University Hospitals Bristol
NHS Foundation Trust

COUNCIL OF GOVERNORS

Meeting to be held on 28 July 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

SUPPORTING INFORMATION

Item 7.1b - Q4 16/17 Complaints Report

Item 7.1b - Q4 16/17 Patient Experience Report

Item 7.1c - Annual Quality Report 2016/17

Item 7.1d - Independent Auditor's Report to Governors on the Quality Report

Item 7.2 - Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children (BRCH)

Report to the Council of Governors meeting to be held on 28 July 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Agenda Item	7.1b
Meeting Title	Council of Governors	**Meeting Date**	28 July 2017
Report Title	a) Quarterly Complaints Report (Quarter 4) b) Patient Experience Report (Quarter 4)		
Author	a) Louise Townsend, Acting Patient Support & Complaints Manager, and Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness) b) Paul Lewis, Patient Experience & Involvement Team Manager		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Governor Responsibility (please tick any which are impacted on / relevant to this paper)	
Holding the Non-Executive Directors to account	☐
Non-Executive Director appointments (appraisal review)	☐
Constitutional/forward plans	☐
Member/Public interests	☒
Significant transaction/private patient increase	☐
Appointment of External Auditor	☐
Appointment of the Chief Executive	☐

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

Executive Summary

Purpose

To share insight and learning from patient-reported experience generated from complaints, patient surveys and patient and public involvement activities during Quarter 4.

Key points to note

Complaints: Improvements in Q4:

- Although the total number of complaints received in Quarter was 11% more than in Quarter 3, it was significantly less than in Quarter 2, and 8% less than the corresponding quarter one year previously.
- In Quarter 4, complaints about cancelled/delayed appointments and operations fell to a historical low of 54. The Trust had also received only 66 complaints in quarter 3; this was the first time the quarterly total for this reporting theme had fallen below 100 since the third quarter of 2013/14.
- Complaints about failure to answer telephones fell for a third consecutive quarter, returning to its lowest (best) point since the third quarter of 2015/16.

- Complaints about Trauma and Orthopaedics fell significantly to 14 in quarter 4 compared to 37 in quarter 3.
- No formal complaints were received by the Diagnostics and Therapies division in February and March 2017.
- No cases referred to the Ombudsman were upheld against the Trust in quarter 4.

However:

- Complaints about Specialised Services division increased significantly in Q4, driven largely by increases in complaints about outpatient services and the waiting list office, both at the Bristol Heart Institute.
- Complaints about Bristol Dental Hospital rose in quarter 4 following previous reductions. This was largely driven by increases in complaints about the Administration Department and Oral Surgery Department.

Patient experience and involvement:

- All of the UH Bristol's Trust-level patient survey measures remained above target - demonstrating the continued provision of a high quality patient experience.
- UH Bristol has a contractual obligation with the Bristol Clinical Commissioning Group to meet specified Friends and Family Test response rate targets. In Quarter 4 the Trust continued to meet these targets. There was an improvement in the response rate for the inpatient and day case element of this survey during Quarter 4, having only just been meeting the 30% target in Quarter 3.
- Ward C808 (care of the elderly) had the lowest score across the headline survey measures. It has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this theory, in Quarter 1 the Patient Experience and Involvement Team have been carrying out a range of activities on care of the elderly wards.
- Ward A602 (trauma and orthopaedics) had a relatively low survey score on two key survey measures. This was an unusual result for this ward, further analysis did not identify any specific improvement issues, and the number of complaints actually fell over this period. The most likely explanation at present is that this was a statistical "blip", but the ward Sister has been alerted to the result and the score will continue to be monitored to look for any consistent trend.

Recommendations

Governors are asked to:

- **Note** the report.

Intended Audience
(please tick any which are relevant to this paper)

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

Date papers were previously submitted to other committees

Nominations & Appointments Committee	Quality Focus Group	Governor Strategy Group	Constitution Focus Group	Public Trust Board 29/06/17

University Hospitals Bristol
NHS Foundation Trust

Complaints Report

Quarter 4, 2016/2017

(1 January 2017 to 31 March 2017)

Authors: Louise Townsend, Acting Patient Support and Complaints Manager
Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness

Overview

Successes	Priorities
• Although the total number of complaints received in Quarter was 11% more than in Quarter 3, it was significantly less than in Quarter 2, and 8% less than the corresponding quarter one year previously. • In quarter 4, complaints about cancelled/delayed appointments and operations fell to a historical low of 54. The Trust also received only 66 complaints in quarter 3; this was the first time the quarterly total for this reporting theme had fallen below 100 since the third quarter of 2013/14. • Complaints about failure to answer telephones fell for a third consecutive quarter, returning to its lowest (best) point since the third quarter of 2015/16. • Complaints about Trauma and Orthopaedics fell significantly to 14 in quarter 4 compared to 37 in quarter 3. • No formal complaints were received by the Diagnostics and Therapies division in February and March 2017. • No cases referred to the Ombudsman were upheld against the Trust in quarter 4.	• To re-focus on ensuring timely complaints responses – in quarter 4, 86.0% of formal complaints were responded to within the agreed timeframe. • To continue to focus on getting the tone and substance of response letters right. Despite our efforts, in 2016/17 as a whole, more complainants expressed dissatisfaction with our initial response to their formal complaints than in 2015/16 (65 compared to 59).
Opportunities	**Risks & Threats**
• To bring more detailed monitoring of informal complaints into the quarterly reporting process. From Quarter 1 2017/18 onwards, we will start to report on divisional performance in responding to informal complaints within timescale. • To establish a new complaint review panel. • To continue to work with the Patients Association to develop a potential model for external patient advocacy for high-risk complaints.	• Complaints about Specialised Services division increased significantly in Q4, driven largely by increases in complaints about outpatient services and the waiting list office, both at the Bristol Heart Institute. • Complaints about Bristol Dental Hospital rose in quarter 4 following previous reductions. This was largely driven by increases in complaints about the Administration Department and Oral Surgery Department.

1. Complaints performance – Trust overview

The Board monitors three indicators of how well the Trust is doing in respect of complaints performance:

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

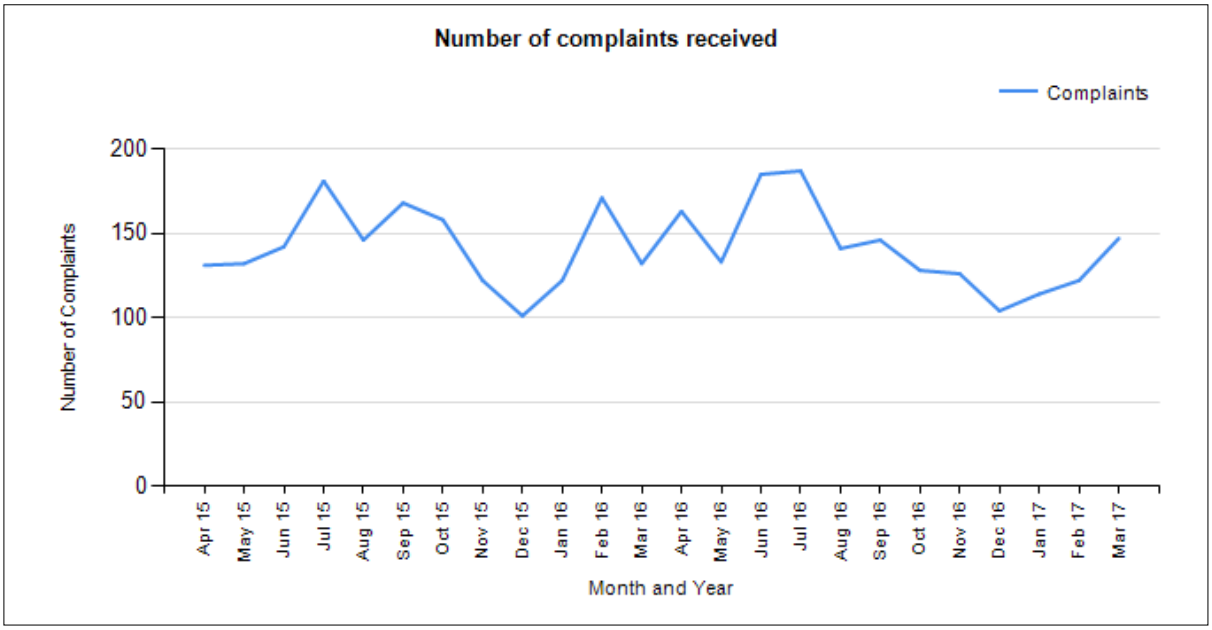
1.1 Total complaints received

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

We received 441 complaints in Q4, which equates to 0.20% of patient activity. This includes complaints received and managed via either formal or informal resolution (whichever has been agreed with the complainant)[1]. This figure does not include concerns which may have been raised by patients and dealt with immediately by front line staff. The number of complaints received in Q4 represents an increase of 11% compared to Q3 and an 8% decrease on the corresponding period one year previously.

Figure 1 shows the pattern of complaints received in the last 22 months. Figure 2 shows the complaints received as a percentage of patient activity and Figure 3 shows the numbers of complaints dealt with via the formal investigation process compared to those dealt with via the informal investigation process.

Figure 1: Number of complaints received



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

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

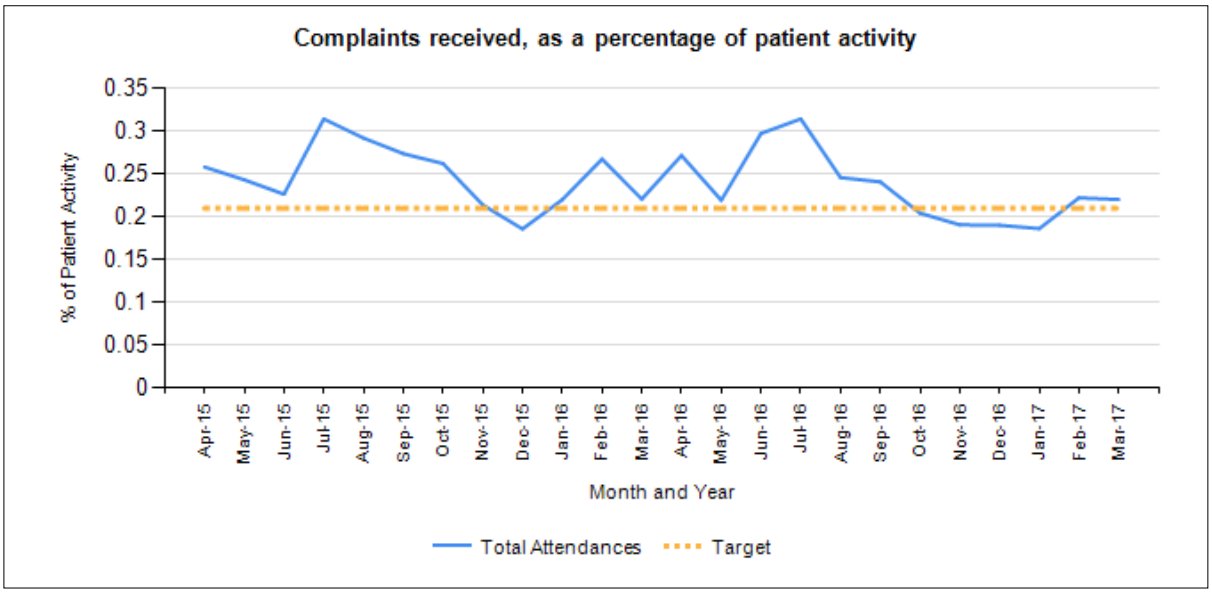
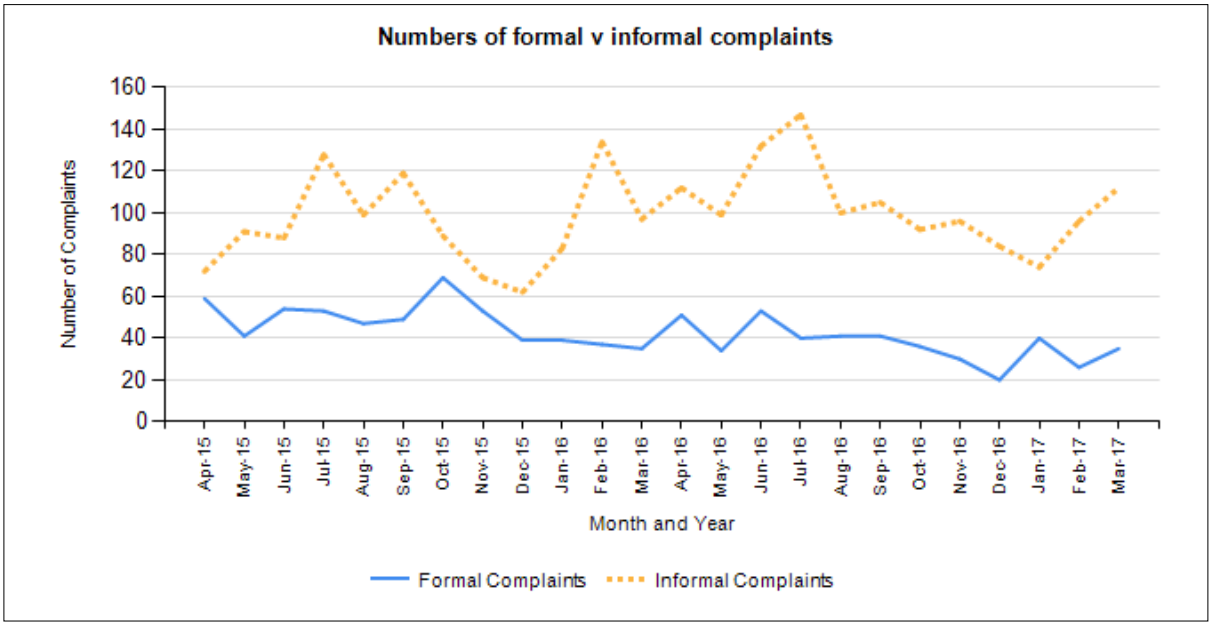


Figure 3: Numbers of formal v informal complaints



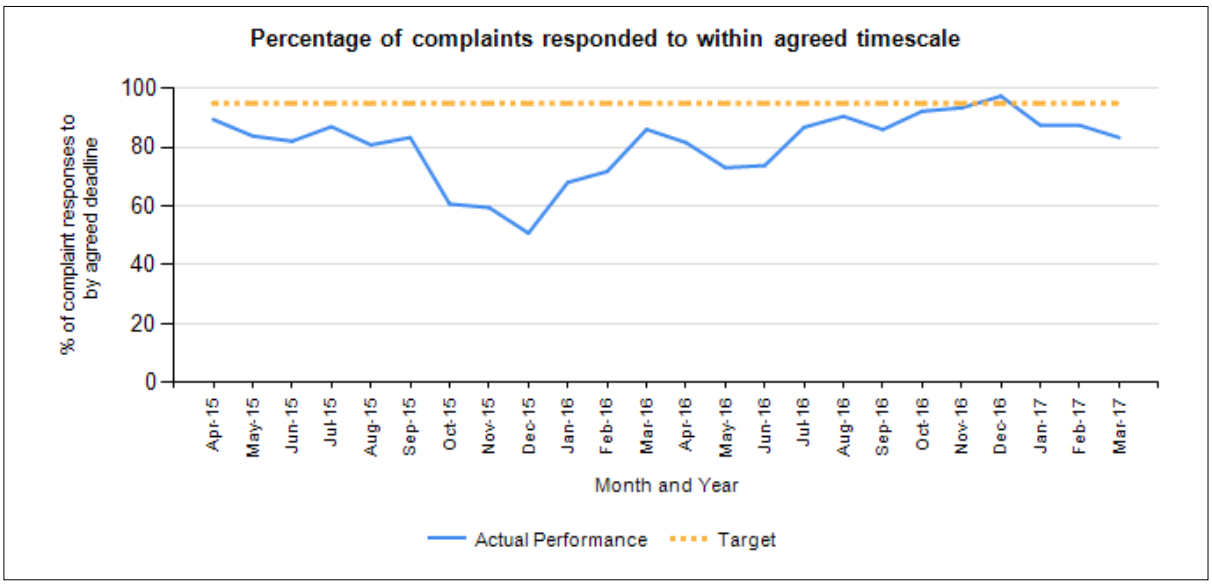
1.2 Complaints responses within agreed timescale

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

The Trust's target is to respond to at least 95% of complaints within the agreed timescale. The end point is measured as the date when the Trust's response is posted to the complainant. In Q4, 86.0% of responses were posted within the agreed timescale, compared to 94.2% in Q3, 88.1% in Q2, and 76.2% in Q1. This represents 19 breaches out of 136 formal complaints which were due to receive a

response during Q4[2]. Figure 4 shows the Trust's performance in responding to complaints since February 2016.

Figure 4: Percentage of complaints responded to within agreed timescale



1.3 Dissatisfied complaints

Reducing numbers of dissatisfied complainants was one of the Trust's corporate quality objectives for 2015/16 and has remained a priority throughout 2016/17. We are disappointed whenever anyone feels the need to complain about our services; but especially so if they are then dissatisfied with the quality of our investigation into and response to their concerns. For every complaint we receive, our aim is to identify whether and where we have made mistakes, to put things right if we can, and to learn as an organisation to that we do not make the same mistake again. Our target is that nobody should be dissatisfied with the quality of our response to their complaint[3].

The way in which dissatisfied cases are reported is expressed as a percentage of the responses the Trust has sent out in any given month. Since Q3 2015/16, our target has been for less than 5% of complainants to be dissatisfied. This data is now reported two months' in arrears in order to capture the majority of cases where complainants tell us they were not happy with our response.

In Q4, of the 48 responses sent out in January 2017 and by the cut-off point of mid-April 2017 (the date on which the dissatisfied data for January 2017 was finalised), seven people had contacted us to say they were dissatisfied. This represents 14.6% of the responses sent out that month. Previously, in Q3, of a total of 139 responses sent out in the quarter, 15 had received a dissatisfied response at the point when monthly data was frozen for board reporting. This represents 10.1% of the responses sent out.

Figure 5 shows the percentage of complainants who were dissatisfied with aspects of our complaints response up until January 2017.

[2] Note that this will be a different figure to the number of complainants who *made* a complaint in that quarter.
[3] Please note that we differentiate this from complainants who may raise new issues or questions as a result of our response.

Table 2: Complaints performance

Items in italics are reportable to the Trust Board. Other data items are for internal monitoring/reporting to the Patient Experience Group where appropriate.

		Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Total complaints received (inc. TS and F&E from April 2013)	TOTAL	150	176	147	199	200	155	162	140	139	118	129	144	168
	Formal	39	54	36	57	44	45	45	41	32	24	40	30	39
	Informal	111	122	111	142	156	110	117	99	107	94	89	114	129
Number & % of complaints per patient attendance in the month	*%*	*0.22%*	*0.27%*	*0.22%*	*0.30%*	*0.31%*	*0.25%*	*0.24%*	*0.20%*	*0.19%*	*0.19%*	*0.19%*	*0.22%*	*0.22%*
	Complaints	*150*	*176*	*147*	*199*	*200*	*155*	*162*	*140*	*139*	*118*	*129*	*144*	*168*
	Attendances	*67,932*	*64,750*	*66,973*	*66,816*	*63,580*	*63,073*	*67,371*	*68,647*	*73,004*	*62,047*	*69,202*	*64,798*	*76,321*
% responded to within the agreed timescale (i.e. response posted to complainant)	*%*	*86.1%*	*81.6%*	*73.1%*	*73.8%*	*86.8%*	*90.6%*	*86.0%*	*92.3%*	*93.4%*	*97.4%*	*87.5%*	*87.5%*	*83.3%*
	Within timescale	*31*	*40*	*38*	*31*	*33*	*48*	*37*	*36*	*57*	*38*	*42*	*35*	*40*
	Total	*36*	*49*	*52*	*42*	*38*	*53*	*43*	*39*	*61*	*39*	*48*	*40*	*48*
% responded to by Division within required timescale for executive review	%	100.0%	87.8%	92.3%	95.2%	89.5%	94.3%	81.4%	92.3%	85.2%	76.9%	85.4%	85.0%	72.9%
	Within timescale	36	43	48	40	34	50	35	36	52	30	41	34	35
	Total	36	49	52	42	38	53	43	39	61	39	48	40	48
Number of breached cases where the breached deadline is attributable to Division	Attibutable to Division	5	3	8	7	4	4	4	2	3	1	3	1	5
	Total Breaches	5	9	14	11	5	5	6	3	4	1	6	5	8
Number of extensions to originally agreed timescale (formal investigation process only)		25	21	8	11	15	18	12	15	16	13	16	11	15
Informal Complaints														
% responded to within the agreed timescale (i.e. Division to make contact with the complainant)	%	-	-	-	-	-	-	-	-	-	-	-	-	-
	Within timescale	-	-	-	-	-	-	-	-	-	-	-	-	-
	Total	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of breached cases	Total Breaches	-	-	-	-	-	-	-	-	-	-	-	-	-
Number of extensions to originally agreed timescale *(Informal investigation process only)*		-	-	-	-	-	-	-	-	-	-	-	-	-
"% of complainants dissatisfied with response and case re-opened	%	8.3%	8.2%	9.6%	16.7%	10.5%	13.2%	18.6%	0.0%	14.8%	12.8%	14.6%	10.0%	-
	Reopened Dissatisfied	3	4	5	7	4	7	8	0	9	5	7	4	-
	Total Responses Due	36	49	52	42	38	53	43	39	61	39	48	40	-

For each case where a complainant advises they are dissatisfied, the case is reviewed by a Patient Support and Complaints Officer, leading to one of the following courses of action, according to the complainant's preference:

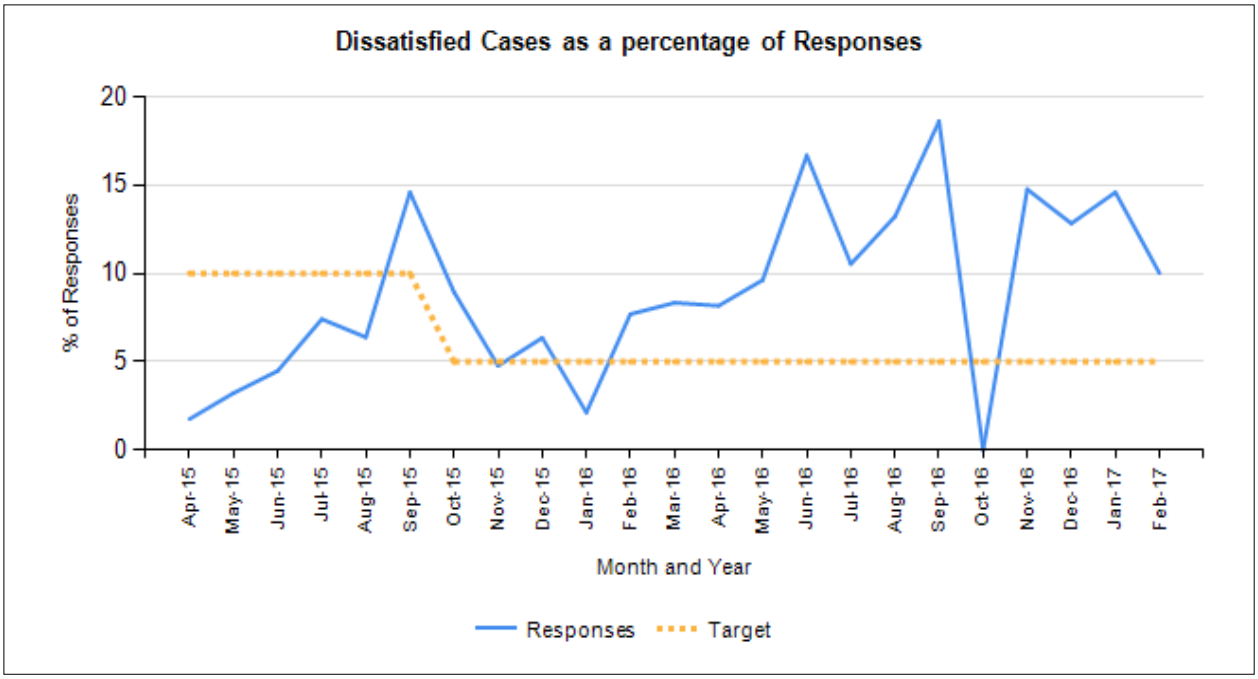
- The lead Division is asked to reinvestigate the outstanding concerns and send a further response letter to the complainant addressing these issues;
- The lead Division is asked to reinvestigate the outstanding concerns and arrange to meet with the complainant to address these issues
- On rare occasions, a letter may be sent to the complainant advising that the Trust feels that it has already addressed all of the concerns raised and reminding the complainant that if they remain unhappy, they have the option of asking the Ombudsman to independently review their complaint. This option might be appropriate if, for example, if a complainant was disputing certain events that had been captured on CCTV and were therefore incontrovertible.

In the event that we do not have enough information to initiate the process outlined above, the allocated caseworker from the Patient Support and Complaints Team will contact the complainant to clarify which issues remain unresolved and, where possible, identify some specific questions that the complainant wishes to be answered. Following this, the process noted above would then be followed.

In all cases where a further written response is produced, the draft is reviewed by the Patient Support and Complaints Manager and by the Head of Quality (Patient Experience and Clinical Effectiveness) before sending it to an Executive Director for signing.

In the event that a complainant comes back to us again, having received two responses (whether in writing or by way of a meeting), the case will be escalated to an Executive Director (usually the Chief Nurse) to review. As part of the escalation, Divisions are asked to consider whether some form of independent input might assist with achieving resolution and to discuss this with the Executive Director.

Figure 5: Percentage of complainants dissatisfied with complaint response



2. Complaints themes – Trust overview

Every complaint received by the Trust is allocated to one of eight major categories, or themes. Table 3 provides a breakdown of complaints received in Q4 2016/17 compared to Q3 2016/17. In Q4, complaints in most of the major categories/themes increased, including appointments and admissions (increased from 118 complaints to 132), attitude and communication (99 to 104) and clinical care (104 to 126). Complaints about discharge/transfer/transport reduced in Q4 (20 to 15). However the level of complaints reported in each category was lower than in Q2, when a total of 517 complaints were received.

Table 3: Complaints by category/theme

Category/Theme	Number of complaints received in Q4 (2016/17)	Number of complaints received in Q3 (2016/17)
Access	0 (0%) ↓	1 (0.2%) ↓
Appointments & Admissions	132 (29.9%) ↑	118 (29.7%) ↓
Attitude & Communication	104 (23.6%) ↑	99 (24.9%) ↓
Clinical Care	126 (28.6%) ↑	104 (26.2%) ↓
Discharge/Transfer/Transport	15 (3.4%) ↓	20 (5.3%) ↓
Documentation	4 (0.9%) ↑	3 (0.7%) =
Facilities & Environment	21 (4.8%) ↑	20 (5.3%) ↓
Information & Support	39 (8.8%) ↑	32 (8.6%) =
Total	**441**	**397**

Each complaint is also assigned to a more specific sub-category, for which there are over 100. Table 4 lists the ten most consistently reported sub-categories. In total, these sub-categories account for approximately two thirds of the complaints received in Q4 (397/517).

Table 4: Complaints by sub-category

Sub-category	Number of complaints received in Q4 (2016/17)	Q3 (2016/17)	Q2 (2016/17)	Q1 (2016/17)
Cancelled/delayed appointments and operations	54 ↓ (18.2% decrease compared to Q3)	66	106	142
Communication with patient/relative	20 ↓ (20% decrease compared to Q3)	25	23	34
Clinical Care (Medical/Surgical)	70 ↑ (29.6% increase compared to Q3)	54	60	70
Failure to answer telephones/failure to respond	22 ↓ (8.3% decrease compared to Q3)	24	27	34
Clinical Care (Nursing/Midwifery)	13 =	13	19	22
Attitude of Medical Staff	27 ↑ (92.8% increase compared to Q3)	14	24	23
Attitude of Admin/Clerical Staff	18 ↑ (63.6% increase compared to Q3)	11	11	16

Attitude of Nursing Staff	4 ↓ (20% decrease compared to Q3)	5	17	12
Appointment Administration Issues *(new sub-category)*	35 ↑ (57.1% increase compared to Q3)	15	38	20
Transport (Late/Non Arrival/Inappropriate)	2 =	2	11	6

Complaints about 'cancelled or delayed appointments or operations/procedures' and 'failure to answer telephones/failure to respond' have reduced for three consecutive quarters. In other sub-categories, levels of complaints in Q4 tended to revert to those reported prior to Q3. The data in Table 3 suggests a possible upturn in complaints about staff attitude – we will continue to monitor this and will undertake a more detailed analysis if the reporting pattern is sustained in Q1 of 2017/18.

Figures 6, 7, and 8 show the four most commonly recorded sub-categories of complaint as detailed above, tracked since March 2016.

