University Hospitals Bristol
NHS Foundation Trust

Public Trust Board Meeting Papers

Date: Friday 27 September 2019

Time: 11.00 – 13.00

Venue: Conference Room, Trust Headquarters

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Conference Room, Trust HQ, Marlborough St, Bristol, BS13NU

NHS
University Hospitals Bristol
NHS Foundation Trust

Board of Directors (in Public)

Meeting of the Board of Directors to be held in Public on
Friday 27 September 2019 11.00 – 13.00
Conference Room, Trust HQ, Marlborough St, Bristol, BS1 3NU
AGENDA

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
Preliminary Business				
1.	Apologies for Absence – *Verbal update*	Information	Chair	
2.	Declarations of Interest – *Verbal update*	Information	Chair	
3.	What Matters to Me – a Patient Story	Information	Chief Nurse	
4.	Minutes of the Last Meeting • **30 July 2019**	Approval	Chair	
5.	Matters Arising and Action Log	Approval	Chair	
6.	Chief Executive's Report	Information	Chief Executive	
Patient Care and Clinical Outcomes				
7.	Quality and Performance Report	Assurance	Deputy Chief Executive and Chief Operating Officer, Chief Nurse, Medical Director, Director of People	
8.	Care Quality Commission Inspection Report 2019	Information	Chief Nurse, Medical Director	
9.	Quality and Outcomes Committee - Chair's Report - *Verbal Update*	Assurance	Chair of the Quality and Outcomes Committee	
10.	People Committee – Chair's Report – *Verbal Update*	Assurance	Chair of the People Committee	
11.	Six-Monthly Report of Safe Staffing	Assurance	Chief Nurse	
12.	Learning from Deaths Report	Assurance	Medical Director	
13.	Patient Experience Report - Q1	Information	Chief Nurse	

NO.	AGENDA ITEM	PURPOSE	SPONSOR	TIMINGS
14.	Patient Complaints Report - Q1	Information	Chief Nurse	
Workforce				
15.	Medical Revalidation Appraisal Report	Assurance	Medical Director	
Strategic Performance and Oversight				
16.	Improvement, Transformation and Innovation Strategy	Approval	Director of Strategy & Transformation	
Financial Performance				
17.	Finance Report	Assurance	Director of Finance and Information	
18.	Finance Committee – Chair's Report – *Verbal Update*	Assurance	Chair of Finance Committee	
Governance				
19.	Governors' Log of Communications	Information	Chair	
20.	Annual Report for the South Wales and South West Congenital Heart Disease Network	Information	Medical Director	
Concluding Business				
21.	Any Other Urgent Business – *Verbal Update*	Information	Chair	
22.	Date and time of next meeting • **31 October 2019**	Information	Chair	

Meeting of the Board of Directors in Public on
27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**What Matters to Me – a Patient Story**
Report Author	**Tony Watkin, Patient and Public Involvement Lead**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

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.

2. Key points to note

(Including decisions taken)

In this story we will meet Sage. Sage currently receives specialist speech and language therapy at UH Bristol. In sharing her story Sage will talk about how, as a Trans person, she has the same basic health needs as cisgender[1] people whilst at the same time having health care needs related to her transition. Sage will illustrate how this is not always understood by healthcare professionals and how accessing health care can be challenging for transgender people particularly when engaging with health care staff who are not sensitive to her health care needs or informed about issues affecting the transgender community. In doing so Sage will explore the impact this can have on her and the importance of culturally competent care.

By way of context, in 2018 the Trust received a Healthwatch and Diversity Trust report on Trans Health, Care and Well-being. The report concluded that Trans people face a significant amount of hostility in society and the health care system can be a contributing factor to that. In responding to the report the Trust, by virtue of the Workforce Diversity and Inclusion Group and the Patient Inclusion and Diversity Group, made a number of commitments with respect to training, awareness raising and policy development to better meet the needs of Transgender people at UH Bristol. Having Sage share her experiences at Trust Board is part of delivering on those commitments.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

N/A

[1] *Cisgender is a term for people whose gender identity matches the sex that they were assigned at birth. For example, someone who identifies as a woman and was assigned female at birth is a cisgender woman. The term cisgender is the opposite of the word transgender.*

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **INFORMATION** • The Board is asked to **NOTE** the report
5. History of the paper **Please include details of where paper has previously been received.**
N/A

Minutes of the Board of Directors Meeting held in Public
University Hospitals Bristol NHS Foundation Trust (UH Bristol)

Tuesday 30 July 2019 at 11:00 – 13:00, Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Present:
Board Members

Name	Job Title/Position
Jeff Farrar	Chair of the Board
Robert Woolley	Chief Executive
David Armstrong	Non-Executive Director
Sue Balcombe	Non-Executive Director (Designate)
Paula Clarke	Director of Strategy and Transformation
Julian Dennis	Non-Executive Director
Bernard Galton	Non-Executive Director
Matt Joint	Director of People
Neil Kemsley	Director of Finance and Information
Jayne Mee	Non-Executive Director
Carolyn Mills	Non-Executive Director
Guy Orpen	Non-Executive Director
William Oldfield	Medical Director
Mark Smith	Deputy Chief Executive and Chief Operating Officer

In Attendance:

Name	Job Title/Position
Eric Sanders	Trust Secretary
Tony Watkin	Patient and Public Involvement Lead (for Item 3)
Bob	Patient (for Item 3 – Patient Story)
Andy Headdon	Director of Facilities and Estates (for Item 15)
Carol Sawkins	Lead Safeguarding Nurse (for Item 13)
Martin Williams	Director for Infection Prevention and Control (for Item 18)
Alistair Johnstone	Guardian of Safe Working Hours (for Item 14)
Matthew Thackray	Press Officer
Mo Phillips	Public Governor
Ray Phipps	Public Governor
Hessam Amiri	Public Governor
Graham Briscoe	Public Governor
Carole Dacombe	Public Governor
Ed Leonardo	Member of the public
William Thomas	Member of the public
Mike Lyall	Member of the public/Foundation Trust Member
Kieran Oglesby	Member of staff
Adam Postans	Member of the press

Minutes: Sarah Murch: Membership and Governance Administrator

The Chair opened the Meeting at 11:15

Minute Ref	Item Number	Action
Preliminary Business		
43/07/2019	**1. Welcome and Introductions/Apologies for Absence**	
	The Chair of the Board, Jeff Farrar, welcomed everyone to the meeting. Apologies had been received from Non-Executive Directors John Moore, Steve West and Martin Sykes, and Madhu Bhabuta, Non-Executive Director (Designate).	
44/07/2019	**2. Declarations of Interest**	
	There were no new declarations of interest.	
45/07/2019	**3. Patient Story**	
	The meeting began with a patient story from Bob, who had spent nine weeks in hospital after developing sepsis in June 2018. His care had begun at Southmead Hospital, but after a short stay, he had been transferred to the Bristol Heart Institute for additional specialist care with respect to a heart arrhythmia alongside continued care for his sepsis. Bob told the Board what it had felt like to be a patient at the Bristol Heart Institute over a long period of time and the impact it had on him. Overall, he had found the attention that he had received to be of very high quality. Where mistakes had been made by a member of nursing staff, he had been impressed with the way that senior staff had quickly and sensitively dealt with the matter. The main area for improvement that he wished to highlight was around the consistency of communication and information from medical staff. Different doctors had given him different information about when he might be ready to go home, and this had caused him anxiety and stress, particularly after so long in hospital. Bob's story also revealed the importance of the human touch: when he was eventually discharged, he was overwhelmed with the number of members of staff who came to say goodbye and wish him well. The Chair, Jeff Farrar, thanked Bob for sharing his story. Bill Oldfield, Medical Director, offered his apologies for the communication shortcomings that Bob had experienced from the medical team. Guy Orpen, Non-Executive Director, asked how the Trust could help people who were used to being active and in control of their lives adapt to a long hospital stay. Bob responded that it was important to offer people something to do, mentally and physically, in order to keep them occupied and aid their recovery. *Bob left the meeting.*	
46/07/2019	**4. Minutes of the last meeting**	
	Board members reviewed the minutes of the meeting held on 24 May 2019. There were no amendments.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the minutes of the Board of Directors meeting held in public on 24 May 2019 as a true and accurate record.	
47/07/2019	**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: **120/05/2019: Patient Story- Circulate Patients Not Passports question and response to Board and Governors.** This had been completed. **24/05/2019: Quality and Performance Report - Mark Smith to review Emergency Department performance and improvement measures in the light of ever-increasing demand and to report back to Board**. An improvement plan was being developed and had been shared with the Quality and Outcomes Committee. **26/05/2019: Report from the Chair of the People Committee - Review Terms of Reference for Board Committees to ensure alignment with the new Trust five-year strategy.** This was in progress and revised Terms of Reference would be reviewed by each committee and the Board. **30/05/2019: Research and Innovation Strategy - Review and strengthen key performance indicators in the Research and Innovation Strategy to include more detail on their ownership and their reach throughout the organisation. Include reference to the Local Enterprise Partnership and West of England Combined Authority.** The key performance indicators were being revised in line with the Board's recommendations and would be finalised in the coming weeks. **31/05/2019: Education Strategy - Review and strengthen key performance indicators in the Education Strategy. Include reference to the Local Enterprise Partnership and West of England Combined Authority.** The updates had been made and the revised strategy would be circulated to the People Committee. **06/04/2019: Quality and Performance Report - Consideration to be given as to whether cancelled operations metrics in the Quality and Performance Report should be changed to provide further detail of the types of operations cancelled.** The Trust's quality, access and workforce indicators were currently being reviewed. More detail was now included in the Quality and Performance Report. **10/04/2019: Healthier Together Sustainability and Transformation Partnership Update - UH Bristol's response to system working to be included in future Board seminar.**	

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	214/03/2019: Quality and Performance Report - Connection between demand, capacity and estate to be explored at a future Board Seminar. **217/03/2019: Six-Monthly Nurse Staffing Report - Model Hospital digital tool to be demonstrated to the Board.** All three of these items would be included in the 2019/20 Board Development plan. There would be an update on the Board development programme at the next Board meeting. **Members RESOLVED to:** • **Note** the updates against the action log.	
48/07/2019	**6. Chief Executive's Report**	
	The Board received a summary report of the key business issues considered by the Senior Leadership Team in July 2019. Robert Woolley, Chief Executive, provided updates on the following matters: • There would be a public announcement today about a change in leadership arrangements at Weston Area Health NHS Trust (WAHT). As a consequence of the partnership, which had been running since May 2017, and as the full business case for the merger between the two Trusts was being developed, with a target date of 1 April 2020, Jeff Farrar and Robert Woolley had agreed to take on the roles of Chair and Chief Executive respectively at WAHT from 1 September 2019. This would be a dual arrangement and both would retain their full responsibilities in the same roles at UH Bristol. The current Chief Executive and Chair of WAHT had agreed to stand aside at the end of August to allow this arrangement to take effect. The purpose of the change was to provide a mechanism for alignment between the two Trusts in advance of the merger to help them to manage it effectively for the benefit of both organisations. Communication about the change in leadership had been disseminated yesterday to staff at both Trusts and to UH Bristol's Council of Governors. • The National Institute for Health Research had made an announcement of £135m investment in 15 new Applied Research Collaborations supporting applied health and care research to meet the needs of local populations. UH Bristol would be hosting a £9m Applied Research Collaboration for the West of England, in collaboration with the universities and others, focussing on mental health, prevention, public health and behavioural science. Guy Orpen, Non-Executive Director, highlighted the contribution of Bristol Health Partners in securing this grant. • UH Bristol was waiting to hear the results of the Care Quality Commission inspection of the Trust which had taken place earlier in the year. An announcement was expected in mid-August. • UH Bristol was one of six Trusts involved a national pilot for the field testing for new elective care standards (for the referral-to-treatment time standard).	

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	• Bristol City Council had launched a public consultation on the implementation of a Clean Air Zone with options which could exclude all diesel cars from Upper Maudlin Street and Marlborough Street. UH Bristol would be submitting a response as there would be significant implications for supply vehicles and emergency vehicles as well as patient and visitor arrivals. Mike Lyall, member of the public, expressed his surprise as a North Somerset resident at the announcement of the leadership change at WAHT and enquired whether it meant that the Boards of both Trusts would amalgamate. Robert Woolley clarified that the two organisations would retain their own Board governance and accountability structures until the merger was complete on 1 April 2020, though the Boards would look for opportunities to align their activities. He added that as the announcement had involved individual people's contracts it had not been possible to discuss it publicly in advance of today's announcement, but that discussions between both Boards had been developing for some time and the outcome had been agreed mutually. In response to a further question from Graham Briscoe, Public Governor for North Somerset, about whether there was an intention to set up a shadow board, Jeff Farrar emphasised that the two Trusts would remain separate statutory organisations until the point of merger. **Members RESOLVED to:** • **Receive** the Chief Executive's Report for assurance.	
Patient Care and Clinical Outcomes		
49/07/2019	**7. Quality and Performance Report**	
	Mark Smith, Deputy Chief Executive and Chief Operating Officer, presented the Quality and Performance Report, the purpose of which was to enable the Board to review the Trust's performance on Quality, Workforce and Access standards during the past month. **Access Standards:** • Overall, the Trust was performing well across most indicators. However, the hospitals were still very busy, with high volumes of patients attending. The percentage of Emergency Department patients seen in less than 4 hours was now showing signs of improvement but it was still below target. There was also an impact on waiting times for elective care. Work was being undertaken to understand where the pressures and the delays were and to produce evidence for this. Additional recruitment to the Trust's frailty service and Emergency Department was underway and would be mobilised later in the year. • UH Bristol was one of six Trusts involved a national pilot for the field testing for new elective care standards. This Clinical Referral Service trial was due to go live in August and progress would be reported at the next Board meeting.	

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	• The Trust was still achieving its 62-day cancer standard for GP referrals which was one of the best nationally. • Cardiac diagnostics presented a challenge to the delivery of the 6 week wait standard. A new cardiac-enabled scanner was due to be installed during Quarter 3. **Action: Progress to be reported to the Board on the Clinical Referral Service trial (testing of new elective care standards).** **Quality Standards:** • William Oldfield, Medical Director, advised the Board that the method of recording venous thromboembolism (VTE) risk assessments was set to change from a paper-based to an electronic system on 1 August and preparations for this were underway. • He outlined two incidents in the month in which medication errors had caused moderate harm. These would be subject to formal investigation and the results of the investigations would be reported to the Quality and Outcomes Committee. • The Board noted that mortality rates remained within expected levels, and were being monitored where they were higher than anticipated. • New consultants had been appointed to support the Trust's Fractured Neck of Femur pathway. This was a significant step forward and the Trust had been impressed with the strength of the candidates. It was anticipated that they would start in November. • Carolyn Mills, Chief Nurse, reported that there had been one 'never event' in the month which was detailed in the report. • The Board welcomed the news that UH Bristol had received the best overall patient experience score of all general acute Trusts in the 2018 Care Quality Commission National Adult Inpatient Survey. **Workforce Standards**: • In relation to workforce standards for the month, Matt Joint, Director of People, reported that compliance for statutory training remained high at 90%, and that turnover was steady, though vacancy rates and staff sickness rates had seen a small increase. • Board members heard that a clinical talent acquisition manager had been appointed to help the Trust to recruit specialists and consultants both nationally and internationally. Sue Balcombe, Non-Executive Director, enquired about recent challenges in relation to the Trust's apprentice programme and asked whether the Trust had factored in backfill for training time for apprentice positions. Matt Joint, Director of People, acknowledged that this issue had not been adequately understood at the time of implementation. There was now a drive to ensure that all staff appreciated the importance of releasing apprentices for training, particularly as Ofsted inspectors would return in January to evaluate whether improvements had been made since their last visit in this regard.	Deputy Chief Executive /Chief Operating Officer

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	Jayne Mee, Non-Executive Director, enquired what the Trust was doing to improve disappointing staff appraisal rates and whether the Trust had considered conducting all staff appraisals once annually rather than at different times during the year. Matt Joint responded that the appraisal compliance rates had seen some improvement but agreed that they were still not as good as they should be. He added that challenges in encouraging staff to move from paper-based appraisals to e-appraisals needed to be overcome before introducing any further large-scale changes. **Members RESOLVED to:** • **Receive** the Quality and Performance Report for assurance.	
50/07/2019	**8. Quality and Outcomes Committee Chair's Report**	
	Julian Dennis, Chair of the Quality and Outcomes Committee, highlighted the following key issues from the Committee's meetings in July: • They had received an update on the Trust's performance against key targets and considered the key risks allocated to the committee. • The Committee had received a presentation on the development of Emergency Medicine and the actions undertaken to develop the Trust's emergency medicine provision given the increasing demands on the service. • The Committee had welcomed the successful and much-needed recruitment to the Trust's silver trauma and frailty service. • They had received information about the Trust's participation in a national trial of new access standards. **Members RESOLVED to:** • **Receive** the Quality and Outcomes Committee Chair's report for assurance.	
51/07/2019	**9. Report from the Chair of the People Committee**	
	Bernard Galton, Chair of the People Committee, reported the following key issues from the Committee's meeting in July: • The Committee had received an update on workforce performance including progress against Key Performance Indicators. • The Committee received an update on the Estates and Facilities Organisational Development and Retention Plan. They had been pleased to note that vacancy rates and staff sickness rates were reducing as a result of the implementation of the plan. • The Committee had discussed the new People Strategy and had agreed to recommend it for approval to the Board subject to revisions to its introductory and contextual information. They also commented that the strategy should be continually revised and updated to ensure its continuing relevance.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the People Committee Chair's report for assurance.	
52/07/2019	**10. Audit Committee Chair's Report**	
	David Armstrong, Chair of the Audit Committee, reported that the Committee's meeting in July had focussed primarily on the Estates and Facilities Report and a number of Internal Audit Reports. He informed the Board that he had attended the first meeting of Audit Committee Chairs across Bristol, North Somerset and South Gloucestershire which was a significant step forward and would hopefully enable organisations to share their different approaches and work together. **Members RESOLVED to:** • **Receive** the Audit Committee Chair's report for assurance.	
Strategic Performance and Oversight		
53/07/2019	**11. Emergency Preparedness Resilience and Response Annual Report**	
	Mark Smith, Chief Operating Officer and Accountable Emergency Officer, introduced the annual report on the Trust's Emergency Preparedness, Resilience and Response (EPRR). The purpose was to give the Board assurance that the Trust remained substantially compliant with NHS England's Core Standards for EPRR. The report listed a summary of key risks in terms of critical incidents and business continuity failures as well as training and exercises undertaken over the past 12 months and priorities for the year ahead. Board members discussed the report. Julian Dennis, Non-Executive Director, requested further information about the report's terminology, as he did not feel that phrases such as 'substantially compliant' provided sufficient assurance. Bernard Galton, Non-Executive Director, enquired as to the impact of the heatwave the previous week. Mark Smith noted that there had been an impact on staff and patients due to insufficient air-conditioning in the hospitals. There had been several theatres in which the temperature reached over 30℃. Measures taken had included the installation of chillers and coolers but one theatre had remained too hot and could not be used. Robert Woolley, Chief Executive, referred to the risk identified in the report relating to a no-deal EU Exit and added that NHS England had announced that they would be running events in September for providers to ensure that their requirements were understood. Mark Smith added that table top exercises were being carried out regionally to determine how to best to deal with potential supply chain issues.	

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	It was noted that Guy Orpen was the Non-Executive Director for EPRR. David Armstrong suggested that the Audit Committee should have more oversight of EPRR and that the annual report should be reviewed by the Audit Committee. **Actions:** • **Mark Smith to provide more detail on EPRR ratings to Julian Dennis.** • **EPRR Board reporting to be reviewed (Annual Report to be received by Audit Committee)** **Members RESOLVED to:** • **Receive** the Emergency Preparedness Resilience and Response Annual Report for assurance.	Deputy Chief Executive /Chief Operating Officer Trust Secretary
54/07/2019	**12. Clinical Negligence Scheme for Trusts (CNST) Compliance Report**	
	Carolyn Mills, Chief Nurse, introduced this report which outlined the compliance of the Trust's maternity service with the standards set out by the Clinical Negligence Scheme for Trusts (CNST). This required Trusts to demonstrate that they had achieved the required progress against ten actions in order to qualify for a rebate of their financial contribution to an incentive fund. The report provided the Board with assurance that the Trust could demonstrate full compliance with the standards. Board members were asked to approve the Trust's declaration of compliance. **Members RESOLVED to:** • **Approve** the Trust's declaration for compliance with the Clinical Negligence Scheme for Trusts.	
55/07/2019	**13. Safeguarding Annual Report**	
	Carolyn Mills, Chief Nurse, introduced this report, which provided the Board with assurance that the Trust continued to fulfil its statutory and regulatory responsibilities to safeguard the welfare of children and adults across all areas of service delivery. She brought the Board's attention to two risks on the corporate risk register relating to safeguarding. She also highlighted that the year ahead would see a focus on improving the Trust's compliance with Level 3 Core Specialist Training. Carol Sawkins, Lead Safeguarding Nurse, was also in attendance for this item. She added that while it had been a busy year in relation to safeguarding, a lot of work had been undertaken to maintain regulatory compliance and keep sight of the risks. **Members RESOLVED to:** • **Receive** the Safeguarding Annual Report for assurance.	

Minute Ref	Item Number	Action
56/07/2019	**14. Safe Working Hours Guardian Report**	
	Alistair Johnstone, Guardian of Safe Working Hours, was in attendance to introduce the annual report on rota gaps and vacancies for doctors and dentists in training. Key points included: • The 2016 junior doctors' contract was now well-established for all junior doctors in training across the Trust and, from August 2019, and would be implemented for all new locally employed doctors. • There were significant numbers of rota gaps across the Trust and these appeared to be increasing in number over the past year. This was a key cause of decreased job satisfaction and poor morale in the junior doctor workforce. Board members discussed the issues raised in the report. They agreed with Alistair Johnstone's assessment that rota gaps were a serious problem that needed addressing as a matter of urgency, particularly given the national shortage of doctors. In response to questions from Jayne Mee, Non-Executive Director about recruitment challenges, Matt Joint, Director of People, acknowledged that there was room for improvement in the Trust's medical HR processes, particularly in attracting medical staff from abroad. However, Board members noted that the solutions were also likely to involve a significant review of current working practices and consideration of recruitment of a 'non-medical' workforce to reduce the impact of the gaps. William Oldfield, Medical Director, added that the Trust had already taken steps to recruit six physician associates, and were considering the expansion and introduction of other such roles to take on some of the work currently carried out by junior doctors. Non-Executive Directors asked that this programme be expanded with urgency and form a more explicit part of the Trust's new People Strategy. In response to a question from Julian Dennis, Non-Executive Director, about how acceptable the new roles would be to UH Bristol's consultant body, Robert Woolley, Chief Executive, responded that consultants themselves had requested this kind of support, and that the introduction of the new roles were also now supported by the Royal Colleges. Alistair Johnstone confirmed that junior doctors would also welcome the support, though reassurance would be needed in relation to the impact on their training. Carole Dacombe, Public Governor, added that there had also been strong support among governors at a recent meeting for the Board's efforts to tackle this issue through the proposed creation of alternative roles. **Members RESOLVED to:** • **Receive** the Annual Safe Working Hours Guardian Report for assurance**.** *Alistair Johnstone left the meeting.*	

Minute Ref	Item Number	Action
57/07/2019	**15. Annual Fire Report**	
	Andy Headdon, Director of Facilities and Estates was in attendance to introduce a report of the main fire safety issues for 2018-19 and compliance against national standards. Key points were as follows: • During the period covered, there had been 3 small fires and 1 major incident (the latter being the fire in the Bristol Haematology and Oncology Centre in May 2018). The Board had received reports of the investigations into the major incident at the time and was monitoring actions taken as a result of these. • Key risks to compliance and mitigations were noted in the report including a significant capital investment (£4.5m) approved in the reporting period to address the identified compliance issues relating to the 60-minute compartmentation across the estate. The Trust had also established a dedicated fire safety committee. • The Trust was making good progress in reducing its numbers of unwanted fire signals. In response to a question about fire safety compliance at South Bristol Community Hospital (SBCH), Andy Headdon reminded the Board that the Trust did not own the SBCH building and that an external landlord was therefore responsible for fire precautions. Areas of non-compliance revealed in a recent survey had necessitated consultation between the Trust and the landlord and progress was now being made to resolve the issues. Non-Executive Directors expressed concern about the relatively high rate of non-attendance at staff fire training sessions. Andy Headdon clarified that while all staff were required to complete e-learning, certain staff types also required face-to-face training but faced challenges in being released from clinical duties for this. It was noted that the People Committee would monitor this as part of its routine examination of mandatory training compliance. David Armstrong, Non-Executive Director, asked that this report be received by the Audit Committee in the future. This was agreed. **Action: Annual Fire Report to be included in the annual business cycle for the Audit Committee.** **Members RESOLVED to:** • **Receive** the Annual Fire Report for assurance. *Andy Headdon left the meeting.*	Trust Secretary
58/07/2019	**16. Patient Experience Q4 Report**	
	Carolyn Mills, Chief Nurse, introduced this report, which was for information and public awareness. The Board had previously discussed the report at its Quality and Outcomes Committee.	

Minute Ref	Item Number	Action
	Members RESOLVED to: **Receive** the Patient Experience Q4 Report for assurance.	
59/07/2019	**17. Patient Complaints – Q4 Report and Annual Report**	
	Carolyn Mills, Chief Nurse, introduced this report, which was for information and public awareness. Again, the Board had previously discussed the report at its Quality and Outcomes Committee. **Members RESOLVED to:** **Receive** the Patient Complaints Q4 Report and the Annual Report for assurance.	
60/07/2019	**18. Infection Prevention and Control Annual Report**	
	Carolyn Mills, Chief Nurse, introduced this report, the purpose of which was to provide assurance to the Board and the general public that the Trust had discharged its statutory responsibilities with regards to infection prevention and control in 2018/19 and demonstrate progress against performance targets. Martin Williams, Consultant Microbiologist and the Trust's Director for Infection Prevention and Control, was in attendance for this item. He highlighted the following key points from the report: • The Trust was in excess of its targets for MRSA bacteraemia and MSSA bacteraemia. There had been six MRSA bacteraemia cases attributed to the Trust for 2018/19 against a threshold of zero. All cases had been carefully assessed and any issues highlighted were addressed. The Trust had reported 28 cases of MSSA infections in the year (against a Trust limit of 25). Investigations had revealed that some of these infections had been related to the change from paper-based to electronic prescribing which had affected the way that information was recorded. Rates of *Clostridium Difficile* infections continued to be low (31 for 2018/19 against a threshold of 44. Of those, 9 were determined to be due to a lapse in care. • It had been a relatively quiet year for influenza with little impact on the Trust this year. However, he highlighted that the Trust would need to be prepared in good time this winter particularly as Australia had seen an early outbreak of influenza this year. In response to a question from Robert Woolley about news reports of the spread of Klebsiella pneumoniae in hospitals, Martin Williams clarified that this was one of the strains of pneumonia that were resistant to antibiotics but that the Trust had a robust system of identifying and dealing with these. *Martin Williams left the meeting.* **Members RESOLVED to:** **Receive** the Infection Prevention and Control Annual Report for assurance.	

Minute Ref	Item Number	Action
Strategic Performance and Oversight		
61/07/2019	**19. People Strategy**	
	Matt Joint, Director of People, introduced the Trust's new People Strategy for 2020-2025 and recommended it for approval by the Board. The strategy set out the Trust's priorities in terms of its workforce over the next five years and the actions that would be necessary to achieve these. Bernard Galton, Chair of the People Committee, added that the Committee would be monitoring the Trust's progress against the strategy. Matt Joint confirmed that the strategy had been updated to reflect feedback from the People Committee. He accepted the challenge from Non-Executive Directors that the strategy could have been bolder in terms of its aspirations, but added that would be refreshed periodically to ensure that it remained relevant and up-to-date. Non-Executive Directors asked that an amendment be made to include reference to engagement with staff and unions in the development of the strategy. This was agreed. **Action: People Strategy to be amended to demonstrate staff engagement in its development.** **Members RESOLVED to:** • **Approve** the People Strategy subject to this amendment and the caveat that it should be implemented flexibly to ensure that it remained responsive to the changing landscape.	Director of People
62/07/2019	**20. Arts and Culture Strategy**	
	Matt Joint, Director of People, introduced the Trust's new Arts and Culture Strategy for 2020-2025 and recommended it for approval by the Board. The paper made the case for the continuation and development of the arts programme piloted in 2018/19, described the national and local context for the arts in hospital, and outlined the aims and priority areas for the establishment of the programme and the approach to funding. The strategy sought a level of core funding support from the Trust for its arts and culture programme. It was proposed that this would be effected by using one percent of the funding set aside for the Trust's 'Phase 5' capital programme for 2020-2025. Funding support would also be sought from charities and other organisations. Non-Executive Directors supported the concept of the strategy in terms of the benefits for patient and staff experience, though noted that a stronger business case and clearer financial expectations would be helpful so that return for investment could be demonstrated. After discussion, Board members agreed that capital funding could be used to support the arts programme, but asked that once a budget was set a more detailed plan	

Minute Ref	Item Number	Action
	should return through the People Committee including success criteria. **Action: People Committee to receive detailed report on Arts Strategy including budget and success criteria** **Members RESOLVED to:** • **Approve** the Arts and Culture Strategy subject to the caveat that the strategy would be followed by a more detailed plan.	Director of People
63/07/2019	**21. Risk Management Strategy**	
	Robert Woolley, Chief Executive, introduced this paper, the purpose of which was to review the refreshed Board's risk appetite and tolerance statements as part of the annual review of the Risk Management Strategy. He highlighted that the Risk Appetite Statement had been developed following consultation at a recent Board Seminar. The Board had determined the Trusts risk appetite as an 'open' one which meant that a level of risk-taking was encouraged to maintain a progressive approach to the delivery of services, as long as assurance could be sought that any associated risks could be mitigated to a tolerable level. There was also a new section in the strategy on risk tolerance. **Members RESOLVED to:** • **Receive** the Risk Management Strategy for approval.	
64/07/2019	**22. WAHT Partnership and Merger Update**	
	Paula Clarke, Director of Strategy and Transformation, introduced a report updating the Board of Directors on the partnership with Weston Area Health NHS Trust (WAHT) and progress with the merger plan. The report provided assurance that the intent to merge was being underpinned by a significant amount of detailed work to ensure that the merger would be achieved by 1 April 2020. The full business case was in development with the aim of conclusion in November 2019. This would identify risks, mitigations and benefits for the population as a whole. She confirmed that the Boards of both Trusts were committed to the merger. Communication about the merger was increasing and frequently-asked-questions would be put together to share with staff and external stakeholders to help to alleviate concerns. Mike Lyall, member of the public, asked whether the closure of the Emergency Department at Weston General Hospital was still a possibility. Robert Woolley, Chief Executive, explained that this decision would need to be made by the Clinical Commissioning Group for the region, which was currently reviewing the services that it wished to fund at Weston General Hospital. Their decision was expected in October.	

Minute Ref	Item Number	Action
	Members RESOLVED to: • **Receive** the WAHT Partnership and Merger update for assurance.	
65/07/2019	**23. Healthier Together update**	
	Robert Woolley, Chief Executive, introduced a report updating the Board on work carried out within the Healthier Together Sustainability and Transformation Partnership (the collaboration between health and care organisations across Bristol, North Somerset and South Gloucestershire). He drew the Board's attention to the creation of a five-year plan by all system partners. The initial submission date for the plan was September with a final submission date in November. The Board would be kept informed as this developed. **Members RESOLVED to:** • **Receive** the Healthier Together Update for information.	
66/07/2019	**24. Transforming Care Programme Board Report (Quarter 1)**	
	Paula Clarke, Director of Strategy and Transformation, introduced a report updating the Board on the progress and highlights in the period April to June 2019 against the three priority areas agreed at the Trust's Transformation Board for improving quality of care: Digital Transformation, Working Smarter (Productivity Improvement) and the Quality Improvement programme. The Board noted progress against each current project. In response to a question from Robert Woolley about the timescales for implementing People Web (a new HR intranet resource for staff and managers), Paula Clarke explained that this was dependent on the Trust's decision on whether to implement Microsoft 365 but was expected to be within the next three months. **Members RESOLVED to:** • **Receive** the Transforming Care Programme Board report for info.	
67/07/2019	**25. Phase 5 Strategic Capital Update**	
	Paula Clarke, Director of Strategy and Transformation, introduced this quarterly update on the progress of the strategic capital investment programme. The schemes, which had been approved by the Board in September 2018, included renewing and upgrading the Trust's aged estate, as well as supporting its expansion of specialist acute care. The report also advised that a Procure22 principle supply chain partner had been appointed (BAM Construction). She drew the Board's attention to the progress that was being made on each of the individual schemes, but noted that priorities would be kept under review in line with the changing local and regional	

Minute Ref	Item Number	Action
	healthcare landscape. **Members RESOLVED to:** • **Receive** the Phase 5 Strategic Capital Update for information.	
68/07/2019	**26. Corporate Objectives Update – Q1**	
	Paula Clarke, Director of Strategy and Transformation, introduced this report which provided an update to the Board on the delivery of the Trust's Corporate Objectives for Quarter 1. The report aimed to provide the Board with assurance that detailed actions were underway to ensure progress on each one of objectives. **Members RESOLVED to:** • **Receive** the Corporate Objectives Update (Q1) for assurance.	
Financial Performance		
69/07/2019	**27. Finance Report**	
	Neil Kemsley, Director of Finance and Information, introduced the Finance Report which informed the Board of the financial position of the Trust in June. Key points included: • The Trust was reporting a core deficit of £0.377m to date excluding technical items. This was £0.012m favourable to plan. • The Trust had secured around £1.5m of Provider Sustainability Funding for the quarter. • The main areas of concern were activity under-performance of £1.269m year to date and nursing overspending of £1.579m year to date. • There would be a review of risks and mitigations in the Medicine and Surgery Divisions as these were both areas of concern in terms of their ability to deliver the operating plan. • National concerns in terms of tax and consultant pensions could impact on the Trust's proposals to recover elective activity. • The Trust had been required to take part in a national exercise to reduce this year's expenditure programme by 20%. This had been reasonably straightforward to achieve due to capital programme slippage. • The format of the Finance Report would be reviewed to include greater emphasis on tracking recovery actions and more focus on the underlying financial position rather than the in-year financial position. **Members RESOLVED to:** • **Receive** the Finance Report for assurance.	

Minute Ref	Item Number	Action
70/07/2019	**28. Finance Committee Chair's report**	
	In the absence of the Finance Committee Chair, Jeff Farrar introduced a report from the meeting of the Finance Committee on 25 July, including the following key points: • The committee had discussed the financial position of the Trust and key risks, particularly divisional overspends. • The committee had received an update on the Trust's progress regarding the 'Working Smarter' Programme, outlining the approach and methodology employed to deliver productivity, how it was embedded in divisions, as well as governance and assurance. The committee had been assured that this was a very positive and detailed programme and showed good progress. **Members RESOLVED to:** • **Receive** the Finance Committee Chair's report for assurance.	
Governance		
71/07/2019	**29. West of England AHSN Board Report**	
	Robert Woolley introduced this report for information. This was a quarterly report providing the Board with an update on work undertaken by the West of England Academic Health Science Network (AHSN). **Members RESOLVED to:** • **Receive** the West of England Academic Health Science Network report for information.	
72/07/2019	**30. Register of Seals report**	
	Eric Sanders, Trust Secretary, introduced the quarterly report showing that there had been two new applications of the Trust Seal since the previous report in January 2019. He clarified that entry no. 818 represented the building contract for the conversion of Myrtle Road. **Members RESOLVED to:** • **Receive** the Register of Seals report for information.	
73/07/2019	**31. NIHR CRN Annual Report 2018/19 and Annual Plan 2019/20**	
	William Oldfield, Medical Director, introduced the Annual Report and Annual Plan of the National Institute for Health Research's Clinical Research Network (CRN) in the West of England. Board members were reminded that UH Bristol hosted this network. It had improved significantly in recent years and was now over target compared with other networks since it had moved from a devolved to a centralised model. The Annual Report 2018/19 reported on its achievements during the year, and the Annual Plan set out ambitious aspirations for the year ahead,	

Minute Ref	Item Number	Action
	which was particularly notable in the context of national squeeze on funding for research networks. **Members RESOLVED to:** • **Approve** the NIHR CRN Annual Report and the Annual Plan.	
74/07/2019	**32. Self-Assessment of Board Cycle**	
	Eric Sanders, Trust Secretary, asked the Board to approve its annual cycle of business for September 2019-August 2020. David Armstrong, Non-Executive Director, had a number of recommendations for improvement which he agreed to discuss with Eric Sanders following the meeting. **Action: David Armstrong and Eric Sanders to discuss improvements to the Annual Business Cycle** **Members RESOLVED to:** • **Approve** the annual business cycle with the caveat that the Board would have the opportunity to continuously improve it.	Trust Secretary
75/07/2019	**33. Reimbursement of Expenses for the Council of Governors policy**	
	The purpose of this report was to approve a change to the Reimbursement of Expenses for the Council of Governors Policy to reduce the standard mileage rate paid to governors. Eric Sanders, Trust Secretary, informed the Board of Directors that following an HMRC inspection in May it had been discovered that the level of mileage that the Trust was paying to its governors (£0.56p per mile) was above the tax threshold (£0.45p per mile). As governors were not employees of the Trust and not subject to PAYE, if they continued to claim the higher rate, they would have to complete a self-assessment form to declare tax, and tax would be deducted from their expenses claim. Board members were therefore asked to approve a reduction in the standard mileage rate paid to governors to the HMRC maximum tax exempt level of £0.45 per mile. Public governors present voiced their acceptance of this change. Graham Briscoe, Public Governor, added that he had first questioned the governors' mileage rate several years ago and had highlighted the issue again in recent weeks. **Members RESOLVED to:** • **Approve** the Reimbursement of Expenses for the Council of Governors policy	

Minute Ref	Item Number	Action
Items for Information		
76/07/2019	**34. 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. Carole Dacombe, Public Governor, voiced appreciation for the facility which governors found very useful and which was functioning well. **Members RESOLVED to:** • **Receive** the Governors' Log of Communications for information.	
Concluding Business		
77/07/2019	**35. Any Other Urgent Business**	
	There was no further business. The Chair closed the meeting at 13:20.	
78/07/2019	**36. Date and time of Next Meeting**	
	The date of the next meeting was confirmed as **11.00 – 13.00, Friday 27 September 2019, 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 2019
Action Tracker

Outstanding actions from the meeting held on 30 July 2019					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	49/07/2019	**Quality and Performance Report** Progress to be reported to the Board on the Clinical Referral Service trial (testing of new elective care standards).	Deputy Chief Executive/Chief Operating Officer	September 2019	**Work in Progress** This item had been added to the October 2019 Quality and Outcomes Committee agenda.
2.	53/07/2019	**Emergency Preparedness Resilience and Response Annual Report** i. Mark Smith to provide more detail on EPRR ratings to Julian Dennis. ii. EPRR Board reporting to be reviewed (Annual Report to be received by Audit Committee)	Deputy Chief Executive/Chief Operating Officer Trust Secretary	September 2019	i. **Completed since last meeting** – An update had been sent to Julian Dennis in August 2019. ii. **Work in Progress** – Item added to Audit Committee business cycle and October agenda. Item to be closed once Audit Committee reviewed the revised cycle.
3.	57/07/2019	**Annual Fire Report** Annual Fire Report to be included in the annual business cycle for the Audit Committee.	Trust Secretary	September 2019	**Work in Progress** Item added to Audit Committee business cycle. Item to be closed once Audit Committee reviewed the revised cycle.
4.	61/07/2019	**People Strategy** People Strategy to be amended to demonstrate staff engagement in its development.	Director of People	November 2019	**Work in Progress** Verbal update to be provided at the September 2019 meeting

5.	62/07/2019	**Arts and Culture Strategy** People Committee to receive detailed report on Arts Strategy including budget and success criteria	Director of People	November 2019	**Work in Progress** Timing of People Committee review to be agreed.
6.	74/07/2019	**Self-Assessment of Board Cycle** David Armstrong and Eric Sanders to discuss improvements to the Annual Business Cycle	Trust Secretary	November 2019	**Work in Progress** Initial discussion held and further work to be completed over next two months.
7.	26/05/2019	**Report from the Chair of the People Committee** Review Terms of Reference for Board Committees to ensure alignment with the new Trust five-year strategy.	Trust Secretary/ Committee Chairs	October 2019	**Work in Progress** This was in progress and the revised Terms of Reference would be reviewed by each Committee and the Board - update to be provided at the October 2019 meeting.
8.	30/05/2019	**Research and Innovation Strategy** Review and strengthen key performance indicators in the Research and Innovation Strategy to include more detail on their ownership and their reach throughout the organisation. Include reference to the Local Enterprise Partnership and West of England Combined Authority.	Medical Director	September 2019	**Work in Progress** The key performance indicators were being revised in line with the Board's recommendations and would be finalised in the coming weeks. Verbal update to be provided at the September 2019 meeting.
9.	31/05/2019	**Education Strategy** Review and strengthen key performance indicators in the Education Strategy. Include reference to the Local Enterprise Partnership and West of England Combined Authority.	Director of People	September 2019	**Work in Progress** Verbal update to be provided at the September 2019 meeting
Closed actions from the meeting held on 30 July 2019					
No.	**Minute reference**	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
1.	24/05/2019	**Quality and Performance Report** Mark Smith to review Emergency Department performance and improvement measures in the light of ever-increasing demand and to report back to Board.	Deputy Chief Executive and Chief Operating Officer	July 2019	**Completed** An improvement plan was being developed and had been shared with the Quality and Outcomes Committee.
2.	20/05/2019	**Patient Story** Circulate Patients Not Passports question and response to Board and Governors.	Trust Secretary	July 2019	**Completed** The Board and Governors were sent the question and response via

					email.
3.	06/04/2019	**Quality and Performance Report** Consideration to be given as to whether cancelled operations metrics in the Quality and Performance Report should be changed to provide further detail of the types of operations cancelled.	Deputy Chief Executive and Chief Operating Officer	July 2019	**Completed** More detail was now included in the Quality and Performance Report.
4.	10/04/2019	**Healthier Together Sustainability and Transformation Partnership Update** UH Bristol's response to system working to be included in future Board seminar.	Trust Secretary	July 2019	**Completed** This item had been included as part of the 2019/20 Board Development plan and an update on the Board Development Programme is on September 2019 agenda.
5.	214/03/2019	**Quality and Performance Report** Connection between demand, capacity and estate to be explored at a future Board Seminar.	Trust Secretary	July 2019	**Completed** This item had been included as part of the 2019/20 Board Development plan and an update on the Board Development Programme is on September 2019 agenda.
6.	217/03/2019	**Six-Monthly Nurse Staffing Report** Model Hospital digital tool to be demonstrated to the Board.	Trust Secretary	July 2019	**Completed** This item had been included as part of the 2019/20 Board Development plan and an update on the Board Development Programme is on September 2019 agenda.

Meeting of the Board of Directors in Public on Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Chief Executive's Report**
Report Author	**Robert Woolley, Chief Executive**
Executive Lead	**Robert Woolley, Chief Executive**

1. Report Summary
To report to the Board on matters of topical importance, including a report of the activities of the Senior Leadership Team.
2. Key points to note *(Including decisions taken)*
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 2019.
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
N/A
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **INFORMATION**. • The Board is asked to **NOTE** the report.
5. History of the paper **Please include details of where paper has previously been received.**
N/A

APPENDIX A

SENIOR LEADERSHIP TEAM

REPORT TO TRUST BOARD – SEPTEMBER 2019

1. INTRODUCTION

This report summarises the key business issues addressed by the Senior Leadership Team in August and September 2019.

2. QUALITY, PERFORMANCE AND COMPLIANCE

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

3. STRATEGY AND BUSINESS PLANNING

The group **received** an update on the proposed process to develop a local system response to the BNSSG Sustainability and Transformation Partnership to the NHS Long Term Plan.

The group **approved** the recommendation for the Chief Information Officer, and Associate Director of Education to join the membership of the Senior Leadership Team Business Meeting.

The group **approved** the business case for education.

The group **approved** the Transformation, Improvement and Innovation Strategy prior to submission to Trust Board.

The group **approved** the proposed Operating Planning Process for 2020/2021.

The group **approved** the strategic capital review process, noting further discussion required to take this forward.

4. RISK, FINANCE AND GOVERNANCE

The group **received** updates on the financial position.

The group **supported** the proposal for a second protected off the job training day to be mandated for nursing assistants.

The group **supported** the proposal for a project manager to undertake a Junior Doctor Rota review.

The group **support in principle** the proposal to continue with the use of the Point of Care Tool 'uptodate'.

The group **received** the proposal and rationale for the proposed quality and access indicators and **approved** the proposed indicators in respect of initial benchmarking for upper quartile performance.

The group **received** an update on the implementation of the High Cost Agency Reduction project.

The group **received,** at the August meeting of the Senior Leadership Team, one satisfactory Internal Audit Report in relation to Quality & Performance Management (Governance of ED 4-hour and ambulance handover process), one significant rating in respect of the Savings Programme Internal Audit Report. A limited assurance rating was given for local inductions, and a satisfactory/limited rated received for the Conflicts of Interest Internal Audit Report.

The group **received,** at the September meeting of the Senior Leadership Team, one Limited assurance rating in relation to Infection Control and the Use of FFP3 Respirators. Three satisfactory ratings were received for Risk Management – Divisional Level; Operation of WHO checklists; and, Estates Maintenance Operations.

The group **approved** the divisional winter plans acknowledging that these were iterative and would be subject to change.

The group **approved** the proposal to award a 12 month contract for the disposal of confidential waste.

The group **approved** minor iterations to the Terms of Reference for the Senior Leadership Team, Cancer Steering Group and the Trust Research Group.

The group **received** the Care Quality Commission Must Do Action Plan.

The group **received** the risk exception reports from Divisions.

The group **discussed** the risk relating to critical care capacity and cancer cancellations and the developing action plan including capital plan associated with this at the next Business SLT.

The group **received** the Patient Safety Programme board update.

The group **received** the Quarter 1 Freedom to Speak Up Update prior to submission to People Committee.

The group **received** the Quarter 1 Complaints and Quarter 1 Patient Experience report prior to submission to Trust Board.

The group **received and approved** the proposed Sustainable Development Strategy prior to submission to Trust Board.

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

The group **received** the annual quality assurance report for annual appraisal and revalidation.

The group **received** the South Wales and West Congenital Heart Disease Network annual report for 2018/19.

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.

Mark Smith
Deputy Chief Executive/Chief Operating Officer
September 2019

University Hospitals Bristol
NHS Foundation Trust

Quality and Performance Report

September 2019

1.1 OVERVIEW – Executive Summary

Single Oversight Framework

- The 62 Day Cancer standard for GP referrals achieved 86.8% for July and 85.7% for Quarter 1 overall. So the national standard of 85% has been achieved in July and quarter 1.
- The measure for percentage of A&E patients seen in less than 4 hours was 84.8% for August. This did not achieve the 95% national standard or the improvement trajectory target of 90.5%. However it is an improvement on previous months in 2019/20 (78% in April/May and 82% in June/July).
- The percentage of Referral To Treatment (RTT) patients waiting under 18 weeks was 84.3% as at end of August. This did not achieve the national 92% standard or the improvement trajectory target of 87.9%. This is showing a reduction in performance following 14 months (to May) of achieving the recovery trajectory.
- The percentage of Diagnostic patients waiting under 6 weeks at end of August was 95.1%, with 369 patients waiting 6+ weeks. This is lower than the national 99% standard. The divisions have plans for recovery by quarter 4.

Headline Indicators

There were five Clostridium Difficile cases in August but this still keeps the Trust below the maximum allowed for the financial year of 57 cases. In addition, there was one MRSA cases in August which was the first incidence this financial year. Pressure ulcer and patient falls incidence remained below target in August, with two grade 3 pressure ulcers and one fall resulting in harm.

The headline measures from the monthly patient surveys and the Friends and Family Test remain above their minimum target levels in August 2019. In Complaints, 85% of formal complaints were responded to within deadline which is below the Trust standard of 95%. 8.2% of June's complaint responses were re-opened due to complainant being dissatisfied with the original response.

Last Minute Cancelled Operations (LMCs) were at 1.5% of elective activity and equated to 95 cases. Six patients were not re-admitted within 28 days following an LMC.

Workforce

August 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs. Overall compliance for 'Remaining Essential Training' is also holding at 95% overall for the fourth consecutive month.

Bank and Agency Usage (5.2% and 1.2% respectively) remains above the Trust's targets. Turnover remained at 13.6% and the vacancy rate was 5.2%. A review of activity will be undertaken to understand the vacancy issues across all staff groups; this will be through the newly established Recruitment sub-group. A reduction in high cost nurse agency programme went live 2nd September 2019 across the BNSSG & Bath partnership with system wide and local mitigations in place, ensuring patient safety remains uncompromised. Focus on engagement and staff experience at work will be delivered throughout the 'You Said We Did' week 16th to 20th September 2019

Sickness absence reduced to 3.9% from 4.2%, with reductions in five divisions. Since launching in May 2019, 585 staff have attended the workplace wellbeing workshops designed to support wellbeing in the workplace. Also, the Trust has been selected to undertake the South West NHS Healthy Weight Declaration pilot designed to improve staff health both in and out of the workplace.

Overall appraisal compliance reduced to 73.3% in August (from 73.5%). There were increases in two divisions; Medicine and Specialised Services. The appraisal recovery plan continues focusing on action with areas of low compliance.

1.2 OVERVIEW – Single Oversight Framework

Financial Year 2018/19

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	83.96%	91.14%	92.84%	90.26%	90.07%	85.00%	89.16%	84.24%	83.05%	84.50%	81.05%	81.23%
	"Trust Footprint" (Year To Date)	92.05%			91.77%			90.84%			89.84%		
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
	"Trust Footprint" Trajectory	90.0%			90.0%			90.0%			95.0%		
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%	86.0%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%
	Actual (Quarterly)	84.2%			87.3%			86.6%			83.8%		
	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%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%
	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%	98.1%	98.4%	96.9%	93.8%	93.3%	96.9%	95.5%
	Trajectory	97.9%	97.9%	97.9%	98.4%	99.0%	98.0%	98.0%	98.0%	98.0%	98.0%	99.0%	99.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
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 (WIC) and Minor Injury Units (MIU) in their region. This apportionment is 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. The A&E "Trust Footprint" data above relates to Trust performance after WIC and MIU data has been added.

1.2 OVERVIEW – Single Oversight Framework

Financial Year 2019/20

Access Key Performance Indicator		Quarter 1 2019/20			Quarter 2 2019/20			Quarter 3 2019/20			Quarter 4 2019/20		
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E 4-hours Standard: 95%	Actual	78.3%	78.0%	81.5%	81.9%	84.8%							
	Trajectory	84.5%	90.5%	90.5%	90.5%	90.5%	85.5%	89.7%	84.7%	83.5%	85.0%	81.6%	81.7%
Cancer 62-day GP Standard: 85%	Actual (Monthly)	86.8%	86.0%	84.0%	86.8%								
	Actual (Quarterly)	85.7%											
	Trajectory (Monthly)	85%	85%	85%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	85%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	89.0%	88.1%	87.5%	86.5%	84.3%							
	Trajectory	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	86.9%	86.9%	86.9%	87.9%
6-week wait diagnostic Standard: 99%	Actual	95.3%	93.4%	93.5%	96.2%	95.1%							
	Trajectory	96%	96%	97%	97%	98%	99%	99%	99%	99%	99%	99%	99%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard).
RED rating = national standard not achieved, the STF trajectory not achieved

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	• Delivery of the 62 day GP national standard in July, following achievement in quarter 1. • Delivery of the 31 day First Definitive Treatment and Subsequent Radiotherapy cancer standards in July • The non-obstetric ultrasound diagnostic waiting list has shown significant improvement in 6 week breaches: 173 at end of May, down to 2 at end of August. • The implementation of electronic Referral Service (eRS) is now business as usual. There were only 11 appointments with paper referrals in August 2019. • Bristol Royal Infirmary ED is currently recruiting into new roles, including two ED consultants who start in September, and a further post that is currently out to advert. A new acute frailty team will be in place by the end of October. • Our first training course around the Local Access Policy has been delivered to 15 different specialities in the Trust. This has resulted in requests for the RTT Performance Lead to attend various consultant meetings to discuss the importance of their role around clinical review.	• Sustain compliance with the GP Cancer 62 Day standard of 85% in August, September and quarter 2. • Sustain compliance with the 31 day Cancer First Definitive Treatment standard of 96% in quarter 2 • Recover performance against the subsequent radiotherapy standard following deterioration due to the extensive cleaning requirement. • August's Referral To Treatment performance was below the 87.9% standard; the Trust achieved 84.34%. We continue to focus on returning to standard where activity allows. For recovery to be successful Divisions need to focus on increasing their inpatient and outpatient activity and delivery against their set RTT Trajectories. • Divisional focus remains on reducing Outpatient follow-ups that are overdue by more than 6 months • Delivery of the 6 week wait diagnostic standard to be achieved from January 2020. Diagnostics and Therapies division are working through capacity & demand to ensure the new CT scanner (due for installation November 2019) and existing capacity will be sufficient to meet ongoing demand. • Gain approval for Band 7 Analysts in Digital Services to support the RTT improvement work that is required in the corporate team.

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

	Opportunities	Risks and Threats
ACCESS	• Current implementation plan of Medway PAS at Weston has commenced. An initial meeting around staffing levels has taken place between the RTT Performance Lead, Deputy Chief Executive and Chief Operating Officer. Recruitment will be undertaken at Weston to support the validation and migration process from Cerner to Medway. • The Bristol, North Somerset and South Gloucestershire (BNSSG) outpatients group has been chosen to be part of the national Elective Care Transformation Programme, led by NHS Improvement. This will enable whole system transformation and provide training and networking opportunities to staff and patient representatives. • A system-wide review of Endoscopy services is underway, across BNSSG, to assess the potential for improved utilisation of capacity across the region. • The BNSSG have commenced a piece of work under the patient experience banner to inform patients of the importance of attending appointments within set timescales and which have been offered on a clinically appropriate timescale.	• Surgical cancellations of cancer patients have affected the 62 day GP, 31 day first definitive treatment, and 31 day subsequent surgery standards for cancer, with subsequent surgery continuing to be non-compliant. Preventing further cancellations which mainly occur due to lack of critical care beds. • The Trust continues to report 52 week breaches in Paediatric Services and the Division of Surgery due to a number of last minute cancellations. We are anticipating 2-3 patients to breach in October due to patient choice; this will prevent achievement of zero 52 week breaches. Clinical Genetics remains the biggest risk to non-delivery of 52 week breach standard. A meeting took place on 17th September with the Deputy COO and Divisional Director to discuss the viability of the Clinical Genetics Service. • The local commissioners and NHSEngland/Improvement have confirmed that there is no waiver for patients who have resulted in a 52 week breach due to patient choice. The fine is £2,500 per breach, per month. • Although the local access policy has been revised; the policy still includes a focus on allowing the patient to exercise their right to choice. • The Due Diligence work at Weston continues, which has identified a risk to the delivery of RTT Performance. A meeting took place with NHSI, Intensive Support Team, Deputy Chief Executive and Deputy COO on 16th September to discuss the Data Quality issues that have been identified. Further action plans and recruitment of validation staff at Weston will be required to support delivery of this plan • Without an allocation of 1 WTE or 0.5 WTE RTT analysts in the Corporate Performance team, there continues to be a significant risk in moving forward with the development of new business rules.

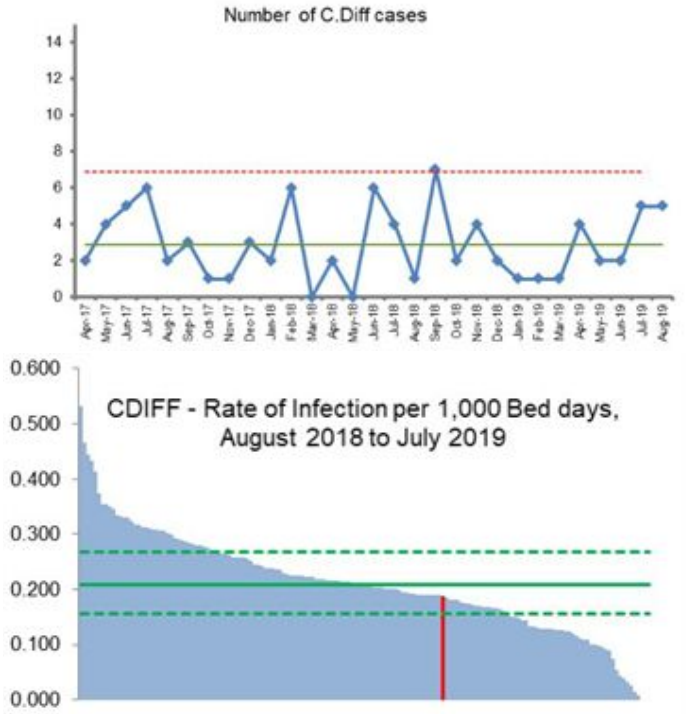
1.4 OVERVIEW – Successes, Priorities, Opportunities, Risk & Threats

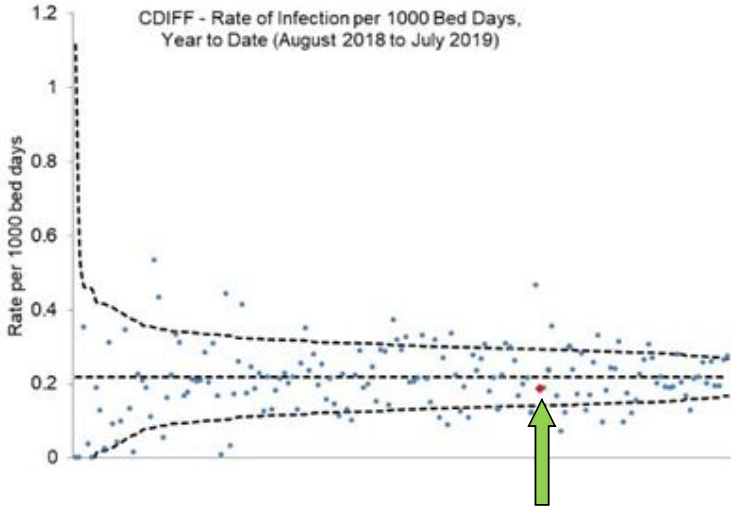
	Successes	Priorities
QUALITY	• Continued high percentages of patients with fractured neck of femur reviewed by an ortho-geriatrician within 72 hours (100% for August).	• One 'Wrong Site Surgery' never event was reported in August at the South Bristol Community Hospital whereby a tenth tooth was removed, extra to the consented plan to remove nine teeth. Initial review evidences that the dental bib showing the teeth for extraction was in place and the World Health Organisation pre-procedure safety checks were carried out correctly. A full investigation is underway and will be reported to the Board Quality and Outcomes Committee in due course. • Obtain data for August for new electronic VTE risk assessment compliance which is equivalent to that previously reported using the old recording methodology
	Opportunities	**Risks and Threats**
QUALITY	• To further review quality metrics in the dashboard in the light of the recent publication of NHS Improvement's updated Single Oversight Framework, identification of an initial local suite of benchmarking quality indicators and agreement of alternative monitoring of harm free care across BNSSG with commissioners.	• There are no new risks and threats to report.

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

	Successes	Priorities
WORKFORCE	• 131 members of staff attended 'self-care' workshops designed to support wellbeing in the workplace • Management Development training now includes a focused session on 'Managing outstanding teams' in response to the Staff Survey scores indicating more consistent team management was needed. • The new Trust recruitment website has gone live. A professional, one-stop, online platform designed to offer a wealth of support and information for anyone considering UHBristol as a place to work and the City of Bristol as a place to live. The website will be core to all marketing and attraction advertising campaigns for all staff groups and roles. • August 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programmes, and also at 95% for 'Remaining Essential Training', for the fifth consecutive month.	• Launch of the Rainbow Badge scheme in support of patients and staff in the LGBT+ community, in line with the Trust's year one strategy plan. • Launch of Seasonal Influenza implementation plan on 30th September to ensure CQUIN target of 80% vaccination of frontline clinical workers is achieved by end of Feb 2020. • Delivery of Trust wide `You said …We Did` week commencing on 16th September to share and celebrate service and team achievements, and provide an opportunity for staff to have positive conversations about their experiences at work. • Launch of National Staff Survey 2019 on 23rd September until 30th November, supported by a robust communication plan aimed to further improve the Trust-wide response rate. • Go-live of the reduction in high cost nurse agency programme on 2 Sept 2019 across the BNSSG & Bath. Both system wide and local mitigations are in place, ensuring patient safety remains uncompromised. • As of August the e-learning modules for Acute Care and ReSPECT Awareness became required Essential Training for all Trust doctors. Both carry an annual update frequency and are published on the appropriate learning plans. The propriety of compliance reporting will now be determined through governance channels.
	Opportunities	**Risks and Threats**
WORKFORCE	• The new Clinical Talent Acquisition Manager took up post on 2 September 2019 and meeting with clinical areas to develop targeted interventions for hard to recruit roles.	• Appraisal compliance continues not to meet target. Robust mitigations continue. • Attainment of the Trust smoke free status is compromised by colleagues continuing to smoke whilst in uniform. This is being addressed by the smoking group. • Of the eleven core skills, Resuscitation currently has the lowest individual compliance at 78%.

Infections – Clostridium Difficile (C.Diff)	
Standards:	Number of Trust Apportioned C.Diff cases to be below the national trajectory of 57 cases for 2019/20. Review of these cases with commissioners' alternate months to identify if there was a "lapse in care".
Performance:	There were five trust apportioned C.Diff cases in July 2019, giving 18 cases year-to-date. This is still below the maximum allowable year-to-date cases of 24.
Commentary/ Actions:	These five cases require a review by our commissioners before determining if the cases will be Trust apportioned due to a lapse in care. Cases are now attributed to the Trust after patients have been admitted for two days (day 3 of admission). This is a new criterion from NHS Improvement which commenced in April 2019. The increase in August includes paediatric oncology patients, a high risk group.
Ownership:	Chief Nurse



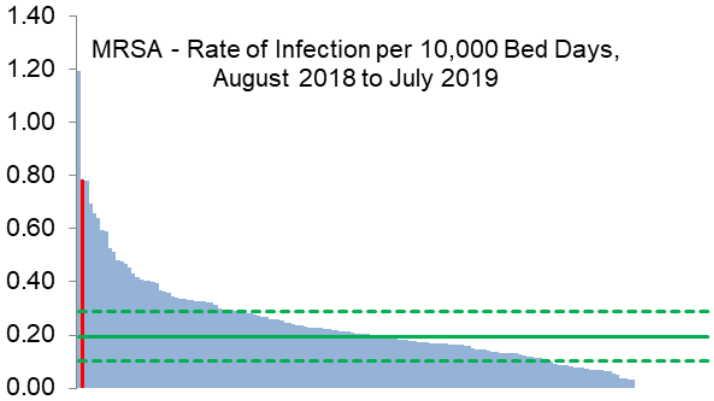


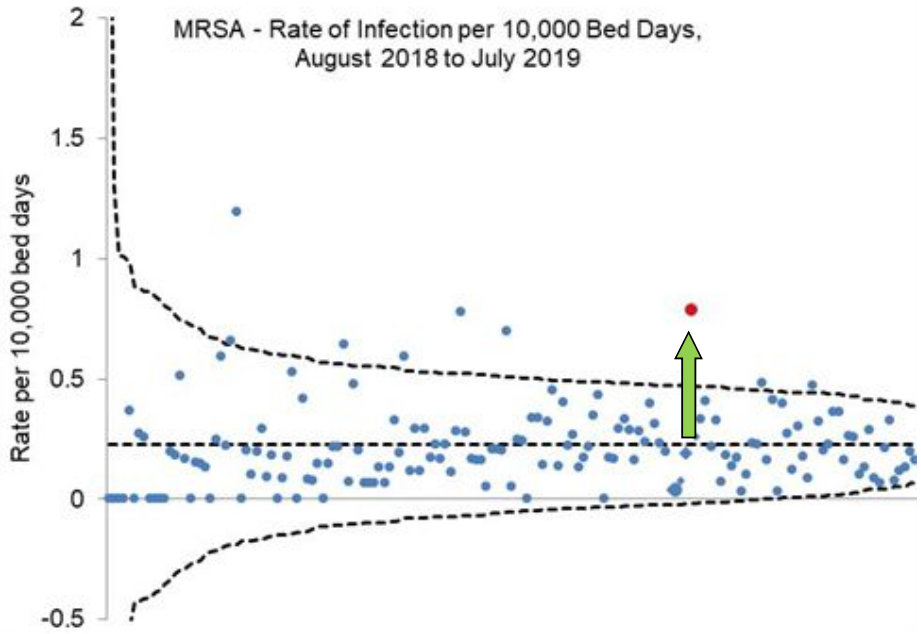
CDIFF Cases	Aug-19	2019/2020
Medicine	1	3
Specialised Services	1	2
Surgery	0	1
Women's and Children's	3	12
Grand Total	5	18

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

Infections – Methicillin-Resistant Staphylococcus Aureus (MRSA)	
Standards:	No Trust Apportioned MRSA cases.
Performance:	There was one Trust apportioned MRSA cases in August 2019 and so one case year to date.
Commentary/ Actions:	There has been one case of MRSA attributed to the Trust during August 2019. This patient has a continuing infection and is part of a high risk group, People Who Inject Drugs (PWID). There will be a review of the case with commissioners.
Ownership:	Chief Nurse

MRSA	Aug-19	2019/2020
Medicine	0	0
Specialised Services	1	1
Surgery	0	0
Women's and Children's	0	0
Grand Total	1	1

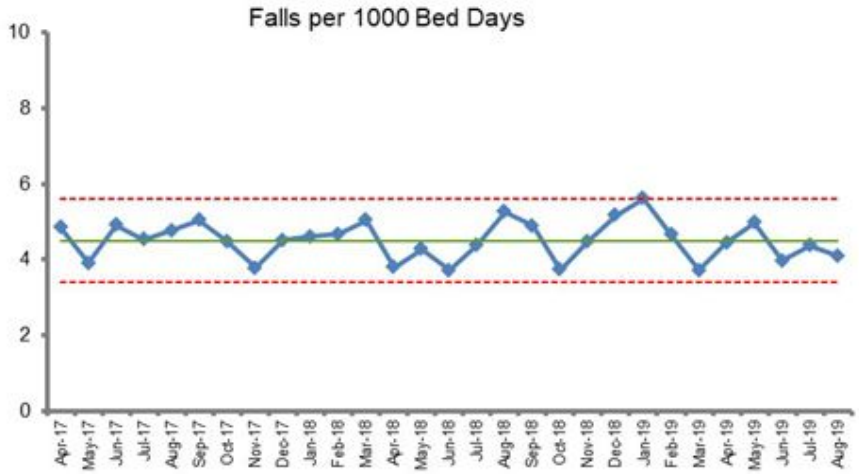




Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

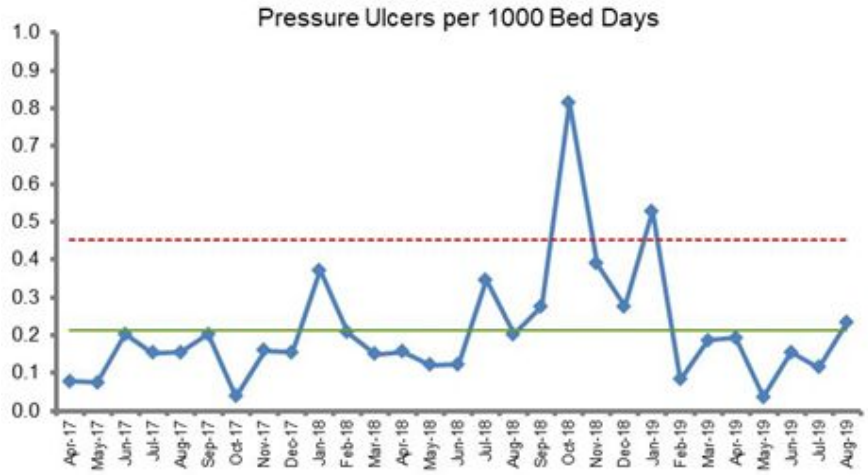
2.1 PERFORMANCE – Safe Domain

Patient Falls	
Standards:	Inpatient Falls per 1,000 beddays to be less than 4.8. Less than 2 per month resulting in Harm (Moderate or above)
Performance:	Falls rate for August was 4.11 per 1,000 beddays. This was 106 falls with one resulting in harm.
Commentary/ Actions:	The actions being taken remain as: 1. Implementing actions required to achieve new 2019/20 Falls CQUIN has commenced, which include: a. The revised draft multifactorial falls risk assessment, including a vision check which is now being tested across the Trust with a group set up to review how this is operationalised and make any amendments before final approval. b. Measuring lying and standing blood pressure measurement for all patients 65 and over c. Ensuring no anti-psychotic, anxiolytics or hypnotics, are given during hospital stay or if required there should be documentation of rationale d. Ensuring patient mobility assessment is documented within 24hrs or mobility aid provided within 24hrs 2. The 2019/20 Falls Group work and audit plans are closely monitored and reviewed at each meeting.
Ownership:	Chief Nurse

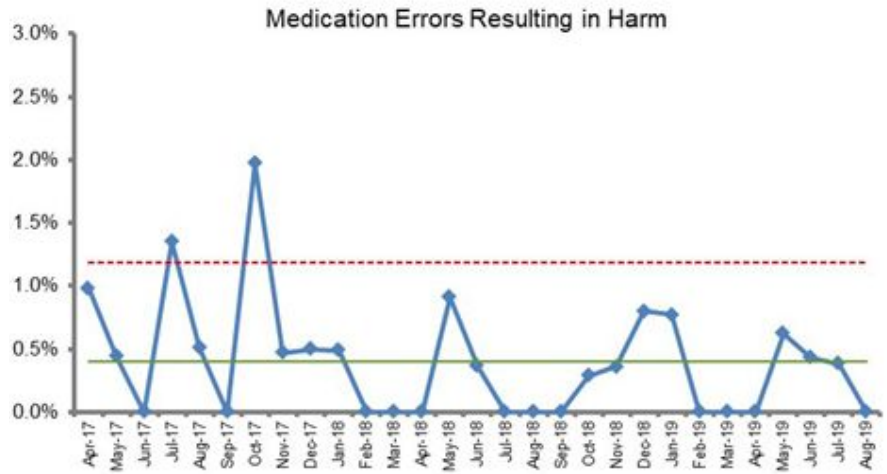


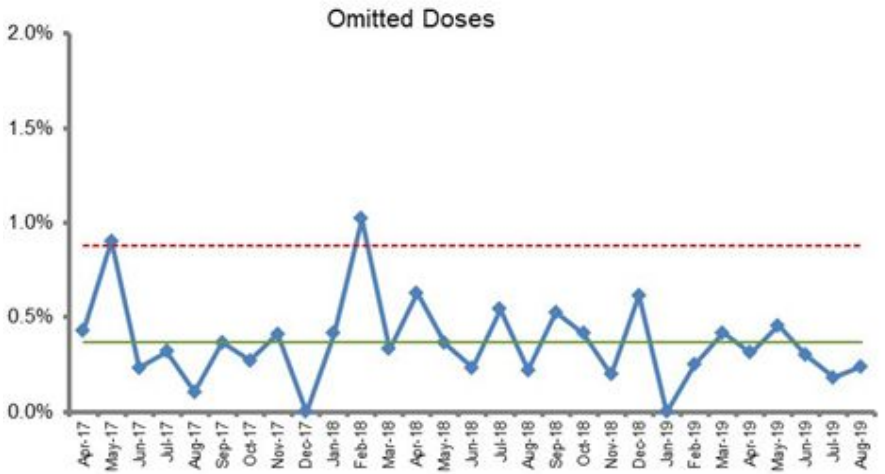
2.1 PERFORMANCE – Safe Domain

Pressure Ulcers	
Standards:	Hospital acquired Pressure Ulcers to be below 0.4. No Grade 3 or 4 Pressure Ulcers
Performance:	Pressure Ulcers rate for August was 0.233 per 1,000 beddays. There were four category 2 pressure ulcers and two category three pressure ulcers.
Commentary/ Actions:	The category 3 pressure ulcers were both initially validated as suspected deep tissue injuries, actions implemented, however over time wound progression revealed category 3 pressure ulcers. Full investigations are underway for each. The 2019/20 Tissue Viability Group work plan continues to focus on reducing the number of pressure ulcers developed on wards. Actions in addition to those described in last month's report include: • Re-circulate poster to display in clinical areas regarding deep tissue injuries and actions to take. • Develop staff information leaflet / guide to support staff in pressure prevention and management • Review and update tissue viability champions' role description • Task and finish group to discuss risk assessment and re-assessment (pressure ulcer, falls, nutrition etc) All actions are monitored through the tissue viability steering group.
Ownership:	Chief Nurse



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:	One moderate harm medication incidents were reported in July 2019, out of 262 cases audited (0.38%) Omitted doses were at 0.24% in August (1 case out of 415 reviewed in areas using paper drug charts).
Commentary/ Actions:	The moderate harm **medication incident** was reported following a research follow up phone call where the patient stated that they had not been discharged with their medicines and had subsequently required treatment for atrial fibrillation in their local ED. Investigation found it was clearly documented that the patient declined to stay in hospital to await their discharge medication, was given a critical medicine to take home in a ward discharge pack, was appropriately advised and instructed to contact the GP the following day to obtain further medicines. The unintentional **omission of medicine** was a single dose of oral anticoagulant in the Acute Medical Unit. The reason for the non-administration was not specified on the drug chart so it is not possible to say whether the medicine had been administered but not signed for, or not administered at all.
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 2019 Essential Training overall compliance remained static at 90% compared to the previous month (excluding Child Protection Level 3).
Commentary/ Actions:	August 2019 compliance for Core Skills (mandatory/statutory) training remained at 90% overall across the eleven programs. There were two reductions, of 1%, for Health, Safety and Welfare, and Resuscitation. There were four increases, of 1%, for Fire Safety, Infection Prevention and Control, Information Governance, and NHS Conflict Resolution Training. Overall compliance for 'Remaining Essential Training' is also holding at 95% overall for the fourth consecutive month. Of the eleven core skills, Resuscitation currently has the lowest individual compliance at 78%. Of the remaining Essential Training', compliance for the Staff Local Induction Workbook (through eLearning since January) increased by 5% to 65%. In comparison, in December 2018, manual local induction checklist returns were only 48%.
Ownership:	Director of People

Essential Training	Aug-19	KPI
Equality, Diversity and Human Rights	97%	90%
Fire Safety	88%	90%
Health, Safety and Welfare (formerly Health & Safety)	92%	90%
Infection Prevention and Control	87%	90%
Information Governance	86%	95%
Moving and Handling (formerly Manual Handling)	89%	90%
NHS Conflict Resolution Training	94%	90%
Preventing Radicalisation	95%	90%
Resuscitation	78%	90%
Safeguarding Adults	94%	90%
Safeguarding Children	93%	90%

Essential Training	Aug-19	KPI
UH Bristol NHS Foundation Trust	**90%**	**90%**
Diagnostics & Therapies	93%	90%
Medicine	89%	90%
Specialised Services	92%	90%
Surgery	90%	90%
Women's & Children's	88%	90%
Trust Services	92%	90%
Facilities & Estates	93%	90%

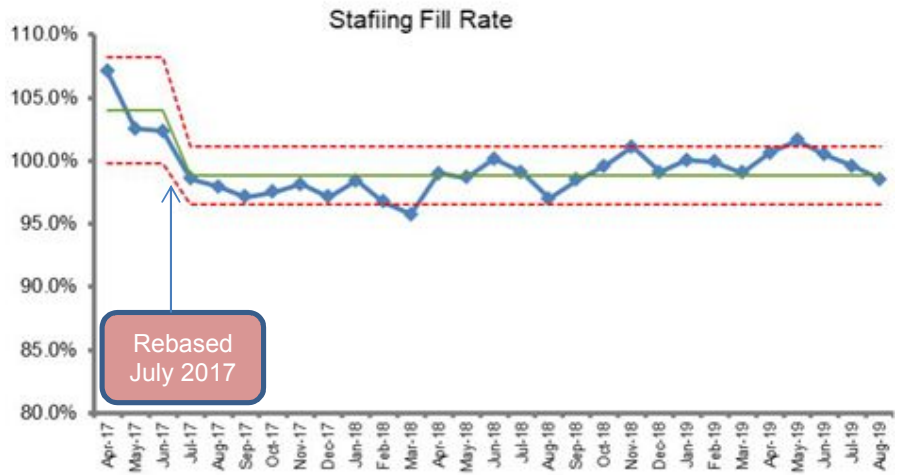
2.1 PERFORMANCE – Safe Domain

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 98.5% (238,140 hours worked against 241,692 planned). Registered Nursing (RN) level was at 94.6 % and Nursing Assistant (NA) level was at 108.8%
Commentary/ Actions:	Overall for the month of August 2019, the trust had 94% cover for RN's on days and 95% RN cover for nights. The unregistered level of 104% for days and 116% for nights reflects the activity seen in August 2019. This was due primarily to NA specialist assignments to safely care for confused or mentally unwell patients in adults particularly at night. Ongoing Action: • Continue to validate temporary staffing assignments against agreed criteria. • Assurance: Monitored through agency controls action plan
Ownership:	Chief Nurse

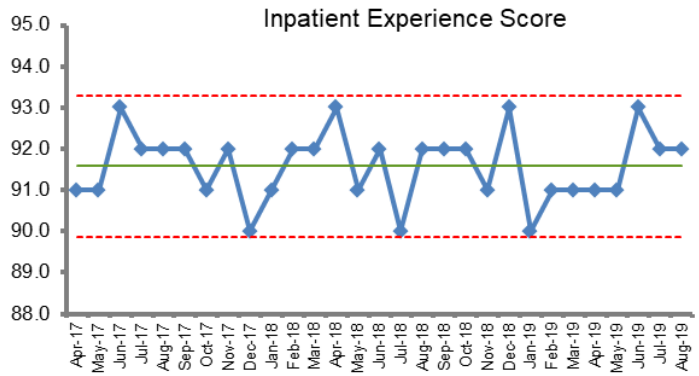
AUGUST 2019 DATA

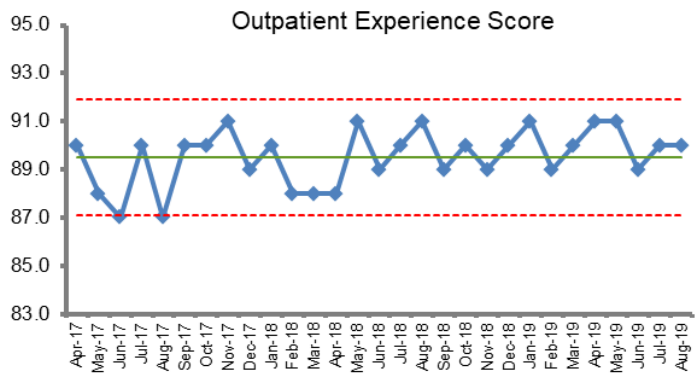
	Day	Night	TOTAL
Registered Nurses	94.4%	94.9%	94.6%
Nursing Assistants	103.7%	116.0%	108.8%
TOTAL	**97.1%**	**100.3%**	**98.5%**

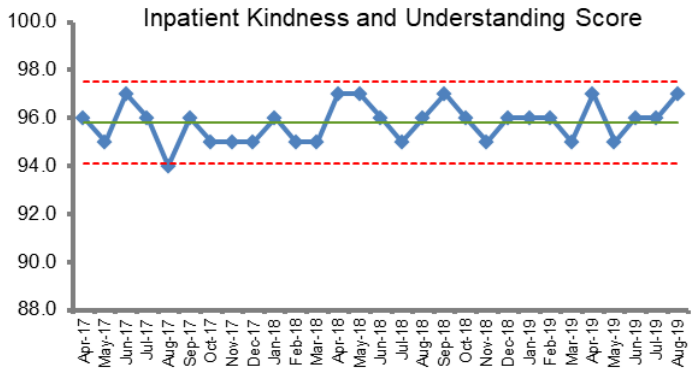
Medicine	107.9%
Specialised Services	100.4%
Surgery	101.7%
Women's and Children's	89.6%
TOTAL	**98.5%**



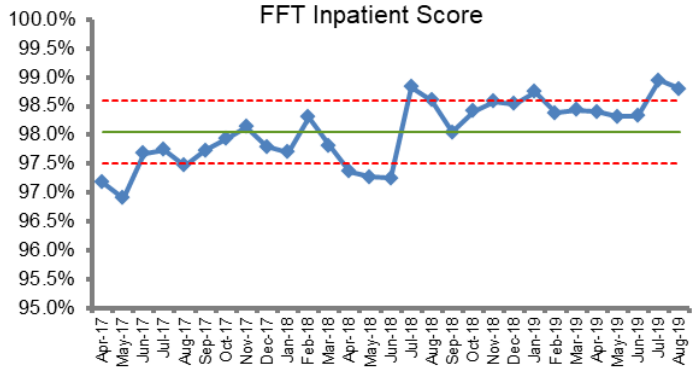
Monthly Patient Survey	
Standards:	For the inpatient and outpatient Survey, 5 questions are combined to give a score out of 100. For inpatients, the target is to achieve 87 or more. For outpatients the target is 85. For inpatients, there is a separate measure for the kindness and understanding question, with a target of 90 or over.
Performance:	For August 2019, the inpatient score was 92/100, for outpatients it was 90. For the kindness and understanding question it was 97.
Commentary/ Actions:	The headline measures from these surveys remained above their minimum target levels, indicating the continued provision of a positive patient experience at UH Bristol.
Ownership:	Chief Nurse

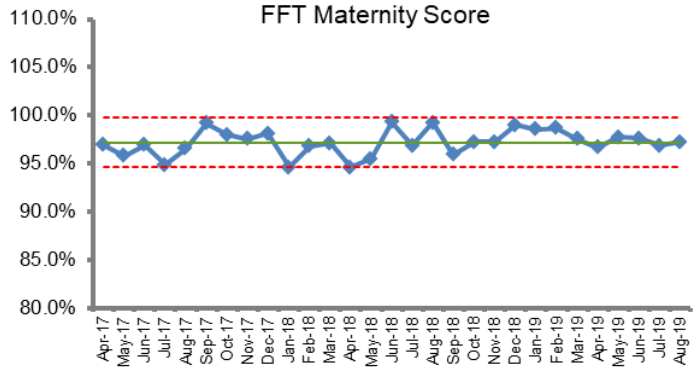


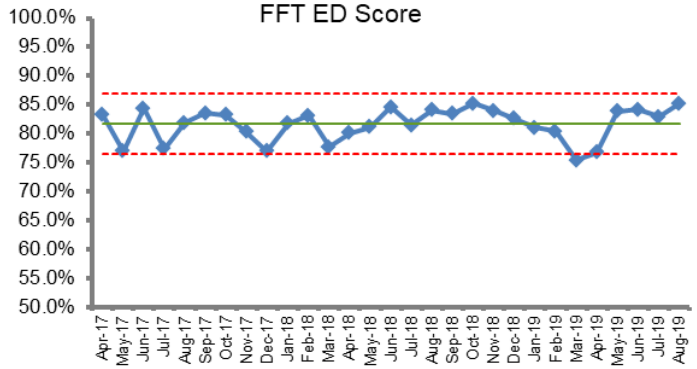




Friends and Family Test (FFT) Score	
Standards:	The FFT score is the number of respondents who were likely or very likely to recommend the Trust, as a percentage of all respondents. Standard is that the score for inpatients should be above 90%. The Emergency Department minimum target is 70%.
Performance:	August's FFT score for Inpatient services was 98.8% (2142 out of 2168 surveyed). The ED score was 85.2% (1299 out of 1524 surveyed). The maternity score was 97.2% (387 out of 398 surveyed).
Commentary/ Actions:	The Trust's scores on the Friends and Family Test were above their target levels.
Ownership:	Chief Nurse



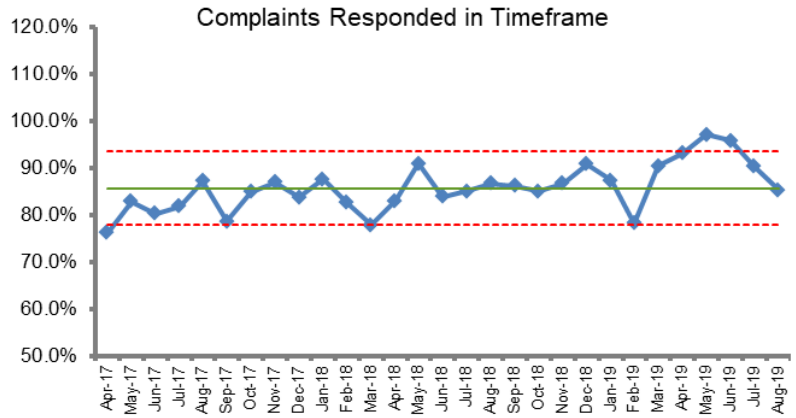


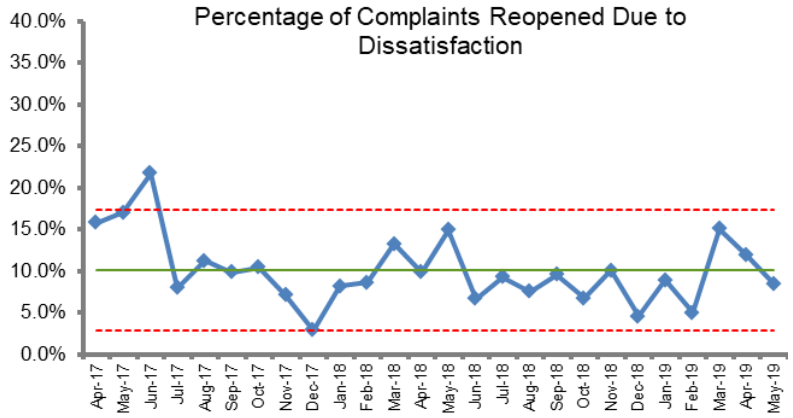


	Response Rate		Score	
	Aug-19	2019/2020	Aug-19	2019/2020
Inpatients				
Medicine	39.1%	41.8%	98.6%	98.1%
Surgery	36.2%	37.2%	98.8%	98.9%
Specialised Services	40.1%	40.2%	99.7%	98.7%
Women's and Children's	30.8%	33.1%	98.4%	98.4%
TOTAL	**36.2%**	**37.7%**	**98.8%**	**98.6%**
Emergency Department				
Bristol Royal Infirmary	12.1%	11.7%	70.8%	65.9%
Children's Hospital	19.1%	17.4%	84.8%	84.6%
Eye Hospital	28.4%	27.0%	96.6%	95.0%
TOTAL	**18.2%**	**17.2%**	**85.2%**	**82.9%**
Maternity				
TOTAL	**31.6%**	**28.9%**	**97.2%**	**97.2%**

