University Hospitals Bristol NHS
NHS Foundation Trust

Agenda for a Council of Governors meeting to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough St, Bristol, BS1 3NU

Item	*Sponsor*	*Page*
1. Chairman's Introduction and Apologies To **note** apologies for absence received	Chairman	
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman	
3. Minutes from the Previous Meeting -To consider the minutes of the meeting of the Council of Governors on 30 July 2015 for **approval** -To consider the minutes of the Annual Members Meeting held on 15 September 2015 for **approval.**	Chairman	3 12
4. Matters Arising (Action Log) To consider the status of Actions from previous meetings	Chairman	21
5. Nominations and Appointments Committee report - To receive and **note** this report - To **adopt** the revised succession planning processes for Non-Executive Directors. - To **approve** the recommendation to extend Emma Woollett's term of office as Non-executive Director and Vice-Chair for a further 6 months i.e. until 30 November 2017.	Chairman	22 24 36
6. Governor Development Seminar report To receive and **note** this report.	Head of Membership and Governance	37
7. Governor Project Focus Groups reports To receive and **note** the following reports: a) Governors' Strategy Group b) Quality Focus Group c) Constitution Project Focus Group	Project Focus Group Governor Leads	39 41 43
8. Membership and Governor Engagement To receive the update reports on a) Membership Engagement, and b) Governor Activity to **note**.	Head of Membership and Governance	45 48
9. Governors' Meeting Dates 2016/17 To **approve** the governors' schedule of meeting dates 2016/17.	Head of Membership and Governance	56

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Item	*Sponsor*	*Page*
10. Governor Elections 2016 To **note** the timetable for the 2016 Governor Elections.	Head of Membership and Governance	58
11. Review of Governor Compliance To **note** the review of governor compliance.	Head of Membership and Governance	To follow
12. Governors' Log of Communications To **note** the current position of the Governors' Log of Communications	Chairman	60
13. Performance Update and Strategic Outlook a) **Chief Executive's report** To receive and **note** a verbal update from the Chief Executive b) **Quarterly Patient Experience and Complaints Reports** To receive and **note** these reports. c) **UH Bristol Children's Services Annual Report 2014/15** To receive and **note** this report.	Chief Executive Chief Nurse Chief Nurse	 68 To follow
14. Governors' Questions arising from the meeting of the Trust Board of Directors To respond to questions arising from matters of business discussed at the preceding meeting of the Trust Board of Directors, including quality and performance	Chairman	
15. Any Other Business To **note** any other relevant matters	Chairman	
16. Foundation Trust Members' Questions To **receive** questions from Foundation Trust members and members of the public present (preferably notified in advance of the meeting).	Chairman	
Meeting Close and Date of Next Meeting The next meeting of the Council of Governors will be held at 14:00 on Friday 29 January 2016 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.		

University Hospitals Bristol NHS
NHS Foundation Trust

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Minutes of the Council of Governors Meeting held on 30 July 2015 at 2:00pm in the Conference Room, Trust Headquarters, Marlborough Street, BS1 3NU

Present:
John Savage – Chairman
Ben Trumper – Lead Governor and Staff Governor
Bob Bennett – Public Governor
Clive Hamilton – Public Governor
Brenda Rowe Public Governor
Mo Schiller – Public Governor
Sue Silvey – Public Governor
Tony Rance – Public Governor
Tony Tanner – Public Governor
Sylvia Townsend – Public Governor
Sue Milestone – Patient/Carer Governor
Lorna Watson – Patient/Carer Governor
Angelo Micciche – Patient Governor
Ray Phipps – Patient Governor
Anne Skinner – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Ian Davies – Staff Governor
Thomas Davies – Staff Governor
Karen Stevens – Staff Governor
Florene Jordan – Staff Governor
Jeanette Jones – Appointed Governor
Sue Hall – Appointed Governor
Bill Payne – Appointed Governor
Tim Peters –Appointed Governor

In Attendance:
Robert Woolley – Chief Executive
Deborah Lee – Deputy Chief Executive and Chief Operating Officer
Sean O'Kelly – Medical Director
Paul Mapson –Director of Finance & Information
Sue Donaldson – Director of Workforce and Organisational Development
James Rimmer – Director of Strategy and Transformation (outgoing)
Anita Randon – Interim Director of Strategy and Transformation (incoming)
Carolyn Mills – Chief Nurse
Emma Woollett – Non-executive Director
David Armstrong – Non-executive Director
Alison Ryan – Non-executive Director
Julian Dennis – Non-executive Director
Guy Orpen – Non-executive Director
Lisa Gardner – Non-Executive Director
Debbie Henderson – Trust Secretary
Amanda Saunders – Head of Membership and Governance
Sarah Murch – Membership and Governance Administrator (minutes)
Garry Williams – Foundation Trust Member

Bob Skinner – Foundation Trust Member

20/07/15 Chairman's Introduction and Apologies (Item 1)
The Chairman, John Savage, welcomed everyone to the meeting. Apologies had been received from Pauline Beddoes (Public Governor), Graham Briscoe (Public Governor), Edmund Brooks (Patient Governor), Mani Chauhan (Public Governor), Wendy Gregory (Patient – Carer Governor), Marc Griffiths (Appointed Governor), Philip Mackie (Patient Governor – Carer), Jim Petter (Appointed Governor), Jill Youds (Non-executive Director) and John Moore (Non-executive Director).

21/07/15 Declarations of Interest (Item 2)
In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the meeting agenda. It was noted that James Rimmer, Director of Strategy and Transformation, had been appointed interim Chief Executive of Weston Area Health Trust, and would be seconded from UH Bristol from the end of July until the end of March 2016. Governors wished James success in his new role.

There were no declarations of interest.

22/07/15 Minutes from Previous Meeting (Item 3)
Governors considered the minutes of the meeting of the Council of Governors on 30 April 2015 and approved them as an accurate record of the meeting. It was:

RESOLVED:
- **That the minutes of the meeting held on 30 April 2015 be approved as an accurate record of proceedings.**

23/07/15 Matters Arising/Action Log (Item 4)
The Action Log was noted.

24/07/15 Nominations and Appointments Committee report (Item 5)
Emma Woollett and Guy Orpen left the room for this item.

John Savage introduced this report. At their last meeting the Nomination and Appointments Committee had considered the annual appraisal papers for Emma Woollett and Guy Orpen. The Committee had recommended that the Council of Governors continue the appointment of Emma Woollett as Non-executive Director and Senior Independent Director, and re-appoint Guy Orpen for a second 3-year term of office as Non-executive Director. It was:

RESOLVED:
- **That the Council of Governors receive the report for approval.**
- **That the Council of Governors formally approve the recommendation to continue the appointment of Emma Woollett as Non-executive Director and Senior Independent Director, subject to annual review in line with the Monitor Code of Governance.**
- **That the Council of Governors approve the recommendation to re-appoint Guy Orpen for a second 3-year term of office as Non-executive Director as of 1st August 2015**

The Committee had also noted that the terms of office of both the Chairman and the Vice-Chair were due to expire in 2017 and had agreed that, in preparation for these vacancies, the Chairman and the Trust Secretary would draft a plan for recruiting Non-executive Observers.

Emma Woollett and Guy Orpen re-joined the meeting.

25/07/15 Governor Development Seminar report (Item 6)
Amanda Saunders, Head of Membership and Governance, introduced a report of the last Governor Development Seminar in June. There had been a positive discussion around workforce planning, for which she thanked Sue Donaldson, Director of Workforce and Organisational Development, and her team. There had also been further discussion on membership representation and engagement activity.

She added that details for the next Governor Development Seminar on 11 August would follow shortly, and that this session would be shorter than previously advised due to the number of apologies received. It was:

RESOLVED:
- **That the Council of Governors receive the Governor Development Seminar report for information**

26/07/15 Governor Groups Meeting reports (Item 7)

Written reports were circulated for all groups.

a) Governors' Strategy Group
As Wendy Gregory, Lead Governor for the Governors' Strategy Group, was absent, Amanda Saunders introduced this report. At the last meeting of the group, governors had received updates on the Trust's strategic implementation plan and business planning, and the Review of Operational Productivity in NHS Providers (Carter review).

Clive Hamilton, Public Governor, added that the group had suggested that the Trust's plan and consultation process incorporate more context of working with partners in the community. Robert Woolley, Chief Executive, added that a current example of positive collaboration was the Better Care Fund initiative to reduce emergency admissions (a system leadership group of NHS organisations and directors of social services). At the request of governors, he also provided clarification on Bristol City Council's role in the area of public health.

b) Quality Project Focus Group
Clive Hamilton, Lead Governor for the Quality Project Focus Group, introduced this report. The group's recent meetings had included regular items on Trust performance, histopathology and the Governors' Log of Communications, and talks on patient discharge planning, patient experience and complaints, cancer services, and the Boots pharmacy post-implementation review. Clive informed governors that the next meeting on 8 September would include an item on group self-evaluation, and he invited governors with any ideas for improvements to the group or potential agenda items to contact Amanda Saunders. Debbie Henderson echoed this request, explaining that work was ongoing this year to align the work of the Quality Project Focus Group with the Board's Quality and Outcomes Committee, with any outstanding areas being covered by the Governor Development Seminars.

c) Constitution Project Focus Group
Sue Silvey, Lead Governor for the Constitution Project Focus Group, introduced this report. The group had met twice. Meeting attendance by governors had been discussed and there had been a proposal to write to governors who had not attended meetings recently. There were several recommendations from the group for the Council of Governors to consider and approve. Firstly, the Council of Governors was asked to approve the Group's recommended amended Lead Governor role description and to decide whether to retain the title *Lead Governor* or revert to the title *Governor*

Representative. Secondly, the Council of Governors was asked to approve the Group's recommendation to discontinue the Deputy Lead Governor role.

Governors agreed to approve the updated Lead Governor role description. There followed a discussion about the title of Lead Governor, and a vote was called on changing the title to Governor Representative. However, with only one vote in favour of the change, it was agreed that the title of Lead Governor should be retained.

Regarding the Deputy Lead Governor role, it was noted that Mo Schiller had held this title for the past seven years, as it had been difficult to find other governors to take on the role. Debbie Henderson explained that as the role of Lead Governor had now been streamlined to allow some of the more operational duties to be undertaken by the Membership Team, it was a challenge to define the role of Deputy Lead Governor, and she recommended that it be discontinued with immediate effect. This was agreed. All present wished to thank Mo Schiller and acknowledge the significant support that she had provided to successive lead governors in this role over the years. It was:

RESOLVED:

- **That the Council of Governors receive the following updates**
  - **Governors' Strategy Group**
  - **Quality Project Focus Group**
  - **Constitution Project Focus Group**

- **That the Council of Governors approve the Constitution Project Focus Group's recommended amended Lead Governor role description and retain the title *Lead Governor*.**
- **The Council of Governors approve the Constitution Project Focus Group's recommendation to discontinue the Deputy Lead Governor role.**

27/07/15 Terms of Reference for Governor Project Focus Groups (Item 8)

Amanda Saunders, Head of Membership and Governance, asked governors to consider the revised terms of reference for Governor Project Focus Groups for approval. The revisions had been discussed by governors at a Constitution Project Focus Group meeting and had been circulated to all governors by email.

She highlighted that the Project Focus Group Governor Leads were remaining unchanged for 2015/16 (Wendy Gregory, Clive Hamilton and Sue Silvey), but that interest would be sought from governors to 'shadow' Project Focus Group leads for 6 months with a view to new appointments in 2016/17. Anyone interested in shadowing should let the Membership team know. It was:

RESOLVED:

- **That the Council of Governors approve the revised Terms of Reference for Project Focus Groups.**
- **That interest be sought from governors to 'shadow' Project Focus Group leads for 6 months with a view to new appointments in 2016/17.**

28/07/15 Membership and Governor Engagement (Item 9)

Amanda Saunders introduced this report, which reported progress against the Membership Engagement and Governor Development Strategy (April 2015). It was requested that at future meetings, the strategy be attached as an appendix.

Key areas of progress since the previous meeting included linking with local partners, for example North Bristol Trust, Above and Beyond and Healthwatch. A series of recruitment events was being planned for the autumn to address the decline in membership.

Amanda acknowledged that there had been a drop-off in numbers attending Health Matters events, and added that the team would be linking with the National Osteoporosis Society for the next one on 12 November to boost the numbers.

Ben Trumper, Lead Governor, referred to the revision of the governors' activity report to reflect the ways in which governors were carrying out their statutory responsibilities, and asked whether it had identified any gaps. Amanda responded that the main gap was in enabling governors to engage with their members, but the recruitment and engagement events planned for the autumn should help to address this.

John Steeds enquired as to the expectations around membership numbers. Debbie Henderson responded that there was an expectation that Trusts would aim for 1% of the population, but that currently the UH Bristol constitution required 0.5%, and even that figure was not being reached in some constituencies. This was because of a reduction in active recruitment work over the past several years to replace members who had left. Governors suggested various ways to increase recruitment, including letters to patients, increased publicity and regular stands in the Welcome Centre, university recruitment fairs, and advertising Youth Council opportunities for younger members in schools. Sue Silvey asked that governors be actively involved in order to take ownership in this area.

There was also a discussion about ideas for increasing the audience for Health Matters Events. Suggestions included producing publicity further in advance, varying the dates and times of events, and press releases targeting health supplements in newspapers, local events listing publications and neighbourhood partnerships. It was:

RESOLVED:

- **That the Council of Governors receive the report on membership and governor engagement**

29/07/15 Review of Governor Compliance (Item 10)

Amanda Saunders introduced this report into a review of governor compliance in the following areas:

- Attendance at Council of Governors Meetings;
- Compliance with the Governors' Code of Conduct;
- Compliance with Trust procedures (Register of Business Interests and Disclosure and Barring Service/Criminal Records Bureau checks).

Amanda reported that John Savage had now written to two governors who had not met their statutory requirements for meeting attendance nor undertaken other governor duties.

A report of governor attendance at meetings and other activities since April 2014 was also included for information and to emphasise the range of activities that governors were involved in. Amanda asked governors to let the membership team know of any corrections that needed to be made. She reminded governors that involvement took many forms, and that it was appreciated that some governors would not be able to attend as many meetings as others. The key point was that as a collective, the Council of Governors was very effective, active and involved. This view was echoed by Emma Woollett, Vice-Chair, who felt that the report was a tremendous and powerful statement of the level of dedication and commitment by governors and of their collective responsibility.

James Rimmer, Director of Strategy and Transformation, expressed concern that two governors had not yet signed the Code of Conduct and that seven Disclosure and Barring Service checks were still outstanding. He enquired as to the potential restrictions on the work of these governors. Amanda explained that there had been various issues concerning the DBS paperwork, adding that she was working with the governors whose DBS checks were still outstanding, and gave assurance that she was mindful of the risks and those governors who had not completed a DBS check were prohibited from taking part in on-site governor activity. Tony Rance, Public Governor, acknowledged that he was one of those with an outstanding DBS check and expressed considerable frustration about the process, which in his experience had been both time-consuming and confusing. Sue Donaldson responded that the Trust was required to follow official DBS requirements and process. It was agreed that Sue and Tony would discuss the issue further outside the meeting.

(Carolyn Mills, Chief Nurse, and Sean O'Kelly, Medical Director, left the meeting at this point.) It was:

RESOLVED:

- **That the Council of Governors receive the report on the review of governor compliance to note.**

30/07/15 Governors' Log of Communications (Item 11)

Governors received an updated report of the questions on the Governors' Log of Communications. The Chairman welcomed the increase in the number of governors asking questions, and the increase in the speed of responses. It was:

RESOLVED:

- **That the Council of Governors receive the Governors' Log of Communications report to note**

31/07/15 Performance Update and Strategic Outlook (Item 12)

Item 12a) – Chief Executive's Report

Robert Woolley, Chief Executive, gave a verbal update on the Trust's performance and its strategic outlook.

National Context: Robert updated governors on the national context in the early days of the new government. The Secretary of State for Health had announced several large-scale reviews and drives to increase transparency and quality of care in the NHS, while at the same time emphasising productivity requirements. A key priority of the government was seven-day working, with a challenge that services provided and quality of care should be as good on Saturday and Sunday as on any other day of the week. As a result, all providers were being asked to submit their current position in relation to seven-day working by the beginning of September. There was also a national review of cancer services, signalling a greater focus on 62-day referral-to-treatment times. There were also reviews on mental health services and maternity services for which reports were scheduled to be published in September.

In relation to the budget, according to the government, NHS funding was still protected and an £8bn increase had been pledged by 2020, though this in fact equated to an increase of 1% in the NHS budget per annum, compared with an annual average 4% uplift that the NHS had previously received in order to meet demand. It was also not yet clear when and where the £8bn would be received. This made the financial situation increasingly difficult, particularly in the context of the £22bn productivity savings that the NHS was required to find. According to the King's Fund quarterly

status report on the NHS, 2015/16 would be the most difficult year for the NHS so far in the last decade, with two thirds of providers – and nearly 90% of acute providers – forecasting a deficit this year.

Performance at UH Bristol: Despite this challenging context, Robert reported that UH Bristol was performing well in comparison with other Trusts. Quality of care was fundamentally sound: the Care Quality Commission's intelligent monitoring data had placed the Trust in a low risk band (Band 5, with 6 being the lowest risk category). Performance around Access targets was still mixed: the Trust had achieved the A&E standard, but was struggling to meet recovery trajectories for referral-to-treatment times for cancer. The Monitor rating was still Green, reflecting the progress that had been made.

The Trust had previously forecast that the 2015/16 budget would result in a deficit; however, this morning the Board had approved a revised financial plan to be submitted to Monitor of a break-even position for the end of the financial year (before technical items), mainly due to contract settlement which had been very positive since the plan was originally submitted. However, Robert cautioned that this did not relieve the pressures on the Trust. In order to fund its investments in new buildings and the forward capital plan, the Trust needed to deliver a surplus of £5m-£6m per year. He noted a particular focus on recruitment and retention: the key to reducing expenditure on agency nurses. He welcomed progress made in the area of staff engagement activities.

Finally, Robert congratulated James Rimmer on his secondment to the position of Chief Executive of Weston Area Health Trust from next week for nine months, and he introduced Anita Randon who would be taking on his role as Interim Director of Strategy and Transformation. Anita was already working on the vanguard acute model of care programme (an NHS England initiative to find partnerships of acute trusts willing to look radically at the way services could be provided), and an application for this would be submitted in conjunction with North Bristol Trust this week.

Questions from governors:

a) In relation to the challenges faced by the Trust in relation to staff recruitment, Anne Skinner, Patient Governor, enquired whether it was difficult to capture experience and expertise from staff approaching retirement when new staff were not found to replace them. Robert agreed, explaining that the Trust was currently trying to recruit substantive ward staff in specialist areas, but was experiencing difficulty as it was competing with all Trusts in a limited labour market, so were needing to bring people in with little experience and train them. This was unavoidable and the Trust was seeking to manage it as best it could. He assured governors that the Trust was working proactively to look at ways of developing staff and was trying hard to communicate the issues to staff and listen to their ideas and concerns.

b) Mo Schiller, Public Governor, enquired if the Trust encouraged graduates who had not been successful in finding trainee nurse placements to come to the Trust to work as healthcare assistants instead. Robert provided assurance that the Trust was working creatively with the universities in relation to securing new recruits and encouraging them to stay. In response to a further question from Mo Schiller about retaining staff post-retirement, Sue Donaldson confirmed that the Trust offered opportunities to stay, including in part-time and different roles.

c) Clive Hamilton asked for a progress update on the Better Care Fund. Robert responded that the Better Care Fund project manager had visited the Trust recently to discuss its objectives and the way that programme was being taken forward. His impression was that the Better Care Fund was still in its scoping phase: there was some very clear targets about reducing emergency admissions but it was not yet clear which initiatives were going to achieve this. James Rimmer, who attended Better Care Fund Programme Board meetings, added that had been re-named Better Care Bristol

to more accurately reflect that it was more of a redistribution of existing funding rather than a fund itself. The aim of it was to enable health and social care to work together to reduce hospital emergency admissions. Current projects included initiatives to keep people well in their homes and the creation of a single point of access to services.

Item 12b - Independent Auditor's Report to the Governors on the Quality Report 2014/15 and University Hospitals Bristol Quality Report 2014/15
Item 12c – Achievement on Corporate Quality Objectives – Quarter 1.
Robert Woolley introduced this report. NHS Foundation Trusts were required to prepare and publish a Quality Report each year, with input from the Council of Governors. Also, the Trust's Auditors, PricewaterhouseCoopers LLP, were required to review the content of the 2014/15 Quality Report and produce a report to provide the Council of Governors with their findings.

Clive Hamilton thanked Marc Griffiths, Appointed Governor, on behalf of the governors for writing the Governors' statement in the Quality Report. He also enquired about the quality indicator chosen by governors to be tested by the auditors in relation to dementia. The auditors had identified some missing data in relation to this indicator. He requested assurance that this was being addressed. Deborah Lee explained that this had related to extracting the data from manual records, in which the date had not always been recorded. The move towards e-recording should address the issue. Robert added that PwC had also issued a limited assurance opinion in relation to Referral-to-Treatment Times, which was a significant finding which the Trust was fully aware of and was active in rectifying. It was:

RESOLVED:
- **That the Council of Governors receive the Independent Auditor's Report to the Governors on the Quality Report 2014/15 and University Hospitals Bristol Quality Report 2014/15 to note**
- **That the Council of Governors received Item 12c – Achievement on Corporate Quality Objectives – Quarter 1 to note**

32/07/15 General Discussion (including Governors' Questions arising from the meeting of the Trust Board of Directors) (Item 13)

John Savage opened the floor to discussion and questions from governors.

a) Florene Jordan, Staff Governor, voiced her appreciation for the encouraging reports regarding the work around staff engagement, as reported to this morning's Trust Board meeting. She particularly welcomed the work focussing on theatres.
   Florene also thanked James Rimmer for his support for staff during challenging times at Bristol Eye Hospital and Bristol Royal Hospital for Children. She added that the reverse mentoring initiative that she had carried out with James had been a motivational, inspirational and helpful experience and she thanked him for his role as mentee.
b) Sue Silvey, Public Governor, enquired whether any action was being taken to rectify problems with the new signage in the hospitals. Deborah Lee confirmed that work was ongoing and that changes would be made in September to make it clearer and to return to using department names rather than codes in some areas. Guy Orpen, Non-executive Director, asked that the Trust also ensure that appointment letters contain adequate explanation of locations and directions.

33/07/15 Any Other Business (Item 14)
There was no other business.

34/07/15 Foundation Trust Members' Questions (Item 15)
There had been one pre-notified question.

Received from Garry Williams, Foundation Trust Member (Patient – Carer) by telephone on 29/7/2015:

Question: Given the recent resurgence of media interest in the Liverpool care pathway, can the Board provide up-to-date reassurance that the Trust's end-of-life care pathway is as positive as possible both for patient and family?

Robert Woolley responded that the Trust had never used the Liverpool care pathway, but that the Trust's own end-of-life care pathway had been reviewed in light of the issues raised, and that he was confident that the Trust's care pathway was as good as it could be.

Garry Williams, who was in attendance at the meeting, further requested assurance that patients on an end of life care pathway would never be unnecessarily transferred between one place of care and another, and also whether there was sufficient support for families to be able to remain in touch with them. Robert gave assurance that this was the standard that the Trust aspired to, and that staff were very aware of the support that families would need. The Trust had been commended for its openness to requests from relatives to be present when patients were on a palliative care pathway. In response to a question from Sue Milestone, Patient-Carer Governor about whether the Trust was taking part in a recently announced Wellcome Trust study on End of Life care, Deborah Lee clarified that there was a national audit into care of dying which the Trust was participating in. Alison Ryan added that National Institute for Health and Care Excellence (NICE) guidance to replace the Liverpool care pathway had been released yesterday for consultation.

35/07/15 Meeting Close and date of next meeting (Item 16)

There being no other business, the Chair declared the meeting **closed**.

The Annual Members' Meeting/Annual General Meeting will be held at 17:00 on Tuesday 15 September 2015 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE
The next meeting of the Council of Governors will be held at 14:00 on Friday 30 October 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

…….(Chair) ……2015 (Date)

University Hospitals Bristol NHS
NHS Foundation Trust

Minutes of the Annual Members Meeting held on Tuesday 15 September 2015 at 17:00 in the Conference Room, Trust Headquarters, Marlborough Street, BS1 3NU

Present:

UH Bristol Board Members
John Savage – Chairman
Robert Woolley – Chief Executive
Deborah Lee – Chief Operating Officer and Deputy Chief Executive
Sean O'Kelly – Medical Director
Paul Mapson –Director of Finance & Information
Anita Randon –Interim Director of Strategy and Transformation
Carolyn Mills – Chief Nurse
Emma Woollett – Non-executive Director
David Armstrong – Non-executive Director
Alison Ryan – Non-executive Director
Guy Orpen – Non-executive Director
Lisa Gardner – Non-executive Director
John Moore – Non-executive Director
Jill Youds – Non-executive Director

UH Bristol Council of Governors
Sue Silvey – Public Governor
Bob Bennett – Public Governor
Wendy Gregory – Patient/Carer Governor
Clive Hamilton – Public Governor
Mo Schiller – Public Governor
Tony Rance – Public Governor
Tony Tanner – Public Governor
Sylvia Townsend – Public Governor
Edmund Brooks – Patient Governor
Angelo Micciche – Patient Governor
Anne Skinner – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Florene Jordan – Staff Governor
Jeanette Jones – Appointed Governor
Isla Phillips – Appointed Governor (Youth Council)
Julia Lee – Appointed Governor (Youth Council)

UH Bristol Trust Representatives
Debbie Henderson – Trust Secretary
Amanda Saunders – Head of Membership and Governance
Sarah Murch – Membership and Governance Administrator (minutes)
Giles Haythornthwaite – Consultant in Paediatric Emergency Medicine/Clinical Lead for Major Trauma
Caitlin Marnell – General Manager, Bristol Royal Hospital for Children
Jenni Fryer – Nurse and Rehab Co-Ordinator
Aimee White – Nurse and Rehab Co-Ordinator
Lynn Pamment - Partner, PricewaterhouseCoopers LLP (External Auditor)

Fiona Reid – Head of Communications
Ian Barrington – Divisional Director for Women's and Children's Services
Tony Watkin – Patient Experience Lead (Engagement and Involvement)

Approximately 25 other members of staff, Foundation Trust members and members of the public were also in attendance.

1. Chairman's Introduction and Apologies

The Chairman, John Savage, welcomed everyone to the meeting.

Apologies had been received from:
Trust Board: Sue Donaldson – Director of Workforce and Organisational Development, David Armstrong – Non-executive Director.
Governors: Pauline Beddoes, Graham Briscoe, Ian Davies, Thomas Davies, Marc Griffiths, Sue Hall, Philip Mackie, Nick Marsh, Sue Milestone, Bill Payne, Tim Peters, Jim Petter, Ray Phipps, Brenda Rowe, Karen Stevens, Ben Trumper and Lorna Watson.

2. Minutes of the Previous Meeting

The minutes of the Annual Members Meeting on 18 September 2014 were accepted as an accurate record of proceedings.

3. Independent Auditor's Report to the governors.

Lynn Pamment, Partner at PricewaterhouseCoopers (PwC), formally introduced the External Auditor's Report, which was published in the Annual Report and Accounts. The Auditors were required to give an opinion on the Trust's financial statements, the quality account and also whether the Trust was achieving value for money.

In relation to the financial statements, the auditors' work had focussed on particular risk areas, such as income and expenditure recognition, and appropriateness of spend on capital schemes. They had concluded that the financial statements were a true and fair view of the state of the Trust's affairs and confirmed the issue of an unqualified audit opinion.

Regarding the quality account, PwC had examined two specified indicators. They had expressed an adverse conclusion on one of the indicators which related to the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period'. As a result, their certificate to this report was qualified in this respect.

In relation to delivering value for money, nothing had come to PwC's attention, and overall UH Bristol had been given a clean bill of health.

4. Presentation of the Annual Report and Accounts for 2014/15

Robert Woolley, Chief Executive, and Paul Mapson, Finance Director, jointly presented the 2014/15 Annual Report and Accounts for University Hospitals Bristol NHS Foundation Trust (UH Bristol).

Robert Woolley spoke first to give an overview of the Trust's main achievements, developments and challenges over 2014/15.

He reminded those present of the Trust's purpose. The Trust's **mission** was 'to improve the health of the people we serve by delivering exceptional care, teaching and research every day'. Its **vision** was 'for Bristol, and our hospitals, to be among the best and safest places in the country to receive care.' The Trust was continually striving to achieve the mission and vision in the context of the national pressures and challenges faced by the NHS nationally.

He highlighted the main developments in 2014/15 under the six strands of the Trust's Transforming Care programme.

Delivering Best Care: There had been a full Care Quality Commission (CQC) inspection on all Trust sites during September 2014. This had concluded an overall rating of 'requires improvement'. There had been positive findings about quality of care, with all services rated 'good' for caring. Overall, services were rated as 'good' or 'outstanding' in 44 areas, with 12 areas rated as requiring improvement, and no service or domain rated inadequate. South Bristol Community Hospital and the Central Health Clinic had been rated 'good' in every domain. Also children's services, maternity services and end of life care had been all rated as 'good' or 'outstanding'.

The Trust had received patient feedback from Friends and Family tests for more than 26,000 people, with 94% recommending the Trust's care to others. The Trust had also carried out postal surveys which revealed that 97% of inpatients and parents of 0-11 year olds rated the care they received as excellent, very good, or good. However, the National Cancer Patient Survey had revealed disappointing results, and as a result the Trust was now working with the Patients' Association to improve the experience of cancer patients.

Improving Patient Flow: The Trust had experienced challenges relating to patient flow in 2014/15, but recognised that improvements were fundamental to delivering best care. There had been challenges in relation to A&E waits, referral-to-treatment times and cancer standards. The Trust's 'Green' governance rating had been suspended by regulator Monitor after Q1, because of targets not being achieved in these areas, though the Green rating had been restored in Q4. The CQC had recognised the impact of patient flow difficulties, and in its inspection report had recognised that it was not an issue that the Trust could resolve on its own, highlighting the need for the Trust to work with others in the area.

The Trust was continuing to use the 'Breaking the Cycle Together' approach - a rapid improvement initiative which focussed everyone's attention on standards of care and patient flow in a particular hospital over one week. The model had been pioneered by UH Bristol and was now being adopted nationally as an innovative way of approaching the everyday problems that get in the way of patient flow and providing excellent care.

