.2%	97%	97.1%	97.8%	97.3%
	DB02	Antibiotic Compliance	86.4%	82.5%	84.4%	85.1%	89.1%	85.4%	85.2%	89.6%	85.3%	82.8%	81.3%	83%	84.6%	-	84.3%	86.4%	86.6%	82.5%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	97%	96%	96%	95%	98%	94%	95%	95%	96%	95%	95%	95%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	98%	98%	98%	98%	96%	97%	98%	97%	97%	98%	97%	97%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	97%	96%	97%	96%	93%	96%	96%	96%	95%	96%	96%	95%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	57	29	9	2	4	4	6	2	7	3	10	4	4	8	17	10	15	17
	S02a	Number of Confirmed Serious Incidents	53	13	9	2	3	4	6	2	6	3	10	-	-	-	17	9	14	13
	S02b	Number of Serious Incidents Still Open	-	16	-	-	-	-	-	-	-	-	-	4	4	8	-	-	-	4
	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%	96.6%	100%	100%	50%	100%	100%	100%	100%	100%	100%	100%	75%	100%	100%	80%	100%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.2%	96%	100%	100%	100%	100%	83.3%	100%	100%	100%	75%	100%	100%	100%	100%	100%	93.3%	92.9%
	S04a	Overdue Exec Commissioned Non-SI Investigations	19	9	2	1	1	3	3	1	1	2	2	1	2	2	4	5	5	5
Never Events	S01	Total Never Events	8	1	0	2	0	0	1	0	1	0	0	0	0	1	1	2	2	0
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	15656	7289	1229	1311	1332	1193	1347	1379	1480	1428	1311	1445	1566	1539	3766	3836	4206	4184
	S06b	Patient Safety Incidents Per 1000 Beddays	50.86	58.11	49.91	50.19	52.96	46.38	50.04	57.11	55.29	55.84	52.85	59.13	60.39	62.35	49.25	49.82	54.04	55.92
	S07	Number of Patient Safety Incidents - Severe Harm	92	37	7	4	9	9	10	7	7	6	13	10	5	3	20	22	24	29
Patient Falls	AB01	Falls Per 1,000 Beddays	4.59	4.29	5.04	4.48	3.78	4.51	4.61	4.68	5.04	3.79	4.27	3.72	4.4	5.27	4.77	4.26	4.78	3.93
	AB06a	Total Number of Patient Falls Resulting in Harm	25	13	3	2	2	5	2	0	2	2	4	1	1	5	3	9	4	7
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.162	0.191	0.203	0.038	0.159	0.156	0.372	0.207	0.149	0.156	0.121	0.123	0.347	0.203	0.17	0.117	0.244	0.134
	DE02	Pressure Ulcers - Grade 2	45	20	4	1	4	4	10	5	4	2	3	3	8	4	10	9	19	8
	DE04A	Pressure Ulcers - Grade 3 or 4	5	4	1	0	0	0	0	0	0	2	0	0	1	1	3	0	0	2
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.4%	98.4%	98.3%	98.4%	98.2%	98%	98%	98.3%	98.3%	98.1%	98.4%	98.5%	98.3%	98.7%	98.2%	98.2%	98.2%	98.3%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	95%	93.9%	92.3%	97.1%	94%	92.3%	91.4%	94.4%	97.1%	93.8%	96.1%	91.1%	95%	93.4%	94.7%	94.5%	94.1%	93.8%
	N04	Number of Hospital Associated VTEs	50	12	3	6	1	3	8	3	7	3	4	0	5	-	9	10	18	7
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	2	0	0	1	0	0	0	0	0	0	0	0	0	-	0	1	0	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	4	7	0	0	0	1	0	1	2	1	1	0	5	-	0	1	3	2
Nutrition	WB03	Nutrition: 72 Hour Food Chart Review	92.1%	-	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%	92%	-	-	88.9%	-	-	86.3%	-	-	92%	-	-	92%	88.9%	86.3%	92%
Safety	Y01	WHO Surgical Checklist Compliance	99.7%	99.8%	99.9%	99.8%	99.2%	99.8%	100%	99.8%	99.7%	99.9%	99.7%	99.7%	99.9%	99.8%	99.8%	99.6%	99.8%	99.7%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual 17/18	Annual 18/19 YTD	Monthly Totals Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Quarterly Totals 17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1
Medicines	WA01	Medication Incidents Resulting in Harm	0.55%	0.3%	0%	1.97%	0.47%	0.5%	0.49%	0%	0%	0%	0.91%	0.37%	0%	-	0.64%	0.97%	0.15%	0.42%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.4%	0.39%	0.37%	0.27%	0.41%	0%	0.42%	1.02%	0.33%	0.63%	0.36%	0.24%	0.54%	0.22%	0.25%	0.24%	0.57%	0.43%
Safety Thermometer	AK03	Safety Thermometer - Harm Free Care	97.9%	-	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%	-	98.7%	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%	-	100%	90%	93%	97%	95%	91%	100%	-	-	-	-	-	99%	94%	95%	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	9.5%	9.7%	9.1%	9.4%	9.1%	8.7%	8.2%	9%	10.2%	8.8%	8.9%	10.3%	9.5%	9.7%	9.2%	8.6%	9.3%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	22.4%	21.5%	24%	24.2%	24%	20.8%	20.5%	20.9%	21.9%	20.3%	22.4%	21.7%	21.4%	21.4%	22.9%	23%	21.1%	21.5%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	11138	4486	983	1024	1010	863	867	814	945	834	963	875	902	912	2854	2897	2626	2672
Staffing Levels	RP01	Staffing Fill Rate - Combined	98.9%	98.8%	97.1%	97.5%	98.1%	97.2%	98.5%	96.8%	95.7%	99%	98.7%	100.1%	99.1%	97%	97.9%	97.6%	97%	99.2%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Data	100.6	-	100.4	-	-	101.7	-	-	102.7	-	-	-	-	-	100.4	101.7	102.7	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	106.4	103	123.7	113.5	117.1	125.3	110.5	91.9	112.6	119.7	85.8	-	-	-	100.7	119.2	105.2	103
Readmissions	C01	Emergency Readmissions Percentage	3.62%	3.53%	3.81%	3.48%	3.75%	3.62%	3.62%	3.39%	3.84%	3.31%	3.55%	3.78%	3.46%	-	3.6%	3.62%	3.62%	3.55%
Sepsis (Inpatients)	AG02a	Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	51.1%	95.7%	16.7%	20%	33.3%	46.7%	64.7%	87%	83.3%	87.1%	100%	100%	-	-	29.7%	35.5%	79.7%	95.7%
	AG03a	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatient	77.4%	57.1%	100%	50%	-	100%	-	100%	50%	75%	-	33.3%	-	-	88.9%	75%	75%	57.1%
	AG04a	Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	93.3%	100%	100%	66.7%	-	75%	-	100%	-	100%	-	-	-	-	100%	71.4%	100%	100%
Sepsis (Emergency Department)	AG02b	Percentage of Patients Meeting Criteria Screened for Sepsis (ED)	83.4%	89.3%	92.9%	91.7%	76%	68%	86%	88%	88%	80%	89.2%	92.8%	-	-	94%	75.8%	87.3%	89.3%
	AG03b	Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (ED)	85.5%	81.1%	100%	94.1%	86.2%	91.7%	90%	74.2%	94.1%	75%	91.3%	76.9%	-	-	90%	90%	83.8%	81.1%
	AG04b	Sepsis Patients Percentage with a 72 Hour Review (ED)	93.1%	94.9%	100%	88.9%	84%	90.9%	100%	82.1%	100%	100%	95.1%	92.9%	-	-	100%	87.7%	91.2%	94.9%
Maternity	G01	Percentage of Low Weight Babies	2.5%	2.9%	3.4%	0.9%	2%	4.6%	3.2%	2%	3.2%	3.2%	2.1%	4.2%	2.8%	2.5%	2.7%	2.5%	2.8%	3.1%
	G01A	Number of Low Weight Babies	119	56	13	4	7	18	13	7	12	12	8	15	11	10	32	29	32	35
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	64.2%	61.7%	85.7%	61.9%	34.6%	48.5%	57.7%	45.5%	60%	72.7%	59.3%	53.3%	45%	70%	77.8%	47.5%	54.8%	64%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	61.6%	98.3%	33.3%	47.6%	69.2%	60.6%	69.2%	77.3%	92%	97%	100%	93.3%	100%	100%	39.5%	60%	79.5%	97.3%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	34.8%	55.7%	28.6%	28.6%	26.9%	24.2%	38.5%	22.7%	48%	63.6%	48.1%	46.7%	45%	70%	28.4%	26.3%	37%	54.7%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	37.1	53.3	75.9	58.6	64.8	65.7	81.5	48.7	72.7	50.6	61.3	79.3	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	62.6%	49.4%	70%	60.7%	55.6%	60.9%	57.9%	61.3%	54.3%	58.1%	30.8%	65%	41.2%	-	68.5%	59.1%	57.4%	51.6%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	85.8%	84%	92.5%	96.4%	83.3%	87%	84.2%	93.5%	80.4%	81.4%	76.9%	90%	88.2%	-	85.4%	88.2%	85.2%	82.8%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	54.6%	47.1%	75%	66.7%	70%	42.9%	50%	36.4%	20%	15.4%	54.5%	63.2%	30.8%	66.7%	55.9%	62.9%	34.2%	46.5%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	89.3%	81%	93.5%	87.7%	93.7%	87.9%	90.7%	87.3%	86.3%	87.3%	84.8%	77.6%	74.7%	80.2%	91.5%	89.6%	88.2%	83.6%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	96.2%	93.9%	97.9%	94%	97.4%	100%	93.8%	86%	96.5%	95%	91.9%	89.5%	94.9%	97.7%	98.6%	96.9%	92%	92.2%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	92.9%	88.9%	100%	75%	100%	100%	100%	-	100%	-	0%	100%	100%	100%	100%	87.5%	100%	50%
	AC04	Percentage of Dementia Carers Feeling Supported	60%	100%	-	-	-	-	100%	-	33.3%	-	-	100%	-	-	-	-	50%	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying.	9098	3326	424	558	499	730	1411	1120	1377	800	945	543	531	507	1409	1787	3908	2288

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual		Monthly Totals												Quarterly Totals			
			17/18	18/19 YTD	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-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	-	-	92	91	92	90	91	92	92	93	91	92	90	92	92	91	92	92
	P01g	Patient Survey - Kindness and Understanding	-	-	96	95	95	95	96	95	95	97	97	96	95	96	95	95	96	96
	P01h	Patient Survey - Outpatient Tracker Score	-	-	90	90	91	89	90	88	88	88	91	89	90	91	89	90	89	89
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35%	36.5%	35.3%	39.5%	33.2%	28.4%	34.9%	36.2%	30.3%	40.7%	37.6%	33.7%	35.6%	35.4%	35.4%	33.9%	33.7%	37.2%
	P03b	Friends and Family Test ED Coverage	17.3%	17.5%	18.3%	17.9%	17.9%	14.6%	17.8%	17.4%	15.2%	17.3%	17.2%	18.4%	17.3%	17.4%	18%	16.9%	16.8%	17.6%
	P03c	Friends and Family Test MAT Coverage	19%	13.6%	18.3%	21%	12.4%	23.1%	17.5%	17.7%	18.2%	19.8%	13.2%	11.2%	14%	9.8%	18.6%	19%	17.8%	14.8%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	97.7%	97.9%	97.7%	97.9%	98.1%	97.8%	97.7%	98.3%	97.8%	97.4%	97.3%	97.3%	98.8%	98.6%	97.6%	98%	97.9%	97.3%
	P04b	Friends and Family Test Score - ED	81%	82.2%	83.5%	83.3%	80.3%	77%	81.8%	83.2%	77.7%	80.1%	81.1%	84.6%	81.4%	84.1%	81%	80.5%	81%	81.9%
	P04c	Friends and Family Test Score - Maternity	96.9%	96.7%	99.2%	98%	97.5%	98.1%	94.6%	96.8%	97.1%	94.6%	95.5%	99.3%	96.8%	99.3%	96.8%	98%	96.1%	96%
Patient Complaints	T01	Number of Patient Complaints	1815	737	138	154	155	98	143	121	159	149	157	140	148	143	430	407	423	446
	T01a	Patient Complaints as a Proportion of Activity	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	T03a	Complaints Responded To Within Trust Timeframe	83%	85.3%	78.7%	85.1%	87.1%	83.8%	87.8%	82.8%	77.9%	83.1%	91%	84%	85.2%	83%	83%	85.4%	82.3%	85.9%
	T03b	Complaints Responded To Within Divisional Timeframe	83.8%	83.1%	86.9%	83.6%	90%	82.4%	91.8%	82.8%	77.9%	85.9%	82.1%	78.7%	85.2%	84.9%	85.7%	85.4%	83.4%	82.2%
	T04c	Percentage of Responses where Complainant is Dissatisfied	10.68%	10.8%	9.84%	10.45%	7.14%	2.94%	8.16%	8.62%	13.23%	9.86%	13.43%	9.33%	-	-	9.89%	6.83%	10.29%	10.8%
Cancelled Operations	F01q	Percentage of Last Minute Cancelled Operations (Quality Objective)	1.19%	1.16%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.91%	1.37%	1.9%	0.59%	1.17%	0.8%	0.88%	1.15%	1.69%	1.29%
	F01a	Number of Last Minute Cancelled Operations	919	384	58	68	85	71	102	98	121	85	125	39	80	55	173	224	321	249

RESPONSIVE

			Annual Target		Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	Green	Red	17/18	18/19 YTD	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	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%	88.7%	89.4%	90%	88.9%	88.3%	88.1%	88.4%	87%	88.2%	89.1%	88.6%	88.9%	88.7%	89.8%	89.1%	87.8%	88.6%
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	-	-	3524	3300	2927	3085	3138	3308	3783	3510	3244	3377	3208	3290	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	0	1	209	54	19	10	13	9	1	15	18	15	12	9	11	7	81	32	34	36
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	-	-	182	155	136	158	160	148	164	154	141	129	126	119	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	93%	93%	94.3%	94.9%	94.6%	94.6%	95.5%	94.8%	92.2%	96.9%	92.1%	92.6%	95.1%	95.3%	96.5%	-	93.7%	95%	93.6%	94.3%
	E01c	Cancer - Urgent Referrals Stretch Target	80%	80%	58.9%	53%	59.9%	64.2%	57.6%	54.4%	58.8%	59.6%	54.6%	41.3%	53.1%	56.7%	60.6%	-	62%	59%	57.7%	50.6%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	96%	96%	95.8%	95.4%	96.9%	95.4%	98.1%	96.7%	92.9%	95.1%	95.8%	94.4%	95%	94.7%	97.4%	-	97.3%	96.7%	94.5%	94.7%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98%	98%	98.6%	96.9%	98.5%	99.3%	98.7%	98.9%	98.7%	98.6%	98.4%	97.6%	96.6%	97.6%	96.1%	-	98.6%	99%	98.6%	97.2%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	94%	94%	92%	93.5%	94.7%	95.7%	96.8%	93%	96.6%	87.7%	79.5%	93%	85%	95.6%	98.2%	-	94.3%	95.2%	89%	91.4%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	94%	94%	96.3%	93.7%	98%	96.4%	96.1%	97.6%	92.9%	97.9%	96.4%	98.5%	85.4%	91.6%	97.1%	-	96.3%	96.6%	95.6%	92.2%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85%	85%	81.7%	84.6%	80.2%	84.3%	88.6%	82.9%	78.4%	81.3%	87.3%	84.1%	82.4%	86%	85.7%	-	80.1%	85.4%	82.4%	84.2%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	90%	90%	74.8%	53.6%	100%	66.7%	76.5%	71.4%	100%	58.3%	28.6%	66.7%	37.5%	41.7%	100%	-	96.3%	73.3%	61.5%	43.5%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	85%	85%	85.4%	79.9%	90.7%	74.7%	88.5%	85.7%	88.7%	83.9%	90.9%	79.3%	77.9%	84.4%	77.7%	-	84.6%	83%	87.9%	80.4%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	-	-	47.5	15.5	3	3.5	2	4.5	3	2.5	2	3	5	5.5	2	-	16	10	7.5	13.5
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	0.8%	0.8%	1.19%	1.16%	0.91%	1%	1.26%	1.2%	1.53%	1.63%	1.91%	1.37%	1.9%	0.59%	1.17%	0.8%	0.88%	1.15%	1.69%	1.29%
	F01a	Number of Last Minute Cancelled Operations	-	-	919	384	58	68	85	71	102	98	121	85	125	39	80	55	173	224	321	249
	F02	Cancelled Operations Re-admitted Within 28 Days	95%	85%	94.2%	92.7%	95.1%	96.6%	91.2%	94.1%	88.7%	94.1%	92.9%	90.9%	88.2%	95.2%	97.4%	93.8%	97.6%	93.8%	92.3%	91.8%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	-	-	1.61%	1.63%	1.73%	1.28%	1.9%	1.38%	1.81%	2.08%	2.31%	2.26%	2.36%	1.67%	0.41%	1.53%	1.26%	1.53%	2.06%	2.1%
	F07a	Number of Admissions Cancelled Day Before	-	-	1244	538	110	87	128	82	121	125	146	140	155	110	28	105	249	297	392	405
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	90%	70%	76.1%	79.4%	84.8%	73.8%	77.4%	63.8%	80.9%	71.1%	65.2%	86.2%	80%	81.8%	70.6%	-	80.2%	70.8%	74.1%	82.4%
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	90%	90%	93.2%	94.1%	97%	92.9%	93.5%	93.6%	95.7%	97.4%	91.3%	93.1%	92.5%	100%	91.2%	-	93.1%	93.3%	95.4%	95.1%
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	99%	99%	98.29%	97.45%	97.7%	98.19%	98.28%	97.62%	97.81%	99.19%	98.51%	96.8%	97.64%	97.83%	97.88%	97.13%	97.94%	98.03%	98.53%	97.41%
Outpatients	R03	Outpatient Hospital Cancellation Rate	9.7%	11.7%	10.7%	9.7%	10.5%	9.9%	9.7%	10.1%	9.4%	11.1%	11.6%	9.7%	9.5%	10%	9.6%	10%	10.9%	9.9%	10.6%	9.7%
	R05	Outpatient DNA Rate	5%	10%	7.2%	6.9%	7.4%	7.1%	7.1%	7.6%	6.8%	6.4%	7.3%	6.4%	7.2%	6.7%	7.1%	6.8%	7.4%	7.2%	6.8%	6.8%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.03	2.03	2.19	2.06	2.16	2.1	2.15	2.2	2.22	2.17	2.1	2.06	1.99	2.05	2.1	2.11	2.22	2.15	2.16	2.03
ERS	BC01	ERS - Available Slot Issues Percentage	-	-	20.2%	21.4%	15.8%	20.2%	22.3%	20.8%	20.8%	22.6%	14.6%	18.6%	21.5%	23.8%	-	-	17.1%	21.1%	19.4%	21.4%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual Target Green	Annual Target Red	Annual 17/18	Annual 18/19 YTD	Monthly Totals Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-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	93	22	26	17	23	27	23	19	22	18	25	17	11	71	66	69	65
	Q02A	Non-Acute Delayed Transfers of Care - Patients	-	-	103	34	11	10	8	9	9	9	5	5	8	8	4	9	33	27	23	21
	Q01B	Acute Delayed Transfers of Care - Beddays	-	-	8466	2768	757	774	854	606	836	715	696	576	471	632	503	586	2149	2234	2247	1679
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	-	-	3106	1088	243	315	273	255	272	182	204	291	161	207	204	225	895	843	658	659
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	-	-	36	46	44	47	53	54	52	59	56	60	54	42	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	-	-	22	22	11	13	15	26	17	18	14	21	17	19	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	-	-	1502	1461	1555	1532	1757	1652	1989	1832	1574	1836	1571	1621	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	-	-	515	671	451	479	593	453	501	614	451	459	618	570	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	-	-	4.05	3.86	4.12	3.87	4	3.74	4.15	4.15	3.96	4.01	3.93	3.66	3.8	3.92	4.09	3.87	4.08	3.87
	J04D	Percentage Length of Stay 14+ Days	-	-	6.8%	6.4%	6.8%	6.8%	6.9%	6%	6.6%	6.9%	7.1%	6.5%	6.4%	6.3%	6.5%	6.5%	6.7%	6.5%	6.9%	6.4%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	-	-	237	240	213	243	242	252	238	234	207	243	234	211	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	3.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	2%	1.3%	0.5%	4.2%	5.6%	3.3%	5%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	35.2%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	50%	25%	25%	40.9%	48.3%	50.6%	36.5%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	95%	90%	86.48%	89.64%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.26%	90.07%	90.87%	88.64%	81.54%	89.3%
	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%	89.64%	90.84%	90.06%	90.33%	85.33%	82.69%	83.2%	78.89%	83.95%	91.14%	92.84%	90.26%	90.07%	90.87%	88.64%	81.54%	89.3%
	BB07	BRI ED - Percentage Within 4 Hours	-	-	78.35%	83.34%	86.53%	84.11%	88.22%	77.24%	71.39%	73.24%	65.06%	73.92%	85.56%	89.08%	84.8%	83.37%	86.14%	83.2%	69.78%	82.81%
	BB03	BCH ED - Percentage Within 4 Hours	-	-	94.89%	96.17%	94.99%	96.34%	91.54%	92.56%	93.91%	94.5%	95.08%	94.45%	96.25%	96.26%	96.39%	97.9%	95.97%	93.42%	94.49%	95.67%
	BB04	BEH ED - Percentage Within 4 Hours	99.5%	99.5%	96.26%	97.02%	96.58%	97.43%	94.21%	98.34%	96.63%	94.35%	92.9%	94.4%	98.11%	97.66%	96.19%	98.75%	96.74%	96.59%	94.62%	96.7%
	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	5	3	0	0	0	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%	95.9%	97.8%	98.8%	98.6%	98.2%	97.6%	96.5%	96.3%	96.8%	94.8%	98.4%	94.3%	95.1%	98.5%	98.5%	96.8%	96.7%
	B02b	ED Time to Initial Assessment - Data Completness	95%	95%	94.4%	91.4%	90.7%	94.2%	94.8%	99.4%	99.4%	98.4%	93.7%	91.9%	90.2%	92.8%	91.4%	90.6%	91.7%	96.2%	97.2%	91.6%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	50%	50%	52.2%	52.2%	54.1%	53.2%	48.4%	51%	54.4%	52.4%	48%	49.5%	53.8%	51.3%	50.8%	55.6%	54.5%	50.8%	51.6%	51.6%
	B03b	ED Time to Start of Treatment - Data Completeness	95%	95%	97.4%	96.9%	97.5%	97.1%	97.8%	98%	98%	97.6%	96.5%	96.5%	96.7%	97.3%	96.8%	97.1%	97.4%	97.6%	97.4%	96.8%
Others	B04	ED Unplanned Re-attendance Rate	5%	5%	2.8%	2.9%	2.3%	2.9%	3.3%	3.3%	3.1%	2.9%	2.9%	3%	3%	2.8%	2.9%	2.7%	2.3%	3.2%	3%	2.9%
	B05	ED Left Without Being Seen Rate	5%	5%	1.9%	1.6%	3.7%	1.1%	1.1%	1%	1%	1.1%	1.5%	1.4%	1.6%	1.7%	1.9%	1.6%	2.6%	1.1%	1.2%	1.5%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	-	-	840	280	44	63	63	87	62	59	85	75	48	54	45	58	144	213	206	177
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	-	-	4.2%	3.3%	4.2%	4.9%	6.4%	5.6%	2.5%	4.2%	3.4%	7%	6%	2%	1.3%	0.5%	4.2%	5.6%	3.3%	5%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	-	-	47%	35.2%	32.4%	44.2%	60%	38.8%	61.9%	61.3%	29.6%	31%	38.5%	50%	25%	25%	40.9%	48.3%	50.6%	36.5%

Cover report to the Trust Public Board meeting to be held on Thursday 27 September 2018, 10:00 – 12:30 in the Conference 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 William Oldfield Medical Director	Mark Smith, Deputy Chief Executive and Chief Operating Officer	
Freedom of Information Status	Open		

Reporting Committee	Quality and Outcomes Committee
Chaired by	Julian Dennis, Non-Executive Director
Date of last meeting	28 August 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 28 August 2018.

Quality and Performance Report
Chief Operating Officer and Deputy Chief Executive Mark Smith, Carolyn Mills, Chief Nurse, and Matt Joint, Director of People presented the report to the Committee. The following key points were highlighted:

- Emergency department activity remained high, although the predictive tool used to plan was showing a high level of accuracy, and was helping staff to better understand arrival patterns.
- The Emergency Department trajectory had been delivered for July at 90.26%
- The Trust was on track against its Referral to Treatment (RTT) trajectory, and staff were being given additional training to ensure they understood the booking system.
- Despite the fire at the Bristol Haematology and Oncology Centre, the Trust was meeting the GP Cancer 62 Day recovery trajectory, with performance at 86% in June. The forecast suggested that the Trust would achieve its trajectory for the quarter.
- In relation to diagnostics, the biggest risk related to cardiac echo's, with a number of staff absences. A plan was in place and improvements were expected, but this would take several months to materialise.
- A rebasing of the Hospital Standardised Mortality Ratio (HSMR) data had occurred and this now showed the Trust at 120, which whilst within the expected range, would be considered by the Medical Director.
- Challenges remained to respond to complaints within the timescales CQG were

receiving detailed performance reports on this KPI each month to understand reasons for delays/support specific actions to improve performance. Specific work was ongoing in Women's and Children's to strengthen processes and oversight as this was the poorest performing division.
- Essential training compliance and levels of sickness were good, but turnover remained a concern.

On-hold Update
Deputy Chief Executive and Chief Operating Officer Mark Smith presented this update to the Committee. Key points discussed included the following:

- Significant work had been undertaken by the Performance Team to conclude the validation of the circa 87,000 on-hold pathways.
- From the 87,000 patients records, 77 were sent to the harm panel for review and resulted in no identified harm; one serious incident had been reported.
- There had been positive recognition from the Intensive Support Team of the hard work undertaken and the completion of the task to a successful conclusion in a short timescale.
- NHS Improvement had asked that the Performance Team to present on this nationally as an exemplar of how this has been successfully delivered.
- 1,000 patients left were left on the register who were considered the lowest risk
- A bi-annual paper on the status of on-hold patients would be presented to the Audit Committee for ongoing assurance.

Workforce and Organisational Development Report – Q1
Matt Joint, Director of People, presented the report. Key points discussed included the following

- The focus in quarter 1 was on the outcomes of the staff survey and availability and awareness of staff support and wellbeing services as well as building user confidence in e-appraisal.
- Average sickness rates were good and essential training compliance stable, but turnover was a concern, although this was noted as reducing in Facilities.
- There were challenges in recruiting to specialist roles.
- Nursing recruitment initiatives were being explored to support recruitment from London and Portugal.
- Divisions were being encouraged to review the use of Happy App, which had provided rich data to back up staff engagement work.

Assessment of Governance for Opioid Prescribing and Administration
Director of Pharmacy, Jon Standing, presented the report to the Committee to provide assurance to the Board following the publication of the report from The Gosport Independent Panel into deaths at Gosport War Memorial Hospital. Key points discussed included the following:

- Gosport was an isolated care delivery unit, with limited medical support and predominantly one prescriber.
- Opioids were prescribed within a large dose range, which were not necessarily appropriate for the patients

- There was a culture issue within Gosport around use of opioids – common practice for patients to be prescribed and doses escalated relatively quickly to levels which were clinical concerning.
- There was no sense of challenge back to prescriber from nurses or pharmacists.
- Following a review of practice in UH Bristol there were no concerns identified.

Reports also received by the Committee included:

- **Serious Incident Report**
- **Root Cause Analysis Reports**
- **Monthly Nurse Safe Staffing Report**
- **Infection Control Annual Report and Q1 Update**
- **Clinical Quality Group Meeting Report**

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

Cover report to the Public Trust Board Meeting to be held on 27 September 2018 at 11.00 – 13.00 in the Conference Room, THQ

		Agenda Item	10
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Six-Monthly Nurse Staffing Report. February – July 2018**		
Author	Helen Morgan, Deputy Chief 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 the paper is to provide assurance to the Trust Board that wards have been safely staffed over the last six months.

Key issues to note

The total average fill rate for RN and NA staffing remains within the green threshold at 99%.

The Trust level quality performance dashboard for the last six months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience).

Where lower than expected staffing forms are submitted, the actual harm continues to be assessed as near miss to minor, with no moderate or actual harm impact seen over the last six months

There have been no requests from regulators in regard to nursing and midwifery staffing. This paper can assure the Board of Directors that UHBristol has had safe staffing levels over the last six months.
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)**
		25 September 2018		

Report on Staffing Levels for UHBristol Adult Inpatient Wards, Midwifery and Bristol Children's Hospital (February 18- July 18).
September 2018 Trust Board

1.0 Introduction

There is a requirement, post the publication of the Francis Report 2013 that all NHS organizations take a six monthly report to their Public Board Boards on nursing and midwifery staffing capacity and capability which has involved the use of an evidence-based tool.

This report details:

a) Any significant changes that have occurred in the last six months
b) How the Trust knows the wards have been safe over the last six months
c) An update on actions detailed in the last report

2.0 Significant Changes to nursing staffing levels in the last six months

As detailed in appendix 2 there are a number of triggers that indicate when a staffing review is required. These would be in addition to the annual divisional reviews of nursing establishments and skill mix with the Chief Nurse which have all been completed in the last six months.

The majority of UH Bristol's funded establishments have had no significant changes over the last six months, apart from Specialised Services which includes:

- An additional 4.86 WTE for the Cardiac Intensive Care Unit, funded within the 18/19 Operating Plan to support a supernumerary Nurse in Charge.
- 1.80 WTE to staff an additional 6 chairs in the Chemotherapy Day Unit funded within the 18/19 Operating Plan

Establishments continue to provide a ratio of the number of patients per RN between 2.3 - 8 on a day shift and 2.3 - 8 on a night shift. The ratio of registered to unregistered staff for UHB for adult inpatient areas continues to range between 50:50 and 90:10. Where the ratio of registered nurses is less than 60% this is based on the professional judgment of the senior nurses and supported by patient acuity and dependency scoring. There have been no changes to the areas that do not fully meet the agreed ratios or the rationale for these variations since the last report.

3.0 Care Quality Commission (CQC) Requests for staffing information

No requests for staffing information from the CQC were received since the last report.

4.0 How the Trust knows the wards have been safe over the last six months?

The Trust continues to submit monthly returns of the Department of Health via the NHS national staffing return. This return details the overall Trust position on actual

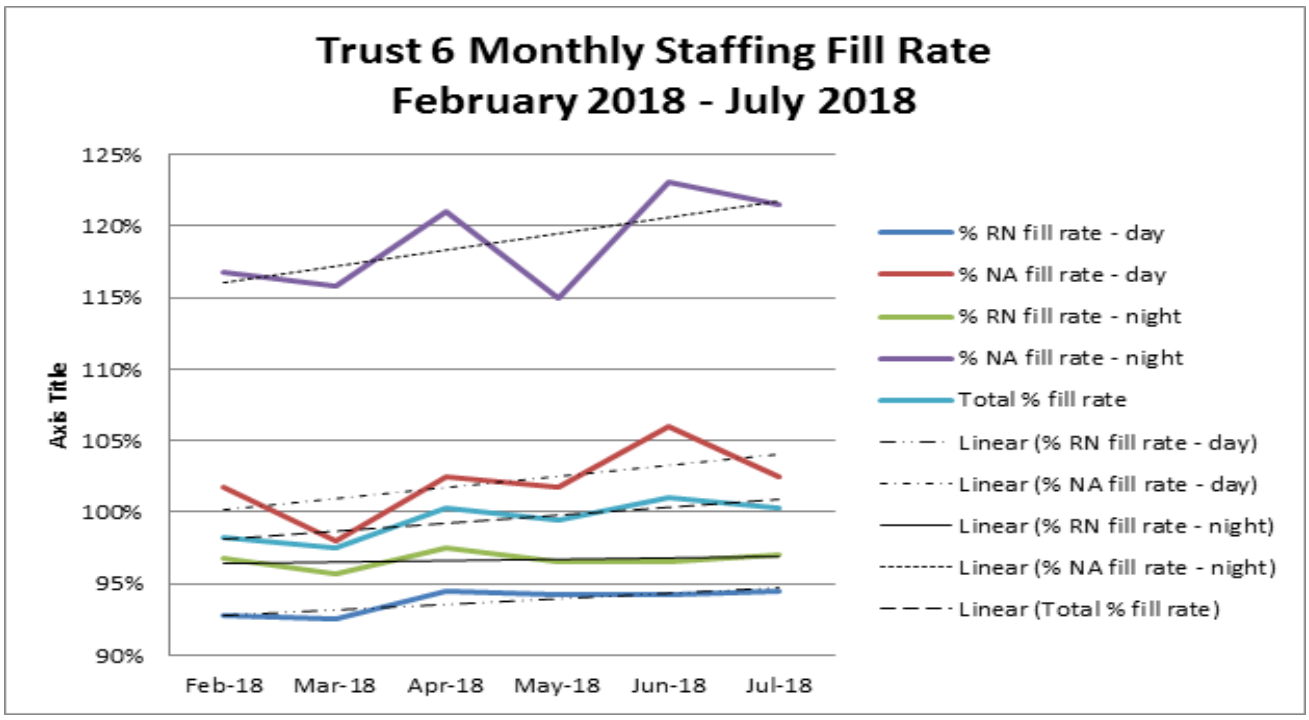
hours worked versus expected hours worked for all inpatient areas, the percentage fill rate for Registered Nurses (RN) and Nursing Assistants (NA) for day and night shifts, together with the overall Trust percentage fill rate. This includes care hours per patient per day (CHPPD). There have been no risks to patient safety identified through these reports in the last six months.

A monthly detailed report on nurse staffing is received and reviewed monthly at the Quality and Outcomes Committee a Non-Executive sub-committee of the Board. This report gives a detailed breakdown of any staffing variances by ward/department and Division. It includes detailed information regarding any NICE staffing red flags.

The graph and table below (Fig 1) show 6 monthly staffing fill rates for inpatient ward areas: Key issues to note:

- The total average fill rate for RN and NA staffing remains within the green threshold at 99%.
- The average RN day fill rate has remained consistent at 94%; the average RN night fill rate has increased slightly from 96 to 97%.
- NA fill rates continue to be above planned staffing levels for days and nights.
- The number of correctly reported red flag incidents for this period increased to 41 across all in patient wards. The actual harm to patients from these incidents remains negligible.

Fig 1



Trust Total	% RN fill rate - day	% NA fill rate - day	% RN fill rate - night	% NA fill rate - night	Total % fill rate
Feb-18	93%	102%	97%	117%	98%
Mar-18	93%	98%	96%	116%	98%
Apr-18	95%	103%	98%	121%	100%
May-18	94%	102%	97%	115%	100%
Jun-18	94%	106%	97%	123%	101%
Jul-18	95%	103%	97%	122%	100%
6 monthly average	94%	102%	97%	119%	99%

RAG rating for Fill Rate	Red	Amber	Green	Blue
Thresholds **(75% is the national red flag level)**	< 75%	76%-89%	90%-100%	101%>

Note: the red rating has been set at 75% to be in line with the national guidance that states that:-

A shortfall of more than 8 hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement for the shift. For example, if a shift requires 33 hours of registered nurse time, a red flag event would occur if 5:45 hours or less of registered nurse time is available
for that shift (which is the loss of more than 25% of the required registered nurse time).

4.2 Nurse Staffing Risks held on risk registers

There are no nurse staffing risks on the corporate risk register. A number of nurse staffing risks are held by divisions which are reviewed regularly at Divisional Board meetings and on a rotational basis at the Trust Risk Management Group.

4.3 Quality metrics

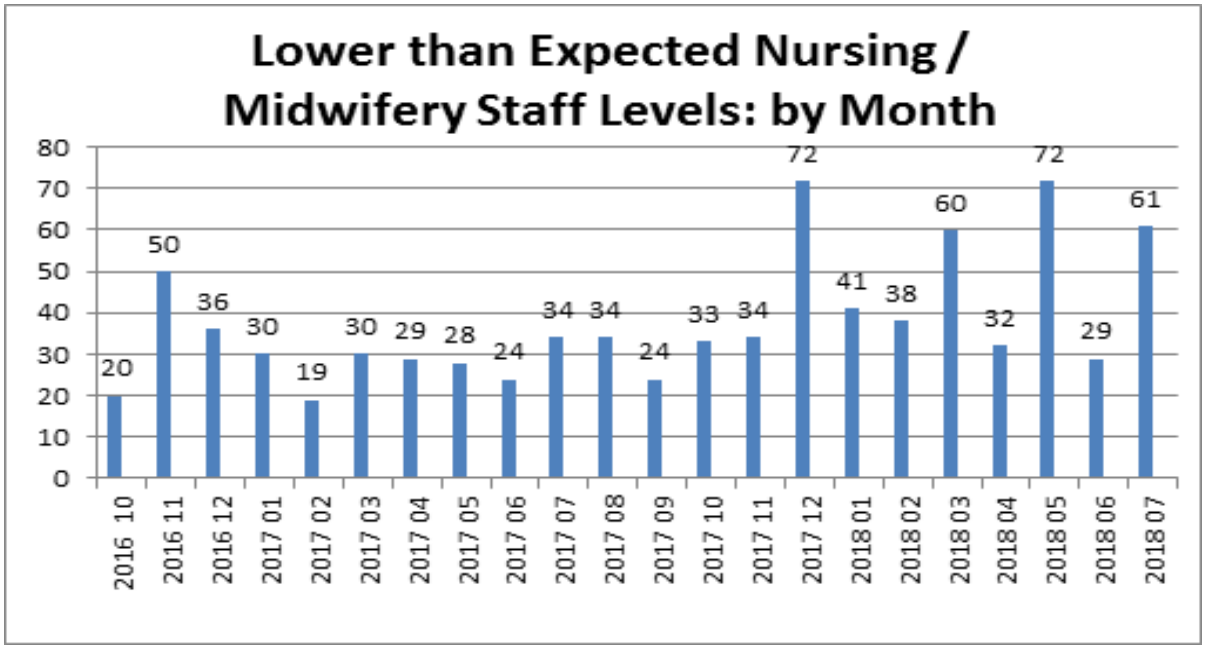
The Trust level quality performance dashboard for the last six months indicates that overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience).

Over the last six months, the number of falls with harm has reduced from 14 to 10. Whilst the overall number of hospital acquired pressure ulcers has reduced over the last 6 months, the number of grade 3 hospital acquired pressure ulcers has increased slightly from 1 to 3. Reviews of RCAs to identify good practice, themes and areas requiring improvement continue to be undertaken for both falls and hospital acquired grade 3 pressure ulcers with actions incorporated into both work plans.

4.4 Staffing incidents

The number (see Fig 2), content and any themes arising staffing incidents related to staffing levels are reviewed and discussed monthly and quarterly via Divisional Performance and Ops Reviews.

Fig 2



There were increases in reported incidents during March, May and July. The incidents were spread across a number of wards and Divisions, or occurred in non-ward specialist areas where for example, 50 of the reported 72 incidents in May came from the Learning Disabilities Team as a result of long term sickness within a small team.

Where lower than expected staffing forms are submitted, the actual harm continues to be assessed as near miss to minor, with no moderate or actual harm impact seen over the last six months

6.0 Conclusion

In the last six months the Chief Nurse and Divisional Teams have continued to review and monitor staffing levels in line with UHBristol principles for initiating a staffing review and the principles of safe staffing.

Ward Sisters and Charge Nurses have an understanding of their funded workforce resource, and are aware that if required this will be adjusted to reflect the acuity and dependency of patients admitted and changes to ward environments.

This paper can assure the Board of Directors that UHBristol has had safe staffing levels in the last six months.

Appendix 1:

UHBristol' s principles for initiating a staffing review (2014)

As a minimum a staffing and skill mix ratio review will be undertaken annually for each clinical area.

OR when there is:

- A significant change in the service e.g. changes of specialty, ward reconfiguration, service transfer
- A planned significant change in the dependency profile or acuity of patients within a defined clinical area e.g. demonstrated by sustained high acuity/dependency scores or an increased specialling requirement.
- A change in profile and number of beds within defined clinical area.
- A change in staffing profile due to long term sickness, maternity leave, other leave or high staff turnover
- If quality indicators in the key performance indicators a failure to safeguard quality and/or patient safety.
- A Serious Incident (SI) where staffing levels was identified as a significant contributing factor
- If concerns are raised about staffing levels by patients or staff.
- Evidence from benchmark group that UHBristol is an outlier in staffing levels for specific services.

Appendix 2:

Principles of Safe Staffing for General Inpatient Wards

Ratio of registered to unregistered professionals
Within UHB adult inpatient areas the Trust set staffing levels based on a principle of 60:40 ratio, registered nurse to nursing assistant in general inpatient areas. This will be higher in some specialist ward areas due to the increasing complexity of care, for example medication regimes and the number of intravenous drugs now given and increased dependency and complexity of elderly patients being admitted.

Ratio of number of patients per nurse
In setting wards establishment and skill mix UHB use the principles of one registered nurse per 6 patients on a day shift and one registered nurse to 8 patients on a night shift.

In adult critical care areas the ratio is one nurse per patient adult intensive care (level 3 patient) day and night and one nurse per two patients in adult high dependency (level 2 patients) day and night

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	**11a**
Meeting Title	Public Trust Board	**Meeting Date**	**Thursday, 27 September 2018**
Report Title	**Patient Complaints Q1 Report**		
Author	Tanya Tofts, 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 first quarter of 2018/19, the Trust's performance in handling those complaints, and assurance about how Divisions have been responding to any 'hot spots' identified.

Recommendations

Summary of performance in Quarter 1

	Q1	
Total complaints received	**446**	↑
Complaints acknowledged within set timescale	**98.7%**	↑
Complaints responded to within agreed timescale – formal investigation	**88.3%**	↑
Complaints responded to within agreed timescale – informal investigation	**85.0%**	↑
Proportion of complainants dissatisfied with our response (formal investigation)	**12.2%***	↑

*April data only

In Q1:

- The Patient Support and Complaints Team handled a particularly high level of enquiries (including complaints): 819, compared with 741 in quarter 4 and 710 in quarter 3).
- The most common causes for complaint related to 'appointments and admissions' and 'clinical care' (as per Q4).

Improvements in Q1:

- In quarter 1, the percentage of responses sent out within the agreed timescale improved to 88.3% for formal responses (compared with 82.3% in quarter 4 2017/18) and 85% for informal responses (compared with 74.7% in quarter 4).
- Quarter 1 also saw a notable increase in the proportion of complaints resolved informally.
- Complaints about discharge arrangements fell notably in quarter 1, returning to levels last seen in the summer of 2017.
- Complaints about failure to answer telephones/failure to respond also fell to their lowest level for four years (since quarter 1 2014/15). This coincides with a concerted Trust-wide focus on improving the quality of telecommunications.
- Areas experiencing a reduction in complaints in quarter 1 included QDU (endoscopy), the BRI Emergency Department and Gynaecology Outpatients.

However:

- Although performance in achieving timely response to complaints improved in quarter 4, further improvement is needed in order to achieve the Trust's target of 95%.
- Complaints about appointments and admissions increased for the third consecutive quarter (from 97 in quarter 3 2017/18, to 126 in quarter 4 2017/18, and to 155 in quarter 1 2018/19).
- Areas experiencing an increase in complaints in quarter 1 included Trauma and Orthopaedics, Paediatric Orthopaedics and Clinic A410.
- In quarter 1, only 11% of respondents to our complaints survey said that they thought the Trust would do things differently as a result of their complaint.

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)**
				Patient Experience Group, Senior Leadership Team

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 1, 2018/2019

(1 April 2018 to 30 June 2018)

Authors: Tanya Tofts, Patient Support and Complaints Manager

Quarter 1 Executive summary and overview

	Q1	
Total complaints received	**446**	↑
Complaints acknowledged within set timescale	**98.7%**	↑
Complaints responded to within agreed timescale – formal investigation	**88.3%**	↑
Complaints responded to within agreed timescale – informal investigation	**85.0%**	↑
Proportion of complainants dissatisfied with our response (formal investigation)	**12.2%**	↑

Successes	**Priorities**
• 98.7% of the 446 complaints received in quarter 1 were acknowledged in the timeframe set out in the NHS Constitution. • In quarter 1, the percentage of responses sent out within the agreed timescale improved to 88.3% for formal responses (compared with 82.3% in quarter 4 2017/18) and 85% for informal responses (compared with 74.7% in quarter 4). • Quarter 1 also saw a notable increase in the proportion of complaints resolved informally. • Complaints about discharge arrangements fell notably in quarter 1, returning to levels last seen in the summer of 2017. • Complaints about failure to answer telephones/failure to respond also fell to their lowest level for four years (since quarter 1 2014/15). This coincides with a concerted Trust-wide focus on improving the quality of telecommunications. • Areas experiencing a reduction in complaints in quarter 1 included QDU (endoscopy), the BRI Emergency Department and Gynaecology Outpatients.	• Although performance in achieving timely response to complaints improved in quarter 4, further improvement is needed in order to achieve the Trust's target of 95%. Detailed reports describing any breaches of timescales which have been agreed with complainants are now being reviewed by the Trust's Clinical Quality Group on a monthly basis. • The proportion of complainants who tell us that they are dissatisfied with our response to their complaint remains within expected levels but has been slowly increasing since December 2017. In the response to this, the Trust has reinstated detailed monthly reviews of dissatisfied cases. These reviews are conducted by the Trust's Head of Quality (Patient Experience and Clinical Effectiveness) and Heads of Nursing; learning is shared with Clinical Quality Group and Patient Experience Group.

Opportunities	Risks & Threats
• The Division of Surgery is focussing on implementing actions to increase bed availability and avoid patient cancellations. This will involve early patient discharge, increased use of the discharge lounge and criteria-led discharge. • The Division of Medicine is focussing on learning from complaints relating to communication. • Women's Services will be recommencing 'Patient Experience at Heart' workshops in September 2018. • Children's Services plan to ensure that actions plans are clearly articulated to the family, together with clear plans for implementing required changes and auditing their effectiveness going forward. • The Trust will hold its first focus group with previous complainants in quarter 4 2018/19 – there is an opportunity to use this first group to explore complainants' perceptions of whether their complaint will make a difference (see Risks and Threats).	• Complaints about appointments and admissions increased for the third consecutive quarter (from 97 in quarter 3 2017/18, to 126 in quarter 4 2017/18, and to 155 in quarter 1 2018/19). • Areas experiencing an increase in complaints in quarter 1 included Trauma and Orthopaedics, Paediatric Orthopaedics and Clinic A410. • The Patient Support and Complaints Team handled a particularly high level of enquiries (including complaints) in quarter 1: 819, compared with 741 in quarter and 710 in quarter 3). • In quarter 1, only 11% of respondents to our complaints survey said that they thought the Trust would do things differently as a result of their complaint.

1. Complaints performance – Trust overview

1.1 Total complaints received

The Trust received 446 complaints in quarter 1 (Q1) of 2018/19. This total includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1] but 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

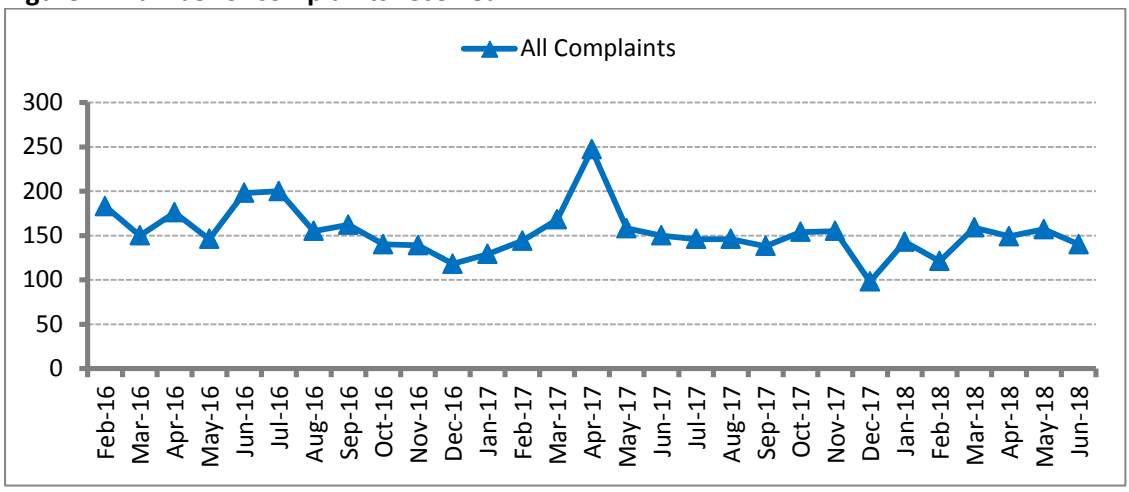
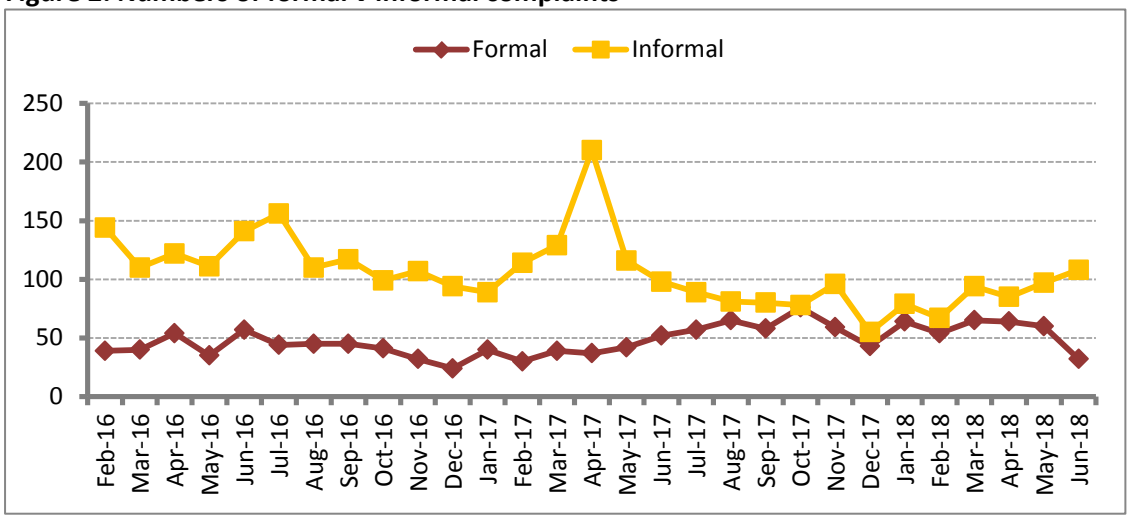


Figure 2 shows complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process, over the same period. We want to address concerns raised as quickly and as close to the point of care as possible, so it is encouraging to see that the proportion of informal complaints, relative to formal complaints, continued to increase during Q1.

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.

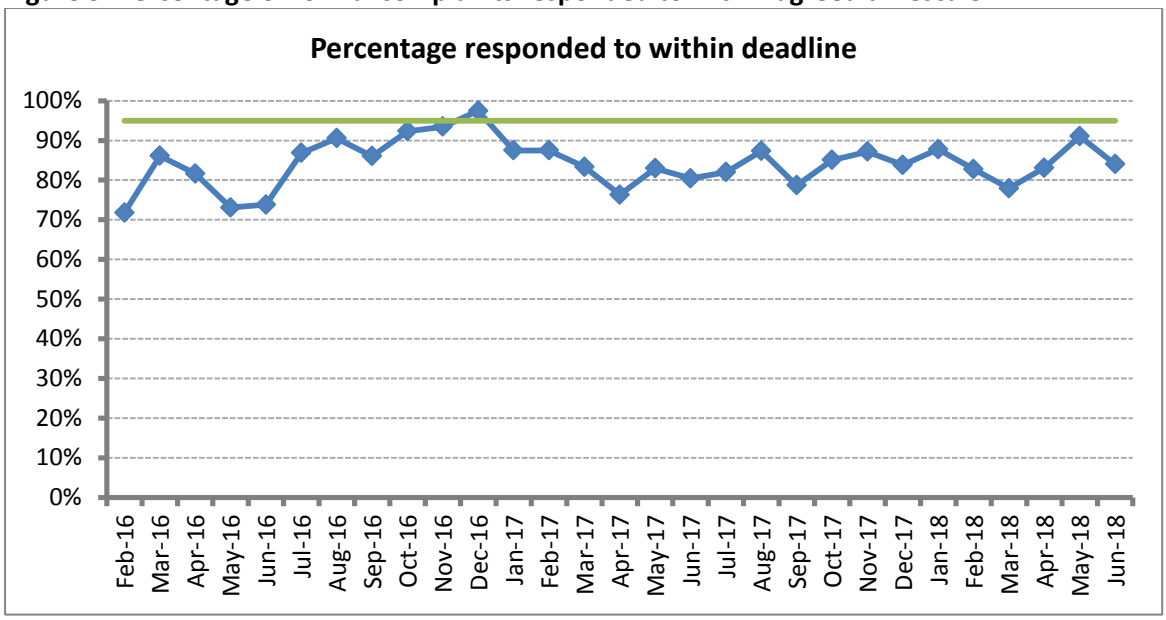
When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

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 Q1 of 2018/19, 88.3% of responses were posted within the agreed timescale. This represents 25 breaches out of the 213 formal complaints which received a response during the quarter[2]. Although this remains below the Trust's target of 95%, it is nonetheless a step forward from Q4 2017/18 when our performance was 82.3%. 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 Q1 2018/19, the Trust received 290 complaints that were investigated via the informal process. During this period, 253 informal complaints were responded to and 85.0% of these (215 of 253) 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.

By the cut-off point of mid-July 2018 (the point at which dissatisfied data was calculated for board reporting), 24 people who received complaints responses in February, March and April 2018 had contacted us to say they were dissatisfied. This represents 12.2% of the 197 responses sent out during that period.

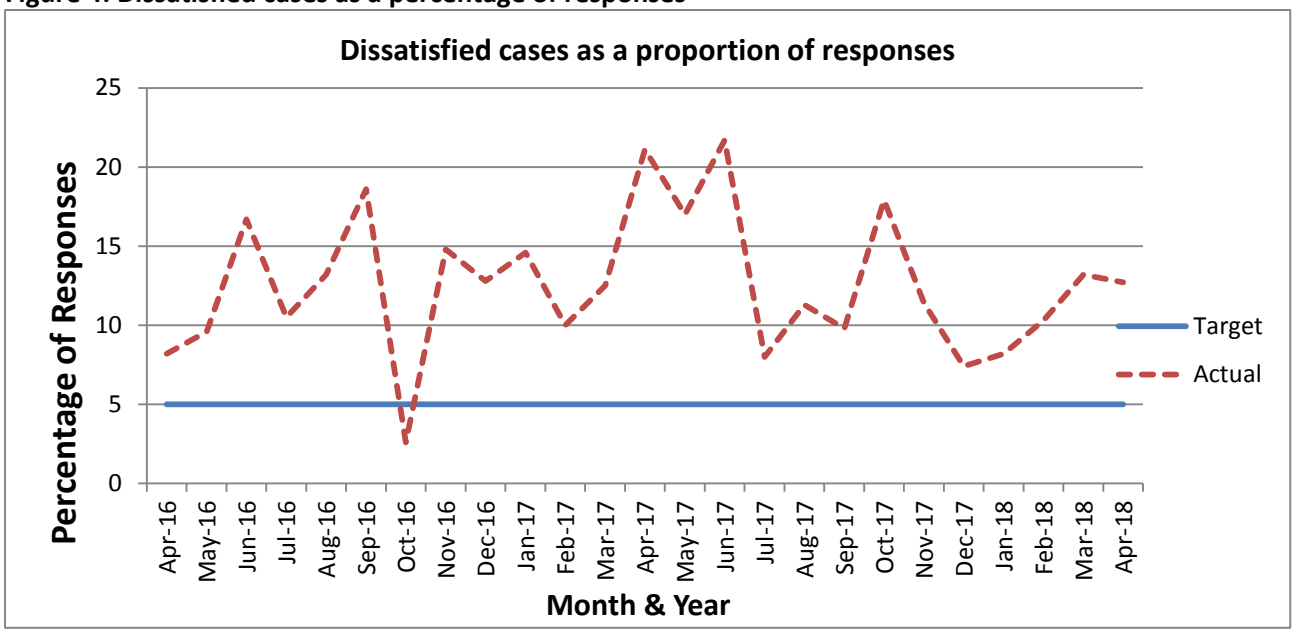
Of these 24 dissatisfied cases, 11 were received by the Division of Medicine; six by the Division of Women & Children; four by the Division of Surgery; two by the Division of Specialised Services and one by the Division of Trust Services.

As a result of increasing numbers of dissatisfied complainants since December 2017, a monthly review of all dissatisfied cases is being reinstated, in addition to the existing divisional complaints review panels. These reviews will be carried out by the Head of Quality (Clinical Effectiveness and Patient Experience) and a nominated Divisional Head of Nursing. The findings of these reviews will be reported to the Clinical Quality Group on a monthly basis.

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 and this revised data is reflected in Figure 4.

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 Q1 2018/19 compared to Q4 2017/18. In Q1, complaints about 'discharge/transfer/transport' fell but complaints about 'appointments and admissions' rose.

Table 1: Complaints by category/theme

Category/Theme	Number of complaints received in Q1 (2018/19)	Number of complaints received in Q4 (2017/18)
Appointments & Admissions	155 (34.8%) ↑	126 (29.8%) ↑
Clinical Care	124 (27.8% of total complaints) ↑	123 (29.2% of total complaints) ↑
Attitude & Communication	95 (21.3%) ↑	85 (20.1%) ↓
Information & Support	26 (5.8%) ↑	25 (5.9%) ↓
Facilities & Environment	26 (5.8%) =	26 (6.1%) ↑
Discharge/Transfer/Transport	10 (2.2%) ↓	25 (5.9%) ↑
Documentation	7 (1.6%) ↓	9 (2.1%) ↓
Access	3 (0.7%) ↓	4 (0.9%) ↓
Total	**446**	**423**

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 66% of the complaints received in Q1 (295/446).

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q1 (2018/19)	Q4 (2017/18)	Q3 (2017/18)	Q2 (2017/18)
Cancelled/delayed appointments and operations	96 (31.5% increase) ↑	73	47	68
Clinical care (Medical/Surgical)	53 (1.9% increase compared to Q4 2018/19) ↑	52	53	58
Appointment administration issues	37 (60.9% increase) ↑	23	29	45
Communication with patient/relative	29 (52.6% increase) ↑	19	17	18
Clinical care (Nursing/Midwifery)	24 (11.1% decrease) ↓	27	20	28
Attitude of medical staff	20 (5.3% increase) ↑	19	19	28
Attitude of admin/clerical staff	12 (20% increase) ↑	10	18	7
Failure to answer telephones/failure to respond	9 (18.2% decrease) ↓	11	18	25
Attitude of nursing/midwifery staff	8 (27.3% decrease) ↓	11	9	16
Discharge arrangements	7 (66.7% decrease) ↓	21	15	13

In summary, complaints about 'cancelled/delayed appointments and operations', 'appointment administration issues' and 'communication with patient/relative' rose in Q1 2018/19, whilst complaints about 'discharge arrangements' decreased.

Figures 5-7 below show the longer term pattern of complaints received since February 2016 for a number of the complaints sub-categories reported in Table 2.

Figure 5: Cancelled or delayed appointments and operations

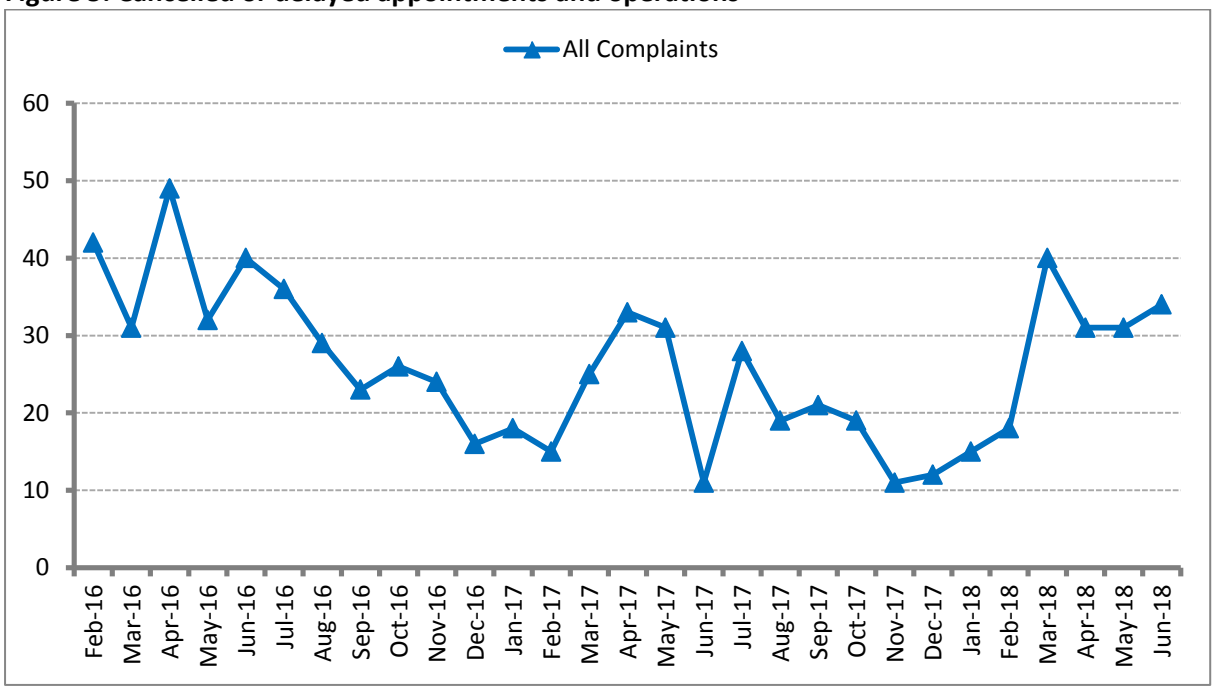


Figure 6: Clinical care – Medical/Surgical

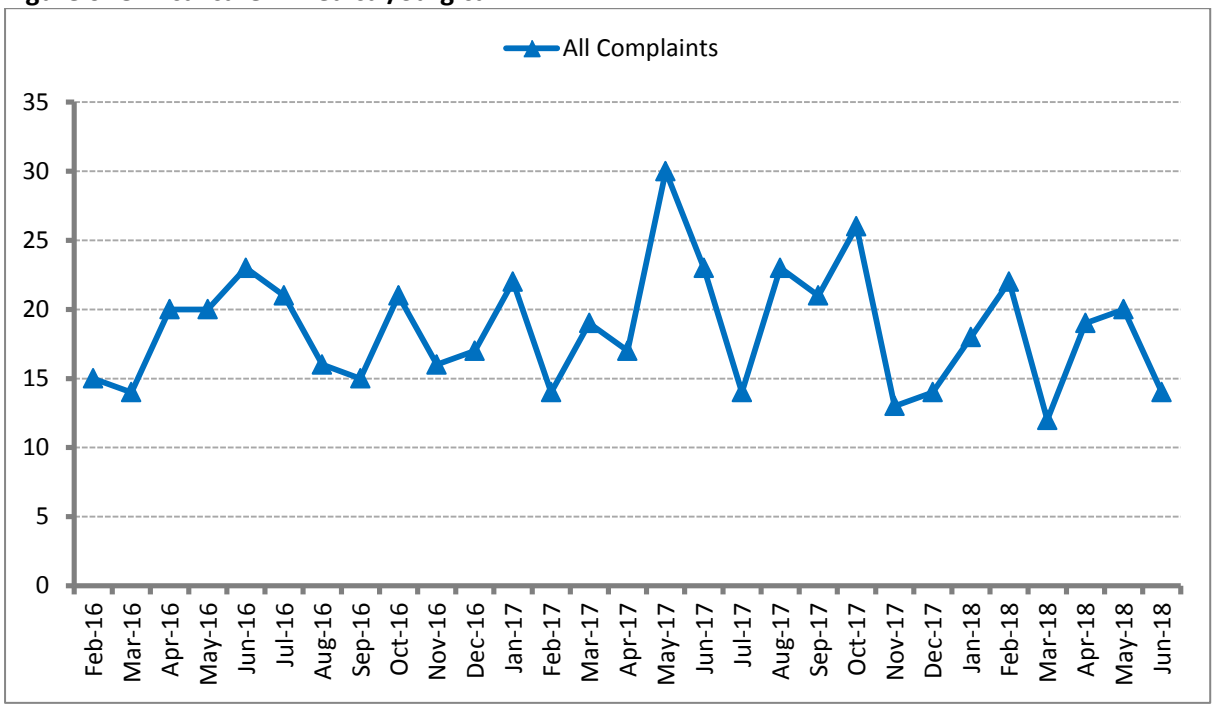


Figure 7: Clinical care – Nursing/Midwifery

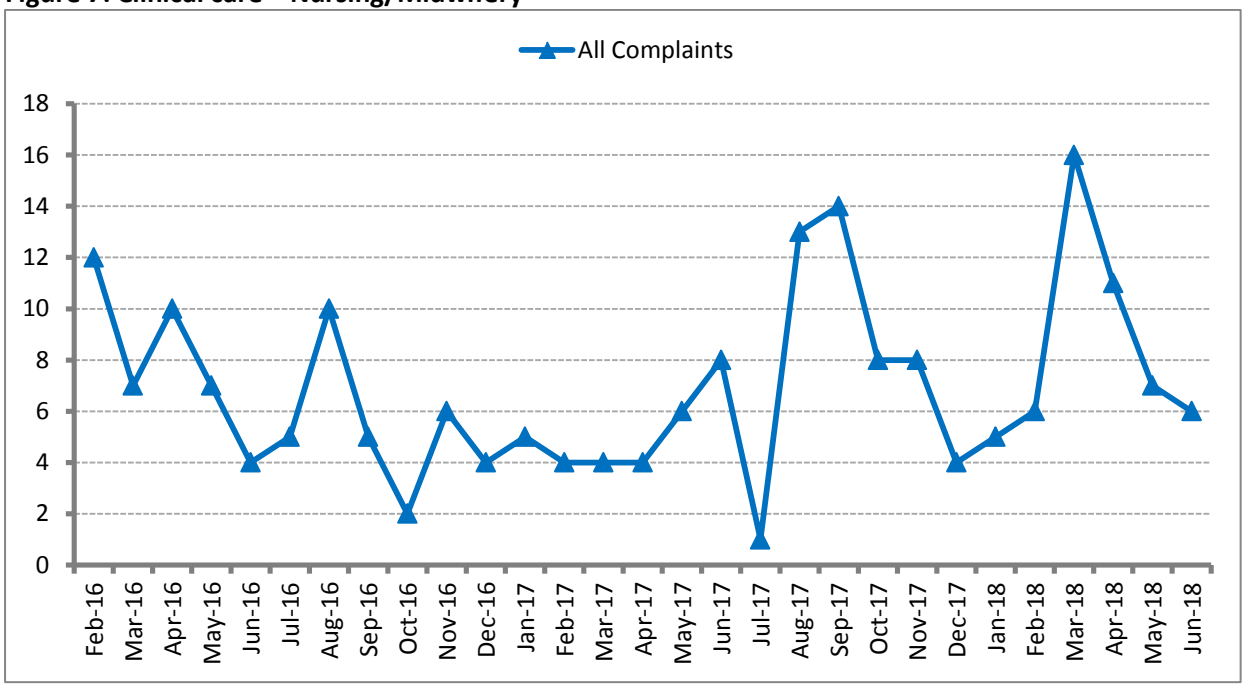
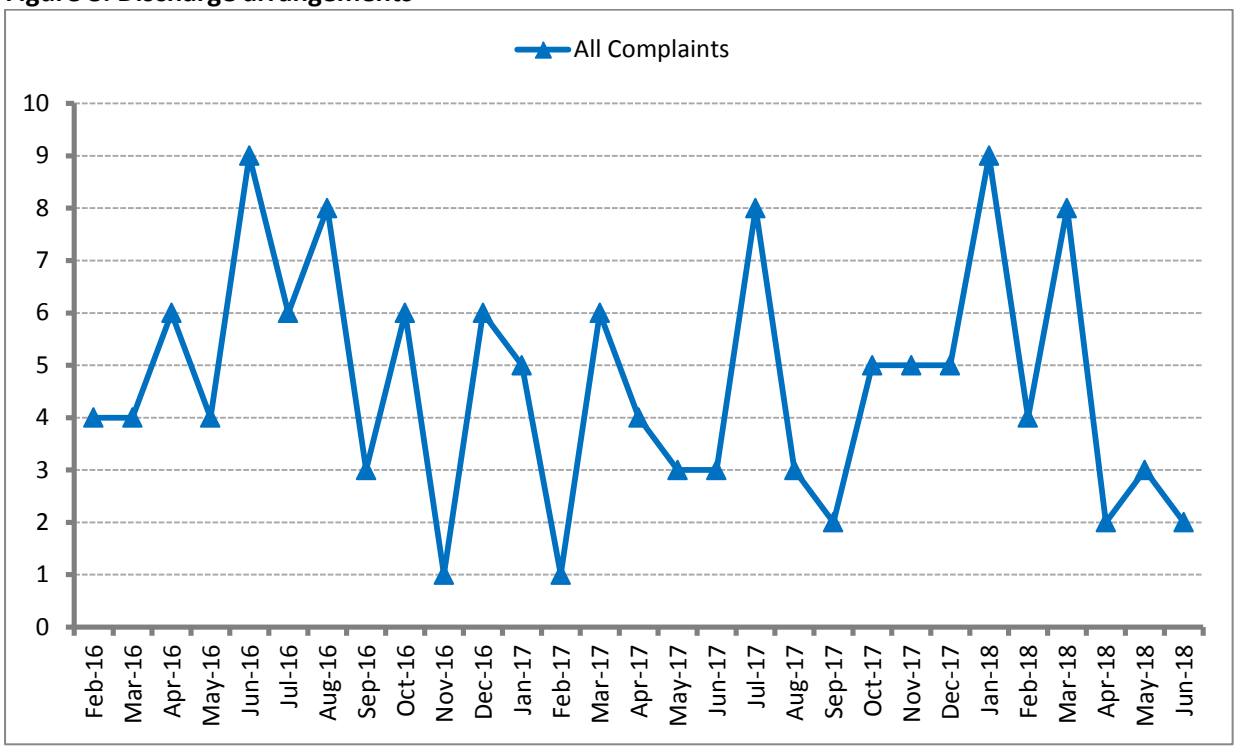


Figure 8: Discharge arrangements



3. Divisional Performance

3.1 Divisional analysis of complaints received

Table 3 provides an analysis of Q1 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	162 (158) ↑	102 (101) ↑	76 (55) ↑	63 (69) ↓ (BRHC – 41/StMH – 22)	16 (20) ↓
Number of complaints about appointments and admissions	84 (71) ↑	23 (16) ↑	24 (16) ↑	17 (18) ↓	5 (4) ↑
Number of complaints about staff attitude and communication	26 (31) ↓	25 (22) ↑	16 (10) ↑	17 (12) ↑	7 (5) ↑
Number of complaints about clinical care	39 (38) ↑	29 (32) ↓	28 (18) ↑	25 (31) ↓	2 (3) ↓
Area where the most complaints have been received in Q1	Bristol Dental Hospital – 50 (50) Bristol Eye Hospital – 32 (33) Trauma & Orthopaedics – 22 (16) ENT – 12 (12) Lower GI – 9 (5) Upper GI – 8 (10)	Emergency Department (BRI) – 24 (35) Dermatology – 17 (14) Clinic A410 – 8 (0) Ward A300 – 5 (6) Ward A400 –5 (6) Respiratory – 5 (2)	BHI (all) – 53 (42) BHI Outpatients – 26 (18) Chemo Day Unit / Outpatients (BHOC) – 11 (7) Ward C708 – 7 (3) Clinical Genetics – 5 (1)	Children's ED & Ward 39 (BRHC) – 5 (5) Paediatric Orthopaedics – 7 (1) Gynaecology Outpatients (StMH) – 5 (12) Ward 78 – 2 (6)	Radiology – 8 (7) Physiotherapy – 4 (6)
Notable deteriorations compared to Q4	Trauma & Orthopaedics – 22 (16)	Dermatology – 17 (14) Clinic A410 – 8 (0)	BHI Outpatients – 26 (18) Ward C708 – 7 (3) Clinical Genetics – 5 (1)	Paediatric Orthopaedics – 7 (1)	None
Notable improvements compared to Q4	QDU (Endoscopy) – 1 (6)	Emergency Department (BRI) – 24 (35)	None	Gynaecology Outpatients (StMH) – 5 (12) Ward 78 – 2 (6)	None

3.1.1 Division of Surgery

In Q1, 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) with 84 compared to 71 in Q4. The number of complaints about Bristol Dental Hospital (BDH) remained essentially unchanged since Q2 of 2017/18, with 50 complaints. Complaints about attitude and communication decreased for the third consecutive quarter, from 41 in Q3 and 31 in Q4 to 26 in Q1. There was an increase in the number of complaints received in Trauma & Orthopaedics, from 16 in Q4 to 22 in Q1.

Table 4: Complaints by category type

Category Type	**Number and % of complaints received – Q1 2018/19**	**Number and % of complaints received – Q4 2017/18**
Appointments & Admissions	84 (51.9% of total complaints) ↑	71 (44.9% of total complaints) ↑
Clinical Care	39 (24.1%) ↑	38 (24.1%) ↓
Attitude & Communication	26 (16.0%) ↓	31 (19.6%) ↓
Information & Support	6 (3.7%) ↑	3 (1.9%) ↓
Facilities & Environment	0 (0%) ↓	4 (2.5%) ↑
Access	3 (1.9%) =	3 (1.9%) =
Discharge/Transfer/ Transport	1 (0.5%) ↓	6 (3.8%) ↑
Documentation	3 (1.9%) ↑	2 (1.3%) ↑
Total	**162**	**158**

Table 5: Top sub-categories

Category	**Number of complaints received – Q1 2018/19**	**Number of complaints received – Q4 2017/18**
Cancelled or delayed appointments and operations	54 ↑	45 ↑
Appointment administration issues	21 ↑	11 ↓
Clinical care (medical/surgical)	16 =	16 ↑
Failure to answer telephones/ failure to respond	4 =	4 ↓
Attitude of admin/clerical staff	4 ↓	5 ↓
Attitude of medical staff	8 ↑	7 =
Communication with patient/relative	5 =	5 ↓
Clinical care (nursing)	5 ↓	8 ↑
Attitude of nursing staff	2 =	2 =
Discharge arrangements	5 =	5 ↑

Table 6: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Complaints about Bristol Dental Hospital remained the same when compared with quarter 4, with BDH continuing to receive high levels of complaints. Of the 50 complaints received, 16 were for Adult Restorative Dentistry; 12 were received for the Administration Department; and there were seven each received for Child Dental Health and Oral Surgery. The majority of complaints received by the Dental Hospital (28) were in respect of 'appointments and admissions', 17 of which were about cancelled/delayed appointments and operations. A total of 10 complaints were received in respect of 'clinical care'.	The volume of complaints received by Bristol Dental Hospital has remained essentially unchanged since Q2 of 2017/18. The main cause of complaints about Restorative Dentistry in Q1 was rejected referrals due to implementation of restricted criteria for treatment. The majority of complaints received about the Administration Department were due to waiting times for treatment. Two complaints related to the attitude/behavior of two different receptionists. Complaints about appointment and admissions spans a wide category of reasons including delayed appointments and incorrect bookings.	The Division continues to monitor complaints and take action if any themes are identified. Ongoing work with commissioners and Managed Clinical Networks to attempt to 'loosen' the criteria as soon as reasonably possible. We are working to reduce waiting times as part of our Operating Plan. The delivery plan should ensure we have compliant Referral to Treatment pathways by April 2018. We are working with the reception team to improve standards of customer service. The team has already started attending internal customer services training to look to improve this and the line managers of the receptionists that have been highlighted by these complaints have spoken to the individuals. We are working closely with the call centre to ensure that clear information is exchanged between the various administrative teams.
Within the Division as a whole, complaints regarding 'appointments and admissions' increased from 53 in quarter 3 to 71 in quarter 4 and again in quarter 1 to 84. Of these 84 complaints, 54 were received in respect of cancelled/delayed appointments and operations. A further 16 complaints were about appointment administration issues, including	The majority of complaints about appointments were resolved via informal resolution - the appointments were rebooked at the time of the complaint arriving. The Division has at times during Q1 experienced difficulties with bed availability causing cancelled operations. No specific trends have	Staff have been encouraged to attend Trust-wide training on managing complaints with confidence. The divisional complaints co-ordinator has also run training for Performance and Operations Managers and Deputies to improve their understanding of the complaints process within the division. All complaints continue to be monitored for any themes where

appointment letters not received and the appointment reminder system.	been identified in respect of complaints about administration.	action can be taken. A process has been developed within the Division to monitor last minute cancellations, identifying themes and where necessary actions taken.
The number of complaints received by the Trauma & Orthopaedics Department increased again from 16 in quarter 4 to 22 in quarter 1. 10 of the complaints received related to cancelled or delayed appointments and five were in respect of clinical care.	There is a high demand for this service as one of the busiest clinics in the division, which can result in a higher number of complaints given the volume of patients seen. Complaints about clinical care refer to queries raised and patients' understanding of their planned care.	The VFC (virtual fracture clinic) went live on 09.07.18. Patients who attend ED with suspected fractures are X-rayed and sent home. The X-ray is then reviewed the following working day; the patient is contacted by telephone, where a decision is made on plan of care. This means that patients are not waiting for a clinic appointment and should see an improvement in complaints about waiting times.

Current divisional priorities for improving how complaints are handled and resolved:

- To resolve a higher proportion of informal complaints within the required 10 day turnaround.

Priority issues we are seeking to address, based on learning from complaints.

- Focus is on implementing actions to increase bed availability and avoid patient cancellations. This involves, early patient discharge, increased use of the discharge lounge and criteria led discharge.

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

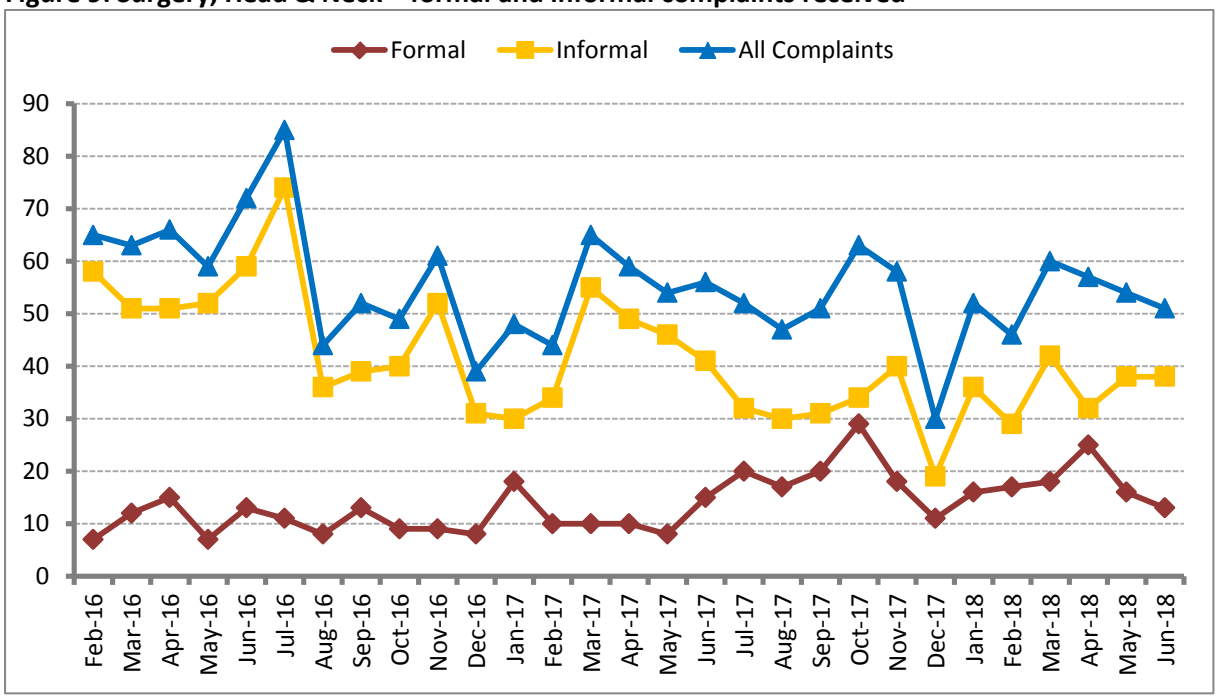


Figure 10: Complaints received by Bristol Dental Hospital

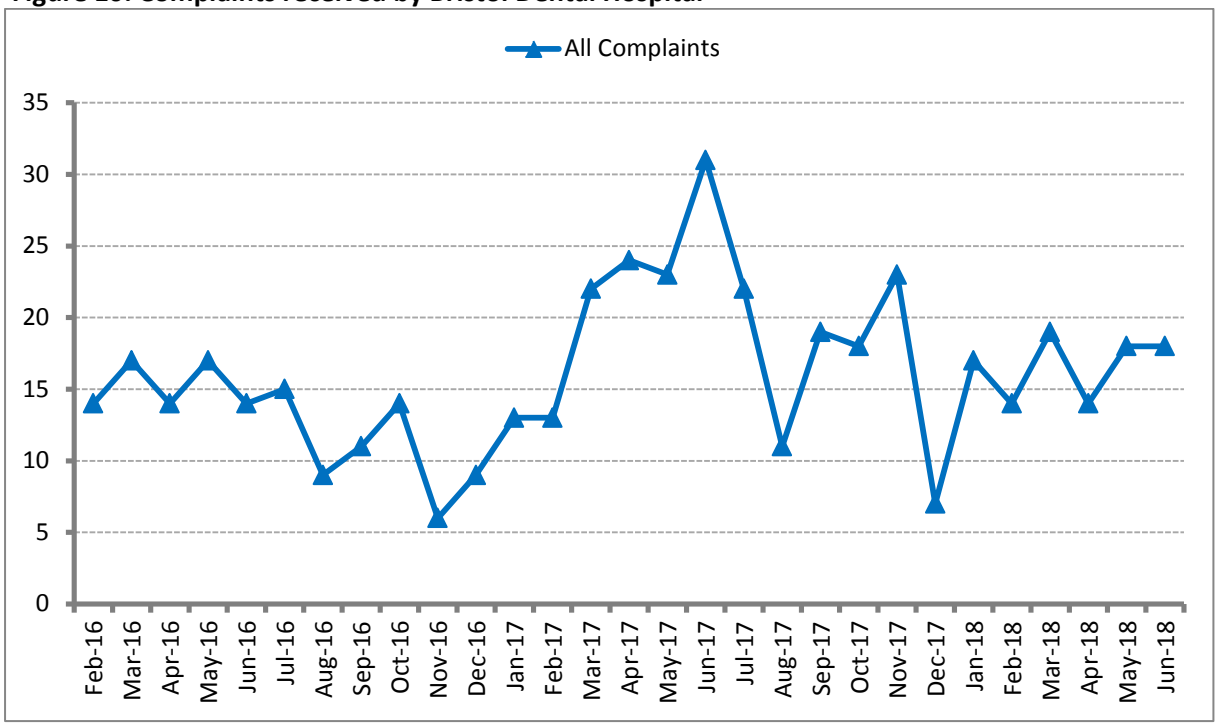
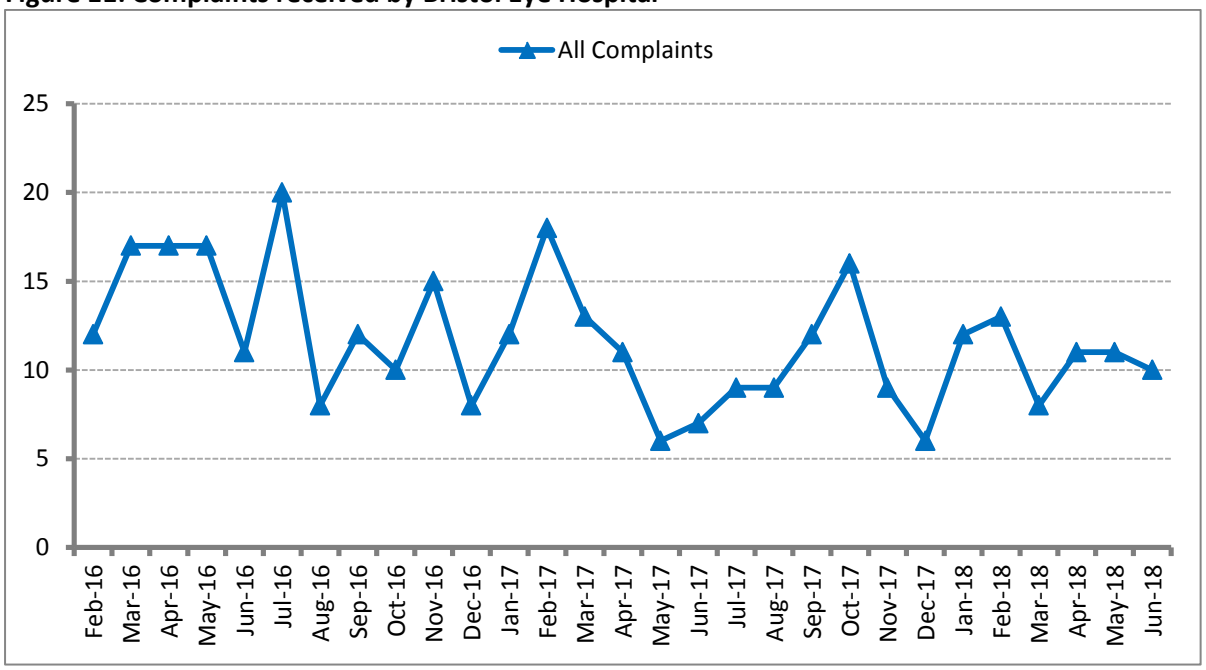


Figure 11: Complaints received by Bristol Eye Hospital



3.1.2 Division of Medicine

In Q1, the Division of Medicine received a similar number of complaints to the previous quarter (102 compared with 101 in Q4). Complaints about 'cancelled or delayed appointments and operations' increased, with 18 complaints compared with just five in Q4. There was also an increase in complaints about 'communication with patient/relative, with 10 complaints received, compared with five in Q4. However, complaints received by the Emergency Department (ED) fell from 35 in Q4 to 24 in Q1 and there were no complaints received about waiting times in the ED. Complaints received by the Dermatology service continued a small but steady rise, with 17 complaints in Q1, compared with 14 in Q4 and 11 in Q3.

