Our target for the year was to achieve fewer falls than the national benchmark of 5.6 per 1,000 bed days (National Patient Safety Agency); we achieved this for every month during 2014/15 (see Figure 1) and an overall rate of 4.8 falls per 1,000 bed days. This reduction has been achieved through a combination of focused work by the falls steering group, the falls assistant, and the promotion of initiatives such as the 'eyes on legs' campaign, which reminds all staff that they have a responsibility to help reduce falls. A revised falls care plan has been developed and implemented as part of a wider Trust initiative, and will be audited to ensure this is fully embedded in practice across the Trust. Each division reports their progress, incidents and actions to the falls steering group on a monthly basis to ensure learning and any changes in practice required take place.

The deputy chief nurse and head of quality (patient safety) have undertaken a review of 16 root cause analysis (RCA) reports following incidents involving falls between April and November 2014. Recurring themes included:

- lack of Fallsafe training for some staff, especially those new to the Trust
- lack of awareness of the post falls protocol noted for doctors and nurses in two cases
- 1:1 requests for staff to support three patients could not be filled
- poor or incomplete documentation noted for both nursing and medical notes, ranging from initial risk assessment, care plan, bathroom and toilet assessment to re-assessment as clinical condition changed
- lack of awareness and or training to use the scoop (a piece of equipment which assists staff in picking up patients who have had a fall)
- handover information when transferring patients was incomplete in two cases
- six of the patients had two or more ward moves; one patient was moved overnight.

Work to address some of these areas has been undertaken throughout 2014/15. The work of the Trust falls group in 2015/16 will focus on reducing the level of harm to patients as a result of a fall. Additional planned actions include: participation in the national falls audit; further development of the role of Trust falls champions; and a review and update of falls training to include the management of challenging cognitive behaviour, with the aim of further reducing avoidable falls and harm to our patients.

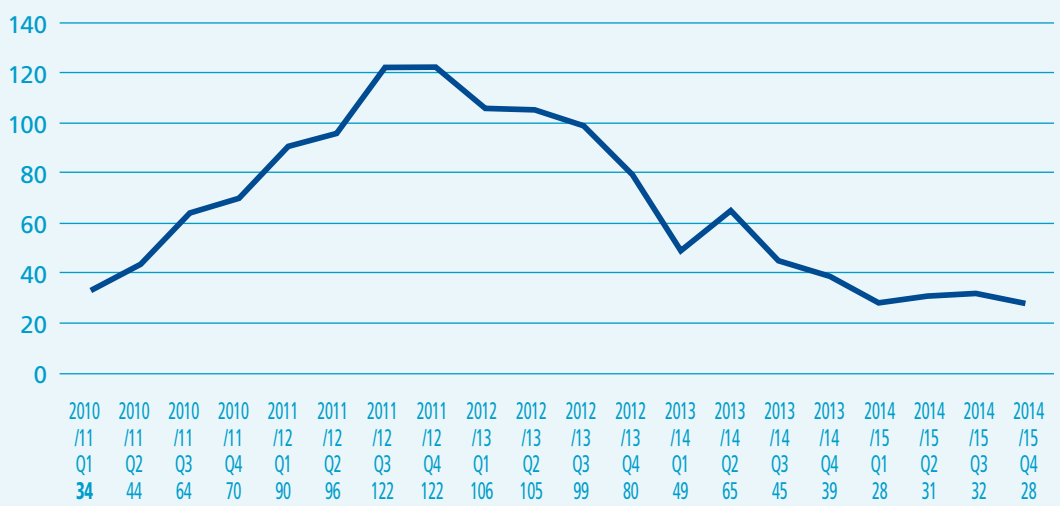
3.2.2 Pressure ulcers

Pressure ulcers are defined as localised skin or tissue damage as a direct result of pressure. They can range from small superficial skin damage to deep tissue injury that can lead to life-threatening complications.

In 2014/15, the Trust's target was to achieve fewer than 0.651 category 2 to 4 pressure ulcers per 1,000 bed days. The Trust achieved 0.398 per 1,000 bed days compared to a target of 0.651; this compares with a rate of 0.656 in 2013/2014 (fractionally short of our target for that year), and 1.264 in 2012/13, demonstrating the Trust's continued commitment to pressure ulcer prevention (see Figure 2).

Figure 2

Hospital acquired pressure ulcers, grade 2-4



Source: Ulysses Safeguard system

Achieving and sustaining pressure ulcer prevention requires a multifaceted approach. This incorporates: good communication; documentation and clinical rationale, underpinned by national guidance and current best practice. It also requires access to specialist clinicians, equipment, products and dressings in a timely manner.

Achievements during 2014/2015 included:

- weekly reports published on all category 2 to 4 pressure ulcers using national SSKIN tool sent to senior nursing staff and Trust executives, and cascaded to staff demonstrating good practice and areas for improvement
- bi-monthly review of pressure ulcers and feedback to each division through steering group
- development of key performance indicators for the tissue viability service
- implementation of standardised wound assessment documentation (to meet requirement of NICE clinical guideline 29), in alignment with community partners to aid continuity of care and joint working partnerships
- commencement of a three year project to standardise all dressings across acute and community healthcare services in the Bristol, North Somerset, South Gloucestershire area (BNNSG)
- introduction of a process to provide instant access to dressings and specialist equipment in all clinical areas, including negative pressure wound therapy (NPWT)
- extension of the current monthly pressure ulcer prevention training for all Trust staff to healthcare professionals in partner Trusts and organisations
- development of e-learning for staff on pressure ulcer prevention
- review of all Trust pressure ulcer care plans and risk tools
- implementation of a rolling quality audit programme on wound documentation.

Planned actions for 2015/2016 include:

- implementation of new patient-centric pressure ulcer care plans following a review and audit of the current care plan
- working with community partners to develop and implement new patient information leaflets, increasing patient awareness and encouraging greater engagement in self-care, with a consistent message across acute and community environments
- developing second generation e-learning – interactive learning, tailored for different specialities and clinical environments
- implementation of the new dressings formulary within the Trust.

3.2.3 Venous thromboembolism (VTE)

(Mandatory indicator)

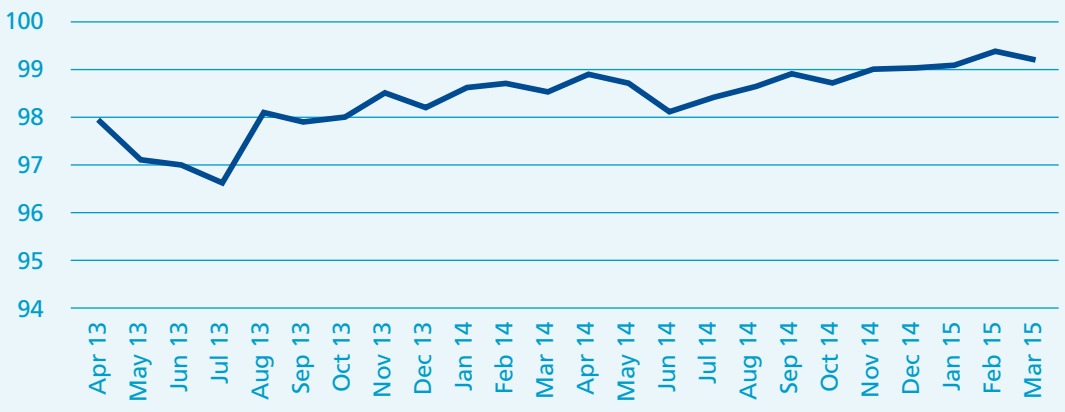
In 2014/15, we have consolidated on our strong performance in 2013/14 and have consistently achieved the required target of greater than 95 per cent of adult inpatients being risk assessed for risk of venous thromboembolism (VTE). For the year as a whole, we achieved 98.8 per cent[15]; this compares with 98.0 per cent in 2013/14. Since November 2014, we have consistently achieved 99 per cent or above.

[15] This figure differs from the 98.0 per cent quoted in table 7, which is from the Health & Social Care Information Centre and covers the first three quarters of the year only

[16] This is a requirement of our commissioners

Figure 3

Percentage of patients receiving VTE risk assessment



Source: Ulysses Safeguard system

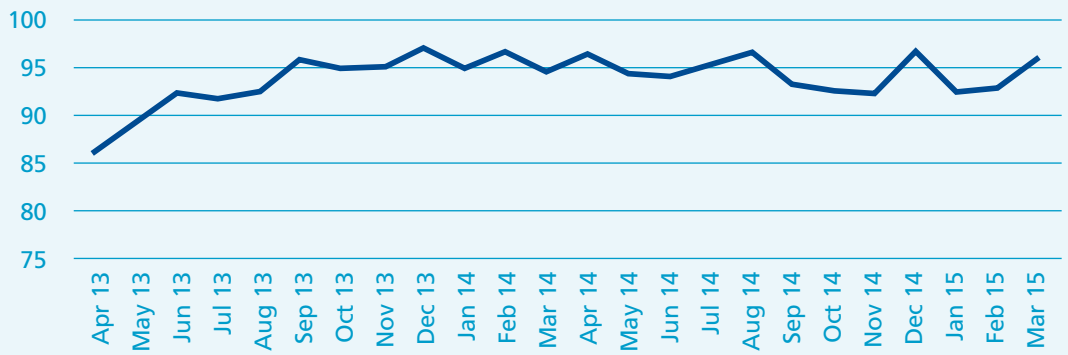
The Trust considers its VTE risk assessment data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework.

The Trust has taken the following actions in 2014/15 to sustain 95 per cent+ compliance with VTE risk assessments: all hospital associated VTE are subject to a modified root cause analysis (RCA) investigation[16], and should there be any learning regarding the timeliness or appropriateness of the VTE risk assessments and appropriate thromboprophylaxis, this is shared across the organisation. During the last year, there have been 66 cases of hospital acquired thrombosis (comparative data for 2013/14 is not available); at the time of writing, the Trust is fully up to date with the RCA process. In 2014/15, as a result of these investigations, we have implemented extended thromboprophylaxis for patients with lower limb fractures.

In 2014/15, 94.4 per cent of patients at risk of VTE received appropriate thromboprophylaxis, compared to 93.4 per cent in 2013/14 and 94.6 per cent in 2012/13. See Figure 4 below.

Figure 4

Percentage of patients receiving appropriate thrombo-prophylaxis



Source: Ulysses Safeguard system

3.2.4 Infection control

3.2.4.1 Clostridium difficile

(Mandatory indicator)

The Trust's focus on preventing healthcare acquired infections (HCAIs) is constant and ongoing. In 2014/15, a new process was introduced by Public Health England for assessing patients with *Clostridium difficile* to determine whether acquisition was avoidable or non-avoidable.

Although the Trust reported an increase in the total number of cases of *Clostridium difficile* infections in 2014/15 compared with 2013/14 (50 in 2014/15 compared with 38 in 2013/14), our commissioners' review of these cases confirmed that only eight of the 50 cases were considered avoidable by the Trust. The Trust was therefore confirmed as having far fewer cases than the centrally set annual limit of 40 cases, and also achieved the limit set for each quarter of 2014/15.

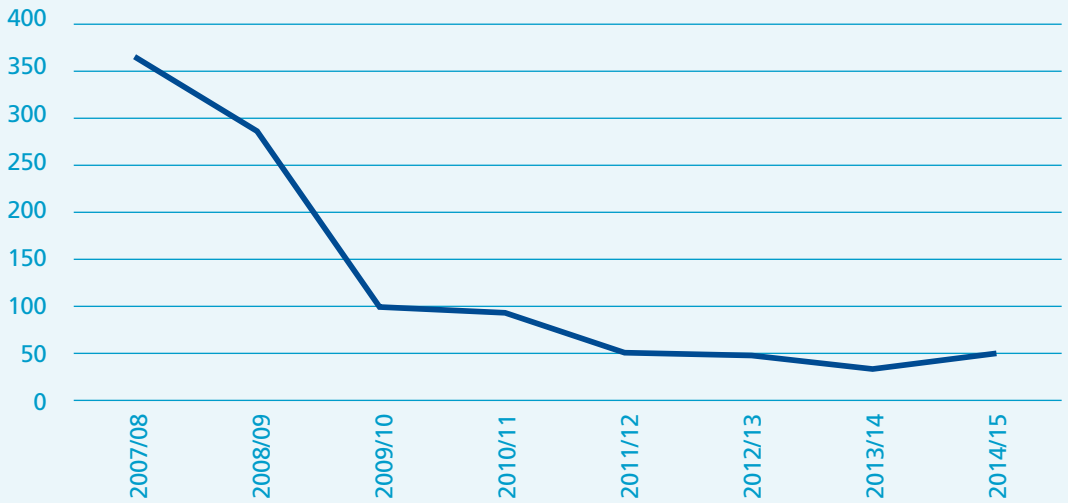
Possible reasons for the increase in the total number of *Clostridium difficile* infections include:

- slowly increasing mean age of patients with significant co-morbidities and immobility
- increased bed occupancy which reduces time for bed-space cleaning
- increased exposure to antibiotics because of respiratory and urinary tract infections in the hospital and community populations.

The Trust considers its *Clostridium difficile* data to be accurate because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the collection and validation of the data and its submission to a national database.

Figure 5

Number of reported cases of *Clostridium difficile*



Source: Public Health England Data Capture System

The Trust has taken the following actions in 2014/15 to manage *Clostridium difficile* infection and so improve patient safety:

- patients continue to be nursed in a separate cohort area and are not admitted back into the general patient population for their duration of stay in hospital
- patients are monitored on a daily basis by the infection control team, medical microbiologist and anti-infective pharmacist. When patients are discharged, patients' rooms are deep-cleaned. A hydrogen peroxide vapour is used for added assurance of cleaning
- antibiotic prescribing is monitored
- hand hygiene audits are undertaken each month. If the required standard is not reached, audits are repeated weekly until three consecutive weeks at the required standard are achieved
- patients with *Clostridium difficile* are managed by gastro-intestinal consultants and an infection control doctor.

3.2.4.2 Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia

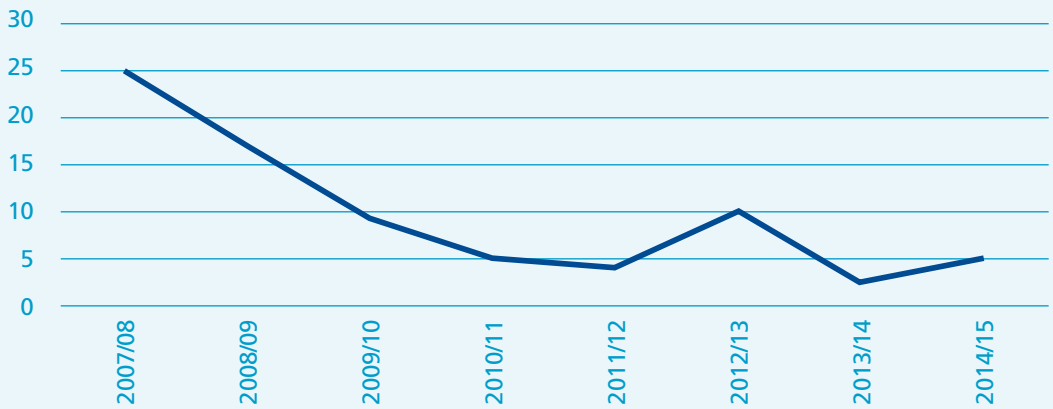
Disappointingly, the target of zero MRSA (Meticillin-resistant Staphylococcus aureus) bacteraemias was not achieved in 2014/15, with five cases being reported; an increase on the two cases reported in 2013/14. Of these five cases, three were patient infections. One case was confirmed to be a contaminated sample: this means that when the case was investigated, it was shown this was not an infection and did not adversely affect the patient, however it was still attributed to the Trust for reporting purposes. The remaining case was attributed to another NHS Trust however it is still counted against UH Bristol as it was first reported by us. Post infection reviews have been undertaken and have shown:

- results not being actioned in a timely manner
- MRSA screening not being performed as per Trust policy
- documentation not being completed appropriately in relation to cannulation
- removal of vascular access devices not undertaken as per Trust policy.

Action plans have been agreed to ensure these concerns are addressed.

Figure 6

Number of reported cases of *MRSA*



Source: Public Health England Data Capture System

3.2.4.3 Peripheral and central line care

Poor standards of aseptic technique are a fundamental cause of healthcare acquired infections (Department of Health, 2003).The aseptic non-touch technique (ANTT) is the standard intravenous technique used for the accessing of all venous access devices[17] regardless of whether they are peripherally or centrally inserted; the main focus of ANTT is to minimise the introduction of micro-organisms, which may occur during preparation, administration and delivery of IV therapy. Developments in 2014/15 include the following:

- the Trust's infection control link practitioners have taken on the role of ANTT champions throughout the organisation
- ANTT is now part of essential staff training
- an ANTT audit has been carried out Trust-wide to assess practice
- ANTT workshops have been well attended by staff
- attendance at the South West Forum by the Trust's intravenous access coordinator allows benchmarking with neighbouring Trusts with regard to practice and standards
- a database has been developed and piloted in the Bristol children's hospital for surveillance and management of vascular access devices
- the introduction of bio patches in the Medical Division has seen a decrease in line infections. Specialised Services are looking to also introduce this device
- central venous catheter and peripheral line policies have been updated
- a Trust-wide central line complications guideline has been developed and is now in use
- a blood culture-taking standard operating procedure has been developed and is in use.

3.2.4.4 Meticillin susceptible Staphylococcus aureus (MSSA) bacteraemia

In 2014/15, the Trust recorded 32 cases of MSSA bacteraemia. This exceeded our target of 25. Actions to prevent MSSA are similar to those for MRSA although, at present, widespread screening for MSSA is not recommended nationally. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA.

15 out of the 32 cases were related to vascular access devices. Work continues on care pathways for vascular access devices and standardisation of care. Education and awareness has increased, and aseptic non-touch technique continues to be a focus for infection control link nurses throughout the Trust.

3.2.4.5 Norovirus

In 2014/15, the Trust has had six full ward closures and 16 bay closures as a result of norovirus; a total of 22 closures in all. This equates to 153 bed days lost. This is a significant improvement compared to 2013/14, when there were 47 closures. Norovirus is being managed much more effectively following the opening of the new Bristol Royal Infirmary ward block and the corresponding increase in side room capacity. We continue to follow national norovirus guidelines and report outbreaks through the Public Health England hospital norovirus outbreak reporting system.