Renewing our hospitals: 2014/15 had been a seminal year for the hospital's building programme. The Trust had opened new, purpose- designed facilities in May 2014. Specialist children's services had moved from Frenchay to the extended children's hospital. The last inpatient beds in the Bristol Royal Infirmary's Old Building had been closed as a result of the BRI redevelopment. There was now a new helideck, to support Bristol Royal Hospital for Children as the Paediatric Major Trauma Centre for the South West. The redevelopment of the Bristol Royal Infirmary had included two brand new assessment units: an Older Persons Assessment Unit (OPAU) and an Acute Medical Unit (AMU) and also a new state-of-the-art Intensive Care Unit. At the Haematology & Oncology Centre, a new-generation linear accelerator opened in January 2015 – the first of its kind in the region.

There was also a new signage and wayfinding system operating in the Bristol Royal Infirmary (BRI), Bristol Heart Institute and the Bristol Haematology and Oncology Centre, though Robert acknowledged that there were still improvements to the made with regard to signage.

Building capability: There was currently a major focus on developing staff. This included improvements to teaching and learning opportunities, for example, more than 800 staff had attended internal leadership and management courses in the year. The contribution made by staff was recognised in the annual Recognising Success staff awards ceremony. A staff survey last year had revealed the

extent of pressures felt by staff at work, and a strong desire for improved communication and listening. At the end of last year, the Trust had introduced 'Schwartz Rounds' to support staff wellbeing: private sessions facilitated professionally to allow staff to talk about the emotional impact of their work, which had very positive feedback.

Leading in partnership: Robert emphasised the Trust's responsibility to engage with health and social care partners to improve the experience of the NHS as a whole across the region. The year had seen an active partnership with North Bristol NHS Trust, and the redevelopment of the Children's Hospital and the BRI had been timed to support the work around the closure of Frenchay Hospital and opening of Southmead last year. Also the Trust had teamed up with commissioners and primary, community and social care partners for work on discharge and patient flow. With the universities, the Trust was working to maintain excellence in clinical education and research including in its two biomedical research units. It had also worked with the City Council on the sustainability agenda (for example the solar panel installation at St Michael's Hospital – one of the largest in Bristol.)

Looking to the future, Robert summed up the Trust's immediate priorities as: engaging staff in transforming services and improving the quality of care; engaging with patients to help the Trust improve services; and engaging with partners, both to ensure that patients were discharged appropriately, and also to remodel health and social care services for current and future generations.

Annual Accounts and Financial Context

Paul Mapson, Director of Finance and Information, delivered a presentation on the Trust's annual accounts and financial context in 2014/15 and noted:

- Total income was £589.33m excluding technical items and total expenditure was £582.99m excluding technical items.
- UH Bristol had delivered a net income and expenditure surplus of £6.340m, against a plan for £5.803m before technical items.
- A technical items (impairments, donations and depreciation on donated assets) charge of £22.690m led to reported deficit of £16.350m.
- The Trust had a Continuity of Services Risk Rating of 4.
- EBITDA (Operating surplus) was £35.820m (6.19%).
- Savings had been achieved of £16.5m.
- Capital expenditure was £44.3m.
- There was a healthy cash position of £63.5m and strong working capital at £21.6m.

The Accounts had received an unqualified audit opinion. Results for 2014/15 demonstrated that the Trust had delivered the seventh year of its financial strategy as a foundation trust and the twelfth year of breakeven or better (before technical items). Paul provided a breakdown of the Trust's income and expenditure and more detail on the continuity of services risk rating and the historic and forecast position of income and expenditure surplus. He explained that a surplus of £6m (1%) was needed each year in order to meet the loan payments on the buildings.

He summarised the Trust's current financial priorities as continuing to provide fit for purpose clinical accommodation, with completion of the BRI Redevelopment ward block; centralisation of Specialist Paediatrics; BHOC development; Welcome Centre; and South Bristol Community Hospital. Other priorities for the Trust in 2015/16 were the planned decommissioning of the BRI Old Building in July 2016, as well as investment in technology to facilitate innovation and transformation, improving quality in face of severe economic challenges, facilitating the delivery of clinical activity to meet the needs of patients, understanding service efficiency, enhancing Research and Development in the Trust, providing high quality teaching for doctors and other staff, and continuing to manage the money so the Trust was in control of its own destiny.

Paul also reported on the progress of the financial strategy, actual and projected income, the progress of the medium-term capital programme 2008/9 to 2020/21 and the forward position. He explained that the Trust had originally declared a planned net deficit of £5.0m for 2015/16, which had been revised to a break-even position. However, he emphasised that fundamental to this plan was the delivery of the savings programme and planned activity volumes, avoiding performance fines and reducing agency expenditure. Effective recruitment and retention of staff and reduced absence was also a pre-requisite.

In conclusion, he explained that the macro-economic outlook was still very difficult in relation to public spending plans, with NHS growth significantly reduced compared with recent settlements. The Trust would however continue its approach of applying sound financial management principles, governance and methodology, and would not compromise on clinical quality and standards.

5. Quality Report 2014/15

Members formally received the Quality Report 2014/15 from Carolyn Mills, Chief Nurse. Carolyn explained that the Quality Report was an assessment of the quality of the Trust's services, focussing on patient safety, patient experience, clinical effectiveness and performance against national access targets. It documented progress in achieving annual quality objectives for the past year and set out priorities for the year ahead. This year, the report also included a summary of the Care Quality Commission inspection findings.

Carolyn presented graphs to show the Trust's performance in relation to several key measures of patient safety: falls per 1000 bed days, pressure ulcers, the percentage of patients receiving a VTE risk assessment, and incidences of Clostridium difficile infection. These metrics presented a generally positive picture, with improvements in some areas. Regarding Patient Experience, she showed results of Friends and Family tests in three different areas (in which the Trust was generally above the national average but with occasional dips) and also the results of the Trust's own inpatient survey. Carolyn also demonstrated that according to the Summary Hospital Level Mortality Indicator, UH Bristol was performing consistently well – a measure of its clinical effectiveness.

The Trust had set Quality Objectives for 2014/15 to:

- Reduce the number of cancelled operations.
- Minimise patient moves between wards, including out of hours.
- Ensure patients were treated on the right ward for their clinical condition.
- Ensure no patients were inappropriately discharged from our hospitals out of hours.
- Renew and refresh the Trust's approach to patient and public partnership – lot of work.

The Quality Report examined the Trust's progress on these objectives.

Carolyn outlined the objectives that had been set for 2015/16, three of which had been carried forward from 2014/15: reducing the number of cancelled operations; minimising patient moves between wards for non-clinical reasons; and ensuring patients are cared for on the right ward for their clinical condition. New objectives for 2015/16 were identified as: improving the management of infection (sepsis); improving the experience of cancer patients; improving how the Trust communicates with patients; improving the quality of our written complaints responses; reducing delays in outpatients (and keeping patients better informed about delays); and improving patient discharge, including the timeliness of drugs to take home.

6. Membership and Governors' Review

John Savage, Chairman of the Board and Chairman of the Council of Governors, and Sue Silvey, Public Governor, presented the membership and governors' review of the year.

John Savage spoke briefly to pay tribute to the staff and leadership at the Trust. In a momentous year for the whole of the NHS with significant challenges, senior staff had, in his view, managed to respond to enormous pressures and change while maintaining both quality of care and the Trust's finances – certainly not an easy task. He emphasised the urgent need in an uncertain future to maintain sight of the Trust's core purpose: to provide excellent care to our patients.

He reminded those present that as a Foundation Trust, UH Bristol had a governing body consisting of elected representatives of the public and stakeholders. Governors and the Trust Board were working well together to make the model function effectively.

Sue Silvey, Lead Governor 2013-14 and 2014-15, presented a governors' review of 2014/15. She reported that governors had worked hard and had benefited greatly from the advice received from Trust Secretary and the Head of Membership and Governance.

She summarised the key achievements of the governing body during the year. They had worked to revise the Trust's Constitution to make it more user-friendly, and had followed up matters raised by members to improve patient experience. The governors also had a Log of Communications on which they could pose questions to Directors, and the use of this had been improved. Governors had played their part in the CQC inspection and the Well-Led Governance Review. They had contributed to the development of a formal and rigorous annual appraisal process for Non-Executive Directors and had appointed the Senior Independent Director and two further substantive Non-Executive Director posts. They had supported the development of the Trust's Annual Planning process and had oversight of the corporate quality objectives to inform and contribute to the Trust's Quality Account. As part of their membership engagement work, they contributed to the Trust's 'Voices' magazine; and had participated in patient/staff activity: e.g. PLACE visits (Patient-Led Assessments of the Care Environment); patient interviews and staff surveys. Governors had also overseen the development of a revised Membership Engagement and Governor Development Strategy for 2015 – 2019.

Elections to the Council of Governors had taken place in March-May 2014, with new governors taking up office in June. A report of the election results was available at the meeting. The next elections were due to take place in Spring 2016, and for the first time would include the option to vote electronically. Sue reminded members that if they wished to get more involved in the Trust's work, they had the opportunity to stand for election as governor.

The Trust had a total of 21,090 members (at 31 March 2015), including 6,466 Public members, 4,763 Patient & Carers members and 9,861 Staff members. This was a broadly representative membership, although there had been a slight decline in membership numbers since the previous year. Work in the coming year would focus on an active recruitment campaign to increase member numbers, particularly in groups where the Trust was under-represented. Plans were also in place to deliver increased membership engagement and activity.

7. Paediatric Major Trauma Centre Update

Giles Haythornthwaite, Consultant in Paediatric Emergency Medicine and Clinical Lead for Major Trauma, gave a presentation on the first year of the Paediatric Major Trauma Centre.

The Paediatric Major Trauma Centre had transferred from Frenchay in May 2014 and now ran from Bristol Royal Hospital for Children. As part of the move, the service had been redesigned in order to centralise paediatrics within the region under one roof. Giles discussed the planning and process of establishing the Centre, effecting the transfer, and making it work. One year on, he reflected on how the service was improving outcomes for children who had life-threatening injuries.

In particular, he emphasised the guiding principles that had been followed to ensure that the new service had resulted in improved care:

- Building teams across clinical boundaries
- Senior (consultant) timely decision making
- Access to rapid diagnostics
- Access to rapid treatment (blood/theatre/supportive care/intensive care)
- Rehabilitation (co-ordination)
- Creating a cycle of improving care
- Remembering we are all on the same side.

The Chairman thanked Giles for his presentation.

8. Ask the Board – Q&A with Trust Board

Three questions had been submitted in advance, one from Garry Williams (Patient-Carer Member) and one from Paul Thomas (Public Member – Rest of England & Wales)

From Garry Williams, Patient (Carer) Member:

a) **Can a card terminal for extending car parking times be located at the main entrance so as to relieve anxiety of those unavoidably detained in the building?** *Garry Williams had sent his apologies for the meeting but had submitted this question.*

Deborah Lee, Chief Operating Officer/Deputy Chief Executive acknowledged that this was a real issue, but explained that the current technology used in that car park was not configured in a way that would make this possible.

Several years ago consideration had been given to a solution enabling people to pay for their parking by phone, which could be then topped up anywhere at any time. However, it was found that this would be very costly to implement and consultation with patients at that time had not revealed an appetite for it. However, she could provide assurance that technological solutions would certainly be considered for the new proposed multi-storey carpark at Eugene Street.

From Paul Thomas (Public Member):

b) Following on from last year's AGM and my question regarding the effectiveness of the Impact Assessment carried out before the closure of the pharmacy at the Eye Hospital, I would like to hear about the improvements to the Impact Assessment process (when changes are being planned anywhere in the hospitals) and also what improvements have been made to the training programmes for staff charged with conducting the assessments?

c) What are the reported waiting times at the pharmacy for out- patients? As a consumer I still think that they are worse than when the eye hospital operated a pharmacy because now patients at the Eye Hospital, the Dental hospital and all the BRI departments make use of a single pharmacy that does not seem to be any bigger than that at the Eye Hospital.

Paul Thomas was present at the meeting and introduced his questions, emphasising that they were intended to be helpful rather than critical. He thanked Trust governors and staff for giving up their time over the year to look into his concerns, which he had first raised at last year's Annual Members' Meeting.

He explained the reasons behind his questions – in his view the impact assessment that had been carried out in relation to the closure of the Eye Hospital pharmacy had been ineffective as there had been no

walkthrough of the patient pathway by a patient. He was therefore waiting for a response as to how the impact assessment process had been improved.

Carolyn Mills, Chief Nurse, responded to Paul's questions. She explained that the Trust carried out a Quality Impact Assessment (QIA) with each major change in order to establish the impact of the change on quality of care. Where relevant, a walkthrough was part of the QIA, carried out by a member of staff on behalf of patients. In her view, the process was robust and no change was necessary. In relation to the QIA for the Eye Hospital, she acknowledged that no-one had walked the patient pathway; however, the patient experience had been taken into account. She added that there had been a post-project review in relation to the Eye Hospital pharmacy closure, as a result of which issues had been identified and improvements made.

Clive Hamilton, Public Governor and chair of the Governors' Quality Group, explained that governors had taken up the issue on Paul's behalf, and confirmed that considerable improvements had been made as a result post-implementation – for example, notices had been improved, people were better informed, and improvements had been made to the pharmacy. Overall, governors had been satisfied that work had been carried out to improve the situation.

The comments made in Paul's second question were noted. A more comprehensive response would be provided to Paul after the meeting.

There were several other questions from the floor:

d) A member asked Giles Haythornthwaite why it would be unusual for a consultant for adult treatment to operate on a child. Giles explained that training was different for those operating on children below 16 due to anatomical differences and other considerations. However, in the Paediatric Major Trauma Centre, when specialist expertise had been required, they were able to bring in consultants from adult areas and use overlapping skills.

e) There was a further question about why Trust car parks did not have pay-on-exit technology. Robert Woolley responded that while some of the Trust car parks allowed this, others were physically arranged in a way that made this impossible and were therefore pay and display. He reiterated that the issue was understood and would be taken into account when the new car park was built.

f) John Steeds, Public Governor, referred to the good Care Quality Commission inspection report of South Bristol Community Hospital (SBCH) but questioned whether it was run as efficiently as the rest of the hospital at the moment. He asked when this would be reviewed. Robert explained that UH Bristol provided some of the services at SBCH alongside other organisations, and acknowledged that SBCH was not at full capacity. A strategic review would be undertaken as the end of contract approached to establish how best to work with commissioners and other health partners to ensure that the hospital met the needs of the people of South Bristol. Deborah Lee added that a significant amount of work had been undertaken last year as to how the Trust could better utilise the space, and for the first time there was now a full timetable in respect of outpatients and theatres, and a queue of services currently delivered at the BRI which had requested to be moved to SBCH.

g) Clive Hamilton, Public Governor, asked Paul Mapson to explain the reduction in teaching income mentioned in his presentation on the Annual Accounts. Paul explained that tariffs for teaching income had been reduced nationally, and there had also been reductions in numbers of students.

h) Wendy Gregory, Patient-Carer Governor, asked Paul Mapson for more information about his suggestion that there might be plans for further improvements to the Bristol Haematology and Oncology Centre. Paul responded that the Oncology Centre was one of several areas that it was recognised was in need of further development. As yet, there was no plan in place for this: priority areas would be identified for development and a decision would be taken on affordability and timescale.

i) Hugh Silvey, Public Member, enquired about the Trust's plans to implement government directives to introduce 7-day working. Robert Woolley responded that the Trust already provided 7-day services to some extent. While he accepted that the government's commitment was positive, it was clear that the objective could not be met by taking existing staffing and spreading it more thinly. There would therefore need to be a significant investment, which posed a challenge for the government, as much of the £8bn that they had promised to the NHS was already committed. Also, there were recruitment shortages in certain specialities. A government taskforce had been set up, led by the Medical Director of NHS England, and their first tranche of work was to carry out a baseline assessment, for which UH Bristol had submitted a report last week.

   Sean O'Kelly, Medical Director, added that the taskforce would take time to digest the information from these assessments and translate it into policy. UH Bristol would then need to evaluate the evidence to decide where it would get the most benefit from increased investment and would roll out services accordingly.

The Chairman thanked everyone for attending and closed the meeting.

The next Annual Members' Meeting/Annual General Meeting will be held at 17:00 on Thursday 15 September 2016 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE.

University Hospitals Bristol NHS
NHS Foundation Trust

Council of Governors meeting
Item 04 - Action tracker

Outstanding actions following meeting held 30 July 2015				
Minute reference	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
27/07/15	**That interest be sought from governors to 'shadow' Project Focus Group leads for 6 months with a view to new appointments in 2016/17.**	Head of Membership and Governance.		Amanda Saunders will email to request interest from governors in November.
Completed actions following meeting held 30 July 2015				

Nominations and Appointments Committee Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 05 - Nominations and Appointments Committee Report

Purpose

The purpose of this report is to provide the Council of Governors with an update on the activities of the Governors' Nominations and Appointments Committee.

Abstract

The Nominations and Appointments Committee is a formal Committee of the Council of Governors established for the purpose of carrying out the duties of governors with respect to the appointment, re-appointment, removal, remuneration and other terms of service of the Chairman and Non-executive Directors.

Recommendations

The Council of Governors is asked to **note** the report and:

- **adopt** the revised succession planning processes for Non-Executive Directors.
- **approve** the recommendation to extend the term of office of Emma Woollett as Non-executive Director and Vice-Chair for a further 6 months i.e. until 30 November 2017.

Report Sponsor or Other Author

Sponsor: Trust Secretary

The Nominations and Appointments Committee has held **one** meeting since the last Council of Governors meeting.

Nominations and Appointments Committee: 25 September 2015

Governors present: Sue Silvey, Mo Schiller, John Steeds, Angelo Micciche, Wendy Gregory, Philip Mackie and Jeanette Jones.

Others present or in attendance: Julian Dennis – Non-executive Director (chairing the meeting in the absence of the Chairman), Amanda Saunders – Head of Membership and Governance, and Sarah Murch – Membership & Governance Administrator.

Topics discussed:

- **Succession planning for Non-executive Directors:** The Committee received a report containing proposed revisions to the processes around succession planning and recruitment of the Chairman and Non-executive Directors. It formally incorporated the proposal to continue with the appointment of Non-executive Observers as the basis for improved succession planning. The Committee were supportive of the revised process. Some minor amendments were proposed and will be incorporated prior to the next meeting.
- **Proposal to extend Emma Woollett's term of office:** The term of office of both the Chairman (John Savage) and Vice-Chair (Emma Woollett), had been due to expire at the same time (May 2017). To avoid a potential impact on the Trust resulting in sudden loss of continuity of experience, it was proposed that Emma Woollett's term of office as Non-

executive Director and Vice-Chair be extended for a further period of 6 months to end 30 November 2017. This was agreed.

The next meeting of the Nominations and Appointments Committee will take place on Friday 18 December 2015 at 13:30-14:30 in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

Appendices

Appendix A – Succession planning for Non-executive Directors.

Appendix B – Proposal to extend Emma Woollett's term of office.

University Hospitals Bristol NHS
NHS Foundation Trust

Succession Planning for Non-Executive Directors

1. Rationale

The Non-Executive Director (NED) position in an NHS Foundation Trust is a central element in the Trust's success. Therefore, ensuring that the functions of the NED role are well understood and shared among Council of Governors, is important for safeguarding the Trust against planned and unexpected change.

This kind of risk management is helpful in facilitating a smooth leadership transition. This document provides a proposal for the succession plan for Non-Executive Directors for University Hospitals Bristol NHS Foundation Trust.

The proposal demonstrates a commitment to sustaining a healthy functioning organization. The purpose of this plan is to ensure that the organization's leadership has adequate capability and capacity to effectively manage UHB in the event that a NED either stands down from their role, or are unable to fulfil their duties.

The current NED job description is attached in Appendix A. As well as the duties provided in the job description, the following are considered to be the key competencies of the NED:

Competency	Examples
Shapes corporate strategy	Is aware of the Trust and the external operating environment. Can raise strategic issues and influence the shape of strategy. Can demonstrate understanding of the bigger picture, but does not become preoccupied with detail.
Adds value to the Board via experience and expertise	Willingness to challenge thinking and can test assumptions while seeking assurance. Can demonstrate good judgement about innovation to add value to service delivery.
Patient, carer and community focus	Personal behaviours demonstrate support for and adherence to the Trust vision aims and values. Can demonstrate understanding of issues affecting service users, and awareness of their views.
Operates as an effective team player	Seeks to improve personal effectiveness by refreshing knowledge and skills. Can demonstrate commitment and motivation and has effective relationships with colleagues.
Can understand the detail as well as the bigger picture	Takes advantage of opportunities to bring about improvements. Demonstrates ability to interpret direction of change using strategic insight of health and social care agenda.
Able to hold colleagues to account in a constructive way	Can demonstrate ability to challenge constructively and effectively. Can accept personal accountability and responsibility.
Intellectual Flexibility	Can digest and analyse information and adapt and modify own thinking. Can think creatively and is comfortable dealing with concepts and complexity.
Self-belief and emotional resilience	Behaves confidently and authoritatively and while accepting a challenge, can be tough and emotionally resilient. Can act as an ambassador for the Trust.

2. Planning

Expectations of NEDs are changing rapidly, and their role is under more scrutiny than ever before. For this reason, it is important for potential NEDs to ask key questions of themselves and of the Trust before submitting an expression of interest.

To facilitate the decision-making process, PwC have developed a 'Test', a due diligence tool designed to help potential NEDs through the process of assessing whether or not to accept a non-executive directorship.

Before accepting an appointment a prospective NED should undertake their own thorough examination of the Trust to satisfy themselves that it is an organisation in which they can have faith and in which they will be well suited to working. This would involve NEDs answering the following key questions:

- Do I have something to contribute to this board?
- Am I capable of passing judgement on the company's management/strategy/ risks/ alternatives?
- Do I have sufficient time and am I sufficiently committed?
- Am I aware of the organisational risks?

3. Process

It is the responsibility of each NED to inform the Chairman of a planned absence, to enable the Trust to plan accordingly, and in turn, it is the responsibility of the Chairman to immediately inform the Board of Directors. As soon as feasible, following notification of a planned absence, the Chairman shall convene a meeting of Governors' Nomination and Appointments Committee ('the Committee').

3a. Preparation

The Committee with the guidance of the Chairman will outline the required skills and abilities necessary to be a successful NED, taking into consideration strategically, what it will take to be successful in the next 3-5 years. The Committee should agree on the technical skills and expertise that they are seeking and conduct a skills review to ensure that they know what gaps need to be filled.

The Committee will agree the job description and person specification together with the level of remuneration and number of days required. It is important to be clear about eligibility requirements and ensuring these are made clear in the recruitment process, particularly in relation to the requirement for the potential Non-Executive Director to be member of one of the patient or public constituencies of the Trust.

A detailed plan identifying the key milestones needed should be developed so that candidates know what to expect at every stage of the process.

The Committee should decide whether to utilise the services of an External Recruitment Agency (ERA), to undertake the candidate search. If so, with the support of the Chairman and Trust Secretary, the Committee will develop a brief including the type of experience required. The

benefits of using an ERA are the ability to approach individuals who may not be actively looking for a Non-Executive Director role and actively make efforts to bring diversity to the Board table and target specific background and/or skill sets, which may otherwise be overlooked.

Use of the ERA would also run alongside an advertisement campaign to ensure the broadest reach into the desired target community.

The interview assessment programme should be confirmed at the planning stage; prior to any advertising. The interview panel will be comprised of:

- Nominations and Appointments Committee representatives
- Independent Assessor (if required)
- Chair (for Non-Exec Directors appointments)
- Senior Independent Director (for Chair appointments)
- Director of Workforce and Organisational Development in an advisory capacity; and
- Trust Secretary in an advisory capacity

3b. Shortlisting and Interview

All applications will need to be assessed against the job description and person specification and those that meet the criteria will be shortlisted for interview. Shortlisting will be undertaken by the Nomination and Appointments Committee, led by Chairman (and the Senior Independent Director in the recruitment of a Chair), with the Director of Workforce and Organisational Development and the Trust Secretary in attendance in an advisory role.

A briefing session for candidates and an opportunity to meet members of the Council of Governors and Board of Directors should be offered to any expressions of interest. Attendance at the briefing event should be voluntary and would not affect applications. Any interested candidates would also be invited to meet with the Chairman to discuss the role and be provided with research material including Monitor's requirements, governance arrangements and the organisation's strategic documents.

At interview stage, there are a range of criteria that candidates should be assessed against including their understanding and adherence to the Nolan Principles and Trust values. In addition candidates should be questioned on the role of the Non-Executive, their style at Board, their local networks, previous Board experience, their accessibility, their commitment, taking into consideration their existing responsibilities, any conflicts of interest and fundamentally their motivation for application.

The panel will need to be very focused on obtaining the critical information from the candidate as questions at final interview need to be open and enable candidates to draw examples of their capability from their career experience.

As well as a formal interview, candidates will be required to attend a discussion group comprising of members of the wider Council of Governors, and members of the Board of Directors.

Throughout the recruitment process consideration should be given to the additional recruitment of Non-Executive Director Observers, in line with section 4 of this document.

3c. Selection Process

When all candidates have been interviewed, the Chair of the interview panel (either the Chairman or the Senior Independent Director) will lead discussions to include;

- Advice and opinions from the Independent Assessor (if appropriate)
- Views from panel members and their opinion of each candidate
- Opinion of the Board of Directors and members of the Council of Governors
- Consideration of references provided
- Conduct a vote among the panel

The Governors will approve the Committee recommendation for the appointment of any new Non-Executive Director appointments at a general meeting of the Council of Governors.

The Chair (or Senior Independent Director) will inform the successful (and unsuccessful) candidate(s) of the interview results, and appropriate recruitment checks will be undertaken including occupational health clearance and DBS.

Following the recruitment and appointment process (likely to be undertaken within approximately an 18 week process), an induction programme will be undertaken in line with the programme in Appendix B.

4. Non-Executive Director Observers

In 2013 the Council of Governors' Nominations and Appointments Committee successfully appointed two new Non-Executive Directors. The recruitment process was carried out by an External Recruitment Agency, and following an open day and shortlisting process, it was acknowledged that there had been an extremely strong field of candidates for the role.

As a result, the Trust appointed two additional Non-Executive 'Observers' to the Board. These appointments were equivalent to the office of Non-Executive Director Designate, but without a vote on the Board. The appointment of Non-Executive Director observers has since been highlighted as best practice in terms of succession planning as part of the Trust's 2015 independent assessment against Monitor's Well Governance Review Framework, and is a process rarely seen within the NHS.

The appointment of Non-Executive Director observer's will therefore, form part of the formal succession planning for Non-Executive Directors, and will be considered during any future recruitment processes as outlined above. It would be prudent to continually have a minimum of 8 Non-Executive Directors represented on the Board at all times.

This would ensure the Trust continues to fulfil the requirements of Monitor's NHS Code of Governance, B.1.2 that at least half the board, excluding the chairperson, should comprise Non-Executive Directors determined by the board to be independent.

5. Recommendation

The Nomination and Appointments Committee are asked to consider the content of this report and recommend this document as the Committee's Succession plan for Non-Executive Directors.

Debbie Henderson
Trust Secretary

APPENDIX A

JOB DESCRIPTION

Non-Executive Director

Accountable to: Chair of the Trust Board

Role Profile

The Non-executives of the Trust Board are drawn from their local community and the membership. They bring their expertise and experience, as well as their particular knowledge as a member of the community to the work of the Board.

Non-executives work as a member of the Board team with the executive members.

The key responsibilities of an NHS Non-Executive are:

- helping to plan for the future to improve healthcare services;
- making sure that the management team meets its performance targets;
- making sure that the finance of the organisation are managed properly with accurate information;
- helping the Board to be sure that it is working in the public interest and keeps its patients and the public properly informed;
- serving on important Board committees.

Responsibilities

- To commit to working to, and encouraging within the Trust, the highest standards of probity, integrity and governance and contribute to ensuring that the Trust's internal governance arrangements conform with best practice and statutory requirements;

- To provide independent judgement and advice on issues of strategy, vision, performance, resources and standards of conduct and constructively challenge, influence and help the executive Board develop proposals on such strategies;

- In accordance with agreed Board procedures, to monitor the performance and conduct of management in meeting agreed goals and objectives and statutory responsibilities, including the preparation of annual reports and annual accounts and other statutory duties;

- To obtain comfort that financial information is accurate and that financial controls and risk management systems are robust and defensible;

- To contribute to the determination of appropriate levels of remuneration for executive directors;

- To chair or participate in the Audit and Assurance Committee and/or take an active part in other Committees (including the finance and remuneration committees) established by the Board of Directors to exercise delegated responsibility. In respect of the Audit and Assurance Committee, at least one of the Non-Executive Director members of the committee should have recent and relevant financial experience;

- As a member of Board committees, to appoint, remove, support, encourage and where appropriate 'mentor' senior executives;

- To bring independent judgement and experience based on commercial, financial, legal or governance expertise from outside the Trust and apply this to the benefit of the Trust, its stakeholders and its wider community;

- To assist fellow directors in setting the Trust's strategic aims, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives, and that performance is effectively monitored and reviewed;

- To assist fellow directors in providing entrepreneurial leadership to the Trust within a framework of prudent and effective controls, which enable risk to be assessed and managed;

- To assist fellow directors in setting the Trust's values and standards and ensure that its obligations to its stakeholders and the wider community are understood and fairly balanced at all times; and

- To engage positively and collaboratively in Board discussion of agenda items and act as an ambassador for the Trust in engagement with stakeholders including the local community, dealing with the media when appropriate.

- To participate as Chair of the interview panel in the selection of medical consultant staff.

General Information:

University Hospitals Bristol NHS Foundation Trust is committed to provide patient care, education and research of the highest quality. In delivering this ambition, we will be guided by the following values:

- Respecting Everyone
- Embracing Change
- Recognising Success
- Working Together

The Trust expects all staff to work in ways which reflect these values at all times as follows:

Respecting Everyone

- We treat everyone with respect and as an individual
- We put patients first and will deliver the best care possible
- We are always helpful and polite
- We have a can do attitude in everything we do

Embracing Change

- We will encourage all change that helps us make the best use of our resources
- We learn from our experiences and research new ideas
- We look to constantly improve everything we do

Recognising Success

- We say thank you and recognise everyone's contribution
- We take pride in delivering the best quality in everything we do
- We share and learn from each other
- We encourage new ideas that help us to be the best we can

Working Together

- We work together to achieve what is best for our patients
- We support each other across the whole Trust
- We listen to everyone
- We work in partnership

Equal Opportunities

The Trust is committed to eliminating unlawful discrimination and promoting equality of opportunity. All staff have a personal responsibility to contribute towards an inclusive and supportive environment for patients, carers, visitors and other colleagues from all the equality strands (race, gender, age, sexual orientation, religion, disability).

