NHS
University Hospitals Bristol
NHS Foundation Trust

Quality Report 2016/17

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

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1.1 Statement on quality from the chief executive

Welcome to this, our ninth annual report describing our quality achievements. Our mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day.

The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates to the public and its stakeholders that its services are safe, effective, caring and responsive. The report is an open and honest assessment of the last year, its successes and its challenges.

I write with a deep sense of pride in the staff of University Hospitals Bristol (UH Bristol) and the care they give to hundreds of thousands of patients across Bristol and the south west of England each year. Following their inspection in November last year, the Care Quality Commission (CQC) has assessed the Trust as Outstanding – making us one of only half a dozen acute Trusts in England to achieve this recognition, and currently the only Trust to have gone from Requires Improvement to Outstanding in one step. This is a great achievement and is testimony to the dedication, passion and focus of our staff. You can read more about what the CQC found in the pages of this report.

Prior to the CQC's visit, our Trust Board had approved a new four year strategy for quality, setting out our road map for quality improvement and describing the kind of organisation we aspire to be. I've asked the Trust's medical director and chief nurse to say a few words about the strategy in their introduction to this report. The fact that the vast majority of our patients receive treatment and care of the highest standards must not overshadow the reality that we don't always get it right. As we seek to build on a safe, effective, caring, responsive and well-led foundation, it is timely and appropriate that, in the quality strategy, our Board has laid down a challenge to everybody in the organisation to think about what consistently great customer service looks and feels like and to develop that mindset in all our dealings with patients, relatives and carers.

Apart from the CQC outstanding rating, the past year has included a number of significant developments which have the potential to transform care of patients in the future. To give you a flavour of these, UH Bristol is one of 16 acute trusts in the UK designated as 'digital exemplars', trialling the next generation of information technology; we were delighted to receive a grant of £21 million over the next five years from the National Institute for Health Research Biomedical Research Centre, underpinning our research collaboration with the University of Bristol and its partners; and 2016/17 also saw the opening of the West of England Genomic Medicine Centre, hosted by our Trust.

Elsewhere, UH Bristol is leading the process to create a five-year plan for Bristol, North Somerset and South Gloucestershire, so we have a real opportunity to influence the transformation

in health and social care that's required for the long term and which is a condition of our continuing success.

Finally, you may notice that our Quality Report is shorter and more focussed than has been our practice in recent years. If you have any views about this or any other aspect of this report, I would be delighted to hear from you. As always, I would like to thank everyone who has contributed to this year's Quality Report, including our staff, governors, commissioners, local councils, and local Healthwatch. To the best of my knowledge, the information contained in this Quality Report is complete and accurate.

Robert Woolley, chief executive

1.2 Introduction from the medical director and chief nurse

In writing this introduction to the annual Quality Report, we would like to begin by echoing the sense of pride already expressed by Robert, our chief executive, about the outcome of our recent Care Quality Commission inspection.

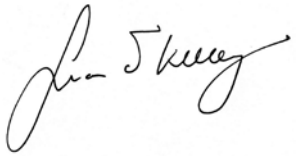
The Chief Inspector of Hospitals' report spoke of the compassionate, sensitive and respectful way that the CQC team saw patients being cared for, and highlighted numerous areas of best practice. You can read more about the CQC's findings later in the pages of this report.

In 2016 our Trust Board approved a new four year quality strategy, the purpose of which is to articulate our ambitions for quality in a way that is meaningful and serves as a statement of intent that patients, carers, staff, commissioners and other stakeholders can use to hold the Trust Board to account for the delivery of high quality services.

At the beginning of 2016, we met with members of our Trust's Involvement Network to hear what patients and members of the public had to say about quality priorities. The overriding message from this event was that we cannot divorce the concept of quality from the process of waiting to access health services as somehow being an 'administrative' process, be that in one of our emergency departments, in an outpatient clinic, or whilst waiting on a list for cancer treatment or planned surgery. We also asked our staff what quality meant to them: we received hundreds of truly inspiring responses. We used this feedback from the public and our staff to shape our strategy, the strapline of which is "We are proud to care".

In summary, our strategy says that we will cancel fewer operations, reduce patient waiting times, improve the safety of patients by reducing avoidable harm and strengthen our patient safety culture. We will also create new opportunities for patients, families and staff to give us feedback about their experiences, and in a way which enables concerns to be addressed in real-time. Elsewhere, the Trust will take a lead role in the implementation of a new national 'learning from mortality' system, screening all deaths in hospital and undertaking structured review of those deaths from which learning may be derived. And finally, we will continue our work to significantly improve staff satisfaction, making UH Bristol an employer of choice.

As you would expect, the strategy has influenced our choice of quality objectives for 2017/18, which you can read more about in this report. The same strapline, "We are proud to care", is the title of our new Trust film, which was launched in 2016/17. The film promotes the commitment that binds our staff together and is the essence of what it means to work at UH Bristol. You can watch it at **http://www.uhbristol.nhs.uk/about-us/who-we-are/**



Dr Sean O'Kelly
Medical director

Carolyn Mills
Chief nurse

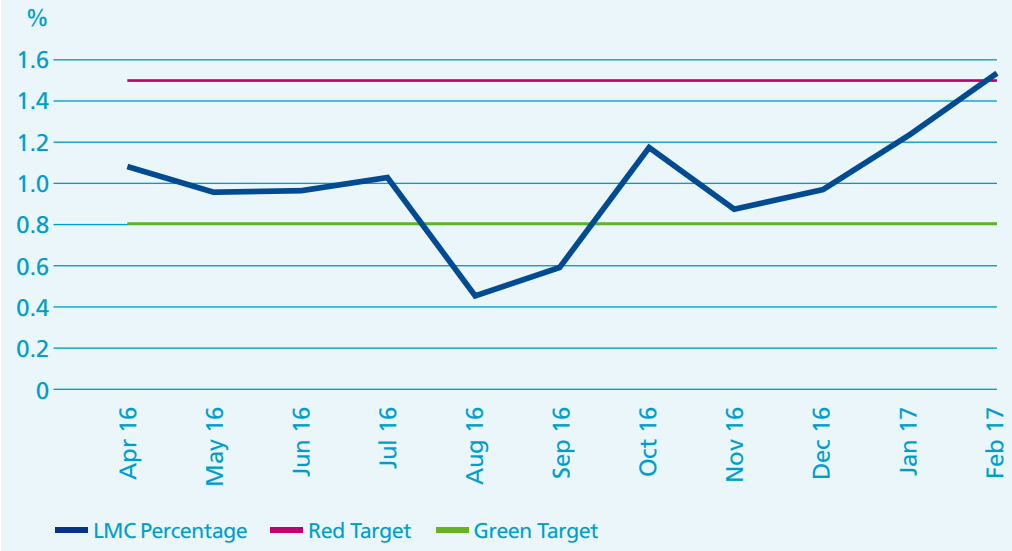
2 Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2016/17

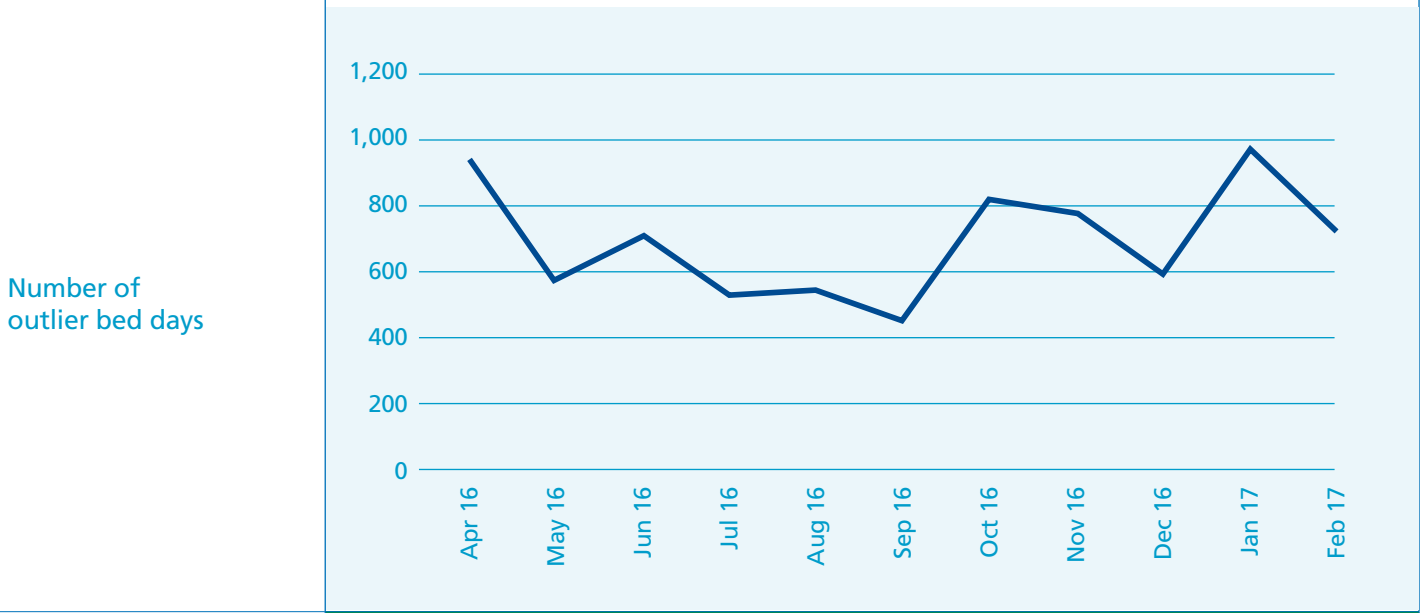
Twelve months ago, we identified 12 specific areas of practice where we wanted to see improvements in 2016/17. These were a combination of ambitions we had not fully realised in 2015/16 and new objectives aimed at improving different aspects of patient experience. A progress report is set out below, including a reminder of why we selected each objective and an overall 'RAG' rating of the extent to which we achieved each ambition. Overall, we fully achieved five objectives and made significant progress in six more.

Objective 1	To reduce the number of cancelled operations
Rationale and past performance	We had set this objective for the last two years, but had not achieved our goal. Our target in 2015/16 – as per 2014/15 – was to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent. In 2015/16, we achieved 1.03 per cent.
What did our patients say?	"Any operation is a big deal but when it's cancelled and, in my case, cancelled twice the impact is devastating - I had cancer and was really worried this would affect the success of the operation when it finally happened."
What did we say we would do?	We said that we would embed a revised standard operating procedure across all our divisions and amend our escalation plan to ensure that everyone is aware of the current Trust-wide state-of-play relating to cancellations and that decisions to cancel are recorded through escalation 'Silver meetings'. Further, we said that our divisions would review the reasons why operations are cancelled at the last minute and agree a plan which sets out specific actions to reduce cancellations further related to the cause of breach.
Measurable target/s for 2016/17	We retained our previous target to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent.

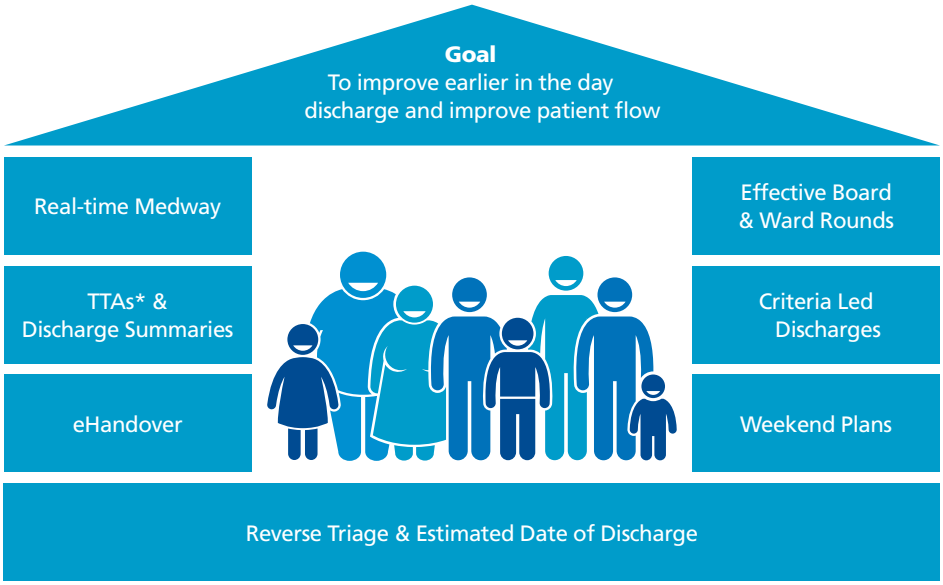
How did we get on?	Throughout the year it has been apparent that hospital occupancy levels and emergency demand are the key triggers for suboptimal performance in respect of last minute cancelled operations. Divisions are held accountable for their performance in respect of cancelled operations, providing monthly updates to a shared action plan to deliver necessary improvements. The Trust's standard operating procedure for management of last minute cancelled operations was refreshed; any on-the-day cancellations related to bed pressures are recorded on patient flow boards and as part of the 'sitrep'[1]. In 2016/17 0.98 per cent of operations were cancelled at the last minute. This represents an improvement on 2015/16 but fell short of both our annual target (0.92 per cent) and the national target (0.8 per cent).
Last minute cancellations as a percentage of admissions	
RAG rating	**Amber –** our performance in 2016/17 was better than in the previous year but fell short of our target. This objective is being carried forward into 2017/18.

[1] Situation report - across the day the hospital produces a snapshot picture of the operational pressures and levels of escalation

Objective 2	To ensure patients are treated on the right ward for their clinical condition
Rationale and past performance	We had set this objective for several consecutive years, but had not achieved our goal. Our target in 2015/16 was to have no more than 9,029 outlier bed days in total; we achieved 9,666.
What did we say we would do?	We said we would continue our work focussing on improving flow through our hospitals and, by doing so, improving bed occupancy. We said that in 2016/17 we would roll out our ward processes to all wards and implement our new virtual ward scheme, ORLA Healthcare, enabling patients to receive hospital care at home.
Measurable target/s for 2016/17	We retained our previous target, to have fewer than 9,029 outlier bed days during the year.
How did we get on?	During the year the total number of bed days spent by patients outlying into a different ward was 8,178, therefore the Trust achieved its annual target by a significant margin. During the second and third quarters of the year in particular, we built further on our ward processes programme, embedding routines in adult inpatient areas in collaboration with matrons and ward sisters, improving patient flow through our hospitals. The development of our virtual ward scheme (ORLA) increased capacity, with staff gaining in confidence with the processes for referring patients into the new service. During periods of escalation, particularly in the final quarter of the year, we have focussed on identifying the most suitable patients to move and providing more structured medical cover to each ward so that patients are seen in a timely way and their care progressed.
RAG rating	**Green –** we achieved our target for 2016/17 and our performance was significantly better than in 2015/16.



Objective 3	To improve timeliness of patient discharge
Rationale and past performance	Despite huge efforts, we had yet to achieve our goal of increasing the number of discharges before noon. This has an impact on the number of cancelled operations as operations cannot start if a bed hasn't been identified. Delayed discharges are also a source of frustration for patients who may spend many hours awaiting their discharge.
What were our patients saying?	"I was required to wait for a letter of discharge, I saw the doctor at approximately 8.30am. My letter of discharge was given to me at 3pm." "I think the discharge process could be a lot more organised."
What did we say we would do?	We said we would continue to embed our ward processes in order to promote timely discharge with an emphasis on pre-day planning of pharmacy requirements, patient transport and discharge letters. We also said we would pilot new models of discharge including therapists such as physiotherapists and occupational therapists being able to discharge patients based on agreed criteria.
Measurable target/s for 2015/16	We retained our previous target, for at least 1,100 patients per month to be discharged between 7am and 12noon. We also set a target to increase the number of patients discharged at weekends by 20 per cent.
How did we get on?	Throughout the year, we have continued to roll out and embed the ward processes work across the Trust, supported by a schedule of workshops with multi-disciplinary ward teams.



Alongside this, we ran two successful "reset" events. In May, an event called "Plans for the Weekend" focussed on weekend discharges and provided a good understanding of the progress we have made with discharge and weekend planning, and the areas we are continuing to address to support improvement in weekend discharges. In December and January we ran another event to promote discharges to support improved flow before and after the Christmas period.

We have continued to make good progress in the adoption and embedding of the ward processes good practice. Progress has been most notable in the Division of Medicine where our ward processes routines are most embedded and levels of timely discharge have continued to increase, but it is notable that in the second half of the year other divisions also matched this progress. The winter reset events further reinforced key messages around ward processes and confirmed areas where further work is required. All of this learning has been taken into the next phase of our operating model programme.

These activities contributed to an overall improvement in timely discharge compared to 2015/16: across the year as a whole, more patients were discharged between the hours of 7am and 12noon (946 on average per month in 2016/17 versus 870 per month in 2015/16). At the same, we were disappointed that our performance once again fell short of our stretching annual target.

	Our reset events allowed us to specifically test progress in the use of Criteria Led Discharge (CLD) to try to increase the number of weekend discharges. While we have seen an improvement in the number and proportion of weekend discharges, this has fallen well short of the very stretching ambition we set, with growth in the number of weekend discharges of approximately three per cent. The winter reset events highlighted the limited progress we have made in CLD, in part as we have prioritised our improvement work to focus on the greater adoption, and accuracy of expected date of discharge in order to improve the predictability and number of discharges every day of the week.
RAG rating	**Amber –** our performance was better than in 2015/16 but fell short of our target. This objective is being carried forward into 2017/18.

Objective 4	To reduce appointment (in-clinic) delays in outpatients, and to keep patients better informed about any delays
Rationale and past performance	We carried forward this objective from 2015/16 because we had more work to do.
What were our patients saying?	"Staff treated me well and with respect, but my appointment time was delayed, and no-one informed us of this until my wife asked at the reception desk. Then we had a 90 minute delay, but the sign over the desk area indicated no delays."
What did we say we would do?	We said that we would complete the Trust-wide implementation of our new standardised layout for information boards in outpatient departments, and embed a standard operating procedure to ensure teams proactively inform patients about any delays. We anticipated that associated work reviewing clinic productivity and utilisation would lead to improved booking practices and scheduling to help minimise delays. Each quarter, we committed to carrying out a '15-step'[2] senior management walk around to ensure our redesigned clinic status boards are being used correctly.
Measurable target/s for 2015/16	In the absence of service-wide real-time data about clinic running times, we agreed to set targets based on patient feedback using our monthly survey, setting minimum targets which would represent a statistically significant improvement on our patient-reported performance in 2015/16. We agreed that the questions we would use and our minimum target scores would be as follows: • How long after the stated appointment time did the appointment start? (Our target was that at least 78 per cent of patients would say that they were seen within 15 minutes of their appointed time) • Were you told how long you would have to wait? (Our target was that at least 50 per cent of patients would say 'yes') • Did you see a display board in the clinic with waiting time information on it? (Our target was that at least 55 per cent of patients would say 'yes') In addition to asking patients about their experiences, we also wanted to progress work to develop our own real-time objective measurement of clinic running times.
How did we get on?	We established a 'task and finish' group to oversee the replacement of information boards in outpatient clinics. New boards were installed in approximately half of our outpatient clinics during October and November 2016, focussing initially on areas where there were no boards or where existing boards were in a poor state of repair. Further funding is currently being identified to complete the project to ensure that boards in all areas are consistent. At the same time, a new standard operating procedure has been introduced in outpatient clinics to improve the way that staff keep patients updated and to ensure consistent use of the boards displaying information. As part of our work to improve productivity in our outpatients departments we have been focussing on improving booking practices and reducing cancellations through a work stream focussed on improved usage of the Electronic Referral Service which is a CQUIN in 2016-18. Due to a key vacancy in the role of outpatient manager, the introduction of senior management walk rounds has been delayed until the summer of 2017. Our new outpatient standards have been published on Connect (our internal web site) specific to staff roles, and we hope that

	increased awareness of the contribution each member of staff makes to the experience of the patients will drive up quality particularly in this area of communication whilst patients are in the department. In 2016/17, a marginally greater proportion of outpatient attendees told us that their appointment had started on time (within 15 minutes of the appointed time): 73 per cent compared to 72 per cent in 2015/16. However this fell short of the threshold that would constitute a statistically significant improvement (78 per cent). Disappointingly, in 2016/17, a smaller proportion of outpatient attendees said that they were told how long they would have to wait in-clinic (37 per cent compared to 39 per cent in 2016/17) and the same was true of patients who saw a display board with waiting time information on it (46 per cent in 2016/17 compared to 51 per cent in 2016/17). Our plans for developing real-time measurement of in-clinic waiting times have been extended into 2017/18 – see section 2.1.2 of this report.
RAG rating	**Red –** despite targeted improvement activities, performance for all three patient-reported indicators has fallen short of our targets. This objective is being carried forward into 2017/18.