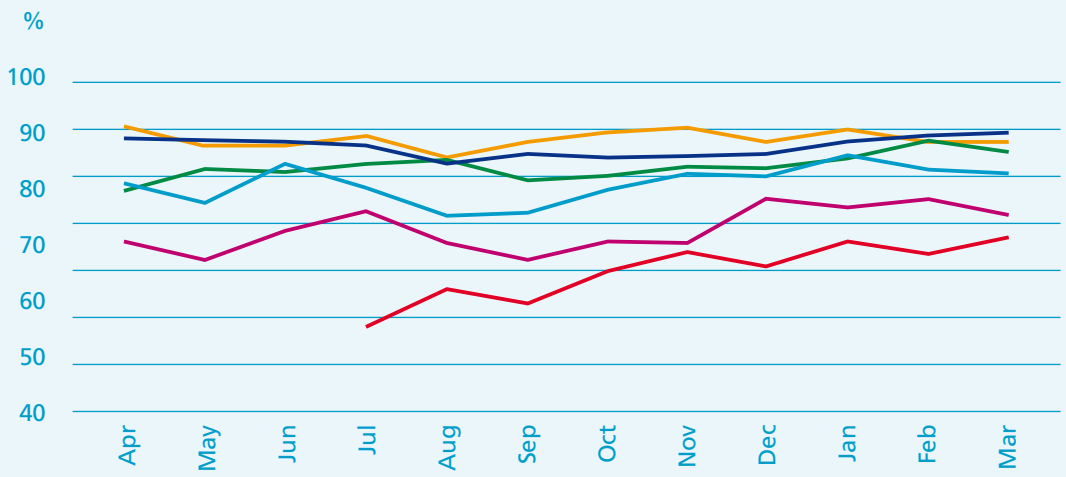
[17] An indwelling catheter, cannula, or other instrument used to obtain venous or arterial access

3.2.4.6 Hand hygiene and antibiotic compliance

We continue to train all staff in infection prevention and control measures. Antibiotic compliance (checking the appropriateness of the antibiotic, whether start and stop dates are recorded, and whether the prescriber's name is legible) is monitored on a monthly basis. 2014/15 has continued a pattern of year-on-year improvement in compliance, as demonstrated by Figure 7 below.

Figure 7

Trustwide antibiotic prescribing compliance



Source: University Hospitals Bristol pharmacy department

Trust hand hygiene audits achieved scores of 97 per cent or more across all four quarters of 2014/15, against a target of 95 per cent.

What patients said in our monthly survey:

"I work for a private volunteer ambulance service and I watched the cleaner closely – he did an outstanding job on floor, fixtures and fittings and the whole bed frames and equipment in the room."

3.2.5 Reducing medication errors

In 2014/15, our aim was to comply with the Patient Safety Alert NHS/PSA/D/2014/005 ('Improving medication error incident reporting and learning'), and ensure the level of moderate or greater harm resulting from medication errors was kept to a minimum.

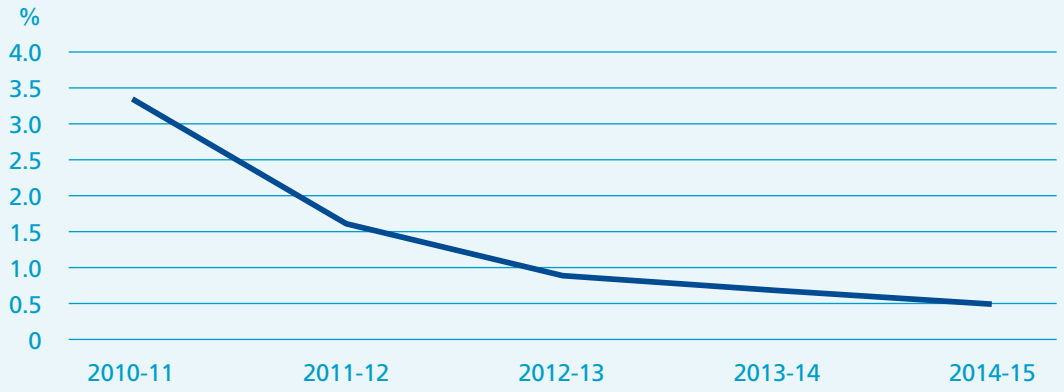
Patient Safety Alert NHS/PSA/D/2014/005 focused upon effective reporting of medication error incidents, and ensuring that lessons are learned within the organisation. This alert was implemented in a timely manner, with a Trust medication safety officer assigned to co-ordinate the regular review of all medication safety incidents and to engage in a national medication safety network. This key post ensures there is multidisciplinary review of local incidents, focuses on organisational learning, and feeds back important lessons from reported incidents and national priorities.

Once again, more than 99 per cent of reported medication incidents at our Trust in 2014/15 did not result in major harm to patients (defined as no obvious harm or damage to the patient). Our target was to improve on our 2013/14 performance, when 0.68 per cent (13/1,910) of reported medication incidents involved moderate, major or catastrophic harm to patients; in 2014/15, 0.5 per cent (10/2007) of medication related incidents resulted in moderate (8/10), major (1/10) or catastrophic (1/10) harm. This compares to 10 moderate, two major and one catastrophic incident in 2013/14. Changes in 2014/2015 that have contributed to this improvement in our performance include: further face to face sessions with all clinical staff at both induction and clinical updates on safer medicines management; review and learning from incidents as detailed in the above Patient Safety Alert; feedback to clinical staff through

safety bulletins, 'grand rounds' and other opportunities; and ongoing improvement from work focusing on the reduction of omitted doses.

Figure 8

Medication errors resulting in moderate or greater actual harm



Source: Ulysses Safeguard system

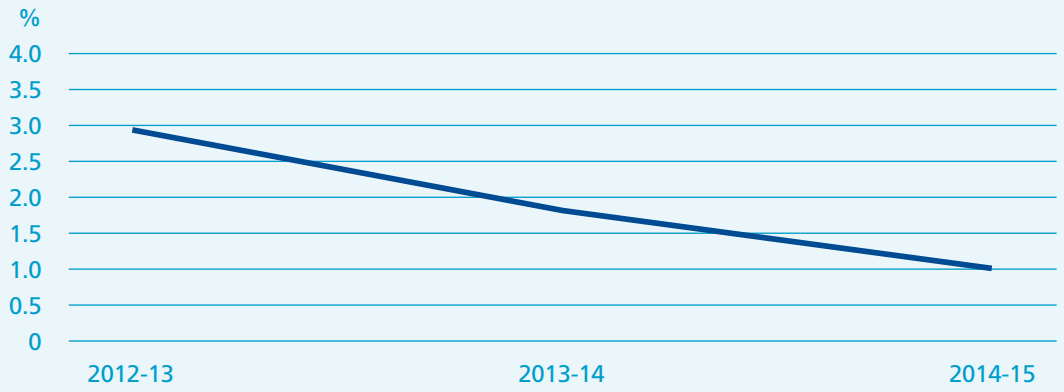
As in 2013/14, we set ourselves the goal of reducing omitted doses of critical medicines. This is important to patient safety and quality of care, to ensure that the patient receives the maximum benefit from their medicines and avoids harm. From the improved baseline at the end of 2013/14 (1.91 per cent of patients having a non-purposeful omitted dose, measured by sampling methodology in approximately 1,000 patients each month, monitoring the previous three days of treatment), we continued to focus on this measure as a priority. We were successful in reducing the percentage of omitted doses of critical medicines to 1.01 per cent – a 47 per cent reduction, following an ongoing detailed ward level focus.

To enable further learning, we also undertook a detailed review of 182 patients by applying the NHS Medication Safety Thermometer, and an audit of 40 of these patients who were readmitted during the year. This work, linked to a CQUIN, assessed whether patient medication influenced the need for readmission, and has resulted in a range of local actions and improvements.

In 2015/16, our aim is to further improve the low level of omitted doses of critical medicines, and to continue the overall improvement in medication safety, ensuring the level of moderate or greater harm resulting from medication errors is kept to a minimum. We will also be focusing on the safe use of medicines at the transfer of care; specifically on avoiding harm from insulin as part of the Patient Safety Collaborative, which is being co-ordinated by the Academic Health Science Networks. Patient safety benefits are also being planned as part of the implementation of the electronic prescribing and medicines administration system, which is being piloted later in 2015, and work is also being planned to further reduce any delays in the prescribing of discharge medication.

Figure 9

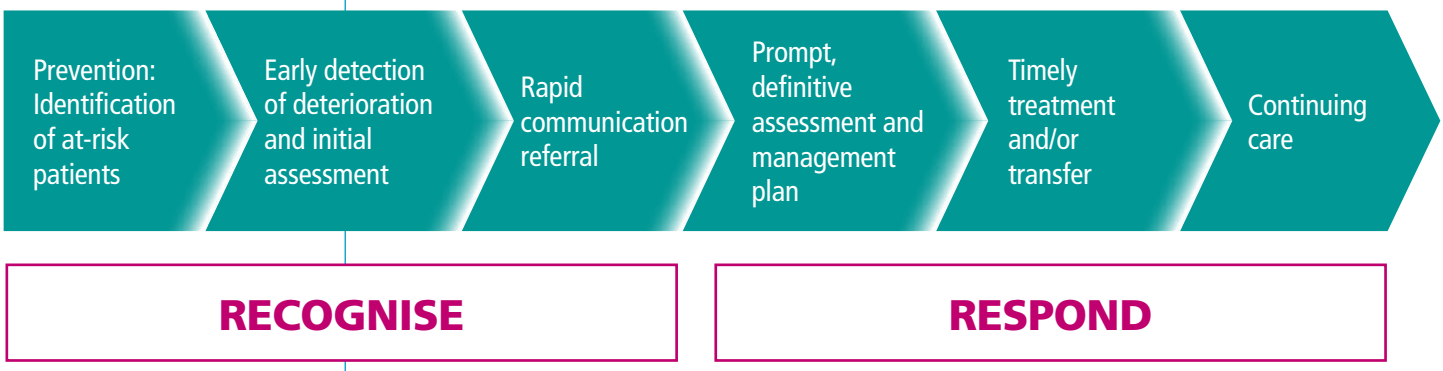
Percentage of patients with one or more critical medicines missed



Source: Ulysses Safeguard system

3.2.6 Early identification and escalation of care of deteriorating patients

There are six key points in a deteriorating patient's pathway that provide opportunities for action by healthcare professionals to improve the patient's chances of a good outcome.



In last year's Quality Report, we described how we had improved the monitoring of patients through greater accuracy of measuring and recording patient observations or vital signs. This is the first part of the 'early detection' shown above. We also reported that in 2014/15 we would focus on improving responses to less sick patients who may be in earlier stages of deterioration – in other words, adult patients with an early warning score[18] of 2 or more – in particular, focusing on the response by healthcare professionals to observations outside of normal parameters – that is, the initial assessment and rapid communication referral shown above.

Therefore for 2014/15, we agreed a two-part local CQUIN with our commissioners:
Part 1: Improving the response to an early warning score of 2 or more (adult patients) to 90 per cent in quarter 3 of 2014/15, rising to 95 per cent in quarter 4. This is a process measure that contributes to better outcomes for those patients whose deterioration, if identified early enough, may be reversible.

Part 2: Reducing the number of validated cardiac arrest calls from general ward areas. This is an outcome measure that we would expect to reduce through earlier recognition of deterioration and medical intervention, thereby preventing a cardiac arrest. We agreed a 5 per cent reduction from the baseline position (quarter 4 2013/14), which equated to a target of no more than 91 validated cardiac arrests from general ward areas in 2014/15.

To achieve improvement in these two measures, during 2014/15 we carried out a deteriorating patient project based on work previously undertaken in Salford NHS Foundation Trust, which had demonstrated a 41 per cent reduction in cardiac arrests from general ward areas (Turkington et al. 2014)[19]. The Salford work comprised five key changes, including the use of early warning scores and a structured communication tool to escalate deteriorating patients. As these two changes had been previously implemented within UH Bristol, we took the opportunity to use the project to further embed this, and we also made two further changes:

1. Re-introducing reliable manual observations once a day to refresh and maintain the nursing skills required to monitor deteriorating patients.
2. Implementing the use of treatment escalation plans (sometimes known as 'ceilings of care')[20].

In relation to Part 1 of the 2014/15 deteriorating patient CQUIN, Figure 10 below shows the percentage of appropriate responses to an early warning score of 2 or more (adult patients) during 2014/15. We did not achieve our target of 90 per cent for quarter 3 as a whole (performance 85 per cent) nor 95 per cent for quarter four as a whole (performance 91 per cent).

Anecdotally, it is reported that some of the breaches reflect poor documentation rather than lack of response to a deteriorating patient. However, we are aware from incident reporting that there are occasions where we have failed to respond as expected to signs of deterioration.

For Part 2 of our 2014/15 deteriorating patient CQUIN, we have exceeded our 5 per cent reduction in validated cardiac arrests from adult general wards. Our limit was 91 arrests, and

[18] An early warning score is calculated from measuring the patients 'observations' (vital signs) of respirations, pulse, blood pressure, temperature, oxygen saturations, neurological response and pain. Readings outside of certain parameters for each observation generate a score which, when totalled, may trigger the need for a response for review by a senior healthcare professional. There are different early warning scores and triggers for adults, children and maternity.

[19] Turkington, P., Power, M., Hunt, C., Ward, C., Donaldson, E., Bellerby and Murphy, P. (2014) There is another way: empowering frontline staff caring for acutely unwell adults. International Journal for Quality in Health Care 26 (1): 71-78

[20] Treatment escalation plans recognise that disease processes towards the end of life can be complex with varying elements of reversibility, and that 'do not attempt resuscitation' decisions can be too blunt an instrument in some circumstances.

for the year as a whole there were 51 arrests, representing a 47 per cent reduction from the baseline of 96 arrests. Progress against the trajectory for the year is shown in Figure 11 below.

In 2015/16, we have more work to do to embed prompt identification of deterioration and escalation of these patients. We will maintain a deteriorating patient workstream in our new three year 'Sign up to Safety' patient safety improvement programme 2015-2018. We will focus on a system-wide early warning score with our local health partners, incorporating some of the learning identified from incidents; for example, taking into account the patient's need for the administration of oxygen. In addition, we will be focusing on improving the management of sepsis (a common cause of deterioration) and acute kidney injury.

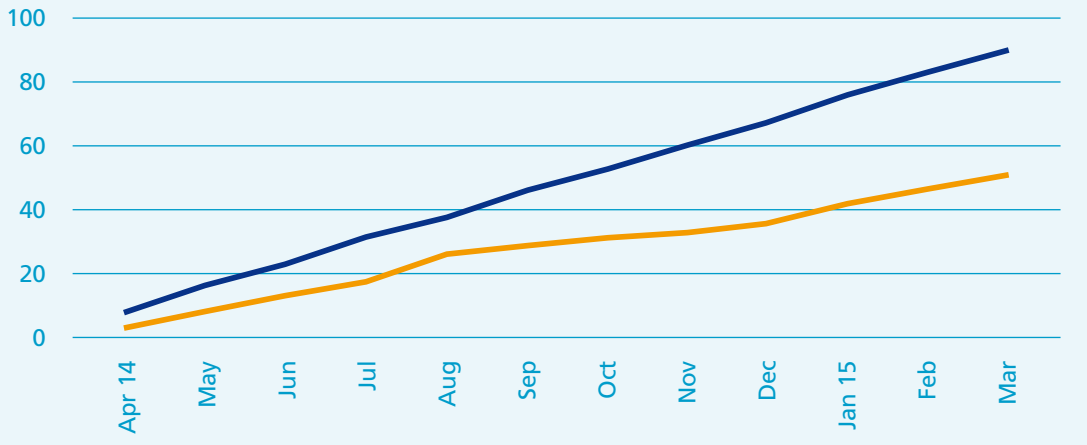
Figure 10

Percentage of adult patients who had a documented response to an Early Warning score of 2 or more

Source: monthly audit

Figure 11

Cumulative reduction in validated cardiac arrests in adult patients on general wards



Trajectory
Actual cumulative

Source: monthly cardiac arrest audit

3.2.7 Rate of patient safety incidents reported and proportion resulting in severe harm or death

(Mandatory indicators)

The data for 2014/15 presented in this section of the report are a combination of NHS England's National Reporting and Learning System (NRLS) data, released in April 2015 covering the period from April to September 2014, and provisional data submitted to the NRLS by UH Bristol for the period from October 2014 to March 2015; the final data for this period will be published by the NRLS in November 2015.

The data shows that the total number of incidents reported in April to September 2014 was 6,453, which gives a rate of 54.8 incidents per 1,000 bed days. In the second six months of 2014/15, the number of reported incidents to the NRLS was 6,661; a rate of 49.12 incidents

per 1,000 bed days. For 2014/15 as a whole , this gives a provisional total number of 13,114 incidents and a rate of 51.83 incidents per 1,000 bed days.

The percentage of reported incidents at UH Bristol resulting in severe harm during April to September 2014 was 0.32 per cent (21 incidents); this represents a reduction compared to the previous six months (0.50 per cent, 30 incidents), but an increase from the corresponding period in 2013 (0.20 per cent, 12 incidents). The percentage of reported incidents resulting in death remains at 0.11 per cent (seven deaths) for the period of April to September 2014. This represents an increase from the two previous six month periods, when one death was reported in each period, but it remains slightly below our NHS peer group average (7.3 deaths).

Provisional data sent to the NRLS by UH Bristol for the period October 2014 to March 2015 indicates that 0.33 per cent of reported incidents in that period resulted in severe harm or death (17 severe harm incidents and five potentially avoidable deaths).

The provisional percentage of reported incidents resulting in severe harm or death in 2014/15 as a whole was therefore 0.38 per cent (38 severe harm events and 12 deaths); this compares with 0.36 per cent in 2013/14 (42 severe harm events and two deaths).

The Trust considers its incident reporting data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the identification and review of incident data prior to submission to the National Reporting and Learning System (full details are available upon request).

In 2015/16, the Trust intends to take the following actions to continue to reduce harm from avoidable patient safety incidents:

- Launch our Sign up to Safety patient safety improvement programme 2015-201,8 which builds on previous work safety improvement work and aligns with key priorities of the West of England Patient Safety Collaborative. Our priorities are:
  - early recognition and escalation of deteriorating patients, to include early recognition and management of sepsis and acute kidney injury (safety-specific and disease-specific improvement areas)
  - medicines safety, including at the point of transfer of care (safety-specific improvement area)
  - developing our safety culture to help us work towards, for example, zero tolerance of falls (cross cutting theme)
  - quality of use of the World Health Organisation surgical safety checklist (safety-specific improvement area).
- Continue to investigate incidents proportionally to their level of harm or risk, and improve how we share learning and take action across the organisation to reduce the likelihood or impact of the same kind of incident happening again.

3.2.8 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 2014/15, 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 78, compared to 73 in 2013/14. Of the 78 serious incidents initially reported, six were subsequently downgraded, and one serious incident was downgraded from a never event. Nine investigations were still underway at the time of writing (April 2015). A breakdown of the categories of the 78 reported incidents is provided in Figure 12 below.

All serious incident investigations have robust action plans, which are implemented to reduce the risk of recurrence.