Table 7: Complaints by category type

Category Type	**Number and % of complaints received – Q1 2018/19**	**Number and % of complaints received – Q4 2017/18**
Clinical Care	29 (28.5%)	32 (31.7%) ↑
Attitude & Communication	25 (24.5% of all complaints)	22 (21.8% of all complaints) ↓
Appointments & Admissions	23 (22.5%)	16 (15.8%) ↑
Information & Support	10 (9.8%)	8 (7.9%) ↑
Facilities & Environment	6 (5.9%)	7 (6.9%) ↑
Discharge/Transfer/ Transport	6 (5.9%)	14 (13.9%) ↑
Documentation	3 (2.9%)	2 (2%) ↓
Access	0 (0%) =	0 (0%) ↓
Total	**102**	**101**

Table 8: Top sub-categories

Category	Number of complaints received – Q1 2018/19	Number of complaints received – Q4 2017/18
Cancelled or delayed appointments and operations	18 ↑	5 ↓
Clinical care (medical/surgical)	15 =	15 ↑
Communication with patient/relative	10 ↑	5 ↑
Clinical care (nursing)	5 ↓	9 ↑
Discharge arrangements	4 ↓	12 ↑
Attitude of medical staff	3 ↓	5 ↓
Failure to answer telephones/failure to respond	3 ↓	4 =
Attitude of admin/clerical staff	3 ↑	1 ↓
Attitude of nursing staff	2 ↓	6 =
Appointment administration issues	1 ↓	5 ↑

Table 9: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Complaints received by the Dermatology service have shown a small but steady rise, with 11 complaints in Q3, 14 in Q4 and 17 in Q1. Of the 17 complaints received in Q1, 10 were in respect of cancelled or delayed appointments.	The continued rise in complaints reflects an increase in the number of patients accessing the service; this puts increasing pressure on staff to manage the patient journey; it also increases waiting times, resulting in an increase in patients contacting the service to move/re-arrange or attempt to bring forward an appointment. This, coupled with a staffing vacancy of 2.0 wte clerical and administrative posts, has increased the strain on service.	Plan: The AGM for Dermatology is working with the clinical team and the Communications team to set Dermatology up with an online form that will allow patients to request a change of appointment online and then the appointment centre will action the online request. The AGM is in discussions with the appointment centre team to support this need. BEH are already using this system and it works well for patients. This will improve access to appointments.
The Division received eight complaints about Clinic A410 during Q1, compared with none at all in Q4. Three of these complaints related to 'clinical care'; there were two each about 'appointments and admissions' and 'attitude and communication' and one was in	The endocrine service has recently gone through a period of instability; one consultant had to take personal leave with little notice, destabilising the service and leading to appointments being cancelled and postponed.	The consultant requiring personal leave has since returned to work; however, another consultant has had to take time off with no/little notice due to bereavement. The specialist nursing team is undergoing a service review led

respect of 'documentation'.	The specialist nursing team, who would normally support the medical team, were themselves challenged with changes to the team structure, causing a degree of instability. The retirement of one consultant and transferring of his patients to other members of the team may have caused some anxiety for some long standing patient groups, due to a difference of professional delivery.	by the general manager. Communication with patients/families regarding a change of consultant care (following this retirement) has been provided for those patients who have found the change challenging.
There was an increase in the number of complaints received by the Division in Q1 in respect of 'cancelled or delayed appointments and operations', with 18 received, compared with just five in Q4. Of these 18 complaints, 10 were received by the Dermatology service (see above). In addition to clinics run at Bristol Royal Infirmary, the Trust also runs dermatology clinics at Weston General Hospital.	It has been identified that there was no available equipment (couch) to safely undertake fibro-scans at Weston General Hospital. Scans therefore had to be suspended at this site. See issues above relating to dermatology.	A clinical treatment couch is now in-situ at Weston and scanning has resumed without compromising patient or staff safety. Clinics in Weston have seen an increase in capacity due to an increase with the clinical fellow outpatient clinic and biopsy service. A scoping exercise is underway to see if there is a possibility of performing day case surgery at Weston General Hospital. A new locum is starting in OPA to support demand for new appointments.

Current divisional priorities for improving how complaints are handled and resolved:

- To have a consistent approach in managing dissatisfied complaints and an early meeting with management on complex cases to agree approach.
- To work closer with the Patient Support and Complaints Team to agree appropriate timescales for complaints investigations (we recently had a situation where lack of timely communication from the PSCT meant that the Division was only given two days to resolve an informal complaint.
- There is now clinical input with the divisional Quality and Patient Safety Team as Matron Sarah Jenkins is has oversight and is able to provide clinical advice where necessary.
- To maintain early contact with complainant if case is unclear/complex case.
- In complex complaints, to assign a case manager to remain a single point of contact to avoid confusion.

Priority issues we are seeking to address, based on learning from complaints:

As described in the responses above, however there is a recognition that many of the complaints we received are fundamentally about communication.

Figure 12: Medicine – formal and informal complaints received

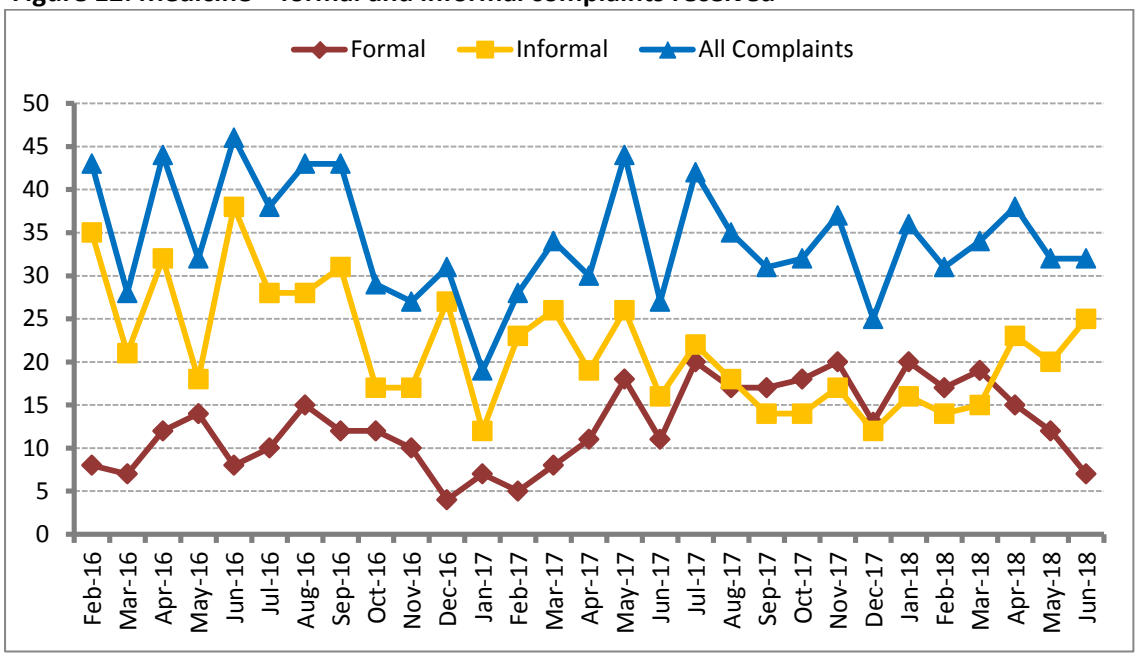
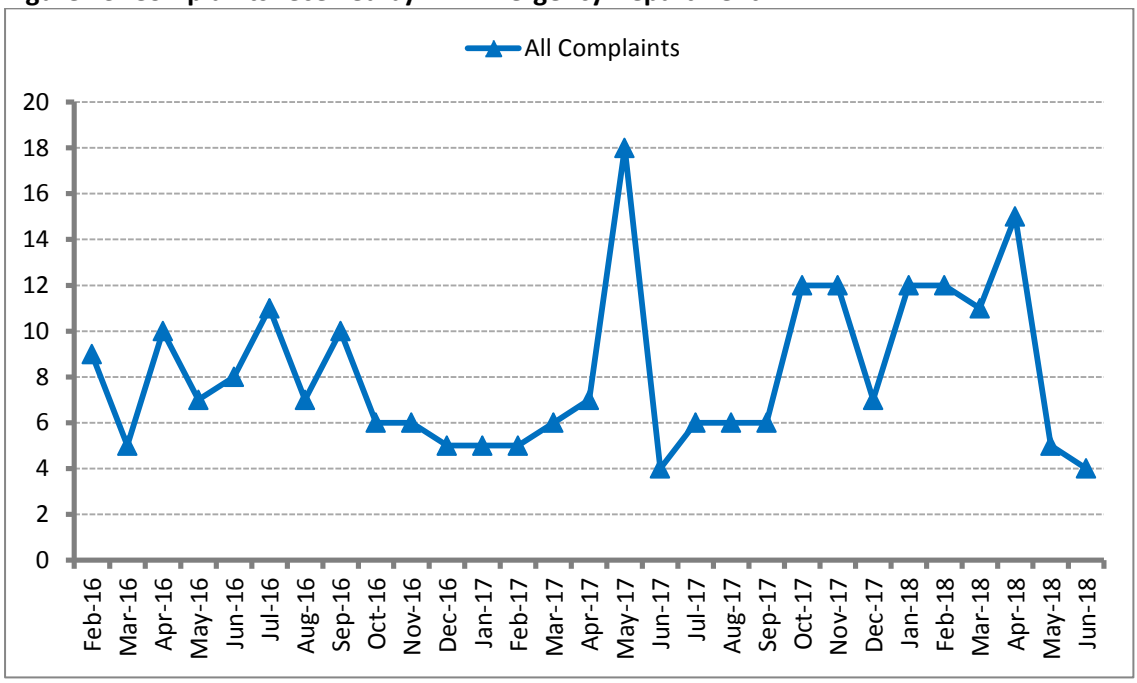


Figure 13: Complaints received by BRI Emergency Department



3.1.3 Division of Specialised Services

In Q1, the Division of Specialised Services received 76 complaints, compared with 55 in Q4 and 57 in Q3. The largest increase was in the category of 'clinical care', with 28 complaints received, compared with 18 in Q4. There was also a rise in the number of complaints received in respect of 'attitude and communication', with 16 complaints received, compared with 10 in Q4. In total, 53 complaints were received by Bristol Heart Institute and 18 were received by Bristol Haematology & Oncology Centre. The remaining five complaints for the Division were for the Clinical Genetics service based at St Michael's Hospital. Of the 76 complaints received in Q1, the Division investigated 22 via the formal investigation process and the remaining 54 via the informal investigation process.

Table 10: Complaints by category type

Category Type	**Number and % of complaints received – Q1 2018/19**	**Number and % of complaints received – Q4 2017/18**
Clinical Care	28 (36.8% of all complaints) ↑	18 (32.7% of all complaints) ↑
Appointments & Admissions	24 (31.6%) ↑	16 (29.1%) =
Attitude & Communication	16 (21.1%) ↑	10 (18.2%) ↓
Information & Support	5 (6.6%) ↓	6 (10.9%) ↑
Discharge/Transfer/Transport	2 (2.6%) ↓	4 (7.3%) ↑
Facilities & Environment	1 (1.3%) ↑	0 (0%) ↓
Documentation	0 (0%) ↓	1 (1.8%) ↓
Access	0 (0%) =	0 (0%) =
Total	**76**	**55**

Table 11: Top sub-categories

Category	**Number of complaints received – Q1 2018/19**	**Number of complaints received – Q4 2017/18**
Cancelled or delayed appointments and operations	17 ↑	10 ↑
Clinical care (medical/surgical)	8 ↓	9 ↑
Appointment administration issues	6 ↑	2 ↓
Communication with patient/relative	6 ↑	2 ↓
Clinical care (nursing)	3 ↑	2 ↓
Attitude of medical staff	3 =	3 ↑
Failure to answer telephone/failure to respond	2 ↑	1 =
Attitude of nursing staff	2 =	2 ↑
Discharge arrangements	2 ↓	4 ↑
Attitude of admin/clerical staff	1 ☐	0 ☐

Table 12: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
The largest increase in complaints received by the Division in quarter 1 was in the category of 'clinical care'. Nine of those complaints related to 'clinical care medical' and 'clinical care nursing'. There were also seven complaints about 'lost/misplaced/delayed test results', five in respect of 'delayed treatment' and four regarding issues with medication.	**Key Considerations:** 1) The need for ePMA (Electronic Prescribing and Medicines Administration System) roll out 2) Vital Pack (electronic patient observation records) roll out including VTE Assessments 3) BHOC fire in May 2018 4) Ongoing delays in Chemotherapy Day Unit (CDU) due to a capacity vs. demand issues. 5) Cath Lab staffing shortages resulting in ECHO sessions reduced.	1) ePMA • Familiarity with the system, which much improved in BHI. • Roll out in BHOC for September having learnt from BHI roll out. 2) Vital Pack • Transition to online from paper. Need to become comfortable with the system and this is improving. 3) BHOC Fire • Major Incident resolved. 4) Chemo Capacity • Agency usage to maximize current physical capacity. • Capital works to build in six additional chairs to increase physical capacity. • Recruitment of additional staff for CDU and Clinical Trials Unit (CTU). 5) Cath Lab Staffing • Agency usage within Cath Lab to reduce pressures. Agency usage on C805 to be able to support the Trans Oesophageal Echo (TOE) list.
There was a further increase in the number of complaints received by the Bristol Heart Institute Outpatients Department (including Outpatient Echo). 26 complaints were received by this service, compared with 18 in Q4 and 11 in Q3. Of these complaints, 11 were in respect of 'appointments and admissions'; seven were received about 'attitude and communication'; five were about 'clinical care' and three related to 'information and support'.	**Recurring themes:** 1) Delays obtaining test results 2) Difficulty making contact with the department 3) Cancelled appointments	1) Test results • Project initiated with transformation team support to improve process for following up test results • Agency staff in place to cover high vacancy rates in echo and cardiac physiology 2) Contacting the department • New hunt group set up for clinic coordinators so that all calls come through a single number which feeds into all phones 3) Cancelled appointments • New process implemented for tracking consultant leave to avoid any last minute clinic changes. • Outpatient Directory of Services updated as part of

		eRS (Electronic Referral System) roll-out and electronic triage (prioritisation system) started to ensure patients are booked in to the correct clinic at the outset.
A total of five complaints were received by the Clinical Genetics service based at St Michael's Hospital. Three of these five complaints related to 'lost /misplaced /delayed test results'.	**Key Considerations** 1) Laboratory service is provided by North Bristol NHS Trust. 2) Lab not providing results within given timeframes. 3) Lab experiencing staff shortages.	1) Not within our influence 2) Timeframes • Fed back to the labs • Discussed in genetic counsellor meeting and cancer meeting; to be cautious when giving test turnaround time scales (due to dependency on lab).
In Q1, the Division responded to 20 formal complaints. Five of these responses (25%) breached the deadline agreed with the complainant.	**Key influencers:** 1) The May BHOC Fire exacerbated the existing BHOC management shortage in writing complaints. May also corresponded with a new Head of Nursing starting in post who needed to understand the process around complaints.	1) BHOC Fire & Vacancies • Fire resolved • Management vacancies recruited into. 2) Head of Nursing • SOP has now been drawn up, in process of cross referencing with PSCT SOPs to prevent any contradiction then roll out end of August.

Figure 14: Specialised Services – formal and informal complaints received

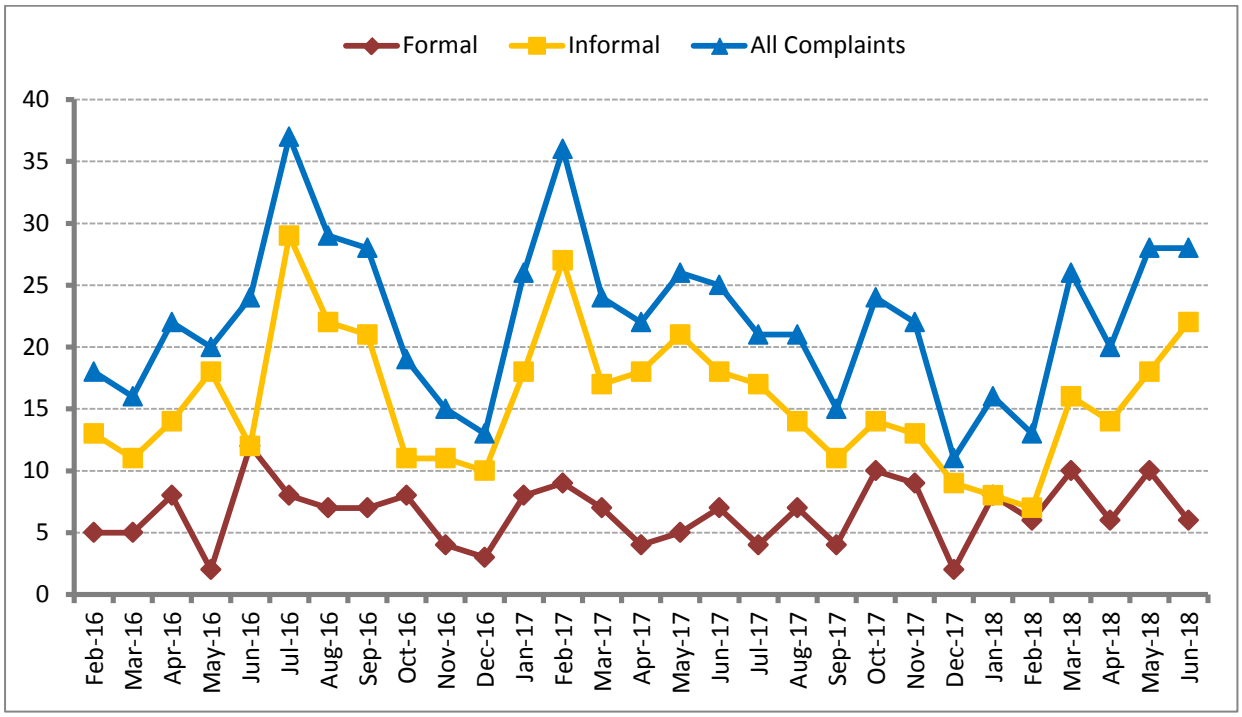


Figure 15: Complaints received by Bristol Heart Institute

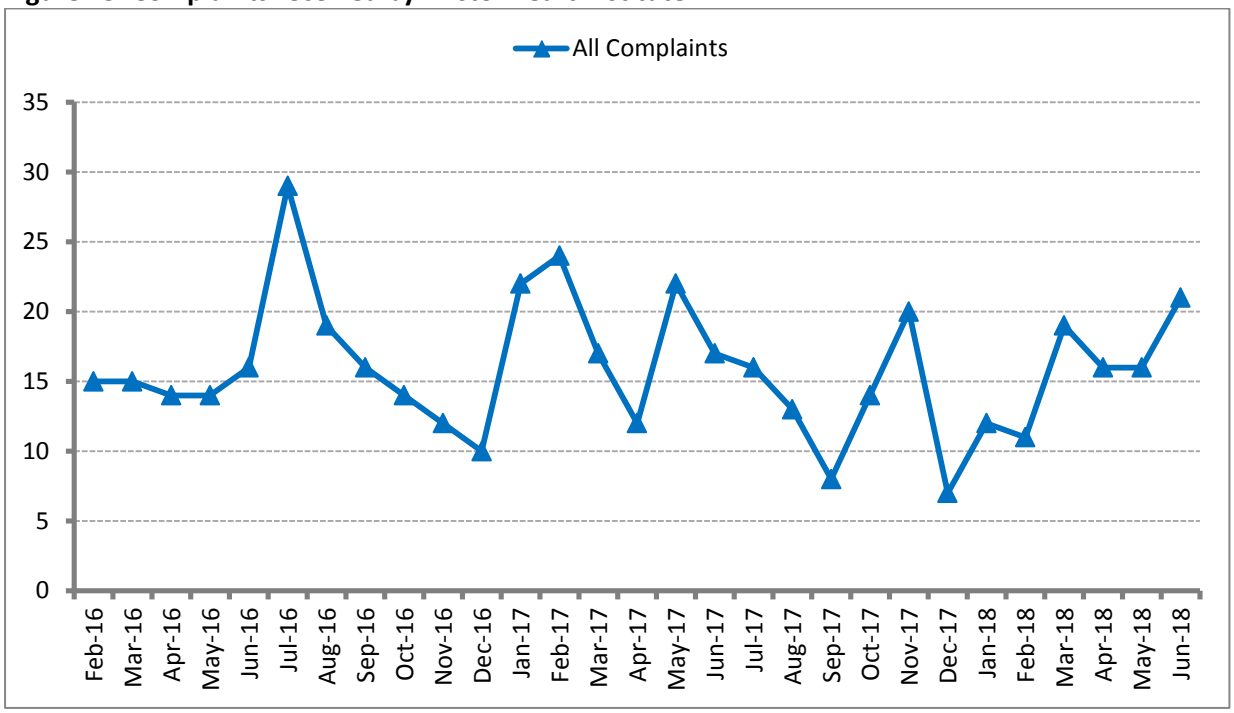


Figure 16: Complaints received by Bristol Heart Institute Outpatients

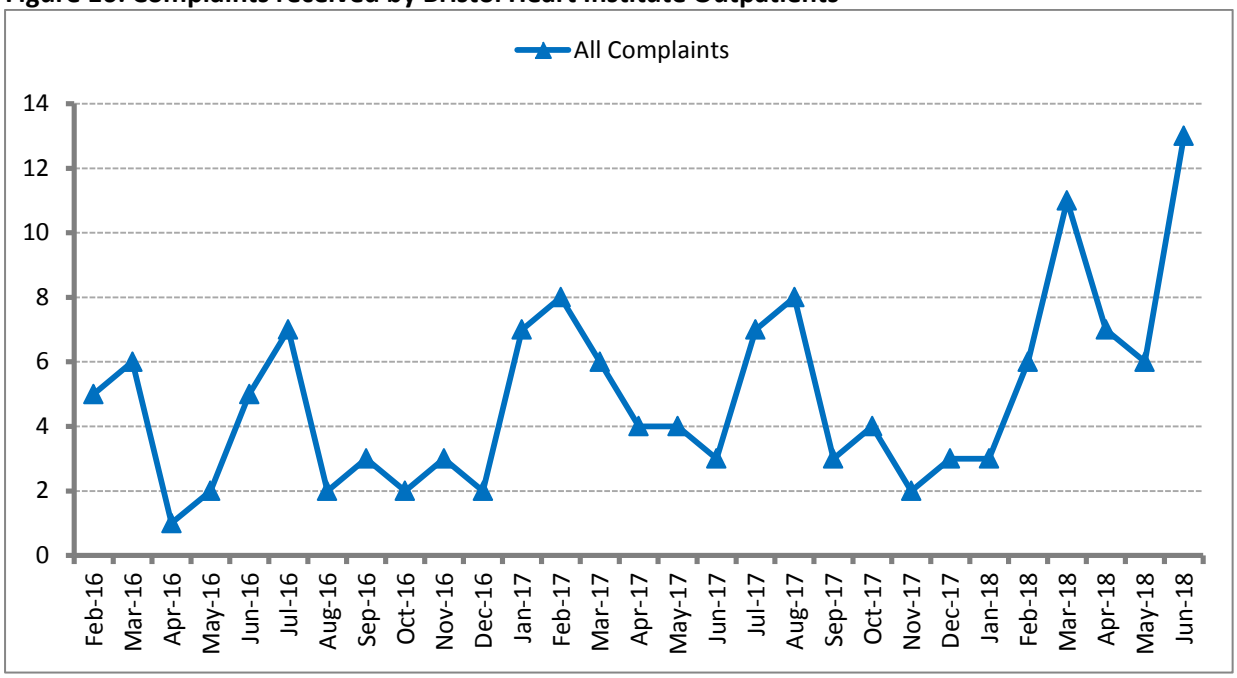
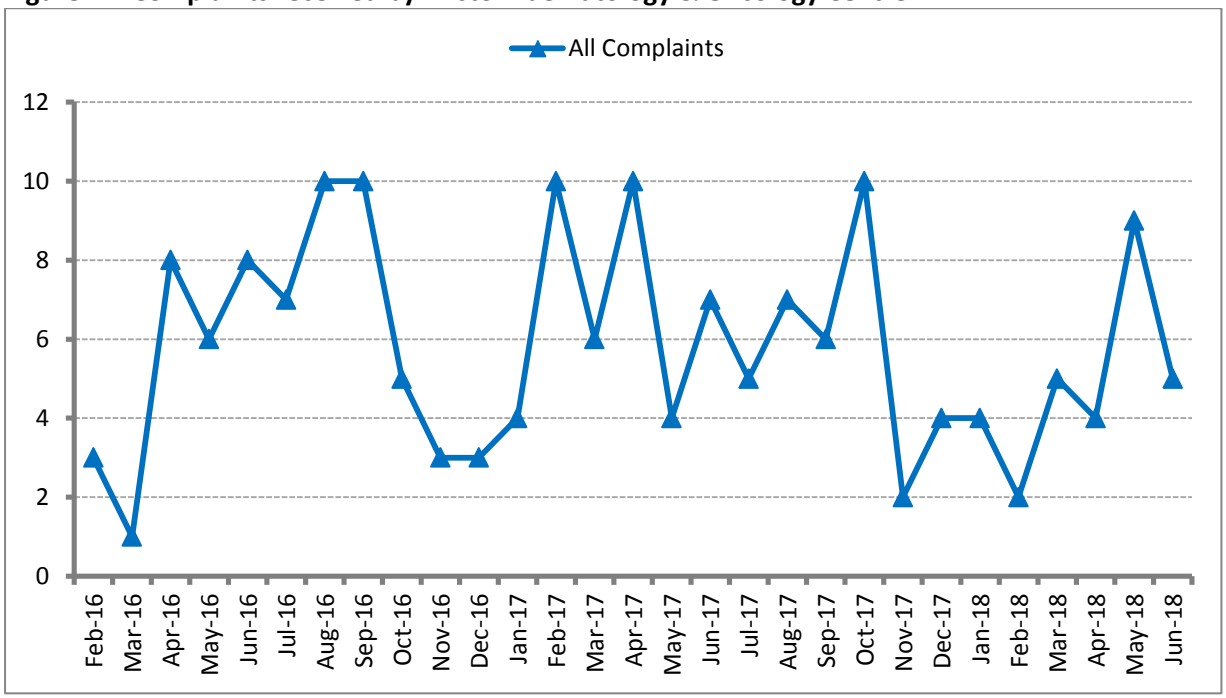


Figure 17: Complaints received by Bristol Haematology & Oncology Centre



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division decreased slightly compared with the previous quarter. There was a decrease in the number of complaints received in all categories except 'attitude and communication', however there were increases in the sub-categories of 'clinical care medical' and 'clinical care nursing/midwifery'. Of the 63 complaints received in Q1 2018/19, the division investigated 35 via the formal process and 28 via the informal process.

Table 13: Complaints by category type

Category Type	**Number and % of complaints received – Q1 2018/19**	**Number and % of complaints received – Q4 2017/18**
Clinical Care	25 (39.6% of total complaints) ↓	31 (44.9% of total complaints) ↑
Appointments & Admissions	17 (27%) ↓	18 (26.1%) ↑
Attitude & Communication	17 (27%) ↑	12 (17.4%) ↑
Facilities & Environment	2 (3.2%) ↓	3 (4.3%) =
Information & Support	1 (1.6%) ↓	2 (2.9%) ↓
Documentation	1 (1.6%) ↓	2 (2.9%) ↑
Discharge/Transfer/Transport	0 (0%) =	0 (0%) ↓
Access	0 (0%) ↓	1 (1.5%) ↑
Total	**63**	**69**

Table 14: Top sub-categories

Category	**Number of complaints received – Q1 2018/19**	**Number of complaints received – Q4 2017/18**
Clinical care (medical/surgical)	14 ↑	11 ↓
Cancelled or delayed appointments and operations	9 ↓	10 ↑
Clinical care (nursing/midwifery)	10 ↑	8 ↑
Communication with patient/relative	6 ↑	5 ↑
Attitude of admin/clerical staff	2 ↑	1 ↓
Attitude of medical staff	5 ↑	3 ↑
Failure to answer telephones /failure to respond	0 ↓	1 =
Appointment administration issues	7 ↑	3 ↑
Discharge arrangements	0 ↓	1 =
Attitude of nursing/midwifery	4 ↑	1 ↑

Table 15: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Approximately 40% of all complaints received by the Division (25 of 63) in Q1 were in respect of clinical care. Clinical care has been the category with the highest number of complaints for the Division for the last five consecutive quarters. 15 of the complaints about clinical care were received by Bristol Royal Hospital for Children (BRHC) and 10 by St Michael's Hospital (STMH).	**BRHC** We have seen a substantial increase in A&E activity over this quarter in relation to this time last year (approximately 15%). This has contributed to an increase in complaints as our level of responsiveness has been stretched with this acute increase in activity. **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.	**BRHC** We have reviewed and adjusted services as appropriate and we have seen a decrease in overall complaints in all categories in June, despite the continued high levels of activity. **STMH** The Maternity Service at UHBristol is working with the other providers of Maternity Services and the Commissioners across the BNSSG Local Maternity system (LMS) to implement the recommendations of Better Births which is a national must do. A work stream of the is to improve the post -natal experience of women by providing better infant feeding support, staff training, and a review of the bereavement care pathway. As part of the work stream it has been highlighted that now the partogram (pink paper work that labour care is documented on from the hand held maternity notes) no longer goes home with the patient, community midwives are not able to debrief women about their care. The partogram is put onto Evolve before the rest of the hand held notes to ensure it does not go missing, as the labour record is the most essential document where there is the possibility of litigation. The post- natal work stream has agreed to place posters on the post-natal wards inviting women to read their birth notes prior to discharge and midwives will encourage omen in the hospital to discuss their labour and ask any questions. The Head of Midwifery is working with the information governance team to see whether it is possible for Midwives to encourage women to photograph

		their partogram. In some areas Maternity services have Birth after thoughts services. This is being looked at as part of the post-natal work stream within the LMS. In order to help with women's' expectations of the post-natal wards, the ward sisters have written an information welcome leaflet to inform patients and their partners about ward routine and processes. In addition there have been complaints relating clinical in gynaecology which are being addressed with individuals. Posters have also been put up in the ward to encourage patients who have issues to ask to speak to the sister or Matron.
Complaints about the paediatric orthopaedic service increased from one in Q4 to seven in Q1. Five of these seven complaints were in respect of 'appointments and admissions'.	**BRHC** We have seen a substantial increase in A&E activity over this quarter in relation to this time last year, with a substantial increase in trauma and orthopaedic cases. This has led to increased pressure on services from A&E, to Theatre to outpatients.	**BRHC** We have reviewed the pathways for orthopaedic cases in Theatres which has improved response times, and now need to review outpatients, which is under increasing pressure in relation to overall capacity.
During Q1, the Division responded to 44 formal complaints. Of these 44 responses, 10 breached the deadline that had been agreed with the complainant (22.7%). Nine of these breaches were attributable to delays within the Division. Of the nine breaches, eight were complaints investigated by BRHC. Also during Q1, the Division responded to 27 informal complaints and eight of these breached the agreed deadline. Seven of these breaches were in respect of	**BRHC** We recognise that our internal processes have areas that need improvement, both in terms of clinician involvement and ability to draft replies when several clinicians have been involved.	**BRHC** We are developing an alternative approach to complaint management that will be more family centric. It will involve meeting with the complainant at the start of the process to understand what their concerns are, and ensuring we feedback in the way that they are happy with (whilst remaining within national and Trust guidance). .

complaints investigated by BRHC.		

Current priorities for improving how complaints are handled and resolved (STMH)

- Taking learning from Complaint Review Panel.

Priority issues we are seeking to address, based on learning from complaints (STMH):

- Patient Experience at the Heart workshops being started again in September.

Current priorities for improving how complaints are handled and resolved (BRHC)

- Following feedback from some families in relation to our responsiveness to complaints, recognition and imbedding of learning from complaints and understanding of the complainant's actual concerns, we are aiming to implement some different ways of addressing and handling complaints. We will be meeting with families wherever possible, or consulting them over the telephone on receipt of their complaint, to fully understand what they are asking us to investigate.

Priority issues we are seeking to address based on learning from complaints (BRHC):

- We will ensure that actions plans are clearly articulated to the family, together with clear plans for implementing required changes and auditing their effectiveness going forward.

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

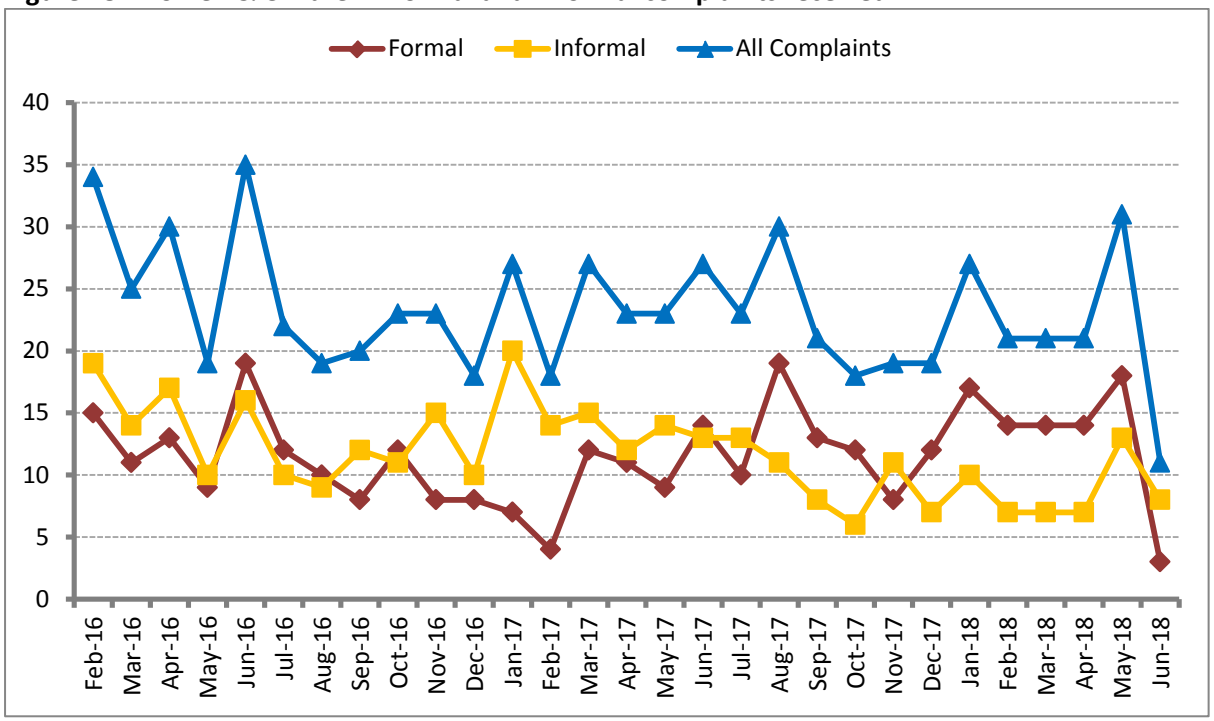


Figure 19: Complaints received by Bristol Royal Hospital for Children

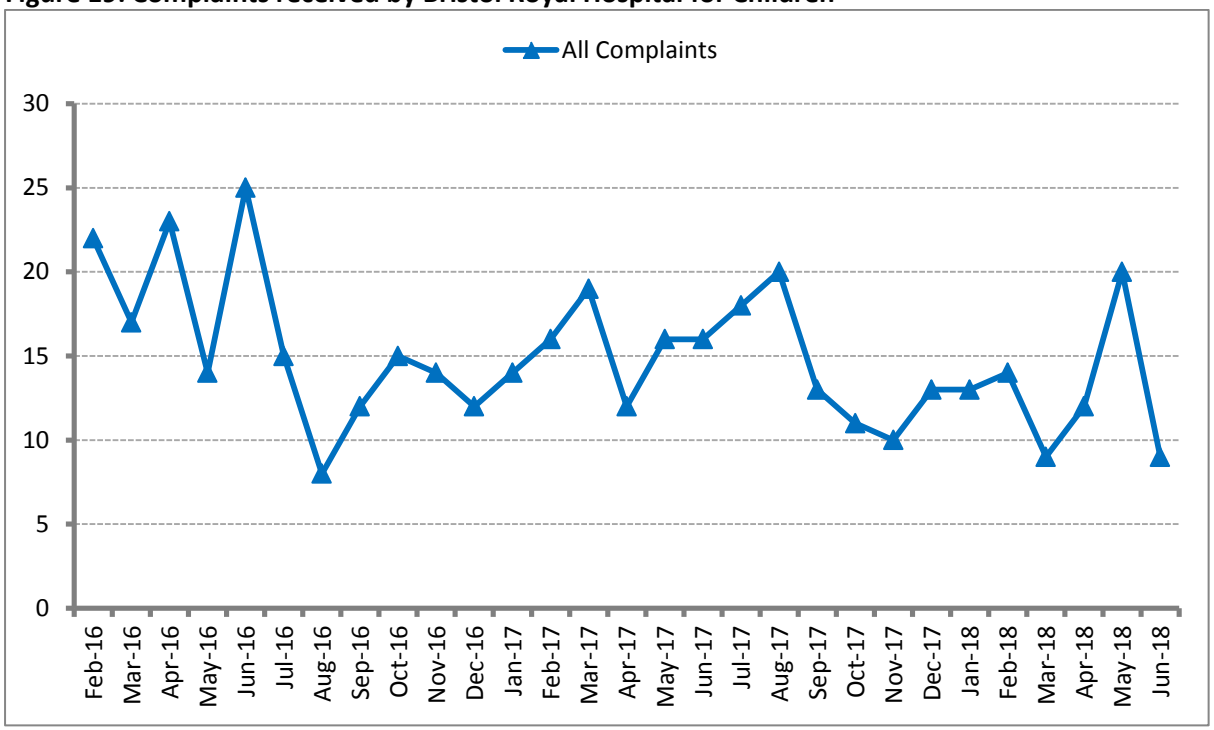
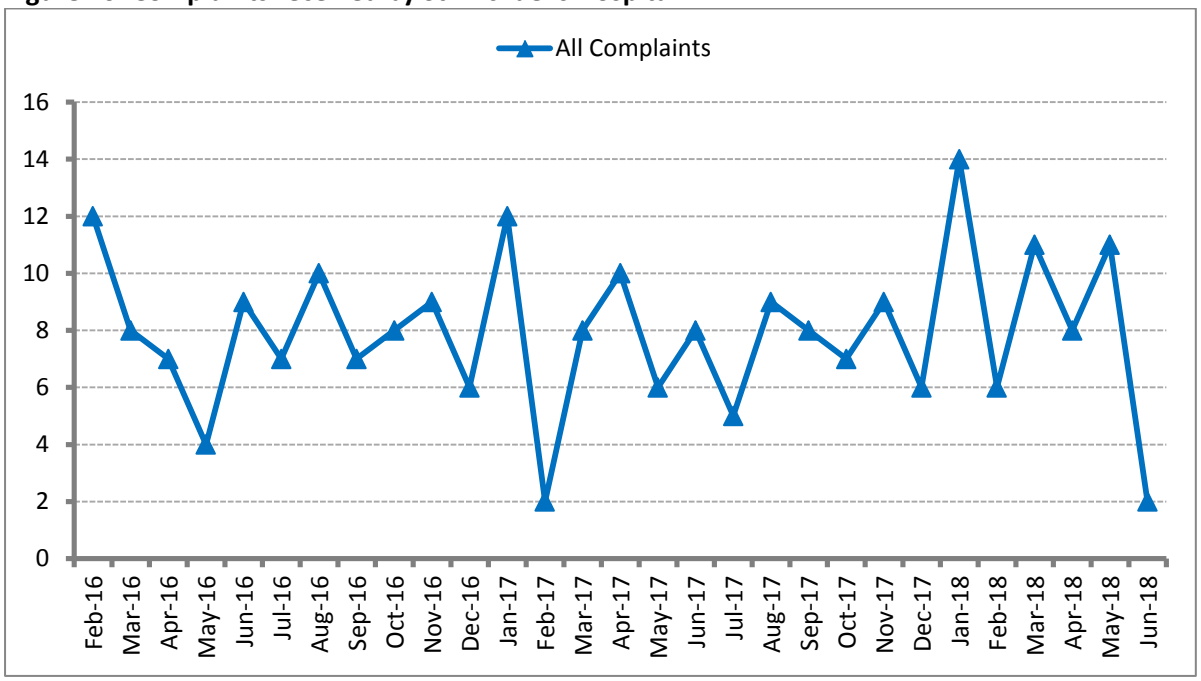


Figure 20: Complaints received by St Michael's Hospital



3.1.5 Division of Diagnostics & Therapies

Complaints received by the Division of Diagnostics and Therapies fell to 16 in Q1, compared with 20 in Q4. The majority of complaints received (seven each) were in respect of 'attitude and communication' and 'appointments & admissions' The Division dealt with three of the 16 complaints received via a formal investigation, with the remaining 13 complaints being investigated informally. During Q1, the Division responded to five formal complaints and 16 informal complaints – they met the deadline on every one of these responses, with no breaches.

Table 16: Complaints by category type

Category Type	**Number and % of complaints received – Q1 2018/19**	**Number and % of complaints received – Q4 2017/18**
Appointments & Admissions	7 (41.2%) ↑	4 (25%) ↓
Attitude & Communication	7 (41.2%) ↑	6 (%) ↓
Clinical Care	2 (11.8% of total complaints) ↓	5 (25% of total complaints) ↓
Information & Support	1 (5.9%) =	1 (6.3%) ↑
Facilities & Environment	0 (0%) ↓	4 (%) =
Discharge/Transfer/Transport	0 (0%) =	0 (0%) =
Documentation	0 (0%) =	0 (0%) =
Access	0 (0%) =	0 (0%) =
Total	**17**	**20**

Table 17: Top sub-categories

Category	**Number of complaints received – Q1 2018/19**	**Number of complaints received – Q4 2017/18**
Cancelled or delayed appointments and operations	2 ↓	3 =
Appointment administration issues	2 ↑	1 =
Attitude of medical staff/AHPs	2 ↓	3 ↑
Communication with patient/relative	2 ↑	1 =
Clinical care (nursing)	1 ↑	0 =
Clinical care (medical/AHPs)	0 ↓	2 =
Failure to answer telephones /failure to respond	0 ↓	1 ↓
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 Q1 data

Concern	Explanation	Action
The Division received eight complaints about Radiology services during Q1. Five of the eight complaints were in respect of 'attitude and communication'.	The five complaints regarding 'attitude and communication' were with regarding: Lack of communication and ease of rearranging appointment. Staff member rude and abrupt to parent and patient. Lack of communication from staff around reasons for appointment delay while waiting. Lack of communication between hospitals. Poor communication and explanation of cancelled scan.	Current staffing shortages mean appointments are not able to be booked as quickly as usual, recruitment is ongoing. Patient was offered four appointments, three of which she could not attend. Apology from the consultant paediatric radiologist, unaware that he had come across in such a manner and it was not his intention. Patient called and explanation that given there are several modalities for the waiting area so it may seem other patients are being called out of turn. Apologised for the lack of communication from staff and a reminder to staff to keep patients updated on any delays. Investigation ongoing – now a formal complaint in Q2. Explanation for cancellation of scan detailing safety concerns provided. Confirmation this was shared with appropriate consultant on the day and the family were informed at the time the reasons for cancelling.

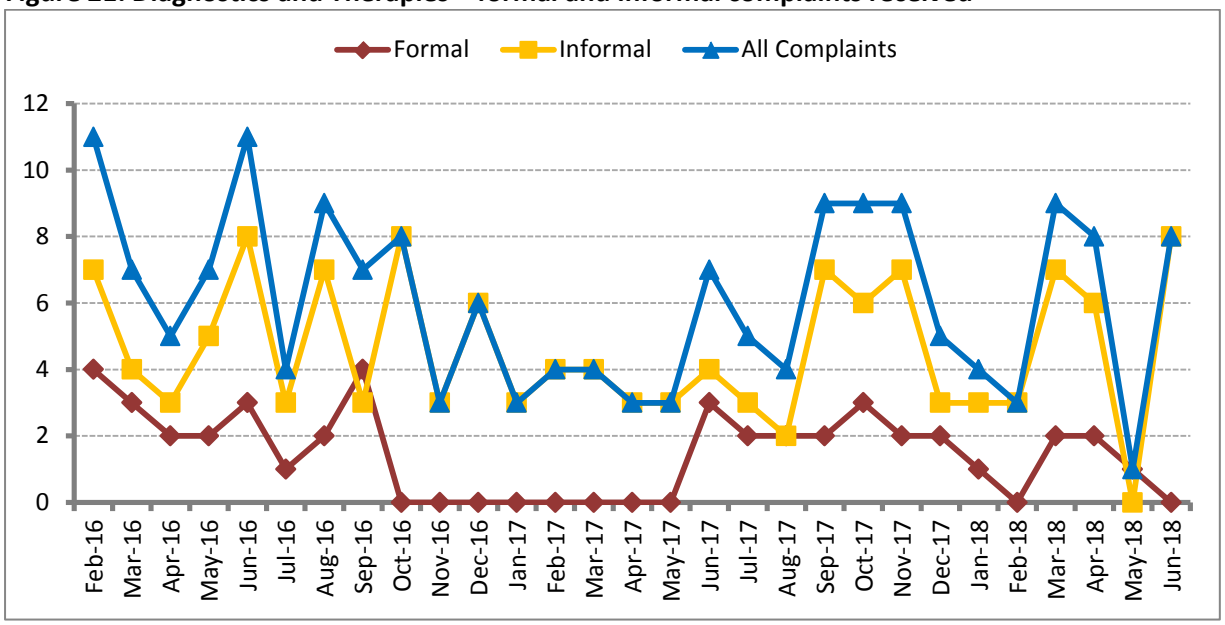
Current divisional priorities for improving how complaints are handled and resolved

- Within Diagnostics and Therapies, there is a robust process in place for the handling and resolving of complaints, there have been no breaches for formal complaints led by the division in the last year.

Priority issues we are seeking to address based on learning from complaints:

- There have only been six formal complaints led by D&T to date for 2018/19 with no current issues or themes to report on for the division this financial year so far.

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 23 complaints in Q1, compared with 20 in Q4. Of the 23 complaints received in Q1, eight were related to parking (mainly disputed parking tickets/fines) and four were received about the Welcome Centre/Reception at the BRI. The remaining 11 complaints were spread across various services, including the Private & Overseas Patients Office, Cashiers, Patient Affairs and Portering. No discernible trends were noted in respect of these 11 complaints.

Figure 22: Trust Services – formal and informal complaints received

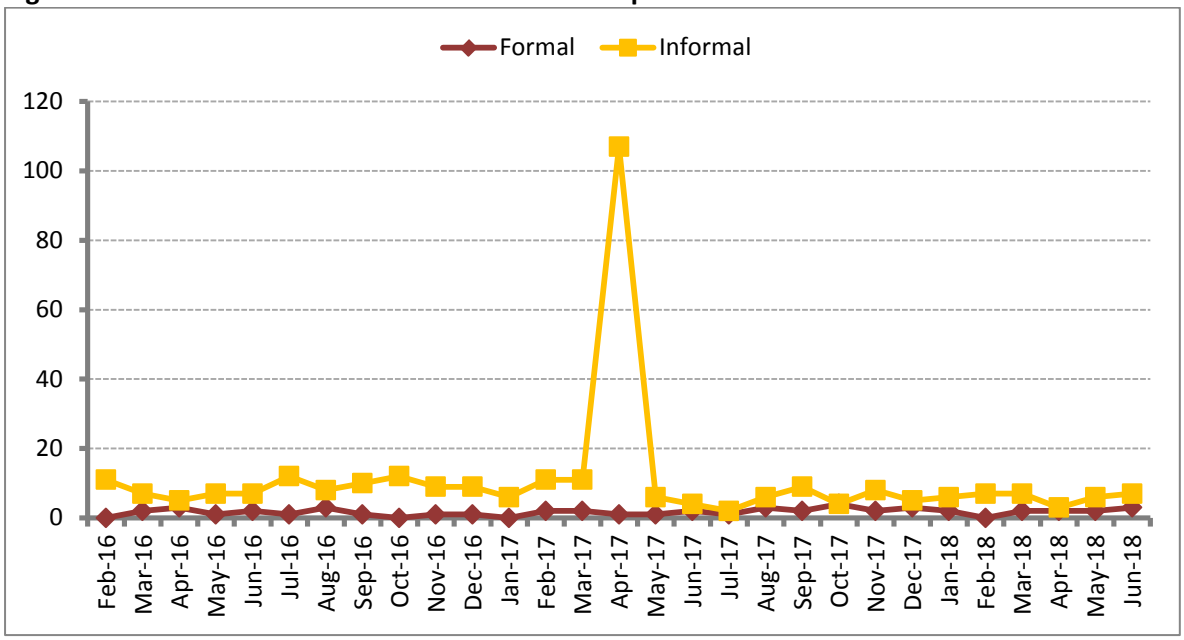
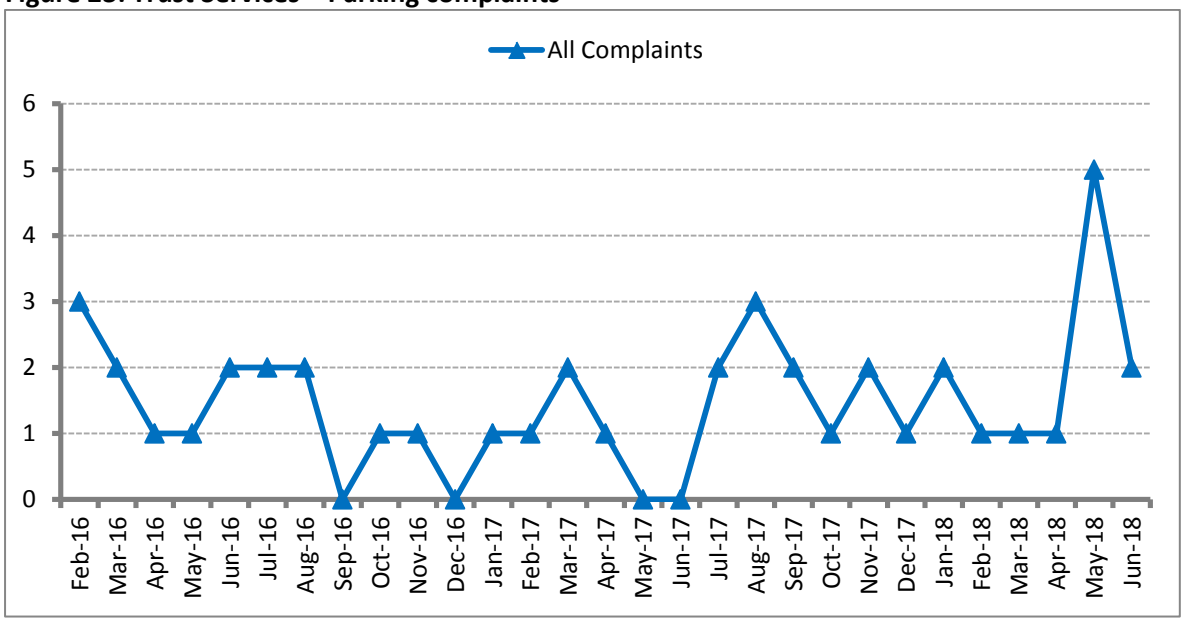


Figure 23: Trust Services – Parking complaints



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[3]

Hospital/Site	Number and % of complaints received in Q1 2018/19	Number and % of complaints received in Q4 2017/18
Bristol Royal Infirmary	178 (39.9% of total complaints) ↓	182 (43% of total complaints) ↑
Bristol Heart Institute	58 (13%) ↑	42 (9.9%) ↓
Bristol Dental Hospital	50 = (11.2%)	50 (11.8%) ↑
Bristol Royal Hospital for Children	46 (10.3%) ↑	37 (8.8%) ↑
St Michael's Hospital	38 (8.5%) ↓	45 (10.7%) ↑
Bristol Eye Hospital	32 (7.3%) ↓	33 (7.8%) ↑
Bristol Haematology & Oncology Centre	18 (4%) ↑	12 (2.8%) ↓
South Bristol Community Hospital	11 (2.6%) ↓	12 (2.8%) ↑
Central Health Clinic	6 (1.3%) ↑	3 (0.7%) ↓
Southmead and Weston Hospitals (UH Bristol services)	3 (0.7%) ↑	2 (0.5%) ↓
Trust Car Parks	2 (0.4%) =	2 (0.5%) =
Trust Headquarters	1 (0.2%) ↑	0 (0%) ↓
Off Trust Premises	1 (0.2%) ↑	0 (0%) ↓
Unity Community Sexual Health	1 (0.2%) ↓	1 (0.2%) ↓
Community Midwifery Services	1 (0.2%) ↑	0 (0%) =
Community Dental Sites (Charlotte Keel)	0 (0%) ↓	2 (0.5%) ↑
TOTAL	**446**	**423**

[3] 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.

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, Figure 24 below shows 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 Q1, 49.3% (*45.3%) of complaints received were about outpatient services, 30% (34.3%) related to inpatient care, 6% (9.7%) were about emergency patients; and 14.7% (10.8%) were in the category of 'other' (as explained above).

** Q4 percentages are shown in brackets for comparison.*

Figure 24: All patient activity

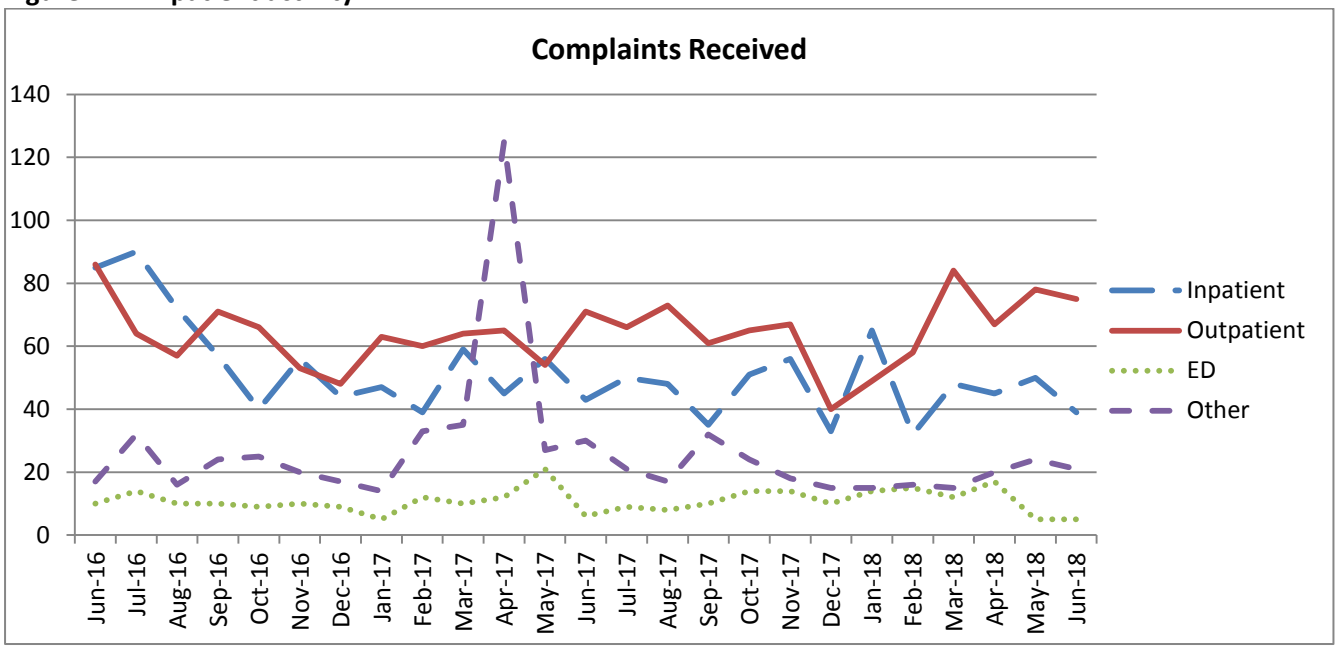


Table 20: Breakdown of Area Type

Complaints	Area Type				
Month	**ED**	**Inpatient**	**Outpatient**	**Other**	**Grand Total**
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
Apr-18	17	45	67	20	149
May-18	5	50	78	24	157
Jun-18	5	39	75	21	140
Grand Total	**282**	**1331**	**1675**	**672**	**3960**

3.3 Complaints responded to within agreed timescale

All Divisions, with the exception of Diagnostics & Therapies, reported breaches in Q1, totalling 25 breaches, which is fewer than the number recorded in the three preceding quarters. The largest percentage of breaches reported was by the Division of Trust Services (33.3% of all responses).

Table 21: Breakdown of breached deadlines

Division	**Q1 (2018/19)**	**Q4 (2017/18)**	**Q3 (2017/18)**	**Q2 (2017/18**
Surgery	4 (5.0%)	5 (9.2%)	9 (10.8%)	8 (14.3%)
Women & Children	10 (22.2%)	11 (34.4%)	9 (25.7%)	15 (38.5%)
Trust Services	3 (33.3%)	6 (42.8%)	5 (62.5%)	5 (45.5%)
Medicine	4 (7.4%)	6 (11.8%)	4 (8%)	5 (11.1%)
Specialised Services	4 (20%)	2 (10.5%)	3 (12.5%)	3 (12%)
Diagnostics & Therapies	0 (0%)	1 (20%)	0 (0%)	0 (0%)
All	**25 breaches**	**31 breaches**	**30 breaches**	**36 breaches**

(So, as an example, there were 4 breaches of timescale in the Division of Specialised Services in Q1, which constituted 20% of the complaint responses which were sent out by that division in Q1.)

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 Q1. The Divisions were responsible for 18 of the breaches, three were caused by delays in the Patient Support & Complaints Team and four breaches were attributable to delays during Executive sign-off. Delays caused by the Patient Support & Complaints Team were due to staff sickness when the team was short-staffed so some responses were not checked and sent for signing as soon as they were received from the Divisions.

Table 22: Reason for delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	All
Division	3	2	3	8	0	2	18
Patient Support & Complaints Team	1	0	1	0	0	1	3
Executives/sign-off	0	2	0	2	0	0	4
All	**4**	**4**	**4**	**10**	**0**	**3**	**25**

3.4 Outcome of formal complaints

In Q1 we responded to 213 formal complaints[4]. Tables 23 and 24 below show a breakdown, by Division, of how many cases were upheld, partly upheld or not upheld in Q1 of 2018/19 and Q4 of 2017/18 respectively.

Table 23: Outcome of formal complaints – Q1 2018/19

	Upheld	Partly Upheld	Not Upheld
Surgery	22 (27.4%)	41 (51.3%)	17 (21.3%)
Medicine	14 (26%)	20 (37%)	20 (37%)
Specialised Services	7 (35%)	10 (50%)	3 (15%)
Women & Children	15 (33.3%)	23 (51.1%)	7 (15.6%)
Diagnostics & Therapies	2 (40%)	2 (40%)	1 (20%)
Trust Services	4 (44.4%)	1 (11.2%)	4 (44.4%)
Total	**64 (30%)**	**97 (45.5%)**	**52 (24.5%)**

Table 24: 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%)**

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 recorded and acknowledged 49 compliments received during Q1 and shared these with the staff involved and their Divisional teams.

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

Table 25 below shows a breakdown of the 165 requests for advice, information and support dealt with by the team in Q1.

Table 25: Enquiries by category

Category	Enquiries in Q1 2018/19
Hospital information request	48
Information about patient	27
Medical records requested	18
Signposting	15
Clinical information request	14
Appointment enquiries	7
Appointment administration issues	5
Clinical care	4
Accommodation enquiry	4
Personal property	4
Emotional support	3
Travel arrangements and transport	2
Benefits and social care	2
Discharge arrangements	2
Support with access	2
Expenses claim	1
Communication	1
Freedom of information request	1
Disability support	1
Admission arrangements	1
Patient choice information	1
Invoicing	1
Translating and interpreting	1
Total	**165**

In addition to the enquiries detailed above, in Q1 the Patient Support and Complaints team recorded 159 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 819 separate enquiries in Q1 2018/19, compared with 741 in Q4 and 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 Q1, 236 complaints were received in writing (email, letter or complaint form) and 210 were received verbally (33 in person via drop-in service and 177 by telephone). Of the 446 complaints received in Q1, 98.7% (440 out of the 446 received) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written). This compares with 97.6% in Q4.

The Patient Support & Complaints Manager has reviewed the cases that were not acknowledged within timescale and, as during Q4, all six occurred when the team were experiencing high levels of sickness during April 2018 and were without administrative cover for a short period. As a result, some administrative work unfortunately fell slightly behind.

6. PHSO cases

During Q1, the Trust was advised of two new Parliamentary and Health Service Ombudsman (PHSO) interest in specific complaints. During the same period, two existing cases remain ongoing. Three cases were closed during Q1, one of which was upheld and all recommendations have been complied with, one was partly upheld and all recommendations have been complied with and one was closed by the PHSO without investigation or further action required.

Table 26: Complaints opened by the PHSO during Q1

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
5741	JF	SM	23/01/2017 [21/05/2018]	BHI	Ward C604 (CICU)	Specialised Services
Contacted by PHSO asking if we were still investigating this complaint. We advised that we had sent several responses in writing and had met with the complainant and sadly not much further we could tell her. We also advised that an RCA investigation had been carried out. We have not heard anything from the PHSO since sending them that information on 21 May 2018.						
11432	KW	IW	23/11/2017 [19/04/2018]	BDH	Adult Restorative Dentistry	Surgery
We advised the PHSO that the complaint was made due to the patient not qualifying for NHS treatment in this instance. The PHSO have informed us that they are taking no further action on this case. They explained to the patient that the NHS Constitution recognises that there are circumstances which prevent providers from treating all patients who need its service. In such cases, it is the responsibility of the patient's local Clinical Commissioning Group (the CCG) to facilitate treatment elsewhere or consider procuring treatment in the private sector.						

Table 28: Complaints ongoing with the PHSO during Q1

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
10267	SL		20/09/2017 [02/07/2018]	SBCH	Radiology (SBCH)	Diagnostics & Therapies
Complaint investigation and response led by Bristol Community Health (BCH). PHSO have asked whether we will jointly pay patient financial remedy for her suffering. Currently awaiting response from Division and Legal Services as this may become a clinical negligence case.						

695	BG	N/A	04/03/2016 [12/03/2018]	BEH and BRI	BEH ED and BRI Radiology	Surgery and Diagnostics & Therapies
Copy of complaint file and medical records sent to PHSO on 26/03/2018 so they could decide whether to investigate and/or take any further action. We contacted PHSO on 07/06/2018 to enquire as to progress but have not received a reply as yet. Currently waiting to hear further from PHSO.						

Table 29: Complaints formally closed by with the PHSO during Q1

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
The Trust accepted the findings of the PHSO's report and their decision to partly uphold the complaint. We have complied with their recommendations, which included sending the patient a payment of £629.40.						
7407	JW-S	LS	20/04/2017 [31/01/2018]	BHI	Cardiology	Specialised Services
PHSO's final report received 30/05/2018 upholding the complaint. All recommendations of report accepted and complied with, including a payment of £750 to the complainant.						
6693	CL	SL	16/03/2017 [01/02/2018]	BRI	Ward A700	Surgery
PHSO closed the case in May 2018 with no further action taken.						

7. Complaint Survey

Since February 2017, the Patient Support and Complaints 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.

Approximately 300 surveys are sent out every quarter.

Table 28: Complaints Survey Data

Survey Measure/Question	**Q1 2018/19** *(45 responses received)*	**Q4 2017/18**	**Q3 2017/18**	**Q2 2017/18**
Respondents who confirmed that a timescale had been agreed with them by which we would respond to their complaint.	68.2%	66.7%	83%	71.1%
Respondents who felt that the Trust would do things differently as a result of their complaint.	11.1%	22.2%	20%	37.2%
Respondents who found out how to make a complaint from one of our leaflets or posters.	7.5%	10.3%	5.6%	14.3%
Respondents who confirmed we had told them about independent advocacy services.	33.3%	35.7%	37%	31.1%
Respondents who confirmed that our complaints process made it easy for them to make a complaint.	66.7%	72.4%	64.3%	73.9%
Respondents who felt satisfied or very satisfied with how their complaint was handled.	64.5%	57.2%	66.1%	67.4%
Respondents who said they did not receive their response within the agreed timescale.	18.6%	33.3%	28.6%	20.5%
Respondents who felt that they were treated with dignity and respect by the Patient Support & Complaints Team.	95.5%	92.9%	91.1%	100%
Respondents who felt that their complaint was taken seriously when they first raised their concerns.	84.5%	71.5%	83.9%	78.3%
Respondents who did not feel that the Patient Support & Complaints Team kept them updated on progress often enough about the progress of their complaint.	31.8%	33.3%	20.4%	23.9%
Respondents who received the outcome of our investigation into their complaint by way of a face-to-face meeting.	2.3%	0%	1.8%	6.8%
Respondents who said that our response addressed all of the issues that they had raised.	60%	50%	62.3%	44.4%

Although the number of responses to this survey is small (45 in Q1, representing a response rate of approximately 15%), the quarterly decline in complainants stating that they believe that the Trust will do things differently as a result of their complaint is nonetheless a concern. We will continue to monitor answers to this survey question and propose that this should be a topic for discussion at our first planned focus group with complainants in Q4 2018/19.

8. Protected Characteristics

This report includes statistics relating to the protected characteristics of patients who have made a complaint. The areas recorded are age, ethnic group, gender, religion and civil status.

The Patient Support and Complaints Team continues to work hard to ensure that as much of this information as possible is gathered from patients, in order to reduce the numbers reported in each category as "unknown". It should be noted that these statistics relate to the **patient** and not the complainant (if someone else has complained on their behalf).

8.1 Age

Age Group	**Number of Complaints Received Q1 2018/19**
0-15	36
16-24	24
25-29	29
30-34	32
35-39	29
40-44	18
45-49	25
50-54	30
55-59	25
60-64	28
65+	126
Unknown	44
Total Complaints	**446**

8.2 Ethnic Group

Ethnic Group	**Number of Complaints Received Q1 2018/19**
White British	303
Any Other White Background	15
Mixed - White and Black Caribbean	8
Black Caribbean or Black British Caribbean	5
Black African or British African	4
Indian or British Indian	3
White Irish	3
Any Other Asian Background	3
Pakistani or British Pakistani	2
Any Other Ethnic Group	2
Bangladeshi or British Bangladeshi	1
Chinese	1
Any Other Black Background	1
Mixed – White and Asian	1
Unknown/Not stated	94
Total Complaints	**446**

8.3 Religion

Religion	Number of Complaints Received Q1 2018/19
Christian:	164
Church of England	113
'Christian'	22
Catholic (Roman Catholic)	18
Baptist	4
Methodist	3
Church of Scotland	2
Protestant	1
Salvation Army	1
Not Religious	93
Muslim	8
Atheist	6
Agnostic	3
Hindu	1
Jehovah's Witness	1
Jewish	1
Spiritualist	1
Unknown/Not stated	168
Total Complaints	**446**

8.4 Civil Status

Civil Status	Number of Complaints Received Q1 2018/19
Married/Civil Partnership	127
Single	122
Divorced/Dissolved Civil Partnership	20
Co-habiting	16
Widowed/Surviving Civil Partner	9
Separated	7
Unknown/Not Stated	137
Total Complaints	**446**

8.5 Gender

Of the 446 complaints received in Q1 2018/19, 273 (61.2%) of the patients involved were female, 161 (36.1%) were male and 12 (2.7%) did not state their gender.

Cover report to the Public Trust Board. Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	**11b**
Meeting Title	Public Trust Board	**Meeting Date**	**Thursday, 27 September 2018**
Report Title	**Patient Experience Q1 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 Trust Board with 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

UH Bristol patient-reported experience surveys

The key messages from the Trust's corporate survey programme are as follows:

- All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 1, indicating the continued provision of a high quality experience for service-users

- UH Bristol continues to receive positive scores in our surveys, with 99% of patients rating their care as excellent, very good or good
- South Bristol Community Hospital's headline survey scores increased for the fourth consecutive quarter. This coincides with the ongoing work that has been carried out to improve patient experience at the hospital
- Three negative outliers are highlighted in the report:
    - Ward C808 (care of the elderly) had the lowest headline survey scores during Quarter 1: the Division of Medicine is working with the ward to address a large number of staff vacancies and manage significant increases in the number of patients requiring intensive support from the ward staff
    - Ward A528 (care of the elderly ward) continues to receive relatively low survey scores. In Quarter 1 the *Face2Face* volunteer interview team talked to patients and families on the ward to try and understand the reasons for this, but the feedback received was generally very positive. The Division of Medicine is supporting the ward to help manage a significant increase in the number of patients requiring intensive support from staff
    - Patient-reported waiting times in outpatient clinics at the Bristol Haematology and Oncology Centre were relatively long in Quarter 1: this reflects disruption caused by a fire at the hospital during the period. It is also set against a wider backdrop of increasing service demand, which the Division of Specialised Services is working to meet through a range of development and improvement projects.

Care Quality Commission National Inpatient Survey

The Care Quality Commission 2017 National Inpatient Survey results were released in Quarter 1 18/19. In this survey, four UH Bristol survey scores were classed as being better than the national average to a statistically significant degree, with one score being below this benchmark. The remaining 53 UH Bristol scores were classed as being in line with the national average. In the previous national inpatient survey (2016), twenty UH Bristol scores were classed as being better than the national average. Analysis by the Trust's Patient Experience and Involvement Team suggests that the Trust's performance in 2017 was in line with 2016, when margins of error in the survey data are taken into account. UH Bristol achieved the second highest overall patient experience rating of any general acute trusts nationally in 2017. A detailed analysis report, including a summary of activities being carried out that will address the improvement themes identified through the survey, was provided to the Trust's Patient Experience Group and the Quality and Outcomes Committee of the Trust Board in June 2018.

Patient and Public Involvement

Examples of Patient and Public Involvement projects undertaken during Quarter 1are provided in the Quarterly Report, including:

- In collaboration with the adult Ear, Nose and Throat team and the University of Bristol, patient focus groups were held to inform the design of a novel implantable artificial larynx. Patients who had undergone the removal of their larynx and the separation of the airway from the mouth, nose and oesophagus participated in the group. This insight will inform the development of a research project
- The Trust's Patient and Public Involvement Lead attended the Bristol Deaf Health Partnership, comprising a range of deaf community representatives and local NHS providers
- Members of UH Bristol's Involvement Network contributed their views about the proposed UH Bristol Transport Hub.

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)**
		September 2018		Patient Experience Group - August 2018; Senior Leadership Team – September 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 1 2018/19

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

Patient Experience and Involvement Team

Paul Lewis, Patient Experience and Involvement Team Manager (paul.lewis@uhbristol.nhs.uk)
Tony Watkin, Patient and Public Involvement Lead (tony.watkin@uhbristol.nhs.uk)
Anna Horton, Patient Experience and Regulatory Compliance Facilitator (anna.horton@uhbristol.nhs.uk)

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

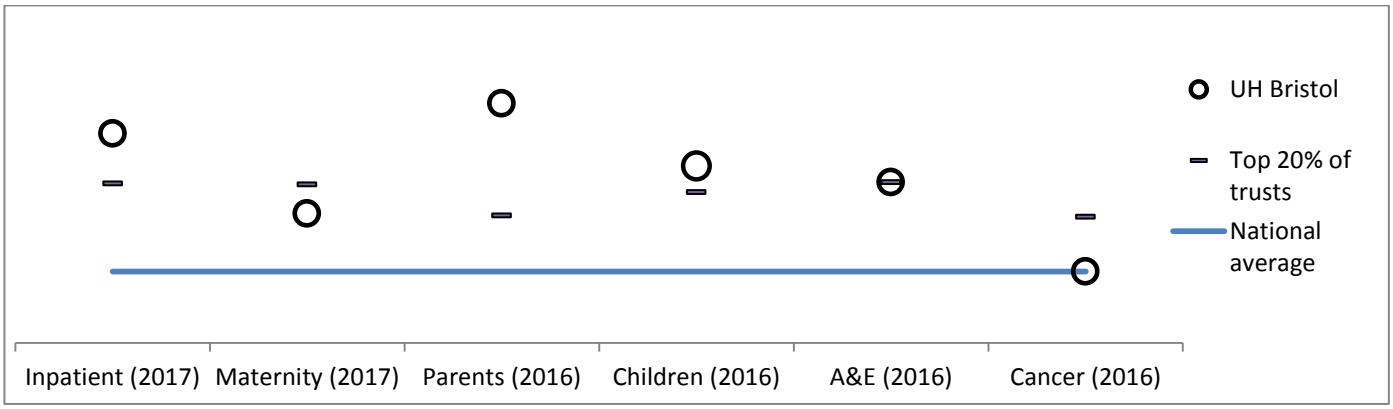
Successes	Priorities
• The 2017 national inpatient survey results were released in Quarter 1: UH Bristol's overall experience rating from patients was the second highest non-specialist trust score nationally • UH Bristol continues to receive positive scores in our local surveys, with 99% of inpatients and outpatients rating their care as excellent, very good or good • All of UH Bristol's headline Trust-level patient satisfaction survey measures were above their target levels in Quarter 1, indicating the continued provision of a high quality experience for our service-users • South Bristol Community Hospital's headline inpatient survey scores have improved for four successive quarters. This coincides with ongoing work that has been carried out to improve patient experience at the hospital	During Quarter 1 a tender exercise was completed for the purchase of an electronic patient feedback system. This system will comprise around 15-20 touchscreen feedback points located in the Trust's hospitals. Patients and visitors will also be able to give feedback through the system via their own mobile devices. The system will capture general survey feedback as well as allowing people to request a call back if they have a specific issue or concern: this request will generate an automated email that, in the first phase of the implementation, will be sent to the Patient Support and Complaints Team. The roll out of the touchscreens and accompanying marketing (e.g. posters, signage) will take place in the Bristol Royal Infirmary during Quarter 3. Following an evaluation period, a wider roll out to all hospital sites will commence, including the direct routing of email alerts into Divisional teams.
Opportunities	**Risks & Threats**
The 2017 national inpatient survey results were released in Quarter 1. The Trust achieved a positive performance in the survey. Key work streams being carried out at UH Bristol to further improve patient experience include: • Learning from the concept of "customer service" in the private sector, to provide a more <u>consistently</u> excellent experience for our patients and visitors • Procurement of a rapid-time electronic feedback system, to encourage service users to give feedback - particularly when they have concerns / issues • Improved "marketing" around our hospitals to ensure that patients and visitors know how to give feedback or make a complaint, and feel empowered to do so • A focus on improving patient experience in care of the elderly, maternity and cancer services	• Ward C808 (care of the elderly) had the lowest headline survey scores during Quarter 1: the Division of Medicine is currently working with the ward to address a large number of staff vacancies and manage significant increases in the number of patients requiring intensive support from the ward staff. • Ward A528 (care of the elderly ward) continues to receive relatively low survey scores. In Quarter 1 the *Face2Face* volunteer interview team talked to patients and families on the ward to try and understand the reasons for this, but the feedback received was generally very positive. The Division of Medicine is currently supporting the ward to help manage a significant increase in the number of patients requiring intensive support from staff. • Patient-reported waiting times in outpatient clinics at the Bristol Haematology and Oncology Centre were relatively long in Quarter 1: this reflects disruption caused by a fire at the hospital during the period. It is also set against a wider backdrop of increasing service demand, which is putting significant pressure on clinic capacity that the Division of Specialised Services is working to address.

2. Patient survey data

2.1 National benchmarks

The national survey programme provides a comparison of patient-reported experience at UH Bristol against 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 and the Quality and Outcomes Committee of the Trust Board.

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



The 2017 national inpatient survey results were released in Quarter 1. In this survey, four UH Bristol survey scores were classed as being better than the national average to a statistically significant degree, with one score being below this benchmark. The remaining 53 UH Bristol scores were classed as being in line with the national average.

In the previous national inpatient survey (2016), twenty UH Bristol scores were classed as being better than the national average. Analysis of the national survey results and our own (much more accurate) local survey data by the Trust's Patient Experience and Involvement Team, suggests that this apparent decline in performance between 2016 and 2017 was primarily caused by margins of error in the survey data, rather than a deterioration in service quality. For example, in 2017, UH Bristol still achieved the second highest overall patient experience rating of any general acute trusts nationally.

A number of improvement projects are underway at UH Bristol that have been developed specifically in response to our local and national survey results. These projects include:

- The Trust's corporate quality objective relating to embedding a customer service mind set across the organisation, which will help to ensure that a more consistently excellent experience is provided to service-users and colleagues
- Procurement of a rapid-time electronic feedback system, to empower our service users to give feedback - particularly when they have an or concern about their care
- Improved "marketing" around our hospitals to ensure that patients and visitors know how to give feedback or make a complaint
- A focus on improving patient experience in care of the elderly, maternity and cancer services

2.2 Overview of Quarter 1 performance

In Quarter 1, 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 in the outpatient Friends and Family Test exceeded its target in Quarter 1 (6.3% against a target of 6%), having been slightly below this in the previous quarter. This improvement was attributable to the extension of the SMS (text message) arm of this survey to the Bristol Royal Hospital for Children, significantly boosting the number of participants / responses.

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[1]. 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.

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

	Current Quarter (Quarter 1)	Previous Quarter (Quarter 4)
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	Green	Red
Emergency Department Friends and Family Test response rate	Green	Green

[1]The survey scores shown in this report provide an indication of how service-users rate their experience at UH Bristol. The Trust's Patient Experience and Involvement Team Manager carries out an annual review of the targets associated with these scores to ensure that they remain fit for purpose. These targets perform a quality monitoring function: if a score deteriorates to a significant degree it will trigger an alert, providing an opportunity for the senior management team to intervene. The current target levels were found to strike the right balance between being able to detect a Trust level change (where the data is usually very stable over time), whilst taking into account the larger margins of error when the data is broken down by hospital and ward (making it more difficult to identify genuine negative outliers at this level). Therefore, all of the current targets will be maintained during 2018/19. The one exception is the Emergency Department Friends and Family Test target score: this target will be increased due to significant changes to the survey methodology, which over the course of 2017/18 in effect raised the Trust's average score in this survey. This change has been applied to the current report.

Table 2: Patient survey data exception reports for Quarter 1 (full data can be found in Section 2.3 of this report)

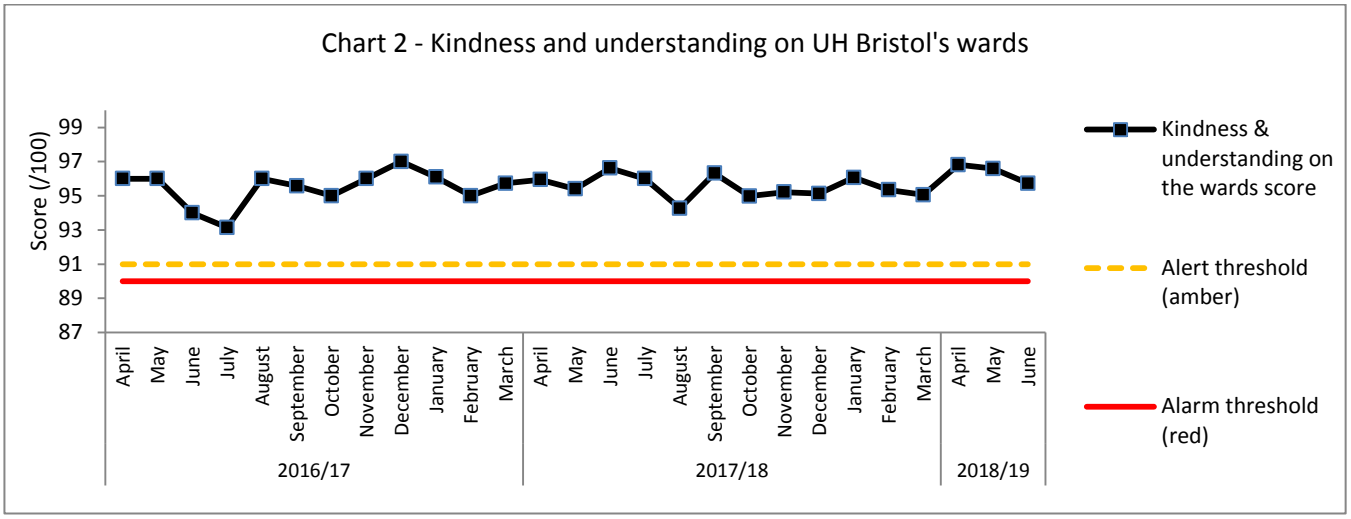
Issue	Description	Response / Actions
1. Survey scores on ward C808	Ward C808 is a care of the elderly ward that had the lowest headline survey scores during Quarter 1 (see Charts 20-22). This was a particularly disappointing result because during 2017/18 the ward's scores had been on an improvement trend.	The ward is currently experiencing recruitment challenges, with around a 35% vacancy rate. This increases the reliance on temporary staff, which in turn can impact on patient experience. In addition, there have been significant increases in the number of patients requiring intensive support on the ward. The Division of Medicine is carrying out work to address and resolve these issues.
2. Friends and Family Test score on ward A605	Ward A605 had the lowest Friends and Family Test (FFT) score in Quarter 1 (Chart 22).	This result is an artefact the FFT scoring system. Of the 29 patients who responded to the FFT on Ward A605 in Quarter 1, three said that they didn't know whether they would recommend the ward to friends and family (no patients said they wouldn't recommend the ward). A "don't know" response counts as a negative in the FFT scoring mechanism – meaning that the overall score for A605 was pulled down by these responses. The ward is not appearing as an outlier in the other quality data that is being monitored by the Division of Medicine.
3. Survey scores on ward A528	Ward A528 is a care of the elderly ward in the Bristol Royal Infirmary. In Quarters 3 and 4 the ward was identified in this report as a negative outlier. The scores improved slightly in Quarter 1, but were still towards the lower end on our headline survey measures (Charts 20-22).	The Trust's *Face2Face* volunteer interview team visited the ward in May 2018 to try and better understand the causes of these relatively low survey scores. Generally the feedback received about the ward was very positive. The Matron for the ward is currently drawing up an improvement plan primarily focussed on staff experience, but which should in turn have a positive effect on patient experience. As part of this, the Patient Experience and Involvement Team will run a staff workshop ("Patient Experience and Heart") to explore how each member of the team can contribute to a positive patient experience. This is likely to be carried out during Quarter 2 (a date is currently being identified).

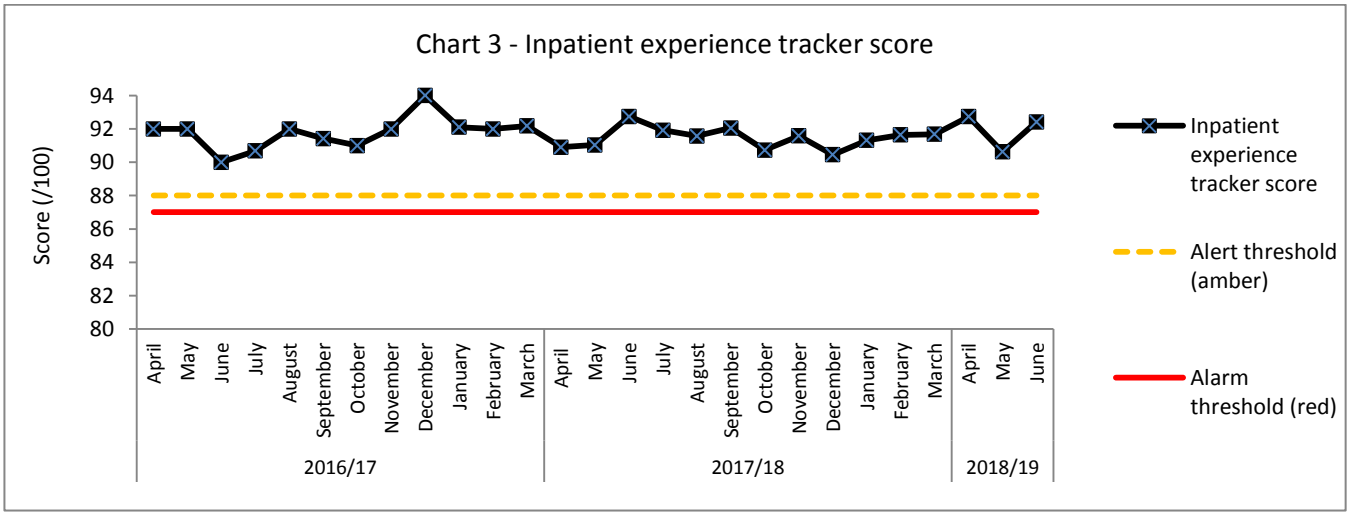
Issue	Description	Response / Actions
4. Survey score on Ward A604	The scores for Ward A604 (trauma and orthopaedics) were relatively low in the previous two quarters. The scores improved slightly in Quarter 1, but the ward still had the second lowest "kindness and understanding" survey score (Chart 20).	Whilst the scores improved in Quarter 1, the Division of Surgery management team is continuing to address issues with staffing levels on the ward, with short and long term plans developed for recruitment and retention. A number of actions are also being carried out by the Division to ensure that safe care is being delivered on the ward.
5. Bristol Haematology and Oncology Centre outpatient experience score	The outpatient survey tracker score target for the Bristol Haematology and Oncology Centre was below target in Quarter 1 (Chart 18). Further analysis has shown that it was the "waiting times in clinic" element of the tracker that pulled down the overall result.	It is recognised by the management team that there are significant demand pressures on outpatient oncology services. On a day-to-day basis the clinic teams continue to try and effectively meet this demand. Alongside this, a number of actions are being carried out and developed by the Specialised Services Division to increase capacity. Quarter 1 was particularly challenging due to the disruption caused by a fire in the Bristol Haematology and Oncology Centre.
6. 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).	This issue was identified in the last quarter and, as a result, the department Sister reminded her staff about the importance of telling families if there were delays in clinic. These scores subsequently showed an improvement during Quarter 1. The data in Table 4 spans six months and so the result presented here largely reflects "historic" data from Quarter 4 (we pool the data across six months to ensure that the sample sizes are sufficiently large to work with).
7. Communicating key information at discharge in the Division of Medicine	The Division attracts relatively low scores around conveying key information at discharge from hospital (e.g. medication side effects, who to contact with concerns – 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 prompts for this information. The revised checklist is currently being trialled and it is anticipated that it will go fully live during Quarter 2 2018/19.

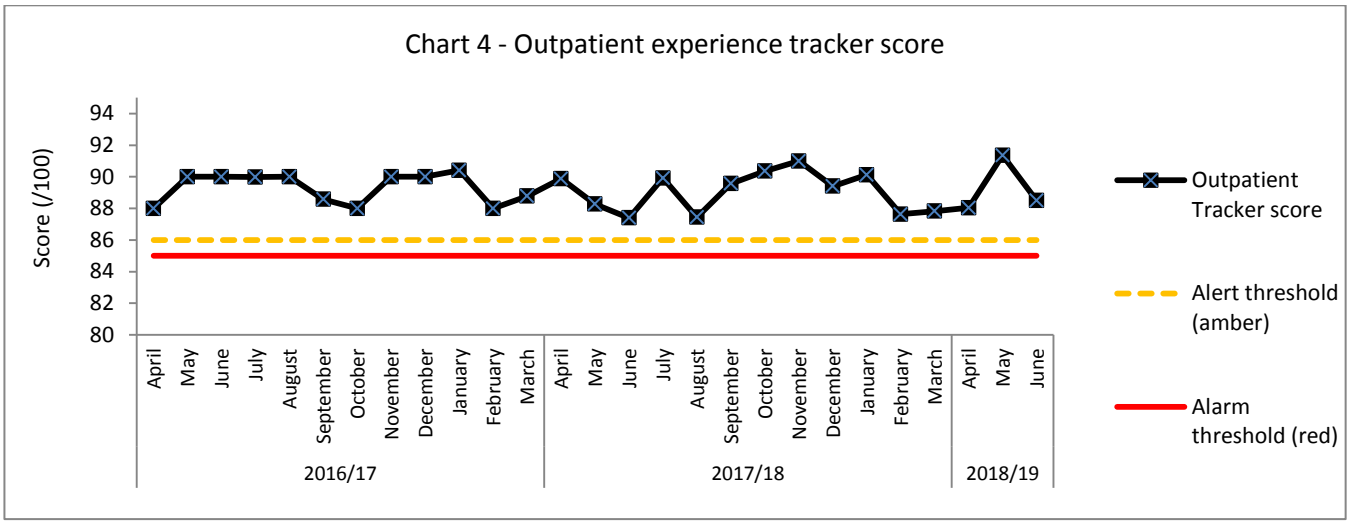
Issue	Description	Response / Actions
8. Maternity services Friends and Family Test response rate	In Quarter 1, the Trust's maternity services Friends and Family Test response rate was 14.8%, against a target of 15% (Chart 8).	The Head of Midwifery has discussed the importance of providing service-users with an opportunity to give feedback via the Friends and Family Test with the senior midwifery team, who will ensure that their staff do this.
9. Choice of outpatient appointment at the Bristol Royal Hospital for Children	The Bristol Royal Hospital for Children receives relatively low survey scores in relation to whether people are offered a choice of time / date for their outpatient appointment (Table 4)	People aren't currently routinely offered a choice of appointments at the Bristol Royal Hospital for Children. The management team is introducing a new booking process ("partial booking") that will help to address this issue. This will also allow people to book their appointments via the Trust's central appointment centre. The implementation of partial booking has taken place in two services to date: paediatric allergy and paediatric dermatology. Preparatory work is being undertaken for partial booking in a further three services (medicine, surgery, urology), with an anticipated launch during Quarter 2 2018/19. The management team will then seek to roll out partial booking to other services at the hospital.

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.