2.2 PERFORMANCE – Caring Domain

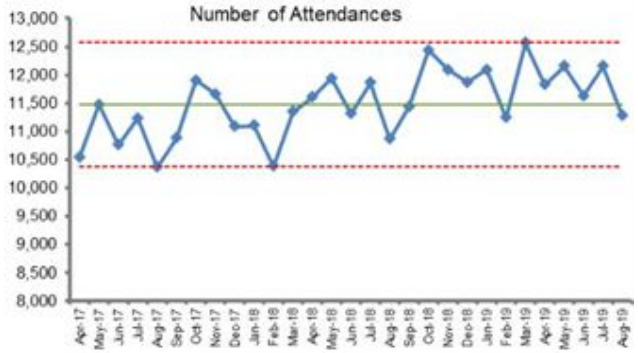
Patient Complaints	
Standards:	For all formal complaints, 95% of them should have the response posted/sent to the complainant within the agreed timeframe, with a lower tolerance (Red) of 85%. Of all formal complaints responded to, less than 8% should be re-opened because complainant is dissatisfied, with an upper tolerance (Red) of 12%.
Performance:	In August, 41 out of 48 formal complaints were responded to with timeframe (85.4%) Of the 49 formal complaints responded to in June, 4 resulted in the complainant being dissatisfied with the response (8.2%)
Commentary/ Actions:	There were seven breaches from the 48 formal responses sent out in August. Four of those breaches were attributable to the Divisions, with one due to delays in the Patient Support and Complaints Team and two during the Executive sign-off process. It should however be noted that at the time of writing this report, the Divisions have not yet had an opportunity to finish the validation of this data. The Trust's performance in responding to complaints via informal resolution within a timescale agreed with the complainant was 86%, which is similar to the 85% reported in July. This equates to eight breaches from the 58 responses sent out in August. The rate of dissatisfied complaints in June (this measure is reported two months in arrears) was 8.2%. This represents four cases from the 49 first responses sent out during that month and is a slight improvement on the 8.5% reported last month in respect of responses sent out in May.
Ownership:	Chief Nurse





2.3 PERFORMANCE – Responsive Domain

Emergency Department (ED) 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 90.5% for August.
Performance:	Trust level performance for August was 84.78% (11275 attendances and 1716 patients waiting over 4 hours).
Commentary/ Actions:	The Division of Medicine, as part of the Trust-wide seasonal planning group, has developed a comprehensive plan to help manage the additional demand this winter. Some key actions are outlined below: • A Winter Consultant will arrive mid-November and be in post to the end of April. They will lead the team running A512, short stay winter ward, and will also support the acute medicine team to offer "bring back" clinics to support new patients to return home where possible • The Acute Frailty Team will be up and running by December. This team consists of a consultant geriatrician, frailty ACP, frailty nurse specialists and a specialist pharmacist, working together with community therapy teams to support older patients with frailty to receive a comprehensive geriatric assessment at the front door, and to avoid admission where safe and appropriate. • We are working with Bristol City Council on a proposal to bring an enhanced brokerage team into the Trust for winter to support length of stay reductions for patients who require packages of care or placements on discharge. • In partnership with Bristol Community Health we are working up a plan to recruit HCAs in rotational roles across acute and community to support the homecare elements of discharge to assess pathways. This will improve access for people who can return home but require a rehab or reablement package. • Over the next two months, seven Physician's Associates will be joining the Division, working across the bed holding specialties to support the medical teams. This is a new way of working for the Division and we are excited to be welcoming this talented group of clinicians.
Ownership:	Chief Operating Officer

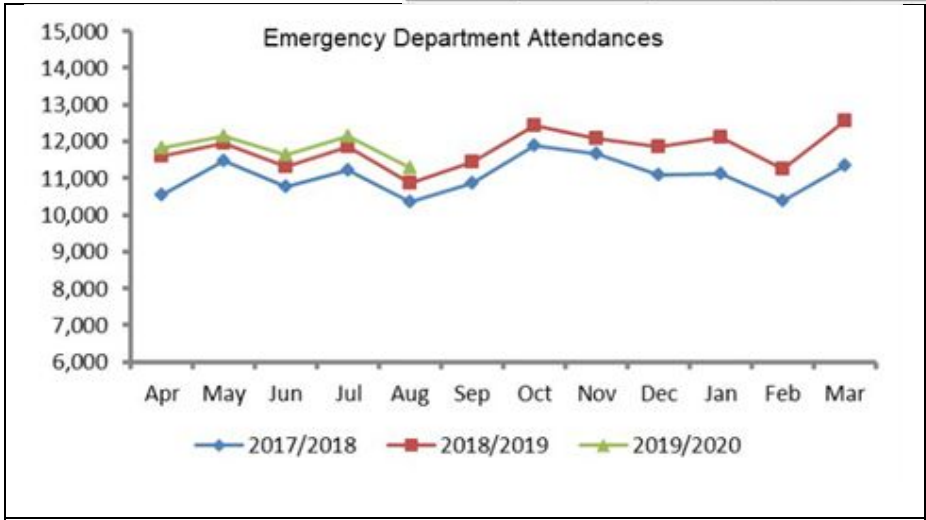


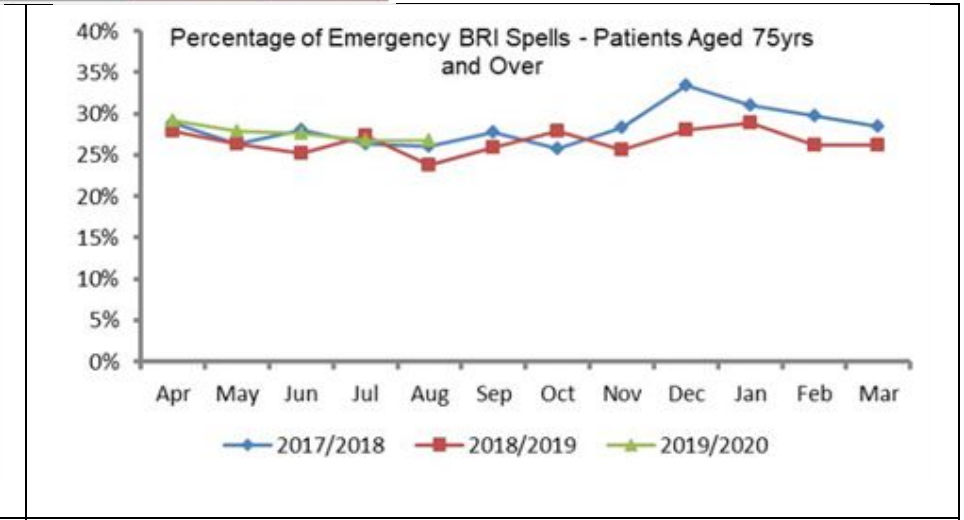
2.3 PERFORMANCE – Responsive Domain

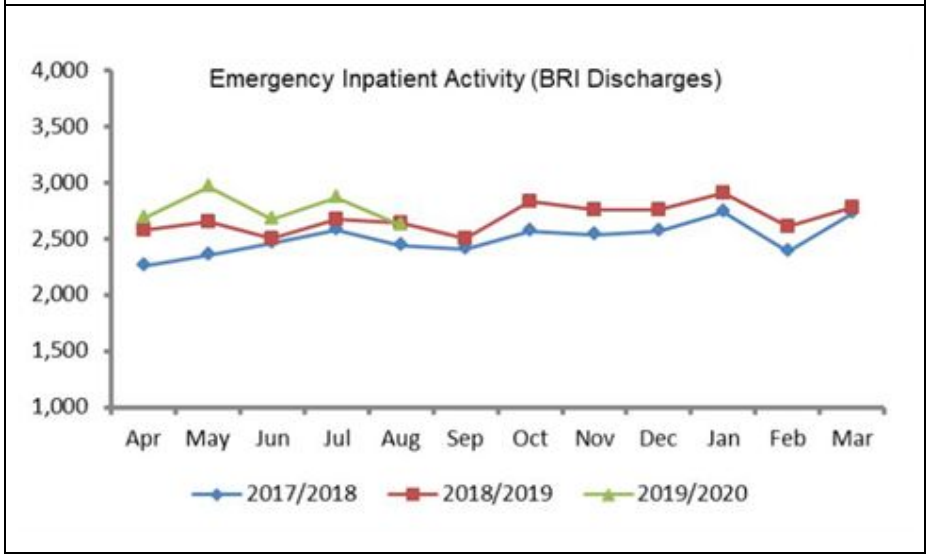
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

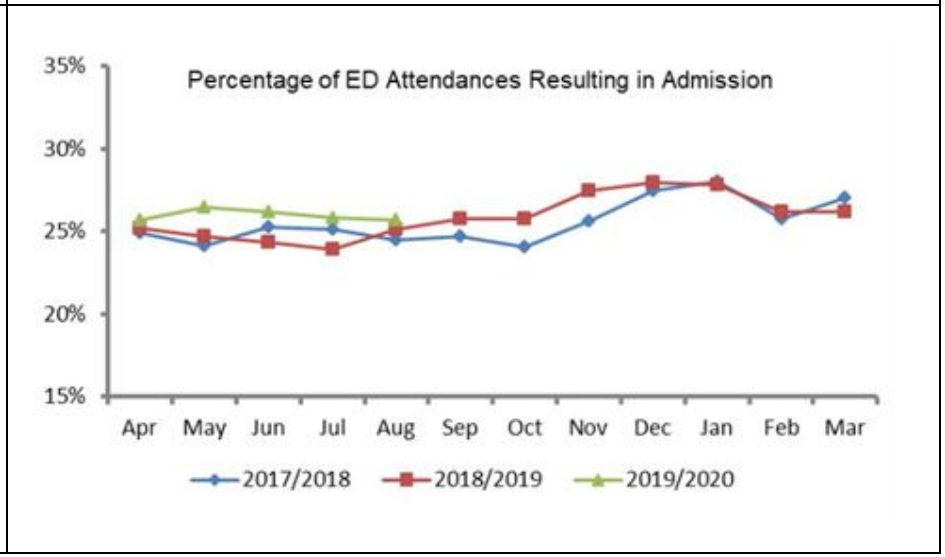
2.3 PERFORMANCE – Responsive Domain

	Attendances		Under 4 Hours		Performance	
	Aug-19	2019/2020	Aug-19	2019/2020	Aug-19	2019/2020
BRI	6117	30863	4576	20982	74.81%	67.98%
Trust	11275	59027	9559	47703	84.78%	80.82%

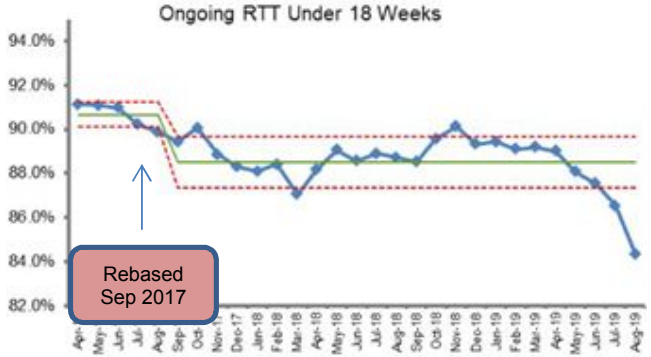


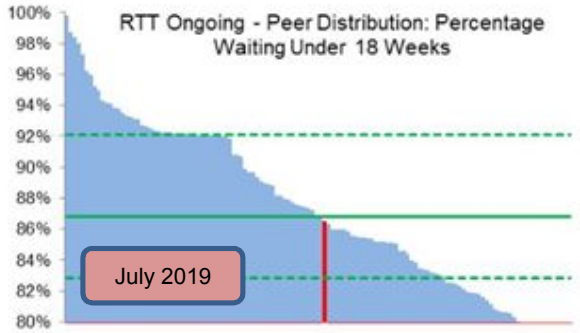






Referral to Treatment (RTT)	
Standards:	At each month-end, the Trust reports the number of patients on an ongoing RTT pathway and the percentage that have been waiting less than 18 weeks. The national standard is that over 92% of the patients should be waiting under 18 weeks. The Trust's improvement trajectory has been set at 87.9% for end of August. In addition, no-one should be waiting 52 weeks or over from September 2019.
Performance:	At end of August, 84.3% of patients were waiting under 18 week (28,084 out of 33,300 patients). 9 patients were waiting 52+ weeks
Commentary/ Actions:	The 92% national standard was not met at the end of August and the improvement trajectory of 87.9% was missed. The Trust had been achieving the RTT recovery trajectory prior to June. The reduction in performance is based on an increase in the waiting list size and cancellations that have occurred in month. In addition, there are less clock stops being recorded due to lower than normal activity levels across Divisions. Looking ahead, recovery for RTT is planned to be in October and early sight for September is 85%. At the end of August 2019, the Trust reported nine 52 week waiters. All patients are now dated and this will result in zero 52 week waiting patients at the end of September, with the proviso that no patient cancels or misses their appointment.
Ownership:	Chief Operating Officer



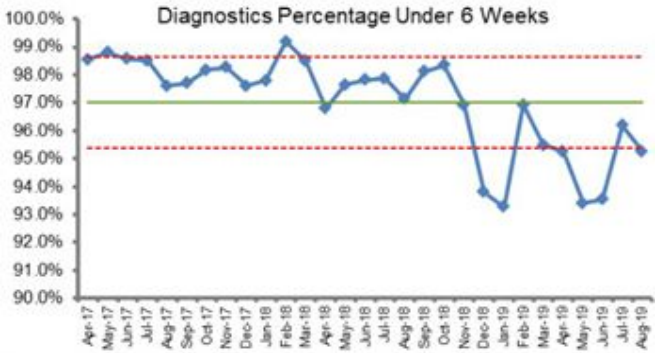


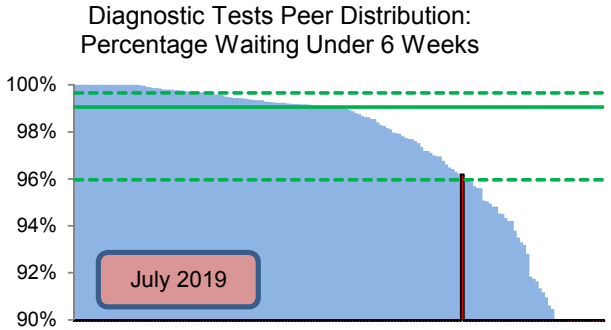
Unbroken horizontal line is England median; dotted lines are upper & lower quartiles

Ongoing Pathways at Aug-19

	Ongoing Pathways	Ongoing Over 18 Weeks	Ongoing Performance
Cardiology	2,595	500	80.7%
Cardiothoracic Surgery	327	93	71.6%
Dermatology	2,885	384	86.7%
ENT	2,067	149	92.8%
Gastroenterology	1,001	7	99.3%
General Medicine	9	1	88.9%
Geriatric Medicine	109	0	100.0%
Gynaecology	1,624	341	79.0%
Neurology	251	23	90.8%
Ophthalmology	4,175	388	90.7%
Oral Surgery	3,513	758	78.4%
Other (Clinical Genetics)	770	76	90.1%
Other (Dental)	3,007	618	79.4%
Other (General Surgery)	1,630	434	73.4%
Other (Haem/Onc)	216	18	91.7%
Other (Medicine)	586	23	96.1%
Other (Other)	341	3	99.1%
Other (Paediatric)	6,111	1,202	80.3%
Other (Pain Relief)	59	0	100.0%
Other (Thoracic Surgery)	138	14	89.9%
Plastic Surgery	0	0	-
Rheumatology	586	41	93.0%
Thoracic Medicine	722	45	93.8%
Trauma & Orthopaedics	578	98	83.0%
TOTAL	**33,300**	**5,216**	**84.3%**

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 has committed to recovery by beginning of Quarter 4 2019/20
Performance:	At end of August, 95.3 % of patients were waiting under 6 weeks (7,411 out of 7,780 patients). There were 369 breaches of the 6-week standard.
Commentary/ Actions:	The Trust did not achieve the 99% national standard at end of August. The maximum number of breaches needed to achieve 99% was 78 breaches. • MRI breach volumes are in Cardiac MRI (20) and Paediatrics (54). Outsourcing options are being pursued to clear the backlog and then return to sustainable levels of capacity by start of January 2020. • CT Cardiac recovery is reliant on the installation/upgrade of a new cardiac-compatible CT scanner, which is due for installation during Quarter 3. The division has worked through the capacity and demand issues for the remainder of the year and is predicting recovery by Quarter 4. • Adult Endoscopy have recruited a second Clinical Fellow, to commence sessions in November and recruitment of an additional nurse endoscopist to start in December. Glanso lists are in place to cover capacity gaps in the interim.
Ownership:	Chief Operating Officer





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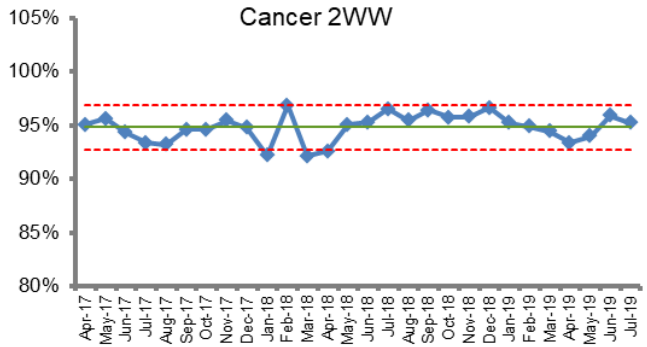
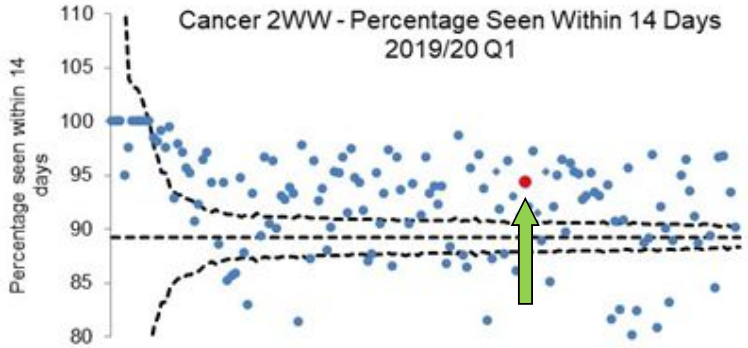
Diagnostic Tests Waiting List at Aug-19	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Audiology	681	0	681	100.0%
Colonoscopy	172	50	222	77.5%
CT	1,330	78	1,408	94.5%
Cystoscopy	1	0	1	100.0%
DEXA Scan	234	1	235	99.6%
Echocardiography	728	89	817	89.1%
Flexi Sigmoidoscopy	56	33	89	62.9%

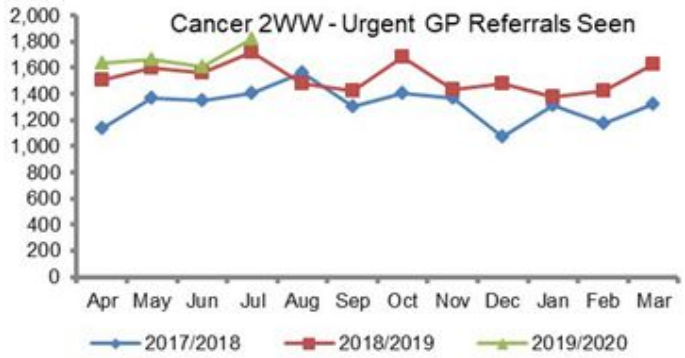
	Under 6 Weeks	6+ Weeks	Total Waiting	Percentage Under 6 Weeks
Gastroscopy	219	25	244	89.8%
MRI	1,658	74	1,732	95.7%
Neurophysiology	195	9	204	95.6%
Sleep Studies	129	8	137	94.2%
Ultrasound	2,008	2	2,010	99.9%
Grand Total	**7,411**	**369**	**7,780**	**95.3%**

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, 95.2% of patients were seen within 2 weeks (1730 out of 1817 patients). Quarter 1 2019/20 achieved 94.4%.
Commentary/ Actions:	The standard has been achieved in each quarter since 2018/19 Q1. Quarter 2 is at high risk of non-compliance. This is due to a 33% increase (equating to around 350 patients) in two week wait suspected skin cancer referrals compared to same period last year. This is above any forecast growth and whilst much of the demand has been accommodated within target, a proportion has been booked a small number of days outside the 14 day standard. The dermatology team is working to recover the position by October.
Ownership:	Chief Operating Officer

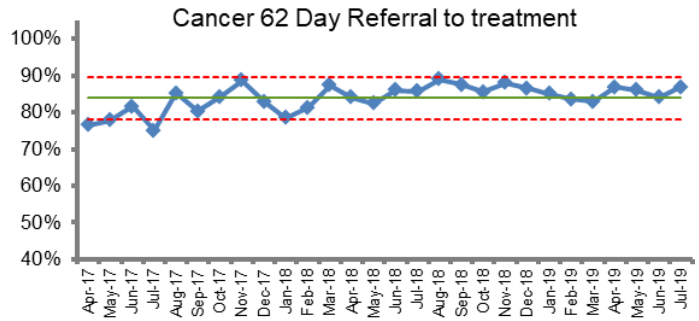


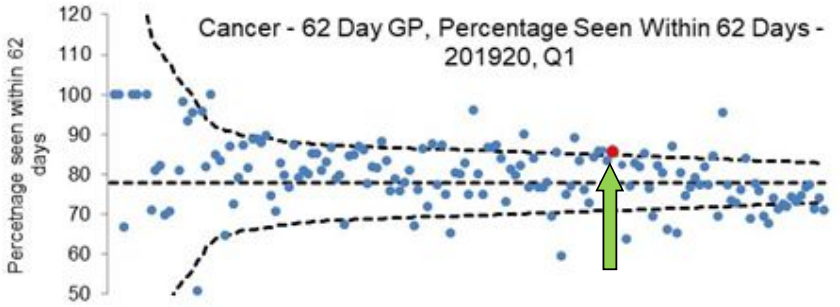


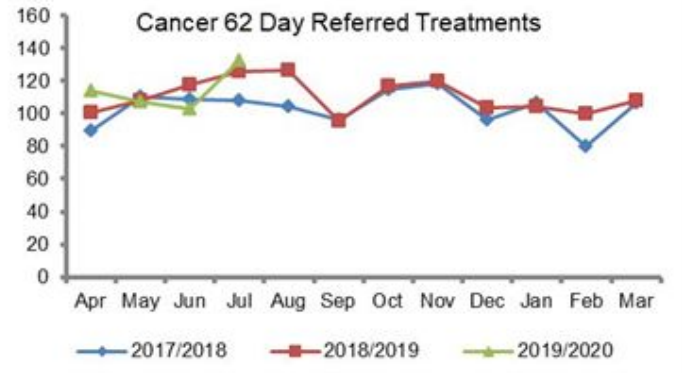


	Cancer 2WW - Jul-19		
	Under 2 Weeks	Total Pathways	Performance
Suspected children's cancer	18	18	100.0%
Suspected head and neck cancers	395	410	96.3%
Suspected lower gastrointestinal cancers	173	192	90.1%
Suspected lung cancer	20	22	90.9%
Suspected skin cancers	941	969	97.1%
Suspected upper gastrointestinal cancers	84	96	87.5%
Upper Gastrointestinal	0	0	
Urological	0	0	
Grand Total	**1,730**	**1,817**	**95.2%**

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, as submitted to NHS Improvement, has also been set at 85%.
Performance:	For July, 86.8% of patients were seen within 62 days (115.0 out of 132.5 patients). Quarter 1 2019/20 achieved 85.7%
Commentary/ Actions:	The Trust achieved compliance in July 2019 (86.8% against the 85% standard). Risk remains around surgical cancellations due to lack of critical care beds, with the Trust working on solutions to increase critical care capacity. Whilst the position has improved, cancellations have continued throughout the summer and the relatively low numbers against the cancer standards combined with the way performance is allocated between different providers under the waiting time rules means this can have a significant impact on performance in individual months.
Ownership:	Chief Operating Officer



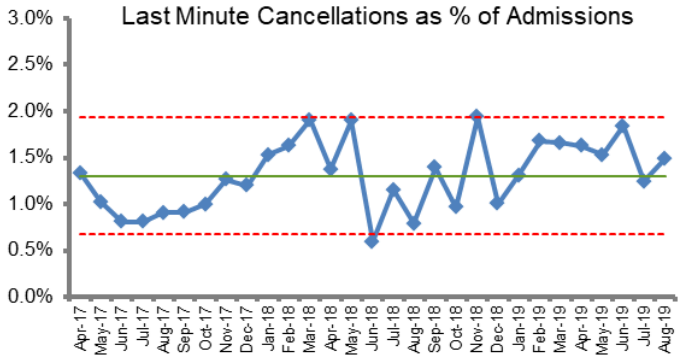


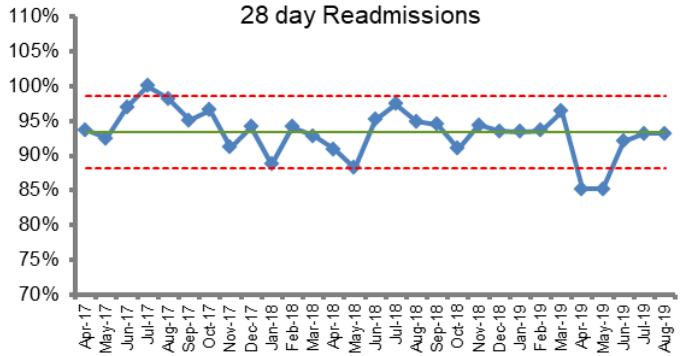


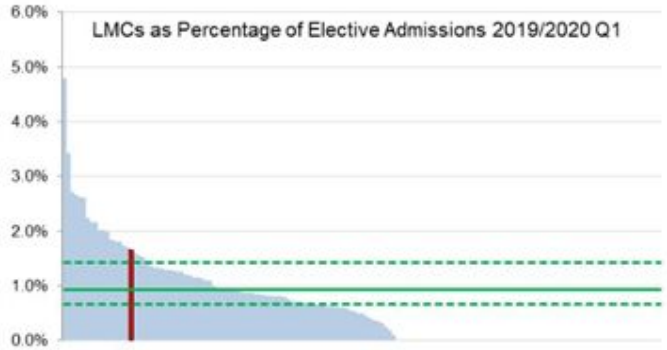
Cancer 62 Day - Jul-19

	Within Target	Total Pathways	Performance
Breast	3.0	3.0	100.0%
Gynaecological	6.0	8.5	70.6%
Haematological	2.0	3.0	66.7%
Head and Neck	13.5	16.0	84.4%
Lower Gastrointestinal	10.5	12.5	84.0%
Lung	12.5	16.0	78.1%
Other	1.0	2.0	50.0%
Sarcoma	1.0	1.0	100.0%
Skin	54.0	55.0	98.2%
Upper Gastrointestinal	10.5	14.5	72.4%
Urological	1.0	1.0	100.0%
Grand Total	**115.0**	**132.5**	**86.8%**

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 95 last minute cancellations, which was 1.49% of elective admissions. Of the 88 cancelled in July, 82 (93.2%) had been re-admitted within 28 days. This means six patients breached the 28 day readmission standard.
Commentary/ Actions:	The most common reason for cancellation was "Other Emergency Patient Prioritised" (18 cancellations). There were 7 in Medicine, 11 in Cardiac Services, 10 in ENT & Thoracics, 30 in Gastrointestinal Surgery, 20 in Ophthalmology, 2 in Trauma & Orthopaedics, 6 in Dental Services, 4 in Gynaecology and 5 in Paediatrics. Of the eight 6 day breaches: 1 was Dental, 1 was ENT/Thoracics, 2 were General Surgery, 1 was T&O and 1 was Gynaecology.
Ownership:	Chief Operating Officer







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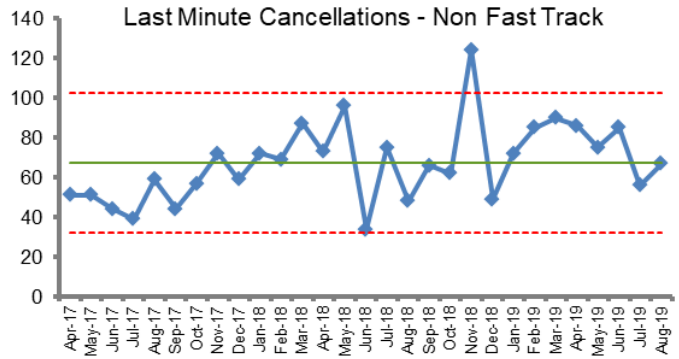
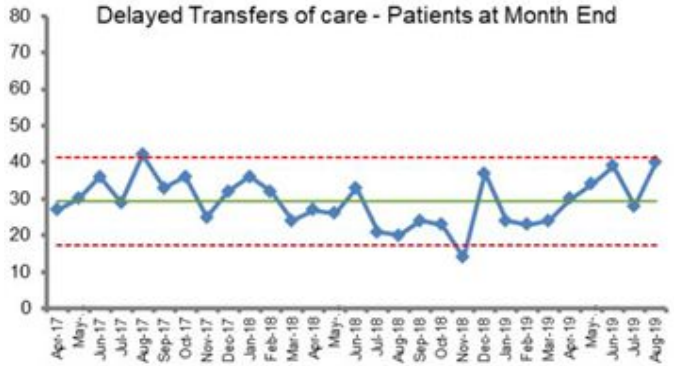
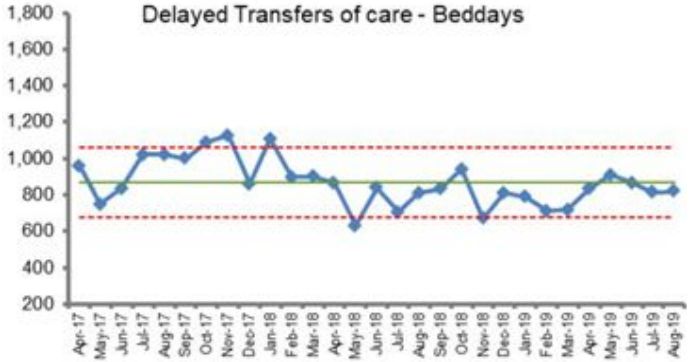


Cancellation Reason	Fast Track	Routine	Urgent	TOTAL
Other Emergency Patient Prioritised	4	11	3	18
No HDU Beds	11	4	1	16
AM list over-ran	1	8	1	10
Surgeon Unavailable	1	6	2	9
Technician Not Available	0	6	1	7
Equipment Failure	1	3	2	6
Booking Error	1	3	2	6
Surgeon Taken Ill	3	1	0	4
No Beds Available	2	1	1	4
Other clinically complicated Patient in theatre	2	1	1	4
Other Non Emergency Patient Prioritised	1	1	1	3
List Overbooked	0	2	0	2
No Lab Staff	0	1	1	2
List did not start on time	0	2	0	2
Anaesthetist Unavailable	0	1	0	1
No ITU Beds	1	0	0	1
TOTAL	**28**	**51**	**16**	**95**

2.3 PERFORMANCE – Responsive Domain

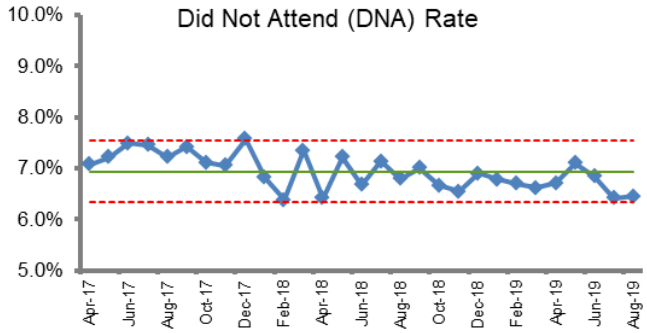
Delayed Transfers of Care (DToC)	
Standards:	Patients who are medically fit for discharge should wait a "minimal" amount of time in an acute bed.
Performance:	In August there were 40 Delayed Transfer of Care patients as at month-end (including 8 at South Bristol), and 819 beddays consumed by DToC patients.
Commentary/ Actions:	The Integrated Care Bureau (ICB) model continues to work well in relation to early identification of patients approaching discharge ready and agreement with partners regarding the most appropriate pathway for discharge. This is clearly demonstrated by consistently high number of patients on the Green To Go (G2G) list, however the number of formal Delayed Transfers of Care remains stable at approximately 25 – 35. In Surgery, staff are working with North Bristol Trust to see if they can take patients into their hospital at home service (will focus on Gastrointestinal Surgery and Trauma & Orthopaedics specialties). They have a team of nurses who can treat patients at home, freeing up inpatient beds.
Ownership:	Chief Operating Officer

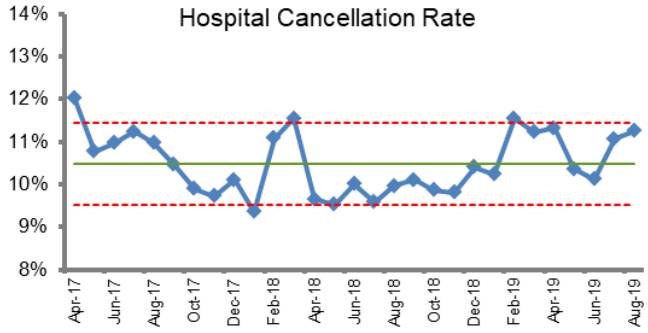




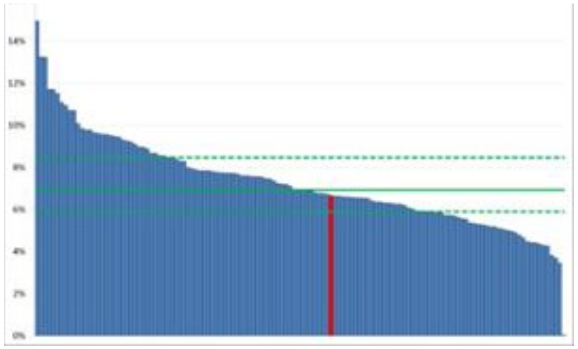
			Aug-19			
Code	Reason	Accountable	Patients (Acute)	Beddays (Acute)	Patients (Non-Acute)	Beddays (Non-Acute)
A	Completion of assessment	Both	4	64	2	13
		NHS	2	14	0	8
		Social Care	10	129	1	13
B	Public Funding	Social Care	0	0	1	3
C	Further non acute NHS care	NHS	0	12	0	0
Di	Care Home Placement	NHS	0	20	0	0
		Social Care	1	10	2	72
Dii	Care Home Placement	NHS	2	42	1	1
		Social Care	1	26	0	5
E	Care package in own home	NHS	1	36	0	4
		Social Care	10	232	1	46
F	Community equipment / adaptions	NHS	1	12	0	0
		Social Care	0	30	0	0
G	Patient or family choice	NHS	0	12	0	0
H	Disputes	Social Care	0	5	0	0
I	Housing - patient not covered by NH	NHS	0	10	0	0
TOTAL			32	654	8	165

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. DNA Target at Trust level is to be below 6.7%, with an amber tolerance of between 6.7% and 7.2%. 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 8,753 hospital-cancelled appointments, which was 11.2% of all appointments made. There were 3,570 appointments that were DNA'ed, which was 6.5% of all planned attendances.
Commentary/ Actions:	All divisions have set targets to reduce DNA's in specific specialities as part of the productivity workstreams for 2019/20. The Outpatient Steering Group (OSG) will monitor progress towards the targets set by each division and reviewing the Trust DNA rate on a monthly basis. The trend towards a more stable DNA rate is thought to be due to patients having greater choice over when and where they are seen for their first outpatient appointment through e-RS and the ongoing work to reduce the number of patients who are overdue their follow-up by more than 6 months. The increase in hospital cancellation rate is due to the introduction of e-RS, which whilst it allows the patient to book an appointment, if they require a different speciality or a particular clinic their original appointment will be cancelled to allow the correct appointment to be booked. Patients are informed their appointment is not confirmed until they receive confirmation following triage.
Ownership:	Chief Operating Officer

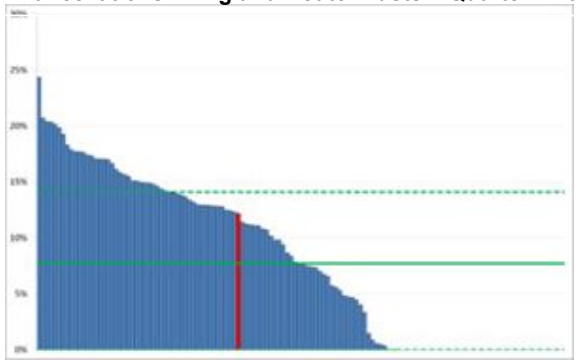




DNA Rate – England Acute Trusts – Quarter 1 2019/20



Hospital Cancellations – England Acute Trusts – Quarter 1 2019/20



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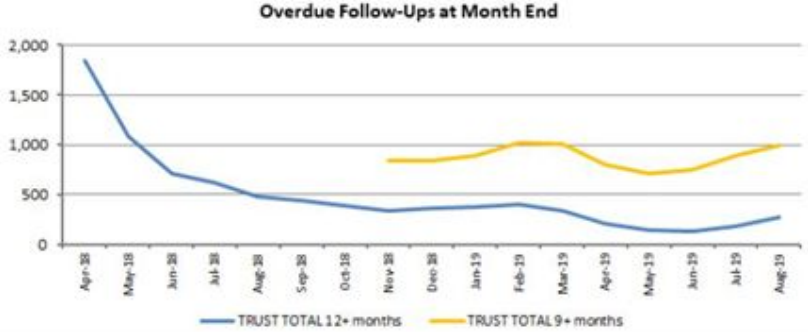
2.3 PERFORMANCE – Responsive Domain

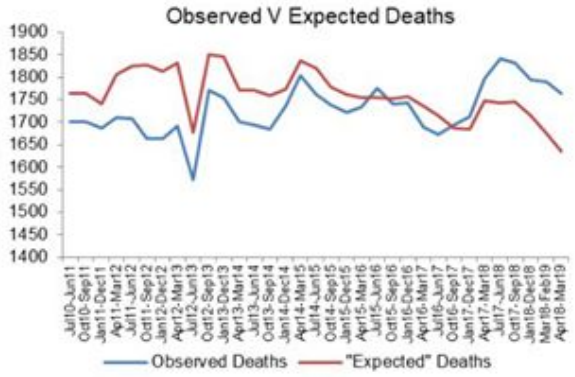
Outpatient – Overdue Follow-Ups	
Standards:	This measure looks at referrals where the patient is on a "Partial Booking List", which indicates the patient is to be seen again in Outpatients but an appointment date has not yet been booked. Each patient has a "Date To Be Seen By", from which the proportion that are overdue can be 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 is 276 and overdue by 9+ months is 996.
Commentary/ Actions:	Although there has been a small deterioration in the numbers, this is focussed on two specialties: Trauma & Orthopaedics and Clinical Genetics. All other areas have cleared the 9+ month backlog and are focussed on the 6-8 month cohort. Plans are being worked through, via the weekly performance meetings, for the two specialties to achieve clearance of the backlogs by November.
Ownership:	Chief Operating Officer

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Outpatients Overdue by 12+ Months	Diagnostics and Therapies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Medicine	461	133	23	5	7	3	3	2	3	4	3	3	3	3	3	3	3
	Specialised Services	188	206	214	208	95	58	67	7	5	8	12	0	0	34	62	90	136
	Surgery	444	221	92	17	3	0	0	0	0	11	23	49	61	62	66	91	135
	Women's and Children's	756	526	387	387	371	375	322	323	350	351	360	282	150	46	3	0	2
	TRUST TOTAL 12+ months	**1,849**	**1,086**	**716**	**617**	**476**	**436**	**392**	**332**	**358**	**374**	**398**	**334**	**214**	**145**	**134**	**184**	**276**
Outpatients Overdue by 9+ Months	Diagnostics and Therapies								3	2	0	0	0	0	0	2	0	0
	Medicine								20	4	4	3	4	4	3	3	4	4
	Specialised Services								125	95	142	247	253	181	261	278	323	392
	Surgery								125	124	108	146	216	264	272	333	450	499
	Women's and Children's								565	620	640	629	530	349	174	128	111	101
	TRUST TOTAL 9+ months								**838**	**845**	**894**	**1025**	**1003**	**798**	**710**	**744**	**888**	**996**

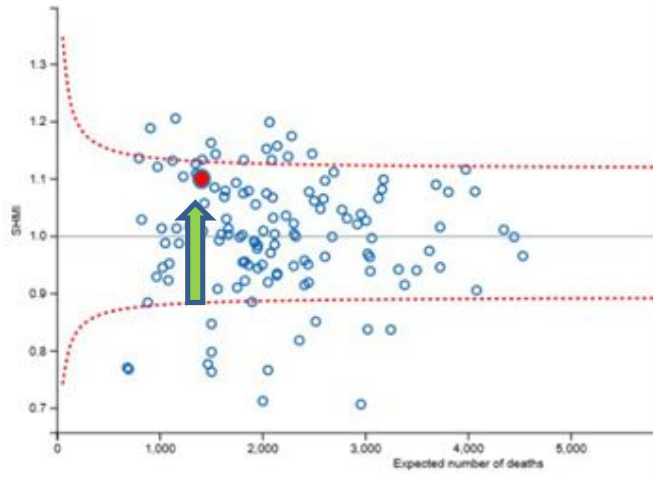


Mortality - Summary Hospital Mortality Indicator (SHMI)	
Standards:	This is the national measure published by NHS Digital .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Summary Hospital Mortality Indicator (SHMI) covers deaths in-hospital and deaths within 30 days of discharge. It is now published monthly and covers a rolling 12 –month period. Data is published 6 months in arrears.
Performance:	Latest SHMI data is for 12 month period May 2018 to April 2019. The SHMI was 106.2 (1750 deaths and 1645 "expected"). The Trust is in NHS Digital's "As Expected" category.
Commentary/ Actions:	The Trust Quality Intelligence Group maintains surveillance of all mortality indicators, drilling down to speciality level if required. Please also see narrative for HSMR below.
Ownership:	Medical Director

Timeframe	Observed Deaths	"Expected" Deaths	SHMI
Jul15-Jun16	1775	1754	101.18
Oct15-Sep16	1741	1752	99.37
Jan16-Dec16	1743	1758	99.13
Apr16-Mar17	1690	1737	97.31
Jul16-Jun17	1674	1714	97.64
Oct16-Sep17	1693	1686	100.40
Jan17-Dec17	1712	1684	101.68
Apr17-Mar18	1796	1748	102.74
Jul17-Jun18	1841	1744	105.56
Oct17-Sep18	1833	1745	105.04
Jan18-Dec18	1795	1715	104.66
Mar18-Feb19	1790	1675	106.87
Apr18-Mar19	1765	1635	107.95

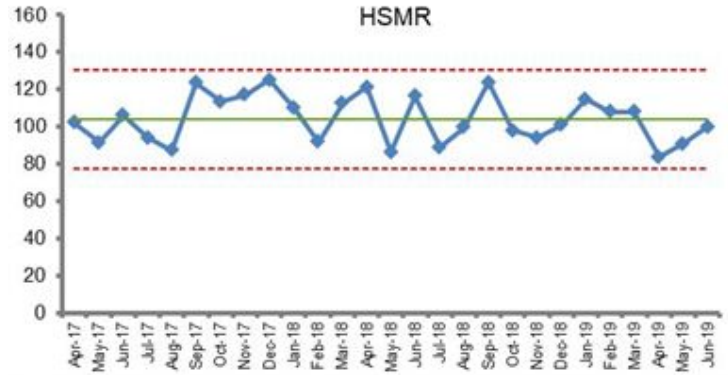


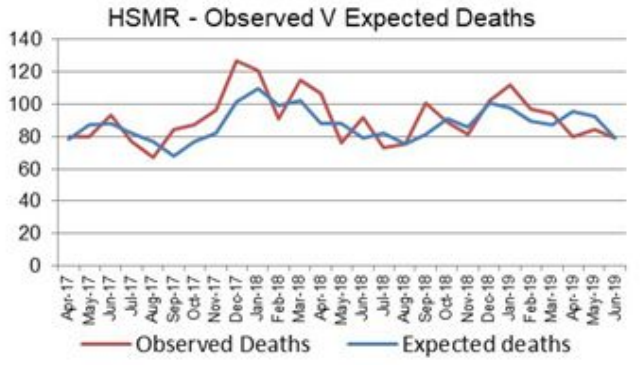
April 2018 to March 2019



2.4 PERFORMANCE – Effective Domain

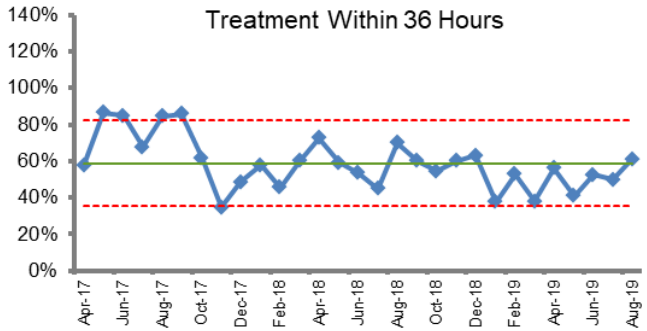
Mortality – Hospital Standardised Mortality Ratio (HSMR)	
Standards:	This is the national measure published by Dr Foster .It is the number of actual deaths divided by "expected" deaths, multiplied by 100. The Hospital Standardised Mortality Ratio (HSMR) is in-hospital deaths for conditions that account for 80% of hospital deaths
Performance:	Latest HSMR data is for June 2019. The HSMR was 99.9 (79 deaths and 79 "expected")
Commentary/ Actions:	As previously reported, actions are being taken in response to the detailed report into the Trust's HSMR and mortality for acute myocardial infarction. These actions include improving palliative care coding and improvements in repatriating patients to their local hospital following acute coronary intervention. The recording of mode of admission for 'open door' oncology patients is also under review. Current admission mode for these patients is recorded differently from other Trusts and is thought to statistically underestimate risk of dying and impact HSMR. It will take several months before the impact of any actions is seen in HSMR
Ownership:	Medical Director

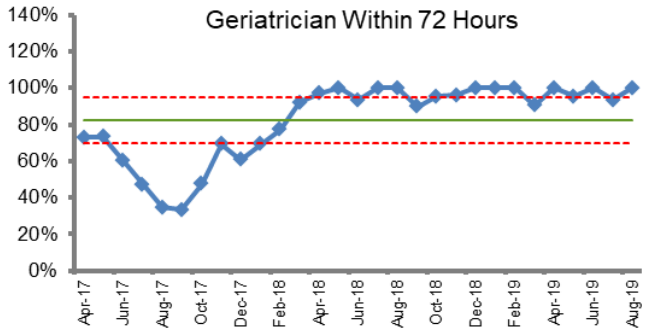


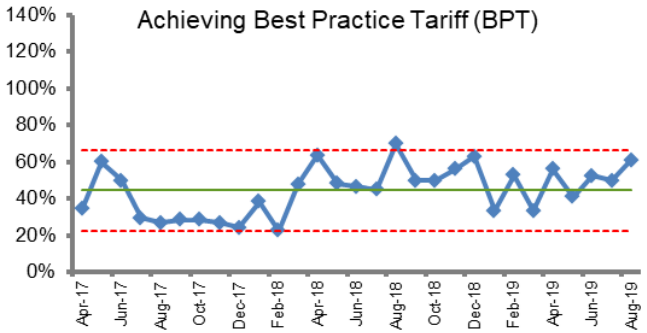


2.4 PERFORMANCE – Effective Domain

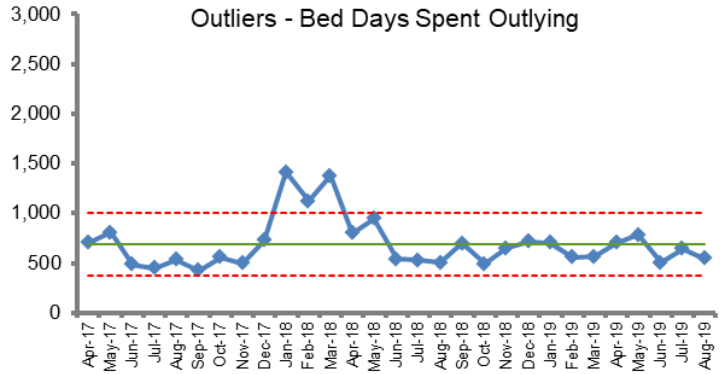
Fracture Neck of Femur	
Standards:	Best Practice Tariff (BPT), is a basket of indicators covering eight elements of what is considered to be best practice in the care of patients that have fractured their hip. 90% of patients should achieve Best Practice Tariff. Two key measures are being treated within 36 hours and seeing an orthogeriatrician within 72 hours. Both these measures should achieve 90%.
Performance:	In August, there were 20 patients discharged following an admission for fractured neck of femur, of which 18 were eligible for Best Practice Tariff (BPT). For the 36 hour target, 61% (11 patients) were seen with target. For the 72 hour target, all 18 patients (100%) were seen within target. 11 patients (61%) achieved all elements of the Best Practice Tariff.
Commentary/ Actions:	Actions underway to support improvements includes: • Recruitment to two additional Trauma & Orthopaedic consultants underway. Start dates likely to be October / November. This will release consultants to cover the trauma list. The appointment of additional consultants will also enable all day operating lists to be organised for trauma which will increase efficiency. • On-call rotas are changing which will mean more sub- speciality availability on any given day/week for trauma cover. • Appointment of a third orthogeriatric consultant to support silver trauma • Trauma list report amended to improve visibility of trauma list status • When trauma demand peaks, additional trauma lists can be organised by taking down elective activity. • A 'Silver Trauma Business Case' has been agreed and is being implemented which will provide support for treating trauma patients.
Ownership:	Medical Director

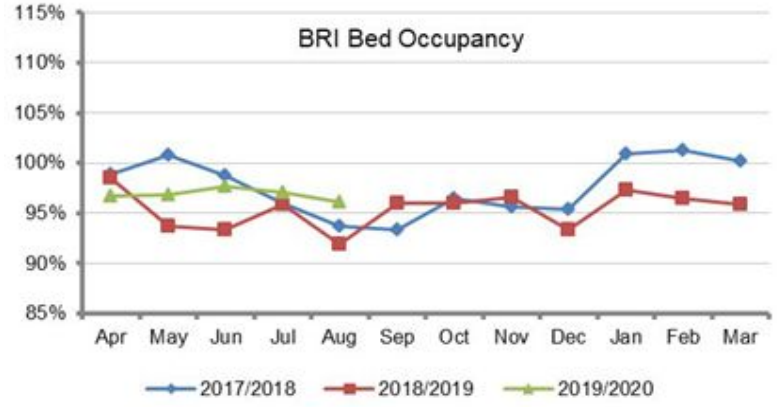


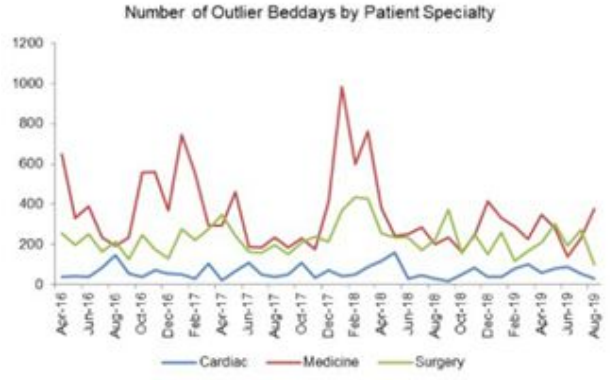




Outliers	
Standards:	This is a measure of how many bed-days patients spend on a ward that is different from their broad treatment speciality: medicine, surgery, cardiac and oncology. Our target is a 15% reduction which equates to a 9029 bed-days for the year with seasonally adjusted quarterly targets.
Performance:	In August there were 547 outlying beddays (1 bedday = 1 patient in a bed at 12 midnight).
Commentary/ Actions:	The August target of no more than 563 beddays was achieved. Of all the outlying beddays 378 were Medicine patients, 54 were Specialised Services patients and 98 were Surgery patients. A Standard Operating procedure has been developed for pre-emptive boarding into the Heart Institute and this is being developed to be rolled out in the Oncology Centre. Also, in Specialised Services, consultants are trialling a new ward round model to determine whether this supports flow and the initial data looks positive and has been implemented until December 2019
Ownership:	Chief Operating Officer

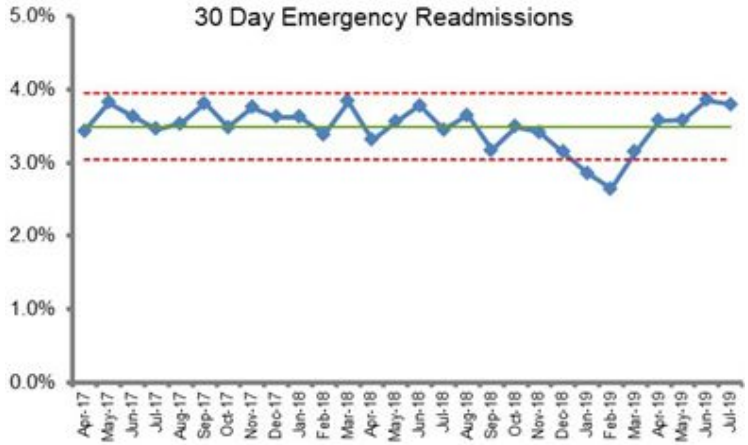






2.4 PERFORMANCE – Effective Domain

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 13,291 discharges, of which 504 (3.78%) had an emergency re-admission within 30 days.
Commentary/ Actions:	10.0% of Medicine division discharges were re-admitted within 30 days as an emergency, 4.0% from Surgery and 1.3% from Specialised Services. Although July exceeded the target of 3.62%, this is still within normal process limits. Data is monitored on a regular basis through divisional performance reviews and is included on the speciality performance reports.
Ownership:	Chief Operating Officer

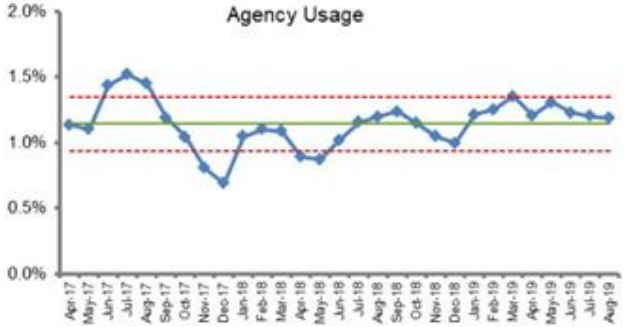


Discharges in July 2019

	Emergency Readmissions	Total Discharges	% Readmissions
Diagnostics and Therapies	1	34	2.94%
Medicine	273	2,733	9.99%
Specialised Services	37	2,844	1.30%
Surgery	139	3,485	3.99%
Women's and Children's	54	4,191	1.29%
TRUST TOTAL	**504**	**13,291**	**3.79%**

2.5 PERFORMANCE – Efficient Domain

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 2019, total staffing was at 8977 FTE. Of this, 5.2% was Bank (468 FTE) and 1.2% was Agency (106 FTE).
Commentary/ Actions:	**Agency usage** reduced by 1.0 FTE. The largest reduction was seen in the division of Women's and Children's, decreasing to 16.2 FTE from 20.6 FTE the previous month. The largest increase was seen in the division of Surgery with 29.0 FTE compared to 22.3 FTE in the previous month. The largest staff group increase was within Nursing and Midwifery, increasing to 89.5 FTE from 84.9 FTE in the previous month. **Bank usage** reduced by 19.2 FTE. The largest increase was seen in the division of Surgery, increasing to 102.9 FTE from 100.8 FTE the previous month. The largest reduction was seen in the division of Specialised Services, decreasing to 64.0 FTE from 71.4 FTE the previous month. The largest staff group increase was within Health Professionals, increasing to 21.1 FTE from 19.4 FTE in the previous month. • Reduction in high cost nurse agency programme went live 2nd September 2019 across the BNSSG & Bath partnership with system wide and local mitigations in place, ensuring patient safety remains uncompromised. • New bank incentive model live from 2nd September supporting the ambitions of the nurse agency reduction programme. • Successful Trust's 'Get Set for Summer' recruitment campaign concluded supporting the recruitment to the staff bank for all staff groups. This will be followed by an Autumn/Winter recruitment campaign to support the ongoing growth of the bank. The last month has seen 21 new NA's and 4 RN's appointed to the Bank with a further 13 NA's and 9 RN's reappointed to the Bank.
Ownership:	Director of People

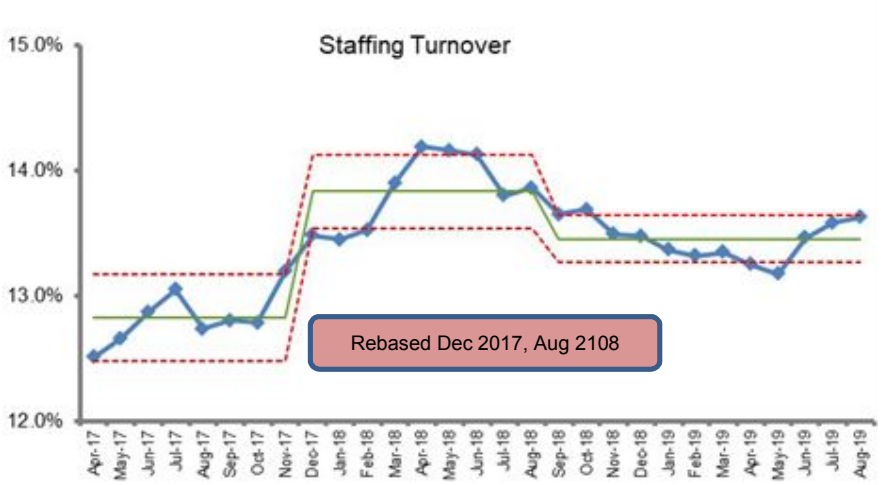


Bank	Aug FTE	Aug Actual %	KPI
UH Bristol NHS Foundation Trust	**467.6**	**5.2%**	**4.6%**
Diagnostics & Therapies	14.2	1.3%	1.5%
Medicine	135.1	10.3%	9.0%
Specialised Services	64.0	6.0%	6.3%
Surgery	102.9	5.5%	5.1%
Women's & Children's	67.3	3.2%	1.4%
Trust Services	29.9	3.5%	3.8%
Facilities & Estates	54.3	7.1%	7.0%

Agency	Aug FTE	Aug Actual %	KPI
UH Bristol NHS Foundation Trust	**106.3**	**1.2%**	**0.8%**
Diagnostics & Therapies	7.8	0.7%	1.0%
Medicine	36.5	2.8%	1.7%
Specialised Services	16.6	1.6%	1.2%
Surgery	29.0	1.6%	0.5%
Women's & Children's	16.2	0.8%	0.3%
Trust Services	0.0	0.0%	0.9%
Facilities & Estates	0.3	0.0%	0.3%

2.5 PERFORMANCE – Efficient Domain

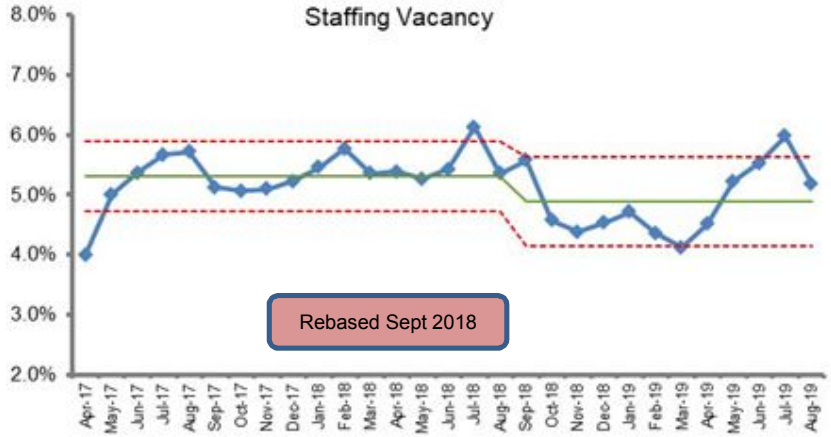
Staffing Levels (Turnover)	
Standards:	Turnover is measured as total permanent leavers (FTE) as a percentage of the average permanent staff over a rolling 12-month period. The Trust target is the trajectory to achieve 12.3% by the end of 2018/19. The red threshold is 10% above monthly trajectory.
Performance:	In August 2019, there had been 973 leavers over the previous 12 months with 7137 FTE staff in post on average over that period; giving a Turnover of 973 / 7137 = 13.6%.
Commentary/ Actions:	Turnover increased to 13.63% from 13.59% last month, with increases in four divisions – Diagnostics and Therapies, Specialised Services, Surgery and Trust Services. The largest divisional reduction was seen within Women's and Children's reducing to 11.1% from 11.7% the previous month. The largest divisional increase was seen within Surgery increasing to 13.9% from 13.3% the previous month. The biggest reduction in staff group was seen within Healthcare Scientists (0.9 percentage points). The largest increase in staff group was seen within Nursing and Midwifery Unregistered (1.0 percentage points). • Focus on engagement and staff experience at work will be delivered throughout the 'You Said We Did' week 16th to 20th September 2019. • Exit Interview questionnaire return rates continue to be above 80% and this is providing useful data for the organisation including breakdown of contract type, ethnicity and age. • The 12-month NHSI Clinical Retention Programme continues to focus on initiatives covering flexible working and flexible retirement options, internal mobility and career progression.
Ownership:	Director of People



Turnover	Aug-19	KPI
UH Bristol NHS Foundation Trust	**13.6%**	**13.2%**
Diagnostics & Therapies	12.3%	10.7%
Medicine	16.2%	14.5%
Specialised Services	16.3%	14.6%
Surgery	13.9%	13.2%
Women's & Children's	11.1%	11.7%
Trust Services	15.0%	14.5%
Facilities & Estates	12.9%	15.2%

2.5 PERFORMANCE – Efficient Domain

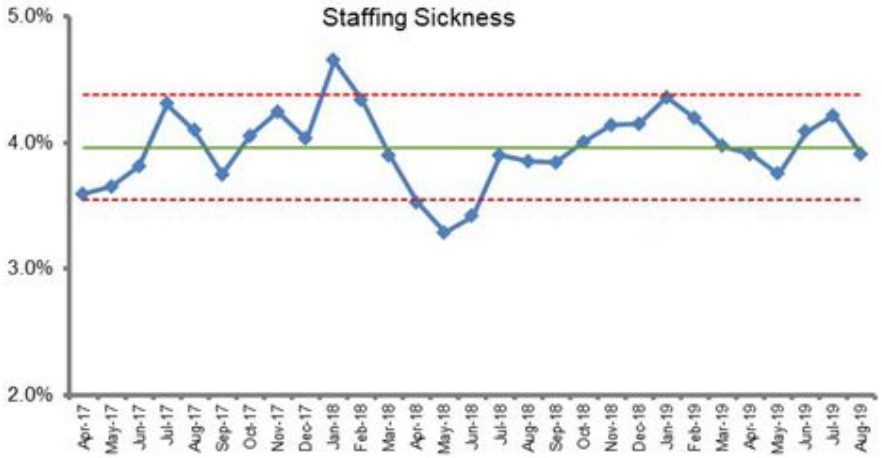
Staffing Levels (Vacancy)	
Standards:	Vacancy levels are measured as the difference between the Full Time Equivalent (FTE) budgeted establishment and the Full Time Equivalent substantively employed, represented as a percentage, compared to a Trust-wide target of 5%.
Performance:	In August 2019, funded establishment was 8863 FTE, with 459 FTE as vacancies (5.2%).
Commentary/ Actions:	Overall vacancies reduced to 5.2% compared to 6.0% in the previous month. There were two staff groups with increases, the largest being within Nursing and Midwifery which increased to 248.7 FTE from 239.2 FTE the previous month. There were two staff groups with reductions; the largest was in Medical and Dental, which reduced to -38.0 FTE from 34.0 the previous month. Surgery had the largest Divisional reduction to 102.9 FTE from 126.9 FTE the previous month. • New Trust recruitment website is now live. A social media launch campaign is in place throughout the autumn. Development of the website will be continued to enhance the information available for prospective candidates. • 9 new 'Return to Practice' candidates have now commenced placement with UH Bristol and supported training at UWE. • Review of activity under way to understand the vacancy issues across all staff groups which will be reported through the newly established Recruitment sub-group. • Successful nurse recruitment day held on 11th September with 12 RN offers made.
Ownership:	Director of People



Vacancy	Aug-19	KPI
UH Bristol	5.2%	5.0%
Diagnostics & Therapies	3.7%	5.0%
Medicine	8.1%	5.0%
Specialised Services	6.1%	5.0%
Surgery	5.6%	5.0%
Women's & Children's	2.3%	5.0%
Trust Services	4.5%	5.0%
Facilities & Estates	8.7%	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 261,993 of which 10,243 (3.9%) were lost to staff sickness.
Commentary/ Actions:	Sickness absence reduced to 3.9% from 4.2%, with reductions in five divisions. The Divisions of Trust Services saw the greatest increase, rising from 3.8% last month to 3.9%. Facilities and Estates saw the largest divisional reduction to 6.1% from 7.1% the previous month. The largest staff group increase was seen in Admin and Clerical, rising to 4.8% from 4.1% the previous month. The largest staff group reduction was seen within Nursing and Midwifery Unregistered reducing to 7.4% from 8.8% the previous month. • Since launching in May 2019, 585 staff have attended the workplace wellbeing workshops designed to support wellbeing in the workplace. • The Trust has been selected to undertake the South West NHS Healthy Weight Declaration pilot designed to improve staff health both in and out of the workplace. • The monthly 'Workplace Wellbeing during the Menopause' workshop and accompanying self-help guide has been designed to raise awareness of the support available. • The Supporting Attendance eLearning is in the final stages of testing with a view to going live at the beginning of October. • Limited capacity to deliver face to face training for managers through Employee Services due to volumes of urgent / critical casework.
Ownership:	Director of People



Sickness	Aug-19	KPI
UH Bristol	**3.9%**	**3.8%**
Diagnostics & Therapies	2.6%	3.0%
Medicine	4.3%	4.7%
Specialised Services	3.3%	3.4%
Surgery	4.3%	3.6%
Women's & Children's	3.6%	3.7%
Trust Services	3.9%	2.7%
Facilities & Estates	6.1%	6.3%

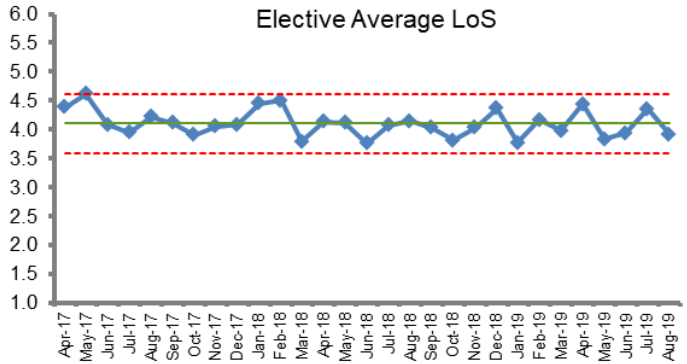
2.5 PERFORMANCE – Efficient Domain

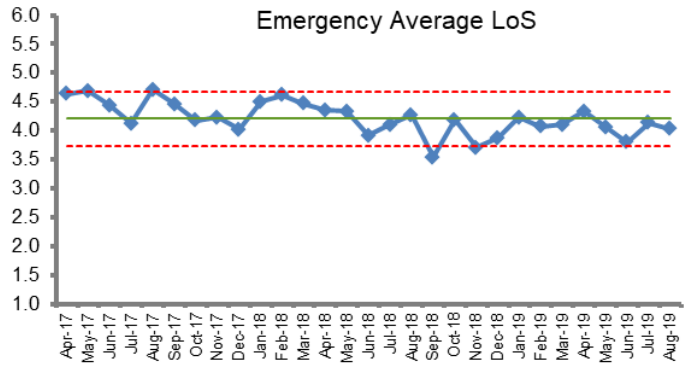
Staff Appraisal	
Standards:	Staff Appraisal in measured as a percentage of staff excluding consultants who have had their appraisal signed-off. The target is 85% Trust-wide.
Performance:	In August 2019, 6,026 members of staff were compliant out of 8,216 (73.3%)
Commentary/ Actions:	Overall appraisal compliance reduced to 73.3% (from 73.5%). There were increases in two divisions; Medicine and Specialised Services. With the largest divisional increase seen in Medicine increasing to 69.7% (from 67.8% the previous month). The largest divisional reduction was seen within Surgery, reducing to 64.7% (from 66.6% the previous month). All divisions are non-compliant. The appraisal recovery plan continues focusing on action with areas of low compliance. Support includes: • Fortnightly communications to all managers focussing on objective setting and systems training • Increased appraisal training frequency • A number of new guides for staff and managers have been developed and are held on HRWeb. • Stakeholder workshop held in August on supporting improved compliance and quality • Hot spot reports continue
Ownership:	Director of People

Appraisal (Non-Consultant)	Aug-19	Jul-19	KPI
UH Bristol NHS Foundation Trust	**73.3%**	**73.5%**	**85.0%**
Diagnostics & Therapies	83.3%	83.8%	85.0%
Medicine	69.7%	67.8%	85.0%
Specialised Services	82.9%	82.6%	85.0%
Surgery	64.7%	66.6%	85.0%
Women's & Children's	73.9%	74.0%	85.0%
Trust Services	67.9%	67.9%	85.0%
Facilities & Estates	74.8%	74.8%	85.0%

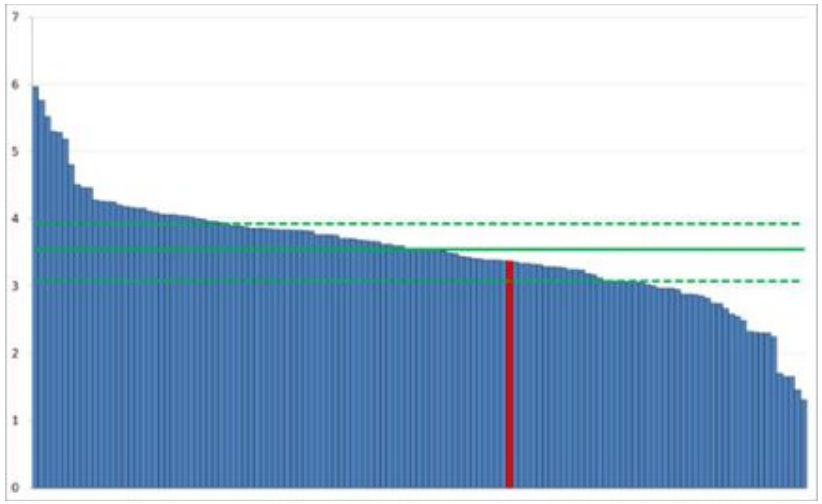
2.5 PERFORMANCE – Efficient Domain

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 6,331 discharges that consumed 24,195 beddays, giving an overall average length of stay of 3.82 days.
Commentary/ Actions:	In Specialised Services: • All patients for cardiac surgery are now being bought in on the day of surgery unless there are clinical reasons why this is not appropriate, this has been supported by an anaesthetic led pre-op to make sure all cardiac surgery patients are fit for surgery. • Work is ongoing to improve flow with the development of nurse led discharge. Criteria led discharge is also being rolled out in the Oncology Centre for Neutropenic Sepsis, Post Chemo and Brachythery. In Surgery: • Criteria Led Discharge and early discharge continue to progress well. Utilisation of the discharge lounge remains static therefore will continue to reinforce importance of sending patients to the DL where appropriate. • The surgical patient flow project has been accepted onto the Gold Quality Improvement (QI) Trust programme which commences week beginning 23rd September. The project will enable the division to continue to develop sustained and effective patient flow across the surgical pathways of care. It involves multiple work streams and concepts e.g. emergency access, elective access, effective ward processes, robust escalation protocols and optimising early safe discharge. The project is multi-professional and requires active participation from nursing, medical and general managers.
Ownership:	Chief Operating Officer





Average Length of Stay – England Trusts - 2019/20 Quarter 1



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

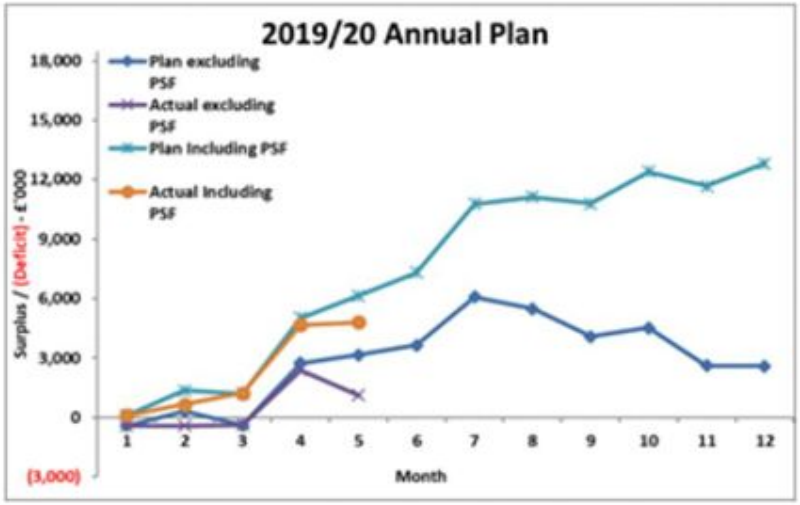
Length of Stay of Inpatients at month-end

Aug-19	7+ Days	14+ Days	21+ Days	28+ Days
Bristol Children's Hospital	61	44	35	30
Bristol Haematology & Oncology Centre	24	17	9	5
Bristol Royal Infirmary	232	140	90	66
South Bristol Hospital	60	49	44	33
St Michael's Hospital	35	22	17	11
TRUST TOTAL	416	274	196	146

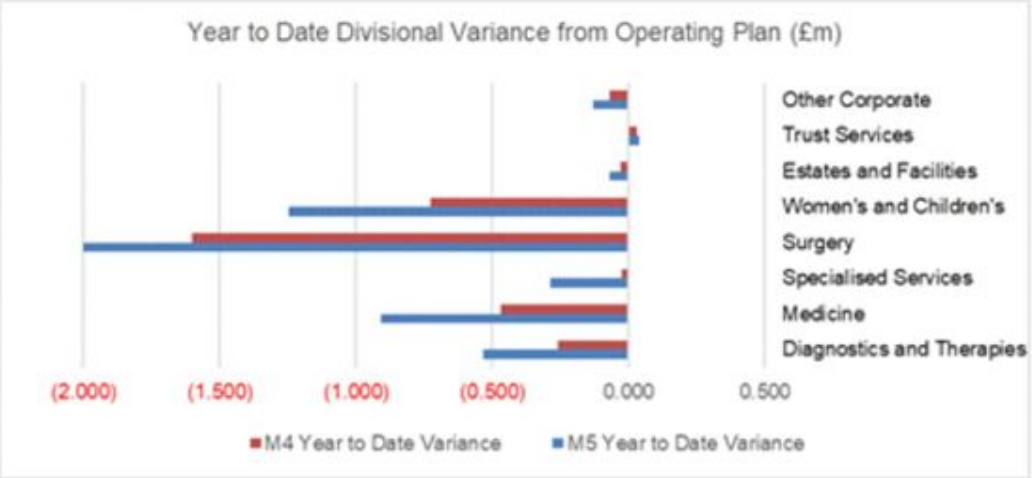
Bristol Royal Infirmary Divisional Breakdown:

Medicine	137	91	62	49
Specialised Services	45	27	17	10
Surgery, Head & Neck	49	21	10	6

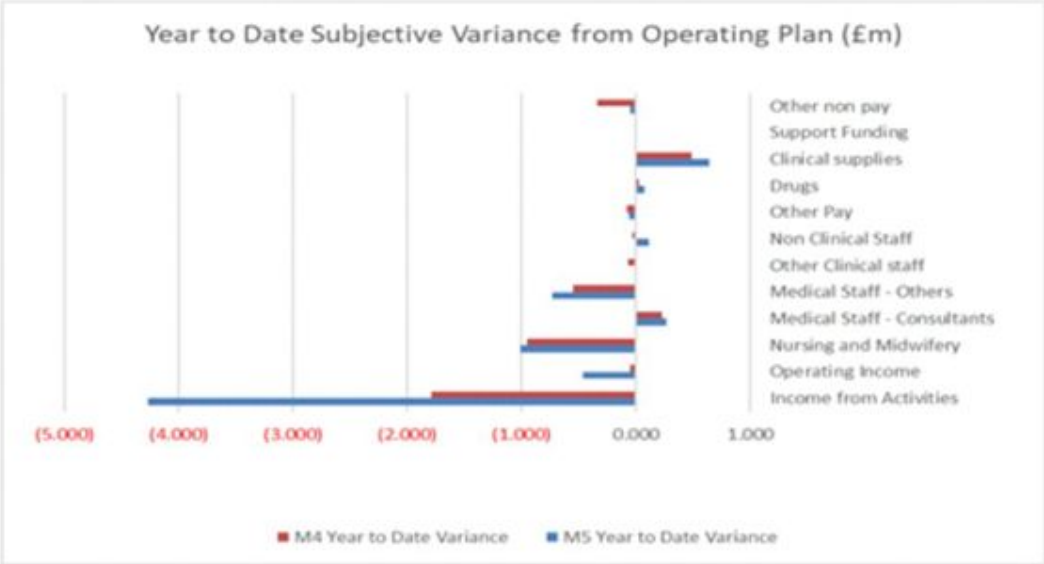
2.6 FINANCIAL PERFORMANCE

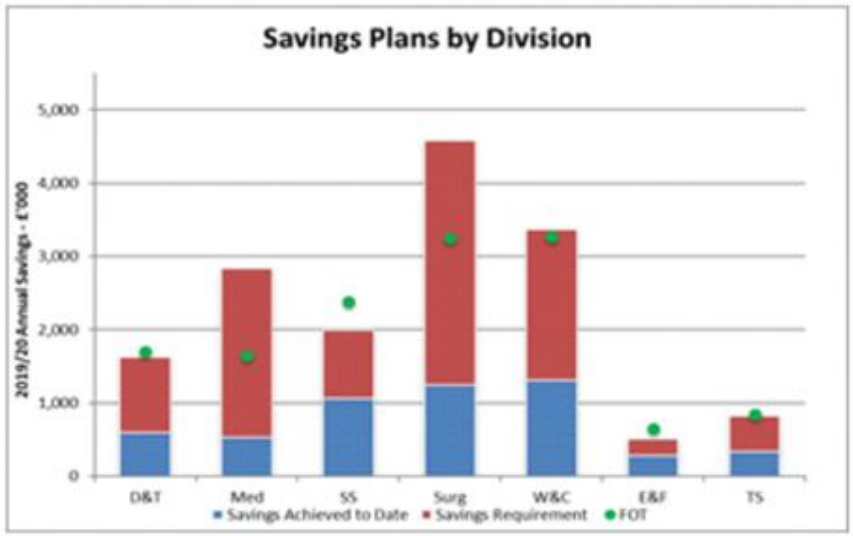


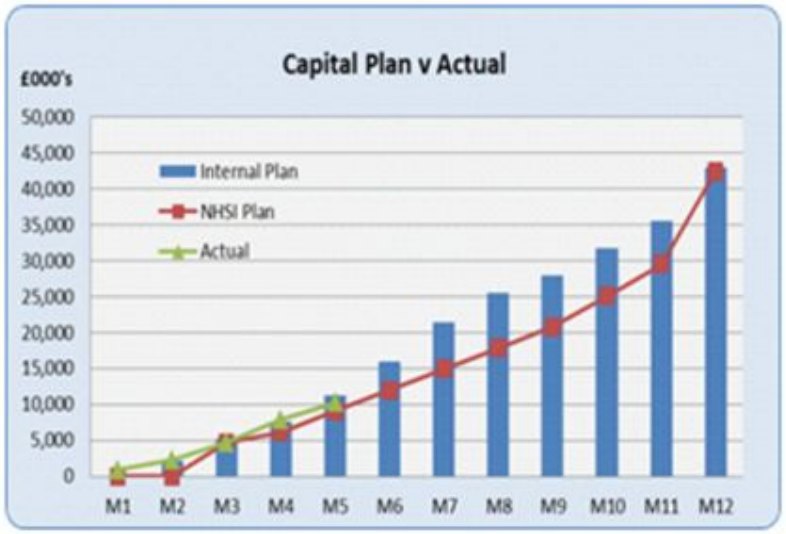
2.6 FINANCIAL PERFORMANCE



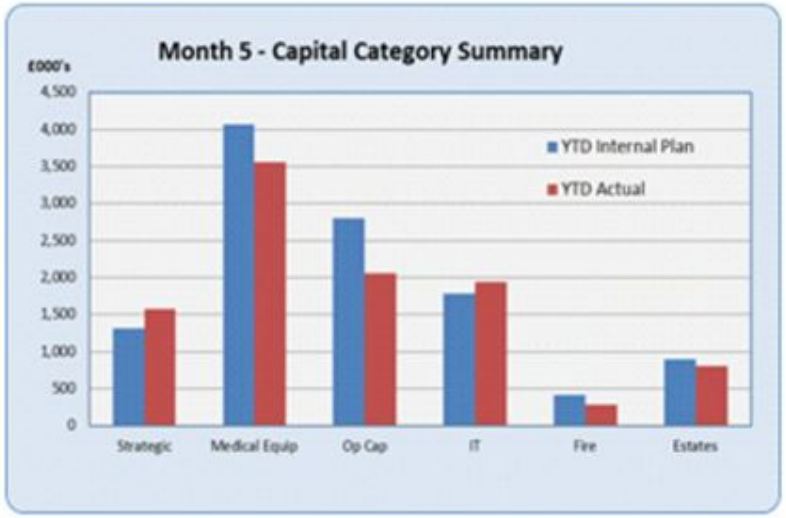
RAG Rating to Operating Plan	In Month	Year to Date
D & T	R	R
Medicine	R	R
Specialised	R	R
Surgery	R	R
W & C	R	R
E & F	R	A
Trust Services	G	G




Savings Plans by Division
2019/20 Annual Savings - £'000
5,000
4,000
3,000
2,000
1,000
0
D&T
Med
SS
Surg
W&C
E&F
TS
Savings Achieved to Date
Savings Requirement
FOT


Capital Plan v Actual
£000's
50,000
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Internal Plan
NHSI Plan
Actual
M1
M2
M3
M4
M5
M6
M7
M8
M9
M10
M11
M12

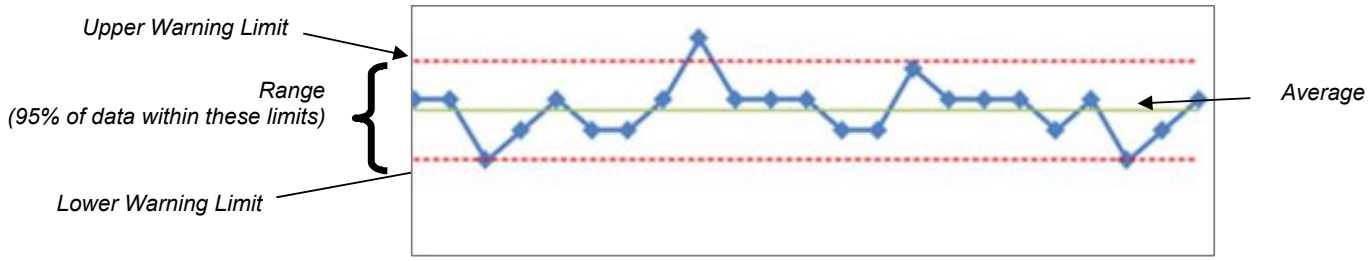

2019/20 SAVINGS MONTHLY RUN RATE


Month 5 - Capital Category Summary
£000's
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
YTD Internal Plan
YTD Actual
Strategic
Medical Equip
Op Cap
IT
Fire
Estates

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 Care Quality Commission Rating

The Care Quality Commission (CQC) published their latest inspection report on 16th August 2019. Full details can be found here: https://www.cqc.org.uk/provider/RA7

The overall rating was OUTSTANDING, and the breakdown by domain and category is shown below.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good ↓ May 2019	Requires improvement ↓ May 2019
Medical Care (including older people's care)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Outstanding ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Services for children and young people	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2017	Outstanding ↑ May 2019	Outstanding ↑ May 2019
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients and diagnostics	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall trust	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

SAFE, CARING & EFFECTIVE

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	18/19	19/20 YTD	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Patient Safety																				
Infections	DA01	MRSA Trust Apportioned Cases	6	1	1	1	0	0	0	1	0	0	0	0	0	1	1	1	0	1
	DA02	MSSA Trust Apportioned Cases	34	26	1	1	3	3	3	2	4	5	6	4	6	5	7	9	15	11
	DA03	CDiff Trust Apportioned Cases	31	18	7	2	4	2	1	1	1	4	2	2	5	5	8	3	8	10
	DA06	EColi Trust Apportioned Cases	83	41	12	7	0	7	5	5	8	6	8	9	14	4	14	18	23	18
C.Diff "Avoidables"	DA03B	CDiff Trust Apportioned Cases - Lapse in Care	10	1	2	1	0	1	0	0	1	1	0	0	0	0	2	1	1	0
	DA03D	CDiff Trust Apportioned Cases - Still Under Review	2	13	2	0	0	0	0	0	0	1	0	2	5	5	0	0	3	10
Infection Checklists	DB01	Hand Hygiene Audit Compliance	97%	96.6%	98%	97%	96.5%	96.8%	96.3%	96.6%	96.7%	95.6%	95.7%	96.6%	96.9%	98%	96.8%	96.6%	95.9%	97.5%
	DB02	Antibiotic Compliance	78.9%	81.2%	75.1%	76.7%	75.7%	85%	79.1%	66.3%	68%	76.1%	84.2%	80.2%	88.6%	85.6%	77.6%	72.2%	79.1%	86.5%
Cleanliness Monitoring	DC01	Cleanliness Monitoring - Overall Score	-	-	95%	95%	96%	95%	96%	96%	95%	96%	96%	95%	96%	96%	-	-	-	-
	DC02	Cleanliness Monitoring - Very High Risk Areas	-	-	97%	98%	98%	97%	97%	98%	98%	98%	98%	98%	97%	98%	-	-	-	-
	DC03	Cleanliness Monitoring - High Risk Areas	-	-	95%	96%	96%	96%	96%	97%	97%	97%	96%	96%	96%	96%	-	-	-	-
Serious Incidents	S02	Number of Serious Incidents Reported	70	36	8	4	10	4	3	7	5	7	3	8	10	8	18	15	18	18
	S02a	Number of Confirmed Serious Incidents	63	12	6	4	8	3	2	6	5	7	3	2	-	-	15	13	12	-
	S02b	Number of Serious Incidents Still Open	5	24	1	0	2	0	1	1	0	0	0	6	10	8	2	2	6	18
	S03	Serious Incidents Reported Within 48 Hours	98.6%	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%
	S03a	Serious Incidents - 72 Hour Report Completed Within Timescale	94.3%	97.2%	100%	100%	80%	75%	100%	100%	100%	85.7%	100%	100%	100%	100%	83.3%	100%	94.4%	100%
	S04	Serious Incident Investigations Completed Within Timescale	96.8%	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%	100%	100%	93.8%	100%	100%
	S04a	Overdue Exec Commissioned Non-SI Investigations	12	4	0	0	0	0	1	0	0	1	1	1	1	-	0	1	3	1
Never Events	S01	Total Never Events	5	3	0	0	1	2	0	0	1	0	0	1	1	1	3	1	1	2
Patient Safety Incidents	S06	Number of Patient Safety Incidents Reported	17839	7525	1510	1517	1511	1371	1520	1551	1570	1373	1027	1765	1710	1650	4399	4641	4165	3360
	S06b	Patient Safety Incidents Per 1000 Beddays	58.56	57.85	59.72	58.92	58.92	54.11	57.27	64.61	58.94	53.22	38.47	68.73	65.54	63.96	57.33	60.13	53.28	64.75
	S07	Number of Patient Safety Incidents - Severe Harm	88	24	9	9	7	5	7	4	10	7	1	6	10	-	21	21	14	10
Patient Falls	AB01	Falls Per 1,000 Beddays	4.48	4.38	4.9	3.73	4.48	5.17	5.61	4.67	3.72	4.46	4.98	3.97	4.37	4.11	4.46	4.66	4.48	4.24
	AB06a	Total Number of Patient Falls Resulting in Harm	27	6	2	2	1	2	3	1	3	3	0	0	2	1	5	7	3	3
Pressure Ulcers Developed in the Trust	DE01	Pressure Ulcers Per 1,000 Beddays	0.295	0.146	0.277	0.816	0.39	0.276	0.527	0.083	0.188	0.194	0.037	0.156	0.115	0.233	0.495	0.272	0.128	0.173
	DE02	Pressure Ulcers - Grade 2	80	15	7	18	8	7	13	2	5	4	1	4	2	4	33	20	9	6
	DE04A	Pressure Ulcers - Grade 3 or 4	10	4	0	3	2	0	1	0	0	1	0	0	1	2	5	1	1	3
Venous Thrombo-embolism (VTE)	N01	Adult Inpatients who Received a VTE Risk Assessment	98.3%	98.3%	98.4%	98.4%	98%	98.3%	98.2%	98%	98.7%	98.5%	98.2%	98.2%	98.2%	-	98.2%	98.3%	98.3%	98.2%
	N02	Percentage of Adult Inpatients who Received Thrombo-prophylaxis	92.6%	93.4%	89.6%	87.8%	92.2%	95.5%	91.4%	88.6%	94.5%	93.4%	93.2%	94.2%	93.1%	-	91.1%	91.9%	93.5%	93.1%
	N04	Number of Hospital Associated VTEs	52	15	3	2	2	6	5	10	4	4	5	0	6	-	10	19	9	6
	N04A	Number of Potentially Avoidable Hospital Associated VTEs	3	0	0	0	0	0	0	1	0	0	0	0	0	-	0	1	0	0
	N04B	Number of Hospital Associated VTEs - Report Not Received To Date	15	13	0	1	0	2	4	2	1	3	4	0	6	-	3	7	7	6
Nutrition Audit	WB10	Fully and Accurately Completed Screening within 24 Hours	91.1%	84.4%	90.4%	-	-	92.1%	-	-	89.9%	-	-	84.4%	-	-	92.1%	89.9%	84.4%	-
Safety	Y01	WHO Surgical Checklist Compliance	99.8%	99.9%	99.8%	99.8%	99.8%	99.8%	99.8%	99.8%	99.9%	99.9%	99.6%	99.9%	99.9%	100%	99.8%	99.8%	99.8%	99.9%
Medicines	WA01	Medication Incidents Resulting in Harm	0.29%	0.37%	0%	0.29%	0.36%	0.8%	0.77%	0%	0%	0%	0.62%	0.43%	0.38%	-	0.46%	0.28%	0.37%	0.38%
	WA03	Non-Purposeful Omitted Doses of the Listed Critical Medication	0.37%	0.31%	0.53%	0.41%	0.2%	0.62%	0%	0.25%	0.42%	0.31%	0.46%	0.3%	0.18%	0.24%	0.39%	0.24%	0.37%	0.21%