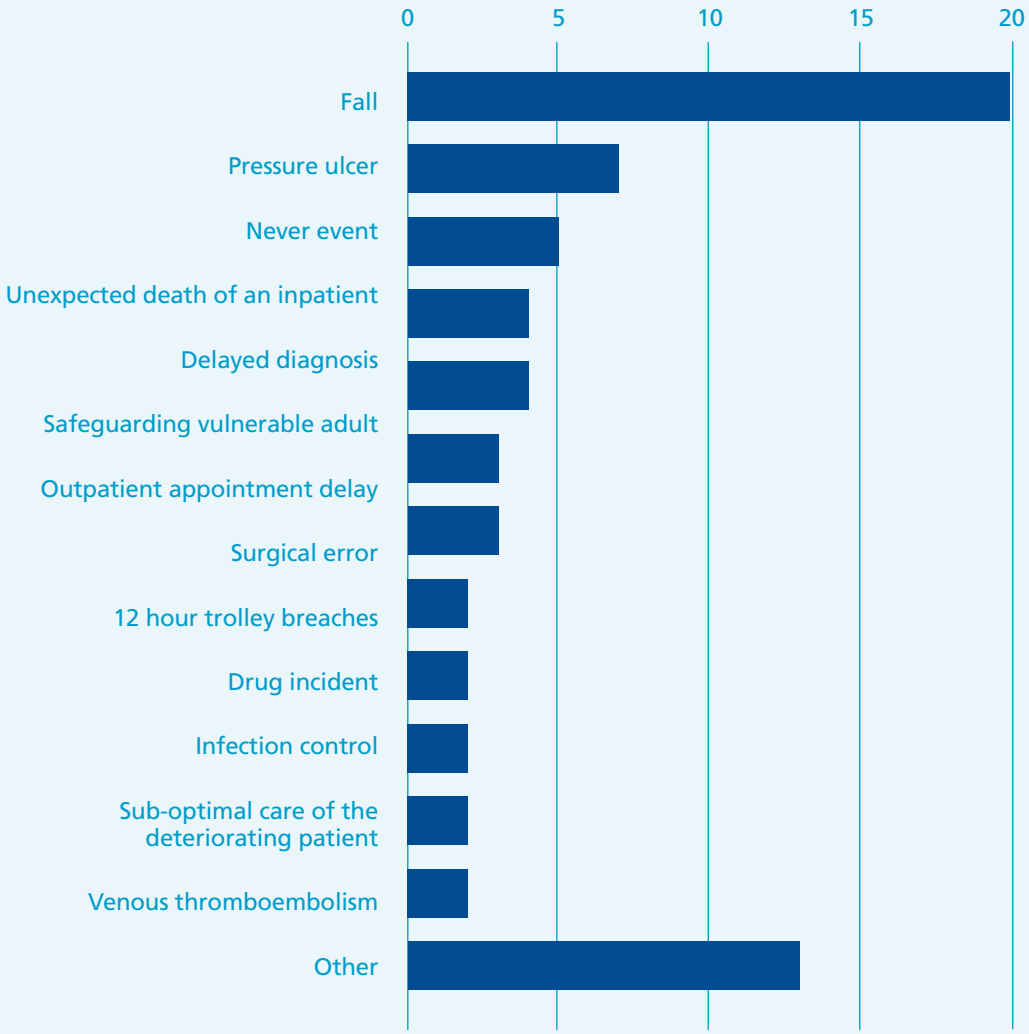
3.2.8.1 Learning from serious incidents

Learning and actions arising from serious incidents involving falls and pressure ulcers is provided in the falls and tissue viability sections of this report, and learning from never events is provided in the section below. Examples of learning themes from other serious incident investigations in 2014/15 include:

- the need for continued improvement in the recognition and response to deteriorating patients in 2015/16; this will happen as part of our 'Sign up to Safety' improvement programme, which will include changing from our local early warning scoring system to one based on the national early warning score, which has different triggers. This change, also to be adopted by North Bristol NHS Trust, would result in a consistent approach to use of early warning scores across the local health system

Figure 12

Serious incidents by type 2014/15



Source: UH Bristol Serious Incident Log

Note: The category 'other' includes all categories where only one serious incident of its type was reported

- sepsis is a common cause of deterioration in patients and has been a factor in some of our reported serious incidents, so we will also build on existing work to further improve the recognition and management of sepsis. This is one of the Trust's corporate quality objectives for 2015/16 – see section 2.1.2
- we have changed our administrative systems to prevent patients being lost to follow-up due being placed on an 'on hold' list in the patient administration system in the absence of a confirmed next step in their pathway, leading to delays in monitoring of their condition and timely action to reduce the risk of avoidable harm.

3.2.9 Never events

'Never events' are a particular type of serious incident that are wholly preventable, have the potential to cause serious patient harm. There is evidence that the type of never event has occurred in the past, and is easily recognised and clearly defined as such. (NHS England 2015)[21]

There were four confirmed never events reported by UH Bristol in 2014/15; two further never events remain under investigation at the time of writing.

[21] Revised Never Events Policy and Framework March 2015

3.2.9.1 Wrong site surgery, South Bristol Community Hospital

One never event occurred in May 2014 in the category 'wrong site surgery', whereby the wrong procedure was performed on a day case patient. The patient was correctly identified and the correct hand operated upon. However, the surgeon performed a carpel tunnel release instead of a De Quervain's release. The patient was informed of the error as soon as it was identified and an apology was given. The patient elected to have the correct procedure the same day, which was performed uneventfully.

The learning from this incident included: the need for all surgical team members to be present and engaged in all stages of the World Health Organisation (WHO) Surgical Safety Checklist; greater clarification of use of the WHO checklist when using local anaesthesia; and the need for updates to pre-operative assessment documentation at South Bristol Community Hospital.

3.2.9.2 Three wrong/unplanned teeth extractions[22]

- In April 2014, during multiple dental extractions at the primary dental care department at Bristol Dental Hospital, an unplanned tooth at the back of the mouth was removed by a dental student instead of the adjacent one. The WHO Surgical Safety Checklist was completed prior to the treatment and the X rays were on display. The patient was informed of the error as soon as it was identified and an apology was given. Remedial treatment in the form of re-implanting the tooth was offered, but declined. The cause was identified as human error.
- In November 2014, during multiple dental extractions on a child, a wrong tooth was extracted in the general anaesthetic department in the Bristol Dental Hospital. The cause was identified as human error contributed to by inadequate visibility in the mouth due to bleeding, and also lack of communication between the surgeon and anaesthetist on the impact of a period of patient instability during the case. Learning from this incident included amending the standard operating procedure for the management of dental extraction to address the identified causes and amendments to the WHO Surgical Safety Checklist used at the Bristol Dental Hospital.
- In January 2015, an additional tooth was extracted during treatment in the oral surgery department in the Bristol Dental Hospital. The investigation identified that the WHO Surgical Safety Checklist was only partially adhered to; the counting of teeth and verbal agreement to confirm which teeth were to be extracted did not take place between the supervising clinician, the dental core trainee and the qualified dental nurse. In addition to the actions already underway from previous incidents, this incident prompted the clinical team to come up with an innovative visual cue to chart the teeth to be extracted on the dental bib, as shown in the picture to the right.

A thematic review of these dental never events has been conducted by the deputy medical director, resulting in a report and a set of recommendations, which have been shared with our commissioners and with NHS England. These include: involvement of dentists in root cause analysis investigations and provision of training to enable them to do so; identification of a dentist as a patient safety clinical lead for dental services; and reviewing procedures for paediatric day case general anaesthesia extractions.

3.2.9.3 Wrong gas administered

A patient with chronic lung disease, who was dependent on long term oxygen therapy at home, was admitted following a fall that occurred in her home and had resulted in a fracture. Due to her being a high anaesthetic risk, the fracture was being treated conservatively. During her admission to a trauma ward, her respiratory condition deteriorated, and she required non-invasive ventilation and transfer to a higher care area where staff are experienced in managing such patients. She was transferred to the medical admissions unit where, upon arrival, it was discovered that oxygen was not connected to the non-invasive ventilator that had been set up prior to her transfer. The patient was 'not for resuscitation' due to her end stage lung disease, and she died shortly afterwards. At the time of writing, the investigation is being finalised. From April 2015, 'wrong gas administered'

[22] A further dental incident occurred in August 2014 (which was subsequently downgraded from a never event) but which prompted a visit to be organised to Central Manchester NHS Foundation Trust to learn from their experience in reducing wrong tooth never events.

incidents are no longer classed as never events by NHS England, as the guidance relating to the administration of gases does not represent a sufficiently strong systemic barrier to prevent inappropriate administration.

Immediate actions that have been put in place to reduce the risk of a recurrence of this type of incident at UH Bristol include a warning notice attached to all adult non-invasive ventilators used outside of intensive care areas, reminding staff that they should not use the equipment unless they have been trained and assessed as competent. A serious incident panel review has also been commissioned by the chief nurse to review the wider organisational issues that relate to this incident.

3.2.9.4 Wrong site surgery, Bristol Eye Hospital

A biopsy of a lesion on the right lower eyelid was performed instead of a biopsy of a lesion on the right caruncle[23] of the eye. The full investigation of this incident is still underway at the time of writing (April 2015) however the initial review showed that an administrative error led to the wrong operation being listed, so that the surgeon consented the patient (who also had a lesion right lower eyelid) for the listed operation rather than the operation planned in the patient's notes. The surgeon carried out the operation the patient had consented for. The WHO Surgical Safety Checklist was correctly used; it incorporates a check for the correct operation, however the check is made against the consent form and so would not have prevented this incident.

3.2.10 NHS England Patient Safety Alerts

At the end of 2014/15, there were no outstanding patient safety alerts relating to UH Bristol.

3.2.11 Medical device management

Our governors have specifically requested that our Quality Report this year includes a report about our assurances regarding the safety of medical equipment. The term 'medical device' covers a wide range of healthcare products other than medicines used every day in all healthcare settings. A medical device[1] is any product used in:

- the diagnosis, prevention, monitoring and treatment of disease or disability
- the diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap
- the investigation, replacement or modification of the anatomy, or of a physiological process
- the control of conception.

Medical devices are an important part of modern healthcare, and many diagnostic and treatment options would be impossible without them. There are large numbers of items of medical equipment used within the Trust. In 2014/15, new equipment was purchased for the Bristol Royal Hospital for Children as part of the centralisation of specialist paediatrics in Bristol, and for the Bristol Royal Infirmary's new ward block.

The Trust's MEMO[24] clinical engineering department maintains an asset register database of all powered medical devices. This is updated as new devices are bought in or subsequently disposed of. A bright yellow label is attached so that at any time a member of staff can find out its age, owner and service history. MEMO's database generates reminders of when equipment services are due; servicing is performed by either the in-house MEMO teams or outside contractors. The Trust keeps records of every service and can use this to see if a device is becoming unreliable and needs replacement. Planned preventative maintenance is arranged to ensure devices are kept fit for service. If a device breaks down or is damaged in use, it will be reported to MEMO or the outside contractor for repair. The Trust's target is to respond to 80 per cent of device breakdowns within eight hours, and we typically achieve a 90 per cent success rate[25]; the speed with which repairs can be made will depend on a number of factors, including access to the equipment and how quickly spare parts can be sourced. The Trust consistently achieves its target for 90 per cent of repair jobs to be completed within 20 working days of being notified; the exception to this in 2014/15 was a period when priority was necessarily given to the installation of new medical equipment in the Bristol Royal Infirmary and Bristol Royal Hospital for Children as described above.

When a new type of device is acquired by the Trust, we set up a staff training programme for the technical and clinical staff. Each ward and theatre area keeps a record of staff competencies for the devices they use, and this is audited by MEMO on a regular basis. We also

[23] The lacrimal caruncle is the red prominence at the inner corner of the eye

[1] Source – 'Devices in Practice' June 2014, Medicines and Healthcare Products Regulatory Agency

[24] Medical Equipment Management Organisation

[25] Source: AssetPlus database in MEMO Clinical Engineering

review all reported clinical incidents involving medical devices. MEMO is currently reviewing device incident trends to proactively reduce their occurrence; the most common categories of reported medical device incidents involve surgical instruments and beds. The CQC reviewed our practice during their comprehensive inspection in September 2014, and were satisfied with the management of medical devices.

In 2015/16, we will be forming a new Trust medical devices management group with broad membership including pathology, pharmacy and – we hope – patient representation. As part of the remit of this group, we will be developing new planning tools to enable departments and divisions to look ahead to their future equipment needs and group these together to achieve best value for money.

3.2.12 Safe staffing

Nursing, midwifery and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for our patients. There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. Following the publication of the Francis Report in 2013, and the new nursing vision 'Compassion in Practice', there is a requirement that all NHS providers will submit a six monthly report to their public Board meetings describing staffing capacity and capability using an evidence-based tool. The report must:

- draw on expert professional opinion and insight into local clinical need and context
- make recommendations to the Board which are considered and discussed
- be presented to and discussed at the public Board meeting
- result in prompt agreement of actions which are recorded and followed up on
- be posted on the Trust's public website along with all the other public Board papers.

In June 2014 and January 2015, the Board of Directors at UH Bristol received the first reports from the chief nurse in line with this guidance, detailing staffing levels for UH Bristol adult inpatient wards, including midwifery and the Bristol Royal Hospital for Children. The reports detailed:

- any significant changes in the previous six months for nursing staffing levels at UH Bristol adult inpatient wards
- how the Trust knows the wards have been safe during that time
- information about the non ward-based nursing and midwifery workforce
- the principles of safe staffing (where in existence) that the Trust uses to set and review establishments and skill mix for these non-ward based areas.

In 2014, the Board also received a report detailing the principles for setting safe staffing levels in other professional groups. In the last year, the chief nurse and divisional teams have also undertaken a comprehensive ward by ward review of staffing levels to ensure they are staffed safely. The board has received assurance that UH Bristol has safe staffing levels, however there is no element of complacency and there is an ongoing need to stabilise the workforce with an effective recruitment campaign and to ensure if the service model changes, that staffing is adjusted accordingly.

3.3 Patient experience

We want all our patients to have a positive experience of healthcare. All our patients and the people who care for them are entitled to be treated with dignity and respect, and should be

[26] As required by the Medicines and Healthcare Products Regulatory Agency

fully involved in decisions affecting their treatment, care and support. Our staff should be afforded the same dignity and respect by patients and by their colleagues. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's values. Through our core patient surveys, we have a strong understanding of the things that matter most to our patients; these priorities continue to guide our choice of quality objectives. Our clinical divisions continue to focus on providing a first class patient experience.

3.3.1 Overall patient experience

What our patients said in our monthly survey

> ***"I was treated impeccably during my two nights at the BRI. I was lucky enough to have a room to myself and the care I received from the nurses both of the ward and in A&E was faultless. I had someone come in and clean my room both mornings and it was a thorough clean. I was checked on every hour and the nurses were really friendly and respectful. Thank you for looking after me."***

3.3.1.1 Local inpatient experience 'tracker' score

Our local patient experience tracker is a combined score from our monthly inpatient survey, based on the aspects of care that our patients have told us matter most to them:

- involvement in decisions about care and treatment
- being treated with respect and dignity
- doctors and nurses giving understandable answers to the patient's questions (in other words, communication)
- ward cleanliness.

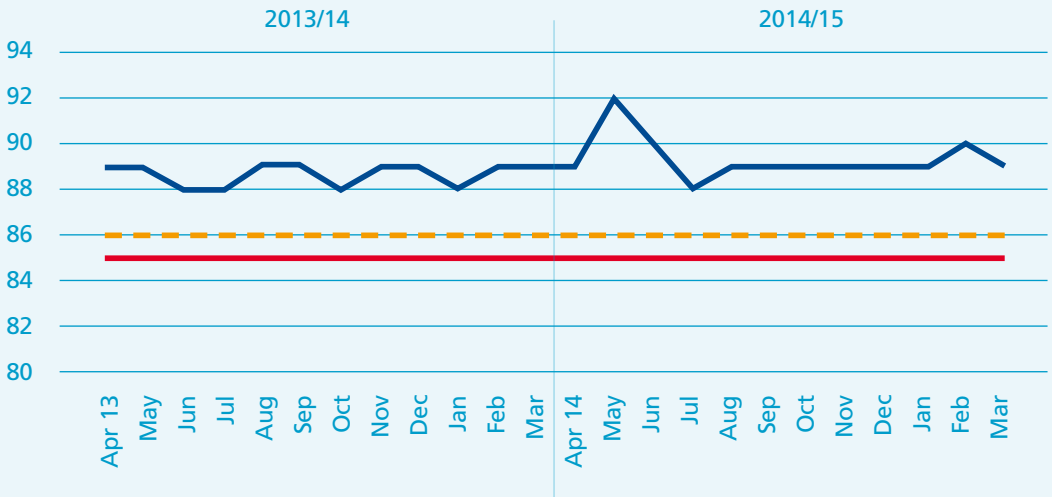
This is a key quality assurance indicator that is reported to our Trust Board each month. If our high standards were to begin to slip, this would be identified in the survey, and actions would be taken to remedy this. Throughout 2014/15, our tracker score has been consistently above our minimum target (see Figure 13). The Board will continue to monitor the monthly tracker score in 2015/16.

3.3.1.2 Friends and Family Test

The Friends and Family Test is a survey that all hospitals in England carry out at, or near to, a patient's discharge from hospital. The survey focuses on one main question: whether the patient would recommend the hospital ward to friends and family if they needed similar care or treatment. UH Bristol's scores have been consistently better than the national average for the inpatient, emergency department, and maternity surveys (Figures 14 to 16). From May 2015, the Trust will commence reporting new Friends and Family Test data for day case, outpatient and children's services.

Figure 13

Inpatient experience quality tracker score (/100)

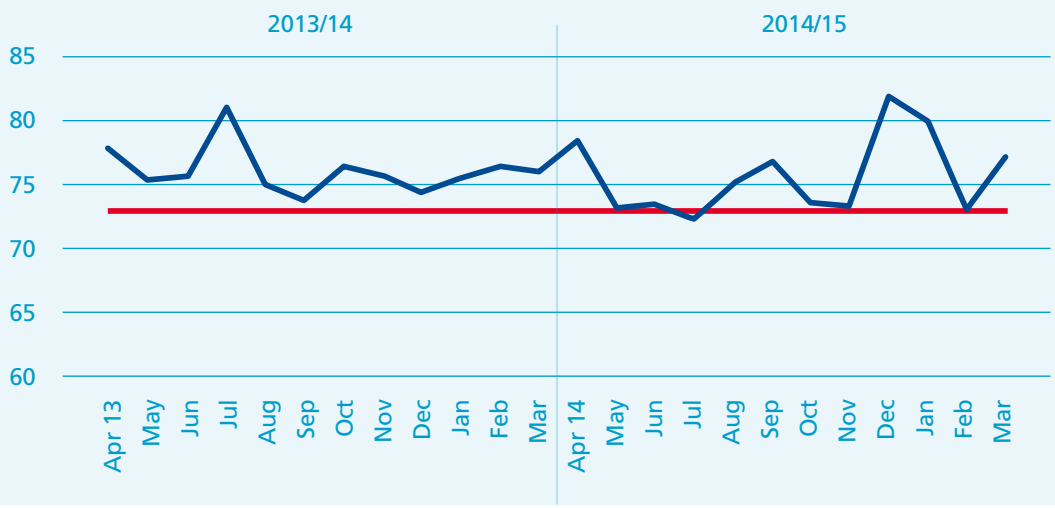


Source: UH Bristol monthly inpatient survey

Note: the alarm limit would represent a statistically significant deterioration in the Trust's patient-reported experience score, prompting us to take remedial action in response.