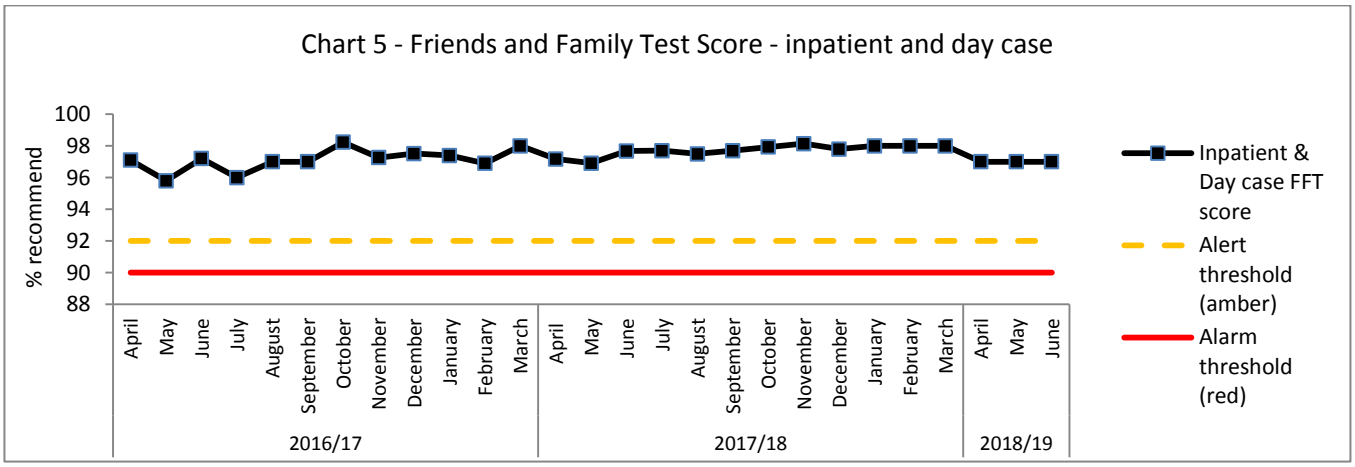


Chart 5 - Friends and Family Test Score - inpatient and day case
% recommend
100
98
96
94
92
90
88
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

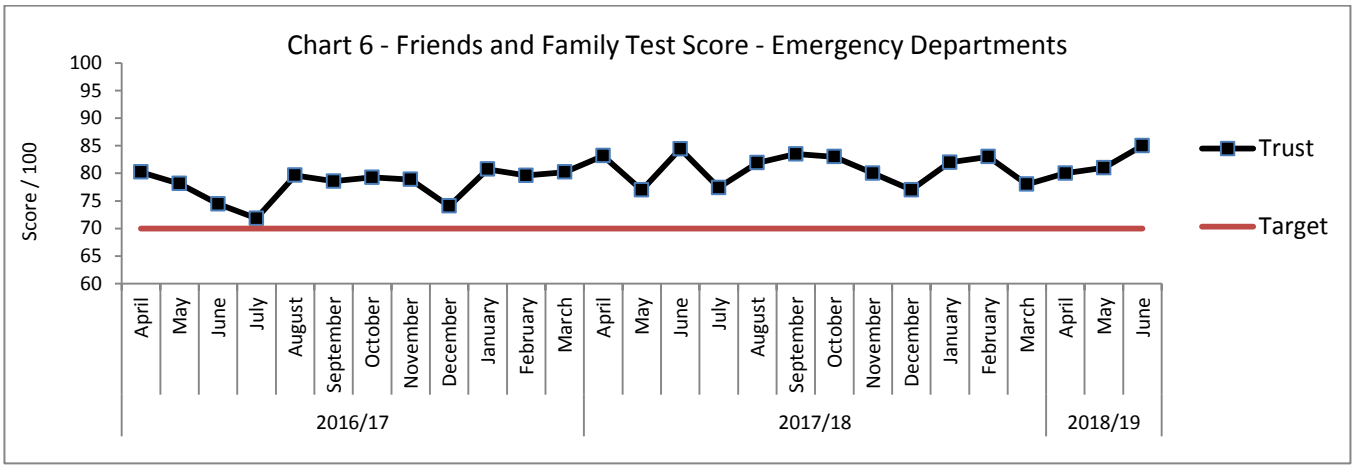


Chart 6 - Friends and Family Test Score - Emergency Departments
Score / 100
100
95
90
85
80
75
70
65
60
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
Trust
Target

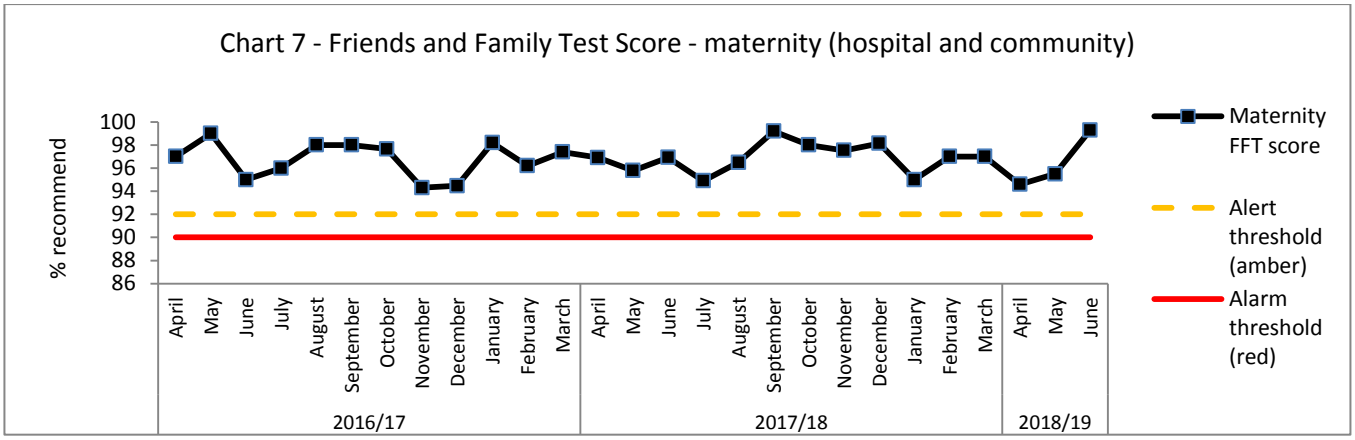


Chart 7 - Friends and Family Test Score - maternity (hospital and community)
% recommend
100
98
96
94
92
90
88
86
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

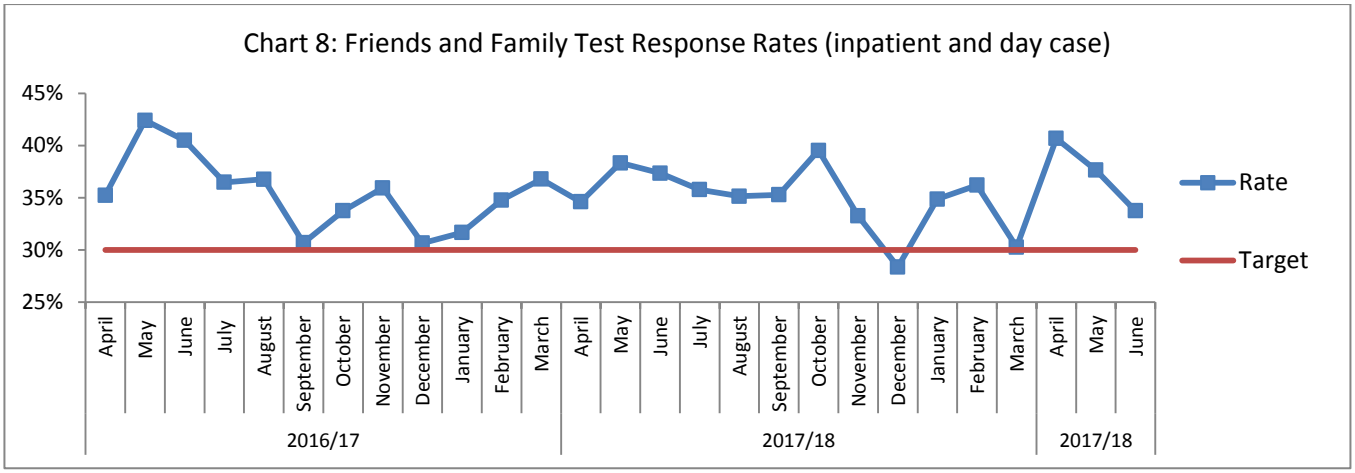


Chart 8: Friends and Family Test Response Rates (inpatient and day case)
45%
40%
35%
30%
25%
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2017/18
Rate
Target

Chart 9: Friends and Family Test Response Rate (maternity combined)

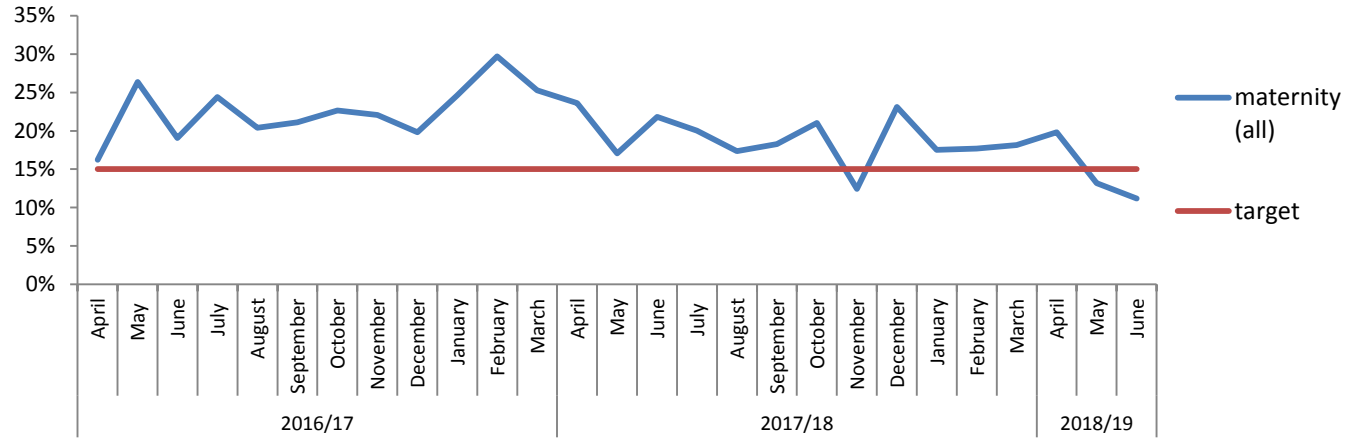


Chart 10: Friends and Family Test Response Rate (Emergency Departments)

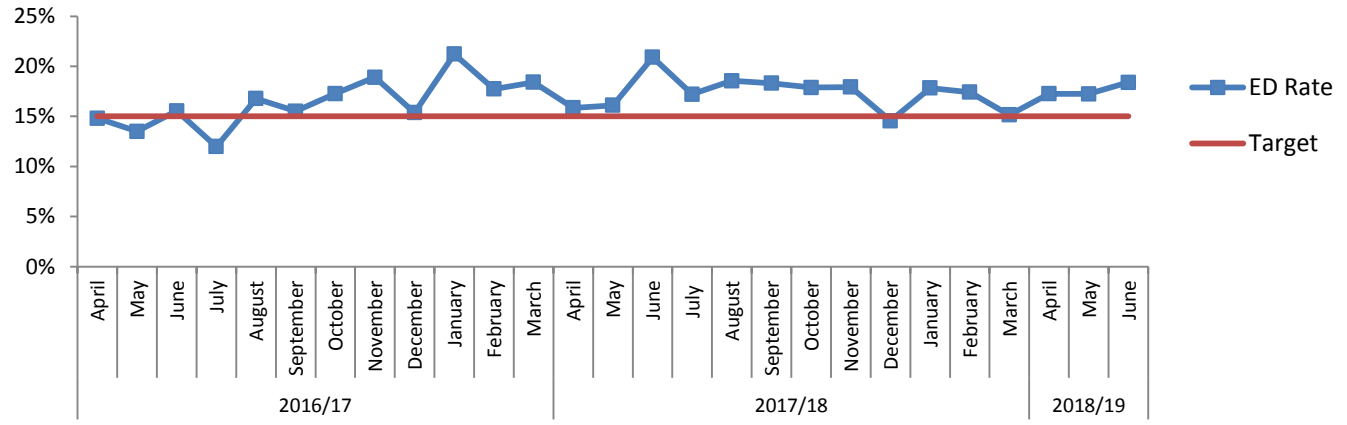
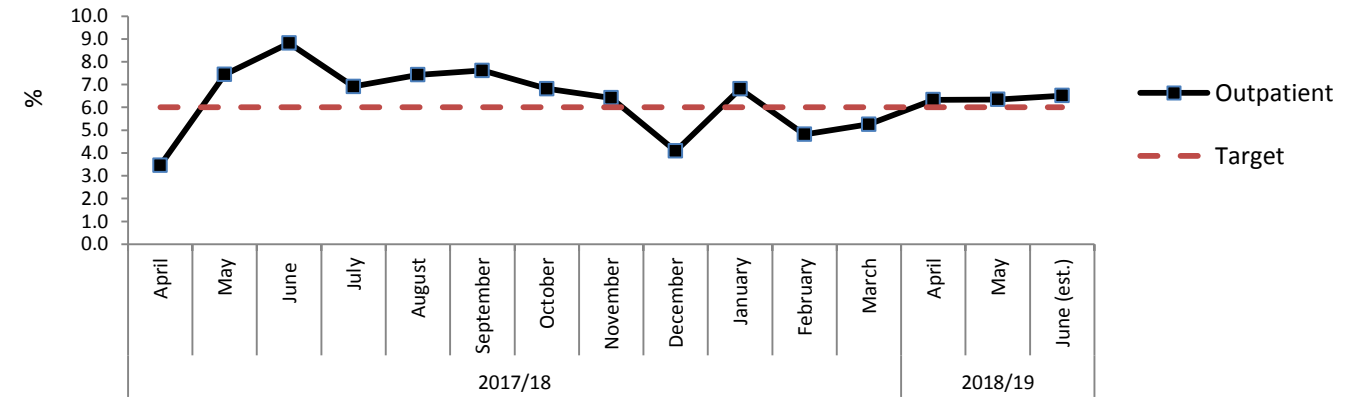


Chart 11: UH Bristol Outpatient Friends and Family Test Response Rate



2.3.2 Divisional level survey results

Chart 12 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

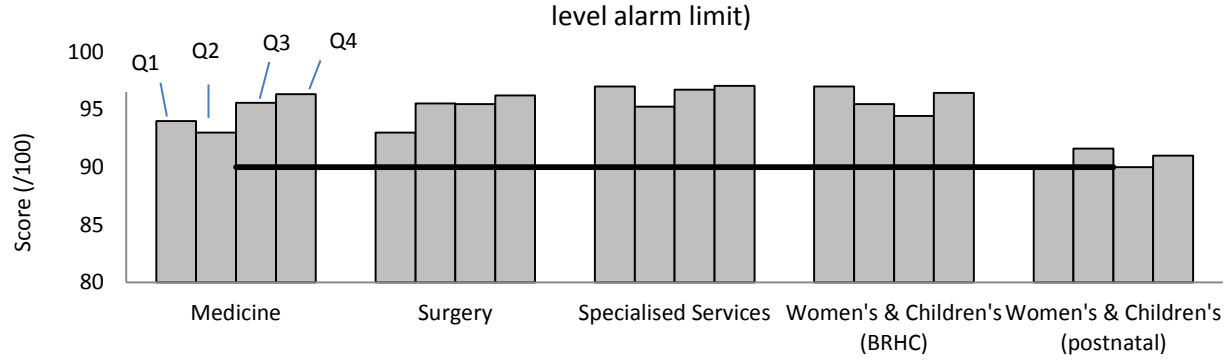


Chart 13 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

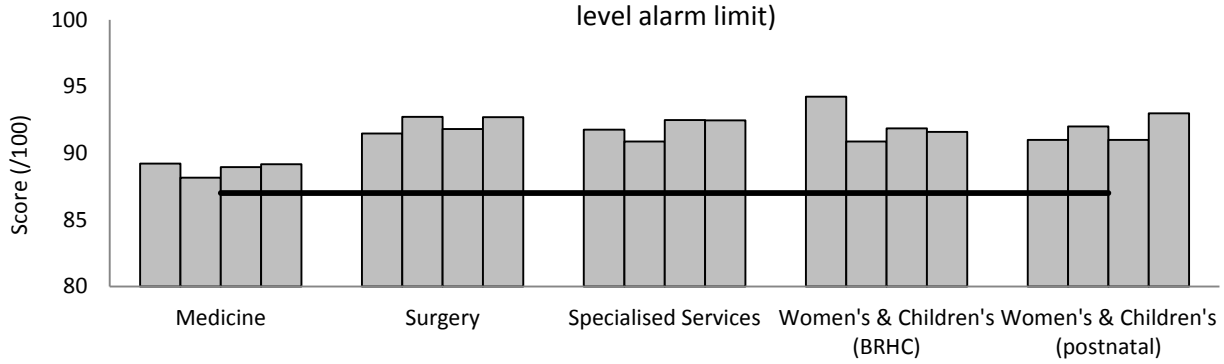


Chart 14 - Outpatient experience tracker score by Division - with Trust-level alarm limit

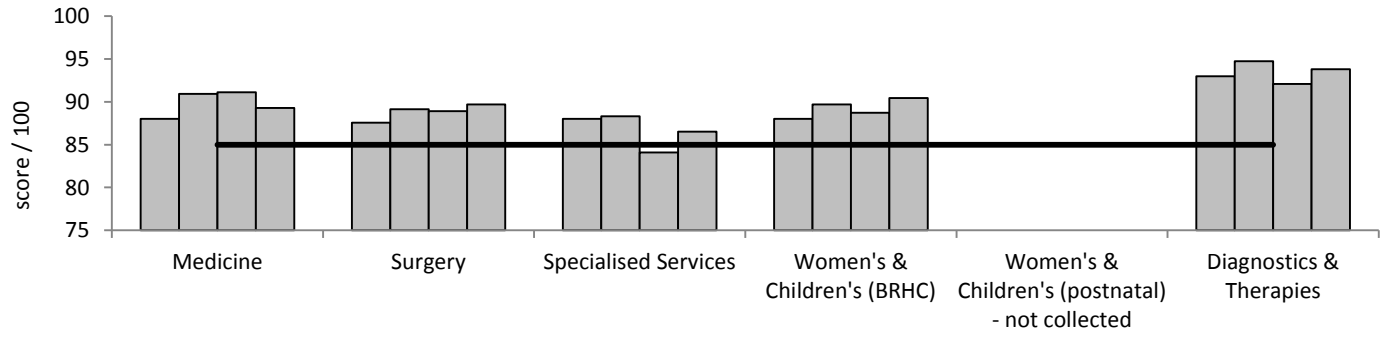
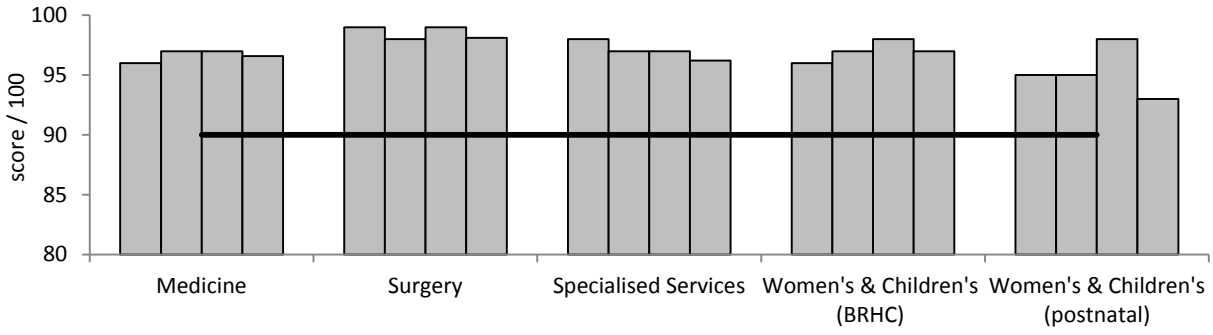


Chart 15 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)



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

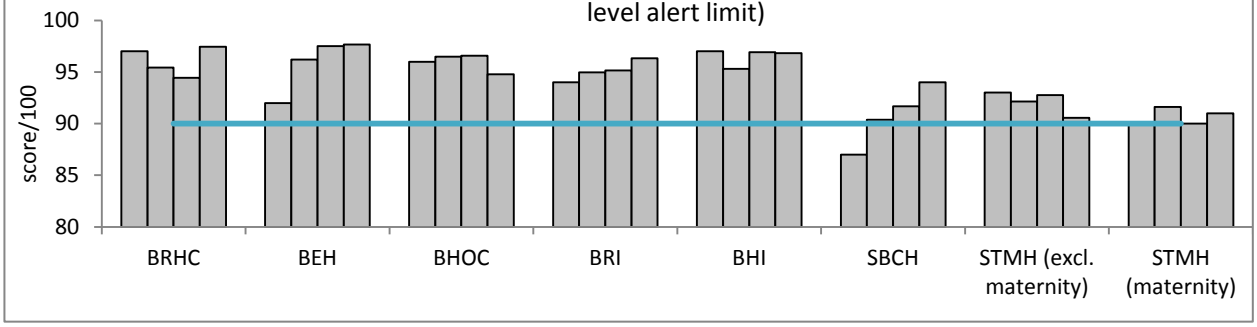


Chart 17: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

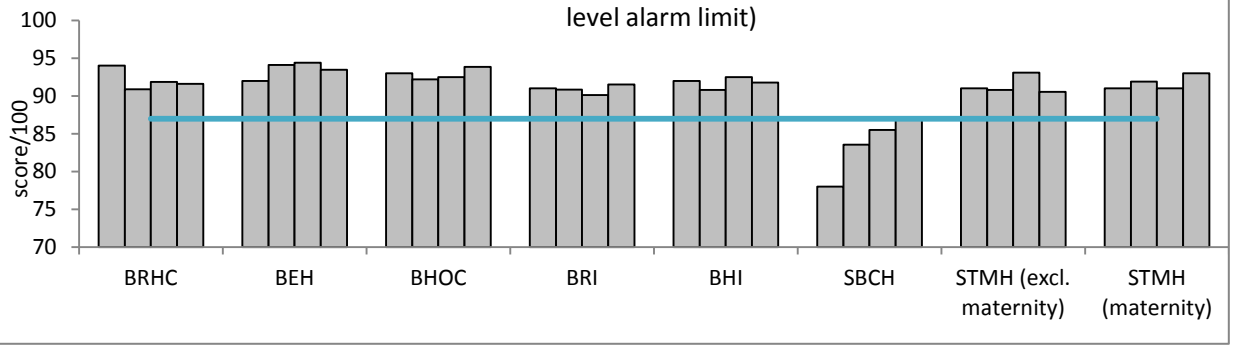


Chart 18: Inpatient and day case Friends and Family Test score (last four quarters; with Trust-level alarm limit)

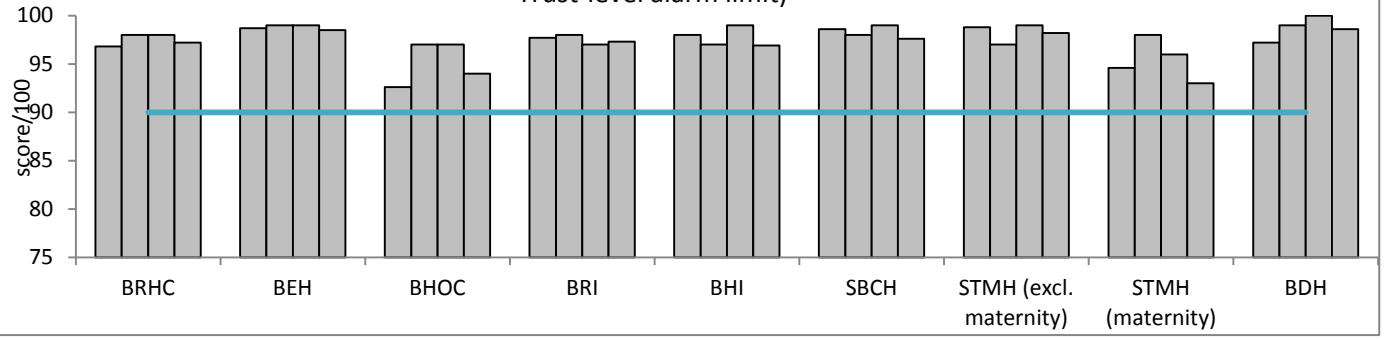
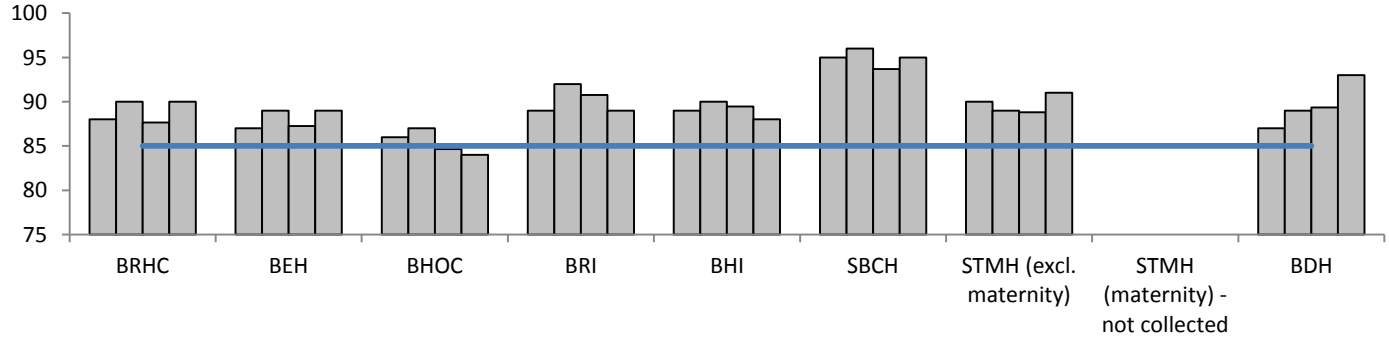
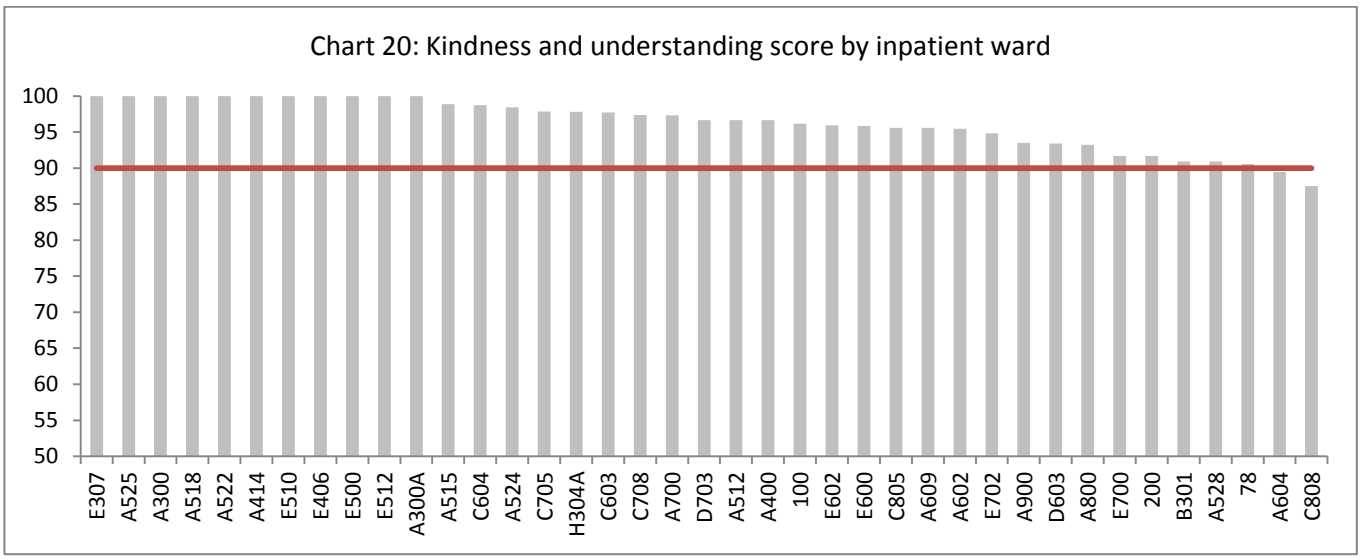
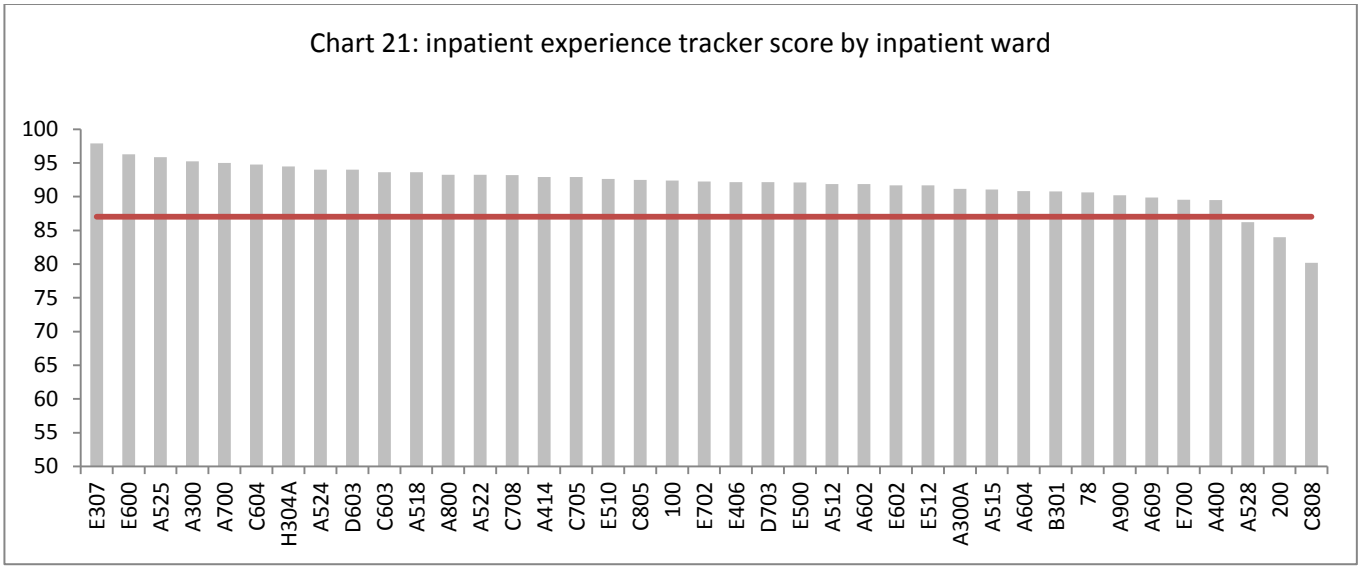


Chart 19: Outpatient experience tracker score by hospital (with Trust-level alarm limit)



2.3.4 Ward level headline inpatient survey results





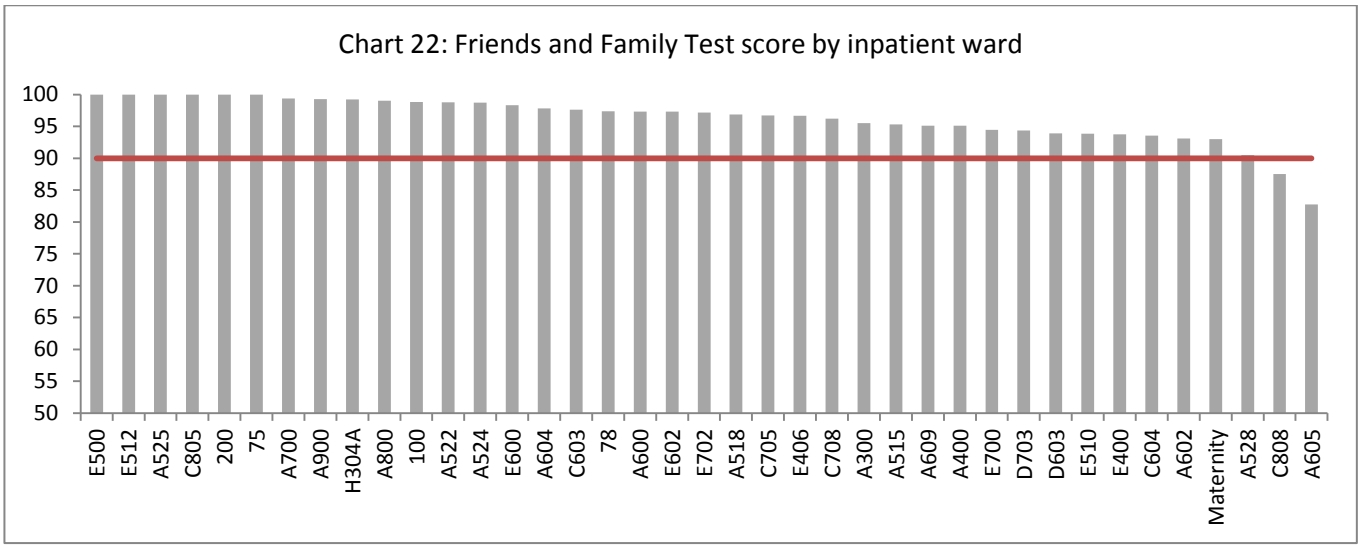


Table 3: Full Quarter 1 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for an explanation of the scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	Specialised Services	Surgery	Women's & Children's	Maternity*	Trust
Were you given enough privacy when discussing your condition or treatment?	93	95	92	94		94
How would you rate the hospital food?	62	61	62	61	55	61
Did you get enough help from staff to eat your meals?	82	90	77	87		86
In your opinion, how clean was the hospital room or ward that you were in?	94	96	94	96	93	95
How clean were the toilets and bathrooms that you used on the ward?	90	91	90	92	84	91
Were you ever bothered by noise at night from hospital staff?	82	81	85	88		85
Do you feel you were treated with respect and dignity by the staff on the ward?	97	98	98	97	95	98
Were you treated with kindness and understanding on the ward?	96	97	96	96	91	96
Overall, how would you rate the care you received on the ward?	89	93	91	91	92	91
When you had important questions to ask a doctor, did you get answers that you could understand?	87	91	88	91	91	90
When you had important questions to ask a nurse, did you get answers that you could understand?	87	91	91	91	92	90
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	77	77	75	80	80	78
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	87	90	86	89	91	88
Were you involved as much as you wanted to be in decisions about your care and treatment?	80	86	88	88	91	86
Do you feel that the medical staff had all of the information that they needed in order to care for you?	89	90	86	90		89

*Not all of the inpatient survey questions are replicated in the maternity survey.

(inpatient scores continued)

	Medicine	Specialised Services	Surgery	Women's & Children's	Maternity	Trust
Did you find someone on the hospital staff to talk to about your worries or fears?	74	76	80	79	85	77
Did a member of staff explain why you needed these tests in a way you could understand?	86	89	90	87		88
Did hospital staff keep you informed about what would happen next in your care during your stay?	82	88	83	85		85
Were you told when this would happen?	80	84	78	83		82
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	85	91	96	95		93
Beforehand, did a member of staff explain how you could expect to feel afterwards?	77	77	84	81		80
Were staff respectful of any decisions you made about your care and treatment?	92	95	95	95		94
During your hospital stay, were you ever asked to give your views on the quality of your care?	29	26	30	29	41	28
Do you feel you were kept well informed about your expected date of discharge from hospital?	81	83	79	87		84
On the day you left hospital, was your discharge delayed for any reason?	63	54	64	68	66	63
Did a member of staff tell you about medication side effects to watch for when you went home?	51	55	63	65		59
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	69	83	91	83		81

Table 4: Full six-monthly Divisional-level scores (January to June 2018) 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)	Trust
When you first booked the appointment, were you given a choice of appointment date and time?	89	65	78	70	42	74
Was the appointment cancelled and re-arranged by the hospital?	95	95	94	95	97	95
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	68	69	63	70	72	68
When you arrived at the outpatient department, how would you rate the courtesy of the receptionist?	85	85	87	84	80	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?	92	95	94	93	90	93
How long after the stated appointment time did the appointment start?	88	72	55	74	71	71
Were you told how long you would have to wait?	43	42	41	35	13	38
Were you told why you had to wait?	60	59	58	64	49	60
Did you see a display board in the clinic with waiting time information on it?	45	56	52	38	48	49
In your opinion, did he / she have all of the information needed to care for you (e.g. medical records, test results, etc)?	92	94	91	94	91	93
Did he / she listen to what you had to say?	96	98	97	96	97	97
If you had important questions to ask him / her, did you get answers that you could understand?	93	95	93	94	95	94
Did you have enough time to discuss your health or medical problem with him / her?	93	94	92	92	95	93
Were you treated with respect and dignity during the outpatient appointment?	98	99	99	97	98	98
Overall, how would you rate the care you received during the outpatient appointment?	92	93	93	90	93	92
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	86	92	82	90	91	88
If you had any tests, did a member of staff explain the results in a way you could understand?	81	80	72	85	86	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 1 themes arising from free-text comments in the patient surveys (the comments are taken from the Trust's postal survey programme, unless otherwise stated)[2]

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[3])	Staff	Positive	66%
	Communication/information	Negative	13%
	Food / catering	Negative	8%
Division of Medicine	Staff	Positive	61%
	Communication/information	Negative	13%
	Food / catering	Negative	10%
Division of Surgery	Staff	Positive	66%
	Communication/information	Negative	13%
	Food / catering	Negative	8%
Division of Specialised Services	Staff	Positive	67%
	Communication/information	Negative	11%
	Food / catering	Negative	9%
Women's and Children's Division (excluding Maternity)	Staff	Positive	68%
	Communication/information	Negative	17%
	Staff	Negative	11%
Maternity	Staff	Positive	65%
	Care during labour and birth	Positive	20%
	Communication/information	Negative	13%
Outpatient Services	Staff	Positive	71%
	Care during labour / birth	Positive	20%
	Food / catering	Negative	13%

[2] 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).

[3] 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	Bristol Royal Infirmary Emergency Department	*I was there because I'd overdosed, so I was feeling pretty embarrassed. Of the two nurses I dealt with, one made a real effort to make sure I was comfortable talking, in a closed room… Once my results came back, another nurse came and started asking me really personal questions about my mental health without introducing himself or even closing the curtain… I wouldn't have minded waiting if it had meant I could have had 5 minutes in a room with a door to talk about feeling suicidal.*	This comment has been shared with the Emergency Department as a point of learning. There is a room available in the Department where patients can talk in private to a member of staff and this should have been used in the situation that this patient describes. The Trust's Liaison Psychiatry Team have also been made aware of this comment and will use it as an opportunity to raise awareness amongst Emergency Department staff about the importance of using a private safe space to discuss sensitive mental health issues with patients.
	Sleep clinic	*The sleep clinic: nobody answers the phone or bothers to reply to queries left on voicemails.*	We are sorry to hear that this patient experienced issues with our telephone service. The department is aware of the need to improve the accessibility of the sleep unit appointments telecoms line and is working with the Trusts Transformation Team to review these processes. A "hunt group" telephone line has now been installed to allow the incoming call to ring on multiple coordinators handsets. We have also rearranged the team's workload with the aim of allowing further time to answer queries. We are continually monitoring the appointments phone line and meeting as a team to identify further improvement measures.
	Dermatology Department	*I waited over an hour for my appointment. The doctor left the consulting room with no explanation for 25 minutes. I was left wondering what was happening and started to feel very anxious.*	We are sorry that this patient was not kept up to date with the delay to their appointment. We will remind staff in the Department of the need to tell patients if there are delays.

Division	Area	Comment	Response from ward / department
Women's & Children's	Bristol Royal Hospital for Children Emergency Department	*I bought my 14 year old son for a CAMHS referral on advice from school and GP following a concern he was at risk of suicide. We waited 3 hours to see a doctor in the A and E waiting room not exactly ideal for a child feeling so vulnerable. We still didn't see a doctor from the CAMHS team we saw an A and E doctor who then got advice from CAMHS and sent us home. That doctor referred him to CAMHS.*	We are very sorry to hear about this family's experience. The Bristol Royal Hospital for Children's Emergency Department does not have a CAMHS (Child and Adolescent Mental Health Service) provision, and so it appears that the patient may have been incorrectly referred to our Department by their school/GP. Unfortunately, as this comment was provided anonymously, we are unable to respond directly to the person who completed the survey. However, it appears from the comment that a referral to CAMHS has now been made.
	Bristol Royal Hospital for Children, Level 3 outpatient department	*The nurse was very kind and understanding. Unfortunately there is no system in place for staff to know a referred patient is deaf, like me. I don't want to always rely on my mother. Information giving is very important and in this case would show staff treat patients as individuals/people.*	The Trust's patient records system ("Medway") does have an alert function for staff to identify if a patient is deaf. The Trust's Patient Experience and Involvement Team (who manage UH Bristol's provision of translation and interpreting services) has contacted the Outpatient Department Matron, who will remind the staff in the outpatient department about this.
	Ward E510 (Caterpillar) Bristol Royal Hospital for Children	*Staff helpful but noisy at night - lights off policy not adhered to. Light not working above bed 22. Kitchenette in relatives room not kept tidy (not staff fault) and no crockery or forks and teaspoons. Toaster next to boiler a health and safety nightmare!*	The Trust has set up a working group that is looking at noise at night across all clinical areas. There will be a focussed week on this issue in September 2018. The issue around ensuring the "lights off" times are adhered to will be added to the staff safety brief as a reminder of its importance. The Sister for Caterpillar ward (E510) has raised a call for the light in bed 22 to be fixed and the issues with the kitchen will be investigated by the ward Sister.

Division	Area	Comment	Response from ward / department
Women's & Children's (continued)	Maternity Services	*Solely the catering. I was berated for being late for lunch when I'd been with the doctor and midwife for 90 minutes. On another occasion in admission a midwife had to go to get me a meal - I am diabetic so even that unacceptable. The way staff treat really vulnerable women in terrible.*	We are very sorry that this lady was not treated courteously by some of the catering staff during her staff. All women on the postnatal wards should be treated with the upmost kindness and understanding by all staff. The comment was provided anonymously and so we are unable to investigate this specific case. Unfortunately however, there have been several pieces of feedback that reflect similar issues to the one raised here. The General Manager and Head of Midwifery / Nursing has therefore arranged to meet with the Facilities Manager to address these issues. In addition, the maternity service management team is going to re-convene the "Patient Experience at the Heart" workshops. These provide an opportunity for all staff in the department to reflect on their role in providing a positive experience to service users and had a significant positive effect on the department's performance in the national maternity survey. The workshops will commence in Quarter 3 2018/19.
Specialised Services	Bristol Heart Institute	*Heart Institute appointments line unavailable for over 3 days this week very bad.*	There has been a significant focus on improving this aspect of our service which has resulted in a large decrease in the number of complaints that we receive about this issue. This includes setting up a single telephone line for outpatients, where calls can be held in one queue and fed through to multiple different phones. This will make it much easier for patients to get through to us. We are unable to investigate this patient's experience as the comment was provided anonymously, but we will continue to monitor our telephone handling performance and to identify further improvement opportunities where they arise.

Division	Area	Comment	Response from ward / department
Surgery	Ward A609	*I have been in a lot of pain and struggled to get a nurse to give me pain relief. A nurse working on Tuesday night spoke to me very inappropriately and demanded to know why I was in a separate room - I had diarrhoea and vomiting the previous day. She said "there are patients that actually need this room unlike you".*	We are sorry that this patient was spoken to inappropriately by a member of our staff. Unfortunately, as the survey is completed anonymously, we are unable to identify the member of staff concerned - but will share this feedback to all of the staff on the ward as a point of learning.
	Ward A609	*It's cold, lacks atmosphere. No chairs, awful food.*	We recognise that the environment on ward A609 requires improvement. We have been successful in obtaining a capital bid to relay the flooring and to redesign the entrance and reception areas. We anticipate that this will be completed by Quarter 3, 2018/19 (we are awaiting final details).
	Ward A602	*Very good nursing care and all staff very friendly and helpful. But the bay had little natural light, no view out and there was a lot of noise at night.*	The issue of noise at night is being addressed by a Matron-led working group, with the aim of a Trust wide launch of this improvement activity during September 2018. Additionally, as part of the senior nursing “back to the floor” programme, the Head of Nursing will carry out a night time ward visit, which will provide a further opportunity to focus on this issue. The Division of Surgery has developed a rota to ensure that at least one Band 7/ Matron undertakes a night shift each month. This senior presence will help to ensure a focus is maintained on reducing 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 1, members of the Involvement Network were invited to contribute their views about the proposed UH Bristol Transport Hub.

4.2 Local Patient and Public Involvement activity:

The UH Bristol Patient Experience Involvement team supports a range of Trust staff to carry out patient involvement projects. In collaboration with the adult Ear, Nose and Throat team and the University of Bristol, patient focus groups were held to inform the design of a novel implantable artificial larynx. Patients who had undergone the removal of their larynx and the separation of the airway from the mouth, nose and oesophagus were invited to participate.

4.3 Mystery Shopping:

The Trust's Quality Strategy (2016-2020) includes a commitment to introduce mystery shopping as a technique to supplement the variety of ways that we gather information about patient-reported experience of care. The initial work stream will focus on training members of the UH Bristol's *Face2Face* volunteer interview team to carry out mystery shopping exercises at key touch points around the Trust, primarily "front of house" services such as reception desks. The scenarios are currently being developed with a view to launching the programme in Quarter 3 2018/19. The Patient Experience and Involvement Team have also developed a number of mystery shopping scenarios that will be incorporated into the customer service apprenticeship programme.

4.4 Focus on patients who are deaf:

The Patient Experience and Involvement Team adopts a quarterly theme and in Quarter 1 this was on the experience of patients who are deaf:

- In April the Trust's Patient and Public Involvement Lead attended the second meeting of the newly convened Bristol Deaf Health Partnership. Working in collaboration with a range of deaf community representatives and local NHS providers, the Bristol Deaf Heath Partnership provides a single forum that fosters dialogue; enabling us to work together to understand and improve the experience of Deaf, hard of hearing and deaf blind people across Bristol.

- Deaf Health Awareness Week: during May 2018 the Patient Experience and Involvement Team raised awareness of deaf health issues, with articles in Newsbeat and on Twitter, and a stall in the Bristol Royal Infirmary. The Trust Board patient story in May focussed on the experience of deaf patients accessing local health service. Awareness raising activity took place in association with Deafblind UK in the Bristol Eye Hospital and the Bristol Royal Infirmary to mark national deafblind week in June 2018.

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). 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.

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.

Cover report to the Public Trust Board Meeting to be held on 27 September 2018 at 11.00 – 13.00 in the Board Room

		Agenda Item	12
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Evaluation of Patient Safety Programme 2015-2018 and Patient Safety Priorities 2019-2021**		
Author	Anne Reader, Head of Quality (Patient Safety)		
Executive Lead	Carolyn Mills, Chief Nurse		
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

The purpose of these two reports are to provide assurance to the Board regarding the outcomes of the Trust's Patient Safety Improvement Programme 2015-2018 and lessons learned, and the Trust's patient safety improvement priorities for 2019-2021.

These reports have been approved by the Patient Safety Improvement Programme Board and Clinical Quality Group.

Key issues to note

1. **Evaluation of Patient Safety Programme 2015-2018**

The executive summary of the report includes key achievements of the programme with detail of the progress of each work stream in subsequent sections. Each work stream includes a narrative lessons learned and recommendations for next steps.

During the course of the programme, in 2017 our maternity services joined the new national Maternity and Neonatal Health Safety Collaborative. There is a separate section on specific progress so far in this regard. Where the new collaborative work overlaps with existing programme work streams, progress is reported in the relevant main sections of the report.

2. Patient Safety Priorities 2019-2021

The Patient Safety Improvement Programme Board agreed the priorities outline in the report with the following inclusions/amendments:

- That a revised governance and reporting structure for patient safety improvement is required to encompass all work streams and what this should look like going forwards
- Strengthening the governance and reporting of children's and maternity services patient safety improvement work streams
- That the in-theatre peri-procedure never events work stream continues to be embedded locally with the support of the QI Academy and QI Hub rather than being part of the formal programme, but the out of theatre procedures continue within the programme structure as not yet embedded.
- That the human factors elements identified as a result of learning from peri-procedure never events is incorporated into the human factors work stream of the new plan to include work on reducing distractions/interruptions.
- That the existing leadership and culture work streams are combined
- The AKI work stream should continue providing a senior medical (consultant) work stream lead is identified to take this forward.
- There will be a 6 month lead in time to commence the next programme to allow for recruitment of a programme manager, development of a communications and engagement plan and to develop detailed plans and measurement strategies for each work stream with leads and key stakeholders.
- The next steps are to appoint a new Programme Manager, work up details plans for each of the proposed work streams by December 2018 and put in a bid for a small non-pay budget for the programme.

Recommendations

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
The Trust Patient Safety Improvement Programme is a key control in relation to the principle risk in the Board Assurance Framework: Risk that the Trust will be unable to maintain the quality of patient services.

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

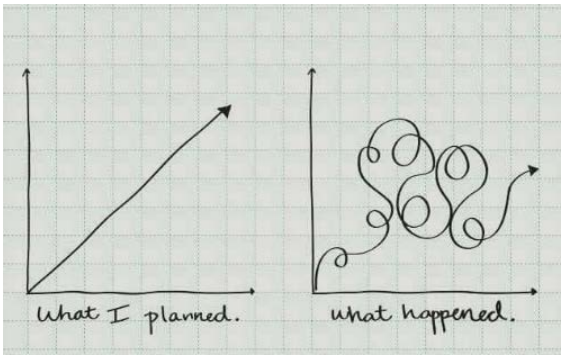
Date papers were previously submitted to other committees				
Audit Committee	**Finance Committee**	**Quality and Outcomes Committee**	**Remuneration & Nomination Committee**	**Other (specify)**
				Patient Safety Improvement Programme Board 04/09/2018, Patient Safety Group 12/09/2018 and Clinical Quality Group 13/09/2018

University Hospitals Bristol NHS
NHS Foundation Trust

Evaluation of UH Bristol Patient Safety Improvement Programme 2015-2018

Report contributors:

Naomi Burns and Caroline Horrobin, Patient Safety Audit and QI Nurses
Joanna Morris, Quality and Patient Safety Manager, Women's and Children's Division
Kevin Gibbs, Pharmacy Manager
Mat Molyneux, Consultant Anaesthetist
Simon Harrison-Boyle, Patient Safety Manager
Ingrid Henderson, Patient Safety Manager, Maternity Services



"What I planned v what happened. The important bit is SOMETHING is happening. Just because your QI Project hasn't followed the plan, doesn't mean it isn't working. It means you are learning a different way."
Credit: @15s30m

Acknowledgement:

With acknowledgement to the committed and enthusiastic work stream leads who drove the programme, our public contributors, the numerous front line staff for their willingness and patience in testing changes and the collaboration and support of colleagues in Bristol Medical Simulation Centre, North Bristol NHS Trust, the West of England Academic Health Science Network and the national Sign up to Safety Campaign.

Work stream leads:

Deteriorating Patient:	Dr Emma Redfern	ED Consultant and Associate Medical Director for Patient Safety
	Anne Reader	Head of Quality (Patient Safety)
	Naomi Burns/Caroline Horrobin	Patient Safety Audit and QI Nurses
	Dr Caroline Haines	Nurse Consultant, Paediatric ICU
	Dr Peter Davis	Consultant, Paediatric ICU
Sepsis:	Dr Jeremy Bewley	Intensive Care Consultant
	Naomi Burns/Caroline Horrobin	Patient Safety Audit and QI Nurses
	Dr Will Christian/Dr Stefania Vergnano	Consultant Paediatrician CED/Paediatric Infectious Disease Consultant
Acute Kidney Injury:	Dr Wesley Hayes (until 2016) /Dr Jim Portal (until 2017)	Paediatric Nephrologist/Consultant Hepatologist
	Naomi Burns/Caroline Horrobin	Patient Safety Audit and QI Nurses
Medicines Safety:	Kevin Gibbs	Pharmacy Manager
	Steve Brown/Jon Standing	Directors of Pharmacy
Peri-procedure Never Events:	Dr Mat Molyneux	Consultant Anaesthetist
	Dr Rachel McKendry	Consultant Anaesthetist
	Simon Harrison-Boyle	Patient Safety Manager
Safety Culture:	Anne Reader	Head of Quality (Patient Safety)
Leadership:	Carolyn Mills	Chief Nurse
	Anne Reader	Head of Quality (Patient Safety)
Maternity and Neonatal Health Safety Collaborative:	Rachna Bahl	Consultant Obstetrician
	Karen Mc Donald-Taylor (until 2018) /Ingrid Henderson (from 2018)	Patient Safety Managers
	Snehe Basude	Consultant Obstetrician
	Bryony Strachan	Clinical Chair and Consultant Obstetrician
Children's Services	Nina Stock/Joanna Morris/ Carly West/Joanna Westlake	Patient Safety Managers

Contents

Executive Summary

This report provides a record of the achievements of our Patient Safety Improvement Programme 2015-2018.

Throughout the report, where there was specific work in Children's and Maternity Services these have been included under each work stream heading. The final section 3.8 provides further information regarding maternity and neonatal services who undertook additional specific improvement work as part of the National Maternity and Neonatal Health Safety Collaborative which began in April 2017.

The summary of our key achievements is as follows:

1. Overarching aims:

- We did not achieve our mortality reduction improvement goal of best (lower) quartile for English Trusts for Summary Hospital Mortality Indicator with a SHMI of 101.7 in the 12 months to December 2018 against a lower quartile of 95.3

- We achieved, exceeded and sustained our improvement goal for adverse event rate reduction to below 3.23 per 1,000 beddays with a rate of zero since July 2017

2. Deteriorating Patient:

- We achieved and sustained our improvement goal of 95% of patients having observations taken early warning scores correctly added up, and successfully switched from the Bristol Early Warning Score to the National Early Warning Score in adult services.

- We achieved our improvement goal of 95% of deteriorating patients being escalated appropriately and are currently sustaining 90-95% improvement

- We did not consistently achieve our 95% improvement goal for the use of SBAR for escalating deteriorating patients

- We implemented an e observations system in adult in-patient areas

- Children's services undertook significant QI projects improving the care of the deteriorating child including developing new age-specific observation charts with integral Paediatric Early Warning Scores and instigating Rapid Review Calls

- Maternity services continued to improve use of the Maternity and Obstetrics Early Warning Score and neonatal services started work to introduce the Newborn Early Track and Trigger Tool

3. Sepsis:

- We achieved the 90% improvement goal for sepsis screening and antibiotics within an hour in adult ED, but this has yet to be sustained

- We achieved and sustained the 90% improvement goal for adult in-patient sepsis screening, and achieved the 90% improvement goal for adult in-patient antibiotics within an hour and 72 hour antibiotic review but this has yet to be sustained

- Across the West of England Academic Health Science Network we reduced mortality in patients with suspicion of sepsis from around 7% to below 6%.

- We implemented sepsis screening and a sepsis pathway in Children's ED and are developing in-patient sepsis pathways for children

- We developed and implemented a maternity specific sepsis screening tool

4. Acute Kidney Injury:

- We implemented a system for automatic electronic alerts to clinical teams for patients with acute kidney injury (AKI)

- We achieved the 90% improvement goal for including four key pieces of information regarding patient with AKI in discharge summaries to GPs

- We achieved a reduction in cases of increasing stages (worsening)of AKI

5. Medicines Safety:

- We implemented an electronic system to refer patients with complex medicines to community pharmacies on discharge to help ensure they continued to take their medicines correctly and safely

- We achieved, exceeded and sustained our improvement goal of less than 0.75% for reduction in non-purposeful omitted doses of critical medicines.

- We made improvements in insulin safety

6. Safety Culture:

- We conducted an organisation-wide baseline self-assessment of our safety culture which resulted in an overall assessment of having a "proactive" safety culture and repeated the self assessments two years later which showed that our safety culture had remained the same.

- We instigated "safety conversations" with front line staff in adults children's and maternity services

- We instigated a programme of human factors training in maternity services and conducted human factors work shops

7. Peri-procedure never events:

- We further developed and strengthened our WHO checklists in theatres and interventional environments in response to national drivers and learning from incidents and sustained over 98% improvement in their use

- We implemented Local Safety Standards for Invasive Procedures in endoscopy and out of theatre settings such as wards, ITUs, Central Delivery Suite, and ambulatory care settings

- Unfortunately we had a number of peri-procedure never events during the programme's lifetime therefore did not achieve our "days between" improvement goal of 365 days.

8. Leadership:

- We did not sustain our previously achieved improvement goal of conducting at least six executive director-led patient safety walk rounds

- We did achieve our 80% improvement goal of completing actions from walk rounds within two months

9. Maternity and Neonatal Health Safety Collaborative

- We achieved a reduction in term admissions to Neonatal ICU

- We achieved a reduction in the number of babies needing neonatal input for respiratory problems, active or passive cooling and suspected hypoxic ischaemic encephalopathy

- We achieved an improvement in the measurement of Symphysis Fundal Height

The recommendations from work stream leads with regard to next steps are found in the detail of the report and will inform the priorities for our next patient safety improvement plan for the next three years.

1. Background and context

Towards the end of 2014, UH Bristol "Signed up to Safety"; a national campaign with an ambitious target for the NHS in England to halve avoidable harm in the NHS and save 6,000 lives as a result. Sign up to Safety's stated aim was to deliver harm-free care for every patient, every time, everywhere to be provided within a culture of openness and honesty and support for everyone to improve the safety of patients. What was unique and fundamentally different was that the campaign was grounded in bottom up, locally owned change and it was for everyone.

As part of the "sign up" process, as a Trust we made a number of pledges under five key themes outlined below and developed a three-year patient safety improvement programme to underpin these pledges.

Key themes of our pledges:

a) Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally.

b) Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are.

c) Honesty. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.

d) Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

e) Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress.

Details of the pledges we made are found in Appendix 1. In order to determine what our patient safety improvement priorities should be we looked back at our achievements to date in our previous patient safety improvement programmes, we conducted a thematic analysis of information from a range of sources within the Trust, and we asked our staff about their main patient safety concerns. These results were reviewed in line with our existing patient safety strategy and in the context of our contribution to the improvement priorities of the West of England of England Patient Safety Collaborative.

This resulted in a programme with five main patient safety work streams:

a) Early recognition and escalation of deteriorating patients to include early recognition and management of sepsis and acute kidney injury

b) Medicines safety, including at the point transfer of care

c) Leadership for keeping people safer

d) Developing our safety culture

e) Reducing peri-procedure never events

1.1 How the programme links with the Trust's strategic objectives

The diagram below, with a worked example, shows the link between the focus within the work streams to drive improvement and the stated aims of our Trust Board-approved Patient Safety Strategy 2014-2017.

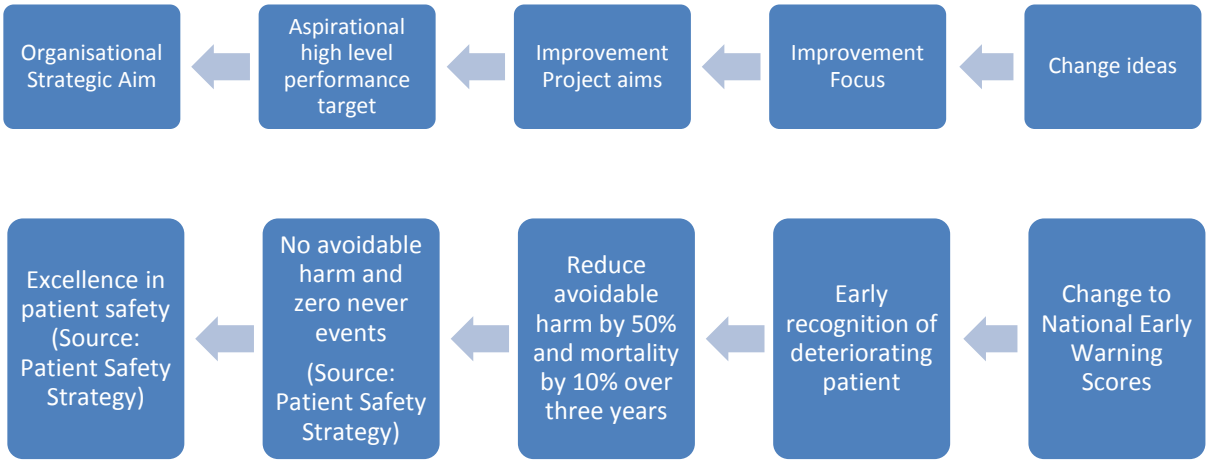


Figure 1: Link between patient safety improvement focus and strategy

During the lifetime of the programme, a number of initiatives arose, such as National Safety Standards for Invasive procedures, the national sepsis and acute kidney injury Clinical Quality Indicators (CQUINs), the Global Digital Exemplar Programme and the Learning from Deaths process, which influenced the direction of our programme. Also in 2017 a National Maternal and Neonatal Health Safety Collaborative was launched which introduced a further work stream in year 3.

2. Overall aim of the programme

In line with the aim of the national Sign up to Safety initiative, we chose an overarching aim of the programme:

- To reduce avoidable harm by 50% and to reduce mortality by a further 10% by 2018.

The overarching driver diagram for the programme is found in Appendix 2.

2.1 What we set out to do:

We set out to establish and deliver a Trust-wide patient safety improvement programme, which would:

- Contribute to reducing mortality and avoidable harm
- Use recognised quality improvement methodologies
- Provide visible leadership for patient safety from the top of our organisation
- Engage our staff and patients in locally led improvement initiatives
- Align with our existing patient safety strategy (see driver diagram at Appendix 1)

- Dovetail with joint working with our system partners in the West of England Patient Safety Collaborative

We intended to measure our progress using mortality indicators (Summary Hospital Mortality Indicator, Hospital Standardised Mortality Ratio) and by monitoring our adverse event rate using the Institute for Healthcare Improvement's[1] Global Trigger Tool case note review methodology. Details of all programme measures are found in Appendix 3.

2.2 What we did:

Our patient safety improvement programme was established along with a communications and engagement plan. We launched our programme with an event in July 2015 hosted by the Medical Director and Chief Nurse, and supported by Professor Jane Reid from the national Sign up to Safety campaign.

Figure 2: Professor Jane Reid at the programme launch July 2015

We reflected on the achievements of our previous Safer Care South West Programme and attendees were encouraged to make personal pledges to improving the safety of patients for the future.

Figure 3: Word cloud from staff pledges at the launch event

[1] Institute for Healthcare Improvement, Cambridge, Massachusetts, USA is an internationally renowned centre of excellence for quality improvement. Professor Don Berwick is a President Emeritus and a Senior Fellow.

We established a Programme Board, which met quarterly and reported into our Patient Safety Group, Clinical Quality Group and the Quality and Outcomes Committee (a non-executive Board sub-committee). We identified a number of risks to delivery of the programme, but also risks contained within that Trust's risk registers that the programme was designed to mitigate.

We had originally planned a specific work stream to develop a human factors approach to learning from incidents and to deliver a three-year programme of point-of-care simulation training across the Trust (adults, paediatrics, and maternity) for clinical teams to address the human factors evident in reported incidents. We submitted a bid to the national Sign up to Safety team to fund staff and equipment to support this work stream but unfortunately, this was not successful so we were unable to proceed. We did however use simulation to support improvements in a number of work streams.

2.3 What improvements we achieved:

We did not achieve the 10% reduction in Summary Hospital Mortality Indicator (SHMI)[2] we originally planned, in fact SHMI increased over the course of the programme as shown in Figure 3 whilst remaining in NHS Improvement's "as expected" category. There were challenges in demonstrating improvement as it became evident the indicator was rebased by NHS Digital each quarter, which meant that measuring improvement relative to where we started from was not possible using this indicator.

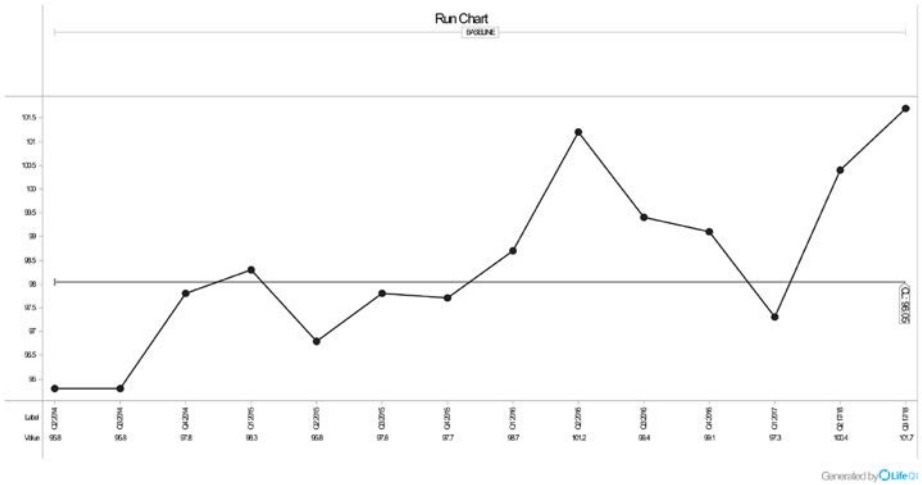


Figure 4: Run chart of quarterly Summary Hospital Mortality Indicator September 2014 to December 2017

In November 2016, the Programme Board took a decision to amend the measure of mortality improvement to look at our position relative to other Trusts in England, aiming to be in the lower (best) quartile. We did not achieve this aim, remaining between the median and the lower quartile throughout the programme. The most recent SHMI for our Trust available at the end of the programme was based on the 12 months January to December 2017 and was 101.7, slightly above the national median of 101.6 and above the lower quartile of 95.3.

In the latter stages of the programme, NHS England developed the national Learning from Deaths process and the Trust became an early adopter, implementing this from April 2017 with the support of the West of England Academic Health Science Network. This is essentially is a structured way of

[2] SHMI is published quarterly, approximately 6 months in arrears, and includes the previous 12 months of mortality data.

reviewing the care and treatment in the episode leading up to a person's death using pre-determined criteria and making an assessment regarding the standard of care provided and the avoidability of the death. The aim is to identify any learning from the review and make improvements to care and the findings are reported to the Trust Board of Directors.

Whilst mortality indicators are derived from clinical documentation, clinical coding, and detailed statistical analysis, the Learning from Deaths process provides a rich insight into where improvement work should be focussed. As a result, we are planning to work with the West of England Patient Safety Collaborative, by participating in a system-wide work stream regarding earlier conversations with patients in the last years of their lives supported by the ResPECT tool[3]. This work aims to avoid patients at the end of life being brought to hospital rather than dying in their preferred circumstances. This will be proposed as one of our patient safety programme work streams for 2018 and beyond.

In 2016, we implemented a slightly more challenging audit tool to identify adverse events[4] than that previously used and monitored the impact the programme's improvement work against this. We achieved and sustained our adverse event improvement goal of 3.23 adverse events per 1,000 bed days as shown in Figure 5 below and in fact have sustained at zero since July 2017.

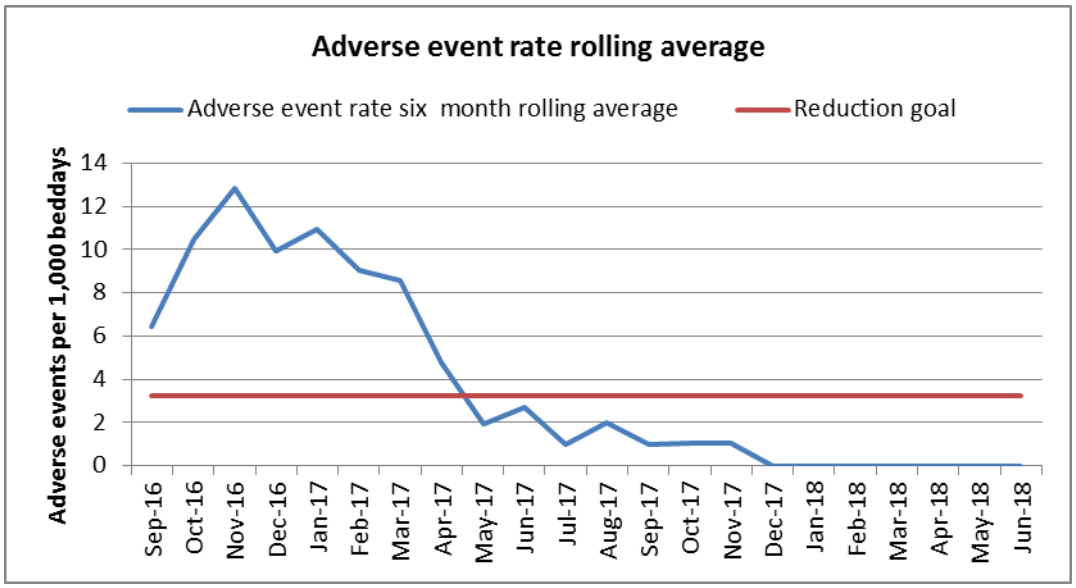


Figure 5: Adverse event rate per 1,000 bed days rolling average

[3] ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. UK Resuscitation Council.

[4] An adverse event is harm associated with healthcare delivery. There is no attribution of causality.

2.4 What we learned/problems we encountered:

2.4.1 Programme management

- It was initially difficult to recruit a programme manager with a clinical background and the required expertise in quality improvement (QI). In 2018, generally there are more clinicians and NHS staff with the requisite skills and experience, partly due the impact of the Berwick report recommending the need for increasing quality and safety improvement capacity and capability within the NHS in order to develop a culture of continuous improvement. This led to such initiatives as the Health Foundation's "Q Community". We also now have the benefit of a QI Academy and QI Hub in the Trust and closer working with our Transformation Team to support QI initiatives and to develop a critical mass of people with QI knowledge and skills within the Trust.

- A programme manager was recruited in October 2015 but due to unforeseen circumstances was absent from August 2016 for the remainder of the programme and fixed term replacements were difficult to source. There was extremely limited scope within the small team to absorb the additional workload and this had an impact on progress and support available within some work streams. In particular, the impact on the programme's communication and engagement plan across the Trust was significant, particularly with front line staff, which effectively stalled in the final year of the programme. Future programmes will have closer working with our Communications Team and a more definite long-term communications and engagement plan. The 1000 Lives Improvement team within Public Health Wales have recently produced some useful guidance on effective communications for QI (#QiComms).

2.4.2 Measuring mortality reduction

- Mortality indicators such as Hospital Standardised Mortality Ratio (HSMR) have previously been used as measures of improvement in former patient safety improvement programmes, and historically it was possible to obtain un-rebased HSMR to continue to populate run charts. This has now ceased due to the recognition of natural degradation of HSMR in the absence of any improvement action. The issue of rebasing mortality indicators, particularly SHMI has been discussed in the previous section. We also subsequently learned that using our Trust's ranking in national SHMI benchmarking data is also not recommended by NHS Digital. In future we will be cognisant that mortality indicators are simply indicators rather than reliable absolute measurements of improvement, and we now (through the Q Community) have links into the Patient Safety Measurement Unit at NHS South, Central and West Clinical Support Unit to advise on future measurement strategies.

2.4.3 Planning

- The Programme would have benefited from a longer period of planning, including how it would be evaluated and ensuring there were comprehensive valid baseline measures for all aspects of each work stream before any changes were made. Shortly after the programme started some work streams subsequently became partly driven by national imperatives, such as CQUINs and safety alerts with timeframes attached to them. This will be a recommendation for future programmes.

2.4.4 Staff engagement and communications

- As previously mentioned, there was good initial engagement at the launch and for the first year, but this could not be sustained without a programme manager and we failed to keep the programme sufficiently vibrant for front line staff over its life time

2.4.6 Integrating adults and children's work streams

- At the start of the programme, we integrated our work streams across adults, children's and maternity services, but learned that we risked losing engagement from paediatric clinicians involved if the work stream at the time was more adult focussed. A more flexible approach was adopted with work stream leads working across specialties on an "as required" basis providing support, delivering training or working through existing and new professional relationships. In some work streams, this worked very well, in others it was more challenging to keep focus without a programme manager to provide some continuity and with staff changes in divisions. Going forwards, we will ensure there is a robust governance structure for aspects of the programme.

2.4.7 New national initiatives

- During the lifetime of the programme, a number of new national initiatives were developed which helpfully enhanced the programme, such as the Learning from Deaths process. Others, such as CQUINs[5], whilst driving much needed improvements in key areas on a national scale, changed the nuance of some work streams from QI to performance management. This was largely due to the associated timescales and targets, which meant that changes were not always owned by front line staff and therefore did not always embed.

- The launch of the National Maternity and Neonatal Safety Improvement Collaborative in 2017 was a springboard for a different focus in our maternity improvement work and was supported nationally with a series of learning sets and by improvement leads from NHS Improvement which benefitted those involved.

2.5 Recommendations for next steps:

It is recommended that:

- We continue with patient safety improvement work in adults and paediatrics with a refreshed programme

- The maternity and neonatal safety improvement work continues under the auspices of the national collaborative

- Work streams that are not formally part of the refreshed programme but need further work to be embedded/or expanded into further areas link into our QI academy and QI hub.

[5] Commissioning for Quality Indicators

- Future programmes will have closer working with our Communications Team and a more definite long-term communications and engagement plan.

- Future programmes should have a longer period of planning, including how it would be evaluated and ensuring there were comprehensive valid baseline measures for all aspects of each work stream before any changes were made

- The governance structure for the future programme is reviewed

3. Achievements of our work streams

3.1 Early recognition and escalation of deteriorating patients

3.1.1 Aim of the work stream:

- To reduce harm arising from lack of recognition and management of the deteriorating patient by 50% by 2018.

This work stream involved both a local focus and collaboration across the local health system working with partners in the West of England Academic Health Science Network to develop and implement a single early warning score across GPs, primary care, mental health providers, the ambulance trust, emergency departments and secondary care providers.

3.1.2 What we set out to do:

The driver diagram for the work stream which illustrates the relationship between what we planned to do and the aim of the work stream is found at Appendix 4.

For adult patients we set out to:

- Complete the implementation of manual observations once a day in general wards;
- Spread our pilot of deteriorating patient magnets for the ward "status at a glance" boards;
- Embed the use of SBAR[6] structured communication tool for escalation;
- Implement structured ward rounds;
- Move to the National Early Warning Score (NEWS);
- Complete human factors training on deteriorating patients

Whilst not in our original plan, the achievement of Global Digital Exemplar status during the programme, meant that we could also introduce an e-observations system which would prompt action by staff should a patient's early warning score trigger a need for more senior review.

Also not in the original plan, during the programme our adult emergency department (ED) developed and tested an ED safety checklist as part of the system wide deteriorating patient work shown in the driver diagram at Appendix 2, which incorporated early warning scores.

For children we set out to:

- Review integrated paediatric early warning tool / observation charts in-line with current evidence and Royal College of Paediatrics & Child Health Guidance (RCPCH)

[6] SBAR, Situation, Background, Assessment, Recommendation is a structured communication tool used in the airline industry which has been adopted in some parts of the NHS.

- Improve knowledge and skills of nurses' recognition of deterioration
- Implement a Rapid Review Team to optimise care of acutely ill children
- Develop parental / family escalation processes if they are concerned about the clinical condition of their child
- Embed the use of SBAR structured communication tool for escalation

3.1.3 What we did:

a) For adult patients:

- We completed the implementation of manual observations once a day in general wards in 2015, but this was not sustained in the latter two years of the programme as our audit of 20 case notes a month shows in Figure 6.

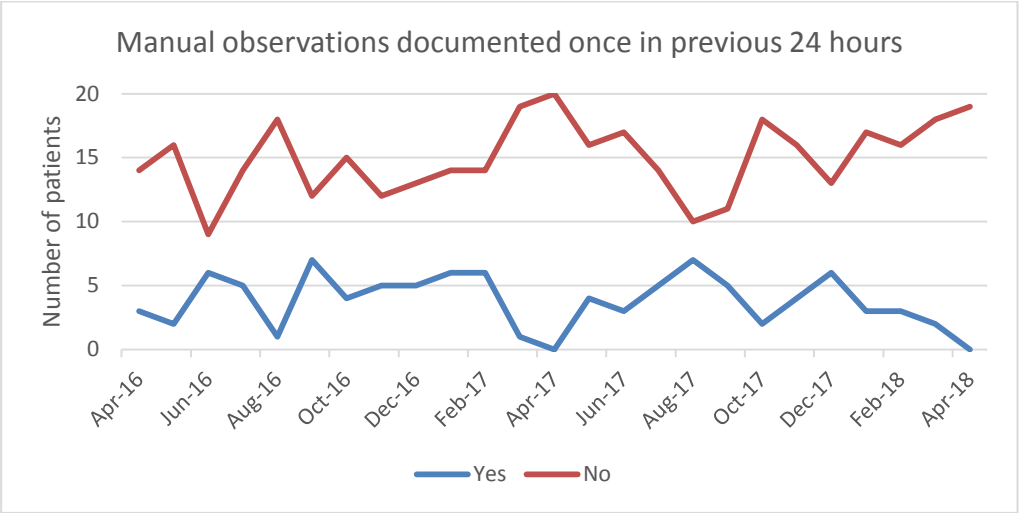


Figure 6: Manual observations taken once every 24 hours

With the implementation of e-observations in adult wards completed in May 2018, going forwards, we will look for an alternative way for staff to sustain their skills and competence should a situation arise where manual observations are required.

- We completed the implementation of deteriorating patient magnets for the ward "status at a glance" boards. These boards have since been replaced by electronic ward view boards with the potential for real-time NEWS scores to be electronically transferred from the e-observations system and made visible to senior clinicians in wards.

- We continued work to embed the use of SBAR structured communication tool for escalation. This included holding an independently facilitated focus group of clinical staff involved in incidents where communication around escalation of deteriorating patients was a contributing factor to try understanding why SBAR wasn't always used and whether we needed to amend the tool to make it easier or more intuitive for staff to use. The outputs from this focus group identified issues such as, difficulties of handover, fear of confrontation, ward staff not being aware of the role of the Clinical Site Manager at night, lack of clear systems for communicating with nurse in charge at night, lack of documented clear management plan for the patient following medical review. These points were subsequently emphasised in deteriorating patient training. The work on reviewing the SBAR sticker was overtaken by the implementation of NEWS in the absence of a programme manager.

- We had some success in implementing a structured ward round checklist in haematology, key checks were successfully included in the haematology daily proforma, however testing in other specialties was delayed due to rotations in junior doctors who took up this element of the work stream.

- We successfully switched from the Bristol Early Warning Score for adult patients to the National Early Warning Score at the end of 2015. This was a collaborative piece of work with North Bristol NHS Trust and we achieved a shared adult observation chart for both Trusts, which incorporated pain scores and an escalation protocol.

- Colleagues in our Simulation Centre led a programme of point of care simulation training on the deteriorating patient, including NEWS and SBAR

b) For children:

- In line with developments recommended by the Royal College of Paediatrics & Child Health Guidance (RCPCH) we implemented patient safety monthly audits. This required the recording of four Paediatric Early Warning Score (PEWS) questions monthly. Figure 7 below gives an example of the type of data that is collected for the Bristol Royal Hospital for Children (BRHC).

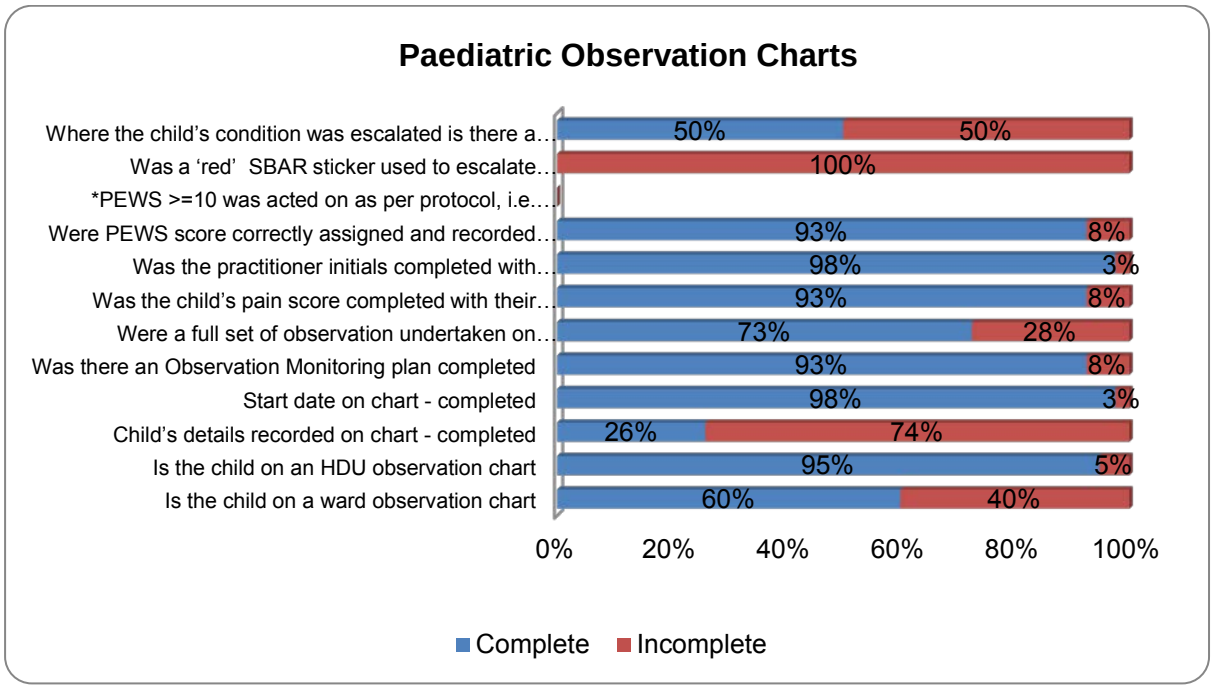


Figure 7: Example of PEWS monitoring audit

- SBAR / PEWS – 'Credit Cards' were developed and are carried by nursing / medical staff

- Through the Faculty of Children's Nurse Education at BRHC four Children's High Dependency Courses (8 days each) are run each year where recognition of the deteriorating child is key to all outcomes

- We updated our age specific observations charts for children based on the latest evidence and updated our clinical protocol on how to complete the Children's Observation Chart which contain an integral PEWS.

- All unplanned admissions to the Paediatric Intensive Care Unit were reviewed from April 2015-2016 to identify areas where practice could be developed.

- We developed a Standard Operating Procedure for families to escalate clinical concerns about their child along with information leaflets for families and staff to support this process

- There is regular simulation education in clinical areas to enhance knowledge and skills regarding the acutely ill child although this has been identified as an area for future improvement

- We are leading a South West Regional Project to standardise in-patient PEWS charts across the southwest

- We introduced Rapid Review Calls from October 2017 which have been fully embraced. This initiative formed part of a larger paediatric resuscitation QI project and has improved the management of and escalation process for deteriorating patients throughout the hospital. The calls enable a deteriorating child to be reviewed within 15 minutes by senior doctors and nurses. They can be activated by anyone who is concerned about a patient in BRHC by calling 2222 & asking for a 'Paediatric Rapid Review Call'. The team who introduced the Rapid Review system were shortlisted in the Patient Safety Category British Medical Journal awards 2018.

c) For maternity

Within maternity we aimed to improve the recognition and escalation of deteriorating patients resulting in the reduction of morbidity and mortality – Maternal and Obstetric Early Warning Score (MOEWS) for maternity and NEWS for Gynaecology. The maternity service has had early warning score charts embedded in practice since 2006 on the post-natal wards, in addition we;

- Introduced the use of SBAR stickers to escalate care for patients that trigger a medical review on the postnatal wards.
- Intrapartum MOEWS charts have been included in the Avon wide hand held maternity notes.
- Training in the use of MOEWS has been included in the Obstetric Emergency study day since May 2017
- Mapped the existing Neonatal observation chart to the BAPM (British Association of Perinatal Medicine) NEWTT (Newborn Early Warning Trigger and Track) tool.

3.1.4 What improvements we achieved:

a) For adult patients:

Our run chart in Figure 8[7] show that we have a system with over 95% reliability for completing patient observations and adding up early warning scores (even before the introduction of e-

[7] In each of the run charts the improvement goal is indicated by a dotted line

observations). The final point on the run chart is 100% when e-observations was fully implemented adult in-patient areas.

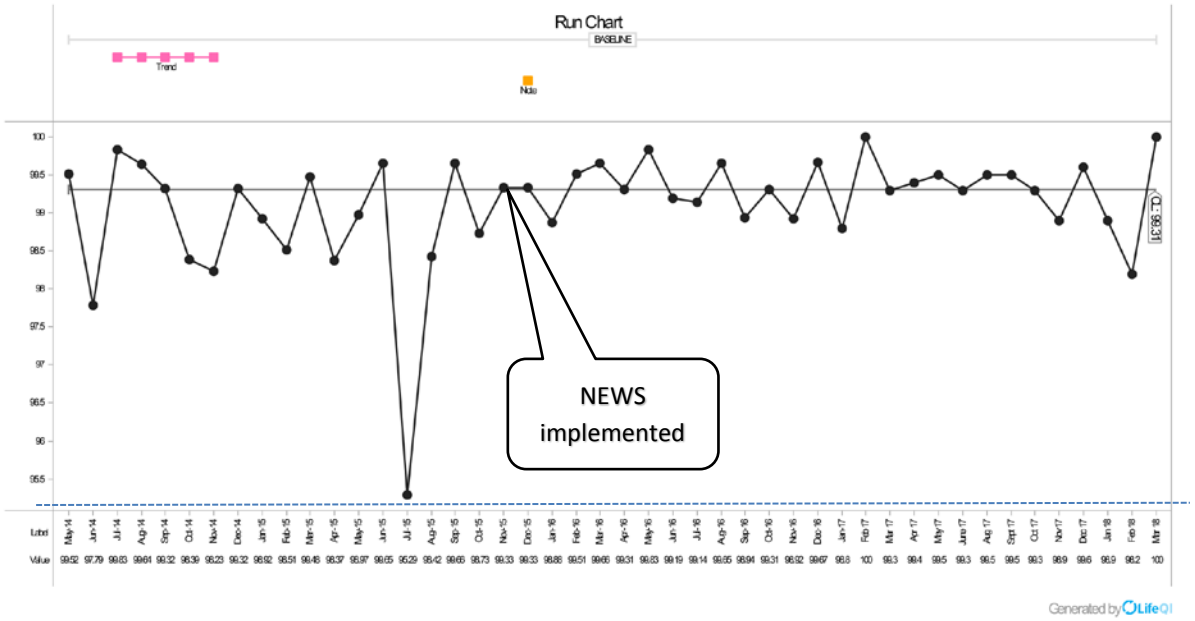


Figure 8: Adult early warning scores completed and added up correctly

Our system for acting on elevated early warning scores shows variation between 80 and 100% prior to August 2016, with a reduction in variation from this point as shown in Figure 9. The current situation requires a staff member to contact a senior clinician using SBAR to review a deteriorating patient. The system allows the receiving clinician to review the patient's electronic observation chart remotely to assist them to prioritise which patients to review first, but in the future plan there will be automatic escalation from the e-observations system using a system called Care Flow.