APPENDIX 3 – Trust Scorecards

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Monthly Totals Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Quarterly Totals 18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Deteriorating Patient	AR03	National Early Warning Scores (NEWS) Acted Upon	88%	-	90%	93%	96%	87%	83%	91%	85%	-	-	-	-	-	92%	86%	-	-
Out of Hours	TD05	Out of Hours Discharges (8pm-7am)	8.7%	7.8%	9.4%	9.2%	8.7%	8.7%	7.9%	6.4%	7%	8.3%	8.3%	8.3%	6.5%	7.8%	8.9%	7.1%	8.3%	7.1%
Timely Discharges	TD03	Percentage of Patients With Timely Discharge (7am-12Noon)	23.9%	22.6%	24.3%	23.7%	25.1%	23.1%	23%	23.1%	22.8%	22.5%	23.5%	22.1%	23.3%	21.7%	24%	23%	22.7%	22.6%
	TD03D	Number of Patients With Timely Discharge (7am-12Noon)	9815	3782	804	832	926	816	821	718	839	749	805	705	815	708	2574	2378	2259	1523
Staffing Levels	RP01	Staffing Fill Rate - Combined	99.3%	100.2%	98.5%	99.6%	101.1%	99.1%	100.1%	99.9%	99.1%	100.6%	101.6%	100.5%	99.6%	98.5%	99.9%	99.7%	100.9%	99.1%
Clinical Effectiveness																				
Mortality	X04	Summary Hospital Mortality Indicator (SHMI) - National Quarterly Data	105.1	-	105	-	-	104.6	-	-	-	-	-	-	-	-	104.6	-	-	-
	X04A	Summary Hospital Mortality Indicator (SHMI) - National Monthly Data	107.2	106.4	-	-	-	-	106.8	106.9	108	106.4	-	-	-	-	-	107.2	106.4	-
	X02	Hospital Standardised Mortality Ratio (HSMR)	105	91	123.9	97.9	94	101	114.7	108	108.1	83.7	91.1	99.9	-	-	97.8	110.4	91	-
Readmissions	C01	Emergency Readmissions Percentage	3.3%	3.7%	3.17%	3.49%	3.42%	3.15%	2.85%	2.64%	3.15%	3.57%	3.58%	3.85%	3.79%	-	3.36%	2.89%	3.67%	3.79%
Fracture Neck of Femur	U02	Fracture Neck of Femur Patients Treated Within 36 Hours	56.3%	51.4%	60%	54.5%	60%	63.2%	37.5%	52.9%	38.1%	56.3%	40.9%	52.4%	50%	61.1%	59.1%	41.9%	49.2%	54.2%
	U03	Fracture Neck of Femur Patients Seeing Orthogeriatrician within 72 Hours	97%	97.2%	90%	95.5%	96%	100%	100%	100%	90.5%	100%	95.5%	100%	93.3%	100%	97%	96.8%	98.3%	95.8%
	U04	Fracture Neck of Femur Patients Achieving Best Practice Tariff	51.3%	51.4%	50%	50%	56%	63.2%	33.3%	52.9%	33.3%	56.3%	40.9%	52.4%	50%	61.1%	56.1%	38.7%	49.2%	54.2%
	U05	Fracture Neck of Femur - Time To Treatment 90th Percentile (Hours)	-	-	63.6	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Stroke Care	O01	Stroke Care: Percentage Receiving Brain Imaging Within 1 Hour	51.1%	47.6%	51.9%	53.8%	51.3%	45.7%	51.1%	48.3%	69.2%	52.8%	44.4%	41%	51.1%	-	50.4%	56.6%	46.1%	51.1%
	O02	Stroke Care: Percentage Spending 90%+ Time On Stroke Unit	84.2%	78.9%	92.6%	66.7%	92.3%	85.7%	80%	100%	82.1%	72.2%	85.2%	74.4%	84.4%	-	81.4%	85.8%	76.5%	84.4%
	O03	High Risk TIA Patients Starting Treatment Within 24 Hours	58.6%	60%	46.7%	55.6%	73.3%	50%	50%	84.6%	90%	69.2%	43.8%	28.6%	92.9%	50%	63.3%	75.5%	50%	75%
Dementia	AC01	Dementia - FAIR Question 1 - Case Finding Applied	83%	86.3%	79.8%	79%	89%	86.8%	88.2%	86.4%	81.5%	84.2%	87.6%	85.8%	85.8%	88.3%	84.7%	85.4%	85.8%	87%
	AC02	Dementia - FAIR Question 2 - Appropriately Assessed	94.3%	91%	91.2%	93.6%	92.6%	89.1%	98%	95.9%	100%	94.1%	95.8%	85.2%	94.6%	76.9%	91.8%	97.9%	92.9%	87.3%
	AC03	Dementia - FAIR Question 3 - Referred for Follow Up	85.7%	86.7%	100%	100%	100%	100%	100%	50%	71.4%	83.3%	66.7%	100%	100%	100%	100%	75%	81.8%	100%
Outliers	J05	Ward Outliers - Beddays Spent Outlying	7708	3181	697	492	649	716	702	559	567	704	782	503	645	547	1857	1828	1989	1192
Patient Experience																				
Monthly Patient Surveys	P01d	Patient Survey - Patient Experience Tracker Score	-	-	92	92	91	93	90	91	91	91	91	93	92	92	92	91	91	92
	P01g	Patient Survey - Kindness and Understanding	-	-	97	96	95	96	96	96	95	97	95	96	96	97	96	96	96	97
	P01h	Patient Survey - Outpatient Tracker Score	-	-	89	90	89	90	91	89	90	91	91	89	90	90	90	90	90	90
Friends and Family Test Coverage	P03a	Friends and Family Test Inpatient Coverage	35.1%	37.8%	29.1%	36.5%	27.8%	38.7%	32.2%	40.5%	34.6%	36.3%	42.4%	34.4%	39.4%	36.2%	34.1%	35.5%	37.7%	37.8%
	P03b	Friends and Family Test ED Coverage	16%	17.2%	17%	16.9%	14.6%	13.6%	16%	15.2%	11.6%	13.8%	18.1%	18.7%	17.4%	18.2%	15.1%	14.2%	16.8%	17.8%
	P03c	Friends and Family Test MAT Coverage	18.3%	28.9%	23.1%	31.4%	19.2%	14.1%	20.2%	23%	20.6%	28.5%	30.4%	24.1%	30.1%	31.6%	21.6%	21.2%	27.7%	30.8%
Friends and Family Test Score	P04a	Friends and Family Test Score - Inpatients	98.2%	98.6%	98.1%	98.4%	98.6%	98.5%	98.7%	98.4%	98.4%	98.4%	98.3%	98.3%	98.9%	98.8%	98.5%	98.5%	98.4%	98.9%
	P04b	Friends and Family Test Score - ED	82.1%	82.9%	83.4%	85.2%	84%	82.6%	81.1%	80.4%	75.4%	76.7%	83.8%	84.2%	82.9%	85.2%	84.1%	79.2%	82%	84.1%
	P04c	Friends and Family Test Score - Maternity	97.3%	97.2%	95.9%	97.2%	97.3%	99%	98.5%	98.7%	97.5%	96.7%	97.7%	97.6%	96.9%	97.2%	97.6%	98.3%	97.4%	97.1%
Patient Complaints	T01	Number of Patient Complaints	1845	804	152	169	193	101	167	155	171	184	161	166	168	125	463	493	511	293
	T03a	Formal Complaints Responded To Within Trust Timeframe	86.1%	92.6%	86.3%	85.1%	86.9%	90.9%	87.5%	78.3%	90.6%	93.2%	97.2%	95.9%	90.4%	85.4%	87.1%	85.2%	95.5%	88.5%
	T03b	Formal Complaints Responded To Within Divisional Timeframe	85.5%	94.8%	82.2%	90.5%	84.8%	88.6%	87.5%	85%	92.5%	93.2%	98.6%	98%	91.6%	93.8%	87.6%	88.2%	96.6%	92.4%
	T05A	Informal Complaints Responded To Within Trust Timeframe	83.7%	88.1%	86.8%	73.6%	84.2%	81.5%	80%	89.9%	81.7%	90.6%	86.9%	89.8%	85.7%	87.9%	80.1%	84%	89%	86.5%
	T04c	Percentage of Responses where Complainant is Dissatisfied	9.11%	9.5%	9.59%	6.76%	10.1%	4.54%	8.93%	5%	15.09%	11.86%	8.45%	8.16%	-	-	7.83%	9.47%	9.5%	-

RESPONSIVE

			Annual		Monthly Totals												Quarterly Totals			
Topic	ID	Title	18/19	19/20 YTD	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Referral to Treatment (RTT) Performance	A03	Referral To Treatment Ongoing Pathways Under 18 Weeks	-	-	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%	89%	88.1%	87.5%	86.5%	84.3%	-	-	-	-
	A03a	Referral To Treatment Number of Ongoing Pathways Over 18 Weeks	-	-	3354	3000	2810	2975	2915	3100	3081	3161	3578	3874	4436	5216	-	-	-	-
Referral to Treatment (RTT) Wait Times	A06	Referral To Treatment Ongoing Pathways Over 52 Weeks	144	54	10	9	14	7	16	21	13	14	11	11	9	9	30	50	36	18
	A07	Referral To Treatment Ongoing Pathways 40+ Weeks	-	-	113	113	111	139	147	161	119	115	136	128	152	211	-	-	-	-
Cancer (2 Week Wait)	E01a	Cancer - Urgent Referrals Seen In Under 2 Weeks	95.3%	94.6%	96.4%	95.7%	95.8%	96.6%	95.2%	94.9%	94.4%	93.4%	94%	95.9%	95.2%	-	96%	94.8%	94.4%	95.2%
	E01c	Cancer - Urgent Referrals Stretch Target	56.5%	44.8%	68.8%	57%	62.8%	54.2%	63.7%	46.5%	49%	43.8%	45.6%	54.7%	35.2%	-	58%	52.7%	47.9%	35.2%
Cancer (31 Day)	E02a	Cancer - 31 Day Diagnosis To Treatment (First Treatments)	97.2%	95.5%	99.1%	98.8%	98.5%	98.6%	97%	96.5%	98.3%	95.4%	94.1%	95.1%	97.1%	-	98.6%	97.2%	94.9%	97.1%
	E02b	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Drug)	98.4%	98.6%	99.1%	99.4%	97.2%	99%	99.2%	99.1%	100%	98.4%	97.9%	99.1%	99%	-	98.6%	99.5%	98.5%	99%
	E02c	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Surgery)	96.1%	91.6%	98.1%	100%	98.3%	96.2%	95%	96.3%	97.6%	95.9%	90.9%	89.7%	90.4%	-	98.2%	96.2%	92.1%	90.4%
	E02d	Cancer - 31 Day Diagnosis To Treatment (Subsequent - Radiotherapy)	95.8%	93.2%	95.6%	97.6%	98.1%	98.2%	95.7%	98%	94.1%	96.4%	89.6%	91.8%	94.4%	-	97.9%	96%	92.7%	94.4%
Cancer (62 Day)	E03a	Cancer 62 Day Referral To Treatment (Urgent GP Referral)	85.6%	86%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%	86.8%	86%	84%	86.8%	-	86.6%	83.8%	85.7%	86.8%
	E03b	Cancer 62 Day Referral To Treatment (Screenings)	66.7%	77.1%	100%	100%	100%	90%	35.7%	75%	66.7%	71.4%	100%	83.3%	66.7%	-	96%	47.6%	82.6%	66.7%
	E03c	Cancer 62 Day Referral To Treatment (Upgrades)	83.7%	88.6%	86.8%	85.6%	91.3%	88.5%	86.8%	74.7%	91.8%	95%	89.6%	83.5%	85.7%	-	88.4%	84.6%	89.7%	85.7%
	E03f	Cancer Urgent GP Referrals - Numbers Treated after Day 103	54	14.5	4	7.5	3.5	4	4	3	7	3.5	3.5	3	4.5	-	15	14	10	4.5
Cancelled Operations	F01	Last Minute Cancelled Operations - Percentage of Admissions	1.31%	1.54%	1.39%	0.97%	1.94%	1%	1.31%	1.68%	1.66%	1.63%	1.53%	1.84%	1.25%	1.49%	1.31%	1.54%	1.67%	1.36%
	F01a	Number of Last Minute Cancelled Operations	1059	508	89	71	138	61	94	109	115	108	100	117	88	95	270	318	325	183
	F02	Cancelled Operations Re-admitted Within 28 Days	93.4%	89.6%	94.4%	91%	94.4%	93.5%	93.4%	93.6%	96.3%	85.2%	85.2%	92%	93.2%	93.2%	93%	94.7%	87.3%	93.2%
Admissions Cancelled Day Before	F07	Percentage of Admissions Cancelled Day Before	1.67%	1.8%	2.05%	1.82%	1.91%	1.37%	1.75%	2.17%	0.85%	1.65%	2.39%	1.62%	1.81%	1.54%	1.72%	1.58%	1.89%	1.68%
	F07a	Number of Admissions Cancelled Day Before	1348	594	131	134	136	83	126	141	59	109	156	103	128	98	353	326	368	226
Primary PCI	H02	Primary PCI - 150 Minutes Call to Balloon Time	73.2%	71%	72%	69%	71.1%	62.5%	71.4%	76.7%	65.2%	83.9%	61.8%	68.6%	-	-	67.5%	70.3%	71%	-
	H03a	Primary PCI - 90 Minutes Door to Balloon Time	91.9%	90%	96%	92.9%	89.5%	90%	88.6%	93.3%	87%	96.8%	88.2%	85.7%	-	-	90.8%	89.2%	90%	-
Diagnostic Waits	A05	Diagnostics 6 Week Wait (15 Key Tests)	-	-	98.13%	98.36%	96.94%	93.81%	93.28%	96.93%	95.5%	95.27%	93.41%	93.54%	96.19%	95.26%	-	-	-	-
Outpatients	R03	Outpatient Hospital Cancellation Rate	10.1%	10.8%	10.1%	9.9%	9.8%	10.4%	10.2%	11.6%	11.2%	11.3%	10.4%	10.1%	11.1%	11.2%	10%	11%	10.6%	11.2%
	R05	Outpatient DNA Rate	6.8%	6.7%	7%	6.7%	6.5%	6.9%	6.8%	6.7%	6.6%	6.7%	7.1%	6.8%	6.4%	6.5%	6.7%	6.7%	6.9%	6.4%
Outpatient Ratio	R01	Follow-Up To New Ratio	2.12	2.15	2.13	2.14	2.17	2.14	2.2	2.25	2.13	2.09	2.1	2.21	2.12	2.25	2.15	2.19	2.13	2.18
ERS	BC01	ERS - Available Slot Issues Percentage	16.5%	16.2%	15.5%	10.9%	13.8%	13.5%	12.5%	16.8%	17.3%	13.9%	16.9%	15.8%	17.9%	-	12.6%	15.5%	15.5%	17.9%

Topic	ID	Title	Annual 18/19	Annual 19/20 YTD	Monthly Totals Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Quarterly Totals 18/19 Q3	18/19 Q4	19/20 Q1	19/20 Q2
Delayed Discharges	Q01A	Acute Delayed Transfers of Care - Patients	216	123	16	18	10	26	20	13	20	22	23	27	19	32	54	53	72	51
	Q02A	Non-Acute Delayed Transfers of Care - Patients	80	48	8	5	4	11	4	10	4	8	11	12	9	8	20	18	31	17
	Q01B	Acute Delayed Transfers of Care - Beddays	6744	3027	513	691	482	568	653	550	519	609	607	625	532	654	1741	1722	1841	1186
	Q02B	Non-Acute Delayed Transfers of Care - Beddays	2590	1216	321	250	191	243	138	161	198	223	302	243	203	165	684	497	768	448
Green To Go List	AQ06A	Green To Go List - Number of Patients (Acute)	-	-	55	39	47	51	48	65	62	53	56	61	48	75	-	-	-	-
	AQ06B	Green To Go List - Number of Patients (Non Acute)	-	-	24	21	14	26	7	30	19	26	25	27	31	23	-	-	-	-
	AQ07A	Green To Go List - Beddays (Acute)	-	-	1562	1608	1620	1693	1814	1894	1962	1882	2435	1916	1986	2402	-	-	-	-
	AQ07B	Green To Go List - Beddays (Non-Acute)	-	-	753	681	580	616	463	631	819	759	842	830	877	659	-	-	-	-
Length of Stay	J03	Average Length of Stay (Spell)	3.79	3.81	3.52	3.87	3.62	3.76	3.83	3.74	3.78	4.05	3.73	3.61	3.83	3.82	3.75	3.79	3.8	3.83
	J04D	Percentage Length of Stay 14+ Days	6.3%	6.6%	5.8%	6.9%	6%	6%	6.6%	6.4%	6.4%	7.2%	6.5%	6%	6.6%	6.6%	6.3%	6.5%	6.6%	6.6%
14 Day LOS Patients	C07	Number of 14+ Day Length of Stay Patients at Month End	-	-	233	224	212	200	221	234	222	247	256	262	238	274	-	-	-	-
AMU	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.7%	0%	3.4%	4.1%	3.7%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	4.4%	5.3%	3.6%	5.2%	4.7%	4.8%
	J35A	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	32.4%	-	23.3%	45.9%	52.9%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	40%	45.2%	41.6%	32.6%	25.2%	42.9%

Emergency Department Indicators

ED - Time In Department	B01	ED Total Time in Department - Under 4 Hours	86.34%	80.82%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	81.86%	84.78%	85.53%	82.27%	79.2%	83.27%
	This is measured against the national standard of 95%																			
ED - Time In Department (Differentials)	BB14	ED Total Time in Department - Under 4 Hours (STP)	86.34%	80.82%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%	78.25%	77.95%	81.48%	81.86%	84.78%	85.53%	82.27%	79.2%	83.27%
	BB07	BRI ED - Percentage Within 4 Hours	78.39%	67.98%	75.44%	81.79%	78.89%	73.49%	74.67%	69.23%	70.33%	63.57%	63.86%	68.78%	68.95%	74.81%	78.07%	71.46%	65.38%	71.82%
	BB03	BCH ED - Percentage Within 4 Hours	93.05%	93.12%	94.16%	95.05%	85.39%	91.02%	92.92%	90.46%	89.39%	91.96%	90.38%	93.61%	94.02%	95.3%	90.38%	90.9%	91.96%	95.04%
	BB04	BEH ED - Percentage Within 4 Hours	97.38%	97.7%	97.46%	98.67%	97.34%	97.12%	97.7%	98.02%	97.07%	96.1%	98.39%	97.55%	98.16%	98.37%	97.76%	97.58%	97.32%	98.26%
	This is measured against the trajectories created to deliver the Sustainability and Transformation Fund targets																			
Trolley Waits	B06	ED 12 Hour Trolley Waits	1	0	0	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0
Time to Initial Assessment	B02	ED Time to Initial Assessment - Under 15 Minutes	95.6%	97.7%	96.2%	95.4%	93.4%	92.1%	97.7%	97.9%	96.5%	96.8%	97%	98.3%	98%	98.4%	93.6%	97.3%	97.4%	98.2%
	B02b	ED Time to Initial Assessment - Data Completness	97.2%	97.7%	97.3%	97.2%	97.6%	95.2%	96.5%	97.4%	99%	97.6%	98.4%	98%	98.3%	96.1%	96.6%	97.6%	98%	97.2%
Time to Start of Treatment	B03	ED Time to Start of Treatment - Under 60 Minutes	49.3%	49.8%	48%	53.1%	44.8%	46.9%	48.9%	45.2%	43.9%	46.1%	47.6%	49.9%	50.1%	55.6%	48.3%	46%	47.9%	52.8%
	B03b	ED Time to Start of Treatment - Data Completeness	96.9%	96.5%	96.6%	97.1%	97%	97%	97.5%	96.7%	96.4%	96.6%	96%	96.1%	96.8%	97.2%	97.1%	96.9%	96.2%	96.9%
Others	B04	ED Unplanned Re-attendance Rate	3.3%	3.3%	3.2%	3.9%	4.4%	3.8%	3.2%	3.3%	3.6%	3.5%	3.2%	3.1%	3.4%	3.3%	4%	3.3%	3.3%	3.3%
	B05	ED Left Without Being Seen Rate	1.7%	1.6%	2.2%	2.1%	1.8%	1.6%	1.3%	1.6%	2.1%	1.6%	1.8%	1.6%	1.7%	1.5%	1.8%	1.7%	1.7%	1.6%
Ambulance Handovers	BA09	Ambulance Handovers - Over 30 Minutes	698	299	71	74	65	59	42	57	50	96	87	55	36	25	198	149	238	61
Acute Medical Unit (AMU)	J35	Percentage of Cardiac AMU Wardstays	3.6%	4.7%	0%	3.4%	4.1%	3.7%	4%	6.3%	5.6%	3.6%	3.7%	6.9%	4.4%	5.3%	3.6%	5.2%	4.7%	4.8%
	J35a	Percentage of Cardiac AMU Wardstays Under 24 Hours	36.1%	32.4%	-	23.3%	45.9%	52.9%	55.6%	24.5%	24%	39.3%	18.8%	21.6%	40%	45.2%	41.6%	32.6%	25.2%	42.9%

FINANCIAL MEASURES

Topic	Title	Monthly Totals											
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Year To Date Annual Plan Surplus / (Deficit) £'000	Annual Plan excluding PSF	(416)	302	(389)	2,740	3,171	3,633	6,086	5,489	4,521	4,521	2,622	2,593
	Actual excluding PSF	(416)	(410)	(378)	2,382	1,116	0	0	0	0	0	0	0
	Annual Plan including PSF	117	1,368	1,209	5,030	6,153	7,308	10,773	11,118	10,793	12,402	11,674	12,815
	Actual Plan including PSF	117	656	1,220	4,672	4,808	0	0	0	0	0	0	0
Year to Date Variance Divisional Position Favourable / (Adverse) £'000	Diagnostics & Therapies	(4)	(39)	(56)	(66)	(328)							
	Medicine	(167)	(320)	(502)	(701)	(1,222)							
	Specialised Services	(54)	13	201	82	(173)							
	Surgery	(175)	(659)	(1,168)	(1,867)	(2,760)							
	Women's & Children's	(215)	(311)	(407)	(534)	(1,029)							
	Estates & facilities	(5)	(9)	(13)	(24)	(66)							
	Trust Services	4	3	(33)	17	25							
	Other Corporate Services	42	29	(85)	(37)	(89)							
	Total	**(574)**	**(1,293)**	**(2,063)**	**(3,130)**	**(5,642)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Year To Date Savings Actuals £'000	Diagnostics & Therapies		299	438	543	591							
	Medicine		231	324	426	532							
	Specialised Services		381	555	811	1,060							
	Surgery		572	788	1,063	1,249							
	Women's & Children's		660	941	1,171	1,310							
	Estates & facilities		120	183	232	281							
	Trust Services		134	202	270	341							
	Other Corporate Services		195	292	382	477							
	Total	**0**	**2,591**	**3,723**	**4,898**	**5,841**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In Month Variance Subjective Analysis Favourable / (Adverse) £'000	Nursing & Midwifery Pay	(604)	(491)	(484)	(502)	(274)							
	Medical & Dental Pay	(360)	(187)	(445)	(433)	(381)							
	Other Pay	243	197	109	289	185							
	Non Pay	954	189	356	(108)	460							
	Income from Operations	(173)	(94)	(2)	(18)	(116)							
	Income from Activities	(632)	(336)	(301)	(303)	(2,420)							
	Total	**(572)**	**(722)**	**(767)**	**(1,075)**	**(2,546)**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
In Month Agency Expenditure Actuals £'000	Nursing & Midwifery	684	660	648	626	610							
	Medical												
	Consultants	72	82	92	93	54							
	Other Medical	56	20	85	108	112							
	Other	140	144	131	154	185							
	Total	**952**	**906**	**956**	**981**	**961**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cash £'000	Actual Cash	**110,000**	**109,402**	**100,954**	**119,042**	**127,950**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Capital Spend £'000	Actual Capital Expenditure	**916**	**2,300**	**4,704**	**7,868**	**10,229**							

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Quality and Performance Report**
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/William Oldfield, Medical Director** **Workforce – Matt Joint, Director of People**

1. Report Summary

To review the Trust's performance on Quality, Workforce and Access standards.

2. Key points to note
(Including decisions taken)

Please refer to the Executive Summary in the report.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:
None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **ASSURANCE**
- The Board is asked to **NOTE** the report

5. History of the paper
Please include details of where paper has previously been received.

Quality and Outcomes Committee	26 September 2019
People Committee	26 September 2019

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Care Quality Commission Inspection Report 2019**
Report Author	**Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

The Care Quality Commission (CQC) carried out an unannounced inspection of the Trust's core services between 30th April and 3rd May 2019. This inspection was preceded by a Use of Resources assessment and followed by a Well-led review.

Overall, UH Bristol retained the Outstanding rating previously awarded by the CQC in 2017 following its last inspection of core services in 2016.

2. Key points to note

(Including decisions taken)

Four core services were inspected:

- Maternity
- Surgery
- Services for children and young people
- Urgent and emergency care

The following core services were not inspected on this occasion:

- Medical care
- Critical care
- End of life care
- Outpatients (and diagnostics)

Each core service was assessed against the CQC's five domains of quality:

- Safe
- Effective
- Caring
- Responsive
- Well-led

There were a number of changes to individual ratings for core services and domains of quality, summarised on page 15 of the CQC's report. Overall, UH Bristol retained the Outstanding rating previously awarded by the CQC in 2017 following its last inspection of core services in 2016.

The CQC's report identifies two 'must do' regulatory requirements and 28 'should do' recommendations to improve quality of care (see 'Areas for improvement' on pages 10 and 11). Action plans in response to 'must do' requirements have been submitted to the CQC in accordance with the stipulated deadline of 16th September. Divisions and corporate services have been asked to respond to the various 'should do' recommendations, with an internal deadline of 18th October for submitting draft plans.

3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
Risk to regulatory compliance if appropriate action is not taken to address 'must do' requirements identified by the CQC.
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **INFORMATION** • The Board is asked to **NOTE** the report
5. History of the paper **Please include details of where paper has previously been received.**
None

University Hospitals Bristol NHS Foundation Trust

Inspection report

Marlborough Street
Bristol
BS1 3NU
Tel: 0117 923 0000
www.uhbristol.nhs.uk

Date of inspection visit: 30 April to 3 May 2019
Date of publication: 16/08/2019

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Outstanding ☆
Are services safe?	**Requires improvement** ●
Are services effective?	**Good** ●
Are services caring?	**Outstanding** ☆
Are services responsive?	**Good** ●
Are services well-led?	**Outstanding** ☆

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Summary of findings

Background to the trust

University Hospitals Bristol NHS Foundation Trust was established in June 2008. The trust is based in the centre of Bristol and provides a wide range of acute hospital services as well as some health services in South Bristol.

The trust provides a full range of acute clinical services to three populations. Acute and emergency services are provided to the local population in South and central Bristol. Specialist regional services from Cornwall to Gloucestershire such as children's services, cardiac and cancer services, as well as specialist services across the whole of the South West, South Wales and beyond.

The trust is divided into five clinical divisions: Women's & Children's, Medicine (including adults urgent and emergency care), Surgery, Specialised Services and Diagnostic & Therapies.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Outstanding ☆ ➔➔

What this trust does

University Hospitals Bristol NHS Foundation Trust provides a full range of acute clinical services to three populations and is one of the country's largest acute NHS trusts, with over 11,000 staff delivering over 100 different clinical services.

Services provided include acute and emergency services, specialist regional services such as children's services, cardiac and cancer services and specialist services.

It has four locations registered with Care Quality Commission. There are the University Hospitals Bristol Main Site, Central Health Clinic, South Bristol Community Hospital and Trust Headquarters. The main site comprises:

- Bristol Royal Infirmary
- Bristol Royal Hospital for Children
- Bristol Eye Hospital
- Bristol Dental Hospital
- Bristol Heart Institute
- Bristol Haematology & Oncology Centre
- St Michael's Hospital

The trust also operates two external sites that are classed within CQC as separate registered locations. These are the Central Health Clinic and South Bristol Community Hospital.

The trust provides services to both local and regional clinical commissioning groups and specialised services through NHS England. There are also patients treated on behalf of Welsh Health Boards and Welsh Specialist Commissioners.

The trust has academic and teaching links to the University of Bristol and University of West of England (UWE), and is the major medical research centre in the region and the largest centre for medical training in the South West. It works in partnership with UWE to provide pre and post-registration training for nurses and allied health professionals.

Summary of findings

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

We inspected four core services in April/May 2019, and the 'well led' aspect of the trust in May 2019. The four core services we inspected at University Hospitals Bristol NHS Foundation Trust were, urgent and emergency services, surgery, children and young people and maternity. We also inspected surgical services at South Bristol Community Hospital.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at trust level. Our findings are in the section headed 'Is this organisation well-led?

Prior to our inspection on site, we gathered information and data from the trust, NHS Improvement, and stakeholders (community organisations with an interest in healthcare provided by the trust and the clinical commissioning group). We held focus groups for different staff prior to the core service inspections as part of regular engagement meetings, and during the well-led inspection.

At our last comprehensive inspection of the trust in November 2016 (the report published in March 2017) we rated the trust overall as outstanding, with outstanding ratings for effective and well led. We rated the trust good for caring and safe and requires improvement for responsive.

We considered all the information we held about the trust when deciding which core services to inspect and based our inspection plan on the areas considered to be the highest risk.

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

What we found

Overall trust

Our rating of the trust stayed the same. We rated it as outstanding because:

Effective and responsive at core service level were rated good overall. Safe was rated requires improvement, and caring and well led as outstanding at core service level. The rating for trust management was outstanding. The combined to create an overall trust rating of outstanding.

We rated **well-led** at the trust as outstanding because:

Summary of findings

- The executive team, the trust's non-executive directors and other senior leaders, demonstrated evidence of solid and positive working relationships within the team. All staff we met who were accountable to the executive team supported our view of a leadership team with commitment and integrity who upheld and demonstrated the values of the organisation. There was compassionate, inclusive and effective leadership at all levels of the organisation. Leaders at all levels were visible, approachable and supportive of their patients and staff. Nearly all groups of staff were positive about the strengths of the management team. Safe and high-quality patient care was reflected within all the priorities for the leadership and could be seen throughout trust documents and in the values of the staff.
- There was a clear interconnected vision and strategy for the trust which recognised quality alongside sustainability. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy. The strategy was aligned with local plans for delivery of care in the wider health and social care economy. The trust was active in developing relationships in the community with partners and stakeholders to drive the goal of providing better and more integrated care in Bristol and the surrounding areas.
- The culture of the organisation was centred on people who used services. The values and vision for the trust placed people who used services at University Hospitals Bristol at the centre. The vision and values aimed to improve the quality and availability of services for the population served by the trust.
- There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance. There was an effective and productive governance team at the trust with comprehensive roles and responsibilities. There were good arrangements to ensure the trust executive team discharged their specific powers and duties.
- The trust recognised, acted upon and met its legal obligations to safeguard those people at risk from abuse, neglect or exploitation. The trust had appointed named nurses and doctors for both safeguarding adults and children, but the team worked in a combined way providing a joined-up service to the trust. We were assured that through the competent management of the safeguarding team, the trust worked well to protect those at risk from abuse, despite the particularly challenging demographic of the population it served.
- The trust encouraged openness and honesty at all levels of the organisation in response to serious incidents. Staff at the trust were trained from induction onwards to understand and recognise the duty of candour. Staff we met said they recognised the need to be open and honest with patients and their families and told us this led to learning and better care.
- The risks of the environment and estate were well understood and managed. There was a strong and cohesive team working within the estates and facilities team at the trust. The director of facilities and estates demonstrated a comprehensive understanding of the strengths and challenges of the organisation in relation to the estate and its infrastructure.
- The trust engaged in a variety of ways with the public and local organisations to plan, manage and deliver services. The service was transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them. During our core services inspection we found numerous examples of how feedback from patients and those close to them had shaped the way in which services were delivered. In the work surrounding learning from deaths the scope had been extended to include issues such as dignity for patients who were dying at the trust, in response to feedback from relatives.
- There was a strong culture of reporting incidents to learn and improve. There was a fully embedded and systematic approach to learning from incidents to drive improvements. The trust and its staff understood the importance of learning from incidents and near misses. In all areas we visited during the core service inspection staff demonstrated a clear understanding of the requirement to, and reason for reporting incidents. We heard that feedback was given to those reporting incidents, so they could be assured the issues had been acted upon.

Summary of findings

- There were systems to improve the service and performance which aimed to provide continuous learning and quality improvement. The trust ran several strands of quality improvement (QI) projects including the junior doctors' QI projects. The QI lead at the trust was an emergency medicine consultant who was supported by the executive director of strategy and transformation as the executive lead. QI was seen as everyone's business at the trust, and ideas encouraged.
- There was a clear commitment from the trust to research and development and a recognition that to maintain pace in a changing environment it must be a key stakeholder in the development of research-based clinical improvements in the region, and nationally. Research was embedded within the divisional structure of the organisation, and we saw how it was available to all, and not reserved for specialist services.

However:

- Poor representation from the black and minority ethnic (BME) group in the higher levels of management was seen to represent limitations to development opportunities for this group of staff. Whilst the group spoke highly of the behaviours and attitudes of senior leaders with regards to staff of a BME background, it was also felt that a lack of movement to better represent the diversity of the workforce at a more senior level was a cultural issue borne out of a lack of action in this regard for many years.
- The trust had yet to audit its service against compliance with the requirements of the Accessible Information Standards (AIS) and had not published its policy on the website.
- **Urgent and Emergency services** also known as accident and emergency services or A&E; were rated overall as requires improvement. Caring improved with a rating of outstanding. Responsive remained the same with a rating of requires improvement. Safe dropped from good to requires improvement and effective and well led dropped from outstanding to good. We were not assured the service was always meeting the requirements to provide safe care in all areas. There were limited facilities and systems to care for patients with suspected communicable diseases in the adult emergency department, and the mental health assessment rooms for both adults and children did not meet the required standards for safety. People could not consistently access the service in a timely way and this was a continuing problem since our last inspection. However, the service provided care and treatment based on national guidance and reviewed how effective this was. There was good care provided to patients and the service was well led with a skilled leadership team, effective governance process and a culture of high-quality care.
- **Surgery** maintained an overall rating of outstanding. Caring and well led were rated as outstanding which was the same as our last inspection. Safe and effective were rated as good which was the same as our previous inspection. Responsive improved with a rating of outstanding. The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. There was also a strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. A person-centred culture was at the forefront and staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. The service provided care and treatment based on national guidance and evidence of its effectiveness.
- **Maternity** was rated as good overall with good ratings in effective, caring, responsive and well led. Safe was rated as requires improvement. We had not previously inspected maternity as a stand-alone core service therefore we do not have previous ratings to compare to. Doctors, midwives and other healthcare professionals worked together as a team to benefit patients. The service provided care and treatment based on national guidance and evidence-based practice, and actively participated in NHS England initiatives. Staff cared for patients with compassion and the service planned and provided care in a way that met the needs of local people and the communities served. However, there were issues with the safety of the management of medicines including safe storage, handling and disposal. Also, the environment and equipment within the maternity department were not always maintained.

Summary of findings

- **Children and Young People** was rated as outstanding with safe, caring and responsive rated as good which was the same as our last inspection. Effective maintained the rating of outstanding, with well led improved to a rating of outstanding. Patient risk was well considered and there were clear processes for escalation and support should a patient deteriorate. Patient safety incidents and patient safety performance was monitored, managed and learning identified to make improvements to the service. There was effective care within the children and young person's service and these were monitored. Staff were committed to giving the best care to patients and provided emotional support to those with physical or mental health needs. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The children and young person's leadership team were clear about their roles and understood the challenges for the service. The leadership and culture of the service drove improvement and the delivery of high-quality individual care.
- On this inspection we did not inspect medicine, critical care, outpatients, diagnostic imaging or end of life care. The ratings we gave to these services on previous inspections in 2014 and 2016 are part of the overall rating awarded to the trust this time.
- Our decisions on overall ratings take into account, for example, the relative size of services and we use our professional judgement to reach a fair and balanced rating.
- Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – www.cqc.org.uk/provider/RA7/reports.

Are services safe?

Our rating of safe went down. We rated it as requires improvement because:

In surgery, maternity and urgent and emergency care, the service did not always follow best practice in all areas of prescribing, recording and storing medicines for adults and children. Mandatory training and safeguarding levels did not meet trust targets. Some facilities and equipment in the maternity and urgent and emergency care service were not sufficiently well managed and posed a risk to patients.

However:

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Apart from in the neonatal unit, services had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service managed patient safety incidents well with incidents reported, investigation and learning shared.

Are services effective?

Our rating of effective went down. We rated it as good because:

All services provided care and treatment based on national guidance and reviewed how effective this was. Staff worked together to provide cohesive and multidisciplinary care across the different divisions. The service understood the continuing development of the staff, skills, competence and knowledge was integral to ensuring high quality care. Staff were inducted, trained and given the opportunity to develop.

However:

Not all staff had received an appraisal of their work and this was significantly below the trust target. This had not improved since our previous inspection.

Are services caring?

Our rating of caring improved. We rated it as outstanding because:

Summary of findings

Staff cared for patients with compassion. Feedback from patients was positive. Throughout our inspection we observed patients being treated compassionately and with dignity and respect. In surgery we found care to be outstanding with people reporting that staff went the extra mile and their care and support exceeded their expectations.

Are services responsive?

Our rating of responsive improved. We rated it as good because:

The trust planned and provided services in a way that met the needs of local people and took account of patients' individual needs. In most core services, people could access the service when they needed it. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

In urgent and emergency services, people did not always receive care and treatment in a timely way. This was a continuing problem since our last inspection and patients experience delays to accessing treatment and onward care and waiting times to admit, treat and discharge patients were getting longer and did not all meet national standards.

Are services well-led?

Our rating of well led stayed the same. We rated it as outstanding because:

Managers and leaders in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Leadership teams were well-motivated and understood the challenges of the department and implemented a drive to improvement. The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. There was a systematic approach to continually improve the quality of the services it provided. In surgery we found well led to be outstanding.

However:

In maternity, we found there had been a lack of action to address medicine storage and remedy issues with fixtures and fittings.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, and for the whole trust. They also show the current ratings for services not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also accounted for factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

See the Ratings tables section below for the detail.

Outstanding practice

We found examples of outstanding practice in services for children and young people, urgent and emergency services and surgery.

For more information, see the Outstanding practice section of this report.

Areas for improvement

We found areas for improvement including two breaches of one legal requirement that the trust must put right. We found 30 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

Summary of findings

For more information, see the Areas for improvement section of this report.

Action we have taken

We issued requirement notices to the trust. That meant the trust had to send us a report saying what action it would take to meet these requirements.

Our action related to breaches of legal requirements in maternity and urgent and emergency services. We did not issue any requirements in services for children and young people and surgery.

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Trust-wide well led

- There was a clear interconnected vision and strategy for the trust which recognised quality alongside sustainability. During our inspection, the trust launched its new strategy “Embracing Change, proud to care” which underpinned this mission and took the strategy to 2025. This strategy was stretching, challenging and innovative whilst remaining achievable.
- The approach to learning from deaths was exemplary with a clear focus on areas other than clinical needs such as dignity, end of life care and the experiences of those close to patients. The team had discovered the extra benefits the bereavement team could offer given their proximity to those close to patients who had died. The importance of the soft intelligence they could gain was clearly understood and used to make improvements to the care of patients who were dying and those close to them.

Urgent and emergency care

- An apple juice fountain had been placed within the children’s ED department. Staff within the children’s ED recognised children often did not like the taste of the rehydrating solution needed and so refused a drink used to improve hydration. To improve children’s hydration, staff had investigated alternatives. They found diluted apple juice was not only more popular with children but also provided the required physiological effects needed to improve hydration.

Services for Children and Young People

- Simulation was actively used to ensure processes were safe and effective. A full run through of the abduction process was carried out annually. This included relevant members of staff and the hospital security team. This simulation event was made as real as possible for staff including the hospital being put into a controlled lockdown.
- The transition of children and young people from children’s services to adults' services was a high priority for the service and was seamless. In order to better understand what support children and young people required from a transition service two young people, one who had gone through the transition process and one who was undergoing this process at the time of our inspection, sat on the transition delivery board to support the transition team and drive developments in this area.

Summary of findings

- Staff in the neonatal intensive care unit sent videos of babies to their parents using a secure online service. We were told this was especially supportive over Christmas and Easter. On the neonatal unit one parent told us she was provided with an Easter egg, Valentine's and Mother's Day gifts, recognising and celebrating her role as a parent and individual.
- The endocrine department was recognised as the centre of excellence within the European Reference Network for rare endocrine conditions. Research into boys with Duchenne Muscular Dystrophy, achieved by long term observations and natural history studies, had improved patient outcomes for those who have very few treatment options and have had to travel nationally or internationally to access clinical trials.
- At board level two young governors, who are on the Youth Involvement Group, form part of the Trust's Council of Governors. The Youth Involvement Group ensure young people's views about what happens in the hospital are heard.

Surgery

- There was a strong, visible person-centred culture. A significant amount of positive feedback was displayed on wards. Friends and family test results often included mostly 'extremely likely' to recommend responses, from the recent survey results we saw displayed. We saw staff went out of their way to improve the experience of patients during their stay. For example, we saw staff had arranged for two friends in different specialties to be accommodated so they could share a side room.
- Staff understood the totality of patients' needs, including the need for social interaction and support. On the cardiac surgery ward, nurses had made sure two friends were accommodated in beds close to each other. Staff took the time to interact with patients and those close to them, in a respectful and considerate manner, for example by taking the time to have a cup of tea with a patient who doesn't get many visitors. Staff spoke very positively about the hospital befriending volunteers and of the valuable service they provided to patients.
- Staff were sensitive to the needs of patients, confused or phobic. Nurses in the pre-operative assessment unit were clear about how they would discuss and try to reduce patients' anxieties before an operation. Nurses would prioritise highly anxious patients on the theatre list, so they had a reduced waiting time. Nurses in the surgery assessment unit explained they would use treatment rooms for patients if they became distressed in an open ward area.
- We saw the service planned and provided treatment to meet the needs of local people. Patients with complex needs were well accommodated, and referral to treatment times were steadily improving. Patient flow was well managed.
- We met with the leadership team during the inspection. We found that they were an effective, cohesive team that were aware of their strengths and weaknesses. We saw that each had their own area of expertise and were respectful to each other recognising each person's strengths. All leaders we spoke with, at both ward and divisional level understood and carried out their responsibilities well and had a clear understanding of their own work and the work of others around them.
- Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. It also included the national and local strategic context. The surgical operating plan was developed within the context of the clinical commissioning group's (CCG) five-year sustainability and transformation partnership (STP). This included integrated primary and community care, and acute care collaboration. The surgical divisional priorities were developed and highlighted where they were contributing to the STP or commissioning priorities.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. A surgery wellbeing day was held for staff in

Summary of findings

November 2018, which included art therapy, occupational health, yoga and massages. The directorate also held listening events for nursing assistants, administrative staff and anaesthetists. As well as this there had also been engagement opportunities at the dental hospital. Staff we spoke with enthusiastically told us about charity fundraising, cake sales, bowling nights, as well as the staff recognition yearly awards ceremony.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve

We told the trust that it must take action to bring services into line with one legal requirement. This action related to maternity and urgent and emergency care services.

Urgent and emergency care

- Ensure the service correctly uses systems for the use of patient group directions to ensure medicines are given with the correct legal authority.

Maternity

- Ensure that it complies with the requirements of the regulations relating to the "proper and safe management of medicines". In particular that:

1. staff follow the trust medication policy and procedures in the safe administration, storage and disposal of medicines.
2. the storage room temperature for medicines in the midwife-led unit is within range at all times.
3. staff are competent in the denaturing process for controlled drugs

Action the trust SHOULD take to improve

Trust wide

- Consider strategies to improve the representation of staff from black and minority ethnic groups in senior leadership roles.
- Consider ways in which it engages with business plans and other initiatives put forward by the consultant body.
- Consider a plan to audit its service against compliance with the requirements of the Accessible Information Standard and publish the policy on its website.
- Consider plans to improve compliance with mandatory training within core services where levels fall below trust targets.
- Continue to improve the completion rates of appraisals across the trust.

Urgent and emergency care

- Audit children's safeguarding assessments to ensure they provide assurance of safe and effective care.
- Review the response times with the provider of children's mental health services to look for ways to improve the delays.
- Assess ways it can better manage facilities and systems to care for patients with suspected communicable diseases.

Summary of findings

- Store all chemicals and equipment safely.
- Improve the signage and access by stairs and lifts, so they clearly identify the right route.
- Improve systems and training to help support all receptionists in identifying patients who need to be seen urgently.
- Consider plans to implement a formal process for receptionists to summon help in the event of a patient deteriorating in the waiting room.
- Consider ways to monitor the completion of audit action plans within a reasonable timescale.
- Consider implementing a mental health strategy for both the adult and child emergency department.

Surgery

- Record where pharmacy staff have been consulted on the most appropriate way to administer covert medicines.
- Consider ways it could improve seven-day services to meet the seven-day service standards.
- Consider making patient leaflets available in languages other than English.

Maternity

- Manage and respond to complaints within 30 days, in accordance with their policy and procedure.
- Consider how the service could benefit from the skills of a specialist bereavement midwife.
- Maintain all fixtures and fittings including all hand basins, bathroom showers and toilet facilities.

Services for Children and Young People

- Review how mandatory and safeguarding training compliance is recorded for children and young people service to confirm the accuracy of training compliance reported.
- Review processes and risk assessments for accommodating parents.
- Continue to monitor staffing levels for the neonatal intensive care unit (one to one) and supernumerary team lead role, in line with the British Association of Perinatal Medicine standards.
- Consider a system for recording interventions, care and treatment which is clear to all staff in different specialities, within the children and young people's service.
- Review the process of recording of written venous thromboembolism assessments in records, including whether it is applicable to the child or young person, within the children and young person's service.
- Review the process for recording actions taken in line with the sepsis screening tool, including whether it is applicable to the child or young person, within the children and young person's service.
- Consider ways in which improvements to the environment for the children and young people's recovery area in the eye hospital could be made.
- Follow best practice when recording and storing medicines.

Summary of findings

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

We rated well-led at the trust as outstanding because:

- The executive team, the trust's non-executive directors and other senior leaders, demonstrated evidence of solid and positive working relationships within the team. All staff we met who were accountable to the executive team supported our view of a leadership team with commitment and integrity who upheld and demonstrated the values of the organisation. There was compassionate, inclusive and effective leadership at all levels of the organisation. Leaders at all levels were visible, approachable and supportive of their patients and staff. Nearly all groups of staff were positive about the strengths of the management team. Safe and high-quality patient care was reflected within all the priorities for the leadership and could be seen throughout trust documents and in the values of the staff.
- There was a clear interconnected vision and strategy for the trust which recognised quality alongside sustainability. There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy. The strategy was aligned with local plans for delivery of care in the wider health and social care economy. The trust was active in developing relationships in the community with partners and stakeholders to drive the goal of providing better and more integrated care in Bristol and the surrounding areas.
- The culture of the organisation was centred on people who used services. The values and vision for the trust placed people who used services at University Hospitals Bristol at the centre. The vision and values aimed to improve the quality and availability of services for the population served by the trust.
- There were structures, processes and systems of accountability to operate a governance system designed to monitor the service and provide assurance. There was an effective and productive corporate governance team at the trust with comprehensive roles and responsibilities. There were good arrangements to ensure the trust executive team discharged their specific powers and duties.
- The trust recognised, acted upon and met its legal obligations to safeguard those people at risk from abuse, neglect or exploitation. The trust had appointed named nurses and doctors for both safeguarding adults and children, but the team worked in a combined way providing a joined-up service to the trust. We were assured that through the competent management of the safeguarding team, the trust worked well to protect those at risk from abuse, despite the particularly challenging demographic of the population it served.
- The trust encouraged openness and honesty at all levels of the organisation in response to serious incidents. Staff at the trust were trained from induction onwards to understand and recognise the duty of candour. Staff we met said they recognised the need to be open and honest with patients and their families and told us this led to learning and better care.
- The risks of the environment and estate were well understood and managed. There was a strong and cohesive team working within the estates and facilities team at the trust. The director of facilities and estates demonstrated a comprehensive understanding of the strengths and challenges of the organisation in relation to the estate and its infrastructure.
- The trust engaged in a variety of ways with the public and local organisations to plan, manage and deliver services. The service was transparent, collaborative and open with all relevant stakeholders about performance, to build a

shared understanding of challenges to the system and the needs of the population and to design improvements to meet them. During our core services inspection we found numerous examples of how feedback from patients and those close to them had shaped the way in which services were delivered. In the work surrounding learning from deaths the scope had been extended to include issues such as dignity for patients who were dying at the trust, in response to feedback from relatives.

- There was a strong culture of reporting incidents to learn and improve. There was a fully embedded and systematic approach to learning from incidents to drive improvements. The trust and its staff understood the importance of learning from incidents and near misses. In all areas we visited during the core service inspection staff demonstrated a clear understanding of the requirement to, and reason for reporting incidents. We heard that feedback was given to those reporting incidents, so they could be assured the issues had been acted upon.
- There were systems to improve the service and performance which aimed to provide continuous learning and quality improvement. The trust ran several strands of quality improvement (QI) projects including the junior doctors' QI projects. The QI lead at the trust was an emergency medicine consultant who was supported by the executive director of strategy and transformation as the executive lead. QI was seen as everyone's business at the trust, and ideas encouraged.
- There was a clear commitment from the trust to research and development and a recognition that to maintain pace in a changing environment it must be a key stakeholder in the development of research-based clinical improvements in the region, and nationally. Research was embedded within the divisional structure of the organisation, and we saw how it was available to all, and not reserved for specialist services.

However:

- Poor representation from the black and minority ethnic (BME) group in the higher levels of management was seen to represent limitations to development opportunities for this group of staff. Whilst the group spoke highly of the behaviours and attitudes of senior leaders with regards to staff of a BME background, it was also felt that a lack of movement to better represent the diversity of the workforce at a more senior level was a cultural issue borne out of a lack of action in this regard for many years.
- The trust had yet to audit its service against compliance with the requirements of the Accessible Information Standards (AIS) and had not published its policy on the website.

Use of resources

Please see the separate use of resources report for details of the assessment and the combined rating (www.cqc.org.uk/provider/RA7/Reports).

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding ➔➔ May 2019	Outstanding ➔➔ May 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good ↓ May 2019	Requires improvement ↓ May 2019
Medical Care (including older people's care)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Outstanding ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Services for children and young people	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2017	Outstanding ↑ May 2019	Outstanding ↑ May 2019
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients and diagnostics	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall trust	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

University Hospitals Bristol Main Site

Bristol Royal Infirmary
Upper Maudlin Street
Bristol
BS2 8HW
Tel: 0117 923 0000
www.uhbristol.nhs.uk

Key facts and figures

University Hospitals Bristol NHS Foundation Trust provides a full range of acute clinical services to three populations and is one of the country's largest acute NHS trusts, with over 11,000 staff delivering over 100 different clinical services.

Services provided include acute and emergency services, specialist regional services such as children's services, cardiac and cancer services and specialist services.

It has four locations registered with Care Quality Commission. There are the University Hospitals Bristol Main Site, Central Health Clinic, South Bristol Community Hospital and Trust Headquarters. The main site comprises:

- Bristol Royal Infirmary
- Bristol Royal Hospital for Children
- Bristol Eye Hospital
- Bristol Dental Hospital
- Bristol Heart Institute
- Bristol Haematology & Oncology Centre
- St Michael's Hospital

The trust also operates two external sites that are classed within CQC as separate registered locations. These are the Central Health Clinic and South Bristol Community Hospital.

The trust provides services to both local and regional clinical commissioning groups and specialised services through NHS England. There are also patients treated on behalf of Welsh Health Boards and Welsh Specialist Commissioners.

The trust has academic and teaching links to the University of Bristol and University of West of England (UWE), and is the major medical research centre in the region and the largest centre for medical training in the South West. It works in partnership with UWE to provide pre and post-registration training for nurses and allied health professionals.

Summary of findings

Summary of services at University Hospitals Bristol Main Site

Outstanding ☆ ➔➔

Our rating of the trust stayed the same. We rated them as outstanding because:

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Apart from in the neonatal unit, services had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The service managed patient safety incidents well with incidents reported, investigation and learning shared.

All services provided care and treatment based on national guidance and reviewed how effective this was. Staff worked together to provide cohesive and multidisciplinary care across the different divisions. The service understood the continuing development of the staff, skills, competence and knowledge was integral to ensuring high quality care. Staff were inducted, trained and given the opportunity to develop.

Staff cared for patients with compassion. Feedback from patients was positive. Throughout our inspection we observed patients being treated compassionately and with dignity and respect. In surgery we found care to be outstanding with people reporting that staff went the extra mile and their care and support exceeded their expectations.

The trust planned and provided services in a way that met the needs of local people and took account of patients' individual needs. In most core services, people could access the service when they needed it. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Managers and leaders in the trust had the right skills and abilities to run a service providing high-quality sustainable care. Leadership teams were well-motivated and understood the challenges of the department and implemented a drive to improvement. The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. There was a systematic approach to continually improve the quality of the services it provided. In surgery we found well led to be outstanding.

However:

In surgery, maternity and urgent and emergency care, the service did not always follow best practice in all areas of prescribing, recording and storing medicines for adults and children. Mandatory training and safeguarding levels did not meet trust targets. Some facilities and equipment in the maternity and urgent and emergency care service were not sufficiently well managed and posed a risk to patients.

Not all staff had received an appraisal of their work and this was below the trust target.

In urgent and emergency services, people did not always receive care and treatment in a timely way. This was a continuing problem since our last inspection and patients experience delays to accessing treatment and onward care and waiting times to admit, treat and discharge patients were getting longer and did not all meet national standards.

In maternity, we found there had been a lack of action to address medicine storage and remedy issues with fixtures and fittings.

Urgent and emergency services

Requires improvement  

Key facts and figures

The trust has three emergency departments that fall into the urgent and emergency core service category:

The adult emergency department (ED) is a 24 hour, seven day service located on level three of the Bristol Royal Infirmary and is managed by the division of medicine. The emergency department is a designated trauma unit. The department consists of six resus bays, 11 majors' bays, an eight-bedded observation unit and nine treatment rooms in the fast flow/minors' area. All admissions or referrals of young people aged 16 and above are managed through the adult emergency department in line with trust policy.

The children's emergency department (CED) is a 24 hour, seven day service located on level three of the Bristol Royal Hospital for Children and is managed by the women's and children's division. The department consists of three triage rooms, a five-bay resuscitation room (three trolleys and two baby resuscitaires), and 12 fully equipped cubicles. The eight bedded observation ward adjacent to the CED is managed clinically and administratively by the department.

The children's emergency department in the Bristol Royal Hospital for Children is the biggest emergency department specifically for children in the South West of England. It is the designated regional paediatric major trauma centre seeing severely injured children from across the South West. All patients under the age of 16 years attend this department.

The Bristol Eye Hospital (BEH) emergency department offers a seven day 8.30am to 4.30pm regional service for ophthalmic emergencies. It is located on the ground floor of the BEH and is managed by the division of surgery. The department consists of doctors, optometrists, nurses and administrative staff and has five cubicles and one couch and three consultation rooms. The department sees both adults and children.

The trust had 138,039 ED attendances from August 2017 to July 2018. This was an increase of 4% compared to the previous year. Of these, 45,635 were for children and 35,919 arrived by ambulance. Over the winter period of October 2018 to March 2019, there had been a 4% increase in adult emergency attendances and a 9% increase for children's emergency attendances.

We inspected all key questions; is the service safe, effective, caring, responsive and well-led? Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Our last inspection was in November 2016 when we undertook a comprehensive inspection (reviewing all key questions) and the service was rated good overall. Effective and well led were rated outstanding, safe and caring good and responsive requires improvement. The ratings at this inspection reflect an increase in demand and challenges faced by the emergency departments.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- We rated safe and responsive as requires improvement and effective, and well-led as good. We rated caring as outstanding.
- We were not assured the service was always meeting the requirements to provide safe care in all areas. The service did not follow best practice in all areas of managing medicines including storing and record keeping. There were limited facilities and systems to care for patients with suspected communicable diseases in the adult emergency

department, and the mental health assessment rooms for both adults and children did follow national guidance in all areas. There were delays in accessing the children's mental health services. Some aspects of the environment were not suitably safe, for example, the access for children and the entrance stairs. The assessment and needs of mental health patients were not all met in a timely way. There was training for receptionists and no formal processes for receptionist to urgently access medical care for patients.

- Effective care was rated as good. Audits did not all meet the required standards and the action plans made as a result showed not all had been completed. A further area of improvement needed was the completion of staff yearly appraisal.
- The responsiveness of the service required improvement. People could not consistently access the service in a timely way. This was a continuing problem since our last inspection and while actions had been taken to improve the flow through the department, more was needed to ensure performance was able to meet patient need. There were delays to accessing treatment and onward care, and waiting times to admit, treat and discharge patients were getting longer.
- Well led was rated as good.

However:

- The departments were clean, and equipment well maintained. Patients in the emergency department were managed safely by using observation tools and risk assessments and were cared for by skilled staff. Records of patient care were well maintained, and any incidents reported, and action taken to address them.
- The service provided care and treatment based on national guidance and reviewed how effective this was. Staff worked together to provide cohesive and multidisciplinary care. Staff provided pain relief, food and drink when needed, and understood their responsibilities to ensure consent and mental capacity were used to support patients' choices.
- There was excellent care provided to patients. Staff were committed to giving the best care to patients. The emotional needs of patients and relatives were recognised, and patients felt understood, involved and included.
- The location and demographic of the service showed visibly high levels of patients with complex social and physical conditions including homelessness and drug and alcohol misuse. Staff approached the challenges in a proactive way, looking for ways to support these patients which were individual and considered the patients' circumstances. Staff showed both determination and creativity to overcome obstacles to delivering care and their approach did not show any fatigue.
- Staff took account of patients' needs and planned a service to meet them. Pathways had improved to support patients and staff to manage challenging situations in a positive way. Complaints were handled well.
- The service was well led with a skilled leadership team, effective governance process and a culture of high-quality care. The trust used a systematic approach to continually improve the quality of its services and manage risks.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and was committed to improving services by learning from when things went well and promoting training, research and innovation.

Is the service safe?

Requires improvement 

Our rating of safe went down. We rated it as requires improvement because:

Urgent and emergency services

- The adult and children's emergency departments did not follow best practice in all areas of prescribing, recording and storing medicines for adults and children. The systems in place did not ensure patient safety.
- The service provided mandatory training in key skills to staff although not everyone had completed their required updates. For nursing and medical staff, the 90% target was not met.
- In all three departments, mental health training for adults and children was not included in the mandatory training agenda.
- Not all staff had received updated safeguarding training. The trust set a target of 90% for completion of safeguarding training, this had not been met. There were insufficient levels of staff with safeguarding level three training.
- There were limited facilities and systems to care for patients with suspected communicable diseases in the adult emergency department. The systems available were not sufficiently well managed.
- The adult emergency department had a dedicated mental health assessment room although the design of the environment did not follow national guidance in all areas. Patients at risk and in need of mental health support, were supported although not always in a timely way. There were delays in accessing the children's' mental health service.
- The initial access for those patients, both adults and children arriving independently, was not clear. Access was by either stairs and lifts and signage did not clearly identify the right route. This meant patients may take the stairs and be delayed or at risk. Monitoring of the stairs was not consistently maintained to ensure patients were not delayed there. The environment used for children to access the emergency department out of hours was a risk to safety.
- There were limited systems in the adult emergency department to help support receptionists in identifying patients who needed to be seen urgently.
- Equipment was not always stored safely in the children's emergency department.

However:

- In all three emergency departments, staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The trust had systems and processes to ensure standards of cleanliness and hygiene were maintained. All three departments were visibly clean.
- In all three emergency departments, staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Patients in the emergency department were managed safely by using observation tools and risk assessments.
- The service had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- In all three departments, staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Good 

Urgent and emergency services

Our rating of effective went down. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff supported patients with nutrition and hydration while in all three emergency departments.
- Staff assessed and monitored patients in all three departments regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- Staff of different disciplines worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- In the adult and children's departments there were the right services available 24 hours a day with enough access to support patient care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They followed the trust policy and procedures when a patient could not give consent. They knew how to support patients experiencing mental ill health and those who lacked the mental capacity to make decisions about their care.

However:

- Adult and children's audits had not recorded action plans as completed within a reasonable timescale.
- In all three departments not all staff had received an appraisal of their work and this was significantly below the trust target. This had not improved since our previous inspection.

Is the service caring?

Outstanding ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- All staff in all departments, staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness. Patients told us they had been treated with dignity and respect by all staff, always. Patients felt staff often went above and beyond to give the care they needed.
- Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided emotional support to patients to minimise their distress. Emotional support was provided by all staff to patients and relatives. We saw staff sitting with patients and families providing explanations, listening and supporting patients and relatives. When patients were visibly distressed we saw staff take time to reassure and support them.
- Staff involved patients and those close to them in decisions about their care and treatment. Patients and relatives were given opportunities to ask questions and staff gave them time to do this. Relatives and carers were given timely support and a space to have discussions.
- We saw all staff engaged in such a way that patients felt at ease and felt able to ask questions and be part of their plan of care. We particularly saw the medical staff were exceptional in sitting with patients to explain treatment plans and taking time to answer questions and making sure patients understood the next stages of their care.

Urgent and emergency services

- The location and demographic of the service showed visibly high levels of patients with complex social and physical conditions including homelessness and drug and alcohol misuse. Staff approached the challenges in a proactive way, looking for ways to support these patients which were individual and considered the patients circumstances. Staff showed both determination and creativity to overcome obstacles to delivering care and their approach did not show any fatigue.

However:

- Premises and facilities did not fully meet people's needs. In the adult emergency department, corridor areas A, B and C had no means to ensure patients' privacy and dignity.

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People did not always receive care and treatment in a timely way. This was a continuing problem since our last inspection and while actions had been taken to improve the flow through the adult department, more was needed to ensure performance met patient need. There were delays to accessing treatment and onward care and waiting times to admit, treat and discharge patients were getting longer and did not all meet national standards. We looked at what caused the delays for patients and saw multiple causes influenced the delays, some were beyond the departments' control.

However:

- The trust planned and provided services in a way that met the needs of local people. Escalation procedures were responsive when the department experienced capacity issues.
- The service took account of patients' individual needs. Since our last inspection changes had been made to the environment in the adult and children's emergency departments to support patients' different needs.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Good 

Our rating of well-led went down. We rated it as good because:

- The emergency departments had a proactive, well-motivated leadership team. The leadership team understood the challenges of the department and implemented a drive to improvement. Staff of all levels told us their strongest attribute was the supportive team working and good leadership.
- There was a clear leadership direction to meet the needs of the patients in a creative, cohesive and pragmatic way.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff. A vision and strategy had been produced for the emergency departments.

Urgent and emergency services

- Managers across the trust promoted a positive culture which supported and valued staff, creating a sense of common purpose based on shared values. Many staff told us these were the best emergency departments they had worked in and put this down to the positive culture and teamwork, all staff we spoke with told us the team supported each other.
- The trust used a systematic approach to continually improve the quality of its services. There was a governance framework focused on supporting the delivery of safe, quality care. There were clear reporting structures between the department and the board.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Risk registers were used in each department, at divisional and trust level to review and monitor risk.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Information needed to deliver effective care and treatment was well organised and accessible.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation. Staff considered there had been real change in the last 12 months which had a positive impact on the department.

Outstanding practice

We found areas of outstanding practice in this service. See outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Surgery

Outstanding ☆ ➔➔

Key facts and figures

Surgery is delivered from five main locations: the Bristol Royal Infirmary (BRI), Bristol Dental Hospital (BDH), Bristol Eye Hospital (BEH), St. Michael's Hospital (StMH) and South Bristol Community Hospital (SBCH).

Adult theatres and recovery are based in the BRI and managed by the division of Surgery. There are 10 theatres in total and nine recovery beds in Heygroves theatres.

The Queen's Day Unit (QDU) in the BRI contains two day theatres and a four-bedded recovery area. The following specialities operate in Heygroves theatres and QDU, all of which are managed by the Division of Surgery:

- General surgery (upper GI, lower GI and hepatobiliary surgery)
- Trauma
- Cardiac surgery
- Thoracic surgery
- Oral and maxilla facial surgery (OMFS)
- Ear, nose and throat surgery
- Confidential enquiry into patient outcome and death (CEPOD)
- Limb reconstruction

The BEH has 11 inpatient surgical beds on H304 and between H303 and H402. There are four BEH theatres and a three-bedded recovery area.

The BDH has three recovery bays in the dental day unit and one theatre.

StMH has five theatres in total. Two theatres are dedicated to obstetrics. The other three theatres are attributed to Gynae, ENT, upper GI, OMFS (special care dentistry). These theatres are supported with an eight-bedded recovery. The St. Michael's Hospital surgery day case unit has 12 trolleys and two side rooms. The theatres provide a mixture of day and inpatient activity through ward 78..

SBCH has two day case theatres and a recovery area attributed to orthopaedics, upper GI, dental surgery, gynaecology, pain, cardioversions, lower GI, ocularplastics and dermatology. There are two endoscopy rooms on this site providing diagnostic endoscopy and supporting the bowel scope programme.

The trust had 27,824 surgical admissions from August 2017 to July 2018. Emergency admissions accounted for 8,618 (31%), 14,846 (53%) were day case, and the remaining 4,360 (16%) were elective.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Summary of this service

Our rating of this service stayed the same. We rated it as outstanding because:

Surgery

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so, and safeguarding incidents were reported and investigated. The service did have enough medical staff with the right qualifications, with vacancies in some specialties. There was safe provision of physiotherapy and occupational therapy for patients following surgery.
- Staff from different professions or departments worked together as a team to benefit patients. All necessary staff, including those in different teams and services, were involved in assessing patients' care and treatment. The patient records showed input from dieticians, physiotherapists and occupational therapists and therapy technicians. Records also showed input from pharmacists, medical teams, and diagnostic and screening services.
- Feedback from people who used the service, those who were close to them and stakeholders was consistently positive about the way staff treated people. People thought that staff go the extra mile and their care and support exceeded their expectations. Staff delivered strong person-centred care, and were genuinely proud of the services they delivered.
- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders were visible and available to staff, and we saw and heard about good support for all members of the team. The matrons and ward sisters were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other.
- Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. It also included the national and local strategic context.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they function and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.

Is the service safe?

Good  

Our rating of safe stayed the same. We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff we spoke with were knowledgeable about the trust's safeguarding policy and processes and were clear about their responsibilities. Staff had access to a safeguarding lead nurse who gave good support. Staff could clearly describe what action they should take if they had concerns regarding the welfare of a patient.
- Safeguarding incidents were reported and investigated. Staff sought advice from safeguarding leads and information was provided on the intranet site for staff to refer to. Staff we spoke with told us they were encouraged to and did report any potential safeguarding concerns. These were investigated by either a senior nurse or a safeguarding lead. Staff told us they always received feedback on concerns they had raised.
- The service controlled infection risk well. Patients we spoke to on the wards said their environment was regularly cleaned and they felt physically safe on the ward. There were arrangements for cleaning surgical wards and theatres. There were daily schedules and weekly tasks, alongside deep cleaning as and when required. We saw that all clinical areas were audited monthly, and a report provided to the division. Incidents and action plans were acted on.

Surgery

- Good infection control practice was observed being followed by staff. All staff were seen to be following the trust dress code, for example in appropriate theatre clothing and bare below the elbow.
- The service had suitable premises and equipment and looked after them well. During the inspection we visited six different surgical wards, looked at the environment on each of them and randomly sampled the equipment in use on those wards. We saw that store rooms were tidy, well-ordered and well stocked. Dirty utility rooms were clean and substances hazardous to health were well managed.
- Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary. Risk assessments relating to patients' needs were completed and evaluated. Patients for elective surgery attended a pre-operative assessment consultation prior to their operation in line with national guidance.
- There was clear escalation of a deteriorating patient. There were processes and policies used to monitor, assess, identify and respond to patient risks. Staff were trained in the diagnosis of sepsis and recognition of a deteriorating patient.
- The service did have enough nursing staff and were managing staffing gaps to ensure people were safe from avoidable harm, and to provide the right care and treatment. At the time of our inspection staffing levels and skill mix were at an appropriate level to ensure patients received safe care and treatment at all times.
- The service did have enough medical staff with the right qualifications, with vacancies in some specialties. However, there was adequate medical staffing levels on the wards to safely meet the needs of patients.
- There was safe provision of physiotherapy and occupational therapy for patients following surgery. There was joint working between physiotherapy and occupational therapy giving comprehensive assessments of mobility and independence and medical fitness for discharge.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and generally available to all staff providing care. Staff told us there was a mixed system of record keeping which included paper records, and an electronic system to observe patients.
- Wards had good clinical pharmacy support and we saw that medicines reconciliation wascompleted and prescription charts were verified by pharmacist. There were appropriate arrangements for the recording of medicines administration and prescription charts showed medicines were being given as directed.
- The service managed patient safety incidents well. We found a strong learning from incidents culture. Staff recognised incidents and reported them appropriately. Managers were responsible for investigating incidents and sharing the learning. When things went wrong, staff apologised and gave patients honest information and suitable support.

However:

- The service provided mandatory training in key skills, however not all staff were fully compliant with their training, particularly medical staff.

Is the service effective?

Good ➔➔

Our rating of effective stayed the same. We rated it as good because:

Surgery

- The service provided care and treatment based on national guidance and evidence of its effectiveness. They continually reviewed guidance to help improve services. We found information about the outcomes of patients' care and treatment wasroutinely collected and monitored. The surgical division participated in a number of clinical audits based on national and local guidance. Some of these were joint audits across the hospital site.
- Staff gave patients enough food and drink to meet their needs and improve their health. Special feeding and hydration techniques were used when necessary. Food and hydration charts were used and completed.
- Staff assessed and monitored patients regularly to see if they were in pain. Patients' pain was managed effectively for patients who had the capacity to communicate effectively. Staff supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.
- The service made sure staff were competent for their roles. Staff had the right qualifications, skills, knowledge and experience to do their job when they started employment, took on new responsibilities, and these were reviewed on a continual basis.
- The service used volunteers well and trained them appropriately. Volunteers supported on surgical wards with feeding patients and befriending. Volunteers were encouraged to make a better environment for patients, help to ensure a relaxed atmosphere and assist people who required help with eating and drinking.
- Staff from different professions or departments worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. All necessary staff, including those in different teams and services, were involved in assessing patients' care and treatment. The patient records showed input from dieticians, physiotherapists and occupational therapists and therapy technicians. Records also showed input from pharmacists, medical teams, and diagnostic and screening services.
- There were established links with mental health specialists, such as the learning disability team and the falls and dementia team within the Trust accompanied staff on their morning ward round if they had identified that a patient required specialist mental health support during their stay.
- Health promotion was a routine part of all care provided to patients. All staff worked collaboratively to assess all aspects of general health and to give support and advice to promote healthy lifestyles.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. We spoke to nursing and medical staff who showed a good knowledge of consent, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS) and knew how to access advice if required.

However:

- The surgical division did not meet the seven-day service standards. Physiotherapists were available Monday to Saturday 8am to 4.30pm and covered the fractured neck of femur service for patients over 60 and one day postoperatively on a Sunday. Speech and language therapists, dietetics, podiatry and occupational therapists were available Monday to Friday 8am to 5pm.

Is the service caring?

Outstanding ☆ ➔➔

Our rating of caring stayed the same. We rated it as outstanding because:

- Feedback from people who used the service, those who were close to them and stakeholders was consistently positive about the way staff treated people. People thought that staff go the extra mile and their care and support

exceeded their expectations. Staff delivered strong person-centred care, and were genuinely proud of the services they delivered. We observed discussions between patients, relatives and clinical staff. We saw that these were planned well and handled sensitively. Any decisions made were then communicated to the wider team providing care to the patient to ensure all were aware of them.

- There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between people who used the service, those close to them and staff were strong, caring, respectful and supportive. These relationships were highly valued by staff and promoted by leaders. A significant amount of positive feedback was displayed on wards. Friends and family test results often included mostly 'extremely likely' to recommend responses. We saw staff went out of their way to improve the experience of patients during their stay.
- There was a strong person-centred culture. All staff we spoke with were highly motivated to deliver care that is kind and promotes people's dignity. Staff understood and respected the personal, cultural, social and religious needs of people using the services.
- Staff understood the totality of patients' needs, including the need for social interaction and support. Staff took the time to interact with patients and those close to them, in a respectful and considerate manner, for example by taking the time to have a cup of tea with a patient who doesn't get many visitors. Staff spoke very positively about the hospital befriending volunteers and of the valuable service they provided to patients.
- Staff provided emotional support to patients to minimise their distress. Staff understood the impact the care, treatment or condition might have on the patient's wellbeing and on those close to them both emotionally and socially.
- Staff involved patients and those close to them in decisions about their care and treatment. We saw staff explaining things to patients in a way they could understand. The patients spoken with felt well informed as to their diagnosis and care plans, they felt their management was being discussed with them as much as possible.

Is the service responsive?

Outstanding ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

- The trust planned and provided services in a way that met the needs of local people. As recognised by staff, the main difficulties facing the trust were the impending reorganisation of services and the uncertainties which implicated on local planning.
- The service took account of patients' individual needs. Patients were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs. Staff understood how to access extra support for patients living with dementia. Staff spoke confidently about the additional support they would give to patients living with dementia including supporting them to orientate themselves, offering company and distraction and involving those close to the patient.
- People could access the service when they needed it. Performance for referral to treatment times was generally 89.3% at the end of December 2018. Although the trust did not meet the national standard of 92%, the trust's own improvement trajectory of 87% was achieved. Cancellation of procedures tended to be due to times of escalation across the hospital which restricted the available bed space post surgery, including cancellation of cancer operations because of a lack of critical care and high dependency beds.

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Staff we spoke with explained they got more positive feedback than complaints. Senior nurses shared feedback from patients and learning from complaints and safety briefing meetings that were held every morning. We saw examples of safety briefs that included information and actions from learning from complaints.

Is the service well-led?

Outstanding ☆ ➔➔

Our rating of well-led stayed the same. We rated it as outstanding because:

- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Comprehensive and successful leadership strategies were in place to ensure and sustain delivery and to develop the desired culture. Leaders had a deep understanding of issues, challenges and priorities in their service, and beyond.
- The local leadership team were very experienced and demonstrated a good understanding of the performance challenges and risks within the surgical services. Leaders were clear about the challenges of critical care capacity and the impact on patients and outcomes.
- Leaders were visible and available to staff, and we heard about good support for all members of the team. The matrons and ward sisters were an experienced and strong team with a commitment to the patients who used the service, and to their staff and each other. We saw matrons and ward sisters were integral in the areas they worked in and highly visible to staff and patients. Nurses in all areas we visited spoke highly of their managers and told us they were available to listen and act upon concerns.
- The surgical division's strategy and supporting objectives and plans were stretching, challenging and innovative, while remaining achievable. Surgery had an operating plan for 2018/19 to 2019/20 which outlines the key divisional challenges, risks and priorities. Strategies and plans were fully aligned with plans in the wider health economy, and there was a demonstrated commitment to system-wide collaboration and leadership. It also included the national and local strategic context. The surgical operating plan was developed within the context of the clinical commissioning group's (CCG) five-year sustainability and transformation partnership (STP). These included integrated primary and community care, and acute care collaboration. The surgical divisional priorities were developed and highlighted where they were contributing to the STP or commissioning priorities.
- Leaders had an inspiring shared purpose and strive to deliver and motivate staff to succeed. There were high levels of satisfaction across all staff. There was a positive culture which supported and valued staff. Staff were positive about working for the trust and told us they were enabled to make improvements.
- Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff at all levels were actively encouraged to speak up and raise concerns, and all policies and procedures positively supported this process.
- There was strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences. Staff we spoke with enthusiastically told us about charity fundraising, cake sales, and bowling nights, as well as the staff recognition yearly awards ceremony.
- Governance arrangements were proactively reviewed and reflected best practice. A systematic approach was taken to working with other organisations to improve care outcomes. A monthly Division of Surgery board meeting took place. We saw these meetings were well attended, including representatives for all clinical sites and all clinical specialities.

Surgery

- There were governance processes and oversight in the surgical division. Staff at all levels were clear about their responsibilities, roles and accountability within the governance framework. There were comprehensive assurance systems and service performance measures which were reported and monitored on a regular basis.
- There was a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviewed how they function and ensured that staff at all levels had the skills and knowledge to use those systems and processes effectively. Problems were identified and addressed quickly and openly.
- The trust had effective systems for identifying risks and had the action summary and actions completed. Risk was identified and managed at a local level, for example in wards, units and theatres and included in the departmental risk register. We saw risk registers where risks were well defined, with mitigating controls in place. Actions were detailed with due dates noted. We noted that actions were reviewed and updated regularly.
- The risks in the service were understood by staff and leaders. Ward staff understood, recognised and reported their risks. The concerns staff raised with us were reflected on the risk registers. Equally, senior managers and leaders in the service understood the concerns and risks raised by their teams and could describe what mitigating actions were in place.
- There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. The surgical division held monthly governance meetings. Detailed quality data and performance information was provided at these meetings. We saw
- Data regarding the division's money and resources was also shared with the inspection team. This was a comprehensive suite of information that showed income against expenditure for matters such as medical and nursing staffing, including agency spending, and outsourcing, broken down by service line (department).

Outstanding practice

We found areas of outstanding practice in this service. See outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Maternity

Good

Key facts and figures

Maternity services are based at St Michael's Hospital and provide a wide range of facilities.

A midwifery led unit and central delivery suite deliver approximately 5,400 babies per year. The hospital provides tertiary fetal medicine expertise. Women from the south west requiring delivery at St Michael's as part of a complex care plan with onward care of their baby will also deliver there. They are supported by level three neonatal services and a portfolio of paediatric services at the children's hospital. A large antenatal and postnatal ward cares for women before and after birth, and a transitional care ward supports women and/or their babies who need a period of additional care or monitoring prior to discharge.

The maternity bed base comprises 38 maternity (antenatal and postnatal) beds in ward 73, 16 maternity (transitional care) beds in ward 76, four beds in the midwifery led unit and 14 beds in the central delivery suite. The central delivery suite has 13 rooms. One is an assessment room with two beds and there is a recovery bay with two bed spaces.

The maternity services were accessible by lifts and stairs. The central delivery suite and the obstetric theatres were on level C, which was the level of the main entrance to the hospital. The neonatal intensive care unit was on level D. The day assessment unit, fetal medicine and antenatal clinic were on level E. The antenatal and postnatal ward 73 (with 38 beds) and the postnatal transitional care ward 76 (16 beds) were also on level E, with access only through ward 73 for all visitors, who had to report to the main reception at ward 73. The midwife-led unit was on level E and had its own entrance.

During our inspection, we visited all the maternity wards and units. We checked 10 sets of women's clinical records and observation charts. We spoke with 33 women, eight relatives, and 57 staff, including consultant obstetricians and divisional director, clinical leads, matrons, ward managers, specialist midwives and educators, midwives and healthcare assistants, trainees, receptionists and administrative staff.

Summary of this service

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. The midwifery staffing levels in the central delivery suite, wards and clinics were maintained through daily assessment of acuity and safe staffing on a shift by shift basis.
- The service had enough consultant obstetricians with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. There were two locum consultants as part of the team.
- There was a consultant on call out of hours, every night of the week.
- There had been a reduced number of senior registrars, from seven to five due to maternity leave, but steps had been taken to remedy the problem.
- Women in labour received one-to-one care.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Maternity

- Patients received good care and support from the perinatal mental health team of psychiatrists and psychologists and from the mental health liaison team.
- Doctors, midwives and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.
- The service worked well with multidisciplinary teams within the trust and with other trusts in the south west region.
- The midwives worked closely with the neonatal team from the neonatal intensive care unit.
- The Friends and Family Test showed that women were very satisfied with the care and treatment provided.
- Women in labour and in the postnatal stage received effective pain relief.
- Staff kept detailed records of patients' care and treatment.
- Staff completed and updated risk assessments for each patient and removed or minimised risks.
- The service managed patient safety incidents well. Serious incidents had been dealt with in accordance with the trust's policy and procedure.
- The service provided care and treatment based on national guidance and evidence based practices. The service followed national guidance, and actively participated in NHS England initiatives. The continuity of carer initiative was launched recently.
- The service used monitoring results well to improve safety. The performance of the service was monitored by bringing together a number of critical indicators on a monthly basis in the maternity dashboard spreadsheet and highlighting any surprising figures.

However:

- In the maternity service, medicines had not been managed appropriately.
- In the central delivery suite, some medicines were not stored securely. These medicines were kept on open shelves within the clinical room, where non-clinical staff could access them.
- In the midwife-led unit, medicines had been exposed to high room temperatures for long periods of time. Therefore, patients could be given suboptimal medicines.
- Staff used denaturing kits intended to render CD drugs unusable, so that they were less hazardous for disposal, but were doing this incorrectly, so the CD drugs were still active.
- In the fetal medicine unit, the keys for the medicine fridge were found in an unlocked drawer in the treatment room which non-clinical staff could access.
- The service provided mandatory training in key skills to all staff. However, the trust had not ensured everyone completed it. In maternity the 90% target was met for 15 of the 28 mandatory training modules for which qualified nursing and midwifery staff were eligible. The 90% target was met for seven of the 18 mandatory training modules for which medical staff were eligible.
- The service provided mandatory training in five safeguarding training modules. However, the trust information showed not all the staff, including medical staff, had completed the mandatory safeguarding training modules for the period April to December 2018. The 90% target had not been met for four out of five topics, for nursing, midwifery and medical staff.

- The fixtures and fittings had not been well maintained. We found bathroom, toilet and handwashing facilities were in a state of disrepair. There was a risk of cross-contamination in the wards due to cracks in the panels of some baths and showers which had not been repaired.
- There were a number of showers, handbasins and toilet facilities in the antenatal and postnatal ward that had been out of order for some time. Despite repeated reminders, senior managers had not taken appropriate action to address the problem.
- The trust was taking too long to investigate complaints in maternity, 59.9 working days on average, whilst the trust policy specified 30 days maximum. Although some complaints make have taken longer to respond to as the trust needed to seek further clarification from the complainant.
- The service had no specialist bereavement midwife to support women going through bereavement.

Is the service safe?

Requires improvement

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as requires improvement because:

- The trust had not always ensured staff followed the trust medication policy and procedures in the safe administration, storage and disposal of medicines. (Health and Social Care Act 2008 (Regulated Activities) Regulation 2014, Regulation 12(2)(g).
- In the midwife-led unit, medicines kept in the drug cupboard had been constantly exposed to very high room temperatures since 2017. Patients would be exposed to the risk of being given suboptimal medicines.
- In the central delivery suite, there were medicines kept on the open shelves within the clinical room which non-clinical staff could access.
- Staff used denaturing kits intended to render CD drugs unusable, so that they were less hazardous for disposal, but were doing this incorrectly, so the CD drugs were still active.
- In the foetal medicine unit, we found that the keys for the medicine fridge were not kept with the midwives. Instead they were kept in an unlocked drawer in the treatment room which non-clinical staff could access.
- The service provided mandatory training in key skills to all staff. However, the trust had not made sure everyone completed it. For the period April to December 2018, in maternity the 90% target was met for 15 of the 28 mandatory training modules for which qualified nursing and midwifery staff were eligible. The 90% target was met for seven of the 18 mandatory training modules for which medical staff were eligible.
- The service provided mandatory training in five safeguarding training modules. However, the trust information showed not all the staff, including medical staff, had completed the mandatory safeguarding training modules for the period April to December 2018. The 90% target had not been met for four out of five topics, for nursing, midwifery and medical staff.
- The service controlled infection risk well in regards to clinical equipment and control measures to protect patients, themselves and others. However the fixtures and fittings had not been well maintained, compromising patient safety. In the antenatal and postnatal ward, there were cracks in the panels of some baths and showers and two showers and two toilets were out of order, including the disabled access toilet. A sink at the nurses' station and another in a

mother and baby room were not working. Plaster was peeling off in several rooms. There was one chair with ripped seats in the ward and another in the central delivery suite. There was a hole in the ceiling in the day assessment unit. The trust estates team had been notified, but to date there had been no action taken to repair these facilities. This also meant there were fewer bathroom and toilet facilities for women to use.

- There were a number of consumables kept in the midwife-led unit (MLU) that were out of date, with expiry dates ranging from 2016 to 2019. We found 20 bottles of hand gels and several other items that were past their use-by date, including hand moisturiser, hand soap, water for injections and powder-free gloves on the shelves in the clinical room and a box of similar items in the sluice. Staff had not ensured the safe use of consumables.

However:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The midwifery staffing levels in the central delivery suite, wards and clinics were maintained through daily assessment of acuity and safe staffing on a shift by shift basis. Each ward had a number of core staff and they were supported by additional staff who could be relocated when needed. This had ensured the staffing level was adequate, with a good skill mix of staff.
- The maternity service had a pool of bank staff who would be used if necessary to ensure safe care for patients. The trust had stopped using agency staff.
- Women in established labour received one-to-one care by an experienced midwife.
- The maternity service had an adequate number of consultant obstetricians, with two locums among the numbers covering maternity services.
- The maternity service had five registrars working instead of the planned number of eight for a time. However, one registrar had returned from maternity leave and another would be returning in June 2019. One new registrar had been recruited and would be commencing work in August 2019.
- The daily handovers by the medical team were informative, with detailed multidisciplinary discussions of current cases and the actions taken.
- There was a consultant obstetrician and an anaesthetist on call out of hours.
- The service made sure staff were competent for their roles. There were organised obstetric emergency skills days for midwives and doctors. The training included fetal well-being and cardiotocography (CTG), neonatal basic life support and managing clinical emergencies, with simulations of emergency scenarios such as breech deliveries, shoulder dystocia and cord prolapse. This ensured safe and improved clinical practice.
- Staff kept detailed records of the patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.
- Staff completed and updated risk assessments for each patient and removed or minimised risks. They carried out risk assessments of pregnant women antenatally, including a perinatal mental health assessment, and referrals were made when required.
- Staff used the modified early obstetric warning score (MEOWS) tool to observe mothers and the newborn early warning trigger and track (NEWTT) tool for babies at risk of clinical deterioration. Staff had training on when to escalate by referring appropriately the mother and baby for medical assistance.
- Staff assessed and monitored patients regularly to see if they were in pain. Women experienced effective pain relief during labour and postnatally.

