University Hospitals Bristol NHS
NHS Foundation Trust

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

Item	*Sponsor*	*Page*	*Time*
1. Chairman's Introduction and Apologies To **note** apologies for absence received	Chairman		14:00
2. Declarations of Interest In accordance with Trust Standing Orders, all members present are required to declare any conflicts of interest with items on the Meeting Agenda.	Chairman		14:02
3. Minutes from the Previous Meeting To consider the minutes of the meeting of the Council of Governors on 30 April 2015 for **approval**	Chairman	3	14:05
4. Matters Arising (Action Log) To consider the status of Actions from previous meetings	Chairman	14	14:07
Statutory and Foundation Trust Constitutional Duties			
5. Nominations and Appointments Committee report - To receive and **note** this report. - To **approve** the recommendation to continue the appointment of Emma Woollett as Non-executive Director and Senior Independent Director subject to annual review. - To **approve** the recommendation to appoint Guy Orpen for a second 3-year term of office as Non-executive Director	Chairman	15	14:10
6. Governor Development Seminar report To receive and **note** this report.	Head of Membership and Governance	21	14:15
7. Governor Project Focus Groups reports To receive and **note** the following reports: a) Governors' Strategy Group b) Quality Project Focus Group c) Constitution Project Focus Group - To receive the Constitution Project Focus Group's recommendation to **approve** the amended Lead Governor role description *and to* **approve** the Group's recommendation to discontinue the Deputy Lead Governor role.	Project Focus Group Governor Leads	23	14:20
8. Terms of Reference for Governor Project Focus Groups To approve the revised terms of reference for Governor Project Focus Groups. - To note the Governor Project Focus Group Leads remain unchanged for 2015/16. To seek interest from governors to 'shadow' Project Focus	Head of Membership and Governance	31	14:30

Page 2 of 2 of an agenda for a Council of Governors meeting to be held on 30 July 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough St, Bristol, BS1 3NU

Item	*Sponsor*	*Page*	*Time*
Group leads for 6 months with a view to new appointments in 2016/17.			
9. Membership and Governor Engagement To receive the update reports on a) Membership Engagement, and b) Governor Activity for **discussion**.	Head of Membership and Governance	38	14:35
10. Review of Governor Compliance To **note** the review of governor compliance with statutory requirements.	Head of Membership and Governance	To follow	14:45
11. Governors' Log of Communications To **note** the current position of the Governors' Log of Communications	Chairman	51	14:50
Strategic Outlook			
12. Performance Update and Strategic Outlook a) **Chief Executive's report** To receive and **note** a verbal update from the Chief Executive b) **Independent Auditor's Report to the Governors on the Quality Report 2014-2015** To receive and **note** this report. **University Hospitals Bristol Quality Report 2014-2015** To receive and **note** this report. c) **Achievement on Corporate Quality Objectives – Quarter 1** To receive and **note** this report.	Chief Executive Chief Nurse	 57 76 152	14:55
Governors' Questions			
13. Governors' Questions arising from the meeting of the Trust Board of Directors To respond to questions arising from matters of business discussed at the preceding meeting of the Trust Board of Directors, including quality and performance	Chairman		15:15
14. Any Other Business To **note** any other relevant matters	Chairman		15:25
Members' Questions			
15. Foundation Trust Members' Questions To **receive** questions from Foundation Trust members and members of the public present (preferably notified in advance of the meeting).	Chairman		15:30
16. Meeting Close and Date of Next Meeting - The Annual Members' Meeting/Annual General Meeting will be held at 17:00 on Tuesday 15 September 2015 in Lecture Theatre 1, Education Centre, Upper Maudlin Street, Bristol, BS2 8AE - The next meeting of the Council of Governors will be held at 14:00 on Friday 30 October 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.			

University Hospitals Bristol NHS
NHS Foundation Trust

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

Present:
John Savage – Chairman
Bob Bennett – Public Governor
Clive Hamilton – Public Governor
Mo Schiller – Public Governor
Tony Tanner – Public Governor
Sylvia Townsend – Public Governor
Angelo Micciche – Patient Governor
Ray Phipps – Patient Governor
Anne Skinner – Patient Governor
John Steeds – Patient Governor
Pam Yabsley – Patient Governor
Wendy Gregory – Patient – Carer Governor
Ian Davies – Staff Governor
Thomas Davies – Staff Governor
Karen Stevens – Staff Governor
Florene Jordan - Staff Governor
Ben Trumper – Staff Governor
Jeanette Jones – Appointed Governor
Sue Hall – Appointed Governor
Bill Payne – Appointed Governor

Board of Directors present:
Robert Woolley – Chief Executive
Deborah Lee – Deputy Chief Executive and Director of Strategic Development
Sean O'Kelly – Medical Director
James Rimmer – Chief Operating Officer
Carolyn Mills – Chief Nurse
Emma Woollett – Non-executive Director
David Armstrong – Non-executive Director
Alison Ryan – Non-executive Director
Julian Dennis – Non-executive Director
John Moore – Non-executive Director

Others present
Richard Lewis – Head of Human Resources (attending on behalf of Sue Donaldson, Director of Workforce & Organisational Development)
Paul Tanner – Head of Finance (attending on behalf of Paul Mapson, Director of Finance)
Alison Grooms – Deputy Chief Operating Officer
Debbie Henderson – Trust Secretary
Amanda Saunders – Head of Membership and Governance
Sarah Murch – Membership and Governance Administrator (minutes)
Debbie Marks – Membership Support Assistant.
Several members of University Hospitals Bristol NHS Foundation Trust.

01/04/15 Chairman's Introduction and Apologies
The Chairman, John Savage, welcomed everyone to the meeting.

Apologies had been received from:
Sue Silvey (Lead Governor and Public Governor), Pauline Beddoes (Public Governor), Brenda Rowe (Public Governor), Philip Mackie (Patient Governor – Carer), Nick Marsh (Staff Governor), Marc Griffiths (Appointed Governor), Tim Peters (Appointed Governor), Jim Petter (Appointed Governor), Graham Briscoe (Public Governor), Edmund Brooks (Patient Governor), Mani Chauhan (Public Governor), Sue Milestone (Patient/Carer Governor), Tony Rance (Public Governor), Lorna Watson (Patient/Carer Governor), Paul Mapson (Director of Finance), Sue Donaldson (Director of Workforce and Organisational Development), Jill Youds (Non-executive Director), Guy Orpen (Non-executive Director) and Lisa Gardner (Non-Executive Director).

02/04/15 Declarations of Interest
In accordance with Trust Standing Orders, all members present were required to declare any conflicts of interest with items on the Meeting Agenda. There were no declarations of interest.

03/04/15 Minutes from Previous Meeting
Governors considered the minutes of the meeting of the Council of Governors on 29 January 2015 and approved them as an accurate record of the meeting, subject to the inclusion of Thomas Davies, Staff Governor, in the list of attendees. It was:

RESOLVED:
- **That the minutes of the meeting held on 29 January 2015 be approved as an accurate record of proceedings.**

04/04/15 Matters Arising (Action Log)
The Action Log was noted.

05/04/15 Lead Governor Appointment
It was noted that Sue Silvey would be standing down as Lead Governor on 31 May, after two 12-month terms in the role. There had been one application for the role from Ben Trumper, Staff Governor. Ben's statement to support his application had been circulated to the Council of Governors in advance of the meeting. The Chairman and governors voiced their support for Ben's application. Clive Hamilton, Public Governor, added that other governors could help out where necessary if Ben was experiencing time pressures. It was:

RESOLVED:
- **That the Council of Governors elect Ben Trumper as Lead Governor for a period of 12 months as of 1 June 2015.**

06/04/15 Nominations and Appointments Committee report

John Savage left the room for this item as it concerned his appraisal and annual review. Emma Woollett, Vice-Chair, took the chair.

A paper had been circulated in advance about the appraisal process, the Chairman's appraisal, and the part played by the Governors' Nominations and Appointments Committee. Governors were informed that, by 31 May 2015, John Savage would have served 7 years in office as Chairman. At the

Nomination and Appointments Committee meeting in February 2015, it had been agreed to implement a revised, rigorous annual appraisal process for all Non-Executive Directors to reflect the requirements of Monitor's Code of Governance for Non Executives who serve longer than six years.

Emma Woollett informed governors that she had carried out John Savage's appraisal, taking into account views from governors, Executives and other Non-executive Directors, and the paperwork had been received and discussed by the Nominations and Appointments Committee. The outcome was that the committee recommended to the Council of Governors that John Savage's term of office be extended by one year, to 31 May 2016, with any subsequent extension be based upon the annual appraisal / review process in line with the guidance outlined in Monitor's Code of Governance.

Governors were also informed that the committee had agreed to extend Guy Orpen's appointment for 3 months, to allow his appraisal to be conducted and reviewed at the committee's June meeting.

Emma further added that there was a vacancy on the Nominations and Appointments Committee, and that one application supported by a statement had been received from Angelo Micciche. She asked the Council of Governors to formally approve his appointment to the Committee. It was:

RESOLVED:

- **That the Council of Governors receive the report for information.**
- **That the Council of Governors formally approve the extension of John Savage's term of office as Chairman for 1 year, to 31 May 2016, subject to annual review in line with the Monitor Code of Governance.**
- **That the Council of Governors approve the extension of Guy Orpen's appointment for 3 months.**
- **That the Council of Governors appoint Angelo Micciche, Local Patient Governor, to the Nominations and Appointments Committee.**

Governors on the Nominations and Appointments Committee voiced their support for the new appraisal process. They encouraged all governors to take part in the process by completing the questionnaires as necessary.

The Chairman re-joined the meeting and took the chair.

07/04/15 Governor Development Seminar report

A report had been circulated. Wendy Gregory, Patient – Carer Governor, added that she and Sue Silvey had attended the inaugural NHS Providers Governor Focus Conference on 8 April in London. She reported that she had found it disappointing compared with events that she had attended in the past organised by the Foundation Trust Governors' Association (before the FTGA merged with the Foundation Trust Network last year and became NHS Providers). She felt it was not particularly informative or useful for experienced governors.

The presentations from the NHS Providers talks will be circulated to other governors for information. It was:

RESOLVED:

- **That the Council of Governors receive the Governor Development Seminar report for information.**
- **That the presentations from the NHS Providers Governor Focus Conference on 8 April be circulated to governors for information.**

08/04/15 Governor Groups Meeting reports

Written reports were circulated for all groups.

Governors' Strategy Group
Wendy Gregory, Lead Governor for the Governors' Strategy Group, reported that governors had considered the final draft of the Monitor Annual Plan at their last meeting. She was appreciative of the amount of input that governors had been given, though she noted that they had very little time to consider the final draft as it had not been available until just before the meeting. She welcomed the format and tone of the Annual Plan document.

She added that the group had changed its name from the Annual Plan Project Focus Group to the Governors' Strategy Group in order to reflect a wider remit than just reviewing the annual plan.

Quality Project Focus Group
Clive Hamilton, Lead Governor for the Quality Project Focus Group, reported back from the two meetings of the group in February and March. He added that the February meeting had been a special one to enable governors to have input into the Quality Report, and that following the meeting, Dementia Care had been chosen as the governors' chosen quality indicator to be tested by External Audit.

Clive added that he was now working with Marc Griffiths on the governors' section of the Quality Report, and he invited input from other governors if there was anything they wished to be included.

He highlighted the Quality Project Focus Group's continuing focus on the Trust's performance, and welcomed the improvements that were being made in this regard. He encouraged all governors to attend the group's next meeting on 5 May.

Constitution Project Focus Group
In the absence of Sue Silvey, Lead Governor for the Constitution Project Focus Group, Mo Schiller introduced this report.

She informed governors that the next meeting on 12 May would be looking at whether there needed to be provision for a Deputy Lead Governor role in the Trust's constitution. In the meantime, if governors were in agreement, it had been suggested that Mo retain the role of Deputy Lead Governor until the question was resolved. It was:

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

09/04/15 Governor and Membership Activity Reports
Amanda Saunders, Head of Membership and Governance, introduced the draft Membership and Governor Engagement Strategy, which had been circulated to governors in advance of the meeting. She explained that the document had been significantly rewritten from the version considered at the Constitution Project Focus Group meeting in March, in order to make the intentions of the strategy clearer.

The strategy covered 2015-17 in order to cover the next rounds of governor elections in 2016 and 2017. It was split into 3 key themes:

- **Membership Development and Engagement**: as membership numbers were declining, the Trust needed to be more proactive in recruitment, but also clearer about the opportunities for engagement that it was offering members.
- **Governor Support and Development**: continuing to support governors in their role, making sure that they were informed and had the necessary tools to undertake the role, and also working with them to reach out to our members.
- **Working in collaboration**: to work on membership and governor engagement more systematically with colleagues both within the Trust and with health partners locally.

Amanda added that an aim of the strategy was to also build the profile of the value that membership and governors could bring to the Trust. It is a live document which would be frequently updated: feedback was welcome. The strategy would be discussed and monitored by governors at Constitution Project Focus Group meetings. It was:

RESOLVED:
- **That the Council of Governors receive the Membership Engagement and Governor Development Strategy 2015-2017 and the quarterly Governor and Membership activity reports for information.**

10/04/15 Governors' Register of Business Interests
The Governors' Register of Business Interests had been updated in March-April 2015 and was now circulated for information. Wendy added that she was a Trustee of the Carers Support Centre. It was:

RESOLVED:
- **That the Council of Governors receive the Governors' Register of Business Interests for information.**

11/04/15 Council of Governors Meetings Forward Planner for 2015/16
The forward planner for Council of Governors Meetings for 2015/16 was circulated. As the print size was small, it was agreed to circulate this again. Debbie Henderson, Trust Secretary, explained that the Forward Planner included all the formal responsibilities of the Council of Governors, and also additional areas around membership engagement. She asked everyone to review it and inform the team if there were any discrepancies. It was:

RESOLVED:
- **That the Council of Governors receive the Council of Governors Meetings Forward Planner for information.**
- **That the forward planner be recirculated and larger-print versions printed.**

12/04/15 External Auditors – Extension of Contract
Governors received a written proposal and recommendation from the Trust's Audit Committee to extend the contract of the External Auditors, Price Waterhouse Coopers for a period of 12 months. Debbie Henderson explained that governors had a statutory duty to appoint, re-appoint, or remove the Trust's External Auditors. John Moore, Chair of the Trust's Audit Committee, explained that the contract for external audit services had been awarded to Price Waterhouse Coopers on 1 July 2012 for an initial period of three years with an option to extend of 2 x 12 months. The contract was for statutory audit services, auditing services, accounting, auditing and fiscal services. John Moore added

that the Audit Committee had been pleased with PwC's performance and asked governors to extend the existing contract by a further period of 12 months as of 1st July 2015.

This was agreed by governors. Jeanette Jones, Appointed Governor, who had been involved in the initial tender process, voiced her support for this decision. It was:

RESOLVED:

- **That the Council of Governors approve the extension of the contract of the External Auditors, Price Waterhouse Coopers for a further period of 12 months as of 1st July 2015.**

13/04/15 Governors' Log of Communications

Governors received an updated report of the questions on the Governors' Log of Communications. A revised process for managing and co-ordinating responses to the questions had also been circulated. Amanda Saunders, Head of Membership and Governance, explained that the revisions were more pertinent to staff than to governors but added that there was a need to ensure that all items on the Governors' Log were appropriate for publication and in line with the Trust's procedures on information governance. She added that she would be considering how to make the Governors' Log more visible within the organisation and to members.

Wendy Gregory asked that the Governors' Log report that was considered at Council of Governors meetings be amended to indicate which Executive Lead the question had been assigned to.

Clive Hamilton voiced his appreciation for the Governors' Log system and was pleased that it would be properly regulated. John Savage agreed, with the proviso that, where questions needed to be edited prior to publication, that this be done in consultation with the governor who had asked the question.

RESOLVED:

- **That the Council of Governors receive the Governors' Log of Communications report and the revised standard operating procedure for information.**

14/04/15 Performance Update and Strategic Outlook

At the start of a new Trust year, Robert Woolley, Chief Executive, shared with governors his reflections of the year 2014-15 and the challenges that lay ahead.

National Challenges: To illustrate the national challenges of the past year, Robert drew governors' attention to a King's Fund survey of Finance Directors published this month, which had commented on the extent of demand and acuity increases which Trusts had been dealing with and meeting through increasing staff numbers and staff costs, in conjunction with the emphasis on care quality following the Francis and Keogh reports. Those pressures had led to widespread breaches of the access standards, particularly in relation to referral-to-treatment times, A&E waiting times, and the 62-day cancer standard, which had been failed widely across the NHS in 2014/15. The number of delayed transfers of care out of hospital was at its highest level since 2008. It was therefore unsurprising that in a survey of plans for the coming year, carried out by NHS Providers, 37 out of 44 acute Trusts that had responded were predicting a deficit in their financial plans for 2015-16, with an average value of the deficit at £15m.

Performance at UH Bristol: At UH Bristol, the standards for 18-week referral-to-treatment times for A&E and 62-day cancer targets had not been achieved in 2014-15. However, the Trust had prepared recovery trajectories, and these were now being met at the end of March across most standards. Monitor had visited recently to examine the Trust's performance and the draft Annual

Plan, and they had signalled that they were satisfied that the Trust was meeting its trajectories. In May, Monitor was therefore expected to take a decision in the next few weeks about the Trust's governance rating against the risk assessment framework about whether to proceed to formal investigation of the Trust, or whether to put its rating back to a green status, given that it was now delivering the trajectories that it had set out to deliver.