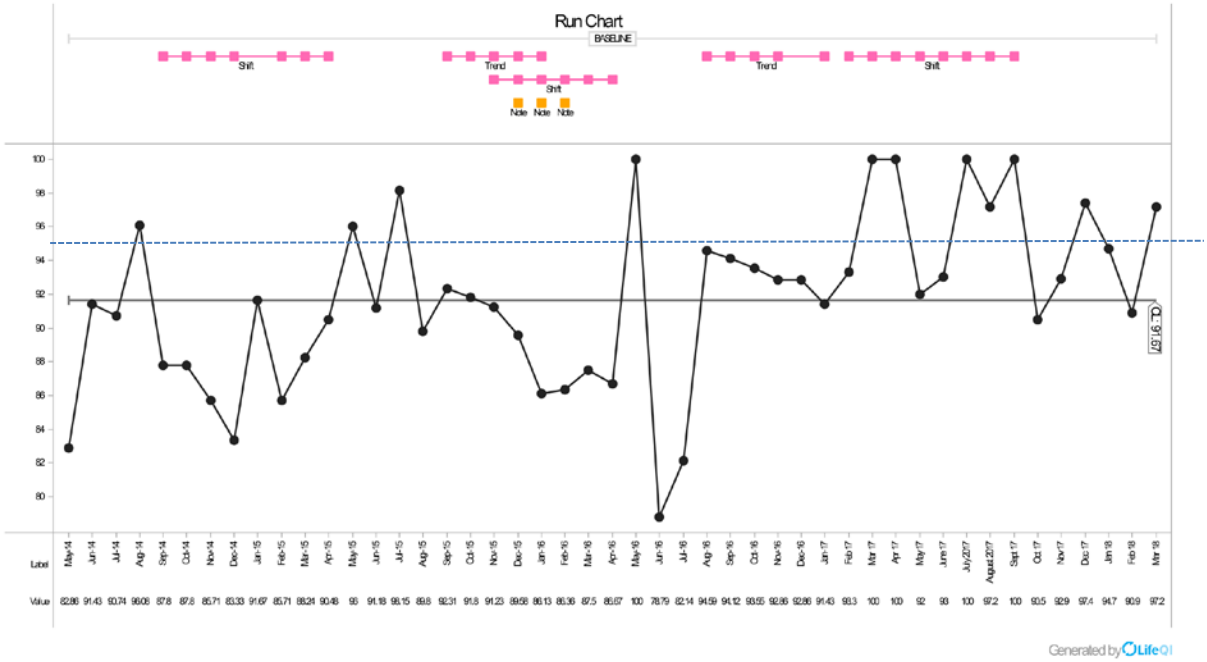


Figure 9: Early warning scores acted upon appropriately

The use of SBAR for escalation of deteriorating patients shows a reduction in variation in the most recent twelve months but we have still not achieved a system that is 95% reliable as seen in Figure 10.

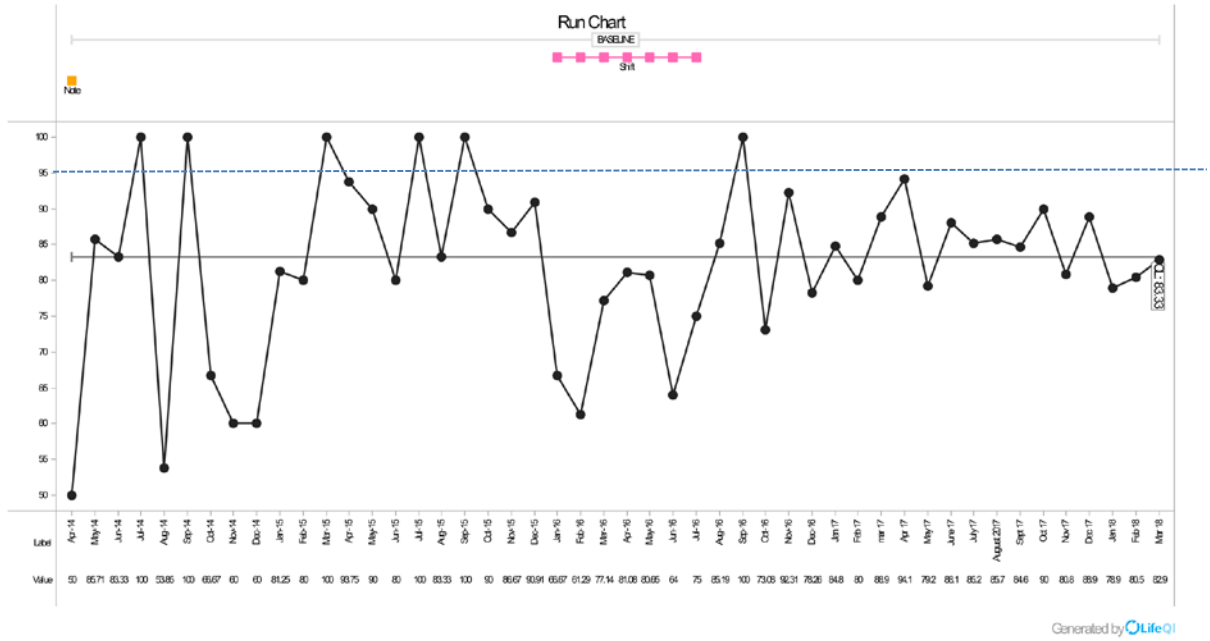


Figure 10: Use of SBAR to escalate deteriorating patients

In terms of outcome measures, we achieved and sustained our improvement goal (fewer than seven a month) for reduction in cardiac arrests from adult in-patient general wards from April 2016 as shown in Figure 11.

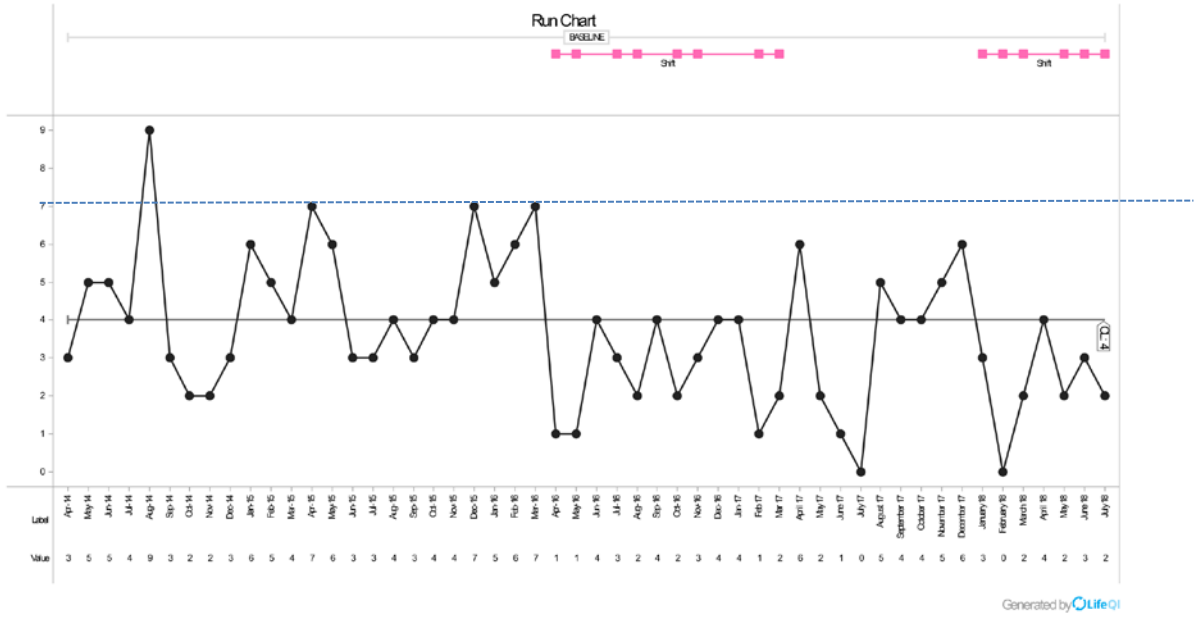


Figure 11: Cardiac arrests in adult in-patient general wards

Our ICNARC[8] data for the 12 months to June 2018 in Figure 12 shows we are ensuring deteriorating patients who need to be cared for in ITU are getting there promptly to give them the best chance of a good outcome.

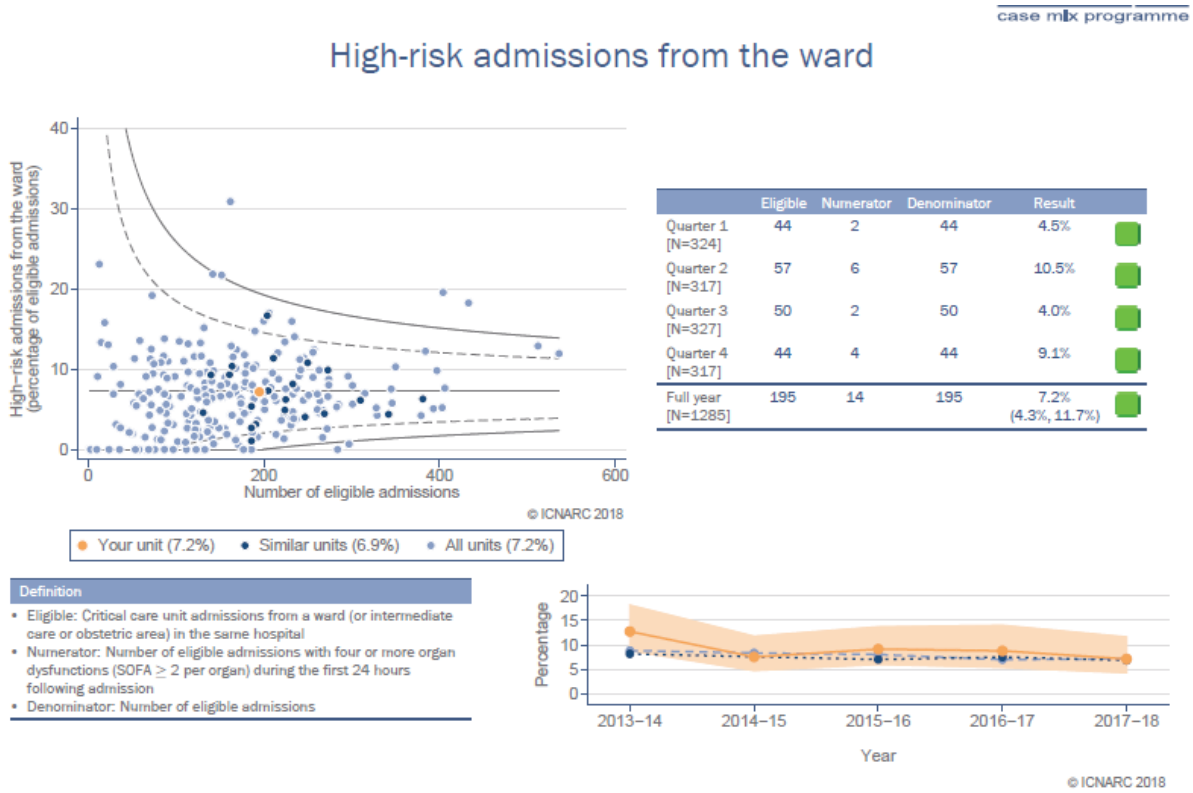


Figure 12: Timeliness of high-risk patients being transferred from wards to ITU

The system-wide work on the deteriorating patient and the implementation of NEWS across all providers in the West of England Academic Health Science Network won a British Medical Journal award 2018 for Patient Safety Team of the Year and the Deteriorating Patient and Rapid Response Systems Category of the Health Service Journal Patient Safety Awards 2018.

Our ED safety checklist has been implemented across our local health system and has been taken up by NHS Improvement as a national initiative. It also won the 2017 Health Service Journal Patient Safety Award 'Best Patient Safety Initiative in A&E'.

b) For children:

Within BRHC, there has been a safety shift; staff are calling for help earlier and activating Rapid Review Calls if they are not receiving the support they need. Primary teams are being involved early (in 96% of calls) leading to early addition of specialist treatments, e.g. specialist seizure management. Clinicians' anticipation of patients who are at risk of deterioration is improving.

The Faculty of Children's Nurse Education High Dependency Course at BRHC began around 10 years ago and since 2015, 72 nurses (24 from BRHC) have been taken through the programme each year across the region. The Nurse Orientation Programme runs four times per year for new nurses to BRHC, this has been running for around 5 years and gives both newly qualified and experienced

[8] Intensive Care Audit and Research Centre

nurses comprehensive understanding and knowledge about many different areas of nursing within BRHC. Topics covered range from escalation of deterioration, documentation and practices specific to BRHC to more advanced nursing skills such as tracheostomy care.

The South West Regional Project is in-progress to standardise in-patient PEWS charts across the southwest. By August 2018 64% of paediatric in-patient areas across the region are now using the same PEWS tool.

c) For maternity

Work to map the Newborn Early Warning Trigger and Track (NEWTT) tool against the existing new-born observations (NObs) chart is continuing but has not yet been implemented. This work aligns with our objective to reduce term admissions to the Neonatal Unit and is also being addressed through the Clinical Excellence dimension of the Maternal and Neonatal Health Safety Collaborative QI plans as described in section 3.8.3.

3.1.5 What we learned:

a) For adult patients:

- The benefits of working collaboratively across organisations with the support of the West of England Patient Safety Collaborative hosted by the West of England Academic Health Science Network with great clinical, as well as managerial, leadership

- The impact of culture and buy-in from front line staff in determining whether change becomes embedded and sustainable.

b) For children:

- Education across BRHC with the programmes the Faculty of Education run have hugely improved the level of understanding about deterioration of patients, that the staff within the hospital have.

- Whilst it is widely acknowledged across the Children's Hospital that recognition of deterioration in children has been further enhanced, data to quantify the changes is quite inconsistent and for the purposes of this evaluation, gaining access to all the data that is available has been difficult.

3.1.6 Recommendations for next steps:

a) For adult patients:

- Implement NEWS2 by Q3 2018/19

- Progress electronic escalation of deteriorating patients using Care Flow

- Implement ResPECT [9] process (or similar) in conjunction with West of England Academic Health Science Network system wide project

- Research alternative ways for staff to sustain their skills and competence in taking manual observations should a situation arise where these are required.

b) For children:

- Development of a more co-ordinated approach in the BRCH so that we can more clearly and consistently track learning, gain a deeper understanding of the barriers to change and promote better outcomes.

- When an appropriate configuration for electronic PEWS is available, look towards implementation in BRCH

- Continue regional PEWS implementation and play a key role in the work to develop national PEWS.

c) For maternity

- Continue with work to map the NEWTT (Newborn Early Warning Trigger and Track) tool against the existing new-born observations (NObs) chart. This work aligns with the ATTAIN initiatives to reduce term admissions to the Neonatal Unit and is also being addressed through the Clinical Excellence dimension of the Mat Neo collaborative QI plans.

3.2 Early recognition and management of sepsis

Sepsis is a life threatening organ dysfunction caused by a dysregulated host response to infection, which causes over 250,000 hospital admissions and kills over 44,000 people in the UK every year.

Or put more simply

“Sepsis (also known as blood poisoning) is the immune system’s overreaction to an infection or injury. Normally our immune system fights infection – but sometimes, for reasons we don’t yet understand, it attacks our body’s own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics.” (UK Sepsis Trust.)

It is important to note that some patients with sepsis will die from organ failure despite early recognition and prompt, appropriate treatment. There is a close link between early recognition and general deterioration of patients and the early recognition and treatment of sepsis, indeed the latest evidence-based trigger for sepsis screening in adults is a raised NEWS score.

[9] ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. UK Resuscitation Council.

3.2.1 Aim of the work stream:

The original aim of the work stream was to spread use of Sepsis 6[10] across all specialties focussing on in-patients who develop sepsis post admission; however, this was refined as the national Sepsis CQUIN was published a few months after the start of the programme.

Our revised aim was firstly to implement the use of a sepsis pathway and the Sepsis 6 in adult emergency department (ED) followed by children's emergency department (CED), and then focuses on implementing a sepsis pathway across all inpatient areas.

The UH Bristol team comprised of Lead Consultants and Patient Safety/Sepsis Nurses, who are actively involved in the regional sepsis groups. This work was also supported across the local health system by the West of England Academic Health Science Network. The system wide driver diagram for this work is shown in Appendix 5.

3.2.2 What we set out to do:

a) For adult patients:

- Year 1: Implement a sepsis pathway and the use of the Sepsis 6 in ED and aiming to achieve the CQUIN target of 90% of patients screened for sepsis and 90% of patients meeting the criteria receiving intravenous antibiotics (IVABs) within 1 hour.

- Year 2: Change the ED sepsis pathway to incorporate a NEWS score, continue with the 90% targets for ED with the addition of ensuring a 72-hour review was completed on IVABS given within 1 hour. Also in Year 2 in line with the national sepsis CQUIN we planned to design and implement a sepsis pathway for inpatient areas with the aim of achieving locally agreed targets.

- Year 3: To improve the use of the sepsis screening tool across ED and inpatient areas to achieve the CQUIN set targets of 90% of patients meeting the criteria screened for sepsis, 90% of eligible patients receiving IVABS within 1 hour and 90% of antibiotics receiving an empirical review within 72 hours.

b) For children:

- In years 2 & 3: to screen 90% of eligible patients in CED as per national CQUIN, to deliver IVABs within 1 hour in 90% of eligible patients and for 90% of eligible antibiotics to have been reviewed within 72 hours.

- Design and implement a sepsis screening pathway into paediatric inpatient areas, and to screen 90% of eligible patients, deliver IVABS within 1 hour in 90% of eligible patients and for 90% of these antibiotics to be reviewed within 72 hours.

3.2.3 What we did:

a) For adult patients:

[10] Sepsis 6 comprises six early interventions to diagnose and treat sepsis and help prevent the condition worsening, including prompt administration of antibiotics.

Sepsis pathways were developed using PDSA cycles, and adapted and implemented in both ED and inpatient areas. Teaching sessions on sepsis as a condition and how and when to appropriately use the pathways took place and a patient information leaflet on sepsis was designed and implemented. The PDSA testing ramps for the adult sepsis pathway are found in Appendix 6.

b) For children:

A process for sepsis screening in CED was developed and incorporated as an electronic screening tool in the Medway Patient Administration System alongside a sticker for nurses to highlight these patients for urgent review on the front of the 'casualty card'. Following on from the success of this, a sepsis care pathway for CED was developed and implemented to improve antibiotic administration. A dedicated Paediatric Sepsis Nurse is now in post for 1 day a week. The PDSA testing ramps for the children's sepsis pathway are found in Appendix 7.

c) For maternity:

The "Sepsis in Pregnancy and the Puerperium" guideline was added to the DMS in January 2017 and the Maternity Specific Sepsis Screening tool has been fully tested and is in use within the unit.

Sepsis is the 'Hot Topic' in the programme for Obstetric Emergency training for 2017/18 which is attended by all midwives, obstetric doctors and anaesthetists working in maternity services at St Michaels. This session includes signs and symptoms of potential sepsis and how to use the Maternity Specific Sepsis Screening tool.

A local audit of Inpatient Maternal Sepsis Screening Tool was undertaken during October and November 2017. The screening tool was used in 32% of eligible cases. The general findings were that low-risk women may be receiving treatment earlier than the guideline suggests and that the current guidance and modified tool needs amendment to be fully fit for purpose; only two women in the audit were truly septic. The World Health Organisation are conducting a global Maternal Sepsis study (GLOSS) and once this has been reported further discussion with other units across the southwest region will be taken forward to find ways to amend the tool.

3.2.4 What improvements we achieved:

a) For adult patients:

We first achieved the 90% improvement goal for sepsis screening in ED in January 2016, and then again in March 2017 but this was not sustained as shown in Figure 13 because the process was not yet embedded and relied on the ED Sepsis Nurse to prompt screening which did not happen when the post was vacant. We reached 90% again in July 2018, with preceding data showing less variation than in previous years and it remains to be seen if this will be sustained.

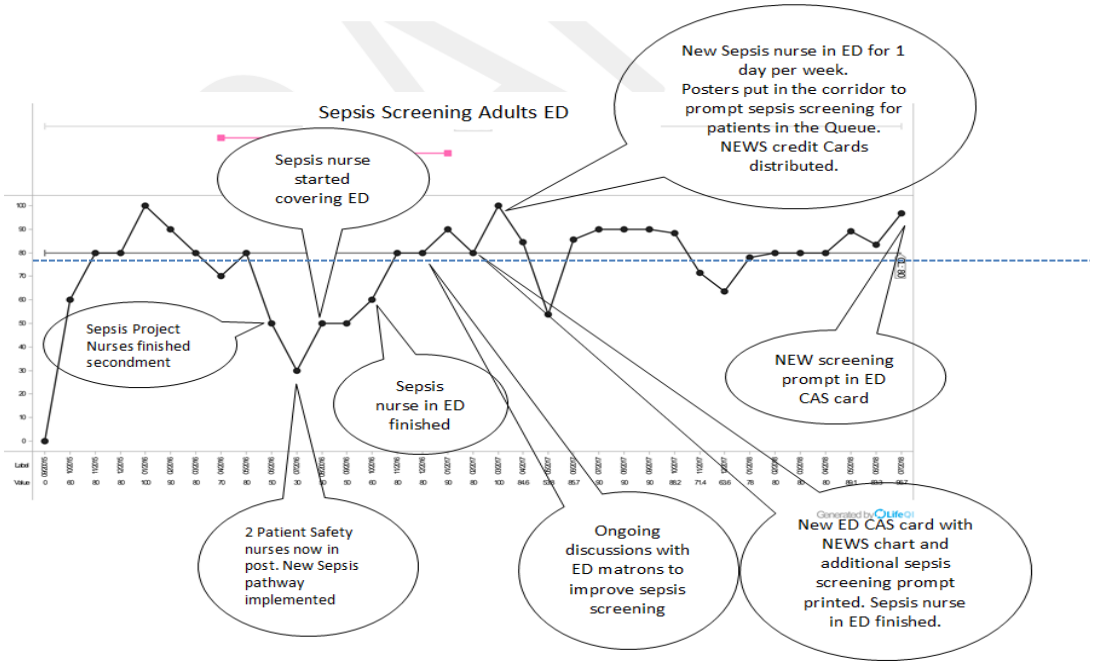


Figure 13: Sepsis screening in ED

In ED, we did not achieve sustained improvement[11] above the 90% improvement goal for antibiotics given within an hour in ED, but more recent data is also showing less variation as shown in Figure 14.

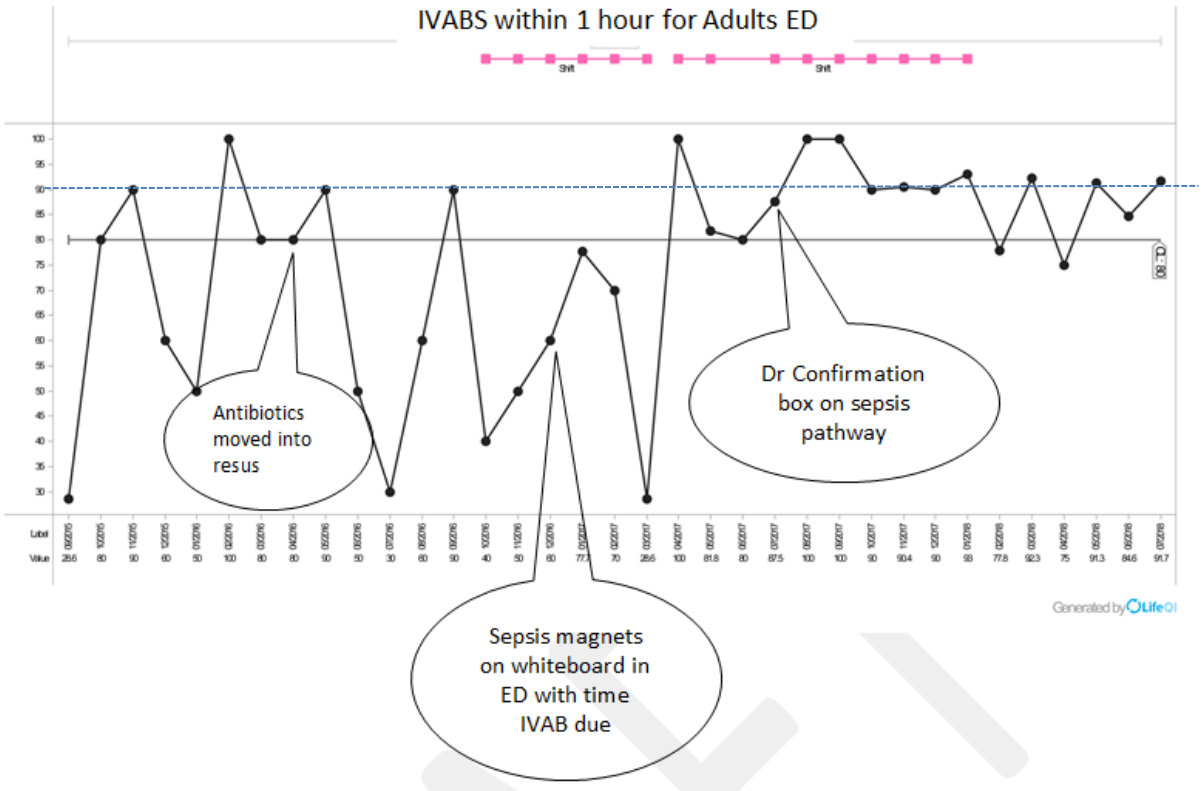


Figure 14: Antibiotics given within an hour in ED

[11] Sustained improvement is defined at three consecutive months of achieving the improvement goal without slipping back wards

For in-patient sepsis screening we initially had persistently low screening rates in adult inpatient areas when using the paper sepsis pathways and only started to see the improvements when electronic screening was brought in as shown in Figure 15.

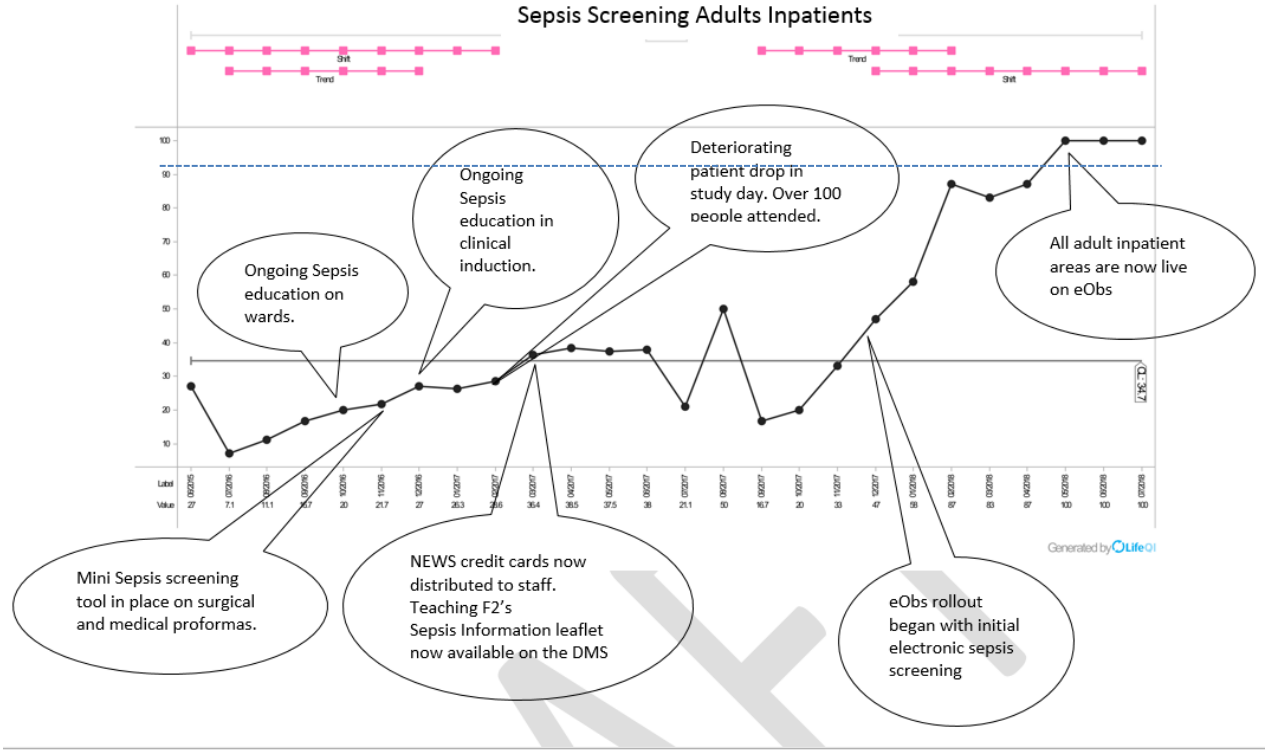


Figure 15: In-patient sepsis screening

Figure 16 shows wide variation in administration of antibiotics within an hour for adult in-patients, mainly due to the very small numbers of in-patients that are eligible to be taken through to this part of the CQUIN audit. This includes the three 'zero' entries where there were no patients eligible to take through to this part of the audit, not zero patients receiving antibiotics within an hour when they should have.

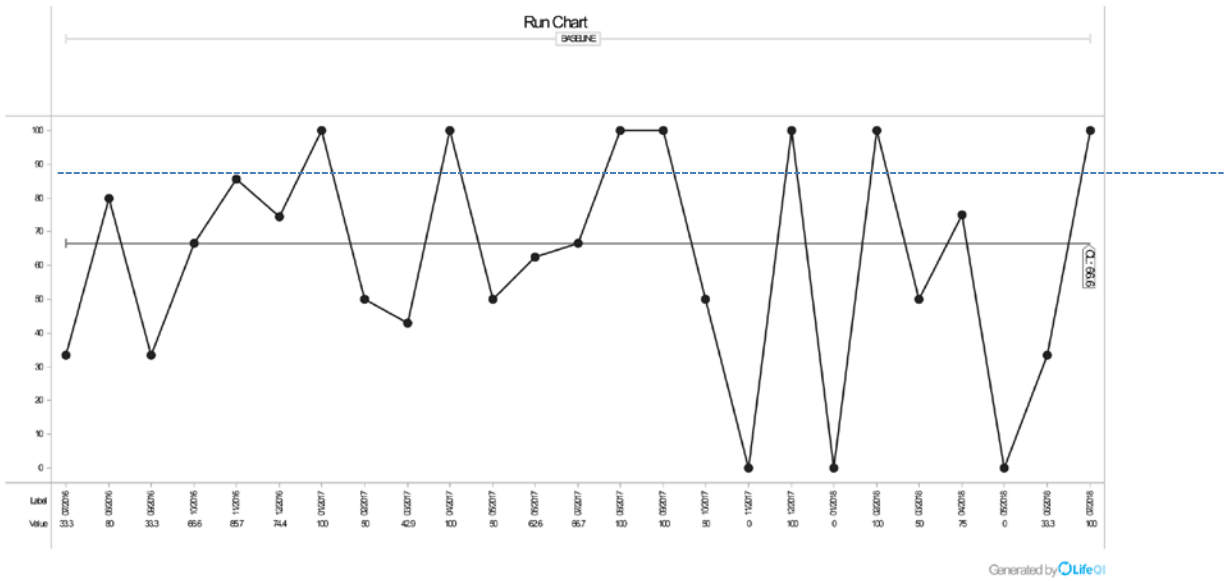


Figure 16: Administration of antibiotics within an hour adult in-patients

The 72-hour review of antibiotics for in-patients shown in Figure 17 achieved the 90% improvement goal but this was not sustained in recent months.

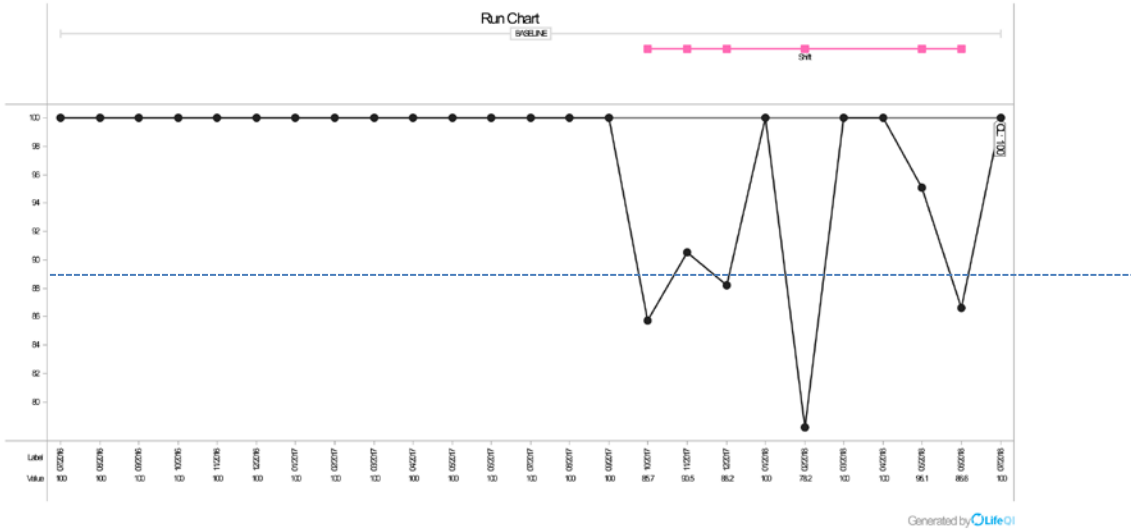


Figure 17: 72 hour review of antibiotics

We also improved the coding of patients with sepsis with the addition of a sepsis question on the discharge summary, which also allows for appropriate follow up in the community.

Outcome measures for adult patients with sepsis:

Our ICNARC data for the 12 months to June 2018 in Figure 18 shows that our patients with sepsis are being transferred and treated in ITU promptly compare to other hospitals with similar ITUs and have less organ failure as a result.

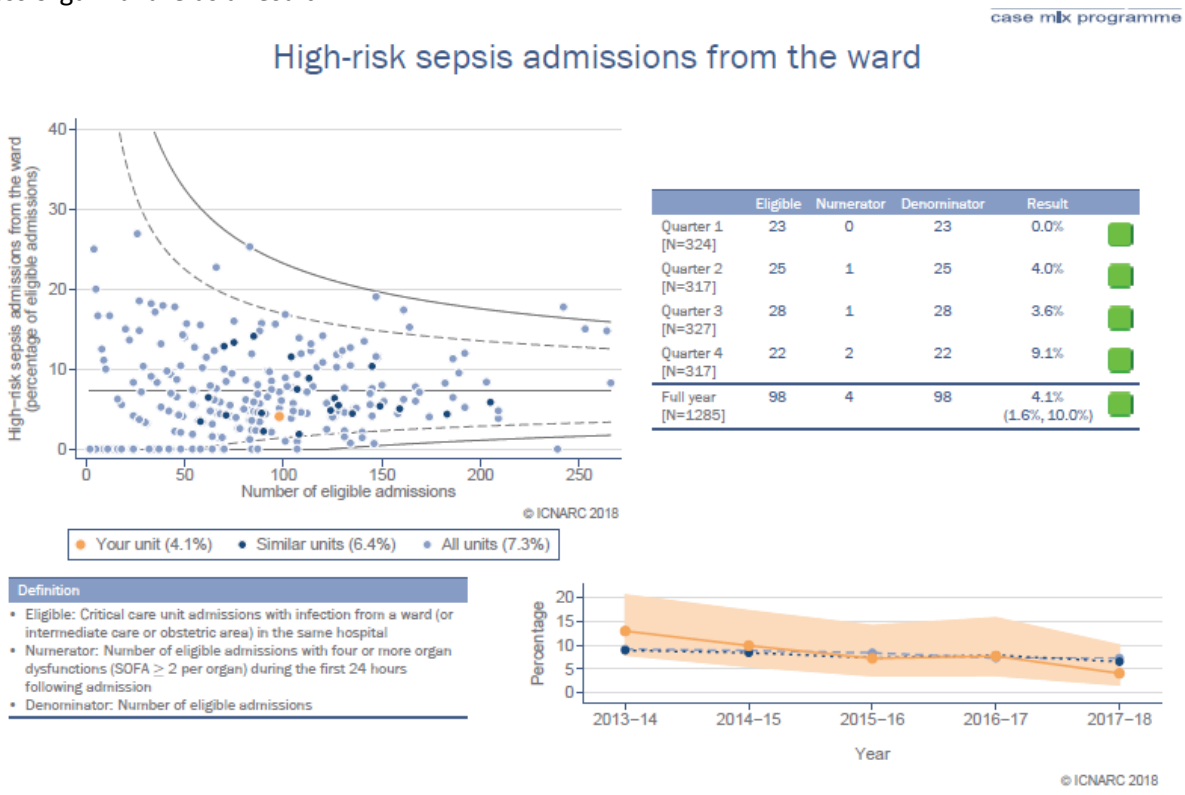


Figure 18: High-risk sepsis admissions to ITU from wards

System wide outcome measures:

Figures 19 and 20 below show across our West of England Patient Safety Collaborative footprint we have reduced mortality from suspicion of sepsis from 2013 to 2017 from about 7% to less than 6%, and have been more successful in doing so relative to other Academic Health Science Networks (AHSNs).

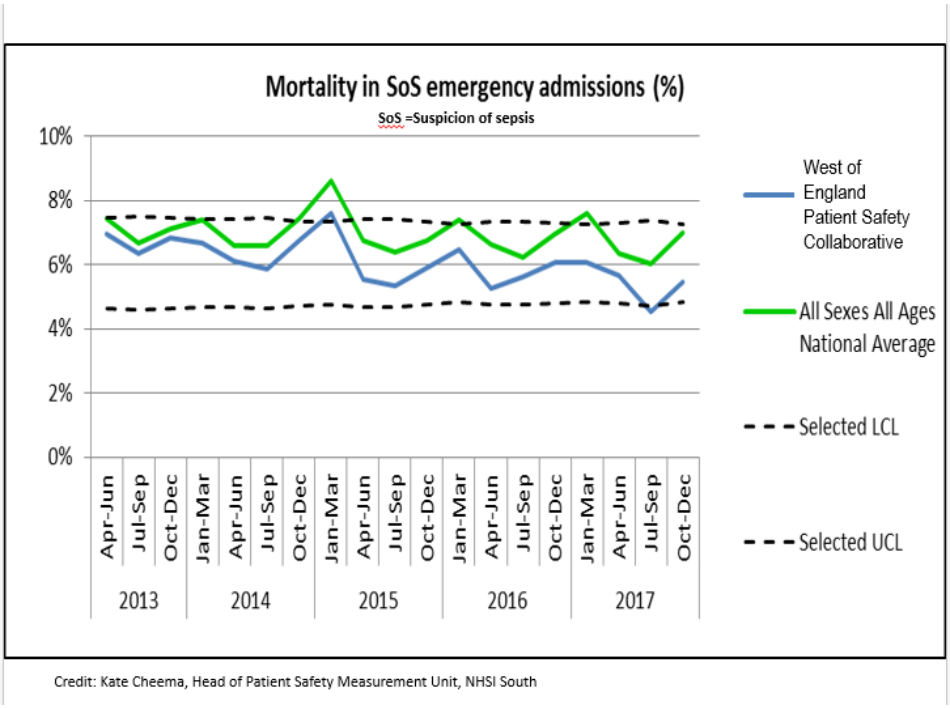


Figure 19: Mortality suspicion of sepsis emergency admissions 2013 to 2017

Figure 20: Suspicion of sepsis death in hospital by AHSN April 2013 and October 2017

b) For children:

Automatic sepsis screening using Medway data in the Children's Emergency Department has now been embedded for some time and the screening rates for sepsis have remained at 100% of eligible children as a result of this as shown in Figure 21. If the screen is positive, the patient is flagged to the nurse in charge, triaged as a category 2 (urgent) and has a green "sepsis" sticker placed on the front of the notes. This helps to highlight to the clinician seeing the child that they are in a higher risk category.

Time to delivery of antibiotic in suspected sepsis in the CED (target is within 1 hour of diagnosis of sepsis) has improved considerably overall. In children who are clinically shocked / haemodynamically unstable (and require resuscitation) on initial assessment, the antibiotic administration target is being achieved in 100% of cases. This is the highest risk group of children (and arguably the group that this part of the CQUIN should be designed to address) and management of this group is invariably excellent.

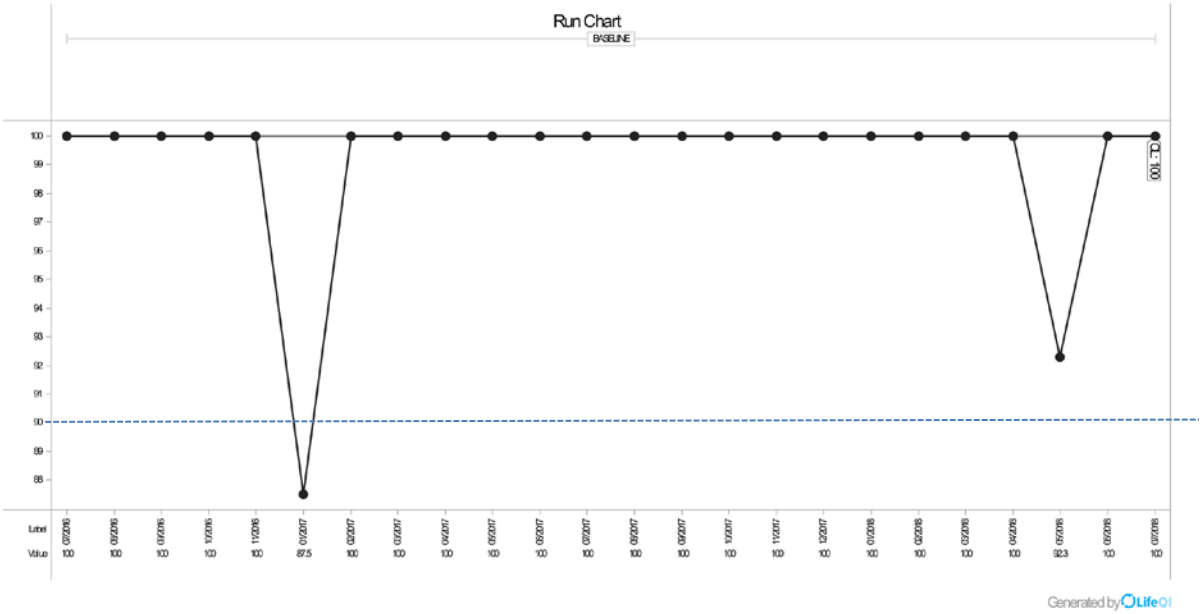


Figure 21: Sepsis screening in CED

For timely antibiotic delivery for children requiring treatment for suspicion of sepsis we achieved 44.4% and 62.5% in June and July 2018 respectively (please note these are based on small numbers), and 72 hour antibiotic review for children who were still in-patients at 72 hours was 100%.

3.2.5 What we learned:

a) For adult patients:

- As CQUIN audit requirements became more time consuming, the ability to go out to ward areas to deliver teaching was impacted. However, the targeted teaching days always proved popular and feedback from staff suggests that they learnt from these sessions and that they were useful to their practice.

- The introduction of electronic sepsis screening in the e-observations system into adult in-patient areas enabled a significant improvement in the numbers of patients screened for sepsis.

- Learning from the work carried out over the last three years, the key area in which things could have been done differently would be to have engaged the junior doctors sooner as this would have allowed for a more joined up approach to the identification of, screening and treatment of the septic patient. Also having the involvement of the simulation team earlier to help address any early issues.

b) For children:

- Introducing a children's sepsis in-patient pathway has been more difficult and has involved many changes including a change in the sepsis lead. Some of the problems encountered included medical engagement. The need for a pathway was not clear among clinicians, due to the relatively low numbers of paediatric in-patients who develop sepsis.

- The involvement of the simulation team in testing the pathway in its most recent form was invaluable and this enabled testing of the pathway by both medical and nursing staff to ensure, as far as possible, that the pathway was fit for purpose in a clinical environment. Nursing staff were engaged in the process and understood the benefit of using a pathway for facilitating a prompt senior review of patients who may be septic.

c) For maternity:

- The team's understanding and use of lactate when screening for sepsis and the value and use of the sepsis screening tool.

- That the current guidance and modified tool needs amendment to be fully fit for purpose.

- The team need support to understand the requirements for lactate screening as described in the NICE guidance. It transpired that the way the requirement for lactate testing had been interpreted in the maternity sepsis screening tool and guideline was incorrect, leading to the testing of women when it wasn't required.

- The sepsis screening tool and the sepsis guideline were updated to meet the requirements of the sepsis work stream.

- The point of care testing for lactate levels is difficult for maternity (and gynaecology) patients at St Michael's. The only blood gas analyser which will process lactate levels is on NICU, but only a small number of maternity staff have log in's for this machine. NICU staff are not permitted to process samples on behalf of another specialty due to the governance issue of who takes responsibility for an abnormal result. We have approached the point of care testing group who have advised they would not support a generic login for the department. As an interim it has been proposed that we apply for a login to be linked with the anaesthetic and obstetric registrar on call bleep. A risk assessment has been drafted to highlight this and a business case for a blood gas analyser with the functionality to process lactates is being discussed.

3.2.6 Recommendations for next steps:

a) For adult patients:

- In October 2018, the adult in-patient sepsis pathway will be electronic and therefore should become embedded in practice.

- ED is not currently using electronic sepsis screening or e-observations and this may not be in place until 2019. It has been identified that the only way sepsis screening will become fully

embedded in practice is for sepsis screening to be electronic and therefore automatically prompted.

- The work stream will continue in its current form whilst the2017/19 sepsis CQUIN is a national contractual requirement, however in the future there could be the potential for it to combine with work being done through e-observations and Electronic Prescribing and Medicines Administration (EPMA) to provide a more joined up digital approach.

b) For children:

- To continue to teach and share information about the paediatric in-patient sepsis pathway to ensure that it is fully embedded.

c) For maternity:

- The World Health Organisation are conducting a global maternal sepsis study (GLOSS) and once this has been reported we will work with partners the Local Maternity System to adapt the maternal sepsis tool in response to the latest evidence.

- We will continue to monitor our practice and make further improvements informed by our data

- We will progress a business case for a blood gas analyser with the functionality to process lactates for Central Delivery Suite.

3.3 Early recognition and management of acute kidney injury

Acute kidney injury (AKI) is a sudden and recent reduction in a person's kidney function. It is estimated that 100,000 deaths each year in hospital are associated with acute kidney injury, up to 30% could be prevented with the right care and treatment, and that one in five people admitted to hospital each year as an emergency has acute kidney injury.

AKI is classified into three stages determined by laboratory blood results, stage 1 being the least severe reduction in renal function and stage 3 being the most severe.

3.3.1 Aim of the work stream:

- The original aim of the work stream was to make improvements to meet the National Institute for Clinical Excellence quality standard for AKI; however, this was refined as the national AKI CQUIN was published a few months after the start of the programme.

- Our revised aim was to reduce incidence of deteriorating renal function and mortality in patients with AKI and following the national AKI CQUIN to improve the follow up and recovery for individuals who have sustained AKI. This included reducing the risks of readmission, re-establishing medication for patients with other long-term conditions and improving follow up of episodes of AKI, which is associated with increased cardiovascular risk in the long term.

- The work stream was a Trust wide initiative initially driven by the national AKI CQUIN. The core team included a consultant AKI lead (initially from paediatrics, but subsequently from adult services) and an AKI project nurse, but also included members of the wider multidisciplinary team, including (but not limited too) IT, Pharmacy, a Consultant Chemical Pathologist, and Intensivists. There was a collaborative approach with North Bristol NHS Trust to align processes and ensure we learnt from their specialist knowledge of adult renal care.

3.3.2 What we set out to do:

We planned to:

- Add four questions into the patients discharge summary to ensure we met the AKI CQUIN goal of 90% patients having the following requirements included in their discharge summary to their GP:
    1. Stage of AKI;
    2. Evidence of medicines review having been undertaken;
    3. Type of blood tests required on discharge for monitoring;
    4. Frequency of blood tests required on discharge for monitoring.

- Implement electronic AKI alerts on ICE (laboratory system).
- Develop and implement AKI guidelines

We measured improvement towards completion of the four discharge summary questions and the completeness and accuracy of fluid balance monitoring for patients who required this. When the CQUIN ended, the work stream became solely adult focussed and we added new measures on the number of hospital acquired AKIs for each stage , number of patients whose AKI was progressing (getting worse) and the progression of AKIs with the overall aim to improve the care of inpatients with AKIs

3.3.3 What we did:

- Added the four questions electronically to all adult in-patient discharge summaries.
- Implemented AKI alerts available in the ICE system and ensured alert banners were in place for 4 weeks.
- Developed and published AKI guidelines for clinicians
- Developed and tested AKI medication chart stickers to prompt medication reviews[12] when a patient has an AKI.
- Developed and tested two different versions of AKI care bundles in conjunction with junior doctors to improve the care of inpatients with AKI.

The PDSA ramps for our improvements are found in Appendices 7-9.

3.3.4 What improvements we achieved:

[12] Some medicines are nephrotoxic and can worsen kidney function, and so should be reviewed and changed where clinically appropriate to preserve renal function

We achieved the 90% improvement goal for the four requirements for discharge summaries as shown in Figure 22 below. The questions remain on the discharge summaries and completion is embedded in practice.

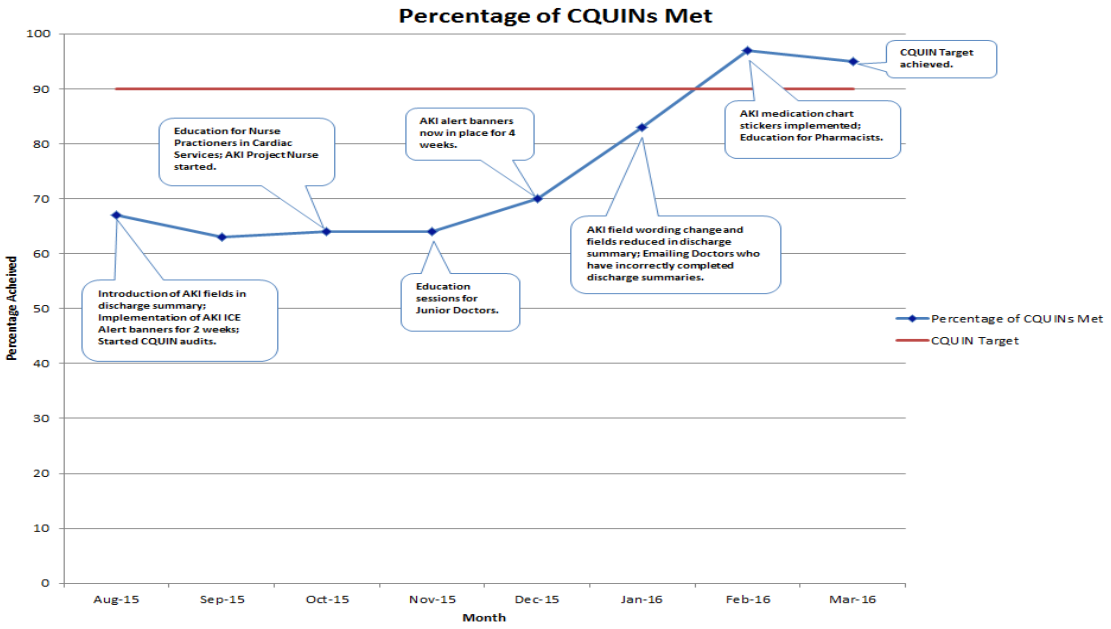


Figure 22: Improvement in the four AKI requirements in discharge summaries

We improved the percentage of patients who progressed from stage 1 to stage 2 AKI and from stages 1 and 2 to stage 3 AKI as shown in Figures 23 and 24.

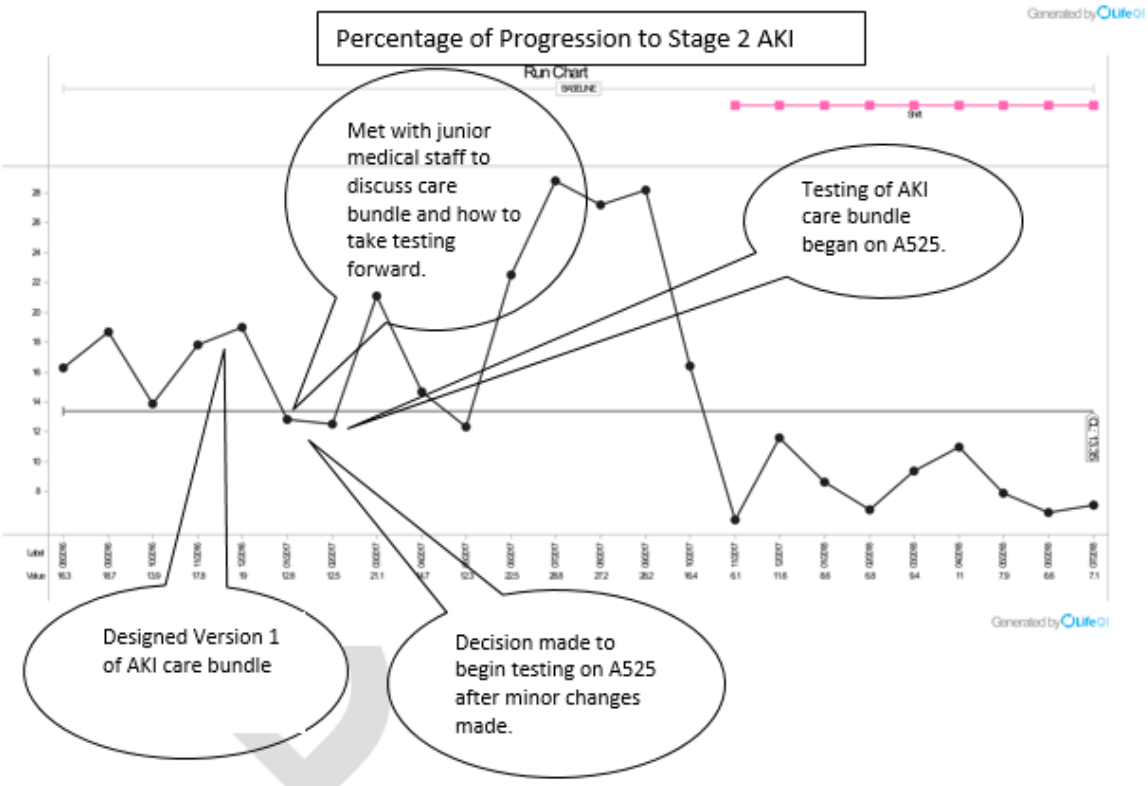


Figure 23: Progression to stage 2 AKI

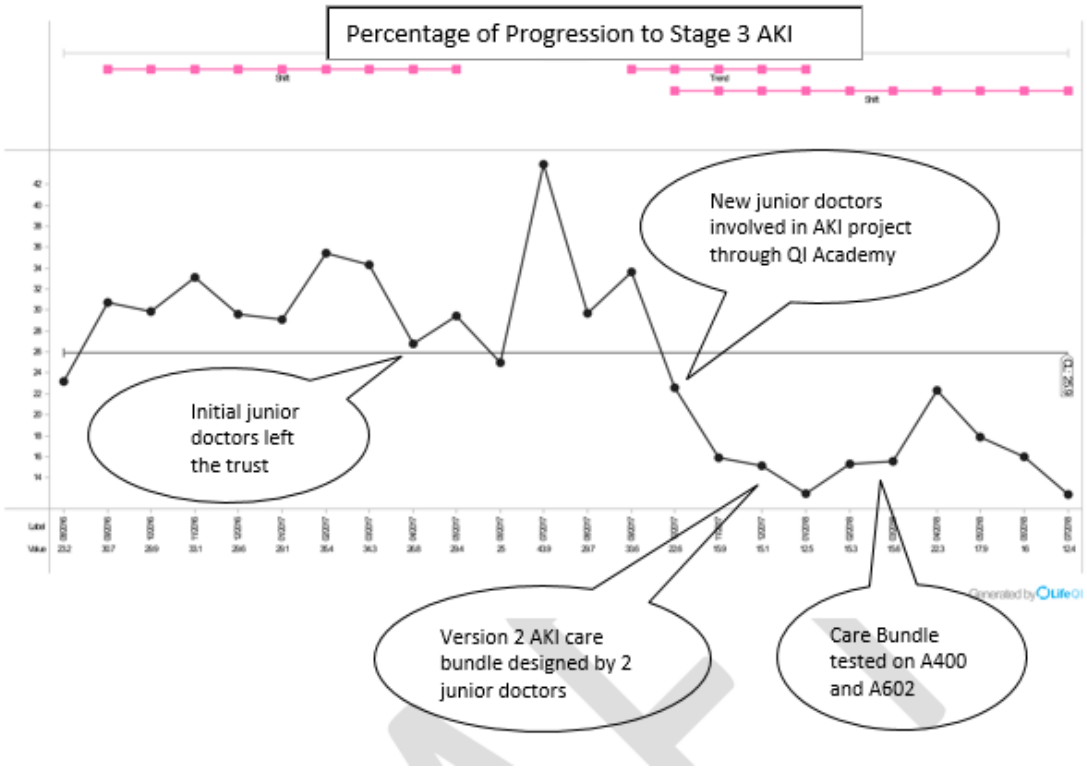


Figure 24: Progression to stage 3 AKI

A snapshot audit of fluid balance charts across the trust showed a variance in completeness and accuracy Fluid charts in ward areas have since been redesigned and a hydration chart is now also in use for patients who do not require strict fluid balance monitoring.

3.3.5 What we learned:

- After the CQUIN was completed in April 2016, the work stream no longer had a medical lead and the ongoing work was undertaken by the patient safety nurses. Having no medical lead adversely affected the ability to implement and sustain changes, which primarily involve medical practice. This was especially found when implementing the AKI care bundle due to junior doctors rotating out of the Trust.

3.3.6 Recommendations for next steps:

- We should continue the work to introduce an AKI care bundle as this has the potential to further reduce worsening AKI in patients

- If the work stream is to continue it is recommended a medical lead is identified to help drive through changes and continue to make improvements in the care of inpatients with AKI.

3.4 Improving Medicines Safety

Nationally, up to 600,000 (11%) of non-elective hospital admissions are due to medicines. 20% of people over 70 years old take five or more medicines.

Locally, in our West of England Academic Health Science Network region, data suggests there are 10,938 admissions related to medicines (4% of total hospital bed capacity) with a projected annual cost of £20.6 million.

In 2015, HealthWatch carried out an investigation into discharge across England. Their report found that:

> *"Some older people told us they were left confused about the new medicines they had been prescribed, and weren't told how it might fit with their existing medicine."*

3.4.1 Aim of the work stream:

The aim of the work stream was to work together across the West of England Academic Health Science Network (with patients and each other) to deliver safer and better outcomes from medicines, with a primary focus to improve medicines safety at the point transfer of care.

3.4.2 What we set out to do:

We set out to:

- Improve medicines reconciliation: 'getting the medicines right';
- Improve handovers: clinician to clinician, shift to shift, ward to ward, sector to sector, hospital to home;
- Improve safety of high risk medicines processes e.g. insulin, anticoagulation;
- Develop the use of innovation and technology in medicines safety;
- Improve the involvement of patients in their medicines;
- Assist the Trust in reducing the number of unintentional omitted doses of critical medication to below 2.25%.

3.4.3 What we did:

We put in place several measures to improve the quality of medicines information at handovers and transfers of care to allow accurate reconciliation of medicines at these transfers:

- We introduced an electronic means of recording a patient's medication history and subsequent reconciliation with the patient's currently prescribed medication (Using a Medway Clinical note). This is now routinely used in all adult areas and will be rolled out to paediatrics over the next 6-12 months. This also includes sections for tracking of issues raised by pharmacy staff at admission and a section for the handover of information at patient discharge, and the review of their take-home medication.

- We have continued to work with Orion Health to help further develop their Connecting Care integrated Health Record; which included a medication and allergy list. This is now accessible as a contextual link from within Medway, removing the need for an additional log-in.

- We have developed a patient dashboard to allow the easy tracking of newly admitted patients who require their medication history to be checked and reconciled (2nd column in Figure 25 – "Meds Rec", green if completed, red if to be completed).

Figure 25: Medicines reconciliation dashboard

- We looked at processes around the prescribing and administering of insulin and introduced measures to assist medical and nursing staff prescribe insulins, particularly at admission: prescribing guidance for insulins and management of diabetic ketoacidosis

- We introduced a dashboard within our incident reporting system which shows incidents relating to insulin

- We used the "PharmOutcomes" system to refer high-risk patients to community pharmacies for a formal medication review post-discharge. This has been incorporated into the on-line "medicines note".

- We procured a patient medication information system (MaPPs) - "user-friendly" information about an individual patient's medication can be printed for them to take away.

- We revised the Trust patient self-administration policy and guidance

3.4.4 What improvements we achieved:

We made a good start in 2016 with referrals of high-risk patients to community pharmacies for a formal medication review post-discharge as shown in Figure 26, but due to problems with speed of IT connection outside of the Trust we struggled to increase the number of referrals.

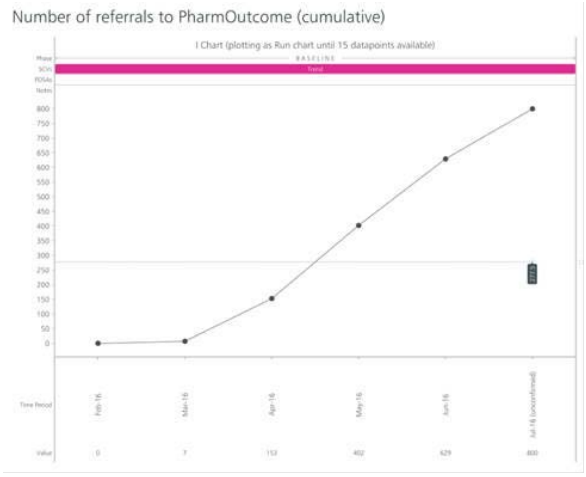


Figure 26: Cumulative PharmOutcomes referrals 2016

In 2018/19 to the end of June, we have referred 124 high risk-patients (92% aged over 60 years and 75% over 75 years) to community pharmacies for a formal medication review post-discharge.

The number of unintentionally omitted critical medication has further reduced form the stated 2.25% improvement goal to being routinely below 0.5% as shown in Figure 27.

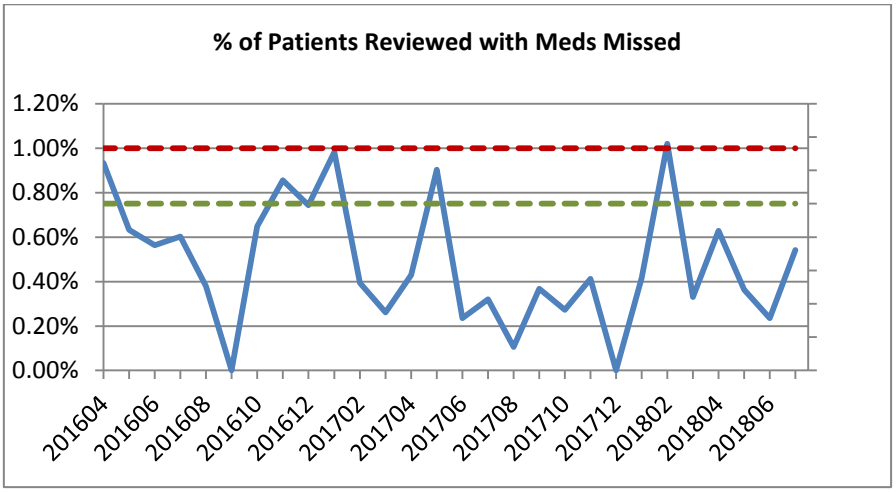


Figure 27: Percentage of non-purposeful missed doses of critical medicines

3.4.5 What we learned/problems we encountered:

- Clinician engagement has been a challenge within the insulin safety work stream due to the pressures of clinical time. The Diabetes Steering Group has overseen this work stream but practically has had little time to engage fully with the safety measures.

- The PharmOutcomes referral process is lengthy and can take 10-15 minutes per patient including log-ins. This limits our referral rate to Primary Care to around 40-50 a month due to staffing time for the process.

- We have not managed to engage patient groups in this work stream. Patient self-administration is also not well established in the Trust; reasons for this still need to be fully understood.

- The use of the patient information leaflet system has been slow to take off due to overall work pressures; as this takes some time to input a patient's medication and generate the personalised leaflet.

3.4.6 Recommendations for next steps:

- The Trust has a new quality objective for 2018/19 to measure the number of insulin prescriptions omitted at admission to our two medical assessment units and reduce this incidence by 25% within the next year.

- Revise the medicines optimisation driver diagram for the next steps

- Engage with the AHSN national projects work stream through West of England AHSN. Their focus is on reducing unnecessary polypharmacy. Locally this will be in partnership with the Strategic Transformation Plan Medicines Optimisation Polypharmacy work stream including GP use of the PINCER tool to review medication safety indicators within practices.

- We will investigate how these (or other published) medication safety measure could be enacted within electronic prescribing

- Increase the use of PharmOutcomes for hospital referral to primary care with an internal focus is now on integrating this referral automatically through our electronic prescribing system

- Engage with the WHO patient safety challenge – Medication without harm; and the ongoing national work to support this.

- Continue to develop integrated clinical informatics systems through the STP Medicines Optimisation IT work stream and the Local Health Record Exemplar work

- Further develop clinical dashboards, linked to electronic prescribing, to highlight individual patient safety issues, safety & process measures and outcome data. This includes real-time measure of omitted medication and reports to show critical medication omissions.

- Look at ways to better engage patient involvement in medicines safety

- Re-focus on patient self-administration and the reasons for poor adoption of this in practice.

3.5 Developing our safety culture

The National Patient Safety Agency defined a safety culture as

"A culture where staff have a constant and active awareness of the potential for things to go wrong. A culture that is open and fair and one that encourages people to speak up about mistakes"

Some studies[13] have found simultaneous improved safety culture and patient outcomes following improvement initiatives. Therefore rather than a one-way causal relationship, with culture influencing behaviours and clinical outcomes, there may be a circular relationship, with changes in behaviours and outcomes also improving safety culture.

In the national Maternal and Neonatal Health Safety Collaborative there is a specific theme for the 'human' dimension focussing on leadership and culture.

There are a number safety culture and climate assessment tools, after testing in 2014/15 we selected the Manchester Patient Safety Framework[14] (MaPSaF) due to its academic evidence base and validation.

[13] Does improving safety culture affect patient outcomes? The Health Foundation 2011

[14] Manchester Patient Safety Framework University of Manchester 2006

3.5.1 Aim of the work stream:

For the organisation's safety culture to develop one step along the MaPSaF continuum from the baseline assessment towards a generative safety culture by March 2018.

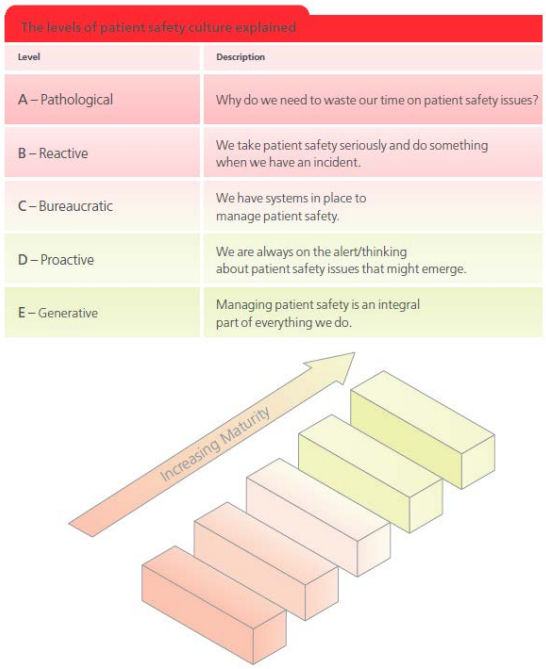


Figure 28: Diagrammatic representation of MaPSaF

3.5.2 What we set out to do:

We set out to

- Conduct baseline safety culture assessments of clinical teams, divisional boards and the Trust Board of Directors seeking their assessment of their culture as a team and of the organisation as a whole;
- Feed back results to specific teams and facilitate a discussion to enable team members to identify what actions they will take. The impact of their locally owned development actions will be monitored though repeat annual surveys;
- Feed back the aggregated views of the organisation's safety culture to the Trust Board for its consideration;
- Repeat safety culture assessments annually;
- The Executive Director Team will be visible in their commitment to patient safety and listening to the safety concerns of staff by continuing their patient safety walk-rounds;
- The Senior Nursing Team will do likewise through 'Back to the Floor' days.

3.5.3 What we did:

a) Generally

- We conducted baseline safety culture assessments of clinical teams in Q2 and 3 of 2015/16, divisional boards and the Trust Board of Directors

- We fed back results to specific teams and facilitate a discussion to enable team members to identify what actions they will take. Following feedback teams and divisions decided what aspects of safety culture they wished to focus on.

- We fed back the aggregated views of the organisation's safety culture to the Trust Board for its consideration.

- We did not repeat safety culture assessments annually due to the time it took to conduct the initial assessments and feed back results to teams. The second assessment occurred in Q4 of 2017/18 and into Q1 of 2018/19.

- We developed a safety culture toolkit of resources for teams to access as required

- We revised the process for Executive Director patient safety walk rounds

- The Senior Nursing Team continued 'Back to the Floor' days.

- We facilitated safety conversations with front line staff via the Sign up to Safety campaign's "National Kitchen Table Week" during the programme life time as shown in Figure 29.

Figure 29: Staff participating in National Kitchen Table Week

b) For children:

- The Quality and Patient Safety Team are sharing weekly Patient Safety Messages, in the form of eye catching bulletins. The aim for these messages is to share the learning from serious incidents and themes of incidents. The messages have been well received with staff appreciating the different approach that delivers the important messages in a format that is quick and easy to interpret.

- With a preventative ethos in mind the Children's Quality and Patient Safety Team have increased awareness throughout BRHC about the changing focus: walk-arounds, increased involvement with education, quality improvement projects and one-to-one meetings, have all improved understanding about clinical governance and safety issues, improving compliance levels throughout the hospital.

- Children's services also held conversations weeks during the programme life time

c) In maternity:

- Human Factors week was celebrated in St Michael's Hospital in the first week of October 2017. There was excellent support from a variety of staff groups and a total of 169 staff members participated over the five days. A daily morning round was conducted by the human factors team talking about the theme of the day and inviting staff to join in the daily drop-in workshops.

- Activities during Human Factors week included exploring feelings associated with involvement in incident using Emoji Boards, looking at work place behaviour and how we could improve sharing learning from when things went wrong.

3.5.4 What improvements we achieved:

a) In general

The baseline MaPSaF assessments completed during 2016 and the repeat assessment completed during 2018 showed overall that our staff thought that their team's and the Trust's safety culture was "Proactive" as shown in Figures 30 and 31. The MaPSaF tool describes proactive organisations as those that place a high value on improving safety, actively invest in continuous safety improvements and reward staff who raise safety related issues.

Although there were some slight changes in percentage responses across the categories between 2016 and 2018, these were not statistically significant. Therefore, we did not achieve a one-step shift towards a generative safety culture by March 2018.

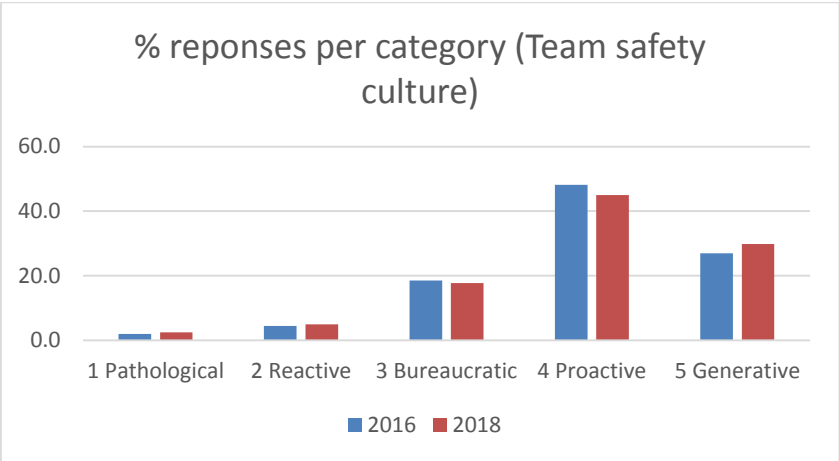


Figure 30: Team safety culture assessment responses 2016 and 2018

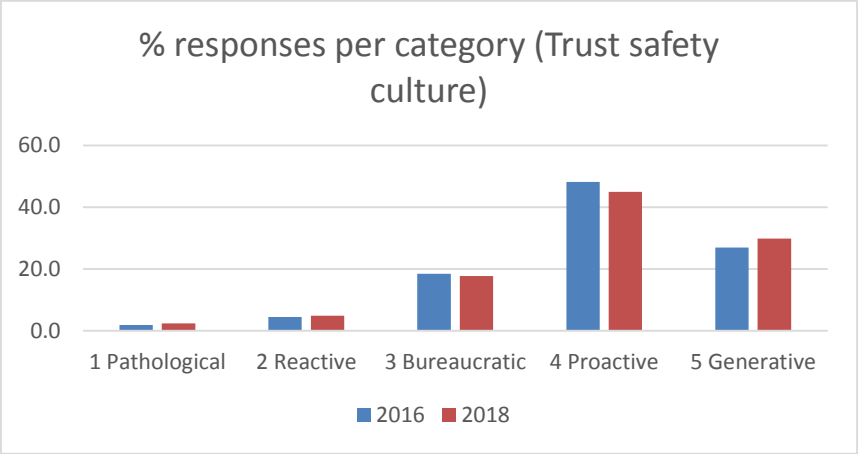


Figure 31: Trust safety culture assessment responses 2016 and 2018

b) For children:

It is widely recognised that patient safety has a much higher profile at BRHC than at the beginning of the patient safety programme and this is evident both by the increased staff interaction with the patient safety team (on a daily basis) and the enthusiasm of many clinicians to be a part of speciality clinical governance within the Children's Hospital.

c) For maternity:

With regard to MaPSaF Safety culture assessments we aimed to increase the percentage of responses relative to the whole Trust. In 2016 maternity services made up 4.5% of the total responses and in 2018, this increased slightly to 5%.

The majority of staff who responded via the Emoji Boards indicated they felt anxious about being involved in an incident review as shown in Figure 32. The reasons behind the emotions were explored further and were appropriate and reflected good incident review culture.

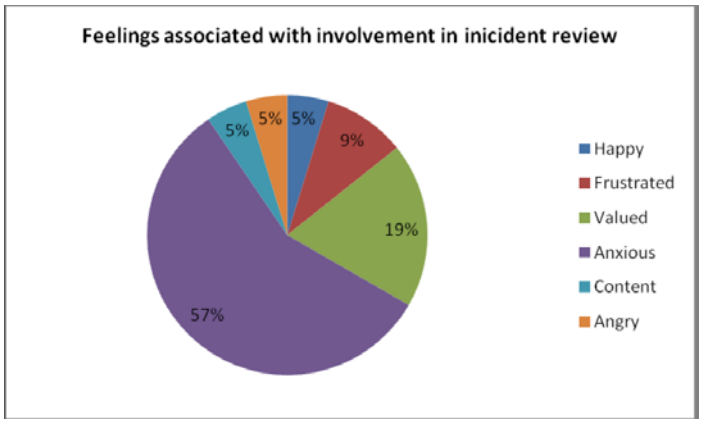


Figure 32: Feelings associated with involvement in an incident review

The staff who participated in the work place behaviour activity were asked to assess their own and their team members' behaviours at their workplace based on given definitions of assertive, submissive and aggressive. They could only pick one option for themselves and were encouraged to pick one representing their team; however some participants used more than one to represent their teams as they felt there was significant variation within their teams. The results are shown in Figure 33 below.

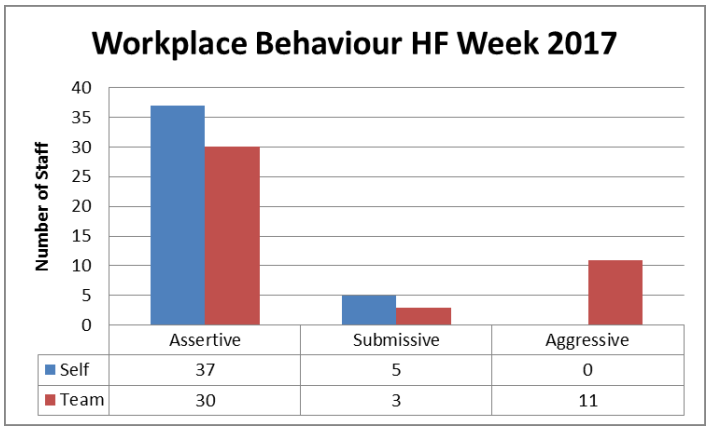


Figure 33: What staff in maternity said about work place behaviour

The human factors workshop used participant interaction to identify ways of effectively communicating learning from incidents and their reviews. As individuals the participants wanted honesty, one-to-one debrief, discussion, constructive, supportive feedback. They felt effective ways of communicating with the teams would be via display on boards, toilets, handovers, team-briefs, home page alerts and emails.

As part of the Human factors work shop staff were also asked to indicate their current view of the safety culture in maternity services using the MaPSaF domains. The results in Figure 34 below show the majority (60%) rated it as “Proactive”.

Figure 34: Staff assessments if safety culture in maternity services 2017

3.5.6 What we learned/problems we encountered:

a) In general

- We learned from feedback from survey respondents that the survey was too time consuming and the statements relating to the categories were long-winded and not always easy to choose between. More tools for measuring safety culture have been developed since our programme began. In particular, the SCORE[15] tool has been taken up within the NHS.

[15] The SCORE survey is an internationally recognised way of measuring and understanding culture that exists within organisations and teams. The tool was developed by Safe and Reliable Healthcare LLC.

- Analysing and giving face-to-face feedback to over 100 clinical teams was very time consuming and it was difficult to get teams together to share what they had said about the Trust and their team's safety culture.

- We struggled to get sufficient responses to the repeat self-assessments which means that we will not be able to provide valid feedback at team level.

- Due to the anonymous nature of the survey, it was not possible to respond to or take forward patient safety issues raised in free text comments. For the repeat assessment we were able to signpost respondents to the Freedom to Speak Up process.

- We should have completed the baseline assessment analysis in full before setting our improvement goal as this proved to be unrealistic in the context of a positive baseline assessment

b) For children:

- Due to a more visible patient safety profile there is evidence that in 2018 engagement in patient safety activity is an accepted part of day to day business.

c) In maternity:

- The staff enjoy their work and work well within their teams, which are friendly supportive and welcoming. Workplace culture and human factor related issues highlighted were about workload management (staff being moved to cover one area leaving other exposed to problems), protected/scheduled breaks and feeling valued and respected.

- The participants felt that they could contribute to a better workplace by being positive and proactive, improving time management, being supportive, approachable and respectful, by appreciating other team member's contributions, listening and smiling.

3.5.7 Recommendations for next steps:

- For future safety culture assessments it is recommended that we use the SCORE tool and, rather than conduct an organisation wide assessment, we should focus on particular specialities in turn starting with maternity services in March to May 2019.

- In children's services, patient safety knowledge will be monitored at the start of each and every episode of staff 'patient safety training'. This will ensure that gaps in knowledge and understanding can be addressed in a timely manner and provide an indicator of the current patient safety culture within children's services.

- In children's services it is acknowledged that patient safety education still does not reliably reach every member of clinical staff and a gap analysis and development of new training programmes is a high priority within the patient safety team at BRHC. Work in the next patient safety programme will explore further, new ideas for a fresh patient safety campaign at BRHC entitled 'Don't whisper incidents aren't a secret'.

3.6 Reducing peri-procedure never events

Peri-procedure never events are incidents associated with surgery and invasive procedures and are considered preventable; namely wrong site surgery, retained foreign object and wrong implants.

3.6.1 Aim of the work stream:

- To eliminate peri-procedure never events;
- To increase quality of engagement with the WHO checklist in all theatre /interventional environments. Specifically to reduce the level and frequency of inattention at the 'time-out" section of the WHO checklist across all theatre/ interventional environments to less than 1%. (Baseline: September 2014 mild inattention in 16% of staff in time-outs in the main theatre suite).

3.6.2 What we set out to do:

- We will visit and learn from the experience of Central Manchester NHS Foundation Trust in reducing wrong tooth extraction never events and implement associated preventative actions;
- We will work with colleagues from NHS Innovation in the West of England Patient Safety Collaborative to see if it is possible to develop a reliable way to mark teeth for extraction;
- We will extend our new way of conducting the WHO checklist in Paediatric and Heygroves Theatres to other applicable theatre/interventional environments.

3.6.3 What we intended to measure:

- Near miss peri-operative never event incidents;
- Peri-operative never events;
- Audits of the quality of engagement in the WHO checklist;
- Safety culture of theatre/interventional teams as outlined in the safety culture section of this report.

3.6.4 What we did:

The National Safety Standards for Invasive Procedures (NatSSIPs) initiative was launched by NHS England in September 2015 alongside a patient safety alert requiring Trusts to develop an action plan to implement Local Safety Standards for Invasive Procedures (LocSSIPs) to be implemented by September 2016. Both of these external drivers really did shape the actions of the work-stream.

The main themes of our work were:

- Reinforcing the existing safety standards with the development of a Trust wide LocSSIP.
- Continuing to engage clinicians and improve the WHO checklist[16] in theatres
- Applying the LocSSIP to areas outside theatres (Cath labs, endoscopy, Ed, wards)
- Developing bespoke checklists for procedures with real risk of patient harm

To do this we used the NatSSIP as a guideline but also worked with NatSSIP leads across the country to share ideas for implementation.

[16] WHO Surgical Safety checklist was designed to prevent peri-procedure never events

Our overarching aim was, and still is, to introduce real improvements in procedural safety by clinician engagement. This means the LocSSIP needs to be (and perceived to be) effective rather than a 'tick box exercise'.

Areas of focus for out-of-theatre LocSSIP development were:

- Intensive Care Units
- Chest Drains and Pleural Procedures
- Ascitic Drains
- Lumbar Punctures
- Endoscopy

A suite of WHO checklists was developed and revised as shown at Appendix 11 to ensure the questions are relevant to the specialities and therefore effective as a safety tool.

On the wards: we have selected invasive procedures with a high risk of potential harm and/or never events. We have developed, with the front line clinicians, specific LocSSIPs that can be easily accessed with one click from any desktop in the Trust as shown in Figure 35.

Figure 35: LocSSIPs developed for out-of-theatre invasive procedures

The WHO checklists for theatres were also continuously evolving as shown in Figure 36.

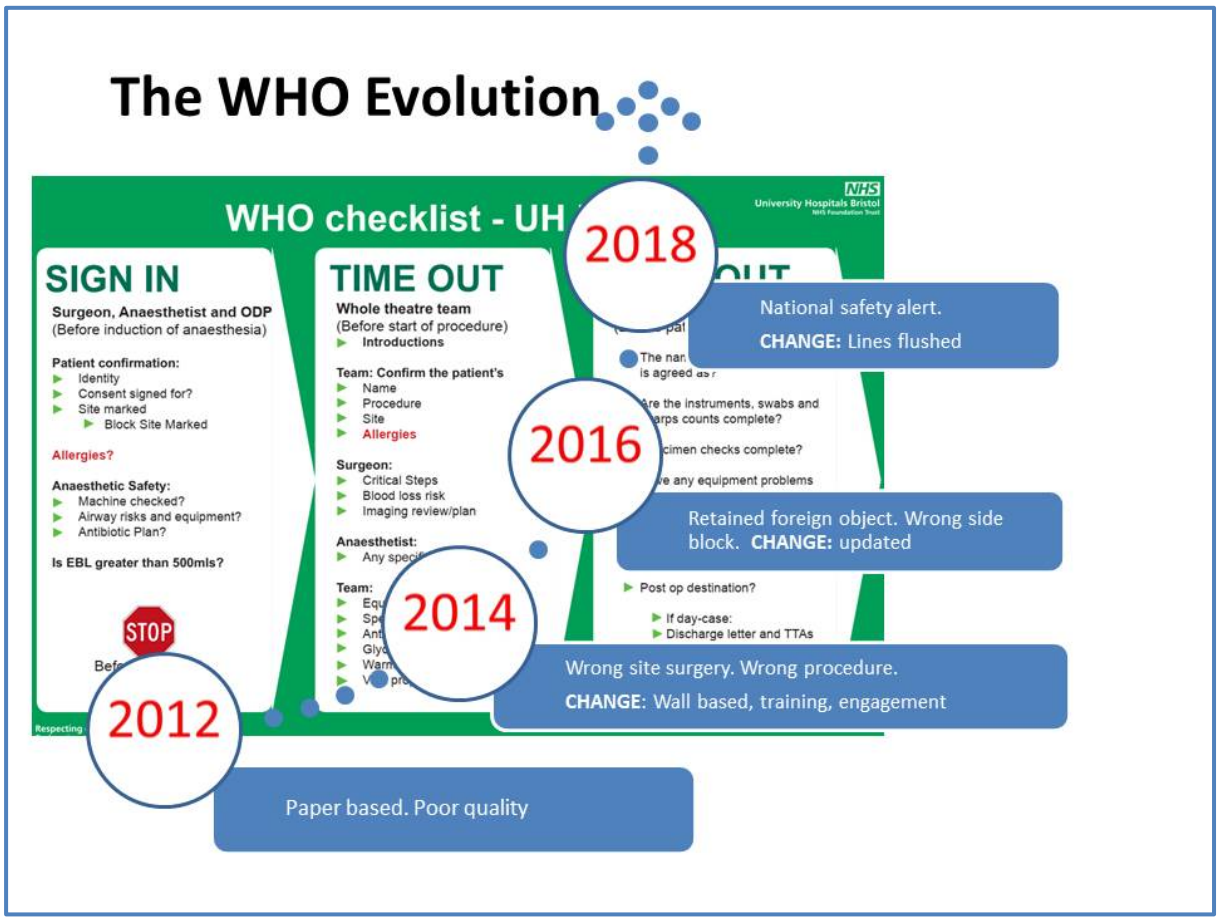


Figure 36: The WHO evolution

In maternity, the WHO style LocSSIP checklist has been incorporated into the handheld maternity records and these are now in circulation in the community. Training on the use of LocSSIPs continues with face to face training and poster campaign.

3.6.5 What improvements we achieved:

We sustained a 95% reliable system for use of the WHO checklist in Theatres, and largely achieved the 99% aspirational improvement apart from the period when we changed from Medway to the Bluespier system there was a drop in 'recording' the WHO as shown in Figure 37.

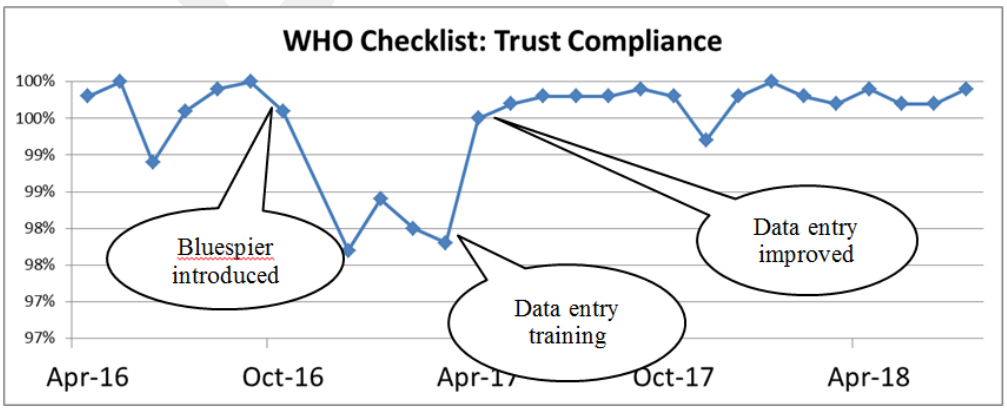


Figure 37: WHO checklist compliance in Theatres

Our annual qualitative audits in Theatres were extended to areas such as Endoscopy, Cath Labs, Ophthalmic Out Patients, Radiology, ED, Paediatric ICU, Cardiac ICU, Adult ITU, and Neonatal ICU.

a) Theatre/Endoscopy/Cath lab audits:

These have been completed every year since 2014. The data is collected and analysed by up to six medical students per year. A 'secret shopper' approach is used and, although labour intensive, these audits have been incredibly effective at both helping us understand the behaviours of staff but also to feedback and improve performance. Figure 38 shows consistent high quality use of the WHO checklist over 4 years. There is a risk that the quality may reduce if constant updates/feedback/ championing of the process is reduced.