Maternity

- The service used monitoring results well to improve safety. The service used a rolling month by month maternity dashboard to raise alerts on safety metrics which exceeded the expected range.
- The service provided care and treatment based on national guidance and evidence based practices. The service followed national guidance, and actively participated in NHS England initiatives. The continuity of carer initiative was launched recently.
- Staff assessed and monitored patients regularly to see if they were in pain. Women experienced effective pain relief during labour and postnatally.
- The service managed patient safety incidents well. Serious incidents had been dealt with in accordance with the trust's policy and procedure.

Is the service effective?

Good

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The maternity service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.
- The service participated in NHS England collaborative initiatives and commenced the continuity of carers project on 25 March 2019. In the pilot, a team of experienced midwives worked together as an integrated community team providing continuity of care to a group of expectant women.
- The trust was a tertiary centre for maternal and fetal medicine. There was good multidisciplinary working with neighbouring trusts in the south west region and other trusts.
- Doctors, midwives and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care. Staff worked well with other internal services and teams to ensure that care was delivered in a coordinated way. This included the theatre team and medical specialities such as the cardiology service, the intensive care unit and the community midwifery teams. Staff had a good working relationship with the psychiatric liaison team in the hospital.
- Staff gave patients enough food and drink to meet their needs and improve their health. At mealtimes, women were given a choice of menu to choose from. This included cultural and dietary requirements. They were offered snacks and sandwiches in-between mealtimes. Women in early labour were offered light refreshments, such as sandwiches, and a light meal after delivery or after having a caesarean section.
- The service had achieved the United Nations Children's Fund (Unicef) Baby Friendly Stage Three for assisting women to breastfeed.
- Staff assessed and monitored patients regularly to see if they were in pain. Women experienced effective pain relief during labour and postnatally.
- The service made sure staff were competent for their roles. Staff regularly attended multi-professional in-service education sessions. Midwives were provided with additional clinical training to ensure their competencies were being maintained.

- Midwives received support from professional midwifery advocates, who gave working group sessions regularly to guide midwives to deliver effective care.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. Staff sought consent for procedures, including suturing, episiotomy, instrumental delivery and caesarean section operations.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. The service monitored patient outcomes through national and local audits.
- We looked at the standardised caesarean section rates from October 2017 to September 2018 from Hospital Episodes Statistics. The total caesarean section rate was 28.0%. The elective rate was 12.4% and the emergency rate 15.6%. All these rates were as expected, compared with the England average. Over the same period, the proportion of instrumental deliveries was 15.5%. This was somewhat higher than the England average of 12.3%.

However:

- The staff appraisal rates from April 2018 to December 2018 showed only 34.3 % of staff in maternity received an appraisal. This was well below the trust target of 85%. We were told the staff appraisal system changed from paper to electronic in May 2016. At the time there had been some system problems. A matron told us the data for appraisal compliance did not reflect an accurate picture. By the time of our inspection this had improved with figures for March 2019 showing a compliance of completed appraisals being 65.2% for qualified midwives, 66.6% non-midwifery staff, 68.9% health care assistants and 87.9% of medical staff.
- The trust information submitted to us stated that the training on the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards were inclusive in the training programme for Safeguarding Level Two. However, evidence showed not all staff had completed the mandatory training module, safeguarding level two. For the period April to December 2018, the completion rate for safeguarding level two training was 87.2 % against the trust target of 90%. Therefore, not all staff had completed mandatory training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
- The service participated in some of the 2017 National Maternity and Perinatal Audit Programme. However, there was no data available for 4 out of 8 of the metrics.

Is the service caring?

Good

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Staff cared for patients with compassion. Patients commented that all the staff were supportive and very caring.
- Women said staff treated them with respect and dignity. Partners felt involved and were encouraged to support their partner during labour.
- The Friends and Family Test for the antenatal ward, the central delivery suite and the postnatal ward from January 2018 to December 2018 showed the trust's performance was similar to the England average.
- The trust participated in the CQC Survey of women's experiences of maternity services, 2017. The trust performed about the same as other trusts for 14 questions and was better than the other trusts on two questions, relating to skin to skin contact with their baby and the handling of concerns.

- Staff involved patients and those close to them in decisions about their care and treatment. Patients felt involved in their care and treatment.
- Patients told us they were well informed by the doctors and midwives before treatment was given or a procedure was performed.
- Women felt involved in decision making regarding their care and treatment.
- Staff provided emotional support to patients to minimise their distress. Patients and their relatives felt well supported. Staff showed understanding and empathy. Staff communicated well with patients and their families.
- Women had access to specialist staff, such as the perinatal mental health team, a psychiatrist and a psychologist.

Is the service responsive?

Good

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.
- There was a consultant-led service for high risk women and a midwife-led service for low risk women.
- There was a named midwife for each woman in labour.
- Staff of different specialities and disciplines worked together to provide coordinated care for women. For example, the cardiac nurse and specialist midwife for mental health saw a patient for a joint review.
- The Fetal Medicine Unit was a referral centre for fetal medicine. It offered women a screening service for various conditions, such as fetal cardiac defects, fetal growth restrictions or Down's syndrome.
- The service gave support to women with complex needs, such as learning disability or perinatal mental health problems. All women with a mental health condition had a 32-week plan. This included a bespoke birth plan for delivery.
- There was a transitional postnatal ward for mothers and their babies who needed extra monitoring; they could be mothers with a history of substance misuse, mental health conditions or complications of pregnancy such as diabetes. It was for women whose baby was under 37 weeks gestation when born and who did not require admission to the special care intensive unit.
- Staff used a phoneline to access translation services, including out of hours and at weekends, for women whose first language was not English. Staff arranged interpreters for in-patients.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The trust was taking too long to investigate complaints in maternity, 59.9 working days on average, whilst the trust policy specified 30 days maximum. Although some complaints make have taken longer to respond to as the trust needed to seek further clarification from the complainant.
- The service had no specialist bereavement midwife to support women going through bereavement.

- Women who booked to have their baby delivered in the midwife-led unit might not have their preferred choice when the midwife led unit was closed for safety reasons. When the midwife-led unit was closed all women would be cared for in the central delivery suite.

Is the service well-led?

Good

We previously inspected maternity jointly with gynaecology, so we cannot compare our new ratings directly with previous ratings. We rated it as good because:

- Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care.
- The maternity service was led by a well structured management team with a good understanding of the needs of the department.
- The trust had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, women using the service, and key groups representing the local community.
- The maternity service was fulfilling the trust's vision by being the tertiary maternity hospital for the south west region.
- Staff demonstrated the trust's values by respecting patients and embracing change. Staff worked together to drive improvement and recognise success in performance.
- Managers across the trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Staff had a positive attitude to their work and felt management cared about them as people.
- Staff were keen to learn new skills and share them with other members of staff.
- The trust used a systematic approach to continually improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- Management closely supervised clinical governance through metrics recorded monthly on the maternity dashboard and taking appropriate action.
- The dashboard used a R-A-G traffic light system to alert management to any metrics going outside the expected range.
- The maternity service took perinatal mental health seriously and held meetings with mental health specialists. This ensured good service was delivered to mental health patients.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The department was moving towards being paperless, and patient discharge notes and staff appraisals had been moved to the electronic system.
- Staff were able to familiarise themselves with trust policies and care pathways on the intranet.
- The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with some partner organisations effectively.

- There was good liaison with the voluntary sector to provide support to women who had experienced trauma during delivery.
- Efforts were made to involve more staff in reviews of care pathways and senior management meetings, so that staff had a sense of engagement.
- The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- Beginning in March 2019, the trust was conducting a pilot of the NHS Continuity of Carer initiative. This will ensure women are cared for by the same midwives from early in their pregnancy through to the postnatal period. This aimed to provide a safer, more personalised, compassionate and professional family-friendly service.
- The trust had effective systems for identifying risks. The quality and patient safety team had been involved in ensuring serious clinical incidents raised were taken seriously and resolved quickly.

However:

- There had been ongoing issues regarding the medicine storage room temperature. Senior managers had not taken appropriate action to reduce the risk of medicines becoming suboptimal due to continuous exposure to high room temperatures in the midwife led unit, experienced since 2017.
- Senior managers had not taken appropriate action to remedy fixtures and fittings that were in disrepair. For example, there were cracks in the panels of baths and showers, which were sites for cross-infection. These items were on the risk register as potential risk hazards for cross infection. There were sinks, showers and toilets that had been broken for some time. To date, staff were not able to tell us if and when repairs would be carried out.

Outstanding practice

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

Services for children and young people

Outstanding ☆ ↑

Key facts and figures

The Bristol Royal Hospital for Children (BRHC) is a 157-bed hospital providing secondary care services for Bristol, tertiary services for the south west, as well as some specialist services to wider Southern England and South Wales regions and beyond. The hospital is the paediatric major trauma centre for the south west.

Neonatal services are provided from a 31-cot unit and 16 transitional care cots at St Michael's Hospital. The service is one of three level three units in the south west neonatal operational delivery network.

Bristol Royal Hospital for Children provides dedicated paediatric services including an emergency department, theatres, critical care, radiology, outpatients, inpatient wards, day surgery and therapies. All paediatric inpatient care is provided in BRHC, apart from a Teenage and Young Adult (TYA) cancer unit for patients aged 16-24, which is located in Bristol Haematology and Oncology Centre (BHOC). There are no other acute medical inpatient beds for children in the Bristol area. Children's services are also provided in dedicated facilities in Bristol Eye Hospital (BEH), Bristol Dental Hospital (BDH), and radiotherapy in BHOC. Outpatient clinics are also run at South Bristol Community Hospital. Outpatient clinics are run by BHRC at a neighbouring NHS trust.

Services for children and young people in BRHC and St Michael's are managed within the division of women's and children's services. The TYA services are managed in the division of specialised services. Services in BEH and BDH are managed in the division of surgery. Paediatric radiology and pathology are managed by the division of diagnostics & therapies.

During this inspection, as well as the outpatients departments (including the eye hospital outpatient department), we visited the neonatal unit, neonatal intensive care unit, paediatric intensive care unit and a number of wards including: Caterpillar (general medicine), Penguin (surgical), Dolphin (cardiac), Daisy (burns and high dependency), Starlight (oncology and bone marrow transplant), Apollo 35 (adolescent), Lighthouse (renal and urology), Bluebell and Sunflower (neurosciences), Puzzle Wood (clinical investigations), Rainforest (burns and plastics), and Seahorse. During this inspection we did not visit the dental hospital or the haematology and oncology centre.

The trust had 15,216 admissions from November 2017 to October 2018. Emergency admissions accounted for 37% (5,653 admissions), 46% (6,977 admissions) were day case admissions, and the remaining 17% (2,586 admissions) were elective.

From January to December 2018 the trust received 88 complaints in relation to children's services at the trust (11.8% of total complaints received by the trust). The trust took an average of 46.5 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be closed within 30 working days. There were 20 complaints still open which had been open for an average time of 67.7 days.

During our inspection we spoke with 115 staff, including nurses, consultants, and support staff and 53 patients and their families or carers. We reviewed 27 records overall.

Summary of this service

Our rating of this service improved. We rated it as outstanding because:

Services for children and young people

- Safe care was mostly being provided in children and young people's service. Staff understood how to protect patients from abuse. Patient risk was well considered and there were clear processes for escalation and support should a patient deteriorate. Patient safety incidents and patient safety performance was monitored, managed and learning identified to make improvements to the service.
- There was effective care within the children and young person's service. Care and treatment was based on national guidance and evidence of its effectiveness. The effectiveness of care and treatment was monitored, and the trust was generally performing similar when compared to other trusts. Patients' nutrition, hydration and pain was well managed. Teams worked extremely well together to deliver care which benefitted the patient.
- Excellent care was delivered to children and young people with dignity and respect. Staff were committed to giving the best care to patients and provided emotional support to those with physical or mental health needs. Patients were involved, informed and supported in the care and treatment provided, and relatives were included and involved too. Patients suffering pain were well managed within guidelines and protocols.
- The trust delivered responsive care and planned and provided services tailored to meet the needs of children, young people and their families to ensure flexibility, choice and continuity of care. Children and young people, and their families were engaged in the design and running of the service. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice. The service treated concerns and complaints seriously, investigated them and learned lessons from the results.
- The children and young person's leadership team were clear about their roles and understood the challenges for the service. The leadership and culture of the service drove improvement and the delivery of high-quality individual care. Innovation, high performance and the high quality of care were encouraged and acknowledged. There was excellent engagement with stakeholders and partners to improve and coordinate services. There were no barriers to innovation and development.

However:

- In some areas safety could be improved and brought in line with good practice. Improvement in mandatory training for medical staff, particularly in resuscitation and safeguarding training, would assist the service to meet trust targets.
- The service needed to monitor staffing levels for neonatal intensive care unit (one to one) and supernumerary team lead role, in line with the British Association of Perinatal Medicine standards.
- The clarity of recording of sepsis monitoring, along with any interventions taken, could be improved along with further improvement of clear, up-to-date and coherent patient records. Further safety improvements could be made by following best practice when recording and storing medicines.
- Consideration could also be made to improve the environment for the children and young people's recovery area in the eye hospital, although it is acknowledged that there is limited space to do so.
- To improve the effectiveness of the service further improvement in appraisal rates to meet compliance of trust targets needed to be focused on.

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Services for children and young people

- The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service had suitable premises and equipment and looked after them well. The service had access to equipment which was regularly serviced and maintained.
- Staff completed and updated risk assessments for each patient and asked for support when necessary. Patient risk was well considered within the children and young people service and there were processes to assess and respond to potential or presenting risk.
- The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- The service mostly followed best practice when recording and storing medicines.

However:

- The service provided mandatory training in key skills to all staff, but not all staff were up-to-date with the trust's mandatory training courses. For example, resuscitation training was consistently not meeting trust targets. This meant some staff were not up-to-date with their skills and knowledge to enable them to care for children and young people appropriately.
- Compliance with safeguarding training did not always meet trust targets.
- The neonatal unit was unable to adhere to the British Association of Perinatal Medicine standards in achieving recommended safe staffing levels. The service did not always meet the one to one recommendation in the intensive care unit or the supernumerary team lead role on each shift, although this was on the risk register and risks were mitigated as far as possible.
- Records were not always clear and up-to-date, when recording patient' care and treatment. We reviewed 27 sets of patients' records and found records did not always clearly reflect the needs of children and young people.
- Venous thromboembolism (VTE) assessments, assessing the risk of a blood clot, were not always being completed. It was unclear whether the service was following their standard operating procedure around VTE, as assessments were left blank on six out of the eight sets of notes.
- Multidisciplinary notes were completed but were not filed in the same place. This did not make accessing them easy. Nurses and doctors maintained paper records on the wards, which were held in separate files.
- The recording of sepsis monitoring and intervention was not always clear within patient records. We saw a number of records with a sepsis pathway in a child's records, however, the documentation was incomplete, and it was unclear what action had been taken and the outcome.
- We found medicines out of date on ward trolleys and opening dates were not always recorded on reduced shelf-life medicines. On the Neonatal Intensive Care Unit, we saw the temperature of the fridge had been outside the recommended range with no evidence of action taken.

Is the service effective?

Outstanding ☆ ➔ ➔

Services for children and young people

Our rating of effective stayed the same. We rated it as outstanding because:

- All staff actively engaged in activities to monitor and improve quality and outcomes.
- Policies, care and treatment pathways, and clinical protocols had been developed in line with national guidance.
- There was an annual audit plan which the clinical teams contributed to. Action plans resulting from participation in audits to address areas requiring improvement and regular reviews were undertaken to monitor progress.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.
- Staff assessed and monitored patients regularly to see if they were in pain. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain. Children and young people had their pain assessed and appropriate methods of reducing pain were offered. We also observed pain was a focus during treatment sessions with the therapy team.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. Regular audits were carried out to review and demonstrate the quality and safety of services delivered against national patient outcomes. These audits were monitored and action plans to address areas of improvement were regularly reviewed.
- The service understood the continuing development of the staff, skills, competence and knowledge was integral to ensuring high-quality care. Managers held supervision meetings with staff to provide support and monitor the effectiveness of the service.
- Staff of different kinds were committed to working collaboratively and found innovative and efficient ways to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care. Multi-disciplinary meetings took place to review and plan care and treatment for children and young people. Staff supported colleagues in the wider trust and community with the care of children and young people who had been admitted to other departments.
- Providing a seamless service for the transition of children and young people from children's services to adult services was a high priority for the service. The transition policy identified the roles and responsibilities of the staff across the trust in supporting the transition of children into adult services. Care and treatment was available to children and young people seven days a week. There was 24-hour medical cover seven days a week on the children's ward and the neonatal unit.
- Health promotion was a routine part of all care provided to children and young people. All staff worked collaboratively to assess all aspects of general health and to provide support and advice to promote healthy lifestyles.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent. Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.

However:

- Appraisal compliance had improved but was not compliant with trust targets. Although staff we spoke with said they had received an appraisal during the last year the data received before the inspection showed appraisal compliance had not been met. We were told during 2018 there was a problem with transferring paper appraisal data to the electronic system and the trust had been working on updating the data.

Services for children and young people

Is the service caring?

Good  

Our rating of caring stayed the same. We rated it as good because:

- Staff understood the impact that a child or young person's care, treatment or condition would have on their wellbeing and on those close to them, both emotionally and socially. They understood their emotional and social needs were as important as their physical needs.
- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness. Throughout our inspection we observed children and young people being treated compassionately and with dignity and respect.
- Staff took the time to interact with those using the service in a respectful, kind and considerate way. We observed staff speaking directly to children about their care whilst also including their families in the consultation. Humour was used to encourage children to be involved and to feel comfortable in the environment.
- Staff were mindful and respectful of the personal, cultural, social and religious needs of people in their care. Staff recognised the waiting rooms were busy and overwhelming for some patients with autism and mental health conditions and could find quiet rooms.
- Children, young people, their families and carers spoke positively about their care experienced within the Children's hospital.
- Staff provided emotional support to patients to minimise their distress.
- We observed staff talking to patients in a non-judgemental way and demonstrated a good understanding of their physical and mental health needs.
- Staff involved patients and those close to them in decisions about their care and treatment.
- Staff were passionate about making the hospital feel as normal as possible.

Is the service responsive?

Good  

Our rating of responsive stayed the same. We rated it as good because:

- The trust planned and provided services tailored to meet the needs of children, young people and their families to ensure flexibility, choice and continuity of care. Children and young people, and their families were engaged in the design and running of the service. We saw examples of changes made as a result of engagement and feedback.
- The environment on the children's wards, outpatient departments, neonatal unit and paediatric intensive care unit were designed to meet the needs of babies, children and young people and their families.
- The service took account of patients' individual needs. Children and young people were treated as individuals with treatment and care being offered in a flexible way and tailored to meet their individual needs.
- People could access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with good practice.

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff. Parents knew how to make a complaint if they needed and felt they could raise concerns with clinical staff. We saw evidence of a number of formal and informal complaints, the investigations that followed and actions, including duty of candour applied.

Is the service well-led?

Outstanding ☆ ↑

Our rating of well-led improved. We rated it as outstanding because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. Clinical managers were experienced and had a strong commitment to provide the best possible service to the children, young people and their families. The leadership team clearly understood the challenges to delivering good quality care and improving patient outcomes. They could identify areas where each department needed to improve and the support they had to provide to make changes.
- The service had a vision for what it wanted to achieve and workable plans to turn it into action developed with involvement from staff, patients, and key groups representing the local community. The leadership team were very clear about their vision and strategy for the next five years.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff we spoke with during the inspection said they were positive about working for the service and proud to work at the hospital. They were passionate about the care they provided and improving patient outcomes. There was an overwhelming culture of putting the child and family at the heart of everything.
- Managers encouraged learning and a culture of openness and transparency. Staff felt confident to raise issues with their managers.
- The service used a systematic approach to continually improving the quality of its services and safeguarding high standards of care. The governance team worked cohesively and there was effective governance processes and oversight in the division.
- There was a clear performance management reporting structure with regular meetings looking at operational performance.
- The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. There were arrangements for identifying, recording and managing risks, issues and mitigating actions. Risks for the service were held on a comprehensive divisional risk register. The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards. Information technology systems were used effectively to monitor and improve quality of care.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively. The service had strong links with the community to engage with the public to ensure regular feedback on services. This was used for learning and development.
- Since our last inspection the division had significantly increased the amount of engagement and involvement of patients and families at all levels, including board and service level.
- Children and young people were engaged to help improve services. At board level two young governors, who were on the Youth Involvement Group, form part of the Trust's Council of Governors. The Youth Involvement Group ensure young people's views about what happens in the hospital is heard.

Services for children and young people

- The division was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- There was innovation and development through significant research and leaders and staff strived for continuous learning, improvement and innovation. There was a strong focus on looking for innovative solutions to ensure continual delivery of high-quality care for children, young people and their families. Staff and managers felt there was a willingness of all staff to develop services and improve patient outcome.

Outstanding practice

We found areas of outstanding practice in this service. See the outstanding practice section above.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Our inspection team

Mary Cridge, Head of Hospital Inspection, chaired this inspection and Marie Cox, Inspection Manager, led it. An executive reviewer, Jane Tomkinson, ChiefExecutivesupported our inspection of well-led for the trust overall.

The team included11 inspectors, one further inspection manager, one executive reviewer, and10 specialist advisers.

The team were also joined by a financial governance assessor from NHSI and a NHS digital employee.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ. Experts by experience are people who have personal experience of using or caring for people who use health and social care services.

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Six-Monthly Report of Safe Staffing**
Report Author	**Helen Morgan, Deputy Chief Nurse Abigail Sleight, Head of Medical HR**
Executive Lead	**Carolyn Mills, Chief Nurse, William Oldfield, Medical Director**

1. Report Summary

The purpose of the paper is to provide assurance to the Trust Board that wards and departments have been safely staffed over the last six months. The paper outlines

- Any significant changes that have occurred in nursing, midwifery, Allied Healthcare Professionals and medical staff staffing establishments and skill mix in the last six months
- Any risks on the corporate risk register related to nursing, midwifery, Allied Healthcare Professionals and medical staffing.
- How the Trust knows the wards and departments have been safely staffed over the last six months, including Care Hours Per Patient Per Day and Weighted Activity Unit data

The NHS Improvement "Developing Workforce Safeguards" (October 2018) recommends that Trust reports include safe staffing information for Allied Healthcare Professionals (AHPs) and Medical staff as well as nursing and midwifery staff. This information is included within this report for the first time and the content will develop over time supported by e-rostering roll out to these professional groups.

2. Key points to note

(Including decisions taken)

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).

Following an inspection by the CQC in May 2019, the published report in August 2019 saw the Trust retain its rating of Outstanding.

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

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

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

ID 920 - Risk that there are insufficient numbers of doctors in training to safely cover rotas.

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **ASSURANCE** • The Board/Committee is asked to **NOTE** the report.	
5. History of the paper **Please include details of where paper has previously been received.**	
People Committee	**26.09.19**

Report on Medical, Nurse and Allied Health Professionals (AHP's) Staffing Levels UHBristol (February 2019- July 2019).

September 2019 Trust Board

1.0 Introduction

Following publication of the Francis Report 2013 and the subsequent "Hard Truths" (2014) document, NHS England and the Care Quality Commission issued joint guidance to Trusts on the delivery of the commitments associated with publishing staffing data on nursing, midwifery and care staff levels. These include:

- Report and publish a monthly return to NHS England indicating planned and actual nurse staffing by ward. This is published on the NHS Choices website.
- Publish information with the planned and actual registered and unregistered nurse staffing for each shift
- Provide a 6 monthly report on nurse staffing to the Board of Directors.

The NHS Improvement "Developing Workforce Safeguards" (October 2018) recommends that Trust reports include safe staffing information for Allied Healthcare Professionals (AHPs) and Medical staff as well as nursing and midwifery staff. The document suggests that best practice on the following areas at board level should be included.

"*Any workforce review and assessment and the safeguards reported should cover all clinical groups, areas and teams. Nursing/midwifery is the most often represented group at board level, but a focus on medical staff, AHPs, healthcare scientists and the wider workforce is needed too. Reports need to cover all areas, departments and clinical services".*

This information is included within this report for the first time and the content will develop over time supported by e-rostering roll out to these professional groups.

This report details

1.1 Nursing and Midwifery

- Any significant changes that have occurred in nursing and midwifery staffing establishments and skill mix in the last six months and any risks on the corporate risk register related to nursing and midwifery staffing.
- How the Trust knows the wards have been safely staffed over the last six months, including Care Hours Per Patient Per Day and Weighted Activity Unit data

1.2 **Allied Healthcare Professionals (AHPs)**

- Any significant changes that have occurred in Allied Healthcare staffing establishments and skill mix in the last six months and any risks on the corporate risk register related to Allied Healthcare staffing.
- How the Trust knows the wards have been safely staffed over the last six months, including Weighted Activity Unit information

1.3 **Medical Staff**

- Any significant changes that have occurred in Medical & Dental staffing establishments and skill mix in the last six months and any risks on the corporate risk register related to Medical & Dental staffing.
- How the Trust knows the wards and rotas have been safely staffed over the last six months, including Weighted Activity Unit information

2.0 Significant Changes to staffing levels in the last six months

2.1 Nursing and Midwifery

As detailed in appendix 1 there are a number of triggers that indicate when a nurse staffing review is required, these are unchanged. Any adhoc reviews triggered by would be in addition to the annual divisional reviews of nursing and midwifery establishments and skill mix, undertaken with the Chief Nurse.

The majority of UH Bristol's funded establishments have had no significant changes over the last six months, with one exception in the division of Women's and Children's and Surgery:

Surgery - A604 have an additional Nursing Assistant on an early shift (1.47 WTE increase) as part of their remodeling to become a Silver Trauma Unit. This increase was included within an approved business case and contained within the Divisional Operating Plan 19/20.

Midwifery- whilst no change to the skill mix/establishments, it is important to note that from 1st June 2019, Weston Hospital maternity staff moved employment to UHBristol, via a TUPE agreement. The Matron post at Weston became a Supervisory Band 7, which covers Weston and UHBristol community midwifery services.

2.2 **Allied Healthcare Professionals (AHPs)**
Women's and Children's Division

A number of additional posts have been funded within Women's and Children's Divison to support a service development, the changes were part of the Divisional Operating Plan 19/20

Selective dorsal rhizotomy	0.6wte Band 7 Physio 1.0wte Band 6 physio	Due to increased activity subsequent to NHS England funding

High Dependency	1.0 wte Band 7 Physio	Operating Plan
Metabolics	1.0wte Band 7 Dietitian	Operating Plan
Gastroenterology	0.5wte Band 6 Dietitian	NHS England

No other significant changes have been reported in the last six months in other Divisions.

2.3 **Medical Staff**

The Trust is dependent upon Health Education England to allocate sufficient numbers of doctors in training to ensure services can be delivered and rotas run safely. Frequently the number of doctors the Trust is allocated does not correlate with optimum staffing levels and the notification process of how many doctors the Trust will receive for each rotation is not robust. This results in high vacancy rates which impacts on the compliance of rotas, the wellbeing and quality of training that we can provide to our junior medical workforce.
Between the months of February and July 2019 there were a total of 29.5 whole time equivalent vacancies (locally employed doctors and doctors in training). These gaps were either absorbed locally by rewriting of rotas, recruiting locally employed doctors or filled by locums.

3.0 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 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.

Based on the above principles nursing and midwifery 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 these ratios in inpatient areas in the last six months.

For wards and departments that have specialty specific safe staffing guidance the annual staffing reviews have confirmed that the Trust is compliant with the relevant guidance/ recommendations.

4.0 Regulatory requests for staffing information

Following an inspection by the CQC in May 2019, the published report in August 2019 saw the Trust retain its rating of Outstanding.

4.1 Nursing and Midwifery

The report states that:

"***Apart from in the neonatal unit, services had enough nursing staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment".***

Acknowledging that the neonatal risk was on the risk register, (a risk score of 6) and noting that risk was mitigated as far as possible, the CQC has recommended a "should do action" that staffing levels for the neonatal intensive care unit (one to one) and supernumerary team lead role are monitored in line with the British Association of Perinatal Medicine standards. A plan to address this "should do" action will be contained within the Trust action plan in response to the CQC report.

4.2 Allied Healthcare Professionals (AHPs)

There were no specific actions re staffing levels for AHP's

5.0 How the Trust knows it has been safely staffed over the last six months?

5.1 Nursing and Midwifery

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).

A 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 (2014) staffing red flags that have been reported, the reasons and any actions that have been taken.

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%.

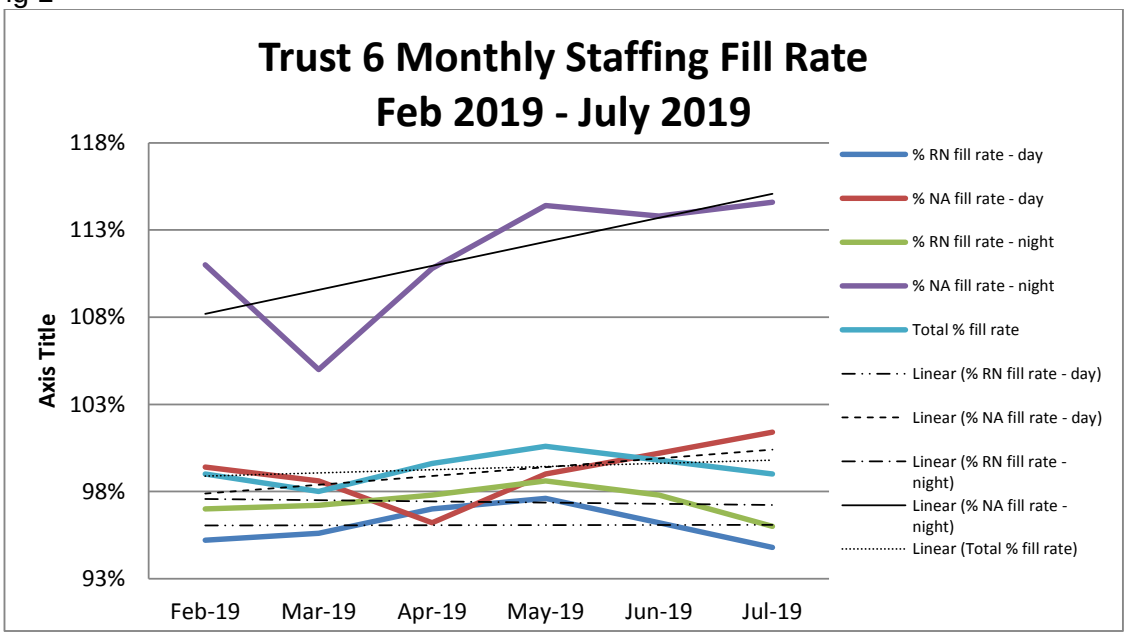
- The average RN day fill rate has remained at 95% or above consistently for the period. It has not exceeded 100% in any one month.

- The average RN night fill rate has decreased slightly from 98 to 97% but has remained above 95% throughout.

- NA fill rates continue to be above planned staffing levels for both days and nights. The actual night fill rate continues to be significantly above 100% established staffing levels due to covering Enhanced Care Observation assignments.

- The NA 6 monthly trend for days and nights shows a gradual increase over the period.

Fig 1



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

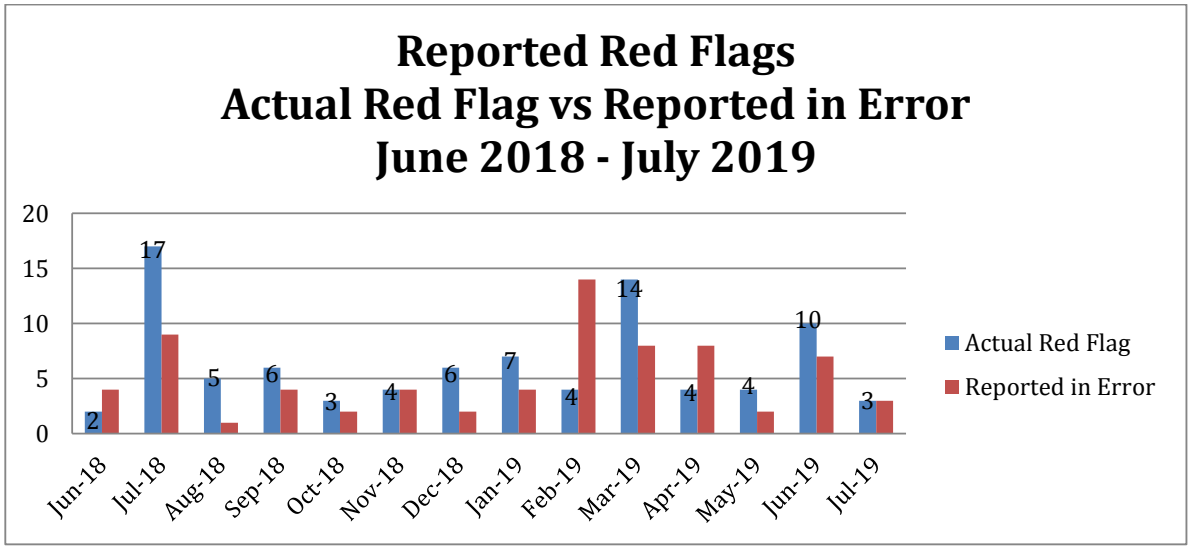
Trust Total	% RN fill rate - day	% NA fill rate - day	% RN fill rate - night	% NA fill rate - night	Total % fill rate
Feb-19	95%	99%	97%	111%	99%
Mar-19	96%	99%	97%	105%	98%
Apr-19	97%	96%	98%	111%	100%
May-19	98%	99%	99%	114%	101%
Jun-19	96%	100%	98%	114%	100%
Jul-19	95%	101%	96%	115%	99%
6 monthly average	96%	99%	97%	112%	99%

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).

5.2 Red Flags

- The number of correctly reported red flag incidents across all in patient wards for this period was 39, compared to 31 in the previous 6 months (see Fig 2).

Fig 2.



The common themes identified through review of the reported red flags in the last six months were;

- Unfilled staffing gaps, due to short term sickness where the Trust was unable to secure a temporary staff member to cover at short notice. In this situation the Trust SOP for ensuring safe staffing was followed.

- Staff being moved from ward areas for two hours at a time, to care for patients when there is pressure in the emergency department, and patients are waiting in a queue. Movement of staff to ED is risk assessed by the on call/site management teams and staff are moved to minimize as much as possible risks in staffing levels in other areas.

- A new haematology treatment Car-T commenced in May 2019 in Specialized Services. This required additional specialist staffing at very short notice who, on occasion were delayed in arriving, triggering a low staffing incident. Plans to mitigate the requirement for short notice shifts have been introduced.

5.3 Weighted Activity Unit (WAU) and Care Hours Per Patient Day (CHPPD) (see appendix two for definitions)

5.3.1 Weighted Activity Unit (WAU)

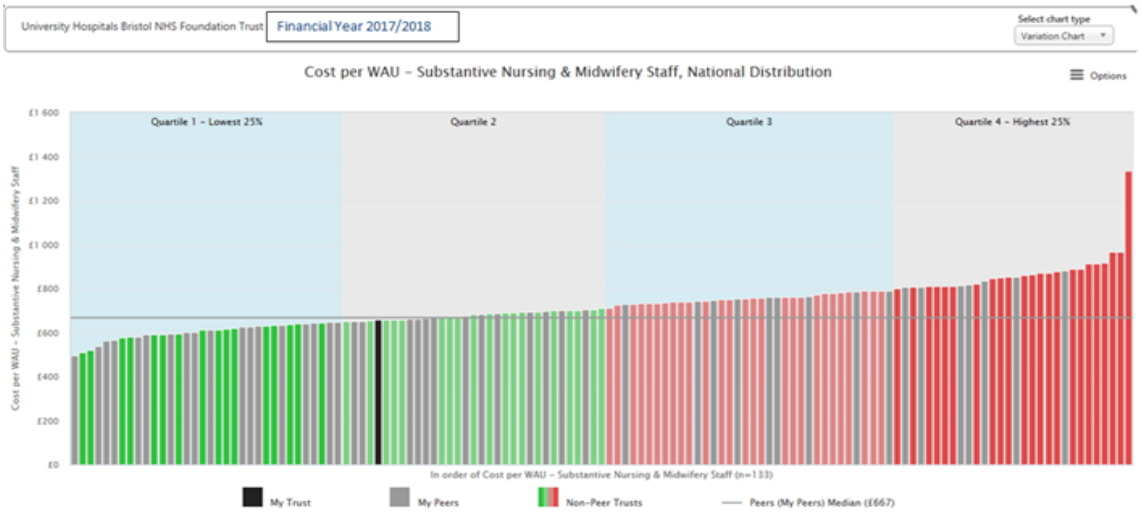
Nursing and Midwifery

The graph below (fig 3) shows the staff cost for substantive nursing and midwifery staff per Weighted Activity Unit, UHBristol shown in black. This remains the most up to date information available on the Model Hospital dashboard.

The Use of Resources Assessment Report from the CQC, published in August 2019, highlighted that the Trust was in the second (best) quartile for nursing costs per WAU (£657), which means that it spends less on staff per unit of activity than a number of Trusts both nationally and within our peer group. The Trust's agency spend also was noted as benchmarking well at 2.15% in February 2019 against a peer median of 3.51% and a national median of 4.94%. The implementation of the e-rostering system for nurses and midwives together with SafeCare demonstrated to the CQC that the Trust is able to "review nursing spend at a divisional level and enhanced the understanding of nursing costs and reasons behind budget spend and created a greater visibility of critical staffing shortages

This evidence, together with the clear processes in place, gives assurance that the nursing workforce is being productively utilised and productivity is constantly monitored.

Fig 3. **Dec 16- Nov 18 Weighted Activity Unit Data**



Allied Healthcare Professionals (AHPs)

The Use of Resources Assessment Report from the CQC, published in August

2019, highlighted that the Trust was in the first (best) quartile for Allied Healthcare Professional staff per WAU (£99).

E-rostering is in place for a small number of AHP teams, which include :-

- All Adult Physios, OT and Dieticians
- Adult Radiology including MRI

Plans to extend E-Rostering to other AHP group will be included in the divisional operating plans for 20/21 in line with the NHSI levels of attainment work mandating all clinical teams are on E-Rostering by 2021.

The level of detail currently available for AHPs is somewhat limited compared to that of nursing and midwifery. However a report taking data from the Model Hospital dashboard (Fig 4) indicates that AHP specialties registered to unregistered ratios benchmark similarly to peers and in some cases higher. Further interrogation and analysis will be undertaken and presented in the next 6 monthly staffing export

Fig 4

Specialty	UHB DATA				Peer Median	National Median
	Total	Qualified	Unqualified	Ratio	Ratio	Ratio
All	460	397	63	6.3:1	4.8:1	4.5:1
Physio	117	108	9	11.8:1	6.0:1	4.3:1
Dietetics	56	44	12	3.6:1	6.8:1	8.3:1
Occupational Therapy	44	37	7	5.2:1	5.6:1	4.6:1
Speech & Language Therapy	29	27	2	13.5:1	13.6:1	12.3:1
Radiography	184	150	33	4.5:1	3.9:1	3.5:1
Other AHP	31	31	0	N/A	13.5:1	14.4:1

Medical Staff

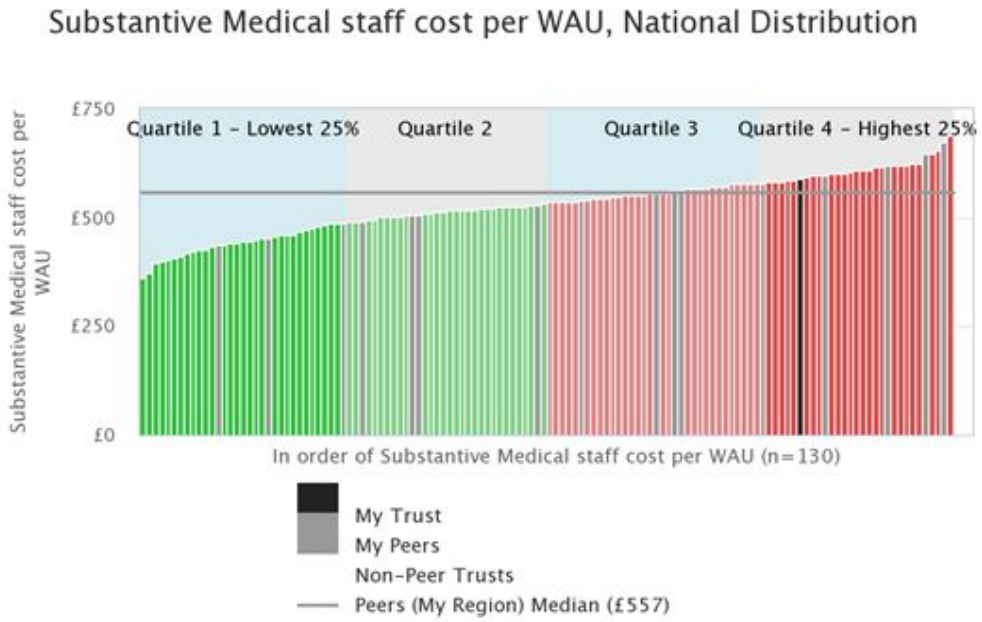
5.3.2 Substantive Medical Staff

The graph below (fig 5) shows the staff cost for substantive medical & dental staff per Weighted Activity Unit, UHBristol shown in black. This remains the most up to date information available on the Model Hospital dashboard.

The Trust is in the in the highest quartile for WAU. However, the mitigation to this is that the Trusts non-substantive staff spend is in the lowest quartile, which counteracts the substantive costs as our bank and agency spend are well controlled relative to peers.

Our agency cost per WAU is £46, compared to our peer median of £68, or £107 nationally and our non-substantive WAU cost is £107 compared to £118 and £157, peer median and national median respectively.

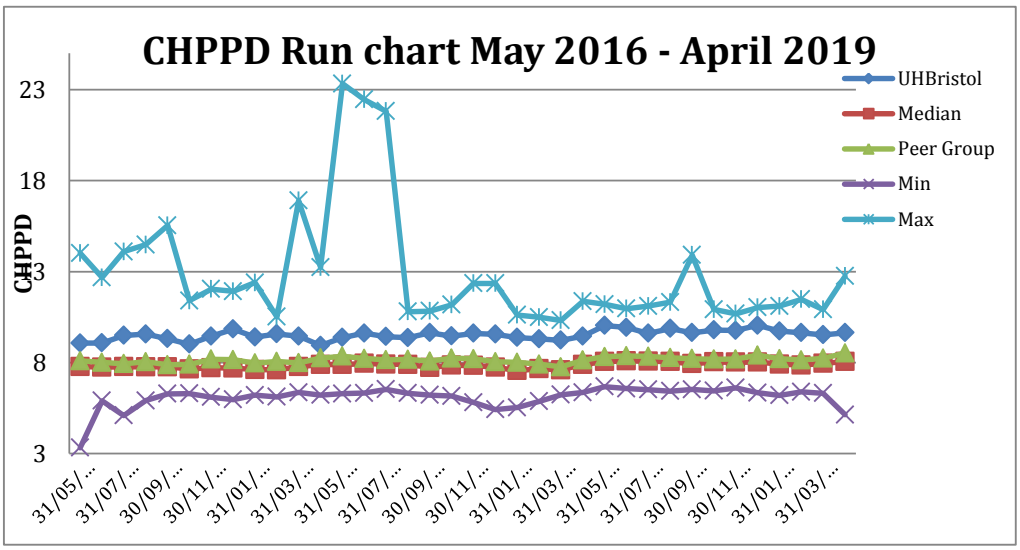
Fig 5



5.3.3 Nursing Care Hours Per Patient per Day

The graph below (fig 6) shows that UHBristol CHPPD sits above the national mean and that of the model hospital peer group giving assurance that the Trust has safe levels of staffing. This figure needs to be considered alongside the WAU productivity measure and the Trust's performance against quality metrics and workforce metrics.

Fig 6 **CHPPD May 16 –April 2019**



6 Monthly Report Safe Staffing CM/HEM/WO/AS/DT. September 19 Trust Board.

6.0 Staffing Risks held on the corporate risk registers

6.1 **Nursing and Midwifery**

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, on a rotational basis at the Trust Risk Management Group and at annual staffing reviews.

Allied Healthcare Professionals (AHPs)

There are no AHP 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, on a rotational basis at the Trust Risk Management Group and at annual staffing reviews.

Medical Staff

Due to the volume of vacant junior doctor posts (see section 2.3) there is a risk on the corporate register relating to the 'Risk that there are insufficient numbers of doctors in training to safely cover rotas.' The current rating is 12 and the level is high risk.

There is an increasing reliance upon locally employed doctors to support rota compliance however; there are insufficient numbers of suitably qualified locally employed doctors, both within the UK and overseas.

The Trust has developed innovative approaches to try and attract locally employed doctors but the competition for these individuals when coupled with the widespread shortage means that this staff group are challenging to recruit and are also an unpredictable resource.

The introduction of e-rostering will support rota compliance, provide information to provide assurance or action required re productivity and provide greater levels of governance with regards to the management of safe working hours. However, it will bring improved efficiencies in the deployment of medical staff and support the development of sustainable workforce solutions. It will provide visibility and a better understanding of our allocation of resource and where there are shortfalls to assist with workforce redesign to help drive effective reorganisation.

The development of the locum bank, which is linked to the e-rostering roll out will also enable the access to a broader pool of doctors which will help mitigate against the reduction in available working hours of our existing medical staff.

The Trust also has an established marketing brand and has a variety of recruitment initiatives to continue to promote us as employer of choice.

7.0 Performance against key quality metrics.

The Trust level quality performance dashboard for the last six months indicates that

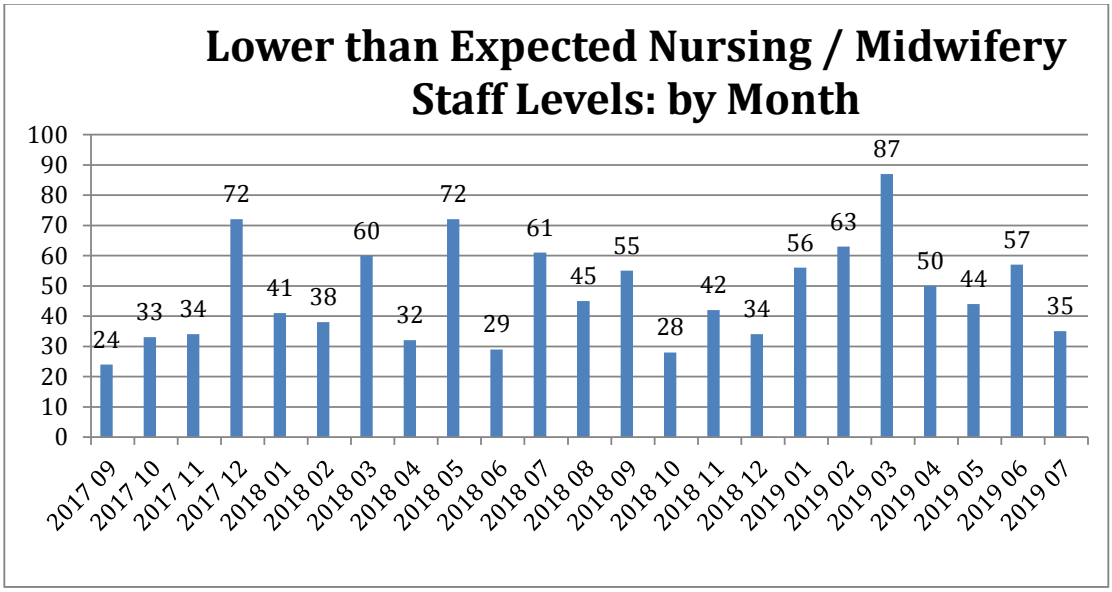
overall the standard of patient care during this period was of good quality (safety/clinically effective/patient experience).

7.1 Staffing Incidents

Nursing and Midwifery

The number (see Fig 7), content and any themes arising staffing incidents related to staffing, are reviewed and discussed monthly at Nursing Controls Group and via Divisional Performance and Ops Reviews.

Fig 7



There were increases in reported incidents during February, March and June. The incidents were spread across a number of wards and Divisions or occurred in non-ward specialist areas due to specific issues related to lack of resilience in small teams.

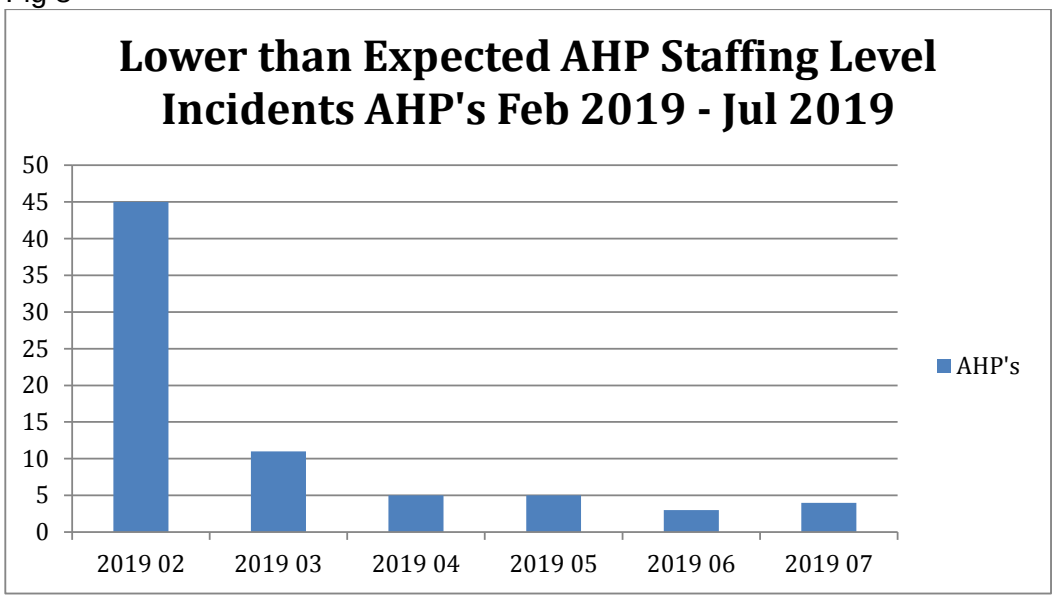
Where lower than expected staffing forms were submitted, the actual harm was assessed as near miss to minor actual harm impact only.

Allied Healthcare Professionals (AHPs)

Lower than expected staffing level incidents for AHP's, for February to July 2019 are shown below (Fig 8). There was a spike in February due to a single department having significant difficulties covering the service due to a lack of specialists. The most frequent cause in the other months was due to sickness. This resulted in reducing the service available on that day.

Where lower than expected staffing forms were submitted, the actual harm was assessed as near miss to minor actual harm impact only.

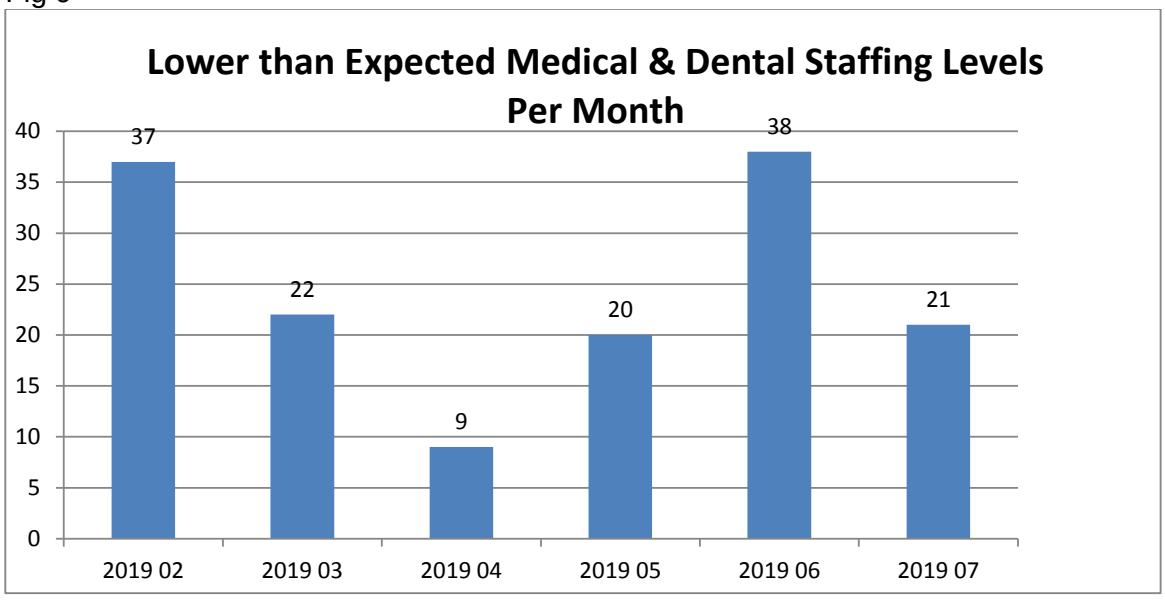
Fig 8



Medical Staff

There have been a number of occasions where there were lower than expected staffing levels, the volume of which are detailed in Fig 9 below. Each incident is reviewed within the relevant Division.

Fig 9



The incidents were across a variety of different specialties and mainly relate to sickness absence, vacant shifts or rota management.

Where lower than expected staffing forms are submitted, the actual harm was assessed as near miss to minor actual harm impact only.

8.0 Workforce Planning for the Future

Nursing and Midwifery

8.1 Nursing Associates

Two thousand Nursing Associate roles were introduced in England as a pilot scheme in 2017. The introduction of Nursing Associates aims to bridge the gap between healthcare support workers and registered nurses providing a clear career pathway into the latter role, The role is focussed on supporting RN's to spend more time using their skills and knowledge to focus on complex clinical duties and leading decisions in the management of patient care. The role of Nursing Associate will be registered with the NMC.

A business case for 20 Trainee Nursing Associates per year, over the next 3 years was approved by the Trust Senior Leadership Team (SLT) in June 2019, with the first cohort, 12 in Medicine and 8 in Surgery commencing their training in October 2019.

Medical Staff

8.2 Doctors in Training and Locally Employed Doctors (Junior Doctors)

Following the Medical & Dental workforce planning session in January 2019, it was agreed that there should be a review of the junior doctor rotas. The review will assess current working arrangements in order to progress new models of working to allow for a risk based integration of Physician Associates and Advanced Practitioner roles and any further areas for action that would support more sustainable models of working.

8.3 Physician Associates

The Division of Medicine has recently recruited seven Physician Associate roles. The roles will be assessed to understand their impact upon clinical care, their integration with the wider clinical team and whether the posts are cost efficient. The satisfaction of the post holders and the quality of their education will also be assessed. This evaluation will feed into the rota review to inform the potential expansion of the Physician Associate role across the Trust.

9.0 Conclusion

Nursing and Midwifery

Reviewing and aligning nursing and midwifery staffing against the care needs of our patients remains a high priority across the Trust. In the last six months the Chief Nurse

and Divisional Teams have continued to review and monitor both short term and longer term staffing skill mix and establishments, in line with UHBristol principles for initiating a staffing review and the principles of safe staffing in line with speciality specific guidance/recommendations.

This paper can assure the Board of Directors that UHBristol has had sufficient processes and oversight of its staffing arrangements to ensure safe nursing and midwifery staffing levels over the last six months.

Medical Staff

There is significant impetus across the Trust to develop new ways of working to help improve the sustainability of the medical workforce. The implementation of e-rostering will significantly improve the visibility of rotas which will assist in proactive management of staffing levels and enable more efficient allocation of our resources. There is a detailed workforce action plan to help mitigate against vacancies at the junior doctor level and it is anticipated in the longer term that there will be a reduced reliance upon this grade of doctor for service delivery.

Allied Healthcare Professionals (AHPs)

With the information available, this paper can assure the Board of Directors that UHBristol has had sufficient oversight of its staffing arrangements to ensure safe AHP staffing levels over the last six months. However, further work to review AHP staffing and processes in more detail, is underway and will be presented in the next 6 monthly staffing paper.

Appendix 1:

UHBristol's principles for initiating a nurse 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.

Care Hours per Patient Per Day and How its calculated

CHPPD was developed, tested and adopted by the NHS to provide a single consistent way of recording and reporting deployment of staff on inpatient wards/units. The metric produces a single figure that represents both staffing levels and patient requirements, unlike actual hours alone. The data gives a picture of how staff are deployed and how productively they are used. It is possible to compare a ward's CHPPD figure with that of other wards in the hospital, or with similar wards in other hospitals. If a wide variation between similar wards is found it is possible to drill down and explore this in more detail.

Every month, the hours worked during day shifts and night shifts by registered nurses and midwives and by healthcare assistants are added together. Each day, the number of patients occupying beds at midnight is recorded. These figures are added up for the whole month and divided by the number of days in the month to calculate a daily average. Then the figure for total hours worked is divided by the daily average number of patients to produce the rate of care hours per patient day. This figure is reported monthly to NHSI.

The care hours per patient day required to deliver safer care can vary in response to local conditions, for example the layout of wards or the dependency and care needs of the patient group it serves. Therefore, higher levels of CHPPD may be completely justifiable and reflect the assessed level of acuity and dependency. Lower levels of CHPPD may also reflect organisational efficiencies or innovative staffing deployment models or patient pathways.

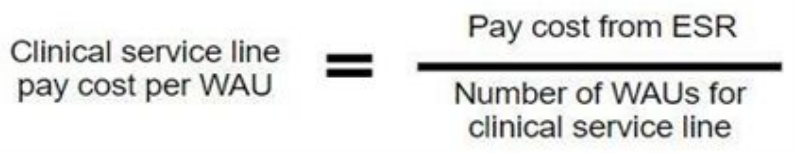
Weighted Activity Unit

Weighted Activity Unit (WAU) is defined as a 'common currency' to describe an amount of clinical activity, with a weighting applied that takes account of case mix and complexity. It is used in the Model hospital, following the work under taken by Lord Carter, as a method of viewing NHS operational productivity and comparing this between Trusts.

A WAU is quantity of any types of clinical activity including inpatients, outpatients, diagnostic testing and others. The national average cost is taken of each clinical activity, and divided by 3,500 to say how many WAUs that clinical activity is 'worth'. The national average cost of a procedure comes from reference costs. One WAU equates to £3,500 'worth' of healthcare services.

Slightly different methodologies are used to calculate all staff cost per WAU (weighted activity unit) metrics at trust level and for individual clinical service lines

.A simple calculation is used for staff cost per WAU metrics at clinical service line level, using data from ESR (the Electronic Staff Record) for costs:


Clinical service line pay cost per WAU
=
Pay cost from ESR
Number of WAUs for clinical service line

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Learning from Deaths Report**
Report Author	**Mark Callaway, Deputy Medical Director**
Executive Lead	**William Oldfield, Medical Director**

1. Report Summary
This report records the results from Learning from deaths in 2018/2019. The total number of deaths is very similar to the previous year with the number of deaths subject to structured case note review almost identical. One potentially avoidable death has been identified
2. Key points to note *(Including decisions taken)*
Very similar numbers of adult deaths to the previous years with a very similar deaths subject to structured case note review Eight death subject to a second review by the Medical Directors team but only one potentially avoidable death identified
3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: *None*
4. Advice and Recommendations *(Support and Board/Committee decisions requested)***:**
• This report is for **ASSURANCE** • The Board is asked to **NOTE** the report
5. History of the paper **Please include details of where paper has previously been received.**

Quality and Outcomes Committee	**26 September 2019**

University Hospitals Bristol
NHS Foundation Trust

Learning from Deaths

Report for 2018/2019

12

MP Callaway

16th Sept 2019

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 Division for further assessment and further reviews are undertaken, the results of these reviews are co-ordinated by the Divisional Mortality Leads who feedback via the Mortality Surveillance group which meets on a monthly basis.

This report summarises the activity in 2018/2019

Report

The number of adult in patient deaths within 2018/2019, are almost identical to the number of deaths for the previous year 1326 in 2018/2019 compared to 1346 in the previous year. In addition, the number of patients being referred for a structured case note review is also very similar with 27% of all adult in patient deaths being referred in 2018 and 28% of cases being reviewed in this year.

The Medical Directors team carried out a further review of 5 patients during Quarter 2. These were reviews in elderly patients undergoing orthopaedic procedures and full report was commissioned by the Medical Director and action instigated, no further deaths within this group have been referred for further review. In quarter three 3 further reviews were undertaken and a potentially avoidable death was identified.

There were 17 deaths in patients in whom review of the notes suggested potential learning difficulties in this year. These deaths are undergoing a further review in addition to the SCNR by Laura Holmes, our lead for patients with learning difficulties.

One potentially avoidable death has been identified, and although the death occurred in a neighbouring Trust a potential lack of clarity as to the follow up in a patient with complex congenital heart disease during and following the period of transition from paediatric to adult was identified as a potential causative factor. Throughout the year the themes of recognition of end of life and timeliness of senior review remain apparent.

These identified themes are closely aligned to those found in other Trusts in the region. The AHSN are supporting the roll of the ReSPeCT process across the health care system, this will improve the advanced care planning in the future. The Trust is about to embark on the system wide roll out of the ReSPeCT process which is due to commence on October 10th.

The National introduction of medical examiners over the next 18 months will result in changes to UHBristol learning from deaths process, however we have commenced a pan Bristol and Weston approach to standardise the system approach to the required changes. A project manager to co-ordinate the roll out within the 3 Trusts will shortly be appointed with the remit to introduce this system by April 2020.

Update from 2018/2019

	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)	335	288	332	371	**1326**
OOHCA	46	27	27	34	**134**
Total excluding OOHCA	289	261	305	337	**1192**
ITU deaths	52	44	58	60	**214**
Total SCNR identified	60 (21%)	71 (26%)	107 (35%)	131(35%)	**369(28%)**
Medicine	22 (36%)	46(66%)	65(61%)	77(59%)	**210**
complete	15	31	21	15	**82**
pending	7	15	44	62	**128**
Surgery	13 (21%)	11 (15%)	22 (20%)	23(17%)	**69**
complete	7	5	10	3	**25**
pending	6	6	12	20	**44**
Specialised Services	25 (41%)	14(19%)	21 (19%)	31(23%)	**91**
	24	13	18	16	**71**
complete	1	1	3	15	**20**
pending					
Number triggering MDO Review	3	0	5	**0**	**8**
Number of SI reports in the last episode of life related to patient death	1	2	6	**3**	**12**
Number of avoidable deaths	0	0	0	**1**	**1**
Number of Deaths in patients with Learning Difficulties	5	3	3	**3**	**14**
Death within 30 days of discharge					
Total	146				**146**
From ED	27				**27**

1. **The conversion of the database to a Medway based system**

The method of data collection changed at the end of quarter 2 2018/2019, with the introduction of a new method of electronic recording of the SCNR in Medway, which has led to the automatic generation of a database which allows much greater visibility around the system. This came into operation on September 1st 2018 and has become a fully integrated method for data collection. This system is now fully integrated into the method of data capture and generates a weekly report which is feedback to the Divisional Mortality Leads.

2. **Review of the Category Deaths.**

The following are mandated for SCNR; deaths following elective procedures, deaths in patients with a history severe mental illness, deaths in patients with learning difficulties, where concern has been raised by family or friends or in death where raised, an alarm raised by SHMI.

Category 7 is the additional category, unique to UHBristol, which was assigned at the time of inception of the process of learning from deaths, and was an additional category to those mandated categories outlined in the initial paper learning from deaths produced by the Department of Health. This category was to identify patients in whom the mortality group perceived there was an increase risk, such as multiple ward moves during a patient's admission. Patients were assigned a category 7 status by the lead Mortality nurse and a structured case note review was undertaken.

A piece of work was undertaken during the year to review the category 7 reviews for 2018. This work was undertaken by the Mortality Fellows assigned to the team.

During the year 14 deaths were identified in patients with learning difficulties. These patients have a structured case note review and are referred to the LeDeR for a further review. If any areas of concern are identified these are then fed back to the Medical Director. No areas of concern have been identified to the Medical Director in 2018/2019

All the deaths in this category were reviewed in 2018, and the major themes identified. This was the largest group of patients sent for SCNR and there were 303 patients in whom a category 7 issue was raised, in 1361 adult deaths. The single largest identifiable factor in this group was re admission following recent admission, and this was a factor in 63 patients in this group. This supports the work that is being undertaken to introduce the system wide approach to advance end of life care planning being co-ordinated by the ASHN with the move to introduce the ReSPeCT form which is planned for a system roll out on October 10th.

In addition the institution of timely end of life care was also identified as a factor in this group and this also supports the work being undertaken around advanced end of life care planning and the ReSPeCT form.

3. **Reviews and Involvement of the consultant body**

All consultants are now expected to undertake SCNR as part of the patient safety assessment of their supporting programme activities. Involvement of the entire adult consultant body means that although important this process will only have a minimal impact on any single individual. This process has started from the beginning of December, and has meant that all outstanding reviews have now been allocated to a Consultant for review. Difficulties with the evolve system of notes has slowed down the potential reviews, with several of the Divisional Leads trying to ask and obtain reviews prior to the scanning of notes onto evolve. In addition, notes being sent to the Coroner's office has been identified as potential cause for delay in the review process this year, and a separate category has been established on Medway to record the numbers of patients who fall into this group, although early estimations suggest this to be as many as 35% of cases.

4. Deaths for MD team Review

As reported during the first part of the year, three deaths from within the Surgical Division were refereed for a second review by the MD team; these deaths were in elderly patients who had undergone orthopaedic procedures. The MD team carried out a second SCNR and concluded that although there was no evidence of avoid ability of death, there were multifactorial factors around the post-operative patient care that raised concern. These concerns were raised with both the Division and Executive team.

In late October another 5 cases were highlighted were as causing concern and all of these patients had undergone orthopaedic procedures or were being managed with orthopaedic problems. This again was in the elderly patient population.

Following an initial review it was noted that from April 2017 until the end of October 2018 there were 70 deaths within Trauma and orthopaedics, of which 35 triggered an SCNR, of these 8 patients, had a score of 2 and these patients have now been reviewed. This indicates a referral for SCNR of 50% in this patient population.

The Trust rate of SCNR in all deaths in April 2017-March 2018 was 26.9%.

The mortality lead for surgery and the Medical director team conducted the SCNR which identified several consistent themes; a report was then submitted to the Medical Director. This report identified that there were no avoidable deaths but again there were issues around patient's post-operative management. This multi author report identified several themes around the deteriorating frail elderly patient, and a resulting action plan is being co-ordinated by the Medical Director.

5. Clinical Education Fellows

During the year three clinical fellows, Dr Catrin Evans, Dr Michael Fitzpatrick and Dr Sita Elsaesser have undertaken several projects that have been associated with the Learning from deaths process; these have included reviewing the arbitrary category 7 and assessing the potential of risk associated with deaths in this group and developing themes within the group of patients. This work was recently presented at the national patient safety congress in Manchester. (Appendix 1).

6. Medical Examiners Role

The Trust has been leading on the cross system development of the Medical Examiner's role. This new system around the certification of death will be introduced in April 2020. Agreement has been reached by the 3 local Trusts, UHBristol, NBT and Weston, to appoint a project manager to oversee the development and introduction of the Medical examiner system, with the appointment of a number of medical examiners in each organisation.

Conclusion

Overall the number of adult deaths and the number of deaths that following initial review have undergone a SCNR are very similar in 2017/2018 and 2018/2019. Overall the care provided has been assessed as Good. The major themes remain the instigation of the appropriate end of life pathway and Senior Decision making when to move from physiological care to symptom monitoring.

The Trust is just about participate in the system wide roll out of ReSPecT which is system designed to initiate a conversation with the patient about their end of life care, this approach has been adopted in all aspects of the health care system.

Several deaths in an elderly orthopaedic population were identified by the screening process and these deaths were subject to a formal 2nd review by the MD office. No unavoidable deaths were identified but issues with Senior Decision making and the instigation of end of life care were; this formed the basis of a separate report commissioned by the Medical Director.

During the year a single avoidable death was identified, this death was identified via the SI process as the death occurred in a neighbouring Trust but issues around on going management and transition from paediatric to adult care were raised as part of the investigation.

Appendix 1

Dr MP Callaway

16th September 2019

What happens when patients leave hospital: Learning from 30 day community deaths

Authors: Dr. Sita Elsaesser [1], Dr. Catrin Evans [1], Dr. Michael Fitzpatrick [2], Tina Whiting [2], Dr. Mark Callaway [3] &Dr. Emma Redfern [3]
(1) Clinical education fellow (2) Lead mortality nurse (3) Mortality Lead
Contact: catrin.evans@uhbristol.nhs.uk

University Hospitals Bristol
NHS Foundation Trust

Overview

- Following a BMJ article that claimed 750 deaths in the NHS per month were avoidable (1) national guidance on learning from deaths was published (2) in an attempt to standardise the approach to reviewing death across the NHS.
- The University Hospitals Bristol (UHB) Foundation trust has undertaken screening and review of all inpatient deaths since April 2017. This process has proved effective in identifying potential areas for improvement in patient care.
- The national guidance (2) recommends a review of those who die in the community within 30 days of discharge from trust services, however few hospitals have achieved this due to lack of capacity . To the best of our knowledge no other NHS trust has published data following review of this cohort of patients.

Project Aims

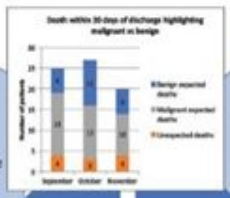
- We aimed to examine all community deaths within 30 days of discharge from UHB for a 3 month period in order to determine whether these deaths were unexpected or expected and also whether any improvement could have been made to their care.
- We aim to look in particular at the quality of the patient's discharge summaries to determine whether, in the case of expected deaths, appropriate information was being communicated to the primary care physician to alert them of their poor prognosis.

Method

- All community deaths within 30 days of discharge from hospital or A&E at UHB were examined from the 1st of September to the 30th of November 2018.
- We excluded those who were treated as day cases.
- The source of information was their discharge letters and clinic letters on the hospital computer system (Medway).
- Using this information we determined, according to national (3) poor prognostic indicator guidelines, whether their death could be deemed expected or not.

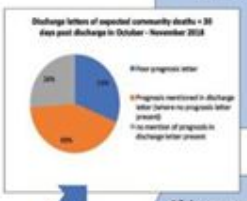
Results

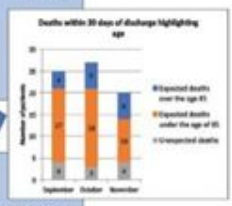
72 patients who died within 30 days of discharge from UHB were identified between 1st September 2018 and 30th November 2018.



Of the expected deaths:
- 24 of the patients (39.3%) had been admitted or attended A&E more than once in the 3 months leading up to their death.

61 deaths were found to be expected on the basis of their discharge letters. Of these deaths, 16 were over the age of 85 and 38 were attributed to malignant causes.





Of the expected deaths:
- 19 had a poor prognosis letter filled out and sent to their GP
- 26 had their prognosis clearly described in their discharge summaries (although there was no poor prognosis letter)
- 16 patients had no documentation in their discharge letters that their prognosis was poor.
- 32 (51.6%) of the discharge summaries did not clearly state that the patient had a DNAR or TEP form.

11 of the deaths were found to be unexpected on the basis of the patient's discharge letter. 5 (45.5%) of the unexpected deaths occurred in adults engaging in risk-taking behaviour (i.e. IVDU users, alcohol abuse) and 2 of these patients left the A&E department prior to being assessed. In unexpected cases, the cause of death was not always determined if the deaths had not been reported to the coroner.

Actions we have taken on the basis of the above results

- Survey sent to all hospital doctors to attempt to identify barriers towards discussing prognosis with patients.
- Integrated our findings with ongoing palliative care projects within the trust.
- Suggested ways of streamlining the mortality review process to IT as the process is currently time consuming.

Discussion

- We are unable to compare this to national figures as there is currently no published data in this area.
- It is reassuring that the majority of community deaths (84.7%) were expected on the basis of the patient's comorbidities. Moreover, a significant proportion of these expected deaths were attributed to malignancy (61%).
- There was considerable difficulty in obtaining further information on those unexpected deaths in the community - highlighting the need for a more robust and central system for the recording of deaths.
- Poor communication between primary and secondary care regarding patient prognosis was a significant issue ;over a quarter of patients who, as a result of their comorbidities are likely to be in their last year of life, had no documentation of their prognosis in their discharge letters or no poor prognosis letter generated.
- 39.3% of the expected community deaths had been admitted to hospital more than once within the preceding 3 months, further work needs to be done to correlate the number of admissions with risk of mortality and poor prognosis.
- Our findings correlate with those of the Royal college of physicians(4) which suggests that as hospital clinicians we need to improve our communication with primary care regarding prognosis and end of life care.

References
1. Hogan, Helen, et al. "Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis." bmj 351 (2015): h3239.
2. https://www.england.nhs.uk/wp-content/uploads/2017/01/nqb-national-guidance-learning-from-deaths.pdf
3. The National Gold Standard Framework Centre's guidance for clinicians to support earlier recognition of patients nearing the end of life-https://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf
4. https://www.rcplondon.ac.uk/projects/outputs/talking-about-dying-how-begin-honest-conversations-about-what-lies-ahead

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Patient Experience and Involvement Report Q1**
Report Author	**Paul Lewis, Patient Experience and Involvement Team Manager**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

This report item provides a review of patient-reported feedback received via the Trust's corporate patient survey programme, up to and including Quarter 1 2019/20. It also includes examples of current patient experience and involvement activity at the Trust.

2. Key points to note

(Including decisions taken)

- UH Bristol achieved a very positive set of results in the 2018 national inpatient survey (data released in Quarter 1), achieving the highest overall experience rating amongst general acute trusts.
- 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
- Nearly 2,000 people responded to UH Bristol's inpatient and outpatient postal surveys in Quarter 1, with 99% rating their care as excellent, very good, or good.
- Ward A605 received the lowest Friends and Family Test score in Quarter 1. However, there is a wider improvement context behind this result, with the Trust's postal survey data showing a positive improvement compared to previous quarters. This is likely to be a result of leadership changes on the ward, which should continue to impact positively on patient experience.
- The Trust's postnatal wards 73 and 76 had the lowest "kindness and understanding" survey score in Quarter 1. The maternity service was extremely busy in Quarter 1, with extra capacity having to be opened in June and inductions being delayed. Unfortunately this may have impacted on the experience of women on the wards at the time. The management team have shared this result with the ward team as a reminder about the importance of focussing on person-centred care even in the most challenging operational situations.
- Ward D703 received relatively low postal survey scores in Quarter 1. This was an unusual result for the ward. There were staffing pressures on the ward during this period, due to vacancies and the introduction of a new type of treatment (CAR-T). This may have impacted negatively on patient experience. The vacancy levels have since improved and CAR-T is now fully embedded on the ward. It is therefore anticipated that the survey scores will return to their normal range during Quarter 2.

3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**	
The risks associated with this report include: N/A	
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **ASSURANCE.** • The Board is asked to **NOTE** the report.	
5. History of the paper **Please include details of where paper has previously been received.**	
Patient Experience Group	22 August 2019
Senior Leadership Team	18 September 2019
Quality and Outcomes Committee	26 September 2019

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 2019/20

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

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Patient Experience and Involvement Team

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Anna Horton, Patient Experience and Regulatory Compliance Facilitator (anna.horton@uhbristol.nhs.uk)

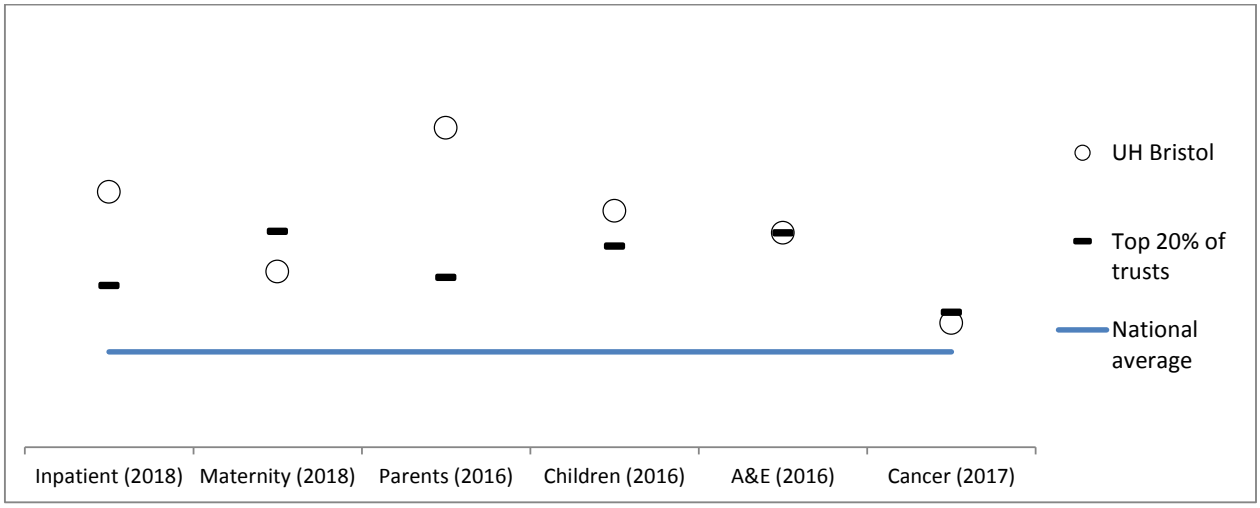
1. Overview of patient-reported experience at UH Bristol

Successes	Priorities
• UH Bristol achieved a very positive set of results in the 2018 national inpatient survey (data released in Quarter 1), achieving the highest overall experience rating amongst general acute trusts. • 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. • Nearly 2,000 people responded to UH Bristol's inpatient and outpatient postal surveys in Quarter 1, with 99% rating their care as excellent, very good, or good.	The Trust has procured an electronic feedback system that allows patients and visitors to give feedback about their hospital experience in real-time, via touchscreens located around the Trust and their own devices. The touchscreens were installed in the Bristol Royal Infirmary in Quarter 1. In addition, new "here to help" posters were installed in all wards and departments, which signpost people to the Trust's key feedback and complaint channels, including the new system. The Patient Experience and Involvement Team is currently working with Divisional leads to identify suitable locations for touchscreens in the Trust's other hospital sites. These locations have now been identified at St. Michael's Hospital and the electrical / estates work to implement the screens will commence there shortly. The plan is to have the screens fully rolled-out across the Trust by the end of December 2019.
Opportunities	**Risks & Threats**
The Trust's Patient Experience and Involvement Team is currently running a tender in collaboration with neighbouring trusts, for a new external supplier of translating and interpreting services. This exercise is likely to be completed during September 2019. This will be an opportunity to develop and enhance the support provided to patients with a translating and interpreting need.	• Ward A605 received the lowest Friends and Family Test score in Quarter 1. However, there is a wider improvement context behind this result, with the Trust's postal survey data showing a positive improvement compared to previous quarters. This is likely to be a result of leadership changes on the ward, which should continue to impact positively on patient experience. • The Trust's postnatal wards 73 and 76 had the lowest "kindness and understanding" survey score in Quarter 1. The maternity service was extremely busy in Quarter 1, with extra capacity having to be opened in June and inductions being delayed. Unfortunately this may have impacted on the experience of women on the wards at the time. The management team have shared this result with the ward team as a reminder about the importance of focussing on person-centred care even in the most challenging operational situations. • Ward D703 received relatively low postal survey scores in Quarter 1. This was an unusual result for the ward. There were staffing pressures on the ward during this period, due to vacancies and the introduction of a new type of treatment (CAR-T). This may have impacted negatively on patient experience. The vacancy levels have since improved and CAR-T is now fully embedded on the ward. It is therefore anticipated that the survey scores will return to their normal range during Quarter 2.

2. National benchmarks

The Care Quality Commission's national patient survey programme provides a comparison of patient-reported experience across NHS trusts in England. UH Bristol tends to perform better than the national average in these surveys (Chart 1). The results of each national survey, along with improvement actions / learning, 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[1]



In Quarter 1 2019/20 the results of the 2018 national inpatient survey were published. UH Bristol achieved a positive set of results in this survey:

- The scores on fourteen of the Trust's survey questions were classed by the Care Quality Commission as being better than the national average to a statistically significant degree
- The remaining 49 UH Bristol scores were in line with the national average.

These results put UH Bristol amongst the best scoring trusts nationally. In particular, we received the highest score of all general acute trusts on the survey question asking patients to rate their overall hospital experience[2]. This was the Trust's third successful year in a row on this question, having received the best general acute score in 2016 and the second best in 2017.

There were two strong improvement themes in the survey data: ensuring that patients can give feedback whilst in hospital and that they are made aware of complaints / feedback processes. Over the last year the Trust has invested in an electronic rapid-time feedback system to enhance in-hospital feedback opportunities. This is currently being rolled-out across the Trust. New promotional materials, designed by a professional marketing agency, have also been implemented in all wards and departments to more clearly signpost patients and visitors to feedback and complaint channels. These developments occurred after the sample of patients in the 2018 national inpatient survey were in hospital. We could therefore anticipate an improvement in these scores from the 2019 survey onwards.

[1] This is based on the survey question that asks patients to rate their overall experience. This question is not included in the national maternity survey, and so we have constructed this score based on a mean score across all of the survey questions.
[2] This was the tenth highest score nationally, with all of the top nine scores going to specialist trusts.

3. Survey results

3.1 Survey results overview

UH Bristol continues to receive very positive feedback from the people who use our services. For example, nearly 2,000 people responded to the Trust's inpatient and outpatient postal surveys in Quarter 1; 99% rated their care as excellent, very good or good. Table 1 provides an overview of the Trust's performance against key survey metrics. An exception report is provided on the next page of the report detailing areas that did not perform at the expected levels.

Table 1: summary of headline survey metrics

	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	Red

3.2 Update from Quarter 4

In Quarter 4, the Trust's Emergency Department Friends and Family Test (FFT) response rates were below the 15% response rate target. The Emergency Departments were alerted to this and the target was subsequently met in Quarter 1.

The Outpatient FFT response rate was also below target in Quarter 4. This survey is primarily carried out via SMS text message. We could not identify a specific reason for the decline in the rates, other than natural variation in response levels. The target was met in Quarter 1. The FFT question has now been added to the Trust's monthly outpatient postal survey to provide an additional source of data for this survey.

In Quarter 4, four FFT comments were received from patients with mental health issues stating that they had a poor experience at UH Bristol. Although this is a very small proportion of the feedback received via the FFT, the Patient Experience and Involvement Team has used it as an opportunity to carry out a more detailed analysis of survey data from this patient group. This analysis is in progress and an update will be provided in the next Quarterly Patient Experience and Involvement report.

3.3 Quarter 1 Exception Reports

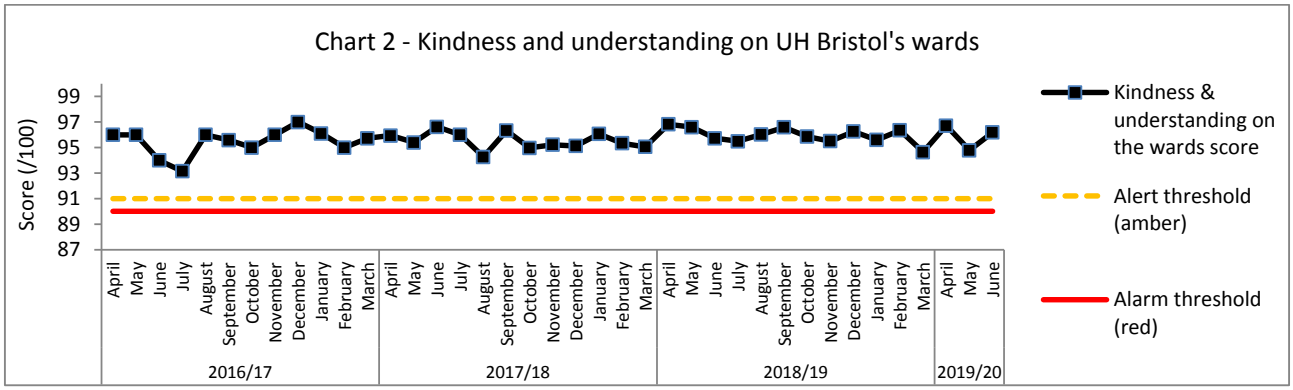
Issue	Description	Response
1. Kindness and understanding on postnatal wards	Wards 73 and 76 had the lowest "kindness and understanding" score in Quarter 1. The other key patient-reported experience scores for the maternity wards were above target.	The maternity service was extremely busy in Quarter 1, with extra capacity having to be opened in June and inductions being delayed. Unfortunately this may have impacted on the experience of women on the wards at the time. This survey result has been shared with the ward teams as a reminder about the importance of focussing on person-centred care even in the most challenging operational situations. A series of workshops has recently been carried out in maternity services, which have given staff an opportunity to reflect on the importance of providing a positive patient experience and to identify blocks to doing so. The outcomes from this exercise are currently being reviewed by the maternity management team and will be used to identify improvement actions.
2. Ward A605 Friends and Family Test score	A605 received the lowest Friends and Family Test (FFT) score in Quarter 1 (88/100 against a target of 90). This is the third consecutive quarter where this "delayed discharge" ward has been identified as a negative outlier in the survey data. However, building on positive signs in the Quarter 4 data, there were further improvements in the wider survey data in Quarter 1: the ward received top marks on the "kindness and understanding" score and achieved the best inpatient tracker score of all UH Bristol wards during this period.	A new Sister was appointed to the ward earlier this year. The Division of Medicine management team anticipate continued improvement in the survey scores as a result of these changes to the leadership team on the ward.
3. Ward D703	Ward D703 at the Haematology and Oncology Centre received relatively low postal survey scores in Quarter 1. This is an unusual result for the ward as it usually achieves very positive scores/feedback.	A new type of cancer treatment (CAR-T) was introduced at the Bristol Haematology and Oncology Centre during this period. UH Bristol is one of a small number of centres to provide this treatment, but its introduction saw an increased demand on nursing ratios at a time when there were already vacancies on D703. The vacancy levels have since improved and CAR-T is now fully embedded on the ward. It is therefore anticipated that the D703 survey scores will return to their normal range in Quarter 2.