Staff have a personal responsibility to:

- Ensure their behaviour is not discriminatory
- Does not cause offence
- To challenge the inappropriate behaviours of others
- Adhere to the Trust's values, including 'Respecting Everyone', as well as the Staff Conduct Policy and the Equal Opportunities policy

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Health and Safety

Under the provisions contained in the Health and Safety at Work Act 1974, it is the duty of every employee to:

- Take reasonable care of themselves and for others at work
- To co-operate with the Trust as far as is necessary to enable them to carry out their legal duty
- Not to intentionally or recklessly interfere with anything provided including personal protective equipment for Health and Safety or welfare at work.

Senior Management is responsible for the implementation throughout the Trust of suitable arrangements to ensure the health, safety and welfare of all employees at work and the health and safety of other persons who may be affected by their activities. Where health and safety matters cannot be resolved at Senior Management level the appropriate Executive Director must be notified.

Each Line Manager is responsible for the health and safety management of all activities, areas and staff under their control. This includes responsibility for ensuring risk assessments are completed and implementation of suitable and sufficient control measures put in place. Health and safety issues are dealt with at the lowest level of management practicable. Where health and safety matters cannot be resolved at a particular management level the appropriate Senior Manager must be notified.

Child Protection

University Hospitals Bristol is committed to safeguarding and promoting the welfare of all children, young people and vulnerable adults, and as such expects all staff and volunteers to share this commitment.

Clinical Governance
Clinical Governance is the framework through which this Trust is accountable for continuously improving the quality of its services and safeguarding the high standards of care. It does so by creating and maintaining an environment in which excellence in clinical care will flourish.

Every member of staff must work within this framework as specified in his/her individual job description. If you have concerns on any clinical governance matters these should be raised with your line manager, professional adviser, or a more senior member of management. Your attention is also drawn to the Trust guidance on Raising Concerns about Provision of Patient Care.

You have a responsibility for contributing to the reduction of infections.

Information Governance
It is the responsibility of all staff to respect the confidentiality of patients and staff, as specified in the Caldicott Principles, Data Protection Act and the Human Rights Act. It is the duty of every employee to:

- Only access person identifiable information as required in the execution of their duties.
- Disclose information appropriately, in line with the Data Protection Act 1998.
- To ensure good quality data by recording, promptly and accurately, clinical and non-clinical information within agreed timescales to PAS, the health record or the appropriate clinical or non-clinical information system
- Always trace patient notes on the Patient Administration System
- Maintain the confidentiality of their password / username and if in possession of a 'Smartcard' abiding by the terms and conditions of its use.

Job Description completed/reviewed by:

Claire Buchanan and Anne Reader with the Nominations and Appointments Committee

Date: June 2010

All job descriptions are subject to review. Post holders are expected to be flexible and be prepared to carry out any similar or related duties which do not fall within the work outlined. The Line Manager, in consultation with the post holder will undertake any review.

The NHS Knowledge and Skills Framework (the NHS KSF) defines and describes the knowledge and skills which NHS staff need to apply in their work in order to deliver quality services. It provides a consistent, comprehensive and explicit framework on which to base review and development for all staff. Closely aligned with this job description is a KSF profile supporting the effective learning and development of the post holder in a variety of ways.

APPENDIX B – NED Induction Checklist

The following checklist is not intended to be prescriptive or exhaustive, but to act as an aide-memoire when developing an induction programme. The expectation is that the programme will be tailored to the needs of the particular individual to avoid repeating information they are already well versed, and the content will be delivered using a variety of methods, over an extended period.

The role of a director

- The role of a director and their statutory duties
- The Board of Directors Code of Conduct
- Trust policies relating to register of interest, gifts and hospitality
- Role of the company secretary/Trust secretariat
- Policies relating to receipt of independent professional advice, expenses, etc)
- Information on Directors' and officers' liability insurance
- Non-Executive Director appraisal and personal development process
- Schedule of Non-Executive Director activity and site visits
- Biographical details for the Trust's website

Board and committees

- Board and committee structure and terms of reference for the Board and committees
- Schedule of matters reserved for the board, Standing Orders and Standing Financial Instructions
- Biographical and contact details of all directors, governors and the company secretary
- Details of board committee membership
- Details of Board composition, terms of office and succession plans

Board meetings

- Minutes of recent board meetings
- Schedule of meeting dates of future board and committee meetings
- Board Development Plan for the coming year

Rules, regulation and guidance

- Most recent version of the Trust's Constitution and Standing Orders
- Monitor's Risk Assessment Framework
- Monitor's Code of Governance and associated guidance
- Most recent Board External Independent Governance Review
- Copy of the most recent Annual Report & Accounts
- Copy of the most recent Quality Account
- Copy of the Trust's Strategic Plan
- Copy of the Trust's Annual Business Plan

Current issues

- Overview of key issues affecting the Trust
- Remuneration policy
- An overview of the history of the Trust
- Organisational chart
- Trust's risk management strategy and policy
- Glossary of jargon/acronyms

Building a link with the company's people

- Meetings with senior management
- Visits to Trust sites in addition to Trust Headquarters
- Most recent staff survey and patient experience results

Appendix C

University Hospitals Bristol NHS Foundation Trust
Draft Timetable

Activity	Action	Timescales
Briefing meeting	ERA/Trust	Week 1
Preparation of all paperwork to include, role description and spec, advert copy, applicant information pack and application form.	ERA/Trust	Beginning of Week 3
Advert, applicant information pack and application form sign off	Trust	End of Week 3
Advertisement appears	ERA	End of Week 5
Search and Trawl activity	ERA	Between week 5 and week 10
Closing date for receipt of applications	ERA	Week 10
Eligibility checking, paper assessment of candidates by ERA with summary report on each applicant.	ERA/Trust	Week 11
Applicants assessed as strong or meeting some of the criteria will be sent to members of the Nominations and Appointments Committee with relevant shortlisting paperwork.	ERA	Week 11
Nominations and Appointments Committee to review applications. Members to return shortlist recommendation to ERA for collation for use at shortlisting meeting. One other panel member (usually the panel Chair) will receive all applications.	Nomco	Week 12
Nominations Committee convene to discuss their individual shortlisting results and agree which candidates to invite for interview. Interview planning will also be covered at the meeting.	Nomco/ ERA	Week 13
Preparation of interview paperwork	ERA	Week 15
Interviews (1 day – at least one week after shortlisting)	Nomco	Week 16
Prepare draft paper for Council of Governors summarising detail i.e. process followed, number of candidates etc., and recommendation	ERA	Week 16
Papers out to Council of Governors	ERA	Week 16
Recommendation presented to Council of Governors	Nomco	Week 17
Appointment to commence	Trust	**TOTAL PROCESS = 18 WEEKS**

University Hospitals Bristol NHS
NHS Foundation Trust

Proposal to extend the term of office for Emma Woollett by 6 months to end 30th November 2017

1. Rationale

Nomination and Appointment Committee members raised concern at the meeting held 25th February 2015 regarding the term of office of both the Chairman (John Savage) and Vice-Chair (Emma Woollett), which were due to expire at the same time (May 2017).

It was acknowledged that this could have a potential impact on the Trust resulting in sudden loss of continuity of experience, and Board stability.

2. Term of Office Overview

Both John Savage and Emma Woollett's terms of office are detailed below:

Name/ Designation	Date of appointment (1st term)	Date of appointment (2nd term)	Date of appointment (max 3 years subject to annual review)
John Savage Chairman	1st June 2008 – 31st May 2011	1st June 2011 – 31st May 2014	1st June 2014 – 31st May 2017
Emma Woollett Vice-Chair/SID	1st June 2008 – 31st May 2011	1st June 2011 – 31st May 2014	1st June 2014 – 31st May 2017

3. Recommendation

Following discussion with John Savage, Chairman and Emma Woollett, Vice-Chair/Senior Independent Director, the Committee are asked to consider extending the term of office for Emma Woollett for a further period of 6 months, to mitigate the risk of potential Board instability.

If agreed, a recommendation will be submitted to the Council of Governors, meeting scheduled to take place on 30th October 2015, to approve the extension of Emma Woollett's term of office by 6 months to end 30th November 2017 (subject to annual review in line with Monitor's Code of Governors guidelines).

Debbie Henderson
Trust Secretary

University Hospitals Bristol NHS
NHS Foundation Trust

A Governor Development Seminar Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 06 – Governor Development Seminar Report

Purpose

To provide the Council of Governors with an update on the governor development programme.

Abstract

The governor development programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Author: Head of Membership and Governance

Report

There have been **two** Governor Development Seminars since the last Council of Governors meeting.

Governor Development Seminar: 11 August 2015

Governors attending: Jeanette Jones, Marc Griffiths, Bill Payne, Wendy Gregory, Angelo Micciche, Sue Milestone, Edmund Brooks (part), Clive Hamilton, Brenda Rowe, Graham Briscoe, Sylvia Townsend, Tony Rance, Ian Davies, Florene Jordan, Thomas Davies, Karen Stevens.

Others in attendance:

Amanda Saunders – Head of Membership and Governance, Prof. David Wynick – Director of Research, Diana Benton – Head of Research and Innovation, Prof. A Ramanan – Consultant Paediatric Rheumatologist, Andrew Hooper - Head of IM&T, Steve Gray – Clinical Systems Improvement Programme Director, and Rhys Thomas – Medical Devices Safety Officer.

Topics discussed:

- **Research and Innovation update**: A broad overview and update on research activity underway at the Trust, across the region and an update from one of our successful research studies – the Sycamore Trial – by Prof. David Wynick, Director of Research, Diana Benton, Head of Research and Innovation and Prof. A Ramanan, Consultant Paediatric Rheumatologist.
- **Information Management & Technology Update:** An update on the Trust's IM&T strategy from Andrew Hooper, Head of IM&T and Steve Gray, Clinical Systems Improvement Programme Director.
- **Medical Equipment Management Organisation (MEMO):** A general overview of the

Page 2 of 2 of a Governor Development Seminar Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

department by Rhys Thomas, Medical Devices Safety Officer.

- **Update on actions from the last Governor Development Seminar and plans for the next meeting.**

Governor Development Seminar: 6 October 2015

Governors attending: Graham Briscoe, John Steeds, Ben Trumper, Bob Bennett, Karen Stevens, Angelo Micciche, Clive Hamilton, Mo Schiller, Sue Silvey, Wendy Gregory, Jeanette Jones, Julia Lee (part), Tony Rance (part), Ed Brooks (part).

Others in attendance: Amanda Saunders – Head of Membership and Governance, Debbie Henderson – Trust Secretary, John Savage – Chairman, Robert Woolley - Chief Executive, Jeremy Spearing – Associate Director of Finance.

Topics discussed:

- **Accountability Framework**: Debbie Henderson, Trust Secretary.
- **Governors Skills Audit and Personal Objective Setting:** Amanda Saunders, Head of Membership & Governance and Ben Trumper, Lead Governor.
- **Well Led Review Update**: John Savage, Chairman and Robert Woolley, Chief Executive.
- **Financial overview of NHS funding streams**: Jeremy Spearing, Associate Director of Finance.
- **Update on actions from last Governors Development Seminar and plans for the next meeting.**

The next Governor Development Seminar will be held on 14 January 2015 2015 from 10:00-16:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU. This will be a one-day training session from **NHS Providers**, which will cover effective questioning and holding Non-Executives to account.

University Hospitals Bristol NHS
NHS Foundation Trust

Governors' Strategy Group Meeting Account for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 7a – Governors' Strategy Group Meeting Account

Purpose

To provide the Council of Governors with an update on meetings of the Governors' Strategy Group.

Abstract

The Governors' Strategy Group (formerly known as the Annual Plan Project Focus Group) provides an opportunity for engagement with governors to develop the Monitor Annual Plan and to contribute to the Trust's strategic planning.

David Relph is the Chair of the Governors' Strategy Group and the Lead Governor for the group is Wendy Gregory. There are around 6 meetings a year, and they are open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Governor Lead for Strategy Project Focus Group

The Governors' Strategy Group has held **one** meeting since the last Council of Governors meeting.

Governors' Strategy Group: 8 October 2015

Governors attending: John Steeds, Bob Bennett, Ray Phipps, Clive Hamilton, Angelo Micciche, Mo Schiller, Pam Yabsley, Wendy Gregory, Sylvia Townsend, Sue Milestone and Sue Silvey.

Others present or in attendance: Anita Randon – Interim Director of Strategy and Transformation, David Relph – Head of Strategy and Business Planning *(Group Chair)*, Jeremy Spearing – Associate Director of Finance, Alex Crawford – Deputy Head of Commissioning and Planning, Amanda Saunders – Head of Membership and Governance, Justine Rawlings – Head of Strategic Planning for NHS Bristol Clinical Commissioning Group and Martin Jones – Chair of Bristol Clinical Commissioning Group.

Topics discussed:

- Presentation from Justine Rawlings, Head of Strategic Planning for NHS Bristol Clinical Commissioning Group and Martin Jones, Chair of Bristol Clinical Commissioning Group, about the work of the Clinical Commissioning Groups.
- Update on UH Bristol Strategic Implementation Plan.
- Update on Business Planning.
- There were also brief updates on Weston General Hospital and Histopathology reconfiguration.
- The group wished David Relph well in his new role as Director of Bristol Health Partners, thanked him for his support, and welcomed the update with regards to the appointment of Sarah Nadin to the Head of Strategy and Business Planning role on a seconded basis.
- The group welcomed the news that Jill Youds was to join the group as the Non-executive Director representative as she is involved in the Well Led Review follow-up work-stream on Strategy.
- For the next meeting, updates were requested on the proposed changes to the junior doctor rota, seven day working, and future plans for South Bristol Community Hospital.

Page *2* of *2* of a Governors' Strategy Group Meeting Account for a Council of Governors Meeting to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

- As the group's remit had recently been widened, governors were asked to consider other strategic areas that the group should focus on in addition to the Annual Plan.

The next meeting of the Governors' Strategy Group will be held on Thursday 3 December 2015 from 14:00-16:00 in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Quality Focus Group Meeting Account for a Council of Governors Meeting, to be held at 14:00 on 30 October 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07b- Quality Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Quality Focus Group.

Abstract

The objectives of the Quality Focus Group are to provide:

a) engagement with governors to develop the Board's Annual Quality Report;
b) regular support to enable governors to understand, interpret and raise questions on the Board Quality and Performance Report;
c) regular support to enable governors to understand and interpret reported progress on the Board's Quality Objectives; and,
d) opportunities for input from governors on quality matters.

The group is chaired by Clive Hamilton and includes input from the Chief Nurse and Medical Director. Meetings are held bi-monthly and open to all governors.

Recommendations

The Council of Governors is asked to **note** the meeting account.

Report Sponsor or Other Author

Sponsor: Trust Secretary/ Governor Lead for the Quality Focus Group

The Quality Focus Group has held **one** meeting since the last Council of Governors meeting.

Quality Focus Group Meeting: 8 September 2015

Governors attending: Clive Hamilton (Lead governor for the group), Sue Silvey, Florene Jordan, Mo Schiller, John Steeds, Angelo Micciche, Ray Phipps, Marc Griffiths, Anne Skinner and Sue Milestone.

Others present or in attendance: Deborah Lee - Deputy Chief Executive and Chief Operating Officer, Jill Youds – Non-executive Director and Amanda Saunders – Head of Membership and Governance.

Topics discussed:

- **Theatre staffing shortfalls and action plans to improve skills training and development opportunities. –** At a previous meeting Florene Jordan had raised concerns about the loss of skilled and experienced staff. Governors were advised that there is a proposal to provide additional training places to improve professional development opportunities and that this was being implemented
- **The Governors Quality Focus Group – a review of function and purpose.** – The Chair of the group, Clive Hamilton, presented a brief report on this for consideration. It was agreed that the group core function was to examine Trust quality performance, access

standards and workforce data in relation to the effect on Patient Safety, Patient Environment (Experience) and Clinical Outcomes. A number of suggestions were discussed and agreed in relation to administration which included punctual production of minutes, number of meetings per year, page numbering, the need for executive summaries, executive representation, the importance of Non-Executive Director representation from the Board Quality and Outcomes Committee and succession planning for replacement of Governor Chair/Lead next year.

- **Report on the proceedings of the last Quality and Outcomes Committee of the Board.** - Jill Youds gave a comprehensive account of challenges and assurances obtained together with a written report. This new approach to Non-Executive Director representation at our meeting was very well received and Jill was thanked for her detailed verbal report and response to questions.
- **Quality Focus Group Chair's summary of the Quality and Performance reports from the last two Board meetings.** – The revised Board Quality and Performance Report has improved our understanding of Trust performance relative to historical data and levels of activity making the process of summary much easier. Improvements in quality performance had been noted since the first quarter of 2015/16 and the levels have been maintained to date (8th September 2015). There was concern over access targets not achieved and backlog clearance relative to revised compliance trajectories and Monitor's Risk Assessment Framework. The trusts workforce recruitment and retention activities were discussed and it was noted that these may be have resulted in an improved situation. The staff vacancy level was the highest this year but a substantial number of new starters and increased university student intakes will improve the situation. We were assured however that safe staffing levels had been maintained throughout.
- **Feedback to staff on the learning from investigations into incident reports. –** This does not always happen and it was felt that some assurance on timely responses was needed.
- **The Governor's Log of Communications. –** Governors are using the system regularly and there was no specific feedback from the group except that Jill Youds affirmed that it was very helpful in keeping the Non-Executive Directors informed of governor concerns.
- **Update on the progress towards an integrated Histopathology service. –** The group was advised that this was on track for completion in March next year at the North Bristol site.
- **Cystic Fibrosis ward staffing changes and the effect on standards of care. –** Angelo Micciche sought assurance about ward A900 where reorganisation had changed the skill mix and experience of care staff.

The next meeting of the Quality Focus Group will be held on Thursday 5 November 2015, 14:00-16:00 in Lecture Theatre 1, Education & Research Centre, Upper Maudlin St, Bristol, BS2 8AE**.**

University Hospitals Bristol NHS
NHS Foundation Trust

Constitution Project Focus Group Meeting Account for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 07c – Constitution Project Focus Group Meeting Account

Purpose

To provide the Council of Governors with an update on the meetings of the Constitution Project Focus Group.

Abstract

The objectives of the Constitution Project Focus Group are to provide:

(i) engagement with governors in drafting Constitutional changes;

(ii) assessing the membership profile; and,

(iii) advice from governors on communications and engagement activities for Foundation Trust members.

The group meets quarterly and is open to all governors. The Chair of the Group is Sue Silvey and the executive lead for the Group is Debbie Henderson, Trust Secretary.

Recommendations

- The Council of Governors is asked to **note** the update.

Report Sponsor or Other Author

Sponsor: Trust Secretary/Lead Governor for the Constitution Project Focus Group

The Constitution Project Focus Group has held **one** meeting since the last Council of Governors meeting.

Constitution Project Focus Group Meeting: 8 September 2015

Governors attending: Sue Silvey (Chair of the group), Ben Trumper, Angelo Micciche, Florene Jordan, Bill Payne, Graham Briscoe, Clive Hamilton, Bob Bennett, Ray Phipps, Mo Schiller, Anne Skinner, Sue Milestone and Pam Yabsley.

Others present or in attendance: Debbie Henderson - Trust Secretary, Amanda Saunders – Head of Membership and Governance, Kate Hanlon – Communications Officer, Debbie Marks – Membership Support Assistant.

Topics discussed:

- **Skills Audit and Objective Setting:** Governors were invited to give their views on what should be included in a skills audit, including the opportunity for governors to set individual objectives. It was discussed how governors could use this to strengthen their engagement with members.
- **Membership Report and Engagement Activities Update:** Governors gave feedback on planned engagement activities and other ideas for promoting membership.
- **Draft new membership promotional materials:** Governors gave feedback on the redesign of membership recruitment materials
- **Governor Elections 2016:** Governors were informed of the timeline, the election process, and the constituencies that are due for election next year. Governors gave feedback on key messages that should be included when promoting the governor role, such as the time commitment required.
- **Annual Members Meeting 2015:** Governors were given an update on the planning for this

year's Annual Members Meeting. They gave feedback with regards to the importance of showcasing the governor role and contribution to the Trust at the meeting.

Following the meeting it has been agreed that **John Moore** will join the group as Non-executive Director representative.

The next meeting of the Constitution Project Focus Group will be held on Thursday 3 December 2015 from 11:00-13:00 in the Board Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

Membership Activity Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 08a- Membership Engagement Report

Purpose

To provide the Council of Governors with current membership details, and a summary of membership engagement since the last Council of Governors meeting on 30 July.

Abstract

The Trust has a formal requirement to maintain a Foundation Trust membership and a responsibility to engage with its membership. Progress against the Membership Engagement and Governor Development Strategy (April 2015) is reported below.

Recommendations

The Council of Governors is recommended to **note** the Membership Activity Report.

Report Sponsor or Other Author

Sponsor: Head of Membership and Governance

Report

Key areas of progress against the Membership Engagement and Governor Development Strategy have included:

- Increased visibility of UH Bristol membership through recruitment stalls at events organised by UH Bristol and others.
- Review of membership sign-up process and membership offering has continued.
- Membership team is continuing to work with others both internally and externally to promote membership.

Current Membership Numbers:

At **20 October 2015**, Foundation Trust membership stands at 20,995 members (6,442 public members, 4,693 patient members and 9,860 staff members).

This compares with membership at **20 July 2015** of 21,007 members (6,437 public members, 4,710 patient members and 9,860 staff members).

22 patient and public members joined in the period 20/07/2015-20/10/2015 (compared with 10 in the same period last year). 34 patient and public members were deleted from membership in the period (19 deceased, 4 moved out of the area, 11 opted out).

Membership can be broken down as follows:

Page 2 of 3 of a Membership Activity Summary Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Member Type Breakdown	Total
Public Constituencies	**6,441**
Out of Trust Area	4
Bristol	3,151
North Somerset	1,263
South Gloucester	1,247
Rest of England and Wales	776
Patient Constituencies	**4,692**
Unspecified	26
Carer of patients 16 years and over	208
Carer of patients 15 years and under	535
Patient - Local	3,923
Staff Classes	**9,860**
Unspecified	1
Medical and Dental	1,189
Nursing and Midwifery	2,826
Other clinical healthcare professionals	1,957
Non Clinical Healthcare Professionals	3,887

Membership Recruitment

There were Foundation Trust membership recruitment and engagement stalls at the following events:

- 12/09/2015 - Bristol Open Doors Day (Bristol Royal Infirmary)
- 24/09/2015 – Bristol University Welcome event for new undergraduate medical students
- 14/10/2015 – UH Bristol Big Green Scheme event (part of Bristol Green Capital Healthy City Week) in the Bristol Heart Institute atrium
- 17/10/2015 – South Bristol Community Hospital Open Day (part of Bristol Green Capital Healthy City Week)

Membership Engagement and Communication July-Oct 2015:

- **15/09/2015 - Annual Members Meeting/AGM**

The Trust's Annual Members' Meeting took place on 15 September and was attended by about 65 staff, governors and members. The Annual Report and Accounts for 2014/15 was presented at the meeting, and there were talks on the Trust's main achievements, developments and challenges over 2014/15 and plans for the coming year. There was a lively discussion and Q&A session, with questions from members on various issues such as pharmacy provision, car parking and seven-day working.

The keynote speaker for this year's Annual Members' Meeting was the clinical lead for the region's paediatric major trauma centre, **Dr Giles Haythornthwaite.** Following transfer from Frenchay last May, the centre now runs from Bristol Royal Hospital for Children. A year on, Giles discussed how the service is improving outcomes for children who have life-threatening injuries.

- 15/10/15 – Members were invited to attend an information evening about setting up a UH Bristol 'Involvement Network' - a new way for patients and carers to get involved in planning and

shaping the future of our hospitals.

- 9/10-16/10/2015 – Sept/Oct edition of Voices magazine sent to all members. Voices, the magazine for the UH Bristol community, is sent to Foundation Trust members 3 times a year.

Areas of Focus for the next quarter:

- The next members' event will be a Health Matters Talk on Osteoporosis on Thursday 12 November 2015, 4pm-5.30pm, Education & Research Centre.
- Review of topics for the 2016 programme of Health Matters Events and offering members the opportunity to vote via email on topics they would like to see covered.
- Development of improved membership promotional materials and membership communications.
- Increase visibility of membership around the Trust, for example by regular recruitment stalls in the Welcome Centre.
- Promotion of the extension of the NHS staff discount scheme to Foundation Trust members.

University Hospitals Bristol NHS
NHS Foundation Trust

Governor Activity Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 9b – Governor Activity Report

Purpose

To report on the ways in which governors have discharged their responsibilities and governor activity in the period 30 July 2015- 30 October 2015.

Abstract

The Council of Governors has responsibilities that are set out in Acts of Parliament such as the National Health Service Act 2006 and more recently new powers within the Health and Social Care Act 2012.

The report below shows how governors have discharged their responsibilities in the areas of:

- Engagement with their members
- Holding Non-executive Directors to account
- Strategic and other responsibilities.

Governors are also entitled to attend such training events and receive such information as may be necessary in order to fulfil their role. The report also therefore shows training opportunities and information given to governors in order to fulfil their role.

It is followed by a summary of governors' activity in the period.

Recommendations

The Council of Governors is recommended to **note** the report.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Appendices

Appendix A – Governor engagement activities 30/07/2015-30/10/2015

Page 2 of 7 of a Governor Activity Report for a Council of Governors Meeting, to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Constitution of the Council of Governors:

- In October 2015 there were 35 governors in post and 1 vacancy.
- Two new Appointed Governors took up post on 1 September 2015: Isla Phillips and Julia Lee. They were appointed by the UH Bristol Youth Council to represent the views of the Youth Council on the Council of Governors.

Governors' Activities in relation to responsibilities (30 July 2015-30 October 2015)

Statutory Responsibilities of the Council of Governors	***Other non-statutory responsibilities***	**How governors discharged their duties 30/7/2015 – 30/10/15**
1. Membership Engagement: • *represent the interests of the Members of the Trust as a whole and the interests of the public*	• *developing the membership by overseeing the implementation of the Trust's Membership Strategy and by direct engagement with members at events and meetings* • *feed back information about the Trust, its vision and its performance to members or stakeholder organisation* • *represent the interests of the community, including service users and carers, by ensuring effective communication with Members, feeding back information to the Trust as necessary*	• The Sept/Oct issue of Voices magazine included governor input and was sent to all members. • Governors attended the following events to help promote membership: - Sat 12 Sept – Bristol Doors Open Day at the BRI (Mo Schiller) - Thurs 24 Sept - University of Bristol Freshers' Week - Welcome Event for undergraduate medical students (Angelo Micciche and Ben Trumper). - Wed 14 Oct - UH Bristol Big Green Scheme event (part of Bristol Green Capital Healthy City Week) - Bristol Heart Institute atrium. (Karen Stevens and Tony Rance) - Thurs 15 Oct – Crohn's and Colitis UK Regional Education Event, UH Bristol Education & Research Centre (Mo Schiller)

	• *providing a Governor perspective on the efficacy of staff engagement mechanisms*	- Sat 17 Oct - South Bristol Community Hospital Open Doors Day, SBCH, Hengrove (Bob Bennett and Lorna Watson). • Governors actively participated in the Annual Members Meeting on 15 September. • Governors attended the Sign up to Safety launch event on 31 July (and one of the event's sessions was hosted by Clive Hamilton, Public Governor). • Governors attended an information evening at the Trust on 15 Oct to discuss setting up an 'Involvement Network' – a new way for patients and carers to get involved in planning and shaping the future of our hospitals. • Governors gave their input on the redesign on membership recruitment materials and ideas for promoting membership at the Constitution Project Focus Group meeting on 8 September. • A skills audit was undertaken at the Governor Development Seminar on 6 October. This would lead to personal objective-setting which it was hoped would help governors strengthen their engagement with members. • Governors fed back issues raised by patients and by staff through their Quality Focus Group and the Governors Log of Communications.
2. *Holding Non-executive Directors to account:* • *hold the Non-Executive Directors individually and collectively to*	• *being assured that that the Non-Executive Directors act so that the Trust does not breach the conditions of its NHS*	• Non-executive Directors are now regularly attending the Quality Focus Group to report to governors from the Quality and Outcomes Committee. Their input has

account for the performance of the Board of Directors • *receive performance appraisal information regarding the Trust Chairman and Non- Executive Directors* • *set the pay and terms & conditions of appointment for the Trust Chairman and Non-Executive Directors* • *appoint and (if necessary) remove the Trust Chairman and Non-Executive Directors* • *approve the appointment of the Chief Executive - however, the Council of Governors will not appoint the Chief Executive* • *if necessary, inform Monitor, via the Lead Governor, if there are any 'material concerns' about the actions of the Board of Directors which cannot be resolved locally*	*Provider Licence*	been welcomed by governors and the value of their reports acknowledged in providing governors with assurance that Non-executive Directors were effectively carrying out their role. • There is still a strong focus in this period on aligning the work of Governor Project Focus Group with Non-executive Director Committees. As a result, Non-executive Directors have now agreed to send one representative to other two governor Project Focus Groups. • Chairman's Counsel meetings were chaired by Non-executives Guy Orpen (in August) and Julian Dennis (September). These meetings give governors the opportunity to discuss current issues and any areas of concern with Non-executive Directors. • Governors have attended the monthly meetings of the Public Trust Board of Directors, and have been pleased to observe Non-executive Directors raising issues with the Executives on their behalf at these meetings. • Governors on the Nominations and Appointments Committee met on 25 September and agreed revisions to the processes around succession planning and recruitment of the Chairman and Non-executive Directors.
Strategic Direction: • *give a response when consulted by the Board of Directors on the*	• *supporting the Board of Directors in setting the long-term strategic direction for*	• The Governors' Strategy Group met on 8 October to enable governors to update the governors on the Strategic Implementation Plan and Business Planning.

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Trust's Annual Plan • *satisfy itself that proposals in the Annual Plan (other than those relating to the provision of health services in England) will not significantly interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions* • *approve any proposal to increase by 5% or more the proportion of the Trust's total annual income from activities other than the provision of health services in England.* • *approve any applications for significant transactions* • *approve any applications for mergers, acquisitions, separation or dissolution of the Trust* • *agree, in conjunction with the Board of Directors, changes to the Trust's Constitution*	*the Trust* • *promote and support the organisation's strategy*	• Governors received an update on the Well-led Governance Review from the Chief Executive and the Chairman at their Governor Development Seminar on 6 October. • Governors received an update on the Trust's IM&T strategic approach at their Governor Development Seminar on 6 October. • Governors receive updates on the Trust's strategic outlook from the Chief Executive at their quarterly Council of Governors meetings.
Other responsibilities: • *appoint or (if necessary) remove the Trust's external auditors* • *receive the Trust's Annual Report and Accounts, and the Auditor's report*		• The Council of Governors received the Auditor's Report at their meeting on 30 July 2015. • The Council of Governors also received the Trust's Annual Report and Accounts and the Auditor's reports on the Accounts at the Annual Members Meeting on 15 September.