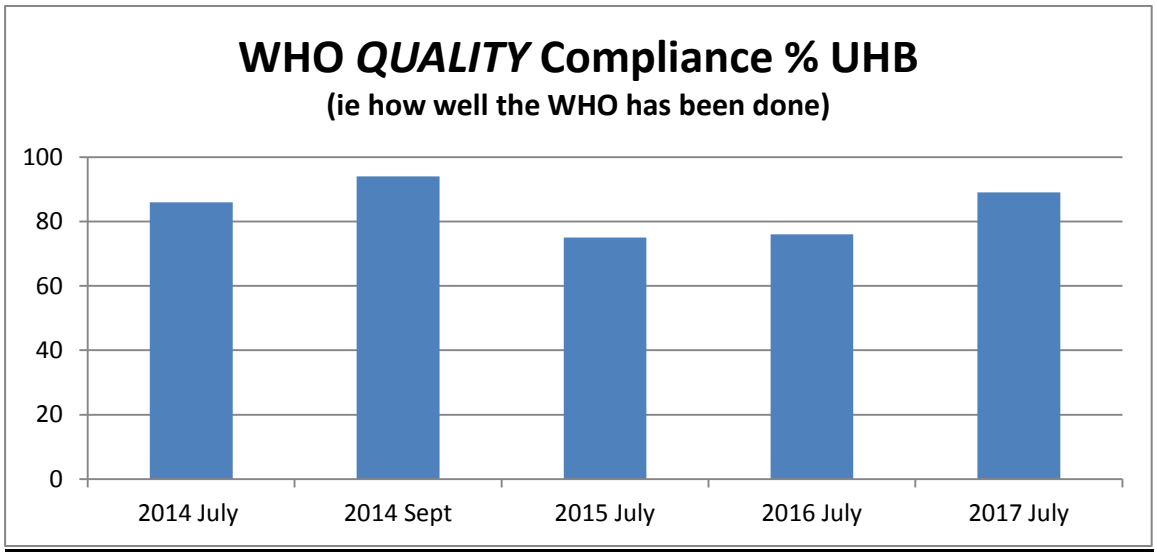


Figure 38: Quality of use of the WHO checklist

When looking at the data by speciality, Figure 39 shows high quality in endoscopy. The endoscopy teams have worked tirelessly to improve their processes both in the suites and on the ward based scopes. Cath labs remain low with respect to the quality of WHO but it must they have not had a never even which the WHO is designed to prevent.

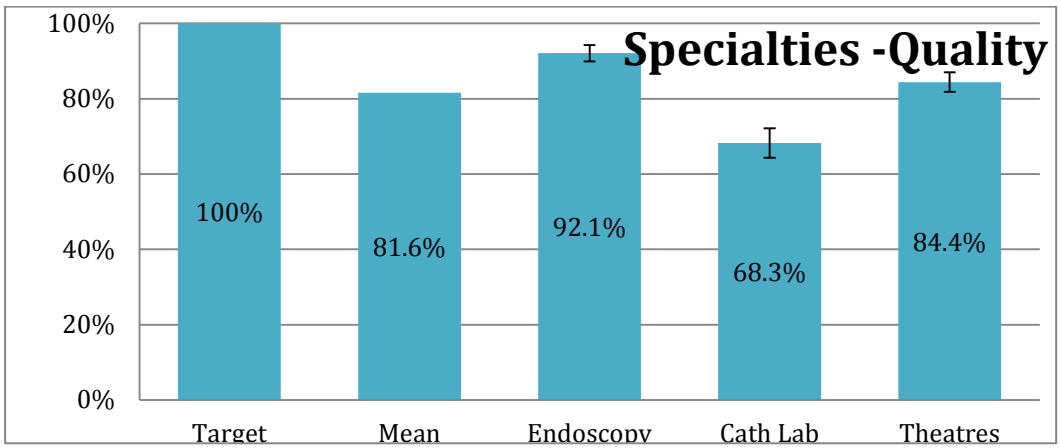


Figure 39: Quality of WHO checklist by speciality

b) Awareness of LocSSIPs

We completed annual audits to understand how many clinicians are aware of LocSSIPs and if they 'buy in' to the checklist culture given that junior doctors rotate. Figure 40 shows that there has Improvement in awareness between 2017 and 2018 as a result of activities which included monthly presentations to staff group and banners and posters designed and displayed in clinical areas.

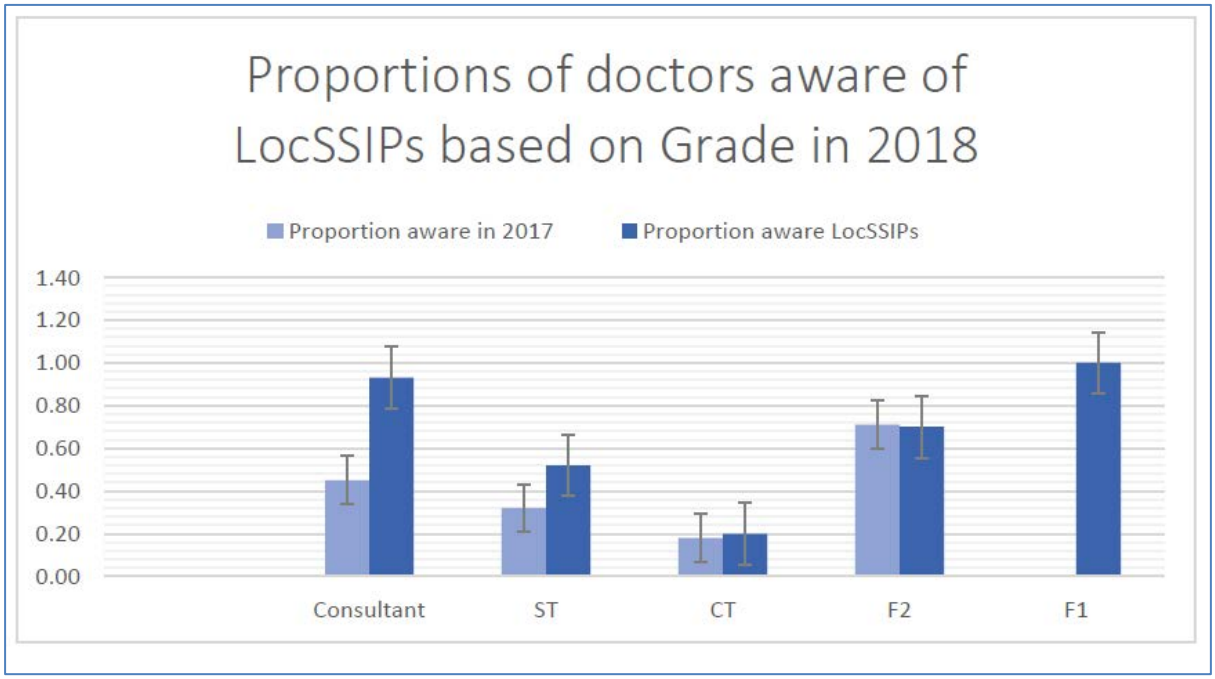


Figure 40: Doctors' awareness of LocSSIPs

The constant rotation of doctors in and out of the hospital with the lack of LocSSIPs at surrounding hospitals is an issue that must be resolved if there is to be any sustainability of ward based LocSSIP.

Figure 41 shows most clinicians support the LocSSIP process in both years that we surveyed (2017 and 2018.

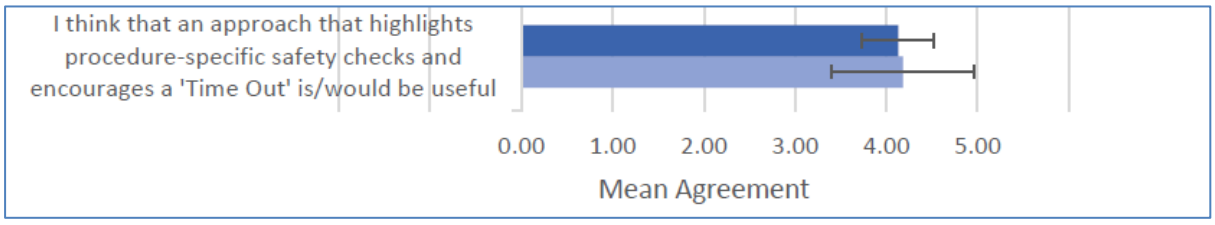


Figure 41: Doctors buy-in of the LocSIPP process (5 is strongly agree, 0 is strongly disagree).

c) Out of theatre procedures

Our monitoring of LocSSIP use outside theatres: for pleural aspiration (chest drain insertion) in Figure 42 shows we do not yet have a reliable system across the organisation. Data availability is variable from procedure coding suggests a focus on procedures carried out on A300 would be beneficial.

There is a good level of buy in from physicians, less from surgical side. It is very difficult to find the denominator for chest drains from the patient record as so many are completed in theatre.

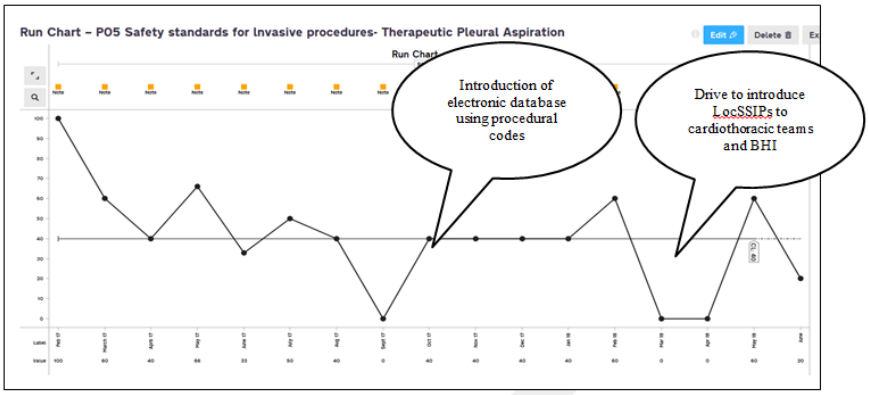


Figure 42: Use of LocSSIP for pleural aspiration

For lumbar punctures, Figure 43 shows improvements in use of LocSSIP during the project, especially on Ward A300. There is excellent engagement from medicine and oncology. Finding the denominator (although better than pleural) can be difficult and though this process we have identified that anticoagulation guidelines are required.

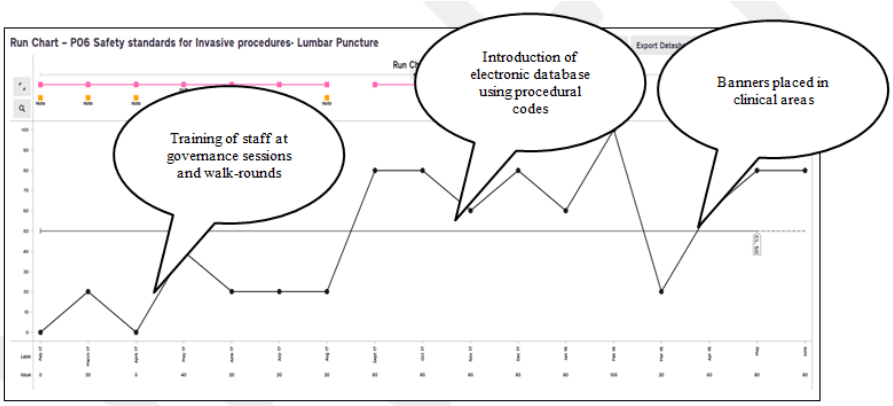


Figure 43: Use of LocSSIP for lumbar puncture

For abdominal paracentesis, Figure 44 shows there is a reliable system and excellent clinical engagement in the Ambulatory Care Unit where the LocSSIP is embedded and we should now focus on other areas where this procedure takes place.

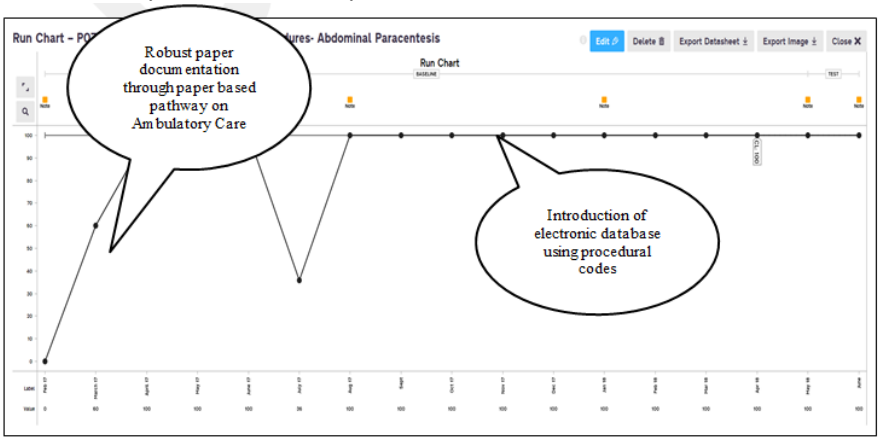


Figure 44: Use of LocSSIP for abdominal paracentesis

Figure 45 shows we did not achieve our aspiration of 365 days between peri-procedure never events, in fact we had several during the life of the programme which were fully investigated and risk reduction actions put in place.

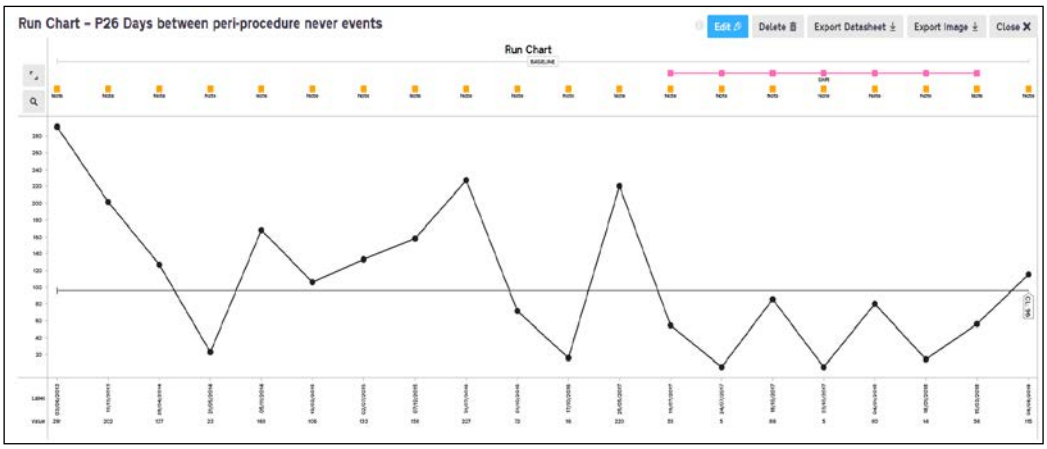


Figure 45: Days between peri-procedure never events

d) In maternity:

A prospective blind audit of perineal repair took place. Results showed there was a discrepancy in swab count practices on Central Delivery Suite following repair of vaginal tear/episiotomy. After this PDSA cycle the Devon swab count bag was introduced to standardise swab counting practice has been introduced across the delivery suite with teaching and training targeted at the multidisciplinary team to improve use of Devon swab count bag. A Second PDSA cycle after the training around the Devon swab count bag increased compliance to 100% as shown in Figure 46.

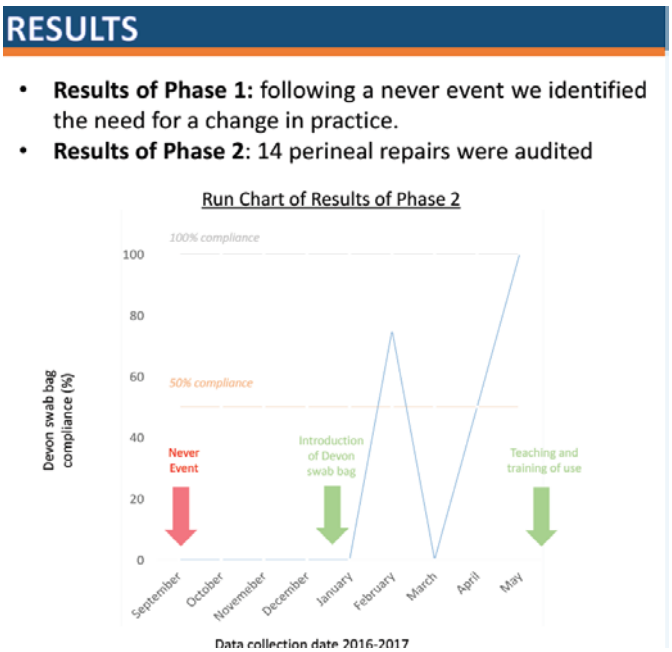


Figure 46: Improvement in swab counts for perineal repairs

e) Other celebrations and successes:

- Publication British Medical Journal Open Quality: *"Improvement in staff compliance with a safety standard checklist in endoscopy in a tertiary centre."*
- Posters: *Eight* posters locally and nationally have highlighted the good work
- CQC report 2017: Page 19. WHO surgical safety checklist. One member of staff we spoke with said there had been "a massive culture change" around the checklist and they felt they had "the freedom to speak up without repercussions".
    - The trust had a National Safety Standards for Invasive Procedures (NatSSIPs) workgroup in order to streamline practice across the hospital. NatSSIPs provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs), which were embedded.
- NHS Improvement article: WHO champion QI piece
- Visits from Hull, Glasgow, Gloucester and North Bristol Trust to share our LocSSIP implementation.
- We have incorporated the 2018 line flushing patient safety alert into our WHO checklist
- Repeated comments from trainees and staff that rotate from other hospitals that our checklists are by far the most effective and well established. This is the greatest accolade!

3.6.6 What we learned/problems we encountered:

- It has been a real privilege to work with healthcare professionals across the Trust to reinforce the safety culture.

- Preventing never events is a challenge especially in high-volume, fast turnaround procedures. They are, by definition, very rare so keeping all staff alert to the risks at all time is difficult as actual never events or near misses are the only real way to reinforce that the risk is, indeed, real. Our strategy has been to share best practice, share incidents and to keep the safety standards high on the agenda.

- One of the emerging issues is that the 'TIME OUT' or 'PAUSE' is really designed to stop automaticity errors. One risk is that the 'TIME OUT' in its own right is automatic and, therefore, losing its impact.

- The swab count improvement work in maternity reinforced the rationale for implementing LocSSIPs across the service and the importance of audit as part of a PDSA cycle.

3.6.7 Recommendations for next steps:

We have had discussions as a team and asked others on the front line as to where to take this.

- In theatre: the processes are well established. However, the governance leads are keen we keep the topics live so there is not a drift downwards
- Outside theatre: this still needs more work. It is not in the culture yet so we recommend
    - Continue the LocSSIP programme locally
    - Set up a cross-region working group to establish in all hospitals so it is not a UH Bristol only initiative.
- Change of leadership: Mat Molyneux to make way for Rachel McKendry who has recently been appointed to a substantive consultant anaesthetist post.

- In maternity we will continue to audit our practice to maintain high standards and reduce the risk of never events both with patient note audit and secret shopper style observational audit, results of which will be presented at the Central Delivery Suite working party and will influence training programmes.

3.7 Leadership

3.7.1 Aim of the work stream:

a) In general:

To provide the leadership system to support the improvement of safety and quality outcomes in the trust. This work stream is led by our executive director team.

During the programme, we identified a need from reported incidents for a process for patients and families in adult services to raise concerns about their condition if they felt their concerns were not being listened to, similar to the process in the BRCH previously mentioned in section 3.1.3 b.

b) For maternity:

There is a specific theme for women from "Spotlight on Maternity" for a board level focus of safety in maternity, data capture and sharing information, education and training and raising awareness of perinatal mental health. This is also being expanded by the 'Human' dimension within the National Maternity and Neonatal Health Safety Collaborative

What we set out to do:

a) In general

- To develop a programme structure and governance that is fit for purpose and engages patients and staff in its delivery
- To ensure effective communication to all key stakeholders regarding progress of the programme
- To take opportunities to collaborate with partner organisations in delivering quality and safety improvements
- To develop the capacity and capability in use of quality improvement (QI) methodologies within the trust
- To ensure all clinical areas will receive at least one executive led patient safety walk round a year
- To ensure identified actions from patient safety walk rounds are completed promptly
- To develop, test and implement a ward round checklist
- To use a co-design approach to develop a process for escalation of patient/family concerns in adult services

b) For maternity

- Engage in the Trust wide safety culture survey and conduct focussed work on human factors and described in section 3.5

3.7.2 What we did:

a) In general

Earlier sections of this report describe the programme structure, successful collaborations with partner organisations to make quality and safety improvements and progress in implementing a ward round checklist.

We made a communications and engagement plan at the outset of the programme and earlier in this report described the difficulties in sustaining engagement with front line staff in the absence of a programme manager.

During 2017, a QI Academy and QI Hub were launched within the Trust as a vehicle to extend the capacity and capability for making quality and safety improvements.

We reviewed and implemented a new process for executive led patient safety walk rounds as planned.

We started a new, co-design approach with patients and families to develop a process for escalation of concerns in adult services; however our initial scoping work revealed that patients and families we talked to did not see the need for such a process as they felt that their concerns were listened and responded to. We therefore changed our approach to adapt and test the tools available in the BRCH for adult services. The testing phase of this work is now completed and the tools are being finalised.

b) For maternity

Eight members of staff attended a week long course accredited by the Global Air Training Group as part of the Health Education England – Maternity Safety Programme. As a result of this the group (and others) ran a Human Factors week in October 2017. There were different themes each day looking at varying aspects of human factor. These included Culture/ Behaviour; Leadership and Management; Situation awareness/ learning from RCAs; Health and fitness/ Fatigue/ Resilience; Communication/ Decision making and Error mitigation; Automation/Information processing and conflict resolution.

3.7.3 What improvements we achieved:

a) In general

We did not always achieve our goal of six walk rounds a month as shown in Figure 47. This was mainly due to needing to rearrange walk rounds due to changes in executive director diary commitments, but on occasions included unforeseen reasons such as medical emergencies and a fire in the Bristol Haematology and Oncology Centre.

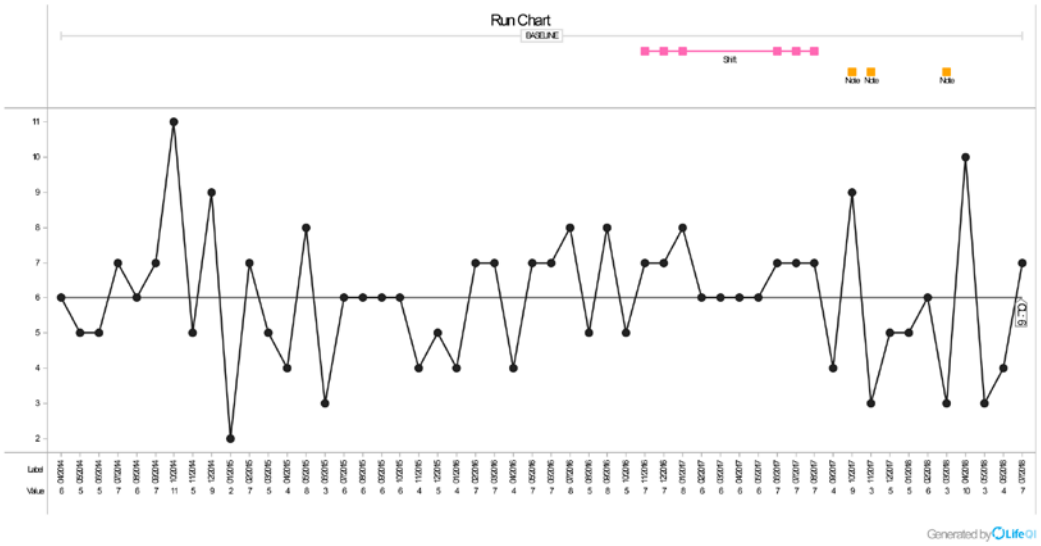


Figure 47: Number of executive led patient safety walk rounds a month

We largely achieved completing the actions identified within two months of each executive walk round as shown in Figure 48.

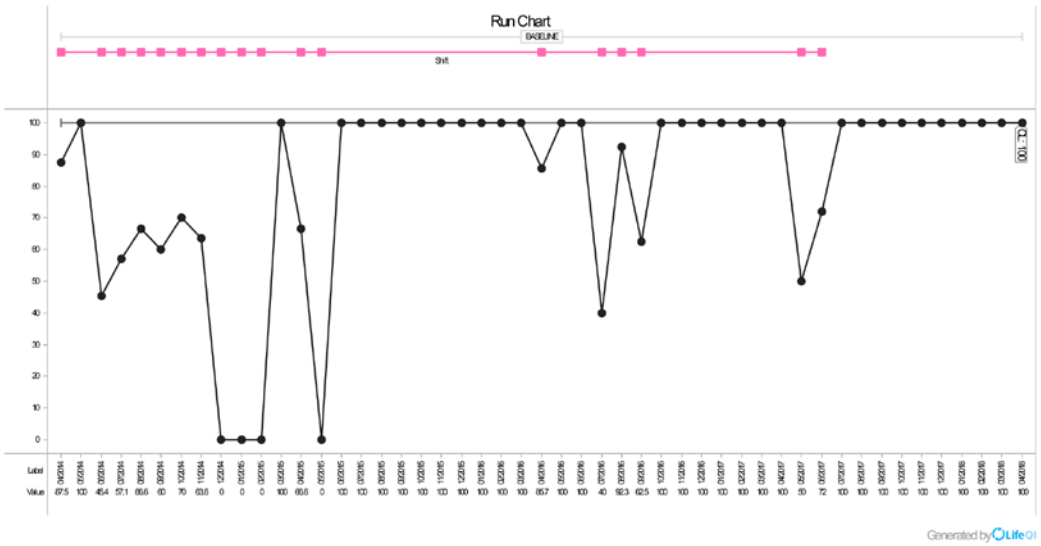


Figure 48: Completion of actions from executive walk rounds within two months

b) For maternity:

The human factors study day for staff working in maternity and neonatology had very positive feedback, staff felt appreciated and listened to.

A total of 169 staff members participated over the five days of human factors week and each day there were a series of structured questions to capture feedback. There was also an Emoji workshop each day relating to the topic for that day.

Results and findings have been analysed and a full report was presented at Women's Governance in December 2017. An action plan has been devised and this also links with the Human Dimension quality improvement plan within the Maternity and Neonatal Health Safety Collaborative. Human factors continue to be taught on the annual obstetric emergency day.

3.7.4 What we learned/problems we encountered:

- The governance structure for future programmes should be reviewed as mentioned in section 2.5 with greater emphasis on the communication and engagement with front line staff

- Rescheduling walk rounds due to changes in executive diary commitments within the same month remains challenging

- In maternity services, staff really appreciated the time given for them over the course of the human factors training week, ideally more staff to be facilitated to attend.

3.7.5 Recommendations for next steps:

- It is recommended that visible executive leadership for patient safety continues following a review of the current process

- Seek input from Programme Board members, including our public contributors, on the governance structure and implement changes for the next improvement programme.

- In maternity services, we will repeat the human factors study day for staff working in maternity and neonatology and plan to embed SBAR in handovers of care and use of safety huddles in intrapartum care.

3.8 Maternity and Neonatal Health Safety Collaborative

The national maternal and neonatal health safety collaborative was launched in February 2017 and is a three-year programme led by the NHS Improvement's National Patient Safety team.
The collaborative is structured into three waves, each running April to March. St Michael's maternity and neonatal services aligned to the first wave which commenced in April 2017. During a 12 month wave there are three phases: diagnose, test and refine and scale up. Trusts receive support from a named NHS Improvement Manager, as well as a safety culture assessment, access to the Life QI system, and three national learning sets (3 days each). There is also a national sharing day at the end of each wave.

The programme supports the aims of NHS England's Better births maternity review and the maternity transformation programme.

There are further details of quality improvement within maternity services in Appendix 12.

3.8.1 Aim of the programme:

The Maternal and Neonatal Health Safety Collaborative aims to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide high quality healthcare experience for all women, babies, and families across England.

The programme also aims to:

- Create the conditions for continuous improvement, a safety culture and a national maternal and neonatal learning system.

- Contribute to the national ambition of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 20% by 2020.

The driver diagram for the programme is shown in Appendix 13.

3.8.2 What we set out to do:

Supported by NHS Improvement, we have developed a programme of work focussing on four national themes:

- Leadership and safety culture
- Clinical excellence
- Systems and processes
- Person centred care

3.8.3 What have done so far:

a) Leadership and safety culture.

- We ran a week long human factors workshop as described in section 3.7.3

- We also participated in the Trust safety culture survey as described in section 3.5 with the intention of improving the percentage of staff who engaged with the on-line survey

- We also ran a human factors study day for staff working in maternity and neonatology

- Human factors element has been incorporated into the mandatory annual obstetric emergency study day following on from the success of the inaugural human factors study day for staff working in maternity and neonatology

b) Clinical excellence.

- We developed guideline for management of hypoglycaemia in neonatal period which was launched on 25th May 2018

- We introduced glucose gel on post-natal wards to treat initial signs of hypoglycaemia in babies and prevent separation from mothers.

- We introduced training regarding the management of respiratory issues in the early neonatal period. This included initial new-born resuscitation and assessment of "grunting" to prevent unnecessary admissions to NICU for respiratory support.

- Please see section 3.1 about our work on the Newborn Early Warning Track and Trigger tool and Maternal and Obstetric Early Warning Score.

c) Systems and processes

- To improve fetal monitoring in labour to reduce neonatal morbidity:
    - We introduced a 'fresh eyes' approach to reviews of cardiotocograph traces and interpretation, (85% compliance – latest audit)
    - We are auditing practice regarding uterine hyper-stimulation, intermittent auscultation and Maternal and Obstetric Early Warning Scores (MEOWS)
    - We launched an updated fetal monitoring guideline

- To improve assessment of fetal growth by measuring and plotting symphysis fundal height (SFH):
    - We delivered training on measurement of symphysis fundal height and increased staff awareness of importance of measurement of SFH

    - We introduced a card for women to be empowered to ask the midwife to measure their SFH and plot measurement and raised women's awareness to expect SFH measurement at each antenatal visit

d) Person centred care

- To improve patient experience and patient flow on discharge from hospital we conducted an audit of processes involved in discharge of a mother and baby following birth. The aim is to reduce the waiting time to within 2 hours of a patient being informed they can go home by 50% by November 18. A second audit is in place to assess the timings and the areas of delay in the discharge process pathway
- We also introduced patient information infographics regarding processes involved prior to then getting discharged from hospital as shown in Figure 49, which helps to manage expectations.
- We are developing processes to enable women to be more involved in the care for their babies on NICU including teaching parents how to perform naso-gastric feeds and progressing NICU baby-friendly standards.
- We have set up a parent support coffee morning to improve family integrated care and have a conversations week planned to support parents taking a more active role.

Figure 49: Patient information infographics for maternity discharge

3.8.4 What improvements we achieved so far:

Our unexpected term admissions to NICU have reduced since the start of our programme as shown in Figure 50.
Also the number of babies needing neonatal input for respiratory problems, active or passive cooling and suspected hypoxic ischaemic encephalopathy has approximately halved as shown in Figure 51.

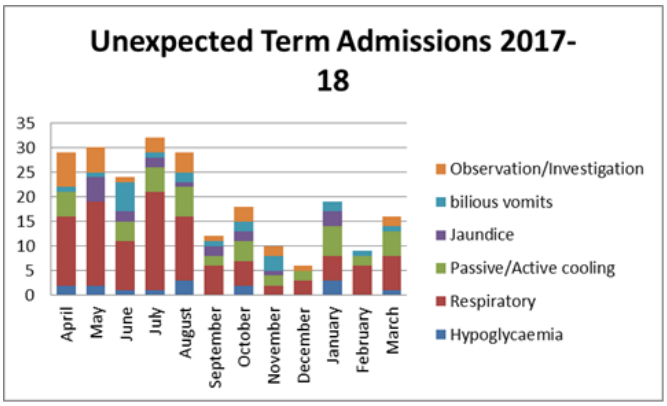


Figure 50: Unexpected term admissions to NICU 2017-2018

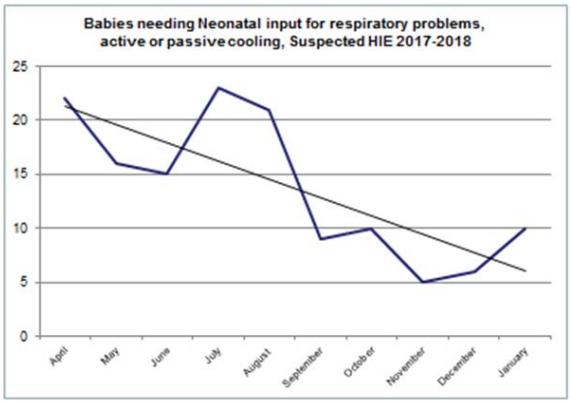


Figure 51: Number of babies needing neonatal input for respiratory problems, active or passive cooling and suspected hypoxic ischaemic encephalopathy

An audit performed in Feb 2018 showed improved rate of SFH measurement (77%) by maternity staff as a result of the improvement we made as shown in Figure 52.

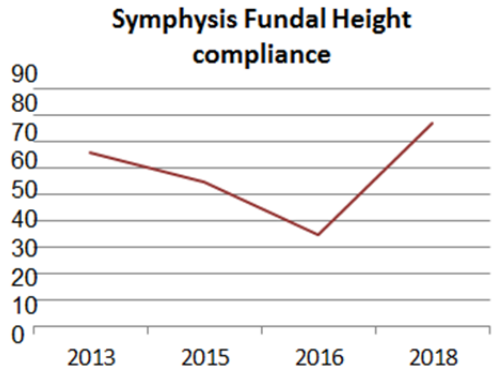


Figure 52: Improvement in symphysis fundal height measurement

3.8.5 What we learned/problems we encountered so far:

- Due to long-term sickness within the patient safety team the QI meetings have not taken place since June 2018.
- Time has not been allocated to plan and review the programme
- Staff have to contend with conflicting challenges to their time to commit to QI work when the clinical need is high.

3.8.6 Recommendations for next steps:

Re-establish the monthly QI meetings to reinvigorate the programme.

The Maternal and Neonatal Health Safety Collaborative local learning system was launch in July 2018 to review progress and plan next steps for continued improvements in our work streams.

Plan for 2018/2019

Leadership and safety culture

- Annual human factor study days
- Learning from excellence – introduce “Greatix”
- Participate in SCORE patient safety survey in March 2019
- Through the Local Maternity System (LMS) , implement the patient safety work stream in the National Better Births transformation program
- Participate in the review of the Bristol Neonatal Services

Clinical excellence

- Training and introduction of hypoglycaemia guideline
- Review impact of new guideline
- Monthly review of rates of term neonatal admissions for respiratory conditions

Systems and processes

- Regular audit of care of women undergoing continuous fetal monitoring in labour
- Re-audit of SFH measurement and plotting planned for September 2018

Person centred care

- Review the audit findings to improve the postnatal discharge pathway
- Staff training in supporting parents caring for their baby on NICU

Appendix 1: Our Sign Up to Safety pledges

Our "Sign up to Safety" pledges

1. **Put safety first. Commit to reduce avoidable harm in the NHS by half and make public the goals and plans developed locally. We will:**

   - Work towards our stated Vision which is for Bristol, and our hospitals, to be among the best and safest places in the country to receive care;
   - Achieve the successful transition of the work of our existing patient safety improvement programmes into the work streams of the emerging national Patient Safety Collaborative programme;
   - Achieve year on year improvement in our NHS Safety Thermometer benchmarked position for the percentage of patients who are "harm free" and have no "new harms";
   - Review and improve our patient safety executive walk rounds to support the development of our safety culture and to act on safety concerns raised by staff, patients and visitors;
   - Work in partnership with patients in developing the Trust's safety agenda, for example in the design of information and processes to reduce harm, and within the proactive patient safety improvement work of the West of England Patient Safety Collaborative.

2. **Continually learn. Make their organisations more resilient to risks, by acting on the feedback from patients and by constantly measuring and monitoring how safe their services are. We will:**

   - Systematically review our arrangements for preventing never events and identify and implement any further risk reduction measures. We will prioritise our highest risk areas which will include surgical never events;
   - Review and strengthen our arrangements for learning from all serious incidents;
   - Continue to focus on encouraging incident reporting and systematic incident analysis and implementation of risk reduction actions;
   - Spread the breadth of our Safety Bulletins and review and strengthen our systems for sharing organisation wide learning;

- Complete our “Southwest STAR” project to test two innovations designed to improve patient safety in emergency care systems as part of Shine programme supported by The Health Foundation.

3. **Honesty. Be transparent with people about their progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong. We will:**

- Continually develop an open and transparent culture when things go wrong and a mind-set of seeking continuous improvement;

- Build on initial pilots of patient safety culture/climate assessments tools and implement a programme of patient safety culture/climate assessments across the organisation. Learning from these assessments will be used by local teams to develop their patient safety culture;

- Review our processes for working with patients and their families when things go wrong, i.e. ensure that patient safety incidents, complaints, mortality and morbidity reviews are joined up from the patient/family perspective and they have a key and clear point of contact.

4. **Collaborate. Take a leading role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We will:**

- Initially continue to focus on existing patient safety improvement measures until the strategic direction and the resources to support the work of the collaborative are established. These are aligned with the proposed national patient safety collaborative programme framework and our quality objectives;

- Work with our colleagues in the West of England Patient Safety Collaborative to engage and involve patients in the patient safety agenda and develop cross system working;

- As new safety thermometers are developed e.g. for medication, maternity and paediatrics, we will review how they can best be used within our Trust.

5. **Support. Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate the progress. We will:**

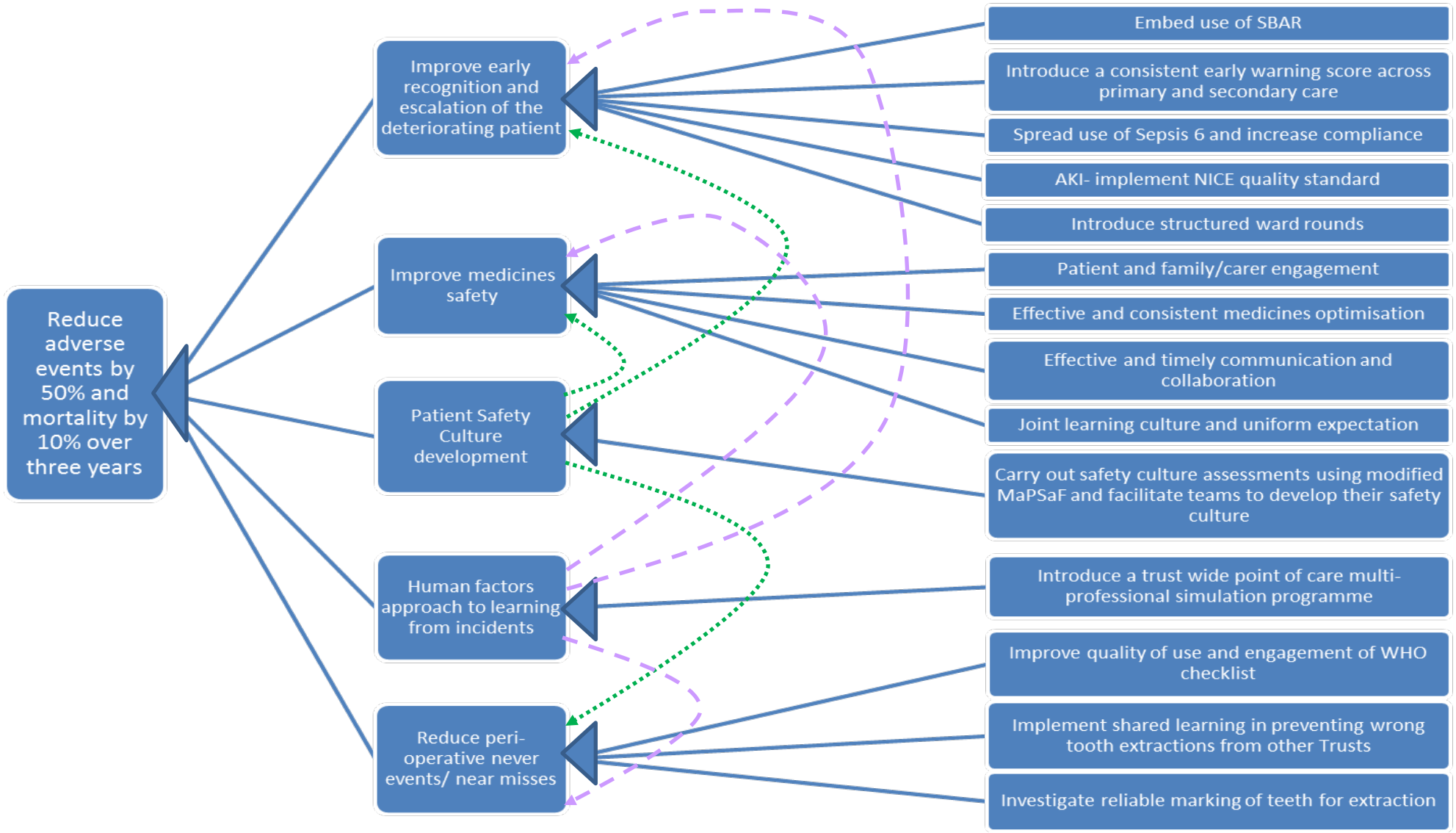
- Develop our culture so that staff, patients and their families feel able to raise concerns and report incidents about the safety of care being provided without fear of repercussions and in the knowledge that these will be investigated and acted on;

- Ensure support is there when staff need it if something goes wrong;

- Develop a human factors approach to patient safety updates over the next three years;

- Celebrate the successes of staff who have achieved patient safety improvements through our internal Patient Safety Champion annual staff award and beyond.

Appendix 2 Sign up to Safety Programme 2015-2018 driver diagram



Appendix 3: Details of Programme Measurements

Data sources for programme measurement varied depending whether there was a readily available existing monitoring or electronic system in place or whether new monitoring was required to understand the impact of changes implemented. For quality improvement small scale tests of change a sample of five is considered sufficient to understand whether a change is an improvement.

Aspect	Improvement	Accountability	Research
Aim	Improvement of care	Comparison, reassurance, spur for change, choice	New knowledge
Method			
Test observability	Tests are observable	No test, evaluate current performance	Blinded or controlled tests
Bias	Accept consistent bias	Measure and reduce bias	Design to eliminate bias
Sample size	"Just enough" data, small sequential samples	Obtain 100% of relevant data	"Just in case" data
Flexibility of hypotheses	Flexible hypothesis change as learning takes place	No hypothesis	Fixed hypothesis
Testing strategy	Sequential tests	No tests	One large test
Is change an improvement?	Runs charts or SPC charts	No change focus	Statistical tests (t test, Chi square)
Confidentiality of data	Data used by improvement teams	Publically available	Research subjects identities protected

The data sources used for each measure are outlined below:

Measure	Data Source	Sample size
Summary Hospital Mortality Indicator	NHS Digital	No sampling. All deaths in hospital and within 30 days of discharge.
Adverse event rate per 1,000 beddays	Global Tigger Tool case note review	20 sets of notes a month randomly selected
Manual observations documented once in previous 24 hours	Global Tigger Tool case note review	20 sets of notes a month randomly selected
Paediatric observations charts	Manual ward documentation audit	40 patients
Adult Observations completed and Early Warning Scores added up correctly	Monthly safety thermometer audits	All adult in-patients on the day of audit approx.750 patients
Adult deteriorating patients escalated appropriately	Monthly safety thermometer audits	All adult in-patients with a NEWS of 5 or more or 3 in one parameter requiring escalation

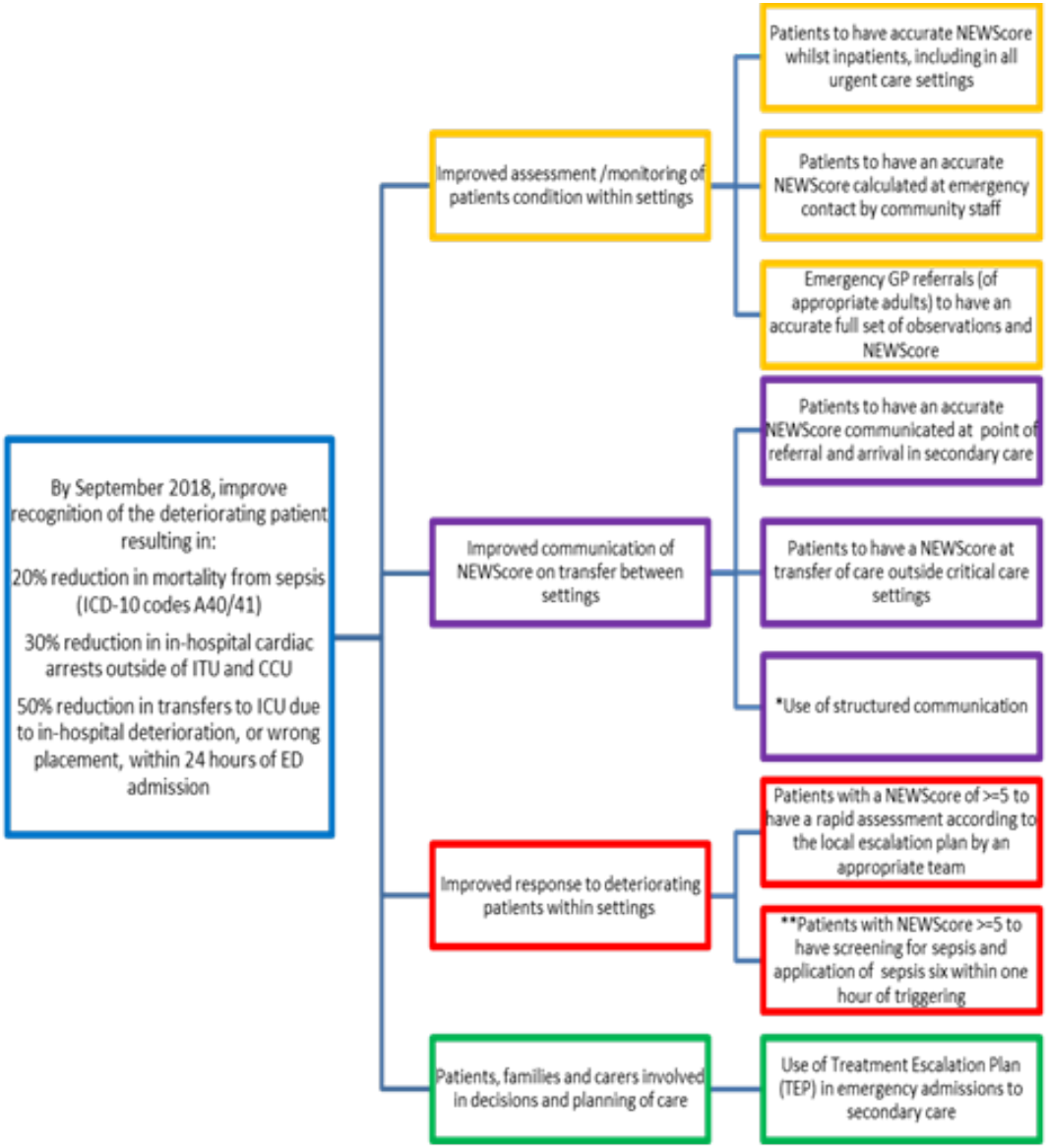
Measure	Data Source	Sample size
		on the day of audit approx.20-40 patients
Use of SBAR to escalate deteriorating patients	Monthly safety thermometer audits	All adult in-patients with a NEWS of 5 or more or 3 in one parameter requiring escalation on the day of audit approx.20-40 patients
Cardiac arrests in adult in-patient general wards	Monthly cardiac arrest audit	No sampling
Sepsis Screening in ED	Coding data plus case notes	Sampling methodology set nationally. 50 patients a month (20 children, 30 adults) presenting in ED triggering need for sepsis screening (adults NEWS of 5 or more, children local trigger criteria)
Antibiotics within an hour ED	Manual case note audit	Sampling methodology set nationally. All patients in the ED sepsis screening sample who triggered the need for sepsis screening and had a red flag for sepsis who received antibiotics within an hour
Sepsis Screening in-patients	Safety thermometer audit From July 2018 data from e observations.	Sampling methodology set nationally. 50 in-patients a month triggering need for sepsis screening (adults NEWS of 5 or more)
Antibiotics within an hour in-patients	Manual case note audit	Sampling methodology set nationally. All patients in the in-patient sepsis screening sample who triggered the need for sepsis screening and had a red flag for sepsis who received antibiotics within an hour
72 hour antibiotic review	Manual case note audit	Sampling methodology set nationally. 30 patients a quarter diagnosed with sepsis

Measure	Data Source	Sample size
		(ED and in-patients) who were still in-patients at 72 hours.
Intensive Care National Audit and Research Centre data	Intensive Care National Audit	No sampling. All admissions to adult ITU.
Mortality in suspicion of sepsis emergency admissions	Patient Safety Measurement Unit NHS South	No sampling
Suspicion of sepsis death in hospital	Patient Safety Measurement Unit NHS South	No sampling
Sepsis Screening in CED	Medway CED triage data	No sampling
Four AKI requirements in discharge summaries	Manual audit of discharge summaries	Sampling methodology set nationally. First 25 cases of AKI each month.
Percentage progression to Stage 2 AKI	Laboratory Information Management System	Agreed exclusions by consultant paediatric nephrologists e.g. children awaiting renal transplantation
Percentage progression to Stage 3 AKI	Laboratory Information Management System	Agreed exclusions by consultant paediatric nephrologists e.g. children awaiting renal transplantation
Medicines reconciliation	Manual ward pharmacy audits	Five patients per ward per week randomly selected by ward pharmacist. (Wards: A300, A609, C603, C705, C708, C805, D703, D603, 78)
Cumulative number of PharmOutcomes referrals	PharmOutcomes system	No sampling
Non-purposeful omitted doses of critical medicine	Manual ward pharmacy audits	Five patients per ward per week randomly selected by ward pharmacist
Safety Culture Survey	On-line Survey	No sampling n= 2,228 in 2016, n=1,094 in 2018
Maternity: Feelings associated with involvement in incident	Responses from attendees during human factors week	No sampling n=21

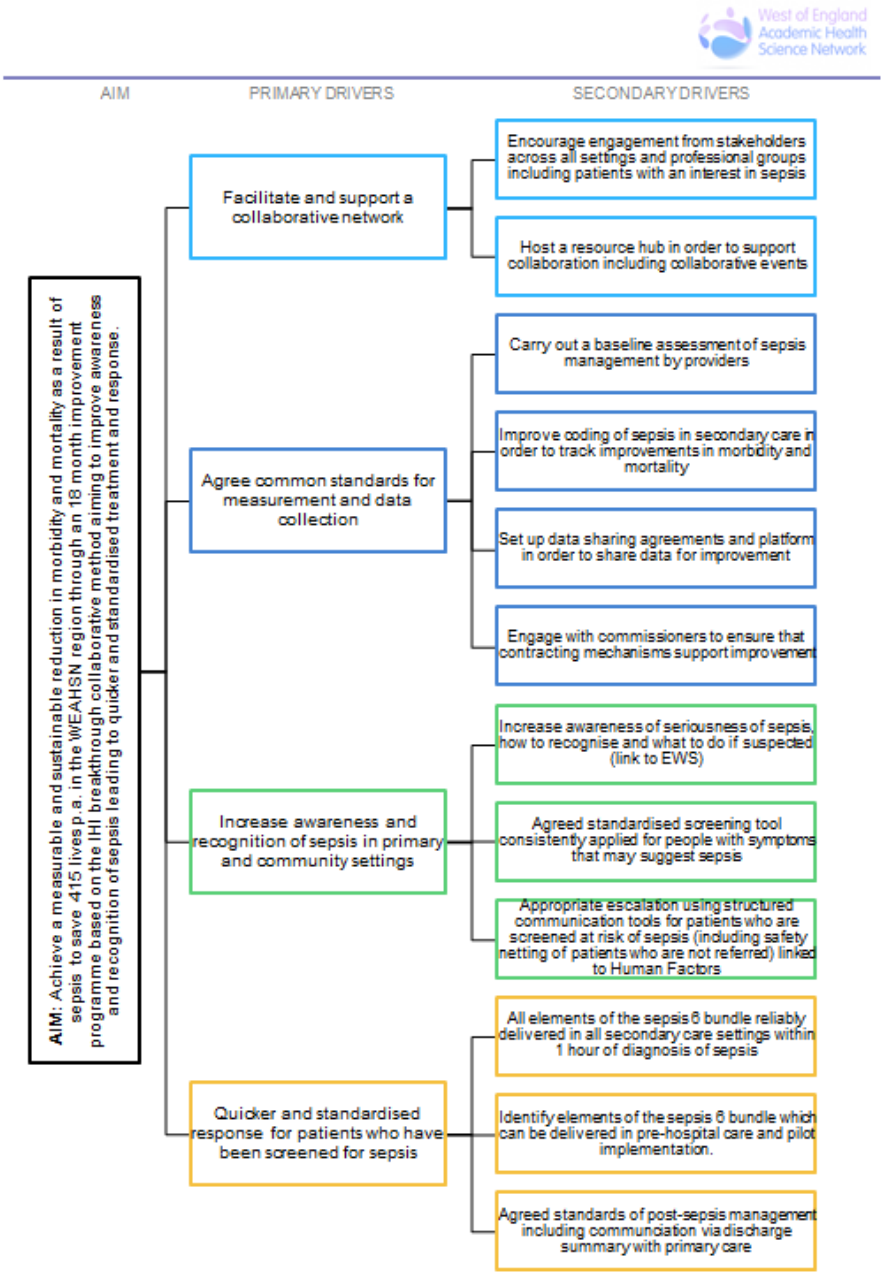
Measure	Data Source	Sample size
review		
Maternity: Work place behaviour	Responses from attendees during human factors week	No sampling n=42
Maternity: Safety culture at workplace	Responses from attendees during human factors week	No sampling n=25
WHO checklist compliance	Medway/Bluespier	No sampling. All operating theatre procedures.
WHO quality compliance	Mystery shopper observational audits	153 cases observed in all theatres
Proportion of doctors aware of LocSSIPs	Point prevalence survey respondents	No sampling n=96 doctors
Doctors' buy-in of the LocSSIP process	Point prevalence survey respondents	No sampling n=96 doctors
Use of LocSSIP for pleural aspiration	Case note audit	5 patients per month
Use of LocSSIP for lumbar puncture	Case note audit	5 patients per month
Use of LocSSIP for abdominal paracentesis	Case note audit	5 patients per month
Days between peri-procedure never events	Serious incident log	No sampling
Improvements in swab count for perineal repairs	Observational audit	No sampling n=14
Number of executive led patient safety walk rounds per month	Executive walk round schedule	No sampling
Completion of actions from executive led patient safety walk rounds	Action schedule	No sampling
Unexpected term admissions to Neonatal ICU	NICU admission data	No sampling
Babies needing neonatal input for respiratory problems, active or passive cooling, and suspected hypoxic ischaemic	NICU clinical data	No sampling

Measure	Data Source	Sample size
encephalopathy		
Symphysis fundal height measurement	Clinical Audit	To be confirmed

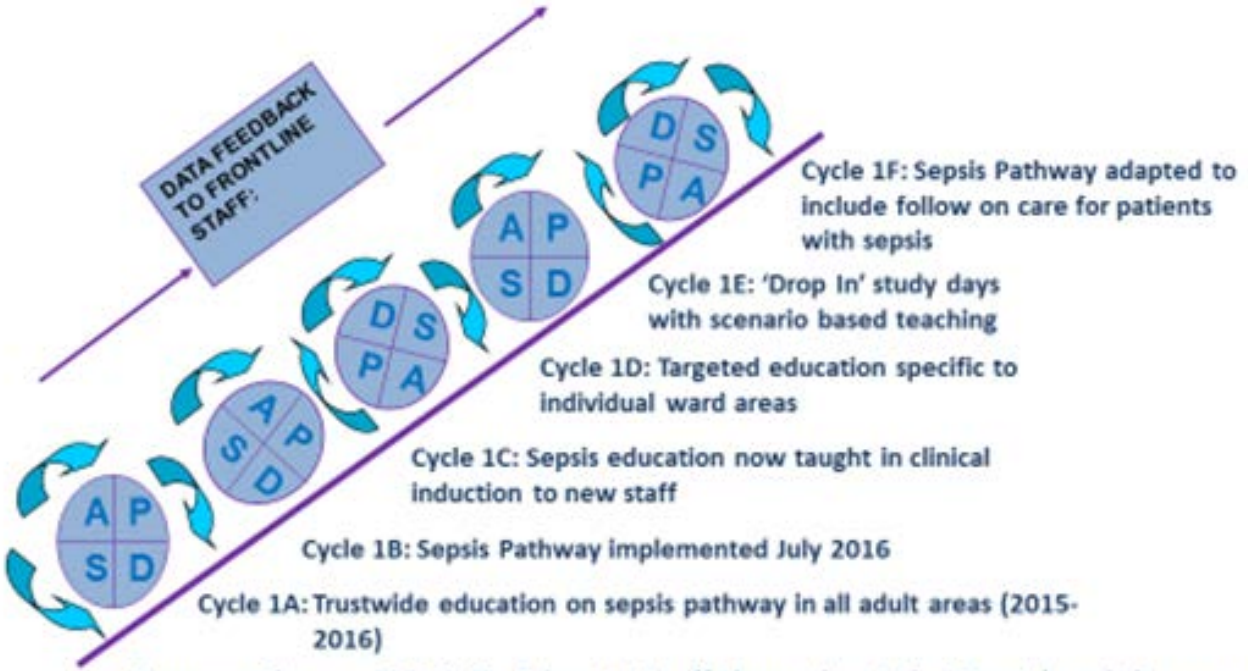
Appendix 4: Cross-system deteriorating patient work stream driver diagram



Appendix 5: Cross system sepsis driver diagram

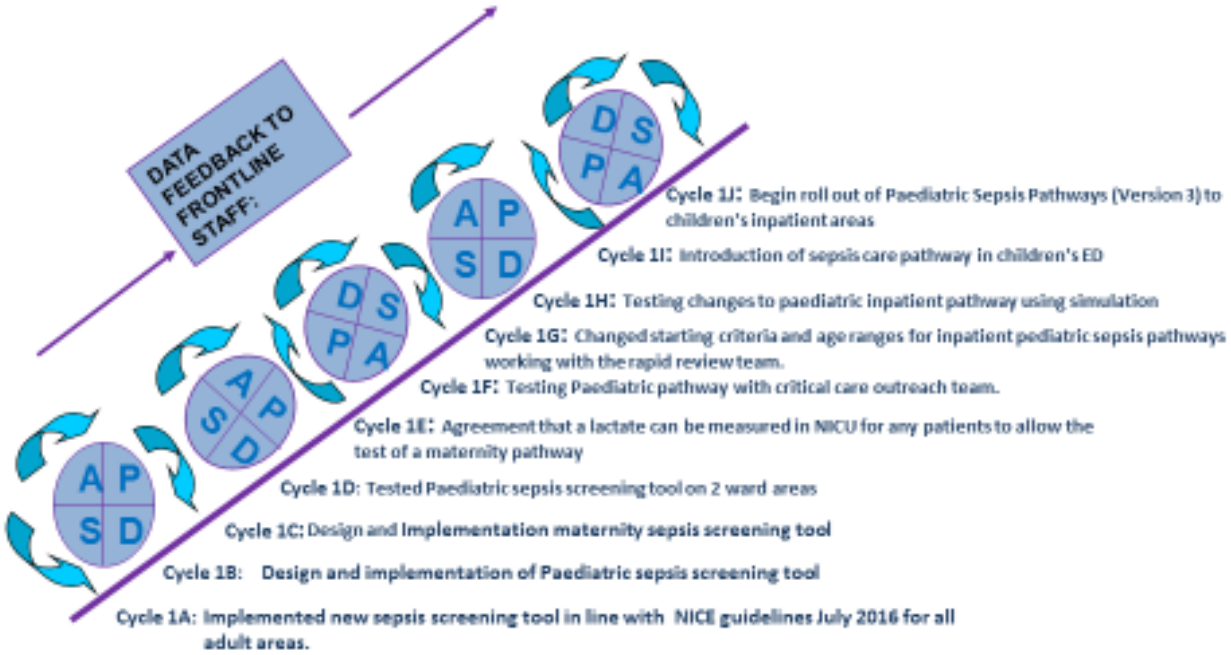


PDSA Testing Ramps for:



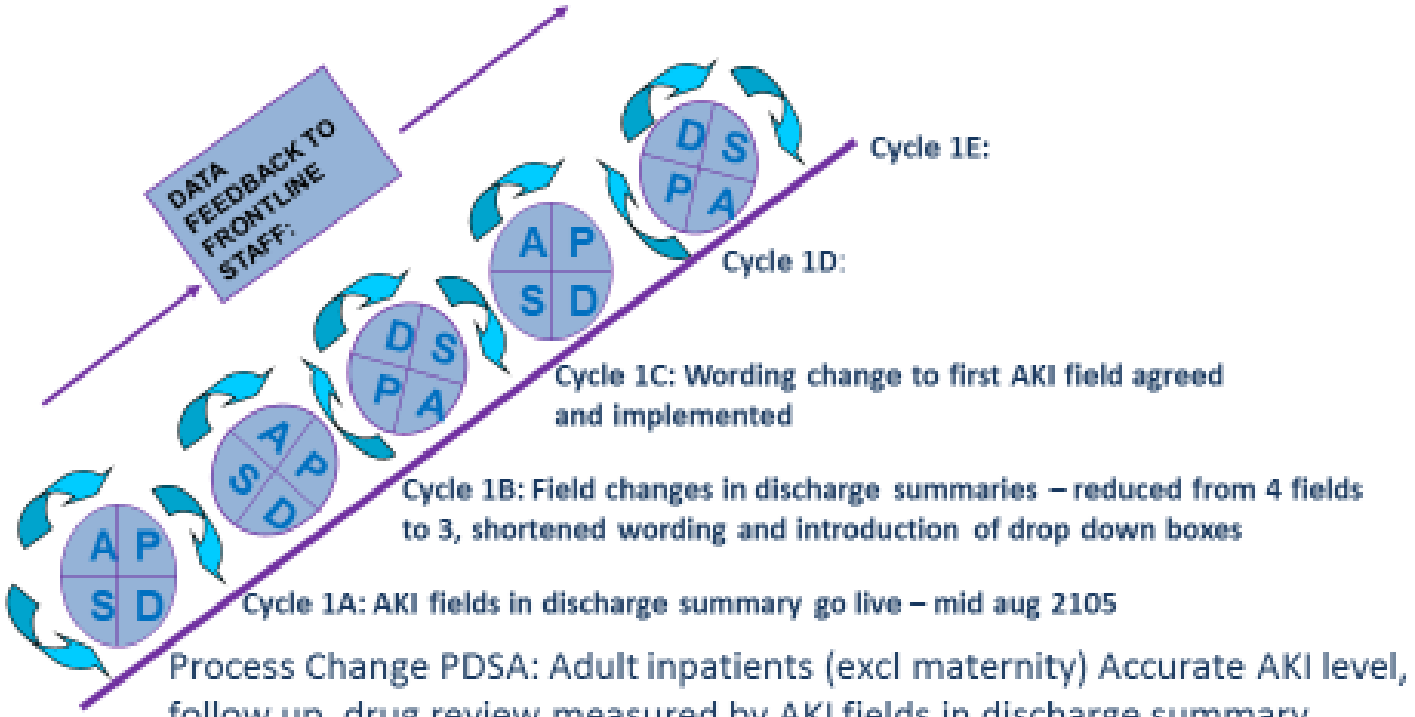
Process Change PDSA: To Educate Staff throughout the Trust in adult areas about sepsis screening and the importance of rapid antibiotic administration in those with 'Red Flag' sepsis

PDSA Testing Ramps for:



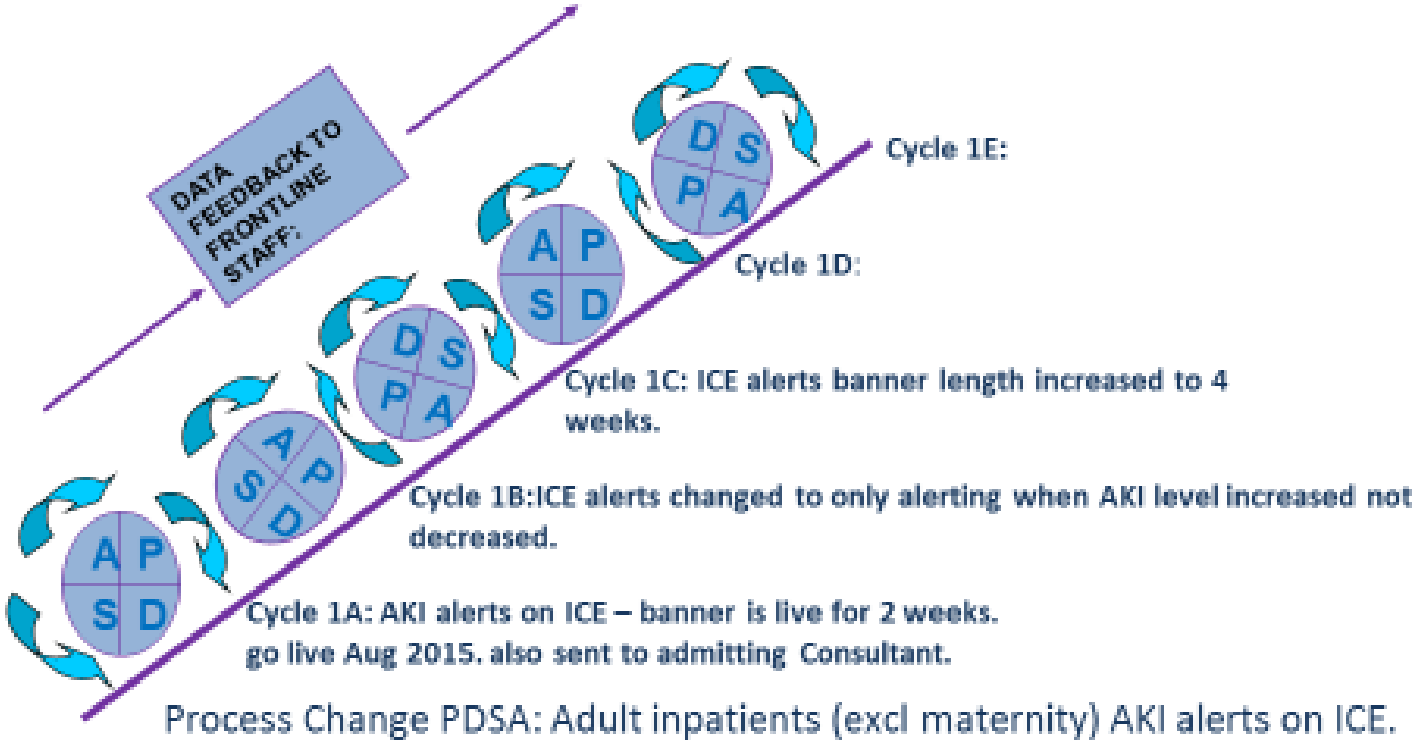
Process Change PDSA: Implementation of sepsis screening tool for all patients Trustwide.

PDSA Testing Ramps for Information in Discharge Summaries:



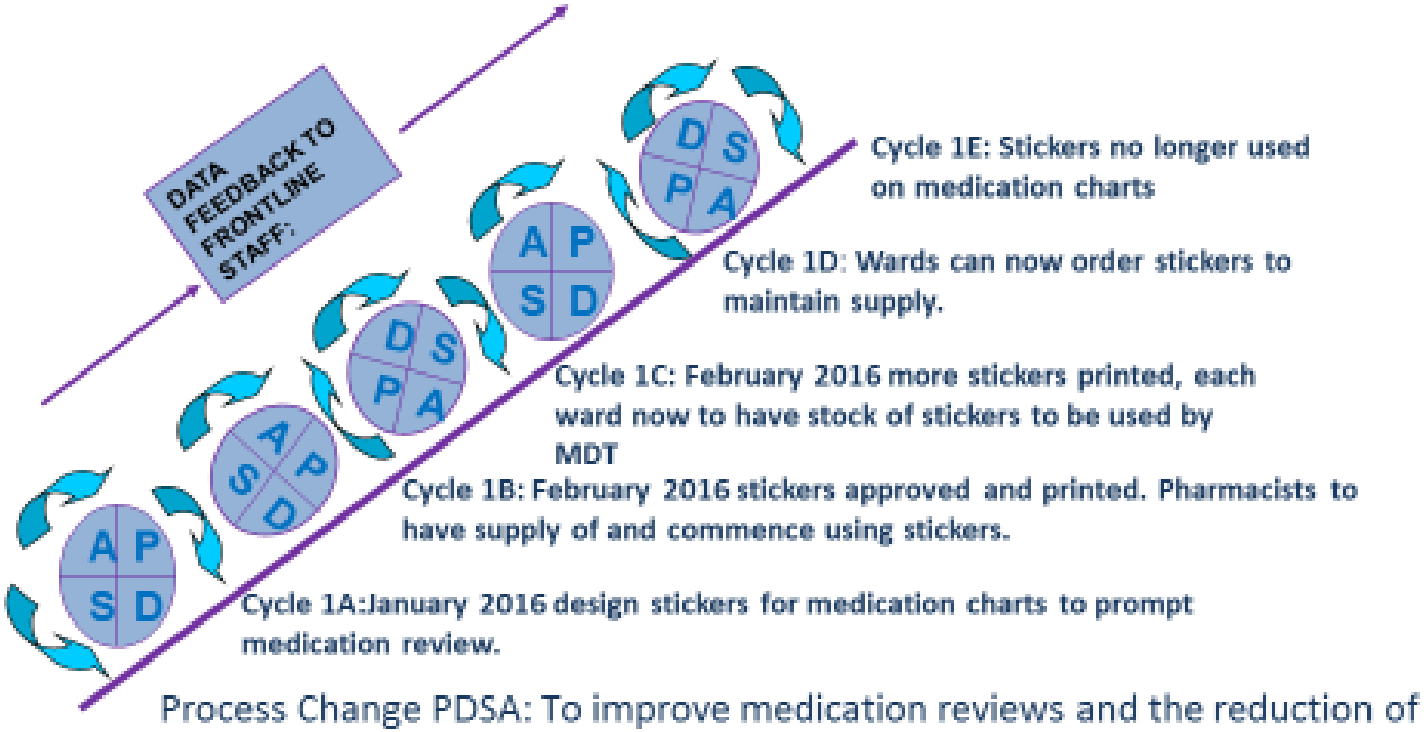
Process Change PDSA: Adult inpatients (excl maternity) Accurate AKI level, follow up, drug review measured by AKI fields in discharge summary completed.

PDSA Testing Ramps for AKI Alerts:

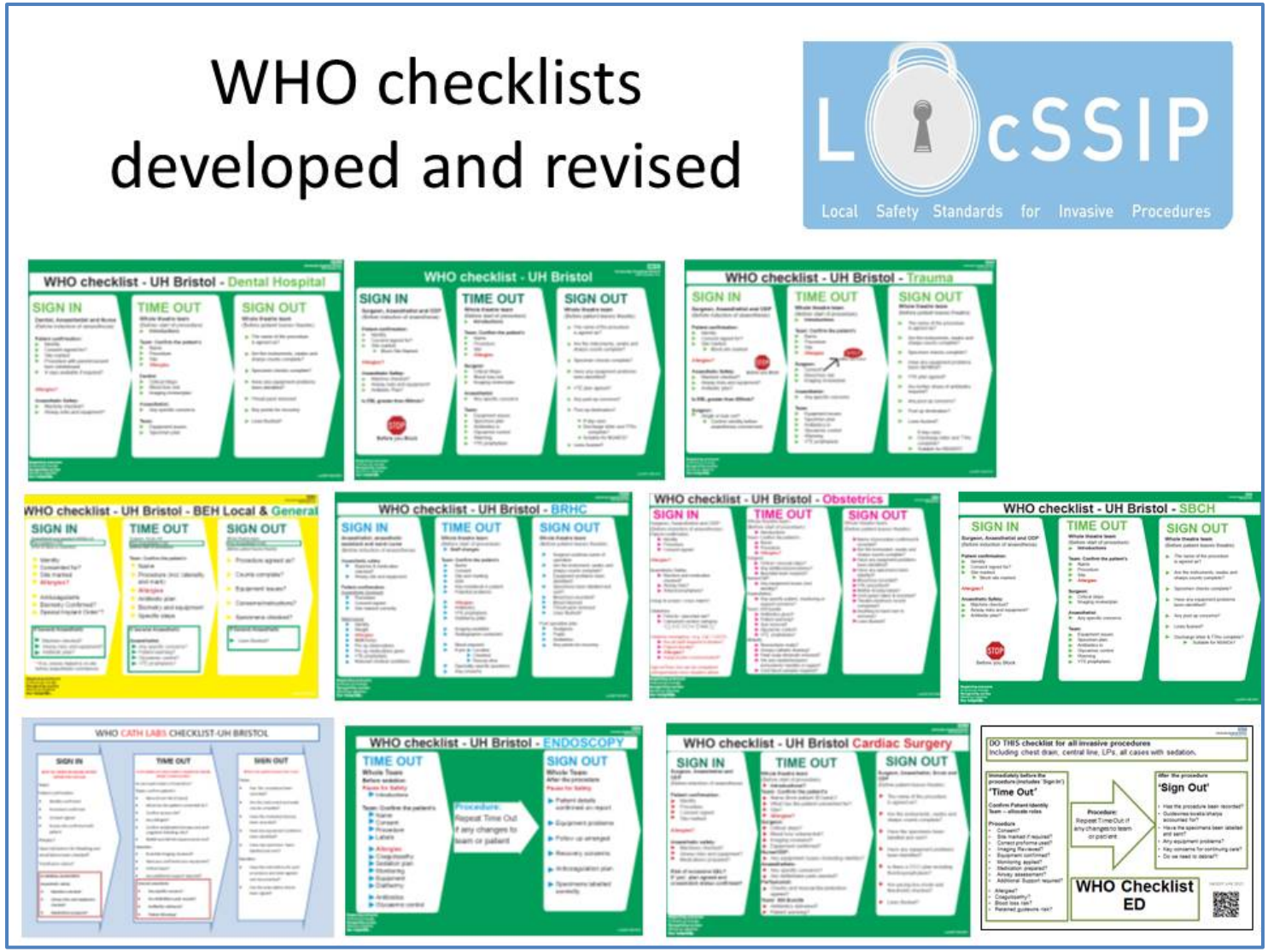


Process Change PDSA: Adult inpatients (excl maternity) AKI alerts on ICE.

PDSA Testing Ramps for AKI Medication Chart Stickers:



Process Change PDSA: To improve medication reviews and the reduction of nephrotoxic drugs used in adult inpatients (excl maternity) with AKI.


WHO checklists developed and revised
LocSSIP
Local Safety Standards for Invasive Procedures
WHO checklist - UH Bristol - Dental Hospital
WHO checklist - UH Bristol
WHO checklist - UH Bristol - Trauma
WHO checklist - UH Bristol - BEH Local & General
WHO checklist - UH Bristol - BRHC
WHO checklist - UH Bristol - Obstetrics
WHO checklist - UH Bristol - SBCH
WHO CATH LABS CHECKLIST-UH BRISTOL
WHO checklist - UH Bristol - ENDOSCOPY
WHO checklist - UH Bristol Cardiac Surgery
DO THIS checklist for all invasive procedures
including chest drain, central line, LPs, all cases with sedation.
'Time Out'
'Sign Out'
WHO Checklist ED

Appendix 12: Further information on quality improvement in maternity services

1. Each Baby Counts

Each Baby Counts is the Royal College of Obstetrician and Gynaecologist's (RCOG's) national quality improvement programme introduced in 2015 to reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour.

St Michael's maternity service is required to complete an online data collection form for each eligible incident that occurs under their care. Notifiable cases include term deliveries (≥37+0 completed weeks of gestation) following labour that resulted in one or more of the following three outcomes:

i. Intrapartum stillbirth: when the baby was thought to be alive at the start of labour but was born with no signs of life; this includes cases in which:

- Labour was diagnosed by a health professional; this includes the latent phase of labour, i.e. less than 4cm dilatation.
- The woman called the unit to report any concerns of being in labour, for example (but not limited to) abdominal pains, contractions or suspected ruptured membranes
- The baby was thought to be alive at induction of labour
- The baby was thought to be alive following suspected or confirmed premature rupture of membranes (PROM)

ii. Early neonatal death: when the baby died within the first week of life (i.e. days 0–6) of any cause.

iii. Severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories:

- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) OR Was therapeutically cooled (active cooling only) OR had decreased central tone AND was comatose AND had seizures of any kind.

2. NHS Resolution Early notification Scheme

From April 2017 the service is required to report to NHS Resolution all maternity incidents meeting the definition below:

- Babies born at Term (>37 weeks), following labour, that had a severe brain injury diagnosed in the first seven days of life, including:
- Diagnosed with grade III hypoxic ischaemic encephalopathy (HIE)
- Actively therapeutically cooled
- Had all three of the following signs: decreased central tone; comatose; seizures of any kind

For a proportion of these incidents, different care may have made a difference to the outcome.

The Early Notification Scheme is aligned with RCOG's Each Baby Counts national quality improvement programme and the two organisations are working together to develop an approach towards collection of this data to ensure Trusts do not need to submit the same data twice. At

present, however, the data for these same babies is being reported to both RCOG and NHS Resolution.

3. Healthcare Quality Improvement Programme (HQIP)

The MBRRACE-UK collaboration was appointed by HQIP (on behalf of NHS England) to develop and establish a national standardised Perinatal Mortality Review Tool (PMRT).

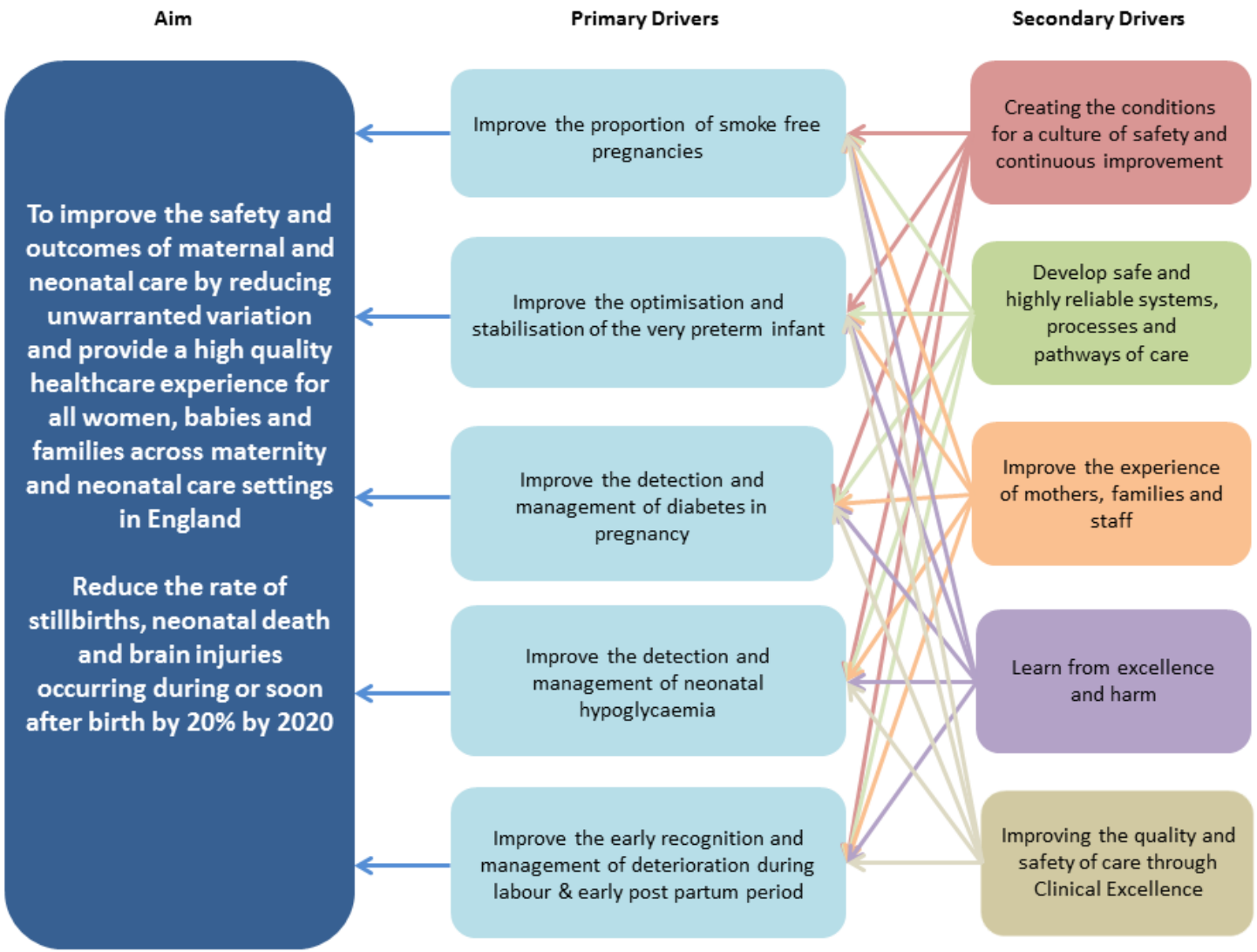
The PMRT was introduced in February 2018 and requires the service to develop its mortality reviews by:-

- Completing the NPMRT for every baby that dies. The criteria for those babies has been expanded to include:
    - Late fetal losses – 22+0 to 23+6
    - All post neonatal deaths where a baby dies in NICU > 28 weeks following care in a neonatal unit

4. Healthcare Safety Investigation Branch (hosted by NHS Improvement)

All babies eligible for the Each Baby Counts database will have to be notified to HSIB (the time scale has yet to be announced). At the moment, there is not a common database with EBC or the Early Notification Scheme so duplicate data entries will have to be made. St Michael's maternity service is one of the first wave hospitals with notification commencing July 2018. We had our first case in August which is eligible for HSIB.

Appendix 13: Driver diagram for national maternal and neonatal health safety collaborative



University Hospitals Bristol NHS
NHS Foundation Trust

Sign up to SAFETY
LISTEN LEARN ACT

UH Bristol Patient Safety Improvement Plan 2019-2021

1. Introduction

Since 2007, UH Bristol has been implementing patient safety improvement programmes which have become more sophisticated over the years due to more emphasis on collaborative and system wide improvement work.

Over the past three years we have benefited from support from the national Sign up to Safety team, the West of England Patient Safety Collaborative and, more recently, our Trust Quality Improvement (QI) Academy and QI Hub to strengthen capacity and capability for QI within our hospitals

This plan is based on the evaluation of our 2015-2018 Patient Safety Improvement Programme, patient safety priorities in our Quality Strategy 2016 -2020 and national and local system priorities. It sets the direction for our quality and patient safety improvement journey for the next three years.

2. Setting our patient safety priorities for 2019-2021

Information was gathered from a number of sources in order to identify what our priorities should be the next three years. These included:

- a survey of staff on their top five patient safety concerns;
- analysis of reported incidents;
- analysis of serious incidents;
- the Learning from Deaths process;
- claims data;
- priorities for joint working with the West of England of England Patient Safety Collaborative;
- NHS Improvement national priorities
- themes from safety conversations events which have taken place in our hospitals

Table 1 below shows the results of this exercise.

Information source	Theme1	Theme 2	Theme 3
Staff survey of top five patient safety concerns (August 2018)	Handover, transfer and discharge	Medication errors	Linking up of IT and paper systems that support clinical care
Reported incidents (Source: Datix July 2017 to June 2018)	Medication incidents	Other high volume incident categories (clinical assessment/review and the treatment/procedure) too broad to identify specific themes	

Human factors in serious incidents (Source: STEIS/local thematic analysis)	Poor / lack of effective communication (verbal or	Leadership of the service or team	Staff feeling pressured	Distractions/ interruptions

Information source	Theme1		Theme 2		Theme 3
	written) between staff				
Learning from deaths annual report (2017/18)	Early poor prognosis conversations				
Claims Scorecard (Source NHS Resolution: April 2013 to March 2018)	High volume/high value: maternity related claims		High volume/low value claims: failure/delay in treatment but wide ranging alleged causes		
West of England Patient Safety Collaborative local priorities 2018 pertinent to acute providers, excluding national priorities below	NEWS2	ResPECT	Emergency Department Community of Practice	Frailty Community of Practice	
UH Bristol Quality Strategy 2016-2020	Deteriorating patient including sepsis and acute kidney injury (AKI)	Safety Culture	Improve learning from incidents	Medicines safety	Reducing never events
NHS Improvement national priorities	Maternity and Neonatal Health Safety Collaborative		Leadership and culture		Deteriorating Patient
National Kitchen Table Week Safety Conversations 2017 and 2018	No particular general themes				

Table 1: Top patient safety themes from a range of sources

3. Thematic Analysis

From the information gathered above the key themes are:

1. Medication safety
2. Deteriorating patient including sepsis and AKI
3. Maternity and neonatal care
4. Leadership and culture
5. Human factors elements of incidents/never events/distractions/interruptions
6. Communication particularly regarding handover and discharges and interface with IT systems

3.1 Next steps recommendations from 2015-18 Patient Safety Programme

3.1.1 General recommendations and lessons learned

- We continue with patient safety improvement work in adults and paediatrics with a refreshed programme

- The maternity and neonatal safety improvement work continues under the auspices of the national collaborative

- Work streams that are not formally part of the refreshed programme but need further work to become embedded/or expanded into further areas should link into our QI academy and QI hub.

- Future programmes will have closer working with our Communications Team and a more definite long-term communications and engagement plan/branding/use of infographics etc.

- Future programmes should have a longer period of planning, including how it would be evaluated and ensuring there were comprehensive valid baseline measures for all aspects of each work stream before any changes were made

- The governance and reporting structure of the programme is reviewed to encompass all work streams across adult, children's and maternity services.

3.1.2 Recommendations for deteriorating patient work stream:

This work stream should continue with new aims and objectives.

a) For adult patients:

- Implement NEWS2 by Q3 2018/19

- Progress electronic escalation of deteriorating patients using Care Flow

- Implement ResPECT [1] process (or similar) in conjunction with West of England Academic Health Science Network system wide project

- Research alternative ways for staff to sustain their skills and competence in taking manual observations should a situation arise where these are required.

b) For children:

- Development of a more co-ordinated approach in the BRCH so that we can more clearly and consistently track learning, gain a deeper understanding of the barriers to change and promote better outcomes.

- When an appropriate configuration for electronic PEWS is available, look towards implementation in BRCH

[1] ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. ReSPECT can be complementary to a wider process of advance/anticipatory care planning. UK Resuscitation Council.

- Continue regional PEWS implementation and play a key role in the work to develop national PEWS.

c) For maternity

- Continue with work to map the NEWTT (Newborn Early Warning Trigger and Track) tool against the existing new-born observations (NObs) chart. This work aligns with the ATTAIN initiatives to reduce term admissions to the Neonatal Unit and is also being addressed through the Clinical Excellence dimension of the Mat Neo collaborative QI plans.

3.1.3 Sepsis

This work stream should continue with new aims and objectives.

a) For adult patients:

- In October 2018, the adult in-patient sepsis pathway will be electronic and therefore should become embedded in practice.

- ED is not currently using electronic sepsis screening or e-observations and this may not be in place until 2019. It has been identified that the only way sepsis screening will become fully embedded in practice is for sepsis screening to be electronic and therefore automatically prompted.

- The work stream will continue in its current form whilst the2017/19 sepsis CQUIN is a national contractual requirement, however in the future there could be the potential for it to combine with work being done through e-observations and Electronic Prescribing and Medicines Administration (EPMA) to provide a more joined up digital approach.

b) For children:

- To continue to teach and share information about the paediatric in-patient sepsis pathway to ensure that it is fully embedded.

c) For maternity:

- The World Health Organisation are conducting a global maternal sepsis study (GLOSS) and once this has been reported we will work with partners in the Local Maternity System to adapt the maternal sepsis tool in response to the latest evidence.

- We will continue to monitor our practice and make further improvements informed by our data

- We will progress a business case for a blood gas analyser with the functionality to process lactates for Central Delivery Suite.

3.1.4 Acute Kidney Injury

The Programme Board should decide whether this work stream should continue. There is no recommendation because there is currently no medical AKI lead.

- If the work stream is to continue it is recommended a medical lead is identified to help drive through changes and continue to make improvements in the care of inpatients with AKI.

3.1.5 Medicines Safety

This work stream should continue with new aims and objectives.

- The Trust has a new quality objective for 2018/19 to measure the number of insulin prescriptions omitted at admission to our two medical assessment units and reduce this incidence by 25% within the next year.

- Revise the medicines optimisation driver diagram for the next steps

- Engage with the AHSN national projects work stream through West of England AHSN. Their focus is on reducing unnecessary polypharmacy. Locally this will be in partnership with the Strategic Transformation Plan Medicines Optimisation Polypharmacy work stream including GP use of the PINCER tool to review medication safety indicators within practices.

- We will investigate how these (or other published) medication safety measure could be enacted within electronic prescribing

- Increase the use of PharmOutcomes for hospital referral to primary care with an internal focus is now on integrating this referral automatically through our electronic prescribing system

- Engage with the WHO patient safety challenge – Medication without harm; and the ongoing national work to support this.