[2] The '15 Step Challenge' is a series of toolkits which are part of the resources available for the Productive Care work stream. They have been co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help look at care in a variety of settings through the eyes of patients and service users, to help capture what good quality care looks, sounds and feels like. - See more at: **http://www.institute.nhs.uk**

Objective 5	To improve the management of sepsis
Rationale and past performance	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these, estimates suggest as many as 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis nationally are thought to contribute to the number of preventable deaths from sepsis. Locally, we have identified – through mortality reviews and incident investigations into deteriorating patients – that we can improve our management of patients with sepsis. Therefore, this is one of the sub work streams of our patient safety improvement programme and a continuation of a quality objective we first set ourselves in 2015/16.
What were our patients saying?	"During my three months after suffering sepsis, the treatment I received was first class, the doctors and surgeons saved my life. I would like to put on record that all staff at BRI are fantastic." "The ward did not recognise how unwell my wife was (viral sepsis) and at first did not manage her symptoms very well."
What did we say we would do?	Our goal was to achieve the national sepsis CQUIN, which requires rapid identification and treatment of sepsis in emergency departments and acute inpatient settings.
Measurable target/s for 2016/17	In paediatrics, the measurable target for 2016/2017 was the proportion of patients in the children's emergency department who met the requirements for sepsis screening who received screening. In adult services, this target was also measured in addition to time taken to antibiotic administration from arrival. This target was analysed in the paediatric group as well but not

	included as a reflection of the "watch and wait" approach often required in paediatric medicine as most children will settle with time, antipyretics, fluids etc. due to the viral aetiology of most febrile illness. The paediatric population will be included next year as the quality measure has since been changed to the time from diagnosis rather than arrival, which is more relevant to the paediatric population, provided that adequate screening is already in place.
How did we get on?	In adult services: Two whole time equivalent sepsis nurses were appointed by the Trust and commenced in post in August 2016. These appointments facilitated a number of positive developments in the timely and effective identification and treatment of sepsis, including: • Development and implementation of a new adult sepsis guideline written in line with NICE guideline NG51 published in July 2016. • Sepsis education in the emergency department, acute medical unit and the surgical trauma assessment unit for nursing and medical staff. • Trust-wide sepsis training with participation in the Academic Heath Science Network '600 in 60 days' initiative (the goal of training 600 staff in 60 days): more than 800 staff were trained. • Foundation doctor teaching. • Completion of a sepsis death certification audit which highlighted that fewer than 30 per cent of patients who die with an infection have sepsis written on their death certificate. This was presented at medical grand round and has now been incorporated in foundation doctor sepsis teaching programmes. • Improved sepsis coding has been achieved through implementation of local policy in line with updated national guidance. As a result, identification of sepsis cases has increased from an average of 38 per month in 2014/15 to an average of 61 per month in 2016/17. • Implementation of new sepsis pathway in maternity services. • Creation of a new sepsis patient and relative information leaflet. • Inclusion of sepsis prompts on medical and surgical admission proformas. In children's services: The Bristol Royal Hospital for Children's (BRHC) emergency department undertook a range of activities to improve the identification and treatment of sepsis. These include: • A rolling programme of rapid-cycle audits to assess ability to meet the CQUIN standards for sepsis screening and antibiotic delivery. • Raising awareness of the sepsis CQUIN amongst medical and nursing staff through educational study days and self-directed online learning resources. • Implementing a triage screening tool to help increase recognition of potentially septic children. This is now a mandatory, electronic screening tool which ensures that all children meeting the criteria are screened and flagged as potentially septic. • Adapting NICE guideline NG51 for use in the BRHC emergency department to create a paediatric sepsis guideline. In 2016/17 the scope of the national CQUIN was broadened to encompass paediatric inpatient services. In response to this, the Trust appointed a sepsis implementation lead working across the BRHC (Dr Marion Roderick). The patient safety team at BRHC has developed an age-appropriate sepsis screening tool which has been piloted on wards 30 and 35, with plans to roll this out to surgical ward 31. Our progress meant that, in the final quarter of the year: • A 90 per cent screening rate was achieved in the adult emergency department. • Antibiotic delivery within one hour of patient arrival in adult emergency department with sepsis was 63.3 per cent (target was 65 per cent for partial delivery / 80 per cent for full delivery). • Antibiotics were reviewed within 48 hours for 100 per cent of adult emergency department patients with sepsis. • Inpatient sepsis screening was embedded and was much improved at 31.8 per cent; timely inpatient antibiotic delivery was 68 per cent (antibiotic target delivery was 75 per cent).

	• Antibiotics were reviewed for 100 per cent of inpatients with sepsis. • 93 per cent of eligible children were screened for sepsis in the children's emergency department. Overall, although many challenging individual targets were met, the Trust achieved 66.3 per cent of the total value of the national CQUIN.
RAG rating	**Amber –** the Trust made significant strides in the recognition and rapid treatment of sepsis during 2016/17, including a two thirds achievement of the related CQUIN. This objective is being carried forward into 2017/18.

Objective 6	To ensure public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible
Rationale and past performance	The objective formed part of the Trust's previous two year commitment to improve key aspects of communication with patients. The issue was raised via a previous consultation on quality priorities. The intention is that patients and visitors walking through our hospital campus will see information that is relevant, up-to-date, standardised and accessible.
What did we say we would do?	We said we would: • Produce guidelines for all staff about the standard of information that should be displayed in public areas and advice on how to get support to produce it. • Work with areas to professionally produce and print any materials that arise from this process. • Continue to provide good quality corporate posters, publications and other materials for display in public areas – ensuring they communicate key information and messages.
How did we get on?	As part of its work, the Trust's communications team advises services, teams, individuals and hospitals on the best way of communicating to a wide range of audiences. This includes supporting our divisions to ensure that public-facing information in our hospitals meets the criteria set out above. Guidance has been produced and made available on the Trust's intranet site. Periodic walk-rounds have been carried out in 2016/17 and will become a more regular feature in 2017/18.
RAG rating	**Amber** – guidance is available for our divisions but we need to make walk-rounds a more regular feature to ensure the guidance is being followed.

Objective 7	To reduce the number of complaints received where poor communication is identified as a root cause
Rationale and past performance	This objective was identified by our Trust Board as an improvement area – we know that failures in communication account for a significant proportion of complaints received by the Trust.
What were our patients saying?	"The information relayed by doctors was vague and the language that they used was jargon." "My experience was a very positive one and this has not been the case in some other hospitals I have used. The big difference was UH Bristol provided clear, timely communication."
What did we say we would do?	Analysis of complaints data revealed that in 2015/16, the Trust received a total of 320 complaints relating to the following categories: - Telecommunications and failure to answer phones (97) - Administration including waiting for correspondence (64) - Communication with patients and relatives (159). We said that we would roll out the changes to patient letters and that we would run a transformation project to improve the quality of telephone communications. Finally, we said that we would conduct further analysis of complaints previously received within the "communication with patients and relatives" category, to see whether common themes and opportunities could be identified.
Measurable target/s for 2016/17	Our target was to achieve a reduction in complaints received in the categories described above.

How did we get on?	**Patient letters project** After a considerable amount of work to ensure that letters meeting our local quality standard are delivered through the Medway patient administration system and Synertec, a pilot went 'live' in the Bristol Heart Institute outpatients department during the summer of 2016. Initial teething problems relating to system connectivity were resolved and an evaluation of the pilot showed a positive improvement in the quality of letters. The project group is now overseeing the implementation of revised letters across the Trust with new letters approved for obstetrics and gynaecology, the children's hearing centre, and diagnostics and therapies. The outpatient letters for the children's hospital and inpatient letters in Surgery, Head and Neck Division will be the next areas to go live. The project group will continue to oversee this process ensuring adherence to the standard. A pilot of 'easy read' letters is also planned, linking with Medway alerts (system flags which tell staff that a patients has a particular communication need). **Telephone communications** We know that there are a number of factors which contribute to the quality of telephone communications. These include staff training, the way that staff who receive incoming telephone calls are organised, and the switchboard technology and directory information available. In the first quarter of the year, we undertook further analysis of complaints data about telephone communications, and agreed the scope of work needed in response to this. In the second quarter, we completed further work with the information management and technology team to understand the areas in which improvements would reap the greatest benefits for patients. Unfortunately, progress thereafter was hampered by vacancies in the Trust's transformation team. Work on the project recommenced in February 2017 and has been carried forward in our quality objectives for 2017/18. **Analysis of complaints** Further analysis of complaints coded in the category of "communication with patients and relatives" (as described above) in 2015/16 initially identified six potential 'hot spots' around the Trust, however closer inspection of these complaints failed to reveal any common themes over and above those already being acted upon, for example quality of letters and telephone communications. At the outset of the year, we said that our target was to achieve a reduction in complaints received in the categories described here. In 2016/17, the Trust received a total of 342 complaints which were subsequently coded in the three categories described above, a small increase compared to 2015/16.
RAG rating	**Amber –** The patient letters project has been successfully piloted and is in the process of being rolled out. The telephone communications project has not yet progressed to the extent we had intended and will now be taken forward as a work stream within the Trust's ambitions for embedding a customer service culture.

Objective 8	To ensure inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen
Rationale and past performance	This objective was identified in discussions with our involvement network as an important marker of positive patient experience when in hospital.
What were our patients saying?	"I was kept informed at all times, from the cleaners to the doctors, and had excellent treatment." "I would like to see more communication between doctors and patients keeping them informed of what is happening with treatment."
What did we say we would do?	During the first half of the year, we said that we would carry out targeted 'Face2Face' interviews with inpatients to gain a clearer understanding of their needs and expectations around being kept informed, the ways in which patients are kept informed, and opportunities to do this better.
Measurable target/s identified for 2016/17	We said that a target would be determined by the chief nurse and medical director following scoping work described above.

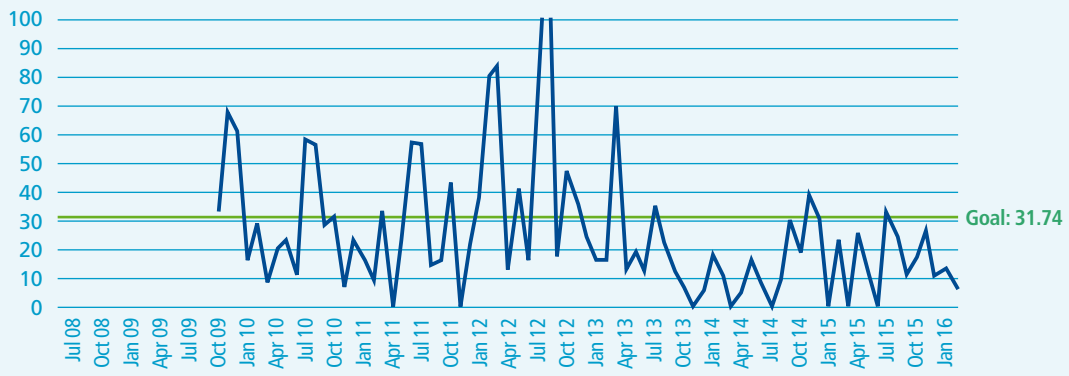
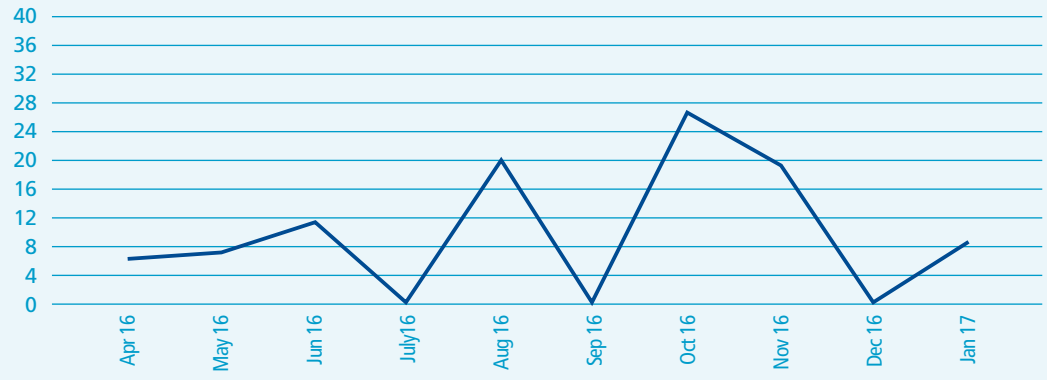
How did we get on?	In the first quarter of the year, we asked our Face2Face ward interview team to go out onto wards to talk to patients about the things they wanted/expected to be kept informed about. Answers included: - my treatment options - my plan for care over the next few days - what's going to happen in respect of my hospital care and treatment each day - whether any tests or procedures are due - getting test results and what they mean - when I'm going to be discharged - what's going to happen with my care when I go home. Detailed patient feedback gathered during May and June 2016 suggested that, in relative terms, the specific areas we perform least well in are keeping patients informed about plans for discharge and going home. However, overall, our performance was not a cause for concern: 72 per cent of inpatients told us that hospital staff had "always" kept them informed about what would happen next in their care and treatment during their stay, and 65 per cent said they were told when this would happen. We continued to monitor this aspect of care throughout the remainder of 2016/17, during which these scores further improved. In the final quarter of the year, 74 per cent of patients said that they had always been kept informed about next steps and 70 per cent said that they were told when that would happen (the latter being a statistically significant improvement). In light of this positive feedback, the Trust did not initiate a specific improvement project however there are a number of ongoing Trust plans which will support progress in this area. Specifically: • The Trust's ward round check-list will be adapted to include a check that the patient has understood what's been discussed with them. • Based on learning from the Bristol Royal Hospital for Children, the Trust is developing a system to enable adult patients and their families to quickly escalate any matters of clinical concern to Trust staff. • As described elsewhere in this report, in 2017/18 we will be implementing a system to enable patients and their families to give real-time feedback about their experiences of care, which will open up the possibility of staff being able to make positive interventions where feedback is poor, including any situations where communication about plans for care has not met expectations. We will also continue to monitor this theme and will take further appropriate action in accordance with what our patients tell us.
RAG rating	**Green** – following the Involvement Network's suggestion, we investigated this theme in detail as planned; patient feedback on this topic was significantly more positive than we had anticipated, and our patient-reported scores improved during the year. There are related improvement plans which will maintain our focus on this topic in 2017/18.

Objective 9	To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted
Rationale and past performance	This is a key national standard which has the potential to make a significant difference to patients with disabilities who are cared for in our hospitals.
What were our patients saying?	"Some nurses didn't know my child was disabled." "This operation was for my 15-year-old son who is deaf. We never got help from anyone who could sign to him and, if I wasn't there, he would have been lost. No-one could talk to him. They knew that he was deaf."
What did we say we would do?	We said we would develop and implement a Trust-wide plan to address the requirements of the standard.
How did we get on?	The Trust seconded an experienced sister to become a dedicated AIS implementation lead and convened a steering group chaired by the Trust's deputy chief operating officer

	to scope out the detailed actions and resources needed in order to systematically identify, record and respond to patients' communication needs. The AIS steering group has met monthly to oversee the delivery of our implementation plan, which has incorporated a number of standards contained within the Bristol Deaf Charter. Work with the Trust's Medway (patient administration system) team is ongoing to improve the management of alerts on the system. This is a key component of our approach because the alerts bring staff's attention to the existence of a communication need. Standard operating procedures have been implemented to govern the processes by which communication needs are identified and recorded and have been incorporated into the Trust's outpatient standards. A related project is underway to offer patients the opportunity to receive their Medway generated letters by email. This will provide the Trust with an alternative solution to written material but more work is underway to scope technical solutions to deliver information in an accessible format.
RAG rating	**Green** – significant progress has been made to enable the Trust to become compliant with Accessible Information Standard. Further work will be taken forward into 2017/18 to embed the consistent and effective use of Medway flags to alert staff to the existence of a communication need.

Objective 10	To increase the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving
Rationale and past performance	All trusts perform relatively poorly on this measure in the national inpatient survey; UH Bristol particularly so, because our current surveys are geared largely towards asking patients to reflect on their care post-discharge.
What were our patients saying?	"Please remember that you (midwives/doctors etc.) do this daily, patients don't, so don't forget to take a moment however busy you are, to mean it when you ask a patient if they are okay and listen. Too often the question is asked but the reply is unheard."
What did we say we would do?	We said that, during 2016/17, we would procure a new in-hospital patient feedback system to run alongside our existing post-discharge survey. We said that this would enable staff to routinely ask patients about the quality of care they are receiving whilst they are still in hospital, at point of care, as part of a wider theme of delivering responsive care. During the first half of the year, we said that we would carry out targeted Face2Face interviews with inpatients to gain a clearer understanding of their needs and expectations around being asked about quality of care and raising anything they are unclear or concerned about.
Measurable target/s identified for 2016/17	To achieve significantly improved scores in this measure in the 2017 National Inpatient Survey (by virtue of when the survey takes place), but in the meantime, to see consistent progress through our own monthly survey.
How did we get on?	We set this quality objective for 2016/17 with the aim of delivering a "real-time" patient feedback and reporting system. During the second quarter of the year, the Trust's patient experience and involvement team carried out an extensive literature search, spoke to the Picker Institute (who run the national patient surveys for the Care Quality Commission) about patients' understanding of the question "Were you asked about the quality of your care whilst you were in hospital?" and carried out Face2face interviews on our wards. This confirmed that patients usually interpret this question as being about participation in a survey or an opportunity to give feedback. The purpose of this background review was to rule out the possibility that patients might interpret this question in a different way: it confirmed that the survey question is a valid way of assessing the impact of our plans to increase in-hospital feedback opportunities. At the same time, a conscious decision was taken to delay the system procurement to ensure that it supports the ambitions set out in the Trust's new Quality Strategy 2016-2020 which was approved by the Trust Board in October 2016. The system requirements have subsequently been refined and a functional specification has been developed that will form the basis of a procurement exercise during 2017/18. This objective will therefore be carried forward into 2017/18. We have also established a baseline measure from patient feedback to enable us to set future improvement targets: in 2016/17, 30 per cent of respondents to our local post-discharge survey said that they had been asked to give their views on the quality of their care whilst in hospital.

RAG rating	**Amber –** we carried out background research and have developed a functional specification for a new patient feedback system, however the procurement has been delayed until early 2017/18.

Objective 11	To reduce avoidable harm to patients
Rationale and past performance	Reducing avoidable harm is a stated aim of our 'Sign up to Safety' Patient Safety Improvement Programme 2015-2018 and aligns with our vision 'to be among the best and safest places to receive healthcare' and the national 'Sign up to Safety' campaign's aims and objectives. Avoidable harm reduction is a longer term goal over several years. In our previous Safer Care Southwest Patient Safety Improvement Programme[3] 2009-2015, we set an improvement goal to reduce our adverse event rate[4] by 30 per cent. The graph below shows that over a five year period we achieved our goal to reduce our adverse event rate to below 31.74 per 1,000 patient days and sustain this.
UH Bristol NHS FT (SPI-2) A03: adverse event rate per 1,000 patient days - adverse event rate for whole of UHBristol	
What did we say we would do?	We said we would broaden the scope of our adverse event rate audit tool for adult patients to include additional types of adverse events not previously included. We said that we would test this new tool during the first quarter of 2016/17. We predicted that the new tool would initially increase our adverse event rate, and so we planned to establish a new baseline and to then set an improvement target of 50 per cent reduction in avoidable harm to be achieved over the next three years.
Measurable target/s identified for 2016/17	Completion of testing of the new audit tool in quarter 1 and establishing a new baseline by the end of quarter 3. Then, in quarter 4, setting a future improvement goal of a 50 per cent reduction against baseline.
How did we get on?	In Q1, we tested a new audit tool to look for adverse events. Adverse events are not the same as incidents. Incidents can include an element of error, but adverse events are about harm as an outcome of healthcare provision which may not necessarily be caused by error or be preventable. The new tool was based on the Institute of Healthcare Improvement[5] Global Trigger Tool for identifying adverse events, with additional items added to the audit tool as potential triggers for harm to patients. The new tool was successfully implemented in June 2016, starting with a review of a sample of patients who were discharged in April 2016. Baseline data was gathered using the new tool throughout quarter 2 and quarter 3 as planned.
UH Bristol NHS FT (SPI-2) 004: adverse event rate from April 2016	

	In February 2017, the Patient Safety Programme Board considered evidence for reliably identifying avoidable harm, drawing on Professor Sir Charles Vincent's work[6]. The Board agreed a new improvement goal for harm reduction of 3.23 adverse events per 1,000 bed days to be achieved over a three year period commencing October 2016.
RAG rating	**Green –** we tested the new tool, gathered data and have set ourselves a three year improvement target.

[3] Formerly known as the South West Quality and Patient Safety Improvement Programme

[4] Adverse events are events which are judged to have caused moderate or a higher level of harm to patients and which we want to reduce, whereas reported incidents may or may not have caused any harm to patients. We want to increase incident reporting so that we can learn as much as possible about events which could impact on our patients and enable us take action to minimise the risk of a similar incident.