Figure 6: Cancelled or delayed appointments and operations

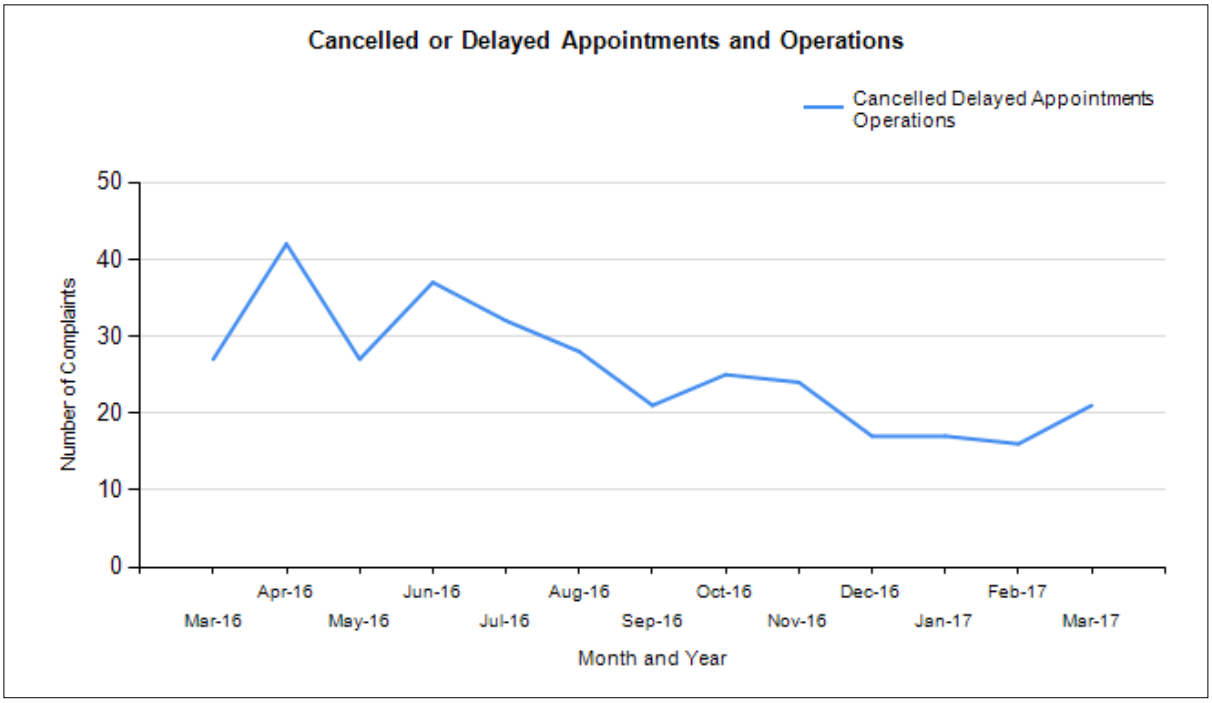


Figure 7: Clinical care – Medical/Surgical

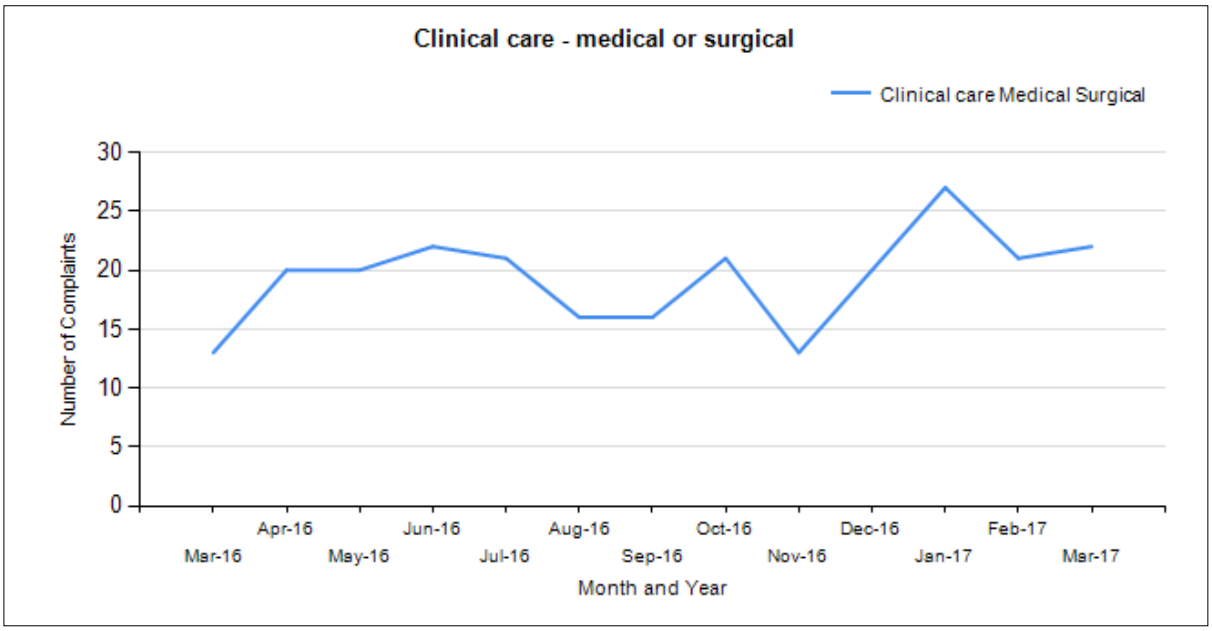
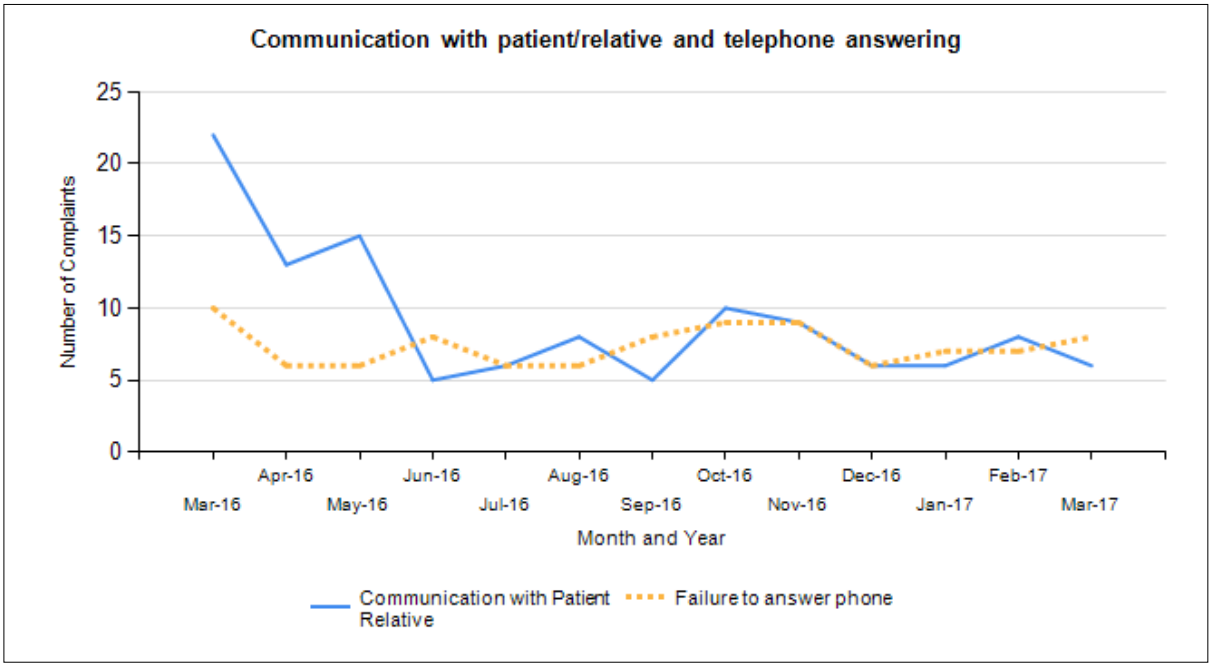


Figure 8: Communication with patient/relative and telephone answering

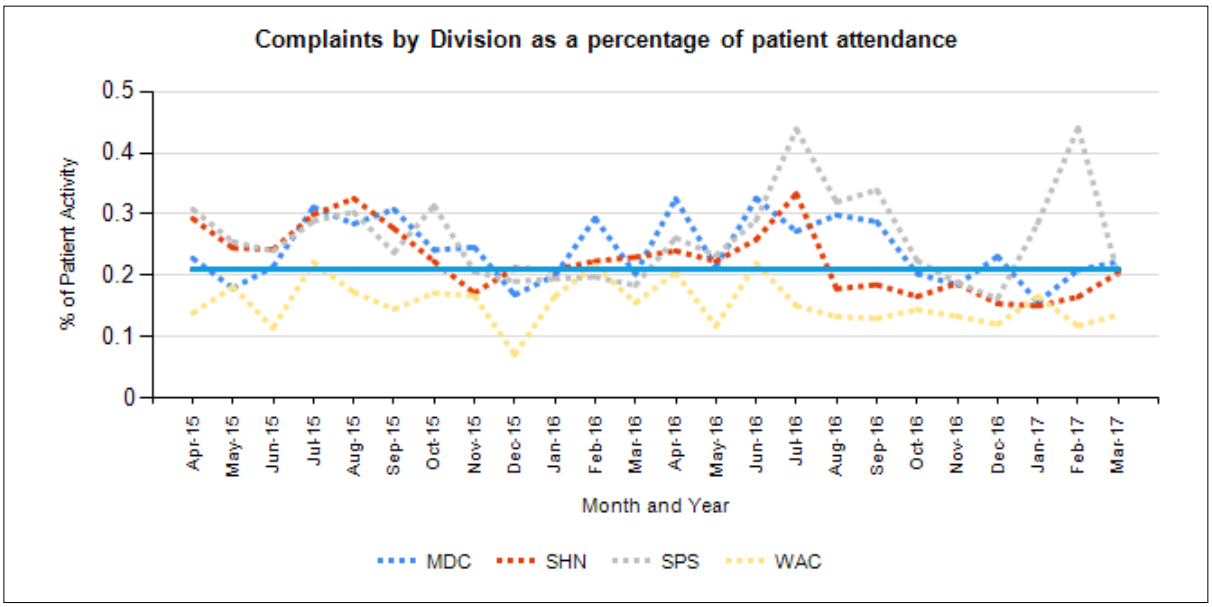


3. Divisional performance

3.1 Total complaints received

A divisional breakdown of the percentage of complaints per patient attendance is provided in Figure 9. The overall increase in complaints received by the bed holding Divisions during Q4 was driven largely by an increase in complaints about Specialised Services (see analysis later in this report).

Figure 9: Complaints by Division as a percentage of patient attendance



It should be noted that data for the Division of Diagnostics and Therapies is excluded from Figure 9 because this Division's performance is calculated from a very small volume of outpatient and inpatient activity. Overall, reported Trust-level data includes Diagnostics and Therapies complaints, but it is not appropriate to draw comparisons with other Divisions. Since January 2016, the number of complaints received by the division has been as follows:

Table 5: Complaints received by Division of Diagnostics and Therapies

	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
No. of complaints received	5	13	6	5	7	12	4	9	6	7	3	7	3	4	3

3.2 Divisional analysis of complaints received

Table 6 provides an analysis of Q4 complaints performance by Division. In addition to providing an overall view, the table includes data for the three most common reasons why people complain: concerns about appointments and admissions; concerns about staff attitude and communication; and concerns about clinical care.

Table 6	Surgery, Head & Neck	Medicine	Specialised Services	Women & Children	Diagnostics & Therapies
Total number of complaints received	155 (145) ↑	88 (89) ↓	82 (49) ↑	67 (64) ↑	11 (17) ↓
Total complaints received as a proportion of patient activity	44.6% (0.19%) ↑	22.4% (0.21%) ↑	13.6% (0.2%) ↑	23.9% (0.13%) ↑	1% (0) ↑
Number of complaints about appointments and admissions	72 (60) ↑	19 (20) ↓	17 (11) ↑	15 (15) =	7 (11) ↓
Number of complaints about staff attitude and communication	37 (41) ↓	17 (25) ↓	17 (7) ↑	22 (15) ↑	2 (3) ↓
Number of complaints about clinical care	29 (28) ↑	34 (30) ↑	35 (21) ↑	27 (23) ↑	1 (2) ↓
Area where the most complaints have been received in Q4	Bristol Dental Hospital – 48 (29) Bristol Eye Hospital – 44 (33) Trauma & Orthopaedics – 15 (37) ENT – 10 (13) Upper GI – 12 (10)	Emergency Department (BRI) – 18 (20) Dermatology – 10(9) Sleep Unit 7 (5) Ward A300 (AMU) – 5(5)	BHI (all) – 64(41) BHI Outpatients – 20 (11) BHI Waiting List Office 8 (5) Ward C708 – 6 (5) GUCH Services – 0 (7)	Children's ED & Ward 39 (BRHC) – 9 (9) Gynaecology Outpatients (StMH) – 7 (9) Paediatric Orthopaedics –7 (5)	Radiology – 3 (3) Physiotherapy – 2 (5) Audiology – 1 (3)
Notable deteriorations compared to Q3	Bristol Eye Hospital 44 (33) Bristol Dental Hospital 48 (31)	None	BHI (all) 64(41) BHI Outpatients 20 (11) BHI Waiting List Office 8 (5)	None	None
Notable improvements compared to Q3	Trauma & Orthopaedics – 14 (37)	None	None[4]	None	Physiotherapy – 2 (5) Audiology – 1 (3)

[4] Complaints about GUCH Services appear as a reduction however this is due to a change in reporting categories: GUCH is now recorded as a speciality rather than a sub category.

3.2.1 Division of Surgery, Head & Neck

In Q4, the Division of Surgery Head & Neck experienced an increase in complaints about appointments and admissions, but an improvement in complaints about cancelled or delayed appointments and operations. There was a significant decrease in complaints about trauma and orthopedics (previously down from 37 in Q3 to 14 in Q4). Complaints relating to the Bristol Eye Hospital and the Bristol Dental Hospital both rose in Q4, breaking previous long term downwards (improving) trends.

Table 7: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	72 (46.6%) ↑	60 (41.4%) ↓
Attitude & Communication	37 (23.9%) ↓	41 (28.3%) ↑
Clinical Care	29 (18.7%) ↑	28 (19.3%) ↓
Facilities & Environment	2 (1.29%) =	2 (1.4%) ↓
Information & Support	13 (8.39%) ↑	8 (5.5%) ↑
Discharge/Transfer/ Transport	1 (0.64%) ↓	6 (4.1%) ↓
Documentation	1 (0.64%) ↑	0 (0%) ↓
Total	**155**	**145**

Table 8: Top sub-categories

Category	Number of complaints received – Q4 2016/17	Number of complaints received – Q3 2016/17
Cancelled or delayed appointments and operations	30 ↓	35 ↓
Clinical Care (Medical/Surgical)	16 =	16 =
Communication with patient/relative	6 ↓	15 ↑
Attitude of Medical Staff	10 ↑	4 =
Attitude of Nursing/Midwifery	0 ↓	1 ↓
Attitude of Admin/Clerical Staff	7 ↑	2 ↓
Clinical Care (Nursing/Midwifery)	0 ↓	1 ↓
Failure to answer telephones	9 ↓	14 ↑
Transport (late/non arrival/inappropriate	0 ↓	2

Table 9: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints about the Bristol Dental Hospital increased in Q4 (31 to 50). Of these the most noticeable single increases related to the Administration Department (8 to 17) and the	A number of BDH's formal complaints Quarter 4 related to communication about dental care and treatment plans, however there were no common themes in terms of	All complaints are shared monthly with the BDH team. As part of the monthly validation process, all informal complaints continue to be shared with the divisional teams, for accuracy,

Oral Surgery Department (5 to 12).	the precise circumstances and staff involved. An increase with informal complaints during Quarter 4 related to appointments and referrals.	learning/themes of if there are any actions to be taken/prevention.

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

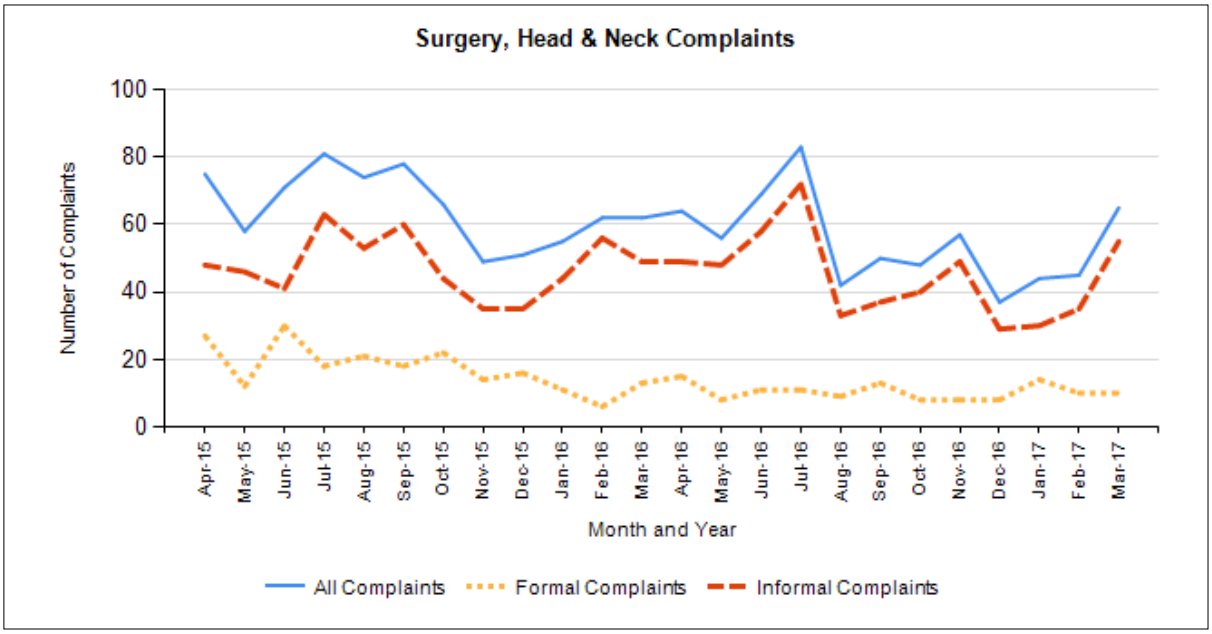
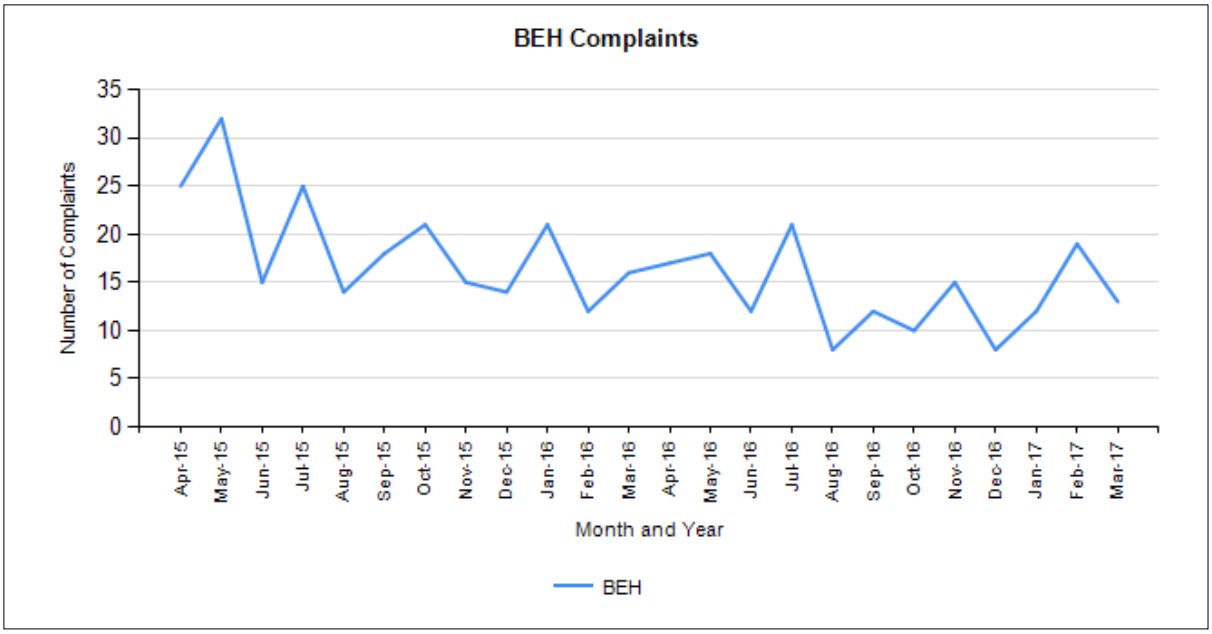


Figure 11: Complaints received by Bristol Eye Hospital



3.2.2 Division of Medicine

In Q4, the pattern of complaints received by the Division of Medicine was similar to Q3 across all major reporting categories. Q4 data also shows a continued concerted shift toward informal resolution of concerns.

Table 10: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0%) =	0 (0%) ↓
Appointments & Admissions	19 (21.6%) ↓	20 (22.5%) ↓
Attitude & Communication	17 (19.3%) ↓	25 (28.1%) ↓
Clinical Care	34 (38.6%) ↑	30 (33.7%) ↑
Facilities & Environment	6 (6.8%) =	6 (6.7%) ↓
Information & Support	4 (4.5%) ↑	3 (3.4%) ↓
Discharge/Transfer/ Transport	6 (6.8%) ↑	5 (5.6%) ↓
Documentation	2 (2.3%) ↑	0 (0%) ↓
Total	**88**	**89**

Table 11: Top sub-categories

Category	Number of complaints received – Q4 2016/17	Number of complaints received – Q3 2016/17
Cancelled or delayed appointments and operations	6 ↓	9 ↓
Clinical Care (Medical/Surgical)	17 ↑	15 ↑
Communication with patient/relative	3 ↓	4 ↓
Attitude of Medical Staff	7 ↑	3 ↓
Attitude of Nursing/Midwifery	0 ↓	1 ↓
Attitude of Admin/Clerical Staff	2 ↓	3 ↓
Clinical Care (Nursing/Midwifery)	4 ↓	6 ↓
Failure to answer telephones	4 ↓	5 ↓

Figure 12: Medicine – formal and informal complaints received

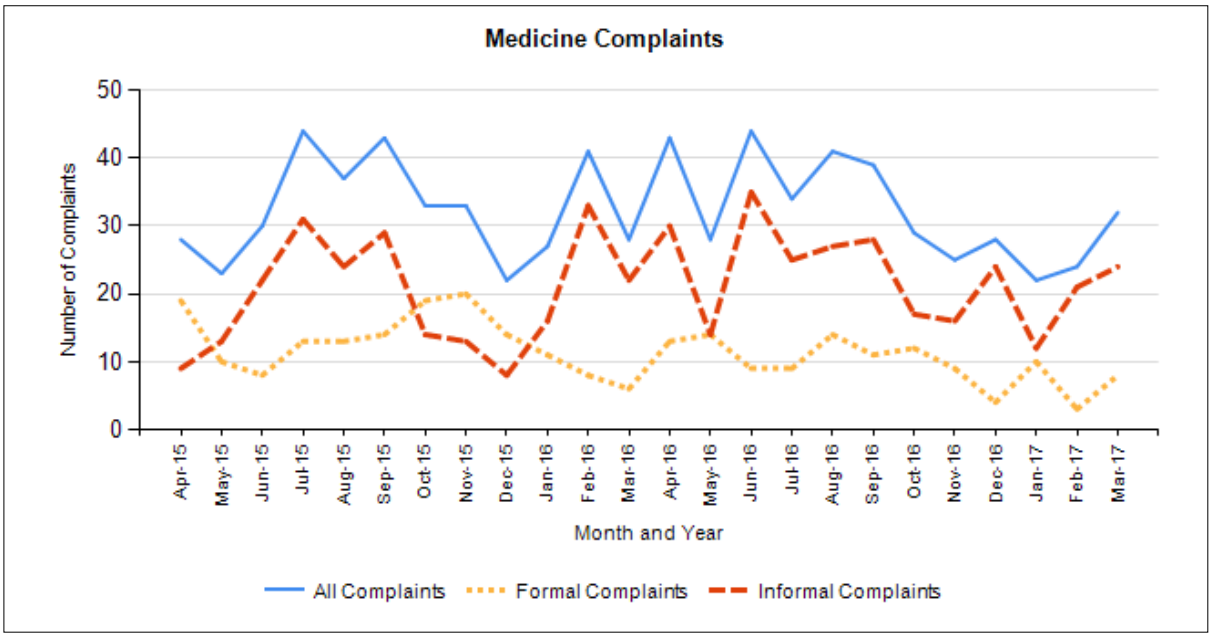
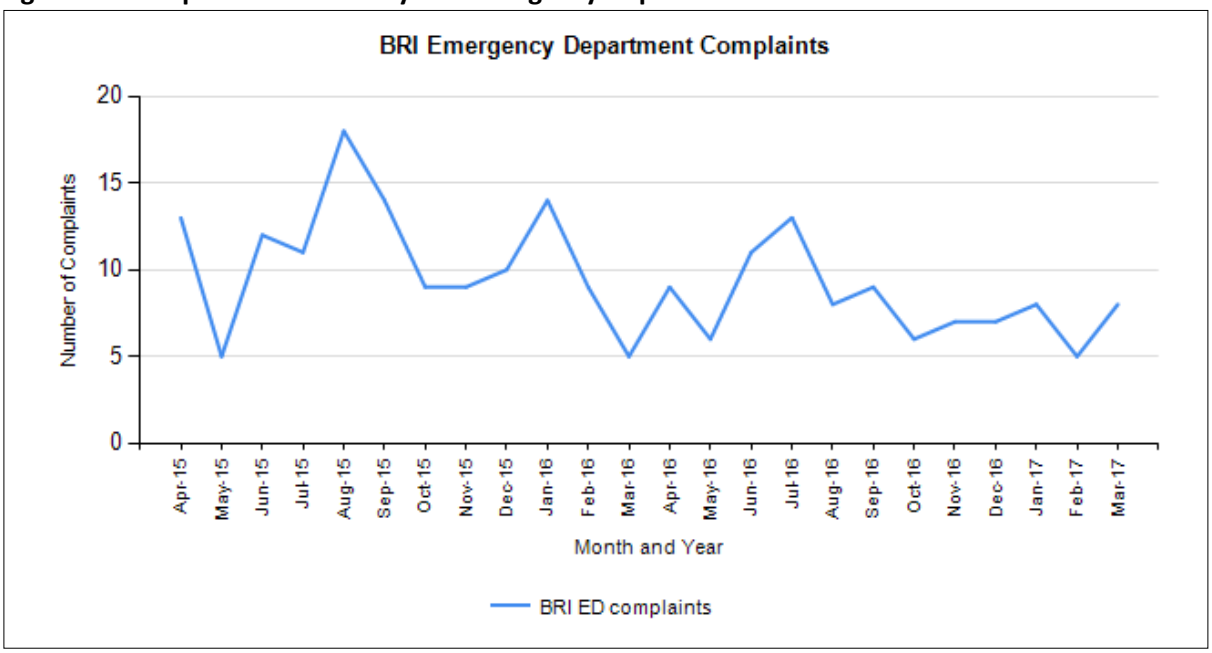


Figure 13: Complaints received by BRI Emergency Department



3.2.3 Division of Specialised Services

In Q4, the Division of Specialised Services experienced a significant increase in complaints from 49 in Q3 to 82 in Q4, including a notable spike in February 2017. This follows a correspondingly large fall in Q3 which suggests we may simply be seeing natural fluctuation in reporting data rather than significant changes in patient experience.

Table 12: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	17 (20.7%) ↑	11 (22.4%) ↓
Attitude & Communication	17 (20.7%) ↑	7 (14.3%) ↓
Clinical Care	35 (42.7%) ↑	21 (43.8%) ↓
Facilities & Environment	1 (1.2%) ↓	2 (4.0%) ↓
Information & Support	7 ↓	4 (8.2%) ↓
Discharge/Transfer/Transport	5 ↓	4 (8.2%) ↓
Documentation	0 =	0 (0%) ↓
Total	**82**	**49**

Table 13: Top sub-categories

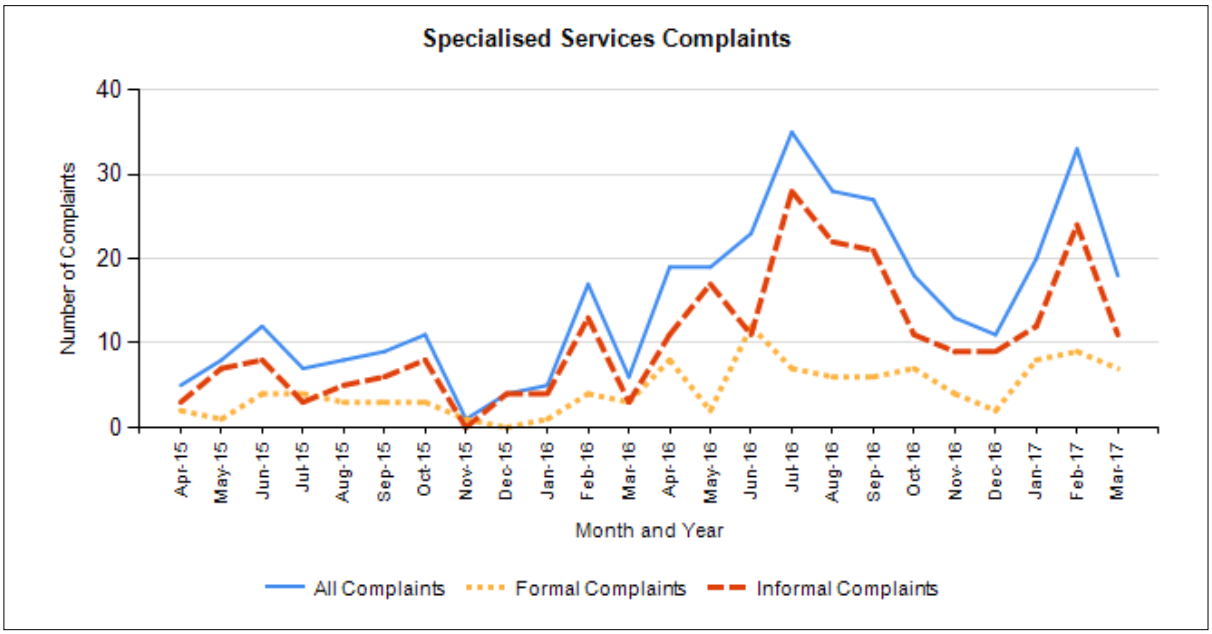
Category	Number of complaints received – Q4 2016/17	Number of complaints Q3
Appointment & Administration Issues	3 =	3
Cancelled or delayed appointments and operations	8 =	8 ↓
Clinical Care (Medical/Surgical)	3 ↓	10 ↓
Communication with patient/relative	5 ↑	3 ↓
Attitude of Medical Staff	3 ↑	2 ↓
Attitude of Nursing/Midwifery	1 ↑	0 ↓
Attitude of Admin/Clerical Staff	0 =	0 ↓
Clinical Care (Nursing/Midwifery)	1 ↓	3 ↓
Failure to answer telephones	7 ↑	0 ↓

Table 14: Divisional response to concerns highlighted by Q4 data

Concern	Explanation	Action
Complaints about the BHI (all) increased in Q4 (41 to 64). The most noticeable increases related to the Outpatients Department 20 (11). 5 (5) complaints related to the Waiting List Office.	Delays in accessing mobile cardiac monitoring systems and in accessing subsequent test results increased within the BHI outpatients department across Q4.	The division has invested in a number of new cardiac monitors to reduce the delays for patients. Further to this, the General Manager is currently reviewing the processes for analysing these tests and communicating these results with the senior medical staff.

	Unexpected staff shortages within the waiting list office led to significant issues with the staff's ability to respond to questions and queries from patients during a period within Q4.	Although action was taken immediately and staff were moved to support the waiting list office, there remained a shortage of staff over a period of time. Short term staffing issues have now been resolved within the department.