Figure 14

Friends and family test score (adult inpatient wards)



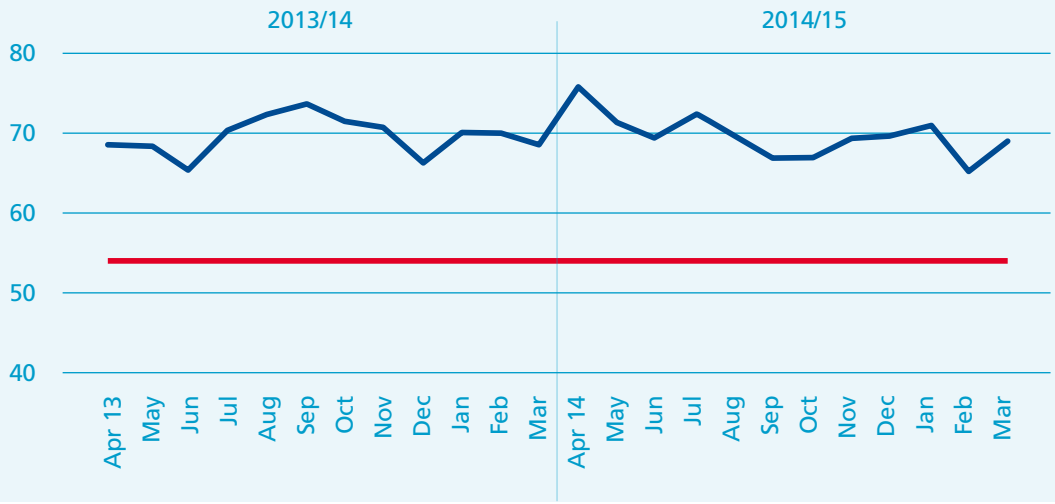
UH Bristol
National average (14/15)

Source: UH Bristol Friends and Family Test survey

Note: the alarm limit would represent a statistically significant deterioration in the Trust's patient-reported experience score, prompting us to take remedial action in response.

Figure 15

Friends and family test score (adult emergency departments)

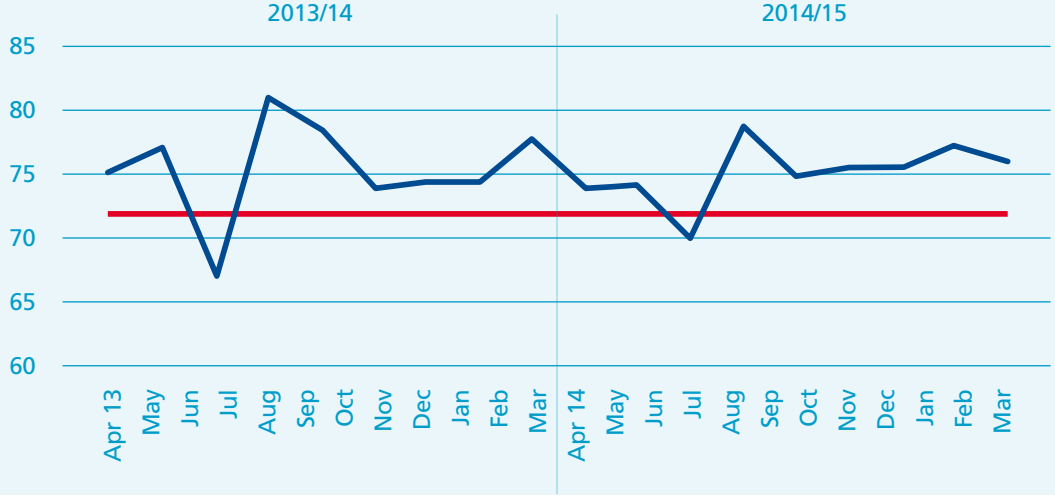


UH Bristol
National average (14/15)

Source: UH Bristol Friends and Family Test survey (excludes Bristol Royal Hospital for Children)

Figure 16

Friends and family test score (maternity services)



UH Bristol
National average (14/15)

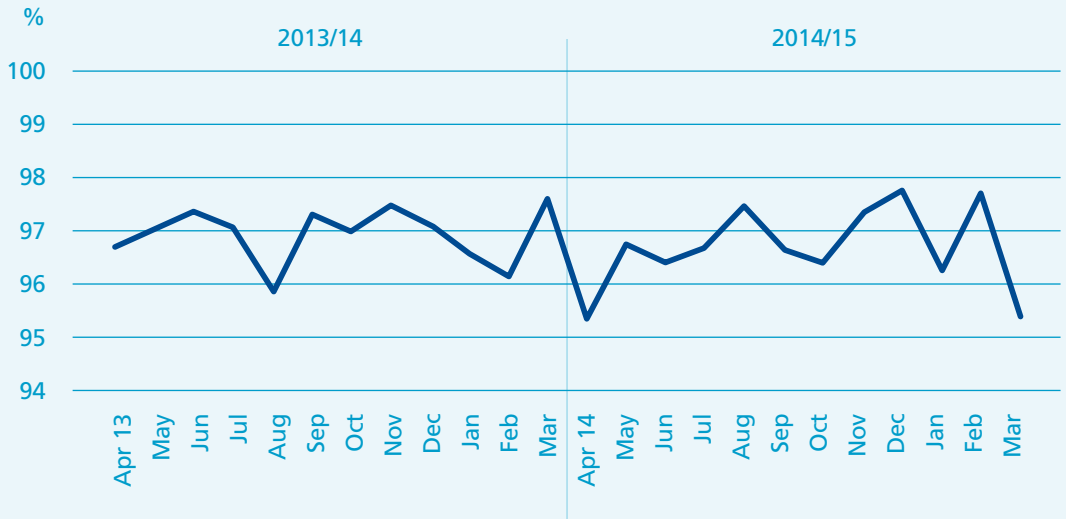
Source: UH Bristol Friends and Family Test survey

3.3.1.3 Overall care ratings

Another way of measuring overall experience of care is to pose that question to patients directly. In 2014/15 (to January 2015), 97 per cent of all survey respondents rated the care they received at the Trust as excellent, very good, or good (see Figure 17).

Figure 17

Percentage of inpatient rating the care at UH Bristol as excellent, very good or good

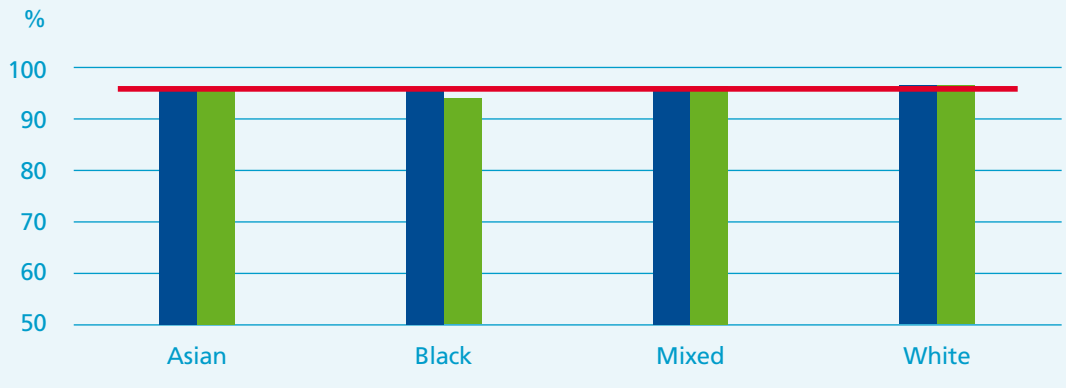


Source: UH Bristol monthly inpatient and parent survey

We continue to monitor patient-reported experience data to ensure that there is no evidence of statistically significant variation in reported experience according to the ethnicity of our patients. The differences shown in Figure 18 (between ethnic groups and between years) are not statistically significant, and are most likely caused by the margins of error that are present in the survey data.

Figure 18

Percentage of inpatients rating their care as excellent, very good or good by ethnic group



Source: UH Bristol monthly inpatient survey

3.3.2 National patient surveys

Each year, the Trust participates in the national patient experience survey programme. These surveys allow the experience of patients at UH Bristol to be benchmarked against other NHS acute Trusts in England. In 2014/15 we received the results to three national surveys :

- the national inpatient survey
- the national accident and emergency survey
- the national cancer survey.

Overall, UH Bristol tends to perform in line with or better than the national average in national patient surveys (see Figure 19 - and also the national Friends and Family Test survey described above). In the national inpatient survey, all but one score was in line with the national average, whilst the national accident and emergency survey again re-affirmed that UH Bristol's emergency departments are among the best nationally.

In contrast, the national cancer survey produced a disappointing set of results for UH Bristol. These results do not correlate with the other surveys we carry out, or the wider quality data that we collect. We have identified issues with the survey methodology that are likely to skew the results; however, we are also committed to acting upon patient feedback, and accept that there are opportunities to improve patients' experience of cancer services. In order to fully inform our improvement plans, we are currently carrying out a series of patient engagement activities. This includes a re-run of the cancer survey (but with a sample of UH Bristol patients only), and a series of patient focus groups to explore cancer care at UH Bristol and our partner Trusts. We have commissioned the Patients Association to run these in order to ensure that an independent perspective on our services can be obtained. In addition, UH Bristol is participating in a scheme being run by NHS England, which will see us 'buddied' with a Trust that has consistently performed well in the survey (South Tees NHS Foundation Trust), so that we can identify any learning for our own services. All of these activities will inform the development of a comprehensive cancer service patient experience improvement plan. In recognition of the importance of this work, it will also be one of the Trust's corporate objectives for 2015/16.

Table 8

Results of national patient survey reports received by the Trust in 2014/15

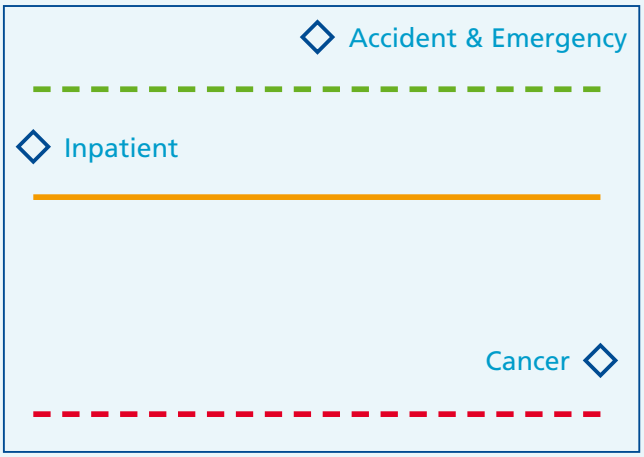
	Comparison to national average		
	Above (better)	Same	Below
National inpatient survey (2013)	0	59	1
National A&E survey (2014)	2	33	0
National cancer survey (2013)	2	30	28

Source: UH Bristol patient administration system (Medway)

[27] Please note that these surveys were based on patients who attended in 2013/14. However, the results were published in 2014/15, making this the most current data available.

Figure 19

Overview of UH Bristol's performance in the national patient surveys



Best 20% of trusts nationally
UH Bristol
National average
Worst 20% of trusts nationally

Source: CQC national inpatient and accident and emergency surveys / NHS England national cancer survey (analysis of data by UH Bristol patient experience and involvement team)

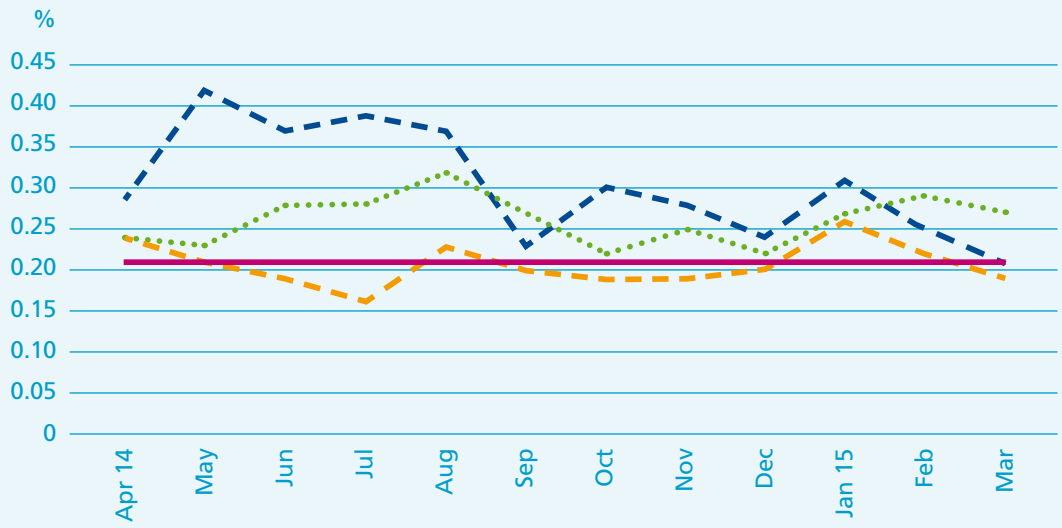
3.3.3 Complaints

In 2014/15, 1,883 complaints were reported to the Trust Board, compared with 1,442 in 2013/14; this is an annual increase of 31 per cent. This volume of complaints equates to 0.26 per cent of all patient episodes, against a target of <0.21 per cent. Figure 20 shows the number of complaints received each month as a proportion of patient activity; complaints received in each month of 2014/15 were higher than in each corresponding month of the previous year. The Trust's patient experience survey ratings are similar to, or better than, in 2013/14[28] (see section 3.3.1), so one possible explanation is that the increase in complaints reflects the increased accessibility of the Trust's complaints service; since December 2013, the patient support and complaints team has been located in a prominent position in the front entrance Welcome Centre of the Bristol Royal Infirmary.

Staff in our Trust work hard to ensure that complaints are investigated thoroughly and that our response letters are professional and comprehensive, but we also recognise that our responses could be more personal and empathetic; addressing this is one of the Trust's corporate quality objectives for 2015/16. Our target for 2014/15 was that no more than 47 complainants would tell us that they were dissatisfied with the quality of our response. In the event, 84 complainants told us that they remained unhappy (compared to 62 in 2013/14 and only 20 in 2012/13). Improving this position is a corporate quality objective for the Trust for 2015/16 (see section 2.1.2 of this report).

Figure 20

Complaints as a proportion of total patient activity



2012/13
2013/14
2014/15
Target

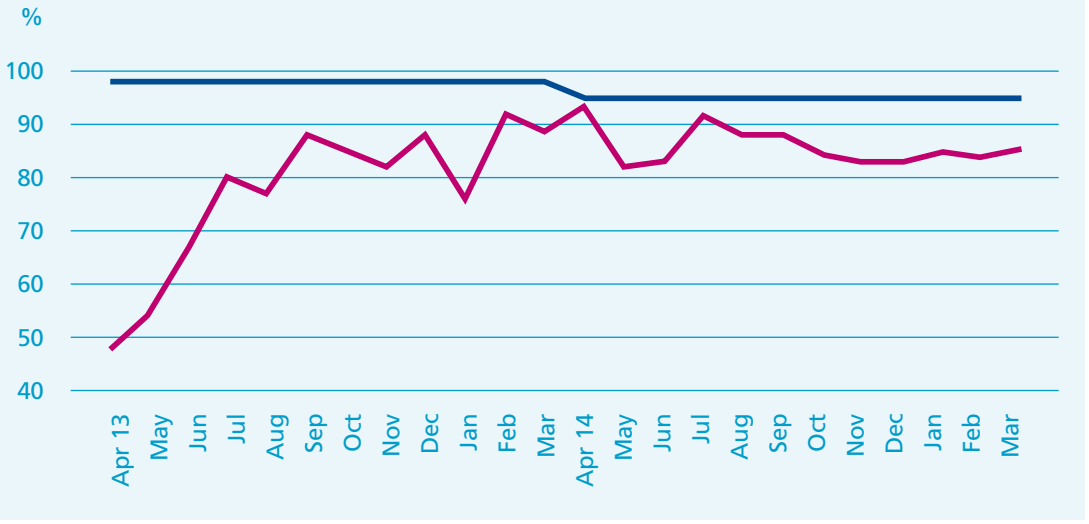
Source: UH Bristol Ulysses Safeguard system

[28] Previously 1,651 in 2012/13, 1,465 in 2011/12 and 1,532 in 2010/11

In 2014/15, we carried out complaints investigations and replied to complainants within agreed timescales in 85.9 per cent of cases; this is a significant improvement on 2013/14, when we achieved 76.4 per cent. Figure 21 below shows our performance over the last two years. In 2014/15, the Trust's internal target was adjusted from 98 per cent to 95 per cent after we benchmarked ourselves against peer Trusts, and because the metric is based on a relatively small data set (anything above one monthly breach would cause the monthly 98 per cent target to not be met).

Figure 21

Percentage of inpatient rating the care at UH Bristol as excellent, very good or good



Source: UH Bristol Ulysses Safeguard system

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2015.

In addition to improving the quality of our written complaints responses – thereby hopefully reducing the proportion of complainants who are unhappy with our response – other key themes in our complaints work plan for 2015/16 include:

- embracing and consistently implementing national guidance, constitutional entitlements and regulatory requirements relating to complaints management
- ensuring the complaints service is accessible to all
- developing and improving Trust-wide sharing and reporting of complaints.

In 2014/15, the Trust invested in increased staffing for the patient support and complaints team, and successfully addressed a longstanding backlog of enquiries. During the year, in addition to receiving and handling complaints, the team dealt with 441 enquiries for help and information and received 279 compliments on behalf of the Trust[29].

3.3.4 NHS Staff Survey 2014

As in previous years, in line with the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual NHS Staff Survey that have a bearing on quality of care. Relevant results from the 2014 survey are presented below.

Questionnaires were sent on a census basis to all substantively employed staff across UH Bristol; 3,641 staff responded. This represents a response rate of 47 per cent, which is above average for acute Trusts in England, and compares with a response rate of 52 per cent in this Trust in the 2013 survey.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment, but are treated respectfully and with dignity and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated, and treat each other, in line with the Trust's values, and with the same level of dignity and respect that we expect for our patients. These values (respecting everyone, embracing change, recognising success and working together) are a guide to our staff about how they are expected to behave towards patients, relatives, carers, visitors and each other, and how they can, themselves, expect to be

[29] That is, unsolicited compliments sent directly to the PSCT – this data has been included in the report at the request of our governors and does not take into account compliments made directly to our wards, departments and other services

treated. The values are embedded in values-based recruitment, in staff induction, through training, and are clearly and regularly communicated.