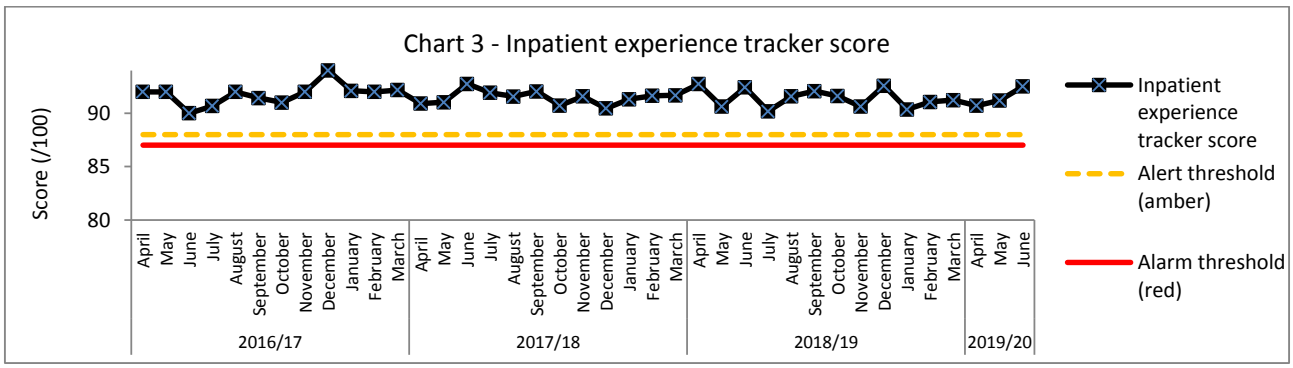
Issue	Description	Response
4. South Bristol Community Hospital inpatient tracker score	The inpatient tracker combines five key survey scores to give an overall indicator of inpatient experience. This score was below target for South Bristol Community Hospital (SBCH) in Quarter 1 (85/100 against a minimum target of 87). However, this represents an improvement trend over the last four quarters. The hospital also received a positive Friends and Family Test score and the "kindness and understanding" score was above target for the second consecutive quarter.	The relatively low inpatient postal survey scores for SBCH has been a focus of ongoing discussion and analysis by the Patient Experience and Involvement Team and Division of Medicine. Healthwatch Bristol has also carried out an "enter and view" at the hospital, to support this work. The feedback from Healthwatch was very positive and it has not been possible to identify a specific reason why the postal survey scores have been consistently below Trust targets. It does not correlate with the other quality data for SBCH that is reviewed by the Division. In Quarter 3 2019/20, the hospital management team will work with the Patient Experience and Involvement Team to run a "touchpoint mapping" exercise with patients and carers. This is a customer service tool used in the private sector, which offers an opportunity to understand the whole patient journey and identify improvements at key "touchpoints". This may be particularly helpful in the context of SBCH, where the patient journey can be long and complex. The outcomes will be reported in the next Patient Experience and Involvement Report.
5. Ward C808 inpatient tracker score	Ward C808 (care of the elderly) received the lowest "inpatient tracker" score in Quarter 1 (78/100), which is the second consecutive quarter that the ward has been identified as a negative outlier on this aggregated survey score. The "communication" elements of the tracker were particularly low. The large majority of feedback received for the ward remains very positive.	The relatively low survey scores for care of the elderly services are something that is reflected at a national-level. Analysis by the Patient Experience and Involvement Team (presented in a previous Quarterly Patient Experience and Involvement Report) demonstrated that UH Bristol performs significantly better than the national average in this respect. However, there is scope to improve patient experience in these services. In June 2019 a new job role commenced in the Division of Medicine that will see the roll out of an education programme for staff working on care of the elderly wards. This will include a focus on improving communication with patients, visitors and carers. The Division will use this as an opportunity to convene a short-life working group in Quarter 3, to review the patient experience feedback / data for care of the elderly services and identify improvement opportunities.

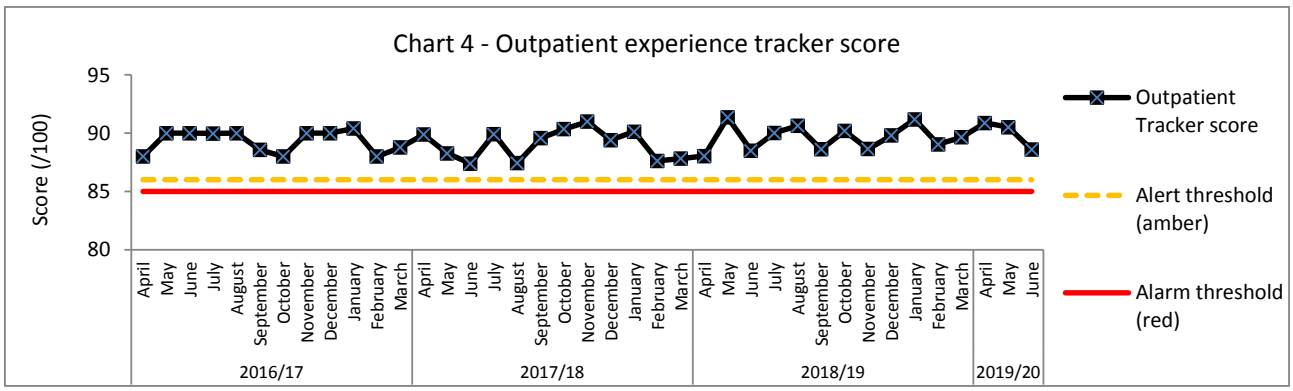
6. Communication at discharge in the Division of Medicine	Three postal survey scores relating to communication at discharge were relatively low for the Division of Medicine in Quarter 1.	A key challenge is that patients in this Division often have complex / long-term clinical needs, and so often leave with a large amount of information / medication. The "discharge checklist" used by the Division was amended last year to further ensure that key information is brought to patients' attention at discharge. The senior management team is confident that the checklist is being followed. A short-life working group is being planned for Quarter 3, to review the patient experience feedback / data for care of the elderly services and identify improvement opportunities. Conveying information at discharge will be a key focus of this work.

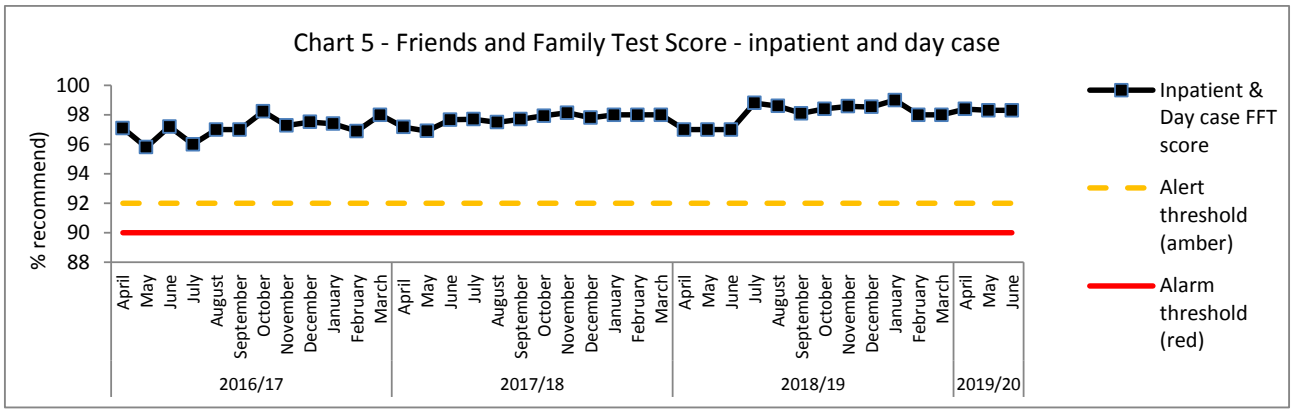
4. Full survey data

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.









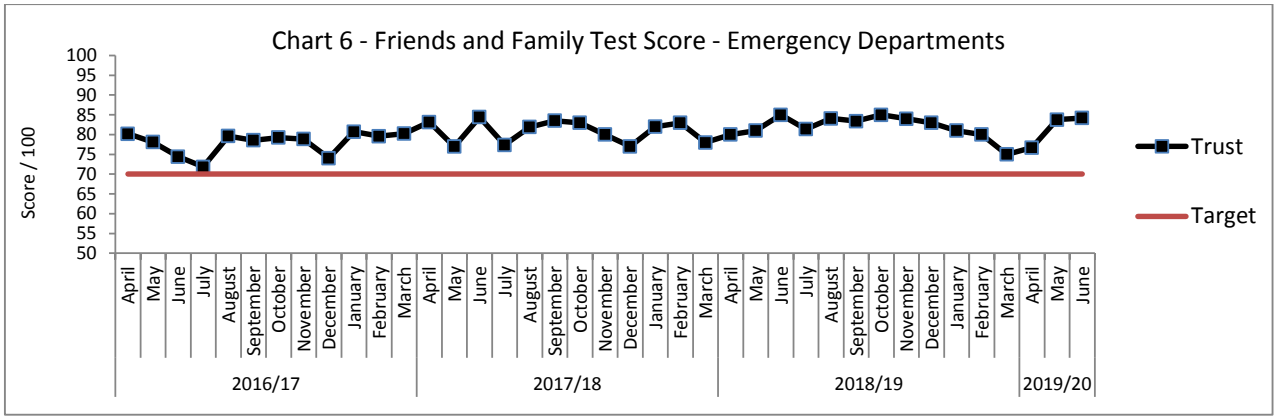


Chart 6 - Friends and Family Test Score - Emergency Departments
Score / 100
100
95
90
85
80
75
70
65
60
55
50
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
2019/20
Trust
Target

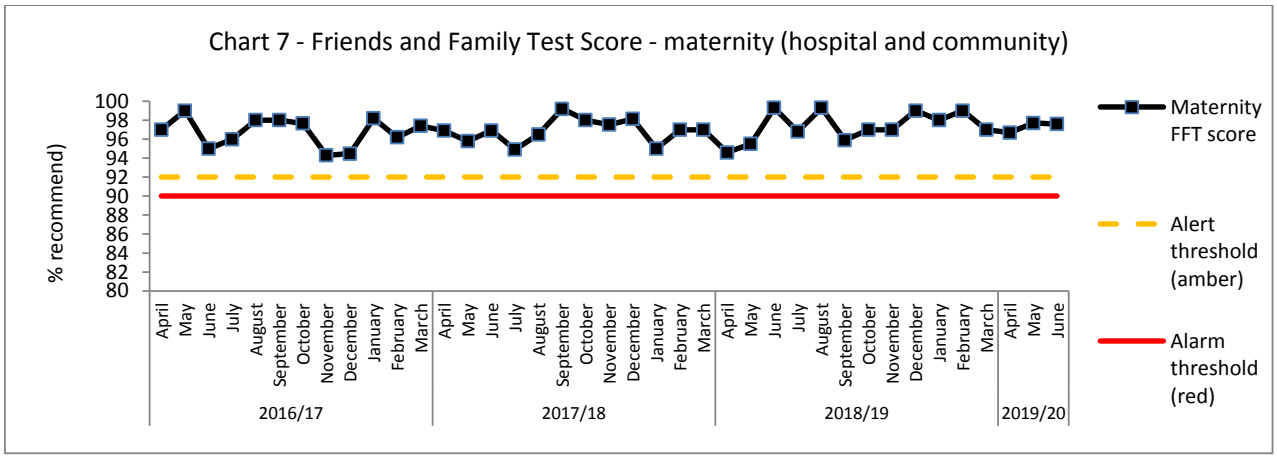


Chart 7 - Friends and Family Test Score - maternity (hospital and community)
% recommend)
100
98
96
94
92
90
88
86
84
82
80
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
2019/20
Maternity FFT score
Alert threshold (amber)
Alarm threshold (red)

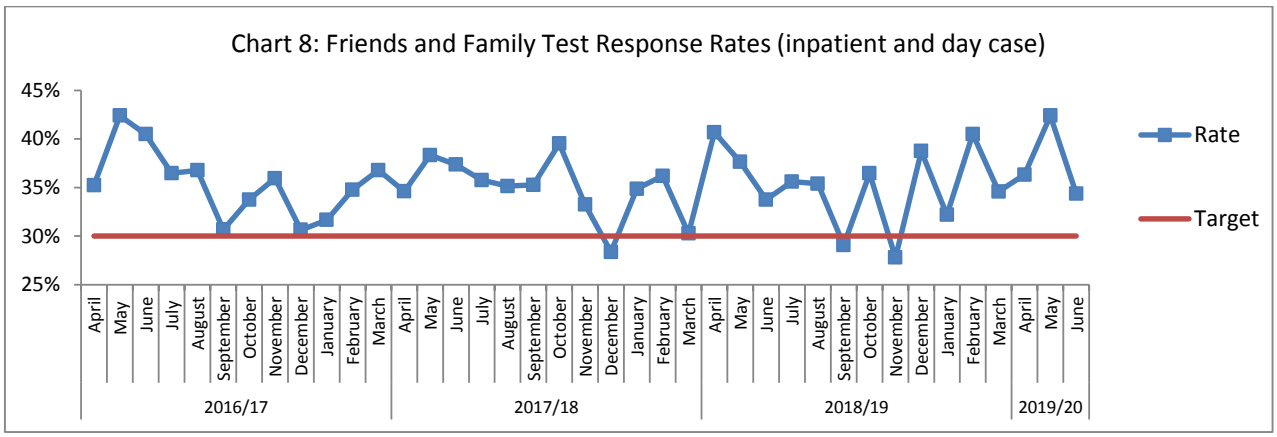


Chart 8: Friends and Family Test Response Rates (inpatient and day case)
45%
40%
35%
30%
25%
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
2019/20
Rate
Target

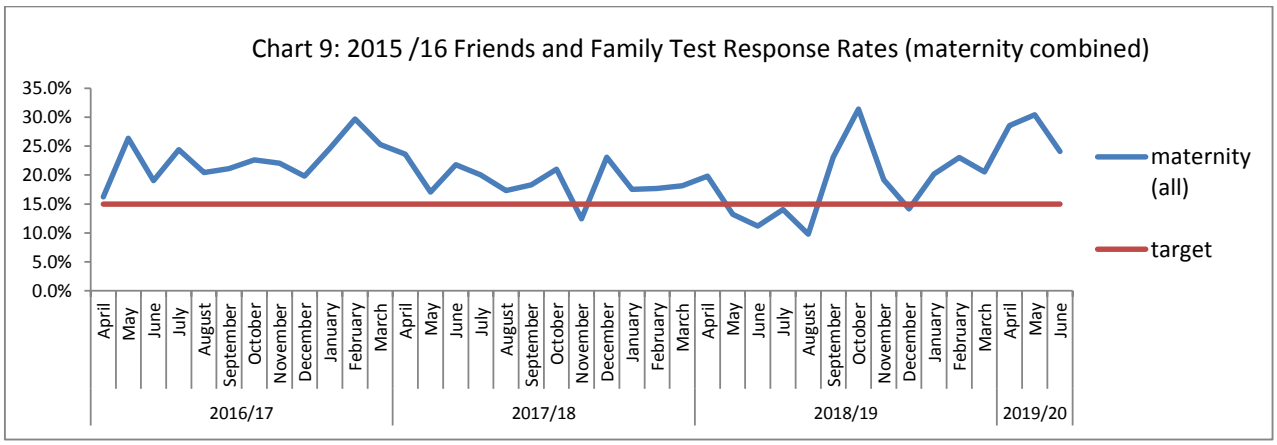


Chart 9: 2015 /16 Friends and Family Test Response Rates (maternity combined)
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
April May June July August September October November December January February March April May June July August September October November December January February March April May June July August September October November December January February March April May June
2016/17
2017/18
2018/19
2019/20
maternity (all)
target

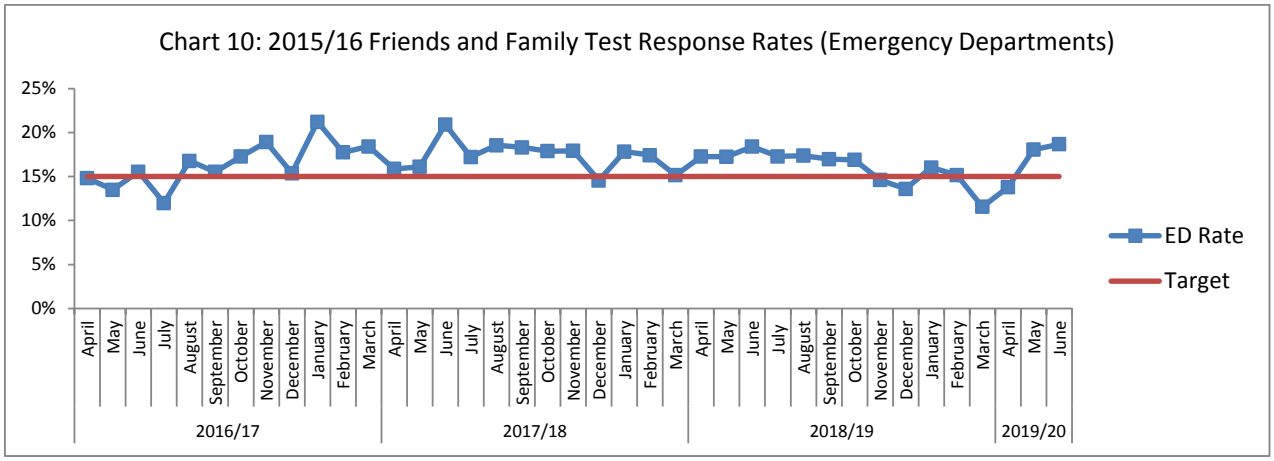


Chart 10: 2015/16 Friends and Family Test Response Rates (Emergency Departments)
25%
20%
15%
10%
5%
0%
April May June July August September October November December January February March
2016/17
2017/18
2018/19
2019/20
ED Rate
Target

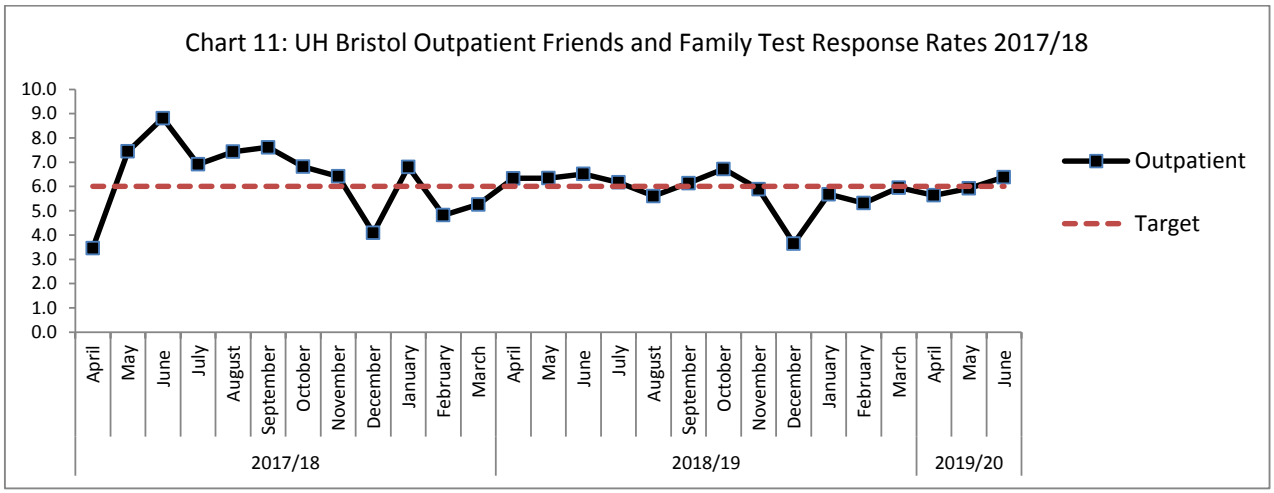
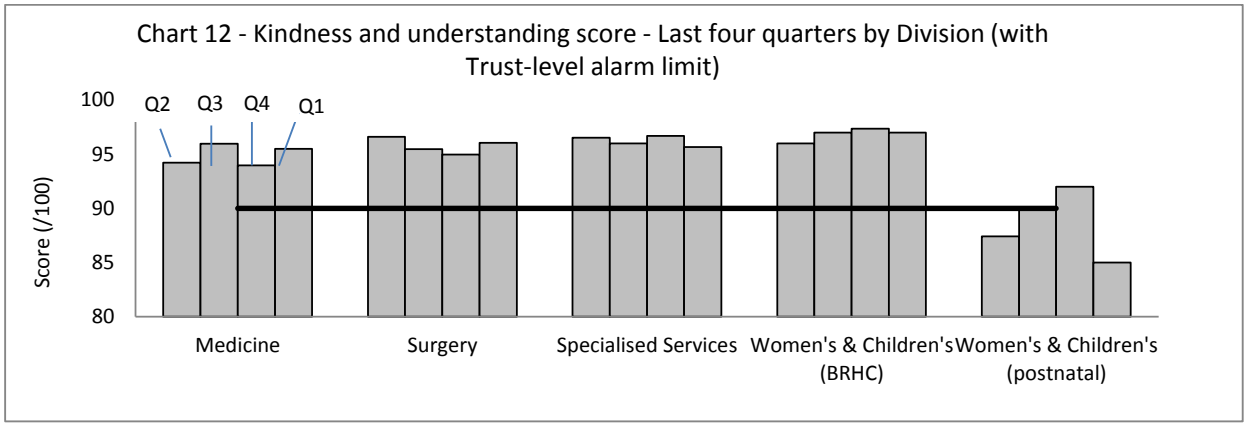
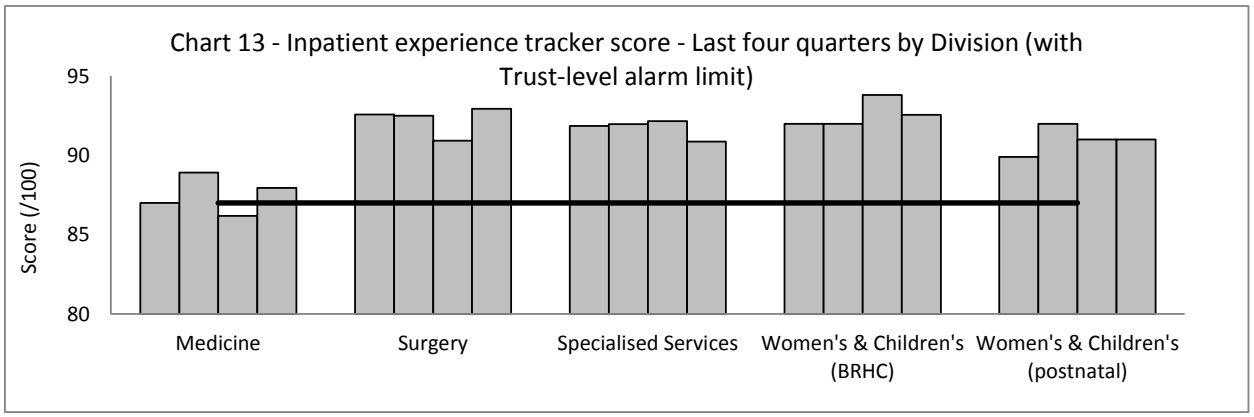
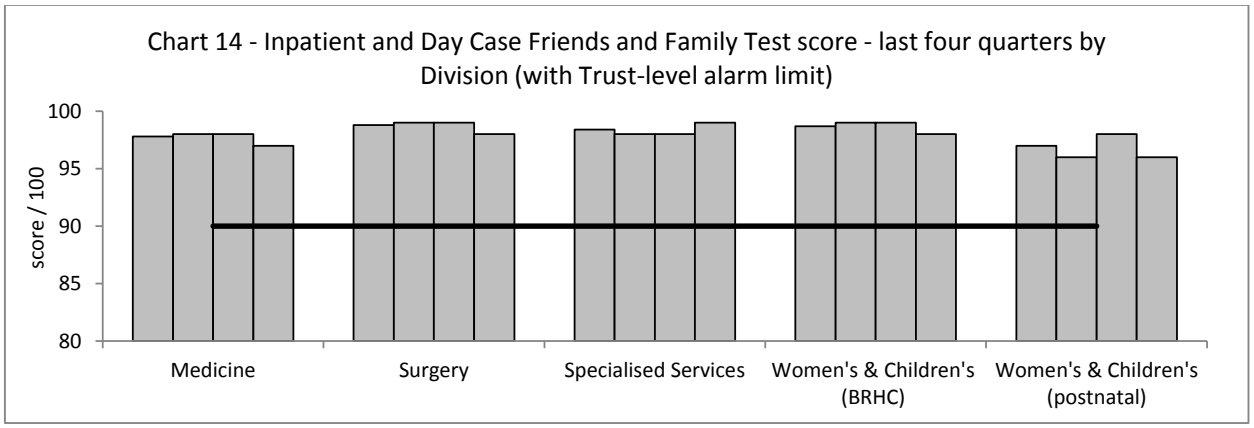


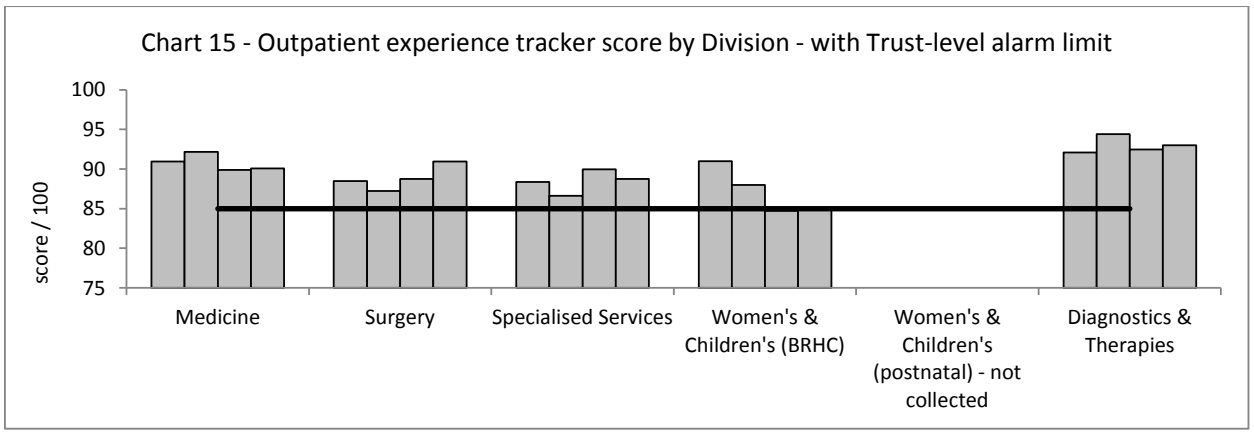
Chart 11: UH Bristol Outpatient Friends and Family Test Response Rates 2017/18
10.0
9.0
8.0
7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0
April May June July August September October November December January February March
2017/18
2018/19
2019/20
Outpatient
Target

4.1 Divisional level survey results









4.2 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)

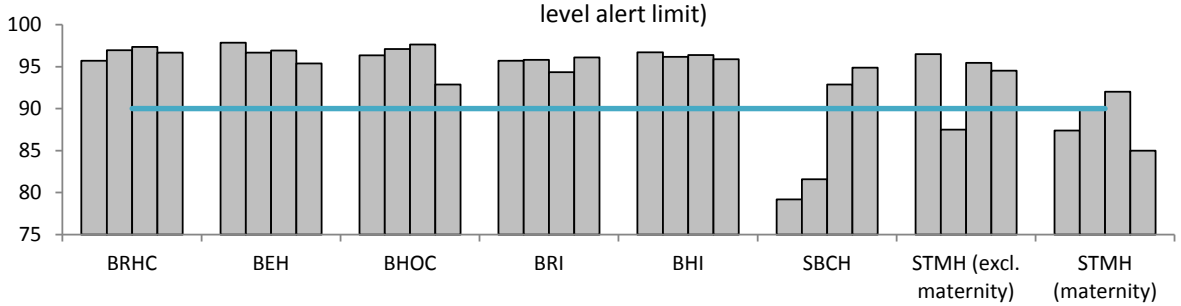


Chart 17: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

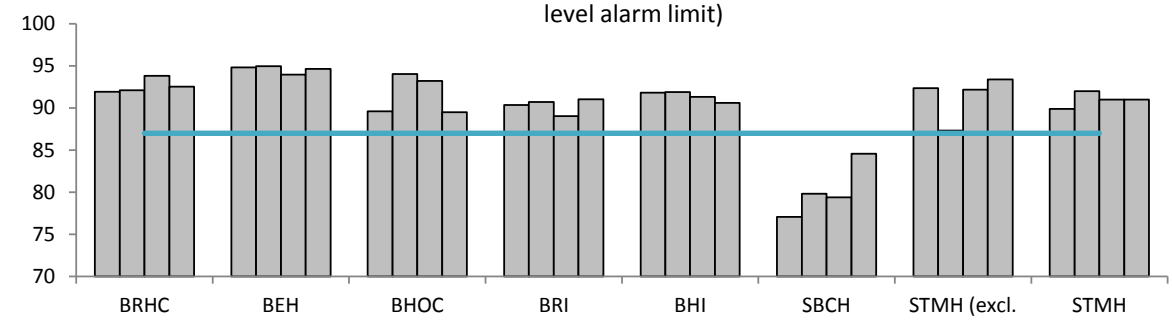


Chart 18: Inpatient and day case Friends and Family Test score (last four quarters; with Trust-level alarm limit)

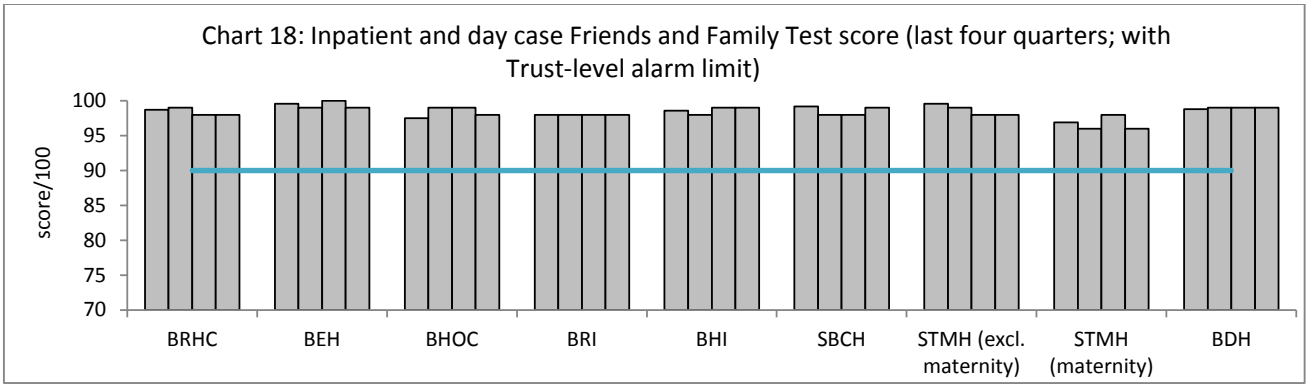
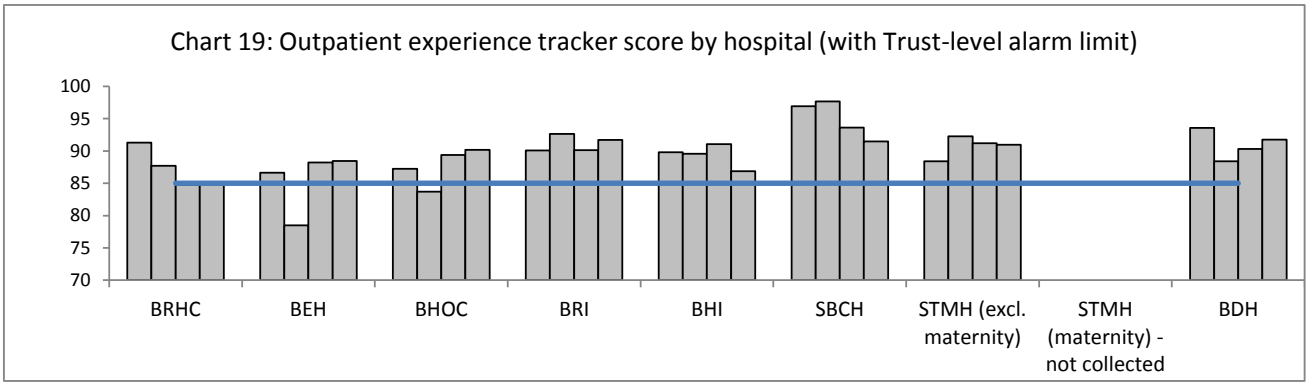
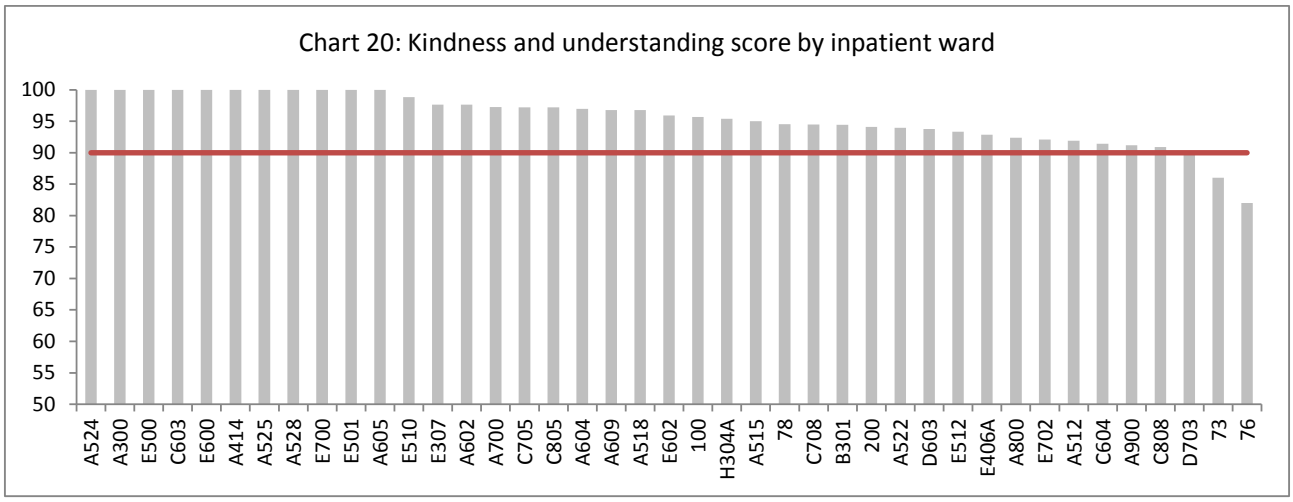
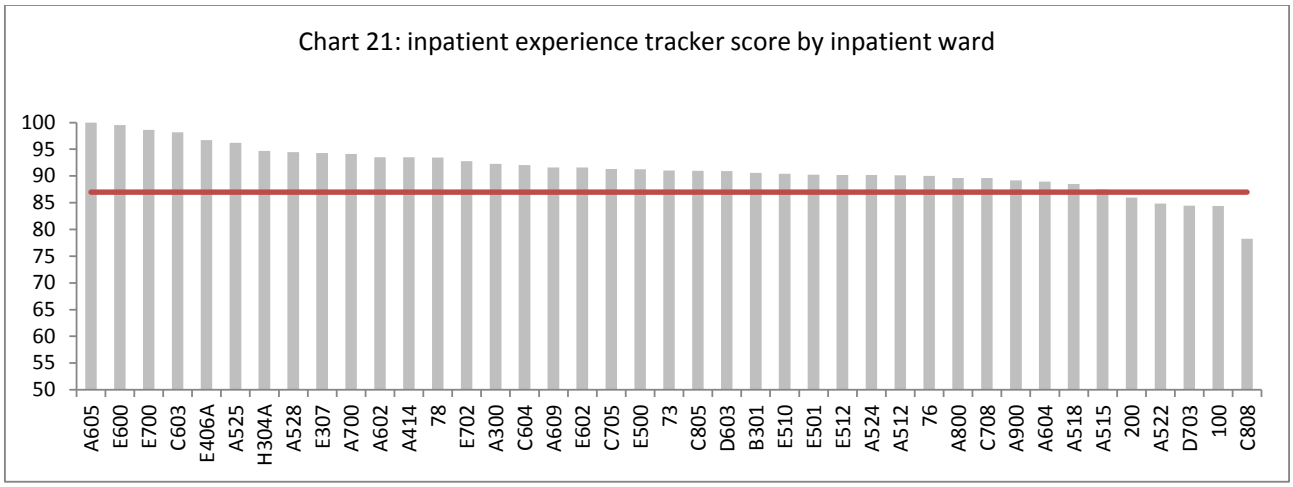


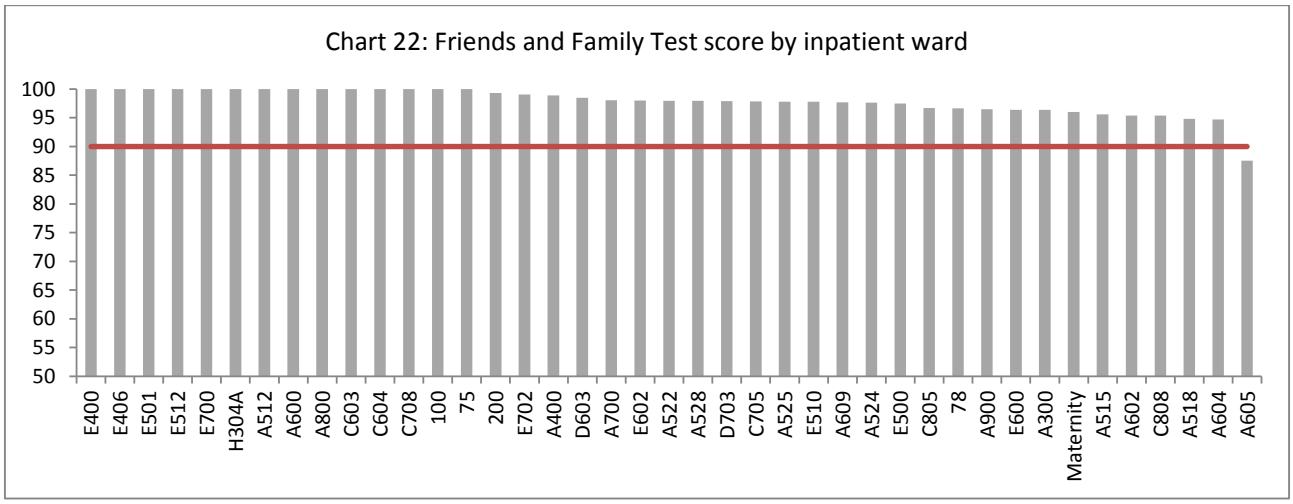
Chart 19: Outpatient experience tracker score by hospital (with Trust-level alarm limit)



4.3 Ward level headline inpatient survey results







Please note that scores are not published for wards with less than five responses as this is insufficient data to work with.

4.4 Full inpatient survey data by Division

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.

	Medicine	Specialised Services	Surgery	Women's & Children's (excl. maternity)	Maternity	TOTAL
Were you given enough privacy when discussing your condition or treatment?	92	93	94	95		93
How would you rate the hospital food?	62	65	63	64	57	64
Did you get enough help from staff to eat your meals?	83	93	75	88		86
In your opinion, how clean was the hospital room or ward that you were in?	93	94	92	96	90	94
How clean were the toilets and bathrooms that you used on the ward?	88	90	92	92	79	91
Were you ever bothered by noise at night from hospital staff?	81	80	85	85		83
Do you feel you were treated with respect and dignity by the staff on the ward?	95	96	97	97	92	97
Were you treated with kindness and understanding on the ward?	96	96	96	96	85	96
Overall, how would you rate the care you received on the ward?	88	91	91	91	91	90
When you had important questions to ask a doctor, did you get answers that you could understand?	83	89	93	91	89	89
When you had important questions to ask a nurse, did you get answers that you could understand?	89	90	91	92	91	91
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	70	75	80	80	77	77
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	86	88	90	90	86	88
Were you involved as much as you wanted to be in decisions about your care and treatment?	80	84	91	89	89	86
Do you feel that the medical staff had all of the information that they needed in order to care for you?	86	91	90	91		90

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

	Medicine	Specialised Services	Surgery	Women's & Children's (excl. maternity)	Maternity	Trust
Did you find someone on the hospital staff to talk to about your worries or fears?	68	79	83	79	83	77
Did a member of staff explain why you needed these test(s) in a way you could understand?	83	90	89	89		88
Did hospital staff keep you informed about what would happen next in your care during your stay?	78	87	85	86		84
Were you told when this would happen?	79	83	79	85		82
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	86	90	95	94		92
Beforehand, did a member of staff explain how you could expect to feel afterwards?	77	76	87	82		80
Were staff respectful of any decisions you made about your care and treatment?	93	94	94	95		94
During your hospital stay, were you ever asked to give your views on the quality of your care?	27	30	31	29	31	29
Do you feel you were kept well informed about your expected date of discharge from hospital?	72	79	86	90		83
On the day you left hospital, was your discharge delayed for any reason?	62	52	73	64	63	61
Did a member of staff tell you about medication side effects to watch for when you went home?	51	57	66	70		62
Did hospital stafftell you who to contact if you were worried about your condition or treatment after you left hospital?	67	82	92	85		82

5. Specific issues raised via the Friends and Family Test

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 5 provides a response from Divisions / services for the relatively small number of negative ratings, where that rating was accompanied by a specific, actionable, comment.

Table 5: Divisional response to specific issues raised via the Friends and Family Test, 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	BRI Emergency Department	*The Psychiatric Liaison Team were amazing. Unfortunately, I was in crisis and forced to wait with disruptive people who were swearing and acting inappropriately…Could a quiet place for mental health patients be created? A room with calming surroundings and fewer people would be really helpful.*	Thank you for your positive feedback about the Liaison Psychiatry service. We are very sorry that the waiting environment during your visit was unsuitable for your needs and caused you distress. We are currently developing a business case to put in quiet areas. Unfortunately, this is not possible within our current space, but this will be a priority for refurbishments of the Department. Thank you again for your feedback.
		Vending machine not working. I felt so hungry. The waiting was long, chairs uncomfortable. The waiting area was filthy dirty. I will never recommend to anyone.	We are very sorry that you had a poor experience in the waiting area. The area is cleaned regularly but we will introduce additional cleanliness checks. We appreciate that waits can be long during busy periods and are sorry that this was the case during your visit: in these situations it is necessary to prioritise care by clinical need, but we do appreciate that waiting to be seen can be a distressing situation for our patients and try to see people as quickly as possible. The vending machines are operated by an external company and this issue has now been resolved.
	A524	*All staff are lovely and friendly: cleaning staff could be more polite- smiley though. At night time the ward is very loud with nurses talking and using the shredder.*	Thank you for your feedback. The ward team has been spoken to about the noise at night. Spot-checks by senior staff will be undertaken over the summer to ensure staff are being quieter at night.
	A512	*It's a clean room and ward, very nice staff. Needs more toilets and shower was not working for the week I was here. No lights by beds (bed 7).*	Ward A512 is an area opened for short periods of time when the hospital is full. Unfortunately we do recognise that the facilities are limited on the ward, as it is expected patients will usually be there less than 24 hours. We are sorry that you experienced issues with the facilities during your stay: the lights and shower are now repaired.

Division	Area	Comment	Response from ward / department
Surgery	Bristol Eye Hospital ED	*Good service but the doctor left the door open during the eye injection procedure so everyone from the waiting room could see and hear.*	We are very sorry that your privacy was not maintained during your appointment. We have shared this feedback with the staff in the Emergency Department to remind them of the importance of privacy.
	Bristol Eye Hospital ED	*Pleasant and efficient, felt at ease. If you have a toy room the toys should be complete, very poor. Ask for donations, I would have given plenty of toys over time.*	We are sorry that the toys were not of a better standard during your visit. We have a process for replacing these as required and have done so since receiving your comment / suggestion. We are pleased that overall you had a pleasant visit. Thank you for your feedback.
	South Bristol Community Hospital (Day Surgery and Endoscopy Unit)	*Friendly staff, efficient. However, it would be nice to let the patient know that they can bring in their partner/parent if the wait is long. This is my first surgery and I would have liked my mum to be there in the waiting cubicle!*	Thank you for your feedback and we are pleased to hear that you found our staff to be so friendly and efficient. The Day Surgery and Endoscopy Unit operates a single-sex policy, which may have been the reason why your Mum wasn't able to stay with you. This is to ensure privacy and dignity for all patients and is a national quality standard for endoscopy services. However, we would always try to accommodate a patient's support needs if at all possible, if this is raised with us. Thank you again for your feedback.
	A700	*A pleasure to be here. Everyone was helpful and cheerful and polite. What about a good TV, some books or jigsaws or something to do when long stay. Do you encourage patients to meet/talk to each other? A softening of the quiet room would be nice.*	Thank you for your feedback - we are pleased to hear that your experience of the ward team was so positive. Thank you for raising the suggestions about the quiet room as a way of further improving our service. The Matron and Ward Sister will review this space and look at ways in which it can be improved. The team will also obtain some books and suitable games for patients to use.
	Bristol Dental Hospital (Day Case)	*Staff friendly and caring, made sure recovery was OK. Service great. Only thing waiting room needs upgrading paint and decor dated and very hot.*	Thank you for your positive feedback about the Day Case staff. We appreciate that the waiting room is in need of redecoration and this is in our Divisional works programme (timescales are being discussed). We have now put in place a portable air conditioning unit to help reduce temperature levels during the hot weather.

Division	Area	Comment	Response from ward / department
Women's and Children's (Bristol Royal Hospital for Children)	E510	There were two comments relating to facilities on the ward: *Better facilities for parents needed. Not enough fridge space, no toaster, cutlery scarce. Plenty for patients to do and play with and great interaction from playroom.* *The staff all were friendly and kind to me and my baby. I wish them all the best. The kitchen, seems unkempt, especially the fridge.*	We recognise that the facilities need to be updated / upgraded and are working with the Grand Appeal in order to try and progress this. The fridge is checked weekly by our housekeeper to ensure it is clean and any food that is not in date is removed. We have asked our housekeeper to carry out additional spot-checks going forward, along with checking the cutlery supplies which we replenish when required. Thank you for your feedback and we are sorry that you experienced these issues with the facilities during your stay.
	E600	There were two comments about the ward: *Staff very very good and professional. Cleaning staff leave/enter without using hand gel and use same cloth from floor to bed! Not ideal.* *The toy room is messy and looks grubby. The play therapist needs to interact more with the children who can't go to the playroom.*	We are very sorry to hear that aspects of the stay could have been better for these families. We have provided the comment about hand gel / cleaning to the cleaning team as a point of learning. The Ward Sister has discussed the comment about the play area with the Play team. The room mentioned is a shared open access area used by Dolphin and Penguin wards. The two staff who work in this play area also work on the wards, and so when they aren't present the tidiness of the room is dependent on users tidying toys away after them – which may explain why it was messy on this occasion. The play room is currently awaiting a complete refurbishment, including more storage, which should make it easier to manage, clean and maintain. Interior designers recently visited the space and are currently drawing up the new designs. We do provide play support to patients who can't make it to the play room, but we appreciate this was not the experience for this family. We have therefore put a play request form outside the play room, which parents / carers can use to request a bed visit by the Play Therapists.

Division	Area	Comment	Response from ward / department
Women's & Children's (Maternity)	Postnatal Wards	Two comments were received about the environment on wards 73 and 76: *Central delivery suit were amazing. Ward 73 the staff were nice but no consistency. The state of the ward is shocking. Side board coming away, crack in wall.* *Can feel overcrowded/cramped. Visitor toilets are not close enough. Washing facilities need to be updated with greater access to same level showers/bathroom suitable for post surgery.*	Thank you for your feedback. We are sorry to hear about your poor experiences of the environment on our postnatal wards. We recognise that these areas need a significant update. We are pleased to advise that a refurbishment programme is currently being planned. This is a large and complex project that requires a number of fundamental updates to these areas, alongside cosmetic improvements. The Estates Department are currently anticipating a start date of March 2020 for these works and they would be carried out over a period of 18-24 months, but these timescales are subject to ongoing discussion. Thank you again for your feedback.
	Ward 73	*ridiculous policy: visiting that allows unlimited children but only 1 adult before 2 PM- preventing my mother seeing her new grandchild at the same time as my partner. No clear explanation why this is different after 2 PM.*	We are sorry to hear that the visiting policy did not work well in this case. It is a difficult balance to get right and the current policy was written after consultation with women who use the service. The majority wanted a period of time during the day where visiting was restricted to partners and siblings, which is why general visiting hours now start at 2pm.
Specialised Services	Cardiology outpatients	*Cardiology staff are brusque, struggle to introduce themselves when you enter the room. I have never ever had a positive experience at the devices clinic. Would not recommend*	We are very sorry to hear about this experience of the Cardiology service. We strive to provide a very positive experience for all of our patients. Unfortunately, as the feedback was provided anonymously, we are unable to investigate it fully. However, it has been shared with the staff by the Sister as an important point of learning.
	D603	*Staff are really friendly at all levels. Nothing is too much to ask. Downfall is sharing a bay, especially when chemo runs to early hours. Noise at night and lack of sleep is also a downfall.*	We are pleased to hear such positive feedback about the team on ward D603, thank you. We are sorry that it was so noisy at night. During October 2019 we are relaunching our noise at night campaign to remind staff about the importance of this issue. Shared bays are an important way of delivering nursing ratios that maintain patient care and safety during chemotherapy. We are though increasing the number of staff trained to give chemotherapy, which should help reduce the number of occasions that patients have to wait. Thank you again for your feedback.

Specialised Services (continued)	C705	*a lovely ward with great staff. A few points, 1) night shift need to respect noise levels they make, very disrespectful at times, 2) WD40 needed for trolley wheels!*	Thank you for your kind feedback about the staff on ward C705. We apologise for the noise at night: we have shared this feedback with the ward staff as a point of learning, and in October we will be relaunching our noise at night reduction campaign. The ward Sister is seeking to identify the noisy trolley and we will ensure that this is addressed.

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

This section of the report provides examples of some of the corporate Patient and Public Involvement (PPI) activities being carried out at the Trust. Each quarter a comprehensive summary of PPI activity is reviewed by the Trust's Patient Experience Group.

Supporting UH Bristol lay representatives

During Quarter 1 the Trust's Patient and Public Involvement lead has started to identify UH Bristol groups, formal networks, and committees that have "lay representatives" on them (e.g. patients and / or members of the public). This is part of a Trust corporate quality improvement objective for 2019/20
that will see lay representatives receive better training and support for their role.

Transgender health and well-being

Representatives of the Transgender community are working with the Trust to develop and deliver a transgender awareness training session for doctors and nurses in September 2019.

Cardiac Services

In Quarter 1, the Cardiology and Cardiac Surgery teams carried out patient focus groups to hear about the social and psychological impact of invasive heart procedures. Attendees also contributed to a review of the cardiac surgery pathway being carried out by the management team.

The Bristol Deaf Health Partnership

UH Bristol is a founding member of the Bristol Deaf Health Partnership, which seeks to engage members of the deaf community to understand and improve the hospital experience for this patient group. The latest meeting took place in Quarter 1. A key topic of focus was the procurement process currently being carried out for the Trust's translating and interpreting services, including for British Sign Language.

Living well with and beyond Cancer

Following the success of an event in March 2019, a second patient and carer listening event is being planned for Quarter 2 2019/20 as part of the Macmillan Treatment and Therapy service hosted by UH Bristol. In attending the event, participants will be able to discuss the value and impact the service has had on their lives.

Bristol Sight Loss Council

The Bristol Eye Hospital management team is actively involving the Bristol Sight Loss Council in discussions about refurbishment plans for the hospital.

Appendix A – UH Bristol corporate patient experience programme

The Patient Experience and Involvement Team at UH Bristol manages 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.
	Rapid-time feedback system	Patients, carers and visitors can feedback via electronic devices automatically and in real-time.
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.
	"My Journey" mystery shopping	A structured programme of visits to departments and use of front-of-house services (e.g. Trust web site, reception areas)
	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

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.

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Quarter 1 Complaints Report**
Report Author	**Tanya Tofts, Patient Support and Complaints Manager; Chris Swonnell, Head of Quality (Patient Experience & Clinical Effectiveness)**
Executive Lead	**Carolyn Mills, Chief Nurse**

1. Report Summary

Summary of performance in Quarter 1

	Q1	
Total complaints received	**511**	↑
Complaints acknowledged within set timescale	**99.0%**	=
Complaints responded to within agreed timescale – formal investigation	**95.5%**	↑
Complaints responded to within agreed timescale – informal investigation	**89.0%**	↑
Proportion of complainants dissatisfied with our response (formal investigation)	**13.4%**	↑

2. Key points to note

(Including decisions taken)

Improvements:

- Following a concerted effort across all Divisions, the percentage of formal and informal complaints responded to within the agreed timescale remains high, despite an increased number of responses being sent during Q1.
- Notable decrease in the number of complaints received for Bristol Eye Hospital (BEH) outpatient services in Q1 and overall complaints received by the BEH decreased by 26%.
- Examples of specific service improvements made in response to complaints in Q1 can be found in section 4 of this report.

However:

- The proportion of complainants expressing dissatisfaction with the outcome of the investigation of their concerns was above target at 13.4% following previous improvement in Q4 and Q3 of 2018/19.
- Complaints received by the Dermatology service increased in Q1.
- Complaints regarding 'appointments and admissions' increased across all clinical Divisions, with the exception of Diagnostics & Therapies.
- The overall number of complaints being received each month/quarter has increased from a steady average of around 150 per month to nearer 170. Other enquiries received by the Patient Support and Complaints Team have also increased.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

None

4. Advice and Recommendations
(Support and Board/Committee decisions requested):

- This report is for **INFORMATION.**
- The Board is asked to **NOTE** the report.

5. History of the paper
Please include details of where paper has previously been received.

Patient Experience Group	22/8/19
Senior Leadership Team	18/9/19
Quality and Outcomes Committee	26/9/19

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 1, 2019/2020

(1 April 2019 to 30 June 2019)

14

Author: Tanya Tofts, Patient Support and Complaints Manager

Quarter 1 Executive summary and overview

	Q1	
Total complaints received	511	↑
Complaints acknowledged within set timescale	99.0%	=
Complaints responded to within agreed timescale – formal investigation	95.5%	↑
Complaints responded to within agreed timescale – informal investigation	89.0%	↑
Proportion of complainants dissatisfied with our response (formal investigation)	13.4%	↑

Successes	Priorities
• There was a notable decrease in the number of complaints received for Bristol Eye Hospital (BEH) outpatient services in Q1 and overall complaints received by the BEH decreased by 26%. • Examples of specific service improvements made in response to complaints in Q1 can be found in section 4 of this report. • Following a concerted effort across all Divisions, the percentage of formal and informal complaints responded to within the agreed timescale remains high, despite an increased number of responses being sent during Q1. • 99% of complaints were acknowledged within the required timescale.	• Responding to complaints within the timescale agreed with the complainant remains a priority across all Divisions. Due to the majority of complaints now being responded to via the informal complaints process, breaches of timescales for informal complaints are now being reported to the Trust Board, in addition to breached formal responses. The target for both formal and informal responses is for 95% to be sent out by the deadline agreed with the complainant.
Opportunities	**Risks & Threats**
• The Trust's Deputy Patient Support and Complaints Manager is currently supporting the process of aligning complaints processes across UH Bristol and Weston General Hospital ahead of organisational merger next year. • In order to support the complaints training sessions already available, the Patient Support and Complaints Team is developing training via e-learning in order to help make training accessible to more staff.	• The proportion of complainants expressing dissatisfaction with the outcome of the investigation of their concerns was above target at 13.4% following previous improvement in Q4 and Q3 of 2018/19. • Complaints received by the Dermatology service increased in Q1. • Complaints regarding 'appointments and admissions' increased across all clinical Divisions, with the exception of Diagnostics & Therapies. • The overall number of complaints being received each month/quarter has increased from a steady average of around 150 per month to nearer 170. Other enquiries received by the Patient Support and Complaints Team have also increased.

1. Complaints performance – Trust overview

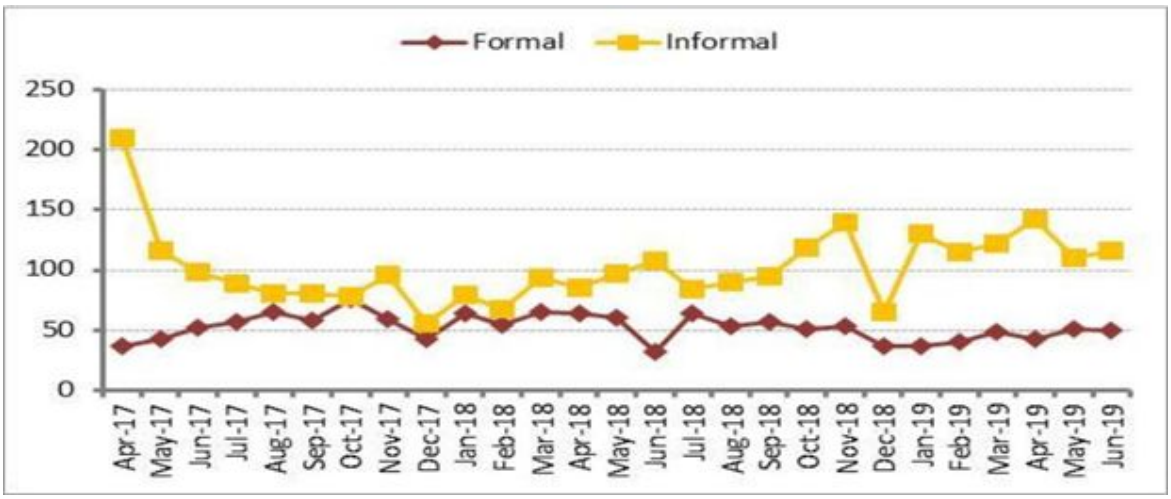
The Trust is committed to supporting patients, relatives and carers in resolving their concerns. Our service is visible, accessible and impartial, with every issue taken seriously. Our aim is to provide honest and open responses in a way that can be easily understood by the recipient.

1.1 Total complaints received

The Trust received 511 complaints in quarter 1 (Q1) of 2019/20. 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. This shows that the Trust typically received around 150 complaints per month; however, this has increased to an average of 170 per month over the last three quarters, with the exception of December 2018, when there was the usual seasonal dip in the number of complaints received.

Figure 1: Number of complaints received

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.

Figure 2 (above) shows complaints dealt with via the formal investigation process compared with those dealt with via the informal investigation process, over the same period. We continue to deal with a higher proportion of complaints via the informal process, which means that these issues are being dealt with as quickly as possible and by the specialty managers responsible for the service involved.

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 our findings, or arrange a meeting to discuss them. The timescale is agreed with the complainant upon receipt of the complaint and is usually 30 working days.

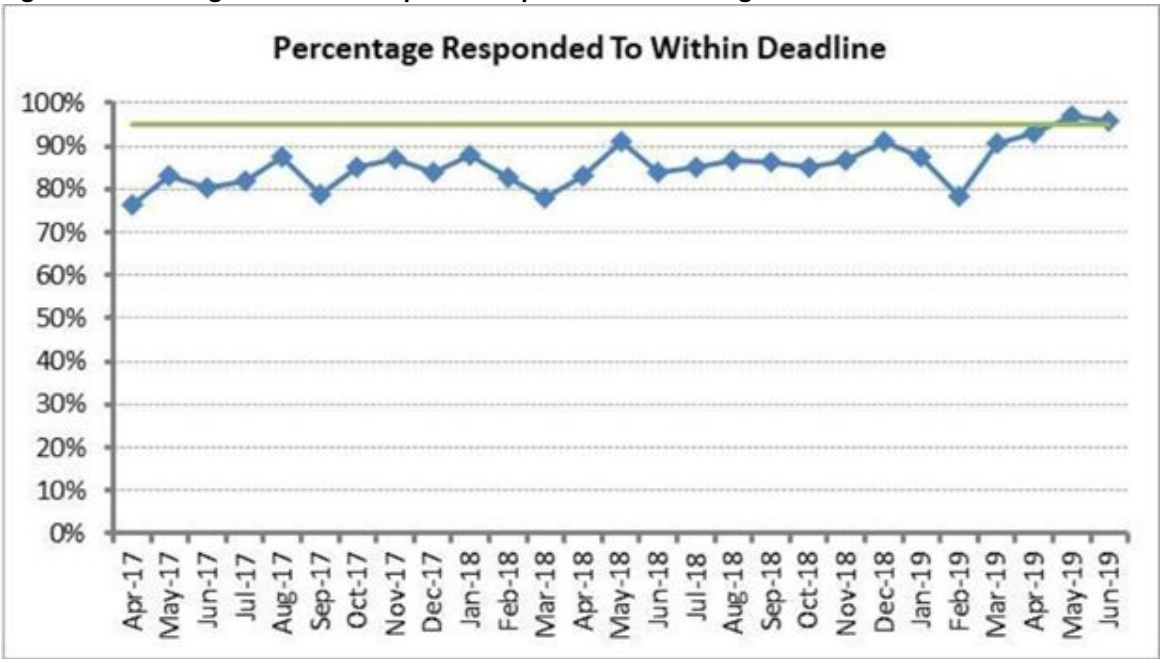
When a complaint is managed through the informal resolution process, the Trust and complainant also agree a timescale and this is usually 10 working days.

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 2019/20, 96.6% of responses were posted within the agreed timescale. This represents eight breaches out of the 179 formal complaints which received a response during the quarter[2]. This is a significant improvement on the 88.2% reported in Q4 and 87.6% in Q3 and exceeds the Trust's target of 95%. Figure 3 shows the Trust's performance in responding to complaints since April 2017.

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



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

1.2.2 Informal Investigations

In Q1 2019/20, the Trust received 368 complaints that were investigated via the informal process. During this period, the Trust responded to 335 complaints via the informal complaints route and 89.0% of these were responded to by the agreed deadline.

The percentage of informal complaints resolved within the agreed deadline is now being formally reported to the Board (since Q4 2018/19) given that so many complaints are now resolved informally. Figure 4 (below) shows performance since January 2018, for comparison with formal complaints, although it should be noted that the 95% target was only formally set with effect from Q4 2018/19.

Figure 4: Percentage of informal complaints responded to within agreed timescale

1.3 Dissatisfied complainants

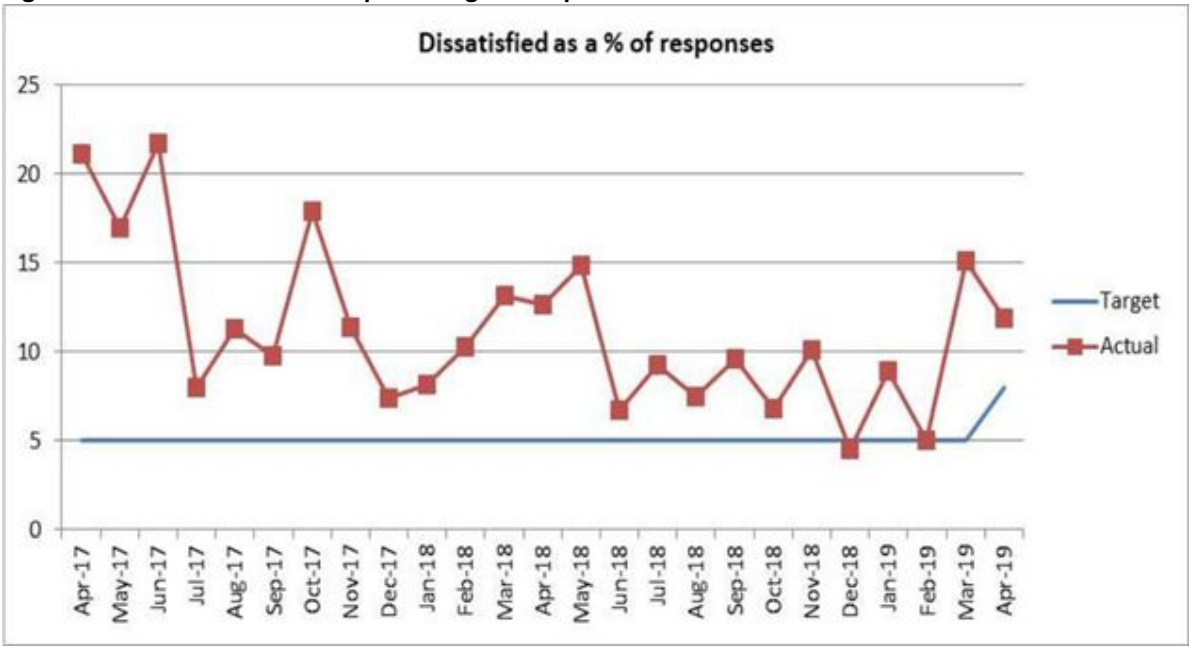
Our revised target for 2019/20 is that no more than 8% of complaints responses should lead to a dissatisfied response.

This data is reported **two months in arrears** in order to capture the majority of cases where, having considered the findings of our investigations, complainants tell us they are not happy with our response.

In Q1 2019/20, by the cut-off point of mid-August 2019 (the point at which dissatisfied data for Q1 was confirmed for board reporting), 15 complainants who received a first response from the Trust in March and April 2019, had contacted us to say they were dissatisfied. This represents 13.4% of the 112 first responses sent out during that period.

Figure 5 shows the monthly percentage of complainants who were dissatisfied with aspects of our complaints responses since April 2017.

Figure 5: 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 2019/20 compared with Q4 2018/19.

Complaints regarding 'appointments and admissions' increased for the third successive quarter, accounting for more than a third of all complaints received, with 31 of these being for Bristol Dental Hospital, 27 for Bristol Heart Institute and 20 for Bristol Eye Hospital.

There was an overall increase in complaints about 'clinical care', with more than half of these (85) being recorded under the sub-category of 'clinical care (medical/surgical)', 58 of which were for areas located in Bristol Royal Infirmary.

There were reductions in the numbers of complaints received in respect of 'attitude and communication', 'facilities and environment', 'documentation' and 'access'.

Table 1: Complaints by category/theme

Category/Theme	**Number of complaints received in Q1 (2019/20)**	**Number of complaints received in Q4 (2018/19)**
Appointments & Admissions	190 (37.2% of all complaints) ↑	154 (31.2% of all complaints) ↑
Clinical Care	141 (27.6%) ↑	124 (25.2%) ↑
Attitude & Communication	100 (19.6%) ↓	114 (23.1%) ↑
Facilities & Environment	36 (7.0%) ↓	56 (11.4%) ↓
Information & Support	21 (4.1%) =	21 (4.3%) ↓
Discharge/Transfer/Transport	13 (2.5%) ↑	7 (1.4%) ↓
Documentation	9 (1.8%) ↓	14 (2.8%) ↑
Access	1 (0.2%) ↓	3 (0.6%) ↑
Total	**511**	**493**

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 70% of the complaints received in Q1 (356/511).

Table 2: Complaints by sub-category

Sub-category	Number of complaints received in Q1 (2019/20)	Q4 (2018/19)	Q3 (2018/19)	Q2 (2018/19)
Cancelled/delayed appointments and operations	106 (21.8% increase compared to Q4) ↑	87	82	69
Clinical care (Medical/Surgical)	85 (26.9% increase) ↑	67	94	87
Appointment administration issues	65 (54.7% increase) ↑	42	42	48
Attitude of medical staff	21 (25% decrease) ↓	28	18	15
Failure to answer telephones/failure to respond	21 =	21	14	10
Communication with patient/relative	18 (5.3% decrease) ↓	19	12	24
Car Parking	16 (36% decrease) ↓	25	46	16
Clinical care (Nursing/Midwifery)	16 (60% increase) ↑	10	13	37
Attitude of administrative/clerical staff	13 =	13	16	10
Attitude of nursing/midwifery staff	10 (23.1% decrease) ↓	13	8	13

In Q1, there were notable increases in complaints about 'cancelled/delayed appointments and operations', clinical care (medical/surgical)' and 'appointment administration issues'.

The most noticeable decrease was in complaints received about 'car parking'.

Figures 6-9 (below) show the longer term pattern of complaints received since April 2017 for a number of the complaints sub-categories reported in Table 2. Figure 6 shows an increase towards the end of Q1 in complaints about clinical care (medical/surgical) and Figure 8 shows the downward trend in complaints about car parking since its peak in November 2018. Trends in sub-categories of complaints are explored in more detail in the individual divisional details from section 3.1.1 onwards.

Figure 6: Clinical care – Medical/Surgical

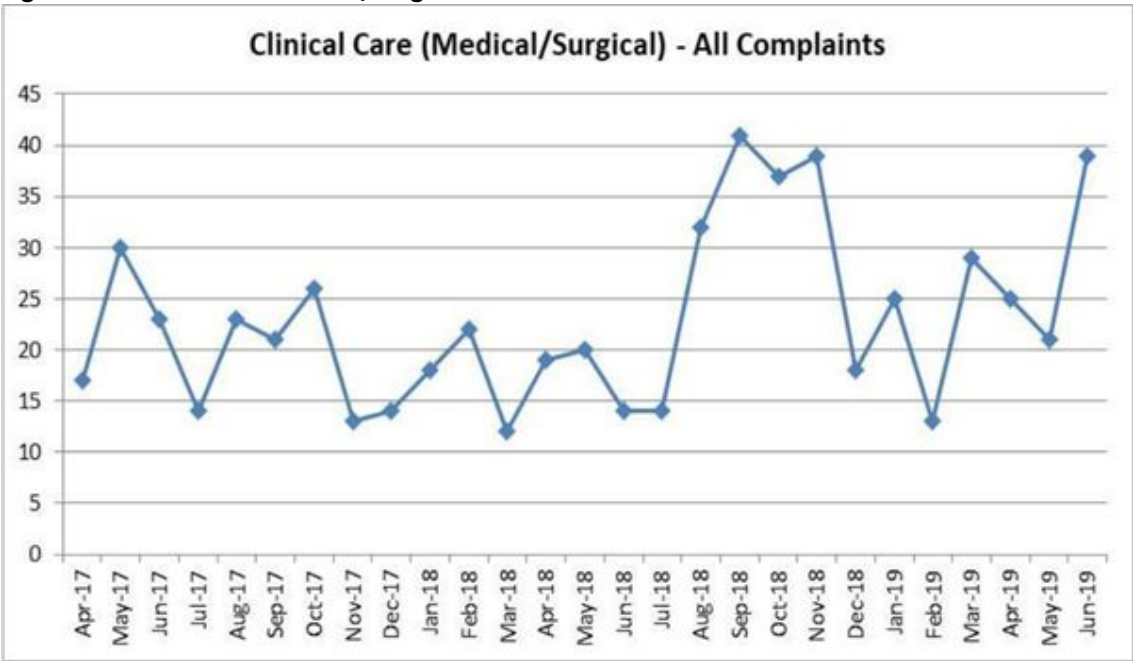
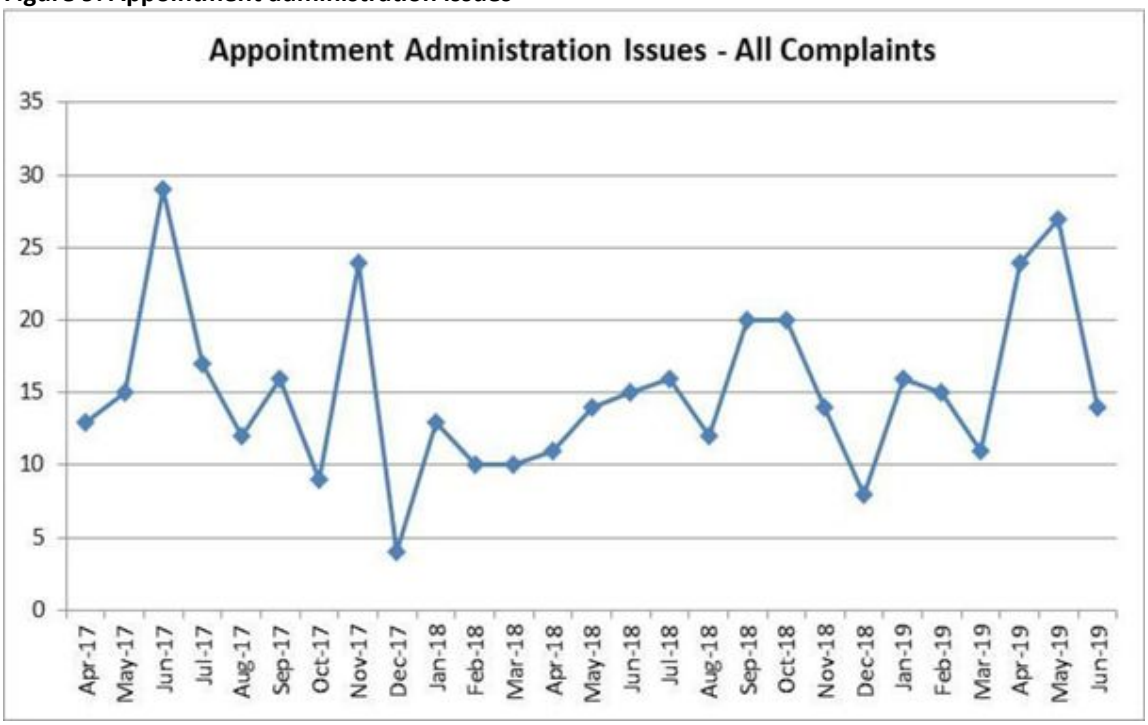


Figure 7: Cancelled or delayed appointments and operations

Figure 8: Car Parking

Figure 9: Appointment administration issues



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; and concerns about staff attitude and communication. 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	187 (176) ↑	116 (98) ↑	82 (65) ↑	73 (70) ↑	17 (25) ↓
Number of complaints about appointments and admissions	97 (66) ↑	30 (25) ↑	35 (34) ↑	16 (20) ↓	10 (8) ↑
Number of complaints about staff attitude and communication	31 (43) ↓	26 (26) =	18 (13) ↑	15 (21) ↓	4 (6) ↓
Number of complaints about clinical care	46 (52) ↓	40 (28) ↑	19 (12) ↑	34 (24) ↑	2 (5) ↓
Area where the most complaints have been received in Q1	Bristol Dental Hospital (BDH) – 44 (34) Administration Department (BDH) – 12 (7) Adult Restorative Dentistry (BDH) – 11 (8) Bristol Eye Hospital (BEH) – 43 (57) BEH Outpatients – 17 (29) Trauma & Orthopaedics – 22 (18) ENT – 19 (8) QDU Endoscopy – 13 (7)	Emergency Department (BRI) – 25 (23) Dermatology – 27 (15) Ward A300 (AMU) – 7 (5) Ward A400 (OPAU) – 5 (5)	**BHI (all) –53 (44)** **BHOC (all) – 25 (18)** BHI Outpatients – 28 (24) BHI & BHOC Appt Depts – 15 (13) Chemo Day Unit / Outpatients (BHOC) – 6 (10) Ward C708 – 6 (3)	**BRHC (all) – 48 (46)** Carousel Outpatients (E301) – 8 (7) Paediatric Neurology & Neurosurgical – 5 (5) Children's ED (E308) – 6 (3) Caterpillar Ward E510) – 4 (2) **StMH (all) – 22 (24)** Gynaecology Outpatients (StMH) – 9 (6) Ward 73 (Maternity) – 4 (3)	Radiology – 10 (9) Audiology – 3 (2) Physiotherapy – 2 (3)
Notable deteriorations compared with Q4	ENT – 19 (8) QDU Endoscopy – 12 (7)	Dermatology – 27 (15)	Ward C708 – 6 (3)	Caterpillar Ward E510) – 4 (2) Gynaecology Outpatients (StMH) – 9 (6)	No notable deteriorations
Notable improvements compared with Q4	BEH Outpatients – 17 (29)	No notable improvements	No notable improvements	No notable improvements	No notable improvements

3.1.1 Division of Surgery

There was a small increase in the total number of complaints received by the Division of Surgery in Q1; 187 compared with 176 in Q4. Complaints received by Bristol Dental Hospital (BDH) increased in Q1; however, those received by Bristol Eye Hospital (BEH) decreased by over 26%. In particular, there was a notable reduction in the number of complaints received for BEH Outpatients. The most notable increases in the numbers of complaints received were for ENT and QDU (Endoscopy).

Complaints about 'appointments and admissions' increased significantly in Q1, whilst there were reductions in complaints about 'attitude and communication' and 'clinical care'.

The most noticeable increases in complaints received by sub-category, were those that came under 'cancelled/delayed appointments and operations' and 'appointment administration issues'; which is reflected in the overall increase in complaints about 'appointments and admissions'.

Table 4: Complaints by category type

Category Type	Number and % of complaints received – Q1 2019/20	Number and % of complaints received – Q4 2018/19
Appointments & Admissions	97 (51.9% of total complaints) ↑	66 (37.5% of total complaints) =
Clinical Care	46 (24.6%) ↓	52 (29.5%) ↑
Attitude & Communication	31 (16.6%) ↓	43 (24.3%) ↑
Information & Support	5 (2.6%) ↓	7 (3.9%) ↑
Facilities & Environment	3 (1.6%) ↑	2 (1.2%) ↑
Discharge/Transfer/ Transport	3 (1.6%) ↑	2 (1.2%) ↓
Documentation	2 (1.1%) =	2 (1.2%) ↓
Access	0 (0%) ↓	2 (1.2%) ↓
Total	**187**	**176**

Table 5: Top sub-categories

Category	Number of complaints received – Q1 2019/20	Number of complaints received – Q4 2018/19
Cancelled or delayed appointments and operations	57 ↑	37 ↓
Clinical care (medical/surgical)	30 ↑	26 ↑
Appointment administration issues	34 ↑	17 ↓
Failure to answer telephones/ failure to respond	6 ↓	13 ↑
Waiting Time in Clinic	5 ↑	3 ↑
Attitude of Medical Staff	4 ↓	10 ↑
Communication with patient/relative	4 ↓	8 ↑
Attitude of Nursing/Midwifery	4 ↑	1 ↓

Table 6: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
There was a significant increase in complaints received under the category of 'appointments and admissions'. The majority of complaints in this category related to cancelled and delayed appointments and operations (57) and appointment administration issues (34)	Clinical services continue to be under extreme operational pressure. Clinical specialties have systems in place to monitor waiting lists, which are subject to regular re-prioritisation based on clinical urgency.	Patient pathways are actively reviewed to identify opportunities to improve efficiency and capacity and minimise delays and cancellations.
Of the 97 complaints received in this category, 19 were for the BEH Administration Department; 12 were received by Trauma & Orthopaedics; and 10 were for the ENT Outpatient Clinic. By hospital site, 31 of the 97 complaints were for the BDH and 19 were for the BEH.	Whilst there have been a number of admin complaints, the wider context is a notable reduction in complaints about BEH outpatient services. Fracture clinic – patient appointments have been rearranged to accommodate urgent patients. BDH/BEH formal complaints show main theme refers to clinical outcome/ communication	The BEH admin structure has been changed and a new Assistant Performance & Operations Manager and senior admissions team leader appointed. This will strengthen booking processes and utilisation of appointments, and should lead to a reduction in admin queries. Three new consultants have been recruited and have fracture clinic in their job plans – this will increase capacity to see patients. A project manager is in post at the BEH to review and drive improvement in patient systems and processes.
The number of complaints received for the ENT service, more than doubled from 8 in Q4 of 2018/19 to 19 in Q1 of 2019/20. 11 of the 19 complaints related to 'appointments and admissions'.	During this period, the clinical team was affected by vacancies in registrar posts, combined with annual leave for registrars and consultants. As a result, routine patients were cancelled for fast track patients in order to meet demand.	Clinical team now fully established and cancellations are reducing.
A total of 12 complaints were received for QDU Endoscopy, compared with seven in Q4. Six of these complaints related to 'attitude and communication'; five were in respect of 'appointments and admissions' and one was about 'clinical care'.	Shortage of four staff within the administration team has been affecting booking of appointments and telephone lines.	Two vacancies have been filled and recruitment to the other posts is ongoing.

Current divisional priorities for improving how complaints are handled and resolved

We are pleased with our overall performance with formal complaints, which continues to be at 100% of responses being sent out by the agreed deadline. However, we are not complacent and recognise that we need to improve our performance regarding our response to informal complaints.

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

We have undertaken a trend analysis for BEH complaints covering the period May 2017 to June 2019. This analysis showed 'appointments/admissions' and 'clinical care' to be the main themes. The main drivers of these complaints have been capacity for appointments and quality of communication around clinical care. In a number of cases, concerns were raised following clinic appointments where patients have been unclear about their diagnosis/treatment. A comprehensive review of patient literature is being undertaken as a result.

Figure 10: Surgery, Head & Neck – formal and informal complaints received

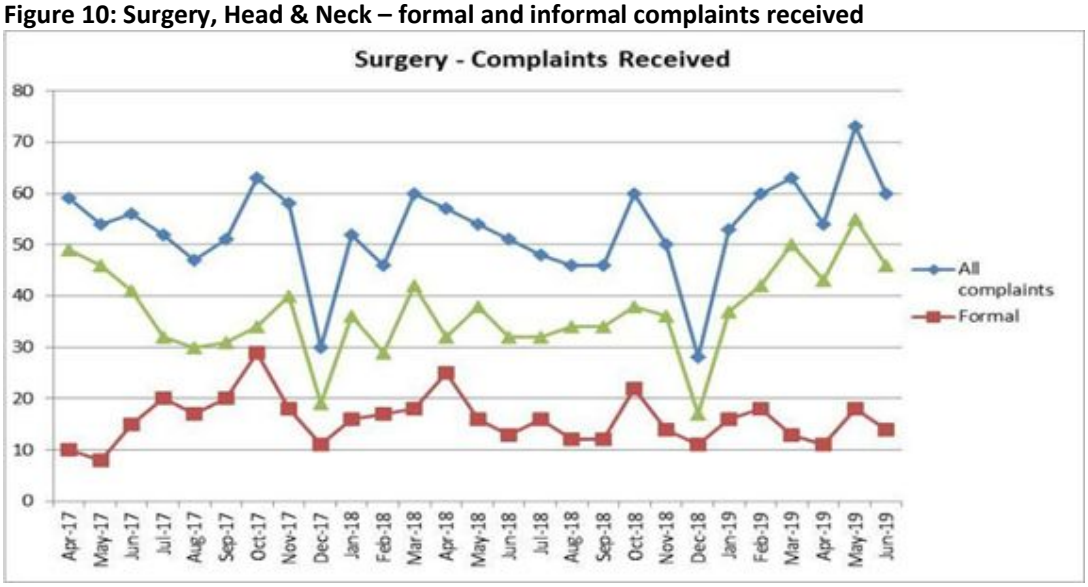


Figure 11: Complaints received by Bristol Dental Hospital

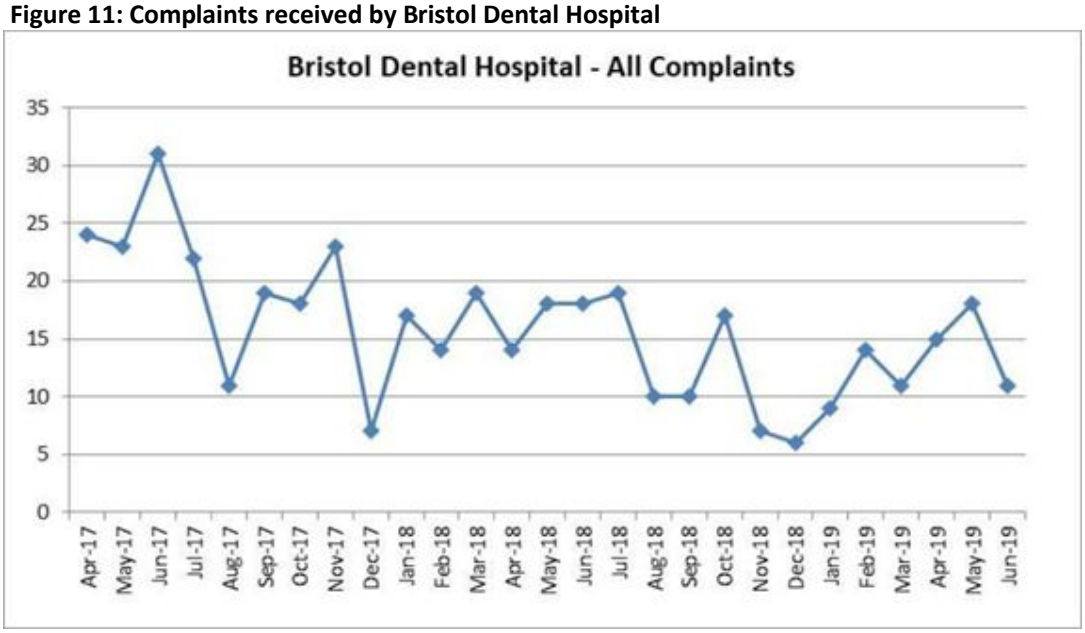


Figure 12: Complaints received by Bristol Eye Hospital

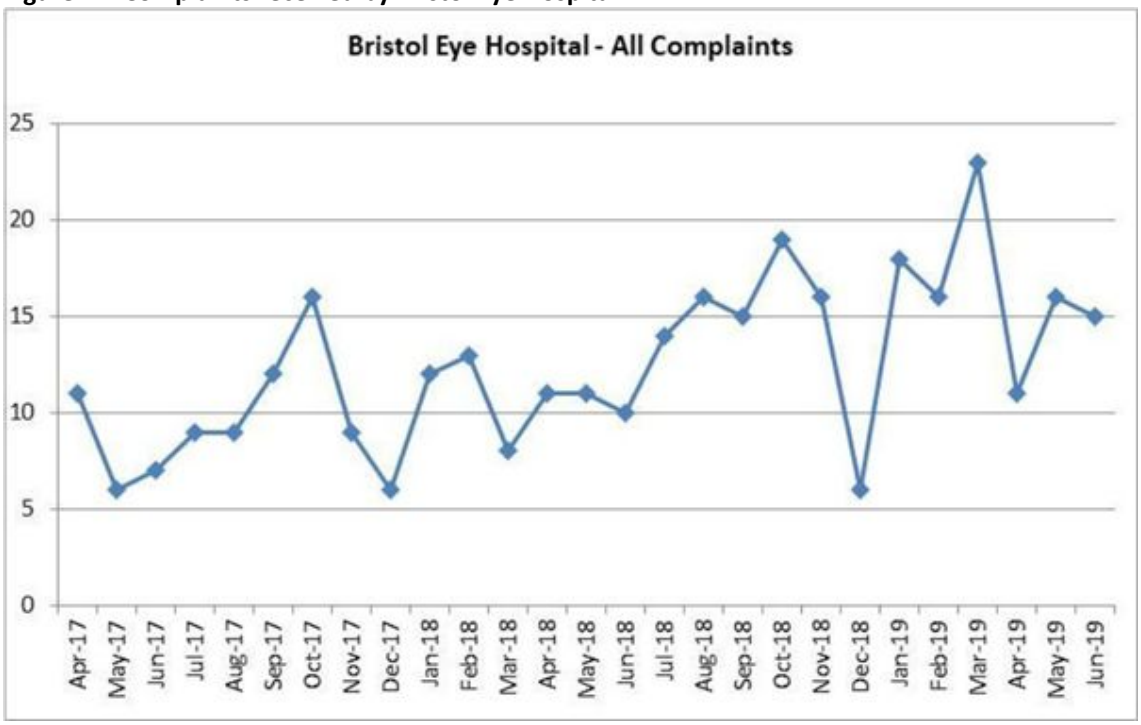
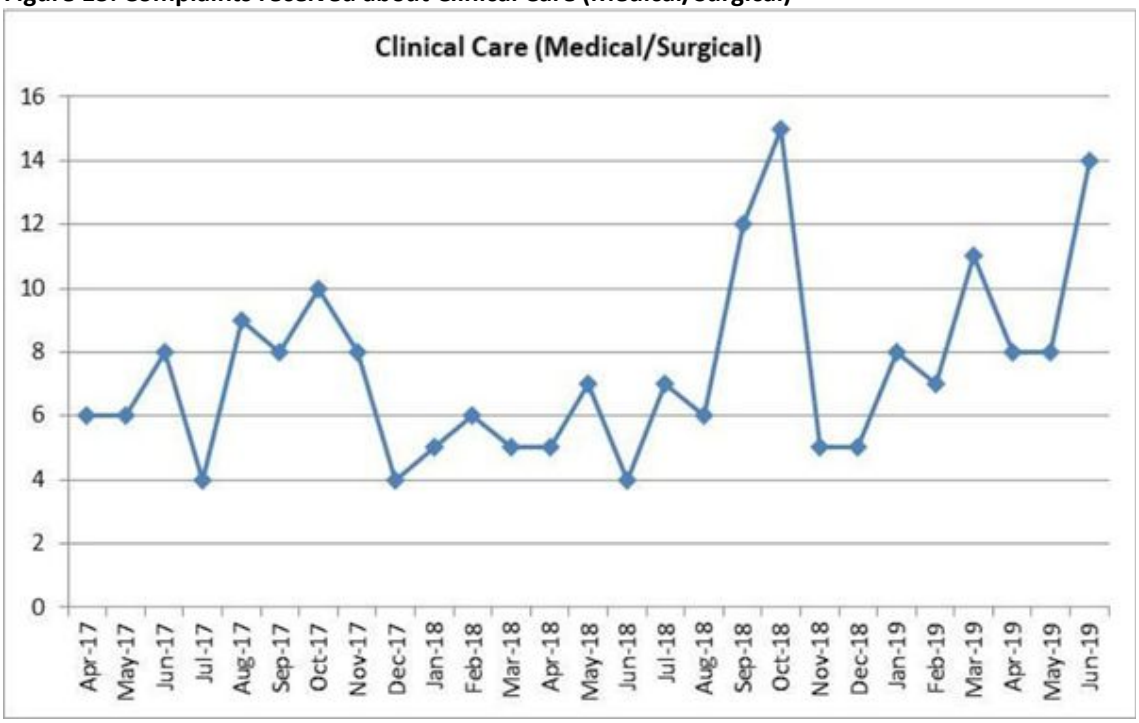


Figure 13: Complaints received about Clinical Care (Medical/Surgical)



3.1.2 Division of Medicine

In Q1, the Division of Medicine received almost 20% more complaints (116) than in Q4 (98). Following a concerted effort by the Division, the complaints received by the Dermatology service decreased in Q4; however, they increased again in Q1.