- Continue to develop integrated clinical informatics systems through the STP Medicines Optimisation IT work stream and the Local Health Record Exemplar work

- Further develop clinical dashboards, linked to electronic prescribing, to highlight individual patient safety issues, safety & process measures and outcome data. This includes real-time measure of omitted medication and reports to show critical medication omissions.

- Look at ways to better engage patient involvement in medicines safety

- Re-focus on patient self-administration and the reasons for poor adoption of this in practice.

3.1.6 Safety Culture

This work stream should continue with new aims and objectives. It could potentially combine with leadership.

- For future safety culture assessments it is recommended that we use the SCORE tool and, rather than conduct an organisation wide assessment, we should focus on particular specialities in turn starting with maternity services in March to May 2019.

- In children's services, patient safety knowledge will be monitored at the start of each and every episode of staff 'patient safety training'. This will ensure that gaps in knowledge and understanding can be addressed in a timely manner and provide an indicator of the current patient safety culture within children's services.

- In children's services it is acknowledged that patient safety education still does not reliably reach every member of clinical staff and a gap analysis and development of new training programmes is a high priority within the patient safety team at BRHC. Work in the next patient safety programme will explore further, new ideas for a fresh patient safety campaign at BRHC entitled 'Don't whisper incidents aren't a secret'.

3.1.7 Peri-procedure never events

The team recommend:

- In theatre: the processes are well established. However, the governance leads are keen we keep the topics live so there is not a drift downwards
- Outside theatre: this still needs more work. It is not in the culture yet so we recommend
    - Continue the LocSSIP programme locally
    - Set up a cross-region working group to establish in all hospitals so it is not a UH Bristol only initiative.
- Change of leadership: Mat Molyneux to make way for Rachel McKendry who has recently been appointed to a substantive consultant anaesthetist post.
- In maternity we will continue to audit our practice to maintain high standards and reduce the risk of never events both with patient note audit and secret shopper style observational audit, results of which will be presented at the Central Delivery Suite working party and will influence training programmes.

3.1.8 Leadership

This work stream should continue with new aims and objectives. It could potentially combine with safety culture.

- It is recommended that visible executive leadership for patient safety continues following a review of the current process

- Seek input from Programme Board members, including our public contributors, on the governance structure and implement changes for the next improvement programme.

- In maternity services, we will repeat the human factors study day for staff working in maternity and neonatology and plan to embed SBAR in handovers of care and use of safety huddles in intrapartum care.

3.1.9 Maternity and Neonatal Health Collaborative

This work stream should continue with existing aims and objectives.

- Re-establish the monthly QI meetings to reinvigorate the programme.

- The Maternal and Neonatal Health Safety Collaborative local learning system was launch in July 2018 to review progress and plan next steps for continued improvements in our work streams.

Plan for 2018/2019

Leadership and safety culture

- Annual human factor study days

- Learning from excellence – introduce “Greatix”
- Participate in SCORE patient safety survey in March 2019
- Through the Local Maternity System (LMS) , implement the patient safety work stream in the National Better Births transformation program
- Participate in the review of the Bristol Neonatal Services

Clinical excellence

- Training and introduction of hypoglycaemia guideline
- Review impact of new guideline
- Monthly review of rates of term neonatal admissions for respiratory conditions

Systems and processes

- Regular audit of care of women undergoing continuous fetal monitoring in labour
- Re-audit of SFH measurement and plotting planned for September 2018

Person centred care

- Review the audit findings to improve the postnatal discharge pathway
- Staff training in supporting parents caring for their baby on NICU

3.3 Proposed Patient Safety Priorities

Based on the thematic analysis and supporting information, our patient safety priorities should be:

a) Medication safety

Rationale:

- Medication incidents are highest reported incident type
- There is a patient safety collaborative work stream on reducing unnecessary polypharmacy. Locally this will be in partnership with the Strategic Transformation Plan Medicines Optimisation Polypharmacy work stream including GP use of the PINCER tool to review medication safety indicators within practices.
- Interruptions/distractions during medicines prescribing/checking/administration are a feature of learning from incidents and serious incidents and can be picked up by the human factors work stream below
- The existing work stream lead has recommended medicines safety priorities for the next three years

b) Deteriorating patient including sepsis and AKI.

(Whether to incorporate AKI requires a decision by the Programme Board)

Rationale:

- Deteriorating patient is a national priority
- NEWS2 implementation is a national CQUIN requirement
- NEWS2 and ResPECT are a patient safety collaborative work stream
- The learning from deaths process has identified the need for early poor prognosis conversations
- Implementing e-observations in ED and developing e-observations for children and maternity is a UH Bristol priority

- Linking e-observations with the Care Flow communication tool is planned as part of our digital programme
- Completing the implementation of regional PEWS is already underway
- The existing work stream leads in adults, paediatrics and maternity have recommended deteriorating patient priorities for the next three years
- The national Sepsis CQUIN will continue into 2019 and potentially beyond subject to further announcement from NHS England/NHS Improvement

c) Maternity and neonatal care

Rationale:

- This is national and local priority and we are already a part of the National Maternal and Neonatal Heath Safety Collaborative
- Maternity related claims make up the majority of the high value/high volume quadrant of our NHS Resolution claims scorecard.

d) Leadership and culture combined work stream

Rationale:

- Leadership and culture are a national priority
- Significant impact of culture and leadership on the safety and quality of services provided
- Local leadership is a theme from incident analysis
- Links with staff engagement and well-being work being led by the Director of People

e) Human factors elements of incidents/never events/distractions/interruptions

- Analysis of incidents, serious incidents and never events suggest that distractions/interruptions invariably contribute especially in high volume services and routine tasks.
- Increasing complexity of healthcare related tasks, clinical decision making, staff feeling pressured and rotational staff comprising virtual teams increases the risk of error through human factors

f) Communication particularly regarding handover and discharges and interface with IT systems

Rationale:

- The safety priorities survey indicated both handover and discharges and interface with IT systems where two of the top three concerns

- Incident and serious incident analysis suggested communication breakdown is a common contributing factor particularly during transfers of care internally and externally.
- Digital solutions for improving the process of communication are being implemented, and there is opportunity to use intelligence from such systems to further drive improvement

4. Decisions for the Programme Board to consider:

- That a revised governance and reporting structure for patient safety improvement is required to encompass all work streams across adult, children's and maternity services and what this should look like going forwards

- Agree the proposal for a 6 months lead in time to commence the next programme to allow for recruitment of a programme manager, development of a communications and engagement plan and to develop detailed plans and measurement strategies for each work stream with leads and key stakeholders.

- That the peri-procedure never events work stream continues to be embedded locally with the support of the QI Academy and QI Hub rather than being part of the formal programme

- That the human factors elements identified as a result of learning from peri-procedure never events is incorporated into the human factors work stream of the new plan to include work on reducing distractions/interruptions.

- That the existing leadership and culture work streams are combined

- Whether to continue the AKI work stream, and if so, agree the recommendation to appoint a senior medical (consultant) work stream lead to take this forward.

- Approve the proposed patient safety improvement priorities for 2019-2021 in section 3.3 of this paper.

Cover report to the Public Trust Board Meeting to be held on 27 September 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 27 September 2018
Report Title	**Learning from Deaths Report**		
Author	Mark Callaway, Deputy Medical Director		
Executive Lead	William Oldfield, 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 report on the first quarter of 2018/2019 learning from death process

Key issues to note

1. The numbers are very similar to quarter 1 2017/2018
2. All adult in patient deaths have been screened
3. A Structured case note review occurs in between 20-30%
4. The majority of care provided when reviewed is good
5. 0 death has been identified as potentially avoidable

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)**
		25 September 2018		

University Hospitals Bristol NHS
NHS Foundation Trust

Learning from Deaths

Report for Quarter 1 for 2018/2019

MP Callaway

17th September 2018

Introduction

The learning from deaths process has been established within the organisation and all adult deaths excluding out of hospital cardiac arrests continue to be screened by the lead Mortality Nurse. This process allows the Mortality Nurse to assess the quality of patient care and where the patient notes trigger the Structured Case Note Review these are then are distributed to the relevant Division for further assessment and further reviews are undertaken.

This report summarises the activity in quarter 1 2018/2019

Report

The figures for quarter 1 2018/2019 are very similar to the figures reported for the same quarter last year. All adult in patient deaths were screened by the lead Nurse in Mortality and 22% were identified as needing a further Structured Case Note Review (SCNR).

No death in quarter one required a further secondary screen and no death within this quarter was identified as potentially avoidable

Additional information that was obtained for the first quarter of 2018/2019 was the number of deaths that occurred within 30days of admission to the Trust. This information was further broken down into patients that attended the ED department, prior to death within 30 days.

The standard of care across the domains of care remained good, with little identified change when compared to the recent Annual report

No death has triggered a secondary review during quarter one. There were 5 deaths in patients with learning difficulties in quarter 1

	Quarter 1 (Apr – Jun 18)	Quarter 2 (July – Sept 18)	Quarter 3 (Oct – Dec 18)	Quarter 4 (Jan – Mar 19)	Totals
Total deaths (in Patients)	290				**290**
OOHCA	46				**46**
Total excluding OOHCA	244				**244**
ITU deaths	14				**14**
Total SCNR identified	49 (21%)				**49 (21%)**
Medicine	20 (41%)				**20**
complete	10				**10**
pending	10				**10**
Surgery	10 (20%)				**10**
complete	7				**7**
pending	3				**3**
Specialised Services	19 (39%)				**19**
complete					
pending					
Number triggering MDO Review	0				**0**
Number of SUI reports related to patient death	4				**4**
Number of avoidable deaths	0				**0**
Number of Deaths in patients with Learning Difficulties	5				**5**
Death within 30 days of discharge					
Total	146				**146**
From ED	27				**27**

Proposals going forward for 2018/2019

Deaths within 30 days of admission

The number of deaths within 30 days of admission is a larger number than had been predicted and the work conducted by the Mortality Fellow in the last 6 months of last year demonstrated a likely need for a SCNR in 24% of these deaths as these deaths were unexpected.

This work has been further evaluated and the Mortality Team is working closely with the Coroner's Officer around the deaths that occurred within 30 days of attendance within the Emergency Department to establish what the cause of death was, as reported to the Coroner on the Death Certificate, and correlation with the attendance at the Emergency Department.

Four Education fellows have recently joined the Mortality Team; these Fellows will develop this stream of working going forward this year.

Reviews and Involvement of the Consultant Body

Over the next year, the proposal is to fully integrate the process into the organisation to embed the review pathway into the ongoing supportive activity of all Consultants managing adult patients - these changes need to be introduced for several reasons

1. To raise awareness amongst the Consultant body of this process and the ongoing commitment to patient safety, and to educate around the overall processes around in patient care

2. To integrate this method of peer review into the standard working practice of the consultant body

3. To ensure a fair distribution of the workload throughout the consultant body

4. To minimise the impact of delivering high quality review process for both the mandatory indications and the additional screened note to deliver a patient centred, locally adapted process to really integrate learning from deaths into the organisation.

Currently a proposal is being taken through the Senior Leadership Team to support this development

Learning from Deaths

A consistent message arising around the structured case note review is the introduction of a patient onto an end of life care pathway and this work is being co-ordinated by Dr Amanda Beale and Dr Colette Reid

This work has led to some initial change including changing the week end sticker on a patient's notes to clearly indicate the patient is on an end of life pathway.

Dr MP Callaway

Cover report to the Public Trust Board Meeting to be held on 27 September 2018 from 11.00 – 13.00 in the Board Room, Trust Headquarters

		Agenda Item	14
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Infection Prevention and Control Annual Report 2017/18**		
Author	Martin Williams DIPC & Lisa Hinton, Deputy Director of Infection and Prevention and Control		
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

All NHS organisations must have effective systems in place to control healthcare associated infections as set out in the Health and Social Care Act (2008). Prevention and control of infection is part of University Hospital Bristol NHS Foundation Trust's overall risk management strategy. This report provides assurance to the Board that the Trust has discharged its responsibilities as per the Health and Social Care Act to manage, monitor and control infection during 2017/18.

Recommendations

Members are asked to:

- **Receive** the 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
None identified.

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)**
		28 August 2018		**Infection Control Steering group.**

Infection Prevention and Control Annual Report 2017/18

1. Introduction

All NHS organisations must have effective systems in place to control healthcare associated infections as set out in the Health and Social Care Act (2008). Prevention and control of infection is part of University Hospital Bristol NHS Trusts overall risk management strategy. This report provides assurance to the Board that the Trust has discharged its responsibilities as per the Health and Social Care Act to manage, monitor and control infection during 17/18.

Table I details the standards that the Trust has to evidence compliance with.

Table 1: The requirements of the Health and Social Care Act (2008) updated in this report in line with revised guidance issued July 2015.

Compliance criterion	**What the registered provider will need to demonstrate**
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

2. Description of Infection Control Arrangements

2.1 Corporate Responsibility

The Director of Nursing is the responsible Executive Director within the Trust for Infection Prevention and Control and reports to the Chief Executive and the Board of Directors. The Director for Infection Prevention and Control (DIPC) is a Consultant Microbiologist in the Trust.

2.2 Infection Prevention & Control Team

Specialist advice is provided to clinicians throughout the hospital by the infection prevention and control team. The DIPC is the designated Infection Prevention and Control Doctor (IPCD) with the weekly allocation of 4.5 programmed activities (18 hours) of infection control doctor time. A second Consultant

Microbiologist provides an additional 0.5 (2 hours) programmed activities of infection control doctor time. When needed, cover for leave of absence is provided by another Consultant Microbiologist the Hospital.

Additional support to the team is provided by on-call cross cover arrangements which are in place for Microbiologists from University Hospitals Bristol, North Bristol Trust, Royal United Hospital and Weston hospital. Specialist advice in virology is provided by the North Bristol Trust Consultant Virologists.

The specialist infection, prevention and control nursing team provide education, support and advice to all Divisions, Trust staff and patients and relatives.. The key responsibilities of the IPC team are to:

- Ensure there are policies, procedures and guidelines in place for the prevention, management and control of infection across the organisation.
- Communicate information relating to communicable disease to all relevant parties within the Trust.
- To provide and oversee the provision of education and training in the principles of infection control to the relevant staff groups.
- Work with clinicians to improve surveillance and to strengthen prevention and control of infection in the Trust.
- Provide appropriate expert infection control advice in the Trust, taking into account national guidance,
- Share information between relevant parties within the NHS when transferring the care of patients to other healthcare institutions or community settings.

2.3 Infection Prevention & Control governance.

The Infection Control Group (ICG) is responsible for ensuring that there is internal scrutiny of compliance with national standards/key performance limits, local policies and guidelines, external assessments e.g. decontamination standards, Care Quality Commission standards and the Patient-led assessments of the care environment (PLACE). ICG is chaired by the Chief Nurse or DIPC and meets bi-monthly.. Reports are received at each meeting from the sub groups which are; Decontamination Group, Antimicrobial Stewardship Group, Facilities and Estates, Occupational Health and each clinical Division. ICG reports to the Clinical Quality Group, Service Delivery Group, and Quality and Outcomes Committee.

2.4 Compliance with external standards

<table>
<tr><td>Standards for Decontamination</td><td>Sterile Services Department has been audited and meets the requirements of disinfection, assembly, packing, moist heat and gas plasma sterilisation of theatre trays and procedure packs and supplementary instruments in accordance with ISO 13485:2003 and ISO 9001:2008. For moist heat and gas plasma sterilisation of theatre trays, procedure packs and supplementary instruments in accordance with Medical Devices Directive 93/42/EEC Annex V, Article 12 (Sterility Aspects Only).</td></tr>
<tr><td>PLACE</td><td>The PLACE audit was conducted between March - May 2017. Below are the overall scores across all UHBristol sites with a comparison between 2017 and 2016 audits:

<table>
<tr><th>Element</th><th>2017</th><th>2016</th></tr>
<tr><td>Food</td><td>96%</td><td>95%</td></tr>
<tr><td>Privacy and dignity</td><td>90%</td><td>90%</td></tr>
<tr><td>Condition</td><td>94%</td><td>93%</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>Cleaning</td><td>99%</td><td>99%</td></tr><tr><td>Dementia</td><td>85%</td><td>86%</td></tr><tr><td>Disability</td><td>81%</td><td>77%</td></tr></table> The results from the audits were issued in September 2017 to the Estates and Facilities Divisional Board, and as appropriate the privacy and dignity group, dementia group and patient operational environmental groups. Actions and progress are reported through the Service Delivery Group.
CQC regulation	CQC regulation 12 - The intention of CQC regulation 12 is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm. Providers must assess the risks to people's health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe. Providers must prevent and control the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people's health, safety and welfare. The Trust's self-assessment against the key lines of inquiry related to IPC show compliance.
Regulatory limits	The Trust reported the following for 2017/18: • MRSA bacteraemia 5 (against a limit of 0) • *C.difficile* 33 attributable cases identified of which 11 were assigned as a lapse in care (against a limit of 45) • MSSA 25 Trust apportioned (against a limit of 28) • E.Coli 65 Trust apportioned (no set limit) • Pseudomonas 30 Trust apportioned (no set limit) • Klebsiella 33 Trust apportioned (no set limit)

2.5 DIPC Reports to Board of Directors

The DIPC reports to Quality and Outcomes Committee quarterly, key IPCC performance metrics are reported monthly as part of the Board quality and performance report. The DIPC annual report is submitted to the Board of Directors.

2.6 Compliance with The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance

Compliance criterion 1.
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
• The Infection Prevention and Control Team (IPCT) has an Infection Control Doctor (ICD), Infection Control Nurses (ICN) (which includes the deputy Director of Infection Prevention & Control), an Intravenous Access Co-ordinator, a surgical site surveillance team, an antimicrobial pharmacist, an analyst and administrative support. • The Director of Infection Prevention and Control (DIPC) who is also a consultant microbiologist leads the team and reports directly to the Chief Nurse who is the executive lead for infection control. • The Chief Nurse chairs the Infection Control Group (ICG) which meets bi-monthly.

- The Trust Board receives monthly infection control exception reports within the quality report for key performance indicators related to infection.
- The Quality Outcomes Committee (Board sub-committee) receives quarterly infection control reports.
- The IPCT has an annual work plan delivery of which is monitored by the divisional management team and ICG.
  All infection control incidents are managed through the Trust's incident reporting process and any risks that relate to infection control are managed via the Trust's risk management process. ICG reviews and monitors all IPC corporate and divisional risks. Divisional reports to the group include updates on risks and their management.
- There is a programme of cleanliness audits with audits conducted in high and very high risk areas monthly. The reports from these audits are presented through ICG and disseminated across the Divisions for local action and re-audit accordingly.
- Infections are reported via the Datix incident management system and are also reported externally via the Public Health England Health Care Associated Infection Control database.
- All infection control training is mapped against the UK Core Skills Training Framework Statutory/Mandatory Subject Guide, Version 1.4 (2017). This includes measures to prevent risks of infection.
- The IPCT are responsible for the development and updating of Trust wide infection control policies which are ratified through the ICG.
- Audits to monitor compliance against key policies are undertaken as per the annual audit plan this includes monthly hand hygiene audits and audits relating to Aseptic Non-Touch Technique (ANTT) practice.
- The Trust water safety group work oversee the work to deliver the requirements set out in the HTM 04 revision. This multi-disciplinary group ensures that there are systems and processes in place to manage the complex water systems and a water safety plan is in place. The estates currently share information / assurance around maintenance activities undertaken, share sample results taken and identify where risks might be in line with guidance documentation. The group shares knowledge, learning from past experiences and ensures that the governance structures are in place. Background levels of pseudomonas in the augmented care areas are monitored and microbiology flag areas of concern. Investigations take place as required and exception reports go through ICG.
- The Trust decontamination lead is the Consultant Microbiologist.

Compliance criterion 2.

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

- The Trust has designated leads for environmental cleaning and decontamination of equipment.
- Annual audits relating to Decontamination are conducted by external auditors to monitor compliance.
- The Trust employs an external expert advisor in Decontamination who completed audits within Decontamination areas annually.
- SGS are the external auditing body that conduct annual audits CSSD to ISO 13485:2016 standard - international auditing company.
- There is a system in place to ensure decontamination before equipment is maintained/serviced/repaired whether within the area or transferred from the area via a DC1 form. Staff complete this form when returning items to MEMO for repair.
- MEMO are audited by the British Standard Institute twice a year as part of the ISO 13485:2016

quality management standard.

- Monthly cleanliness audits are carried out within clinical area, areas for improvement are identified and follow up audits are undertaken to ensure improvements in standards have been made.
- Regular Quality in Care audits are undertaken these include infection control practices, the clinical environment.
- Cleaning schedules are available for public view within each clinical area.
- There are suitable handwashing facilities in all appropriate areas and hand gels with signage on entry to each ward area.
- The Trust has policies in place to manage the clinical environment and ensure appropriate cleaning mechanisms are used at all times including cleaning an environment after a patient with an infection is cared for within it.
- When an enhanced, deep clean is undertaken due to an infection, the standards of cleaning are signed off by a senior person within the clinical area to confirm they meet the requirements.
- All clinical staff receive training on infection prevention and control which includes decontamination and cleaning of equipment. Compliance with infection control training at the end of 2017/18 was 93%.
- Within the current linen policy it clearly states the Trust will ensure that throughout the collection and distribution functions Used Linen is segregated from Clean Linen. Monthly service user meetings are held with the clinical teams, where the laundry quality and satisfaction are discussed and documented. Quarterly contract performance review meetings are held with the supplier, where it is evidenced the compliance with the agreed KPIs.
- Within the current linen policy it clearly states the colour coding of bags to be used for dirty and infected linen.
- The current contract linen provider adheres to the current Legislation with regard to supply of Laundry services to the NHS as stated in HSG (95) 18 and the 3 parts of document HTM 01-04
- All laundry is taken off site to be cleaned by the linen provider for all waste and laundry for VHF.

Compliance criterion 3.

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

- Joint specialist pharmacist/microbiologist ward rounds undertaken to all relevant areas weekly. These include auditing antimicrobial prescriptions for compliance with the anti-infective guidelines, providing advice on the management of all infections where appropriate and applying the Start Smart Then Focus (SSTF) principle to all prescriptions. Application of the Sepsis Six toolkit ensures patients with sepsis are treated promptly and a the review team follow them up to ensure therapy is narrowed where possible.
- Antimicrobial Stewardship (AS) Group meet quarterly, and discuss, compliance with guidelines, expenditure, anti-infective incidents, guidelines, Anti-Microbial Resistance (AMR) CQUIN targets & and other items relating to antimicrobial use. Membership includes the medical director, DIPC, consultant microbiologists, paediatric ID, senior clinicians representing the divisions, representation from the NMPs, representation from Infection Control, director of pharmacy and the anti-infective specialist pharmacists. AS activity is reported monthly to the trust board, divisional leads and consultants throughout the trust.
- The Trust has an Anti-infective prescribing Policy and guidelines covering all the points below. These are available on the trust intranet (dedicated anti-infective pages) and the Microguide app for all users. Compliance is monitored weekly as detailed above. Regional and national benchmarking is undertaken; the Trust participates in an annual Point Prevalence Audit within the South West Region, there is also a regional Antimicrobial Stewardship Group that meet 6 monthly. National benchmarking is available on the NHSE Fingertips website, UHB submit data for inclusion.

- Microbiology systems provide readily accessible computer data and telephone advice both in and out-of-hours on microbiological data and susceptibility results.
- Trust induction covers expectations and sign-posting to guidelines etc. for those prescribing antimicrobials. FY1s are provided with a teaching session that covers antimicrobial resistance, common infections and the rationale for stewardship practices.

Compliance criterion 4.

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

- National information is utilised for patient and public information on infection control where appropriate.
- Where local information is produced this is submitted to the patient experience lead for the Trust for appropriate approvals.
- Posters, leaflets and signage is used to promote good hand hygiene practices, inform patients and visitors if there are particular requirements for infection control and also to provide public health information and advice.
- Information is also available on the Trust website and relevant information is sent out using social media.
- Patient confidentiality is maintained at all times and information is only shared with other organisations in accordance with Data Protection principles and the GDRP Regulations.

Compliance criterion 5.

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

- The Trust infection control team work closely with partnering organisations including Public Health England, the CCG and other healthcare providers to ensure and information regarding infection within the local area is known and action is taken accordingly.
- Public Health England are informed of any notifiable infection and any outbreaks or serious incidents are notified to Public Health England and the CCG.
- The responsibility for infection control and prevention is devolved to all groups in the organisation and Trust wide representation at the alternate monthly infection control group ensure timely and effective cascading of information to all areas.

Compliance criterion 6.

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

- All staff receive infection control training on induction to the Trust and this includes volunteers.
- In addition, the Trust adheres to the UK Core Skills Training Framework on all training including updates.
- Infection control is core within all job descriptions for staff employed within the Trust.
- Additional training and competencies are in place for skills such as Aseptic Non Touch Technique and urinary catheterisation, for example.

Compliance criterion 7.

Provide or secure adequate isolation facilities.

- The Trust has policies in place for the appropriate isolation of patients as required.
- There is a ward that can be converted into a cohort ward should this be required in the situation of an outbreak.
- The Trust's estates strategy has seen an investment in facilities for isolating patients. The Trust has a number of standard side rooms plus specialist ventilation rooms. Specialist ventilation rooms are required for patients with certain infections such as those that are airborne or for patients who are highly immunocompromised (Department of Health, 2013).
- The table below shows the breakdown of the isolation facilities across the Trust by Division/location:

Division/location	Specialist ventilation	Ensuite side room	Room only (no ensuite)
Medicine	2	56	3
South Bristol Community Hospital	2	28	
Surgery	5	54	6
Women's		6	17
Specialised services	7	48	3
Children's	4	42	25

Compliance criterion 8.

Secure adequate access to laboratory support as appropriate.

- Microbiology is accredited to UKAS ISO:15189 standard.
- Appropriate policies and procedures are in place.

Compliance criterion 9.

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

- The Trust has policies within each of the areas specified within this criterion and audits are undertaken where appropriate to identify compliance.
- All policies are available to staff on the internal website and are updated in accordance with their requirements.
- All new or amended Trust wide infection control policies are approved through the infection control group prior to being published.

Compliance criterion 10.

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

• All staff can access occupational health services or access appropriate occupational health advice between 08:00 – 17:00 with advice line being open 08:30 – 15:30 5 days per week.
• Occupational health policies on the prevention and management of communicable infections in care workers are in place
• OH have in place risk assessment categories that are applied at time of commencing work via the Health and Wellbeing process. All vaccines are free of charge
• In keeping with Occupational Health recommendations an independent confidential recording system is in place.

•
• All risks are assessed pre-employment and clearance is based on the Department of Health Guidance.
• Those staff at constant risk due to non-conversion are recalled automatically annually.
New staff are seen pre-employment and recommendations made. In employment they are recalled for blood testing as required.
• Occupational Health liaised with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed; Clinicians see each affected staff member and monitor as needed
• a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids is undertaken.
• There is a 24 hour service for the management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call infection prevention and control specialists.
• Arrangements are in place for the provision of influenza vaccination for healthcare workers where appropriate**.** This year the Trust vaccinated 73% of front line staff.

3. Health Care Associated Infections

3.1 Overview

University Hospitals Bristol NHS Foundation Trust continues to take part in mandatory surveillance of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemias, Methicillin-Sensitive Staphylococcus aureus (MSSA) bacteraemias , *E. coli* and Clostridium difficile cases.

To support the halving of healthcare-associated Gram-negative bloodstream infections (GNBSI) by March 2021, in September 2017, NHS Improvement extended mandatory reporting to include *Klebsiella* species and *Pseudomonas aeruginosa*. Together with *Escherichia coli (E. coli)* these organisms account for more than 70% of all healthcare-associated GNBSI. GNBSI continue to increase in England and cause significant morbidity and mortality in our patients. University Hospitals Bristol reported on *Klebsiella* species and *Pseudomonas aeruginosa* GNBSIs retrospectively from 1 April 2017 to Public Health England's (PHE) data capture system (DCS).

MRSA bacteraemias and laboratory detected *C. diff* toxin results are reported monthly via the Public Health England healthcare associated infections Data Capture System (HCAI DCS) website and signed off on behalf of the Chief Executive.

3.2 National Limits

MRSA
There is a zero limit for MRSA bacteraemias. In 2017/18 the Trust exceeded the threshold with 5 MRSA bacteuremias of which 1 was due to a vascular access ~~device .~~ device. All Trust attributed MRSA infections are reviewed by the IPCT, a bacteraemia infection review is completed and an action plan is generated and is detailed within the Datix system for each case..

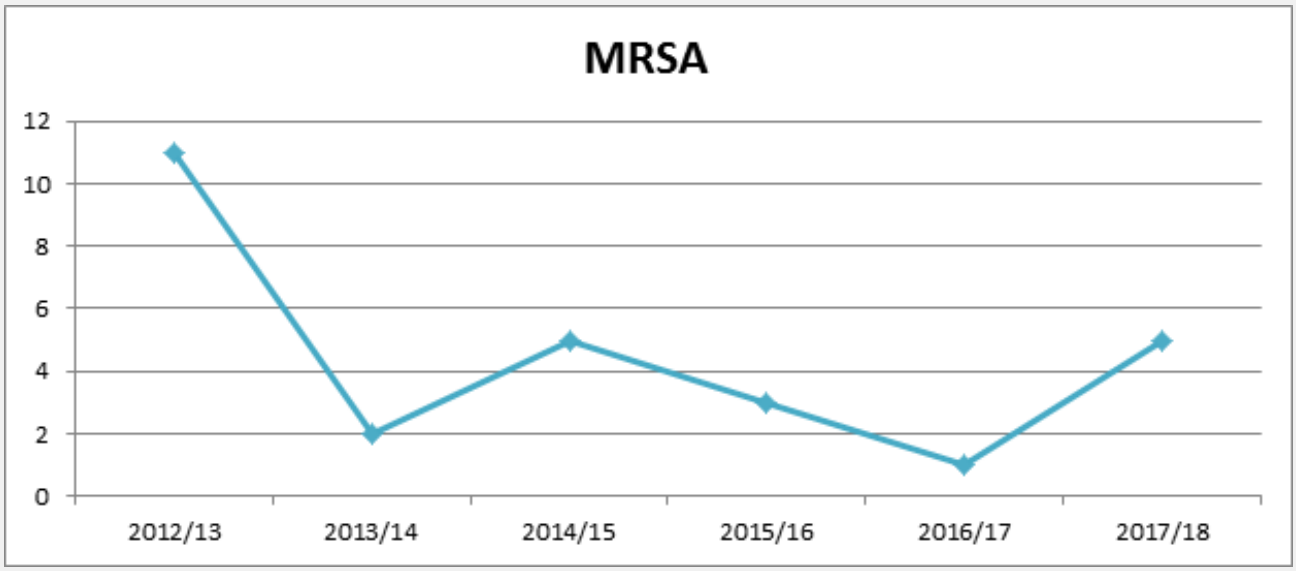
There were no common themes between the cases however action has been taken to share the learning.

Action taken:

- LASER posters produced and shared within Divisional governance processes
- Learning shared within divisional reports to the Infection Control Group
- Learning included within ward based safety briefings

Updated Trust wide training programmes

- Documentation reviewed and updated
- Amended review paperwork to improve investigating and reporting
- Clinical procedure for screening updated



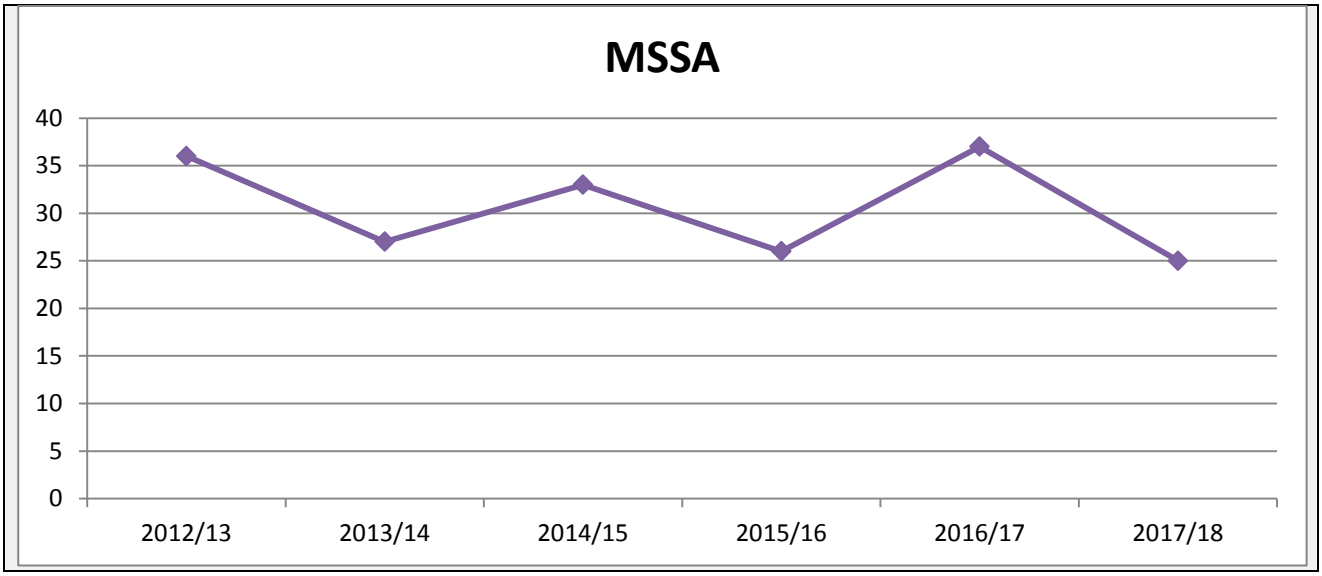
MSSA

NHS England set UH Bristol a limit of up to 28 cases of MSSA for the financial year 2017-2018. The Trust performed within target in this area in 2017/18 by remaining within the set threshold of Trust apportioned cases.

There were 25 reported cases, 6 out of these cases were Healthcare associated infections related to vascular access devices. This has reduced from 2014/2015 where there were 11 cases of MSSA which were related to vascular access devices.

All Trust attributed MSSA infections are reviewed by the IPCT, a bacteraemia infection review is completed and an action plan is generated and is detailed within the Datix system for each infection.

There has been an increase in patients being admitted with an established MSSA infection from the community. Six outpatients were admitted from the community with an MSSA Bacteraemia from a vascular access device.



C.Diff

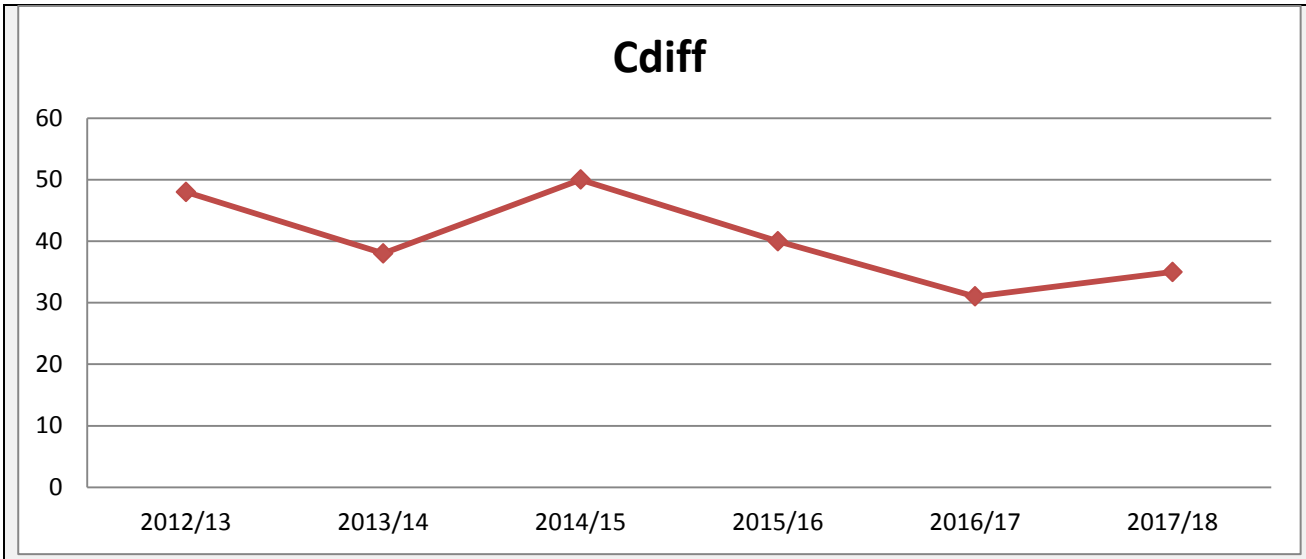
The limit set for C.Diff infections by the CCG for 2017/18 was 45. The Trust performed well in this area with 33 Trust apportioned C.Diff infections. Of those, 11 were determined to be due to a "lapse in care". The graph below shows there has been a reduction in C.Diff at UHBristol over the last 5 years.

There were clear themes for improvement in where "lapses in care" were identified. These were as follows:

- Incomplete documentation (8/11 cases)
- Delays in sending stool samples (5/11 cases)
- Inadequate scores or incomplete hand hygiene audits (3/11 cases)
- Inappropriate antibiotics prescribed (3/11 cases)

Action taken:

- Documentation reviewed and updated
- Bespoke ward based training on infection control delivered incorporating learning
- Updated Trust wide training programmes
- Amended review paperwork to improve investigating and reporting
- Hand hygiene audit tool under review to update to a tool with improved reporting mechanisms
- A dashboard is being developed to improve oversight of infection control and support early intervention
- Joint specialist pharmacist/microbiologist ward rounds to most wards at least weekly, auditing antimicrobial prescriptions for compliance with the Anti-infective Guidelines



The table below shows the breakdown of C.Diff infections by Division

	Medicine	Specialised Services	Surgery	Women's & Children's	No value	Total
Decision pending	1	0	0	0	0	1
Lapse in care	8	2	0	1	0	11
No lapse in care	5	4	5	7	0	21
No value	0	0	0	0	0	0
Total	14	6	5	8	0	33

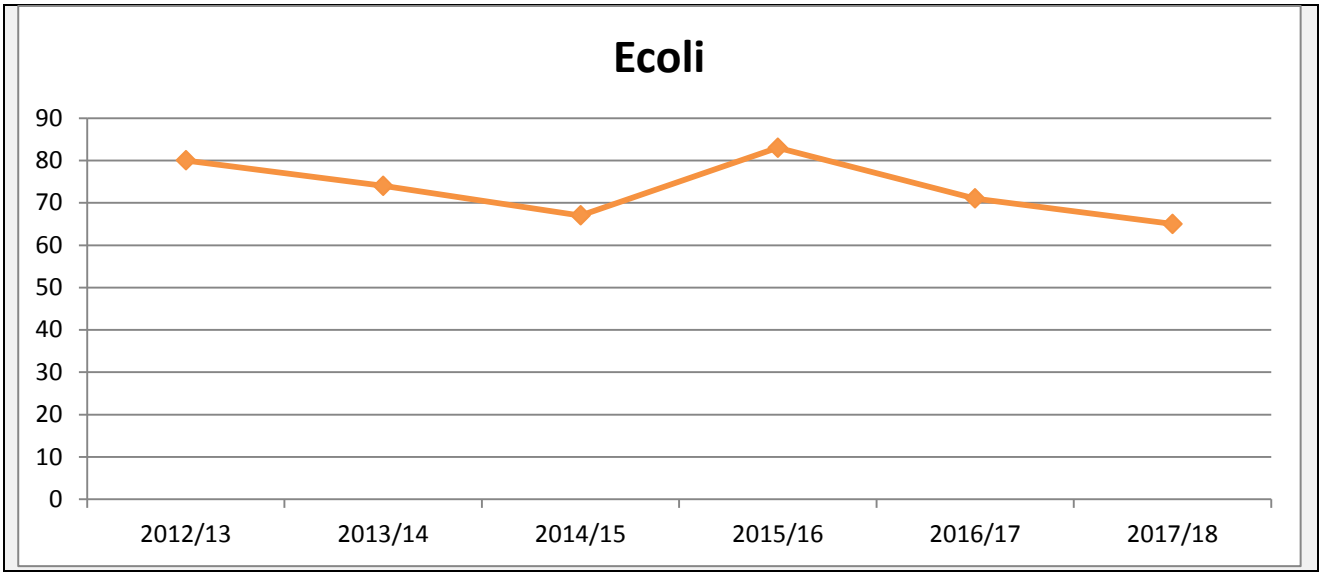
Gram negative infections

In 2017 Public Health England introduced mandatory surveillance of E.Coli, Pseudomonus and Klebsiella. In 2017/18 there was a BNSSG healthcare community wide target for a 10% reduction in E.Coli infections. There was a reduction in rates of E.Coli in the latter months of 2017/18 at University Hospitals Bristol. There are no limits at present for Pseudomonus and Klebsiella.

The IPCT complete the mandatory paperwork on the National system for the above. Work is underway to look at how we can review the learning and share good practice.

E.Coli

NHS England strategy in 17/18 was focussed on provider organisations working with clinical commissioning groups to reduce E Coli blood stream infections by 10% across the whole healthcare community based on 2016 data. This work is ongoing and UHBristol work jointly with the CCG and other NHS organisations to deliver reductions in this area. UHBristol have noted a 24% reduction in E coli blood stream infections since 2016.



Klebsiella and Pseudomonas

Through 2017/18 the Trust has been collecting data on these infections with a view to benchmark any improvements against this in the next year.

3.3 Surgical Site Surveillance

The Trust captured all the categories possible within the surveillance programme, except for laparoscopic work. This includes cardiac patients, GI patients and abdominal hysterectomy patients, hip fracture operations and paediatric cardiac patients

The methodology from Public Health England is used and data is entered onto the National database which then produces reports and figures on a quarterly basis. The surveillance team follow up all patients at 30 days post discharge. This process captures the whole patient journey and gives data on post discharge infections and readmissions to the trust, or other trusts, with infections of the surgical site.

4. Incidents, risks and outbreaks

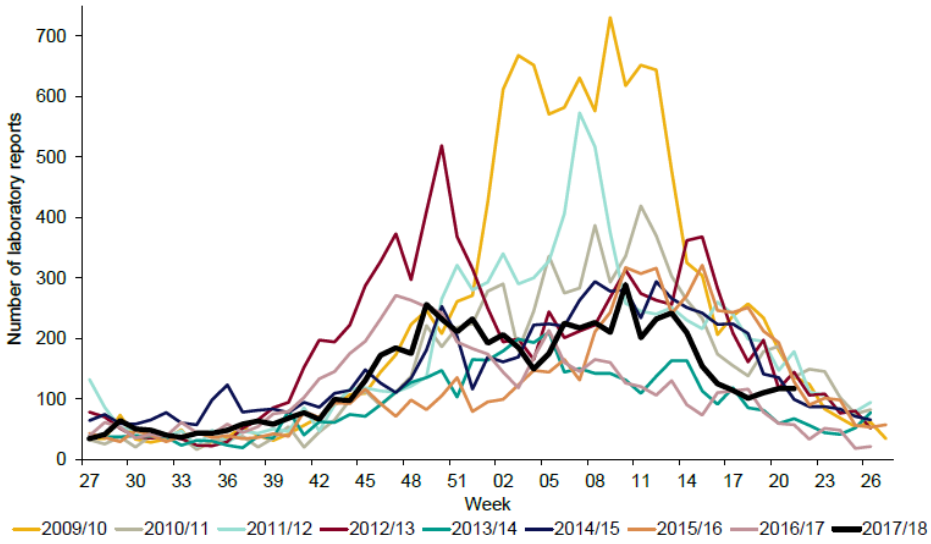
During 2017/18 there were no formal outbreaks declared. The Trust has had some bay and bed closures due to infections. All infection controls including incidents of outbreaks are reported via the Datix incident management system.

The Trust Board review the corporate risk register quarterly. There are 21 risks on the corporate risk register one relates to infection prevention and control Risk ID 2242 risk of non-compliance with statuatory requirements in relation to water safety.

4.1 Norovirus Activity

Norovirus cases are proactively managed with involvement from the infection control team. Patients are managed and tested in accordance with local policy, reporting cases through the Public Health England hospital norovirus reporting system. The infection control team support the re-opening of areas as appropriate.

There was an increase in Norovirus nationally in 2017/18 from the previous year as shown in the chart below.



Seasonal comparison of laboratory reports of norovirus 2009/10-2017/18 (England and Wales): Public Health England (2018) National norovirus and rotavirus Report, Summary of surveillance of norovirus and rotavirus, 7 June 2018 – Week 23 report (data to week 21).

The table below shows over the last two years ward closures, bay closures and bed days lost due to Norovirus at University Hospitals Bristol. Although there were more bays closed this year as opposed to last year the number of bed days lost was less due to proactive management of patients led by the infection control team. This increase in closures reflects the National picture of high numbers of patients with norovirus from the following year.

	Wards Closed	**Bays Closed**	**Bed days lost**
2016-17	4	14	191
2017-18	4	18	108

4.2 Influenza

In winter 2017/18 there were relatively low numbers of confirmed flu patients at University Hospitals Bristol in comparison with other NHS organisations.

The Trust undertook a pilot of on-site flu testing to obtain rapid results in order to manage patients and hospital flow efficiently. A review of benefits of this on productivity is currently underway with a view to implementing this in 2018/19 winter season.

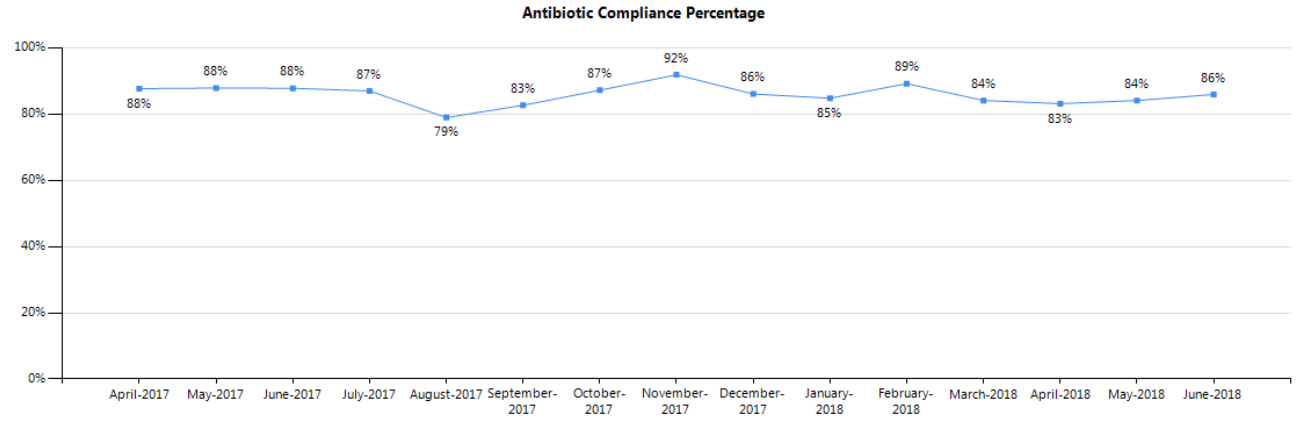
5. Antimicrobial Stewardship

The term 'antimicrobial stewardship' is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' (National Institute for Health and Care Excellence (NICE) Guidance NG15 (2015)). Antimicrobial Stewardship operates across all clinical areas of UHBristol as part of the Trusts antimicrobial stewardship programme.

The activity of the antimicrobial stewardship team is monitored through the anti-infective steering group, chaired by the medical director. The group has continued to meet quarterly throughout 2017/2018 regularly reviewing compliance, expenditure, CQUIN delivery, incident trends, guideline review, audit and education and training policy, in line with the recommendations from the Department of Health on delivering a robust antimicrobial stewardship programme.

5.1 Prescribing compliance

The Anti-infective Pharmacy team has continued to work with the microbiologists and paediatric infectious diseases team reviewing antimicrobial prescribing across the Trust. Compliance continues to vary. The increase in stewardship rounds on AMU has been identified as a reason for this as there is more data collection very early on in the patient journey. The Anti-infective Pharmacy team are working with the AMU team to rectify this.



In February the Trust took part in the annual regional point prevalence study which showed UHBristol to be the best performing trust achieving the highest level of compliance to antimicrobial prescribing.

In March The Anti-infective Pharmacy team changed the way we record our stewardship reviews were recorded. They are now entered on to medway in a clinical note attached to the patient. This allows clinicians to see when the prescription has been reviewed, any recommendations made and which member of the team carried out the review. This development will increase transparency in our review process.

5.2 Antimicrobial CQUIN 2017/2018

The Trust managed to achieve the three CQUIN targets for reduced antibiotic consumption. The final figures were:

- Reduction in total antibiotic consumption – 2.1% reduction (target 2%)
- Reduction in piperacillin/tazobactam consumption – 18.3% reduction (target 1%)
- No increase in carbapenem consumption – 0.3% reduction

The targets for 2018/19 are:

- Total antibiotic consumption: 1% reduction
- Carbapenem consumption: 2% reduction
- Increase our use of narrow spectrum agents, based on WHO AWARE list (see below). The aim is to use more of the 'access' group and less of the 'watch' and 'reserve' groups.

6. References

Department of Health (2013) Health Building Note 00-09: Infection control in the built environment.

Health and Social Care Act (2008), Available at: https://www.legislation.gov.uk/ukpga/2008/14/contents (Accessed 5 June 2018)

National Institute for Health and Care Excellence (NICE) Quality Standard 113 (2016) Healthcare-associated infections, NICE

National Institute for Health and Care Excellence (NICE) Guidance NG15 (2015) Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use, NICE

Public Health England (2018) Official Statistics - Norovirus and rotavirus: summary of surveillance 2017 to 2018, Available at: https://www.gov.uk/government/statistics/norovirus-national-update (Accessed 11 June 2018)

Cover report to the PublicTrust Board Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	15
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Revalidation and Medical Appraisal Report**		
Author	Frances Forrest DMD (interim) Revalidation		
Executive Lead	Matt Joint, Director of People		
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 that Medical Revalidation processes are operating satisfactorily

Key issues to note

- Revalidation of a doctors' licence to practice has now been operational for five years. The second cycle of Revalidation has commenced, meaning some doctors are re-licensing for the second time
- 42 recommendations of revalidation were made in 2017/2018. 7 doctors were deferred. No doctors were considered to have non-engagement with the revalidation process. One doctor showed signs of non-engagement but on further investigation was under-performing and was referred to the GMC as a Fitness to Practice issue. This case is on-going.
- The reasons for deferral are outlined in the full report.
  Deferral appears to be more common in the Clinical Fellow group. This group appear to be less familiar with their responsibilities for revalidation. Appendix 1 in the full report outlines the issues related to this group of doctors

❖ The contract for the e-portfolio system for medical appraisal (currently Premier IT) is out to tender. In late 2017, UHBFT and NBT started a joint tender for this process. The process includes WGH as an observing partner. Conclusion of the tender is projected to be at the end of September 2018.
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)**

Annual Quality Assurance Report for Appraisal and Revalidation University Hospitals Bristol NHS Foundation Trust 2017-2018

Responsible Officer: Dr. Mark Callaway, Interim Medical Director

Interim Deputy Medical Director-Revalidation: Dr. Frances Forrest

Report produced by: Dr. Frances Forrest

Time period covered in report: 1st April 2017 – 31st March 2018 (Year 5 of the first 5 year Revalidation cycle)

Introduction

Since April 2013 all medical practitioners are required to revalidate their licence to practice with the General Medical Council (GMC) every five years. Each medical practitioner is formally linked to a Designated Body by the GMC, such as the Trust at which they are employed, and revalidate by engagement with governance processes operated by the Designated Body for this purpose. Revalidation is achieved through successful annual appraisal and review of patient and colleague feedback information. The process requires the Trust Responsible Officer (RO) to make a positive revalidation recommendation to the GMC when all professional practice information is taken into account. This report summarises the activity related to Medical Revalidation and appraisal for the year 17/18 and highlights current issues in the process that are the focus of work for the Revalidation office.

Activity levels 2017/18

Revalidation

The table below summarises the numbers of positive recommendations, deferrals and notices of non-engagement to the General Medical Council made by the Trust's Responsible Officer since the initiation of the GMC medical revalidation process in April 2013.

	Year 5 Apr17-Mar18	Year 4 Apr16-Mar17	Year 3 Apr 15-Mar16	Year 2 Apr14-Mar15	Year 1 Apr13-Mar14
Number of doctors for whom UHBristol is the designated body	747	668	665	556	503
Number of positive recommendations for revalidation	42	31	187	194	74
Number of deferrals	8*	6	23	24	4
Number of notices for non-engagement	0**	0	0	0	1

*Actual deferrals 7. At the time of interim RO handover in September 2017 the GMC suspended our ability to make recommendations for one week while the interim RO was recognised. This resulted in an admin error on the part of the GMC.

** One Clinical Fellow was showing signs of non-engagement with revalidation. Investigation led to a fitness to practice referral to the GMC in relation to poor surgical performance rather than notice of non-engagement

When revalidation was introduced all medical practitioners were required to revalidate within the first three years of its introduction (April 2012 – April 2015). Consequently, the number of doctors revalidating was much higher in the first three years than has been seen in 2016/17 and 2017/18. As we enter the second cycle of revalidation in 2018, numbers of doctors revalidating is rapidly increasing.

Appraisal rates

The figure below shows 17/18 appraisal rates by grade of medical practitioner. This year the presentation of this data differs slightly from previous Board reports as it is now in line with reports sent to NHSE.

Grade of practitioner	Total Number	Appraisals in year	% of doctors undertaking appraisal by grade 17/18. In () 16/17
Consultants (excludes locums)	502	421	83.8 % (82%)
SAS	39	24	61.5% (78.5%)
Locally employed Doctors (Clinical Fellows) and short term contracts (locums at all grade)	202	112	55.4 %
Total number	743	557	74.9 % (77%)

Note the total number of doctors recorded (743) is different from those attached to the Designated Body (747). This discrepancy is accounted for by 4 doctors who are appraised externally to the Trust but maintain a connection to us.

Quarterly appraisal reports are submitted on behalf of the RO to NHS England by the AMD for Revalidation. These reports contain detailed information on appraisal rates for doctors of different grades.

The change in monitoring appraisal compliance to 12 months, previously 15 months, began in summer 2016. As a consequence UHB appraisal consultant compliance rates reduced from 92.7% to 82% in the period 15/16 to 16/17. Despite a continuing programme of work to address this, only slight improvement has been demonstrated in consultant appraisal rates. Closer inspection of this data reveals that the vast majority of consultants who fail to appraise within 12 months slip by 1-2 months.

SAS doctors are part of the permanent workforce. The significant decrease in appraisal rates in this group can only be explained by anecdotal reports of and insufficient time to undertake administration responsibilities within job plans. The AMD for revalidation will undertake a focused piece of work to explore this going forward.

Within the Locally Employed Doctor group, Clinical fellow compliance remains poor. This is due to a number of issues:

a) Failure of individual doctors to understand responsibilities for re-licensing (contributing factors include inexperience, no previous appraisal experience – new to the UK or previously in training posts)
b) Issues with tracking and communicating with this rapidly expanding group of doctors
c) Limitations of the Electronic Staff Record (ESR) in recognising doctors on honorary or zero hours contracts
d) Lack of central administration or education point of contact for this group of doctors (i.e. no equivalence to PGME for trainees)

A document (Appendix 1) summarizing the challenges of locally employed doctors was presented to the Medical director team highlighting these issues

The accuracy of the data has improved. Projects with Medical Human Resources (MHR) to improve data flows further have started but stalled currently due to the more acute needs to reorganize processes around recruitment. The use of Allocate software for junior doctor rotas may provide a better tracking solution than ESR in the future.

The issue of improving Clinical Fellow compliance with appraisal remains a high priority for the AMD in Revalidation but exposes a new administration burden for managing this group of doctors.

Activity Levels 2017/18 Exception reporting 1: Deferred Recommendations

The table below lists the reasons for deferral of a revalidation recommendation for each of the seven practitioners deferred in 2017/2018

	Grade	Date of Deferral	Reason	New Revalidation date	Outcome
1	Consultant (locum)	2/6/2017	Insufficient evidence: Deanery failed to complete paperwork on exiting training	3/10/2017	Revalidated 26/6/2017
2	Consultant	25/7/2017	Insufficient evidence: Deanery failed to complete paperwork on exiting training	28/11/2017	Revalidated 23/10/2017
3	SAS	4/8/2017	Return from long term sick & performance monitoring	3/8/2018	Revalidated 3/8/2018
4	Clinical Fellow	5/9/2017	Insufficient evidence: Deanery failed to complete paperwork whilst in post	5/3/2018	Revalidated 5/12/2017
5	Clinical Fellow	3/10/2017	Insufficient evidence	16/2/2018	Revalidated 25/10/2017
6	Consultant (locum)	25/10/2017	New to NHS No evidence of colleague or patient feedback	2/3/2018	Revalidated 2/11/2017
7	Clinical Fellow	6/3/2018	Insufficient evidence- back to work following GMC suspension	6/9/2018	Revalidated 26/6/2018

Note: “insufficient evidence” is a GMC defined category chosen by the RO when it is not possible to make a recommendation for Revalidation based on the evidence the individual has submitted to the Revalidation Office. In most instances it is expected that the individual will go on to revalidate within a period of 6-12 months and it is not usually associated with concerns about the individual doctor. Common reasons for insufficient evidence are doctors being new to UK practice and not having appraised before, or doctors having significant absences from work (e.g. maternity leave) and then returning to a non-training post such as a clinical fellow role.

This year it was noticed that several doctors’ paperwork for revalidation was not completed by the Deanery (their previous Designated Body) before they disconnected and joined UHBFT. We believe this reflects the volume of administrative work within the Deaneries in completing final ARCP and revalidation recommendations in combination with poor understanding of individual doctors of their responsibilities with respect to re-licensing.

2: Non Engagement

One clinical fellow did not show evidence of engagement with revalidation whilst employed by the Trust. Concerns over the standards of practice of this doctor were subsequently flagged through Divisional governance processes. This doctor was referred to the GMC through the Fitness to Practice route rather than failure to engage in Revalidation after they had left UHBristol. The case is ongoing with the GMC.

Management of the appraisal process

E-portfolio system

Doctors on permanent contracts use an e-portfolio system for collection of their appraisal information. Currently the Trust’s contract is with Premier IT. Those on non-permanent contracts use a MAG (Medical Appraisal Guide) form which is an electronic form recognised by UK Designated bodies and “transportable” between hospitals.

The contract with premier IT started in 2013 and was extended for two years under single tender action in early 2017. This year UHBFT have joined with NBT to undertake a joint tender for the e-portfolio system. The joint tender was extended to include Weston general hospital and AWP. In June 2018 AWP decided not to continue with the joint tender. WGH continues as an observer in the process with consideration of aligning their systems and processes in the future.

UHBFT continues to work closely with NBT in the tender process. This is a seen as an opportunity to work together and to align our revalidation policies as was highlighted as

a potential area for joint working at the NBT/UHBFT clinical strategy event (Appendix 2).

The tendering process should conclude at the end of September 2018 with implementation of a new system (or renewal with the current provider) scheduled for April 2019.

Governance and Quality Assurance

Governance

The Medical Director's Team maintains a list of potential low level Governance concerns. This is reviewed regularly for revalidation purposes. Doctors for whom the concern may cause doubt about the RO's ability to make a recommendation for revalidation are invited to discuss the issues with the RO and AMD. Further escalation of concerns to the GMC can be made if necessary. No referrals were made to the GMC through this route in 17/18.

Quality Assurance

The last NHS England Framework of Quality Assurance independent verification process took place in April 2016. It is unlikely we will be reviewed by NHSE until 2020.

Audit Southwest commenced a Medical Staff Appraisals Internal Audit in June 2018

Summary of fifth Year of Revalidation at UHBristol

UHBristol employs high performing and highly motivated doctors. This continues to be reflected in the high quality of evidence submitted for revalidation. Work continues to try and improve the compliance with 12 monthly appraisal target (introduced summer 2016) rather than the previous 15 month target.

In April 2018 we entered the second cycle of Revalidation. This has led to a sudden rise in the number of doctors due to revalidate and an administrative burden associated with this

The number of locally employed doctors (Clinical Fellows) continues to rise and is a reflection of the need to fill gaps on the junior doctors' rotas secondary to the new juniors doctors contract. The administrative workload to monitor and support this group with appraisal and revalidation is escalating and needs a more comprehensive review.

A joint tender project is underway with NBT to replace or renew the electronic portfolio system used for medical appraisal

Supporting Locally Employed Doctors in UHBristol

The case for clinical and administrative support for Locally Employed Doctors (LED's)

- Non-consultant , non-training (NCNT) doctors consist of two groups, SAS doctors and Locally Employed Doctors. The SAS grade is no longer being developed. SAS grades are on national terms and conditions and being replaced by LED's on local terms and conditions. LED's contribute to junior doctor rotas in and out of hours and help to provide clinical care of patients at UHB.

- The numbers of LED's employed by UHBristol is rising (now 198 recognised through ESR data). The majority are have regular working hours with short term (6-12 month contracts) on local terms and conditions. However, some are on zero hours contracts providing flexible workforce support and requiring support from the Trust in line with their counterparts

- LED's are a very heterogenous group of doctors, many coming to UHB with no previous NHS experience

- Irrespective of their career background, LED's require educational support, training, career development and support for relicensing with the GMC. Due to the heterogenous backgrounds this can be time consuming compared to doctors in training who follow well prescribed and monitored career pathways.

- In UHB doctors in training receive this support through Deanery funding which is manage through the PGME department (appendix A&B)

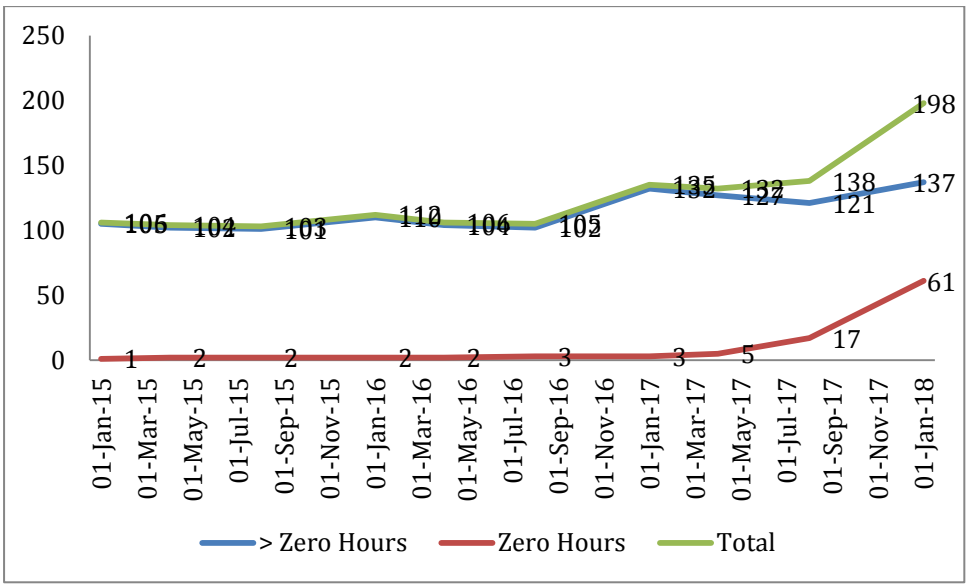
- In UHB, SAS doctors receive support through a specific SAS tutor and PGME (appendix A)

- There is no central monitoring point or senior doctor responsible for LED's in UHB

The National Association of Clinical Tutors (NACT UK) published a document in October 2017 which highlights the need for increasing support to all locally employed doctors (1).

The numbers of LED's employed by UHBristol are rising primarily following the implementation of the new junior doctors contract (reduced hours and changes to rota patterns have exposed rota gaps). The rising number of LED's also reflects poor workforce planning nationally over the last 5-10 years.
In 2014 in the Severn region 19.1% of of the junior doctors workforce were LED's (1).

The numbers of LED's employed by UHB is shown below. There has been a significant trend up in both LED's with contracted hours and those with zero hour contracts since the start of 2017



Clinical fellows are a heterogenous group of doctors, many coming to UHB with no previous NHS experience. They vary considerably in experience, some working at junior level (up to ST3). Others have much more experience and are gaining experience outside of a training programme at peri-consultant grade.

All LED's require support for:

- Educational supervision
- Teaching and training
- Personal development
- Governance issues/complaints when they occur
- Terms of employment/rota monitoring
- Annual appraisal and revalidation

Comparison of funding for doctors in training versus LED's

In appendix A&B the funding to support doctors in training is described.

- There are approximately 500 doctors in training in UHB.

Note: there is historic funding for SAS tutors and some administrative support.

- There are approximately 40 SAS doctors employed by UHB

To date there is no funding identified to support a clinical lead or administrative role for LED's. Currently some tasks are absorbed into the work of PGME and

there is ad hoc across the Divisions. There is no central monitoring point or senior doctor responsible for LED's in UHB.

- There are currently 198 LED's who have variable contracts with UHB.

Specific problems in UHB

The Guardian for safe working and the DMD for Revalidation have both identified problem with the management and supervision of LED's. Problems can be broadly categorized into two groups

- Contact and tracking
- Governance and safety

Contact and tracking

- short term contracts and zero hours contracts means ESR is often inaccurate and an unreliable source of employment information
- there is no central database of LED's
- LED's often don't use UHB email rely on home email for contact
- Divisions often have little or no information about transitory and zero hours LED's
- LED's on zero hours often connect to UHB for re-licensing purposes although providing little clinical work for the hospital
- LED's on honorary contracts don't appear on ESR yet connect to UHB for re-licensing purposes

Governance and safety

a) LED's often don't revalidation requirements (particularly if new to the NHS)
b) Annual appraisal rates are consistently poor in LED group despite initiatives to improve. LED appraisal rate 2015/16 =36% and 2016/17 = 63%
c) Appraisal and educational support offer opportunities for LED's to reflect and discuss incidents involving patient safety.
d) A recent increase in the number of LED's without the primary GMC requisite for the English language assessment has been noted. LED's coming in using the alternative SELR route has been noticed in W&C due to difficulties in recruitment.

Solutions

1) Create a LED tutor role who works alongside the SAS tutors
2) Provide administrative support through PGME funded by UHB

Frances Forrest
DMD Revalidation
7/2/2018

References

1) NACT UK. October 2017 Supporting Locally employed doctors (LEDs) across the UK

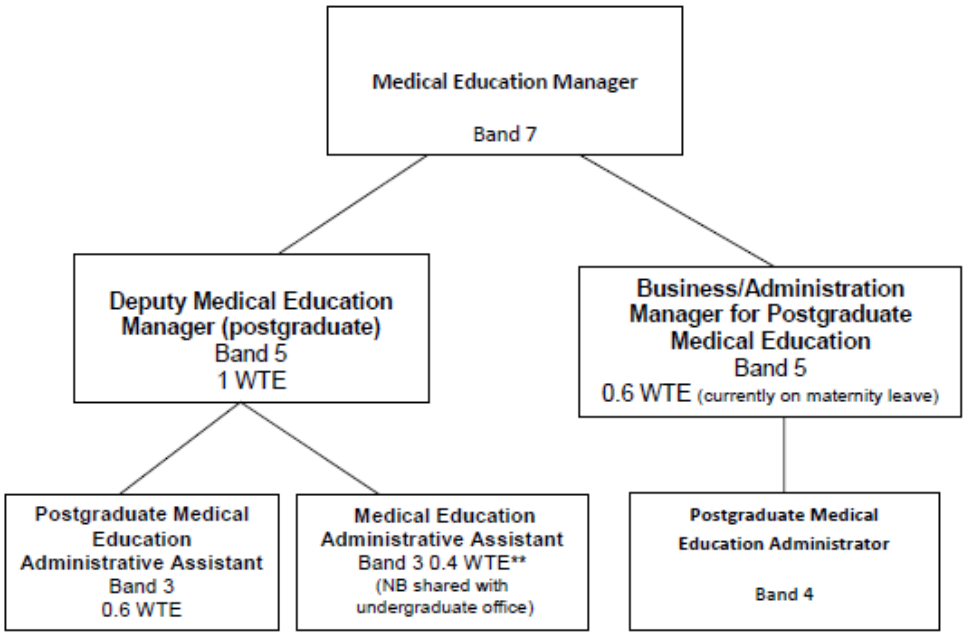
Appendix A: funded PA's in PGME

Funded Medical Support for PGME

Post	Total PA support
Director of Medical Education (1)	3PA's
Foundation Programme Directors (3)	3PA's
Specialty Tutors (5)	5PA's
SAS tutors (2)	1PA
Mentor and career supporter (1)	2PA's

In addition SPA is recognised within consultant job plans across all divisions for educational supervision of doctors in training.

Appendix B: administrative support to PGME



Revalidation of doctors at UHBFT and NBT -proposal for joint project to align services

- UHBFT and NBT are sister trusts in Bristol of similar size
- Each hospital is recognized as a Designated Body for Revalidation purposes with the GMC
- The administration and management of Revalidation for doctors is different on each site. Currently NBT achieves above 90% compliance (to 12 month target) for consultant appraisal. UHBFT achieve 83%

- There are a number of permanent doctors who are contracted to work in both hospitals or who move over time from one hospital to the other; aligning policies creates a uniform approach and message about re-licensing and may help to improve understanding and engagement with Revalidation
- Working together, the hospitals could develop and share training programs for appraisers and appraisees. This would provide assurance that the quality of appraisers and appraisals was maintained on each site

RO responsibilities are considerable and assurance that doctors are working safely is at the heart of Revalidation. Ensuring that information about doctor's practice is communicated between RO's and, that doctors include that information for discussion and reflection in appraisal is imperative.
Currently there are two joint projects involving NBT and UHBFT Revalidation teams that help support this.

- Re-tendering for the e-portfolio system for appraisal (both sites use the same system currently and intend to in the future)
- A review of information flows about doctors performance in private practice locally (The Spire)

This work has demonstrated to the DMD's for Revalidation on each site the value of joint working:

- Sharing information and experience
- Agreeing best practice
- Streamlining systems
- Maintaining quality

In summary, a joint project focused on Revalidation could;

1) Review the management and administration processes for Revalidation on each site and adopt an identical approach
2) Align notices and policies for Appraisal and Revalidation
3) Share training programs; appraisers and appraisees
4) Consider appointing a joint manager to oversee the administration Revalidation on each site

FCF Interim DMD – Revalidation UHBFT 23/5/2018

Cover report to the Public Trust Board. Meeting to be held on 27 September 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, 27 September 2018
Report Title	**Healthier Together Sustainability and Transformation Partnership Update**		
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

This is the regular (bi-monthly) update report provided to Partner Boards on the priorities and status of the Healthier Together Sustainability and Transformation Partnership (STP)

Key issues to note

Since the last report in May, the Healthier Together programme has successfully completed a collaborative approach to the annual planning round. Planning work has been led by the System delivery oversight group (SDoG). The system made good progress in 2017/18 – improving the overall financial and key performance positions against 2016/17.

The SPT has run a major conference for partners and close external stakeholders which has

accelerated the development of plans in 10 key areas that will make a significant difference to citizens and service users across our area. This was attended by almost 300 people from across the partnership.

In the November 2017 Budget the Government announced an additional £4bn of Capital funding for the NHS for the period up to 2022/23. Expressions of Interest were invited by the Healthier Together team from acros the region with a deadline of 18 May 2018, and 35 schemes were submitted. Proposals are now being reviewed by NHSE/I colleagues as part of a national process. Successful bids are likely to be announced in the autumn.

Recommendations

Members are asked to:

- **Note** the Report.
- **Note** the emerging forward programme.

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)**

Healthier Together Sponsoring Board meeting paper

Agenda Item: 3

Title	**Healthier Regular Report to Partner Boards**
Date of meeting	2 August 2018
Author	Robert Woolley / Julia Ross / Laura Nicholas
Sponsor / Director	Julia Ross / Robert Woolley
Presenter	Julia Ross / Robert Woolley
Purpose:	Information
Previously discussed / endorsed at (Group / forum)	None

Purpose:
The purpose of this paper is to share the progress report for presenting to partner Boards on the priorities and status of the Healthier Together Sustainability and Transformation Partnership.

Issue / summary:
Partner Boards / committees will be asked to:

- Note the information in this report
- Note the emerging forward programme

Provide organisational feedback to the Programme team about the value of this report and suggestions for future content and reporting arrangements.

This report will be produced on a bi-monthly basis.

Recommendations:

The Sponsoring Board is asked to:

- Note the report content.
- Consider taking this report into partners' next Board / governing body meeting.
- Note the intention to provide a similar report every 2 months.

HEALTHIER TOGETHER UPDATE REPORT TO PARTNER BOARDS JULY 2018

1. INTRODUCTION

The purpose of this report is to brief partner Boards on the priorities and status of the Healthier Together Sustainability and Transformation Partnership. This is the second of these reports.

Since the last report in May, the Healthier Together programme has continued to make good progress. As well as successfully completing a collaborative approach to the annual planning round, the partnership has run a major conference for partners and close external stakeholders which has accelerated the development of plans in 10 key areas that will make a significant difference to citizens and service users across our area.

2. 2018/19 ANNUAL SYSTEM PLAN

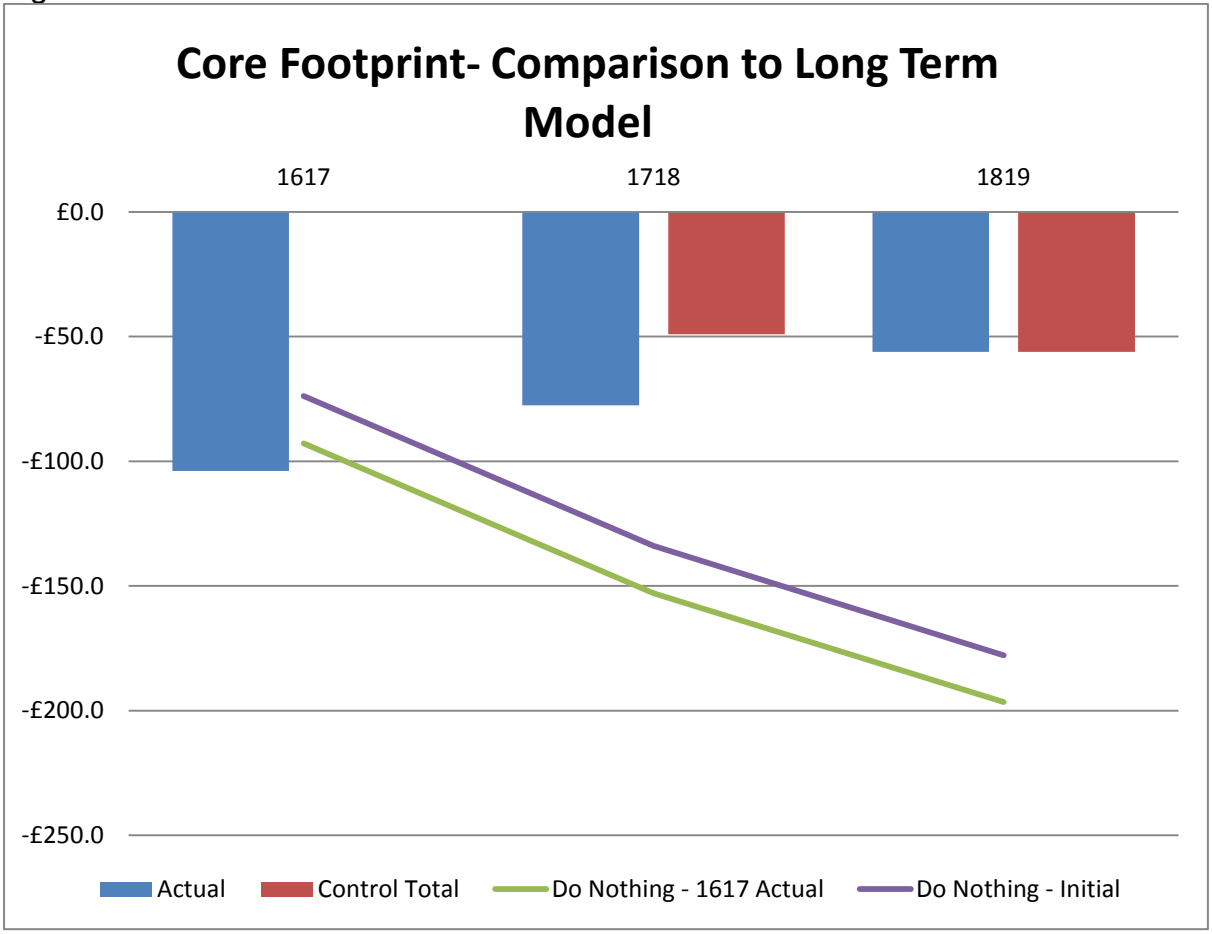
System NHS and community interest company partners have worked more closely together than before in preparing our annual operating plans for 2018/19. As a result we have been able to take account of, and start to align, individual organisation planning assumptions including activity, finance and key performance trajectories.

This has been possible through greater transparency of planning information from the outset and agreement of core planning principles for the system.

Planning work has been led by the System delivery oversight group (SDoG). The system made good progress in 2017/18 – improving the overall financial and key performance positions against 2016/17. SDoG has facilitated a more joined up and consistent approach to planning across system partners for 2018/19. This has delivered plans to further improve the NHS financial position and further performance improvement in some areas. Partners have contributed to achieving a “single version of the truth” at system level for key planning components including a system financial planning total, single activity plan and single set of key performance trajectories. This provides a sound basis on which to build more consistent delivery.

Figure 1 shows the system (NHS organisations) progress towards financial recovery over the past year, and as planned for 2018/19, against our original STP “do nothing” forecast.

Figure 1



The overall system financial position improved by £25.2m in 2017/18 compared to the 2016/17 out turn. We now have a plan that is £27.4m away from the sum of our NHS control totals.

Our community interest companies (CiCs) have contributed to the development of plans and are sharing their high level finance, activity and performance information. Local authorities are not yet formally part of these system planning arrangements but they have expressed a willingness to share high level information and contribute in future.

Four task and finish groups were established to work on BNSSG wide savings areas and these are progressing with schemes aimed at reducing non-elective acute length of stay and excess bed days now agreed and working towards implementation.

The system-wide (NHS) financial position summary is as follows:

- All 5 core NHS bodies signed up to Control Totals
- Control totals excluding Provider Sustainability Fund (PSF) /Commissioner Sustainability Fund (CSF) £56.1m deficit; which is £11.6m deficit including PSF/CSF. This position will be a £21.7m improvement in underlying finances year on year and requires £108m of savings, which is greater than £97m delivered in 17/18.

Organisation	Plan excl PSF/CSF
UH Bristol	3.0
NBT	(34.6)
Weston	(12.4)
AWP (55%)	(2.1)
Core Providers	(46.1)
CCG	(10.0)
Core Footprint Total	(56.1)

- Full alignment of financial and activity plans between commissioner and provider, excluding CCG acute care QIPP plans
- Planning gap remains for Specialised Commissioning and major acute providers
- Activity growth higher in emergency and lower in planned care due to current trends and impact of referral management. Agreed £4.6m shared investment plans to reduce demand on acute beds via SDOG
- Meeting Mental Health Minimum Investment Standard

3. HEALTHIER TOGETHER CONFERENCE 21 JUNE

On 21 June almost 300 people from across the Healthier Together partnership and our close external partners joined system leaders at our first big event as Healthier Together. The objectives for the event were:

- Celebrate our progress so far as an STP
- Understand the challenges and recognise the opportunities to address them collectively
- Come together to shape solutions to achieve the ambition
- Leave feeling that we can be advocates of the vision in our teams and organisations

Delegates heard about further development of our system vision and key challenges. Professor Sir Muir Gray provided an engaging keynote address that challenged the system to think about population health and optimising value in clinical intervention.

10 STP priority areas were chosen to participate in sharing their challenges, vision and emerging future plans in a market place and in seminars. The areas were:

- Integrated community localities
- Primary care
- Acute care collaboration
- Urgent care
- Mental health
- Prevention

- Maternity
- Healthy Weston
- Workforce
- Digital

These are consistent with the work areas listed in the previous report. The feedback from the event will be used to shape the STP plans for the next 12 month phase. These plans are being considered by the Sponsoring Board at its 2 August meeting. More detail on each of these areas and the emerging plans can be found in the library section of the Healthier Together website. *https://bnssghealthiertogether.org.uk/*

4. BIDS FOR CAPITAL AGAINST NATIONAL FUND

In the November 2017 Budget the Government announced an additional £4bn of Capital funding for the NHS for the period up to 2022/23. This money is on top of the current NHS Capital Budget of £4.8bn per annum.

The £4bn was part of a package of reform in the Naylor Review which identified £10bn requirement for the NHS. The STP capital bidding route will be the main route through which to seek new public capital going forward. £425m was committed last financial year. c.£800m has been recently announced, including the successful £7.5m bid to consolidate mental health estates in Bristol.

£1.8bn of the STP public capital remains uncommitted and bids were invited by NHSI/NHSE in May.

Healthier Together STP was required to submit to NHSI/NHSE by 29 June 2018:

- Prioritised Wave 4 Capital Bids to cover major estates and facilities projects, equipment and certain elements of IT across the STP footprint.

- An STP estates strategy including a consolidated capital programme.

Expressions of Interest were invited by the Healthier Together team with a deadline of 18 May 2018; 35 schemes were submitted from across BNSSG. A Prioritisation Panel was convened on 25 May, chaired by James Rimmer, Chief Executive of Weston Area Health Trust, to consider the proposals against a range of criteria. The panel which was also made up of senior finance and estates leads from across the system recommended 14 schemes to be worked up for submission to NHSE/I by 29 June 2018.

The Prioritisation Panel re-convened on Monday 25 June to review the developed bids. The panel considered:

- the maturity of the bid
- the strategic fit of the scheme with the vision of Heathier Together
- the financial viability of the scheme

The NHSE/I bid documentation called for proposals with a complex mix of:

- economic value for money as defined by the Treasury
- financial impact on NHS organisations and whole system
- impact on Transformation, Service Need, Consistency with STP Plans, Patient Benefit & Demand
- Schemes under the different financial regimes of NHS Foundation Trusts & Trusts, NHS England (replacement for ETTF), Primary Care and Community Interest Companies

This has understandably led to some different presentation of both financial and non-financial benefits. The panel therefore felt that a range of schemes should be recommended, representing both an assured financial return and a strategic fit.

Proposals are now being reviewed by NHSE/I colleagues as part of a national process. Successful bids are likely to be announced in the autumn.

A summary of the ranked submitted bids is shown in appendix 1.

5. WORKFORCE STRATEGY

In May the Sponsoring Board received the Healthier Together Workforce Strategy which had been developed by a group drawn from across the BNSSG health and social care partnership, and also including third sector organisations and staff side representation.

The strategy is intended to be a living document that will continue to develop as our plans for system transformation continue to take shape. In this initial stage, the strategy is focussed on the key clinical workforce supply pipeline.

The workforce programme is focussed on addressing the future supply of appropriately trained staff in a sustainable and transformational way through partnership working.

The vision, goals and ways of working for the workforce programme were reviewed by the Sponsoring Board on 31 May. The three goals for the next 2-3 years are summarised in the diagram below, with a focus on significant increases in supply at entry level, registered practitioner roles, and in advanced practice. The goals are intended to support all Healthier Together workstreams, and are underpinned by some key enablers such as workforce planning and training passports.

Workforce Strategy Goals

A baseline assessment has been undertaken to understand our workforce gaps. Registered nursing and entry level health and social care vacancies are the most numerically significant gap. There are 546 FTE registered nurse vacancies across acute and community health organisations, and a further 203 (pro-rata) in AWP (June 2018) plus significant registered nurse vacancies in primary care and 7.8% registered nurse vacancies in social care (2017 data).

The headlines by sector are summarised below.

Social Care

- BNSSG Social care has the highest vacancy rates across social care in the South West, with a care worker vacancy rate of 10.9%, representing 1,300 vacancies. The high turnover rate of 37.7% means more than a third of the workforce leave every year, presenting a significant recruitment challenge. 1.9% of the workforce for care workers are agency staff.
- 19% of all care worker roles across BNSSG were non UK born, with 9% born in the EEA (non UK). This reliance on the EEA as a source of care home workforce indicates potential issues for the future if there are changes to free movement within Europe.

- 15% of local authority employed carers and 59% of independent sector do not have any appropriate care qualifications.

NHS and Community Providers

- There is a well-documented national vacancy problem for registered nursing, which is impacting on BNSSG in hospital, community and primary care settings.
- BNSSG has difficulty in recruiting medical staff, including consultants, middle grades and doctors in training, in certain specialties, particularly care of the elderly and emergency department.
- High sickness and vacancy levels are linked to agency spend, with particular hot spots being registered nursing in the acute and community sectors.
- The high proportion of staff reaching retirement age is a particular risk in the context of existing high vacancy and turnover levels, with 29% of all NHS and community staff in BNSSG being over 50.

Primary Care

- The range and quality of primary care workforce data is more limited than for other sectors.
- Only 6% (3,082) of the BNSSG health and social care workforce work in primary care.
- There are 5% fewer GPs in BNSSG WTE compared with 2012.
- Whilst GP age profiles across BNSSG overall are better than the national median in BNSSG, North Somerset has an older age profile, presenting a potential future risk to supply.
- More GPs are choosing to work part-time and/or have portfolio careers.
- The primary care Registered Nursing workforce has seen a 4% increase in WTE. Over 50% of the current nursing workforce is over 50 years.

Our overarching aim is to attract, support and develop a workforce that is skilled, committed, compassionate and engaged. We recognise that unprecedented workforce gaps will undermine service transformation, and our objective is to ensure there are sufficient numbers of staff with the right skills to deliver our new models of care. In order to do this, our objective is to develop sustainable approaches to reducing the gap between workforce supply and demand.

Our specific objectives are as follows:

- Develop a sustainable pipeline of entry level health and social care workers through the creation of career pathways and frameworks that attract and retain staff from school through to advanced practice.
- Considerable expansion of the numbers of registered clinicians both in post and in the pipeline through a robust business case to identify the most cost effective approaches to increasing supply
- Significant increase in the capacity and capability of advanced practice skills, through the development of a common framework and competencies across BNSSG, underpinned by apprenticeship routes to enable progression
- All organisations are enabled to become model employers for recruitment, retention and health and well being

- Workforce planning to ensure that new models of care have robust and realistic staffing models with a focus on improved career pathways, reduced vacancies and more integrated services through joint working**.**
- Staff are enabled to move between organisations through the 'passporting' of training and development, underpinned by common competences. This is supported by common recruitment processes and checks.
- Equality and diversity is a theme which runs throughout our goals and vision.

The specific work packages being put in place to deliver these objectives are summarised in the strategy diagram.

The workforce programme benefits from a significant funding stream from Health Education England (around £1m in total in 2017/18) that is supporting the Healthier Together workforce team resource and funding some of the work programmes.

6. URGENT CARE STRATEGY

At its June meeting the Healthier Together Executive Group signed off the new BNSSG system urgent care strategy. This has been developed over recent months with a wide range of stakeholders including staff, clinicians, service users and members of the public. It is attempting to set out the future ambition and key objectives for addressing one of our system's most enduring challenges.

Appendix 2 shows the urgent care "strategy on a page" and plan on a page, including the key drivers of our challenges, opportunities to transform, our ambitions for the future and the emerging solutions, including our local response to the national five year forward view "seven pillars" of urgent and emergency care:

1. NHS 111 Online
2. NHS 111 Calls
3. GP access
4. Urgent Treatment Centres
5. Ambulance services
6. Hospital services
7. Hospital to home

Arrangements to start implementing the strategy are now being put in place at a system level as one of the STP 10 priority areas.

7. HEALTHY WESTON PROGRAMME DEVELOPMENTS

The Healthy Weston programme is now entering its second phase. The first phase of the work produced a commissioner led strategic context; a well-received process of public engagement; overnight closure of the A&E department at Weston Hospital and generation of a number of opportunities and ideas for addressing the local system challenges which are now being assessed and prioritised for implementation. New governance arrangements have been put in place for the second phase and the

first meeting of the newly established Healthy Weston Steering Group was held on 19th June 2018. The next phase is focussed on developing the key change proposals for the local population and specifically those that will require public consultation. BNSSG CCG has the formal statutory responsibility in the system for publically consulting on the proposals. The scope of the Pre-Consultation Business Case (PCBC) was confirmed at the meeting on 19 June, and the more detailed governance arrangements to support the next phase of work agreed. The PCBC will focus on proposals for realising the ambition to see a vibrant and dynamic future for Weston General Hospital at the heart of a local, integrated care system. The Healthy Weston Programme is therefore working to identify proposals that can address a number of long standing issues, including clinical and financial sustainability of some services as well as continuing to meet the health and care needs of local people.