Governor Engagement: training and information received

Training received:

- **Governor Development Seminars:** At governor development seminars in August and October, governors received updates on Trust activities in Research and Innovation, IM&T, and the Medical Equipment Management Organisation (MEMO), They were also given presentations on the Accountability Framework, the Well-Led Review, and a financial overview of NHS funding streams.
- **Governor Meetings:** Governors receive much of their information through their Governor Groups for Quality, Strategy and Constitution. These meetings provide important opportunities for governors to improve their understanding and seek clarification on the Trust's work and current issues. They also receive talks from key personnel in the Trust and outside to improve their understanding in particular areas. In this period, these included:
- Annette Giles, Head of Central Sterile Services Department (CSSD) and Trust Decontamination Manager, attended a Governors' Informal meeting on 28 August to give a service overview.
- Jayne Weare, Head of Therapy Services, spoke at a Governors' Informal Meeting on 25 September to give an update on how this department is supporting the trust with improved patient flow.
- Governors received a presentation from Justine Rawlings, Head of Strategic Planning for NHS Bristol Clinical Commissioning Group (CCG) and Martin Jones, Chair of Bristol CCG about the work of the Clinical Commissioning Groups at a meeting of the Governors' Strategy Group on 8 October.

Information received:

- Governors received the first issue of the NHS Providers Governor Focus newsletter in August. Governor Focus is a new quarterly bulletin for NHS governors from NHS Providers, and provides round-up of the latest news from NHS Providers, the wider health sector and other organisations, policy updates and their impact on governors, case studies and interviews with governors to share experiences and good practice, and benchmarking data in relation to governors and membership.
- The People in Health West of England newsletter was shared with governors in September.
- Message of the Month from the Senior Leadership Team was shared with governors. As always, governors were kept informed of news stories affecting UH Bristol and the Trust's weekly staff e-newsletter Newsbeat was shared with governors.

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Key plans for the next quarter include:

- Analysis of the information gained from the governor skills audit to enable personal objective-setting for governors.
- Continue to strengthen governor engagement with members, for example, by supporting governors to undertake engagement activities in their own areas or in different ways.
- Continue to strengthen governor opportunities to hold Non-executive Directors to account, for example via attendance at the Governors Focus Group meetings, and reviewing the format of Chairman's Counsel meeting. In addition, NHS Providers will be running a one day training session at the Governors Development Seminar on 14 January 2016, which will cover effective questioning and holding Non-Executives to account.
- Specific support for the new Youth Council governors to help them to feel confident in their role.
- Governor involvement in planning and promoting the Governor Elections 2016.

Governor Activity from 30 July - 30 Oct 2015	Public Governors									Public, Rest of Eng & Wales		Patient Governors						Carers 16+		Carers -16		Staff Governors						Appointed Govs								
Name of Event	Pauline Beddoes	Tony Tanner	Clive Hamilton	Sue Silvey	Mo Schiller	Brenda Rowe	Bob Bennett	Sylvia Townsend	Graham Briscoe	Tony Rance	Mani Chauhan	Anne Skinner	Pam Yabsley	Angelo Micciche	Edmund Brooks	Ray Phipps	John Steeds	Wendy Gregory	Sue Milestone	Philip Mackie	Lorna Watson	Ian Davies	Karen Stevens	Nick Marsh	Thomas Davies	Florene Jordan	Ben Trumper	Marc Griffiths	Sue Hall	Jim Petter	Tim Peters	Bill Payne	Jeanette Jones	Juila Lee (from 1/9)	Isla Phillips (from 1/9)
Council of Governors																																			
30 July 2015		X	X	X	X	X	X	X		X		X	X	X		X	X		X		X	X	X		X	X	X		X		X	X	X		
15 Sept 2015 Annual Members Meeting		X	X	X	X		X	X		X		X	X	X	X		X	X								X							X		X	X
Nominations and Appointments Committee (Committee members only)																																			
25 September 2015				X	X									X			X	X	X	X													X		
Governors Development Seminar																																			
11 Aug 2015			X			X		X	X	X				X	X			X	X			X	X		X	X		X				X	X		
6 Oct 2015			X	X	X		X		X	X				X	X		X	X					X				X						X	X		
Quality Project Focus Group																																			
8 Sept 2015			X	X	X							X		X		X	X		X							X		X							
Governors Strategy Group/Annual Plan Project Focus Group																																			
8 Oct 2015			X	X	X		X	X					X	X		X	X	X	X																
Constitution Project Focus Group																																			
8 Sept 2015			X	X	X		X		X			X	X	X		X			X							X	X				X				
Chairman's Counsel/Govs Informal Meeting																																			
28 Aug 2015	X		X	X	X		X		X			X	X	X		X		X								X	X					X			
25 Sept 2015			X	X	X	X		X	X					X		X	X	X		X			X				X					X			
Public Trust Board meetings																																			
30 July 2015		X	X	X	X		X			X			X	X			X		X							X						X			
30 Sept 2015			X	X	X								X	X			X											X							
Chair and Chief Exec Walkrounds (2 governors per walkround)																																			
Sept and Oct Walkrounds cancelled																																			
Members' Events																																			
None in period except Annual Members Meeting (above)																																			
Other regular meetings or events																																			
Youth Council meeting 28/7/15					X													X							X										
Voices Editorial Group meeting - 24/8/15																		X																	
Face-to-face patient interviews -26/6/15 & 6/8/15 Anne Skinner, 10/9 Mo Schiller					X							X																							
Ad-hoc meetings/events																																			
Sign up to Safety Launch Event 31/7/15			X																																
Bristol Doors Open Day at the BRI (membership stall) - Sat 12/9/15					X																														
UH Bristol Big Green Scheme event (membership stall) - 14/10/15										X												X													
UH Bristol Involvement Network launch - 15/10/15																																	X		
SBCH Open Doors Day (membership stall) - 17/10/15							X													X															
UH Bristol Governor Representation at External Events																																			
WEAHSN Safer Care Through Early Warning Scores meeting 17/9/15																		X														X			
University of Bristol Fresher's Week (membership stall)- 24/9/15														X												X									
Crohn's and Colitis UK Regional Educational Event 14/10/15					X																														
Trust Operational Groups with governor representation																																			
Clinical Ethics Advisory Group - gov rep is Anne Skinner - **MET 2/9/15**												X																							
Nutrition Steering Group - gov rep is Anne Skinner - **MET 6/8/15**												X																							
Carers' Reference Group - gov rep is Anne Skinner **MET 26/8/15**												X																							
Carers Steering Group - gov reps are Wendy and Lorna - **MET July 2015**																		X																	
Patient Experience Group - gov rep is Pam Yabsley																																			
Organ Donation Group - regular meetings- gov rep is Pauline Beddoes																																			
Patient Flow and R3 Steering Group - gov rep was Ben Trumper																																			
Equality and Diversity Staff Group - gov rep is Florene Jordan																																			
Decontamination Board/Decontamination Group - gov rep is Florene																																			

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 9 – Governors' Meeting Dates 2016-17
Purpose
The purpose of this report is to inform governors of their proposed meeting dates for April 2016-March 2017.
Recommendations
The Council of Governors is asked to **approve** the proposed meeting dates.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governors' Meeting Dates April 2016-March 2017

University Hospitals Bristol NHS
NHS Foundation Trust

Governors' Meeting Dates Apr 2016 – Mar 2017 (draft Oct 2015)

	Governor Development Seminars	Public Trust Board	Council of Governors *(preceded by Trust Board)*	Nominations and Appointments Committee (committee members only)	Chairman's Counsel *(preceded by Governors' Informal Meeting)*	Quality Project Focus Group	Constitution Project Focus Group	Governors Strategy Group (formerly Annual Plan Project Focus Group)	Chair and CE Walkabouts *(2 governors per walkround)*	Members' Events
Chair	**Amanda Saunders**	**John Savage**	**John Savage**	**John Savage**	**John Savage**	**Sean O'Kelly/ Carolyn Mills**	**Amanda Saunders**	**David Relph**	**Robert Woolley**	
Gov Lead		**N/A**	**N/A**	**N/A**	**(Ben Trumper for Govs Informal)**	**Clive Hamilton**	**Sue Silvey**	**Wendy Gregory**	**N/A**	
Apr 2016	Fri 8 April 2016 10am-4pm (CR)	Thurs 28/04/2016 11:00-13:00 (CR)	Thurs 28 April 2016 14:00-15:30 (CR)	Wed 13 April 2016 10:00-11:00 (CR)					5 April 2016 1pm – 3pm IM&T	
May 2016		25/05/2016 11:00-13:00 (CR)			Tue 24 May 2016 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)	Thurs 05 May 2016 12:30-14:30 (CR)			16 May 2016 2- 4pm Medicine	Health Matters Event
Jun 2016	Mon 13 June 2016 10am-4pm (CR)	30/06/2016 11:00-13:00 (CR)		Mon 27 June 2016 13:30-14:30 CR	Mon 27 June 2016 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)		Wed 8 June 2016 10:00-12:00 (CR)	Fri 10 June 2016 10:30-12:30 (BR)	15 June 2016 12.30 – 2.30pm Surgery Head and Neck	
Jul 2016		Thurs 28/07/2016 11:00-13:00 (CR)	Thurs 28 July 2016 14:00-15:30 (CR)			Fri 08 July 2016 09:30-11:30 (CR)			12 July 2016 1-3pm Specialised Services	Health Matters Event
Aug 2016					Fri 26 Aug 2016 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)					
Sept 2016		29/09/2016 11:00-13:00 (CR)	Annual Members Meeting Thurs 15/09/2016 (LT1) 17:00-19:00	Tue 27 Sep 2016 13:30-14:30 BR	Tue 27 Sep 11:30-12:30 Governors' Informal Meeting (BR) 12:30-13:30 Chairman's Counsel (BR)	Thurs 01 Sept 2016 13:30-15:30 (CR)	Thurs 01 Sept 2016 11:00-13:00 (CR)	Fri 09 Sept 2016 10:30-12:30 (CR)	8 Sept 2016 10am–12 noon Estates and Facilities	
Oct 2016	Tues 11 Oct 2016 10am-4pm (CR)	Mon 31/10/2016 11:00-13:00 (CR)	Mon 31 Oct 2016 14:00-15:30 (CR)						11 Oct 2016 1-3pm Women's and Children's	
Nov 2016		29/11/2016 11:00-13:00 (CR)			Fri 25 Nov 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)	Tues 08 Nov 2016 10:00-12:00 (CR)			17 Nov 2016 9–11am Diagnostic and Therapies	Health Matters Event
Dec 2016				Thurs 22 Dec 2016 13:30-14:00 BR	Thurs 22 Dec 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)		Wed 14 Dec 2016 10:00-12:00 (CR)	Tues 06 Dec 2016 13:00-15:00 (CR)	12 Dec 2016 1–3pm Information Management and Technology	
Jan 2016	.Tue 17 Jan 2017 10am-4pm CR	Tue 31/01/2017 11:00-13:00 (CR)	Tue 31 Jan 2017 14:00-15:30 (CR)			Tues 10 Jan 2017 12:00-14:00 (BR)				
Feb 2016		28/02/17 11:00-13:00 (CR)		Fri 24 Feb 2017 13:30-14:00 CR	Fri 24 Feb 2017 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)			Thurs 09 Feb 2017 11:00-13:00 (BR)		
Mar 2016		30/03/17 11:00-13:00 (CR)			Mon 27 Mar 2017 11:30-12:30 Governors' Informal Meeting (CR) 12:30-13:30 Chairman's Counsel (CR)	Thurs 02 March 2017 11:00-13:00 (CR)	Thurs 02 March 2017 13:30-15:30 (CR)	Fri 10 March 2017 10:30-12:30 (CR)		Health Matters Event

CR - Conference Room, Trust Headquarters, Marlborough St, Bristol, BS1 3NU BR - Board Room, Trust Headquarters, Marlborough St, Bristol, BS1 3NU LT1 – Lecture Theatre 1, Education Centre, Upper Maudlin St, Bristol, BS2 8AE

University Hospitals Bristol NHS
NHS Foundation Trust

Report for a Council of Governors Meeting to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 10 – Governor Elections 2016

Purpose

The purpose of this report is to provide the Council with an overview of the timelines of the Governor Election process for 2016.

Recommendations

The Council of Governors is asked to **note** the timelines.

Report Sponsor or Other Author

Sponsor: Head of Membership & Governance

Report

In total 14 Governor roles will be due for re-election in early 2016. This includes 6 Public Governor roles, 5 Patient and Carer of Patient Governor role and 3 Staff Governor Roles.

In preparing for the Governor elections, the Membership & Governance Team in association with the Council will undertake the following activities from November onwards:

- November – Review Membership database for potential candidates/ warm contacts.
- November onwards – promote Governor posts and Governor elections at all membership events including Health Matters.
- January - Write to all members to advise of forthcoming election and voting changes. Include request for expressions of interest to stand as Governor (and email addresses for contact). Include dates and details of Governor information events.
- February/ March – Governor information events and general promotion (local media, GPs, Dentists and Libraries). Targeted events and promotion as required. Distribution of nomination packs.

The detailed dates for the election process will then run as follows, with support from Electoral Reform Services (ERS):

- 6th April – Nominee Deadline
- 28th April – Voting open, all members sent details of nominees and instruction on how to vote
- 29th April – 23rd May – During this time, Membership & Governance team – including governors - support additional promotion
- 24th May – Voting closes
- 25th May – Declaration of results – ERS/ Membership & Governance team to confirm to nominees
- 26th May – Website and communications to announce results of elections, new appointees contacted and inducted into role from 1st June 2016

Additional Information:

- For the first time, members will have the opportunity to vote on-line, as well as by post.
- The Membership & Governance Team will work with Governors to ensure information at promotional events is informative, engaging and reflective of the requirements of the role.

University Hospitals Bristol NHS
NHS Foundation Trust

Cover Sheet for a Report for a Council of Governors Meeting to be held on 30 October 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Item 12– Governors' Log of Communications
Purpose
The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications added or modified since the previous Council of Governors meeting.
The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governor Log – Items since the previous meeting.

ID **Governor Name**

137 **Mo Schiller** ***Theme:*** Dermatology Services ***Source:*** Governor Direct

Query **22/10/2015**

I understand that Weston dermatology has now transferred to UHB. In view of the increase in numbers of skin cancers coming to us now from there are the trust considering setting up nurse led PDT [photodynamic therapy] centre at UHB.This is proven treatment without surgical excision. The nearest centres for patients to access this are Cardiff and Bath.

Division: Medicine ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 22/10/2015

Response

Pending Executive response.

Status: *Assigned to Executive Lead*

136 **Mo Schiller** ***Theme:*** Workforce ***Source:*** Governor Direct

Query **30/09/2015**

Staff participated in a consultation regarding 12-13 hour shifts this year.Recent reports appear to show increased stress levels,sickness and burn out nationally.Did the UHB survey have any similar findings and if so what is being done to address the matter.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:*** 30/09/2015

Response **14/10/2015**

From December 2014 to February 2015 a variety of methods were used to gather staff views regarding 12 hour shift patterns. These included, an online survey monkey which saw 253 responses and a series of focus groups open to all staff, run at different times of the day and in different locations. The data was triangulated together with information from the most recent staff surveys and stress audits.

The consensus view emerging from the shift review processes were that the majority of staff taking part felt positive about working a twelve hour shift pattern, in respect of the impact on their work-life balance and childcare/dependent responsibilities. Some staff did identify that working a twelve hour shift pattern could have a negative impact on their health and well-being.

From the survey results there was no indication of a need to review undertaking a complete review of the current shift patterns that staff work.

The feedback also indicated that work in a number of areas would potentially reduce the negative health impact of the current shift patterns. These include:

• Review the e–rostering rules to ensure that the necessary controls are in place to avoid rostering of more than two consecutive long days/nights and an adequate time off is rostered. (unless this is a personal request) – this should reduce fatigue.
• There is a re-communication that there is an option available for staff to work half twelve hours shifts. (NB this is only possible if two members of staff want to work shorter shifts in one area so may necessitate staff moving area to accommodate these requirements)
• The importance of taking allocated breaks is re-enforced with all staff and managers
• Review options to identify and flag staff working excess hours using e-roster so that impact on these staff can be assessed.
• Issues of health and well-being of staff undertaking a 24/7 shift pattern are reviewed as appropriate in the context of their shift patterns.

A number of these actions have already been implemented

Status: *Closed*

ID **Governor Name**

135 **Mo Schiller** ***Theme:*** CF Ward ***Source:*** Governor Direct

Query **18/09/2015**

Ref 114 submitted 10.2.15 Angelo Micciche

I participated in the Face to face interviews last week speaking with CF patients on Ward A900. In view of the comments I received I referred to log item 114 submitted in February of this year by Angelo. Despite reassurance in the response that concerns had been rectified I feel I need to check on concerns given by CF patients to me last week.The initial consultation process would appear to have looked at different patients being on the new ward to those who are now there.

They cannot understand why there are not more trained CF nurses on the ward. They identified problems of confidence in carrying out tasks, i.e. one nurse had to call in help from another ward at night as she was not competent to give IV antibiotics into an IV long line. There was also feedback about less time spent supporting patients compared with the old ward. Patients expected the nursing staff to have more knowledge of CF problems. Housekeeping and physio were satisfactory.

There are obviously still concerns despite reassurance from the origianl exec response ,it is now 6 months since the log question so initial concerns should have settled, they appear to still be ongoing.

Division: Medicine ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/09/2015

Response **14/10/2015**

The outcomes of the face to face work and feedback through other sources, formal and informal tell us that patients like the new physical environment and that there are a number of areas where the actions detailed in my previous response have led to improved patient experience. The key ongoing issue of concern for patients is their lack of confidence in the staff's expert knowledge related to their condition. The patients miss knowing all of the staff and the continuity and confidence that this provides them when they are admitted as an inpatient. It would be fair to say that the transition to a new ward environment has been more difficult both for patients and staff than was anticipated.

Training within the current team on care of CF patients continues, as does the increased support from the clinical nurse specialist team. The level of vacancies in team on Ward A900 has meant that some shifts are being covered by temporary staff, bank and agency, who may not be as familiar with the Trust's/wards ways of working and may not have an expert knowledge of CF. This has been identified as a specific areas of concern by some patients. Recruitment to these vacancies means that the level of temporary staff usage is reducing. Training has been planned for the new staff on the specialities that the ward covers CF and gastroenterology. This should start to develop an increased level of expert knowledge within the team and improve the continuity of carers for the CF patients.

Status: *Awaiting Governor Response*

134 **Pam Yabsley** ***Theme:*** Inpatient Care ***Source:*** From Constituency/ Members

Query **18/09/2015**

Recently I have heard about a patient being discharged from UHB following a six week stay. He suffers from dementia and was cared for on the appropriate ward. Whilst in the care of UHB he developed a pressure ulcer and furthermore his bottom set of dentures were lost. Regardless of the reasons for the issues in this patient's case, this to me reflects poor nursing care. Unfortunately he will end his life in a very uncomfortable situation which is distressing for his family members. What assurances can be given that care for these patients is good.

Division: Medicine ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 24/09/2015

Response **14/10/2015**

There are a number of assurances which the Trust Board and Governors received regularly via the monthly performance report related to both the care of patients with dementia and care of patients at risk of developing a pressure ulcer. The Governors quality group recently had a presentation, at their request, related to the provision of dementia care within UHBristol from the lead consultant and specialist practitioners, this included information on national dementia standards and how the Trust performs against these.

Sometimes people do develop pressure ulcers which are generally a reflection of a breakdown in the process of risk assessment and/or care deliver, I agree this does not reflect a high enough standard of care. Occasionally pressure ulcers can develop as a result of patient non-compliance with planned care. High quality care provided by UHBristol staff has played a significant part in reducing new pressure ulcers. The efforts of healthcare colleagues across the Trust has seen the proportion of patients with new grade 2, 3 or 4 pressure ulcers reduce year on year. In 2013/14, we also set an internal Trust target to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1,000 bed days (based on a percentage reduction of a previous NPSA benchmark): we achieved a rate of 0.656 per 1,000 bed days. This compares with a rate of 1.264 in 2012/13. . The ambition to eliminate hospital acquired grade 3 and 4 avoidable pressure ulcers continues to be a clear quality priority for UHBristol.

Status: *Awaiting Governor Response*

ID	Governor Name		
133	Graham Briscoe	***Theme:*** Outpatient Services	***Source:*** Governor Direct

Query **21/08/2015**

There appear to be two telephone number pathways into the Outpatient Appointment Service for the Bristol Eye Hospital, but staff manning these lines do not seem to have access to the same booking system information.

Also, the main UHB Outpatient Appointment Service situated at the Main Entrance in the Welcome Centre does not delay with Eye Hospital Outpatient bookings.

From experience this caused issue when trying to change an appointment and confirm the location of the clinic for the appointment. Please can further detail regarding the structure and running of BEH Outpatient services, including the BEH A&E Clinic, be provided.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 18/09/2015

Response **24/09/2015**

The Trust is aware that patients are encountering issues when attempting to telephone the Bristol Eye Hospital Accident & Emergency Department. There are two telephone lines to reach the services at the Eye Hospital, one is a dedicated administrative call centre for outpatient appointments at the Eye Hospital and the other is a line into the Eye Accident and Emergency Department. The phone number indicated on the patient letter is dictated by whether the clinic is held in outpatients or in the Accident and Emergency department. Whilst both lines are answered by teams who do have access to the same trust wide booking system, they are in practice more likely to respond only on matters related to the clinics that they arrange and are held in each respective department because they will have local knowledge about them.

With regard to the line in the Accident and Emergency department, this is also used for direct clinical referrals from GPs and other patients requiring advice, which means it would not be possible to redirect this entirely to the local call centre. The department has recently lost approximately 20% of its experienced nurse practitioners, to retirement and new opportunities. Whilst we have replaced these posts the new staff do not yet have the experience to manage the telephone triage to the level required which has also impacted on our ability to respond to calls in a timely way.

To alleviate the issue in the short-term, additional administrative resource has been allocated to the Accident & Emergency department to ensure the telephones are answered in a timely manner.

The long term solution is to fund a dedicated triage telephone line manned by a nurse practitioner who is able to help and support patients with a view to reducing hospital attendances wherever possible, this will free up the administration lines for patients with appointment queries. The Division of Surgery Head and Neck is currently working up a business case to develop this further.

Currently the BRI Main Appointment Centre only manages a portion of our general outpatient specialities and at this time this does not include the services at the Bristol Eye Hospital. Any patient presenting with a clinic query outside of these specialties would be redirected as the team there would be unable to help. As part of wider improvements to the Outpatient Services it is intended to review the remit and function of this team.

The Trust has convened an Outpatients Steering Group which commenced in July 2015. This group consists of senior staff from all divisions, the transformation team and the Trust patient experience lead. This steering group has identified a programme of work that will improve standards across all our outpatient areas. A project plan and associated work streams have been produced and agreed, which includes development of the BRI Appointment Centre and telephone line enquiries.

We understand that patient's letters in some areas need to be revised and improved to ensure patients have the correct information for attending their appointment and the ability to contact the correct department in the hospital in a timely manner. We have identified this as a quality objective for this year and created a Patient Letters Group to deliver the required improvements.

Supplementary update:
Why cannot any outpatient clinic in the Eye Hospital Accident & Emergency Department be handled by the Team that handles the normal outpatient appointment bookings. Why is it required to even mention the Eye Hospitals Accident & Emergency department when handling outpatient appointment bookings ?

The nature of the outpatient services in the two areas with BEH are distinct. The clinics which operate in the A&E area are for those patients who have been referred by their GP for an urgent opinion or were originally seen in the A&E department and require follow up. Yhe main outpatient area is dedicated to providing clinics for patients who have been routinely referred by their GP or optician or are in long term follow up for conditions such as glaucoma. This approach ensures that there is an appropriate supply of "A&E" outpatient appointments for those that need them urgently and it allows the A&E administrative staff to keep track of this group of patients, pull their notes and manage the outpatient capacity so it is line with the needs of the A&E service.

Registering at the main reception is not part of the pathway for A&E outpatient attenders and I can only assume that the member of staff you came into contact with, was not familiar with the processes for which I apologise.

Status: *Closed*

ID **Governor Name**

132 **Mo Schiller** ***Theme:*** Staff engagement ***Source:*** Governor Direct

Query **17/08/2015**

Following on from the recent report in Newsbeat; Robert's visit to the eye hospital theatres. The fact that the Chief Exec dons scrubs and spends time with the team provides support and encouragement and must have been appreciated. Does the Executive team consider going back to the floor in all areas and that spending time with the teams should be a regular occurrence? I appreciate the walk-arounds give an opportunity for Executives to be seen but actually participating in a working day/part day with all members of the workforce could be a valuable exercise?

Division: Trust-wide ***Executive Lead:*** *Chief Executive* ***Response requested:*** 18/08/2015

Response **04/09/2015**

Although all Executives do this periodically and the Chief Nurse on a regular basis, a formal 'back to the floor' programme is not currently in operation across the Trust. However, it is something we will be considering as part of the programme following feedback from the recent listening events with staff. We will update you again once further discussion have taken place with the Senior Leadership Team in October.

Status: *Closed*

131 **Bob Bennett** ***Theme:*** ***Source:*** Governor Direct

Query **14/08/2015**

Following recent media coverage, can the Board confirm that no senior member of staff is involved in obtaining financial remuneration from any pharmaceutical company.

Division: Trust-wide ***Executive Lead:*** *Trust Secretary* ***Response requested:*** 17/08/2015

Response **14/10/2015**

In line with other NHS Teaching Trusts, there are a small number of Medical Consultants who participate as ‘expert advisors’ on Advisory Boards of Pharmaceutical Companies. These are not statutory boards of directors and do not have authority over the governance of an organisation. An advisory board provides support and expert insight, and are not responsible for decision-making. These Consultants may be in receipt of remuneration, the declaration of which is required under Trust policy. With regard to ‘senior managers’, I can confirm that no member of the Board of Directors are in receipt of financial remuneration from any pharmaceutical company.

Status: *Awaiting Governor Response*

130 **Mo Schiller** ***Theme:*** Management of patient records ***Source:*** Governor Direct

Query **13/07/2015**

Can the Trust advise on policy and procedure for updating records following the death of a patient. What checks are in place to ensure records are accurately maintained and patients or their family members aren't contacted by the Trust unnecessarily?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 21/07/2015

Response **23/09/2015**

The Trust is very mindful of the distress which can be caused to family when a deceased former patient is sent correspondence from the Trust. The Trust has two specific “routines” it runs on our information system to ensure that this does not happen. Firstly, when a patients dies in our care, this is documented promptly on the patient administration system (Medway) and a programme runs 5-6 per day where this deceased status results in the automatic cancellation of any outstanding appointments, admissions or letters recorded on the patient administration system. For patients who die outside of the Trust, these deaths are entered onto a national “spine” linked to GP records and the Trust receives an upload from the spine every two weeks. The Trust This relies upon the timely recording of death on the GP system. There remains an unavoidable risk that deceased patients may receive correspondence from the Trust in the period between GP registration of death and Trust reconciliation with the national spine though there is no evidence to suggest this is happens on a regular basis.

Status: *Closed*

ID **Governor Name**

129 **Karen Stevens** ***Theme:*** Medicines management ***Source:*** Governor Direct

Query **15/07/2015**

What pre-operative and post-operative medicines reconciliation processes are in place? Are they sufficiently robust to ensure patient safety? Are there any measures which could be introduced to reduce potential avoidable harm to patients?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 21/07/2015

Response **31/07/2015**

The minutes of the Medicines Governance Committee of the 21st July address this issue as below;

1.4.1 Pre-op Admission Prescriptions for division of surgery head and neck.

Issues have been raised by the surgical lead pharmacist regarding the risk of surgical patients' medicines being inaccurate when attending for surgery. This has been discussed with the UHBristol anaesthetists at their departmental meeting on 17th July, and Ms Wilson (Pharmacy) and Dr Bewley (Anaesthesia) attended the Medicines Governance Group to discuss the issues and resolution. Currently patients arrive on the ward with a signed but not dated drug chart that nurses cannot administer medicines against.
The current process is that patients are seen in pre-op assessment clinic and a drug history is taken at this time by a case manager nurse. The junior F1/F2 doctor writes the drug chart in pre-op but without start dates as the medicines will not be administered until admission. There was a previous arrangement that start dates are added by anaesthetists on the morning of the operation but this is now considered by the anaesthetists to be impractical.

The issue was raised that no current drug history is available at 7.30am on the day of surgery when patients arrive in hospital, and the staff are then focussing on commencing the theatre list. Although the F1/F2 doctor signed the drug chart in pre-op, this assessment may have been several months prior to the day of surgery. The nursing staff cannot, however, administer he medicines as no start dates have been added. This can result in patient safety issues arising from missed doses.

Various options for resolving the issues were discussed.
Anaesthetists consider it impractical for medicines reconciliation to be performed on the morning of surgery as there is no time to do so and GP practices are not open to check any details. Patients require a second medicines review to highlight any medicines changes between pre-op and admission.

Following detailed discussion, Medicines Governance Group proposed the following process:
Nursing staff and junior medical staff in pre-op will write the drug chart and date and sign it as accurate at that time. When completed at pre-op, an orange sticker is applied stating that the chart has been written and was correct on the day of writing. On the day before the operation, pre-op nurses will check that there are no changes to the medicines. A new green label will be applied to the chart highlighting that the second check has been performed and whether a change to the drug chart is required or not.
An exception to this process would be if a patient is being admitted to the ward prior to surgery in which case normal clerking and medicines reconciliation applies and the drug chart will be written on the ward preoperatively.
It was agreed that Ms Wilson will map out the above process in a Standard Operating Procedure and that it will be trialled. SB requested that feedback is provided to Medicines Governance Group in 2 or 4 months regarding whether this has resulted in safe, appropriate treatment for patients.
It was noted in the discussion that the Trust Clinical Guideline for Perioperative Medicines Management is an extremely helpful document so the key issue with regard to patient safety perioperatively is for all staff involved to be aware of and apply this guidance. It was also noted that the surgical staff would manage the routine medicines postoperatively when the patient returns to the ward.

Action: B Wilson to prepare SOP and feed back experience of implementation to MGG.