Figure 14: Specialised Services – formal and informal complaints received



3.2.4 Division of Women's and Children's Services

In Q4, the Division of Women's and Children's Services received a similar number of complaints to Q3. Complaints about Attitude and Communication rose (up from 15 to 22), however, there were no discernable patterns within this group of complaints.

Table 15: Complaints by category type

Category Type	Number and % of complaints received – Q4 2016/17	Number and % of complaints received – Q3 2016/17
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	15 (22.4%) =	15 (23.4%) ↓
Attitude & Communication	22 (32.8%) ↑	15 (23.4%) =
Clinical Care	27 (40.3%) ↑	23 (35.9%) ↑
Facilities & Environment	1 (1.5%) =	1 (1.6%) ↓
Information & Support	1 (1.5%) ↓	6 (9.4%) ↑
Discharge/Transfer/Transport	0 (0%) ↓	4 (6.2%) ↑
Documentation	1 (1.5%) ↑	0 (0%) ↓
Total	**67**	**64**

Table 16: Top sub-categories

Category	Number of complaints received – Q4 2016/17	Number of complaints received – Q3 2016/17
Cancelled or delayed appointments and operations	8 ↑	7 ↓
Clinical Care (Medical/Surgical)	15 ↑	13 ↓
Communication with patient/relative	6 ↑	2 ↓
Attitude of Medical Staff	6 ↑	5 ↓
Attitude of Nursing/Midwifery	3 =	3 ↓
Attitude of Admin/Clerical Staff	3 ↑	2 ↑
Clinical Care (Nursing/Midwifery)	8 ↑	3 ↓
Failure to answer telephones	1 =	1 =

Figure 15: Women & Children – formal and informal complaints received

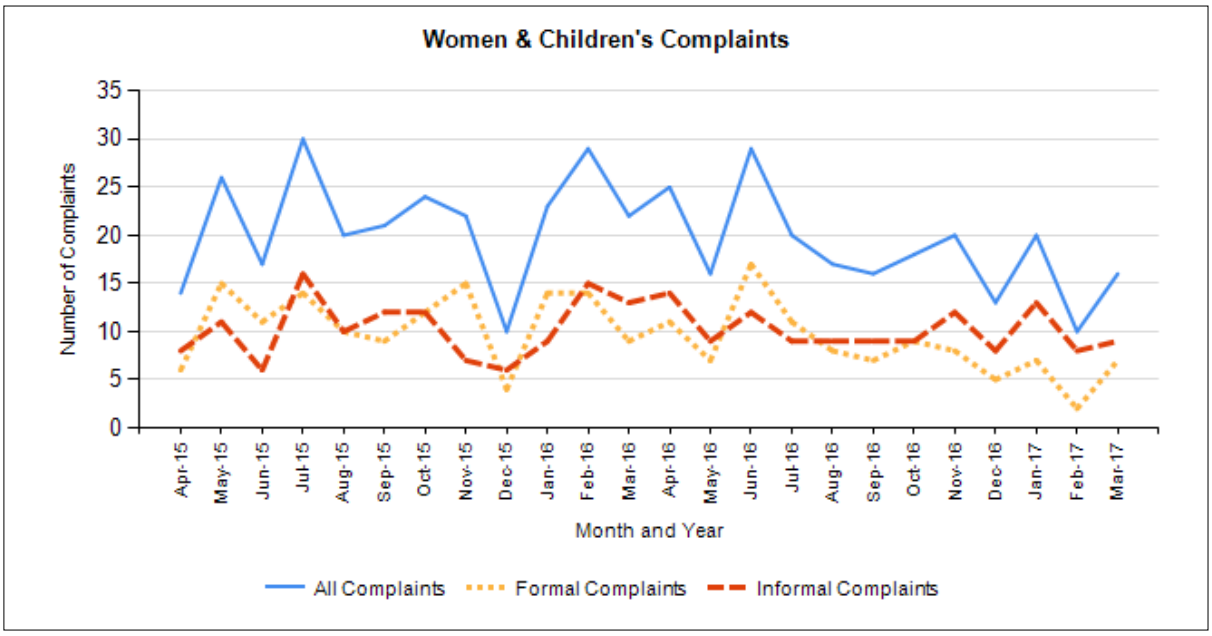
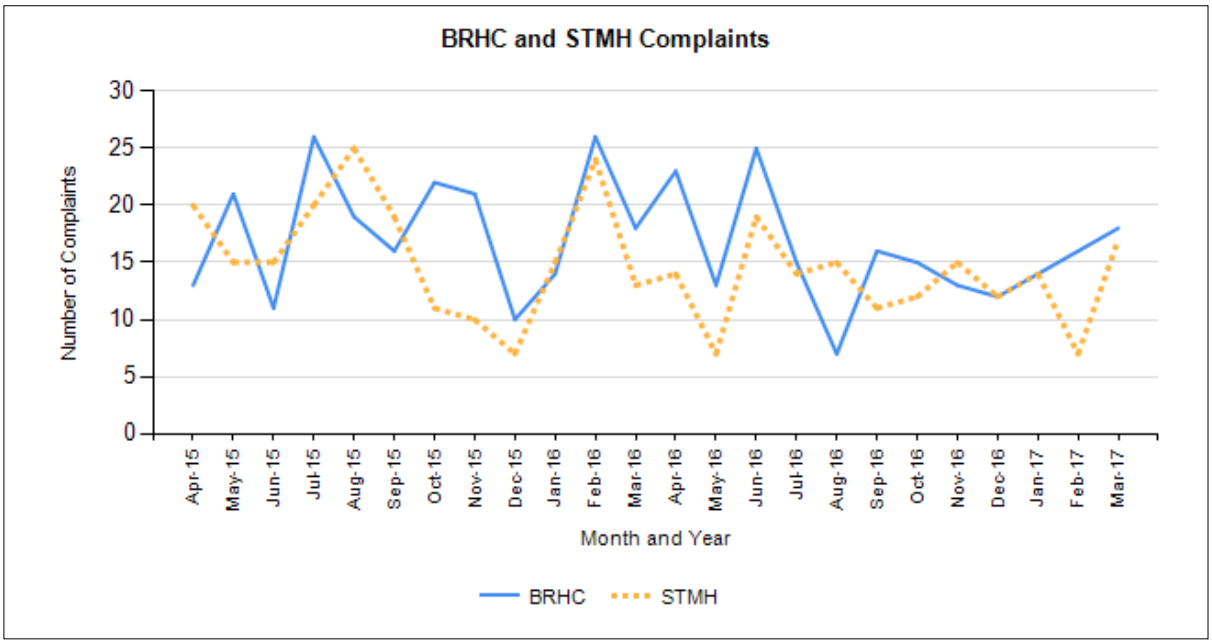


Figure 16: Complaints received by Bristol Royal Hospital for Children and St Michael's Hospital



3.2.5 Division of Diagnostics & Therapies

In Q4, complaints received by the Diagnostics and Therapies Division continued to fall; 11 in Q4, compared to 17 in Q3 and 19 in Q4. In February and March the division received zero formal complaints.

Table 17: Complaints by category type

Category Type	**Number and % of complaints received – Q4 2016/17**	**Number and % of complaints received – Q3 2016/17**
Access	0 (0% of total complaints) =	0 (0% of total complaints) ↓
Appointments & Admissions	7 (63.6%) ↓	11 (64.7%) ↑
Attitude & Communication	2 (18.9%) ↓	3 (17.6%) =
Clinical Care	1 (9%) ↓	2 (11.7%) ↓
Facilities & Environment	0 (0%) =	0 (0%) ↓
Information & Support	0 (0%) ↓	1 (5.9%)
Discharge/Transfer/Transport	1 (9%) ↑	0 (0%) ↓
Documentation	0 (0%) =	0 (0%) =
Total	**11**	**17**

Figure 17: Diagnostics and Therapies – formal and informal complaints received

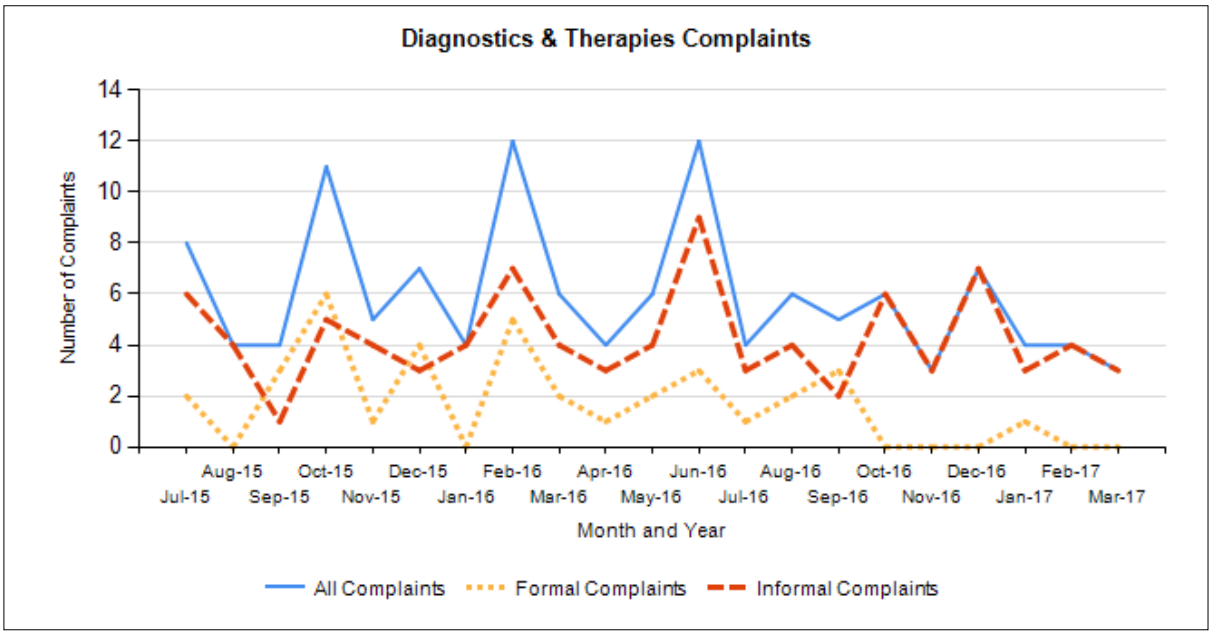
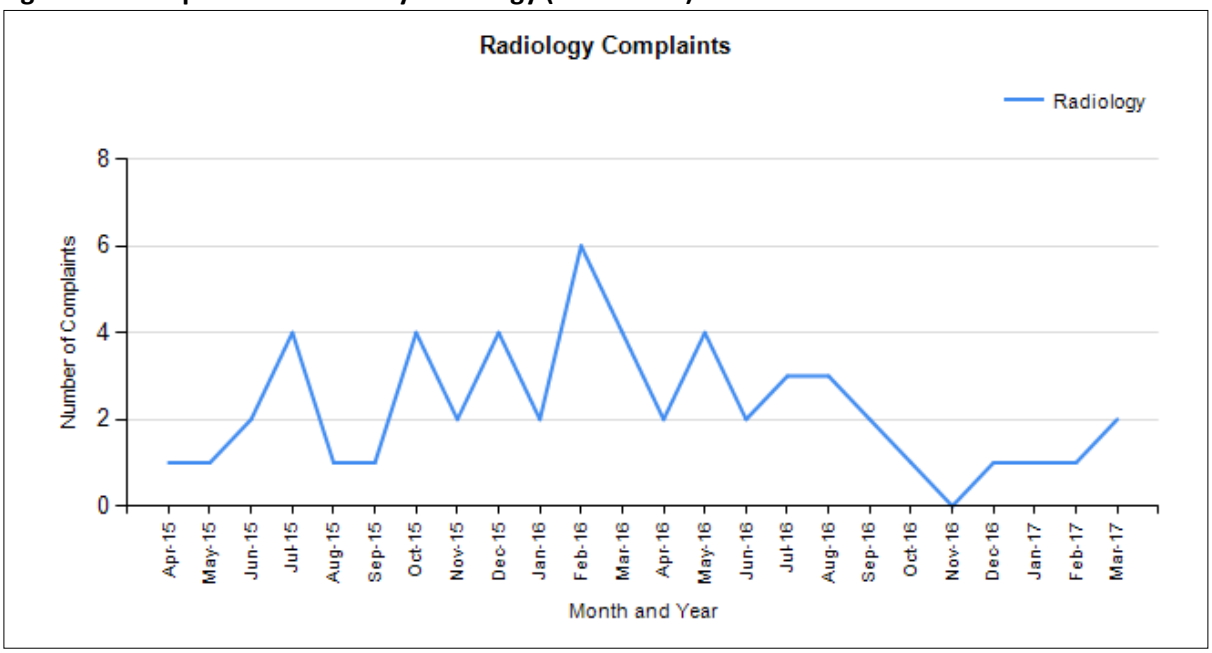


Figure 18: Complaints received by Radiology (Trust-wide)



3.3 Complaints by hospital site

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

Table 18: Breakdown of complaints by hospital site

Hospital/Site	Number and % of complaints received in Q4 2016/17	Number and % of complaints received in Q3 2016/17
Bristol Royal Infirmary (BRI)	164 (37.2%) ↓	178 (44.9%) ↓
Bristol Eye Hospital (BEH)	44 (9.8%) ↑	33 (8.3%) ↓
Bristol Dental Hospital (BDH)	48 (10.9%) ↑	29 (7.3%) ↓
St Michael's Hospital (StMH)	38 (8.6%) ↓	39 (9.8%) ↓
Bristol Heart Institute (BHI)	64 (14.5%) ↑	41 (10.3%) ↓
Bristol Haematology & Oncology Centre (BHOC)	20 (4.5%) ↑	13 (3.3%) ↓
Bristol Royal Hospital for Children (BRHC)	48 (10.9%) ↑	40 (10.1%)
South Bristol Community Hospital (SBCH)	7 (1.6%) ↓	11 (2.8%) ↓
Trust Headquarters	1 (0.2%) ↓	2 (0.5%) ↑
Southmead Hospital (UH Bristol services)	0 (0%) ↓	1 (0.2%) ↑
Central Health Clinic	3 (0.7%) ↑	2 (0.5%) ↓
Car parks	2 (0.4%) =	2 (0.5%)
Community Midwifery Services	1 (0.2%) ↑	0 (0%) ↓
Community Sexual Health	0 (0%) =	0 (0%) ↓
Community Dental Service	1 (0.2%) ↑	0 (0%) =
Other Trust Concerns	0 (0%) ↓	6 (1.5%) ↑
Total	**441**	**397**

Table 19 below breaks this information down further, showing the complaints rate as a percentage of patient activity for each site and whether the number of complaints each hospital site receives is broadly in line with its proportion of attendances. For example, in Q4, the BRI accounted for 30.2% of all attendances and 37.2% of all complaints.

Table 19: Complaints rates by main hospital sites

Site	No. of complaints	No. of attendances	Complaints rate	Proportion of all attendances	Proportion of all complaints
BRI	164	63,467	0.26%	30.2%	37.2%
BEH	44	34,511	0.13%	16.4%	10.0%
BDH	48	23,902	0.20%	11.4%	10.9%
StMH	38	23,728	0.16%	11.3%	8.6%
BHI	64	5,518	1.24%	2.6%	14.5%
BHOC	20	19,496	0.10%	9.3%	4.5%
BRHC	48	32,176	0.15%	15.3%	10.9%
SBCH	7	7,895	0.09%	3.8%	1.6%
Other	8				
Total	**441**	**210,333**			

Figures 19 and 20 below show that the Bristol Royal Infirmary consistently receives more complaints than other UH Bristol sites, measured in terms of total complaints received. However the Bristol Heart Institute receives more complaints than other sites when measured as a proportion of patient attendances. Reasons for this longstanding difference at the BHI continue to be explored, one hypothesis being that this may be statistical artefact of a different inpatient to outpatient activity ratio (inpatients are statistically more likely to make a complaint than outpatients). However patient feedback scores for the BHI (reported in the Trust's quarterly Patient Experience & Involvement report) are positive; we therefore do not believe that the pattern of complaints is a reflection of poor patient experience per se.

Figure 19: Complaints received by hospital site

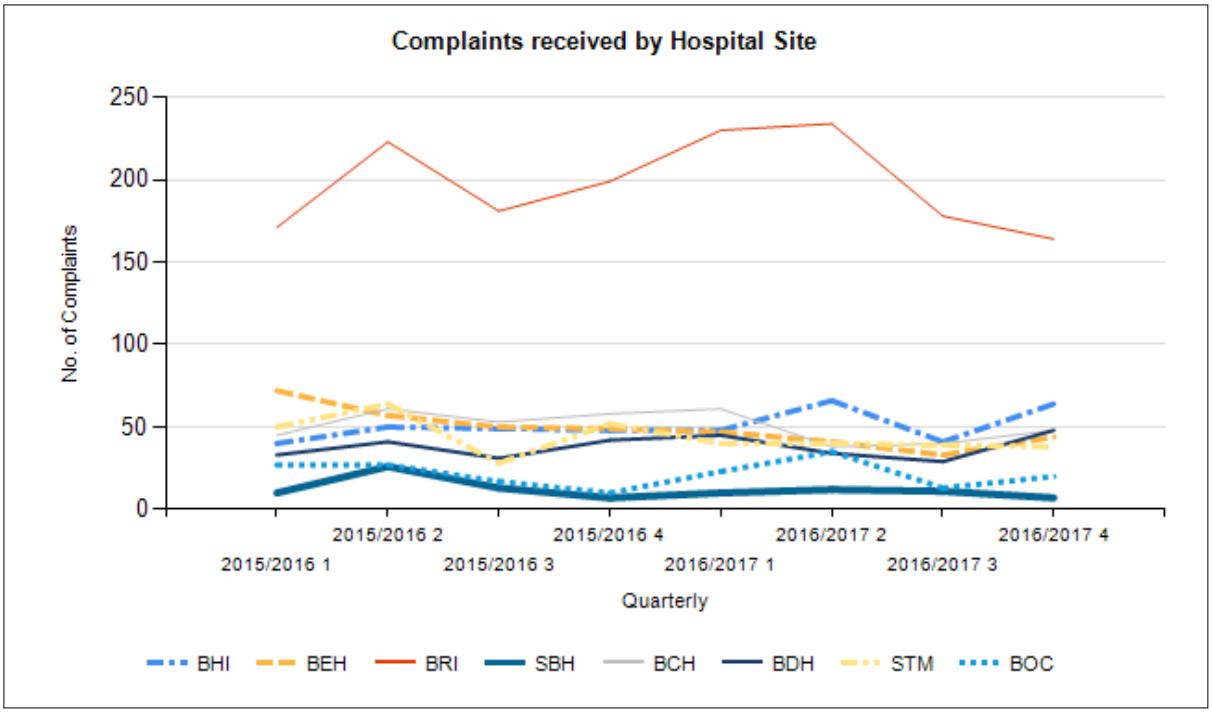
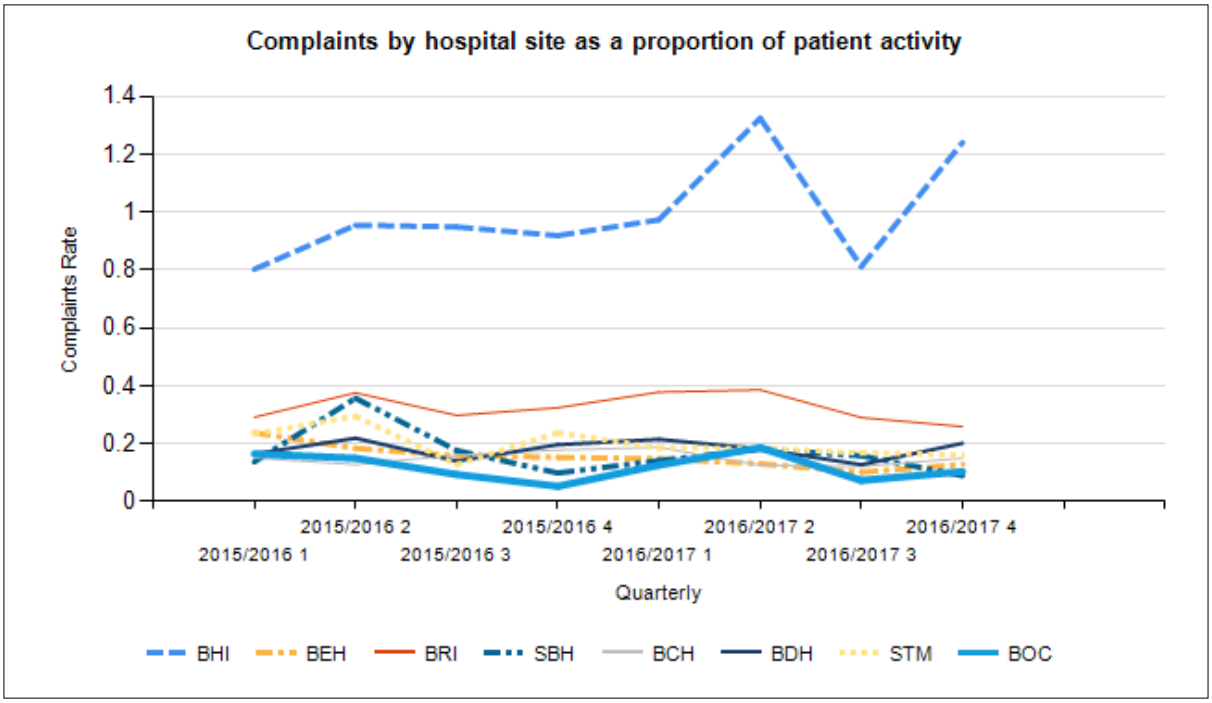


Figure 20 – Complaints rate by hospital site as a proportion of patient activity



3.4 Complaints responded to within agreed timescale

The Divisions of Surgery, Head and Neck, Medicine, Specialised Services and Women and Children reported breaches in Q4, totalling 19, which is an increase on the eight breaches recorded in Q3.

Table 20: Breakdown of breached deadlines

Division	Q4 (2016/17)	Q3 (2016/17)	Q2 (2016/17)	Q1 2016/17
Surgery, Head & Neck	7 (14.3%)	1 (0.69%)	0 (0%)	6 (14.6%)
Medicine	4 (15.4%)	0 (0%)	4 (11.1%)	12 (36.4%)
Specialised Services	2 (6.4%)	4 (8.9%)	1 (4.5%)	2 (15.4%)
Women & Children	6 (24%)	3 (4.7%)	5 (16.7%)	12 (30.8%)
Diagnostics & Therapies	0 (0%)	0 (0%)	0 (0%)	2 (18.2%)
Trust Services	0 (0%)	0 (0%)	2 (66.7%)	0 (0%)
All	**19 breaches**	**8 breaches**	**12 breaches**	**34 breaches**

(So, as an example, there were seven breaches of timescale in the division of Medicine in Q4, which constituted 15.4% of the complaints responses which had been due in that division in Q4).

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

Table 21: Source of delays

	Source of delays in Q4 2016/17				Totals
	Division	**PSCT**	**Executive sign-off**	**Other**	
Surgery, Head & Neck	3	2	2	0	**7**
Medicine	1	2	1	0	**4**
Specialised Services	2	0	0	0	**2**
Women & Children	3	1	2	0	**6**
Diagnostics & Therapies	0	0	0	0	**0**
Trust Services	0	0	0	0	**0**
All	**9**	**5**	**5**	**0**	**19 breaches**

Ongoing actions to improve the quality of responses and reduce the number of breaches include have been described in previous quarterly reports.

3.5 Outcome of formal Complaints

In Q4 we responded to 136 formal complaints[5]. Table 22 below shows a breakdown, by Division, of how many cases were upheld, partially upheld or not upheld.

Table 22: Outcome of formal complaints

	Upheld	Partially Upheld	Not Upheld
Surgery, Head & Neck	3	31	12
Medicine	3	21	2
Specialised Services	1	26	4
Women & Children	2	17	6
Diagnostics & Therapies	0	1	1
Trust Services	0	3	1
Total	**9**	**99**	**28**

4. Information, advice and support

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

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

In Q4, the team dealt with 193 such enquiries, compared to 151 in Q3. These enquiries can be categorised as:

- 142 requests for advice and information (117 in Q3)
- 47 compliments (34 in Q3)[6]
- 4 request for support (1 in Q3)

The table below shows a breakdown of the 142 requests for advice, information and support dealt with by the team in Q4.

Table 23: Enquiries by category

Category	Number of enquiries
Hospital information request	42
Information about patient	24
Signposting	12
Appointments administration issues	12
Clinical care	9
Medical records requested	7
Clinical information request	3

[5] Note: this is different to the number of formal complaints we *received* in the quarter
[6] This figure includes compliments added directly to the Datix system by Divisions.

Accommodation enquiry	3
Transport request	2
Employment and volunteering	2
Communication with patient/relative	2
Benefits and social care	2
Personal property	2
Patient choice information	2
Failure to answer phone	2
Admissions arrangements	2
Delayed operation	2
Freedom of information request	1
Support with access	1
Confidentiality	1
Aids and appliances	1
Cancelled appointments	1
Car park	1
Delayed procedure	1
Delayed treatment	1
Diagnosis incorrect	1
Lost/misplaced test results	1
Disability Support	1
Family support referral	1
Total	**142**

In addition to the enquiries detailed above, in Q4 the Patient Support and Complaints team recorded 167 enquiries that did not proceed. This is where someone contacts the department to make a complaint but does not leave enough information to enable the team to carry out an investigation, or they subsequently decide that they no longer wish to proceed with the complaint.

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

One of the Key Performance Indicators (KPIs) used to monitor the performance of the Patient Support and Complaints Team is the length of time between receipt of a complaint and sending an acknowledgement.

The Trust's Complaints and Concerns Policy states that when the Patient Support and Complaints Team reviews a complaint following receipt:

- a risk assessment will be carried out;
- agreement will be reached with the complainant about how we will proceed with their complaint and a timescale for doing so;
- The appropriate paperwork will be produced and sent to the Divisional Complaints Coordinator for investigation; and
- An acknowledgement letter confirming how the complaint will be managed will be sent to the complainant.

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

that complaints made orally (via the telephone or in person) will be acknowledged within two working days.

In Q4, 261 complaints were received in writing (email, letter or complaint form) and 180 were received orally (44 in person via drop-in service and 136 by telephone). Of the 180 oral complaints, 175 (97.2%) met the Trust's standard of being acknowledged within two working days. Of the 261 complaints received in writing, 246 (94.3%) met the NHS standard of being acknowledged within three working days (the remaining 15 cases were all acknowledged within four working days). Overall compliance in Quarter 4 was therefore 96.6% (426/441).

The reasons why 15 cases submitted in writing missed the NHS standard have been investigated. Although the Patient Support and Complaints Team ensure that an acknowledgement letter is sent for all complaints received in writing, it has become apparent that when a complaint letter or email has been forwarded to the team via another department in the Trust or if the Trust has received website feedback raising a complaint, these complaints have not been directly acknowledged by the complainant. Processes have now been put in place to ensure that all written complaint communications receive an acknowledgement letter or email.

6. PHSO cases

During Q4, the Trust was advised of new Parliamentary and Health Service Ombudsman (PHSO) interest in two complaints. During the same period, one existing case was closed (the Trust was removed from the investigation). As of 31 March 2017, the PHSO had ongoing interest in five other UH Bristol complaints, as detailed below.

Table 24: Complaints opened by the PHSO in Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
3604	GV	PV	16/9/16 [17/1/17]	BRI/St Michael's	Lower GI/Ward 78	Surgery, Head & Neck and Women and Children
Copy of complaint file and medical records sent to the PHSO. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						
2870	AM	PM	3/11/16 [7/3/17]	BHOC	Ward D603	Specialised Services
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						

Table 25: Complaints ongoing with the PHSO during Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
2095	NH	MH	16/6/16 [26/10/16]	BRI	Lower GI	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO. Pending further contact from the PHSO.						
3983	AG	LCY	29/9/15 [7/9/16]	BRI	Trauma and Orthopaedics	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						
4841	AJ		9/11/15 [30/9/16]	BEH	Outpatients	Surgery, Head and Neck
Copy of complaint file and medical records sent to the PHSO on 17 November 2016. Currently awaiting PHSO response.						
17173	DF	DJ	29/10/14 [21/9/15]	BDH	Adult Restorative Dentistry	Surgery, Head & Neck
Currently awaiting further contact from the PHSO.						
18856	SC	VP	22/5/15 [15/2/16]	BRI	Ward B501	Medicine
Information relating to this case was most recently submitted to the PHSO in July 2016. The PHSO have advised the Trust that their draft decision is not to uphold this complaint. Pending the PHSO's final report.						

Table 26: Complaints formally closed by the PHSO in Q4

Case Number	Complainant (patient unless stated)	On behalf of (patient)	Date complaint received by Trust [and date notified by PHSO]	Site	Department	Division
984	MR		24/3/16 [27/2/17]	BEH	Administration	Surgery, Head and Neck
The PHSO advised the Trust on 27 March 2017 that they have decided to remove the Trust from this complaint and will be liaising directly with Royal Cornwall Hospitals NHS Trust. No further action required by the Trust.						

University Hospitals Bristol
NHS Foundation Trust

Quarterly Patient Experience and Involvement Report

Incorporating current Patient and Public Involvement activity and patient survey data received up to Quarter 4 2016/17

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

Patient Experience and Involvement Team

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

Successes	Priorities
• Consistently high service-user satisfaction scores were achieved in Quarter 4. For example, 98% of inpatients would recommend the care to their friends and family • The Trust met all of its Friends and Family Test response rate targets in Quarter 4 • Praise for UH Bristol staff remains by far the most frequent form of feedback received from patients	For 2017/18, the Trust has been set a 6% response rate target for the outpatient Friends and Family Test by the Bristol Clinical Commissioning Group. To achieve this it will be necessary to survey in the region of 20,000 outpatients *per month*. An options appraisal supported the introduction of a proactive SMS (text message) based approach, operating alongside existing feedback methods (e.g. card, e-kiosk, online and telephone). The new SMS survey commenced in April 2017. The response rate for April did not meet the target (3.5%, up from 1.9% in March), but this was primarily because a number of days were "lost" due to bank holidays and a relatively late start to the survey whilst operational details were finalised. The survey went fully live in May 2017 and the target was exceeded during this month (7.6%). This survey process will continue to be evaluated / refined so that it consistently delivers the required response rate.
Opportunities	**Risks & Threats**
• Trust funding has been secured to deliver a real-time feedback system at UH Bristol. The system will have the ability to collect feedback and send email alerts where a respondent states that they require a response. The system will also serve as a reporting hub for staff to better utilise the wealth of feedback that is already collected in the Trust. A formal procurement process will take place over the summer of 2017. • A Trust corporate quality objective for 2017/18 will focus on instilling consistently positive "customer service" at UH Bristol. A staff workshop on this theme was successfully held in April, building on a similar stakeholder event in January. The outcomes from these workshops are currently being developed to form specific work streams.	The following wards received relatively low survey scores in Quarter 4 (a full exploration of these results is provided in Section 3 of the current report): • Ward C808 (care of the elderly) had the lowest score across the headline survey measures. It has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this theory, in Quarter 1 the Patient Experience and Involvement Team are carrying out a range of patient / family feedback activities on care of the elderly wards. • Ward A602 (trauma and orthopaedics) had relatively low scores on two key survey measures. This was an unusual result for this ward, further analysis did not identify any specific improvement issues, and the number of complaints actually fell over this period. The most likely explanation at present is that this was a statistical "blip", but the ward Sister has been alerted to the result and the score will continue to be monitored to look for any consistent trend.