Local NHS partners: Robert reported that there had recently been a third escalation meeting called by NHS England and Monitor regarding the whole of Bristol's health and social care system. At this meeting, UH Bristol's partners were asked to account to NHS England about how they were supporting UH Bristol as an acute trust to deliver patient flow and discharge patients appropriately when they were clinically fit for discharge into the community. One of the benefits of this approach was that the Trust had a very positive partnership with Bristol Social Services, Bristol Community Health and commissioners as a basis for considering the issue of improving patient flow outside, as well as inside, the hospitals. This would remain a subject of significant attention, but NHS England had signalled that perhaps only one more escalation meeting would be necessary, given the progress that the Trust was making.

Looking forward: Robert continued that the Trust's attention was now on delivering the Annual Plan for 2015/16. He highlighted the scale of last year's achievements in the face of the challenges faced by the NHS nationally, including the enormous changes that the Trust hade made to its facilities in Bristol Children's Hospital, the Bristol Royal Infirmary, and Bristol Haematology and Oncology Centre. This year, the Trust would continue to deliver estates improvements and use them as the basis for transforming care. He emphasised the achievement of having delivered a net surplus before technical adjustments, according to plan.

He was pleased that Board and the Executive team were united in the view that they were operating a healing business and that their job was to allow staff to deliver the best care that they possibly could. Staff were reporting through the staff surveys how much pressure they were under, and the Board was therefore putting a great deal of time and effort into working out how they could mitigate that pressure, through leadership and communication, as well as through delivering flow improvements to decrease occupancy levels.

Robert warned governors that this year was also likely to be challenging, but in context of the current climate, he was confident that the Trust had prepared a good and deliverable plan. He was enthusiastic that the Trust could deliver this plan while also proceeding with its partnership around the wider transformation of the Bristol health and social care system necessary to find a sustainable way to deliver care to Bristol people in the long term. In his view, UH Bristol had an opportunity and a moral duty to play a part in this agenda, and the forthcoming realignment of its executive structure would enable it to do so.

Questions from governors:

a) John Steeds, Local Patient Governor, commented on a feature in Saturday's Guardian newspaper about UH Bristol (which was the result of a number of staff being shadowed by novelist Nathan Filer in order to 'portray the real NHS through the eyes of its staff'). John felt that the piece had been very fair and he was impressed that the staff interviewed at every level had displayed a clear passion for and commitment to their job.
b) John Steeds also asked for a formal report of the changes alluded to by Robert regarding the Executive portfolios. Robert Woolley noted that as of 1 May, James Rimmer (currently Chief Operating Officer) would take on the new portfolio of Director of Strategy and Transformation, responsible for all annual planning and strategic planning in the Trust and also - crucially - for progressing the Trust's contribution to the whole system transformation task. Deborah Lee

(currently Deputy Chief Executive and Director of Strategic Development) would retain her Deputy Chief Executive role, but would also assume the role of Chief Operating Officer. Robert explained that this had been the Board's solution to the twin challenges of both delivering the Annual Plan and also the strategic agenda of ensuring a long-term sustainable future for UH Bristol and the wider health community in Bristol. John Savage commended the constructive and positive leadership demonstrated in the implementation of these changes, which he felt had been carried out in an exemplary way.

14/04/15 Patient Experience and Complaints Reports
Carolyn Mills, Chief Nurse, introduced these reports, which had been circulated to governors in advance.

Patient Experience Report: Carolyn highlighted the overall continuation of positive feedback from patients, a strong performance in the Trust's Friends and Family tests and also an increase in the volume of feedback forms collected. She drew governors' attention to the issue of the post-natal wards, which continued to receive lower ratings on some of their key metrics. While in line with the national benchmark for similar areas, this was an outlier to the standards set by the Trust. She reported that, following concerns expressed about this by the Non-executive Directors, two of them had visited the maternity unit yesterday, and their visit had provided a degree of assurance about the commitment and intent of the team and the challenges that they face.

Complaints Report: The report had been slightly revised in order to take into account volumes of activity in relation to the number of complaints. Carolyn highlighted that one of the main themes of complaints across the Trust continued to be around appointments and admissions, though there was an improvement in this from the previous quarter. She added that the report detailed the actions taken in divisions to address concerns, and that one of the Trust's quality objectives for this year was to improve the quality of complaints responses.

Questions from governors:

a) Wendy Gregory, Patient (Carer) governor, requested further information about the evaluation of the 2014 National Cancer Survey and the timeline for an action plan, as this had been a long-running issue. Carolyn Mills responded that work was currently ongoing on to gather patients' views about the service. The Trust was also operating a buddy system with South Tees Hospitals NHS Foundation Trust, who were seen as an exemplar in cancer services. It was clear that UH Bristol needed in particular to improve the experience of those who were referred to the Trust as a secondary referral having had their primary treatment elsewhere. She added that there had been some concern about the National Cancer Survey questions, and as a result the survey was not in fact being carried out this year.

   James Rimmer, Chief Operating Officer, added that one of the key suggestions from South Tees was the introduction of a key worker for patients going across hospitals which could potentially be put in place here. An action plan would be put together in August on a timescale of 18-24 months.

b) John Steeds asked for more details about the work that the Trust was carrying out to rectify failures to answer phones and inability to leave messages at Bristol Eye Hospital. Deborah Lee responded that the Trust had procured new telephony technology for BEH and were replacing all telephones, which should resolve the issue within a matter of weeks.

RESOLVED:
- **That the Council of Governors receive the Performance Update and Strategic Outlook and**

the quarterly patient experience and complaints report to note.

15/04/15 Monitor Annual Plan 2015/16

The Plan had been circulated in advance. Deborah Lee introduced this item. She thanked governors for their input at their Governors' Strategy Group meeting this month. She explained that the plan described the challenging context that the Trust continued to face, but also described the journey of recovery towards a sustainable performance for the future. It was an honest and fair reflection of the fact that the Trust had not been able to progress all of its longer-term aspirations this year because of the need to focus on immediate priorities. The Trust could expect a similar year in 2015/16 with a focus on operational delivery, but hopefully towards 2016/17 it could start to look again to a further period of building strategic intent over 3-5 years.

In relation to this year's performance, the Trust predicted that it would fail to deliver national minimum standards in a broad number of areas throughout the year, but that performance would begin to improve going into Quarter 4. It was planned that by Quarter 1 in the following year the Trust would see an improvement in the referral-to-treatment issues that had posed a challenge this year.

16/04/15 General Discussion (including Governors' Questions arising from the meeting of the Trust Board of Directors)

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

a) John Steeds referred to the Senior Leadership Team report that had been discussed at the Trust Board meeting that morning, and sought further clarification on the group's endorsement of action to take forward a new approach to staff engagement.

   Robert Woolley drew governors' attention to the list of actions in the Trust Board's Workforce report describing developmental work, and added that there was also work ongoing with Aston University on staff engagement. Further actions included devoting a significant amount of Senior Leadership Team meeting time to the issue of staff experience and devising appropriate plans for intervention. The Senior Leadership Team also planned to consult with staff to listen and find out what they themselves think would help their experience. He highlighted the use of local self-improvement mechanisms, for example, there was a pilot initiative running in the Emergency Department at Bristol Children's Hospital which allowed staff to log any concerns or issues on a staff-room computer, for 24-hour response.

   Florene Jordan, Staff Governor, welcomed Robert's response and emphasised the importance of the Executive team being more visible and listening to staff. She added that she had been asked by a colleague to request a debrief meeting inclusive of all staff, 12 months on from the Transfer of Specialist Paediatrics, to discuss whether it had progressed as expected, and what lessons could be learned. Deborah Lee responded that a review meeting had been held after 6 months which had included certain staff from all aspects of the transfer of services, and that this had captured some unresolved issues, but that it would be timely to have another meeting to assess the progress of the resulting action plan. Florene asked that this meeting be open to all. Deborah agreed to liaise with Bristol Children's Hospital to give this further consideration. It was:

RESOLVED:

- **That Deborah Lee liaises with Bristol Children's Hospital to consider how the views of all**

staff could be taken into account in relation to lessons learnt from the transfer of specialist paediatrics, and report back to governors.

Deborah Lee and Robert Woolley both reiterated the commitment of Executive Team to listening to staff and being visible around the Trust, adding that divisional leadership should also be visible. Debbie Henderson, Trust Secretary, added that Non-executive Directors were looking at improving their visibility as part of their current focus on the influence of the Trust Board on corporate culture, and how it linked with patient experience.

In response to a further question from Mo Schiller about whether divisional leads attended team briefings, Robert responded that team briefings were variable across the trust, with a significant proportion of staff reporting that they did not routinely have them at all, which was an issue that he fully intended to address.

Ben Trumper, Staff Governor, expressed the view that staff were perhaps more likely to respond to locally-based exercises. For example, in his department (the Intensive Therapy Unit), they had conducted an informal feedback exercise for staff 2 months after they had moved into their new unit, which had received a lot of responses.

b) Wendy Gregory enquired whether the Quality Project Focus Group could be provided with reports from the Quality and Outcomes Committee. Clive Hamilton responded that this had been requested, and should happen with effect from the next meeting.

c) Wendy also expressed her gratitude for the improved efficiency and support of the membership and governance team which, in her view, had transformed the way in which the governors worked, making them better informed and more efficient.

d) John Steeds again referred to the Senior Leadership Team report that had been discussed at the Trust Board meeting that morning, and asked for more information about the extreme escalation plan. Robert explained that the Trust constantly reviewed its operational escalation procedures, and that the Senior Leadership Team had been concerned that it had increasingly been in 'black escalation' in recent months: i.e. experiencing extremely high operational pressure and demand. The aim of the plan was to address the question of the circumstances in which the Trust would effectively lock the hospital down and declare a significant internal incident, and the steps that would be taken as a result. Deborah Lee assured governors that this was a response that would be only triggered on a very occasional basis.

e) In response to a further enquiry from John Steeds about the current status of plans for a new car park, Deborah Lee advised governors that a formal update would be received at the Trust Board meeting next month. A planning group had been established, but a planning application would not be submitted until further clarification had been received about the Trust's financial strategy. The plans were for a new Trust Headquarters building and a multi-storey car-park, and the footprint included the current Trust Headquarters building and the small carpark and buildings on Eugene Street. In response to a question about financing, Deborah added that it would be funded through 2 primary routes – some capital from the Trust itself through the re-provision of Trust Headquarters, and also by entering into a partnership with a third party to build and operate the car park.

f) John Steeds enquired about the progress of the new façade of the Bristol Royal Infirmary, and Deborah Lee responded that planning issues had now been resolved. The new facade would be delivered within this calendar year.

g) In relation to the Trust's Safe Staffing report for March, Clive Hamilton enquired why it appeared that the Specialised Services and the Women's and Children's divisions had sizeable deficits of hours. Carolyn responded that this had been due to flexible bed capacity, and assured Clive that detailed reports had been provided to the Quality and Outcomes Committee (QOC) and Trust Board. Alison Ryan, Chair of the Quality and Outcomes Committee, concurred that there had been a lot of detail in the reports provided to the committee and that they had raised no key concerns.

17/04/15 Any Other Business
There was no other business.

18/04/15 Foundation Trust Members' Questions
There were no questions from Foundation Trust Members.

19/04/15 Meeting Close and date of next meeting.

There being no other business, the Chair declared the meeting **closed**. The next meeting of the Council of Governors will be held on Thursday 30 July 2015 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

…….(Chair) ……2015 (Date)

University Hospitals Bristol NHS
NHS Foundation Trust

Council of Governors meeting
Item 04 - Action tracker

Outstanding actions following meeting held 30 April 2015				
Minute reference	**Detail of action required**	**Responsible officer**	**Completion date**	**Additional comments**
There are no outstanding actions.				
Completed actions following meeting held 30 April 2015				
11/04/15	Forward planner of Council of Governors meetings business to be re-circulated and larger-print versions made available on request.	Head of Membership and Governance	1/5/15	
07/04/15	Presentations to be circulated to governors from NHS Providers Governor Focus Conference 8/4/15.	Head of Membership and Governance	13/5/15	
16/04/15	Deborah Lee to liaise with Bristol Children's Hospital and ask them to consider how the views of all staff could be taken into account in relation to lessons learnt from the transfer of specialist paediatrics, and report back to governors.	Deputy Chief Executive	21/7/15	Feedback provided to W&C who were able to demonstrate a number of communication and listening events with staff in theatres. Recently concluded one year review post CSP transfer and a number of actions arising, which are in hand. Action now resting within W&C Division.

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

Item 05 - Nominations and Appointments Committee Report

Purpose

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

Abstract

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

Recommendations

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

- To **approve** the recommendation to continue the appointment of Emma Woollett as Non-executive Director and Senior Independent Director, subject to annual review in line with the Monitor Code of Governance.
- To **approve** the recommendation to re-appoint Guy Orpen for a second 3-year term of office as Non-executive Director.

Report Sponsor or Other Author

Sponsor: Trust Secretary

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

Nominations and Appointments Committee: 14 July 2015

Governors present: Sue Silvey, Mo Schiller, John Steeds, Anne Skinner, John Steeds, Pam Yabsley, Angelo Micciche, Wendy Gregory, Florene Jordan, Ian Davies and Jeanette Jones.

Others present or in attendance: John Savage – Chairman, Debbie Henderson – Trust Secretary and Sarah Murch – Membership & Governance Administrator.

Topics discussed:

- **Non-executive Director Activity Reports:** The committee reviewed the activity of the Chairman and Non-executive Directors over the past six months.
- **Appraisal of Non-executive Directors – Emma Woollett:** The committee reviewed the appraisal papers for Emma Woollett and supported her continuing appointment in her third term of office. They formally proposed a recommendation to the full Council to continue her appointment as Non-executive Director and Senior Independent Director subject to the annual review in line with the Monitor Code of Governance.
- **Appraisal of Non-executive Directors – Guy Orpen:** The committee agreed to continue

to support Guy and note his appraisal and annual review.

- **Re-appointment of Guy Orpen:** Governors agreed to recommend to the Council of Governors the re-appointment of Guy Orpen for a second term of office as Non-executive Director.
- **Any other business – Recruitment Plan:** It was agreed that, in preparation for potential Non-executive Director vacancies next year, the Chairman and the Trust Secretary should draft a plan for recruiting Non-executive Observers.

The next meeting of the Nominations and Appointments Committee will take place on Friday 25 September 2015 at 13:15-14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

Appendices

Appendix A – Appraisal report for Emma Woollett

Appendix B – Appraisal report for Guy Orpen

Council of Governors

Nomination and Appointments Committee Report

Recommendation to re-appoint Emma Woollett, Vice-Chair and Senior Independent Director, University Hospitals Bristol NHS Foundation Trust

1. INTRODUCTION

Governors will be aware that it is one of their statutory duties to appoint the Chairman and Non-Executive Directors of the NHS Foundation Trust. The Council of Governors have delegated this responsibility to a formally constituted Nomination and Appointments Committee comprised of Governor representatives, selected by the Council. The recommendations of the Committee are brought to the full Council for review and ratification.

2. BACKGROUND

Emma Woollett, Non-Executive Director and Vice-Chair was re-appointed on 1st June 2011 for a second three year term of office, which expired on 31st May 2014.

Emma was then re-appointed for a further third term of office on 1st June 2014 and was also appointed as Senior Independent Director. It was acknowledged by the Committee that this would represent Emma's seventh year as Non-Executive Director of the Trust and at the Nomination and Appointments Committee meeting in February 2015, it was agreed to implement a revised, rigorous annual appraisal process for Non-Executive Directors to reflect the requirements of Monitor's Code of Governance for Non Executives who serve longer than six years. The Code of Governance states:

"Non-executive directors may, in exceptional circumstances, serve longer than six years but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence".

It was also agreed that to reflect best practice, this process would be undertaken annually for all Non-Executive Directors, regardless of the length of term. This would provide additional assurance to the Council of Governors of the continued independence and commitment of all Non-Executive Directors and to enable the Council to fulfil their statutory duty to hold the Non-Executive Directors to account for the performance of the Board.

3. APPRAISAL/ANNUAL REVIEW PROCESS

An appraisal/annual review is a tool used in managing performance and acts as a vehicle for assessing the performance of staff (including Board members) to identify areas for development moving forward. The Appointments Commission stated that the appraisal process for Non-Executive Directors should aim to achieve the following:

- Hold all Non-Executive Directors to account for their performance
- Set appropriate objectives consistent with the role, and the objectives of the organisation
- Identify learning and development needs
- Support succession planning for the organisation

The appraisal/review process for the Chairman and Non-Executive Directors included:

- Self-assessment against the core competencies for NHS Non-Executive Directors as defined by the NHS Leadership Academy. The Core Competencies are; shaping corporate strategy; adding value to the Board; patient, carer and community focus; acting as a team player; balance of understanding; holding colleagues to account; intellectual flexibility; and self-belief and emotional resilience;
- Curriculum vitae information;
- Summary of Trust involvement during the period;
- feedback from the Non-Executive Director cohort;
- feedback from the Executive Director cohort; and
- Statement from John Savage, Chairman

John Savage, Chairman, chaired the meeting of the Nomination and Appointments Committee on 14th July 2015. Following the Committee's review of the appraisal/annual review paperwork, the Committee came to the view that Emma Woollett is an excellent Non-Executive Director and Vice Chair. Positive feedback was received from Non-Executive Directors and Executive Directors about Emma's performance over the last year particularly with regard to:

- Emma's understanding of the whole organisation and its challenges both at strategic and operational level;
- Emma's commitment to the role both in terms of time dedicated to the role and in terms of her ability to forge relationships out-with formal meeting structures;
- Emma's consistent high level of challenge and scrutiny and the ability to deal with issues which may be viewed as 'uncomfortable';
- Her ability to communicate in an authoritative way and yield results;
- Emma's value-driven approach to governance issues;
- Emma's ability to analyse and interpret complex data and information;
- Emma's collaborative approach to working with other non-executive director colleagues; and
- Emma's unwavering ability to extract information from Board colleagues in a way in which others can understand, reflecting her commitment to consider lay members in complex discussions

4. RECOMMENDATION

The Committee acknowledged the challenges facing the Trust over the next 12-36 months and the importance of maintaining continuity and stability on the Board at this time, particularly with regard to the leadership role of the Senior Independent Director.