Table 9

Key findings from NHS Staff Survey 2014

	UH Bristol score 2014	UH Bristol score 2013	UH Bristol score 2012	UH Bristol score 2011	National average score 2014	National best score 2014
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	74% Lowest (worst) 20%[30]	74% Lowest (worst) 20%	79% (average)	74%	77%	88%
Percentage of staff agreeing that their role makes a difference to patients	90% Lower (worse than) average	91% (average)	92% Highest (best) 20%[31]	92%	91%	95%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (to other staff or to patients)	39% Highest (worst) 20%	39% Highest (worst) 20%	39% Highest (worst) 20%	39%	34%	20%
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	91% (average)	90% (average)	91%	96%	90%	99%
Percentage of staff agreeing that feedback from patients / service users was used to make informed decisions within their directorate / department	54% (average)	New factor	New factor	New factor	56%	74%
Staff recommendation of the Trust as a place to work or receive treatment (mandatory indicator[32])	3.68 (average)	3.76 Above (better than) average	3.66	3.65	3.67	4.20

[30] This score was in the lower quintile (worst 20 per cent) of NHS acute Trusts

[31] This score was in the upper quintile (best 20 per cent) of NHS acute Trusts

[32] In the NHS Staff Survey, Trusts receive a score out of a maximum of five points for each question. This score equals the average response given by their staff on a scale of 1-5, where 5 means that they 'strongly agreed' with the statement "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". The mandatory indicator on page 25 of this report, made available by the National NHS Staff Survey Co-ordination Centre, analyses the same data in a different way; in this instance, the indicator measures the percentage of staff who said that they either 'agreed' or 'strongly agreed' with the statement, "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

Source: NHS Staff Survey 2014

The Trust's overall score in staff recommending the Trust as a place to work or receive treatment is arrived at by an aggregation of scores in the following areas:

- whether or not staff thought care of patients and service users was the Trust's top priority
- whether or not staff would recommend the Trust to others as a place to work
- whether or not staff would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.

Table 10

Question/statement	UH Bristol score 2014	National average (median) score for acute Trusts 2014	UH Bristol score 2013
"Care of patients / service users is my organisation's top priority"	70	70	69
"I would recommend my organisation as a place to work"	56	58	60
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	70	65	74
Staff recommendation of the Trust as a place to work or receive treatment	3.68	3.67	3.76

Source: NHS Staff Survey

The Trust considers that this data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. The reported data is taken from a national survey[33], which the Trust participates in through an approved contractor, adhering to guidance issued by the Department of Health.

Whilst the 2014 staff survey results are positive in some areas – including people saying that they have received teaching and learning relevant to their job, and a slightly above average recommendation of the Trust as a place to work or receive treatment – the results are, in many areas, disappointing, and we recognise that significant improvement is required. An extensive staff experience programme is already underway across the Trust. This work, which is being directed both centrally by the senior leadership team and locally by divisional management teams, includes a focus on: improving two way communication; recognition events; team building; review of our appraisal process; training programmes for managers and supervisors; a wide range of health and wellbeing initiatives – including specific work on stress-related illness – and a piloted employee assistance programme; targeted action to address harassment and bullying; a revision and re-launch of the 'Speaking Out' process; and support for staff forums and reverse mentoring.

3.3.5 Carers

It has been several years since we included a report about our work with carers in our annual Quality Report; our governors have asked that we include an update this year.

A carer is someone who provides unpaid help and support to another person who could not cope without their help; this could be due to age, physical or mental illness, disability or addiction. A carer may be a partner, child, relative, friend or neighbour. Carers can also be of any age; for example, it might be a young carer who cares for a parent or sibling, or a parent carer of a disabled child. A carer is not necessarily the closest relative of a patient or their next of kin. A carer often does not realise that they are a carer, and can struggle to tell someone they are finding it difficult to cope.

Our vision is for the role and contribution of carers to be universally recognised across our organisation; we want carers to be true partners in care. Our Carers' Work Plan, which was developed with this vision and commitment in mind, has four intended outcomes:

1. All carers are identified at UH Bristol if they want to be.
2. Carers who are identified at UH Bristol receive information and support whilst they or the person they care for are in hospital and throughout the discharge process.
3. Carers are acknowledged, represented and involved at a strategic level at UH Bristol.
4. There is an increase in staff awareness and knowledge about carers and their needs.

[33] Important note: the UH Bristol figures quoted for 2011 and 2012 are those which will be found in the 2011 and 2012 NHS Staff Attitude Survey reports. The 2011 figures may differ slightly from the 2011 figures quoted in the 2012 report, and the 2012 figures may differ slightly from the 2012 figures quoted in the 2013 report. This is because the Picker Institute, which runs the surveys, re-calculates the data each year. The Picker Institute has advised that either version of the data is appropriate for publication; we have chosen to use the original data for purposes of consistency and transparency.

The introduction of a Carers' Information Scheme in our medical and surgical divisions has helped to embed the principles of identifying and supporting carers. The scheme involves the early identification of carers through an initial documented conversation, which ensures that everyone (staff, the patient and the carer) is clear about their role during the patient's stay and that carers are supported to remain involved if this is their wish. The scheme was referenced in the Houses of Parliament as an example of good practice, during an adjournment debate on 18 December 2014, by the Labour MP for Walsall South, Valerie Vaz. The MP highlighted her involvement with 'John's Campaign': a campaign for the rights of family and carers to stay with people with dementia during periods of hospitalisation. The co-founder of John's Campaign also used examples of good practice at UH Bristol when she met with NHS England to present the campaign:

> "University Hospitals Bristol allows carers to continue their care in hospital. Ward staff have an initial daily conversation with carers, so they are clear what their role is in hospital. Carers are allowed to be with the patients outside visiting hours, including through the night"[34].

The Trust has also been working in partnership with a third sector organisation, the Carers Support Centre. A carer liaison worker, funded by Bristol Clinical Commissioning Group, works from within the Trust, and provides a number of services to carers, including: information and support to carers; acting as the carer's advocate and helping the carer through the admission and discharge process; and sign-posting carers to other support and information outside of the organisation. This work is supported by an assistant chief nurse, who leads the programme, chairs the Carers' Group, and supports the carers' liaison worker. Examples of the contribution made by the carer liaison worker include:

- running monthly 'drop in' sessions for carers of haematology and oncology patients, and establishing a referral pathway for carers requiring support or advice
- creating a joint referral pathway between the Trust's dementia lead practitioner, dementia support worker and the carer liaison worker, so that carers of people with dementia are identified and supported throughout their stay in hospital. A dementia care plan has also been implemented, which includes the identification and involvement of carers at the earliest point in the patient's journey.

Other developments to support carers include:

- access to discounted car parking
- extended visiting times in all inpatient areas
- updated information for carers on the Trust's website, including a section for young carers
- information leaflets to help identify 'hidden' sibling carers within Children's Services
- carer awareness training for staff.

CASE STUDY

Mrs A was admitted to hospital after a fall in her home. Her daughter was her main carer before her hospital admission, providing all her care needs without any input from social services. The lead nurse for dementia made a referral to the carer liaison worker as she felt the carer would benefit from some additional support. After speaking with the professionals involved in the patient's care, the carer liaison worker realised that tensions between the family and staff were high and that some independent support would be beneficial. The carer liaison worker met with the carer on a regular basis while her mother was in hospital and kept in regular telephone contact with her. Her concerns and fears were passed onto the professionals involved, and the carer liaison worker provided regular updates for the carer about the hospital processes. The carer desperately wanted her mum home and was terrified she was going to die in hospital, which had been against her mother's wishes. The carer liaison worker attended her mother's 'best interest meeting' to support the carer and her family, explaining to her the process of the meeting and debriefing with her afterwards; they also attended the 'pre-meeting' to explain why the carer was so keen to speed the discharge process up, and to present the carer's wishes regarding her mother's discharge. The patient was later discharged home with a large package of care. The carer liaison worker kept in contact with her for several weeks after discharge and signposted her to ongoing support. The carer thanked the carer liaison worker for the support, and said how helpful it was having someone to support her whilst her mother was in hospital and immediately afterwards.

[34] Quote from adjournment debate

Our plans for 2015/16 include:

- rolling out the Carers' Information Scheme to the whole Trust
- developing a 'memory café'[35] as part of the Trust's commitment to develop a more dementia-friendly environment
- launching a carers' logo (a way of readily identifying carers in our hospitals, similar to the 'Forget-me-not' for patients with dementia) and a revised Carers Charter (a set of principles developed jointly by UH Bristol and North Bristol NHS Trust to promote a culture that recognises the vital role carers play within our hospitals) during Carers' Week in June 2015.

What our patients said in our monthly survey

"Both my son and myself were impressed with the way we were treated. Having had quite a few overnight stays in hospital all in the last 19 years we could tell that staff were much more aware of how to treat someone with a disability and also how to treat a carer. Never before have we been so looked attentive looked after, having tea brought to us on a very regular basis. A huge thank you to all the staff involved, you were wonderful."

3.4 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.

3.4.1 Dementia

Dementia is an umbrella term for a set of symptoms that may include memory loss, difficulties with thinking, language and problem solving. It is a progressive and terminal condition. Currently, nearly 80,000 people in the South West of England are affected, with this figure expected to increase significantly over the next 20 years (Alzheimer's Society 2015).

In 2014, the findings of our annual audit against the South West dementia standards demonstrated an improvement in most areas of dementia practice compared to 2013. Visual identification – the 'Forget-me-not' symbol – was in place in 68 per cent of cases (45.9 per cent in 2013/14); the ABC behaviour chart was evident in 35 per cent of cases (zero in 2013/14); and there was a 13 per cent increase in referrals to the later life liaison psychiatry team. However, we know that we need to make further improvements to ensure consistency across all clinical areas and to achieve the targets set for each standard. This audit will be repeated in spring 2015.

When the CQC inspected the Trust in September 2014, they identified that the Abbey Pain scale needed to be used for people with cognitive impairment who cannot communicate their needs. We are currently working to embed this tool into practice to ensure that it is used consistently. The CQC also highlighted the need for a review of the needs of dementia patients to ensure needs are met – this will be achieved via audit, monthly and annually, with appropriate action plans to change practice.

The majority of clinical areas across the Trust[36] now have identified 'dementia champions': staff from a variety of clinical and non-clinical backgrounds who act as advocates for patients

[35] A memory café can offer help, support and information for people affected by memory problems or who have a diagnosis of a dementia. This may be the person themselves or their carer, family or friends. The cafés are free and work on a drop-in basis. At the time of writing, the Trust is actively engaged with the Alzheimer's Society and UH Bristol's Above & Beyond Appeal to make the café a reality.

[36] Including inpatient wards and outpatient clinics

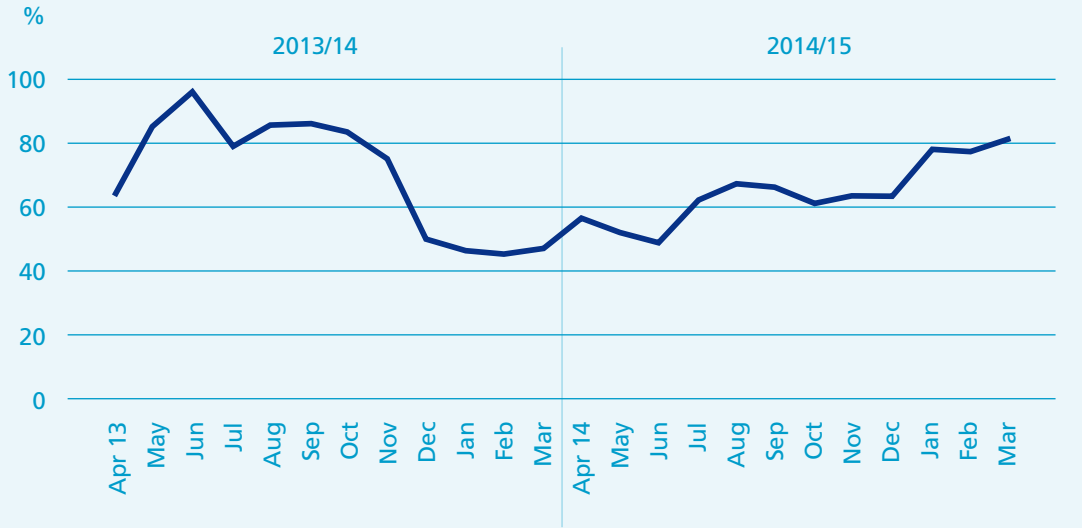
with dementia and their carers. We hold a champions' conference each year jointly with North Bristol NHS Trust, plus an annual UH Bristol dementia conference to celebrate good practice and share learning.

Training compliance for dementia remains high, with all our staff undergoing a mandatory dementia awareness session during their induction programme. As of the end of March 2015, 7,296 staff had received dementia awareness training, either face-to-face or via e-learning. Ward-based volunteers working in the Trust also undergo dementia training as part of their own induction.

The Trust continues to work towards achieving the national CQUIN for dementia, which set us the challenge of finding (identifying), assessing and referring patients[37] with Dementia; for each of these elements, the target is 90 per cent. Figures 22-24 show that we have made progress over the past year as the process has become embedded into admission clerking and assessment. Focused work in the admission units by the dementia project nurse has helped drive up the numbers of patients being screened for dementia, with the numbers steadily increasing – for example, 81.6 per cent in March 2015, compared to 46.9 per cent 12 months previously for the Find element. At the beginning of quarter 4 of 2014/15, the Trust moved to an electronic data capture system, enabling the CQUIN data to be captured in real time[38] as part of the electronic handover system. A live countdown serves as a reminder to the medical and nursing teams that a screening is required, and when the patient is discharged, a PDF document is created and automatically uploaded onto the clinical document service, where it can be accessed by the patient's GP.

Figure 22

Percentage of emergency admissions who are asked the dementia case finding question within 72 hours*

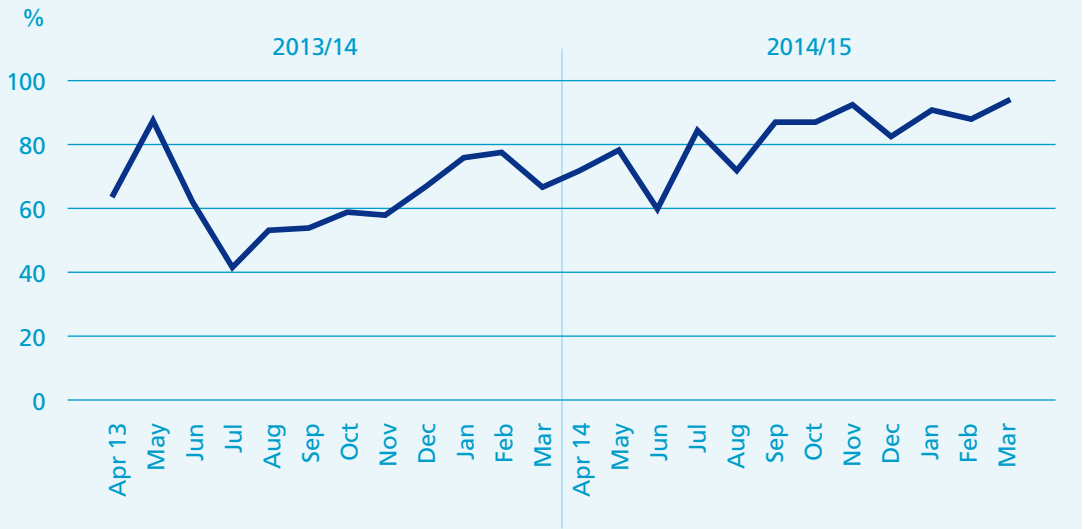


Source: UH Bristol eHandover system

Externally audited 'Find' data is confirmed as 65 per cent for 2014/15 as a whole, with 79.3 per cent achieved in quarter 4 (when the new data capture system was in place).

Figure 23

Percentage of emergency admissions who have scored positively on the casefinding question*



Source: UH Bristol eHandover system

[37] Known as 'FAIR' – (Find, Assess and Investigate, Refer)

* or who have a clinical diagnosis of delirium

We continue to be committed to supporting carers of those with dementia. It remains a challenge to identify dementia carers. Here are some quotes from the carers we have supported in the past year:

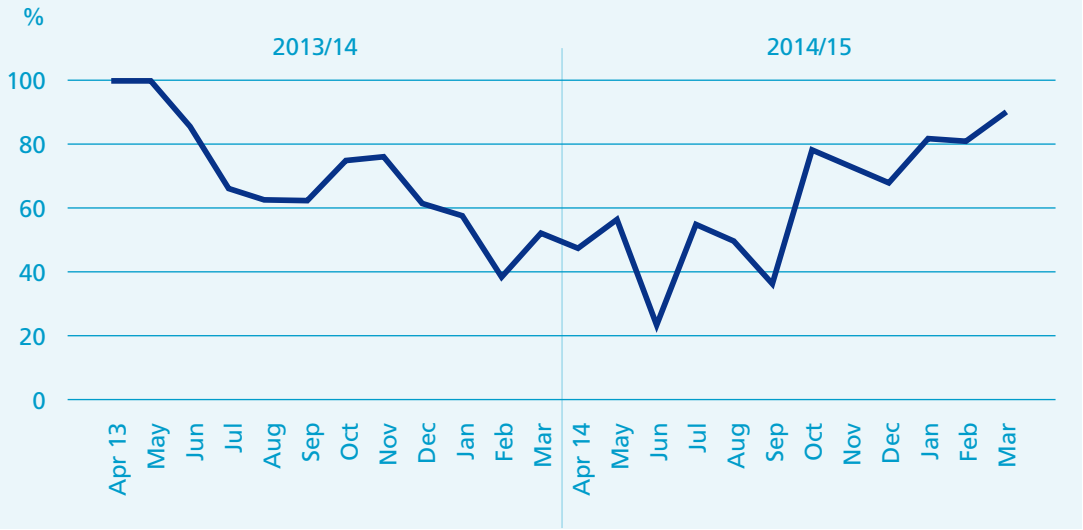
"I feel very supported by all staff members!"

"I would like staff to acknowledge visitors."

"Staff are very helpful - a dementia pack was given to me."

Figure 24

Percentage of emergency admissions who have a diagnostic assessment who are referred for further diagnostic advice/ follow-up~*



Source: UH Bristol eHandover system

~ outcome of either 'positive' or 'inconclusive'
* or who have a clinical diagnosis of delirium

The involvement of our dementia clinical leads in the design of the new Bristol Royal Infirmary ward block has resulted in wards which are now open and welcoming for people with dementia. We aim not to move patients with a cognitive impairment for non-clinical reasons between the hours of 8pm and 8am; we conducted a transfer audit in July 2014 and achieved 97 per cent compliance, and the audit will be repeated in the autumn of 2015.

In 2015/16, we will continue to work towards achieving the dementia CQUIN. We will engage more with carers of patients with dementia, through focus groups and surveys, to identify their needs and ideas for improving care for patients. We also have plans to introduce a memory café (see footnote 35 above). Focused training and information events will take place during Dementia Awareness Week in May 2015, and we plan to introduce more reminiscence activities to our older people's wards to engage with patients and carers during their admission.

3.4.2 Summary Hospital-Level Mortality Indicator (SHMI)

(Mandatory indicator)

The Summary Hospital-level Mortality indicator (SHMI) is a measure of all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. It should be noted that SMHI does not provide definitive answers; rather it poses questions that Trusts have a duty to investigate. 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. In Figure 25, the blue vertical bars are UH Bristol data, the green solid line is the median for all Trusts, and the dashed red lines are the upper and lower quartiles. The graph shows that patient mortality at UH Bristol, as measured using SHMI, is consistently lower than the national norm. The most recent comparative data available to us at the time of writing is for the period July 2013 to June 2014, and shows the Trust as having a SHMI of 95.8.