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

2.1 Overview

A range of activities are carried out at UH Bristol to ensure that patients and the public influence and shape the services that the Trust provides. There are three broad areas of work in this respect:

- The corporate Patient and Public Involvement (PPI) programme carried out by the Trust's Patient Experience and Involvement Team (principally the Involvement Network, *Face2Face* patient interviews, Patient Experience at Heart staff workshops, and the "15 steps challenge" – see Appendix B for a summary)
- Engagement with partner organisations, principally through the Patient Experience and Involvement Team (e.g. Healthwatch, Patient's Association, local health and social providers)
- Service-level PPI activity

This section of the Quarterly Report provides examples of some of the PPI developments/activity that have recently been carried out.

2.2 Update on current corporate Patient and Public Involvement activity

2.2.1 Quarter 1 focus on care of the elderly wards

A plan of quarterly patient and public involvement themes for 2017/18 was agreed by the Patient Experience Group in December 2016:

- Quarter 1 (April-June 2017): Patient experience in care of the elderly services
- Quarter 2 (July-September 2017): exploring the theme of "customer service"
- Quarter 3 (October-December 2017): providing a positive patient experience to patients with a learning disability
- Quarter 4: "Quality Counts" – informing the Trust's corporate quality objectives for 2018/19

The Quarter 1 focus care of the elderly is well underway. Over 50 patient / family / carer interviews have been carried out by the *Face2Face* interview team. An initial review of feedback from the interviews suggests that experiences of care are positive. A "patient experience at heart" staff workshop has also been carried out to explore the consistent delivery of a positive patient experience in this context. The next stage is to utilise the Trust's Involvement Network for a discussion on this topic. The results of this activity will be analysed in June 2017. A summary of outcomes and resulting actions will be provided in the next Quarterly Patient Experience and Involvement Report.

2.2.2 Customer service

Delivering a consistently positive customer service at UH Bristol is a key theme in the Trust's Quality Strategy (2016-20). In January 2017, the Trust's "Quality Counts" event brought together a range of stakeholders (including the Involvement Network, Healthwatch, and Trust Governors) to discuss customer service in an acute hospital setting. In April 2017 a similar workshop was carried out for UH Bristol staff and was also attended by a customer service expert from the private sector. The outcomes from this work are currently being analysed and will be the subject of a Trust quality improvement objective during 2017/18. In Quarter 2, the Patient Experience and Involvement Team will further explore this topic with patients as part of the focus on customer service (see above).

2.3 Engaging with partner organisations

2.3.1 Translating and interpreting services at UH Bristol

Representatives from the Trust's Patient Experience and Involvement Team attended a stakeholder meeting in March to discuss the provision of British Sign Language interpreting services in hospital. The meeting also included representatives from the Bristol City Council Sensory Impairment team, patient advocates, interpreters, Healthwatch Bristol, North Bristol NHS Trust and Sign Solutions Ltd (who provide British Sign Language interpreters to UH Bristol and North Bristol Trust). A range of issues were discussed that relate to developments being taken forward by the Trust in 2017/18, including:

- Ensuring that patients who require access translating and interpreting services have a flag on their Medway patient record to reflect this need
- Establishing new feedback systems for patients who access language interpreting services
- Exploring the use of video British Sign Language interpreting for use via ward / department iPads

2.3.2 Bristol Clinical Commissioning Group – Respiratory pathway interviews

At the request of the Bristol Clinical Commissioning Group, during May 2017 a member of UH Bristol's *Face2face* volunteer interview team talked to patients in the Trust's respiratory clinics about their experiences of NHS respiritory care. This insight will be used by the Clinical Commissioning Group to inform a new model of respiritory care across Bristol, North Somerset, and South Gloucestershire.

2.3.3 Bristol City Council Overview and Scrutiny Committee visits

Members of the Bristol City Council People's Scrutiny Committee were invited by the Trust to visit the paediatric cardiac service (in February 2017) and the Bristol Eye Hospital (April 2017). These visits offer committee members a further understanding of how UH Bristol functions, in order to support their scrutiny role over local health and social care services. The Trust was thanked by the visiting members for being proactive in providing these opportunities and the insight that they provide.

2.4 Service-level Patient and Public Involvement activity

2.4.1 Hospital food / food service staff workshop

In March, 38 staff from a range of roles attended a Nutrition and Hydration Study day at the Trust. The morning of the workshop explored how patient experience during mealtimes could be improved, including around breakfast provision and ensuring protected mealtimes are adhered to. The afternoon session focused on learning about different special dietary needs patients may have. This included a visit from the Trust Iman, Rafiqul Alam, who talked to the group about the religious basis for the Halal diet and heard about how the Trust ensures that patients can follow a Halal diet in hospital.

2.4.2 Spiritual and Pastoral Care Strategy

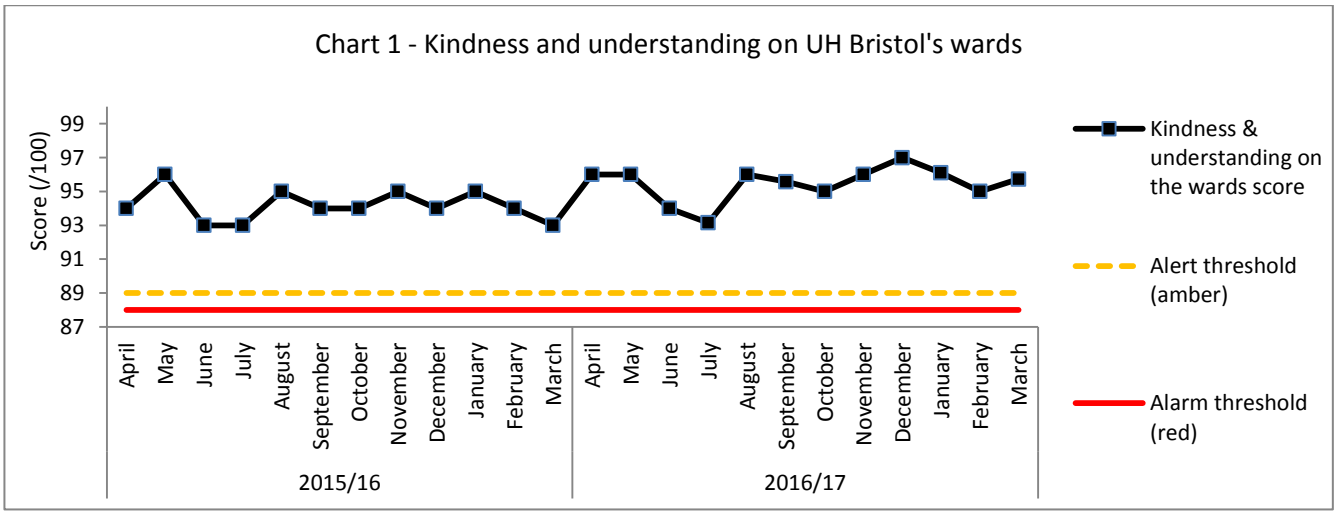
The Spiritual and Pastoral Care Team ("Chaplaincy") play a key role in the delivery of a positive patient, visitor and staff experience at UH Bristol. In April 2017, the Trust's Patient and Public Involvement Lead facilitated focus groups with Chaplains and Volunteer Chaplains across UH Bristol and North Bristol NHS Trust, to explore their aspirations for spiritual and pastoral care and inform the development of a new strategy. Further discussions are planned with matrons and sisters to explore the role of spiritual care within our hospitals.

3. Patient survey data to Quarter 4

3.1 Trust-level patient reported experience

The Trust's Patient Experience and Involvement Team is also responsible for measuring patient-reported experience, primarily via the Trust's patient survey programme[1]. This ensures that the quality of UH Bristol's care, as perceived by service-users themselves, can be monitored on an ongoing basis to ensure that high standards are maintained. It should be noted that the postal survey methodology changed in April 2016, to provide the data a month earlier than had previously been the case: this appears to have had a marginally positive effect on the scores, so caution is needed in directly comparing 2016/17 data with previous years[2]. The key messages from Quarter 4 are:

- All of the UH Bristol's Trust-level patient survey measures remained above target - demonstrating the continued provision of a high quality patient experience (Charts 1-6).
- UH Bristol has a contractual obligation with the Bristol Clinical Commissioning Group to meet specified Friends and Family Test response rate targets. In Quarter 4 the Trust continued to meet these targets (Charts 7-9). There was an improvement in the response rate for the inpatient and day case element of this survey during Quarter 4 (Chart 7), having only just been meeting the 30% target in Quarter 3.
- As noted in previous Quarterly Reports, it has not been possible to set a target FFT score for the Emergency Department Friends and Family Test so far in 2016/17 (Chart 5). This is because of the trialling of different approaches to collecting feedback in this setting, including cards, touchscreen and more recently SMS (text message). These methods have varying effects on the score, which made it difficult to set an appropriate minimum target score. However, from Quarter 1, a target threshold will be put in place and this will be reported from the next Quarterly Patient Experience and Involvement Report.



[1] A description of the key Trust surveys is provided in Appendix B. The headline metrics that are used to track patient-reported experience are: being treated with kindness and understanding, the inpatient and outpatient trackers (which combine several scores across the surveys relating to cleanliness, respect and dignity, communication, and waiting times), and the Friends and Family Test score. The postal survey target thresholds are set to detect a deterioration of around two standard deviations below the Trust's average (mean) score, so that these measures can act as an "early warning" if the quality of patient experience significantly declines, and action can be taken in response.

[2] In light of these increases in the scores, a review of the target thresholds has taken place and the minimum target thresholds will be increased from 2017/18. It is important to note that in survey terms these effects are marginal: even discounting the inflationary effect of these changes, at a Trust level we would not be scoring below our target levels. The effects at Divisional and site level will be more marked and we will need to evaluate the application of the thresholds below Trust level.

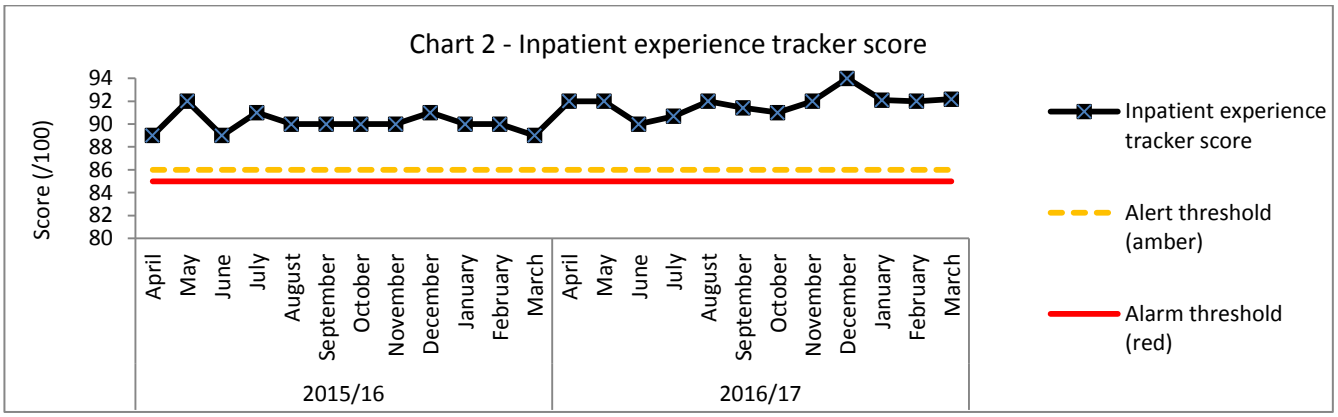


Chart 2 - Inpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
Inpatient experience tracker score
Alert threshold (amber)
Alarm threshold (red)

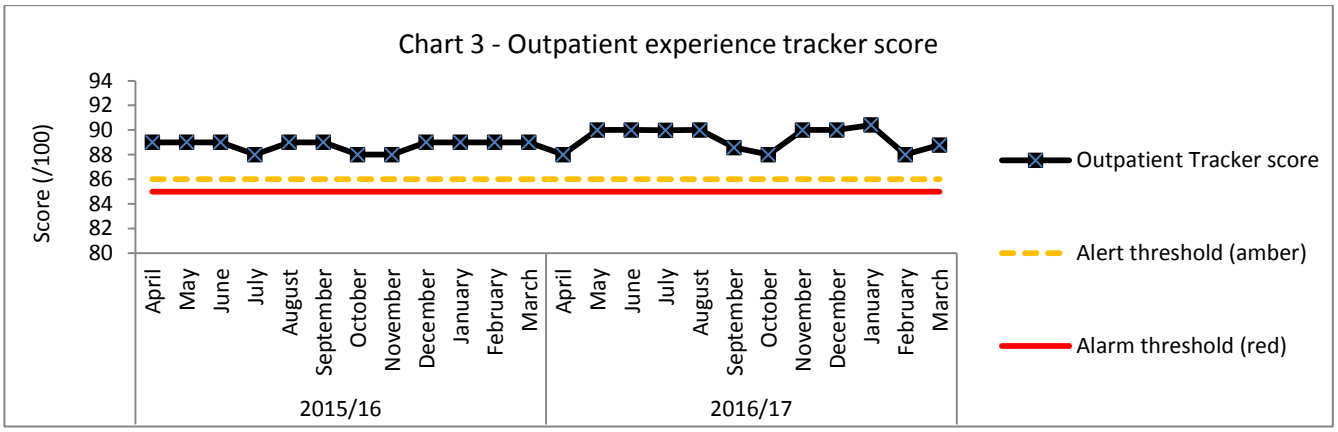


Chart 3 - Outpatient experience tracker score
Score (/100)
94
92
90
88
86
84
82
80
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
Outpatient Tracker score
Alert threshold (amber)
Alarm threshold (red)

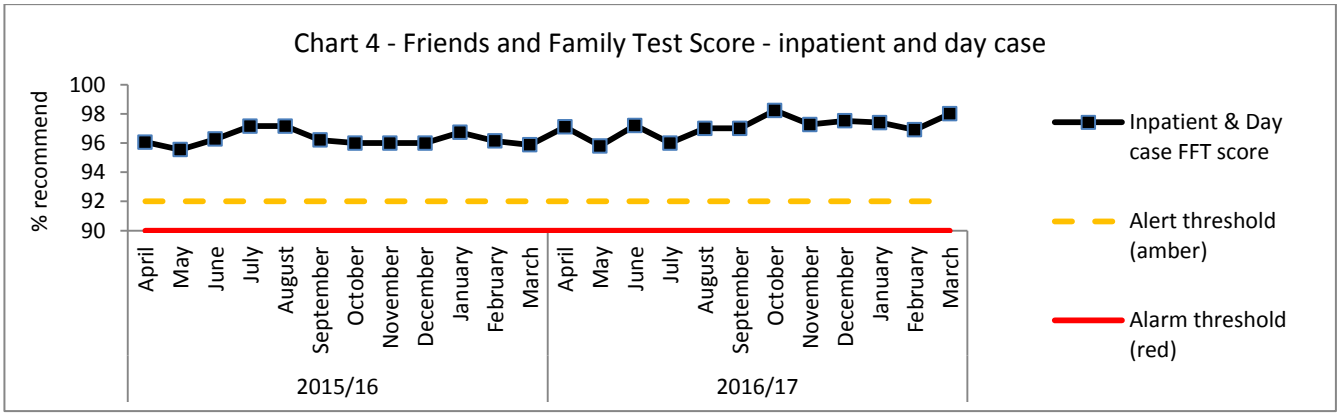


Chart 4 - Friends and Family Test Score - inpatient and day case
% recommend
100
98
96
94
92
90
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
Inpatient & Day case FFT score
Alert threshold (amber)
Alarm threshold (red)

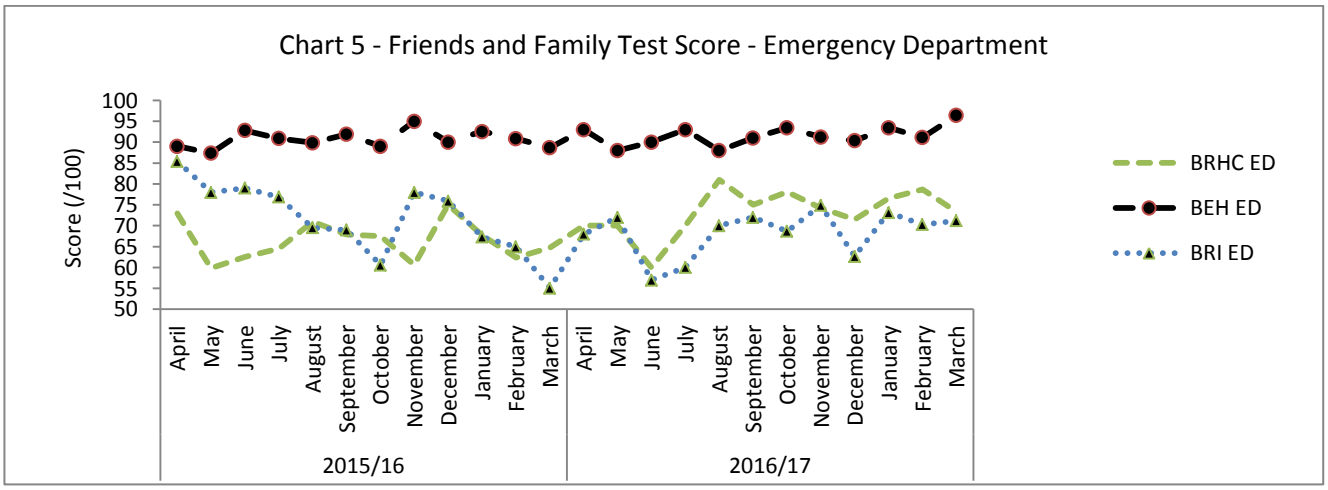


Chart 5 - Friends and Family Test Score - Emergency Department
Score (/100)
100
95
90
85
80
75
70
65
60
55
50
April
May
June
July
August
September
October
November
December
January
February
March
2015/16
2016/17
BRHC ED
BEH ED
BRI ED

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

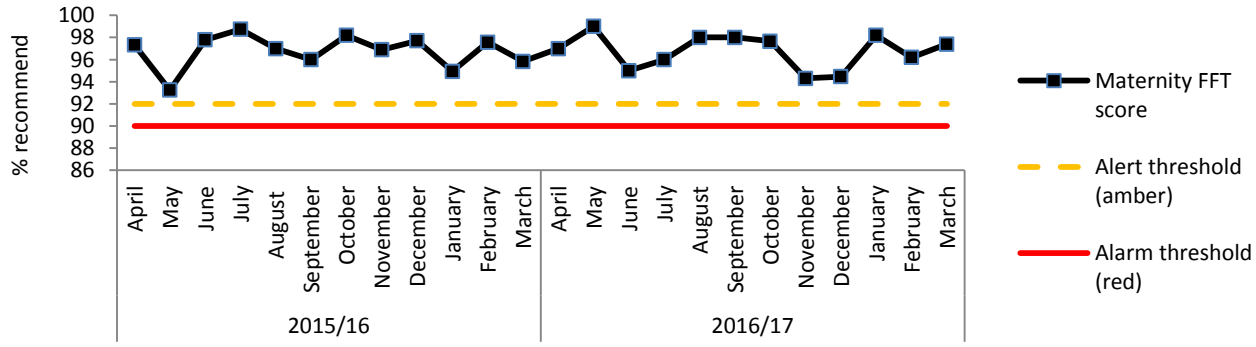


Chart 7: Friends and Family Test Response Rates (inpatient and day case) 2015/16

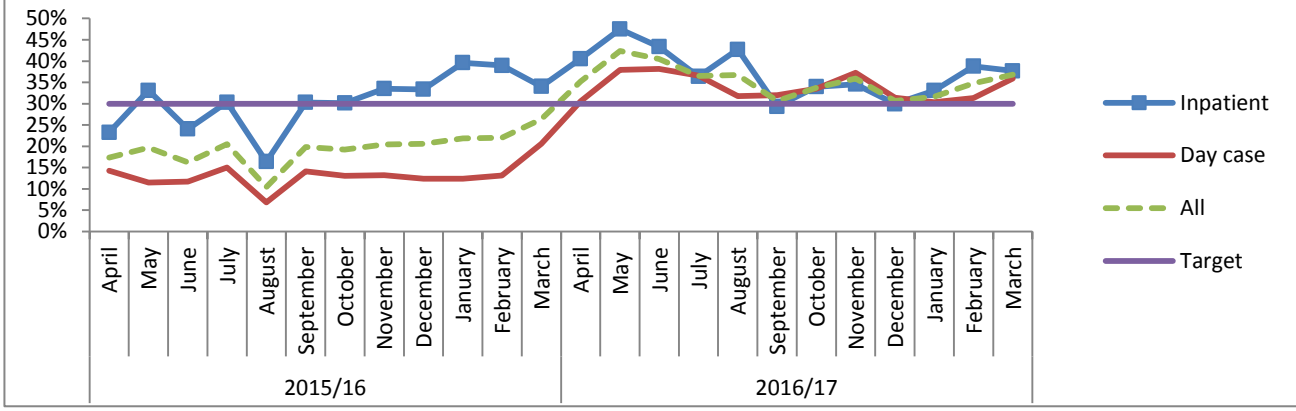


Chart 8: 2015 /16 Friends and Family Test Response Rates (maternity combined)

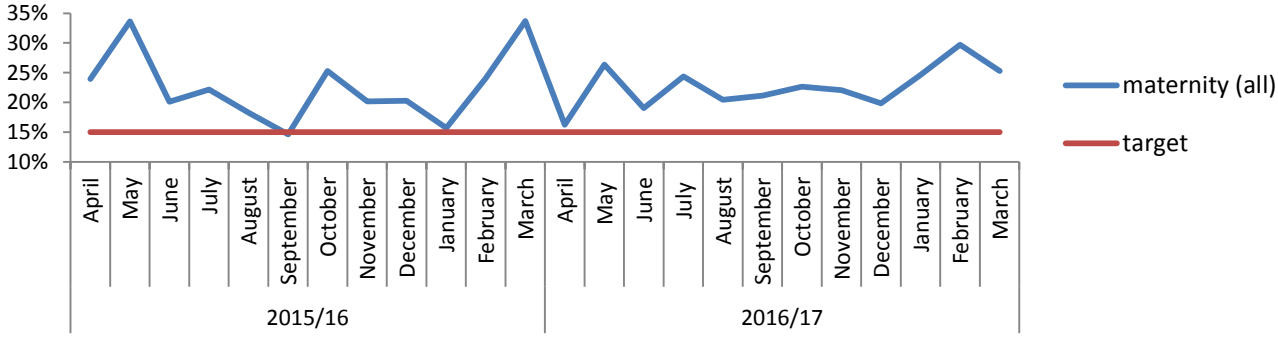
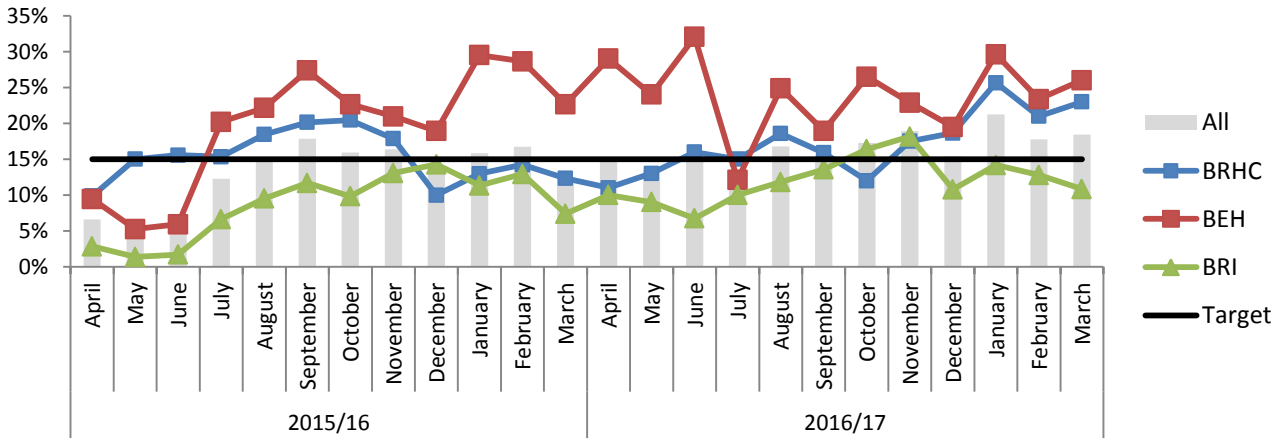


Chart 9: 2015/16 Friends and Family Test Response Rates (Emergency Departments)



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3.2 Survey scores at Division, hospital and ward level

Charts 10-20 provide a view of patient-reported experience at UH Bristol, from a Division to ward-level. The margin of error gets larger as the data is broken down and so the Trust alert / alarm threshold shown on the charts is only a guide at this level (at a ward level in particular it becomes important to look for consistent trends across more than one of the survey measures). The full Divisional-level inpatient and outpatient survey question data is provided in Tables 1 and 2 (pages 12-14).

None of the Divisional or hospital level scores were below the minimum target level in Quarter 4. At a ward-level (Charts 18-20), there are two negative outliers across the headline measures:

- Ward C808 (care of the elderly, Division of Medicine): in Quarter 4, ward C808 had the lowest score across all of our headline measures. Whilst the ward-level scores can fluctuate considerably between quarters, it has been a consistent feature of the survey data that care of the elderly areas tend to attract lower patient experience scores. This has led to additional analysis and exploration of the data, which suggests that the scores are a realistic reflection of the challenges of caring for patients (and being a patient / carer) in this setting - rather than a reflection of the quality of care being provided. To further test this idea, in Quarter 1 the Patient Experience and Involvement Team are focusing on care of the elderly wards (see Section 2 above). Initial analysis of this feedback is very positive, but a more detailed review of this data will be carried out in June 2017. An update will be provided in the next Quarterly Report.
- Ward A602 (trauma and orthopaedics) had a relatively low survey score on two key measures (the inpatient tracker and kindness and understanding). This was an unusual result for this ward and further analysis did not identify any specific improvement issues. The Division of Surgery, Head and Neck have reviewed this result / analysis, but it did not correlate it with other quality data for Quarter 4. The most likely explanation at present is that this was as statistical “blip”, but the ward Sister has been alerted to the scores and they will continue to be monitored to look for any consistent trend (in Quarter 1 to date, the April and May 2017 scores have reverted to being within the expected range).

The Division of Medicine has two relatively low scores around inpatient communication themes in Table 1 (explaining operations / procedures and being told who to contact after leaving hospital). As noted in previous Quarterly Reports, this result has been difficult to account for, besides the possibly of it being related to the trend for relatively lower “involvement” and “communication” scores seen for this Division (see above re: ward C808). For this reason, communication is a key theme in the Trust’s focus on patient experience in the care of the elderly wards being carried out in Quarter 1. Learning from this will be shared with the wards and Division.

A cluster of low survey scores are present in the outpatient survey data (Table 2), relating to ensuring patients are kept informed about delays in clinic, either via a member of staff or an information board (ideally both). The Trust recognises these issues and ensuring that patients are kept informed of delays was a corporate quality objective for 2016/17. There have been demonstrable actions to improve this score, for example standardised clinic information boards have now been implemented in a large number of outpatient departments. But it has proved very difficult to move the score and in effect it stayed static over the year. This quality objective will therefore be carried over to 2017/18. It should be noted that whilst the Diagnostics and Therapies Division doesn’t generally have information boards in place (hence their particularly low survey score on this question), relatively few of their patients report delays in clinic.

The Bristol Royal Hospital for Children has a relatively low score on whether parents / patients are offered a choice of outpatient appointment time (Table 2). Many appointments are currently sent straight out in the post without a choice being given, but a new “partial booking” system will shortly commence at the hospital in a number of areas, which should have a positive impact on this score.