The Nomination and Appointments Committee therefore recommend to the Council of Governors the following:

- That Emma Woollett has her term of office extended as both Non-Executive Director and Senior Independent Director, initially by one year, to 31st May 2016 and that any subsequent extensions continue to be based upon the annual appraisal / review process in line with the guidance outlined in Monitors' Code of Governance

John Savage
Chairman, for and on behalf of the Nomination and Appointments Committee
23rd July 2015

Council of Governors

Nomination and Appointments Committee Report

Recommendation to re-appoint Guy Orpen, Non-Executive Director, University Hospitals Bristol NHS Foundation Trust

1. INTRODUCTION

Governors will be aware that it is one of their statutory duties to appoint the Chairman and Non-Executive Directors of the NHS Foundation Trust. The Council of Governors have delegated this responsibility to a formally constituted Nomination and Appointments Committee comprised of Governor representatives, selected by the Council. The recommendations of the Committee are brought to the full Council for review and ratification.

2. BACKGROUND

Guy Orpen, Non-Executive Director was appointed to the Trust on 2nd May 2012 for a three year term of office, which expires on 31st July 2015.

At the Nomination and Appointments Committee meeting in February 2015, it was agreed to implement a revised, rigorous annual appraisal process for Non-Executive Directors to reflect the requirements of Monitor's Code of Governance for Non Executives who serve longer than six years. The Code of Governance states:

"Non-executive directors may, in exceptional circumstances, serve longer than six years but this should be subject to annual re-appointment. Serving more than six years could be relevant to the determination of a non-executive's independence".

It was also agreed that to reflect best practice, this process would be undertaken annually for all Non-Executive Directors, regardless of the length of term. This would provide additional assurance to the Council of Governors of the continued independence and commitment of all Non-Executive Directors and to enable the Council to fulfil their statutory duty to hold the Non-Executive Directors to account for the performance of the Board.

3. APPRAISAL/ANNUAL REVIEW PROCESS

An appraisal/annual review is a tool used in managing performance and acts as a vehicle for assessing the performance of staff (including Board members) to identify areas for development moving forward. The Appointments Commission stated that the appraisal process for Non-Executive Directors should aim to achieve the following:

- Hold all Non-Executive Director's to account for their performance
- Set appropriate objectives consistent with the role, and the objectives of the organisation
- Identify learning and development needs
- Support succession planning for the organisation

The appraisal/review process for the Chairman and Non-Executive Directors included:

- Self-assessment against the core competencies for NHS Non-Executive Directors as defined by the NHS Leadership Academy. The Core Competencies are; shaping corporate strategy;

adding value to the Board; patient, carer and community focus; acting as a team player; balance of understanding; holding colleagues to account; intellectual flexibility; and self-belief and emotional resilience;
- Curriculum vitae information;
- Summary of Trust involvement during the period;
- feedback from the Non-Executive Director cohort;
- feedback from the Executive Director cohort; and
- Statement from John Savage, Chairman

John Savage, Chairman, chaired the meeting of the Nomination and Appointments Committee on 14th July 2015. Following the Committee's review of the appraisal/annual review paperwork, the Committee came to the view that Guy Orpen is an excellent Non-Executive Director. Positive feedback was received from Non-Executive Directors and Executive Directors about Guy's performance over the last year particularly with regard to:

- Guy's understanding of the strategic agenda and his contribution to the Board, particularly relating to issues of health, education and research in the wider community;
- Guy's link to the wider stakeholder group and ability to bring these into Board discussions;
- Guy's leadership and integrity at the Board and the ability to constructively challenge Board members in a supportive and collaborative way;
- Guy's ability to communicate in an authoritative yet respectful way and earn the respect of his colleagues, resulting in a powerful presence on the Board;
- Guy's demonstration of a clear interest in the success of the Trust as well as the impact on Bristol as a whole; and
- Guy's commitment and engagement with regard to the workforce agenda and his ability to reflect this in Board discussions

4. RECOMMENDATION

The Committee acknowledged the challenges facing the Trust over the next 12-36 months and the importance of maintaining continuity and stability on the Board at this time. The Nomination and Appointments Committee therefore recommend to the Council of Governors the following:

- That Guy Orpen be re-appointed as Non-Executive Director for a second 3-year term of office as of 1st August 2015.

John Savage
Chairman, for and on behalf of the Nomination and Appointments Committee
23rd July 2015

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 06 – Governor Development Seminar Report

Purpose

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

Abstract

The governor development programme was established to provide governors with the necessary core training and development of their skills to perform the statutory duties of governors effectively. The programme was co-created with governors using self-assessment and short-life task and finish groups.

Recommendations

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

Report Sponsor or Other Author

Sponsor: Trust Secretary

Author: Head of Membership and Governance

Report

There has been **one** Governor Development Seminar since the last Council of Governors meeting.

Governor Development Seminar: 10 June 2015

Governors attending: Bill Payne, John Steeds, Philip Mackie, Wendy Gregory, Sue Silvey, Brenda Rowe, Graham Briscoe, Bob Bennett, Ian Davies, Nick Marsh, Florene Jordan, Ben Trumper, Karen Stevens, Jeanette Jones, Clive Hamilton, Tim Peters and Anne Skinner.

Others in attendance:

Sue Donaldson - Director of Workforce and Organisational Development, Trish Jay-Ferguson - Head of Organisational Development Mel Fewkes - Associate Director of Occupational Health, Safety and Wellbeing, Amanda Saunders - Head of Membership and Governance, Debbie Marks - Membership Support Assistant.

Topics discussed:

- **Workforce and Organisational Development**: Governors received an update from Sue Donaldson, Director of Workforce and Organisational Development and then a presentation from Trish Jay-Ferguson, Head of Organisational Development and Mel Fewkes, Associate Director of Occupational Health, Safety and Wellbeing, on the Trust's work to improve staff experience and engagement at UH Bristol. An overview of the journey so far, the programme of work being undertaken and anticipated results.
- **Update from Governors Effectiveness Survey**: Progress update on feedback and outcomes of the survey undertaken earlier in the year – Amanda Saunders, Head of Membership and Governance.

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

- **Representing Members – the role of Governors:** including case study examples from other Foundation Trusts – Amanda Saunders, Head of Membership and Governance.
- **Workshop Session: Membership Engagement Calendar, Tools and Techniques**: Governors discussed the opportunities and plans for membership engagement in the future, including what the key messages should be, what membership materials should look like and ideas for new ways to reach potential members.

The next Governor Development Seminar will be held on 11 August 2015 from 10:00-15:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU. We continue to listen to governors' feedback, and so the next session will include a governor skills review and a visit to service locations around the Trust.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 07a – Governors' Strategy Group Meeting Account

Purpose

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

Abstract

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

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

Recommendations

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

Report Sponsor or Other Author

Sponsor: Governor Lead for Strategy Project Focus Group

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

Governors' Strategy Group: 16 July 2015

Governors attending: Wendy Gregory *(Lead Governor for the Group)*, Bob Bennett, Clive Hamilton, Florene Jordan, Angelo Micciche, Brenda Rowe, Mo Schiller, John Steeds and Ben Trumper.

Others present or in attendance: David Relph – Head of Strategy and Business Planning *(Group Chair)*, Jeremy Spearing – Associate Director of Finance, Alex Crawford – Deputy Head of Commissioning and Planning, Debbie Marks – Membership Support Assistant.

Topics discussed:

- Strategic Implementation Plan - The group received an update from David Relph on the strategic implementation plan.
- Review of Business Planning – update from Alex Crawford.
- Staffing – issues relating to recruitment, retention and new models of working and their implications and threats.

The group also received brief updates on:

- New and temporary wards
- Weston General Hospital
- Histopathology reconfiguration
- Engagement with Primary Care to support Business Planning
- 2014/15 Outturn and 2015/16 plan
- Review of Operational Productivity in NHS Providers (Carter review) – interim report

The next meeting of the Governors' Strategy Group will be held on Thursday 8 October 2015 from 13:00-15:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 07b- Quality Project Focus Group Meeting Account

Purpose

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

Abstract

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

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

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

Recommendations

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

Report Sponsor or Other Author

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

The Quality Project Focus Group has held **two** meetings since the last Council of Governors meeting.

The format of the meetings have been reviewed in the period and the following changes have been made:

- The meeting is now chaired by the Lead Governor for the Group, rather than a member of the Executive team.
- There will now be a regular item on the Trust's corporate quality objectives.
- Work is ongoing to provide greater alignment between the Quality and Outcomes Committee and the Quality Project Focus Group.

Quality Project Focus Group Meeting: 5 May 2015

Governors attending: Clive Hamilton (Lead governor for the group), Sue Silvey, Florene Jordan, Brenda Rowe, Lorna Watson, Graham Briscoe, Pam Yabsley, Ian Davies, Wendy Gregory, Mo Schiller and John Steeds.

Others present or in attendance: Sean O'Kelly (Medical Director and Chair), Carolyn Mills (Chief Nurse), Simon Chamberlain (Director of Transformation), Julia Wynn (Complex Discharge Lead UH Bristol Trust & General Manager Division of Medicine) and Debbie Marks (Membership

Support Assistant and note-taker).

Topics discussed:

- **Trust Board Quality and Performance report**
- **Serious Incidents and Never Events Quarterly report**
- **Complaints and Patient Experience reports**
- **Histopathology update**
- **Governors' Log of Communications**
- **End-of-Life Focus Groups:** Clive Hamilton talked the group through his paper: 'Trust Public and Patient Involvement sponsored End of Life Care Focus Groups'.
- **Patient Discharge Planning -** Simon Chamberlain (Director of Transformation) and Julia Wynn (Complex Discharge Lead UH Bristol Trust & General Manager Division of Medicine) gave governors a presentation on the Trust's patient discharge planning, including an overview of the planning process, and the challenges faced in terms of the reasons for delayed discharge.
- The group agreed to support Clive Hamilton's continuation as the group's Lead Governor for 2015/16.

Quality Project Focus Group Meeting: 14 July 2015

Governors attending: Bob Bennett, Wendy Gregory, Clive Hamilton, Jeanette Jones, Florene Jordan, Angelo Micciche, Mo Schiller, Anne Skinner, Sue Silvey, John Steeds, Karen Stevens, Ben Trumper, Lorna Watson, Pam Yabsley.

Others present or in attendance:, Sean O'Kelly – Medical Director, Chris Swonnell - Head of Quality (Patient Experience and Clinical Effectiveness) , Anne Reader – Head of Quality (Patient Safety), Amanda Saunders – Head of Membership and Governance, Emma Woollett (Non-executive Director), Ruth Hendy – Lead Nurse for Cancer, Steve Brown - Director of Pharmacy.

Governors received and discussed:

- **Trust Board Quality and Performance Report**
- **Quarterly Serious Incident Report**
- **Quarterly Never Events Report**
- **Quarterly Patient Experience and Complaints Reports**
- **UH Bristol Annual Quality Report 2014/15**
- **Histopathology update**
- **Governors' Log of Communications.**
- **Boots Post-implementation Review:** Governors were given an update on the Boots Pharmacy post-implementation review, from Steve Brown, Director of Pharmacy.
- **Quality Objective Update –Experience of Cancer Patients-** Governors were given a presentation on improving the experience of cancer patients by Ruth Hendy, Lead Nurse for Cancer.

The next meeting of the Quality Project Focus Group will be held on Tuesday 8 September 2015, 14:00-16:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU**.**

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 07c – Constitution Project Focus Group Meeting Account

Purpose

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

Abstract

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

(i) engagement with governors in drafting Constitutional changes;

(ii) assessing the membership profile; and,

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

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

Recommendations

- The Council of Governors is asked to **note** the update.
- The Council of Governors is asked to **approve** the Group's recommended amended Lead Governor role description and to decide whether to retain the title *Lead Governor* or revert to the title *Governor Representative.*
- The Council of Governors is asked to **approve** the Group's recommendation to discontinue the Deputy Lead Governor role.

Report Sponsor or Other Author

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

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

Constitution Project Focus Group Meeting: 12 May 2015

Governors attending: Sue Silvey (Lead governor for the group and meeting Chair), Angelo Micciche, John Steeds, Wendy Gregory, Pam Yabsley, Anne Skinner, Ben Trumper and Florene Jordan.

Others present or in attendance: Debbie Henderson - Trust Secretary, Amanda Saunders – Head of Membership and Governance, Sarah Murch – Membership & Governance Administrator, Debbie Marks – Membership Support Assistant.

Topics discussed:

- **Draft Membership Engagement and Governor Development Strategy:** Governors discussed ways of increasing governor involvement in meetings, events and recruitment activities.
- **Deputy Lead Governor Role** – this role was reviewed and it was generally felt by those present that, while Mo Schiller's contribution in this role had been very valuable, the role itself was no longer required. **It was agreed therefore to take a recommendation for approval to the next**

Council of Governors to discontinue the Deputy Lead Governor role.

- **Project Focus Group leads -** All leads to maintain their roles in 2015/16, but it was proposed to seek replacements for 2016/17. Expressions of interest would be invited in order to find 'shadow' leads who would then take on the roles.
- **Lead Governor Role.**
- **Terms of Reference for Governors' Project Focus Groups.**
- **Annual Members' Meeting –** Tuesday 15 September, 17:00-19:00, in Lecture Theatre 1.

Constitution Project Focus Group Meeting: 16 June 2015

Governors attending: Sue Silvey (Lead governor for the group and meeting Chair), Clive Hamilton, Graham Briscoe, Angelo Micciche, Wendy Gregory, Ben Trumper (Lead Governor), Florene Jordan and Bill Payne.

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

Topics discussed:

- **Meeting attendance:** There was further discussion on governor attendance and engagement. Actions were agreed and progress would be reviewed at the September meeting.
- **Lead Governor Role Description:** The role description was reviewed. Members of the group expressed a preference to use the title 'Governor Representative' instead of 'Lead Governor'**. A decision on this would be taken at the Council of Governors meeting on 30 July.**
- **Terms of Reference for Governor Project Focus Groups**: The Terms of Reference for the Focus Groups to be amended as per feedback from the meeting and presented for approval at Council of Governors meeting in July. Governors requested representation from the Communications Team at the Constitution Project Focus Group meetings, and greater Non-executive Director involvement in all governor groups.
- **Annual Members Meeting – 15 September 2015** – programme to be shared with governors in due course.

The next meeting of the Constitution Project Focus Group will be held on Tuesday 8 September 2015 from 11:00-13:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU.

Appendices

Appendix A – Lead Governor Role Description

University Hospitals Bristol NHS
NHS Foundation Trust

Lead Governor

1. Introduction

The Lead Governor for University Hospitals Bristol NHS Foundation Trust ("the Trust") will be a Governor elected by the Council of Governors to act as a spokesperson on behalf of all Governors.

2. Role, Purpose and Duties

a. The Lead Governor will occasionally act as the spokesperson for the whole of the Governor group or an individual Governor where required. This applies where contact is required with external organisations such as Monitor, when the Lead Governor would also be support by the Trust Secretary in this regard. Contact with external bodies and individuals shall be conducted in accordance with the Governor Code of Conduct. The role of the Lead Governor is intended to be an additional resource to all of the members of the Council of Governors.

b. The generality of the stated duty in "a." above will not in any way invalidate the rights and responsibilities of any other Governor in the Trust.

c. The Lead Governor may call for support from other Governors, the Chairman, the Trust Board of Directors, the Trust Secretary and the Head of Membership and Governance to enable the role to be carried out effectively.

d. The Lead Governor will, as required, act as a contact between the Governors and Monitor.

e. The Lead Governor will promote a continuing good relationship between Governors and the Trust Board.

f. The Lead Governor will bring to the Trust Chair's notice if any issues as requested by the Governors.

g. The Lead Governor will Chair the Informal Governors' meetings and the Chairman's Counsel meetings, however, this does not prohibit any other Governor from carrying out his role.

h. The Lead Governor will meet occasionally with the Chair and the Chief Executive to support effectiveness of the role, will represent the Council of Governors as a collective and feedback to other members of the Council, where appropriate, however this will not involve taking decisions on behalf of the Council, and the Lead Governor will report back on discussions to all Governors at the Informal Meetings.

i. The Lead Governor will liaise regularly with the Trust Secretary and their team in relation to meetings, minutes and follow up actions, on behalf of the Council.

j. The Lead Governor will present an overview of the work of the Governors at the Trust Members Annual Meeting on behalf of the Council of Governors.

k. The Lead Governor will support the development of Governor skills, a strong Council of Governors and a raised public awareness of the Governor role in conjunction with the Head of Membership and Governance, Trust Secretary and the Chair of the Trust.

l. The Lead Governor is not a shadow or vice chair for the Trust Chair in the same way that the Council of Governors is not a shadow Trust Board.