[38] External audit of this indicator – selected by our governors – has therefore focused on the new system rather than data captured prior to January 2015

The Trust considers its SHMI data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This includes data quality and completeness checks carried out by the Trust's IM&T systems team. SHMI dated is governed by national definitions.

3.4.3 Adult cardiac surgery outcomes

The Bristol Heart Institute is one of the largest centres for cardiac surgery in the United Kingdom. The centre currently performs approximately 1,500 procedures per annum. The Trust has supported a cardiac surgical database for more than 20 years, which now contains information relating to clinical outcomes for more than 26,500 patients. This is an extremely valuable resource for research and audit, service planning, and quality assurance. An annual analysis of cardiac outcomes is published and can be viewed in detail on the Trust website (http://www.uhbristol.nhs.ukabout-us/key-publications).

In general, our adult cardiac outcomes measured in terms of mortality have been better than the UK average for all procedures. Figure 26 shows a pattern of relatively static activity and a crude mortality rate that is below the national average. It should be noted that the 2014/2015 data is preliminary at the time of writing (April 2015), as the discharge status of some patients is still awaited.

Cardiac surgical outcomes data is collected and analysed under the auspices of the National Institute for Cardiovascular Outcomes Research (NICOR) at University College London. The data is analysed and presented in association with the Society for Cardiothoracic Surgery of Great Britain and Ireland (SCTS) and fed back to the individual participating centres (http://scts.org/patients/hospitals/centre.aspx?id=27&name=bristol_heart_institute) using national contemporary comparators.

More detailed analysis of 2014/15 data is currently awaited from the NICOR/SCTS collaboration to enable us to benchmark our performance against other centres in the UK.

What our patients said in our monthly survey

> ***"I was more than happy with the care and attention I received from the hospital. The whole cardiac team has been wonderful, right from the porters, cleaners, caterers, nurses, doctors, surgeons, consultants to the medical researchers I have seen."***

3.4.4 Paediatric cardiac surgery outcomes

The Bristol Royal Hospital for Children (BRHC) provides a congenital cardiac service to the whole of the South West of England and South Wales, serving a population of 5.5 million people. It functions as a network with the specialist cardiology centre at University Hospital of Wales in Cardiff, with Welsh consultants providing sessions in BRHC. The pathway starts in the antenatal period, with close collaboration with fetal cardiology and fetal medicine, and transitions into the adult congenital cardiac services provided at the adjacent Bristol Heart Institute.

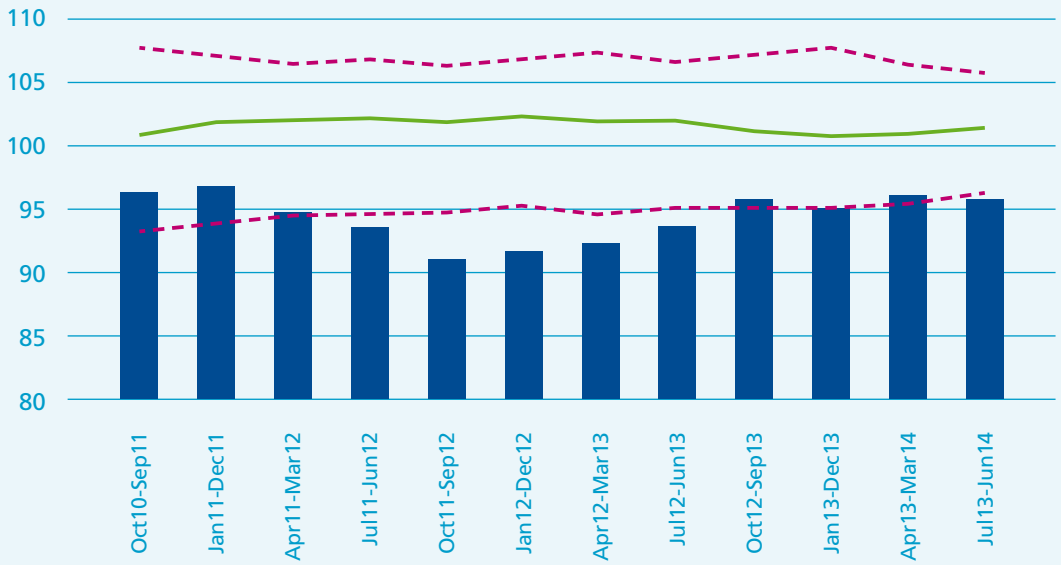
The number of paediatric cardiac cases performed in the children's hospital has remained constant over the last five years, at approximately 325 cases per year. Over this time, crude survival following cardiac surgery in our unit has continued to improve, and in 2014/15 was 98.8 per cent. This is well within expected limits when controlled for case mix and co-morbidities using a risk-stratification scoring system called the PRAiS score, and has been achieved despite the continuing increase in complexity of cases. Crude survival has remained constant over the last seven years at approximately 98 per cent across all other centres in the country according to the latest available data from the National Institute for Cardiovascular Outcomes Research (NICOR).

Crude survival is, however, a very coarse demonstration of the quality of outcomes, because children born with congenital heart disease frequently have associated co-morbidities that influence their clinical outcome as much as the cardiac defect. Consequently, as risk

profiles vary between centres, direct comparison between units is inappropriate. Using risk-stratification statistical analysis that has been developed by NICOR, more sophisticated analysis of the outcomes following surgery at BRHC has been possible, allowing us to monitor our results in real time and demonstrate a progressive improvement in our outcomes. Figure 27 shows verified NICOR data for the three year period April 2011 to March 2014 (the most recent reporting period available).

Figure 25

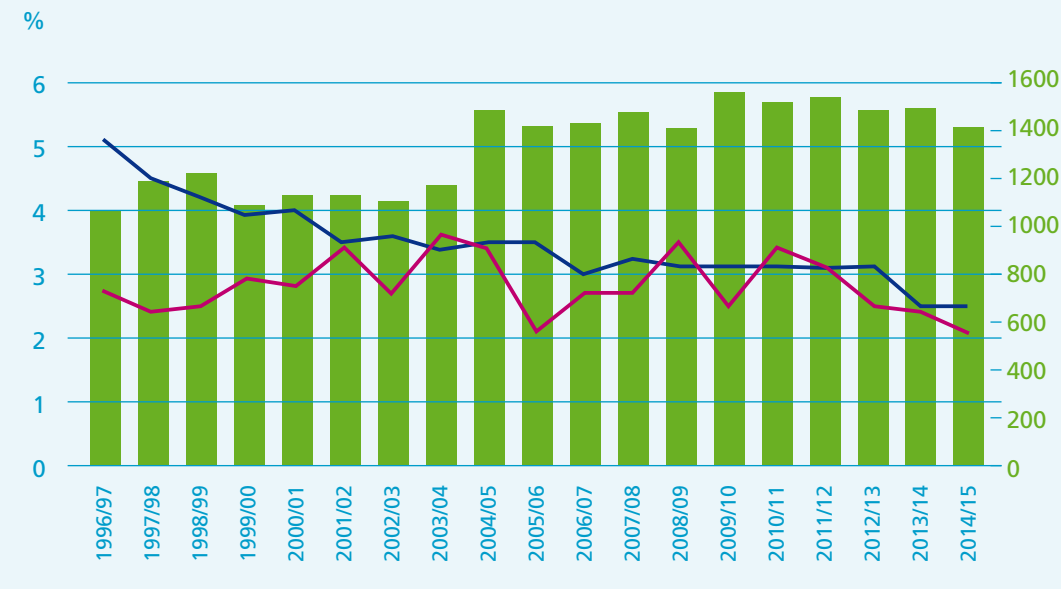
Summary Hospital-level Mortality Indicator (SHMI)



Source: CHKS benchmarking

Figure 26

Adult cardiac surgery activity and mortality – all procedures



Source: Central Cardiac Audit Database / Patient Analysis Tracking System

An independent review into paediatric cardiac services in Bristol was announced in February 2014 by Professor Sir Bruce Keogh, Medical Director of NHS England, following some complaints from parents. The Trust welcomes the ongoing review and hopes that it will restore trust and confidence in the service. We recognise that treating children with congenital heart disease is more than just managing their clinical condition; it's also about supporting and preparing families for procedures, and giving them all the information they need. In 2014/15, we have held a number of 'listening events' at which parents have shared their experiences and explained how we can help them more. Following the first of these events,

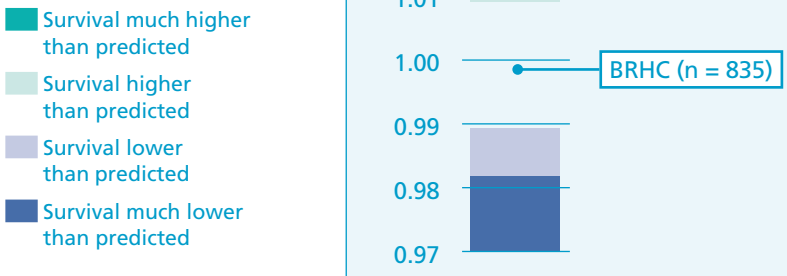
we revised and modified the department's website in accordance with suggestions from parents; our information leaflets have similarly been revised and sent out to parents for review and comment. At the most recent listening event, we focused on the issue of consent for treatment: making sure that parents and patients have enough information in a form that's accessible to them. As a result, we are reviewing and revising our consent and information forms to better meet the needs of families.

In addition, to support this improvement, BRHC implemented a system in 2013 to empower parents to escalate concerns if they are worried about the clinical condition of their child. Rapid recognition of deterioration in a child's clinical condition improves their quality of care and outcome, and the parents of children who unexpectedly deteriorate often report awareness of the child's decline before medical staff. Furthermore, involving parents in all decisions regarding clinical care, in an environment of openness, transparency and candour, is recognised as an essential for good care. This was audited in 2014, and levels of awareness with staff and families were found to be good on children's cardiac ward 32.

The Trust welcomes feedback from families. Our ongoing monthly survey of parents of children cared for on ward 32 shows that 98 per cent of parents consistently rate their experience of care as good, very good or excellent[39].

Figure 27

Paediatric surgery 2011-2014



Source: NICOR

Validated overall outcomes for paediatric cardiac surgery at BRCH April 2011 to March 2014

Actual 30 day survival rate (risk adjusted)	97.7%
Expected survival rate for BRHC using PRAiS	97.8%
Ratio of BRHC survival rate to expected survival rate	0.999

What our patients said in our monthly survey

"I work as a health care professional and was amazed at the patience and kindness from staff. I felt that my child was in extremely good hands as staff demeanour was so confident, knowledgeable and caring. The staff at Bristol Child's Hospital Cardiac ward should be very proud of the level of care they attain."

"During my child's stay at Bristol Children's Hospital we stayed in PICU Cardiac HDU and Cardiac Ward. At all times I felt that my child, who was only 5-6 weeks old, was cared for in 'loving' way which I found incredibly reassuring and meant I was completely comfortable leaving her in the nurses care overnight (meaning I could get home to my other children). I trusted all staff 100% to care for her, and do the best for her. Also as parents we felt completely supported by the nurses and doctors, and felt our welfare was also important, which meant a lot during a very difficult time."

[39] UH Bristol inpatient experience survey 2014/15

3.4.5 Patient Reported Outcome Measures (PROMs)

(Mandatory indicator)

Since 2009, Patient Reported Outcome Measures (PROMs) have been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. Only two of these procedures – groin hernia surgery and varicose vein surgery – are carried out at UH Bristol.

PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the EQ-5D index asks patients questions about factors such as mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a visual analogue scale (VAS); and finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

The most recent full-year data available from the NHS Health and Social Care Information Centre (HSCIC) is for 2013/14. Although provisional, this shows that fewer than five UH Bristol patients who underwent varicose vein surgery returned PROM questionnaires; this data is therefore not publishable due to inherent statistical unreliability and to protect patient confidentiality. Nine patients returned groin hernia PROM questionnaires in this time period, 88.9 per cent of whom (8/9) scored more highly on the EQ-5D index after surgery than before; this compares with 50.6 per cent in England (10,543/20,856). Six patients completed and returned the EQ-VAS section of the PROMS questionnaire: 33.3 per cent (2/6) of UH Bristol patients scored more highly on the EQ-VAS scale after surgery than before; this compares with 37.3 per cent (8,097/21,696) in England.

The Trust considers its groin hernia PROM data to be as described. The Trust follows nationally determined PROM methodology and outsources administration to an approved contractor. The Trust acknowledges that gaps in post and in process from October 2012 until November 2013 has meant that overall participation rates for 2012/13 and 2013/14 are lower than expected. New processes were put in place in place to address this, and the latest unpublished participation figures from the HSCIC for 2014/15 (as at February 2015) show that 78.8 per cent of patients returned the pre-operative questionnaire for groin hernias (93/118); this compares with 58.2 per cent (37,863/65,003). To enable a change in healthcare status to be measured, patients must also return a post-operative questionnaire. Latest figures show that 38.5 per cent (20/52) of patients have done so; this compares to 52.7 per cent (14,536/27,560) nationally.

In October 2014, vascular surgery transferred to North Bristol NHS Trust, and therefore University Hospitals Bristol will no longer be participating in or reporting on the varicose veins PROM.

3.4.6 Hip fracture best practice tariff

Best practice tariffs (BPTs) help the NHS to improve quality by reducing unexplained variation between providers and universalising best practice. Best practice is defined as care that is both clinically and cost effective; to achieve the BPT for hip fractures, Trusts have to meet eight indicators of quality as recorded in the national hip fracture database. The indicators are:

- surgery within 36 hours of admission to hospital
- ortho-geriatric review within 72 hours of admission to hospital
- joint care of patients under a trauma and orthopaedics consultant and ortho-geriatrician consultant
- completion of a joint assessment proforma
- multi-disciplinary team (MDT) rehabilitation led by an ortho-geriatrician
- falls assessment
- bone health assessment
- abbreviated mental test done on admission and pre-discharge.

We are pleased to report that UH Bristol's performance against the national best practice tariff for hip fracture management improved significantly in 2014/15 compared to 2013/14 and 2012/13, as shown in Figure 28. Overall performance for 2014/15 was 71.6 per cent. This is significantly better than in 2013/14 (61.7 per cent) and 2012/13 (37 per cent), but we know that there is much work still to do. Historically, the Trust has struggled to achieve the BPT due

to poor performance against time to theatre and ortho-geriatric review, despite consistently achieving over 90 per cent for the other six indicators.

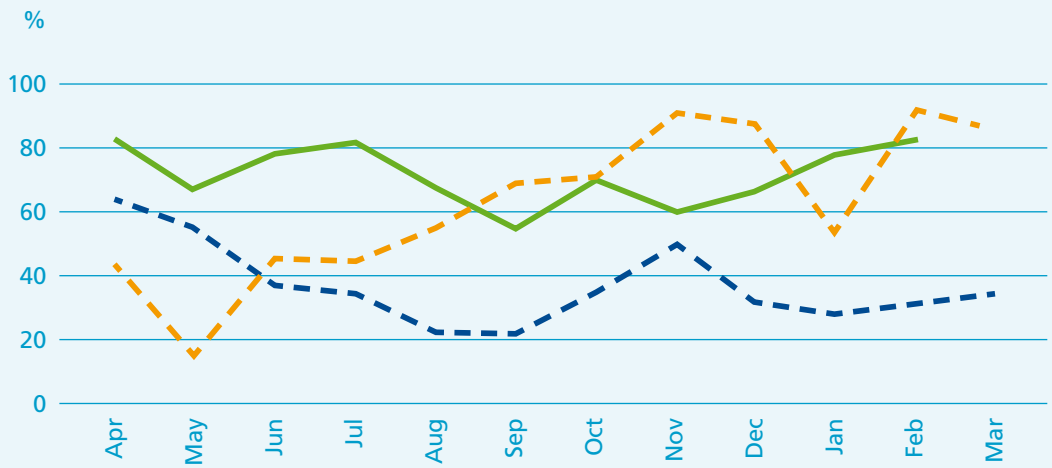
Expansion of the workforce supporting ortho-geriatric review has led to significant improvements in this aspect of practice, with the 90 per cent standard being exceeded in 2014/15 at 94 per cent, compared to 78.8 per cent in the previous year.

The Division of Surgery, Head and Neck has focused on improving performance in the time to theatre for hip fracture patients, and has instigated the following actions:

- operational focus is currently on embedding the new all-day weekend operating lists, and ensuring staffing can support this on an ongoing basis; this will include running these lists on bank holidays, starting at Easter
- a new Trust-wide transformation programme has commenced, with a project specifically focused on orthopaedic theatre utilisation and efficiency, including a specific workstream on emergency pathways
- further job plan changes have been agreed; these will improve the spread of trauma time across the week, and enable an additional hip fracture case to the start of planned limb reconstruction theatre lists
- enhancement of theatre staffing in the evening to allow for two 'planned over-runs' as opposed to the current one.

Figure 28

Hip fracture best practice tariff



Source: National Hip Fracture Database

3.4.7 Consultant Outcomes Programme

Consultant 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 10 National Clinical Audits in 2013, with three further audits/registries added for 2014. Those that published in 2013 expanded the number of procedures and quality measures covered to include length of stay and readmission rates.

Table 11 shows the medical specialties/societies that reported consultant outcomes during 2014/15, and whether the Trust submitted data to the required national audit/registry.

Table 11

Specialty	Clinical audit/registry title	Specialist Association	Submitted
Adult cardiac surgery	National Adult Cardiac Surgery Audit	70	69
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
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	No[40]
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 for conditions affecting the musculoskeletal system**	British Orthopaedic Association	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	Yes

[40] The majority of UH Bristol consultants in this clinical specialty are not members of BAETS and therefore cannot contribute to the BAETS registry (which is not part of any mandatory national clinical audit).

All data can be found on the relevant association websites and has also been published on NHS Choices (MyNHS - https://www.nhs.uk/Service-Search/performance/search). No UH Bristol consultant has been identified as an 'outlier' within these published outcomes.

3.4.8 28-day readmissions

(Mandatory indicator)

The need for a patient to be readmitted to hospital following discharge can sometimes be an indicator of the effectiveness of a clinical intervention. The Trust monitors the level of emergency readmissions within 30 days of discharge from hospital. Readmission within 30 days is used as the measure, rather than 28 days, to be consistent with Payment by Result rules and contractual requirements. The level of emergency readmissions within 30 days of a previous discharge from hospital was marginally higher in 2014/15 than in the previous year (2.82 per cent in 2014/15 versus 2.71 per cent in 2013/14), following a significant reduction from levels recorded in 2012/13. Previous audits have found that a high proportion of emergency readmissions to the Trust are unrelated to the original admission to hospital. For this reason, it is difficult to interpret any changes in readmission rates at a Trust level. The Trust, via the work of its quality intelligence group, continues to review the reasons behind any specialty being an outlier from its clinical peer with regards to levels of emergency readmission. Where a specialty is at or above the readmission rate of the top 25 per cent of Trusts in the clinical peer group, a formal review process is instigated. This includes a review of the clinical coding and admission classification of the cases in the period for which the specialty is shown to be an outlier, and then progresses to a notes review by an appropriate clinician if the specialty remains an outlier with any corrections to the coding or classification applied.