[5] Institute for Healthcare Improvement, Cambridge, Massachusetts

[6] Vincent C, Burnett S, Carthey J. BMJ Quality and Safety 2014; 23:670-677, Vincent C. Patient safety. 2nd edition. Oxford: Wiley Blackwell, 2010

Objective 12	To improve staff-reported ratings for engagement and satisfaction
Rationale and past performance	Although our 2015 staff survey results were better than the previous year, we recognised that we still needed to make considerable improvements in order to achieve our ambition of being rated as one of the best teaching hospitals to work for.
What did we say we would do?	Our plans for 2016/17 included: • a focus on improving two way communication between staff and management • recognition events and team building • a review of the Trust's appraisal process • training programmes for line managers • health and wellbeing initiatives, with a specific focus on stress related illness • reduction in staff seeing errors and near misses and an increase in reporting where they are seen to increase lessons learned from the reporting • a piloted employee assistance programme • targeted action to address harassment and bullying • a revision and re-launch of the 'Speaking Out' policy • support for staff forums and reverse mentoring.
Measurable target/s identified for 2016/17	Our target was to achieve improvements in the following areas of staff-reported experience: • staff Friends and Family Test scores (this asks whether staff would recommend the Trust as a place to work and receive treatment) • overall staff engagement (a 'basket' of measures covering staff motivation, involvement and advocacy)

	• the percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month. We said that we would measure improvement via our annual all-staff census (this takes place in the third quarter of the year) as well as tracking progress via our quarterly Friends and Family Test survey (different staff groups are surveyed each quarter: scores for each quarter are directly comparable to the equivalent survey 12 months previously).
How did we get on?	In 2016/17 we have moved forward with a broad range of initiatives and activities as described above, designed to improve staff experience and engagement. This has included in-depth staff consultation regarding two significant new initiatives, both of which will be launched in the first quarter of 2017/18. Firstly, the introduction of electronic staff appraisal and secondly the development of a leadership behaviours framework for the Trust. Two of our divisional boards have also completed the Aston 'team journey'. Relevant Trust scores in the 2016 NHS Staff Survey improved: • Our score for staff engagement improved from 3.78 in 2015 to 3.83 in 2016 so that we are now ranked better than the average in our benchmark group. • Our score for whether staff would recommend the Trust as a place to work and receive treatment has also improved from 3.81 in 2015 to 3.90 in 2016; again better than the average score in our benchmark group. Our own all-staff Friends and Family Test scores (measured in the first quarter of the year) have also improved: • In 2016/17, 70 per cent of staff said that they would recommend UH Bristol as a place to work, compared to 62 per cent in 2015/16. • In 2016/17, 86 per cent of staff said that they would recommend UH Bristol as a place to receive treatment, compared to 85 per cent in 2015/16. Similarly, the Trust achieved improvements in two NHS staff survey indicators which we are required to publish in our quality report: • In 2016, 23 per cent of staff said that they had experienced harassment and bullying or abuse from other staff[7], compared to a national average of 25 per cent and a Trust score of 27 per cent in 2015. Amongst Black, Minority and Ethnic (BME) staff, reported experience improved from 34 per cent in 2015 to 28 per cent in 2016 (national average 27 per cent). • In 2016, 89 per cent of staff said that they believed that the organisation provides equal opportunities for career progression or promotion[8], compared to a national average of 87 per cent and a Trust score of 87 per cent in 2015. Amongst BME staff, reported experience improved from 73 per cent in 2015 to 77 per cent in 2016 (national average 75 per cent).
RAG rating	**Green –** improving staff engagement and experience has been the focus of significant activity throughout 2016/17, the early benefits of which have been reflected in the 2016 NHS Staff Survey scores and were a contributory factor in the Trust's Outstanding Care Quality Commission's rating.

[7] Indicator KF26 in the NHS staff survey

[8] Indicator KF21 in the NHS staff survey

2.1.2 Quality objectives for 2017/18

The Trust is setting eight quality objectives for 2017/18. Five of the objectives relate to ambitions we have only partially realised in 2016/17: reducing last minute cancelled operations; reducing cancellations and delays in outpatients; improving the management of sepsis; implementing a new patient feedback system; and improving staff-reported ratings for engagement and satisfaction. In addition, we have identified three new objectives, which relate to initiatives described in our 2016-2020 Quality Strategy: creating a new Quality Improvement Academy; establishing a new mortality review programme; and developing a consistent customer service mindset in all our interactions with patients and their families.

Objective 1	To reduce the number of last minute cancelled operations
Rationale and past performance	We understand the impact that the last minute cancellation of operations can have on patients – particularly those who require urgent treatment – and their families, creating uncertainty and adding to worry. We have set this objective for the last three years but have yet to achieve our goal. In 2016/17, 0.97 per cent of operations were cancelled at the last minute, against a target of no more than 0.92 per cent. This means that 734 patient operations were cancelled on the planned day of surgery.
What will we do?	We will conduct a detailed review of 2016/17 data to understand reasons for cancellations and will ensure that our action plan is directed towards areas where the greatest improvement is needed. In particular, we will adopt a new approach around the key themes of staffing, scheduling, capacity (linked to wider issues of bed occupancy and escalation) and improved understanding of the risks and impacts of cancelling operations.
Measurable target/s for 2017/18	We are retaining our existing target to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent.
How progress will be monitored	Progress will be monitored by the Trust's Service Delivery Group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 2	To reduce cancellations of outpatient appointments and to reduce waiting times in clinic
Rationale and past performance	We recognise the inconvenience and stress caused to patients by altering their planned appointments. From a Trust operational perspective, changing appointments is an inefficient use of our administrative team's resources; there is also evidence to suggest that it contributes to overall Did Not Attend (DNA) performance. In 2016/17, we cancelled 12.8 per cent of consultant-led clinics and 11.6 per cent of all outpatient appointment. We have set the objective of reducing waiting times in clinic for the last two years. A significant amount of work has been undertaken. However, in the absence of a method for reliably and objectively measuring waiting times, improvements have yet to be seen in patient-reported feedback about in-clinic waits.
What will we do?	**Reducing cancelled appointments:** Working with the Trust's information management and technology team, we will improve the reporting of reasons for cancellation. This requires an effective link between our patient administration system and the national Electronic Referral Service (ERS). We also hope to extend the notice period for booking of annual leave by consultants from six weeks to eight weeks which we believe will help reduce the number of clinics cancelled for booked leave that have already been open to book into. Most significantly, we believe that the improved management of the ERS will lead to a reduction in the number of patients who are cancelled and rebooked because they have been booked into the wrong clinic initially. Planned activity includes a full review of the directory of services available to referrers, improved management of capacity and reduction in unavailability of appointment slots – all part of a national CQUIN. **Reducing waiting times in clinic:** We will complete the installation and upgrade of all waiting times boards and 'you said-we did' boards in outpatient departments, and embed the daily management of them into the outpatient standards and monthly quality visits. We will also continue to pursue objective measurement of

	in-clinic waits using the Medway-based tracker that follows patients through their outpatient visit. We will review the findings of our pilot project and consider extending it to the Bristol Eye Hospital where patients often attend multiple departments on a single visit.
Measurable target/s for 2016/17	**Reducing cancelled appointments:** Using CHKS benchmarking information which compares us with a group of 50 other hospitals, we have set a target of 2 per cent improvement in both hospital and patient cancellation rates. **Reducing waiting times in clinic:** We will continue to pursue the stretching targets for patient-reported experience that we set ourselves last year, and complete the implementation of all standardised boards and processes.
How progress will be monitored	Progress will be monitored via reports to the Trust's Outpatient Steering Group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 3	To improve the management of sepsis
Rationale and past performance	Sepsis is recognised as a major cause of mortality and morbidity in the NHS. We made significant strides in the recognition and rapid treatment of sepsis during 2016/17, but we know there is more to be done. Despite our progress, early recognition and administration of IV antibiotics within one hour of sepsis presentation, while improving, is still being performed reliably in only 60-70 per cent of patients who present with possible sepsis. Audit evidence also shows that in inpatient areas only 30 per cent of deteriorating patients are appropriately screened for sepsis. In 2016/17, NCEPOD and NICE produced updated guidance on the management of sepsis following new worldwide Sepsis 3.0 definitions that were developed in 2016. The terms of a national sepsis CQUIN for 2017-19 have been agreed as a result.
What will we do?	We will: • update the Trust's sepsis guideline following its initial implementation in August 2016 • implement NICE sepsis guidance • complete mini-Root Cause Analysis investigations to gain a better understanding of the reasons why inpatients are not appropriately screened for sepsis and/or receiving timely antibiotics. Learning from these will be fed back to the clinical teams • undertake training and education in sepsis for all new staff at induction • provide targeted education to foundation doctors, core trainees and higher specialist trainees in medicine, surgery, emergency medicine and anaesthesia/intensive care • provide Face2Face ward based sepsis education for ward teams • review SHMI, HSMR and ICNARC data to ensure that sepsis associated mortality continues to be lower than average.
Measurable target/s for 2016/17	Our goal is to achieve the national sepsis CQUIN: timely identification and treatment of sepsis in emergency departments and acute inpatient settings. The following emergency department targets have been agreed: • 90 per cent of appropriate emergency department patients to be screened for sepsis • 90 per cent of emergency department patients who present with sepsis to receive antibiotics within one hour of diagnosis. • 90 per cent of patients with sepsis on antibiotics to have a 72 hour antibiotic review. Sepsis CQUIN targets and milestones for inpatient services remain subject to negotiation with commissioners at the time of writing (May 2017).
How progress will be monitored	Progress will be monitored by the Trust's Deteriorating Patient Group and the Patient Safety Programme Board.
Board sponsor	Medical director

Implementation lead	Adult services – Dr J Bewley, consultant in intensive care Children's services – Dr Marion Roderick, consultant paediatrician immunology and infectious disease Children's emergency department – Dr W Christian, consultant in paediatric medicine

Objective 4	To implement a new, more responsive, system for gathering patient feedback at point of care
Rationale and past performance	Implementation of the new system was postponed from 2016/17 and has been carried forward into 2017/18 (see section 2.1.1 of this report).
What will we do?	During 2017/18, as part of a wider focus on delivering responsive care, we will procure a new in-hospital patient feedback system to run alongside our existing post-discharge surveys. This will enable patients, their families and carers to give feedback about quality of care whilst the patients are still in hospital, thereby increasing our opportunities to address issues and concerns in real-time. The system that we procure will create a data 'hub' which brings together different streams of patient feedback and enables this information to be shared with staff more rapidly and in a format which facilitates its use for service improvement.
Measurable target/s for 2016/17	Our target is to achieve a significantly improved score in the 2018 National Inpatient Survey (by virtue of when the survey takes place), in relation to whether patients say that they have been asked about the quality of their care whilst they have been in hospital. In the meantime, we will measure progress through our own monthly survey.
How progress will be monitored	Reports to patient experience group
Board sponsor	Chief nurse
Implementation lead	Patient experience and involvement team manager

Objective 5	To improve staff-reported ratings for engagement and satisfaction
Rationale and past performance	Our Quality Strategy sets out our ambition that, by 2020, we will be recognised as one of the top 20 NHS trusts to work for. The 2015 and 2016 NHS staff survey results have shown incremental improvements in our score for staff engagement (3.69 in 2014, 3.78 in 2015, 3.83 in 2016). We need to maintain focus in order to realise our 2020 ambition: a staff engagement score of at least 4.00.
What will we do?	Our plans for 2017/18 include: • Implementation of a new E-Appraisal system • Developing a new framework to support line managers to consistently display positive leadership behaviours • Continuing to deliver established and successful health and wellbeing initiatives • Revising our Tackling Bullying and Harassment policy and further developing our tackling bullying advisory service • Developing local improving staff experience plans, in response to the findings of the 2016 NHS Staff Survey.
Measurable target/s for 2017/18	Our target is to achieve year-on-year improvements in the following areas of staff-reported experience: • Staff Friends and Family Test scores (this asks whether staff would recommend the Trust as a place to work and receive treatment) • Overall staff engagement (a 'basket' of measures covering staff motivation, involvement and advocacy) • The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month. We will measure improvement via our annual all-staff census (this takes place in the third quarter of the year). We will also track progress via our quarterly Friends and Family Test survey (different staff groups are surveys each quarter. Scores for each quarter are directly comparable to the equivalent survey 12 months previously).

How progress will be monitored	Divisional Board meetings, Workforce and Organisational Development Board, and Trust Board
Board sponsor	Director of people
Implementation leads	Divisional directors, supported by corporate organisational development team

Objective 6	To create of a new Quality Improvement Academy
Rationale and past performance	The quality strategy describes our plans to link up a number of strands of current activity that fall within our shared understanding of quality improvement, creating a learning environment to promote and encourage quality improvement. This includes clinical audit, research and innovation, patient safety and transforming care. All of these existing programmes continue to demonstrate huge value to the organisation, however we recognise that there are opportunities to work together more closely to support innovation and improvement across all areas of the Trust. A key part of this is the development of a new Quality Improvement Academy.
What will we do?	We want to promote and encourage innovation and improvement, so that staff with good ideas can bring them to life for the benefit of patients, staff, the Trust and the wider NHS. Within this ambition, we have three aims: • to support and connect people with our existing quality improvement programmes • to provide support to staff with good ideas outside these programmes • to build capability to support staff to lead improvement independently of these programmes. To create ownership and to build capacity to change, we should encourage staff with ideas to implement their ideas themselves. To drive and encourage this we will provide staff with support and education to give them the skills to lead improvement themselves. A key part of this will be the creation of a new Quality Improvement (QI) Academy to provide a broad range of staff with the quality improvement skills and tools they will need. The academy will be supported by a virtual team consisting of leads from established quality improvement programmes, who will offer advice and guidance to those implementing change, including project management skills and more general business innovation expertise. As part of our plan, we will establish a quarterly innovation forum to bring together the leaders of QI projects in a structured event to share learning. We will also seek to further strengthen our partnership with the West of England Academic Health Science Network.
Measurable target/s for 2017/18	Our target is for 100 members of staff to attend the QI Academy 'Bronze' programme during 2017/18.
How progress will be monitored	Progress will be monitored by the Innovation and Improvement Group which reports into Transformation Board.
Board sponsor	Director of strategy and transformation
Implementation lead	Clinical lead for transformation

Objective 7	To establish new mortality review programme
Rationale and past performance	This mortality review will further underpin the established work around patient safety, assessing the care provided to inpatients. Where areas of excellent and good care are established, this can be highlighted and learning fed back. Learning from poorer aspects of care can form the basis of developing quality improvement programmes which will lead to improvement in the provision of inpatient care. This programme replaces the previous inpatient mortality review which was established in 2014.
What will we do?	In response to national guidance published in March 2017, and as part of a national pilot, the Trust has redesigned the way it undertakes mortality review. We have assembled a multi-disciplinary team which will review all inpatient adult deaths. The process will involve an initial

	screening assessment, leading to a structured case note review wherever a death has followed an elective procedure or, for example, has involved a patient with learning difficulties or severe mental illness, or where a family has expressed concerns about a patient's care. The case note review will use methodology recently introduced by the Royal College of Physicians and we anticipate it will highlight aspects of both good and potentially poor care. Care is graded using both a scoring system and subjective comments and if concerns are raised by the reviewer then a further review of the case notes will be undertaken by the medical director's office.
Measurable target/s for 2017/18	The national guidance illustrates measures that will need to be reported to our Trust Board by the third quarter of 2017/18. This includes the total number of the Trust's inpatient deaths (including emergency department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
How progress will be monitored	Progress will be monitored via the Trust's Mortality Surveillance Group.
Board sponsor	Medical director
Implementation lead	Deputy medical director and associate medical director

Objective 8	To develop a consistent customer service mind set in all our interactions with patients and their families
Rationale and past performance	Customer service is a thread running throughout our Quality Strategy for 2016-20. UHBristol is a caring organisation: we know from our surveys that the vast majority of patients (97 per cent+) have a positive experience of care in our hospitals, but we also acknowledge that this isn't true of everyone. Aimed squarely at addressing issues which give rise to "the three percent", this objective marks the first year of an ongoing project aimed at embedding the consistent understanding and application of customer service principles across our organisation. The project will be developed and led by the Transformation Team in partnership with the Patient Experience & Involvement Team. The 2016/17 quality objective relating to improving telephone communications will be taken forward in 2017/18 under the banner of this customer service objective.
What will we do?	We have identified three levels of intervention to target future improvement activities: • individual and team behaviours that demonstrate and support a customer service mindset • establishing a set of customer service principles that can be held up as a mirror to proposed service changes and programmes of work • initiating specific improvement programmes that directly support excellence in customer service (e.g. telephones, letter, receptions, complaints handling). In the first quarter of the year, we will: • hold a workshop targeted at a broad range of hospital staff to explore the concept of customer service within healthcare and to test staff appetite for developing future programmes of work supporting this objective • engage with an external consultant with international experience in leading customer care programmes • achieve sign-up from our Transformation Board for our direction of travel. In the second quarter of the year, we will: • continue with staff and patient engagement activities, enabling us to define what customer service means for UH Bristol and to begin to develop our set of customer service principles; these conversations will be supported by the Trust's Face2Face interview team and will include our involvement network • identify key customer service "touchpoints" within the organisation • mobilise an executive-led steering group to finalise priorities and objectives and ensure clear ownership for our year 1 activities

	• agree at least four work streams which will directly support excellence in customer service, including measurable improvement targets; this will include a telecommunications work stream, carried forward from last year's objectives • agree how existing improvement programmes (e.g. outpatients transformation) will support our customer service objective. In the second half the year, we will begin to deliver the products and programmes of work described above, some of which may continue into 2018/19 and beyond as we work towards our goal of customer service accreditation by 2020 (as set out in our quality strategy).
Measurable target/s for 2017/18	To be agreed at the end of quarter 2.
How progress will be monitored	Progress will be monitored via the Trust's Transformation Board.
Board sponsor	Chief nurse
Implementation lead	Director of transformation and patient experience and involvement team manager

2.1.2.1 How we selected these objectives

These objectives have been developed, following consideration of:

- the quality priorities of our Trust Board as set out in our quality strategy for 2016-2020
- feedback from staff, governors and members of the public received during the consultation which resulted in that strategy feedback from our governors
- our desire to maintain our focus on any quality objectives that were not achieved in 2016/17 feedback from patients via ongoing surveys
- views expressed by our members of our involvement network at a meeting in January 2017.

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2016/17, UH Bristol provided relevant health services in 70 specialties via five clinical divisions (medicine; surgery, head and neck; women's and children's services; diagnostics and therapies; and specialised services).

During 2016/17, the Trust Board has reviewed and selected high-level quality indicators covering the domains of patient safety, patient experience and clinical effectiveness as part of monthly performance reporting. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by UH Bristol services reviewed in 2016/17 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2016/17.

2.2.2 Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Account, the Department of Health published an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of any trust clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms percentage participation and case ascertainment. The detail which follows, relates to this list.

During 2016/17, 40 national clinical audits and four national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, University Hospitals Bristol NHS Foundation Trust participated in 100 per cent (40/40) national clinical audits and 100 per cent (4/4) of the national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2016/17, and whether it did participate, are as follows:

Table 1

Name of audit / Clinical Outcome Review Programme	Participated
Acute	
Adult asthma	Yes
Case Mix Programme (CMP)	Yes
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes
National Emergency Laparotomy Audit (NELA)	Yes
National Joint Registry (NJR)	Yes
Moderate & acute severe asthma (care in emergency departments)	Yes
Severe sepsis and septic shock (care in emergency departments)	Yes
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	Yes

Cancer	
Bowel cancer (NBOCAP)	Yes
Head & neck cancer (HANA)	Yes
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Heart	
Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes
Cardiac Rhythm Management (CRM)	Yes
Congenital heart disease (paediatric cardiac surgery) (CHD)	Yes
Coronary Angioplasty/National Audit of PCI	Yes
National Adult Cardiac Surgery Audit	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Heart Failure Audit	Yes
Long term conditions	
Inflammatory bowel disease (IBD)	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes
National Diabetes Core Audit (Adult)	Yes
National Diabetes Foot Care Audit (NDFA)	Yes
National Diabetes Inpatient Audit	Yes
National Pregnancy in Diabetes Audit	Yes
Renal Replacement Therapy (Renal Registry)	Yes
National Ophthalmology Audit	Yes
UK Cystic Fibrosis Registry	Yes
Older people	
Fracture Liaison Service Database (FLS)	Yes
National Audit of Dementia	Yes
National Audit of Inpatient Falls (NAIF)	Yes
National Hip Fracture Database (NHFD)	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
Other	
Elective surgery (National PROMs Programme)	Yes
Endocrine and Thyroid National Audit	Yes
Women's and Children's Health	
National Diabetes (Paediatric) (NPDA)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric intensive care (PICANet)	Yes
Neurosurgical National Audit Programme	Yes

Outcome Review Programmes	
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Yes
Child Health Clinical Outcome Review Programme	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes
Learning Disability Mortality Review Programme (LeDeR)	Yes

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (where known).

Table 2

Acute	
Adult asthma	27*
Case Mix Programme (CMP)	100% (1,242/1,242)
Major Trauma: The Trauma Audit & Research Network (TARN)	117% (368/312)**
National Emergency Laparotomy Audit (NELA)	106% (168/158)**
National Joint Registry (NJR)	42*
Moderate & acute severe asthma (care in emergency departments)	92% (92/100)
Severe sepsis and septic shock (care in emergency departments)	100% (50/50)
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	90% (36/40)
Cancer	
Bowel cancer (NBOCAP)	113% (147/166)**
Lung cancer (NLCA)	178*
Oesophago-gastric cancer (NAOGC)	>90% (198)*
Heart	
Acute coronary syndrome or acute myocardial infarction (MINAP)	832*
Cardiac Rhythm Management (CRM)	987*
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (1,081/1,081)
Coronary Angioplasty/National Audit of PCI	100% (1,713/1,713)
National Adult Cardiac Surgery Audit	100% (1,325/1,325)
National Cardiac Arrest Audit (NCAA)	79*
National Heart Failure Audit	482*
Long term conditions	
Inflammatory bowel disease (IBD)	10*
National Diabetes Core Audit (Adult)	488*
National Diabetes Foot Care Audit (NDFA)	57*
National Diabetes Inpatient Audit	77*
National Pregnancy in Diabetes Audit	116*
Renal Replacement Therapy (Renal Registry)	57*
National Ophthalmology Audit	100% (4,215/4,215)
UK Cystic Fibrosis Registry	380*

Older people	
Fracture Liaison Service Database (FLS)	100% (1,443/1,443)
National Audit of Dementia	100% (50/50)
National Hip Fracture Database (NHFD)	100% (320/320)
Sentinel Stroke National Audit Programme (SSNAP)	>90% (453)
Other	
Elective surgery (National PROMs Programme)	45% (70/155)
Endocrine and Thyroid National Audit	9*
Women's and Children's Health	
National Diabetes (Paediatric) (NPDA)	511*
Neonatal intensive and special care (NNAP)	100% (432/432)
Paediatric intensive care (PICANet)	100% (761/761)
Neurosurgical National Audit Programme	Yes
Outcome Review Programmes	
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	7*
Maternal, Newborn and Infant Clinical Outcome Review Programme	100% (74/74)

* No case requirement outlined by national audit provider/unable to establish baseline

** Case submission greater than national estimate from Hospital Episode Statistics (HES) data

The reports of 13 national clinical audits were reviewed by the provider in 2016/17. University Hospital Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

British Thoracic Society (BTS) Smoking Cessation Audit (actions to be completed by December 2017)

- To amend the current admission clerking paperwork to improve the documentation of smoking status and provision of nicotine replacement therapy.
- To introduce a new 'smoking status' box on the Trust patient administration system to record current smoking status for inpatients.
- To provide brief intervention training for more front line staff (in particular F1 and F2 doctors).
- To seek funding for a smoking cessation service that will be available to staff and patients.