Chart 10 - Kindness and understanding score - Last four quarters by Division (with Trust-level alarm limit)

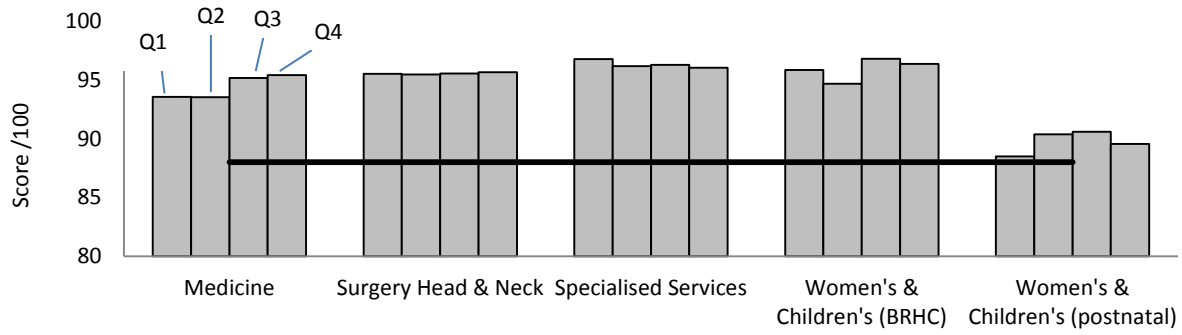


Chart 11 - Inpatient experience tracker score - Last four quarters by Division (with Trust-level alarm limit)

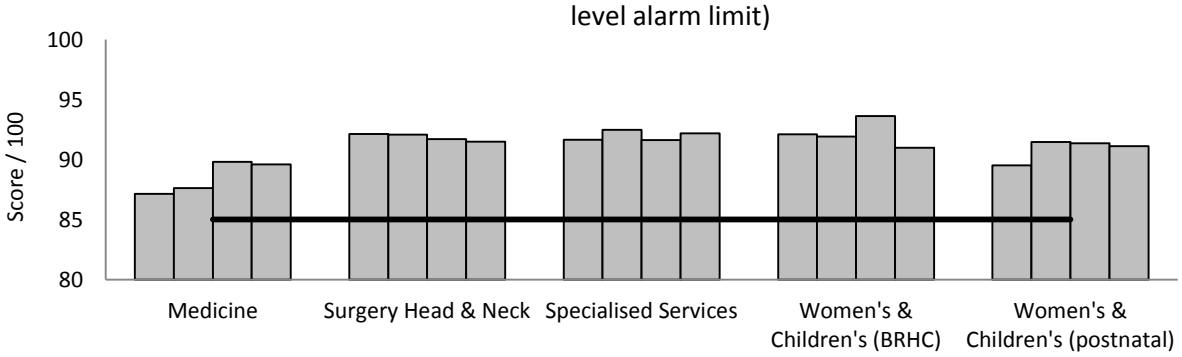


Chart 12 - Inpatient Friends and Day Case Family Test score - last four quarters by Division (with Trust-level alarm limit)

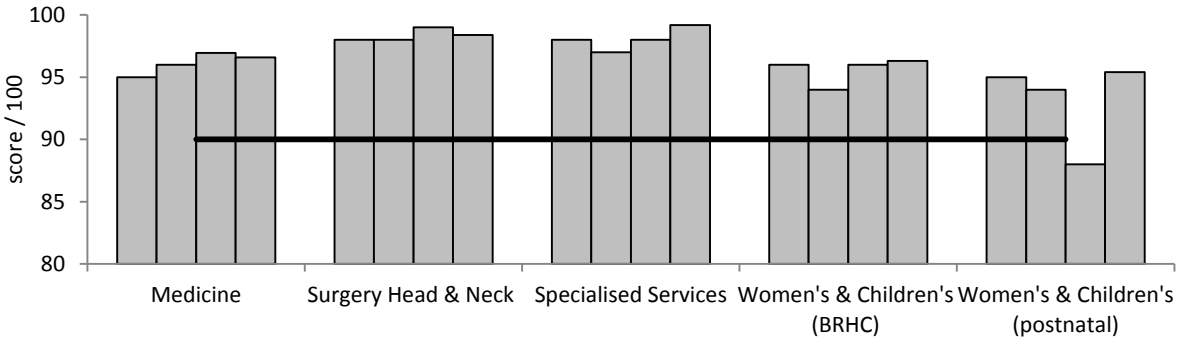
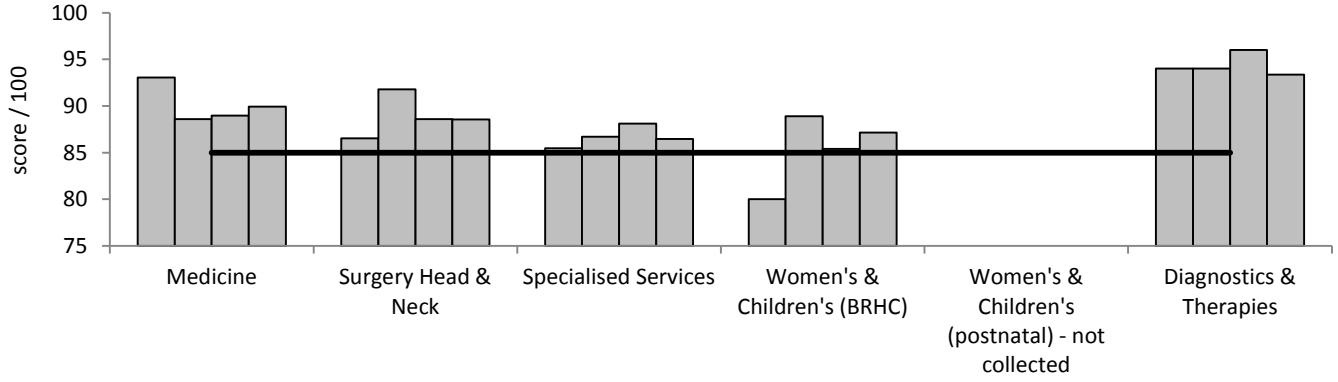
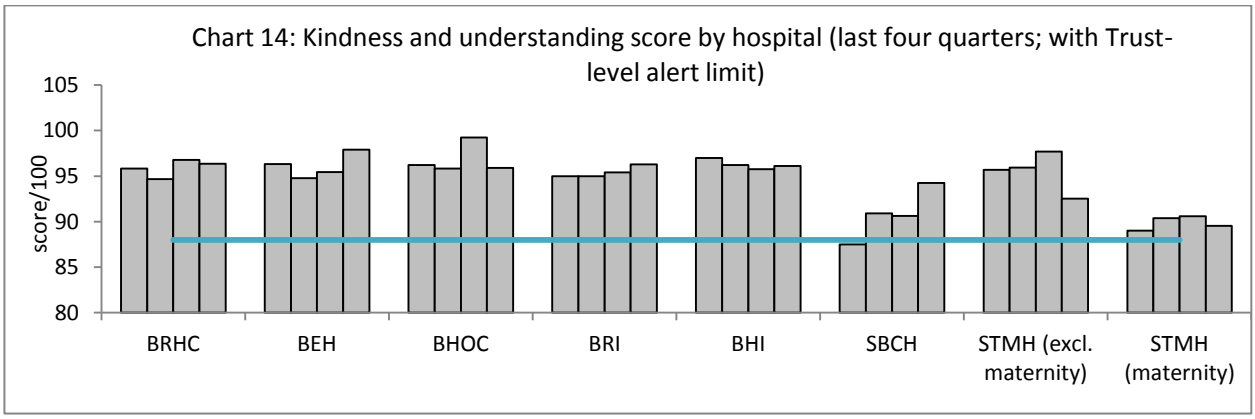
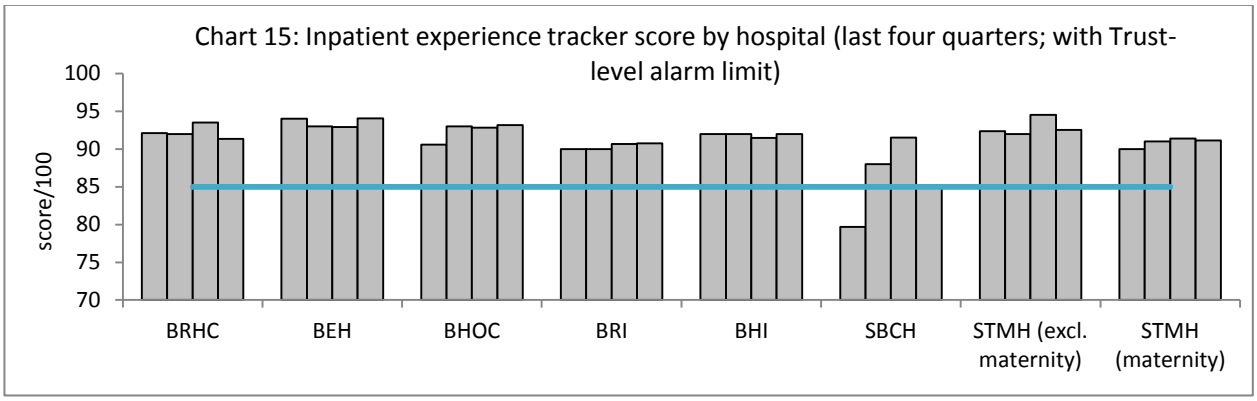
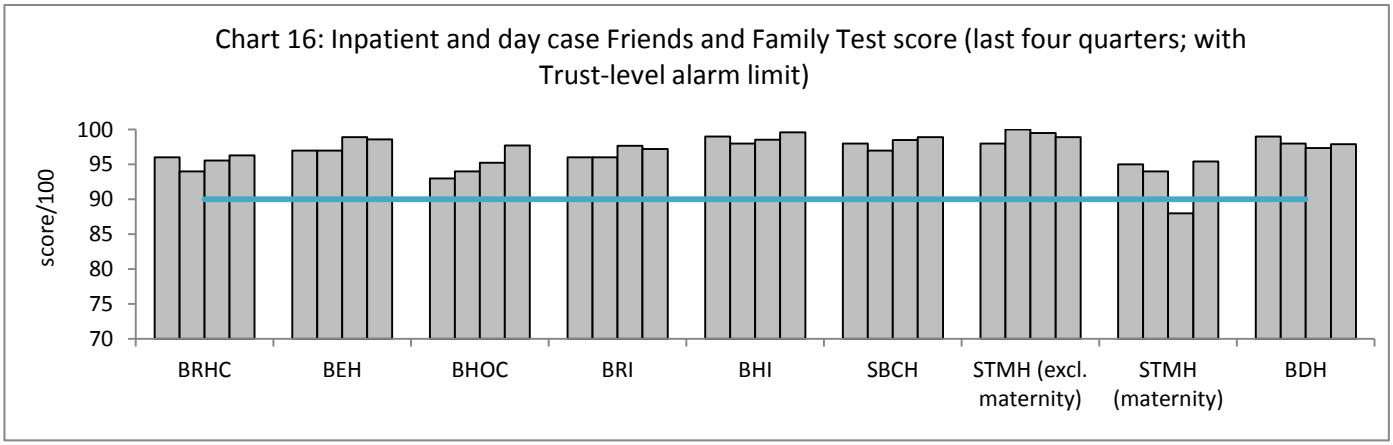


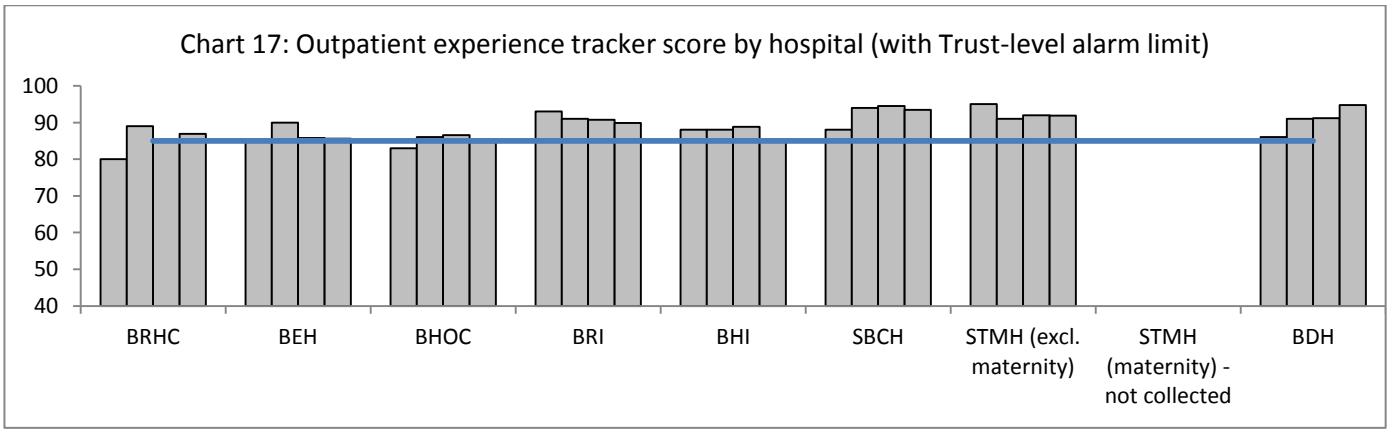
Chart 13 - Outpatient experience tracker score by Division - with Trust-level alarm limit



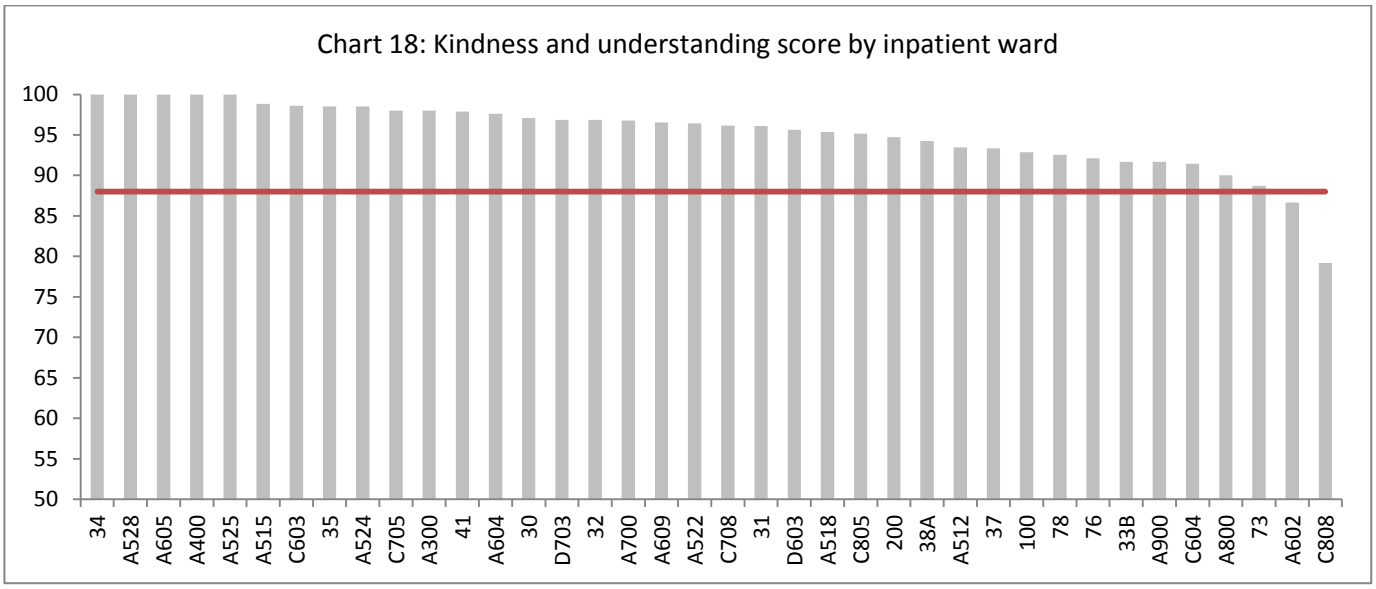


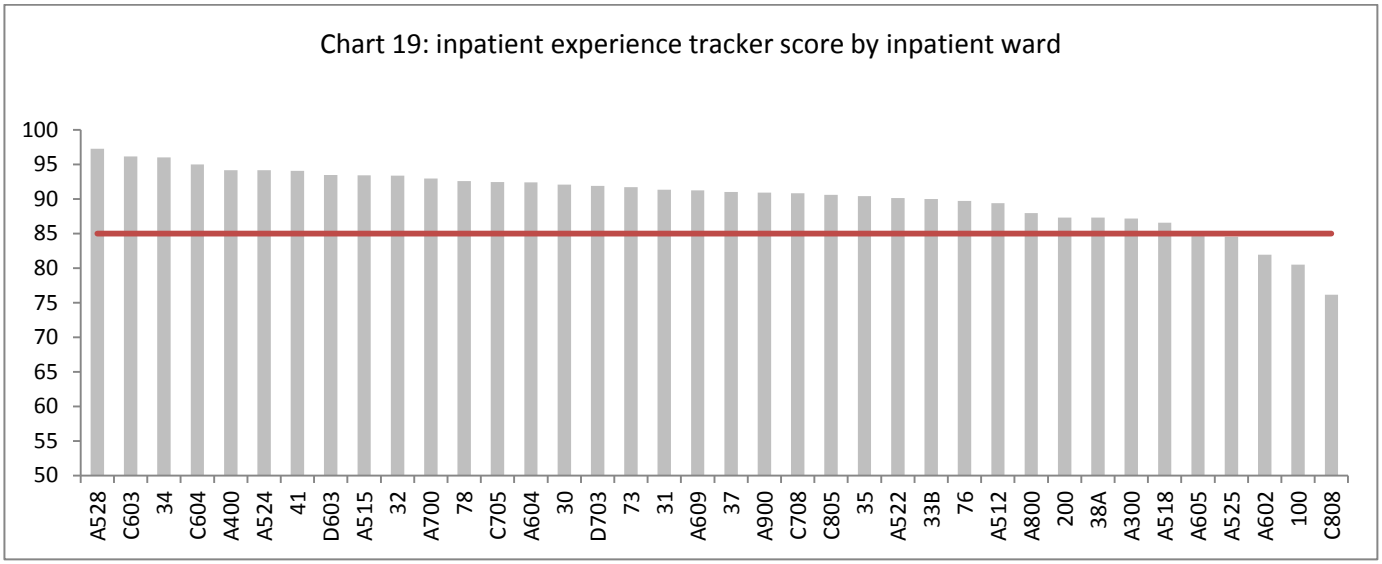


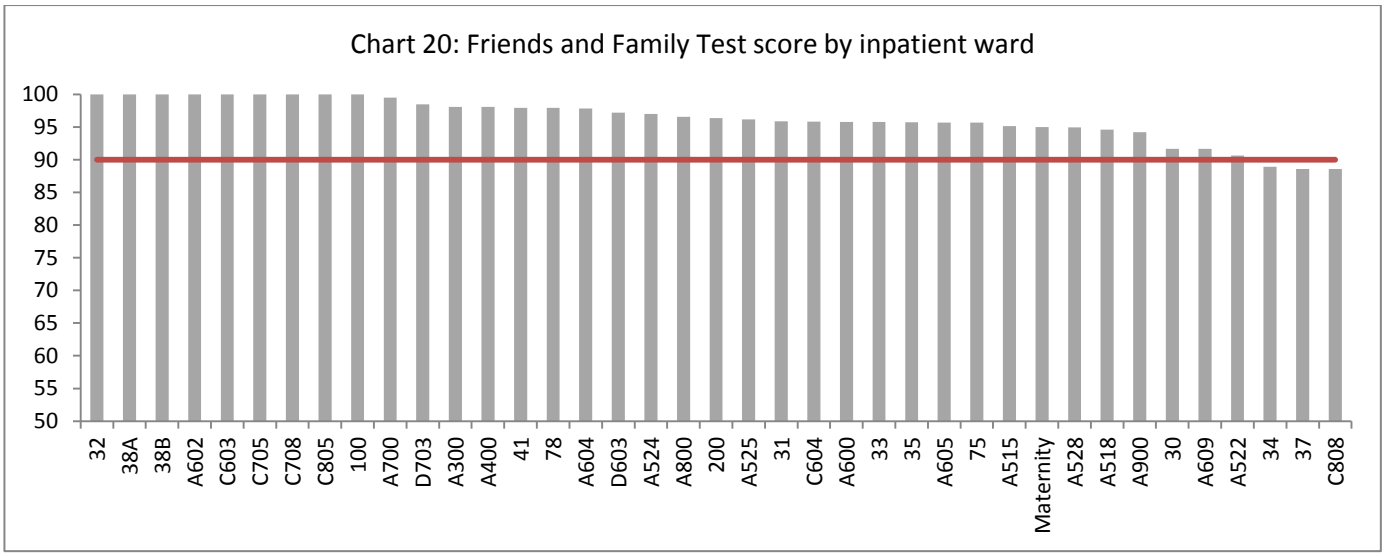




Key: BRHC (Bristol Royal Hospital for Children), BEH (Bristol Eye Hospital), BHOC (Bristol Haematology and Oncology Centre), BRI (Bristol Royal Infirmary), BHI (Bristol Heart Institute), SBCH (South Bristol Community Hospital), STMH (St Michael's Hospital), BDH (Bristol Dental Hospital)







(Please note tha,t as per NHS England national-level reporting protocol, the maternity Friends and Family Test data is reported at "postnatal ward" level).

Table 1: Full Quarter 4 Divisional scores from UH Bristol's monthly **inpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – see appendices for an explanation of the scoring mechanism. Note: not all inpatient questions are included in the maternity survey.

	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Maternity	Trust
Were you given enough privacy when discussing your condition or treatment?	92	94	92	95		93
How would you rate the hospital food?	69	62	61	65	60	63
Did you get enough help from staff to eat your meals?	77	90	83	84		84
In your opinion, how clean was the hospital room or ward that you were in?	95	96	96	94	93	96
How clean were the toilets and bathrooms that you used on the ward?	92	93	93	92	83	93
Were you ever bothered by noise at night from hospital staff?	80	82	87	84		83
Do you feel you were treated with respect and dignity by the staff on the ward?	96	98	96	96	93	97
Were you treated with kindness and understanding on the ward?	95	96	96	96	90	96
Overall, how would you rate the care you received on the ward?	88	92	91	92	85	91
When you had important questions to ask a doctor, did you get answers that you could understand?	86	90	88	89	90	88
When you had important questions to ask a nurse, did you get answers that you could understand?	87	90	91	90	91	90
If your family, or somebody close to you wanted to talk to a doctor, did they have enough opportunity to do so?	72	75	79	79		76
If your family, or somebody close to you wanted to talk to a nurse, did they have enough opportunity to do so?	81	88	88	91		88
Were you involved as much as you wanted to be in decisions about your care and treatment?	84	87	86	90	89	87
Do you feel that the medical staff had all of the information that they needed in order to care for you?	90	91	91	88		90
Did you find someone on the hospital staff to talk to about your worries or fears?	67	79	78	82	85	77
Did a member of staff explain why you needed these test(s) in a way you could understand?	82	88	89	89		87

	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	Maternity	Trust
Did hospital staff keep you informed about what would happen next in your care during your stay?	81	86	85	87		85
Were you told when this would happen?	78	83	83	84		82
Beforehand, did a member of staff explain the risks/benefits in a way you could understand?	74	91	94	95		92
Beforehand, did a member of staff explain how you could expect to feel afterwards?	69	78	78	81		78
Were staff respectful of any decisions you made about your care and treatment?	90	95	93	94		93
During your hospital stay, were you ever asked to give your views on the quality of your care?	26	24	28	31	30	27
Do you feel you were kept well informed about your expected date of discharge from hospital?	80	84	86	84		84
On the day you left hospital, was your discharge delayed for any reason?	65	53	67	69	70	63
Did a member of staff tell you about medication side effects to watch for when you went home?	54	63	65	64		62
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	62	84	79	89		80
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	88	94	91	92	90	91

Table 2: Full six-monthly Divisional-level scores (October 2016 – March 2017) from UH Bristol's monthly **outpatient** postal survey (cells are highlighted if they are more than 10 points below the Trust score). Scores are out of 100 unless otherwise stated – please see appendices for an explanation of this scoring mechanism.

	Diagnostic & Therapy	Medicine	Specialised Services	Surgery, Head & Neck	Women's & Children's	**TOTAL**
When you first booked the appointment, were you given a choice of appointment date and time?	86	68	78	69	59	**74**
Was the appointment cancelled and re-arranged by the hospital?	96	94	95	95	97	**95**
When you contacted the hospital, was it easy to get through to a member of staff who could help you?	76	63	70	67	71	**69**
How would you rate the courtesy of the receptionist?	87	86	87	85	84	**86**
Were you and your child able to find a place to sit in the waiting area?	100	100	98	99	96	**99**
In your opinion, how clean was the outpatient department?	95	94	95	94	89	**94**
How long after the stated appointment time did the appointment start? (% on time or within 15 minutes)	92	71	65	73	64	**73**
Were you told how long you would have to wait?	48	39	35	22	33	**35**
Were you told why you had to wait?	63	56	58	55	64	**59**
Did you see a display board in the clinic with waiting time information on it?	30	60	50	36	45	**45**
Did the medical professional have all of the information needed to care for you?	88	89	93	92	92	**91**
Did he / she listen to what you had to say?	96	97	95	97	95	**96**
If you had important questions, did you get answers that you could understand?	92	94	91	90	92	**92**
Did you have enough time to discuss your health or medical problem?	91	94	91	92	94	**92**
Were you treated with respect and dignity during the outpatient appointment?	99	99	97	98	99	**98**
Overall, how would you rate the care you received?	92	92	91	92	91	**91**
If you had any treatment, did a member of staff explain any risks and/or benefits in a way you could understand?	88	90	81	91	89	**88**
If you had any tests, did a member of staff explain the results in a way you could understand?	80	86	74	78	86	**80**
Did a member of staff tell you about medication side effects to watch for when you went home?	60	73	63	66	76	**68**
How likely are you to recommend the outpatient department to friends and family if they needed similar care or treatment?	92	90	92	91	91	**91**

3.3 Divisional, hospital and ward-level patient-reported experience

3.3.1 Themes arising from free-text comments

At the end of the Trust's postal survey questionnaires, respondents are invited to comment on any aspect of their stay. The themes from these comments are provided in Table 3. By far the most frequent type of feedback is praise for staff. Key improvement themes focus on communication, staff behaviour and waiting times. Although these categories do not directly overlap with the way that the Trust classifies complaints, there are similarities between these issues and themes seen in the complaints data (see accompanying Quarterly Complaints Report).

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

	Theme	*Sentiment*	*Percentage of comments containing this theme*
Trust (excluding maternity[4])	Staff	Positive	72%
	Staff	Negative	12%
	Communication/information	Negative	9%
Division of Medicine	Staff	Positive	70%
	Information/communication	Negative	8%
	Waiting / delays	Negative	8%
Division of Specialised Services	Staff	Positive	69%
	Staff	Negative	12%
	Information/communication	Negative	10%
Division of Surgery, Head and Neck	Staff	Positive	74%
	Staff	Negative	14%
	Communication/information	Negative	10%
Women's and Children's Division (excluding Maternity)	Staff	Positive	75%
	Staff	Negative	12%
	Noise	Negative	9%
Maternity	Staff	Positive	67%
	Care during labour and birth	Positive	23%
	Staff	Negative	12%
Outpatient Services	Staff	Positive	59%
	Waiting/delays	Negative	12%
	Communication/information	Negative	10%

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

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

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

The feedback received via the Trust's Friends and Family Test is generally very positive. Table 4 provides an overview of activity that has arisen from the relatively small number of negative ratings, where that rating was accompanied by a specific, actionable, comment from the respondent.

Table 4: Divisional response to specific issues raised via the Friends and Family Test in Quarter 4, where respondents stated that they would not recommend UH Bristol and a specific / actionable reason was given

Division	Area	Comment	Response from ward / department
Medicine	Rheumatology outpatient department	Appointments keep getting cancelled or changed, then not informed so you turn up anyway. Bookings they are rude - saying it's hard for them that appointments are changed. The consultant is nice. The admin side spoils the whole process.	We are sorry the patient didn't have a positive experience with us. This feedback has been shared with the clinic admin staff and will be discussed further at a departmental meeting to determine changes that can be implemented to address these concerns. Additional customer care skills training will be implemented where necessary.
	A515	All nurses and doctors repeatedly slam bin lid, 20 times a day, with no consideration for patients. Occasionally machines left beeping, no consideration for patients. Men's toilet often left in a dirty state	The ward Sister has carried out checks and confirmed that all bins in patient areas are "quiet closing", making it difficult to corroborate this aspect of the comment and identify specific improvements. Patients in the high care end of the ward may be on monitors and, whilst the sound may be on low, unfortunately it cannot be turned off altogether as staff need to be able to hear them. We are sorry that the patient found the toilet in a dirty state. We can confirm that all the toilets are checked several times each day, but we are also reliant on being informed by staff / patients if extra cleaning is required.
	Emergency Department (Bristol Royal Infirmary)	Somewhat unsanitary (toilets were occasionally covered in urine etc)	The Emergency Department takes cleanliness standards extremely seriously and we are disappointed to hear this comment. Our staff inspect the various areas of the ED throughout the day, formally and informally. We will continue to respond quickly if any concerns are raised about cleanliness in the toilets.
	A300	Given no food… left out when asked they said they'd ran out. Didn't even get a sandwich.	The ward sister has discussed this with the nursing, housekeeper and catering team on the ward. Food is always available and the team ward work hard to be flexible in this respect, as patients often miss formal meal times due to transfers from other departments / wards. This patient should have been offered food and we are very sorry that this did not occur.

Division	Area	Comment	Response from ward / department
Surgery, Head and Neck	Ward 43 (Bristol Eye Hospital day case)	I was told I would be woken just around 7.00 am but was woken at 5.45 and there did not seem any justification for disturbing me. Only two people had been in the ward overnight.	We are sorry that the patient was given this incorrect information. Sometimes patients have to stay in the day surgery unit overnight. Unfortunately they need to be woken up early, as day surgery patients arrive at 07:30 and the area needs to be prepared for their admission. We will remind staff to ensure that if a patient has to stay overnight then they are told about the early start.
	Ward 41 (Bristol Eye Hospital inpatient ward)	Had to change in toilets. No lock on door. Toilet roll on floor - not nice. However, no bed available so all pre-op discussions, getting changed, putting on socks in Day Ward, in front of many other people. No privacy.	Unfortunately, if there is no bed available at the time of admission, a patient may have to be prepared for theatre in the day surgery unit. Privacy and dignity is challenging in these circumstances, but remains a priority and the charge nurse will share these comments with staff as a point of learning. The toilets are checked regularly throughout the day to ensure levels of cleanliness remain high. It is not possible to check after every patient and unfortunately in this case toilet roll may have been left on the floor by someone using the room previously.
	Ward A609	Arriving with my wheelchair using wife, we were faced with a desk so high staff didn't realise she was there.	We are sorry that this situation arose. We are reviewing whether it is possible to change the reception desk, to make it more accessible to all patients. In the meantime, we will share this feedback with our staff as a reminder to be alert to this issue, and to come around to the front of the desk to talk to people if necessary. Despite this feedback, we are pleased to say that the patient did go on to say the reception staff were “fantastic” and made every effort to communicate with them.
Women’s and Children’s - maternity	Postnatal wards	Every day at reception my mum who was my birthing partner was asked several questions and numerous times told she is not my partner so she cannot come in the times partners could. There are numerous reasons women do not have a male partner visiting and they should not be interrogated in this way if that is the case.	We are very sorry that this situation arose, as we recognise that a birthing partner may not necessarily be a spouse. The Head of Midwifery has asked the ward Sisters to put in place a process where, once it is identified that a patient is having their mother or someone else as their birth partner, this is communicated to everyone including the reception team.