3. Election Process and Appointment to Office

The election shall be conducted using a formal written nomination process with nomination forms sent to every Governor. The stages in the election process will be as follows:

a. The Trust will send a nomination paper together with a copy of the purpose, duties and responsibilities description to each Governor.

b. Any Governor may nominate themselves with the support of one seconder, (the seconder should be named on the nomination form).

c. Any Governor may nominate another Governor with the agreement of the nominee. In this event the nominee will still be required to submit a nomination form.

d. Nominations must be returned to the Membership and Governance Office in accordance with advised deadline.

e. All candidates must provide a statement setting out what they would bring to the role.

f. If there is more than one candidate there will be an election conducted by email. A simple majority will win.

g. If there is a tie the Trust Chair has a casting vote in consultation with the Nominations & Appointment Committee.

h. If there is a single nomination the Governors will be asked to endorse (or not) that nomination by voting for the nominee or abstaining.

i. If there are no nominations the Trust Chair in consultation with the Nominations & Appointment Committee will nominate a Lead Governor for approval by the Council of Governors.

j. The election will be co-ordinated by the Trust Membership and Governance Office, scrutinised by the Trust Secretary and authorised by the Trust Chairman.

k. When a Lead Governor vacancy arises as a result of the end of a term of office or the Lead Governor resigning or not being able to continue before the end of the elected term, the Chairman will invite expressions of interest for nomination to the role from the Trusts Governors. The election process will then proceed as from "b." above.

4. Conditions of Appointment and Term of Office

a. The Lead Governor should be a Governor of at least one year's standing, but ideally 2 years.

b. The elected Governor will serve as Lead for a period of 12 months, (unless terminated early as in 3.k. above), or until the end of their term of office depending on which results first.

c. After this period, the election process as outlined in Section 3 above will be put in motion. It is possible for the same Governor to be re-elected for further terms if Governors elect to do so. The Lead Governor may be reappointed by the Council of Governors, as required the reappointment may be delayed by 6 months to allow new Governors to get to know the incumbent.

d. The Lead Governor will be required to step down in the event of three-quarters of the members of the whole Council of Governors returning a vote of no confidence at a Council of Governors meeting.

e. The Lead Governor must present the position and wishes of Governors and be able to commit the time necessary for the role.

f. The Lead Governor should be IT literate and have the ability to influence and negotiate, and be able to present a well-reasoned argument.

Updated: Following amends to Role Description at the Constitution Focus Group meeting, June 2015.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 08 – Terms of Reference for Governor Project Focus Groups

Purpose

The purpose of the Governor Project Focus Groups is to facilitate engagement with the Trust Board and governors on matters of constitution (including membership), strategy and planning (including significant transactions), and reporting (including quality and performance monitoring and metrics) as part of the annual cycle of business.

The terms of reference for the Governor Project Focus Groups have been revised and the revisions were discussed by governors at their Constitution Project Focus Group meeting on 16 June 2015. Governors at the group recommended approval of the revised terms of reference. Following a discussion about succession planning for Governor Leads for the groups, it was also suggested that interest be sought from governors to 'shadow' Project Focus Group leads for 6 months with a view to new appointments in 2016/17.

Recommendations

The Council of Governors is asked:

- To **approve** the revised terms of reference for Governor Project Focus Groups.
- To note that the Project Focus Group Governor Leads remain unchanged for 2015/16. To seek interest from governors to 'shadow' Project Focus Group leads for 6 months with a view to new appointments in 2016/17.

Report Sponsor or Other Author

Sponsor: Trust Secretary

Appendices

Appendix A – Terms of Reference for Governor Project Focus Groups – revised June 2015.

University Hospitals Bristol NHS
NHS Foundation Trust

Terms of Reference – Focus Groups for Governors

Document Data	
Corporate Entity	Council of Governors
Document Type	Terms of Reference
Document Status	Draft
Executive Lead	Trust Secretary
Document Owner	Head of Membership & Governance
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Document Abstract
The Health and Social Care Act 2012 (the Act) introduces both new and changed duties for governors and directors of NHS Foundation Trusts, and makes a clear distinction between the duties and accountabilities of governors and directors. The Trust Board of Directors' duty to take into account the views of the Council of Governors in its planning remains unchanged. It is the stated intention of the Chairman and Trust Board of Directors to work as closely as possible with the Council of Governors on all matters of joint interest to the Board and the Council of Governors. The revised annual cycle of business for the Board and Council of Governors includes new formal mechanisms to support and enable their working together. The purpose of the Focus Groups is to facilitate engagement with the Trust Board and governors on matters of constitution (including membership), strategy and planning (including significant transactions), and reporting (including quality and performance monitoring and metrics) as part of the annual cycle of business. Focus Groups are Chaired by nominated Governors (Lead Governor for the Focus Group), have nominated Executive Leads, and are open to attendance by any interested governor and Non-Executive Director.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
15 January 2013	0.1	Trust Secretary	First Draft	First Draft
3 February 2013	0.2	Trust Secretary	Draft	Draft for comment by Governor Representative
4 February 2013	0.3	Trust Secretary	Draft	Draft for comment by Chairman
5 February 2013	0.4	Trust Secretary	Version	Version for implementation
25 April 2013	0.5	Trust Secretary	Minor	Revision of Project Group titles
11 May 2015	0.6	Head of Membership & Governance	Draft	Amendments to bring Terms of Reference up to date
23 July 2015	0.7	Head of Membership & Governance	Draft	Amendments post discussion at Constitution Focus Group meeting

Table of Contents

1. Purpose

1.1 The purpose of the Focus Groups is to facilitate engagement with the Trust Board (the Board) and governors on matters of:

(a) constitution (including membership);

(b) strategy and planning (including significant transactions); and,

(c) reporting (including quality and performance monitoring and metrics).

1.2 Meetings of the Focus Groups are intended to support the development of governors in their role and provide them with information in order to be able to undertake their statutory duty of holding Non-Executive Directors to account.

1.3 Meetings of the Focus Groups are part of the annual cycle of business managed on behalf of the Board by the Trust Secretariat.

1.4 When it is determined to be required and in exceptional circumstance, the Lead Governor for each group can request external advisors are invited to attend a Focus Group meeting in order to provide Governors with additional information determined to be necessary.

2. Authority

2.1 The Chairs of Focus Groups are authorised by the Chairman to conduct consultation, engagement and development activities with Governors in accordance with these Terms of Reference.

3. Reporting

3.1 The Governor Lead for each Focus Group is required to provide a brief summary of activity to the Trust Secretary for reporting to the quarterly meeting of the Council of Governors. (See also 5.1)

4. Chairing

4.1 Focus Groups are chaired by a nominated Governor, the Lead Governor for the Group. In circumstances where it is not possible for the Lead Governor to attend, another Governor may Chair the meeting.

5. Membership and Attendance

5.1 Each Group has a Governor Lead who is nominated by the group as a whole at the start of the Financial Year. They will link with Executive Lead/s and have involvement with the forming of the agenda for meetings.

5.2 There is no fixed membership for the groups, they are open to all governors to attend. This is to allow for equitable access to any of the Focus Groups by any governor.

5.3 The minimum number of governors required for any meetings of the Focus Groups to be considered a valid consultation or engagement activity is any four (4) governors and at least one (1) Trust representative.

6. Focus Groups Objectives

The objectives of each Focus Group are as follows:

6.1 Constitution Focus Group

(a) The objectives of the Constitution Focus Group are to provide:

(i) engagement with governors in drafting Constitutional changes;

(ii) assessment of the public, patient and staff membership profile and monitoring of recruitment initiatives;

(iii) engagement of governors on communications and engagement activities for Foundation Trust members;

(iv) ownership and oversight of the Trust's Membership Engagement and Governor Development Strategy, to include recommendations for updates to this working strategy as required.

(b) The group shall be chaired by the Governor Lead and the nominated Executive Lead shall be the Trust Secretary.

6.2 Governors Strategy Group

(a) The objectives of the Governors Strategy group are to provide:

(i) engagement with governors to develop the Monitor Annual Plan;

(ii) engagement with governors on both the short and long term strategic plan of the Trust;

(iii) engagement with governors on strategic objectives and matters affecting the strategic outlook of the Trust and to contribute to the strategic direction of the organisation.

(b) The group shall be chaired by the Governor Lead and the Executive Lead shall be the Director of Transformation & Strategic Development or their duly authorised deputy.

6.3 Quality Focus Group

(a) The objectives of the Quality Focus Group are to provide:

(i) engagement with governors to develop the Board's Annual Quality Report;

(ii) regular support to enable governors to understand and interpret the Board Quality and Performance Report and to enable Governors to hold the Board to account;

(iii) regular support to enable governors to understand and interpret reported progress on the Trust's Corporate Quality Objectives;

(iv) opportunities for input from governors on quality, (as defined by Monitor), matters;

(v) reflect upon updates from the Trust's Quality and Outcomes Committee;

(vi) provide input into the Trust's Quality Report and provide the statement for inclusion in the report on behalf of the Council of Governors.

(b) The group shall be chaired by Lead Governor and attended by the Medical Director and/ or Chief Nurse as the Executive Leads, or their duly authorised deputies.

7. Secretariat Services

7.1 Focus Groups shall be facilitated by the Trust Secretariat, specifically the Membership & Governance Team. This shall include the scheduling of meetings dates, circulation of papers for meetings and note taking.

7.2 In addition to the "Reporting" requirements, as detailed at 3.1, the facilitator of each meeting shall keep notes of the meeting as a record for decisions and future plans, these will be circulated to all attendees following each meeting.

8. Frequency of Meetings

8.1 The governors annual cycle of meetings will be available at the beginning of each Financial Year from the Trust Secretariat.

8.2 Additional meetings will be scheduled as required in agreement by the Lead Governor and Executive Lead for each group.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 9a - Membership Engagement Report

Purpose

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

Abstract

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

Recommendations

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

Report Sponsor or Other Author

Sponsor: Head of Membership and Governance

Report

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

- Meeting with Above & Beyond to discuss a range of ways in which the Membership Team could link with the charity including; joint promotion of membership and fundraising, potential of Above & Beyond to fund the development of new membership materials, planning together in order to run events that serve dual purpose of bringing into the Trust new members from service areas that sit alongside the charity's fundraising appeal schedule.
- Meeting with Healthwatch to discuss opportunities for joint working and planned attendance at their next quarterly event to promote membership – date TBC.
- Linking on a regular basis with North Bristol Trust (NBT) Membership Lead in order to maximise local membership opportunities. The last Health Matters Event was promoted to NBT members via email, and posters displayed in key areas on NBT site.
- In response to governor feedback and recognition from our team that Health Matters numbers of attendees have dropped in recent months, for the next event we will once again promote to other local Trusts, this time to include those in Weston and Bath, but also working with relevant charity partners to promote to their contacts: for example, the National Osteoporosis Society will be teaming up with us for the November event. We are also reviewing topics for the 2016 programme of events, looking at busy service areas in the Trust and offering members the opportunity to vote via email on topics they would like to see covered, timings that best suit, etc.
- Meeting with UH Bristol Communications Team to identify opportunities to improve membership promotional materials and membership communications – new materials now in development.
- The Membership Team is now actively reviewing membership recruitment best practice and utilising contacts to identify improvements that can be adopted at UH Bristol, to prepare for membership recruitment activities later in the year.

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

- See also planned membership recruitment event details below.

Current Membership Numbers:

As of 20 July 2015, Foundation Trust membership stands at 21,007 members (6,437 public members, 4,710 patient members and 9,860 staff members).

This compares with 21,090 members as of 31 March 2015: (6,466 public members, 4,763 patient members and 9,861 staff members).

Membership can be broken down as follows:

Member Type	***Total***
Public Constituencies	**6,437**
Out of Trust Area	4
Bristol	3,146
North Somerset	1,265
South Gloucester	1,248
Rest of England and Wales	774
Patient Constituencies	**4,710**
Unspecified	29
Carer of patients 16 years and over	206
Carer of patients 15 years and under	537
Patient - Local	3,938
Staff Classes	**9,860**
Unspecified	1
Medical and Dental	1,189
Nursing and Midwifery	2,826
Other clinical healthcare professionals	1,957
Non Clinical Healthcare Professionals	3,887

Members Events May-July 2015:

7 May 2015	Health Matters Event: Diabetes in Children • Dr Julian Hamilton-Shield, Professor of diabetes and metabolic endocrinology, gave a talk on nutrition and diabetes in children, and transition to adulthood. • There was also a talk from Deborah Lee, UH Bristol's new Chief Operating Officer, about the re-organisation of hospital outpatients' departments.
2 July 2015	Health Matters Event: Kidney Health • Dr Albert Power, Consultant Nephrologist at North Bristol Trust gave an overview of chronic kidney disease in adults.

	• Professor Moin Saleem, Consultant at Bristol Children's Hospital, spoke about kidney disease in relation to genetics and familial disease from a paediatric viewpoint. • Carolyn Mills, Chief Nurse, provided an update on the Trust's Quality Objectives. Also at this event we were pleased to welcome an information stand from the North Bristol Trust Living Kidney Donor Team.

Other Membership Engagement and Communication May-July 2015:

- 14/05/2015 – Patient and Carer Members invited to join Radiation Oncology Group at UH Bristol.
- 1/6/2015 – Voices magazine sent to all members.
- 8/6/2015 – Members invited to take part in NHS England consultation on Paediatric Epilepsy Surgery Services.
- 12/6/15 – Members invited to take part in Design Together, Live Better workshops - a new project to encourage people living with challenging health conditions, their carers and health professionals, to help shape the services they need organised by the West of England Academic Health Science Network.
- 8/7/2015 – 'Sign up to Safety' patient safety improvement campaign - patient contributors invited to get involved in a number of work streams at UH Bristol including Medicine Safety, Sepsis and Acute Kidney Injury, and members invited to launch event on 31 July.

Forthcoming members' events:

Engagement Events:

- Tuesday 15 September 2015, 5pm-7pm - Annual Members Meeting/AGM
- Thursday 12 November 2015, 4pm-5.30pm: Health Matters Event –Osteoporosis.

Recruitment events:

- Welcome Centre recruitment stand – Monday 24 August/ Tues 25 August TBC
- Bristol Doors Open Day - Bristol Royal Infirmary Level 9 - Saturday 12 September.
- University of Bristol Freshers' Week for new students- stall at @Bristol Welcome Event on Thursday 24 September.

More membership recruitment events are being planned for the autumn – details to follow in due course.

Voices magazine

Voices, the magazine for the UH Bristol community, is sent to Foundation Trust members 3 times a year. Next issue Sept/Oct 2015.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 9b – Governor Activity Report

Purpose

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

Abstract

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

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

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

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

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

Recommendations

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

Report Sponsor or Other Author

Sponsor: Trust Secretary

Report

Constitution of the Council of Governors:

- As at 23 June 2015 there were 33 governors in post and 3 vacancies (2 Youth Council Governors and 1 Voluntary/Community Sector

governor). A joint event has been scheduled with the Youth Council on 28 July, which we hope will generate interest in the Youth Council Governor roles (further verbal update at meeting). The Voluntary/ Community Group Governor draft advert is to be reviewed for issue and will be promoted via a range local contacts.

- Ben Trumper (Staff Governor – Nursing & Midwifery) took up the role of lead governor on 1 June.

Governors' Activities in relation to Membership Engagement, Holding Non-executive Directors to Account and Strategic/other responsibilities (30 April 2015-30 July 2015)

Statutory Responsibilities of the Council of Governors	Other non-statutory responsibilities	How governors discharged their duties 30/4/2015-30/7/2015
1. Membership Engagement: • represent the interests of the Members of the Trust as a whole and the interests of the public	• developing the membership by overseeing the implementation of the Trust's Membership Strategy and by direct engagement with members at events and meetings • feed back information about the Trust, its vision and its performance to members or stakeholder organisation • represent the interests of the community, including service users and carers, by ensuring effective communication with Members, feeding back information to the Trust as necessary • providing a Governor	• Governors hosted 2 Health Matters Events – talks for public, patient and staff members - on Diabetes in Children (7 May) and Kidney Health (2 July). • Governors explored new ways of improving their engagement with members at both the Constitution Project Focus Group meeting on 16 June and 12 May and their Governor Development Seminar on 10 June. Governors discussed the opportunities and plans for membership engagement in the future, including what key messages should be, what membership materials should look like and ideas for new ways to reach potential members. • Governors have taken part in PLACE visits (Patient-Led Assessments of the Care Environment). Anne Skinner brought the perspective of a patient governor to a Dementia Champions Conference and a meeting of the Trust's Clinical Ethics Group, and Wendy Gregory represented Carer Governors at the Trust's Carers' Strategy Group meeting. All governors have

	perspective on the efficacy of staff engagement mechanisms	been invited to the Trust's Sign up to Safety launch event on 31 July. • In relation to staff engagement, Florene Jordan has been promoting the staff governor role at several staff meetings and the feedback collected from these will be used to inform future engagement with staff members. • Florene has also been invited to be the staff governor representative on the Trust's Equality and Diversity Group. • Governors received a report and gave feedback at their June Governor Development Seminar from the Director of Workforce and Organisational Development on the Trust's work to improve staff experience and engagement at UH Bristol. • Several staff governors contributed to articles in Newsbeat and July/Aug issue of Voices magazine. • Governors supported the Trust's Nurses Day celebrations.
2. Holding Non-executive Directors to account: • hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors • receive performance appraisal information regarding the Trust Chairman and Non- Executive Directors	• being assured that that the Non-Executive Directors act so that the Trust does not breach the conditions of its NHS Provider Licence	• A particular area of focus is this period has been the alignment of the work of Governor Project Focus Group with Non-executive Director Committees. As a result, governors are now receiving reports from the Quality and Outcomes Committee, and invitations have been extended to Non-executive Directors to attend governor Project Focus Groups. • Governors on the Nominations and Appointments Committee met on 14 July to review activity and

• set the pay and terms & conditions of appointment for the Trust Chairman and Non-Executive Directors • appoint and (if necessary) remove the Trust Chairman and Non-Executive Directors • approve the appointment of the Chief Executive - however, the Council of Governors will not appoint the Chief Executive • if necessary, inform Monitor, via the Lead Governor, if there are any 'material concerns' about the actions of the Board of Directors which cannot be resolved locally		appraisal papers of Non-executive Directors. • Governors met with the Chairman and Non-executive Directors at Chairman's Counsel meetings in May and June which gave them the opportunity to discuss current issues and any areas of concern. • There has been good governor attendance at monthly meetings of the Public Trust Board of Directors, at which governors contribute challenge and questions. • Two governors accompanied the Chairman and Chief Executive on their monthly Divisional Visits to the IM&T Department and Diagnostic & Therapies, to observe first-hand how the Board are responding to key issues in these areas.
Strategic Direction: • give a response when consulted by the Board of Directors on the Trust's Annual Plan • satisfy itself that proposals in the Annual Plan (other than those relating to the provision of health services in England) will not significantly interfere with the fulfilment by the Trust of its principal purpose or the performance of its other functions	• supporting the Board of Directors in setting the long-term strategic direction for the Trust • promote and support the organisation's strategy	• The Governors' Strategy Group met on 16 July to enable governors to contribute to the Trust's strategic planning With input into the 2015/16 Operational Plan, they are given the opportunity to review with David Relph and Alex Crawford the strategic and business planning processes underway, and will continue to support this work. • Governors continued to receive updates on the Trust's strategic outlook from the Chief Executive at their quarterly Council of Governors meetings.