National Emergency Laparotomy Audit (actions completed by October 2016)

- To introduce pre and post theatre checklists to help guide decisions around pre and post-operative care and to improve the standardisation of care in theatres. These will be integrated into the current theatre system.
- To implement formalised care pathways for emergency laparotomy surgery.
- To implement a consistent mortality review approach following emergency laparotomy.

College of Emergency Medicine Audits (actions to be completed by December 2017)

- To attach a patient information leaflet to the current thromboprophylaxis risk assessment to help ensure that patients receive information regarding their care.
- To move from the use of injectable anticoagulants to oral anticoagulants within the emergency department.
- To update the department sedation proforma.
- To produce age-specific CAS (Central Alerting System) cards with clear abnormal level guidance, to help prompt appropriate action when vital signs cause concern.

National Audit of Inpatient Falls (actions completed by April 2016)

- To develop local guidelines on lying and standing blood pressures.
- To introduce 'falling star' stickers onto all assessment areas, indicating where a patient is at risk of falling.
- To undertake a re-audit of key areas including medication, vision, hearing, continence, call bell, multi-disciplinary team documentation and giving of patient leaflets.

National End of Life Care Audit (actions completed by April 2017)
- To establish additional core medical trainee and F2 formal training sessions.
- To develop an information leaflet to aid communication with nominated relatives regarding hydration and nutrition for patients without capacity.

National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis (actions completed by December 2016)
- To introduce an early inflammatory arthritis pathway as a separate referral stream for GPs.

Sentinel Stroke National Audit Project (actions completed by September 2016)
- To increase the role of specialist stroke nurses in facilitation of the pathway.
- To undertake further education of clinical staff regarding the importance of the stroke pathway.
- To introduce an information stamp which will be used in the notes to help to make it clear when patients have been discharged from occupational therapy.

National Cancer Audits
- There has been an increase in proactive data collection for this audit with much day-to-day work now delegated to multi-disciplinary team coordinators and teams, supported by full guidance and data completeness trackers. Our data completeness is now better than the national average for most data fields.

National Diabetes Audit – Pregnancy in Diabetes (actions completed by June 2016)
- To update the diabetes antenatal database to enable the endocrine antenatal team to record folic acid use at first contact with patient on diabetes antenatal database to ensure capture of information.
- The endocrine antenatal team will continue to deliver teaching/training for community midwives but will broaden teaching to practice nurses and primary care clinicians.
- To undertake local audit to determine the location of care of babies born to women with diabetes at UH Bristol, the causes of admission to the Neonatal Intensive Care Unit and the causes of preterm births.

National Parkinson's Disease Audit (actions to be completed by December 2017)
- To develop a patient leaflet introducing the roles of all members of the team and providing contact details.
- To update Band 7 staff appraisals to include wheelchair and specialist seating competencies.
- To introduce screening documentation for identifying and referring onwards those with specialist seating needs.
- To develop an assessment and review checklist for inpatients with Parkinson's disease to improve assessment and documentation of communication, swallow and saliva control.
- To identify standardised assessments for communication and swallow for speech and language therapists to complete as part of Parkinson's disease specific assessment and reviews.
- To increase the speech and language therapy profile on older people's rehabilitation wards by attending board round and providing training to ensure any patients are seen in a timely way.
- To investigate the use of Skype to deliver intensive LSVT (Lee Silverman Voice Treatment) programme.

The outcome and action summaries of 260 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2016/17; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Trust's Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2016/17[10].

Clinical Outcomes Publication (COP)
Previously the Consultant Outcomes Publication, the Clinical Outcomes Publication (COP) is an NHS England initiative, managed by the Healthcare Quality Improvement Partnership (HQIP) to publish quality measures at the level of individual consultant doctors using National Clinical Audit and administrative data. COP began with ten national clinical audits in 2013, with two further audits/registries added in 2014. Those that published in the inaugural year have

[10] Available via the Trust's internet site from July 2017

continued to build on and develop the number of procedures and quality measures covered including team-based or hospital measures.

The table below shows the medical specialties/societies that reported consultant outcomes in 2016/17 and whether the Trust submitted data to the required national audit/registry.

Table 3

Specialty	*Clinical audit/registry title*	*Specialist Association*	*Submitted*
Adult cardiac surgery	National Adult Cardiac Surgery Audit ***Open heart surgery***	Society for Cardiothoracic Surgery	Yes
Bariatric surgery	National Bariatric Surgery Register ***Surgery concerning the causes, prevention and treatment of obesity***	British Obesity & Metabolic Surgery Society	N/A
Colorectal surgery	National Bowel Cancer Audit Programme ***Surgery relating to the last part of the digestive system***	The Association of Coloproctology of Great Britain and Ireland	Yes
Head and neck surgery	National Head and Neck Cancer Audit ***Surgery concerning the treatment of head and neck cancer***	British Association of Head and Neck Oncology	Yes
Interventional cardiology	Adult Coronary Interventions ***Treatment of heart disease with minimally invasive catheter based treatments***	British Cardiovascular Intervention Society	Yes
Lung cancer	National Lung Cancer Audit ***Treatment of lung cancer through surgery, radiotherapy, and chemotherapy***	British Thoracic Society and SCTS	Yes
Neurosurgery	National Neurosurgery Audit Programme	Society of British Neurological Surgeons	Yes
Orthopaedic surgery	National Joint Registry ***Joint replacement surgery***	British Orthopaedic Association	Yes
Thyroid and endocrine surgery	BAETS national audit ***Surgery on the endocrine glands to achieve a hormonal or anti-hormonal effect in the body***	British Association of Endocrine and Thyroid Surgeons	Yes
Upper gastro-intestinal surgery	National Oesophago-Gastric Cancer Audit ***Surgery relating to the stomach and intestine***	Association of Upper-gastrointestinal Surgeons	Yes
Urological surgery	BAUS cancer registry ***Surgery relating to the urinary tracts***	British Association of Urological Surgeons	N/A
Vascular surgery	National Vascular Registry ***Surgery relating to the circulatory system***	Vascular Society of great Britain and Ireland	N/A

All data can be found on the individual association websites and is also published on NHS Choices (MyNHS). No UH Bristol consultant has been identified as an 'outlier' within these published outcomes.

2.2.3 Participation in clinical research

UH Bristol has maintained and expanded its commitment to provide exceptional evidence based care to patients by offering them the opportunity to take part in research.

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 5,521. This compares with 4,429 in 2015/16.

As of 31 March 2017, the Trust had 684 active studies, 49 of which are sponsored by UH Bristol. At the equivalent point 12 months before, the Trust had 756 active studies. Our sponsored research includes trials of investigational medicinal products, investigational devices and surgical interventions.

In a snapshot taken on 31 March 2017, the number of research studies and recruited participants were as follows (March 2016 comparator in brackets):

Table 4

Number of active non-commercial (portfolio) studies	429 (457)
Number of active non-commercial (non-portfolio) studies	121 (144)
Commercial studies registered	134 (155)
Number of recruits in non-portfolio non-commercial trials	564 (555)
Number of recruits in portfolio non-commercial trials	4,539 (3,524)
Number of recruits in commercial trials	418 (350)

In the last year, we have focused on the efficient set up and delivery of both commercial and non-commercial trials, so that we can recruit participants to time and target. This ensures the most effective use of funding. Examples of our successes include:

- In the Bristol Eye Hospital, a number of studies have recruited the first patient in the UK and the first patient globally, and have reached full recruitment a year ahead of target. We have a 100 per cent success rate in recruiting to time and target for our industry led trials in ophthalmology.
- In the Bristol Heart Institute, Bristol Haematology and Oncology Centre, and the Bristol Royal Hospital for Children we routinely recruit all our participants on time and are often recognised in this respect as being among the best performing centres nationally and internationally.

In 2016/17, we successfully expanded our research activity into new areas, including:

- obstetrics, supporting a locally-led study and working collaboratively across the city and the region to deliver the trial
- rheumatology, developing a pipeline of new studies which will start to recruit in 2017/18
- haematology and oncology, focussing on identifying novel treatments for patients.

We continue to work with commercial partners to open new trials. These provide novel treatments under trial protocols that patients might otherwise not access. Our commercial income for 2016/17 surpassed our previous highest yearly income figure and we plan to support more clinical specialities, for example those previously unfamiliar with delivering research, to open commercial trials in 2017/18. This income enables the Trust to build capacity to increase the number of trials and access to research for our patients.

UH Bristol currently holds National Institute for Health Research (NIHR) grants bringing in a total research income of almost £7 million per year. We have recently been awarded a further £20.8m over five years, in partnership with the University of Bristol, in the latest round of NIHR Biomedical Research Centre awards. The award began on 1 April 2017 and the funding will allow us to build on our existing programmes in cardiovascular disease and nutrition, diet and lifestyle with the addition of themes in surgical innovation, reproductive and perinatal health and mental health. Working in close partnership with the University of Bristol, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust, we will draw together population studies, laboratory science and patient-based research to benefit our patients and the local population.

After completing target recruitment on time in 2016/17, two UH Bristol grants are drawing to a close:

- Reducing arthritis fatigue: clinical teams using cognitive-behavioural approaches (RAFT) led by Professor Sarah Hewlett, was awarded through an NIHR commissioning brief that asked us to test whether a simplified psychological intervention that could be delivered widely in the NHS reduces rheumatoid arthritis fatigue and is an efficient use of NHS resources. Professor Hewlett and her team are now analysing the results with the aim of developing the optimal RAFT package for roll out in the NHS.

- Can skin grafting success rates in burn patients be improved by using a low friction environment – a feasibility study? (SILKIE), led by Dr Amber Young. The aims of this NIHR research for patient benefit feasibility study are in part to determine whether patients can be recruited and the study be run in an NHS setting. Once all data have been analysed the team will decide whether the study warrants a full scale clinical trial.

We have been awarded three new project grants in 2016/17. Looking ahead, we continue to work with our staff to develop high quality grants that will help answer important clinical questions and improve patient care.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)
A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2016/17 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The amount of potential income in 2016/17 for quality improvement and innovation goals was approximately £10.74m based on the sums agreed in the contracts (this compares to £9.77m in 2016/17).

The CQUIN goals were chosen to reflect both national and local priorities. 18 CQUIN targets were agreed, covering more than 40 measures. There were three nationally specified goals: staff health and wellbeing, sepsis (screening and timely provision of antibiotics) and antimicrobial resistance (reduce volume prescribed and review prescriptions within 72 hours).

The Trust achieved 15 of the 18 CQUIN targets and three in part, as follows:

- staff health and wellbeing
- sepsis (partial)
- antimicrobial resistance
- paediatric personal asthma action plan
- advice and guidance
- expanding surgical site infection surveillance (ssis)
- discharge communication
- cancer recovery package
- end of life
- achieving 62 day cancer target (partial)
- reduction in alcohol dependence
- hepatitis C
- clinical utilisation review
- adult critical care (partial)
- optimal device
- dose banding
- transition
- bowel cancer screening.

2.2.5 Care Quality Commission registration and reviews
University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The CQC has not taken enforcement action against the Trust in 2016/17.

In November 2016, the Trust received a follow-up to its previous comprehensive inspection in September 2014. A team of CQC inspectors visited the hospitals on and around the Bristol Royal Infirmary campus, reviewing medical care, surgery, outpatient services and emergency departments. On this occasion, inspectors did not visit South Bristol Community Hospital or the Central Health Clinic, these being the other registered locations from which UH Bristol provides healthcare services.

The Trust was delighted to receive an overall rating of Outstanding from the CQC, becoming the first Trust in the country to go from Requires Improvement to Outstanding between two inspections and only the sixth acute Trust to receive this rating. Staff were praised by the Chief Inspector of Hospitals, Professor Sir Mike Richards, who said "the hard work has paid off in making a real difference to the lives of people using the services, in the immediate Bristol area and in the wider South West in general."

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

The CQC's report went on to say that:

"We spoke with over 200 patients and relatives during our inspection. All were overwhelmingly positive about the care and treatment they had received. Patients told us they had received compassionate and sensitive treatment and care by staff. Patients on wards we spoke with were consistently positive about how staff interacted with them. Patients we spoke with said they made sure people's privacy and dignity were always respected, including during physical or intimate care. When patients experienced physical pain, discomfort or emotional distress, we saw staff responded with kindness and compassion in a timely way. Patients said their needs were responded to in time and with good care. Patients told us they felt involved in the decisions about their care, and relatives told us they were kept informed and updated with any changes to their relatives care."

During the inspection, the CQC identified a number of areas of outstanding practice, including (in the words of the Chief Inspector of Hospitals):

- In times of crowding the emergency department was able to call upon pre-identified nursing staff from the wards to work in the department. This enabled nurses to be released to safely manage patients queueing in the corridor.
- The audit programme in the emergency department was comprehensive, all-inclusive and had a clear patient safety and quality focus.
- New starters in the emergency department received a comprehensive, structured induction and orientation programme, overseen by a clinical nurse educator and practice development nurse. This provided new staff with an exceptionally good understanding of their role in the department and ensured they were able to perform their role safely and effectively.
- In the emergency department the commitment from all staff to cleaning equipment was commendable.
- The comprehensive register of equipment in the emergency department and associated competencies were exceptional.
- Staff in the teenagers and young adult cancer service continually developed the service, and sought funding and support from charities and organisations, in order to make demonstrable improvements to the quality of the service and to the lives of patients diagnosed with cancer. They had worked collaboratively on a number of initiatives. One such project spanned a five year period ending May 2015 for which some of the initiatives were ongoing. The project involved input from patients, their families and social networks, and healthcare professionals involved in their care. It focused on key areas which included: psychological support, physical wellbeing, work/employment, and the needs of those in a patients' network.
- The use of technology and engagement techniques to have a positive influence on the culture of an area within the hospital. There were clear defined improvements in the last 12 months in Heygroves Theatres.
- The governance processes across the Trust to ensure risks and performance were managed.
- The challenging objectives and patient focused strategy used to proactively develop the quality and the safety of the Trust.
- The use of real time feedback from staff via the 'happy app' to improve and take action swiftly in areas where staff morale is lower.
- The focus on the leadership development at all levels in order to support the culture and development of the Trust.

- The use of innovation and research to improve patient outcomes and reduce length of stay. The use of a discrete flagging system to highlight those patients who had additional needs. In particular those patients who were diabetic or required transport to ensure they were offered food and drink.
- The introduction of IMAS (Interim Management and Support) modelling in radiology to assess and meet future demand and capacity.
- The use of in-house staff to maintain and repair radiology equipment to reduce equipment down time and expenses.
- The introduction of a drop in chest pain clinic to improve patient attendance.

The inspection team identified four areas of practice where the Trust needed to take action (again, in the words of the Chief Inspector of Hospitals):

- Ensure all medicines are stored correctly in medical wards, particularly those which were observed in dirty utility rooms.
- Ensure records in the medical wards and in outpatient departments are stored securely to prevent unauthorised access and to protect patient confidentiality.
- Ensure all staff are up to date with mandatory training.
- Ensure non-ionising radiation premises in particular Magnetic Resonance Imaging (MRI) scanners restrict access.

The Trust has submitted action plans to the CQC to address each of these concerns. The Trust's rating for responsiveness reflects the need to achieve effective flow of patients into and out of our hospitals, which is a challenge not just for UH Bristol but for the wider local and regional health and social care economy. Details of how the Trust is seeking to address related themes, including cancelled operations and delayed discharges from hospital, can be found in earlier sections of this report.

2.2.6 Data quality

UH Bristol submitted records during 2016/17 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data.

The percentage of records:

- which included the patient's valid NHS number was: 99.2 per cent for admitted patient care; 99.6 per cent for outpatient care; and 97.8 per cent for accident and emergency care
- which included the patient's valid general practice code was: 99.9 per cent for admitted patient care; 100 per cent for outpatient care; and 100 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2016 - January 2017 as at Month 10 inclusion date)

UH Bristol's information governance assessment report overall score for 2016/17 was 67%.

UH Bristol has not been subject to a national payment by results audit in 2016/17 as the accuracy of clinical coding is within accepted norms.

In November 2016/17, the accredited auditor for the Trust's clinical coding team undertook an audit of 81 Finished Consultant Episodes (FCEs) across a range of adult surgery specialties. The following levels of accuracy were achieved (2015/16 results in brackets):

- Primary diagnosis accuracy: 97.5 per cent (90 per cent)
- Primary procedure accuracy: 91.7 per cent (90.3 per cent).

In March 2016/17, the clinical coding team also carried out an audit of 50 FCEs in oral surgery. The results showed an increase in accuracy for diagnoses and procedures (2015/16 results in brackets):

- Primary diagnosis accuracy: 100 per cent (92.2 per cent)
- Primary procedure accuracy: 96.0 per cent (90.2 per cent).

(Due to the sample size and limited nature of the audit, these results should not be extrapolated).

The Trust has taken the following actions to improve data quality:

- The data quality programme involves a regular data quality checking and correction process. This involves the central information system team creating and running daily reports to identify errors and working with the Medway support team and users across the Trust in the correction of those errors (this includes checking with the patient for their most up to date demographic information).
- The Trust has installed self-check-in devices across the Trust in addition to outpatient clinic reception staff to enable patients to update their own demographic information.

2.3 Mandated quality indicators

In February 2012, the Department of Health and NHS Improvement announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2016/17 (or in some cases, latest available information which predates 2016/17) is summarised in the table below. The Trust is confident that this data is accurately described in this Quality Report. The Trust maintains a data quality and reporting framework which details what the measures are, where data comes from and who is responsible for it.

Table 5

Mandatory indicator	UH Bristol 2016/17 (or most recent)	National average	National best	National worst	UH Bristol 2015/16
Venous thromboembolism risk assessment	99.1% Apr-Dec16	95.6%	100%	78.7%	98.2% Apr-Mar16
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)*	15.6 Apr-Dec16	14.9	0.0	66.0	16.7 Apr15-Jan16
Rate of patient safety incidents reported per 1,000 bed days	57.26 Apr-Sep16	40.77	71.81	21.15	55.7 Oct15-Mar16
Percentage of patient safety incidents resulting in severe harm or death	0.38% Apr-Sep16	0.40%	0.02%	1.73%	0.36% Oct15-Mar16
Responsiveness to inpatients' personal needs	71.4 Apr15-Mar16	69.6	86.2	58.9	69.4 Apr14-Mar15
Percentage of staff who would recommend the provider	81% 2016 survey	70%	85%	49%	77% 2015 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	99.4 (Band 2 "As Expected") Oct15-Sep16	100	69.0	116.4	98.8 (Band 2 "As Expected") Apr15-Mar16
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	27.6% Oct15-Sep16	29.7%	56.3%	0.4%	23.9% Apr15-Mar16

Patient Reported Outcome Measures	Provisional comparative groin hernia data for 2015/16 (the most recent available) shows that 61.1% of UH Bristol patients reported an improved EQ-5D score compared to the national average of 50.9%; 62.5% of UH Bristol patients reported an improved EQ-VAS score compared to the national average of 37.7%). An increase in EQ-5D or EQ-VAS scoring indicates that patients felt that their quality of life had improved after surgery. UH Bristol does not carry out any other procedures covered by the national PROMs programme.
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12**: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12**: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.

* NHS Digital has published monthly Clostridium difficile numbers for 2016/17, but not as a rate per bed days. Using our own internal reports and estimated bed days, we get the following totals for Apr16-Jan17: UH Bristol = 14.1, Average = 13.8, Max=79.7,Min=0.0. Note this is NOT official published data.

** NHS Digital quote "Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review" – therefore latest published data is still for financial year 2011/12.

3 Review of services in 2016/17

3.1 Patient safety

The safety of our patients is central to everything we want to achieve as a provider of healthcare. We are committed to continuously improving the safety of our services, and will focus on avoiding and preventing harm to patients from the care, treatment and support that is intended to help them. We will do this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will also continue to conduct thorough investigations and analyses when things go wrong, identifying and sharing learning, and making improvements to prevent or reduce the risk of a recurrence. We will be open and honest with patients and their families when they have been subject to a patient safety incident, and will strive to eliminate avoidable harm as a consequence of care we have provided.

In 2016/17 we have continued to sustain high quality performance in a number of key patient safety indicators as show in Table 7, in particular achieving a reduction in the number of hospital acquired pressure ulcers (40 in 2016/17, a 34 per cent reduction from 2015/16) and comfortably meeting our target for Clostridium difficile infection (10 avoidable cases in 2016/17 against a target of 45). Unfortunately, however, there were more falls per 1,000 bed days in 2016/17 (4.23 compared to 3.95 in 2015/16) and more falls with harm (36 compared to 30 in 2015/16).

Sign up to SAFETY

3.1.1 Our Patient Safety Improvement Programme

UH Bristol 'signed up to safety' in 2014 by making our pledges under five national themes:

- put safety first
- continually learn from feedback and by measuring and monitoring how safe our services are
- be open and honest
- collaborate with others in developing system wide improvements
- support patients, families and our staff to understand when things go wrong and how to put them right.

We reported last year on the development of our 'Sign up to Safety' programme and the partnership work with colleagues in the West of England Patient Safety Collaborative to identify and develop opportunities for system wide safety improvements and to share and learn from each other.