There was a noticeable increase in complaints about 'clinical care', with an increase of over 40% compared with Q4. Of the 40 complaints regarding 'clinical care', 26 were sub-categorised as 'clinical care (medical/surgical)'. Complaints about 'attitude of medical staff' and 'personal (lost) property' both decreased in Q1.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q1 2019/20	Number and % of complaints received – Q4 2018/19
Clinical Care	40 (34.5% of total complaints) ↑	28 (28.6% of total complaints) ↑
Appointments & Admissions	30 (25.9%) ↑	25 (25.5%) ↑
Attitude & Communication	26 (22.4%) =	26 (26.5%) ↓
Facilities & Environment	7 (6.1%) ↓	9 (9.2%) ↑
Discharge/Transfer/ Transport	5 (4.3%) ↑	4 (4.1%) ↑
Documentation	4 (3.4%) ↓	5 (5.1%) ↑
Information & Support	4 (3.4%) ↑	1 (1.0%) ↓
Access	0 (0%) =	0 (0%) =
Total	**116**	**98**

Table 8: Top sub-categories

Category	Number of complaints received – Q1 2019/20	Number of complaints received – Q4 2018/19
Clinical care (medical/surgical)	26 ↑	18 ↓
Cancelled or delayed appointments and operations	18 ↑	17 ↑
Appointment administration issues	9 ↑	5 ↑
Attitude of medical staff	8 ↓	10 ↑
Failure to answer phone/ failure to respond	5 ↑	1 ↓
Diagnosis delayed / missed / incorrect	5 ↑	2 ↑
Attitude of A&C staff	5 ↑	3 ↓
Discharge arrangements	4 ↑	2 ↑
Personal (lost) property	4 ↓	5 ↑

Table 9: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Complaints about the Dermatology service increased in Q1 following a decrease in Q4. The service had been receiving around 20 complaints per quarter since the same period last year and, following a concerted focus on the cause of the complaints, they had decreased to 15 in Q4. However, the service received 27 complaints in Q1. Of the 27 complaints received, 17 were in respect of 'appointments and admissions', six related to 'clinical care' and four were received about 'attitude and communication'.	We know that we continue to have significant capacity issues within Dermatology and a limited resource of staff that can address this despite advertising for staff to support the service. The appointment issues are related to the limited capacity and resilience within the current service.	Ongoing focused recruitment to key roles within the department and role redesign being addressed to look at alternative workforce models. There are no common themes to the clinical care complaints, although two relate to access to the on-site pharmacy. One complaint was about parking, which is not the responsibility of Dermatology.
Overall, the Division saw a notable increase in complaints categorised under 'clinical care' (from 28 in Q4 to 40 in Q1). There were 12 complaints about clinical care for the BRI Emergency Department; six for Dermatology (noted above); and five for Ward A400 (OPAU). The remainder of the complaints in this category were spread across several different wards/locations.	There are no common themes arising from either the informal or formal complaints received by the ED, OPAU or Dermatology. We will continue to monitor.	

Current divisional priorities for improving how complaints are handled and resolved:
There is currently a lack of resilience as the Complaints Coordinator for the division has left the Trust and her replacement is not due to start until the end of September. In the interim, we have part-time cover only so, as a senior team, we are all focused on maintaining the quality of responses within a significantly reduced service.

Priority issues we are seeking to address based on learning from complaints:
There are no themes identified this quarter but we continue to focus on learning from each complaint we receive.

Figure 14: Medicine – formal and informal complaints received

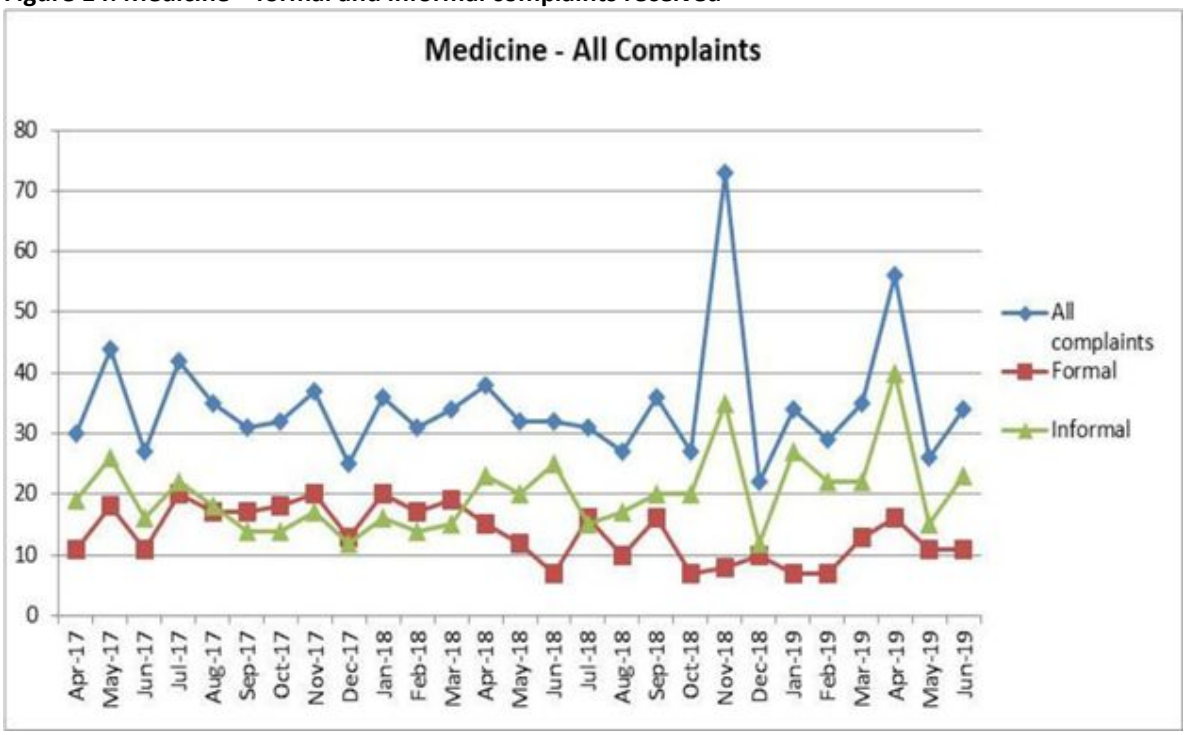


Figure 15: Complaints received by Dermatology

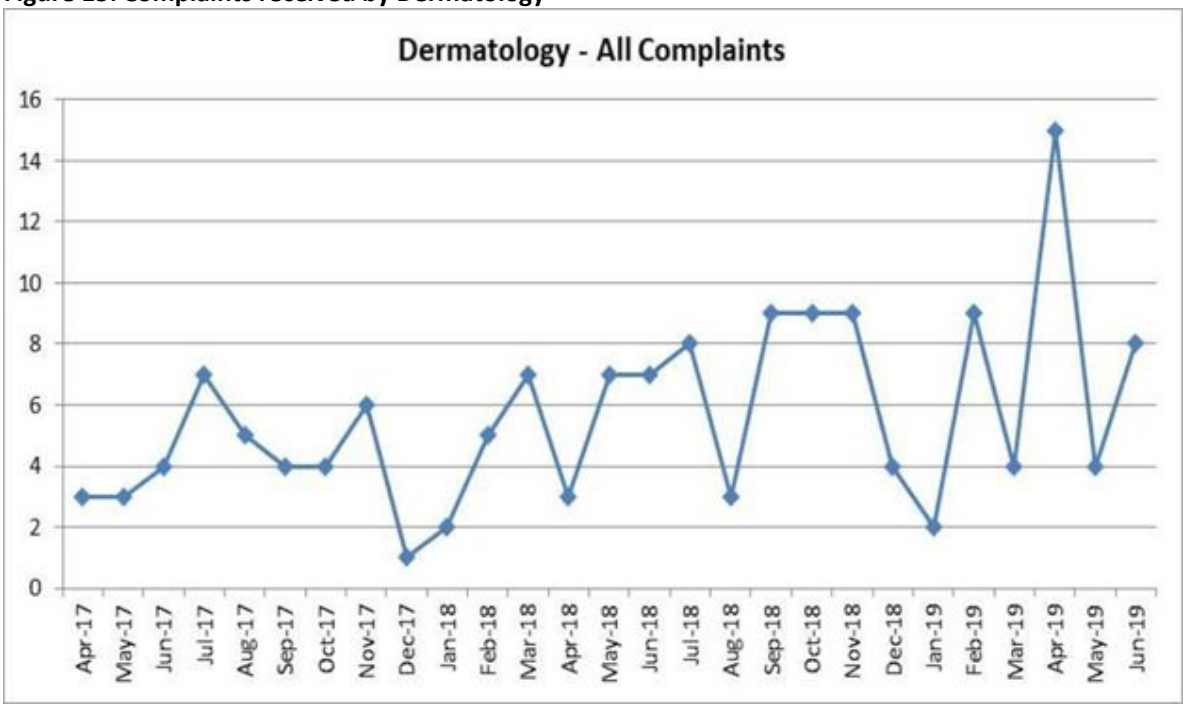


Figure 16: Complaints about attitude and communication

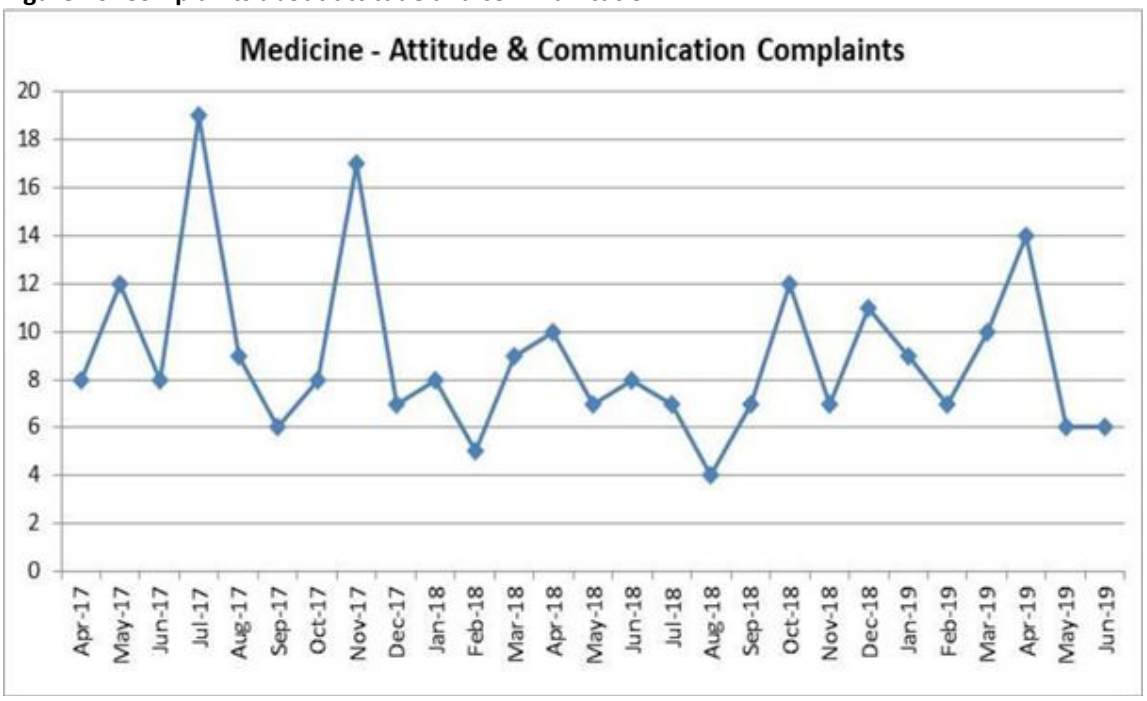
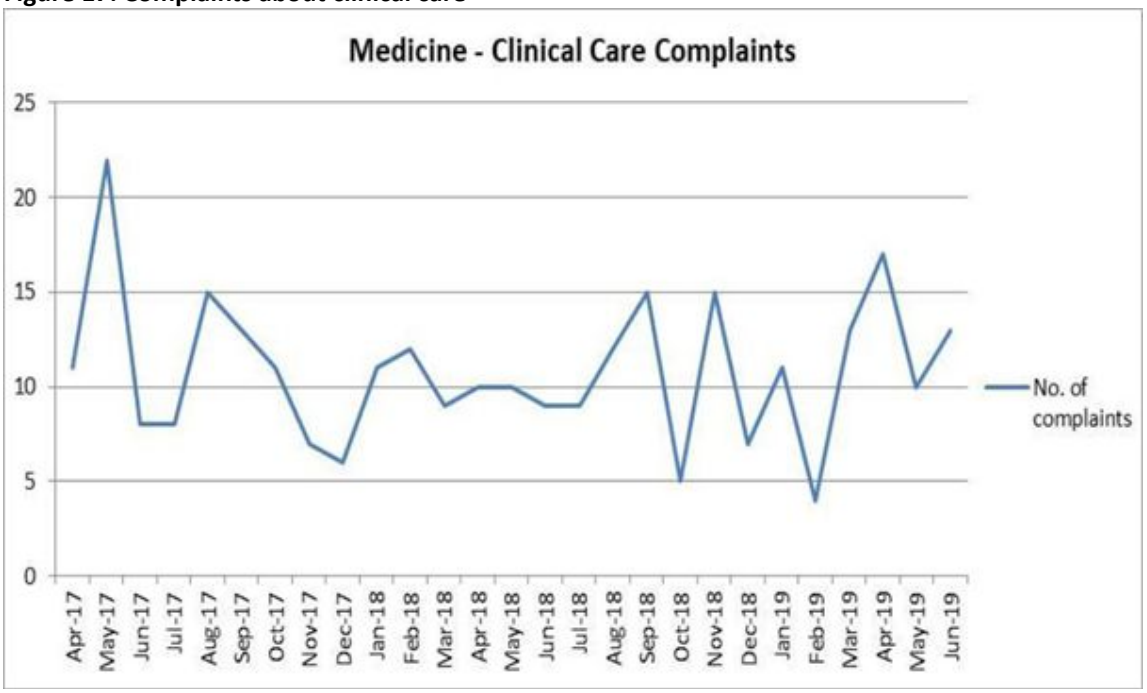


Figure 17: Complaints about clinical care



3.1.3 Division of Specialised Services

The Division of Specialised Services received 82 new complaints in Q1; an increase of 26% on the 65 received in Q4. Of these 82 complaints, 53 were for the Bristol Heart Institute (BHI), compared with 44 in Q4, and 25 were for the Bristol Haematology & Oncology Centre (BHOC), compared with 18 in Q4. The remaining four complaints were for the Clinical Genetics service based at St Michael's Hospital.

Almost half of all complaints received by the Division in Q1 (42.7%) came under the category of 'appointments and admissions', which includes complaints about cancelled and delayed appointments and surgery. There was also a further increase in the number of complaints received in the category of 'attitude and communication' with 18 complaints received, compared with 13 in Q4 and complaints about 'clinical care' increased to 19 compared with 12 in Q4.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q1 2019/20	Number and % of complaints received – Q4 2018/19
Appointments & Admissions	35 (42.7% of total complaints) ↑	34 (52.4% of total complaints) ↑
Clinical Care	19 (23.2%) ↑	12 (18.5%) ↓
Attitude & Communication	18 (21.9%) ↑	13 (20%) ↑
Information & Support	4 (4.9%) ↑	1 (1.5%) ↓
Discharge/Transfer/ Transport	3 (3.7%) ↑	1 (1.5%) =
Documentation	2 (2.4%) ↓	3 (4.6%) ↑
Facilities & Environment	1 (1.2%) =	1 (1.5%) ↑
Access	0 (0%) =	0 (0%) =
Total	**82**	**65**

Table 11: Top sub-categories

Category	Number of complaints received – Q1 2019/20	Number of complaints received – Q4 2018/19
Cancelled or delayed appointments and operations	21 ↑	19 ↑
Appointment administration issues	12 =	12 ↑
Clinical care (medical/surgical)	7 ↑	6 ↓
Failure to answer phone/ Failure to respond	7 ↑	4 ↑
Communication with patient/relative	6 ↑	1 ↓
Clinical care (nursing/midwifery)	4 ↑	0 ↓
Attitude of medical staff	3 =	3 ↑

Table 12: Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Almost half of the complaints received by the division in Q1 were in respect of 'appointments and admissions'. Of the 35 complaints in this category, 19 were about cancelled or delayed appointments and operations and 12 related to appointment administration issues. 29 complaints received in this category related to services in the Bristol Heart Institute (BHI).	**BHI** There were no common themes identified in terms of area or specialty across the 19 complaints. Our current challenges are: • Pacing clinic capacity • Answering phones and responding to answerphone messages. • Changes to the outpatients booking system.	**BHI** • Pacing has restructured its clinics and has organised additional clinics to address the backlog. • The Echo Department has reinforced its training with the admin team on responding to answerphone messages. • ECG has updated its answerphone message giving office hours. • The Outpatients Department has made changes to its appointment booking system.
In Q1, there was an increase in the number of complaints received by the division about 'attitude and communication'. Of the 18 complaints received, five were for Bristol Haematology and Oncology Centre (BHOC), one was for Clinical Genetics and the remaining 12 were for Bristol Heart Institute (BHI). Three of the five complaints for BHOC were recorded under the sub-category of 'communication with patient/relative' and two were for 'attitude of medical staff'. The BHI complaints in this category were sub-categorised as 'failure to answer phone/failure to respond/telecommunications' (8); 'communication with patient/relative' (3) and 'attitude of medical staff' (1).	**BHI** We have issues with the Outpatient Booking System and phones not being answered. Some complaints have related to consultant communication with patient/relatives, with inappropriate comments, lack of clarity and patients chasing results. **BHOC** Some complaints have related to consultant communication, with requests for clarity on diagnosis and results, a complaint about inappropriate comments and two requests to change consultant.	**BHI** • All staff have been reminded about training available for improving communication skills and managing difficult conversations (see below). • A new booking system has been established in Outpatients with a 'hunt group' for three coordinators: There is one phone number for Outpatients and if a call comes in it will go to one of three coordinators. If another call comes in, it will go to the next available coordinator and so on (hunt group). Once all three are engaged (or not available) a message will alert the caller that there is no-one currently available and that they should call back at another time." **BHOC** All staff have been reminded about training available for improving communication skills and managing difficult conversation (see below)s.

Current divisional priorities for improving how complaints are handled and resolved:
Our current priority is to arrange more face to face meetings with complainants and to introduce the recording of those meetings. The Division has commenced a trial which involves providing the complainant with an encrypted/password protected USB stick with a recording of the meeting and a cover letter outlining any actions agreed and updates if applicable.

Priority issues we are seeking to address based on learning from complaints.
We are seeking to improve our communication skills across the Division and have therefore highlighted to all staff via email and newsletter the following:

Communications Skills Training Programmes
Two programmes are offered to increase confidence and improve communication skills for UH Bristol healthcare staff. Delivered by a multi-professional group, these are interactive experiential workshops, using real case scenarios.

Developing your Communications Skills: Supporting Patients
This introductory course is an 'Essential – Specific to Role' programme that is offered and can be self-booked on the Learning Plans of all registered, unregistered and A&C staff working in healthcare at UH Bristol. It is especially recommended for volunteers and Band 1-4 staff, both clinical and non-clinical. It aims to:

- Introduce principles of good communication
- Practice active listening skills: opening conversations, boundaries, unconditional positive regard, reflective listening, summarising and closing conversations.
- Promote better understanding of risk and safeguarding concerns, including the ward environment and self-care.

Advancing your Communication Skills: Managing Difficult Clinical Conversations
This programme is also 'Essential – Specific to Role' but is directed toward all Band 5 and above registered clinical staff (including Doctors, Nursing, Midwives, AHP/, HCSTs, etc.).
By its conclusion this programme will:

- Improve communication with:
  - Patients (all ages)
  - Parents , partners, relatives and carers
  - Colleagues
- Support staff in using communication skills to enhance patient and families experience of compassionate care
- Increase confidence in handling difficult conversations and delivering significant news
- Support staff in caring for themselves and others

Figure 18: Specialised Services – formal and informal complaints received

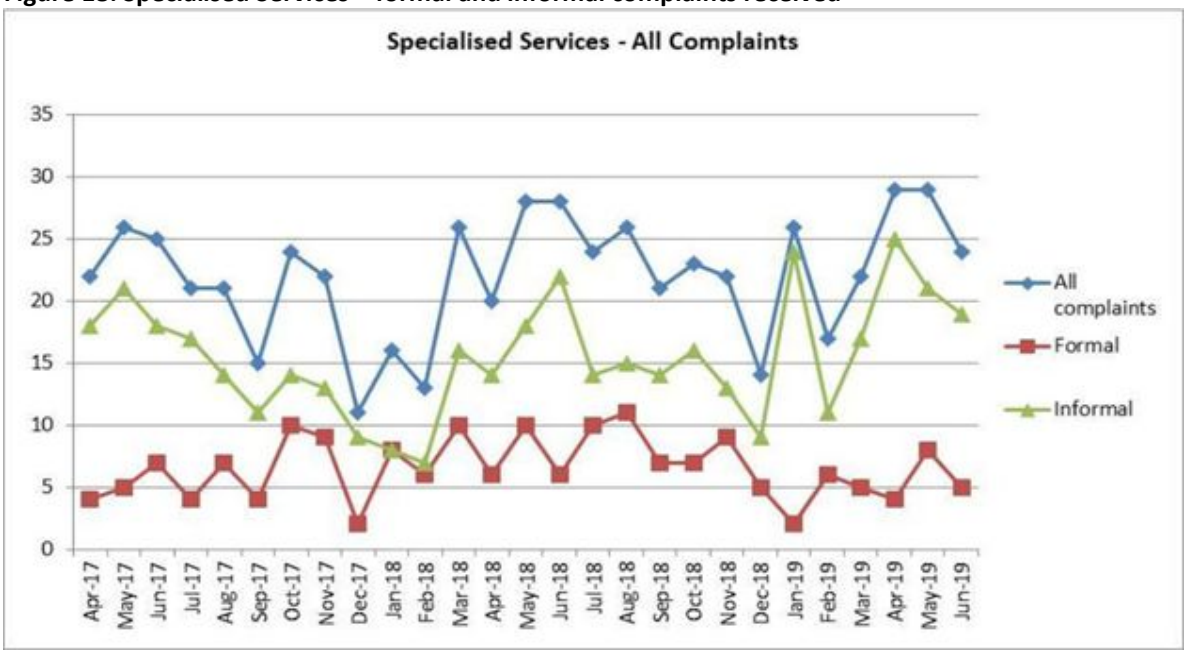


Figure 19: Complaints received by Bristol Heart Institute

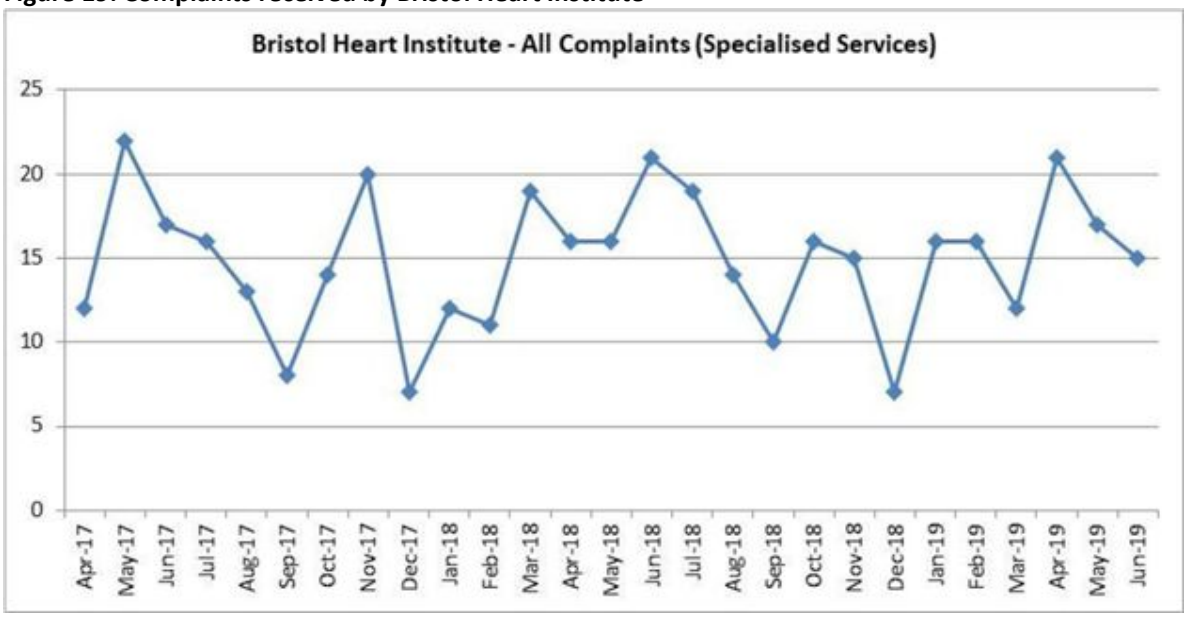


Figure 20: Complaints received by Bristol Haematology & Oncology Centre

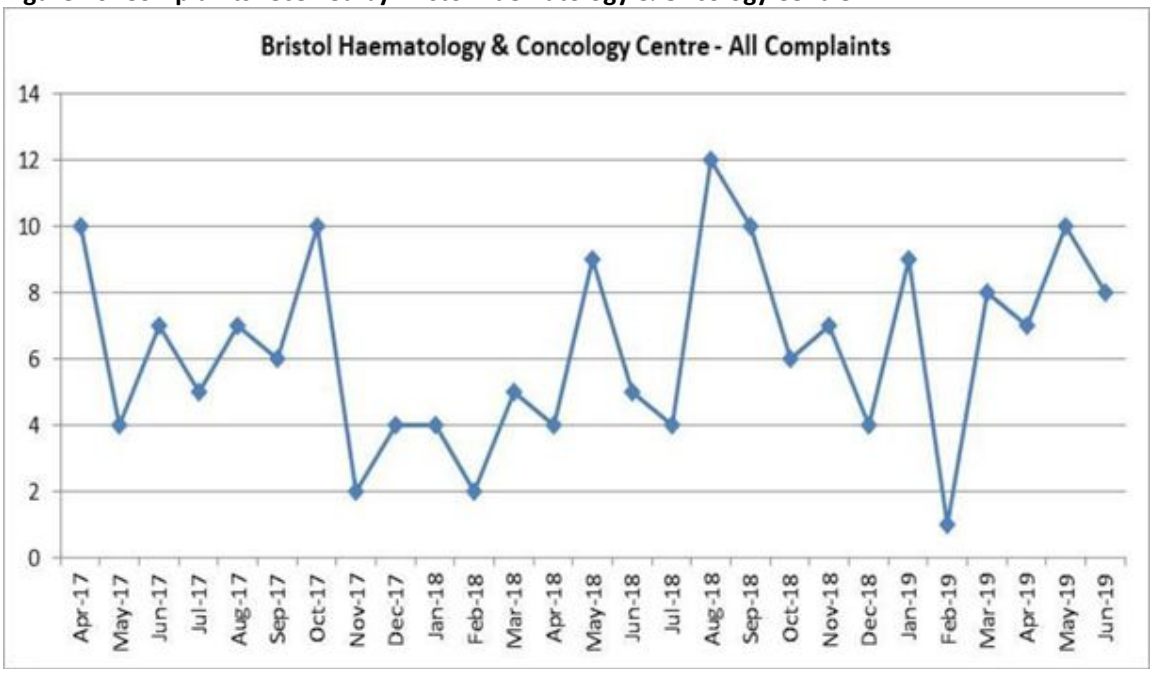
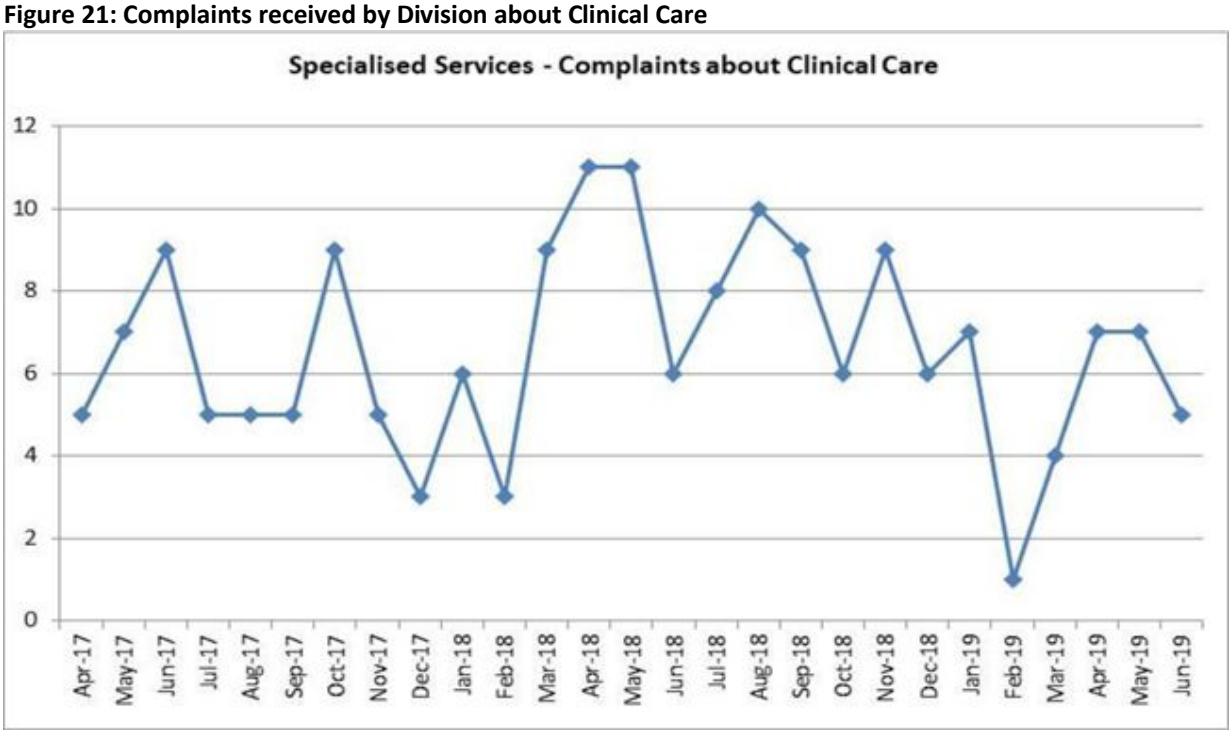


Figure 21: Complaints received by Division about Clinical Care



3.1.4 Division of Women's and Children's Services

The total number of complaints received by the Division increased slightly from 70 in Q4 to 73 in Q1. Complaints for Bristol Royal Hospital for Children (BRHC) accounted for 48 of the 73 complaints, a slight increase on the 46 received in Q4. 22 of the complaints received were for St Michael's Hospital (StMH), which is a decrease on the 24 received in Q4. There were also two complaints for divisional services located at South Bristol Community Hospital and one for Community Midwifery Services.

The division was the only clinical division to see a reduction in the number of complaints about 'appointments and admissions', although they did see a notable increase in complaints about 'clinical care' (34 compared with 24 in Q4).

This was the only clinical division that saw a decrease in complaints received about 'appointments and admissions' in Q1.

Table 13: Complaints by category type

Category Type	Number and % of complaints received – Q1 2019/20	Number and % of complaints received – Q4 2018/19
Clinical Care	34 (46.6% of total complaints) ↑	24 (34.3% of total complaints) ↓
Appointments & Admissions	16 (21.9%) ↓	20 (28.5%) ↑
Attitude & Communication	15 (20.5%) ↓	21 (30.0%) ↑
Information & Support	4 (5.5%) ↑	2 (2.9%) ↓
Facilities & Environment	2 (2.7%) =	2 (2.9%) ↑
Discharge/Transfer/Transport	1 (1.4%) ↑	0 (0%) ↓
Access	1 (1.4%) ↑	0 (0%) =
Documentation	0 (0%) ↓	1 (1.4%) ↓
Total	**73**	**70**

Table 14: Top sub-categories

Category	Number of complaints received – Q1 2019/20	Number of complaints received – Q4 2018/19
Clinical care (medical/surgical)	22 ↑	14 ↓
Cancelled or delayed appointments and	8 ↓	12 ↑
Clinical care (nursing/midwifery)	6 ↑	5 ↓
Communication with patient/relative	4 ↓	5 ↑
Attitude of medical staff	3 ↓	5 ↑
Lost/Misplaced/Delayed test results	3 ↓	4 ↑
Information about patient	3 ↑	1 =
Communication between staff	3 ↑	1 ↑

Table 15: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
There was a notable increase in complaints received by the Division about 'clinical care' (from 24 in Q4 to 34 in Q1). Of the 34 complaints received in this category, 18 were for Bristol Royal Hospital for Children (BRHC), 14 of which were sub-categorised as 'clinical care (medical/surgical). 15 of the complaints were received by St Michael's Hospital (StMH) and one was for Women's services based at South Bristol Community Hospital (SBCH). Of the total 16 complaints (including the one for SBCH), eight were recorded under the sub-category of 'clinical care (medical/surgical)' and six were in respect of 'clinical care (nursing/midwifery).	**BRHC** Some of the complaints referred to families' wishes to change their consultant; a number also involved the communication process between the BRHC and the Welsh NHS; and a few were in relation to provision of parental accommodation **StMH** There were no common themes within the complaints.	**BRHC** A number of the issues raised stemmed from incomplete or poor communication with families, specifically at the point at which concerns were raised (see narrative below). We will be raising the profile of the complaints process, including the feedback loop for learning purposes in alignment with the new coordinator commencing in post. **StMH** Midwives will explain more to women about the placenta after birth and what the checking of it indicates. The communication and sign off of message process within Early pregnancy Clinic has been reviewed. Posters are being displayed in gynaecology to remind patients that they may be asked to see students and explaining the process for declining this. Women using Keynsham Health Centre midwifery service will be reminded that out of hours and at lunchtime, calls are diverted to St Martin's Community Hospital in Bath. Pain relief for patients having endometrial biopsies in outpatients will be reviewed. Patient information for patients who have a two week wait outpatient appointment is also being reviewed.

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

StMH
We are focusing on timely responses and having more face to face meetings.

BRHC
We have appointed to the new complaints co-ordinator role for the Division. The successful applicant will be commencing in post during October 2019. Along with this new appointment, we have agreed a new higher banded job description, with the expectation of the post holder taking a more proactive strategic approach to complaints management.

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

StMH
We are working with the Local Maternity System to ensure women know what to expect when coming into the hospital, especially on the post-natal wards.

BRHC
A key issue from this quarter is an increase in the number of staff directing families to the formal complaint process before local resolution has been attempted. As result, we will be embarking on an education programme to coincide with the new complaints co-ordinator commencing in post.

Figure 22: Women & Children – formal and informal complaints received

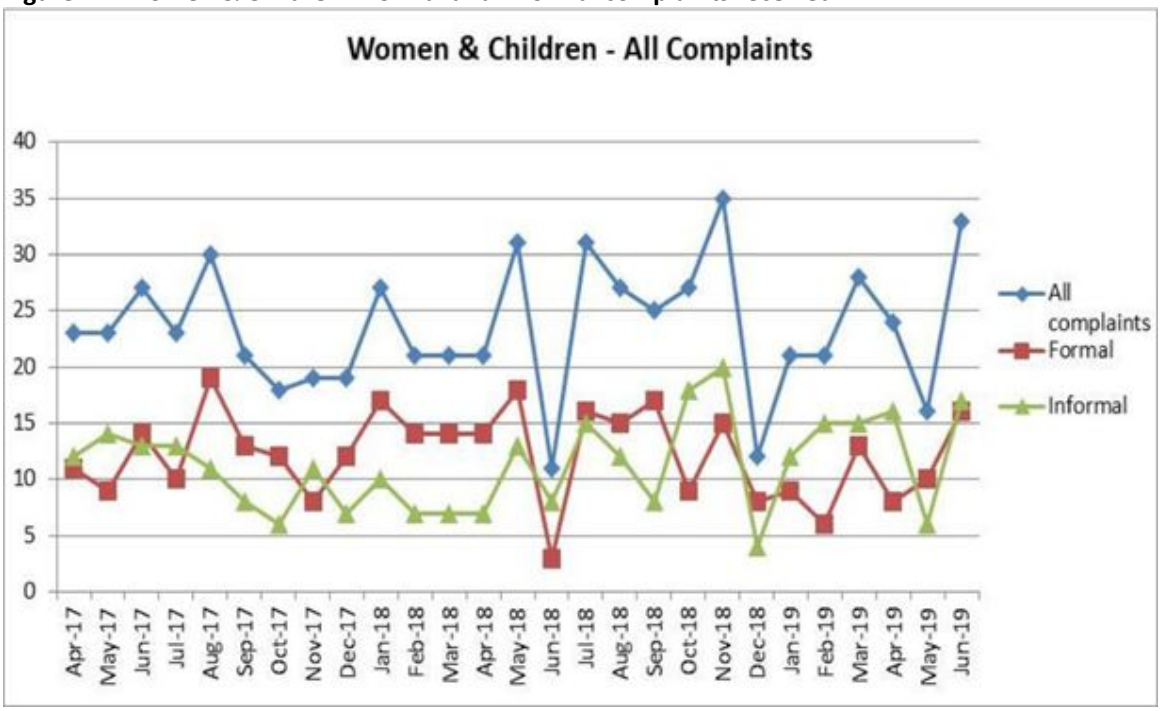


Figure 23: Complaints received by Bristol Royal Hospital for Children

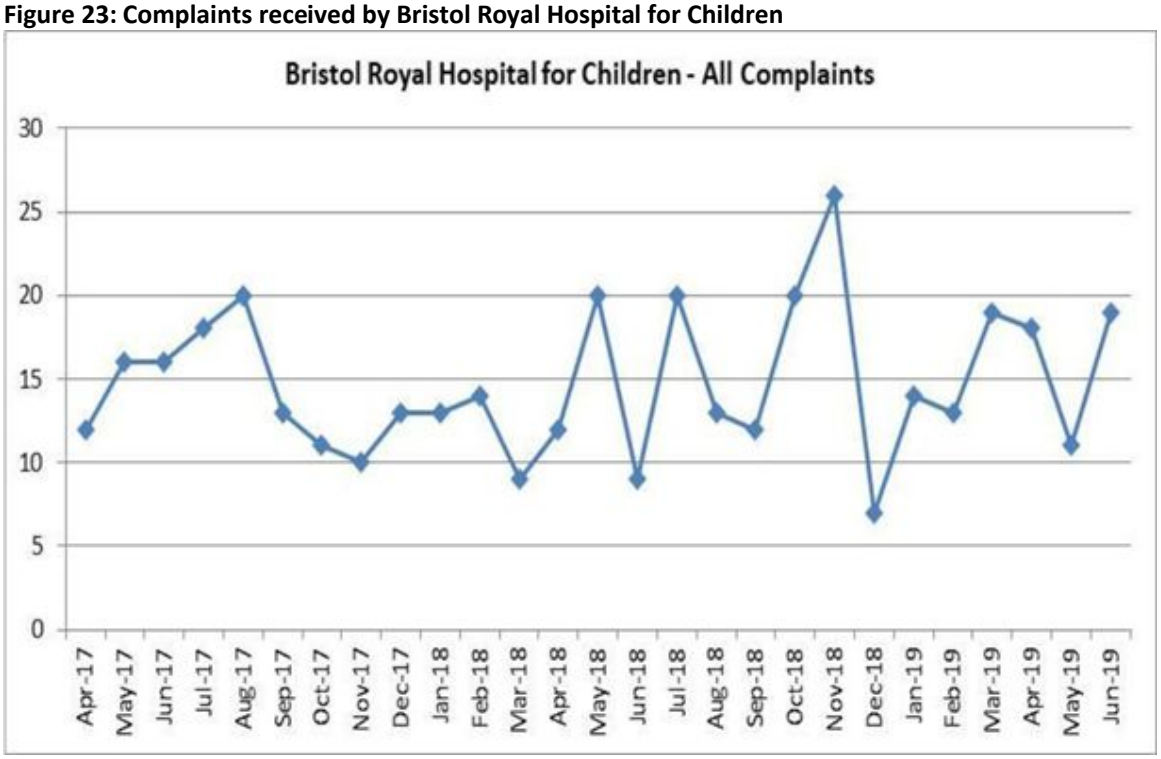
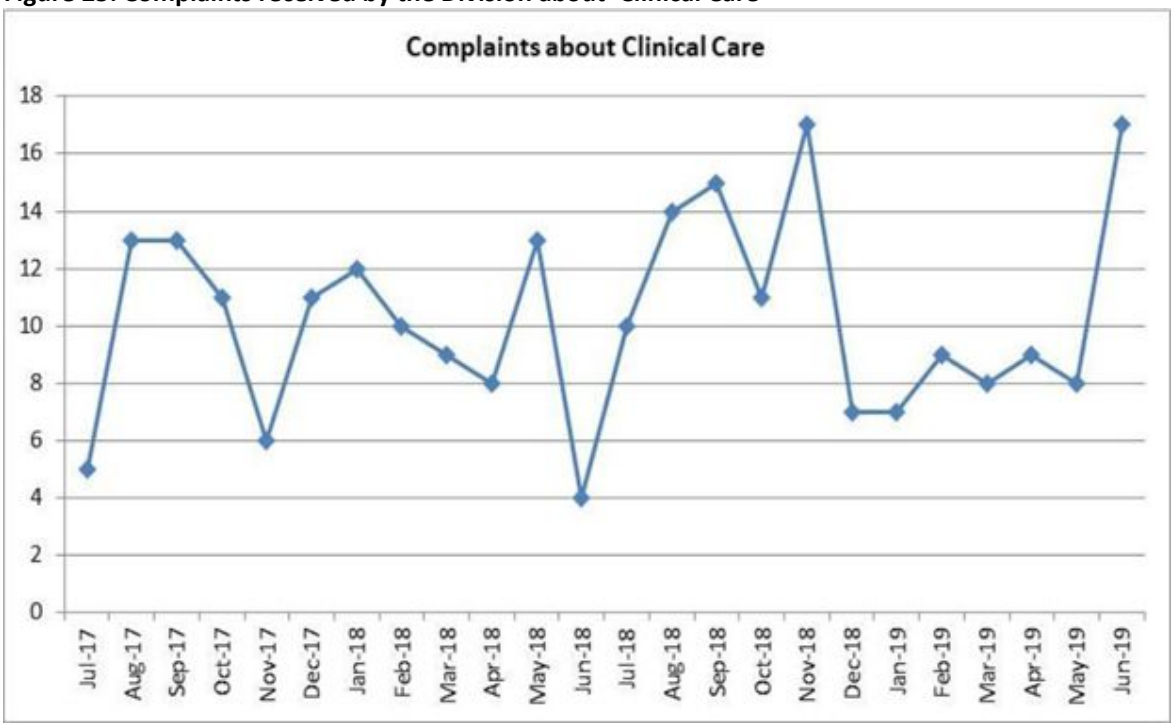


Figure 24: Complaints received by St Michael's Hospital

Figure 25: Complaints received by the Division about 'Clinical Care'



3.1.5 Division of Diagnostics & Therapies

Complaints received by the Division of Diagnostics and Therapies decreased from 25 in Q4 to 17 in Q1.

The majority of complaints received by the division were for Radiology services (10); however, there were no notable deteriorations or improvements in numbers of complaints received overall in Q1. For this reason, there is no table below for the division to comment on concerns highlighted by Q1 data.

Table 16: Complaints by category type

Category Type	Number and % of complaints received – Q1 2019/20	Number and % of complaints received – Q4 2018/19
Appointments & Admissions	10 ↑	8 ↑
Attitude & Communication	4 ↓	6 =
Clinical Care	2 ↓	5 ↓
Information & Support	1 ↓	2 ↑
Facilities & Environment	0 ↓	2 =
Documentation	0 ↓	1 ↑
Access	0 ↓	1 ↑
Discharge/Transfer/Transport	0 =	0 =
Total	**17**	**25**

Table 17: Top sub-categories

Category	Number of complaints received – Q1 2019/20	Number of complaints received – Q4 2018/19
Cancelled/delayed appointments and procedures	5 ↑	2 ↑
Appointment administration issues	4 ↓	5 ↑
Attitude of medical staff/AHPs	3 ↑	0 ↓

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

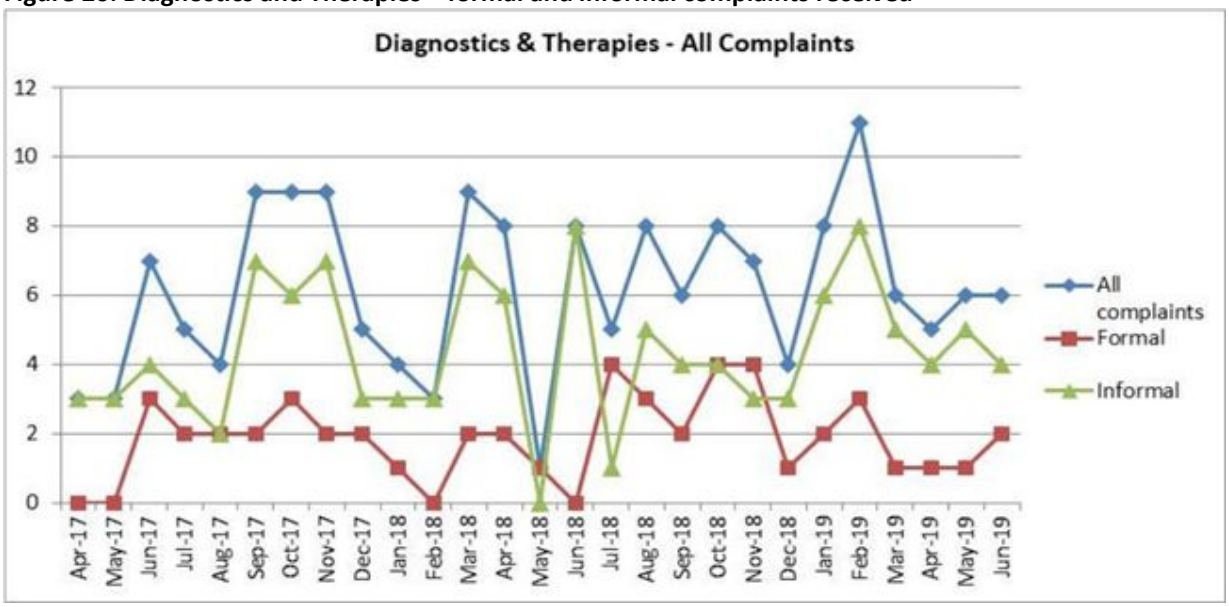
Complaints are a high priority for the division, to ensure timescales are consistently met, and we rarely request extensions to complaint deadlines. There is a robust divisional process in place:

- Complaints coordinator who receives and disseminates the complaints to relevant individuals;
- Input from all services involved;
- Clearly assigned leads within the divisional management team for each complaint;
- Tracking log with timescales for all complaints to ensure deadlines are met;
- Final sign off and review of all formal complaints are undertaken by the Divisional Director; and
- Bi-monthly internal analysis and report on complaints presented at the Divisional Clinical Quality Committee.

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

The division undertakes regular internal analysis on complaint responses it both leads for and contributes to. No concerns were highlighted from the Q1 data and therefore no current priority issues have been identified.

Figure 26: Diagnostics and Therapies – formal and informal complaints received



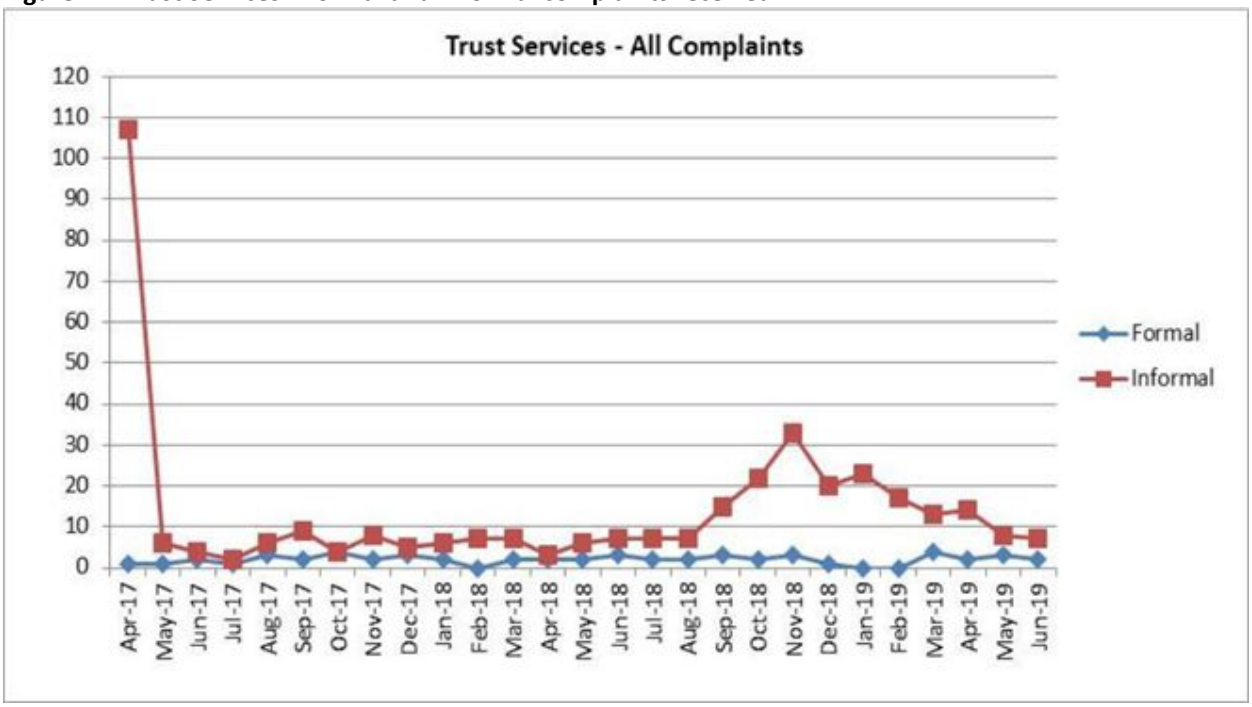
3.1.6 Division of Trust Services

The Division of Trust Services, which includes Facilities & Estates, received 36 complaints in Q1, compared with 57 in Q4 and 81 in Q3.

Of the 36 complaints received in Q1, 16 were about car parking across various Trust sites, although this is a notable reduction on complaints received about parking issues in Q4 and Q3.

The remainder of the complaints received were spread across various departments/areas, including issues about transport and smoking.

Figure 27: Trust Services – formal and informal complaints received



3.2 Complaints by hospital site

Complaints increased across all hospital sites, with the exception of Bristol Eye Hospital, South Bristol Community Hospital and Central Health Clinic/Unity. The most notable increase by percentage was Bristol Dental Hospital, which saw a 29.4% increase compared with Q4. Complaints received for South Bristol Community Hospital decreased for the third consecutive quarter.

Table 18: Breakdown of complaints by hospital site[3]

Hospital/Site	Number and % of complaints received in Q1 2019/20	Number and % of complaints received in Q4 2018/19
Bristol Royal Infirmary	207 (40.5% of total complaints) ↑	193 (39.1% of total complaints) ↑
Bristol Heart Institute	54 (10.5%) ↑	48 (9.7%) ↑
Bristol Royal Hospital for Children	48 (9.4%) =	48 (9.7%) ↓
St Michael's Hospital	48 (9.4%) ↑	42 (8.5%) ↑
Bristol Dental Hospital	44 (8.6%) ↑	34 (6.9%) ↑
Bristol Eye Hospital	43 (8.4%) ↓	57 (11.7%) ↑
South Bristol Community Hospital	27 (5.3%) ↓	30 (6.1%) ↓
Bristol Haematology & Oncology Centre	27 (5.3%) ↑	22 (4.5%) ↑
Central Health Clinic and Unity Community Clinics	7 (1.4%) ↓	8 (1.6%)
Southmead and Weston Hospitals (UH Bristol services)	3 (0.6%) =	3 (0.6%) ↑
Off Trust Premises	2 (0.4%) ↑	1 (0.2%) ↑
Community Midwifery Services	1 (0.2%) ↑	0 =
TOTAL	**511**	**493**

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 28 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, 45.6% (*44.8%) of complaints received were about outpatient services, 33.3% (30.6%) related to inpatient care, 6.5% (5.5%) were about emergency patients; and 14.6% (19.1%) were in the category of 'other' (as explained above).

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

[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 and some services that come under Diagnostics & Therapies are undertaken at the Children's Hospital.

Figure 28: All patient activity

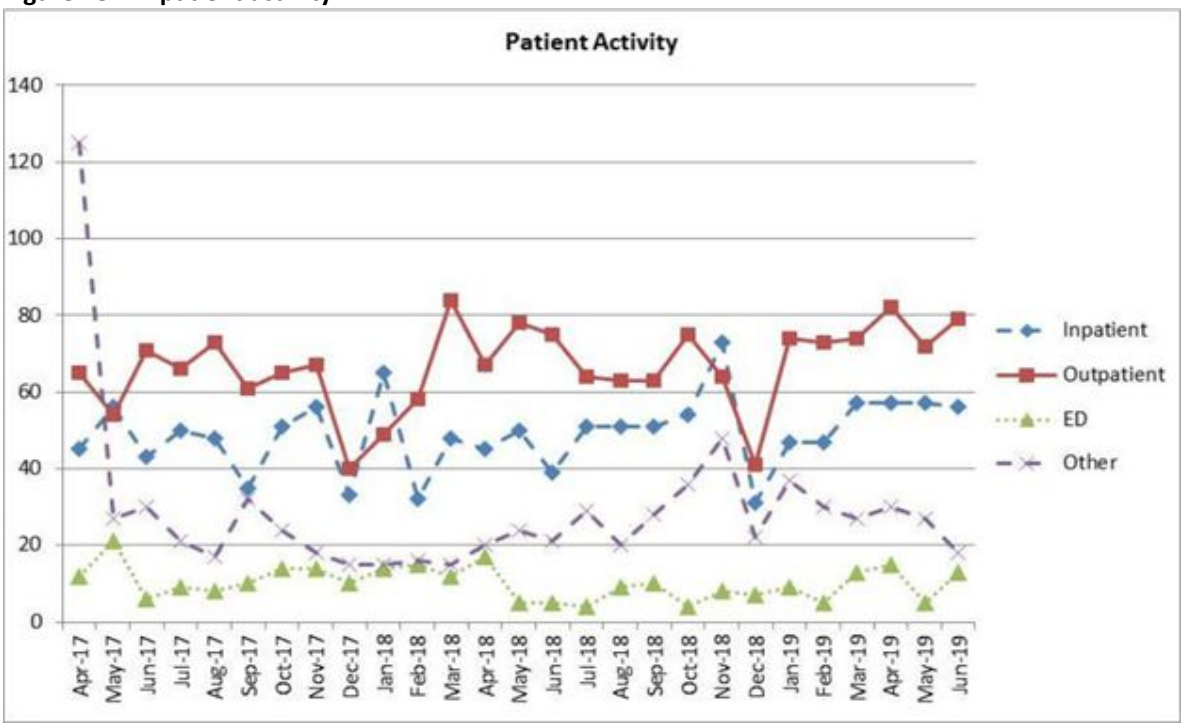


Table 19: Breakdown of Area Type

Complaints	**Area Type**				
Month	**ED**	**Inpatient**	**Outpatient**	**Other**	**Grand Total**
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
Jul-18	4	51	64	29	148
Aug-18	9	51	63	20	143
Sep-18	10	51	63	28	152
Oct-18	4	54	75	36	169
Nov-18	8	73	64	48	193
Dec-18	7	31	41	22	101
Jan-19	9	47	74	37	167
Feb-19	5	47	73	30	155
Mar-19	13	57	74	27	171
Apr-19	15	57	82	30	184
May-19	5	57	72	27	161
Jun-19	13	56	79	18	166
Grand Total	**170**	**911**	**1235**	**463**	**2779**

3.3 Complaints responded to within agreed timescale (for formal resolution process)

The Divisions of Surgery, Medicine, Trust Services and Diagnostics & Therapies did not report any breaches of formal complaint deadlines in Q1, with all four sending out 100% of responses by the agreed deadline.

Of the remaining two Divisions, Specialised Services reported five breaches and Women & Children reported two. It should however be noted that the breaches for Specialised Services and Medicine were **not** attributable to the Divisions (see Table 21 below).

This is a significant improvement on the 25+ breaches reported in the previous four quarters.

In Q1, the Trust responded to 179 complaints via the formal complaints route and 95.5% of these were responded to by the agreed deadline, which is an excellent achievement following a concerted effort by all Divisions.

Table 20: Breakdown of breached deadlines - Formal

Division	Q1 (2019/20)	Q4 (2018/19)	Q3 (2018/19)	Q2 (2018/19)
Surgery	0 (0%)	3 (5.6%)	6 (9.5%)	4 (6.7%)
Women & Children	2 (5.3%)	15 (31.3%)	13 (25%)	13 (27.7%)
Trust Services	0 (0%)	2 (40%)	3 (27.3%)	1 (20%)
Medicine	1 (2.2%)	1 (3.3%)	3 (6.8%)	2 (6.7%)
Specialised Services	5 (23.8%)	3 (12.5%)	0 (0%)	5 (14.3%)
Diagnostics & Therapies	0 (0%)	1 (11.1%)	1 (8.3%)	0 (0%)
All	**8 breaches**	**25 breaches**	**26 breaches**	**25 breaches**

(So, as an example, there was one breach of timescale in the Division of Medicine in Q1, which constituted 2.2% of the complaint responses which were sent out by that division in Q1.)

Breaches of timescale in respect of formal complaints 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. Four of the breaches were caused by delays within the Patient Support & Complaints Team, two were attributable to the Divisions and a further two were caused by delays during the Executive sign-off process.

Table 21: Reason for delay

Breach attributable to	Surgery	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies	Trust Services	All
Division	0	0	0	2	0	0	**2**
Patient Support & Complaints Team	0	1	3	0	0	0	**4**
Executives/sign-off	0	0	2	0	0	0	**2**
All	**0**	**1**	**5**	**2**	**0**	**0**	**8**

3.3.1 Complaints responded to within agreed timescale (for informal resolution process)

In Q4, we commenced reporting of the number of informal complaints that breached the deadline agreed with the complainant. Performance against this measure is now reported to the Trust Board. All breaches of informal complaint timescales are attributable to the Divisions as the Patient Support & Complaints Team and Executives do not contribute to the time taken to resolve these complaints. In Q1, the Trust responded to 335complaints via the informal complaints route (compared with 231 in Q4) and 89.0% of these were responded to by the agreed deadline; an improvement on the 84% reported in Q4.

Table 22: Breakdown of breached deadlines - Informal

Division	Q1 (2019/20)	Q4 (2018/19)	Q3 (2018/19)	Q21 (2018/19)
Surgery	16 (11.0%)	10 (14.5%)		
Women & Children	4 (12.9%)	8 (33.3%)		
Trust Services	6 (20.0%)	10 (22.2%)		
Medicine	7 (11.7%)	3 (7.1%)		
Specialised Services	0 (0%)	5 (12.2%)		
Diagnostics & Therapies	2 (18.2%)	1 (10%)		
All	**35**	**37**		

3.4 Outcome of formal complaints

In Q1, the Trust responded to 179 formal complaints[4]. Tables 23 and 24 below show a breakdown, by Division, of how many of these cases were upheld, partly upheld or not upheld in Q1 of 2019/20 and Q4 of 2018/19 respectively. A total of % of complaints were either upheld or partly upheld in Q4, compared with 87.0% in Q4.

Table 23: Outcome of formal complaints – Q1 2019/20

	Upheld	Partly Upheld	Not Upheld
Surgery	24 (38.1%) ↑	25 (39.7%) =	14 (22.2%) ↑
Medicine	12 (26.7%) ↑	18 (40.0%) ↓	15 (33.3%) ↑
Specialised Services	11 (52.4%) ↑	6 (28.6%) ↓	4 (19.0%) ↑
Women & Children	18 (47.3%) =	11 (29.0%) ↓	9 (23.7%) ↑
Diagnostics & Therapies	2 (40.0%) ↑	2 (40.0%) ↓	1 (20.0%) =
Trust Services	2 (28.6%) ↓	2 (28.6%) ↑	3 (42.8%) ↑
Total	**69** ↑	**64** ↓	**46** ↑

Table 24: Outcome of formal complaints – Q4 2018/19

	Upheld	Partly Upheld	Not Upheld
Surgery	19 (35.8%) ↓	25 (47.2%) ↑	9 (17%) ↓
Medicine	8 (26.7%) ↓	19 (63.3%) ↑	3 (10%) ↓
Specialised Services	12 (50%) ↓	10 (41.7%) ↓	2 (8.3%) ↓
Women & Children	18 (37.5%) ↓	24 (50%) ↓	6 (12.5%) ↑
Diagnostics & Therapies	1 (11.1%) ↓	7 (77.8%) ↑	1 (11.1%) ↓
Trust Services	4 (80%) ↑	0 (0%) ↓	1 (20%) ↓
Total	**62 (36.7%)** ↓	**85 (50.3%)** ↓	**22 (13%)** ↓

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

4. Learning from complaints

All feedback is welcome, as it creates an opportunity to better understand, and to improve the care and treatment we provide to our service users. All complaints are investigated, learning is identified and any necessary changes to practice are made.

Actions resulting from complaints are monitored and reviewed by our Divisions; the Patient Support and Complaints Team also monitor progress.

Below are some examples of actions which have been completed during Q1 2018/19.

- Following a complaint about a patient being given incorrect information at her pre-operative assessment, the Division of Specialised Services launched a booklet called 'My Heart Surgery Plan' to improve the consistency of information given to patients. At the request of surgeons, the anticipated length of stay has been added to pre-operative assessment cards so that nurses are fully aware of this when speaking to the patient (Specialised Services).

- A complaint was received on behalf of a patient with autism who also suffers with Post Traumatic Stress Disorder and has complex mental health needs. Following an operation, the patient felt that staff were not listening to her and not taking her special needs into account. This complaint was shared anonymously with the teams who cared for her so that each team understood how negative a patient's experience could be if we do not communicate with them in a way that takes account of their specific needs. The pre-operative team was also reminded of the importance of sharing this information with the team caring for the patient post-operatively (Surgery).

- A patient complained about their endoscopy being cancelled at the last minute due to miscommunication around the type of sedation to be used. A separate section has now been added to the EUS (endoscopy under sedation) booking request form to indicate where a patient needs Propofol sedation (Surgery).

5. 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. A total of 203 enquiries were received in Q1, a similar number as the 200 received in Q4.

The team also recorded and acknowledged 45 compliments received during Q1 and shared these with the staff involved and their Divisional teams. This is comparable with the 44 compliments reported in Q4.

Table 26 below shows a breakdown of the 'Top 10' requests for advice, information and support dealt with by the team in Q1.

Table 25: Enquiries by category

Category	Enquiries in Q1 2019/20
Information about patient	67
Hospital information request	44
Medical records	25
Appointment queries	21
Clinical care	7
Admissions/Discharge enquiries	5

Employment & Volunteering	4
Expenses claim	3
Accommodation enquiry	3
Signposting	3

In addition to the enquiries detailed above, in Q1 the Patient Support and Complaints team recorded 148 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 (and the team is subsequently unable to obtain this information), 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 is dealing with a steadily increasing volume of activity, with a total of 906 separate enquiries in Q1 2019/20, compared with 903 in Q4 of 2018/19, 865 in Q3, 841 in Q2 and 819 in Q1. This equates to a 10.6% increase in enquiries compared with the corresponding period one year ago.

6. 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, 279 complaints were received in writing (240 by email and 39 letters) and 225 were received verbally (26 in person via drop-in service and 199 by telephone). Seven complaints were also received in Q1 via the Trust's 'real-time feedback' service. Of the 511 complaints received in Q1, 99.0% (506 out of the 511 received) met the Trust's standard of being acknowledged within two working days (verbal) and three working days (written).

The Patient Support & Complaints Manager closely monitors cases that are not acknowledged within timescale and reports to the Head of Quality (Patient Experience & Clinical Effectiveness) if there are any concerns and/or patterns.

7. PHSO cases

During Q1, the Trust was advised of Parliamentary and Health Service Ombudsman (PHSO) interest in two new complaints. During the same period, seven existing cases remain ongoing. A total of six cases were closed during Q4: none were upheld, one was partly upheld and all recommendations have been complied with and the remaining five were closed with the PHSO taking no further action.

Table 26: Complaints opened by the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
17286	AS		05/11/2018 [02/04/2019]	StMH	ENT	Surgery

The PHSO initially contacted the Trust on 02/04/2019 to ask what stage we had reached in trying to resolve this complaint. On 18/06/2019, the PHSO contacted the Trust again advising that the patient had stated that the ENT team had "blocked" his referral to the service by his GP due to no long accepting referrals for the treatment this patient needed. The PHSO wished to know if this was correct and, if so, where the patient could be seen instead. We responded advising there had been an issue with the GP obtaining funding and the patient was seen on 21/05/2019. The PHSO spoke to the patient and his medical records were subsequently sent to them on 27/06/2019. We are currently awaiting further contact from the PHSO.						
16661	LE	JH	26/09/2018 [16/04/2019]	BRHC	Paediatric Neurosurgery	Women & Children
The PHSO asked on 16/04/2019 if the Trust had exhausted local resolution and subsequently requested the patient's records on 28/05/2019. The medical records and complaint file were sent to the PHSO on 26/06/2019 and we are currently awaiting further contact from them.						

Table 27: 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
13256	MR	WR	07/03/2018	BRI	Ward A400 - OPAU	Medicine
The PHSO gave the Trust the opportunity of responding to the family of the patient (we had previously only written to the patient's care home). This response was sent to the family on 30/05/2019 and the Division is currently making arrangements to meet with them to address their outstanding concerns.						
9403	LD	DM	03/08/2017 [07/09/2018]	BHOC	Ward D703 - Haematology	Specialised Services
We last heard from the PHSO on 28/06/2019, when they advised that they were still considering whether they need to investigate this matter further and would either write to us with the scope of their investigation or email us if they decide to take no further action.						
8853	KK		10/07/2017 [24/08/2018]	BRI	Trauma & Orthopaedics	Surgery
On 29/05/2019, the PHSO confirmed that they planned to partly uphold this complaint. We subsequently complied with their recommendations and we are just keeping the case open as the PHSO would like to see a copy of the Trust's action plan following a meeting with the patient scheduled for October 2019.						
16724	GS	HS	01/10/2018 [10/01/2019]	BRHC	PICU	Women & Children
Patient tragically died in BRHC in 2015 at age of 14yrs. Long standing complaint which parents have now sent to the PHSO for investigation. Update from PHSO received on 26/07/2019 advising that they have almost completed their review of the records we sent to them and will then pass them to their clinical advisers, who will take a few weeks to review them.						
15161	DH		25/06/2018 [04/03/2019]	BHI	Outpatients (BHI)	Specialised Services
Call received from PHSO on 04/03/2019 asking if a complaint had been made to the Trust by this patient and whether we had sent our final response. Despite calls back to the PHSO and messages being left, no further contact was received until 02/07/2019 when the PHSO requested a copy of the medical records. These were sent to the PHSO on 23/07/2019 and we are currently awaiting further contact.						
4904	PM	OM	28/11/2016 [15/02/2019]	BRHC	Paediatric Neurology	Women & Children

An update was received from the PHSO on 09/07/2019 advising that they have asked for advice from a clinical neuro-psychiatrist and a neurologist and they were expecting to receive that advice within approximately four weeks. They also confirmed that if they decide to interview Trust staff, this is likely to happen between August and September and they will confirm their intentions in this respect as soon as possible.						
18996 Ulysses	AC	BC	08/06/2015 [01/02/2018]	BRHC	PICU	Women & Children
On 05/08/2019, the PHSO advised that they are having difficulties in finding a suitable qualified clinical adviser to look at this case. They do however hope to have finalised their enquiries by the end of November 2019.						

Table 28: Complaints closed 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
11619	SQ		01/12/2017 [05/10/2018]	StMH	Ward 78 (Gynaecology)	Women & Children
The PHSO advised the Trust on 28/06/2019 that the complaint had been closed with no indication of maladministration. **No Further Action**.						
16122	RR		23/08/2018 [19/02/2019]	StMH	Ward 76	Women & Children
PHSO made contact in February 2019 stating that they had been asked to look at this complaint. Despite UH Bristol returning the PHSO's calls and leaving messages, nothing has been heard from the PHSO since February 2019 and no records have been requested so we have closed the case pending further contact. **No Further Action**.						
15271	DL		02/07/2018 [23/01/2019]	BRI	Endocrinology	Medicine
PHSO partly upheld this complaint in April 2019 and recommended that the Trust send the complainant a letter of apology, which was sent on 15/05/2019. **Partly Upheld**.						
13567	IR		27/03/2018 [05/03/2019]	BHI	Ward C604 - CICU	Specialised Services
The PHSO confirmed on 15/05/2019 that they were aware that an error had been made in the Trust's response to the complainant but they would not be investigating further. **No Further Action**.						
11887	JD		18/12/2017 [21/01/2019]	BRI	Accident & Emergency (BRI)	Medicine
PHSO contacted Trust on 21/01/2019 to ask for a copy of the Trust's response letter dated 22/05/2018. Discussed case with PHSO and sent copy of letter requested on 23/01/2019. As nothing further has been heard from the PHSO since that time, we have now closed the case. **No Further Action.**						
10412	MR	JR	29/09/2017 [19/03/2019]	StMH	Ward 76	Women & Children
PHSO advised on 30/04/2019 that they would not be investigating this case further and had closed their file. **No Further Action**.						

8. Complaint Survey

Since February 2017, the Patient Support & Complaints team has been sending out complaint surveys to all complainants six weeks after their complaint was resolved and closed. The survey responses are now monitored on a regular basis in order that improvements can be made to the way that the Patient Support & Complaints team work as a direct result of the responses received.

Table 31 below shows data from the 25 responses received during Q1, compared with those received in previous quarters. Feedback improved in respect of respondents telling us they found it easy to make a complaint and that they had found out how to do so via one of our leaflets or posters. More respondents told us that they were either satisfied or very satisfied with how the Patient Support & Complaints Team dealt with their complaint, that they felt their concerns were taken seriously and that they were kept updated on the progress of their complaint.

As in Q4 2081/19, no respondents reported that they took up the option of a complaint resolution meeting in Q1. The high number of complaints being resolved informally, usually by way of a telephone call, could also affect this figure.

The improvement in the number of responses being sent out within the agreed timescale is reflected in the corresponding reduction in the number of respondents telling us they received their response late.

Further work is required from the Patient Support & Complaints Team, and from the Divisions, in respect of reassuring complainants that things will change as a result of their complaint and ensuring that all issues raised are addressed in our responses.

Table 29: Complaints Survey Data

Survey Measure/Question	Q1 2019/20	Q4 2018/19	Q3 2018/19	Q2 2018/19
Respondents who confirmed that a timescale had been agreed with them by which we would respond to their complaint.	80.0% ↓	94.1% ↑	67.5%	78.8%
Respondents who felt that the Trust would do things differently as a result of their complaint.	14.3% =	14.3% ↓	15.8%	22.4%
Respondents who found out how to make a complaint from one of our leaflets or posters.	12.5% ↑	8.6% ↓	15.8%	9%
Respondents who confirmed we had told them about independent advocacy services.	48.0% ↓	54.3% ↑	46.2%	32.8%
Respondents who confirmed that our complaints process made it easy for them to make a complaint.	66.7% ↑	62.9% ↓	65%	69.6%
Respondents who felt satisfied or very satisfied with how their complaint was handled by the Patient Support & Complaints Team.	70.8% ↑	65.7% ↑	63.4%	69.1%
Respondents who said they did not receive their response within the agreed timescale.	13.6% ↓	14.3% ↓	17.5%	16.4%
Respondents who felt that they were	91.7% ↓	97.1% ↓	97.5%	81.8%

treated with dignity and respect by the Patient Support & Complaints Team.				
Respondents who felt that their complaint was taken seriously when they first raised their concerns.	84% ↑	80.5% =	80.5%	81.4%
Respondents who did not feel that the Patient Support & Complaints Team kept them updated on progress often enough about the progress of their complaint.	12.5% ↓	17.1% ↓	20%	29.9%
Respondents who received the outcome of our investigation into their complaint by way of a face-to-face meeting.	0% =	0% ↓	2.9%	1.6%
Respondents who said that our response addressed all of the issues that they had raised.	50.0% ↓	58.3% ↑	57.9%	57.1%

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Medical Revalidation Appraisal Report**
Report Author	**William Oldfield, Medical Director**
Executive Lead	**William Oldfield, Medical Director**

1. Report Summary

This report provides a summary of the appraisal and revalidation activity at UHBristol NHS Foundation Trust for 2018/19 and will be submitted to NHS England after approval at Board

2. Key points to note
(Including decisions taken)

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 junior's doctor's contract. The administrative workload to monitor and support this group with appraisal and revalidation is escalating and needs a more comprehensive review.

The tender of the new appraisal system fourteen fish has been completed and the system is now in action in UHBristol. We are maintaining close links with NBT through this process and are now ensuring that the dates within the system are correct so that we can make full use of the benefits of the new system in terms of reporting and assurance.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

None

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **APPROVAL**
- The Board is asked to **APPROVE** the report.

5. History of the paper
Please include details of where paper has previously been received.

SLT	**21st August 2019**

Annual Quality Assurance Report for Appraisal and Revalidation University Hospitals Bristol NHS Foundation Trust 2018-2019

Responsible Officer:	Dr. William Oldfield, Medical Director
Associate Medical Director, Revalidation:	Dr. Anne Frampton
Report produced by:	Dr. Anne Frampton & Dr. Frances Forrest
Time period covered in report:	1st April 2018 – 31st March 2019 (Year 1 of the second 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 (DB) 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 18/19 and highlights current issues in the process that are the focus of work for the Revalidation office.

Activity levels 2018/19

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 1 18/19	Year 5 17/18	Year 4 16/17	Year 3 15/16	Year 2 14/15	Year 1 13/14
Number of doctors for whom UHBristol is the designated body	774	747	668	665	556	503
Number of positive recommendations for revalidation	140	42	31	187	194	74
Number of deferrals	16*	8	6	23	24	4
Number of notices for non-engagement	0	0	0	0	0	1

Due to the nature of introduction of revalidation in 2012/13 a higher proportion of doctors revalidate in the first 3 years of any cycle. This will even out over time.

* One person deferred twice

Appraisal rates

The figure below shows 18/19 appraisal rates by grade of medical practitioner.

Grade of practitioner	Total Number	Appraisals in year	% of doctors undertaking appraisal by grade 18/19. In () 17/18
Consultants (excludes locums)	507	458	90.33 (83.8)
SAS	30	28	93.33 (61.5)
Locally employed Doctors (Clinical Fellows) and short term contracts (locums at all grade)	235	122	51.9 (55.4)
Total number	772	608	78.75 (74.9)

Note the total number of doctors recorded (774) is different from those attached to the Designated Body (772). This discrepancy is accounted for by 2 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.

UHB consultant appraisal compliance has been a focus of work since 2016 when NHSE changed reporting from 15 to 12 month compliance. This year, of the 507 consultants attached to UHBristol, 400 appraised on time (within 8 weeks of their appraisal date, a further 58 appraised in year but slightly outside of the prescribed time frame and 17 had an approved delay- usually due to maternity or sick leave. 32 consultants (6%) did not appraise in year.

Specialty Doctors and Associate Specialist Doctors (SAS doctors) are part of the permanent workforce. The total number of SAS doctors is falling in line with the removal of this grade nationally. Our SAS doctor's compliance is overall good, with 28 out of the 30 SAS grade doctors completing their appraisals. There were no approved delays meaning 2 doctors did not appraise in year.

Within the Locally Employed Doctor group, Clinical fellow compliance remains poor. Our Clinical Fellow numbers have increased slightly from past year (up to 235 from 202).

The issues remain the same and a report was submitted to Board last year highlighting the 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)

The change of e-appraisal software from Premier IT to Fourteen Fish on 1/4/2019 is a major change that will help to address flows of information and tracking of all doctors attached to the designated body.

Hospice

Childrens' Hospice South West (CHSW)
The SLA was set up by Pat Weir and Sean O'Kelly in recognition of the fact UHBristol NHS Foundation Trust is a major Childrens Centre and had local connections to Charlton farm.

CHSW consists of 2 hospice sites
1) Little Bridge House in Barnstaple
2) Charlton Farm in Wraxall, Bristol

Currently 3 hospice doctors are appraised and revalidated under the RO at UHBristol.

St Peter's Hospice

Due to the departure of the RO at St Peters hospice we have been approached to undertake this function on their behalf. An SLA to match that with the CHSW is being drawn up and we anticipate that we will undertake this function for one year in the first instance whilst they review their plans.

There are currently 5 doctors at the hospice who would be appraised an revalidated by UHBristol.

Activity Levels 2018/19 Exception reporting 1: Deferred Recommendations

The table below lists the reasons for deferral of a revalidation recommendation for each of the sixteen practitioners deferred in 2018/19

	Grade	Date of Deferral	Reason	New Revalidation date	Outcome
1	Clinical Fellow	4/4/2018	Insufficient evidence	12/8/2018	Revalidated 30/5/2018
2	Consultant	14/5/2018	Failure to complete 360 colleague and patient feedback	20/9/2018	Revalidated 19/9/2018
3	Clinical Fellow	30/5/2018	Insufficient evidence	5/10/2018	Revalidated 22/8/2018
4	Clinical Fellow	25/6/2018	Insufficient evidence:	21/10/2018	Left trust to return to training in wales.

					Information sent to RO in welsh deanery
5	Clinical Fellow	25/6/2018	Insufficient evidence	2/1/2019	Revalidated 31/12/2018
6	Clinical Fellow	25/7/2018	From Greece – given revalidation date of within one year of starting; insufficient evidence	24/1/2019	Revalidated 29/10/2018
7	Clinical Fellow	25/7/2018 and 10/12/2018	Insufficient evidence- **	28/12/2018 Second deferral 28/6/2018	Revalidated June 2019
8	Consultant	10/12/2018	On maternity leave. Insufficient evidence in current portfolio	1/1/2020	Resigned from Trust May 2019
9	Consultant	10/12/2018	On long term sickness- cancer related therapy	15/3/2020	Returned to work in march 2019 expected to revalidate
10	Consultant	4/1/2019	Failure to provide evidence about private practice and patient feedback	6/5/2019	Revalidated 27/2/2019
11	Consultant	10/1/2019	On maternity leave (second in cycle) insufficient evidence	10/10/2019	Expected to revalidate
12	Consultant (retire and return)	22/1/2019	Failure to complete feedback exercise	26/5/2019	27/2/2019
13	Clinical fellow	8/3/2019	Administrative issue	20/7/2019	Revalidated

			accessing feedback		28/3/2019
14	Consultant	29/3/2019	Failure to complete patient feedback	1/8/2019	Expected to revalidate August 2019
15	Consultant	29/3/2019	Failure to undertake sufficient appraisal within cycle in a timely fashion and complete feedback	17/1/2020	Expected to revalidate

**This trainee was not well supported initially by the team in which she was working and was from outside the UK and so did not initially understand all of the requirements of revalidation. A significant amount of work was undertaken by the clinical director in the area to address this and the trainee responded very positively. She now has appraisal evidence and good colleague and patient feedback as well as a forward plan for her training. She was successfully revalidated in June 2019.

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.

2: Non Engagement

In 2018/19 we reported that 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 still ongoing with the GMC. The doctor has subsequently taken out a work tribunal issue

Management of the appraisal process

Handover of Associate Medical Director Role

In February 2019 Anne Frampton was appointed to take over as Associate Medical

Director for Revalidation and Appraisal from Frances Forrest who was retiring. Anne and Frances had a 3 month handover period which was hugely beneficial and has allowed a smooth handover of the roles. As of 1st June Anne Frampton has taken on this role in its entirety.

E-portfolio system

The contract with Premier IT ended on 31st March 2019. All the data from that system has been successfully transferred to the new system Fourteen Fish. Whilst the data transfer is complete and has gone well, it will take some time to ensure that all of the dates and files are aligned correctly within fourteen fish to allow us to utilize the full functionality as described in the appendix.

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 18/19.

Quality Assurance

The last NHS England Framework of Quality Assurance independent verification process took place in April 2016. The next HLQR will be in summer 2019

Audit Southwest commenced a Medical Staff Appraisals Internal Audit in June 2018 completed and reported April 2019 and this is included in the appendices.

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 junior's doctor's contract. The administrative workload to monitor and support this group with appraisal and revalidation is escalating and needs a more comprehensive review.

The tender of the new appraisal system fourteen fish has been completed and the system is now in action in UHBristol. We are maintaining close links with NBT through this process and are now ensuring that the dates within the system are correct so that we can make full use of the benefits of the new system in terms of reporting and assurance.

Appendix 1: Introduction of Fourteen Fish

In late 2017 work with NBT and WGH commenced on a joint tender for the e-portfolio software. The tender was initiated due to the annual cost for the system (£34K) exceeding the limit for automatic renewal.

Part of this joint project has been to align our processes with NBT who have higher appraisal compliance rates in all grades than UHBFT. NBT used the incumbent system Premier IT for appraisal for all grades of non-training doctors. UHB did not due to the cost per license. Fourteen fish were awarded the contract for the e-portfolio software. From April 1st all doctors will be appraised through this system as the cost is more favourable. This should start to show improvement in compliance in all grades but especially Clinical Fellows compliance by quarter 3. This is because of automatic systems and processes can be introduced that were hitherto undertaken by hand

1) automatic contact and instruction to newly joining doctors to the designated body
2) easier and intuitive software that better suits all grades
3) refresh of all reminder and tightening of all tolerance with automatic letters from fourteen fish (previously done by hand)

UHBFT continues to work closely with NBT in the roll out and utilization of fourteen fish and we have established monthly meetings with the NBT revalidation team. We are now working on ensuring that the dates and reporting within the system are correct prior to launching the automatic letters of notification around appraisal dates. Once the system is embedded we believe this will work well and provide a very accurate report of our appraisal compliance. However in the changeover period between systems there is work to be done to align all of the dates correctly. We anticipate completing this work in Q1 and Q2 of 2019 and that from Q3 our reporting should be robust.

Automatic notifications from Fourteen Fish

On 1st October 2019 we will instigate the following automatic notifications from fourteen fish

1) 2 weeks prior to due date
2) 2 weeks after due date
3) 6 weeks after due date

2 weeks over due:

Dear Dr…….

The Trusts appraisal system Fourteen Fish shows that your annual appraisal was due by [due date] and has not yet been completed.

This may be due to one of the following:

- You have not yet submitted your portfolio to your appraiser
- Your appraiser has not yet completed the appraisal outputs
- You have not accepted the outputs that your appraiser completed

A complete appraisal is one where the meeting has taken place and the above sections are completed on the system. Please log into Fourteen Fish to complete any outstanding tasks you may have. Please note that you have 28 days from the date of your appraisal meeting to complete your paperwork.

If you require any system support or if there are other reasons for not completing your appraisal then please contact anne.frampton@uhbristol.nhs.uk

If your appraisal remains incomplete and you have not notified us of a reason for the delay, you will receive a further communication from the revalidation team in 4 weeks' time.

6 weeks overdue

Dear Dr…….

Following previous correspondence the Trust has yet to receive confirmation of a complete appraisal.

The Trusts appraisal system Fourteen Fish shows that your annual appraisal was due by [due date] and remains incomplete.

This may be due to one of the following:

- You have not yet submitted your portfolio to your appraiser
- Your appraiser has not yet completed the appraisal outputs
- You have not accepted the outputs that your appraiser completed

A complete appraisal is one where the meeting has taken place and the above sections are completed on the system. Please log into Fourteen Fish to complete any outstanding tasks you may have.

If you require any system support or if there are other reasons for not completing your appraisal then please contact anne.frampton@uhbristol.nhs.uk

Please ensure any outstanding actions are completed within 2 weeks. If you do not do this we will review your files to consider whether the GMC will issue you with a non-engagement concern letter.

The requirement is to complete an appraisal every 12 months. Your appraisal due date according to the Fourteen Fish system is [due date] and you have therefore exceeded this timescale.

I would like to take this opportunity to remind you of the purpose of revalidation which is to assure patients and the public, employers and other healthcare professionals that licensed doctors are up to date and are practicing to the appropriate professional standards.

The Trusts Responsible Officer must be assured that an annual appraisal of the appropriate standard has taken place to make a revalidation recommendation to the GMC on your behalf. Revalidation is a 5 year cycle; NHS England and the GMC expect 5 annual appraisals within this 5 year period to enable a positive recommendation to be made.

Failure to make a positive recommendation will likely lead to your licence to practice being suspended. This is something that we would obviously wish to avoid but it is a requirement for your continued employment at NBT that you retain your right to practice.

Yours sincerely

Dr. Anne Frampton
Associate Medical Director

Appendix 2: Internal Audit report (attached)

University Hospitals Bristol NHS Foundation Trust

Final Internal Audit Report: Managing Medical Staff Appraisals

Report Reference: UHB 16/18

April 2019

Distribution List (for action)
Dr Frances Forrest, Associate Medical Director (Revalidation)
Dr Anne Frampton, Associate Medical Director (Revalidation)
Additional Copies (final report, for information)
Dr William Oldfield, Medical Director
John Moore, Chair of People Committee

Assurance Level	Audit Rating
Significant	
Satisfactory	✓
Limited	
No	

Executive Summary

AUDIT BACKGROUND, SCOPE AND OBJECTIVES

Background

As part of the rolling 2017/18 Audit Plan, as approved by the Audit Committee, we have undertaken a review of the processes in place for doctors appraisals.

In December 2012, the General Medical Council (GMC) implemented medical revalidation, a process to ensure doctors are up to date and fit to practice. The GMC began revalidating doctors in December 2012 starting with medical leaders and responsible officers and then from April 2013 with all other doctors. The GMC's aim was to revalidate the majority of doctors for the first time by March 2016.

Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis, through a strengthened annual appraisal process, that they are up to date and fit to practice. Revalidation aims to give extra confidence to patients, the public and employers that doctors are fit to practice in line with the GMCs Good Medical Practice framework. Organisations need to have robust systems of appraisal in place to support revalidation and the Trust's Responsible Officer, in UHB's case the Medical Director, has a statutory duty to make sure that it is in place.

Objectives and Scope of the Audit

The overall objective of this review was to provide assurance that the Trust's appraisal process is fit for purpose and meets the GMC revalidation requirements.