The most recent national risk-adjusted data (2011/12) for the 28-day emergency 'indirectly standardised' readmission rates for patients aged 16 years and above, shows the Trust to be better than average within its peer group (acute teaching Trusts). Of the 23 acute teaching Trusts for which data is available, the Trust is ranked sixth best (that is, the sixth lowest readmission rate), with an indirectly standardised emergency readmission rate of 11.15 per cent, compared to the median for the group of 11.87 per cent (lower and upper confidence intervals of 10.80 per cent and 11.51 per cent respectively). For patients under the age of 16, the Trust has a standardised readmission rate of 7.8 per cent, which is lower (that is, better) than the national median readmission rate of 8.4 per cent, despite the Trust's case mix being biased towards the more complex cases. The readmission rates for both age groups are significantly lower than that of the previous reported year, with the readmission rate for patients aged 16 years and over dropping from 11.93 per cent in 2010/11 to 11.15 per cent in 2011/12, and from 8.2 per cent in 2010/11 for patients under the age of 16 to 7.8 per cent in 2011/12.

The Trust considers its readmission data is robust because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. These include checks on the completeness and quality of the clinical coding, checks conducted on the classification of admission types and lengths of stay as recorded on the patient administration system, and the reviews undertaken of the data quality returns on the commissioning data sets received from the secondary uses service.

3.5 Performance against national priorities and access standards

3.5.1 Overview

In 2014/15, the Trust declared risks to compliance with the accident and emergency four-hour standard, the Referral to Treatment Time (RTT) non-admitted standard, and the 62-day GP cancer standards in its 2014/15 Annual Plan. Reported performance during 2014/15 was consistent with this, with the exception of a wider scale of failure against the RTT standards, and the additional failure of the 62-day referral to treatment cancer standard for patients referred from the national screening programmes.

There was a decline in performance against the three national RTTs during 2014/15, with failure of the three standards being reported in quarters 2, 3 and 4. The failure to sustain achievement of the RTT standards was due to a growth in the number of over 18-week waiters, with demand exceeding the level of capacity that could be put in place. However, the rise in the number of over 18-week waiters during the first quarter of the year led to a detailed review of the capacity required to both address the backlogs, and to achieve

sustainable 18-week waits going forward. There were clear signs of recovery during quarter 4; there were material reductions in the backlogs for both admitted and non-admitted patient pathways being realised, beyond that set out in the recovery trajectories. High levels of demand also brought challenges for achievement of the maximum six week wait for a diagnostic test. A recovery trajectory was put in place, underpinned by detailed capacity and demand modelling, with achievement of the 99 per cent standard now expected by the end of quarter 1 2015/16.

Overall, performance against the cancer waiting times standards remained strong, with six of the eight national standards being achieved in every quarter. The 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer was not achieved in 2014/15; the main reason for the failure to achieve the 85 per cent national standard was the late receipt of referrals from other providers, with late referrals accounting for approximately 40 per cent of breaches each month. Performance for solely internally managed pathways was above 85 per cent in three quarters in 2014/15. The Trust continued to take action to reduce the length of wait for key steps in cancer pathways in 2014/15, including offering as many patients as possible the opportunity to be seen within seven days of referral by the GP, instead of the national requirement of 14 days. The 62-day wait from referral to treatment for patients referred from one of the national screening programmes was achieved in the first two quarters of 2014/15, and then failed for the latter half of the year; the main reason for the failure to achieve the 90 per cent standard was outside of the Trust's control, further details of which can be found in the extended narrative about cancer performance below.

Disappointingly, the Trust failed to achieve maximum four-hour wait in A&E for at least 95 per cent of patients in every quarter of the year. However, the Trust met the national A&E clinical quality indicators in the period. The level of ambulance handover delays remained at a similar level to 2013/14, although significant improvements were seen in the latter half of quarter 4. A system-wide resilience plan was developed during the year, in association with partner organisations, in recognition of the increasing pressure on emergency services both locally and nationally. Encouragingly, the recovery trajectory that was developed from the expected impacts of the joint plan was achieved by the Trust in quarter 4, with year being rounded off with achievement of the 95 per cent standard in March.

Performance against the last-minute cancelled operations and 28-day readmission standards in 2014/15 remained similar to that in 2013/14. This was despite the implementation of the managed beds protocol, which protected the core adult bed-base required for elective operations, and resulted in a significant reduction in ward bed related cancellations during the year. Cancellations due to emergency patients being prioritised, and the lack of an intensive therapy or high dependency unit bed to admit the patient to after surgery, remained leading causes of cancellations.

Performance against the primary percutaneous coronary intervention (PCI) heart revascularisation 90-minute door to balloon standard remained good in 2014/15, and above the 90 per cent standard for the year.

During each quarter of 2014/15, the Trust received performance notices from Bristol Clinical Commissioning Group (CCG) for the areas of performance where national and constitutional standards were not being met. This included RTT, 62-day cancer, A&E hours, last-minute cancelled operations and the six-week standard. Improvement plans and recovery trajectories have been submitted as requested. The failure to consistently meet the standard of 99 per cent of diagnostic tests being carried out within six weeks of referral was mainly due to continuing growth in demand for specialist tests, such as cardiac stress echo, and also the consequence of clearance of the 18-week RTT backlogs; the latter resulting in a particular spike in demand for audiology tests. Detailed capacity and demand modelling has been undertaken, with achievement of the 99 per cent standard forecast for June 2015.

Full details of the Trust's performance in 2014/15 compared with the previous two years are set out in Table 12 below. The table includes performance in controlling healthcare acquired infections, which is described in detail in section 3.2.4 of this report; further information about 28 day readmissions can be found in section 3.4.8; and extended commentary regarding the 18 week RTT, A&E four hour, cancer and other key targets is provided below.

3.5.2 18 weeks Referral to Treatment Time (RTT)

Although the Trust achieved the admitted and incomplete pathways Referral to Treatment Times standards for the first quarter of 2014/15, the number of patients waiting over 18 weeks for treatment increased, and became too high to sustain the required level of performance on an ongoing basis. This was due primarily to the Trust not being able to put in place the planned level of capacity to meet demand. Following a nationwide request from NHS England, the Trust took the decision to participate in a planned failure of the RTT standards from July until the end of November 2014, in order to treat as many long waiting patients as possible during that period. Following detailed capacity and demand planning, which the Trust undertook in each speciality, recovery trajectories were developed with the support of NHS Interim Management & Support (IMAS). The period of planned failure of the RTT standards was therefore extended. The level of activity required to support achievement of the three RTT standards in a sustainable way has been agreed with commissioners for 2015/16. Delivery plans have been developed, with achievement of all three standards planned during 2015/16. During quarter 4 2014/15, significant progress was made in reducing the number of patients waiting over 18 weeks for treatment. The number of patients waiting over 18 weeks for treatment on admitted pathways dropped from a peak of 1,814 in December 2014 to 1,519 at the end of March 2015 (16 per cent reduction). Similarly, the number of patients waiting over 18 weeks for treatment on non-admitted pathways dropped from a peak of 2,308 in December 2014 to 1,826 at the end of March 2015 (21 per cent reduction). At the end of March 2015, 95 per cent of patients were waiting less than 24 weeks from referral to treatment, with 119 patients waiting over 40 weeks and four patients having a wait of over 52 weeks.

3.5.3 Accident & emergency four-hour maximum wait

In 2014/15, the Trust failed to meet the national A&E standard for the percentage of patients discharged, admitted or transferred within four hours of arrival in our emergency departments. In contrast to previous years, when the number of ambulance arrivals and emergency admissions declined in spring and summer, the same seasonal pattern of emergency department activity was not seen in 2014/15; 2013/14 winter levels were sustained into the first half of the year. Whilst the potential failure to achieve the 95 per cent standard in quarter 4 of 2014/15 due to winter and system pressures had been forecast, the resulting early failure of the four-hour standard prompted a review of system-wide resilience, and what needed to be put in place to support emergency access in the coming quarters. Although the 95 per cent national standard failed to be achieved in each quarter of 2014/15, the Trust achieved its recovery trajectory for quarter 4, and achieved the 95 per cent for the month of March.

Trust-level performance against the national 95 per cent standard varied between 94.7 per cent in quarter 1, and 89.6 per cent in quarter 3. The level of emergency work transferring to UH Bristol following the closure of Frenchay Hospital emergency department in quarter 1 of 2014/15 was in line with the predicted levels for both the Bristol Royal Infirmary and the Bristol Royal Hospital for Children (BRHC). However, an earlier than normal peak in levels of paediatric respiratory illnesses across the community coincided with the refurbishment of the BRHC emergency department in readiness for the anticipated higher level of winter demand. This led to a deterioration in performance against the four-hour standard at BRHC, and at a Trust level, during quarter 3.

3.5.4 Cancer

As reported in the summary section above, performance against six of the eight key national cancer waiting times standards remained strong in 2014/15, with full achievement of these six standards in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment wasn't achieved in any quarter. This was mainly due to high volumes of the more 'unavoidable' causes of breaches of standard – such as late referrals from other providers, clinical complexity, and patient choice to delay diagnostics and treatments – but also some more avoidable causes of breaches, such as elective cancellations due to critical care capacity, and delays in outpatients for certain specialties. Demand for thoracic (lung) cancer surgery continued to exceed routine capacity in the first two quarters of the year. However, following the transfer out of the vascular service to North Bristol NHS Trust (NBT) in October 2014, the number of scheduled operating sessions was increased, which reduced breaches of the 62-day standard for this reason. The Trust also put in place additional capacity to enable more patients to be offered a first appointment within seven days of referral by their GP with a suspected cancer, rather than the national standard of 14 days.

Following the transfer out to NBT of the high performing breast and urology cancer services, and the transfer in of the head and neck cancer service at the end of 2012/13, UH Bristol now has a more complex portfolio of cancer services. In combination with increasing levels of breaches due to late referral by other providers, medical deferral, and patient choice to delay pathways, consistent achievement of the 62-day standard will require performance significantly above the national average in most tumour sites. An active programme of cancer pathway improvement work continues into 2015/16, focusing on information gained from the monthly review of the causes of breaches, opportunities identified for reducing the length of steps in patient pathways, and learning from other organisations.

In contrast to 2013/14, the 62-day screening referral to treatment screening standard was failed in quarters 3 and 4, following the transfer out of the Avon Breast Screening service at the end of quarter 2. There are three screening services nationally that refer patients into Trusts on a 62-day pathway; these are breast, bowel and cervical cancer. With the transfer out of the breast screening service, which the Trust previously hosted, bowel screening patients form the highest volume tumour site treated under the 62-day screening standard (with both internally managed and shared pathway across providers). Nationally, performance against the 62-day screening standard is consistently below the 90 per cent national standard for bowel screening patients, mainly due to high levels of patient choice. The Trust reported failure of the 90 per cent standard in quarters 3 and 4, for reasons largely outside of its control (that is, patient choice, medical deferral and capacity related delays at other providers).

National standard	2012/13	2013/14	2014/15 Target	2014/5	Notes
Target	93.8%	93.7%	95%	92.2%	Target failed in each quarter in 2014/15
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	57	15	15 mins	14	Target met in every quarter in 2014/15
A&E Time to Treatment (minutes) median within 60 minutes	53	52	60 mins	54	Target met in every quarter in 2014/15
A&E Unplanned re-attendance within 7 days	2.6%	1.5%	< 5 %	2.3%	Target met in every quarter in 2014/15
A&E Left without being seen	1.9%	1.8%	< 5%	1.8%	Target met in every quarter in 2014/15
Ambulance hand-over delays (greater than 30 minutes) per month	See note[41]	100	Zero	107	Target failed in every month in 2014/15
MRSA Bloodstream Cases against trajectory	10	2	Trajectory	5	Two of the five cases were contaminated samples only
C. diff Infections against trajectory	48	38	Trajectory	50[42]	Target met in every quarter in 2014/15
Cancer - 2 Week wait (urgent GP referral)	95.0%	96.8%	93%	95.5%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (First treatment)	97.0%	97.1%	96%	96.9%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94.9%	94.8%	94%	94.9%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.8%	99.8%	98%	99.6%	Target met in every quarter in 2014/15
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	98.7%	97.4%	94%	97.6%	Target met in every quarter in 2014/15
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	84.1%	80.1%	85%	79.3%	Target failed in each quarter in 2014/15
Cancer 62 Day Referral To Treatment (Screenings)	90.0%	93.8%	90%	89.0%	Target met in quarter 1 and 2 of 2014/15
18-week Referral to treatment time (RTT) admitted patients	92.6%	92.7%	90%	84.9%	Target met until June 2014, but failed thereafter
18-week Referral to treatment time (RTT) non-admitted patients	95.7%	93.1%	95%	90.3%	Target failed in every month in 2014/15
18-week Referral to treatment time (RTT) incomplete pathways	92.2%	92.5%	92%	90.4%	Target met up until July 2014, but failed thereafter
Number of Last Minute Cancelled Operations	1.13%	1.02%	0.80%	1.08%	Target failed in each quarter in 2014/15
28 Day Readmissions *(following a last minute cancellation)*[43]	91.1%	89.6%	95%	89.8%	Target failed in each quarter in 2014/15
6-week diagnostic wait	89.7%	98.6%	99%	97.5%	Target failed in each quarter in 2014/15
Primary PCI - 90 Minutes Door To Balloon Time	91.7%	92.7%	90%	92.4%	Target met in three quarters in 2014/15 (failed in Q3)

Achieved for the year and each quarter | Achieved for the year, but not each quarter | Not achieved for the year | Target not affected

[41] Validated data not available in 2012/13

[42] Please note, the figures quoted for 2014/15 are the total number of cases reported. However, of these, eight were deemed to be potentially avoidable against the limit of 40. For this reason this indicator is RAG rated Green

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

A APPENDIX A
Feedback about our Quality Report

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

Introduction
Overall this is a comprehensive report that identifies the various strengths and areas for improvement over the last 12 months since the previous report. There is clear evidence of consultation and responding to actions highlighted in the 2013/14 quality report and the efforts of all the Trust staff are acknowledged and identified within this report.

Although some of the results themselves are disappointing, there is an accompanying narrative which provides valuable information and in particular highlights some of the challenging conditions that the Trust has faced over the last 12 months. This is an honest, transparent report, which has clearly identified a sense of listening, responding and actioning and real attempts to put the patient first.

Priorities for improvement
Reducing the number of cancelled operations remains a challenge and this report documents some of the new policies that have been introduced in an attempt to tackle the issues of cancelled appointments. The single site for general ITU and HDU will undoubtedly bring future benefits in terms of greater flexibility. There have also been some reported challenges associated with minimising patient moves between wards, with target reduction over baseline figures not being achieved. However, it is acknowledged that the Surgery Head and Neck Division moved into the new Bristol Royal Infirmary ward block, which is larger and thus should help to reduce the number of patient moves between wards.

It is pleasing to see a reduction in the number of patients inappropriately discharged from the hospitals out of hours, with a reduction from 9% in 2013/14 to 7.7% in 2014/15. Accurate documentation / recording and encouraged accountability is welcomed by the Governors.

In terms of the Patient and Public Involvement developments over the last 12 months, there have been some significant steps to further enhancing this relationship with the public. The impact of having improved service improvement reviews and the examples of where this work has been undertaken is an excellent example of partnership working and further plans to create a 'Citizens' Assembly', provide training and support for staff and create a culture of PPI further highlights the Trust's ambitions to ensure PPI is at the heart of all future activity, to understand the needs of patients, their relatives and carers and also to enhance the workforce within the Trust.

The objectives set out in the quality report are open and honest and use quotations from patients. Where objectives have not been met, there is an ongoing action plan outlining the future intentions and monitoring processes, along with the Trust Executive who will be responsible for the objective. A clear rationale has been provided in terms of identifying the nine objectives and how they will be measured moving forward.

Statements of assurance from the board
We are impressed that the Trust actively completed 100% of the 37 national clinical audits and this is to be commended. The list of the audits is also very helpful and demonstrates the breadth and depth of the activities of the Trust. This report also provides evidence in terms of where active participation in 10 of the audits will help inform future practice and improve the quality of clinical services. There are a range of examples provided in this report which cover both patients and staff and it is particularly good to see audit areas relating to previous objectives (e.g. falls / fragility fractures) that were set in past quality reports.
The participation in clinical research is strong and the increase in NIHR portfolio is positive. There is a focus around collaborative research and links with the regional CLAHRC is evident. The Trust is to be commended in its work relating to the national research CQUIN and highlights the commitment to undertaking clinical work with partners.

The Trust achieved 18 out of 24 CQUIN targets and six in part and the review of the Care Quality Commission is also identified within this report. Positive quotes from the CQC report are included within this report along with the areas for improvement. It is worth stressing that the Trust received 44 out of 56 ratings that were good or better and this is a positive result. Although the overall position of the CQC was to award the Trust a status of 'requires improvement', it is important that the Trust informs the public (in the footnote) that roughly 80% of all NHS Trusts have received this rating. The Trust and its staff worked very hard before, during and after the actual CQC inspection in September 2014 and the Governors felt very informed and inputted into the overall review. Two areas of 'outstanding' were awarded for the way in which maternity and family planning was led and how effective services for children and young people was within the Trust at the UH Bristol main site.

Patient safety

The good work of the Trust staff and new directives around preventing patient falls is documented and has resulted in an overall reduction in falls, compared to this time point last year. New campaigns such as the 'eyes on legs' initiative and work conducted by the Falls Steering Group and Falls Assistant have helped to improve current position. The details associated with the root cause analysis is honest and transparent and helps the Trust to identify new training and education developments for staff.

Significant improvements with regards to the reduction in category 2-4 pressure ulcers per 1,000 bed days have also been recorded in this quality report which is welcomed by the Governors and the staff associated with this improvement are to be commended. The associated achievements of this particular patient safety initiative are outlined and demonstrate collaborative working with neighbouring healthcare services (e.g. BNSSG), alignment with NICE guidelines and the development of key performance indicators. Of particular note is the education and training that has been introduced for staff within the Trust. It is also encouraging to see the planned actions for 2015/16 which should help to further reduce the number of category 2-4 pressure ulcers within the Trust.

Strong performance figures are also noted for the risk assessment of VTE, with a figure of 98.8% being reported for 2014/15, along with measures being undertaken to further reduce risks. Although overall figures for *Clostridium difficile* increased for 2014/15, it is acknowledged that only eight of these cases could have been avoided. It is also worth noting that the Trust has undertaken a serious amount of effort over the last several years to address the issue of HCAIs. It is unfortunate that the target of zero MRSA cases was not achieved for 2014/15, however it is again acknowledged that levels are low and actions continued to be taken to reduce the number of episodes within the Trust.

The adoption of ANTT champions within the Trust is welcomed and the education and training and new policy that is associated with this culture change. There have also been improvements in reducing medication errors and it is welcomed that the Trust has adopted the NHS Medication Safety Thermometer, resulting in new local actions.

Significant work has been undertaken to improve the monitoring of patients and recording patient observations or vital signs, based on a local CQUIN with commissioners. It is good to see the previous work undertaken at Salford NHS Foundation Trust has been adopted and a mixed set of results have been recorded overall. Clearly further actions have been documented, in terms of carrying on the initial work associated with patient safety and reflections on incidents that had occurred over the last 12 months.