In line with the national Sign up to Safety initiative, the overall aim of our programme is to reduce mortality and harm to patients. In 2016/17 we have refined our overall measures of the programme, recognising that the measurement of avoidable mortality and avoidable harm is more complex than a single indicator. For mortality we are aiming to achieve and sustain an upper quartile ranking of English NHS trusts for the Summary Hospital Mortality Indicator published quarterly by NHS Digital, and for harm reduction we are aiming to achieve and sustain reduction to 3.23 adverse events per 1,000 bed days to be achieved over a three year period.

Please see section 3.3 of this report for more details of our work on mortality and section 2.1.1 for a summary of progress on our 2016/17 quality objective for harm reduction.

We have four key work streams within our patient safety programme, described below.

3.1.1.1 Safety Culture work stream

Culture is a 'collective mindfulness' which defines how people behave and interact with others. In healthcare, the development of a positive patient safety culture ensures that staff have a constant and active awareness of the potential for things to go wrong and are enabled to acknowledge mistakes, learn from them, and take action to put things right. We have chosen to use a safety culture assessment tool based on the Manchester Patient Safety Framework[11] for acute trusts.

What we have done in 2016/17

Last year we reported that we had completed our first organisation-wide assessment of safety culture of clinical teams across the organisation. In 2016/17 we have completed the analysis of data at team, divisional and Trust level and have given face to face feedback to boards and over 100 clinical teams regarding what they said about their team's and the Trust's safety culture. Across the organisation as a whole, most people rated their team's and the Trust's safety culture as 'proactive' in each of the ten domains within the Manchester Patient Safety Framework tool, indicating that they place a high value on improving safety, actively investing in continuous safety improvements and rewarding staff who raise safety related issues. Each Board – divisional and Trust – and clinical team has been asked to select one or two safety culture areas to develop depending on the detailed feedback received.

What we will do in 2017/18

We will:

- continue with our organisational development work on staff engagement and support
- complete the final feedback to clinical teams
- develop a safety culture toolkit with information and resources to support teams in the areas they have chosen to develop
- conduct a further detailed analysis of the free text comments staff made to look at themes to take forward as a trust
- make plans to repeat the safety culture assessments starting in the first half of 2018.

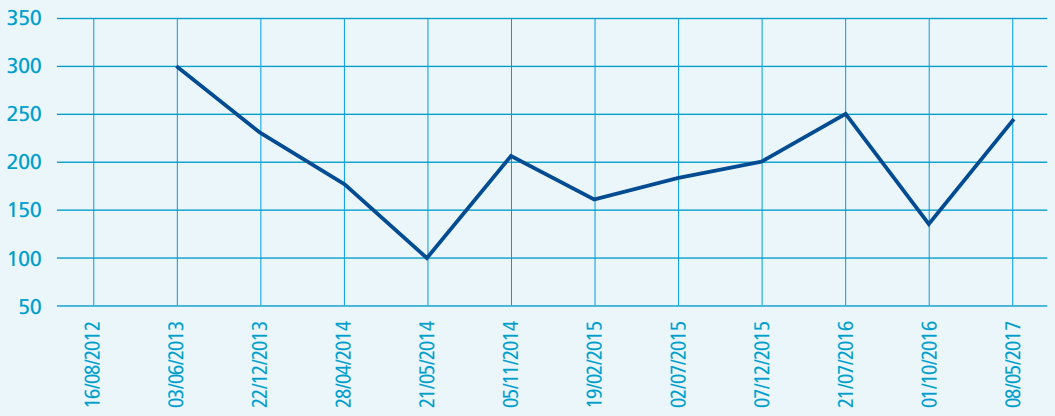
[11] Manchester Patient Safety Framework, University of Manchester 2006.

3.1.1.2 Peri-procedure never events work stream

We are aiming to reduce the incidence of peri-procedure never events: wrong site surgery, retained foreign object and wrong implant/prosthesis by the introduction of a Trust-wide process that staff can use to identify and mitigate any risk associated with the procedure being carried out. Much work has already been done in our operating theatre environments, but in 2016/17 we focussed on adapting and spreading our local safety standards for invasive procedures (LocSSIPs) into other areas such as our emergency departments, our intensive care units and outpatient areas. In the first instance we are aiming to have no never events for a year. The graph below shows, as at the time of writing, that we have had no never events for 219 days.

Figure 1

University Hospitals Bristol NHS Foundation Trust (SPI-2) 026 Days between peri-procedure never events.
219 days since last event (today 5/8/2017)



Source: UH Bristol serious incident log

Despite the work we are doing, there were two peri-procedure never events which occurred in our Trust in 2016/17:

- one retained laparoscopic retrieval bag containing a sample
- one retained vaginal swab following the delivery of a baby.

We have investigated these cases thoroughly and have learned that despite having very high levels of compliance with the WHO[12] surgical safety checklist, there are improvements we can make to our safety systems to make it easier for our staff to do the right thing and harder for them to do the wrong thing.

Examples of these improvements include:

- amending the WHO checklist to clarify the checks for specimens being sent to the laboratory
- appropriate use of the white board in the central delivery suite to record swabs purposefully placed inside (intended for removal at the end of the procedure) and their removal.

What we have done in 2016/17

- We have refined our WHO surgical safety checklist in theatres to include checks on dispatch of samples as a result of learning from a never event.
- We have conducted "mystery shopper" audits of the quality of how we conduct WHO checklists and shared the results with teams to support them in making improvements in areas where required.
- We have worked across clinical teams and specialties to successfully develop and introduce local safety standards for invasive procedures in a number of 'out of theatre' procedures such as chest drain insertion, central line insertion, ascitic tap, lumbar puncture, endoscopy, nerve block.
- We have incorporated awareness of local safety standards for invasive procedures into induction and updates for all clinical staff with more in depth education for staff involved in the procedures.

[11] World Health Organisation

What we will do in 2017/18

- We will continue to adapt and spread local safety standards for invasive procedures.
- We will continue with our education plan.
- We will repeat our "mystery shopper" audits of the quality of how we conduct WHO checklists.

3.1.1.3 Deteriorating patient work stream

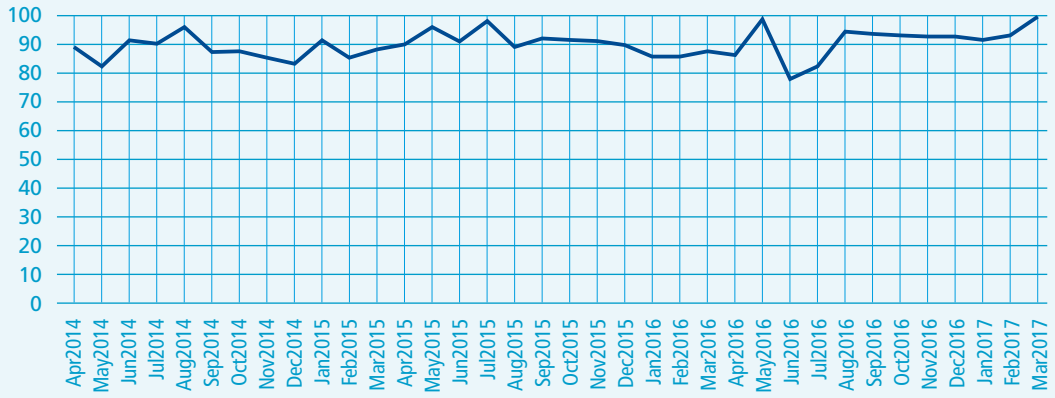
Last year we reported on the introduction of the national early warning score (NEWS)[13] for adult patients (excluding maternity) at the end of 2015 which took place as a collaborative project with North Bristol NHS Trust. We have spent much of 2016/17 embedding this within practice and have worked closely with front line staff to understand the barriers they have encountered in identifying and escalating deteriorating patients within our Trust and working with them to find solutions. We have also been working with our system-wide partners in the West of England Academic Health Science Network to use NEWS as a common language for individual patients at the points of transfer of care. Using NEWS in this way enables receiving healthcare providers to know in advance how sick a patient is and this helps ensure the sickest patients are prioritised for clinical review and are accommodated in the most suitable environment, and have the best chance of a good outcome.

A key measure of success is escalation of deteriorating patients in accordance with protocol. Figure 2 shows that we reached our 95 per cent goal in March 2017. We now need to sustain this improvement.

Figure 2

University Hospitals Bristol NHS Foundation Trust (SPI-2) 006 Adult early warning scores acted upon (ST)

Source: monthly safety thermometer point prevalence audit



3.1.1.4 Deterioration due to sepsis and acute kidney injury

During 2016/17 we have continued to work on two of the key causes of deterioration: sepsis and acute kidney, particularly sepsis. It is widely recognised that early identification of patients with red flag sepsis and prompt administration of antibiotics can reduce mortality due to sepsis. For more information please see section 2.1.1 for progress on our sepsis quality objective for 2016/17.

What we did in 2016/17

- We refined our adult observation chart further working in collaboration with North Bristol NHS Trust in response to feedback from staff and learning from incidents.
- We focussed on targeted education and training on NEWS to support identified areas.
- We devised point of care simulation training in adult services about deteriorating patients.
- We produced and distributed NEWS 'credit cards' as aide memoirs for adult services, and PEWS ones for children's services.
- We conducted individual debriefs with staff to learn more about themes and human factors when NEWS incidents happen and what we can do to improve our systems.
- We have mapped out of hours coverage for adult specialities and identified where further action is needed.
- We have integrated the adult observation chart and NEWS into the existing emergency department pro forma with a prompt for sepsis screening.
- We started testing a new acute kidney injury care bundle for adults.
- In conjunction with North Bristol NHS Trust, we developed an acute kidney injury dashboard so we can monitor the impact of our improvements.

[13] The National Early Warning Score (NEWS) was developed by the Royal College of Physicians in 2012 with the aim of standardising early warning scoring systems already in existence in many healthcare organisations. An early warning score is derived from measuring a range of physiological parameters (commonly known as patient observations) such as temperature, pulse and blood pressure, and scoring each parameter. Higher scores are allocated to measurements further outside of the normal range. The scores for each parameter are added together to reach a single early warning score for the patient. Higher scores indicate sicker patients and progressively higher scores indicate deteriorating patients, both of which will trigger the need for a response. Responses are graded in terms of urgency and the seniority of clinician needed to review the patient.

- Please see section 2.1.1 for information about what we did to achieve our sepsis quality objective for 2016/17.

What we plan to do in 2017/18

- We will use the learning from our incident debriefs to inform further improvements and education in our systems for recognition and escalation deteriorating patients.
- We will conduct a focus group of doctors and nurses to ascertain how we need to change our structured communication tool (SBAR) for handover and the escalation of deteriorating patients so that it works better for our staff.
- We plan to procure and implement an e-observation system that will reduce the risk of human error in the recognition and escalation deteriorating patients.
- We will review our out of hours medical cover in relevant specialities and fine tune our escalation protocol where necessary.
- We will continue to work with our system partners to develop a reliable system to ensure NEWS for individual patients is communicated at the point of transfer of care.
- If agreed and supported by our system partners, we have proposed that we lead work to develop a region wide paediatric early warning score, thus standardising the early warning scoring system for children across the west and south west of England.
- We will continue with our point of care simulation training about deteriorating patients.
- We will complete testing and implement an acute kidney injury pathway for adults.
- Please see section 2.1.2 for information about our sepsis quality objective for 2017/18.

3.1.1.5 Medicines safety work stream

Our medicines safety works stream is a system wide approach across the West of England Academic Health Science Network. Its stated aim is "working together (with patients and each other) to deliver safer and better outcomes from medicines at transfer of care in the domains of patient safety, patient outcomes and patient experience for people in target population. The two main areas of focus are:

- supporting patients with complex medicines to take them safely, thereby reducing hospital readmissions as a consequence of poor compliance with self-administration of medicines in the community
- insulin safety with emphasis on self-administration of insulin by patients and reducing harm from errors in insulin administration."

What we did in 2016/17

- We have been taking a lead role within the West of England Academic Health Science Network in the system-wide work on referrals of patients with complex medicines and compliance aids to community pharmacies.
- We implemented an electronic system (PharmOutcomes) to enable community pharmacies to support patients discharged with complex medicines. PharmOutcomes is a referral system to improve medication safety at patient discharge by referring patients on medication compliance aids and high risk patients to their community pharmacist for a medication review.
- We have incorporated the transfer of care referrals for patients on complex medicines into pharmacy noting systems.
- We have engaged with a research study run by Durham University on outcomes of clinical handover to community pharmacy.
- We have incorporated this work into the BNSSG medicines optimisation STP project.
- Higher strength insulins have recently been introduced which are two, three or five times stronger than the commonly used u100 insulin, and are now being used by some patients. Our diabetes team has drafted a drug chart and guidance document for adults using insulin u500 to help ensure safe administration of this much stronger insulin while patients are in our hospitals.

What we plan to do in 2017/18

We will further develop the PharmOutcomes referrals by:

- incorporating PharmOutcomes into the developing pharmacy noting process using mobile technology in order to embed into practice
- further embedding PharmOutcomes process for patients on warfarin
- testing and implementing an agreed service design (for patients on complex medicines) in a range of clinical areas

- extending PharmOutcomes to GP pharmacists
- implementing an electronic interface between with PharmOutcomes and our hospital systems.

We will ensure that transfer of care issues around insulin are incorporated into the insulin work stream by:

- implementing the u500 insulin drug chart and guidance
- completing and acting on the result of a self-assessment on insulin safety using a tool from the Oxford Academic Health Science Network
- producing patient self-administration of insulin, protocols, procedures and safe storage
- incorporating safe systems of insulin prescribing in the new Electronic Prescribing and Medicines Administration system to be implemented in the Trust.

3.1.2 Further plans for our patient safety programme in 2017/18

In early 2017 NHS trusts were invited to join a new national maternity and neonatal health collaborative which aims to reduce maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20 per cent by 2020 and 50 per cent by 2030. We put ourselves forward to be part of the first wave of the programme and were delighted to be accepted. In 2017/18 we will be developing our local maternity and neonatal improvement programme and will commence implementation.

During 2016/17 we also identified further areas we want to work on as a result of learning from incidents and which support our deteriorating patient work stream in particular. In 2017/18 we will take forward a project to design a system for the escalation of concerns when a family recognises that their loved one in hospital "just isn't right" or "isn't their usual self" and they are worried that they are deteriorating but they can't put their finger on the problem and they feel that their concerns aren't being listened to. We will also be seeking to spread the use of a new ward round checklist which has been piloted in the Bristol Haematology and Oncology Centre.

3.1.3 Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2016/17, the Trust Board was informed of serious incidents via its monthly quality and performance report. The total number of serious incidents reported for the year was 52, compared to 69 in 2015/16. Of the 52 serious incidents initially reported, two were subsequently downgraded and eight investigations were still underway at the time of writing (May 2017). Fifteen further potential serious incidents were initially reported to commissioners but then downgraded as the initial incident review identified they did not meet serious incident criteria. The majority of these were 12 hour trolley breach incidents which caused no harm to patients. A breakdown of the categories of the 50 confirmed serious incidents is provided in Figure 12 below.

All serious incident investigations have robust action plans, which are implemented to reduce the risk of recurrence. The investigations for serious incident and resulting action plans are reviewed in full by the Trust Quality and Outcomes Committee (a sub-committee of the Trust Board of Directors).

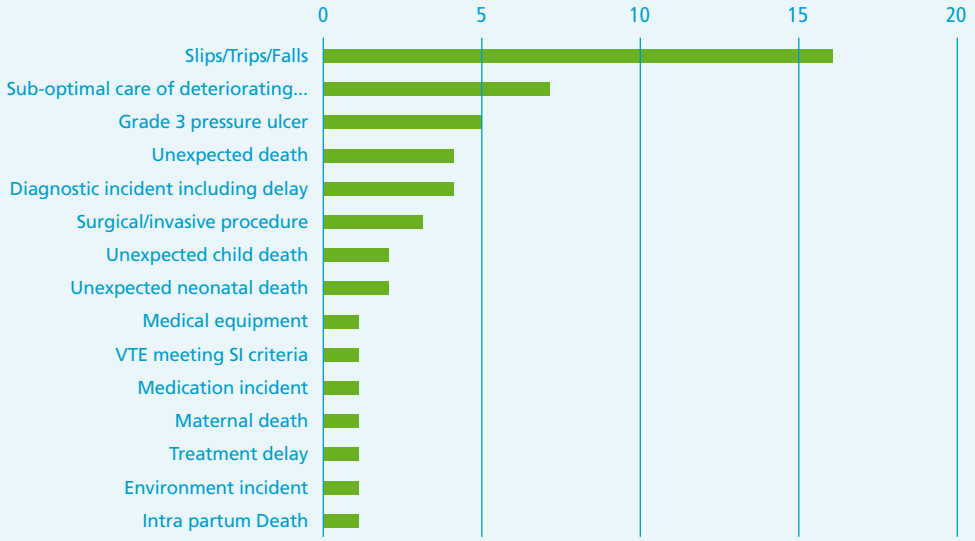
Learning from serious incidents

Learning and actions arising from serious incidents involving deteriorating patients and invasive procedures are imported into our patient safety programme work streams as described in sections 3.1.1.2 and 3.1.1.3. Examples of learning themes from other serious incident investigations in 2016/17 have included actions to:

- improve the use of dynamic risk assessments and frequent reviews of falls risks for patients with fluctuating confusion
- review the enhanced observation policy and bed rails guidance for patients at risk of falls and have confusion
- achieve a consistent standard of documentation and verbal handover of care when escalating or transferring care for individual patients between staff, shifts, wards, hospitals and providers.

Figure 12

Source: UH Bristol serious incident log



3.1.4 Duty of candour

Being open and honest when things go wrong has been an integral part of incident management and patient safety culture development since the advent of the Being Open Framework developed by the National Patient Safety Agency in 2009. The reports by Robert Francis QC (2010 and 2013) and Professor Don Berwick (2013), following the events which took place at Mid Staffordshire NHS Foundation Trust between 2005 and 2009, led to more formal arrangements in this respect: first, a contractual obligation (in 2013) and subsequently, a statutory obligation for duty of candour (in 2014). This was followed by explicit requirements of a professional duty of candour published jointly by the General Medical Council and Nursing and Midwifery Council in 2015.

The Trust has had a Staff Support and Being Open Policy in place since 2007. This policy has been developed over the years in response to learning from within the organisation, national guidance and, more recently, from the aforementioned contractual, statutory and professional obligations for duty of candour.

Last year we reported on our progress with regard to further embedding statutory duty of candour within our systems and culture. In 2016/17 we have been further reviewing our systems for duty of candour in anticipation of the publication of the report of the Independent Inquiry into our Paediatric Cardiac Services in July 2016. We recognise that the needs of individuals (patients, families and staff) require a more flexible approach to being open, based on where they are at particular times of the post-incident or grieving process. We have reviewed the support we provide and our communications to families who use our children's services to help them navigate their way through multiple investigative processes which may occur at a difficult time for them. We have also been looking at how we can ensure patients and families have the opportunity to include their perspective and comments on incident investigations if they want to and how we can involve patients and families more in helping us develop solutions to problems if they want to.

We know that this is an iterative process and in 2017/18 we will be further developing our communications and systems for being open for patients and families who use our adult services, seeking the views of families on our proposals. We will also be finalising and implementing our improvements for patients and families to be involved in investigations and solutions as mentioned above.

3.1.5 Guardian of safe working hours: annual report on rota gaps and vacancies for doctors and dentists in training

The Trust has appointed Dr Alistair Johnstone as the Guardian of Safe Working for Junior Doctors. Our Trust Board receives quarterly reports and an aggregated annual report, all of which are available to read at: http://www.uhbristol.nhs.uk/about-us/key-publications/.

3.1.6 Overview of monthly board assurance regarding the safety of patients 2016/17

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the safety of patients in our care. Where there are no nationally defined targets for safety of patients or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement or sustain already highly benchmarked performance. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable.