In order to provide assurance in relation to the above, the audit focussed on the following areas:

- The Trust has a robust medical Staff Appraisal Policy in place.
- The Trust has a robust appraisal system in place that reflects the GMC core guidance for doctors.
- Monitoring of completion medical staff appraisals is undertaken and action is taken to ensure overdue appraisals are carried out promptly.
- Staff who carry out appraisals have received appropriate training.
- All appraisals are carried out on the required paperwork and are kept on file.
- Appraisals are reviewed to confirm that they are carried out in line with the policy, and training and clinical development needs are identified and are then fed into departmental/specialty training plans.

Ratings Used in this Report

The following ratings have been used in this report to summarise our evaluation of each area we have reviewed:

Performance Ratings Explained

Each finding has an associated individual rating. This is intended to be an indicator of the outcome of our evaluation of the design or operation of the process that is in place to manage the function or task being reviewed. These are explained below.

These indicators are separate from the audit report's overall "single assurance opinion" or the "rating of audit recommendations," both of which are based on a broader evaluation of the system and are explained within the Audit Report Information section on the final page of this report.

Rating	Description
	The process is appropriately designed to manage the task or function and appears to be operating well. Any issues that were identified are not significant and are unlikely to reoccur.
	Some action is needed to address a degree of underperformance and this may include a review of the process in place to manage the task or function. We do not have significant concerns regarding this area and any issues that were identified are unlikely to reoccur if properly managed.
	Urgent action is needed to address underperformance or weaknesses in the processes which are in place to manage the task or function. We have significant concerns regarding this area and consider that issues may arise or reoccur.

Executive Summary

OVERALL CONCLUSION

The Trust has a robust and effective appraisal and evaluation system that is operating for the majority of permanently employed doctors using the e-portfolio system. However a significant number of appraisals are not carried out within the timescales required. The Trust Board have been made aware of this through the annual statement on revalidation, received in September 2018, that indicated that the 2017/18 appraisal rate for the Trust overall was 75%.

We concluded that the process for ensuring that non-permanent doctors that use the Medical Appraisal Guide form for appraisals are adequately tracked and have their appraisals as set out in the Strategy should be strengthened. Improvements to tracking non-permanent staff appointment and departure and the missed milestones escalation procedure would boost the Trust's appraisal compliance rate.

Following the completion of our fieldwork for this review, a new appraisal system called "Fourteen Fish" is being rolled out to replace Premier IT/MAG form and V1P form appraisal. The Appraisal and Revalidation Strategy will be updated to reflect the change in appraisal system. The new system is being introduced as a joint project with NBT. All doctors not in training (consultants/SAS and Clinical Fellows) will be allocated to use Fourteen Fish. This move has been sanctioned by the Trust's Responsible Officer and due to the reduced cost of each license is now feasible.

It is anticipated that the introduction of Fourteen Fish will enable many of the issues identified in our review to be addressed by the Trust.

Area Reviewed	Assessment	Conclusion
1: Trust Medical Staff Appraisal Strategy and Compliance with GMC Guidance		The Trust has a clear and comprehensive Medical and Dental Staff Appraisal and Revalidation Strategy which sets out the Trust's approach and the expectations of the appraisal process. The Strategy is compliant with core guidance from the General Medical Council (GMC) and NHS England. For the financial year 2018/19 reviewed doctors on permanent contracts used an e-portfolio system for collection of their appraisal information. Those on non-permanent contracts use a MAG (Medical Appraisal Guide) form. The e-portfolio and MAG form appraisals were the only acceptable formats for medical staff appraisal documentation at the Trust.

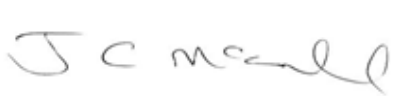
Executive Summary

Area Reviewed	Assessment	Conclusion
2: Monitoring and Reporting Appraisal Completion Rates		The Associate Medical Director (Revalidation) closely monitors the appraisals conducted on the electronic system. Individuals who are approaching or have passed an appraisal milestone are contacted and the reasons for any missed milestones are ascertained and recorded. There is no equivalent monitoring system for doctors on non-permanent contracts using MAG forms. The Trust Board received an annual statement on revalidation in September 2018 as part of the Medical Appraisal and Revalidation Report, presented by the Medical Director. The report indicated that the 2017/18 appraisal rate for the Trust was 75% overall, although it was only 55% for non-permanent doctors that should have used the MAG route. In comparison, NBT reported a 90% compliance rate for 2017/18.
3: Ensuring Appraisals are of an Appropriate Quality and Training Staff Involved in Appraisals		The Trust looks to ensure that it has an adequate pool of appraisers available to conduct all required appraisals across all Divisions and Specialties. The performance of medical appraisers is monitored by the Medical Director's Team. For the 2018/19 year appraisers must have undertaken UH Bristol approved medical appraiser training that was provided in house or by Dedici, a bespoke e-learning service used by a number of NHS Trusts.
4: Identification of Training and clinical development needs		Individual training needs are identified as part of the appraisal process. Where common themes are noted within a specialty these are fed back to the specialty leads.

ASSURANCE OPINION RATING

It is our view that the overall assurance opinion on the design and operation of controls is **Satisfactory** as recorded in the table on the face of this report and in accordance with the opinion definitions under the Audit Report Information section of this report.

We would like to acknowledge the help and assistance given by the staff and management involved in the medical staff appraisal and revalidation programme.



Jenny McCall, Director of Audit & Assurance Services

REPORT DATA

Date Work Undertaken	July 2018 – January 2019
Date of Issue of Draft Report	20th February 2019
Date of Return of Draft Report	29th April 2019
Date of Approval of Final Report	30th April 2019
Lead Auditor	Mark Fitzsimmons, Senior Internal Auditor
Client Lead Manager(s)	Dr Frances Forrest, Deputy Medical Director (Revalidation) Dr Anne Frampton, Associate Medical Director (Revalidation)
Client Lead Director	Dr William Oldfield, Medical Director

Action Plan

Rec No	Recommendation	Risk Rating	Management Response	Manager Responsible	Action Date
1	The Associate Medical Director (Revalidation) should consider whether administrative aspects of the appraisal review process could be delegated, and whether resource could be made available to carry out such tasks. Issues that may arise from these tasks could be escalated to the Associate Medical Director (Revalidation) as they arise.	Low Risk (3)	The introduction of Fourteen Fish will automate many of the administrative processes currently required to provide quarterly and annual returns to NHSE and the Trust. The current RO has reviewed the administrative and managerial support to revalidation and from March 1st 2019 the AMD role has increased to 4PAs and the administrative support is under review – acknowledging current input is insufficient.	Dr Anne Frampton, Associate Medical Director (Revalidation)	30th September 2019
2	The Trust should establish a mechanism for keeping track of all non-permanent doctors appointed within the Trust so that the relevant MAG assessments can be carried out when required.	High Risk (12)	Covered as above – all Clinical Fellows will use Fourteen Fish.	Dr Anne Frampton, Associate Medical Director (Revalidation)	30th September 2019
3	The Trust should strengthen the escalation procedure to ensure that all overdue appraisals are carried out within 8 working weeks. This escalation should first be to the relevant Divisional Clinical Chair and subsequently to the Trust's Medical Director.	High Risk (9)	The introduction of Fourteen Fish has been a joint project with NBT. The Appraisal and Revalidation Strategy will be refreshed to reflect new tighter processes (reminder letters at 8/4 and 2 weeks ahead of appraisal due date. Overdue reminders at 2 and 4 weeks followed by referral to RO and trigger of REV6 form to the GMC at 6 weeks if deemed appropriate).	Dr Anne Frampton, Associate Medical Director (Revalidation)	30th September 2019

Detailed Findings

1: Trust Medical Staff Appraisal Strategy and Compliance with GMC Guidance

What We Checked

We reviewed the Trust's Medical and Dental Staff Appraisal and Revalidation Strategy to ensure that it provided comprehensive, clear guidance to appraisers and appraisees and was fully compliant with NHS England and GMC core guidance.

What We Found

- The Trust's Strategy clearly explains that the annual appraisal is a mandatory requirement for all doctors employed within the Trust.
- The Strategy sets out the Trust's approach to medical and dental staff appraisal including:
    - How appraisal is linked with performance management, job planning and revalidation.
    - What is expected from appraisal.
    - The systems and processes to support appraisal and revalidation.
    - Support for medical appraisers and appraises.
    - The monitoring of systems and process and the safety of confidential information.
- The appraisal records and supporting evidence are kept strictly confidential and are only accessible by the appraisee, appraiser and the Responsible Officer (the Medical Director) or their deputy and the Medical Director's Administrator. The appraisal discussion is strictly confidential to the appraisee and the appraiser except by prior agreement.
- 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 form which is an electronic form recognised by UK Designated bodies and "transportable" between hospitals. The e-portfolio and MAG form appraisals are the only acceptable formats for medical staff appraisal documentation at the Trust. Appraisal documentation must be retained – on the e-portfolio or MAG form – as specified in the strategy.
- Following the completion of our fieldwork a new appraisal system called "Fourteen Fish" is being rolled out to replace Premier IT /MAG form and V1P form appraisal. The policy will be updated to reflect change in appraisal system but also new warnings and tolerances in line with NBT for appraisal compliance. The new system is being introduced as a joint project with NBT. This move has been sanctioned by the Trust's Responsible Officer and due to the reduced cost of each license is now feasible.

Recommendations

No recommendations have been raised.

2: Monitoring and Reporting Appraisal Completion Rates

What We Checked

We reviewed the monitoring arrangements currently in use and the reporting that is carried out internally and externally. We also investigated action taken to address non-compliance with the Strategy's timescales.

What We Found

- The Associate Medical Director (Revalidation) produces a monitoring spreadsheet every two weeks (approximately) for all of the doctors currently attached to UH Bristol on the electronic appraisal system.
- Each entry on the spreadsheet is reviewed for accuracy. This process is carried out for every individual and is time consuming. The nature of this task is primarily administrative and it may not be necessary for the Associate Medical Director to perform this personally each time.
- Individuals who are approaching or have passed an appraisal milestone are contacted and the reasons for any missed milestones are ascertained and recorded.
- There is no equivalent monitoring system for doctors on non-permanent contracts using MAG forms. We were unable to obtain a comprehensive list of doctors who should have been appraised using the MAG route and consequently we have not performed any detailed review in this area. However from early in 2019/20 all doctors not in training (consultants/SAS and Clinical Fellows) will be allocated to use the new appraisal software Fourteen Fish.
- The Associate Medical Director escalates missed milestones in accordance with the Strategy via Divisional leadership.
- The Trust Board received an annual statement on revalidation in September 2018 as part of the Medical Appraisal and Revalidation Report, presented by the Medical Director. The report noted that:
    - Revalidation of a doctor's 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 contract for the e-portfolio system for medical appraisal (currently Premier IT) is out to tender.
    - In late 2017, UHB and North Bristol NHS Trust started a joint tender for this process. The process includes WGH as an observing partner. The tendering process had not concluded as of December 2018.
- The Trust Board report indicated that the 2017/18 appraisal rate for the Trust was 75% overall, although it was only 55% for non-permanent doctors that should have used the MAG route. However this may be inaccurate because there is no established process to keep track of non-permanent doctor appointment and departure. In comparison, NBT reported a 90% compliance rate for 2017/18.
- Review of the Associate Medical Director's monitoring spreadsheet from September 2018 indicates that 45 individuals have annual appraisals that are more than 15 months overdue. The last appraisal date in a small number of instances suggests the appraisal may have been during 2014 or 2015.
- The Trust reports quarterly appraisal and revalidation rates to NHS England and to the Medical Director.

Risk Identified

Primarily administrative tasks cannot be delegated because of a lack of administrative support.
Possible (3) x Negligible (1) = (3) Low Risk

Recommendation 1

The Associate Medical Director (Revalidation) should consider whether administrative aspects of the appraisal review process could be delegated, and whether resource could be made available for such tasks. Issues that may arise from these tasks could be escalated to the Associate Medical Director (Revalidation) as they arise.

Risk Identified

Non-permanent doctors are not being appraised or revalidated in accordance with the Trust's strategy and may therefore not be fit to practice.
Likely (4) x Moderate (3) = (12) High Risk

Recommendation 2

The Trust should establish a mechanism for keeping track of all non-permanent doctors appointed within the Trust so that the relevant MAG assessments can be carried out when required.

Risk Identified
Doctors may be practicing medicine without an up-to-date appraisal as required in the Strategy and may therefore not be up to date with their development.
.
Possible (3) x Moderate (3) = (9) High Risk

Recommendation 3
The Trust should strengthen the escalation procedure to ensure that all overdue appraisals are carried out within 8 working weeks. This escalation should first be to the relevant Divisional Clinical Chair and subsequently to the Trust's Medical Director.

3: Ensuring Appraisals are of an Appropriate Quality and Training of Staff Involved in Appraisals

What We Checked
We reviewed the process for appointing and training staff involved in the appraisals process for the Trust.

What We Found

- The Trust looks to ensure that it has an adequate pool of appraisers available to conduct all required appraisals across all Divisions and Specialties. Medical staff must apply to become appraisers and must meet all the requirements set out in the Person Specification in terms of:
  - Employment status.
  - Knowledge and experience.
  - Qualities and aptitudes.
  - Skills.
- The performance of medical appraisers is monitored by the Medical Director's Team. The AMD reviews the content of recently completed appraisals on the e-portfolio system to ensure that all mandatory sections have been completed and that the appraisal is of sufficient quality. The Medical Director or deputy informs the appraiser of any issues relating to poor quality of Personal Development Plans and issues relating to appraisee feedback.
- There are clear rules in place for the appraisee selecting and appraiser. An appraisee can choose anyone the Trust's list of approved and trained appraisers as their medical appraiser. The appraiser does not have to be in the same Division or specialty as the appraisee but it is recommended that they should have knowledge or insight into the appraisee's area of clinical activity and would normally be a member of the same Royal College.
- Appraisers must undertake UH Bristol approved medical appraiser training that is currently provided in house or by Dedici, a bespoke e-Learning service that delivers one day workshops around the soft skills of working with and leading others, training of trainers, and specialist training in appraisals and revalidation for doctors.
- The Trust maintains a list of trained appraisers and records the date that they received their training. Currently there is no timescale set for refresher training, although with the Trust currently tendering for an e-portfolio system it would be beneficial to retrain all appraisers once the decision has been made and the successor system has been adopted.
- The MAG route of appraisals is considered more intuitive although support is available to appraisers – and appraisees – when required.

Risk Identified
No recommendations have been raised.

4: Training and Clinical Development Needs are identified and fed into Departmental/Specialty Training Plans

What We Checked
We reviewed the process for identifying and taking forward training and development needs.

What We Found

- Actions to address any issues of performance identified through the appraisal process are noted within the Personal Development Plans of each individual which may include specific additional training for the individual. Where common development themes are noted for individuals within the same specialty these are fed back to specialty leads for possible incorporation into local training plans.

Risk Identified
No recommendations have been raised

Audit Report Information

ASW ASSURANCE – ABOUT US

ASW Assurance is the largest provider of internal audit, counter fraud and consultancy services in the South West. We maintain a local presence and close engagement within each health community, with audit teams based in Bristol, Exeter, North Devon, Plymouth, Torquay and Cornwall, linked by shared networks and systems. More information about us, including the services we offer, our client base, our office locations and key people can be found on our website at www.aswassurance.co.uk

ASW Assurance is a member of TIAN; a group of NHS internal audit and counter fraud providers from across England and Wales. Its purpose is to facilitate collaboration, share best practice information, knowledge and resources in order to support the success and quality of our client's services.

All audit reports are conducted in conformance with the International Standards for the Professional Practice of Internal Auditing.

CONFIDENTIALITY

This report is issued under strict confidentiality and, whilst it is accepted that issues raised may need to be discussed with officers not shown on the distribution list, the report itself must not be copied/circulated/disclosed to anyone outside of the organisation without prior approval from the Director of Audit.

INHERENT LIMITATIONS OF THE AUDIT

There are inherent limitations as to what can be achieved by systems of internal control and consequently limitations to the conclusions that can be drawn from this review. These limitations include the possibility of faulty judgment in decision-making, of breakdowns because of human error, of control activities being circumvented by the collusion of two or more people and of management overriding controls. Also there is no certainty that controls will continue to operate effectively in future periods or that the controls will mitigate all significant risks which may arise in future. Accordingly, unless specifically stated, we express no opinion about the adequacy of the systems of internal control to mitigate unidentified future risk.

RATING OF AUDIT RECOMMENDATIONS

The recommendations in this report are rated according to the organisation's risk-scoring matrix. The recommendations have been arrived at by assessing the risk in relation to the organisation as a whole. This should enable recommendations made in different reports to be compared when deciding the priority and level of risk faced by the organisation.

SINGLE ASSURANCE OPINION

ASSURANCE LEVEL	DESCRIPTION
Significant	Controls are well designed and are applied consistently. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Transformation, Improvement and Innovation Strategy**
Report Author	**Cathy Caple, Associate Director of Improvement and Innovation** **Anne Frampton, Clinical Lead for Transformation**
Executive Lead	**Paula Clarke, Director of Strategy and Transformation**

1. Report Summary

This Transformation, Improvement and Innovation strategy is an enabling strategy to support the delivery of Embracing Change, Proud to Care – Our 2025 Strategy. Empowering staff to be able to continuously improve their services and try out innovative ways of working is an essential building block for a high performing organisation. The strategy describes how we will deliver the improvement and transformation agenda over the next five years, and how innovation is supported throughout that continuum.

The literature describes the need for a structured approach to transformation, improvement and innovation, which includes strong leadership at all levels, engaged staff supported by the right culture and training in the tools and techniques for improvement.

In delivering the Trust's strategic priorities and objectives, those for Healthier Together, the BNSSG STP, and to deliver the NHS long term plan, we need to continue to develop the capability and capacity of our people to transform, improve and innovate our services. We will provide effective processes to assure delivery of change and maximise this by working collaboratively with our local health and social care partners and service users. We also need to celebrate and promote our successes to support spread, building our reputation as an innovative organisation and further developing opportunities for research.

An audit of our current improvement programme identifies gaps and areas for improvement (appendix 3). The high level action plan in section 5 addresses these gaps and will continue to develop capability and capacity in line with the dosing model across our staff and leaders. This will ensure that an improvement culture is embedded across the Trust that maximises the outcomes of our improvement and transformation activities. Our staff will feel empowered and able to use their skills to continuously improve services to deliver the best care to our patients and public. The strategy is a key enabler to delivering improved job satisfaction, and will enhance recruitment and retention and succession planning within a competitive local job market.

2. Key points to note

(Including decisions taken)

The Senior Leadership Team approved the strategy on 18th September 2019, noting that the investment required to deliver the strategy will be subject to approval of a business case.

3. Risks **If this risk is on a formal risk register, please provide the risk ID/number.**
The risks associated with this report include: The Senior Leadership Team approved the strategy on 18th September 2019, noting that investment required to deliver the strategy will be subject to approval of a business case.
4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:
• This report is for **APPROVAL** • The Board is asked to **APPROVE** the strategy.
5. History of the paper **Please include details of where paper has previously been received.**

Senior Leadership Team	**18 September 2019**

EMBRACING CHANGE, PROUD TO CARE – OUR 2025 STRATEGY

TRANSFORMATION, IMPROVEMENT AND INNOVATION STRATEGY 2020-2025

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

1. Our Mission and Vision

This Transformation, Improvement and Innovation Strategy supports the delivery of the Trust's mission *to improve the health of the people we serve by delivering exceptional care, teaching and research, every day.*

Our Mission: Ensure we deliver exceptional care to benefit service users, staff and the wider NHS by developing culture and capability for delivery of transformation, improvement and innovation, within the Trust and with our partners.

Our Vision: To empower staff to improve patient and population health through improving, transforming and innovating our services.

The delivery of our mission and vision is underpinned by our values, which provide the principles of how we behave as individual members of staff and as an organisation.

Our Values are:

- Respecting everyone
- Embracing change
- Recognising success
- Working together

2. Background and changing environment

2.1 Background

This Transformation, Improvement and Innovation Strategy describes how we will deliver the capacity and capability needed to continuously improve and transform health and care.

It builds on the Innovation Strategy 2016, updated to the Innovation and Improvement Framework 2017, which recognised the need to do more to support innovation and improvement across the Trust as an enabler to delivering the Trust's quality strategy.

2.1.1 Definitions

The terms improvement, change and transformation are often used interchangeably, however there are some subtle but important differences.

Improvement refers to making something that already exists better, whilst **change** means to make something different. **Transformation** relates to a complete overhaul of the current state or the emergence of an entirely new state, involving both improvement and change.

In order to improve or transform we need to **innovate**, becoming better at what we do by introducing new methods, ideas or services in the following ways:

- Discover – new ways
- Adopt – from others
- Improve – existing ways
- Eliminate – non-value adding activities

Quality improvement refers to the use of systematic tools and methods to continuously improve the quality of care and outcomes for patients.

2.2 Drivers for change

2.2.1 National Context

The King's Fund has reported that there is overwhelming evidence that demonstrates that engaged staff deliver better health care[1]. Evidence also shows that staff are most engaged in their roles when they have a degree of authority and control over their work and environment, as well as the opportunity to stretch themselves and develop. Successful organisations give their staff the tools and resources to lead improvement, enabling them to generate and develop their ideas to deliver best care and services for their patients, and this is often reflected in organisations that are assessed as "outstanding" in Care Quality Commission ratings.

In assessing quality improvement across the NHS, The King's Fund[2] notes that the one consistent lesson from the published literature on quality improvement is that "the delivery of more efficient and higher-quality patient-centred care requires a significant long-term commitment and cultural change based on quality improvement principles" and is not just about providing the tools and training for staff. To ensure that improvement happens across

[1] King's Fund. Staff engagement: Six building blocks for harnessing the creativity and enthusiasm of NHS staff. 2015.
[2] King's Fund. Embedding a Culture of Quality Improvement. 2017.

the whole organisation as part of a standard way of working, more systematic, organisation-wide programmes of capability and capacity development are needed that will build the cultural change required. The Institute for Healthcare Improvement and NHS Improvement recommend guidelines for different groups in an organisation and a "dosing" approach to develop capability and capacity over time[3].

The organisational culture also needs to empower staff to innovate and test new ways of working. This requires "compassionate, inclusive and effective leaders at all levels".[4] This transformation, improvement and innovation strategy therefore sits alongside our People Strategy and our organisational development goals relating to talent management, staff engagement and recognition, leadership and management development, performance management, and diversity and inclusion.

Many elements of the NHS are no longer fit for purpose to deliver today's demands on it. It is acknowledged that "radical change is needed to transform the delivery of health and care services to meet the challenges of the future".[5]

The NHS Long Term Plan sets the vision for how services will be delivered over the next ten years against a backdrop of pressures around funding, staffing, increasing inequalities, pressures from new technologies and treatments and a growing and ageing population, that lead to growing demand for services. In order to realise this vision we need to deliver our services differently, redesigning patient care and implementing new service models where patients get more care options including self-management, better support and joined up care at the right time in the optimal setting. This will require a flexible modern workforce, enabled and empowered to problem solve across teams internally and externally, greater use of digital technology and an appetite to fully transform some aspects of services, innovating for improvement.

2.2.2 Local Context

The Healthier Together Sustainability and Transformation Partnership for Bristol, North Somerset and South Gloucestershire (BNSSG) brings together 13 organisations from Health and Social Care to work towards creating an integrated care system for our population by 2021. Four strategic priorities have been agreed for the Healthier Together partners to focus on, at a scale and pace of change that will require transformation across services. This includes change in both the models of service and the location from which they will be delivered.

UH Bristol Trust's strategy "Embracing Change, Proud to Care – our 2025 Strategy", sets out the Trust's strategic priorities for the next five years:

3 NHS Improvement and Institution for Healthcare Improvement (2017). Building Capacity and capability for improvement: embedding quality improvements skills in NHS providers
4 NHS Improvement. (2016) Developing People – Improving Care.
[5] Ham C. (2014) Reforming the NHS from within: beyond hierarchy, inspection and markets.

We will excel in consistent delivery of **high quality**, patient centred care, delivered with compassion.
We will invest in **our staff** and their wellbeing, supporting them to care with pride and skill, **educating and developing** the workforce for the future.
We will 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.
We will lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve.
We will be at the leading edge of **research and transformation** that is translated rapidly into exceptional clinical care and embrace **innovation**.
We will 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.

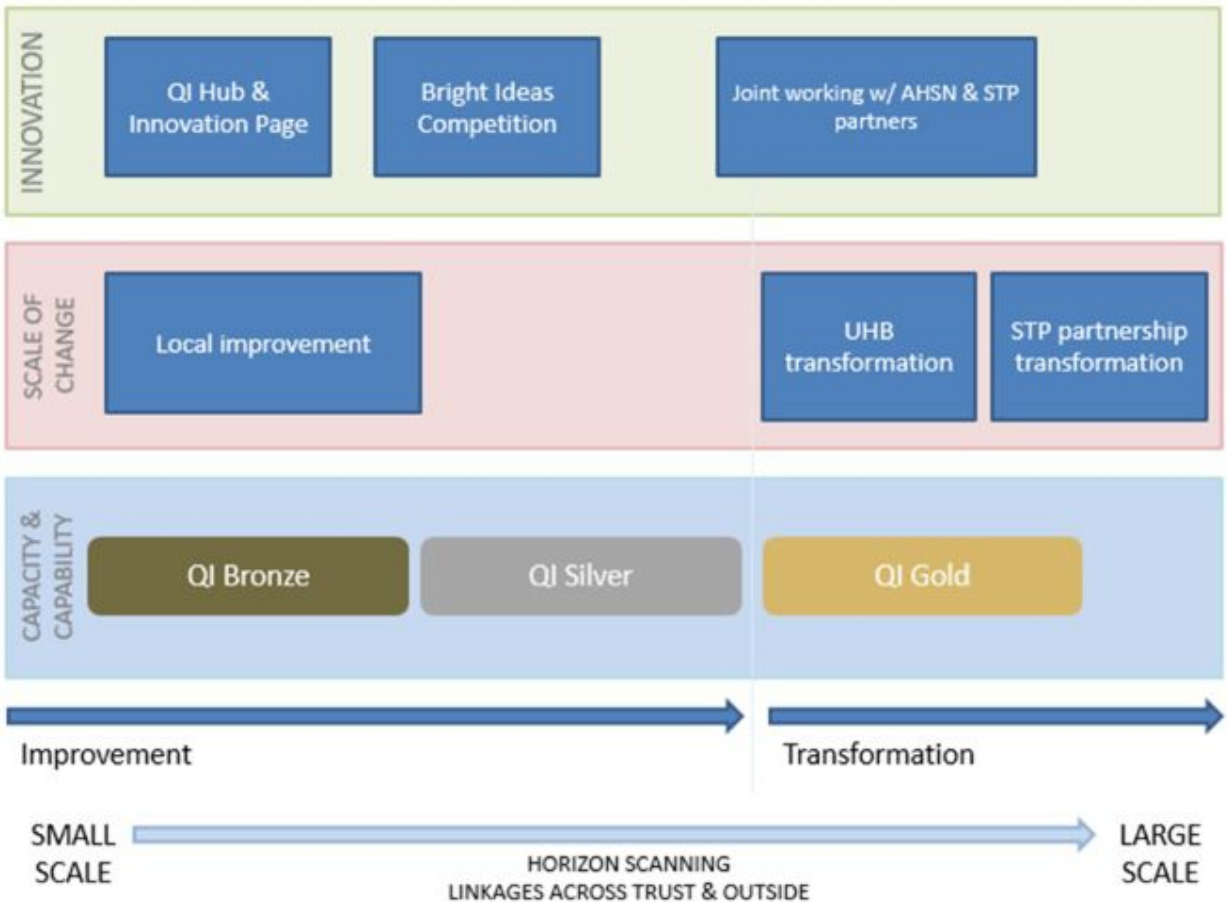
When engaging our staff in our new strategy, the people who manage our teams and services told us they want more training and development so that they can be more effective and they want to spend more time making positive changes happen in clinical services. Our public and governors told us about the service improvements they want us to make, such as using digital technology, improved access to services and new services to stop people attending hospital. Our partners told us they want to form closer working relationships with us in planning and delivering services. Developing clear objectives for transformation, improvement and innovation will enable us to respond to these contributions.

2.2.3 PESTLE and SWOT

The analysis of the environment in which we will transform, improve and innovate is given at appendix 1, and the assessment of our relevant strengths, weaknesses, opportunities and threats is given at appendix 2.

2.3 How the service is delivered

A structured approach for transformation, improvement and innovation is established at UH Bristol, and exists as a continuum as demonstrated in the diagram below.



Capacity and capability development is aligned to different levels according to the scale of improvement or transformation required. This is provided to front line teams through the bronze and silver Quality Improvement Programmes, based on the Institute for Healthcare Improvement model, and some training has been provided for senior leaders in the Trust around the leadership aspects of improvement. Training is provided by the QI Faculty, comprising staff with improvement training and expertise from across professions. The development of the Trust's approach to improvement was recognised by the Care Quality Commission in its inspection report for August 2019, noting that improving was taking place within formal QI and transformation programmes, but also independently within divisions and clinical teams.

Innovation takes place along this continuum, with support from the Trust for small and medium sized innovations, and some joint working with local partners for larger scale innovation. The QI Hub was established in 2017 and supports staff in developing their innovation ideas in a structured manner. The Trust has held Bright Ideas competitions in the past to encourage and support staff to innovate.

The Trust has a well-established programme of improvement and transformation of services through its Transforming Care Programme. Each year the Trust agrees the priorities to deliver its strategy and enabling strategies, divisional strategies and annual operating plans. In recent years the programme of work has focused on projects and programmes relating to working smarter (productivity), digital hospital and quality improvement.

Direct support for staff to deliver transformation is provided through the Transformation Team, who have highly developed knowledge and skills around improvement methodologies and tools, and lead or support improvement and transformation projects, or provide coaching

and mentoring to staff that are delivering projects. The team are aligned to Divisions to build two way understanding and engagement.

2.4 Gaps analysis

An audit of the current position of the Trust's improvement programme using the Health Foundation's checklist for building improvement capability (appendix 3) demonstrates that there are some gaps and some areas for improvement.

Applying the Institute for Healthcare Improvement dosing approach to UH Bristol provides the numbers of substantive staff (headcount) at UH Bristol and Weston Area Health Trust[6] (i.e. not bank staff) that are needed to be trained at differing levels of understanding and expertise, and compares this to the current numbers trained and training capacity available (see diagram below). There is a clear shortfall to deliver the training required within the lifetime of this strategy.

UH Bristol Dosing Model (UHB and Weston headcount = 11,300, August 2019)

Target trained (plus turnover)	Current trained (at Jul 19)	Annual training capacity	Who/what currently
0.05% n=6 (+1)*	21	N/A	Clinical Lead for Transformation. Some QI Faculty.
0.5% n=57 (+7)*			Transformation Team. QI Faculty.
10% n=1,130 (+147)*	71	76	QI Silver. QI Gold. QI for leaders.
25% n=2,285 (+367)*	747	480	QI Bronze. Preceptorship.
100% n=11,300 (+1,469)*	N/K	N/K	Limited information provided at induction.

*** additional staff to be trained annually due to 13% turnover**

2.5 The case for change

The literature describes the need for a structured approach to Transformation, Improvement and Innovation, which includes strong leadership at all levels, engaged staff supported by the right culture and training in the tools and techniques for improvement.

In delivering the Trust's strategic priorities and objectives, those for Healthier Together the BNSSG STP, and to deliver the NHS long term plan, we need to continue to develop the capability and capacity of our people to improve, transform and innovate our services. We will provide effective processes to assure delivery of change and maximise this by working

[6] Weston Area Health Trust staffing headcount is included pending the proposed merger of the Trust with UH Bristol. It is proposed that should the merger not go ahead UH Bristol would still provide QI training to Weston staff to provide economies of scale in training capacity.

collaboratively with our local health and social care partners and service users.

Many changes in our services are incremental, involving improvement and change tools and techniques, and this needs to continue. However, in order to deliver the scale of change identified in national and local plans, true service transformation is also required, often through working in partnership with other NHS and non-NHS organisations. We also need to celebrate and promote our successes to support spread, building our reputation as an innovative organisation and providing opportunities for research.

Addressing the gaps in our current programme will enable us to continue to develop capability and capacity across our staff and leaders, ensuring that an improvement culture is embedded across the Trust and we maximise the outcomes of our improvement and transformation activities. Our staff will feel empowered and able to use their skills to continuously improve services to deliver the best care to our patients and public. The strategy will be a key enabler to delivering improved job satisfaction, and will enhance recruitment and retention and succession planning within a competitive local job market.

Section 4 describes how we will address gaps and respond to this case for change.

3. Outline of process to develop strategy and engagement undertaken

This strategy builds on the significant work undertaken in 2016 and 2017 when there was detailed engagement across staff within key programmes in the Trust to identify the gaps in structure and support for improvement and innovation.

The annual transformation priorities under the Transforming Care Programme are developed through engagement across senior leaders at the Transformation Board, comprising senior managers and clinical leaders, and the Senior Leadership Team (SLT).

The current literature has been reviewed and critically appraised to identify best practice, supported by discussion with external improvement and transformation networks.

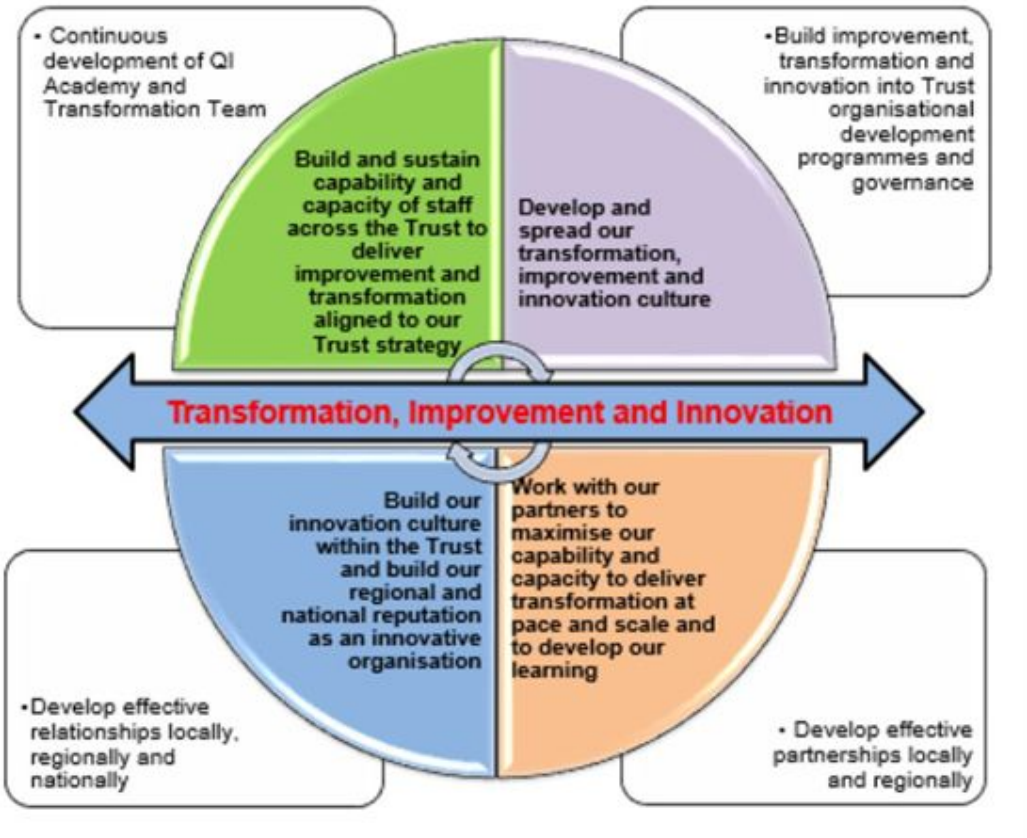
Engagement on the strategy has been undertaken with the following groups or people:

- Trust Board (seminar session)
- Transformation Board
- Strategy Steering Group
- Improvement and Innovation Steering Group
- Head of Organisational Development

We have engaged with the Director of Transformation at BNSSG CCG to commence discussions around how to maximise our transformation capacity and capability across our STP, bringing together teams where appropriate to deliver change at pace and scale.

4. Strategic Priorities and Objectives

This Transformation, Improvement and Innovation Strategy enables delivery of the Trust Priorities, and will focus on the following:



This strategy also supports the delivery of the following enabling strategies:

Quality Strategy: delivering innovation and improvement across the Trust and with our partners, and building the capability and capacity within our staff in order to do so.

People Strategy: improving staff engagement scores: Trust target score of 8.0 by 2025 (2018 score 7.2); key support to Trust recruitment and retention, and succession planning; incorporating continuous improvement into management and leadership development; staff training programmes linked to a culture of organisational learning as part of the Education Strategy.

Digital Strategy: working in partnership with the digital team to deliver the digital transformation agenda, using technology to transform where and how we deliver safe, effective, joined-up care and support patient and service user self-care and independence.

Communications Strategy: building the reputation of UH Bristol as an innovative organisation that supports building the employer brand.

5. How the strategy will be delivered

Build and sustain the capability and capacity of staff across the Trust to deliver improvement and transformation of our services aligned to our Trust strategy

Develop the Trust's Quality Improvement training in line with the UH Bristol dosing model			
Action	**Responsibility**	**Measures**	**Timeline**
Develop the business case for increasing training capacity, in line with the dosing model	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• Business case approved by SLT and Trust Board	• Mar 2020
Undertake a diagnostic assessment of the level of awareness of quality improvement across the Trust to identify a baseline measurement	Associate Director of Improvement & Innovation	• Baseline figure established	• Mar 2020
Develop a methodology to ensure all staff are aware of the Trust's approach to quality improvement	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• Methodology launched • 100% reporting awareness in internal staff survey	• Jul 2020 • Mar 2023
Deliver QI training in line with the dosing model, including development of a QI Gold Programme	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• Number of people trained annually Number of silver projects delivered • Number of gold projects delivered	• Mar 2023
Grow the QI Academy Faculty to be able to deliver QI programmes and provide coaching, mentoring and support to staff in planning and delivering their improvement projects	Associate Director of Improvement & Innovation Clinical Lead for Transformation	• Number of QI Faculty members	• Mar 2023
Explore opportunities and methodologies for implementation of a continuous improvement (CI) methodology	Associate Director of Improvement & Innovation, Clinical Lead for Transformation, Head of Organisational Development	• Evaluation of benefits of CI methodology	• Mar 2021
Embed the QI fellow role, to promote and support junior doctors to take part in improvement and innovation.	Clinical Lead for Transformation	• QI fellows integrated into QI Faculty • Number of improvement projects presented at annual	• Sep 2020

		foundation doctors QI forum	
Connect with other quality improvement communities through the Health Foundation Q Community and support the QI Faculty to become Q members.	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• 25% of QI Faculty qualified as Q fellows • 50% of QI Faculty qualified as Q fellows	• Dec 2020
Undertake continuous review of QI tools and methodologies against best practice to ensure staff are receiving up to date and effective training	Associate Director of Improvement & Innovation	• QI tools and methodologies reviewed annually	• Annually

Continue to provide support from the central Transformation Team and QI Faculty to support delivery of improvement and transformation to the Trust divisions			
Action	**Responsibility**	**Measures**	**Timeline**
Continued development of transformation team capability through the team competency framework	Associate Director of Improvement & Innovation	• Transformation Team competency framework reviewed annually	• Ongoing
Develop succession planning for the Transformation Team to ensure it remains fully skilled up and fit for purpose	Associate Director of Improvement & Innovation	• All Transformation Team personal development plans reflect training needs	• Ongoing
Introduce formal evaluation methodologies to measure the impact of any change being implemented	Associate Director of Improvement & Innovation	• All projects evaluated as part of project closure	• Mar 2020
Develop a database of "virtual" transformation associates from alumni of QI Gold	Associate Director of Improvement & Innovation	• Database in place	• Dec 2019

Develop and spread our transformation, improvement and innovation culture throughout the Trust

Continue to spread a continuous improvement culture across Trust and improve staff engagement by building this into Trust organisational development programmes			
Action	**Responsibility**	**Measures**	**Timeline**
Incorporate the Trust's culture and approach to transformation, improvement and innovation into all recruitment and succession planning activities.	Associate Director of Improvement & Innovation, Head of Resourcing, Head of Organisational Development	• Year on year improvement in scores for questions Q4b and Q4d in NHS national staff survey[7] • Plan developed for specific HR-related actions. • Percentage of leadership roles with QI capability	• Dec 2020 March 2019/20 December 2020

[7] Q4b: I am able to make suggestions to improve the work of my team/department
Q4d: I am able to make improvements happen in my area of work

Develop a plan to ensure transformation, improvement and innovation is embedded in our culture and governance, carried through our policies, processes and assurance approaches.	Associate Director of Improvement & Innovation, Head of Organisational Development	• All relevant policies, processes and assurance approaches reviewed • Plan developed and approved	• Mar 2020 • Jul 2020

Manage talent to ensure future leaders have the right skills and qualities to drive transformation, improvement and innovation			
Action	**Responsibility**	**Measures**	**Timeline**
Build Leadership for Improvement and Innovation into Trust leadership development programmes, with a requirement for all senior leaders to have undertaken QI training	Associate Director of Improvement & Innovation, Head of Organisational Development	• Programme(s) in place • Number of senior leaders trained	• Dec 2020 • Annually from Apr 2021
Explore options for supporting education supervisors to promote and support development of improvement and innovation capability across junior doctors.	Associate Director of Improvement & Innovation, Associate Director of Education	• Proposal developed	• Dec 2020
Explore opportunities for an improvement and transformation apprenticeship post in the Transformation Team	Associate Director of Improvement & Innovation	• Decision made on apprenticeship post	• Mar 2020
Introduce rotational posts in the Transformation Team to spread skills across the organisation	Associate Director of Improvement & Innovation	• Rotational posts introduced	• Mar 2021

Build our innovation culture within the Trust and build our regional and national reputation as an innovative organisation

Encourage, promote and support innovation within the Trust			
Action	**Responsibility**	**Measures**	**Timeline**
Relaunch the annual Bright Ideas competition to promote innovation across the Trust, with support from Above & Beyond and WEAHSN	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• Bright Ideas competition delivered twice a year	• Oct 2019
Establish a virtual “expert panel” to support staff to take forward their innovation ideas	Associate Director of Improvement & Innovation	• Virtual panel in place	• Jul 2020
Develop strong relationships and potentially formal agreements with organisations that support innovation to signpost staff to, including universities, WEAHSN, and ARC	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• Established timetable of engagement events	• Ongoing
Work with ARC and Bristol Health Partners to identify research opportunities	Associate Director of	• Number of improvement and	• Mar 2023

related to improvement and transformation projects, to underpin optimal evidence based care	Improvement & Innovation, Clinical Lead for Transformation	transformation projects incorporating research	
Evaluate opportunities and benefits for hosting WEAHSN Future Challenges projects to support innovation development and spread	Associate Director of Improvement & Innovation, Clinical Lead for Transformation	• Opportunities evaluated by relevant staff/services within the Trust	• Annually
Support clinical teams to adopt new innovations at pace through the annual AHSN Innovation Technology Payment scheme	Head of Commissioning and Contracting	• Number of innovations adopted by clinical teams	• Annually

Develop strong networks with regional and national bodies including WEAHSN, NHS Providers, NHSE-I Improvement Directorate, Shelford Group Transformation Network			
Action	**Responsibility**	**Measures**	**Timeline**
Work collaboratively with the University of Bristol to deliver a QI module as part of the new masters for healthcare leadership and improvement due to be launched in 2020	Clinical Lead for Transformation	• Module developed and delivered • 90% satisfaction scores reported by students	• Sep 2020
Horizon scan to ensure we adopt appropriate innovation from across the NHS and beyond, and assess for commercial opportunities to provide income to the Trust	Associate Director of Improvement & Innovation, Transformation Programme Manager	• Number of innovations adopted	• Ongoing

Showcase our transformation, improvement and innovation successes at national conferences and enter national awards			
Action	**Responsibility**	**Measures**	**Timeline**
Develop forward plan of conferences and awards, and communicate proactively to staff	Transformation Programme Manager	• Number of conferences projects presented at • Number of awards submissions	• Oct 2019

Incorporate sustainability into improvement and transformation projects			
Action	**Responsibility**	**Measures**	**Timeline**
Develop sustainable development checklist for project leads and incorporate into the project workbook	Head of Sustainability Transformation, Programme Manager	• Checklist incorporated into Transformation project workbook	• Mar 2020
Feed sustainability benefits into reporting on the Trust's sustainability strategy	Associate Director of Improvement & Innovation	• Sustainability benefits reported	• Ongoing
Report sustainability benefits in communications to stakeholders for projects and programmes	Associate Director of Improvement & Innovation	• Sustainability benefits communicated	• Ongoing

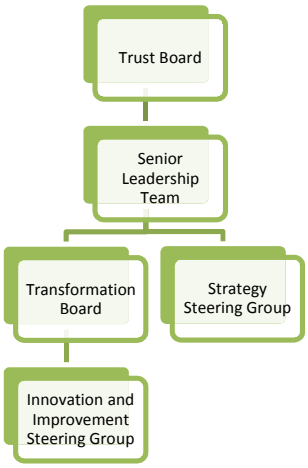
Work with our partners to maximise our capability and capacity to deliver transformation at pace and scale and to develop our learning

Lead, collaborate and co-create sustainable integrated models of care with our partners to improve the health of the communities we serve			
Action	**Responsibility**	**Measures**	**Timeline**
Explore with our partners how to develop the right conditions for transformation, where appropriate moving away from transactional mindset to a systems-based approach to large scale change	Associate Director of Improvement & Innovation	• Systems-based approach agreed with partners	• Mar 2021
Develop clinical pathways using the clinical practice group methodology	Transformation Programme Manager	• CPG methodology developed and used • Number of CPGs in place at assessed levels of maturity	• Mar 2020 • Mar 2021
Ensure patient and carer involvement in all improvement and transformation programmes	Transformation Programme Manager	• Number of projects and programmes involving patients and carers	• Ongoing

Develop networks with transformation leads and teams to share ideas and learning about approaches to improvement and transformation			
Action	**Responsibility**	**Measures**	**Timeline**
Take part in skills and capacity review of transformation teams across BNSSG STP	Associate Director of Improvement & Innovation	• Skills and capacity identified	• Mar 2020
Introduce passport for QI bronze to enable staff to transfer skills between local organisations (QI bronze programmes to be aligned)	Associate Director of Improvement & Innovation	• Passport implemented between UHB and NBT • Passport implemented between other organisations	• Mar 2020 • Mar 2021
Institute regular meetings between QI and transformation teams to share learning and ideas	Associate Director of Improvement & Innovation	• Effective meetings held	• Mar 2020
Be an active member of the Delivering Improvement Network	Associate Director of Improvement & Innovation	• Number of new approaches adopted	• Ongoing
Create opportunities to develop or adopt new approaches to improvement and transformation with local partners	Associate Director of Improvement & Innovation	• Number of new approaches adopted	• Mar 2021

6. How we will assure ourselves of the effectiveness and success of this strategy

Delivery of this strategy will be monitored by the Innovation and Improvement Steering Group and the Transformation Board, reporting to the Senior Leadership Team and Trust Board (see organogram below).



Regular reports on delivery will also be provided to the Strategy Steering Group.

Appendix 1: PESTLE

Political/Policy Drivers	Economic
• NHS long term plan and its priority areas • Forthcoming NHSE/I improvement framework • Patient choice, competition and plurality • Care closer to home, less reliance on hospital based care	• Uncertainty over impact of Brexit on commercial opportunities and investment in the UK • Requirement to deliver system-wide financial balance
Social	**Technological**
• Growing patient expectation of both the quality and experience of care and expectations of access to most up to date healthcare • A more health literate public driving both demands and concerns about healthcare and research • Ageing population and consequent demands upon healthcare providers • Significantly changing local demographic notably in context of ethnicity profile • Diverse deprivation profile and resulting impacts on health of local population • Growing familiarity and use of social media	• Advancements in technology leading to new practice and improved life expectancy and skills development requirements • Digital system development and requirements
Legal	**Environmental**
• GDPR regulation may slow or negatively impact on the delivery of transformation	• Requirement and aspiration to reduce carbon footprint of estate and services • Merger with Weston Area Healthcare Trust expanding the scope and accelerating the timeline for transformation projects and programmes

Appendix 2: SWOT

Strengths	Weaknesses
• Well-developed Quality Improvement Academy incorporating QI hub and QI faculty, providing support, mentoring and coaching to staff across the Trust to deliver successful QI projects • Talented and committed transformation team • Track record of success in delivering improvement and transformation projects across the Trust	• Limited capacity to deliver QI training to the organisation at pace and scale in line with the dosing model • Project management approach and transfer to business as usual • Financial and system constraints restricting ability to change or innovate • Lack of capacity of clinical and non-clinical teams to engage in improvement and transformation projects, both within Trust and with STP partners • Funding to support kick starting innovations • Less embeddedness of quality improvement and transformation capability at Weston Area Health Trust
Opportunities	**Threats**
• Further development of QI Academy and opportunity to partner with University of Bristol • Transformation teams to work as a system across existing organisational boundaries to maximise transformation capacity and capability and share learning and team development • Improvement and transformation projects will support cultural change and team building following merger of UH Bristol NHS Foundation Trust and Weston Area Health Trust • Support from Above & Beyond to fund small innovation schemes, to develop the innovation capability and delivery • Working with WEAHSN and CLAHRC West to kick start innovation and undertake research and advanced evaluation, raising the profile of Trust • Developing networks with national bodies and successful organisations • Communicating our transformation and improvement themes nationally, raising the profile of our Trust and teams.	• System partners not working collaboratively, resulting in potential duplication of transformation work by local organisations • Insufficient capacity to deliver transformation, both clinical and non clinical • Requirement to deliver system-wide financial balance • Commissioners' contractual arrangements impeding transformation • GDE funding expected to cease after year 2 impacting on speed of implementation of digital transformation

Appendix 3: Audit against checklist for building improvement capability
Source: Health Foundation 2015, Building the Foundations for Improvement pp9-10

This audit is undertaken for UH Bristol NHS Foundation Trust. An audit will be undertaken for Weston Area Health Trust following merger.

Element	Degree of implementation			Proposal to address gaps
	None	Partial	Full	
Testing the water				
Financial and organisational stability			✓	
Board and executive level support			✓	
Robust governance and performance structures		✓		Improve link between QI, audit and assurance processes
Some existing QI capability and/or willingness to recruit and external improvement partner			✓	
Building the right foundations				
Develop an integrated approach to quality improvement – strategic aims, structures, workstreams and performance management structures are aligned		✓		Review alignment of performance management structures with quality improvement
Ensure the approach reflects the culture and personality of the organisation			✓	
Business case in place to support the programme	✓			Develop the business case for investment in QI training and leadership development
Establish a central improvement team			✓	
Introduce quality improvement to the workforce and service users – aims, objectives and benefits		✓		Undertake diagnostic for level of awareness across Trust Develop methodology of building awareness for all staff
Engage the main stakeholders		✓		Ensure patients and carers are involved in improvement and transformation work Work with STP partners to develop improvement and transformation capability and capacity
Getting started				
Give training participants the chance to learn by			✓	

Element	Degree of implementation			Proposal to address gaps
	None	Partial	Full	
doing				
Ensure training content is appropriate for all participants			✓	
Ensure participants are given time and space to take part in training			✓	
Combine classroom based learning with access to online resources			✓	
Focus on QI methods and techniques that are really understood by the team			✓	
Once the programme is underway				
Work with service managers at each level to align improvement activity within corporate goals		✓		Embed improvement and transformation activity in annual business planning process
Build a network of training programme graduates to champion improvement and mentor future participants		✓		Grow the QI Faculty in line with the dosing model
Build up knowledge of a range of QI methods and techniques			✓	
Evaluate the training offer regularly		✓		Implement annual review process
Be honest and transparent about the process – publish information externally online		✓		Publish on external webpage and via Twitter

4 Checklist for building improvement capability

Based on what the five trusts told us about their improvement journeys – and also about what they would do differently now if they had their time again – we have compiled a checklist of points for provider organisations to consider before planning, designing and delivering an improvement capability building programme.

However, there is clearly no one approach to building capability. There are lessons that provider organisations can learn from others, but each organisation needs a strategy that bears their particular stamp and is owned and supported by their workforce and service users. Before getting underway, organisations should also do an audit of the assets they already have so that they can make full use of the clinicians and teams with existing quality improvement and patient safety experience.

Testing the water

Before investing in an improvement capability building programme, four key foundations must be in place:

Financial and organisational stability – stability is essential in order to get a programme up and running successfully and ensure that the workforce is ready to engage with it. Any imminent reorganisation, change of leadership or pressing performance or financial challenge will make it almost impossible to gain and retain the attention of your staff.

Board and executive level support – getting the board, particularly the non-executive members, engaged and enthused about investing in improvement capability is critical. Visiting trusts with proven improvement track records and early support from the finance director can help to secure their buy-in.

Robust governance and performance structures – essential pre-requisites for any organisation are a sound quality assurance mechanism and an effective board committee structure. Moreover, adapting corporate processes to ensure that a focus on audit and assurance goes hand in hand with a focus on understanding variation and improving quality is important.

Some existing QI capability and/or a willingness to recruit an external improvement partner – in order to implement and sustain a capability building programme, an organisation must be able to call on people with established QI expertise and coaching skills. In the absence of such expertise internally, consideration must be given to working with an external partner.

Building the right foundations

Having decided that the right conditions are in place to invest in building improvement capability, the following points should be considered:

Develop an integrated approach to quality improvement – ensure there is a purpose for building capability and all strategic aims, structures, work-streams and performance management structures are aligned with the programme.

Make sure the approach reflects the culture and personality of the organisation – the values and vision of an organisation aspiring to continuous improvement need to be clearly articulated and visible at every level.

Put together a business case – How much will the programme cost? Where will the money come from? What approach will be taken? How will the impact be assessed? What return on investment is anticipated and how might one measure at least some of that return?

Establish a central improvement team – at the outset, form a central team to manage and promote the programme, teach QI skills and coach improvement teams. At least some of the team should know the organisation well and have the respect of clinicians and managers.

Spend time introducing quality improvement to the workforce and service users – do not assume that the organisation knows about QI and its potential benefits. Clearly set out the aims and objectives at the start. Make every effort to promote and describe the value that such a programme will provide to patients and staff. Involving clinical and middle management staff is important.

Engage the main external stakeholders – try to get the key commissioners, education providers and regulators involved early on and engage other providers in the local health economy.

Getting started

When developing the outline approach into a detailed strategy and action plan, consider the following:

Give training participants the chance to learn by doing – the evidence suggests that training programmes which include practical exercises and work-based activities are more likely to achieve positive changes in care processes and patient outcomes.[12] However, organisations have to ensure that training participants are part of an improvement team in their service or ward and are supported by their managers.

Ensure that the training content is appropriate for all participants – most existing QI methods and training programmes are geared towards the needs of acute clinical staff. If non-clinical or community or social care-based staff are involved, tailor the content accordingly.

Ensure that participants are given the time and space to take part in training – giving staff dedicated time to participate in training helps to keep the drop-out rate low and signals the organisation's support for quality improvement.

Combine classroom-based learning with access to online resources – aligning what staff see and hear during face-to-face learning sessions with appropriate online content will help to reinforce key messages.

Work with the QI enthusiasts first to gain some early wins – 'go where the energy is' and empower staff to focus on issues that really matter to them.

Focus at the start on QI methods and techniques that are really understood by the team – but make sure they are appropriate for the improvement challenges being addressed.

Once the programme is underway

Once the capability building programme is up and running, start to focus on the following:

Work with service managers at each level to align improvement activity with corporate goals – this will help to ensure the long-term sustainability of any improvement projects carried out by training participants.

Build up a network of training programme graduates to champion improvement and mentor future participants – this will help to create a QI community within the organisation, enable programme graduates to continue to learn from and support each other and remove the need for long-term reliance on the central QI team.

Build up knowledge of a range of different QI methods and techniques – avoid becoming tied to one approach in the long term; be able to use the right approach for each problem.

Evaluate the training offer regularly – where necessary, adjust the programme to meet the changing needs of the organisation.

Be honest and transparent about the process – publishing information online about how the organisation is building capability and the challenges it is addressing helps to encourage and inform other like-minded organisations.

12 De Silva, D. *Quality improvement training for healthcare professionals*. The Health Foundation, 2012.

Appendix 5: Glossary of organisations

Collaboration for Leadership in Applied Health Research and Care West (CLAHRC West) From 1 October 2019 to be known as Applied Research Collaboration (ARC) West	The National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care West (NIHR CLAHRC West) works with partner organisations, including the NHS, local authorities and universities, to conduct applied health research and implement research evidence, to improve health and healthcare across the West.
Bristol Health Partners (BHP)	A strategic collaboration between the city region's major health institutions, covering the Bristol, North Somerset and South Gloucestershire area. These include its three NHS trusts, its clinical commissioning group, two universities and Bristol City Council.
Healthier Together: Bristol, North Somerset, South Gloucestershire Sustainability and Transformation Partnership (BNSSG STP)	13 local organisations which have come together to form a vision and deliver the strategic change required for health and care services. The four strategic priorities are: 1. Transforming how patients receive care to provide better outcomes and value for money 2. Creating a resilient and financially sustainable health and care system 3. Developing better health through prevention and self-care 4. Providing better access to good quality services
Institute for Healthcare Improvement (IHI)	IHI uses improvement science to advance and sustain better outcomes in health and health care across the world. It brings awareness of safety and quality to people and professional across the world to accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilise health systems, communities, regions, and nations to reduce harm and deaths.
Shelford Group	A collaboration between ten of the largest teaching and research NHS hospital trusts in England. UH Bristol is an associate member of the Shelford Transformation Network.
West of England Academic Health Sciences Network (WEAHSN)	One of 15 Academic Health Science Networks (AHSNs) across England, established by NHS England in 2013 to spread innovation at pace and scale – improving health and generating economic growth.

Meeting of the Board of Directors in Public on Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Finance Report**
Report Author	**Kate Parraman, Deputy Director of Finance**
Executive Lead	**Neil Kemsley, Director of Finance and Information**

1. Report Summary

The purpose of this report is to:

- inform the Finance Committee of the financial position of the Trust for August
- provide assurance on the delivery of the Core Control total, including risks and mitigations

2. Key points to note

(Including decisions taken)

Attached is a summary dashboard and performance report.

The plan for August required a core (i.e. excluding Provider Sustainability Funding (PSF) and MRET) surplus of £3.171m.The Trust is reporting a core surplus of £1.116m to date, which is £2.055m adverse to plan.

Division and Corporate Services are £5.515m adverse to Operating Plans.
The key issues are:

- Income from activities underperformance of £4.472m
- Increased nursing and midwifery pay costs of £1.009m

The movement in the month of £2.369m was due to underperformance on activity based contracts, across all Divisions and all points of delivery.

The focus is on understanding the reasons for the particularly low activity in August and providing a realistic assessment of income for September and to inform the Q2 year end forecast.

The Trust is using non-recurring measures to offset the Divisional overspending in the first half of the year with an expectation that the run rate improves in the second half of the year.

Although the August position is adverse to plan, the expectation is to be on plan at the end of quarter two and therefore Provider Sustainability Funding (PSF) is assumed.

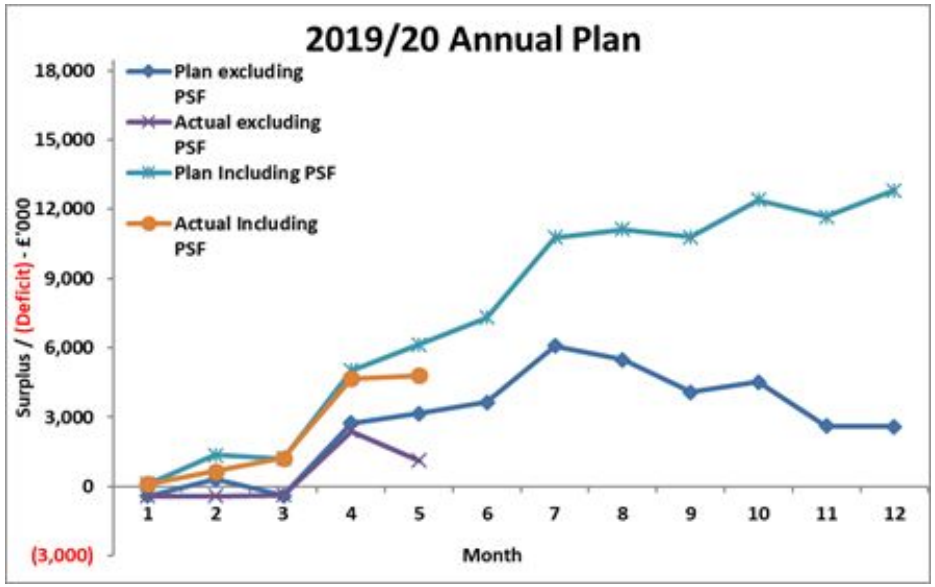
3. Risks

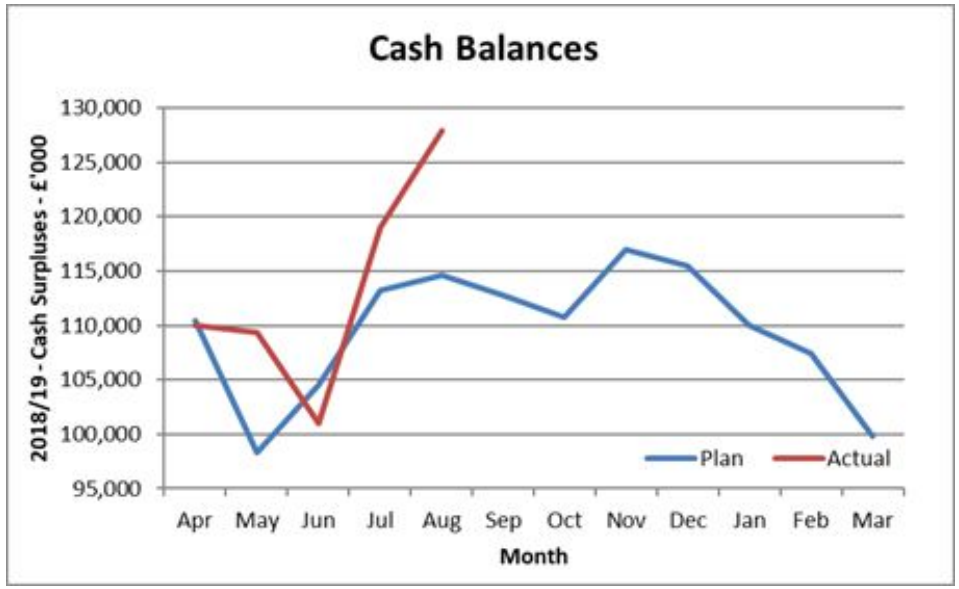
If this risk is on a formal risk register, please provide the risk ID/number.

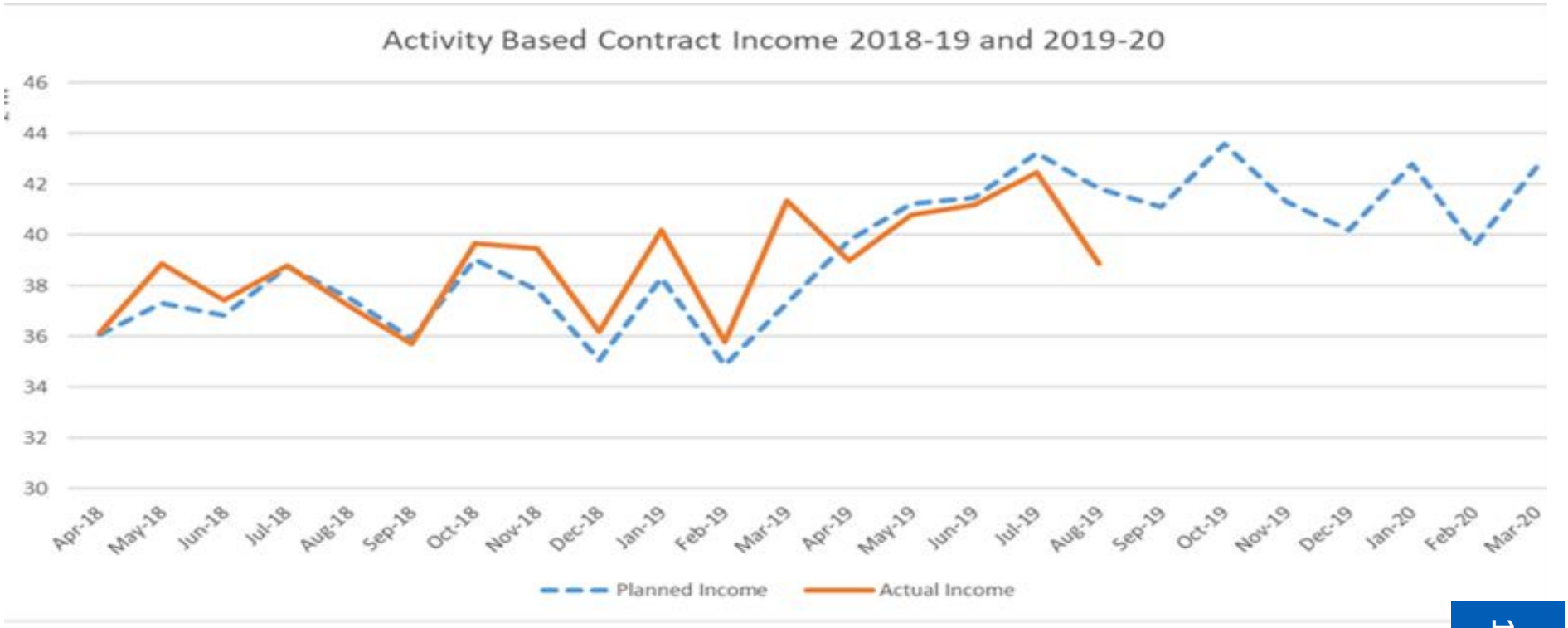
The risks associated with this report include:
Risk 959 – Risk that the Trust fails to deliver the Operational Plan
Risk 1843 – Risk of failure to achieve Trust's Core Control Total

4. Advice and Recommendations *(Support and Board/Committee decisions requested)*:	
• This report is for **INFORMATION** • The [Board/Committee] is asked to **NOTE** the report	
5. History of the paper **Please include details of where paper has previously been received.**	
Finance Committee	***26 September 2019***

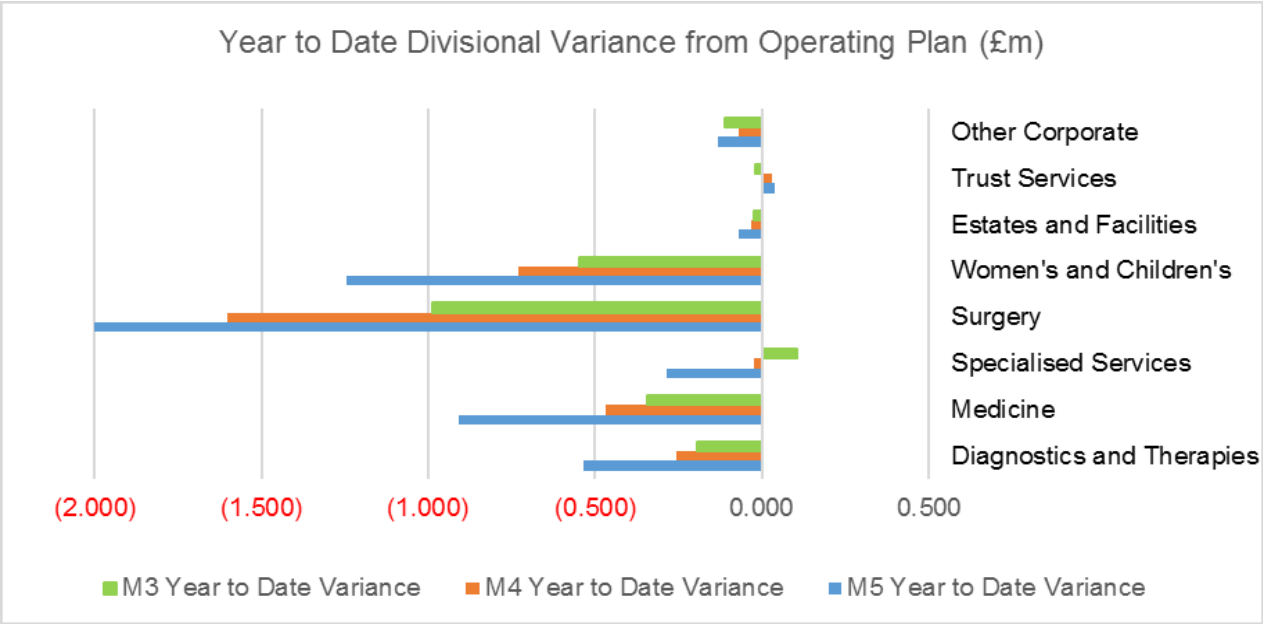
Performance – Finance (plan, income and cash)

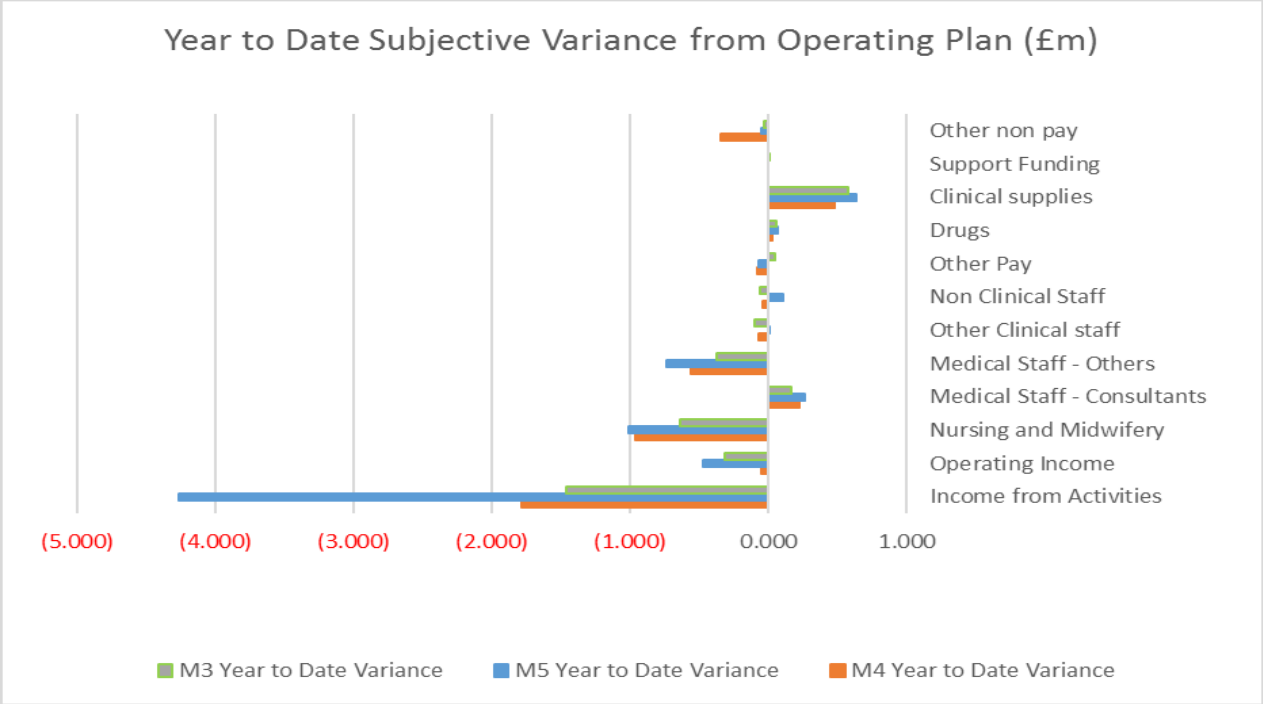






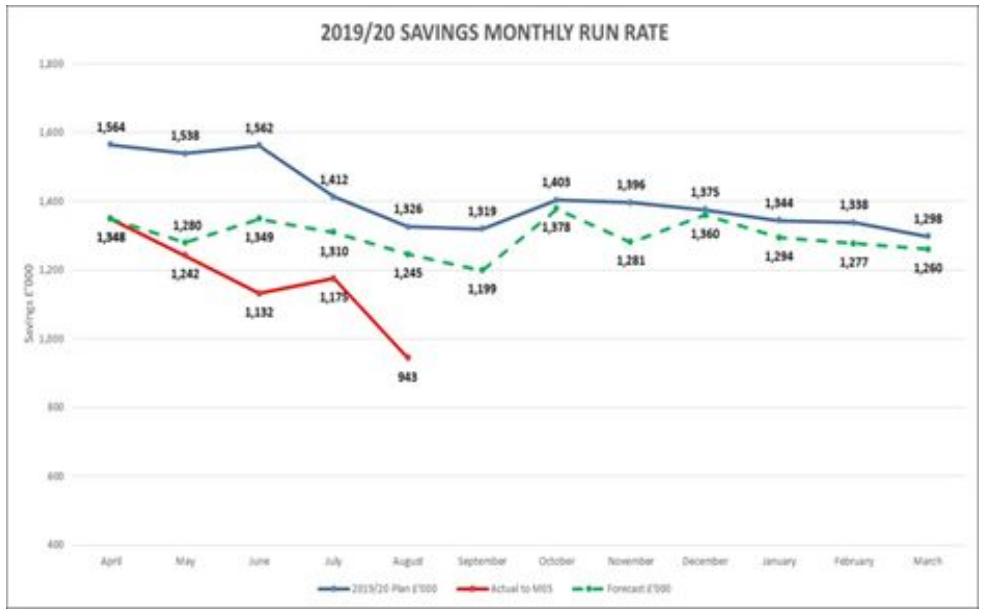
Performance – Finance (Divisional Operating Plans)

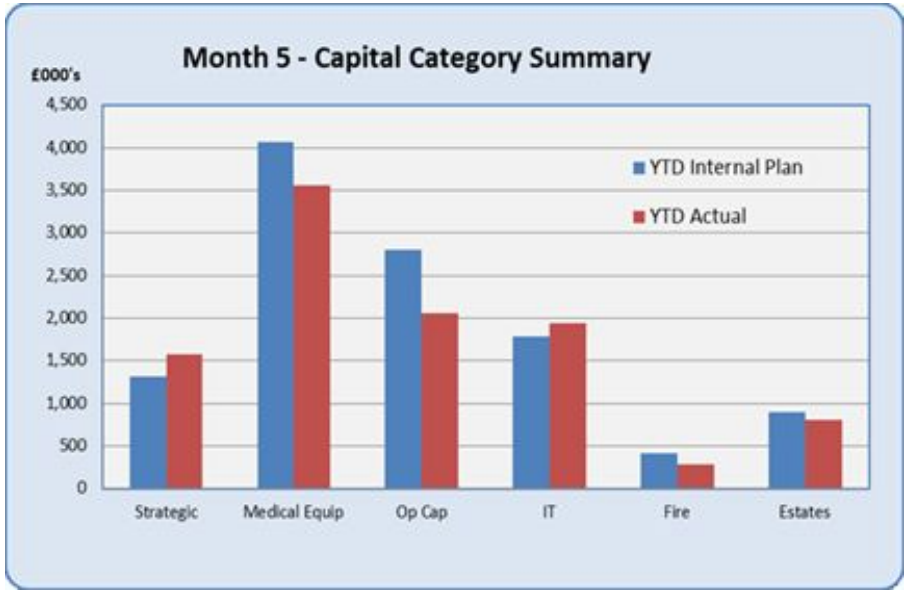




RAG Rating to Operating Plan	In Month	Year to Date
D & T	R	R
Medicine	R	R
Specialised	R	R
Surgery	R	R
W & C	R	R
E & F	R	A
Trust Services	G	G

Performance – Finance (savings and capital)

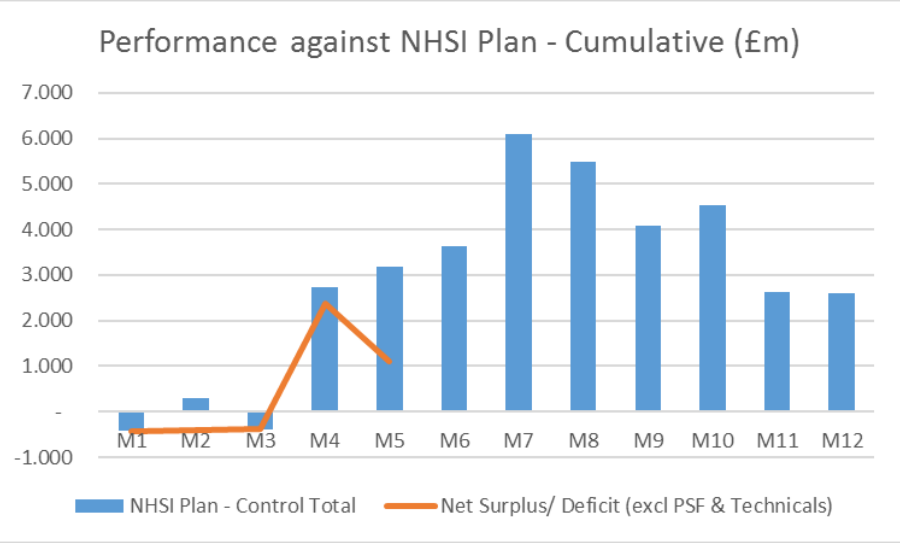




Report of the Finance Director

Section 1 – Executive Summary

Performance to NHSI Plan	2019/20 NHSI Plan	Income / (Expenditure)		Variance
		Plan to date	Actual to date	Favourable /(Adverse)
	£m	£m	£m	£m
Income from Activities	620.546	258.636	256.368	(2.268)
Income from Operations	92.222	38.425	39.693	1.268
Expenses – Pay	(428.393)	(177.591)	(178.401)	(0.810)
Expenses – Non Pay	(245.904)	(101.459)	(101.764)	(0.305)
Financing	(35.878)	(14.840)	(14.780)	0.060
Surplus/(deficit) excl PSF	2.593	3.171	1.116	(2.055)
PSF Core Funding	9.576	2.712	2.712	-
MRET Funding	0.646	0.270	0.270	-
Prior Year PSF Post Accounts Allocation	-	-	0.710	0.710
Surplus/(deficit) incl PSF	12.815	6.153	4.808	(1.345)



- The Trust is £2.055m adverse to the NHSI plan control total year to date, compared with £0.359m last month. The single biggest factor causing this significant deterioration is the low levels of activity delivered in month. Income from activities is £2.3m adverse to plan, compared to £0.7m favourable last month. Activity based income was £3m lower than plan in August. This was across all Divisions and all points of delivery; day cases, outpatients, elective and urgent care.
- The Divisions are focussing on understanding the reasons for the particularly low activity in August and providing a realistic assessment of income for September as well as year end forecasts. The Divisional recovery plans are being reviewed in light of this.
- The Trust continues to use non-recurring measures to offset the Divisional overspending in the first half of the year with an expectation that the run rate improves in the second half of the year.
- Provided the Divisional recovery plans are delivered, the year end position can be managed through non-recurring corporate measures. The month 6 year end forecast will include an assessment of the confidence in the recovery plans.
- Although the August position showed a significant adverse variance to plan, the expectation is that the reported position will be on plan at the end of quarter two and therefore Provider Sustainability Funding (PSF) is assumed.
- Income from activities includes income in respect of high cost drugs which is £1.3m higher than plan (offset by increased non pay costs) and £1m of prior year income. Therefore the activity under performance to date is £4.6m below plan.

Performance to Budget	2019/20 Annual Budget £m	Income / (Expenditure) Budget to date £m	Income / (Expenditure) Actual to date £m	Variance favourable /(adverse) £m
Corporate Income	656.869	273.588	272.541	(1.047)
Divisions & Corporate Services	(604.450)	(251.003)	(256.645)	(5.642)
Financing	(36.161)	(14.972)	(14.780)	0.192
Reserves	(13.665)	(4.442)	-	4.442
Surplus/(deficit) excl PSF	2.593	3.171	1.116	**(2.055)**
PSF Core Funding	9.576	2.712	2.712	-
MRET Funding	0.646	0.270	0.270	-
Prior Year PSF Post Accounts Allocation			0.710	0.710
Surplus/(deficit) incl PSF	**12.815**	**6.153**	**4.808**	**(1.345)**

Note:

The corporate income annual budget comprises contract income (£621.1m) and education levy funding (£35.8m). Contract income differs from the NHSI plan for income from activities due to changes in the contract after the NHSI plan was submitted (£2.4m increase) and the allocation of some income from activities budgets to Divisions (£1.8m).

The income underperformance is shown in the Divisions variances and the corporate income variance, which is the corporate share of contract under performance and penalties, as shown on appendix 2.

- Delivery of the NHSI plan is managed through Divisional Operating Plans and budgets set at cost centre level, assigned to budget managers. Budgets are adjusted for in year funding changes post NHS I plan submission.

- Division and Corporate Services budgets are £5.642m adverse to budgets, of which £3.1m is pay and £4.0m is income from activities, offset by £1.8m on non pay. Surgery is £2.760m adverse, Medicine £1.222m and Women's and Children's £1.029m. This is a deterioration of £2.5m from last month of which £0.9m is Surgery, £0.5m Medicine, £0.3m Specialised Services and £0.5m Women's and Children's.

- Non-recurring support is being used, held in reserves. This has been forecast at £8m for the year, which includes £1.9m from prior year income. The reserves profiling has been weighted towards the first half of the year by bringing in all of the prior year income, with the expectation that the Divisional actions to address the overspend run rate will improve the position in the second half.

Key actions for all divisions are reported section 2 below.

Report of the Finance Director

Section 2 – Division and Corporate Services Performance against Operating Plan

	Diagnostics & Therapies		Medicine		Specialised Services		Surgery		Women's and Children's		Non Clinical Divisions*		Total	
	m5 £m	YTD £m	m5 £m	YTD £m	m5 £m	YTD £m	m5 £m	YTD £m	m5 £m	YTD £m	m5 £m	YTD £m	m5 £m	YTD £m
Income from Activities	(0.289)	(0.496)	(0.340)	(0.390)	(0.455)	(0.357)	(0.781)	(2.160)	(0.604)	(0.800)	0.002	(0.068)	(2.465)	(4.272)
Income from Operations	(0.015)	(0.035)	0.000	0.000	(0.040)	(0.025)	(0.008)	(0.070)	0.003	(0.007)	(0.069)	(0.330)	(0.129)	(0.467)
Nursing & Midwifery	0.002	(0.001)	(0.066)	(0.438)	0.040	(0.075)	(0.044)	(0.233)	(0.040)	(0.336)	0.002	0.073	(0.107)	(1.009)
Medical & Dental Pay	0.006	0.070	(0.037)	(0.235)	(0.020)	(0.299)	(0.030)	(0.015)	(0.002)	0.055	(0.034)	(0.047)	(0.119)	(0.472)
Other Pay	0.010	(0.069)	0.013	0.018	(0.001)	(0.050)	0.042	(0.027)	0.035	0.012	(0.020)	0.167	0.081	0.052
Non Pay	0.010	(0.004)	(0.014)	0.133	0.212	0.519	0.045	0.128	0.091	(0.169)	0.027	0.046	0.371	0.652
Total	**(0.278)**	**(0.535)**	**(0.444)**	**(0.912)**	**(0.264)**	**(0.287)**	**(0.776)**	**(2.377)**	**(0.517)**	**(1.245)**	**(0.092)**	**(0.159)**	**(2.369)**	**(5.515)**

*Includes Estates & Facilities, Trust Services and Corporate Services

Divisions and Corporate Services are £5.5m adverse to their Operating Plans. The areas of key concern are highlighted.

Detailed information is provided by the Divisional reports (agenda item 2.3) and Specialised Services and Women's and Children's recovery plans (agenda item 2.4). Surgery's recovery plan was received by the Committee last month. Key variances and actions are summarised below.

Diagnostic and Therapies

An adverse variance in month of £0.278m resulting in a cumulative adverse variance of £0.535m.

Key variances:
Income from Activities

- An adverse variance of £0.289m in month taking the year to date variance to £0.496m. The Divisions' share of income shortfalls in other divisions is £0.495m adverse year to date. For services hosted by Diagnostics and Therapies, income from activities is favourable by £0.041m year to date.
- The hosted services £0.007m adverse variance in month is due to reductions in direct access activity, offset by continuing overperformance in audiology and radiology.

Key action:
To maintain audiology activity through migration to a new database in September.

Medicine

An adverse variance in month of £0.444m resulting in a cumulative adverse variance of £0.912m.

Key variances:
Income from Activities

- An adverse variance of £0.340m in month taking the year to date variance to £0.390m
- Emergency inpatient income adverse by £0.295m. A 9% reduction in discharges in August following an emergency admission with unprecedented numbers of 'green to go' patients occupying nearly 50% of medical beds as well as fewer admissions from seasonal variation.
- Day case volumes were the lowest this year and adverse by £0.025m in month due to capacity issues.

Nursing pay

- An adverse variance of £0.066m in month taking the year to date variance to £0.438m
- Escalation capacity (ward 512) not included in the operating plan, £0.195m year to date
- ECO and RMN expenditure, £0.060m year to date
- Pressure to staff ED queue, £0.095m year to date
- Cost of using premium rate staffing to cover sickness and vacancies, £0.088m year to date.

Medical pay

- An adverse variance of £0.037m in month taking the year to date variance to £0.235m, within Junior Doctors.
- Some overlapping during the August rotation increased expenditure this month by c. £0.040m.
- Additional posts covering rota gaps within ED and cover for sickness and maternity leave.
- Two additional posts continue to cover Rheumatology 'follow up' backlogs

Key actions:

- Income – re-assess demand and capacity model, monitor elective activity recovery plans, re-locate services moving ENT and Max Facs patients out of ED to improve capacity and flow.
- Nursing – Ongoing review of implementation of ECO policy including working with commissioners/AWP regarding funding, focus on recruitment, including overseas, review of options for accessing RMN support as needed.
- Medical staff – Recruitment of physician associates due to start in October, improving recruitment through reviewing opportunities to for 'joint' speciality posts and streamlining the process, improved rota management through specific group.

Surgery

An adverse variance in month of £0.776m resulting in a cumulative adverse variance of £2.377m. The Financial Recovery Plan realistically forecast a cumulative adverse variance of £2.436m at month 5.

Key variances:
Income from activities

- An adverse variance of £0.781m in month taking the year to date variance to £2.160m
- Underperformance in Oral/Dental services £0.668m due to vacancies with pension tax issue reducing availability of additional sessions
- Underperformance in Ophthalmology £0.375m due to vacancies and sickness
- Underperformance in Trauma and Orthopaedics £0.478m following cancelled elective activity and reduced emergency activity to accommodate cancer recovery work
- Unachieved income productivity £0.268m

Nursing Pay

- An adverse variance of £0.044m in month taking the year to date variance to £0.233m
- QDU £0.094m adverse year to date due to supporting escalation activity
- Adult ITU £0.077m adverse linked to acuity in the ward and vacancy cover
- BRI and T&O Wards combined are £0.161m adverse through covering vacancies and the cost of supernumerary running with the new starters in August

Key actions:

- Income – Exploring ways of increasing capacity to avoid cancelled operations. Recruitment to vacancies and mobilising weekend sessions to recover Oral/ Dental income. Appointment of a project manager to support the Eye Hospital in delivering income recovery. Reviewing the best way to deliver activity including appropriate outsourcing
- Nursing – Staff inpatient beds on QDU using identified staffing model, focus on recruitment, including overseas, to reduce agency expenditure.
- Divisional Working Smarter/ Productivity – working group established and focussing on identifying and implementing additional productivity/savings schemes. Focus on improving scheduling and reducing length of stay. Recruitment of an 'extended role practitioner' is underway to support the surgical ambulatory pathways.