• approve any proposal to increase by 5% or more the proportion of the Trust's total annual income from activities other than the provision of health services in England • approve any applications for significant transactions • approve any applications for mergers, acquisitions, separation or dissolution of the Trust • agree, in conjunction with the Board of Directors, changes to the Trust's Constitution		
Other responsibilities: • appoint or (if necessary) remove the Trust's external auditors • receive the Trust's Annual Report and Accounts, and the Auditor's report		The Council of Governors agreed at their meeting on 30 April 2015 to approve the extension of the contract of the External Auditors, Price Waterhouse Coopers for a further period of 12 months as of 1st July 2015. The Council of Governors will receive the Auditor's Report on the Trust's Quality Report at their meeting on 30 July 2015. They will receive the Trust's Annual Report and Accounts and the Auditor's reports on the Accounts at the Annual Members Meeting in September.

Page 6 of 10 of a Governor Activity Report for a Council of Governors Meeting, to be held on 30 July 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Governors training and information received (30 April 2015-30 July 2015)

Training/information received in the period:

- Seminar: The Governor Development Seminar on 10 June focussed on Workforce Development, with a presentation from Sue Donaldson, the Director of Workforce and Organisational Development. Governors also took part in a session on Membership Engagement with Amanda Saunders, Head of Membership and Governance,
- Governor Meetings: Governors receive much of their information through their Governor Groups for Quality, Strategy and Constitution. These meetings provide important opportunities for governors to improve their understanding and seek clarification on the Trust's work and current issues. Governors also receive a link to the Public Trust Board papers each month.
- There have been various talks and presentations at governor meetings to give them a wider picture of the Trust's work
  - Carole Tookey, Head of Nursing and Rowena Green, Divisional Director –Medicine Division, attended a Governors' Informal meeting on 27 May to update governors on the move of the medical wards to the new building.
  - Jonathan Benger, a Consultant in Emergency Medicine at UH Bristol, and also the National Clinical Director for Urgent Care at NHS England, and Professor of Emergency Care at the University of the West of England, spoke at a Governors' Informal Meeting on 30 June to give a general overview of A&E management and its current challenges.
  - Simon Chamberlain, Director of Transformation, and Julia Wynn, Complex Discharge Lead UH Bristol Trust & General Manager Division of Medicine, gave governors a presentation on the Trust's patient discharge planning at a meeting of the Governors' Quality Project Focus Group on 5 May.
  - Governors were given a presentation on improving the experience of cancer patients by Ruth Hendy, Lead Nurse for Cancer at their Quality Project` Focus Group meeting on 14 July. At the same meeting they were given an update on the Boots Post-implementation review, from Steve Brown, Director of Pharmacy.
- Information for governors: Regular emails inform governors of news stories affecting the Trust, the Trust's weekly staff e-newsletter Newsbeat is shared with governors, and governors have been kept informed of changes to the Trust Board and of particular Trust success stories.
- From external sources, information and presentations from the recent NHS Providers Governors' conference were shared with all governors. Governors were also invited to the NICE (National Institute for Health and Care Excellence) Question Time and Public Board meeting in May. Two governors have been invited to sit on a West of England Academic Health Science Network Patient Safety group on A Single Early Warning Score for the West of England.

Governor attendance at meetings and events:

Page 7 of 10 of a Governor Activity Report for a Council of Governors Meeting, to be held on 30 July 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

Date	Event	Governors attending
30/04/2015	Public Trust Board meeting	Bob Bennett, Wendy Gregory, Florene Jordan, Sylvia Townsend, Anne Skinner, Tony Tanner, John Steeds, Jeanette Jones, Clive Hamilton, Ray Phipps.
30/04/2015	Council of Governors meeting	Bob Bennett, Clive Hamilton, Mo Schiller, Tony Tanner, Sylvia Townsend, Angelo Micciche, Ray Phipps, Anne Skinner, John Steeds, Pam Yabsley, Wendy Gregory, Ian Davies, Thomas Davies, Karen Stevens, Florene Jordan, Ben Trumper, Jeanette Jones, Sue Hall, Bill Payne.
05/05/2015	Quality Project Focus Group meeting	Clive Hamilton, Sue Silvey, Florene Jordan, Brenda Rowe, Lorna Watson, Graham Briscoe, Pam Yabsley, Ian Davies, Wendy Gregory, Mo Schiller and John Steeds.
06/05/2015	Nurses Day Celebrations	Sue Silvey and Mo Schiller
07/05/2015	Health Matters - Diabetes	Clive Hamilton, Mo Schiller, Sue Silvey, John Steeds, Pam Yabsley,
12/05/2015	Constitution Project Focus Group	Sue Silvey, Angelo Micciche, John Steeds, Wendy Gregory, Pam Yabsley, Anne Skinner, Florene Jordan and Ben Trumper
13/05/2015	PLACE (Patient-Led Assessment of the Care Environment) Inspection - SBCH	Anne Skinner and Bob Bennett *(Attendance restricted)*
15/05/2015	Talk at staff meeting organised by Florene Jordan to explain governor role – Bristol Royal Hospital for Children	Florene Jordan *(Attendance Restricted)*
15/05/2015	Decontamination Board - Florene Jordan is governor rep on this group.	Florene Jordan *(Attendance Restricted)*
20/05/2015	PLACE (St Michael's Hospital)	Tony Rance, Anne Skinner, Bob Bennett and Bill Payne *(Attendance restricted)*
20/05/2015	Equality and Diversity Group – Florene	Florene Jordan *(Attendance Restricted)*

Page 8 of 10 of a Governor Activity Report for a Council of Governors Meeting, to be held on 30 July 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

	Jordan is governor rep on this group.	
21/05/2015	Mini-PLACE – St Michael's Hospital	Tony Rance *(Attendance restricted)*
21/05/2015	Chair and Chief Executive Walkround-IM&T	Pam Yabsley, Graham Briscoe *(Attendance restricted – 2 governors)*
22/05/2015	Dementia Champions Conference	Anne Skinner *(Attendance restricted)*
27/05/2015	Public Trust Board meeting	Florene Jordan, Jeanette Jones, Benjamin Trumper, Bill Payne, Mo Schiller, Pam Yabsley, Angelo Micciche, Graham Briscoe, Sue Silvey, Wendy Gregory, Sylvia Townsend, Clive Hamilton, John Steeds, Bob Bennett, Ray Phipps.
27/05/2015	Governors' Informal Meeting/Chairman's Counsel	Ian Davies, Bob Bennett, Wendy Gregory, Sue Silvey, Sue Milestone, Mo Schiller, John Steeds, Clive Hamilton, Pam Yabsley, Angelo Micciche, Ben Trumper, Florene Jordan, Graham Briscoe, Bill Payne, Pauline Beddoes, Jeanette Jones, Ray Phipps, Anne Skinner, Sylvia Townsend, Karen Stevens, Brenda Rowe, Thomas Davies.
08/06/2015	Chair and Chief Executive Walkround – Diagnostic & Therapies	Pauline Beddoes and Jeanette Jones. *(Attendance restricted – 2 governors)*
10/06/2015	Governor Development Seminar	Bill Payne, John Steeds, Philip Mackie, Wendy Gregory, Sue Silvey, Brenda Rowe, Graham Briscoe, Bob Bennett, Ian Davies, Nick Marsh, Florene Jordan, Ben Trumper, Karen Stevens, Jeanette Jones, Anne Skinner, Clive Hamilton, Tim Peters.
10/06/2015	Clinical Ethics Group meeting (Anne Skinner is governor rep on this group)	Anne Skinner *(Attendance Restricted)*
10/06/2015	Voices Editorial Group meeting	Anne Skinner, Wendy Gregory, Florene Jordan and Ben Trumper *(Attendance Restricted)*
16/06/2015	Talk at staff meeting organised by Florene Jordan to explain governor role – Bristol Eye Hospital Outpatients Dept	Florene Jordan *(Attendance Restricted)*

Page 9 of 10 of a Governor Activity Report for a Council of Governors Meeting, to be held on 30 July 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

16/06/2015	Constitution Project Focus Group meeting	Sue Silvey, Clive Hamilton, Graham Briscoe, Angelo Micciche, Wendy Gregory, Ben Trumper, Florene Jordan and Bill Payne.
23/06/2015	Governors Informal Meeting/Chairman's Counsel	Bill Payne, John Steeds, Anne Skinner, Ray Phipps, Wendy Gregory, Angelo Micciche, Sue Milestone, Clive Hamilton, Sue Silvey, Mo Schiller, Graham Briscoe, Tony Rance, Florene Jordan, Ben Trumper and Karen Stevens.
26/06/2015	Talk at staff meeting organised by Florene Jordan to explain governor role – Bristol Eye Hospital Theatres	Florene Jordan *(Attendance Restricted)*
26/06/2015	Patient face-to-face interviews	Anne Skinner *(Attendance Restricted)*
30/06/2015	Public Trust Board Meeting	Clive Hamilton, Florene Jordan, Ray Phipps, John Steeds, Benjamin Trumper, Pam Yabsley, Anne Skinner.
02/07/2015	Health Matters Event - Kidney Health	Pauline Beddoes, Clive Hamilton, Florene Jordan, Angelo Micciche, Tony Rance, Mo Schiller, Sue Silvey, Bob Bennett
03/07/2015	Reverse Mentoring – Florene Jordan	Florene Jordan *(Attendance Restricted)*
03/07/2015	Talk at staff meeting organised by Florene Jordan to explain governor role – BRI Outpatients	Florene Jordan *(Attendance Restricted)*
03/07/2015	Decontamination Group– Florene Jordan is governor rep on this group.	Florene Jordan *(Attendance Restricted)*
14/07/2015	Quality Project Focus Group meeting	Bob Bennett, Wendy Gregory, Clive Hamilton, Jeanette Jones, Florene Jordan, Angelo Micciche, Mo Schiller, Anne Skinner, Sue Silvey, John Steeds, Karen Stevens, Ben Trumper, Lorna Watson, Pam Yabsley.
14/07/2015	Nominations and Appointments Committee meeting	Mo Schiller, Sue Silvey, John Steeds, Anne Skinner, Pam Yabsley, Angelo Micciche, Wendy Gregory, Florene Jordan, Ian Davies and Jeanette Jones. *(Attendance restricted – committee members only)*
16/07/2015	Governors' Strategy Group meeting	Bob Bennett, Wendy Gregory, Clive Hamilton, Florene Jordan, Angelo Micciche, Brenda Rowe, Mo Schiller, John Steeds, Ben

Page 10 of 10 of a Governor Activity Report for a Council of Governors Meeting, to be held on 30 July 2015 at 14:00 in the Conference Room, Trust Headquarters, Marlborough Street, Bristol, BS1 3NU

		Trumper.
16/07/2015	Carers Strategy Group meeting	Wendy Gregory *(Attendance restricted)*
17/07/2015	Reverse Mentoring – Florene Jordan	Florene Jordan

Plans for the next quarter include carrying out a governor skills audit to ensure that each governor can participate in a way that is constructive for both them and the Trust, to help them to identify which meetings or other activities would best utilise their skills.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 11– Governors' Log of Communications
Purpose
The purpose of this report is to provide the Council of Governors with an update on all questions on the Governors' Log of Communications added or modified since the previous Council of Governors meeting.
The Governors' Log of Communications was established as a means of channelling communications between the governors and the officers of the Trust.
Recommendations
The Council of Governors is asked to **note** the report.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Governor Log – Items since the previous meeting.

Governors' Log of Communications

23 July 2015

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

Query **13/07/2015**

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

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

Response

Pending

Status: *Assigned to Executive Lead*

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

Query **15/07/2015**

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

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

Response

Pending

Status: *Assigned to Executive Lead*

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

Query **17/07/2015**

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

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

Response

Pending.

Status: *Assigned to Executive Lead*

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

Query **17/07/2015**

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

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

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

Response

Pending

Status: *Assigned to Executive Lead*

ID **Governor Name**

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

Query **20/04/2015**

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

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

Response **13/07/2015**

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

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

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

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

Status: *Awaiting Governor Response*

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

Query **30/06/2015**

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

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

Response **09/07/2015**

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

Status: *Awaiting Governor Response*

ID **Governor Name**

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

Query **01/06/2015**

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

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

Response **18/06/2015**

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

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

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

Status: *Closed*

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

Query **01/06/2015**

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

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **01/06/2015**

Pending Executive response.

Status: *Assigned to Executive Lead*

122 **Ray Phipps** ***Theme:*** GPs ***Source:*** Project Focus Group

Query **29/05/2015**

A recent BMA poll of 15,000 GP`s suggests that:
•33% were considering retirement in the next five years.
•25% were considering part time working.
•10% were thinking of moving abroad.

As GP care is an essential part of the overall healthcare system, can the Trust advise how it links and works with local GPs to inform planning for future service delivery and does the Trust recognise or for see an impact on our services based on any potential decline of GPs locally?

Division: Other ***Executive Lead:*** *Director of Strategy and Transformation* ***Response requested:***

Response **02/06/2015**

We engage with our GPs and other primary care colleagues at various levels, both formally and informally. As Clinical Commissioning Groups are GP member organisations, they are our primary partner in collaboratively planning for future service delivery. However, we do engage directly with GP practices and their local network forums on a range topics.

As the NHS England 5 year forward view places an strong emphasis on care closer to home and innovative new models of care through primary and community services, NHS England has recognised the need for more GPs. Without this, the impact on our hospitals is likely to be that demand for our services will continue to grow.

We are therefore working very closely with our colleagues in Bristol, North Somerset and South Gloucestershire CCGs, local authorities and other partners to improve the resilience of the Bristol (and surrounding area) health and social care system to meet such challenges in the future.

Status: *Closed*

ID **Governor Name**

121 **Bob Bennett** ***Theme:*** Infection Control ***Source:*** From Constituency/ Members

Query **29/05/2015**

Following a query received from a member of the public, please can the Trust advise on the correct policy and procedure for staff wearing clinical uniform – specifically theatre scrubs and other 'sterile' uniforms – in public areas of the Trust such as Costa Coffee in the Welcome Centre? What is the infection control guidance with regards to wearing such items in non-clinical areas, when it would appear that staff are then going to go back into a clinical environment?

Division: Trust-wide ***Executive Lead:*** *Chief Nurse* ***Response requested:***

Response **16/06/2015**

Clinical uniform such as scrubs are permitted to be worn outside of clinical areas, as guided by the Trust's Uniform Policy. Specifically 'raspberry' coloured scrubs should be covered with a disposable gown when outside of a clinical area. The Policy states that:

'Scrubs - Only appropriate designated clothing should be worn. When designated, hats should fully cover hair. If footwear such as theatre clogs are required they should be clean and in a good state of repair and of appropriate Health and Safety design. Caps/masks/beard coverings should be removed when travelling out of the department. Specifically designed footwear such as theatre clogs should not be worn outside the department. Raspberry coloured scrubs must be covered with a disposable gown whilst travelling within the hospital setting, but not within the department. Staff must not wear theatre scrubs outside the Trust buildings, unless in extreme circumstances, for example in the event of a fire alarm.'

Whilst we recognise the potential for the public to feel concerned about staff in clinical uniform in public areas of the Trust, it is important to note that there is no evidence to show that there is any issue of infection with such clothing being worn out of (and then back into) a clinical area.

Status: *Closed*

120 **Sue Milestone** ***Theme:*** Inpatient Facilities ***Source:*** Project Focus Group

Query **01/05/2015**

Please can more detail be provided about access to communications and entertainment devices available to inpatient's across the Trust; what is the standard set up and what types of items have been provided with charitable funding to enhance patient experience?