Division	Area	Comment	Response from ward / department
Women's and Children's – Bristol Royal Hospital for Children	Emergency Department	On bay 6 in the children's A&E the machines had stickers on them showing the calibration of the machines had expired and needed doing. Also, we used the bed as a cot with the sides up. And we couldn't work out how to lower the cot sides.	The Matron has checked the only fixed patient monitor in the bay and it is in date (expires 2019). The Matron has emailed MEMO to check that all equipment is up to date. The nursing staff will be reminded to show parents who need the cot how to use this.
	Emergency Department	My daughter was referred to the children's hospital with a severe PNS she could not walk, sit, stand. And was in terrible pain. After waiting to be seen by a doctor for hours we were told due to the fact she is 16. No one in the children's hospital was willing to see her. We spent a total of 5 hours only to be sent home.	We are very sorry to hear this feedback. It is our standard practice to inform someone at the point of booking in (usually at the time of arrival) that they need to go to the adult Emergency Department if they are over 16 years old and not under speciality care. We cannot determine why this did not happen in this case, but will share this feedback with the reception team as a point of learning.
	Ward 31	Would have liked to have had the linen changed. My daughter's bed had blood, sweat and antibiotic liquid on it which distressed her.	This patient should have had clean bed linen and we are very sorry that this was not the case. This comment will be used as a reminder to all staff to ensure basic care needs are addressed in a timely manner and levels of cleanliness are maintained.

5. Update on key issues identified in the previous Quarterly report

Table 5 provides a summary and update on issues identified in the previous Quarterly Patient Experience report.

Table 5: update on key issues identified in the previous Quarterly Patient Experience report

Issue / area	*Main action(s) cited*	*Outcome*
Outpatient Friends and Family Test response rate	To explore funding for an SMS based solution to increasing the outpatient Friends and Family Test response rate, in line with 2017/18 commissioning contractual requirements	The funding bid was approved and an SMS survey is now in place.
Patient Experience at Heart workshops in care of the elderly wards	To carry out these patient-focussed workshops with members of staff in the service during Quarter 3 2016/17.	Staffing pressures delayed this action, but a workshop has now taken place with ward A515 (stroke) and ward 100 (rehabilitation). The Patient Experience and Involvement Team will pursue a workshop with ward C808 in response to low survey scores (see main body of the current report).

Issue / area	*Main action(s) cited*	*Outcome*
Low Friends and Family Test score for postnatal wards	This appeared to be a response to temporarily lower (but safe) staffing levels on the wards, due a high sickness level in Quarter 3.	As anticipated, the score has reverted to its previous (higher) levels in Quarter 4. It will continue to be monitored.
Ward C808 – relatively low survey score	Lowest inpatient tracker score in Quarter 3.	As discussed in the current report, the survey results for care of the elderly services are consistently lower than the "Trust average". This will be the focus of Patient and Public Involvement activity in Quarter 1
Ward 38A at the Bristol Royal Hospital for Children had a relatively low Friends and Family Test score	This was an unusual result for this ward and further analysis suggested that it was primarily an artefact of the FFT scoring methodology	The scores are within the normal range in Quarter 4 and it therefore does appear to have been a statistical blip
Ward A605 - low score in the inpatient experience tracker	Ward A605 is the Division of Medicine "delayed discharge ward". It was acknowledged that delivering a positive patient experience is difficult on this ward, but that a number of improvement actions were being carried out	The scores for Quarter 4 are now within the normal range. We will continue to monitor the scores but are hopeful that this reflects a consistent improvement as a result of the service improvement activity.
The Division of Medicine consistently achieves relatively low survey scores around telling patients information about operations / procedures and who to contact if they had concerns after leaving hospital.	It has been difficult to explain this result as relatively few patients have operations / procedures in the Division of Medicine and comprehensive information is given at discharge.	The theme of "communication" is currently being explored in Quarter 1 as part of the Patient Experience and Involvement Team's collaboration with care of the elderly wards in the Division of Medicine
A cluster of low survey scores are present in the outpatient survey data (Table 3), relating to ensuring patients are kept informed about delays in clinic, either via a member of staff or an information board (ideally both).	Although a number of improvement actions were described in the report, the scores have essentially remained static since 2015/16.	This continues to be a challenge for and will remain the focus of a Trust quality improvement objective for 2017/18.

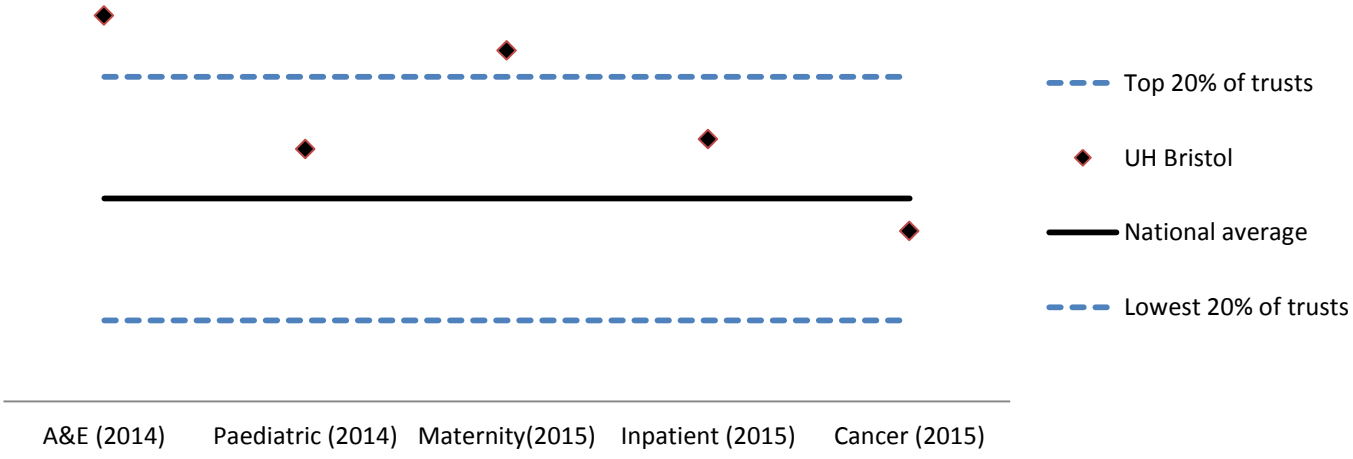
6. National Patient Surveys

The Care Quality Commission's (CQC's) National Patient Survey programme is a mandatory survey programme for acute English trusts. It provides a robust national benchmark against which the patient experience at UH Bristol can be compared to other organisations. Chart 21 provides a broad summary of the Trust's position[5]. The Trust Board receives a full report containing an analysis of each national survey and UH Bristol's response to these results (see Appendix A for a summary).

There have been no further national survey results since the last Quarterly Patient Experience and Involvement Report was published and therefore Chart 21 is provided for information only.

Please note that since this report was reviewed by the Patient Experience Group in May 2017, the 2016 national inpatient survey results have been released. These were very positive with UH Bristol receiving scores that were among the very best trusts nationally. A separate analysis of these national inpatient survey results is being provided to the Senior Leadership Team and Trust Board committees in June 2017. Chart 21 will be updated to reflect this latest data in the next Quarterly Patient Experience and Involvement Report.

Chart 21: Indication of UH Bristol patient-reported satisfaction relative to the national average



[5] It is difficult to directly compare the results of different surveys, and also to encapsulate performance in a single metric. Chart 21 is an attempt to do both of these things. It should be treated with caution and isn't an "official" classification, but it is broadly indicative of UH Bristol's performance relative to other trusts.

Appendix A: summary of national patient survey results and key actions arising for UH Bristol (note: progress against action plans is monitored by the Patient Experience Group)

Survey	*Headline results for UH Bristol*	*Report and action plan approved by the Trust Board*	*Action plan review*	*Key issues addressed in action plan*	*Next survey results due (approximate)*
2015 National Inpatient Survey	61/63 scores were in line with the national average. One score was below (availability of hand gels) and one was (privacy when discussing the patients treatment or condition)	July 2016	Six-monthly	• Availability of hand gels • Awareness of the complaints / feedback processes • Asking patients about the quality of their care in hospital	June 2017
2015 National Maternity Survey	9 scores were in line with the national average; 10 were better than the national average	March 2016	Six-monthly	• Continuity of antenatal care • Partners staying on the ward • Care on postnatal wards	January 2018
2015 National Cancer Survey	45/50 scores were in line with the national average; one score was above the national average (being assigned a nurse specialist); four were worse (related to holistic care)	September 2016	Six-monthly	• Support from partner health and social care organisations • Providing patients with a care plan • Coordination of care with the patient's GP	September 2017
2014 National Accident and Emergency surveys	33/35 scores in line with the national average; 2 scores were better than the national average	February 2015	Six-monthly	• Keeping patients informed of any delays • Taking the patient's home situation into account at discharge • Patients feeling safe in the Department • Key information about condition / medication at discharge	August 2017
2015 National Paediatric Survey	All scores in line with the national average, except one which was better than this benchmark	November 2015	Six-monthly	• Information provision • Communication • Facilities / accommodation for parents	November 2017
2011 National Outpatient Survey	All scores in line with the national average	March 2012	n/a	• Waiting times in the department and being kept informed of any delays • Telephone answering/response • Cancelled appointments	No longer part of the national programme

Appendix B – UH Bristol corporate patient experience programme

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

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

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

Appendix C: survey scoring methodologies

Postal surveys

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

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

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

Friends and Family Test Score

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

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

University Hospitals Bristol NHS Foundation Trust

Report to the Council of Governors meeting to be held on 28 July 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Agenda Item	7.1
Meeting Title	Council of Governors	**Meeting Date**	28 July 2017
Report Title	Quality Report 2016/17 and Independent Auditor's Report to the Governors on the Quality Report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Governor Responsibility (please tick any which are impacted on / relevant to this paper)	
Holding the Non-Executive Directors to account	☐
Non-Executive Director appointments (appraisal review)	☐
Constitutional/forward plans	☒
Member/Public interests	☐
Significant transaction/private patient increase	☐
Appointment of External Auditor	☐
Appointment of the Chief Executive	☐

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

Executive Summary

NHS Foundation Trusts are required to prepare and publish a Quality Report each year. The Quality Report has to be prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the requirements of NHS Improvement, our regulators.

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.

The Trust's External Auditors are required to undertake work on the Quality Report and provide the Council of Governors with a report on its findings and recommendations for improvements.

Governors are asked to:

- Note the Quality Report 2016/17
- Receive the External Auditor's report to governors on the Quality Report 2016/17 for assurance.

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

Date papers were previously submitted to other committees				
Nominations and Appointments Committee	**Quality Focus Group**	**Governor Strategy Group**	**Constitution Focus Group**	**Public Trust Board meeting**

NHS
University Hospitals Bristol
NHS Foundation Trust

Quality Report 2016/17

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents

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.

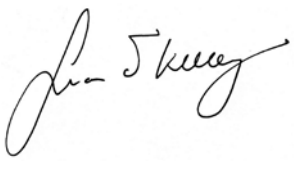
The Chief Inspector of Hospitals' report spoke of the compassionate, sensitive and respectful way that the CQC team saw patients being cared for, and highlighted numerous areas of best practice. You can read more about the CQC's findings later in the pages of this report.

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.

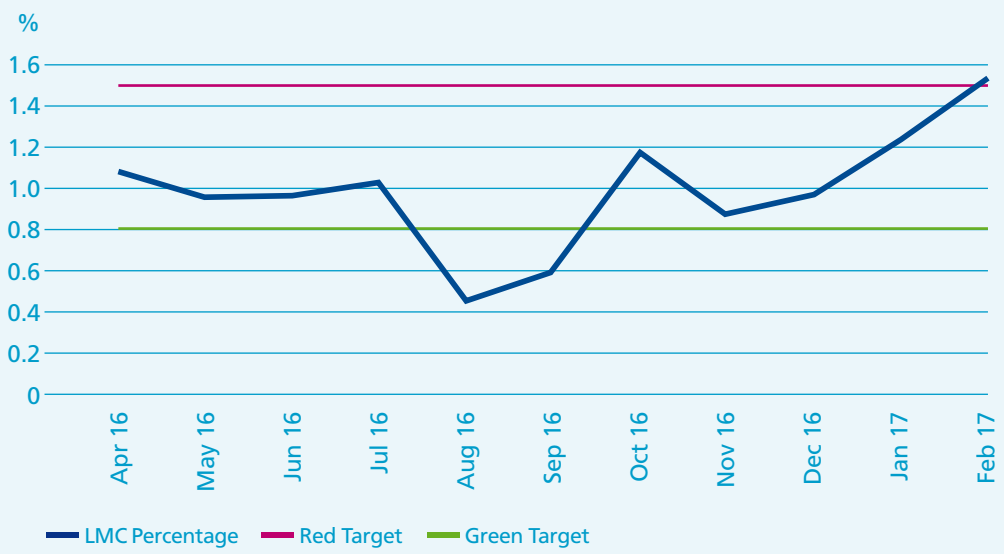
How did we get on?

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



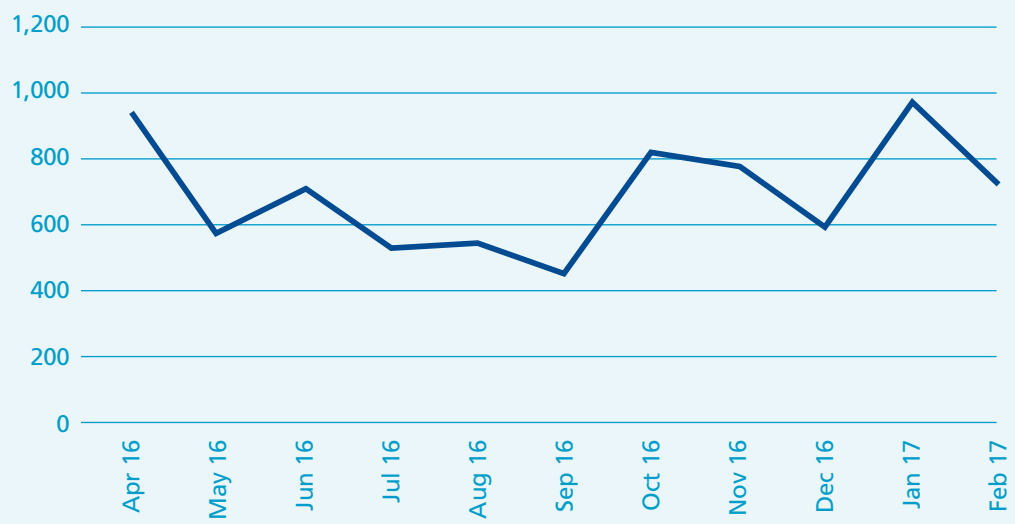
RAG rating

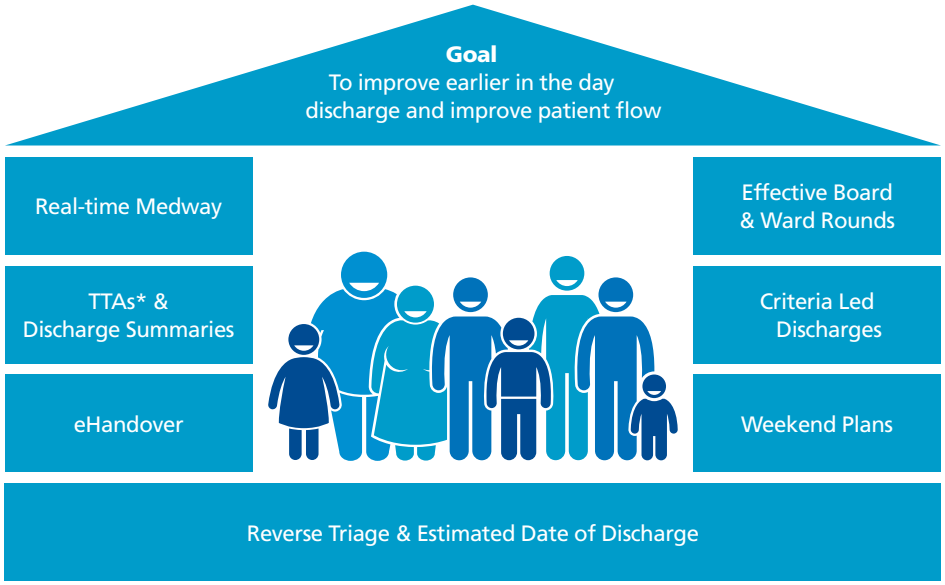
Amber – our performance in 2016/17 was better than in the previous year but fell short of our target. This objective is being carried forward into 2017/18.

[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.

Number of outlier bed days



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

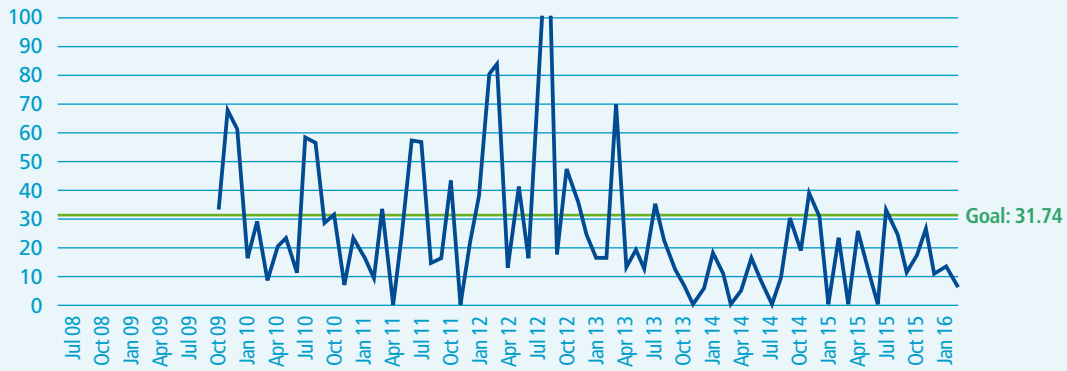
	to scope out the detailed actions and resources needed in order to systematically identify, record and respond to patients' communication needs. The AIS steering group has met monthly to oversee the delivery of our implementation plan, which has incorporated a number of standards contained within the 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.

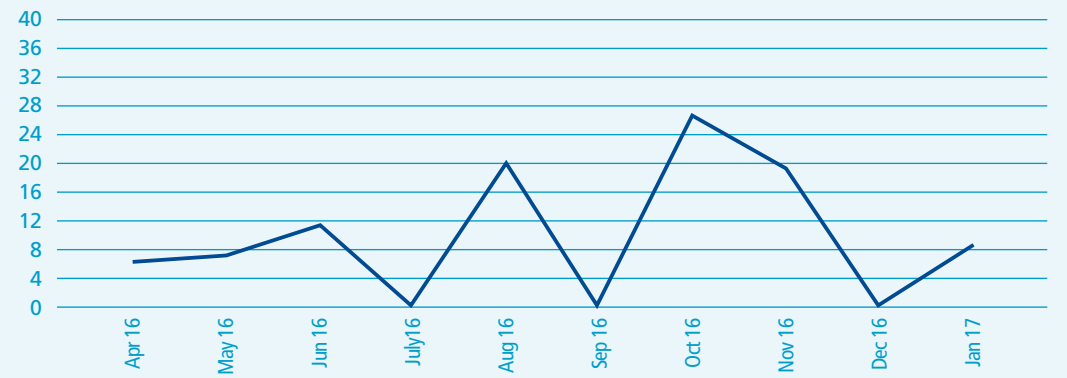
RAG rating	**Amber –** we carried out background research and have developed a functional specification for a new patient feedback system, however the procurement has been delayed until early 2017/18.

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.
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) A03: adverse event rate per 1,000 patient days - adverse event rate for whole of UHBristol



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.

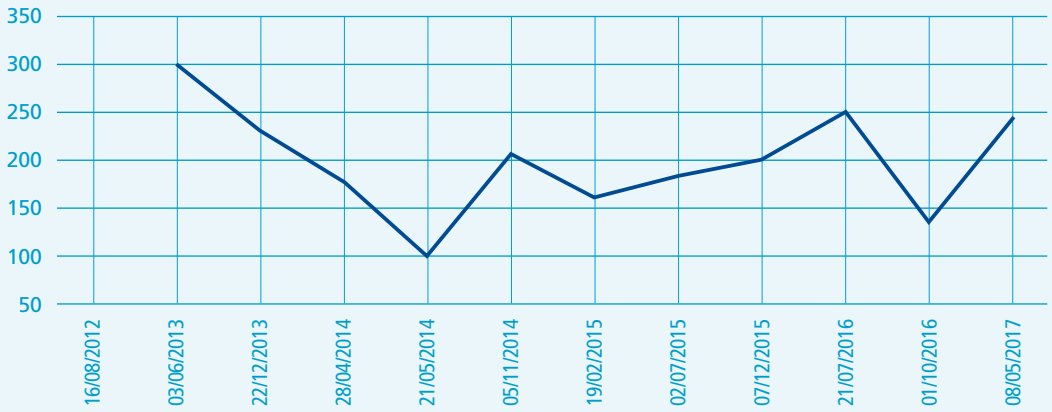
[11] Manchester Patient Safety Framework, University of Manchester 2006.

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

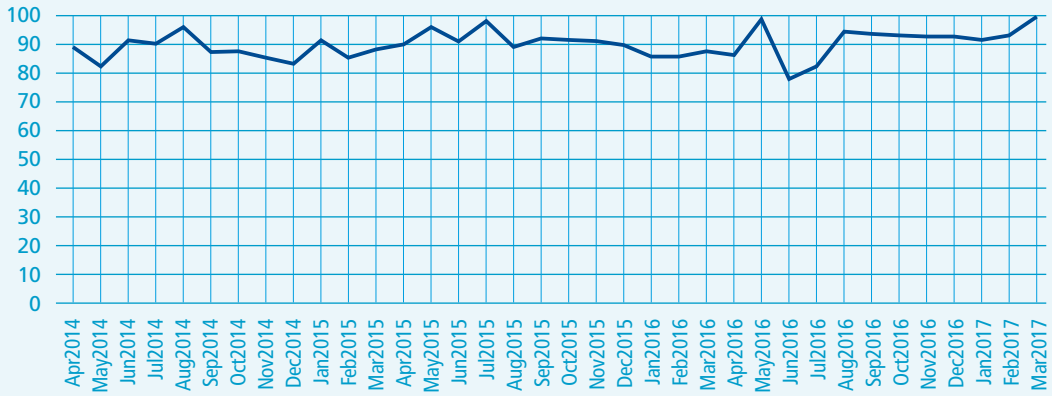
Last year we reported on the introduction of the national early warning score (NEWS)[13] for adult patients (excluding maternity) at the end of 2015 which took place as a collaborative project with North Bristol NHS Trust. We have spent much of 2016/17 embedding this within practice and have worked closely 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).

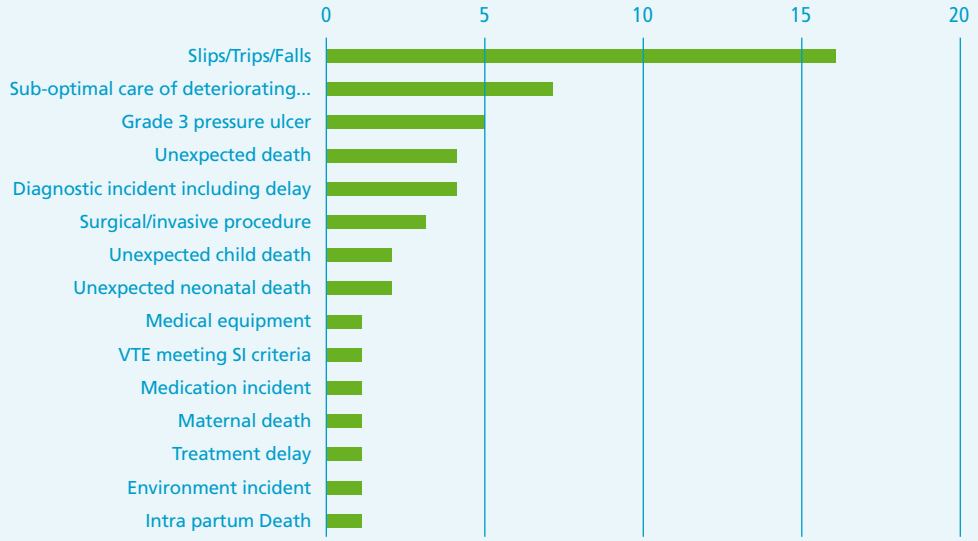
Learning from serious incidents

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.

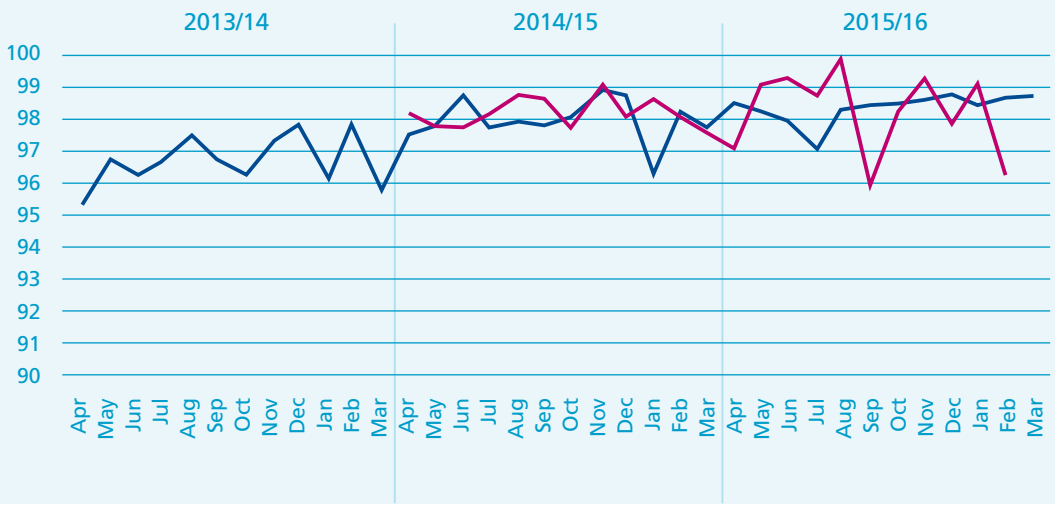
3.2.2 Gathering patient feedback from surveys

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

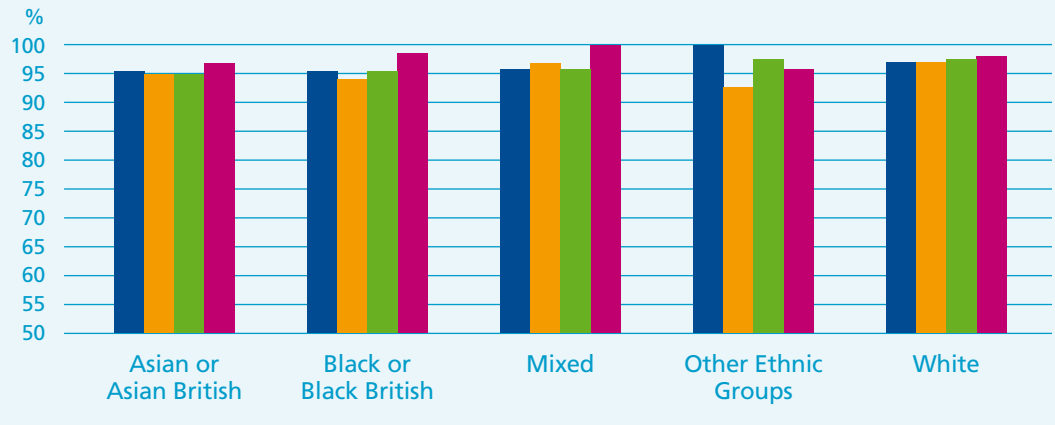
Patients rating the care at UH Bristol as excellent, very good or bad



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.

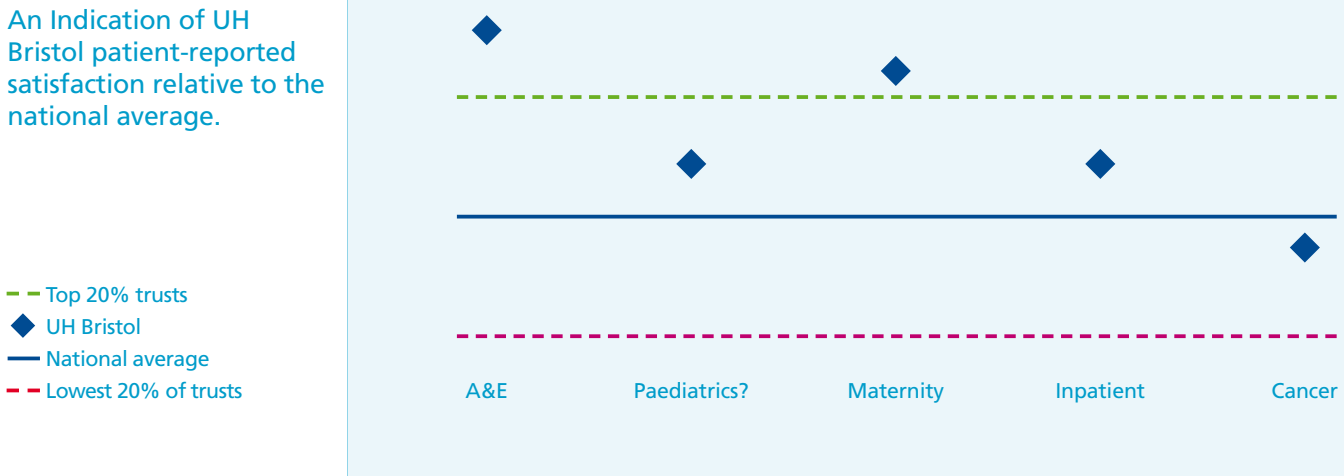
Historically, UH Bristol has performed less well in national cancer surveys. We were particularly disappointed when the 2013 survey results showed nearly half of UH Bristol's scores were in the lowest quintile (bottom 20 per cent) of trusts nationally. In response to this, Trust's lead cancer nurse led 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.