The percentage of reported incidents at UH Bristol is comparable to previous years. Key actions are in place to further reduce the number of reported avoidable patient safety incidents in 2015/16, including signing up to the Safety Patient Safety Improvement Programme (2015-18). The largest percentage of serious incidents in 2014/15 was falls and a comprehensive report detailing 'never events' is also documented. The introduction of a visual cue within the Dental Hospital on patients' bibs is a welcomed procedure and should further minimise any future human error.

In terms of the purchasing and maintenance of medical devices within the Trust, the role that MEMO undertakes is essential and it is pleasing to see that repairs to equipment are

undertaken in a very prompt response time. In addition, the training offered to staff for newly purchased medical devices is also essential, along with a log recording which staff have received training. The introduction of a Trust Medical Devices Management Group is welcomed.

Patient experience
Various results are presented, along with a testament from a patient. The inpatient experience quality tracker score was consistently above the alert threshold and the friends and family test scores were overall above the national average. The Trust's in-house survey revealed that 97% of patients considered their care to be excellent, very good or good.

The Trust has taken the positive step of buddying with another NHS Trust to improve patients' experience of cancer services.

The explanation provided for the increase in the number of complaints received appears to be fair and there is a clear corporate quality objective associated with how complaints were investigated and resolved.

There is a mixed set of performance measurements related to the NHS Staff Survey (2014) and unfortunately the majority of figures presented on page 47 are below / above national average scores, depending on the key finding heading. It is reassuring to see that a Staff Experience Programme is now underway within the Trust, led by its Senior Leadership Team. The introduction of an Employee Assistance Programme within the Trust is paramount and welcomed.

The introduction of the Carers Information Scheme in the Trust's Medical and Surgical divisions is welcomed and will hopefully help to further integrate the important roles that carers provide and work with third sector organisations is also a very positive move. The case study presented in this report highlights the positive experience of a patient and their carer, which promotes sensitivity, understanding and a focus around the patient and their carer.

Clinical Effectiveness
It is encouraging to see the progress with work within the field of dementia care, particularly the initiatives around the 'Forget-me-not' work and dementia champions across the Trust. The training offered to staff is also to be commended and the introduction of an electronic data capture system will allow CQUIN data to be captured real time and is effective at hand over times / discharge etc.

The mortality figures associated with the provision of adult cardiac surgery activity are consistently lower than national norms for the four year in a row, which is an achievement and demonstrates the steps being taken by the Trust to ensure safe working practice.

The Trust's performance against the national best practice tariff for hip fracture management is better than previous years and further developments / plans for improvement in 2015/16 are welcomed.

National Standards
Performance against a number of access standards has declined in 2014/15, with successive trajectories not being met, however the Governors are assured that the Trust is working hard to mitigate the effects of this with many initiatives to accelerate patient flow without compromising quality of care and clinical outcomes. Perhaps the most significant of these is the setting up of the discharge hub of healthcare partners to provide integrated working on discharge care packages.

Dr Marc Griffiths, appointed governor
Clive Hamilton, governor

b) Statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and Healthwatch South Gloucestershire (Healthwatch) are pleased to comment on the University Hospital NHS Foundation Trust Quality Report 2014/15. Healthwatch is mindful that the Quality Report has a range of audiences. It is suggested that future reports contain an easy read summary and a glossary of terms to enable the public to understand acronyms and terminology.

Healthwatch applauds the Trust in fully achieving 18 of the 24 Commissioning for Quality and Innovation payments (CQUINs) during the year.

Healthwatch took part in the CQC inspection 'Quality summit' following the inspection of the Trust in September and looks forward to seeing the improvements in the areas of staff training, outpatients and patient flow back into the community. One area of training identified within the Quality Report that Healthwatch is particularly supportive of is training for all new staff in relation to the falls experienced by people with dementia and, the relevant data to support this. Healthwatch recognises that Trust values are embedded in values-based recruitment, in staff induction, through training, and are clearly and regularly communicated. In addition, Healthwatch considers it important that staff training ties in to the outcomes of the national staff survey and is reviewed regularly so that it reflects and is responsive to emerging themes.

Healthwatch welcomes the Trust's corporate quality objective to address complaints with a more personal and empathetic approach, and was disappointed to see that the number of complaints had increased across the year. In addition, Healthwatch welcomes the plans to develop new ways of working together with patients, carers, relatives and communities of interest as partners for improvement within the priorities for improvement.

Healthwatch was pleased to see that 99 per cent of reported medication incidents did not result in harm. In reducing medication errors, Healthwatch would like the target to be nil, rather than kept to a minimum and looking for continuous improvement.

Under the safe staffing section, Healthwatch would have liked to see the number of staff and vacancies that are presently being filled by bank staff.

Healthwatch applauds the Trust on achieving higher than the national average on the Friends and Family Test, but would like to have seen the number of respondents for understanding the percentages.

Healthwatch would very much like to add to the section on 'Carers' to include the personal assistant, perhaps as a separate category. Carers have fed back to Healthwatch that where car drivers get discounted car parking, for those using public transport to visit they would like a discounted bus ticket.

Healthwatch is aware of the independent review into paediatric cardiac services and the listening events that have taken part; it would be useful to document the timing of the review and the expected conclusion.

Healthwatch was pleased to read under the section on hip fracture best practice tariff that the division of Surgery, Head and Neck has an operational focus imbedding the new all-day weekend operating.

Healthwatch participates in the Trust's Patient Experience Group and is aware of the full range of patient experiences activities and data that supports the Quality Report. Healthwatch suggests that the Quality Report is an excellent opportunity to showcase this work and demonstrate how such work supports the CQC areas for improvement.

Finally, Healthwatch is aware of the pressures the Trust is under particularly with a lack of resources. Healthwatch welcomes the quality objectives for 2015/16 and under the sections 'What will we do' will be keeping a watching brief to see if the actions become concrete proposals for improvement.

c) Statement from Healthwatch North Somerset

Healthwatch North Somerset is pleased to have the opportunity to comment on the University Hospitals Bristol NHS Foundation Trust Quality Report.

We recognise that Quality Reports are a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public for the quality of services they provide. We fully support these reports as a means for providers to review their services in an open and honest manner, acknowledging where services are working well and where there is room for improvement.

The University Hospitals Bristol NHS Foundation Trust (UH Bristol) Quality Report tackles these issues and provides discussion of clinical issues. It is noted that the data is not split up to provide data for the various hospital locations or services covered. So it cannot be seen, for example, if performance is better in one clinical area than another. A list of hospital locations at the beginning of the Quality Report would be useful.

Most strikingly the report does not provide delineated data for North Somerset. In the format provided it is difficult to comment specifically on the service provision for North Somerset patients. Healthwatch North Somerset would welcome the separation of data in future Quality Reports.

We note that that the 2014/15 priorities for improvement targets for reducing the number of cancelled operations, minimising patient moves between wards and ensuring patients are treated on the right ward for their clinical condition were not achieved. We recognise the work done towards achieving these priorities and note that cancellations on day of operation are still in excess of 1% and are attributed to lack of high dependency beds and staff.

Healthwatch North Somerset notes the average number of bed moves and urges a reduction in the number of bed moves for patients so that patients are cared for in the right ward to minimise patient distress and to ensure treatment commensurate with the patient's safety, health and staff expertise.

We also note the 4 hour waiting time figures for A&E were exceeded and again urge resolution of the priority areas underachievement. We recognise that these issues clearly reflect pressure on the system.

Failing to meet targets in cancer, sepsis and OPD delays strike at the most vulnerable groups of people. There are also concerns about rates of infection including MRSA and Norovirus incidents which resulted in the closure of 22 wards and bays.

Healthwatch North Somerset commends the reduction in the number of patients who are discharged out of hours and the commitment towards strengthening the patient and public partnership. We would like to see some information on the numbers of patients that are discharged out of hours to North Somerset and what support and care is put in place for these patients.

The level of Friends and Family Test scores is above the national average and the percentage of positive responses is high, although the data does not provide figures of the responses received. We share the aspiration of placing an increasing focus on placing the patient's experience at the heart of health and social care. An essential part of this is making sure the collective voice of the people of North Somerset is heard and given due regard, particularly when decisions are being made about quality of care and changes to service delivery and provision. The Healthwatch Intelligence data forwarded monthly to UH Bristol shows eight instances associated with UH Bristol, most relate to long waiting times for appointments.

We note the setting of nine Quality Objectives for 2015/16 and commend the inclusion of those that were not achieved in 2014/15 as a commitment to strive to achieve improvement despite indications in the Quality Report of difficulty meeting demand.

Healthwatch North Somerset notes the Care Quality Commission ratings for the Trust and the overall rating of 'requires improvement'; we do however commend the two 'outstanding' ratings received. We also note that Bristol Clinical Commissioning Group issued performance

notices against UH Bristol. Healthwatch suggests that the Trust considers noting these performance notices in the Quality Report.

The increase in serious incidents and the six reported never events are disappointing. The recording of three of the never events occurring during dental extractions is particularly disturbing.

The Trust has received an increased number of complaints compared to previous years and suggests that this may be due increased accessibility to the Trusts complaints service. We suggest that further investigation is conducted as to the increase in complaints received. The number of complainants that were unhappy with the response received is of concern. Healthwatch North Somerset would welcome a an opportunity outside of the Quality Report process to understand in more detail the experience of those patients from North Somerset receiving care at UH Bristol.

Healthwatch North Somerset notes the NHS Staff survey results and has concerns about the 39% of staff who have witnessed potentially harmful errors, near misses or incidents in the last month. This figure is of concern and has continued since 2011. We welcome some comments on how this figure can be reduced. We would welcome information about staffing levels and agency staff.

We commend the work being done by the Trust through the Carers Information Scheme and ensuring the Carer perspective and contribution is recognised. We also commend the work being done towards integrating a greater awareness of dementia.

The Trust performance against national priorities and access standards in A&E waiting over 4 hours and ambulance handover, cancer 62 day referral and 18 week referral to treatment time, cancelled operations, 28 day readmissions and six week diagnostic wait was disappointing and concerning especially as the target was failed in each month/quarter.

This response was completed with the support and input of Healthwatch North Somerset volunteers who read and disseminated the University Hospitals Bristol NHS Foundation Trust Quality Report 2014/15.

d) Statement from South Gloucestershire Health Scrutiny Select Committee

South Gloucestershire Council had been due to receive a presentation from UH Bristol at its meeting of the Public Health and Health Scrutiny Committee on 22 April 2015. However, this meeting was cancelled as it fell within the pre-election Purdah period. The Committee was not able to arrange a subsequent meeting prior to the deadline to enable it to comment on the Quality Accounts from the local providers. The committee will therefore discuss plans and suggest content for Quality Accounts with providers when they reconvene in the summer.

e) Statement from Bristol City Council People Scrutiny Commission

At its meeting of 13 April 2015 the Commission received a presentation setting out the progress against its 2014/15 priorities, and its proposed priorities for 2015/16.

There was general consensus amongst members that the priorities chosen were appropriate, particularly Improving the experience of cancer patients. Reference was made to the need to support patients mental health needs during treatment.

Joint working through the Better Care Fund would be ongoing.

f) Statement from Bristol Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Report 2014/15 is coordinated by Bristol Clinical Commissioning Group following a review by members of its Quality and Governance Committee and inclusion of comments from South Gloucestershire CCG.

The Commissioners considers that the report for 2014/15 provides a comprehensive reflection on the quality performance during 2014/15 and includes the mandatory elements required.

All of the data presented has been reviewed and we are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with data provided and reviewed as part of contract performance management.

The review of the quality objectives was clear and well described. We noted that of the five quality objectives for 2014/15 only two were achieved, however we are pleased to note that three of these will continue to be addressed in 2015/16, but we would like to have seen what will be done differently to support their achievement. The CCGs were pleased to see the reduction in the number of patients discharged out of hours, but wondered for those who were discharged between 10pm and 7am if the impact of this on the patients, family and primary care teams was followed up and fed back to staff to support learning. The CCGs also support the objectives chosen for 2015/16, again developed from the public consultation exercise that will support achievements in tangible benefits and outcomes to patients in terms of safety and experience. The patient stories were pleasing to see and their inclusion really helped to demonstrate the importance of these objectives. In addition, the plans to further develop the patient and public involvement activities and culture at the Trust are commendable and we would support an objective on patient and public involvement in research. The Trust's performance against achieving the quality improvement and innovation goals (CQUINS) is noted in the quality account, but there is little narrative or explanation regarding the schemes that were only partially met". Some are picked up in other sections (but are not referenced in the CQUIN section) and others not at all. The CCGs would like to have seen narrative on the actions for addressing these.

The CCGs noted the inclusion of the CQC inspection which gave the Trust an overall rating of 'requires improvement'. The Trust has naturally focused on the positive outcomes of the inspections, which are commendable, especially noting that all services inspected were regarded as 'caring' and the leadership of maternity services and the effectiveness of the children's and young people's services were highlighted as being outstanding. There was little narrative on the areas where actions for improvement are required. The CCGs would like to have seen more emphasis on these areas and on the progress to date.

Within the quality account, UH Bristol has demonstrated good progress in a number of areas relating to patient safety, experience and effectiveness, specifically:

- Summary Hospital Mortality Indictor (SHMI) consistently below the national norm;
- the reduction in the number of inpatient falls
- achieving and sustaining pressure ulcer prevention with a further reduction in the number of cases reported on previous years and well below the target set for 2014/15;
- sustained compliance with the VTE mandatory indicator where patients are risk assessed for the risk of venous thromboembolism
- Friends and Family Test (FFT) response rates and percentage scores across inpatient wards, emergency departments and maternity wards/departments
- reducing the number of missed medicine doses and the number of moderate and serious harm medicines incidents
- increased identification of the deteriorating patient and reduction in the number of cardiac arrest calls on general wards
- active patient engagement and involvement demonstrated through the good initiatives for supporting carers and through the use of patient stories
- continued focus on dementia care with improvement in the 'FAIR' CQUIN by the end of 2014/15
- the comprehensive involvement with national and local audits and the learning from these.

The number of Never Events relating to dental care was disappointing but it was positive to see that changes had taken place and lessons learned. The staff survey results are also disappointing but the report did describe well the actions in place for 2015/16 to try and improve this.

There was good description of the managed beds protocol and the movement and opening of the new wards. This section was able to demonstrate the impact that these had had, although it is noted that cancelled operations remain at high levels. The Trust has made significant progress with managing complaints and it is very positive to note that they are continuing to focus on the quality of the responses.

The CCGs will continue to work closely with the Trust in areas which need further improvement. These include:

- Infection prevention and control, specifically achieving the national zero tolerance for pre-48 hour MRSA and reduction in the number of C Difficile cases – the CCG is pleased to see that UH Bristol is an active member of the Bristol CCG's Healthcare Associated Infections group to also support improvement across a health care community;
- In sustainable delivery of all of the eight indicators of quality for best practice tariff for hip fractures;
- Performance against national priorities and constitutional standards including mitigating the risks to patients as a result of a delay in receiving treatment or care; and
- Performance in the national cancer patient experience survey.

Having reviewed the quality account we welcome the improvements and progress made by the Trust and acknowledgement of where further improvement work is needed and we look forward to working with UH Bristol in 2015/16.

B APPENDIX B
Performance indicators subject to external audit

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

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:
- the indicator is defined as the total number of patients on an incomplete Referral to Treatment Time (RTT) pathway that have waited 18 weeks or less, expressed as a percentage of all patients waiting on an incomplete RTT pathway
- the number of patients waiting on an incomplete pathway is assessed at each month-end
- an incomplete pathway is defined as one where an RTT clock has been started, but no RTT clock stop has been recorded
- the clock start date is defined as per the national RTT rule suite (Department of Health –
- Referral to treatment consultant-led waiting times), and is when a referral is made by any healthcare professional for a patient to be treated within a consultant-led service
- the clock stop date is defined as the date when first definitive treatment starts, a period of active monitoring commences, or when it is agreed with the patient that they do not need treatment
- the Trust uses the national RTT rules suite to define the types of treatment which stop an RTT clock.

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

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:
- the indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer
- an urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant
- the indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait)
- the clock start date is defined as the date that the referral is received by the Trust; and
- the clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Dementia 'Find' indicator

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:
- the indicator is expressed as a percentage of patients asked the case finding question within 72 hours of admission
- all patients aged 75 and over following emergency admission to hospital are flagged on the eHandover system
- each ward is required to complete the eHandover Dementia case finding questions, a date/time stamp is recorded for each question once populated
- clock starts from time of admission
- clock stops once the last case finding question is answered
- the eHandover system alerts users within the dementia team, to patients that have been admitted for 36 hours, but have yet to have the dementia case finding question or initial assessment started
- if a patient is recorded on the eHandover system as critically ill, unable to communicate or end of life they are excluded from reporting
- patients with a length of stay of under 72 hours are also excluded
- the eHandover data is then linked to Medway (Patient Administration System) activity using the unique spell identifier to report division and ward of admission.

APPENDIX C
Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

Monitor 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 2014/15
- 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 2014 to April 2015
  - papers relating to Quality reported to the board over the period April 2014 to April 2015
  - feedback from the commissioners received 19/5/2015
  - feedback from governors received 19/5/15
  - feedback from overview and scrutiny committees received 6/5/15 and 14/5/15
  - feedback from Local Healthwatch organisations received 14/5/15 and 19/5/15
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[44]
  - the 2014 national patient survey (published 8/4/2015)
  - the 2014 national staff survey (published 24/2/2014)
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 26/5/2015
  - Care Quality Commission Intelligent Monitoring Report dated December 2014.[45]
- 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 review
- and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)).

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

By order of the board

John Savage, Chairman
27 May 2015

Paul Mapson, Director of Finance
27 May 2015

[44] This report is due to be received by the Board in July 2015

[45] At the time of writing, the May 2015 IMR has only been published in draft form

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 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified indicators	Specified indicators criteria
Clostridium Difficile	Appendix C of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Appendix C of the Quality Report

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 2013/14"* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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 Annex 2 to Chapter 7 of the FT ARM and the *"Detailed requirements for quality reports 2013/14";*
- 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 and the six dimensions of data quality set out in the *"2013/14 Detailed guidance for external assurance on quality reports".*

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, 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 period April 2013 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;
- Feedback from the Bristol Clinical Commissioning Group dated 14/5/2014;

- Feedback from Governors dated 16/05/2014;
- Feedback from Healthwatch Bristol and Healthwatch South Gloucestershire dated 15/5/2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2013 national patient survey dated 08/04/2014;
- The 2013 national staff survey dated 25/02/2014;
- Care Quality Commission quality and risk profiles dated 31/07/2013; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 27/05/2014

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales ("ICAEW") Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

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 2014, 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 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- 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 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 the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. 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.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2014,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
  - The Quality Report is not consistent in all material respects with the documents specified above; and
  - the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "*2013/14 Detailed guidance for external assurance on quality reports*".

PricewaterhouseCoopers LLP
Chartered Accountants
Bristol
28 May 2014

The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust 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.