McKinsey's have been appointed to support the CCG in the development of the PCBC following a procurement process, and the PCBC is expected to be presented to the CCG governing body for a decision to consult in the autumn.

8. WORKING TOWARDS AN INTEGATED SYSTEM OF CARE

The Healthier Together Chairs reference group met for the second time in May. The group has begun to explore ideas and options for developing system governance arrangements that would support the partnership to begin to work towards establishing an integrated care system as defined in recent NHSE/I policy. These discussions are still at a very early stage but will help to define some of the key steps and build on work that the STP executive group started at its recent development session. In particular, there is a desire to enable the system in the short term to progress our joint system planning arrangements for 2019/20. Boards will be kept informed and be appropriately involved in any further developments as they emerge.

9. RECOMMENDATIONS

The Board is asked to:

- Note the information in this report
- Provide feedback from organisation boards to the Programme team about the value of this report and suggestions for future content and reporting arrangements, as appropriate.

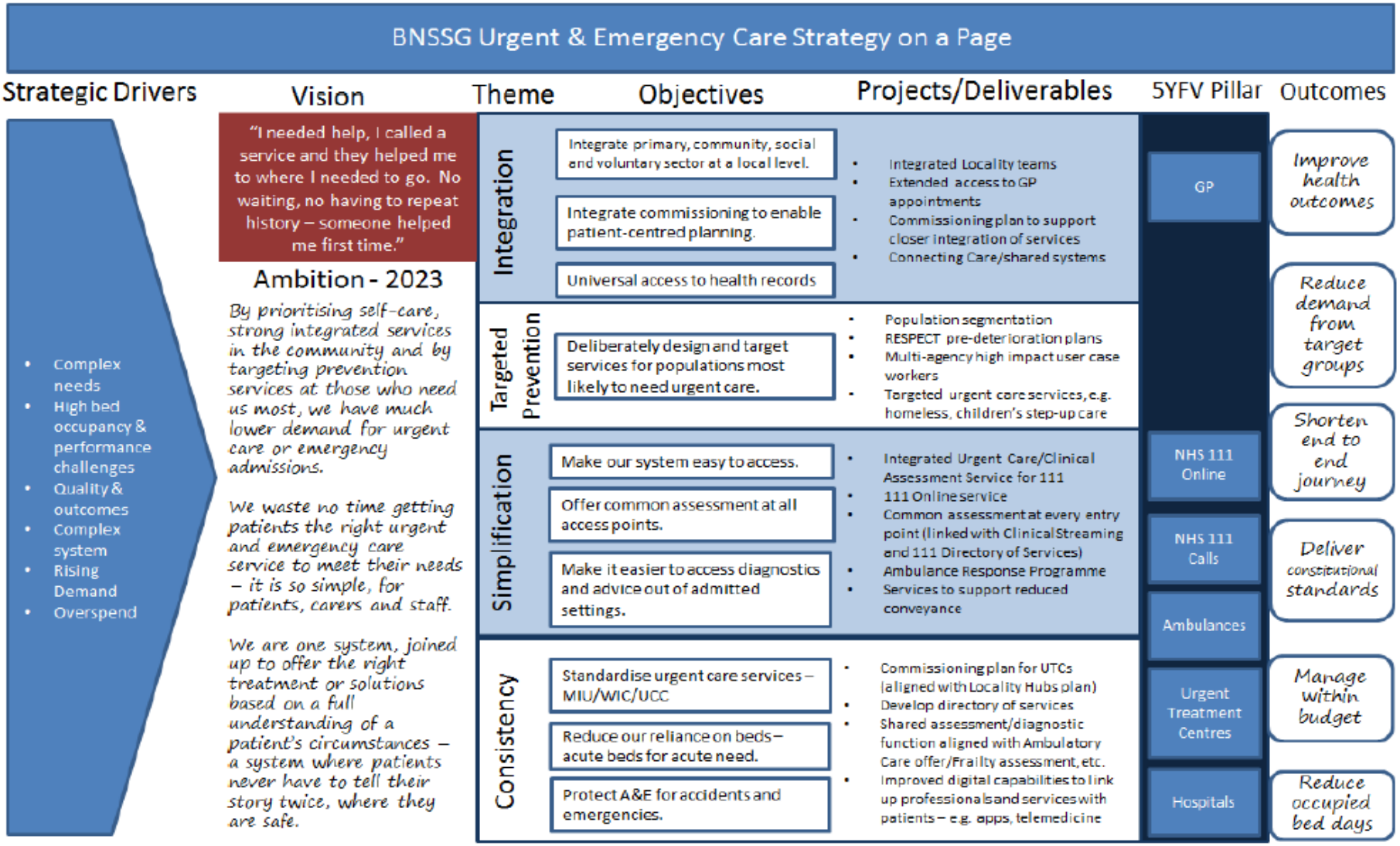
Robert Woolley, Joint STP Lead Executive
Julia Ross, Joint STP Lead Executive
Laura Nicholas, Healthier Together Programme Director

July 2018

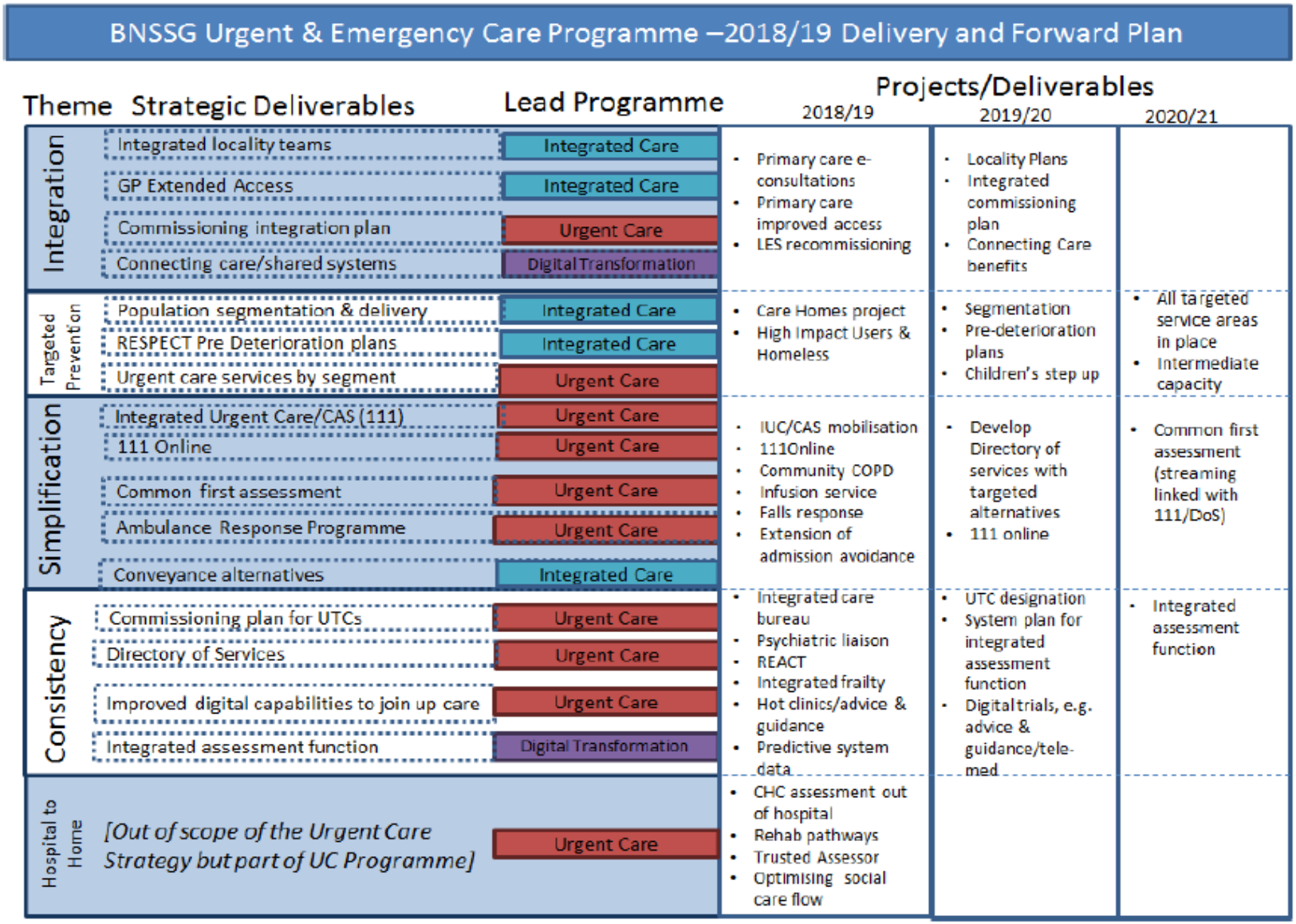
Healthier Together Ranked capital proposals submitted to NHSE/I 29 June 2018

	Bid Reference		Capital spend (k)	Maturity of Bid	Cost Saving (1=Low; 2=High)	Strategic Fit (1=Low; 2=High)	Rank	Final Recomm-endation
Digital Enabler	23	CCHP IT	1,252	M	1	2	1	1
Digital Enabler	5	Replacement of Information Technology Infrastructure - Weston	10,043	M	1	2	2	2
Digital Enabler	25	NSCP & BCH - Mobile Working for Corporate Services	1,549	L	U	1		
Acute Estate	16	12 additional beds through conversion of assisted bathrooms	1,580	H	2	1	1	3
Acute Estate	21	Combined Heat & Power (District Heating)	6,881	H	2	1	2	4
Acute Estate	2	Weston Hospital – infection control improvements	1,600	M	1	1		
Integrated Primary & Community Care	26a	North Somerset - Primary Care - Weston Villages	241	H	1	2	1	5
Integrated Primary & Community Care	26b	North Somerset - Primary Care - Central Weston	2,911	M	1	2	1	5
Integrated Primary & Community Care	29	Thornbury - Primary and Community Development	9,402	M	1	2	3	7
Integrated Primary & Community Care	3	Weston Hospital Site - Children's and Young People's (CYP) Hub	14,830	M	1	2	4	8
Integrated Primary & Community Care	28b	3 Frailty Hubs across BNSSG - North Somerset	5,424	L	2	2	5	9
Integrated Primary & Community Care	28c	3 Frailty Hubs across BNSSG - South Gloucestershire	5,893	L	2	2	6	9
Integrated Primary & Community Care	28a	3 Frailty Hubs across BNSSG - Bristol	7,007	L	2	2	7	9
Integrated Primary & Community Care	10a	Use of technology to support locality development - Care Home Digital	700	U	U	2		
Access to Diagnostics	20	Provision of 3T MRI scanner at South Bristol Community Hospital [Estate enabling work, MRI via charity]	400	H	2	1	1	12
Access to Diagnostics	12	Cossham locality support centre expansion for Imaging Suite	4,200	M	2	1	2	12
			73,913					

Urgent care strategy on a page



Urgent care delivery plan



Cover report to the PublicTrust Board Meeting to be held on 27 September 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 27 September 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 Trust Board of the financial position of the Trust for August

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 requirement to August is a surplus of £7.467m excluding technical items.

The Trust is reporting a surplus of £6.218m, £1.249m adverse to plan. This is due to :

- Divisional and Corporate overspends of £2.820m, offset by
- Corporate share of income over performance £0.159m
- Release of Corporate Reserves of £1.250m
- Financing underspends of £0.162m

The Clinical Divisional year to date deficit in August almost doubled, being £2.974m compared to £1.524m last month, a deterioration of £1.450m. Medicine and Surgery's deterioration increased with in month adverse variances of £0.441m each (£0.395m and £0.344m in July) and Women's and Children's was £0.496m adverse in month.
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)**
	25 Sept 2018			

Report of the Finance Director

University Hospitals Bristol NHS Foundation Trust

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	622.336	262.718	262.877	0.159
Divisions & Corporate Services	(580.202)	(243.557)	(246.377)	(2.820)
Financing	(35.592)	(14.830)	(14.668)	0.162
Reserves	(3.542)	(1.250)	-	1.250
Surplus/(deficit) excl PSF	**3.000**	**3.081**	**1.832**	**(1.249)**
PSF Core Funding	10.836	3.070	3.070	-
PSF Performance Funding	4.644	1.316	1.316	-
Surplus/(deficit) incl PSF	**18.480**	**7.467**	**6.218**	**(1.249)**

The pay costs reported within the August position now include the arrears following the implementation of the Agenda for Change (AFC) pay award.

Funding of £5.6m has been confirmed by NHS Improvement for the additional costs of the AFC award. The Trust has received five twelfths to date.

NHS Improvement requires a monthly analysis of the impact of the additional pay award. In July, after only one month's data, the Trust estimated a shortfall for the year of £0.338m. Following the arrears payments providing additional data the Trust has re-assessed the shortfall to be £0.469m for the year. This increase is partly due to notifications from agencies of their intention to increase their rates (contrary to NHS I assumptions).

- 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 August is a surplus of £7.467m excluding technical items.
- The Trust is reporting a surplus of £6.218m, £1.249m adverse to plan. This is due to :
  - Divisional and Corporate overspends of £2.820m, offset by
  - Corporate share of income over performance £0.159m
  - Release of Corporate Reserves of £1.250m
  - Financing underspends of £0.162m
- The Clinical Divisional year to date deficit in August almost doubled, being £2.974m compared to £1.524m last month, a deterioration of £1.450m. Medicine and Surgery's deterioration increased with in month adverse variances of £0.441m each (£0.395m and £0.344m in July) and Women's and Children's was £0.496m adverse in month.
- PSF core funding was achieved for the first quarter. August's reported position to date of £1.249m adverse to control total is significant. However the forecast to deliver the control total at Q2. The expectation is that activity will improve in September but immediate action is required for Surgery and Medicine to control pay costs and deliver their savings in order to achieve the Q2 control total.
- PSF performance funding was achieved for the first quarter and is expected to be achieved for quarter 2. To date ED performance is 90.07% against a target of 91.3% but this excludes Walk in Centre (WIC) data. WIC data, only available at Q2, once incorporated is forecast to ensure overall delivery.

Section 2 – Delivering the Financial Plan

Three divisions account for the current combined divisional overspend. The values are:

	To July £m	August £m	To August £m
Medicine	(0.844)	(0.441)	(1.285)
Surgery	(0.995)	(0.441)	(1.436)
Women's and Children's	(0.121)	(0.496)	(0.617)

The divisional overspend in August nearly doubled the year to date overspend. This level of deterioration is incompatible with the delivery of the year- end financial control total

Medicine
At month three, the division's recovery plan reported a revised forecast of £0.501m adverse compared to the original operating plan deficit of £0.491m adverse.

The revised trajectory at month five was £0.660m adverse; the actual variance was £1.285m adverse. Therefore, the division was £0.625m adverse to the revised trajectory. The key reasons for this were:

- Lower than forecast overachievement on activity hence SLA income, £0.227m adverse
- Higher than forecast pay costs both for nursing, due to an increase in worked hours, enhanced care and RMN costs, and within medical staff due to additional sessions in ED, maternity cover, sickness and additional agency costs in dermatology and stroke services, £0.376m
- Higher than forecast non-pay variance relating to higher than anticipated recharges re Queen's Square dermatology and unexpected increases in drug prices, £0.022m

Surgery
At month three, the division's recovery plan reported a revised forecast of £0.460m adverse compared to the original operating plan deficit of £0.020m favourable.

The revised trajectory at month five was £1.191m adverse; the actual variance was £1.436m adverse. Therefore, the division was £0.245m adverse to the revised trajectory. The key reasons for this were:

- A continued overachievement in activity resulting in a higher than forecast income from activities, £0.059m
- A better than expected rate of pay spend particularly for nursing, £0.050m
- A higher than forecast variance on non-pay, particularly related to higher than planned variance on Clinical supplies and income related CIP schemes, £0.354m.

Women's and Children's
At month three, the division's recovery plan reported a revised forecast of £0.085m favourable compared to the original operating plan deficit of £0.491m adverse.

The revised trajectory at month five was £0.255m adverse; the actual variance was £0.617m adverse. Therefore, the division was £0.362m adverse to the revised trajectory. The key reasons for this were:

- A significantly lower than forecast overachievement on activity £0.791m, mostly due to an over estimation of income in July.
- An improvement in pay variance against forecast £0.477m. Medical staff £0.139m, nursing £0.210m, other £0.128m.
- A worse than forecast non – pay variance £0.048m.

The divisions will be subject to a further review this month and an assessment of the year-end position will be made formally for the quarter 2 NHS Improvement declaration.

Section 3 – Division and Corporate Services Performance

Performance by Division and Corporate Service Area:

	Variance to Budget favourable/(adverse)			Operating Plan trajectory favourable/(adverse)	
	To 31 July £m	Aug £m	To 31 Aug £m	To 31 Aug £m	Var £m
Diagnostic & Therapies	0.161	(0.001)	0.160	0.094	0.066
Medicine	(0.844)	(0.441)	(1.285)	(0.317)	(0.968)
Specialised Services	0.275	(0.071)	0.204	(0.134)	0.338
Surgery	(0.995)	(0.441)	(1.436)	(0.130)	(1.306)
Women's & Children's	(0.121)	(0.496)	(0.617)	(0.445)	(0.172)
Estates & Facilities	0.016	0.012	0.028	0.039	(0.011)
Trust Services	(0.018)	(0.018)	(0.036)	-	(0.036)
Other Corporate Services	0.245	(0.083)	0.162	-	0.162
Total	**(1.281)**	**(1.539)**	**(2.820)**	**(0.893)**	**(1.927)**

In August the position deteriorated significantly by £1.539m to give a year to date adverse variance of £2.820m. This compares to an adverse position of £0.572m at the end of the first quarter, which increased by £0.709m to £1.281m adverse in July. August exceeded the total adverse variance for the previous four months. Overspending in Medicine and Surgery continued to increase, both deteriorating by £0.441m. Women's and Children's worsened by £0.496m after an improvement last month, primarily due to lower income from activities.

The Trust is £1.927m adverse to the Operating Plan trajectory. Medicine and Surgery are significantly adverse against their Operating Plan trajectories.

- Diagnostic and Therapies – a favourable variance of £0.160m 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 primarily from outsourcing.

- Medicine – an adverse variance of £1.285m, £0.968m higher than the Operating Plan trajectory. Pay was £0.373m adverse in month, of which £0.184m relates to nursing and £0.195m to medical pay, particularly covering sickness and gaps in the middle grade rota in the ED. Income from activities underperformed this month by £0.104m, reducing the cumulative over performance to £0.276m.

- Specialised Services – a favourable variance of £0.204m, £0.338m favourable to Operating Plan trajectory. Income from activities is £0.194m above plan. Over performance on Cardiology reduced in the month, Clinical Haematology and Cardiac Surgery continued. Clinical Genetics and Bone Marrow Transplants continued to be behind plan (although the latter is expected to be in line with contract by year end). Operating income is £0.100m above plan through surpluses on research projects.

- Surgery – an adverse variance of £1.436m which is £1.306m adverse to Operating Plan trajectory. Pay deteriorated by £0.133m in August (of which £0.121m was medical and dental) and is £0.701m adverse to date. Non pay deteriorated by £0.363m in July and is £1.383m adverse to date. Income from activities cumulative over performance increased to £0.670m.

- Women's & Children's – an adverse variance of £0.617m year to date, which is £0.172m adverse to Operating Plan trajectory. Pay is £1.117m adverse of which £0.634m relates to medical pay and £0.406m to nursing and midwifery. Income from activities was £0.368m adverse in month reducing the cumulative over performance to £0.348m above plan.

Section 3 – Division and Corporate Services Performance continued

Performance by subjective heading:

	Monthly Average 2017/18	2017/18 Outturn £m	Quarter 1	July 2018 £m	August 2018 £m	2018/19 To date £m
Nursing & midwifery pay	(0.328)	(3.941)	(1.015)	(0.338)	(0.288)	(1.641)
Medical & dental pay	(0.353)	(4.233)	(1.033)	(0.340)	(0.395)	(1.768)
Other pay	0.076	0.912	0.328	0.260	0.080	0.668
Non-pay	(0.388)	(4.655)	(1.088)	(0.474)	(0.464)	(2.026)
Income from operations	(0.003)	(0.030)	(0.027)	0.075	0.017	0.065
Income from activities	0.396	4.753	2.263	0.109	(0.490)	1.882
Total	**(0.600)**	**(7.195)**	**(0.572)**	**(0.709)**	**(1.540)**	**(2.820)**

A budget realignment exercise in month 5 in Women's and Children's reallocated year to date funding from non-pay reserves to pay lines affecting the reported in month variance shown. If year to date variance is adjusted to account for this nursing pay would be £0.424m adverse, medical pay £0.602 adverse, other pay £0.011 favourable and non-pay £0.052 favourable.

- Nursing pay continues to overspend, with a cumulative overspend of £1.641m. This is predominately from Medicine (£0.791m), Women's and Children's (£0.439m) and Surgery (£0.414m), including theatre ODP's. Medicine showed a small improvement in variance in month and overspent by £0.195m in August compared to £0.237m in July.

- Medical and dental pay variances worsened in month compared to the run rate to date, despite significant funding being applied to Women's and Children's budgets. Of the £1.768m cumulative adverse variance, £0.639m is within Women's and Children's, £0.509m in Surgery and £0.536m in Medicine.

- The adverse non pay variance remains of real concern as overspending on clinical supplies remains high despite controls being applied. The largest Divisional overspend to date is within Surgery which has an adverse variance of £1.373m, although much of this has been linked to activity increases which have additional income associated. Work continues to control all expenditure on clinical supplies.

- Income from Activities had a down turn in August with an adverse variance to plan of £0.490m. The income reduction reflected underperformance on critical care bed days and day cases in Women's and Children's Divisions which worsened overall by £0.360m in month. Medicine Division also had an adverse variance to plan in month of £0.104m.

Section 4 – Subjective Analysis Detail

a) Nursing (including ODP) and Midwifery Pay

Favourable/ (Adverse)	Monthly Average	2017/18 Outturn £m	Quarter 1	July 2018 £m	August 2018 £m	2018/19 To date £m
Substantive	0.837	10.046	2.423	1.002	1.135	4.559
Bank	(0.666)	(7.997)	(2.093)	(0.811)	(0.825)	(3.729)
Agency	(0.999)	(5.988)	(1.345)	(0.529)	(0.598)	(2.472)
Total	**(0.328)**	**(3.939)**	**(1.015)**	**(0.338)**	**(0.288)**	**(1.642)**

b) Medical and Dental Pay

Favourable/ (Adverse)	Monthly Average	2017/18 Total £m	Quarter 1	July 2018 £m	August 2018 £m	2018/19 To date £m
Consultant						
substantive	0.064	0.768	0.287	(0.013)	0.172	0.446
additional hours	(0.179)	(2.143)	(0.540)	(0.180)	(0.211)	(0.931)
locum	(0.061)	(0.736)	(0.340)	(0.026)	(0.059)	(0.425)
agency	(0.016)	(0.190)	(0.007)	(0.059)	(0.049)	(0.115)
Other Medical						
substantive	0.78	0.932	0.478	0.262	0.134	0.874
additional hours	(0.131	(1.575)	(0.405)	(0.111)	(0.196)	(0.712)
Jr Dr exception	-	(0.007)	(0.003)	(0.001)	(0.001)	(0.005)
locum	(0.088)	(1.059)	(0.398)	(0.141)	(0.161)	(0.700)
agency	(0.019)	(0.224)	(0.105)	(0.071)	(0.024)	(0.200)
Total	**(0.411)**	**(4.927)**	**(1.033)**	**(0.340)**	**(0.395)**	**(1.768)**

- Nursing pay variance was £0.288m adverse in the month, £0.050m better than July, the largest overspend remains in Medicine despite a small improvement in July.
- Nursing lost time reduced to 122% compared to 124% in July. Lost time percentages improved across the Divisions with the exception of Specialised who saw a small increase. The highest lost time percentage remained Medicine at 127% and the largest improvement was seen in Women's and Children's.
- Sickness decreased in most areas compared to July, registered nurse sickness is below plan in all areas, whereas unregistered is above plan with the exception of Medicine.
- Registered nurse vacancies are still a significant concern with all areas for above planned vacancy levels.
- Total enhanced observation costs for August were £0.191m a reduction of £0.052m from July. Medicine costs however remain significantly above plan at £0.127m against a plan of £0.044m in month.
- The adverse medical pay variance in August of £0.395m is a slight worsening from July. Spend increased in the Clinical Divisions by £0.227m compared to July, with all Divisions spending more than the previous month. However year to date funding of £0.207m was also applied to the Women's and Children's budget to fund historic vacancy factors and new activity, this has offset the in month adverse variance.
- The cost of maternity and sickness cover continue to impact the positions in particular within Surgery and Women's and Children's, with Medicine Division having high cover costs in August too.

Section 4 – Subjective Analysis Detail continued

c) Non pay

Favourable/ (Adverse)	Monthly Average £m	2017/18 Outturn £m	Quarter 1 2018 £m	July 2018 £m	August 2018 £m	2018/19 To date £m
Blood	(0.021)	(0.248)	(0.063)	(0.004)	0.009	(0.058)
Clinical supplies & services	(0.079)	(0.950)	(0.539)	(0.203)	(0.380)	(1.122)
Drugs	(0.080)	(0.961)	(0.167)	(0.010)	(0.025)	(0.202)
Establishment	(0.014)	(0.166)	0.000	0.075	0.019	0.094
General supplies & services	0.001	0.007	0.067	0.011	(0.015)	0.063
Outsourcing	(0.093)	(1.117)	(0.103)	(0.067)	0.001	(0.169)
Premises	(0.006)	(0.067)	0.046	0.009	(0.132)	(0.077)
Services from other bodies	(0.086)	(1.031)	(0.290)	(0.110)	(0.017)	(0.417)
Research	0.003	0.034	0.030	0.009	0.006	0.045
Other non-pay expenditure	(0.127)	(1.526)	(0.068)	(0.184)	0.070	(0.183)
Tranche 1 Winter Funding	0.114	1.370		-		
Total inc CIP	**(0.388)**	**(4.655)**	**(1.088)**	**(0.474)**	**(0.464)**	**(2.026)**

- The adverse position of £0.464m in August is £0.0.10m better than July.
- Of the £2.026 cumulative overspend, 68% relates to blood, drugs and clinical supplies expenditure. Some of this reflects higher than planned activity levels and is in part offset by income. However improved controls and understanding of the activity and cost links continues to be a crucial to controlling costs. Surgery non pay overspend is £1.383m of which £0.779m is within blood, drugs and clinical supplies.
- Outsourcing levels have continued to fall in Surgery and Specialised Division resulting in a favourable variance for the first time this year in August.
- Services from Other Bodies represents the largest adverse variance outside clinical supplies. The in month position shows an improvement in variance but this mainly reflects a reassessment of year to date accruals for maternity pathways in Women's and Children's rather than a fundamental reduction in underlying expenditure levels. The main areas of adverse variance year to date continue to be Diagnostics and Therapies £0.163m, Surgery £0.114m and Women's and Children's £0.072m.
- Other non pay variance improved in the month mainly due to the allocation of previously unidentified savings targets of £0.229m in Surgery and Facilities and Estates to more appropriate subjective lines.

Section 5 – Clinical and Contract Income

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

	In month variance Fav/(Adv) £m	Year to Date Plan £m	Year to Date Actual £m	Year to Date Variance Fav/(Adv) £m
Activity Based:				
Accident & Emergency	(0.014)	7.814	8.115	0.302
Bone Marrow Transplants	0.172	3.377	3.320	(0.057)
Critical Care Beddays	(0.342)	18.501	18.650	0.149
Day Cases	(0.104)	16.783	16.729	(0.055)
Elective Inpatients	0.144	24.156	25.023	0.867
Emergency Inpatients	0.012	39.731	40.730	1.000
Excess Beddays	0.048	2.319	2.402	0.083
Non-Elective Inpatients	(0.056)	13.483	12.971	(0.512)
Other	(0.032)	41.371	41.141	(0.230)
Outpatients	(0.189)	33.940	34.140	0.200
Total Activity Based	**(0.362)**	**201.474**	**203.221**	**1.747**
Contract Penalties	(0.017)	(0.892)	(1.060)	(0.168)
Contract Rewards	0.112	4.141	4.328	0.187
Pass through payments	(0.540)	39.377	36.829	(2.548)
Prior Year Income	0.028	-	0.138	0.138
S&T Funding	-	4.385	4.385	-
2018/19 Total	**(0.778)**	**248.485**	**247.842**	**(0.643)**

The 2017/18 income has now been finalised and results in an additional £0.332m being invoiced to Commissioners. This is now being reported with five twelfths shown above.

- Activity based income was £0.362m adverse in August, resulting in a £1.747m favourable position year to date.
- Urgent care income to date is significantly above plan. A&E is £0.302m above plan of which £0.248m is adult and £0.054m paediatric. Emergency inpatients is £1.000m above plan of which £0.638m is within Surgery and £0.404m Specialised Services whilst Women's and Children's is £0.350m adverse to plan.
- Paediatric critical care activity was £0.332m lower than plan in August. To date cardiac HDU is £0.064m above plan, paediatric critical care is adverse to plan by £0.107m and adult critical care is above plan by £0.190m.
- Bone Marrow Transplants were above plan in August by £0.172m. The paediatric service improved by £0.272m in month and is now £0.220m ahead of plan. The adult service was £0.100m adverse to plan in month and is £0.277m adverse to date.
- Outpatients is £0.200m above plan to date.
- The Trust has received penalties of £1.060m year to date, £0.168m greater than planned. Cancelled operations account for £0.13m, marginal rate emergency tariff £0.05m and avoidable emergency readmissions £0.07m.
- CQUIN contracts have been finalised and performance is £0.187m above plan. The year end forecast is to achieve 85.6%.
- Income relating to pass through payments was £0.540m below plan in August, taking the cumulative variance to £2.548m adverse. Of this £1.876m relates to excluded drugs, £0.293m excluded devices and £0.319m blood.

Section 6 – 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	0.324	0.328	0.004
Diagnostic Testing	0.156	-	-	-
Estates & Facilities	0.746	0.383	0.386	0.003
Healthcare Scientists Productivity	0.120	0.051	0.051	0.000
Income, Fines, External	2.290	0.813	0.757	(0.056)
Medical Pay	0.625	0.204	0.128	(0.076)
Medicines	0.751	0.316	0.259	(0.057)
Nursing Pay	1.061	0.420	0.313	(0.107)
Other / Corporate	7.874	3.281	3.281	-
Productivity	3.267	1.147	1.274	0.127
Non-Pay	5.020	1.971	1.947	(0.024)
HR Pay and Productivity	0.097	0.044	0.038	(0.006)
Trust Services	0.653	0.272	0.268	(0.004)
Blood	0.046	0.017	0.013	(0.004)
Support funding	1.936	0.581	0.581	-
Unidentified	0.053	0.023	0.000	(0.023)
Total	**25.474**	**9.846**	**9.622**	**(0.225)**

Analysis by Division:

	2018/19 Annual Plan £m	Year to date			Year end
		Plan £m	Actual £m	Variance fav/(adv) £m	FOT £m
Diagnostics & Therapies	1.934	0.667	0.770	0.103	1.977
Medicine	2.858	1.216	0.813	(0.403)	2.245
Specialised Services	2.727	1.005	1.270	0.264	2.811
Surgery	3.521	1.379	1.295	(0.084)	3.961
Women's & Children's	4.869	1.549	1.428	(0.120)	5.147
Facilities &Estates	0.976	0.446	0.466	0.020	0.970
Finance	0.186	0.080	0.079	(0.001)	0.186
Human Resources	0.126	0.052	0.055	0.003	0.123
IM&T	0.201	0.084	0.082	(0.002)	0.201
Trust HQ	0.203	0.088	0.083	(0.005)	0.198
Corporate	7.874	3.281	3.281	-	7.874
Total	**25.474**	**9.846**	**9.622**	**(0.225)**	**25.694**

- The savings requirement for 2018/19 is £25.474m. The Trust has achieved savings of £9.622m against a plan of £9.846m. This includes the Divisional support funding of £1.936m which has been allocated over the ten months June to March.
- Medicine is £0.403m behind plan to date. £0.110m is within productivity (length of stay and savings from contracts) and £0.204m savings yet to be identified. The Division's current forecast is an underachievement of £0.613m at year end.
- Women's and Children's is £0.120m behind plan of which £0.106m is within nursing pay.
- The Trust is forecast to make savings of £25.694m by year end. Medicine is forecasting a shortfall of £0.613m. Surgery is expected to exceed their target by £0.0.440m and Women's and Children's by £0.193m.

Section 7 – Use of Resources Rating

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

		Year to date	
	Weighting	Plan	Actual
Liquidity			
Metric Result – days		26.8	28.7
Metric Rating	20%	1	1
Capital servicing capacity			
Metric Result – times		2.7	2.6
Metric Rating	20%	1	1
Income & expenditure margin			
Metric Result		2.6%	2.1%
Metric Rating	20%	1	1
Distance from financial plan			
Metric Result		0.0%	(0.50)%
Metric Rating	20%	1	2
Variance from agency ceiling			
Metric Result		56.07%	29.32%
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 August 2018 is 1 against a plan of 1.

- The Trust is reporting an adverse variance against the control total of £1.3m. The Trust has assumed full achievement of quarter 2 ED performance. The year to date Provider Sustainability Funding (PSF) assumed for ED performance is £1.316m and Core PSF assumed is £3.070m.

Section 8 – 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	Loan	-	-	-
3.000	Donations	0.714	0.629	(0.085)
	Cash:			
24.338	Depreciation	9.904	9.734	(0.170)
14.962	Cash Balances	(2.509)	(3.302)	(0.793)
47.089	**Total Funding**	**8.109**	**7.061**	**(1.048)**
	Application/Expenditure			
(11.618)	Strategic Schemes	(0.294)	(0.125)	0.169
(17.620)	Medical Equipment	(2.230)	(1.836)	0.394
(16.415)	Operational Capital	(2.437)	(1.979)	0.458
(7.468)	Information Technology	(2.577)	(2.596)	(0.019)
(2.367)	Estates Replacement	(0.571)	(0.525)	0.046
(55.488)	**Gross Expenditure**	(8.109)	(7.061)	1.048
8.399	In-year Slippage			
(47.089)	**Net Expenditure**	**(8.109)**	**(7.061)**	**1.048**

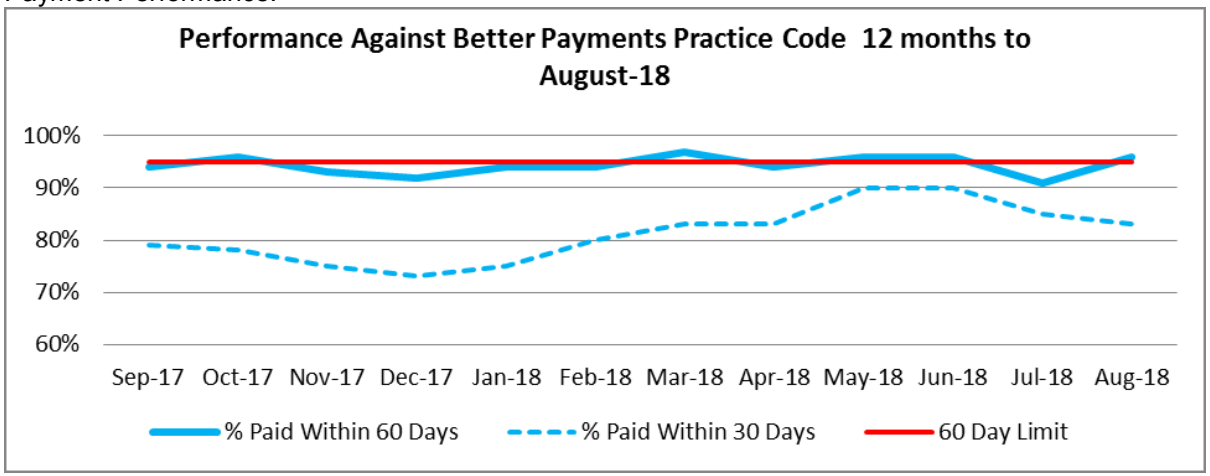
- A full forecast outturn has been drafted in preparation for the Quarter 2 (month 6) report which will also be submitted to NHS Improvement. The draft forecast will be reviewed and finalised in month. The strategic programme is not yet fully established hence reliable year end forecasts are not yet possible.
- The Trust has developed a detailed internal profiled plan which reflects expenditure monthly profiles provided through the Trust Capital Group.
- Capital expenditure was £7.061m to the end of August against an internal plan of £8.109m, £1.048m behind plan.
- Donated income will be received as the specific schemes being funded are completed.
- The key variances are Strategic Schemes, Medical Equipment and Operational Capital which are behind plan by £0.169m, £0.394m and £0.458m (£0.744m excluding unfunded BHOC fire recovery costs) respectively.
- The Strategic Schemes slippage reflects timing delays on feasibility fees for Phase 5 schemes.
- The Medical Equipment slippage reflects timing delays on active schemes.
- Operational Capital includes unfunded expenditure to date of £0.286m relating to the BHOC fire recovery works. Funding is currently unconfirmed and will be subject to the pending insurance claim. An Estates Project Manager has been assigned to the scheme and costs are to be monitored via the BHOC Recovery Board. Excluding this scheme, there are a number of schemes with variance over £0.050m which are timing delays and a significant number of schemes with minor variances.

Section 9 – Statement of Financial Position and Cashflow

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

	Plan as at 31 Aug £m	Actual as at 31 Aug £m	Variance £m
Inventories	13.140	12.570	(0.570)
Receivables	24.173	27.039	2.817
Accrued Income	21.355	16.767	(4.588)
Debt Provision	(10.112)	(5.952)	4.160
Cash	89.493	96.144	6.651
Other assets	3.804	5.264	1.509
Total Current Assets	141.853	151.832	9.979
Payables	(40.387)	(35.294)	5.093
Accruals	(26.732)	(40.448)	(13.716)
Borrowings	(6.170)	(6.167)	0.003
Deferred Income	(6.481)	(4.366)	2.145
Other Liabilities	(2.770)	(2.574)	0.196
Total Current Liabilities	(82.540)	(88.819)	(6.279)
Net Current Assets/(Liabilities)	**59.313**	**63.013**	**3.700**

Payment Performance:



- Net current assets as at 31 August 2018 were £63.013, £3.700m higher than the Operational Plan. Current assets and liabilities are higher than plan by £9.979m and £6.279m respectively.
- Inventories were £12.570m, £0.570m lower than plan which forecast an increase in stock for bulk purchases in the Adult Cath Labs which has not been required
- The Trust's cash and cash equivalents balance was £96.144m. This is £6.651m higher than the Operating Plan resulting from both the higher than planned level of accruals (i.e. invoices due that have not been received) and the capital slippage.
- The total value of debtors was £24.591m (£14.442m SLA and £10.149m non-SLA) the lowest in the year. This represents a decrease in the month of £3.607m (£2.717m SLA decrease and £0.890m non-SLA increase). Debts over 60 days old have increased by £3.065m (£4.078m SLA increase and £1.013 non-SLA decrease) to £13.870m (£8.794m SLA and £5.076m non-SLA). The SLA increase relates to disputed invoices from NHS England, North Bristol Trust and Weston Area Health Authority and the Non-SLA decrease relates to payments from North Bristol Trust and Avon and Wiltshire Mental Health Trust
- In August, 96% of invoices were paid within the 60 day target set by the Prompt Payments Code and 83% were paid within the 30 day target set by the Better Payment Practice Code.

Section 10 – Risk

There are 4 financial risks on the corporate risk register. The following summarises the current risk assessment and any changes following internal finance review and consideration at Risk Management Group. There are no changes to the risk ratings be reported this month.

Action required risks:

Risk 416 – Delivery of Trust's Financial Strategy. Current risk – Moderate (6)
This reflects the current assessment of the national environment, local health economy and delivery of the Trust's 2018/19 Operational Plan. The medium term financial plan was delivered to Board in July. A system wide planning group is developing a five year baseline model against which to assess individual operation plans. This will assist in highlighting external risk factors. There has been no further change to this risk.

Risk 951 – Loss of Provider Sustainability Funding (PSF). Current risk - Very high (15)
The Trust is forecasting achievement of Core PSF through delivery of the financial control total but is expecting to lose Performance PSF for non-delivery of the ED trajectory in the last quarter. The actions to mitigate the risk have been split between the core and performance elements to better describe the different actions required to mitigate each element. Risk 416 is not increased through the loss of Performance PSF as the Trust's Financial Strategy does not rely upon it.

Risk 959 – Failure to deliver Operational Plan through non-delivery of savings. Current risk - High (12))
The Trust was forecasting to deliver savings of £25.7m against a target of £25.5m. This forecast included a Medicine shortfall of £0.618m and a Surgery over delivery of £0.514m and the Trust's total year to date delivery was £0.173m behind plan. The current position is savings to date of £9.622m against a target of £9.846m and the year end forecast is to overachieve the Trust target by £0.220m which has been the consistent position for two months. However Medicine is forecasting to underachieve by £0.613m by year end. Risk 416 is not increased by this as it is expected that recovery plans and non-recurring corporate savings will deliver the 2018/19 Operational Plan at this stage.

Risk 1843 – Failure to deliver the Operating Plan Control Total. Current risk – High (9)
The level of risk is driven by the likelihood assessment of possible which was described before the quarter one results were known. At Q1 the Trust has met its control total and is expecting to deliver the year end control total. However Surgery and Medicine are adverse to their operating plan trajectories with recovery plans required. The Divisional adverse position deteriorated significantly at month 5, seriously risking the Trust's ability to deliver the control total. However it is still forecast that non-recurring underspends will be found corporately to mitigate this.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2018- Summary Income & Expenditure Statement

Approved Budget / Plan 2018/19	Heading	Position as at 31st August			Actual to 31st July
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
582,186	From Activities	242,787	244,063	1,276	193,597
95,268	Other Operating Income (excluding Provider Sustainability Funding)	41,043	41,122	79	33,091
677,454	**Sub totals income**	**283,830**	**285,185**	**1,355**	**226,688**
	Expenditure				
(392,262)	Staffing	(165,358)	(168,099)	(2,741)	(133,251)
(243,058)	Supplies and Services	(99,311)	(100,586)	(1,275)	(80,709)
(635,320)	**Sub totals expenditure**	**(264,669)**	**(268,685)**	**(4,016)**	**(213,960)**
(3,542)	Reserves	(1,250)	-	1,250	-
-	NHS Improvement Plan Profile		-	-	-
38,592	Earnings before Interest,Tax,Depreciation and Amortisation	**17,911**	**16,500**	**(1,411)**	**12,728**
5.70	**EBITDA Margin - %**		**5.79**		**5.61**
	Financing				
(23,703)	Depreciation & Amortisation - Owned	(9,876)	(9,734)	142	(7,816)
244	Interest Receivable	102	144	42	103
(242)	Interest Payable on Leases	(101)	(101)	-	(81)
(2,507)	Interest Payable on Loans	(1,045)	(1,067)	(22)	(855)
(9,384)	PDC Dividend	(3,910)	(3,910)	-	(3,128)
(35,592)	**Sub totals financing**	**(14,830)**	**(14,668)**	**162**	**(11,777)**
3,000	NET SURPLUS / (DEFICIT) before Technical Items excluding Provider Sustainability Funding	**3,081**	**1,832**	**(1,249)**	**951**
4,644	Provider Sustainability Funding - Performance	1,316	1,316	-	1,006
10,836	Provider Sustainability Funding - Core	3,070	3,070	-	2,348
18,480	SURPLUS / (DEFICIT) before Technical Items including Provider Sustainability Funding	**7,467**	**6,218**	**(1,249)**	**4,305**
	Technical Items				
3,000	Donations & Grants (PPE/Intangible Assets)	417	629	212	594
629	Impairments	-	-	-	-
-	Reversal of Impairments	-	-	-	-
(1,519)	Depreciation & Amortisation - Donated	(620)	(652)	(32)	(521)
20,590	SURPLUS / (DEFICIT) after Technical Items including Provider Sustainability Funding	**7,264**	**6,195**	**(1,069)**	**4,378**

Appendix 2

Approved Budget / Plan 2018/19	Division	Total Budget to Date	Total Net Expenditure / Income to Date	Variance [Favourable / (Adverse)]				Total Variance to date	Total Variance 31st July	Operating Plan Trajectory Year to Date	Variance from Operating Plan Year to Date	CIP Variance
				Pay	Non Pay	Operating Income	Income from Activities					
£'000		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	Corporate Income (excluding Provider Sustainability Funding)											
576,920	Contract Income	241,754	241,754	-	-	-	-	-	-			
5,632	Pay Award Funding	2,345	2,345	-	-	-	-	-	-			
-	Penalties	-	-	-	-	-	15	15	1			
-	Contract Rewards	-	-	-	-	-	187	187	75			
3,500	Overhead share of income variance	3,500	3,659	-	752	-	(795)	(43)	105			
36,284	NHSE Income	15,119	15,119	-	-	-	-	-	-			
622,336	**Sub Total Corporate Income**	**262,718**	**262,877**	**-**	**752**	**-**	**(593)**	**159**	**181**			
	Clinical Divisions											
(56,932)	Diagnostic & Therapies	(23,675)	(23,515)	222	(265)	14	189	160	161	94	66	(35)
(87,082)	Medicine	(36,362)	(37,647)	(1,319)	(242)	-	276	(1,285)	(844)	(317)	(968)	(378)
(114,213)	Specialised Services	(47,482)	(47,278)	(82)	(8)	100	194	204	275	(134)	338	133
(112,084)	Surgery	(46,823)	(48,259)	(701)	(1,383)	(22)	670	(1,436)	(995)	(130)	(1,306)	(172)
(129,126)	Women's & Children's	(53,700)	(54,317)	(1,117)	138	14	348	(617)	(121)	(445)	(172)	(601)
(499,437)	**Sub Total - Clinical Divisions**	**(208,042)**	**(211,016)**	**(2,997)**	**(1,760)**	**106**	**1,677**	**(2,974)**	**(1,524)**	**(932)**	**(2,042)**	**(1,053)**
	Corporate Services											
(39,030)	Estates and Facilities	(16,516)	(16,488)	78	(73)	-	23	28	16	39	(11)	59
(28,076)	Trust Services	(11,330)	(11,366)	186	(178)	(44)	-	(36)	(18)	-	(36)	1
(13,659)	Other	(7,669)	(7,507)	(8)	(15)	3	182	162	245	-	162	-
(80,765)	**Sub Totals - Corporate Services**	**(35,515)**	**(35,361)**	**256**	**(266)**	**(41)**	**205**	**154**	**243**	**39**	**115**	**60**
(580,202)	**Sub Total (Clinical Divisions & Corporate Services)**	**(243,557)**	**(246,377)**	**(2,741)**	**(2,026)**	**65**	**1,882**	**(2,820)**	**(1,281)**	**(893)**	**(1,927)**	**(993)**
(3,542)	Reserves	(1,250)	-	-	1,250	-	-	1,250	495			
-	NHS Improvement Plan Profile	-	-	-	-	-	-	-	-			
(3,542)	**Sub Total Reserves**	**(1,250)**	-	-	1,250	-	-	1,250	495			
38,592	**Earnings before Interest,Tax,Depreciation and Amortisation**	**17,911**	**16,500**	**(2,741)**	**(24)**	**65**	**1,289**	**(1,411)**	**(605)**	**(893)**	**(1,927)**	**(993)**
	Financing											
(23,703)	Depreciation & Amortisation - Owned	(9,876)	(9,734)	-	142	-	-	142	85			
244	Interest Receivable	102	144	-	42	-	-	42	22			
(242)	Interest Payable on Leases	(101)	(101)	-	-	-	-	-	-			
(2,507)	Interest Payable on Loans	(1,045)	(1,067)	-	(22)	-	-	(22)	(19)			
(9,384)	PDC Dividend	(3,910)	(3,910)	-	-	-	-	-	-			
(35,592)	**Sub Total Financing**	**(14,830)**	**(14,668)**	-	**162**	**-**	**-**	**162**	**88**			
3,000	**NET SURPLUS / (DEFICIT) before Technical Items excluding Provider Sustainability Funding**	**3,081**	**1,832**	**(2,741)**	**138**	**65**	**1,289**	**(1,249)**	**(517)**	**(893)**	**(1,927)**	**(993)**
4,644	Provider Sustainability Funding - Performance	1,316	1,316						-			
10,836	Provider Sustainability Funding - Core	3,070	3,070						-			
15,480	**Sub Total Provider Sustainability Funding**	**4,386**	**4,386**					**-**	**-**			
18,480	**SURPLUS / (DEFICIT) before Technical Items including Provider Sustainability Funding**	**7,467**	**6,218**	**(2,741)**	**138**	**65**	**1,289**	**(1,249)**	**(517)**	**(893)**	**(1,927)**	**(993)**
	Technical Items											
3,000	Donations & Grants (PPE/Intangible Assets)	417	629	-	-	212	-	212	294			
629	Impairments	-	-	-	-	-	-	-	-			
-	Reversal of Impairments	-	-	-	-	-	-	-	-			
(1,519)	Depreciation & Amortisation - Donated	(620)	(652)	-	(32)	-	-	(32)	(25)			
2,110	**Sub Total Technical Items**	**(203)**	**(23)**	-	**(32)**	**212**	-	**180**	**269**			
20,590	**SURPLUS / (DEFICIT) after Technical Items including Provider Sustainability Funding**	**7,264**	**6,195**	**(2,741)**	**106**	**277**	**1,289**	**(1,069)**	**(248)**	**(893)**	**(1,927)**	**(993)**

REGISTERED NURSING - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*3.1%*	*3.1%*	*3.1%*	*4.3%*	*4.3%*	*4.3%*	*3.9%*	*3.9%*	*3.9%*	*3.8%*	*3.8%*	*3.8%*
Medicine	Actual	3.1%	2.1%	3.2%	3.0%	3.5%							
Specialised Services	*Target*	*3.6%*	*3.6%*	*3.6%*	*3.5%*	*3.5%*	*3.5%*	*3.8%*	*3.8%*	*3.8%*	*3.9%*	*3.9%*	*3.9%*
Specialised Services	Actual	2.2%	2.2%	2.3%	3.6%	2.9%							
Surgery	*Target*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Surgery	Actual	3.5%	3.4%	4.3%	4.2%	3.4%							
Women's & Children's	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.1%*	*4.1%*	*4.1%*	*4.6%*	*4.6%*	*4.6%*	*4.4%*	*4.4%*	*4.4%*
Women's & Children's	Actual	4.5%	4.1%	4.2%	4.6%	4.1%							

Source: HR info available after a weekend- Mth 8 data not available

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	7.9%	7.7%	9.1%	8.8%	9.8%							
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	9.0%	10.1%	9.5%	9.4%	9.1%							
Surgery	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery	Actual	7.9%	8.2%	7.0%	8.8%	7.9%							
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	2.2%	3.8%	5.0%	5.5%	6.4%							

Source: HR

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*	*14.0%*
Medicine	Actual	14.8%	15.5%	16.0%	16.2%	16.4%							
Specialised Services	*Target*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*	*13.5%*
Specialised Services	Actual	18.0%	17.4%	18.2%	17.0%	17.2%							
Surgery	*Target*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*	*11.8%*
Surgery	Actual	16.3%	16.6%	16.9%	16.7%	16.3%							
Women's & Children's	*Target*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*	*10.1%*
Women's & Children's	Actual	12.9%	13.2%	13.4%	13.2%	13.5%							

Source: HR - Registered
Note: M4 figs restated

Graph 4 **Operating plan for nursing agency £000**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*135.2*	*113.8*	*113.8*	*95.2*	*95.2*	*95.2*	*95.2*	*113.8*	*135.2*	*135.2*	*128.0*	*113.8*
Medicine	Actual	118.0	121.6	134.8	187.0	203.5							
Specialised Services	*Target*	*50.8*	*50.8*	*50.8*	*50.8*	*50.8*	*50.8*	*36.3*	*36.3*	*36.3*	*36.3*	*36.3*	*36.3*
Specialised Services	Actual	43.0	23.4	55.4	67.2	88.2							
Surgery	*Target*	*49.7*	*54.6*	*49.7*	*54.6*	*49.7*	*39.7*	*39.7*	*39.7*	*29.8*	*39.7*	*39.7*	*39.7*
Surgery	Actual	90.2	104.0	82.4	93.8	109							
Women's	*Target*	*4.5*	*4.5*	*4.5*	*4.1*	*4.1*	*4.1*	*3.3*	*3.3*	*1.6*	*3.7*	*2.1*	*2.5*
Women's	Actual	0.4	6.0	2.9	4.3	3.3							
Children's	*Target*	*86.2*	*86.2*	*86.2*	*78.4*	*78.4*	*78.4*	*62.7*	*62.7*	*31.3*	*70.5*	*39.2*	*47.0*
Children's	Actual	186.1	167.5	223.2	183.5	202.4							
Trust Total	*Target*	326.4	309.9	305.0	283.2	278.2	268.3	237.2	255.8	234.3	285.5	245.3	239.3
Trust Total	Actual	437.7	422.5	498.7	535.8	606.4	-	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

Graph 5 **Operating plan for nursing agency wte**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*24.6*	*21.8*	*21.8*	*19.0*	*19.0*	*19.0*	*19.0*	*21.8*	*24.6*	*24.6*	*24.6*	*21.8*
Medicine	Actual	20.1	19.1	20.7	27.9	27.2							
Specialised Services	*Target*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*5.0*	*3.5*	*3.5*	*3.5*	*3.5*	*2.0*	*2.0*
Specialised Services	Actual	6.5	3.2	6.9	9.0	10.3							
Surgery	*Target*	*10.0*	*11.0*	*10.0*	*11.0*	*10.0*	*8.0*	*8.0*	*8.0*	*6.0*	*8.0*	*8.0*	*8.0*
Surgery	Actual	10.1	14.5	11.6	13.6	15.4							
Women's	*Target*	*0.6*	*0.6*	*0.6*	*0.5*	*0.5*	*0.5*	*0.4*	*0.4*	*0.2*	*0.5*	*0.3*	*0.3*
Women's	Actual	0.2	0.9	0.4	0.6	0.3							
Children's	*Target*	*10.5*	*10.5*	*10.5*	*9.5*	*9.5*	*9.5*	*7.6*	*7.6*	*2.9*	*8.6*	*4.8*	*5.7*
Children's	Actual	22.7	21.1	25.2	22.7	22.4							
Trust Total	*Target*	50.6	48.8	47.8	45.0	44.0	42.0	38.5	41.3	37.1	45.1	39.6	37.8
Trust Total	Actual	59.6	58.8	64.8	73.7	75.5	-	-	-	-	-	-	-

Source: Finance GL (excludes NA 1:1)

Graph 6 **Operating plan for nursing agency as a % of total staffing**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.4%*	*6.3%*	*6.3%*	*5.3%*	*5.3%*	*5.3%*	*5.3%*	*6.2%*	*7.3%*	*7.3%*	*7.0%*	*6.2%*
Medicine	Actual	6.3%	6.5%	7.2%	9.5%	9.7%							
Specialised Services	*Target*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*3.6%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Specialised Services	Actual	3.1%	1.6%	3.8%	4.5%	5.5%							
Surgery	*Target*	*2.4%*	*2.7%*	*2.4%*	*2.7%*	*2.4%*	*2.0%*	*1.9%*	*1.9%*	*1.5%*	*1.9%*	*1.9%*	*1.9%*
Surgery	Actual	5.0%	5.6%	4.4%	5.0%	5.4%							
Women's	*Target*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.0%*	*0.1%*	*0.1%*	*0.1%*
Women's	Actual	0.0%	0.2%	0.1%	0.1%	0.1%							
Children's	*Target*	*2.4%*	*2.4%*	*2.4%*	*2.2%*	*2.2%*	*2.2%*	*1.7%*	*1.7%*	*0.9%*	*1.9%*	*1.1%*	*1.3%*
Children's	Actual	5.2%	4.6%	6.1%	5.0%	5.1%							
Trust Total	Actual	5.0%	4.8%	5.6%	6.0%	6.3%							

Source: Finance GL (RNs only)

Graph 7 **Occupied bed days**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	Actual	9,172	8,954	8,869	9,261	8,840							
Specialised Services	Actual	4,580	4,135	4,425	4,734	4,482							
Surgery	Actual	4,493	4,456	4,144	4,475	4,477							
Women's	Actual	2,762	2,734	2,580	2,991	2,702							
Children's	Actual	3,885	3,802	3,738	3,633	3,458							
Trust Total	Actual	24,892	24,081	23,756	25,094	23,959	-	-	-	-	-	-	

Source: Info web: KPI Bed occupancy

Graph 8 **ECO £000 (total temporary spend)**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*	*44*
Medicine	Actual	66	69	120	139	127							
Specialised Services	*Target*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*	*20*
Specialised Services	Actual	29	19	26	26	13							
Surgery	*Target*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*	*43*
Surgery	Actual	40	69	21	27	31							
Women's	*Target*	-	-	-	-	-	-	-	-	-	-	-	-
Women's	Actual	-	-	-	-	-							
Children's	*Target*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*	*12*
Children's	Actual	11	19	32	50	20							
Trust Total	*Target*	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6	119.6
Trust Total	Actual	145.6	176.0	199.0	243.2	191.0	-	-	-	-	-	-	-

Source: Service Improvement Team - Nikki

Graph 9 **CIP - Nursing & Midwifery Productivity**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Trust Total	*Target*	83	167	250	339	420	495	580	665	773	852	959	1,061
Trust Total	Actual	51	80	70	35	77							

Source: Service Improvement Team - Russell/Nikki

NURSING ASSISTANTS (UNREGISTERED) - NURSING CONTROL GROUP AND HR KPIs

Graph 1 **Sickness**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*7.1%*	*7.1%*	*7.1%*	*7.9%*	*7.9%*	*7.9%*	*6.1%*	*6.1%*	*6.1%*	*5.9%*	*5.9%*	*5.9%*
Medicine	Actual	6.1%	5.9%	6.6%	8.0%	7.2%							
Specialised Services	*Target*	*6.3%*	*6.3%*	*6.3%*	*5.8%*	*5.8%*	*5.8%*	*7.6%*	*7.6%*	*7.6%*	*6.3%*	*6.3%*	*6.3%*
Specialised Services	Actual	4.0%	3.0%	8.2%	8.7%	6.5%							
Surgery	*Target*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*	*4.0%*
Surgery	Actual	6.1%	5.1%	4.1%	6.0%	6.5%							
Women's & Children's	*Target*	*6.0%*	*6.0%*	*6.0%*	*7.0%*	*7.0%*	*7.0%*	*7.0%*	*7.0%*	*7.0%*	*6.0%*	*6.0%*	*6.0%*
Women's & Children's	Actual	9.1%	8.5%	10.4%	9.1%	7.8%							

Source: HR info available after a weekend- Mth 8 data not available

Graph 2 **Vacancies**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Medicine	Actual	12.5%	11.9%	9.7%	9.8%	6.3%							
Specialised Services	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Specialised Services	Actual	10.4%	10.9%	11.0%	10.0%	6.5%							
Surgery	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Surgery	Actual	9.1%	10.4%	9.7%	10.3%	9.6%							
Women's & Children's	*Target*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*	*5.0%*
Women's & Children's	Actual	3.0%	2.6%	4.3%	6.2%	4.4%							
Source: HR													

Graph 3 **Turnover**

Division	Target/Actual	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Medicine	*Target*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*	*18.5%*
Medicine	Actual	20.2%	19.7%	19.8%	20.0%	21.3%							
Specialised Services	*Target*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*	*17.0%*
Specialised Services	Actual	20.3%	17.7%	16.2%	14.8%	13.5%							
Surgery	*Target*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*	*16.9%*
Surgery	Actual	16.9%	15.4%	14.8%	15.8%	14.4%							
Women's & Children's	*Target*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*	*12.1%*
Women's & Children's	Actual	15.0%	15.0%	14.9%	16.1%	17.9%							

Cover report to the Public Trust Board meeting to be held on Thursday 27 September 2018 at 11:00 am – 13:00 pm in the Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

Agenda Item	18
Meeting Date	Thursday, 27 September 2018

Meeting Title	Public Trust Board
Report Title	**Finance Committee Chair's Report**
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	28 August 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 meeting of 28 August 2018.

Dermatology Demand Management
The Committee received an update on increases in demand for dermatology services and mechanisms to manage this, in particular improved usage of facilities at South Bristol Community Hospital.

Surgery Non-Pay Update
The Committee received an update on the non-pay position of the surgery division, including an analysis of the overspend and mitigating actions.

Finance Director's Report
The Director of Finance and Information Paul Mapson presented the report. Key points of discussion included the following:

- The Operational Plan requirement to July was a surplus of £4.882m excluding technical items, and the Trust was reporting a surplus of £4.305m, £0.517m adverse to plan.
- The key areas of concern were the divisional positions reported for Surgery and Medicine. The focus was on returning the divisions to a sustainable run rate for 2019/20.
- Capital expenditure was slightly behind internal planning, and the forecast was a significant underspend on the capital plan, predominantly relating to strategic capital. This had resulted in higher than plan cash balances.

Contract Income and Activity Reports
The Assistant Director of Finance, Richard Smith, presented the report. Key points noted included the following:

- Contract income for 2018/19 was £0.03m higher than plan in July 2018.
- Uncoded activity was higher than expected and thus the risk around income estimate was higher.
- The 2019/20 tariff engagement document was now likely to be published in November at the earliest which would affect planning for 2019/20.

Detailed Divisional Financial Reports
The detailed Divisional reports were noted, as the detail around the Medicine and Surgical division's performance had been discussed earlier in the meeting.

Savings Programme
The Committee noted the following:

- The Trust had achieved savings of £7.507m against a plan of £7.680m, an underachievement of £173k.
- The majority of plans were expected to deliver towards the end of the financial year and therefore focus was required to ensure delivery and address the under delivery to date.

Capital Income and Expenditure Report
The Committee noted the following:

- Capital expenditure to the end of July was £6.362m compared to an internal plan of £6.493m. This was against an overall capital programme of £47.089m.

<u>The following were received for assurance:</u>

- **Minutes of Capital Programme Steering Group**
- **Statement of Financial Position**
- **Month 4 NHS Improvement Submission**

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 September 2018

Cover report to the Public Trust Board Meeting to be held on 27 September 2018 at 11.00 – 13.00am, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	19
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Strategic Capital Programme and Medium Term Financial Plan**		
Author	Paula Clarke, Director of Strategy and Transformation, Paul Mapson, Director of Finance and Information		
Executive Lead	Paula Clarke, Director of Strategy and Transformation 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

This paper sets out proposals for a Strategic Capital Investment Programme and associated Medium Term Financial Plan (MTFP) for the period 2018/19 to 2022/23.

Key issues to note

Delivering consistent high quality, patient-centred care and valuing our people, are core to the mission of the Trust. Providing a modern, fit for purpose environment is an essential part of achieving these priorities.

Following completion of the 10 year Trust Service and Financial Strategy agreed in 2006 (the Phase 4 redevelopment programme) at the beginning of 2017, it is now essential that the Trust moves forward

to;

- continue to renew and upgrade our medical equipment, IT and estates infrastructure as it comes to the end of its asset life and
- identify future priorities for capital investment aligned to the review, prioritisation and stratification of our core clinical services strategy (phase 5)

The proposed Strategic Capital Investment Programme up to 2022/23 is therefore essential to support the Trust in renewing and upgrading what is an aged estate and supporting expansion of very specialist acute care provision that can only be delivered in a hospital environment.

The prioritised major strategic schemes proposed within the capital investment programme, underpin our existing and draft strategic intentions, balancing proposals for further development of our key specialist service portfolio, with ensuring our environment remains modern, fit for purpose and capable of managing appropriate increasing demand.

The programme covers the priorities within a Phase 5 clinical services programme, the infrastructural programme for medical equipment, operational capital, estates replacement and IT. It also reflects the need for adaptation for any new, emerging requirements from the Trust 2025 strategy renewal process and the external environment at fixed points and on an ongoing, horizon-scanning basis.

Our strategic planning processes have, and will continue to, reflect the emerging priorities of the Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together STP which include the goal of “delivering leading edge specialist acute services for people across the region and beyond.” Continuing to invest in our hospitals infrastructure will support this ambition, helping us to provide the environment required to attract, retain and educate excellent staff, continue to attract research trials, and deliver quality care that can only be delivered in an acute setting.

The proposed investment priorities will be assessed within the context of an updated Site Development Plan, that will set out the current estate, fixed points and support decision-making on the probable scenarios for strategic capital development, and within the financial strategy as set out in the Medium Term Financial Plan (MTFP).

The MTFP sets out the 5 year financial strategy, the source and application of funds for the Programme and an assessment of how major risks to the Programme will be managed. Over 50% of the planned investment is being made into replacement and upgrade of existing estate and equipment.

Alongside this programme, we will support prioritisation capital funding opportunities within the STP that secure investment into primary and community settings, supporting delivery of care out of hospital via networked teams to achieve the shared goal of keeping people healthy, well and independent in their communities. This includes using our digital investment to support connectedness and enhanced integrated care.

While the programme is proposed to be aligned to sub-categories for major clinical services strategic schemes, medical equipment and operational capital, IT, Estates replacement, infrastructure and compliance, it should be recognised that the specific value assigned to each sub-programme has no formula supporting its calculation at this stage and is instead an initial assessment based on preliminary designs alongside the application of experience over the past 10-20 years. The values within the sub-categories within the programme will therefore be subject to modification but the commitment would remain to a total programme of £237m overall.

The governance structures established to ensure effective reporting, authority and accountability for schemes within the approved programme are set out in the paper.

Recommendations

Members are asked to:

- **Approve** commitment to a Strategic Capital Investment Programme totalling £237m to 2022/23
- **Agree** the indicative allocation of this Programme into the proposed categories of
  - Major clinical services strategic schemes
  - Medical Equipment and Operational Capital
  - Information Technology
  - Estates Replacement
  - Estates Infrastructure and Compliance

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**	**SLT**
	25 July 2018			18 July 2018

STRATEGIC CAPITAL INVESTMENT PROGRAMME
AND MEDIUM TERM FINANCIAL PLAN

1. Introduction

1.1 Delivering consistent high quality, patient-centred care and valuing our people, are core to the mission of the Trust. Providing a modern, fit for purpose environment is an essential part of achieving these priorities.

1.2 The 10 year Trust Service and Financial Strategy agreed in 2006 resulted in the Phase 4 redevelopment programme – a significant programme of investment into the Trust's estate, updating and refurbishing wards throughout the Queens building, the consolidation services onto the main precinct to the north of Upper Maudlin Street, ultimately leading to the vacation and sale of the Old Building site. The final component of this programme, the King Edward Building refurbishment, completed at the beginning of 2017.

1.3 It is now essential that the Trust moves forward to;

- identify future priorities for capital investment aligned to the review, prioritisation and stratification of our core clinical services strategy (phase 5);

and

- continue to renew and upgrade our medical, IT and estates infrastructure as it comes to the end of its asset life

by agreeing a Strategic Capital Investment Programme and associated Medium Term Financial Plan (MTFP) for the period 2018/19 to 2022/23.

1.4 Our strategic planning processes have, and will continue to, reflect the emerging priorities of the Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together STP which include the goal of "delivering leading edge specialist acute services for people across the region and beyond." Continuing to invest in our hospitals infrastructure will support this ambition, helping us to provide the environment required to attract, retain and educate excellent staff, continue to attract research trials, and deliver quality care that can only be delivered in an acute setting. Alongside this programme, we will support and prioritise capital funding opportunities within the STP that secure investment into primary and community settings.

1.5 Development of a 'Phase 5' capital programme began in late 2016. In Q4 2017/18, we commenced a strategy renewal process to develop our 5 year forward, 2025 Vision. The alignment of the proposed Phase 5 programme of investment with the draft strategic priorities and objectives to 2025 agreed by the Board in May 2018 is considered in this paper.

1.6 This provides assurance that the prioritised major strategic schemes proposed within the Phase 5 capital investment programme underpin our existing and draft strategic intentions, balancing proposals for further development of our key specialist service portfolio, with ensuring our environment remains modern, fit for purpose and capable of managing appropriate increasing demand.

1.7 The uncertain environment the Trust operates within creates the need for flexibility and effective risk management in investment decisions. This includes the national policy and funding context, the evolving Healthier Together STP plans, and potentially disruptive technologies. The establishment of robust governance processes for the Programme will ensure that, in line with good strategic planning practice, emerging opportunities or risks will be constantly sought out or reacted to, and our plans adapted accordingly.

1.8 If the new Strategic Capital Investment Programme can be delivered, it will create significant momentum to delivery of the Trust's Strategy, enhance patient care and staff satisfaction.

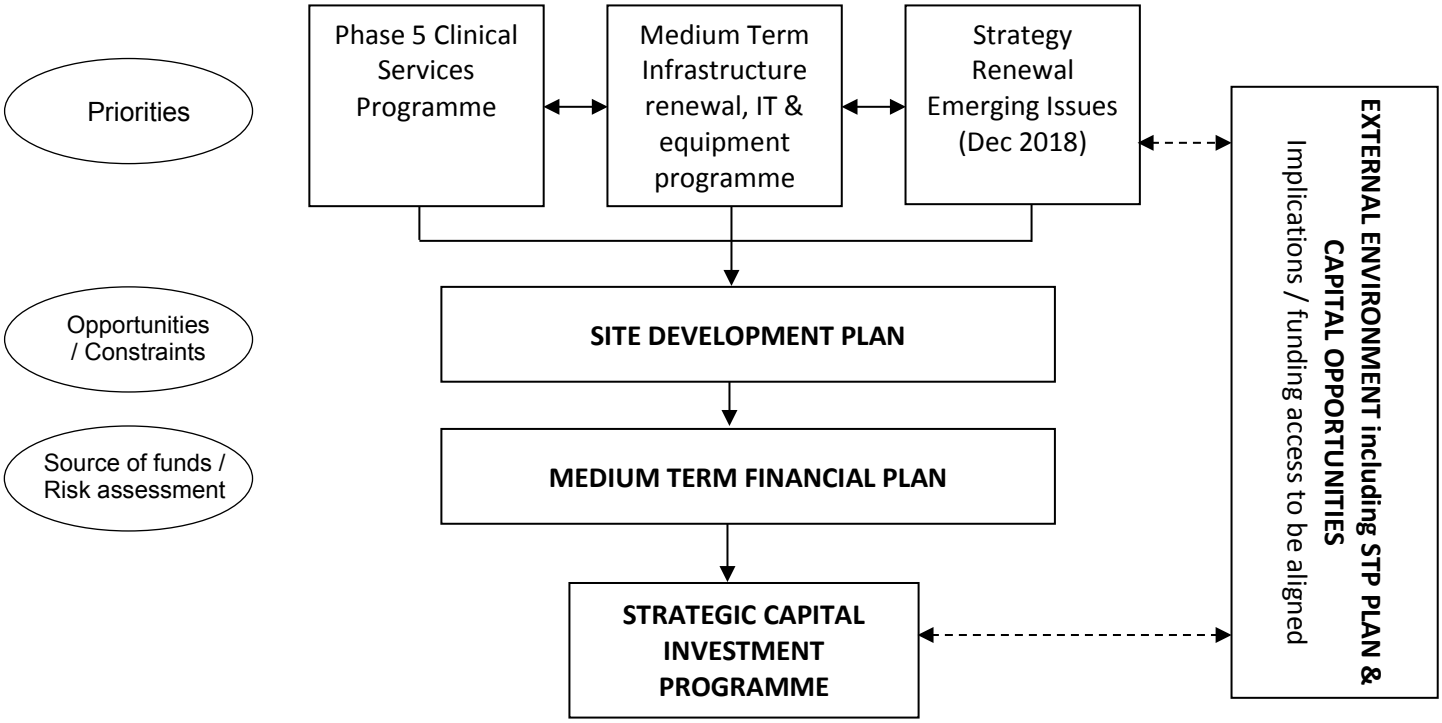
2. Overview

2.1 Diagram 1 provides an overview of the approach being taken to address a comprehensive assessment of the key elements that need to be included in the strategic capital investment programme. This covers the priorities within the Phase 5 clinical services programme and the infrastructural renewal programme for medical equipment, operational capital, estates replacement and IT.

It also reflects the need for adaptation for any new, emerging requirements from the strategy renewal process and the external environment at fixed points and on an ongoing, horizon-scanning basis.

2.2 The priorities for what we want to deliver will be assessed within the context of an updated Site Development Plan that will set out the current estate, fixed points and support decision-making on the probable scenarios for strategic capital development, and the financial strategy as set out in the Medium Term Financial Plan (MTFP). Each of these areas is set out in more detail in the paper.

Diagram 1: Programme Overview:



3. Clinical Services Programme (Phase 5)

3.1 Our current Trust Strategy ("Rising to the Challenge 2020") states that, as an organisation, our key challenge is to maintain and develop the quality of our services, whilst managing within the finite available resources with our focus being on "affordable excellence". We are also clear that we operate as part of a wider health and care community.

3.2 Our Vision is for Bristol and our hospitals to be among the best and safest places in the country to receive care and our strategic intent is to provide excellent local, regional and tertiary services, and maximise the benefit to our patients that comes from providing this range of services.

3.3 We are committed to addressing the aspects of care that matter most to our patients and in 2016/17, we commenced a review to prioritise and stratify our clinical strategy and the associated programme for strategic capital development. The main aim of the Phase 5 programme has been to fund developments on the basis that they either:

- Developed the physical estate to support the implementation of our clinical strategy and our focus on the delivery of specialist services locally and regionally.
- Provide a required update to poor clinical and staff environments in areas not covered by phases 1-4 of the programme.

3.4 The following steps in the process were completed:

- Programme and timeline established and agreed through SLT, including revised prioritisation framework.
- Divisional teams completed bids on a standard database to establish a long list of priorities.
- Divisional teams completed scoring completed against a revised prioritisation framework.
- Senior review of emerging priorities to agree next steps. This process prioritised a number of schemes for consideration.
- Outline business cases (OBCs) completed in most areas, with some areas still to be fully completed. These OBCs assess strategic alignment, operational, financial and clinical viability.

3.5 The schemes currently included in the Phase 5 Clinical Services Programme are summarised in Table 1 overleaf alongside an assurance that these schemes align with the draft 2025 strategic priorities (further explained in section 4.)

Table 1: Phase 5 Clinical Services Programme Summary

Scheme	Brief summary of schemes	Strategic alignment (2025 draft priorities)
Myrtle Road Acquisition and refurbishment	This scheme involves the purchase of the Myrtle Road property at top of St Michael's Hill. This will provide additional non-clinical space to enable the transfer of non-clinical functions out of core clinical areas to support the other schemes in the programme. There is currently no vacant space on the site to enable the required moves. Strategically, this will also support an improved and modern environment for non-clinical staff.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing
Cardiology Expansion	Cardiology services are part of our core specialist and regional provision and the service has demonstrated year on year growth, with further growth planned for 2018/19. Increased contracts for additional activity have been agreed with local and specialised commissioners and additional physical space for catheter laboratories and in-patient beds is now required to ensure we can continue to realise our strategic priority to develop our specialist offer.	Consolidate and grow our specialist clinical services.
Cardiac Research Unit	Cardiac research is central to our research and innovation agenda and to ensuring patients can continue to access leading edge interventions. This scheme proposes to co-locate the Cardiac Research Unit currently provided on Queen's building L7 with the BHI and also vacates core clinical space on L7 of the Queens Building to enable re-provision of medical ward capacity in support of the expansion of cardiac and cardiac inpatient facilities.	Be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation.
D603 (BHOC inpatient ward refurbishment)	Refurbishment of Bristol Haematology and Oncology Centre (BHOC) inpatient ward. Providing an improved and modernised environment for staff and patients.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing.
Integrated critical care	The provision of critical care facilities is core to the development of our specialist surgical cancer and cardiac work, which are central to the strategic development of our specialist and regional services portfolio. The proposed scheme will assess the opportunities to integrate general and cardiac ICU provision, along with expansion in the bed base to address the current constraints in capacity and account for future growth.	Consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services.
BHOC expansion	Cancer services are core to providing high quality services to the local population and to continue to develop and innovate in our specialist and regional services. Sustained growth has been experienced in haematology and oncology services over the last 5 years, supported by increased contracts with our commissioners and income growth in these areas. Additional physical capacity and modernisation of the environment is required in BHOC to respond to this growth and maintain an appropriate environment for staff and patients alongside expanding oncology service access in more local units.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing. Consolidate and grow our specialist clinical services. Be at the leading edge of research and transformation.

Scheme	Brief summary of schemes	Strategic alignment (2025 draft priorities)
Holistic Well-being Centre	Patient feedback has continued to reflect the need for an appropriate environment aligned to, but separate from, the hospital environment for patients with cancer or other long term conditions. Work is underway to assess the development of a holistic/cancer centre for our patients, via a collaboration between the Trust and Maggie's and Penny Brohn charities. This programme is strategically aligned to our quality objectives, as well as our development of general and specialist cancer services.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.
St Michaels Hospital level E (maternity) refurbishment	Upgrade of outdated environment at St Michael's Hospital (STMH) for maternity services. Strategically aligned to providing a modern and up to date environment for our staff and patients and to achieving high quality care in our general services for the local population we serve.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing.
Bristol Eye Hospital ground floor design	We have seen ongoing growth in Ophthalmology services over the past 5 years, resulting in contract growth with commissioners. The environment within the Bristol Eye Hospital (BEH), and particularly on the ground floor is outdated and suboptimal in layout to maximise efficient working for staff and timely throughput for patients. This scheme proposes to change the layout of areas of the BEH identified as suboptimal to enable new ways of working and models of care to improve the productivity of outpatient services, expand capacity to match increased demand and provide a modern environment for staff and patients. There is clear alignment of this programme to our current and future strategic objectives, both in relation to environment and driving productivity and efficiency and to the development of our local and specialist service offer.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing Deliver financial sustainability for the Trust
Bristol Royal Hospital for Children Expansion	The delivery of local, regional and super-regional services for children is a core strand of our clinical, teaching and research agenda, both currently and for the future. Since the centralisation of specialist paediatric services, we have continued to experience growth across a number of our paediatric services. This has led to the requirement for additional space in the children's hospital and this proposal is to expand facilities in the Emergency Department, outpatients, inpatient beds and paediatric intensive care services. This will result in high quality modern environment for staff and patients, as well as enabling the future strategic development of our paediatric services.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing. Consolidate and grow our specialist clinical services. Be at the leading edge of research and transformation.

Scheme	Brief summary of schemes	Strategic alignment (2025 draft priorities)
Transport Hub	Proposed development to provide an 820 space car park, to make it easier for patients and visitors to find a parking space and reduce the need for drop-offs outside our hospitals. The transport hub would only be available for patients, visitors and a proportion for staff. It is also intended that the hub would become a location for shuttle buses to pick-up and drop-off people who wish to reach our hospitals and will provide 400 cycle spaces for staff, helping to free up some of the public cycle parking spaces that our staff currently use.	Excel in consistent delivery of high quality, patient centred care, delivered with compassion. Invest in our staff and their wellbeing
Expansion of the Neonatal Intensive Care Unit /Central Delivery Suite	The provision of high quality neonatal intensive care facilities is central to the strategic development of our maternity and paediatric services portfolio. Work is currently underway with North Bristol NHS Trust (NBT) and commissioners to assess how we can collaborate to deliver safe, sustainable services for the local and regional population into the future. The outcome of this work will determine the physical redesign of the space and capital requirement	Consolidate and grow our specialist clinical services. Lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.
Dermatology upgrade and expansion	The environment within the current dermatology department requires significant refurbishment in order to provide an adequate clinical and non-clinical environment for staff and patients. Its current location is also suboptimal, with patients experiencing difficulty in accessing the department. In addition, dermatology activity has grown significantly over the last 5 years, supported by increased commissioner contracts. This has included the transfer of activity from Weston and more recently, from Taunton. Dermatology services are core to our clinical services strategy, both in relation to general services we provide to our local population and the development of specialist work for the wider region. The proposal is to build a new and modern unit to provide the required space for the expanding service, as well as a modern environment for staff and patients.	Consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions
Queen's Level 7 Ward	An additional medical ward is required on the Bristol Royal Infirmary (BRI) site to support the development of cardiology services as part of the scheme outlined (i.e. provide space within the Bristol Heart Institute (BHI) to increase cardiology ward capacity) and support resilience of patient flow in the context of increasing medical admissions. The development of medical and cardiology inpatient services is core to our provision of urgent and planned care services for our local and regional populations.	Consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions
Theatre and Endoscopy facilities	Proposed review and potential redesign of the current theatre and endoscopy facilities, with a focus on Queen's Day Unit (Level 4 BRI) to support the development of endoscopy and theatre facilities.	Consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions

An indicative scheme cost phasing programme is included in Appendix B and the governance and approvals process for decision-making on the individual schemes is included in section 9.

4. Strategy Renewal – Embracing Change, Proud to Care, Our 2025 Vision

4.1 In Q4 2017/18, the Trust commenced a strategy renewal process to develop our 5 year forward, 2025 Vision. Following extensive analysis and engagement with staff and stakeholders, new strategic priorities and supporting objectives for the organisation were agreed as draft by the Board in May 2018.

4.2 These strategic priorities and objectives provide direction for the Trust to 2025 and Divisions are currently developing detailed plans addressing what the key implications and actions are for achieving these strategic ambitions. This assessment will be completed by October 2018 following which, further work will be undertaken to align our clinical, research, education and learning strategies with the enabling strategies. The latter will include the Estates Strategy, informed by the Site Development Plan currently being updated.

4.3 The Draft strategic priorities are included in Table 2 below with the full details of the proposed priorities and associated strategic objectives attached in Appendix C. Assurance regarding how the strategic capital investment programme aligns with the 2025 strategic intent is demonstrated in Table 1 above.

Table 2: 2025 Draft Strategic Priorities

Excel in consistent delivery of high quality, patient centred care, delivered with compassion.
Invest in our staff and their wellbeing, supporting them to care with pride and skill, educating and developing the workforce for the future
Consolidate and grow our specialist clinical services and improve how we manage demand for our general acute services, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions
Lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve
Be at the leading edge of research and transformation that is translated rapidly into exceptional clinical care and embrace innovation
Deliver financial sustainability for the Trust and contribute to the financial recovery of our health system to safeguard the quality of our services for the future

4.4 Our strategic planning processes have, and will continue to, reflect the emerging priorities of the Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together STP. It is clear that nationally the focus is on allocating significant capital funding (primarily Public Dividend Capital), via STPs. Guidance was issued pre-Easter seeking consolidated capital plans/proposals prioritised across all partners that are aligned with STP objectives and can demonstrate savings delivery/value for money (VFM). The STP Executive have completed an initial prioritisation process and are progressing a system Estates Strategy. Alongside our internal capital investment programme, the Trust will continue to support and prioritise investment for these STP funds in primary and community capacity developments.

4.5 As firmer plans emerge for STP capital investment, it will be important to review our individual Outline Business Case (OBC) options to establish if we can reduce or change the level of physical

requirement internally by delivering some of the service requirement in "STP" facilities. This consideration merely reflects good practice in strategic planning, where emerging opportunities should constantly be sought out or reacted to, and our plans adapted accordingly.

5. Site Development Plan

5.1 The existing Estates Strategy sets out the estate priorities for the period out to 2020/2021. It has been agreed that this will be reviewed in 2018 to provide a Site Development Plan setting out the current estate, fixed points and supporting decision making on the probable scenarios for strategic capital development.

5.2 The plan will incorporate all buildings across the main hospital site, within the Trust boundary line, with all potential future development sites clearly identified. Where known, areas will be designated to specific strategic developments. The massing of potential developments will also be included, as well as options explored based on a range of planning and strategic scenarios.

6. The Financial Strategy

6.1 The Trust agreed a 10 year Service and Financial Strategy in December 2006. In October 2017, the Board approved an update document 'Strategic Finance – the Next Five Years'.

6.2 The planned income and expenditure surpluses from 2018/19 to 2022/23 were assessed at £11.763m each year.

6.3 The updated financial plan revises the position but only marginally i.e.

	2018/19	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Surplus / (Deficit)	£m	£m	£m	£m	£m
October 2017 Plan	11.763	11.763	11.763	11.763	11.763
July 2018 Plan	18.480	11.388	11.074	11.700	10.571

6.4 Clearly planning financial positions 5 years ahead can be subject to spurious accuracy but broadly the £10.0m–12.0m surpluses assumed are considered realist in the light of the following factors:

a) The 2018/19 plan is a £18.5m surplus, even after a likely Q4 loss of sustainability funding the delivery should be in the order of £17m. Hence going forward, the plan assumes a loss of c£6m pa compared to 2018/19, and so can be described as conservative.

b) The judgement of the loss of £6m surplus is based on factors that are likely to deteriorate the Trust's position such as:

- Sustainability funding is likely to be incorporated into tariff from 2019/20. This is likely to favour District General Hospital (DGH) Trusts and smaller hospitals at the expense of large Tertiary Trusts such as UH Bristol.

- Continued loss of teaching tariffs through Health Education England contracts (under graduate, post graduate medical and dental, Continuing Professional Development (CPD)) are highly likely for UH Bristol. This trend has been established already.

- National tariffs are likely to be less favourable in future for specialised services. UH Bristol gained £9.0m from the 2017/18 HRG 4+ tariffs so some adjustment is likely in future.

- Non-recurrent sources are needed to deliver the 2018/19 surplus. They cannot be repeated hence surplus levels may drop.

c) Despite some reduction in the level of surplus, the continued delivery of a c2% surplus is realistic, provided the Trust continues to operate at below average costs. A reference costs index of 96 or below is likely to be compatible with a 2% overall surplus.

6.5 Section 7 describes each line of the Medium Term Capital Programme in more detail (Sources and Applications) and the Trust also holds substantial cash balances (£78.0m at the end of 2018/19) which can be reduced to support the Capital Programme. Broadly, a risk rating of 2 for liquidity requires a working capital balance of £37.0m. The use of this working capital is then available to cover cash losses if they occur. The consequence is an inferior risk rating but risk ratings are not given the level of scrutiny that they received in the early years of Foundation Trusts so this is therefore effectively an available contingency going forward.

6.6 In conclusion, the Trust's financial positon is very healthy going forward and the agreement of a major Capital Investment Programme for the five year period can be considered with significant confidence.

7. The Proposed Capital Programme (2018/19 – 2022/23) – Source and Application of Funds

7.1 Appendix A shows a proposed Source and Application of Funds schedule. This is described below.

7.2 Source of Funds

a) Public Dividend Capital - £10.1m
This is NHS funding receivable and includes the £1.6m Cyber Security, £1.6m Global Digital Exemplar (GDE) and £6.8m STP Capital for the District Heating scheme (bid for but not yet agreed).

b) Borrowing through long term loans - £19.1m
This will either be NHS loans for the Transport Hub (already approved but not delivered) or Private Sector loans (to be commenced once the planning position is known). If the District Heating scheme is not approved as STP PDC then a private sector loan will be sought instead.

c) Donations - £9.9m
The £9.9m shown includes a Magnetic Resonance Imaging (MRI) Scanner, Helideck, Bristol Haematology and Oncology Centre (BHOC) D603 Ward, proposed Cardiac Research Unit and the Holistic Well-being Centre.

The level of current assumption is very conservative at present. There are considerable opportunities for supplementing the Capital Programme. Discussions have been held over the last 12-18 months with Above & Beyond, the hospitals charity, with the Grand Appeal, and with other charitable partners, with agreement to align support with specific clinical services capital schemes. As the programme is firmed up, such donations will be incorporated on a scheme by scheme basis, supported by written pledges by the Charities.

d) Depreciation - £122.7m
This is the annual depreciation charge on current assets and ranges from £24-25m pa. This are often described as internally generated funds for capital.

e) Income & Expenditure Surpluses - £63.2m
As already discussed in section 6.

f) Loan Payments - £31.1m
The existing long-term loan repayments are a first call against the Income & Expenditure surpluses. The value increases in 2021/22, when the Transport Hub loan repayments are due to commence.

g) Cash contribution - £43.0m
Trust cash balances can be used to supplement the Capital Programme. The cash balances shown in Appendix A still leave the Trust a liquidity risk rating of a 2 with a residual cash balance of £37.0m at the end of the five year period.