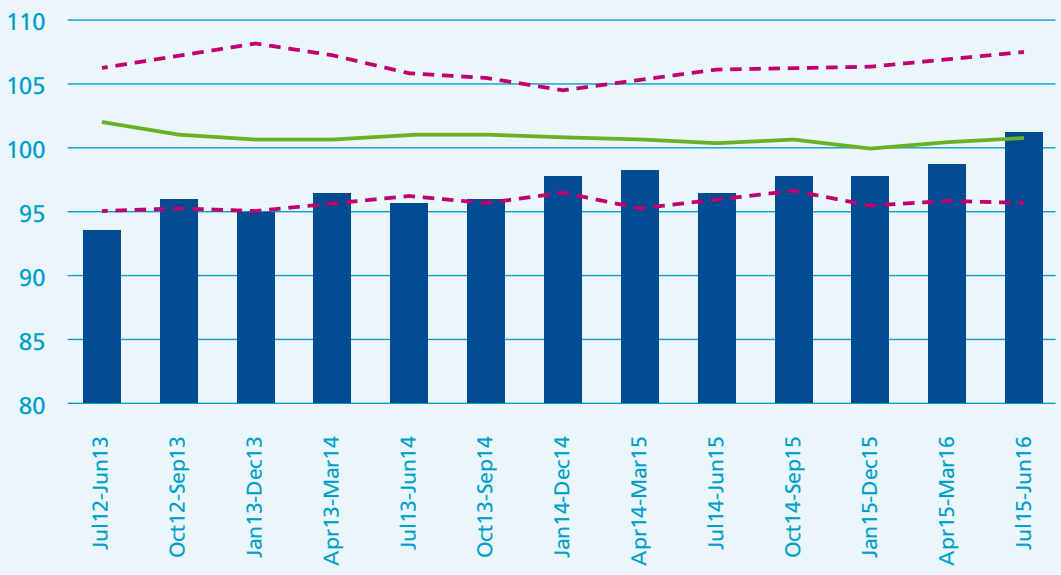
The HSMR includes only the 56 diagnosis groups (medical conditions) which account for approximately 80 per cent of in-hospital deaths. The SHMI is sometimes considered a more useful index as it includes all diagnosis groups as well as deaths occurring in the 30 days following hospital discharge.

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

[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*

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

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.

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.

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University Hospitals Bristol NHS Foundation Trust

Quality Report 2016/17

Government and Public Sector

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pwc

Contents

Scope of this work

We have performed this work in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by Monitor (operating as NHS Improvement) ("NHSI").

Reports and letters prepared by external auditors and addressed to governors, directors or officers are prepared for the sole use of the NHS Foundation Trust, and no responsibility is taken by auditors to any governor, director or officer in their individual capacity, or to any third party. The matters raised in this report are only those which have come to our attention arising from or relevant to our work that we believe need to be brought to your attention. They are not a comprehensive record of all the matters arising, and in particular we cannot be held responsible for reporting all risks in your business or all internal control weaknesses. This report has been prepared solely for your use in accordance with the terms of our engagement letter dated 25 January 2017 and for no other purpose and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

Background and scope

Background

NHS foundation trusts are required to prepare and publish a Quality Report each year. The Quality Report has to be prepared in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by Monitor (operating as NHS Improvement) ("NHSI").

As your auditors, we are required to undertake work on your Quality Report under NHSI's "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17" ('the detailed guidance') which was published in February 2017.

The purpose of this report is to provide the Board of Governors of University Hospitals Bristol NHS Foundation Trust ("the Trust") with our findings and recommendations for improvements, in accordance with NHSI's requirements. It is referred to by NHSI as the "Governors report".

Scope of our work

We are required by NHSI to review the content of the 2016/17 Quality Report, test three performance indicators and produce two reports:

- Limited assurance report: This report is a formal document that requires us to conclude whether anything has come to our attention that would lead 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 aspects with source documents specified by NHSI; 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".

    A limited assurance engagement is less in scope than a reasonable assurance engagement (such as the external audit of accounts). The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited compared to a reasonable assurance engagement.
- Governors report: A private report on the outcome of our work that is made available to the Trust's Governors and to NHSI.

Our limited assurance report is restricted, as required by NHSI, to the content of the Quality Report and two performance indicators only. The Governors report covers all of our work and, therefore, the third local indicator which is chosen by the Governors.

Content of the Quality Report

We are required to issue a limited assurance report in relation to the content of your Quality Report. This involves:

- Reviewing the content of the Quality Report against the requirements of NHSI's published guidance, as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17" and
- Reviewing the content of the Quality Report for consistency with the source documents specified by NHSI in the detailed guidance.

Performance indicators

We are required to issue a limited assurance report in respect of two out of four Acute Trust national priority indicators specified by NHSI in their detailed guidance.

The indicators for the year ended 31 March 2017 which were chosen by the governors and subject to our limited assurance (the "specified indicators") are marked with the symbol Ⓐ in the Quality Report and consist of:

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
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

Our procedures included:

- 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 judgments made by the Trust in preparation of the specified indicators; and
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosure.

Local indicator

We are also required to undertake substantive sample testing of one further local indicator. This indicator is not included in our limited assurance report. Instead, we are required to provide a detailed report on our findings and recommendations for improvements in this, our Governors report. The Trust's Governors select the indicator to be subject to our substantive sample testing. The indicator selected is: The number of patients discharged between 07:00 and 12:00 noon.

Summary of findings

Content of the Quality Report

No issues have come to our attention that lead 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"

For further information refer to page 5.

Limited Assurance Report
As a result of our work, we are able to provide an unqualified limited assurance report in respect of the content of the Quality Report.

Consistency with Other Information

No issues have come to our attention that lead us to believe that the Quality Report is not consistent with the other information sources defined by NHSI's "Detailed requirements for quality reports for foundation trusts 2016/17".

Limited Assurance Report
As a result of our work, we are able to provide an unqualified limited assurance report in respect of the consistency of the Quality Report with the "Detailed requirements for quality reports for foundation trusts 2016/17".

For further information refer to page 6.

Selected Performance indicators

Our findings relating to the performance indicators are summarised as follows:

Performance indicators included in our limited assurance report	Findings
Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period.	Two issues were identified; leading to a qualification of our limited assurance opinion.
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	No issues identified; no impact on our limited assurance opinion

For further information refer to page 6.

Limited Assurance Report

As a result of our work, our limited assurance report in respect of the mandated performance indicators is qualified as follows:

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.

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

Performance indicator not included within our limited assurance report	Findings
The number of patients discharged between 07:00 and 12:00 noon.	No errors identified in sample tested. No control issues identified.

For further information refer to page 6.

Annual Governance Statement

We identified no issues relevant to the Quality Report.

For further details, see page 11.

Detailed findings

Review against the content requirements

We reviewed the content of the Quality Report against the content requirements which are specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17".

No issues came to our attention that led us to believe that the Quality Report has not been prepared in line with the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17".

Review consistency against specified source documents

We reviewed the content of the 2016/17 Quality Report for consistency against the following source documents specified by NHSI:

- Board minutes for the period April 2016 to the date of signing the limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2016 to the date of signing the 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 08/06/16;
- The 2016 national staff survey dated 07/03/2017;
- Care Quality Commission inspection report, dated 02/03/2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2017.

No issues came to our attention that led us to believe that the Quality Report is not consistent with the information sources detailed above.

Performance indicators on which we are required to issue a limited assurance conclusion

As required by NHSI we have undertaken sample testing of two performance indicators on which we issued our limited assurance report:

1. Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period.
2. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

We are required to obtain an understanding of the key processes and controls for managing and reporting the indicators and sample test the data used to calculate the indicator. Our work is performed in accordance with the detailed guidance and included:

- Identification of the criteria used by the Trust for measuring the indicator;
- Confirmation that the Trust had presented the criteria identified above in the Quality report in sufficient detail that the criteria are readily understandable to users of the Quality Report;
- Updating our understanding of the key processes and controls for managing and reporting the indicator through making enquiries of Trust staff and through performing a walkthrough;
- Checking the Trust's reconciliation of the reported performance in the Quality Report to the data used to calculate the indicator from the Trust's underlying systems;
- Testing a sample of relevant data used to calculate the indicator; and
- Obtaining representations that the data used to calculate the indicator is accurately captured at source and that no sources of information/data relevant to the indicator performance have been excluded.

We only tested a sample of data, as stated above, to supporting documentation. Therefore, the errors reported below are limited to this sample.

We have also not tested the underlying systems, for example the patient administration system and the data extraction and recording systems.

Our findings are set out below. Recommendations arising from these findings are presented in Appendix A.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways	
Reported performance:	
2016/17 Threshold: **92.00%**	2016/17 Actual: **91.71%**
Criteria identified:	
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period; • The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2016 to March 2017; • The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and • The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.	
Issues identified through work performed:	

No.	Issue	Impact on limited assurance report
1.	*Our testing identified three errors:* • *One patient was incorrectly excluded from April and May reporting despite having an April clock start.* • *One patient was incorrectly included in December reporting having been discharged in the month* • *One patient was incorrectly included in November and December reporting having been discharged in November.*	*We discussed these errors with the Trust. In respect of the first error this was due to there being a period of just over two months between the decision to refer the patient for surgery and the patient being added to the elective waiting list. The Trust believes this may have been due to the nature of this service and parents sometimes taking time to confirm whether they wish their child to proceed with surgery. The indicator criteria requires a pathway to be started upon referral. Because of the nature of this error, it is not possible for us to conclude on the number of pathways omitted from the reporting although the Trust believe this to be limited to specific departments.* *The other two errors have occurred because information confirming a patient's discharge was not received in a timely manner and as a result, the Trust continued to report incomplete pathways, which were in fact complete.* *Similar to above, due to the nature of these errors we are not able to form a view on the indicator as it is not possible to determine how many pathways are being reported that have already been completed.* *We have therefore disclaimed our limited assurance report in respect of this indicator as we are not able to form a view on the level of incomplete patient pathways which are not included in the data set.*
Overall Conclusion:		
Our substantive testing of the indicator identified 3 issues which impact on our limited assurance report resulting in a disclaimed report in respect of this indicator.		

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	
Reported performance:	
2016/17 Target: at least **95%** each quarter	2016/17 Actual: **85.01%**
Criteria identified:	
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • 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/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf	
Issues identified through work performed:	
No. **Issue**	**Impact on limited assurance report**
1. *No issues noted in our substantive testing*	*No impact on our limited assurance report.*
Conclusion:	
Our substantive testing of the indicator identified no issues. No impact on our limited assurance report resulting in an unmodified report in respect of this indicator.	

Performance indicators not included within our limited assurance report

NHSI also requires us to undertake substantive sample testing of a local indicator selected by the Governors, the results of which are not included within our limited assurance report.

We obtain an understanding of the key processes and controls for managing and reporting the indicator and sample test the data used to calculate the indicator back to supporting documentation.

We tested only a sample, as stated above. Our reported errors below are limited to this sample.

Our findings are detailed as follows:

The number of patients discharged between 07:00 and 12:00 noon.		
Reported performance:		
2016/17 Actual: 946		
Criteria identified:		
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • Percentage of Spells discharged in the month, where the time if discharge was on or after 7am ad before 12:01pm; • Only counts inpatients who have had at least one overnight stay; • For this measure "Discharge Time" is the time the patient left the Trust or the time they were sent to the Discharge Lounge; and • Excludes patients who die.		
Issues identified through work performed:		
No.	**Issue**	**Impact**
1.	*No issues noted from our substantive work*	*This indicator is not subject to our limited assurance opinion*
Conclusion:		
Our substantive testing of the indicator identified no issues.		

Annual Governance Statement

NHSI require Foundation Trusts to include a brief description of the key controls in place to prepare and publish a Quality Report as part of the Annual Governance Statement ("AGS") in the 2016/17 published accounts. The requirements for the content of the AGS are set out in Annex 5 of Chapter 2 of the NHS Foundation Trust Annual Reporting Manual 2016/17.

The Annual Governance Statement, within the Foundation Trust's 2016/17 Annual Report, includes the following statement specific to the Quality Report:

> The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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 in the NHS Foundation Trust Annual Reporting Manual. The annual quality report and quality accounts provide a firm foundation for our quality ambitions: looking back to identify progress, celebrate success and understand our challenges; and looking ahead by setting specific annual quality objectives which, if delivered, will make a significant difference to the safety, effectiveness and experience of care that our patients receive.

As part of our report on the financial statements we were required to:

- Review whether the Annual Governance Statement reflects compliance with NHSI's guidance; and
- Report if it does not meet the requirements specified by NHSI or if the statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements.

The work we undertook on the Annual Governance Statement as part of our work on the financial statements identified no issues relevant to the Quality Report.

Appendix A: Matters arising from our limited assurance review of the Foundation Trust's 2016/17 Quality Report: Performance indicators

	Observation	Recommendation	Trust Response
	Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period.		
1.	We noted that for one patient, although referral was made in April 2016, the pathway was not reported for April or May. The Trust began reporting the pathway in June. The Trust have investigated this and found it to be due to the patient not being put on the waiting list at the time they were referred.	We recommend that the Trust consider the extent of their data validation controls to ensure that clock start dates are accurately recorded.	The Trust already has in place a control to capture clock starts that happened within two weeks of month-end, through a data refresh process prior to submission of data as part of the national return. The Trust will be implementing further opportunities to reduce the delayed capture of clock starts following a decision to add a patient to the elective waiting list through: 1) the implementation of enhanced functionality within the

	Observation	Recommendation	Trust Response
			Medway Patient Administration System (PAS), which allows provisional waiting list entries to be logged at an outpatient attendance following an outcome of a Decision to Admit, and 2) a data quality mismatch report showing patients with an outcome of a decision to admit that have not been added to the elective waiting list, which will be used to validate RTT pathway completeness.
2.	We noted that in two cases, the patient was discharged but the Trust continued to report an open pathway for one and two months after the discharge. The Trust has investigated this and found it to be due to discharge letters not being issued in a timely manner.	The Trust should consider analysing clock stop data to determine if there are specific areas affected and encourage the further use of clinic outcome forms to capture data on a timely basis.	The Trust has indicated that it will make further improvements in the real-time capture of RTT clock stops during 2017/18 through: 1) continued focus on the timely completion of clinic outcome forms through which RTT status codes are captured, using audits as a tool for identifying areas with poor RTT data capture, and 2) a further reduction in clinic letter typing turn-around times in areas of the Trust where there are currently delays.

In the event that, pursuant to a request which University Hospitals Bristol NHS Foundation Trust has received under the Freedom of Information Act 2000, it is required to disclose any information contained in this report, it will notify PwC promptly and consult with PwC prior to disclosing such report. University Hospitals Bristol NHS Foundation Trust agrees to pay due regard to any representations which PwC may make in connection with such disclosure and University Hospitals Bristol NHS Foundation Trust shall apply any relevant exemptions which may exist under the Act to such report. If, following consultation with PwC, University Hospitals Bristol NHS Foundation Trust discloses this report or any part thereof, it shall ensure that any disclaimer which PwC has included or may subsequently wish to include in the information is reproduced in full in any copies disclosed.

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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*** (exact page number where criteria can be found)
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

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.

University Hospitals Bristol NHS Foundation Trust

Report to the Council of Governors meeting to be held on 28 July 2017 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Agenda Item	7.2
Meeting Title	Council of Governors	**Meeting Date**	28 July 2017
Report Title	Independent Review of Children's Cardiac Services progress report		
Author	Carolyn Mills, Chief Nurse		
Executive Lead	Carolyn Mills, Chief Nurse		
Freedom of Information Status		Open	

Governor Responsibility (please tick any which are impacted on / relevant to this paper)	
Holding the Non-Executive Directors to account	☐
Non-Executive Director appointments (appraisal review)	☐
Constitutional/forward plans	☐
Member/Public interests	☒
Significant transaction/private patient increase	☐
Appointment of External Auditor	☐
Appointment of the Chief Executive	☐

Action/Decision Required
(please tick any which are relevant to this paper)

For Decision	☐	For Assurance	☐	For Approval	☐	For Information	☒

Executive Summary

Purpose

This paper provides an update to the Council of Governors on the delivery of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan

Key issues to note

- The June 2017 Steering Group approved the closure of three further recommendations
- There are three remaining recommendations to close, it is anticipated that these will be closed or transferred to the paediatric cardiac network work plan following the July 26th meeting.
- The Board will receive a final report on the delivery of the recommendations at the September meeting of the Trust Board. This will detail ongoing assurance work planned.

Internal audit have been commissioned to undertake two audits to provide additional assurance to Trust Board members, on the robustness of the sign off process of completed recommendations and in 6 months the completion of ongoing follow up/audit actions.

Recommendations

Governors are asked to: • **Note** the report.

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

Date papers were previously submitted to other committees				
Nominations and Appointments Committee	**Quality Focus Group**	**Governor Strategy Group**	**Constitution Focus Group**	**Public Trust Board meeting 29/617**

Independent Review of Children's Cardiac Services at the Bristol Royal Hospital for Children (BRCH)

1.0 Introduction

This paper provides an update to Board members on development of the programme plan to address the recommendations for University Hospitals Bristol NHS Foundation Trust and South West and Wales Congenital Heart Network as set out in the Independent Review of the children's cardiac service at the Bristol Royal Hospital for Children and a CQC expert review of clinical outcomes of the children cardiac service published on 30 June 2016. It also provides and update on work to ensure that clinical leaders and service users (young people and family members) are engaged and involved in the development and delivery of the actions within the programme plan.

2.0 Programme management

The tables below details a high level progress update of delivery against the agreed programme plan for the three delivery groups. The plan shows the progress of the work that is ongoing to deliver the actions to support the closure of the recommendations. It also shows where delivery of the actions is not within the initially set timescales.

Please see below update via delivery groups:

Table 1: Status Women's & Children's Delivery Group (total= 18)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	13	1	4	0	0 of 32
Oct '16	0	0	15	3	0	0	0 of 32
Nov'16	0	3	9	6	0	0	0 of 32
Dec'16	0	3	9	6	0	0	2 of 32
Jan'17	0	9	3	6	0	0	5 of 32
Feb'17	6	3	3	6	0	0	5 of 32
Mar'17	3	2	2	11	0	0	11 of 32
Apr'17	3	2	2	11	0	0	11 0f 32
May'17	2	1	0	15	0	0	13 of 32

Table 2: Consent Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	Red	Amber	Blue- on target	Green- completed	TBC	Not started	
Sept '16	0	0	1	0	1	3	0 of 32
Oct '16	0	0	5	0	0	0	0 of 32

Nov'16	0	0	5	0	0	0	**0 of 32**
Dec'16	0	0	5	0	0	0	**0 of 32**
Jan'17	0	4	1	0	0	0	**0 of 32**
Feb'17	4	0	1	0	0	0	**0 of 32**
Mar'17	0	0	1	4	0	0	**4 of 32**
Apr'17	0	0	1	4	0	0	**4 of 32**
May'17	0	0	0	5	0	0	**5 of 32**

Table 4: Status Incident and Complaints Delivery Group (total= 5)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	1	0	4	0	**0 of 32**
Oct '16	0	0	5	0	0	0	**0 of 32**
Nov'16	0	2	3	0	0	0	**0 of 32**
Dec'16	0	2	3	0	0	0	**0 of 32**
Jan'17	0	3	2	0	0	0	**0 of 32**
Feb'17	1	2	2	0	0	0	**0 of 32**
Mar'17	0	2	1	2	0	0	**2 of 32**
Apr'17	1	1	1	2	0	0	**2 of 32**
May'17	1	0	0	4	0	0	**4 of 32**

Table 5: Status Other Actions governed by Steering Group (total=4)

	Actions in Progress						RECOMMENDATIONS CLOSED BY STEERING GROUP
MONTH	**Red**	**Amber**	**Blue- on target**	**Green- completed**	**TBC**	**Not started**	
Sept '16	0	0	1	0	2	1	**0 of 32**
Oct '16	0	0	1	2	1	0	**0 of 32**
Nov'16	0	0	2	2	0	0	**0 of 32**
Dec'16	0	0	2	2	0	0	**0 of 32**
Jan'17	0	2	0	2	0	0	**0 of 32**
Feb'17	1	0	0	3	0	0	**3 of 32**
Mar'17	1	0	0	3	0	0	**3 of 32**

Apr'17	1	0	0	3	0	0	**3 of 32**
May'17	0	0	0	4	0	0	**4 of 32**

Exception report- Red actions

Recommendation 7 – (Management of follow up appointments) All actions to deliver the recommendation have been completed as has the validation of the outpatient backlog and the development of a recovery trajectory to address the backlog. The recommendation was not supported for closure by the delivery group as the actions in the plan to address the backlog had not yet all commenced. The risk relating to the potential impact on delivery of the recommendation remains on the risk register rated a 6. The plan is to present for closure at the July steering group meeting.

Recommendation 18 – (risk assessment of cancellations) was discussed at the May delivery group meeting however a request to close was not submitted to the steering group because the delivery group did not receive the assurance that they required of the embeddedness of the action to review data weekly at the designated meeting The plan is to present at the June/July meeting for closure.

Exception report – Amber actions

Recommendation 4 - Support for women accessing fetal services between Wales and Bristol; this recommendation is due for closure in June, following one date revision, and is anticipated to be ready for closure at this time. The fetal survey results have been received and are being reviewed; in view of vacancies in the cardiac fetal service on both sites it is expected that some elements of the work required will transfer into the Network work plan for completion.

3.0 Risks to Delivery

No further risks to delivery were added to the project risk register.
Risk ICR1: risk of commitment to changes required for ensure closer working with UHBristol and University Hospital Wales (UHW) and relevant commission organisations was reduced from a risk rating of 12 to 4 as a result of funding being agreed to support additional consultant sessions in UHW.
Risk ICR2: risk of delivery to fetal cardiology service in UHW due to lack of substantive/vacant consultant positions was reduced from a risk rating of 12 to 8 following an agreement on the operational requirements to meet the service need. The rating was not reduced further as the positions have not yet been recruited to.

4.0 Recommendations closed

The June 2017 Steering Group approved the closure of three recommendations:

- recommendation 5
- recommendation 30
- CQC Action 2

This leaves three outstanding recommendations 7,18,CQC 2 requiring completion.

5.0 Family involvement update

The majority of actions on the original plan have been completed.

Work in progress includes:
- Listening events in peripheral clinics
- Fetal pathway satisfaction questionnaire
- Listening event in collaboration with the Welsh commissioners and service providers.

PROGRESS REPORT AGAINST UH BRISTOL RECOMMENDATIONS FROM THE INDEPENDENT REVIEW OF CHILDREN'S CARDIAC SERVICES – 23rd May 2017 Delivery Group update

1. Women's and Children's Delivery Group Action Plan

W&C Recommendation's delivery timeframe

MONTH	Oct '16	Nov '16	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17
Recommendations	**8-** Outpatients experience **Approved as closed by Steering Group (09/01/17)**	18- Cancelled Operations risk assessment - timescale change request to Feb'17 Change req to Mar'17 Final SOP and new Next steps SOP with transformation team. March'17 delivery group felt unable to sign off recommendation; all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly; request for a further delay to May 17 to enable the demonstration of embedding in practice. April'17 Process in place to record all cancelled patients, presented to cardiac clinicians weekly at JCC meeting. All discussions when patients are cancelled are captured here. Further work to provide assurance that the meeting oversees the record of cancelled patients. RT to ensure that all clinicians are aware of the importance of reviewing the list. Reviewing JCC attendance to ensure appropriate oversight. May Delivery – need more data to demonstrate sustained commitment to holding and recording the discussion on risk	16- communication with families about team working/ involvement of other operators timescale change request to Feb'17 Change request to Mar'17 Intervention leaflet amendment & printing as a trial pending additions Mar'17 information booklets complete and approved through the divisional assurance process; some FI comments to include and then print, trial and evaluate; RTC supported by delivery group. Subject to steering group sign off an official launch date will be established and communicated to all staff. **Approved as closed by Steering group 4/4/17**	**7-** periodic audit of follow up care timescale change request to Feb'17 Change request to May'17 in view of numbers of outpatients and inpatients requiring validation to establish risk – added to RR Mar'17 initial validation of data completed; next steps to return to April mtg to consider alternative accommodation for additional clinics and associated costs and equipment requirements before rtc in May '17 April'17 Significant work undertaken to identify capacity gap (backlog and ongoing), locum advert going out, outpatient space being identified, additional clinics being planned. Trajectory of the outcome of this work for May delivery mtg with a view to closing recommendation. May 17 plan devised to address backlog, elements still requiring work before confidence to sign off, return to June delivery		**21-** (Commissioner) - provision of a comprehensive service of Psychological support, Trust-Expression of Interest submission **(green-provider actions)** Mar'17 RTC supported by the delivery group in view of successful recruitment **Approved as closed by Steering group 4/4/17**	**2-** NCHDA data team staffing Mar'17 recommendation added to IR risk register (is also on divisional risk register) as no current solution in place to provide additional resource to the data collection team. Mar'17 EOI unsuccessful, plan outstanding final actions at present, to review current resource and finalise a plan for April '17 mtg- added to risk register in view of no plan Apr'17 current paediatric resource reviewed, additional resource added into fetal service already so the team are able to absorb this additional workload with minimal additional support from paediatric team. Original bid reviewed and agreement received to fund additional paediatric admin and nursing time on a fixed term basis from within the division to allow for a full review of all data teams to establish whether any further economies or efficiencies can be identified. Data team have approved that this will be sufficient for the current workload and supporting the fetal team. Commitment from management team to review the team resource on a quarterly basis and external review pending Sept'17. Further sign off received at joint cardiac board (26/04/17) to ensure no impact on adult services. Sign off by lead consultant for cardiac data confirmed additional input is sufficient for current requirements with ongoing review required. RTC agreed by delivery group. May steering group accepted for closure		
		20- End of life care and bereavement support **(approved as closed by Steering group 07/02/17)**	23- reporting and grading of patient safety issues **(approved as closed by Steering group 07/02/17)**	**9 &11-** Benchmarking exercise (gaps/actions/implement plan) timescale change request			**3 & CQC 5-** review access to information – diagnosis and pathway of care Mar'17 rec. 3 progressing to plan CQC 5 supported for closure in view of the production of information sheets to support		

				to Feb'17 Change request Mar'17 – benchmarking almost complete – action plan to be devised Mar'17 feedback provided to support the RTC of recommendations with the caveat that, as the action plan is a work in progress it would be held and progressed by the cardiac business meeting. **Approved as closed by Steering group 4/4/17**			over 33 different operations; FI comments to be incorporated and then print, trial and evaluate **Rec 5 Approved as closed by Steering group 4/4/17** April'17 template front sheets presented to group; have been to listening events and cardiac governance for review and comment which have been incorporated. To go back to governance on Friday 28th for final approval and agreement on a go live date, location on website (BRHC or Network or both). Links added to patient letters to guide families to website. Patient information leaflets updated and in circulation. RTC approved by delivery group pending governance sign off for visual pathways and caveats as above. May steering group accepted for closure		
		CQC 3- Pain and comfort scores **Approved as closed by Steering Group (06/12/16)**	CQC 4 CNS recording of discussions with families in notes timescale change request to Feb'17 Change request to Apr 17 to allow for additional training Mar17 delivery group supported RTC in view of provision of medway communications page in use and accessible to all appropriate staff; plan to audit quality of records and return to delivery group. **Approved as closed by Steering group 4/4/17**	**CQC 6-** Discharge planning to include AHP advice **(approved as closed by Steering group 07/02/17)**			**4-** Support for women accessing fetal services between Wales and Bristol – *timescale change request to Jun '17* Mar'17 update, FI review of questionnaire complete. April'17 letter sent to all families, questionnaire going out to respondees by end April. Improvements will be identified and planned and are anticipated to be sufficient to sign off recommendation by June however both sites have fetal vacancies and therefore this will impact on the timescale for the delivery of the total plan. May'17 on track for June closure, fetal survey results received.		
		CQC 2 Formal ECHO report during surgery change request to Mar'17 to allow re-audit Mar'17 re-audit shows an improvement in the use of the echo forms however they are still not in use 100% of times. Request to amend delivery date to May'17 to allow for reaudit. Apr'17 Further audit in May to come to delivery group end of May. RT to highlight to cardiologists and IJ to highlight to intensivists. May'17 request to close supported for June steering					**5-** Improved pathways of care paed. cardiology services between Wales and Bristol – timescale change request to May '17 April '17 improvements identified, corresponding with Wales re implementation, awaiting a response. Recommendation on target to close at May delivery meeting May'17 request to close supported for June steering.		