Specialised Services

An adverse variance in month of £0.264m resulting in a cumulative adverse variance of £0.287m.

Key variances:
Income from Activities

- An adverse variance of £0.455m in month taking the year to date variance to £0.357m
- Cardiology is £0.486m adverse year to date with activity below last year.
- Cardiac surgery, £0.152m adverse through vacancies and difficulty in filling sessions
- Oncology £0.199m adverse due to capacity constraints in advance of the planned BHOC expansion and staffing vacancies.

Medical pay

- An adverse variance of £0.020m in month taking the year to date variance to £0.299m
- Consultants are £0.108m adverse to plan, predominately due to difficulty in covering vacancies in Oncology requiring the use of high cost agency and additional sessions required to deliver activity in Haematology.
- Junior staff are £0.191m adverse year to date including the cost of covering high levels of maternity leave and a supernumerary post which is yet to receive anticipated Deanery funding.

Key actions:

- Income performance – Focus on improved scheduling, reviewing annual leave policies and ensuring appropriately trained staff and space are available to deliver activity
- Medical pay – Increased focus on recruitment to both consultant and other medical staff as a priority and working with HEE to fund posts already in situ.

Women's and Children's

An adverse variance of £0.517m in month resulting in a cumulative adverse variance of £1.245m.

Key variances:

Income from activities

- An adverse variance of £0.604m in month taking the year to date variance to £0.800m
- Neurosurgery is £0.404k adverse, activity is below plan for this low volume high cost service.
- ED is £0.451m adverse with the levels of planned growth not being delivered.
- Paediatric surgery is £0.452k adverse through reduced emergency and non-elective activity
- Additional Bone Marrow Transplant activity (18 cases above plan) has provided £0.527m additional income.

Nursing Pay

- An adverse variance of £0.040m in month taking the year to date variance to £0.336m
- Whilst nursing costs are lower than previous months, the cost pressures of using agency to cover sickness and vacancies continues.
- Costs associated with caring for patients with higher acuity have been particularly high in Caterpillar Ward and for stereotactic and burns patients.

Key actions:

- Income – The Division is focussed on delivery of contracted volumes and is undertaking a detailed review to determine forecast going forward and understand opportunities and threats to delivering the contract.
- Nursing – The Division has held a successful recruitment campaign for nurses, expected to have a positive impact in reducing the nursing adverse variance run rate going forward and is reviewing levels to prepare for winter to ensure that there is sufficient capacity in the system.

Section 3 – Division and Corporate Services Performance - Subjective

Performance against Operating Plan by subjective heading:

Subjective	Year to Date (Month 5)		
	Op. Plan Var	Actual Var.	Var. From Plan
	£m	£m	£m
Income from Activities	0.280	(3.992)	(4.272)
Operating Income	0.064	(0.403)	(0.467)
Nursing and Midwifery	(1.170)	(2.179)	(1.009)
Medical Staff - Consultants	(0.888)	(0.623)	0.265
Medical Staff - Others	(0.447)	(1.184)	(0.737)
Other Clinical staff	0.316	0.324	0.009
Non Clinical Staff	0.253	0.361	0.108
Other Pay	0.243	0.179	(0.064)
Drugs	(0.072)	(0.003)	0.070
Clinical supplies	(0.287)	0.350	0.637
Support Funding	0.839	0.840	0.001
Other non pay	0.741	0.687	(0.055)
Total	(0.128)	(5.643)	(5.515)

- 'Other Medical Staff' is £0.737m adverse with the largest adverse variances in Surgery (£0.370m) and Medicine (£0.224m). Medicine have had a number of rota gaps requiring both locum and agency cover leading to their adverse position. Surgery have used additional payments to cover rota gaps and deliver activity.

- Clinical Supplies is £0.637m favourable to plan reflecting the lower activity levels (and therefore lower income from activities).

- Under achievement against plan on income from activities is most significant in Surgery where the variance is £2.160m adverse. Oral and Dental income is £0.668m adverse due to capacity constraints to deliver activity. Locum cover is now in place, but there remains concerns about reduction in additional shifts due to pension/ tax liabilities and the continuing high levels of vacancies and sickness absence. Trauma and Orthopaedics is £0.478m through reduced activity some of which is to accommodate cancer work. Ophthalmology is £0.375m adverse year to date due in part to capacity issues, which are being resolved through recruitment but concerns continue regarding sickness and the willingness of staff to deliver additional activity. Non achievement of income productivity gains account for £0.2638m year to date.

  Women's and Children's is £0.800m adverse to date, a deterioration of £0.604m in the month. Neurosurgery is £0.404k adverse, activity is below plan for this low volume high cost service. ED is £0.451m adverse with the levels of planned growth not being delivered. Paediatric surgery is £0.452k adverse. Additional Bone Marrow Transplant activity (18 cases above plan) has provided £0.527m additional income.

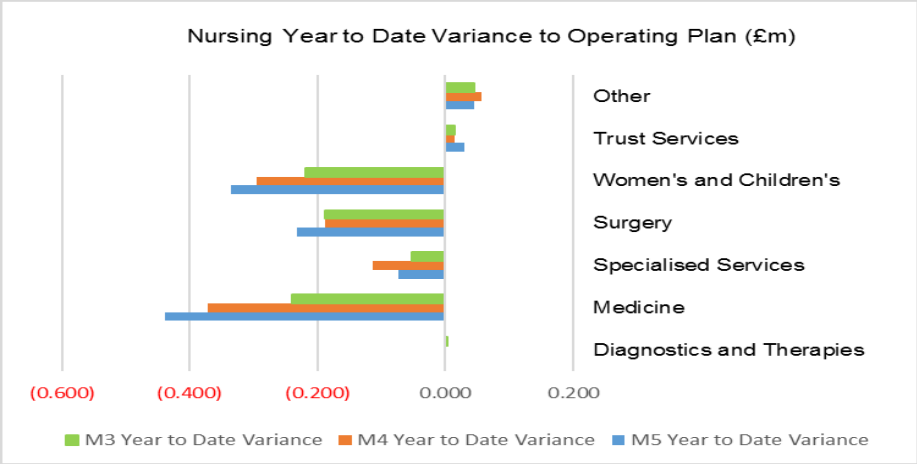
  Specialised Services is £0.357m adverse to plan, a deterioration of £0.455m in the month. This is primarily in cardiology (£0.486m adverse) with activity below last year's.

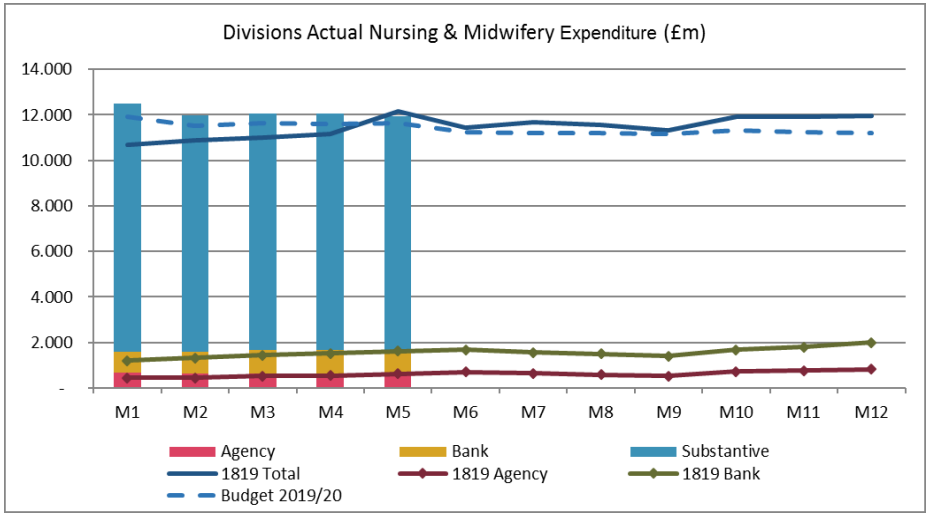
  Medicine is £0.390m adverse to plan, a deterioration of £0.340m in month. Emergency inpatients accounted for £0.295m of the August variance with the significant levels of green to go patients affecting activity.

- Nursing and Midwifery are adverse to plan by £1.009m year to date, of which Medicine is £0.438m, Women's and Children's is £0.336m and Surgery is £0.233m. For Medicine a key driver has been Ward A512 remaining open although closure was achieved in August. Women's and Children's and Surgery variance are driven by costs of covering vacancies and sickness as well as some acuity issues.

Section 4 – Subjective Analysis Detail

a) Nursing and Midwifery Pay





Nursing and midwifery spend continues to be significantly adverse to plan for Medicine, Surgery and Women's and Children's Divisions.

Expenditure reduced slightly in August compared to July which is a change from the trend in previous years. Divisions spent £11.923m compared to £12.050m in July. Agency cost was marginally higher, substantive and bank costs were marginally lower.

The nursing lost time percentage for inpatient staff numbers (i.e. wte/hours worked) was 123%, which is 3% over the 120% allowance. Medicine remained the highest at 128% which represents a 1% improvement on last month. Surgery worsened by 2% to 124%. Specialised Services remained within the wte budget allowance at 119% for the fourth consecutive month. Women's and Children's services both improved by 4% and 1% respectively taking them to 121% and 122%.

Sickness levels for registered nurses (RN) have reduced slightly in Specialised Services, Surgery and Women's Services with most areas now close to or below target. Sickness levels for nursing assistants (NA's) have reduced for all Divisions, though only Specialised Services and Women's Services are below the target percentages.

Vacancies for registered nurses (RN) remain significantly above plan for all except Women's and Children's nurses, with the highest level seen in Medicine, which was 11.9% against a target of 5%. Vacancies for nursing assistant's (NA's) in Women's Services fell from 5.9% to 1.7% and are now below target levels (5%). There is a small over establishment in Children's. Other Divisions remain above target, most notably Surgery with 11.3% NA vacancy level.

The cost of Enhanced Care Observations (ECO's) reduced for the second consecutive month with the exception of Medicine which increased slightly (£0.113m in July to £0.121m in August). The Medicine plan figure is £0.045m per month.

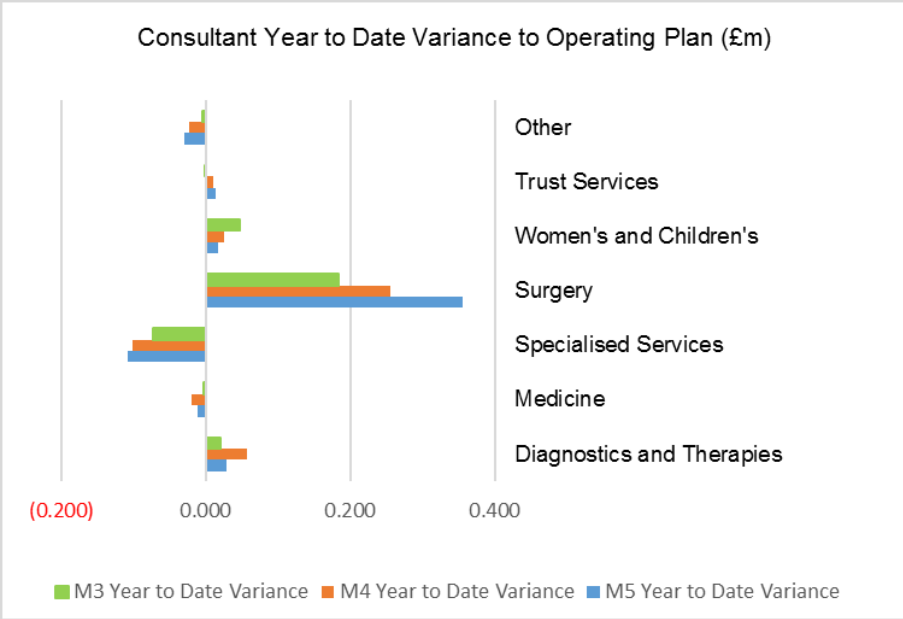
Medicine continues to have the highest variance to Operating Plan (£0.338m adverse year to date) although the actual expenditure reduced in month by £0.063m.

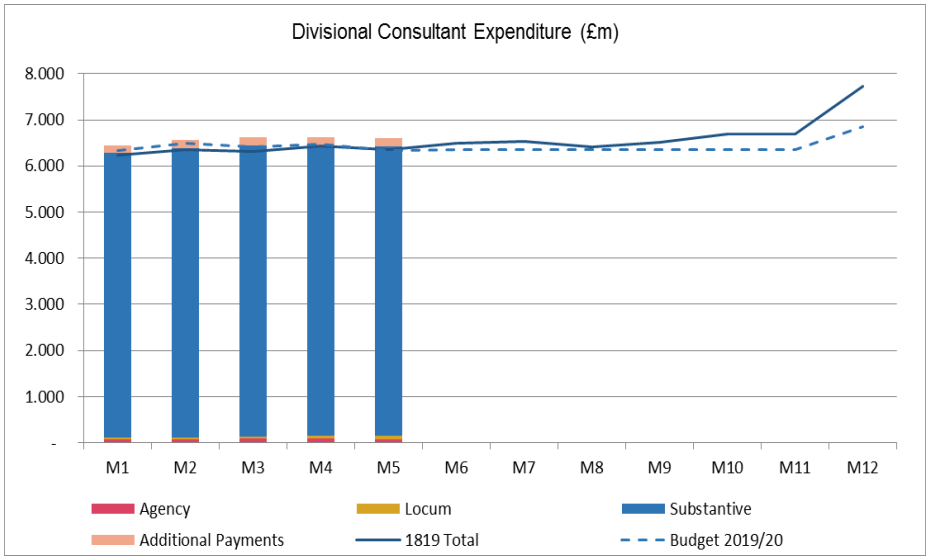
Women's and Children's is £0.336m adverse year to date, a worsening of £0.040m in the month, although actual expenditure reduced with bank and agency lower than July reflecting recruitment to vacancies.

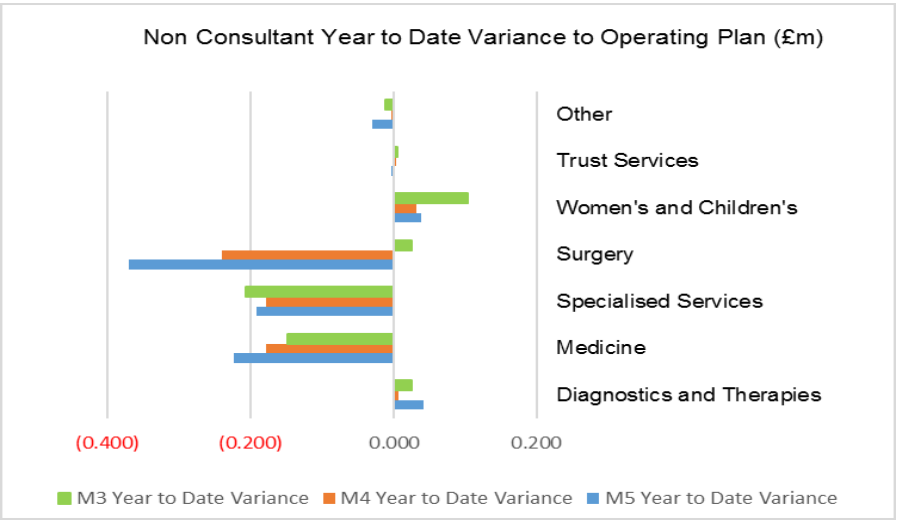
Surgery is £0.233m adverse year to date a deterioration of £0.044m in month. Agency cost increased in August reflecting continued pressure to cover vacancies and escalation capacity.

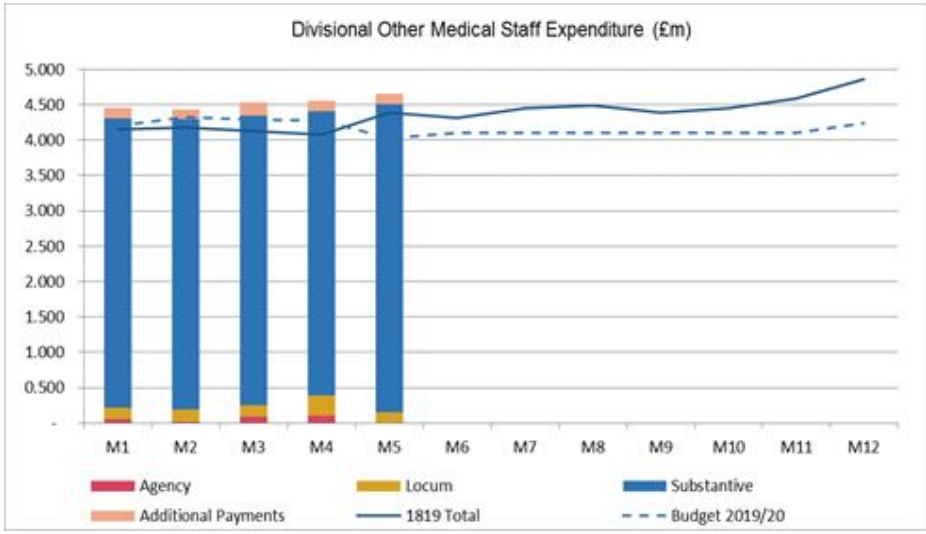
Section 4 – Subjective Analysis Detail continued

b) Medical and Dental Pay









Medical and Dental pay in total has a year to date adverse variance to Operating Plan of £0.472m. Consultant expenditure is favourable to plan with Non Consultant expenditure being the area of largest adverse variance.

Absolute expenditure on Medical and Dental staff increased compared to 2018/19 (prior to the pay award) as would be expected to deliver higher contracted income, however as yet this is not resulting in the higher levels of income anticipated.

In month expenditure reduced slightly from £11.534m in July to £11.328m in August. There was a reduction in all pay types notably agency (£0.125m compared to £0.202m) and substantive staff costs (£10.968m compared to £10.993m in July). Additional session payments to substantive staff remained broadly in line with July's position.

Specialised Services has had vacancies in both the Consultant and Non Consultant workforce resulting in premium agency payments and additional hours payments. The Division is focussing on recruitment to these vacancies to improve the financial position but has concerns about the availability of suitable staff to fill these posts.

Medicine is £0.224m adverse in respect of Junior Doctor costs. There are a number of rota gaps requiring cover due to maternity leave and 'less than full time' trainee's in post.

Surgery is £0.355m favourable to the Operating Plan for consultants, reflecting both vacancies in Dental and T&O as well as reduced additional hours payments with a resulting reduction in activity. There is concern around continuing to deliver activity if uptake of additional sessions continues to decline as it has in the last two months.

Surgery is £0.370m adverse for 'Other Medical Staff' mainly due to additional session payments both to cover existing rota gaps and additional clinic sessions.

The pay award for Medical and Dental staff will be paid in September. The estimated cost is being accrued centrally. It will be fully funded on budgets when the costs come through next month. NHS Improvement have advised they will fund the recognised shortfall, which for the Trust is circa. £0.5m.

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	(0.130)	9.867	9.693	(0.173)
Bone Marrow Transplants	0.312	3.528	3.997	0.469
Critical Care Beddays	0.427	22.725	23.613	0.888
Day Cases	(0.253)	17.392	17.016	(0.376)
Elective Inpatients	(0.951)	25.865	23.474	(2.391)
Emergency Inpatients	(1.358)	46.733	44.728	(2.005)
Excess Beddays	(0.173)	2.686	2.282	(0.404)
Non-Elective Inpatients	0.069	13.968	14.450	0.482
Other	(0.129)	29.995	29.682	(0.313)
Outpatients	(0.789)	34.811	33.408	(1.403)
Total Activity Based	(2.975)	207.569	202.344	(5.226)
Contract Penalties	(0.061)	(0.570)	(0.798)	(0.229)
Contract Rewards	(0.018)	2.315	2.354	0.040
Pass through payments	(0.435)	35.185	36.498	1.313
Prior Year Income	-	1.027	1.027	-
Other	0.110	13.434	13.918	0.484
PSF Funding	(0.000)	2.712	2.712	0.000
Prior Year PSF Allocation			0.710	0.710
2019/20 Total	(3.380)	261.672	258.764	(2.907)

- Activity based income was £2.975m adverse in August, resulting in a £5.226m adverse position year to date. The movement in month was significant in elective and emergency inpatients outpatients and day cases.

- Elective inpatients are £2.391m below plan to date, of which £0.590m is within Surgery, £0.549m in Specialised Services and £0.598m in Women's and Children's with Trust overheads share being £0.430m.

- Urgent care is below plan. Paediatric A&E is £0.301m below plan whilst Adult A&E is £0.128m above plan. Emergency inpatients are £2.005m below plan to date of which £0.169m is within Surgery, £0.206m in Specialised Services, £0.310m in Medicine and £0.678m in Women's and Children's with Trust overheads share being £0.493m.

- Critical care beddays are favourable to plan by £0.888m year to date most notably in adult critical care (£0.206m), paediatric HDU (£0.339m) and NICU (£0.285m).

- Bone marrow transplants are ahead of the year to date plan by £0.469m, of which £0.460m is within paediatrics.

- Outpatients is £1.403m below plan to date. Specialised Services is £0.281m below plan, primarily Cardiology, and Surgery is £0.890m below plan, primarily Dental and Trauma and Orthopaedics.

- The Trust has received penalties of £0.798m year to date, £0.229m greater than planned. This is predominantly due to RTT 52 week waits and cancelled operations.

- CQUIN performance is higher than plan and forecast outturn is 83.16%.

- Income relating to pass through payments was £0.435m below plan in August, and is £1.313m above plan to date. Excluded drugs are £1.259m above plan which includes CAR-T cell therapy products.

- The level of coded spells is 83% (last month 86% coded).

Section 6 – Savings Programme

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

	2019/20 Annual Plan £m	Year to date		
		Plan £m	Actual £m	Variance fav/ (adv) £m
Allied Healthcare Professionals	0.025	0.011	0.011	-
Blood	0.133	0.060	0.060	-
Diagnostic Testing	0.181	-	-	-
Estates & Facilities	0.420	0.200	0.201	0.001
Healthcare Scientists Productivity	0.139	0.058	0.032	(0.026)
HR Pay and Productivity	0.058	0.025	0.025	-
Income, Fines and External	0.579	0.257	0.200	(0.057)
Medical Pay	0.286	0.121	0.096	(0.025)
Medicines	1.070	0.572	0.798	0.226
Non-Pay	4.200	1.932	1.859	(0.074)
Nursing Pay	0.369	0.109	0.095	(0.014)
Other / Corporate	1.361	0.567	0.567	-
Productivity	5.619	2.488	1.698	(0.790)
Trust Services	0.490	0.201	0.199	(0.002)
Plans in development	1.945	0.810	-	(0.810)
Total	**16.876**	**7.412**	**5.841**	**(1.571)**

Analysis by Division:

	2019/20 Annual Plan £m	Year to date		
		Plan £m	Actual £m	Variance fav/(adv) £m
Diagnostics & Therapies	1.625	0.652	0.591	(0.061)
Medicine	2.832	1.090	0.532	(0.558)
Specialised Services	1.992	0.973	1.060	0.087
Surgery	4.577	2.186	1.249	(0.938)
Women's & Children's	3.366	1.460	1.310	(0.150)
Estates & Facilities	0.512	0.232	0.281	0.049
Finance	0.158	0.066	0.065	(0.000)
Human Resources	0.101	0.045	0.042	(0.003)
IM&T	0.164	0.062	0.064	0.002
Trust Headquarters	0.188	0.078	0.079	0.001
Miscellaneous Support	0.216	0.090	0.090	-
Corporate/Capital Charges	1.145	0.477	0.477	-
Total	**16.876**	**7.412**	**5.841**	**(1.571)**

- The savings requirement for 2019/20 is £16.876m. To date, the Trust has achieved savings of £5.841m against a plan of £7.412m leaving a shortfall to date of £1.571m.
- Surgery is £0.938m behind plan of which £0.416m relates to underachievement on productivity plans, the balance is represented by minor slippage on existing plans and a remaining gap which will have to be found through maturing schemes currently in the Divisional pipeline but which are as yet insufficiently developed.
- Medicine is £0.558m behind plan to date. The currently worked up plans are on track to deliver, however the balance will need to be delivered by maturing schemes currently in the Divisional pipeline.
- The Trust is forecasting to make savings of £14.888m by year end, 88% of plan. This is a deterioration of £0.038m from the forecast in July. Forecast delivery for productivity schemes has deteriorated by £0.145m, offset by improved forecast outturns of £0.090m on non-pay and £0.053 on medicines; the balance is due to minor changes in other workstreams.

Key Actions:

- The in year performance and forecast outturn are reviewed and challenged in detail at the monthly Divisional Savings Programme reviews and at the Cost Savings Delivery Group as well as Divisional Finance and Ops reviews.

Section 7 - Risk

There is one Strategic and two Corporate financial risks. These will be considered and reviewed at Risk Management Group (RMG) in October. This section provides information on these risks for the Committee to consider to inform the finance paper to RMG.

Corporate Risks

Risk 959 – Risk that the Trust fails to deliver the Operational Plan

The Divisions' Operating Plans underpin the delivery of the Trust's annual Operational Plan, fundamental to delivering the Trust's Financial Strategy. If the Divisions' don't deliver their annual operating plans through controlling costs, delivering activity and delivering savings targets then the Trust risks delivery of the 2019/20 operational plan impacting on the Trust's Financial Strategy and liquidity and risks regulatory intervention.

Controls in place are:

1. The requirement of a balanced Divisional Operating Plan with monthly finance and operational performance reviews between Divisional Boards and Executive Directors to identify risks to delivery.
2. Escalation and requirement for recovery plans when operating plans are not being delivered.
3. Risk assessed savings programme reported and managed through the Savings Delivery Board
4. Productivity programme led by COO focussing on GIRFT, Model Hospital and other benchmarking
5. Focus on pay controls through nursing and medical steering groups
6. Focus on non pay controls through the non pay steering group

The risk has been re-assessed in the light of the month 5 financial performance. RMG will be asked to consider an increased risk from likely x moderate = 12 (high risk) to likely x major = 16 (very high risk).

The actions to mitigate the risk are to agree the Divisional recovery plans with immediate implementation by Divisional Management Boards with Executive oversight. Given the major cause of the deterioration at month 5 was through non achievement of planned income additional focus is required to understand the drivers and consider further actions required to improve the income position.

Risk 1843 – Risk of failure to achieve Trust's Core Control Total

The Trust has accepted the core control total offered by NHS improvement. If the Trust doesn't achieve its core control total for 19/20 it risks receipt of £9.576m PSF which reduces the source of funding for the strategic financial plan. The Trust would need to agree a recovery plan with the regulator and risk regulatory intervention.

Controls in place:

1. Monthly review with reporting to the Finance Committee
2. Divisional reviews regarding delivery of operating/recovery plan
3. Risk assessed savings programme reported and managed through the Savings Delivery Board
4. Review and management of non-recurring corporate measures to mitigate in year cost pressures

The risk has been re-assessed in the light of the month 5 financial performance. RMG will be asked to consider an increased risk from possible x moderate = 9 (high risk) to likely x moderate = 12 (high risk).

This risk is linked with risk 959 above. It differs in that whist the operating plans may not be delivered, there is the potential to offset the deficits by the use of non-recurring measures and therefore still achieve the control total. The actions to mitigate this risk are the same as for risk 959 above plus an increased focus on identifying further non recurring technical measures to be able to offset the potentially higher than forecast Divisional deficits.

Strategic Risks

Risk 416 – Risk that the Trust may not be able deliver the Trust's Financial Strategy

The Trust's Strategic Capital Programme and Medium Term Financial Plan (MTFP) requires a continued level of operating surplus and other funding including PSF to finance investments. The risks to delivery are:

1. The core control total surplus is not delivered, reducing the Trust's retained cash, including the loss of PSF, available for investment
2. The cost of capital schemes increases beyond that provided for, requiring the plan to be changed through reducing content, deletion or deferral of schemes or seeking alternative funding
3. Additional schemes identified requiring additional funding sources or re-prioritisation
4. External regulation on the use of Trust resources (this may include the requirement to share resources within an STP or restrictions on the use of cash surpluses)
5. Change in national financial strategy removing the PSF funding.

Controls in place include:

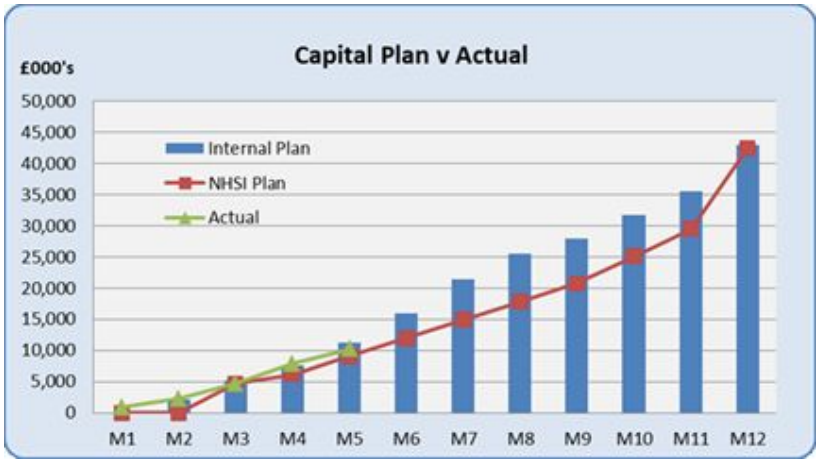
1. Delivery of the 2019/20 core control total through the controls described under risks 959 and 1843.
2. Effective control of the capital programme through CPSG.
3. Engagement at a national level regarding any proposed external regulation.
4. System working to manage and influence investment within the STP
5. Continued effective working relationship with charitable partners

The current risk is possible x moderate = 9, (high risk).

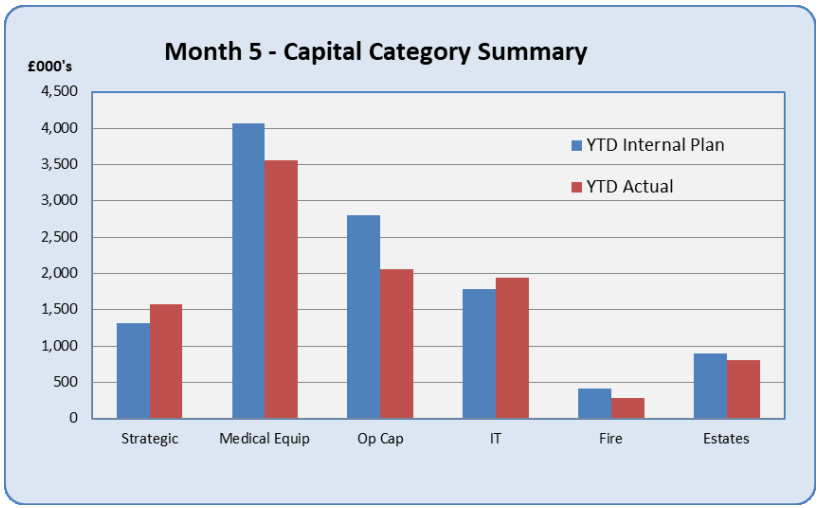
Actions to mitigate this risk are those referred to in the corporate risks above. In addition, the Trust will refresh the Medium Term Financial Plan at the beginning of 2020 in response to internal and external factors (including local and national developments).

An emerging risk is the financial risk of merger with Weston. The risk of adequate financial support to undertake the transaction and organisational change required as well as the ongoing risk of diluting UH Bristol's liquidity and financial strategy. The assessment of risk will be undertaken with the completion of the FBC and will be considered by RMG at quarter three.

Section 8 - Capital Programme



Programme Analysis



Key Points

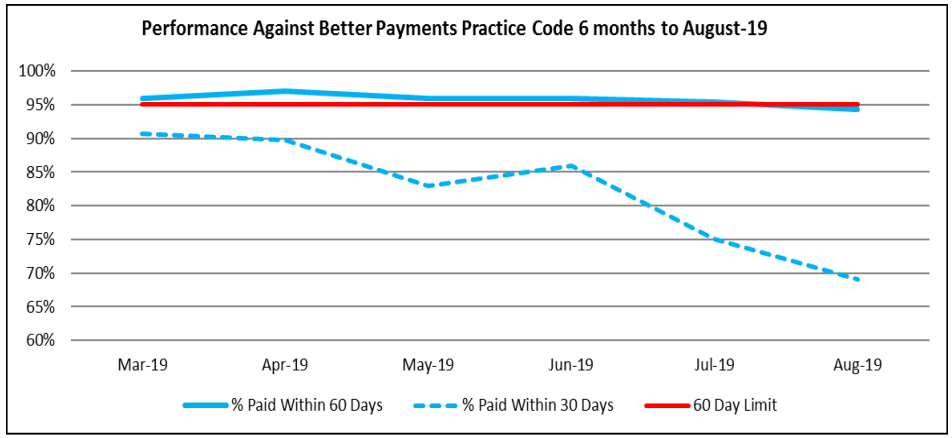
- The revised NHSI/E capital plan included a forecast spend of £42.457m with £9.077m planned to be spent by the end of August.
- The quarterly reforecasting exercise is currently in progress with submissions required by the end of September. The internal plan and forecast outturn positon, including slippage into 2020/21, will be updated accordingly and reported in month six.
- At 31st August capital expenditure is £10.229m against a profiled internal plan of £11.276m, £1.047m behind plan.
- The Programme Analysis chart shows the key variances against plan with medical equipment and operational capital behind plan by £0.506m and £0.737m respectively and strategic schemes £0.257m.ahead of plan.
- The variance on medical equipment primarily relates to procurement gains with the operational capital variance due to a small number of schemes slipping against the original profile.
- The fire improvement programme is split into two phases and the profile in the Programme Analysis chart reflects Phase 1. Whilst the works are in progress the scheme is subject to delays owing to unforeseen asbestos works, availability of areas whilst minimising operational impact and the lead time on delivery of fire doors. In order to ensure the programme completes on plan, by April 2021, phase 2 is expected to commence prior to phase 1 completing.

Section 9 – Statement of Financial Position and Cashflow

Prior year closing 31 March 2019 £000's		Current month plan 31 August 2019 £000's	Current month actual 31 August 2019 £000's	Variance 31 August 2019 £000's
	Current assets			
11,406	Inventories	11,406	11,052	(354)
68,610	Trade and other receivables	51,072	42,105	(8,967)
99,855	Cash	114,634	127,950	13,316
179,871	**Total current assets**	**177,112**	**181,107**	**3,995**
	Current liabilities			
(83,159)	Trade and other payables	(83,554)	(81,535)	2,019
(6,925)	Borrowings	(6,215)	(6,191)	24
(184)	Provisions	(184)	(191)	(7)
(5,311)	Other liabilities	(2,142)	(6,436)	(4,294)
(95,579)	**Total current liabilities**	**(92,095)**	**(94,353)**	**(2,258)**
84,292	**Net current assets / liabilities**	**85,017**	**86,754**	**1,737**

- The net current assets at 31 August 2019 were £86.754, £1.737m higher than the NHSI plan; current assets and liabilities were higher by £3.995m and £2.258m respectively.
- The Trust's cash and cash equivalents balance was £127.950m, £13.316m higher than plan. The higher cash balance primarily relates to slippage on the capital programme, income from Health Education England, now received quarterly in advance, and movement on accrued income.
- The total value of debtors was £25.926m a decrease in month of £12.348m. Furthermore, the Trust received £10.020m in September for invoices outstanding at 31 August.
- Debts over 90 days old decreased by £1.936m to £5.568m, 21.5% of total debts, with the significant debtor balances continuing to be actively reviewed by the Service Agreements Team, Finance Project Manager and Head of Transaction Services

Payment Performance



- In August, 96% of invoices were paid within the 60 day target set by the Prompt Payments Code and 69% were paid within the 30 day target set by the Better Payment Practice Code.
- Performance is below target and trend as the Accounts Payable team continue to focus on clearing aged invoices (>60 days) in month resulting in a steady drop in pre 2019 supplier queries. In August 4,537 of the 13,884 invoices paid were over 30 days compared to an average of 1,977.

UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST

Finance Report August 2019– Summary Income & Expenditure Statement

Approved Budget / Plan 2019/20	Heading	Position as at 31st August			Actual to 31st July
		Plan	Actual	Variance Fav / (Adv)	
£'000		£'000	£'000	£'000	£'000
	Income				
625,019	From Activities	261,509	256,368	(5,141)	207,264
94,162	Other Operating Income (excluding PSF & MRET)	40,095	39,693	(402)	31,898
719,181	**Sub totals income**	**301,604**	**296,061**	**(5,543)**	**239,162**
	Expenditure				
(415,801)	Staffing	(175,362)	(178,483)	(3,121)	(143,131)
(250,961)	Supplies and Services	(103,657)	(101,682)	1,975	(81,806)
(666,762)	**Sub totals expenditure**	**(279,019)**	**(280,165)**	**(1,146)**	**(224,937)**
(13,665)	Reserves	(4,442)	–	4,442	–
–			–	–	–
38,754	Earnings before Interest,Tax,Depreciation and Amortisation	**18,143**	**15,896**	**(2,247)**	**14,225**
5.39	**EBITDA Margin – %**		**5.37**		**5.95**
	Financing				
(23,939)	Depreciation & Amortisation – Owned	(9,854)	(9,911)	(57)	(7,937)
244	Interest Receivable	102	352	250	271
(216)	Interest Payable on Leases	(90)	(90)	–	(72)
(2,300)	Interest Payable on Loans	(985)	(985)	–	(789)
(9,950)	PDC Dividend	(4,145)	(4,146)	(1)	(3,317)
(36,161)	**Sub totals financing**	**(14,972)**	**(14,780)**	**192**	**(11,844)**
2,593	NET SURPLUS / (DEFICIT) before Technical Items excluding PSF & MRET	**3,171**	**1,116**	**(2,055)**	**2,381**
9,576	Provider Sustainability Funding (PSF) – Core	2,712	2,712		2,074
646	Marginal Rate Emergency Tariff (MRET)	270	270		216
	Prior year PSF post accounts reallocation		710	710	710
12,815	SURPLUS / (DEFICIT) before Technical Items including PSF & MRET	**6,153**	**4,808**	**(1,345)**	**5,381**
	Technical Items				
3,800	Donations & Grants (PPE/Intangible Assets)	250	913	663	715
(888)	Impairments	–	–	–	–
–	Reversal of Impairments	–	–	–	–
(1,590)	Depreciation & Amortisation – Donated	(655)	(675)	(20)	(540)
14,137	SURPLUS / (DEFICIT) after Technical Items including PSF & MRET	**5,748**	**5,046**	**(702)**	**5,556**

Approved Budget / Plan 2019/20	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 PSF & MRET)											
621,114	Contract Income	258,690	258,690	-	-	-	-	-	-			
-	Penalties	-	16	-	-	-	16	16	25			
-	Contract Rewards	-	40	-	-	-	40	40	58			
-	Overhead share of income variance	-	(1,103)	-	101	(710)	(494)	(1,103)	(410)			
35,755	NHSE Income	14,898	14,898	-	-	-	-	-	-			
656,869	**Sub Total Corporate Income**	**273,588**	**272,541**	-	**101**	**(710)**	**(438)**	**(1,047)**	**(327)**			
	Clinical Divisions											
(59,884)	Diagnostic & Therapies	(25,118)	(25,446)	386	(333)	2	(383)	(328)	(66)	206	(534)	(86)
(85,604)	Medicine	(35,891)	(37,113)	(1,555)	723	-	(390)	(1,222)	(701)	(314)	(908)	(648)
(118,493)	Specialised Services	(48,694)	(48,867)	(572)	716	18	(335)	(173)	82	114	(287)	231
(117,900)	Surgery	(49,404)	(52,164)	(965)	413	(70)	(2,138)	(2,760)	(1,867)	(383)	(2,377)	(659)
(137,397)	Women's & Children's	(57,441)	(58,470)	(834)	481	26	(702)	(1,029)	(534)	217	(1,246)	(93)
(519,278)	**Sub Total - Clinical Divisions**	**(216,548)**	**(222,060)**	**(3,540)**	**2,000**	**(24)**	**(3,948)**	**(5,512)**	**(3,086)**	**(160)**	**(5,352)**	**(1,255)**
	Corporate Services											
(40,376)	Estates and Facilities	(16,678)	(16,744)	57	(59)	0	(64)	(66)	(24)	2	(68)	68
(32,490)	Trust Services	(13,179)	(13,154)	225	(172)	(28)	-	25	17	(14)	39	(4)
(12,306)	Other	(4,598)	(4,687)	136	106	(351)	20	(89)	(37)	42	(131)	-
(85,172)	**Sub Totals - Corporate Services**	**(34,455)**	**(34,585)**	**418**	**(125)**	**(379)**	**(44)**	**(130)**	**(44)**	**30**	**(160)**	**64**
(604,450)	**Sub Total (Clinical Divisions & Corporate Services)**	**(251,003)**	**(256,645)**	**(3,122)**	**1,875**	**(403)**	**(3,992)**	**(5,642)**	**(3,130)**	**(130)**	**(5,512)**	**(1,191)**
(13,665)	Reserves	(4,442)	-	-	4,442	-	-	4,442	2,970			
(13,665)	**Sub Total Reserves**	**(4,442)**	-	-	**4,442**	-	-	**4,442**	**2,970**			
38,754	**Earnings before Interest,Tax,Depreciation and Amortisation**	**18,143**	**15,896**	**(3,122)**	**6,418**	**(1,113)**	**(4,430)**	**(2,247)**	**(487)**			
	Financing											
(23,939)	Depreciation & Amortisation - Owned	(9,854)	(9,911)	-	(57)	-	-	(57)	(61)			
244	Interest Receivable	102	352	-	250	-	-	250	190			
(216)	Interest Payable on Leases	(90)	(90)	-	-	-	-	-	-			
(2,300)	Interest Payable on Loans	(985)	(985)	-	-	-	-	-	-			
(9,950)	PDC Dividend	(4,145)	(4,146)	-	(1)	-	-	(1)	1			
(36,161)	**Sub Total Financing**	**(14,972)**	**(14,780)**	-	**192**	-	-	**192**	**128**			
2,593	**NET SURPLUS / (DEFICIT) before Technical Items excluding PSF & MRET**	**3,171**	**1,116**	**(3,122)**	**6,610**	**(1,113)**	**(4,430)**	**(2,055)**	**(359)**			
9,576	Provider Sustainability Funding (PSF) - Core	2,712	2,712	-	-	-	-	-	-			
646	Marginal Rate Emergency Tariff (MRET)	270	270	-	-	-	-	-	-			
	Prior year PSF post accounts reallocation		710	-	-	710	-	710	710			
10,222	**Sub Total PSF & MRET**	**2,982**	**3,692**	-	-	**710**	-	**710**	**710**			
12,815	**SURPLUS / (DEFICIT) before Technical Items including PSF & MRET**	**6,153**	**4,808**	**(3,122)**	**6,610**	**(403)**	**(4,430)**	**(1,345)**	**351**			
	Technical Items											
3,800	Donations & Grants (PPE/Intangible Assets)	250	913	-	-	663	-	663	465			
(888)	Impairments	-	-	-	-	-	-	-	-			
-	Reversal of Impairments	-	-	-	-	-	-	-	-			
(1,590)	Depreciation & Amortisation - Donated	(655)	(675)	-	(20)	-	-	(20)	(16)			
1,322	**Sub Total Technical Items**	**(405)**	**238**	-	**(20)**	**663**	-	**643**	**449**			
14,137	**SURPLUS / (DEFICIT) after Technical Items including PSF & MRET**	**5,748**	**5,046**	**(3,122)**	**6,590**	**260**	**(4,430)**	**(702)**	**800**			

Meeting of the Board of Directors in Public on Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Governors' Log of Communications**
Report Author	**Kate Hanlon, Membership Engagement Manager**
Executive Lead	**Jeff Farrar, Chair**

1. Report Summary

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.

2. Key points to note
(Including decisions taken)

Since the last Board, the one question waiting for a response has been answered.

3. Risks
If this risk is on a formal risk register, please provide the risk ID/number.

None

4. Advice and Recommendations
*(Support and Board/Committee decisions requested)***:**

- This report is for **INFORMATION.**
- The Board is asked to **NOTE** the report**.**

ID	Governor Name		
226	Garry Williams	***Theme:*** Plastic waste	***Source:*** From Constituency/ Members

Query **16/07/2019**

What is the Trust doing about plastic pollution – is it proactively reducing and reusing, or recycling? Is the Trust prudent in its use of natural resources to lessen its impact on our environment?

Division: Trust-wide ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:*** 30/07/2019

Response **11/09/2019**

Reducing
• Gloves – trialling an education programme to reduce the overuse of gloves in a clinical setting.
• Catering:
  o Stopped buying plastic straws.
  o Replaced plastic cutlery and stirrers with wooden equivalent (beech).
  o The three Brewnells outlets with seating are using crockery as opposed to disposables.
  o Discount is offered at all Brewnells when using your own/bought reusable cup.
• Pharmacy are transitioning from using plastic bags for pharmaceuticals to paper bags.
• Audit of all Trust water stations to make sure they are mains fed and not bottle fed; signs encouraging people to refill their bottles, not buy bottled water; and sites to be added to the Refill Bristol website.
Reusing
• Working with partners to reuse as much office furniture as possible whether we give them unwanted furniture, saving on the environmental and financial costs of disposal – or they give us furniture, saving us procuring new items.
Recycling
• Introducing recycling bins into public areas.
• Trust owned cafes – Brewnells:
  o Food containers changed from polystyrene to recyclable material.
  o Takeaway cup lids are recyclable.
• Working with partners to recycle various plastic clinical waste items.

Our staff engagement programme, The Green Impact Awards, also actively encourages staff to use resources efficiently and think about alternatives to plastic.

Status: *Awaiting Governor Response*

Meeting of the Board of Directors in Public on
Friday 27 September 2019 in the Conference Room, Trust Headquarters

Report Title	**Annual Report for the South Wales and South West Congenital Heart Disease Network**
Report Author	**Cat McElvaney, Congenital Heart Disease Network Manager**
Executive Lead	**William Oldfield, Medical Director**

1. Report Summary

The Congenital Heart Disease Network Annual Report 2018/19 sets out the key achievements of the network in its third year of operation, the key priorities for future years, and identifies risks to the delivery of NHS England's CHD standards.

2. Key points to note

(Including decisions taken)

Background

The Congenital Heart Disease (CHD) standards were agreed by NHS England in July 2015 mandating that all CHD care be delivered through formal networks. The South Wales and South West Congenital Heart Disease Network was established in April 2016.

Hosting and Oversight:

The network, which functions as an operational delivery network, is hosted by UH Bristol and funded by NHS England. The network reports quarterly to the Senior Leadership Team and Joint Cardiac Board at UH Bristol. In addition it formally reports to NHS England and NHS Welsh Health Specialised Services Committee (WHSSC) on a quarterly basis.

3. Risks

If this risk is on a formal risk register, please provide the risk ID/number.

The risks associated with this report include:

There are 6 key risks on the networks formal risk register as outlined in the annual report (pg12)

4. Advice and Recommendations

*(Support and Board/Committee decisions requested)***:**

- This report is for **INFORMATION**
- The Board is asked to **NOTE** the report

5. History of the paper

Please include details of where paper has previously been received.

Senior Leadership Team	21st August 2019

South Wales and South West
Congenital Heart Disease Network

Annual Report

2018/19

GIG CYMRU NHS WALES

NHS

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Annual Report

Introduction from the clinical director

Welcome to the third annual report for the South Wales and South West Congenital Heart Disease (SWSW CHD) Network, 2018/19.

It has been a particularly busy year for the team for a variety of reasons. There have been core changes to the team. Caitlin Moss left us for her new role as deputy divisional director for strategy and planning, women's and children's services at Bristol Royal Hospital for Children. I am delighted to welcome Cat McElvaney, who takes the helm as our network manager, bringing a wealth of experience. Our administrative support has also been enhanced by the appointment of Morwenna Bugg. Yet again I was pleased to experience a seamless transition during these personnel changes as our work continued without interruption.

I am pleased to be reappointed to serve as clinical director for the next three years. Within the network, we have seen a number of senior consultants retire, whilst we welcome the next generation. Nationally, we continue to be heavily involved in the formation of a "network of CHD networks" community throughout the UK since launching the concept in 2017.

NHS England (NHSE) has recently declared us an operational delivery network. This is an important milestone for us as well as for the other CHD networks emerging around the country. We continue to provide mutual support to these networks and learn from each other as we develop.

We, along with all the congenital heart networks throughout the UK, prepared for an NHSE peer review of our level one and level two services. I would like to thank and congratulate all the contributors who helped to collate the evidence we were asked to provide. This was a mammoth but worthwhile task. I was also very proud to hear colleagues voice how the network team had made a positive impact to services in South Wales and South West England. We were delighted to hear preliminary comments describing our network as an exemplar. A NHSE report by the quality surveillance team will be published later this year.

I am particularly grateful to our senior dental colleagues, Mick Allen and Rosie Power, for their excellent work on developing a dental pathway for our patients across all ages within the entire network. This has been a key piece of work and I congratulate them for this major contribution.

We continue, first and foremost, to be guided by our patient experiences and outcomes and Frankie Carlin is no exception. Please read her story on page 17 and perhaps, like her, become inspired to get involved yourself. We will be enhancing patient and public voice involvement with specific training sessions in the coming year.

There is still much work to be done for us to achieve the 2021 NHS England standards. The team looks forward to continuing the positive and collective engagement with all our partners across the network in the year to come.

This report celebrates our achievements whilst recognising the many challenges that help to form our work plan for the future.

Dr Andrew J P Tometzki
Clinical director
South Wales and South West Congenital Heart Disease Network

Background

The South Wales and South West Congenital Heart Disease Network (SWSW CHD) was officially formed in April 2016. The network brings together clinicians, managers, patient and family representatives, and commissioners from across South Wales and South West England to work together supporting patients with congenital and paediatric acquired heart disease and their families. The network covers a broad geographical area of South Wales and South West England (Aberystwyth to the Isles of Scilly), as outlined in figure one, with a population of approximately 5.5M people. This network is accountable to two separate commissioning bodies: NHS England and NHS Wales.

The network comprises:

- 17 adult and 19 paediatric providers, covering level one (specialist surgical), level two (specialist medical) and level 3 three (local centre) services
- over 6,500 children and 8,000 adults with congenital heart conditions

Figure one: South Wales and South West CHD network centres

Our vision

Our vision is to be a network whereby:

- Patients have **equitable access** to services regardless of geography
- **Care is provided seamlessly** across the network and its various stages of transition (between locations, services and where there are co-morbidities)
- **High quality care** is delivered, and participating centres meet national standards of CHD care
- The provision of **high quality information** for patients, families, staff and commissioners is supported
- There is a strong and **collective voice** for network stakeholders
- There is a strong culture of collaboration and action to **continually improve** services

Our objectives

Our objectives were developed in collaboration with stakeholders from across the network and underpin a detailed work plan overseen by the network team. They are:

- To provide **strategic direction** for CHD care across South Wales and the South West
- To monitor and drive improvements in **quality of care**
- To support the delivery of **equitable, timely access for patients**
- To support improvements in **patient and family experience**
- To support the education, training and development of the **workforce** within the network
- To be a central point of **information and communication** for network stakeholders
- To ensure it can **demonstrate the value** of the network and its activities

Meet the network management team

Pictured left to right: Dr. Andrew Tometzki (CHD network clinical director), Dr. Vanessa Garrett (clinical psychologist) (top row), Cat McElvaney (CHD network manager), Sheena Vernon (CHD network lead nurse), Morwenna Bugg (network support manager) (bottom row).

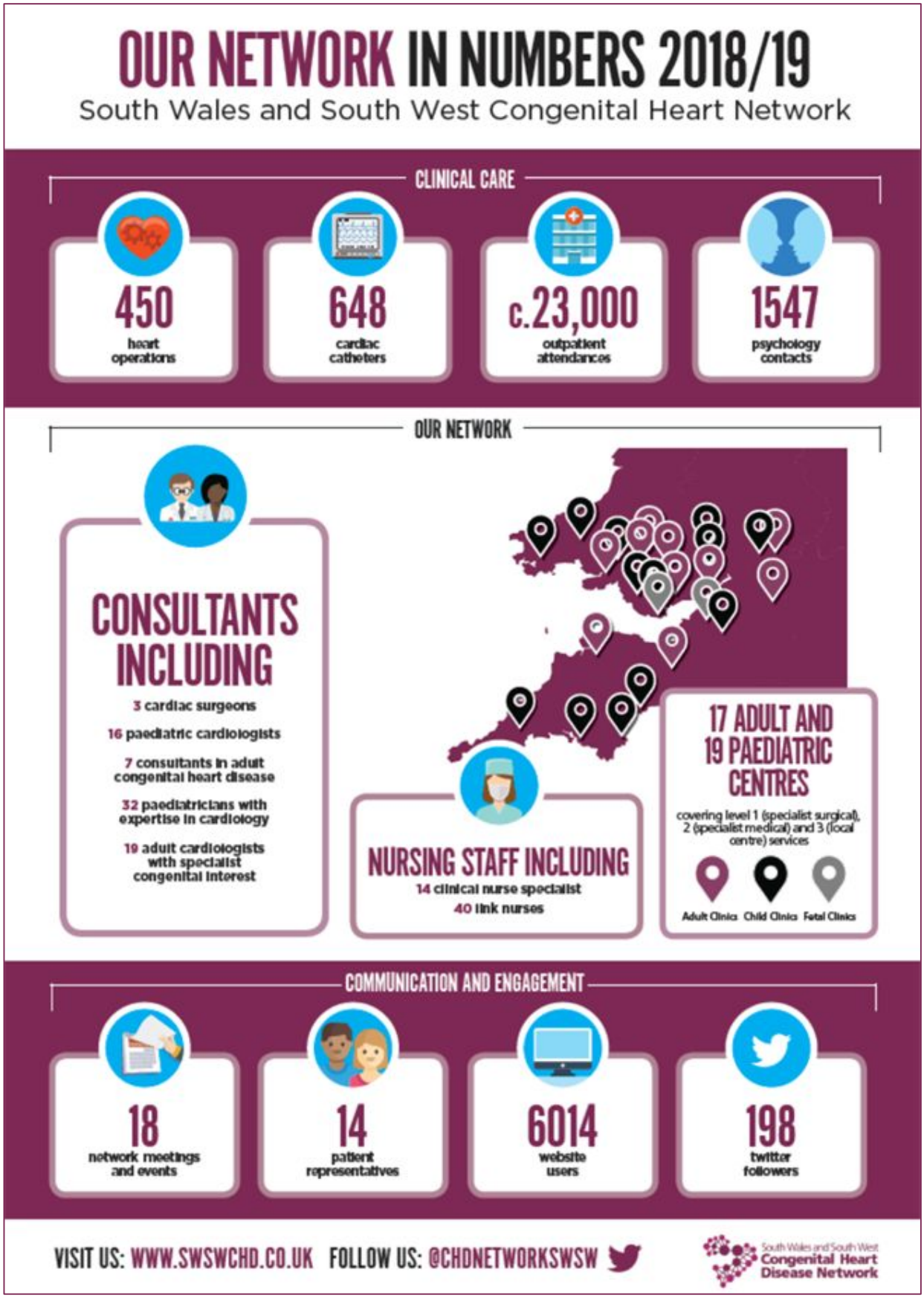
The network management team was established in April 2016, comprising initially of the network clinical director, network manager and administrator, with the network lead nurse joining the team in October 2016. In 2018, a new role of network support manager, following a skill mix review of the network team, was created and recruited to. This has enabled us to place greater focus on enhancing communication and engagement within the network. The key priorities and work of the network team is determined by the network board. It is responsible for ensuring that the activities of the network staff are in line with agreed network priorities and are working towards the achievement of CHD standards.

Our network clinicians

We have a large number of clinicians providing CHD care across the South Wales and South region. This will include:

- Three cardiac surgeons
- 16 paediatric cardiologists and 39 paediatricians with expertise in cardiology
- Seven cardiologists in adult congenital heart disease and 19 cardiologists with a special interest in adult congenital heart disease (ACHD)
- 14 clinical nurse specialists and 40 link nurses
- Four specialist clinical psychologists

To find out more about the clinicians in our network, please visit the “Our hospitals” section of our website (www.swswchd.co.uk).


OUR NETWORK IN NUMBERS 2018/19
South Wales and South West Congenital Heart Network
CLINICAL CARE
450
heart operations
648
cardiac catheters
c.23,000
outpatient attendances
1547
psychology contacts
OUR NETWORK
CONSULTANTS INCLUDING
3 cardiac surgeons
16 paediatric cardiologists
7 consultants in adult congenital heart disease
32 paediatricians with expertise in cardiology
19 adult cardiologists with specialist congenital interest
NURSING STAFF INCLUDING
14 clinical nurse specialist
40 link nurses
17 ADULT AND 19 PAEDIATRIC CENTRES
covering level 1 (specialist surgical), 2 (specialist medical) and 3 (local centre) services
Adult Clinics
Child Clinics
Fetal Clinics
COMMUNICATION AND ENGAGEMENT
18
network meetings and events
14
patient representatives
6014
website users
198
twitter followers
VISIT US: WWW.SWSWCHD.CO.UK
FOLLOW US: @CHDNETWORKSWSW
South Wales and South West Congenital Heart Disease Network

Key successes

The full details of our progress in 2018/19 and plans for 2019/20 are detailed in the work plan – review and plans section on page14. Our key successes in 2018/19 include:

Clinical

- Cohesive and comprehensive joint preparation for the **national CHD network peer review** (June 2019) by the network, level one adult and paediatric services and level two adult and paediatric services
- Development, approval and publishing of several **paediatric and adult CHD protocols**, recommended by NHS England for CHD and required for the national CHD peer review
- **Network wide dental standards for CHD care for adults** developed, approved and published. Paediatric CHD dental standards close to completion
- Excellent progress has been made in delivering **network drug protocols** for paediatric care
- Positive evaluation by patients of families of new transition clinics at Bristol Royal Hospital for Children (BRHC.) **Transition evening** for patients and families held at the Bristol Heart Institute (BHI), with around 50 people attending. Transition protocol updated and approved
- **Network nursing strategy** finalised and being implemented across the network, further nursing progress updates can be found on page 13
- **Link midwife** identified to participate in cardiac obstetric clinics
- **Network audit lead** in place (cardiologist based in Wales) and network audit programme to share learning and best practice in progress
- Network **morbidity and mortality meeting** held with 25 attendees from multi-professional groups around the region.

Patient, charity and support group engagement

- Continued development of **patient representative role** within network. Event for patient representatives held and positively evaluated. Patient representative role description and application form developed
- The network team worked with the local level three paediatricians supporting their **patient engagement evening** for Gloucester families in conjunction with the local parental support group
- Continued to build **partnerships with local and national charities** and support groups with a **CHD Charity day on** 3 October held to facilitate joint working between local cardiac charities
- Development and recruitment of a **youth worker role** for the BHI and broader region, supported by the charity Youth@Heart.

Research and education

- **Network training and education strategy** approved and implemented
- Continued development of resources for professionals on the **network website** and signposting to national and international training events (https://www.swswchd.co.uk/en/page/training-and-education)
- Delivery of multiple training events for network clinicians with excellent attendance and evaluation
- **Draft network research strategy** developed, including a programme of research activity, and shared with Network Board in March 2019.

Highlights from our centres

Network centres report to the network board on progress against delivery of the CHD standards for their areas. Highlights from these reports for 2018/19 are outlined below.

Level one: Bristol, specialist surgical centre

Adults

- Quality improvements in ACHD service, including pilot in ACHD cardiac rehabilitation, exercise ACHD echo service, Fontan associated liver disease pathway
- ACHD journal club established, which provides weekly communication between clinical and research teams
- Wide-ranging ongoing audit programme in progress for shared learning and best practice
- Same day outpatient clinic letter generation
- IT improvements, such as evolve (electronic patient record)
- Youth worker role recruited to adult service

Paediatrics

- New cardiology consultants recruited
- Approval to recruit to fourth surgeon post
- Additional clinics set up in Weston General Hospital and South Bristol Community Hospital
- Set up of Clinical Nurse Specialist anticoagulation service
- Received highest ever data quality indicator of 99% for reported clinical outcome and quality (NICOR) data
- Reduction of cardiac surgery waiting times an overall list

Level two: Cardiff, specialist medical centre

Adults

- Implementation of phase two of the South Wales ACHD service supported and included in the 2019/20 commissioning plan
- New cardiology outpatient department commissioned to support the ACHD service
- New cardiac MRI scanners in use, which provide greatly improved quality, enabling appropriate cardiac MRI scanning, image analysis and reporting
- Text reminder service implemented, resulting in a significant reduction in “did not attend”(DNA) rates (from 18% in 2017 to 10.5% in 2018)
- Investment in image exchange portal to enable electronic transmission of echo images to level one centre
- Systems developed and implemented to reduce patient lost in repatriation process to local health boards.

Paediatrics

- Organisation and delivery of successful Welsh paediatric and Welsh fetal cardiovascular network education conferences
- Recruitment of consultant to enhance fetal cardiology services
- Text reminder service implemented, resulting in a significant reduction in “did not attend”(DNA) rates (from 9.7% in 2017 to 6.6% in 2018)
- Reduction of referral to treatment waiting times within Cardiff and Vale University health board from 23 weeks in 2016/17 to 13 weeks in 2018/19
- Successful introduction of Careflow app, allowing Cardiff clinicians to view progress of Welsh patients admitted to Bristol Royal Hospital for Children
- Business case accepted in principle for Cardiff and Vale based clinical psychologist
- Teenage clinics successfully established at the Noah’s Ark Children’s Hospital

Level three: outreach clinics across South Wales and South West

Adults

- New ACHD consultant in post in Taunton
- Transition clinics set up in Taunton with establishment of link nurse role
- Developing and establishing link nurse role in level three centres across network
- Improved tracking of ACHD patients in general cardiology clinics

Paediatrics

- New consultant paediatrician with expertise in cardiology started in Plymouth
- Progressing cardiac link nurse 0.1 WTE in Torbay
- Reduction in waiting times for new patients in Taunton
- ECHO machine available at all times in Taunton paediatric department
- Physiologists in Taunton able to attend at least two clinics a month to support the PEC
- Urgent patients can be seen within one week on the paediatric assessment unit in Swindon. New patients whose cases are urgent are expedited for the visiting cardiologist
- Improved image storage under progress in Truro
- Recruitment drive in Truro to appoint consultant in substantive position to cover extra clinics provided by local paediatrician with expertise in cardiology (PEC) and paediatric cardiologist

Communication and engagement

Communicating and engaging with our patient and clinical colleagues has been an essential part of our work in our third year of operation. Key activities have included;

- Stakeholder engagement event held with multi-disciplinary team attendance from across the network
- Patient representative group established, inaugural event held which was very positively evaluated
- Promotion of CHD website (www.swswchd.nhs.uk) via posters, charity and support groups, and on clinic letters
- Network bi-annual newsletters published and circulated widely
- Weekly tweets with network updates, news from charity and support groups, and promotion of education and training events
- Event held for all local CHD charities and support groups to help facilitate relationship building and joint working
- Regular meeting established with NHS England specialist commissioners and welsh health specialised services committee (WHSSC), and attended by network team, level one and level two CHD clinical leads and managers
- Participation in a number of national forums such as the clinical reference group for congenital heart disease, British adult congenital nurses association meeting, national CHD networks group and the patient reported experience leads meeting
- The network team has attended and presented at a number of events and groups including the paediatric cardiac study day for community and ward nurses, paediatric critical care advanced module, WHSSC audit day, Cardiff patient engagement day and a number of team days including Dolphin ward and neonatal intensive care team away days.

Network team funding

The network team is funded by NHS England specialised commissioning. The pay budget was marginally underspent in 2018/19 due to gaps in recruitment into substantive posts. Recurring costs are expected to be in-line with the annual budget plan. There was an offset relating to non-pay budgets where there was a reported overspend of £799. The overall budget position was a reported underspend of £1,804 at the financial year end.

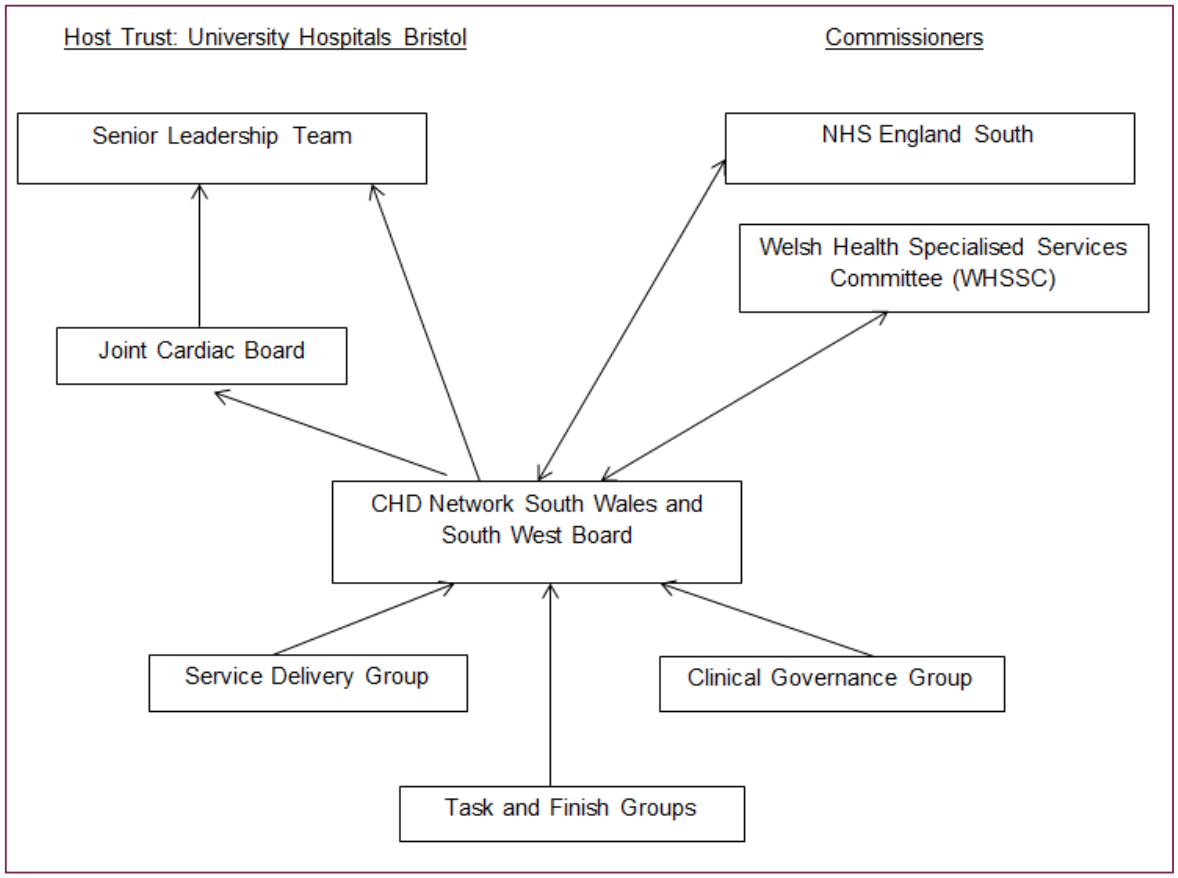
Network Funding	2018/19
Pay	
Pay total expenditure	£152,845
Pay budget	£155,448
Pay Variance	£2,603
Non Pay	
IT, phones & office	£9,980
Travel	£1,038
Network events	£2,826
Miscellaneous	£2,955
Non Pay Total Expenditure	£16,799
Non Pay Budget	£16,000
Non Pay Variance	-£799
Total Variance	£1,804

Update on network governance

The network is governed by the South Wales and South West (SWSW) CHD Network Board, which has representatives from across the level one, two and three centres, including clinicians, nurses, managers, patients and parent representative and commissioners. In 2018/19, it was agreed by the network board to change the configuration and governance of the network to include two subgroups; the network service delivery group (SDG) and the network clinical governance group (CCG). Each of these groups has key roles and responsibilities as outlined in the table below. The change in governance structure for the network was implemented to provide more opportunities for detailed discussions and more focussed work, to use members' expertise and interest more, and overall to have greater accountability within the network. This new structure will be evaluated by network members for effectiveness a year post implementation (October 2019).

Division of responsibilities for CHD SWSW Network groups		
Network board	**Network clinical governance group**	**Network service delivery group**
Overall responsibility Escalation of concerns Risk management Strategic direction Performance assurance Centres, commissioners, charity etc. updates	Education and training programme Incident management and learning Annual mortality and morbidity Audit programme Clinical pathways, protocols, guidance Patient leaflets and pathways	Standards & self-assessments performance and capacity Workforce issues The website and other technology projects Patient engagement and support groups Finance/tariffs

As illustrated below, the network board remains accountable to the joint cardiac board and senior leadership team at University Hospital Bristol NHS Foundation Trust (UH Bristol) as the host organisation; in NHS England to the specialised commissioning (South) oversight group; and in Wales to the Welsh health specialised services committee. This network covers two separate national health bodies: NHS Wales and NHS England. The network meets with representatives from both commissioning groups in a quarterly review meeting and at the Network Board to review key clinical quality outcome measures, progress against plan and any escalated risks and/or issues.



Key network risks

The network risk are recorded on the datix risk management system of its host organisation, University Hospitals Bristol. Risks are assessed and reviewed, and mitigations agreed, at the network board.

	Risk	Mitigation
1	Long-term workforce risk associated with a lack of consultants training with expertise in congenital cardiology, particularly in the adult services	Local clinicians are flagging the issues to their trust management teams, supported by network. Risk discussed at network board and actions agreed including to continue to link in with Health Education England and the CHD clinical reference group to understand any national strategy to address this.
2	Risk that network centres will be unable to identify or fund link nurses, reducing quality of service to patients	The network team working with local hospital teams to explore options. Draft finance guidance completed to help support trusts to develop this role. A link nurse development programme has been established.
3	Risk of cancelled cardiac operations due to paediatric intensive care unit (PICU) capacity pressures	A strategic outline business case for the Bristol Royal Hospital for Children (BRHC) expansion, including Paediatric Intensive Care Unit (PICU), was approved by UH Bristol in March 2019 to proceed to a full business case with more detailed costs and options. It is anticipated that the project could take five years or more to complete, and that planning permission will be a key challenge given the space constraints around the site.
4	Risk of inferior care being provided to patients in some parts of South Wales due to unequal investment in services	The 2019-22 WHSSC integrated commissioning plan has prioritised additional investment in the South Wales adult congenital heart disease service provided by Cardiff and Vale University health board. WHSSC is working with colleagues at Cardiff and Vale University health board to finalise the business case and it is anticipated that this will be submitted to WHSSC in July 2019. This investment will support the ACHD service in meeting the CHD standards.
5	Risk of not meeting the congenital heart disease standard for care around interventional cardiologist case numbers	Data on procedures and clinical outcomes is submitted to NICOR and reviewed on a regular basis by level one centre and NHS England to ensure clinical quality and patient safety. In 2019/20, specific actions and mitigations for the provider and commissioner have been agreed and these actions and mitigations will be jointly reviewed at the NHS quarterly CHD meeting.
6	Risk of failure to deliver of CHD standard relating to image sharing between organisations in the network	Survey has been conducted to scope out current IT system provision for image sharing across the network to understand feasibility of making improvements and working towards the standard.

Nursing update

In 2018/19, work has continued to **support link nurses** across the network, **developing resources** for them to use in the peripheral clinics. There still remains a challenge for link nurses to have allocated time for their role, which limits the opportunity for some to make progress and develop the role to support patients and families in outpatient clinics and during inpatients stays. Working in collaboration with Yorkshire and Humber's CHD Network, a **link nurse job description** has been written and presented at a national CHD network day. A **link nurse resource folder** has also been developed which contains national and international guidelines, toolkits, workbooks and information to support transition of patients to the adult services. This resource will be continually developed. There are opportunities for link nurses to visit level one and two centres to understand how the clinical service runs, meet the team and visit clinical areas.

Pictured; Sheena Vernon, Network Lead Nurse

The clinical nurse specialist (CNS) teams have been focussing on providing care at the fetal clinics, delivering a comprehensive transition service across from Bristol Royal Hospital for Children to the Bristol Heart Institute, and in the young people's clinics in a number of level three centres. Work is ongoing to increase the CNS team numbers across the network. A **level one and two CNS day** takes place every six months with the most recent one held in January 2019. This provided an opportunity for teams to discuss their recent challenges and achievements; to get updates on preparation for the forthcoming peer review, a session on joint working between Dolphin ward and Pelican ward and an update on local charity activity. The day was well evaluated, with those attending finding it particularly beneficial to network and share best practice.

The **Bristol Royal Hospital for Children cardiac link nurses meetings** take place bi-monthly and enables all nurses caring for cardiac patients to discuss clinical issues, share best practice and ideas. Outcomes of that meeting have included work by the neonatal intensive care (NICU) nurses to design a, **'calling card'** with the contact details of the cardiac clinical nurse specialists on it. This can be left for parents if they are not with their baby when the nurse visits, making it easier for the parents to then make contact with them if needed. Transfers of babies from NICU to Bristol Royal Hospital for Children can often cause significant anxiety for new parents .To help support parents during this time, the NICU nurses are drafting a leaflet for parents, explaining how the transfer of their baby will take place. The link nurse meeting has also provided an opportunity to raise awareness of the CHD network workplan, and of the CHD Network website (www.swswchd.nhs.uk) and resources, so nursing staff are able to direct patients and families to the appropriate help and support.

Education opportunities and other specific resources from clinical areas are shared so that all the nurses in the network can benefit. A similar meeting takes place in the Bristol Heart Institute, where nurses from all clinical areas meet on a regular basis to discuss similar issues, sharing learning and best practice. In 2018/19, we have benefited from our **link cardiac midwife** who has supported the cardiac antenatal clinics, providing additional advice, information and support to mothers with congenital heart disease. In Taunton, the ACHD nurse has been able to provide support to the ACHD clinic and also has worked with the paediatric link nurse to support the **first transition clinic** in the children's services. It is hoped this model will be replicated in Exeter this year.

This year, a number of education opportunities for nurses have included attending **cardiac courses** and the **community and ward nurse days** delivered by the faculty of children's nurse education in Bristol, and the adult congenital heart disease study day, which over 90 people attended. In 2018/19, a key role for a number of nurses has also been involvement in supporting local cardiac charities with the aim of raising their profile in clinical areas and supporting more joined-up activities between these groups.

Work plan – 2018/19 review and plans for 2019/20

Key objective	Successes in year 3 (2018/19)	Aims for year 4 (2019/20)
To provide strategic direction for CHD care across South Wales and South West England	- New network governance structure implemented - Engagement with key national and local groups including Clinical Reference Group (CRG), British Adult Congenital Cardiac Nurses Association (BACCNA), British Congenital Cardiac Association (BCCA), CHD national networks group and local non-CHD group - Draft finance guidance produced for centres - Support provided to develop and complete the successful strategic outline case for expansion of the BRHC, which would include a PICU expansion. - Quarterly review meetings with NHS England and WHSSC established	- Strengthen engagement with level three centres with visits to include update of self-assessments, priorities and challenges - Formal commitment from participating network member organisations / memorandum of understanding - Support centres to understand current income and appropriate tariffs for provision of CHD services - Continue to engage with clinical reference groups, NHS England, WHSSC - Actively participate in national CHD networks event and local (non-CHD) networks meeting - Evaluation of network governance structure and implementation of network board agreed outcomes
To monitor and drive improvements in quality of care	- Several paediatric and adult CHD protocols, recommended by NHS England for CHD are now complete - Excellent progress made in delivering network drug protocols for paediatric care - Nursing strategy finalised and being implemented across the network - Network-wide dental standards for CHD care for adults completed and paediatrics being finalised - Network-wide clinical incident shared learning session at network clinical governance group in March 2019 - Network audit lead in place (a cardiologist based in Wales). Work is underway collating audit information across network with plan to share completed audit results at future network clinical governance meetings - Network morbidity and mortality meeting held in Taunton in September 2018, with 25 attendees from multi-professional groups around the region - very positively evaluated - Task and finish group set-up to focus on improving discharge communications from the level one centre in Bristol to regional partners, aiming to improve current processes and timeliness of correspondence	- Implement recommendations of national CHD network peer review - Agree requirements for paediatric disease-related guidance and paediatric drug protocols - Finalise paediatric dental pathway - Continue to support level one and two centres to address amber and red standards - Continue to capture risks on network register and take action to manage or mitigate risks - Promote incident reporting processes. Ensure any learning from incidents is shared - Continue to support improvements in communications to the network following discharge from level one centre - Set up and facilitate fetal working group, with clear terms of reference and action plan - Support network audit lead to run network audit programme with minimum of two audits per annum presented to network to share learning - Continue to deliver annual network mortality and morbidity event - Take forward key elements of network nursing strategy, namely; closer working between levels one and two CNS teams; direct engagement with known level three link nurses and senior nurses/matrons

To support the delivery of equitable, timely access for patients	- Published psychology toolkits available on network website - Palliative care toolkit published on the network website - Support provided to Welsh adult CHD teams to complete phase II business case for WHSSC. Case approved in principle. - Transition protocol has been developed and approved - Continued work to strengthen transition processes within the network - Network performance dashboard regularly reviewed and discussed at network board	- Use published fetal datasets to understand variations in fetal identification and implement actions to address these - To develop better mechanisms for sharing patient information, images and access for MDTs. - Continue to promote awareness of, and access to, regional psychology service and available resources - Evaluate transition clinics at BRHC and young adult clinics in BHI. Consider peripheral transition opportunity. Scope out feasibility of monitoring lost to follow-up ratios - Continue to produce quarterly performance dashboard. Review centres' submissions and offer support and/or seek assurance or escalate concerns - Finalise network-wide transfer and repatriation policy - Continue to support level two centre and commissioners to support phase II investment in Wales
To support improvements in patient and family experience	- Supported successful patient engagement evening for Gloucester families in conjunction with the local parental support group - PREMs surveys promoted across the level one centre to increase response rate (currently on-hold nationally) - Work undertaken to support Youth@Heart with the development of a youth worker role for the BHI and broader region - Continued development of patient representative role within network – meeting for patient representatives held in November 2018 and positively evaluated. Job description and application form developed - CHD Charity day held in March 2019 to facilitate joint working between local cardiac charities	- Continue to work with charity stakeholders and support groups, clarifying relationship and opportunities. Try to encourage fair access across the region - Continue to build on existing relationships with patient representatives. Develop programme of activity. Recruit further representatives - Support centres with local patient engagement events and try to encourage events that allow equal geographical access across the region
To support the education, training and development of the workforce within the network	- Network training and education strategy approved and implemented - Continued development of resources for professionals on the network website and signposting to national and international training events - Annual training day held for paediatricians with expertise in cardiology and annual ACHD study day held - Draft network research strategy developed and programme of research activity shared with network board in March 2019	- Support the delivery of targeted training and education to cover: ACHD and paediatric nurse training, PEC and ACHD study days. Continue to signpost training and education events to network members in line with strategy. Continue involvement with development of national nurse e-learning packages - Continue to support recruitment of medical workforce as needed. Continue to engage with relevant regional bodies on big picture for e.g. Health Education England.) Develop promotion material to support recruitment into the region - Finalise network research strategy. Continue to build relationship with partners in research, seeking information on current research to populate the network central programme of research activity across the region and to update network members

To be a central point of information and communication for network stakeholders	- Bi-annual SWSW CHD newsletters completed - SWSW CHD network website updated (https://www.swswchd.co.uk/) and Twitter account launched (@CHDNetworkSWSW) - Successful network stakeholder day held in July 2018 in Bristol, with over 50 attendees from various stakeholder groups across the region. Positive evaluation received	- Continue to promote website, updating and improving as required. Continue with weekly tweets. Consider setting up Facebook account - Meet with interdependent clinical teams to encourage collaboration and build relationships - Deliver two newsletters per year - Continue to represent network at events, meetings and visits - Continue to use email databases for targeted communications - Deliver large stakeholder event every two years (next one July 2020)
To ensure it can demonstrate the value of the network and its activities	- Cohesive and collaborative preparation between the network level one and two centres for national CHD peer review - Successfully escalated issues in order to be collective voice of network and to influence strategic decisions - Annual report for 2017-18 completed - Successful core team away session held - Sought feedback on all-network events and listened to suggestions on how to improve (events generally well evaluated) - Network remained in budget	- Proactively seek funding opportunities for network and its stakeholders from different sources, such as CQUINs, charity, grants, tariff, commercial sponsorship of events - Continue to seek feedback from stakeholders on value of events and activities - Remain within budget and ensure effective use of resources - Hold team away day to reflect on 2019-20 progress, understand future opportunities and threats, and develop 2020-21 work plan - Complete annual report - Escalate network issues appropriately to commissioners and external bodies and ensure action is taken when required

Our patients and staff

Frankie Carlin, network patient representative

I was born with aortic valve problems and throughout my life I have had yearly appointments with a cardiologist. Over the last 20 years, I have undergone two open heart surgeries - the last one, a Ross Procedure performed in February 2017 in Bristol, was particularly brutal. It was very complex and, as a 'redo', recuperation was even harder. I had to undergo many procedures before and after both surgeries.

I can honestly say that without the support of the cardiac nurses in Cardiff, I wouldn't have recovered as quickly as I did from my recent surgery. Their constant support was invaluable, both before and after the operation. Bethan, the cardiac nurse, was in the room with us when we were being told about the complexity of the operation and the other options that were available. We were bombarded with a lot of information and after the consultation were a bit 'befuddled'. To be able to discuss it with Bethan, straight after the meeting and in follow-up phone calls, was invaluable and meant I didn't have to worry about 'wasting' the consultant's valuable time, whilst still being able to manage my own health.

This was to be the pattern throughout my visits to the hospital. Whenever I needed information, the nurses were there. No question was too trivial, and if they didn't know the answer, they would return my call or email as soon as they found out. ***They treated me as a person and not just a patient. I cannot emphasise enough how important this is when you are undergoing such a serious operation that is totally overwhelming.***

To not have to introduce and explain yourself every time you meet or phone someone is fantastic. To also have people who know your case, family, and circumstances is fabulous and helps with the whole treatment process.

From getting to know the nurses, I was asked to be a **patient representative** for the South Wales and South West CHD Network. I was delighted to take on this role and feel it's a huge honour to participate in meetings and give a patient's view. I have been a huge advocate for **cardiac patients being treated holistically**, as I feel that when you start to feel better physically is when you start to struggle mentally - and there was nowhere for me to turn. The cardiac nurses did what they could but there was no-one to be referred to. Through being part of the network, I have been able to suggest counselling throughout a patient's journey, which has been listened to. We have also tried to come up with ideas on how to 'spread the word' about the network and the continuing role of a patient representative. I have met and become friends with other patient representatives, which has been a bonus.

I am now back at work and trying to enjoy life to the full with my fantastic family and friends.

Susie Gage, lead paediatric cardiac pharmacist, Bristol Royal Hospital for Children.

I have been working as a paediatric pharmacist for the last 14 years. During this time, I have specialised in paediatric cardiology, cardiac surgery, general surgery, supported theatres and I can often be seen on the Paediatric Intensive Care Unit.

As a clinical pharmacist on the paediatric wards, I have a different role to what people may think is the 'traditional' role of the pharmacist. I am based on the wards and I am lucky to be part of the multi-disciplinary team; attending ward rounds.

On the wards, I check all medication prescribed; assessing the suitability of the formulation, the dose prescribed for the

appropriate indication, reviewing kidney and liver function for dose alterations, check for any drug or food interactions and suggest appropriate therapeutic drug monitoring. My main role is providing medicines information and education for nursing, medical staff and parents. In the last year I have become a non-medical independent prescriber, meaning I can prescribe medication for patients on the ward and for outpatients; this is a role I am hoping to develop further.

I was invited to attend a network meeting by Dr. Andy Tometzki, about a year and a half ago, and **I was inspired by the attitudes of members to improve the service across the network.** I was impressed by the inclusive nature of the network board and the desire for seamless care across the network with patients at the centre of decision. Since that meeting, I have become part of the network governance group and have been involved in the development of paediatric medication protocols for the network. I've been asked to present at various network days and I have been involved in subgroups to drive forward the service and outcomes of the network, whilst considering patient safety. Attending these meetings and speaking to clinicians around the region, has highlighted areas that could be improved. These include development of more guidelines in response to governance issues, better communication regarding medication supply problems and access to medications for patients in the community via their GP or local pharmacy. We hope that by co-ordinating this work it **will reduce duplication throughout the network, provide more seamless care and improved communication links locally, regionally and nationally,** as well as ensuring everyone has access and knowledge of the work that is being carried out.

Mick Allen, Consultant, special care dentistry, Aneurin Bevan University health board

I am a consultant in special care dentistry working with Aneurin Bevan University health board community dental services. I also work as a dental strategy advisor to Cardiff and Vale University health board and work with Wales Government. Special care dentistry is best described as caring for adults who cannot access dental care in the conventional sense because of one or more impairments which may be physical, mental, emotional, intellectual, societal or medical. There are similar dental specialists and consultants who work with children and young people. In respect of congenital heart disease, our role is to provide clinical care for more complex patients, often at the request of, and in liaison with, their cardiologist and to provide advice and leadership for other dentists who may want support in managing their patients who have congenital heart disease. **The aim is to ensure correct management is provided by the right person, at the right time, in the best setting and as conveniently as possible for people**. This may be by a dentist in a high street practice, a dentist within the community dental service, a specialist or consultant in a hospital or a community dental clinic. Other members of the dental team such as nurses with enhanced skills and dental therapists will be involved in providing preventative dental care. Dental managed clinical networks are being established to help provide these services.

I became involved with the CHD network because I enjoy a good working relationship with my cardiology colleagues and I have an interest in managing people with CHD and other associated conditions. My role has been to establish a small, specialist dental team, with my paediatric dentistry consultant colleague, Rosie Power, and to develop **dental care pathways**.

We have worked with the CHD network clinical director and the CHD network team to meet the described standards for dental services in relation to congenital heart disease. **These pathways should provide a framework for planning services for commissioning bodies, advice for dentists and help for patients.**

I see the future role of the dental team as being ready to provide updates to the care pathways as guidance changes and develops and also to provide an expert dental resource for the CHD network. The pathways will need to be evaluated and this will involve feedback from patients and dental teams in future.

Delivering continual progress

There are a number of key areas for centres to focus on in the coming year to continue to drive progress against the standards and continue to improve the quality of care we offer as a region to CHD patients

Link nurses	• Seek support in your Trust for the development of the **link nurse role**
Waiting list management	• Manage **waiting lists** effectively. Undertake **demand and capacity planning** for your service if required (We can support with this!) Complete your network performance report and flag up any issues
Education and training opportunies	• Make use of network and other **training opportunities** for staff
Escalate risks, issues and incidents	• Escalate any relevant **risks** or issues to the network team and engage with network **incident management** processes to ensure learning is shared
Image sharing	• Work with the network's IT contacts at the level one centre to ensure **image sharing** links are as good as they can be, and understand where future opportunities are
Annual audit	• Ensure one **annual audit** of clinical significance is completed each year and shared. Participate in network annual mortality and morbity event
CHD resources	• Access CHD resources as required, including network protocols, dental pathways, specialist psychology support, online wellbeing toolkits and support • Direct patients, families and staff to the **CHD Network website (**www.swswchd.nhs.uk).

How to get involved

There are many ways to get involved with the network:

Professionals can:

- Express interest in becoming a member of our board or join one of our task and finish groups'
- Attend one of our training events
- Take part in our annual morbidity and mortality meeting on 8 October 2019 in Bristol
- Come to our stakeholder day in July 2020 in Bristol.

Patients and families can:

- Visit our website (www.swswchd.co.uk)
- Sign-up to our newsletter mailing list
- Become a patient or parent representative for the network
- Attend one of our engagement events
- Come to our stakeholder day in July 2020 in Bristol.

For more information, please visit our website (www.swswchd.co.uk) or email morwenna.bugg@uhbristol.nhs.uk