7.3 Application of Funds

a) Major Strategic Schemes - £120.3m

The schemes are still under development, both in timing and cost but the latest estimates are shown in Appendix B. As already mentioned in section 7.2 c), there is the opportunity to supplement the schemes with donations from charitable sources.

It should be noted that an annual contingency of £2.0m is included on the basis that currently unidentified scheme requirements will crop up during the 5 year period.

b) Medical Equipment - £45.9m

The requirement for replacement of Major Medical equipment (defined as £5k and over per item) has grown enormously over the past few years. The Trust has a good stock of medical equipment but needs to ensure it is kept within its useful life and is fully supported by the manufacturer or maintenance provider.

An analysis of all items of medical equipment over £0.40m gross replacement cost has been undertaken. This identified higher than normal requirements in 2019/20 and 2022/23 so additional sums have been allocated in those years (£2.0m and £3.0m respectively).

The Trust operates a rigorous prioritisation process for agreeing Medical Equipment replacement programmes. This is completed annually as part of the Operational Planning Process (OPP). Through this centrally coordinated process, Divisions submit bids for funding and these bids are prioritised based on technical resilience, business criticality and the risk to clinical services and the organisation of not replacing or investing in the equipment. The prioritised list is approved by Clinical Chairs and Divisional Directors, Clinical Programme Strategy Group (CPSG) and Senior Leadership Team (SLT).

c) Operational Capital - £37.4m

A sum of c£5.5m is allocated each year for schemes which are not agreed as strategic schemes. Again, a rigorous risk-based prioritisation process is operated to ensure the right schemes are approved, with the allocation of funding following the same process as medical equipment, as part of the OPP.

d) Information Technology - £22.0m

This represents the approved CSIP/GDE programme including software, staffing, hardware and other programme costs.

Included in the programme is £1.0m for annual device replacement, an increase of £0.5m on the current provision. This is due to the Divisions not routinely replacing PCs/Laptops when they are older therefore requiring catch-ups corporately to ensure PCs are still adequate to operate Trust systems. A rolling replacement programme will be created (using some funding levied from Divisional budgets to top up central funds).

e) Estates Replacement - £14.2m

The historical allocation of £2.5m pa for backlog maintenance / works replacement has been increased by £0.5m pa to reflect increased demands from backlog maintenance / plant replacement etc.

f) Estates Infrastructure and compliance - £5.0m

There have been occasional issues where schemes fall between the various programme categories and hence can become problematic if not addressed. The Estates Division is currently undertaking a review of key infrastructure systems across the Trust e.g. Theatre ventilation, Uninterrupted Power Supply (UPS) / Isolated Power Supply (IPS), Fire replacement and other areas, with a view to proactively validating performance and developing a comprehensive upgrade programme. Where issues are identified, separate business cases will be submitted to CPSG for funding approval. It is intended that this approach to proactive infrastructure management is extended across other key systems

going forward. £1.0m per annum has been included to provide a contingency fund for this type of requirement.

g) Slippage

From experience, a level of estimated overall programme slippage has been built-in each year for cash management purposes.

7.4 **Summary**

It should be recognised that the value assigned to each sub-programme has no formula supporting its calculation. Instead it is based on experience over the past 10-20 years. The values can be modified but not the total programme which is c. £237m overall.

This is a major financial investment for UH Bristol which will result in major improvements in the quality of clinical services provided.

8. Managing Risks

8.1 In deciding to make major capital investments, the Trust must consider how risks are managed over the five year period. Unforeseen adverse events as well as opportunities will emerge and we need to be clear how they will be managed. The major risks are described in this section along with the way these risks will be managed.

8.2 ***Risk that Income & Expenditure (I&E) surplus is not delivered or cannot be achieved.***
In this scenario, there will be less cash available to fund the Capital Programme.

The management of this risk will include:

a) Implement a financial recovery plan to re-instate the I&E surplus;
b) If a) is not possible (due to structural reasons or external factors such as lower tariffs) then either:
   i. Cash can be increased from other sources such as donations. It would, however, be unwise to use borrowing as a source in this scenario;

   ii. The Capital Programme can be reduced by re-prioritising the schemes within a lower overall value. As the programme is so substantial this should be achievable by either deleting schemes or deferring into later years.

8.3 ***Risk that capital schemes increase in cost beyond that included in the programme***.
Schemes can be reduced in content, deleted or deferred or additional sources obtained e.g. charitable funds. Schemes are being fully worked up as part of the Phase 5 Governance process using experience from the successful delivery and management of Phases 1 – 4.

8.4 ***Risk that new schemes are required that are not included in the proposed programme.***
Allowance has been made in the proposed programme for £2.0m pa Strategic Capital contingency. Other programmes have been reviewed and necessary changes incorporated to reduce the risk of schemes being unexpectedly required.

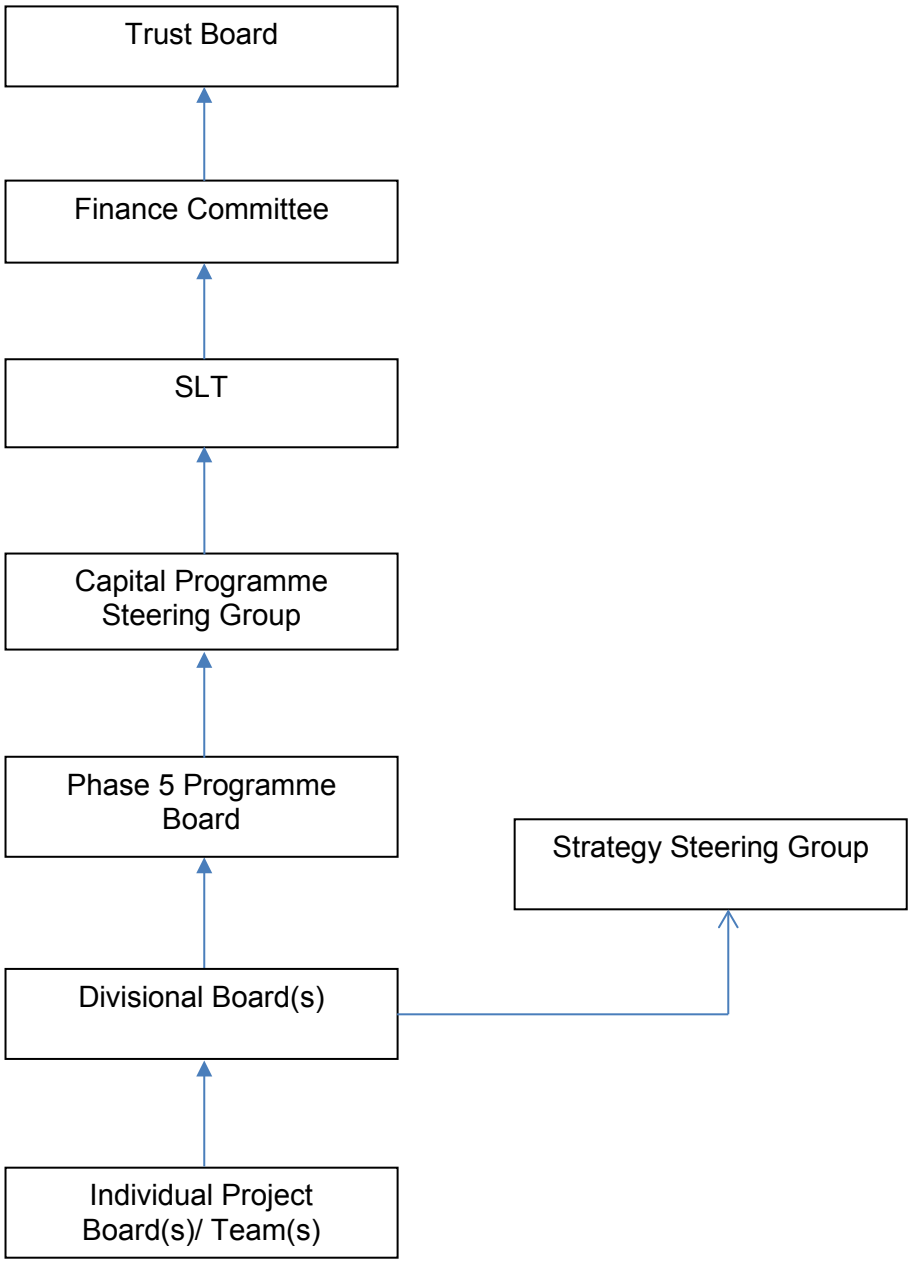
Again, additional sources may be possible; if not, the programme will need to be re-prioritised.

8.5 ***Risk that schemes have been committed contractually***
Therefore, if any of the above events occur, the ability to reduce programme spending may be restricted. In this scenario, scheme slippage or other lines in the Capital Programme will need to be reviewed and re-prioritised.

9. Governance

9.1 Below is an overview of the current governance structures established to ensure the effective reporting, authority and accountability for schemes within the approved programme. Terms of

Reference have been developed for the Phase 5 Programme Board and approved at SLT and are attached at Appendix D.



The process for approving the individual Outline Business Case for each scheme will accord with the Trust capital investment policy, which will require Board approval for all schemes in excess of 1% of Trust turnover.

10. Conclusion

10.1 The proposed investment programme up to 2022/23 is essential to support the Trust in renewing and upgrading what is an aged estate and supporting expansion of very specialist acute care provision that can only be delivered in a hospital environment. Over 50% of the investment is funded by depreciation and is reinvested into essential replacement and upgrades that ensure the delivery of high quality acute care into the future.

10.2 The programme demonstrates the desire of the Trust to continue to make major improvements in the quality of clinical services provided for the benefit of patients and staff, reflecting our key priorities to sustain delivery of excellent acute care alongside supporting delivery of care out of hospital via networked teams. We will continue to work with partners to ensure that STP capital

investment is prioritised into appropriate facilities /environments in primary and community settings and we will using our digital investment to support connectedness and enhanced integrated care.

11. Recommendations

The Board are asked to:

- **Approve** commitment to the Strategic Capital Investment Programme of £237m to 2022/23
- **Agree** the indicative allocation of this Programme into the proposed categories of
  - Major clinical services strategic schemes
  - Medical Equipment and Operational Capital
  - Information Technology
  - Estates Replacement
  - Estates Infrastructure and Compliance

Paula Clarke
Director of Strategy & Transformation

Paul Mapson
Director of Finance and Information Technology

September 2018

Strategic Capital Investment Programme and Medium Term Financial Plan — **Appendix A**

Source and Application of Funds - July 2018

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
Source of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Public Dividend Capital	1,600	8,481		0	0	**10,081**
Borrowing	0	0	19,133	0	0	**19,133**
Donations	3,000	1,300	5,600	0	0	**9,900**
Disposals	0	0	0	0	0	**0**
Grants & Contributions	0	0	0	0	0	**0**
Depreciation	24,338	24,584	23,881	24,405	25,487	**122,695**
Income & Expenditure Surplus	18,480	11,388	11,074	11,700	10,571	**63,213**
Loan Repayment	(5,834)	(5,834)	(5,834)	(6,791)	(6,791)	**(31,084)**
Cash Balances	4,300	7,035	(1,269)	13,615	19,306	**42,987**
Total Source of Funds	**45,883**	**46,954**	**52,585**	**42,929**	**48,573**	**236,924**
Application of Funds						
Major Strategic Schemes	7,611	21,301	32,287	23,241	25,885	**110,325**
Strategic Capital Contingency	2,000	2,000	2,000	2,000	2,000	**10,000**
Sub-Total Major Strategic Capital	**9,611**	**23,301**	**34,287**	**25,241**	**27,885**	**120,325**
Medical Equipment	17,599	9,750	5,168	5,168	8,168	**45,853**
Operational Capital	15,244	5,450	5,570	5,570	5,570	**37,404**
Information Technology	8,461	4,600	3,000	3,000	3,000	**22,061**
Estates Replacement	2,367	2,950	2,950	2,950	2,950	**14,167**
Other	1,000	1,000	1,000	1,000	1,000	**5,000**
Planned Slippage						
2018/19	(8,399)	8,399				**0**
2019/20		(8,496)	8,496			**0**
2020/21			(7,886)	7,886		**0**
2021/22				(7,886)	7,886	**0**
2022/23					(7,886)	**(7,886)**
Total Application of Funds	**45,883**	**46,954**	**52,585**	**42,929**	**48,573**	**236,924**
Cash Balances (After funding the application of funds)	**78,017**	**70,381**	**71,270**	**57,250**	**37,515**	

Strategic Capital Investment Programme and Medium Term Financial Plan — **Appendix B**

Major Phase Five Schemes

Major Strategic Capital	2018/19 Allocation	2019/20 Allocation	2020/21 Allocation	2021/22 Allocation	2022/23 Allocation	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Bri Redevelopment Phase 4 c/fwd	74					74
Combined Heat & Power scheme	950	5,931				6,881
Contingency	(28)	450				422
Medical School			1,000			1,000
Phase 5						
Phase 5 - BEH Refurb			965	3,755		4,720
Phase 5 - BHOC expansion - Stage 1 (L4/5)						
Phase 5 - BHOC expansion - Stage 2	70	1,830	2,570			4,470
Phase 5 - BRHC expansion	25		50	3,450	11,095	14,620
Phase 5 - Cardiac Research Unit	240	4,850	2,910			8,000
Phase 5 - Cardiology Exp - Stage 2				75	2,075	2,150
Phase 5 - Cardiology Expansion - Stage 1	540	1,610				2,150
Phase 5 - Contingency	2,000	2,000	2,000	2,000	2,000	10,000
Phase 5 - D603	270	1,090				1,360
Phase 5 - Dermatology		350	270	810	10,290	11,720
Phase 5 - Fees	500					500
Phase 5 - ICU / CICU	320	2,750	2,342			5,412
Phase 5 - Level 7 Ward		150	7,250	3,450		10,850
Phase 5 - Myrtle Rd	4,000					4,000
Phase 5 - NICU / CDS expansion	150	1,650	2,130			3,930
Phase 5 - Queen's Day Unit				2,425	2,425	4,850
Phase 5 - STM Level E			780	1,680		2,460
Holistic Well-being Centre			1,600			1,600
Transport Hub	500.00	640.00	10,420	7,596		19,156
Major Strategic Schemes Total	**9,611**	**23,301**	**34,287**	**25,241**	**27,885**	**120,325**

OUR STRATEGIC FRAMEWORK

28th May 2018

Our Strategic Priorities – ***We will….***	**Our Strategic Objectives** – ***Which means that we will….***
Excel in consistent delivery of **high quality**, patient centred care, delivered with compassion.	• Sustain our outstanding CQC rating • Achieve all constitutional access standards, through the delivery of agreed in year trajectories. Ensure patients have access to the right care when they need it and are discharged as soon as they are medically fit. • Deliver our quality objectives outlined in our Quality Strategy (Ensuring timely access to services; Improving patient and staff experience; Improving outcomes and reducing mortality; Delivering safe and reliable care) • Continue to develop our estate and provide a modern environment for staff and patients. • Drive improvements in staff engagement and wellbeing to support them to deliver excellent care. • Engage more effectively with our patients and our partners. Covered below • Actively seek opportunities to collaborate with out of hospital partners, redesigning pathways to improve the quality of care we deliver.
Invest in **our staff** and their wellbeing, supporting them to care with pride and skill, **educating and developing** the workforce for the future	• Pursue a new strategic workforce development approach and redefine how we recruit and retain staff as an organisation and as a local healthcare system - continuing to market all vacancies with innovative, cost effective solutions, utilising the strong employer brand Love Life Love Bristol to deliver a highly skilled and productive workforce that is as diverse as the community that we serve - developing a clear plan for what new roles we will need and how we will fund and grow these roles effectively over the next five years, focussing on alternative roles in hard to recruit to areas - use our reputation for excellence in clinical services, research, education and teaching to lever worldwide recruitment opportunities • Place staff health and wellbeing at the centre of planning the future of our services, with a focus on creating a positive work/life balance for our staff. • Focus on the diversity of our workforce and the equality of how we support access to roles. • Develop our teaching and education offer in conjunction with our academic partners to create innovative workforce solutions and train the workforce of the future. • Develop our Leadership and Management Capability through delivery of a comprehensive programme of leadership and management training and development. • Transform and optimise workforce efficiency • Support and enable staff to work more closely with teams in partner organisations and across multiple settings. • Access and use staff feedback to inform targeted actions to improve the day to day experience of our staff
Consolidate and **grow our specialist clinical services** and **improve how we manage demand for our general acute services**, focussing on core areas of excellence and pursuing appropriate, effective out of hospital solutions	• Make choices on our core areas of excellence and target investment to support growth in our very specialised services to provide expert treatment for people across the south-west region, Wales and beyond. • Ensure the reputation of our specialist services is as strong as possible to encourage growth in regional referrals. • Actively support excellence and innovation across our range of general services to ensure the local population we serve have access to the best possible care. • Critically evaluate services which are clinically or financially unsustainable and make active decisions regarding their strategic direction. • Mandate our teams to support delivery of appropriate care out of hospital (default to out of hospital first). • Resolve internal patient flow challenges currently impacting on the effective delivery of general and specialist care – develop an internal operating model that delivers both. • Use technology to improve the safety and effectiveness of our services and be able to offer greater accessibility in and out of our hospitals • Develop our provider to provider relationships with Primary Care, with an expectation that our teams will actively seek new ways of working together for the benefit of pathways and patients.
L**ead, collaborate and co-create sustainable integrated models of care** with our partners to improve the health of the communities we serve	• Build our leadership role in the BNSSG Healthier Together Partnership, supporting steps towards an integrated care system with the aim of making BNSSG Outstanding • Use our digital and research excellence and academic expertise to maximise the implementation of evidenced based clinical pathways across hospital, primary and community provision. • Continue to develop our partnerships with Weston Area Health Trust and North Bristol Trust to support our collective clinical and financial sustainability • Develop our role in leading, with NHSE, the future of Specialised Services for the region, working with NBT to enhance the reputation of Bristol for service excellence and addressing the difficult questions about the remaining duplication of acute services across Bristol • Continue to maximise the opportunities associated with our regional and tertiary provider status and develop and lead clinical networks across the region • Work more closely with patients, families and other healthcare partners to co-design more joined up care that takes account of the whole person not just their immediate health issues • Promote healthy lifestyles, helping to prevent ill health and improve mental and physical well-being through all of our activities. • Actively pursue opportunities to work more effectively and creatively with our voluntary sector and charitable partners. • Support staff to be advocates for collaboration with our partners and to develop relationships and opportunities to work together at a specialty and divisional level. •

Our Strategic Priorities – ***We will….***	**Our Strategic Objectives** – ***Which means that we will….***
Be at the leading edge of **research and transformation** that is translated rapidly into exceptional clinical care and embrace **innovation**	• Build our reputation as a world class leader in population health and biomedical research, maximising the potential of the Biomedical Research Centre to undertake cutting edge studies that will improve care and treatment into the future. • Use our digital capabilities to transform where and how we deliver care, education and research (Digitally enabled transformation) and maximise the opportunity provided by our successful appointment as a National Digital Exemplar site • Provide our staff with improvement skills and capabilities through our QI Academy • Create an environment that makes it easy to innovate within organisation through our QI Hub and continue to develop a culture in which individuals and teams are encouraged to innovate. • Remain agile, using evidence to excel in getting it right first time • Sustain and improve our performance in initiating and delivering high quality clinical research trials, through actively supporting clinical staff to engage with research and through embedding it within clinical practice.
Deliver **financial sustainability for the Trust** and contribute to the **financial recovery of our health system** to safeguard the quality of our services for the future	• Working smarter not harder, by eliminating waste and ensuring we add value from every action we take, however small, to maintain our financial health in the context of severe local and national financial pressures • We will achieve upper quartile productivity benchmarks across all measures. • We will actively implement the GIRFT recommendations across our services. • We will evaluate the financial sustainability of all clinical services with the aim of improving the RCI position of services to the best possible position. • We will secure contracts with commissioners which reflect demand and work with partners to reduce costs across the system through pathway redesign. • We will not allow financial mechanisms to be the reason we do not do the right thing within our system and will look for ways to lead new ways of working to drive change. • We will work with partners to build trust, through encouraging staff to build productive relationships at a service and divisional level and through trialling small changes to build confidence. • We will increase our income through innovative commercial approaches, whilst ensuring focus remains on the delivery of our core services. • We will engage more effectively with staff on the benefits of financial sustainability and improve our communications relating to the financial position of the Trust and how this relates to investment within clinical services.

Terms of Reference – Phase 5 Programme Board

Document Data	
Corporate Entity	Phase 5 Programme Board
Document Type	Terms of Reference
Document Status	Approved
Executive Lead	Director of Strategy and Transformation
Document Owner	Carly Palmer
Approval Authority	CPSG and Strategy Steering group
Document Reference	Not Applicable
Review Cycle	6
Next Review Date	02/11/2018

Document Abstract
The Phase 5 Programme Board is responsible for the oversight and delivery of the approved strategic capital projects approved through, and confirmed in, the annual Resources Book and the Medium Term Capital Programme. It will ensure that each individual business case has the appropriate governance and approval in terms of its clinical delivery model, commissioning support, revenue and capital implications. The board will prioritise a delivery programme to match the strategic and operational requirements of the Trust within the available funding. The Board will direct the programme to take into account any external influences arising from STP, acute care partnerships etc, as required.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
1st Feb 2018	0.1	Carly Palmer	Major	First draft for discussion
21st Feb 2018	0.2	Carly Palmer	Minor	Amendments following review by Working Group members
8th Mar 2018	0.3	Carly Palmer	Minor	Amendments following review by Programme Board members
5th Apr 2018	0.4	Carly Palmer	Minor	Minor amendments to membership
11th May 2018	0.5	Paula Clarke	Minor	Amendments made from Chair
6th Sept 2018	0.6	Carly Palmer	Minor	Amendments from SLT and changes to governance structure

1. Purpose

1.1 The purpose of the Programme Board is to oversee the delivery of a range of capital projects that comprise the strategic capital programme within the Medium Term Financial Plan. The Programme Board will provide overall programme direction and ensure necessary progress is being achieved by the project boards and teams established to support delivery of the programme aims.

1.2 A key function of the Board is to support Divisions in the development of the individual business cases in accordance with the Trusts Capital Investment Policy and NHSI Single Oversight Framework, ensuring that proposed service changes fit with the Trust strategy, have commissioner support where required and take account of external influences including acute care partnerships and the wider STP.

1.3 The Board will ensure oversight of programme risks at all times, reporting upwards as necessary and ensure mitigation plans are developed for all risks that cannot be eliminated.

1.4 The Board will prioritise the projects into a delivery programme that will be developed within funds available.

1.5 The Board will work with charities to agree levels of funding support for individual projects.

2. Authority

2.1 The Programme Board is accountable to the Trust Board through its reporting responsibility to the nominated Executive groups as described at Appendix 1. Approvals for Capital projects will be sought in line with the Capital Investment Policy.

3. Reporting

3.1 The Board reports monthly to Capital Programme Steering Group and bi-monthly to Strategy Steering Group. A quarterly report will be provided to SLT when the programme is approved.

4. Membership

4.1 The following shall be members of the Board and are responsible for executing their portfolio responsibilities and communicating with their constituents (where applicable).

(a) Director of Strategy and Transformation, (Chair)

(b) Chief Operating Officer

(c) Director of Finance & IT

(d) Associate Director of Strategy and Business Planning

(e) Programme Director

(f) Director of Estates and Facilities

(g) Divisional Director Representative

(h) Project Board Chairs by invite

4.2 The quorum necessary for the transaction of business shall be 50% of members.

5. Duties

5.1 The key duties of the Board are to;

(a) Ensure business cases follow the Trusts capital investment policy and make recommendations to Finance Committee and Trust Board

(b) Monitor deployment of the financial plan in accordance with the prioritised schemes

(c) Deliver the phase 5 programme and ensure it is comprised of a series of approved business cases, which are prioritised to form a delivery programme.

(d) Review business cases as required and to provide strategic oversight and scrutiny of service development proposals.

(e) Maintain a log of all programme risks and issues through the rigorous review of project proposals and to ensure effective mitigation plans are developed where risks cannot be eliminated, reporting high risks to the Capital Programme Steering Group or where more appropriate, to the Strategy Steering Group.

(f) Hold project boards and teams to account for delivery, to ensuring all programme milestones are delivered on time and to the required standard; to request and oversee delivery of remedial action plans where progress is compromised.

(g) Ensure effective communication to all programme stakeholders, internal and external, of programme progress and key milestones with the aim of maintaining a positive programme profile, promoting the Trusts' reputations and engaging staff in successful delivery of the programme

(h) Develop and maintain a programme plan that captures all key milestones / deliverables and associated issues logs to ensure all outstanding issues are monitored and progressed to resolution

(i) Direct the work and priorities of individual project teams or boards as required in light of the over-arching programme plan and risks

(j) Ensure that divisions have service business continuity plans through the operational transfer period of individual projects

(k) Lead relationships with the programmes charitable fundraisers, including Above and Beyond and The Grand Appeal to promote the successful fund raising to support the programme

(l) Receive reports from the project boards and teams on the progress of related projects to understand the operational impacts of schemes and actively manage any associated risks

(m) Receive a financial report / plan by scheme detailing spend against the approved phased funding against the overall MTCP

5.2 Procedural Documents and Corporate Record Keeping

(a) The Board shall ensure accurate and comprehensive minutes of the meeting are maintained and approved by the Board

(b) The Board shall maintain an issues log and risk register. Any programme risk with a residual rating of "high" will be entered on the Corporate Risk Register as agreed with Risk Management Group.

6. Frequency of Meetings

6.1 The Board shall meet monthly, and at any such other times that the Chair deems necessary and a quorum can be established.

7. Review of Terms of Reference

7.1 The Board shall review its terms of reference every six months or sooner if deemed necessary by the Chair.

8. Standing Agenda Items

8.1 Minutes review and approval and action log

8.2 Project Board and Team Status Reports

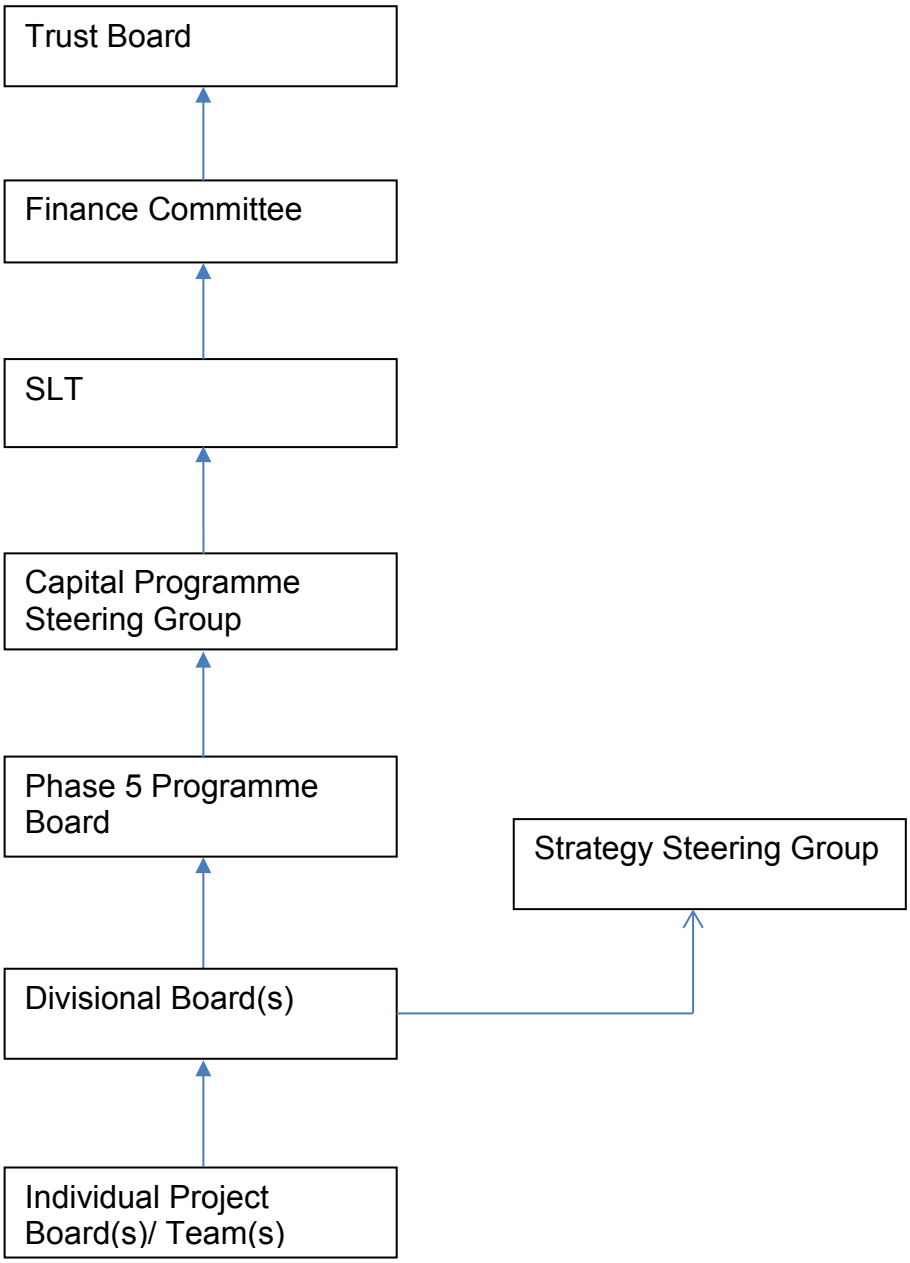
8.3 Capital Finance Report

8.4 Risk Register

8.5 Issues Log

8.6 Programme

Phase 5 Programme Governance Structure



Cover report to the Public Trust Board Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	20
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Well-Led Review Self-Assessment**		
Author	Eric Sanders, Trust Secretary, Sophie Melton Bradley, Deputy Trust Secretary		
Executive Lead	Eric Sanders, Trust Secretary		
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 present the self assessment of the Trust against the Well-led Framework for approval. Key issues to note The self-assessment process has been undertaken with support from operational leads from across the Trust, under the leadership of the Executive Directors and Trust Secretary. The Board considered the self-assessment at its Seminar held on 7 September 2018, which included a detailed document identifying the scoring for each prompt under the Key Lines of Enquiry (KLOE), a narrative description of how the Trust complied with the requirements, evidence to support compliance and any gaps or areas of further work. The Board is now asked to formally approve the self-assessment, prior to the planned external review taking place.

Recommendations
Members are asked to: • **Approve the self-certification against the Well-led framework.**

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
There is no impact identified on corporate risk as a result of this paper.

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)**

Well-led Framework – Self Assessment

1. Background

1.1. The Code of Governance was introduced by Monitor to provide a framework within which it was expected that all NHS Foundation Trusts would operate. The latest version of the Code came into force from 1 January 2014. Non-compliance with the Code is not in itself a breach of NHS Foundation Trust Condition 4 of the NHS provider licence, but the Trust would be required to explain why if it did not comply.

1.2. In addition to the Code, NHS Improvement (NHSI) has published guidance on Well-Led Reviews. This guidance was jointly developed by NHSI and the CQC and aligns with the well-led questions used by the CQC as part of their regular regulatory assessments. It is expected that the Well-led Framework will be used as the basis for the externally facilitated evaluation contained within the Code, specifically provision B.6.2:

"Evaluation of the boards of NHS foundations trusts should be externally facilitated at least every three years. The evaluation needs to be carried out against the board leadership and governance framework set out by Monitor [previously Monitor]. The external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust."

2. Well-Led Framework Overview

2.1. The Well-Led Framework was revised in 2017 to align the approaches of NHS Improvement and the CQC. The framework is structured around eight key lines of enquiry (KLOE):

2.2. Under each KLOE are a number of prompts to consider, and the prompts should be used to inform a self-assessment which needs to be prepared and signed off prior to the external element of the review. The framework also provides examples of good practice which again should be used to inform the self-assessment. This part of the framework is considered the "developmental" element and is the focus of the three yearly reviews.

2.3. Also included in the framework under each KLOE are prompts which the CQC inspectors will consider as part of their annual assessment: this assessment is part of the “assurance” element of the framework.

3. Self-Assessment Process

3.1. To ensure that the organisation would be able to develop a comprehensive and accurate self-assessment response, each KLOE was allocated to an Executive Director Lead, and each prompt to an Operational Lead.

3.2. The Operational Leads were tasked with considering the guidance, identifying evidence to support compliance, and any gaps, and developing a narrative which described how the Trust complied.

3.3. The Executive Directors then reviewed the self-assessment prior to the Board considering the detailed document, and a summary, at its Seminar held on 7 September 2018. The Board were able to consider and challenge the scoring for each KLOE to come to an overall conclusion.

3.4. The scoring mechanism used is as follows:

Score	**Description**
Green	Meets or exceeds expectations
Amber-Green	Partially meets expectations, but confident in management’s capacity to deliver green performance within a reasonable timeframe
Amber-Red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe
Red	Does not meet expectations

4. Outcome of the Self-Assessment Process

4.1. The results of the self-assessment process are outlined below. All areas are reported as Green (Meets or exceeds expectations). A short summary is included in the table below for information, alongside the identified gaps and areas for improvement.

KLOE	Executive Lead	Score	Summary	Gaps/Areas for Improvement
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	Robert Woolley	Green	• The Board has the right capability and capacity to lead the organisation • There are regular reviews of performance (individual and group) which lead to development plans • There is a structure to manage the business which is regularly reviewed • The Board has set a clear strategy, underpinned by a robust operating plan, which clear objectives and priorities • Strategic and operational risks are identified and understood, with actions taken where required • There are leadership programmes in place to develop staff • Leaders are visible and approachable	• Complete formal Board and Committee evaluations • Further develop the Board development programme • Implement NED Clinical Site Visits • Enhance the leadership programme participation evaluation to ensure equality of inclusion • Complete succession plan for all senior managers
2. Is there a clear vision and credible strategy to deliver high quality sustainable care to people, and robust plans to deliver?	Paula Clarke	Green	• There is a clear strategy which articulates the Trust's vision, values and objectives • A refresh of the Strategy is underway which has been informed through engagement with a range of stakeholders • The strategy drives the annual operating plan, and divisional plans, both of which align with national and local system plans • The Board receives quarterly updates on delivery of the Operating Plan • Quality, operational and financial performance is	• None identified

KLOE	Executive Lead	Score	Summary	Gaps/Areas for Improvement
			monitored by the Board and its Committees each month, • Values are communicated and embedded in Trust processes from recruitment and induction to appraisal, as well as through our communications to staff	
3. Is there a culture of high quality, sustainable care?	Carolyn Mills and Matt Joint	Green	• Values are communicated and embedded in Trust processes from recruitment and induction to training and appraisal, as well as through our communications to staff • A programme of staff awards seeks to recognise staff for living the values • The Board has embraced the Freedom to Speak Up (FTSU) agenda and supports the drive for all concerns to be raised • Questions from staff and the public are responded to openly and transparently, Duty of Candour is a core principle and checks are in place to ensure this happens • Staff development is a key priority alongside maintaining high levels of compliance with essential training, and appraisal quality has improved • There are various mechanisms to support staff, and these are being communicated through the divisional "You said, We did" events • There is good engagement with Staff side, and the Trust has implemented Bullying and Harassment Advisers, FTSU Advocates, and Wellbeing Leads as mechanisms to give a voice to staff • There are Board approved Equality and Diversity strategic objectives, which are monitored via a six monthly update to Quality and Outcomes Committee,	• Trust wide talent management approach • FTSU strategy • Fully utilise e-Appraisal system • Greater focus on the E&D agenda from Board to ward

KLOE	Executive Lead	Score	Summary	Gaps/Areas for Improvement
			and driven forward by the Equality and Diversity Group, and its network of staff forums • Teams are encouraged to work together to identify and resolve issues, either directly or through the Quality Improvement Programme	
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Mark Smith	Green	• There are clear structures and processes in place, and individuals and groups understand their roles and responsibilities • Clear objectives are set each year through the Operating Plan, and cascaded through the divisional plans to all staff • Governance of partnerships is strong and supported by a clear understanding of expected outcomes and lines of accountability • The Trust is actively participating in and seeking to support the Sustainability and Transformation Partnership • The Board and Committees operate effectively and balance their business across strategic/operational, improvement/assurance and information/decisions • All staff are encouraged to identify barriers to delivery and identify and implement solutions, supported by the Quality Improvement Academy	• Complete formal Board and Committee evaluations
5. Are there clear and effective processes for managing risks, issues and	Mark Smith	Green	• There is a robust risk management process which seeks to identify, assess, and mitigate risks at strategic and operational level • Internal Audit undertake risk based audits throughout the year to inform their audit opinion and the annual	• Improved divisional risk reporting

KLOE	Executive Lead	Score	Summary	Gaps/Areas for Improvement
performance?			Governance Statement • As part of the planning round, risks associated with cost pressures and investments are considered through the Quality Impact Assessment process and signed off by the Chief Nurse and Medical Director • Performance is monitored, managed and escalated through a framework of meetings including Board, QOC, Finance Committee, Senior Leadership Team as well as weekly, monthly and quarterly divisional reviews • Where performance is deviating from plan, recovery plans are produced and monitored • The clinical and internal audit programmes seek to provide assurance and identify areas for improvement	
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	Mark Smith	Green	• An integrated performance report supports consideration of quality, operational and people performance information, supported by a separate detailed finance report • SPORT reports and SPC charts help identify real trends and highlight where corrective action is required • Data is available to all staff via the intranet to help identify and drive improvement • The most up to date data is always presented to the Board for review, and performance reports are reviewed annually to ensure they continue to meet the Board's needs • The weekly, monthly and quarterly performance meetings are used to hold management to account, with the Board holding Executives to account • Data quality is assured through data validation, internal and external audit, the IST, as well as review and	• Review of the Trust's data quality policy and processes • Development of standard operating procedures for the sign off of data sets

KLOE	Executive Lead	Score	Summary	Gaps/Areas for Improvement
			challenge from commissioners • As a Global Digital Exemplar the Trust is investing in its clinical digital functionality, under the leadership of the CIO and CCIOs • All external reporting requirements are adhered to • There is a robust information governance framework to ensure the availability and integrity of patient data and to maintain confidentiality. This was further enhanced to meet the requirements of GDPR	
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	Carolyn Mills	Green	• There are a range of ways in which the Trust listens and responds to peoples views and concerns including via the Patient Experience and Involvement Team and Patient Support and Complaints Team • The Trust actively engages with a range of partners including patients, Healthwatch, Governors and Foudation Trust members • Patient experience performance information is presented to the Board monthly, with more in-depth quarterly reports • Divisions engage with their staff when developing their operational plans and when undertaking service changes • As well as patient stories, the Board now hears from members of staff about their experiences of working for the Trust through a staff story • There is open dialogue with system stakeholders about performance and any challenges with a view to create a shared, coordinated approach	• Ensure a diversity of views are heard during all planning and service change projects
8. Are there robust systems and processes for	Paula Clarke	Green	• There is a strong focus on driving improvement at all levels of the organisation • Improvement goals are set through the business	• None identified

KLOE	Executive Lead	Score	Summary	Gaps/Areas for Improvement
learning, continuous improvement and innovation?			planning round and are aligning into one of the 5 transformation programmes • The Trust participates in a number of formal and informal learning networks to ensure that ideas from outside are used to inform practice within • As a Global Digital Exemplar, digital transformation is a key priority with examples including e-Observations, Clinical Utilisation Review, e-Prescribing • Research is becoming more embedded within the Trust, with growing patient recruitment and successful grant bids • The Quality Improvement Academy provides training and support to staff who want to undertake improvement projects, and staff are encouraged through the objective setting and appraisal processes to undertake improvement projects • There are robust processes in place to learn from internal and external reviews and ensure that any recommendations identified have associated actions and that these are delivered	

5. Next Steps

5.1. An externally reviewer is beiong commissioned, with the expectation that they complete their review during October and November 2018.

5.2. A final report will then be presented to the Board, with the outrcome notified to NHS Improvement.

6. Recommendation

6.1. The Board is asked to approve the self-certification against the Well-led framework.

Cover report to the Public Trust Board Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	21
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Governors' Expenses Policy Review**		
Author	Kate Hanlon, Membership Engagement Manager		
Executive Lead	Eric Sanders, Trust Secretary		
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 receive the updated Governors' Expenses Policy. Key issues to note: The Governor Expenses Policy, which outlines the criteria for the submission of governor expenses and the process for claiming and repayment, was reviewed in August 2018. It was updated to comply with the current Trust policy template and to provide further clarity to governors with regards to the claiming of expenses in relation to their role. The main update in this version relates to mileage allowances, which are now consistent with the standard rate mileage allowances paid to NHS staff under Agenda for Change.
Recommendations
Members are asked to: • **Approve the Policy.**

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
None

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)**

Reimbursement of Expenses for the Council of Governors Policy

Document Data			
Document Type:	Policy		
Document Reference			
Document Status:	Draft		
Document Owner:	Trust Secretary		
Executive Lead:	Chief Operating Officer		
Approval Authority:	Trust Board of Directors		
Review Cycle:	36		
Date Version Effective From:		**Date Version Effective To:**	

What is in this policy?
This policy sets out the circumstances under which governors of University Hospitals Bristol NHS Foundation Trust (the Trust) may be reimbursed for travel and other expenses as a result of carrying out pre-agreed governor duties.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions (Job title only)**	**Type of Revision**	**Description of Revision**
Aug 2015	1.0	Trust Secretary	Major	First draft
Aug 2018	2.0	Trust Secretary	Minor	Review of policy, amendment of expenses rate, input into updated template

Table of Contents

1. Introduction

As a Foundation Trust, University Hospitals Bristol is accountable to the public, patients and staff members through the elected and appointed governors on the Council of Governors. The roles and responsibilities of a governor require the governors to communicate with their constituencies and attend meetings (as agreed through the Membership Office). This ensures that the public, patient and staff members are engaged in planning, delivering and improving NHS services

2. Purpose

The post of governor of a Foundation Trust is voluntary, and it is a fundamental principle that no governor shall receive any form of salary or remuneration for being a governor, however reasonable expenses should be covered to ensure governors are not out of pocket.

The Trust's Constitution makes the provision for reimbursement of expenses to members of the Council of Governors.[1]

In line with principles of transparency for good governance, the Trust, along with other NHS Foundation Trusts, is required to publish expenses paid to governors in its Annual Report.

3. Scope

This document applies to all governors. The Trust will reimburse governors for reasonable travel and other expenses incurred through participation in pre-agreed governor activities.

4. Duties, Roles and Responsibilities

4.1 Governors

(a) It is the responsibility of each individual governor to ensure value for money when incurring expenses, taking into account both cost and convenience. If there is any doubt then governors must seek prior approval from the Trust Secretary before committing expenditure. Governors should agree with the Trust Secretary the general nature and level of expenditure to be incurred prior to the expenses being incurred. Failure to do so may result in reimbursement being withheld.

(b) It is the responsibility of governors to ensure that correct claims are made.

(c) If a governor is receiving State Benefits, it is their responsibility to check with their local government agency whether the receipt of any expenses might affect their entitlements.

(d) Governors should make their claim for reimbursement of expenses promptly; ideally within four weeks of incurring, and this should be done within three months of the expense being incurred.

(e) All governors should complete a BACs form so that reimbursements can be paid electronically directly into a governor's bank account.

[1] The Trust Constitution is available at the following link: http://www.uhbristol.nhs.uk/about-us/key-publications/

4.2 Membership Office

(a) It is the responsibility of the Membership Office to circulate the policy to all governors, including the claim form and BACS form, and to process expense claims promptly.

4.3 Trust Secretary

(a) It is the responsibility of the Trust Secretary to approve travelling and subsistence expenses incurred by a governor while attending any *external* meetings, seminars and events on behalf of the Trust in his/her capacity as a governor. Any expenses relating to caring should be discussed and agreed with the Trust Secretary before any commitments are made.

5. Policy Statement and Provisions

5.1 Reimbursement of expenses

Expenses will be reimbursed for the following activities:

a) Travelling expenses incurred by a governor while attending meetings, seminars and events organised by the Trust;

b) Travelling and subsistence expenses incurred by a governor while attending external meetings, seminars and events at the request of or on behalf of the Trust in his/her capacity as a Governor. Expenses of this type must be approved in advance by the Trust Secretary and, if necessary, can be arranged by the Membership Office through current Trust travel booking/accommodation mechanisms.

Any expenses other than vehicle mileage must be supported by valid receipts. Failure to produce such receipts may result in reimbursement being withheld. Any expenses outside of the above must be agreed with the Trust Secretary.

In line with Bristol City Council and the Trust's commitment to encouraging greener travel, the general expectation is that governors will use public transport to carry out their duties e.g. standard class rail return, bus and coach. However, if it is necessary to use a vehicle, mileage may be claimed as set out in Appendix E. Please note that where vehicle use applies, the Trust will pay mileage and reasonable parking costs only.

In extreme circumstances (for example, due to physical disability/medical reasons/late evening meetings in circumstances when personal safety may be compromised), reimbursement may be considered for reasonable taxi fares and agreed in advance by the Trust. Where this is the case the claimant may be required to provide documentary evidence to support such a request, for example a doctor's letter to confirm they are unable to use public transport or walk the required distance.

If a governor meeting or event takes place over a lunchtime appropriate provision of food and drink will be made.

Subsistence allowance, where the governor is away from their home for longer than five hours for the purpose of attending a designated meeting and where no refreshment is provided at the Trust's expense, or provided at the venue, will be paid up to a maximum of £5 per person per meeting.

The Trust will also reimburse governors for any reasonable carer costs incurred during the course of carrying out their role. Any cost relating to caring should be discussed and agreed with the Trust Secretary before any commitments are made.

The Trust will aim to provide the governors with hard copies of meeting papers where required, however, on occasions where this does not happen, the Trust will reimburse governors for "out of pocket expenses" for personal office equipment disposables and stationery up to a maximum of £50.00 per year.

5.2 Reimbursement process

Any persons claiming for travel costs must do so using the appropriate expenses claim form (see Appendix F). All governors are encouraged to submit the form electronically to the Membership Office. Receipts must be provided for any travel, carer and other expenses (with the exception of vehicle mileage).

If vehicle mileage is being claimed, the return mileage will be calculated for the actual journey undertaken but will not exceed that from the post code of the governors home address to the venue. This ensures that the Trust does not pay inappropriate mileage, for example in the event that a claimant travels from outside of the local area to a Trust event as a result of commitments unrelated to the Trust.

Reimbursed expenses should be for the exact amount claimed; not for a rounded-up or average amount.

Reimbursement will normally be paid electronically directly into a governor's bank account. This is the quickest and most secure form of payment. All governors should complete a BACs form, see Appendix G, and submit the completed form to the Membership Office. If any governor seeks an alternative payment method then they should speak to the Membership Office.

6. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this Policy.

Objective	Evidence	Method	Frequency	Responsible	Committee
All governors receive a copy of this policy, claims form and BACS form	Email or hard copy of policy to all governors		On induction, and after any approved changes to the policy	Membership Office	Council of Governors
Expenses forms are processed by the Membership Office	Expenses recorded on governor database	Expense claims checked and signed off by Membership Manager before being sent on to Finance Department	As received	Membership Office	Council of Governors
Finance Department reimburses expenses	Claims recorded on monthly membership budget		As received	Finance Department	Council of Governors

7. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Trust Secretary
Is this document: A – replacing an expired policy, B – replacing an alternative policy, C – a new policy:	A
Alternative documentation this policy will replace (if applicable):	2T
This document is to be disseminated to:	Council of Governors
Method of dissemination:	By email, and hard copy where required
Is Training required:	No
The Training Lead is:	2T

Additional Comments
2T

8. Appendix C – Document Checklist

Checklist Subject	Checklist Requirement	Document Owner's Confirmation
Title	The title is clear and unambiguous:	Yes
	The document type is correct	Yes
Content	The document uses the approved template:	Yes
	The document contains data protected by any legislation	No
	All terms used are explained in the 'Definitions' section:	Yes
	Acronyms are kept to the minimum possible:	Yes
	The 'target group' is clear and unambiguous:	Yes
	The 'purpose and scope' of the document is clear:	Yes
Document Owner	The 'Document Owner' is identified:	Yes
Consultation	Consultation with stakeholders (including Staff-side) can be evidenced where appropriate:	Not Applicable
	The following were consulted	Not Applicable
	Suitable 'expert advice' has been sought where necessary:	Not Applicable
Evidence Base	References are cited:	Yes
Trust Objectives	The document relates to the following Strategic or Corporate Objectives:	2T
Equality	The appropriate 'Equality Impact Assessment' or 'Equality Impact Screen' has been conducted for this document:	
Monitoring	Monitoring provisions are defined:	Yes
	There is an audit plan to assess compliance with the provisions set out in this procedural document:	Yes
	The frequency of reviews, and the next review date are appropriate for this procedural document:	Yes
Approval	The correct 'Approval Authority' has been selected for this procedural document:	Yes

9. Appendix D - Equality Impact Assessment (EIA) Screening Tool

Query	Response
What is the main purpose of the document?	This policy sets out the circumstances under which governors of University Hospitals Bristol NHS Foundation Trust (the Trust) may be reimbursed for travel and other expenses as a result of carrying out pre-agreed governor duties.
Who is the target audience of the document (which staff groups)? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ Staff Patients Visitors Carers Others ☑ Governors

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?		NO	Please explain why, and what evidence supports this assessment.
Age (including younger and older people)		X	
Disability (including physical and sensory impairments, learning disabilities, mental health)		X	
Gender reassignment		X	
Pregnancy and maternity		X	
Race (includes ethnicity as well as gypsy travelers)		X	
Religion and belief (includes non-belief)		X	
Sex (male and female)		X	
Sexual Orientation (lesbian, gay, bisexual, other)		X	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		X	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		X	

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant **positive** impact on inclusion by reducing inequalities?	YES		If yes, please explain why, and what evidence supports this assessment.
Will it promote equal opportunities for people from all groups?	X		

Will it help to get rid of discrimination?	X		
Will it help to get rid of harassment?	X		
Will it promote good relations between people from all groups?	X		
Will it promote and protect human rights?	X		

On the basis of the information / evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				Negative Impact		
Significant	Some	Very Little	NONE	Very Little	Some	Significant

Is a full equality impact assessment required? NO

Date assessment completed: 8 August 2018.....

Person completing the assessment: Kate Hanlon, Membership Manager.....

10. Appendix E - Governor Mileage Allowances

These mileage allowances are consistent with standard rate mileage allowances paid to NHS staff under Agenda for Change as of August 2018.

Type of vehicle/allowance	Mileage allowance
Car (all types of fuel) up to 3,500 miles	56p per mile
Motor cycle	28p per mile
Pedal cycle	20p per mile
Passenger allowance	5p per mile

11. Appendix F – Governor Expenses

Please note: Receipts must be provided for public transport fares (bus, coach, train, taxi, etc.) and should be attached to this form. Please note, if you are unable to obtain a car parking receipt, please note details i.e. where you parked.

Name: _____ **Mileage allowance (see back for allowance)**: _____

Date	Description *(what was the title of the meeting etc. you attended? Or include other items i.e. stationery)*	Location *(where was meeting held)*	Travel details *(how did you travel i.e. car, bus, cycle, taxi etc. Include other i.e. car parking)*	Number of car miles *(if applicable)*	Costs *£ p*	
				TOTAL		

PTO

Type of vehicle/allowance	Annual mileage up to 3,500 miles (standard rate)	All eligible miles travelled
Car (all types of fuel)	56 pence per mile	
Motor cycle		28 pence per mile
Pedal cycle		20 pence per mile
Passenger allowance		5 pence per mile

I declare that:

a) The travelling expenses and allowances are in accordance with the appropriate regulations and are in connection with official visits to places indicated on the date(s) shown.
b) The details shown match the vehicle used in respect of this claim.
c) Where a claim for mileage is made:
   - A valid third party insurance policy (including cover against risk of injury to, or death of passengers and damage to property in respect of the vehicle) was held for the period of the claim.
   - This policy will continue to be maintained while the vehicle is used by me on official duties and will cover the use of the vehicle in official business.
d) No other claim has been made or will be made by me on any public body for expenses or allowances in connection with the business stated.

Signature of claimant: _____ Date: _____

Address of claimant including post code: _____

_____

Authorised by Membership Manager: _____ Cost centre: 150227 Acct code: 30216

This form to be emailed or handed to the Membership Office for reimbursement.

12. Appendix G – BACS Form

University Hospitals Bristol NHS Foundation Trust

Expenses for Governors

BACS FORM

Finance Department
Creditor Payments
Trust Headquarters
Marlborough Street
PO Box 1053
Bristol BS99 1YF
Email: Ann.Clark@uhbristol.nhs.uk

Full Name :	
Payee Name if Different to Above :	
Postal Address :	
Tel number :	
Email address :	

Bank Name :	
Bank Branch :	
Bank Address :	
Bank Sort Code	
Bank Account Number :	
Building Society Number :	

Cover report to the Public Trust Board. Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	22
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 2018
Report Title	**Board Evaluation**		
Author	Eric Sanders, Trust Secretary		
Executive Lead	Robert Woolley, 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
<u>Purpose</u> To provide a suite of evidence to support a discussion about the effectiveness of the Board, and any actions to inform the Board development programme. <u>Key issues to note</u> The evidence suggests that the Board has delivered a significant amount of tangible change over the previous year and throughout the timeline of the existing strategy. A range of assessment models have been used to seek different perspectives on the Board's effectiveness, which, combined with other evidence sets, suggest a number of areas where the Board may wish to focus its attention. These include the Board's role in the wider system and how it engages/communicates with stakeholders, the balance of the Board's membership, how the Board allocates its time and the balance of focus on strategic vs

assurance and information vs decision.
Recommendations
Members are asked to: • **Consider** the information presented;. • **Consider** how effective the Board is in delivering its priorities and setting the culture of the organisation; and • **Agree** specific actions to support further improvement.

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	☐

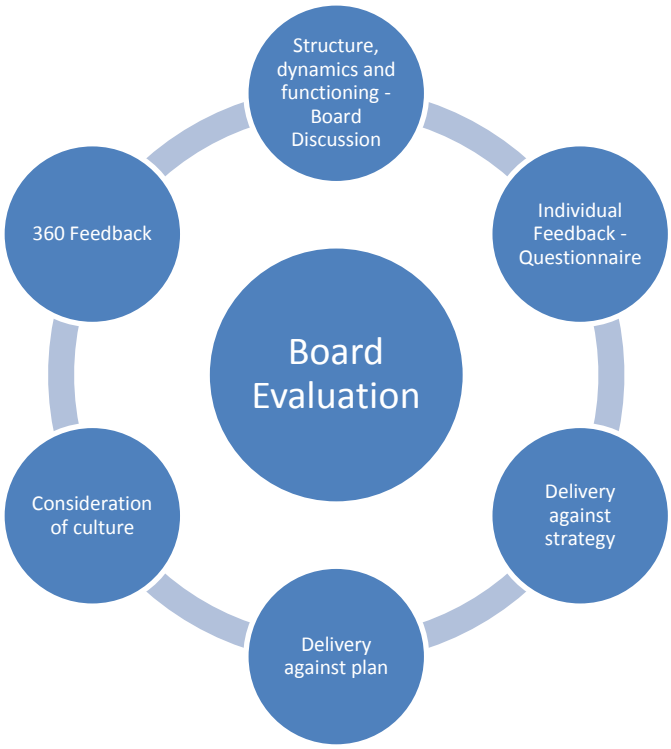
Impact Upon Corporate Risk
None identified

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)**

1. Background

1.1. Boards should evaluate their performance on an annual basis, and in doing so should use a range of information to determine whether they are working effectively. The Board agreed at its Seminar, held on 7 September 2018, that the evaluation should cover the following areas:



1.2. It was agreed that as an externally facilitated Well-led review was planned for later in the year, the 360 element would not be considered at this time, but would feature in future annual evaluations.

1.3. The Board further agreed that the evidence to support the evaluation would include, but was not limited to:

- Strategy review
- Board member questionnaire feedback
- Annual Report and Accounts, including the
- Quality Report Annual Governance Statement
- Staff Survey
- Quality Culture Survey
- Patient Survey

1.4. This paper seeks to set out the evidence above to support a discussion about the Board's effectiveness.

2. Evidence Summary

2.1. The following sections will present a summary of the evidence:

Board Questionnaires

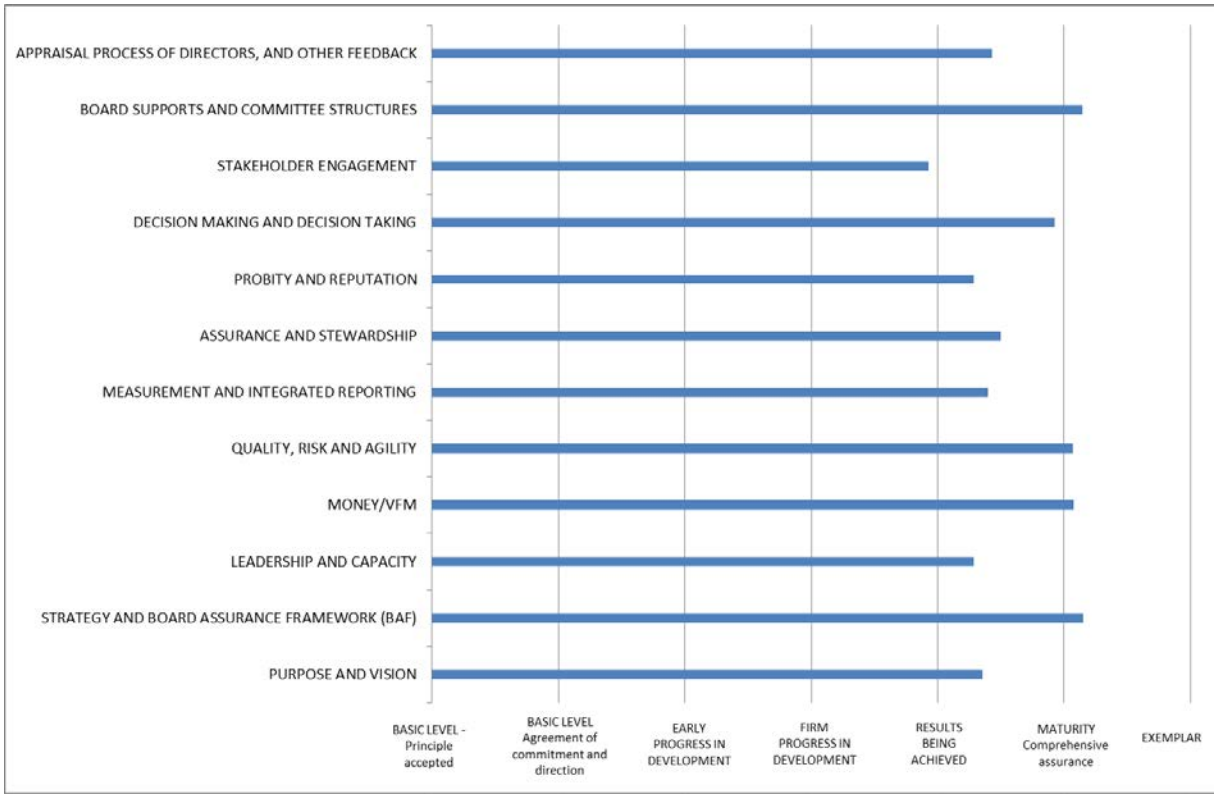
2.2. All Board members were requested to complete a questionnaire which sought to help the Trust better understand how, from an individual perspective, they thought the Board was operating. A summary of the average scores is presented in **Appendix 1**. Those questions whose average scores were below 4/5 are highlighted below (in ascending order):

Question	Score
5 b) [The Board] Is made up of individuals from a diversity of gender, background and psychological type	2.82
21. c) Reports on Board effectiveness including the role of the chairman, diversity, succession planning and Board evaluation	3.36
10. Board members receive proper induction on appointment and ongoing training is available to meet development needs	3.55
27. a) The Board sets itself objectives	3.55
15. b) [The Board] Ensures the necessary financial and human resources are in place to implement [strategic aims]	3.64
21. a) The Board communicates effectively with all of the organisation's stakeholders and takes into account their interests	3.64
11. a) The information that is supplied to the Board is provided on a timely basis	3.73
27. b) [The Board] Carries out a rigorous annual evaluation of its own performance	3.73
27. c) There is effective external facilitation at least every third year	3.82
9. Non-executive Directors are able to commit sufficient time to the organisation to discharge their responsibilities effectively	3.91
23. The Chairman and the Chief Executive work well together and their different skills and experience complement each other	3.91

2.3. The main comments provided by members as part of the questionnaire related to the diversity and skill mix of the Board, the need to strengthen succession planning, and improve communication with stakeholders.

Board Maturity

2.4. The Board members have also considered where they believe the Board sits against the maturity matrix for NHS Trust Boards as published by the Good Governance Institute. The results of this assessment are shown below:



2.5. The results of the maturity assessment indicate that the following areas could require additional focus, with the definition of the next step included in brackets:

- Appraisal process of directors and other feedback (specifically that the Board is recognised as adding value by stakeholders)
- Stakeholder engagement (specifically that the organisation is seen as the employer of choice and there are high levels of trust in the organisation from the public)
- Probity and reputation (specifically that the organisation is recognised externally for its good governance)
- Assurance and stewardship (specifically that the board is confident it has evidence based, intelligent analysis and assurance of all systems and drivers across the health economy)
- Management and integrated reporting (specifically that there is enhanced reporting on the views from stakeholders who provide feedback on the impact of the implementation of Trust plans)
- Leadership and capacity (specifically that the Trust is recognised for being well-led throughout and as system leaders)
- Purpose and vision (specifically that partner organisations and internal stakeholders understand and support the purpose and vision of the organisation)

Annual Report 2017/18 - Overview of Performance

2.6. The latest annual report includes the following statement which provides a summary of the year:

> 2017/18 was a very challenging year for the Trust and despite the backdrop of continual operational and financial pressures, the Trust has continued to deliver high quality care to our patients.
>
> During the year there were significant pressures on the Emergency Department and this coupled with issues in the timely discharge for patients

meant that the Trust was unable to consistently achieve the national access standards, including waiting times for diagnostics, in A&E, for referral to treatment and those relating to cancer.

There were improvements against the access targets in year including achievement of the diagnostics target in February 2018 and the delivery of the cancer 62 day GP standard in quarter three (October to December 2017) for the first time since 2012.

Although the majority of the care delivered was of high quality the Trust reported seven Never Events. These have all been investigated and the learning identified to mitigate the risk of reoccurrence.

Finally the tireless and fantastic contribution of our staff to continue delivering high quality services during this very challenging year needs to be recognised. The latest annual staff survey, which was undertaken in 2017, shows that staff engagement has risen to its highest level and the Trust is now in the top 25 per cent for its peer group in this key measure.

Quality Report 2017/18

2.7. The latest Quality Report includes an assessment against the quality objectives, which are summarised below:

Objective	Rating
1. To create a new Quality Improvement Academy	Green – We have successfully implemented QI training programmes and developed a range of other QI resources and initiatives, creating a consistent framework to enable staff to undertake quality improvement activity. The number of staff attending our bronze programme was double our initial target.
2. To establish a new mortality review programme	Green – We introduced our new mortality review programme as planned. Early learning from the programme has resulted in one of our quality improvement objectives for 2018/19.
3. To develop a consistent customer service mind set in all our interactions with patients and their families	Green – There have been a range of successful activities and developments in the first year of this programme, including the establishment of a set of customer service principles for the organisation. This has provided a firm foundation to build on in 2018/19.
4. To improve staff-reported ratings for engagement and satisfaction	Green – We implemented our plan for 2017/18. Our staff engagement rating has improved for the fourth consecutive year and is now ahead of the national average for acute trusts.
5. To reduce cancellations of outpatient appointments and to reduce waiting times in clinic	Amber – There were fewer cancelled appointments in 2017/18, however the reduction of around one per cent fell short of our two per cent target. More patients said they had been told how long they would have to wait in clinic, but our other patient-reported measures were unchanged from 2016/17.

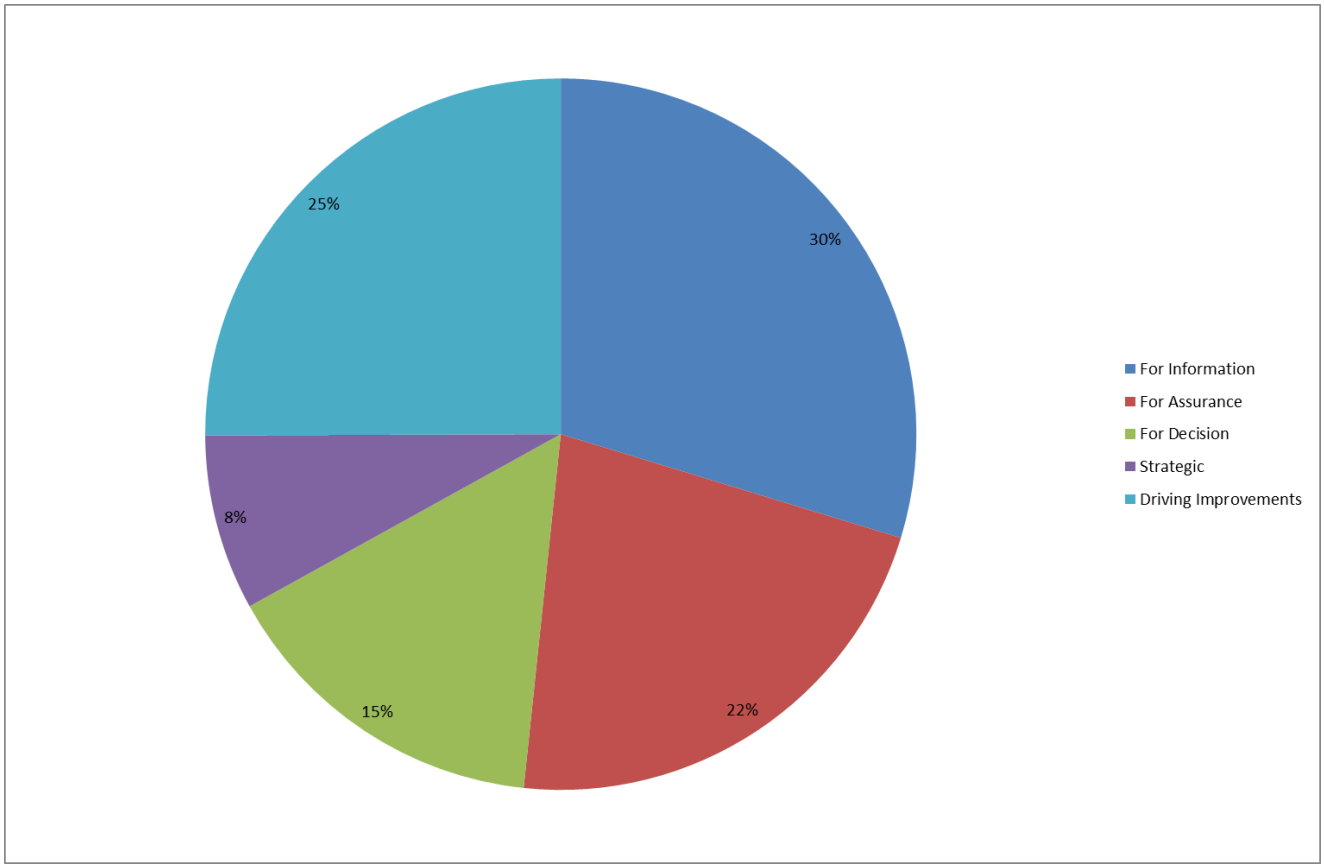
6. To improve the management of sepsis	Amber – we made significant progress in the effective management of sepsis but only partially achieved our CQUIN goals.
7. To implement a new, more responsive, system for gathering patient feedback at point of care	Amber – Progress has been made during 2017/18, and implementation of the new system will take place during the first quarter of 2018/19.
8. To reduce the number of last minute cancelled operations	Red – Our performance in 2017/18 was worse than in previous years and did not meet our target.

Year to Date Performance

2.8. Current performance during 2018/19 is reported to the Board each month and is not replicated in this document.

Review of Board Papers

2.9. The Trust Secretariat have also undertaken a review of the purpose of Board papers from 2017/18, to better understand the balance of items being considered. This analysis shows the following:



- The majority of items (52%) were for information or assurance
- Only 15% of items were for decision
- 8% were considered strategic in nature
- 25% were around driving improvements

2.10. Whilst it is recognised that the content of the papers is not reflected in this analysis it does give a high level indication of the balance of the Board's time.

Strategy Review

2.11. As part of the development of the new Trust Strategy, a review of progress against the existing strategy was undertaken. This highlighted the following achievements and challenges:

Achievements

- Achievement of a CQC rating of Outstanding in 2017, being the only Trust in the country which has moved from a rating of requires improvement to Outstanding.
- Development and delivery of our new quality strategy and objectives.
- Financial sustainability – Throughout the planning period the Trust has continued to operate an annual financial surplus in the context of increasing demand and financial constraints both locally and nationally.
- Maximising the impact from STP system working – UH Bristol has actively engaged with the BNSSG STP, contributing to the development of key clinical pathways
- Estates and capital strategy - Phases 1 to 4 of the redevelopment programme has been completed.
- Service reconfiguration – The Trust has successfully delivered the reconfiguration of a number of clinical services across the city, including the full centralisation of specialist paediatric services in the Bristol Royal Hospital for Children and the transfer of breast, vascular surgery, cellular pathology and urology services to North Bristol NHS Trust.
- Service Development – The Trust has continued to be at the forefront of innovation in the development of new services for our patients, this includes the development of the Icon gamma knife which was installed in July 2015 – only the second such installation in the world.
- Research and Innovation – The Trust secured a significant grant from the National Institute for Health Research to fund a Biomedical Research Centre undertaking cutting edge studies that will improve care and treatment in the future
- Innovation in patient safety - The Bristol Royal Infirmary emergency department is leading the way in the regional/national development of an Emergency Department safety checklist, implemented as part of the SHINE project during 2015.
- Values and Leadership Behaviours – The Trust has developed and implemented standard values with emersion of all staff within a training programme. The newly developed Leadership Behaviours programme establishes the behaviours expected by all leaders and managers within the organisation.
- Achievement of being awarded as a Global Digital Exemplar site.
- Continued development and delivery of our Transforming Care Programme focussing on transforming the way in which we deliver care through service and workforce redesign. Including the development of a QI academy.

Challenges

- Performance against access standards is variable.
- Although there are partnership arrangements in place, the Trust has largely operated independently within the system.
- There is limited internal physical capacity to increase further to meet demand.
- There are significant opportunities in research, innovation and digital.
- There are challenges in sustaining our workforce.
- The Trust needs to clarify the priorities and have clear plans to deliver in relation to our education and teaching agenda.

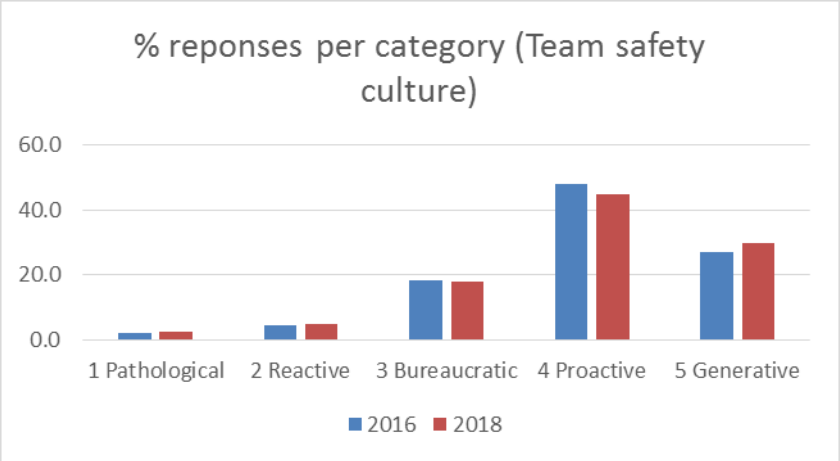
- The Trust cannot thrive/survive without increasingly working with provider partners outside our hospital teams/our organisation.

Patient Safety Culture

2.12. The Trust conducted patient safety culture surveys in 2016 and 2018 using the Manchester Patient Safety Framework (MaPSaF). More details are presented in the Evaluation of UH Bristol Patient Safety Improvement Programme 2015-2018 report to the Board this month.

2.13. The baseline MaPSaF assessments completed during 2016 and the repeat assessment completed during 2018 showed overall that our staff thought that their team's and the Trust's safety culture was "Proactive". The MaPSaF tool describes proactive organisations as those that place a high value on improving safety, actively invest in continuous safety improvements and reward staff who raise safety related issues.

2.14. Although there were some slight changes in percentage responses across the categories between 2016 and 2018, these were not statistically significant. Therefore, we did not achieve a one-step shift towards a generative safety culture by March 2018.



3. Summary and Conclusion

3.1. The evidence presented helps to demonstrate that the Board is operating to a generally high standard and has been able to deliver on its stated strategic priorities, and annual objectives.

3.2. The evidence suggests that the following are areas that the Board may wish to discuss and prioritise for further action:

- Ensuring that the Board is representative of the population it serves and has the right skill mix to deliver its Strategy
- Board members have timely, high quality information which supports decision making, and are inducted into the organisation effectively
- Has strong partnership arrangements which include communicating more proactively its activities and achievements, and seeking feedback from partners on its plans
- Ensuring the Board operates strategically and that it focuses its time on issues that only it can consider, and that the balance of assurance activities and driving improvement is correct
- Having clarity about the enabling strategies which will help deliver the overall Strategy, which will include Digital, Estates and Research

- Ensuring consistency of delivery against all standards – quality, operations, finance, workforce – and that there are adequate resources to achieve this.
- Ensuring that there is a robust framework for the Board to evaluate its own performance and to set clear objectives for itself.
- Whilst there is a strong safety culture and staff engagement is increasing, as reported in the staff survey, there is a need to ensure that all staff are treated equally and have the same opportunities.

4. Recommendation

4.1. The Board is asked to:

- consider the information presented
- agree how effective it has been in delivering its priorities and setting the culture of the organisation
- agree specific actions to support further improvement

Appendix 1 – Board Member Questionnaire Summary

A	Composition and processes		Average Score
1.	**Size of Board**		
	The Board is of sufficient size that the requirements of the business can be met, without being so large as to be unwieldy		**4.36**
2.	**Meetings**		
	a)	The number of meetings of the Board is appropriate, including ad hoc meetings where necessary.	**4.09**
	b)	Board members attend and actively contribute at meetings	**4.18**
3.	**Terms of reference**		
	The Board's role, responsibilities, and matters that it has reserved, are clearly defined		**4.55**
4.	**Committees of the Board**		
	a)	The Board's committees are properly constituted and perform their delegated roles under clear terms of reference;	**4.82**
	b)	Are subject to appropriate refreshment; and	**4.45**
	c)	Report back effectively and promptly to the Board, with sufficient time for the Board to consider matters arising.	**4.18**
5.	**Mix of skills, experience and knowledge & diversity**		
	a)	The Board has an appropriate mix of skills, experience, and knowledge;	**4.00**
	b)	Is made up of individuals from a diversity of gender, background and psychological type.	**2.82**
6.	**Independence**		
	The Board has the right balance of independent Non-executive Directors and Executive Directors.		**4.27**
7.	**Succession planning**		
	There is appropriate succession planning for key Board members and senior executives.		**3.09**
8.	**Appointment process**		
	There is a formal, rigorous and transparent process for the appointment of new directors to the Board.		**4.45**
9.	**Time commitment**		
	Non-executive Directors are able to commit sufficient time to the organisation to discharge their responsibilities effectively		**3.91**
10.	**Induction and training**		

	Board members receive proper induction on appointment and ongoing training is available to meet development needs.		3.55
11.	**Timeliness and quality of information**		
	The information that is supplied to the Board is:		
	a)	Provided on a timely basis; and	3.73
	b)	Of a quality that enables the Board to determine whether the organisation is on track to meet its strategic objectives and is acting within its risk appetite	**4.00**
B	**Behaviours and activities**		
12.	a)	The Board operates in line with the values of the organisation; and	**4.20**
	b)	Sets an appropriate tone from the top that permeates through the organisation	**4.20**
13.	**Board discussions**		
	Board meetings are characterised by a high quality of debate with robust and probing discussions and no 'no-go areas', consistent with the FRC's Guidance that "An effective board should not necessarily be a comfortable place. Challenge, as well as teamwork, is an essential feature".		**4.60**
14.	**Understanding of the business**		
	All Board members have a clear understanding of the organisation's core business and strategic direction.		**4.27**
15.	**Setting strategy**		
	a)	The Board sets the organisation's strategic aims robustly and effectively, with appropriate challenge from the Non-executive Directors; and	**4.27**
	b)	Ensures the necessary financial and human resources are in place to implement them.	3.64
16.	**Risk appetite and risk management**		
	a)	The Board is sufficiently involved in establishing the organisation's appetite for risk in respect of its strategic aims; and	**4.27**
	b)	Satisfies itself that the integrity of the financial controls and systems of risk management are robust and resilient.	**4.55**
17.	**Monitoring performance**		
	a)	The Board has appropriate data to monitor the organisation's performance, including around quality, operational, financial and workforce which includes appropriate benchmarking with peers; and	**4.27**
	b)	Uses the available data effectively.	**4.18**
18.	**Crisis management**		
	The Board responds positively and constructively in the event of a crisis, and has well-established business continuity and disaster recovery plans		**4.45**

19.	**Major developments and transactions**		
	The Board is involved in major developments in the business in the right level of detail and at the right time.		**4.27**
20.	**Quality of decision-making**		
	a)	The Board makes well-informed high quality decisions based on clear line of sight into the business; and	**4.55**
	b)	Appropriate processes are used to facilitate complex judgements – for example obtaining input from experts, establishing separate sub-committees or allowing additional time for debate and decision-making.	**4.36**
21.	**Demonstrating the Board's stewardship**		
	a)	The Board communicates effectively with all of the organisation's stakeholders and takes into account their interests;	**3.64**
	b)	Ensures that the standard of external reporting is high and that the annual report, taken as a whole, is fair, balanced and understandable; and	**4.36**
	c)	Reports on Board effectiveness including the role of the chairman, diversity, succession planning and Board evaluation.	**3.36**
22.	**Role of the Chairman**		
	a)	The Chairman has sufficient time to commit to the role;	**4.91**
	b)	Exhibits a leadership style and tone that promotes effective decision making, constructive debate and ensures that the Board works as a team; and	**4.70**
	c)	Sets an effective agenda for the Board and ensures it is debated fully.	**4.60**
23.	**Chairman and CEO relationship**		
	The Chairman and the Chief Executive work well together and their different skills and experience complement each other.		**3.91**
24.	**Role of the Senior Independent Director ('SID')**		
	The SID is effective and fulfils the role in a way commensurate with the circumstances of the Board.		**4.27**
25.	**Executive directors**		
	a)	The Executive Directors carry out their duties as directors as members of the Board rather than as senior management; but also	**4.18**
	b)	Represent an effective link through to senior management.	**4.18**
26.	**Trust Secretary**		
	The Trust Secretary is effective and works well with the Chairman, Non-Executive Directors and Executive Directors.		**4.36**
27	**Performance evaluation**		

	a)	The Board sets itself objectives;	**3.55**
	b)	Carries out a rigorous annual evaluation of its own performance; and	**3.73**
	c)	There is effective external facilitation at least every third year	**3.82**

University Hospitals Bristol
NHS Foundation Trust

Cover report to the Public Trust Board. Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	23
Meeting Title	Public Trust Board	**Meeting Date**	Thursday 27 September 2018
Report Title	**Committee Terms of Reference – Strategic Review**		
Author	Eric Sanders, Trust Secretary		
Executive Lead	Eric Sanders, Trust Secretary		
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

To present an analysis of how the Board currently receives assurance against the key items of business through the Committee structure and seek to close any identified gaps and remove potential duplication.

Key issues to note

The review has identified that the Board has not explicitly aligned the following areas of required assurance to one of its Committees through their Terms of Reference:

- Estates Strategy
- Estates compliance
- Digital Strategy

- Information Governance

Should the Board agree to the proposed allocations, then the Terms of Reference and cycles of business for the Committees will be updated accordingly.

Recommendations

Members are asked to:

- **Consider the analysis and approve the changes to the Terms of Reference as described in section 3.**

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)**

1. Background

1.1. Following the agreement by the Board to constitute a People Committee, the Trust Secretary was commissioned to review the current allocation of assurance activities amongst the Committees to identify any areas of overlap or gaps in the assurance arrangements.

1.2. The analysis is provided in the form of an assurance map which describes, based on the Terms of Reference for each of the Committees, the areas they are focused on to provide assurance to the Board, and any areas of potential duplication.

1.3. The totality of the assurance arrangements were then considered to identify if there were any gaps in the arrangements.

1.4. The Executive Directors considered the analysis and have agreed a proposal for consideration by the Board.

2. Assurance Map Analysis

2.1. The full assurance map is presented in Appendix 1, which has helped to identify the following:

2.2. Review of workforce performance and the national staff survey are duplicated across the Quality and Outcomes Committee (QOC) and the People Committee.

2.3. The Terms of Reference for the QOC do not make reference to the review of operational and quality risk, which it does through a review of the Board Assurance Framework and Corporate Risk Register every quarter.

2.4. The Terms of Reference for the People Committee does not make reference to the review of people risk.

2.5. The following areas of required assurance are not currently described in the Committee Terms of Reference:

2.5.1. Digital Strategy

2.5.2. Estates Strategy

2.5.3. Estates compliance

2.5.4. Information Governance

3. Proposed Changes to the Terms of Reference

3.1. Based on the review the Executive Directors have proposed the following changes:

3.2. Quality and Outcomes Committee

- Removal of references to workforce performance and review of the national staff survey
- Addition of the review of operational and quality risks

3.3. People Committee

- Addition of the review of people risks

3.4. Audit Committee

- Addition of the review of estates compliance (including fire safety) and information governance to seek assurance on behalf of the Board.

3.5. Finance Committee

- Addition of the review of estates strategy and digital strategy to seek assurance on behalf of the Board

4. Recommendation

4.1. The Board is asked to consider the analysis and approve the changes to the Terms of Reference as described in section 3.

Appendix 1 - Assurance Map

Purpose – to describe which Committees are assuring the Board about which areas of the business and to identify any gaps/overlap.

Source – The following is a summary from the Terms of Reference from the Committees.

Key: Known gaps ~~Duplicates areas~~

	Quality and Outcomes	Finance	People	Audit
Areas of Assurance:	• CQC compliance • Quality performance • ~~Workforce performance~~ • Compliance with healthcare standards • QI objectives • Quality strategy • Quality objectives • Standards of clinical and service quality • Annual clinical audit report • Serious Incidents • Complaints • Never Events • Patient experience including local and national surveys • ~~National staff survey~~ • Safeguarding • Annual report on Children's Services • Equality and diversity • Safe staffing	• Financial performance • Annual budget • Service delivery agreements and key contractual arrangements • Annual capital programme • Financial policies • Changes to SFIs • Financial risks • Major or high risk business cases • Capital Investment Policy	• Staff engagement • Reward • Equality & Diversity • Bullying & Harassment • Workforce performance • Staff wellbeing • Health & Safety (including RIDDOR) • Occupational Health • Management and Leadership Development • Medical and clinical education • Apprenticeships • Essential training • Strategic workforce planning • Recruitment and attraction • Talent management • IT systems • People Risks	• Financial statements • Integrated governance • Assurance • Risk management • Internal audit • Counter fraud • External audit • Annual report and financial statements • Annual governance statement • Delivery of corporate objectives • Governance policies • Clinical Audit • Accounting Policies

	Quality and Outcomes	Finance	People	Audit
	• QIA reviews • Data quality • Operational and quality risks			

Missing components:

- Digital Governance
- Information Governance
- Estates Compliance
- Estates Strategy

University Hospitals Bristol
NHS Foundation Trust

Cover report to the PublicTrust Board. Meeting to be held on 27 September 2018 at 11.00 – 13.00, Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU

		Agenda Item	24
Meeting Title	Public Trust Board	**Meeting Date**	Thursday, 27 September 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)**

Governors' Log of Communications

20 September 2018

ID	Governor Name		
207	Sue Milestone	***Theme:*** Carers	***Source:*** Governor Direct

Query **18/09/2018**

Since the Chair of the Carers' Strategy Group left the Trust in February 2018, the Carers' Strategy Group has not met, nor has there been any word on the status of this vital group. Liaison with carers of vulnerable patients is particularly important, especially in light of the findings in May of the National Learning Difficulties Mortality Review (LeDeR) carried out by NHS England and University of Bristol into deaths of patients with learning difficulties while in NHS care. The conclusions reached were that 25% of patients with LD die on average 20 years younger than the rest of the population, and these vulnerable patients are three times more likely to die from an avoidable death while in the care of the NHS. Can governors understand if the role of the Chair of the Carers' Strategy Group has been filled and the current status of Group? And what is the Trust's involvement with the LeDeR?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 03/10/2018

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
206	Flo Jordan	***Theme:*** Fire safety training and policy implementation	***Source:*** From Constituency/ Members

Query **05/09/2018**

After the recent fire at BHOC, what assurance can staff (and patients) be given that fire safety policies are being followed and that any breaches (e.g. blocking of fire exits) are reported and acted on? And how do we ensure that staff, particularly in surgical areas such as theatres, are adequately trained to safely evacuate patients who may require ongoing complex care in the event of a fire?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response

Status: *Assigned to Executive Lead*

ID	Governor Name		
205	Carole Dacombe	***Theme:*** Outpatients	***Source:*** From Constituency/ Members

Query **18/07/2018**

Governors are aware that a Foundation Trust member has taken the time to offer in-depth and insightful feedback on the running of outpatient clinics at our hospitals – noting some excellent, some good and some very poor practice. Can governors be assured that these comments have been taken on board and that there is a focus on the consistency in the way our outpatient clinics are managed?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 01/08/2018

Response **23/07/2018**

The Trust outpatient programme has worked over the previous two years and continues to work to introduce standardisation across all outpatient areas. Clinic waiting times boards have been introduced to the majority of waiting rooms, these allow patients to see at a glance whether the clinic they are attending is running on time or not. The boards are updated regularly by nursing staff and receptionists are asked to update patients when they check in. A pilot project will be running in B504 Rheumatology outpatients to have real time clinic digital waiting times reports, these will be displayed to the receptionist and nurses and allow accurate waiting times for each clinic to be given to patients, so they are aware on arrival how long they are likely to be in the department and when they will be seen. If the pilot is successful, this will be rolled out to further outpatient areas in 2019.

The Trust is a diverse site with outpatient areas in all of our buildings, these vary in their layout and we acknowledge that some waiting rooms are not always in direct proximity to the clinic rooms that they serve and space for patients to sit can be limited. Where possible waiting rooms are designed for ease of access by all patients including those in wheelchairs or who have a buggy, it is not always possible to designate areas for this, but where possible this has been done.

A delivering best care week was performed in outpatients at the end of February, this is designed to peer review all of the outpatient areas against both internal and external standards. All areas are currently working to complete the action plans that resulted from the visits and all actions will be in place by October 2018.

Thank you for your feedback regarding the Eye Hospital clinic this has been passed onto the appropriate manager for the Eye Hospital specific comments to be addressed.

Status: *Closed*

ID	Governor Name		
204	John Rose	***Theme:*** Medical recruitment	***Source:*** Project Focus Group

Query **16/07/2018**

How seriously have visa restrictions affected the Trust's ability to recruit doctors and nurses from outside the European Union, and have the pledges to lift restrictions actually taken place?

Division: Trust-wide ***Executive Lead:*** *Director of People* ***Response requested:*** 27/07/2018

Response **07/08/2018**

We have had only three visas rejected for medics. The impact hasn't been that severe for our Trust as the majority of our visa applications are for paediatric doctors and they are on the shortage occupation list which were exempt from the cap. The cap has now been lifted and we don't envisage any further issues of this nature. The main problem we have with recruiting overseas doctors is the length of time the process takes, especially when GMC registration is needed and we are looking at ways we can expedite this for future recruitment.

Status: *Closed*