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2	That the Trust should review the adequacy of staffing to support NCHDA's audit and collection of data.	Deputy Divisional Director	Apr '17	**Green-complete**	None		Review of staffing	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green-complete**	Staffing review report
							Results and recommendations reported at Women's and Children's Delivery Group in Sept. '16.	Assistant General Manager for Paediatric Cardiac Services	Sept '17	**Green-complete**	Women's and Children's Delivery Group Agenda and minutes 20.09.16
							Requirement for additional staff will feed into business round 2016-17	Assistant General Manager for Paediatric Cardiac Services	Apr' 17	**Green-complete**	Expression of interest form and Women's and Children's Operating Plan Feb Meeting – review of current resources (FU/VM) Mar'17 added to IR RR in view of concerns over ability to meet recommendation requirements due to lack of support for additional resource Apr'17 review complete, additional resource funded by division, RTC submitted

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3	That the Trust should review the information given to families at the point of diagnosis (whether antenatal or post-natal), to ensure that it covers not only diagnosis but also the proposed pathway of care. Attention should be paid to the means by which such information is conveyed, and the use of internet and electronic resources to supplement leaflets and letters.	Specialist Clinical Psychologist	Apr '17	**Green-complete**			Information given to families at the point of diagnosis reviewed by the clinical team and the cardiac families – remaining information for Catheter Procedures and Discharge leaflet. Website and leaflets updated to reflect improvements	Clinical Team & Cardiac Families	Jan' 16	**Green-complete**	Revised patient information leaflets
							Links to access relevant information to be added to the bottom of clinic letters for patients.	Specialist Clinical Psychologist	Dec '16	**Green - Complete**	Clinic letter with links (examples Feb mtg docs)
							Review and amendment of Catheter and Discharge leaflet	Cardiac CNS team	Feb' 17	**Green - Complete**	Revised Catheter and Discharge leaflet Feb mtg – this may replicate work in recomm 16 CNS team to check (JH/ST)
							Enhance existing information with a visual diagram displaying pathways of care (FI).	Specialist Clinical Psychologist	Apr' 17	**Green-complete**	Pathways of Care devised – update to come to Mar'17 mtg re opportunities to link with Network website to enable interactive functionality VG/LS to discuss timescales to share with Virtual group Mar'17 visual pathways shared at listening event – supportive of structure and content; charitable funding secured; designer commissioned with a timescale of draft drawings by April 17 mtg for RTC

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											April'17 visual pathway designs received, RTC approved caveated by sign off by cardiac governance meeting
							Website proposal to be written for new Children's website including cardiac information similar to Evelina to improve accessibility of our information. *This will be additional and not essential for delivery of the recommendation* (FI).	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Started**	
							Smart phone App proposal to be written for Cardiac Services to enable patient/families to access information electronically (FI). *This will be additional and not essential for delivery of the recommendation*	LIAISE Team Manager and Specialist Clinical Psychologist	tbc	**Not started**	
4	That the Commissioners and providers of fetal cardiology services in Wales should review the availability of support for women, including for any transition to Bristol or other specialist tertiary centres. For example, women whose fetus is diagnosed with a cardiac anomaly and are delivering their baby in Wales should be offered the	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that operational challenges in delivery of the fetal	Jun 17 due to delay in engagement with UHW and the operational challenges in their fetal cardiology service	Meeting arranged for 18th November with English and Welsh commissioners as well as Bristol and Cardiff trusts to establish: 1. Commissioner oversight of network 2. Commissioner support for IR actions (4,5 &11) 3. Establishment of working group(s) to address the specific changes in practices required	CHD Network Clinical Director and Network Manager	Nov '16	**Green - complete**	Agreed pathway of care in line with new CHD standards and in line with patient feedback Update from May delivery group – significant work completed, survey complete and results returned. Pt counselling and CNS cover addressed. Offer in place for families to visit Bristol when antenatal

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	opportunity, and be supported to visit the centre in Bristol, if there is an expectation that their baby will be transferred to Bristol at some point following the birth				cardiology service in UHW prevent focus on the achievement of this recommendation business plan						diagnosis made. Vacancies in both main sites will mean that the full extent of the work planned in this area will move to the Network work plan going forward. Plan to request closure in June 2017
							Ahead of the meeting: define specifics of recommendation (e.g. approaches to diagnosis and counselling); options for patient involvement (survey then focus group); CHD standards that relate to this recommendation; examples of practice from other centres	CHD Network Clinical Director and Network Manager	Nov '16	**Green-complete**	
							University Hospital Wales to define how additional foetal sessions will be delivered and who from foetal cardiology will lead the recommendation implementation and collaborate with Bristol to set up working group in January	Clinical Director for Acute Child Health, university hospital wales	~~Dec '16~~ Revised to Mar '17. UHW have appointed lead, but have not yet resolved operational issues	**Green - Complete**	Feb mtg – outline plan for foetal sessions, process to manage referral through acceptance criteria in short term
							Foetal working group to define changes / new pathways, taking account of patient feedback	Working group	~~Jan '17~~ Revised to Feb '17. Working group established, but	**Amber – behind plan**	Feb mtg - Changes defined; joint review of approach to counselling; establishment of joint service review meeting

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									struggling to coordinate diaries for meeting		Outstanding – patient feedback; survey complete ready to go to QIS group before circulation Mar'17 foetal survey being sent out having been for FI feedback which has been incorporated. April'17 letter sent to all identified families to pre-warn and request agreement to receive survey, survey out this week. On target for June closure
							Undertake patient survey and focus groups (FI).	CHD Network Manager	~~Jan '17~~ Revised to Jun 17due to delay in engagement with UHW and the operational challenges in their fetal service	**Amber – behind plan**	As above
							Co-design the offer with patient representatives for women whose fetus has been diagnosed with cardiac anomaly and deliver agreed model.	CHD Network Manager	Apr 17	**Amber – behind plan**	Feb mtg -Focus group to come from survey results

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											Mar'17 as above
							New pathways in place	CHD Network Clinical Director and Network Manager	~~Apr '17~~ Revised to Jun 17	**Amber – behind plan**	Feb mtg - Summary paper showing previous and new ways of working, detailing an assessment of the benefits; Pathways to follow completion of actions above
5	The South West and Wales Network should regard it as a priority in its development to achieve better co-ordination between the paediatric cardiology service in Wales and the paediatric cardiac services in Bristol.	CHD Network Clinical Director	Apr '17	**Amber – behind plan**	Risk that we are unable to get commitment / agreement on the changes that are required across the two hospitals / commissioning bodies Risk that lack of paediatric cardiology lead in UHW delays the ability to undertake actions	Final completion delayed to May 17 due to initial delay getting engagement from UHW	Network Manager and Network Clinical Director to contact Welsh Commissioners and University of Hospital of Wales to meet to discuss and agree process including method of monitoring its implementation	CHD Network Manager	Nov 16	**Green-complete**	
							Set up joint working group set up with Network Team facilitating. UHB, UHW and commissioners to deliver the relevant actions and improvements required for service.	CHD Network Manager	Dec 16	**Green-complete**	Minutes of meeting and action plan
							To define the opportunities for improvement in coordination and the actions to achieve this	CHD Network Manager	Dec 16	**Green-complete**	Action plan
							To undertake a patient engagement exercise (e.g. focus group, survey, online reference group) to test the proposed options for improvement	CHD Network Manager	Jan 17	**Green - complete**	Feb mtg - Proposal sent to virtual ref group, 1 response to date which will be incorporated into plans; any further feedback received will be incorporated
							Deliver actions to improve coordination	CHD Network Manager	May 17	**Blue- on target**	Feb mtg - improved in-pt transfer process; joint audit and training; improved

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											IT for sharing images; standardised patient information; further changes required to meet recommendation April'17 work ongoing, improvements identified, awaiting contact from UHW on target for May closure May'17 RTC presented and approved by delivery group; work plan for network devised and approved by network board; reviewed quarterly by trust board and annually by commissioners. Welsh cons now have JCC in their job plans to support attendance. Review of process at JCC req to ensure that appropriate clinicians are present for discussions. CNS work plan being reviewed to support peripheral services.

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											Commitment to provide CNS cover for all additional outpatient services at UHW
7	The paediatric cardiac service in Bristol should carry out periodic audit of follow-up care to ensure that the care is in line with the intended treatment plan, including with regards to the timing of follow-up appointments.	Deputy Divisional Director	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	None	Timescale change request to Feb'17 to provide assurance about backlog validation Timescale change request to May 17 in view of requirement to validate backlog to establish risk – item added to risk register	Audit proposal submitted to the audit facilitator for inclusion on the Children's annual audit plan	Patient Safety Manager	Aug '16	**Green-complete**	Audit proposal
							Conduct 1st annual audit into follow up care for cardiac patients as per recommendation	Patient Safety Manager	Nov '16	**Green-complete**	Audit report
							Report findings of the audit	Patient Safety Manager	Jan '17	**Green-complete**	Audit presentation and W&C delivery group Agenda and minutes November meeting
							System developed for the regular reporting and review of follow up waiting lists at monthly Cardiac Business meeting.	Assistant General Manager for Paediatric Cardiac Services	Aug '16	**Green-complete**	Follow up backlog report, Cardiac Monthly Business meeting standard agenda Feb mtg – validation work ongoing; added to RR (VM/FU) action can be RTC once complete and any risks established Mar'17 validation complete; options for delivering additional activity being scoped as described above. April'17 validation ongoing, capacity gap identified, locum advert,

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											space being identified. Trajectory will be in place for May closure. May'17 RTC presented to group. Clear trajectory presented for what is required to happen to address the backlog and also recurrent capacity gaps. RTC rejected on the basis of the requirement for more progress on the proposed plans to address the backlog in view of remaining risks re: funding; clinic space; clinician agreement to undertake WLI. To return to June mtg when there will be more clarity on these elements.
8	The Trust should monitor the experience of children and families to ensure that improvements in the	Nurse Project Lead	Oct '16	**Approved as closed by Steering Group (09/01/17)**			Baseline assessment (monthly outpatient survey) of current experience of children and families in outpatients reviewed)	Outpatients Experience working group	Aug '16	**Green-complete**	1.Outpatients and Clinical Investigations Unit Service Delivery Terms of

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	organisation of outpatient clinics have been effective.			**22/11/16- approved for closure by W&C delivery group**			Gap analysis of current monitoring vs monitoring required to understand patients experience of the organisation of outpatient's completed	Outpatients Experience working group	Sept '16	**Green- complete**	Reference 2. Outpatients and Clinical Investigations Unit Service Delivery Group Agenda(3.10.16) 3. Outpatients and Clinical Investigations Unit Service Delivery minutes of meeting (3.10.16) 4. OPD Patient Experience Report (October 2016) 5. Paediatric Cardiology – Non-Admitted RTT Recovery (Appendix 1) 6. Cardiology Follow-Up backlog update (Appendix 7. Project on a Page: Outpatient Productivity at BRHC (Appendix 7)
							Systems in place for regular and specific monitoring, and reviewing and acting on results (FI)	Outpatients & CIU Service Delivery Group	Oct '16	**Green- complete**	

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9	In the light of concerns about the continuing pressure on cardiologists and the facilities and resources available, the Children's Hospital should benchmark itself against comparable centres and make the necessary changes which such an exercise demonstrates as being necessary.	Divisional Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Risk that other sites are unable to share data required to complete a comprehensive benchmarking exercise Dependent on the action required to address the gaps it may not be possible to have implemented all the changes in the timescale.	Request to delay to Feb '17 due to late return of benchmarking Request to delay to Mar'17 as some benchmarking data received late; analysis ongoing with visits to be planned by Mar'17	Undertake benchmarking exercise with other CHD Networks, reviewing a defined list of criteria including aspects such as: job planning, IT and imaging links, information governance. To include site visits as appropriate	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Feb mtg - Benchmarking data collection analysis ongoing Site visits dates to be agreed for Mar mtg (JD) Mar'17 RTC supported by delivery group with the caveat that the action plan is held by the cardiac business meeting for completion
							Identification of actions required to address the gaps	CHD Network Manager	Jan '17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Gaps to be identified from completion of analysis; action held by Cardiac business group (JD)
							Progress to implementing any changes in practice that are deemed necessary	CHD Network Manager and Divisional Director	Jan '17 Revised to Feb '17. Delayed responses from other centres	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	As above, change implementation plan to be devised following gap analysis (JD)

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11	That the paediatric cardiac service benchmarks its current arrangements against other comparable centres, to ensure that its ability, as a tertiary 'Level 1' centre under the NCHD Standards, to communicate with a 'Level 2' centre, are adequate and sufficiently resourced. Benchmarking would require a study both of the technical resources underpinning good communication, and the physical capacity of clinicians to attend planning meetings such as the JCC (Links to recommendation no. 5)	CHD Network Clinical Director	Jan'17	**Red - behind plan, impact on recommendation delivery date and/or benefits delivery**	Linked to recommendation no.9. Actions detailed under recommendation no. 9 will also achieve recommendation no. 11. Risks to delivery, timescales, progress against delivery and evidence will be the same as per recommendation no. 9 Mar'17 benchmarking complete; RTC supported by delivery group						
16	As an interim measure pending any national guidance, that the paediatric cardiac service in the Trust reviews its practice to ensure that there is consistency of approach in the information provided to parents about the involvement of other	Clinical Lead for Cardiac Services and Consultant Paediatric Cardiac Surgeon	Dec '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow update of catheter leaflets in line with surgery ones Request delay to Mar'17 to allow completion of intervention leaflet and consideration	Enhance existing guidance to describe team working and in particular the involvement of other operators and team members in patient care. Review by the Trust wide consent group and Cardiac Clinical Governance for approval and then implement.	Consultant Paediatric Surgeon and Specialist Clinical Psychologist	Dec '16	**Green-complete**	Revised 'Preparing for Surgery' leaflet and email to surgeons about new guidance VG/LS to add updated leaflets to website Consider revision of ward 32's leaflet to replicate changes made

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	operators or team members.					for any others requiring this information to be included.					(ST) Complete changes to interventional leaflet (AP) and produce in draft as a trial for use with patients (ST). Mar'17 Booklets produced and formatted; shared widely for family input; signed off by business meeting with all comments incorporated prior to printing, trial and evaluation – RTC supported by delivery group
18	That steps be taken by the Trust to review the adequacy of the procedures for assessing risk in in relation to reviewing cancellations and the timing of re-scheduled procedures within paediatric cardiac services.	Deputy Divisional Director	Nov '16	**Red – second revision of timescales**		Request delay to Feb'17 to allow implementation of new cancellation policy Request delay to Mar'17 to allow development of next steps SOP to support process Request to delay to May '17 to enable the demonstration of the implementation of the process to risk assess	Assessment of current process of risk assessing patients who have been cancelled and the timing of their rescheduled procedure	Cardiac Review Programme Manager	Aug '16	**Green-complete**	Current process review report
							Develop new and improved process for risk assessing cancelled patients ensuring outcomes of this are documented	Consultant Paediatric Surgeon and Cardiac Review Programme Manager	Nov '16	**Green-complete**	JCC performance review meeting agenda and cancelled operations report Sops for cancellation and next steps being reviewed/devised for presentation at Mar'17 mtg (ST) March'17 delivery group felt unable to sign off recommendation;

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						patients adequately					all documentation has been produced to support the process however we have been unable to evidence that the process is being followed robustly April'17 process in place to risk assessment cancelled patients, assurance process during May with a view to closing at May mtg. May'17 not presented for closure as process in place and being documented however only 2 weeks documentation available to support closure and therefore agreement to defer to June mtg to ensure sufficient evidence to support process embedded in practice. Consider incorporating some of the processes used at the Evelina re

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											cancellation and performance oversight (VM/RT)
20	That the Trust should set out a timetable for the establishment of appropriate services for end-of-life care and bereavement support.	Deputy Divisional Director	Nov '16	**Green-complete**	None		End-of-life care and bereavement support pathway developed (FI)	Deputy Divisional Director	Sept '16	**Green-complete**	End-of-life and bereavement support pathway
							Implementation and roll out of new pathway	Deputy Divisional Director	Nov '16	**Green-complete**	Communication and presentations to roll out
21	Commissioners should give priority to the need to provide adequate funds for the provision of a comprehensive service of psychological support	Commissioners		**Green-complete (provider actions)**			Previous submission to commissioners for psychological support updated	Head of Psychology Services	Sept '16	**Green-complete**	Submission to Commissions
							Expression of Interest for increased resource to be submitted as part of business planning	Head of Psychology Services / Deputy Divisional Director	Mar'17	**Green-complete**	Expression of interest and W&C Business plan Mar 17 update Recruitment completed RTC supported by delivery group
23	That the BRHC confirm, by audit or other suitable means of review, that effective action has been taken to ensure that staff possess a shared understanding of the nature of patient safety incidents and how they should be ranked.	Deputy Divisional Director	Dec '16	**Green-complete**	None		Review results of Trust wide Manchester Patient Safety (MAPSAF) to understand current baseline for both team level and divisional staff views on patient safety incident reporting and management	Deputy Divisional Director	Sept '16	**Green-complete**	
							Annual programme- Targeted approach to all staff groups to be developed with implementation of bespoke training and regular updates to clinical staff	Deputy Divisional Director	Dec '16	**Green-complete**	Training plan and log of attendance

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CQ C.2	Provision of a formal report of transoesophageal or epicardial echocardiography performed during surgery	Clinical Lead for Cardiac Services	Nov '16	**Red – second revision of timescales**		Mar '17 Delayed to allow audit to demonstrate improvement Mar'17 Request to delay to May '17 to enable the demonstration of robust and consistent implementation	ECHO form for reporting in theatres implemented	Consultant Paediatric Cardiologist	Aug '16	**Green-complete**	
							Audit to assess implementation (Nov'16) and request to Steering Group to close	Patient Safety Manager	~~Nov '16 Revised to Mar 17~~ Revised to May 17	**Red – second revision of timescales**	Repeat audit results expected at Mar'17 delivery group with a view to proposing closure of recommendation (JM/BS) Mar'17 audit shows improvement however not 100% compliance at present therefore further communication to clinicians and reaudit prior to closure April'17 reaudit planned for May 17 with a view to closure at May delivery group; comms going out to all teams re the importance of these records and location on electronic patient record system May'17 RTC presented in view of further audit; approved for closure in view of significant improvement in completion of forms, use of

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											correct forms, consistent filing position on Evolve. 100% compliance for the small cohort of patients able to be audited since the previous audit. Plan to reaudit in Aug 17 to ensure process embedded in practice.
CQ C. 3	Recording pain and comfort scores in line with planned care and when pain relief is changed to evaluate practice	Ward 32 Manager	Aug '16	**Green-complete** **22/11/16-approved for closure by W&C delivery group**			Documentation developed to record pain scores more easily	Ward 32 Manager	Jan'16	**Green-complete**	Nursing documentation
							Complete an audit on existing practise and report findings	Ward 32 Manager	Aug '16	**Green-complete**	Audit of nursing documentation
CQ C. 4	Ensuring all discussions with parents are recorded to avoid inconsistency in communication. This includes communications with the Cardiac Liaison Nurses, who should record contacts with families in the patient records (links with review recommendation 12)	Head of Nursing	Dec '16	**Amber-behind target**		Request delay to Feb'17 to ensure process is robust Request delay to Apr'17 in view of potential training needs for staff	Work with Cardiac Nurse Specialists to improve recording communication in the patients' medical records and review option of Medway proforma's to support recording in notes	Head of Nursing	~~Dec '16~~ Feb 17 revised timescale for wider issue	**Green-complete**	Examples of stickers in notes and Heartsuite entries Audit of compliance to be undertaken by MG/VG pre Mar mtg Process to provide consistent recording in accessible patient records to be established (ST) Mar'17 Medway record in place and in use; RTC supported by delivery group subject to audit of

	Progress overview						Detailed actions				
No.	**Recommendation**	**Lead Officer**	**Completion date**	**Status**	**Delivery Risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											quality of records to return to delivery group April 17 (MG/VG)
CQC. 5	Providing written material to families relating to diagnosis and recording this in the records. (links to review recommendation 3)	Clinical Lead for Cardiac Services	Apr '17	**Blue- on target**	Linked to recommendation no. 3. Actions detailed under recommendation no. 3 will also achieve CQC recommendation no. 5 Mar'17 Information sheets produced and formatted; shared widely for family input; signed off by governance meeting with all comments incorporated prior to printing, trial and evaluation; RTC supported by delivery group.						
CQC.6	Ensuring that advice from all professionals involved with individual children is included in discharge planning to ensure that all needs are addressed.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan '17	**Green-complete**		Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services	Assessment of current Allied Health Professionals input into discharge planning for Cardiac Services Audit completed and results to be formulated 27th October 2016.	Head of Allied Health Professionals	Oct '16	**Green-complete**	Assessment documentation
							Agree with Cardiac Services Team an effective mechanism for including Allied Health Professionals into discharge planning for Cardiac Services. Meeting setup for 4th November.	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Nov'16	**Green-complete**	Agreed mechanism for including AHP advice into discharge planning for children within Cardiac Services
							Implement agreed mechanism for including Allied Health Professionals into discharging planning for Cardiac Services	Head of Allied Health Professionals and Clinical Lead for Cardiac Services	Jan 17	**Blue – on target**	Implementation plan delivery report

Trust wide Incidents and Complaints Delivery Group Action Plan – Senior Responsible Officer; Helen Morgan, Deputy Chief Nurse

TW Incidents and complaints delivery timeframe – May 2017

MONTH	Oct '16	Nov	Dec '16	Jan '17	Feb '17	Mar '17	Apr' 17	May '17	Jun '17

		'16							
Recommendations			**28-**That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or investigations which require it. *Request to delay to Feb ' 17* *Feb mtg – sufficient evidence to complete recommendation to close for March meeting but now red as did not meet revised date;* *Evidence complete, RTC to Apr steering – recommendation supported for closure 4/4/17*	**26-** Development of an integrated process for the management of complaints and all related investigations- *timescale changed from Jan '17 to Jun '17*Mar mtg progress noted; work still to do re integrating adult information and further FI following inclusion of their comments to date April'17 all documentation complete, some documents require ratification however these have already had executive oversight therefore RTC to be submitted to Steering 2/5/17 May'17 accepted for closure by May steering			**29 -** Options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as early as possible, alternative forms of dispute resolution, such as medical mediation. Mar mtg – evidence complete; awaiting outcome of QAC to recommend next steps before RTC April'17 QAC approved training option and evaluate impact, CS to investigate other options; HM to discuss procurement/trust wide process with CM for agreement to progress to mediation. Recommendation requirements met therefore RTC to be submitted to Steering 2/5/17 May'17 accepted for closure by May steering		**27-** Design of the processes (26) should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective dialogue Mar mtg – evidence complete; action plans for ongoing monitoring in place therefore RTC to be submitted to the Apr steering group and supported for closure 4/4/17
			30 - Review its procedures to ensure that patients or families are offered not only information about any changes in practice, seek feedback on its						

			effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation- timescale changed from Dec '16 to Apr'16 Mar mtg progress noted; work still to do **May'17 work all completed, documents produced to support closure of recommendation; review by VRG and ratification through Clinical Quality Group completed, supported by delivery group for closure.**						

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
26.	That the Trust should explore urgently the development of an integrated process for the management of complaints and all related investigations following either a death of a child or a serious incident, taking account of the work of the NHS England's Medical Directorate on this matter. Clear guidance should be given to patients or	Chief Nurse	Jan '17	**Green-Complete**		Jun'17 additional and amended actions to fulfil recommendation	**26.1** Develop an appendix to the Serious Incident (SI) policy defining "link" between Child Death Review (CDR), complaints and SI investigations / reporting, includes adults and children.	Women and Children's Head of Governance	July '16	**Green-Complete** ***Approved by delivery group 15.11.16***	Link between serious incidents and other investigatory procedures (e.g. Complaints and Child Death Review) July 2016
							26.2 Develop and implement guidance for staff in **children's services** on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement.	Women and Children's Head of Governance	Dec '16	**Green – complete. 10.01.17 5/8 members approved remainder virtually.**	Document approved within the Division via Quality Assurance Group. Monitored weekly at the Bereavement Group. Audit Apr 17

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	parents about the function and purpose of each element of an investigation, how they may contribute if they so choose, and how their contributions will be reflected in reports. Such guidance should also draw attention to any sources of support which they may draw upon.										Audit of compliance complete; action plan sits with bereavement group
							26.3 Develop and implement guidance for staff in **adult services** on standards procedures / practices that need to be followed to provide a high quality and equitable service for all patients / families in the event of bereavement. **Supplementary**	Head of Quality (Patient Safety)	Jul '16	**Green-Complete**	Guidance for Supporting and Working with patients/families after unexpected death of an adult or a serious incident involving an adult, July 2016 (latest version)
							26.4 Develop 'guidance' / information for **families** in **children's services** how the x3 processes of Child Death Review (CDR) / Serious Investigation (SI) / Root Cause Analysis (RCA) investigation inquests and complaints are initiated / managed and integrate ***(FI)***	Women and Children's Head of Governance	April '17	**Green action complete Mar mtg action complete**	Unformatted version sent to VRG group for comment on content with an associated leaflet to demonstrate format; comments incorporated to add in adult version and resend to VRG
							26.5 Develop 'guidance' / information for **staff** in **children's services** on how the x3 processes of CDR / SI / RCA investigation inquests and complaints are initiated / managed and integrate.	Women and Children's Head of Governance	Dec '16	**Green action complete Due for presentation at February 17 meeting Now rated red as not approved at meeting Mar mtg – action**	Draft guidance presented; comments from group members to be incorporated and represented at March 2017 meeting SOP completed; to go to Mar QAC and implement; audit initially at

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
										complete	6/12 but then annually. Laura Westaway identified lead for audit.
							26.6 Develop the above **staff** guidance for **adult** patients and families (minus CDR) - **Supplementary**	Head of Quality (Patient Safety)	Dec '16	**Green – action complete**	As above Complete, signed off by CQG
							26.7 Develop the above **family** guidance for **adult** patients and families (minus CDR) **(FI). - Supplementary**	Head of Quality (Patient Safety)	Apr '17	**Green – action complete**	Leaflet produced but ongoing discussion around the process of sharing a draft RCA with family Links to rec 30 Apr'17 guidance complete, for ratification at CQG 4/4/17
							26.8 Review options for how patients / families can participate (if they want to) with the SI RCA process implement preferred options **(FI).**	Head of Quality (Patient Safety)	Jun '17	**Green – action complete**	As above Apr'17 guidance complete, for ratification at CQG 4/4/17
							26.9 Implement a process for gaining regular feedback from patients / families involved in a SI RCAs process to understand what it felt like for them and how we can improve the process for them **(FI)**	Head of Quality (Patient Safety)	Jun '17	**Green – action complete**	Ongoing work on how to achieve this Apr'17 process complete, for ratification at CQG 4/4/17
27	That the design of the processes we refer to should take account also of the need for guidance and training for clinical staff as regards liaising with families and enabling effective	Chief Nurse	Apr '17	**Green - completed**			**27.1** Guidance developed for staff for the preparation and conduct of meetings with parents/families to discuss concerns and/or adverse event feedback	Medical Director	Jun '16	**Green- complete Action approved 10.01.17 pending any further comments within 1 week.**	Guidance for the Preparation and Conduct of Meetings with Parents/Families to discuss concerns and/or adverse event feedback, June 2016

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	dialogue.										
							As per actions 26.4 and 26.5, included in recommendation no. 26 to develop guidance for staff				
							27.2 Develop a framework for training staff to support them to effectively and sensitively manage processes relating to CDR/SI's and complaints. Develop and pilot session. Existing complaints training materials to be reviewed and updated to include guidance on supporting families in circumstances where a complaint is being investigated alongside a CDR or SI. January 2017. Other bespoke training opportunities to be considered in light of development of staff guidance by Children's Services (see 26.5), due April 2017.	Head of Quality (Patient Experience and Clinical Effectiveness) And Head of Quality (Patient Safety)	Jun '17	**Blue- on target**	Training updated for pt safety, RCA, induction and complaints – add link to new documents developed as part of this action plan and then complete. BRHC training programme complete Plans for next steps to combine training for pt safety for BRHC and adults. Evidence to be provided for where & to whom training is being delivered then RTC
28	That guidance be drawn up which identifies when, and if so, how, an 'independent element' can be introduced into the handling of those complaints or investigations which require it.	Chief Nurse	Apr '17	**Green - completed**		Request to delay to Feb ' 17	**28.1** To review UHBristol's previous use of independent review / benchmarking from other trusts to inform above. - Complaints - RCA's	Patient Support and Complaints Manager and Patient Safety Manager	Nov '16 Nov '16	**Green- complete Action approved 10.01.17**	Reports of the Reviews undertaken and available in evidence folder
							28.2 Develop guidance for when to access 'independent advise / review' for - Complaints	Head of Quality (Patient Experience and Clinical Effectivenes	Oct '16	**Green – Complete Action approved 14.2.17**	Complaints policy

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
							- SI RCAs	s) And Head of Quality (Patient Safety)	Dec '16		Serious Incident Policy (appendix 9, pg. 33) Email from CS to all divisions on 6th February 2017
							28.3 The Trust has entered into exploratory discussions with the Patients Association about developing a model for exceptional independent investigation/review. This work will commence with a focus group of previous dissatisfied complainants in February 2017.	Head of Quality (Patient Experience and Clinical Effectiveness)	Mar '17	**Green – complete**	Focus meeting planned but not until May 17 due to pt assoc availability; letter of invitation to be added to evidence; ongoing assurance to be held by PEG RTC to be completed
							28.4 Consider how an independent review can be introduced for 2nd time dissatisfied complainants / involve users in developing a solution.	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	This action has been completed
29	That as part of the process of exploring the options for more effective handling of complaints, including the introduction of an independent element, serious consideration be given to offering as	Chief Nurse	Apr '17	**Green-Complete**			29.0 Visit the Evelina to understand their model for mediation and possible replication at UHBristol. A report will be presented following the visit to consider next steps and possible resource implications. - Action reviewed and agreed to receive a presentation from the Medical Mediation Foundation who provide the Evelina service.	SRO for I&C	Feb 17	**Green - Complete**	Medical Mediation Foundation meeting completed on 9/3/17. Feedback written up and sent to BRHC Quality Assurance

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
	early as possible, alternative forms of dispute resolution, such as medical mediation.										Committee 17/3/17 for recommendation re next steps; April'17 QAC approved training option and evaluate impact. CS to continue work to investigate other options, including work with patients Association; Recommendation requirements met therefore RTC to be submitted to Steering 2/5/17
30	That the Trust should review its procedures to ensure that patients or families are offered not only information about any changes in practice introduced as a result of a complaint or incident involving them or their families and seek feedback on its effectiveness, but also the opportunity to be involved in designing those changes and overseeing their implementation.	Chief Nurse	Dec '16	**Red – Delivery revised twice**		Apr '17 Revised to allow for family involvement	**30.1** Develop a clear process with timescales trust-wide for feedback to families / patients outcomes involved in SI panels / review and actions ongoing from this and staff **(FI).**	Head of Quality (Patient Safety)	Apr '17	**Green - completed**	Links to other engagement work; likely to be completed in conjunction Mar mtg discussed all actions link to Rec 26 (points 4,7,8 & 9) Process exists within Being open policy/Duty of Candour policy. Adult sheet to be added to options available for April 17 Del group RTCApr'17 adult sheet produced to go alongside

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											the paediatric ones already in place and agreed by BRHC QAC,, sent to VRG and to go to CQG 4/4/17 for ratification; agreed RTC May 17 once feedback and ratification & closure of rec 26. May'17 work all completed, documents produced to support closure of recommendation; review by VRG and ratification through Clinical Quality Group completed, supported by delivery group for closure.
							30.2 Ensure complainants are routinely asked whether and how they would like to be involved in designing changes in practice in response to the concerns they have raised **(FI)**	Head of Quality (Patient Experience and Clinical Effectiveness)	Oct '16	**Green-complete**	Evidence pro forma of questions used. Agreed additional action 30.3 before closing. Mar mtg - Audit data to date shows process in place and in use – more detailed audit to sit within the complaints work plan & feed

	Progress overview						Detailed actions				
No	**Recommendation**	**Lead Officer**	**Completion date of recommendation**	**Status**	**Delivery risks**	**Revised timescale & reason**	**Actions to deliver recommendations**	**By**	**When**	**Status**	**Evidence**
											into Patient Experience Group
							30.3 Use of process for asking patients how they would like to be involved in designing changes in practice in response to the concerns they have raised to be audited at the end of February 2017, including review of survey replies.	Head of Quality (Patient Experience and Clinical Effectiveness)	Feb '17	**Green-complete**	Audit results due to be presented at March 2017 delivery group Mar mtg - Audit data to date shows process in place and in use – more detailed audit to sit with the complaints work plan
							30.4 Regular complainant focus groups to be held from April 2017 onwards as part of routine follow-up of people's experience of the complaints system. Ambition is for these focus groups to eventually be facilitated by previous complainants. Supplementary	Head of Quality (Patient Experience and Clinical Effectiveness)	April '17	**Green-complete**	Mar mtg – action out with original scope of Rec and will enhance effectiveness but not fundamental to completion. Process in place to ensure that complainants are asked to attend focus group. First focus group scheduled for May 17 and ongoing will sit within the complaints work plan for ongoing work and scrutiny through PEG

Key	
R	Red - Milestone behind plan, requirement to revise delivery date on more than one occasion; impact on recommendation delivery date and/or benefits delivery

A	Amber - Milestone behind plan, delivery date revised on one occasion
B	Blue - Activities on plan to achieve milestone
TBC	To be confirmed
G	Complete / Closed
FI	Indicates family involvement in the action(s)