Division: Trust-wide ***Executive Lead:*** *Director of Finance* ***Response requested:***

Response **18/05/2015**

TV and Radio:
1.Parity Bedside Patient TV and Radio provided by the Trust – These devices provide patients with access to multi-channel TV, Radio and Hospital Radio and are sited in: The New Ward Block (BRI), Bristol Heart Institute, Bristol Haematology & Oncology Centre and Bristol Eye Hospital. There are no charges to the patients for use of these facilities.

2.Premier Bedside Patient TV and Radio provided by Premier Telesolutions – These devices are provided by a commercial company and provide access to multi-channel TV, Radio and Hospital Radio. The cost of running these services was previously at a charge to patients but these services are now funded by Above & Beyond. These devices are sited in: Queens Building (BRI) and St Michaels Hospital.

3.Bristol Children's Hospital – Locally provide/manage access to TV and Radio to all patients. In the majority of cases devices are funded via charitable funds including donations to ward funds and from The Grand Appeal.

Telephone access:
1.Most patients through choice tend to utilise their own mobile phone (the Trust funded the installation of a network solution within the New Ward Block to allow patients to continue to use their mobile phones to contact friends and family).
2.Each ward either has a phone they are able to allow patients to utilise if no other option available to them.
3.There are a small number of pay phones available around the Trust.

Internet access:
Internet access is possible for patients and carers via the Trust Wi-Fi system e.g. for laptop, smartphone or tablet. Ward teams are able to advise regarding log-on details, and there is specific guidance for access for children in line with the Trust's safeguarding practices.

Status: *Closed*

119 **Graham Briscoe** ***Theme:*** Agency Rates ***Source:*** Governor Direct

Query **24/04/2015**

Recent media reports (Sunday Times 5/4/15) note NHS reliance upon Agency Staff for surgeons, doctors and nurses, with very high rates being reported, especially over weekends. For example: £3,681 for a 24 hour shift by a surgeon, £2,700 for an anaesthetist to be on duty 24 hours and £2,200 for a single shift for an agency nurse . Please can the Trust provide the cost of the highest shift, or 24 hour, agency rates paid and what staff group these rates applied to?

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

Response **26/06/2015**

From recent Trust records it has been identified that the highest hourly rate paid to a medical Consultant was £150 per hour (hours per shift are variable, e.g. total payment of £1,800 for a 12 hr shift), and the highest shift rate paid to a nurse was £1,814 for an 11.5 hour shift on a Bank Holiday.

Status: *Awaiting Governor Response*

ID **Governor Name**

118 **Clive Hamilton** ***Theme:*** Infusion Pumps ***Source:*** Governor Direct

Query **21/04/2015**

I have been made aware by my constituents of concern regarding the availability and use of Infusion Pumps for treatment. Can you provide appropriate assurance that there are sufficient infusion pumps, readily available, in good repair and with an adequate pool of trained staff to ensure safe use?

Division: Trust-wide ***Executive Lead:*** *Medical Director* ***Response requested:***

Response **21/04/2015**

We have a number of systems in place to ensure that we have sufficient numbers of serviceable equipment available and in use by trained staff:

•Currently the common infusion pumps are provided by a manufacturer free of charge and maintained by them. We pay for the giving sets. There are sufficient numbers and wards can ask for more as required.
•Clinical staff are trained on induction and when introduced to new equipment on the ward or in the theatre. They keep comprehensive records of training. The training matrices are regularly audited.
•High risk equipment such as infusion pumps have defined competencies for staff which they must pass before being allowed to use the pumps.
•All medical devices are on an asset register and assigned to wards as required. We have a number of different infusion pumps for different purposes.
•Other specialist pumps are serviced by MEMO Clinical Engineering and we control & monitor the required services through our asset management software
•Both the suppliers and MEMO Clinical Engineering are regularly assessed for quality of service by BSI or other registered assessors
•Finally, incidents where a medical device is not available is logged onto our risk management system and these are monitored for trends.

The CQC visit in September checked on all these areas and were satisfied with our service.

Status: *Closed*

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117 **Mo Schiller** ***Theme:*** Performance & Finance - Waiting List Initatives ***Source:*** Governor Direct

Query **21/04/2015**

In the financial year 2014/2015 how many surgical Waiting List Initiatives were undertaken across the Trust by Speciality, including Lists that were outsourced to other Providers? What is the cost of running a WLI list against a 'normal list'? Finally, when is it determined that a Waiting List Initiative is required and what is the criteria for patient selection?

Division: Trust-wide ***Executive Lead:*** *Chief Operating Officer* ***Response requested:***

Response **27/05/2015**

(The response relates to adult surgical service provision and excludes paediatrics.)

Number of waiting lists in total?
In the Division of Surgery, Head and Neck there were about 350 extra theatre lists within the division.

In the Division of Specialised Services there were 297 Cardiology lists and 120 Cardiac Surgery lists calculated by the volume of consultant WLI payments. The majority of these take place within core hours (e.g. not weekends). The division has a planned under provision of consultant capacity which is then used flexibly to respond to demand when needed.

Number of lists outsourced to other providers?
In Surgery, Head and Neck the use of outsourced activity is that individual patient cases are outsourced rather than whole lists, although in other divisions whole lists are outsourced

In Specialised Services there are no outsourced lists.

What is the cost of running a WLI against a 'normal list?'
In both Divisions we have calculated the baseline cost of providing a standard session against a waiting list and the comparison is a follows;

Theatre list: £ 933 (Standard session) / £1,395 (WLI)
Endoscopy/Cardiology list: £634 (Standard Session)/ £950 (WLI).

These cannot be considered as exact costs as there will always be variances in cost to some extent, for example the list may be scheduled when the theatre recovery is already staffed adequately to manage the additional work and thus incur no further staffing requirements. Alternatively an additional list at a weekend may require additional staff in theatre recovery. Similarly on the ward as staffing levels are lower at weekends routinely when there is no elective planned activity.

When is it determined that a Waiting List Initiative is required and what is the criteria for patient selection?

Waiting List Initiatives are used when additional capacity is required, beyond that which can be delivered through usual capacity. They are typically delivered at weekends and in the early evening. There are no specific patients booked onto waiting lists, beyond them all being patients who need to be treated in the period because they are either clinically urgent or are long waiting patients who we must treat in order to reduce our backlogs at the rate we have agreed.

It is our goal to reduce reliance upon waiting list initiatives however, they will always be a necessary (and useful) part of our delivery plans as they are an effective means of responding to unpredictable peaks in demand.

Status: *Closed*

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 12b –UH Bristol Quality Report 2014-2015
Purpose
NHS Foundation Trusts are required to prepare and publish a Quality Report each year. The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates that its services are safe, clinically effective, and that it is providing treatment in a caring and compassionate manner. The report is an open and honest assessment of the last year, its successes and its challenges. The Quality Report has to be prepared in accordance with the NHS Foundation Trust Annual Reporting Manual. The Trust's Auditors, PricewaterhouseCoopers LLP, are required to review the content of the 2014/15 Quality Report. The purpose of their report is to provide the Council of Governors with their findings, in accordance with Monitor's requirements.
Recommendations
The Council of Governors is asked to **note** the reports.
Report Sponsor or Other Author
Sponsor: Trust Secretary
Appendices
Appendix A – Independent Auditor's Report to the Governors on the Quality Report 2014-2015 Appendix B – University Hospitals Bristol Quality Report 2014-2015

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University Hospitals Bristol NHS Foundation Trust

Quality Report 2014/15

Government and Public Sector

27 May 2015

pwc

Contents

Audit Code and scope of this work

We have performed this work in accordance with Monitor's *Detailed guidance for external assurance on quality reports 2014/15* and Monitor's *Detailed requirements for quality reports 2014/15* which were issued in February 2015, and the NHS Foundation Trust Annual Reporting Manual 2014/15. This is available from the Chief Executive of the NHS Foundation Trust.

Reports and letters prepared by external auditors and addressed to governors, directors or officers are prepared for the sole use of the NHS Foundation Trust, and no responsibility is taken by auditors to any governor, director or officer in their individual capacity, or to any third party. The matters raised in this report are only those which have come to our attention arising from or relevant to our work that we believe need to be brought to your attention. They are not a comprehensive record of all the matters arising, and in particular we cannot be held responsible for reporting all risks in your business or all internal control weaknesses. This report has been prepared solely for your use in accordance with the terms of our engagement letter dated January 2015 and for no other purpose and should not be quoted in whole or in part without our prior written consent. No responsibility to any third party is accepted as the report has not been prepared for, and is not intended for, any other purpose.

Background and scope

Background

NHS foundation trusts are required to prepare and publish a Quality Report each year. The Quality Report has to be prepared in accordance with the NHS foundation trust Annual Reporting Manual ("the FT ARM").

As your auditors, we are required to undertake work on your Quality Report under Monitor's Audit Code and Monitor's 'Detailed Guidance for External Assurance on the Quality Reports 2014/15' ('the detailed guidance') which was published in February 2015.

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

Scope of our work

We are required by Monitor to review the content of the 2014/15 Quality Report, test three performance indicators and produce two reports:

- Limited assurance report: This report is a formal, public document that requires us to conclude whether anything has come to our attention that would lead us to believe that:
  - The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM and *Monitor's 'Detailed requirements for quality reports 2014/15'("the requirements")*;
  - The Quality Report is consistent in all material aspects with source documents specified by Monitor; 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 *detailed guidance*.

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

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

Content of the Quality Report

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

- Reviewing the content of the Quality Report against the requirements of Monitor's published guidance, as specified in Annex 2 to Chapter 7 of the FT ARM and the requirements; and
- Reviewing the content of the Quality Report for consistency with the source documents specified by Monitor in the detailed guidance.

Performance indicators

We are required to issue a limited assurance report in respect of two out of the three indicators specified by Monitor.

The indicators for the year ended 31 March 2015 subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria***
percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	*As detailed on page 76 of the Quality Report*
maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	*As detailed on page 76 of the Quality Report*

Our procedures included:

- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgments made by the Trust in preparation of the specified indicators; and
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosure.

Local indicator

We are also required to undertake substantive sample testing of one further local indicator. This indicator is not included in our limited assurance report. Instead, we are required to provide a detailed report on our findings and recommendations for improvements in this, our Governors report. The Trust's Governors select the indicator to be subject to our substantive sample testing. The indicator selected is the 'Find' element of the Dementia FAIR (finding / identifying, assessing and referring) national CQUIN.

Summary of findings

No issues have come to our attention that lead us to believe that the Quality Report has not been prepared in accordance with the *FT ARM* and the requirements.

No issues have come to our attention that lead us to believe that the Quality Report is not consistent with the other information sources defined by Monitor.

Limited Assurance Report

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

Performance indicators

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

Performance indicators included in our limited assurance report	Findings
percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	A number of issues were noted in our testing ; resulting in a qualified limited assurance opinion
maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	One issue identified; no impact on our limited assurance opinion

Limited Assurance Report

Issues have been identified with regard to the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period. As a result of this, our limited assurance opinion has been qualified.

Performance indicator not included within our limited assurance report	Findings
Dementia FAIR (finding / identifying, assessing and referring) national CQUIN indicator	A number of issues were noted with regard to this indicator, as detailed below.

Annual Governance Statement

We identified no issues relevant to the Quality Report.

Detailed findings

Review against the content requirements

We reviewed the content of the Quality Report against the content requirements which are specified in Annex 2 to Chapter 7 of the *FT ARM* and the requirements.

No issues came to our attention that led us to believe that the Quality Report has not beoen prepared in line with the *FT ARM* or the requirements.

Review consistency against specified source documents

We reviewed the content of the 2014/15 Quality Report for consistency against the following source documents specified by Monitor:

- Board minutes for the period April 2014 to the date of signing the limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2014 to the date of signing the limited assurance report;
- Feedback from the Commissioners;
- Feedback from Governors dated 19 May 2015;
- The 2014 national patient survey dated 8 April 2015;
- The 2014 national staff survey dated 24 February 2014;
- Care Quality Commission Intelligent Monitoring Reports dated December 2014; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 27 May 2015.

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

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

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

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We are required to evaluate the key processes and controls for managing and reporting the indicators and sample test the data used to calculate the indicator back to supporting documentation. Our work is performed in accordance with the detailed guidance and included:

- Identification of the criteria used by the Trust for measuring the indicator;
- Confirmation that the Trust had presented the criteria identified above in the Quality report in sufficient detail that the criteria are readily understandable to users of the Quality Report;
- Obtaining an understanding of the key processes and controls for managing and reporting the indicator through making enquiries of Trust staff and through

performing a walkthrough;

- Reconciling the reported performance in the Quality Report to the data used to calculate the indicator from the Trust's underlying systems;
- Testing a sample of relevant data used to calculate the indicator back to supporting documentation; and
- Considering the completeness of the data reported and performing sample testing on this where relevant.

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

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

Our findings and recommendations are set out below.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	
Reported performance:	
2014/15 Threshold: 92%	2014/15 Actual: 90.4%
Criteria identified:	

We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period;
- The indicator is calculated as the arithmetic average for the monthly reported performance indicators for April 2014 to March 2015;
- The clock start date is defined as the date that the referral is received by the Foundation Trust, meeting the criteria set out by the Department of Health guidance; and
- The indicator includes only referrals for consultant-led service, and meeting the definition of the service whereby a consultant retains overall clinical responsibility for the service, team or treatment.

Issues identified through work performed:		
No.	**Issue**	**Impact on limited assurance report**
1.	*We tested 30 cases, in order to ensure that accuracy and validity of data. We sought to confirm that referral dates were correctly recorded and that wait times were correctly calculated and recognised.* *From this testing the following exceptions were noted:* - *For five patients, the "clock stop" dates was found to agree to patient records, but was incorrectly recorded in the data set. These patients were incorrectly included in the dataset as non-breaches in the 18 week standard. Their inclusion overstates the indicator value.* - *For two patient, the "clock start" date was found to agree to patient records, but was incorrectly excluded from the data set. It is noted that these patients would not be breaches in the 18 week standard and their exclusion understates the indicator value.* - *One patient was found to be included in the indicator value as a duplicate record, and should have been removed;* - *One patient, whose admission was planned, was incorrectly included in the indicator value;* - *For 11 patients, the recalculated wait time did not agree to the waiting time as per the Trust's calculations. However, it is noted that this did not have an impact on the indicator value.*	*Due to the widespread exceptions in our testing, we have qualified our limited assurance opinion.*

As a result of these issues the data set was reanalysed by the Trust, with the indicator value being recalculated.

We completed further testing in order to confirm the validity of adjustments to exclude or amend the patient information underlying the calculation.

From this testing the following issues were noted:

- *For one patient, no evidence could be found to verify their exclusion from the dataset, this patient was noted to be in breach of the 18 week standard,*
- *Two patients were found to be inappropriately excluded from the indicator value for one month, when they should have been recorded as a non-breach in the 18 week standard.*
- *One patient was found to be incorrectly included within the dataset as a breach in the 18 week standard when they should have been excluded from the dataset.*
- *18 patients were found to be inappropriately included within the dataset. These cases were recorded as non-breaches in the 18 week standard and overstate the indicator value.*
- *Two patients were found to be incorrectly included within the dataset for 3 months. They were incorrectly included as non-breaches for 2 months, and as a breach for 1 month.*

Based on the nature of the issues identified above, the Trust was unable to recalculate the indicator value.

Overall Conclusion:
Our substantive testing of the indicator identified a number of issues, as detailed above. As a result of these issues, we have qualified our limited assurance opinion.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	
Reported performance:	
2014/15 Target: 85%	2014/15 Actual: 79.2%

Criteria identified:

We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of 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.

Issues identified through work performed:

No.	Issue	Impact on limited assurance report
1.	*From our sample of 30 cases tested, we identified one instance of a difference in the "clock start" date. However, it is noted that the difference in this case was for only one day, and as such was deemed to be a tolerable difference. This difference has no impact on the indicator value.* *It should be ensured that such dates are recorded accurately in the data set.*	*No impact on our limited assurance report.*

Conclusion:

Our substantive testing of the indicator identified one issues. No impact on our limited assurance report resulting in an unmodified report in respect of this indicator.

Performance indicators not included within our limited assurance report

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

We are required to evaluate the key processes and controls for managing and reporting the indicator and sample test the data used to calculate the indicator back to supporting documentation.

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

Our findings are detailed as follows:

The 'Find' element of the Dementia FAIR (finding / identifying, assessing and referring) national CQUIN
Reported performance:
2014/15 Actual: 65.0% 2014/15 Quarter 4 Actual: 79.3%
Criteria identified:
We confirmed the Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report: • The indicator is expressed as the percentage of the patients aged 75 and over emergency admission to hospital who, using the dementia case finding question and within 72 hours of admission were: o asked the dementia case finding question, o had a clinical diagnosis of delirium on initial assessment, or o had a known diagnosis of dementia. • The numerator is the number of patients 75 and above admitted as emergency inpatients, reported as having been asked the dementia case finding question within 72 hours of admission to hospital or who have a clinical diagnosis of delirium on initial assessment or known diagnosis of dementia; • The denominator is the number of patients aged 75 and above, admitted as emergency inpatients, minus exclusions.