Status: *Closed*

128 **Brenda Rowe** ***Theme:*** Access to the hospital ***Source:*** From Constituency/ Members

Query **17/07/2015**

Please can the Trust advise on the rationale for the current free hospital bus service route? Has the Trust considered extending the route to cover other parts of the city, including North and South Bristol, to further support patients who find getting to hospital via Public Transport challenging?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:*** 21/07/2015

Response **31/07/2015**

The current hospital bus route has been developed to enhance existing transport routes for patients and staff travelling into the UHB hospital sites rather than to be a provider of transport services more widely across the city. The route is created to pick up and drop off passengers at transport links across the city centre e.g. Bristol Temple Meads Railway Station, some car parks and the Bus Station. The concentration on this smaller route means the funding we have available enables a frequent service for a larger volume of passengers who can get into the city on existing public services, undertaking longer journeys with the current funding would result in a reduced frequency in the service. Currently we have a successful 15 minute service from Cabot Circus and 30 minute service from Temple Meads, which services all the hospitals in the central precinct carrying 12,000 passenger per month.
When the Bristol General Hospital closed, the Trust considered incorporating South Bristol Community Hospital but this would have meant a reduction in the frequency of the service to once an hour due to the time travelling to and from SBCH and it was perceived this would have had more of a detrimental impact on the existing users across the more frequent service.

Status: *Closed*

ID	Governor Name		
127	**Wendy Gregory**	***Theme:*** Medical Staff	***Source:*** Governor Direct

Query **17/07/2015**

As referenced in the Trust's 2015/16 Operational Plan (page 15):
'Changes to junior doctor numbers -
Work by the Director of Medical Education has helped to confirm that 10 posts will be lost from 2016 (5 Foundation Year 1 doctors and 5 Foundation Year 2 doctors) as a result of the national change to increase community placements. Work programmes to address the shortfall will be developed when the specialties have been identified, but are likely to include changes in workforce models and roles.'

Please can the Trust provide detail with regard to how these changes in workforce models are developing and the potential outcomes that are anticipated to fellow staff members and patients alike

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:*** 21/07/2015

Response **03/08/2015**

Health Education England (HEE) has now agreed that the losses of the junior doctor posts will be less than anticipated to UH Bristol with only 2 of the potential 8 posts being lost. Whilst this is a favourable outcome, these reductions in posts continue to have an impact in the context of wider shortages in junior doctors across the Trust. To this end, it has been agreed that the risk element of losing these 2 posts will be transferred to the relevant Division's risk register. In the meantime, a meeting has been arranged on the 12th August 2015, between Dr Rebecca Aspinall (Director of Medical Education), Heather Toyne (Head of Workforce Planning) and Kay Collings to discuss the overall impact of junior doctor losses from 2016 and to consider potential plans to mitigate any risks.

Status: *Closed*

ID	Governor Name		
126	**Clive Hamilton**	***Theme:*** Fracture Neck of Femur Target	***Source:*** Governor Direct

Query **20/04/2015**

We have not been able to achieve Best Practice Tariff since February 2014 and it seems that the main issue is lack of Trauma Theatre capacity to cope with fluctuating demand.
The September 2014 Board report (Pages 34-36) set out a comprehensive action plan with a trajectory for achievement of the Best Practice Tariff of 90% by Quarter 4 (January –March 2015). The monthly trajectory targets have not been achieved since then but February 2015 performance was more encouraging with a Best Practice Tariff performance of 82.8% and 89.7% patients treated within 36 hours (March Board report page 65).
The February Board report (page 61) describes a situation during the weekend of 23rd January when breaches of the 36 hour standard occurred due to seven hip fracture patients being admitted over the 2 days, one of whom died in the operating theatre.
Given this history, I request assurance that our trust will ensure that there is sufficient capacity to meet all three 90% standards from now on.

Division: Surgery, Head & Neck ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **13/07/2015**

At the April Trust Board this matter was raised by Clive Hamilton, Governor representative for the public constituent of North Somerset. In response Sean O'Kelly, Medical Director, referred to ongoing work to address capacity. He went on to explain that this service can see significant peaks in demand and analysis of our own data shows we struggle to achieve the theatre standard when 2 or more patients present on the same day, although of note the majority of patients do have their surgery within 48 hours. Also of note is the Trust's mortality data, which shows that despite a minority of patients not achieving theatre within 36 hours, the service achieves good outcomes for its patients.

Whilst the theatre standard remains an importance measure, the Best Practice Tariff captures 9 aspects of care, the majority of which the Trust performs well against. Finally, the question has recently been posed as to whether patients should be admitted to Southmead at times of peak pressure in the BRI; there are three key reasons that suggest this would not be an appropriate step at this time 1) NBT did not achieve the 36 hour theatre standard in either 2013/14 or 2014/15 2) pre-hospital diagnosis of a fractured femur, in the absence of access to imaging, is not reliable 3) Southmead have advised that their own performance is very fragile and any swing of patients to them would lead to an inevitable further deterioration in their own performance.

Finally, the Division remains focussed on making improvements where it can. Analysis of the time and day of breaches, indicates that the biggest single benefit would come from actions that avoid the cancellation of the patient who is scheduled for theatre in the afternoon but is then cancelled because either, the list is overrunning and thus the case is not started if it would end after 5pm or a clinical priority is identified during the course of the day. Given this context, two actions are being focussed upon – attention to the Golden Case (# NOF going first on the trauma list), addition of a # NOF to the elective limb reconstruction list and staffing of an additional theatre overrun (currently staffed for one per day but to be increased to two). The latter has the most to contribute to performance but will take the longest to implement due to high vacancy rates.

It has been agreed, through the Quality and Outcomes Committee (QOC), that the quality dashboard will be amended to reflect two further measures of # NOF performance to include % seen within 48 hours and the longest wait (for non-clinical reasons).

Status: *Closed*

ID **Governor Name**

125 **Mo Schiller** ***Theme:*** Workforce ***Source:*** Governor Direct

Query **30/06/2015**

Research by the Royal College of Nursing (RCN) claims changes to immigration rules — set to be enforced in 2017 — could cause staffing issues for the NHS. Under the new rules, people from outside the European Economic Area (EEA) must be earning £35,000 or more before they are allowed to stay in the UK after six years. The RCN claims 3,365 nurses working in the UK are potentially affected by these changes, Band 5 staff nurses earn £21.692 - £28.180, the mainstay of registered nursing staff in the Trust, and Band 6,senior staff nurses earn £26.041 - £34.876. Can the Trust advise what the likely impact might be at UH Bristol? In the future will the focus on recruitment will now be within the EU.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **09/07/2015**

Currently the Trust has no plans to undertake targeted nurse recruitment campaigns outside the European Economic Area, however it is very mindful of the potential impact of government immigration policy decisions on workforce supply markets. UHBristol is monitoring national consultations around the proposed changes to immigration rules with regards to an increase in salary thresholds. The Trust's initial assessment is that the impact is anticipated to be low if the new enforcements are set in 2017 on existing nursing staff from outside the EEA, but developments will be monitored and a proactive review will be undertaken as more is known.

Status: *Closed*

124 **Wendy Gregory** ***Theme:*** Workforce - Exit Interviews ***Source:*** Governor Direct

Query **01/06/2015**

Can the Trust advise what is the percentage of exit interviews being undertaken in relation to the total numbers of staff leaving the Trust? Also has the format and timing of the exit interview been reviewed to inform if at times it would be possible to encourage an employee to stay with the Trust.

Division: Trust-wide ***Executive Lead:*** *Director of Human Resources and Organisational Development* ***Response requested:***

Response **18/06/2015**

In Q4 the HR Employee Services team had a 31.4% return rate of exit data as a result of a combination of exit questionnaires completed by leavers and exit interviews. This reflects 74 'exit responses' out of 236 leavers in this period.

Concerted efforts continue to be made by the Employee Services team to increase the number of exit interviews being undertaken with staff leaving the organisation and also to improve the quality of information received on reasons for staff leaving the organisation, in order to better inform recruitment and retention strategies.

Furthermore, managers continue to be encouraged to engage with their staff known to be leaving the organisation as early as possible, by way of exploring with their staff member the possibility of remaining with the Trust.

Status: *Closed*

123 **Mo Schiller** ***Theme:*** Nursing Recruitment ***Source:*** Governor Direct

Query **01/06/2015**

When recruiting nurses from Europe and overseas from outside of the EEC, what is the cost comparison for recruitment from the UK? How many of those selected need to follow an adaptation course and what is the time scale for this? Do all staff recruited from Europe and overseas have a language proficiency test and mathematics calculation test for medication?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:*** 02/06/2015

Response **28/07/2015**

The requirement for nurses to undertake an adaptation course depends on their country that they completed their training in. Timescale and outcomes required vary dependent on the individual's needs. This is set by the NMC not the Trust. Overseas recruits registering with the NMC are admitted to the register via different routes depending on the country they trained in. If nurses or midwives trained in countries outside the European Union (EU) or European Economic Area (EEA) and have been admitted to the NMC register, they have had an education and practice check. They also have their character and language competence verified. The NMC requires an IELTS 7 (which is the proficiency level of the International English Language Testing System) for all applicants who register who trained outside of the EU, regardless of which country they are from or whether they came from an English speaking country. Any medication assessments would be part of the local induction and assessment of these nurses when they start work within an organisation.

Status: *Closed*

University Hospitals Bristol NHS
NHS Foundation Trust

Patient Experience Report

Quarter 1, 2015/16

(1 April to 30 June 2015)

Author: **Paul Lewis, Patient Experience Lead (surveys and evaluation)**

1. Patient experience at UH Bristol: Quarter 1 summary and update

This report presents quality assurance data from the UH Bristol patient experience survey programme, principally: the Friends and Family Test, the monthly postal surveys, and the national patient surveys. The key headlines from Quarter 1 (April–June 2015) are:

- The Trust continued to achieve "green" patient satisfaction ratings in the Trust Board Quality Dashboard: reflecting the provision of a high quality patient experience at UH Bristol (see Appendix C and D for a description of the surveys and scoring mechanisms used in this report).
- Praise for UH Bristol staff continues to be the most frequent form of written comment received via the Trust's corporate patient experience surveys - easily exceeding the top five negative themes combined. The negative themes that emerge most frequently are around communication, waiting / delays, food, and staff behaviour (often an isolated incident within an otherwise good hospital experience).
- The Trust commenced a new survey of outpatients in April 2015. The first quarterly data from the survey is presented in this report and indicates that a high quality outpatient experience is being provided. Of the four key survey questions used to derive the UH Bristol outpatient experience "tracker", the lowest score was around waiting times in clinic (improving this score is a Trust Quality Objective for 2015/16).
- The Friends and Family Test (FFT) was formally extended to day-case services in April 2015. This new data is aggregated with the inpatient FFT data to give a single metric, with both services receiving similarly positive scores (typically around 95% of patients saying that they would recommend the care).
- The Friends and Family Test (FFT) was also extended to paediatric services in April 2015. As part of this extension, survey touchscreens were installed in the Bristol Royal Hospital for Children's Emergency Department to automate the data collection. This technology has enabled the Department to meet the challenging response rate targets associated with this survey with minimal impact on staff time, but has generated very low FFT scores – primarily because people are giving feedback at all stages of their "journey", rather than just at the end. (This technology was introduced into the two adult Emergency Departments in July 2015 and has had a similar effect on the response rates and scores). Although these are methodological issues, rather than a reflection of service quality, these lower scores are a concern because they are publically available and intimate that the Trust is performing poorly in respect of patient experience. As such, the Emergency Department element of the FFT is currently in a re-development phase: optimal placing of the screens in the Departments is being explored, and feedback will continue to be captured using FFT "postcards" at discharge (albeit at a lower volume) alongside the screens, in order to ensure a rounded view of patient experience is captured.
- UH Bristol performs in line with national norms in most of the national patient experience surveys. The exception here is the national cancer survey, where a number of low scores were achieved by the Trust. A significant programme of patient engagement has been undertaken by the Trust in order to triangulate and better understand these results. This programme (which included a series of focus groups carried out independently by the Patients Association) found that UH Bristol provides a good patient experience for people with cancer, but that the broad areas for improvement identified via the national cancer survey were valid (e.g. communication / information provision, continuity of care between organisations). An action plan in response to these findings has been developed and is being overseen by the Trust's Cancer Steering Group.
- The variations seen in UH Bristol's hospital site and ward-level survey scores also reflect national trends, with postnatal wards and wards providing long-term care for chronic conditions generally receiving lower patient satisfaction ratings. A large number of service improvement activities continue to be carried out at the Trust that will have a positive impact on patient experience.

2. Trust-level patient experience data

Charts 1 to 6 (over) show the six headline metrics used by the Trust Board to monitor patient satisfaction at UH Bristol[1]. These scores have been consistently rated "green" in the periods shown[2], indicating that a high standard of patient experience is being maintained at the Trust. The scores would turn "amber" or "red" if they fell significantly, alerting the senior management team to the deterioration.

The most frequent form of written feedback via the surveys is praise for staff. Communication, delays, food and staff are the most cited areas for improvement. It is clear from this feedback that UH Bristol's staff are the main determinant of a positive or negative patient experience. Whilst this "people" aspect of care is in general very positive – a single negative experience in this respect often has a detrimental effect on the patient's entire experience of being in hospital.

A new UH Bristol outpatient survey started in April 2015. This is sent by post to approximately 500 patients (or parents of 0-11 year olds) per month. From this data an "outpatient tracker score" is now provided to the Trust Board (Chart 3) [3]. This aggregates four survey scores relating to cleanliness, treating patients with respect and dignity, waiting times in clinic, and communication. Among this group of four questions, waiting times in clinic achieved the lowest (i.e. worst) score in Quarter 1 – although it should be noted that the majority of respondents (73%) reported that they were seen on time or within fifteen minutes of their appointment time. Reducing delays in clinic is currently one of UH Bristol's corporate Quality Objectives and so will be a major focus of improvement at the Trust in 2015/16.

UH Bristol's Friends and Family Test (FFT) for Emergency Departments does not currently have a minimum target score threshold associated with it (Chart 5). A number of methodological changes are currently taking place with this element of the Trust's FFT – in particular its extension to the Bristol Royal Hospital for Children Emergency Department (BRHC ED) from April 2015, and the implementation of touchscreen technology to support data collection. During Quarter 1, the BRHC ED was the only UH Bristol Emergency Department collecting FFT data using touchscreens, with the two adult EDs maintaining their approach of administering an FFT card to patients at discharge. Since then, touchscreens have been introduced into the Bristol Royal Infirmary and Bristol Eye Hospital Emergency Departments. Whilst these changes open up more feedback opportunities for patients / parents and reduce the administrative burden on staff, they affect the scores: the relatively low score for the BRHC ED in Quarter 1 was principally because feedback via the touchscreens is received at all stages of the patient journey, not just at the end (when people are usually feeling more positive). The optimal positioning of the screens and appropriate blend between touchscreen and card collection is currently being explored, before a target threshold is set (with the aim of having this in place during Quarter 3).

[1] Kindness and understanding is used as a key measure, because it is a fundamental component of compassionate care. The "patient experience tracker" is a broader measure of patient experience, made up of five questions from the UH Bristol monthly postal survey: ward cleanliness, being treated with respect and dignity, involvement in care decisions, communication with doctors and with nurses. These were identified as "key drivers" of patient satisfaction via statistical analysis and patient focus groups conducted by the UH Bristol Patient Experience and Involvement Team. The outpatient tracker is made up of four questions relating to respect and dignity, cleanliness, communication and waiting time in clinic.

[2] Note: the Friends and Family Test and outpatient data is available around one month before the inpatient survey data.

[3] Trust Board data from the outpatient survey is provided as a "rolling three monthly score". So for example, in July the Trust Board received the combined survey score for April, May, and June; in August the Board will receive combined data for May, June and July. This is to ensure that the sample sizes are sufficiently large to generate an accurate score. This approach will be reviewed for the 2016/17 Trust Board Quality Dashboard, as there will be enough survey data at that point to test whether reliable discrete monthly data can be generated.

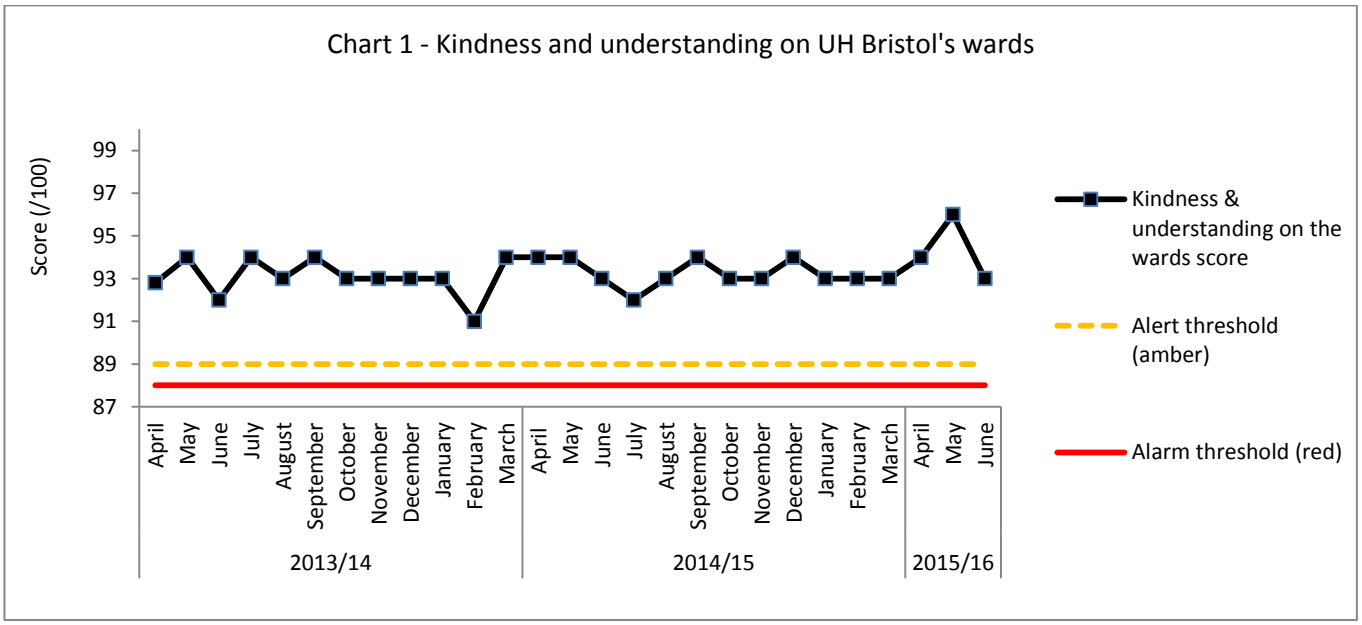


Chart 1 - Kindness and understanding on UH Bristol's wards
Score (/100)
99
97
95
93
91
89
87
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2013/14
2014/15
2015/16
Kindness & understanding on the wards score
Alert threshold (amber)
Alarm threshold (red)

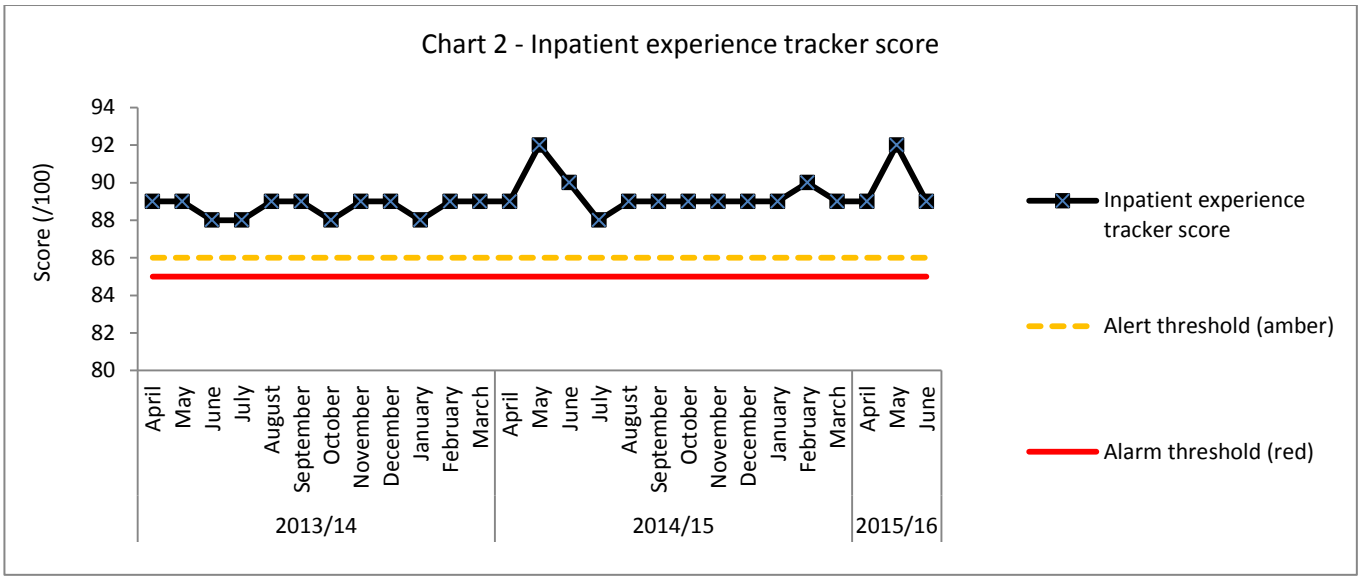


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April May June July August September October November December January February March April May June July August September October November December January February March April May June
2013/14
2014/15
2015/16
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

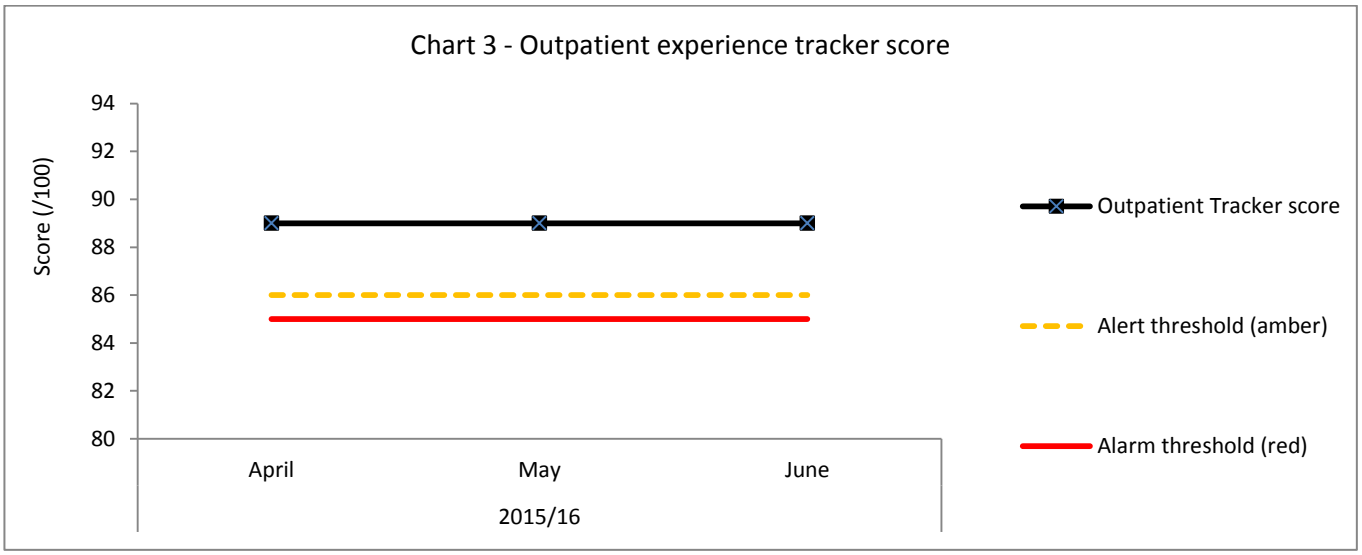


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
2015/16
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

Chart 4 - Friends and Family Test Score - inpatient (includes day cases from April 2015)

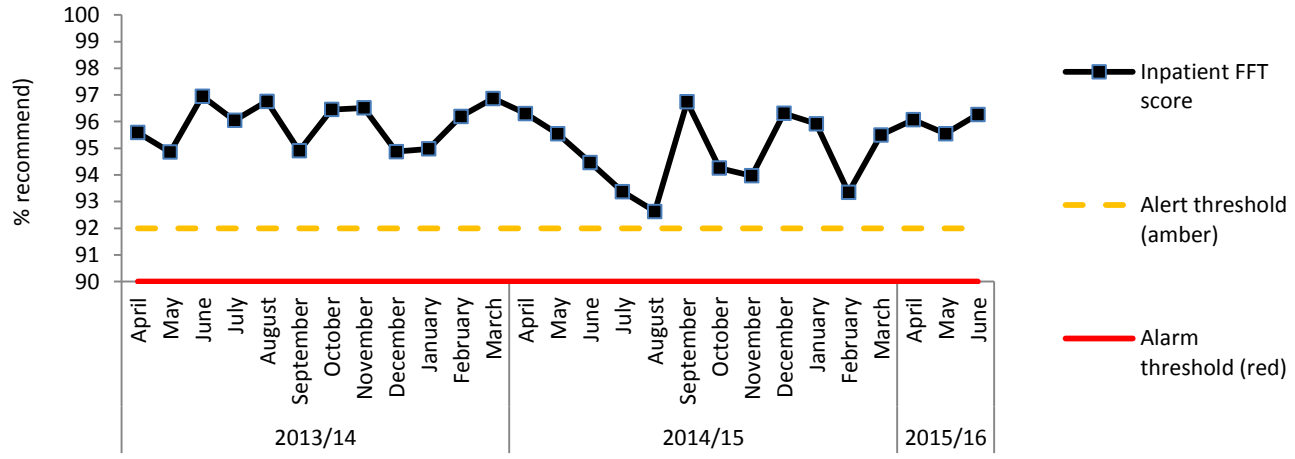


Chart 5 - Friends and Family Test Score - Emergency Department

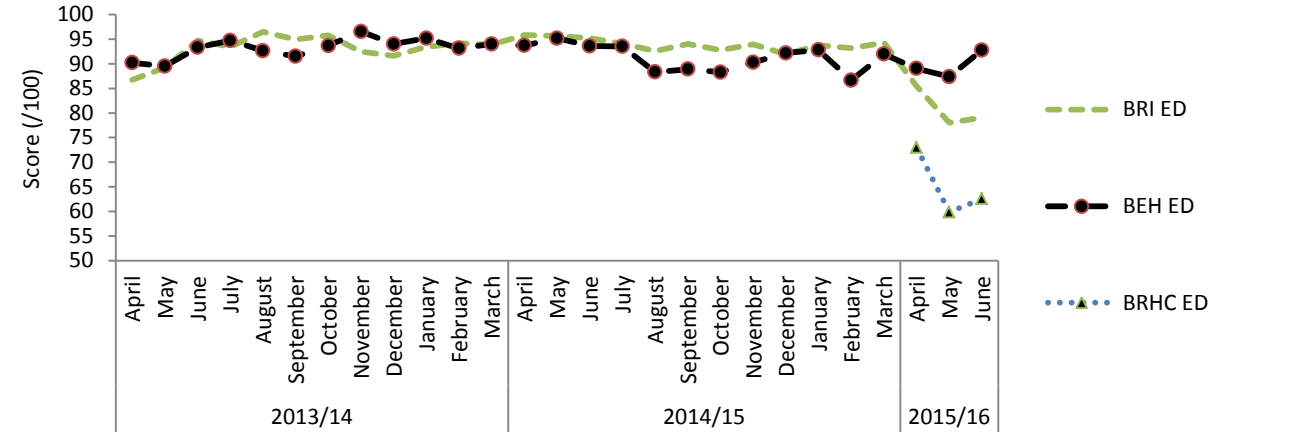
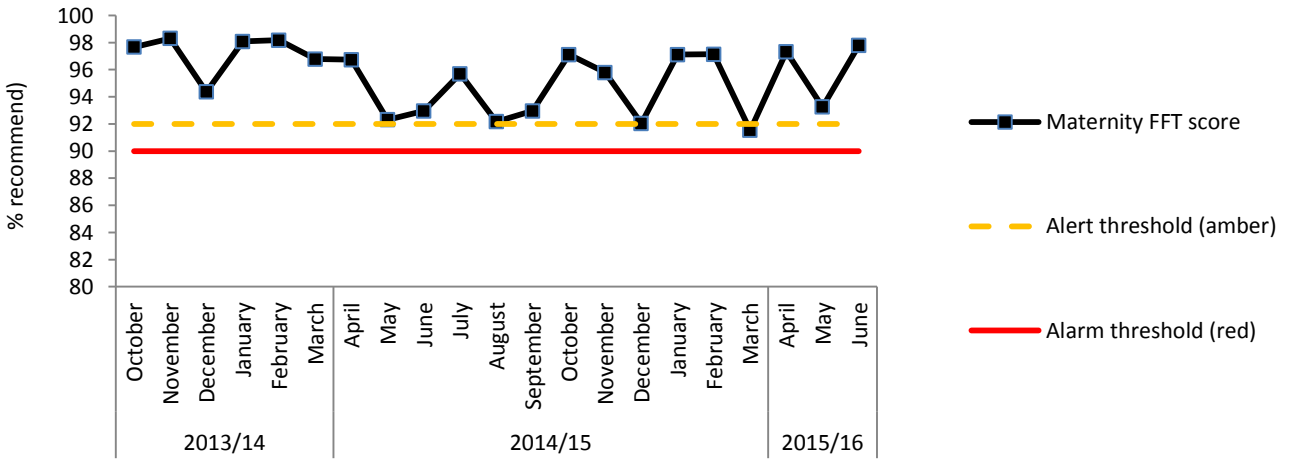


Chart 6 - Friends and Family Test Score - maternity services (hospital and community)



3. Divisional and hospital-level patient experience data

Charts 7 to 10 (page 7) show the headline patient experience metrics by UH Bristol Division. The Trust-level "alarm threshold" is shown in these charts, but this is a guide only - caution is needed in applying this threshold because there is a higher margin of error in the data at this level.

Postnatal wards tend to attract lower survey ratings for kindness and understanding (Chart 7) and in the Friends and Family Test (Chart 9). Directly comparing these scores with other inpatient wards is problematic because the demographics of respondents from maternity services are different to the rest of the Trust. It is important to note that the Trust's maternity scores are in line with (or better than) their national benchmarks (see section 6 of this report). However, the maternity services management team and staff remain committed to acting on service-user feedback, for example –

- To improve the experience of women having an induced labour there has been a reconfiguration of the maternity wards and staff rotas. This includes allocating dedicated staff and space within the ward (including six single rooms) women having inductions.
- Capital funding has been secured to improve the lay out of the post-natal ward and reception area.
- A housekeeper has been appointed to ensure that women are orientated to the ward and are able to obtain food / refreshments as required.
- The Supervisors of Midwives have set up a contact telephone number for patients to contact them with any concerns about their care.
- Setting realistic expectations for future service users is also important. Work has being carried out with the community midwifery teams to ensure that women coming into hospital who have a normal birth know that they won't be treated as patients: they will be encouraged to mobilise soon after birth and to care for their baby.
- Patient experience and feedback from patients is discussed within the midwifery patient safety day, which is mandatory for midwives to attend.