Table 6

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Infection control and cleanliness monitoring									
Number of MRSA bloodstream cases	National Infection Control data (Public Health England)	No Cases	3	0	0	0	1	0	1
Number of Clostridium difficile cases	National Infection Control data (Public Health England)	No target as target is set nationally for cumulative cases	40	No target as target is set nationally for cumulative cases	8	10	9	4	31
Number of MSSA cases	Trust Infection Control system (MESS)	Local standard	26	25	8	13	8	8	37
Clostridium difficile avoidable cases	PHE Data and local CCG/ Trust review	Commissioner/ provider agreement whether avoidable	17	45	2	3	4	1	10
Hand hygiene audit compliance	Monthly local observational audit	Local standard	97.3%	95%	97.3%	96.8%	96.4%	96.0%	96.6%
Antibiotic prescribing compliance	Monthly local pharmacy audit	Local standard	87.6%	90%	84.5%	87.4%	90.8%	90.8%	88.3%
Cleanliness monitoring - overall score	Monthly audit	Local standard	94% (Mar-16)	95%	95% (Jun-16)	95% (Sep-16)	96% (Dec-16)	95% (Mar-17)	95% (Mar-17)
Cleanliness monitoring - very high risk areas	Monthly audit	Local standard	98% (Mar-16)	98%	98% (Jun-16)	98% (Sep-16)	97% (Dec-16)	97% (Mar-17)	97% (Mar-17)
Cleanliness monitoring - high risk areas	Monthly audit	Local standard	95% (Mar-16)	95%	96% (Jun-16)	97% (Sep-16)	97% (Dec-16)	95% (Mar-17)	95% (Mar-17)
Patient safety incidents, serious incidents and Never Events									
Number of serious incidents reported	Local serious incident log	No target so as not to deter reporting	69	No target so as not to deter reporting	13	15	12	12	52

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Number of confirmed serious incidents[14]	Local serious incident log	No target so as not to deter reporting	55	No target so as not to deter reporting	12	13	12	TBC	TBC
Serious incidents reported within 48 hours	Local serious incident log	National Serious Incident Framework	84.1%	100%	93.2%	86.7%	100%	100%	94.2%
Serious incidents - 72 hour report completed within timescale	Local serious incident log	National Serious Incident Framework	Not reported	100%	92.3%	93.3%	75%	100%	90.3%
Serious incident investigations completed within timescale	Local serious incident log	National Serious Incident Framework	74.1%	100%	100%	100%	93.3%	100%	98.3%
Total never events	Local serious incident log	National Never Events Policy and Framework	3	0	0	1	1	0	2
Number of patient safety incidents reported	Datix	No target so as not to deter reporting	13,787	No target so as not to deter reporting	3,619	3,575	3,794	TBC	TBC
Patient safety incidents per 1,000 bed days	Datix/ Medway	No target so as not to deter reporting	44.75	No target so as not to deter reporting	47.41	46.88	48.25	TBC	TBC
Number of patient safety incidents - severe harm[15]	Datix	No target so as not to deter reporting	97	No target so as not to deter reporting	19	22	32	TBC	TBC
Falls									
Falls per 1,000 bed days	Datix/ Medway	Local target set below national benchmark of 5.6 falls per 1000 bed days	3.95	4.8	4.26	4.29	4.22	3.89	4.23
Total number of patient falls resulting in harm	Datix	Local target	30	24	8	9	8	11	36

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Pressure ulcers developed in the Trust									
Pressure ulcers per 1,000 bed days	Datix/ Medway	Local target	0.221	0.4	0.157	0.144	0.127	0.163	0.148
Pressure ulcers - grade 2	Datix	No target	61	No more than 10 in total pressure ulcers per month (all grades)	11	11	9	9	40
Pressure ulcers - grade 3	Datix	Local target	7	0	1	0	1	4	6
Pressure ulcers - grade 4	Datix	Local target	0	0	0	0	0	0	0
Venous thromboembolism									
Adult inpatients who received a VTE risk assessment	Medway	Local target set above 95% national target	98.2%	99%	99.2%	99.1%	99.1%	99.0%	99.1%
Percentage of adult in-patients who received thrombo-prophylaxis	Monthly local pharmacy audit	Local target	94.6%	95%	95.8%	95.8%	96.8%	97.4%	96.4%
Nutrition									
Nutrition: 72 hour food chart review	Monthly local safety thermometer audit	Local target	90.4%	90%	88.5%	89.6%	89.4%	90.6%	89.6%
Fully and accurately completed nutritional screening within 24 hours	Quarterly local dietetics audit	Local target	Not reported	90%	80.8%	88%	91.2%	87.9%	87.9%
WHO checklist									
WHO surgical checklist compliance	Medway/ Bluespier	Local target	99.9%	100%	99.6%	99.9%	98.7%[16]	97.8%	98.1%

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Medicines									
Medication incidents resulting in moderate or greater harm	Datix	Local target	0.8%	0.5%	0.16%	0.51%	0.64%	0.25%	0.41%
Non-purposeful omitted doses of the listed critical medication	Monthly local pharmacy audit	Local target	0.87%	1%	0.73%	0.33%	0.75%	0.52%	0.59%
Safety thermometer									
Safety thermometer-harm free care	Monthly safety thermometer audit	Local target	97.1%	95.7%	97.7%	98.6%	97.5%	97.9%	97.9%
Safety thermometer-harm free care	Monthly safety thermometer audit	Local target	98.6%	98.3%	98.8%	99.2%	98.7%	98.7%	98.9%
Deteriorating patient									
National early warning scores (NEWS) acted upon	Monthly local safety thermometer audit	Local improvement goal	90%	95%	89%	90%	93%	94.6%	91.7%
Timely discharges									
Out of hours departures (20:00 to 07:00)	Medway PAS	No target	10.7%	No target	7.6%	7.9%	7.5%	7.8%	7.7%
Percentage of patients with timely discharge (07:00-12 noon)	Medway PAS	Local improvement	20.3%	25%	22.9%	22.1%	22.2%	21.7%	22.2%
Number of patients with timely discharge (07:00-12 noon)	Medway PAS	No target	10,444	No target as percentage target set above	2,911	2,852	2,892	2,705	11,360

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Staffing levels									
Nurse staffing fill rate combined	National Unify return	No target set. Target would be variable each shift depending on patient numbers, acuity and dependency	103.1%	No target set. Target would be variable each shift depending on patient numbers, acuity depend-ency	103.9%	103%	104%	104%	103.7%

3.2 Patient experience

We want all our patients to have a positive experience of healthcare, to be treated with dignity and respect and to be fully involved in decisions affecting their treatment, care and support. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's values. Our goal is to be continually improving by engaging with and listening to patients and the public when we plan and develop services, by asking patients what their experience of care has been and how we could make it better, and taking positive action in response to that learning.

3.2.1 It's good to talk: conversations with patients and the public

UH Bristol's involvement network provides a point of contact with a range of community organisations across Bristol, giving them a voice within the Trust. In 2016/17, for example, the involvement network:

- engaged in discussions about end of life care with our Palliative Care Team
- participated in an NHS Improvement Quality and Safety review at the Trust
- helped us develop our corporate quality objectives for 2017/18.

In 2016/17, our Face2Face volunteer interview team continued to visit wards and departments across the organisation to have conversations with patients, visitors, and carers about their experiences at UH Bristol. We also explored new ways of utilising the skills of the Face2Face team, for example one member spent several weeks in the adult congenital heart disease service talking to long-term service-users as they came in for appointments, and during September 2016 the team interviewed patients who are homeless or vulnerably housed about their experiences of hospital care.

Other notable examples of patient and public involvement in the past year include:

- Inviting local Healthwatch to carry out an "enter and view" visit at South Bristol Community Hospital. The feedback the Trust received from Healthwatch was very positive and we are currently taking forward a number of their suggestions for further improvement.

- Participating in the Patient and Community Leadership Programme, a multi-agency collaboration co-ordinated by the King's Fund. The aim of the programme is to provide coaching to a group of public participants, equipping them to contribute more effectively in important local discussions about health and social care planning and development.
- Inviting the Patients' Association to carry out an evaluation of the Trust's dermatology service.
- Inviting members of the Bristol City Council Overview and Scrutiny Committee to visit the Bristol Royal Hospital for Children to learn more about the paediatric cardiac service there.

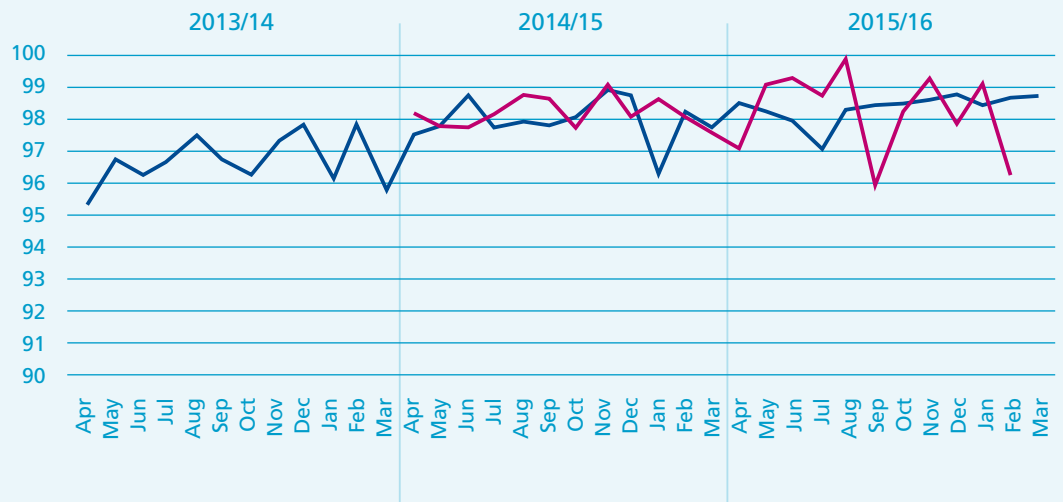
3.2.2 Gathering patient feedback from surveys

Patient surveys enable us to monitor the quality of patient experience and to compare ourselves to other trusts. UH Bristol has a comprehensive patient survey programme, incorporating the Friends and Family Test survey when patients are discharged from hospital, a comprehensive post-discharge postal survey, and participation in the national patient survey programme. In 2016/17 we received more 50,000 individual pieces of feedback about our services from these surveys.

The Trust continues to receive very positive feedback from service-users, consistently achieving overall care ratings in excess of 95 per cent in our monthly postal surveys (Figure 3). Praise for our staff is by far the most frequent form of feedback that we receive. Figure 4 shows that these positive experiences of care are consistent across different demographic groups.

Figure 3

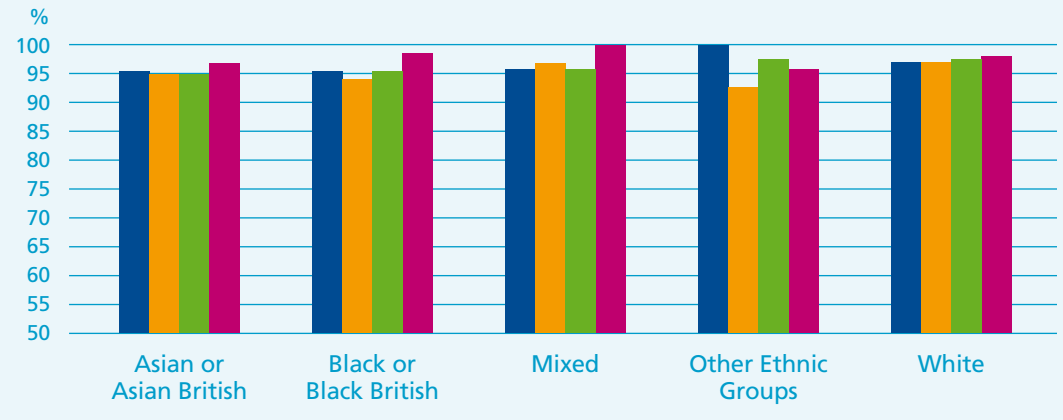
Patients rating the care at UH Bristol as excellent, very good or bad



Source: UH Bristol monthly inpatient/parent survey; UH Bristol monthly outpatient survey

Figure 4

Inpatients rating their care as excellent, very good or good by ethnic group



Source: UH Bristol monthly inpatient and parent survey

Each year, the Trust participates in the Care Quality Commission's national patient experience survey programme. These national surveys reveal how the experience of patients at UH Bristol compares with other NHS acute trusts in England. In 2016/17, the Trust received the results from two national surveys (Table 8).

Table 7

Results of national patient survey reports received by the Trust in 2016/17

	Comparison to national average		
	Above (better)	Same	Below
National inpatient survey (patients who were discharged during July 2015)	1	61	1
National cancer survey (patients who were discharged between April and June 2015)	1	45	4

As in past years, UH Bristol performed broadly in line with the national average in the national inpatient survey. The Trust received particularly good scores for privacy and dignity. One score was slightly below the national average – availability of hand gel (9.3/10 compared to 9.6 nationally), however this was still a good score in itself and our local audits also confirm high levels of hand wash availability for patients, visitors and staff.

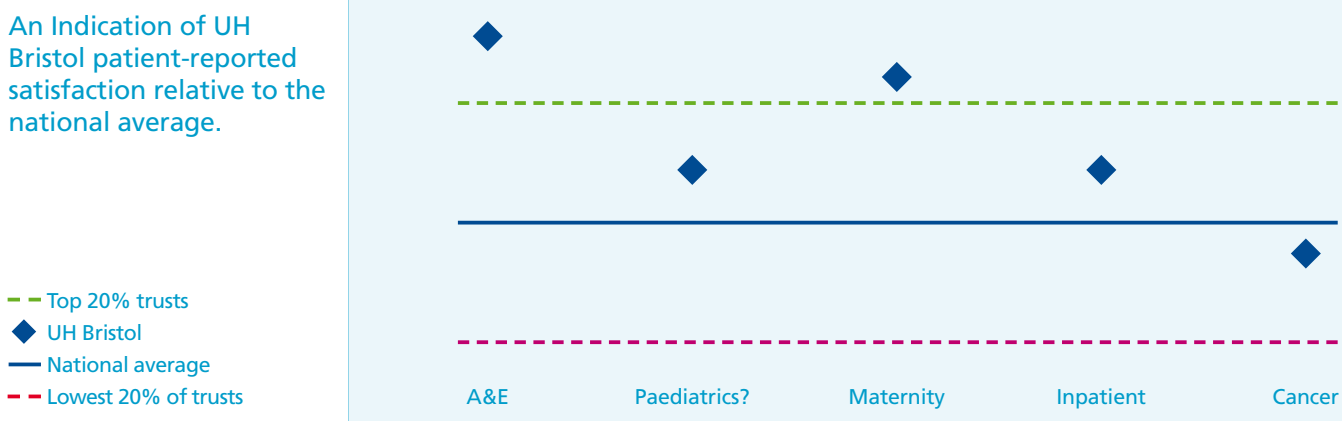
Historically, UH Bristol has performed less well in national cancer surveys. We were particularly disappointed when the 2013 survey results showed nearly half of UH Bristol's scores were in the lowest quintile (bottom 20 per cent) of trusts nationally. In response to this, Trust's lead cancer nurse led a comprehensive programme of stakeholder engagement and participated in an NHS England scheme which saw UH Bristol "buddied" with a trust which had achieved some of the best score in the 2013 survey, South Tees. This led to an improvement plan focusing on:

- patient access to a clinical nurse specialist
- information availability and accessibility
- GP support
- clinic administrative processes and waiting times.

Although changes to the national cancer survey questionnaire and methodology made it difficult to directly compare UH Bristol's 2015 results to the 2013 survey, we were nonetheless encouraged by our achievement of an average five percentage point improvement across the questions that were comparable. Furthermore, a number of our key improvement actions would not have been in place in time to affect the 2015 results. We are therefore cautiously optimistic about the results of the forthcoming 2017 survey.

Figure 5

An Indication of UH Bristol patient-reported satisfaction relative to the national average.



Looking ahead to 2017/18, sections 2.1.1 and 2.1.2 of this report describe our plans to procure a new Trust-wide patient feedback system which will enable patients, their families and carers to give feedback about quality of care whilst patients are still in hospital, increasing our opportunities to address issues and concerns in real-time.

3.2.3 Complaints received in 2016/17

The flip side of saying that more than 98 per cent of inpatients rate their treatment and care at UH Bristol as "good" or better is that, for one or two patients in every hundred, we don't get it right. Some of those patients will tell us about their experience through surveys and comment cards; around one in every 500 patients will make a complaint. How we respond to this group of patients and how we learn from their experiences is as much a marker of quality as the positive experience reported by the vast majority.

In 2016/17, 1,874 complaints were reported to the Trust Board, compared with 1,941 in 2015/16[17]. 487 (26 per cent) of these complaints were investigated under the formal complaints process, with the remainder addressed through informal resolution. This volume of complaints equates to 0.23 per cent of all patient episodes, compared to 0.25 per cent in 2015/16, against a target of <0.21 per cent.

We carried out formal complaints investigations and replied to complainants within agreed timescales in 86.1 per cent of cases: an improvement on the 75.2 per cent we reported last year. To date (May 2017), 65 complainants have expressed dissatisfaction with one or more aspects of our formal response to their concerns, slightly more than at the equivalent point in time last year (59).

In 2016/17, improvements to the way we handled complaints included:

- Systematically surveying complainants approximately six weeks after their concluding communication with the Trust, to better understand their experience of making a complaint and how we could improve what we do.
- Encouraging our divisions to offer appropriate forms of independent review of complaints in circumstances where complainants continue to express dissatisfaction.
- Publishing anonymised summaries of any complaints which are upheld or partially upheld by the Ombudsman.

Looking ahead to 2017/18, our plans include:

- Exploring the potential to develop a partnership approach with the Patients' Association for supporting complainants who remain dissatisfied with the Trust's response to their concerns, but who wish to pursue mutual resolution outside of an Ombudsman referral.
- Introducing a new complaints panel to create a shared learning environment to identify and share examples of best practice in responding to complaints and to identify opportunities to make improvements to the way divisions and the Trust handle complaints.
- Making mediation skills training available to key front line staff, beginning with staff at the Bristol Royal Hospital for Children and the Trust's patient support and complaints team.

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2017.

3.2.4 Turning feedback and complaints into positive action: examples of improvements to patient care in 2016/17

Examples of positive action in 2016/17 included:

- the roll-out of open visiting in adult inpatient areas; visiting hours now extend from 8am to 9pm
- the publication of a new patient and family-friendly welcome guide to our hospitals
- new arrangements so that partners can now stay overnight on our maternity wards, to support mums
- the launch of a hospital Facebook page at the Bristol Royal Hospital for Children for patients, families and staff to share good news stories and updates on services
- the launch of the South Wales and South West Congenital Heart Disease Network which includes parents and patients as part of the network board
- *Patient Experience at Heart* and *#conversations* initiatives which were shortlisted for national awards
- new signage in the Bristol Royal Infirmary emergency department, developed by the Design Council, which helps to explain to patients how the department works, why they may be waiting and what to expect during their experience; also, improved Trust-wide signage telling people how they can give feedback or make a complaint

[17] Previously 1,883 in 2014/15, 1,442 in 2013/14, 1,651 in 2012/13, and 1,465 in 2011/12

- steps taken to improve the patient experience on our delayed discharge ward (A605), including a new nursing assistant who organises activities for patients, and a new role for volunteers.

3.2.5 Overview of monthly board assurance regarding patient experience

The table below contains key quality metrics providing assurance to the Trust Board each month regarding patient experience. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable.

Table 8

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Monthly patient surveys									
Patient survey - patient experience tracker score	Monthly postal survey	Locally agreed	90.1	87	91	91	92	92	91.5
Patient survey - kindness and under-standing	Monthly postal survey	Locally agreed	94.2	90	95	95	95	95	95.3
Patient survey - outpatient tracker score	Monthly postal survey	Locally agreed	88.8	87	89	90	90	88	89.3
Friends and Family Test – coverage									
Friends and Family Test inpatient coverage	Friends and Family Test	Locally agreed	19.5%	30%	39.4%	34.6%	33.5%	34.5%	35.5%
Friends and Family Test emergency department coverage	Friends and Family Test	Locally agreed	13.0%	15%	14.6%	14.7%	17.2%	19.1%	16.4%
Friends and Family Test maternity coverage	Friends and Family Test	Locally agreed	22.7%	15%	20.5%	21.9%	21.6%	26.4%	22.5%
Friends and Family Test – score									
Friends and Family Test inpatient coverage	Friends and Family Test	Locally agreed	96.3%	90%	96.6%	96.7%	97.7%	97.6%	97.2%
Friends and Family Test emergency department coverage	Friends and Family Test	Locally agreed	75.4%	-	77.5%	77.1%	77.6%	80.2%	78.2%
Friends and Family Test maternity coverage	Friends and Family Test	Locally agreed	96.6%	90%	97.2%	97%	95.6%	97.3%	96.8%

Quality measure	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Patient complaints									
Number of patients complaints	Patient Support and Complaints Team	Locally agreed	1,941	-	520	517	397	440	1,941
Patient complaints as a proportion of activity	Patient Support and Complaints Team	Locally agreed	0.25%	-	0.26%	0.27%	0.20%	0.21%	0.23%
Complaints responded to within Trust timeframe	Patient Support and Complaints Team	Locally agreed	75.2%	95%	76.2%	88.1%	94.2%	86%	86.1%
Complaints responded to within divisional timeframe	Patient Support and Complaints Team	Locally agreed	91.3%	-	91.6%	88.8%	84.9%	80.9%	86.6%
Percentage of responses where complainant is dissatisfied	Patient Support and Complaints Team	Locally agreed	6.2%	-	11.2%	14.2%	7.9%	Not yet available	11.4%

3.3 Clinical effectiveness

We will ensure that the each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

3.3.1 Understanding, measuring and reducing patient mortality

Over the last year, the Trust has continued to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by NHS Digital (formally the Health and Social Care Information Centre) and the Hospital Standardised Mortality Ratio (HSMR) produced by CHKS Limited replicating the Dr Foster/Imperial College methodology.

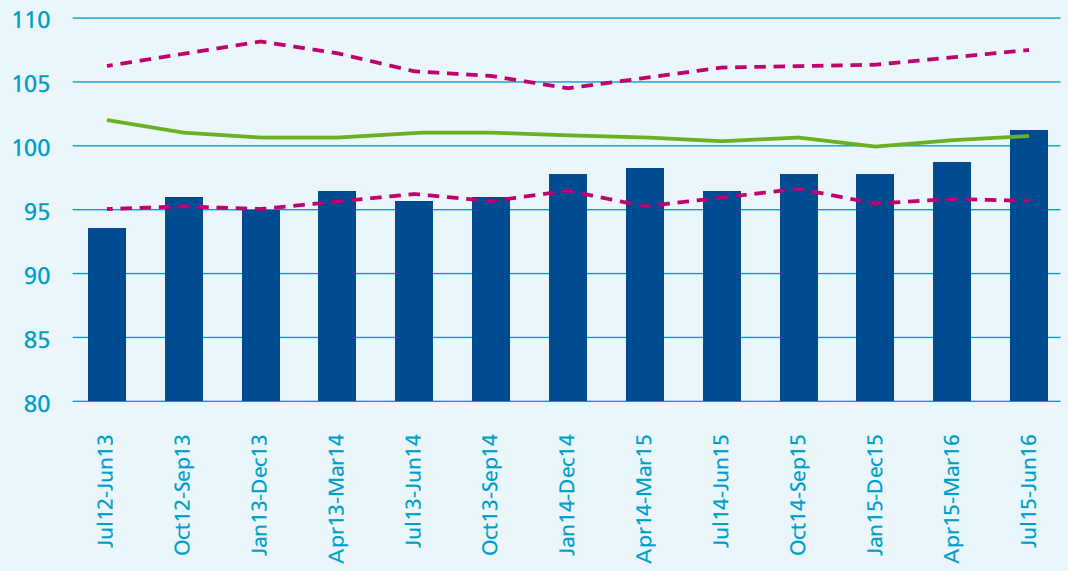
The HSMR includes only the 56 diagnosis groups (medical conditions) which account for approximately 80 per cent of in-hospital deaths. The SHMI is sometimes considered a more useful index as it includes all diagnosis groups as well as deaths occurring in the 30 days following hospital discharge.