Issues identified through work performed:		
No.	**Issue**	**Impact**
1.	*During the year the process and controls with regard to this indicator changed. In December 2014 a web-based tool was implemented. Prior to this, the Trust replied upon a largely manual process, in which the documentation of the case-finding question is produced as part of the discharge notes of the patient. As such, prior to the introduction of the web-based tool, there is no evidence of when the case finding questions were asked as there was time stamp applied to the data. During quarters 1 to 3 of the year the Trust measured performance against target based on whether the question had been asked, not whether it had been completed within the 72 hour period.* *Due to this, our testing was limited to the period in which the web-based tool was operating.* *However, from our testing of 30 cases we noted 3 cases where we unable to verify when the case finding questions were asked.* *We also noted 4 cases where differences between the information contained data set and in patient notes were identified.* *As a result of this we tested a further 30 cases, of which in 3 instances we were unable to verify when the case finding questions were asked.*	*This indicator is not subject to our limited assurance opinion. Had this indicator been reported upon, it would have likely resulted in a modification to our opinion.*
Conclusion:		
Our substantive testing of the indicator identified a number of issues, as detailed above.		

Annual Governance Statement

In the requirements Monitor asks Foundation Trusts to include a brief description of the key controls in place to prepare and publish a Quality Report as part of the Annual Governance Statement in the 2014/15 published accounts.

The Annual Governance Statement, within the Foundation Trust's 2014/15 Annual Report, includes the following statement specific to the Quality Report:

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Whilst these reporting requirements contribute to ensuring that the content of the Quality Report presents a balanced view of the quality of services provided by the Trust, we also take steps to ensure that appropriate controls are in place to ensure the accuracy of the data upon which we base our statements on quality. These controls are undertaken in accordance with the Quality Strategy (2011-2014) and the Data Quality Strategy which describes the standards of data quality assurance required for data supporting information used by the Board and for public reporting. Examples of data accuracy controls for the Quality Report include checks by the author to ensure that published data is consistent with that reported to the Board during the year, a Data Quality Framework covering metrics mandated for Quality Reports from 1 April 2013, and the External Auditor independent assessment of the accuracy of three of the mandated indicators.

The Board recognises that some data quality issues regarding Referral to Treatment times were identified in the External Audit. A comprehensive plan to improve data quality and hence provide better assurance in this area will be implemented during 2015/16.

The Quality and Outcomes Committee and Clinical Quality Group monitor progress of quality objectives at quarterly intervals during the year; this monitoring is reported to the Board. This process ensures there is continuity throughout the production of Quality Reports, and any inconsistencies are challenged by the Clinical Quality Group.
Our governors are instrumental in agreeing the content of sections of the Quality Report in which we have freedom to report other key quality themes from the past year. The governors undertake this work formally under the auspices of the Governor Quality Focus Group.

We follow good practice guidance such as those issued by the Kings Fund by ensuring a wide degree of continuity for clinical themes reported from one year to the next. This ensures that we remain demonstrably committed to ensuring transparency as well as keeping the Quality Report current and fresh.

We invite third parties to comment on an early draft of the Quality Report and listen to requests to amend content or introduce any new quality themes which those third parties feel might be necessary to achieve a fair and balanced view of quality during the year.

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

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

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

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

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University Hospitals Bristol NHS
NHS Foundation Trust

Quality Report 2014/15

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents

1.1 Statement on quality from the Chief Executive

Welcome to this, our seventh annual report describing our quality achievements. Our mission is to provide exceptional healthcare, research and teaching every day.

The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates that its services are safe, clinically effective, and that we are providing treatment in a caring and compassionate manner. The report is an open and honest assessment of the last year, its successes and its challenges.

2014/15 has been a busy and challenging year for University Hospitals Bristol. We have planned for many years to renew our hospital buildings to match the high quality of care given by our staff, and last year saw those plans come successfully to fruition as services moved into state-of-the-art facilities and opened to patients. Specialist children's services at Frenchay Hospital transferred to the extended Bristol Royal Hospital for Children; the new helideck, on the roof of the Bristol Royal Infirmary (BRI), became operational to ensure seriously ill and injured patients could be transferred to either the children's hospital or the BRI and Bristol Heart Institute as quickly as possible; the last inpatient wards moved out of the BRI Old Building, built in 1735, as a result of our £143 million redevelopment programme, with patients now cared for in a newly constructed ward block; and two brand new, state-of-the-art medical assessment units, including an older persons assessment unit, and a new intensive care unit within the new ward block are just some of the facilities that are helping us to transform the care we deliver to our patients.

Overall, 97 per cent of patients consistently report that the care they receive from us is good, very good or excellent, and our monthly scores in the NHS inpatient and accident and emergency Friends and Family Test continue to be better than the national average. We were also pleased that our emergency departments once again received a positive set of results in the Care Quality Commission's (CQC) national patient survey, particularly when compared to other large city centre services. The Trust's mortality rates also continue to be better than the national average.

In 2014/15, we agreed a set of quality objectives focused largely on improving the 'flow' of patients into our hospitals – including through our emergency departments – and back out safely into the community. The CQC inspected our hospitals in September 2014 and highlighted the same core challenge. We are working closely with our local partners in health and social care to create the capacity in the system that will enable these objectives to be achieved. In 2014/15 our performance in the areas of reducing cancelled operations, minimising patient moves between wards, and ensuring that patients are treated on the most appropriate ward for their clinical condition was disappointing. We have therefore extended these goals into 2015/16.

Elsewhere, we were very encouraged by the CQC's findings: 44 of the 56 inspection ratings we received were good or better, and the inspection team singled out the quality of leadership in our maternity services and the effectiveness of care in services for children and young people for particular praise, and rated them as outstanding. You can read more about the CQC's findings in the pages of this report.

I am pleased to be able to tell you that UH Bristol has 'Signed up to Safety' , developing a three year plan which aims to reduce avoidable harm to patients by 50 per cent and to reduce patient mortality by 10 per cent by 2018. The programme includes a focus on improving the early recognition and management of sepsis, which is one of our nine key quality objectives for 2015/16.

I would like to thank everyone who has contributed to this year's report, including our staff, governors, commissioners, local councils, and HealthWatch. To the best of my knowledge, the information contained in this Quality Report is accurate.

Robert Woolley, chief executive

[1] Sign up to Safety is an NHS England initiative where providers sign up to five key safety pledges: putting patients first, continually learning, being honest, collaborating and being supportive

1.2 Introduction from the medical director and chief nurse

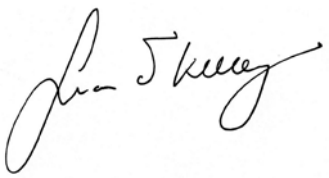
University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of general and specialist hospitals, employing around 7,000 staff (whole time equivalent) and with a turnover of approximately £589m in 2014/15.

We are also the major medical research centre in the South West of England. During 2014/15, the Trust provided treatment and care to around 75,000 inpatients[2], 60,000 day cases and 120,000 attenders at our emergency departments[3]. We also provided approximately 610,000 outpatient appointments.

Our goal has been that each and every one of these patients should be safe in our care, have an excellent experience of being in our care, and enjoy the right clinical outcome: the hallmarks of a quality service. The Trust's quality strategy also underlines our commitment to mitigate any risks to quality that result from our challenging financial cost improvement plans; the quality of our clinical services will not be compromised. We continue to use four key questions to guide our approach to quality:

- do we understand quality and patient experience well enough in the Trust?
- how do we know that the services we provide are safe?
- what will it take to make all our services as good as they can be?
- how well do we involve our staff and patients in this agenda?

These questions, and our commitment to improvement, have informed the development of the Trust's quality objectives for 2015/16, which you can read more about later in this report. In the pages that follow, you will be able to read a detailed account of our performance in 2014/15.



Dr Sean O'Kelly
Medical director

Carolyn Mills
Chief nurse

[2] Elective, emergency, maternity and births
[3] Bristol Royal Infirmary, Bristol Royal Hospital for Children, and Bristol Eye Hospital

2 Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2014/15

2014 was the first year that we held a public/membership consultation event to help shape our quality plans. This coincided with a time when the Trust had been experiencing unprecedented operational pressures on its services. We chose a set of objectives focused largely on patient 'flow' through our hospitals, but we also included an objective to refresh and renew our approach to how we engage patients and the public to improve our services.

2.1.1.1 Reducing numbers of cancelled operations

Cancelled operations are a waste of time and resources, and the process of cancelling operations is distressing and inconvenient for patients. Our ongoing aim is to significantly reduce the number of last minute cancellations (that is, on the day of admission) for non-clinical reasons.

During 2014/15, the Trust cancelled 1.08 per cent of operations on the day of the procedure for non-clinical reasons, such as emergency patients needing to take priority, and critical care and ward bed availability. This compares with 2013/14 performance of 1.02 per cent and a 2014/15 target of 0.92 per cent. Although this result was disappointing, there was nonetheless a significant reduction in the number of cancellations due to a ward bed not being available; this was due primarily to the implementation of the Trust's managed beds protocol, which protects the core adult ward beds needed to admit patients for their elective operations. Overall, however, demand on critical care beds continued to result in a high level of cancellations. This was despite the opening of a 20th critical care bed in February 2014, and the move into a new, single site adult general intensive therapy unit (ITU)/high dependency unit (HDU) in quarter 4 2014/15. Demand for critical care beds remained high throughout 2014/15, with peaks in patient acuity from emergency admissions. The single site for general adult ITU and HDU affords greater flexibility in the acuity of cases that can be managed in the unit. However, changes will also be made to the nursing workforce for adult general critical care in 2015/16 to enable the maximum number of beds to be kept open within the unit during peaks in patient acuity.

Table 1

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Percentage of operations cancelled at last minute for non-clinical reasons	1.02%	0.92%	10% reduction - applied to seasonal variation	Target 1.03%	Target 0.82%	Target 0.81%	Target 1.00%
Performance to date		1.08%		1.02%	1.16%	1.16%	0.97%

Source: UH Bristol patient administration system (Medway)

2.1.1.2 Minimising patient moves between wards, including out of hours

Risks of healthcare-associated infection are greatly increased by the extensive movement of patients. We also know from patient feedback that moves between wards for non-clinical reasons impact adversely on their experience of care. Our aim in 2014/15 has been to reduce unnecessary ward moves by 15 per cent. Baseline data was established in quarter 1; our target was to achieve an average of no more than 1.92 ward moves per patient, compared to 2.26 in 2013/14.

In quarter 3 of 2014/15, relevant services in our Surgery, Head and Neck Division moved into the new Bristol Royal Infirmary ward block. The ward areas are larger than they had been previously, and consequently, patient ward moves are being reduced. In October 2014, a new managed beds programme was implemented in the divisions of Surgery, Head and Neck and Specialised Services in order to support the delivery of the new model of care associated with the new ward layout following the Bristol Royal Infirmary redevelopment. In November, the Division of Medicine commenced the move into the new ward block. The first moves were the two assessment wards (medical assessment unit and older persons assessment unit), which moved into areas that provide an increased bed base and increased isolation facilities. The pathways for expected medical patients, which are aimed at reducing ward moves, have now been implemented.

Two medical wards used as extra capacity during winter 2014/15 will remain open as substantive capacity. This will increase overall capacity within the Division of Medicine and support a lower rate of bed occupancy; this should result in reduced ward moves, as patients will be placed in the right ward for their specialty. There is now a Ward Moves tracking report available to the Trust's clinical site managers (CSMs). This electronic report is updated every 30 minutes and tracks how many ward moves per patient by ward. This will support the risk assessments made by the CSMs when identifying patients to move to create specific capacity.

Table 2

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Average number of ward moves per patient	2.26	1.92	Target reduction increasing to 15% in quarter 4, applied to seasonal variation	Baseline 2.32	Target 2.20	Target 2.09	Target 1.97
Performance to date		2.32		2.32	2.38	2.31	2.25

Source: UH Bristol patient administration system (Medway)

Despite these improvement measures, the rate of reduction is currently behind plan, as we continue to work against significant pressures in the system. These pressures require extra capacity areas to be opened up, resulting in a number of unscheduled moves to create acute capacity and maintain patient flow. In 2014/15 (measured to the end of February 2015), we achieved an average of 2.32 moves per patient.

2.1.1.3 Ensuring patients are treated on the right ward for their clinical condition

We were disappointed not to achieve our target for 2014/15: a 15 per cent reduction in the

total number of days spent by patients as 'outliers'; that is, on wards which did not specialise in their particular clinical condition. However, we were encouraged that our performance improved significantly in the final quarter of the year, despite seasonal pressures. Positive steps taken by the Trust during 2014/15 to address the issue of outlying patients have included:

- the move of clinical services into the new Bristol Royal Infirmary ward block[4] the creation of new clinical pathways for elective and emergency patients
- an increase in the number of medical beds (from 214 beds to 249) with effect from quarter 4, in order to offset the anticipated rise in winter emergency admissions and reduce overall bed occupancy rate, thereby reducing outliers
- the agreement of a standard operating procedure, ratified by the Division of Medicine, identifying the appropriate lead clinical teams for any patients who are outlying in other divisions.

Table 3

Indicator	2013/14	2014/15 target	Target reduction over baseline	Q1	Q2	Q3	Q4
Number of outlier bed days	10622	9029	Overall 15% reduction – applied to seasonal variation with increasing improvements across the quarters	Target 2444	Target 1688	Target 2114	Target 2783
Performance to date		11216		2417	2316	3383	3100

Source: UH Bristol patient administration system (Medway)

2.1.1.4 Ensuring no patients are inappropriately discharged from our hospitals out of hours

Our aim is to ensure that no patients are discharged out of hours, as defined in our hospital discharge policy[5]. Daily auditing of discharge times has demonstrated a reduction in the proportion of patients discharged out of hours during 2014/15. Matrons are now routinely provided with details of patients reportedly discharged out of hours, for them to follow up with ward staff. This has increased awareness of the policy parameters, improved accuracy in recording, and encouraged accountability among ward staff. Overall, the proportion of discharges out of hours during quarter 4 up to the end of February 2015 was 7.7 per cent (8.1 per cent YTD), compared to 9 per cent in 2013/14.

2.1.1.5 Renewing and refreshing the Trust's approach to patient and public partnership

Ensuring that our patients – past, present and future – their families, and their representatives are central to the way we design, deliver and evaluate our services is an important aspiration for the Trust. The healthcare services we provide are for patients, and it is right that they are involved in the development of those services.

Historically, the Trust has a strong track record in patient and public involvement (PPI). However, we recognise that involvement is not always systematic and sufficiently mainstreamed within the organisation. In last year's Quality Report, the Trust made a commitment to refresh its approach to PPI work; specifically, to undertake at least two significant pieces of work – one of which would focus on the experience of a 'seldom heard' patient group – and to use these as a basis for developing a new model of engagement for wider implementation. We did this by supporting a fresh approach to involvement in children's cardiac surgery services at the Bristol Royal Hospital for Children, testing new ways of working together with families as partners in service improvement. This work has enabled families to raise the issues that are important to them in the delivery of care in this service, and to work together with professionals to devise new ways of doing things. In addition, we supported activity to involve adolescents who have learning disabilities and a diagnosis of congenital heart disease, with their families and carers, in conversations about their experiences of care. As part of our ongoing commitment to deliver patient and public involvement, we have delivered involvement activities with families and relatives whose loved ones have died whilst in our care and, with the support of the Patients Association, patients who have received a diagnosis of cancer.

[4] This move took place between November 2014 and February 2015

As a result of bringing together learning from these and other activities, and in consultation with local and national leaders in the field of PPI, we have agreed a PPI model for implementation in 2015/16 based on three goals: in summary, to improve the quality, capacity and culture of PPI.

We will implement new ways of working together with patients, carers, relatives, and communities of interest as partners for improvement.
Our goal is to develop a breadth of activity and consistency of approach which ensures that all Trust developments benefit from PPI, that our PPI work has wider reach into communities of interest, and that we are supportive of PPI initiatives that affect the wider health community. We will:

- establish a citizens' assembly (or equivalent arrangement) to ensure that a broad range of patients and members of the public have opportunities to shape our services
- create a wider range of opportunities for involvement, including developing and supporting a co-design approach to improvement and change.

We will train and support staff so they have the skills to deliver effective PPI. Our goal is to position PPI as an accepted and expected part of the Trust's business. We will:

- set up a learning community (possibly with People in Research) to inform and develop practice in PPI in the Trust
- improve the internal advice and support to divisions around PPI through improved web-based guidance, training, and coaching in involvement techniques.

We will build a culture of PPI. Our goal is to encourage and develop behaviours associated with PPI, demonstrating the value and impact of PPI, and ensuring that the correct systems are in place to support PPI. We will:

- implement reporting and monitoring for impact systems that are part of mainstream business
- develop a greater awareness of the value and impact of PPI in the Trust through improved communications.

The coming year will see the implementation of this plan, with a further quality objective linked to improving the way in which we engage seldom-heard and vulnerable groups in our PPI work.

2.1.2 Quality objectives for 2015/16

As described in the medical director's and chief nurse's introduction to this report, the Trust is setting nine quality objectives for 2015/16. Three of these relate to goals we failed to achieve in 2014/15: reducing cancelled operations; minimising inappropriate patient moves between wards; and ensuring patients are treated on the right ward for their clinical condition. We are also committed to continuing to improve patients' experience of discharge from hospital. In particular, patients and members of the Trust have identified timeliness of receipt of TTA ('to take away') medicines as a recurring theme associated with discharge delays.

In addition, we have identified five new objectives, which take account of feedback from patients, members, governors, staff, and our commissioners and regulators. Two of these objectives are about improving the quality of our written communications with patients. In most cases, we have used direct quotes from patients to help explain our choices. We have

deliberately selected quotations which highlight a need for improvement. Unless otherwise stated, the quotations are taken from the Trust's monthly inpatient survey.