Charts 11 to 14 (page 8) show the headline survey results by hospital. Again, the Trust-level alarm threshold is shown, but should be applied with caution due to the higher margin of error in the data at this level.

The South Bristol Community Hospital (SBCH) receives positive patient ratings for outpatient services (Chart 14) and for the "caring" aspects of inpatient care (Charts 11 and 13). However two elements of the "inpatient tracker" bring down the overall score on this metric (Chart 12): involvement in care decisions and communication (receiving understandable answers to questions put to doctors and nurses). The management team at SBCH are aware of these scores and are constantly striving to improve the service provided to patients and their carers / families, but as a large proportion of inpatients at SBCH are elderly with long-term medical / care needs (e.g. rehabilitation from stroke), these lower "communication" scores are in many ways a realistic reflection of the challenges in caring for this group of patients. This is a trend seen at both national-level[4] and within UH Bristol's own survey data.

Two hospitals had relatively low scores on the new outpatient experience tracker (Chart 14): the Bristol Royal Hospital for Children and the Bristol Eye Hospital. The main reason for these lower scores is that patients in these hospitals reported longer waiting times in clinic. As we have not yet collected sufficient data to establish trends in this new dataset, this may have been a temporary issue during Quarter 1. The Trust has a Quality Objective associated with reduced waiting times and so this information will be fed into the project team.

[4] http://www.pickereurope.org/wp-content/uploads/2014/10/Multi-level-analysis-of-inpatient-experience.pdf

Chart 7 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

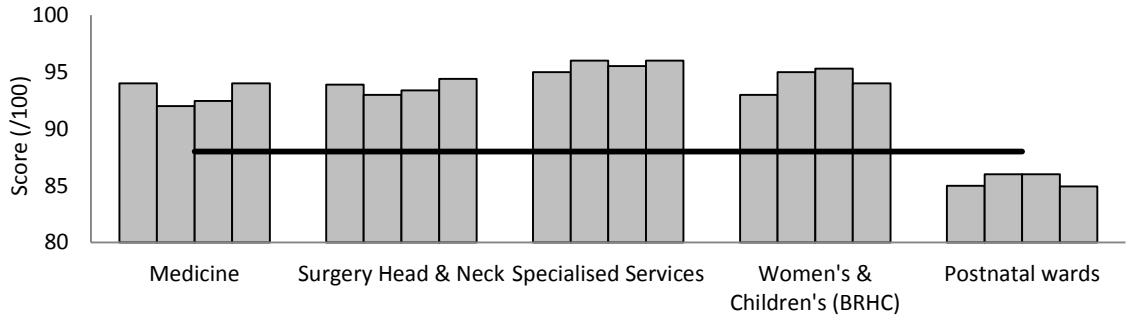


Chart 8 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

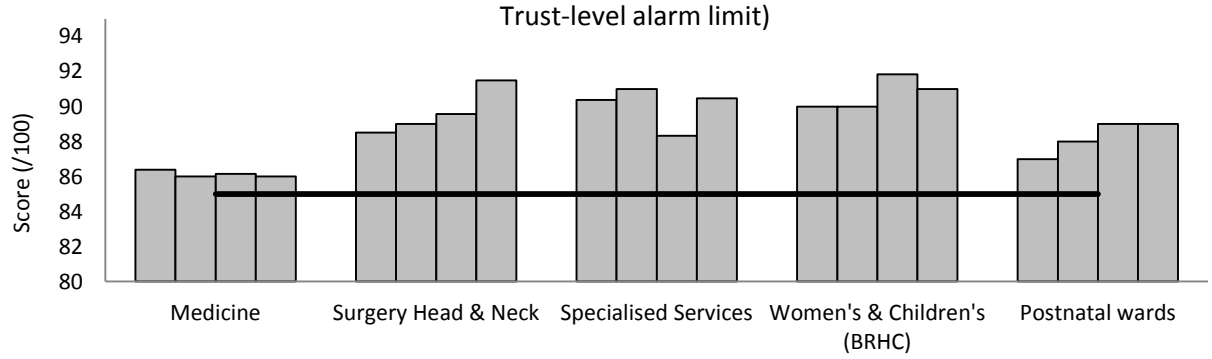


Chart 9 - Inpatient Friends and Family Test score - Last four quarters by Division (with Trust-level alarm limit. Note: does not currently include day cases))

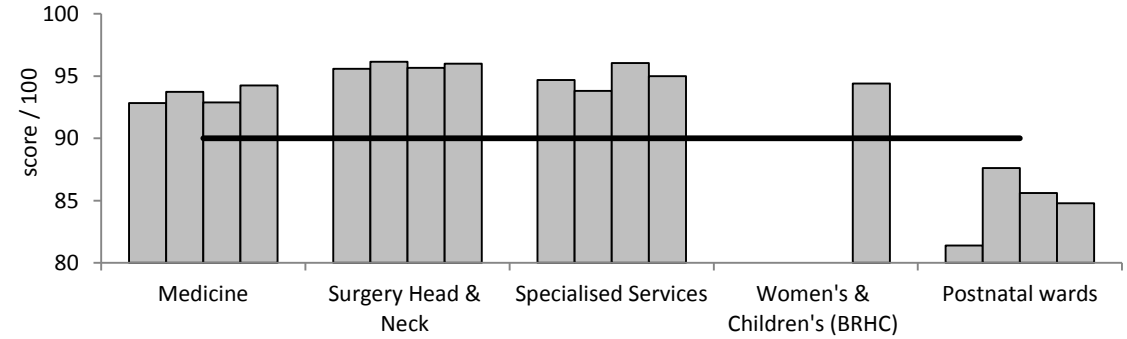


Chart 10 - Outpatient experience tracker score by Division (Quarter 1 15/16 with Trust-level alarm limit)

Chart 11: Kindness and understanding score by hospital (last four quarters; with Trust-level alert limit)

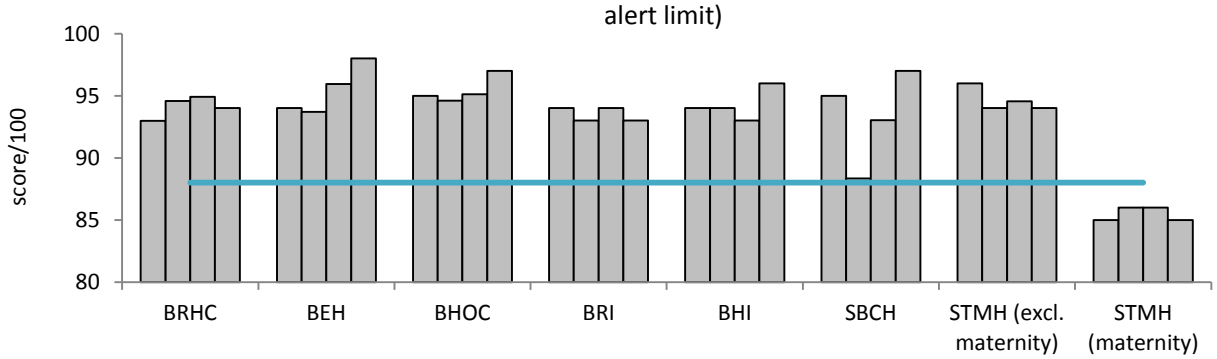


Chart 12: Inpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)

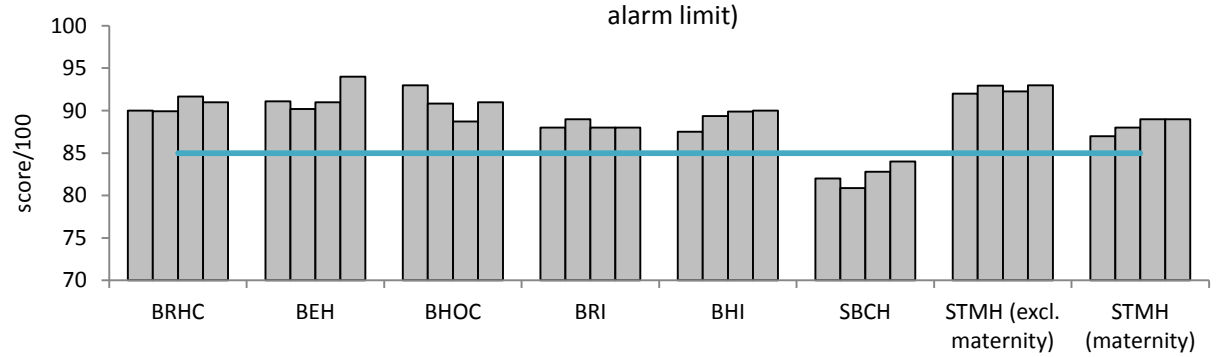


Chart 13: Inpatient and day case Friends and Family Test (last four quarters; with Trust-level alarm limit)

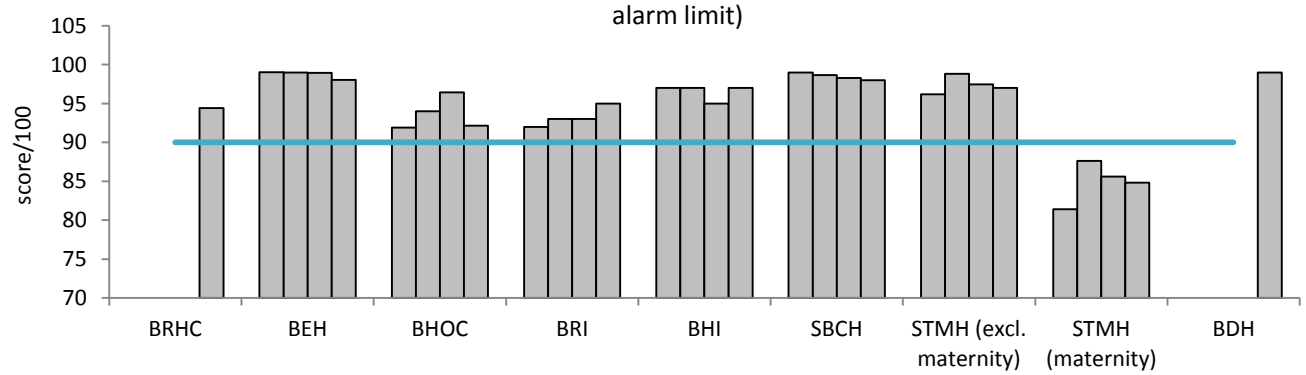
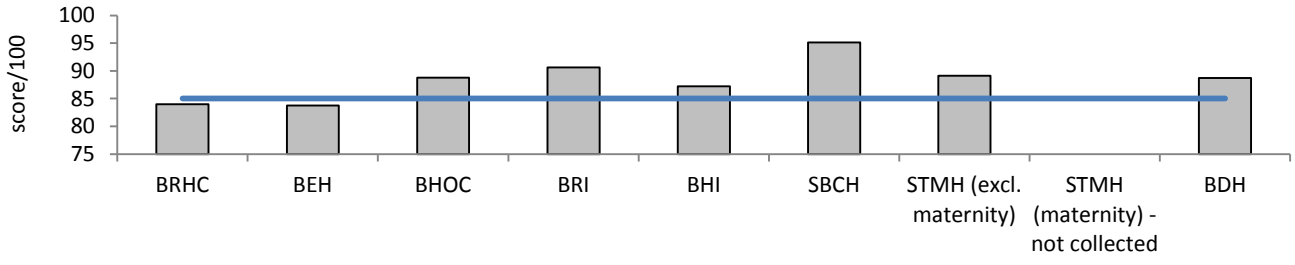


Chart 14: Outpatient experience tracker score by hospital (last four quarters; with Trust-level alarm limit)



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)

4. Ward-level data

Ward-level inpatient survey and Friends and Family Test data is presented in charts 15 to 17 (over)[5]. The quality of this ward-level data has been adversely affected by the ward moves occurring within the Bristol Royal Infirmary. To minimise the effect of these moves on the data, scores from a single Quarter are presented here – but this significantly reduces the sample sizes, which has a detrimental effect on the reliability of the data (ideally we would aggregate this data to a six-monthly view). Furthermore, in the Friends and Family Test, a number of new ward areas went "live" in April 2015 (principally at the Bristol Royal Hospital for Children): these wards have not yet gained full traction in terms of generating high response rates, and so at present the FFT is particularly unreliable at this level. These issues will resolve over the coming months, but caution should be applied to the survey scores presented in this section of the report.

At a ward-level it is important to look for consistent trends across the surveys (particularly given the issues described above) and to draw on wider quality data /research to help interpret the results:

- In Chart 15, the kindness and understanding score for postnatal wards (71,74,76) has been discussed in Section 3 of this report. Whilst the Friends and Family Test survey also tends to be slightly lower for postnatal wards, In Quarter 1 Ward 74 achieved a very low score (Chart 17). The maternity FFT data is particularly prone to fluctuation at a ward level, as the number of responses is generally quite low at this level. However this particular score was mainly attributable an unusually high number of "don't know" responses for Ward 74 in Quarter 1: these are included in the FFT score calculation and so serve to reduce the percentage of respondents stating that they would recommend the care. It is not clear why there were such a large proportion of these responses in Quarter 1 for this ward.

- Ward A900 had the lowest "kindness and understanding" rating and among the lowest scores on the inpatient tracker in Quarter 1. Ward A900 is a new ward at the Bristol Royal Infirmary that provides specialist care for patients admitted with gastro and respiratory problems. It also houses the inpatient beds for the Bristol Adult Cystic Fibrosis Centre, which is an adult specialist centre providing multidisciplinary care to adults with Cystic Fibrosis (CF) in the region. Whilst in general the patient feedback is positive about the ward, some CF patients have expressed concerns about their care. In order to better understand these issues, an analysis of patient feedback about the ward was carried out and the Trust's *Face2Face* survey volunteers visited the ward in September 2015 to talk specifically to CF patients. As frequent users of UH Bristol's services (and often experts in their own care), it is clear that the move to a new environment, with a new care team, poses challenges and requires new relationships and confidence to be built. The outcomes of this exercise are currently being reviewed by the Head of Nursing and ward team, and will be used to target improvements in the experience for these patients.

- B501 (care of the elderly) and B504 (acute stroke) in the Bristol Royal Infirmary had the lowest inpatient tracker scores in Quarter 4. This was primarily due to the communication and involvement in care elements of this aggregate score. As discussed in relation to South Bristol Community Hospital, this is a realistic reflection of the challenges in caring for these patient groups and reflects research findings at a national level. The Divisional Head of Nursing continues to monitor the survey scores and to triangulate them with other data sources, to ensure that a high quality of care is maintained.

[5] Wards with less than ten survey responses have not been included in this analysis.

Chart 15: Kindness and understanding ratings by ward (April to June 2015), with Trust-level alarm threshold)

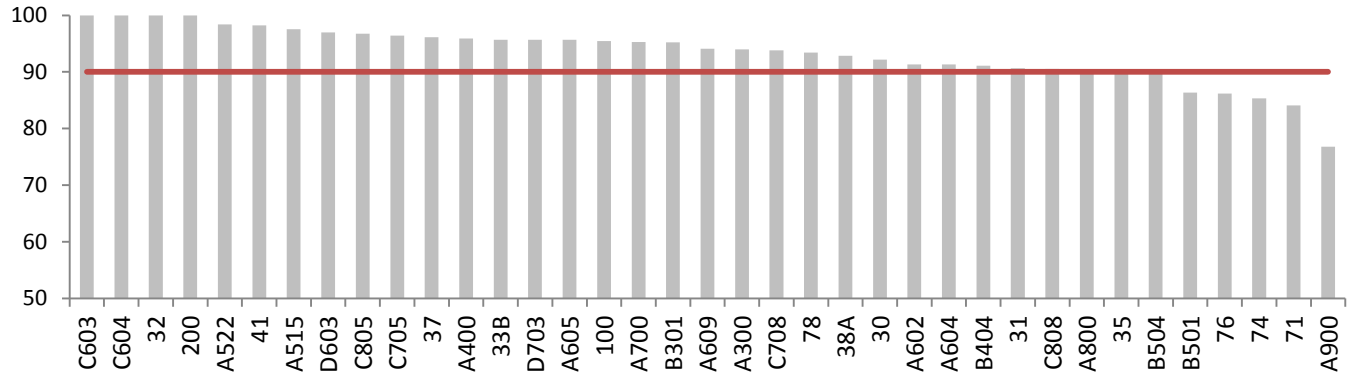


Chart 16: Patient Experience Tracker score by ward (April to June 2015), with Trust-level alarm threshold

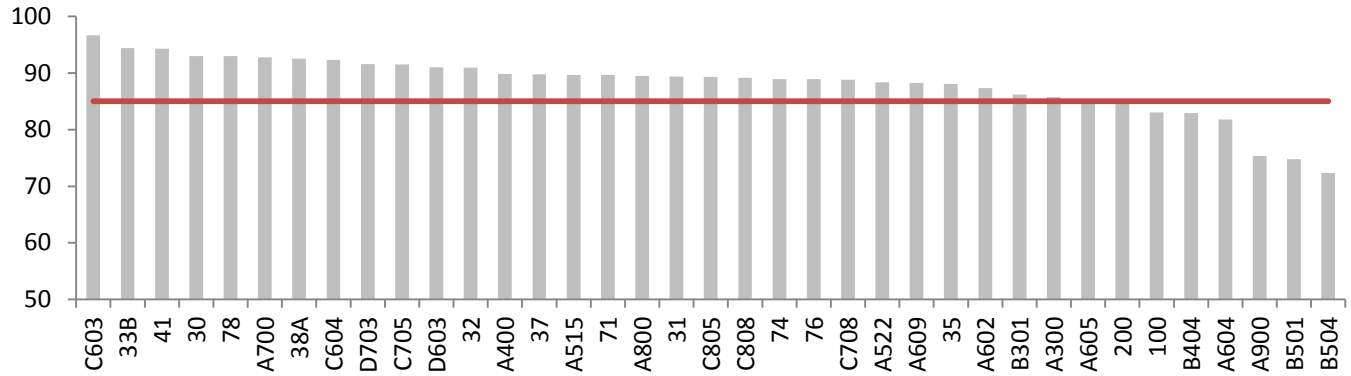
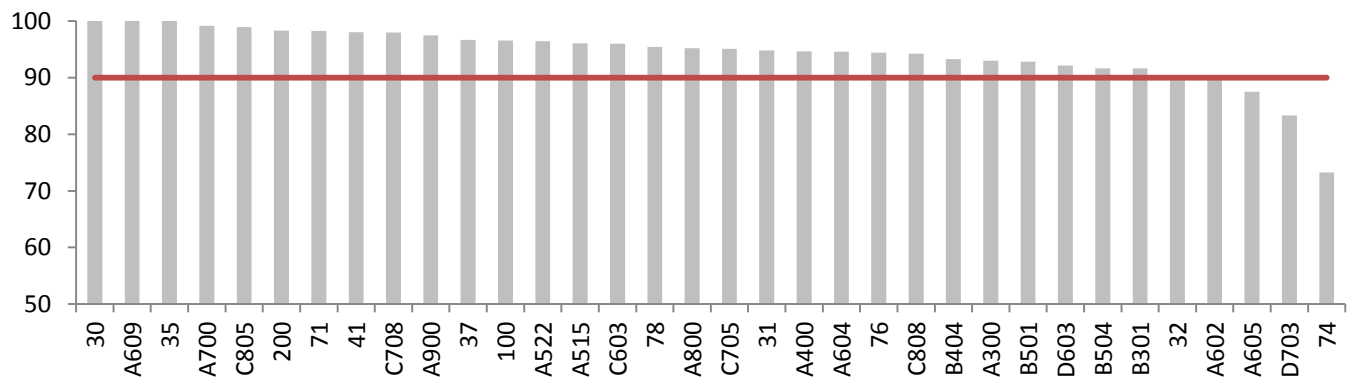


Chart 17: Friends & Family Test inpatient results by ward (April to June 2015), with Trust-level alarm threshold) - no data is available for the Bristol Royal Hospital for Children



5. Themes arising from inpatient free-text comments in the monthly postal surveys

At the end of our postal survey questionnaires, patients are invited to comment on any aspect of their stay – in particular anything that was worthy or praise or that could have been improved. In the twelve months to 30 June 2015, around 5,000 written comments were received in this way. All comments are categorised, reviewed by the relevant Heads of Nursing, and shared with ward staff for wider learning. The over-arching themes from these comments are provided below. Please note that "**valence**" is a technical term that identifies whether a comment theme is positive (i.e. praise) or negative (improvement needed).

All inpatient /parent comments (excluding maternity)

Theme	Valence	% of comments[6]	
Staff	Positive	61%	*61% of the comments received contained praise for UH Bristol staff. Improvement themes centre on communication, staff, waiting/delays, and food. "Food" generates strong feelings, but the majority of patients (65%) rate it as "very good" or "good"*
Communication	Negative	14%	
Waiting/delays	Negative	10%	
Staff	Negative	9%	
Food/catering	Negative	9%	

Division of Medicine

Theme	Valence	% of comments	
Staff	Positive	57%	*Negative comments about "staff" are often linked to other thematic categories (e.g. poor communication from a member of staff). This demonstrates that our staff are often the key determinant of a good or poor patient experience.*
Communication	Negative	13%	
Staff	Negative	10%	

Division of Specialised Services

Theme	Valence	% of comments	
Staff	Positive	63%	*Negative comments about staff also often relate to a one-off negative experience with a single member of staff, showing how important each individual can be in shaping a patient's experience of care.*
Communication	Negative	15%	
Waiting / delays	Negative	10%	

Division of Surgery, Head and Neck

Theme	Valence	% of comments	
Staff	Positive	60%	*Communication is a key issue, but it is a very broad theme which includes ease of contacting the trust, patient information, clinic letters, and face-to-face discussions with individual staff.*
Communication	Negative	16%	
Waiting/delays	Negative	10%	

Women's & Children's Division (excl. maternity)

Theme	Valence	% of comments	
Staff	Positive	68%	*This data includes feedback from parents of 0-11 year olds who stayed in the Bristol Royal Hospital for Children. Again the themes are similar to other areas of the Trust.*
Communication	Negative	14%	
Waiting/delays	Positive	11%	

Maternity comments

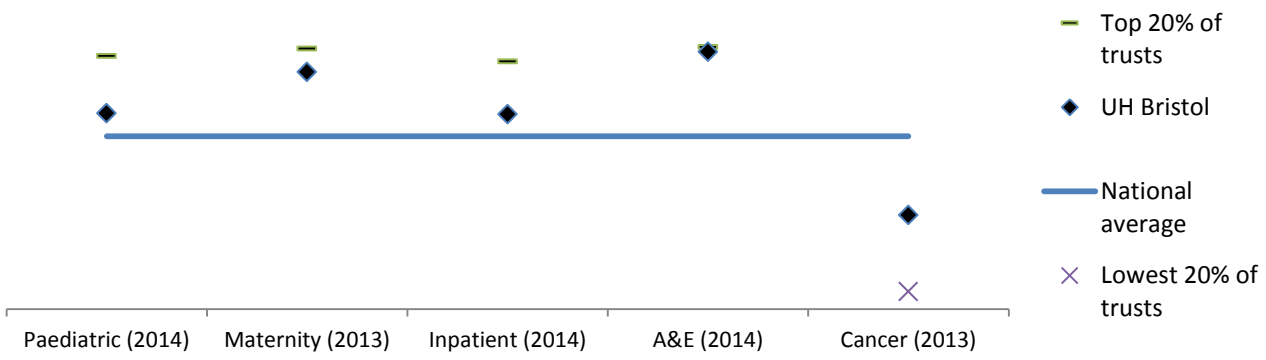
Theme	Valence	% of comments	
Staff	Positive	61%	*For maternity services, the two most common themes relate to praise for staff and praise for care during labour and birth.*
Care during labour	Positive	24%	
Staff	Negative	13%	

[6] Each of the patient comments received may contain several themes within it. Each of these themes is given a code (e.g. "staff: positive"). This table shows the most frequently applied codes, as a percentage of the total comments received (e.g. 61% of the comments received contained the "staff positive" thematic code).

6. National patient survey programme

Along with other English NHS trusts, UH Bristol participates in the Care Quality Commission (CQC) national patient survey programme. This provides useful benchmarking data - a summary of which is provided in Chart 18 below[7] and Appendix A. It can be seen that UH Bristol broadly performs among the mid-performing trusts nationally. The main exception is the 2014 national Accident and Emergency survey, where UH Bristol performed well above the national average. The national cancer survey (NCS) on the other hand tends to produce scores for UH Bristol that are lower than the national average, despite a large number of service improvement actions at the Trust to try and redress this. A comprehensive engagement programme with patients receiving cancer services at UH Bristol has been carried out, in collaboration with the Patient's Association. In addition, the Trust is participating in an NHS England programme which involves working closely with a peer Trust that performs consistently well in the NCS. These activities have formed the development of a service-improvement plan which was received by the Trust's Cancer Steering Group in Quarter 2 (2015/16).

Chart 18: Comparison of UH Bristol's national patient experience survey results against the national average (year in brackets / nearest quintile threshold shown)



It is interesting to ask: how good is the national average? This is a difficult question to answer as it depends on exactly which aspect of patient experience is being measured. However, the national inpatient survey asks people to rate their overall experience on a scale of 1-10, and the table below shows that around a quarter give UH Bristol the very highest marks (presumably reflecting an excellent experience), with around half giving a "good" rating of eight or nine.

Rating (0-10, with 10 being the best)	UH Bristol	Nationally
0 (I had a very poor experience)	0.3%	1%
1 to 4	6%	6%
5 to 7	18%	21%
8 and 9	50%	46%
10	26%	27%

[7] This analysis takes mean scores across all questions and trusts in each survey. The national mean score across all trusts is then set to 100, with upper and lower quintiles and the UH Bristol mean scores indexed to this.

Appendix A: summary of national patient survey results and key actions arising for UH Bristol

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan progress reviewed by Patient Experience Group*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2014 National Inpatient Survey	57/60 scores were in line with the national average. One score was below (availability of hand gels) and two were above (explaining risks and benefits and discharge planning)	July 2015	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Explaining potential medication side effects to patients at discharge	May 2016
2013 National Maternity Survey	14 scores were in line with the national average; 3 were better than the national average	January 2014	Six-monthly	• Continuity of antenatal care • Communication during labour and birth • Care on postnatal wards	January 2016
2013 National Cancer Survey	30/60 scores were in line with the national average; 28 scores were below the national average; 2 were better than the national average	November 2014	Six-monthly	• Providing patient-centred care • Validate survey results • Understanding the shared-cancer care model, both within UH Bristol and across Trusts	September 2015
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	December 2014
2011 National Outpatient Survey	All UH Bristol scores in line with the national average	March 2012	Six monthly	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments • Copy patients in to hospital letters to GPs	No longer in the national survey programme

Appendix B: Full quarterly Divisional-level inpatient survey dataset (Quarter 1 2015/16)

The following table contains a full update of the inpatient and parent data for January to March 2015. Where equivalent data is also collected in the maternity survey, this is presented also. All scores are out of 100 (see Appendix D), with 100 being the best. Cells are shaded amber if they are more than five points below the Trust-wide score, and red if they are ten points or more below this benchmark. See page 14 for the key to the column headings.

	MDC	SHN	SPS	WAC (Excl. Maternity)	Maternity	Trust (excl Mat.)
Were you / your child given enough privacy when discussing your condition or treatment?	90	92	94	91	n/a	92
How would you rate the hospital food you / your child received?	63	62	61	60	59	61
Did you / your child get enough help from staff to eat meals?	78	84	81	70	n/a	79
In your opinion, how clean was the hospital room or ward you (or your child) were in?	94	96	95	92	89	95
How clean were the toilets and bathrooms that you / your child used on the ward?	91	93	91	91	83	92
Were you / your child ever bothered by noise at night from hospital staff?	79	85	85	86	n/a	84
Do you feel you / your child was treated with respect and dignity on the ward?	94	95	97	96	91	96
Were you / your child treated with kindness and understanding on the ward?	94	94	96	94	85	94
How would you rate the care you / your child received on the ward?	85	89	89	89	83	88
When you had important questions to ask a doctor, did you get answers you could understand?	80	88	87	91	88	86
When you had important questions to ask a nurse, did you get answers you could understand?	83	89	87	90	91	87
If you / your family wanted to talk to a doctor, did you / they have enough opportunity to do so?	69	71	71	73	77	71
If you / your family wanted to talk to a nurse, did you / they have enough opportunity to do so?	79	84	85	86	86	83
Were you involved as much as you wanted to be in decisions about your / your child's care and treatment?	78	85	86	88	87	84
Do you feel that the medical staff had all of the information that they needed in order to care for you / your child?	86	88	89	86	n/a	87
Did you / your child find someone to talk to about your worries and fears?	68	73	75	76	78	73

	MDC	SHN	SPS	WAC (Excl. Maternity)	Maternity	Trust (excl Mat.)
Staff explained why you needed these test(s) in a way you could understand?	80	87	86	93	n/a	86
Staff tell you when you would find out the results of your test(s)?	68	68	68	82	n/a	71
Staff explain the results of the test(s) in a way you could understand?	73	78	78	86	n/a	78
Did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	82	93	90	95	n/a	91
Did a member of staff explain how you / your child could expect to feel after the operation or procedure?	72	79	76	87	n/a	79
Staff were respectful any decisions you made about your / your child's care and treatement	88	93	94	94	n/a	92
During your hospital stay, were you asked to give your views on the quality of your care?	22	23	25	25	32	23
Do you feel you were kept well informed about your / your child's expected date of discharge?	84	90	88	91	n/a	88
On the day you / your child left hospital, was your / their discharge delayed for any reason?	65	61	57	67	60	62
% of patients delayed for more than four hours at discharge	21	19	12	20	30	18
Did a member of staff tell you what medication side effects to watch for when you went home?	51	66	59	68	n/a	61
Total responses	448	526	389	366	246	1975

Key: MDC (Division of Medicine); SHN (Division of Surgery, Head and Neck); SPS (Specialised Services Division); WAC (Women's and Children's Division, excludes maternity survey data); Maternity (maternity survey data); Trust (UH Bristol overall score from inpatient and parent surveys)

Appendix C – UH Bristol corporate patient experience programme

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

Purpose	Method	Description
Rapid-time feedback	The Friends & Family Test	Before 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.
	Comments cards	Comments cards and boxes are available on wards and in clinics. Anyone can fill out a comment card at any time. This process is "ward owned", in that the wards/clinics manage the collection and use of these cards.
Robust measurement	Postal survey programme (monthly inpatient / maternity surveys, annual outpatient and day case surveys)	These surveys, which each month are sent to a random sample of approximately 1500 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. A new monthly outpatient survey commenced in April 2015, which is sent to around 500 patients / parents per month.
	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.
	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 D: survey scoring methodologies

Postal surveys

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

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

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

Friends and Family Test Score

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

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

University Hospitals Bristol NHS
NHS Foundation Trust

Complaints Report

Quarter 1, 2015/2016

(1 April to 30 June 2015)

Author: **Tanya Tofts, Patient Support and Complaints Manager**

1. Executive summary

- 459 complaints were received in Quarter 1 of 2015/16 (Q1), representing 0.25% of activity, compared to 517 complaints (0.28%) in Quarter 4 of 2014/15 (Q4) and 421 (0.23%) in Quarter 3 (Q3).
- In Q1, of the 459 complaints received, 175 (38%) were dealt with through the formal complaints process, whilst the majority, 284 (62%), were resolved informally. This compares to 237 (46%) formal and 280 (54%) informal in Q4.
- The Trust's performance in responding to complaints within the timescales agreed with complainants was 84.9% in Q1 compared to 84.7% in Q4 and 83.4% in Q3. 85.7% of breaches (24/28) were attributed to Divisions in Q1 compared to 63% (17/27) in Q4.
- The number of cases where the original response deadline was extended rose to 44 in Q1, compared to 27 cases in Q4 and 46 in Q3.
- The way in which the Trust reports the number of complainants who tell us that they are unhappy with our investigation of their concerns has changed with effect from Q1. "Dissatisfied" cases are now reported as a percentage of the total number of responses sent out in a given month. At the time of completing this report (11th August 2015), performance for Q1 is 3.2% (i.e. by this date, of the 186 responses sent out during Q1, six complainants had told us that they were dissatisfied).
- In Q1, complaints relating to appointments and admissions continued to account for over a third (37%) of the total complaints received by the Trust, in line with each quarter of 2014/15. Complaints about cancelled or delayed appointments and operations decreased in Q1 (124) having previously increased in Q4 (140).
- Complaints about failure to answer telephones rose for the fifth consecutive quarter, from 26 in Q4 to 34 in Q1.
- Complaints about Bristol Eye Hospital remained the same in Q1 as in Q4 at 71 complaints, having increased from 38 in Q3.
- There was a significant decrease in complaints about outpatient services in the Bristol Heart Institute, from 41 in Q4 to 21 in Q1.