In simple terms, the SHMI 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. The score needs to be read in conjunction with confidence intervals to determine if the Trust is statistically significantly better or worse than average. NHS Digital categorises each trust into one of three SHMI categories: "worse than expected", "as expected" or "better than expected", based on these confidence intervals. A score over 100 does not automatically mean "worse than expected". Likewise, a score below 100 does not automatically mean "better than expected".

In Figure 8, the blue vertical bars represent UH Bristol SHMI data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles (top and bottom 25 per cent). Comparative data from July 2015 to June 2016 shows that the Trust remains in the 'as expected' category. The most recent comparative data available to us at the time of writing is for the rolling 12 month period October 2015 to September 2016[18]. In this period the Trust had 1,741 deaths compared to 1,752 expected deaths; a SHMI score of 99.4.

Figure 6

Summary Hospital-level Mortality Indicator (SHMI)



Source: CHKS benchmarking

The latest HSMR data available at the time of writing is for the period January 2016 to December 2016. This shows 1,052 patient deaths at UH Bristol, compared to 1,095 expected deaths: an HSMR of 96.1.

Understanding the impact of our care and treatment by monitoring mortality and outcomes for patients is a vital element of improving the quality of our services. To help facilitate this, the Trust has a Quality Intelligence Group (QIG) whose purpose is both to identify and be informed of any potential areas of concern regarding mortality or outcome alerts. Where increased numbers of deaths are identified in a specific specialty or service, QIG ensures that these are fully investigated by the clinical team. These investigations comprise an initial data quality review followed by a further clinical examination of the cases involved if required. QIG will either receive assurance regarding the particular service or specialty with an explanation of

[18] Figure 8 is sourced from CHKS Limited and does not yet include data for the period October 2015 to September 2016

why a potential concern has been triggered, or will require the service or specialty to develop and implement an action plan to address any learning. The impact of any action is monitored through routine quality surveillance.

3.3.2 Local mortality review

Because the vast majority of deaths that occur in the hospital setting are expected, the SHMI and HSMR provide only a broad measure of the quality of care provided at a hospital. As the inherent limitations of global measures of death rate become more apparent, our desire to continually improve the care we provide has led us to focus our efforts on achieving a better understanding of unexpected and potentially preventable death. The way we are doing this is through individual case note review of deceased patients: a personalised approach which facilitates broad base organisational learning.

If a hospital knows and understands common causes of potentially avoidable mortality in the patients for whom it is responsible, it can also use this knowledge to direct clinical audit and quality improvement activity. Furthermore, this information can form the basis of integrated learning with partners in primary care and can be used as an effective learning tool, in combination with the deanery, to support post graduate education. This cross system involvement allows the construction of an integrated healthcare programme, where understanding and preventing potentially avoidable death becomes the highest safety and quality priority

The Trust's current process for adult mortality review was established for adult inpatient deaths in May 2014 with the aim of reviewing all inpatient deaths occurring in the organisation. The review is carried out by the lead consultant for each patient. However, this is now being revised and relaunched, with a new emphasis on peer review, in line with national guidance. UH Bristol has been selected as one of seven pilot sites for early adoption of the Royal College of Physicians' model of structured judgement case note review. Questions are based on the findings of the Preventable Incidents and Survivable Mortality study (PRISM2). Through the pilot, UH Bristol will play a lead role in shaping and developing this important quality and safety process at national level.

Given that the majority of hospital deaths are unavoidable, rather than review all deaths, we will instead develop a process ensuring detailed review of potential avoidable cases. This will include all deaths of elective admission patients and all deaths of patients with learning difficulties.

This process will also allow us to co-ordinate and integrate already established pockets of excellence such as the ICNARC[19] data which demonstrates we have one of the safest intensive care units in the country. This co-ordinated approach will allow us to accurately identify areas where improvements will save lives.

Full integration with the coroner's office will be established so that pertinent information from patients undergoing coroners' post mortem is fed back into our mortality review group to maximise the learning. In addition, we already have an established process of reviewing both child and maternal deaths. All three of these processes will be fully integrated across the organisation, particularly where there is overlap or transition from childhood to adult.

3.3.3 Overview of monthly board assurance regarding clinical effectiveness

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the clinical effectiveness of the treatment we provide. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable.

[19] Intensive Care National Audit and Research Centre

Table 9

Topic	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Mortality									
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	Locally agreed	97.7	<100	101.2	99.4	Not available	Not available	100.3
Hospital Standardised Mortality Ratio (HSMR)	CHKS	N/A	97.2	N/A	87.2	90.5	100.8	Not available	92.7
Stroke Care									
Percentage receiving brain imaging within one hour	Medway PAS & Radiology Information System	Locally agreed	61.5%	>=80%	67.7%	58.3%	51.4%	51.2%	58%
Percentage spending 90%+ time on stroke unit	Medway PAS & Radiology Information System	Locally agreed	93.5%	>=90%	90%	90.4%	93.3%	87.2%	90.4%
High Risk TIA patients starting treatment within 24 hours	Medway PAS & Radiology Information System	Locally agreed	66.4%	>=60%	63.4%	76.5%	68.2%	60%	66.8%
Dementia Care									
FAIR Question 1 - case finding applied	Local data collection	CQUIN Target	94.8%	>=90%	94.8%	96%	90.2%	81.6%	90.4%
FAIR Question 2 - appropriately assessed	Local data collection	CQUIN Target	97.5%	>=90%	97.5%	98.6%	96.3%	96.2%	97.2%
FAIR Question 3 - referred for follow up	Local data collection	CQUIN Target	97.2%	>=90%	97.2%	92.3%	88.2%	100%	94.7%
Percentage of dementia carers feeling supported	Local data collection	N/A	88.3%	No target agreed	75%	No longer reported			

Topic	Data source	Standard	Actual 2015/16	Target 2016/17	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2016/17
Ward outliers									
Bed days spent outlying.	Medway PAS	Locally agreed	9,666	<9,029	2,218	1,546	2,197	2,217	8,178
Fracture neck of femur									
Patients treated within 36 hours	National Hip Fracture Database	Locally agreed	75.9%	>=90%	77.6%	65.2%	63.5%	76.7%	70.5%
Patients seeing orthog-eriatrician within 72 hours	National Hip Fracture Database	Locally agreed	82.5%	>=90%	78.9%	68.5%	81.1%	68.5%	8,178
Patients achieving best practice tariff	National Hip Fracture Database	Locally agreed	63.5%	>=90%	57.9%	42.7%	54.1%	54.8%	51.9%

3.4 Performance against national priorities and access standards

3.4.1 Overview

This year saw the phasing-out of the NHS Improvement Risk Assessment Framework, and the introduction of the NHS Improvement Single Oversight Framework, reflecting the new approach to regulation and a national focus on four key areas of performance, as shown below:

- accident and emergency (A&E) 4-hour waiting standard
- 62-day GP cancer standard
- Referral to Treatment (RTT) incomplete pathways standard
- 6-week diagnostic waiting times standard.

Sustainability and Transformation Funds (STF) were made available to trusts achieving their improvement trajectories for the first three of the standards listed above. Trajectories were developed and agreed between February and May 2016, with agreement of these trajectories being the (only) pre-requisite for securing STF in the first quarter of 2016/17. The rules for the allocation of STF in quarters 2, 3 and 4 were published later in quarter 1. Performance against these four SOF standards is covered in detail in the following sections of the report.

Table 10

Access Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
A&E 4-hours	Actual	87.2	91.7	89.0	89.3	90.0	87.3	82.9	78.5	79.6	80.4	80.7	83.3
	Traj.	81.9	84.4	85.9	87.6	88.4	92.2	93.3	90.0	89.3	88.5	87.4	91.0
62-day GP cancer	Actual	77.2	70.5	70.8	73.3	84.8	80.5	79.5	85.2	81.5	84.3	78.8	81.2
	Traj.	72.7	73.2	81.8	84.7	81.7	85.0	85.0	85.1	86.9	83.6	85.7	85.9
RTT*	Actual	92.3	92.6	92.1	92.0	90.5	90.4	91.2	92.0	92.0	92.2	92.0	91.1
	Traj.	92.6	92.6	92.8	93.2	93.2	93.4	93.4	93.4	92.8	92.8	92.8	93.0
6-week diagnostic*	Actual	98.3	98.6	96.3	96.1	95.5	96.9	98.9	99.0	98.2	98.4	98.7	98.7
	Traj.	99.2	99.2	99.2	99.2	99.2	99.2	99.2	99.2	99.2	99.2	99.2	99.2

Performance (%) against the agreed trajectories for the four key access standards in 2016/17 during each quarter.

National standard met | STF trajectory met | Neither STF or national standard met

The Trust received a contract performance notice from Bristol Clinical Commissioning Group (CCG) in February 2017, for the areas of performance where national and constitutional standards were not being met. This included the RTT incomplete pathways standard, 62-day GP cancer, A&E 4-hours, last-minute cancelled operations, and the six-week diagnostic standard. Remedial action plans and associated recovery trajectories were already in place for these standards, but were extended into 2017/18 where appropriate.

Full details of the Trust's performance in 2016/17 compared with the previous two years are set out in Table 11 below. Although there was a dip in performance for one quarter of the year due for reasons outside of the control of the Trust[20], performance against the primary percutaneous coronary intervention (PCI) heart revascularisation 90-minute door to balloon standard remained strong in 2016/17 with performance above the 90 per cent standard for the year as a whole. Although the Trust failed to achieve maximum 4-hour wait in A&E for at least 95 per cent of patients in each quarter of the year, the Trust met the other national A&E clinical quality indicators in the period. The level of ambulance hand-over delays was, however, higher in 2016/17 than 2015/16. This reflected higher levels of bed occupancy within the BRI and worsening flow through the hospital, with more patients needing to be cared for, for longer, in the emergency department. The higher levels of bed occupancy also meant that the level of last-minute cancellations (LMCs) of operations for non-clinical reasons remained high. However, there was still an improvement in the overall level of LMCs and an improvement in the percentage of patients readmitted within 28 days following an LMC, relative to 2015/16.

3.4.2 Referral to Treatment (RTT)

The national standard of at least 92 per cent of patients waiting less than 18 weeks from Referral to Treatment (RTT) was achieved at an aggregate (Trust) level in each month between April 2016 and July 2016, and again from November 2016 to February 2017. The Trust failed the 92 per cent standard between August 2016 and October 2016 due to a rising demand, and failed the standard again in March 2017 for the same reason. The number of patients waiting over 18 weeks for treatment grew in a number of specialties leading-up to the failure of the RTT national standard in August. This was related to a significant growth in outpatient referrals in the preceding months. Although this growth was not sustained, the peak in demand could not be matched by sufficient capacity to prevent a growth in the over 18-week waits.

As part of the 2017/18 annual planning round, all specialties have used the NHS Interim Management & Support (IMAS) capacity and demand modelling tools to estimate the amount of capacity required to achieve sustainable 18-week RTT waits by the end of March 2018. This modelling has included in its assumptions the need to reduce waiting times for first outpatient appointments and has informed the service level agreements now agreed with commissioners, and the resulting delivery plans developed.

3.4.3 Accident and emergency 4-hour maximum wait

The Trust failed to meet the national accident and emergency (A&E) 95 per cent standard for the percentage of patients discharged, admitted or transferred within four hours of arrival in our emergency departments, in any month in 2016/17. System pressures continued to be evident in 2016/17 with levels of emergency admissions into the Bristol Royal Hospital for Children (BRHC), via the emergency department, being on average 4.6 per cent above the levels seen in 2015/16, and 9.2 per cent higher across November and December, which is when the BRHC experienced a significant decline in performance against the 4-hour standard. Work with our commissioners to understand the reason for the higher than expected levels of paediatric emergency demand continues.

Levels of emergency admissions into the Bristol Royal Infirmary (BRI) emergency department were variable across the year, but not markedly up on 2015/16. However, the proportion of patients admitted aged 75 years and over, which is a reliable proxy for patient acuity, was significantly higher over the winter months of 2016/17 than in the same period in 2015/16. The number of medically fit patients whose discharge from the BRI was delayed continued to be more than double the jointly agreed community planning assumption. The stays in hospital for these patients were also longer than in the previous year. The resulting increase in bed occupancy within the BRI led to a decrease in 4-hour performance, relative to previous years.

In 2016/17 there was continued focus on ensuring as many patients as possible were managed in the correct specialty ward, with a 15 per cent reduction in outlier bed-days relative to 2015/16. Being cared for on the correct specialty-ward remains important for ensuring patients receive the most appropriate care, but also helps to ensure patients do not stay in hospital longer than necessary.

3.4.4 Cancer

Compared with 2015/16, the Trust had a mixed year in terms of performance against the national cancer waiting times standards, largely for reasons outside of the Trust's control. Performance against the 31-day first definitive and 31-day subsequent surgery waiting times standards was unusually below the national standards in quarter 1, following a significant rise in demand for critical care beds in March and April 2016 due to exceptional emergency pressures. However, the Trust implemented a recovery plan and achieved these national standards again in quarters 2, 3 and 4, and for the year as a whole. The Trust continued to perform consistently well against the 2-week wait for GP referral for patients with a suspected cancer, and the 31-day standards for subsequent drug therapy and radiotherapy, with achievement in each quarter.

The Trust failed to achieve the 62-day RTT standard for patients referred by their GP with a suspected cancer. Achievement of the 85 per cent national standard remains challenging due to the significant tertiary workload of the Trust, and the unusual group of tumour sites that comprise the majority of the Trust's cancer work following the transfer out of the urology and in particular breast cancer service (which nationally is one of only two tumour sites that consistently achieves the 85 per cent standard). However, the Trust achieved the 85 per cent standard for internally managed pathways (for example pathways not shared with other providers) in quarters 2, 3 and 4, and for the year as a whole. Performance was also above the national average in quarters 3 and 4, despite the considerable challenges of case-mix and the tertiary workload.

The three top causes of breaches of the 62-day GP cancer standard were: late referrals from, or pathways delayed by, other providers (36 per cent), medical deferral/clinical diagnostic complexity (21 per cent), and patient choice to delay their pathway (11 per cent). Performance was unusually impacted in quarters 1 and 2 by histology reporting delays following the transfer of the service to North Bristol Trust at the beginning of May 2016. Of the avoidable causes of delays, there are four specific areas of focus for improvement amidst a wider programme of improvement work. These are: reducing delays to thoracic outpatient appointments, reducing request to reporting times for CT (Computed Tomography) Colon and Head and Neck ultrasound scans, improving the availability of critical care beds for surgical patients and improvements to pathway tracking/management.

The Trust failed to achieve the 62-day RTT standard for patients referred by the national screening programmes in 2016/17, although unlike in 2015/16 did achieve the standard in one

quarter of the year. The majority of the breaches (71 per cent) of this standard continued to be outside of the Trust's control, including: patient choice, medical deferral and clinical complexity.

3.4.5 Diagnostic waiting times

Performance against the 6-week wait for the top 15 high volume diagnostic tests remained variable across the year, and below the 99 per cent standard in all except one month. The Trust started the year with a shortfall in adult endoscopy capacity, mainly as a result of a significant loss of capacity following the junior doctor industrial action during the last quarter of 2015/16. Recruitment challenges delayed prompt restoration in capacity, but through additional in-house sessions, the use of the independent sector and other initiatives, the number of long waiters was reduced significantly by December 2016. Sleep studies waiting times were also adversely affected by significant capacity constraints, particularly in quarter 4 of 2016/17. This was further exacerbated by high levels of demand across the year. During the last quarter of the year demand for cardiac CT scans rose sharply, resulting in an increase in over six week waits. This significant rise in demand is currently under investigation and highlights the need for a further review of capacity and demand in this and other services, where increasingly the Trust needs to be able to be responsive to rapidly changing demand.

Performance against national standards

Table 11

National standard	2014/15	2015/16	2015/16 Target	2016/17[21]	Notes
A&E maximum wait of 4 hours[3]	92.2%	90.4%	95%	85.0%Ⓐ	Target failed in each quarter in 2016/17
A&E time to initial assessment (minutes) percentage within 15 minutes	98.3%	99.0%	15 mins	97.6%	Target met in every quarter in 2016/17
A&E time to treatment (minutes) percentage within 60 minutes	55.4%	52.8%	60 mins	52.6%	Target met in every quarter in 2016/17
A&E unplanned re-attendance within 7 days	2.3%	3.0%	< 5 %	2.6%	Target met in every quarter in 2016/17
A&E left without being seen	1.8%	2.4%	< 5%	2.2%	Target met in every quarter in 2016/17
Ambulance hand-over delays (greater than 30 minutes) per month	107	92	Zero	101	Target failed in each quarter in 2016/17
MRSA bloodstream Cases against trajectory	5	3	Trajectory	1	Zero cases in every quarter except quarter 3
Clostridium difficile infections against trajectory	50	40	Trajectory	31[22]	Target met in every quarter in 2016/17
Cancer - 2 week wait (urgent GP referral)	95.5%	95.9%	93%	94.8%	Target met in every quarter in 2016/17
Cancer - 31 day diagnosis to treatment (first treatment)	96.9%	97.5%	96%	96.7%	Target met for the year, and in quarters 2, 3 and 4 of 2016/17
Cancer - 31 day diagnosis to treatment (subsequent surgery)	94.9%	96.8%	94%	94.4%	Target met for the year, and in quarters 2, 3 and 4 of 2016/17
Cancer - 31 day diagnosis to treatment (subsequent drug therapy)	99.6%	98.9%	98%	98.7%	Target met in every quarter in 2016/17
Cancer - 31 Day diagnosis to treatment (subsequent radiotherapy)	97.6%	97.1%	94%	96.6%	Target met in every quarter in 2016/17
Cancer 62 day RTT (urgent gp referral)	79.3%	80.6%	85%	79.3%	Target failed in each quarter in 2016/17
Cancer 62 day RTT (screenings)	89.0%	68.6%	90%	69.4%	Target only met in quarter 3 of 2016/17
18-week RTT admitted patients	84.9%	N/A	90%	N/A	Target no longer in effect
18-week RTT non-admitted patients	90.3%	N/A	95%	N/A	Target no longer in effect

Performance against national standards (cont.)

Table 11

National standard	2014/15	2015/16	2015/16 Target	2016/17[21]	Notes
18-week RTT incomplete pathways[23]	90.4%	91.3%	92%	91.7% Ⓐ	Target met in eight months of the year, but only for quarter 1 as a whole
Number of last minute cancelled operations	1.08%	1.03%	0.80%	0.98%	Target met in quarter 2 only in 2016/17
28 day readmissions (following a last minute cancellation)[24]	89.8%	88.7%	95%	90.8%	Target met in quarter 2 only in 2016/17
6-week diagnostic wait	97.5%	99.0%	99%	97.8%	Target failed in each quarter in 2016/17
Primary PCI - 90 minutes door to balloon time	92.4%	93.3%	90%	91.7%	Target met in each quarter in 2016/17 except quarter 3

Achieved for the year and each quarter

Achieved for the year, but not each quarter

Not achieved for the year

Target not in effect

Ⓐ Data subjected to external audit scrutiny as part of the process of producing this report

[20] All figures shown are up to and including March 2017

[21] Please note: the figures quoted for 2016/17 are the total number of cases reported against the limit of 45. To the end of February 2017 there were 10 cases deemed avoidable by commissioners (with one other case from January 2017 still the subject of review)

[22] Data subjected to external audit scrutiny as part of the process of producing this report

[23] IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures emergency readmissions to hospital within 28 days *following a previous discharge*

A APPENDIX A Feedback about our Quality Report

a) Statement from the Council of Governors of the University Hospitals Bristol NHS Foundation Trust

The Council of Governors welcomes this annual opportunity to comment on the Trust's quality report, which covers all key aspects of patient safety and experience, clinical effectiveness, the Trust's performance against national priorities and its own key quality objectives.

We believe that this is a comprehensive report that identifies both the strengths and areas for improvement at the Trust over the last twelve months. Although some of the results themselves are disappointing, the accompanying narrative highlights the challenging conditions that the Trust has faced over the last year and is honest about the impact of these. Importantly, there is clear evidence of robust response to concerns raised as a result of public and patient consultation and independent enquiries. Overall this is an honest and transparent report, which clearly demonstrates a commitment to listening and responding with action.

Governor involvement:
There is a public meeting of the Trust Board held every month, with a review of the quality and performance report for the previous month along with a report from the Non-Executive Director (NED) Chair of the Trust Quality and Outcomes Committee on the agenda every time. Governors attend these meetings as observers and have the opportunity to raise questions following the board's own discussion on each topic.

There is also a specific Governor Focus Group for Quality that meets every two months, attended by the NED Chair of the Trust Quality and Outcomes Committee, the medical director and the chief nurse, which supports further discussion about the quality reports and allows time for presentations on quality issues by other senior trust staff. This group reports back to the full Council of Governors who may then identify topics of concern for their regular meetings with the NEDs or individual questions to be raised on the Governors' Log of Communications.