This report includes detailed performance data regarding the handling of complaints and an analysis of the themes arising from complaints received in Q1, possible causes, and details of how the Trust is responding.

2. Complaints performance – Trust overview

Until now, the Board has monitored three indicators of how well the Trust is doing in respect of complaints performance:

- Total complaints received, as a proportion of activity
- Proportion of complaints responded to within timescale
- Numbers of complainants who are dissatisfied with our response

In Q1, a change was made to way that the third of these indicators is calculated. "Dissatisfied" cases are now reported as a percentage of the total number of responses sent out in a given month. This indicator will be reported one month in arrears to allow complainants the opportunity to express their dissatisfaction should they wish. For example, in May 2015 the Trust sent out 62 response letters. By the cut-off date of 14th July 2015, two complainants of the 62 who received their responses in May had told us they were dissatisfied with our response. This data will be reported to the Board as a 'headline indicator' each month.

The table on page 4 of this report provides a comprehensive 13 month overview of complaints performance including all three key indicators, with the change to the way in which dissatisfied cases are recorded shown with effect from April 2015.

2.1 Total complaints received

The Trust's preferred way of expressing the volume of complaints it receives is as a proportion of patient activity, i.e. inpatient admissions and outpatient attendances in a given month.

We received 459 complaints in Q1, which equates to 0.25% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]; the figures do not include concerns which may be raised by patients and dealt with immediately by front line staff. The volume of complaints received in Q1 represents a decrease of approximately 11% compared to Q4 (517) and a 7% increase on the corresponding period a year ago.

[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.

Table 1 – Complaints performance

Items in italics are reportable to the Trust Board.

Other data items are for internal monitoring / reporting to Patient Experience Group where appropriate.

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total complaints received (inc. TS and F&E from April 2013)	166	178	170	170	148	14	133	165	171	181	158	147	154
Formal/Informal split	64/102	79/99	73/97	86/84	68/80	61/79	52/81	70/95	79/92	88/93	72/86	46/101	57/97
Number & % of complaints per patient attendance in the month	*0.28% 166 of 60027*	*0.28% 178 of 63,039*	*0.32% 170 of 52,879*	*0.27% 170 of 63,794*	*0.22% 148 of 66,104*	*0.25% 140 of 55,703*	*0.22% 133 of 59,487*	*0.27% 165 of 61,683*	*0.29% (171 of 58,687)*	*0.27% (181 of 66,317)*	*0.27% (158 of 59,419)*	*0.25% (147 of 58,716)*	*0.23% (154 of 66,548)*
% responded to within the agreed timescale (i.e. response posted to complainant)	*83.3% (50 of 60)*	*91.5% (65 of 71)*	*88.3% (53 of 60)*	*88.1% (52 of 59)*	*84.4% (65 of 77)*	*82.9% (58 of 70)*	*82.9% (58 of 70)*	*84.8% (56 of 66)*	*83.7% (36 of 43)*	*85.3% (58 of 68)*	*89.5% (51 of 57)*	*83.9% (52 of 62)*	*82.1% (55 of 67)*
% responded to by Division within required timescale for executive review	91.7% (55 of 60)	76.1% (54 of 71)	83.3% (50 of 60)	81.4% (48 of 59)	77.9% (60 of 77)	78.6% (55 of 70)	87.1% (61 of 70)	87.9% (58 of 66)	81.4% (35 of 43)	92.6% (63 of 68)	87.7% (50 of 57)	91.9% (57 of 62)	94.0% (63 of 67)
Number of breached cases where the breached deadline is attributable to the Division	6 of 10	4 of 6	4 of 7	6 of 7	6 of 12	6 of 12	1 of 12	7 of 10	2 of 7	8 of 10	3 of 6	9 of 10	12 of 12
Number of extensions to originally agreed timescale (formal investigation process only)	8	19	5	17	20	15	11	16	4	7	7	21	16
Percentage of Complainants Dissatisfied with Response											*1.8% (1 case)*	*3.2% (2 cases)*	*4.5% (3 cases)*

Figures 1 and 2 show the decrease in the volume of complaints received in Q1 (2015/16) compared to Q4 (2014/15) and also when compared to the corresponding period last year.

Figure 1: Number of complaints received

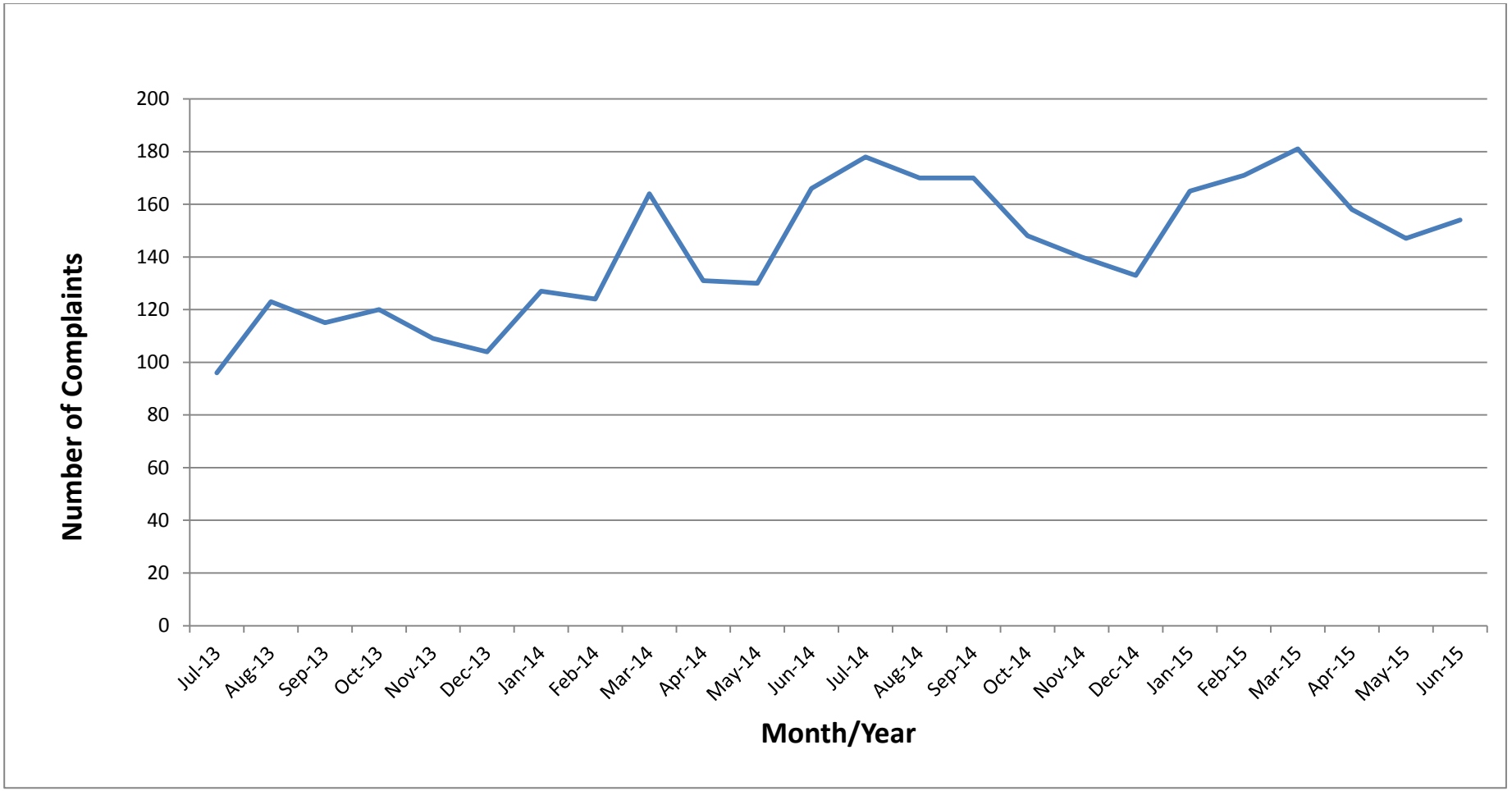
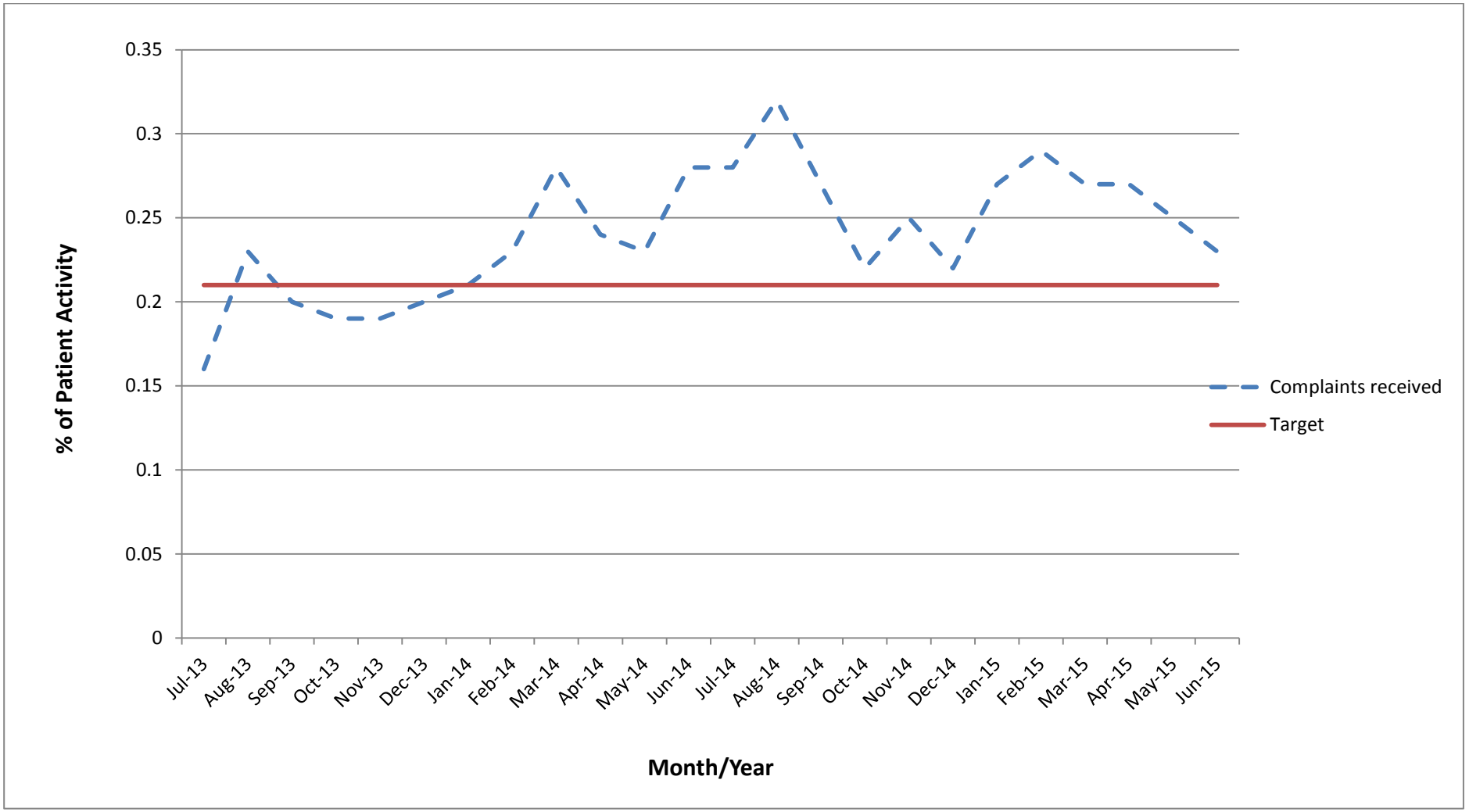


Figure 2: Complaints received, as a percentage of patient activity



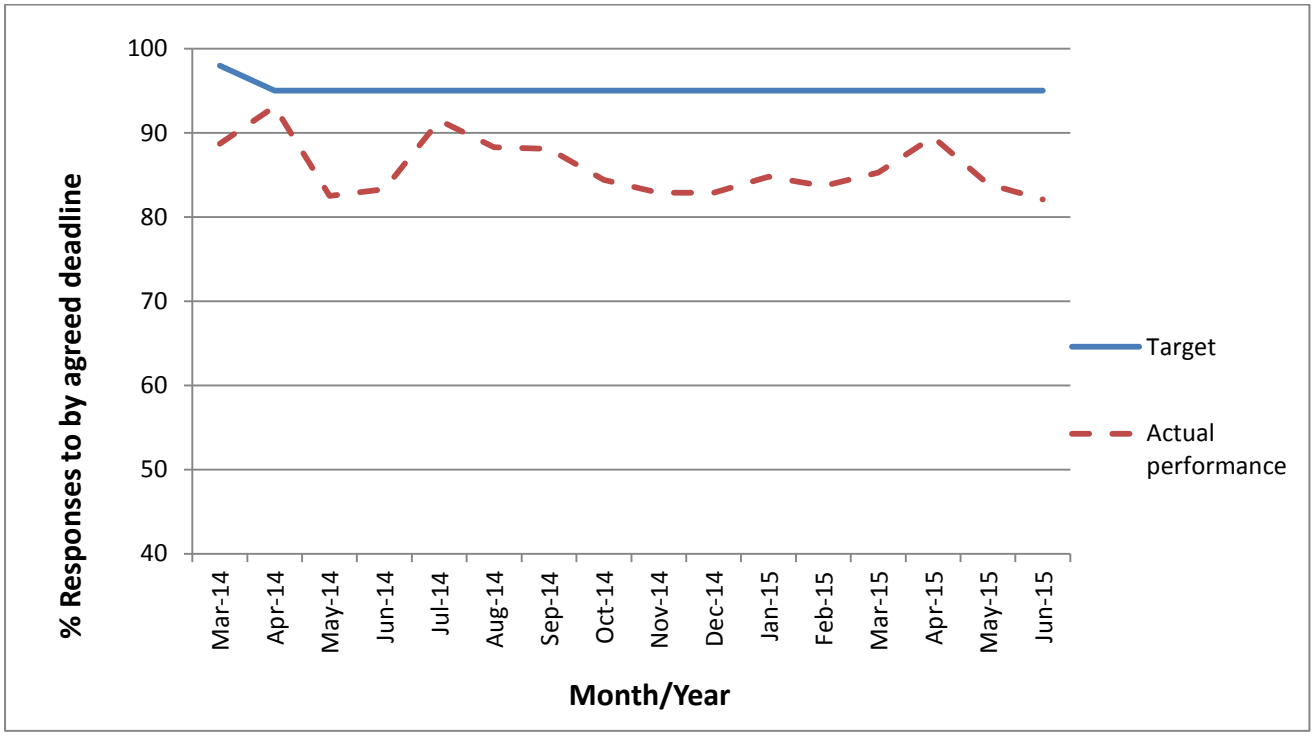
2.2 Complaints responses within agreed timescale

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

The Trust's target is to respond to at least 95% of complainants within the agreed timescale (prior to April 2014 this was 98%). The end point is measured as the date when the Trust's response is posted to the complainant. In Q1, 84.9% of responses were made within the agreed timescale, compared to 84.7% in Q4. This represents 28 breaches out of 186 formal complaints which were due to receive a response during Q1[2]. Figure 3 shows the Trust's performance in responding to complaints since March 2014.

Although overall performance in Q1, Q4 and Q3 was very similar, there was a large increase in the proportion of these breaches that were attributable to the Divisions: 85.7% (24/28) in Q1; 63% (17/27) in Q4; and 36% (13/36) in Q3.

Figure 3. Percentage of 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.

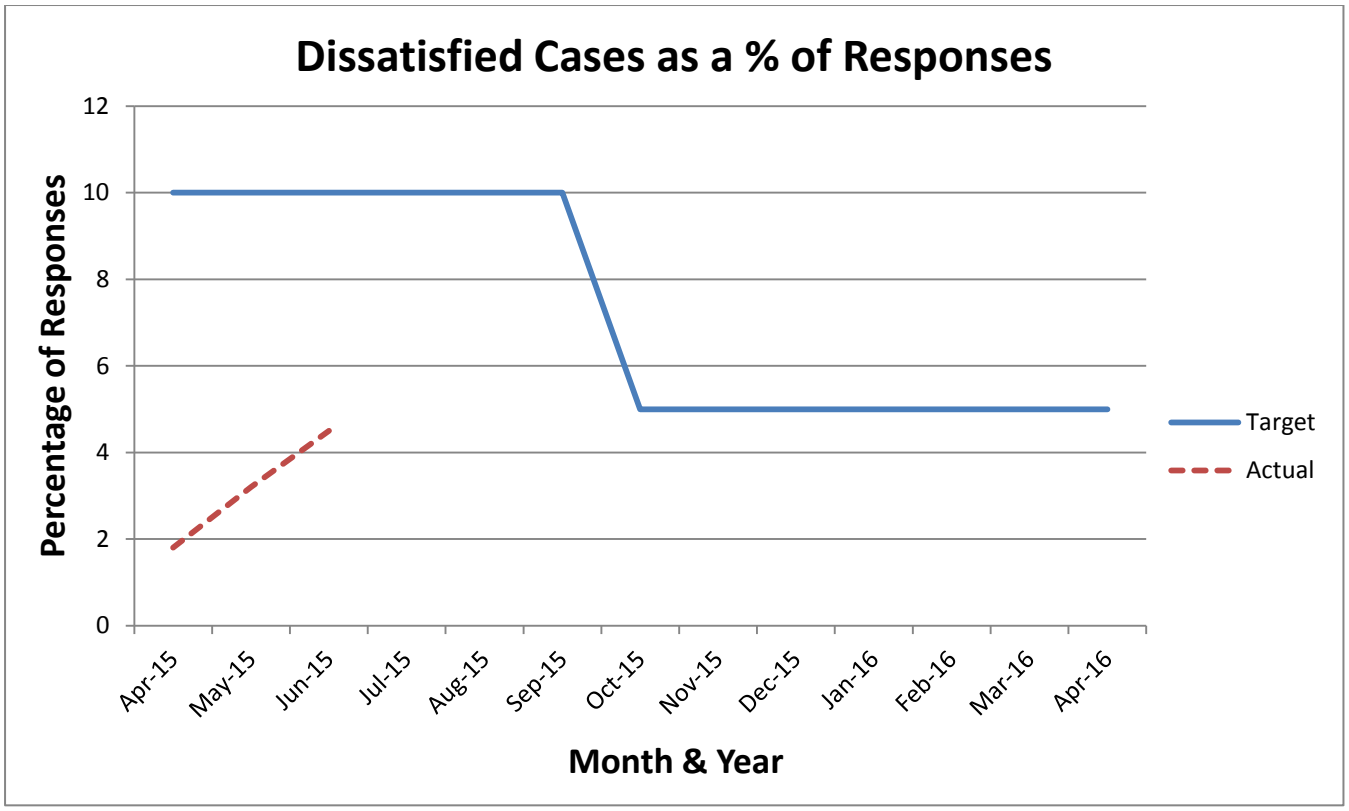
2.3 Dissatisfied complainants

Reducing numbers of dissatisfied complainants is one of the Trust's nine corporate quality objectives for 2015/16. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are dissatisfied with the quality of our investigation of their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation so that we don't make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint. Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response. As noted earlier in section 2 of this report, the way in which dissatisfied cases are reported is now expressed as a percentage of the responses the Trust has sent out in any given month. In Q1 and Q2 of 2015/16, our target is for less than 10% of complainants to be dissatisfied, reducing to less than 5% from Q3 onwards.

In Q1, a total of 186 responses were sent out. By the cut-off point of 11th August 2015 (the date on which the complaints data for June was finalised), six people had contacted us to say that they were dissatisfied with our response. This represents 3.2% of the responses issued during that period.

A validation report is sent to the lead Division for each case where an investigation is considered to be incomplete or inaccurate. This allows the Division to confirm their agreement that a reinvestigation is necessary or to advise why they do not feel the original investigation was inadequate.

Figure 4. Percentage of complainants who were dissatisfied with aspects of our complaints response



2.4 Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of six major themes. The table below provides a breakdown of complaints received in Q1 compared to Q4. Complaints about all category types decreased in Q1 in real terms, although 'appointments and admissions', 'attitude and communication' and 'clinical care' all showed a slight increase when measured as a proportion of complaints received.

Category Type	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Appointments & Admissions	170 (37% of total complaints) ↓	186 (36% of total complaints) ↑
Attitude & Communication	127 (28%) ↓	129 (25%) ↑
Clinical Care	118 (26%) ↓	124 (24%) ↑
Facilities & Environment	12 (3%) ↓	26 (5%) ↑
Access	8 (2%) ↓	21 (4%) ↑
Information & Support	24 (4%) ↓	31 (6%) ↑
Total	**459**	**517**

Each complaint is then assigned to a more specific category (of which there are 121 in total). The table below lists the seven most consistently reported complaint categories. In total, these seven categories account for 62% of the complaints received in Q1 (285/459).

Sub-category	Number of complaints received – Q1 2015/16	Q4 2014/15	Q3 2014/15	Q2 2014/15
Cancelled or delayed appointments and operations	124 ↓ (11% decrease *compared to Q4*)	140	124	152
Clinical Care (Medical/Surgical)	49 ↓ (37% decrease)	78	58	62
Communication with patient/relative	33 ↑ (27% increase)	26	28	35
Clinical Care (Nursing/Midwifery)	24 ↓ (8% decrease)	26	26	34
Attitude of Nursing/Midwifery	10 =	10	14	22
Attitude of Medical Staff	11 ↓ (48% decrease)	21	15	21
Failure to answer telephones	34 ↑ (31% increase)	26	19	12

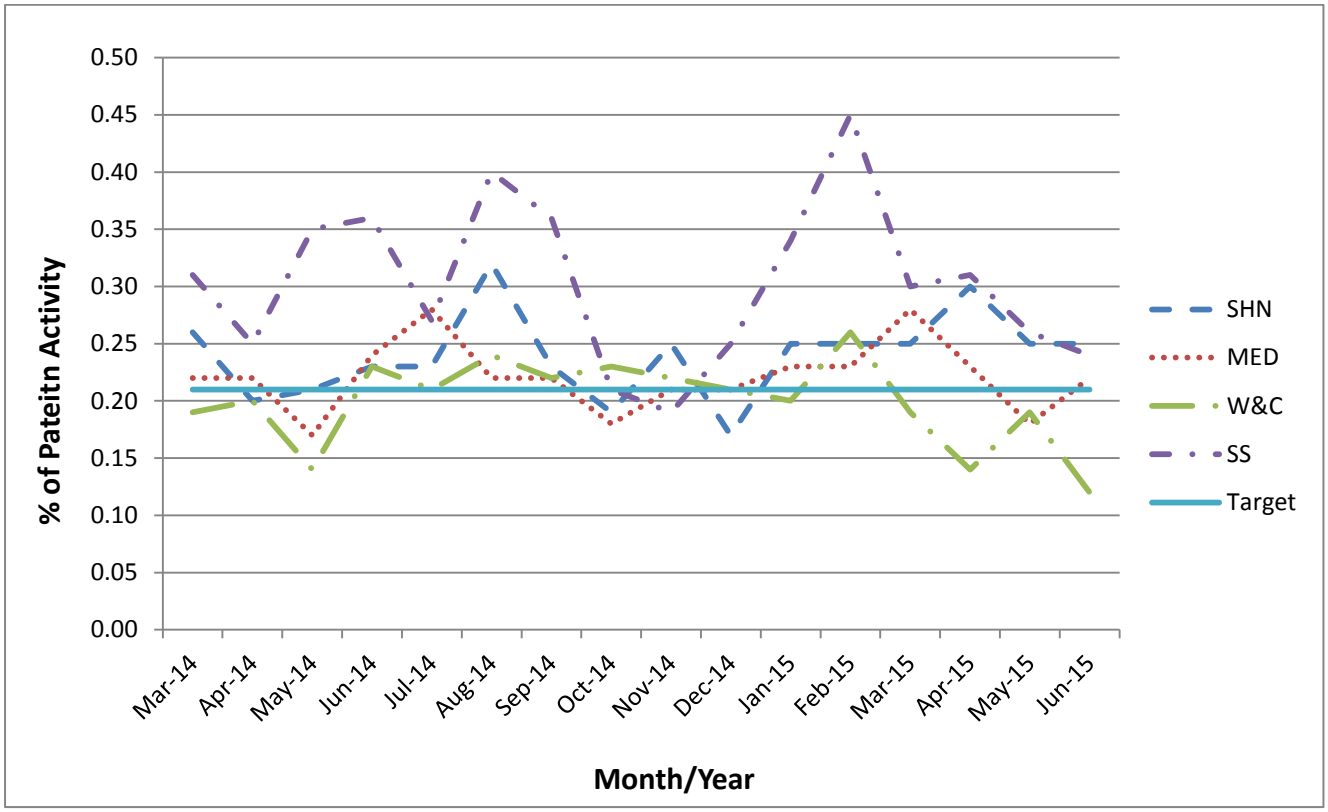
The issue of cancelled or delayed appointments and operations has seen an 11% decrease in Q1, following a significant increase in the previous quarter. There have been significant decreases in complaints about clinical care and attitude of medical staff. Complaints regarding the failure to answer telephones has seen a 31% increase, the fifth successive quarterly increase.

3. Divisional performance

3.1 Total complaints received

A divisional breakdown of percentage of complaints per patient attendance is provided in Figure 5. This shows an overall downturn in the volume of complaints received in the bed-holding Divisions during Q1, although the Division of Surgery, Head & Neck did show a slight upturn compared to Q4.

Figure 5. Complaints by Division as a percentage of patient attendance



It should be noted that data for the Division of Diagnostics and Therapies has been excluded from Figure 5. This is because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Complaints are more likely to occur as elements of complaints within bed-holding Divisions. Overall reported Trust-level data includes Diagnostic and Therapy complaints, but it is not appropriate to draw comparisons with other Divisions. For reference, numbers of reported complaints for the Division of Diagnostics and Therapies since January 2014 have been as follows:

Table 2. Complaints received by Diagnostics and Therapies Division since July 2014

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Number of complaints received	17	6	10	7	7	8	7	5	11	2	5	7

3.2 Divisional analysis of complaints received

Table 3 provides an analysis of Q1 complaints performance by Division. The table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 3.