During the past year this framework has enabled the governors to raise questions and offer challenges about many of the issues referred to in this report.

Quality objectives:
This report examines the Trust's performance against the quality objectives it set itself at the beginning of the year and outlines the key objectives for service improvement over the next year. In setting the objectives for 2017/18, we note that the Trust is now carrying forward key objectives that were not fully achieved in 2016/17 related to the cancellation of operations, cancellations and delays for outpatients and improving the management of sepsis. We welcome this continued effort in such key areas of concern for patients and their families, alongside an on-going commitment to improving staff engagement and satisfaction.

The creation of a Quality Improvement Academy is a new objective with great potential to support further improvements in the future and objective 8 relating to improved communication with a 'customer service mind set' is a great example of a direct response to consultation with staff and members of the public.

Patient safety:
The timing and thoroughness of responses to serious incidents have been closely monitored by the Quality and Outcomes Committee over the past year, and there have been consistently high levels of achievement in key quality measures such as patient falls, pressure ulcers, incidents relating to medication and nutritional standards.

The plans for continued emphasis on the management of sepsis, the National Early Warning Scores system and recognising the deteriorating patient are to be welcomed and it is good to hear about the project to support family involvement in the recognition that their loved one 'just isn't right'.

Supporting patients to understand and safely manage their medicines on discharge is another safety theme with a high level of patient involvement, which is welcomed.

Patient experience:
Listening to previous, current and potential patients in a variety of settings is now established at the Trust via a wide range of projects including patient stories presented at the Public Board meetings, the work of the Face2Face volunteer interview team, patient surveys and visits from external organisations.

Importantly, patients and their family members are also now becoming directly involved in action plans following significant independent reviews such as the recent Independent Review of Paediatric Cardiac Services in Bristol (2014-2016). Plans to develop a partnership approach with the Patients Association for supporting people who remain dissatisfied after receiving the Trust's response to their complaints and further staff training in communication and mediation skills should also enhance the Trust's ability to acknowledge and learn from patients' concerns.

Clinical effectiveness, audit and research:
The Trust continues to closely monitor performance in key areas of clinical effectiveness and staff work incredibly hard to achieve the nationally or locally agreed targets despite increasing levels of demand.

However, there are on-going concerns regarding the performance of the Trust in relation to the Best Practice Tariff for patients admitted with a fractured neck of femur. This service underwent review in May 2016 by the British Orthopaedic Association and their report in September 2016 made clear recommendations for improvement. The action plan in relation to this is under review by the Quality and Outcomes Committee and has been the subject of regular questions from the governors. Determining what level of resource can be made available to achieve the recommended actions is a challenge.

Another area that justifies on-going scrutiny is stroke care, specifically the target to achieve brain imaging within one hour of admission.

Participation in national clinical audits, national confidential enquiries and clinical research are strong themes within the report and we applaud the clear evidence of continuing commitment to these. The Trust is to be congratulated on the recent achievement of an impressive NIHR Biomedical Research Centre funding award (in partnership with the University of Bristol). This will support expansion of current research programmes along with the introduction of new themes over the next five years and we look forward to hearing more about these at Trust research showcase events.

Performance against national priorities and access standards:
The data relating to the Trust's performance against the four key nationally determined standards clearly demonstrates significant periods of time when these could not be achieved. As the report explains trajectories for these targets were affected by high levels of demand, emergency admissions and increased numbers of elderly patients with complex needs. The inability to discharge treated patients to suitable providers of care in the community put severe pressures on bed availability. These problems are common to many acute trusts and our Trust continues to pursue a number of initiatives as part of its Transforming Care programme to improve patient flow without compromising patient safety and quality of care.

Summary:
The governors share the deep sense of pride expressed by our chief executive, Robert Woolley, in the achievements of all staff at the Trust over the past year. In particular, we have been thrilled to see the Trust assessed as Outstanding by the CQC and have been impressed by the progress achieved in key areas of quality monitoring and improvement.

The Quality and Outcomes Committee of the Trust has worked hard over the past year to sharpen their focus on, and strengthen the Trust's responses to, key areas of performance across all areas of the organisation. Increasingly detailed data that can be promptly and thoroughly reviewed is supporting them in this work; and the governors have also benefited from receiving this data alongside monthly reports from the committee meetings and specific updates on external reviews relating to the Trust.

In reflecting on all the work completed or on-going over 2016/17 this report is honest and open in acknowledging the objectives that proved challenging to meet alongside those for which the outcomes clearly warrant celebration.

Progress on quality has undoubtedly been achieved during the year. However, there can be no room for complacency and we are well aware that financial pressures, national requirements and ever-increasing patient numbers and complexity can only increase the challenges faced by everyone at the Trust. Further collaboration with other local healthcare providers, along with implementation of the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan (led by our chief executive), may yet provide sufficient integration of services to ease some of the current and anticipated pressures; but this work also requires an input of time and money.

In facing up to these challenges it is important to remember that the Trust's quality agenda is ultimately delivered by dedicated staff who offer a hugely impressive commitment to their patients and who deserve to be valued for this and constructively supported in every way possible.

Carole Dacombe
Clive Hamilton
May 2017

b) Statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and Healthwatch South Gloucestershire (hereafter 'local Healthwatch') agreed that UH Bristol's performance against their 2015/2016 quality priorities had been very good. We agreed that the document evidences a culture of reflecting upon and learning from the experiences and feedback of patients and the public. It was good to see that objectives from 2015/2016 that had been only partly met were being carried through to the 2016/2017 Quality Account. Local Healthwatch thought the Trust's quality objectives were ambitious enough to drive improvement.

Local Healthwatch made the following comments and recommendations about UH Bristol's Quality Account 2016/2017.

The document suggested that quality improvement at UH Bristol's had been very good. For example:

- UH Bristol had achieved their annual target for the amount of bed days patients spent in outlying to different wards. This means that less patients had to move beds during their treatment at UH Bristol.
- There had been improvements noted in sepsis care. UH Bristol had introduced a new screening tool and recruited two specialist sepsis nurses. It is good that sepsis care has remained a quality priority for 2016/2017 and that UH Bristol has plans to introduce NICE guidelines, staff training and increase screening in its emergency departments for the future.
- UH Bristol had created a new tool for screening adverse incidents and this has worked well and reduced avoidable harm to patients.
- Patients gave very positive feedback about their care at UH Bristol. The Quality Account shows that patients were kept informed about their treatment, involved in decisions and updated about potential discharge dates and aftercare. Local Healthwatch also heard very positive feedback about clinical care and UH Bristol staff during our "Enter and View" visit to South Bristol Community Hospital in October 2016.
- There are plans to improve patient feedback mechanisms further and UH Bristol will introduce a new system that will allow patients to provide comments compliments and complaints in real time, during their care rather than at discharge, in 2017/2018.
- Local Healthwatch was impressed by the excerpt from the CQC's latest inspection. UH Bristol's list of what CQC saw as "Outstanding Practices" on page 35 showed that UH Bristol is providing care that is safe, effective and caring.

However, local Healthwatch did note that:

- Complaints about communication had actually increased between 2016 and 2017 and dissatisfaction with the time or content of responses appeared to have increased. We note

however that this has been recognised and training has been introduced to improve the responses sent out.

- Although UH Bristol had made good progress against its 2015-2016 objective of increasing accessible information for patients, we would recommend that accessible information be added to 2016/2017 quality objective 8 – to develop a consistent customer service mind set – to ensure high quality customer service is received by patients and carers with enhanced needs.
- Timeliness of patient discharge still needs to improve in 2016/2017. UH Bristol had made progress, with more patients being discharged before 12 midday and therefore less patients needing to wait around, for example, medicines and/or discharge letters. During local Healthwatch's recent Enter and View visit to South Bristol Community Hospital, we met a number of inpatients who were healthy enough to leave the hospital but unable to be discharged as they were awaiting care packages from Bristol City Council. Although these delayed discharges were not the fault of UH Bristol, work needs to be done to reduce this as it has an effect on patient experience and wellbeing.
- Feedback in the Quality Account suggests that UH Bristol is not hitting its target of reducing the number of last minute cancelled operations. They have made progress since 2015/2016 but their percentage of cancelled operations is still higher than the national average. It was good to read that UH Bristol will continue to work on this quality priority in 2016/2017.
- Outpatient appointments are starting later than the appointment time. UH Bristol needs to improve its communication in outpatient clinics so patients and families know if their appointment is running late and why.
- We would recommend that staff training be embedded into the Trust's strategy and objectives for quality.

Local Healthwatch has found UH Bristol to be a high performing local provider and looks forward to working with their staff and patients further in the year 2017/2018.

We have noted that UH Bristol recognise their weaknesses and have shown a continued commitment to improvement.

The Trust is pursuing comprehensive and innovative consultation and engagement activities and involving the communities and groups they serve in the development of their services.

c) Statement from Healthwatch North Somerset

Healthwatch North Somerset welcomes the opportunity to provide a statement in response to the University Hospitals Bristol NHS Foundation Trust Quality Account produced by for the year 2016/17.

We would like to commend the Trust for achieving an Outstanding rating from the CQC during the year.

Overall the UH Bristol Quality Account provides a comprehensive reflection on quality performance during 2016/17 and demonstrates a good listening and learning approach. Patient safety and clinical outcomes are good and improvement criteria are clear and measurable. It is noted there was some deterioration against some national standards as compared to the previous year.

UH Bristol occupies nine different sites but it is not fully clear that each site is being reported on for all criteria. Analysis of performance associated with each site would be useful to aid fuller understanding.

The key quality metrics table providing assurance to the Trust Board each month regarding patient experience indicates a consistent and positive approach to managing patient experience – although it is noted that the percentage of responses where the complainant is dissatisfied has increased compared to the previous year. We welcome the proposed implementation of a Trust wide system to enable patient feedback and the objectives to improve communication with patients and relatives; we suggest the report would benefit from a more specific focus on the consistency and quality of information given to patients, and also in the respect and care in managing the relatives of patients.

Healthwatch North Somerset shares many patient feedback experiences directly with the Trust and will continue to share feedback received so that this helps to inform areas of service delivery.

With regards to the feedback provided, we would have welcomed some reference to the feedback that Healthwatch North Somerset shares with UH Bristol on a regular basis, such as the monthly feedback reports provided.

Eileen Jacques
Chief Officer
Healthwatch North Somerset

d) Statement from South Gloucestershire Health Scrutiny Select Committee

It was not possible for the Trust to formally present its Quality Report to a meeting of the Committee because of meeting restrictions in the run up to the local West of England Mayor election and the 2017 General Election. However, the committee chair and lead members received the Quality Report by email in order to provide a response.

These comments are based on the Committee's engagement with UHB on two topics during 2016/17.

On three occasions in 2016/17 UH Bristol attended Committee to present it actions in response to the 'Independent Review of Children's Cardiac Services in Bristol'; and the 'Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital'. Members noted the work that had taken place to address the issues raised in the reports and questioned the Trust on areas that it still needed to progress.

To aid the Committee's understanding during its scrutiny of children's heart services, members were also invited to visit the hospital to view services first hand and have an opportunity to talk to staff. The visit was extremely helpful.

Following the last meeting the Committee resolved that a further update be provided in one year in order to assure members that outstanding actions have been addressed.

The Committee also resolved to write to the Secretary of State for Health to inform him about the existence of the reports, raise awareness of the issues raised therein, and request that consideration is given on a national basis of the need for further awareness raising and dissemination of lessons learned.

The other topic led by UH Bristol during 2016/17 was a presentation regarding the Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Plan (STP). The item was led by the UHB chief executive, in his role as senior responsible officer for the BNSSG STP, with support from other local health and care organisational representatives. The update was well received but concerns were expressed about lack of engagement and the slow pace of the project. Members commented that there was very little detail included in the first presentation received and that it was only a document giving a sense of direction; no detail was given, consequently it would be very difficult to make any comments. South Gloucestershire Council is currently working with Bristol and North Somerset local authorities on the establishment of a formal Joint Health Scrutiny Committee to undertake the statutory health overview and scrutiny function going forward.

To conclude, the Committee received information about the Trust's recent CQC Inspection Report and members were pleased to learn that England's chief inspector of hospitals had given the Trust an 'Outstanding' rating. This was a great achievement in itself, but particularly given that the Trust had moved in two years from a rating of Requires Improvement to Outstanding between two inspections. The Committee sent its congratulations to Trust's Board and employees on achieving this rating.

Councillor Toby Savage
Chair, Health Scrutiny Committee

Councillor Sue Hope
Lead member, Health Scrutiny Committee

Councillor Ian Scott
Lead member, Health Scrutiny Committee

e) Statement from Bristol City Council People Scrutiny Commission

Following the announcement of the 8 June UK Parliamentary General Election the planned meeting with South Gloucestershire Health Scrutiny Committee to formally receive the Quality Report was cancelled as it was scheduled to take place in the pre-election period. Prior to the cancellation of the meeting some Councillors attended a visit to the Trust which was really informative.

The People Scrutiny Commission members received the report via email.

Councillor Brenda Massey, chair of the People Scrutiny Commission asked for the following to be noted:

1. 'Independent Review of Children's Cardiac Services in Bristol'; and the 'Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital'

Bristol City Council People Scrutiny Commission held three meetings in common with the South Gloucestershire Health Scrutiny Committee to receive update reports about the above issues. Senior officers from the University Hospitals Bristol NHS Foundation Trust attended the meetings to provide information on progress to date and progress planned and the councillors questioned the Trust.

Councillors were invited to visit the hospital and talked to staff. The Commission found the visit very useful and informative.

Following the third meeting the People Scrutiny Commission agreed that progress had been made against the actions. Another meeting in common would be held in approximately one year's time to review the processes that should be in place. The 12 month update meeting would require solid evidence to highlight that the recommendations and actions were embedded, with particular focus on feedback from the newly constituted user groups.

Another visit would also be arranged ahead of the update meeting in 12 months.

2. Bristol, North Somerset and South Gloucestershire (BNSSG) Sustainability and Transformation Plan (STP)

A meeting in common was held with the Bristol City Council People Scrutiny Commission, the North Somerset Health Overview and Scrutiny panel and the South Gloucestershire Health Scrutiny Committee to receive an update on the Sustainability and Transformation Plan (STP).

Mr Robert Woolley, UH Bristol chief executive, led the presentation in his role of senior responsible officer for the BNSSG STP. Support was provided from other local health and care organisational representatives.

The report presented outlined a high level strategy and further work was required to provide the detailed plans.

The People Scrutiny Commission welcomed the report but some councillors highlighted concerns about the lack of engagement and a shortage of information which increased frustration around the emotive topic.

The Commission recognised that the meeting had been arranged to receive the first iteration of the STP and to pave the way for further scrutiny and consultation.
Bristol City Council, North Somerset Council and South Gloucestershire Council are currently working to establish a formal Joint Health Scrutiny Committee to undertake the statutory health overview and scrutiny function going forward.

3. CQC Inspection Report

Councillor Massey recognised the improvements made at UHB in the last two years and noted the recent CQC rating of 'Outstanding'.

Robert Woolley and all other employees at UH Bristol should be proud of this achievement.

Councillor Massey was invited to take part in a Care Quality Commission case study which considered the University Hospitals Bristol NHS Foundation Trust. As part of this, Councillor

Massey commented that "the Trust has a greater sense of self-awareness about the things they need to do to change, and that the environment is now a place where there is 'so much more capacity to engage' with one another."

The Bristol City Council People Scrutiny Commission looks forward to continuing the collaboratively working relationship with UH Bristol in 2017.

f) Statement from Bristol Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Report 2016/17 is made by Bristol Clinical Commissioning Group (CCG) on behalf of Bristol, North Somerset and South Gloucestershire (BNSSG) CCGs and has been reviewed by members of the BNSSG Quality and Governance Committee.

Bristol CCG welcomes UH Bristol's quality report, which provides a comprehensive reflection on the quality performance during 2016/17. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

Bristol CCG is pleased to commend the overall CQC's rating of Outstanding achieved by the Trust, noting the actions taken by the Trust to improve from the previous rating of Requires Improvement. The CCG recognises that this is a considerable achievement by UH Bristol in being the first Trust in the country to improve from an overall rating of Requires Improvement to Outstanding and is only the sixth Acute Trust to receive this rating.

During 2016/17, UH Bristol has demonstrated continued high quality performance in a number of key patient safety indicators, including reducing the number of hospital acquired pressure ulcers, sustaining compliance with VTE assessments and meeting the C Difficile target by reporting less than the annual threshold number of cases.

Unfortunately the Trust reported an increase in the number of inpatient falls per 1,000 bed days and also in those causing harm compared with the previous year. The CCG also noted the performance for stroke and fractured neck of femur metrics was below target, but would have welcomed some analysis regarding non achievement of these targets and improvement plans for the future.

Bristol CCG notes UH Bristol's performance in achieving a high proportion of the 2016/17 Commissioning for Quality and Innovation (CQUINS) goals, however as with the previous year's quality report there is no narrative to explain those CQUINs where full achievement was not met.

Bristol CCG noted that of the twelve quality objectives for 2016/17 only five were fully achieved and six partially met. The CCG acknowledges the work put in place for these objectives and is pleased to note that five of the objectives that were either not or only partially achieved have been put forward along with three new quality objectives for 2017/18. The CCG supports the chosen areas for quality improvement for 2017/18.

Bristol CCG notes the ongoing patient experience work within the Trust, acknowledging the significant amount of positive feedback that is received from service-users. The CCG also notes the significant improvement in the Friends and Family Test responses for both inpatient wards and emergency departments. However, this quality report has minimal evidence of actual patient feedback, such as patient stories, other than the patient comments within each quality objective.

Bristol CCG recognises that the paediatric cardiac services independent review is mentioned within the duty of candour section of the report, however we expected the Trust to make more detailed reference to the outcomes of the review in the report and the work undertaken already during 2016/17 to address the recommendations and work being taken forward into 2017/18.

Bristol CCG will continue to work closely with the Trust in 2017/18 in areas that need either further improvement or development. These included:

- improvement in performance against the best practice tariff for patients who have sustained a fractured neck of femur

- closer working with primary care and community partners to help support the reduction in incidences of healthcare associated infections, namely MRSA, C. difficile infection and E coli bacteraemias
- closer working with primary and community partners to help support both implementation of the National Early Warning Scores and handover of care between providers to aid rapid detection of the deteriorating patient.

Bristol CCG acknowledges the good work achieved by the Trust in 2016/17. The quality report clearly demonstrates this and the CQC also acknowledged this by rating the trust as 'Outstanding. We note the areas identified by the Trust for further improvement and we look forward to working with UH Bristol in 2017/18.

B APPENDIX B Performance indicators subject to external audit

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Source of indicator definition and detailed guidance
The indicator is defined within the technical definitions that accompany Everyone Counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf. Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf.

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge).

Denominator
The total number of unplanned A&E attendances.

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance
The indicator is defined within the technical definitions that accompany Everyone Counts: planning for patients 2014/15 - 2018/19 and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf. Detailed rules and guidance for measuring RTT standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waitingtimes/rtt-guidance/

Numerator
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks.

Denominator
The total number of patients on an incomplete pathway at the end of the reporting period.

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-21content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage.

C APPENDIX C
Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the NHS (Quality Accounts) regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2016 to March 2017
  - papers relating to Quality reported to the board over the period April 2016 to March 2017
  - feedback from commissioners received 16/5/2017
  - feedback from governors received 9/5/2017
  - feedback from local Healthwatch organisations received 10/5/2017
  - feedback from Overview and Scrutiny Committees received 12/5/2017 and
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[25]
  - the 2015 national patient survey published 8/6/2016[26]
  - the 2016 national staff survey published 7/3/2017
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 24 May 2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and revie
- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

John Savage, Chairman
26 May 2017

Robert Woolley, Chief executive
26 May 2017

[25] This report is due to be received by the board in July 2017
[26] The 2016 survey results have not yet been published

D APPENDIX D External audit opinion

Independent Auditors' Limited Assurance Report to the Council of Governors of University Hospitals Bristol NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement ("NHSI")):

Specified indicators	Specified indicators criteria
Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period	See Appendix B to the Quality Report, page 77
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	See Appendix B to the Quality Report, page 77

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2016 and up to the date of signing this limited assurance report (the period);
- Papers relating to quality report reported to the Board over the period April 2016 to the date of signing this limited assurance report (the period);
- Feedback from the Commissioners Bristol CCG dated 16/05/2017;
- Feedback from Governors dated 09/05/2017;
- Feedback from Healthwatch Bristol dated 08/05/2017 and Healthwatch North Somerset dated

10/05/2017;
- Feedback from Bristol City Council People Scrutiny Commission 15/05/2017 and from South Gloucestershire Council Health Scrutiny Committee 12/05/2017:
- The 2015 national cancer patient survey dated 08/06/2016;
- The 2016 national staff survey dated 07/03/2017;
- Care Quality Commission inspection, dated 02/03/2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control
We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report
This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial

information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2016/17" and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by University Hospitals Bristol NHS Foundation Trust.

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated by the Trust for any identified errors through a monthly validation process. The process is however not applied to the whole data set, as it focuses only on a limited sample of cases.

In our testing we found an instance of a patient being included which did not meet the inclusion criteria and two cases where the clock had not been stopped at the end of applicable month end. Therefore, some patients had been incorrectly reported within the indicator.

As the Trust has not reviewed or updated the underlying data set, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Conclusion (including disclaimer of conclusion on the Incomplete Pathways indicator)
Because the data required to support the indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the Incomplete Pathways indicator.

Based on the results of our procedures, nothing else has come to our attention that causes us to believe that for the year ended 31 March 2017,

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator has not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

PricewaterhouseCoopers LLP
Bristol
26 May 2017

The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.