	Surgery Head and Neck	**Medicine**	**Specialised Services**	**Women and Children**	**Diagnostics and Therapies**
Total number of complaints received	208 (204) ↑	85 (98) ↓	61 (82) ↓	65 (90) ↓	14 (23) ↓
Total complaints received as a proportion of patient activity	0.26% (0.25%) ↑	0.21% (0.25%) ↓	0.27% (0.36%) ↓	0.15% (0.22%) ↓	N/A
Number of complaints about appointments and admissions	101 (93) ↑	19 (30) ↓	26 (34) ↓	22 (23) ↓	3 (4) ↓
Number of complaints about staff attitude and communication	56 (46) ↑	25 (29) ↓	18 (25) ↓	16 (22) ↓	5 (6) ↓
Number of complaints about clinical care	45 (42) ↑	34 (22) ↑	14 (11) ↑	24 (39) ↓	2 (9) ↓
Areas where the most complaints have been received in Q1	Bristol Eye Hospital – 71 (71) = Bristol Dental Hospital – 33 (37) ↓ Ear Nose and Throat – 25 (16) ↑ Upper GI – 11 (16) ↓ Trauma & Orthopaedics – 18 (13) ↑ Lower GI – 10 (4) ↑ Ward A609 (STAU) – 6 (1) ↑ Ward A700 – 6 (3) ↑	A&E – 18 (18) = Dermatology – 14 (7) ↑ Gastroenterology & Hepatology – 8 (8) = Ward A300 (MAU) – 4 (9) ↓ Ward C808 – 4 (2) ↑	BHI Outpatients – 21 (41) ↓ Chemo Day Unit / Outpatients – 16 (9) ↑ Ward C708 – 6 (9) ↓	Paediatric Orthopaedics – 9 (12) ↓ Children's ED & Ward 39 - 6 (7) ↓ Gynaecology Outpatients – 4 (5) ↓ Ward 78 (Gynaecology) – 4 (2) ↑ Paediatric Neurology – 2 (7) ↓ Ward 31 – 0 (6) ↓	Adult Therapy – 3 (4) ↓ Audiology – 1 (3) ↓

Notable deteriorations compared to Q4	Bristol Eye Hospital – 71 (71) (no improvements seen rather than being a notable deterioration this quarter) Ear Nose & Throat – 25 (16) Trauma & Orthopaedics – 18 (13)	Dermatology – 14 (7)	Chemo Day Unit / Outpatients – 16 (9)	Ward 78 (Gynaecology) – 4 (2)	None
Notable improvements compared to Q3	Upper GI – 11 (16)	Ward A300 (MAU) – 4 (9)	BHI Outpatients – 21 (41)	Paediatric Neurology – 2 (7) Ward 31 – 0 (6)	Audiology – 1 (3) ↓

3.3 Areas where the most complaints were received in Q1 – additional analysis

3.3.1 Division of Surgery, Head & Neck

Complaints by category type[3]

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	1 (0.5% of total complaints) ↓	6 (2.9% of total complaints) ↑
Appointments & Admissions	101 (48.6%) ↑	93 (45.6%) ↑
Attitude & Communication	56 (26.9%) ↑	46 (22.5%) ↑
Clinical Care	45 (21.6%) ↑	42 (20.6%) ↑
Facilities & Environment	1 (0.5%) ↓	11 (5.4%) ↑
Information & Support	4 (1.9%) ↓	6 (2.9%) ↑
Total	**208**	**204**

Top sub-categories

Sub-category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	79 (2.6% increase compared to Q4) ↑	77 (67.4% increase compared to Q3) ↑
Clinical Care (Medical/Surgical)	18 (14.3% decrease) ↓	21 (12.5% decrease) ↓
Communication with patient/relative	17 (88.9% increase) ↑	9 (35.7% decrease) ↓
Attitude of Medical Staff	1 (85.7% decrease) ↓	7 (16.7% increase) ↑
Attitude of Nursing/Midwifery	4 (20% decrease) ↓	5 (66.7% increase) ↑
Clinical Care (Nursing/Midwifery)	6 (33.3% decrease) ↓	9 (125% increase) ↑
Failure to answer telephones	17 (54.5% increase) ↑	11 (22.2% increase) ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Across the Division as a whole, complaints regarding a failure to answer telephones saw a further significant increase in Q1.	Site-specific actions explanations and actions are listed below. It should be noted that for all of these sites, the number of complaints in this category are minimal compared to the large numbers of calls they each receive.	Benchmarking work is being undertaken. The Division will work with Candice Tyers, Outpatients Manager, to identify appropriate workforce for all call centre functions.
Assurances were provided in the Q3 and Q4 Complaints Reports that Bristol Dental Hospital had appointed further call centre staff and hoped to see a decrease in complaints in this category, however they increased from	Two additional medical records-specific staff have been recruited, which will remove the requirement for reception staff to leave the desk to retrieve notes. All reception vacancies have now been recruited to (or are at	Take advantage of better call centre performance information that allows us to review how long each call takes to answer and subsequently the length of time to manage the patient query – this will enable us to monitor staff efficiency (i.e. does it take some staff longer than others

[3] Arrows in Q4 column denote increase or decrease compared to Q3. Arrows in Q3 column denote increase or decrease compared to Q2. Increases and decreases refer to actual numbers rather than to proportion of total complaints received.

four in Q4 to six in Q1.	least out to advert).	and, if so, what training and support can be offered). Staffing levels will also be reviewed regularly. Daily figures are currently monitored but there is a need to look at one to two months' data to gain intelligence on trends and ensure appropriate operational responses.
Complaints in this category for Bristol Eye Hospital decreased slightly from six in Q4 to five in Q1. ENT, having improved in this category with just one case in Q4, saw an increase to four in Q1.	Complaints remain in this area as BEH staffing to call volume ratio outstrips what is available in the BRI call centres as the workload for the BEH is very high. Call centre software now in place which will facilitate increased transparency and better performance reporting. New staff recruited and improved phones ordered.	
A significant increase in complaints regarding cancelled or delayed appointments and operations was recorded in Q3 (46) and Q4 (77) of 2014/15. There was a further slight increase to 79 complaints in Q1. Of particular note were the 35 complaints in this category received by Bristol Eye Hospital (compared to 24 in Q4); 13 by Bristol Dental Hospital (12 in Q4); and 10 in ENT (the same number as for Q4).	Cancellations and delayed treatment/clinics have been largely due to three issues: - Staff sickness in two key areas (oral surgery and oral medicine). - Access to high dependency beds, impacting mainly on MaxFax cases. - Access to Pre-Op Assessment Significant loss of cataract capacity at the beginning of the quarter caused a shortfall in the availability of appointments that could be booked through Choose and Book. This resulted in circa 600 patients being unable to access our services.	Central Pre-Op have now addressed their capacity issues and dental services have put in place dental - specific pre-op capability for low acuity cases. Dental services have responded to staff absence by recruiting to a variety of posts, ranging from temporary locum to addressing substantive vacancies. The division is working to improve 'step down' processes, where patients transition from ITU to HDU to ward bed as their condition improves, to increase the availability of ITU/HDU beds. Additional capacity was provided in June and complaints decreased over the course of this month. Some capacity challenges remain and recruitment and capacity planning work is ongoing to provide this within the substantive workforce so that consistent additional pre-

		operative assessment and theatre slots can be provided.
There was an increase in Q1 in the number of complaints under the Category Type "Attitude & Communication" with 56 complaints, compared with 46 in Q4. The majority of complaints in this category type were for Bristol Eye Hospital, with 17 complaints (compared to 18 in Q4), followed by Bristol Dental Hospital with 13 (11 in Q4). There were also seven complaints in this category type received by the ENT Outpatients Clinic. Whilst there was a noticeable decrease in complaints regarding the attitude of medical and nursing staff, there were a significant number of complaints received under the categories of Communication with Patients/Relatives (17) and Administrative (12), as well as Failure to Answer Phone (17) (see above).	A significant number of the complaints relating to communication with patients and relatives relate to the lack of ability to keep all patients informed of the delays to follow-up appointments and how we are addressing this. This links to the administrative and telephone answering complaints, as patients cannot get through to speak with staff to query their appointments. We did see a sharp rise in informal complaints on this matter over this quarter due to the capacity problems discussed in previous sections.	The Administrative Standards Manager joined the Division on 3rd August. They will be working on the following as part of that role: • Training of all current administrative staff, including training on strong communication and ongoing monitoring of standards. • Implementing a standardised recruitment and induction process for administrative staff that ensures they have the requisite skills for the role, including a telephone test. • Reviewing all correspondence, to include direct patient involvement and feedback to improve clarity and tone of written information received. • We are able to listen back to all calls taken by the hospital call centres, in order to identify where challenges have arisen and, where appropriate, work with staff to help them develop their communication skills to avoid a recurrence. • Recruitment to the additional clinical staff funded for this year is ongoing but it has proven challenging to recruit appropriately qualified and experienced clinicians, which has delayed plans to add additional activity. The recruitment process continues and, in the meantime, we continue with additional out of hours working to maintain patient throughput as far as possible.

3.3.2 Division of Medicine

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	0 (0% of total complaints) ↓	4 (4.1% of total complaints) ↑
Appointments & Admissions	19 (22.4%) ↓	30 (30.6%) ↑
Attitude & Communication	25 (29.4%) ↓	29 (29.6%) ↑

Clinical Care	34 (40%) ↑	22 (22.4%) ↓
Facilities & Environment	2 (2.4%) ↓	7 (7.1%) ↑
Information & Support	5 (5.8%) ↓	6 (6.1%) ↑
Total	**85**	**98**

Top sub-categories

Category	**Number of complaints received – Q1 2015/16**	**Number of complaints received – Q4 2014/15**
Cancelled or delayed appointments and operations	9 (18.2% decrease compared to Q4) ↓	11 (42.1% decrease compared to Q3) ↓
Clinical Care (Medical/Surgical)	12 (9.1% increase) ↑	11 (22.2% decrease) ↑
Communication with patient/relative	8 (33.3% increase) ↑	6 (14.3% decrease) ↓
Attitude of Medical Staff	4 (42.9% decrease) ↓	7 =
Attitude of Nursing/Midwifery	2 =	2 (60% decrease) ↓
Clinical Care (Nursing/Midwifery)	14 (133.3% increase) ↑	6 (40% decrease) ↓
Failure to answer telephones	4 (33.3% decrease) ↓	6 (500%) ↑

Divisional response to concerns highlighted by Q1 data

Concern	**Explanation**	**Action**
Whilst complaints regarding the category type of Attitude & Communication have decreased overall in Q1, there has been an increase in the number of complaints categorised as Communication with Patient/Relative (6).	Having reviewed the complaints within this category, there are no significant concerns, although appointment changes and liaison between health care professionals comes up more than once, particularly in Dermatology. The service is rapidly expanding and covering services at Weston and communication has been difficult. This is being addressed. This included feedback about a lack of interpreting at a planned appointment, communication challenges with a Next of Kin in Australia and a husband who did not feel included in his wife's discharge plans.	The administrative staff in the outpatient departments are undergoing some bespoke values based training to support an improvement in their communication skills. Complex discharges in Medicine and ensuring timely and accurate communication in complex discharge cases, is being addressed via ward based multi-professional workshops, aimed at smoothing discharge planning and ensuring this is timely. Communication remains a focus of these workshops.
There has been an increase in the number of complaints received regarding Clinical Care (34 compared to 22 in Q4). In particular, there has been a significant increase in complaints specifically about nursing care (14 compared to 6 in Q4).	There are nine complaints in this quarter relating to the Emergency Department and diagnosis/treatment in the department. These are being explored in more detail by the senior team in the department.	A further review of these incidents is currently being undertaken to determine whether there is any additional learning.

These complaints were spread across various wards and departments, with the highest amount being in the Emergency Department (8); Ward A522 – Respiratory (3); Ward A605 (3); and Dermatology (3).	There were different clinical care concerns in other areas relating to different professions including therapies, medical staff and nursing. There are no common themes, however the Division will continue to monitor.	

3.3.3 Division of Specialised Services

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	0 (0% of total complaints) ↓	3 (3.7% of total complaints) ↑
Appointments & Admissions	26 (42.6%) ↓	34 (41.5%) ↑
Attitude & Communication	18 (29.5%) ↓	25 (30.5%) ↑
Clinical Care	14 (23%) ↑	11 (13.4%) ↓
Facilities & Environment	2 (3.3%) ↓	3 (3.7%) ↑
Information & Support	1 (1.6%) ↓	6 (7.3%) ↑
Total	**61**	**82**

Top sub-categories

Category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	18 (30.8% decrease compared to Q4) ↓	26 (85.7% increase compared to Q3) ↑
Clinical Care (Medical/Surgical)	6 (14.3% decrease) ↓	7 (12.5% decrease) ↓
Communication with patient/relative	4 = ↑	4 (300% increase) ↑
Attitude of Medical Staff	1	0 (100% decrease) ↓
Attitude of Nursing/Midwifery	1 (50% decrease) ↓	2 =
Clinical Care (Nursing/Midwifery)	0 =	0 (100% decrease) ↓
Failure to answer telephones	9 =	9 (200% increase) ↑

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
16 complaints were around the care and management of patients within the Bristol Haematology & Oncology (BHOC) Outpatients Department. Themes include delays with chemotherapy administration, unanswered telephones, delays in receiving typed letters and general issues with		The Division recognises the issues within the BHOC Outpatients Department and is working with the transformation team to improve the processes currently in place and therefore reduce the incidence of delays to the patient's journey.

typed letters.		
21 complaints were reported in the Bristol Heart Institute (BHI) Outpatients Department, which reflected issues with unanswered telephones, cancellation of appointments on multiple occasions, and delays in referrals and follow ups	Complaints in this category halved in Q1 compared to Q4, so there is evidence of positive progress.	The BHI has undertaken focussed work in relation to the administrative and clerical issues within the outpatient areas. The department's workload has been reviewed and adjusted in order to free up more staff to answer telephones. A specific e-mail address has also been established for patients to use.
Six complaints were received in relation to Ward C708. Two of these complaints specifically reflected concerns over the discharge experience and four also contained queries around the management of medical care and surgical procedures undertaken.	Of the complaints received regarding C708, two have been formally investigated within the formal complaints process. In total, five complaints were received which reflected a less than satisfactory discharge process for patients.	Discharge arrangements are currently under review with the Division, with a view to formulating a formal action plan to be supported and delivered by the Ward Sisters.

3.3.4 Division of Women & Children

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	1 (1.5% of total complaints) ↓	4 (4.4% of total complaints) ↑
Appointments & Admissions	22 (33.9%) ↓	23 (25.6%) ↓
Attitude & Communication	16 (24.6%) ↓	22 (24.4%) ↑
Clinical Care	24 (37%) ↓	39 (43.3%) ↑
Facilities & Environment	1 (1.5%) ↑	0 (0%) ↓
Information & Support	1 (1.5%) ↓	2 (2.2%) ↑
Total	**65**	**90**

Top sub-categories

Category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	18 (25% decrease compared to Q4) ↓	24 (20% decrease compared to Q3) ↓
Clinical Care (Medical/Surgical)	13 (23.5% decrease) ↓	17 (10.5% decrease) ↓
Communication with patient/relative	3 (50% decrease) ↓	6 (100% increase) ↑
Attitude of Medical Staff	5 (28.6% decrease) ↓	7 (600% increase) ↑
Attitude of Nursing/Midwifery	3 =	3 (25% decrease) ↓
Clinical Care (Nursing/Midwifery)	4 (66.7% decrease) ↓	12 (9.1% increase) ↑

Failure to answer telephones	0 =	0 (100% decrease) ↓

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Six complaints were received by Children's ED and Ward 39 - these were a mixture of complaints about Attitude & Communication and Clinical Care.	A variety of complaints were received by Children's ED, with no single theme emerging. The department experienced an unusually high level of attendances in the early part of Q1 (10% more patients than for the same period last year).	Useful learning has been generated from these complaints, including improvements to how samples delivered to the department are handled.
27 complaints were received in total for Paediatric outpatient services – in particular, nine for Paediatric Orthopaedics.	The General Manager for Outpatients at the Children's Hospital has highlighted a concern that "outpatients" has become an umbrella term for the many different types of complaints received and that it is not a fair reflection of the issues raised in some cases.	The General Manager is working with the Trustwide Outpatient Manager and the Patient Support & Complaints Team to refine the categorisation of complaints currently allocated to Outpatients. This will help to monitor trends and direct actions appropriately to improve services offered. The Trauma & Orthopaedics Team is working on increasing capacity to meet demand. Trauma is seasonally busier in the summer months.
Four complaints were received for Gynaecology Outpatients and four complaints for Ward 78 (Gynaecology).	Three of the complaints for Gynaecology Outpatients related to communication issues and one was about a delayed appointment. Of the four complaints received by Ward 78, three related to clinical care and one was about discharge arrangements.	No consistent themes have been identified – the complaints reflect the complex and delicate issues related to the clinical care of this cohort of patients.

3.3.5 Division of Diagnostics & Therapies

Complaints by category type

Category Type	Number and % of complaints received – Q1 2015/16	Number and % of complaints received – Q4 2014/15
Access	2 (14.3% of total complaints) =	2 (8.7% of total complaints) =
Appointments & Admissions	3 (21.4%) ↓	4 (17.4%) ↓
Attitude & Communication	5 (35.7%) ↓	6 (26.1%) =
Clinical Care	2 (14.3%) ↓	9 (39.1%) ↑
Facilities & Environment	0 ↓	1 (4.3%) ↑
Information & Support	2 (14.3%) ↑	1 (4.3%) ↓
Total	**14**	**23**

Top sub-categories

Category	Number of complaints received – Q1 2015/16	Number of complaints received – Q4 2014/15
Cancelled or delayed appointments and operations	5 =	5 ↓ (16.7% decrease compared to Q2)
Clinical Care (Medical/Surgical)	2 ↑	0 ↓ (100% decrease)
Communication with patient/relative	4 ↑ (33.3% increase)	3 ↑ (50% increase)
Attitude of Medical Staff	1 ↑	0 ↓ (100% decrease)
Attitude of Nursing/Midwifery	0 =	0 =
Clinical Care (Nursing/Midwifery)	0 =	0 =
Failure to answer telephones	0 ↓ (100% decrease)	1 ↓ (66.7% decrease)

Divisional response to concerns highlighted by Q1 data

Concern	Explanation	Action
Radiology received three complaints in Q1. Two of these related to Attitude & Communication and one related to Appointments & Admissions.	The complaint regarding Attitude & Communication related to a patient who was refused help to weight bear whilst attending an x-ray appointment.	The complaint was discussed with the Radiographer involved, who asked for their apologies to be passed on to the patient. They had not fully understood the concerns the patient had about falling, and it is standard practice to support patients with weight bearing when required.
	The second complaint related to a patient's mother who was unable to get through to the cardiac MRI clerk by phone, despite ringing the department between 08:30 and 09:00. When the patient subsequently attended the department, they found the staff member (radiographer helper) very rude.	The patient was contacted to rearrange the scan date. They were happy with this and an appointment letter was sent out. The patient and staff member involved did not wish to take the incident any further.
	The complaint regarding Appointments & Admissions related to a GP who referred a patient to St Michael's Hospital for an ultrasound scan. The GP had advised the patient that it was a drop in clinic, which it is not. On arrival, the patient was advised that scans were provided by appointment only, and they were given a date to return.	The patient's GP had provided them with incorrect information. The service will confirm the correct referral process with the GP.
Pharmacy received three complaints in Q1, two of	The first complaint regarding access related to the closure of	The enquirer did not want a response. The department will

which related to access and one to clinical care.	the pharmacy provision at the Bristol Eye Hospital. Patients now collect their medication at the main Bristol Royal Infirmary site. The second complaint related to Boots pharmacy not being open at weekends and patients having to go to external pharmacies. Difficulties have arisen where a consultant signature has not been accepted externally, resulting in patients having to come back to the hospital. The third complaint related to clinical care. The patient had an in-date (within six months) prescription which they handed into Boots Pharmacy. Boots did not have the prescription in stock and had to order it in, resulting in the prescription falling outside of its six month timeframe. Boots would not honour the prescription and informed the patient they would need to get a new prescription.	however feed the comments into the regular review meeting held between the UH Bristol Pharmacy Management team and the Boots teams to ensure that it is recorded on the issues log. This complaint is under investigation by the Pharmacy Operational Manager. The feedback from patients and carers is addressed with the Boots management at monthly review meetings and this issue will be raised at the August meeting. Boots is currently open from 09.00am until 13.00pm each Saturday and the number of customers is very low. The hospital dispensary is open for urgent prescriptions from 09.00am until 15.00pm each Saturday and from 11.00am until 15.00pm each Sunday. A member of the Boots team telephoned the patient to apologise for their poor experience. Boots have acknowledged, having established the reason for the late presentation of the prescription, that they should have supported the patient by sourcing a replacement prescription. The patient was happy to hear that there was learning from the incident and to have received an apology from Boots.
Orthotics received one complaint, relating to Attitude & Communication.	This complaint related to inadequate staffing in the department and the attitude of a temporary staff member in particular.	Staffing levels changed in Q1 due to the retirement of two part time staff members. The temporary staff member in question was employed in the interim for a few weeks in April, and has since left the department. The service lead has fed back to the bank their concerns over the staff member's behaviour. A new full time staff member came into post in late April and no further complaints have been received.
Therapies received two	The first complaint related to a patient who had problems	The patient was contacted and advised that on the occasion they

complaints, relating to Attitude & Communication and Information & Support.	getting through on the telephone to the Physiotherapy Department to book an appointment. The patient also expressed concern about the wording of their appointment letter, as it stipulated that failure to make an appointment would result in them being removed from the waiting list. The second complaint related to an in-patient seen by an Occupational Therapist (OT) on Ward 604 prior to discharge. The OT should have referred the patient for adaptations at home but the patient had heard nothing further.	rang there were staffing issues. They were advised that a new telephone system is being considered to better manage the demand for calls. The service will also review the wording of their letters. They are also taking part in the Trust's outpatient letters audit taking place during the week commencing 3rd August. The patient's referral was completed and they were contacted by an external agency (whose support they subsequently declined due to charges). The Therapy service has since contacted the community team to advise them that the patient will need to have a reassessment.
Laboratory Medicine received one complaint, relating to Information & Support.	This complaint related to a patient who had been contacted by a Consultant asking the patient to call them back; however they did not leave any contact details.	The Patient Support & Complaints Team arranged for the Consultant to call the patient back when he was next in work.

3.3.6 Complaints by hospital site

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

Hospital/Site	**Number and % of complaints received – Q1 2015/16**	**Number and % of complaints received – Q4 2014/15**
Bristol Royal Infirmary (BRI)	183 (39.9% of total complaints) ↓	192 (37.1% of total complaints) ↑
Bristol Eye Hospital (BEH)	71 (15.5%) =	71 (13.7%) ↑
Bristol Dental Hospital BDH)	33 (7.2%) ↓	37 (7.2%) ↑
St Michael's Hospital (STMH)	46 (10%) ↓	50 (9.7%) ↓
Bristol Heart Institute (BHI)	43 (9.4%) ↓	67 (13%) ↑
Bristol Haematology & Oncology Centre (BHOC)	28 (6.1%) ↑	21 (4.1%) ↑
Bristol Royal Hospital for Children (BCH)	44 (9.5%) ↓	71 (13.7%) ↑
South Bristol Community Hospital (inc. Homeopathic Outpatients) (SBCH)	11 (2.4%) ↑	8 (1.5%) ↑
Total	**459**	**517**

The table below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints a hospital site receives is broadly in line with its proportion of attendances. For example, in Q1, St Michael's Hospital (STMH) accounted for 11.6% of the total attendances and received 10% of all complaints

Site	No. of Complaints	No. of Attendances	Complaints Rate	Percentage of Attendances	Percentage of Complaints
BRI	183	56,347	0.32%	30.6%	39.8%
BEH	71	29,892	0.24%	16.2%	15.5%
BDH	33	19,536	0.17%	10.6%	7.2%
STMH	46	21,425	0.21%	11.6%	10%
BHI	43	4,487	0.96%	2.4%	9.4%
BHOC	28	16,378	0.17%	8.9%	6.1%
BRHC	44	28,857	0.15%	15.7%	9.6%
SBCH	11	7,377	0.15%	4%	2.4%
TOTAL	**459**	**184,299**	**0.25%**		

This analysis shows that the Bristol Royal Infirmary and Bristol Heart Institute receive the highest rates of complaints and a disproportionately high volume of complaints compared to their respective shares of patient activity; the share of complaints in all other hospital sites is proportionately less than their respective shares of patient activity.

3.5 Complaints responded to within agreed timescale

All of the clinical Divisions reported breaches in Quarter 1, totalling 28 breaches, which represents an increase on those reported in Q4.

	Q1 2015/16	Q4 2014/15	Q3 2014/15	Q2 2014/15
Surgery Head and Neck	9 (12.9%)	8 (11.6%)	12 (14.6%)	5 (7.1%)
Medicine	9 (20%)	5 (14.7%)	10 (23.8%)	4 (11.1%)
Specialised Services	2 (11.1%)	1 (5.6%)	4 (15.4%)	1 (4.3%)
Women and Children	7 (17.1%)	11 (23.9%)	6 (12.5%)	8 (17%)
Diagnostics & Therapies	1 (10%)	0 (0%)	0 (0%)	1 (11.1%)
All	**28 breaches**	**25 breaches**	**32 breaches**	**19 breaches**

(So, as an example, there were 9 breaches of timescale in the Division of Medicine in Q1, which constituted 20% *of the complaints responses that had been due in Q1*.)

Breaches of timescale were caused either by late receipt of final 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, or by delays during the sign-off process itself. Sources of delay are shown in the table below. The column indicating 'other' breaches relate to delays in other organisations providing their input to the Trust's response.

	Source of delays (Q1, 2015/2016)			Totals
	Division	**Patient Support and Complaints Team**	**Executive sign-off**	
Surgery Head and Neck	9	0	0	**9**
Medicine	8	0	1	**9**
Specialised Services	2	0	0	**2**
Women and Children	5	1	1	**7**
Diagnostics & Therapies	1	0	0	**1**
All	25 breaches	1 breach	2 breaches	**28**

The majority of divisional delays have resulted from increased scrutiny of draft responses. The vast majority of responses were prepared by Divisions within the agreed timescale (170 out of 186 responses or 91.4%),

however the need for significant changes/improvements following executive review led to 28 cases breaching the deadline by which they were sent to the complainant.

Ongoing actions previously agreed via Patient Experience Group:

- The Patient Support and Complaints Team continue to monitor response letters to ensure that all aspects of each complaint have been fully.
- All response letters, as well as being checked by the individual caseworker, are now also checked by the Patient Support & Complaints Manager, prior to being sent to the Executives for final sign-off.
- A random selection of two or three draft responses per week are also sent to the Head of Quality (Patient Experience and Clinical Effectiveness) for an additional level of checking prior to Executive sign-off.
- Response letter cover sheets are sent to Executive Directors with each letter to be signed off. This includes details of who investigated the complaint, who drafted the letter and who at senior divisional letter signed it off as ready to be sent. The Executive signing the responses can then make direct contact with these members of staff should they need to query any of the content of the response.
- Training on investigating complaints and writing response letters has been delivered to at least one group from each Division, with the exception of Surgery, Head & Neck, whose first session is booked for 14th September 2015. The training delivered so far has been well received, with positive feedback from attendees.

3.6 Number of dissatisfied complainants

As reported in Section 1 of this report, the way in which the Trust reports the number of complainants telling us that they were unhappy with our investigation of their concerns has changed with effect from Q1. In Q1, a total of 186 responses were sent out. By the cut-off point of 11th August 2015 (the date on which the complaints data for June was finalised) six people had contacted us to say that they were dissatisfied with our response. This represents 3.2% of the responses issued during that period.

Training on investigating complaints and writing response letters has now been delivered to at least one group of senior staff/management from all Divisions. Dates have been confirmed for further sessions for other staff requesting the training in each Division. The training delivered so far has been well received, with positive feedback from attendees.

4. Information, advice and support

In addition to dealing with complaints, the Patient Support and Complaints Team is also responsible for providing patients, relatives and carers with the help and support including:

- Non-clinical information and advice;
- A contact point for patients who wish to feedback a compliment or general information about the Trust's services;
- Support for patients with additional support needs and their families/carers; and
- Signposting to other services and organisations.

In Q1, the team dealt with 171 such enquiries, compared to 178 in Q4. These enquiries can be categorised as:

- 100 requests for advice and information (110 in Q4)
- 65 compliments (49 in Q4)
- 6 requests for support (19 in Q4)

5. PHSO cases

During Q1, the Trust has been advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in three new complaints (compared to four in Q4 and two in Q3) as follows:

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
16120	CL	LW	30/06/2014	BHI	Coronary Care Unit (CCU)	Specialised Services
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Currently awaiting further contact from the PHSO.						
17608	JR	AH	19/12/2014	BRI	Ward A604	Surgery, Head & Neck
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. PHSO wrote to Trust in July 2015 confirming their intention to carry out an investigation. Currently awaiting further contact from the PHSO.						
15952	KH	JH	09/06/2014	BRI	Ward 11	Medicine
Contacted by PHSO in June 2015. Copy of complaints file, medical records and Division's comments sent to PHSO. Advised PHSO that some issues complainant raised with them had not previously been raised with the Trust. PHSO advised Trust in July 2015 that the case is currently waiting to be allocated to an investigator. Currently awaiting further contact from the PHSO.						

The following cases are currently the subject of ongoing investigations with the PHSO:

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date original complaint received	Site	Department	Division
15213	WE	VE	10/03/2014	BHOC	Chemotherapy Outpatients	Specialised Services
Copy of complaint file, correspondence and medical records sent to PHSO. Received further request from PHSO for patient's oncology records, which were sent to them in August 2015. Currently awaiting further contact from the PHSO.						
12548		CM	05/02/2013	BRI	Upper GI	Surgery, Head & Neck
Copy of complaint file, correspondence and medical records sent to PHSO and acknowledged by them. Letter from PHSO received in July 2015 advising that they will be carrying out an investigation and will contact the Trust in due course. Currently awaiting further contact from the PHSO.						
12124 & 11500		SM	21/11/2012 & 13/08/2012	BRI & BHI	Urology & Cardiology (GUCH)	Surgery, Head & Neck & Specialised Services
Copy of complaints file and medical records sent to PHSO in May 2015. Further contact from PHSO received in July advising that they now have all the information they require and will contact us in due course with their provisional report and findings. Currently awaiting further contact from the PHSO.						

6. Protected Characteristics

The Quarterly Complaints Report includes statistics relating to the Protected Characteristics of patients who have made a complaint. The areas recorded are age, ethnic group, gender, religion and civil status.

The Patient Support and Complaints Team continues to work hard to ensure that as much of this information as possible is gathered from patients, in order to reduce the numbers reported in each category as "unknown".

It should be noted that these statistics relate to the **patient** and not the complainant (if someone else has complained on their behalf).

6.1 Age

Age Group	**Number of Complaints Received – Q1 2015/16**
0-15	52
16-24	22
25-29	17
30-34	35
35-39	17
40-44	22
45-49	23
50-54	26
55-59	32
60-64	34
65+	179
Total Complaints	**459**

6.2 Ethnic Group

Ethnic Group	**Number of Complaints Received – Q1 2015/16**
Any Other Asian Background	1
Any Other Ethnic Group	1
Any Other White Background	13
Asian or British Asian	4
Bangladeshi or British Bangladeshi	2
Black or Black British – African	3
Black or Black British – Caribbean	6
Chinese	2
Indian	2
Mixed – White and Black Caribbean	3
Pakistani	4
Pakistani or British Pakistani	2
White - British	366
White – Irish	2
Not Collected At This Time	36
Not Stated/Given	12
Total Complaints	**459**

6.3 Religion

Religion	**(Christian denomination)**	**Number of Complaints Received – Q1 2015/16**
Christian	Anglican	1
	Baptist	3
	'Christian'	21
	Church of England	162
	Church of Scotland	1
	Methodist	10
	Protestant	3
	Roman Catholic	22
	Salvation Army	1
	United Reform	2
	(Total Christian)	*(226)*
Agnostic		2
Atheist		3
Buddhist		3
Muslim		4
No Religious Affiliation		104
Sikh		2
Spiritualist		1
Unknown		114
Total Complaints		**459**

6.4 Civil Status

Civil Status	**Number of Complaints Received – Q1 2015/16**
Co-habiting	18
Divorced/Dissolved Civil Partnership	21
Married/Civil Partnership	179
Separated	3
Single	126
Widowed/Surviving Civil Partner	26
Unknown	86
Total Complaints	**459**

6.5 Gender

Of the 459 complaints received in Q1 2015/16, 232 (51%) of the patients involved were female and 227 (49%) were male.