Objective 1	To reduce the number of cancelled operations
Rationale and past performance	We set this objective last year, but did not achieve our goal. Our target in 2014/15 was to reduce the percentage of operations cancelled at the last minute for non-clinical reasons. Performance in 2013/14 was 1.02 per cent; our target for 2014/15 was 0.92 per cent; we achieved 1.08 per cent.
What do our patients say?	"The biggest problem is the cancellation of operations. I sat nervously all day in my op gown all ready to go to be informed by an anaesthetist that my op had been cancelled, and I was to await more information. It never came and a staff nurse had to go and find out for me. I had the op the following day. These sort of things do nothing for patients' mental and psychological well-being." "I had mentally prepared myself for the operation I had which was major surgery and there was the possibility of a number of complications during and after surgery. On two occasions my operation was cancelled whilst I was in the admissions ward - the first time after a seven hour wait and the second time after an 8 hour wait. On both occasions I had pre-op procedure and nil by mouth 9 hours before arriving at the hospital. This I found to be quite upsetting mentally, although a number of reasons for the cancellation were given."
What will we do?	Review standard operation procedure; audit reasons for last minute cancellations and develop plan according to findings; link into Urgent Care work programme.
Measurable target/s for 2015/16	The indicator will be the number of operations cancelled on the day of operation/admission for non-clinical reasons. Our goal is to achieve last year's target – 0.92 per cent.
How progress will be monitored	Through divisional performance reporting.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 2	To minimise inappropriate patient moves between wards (time and place)
Rationale and past performance	We set this objective last year, but did not achieve our goal. Our target in 2014/15 was to reduce the average number of ward moves per patient. Performance in 2013/14 was 2.26; our target for 2014/15 was 1.92; we achieved 2.32. An 'inappropriate' patient move is one which happens for reasons which are not related to that patient's clinical circumstances.
What do our patients say?	"I was woken in the middle of the night to be moved to another room, I wasn't happy about it, but did understand that my bed was needed by someone who needed constant supervision." "I moved wards more than once and more from South Bristol to BRI. Communication of these moves should have prepared me better - at times I had less than 1hr. My friends were not sure what hospital or ward I was on (don't have a mobile) and staff too busy to organise mobile phone."
What will we do?	Agree inclusion and exclusion criteria and develop a standard operating procedure.
Measurable target/s for 2015/16	The indicator will be the average number of ward moves per patient, for patients staying a minimum of two nights. Our goal is to achieve last year's target – an average of no more than 1.92 moves per patient.
How progress will be monitored	Progress with this objective will be monitored through emergency access steering group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 3	To ensure patients are treated on the right ward for their clinical condition
Rationale and past performance	We set this objective last year, but did not achieve our goal. Our target in 2014/15 was to reduce the total number of outlier bed days. Performance in 2013/14 was 10,622; our target for 2014/15 was 9,029; we reported 11,216 outlier bed days for 2014/15 as a whole. There was a significant reduction in outlier bed days in February and March 2015 as expected.
What do our patients say?	"I was an inpatient for 3 weeks I was only on the ward I should have been on for one of those weeks. I would have been much happier if I could have been on the correct ward for the whole of my stay as I felt I was just being put anywhere. I was moved 3 times before I went to the right ward."
What will we do?	Link into pathway review work and urgent care programme
Measurable target/s for 2015/16	As in 2014/15, the indicator will be the total number of bed days patients spent outlying from their correct specialty ward. Our goal is to achieve last year's target – no more than 9,029 outlier bed days in total, with seasonally adjusted quarterly targets.
How progress will be monitored	Progress with this objective will be monitored through emergency access steering group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 4	Improving patient discharge
Rationale and past performance	Not achieving our SAFER[6] bundle standards or timely discharge planning.
What do our patients say?	"My overall experience of the stay in hospital was very good. Only thing that could have been better was the time it took in the discharge lounge to receive the medication." "It would be helpful to know of your discharge the day before, with the understanding that the final decision is made by the doctor on the day." "Even though we were aware of discharge date and confirmation was given that morning we waited hours for a discharge letter."
What will we do?	We will ensure more patients are discharged in a timely manner. We will adhere to all aspects of our discharge 'bundles' – delivering our discharge standards every time. The recent Breaking The Cycle Together (BTCT) week had a significant focus on patient discharge; it is proposed that the detail of this objective will be finalised as part of the BTCT programme review process, and may become a transformation project for 2015/16.
Measurable target/s for 2015/16	1. At least 1,100 patients per month to be discharged between 7am and 12 noon (this will be a stretching target – the highest monthly total during 2014/15 was 992; performance in March 2015 was 887). 1. Percentage of wards in scope that complete the Trust's ward processes implementation project (target 100%).
How progress will be monitored	Via transformation board (to be confirmed).
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

[6] Senior review, Assessment, Flow, Early discharge and Review

Objective 5	To improve how the Trust communicates with patients
Rationale and past performance	A large proportion of complaints and informal feedback received by the Trust relate to the poor quality of written and telephone communications patients and carers have with the Trust. In response to this, the executive team has commissioned a Trust-wide improvement project to identify key areas of improvement required, and leads/project groups to deliver the required improvement in specific areas. The project will last for at least two years.
What do our patients say?	"The automatic appointment system left me extremely anxious. NO indication as to which ward I should report to, level or who for my pre-op appointment which came out of the blue - a real shock. I finally had to telephone my referral doctors secretary to get the name of your surgeon to find out who to contact. The appointment line was having 2 days training session so had to wait until after the weekend - day before at 7.30am appointment to find out. I am sure with everything else so well run you would like to look into this system." "Letter referred to MDT. What is that? Plain language would help. Previous letters have been very tardy in being signed/posted or on one occasion, not received at all." "I had to phone for my follow up appointment, I am receiving that 2 weeks later than I was told. I would still be waiting if I had not contacted them. This is not the first time this has happened, I feel your clerical side needs looking into."
What will we do?	In 2015/16, we will focus on improving the quality of appointment letters sent to patients. We will: • define the scope of the project • establish a project steering group and specific project groups/individuals to lead workstreams • monitor delivery against the actions identified and, wherever possible, undertake regular measurement to provide assurance of progress, completion and impact.
Measurable target/s for 2015/16	This is a developmental objective. Our goal is to improve the quality of, and standardise the format of, all appointment letters that are sent to patients (electronically and non-electronically generated). We will test this through proactive engagement with patients (for example via surveys or focus groups).
How progress will be monitored	Via steering group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 6	To improve the quality of written complaints responses
Rationale and past performance	Too many complainants tell us that they are dissatisfied with our complaints responses. Our response letters are consistently detailed and professional, but they often lack empathy and occasionally fail to address key issues. The choice of objective is supported by feedback from Bristol Clinical Commissioning Group (CCG) quarterly reviews and the findings of an independent review by the Patients Association. In 2013/14, 62 complainants contacted us because there were aspects of our complaints response that they were dissatisfied with; in 2014/15, this figure had increased to 84.
What do our patients say?	"Language barrier and many people scared to complain because it's very difficult if person can't explain exactly the situation. I explained my situation, but when I get response I ignore letter because was too complicated and too many things I didn't understand." "The reply letter I received was quite defensive. It gave me the impression they were responding just because they had to rather than genuinely apologising for my upset." "The letter in fact said in some cases 'This is obviously unacceptable and we apologise' but it didn't say what action they would then take."

What will we do?	We will: • roll out targeted training to all divisions • continue to deliver complaints training as part of the Leadership for Leaders course • introduce a good practice checklist to be completed for all complaints • update the Trust's standard operating procedure for how to write a good response letter • identify where there are opportunities for complainants to be involved in developing the solution to the issues they have identified • implement changes to the Trust's response letter template, incorporating advice from the Patients Association and identified good practice from peer Trusts.
Measurable target/s for 2015/16	To be confirmed: the target will be to achieve a rate of less than 5 per cent of dissatisfied complainants in the second half of 2015/16, with an 'amber' target of less than 10 per cent. This will require a change to how we report our performance to the Board in future; measured in this way, our performance for 2014/15 was 11.1 per cent. Informal benchmarking with other NHS Trusts suggests that rates of dissatisfied complainants are typically in the range of 8 to 10 per cent.
How progress will be monitored	Implementation of the actions described here will be monitored via the patient experience group (reports due in June and October 2015, and February 2016). The impact of these changes will be monitored by the Board via numbers of dissatisfied complainants; randomly selected responses will also continue to be reviewed at joint quarterly review meetings with Bristol CCG.
Board sponsor	Chief nurse
Implementation lead	Head of quality (patient experience & clinical effectiveness) and patient support & complaints manager)

Objective 7	To improve the management of sepsis
Rationale and past performance	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually; of these, some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis nationally are thought to contribute to the number of preventable deaths from sepsis. Locally, we have identified – through mortality reviews and incident investigations into deteriorating patients – that we can improve our management of patients with sepsis. Therefore, this is one of the sub workstreams of our patient safety improvement programme for 2015 to 2018. In 2014/15, we agreed a multifaceted sepsis CQUIN (Commissioning for Quality and Innovation) with our commissioners, with an overall aim to sustain mortality from sepsis at 16 per cent or below. We achieved a mortality rate of 15.2 per cent.
What do our patients say?	We are currently discussing with commissioners details of a sepsis CQUIN for 2015/16. This will inform our sepsis quality achievement and the initial sepsis improvement focus of our patient safety improvement programme.
What will we do?	Details of national CQUIN targets are being discussed with commissioners at the time of writing.
Measurable target/s for 2015/16	To be agreed
How progress will be monitored	Medical director
Board sponsor	Adult services – Dr J Bewley, consultant in intensive care
Implementation lead	Children's services – Dr W Christian, consultant in paediatric medicine

Objective 8	To improve the experience of cancer patients
Rationale and past performance	The Trust achieved disappointing results in the 2014 national cancer patient experience survey. These results were significantly at variance with those achieved by the Trust in other national patient surveys.
What do our patients say?	"It was very efficient, but, somewhat, I felt disjointed, as I started at Southmead Hospital then went to the oncology at Bristol. I'm not always sure now where to go if I have a medical problem i.e. GP, breast care nurse." "The hospital needed someone who could hold my overall treatment who I could readily contact." "The nurses and staff are very understanding and friendly. Always willing to listen to patients and are helpful when needed."
What will we do?	The Trust will deliver an 18 month improvement programme, the core elements of which will be to: • repeat an 'in-house' survey of recent UH Bristol cancer patients (completed January to March 2015) • working in collaboration with the Patients Association, carry out a series of patient engagement and involvement activities with cancer patients, to fully understand their experience of our services • work with high-performing acute NHS Trusts, local health and social care partners, patient advocate organisations, and our own staff to identify and implement improvements to our cancer services • monitor the actions identified, and wherever possible undertake regular measurement to provide assurance of progress, completion and impact.
Measurable target/s for 2015/16	The key measurement will be the Trust's scores in the next national cancer patient experience survey; however, this has been delayed until 2016. In the meantime, we will: • complete planned listening exercises and thematic analysis • track progress of the Trust's existing comprehensive action plan, in line with the agreed 18 month timescale • repeat the Trust's 'in-house' cancer patient experience survey in quarter 3 of 2015/16.
How progress will be monitored	Quarterly reports to cancer steering group.
Board sponsor	Chief operating officer
Implementation lead	Cancer lead nurse

Objective 9	To reduce appointment delays in outpatients, and to keep patients better informed about any delays
Rationale and past performance	A large number of recommended improvement actions arising from the Trust's CQC inspection are about outpatient services. There is consensus amongst senior Trust staff that this should be reflected in our corporate objectives – and communication about waiting times is something that our patients consistently tell us that we can do better (also reflected in feedback from our online survey).
What do our patients say?	"I had to wait for 1 and a half hours to be seen for approx. 7 minutes!! It seemed the consultant was totally overbooked." "Whilst this visit was very on time other visits have not been. Sometimes up to 1hr wait."
What will we do?	An action plan will be developed via the Trust's outpatient steering group. This will include a multi-faceted approach to improving communication with patients about any delays they are likely to experience while waiting for a clinic appointment. We will establish baseline targets during quarter 1 of 2015/16.
Measurable target/s for 2015/16	To be confirmed: the intention is to set achievable patient-reported targets based around four survey questions that appear in the National Outpatient Survey: • how long after the stated appointment time did the appointment start? • were you told how long you would have to wait? • were you told why you had to wait? • did you see a display board in the clinic with waiting time information on it?

How progress will be monitored	Reports to outpatient steering group
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

2.1.2.1 How we selected these objectives

These objectives have been developed to take into account:

- the goals of our Quality Strategy
- our desire to maintain our focus on any quality objectives that were not achieved in 2014/15
- views expressed by our members at a specially convened meeting in January 2015
- feedback from our governors
- feedback from staff and members of the public via an online survey
- feedback from patients via ongoing surveys
- findings from the CQC's comprehensive inspection of the Trust in September 2014
- the views and quality priorities of the Trust Board.

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2014/15, UH Bristol provided relevant health services in 70[7] specialties via five clinical divisions (Medicine; Surgery, Head and Neck; Women's and Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2014/15, the Trust Board has reviewed selected high-level quality indicators covering the domains of patient safety, patient experience and clinical effectiveness as part of monthly performance reporting. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by UH Bristol services reviewed in 2014/15 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2014/15.

2.2.2 Participation in clinical audits and national confidential enquiries

For the purposes of the Quality Report (Quality Account), the Department of Health publishes an annual list of national audits and confidential enquiries, participation in which is seen as a measure of the quality of a provider Trust's clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for Trusts in terms of percentage participation and case ascertainment[8]. The detail which follows relates to this list.

During 2014/15, 37 national clinical audits and two national confidential enquiries covered relevant health services that University Hospitals Bristol NHS Foundation Trust provides.

During 2014/15, University Hospitals Bristol NHS Foundation Trust participated in 100 per cent (37/37) of national clinical audits, and 100 per cent (2/2) of national confidential enquiries it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust has been eligible to participate in during 2014/15 are as follows:

[7] Based upon information in the Trust's Statement of Purpose (which is in turn based upon the Mandatory Goods and Services Schedule of the Trust's Terms of Authorisation with Monitor)

[8] In other words, how many cases we submit compared to how many we are told we should submit, according to the requirements of the audit

Name of audit / Clinical Outcome Review Programme	Participated
Acute	
Case Mix Programme (CMP)	Yes
Adult Community Acquired Pneumonia	Yes
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes
National confidential enquiry into patient outcome and death (NCEPOD)	Yes
National emergency laparotomy audit (NELA)	Yes
National Joint Registry (NJR)	Yes
Non-Invasive Ventilation	Yes
Pleural Procedures	Yes
Mental health (care in emergency departments)	Yes
Older people (care in emergency departments)	Yes
Fitting child (care in emergency departments)	Yes
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	Yes
Cancer	
Bowel cancer (NBOCAP)	Yes
Head and neck oncology (DAHNO)	Yes
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Heart	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Inflammatory bowel disease (IBD)	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes
Renal replacement therapy (Renal Registry)	Yes
Rheumatoid and early inflammatory arthritis	Yes
Older People	
Falls and Fragility Fractures Audit Programme (FFFAP)	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
Other	
Elective surgery (National PROMs Programme)	Yes
Women's and Children's Health	
Epilepsy 12 audit (Childhood Epilepsy)	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric intensive care (PICANet)	Yes

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in – and for which data collection was completed during 2014/15 – are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (where known).

Name of audit / Clinical Outcome Review Programme	Participated
Acute	
Case Mix Programme (CMP)	1202*
Major Trauma: The Trauma Audit & Research Network (TARN)	69% (323/471)
National confidential enquiry into patient outcome and death (NCEPOD)	80% (35/44)
National emergency laparotomy audit (NELA)	97% (160/165)
National Joint Registry (NJR)	100% (48/48)
Non-Invasive Ventilation	25*
Pleural Procedures	4*
Mental health (care in emergency departments)	94% (47/50)
Older people (care in emergency departments)	65% (65/100)
Fitting child (care in emergency departments)	100% (54/54)
Fitting child (care in emergency departments)	Yes
Paediatric intensive care (PICANet)	Yes
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	38*
Cancer	
Bowel cancer (NBOCAP)	190*
Head and neck oncology (DAHNO)	166*
Lung cancer (NLCA)	87% (157/180)
Oesophago-gastric cancer (NOGCA)	142*
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	889*
Cardiac Rhythm Management (CRM)	211*
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (777/777)
Coronary Angioplasty/National Audit of PCI	100% (1473/1473)
National Adult Cardiac Surgery Audit	100% (1488/1488)
National Cardiac Arrest Audit (NCAA)	121*
National Heart Failure Audit	358*
National Vascular Registry	279*
Long term conditions	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	479*
Diabetes (Paediatric) (NPDA)	484*
Inflammatory bowel disease (IBD)	86% (43/50)
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	84% (36/43)
Renal replacement therapy (Renal Registry)	54*
Rheumatoid and early inflammatory arthritis	7*
Older People	
Falls and Fragility Fractures Audit Programme (FFFAP)	100% (370/370)

Sentinel Stroke National Audit Programme (SSNAP)	>90% (495)
Other	
Elective surgery (National PROMs Programme)	65% (98/150)
Women's and Children's Health	
Epilepsy 12 audit (Childhood Epilepsy)	33*
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	100% (6/6)
Neonatal intensive and special care (NNAP)	100% (2494/2494)
Paediatric intensive care (PICANet)	100% (662/662)

* No case requirement outlined by national audit provider

The reports of 10 national clinical audits were reviewed by the provider in 2014/15. University Hospitals Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

British Thoracic Society (BTS) Emergency Oxygen Audit
- education sessions on oxygen prescription have been established for foundation year doctors
- oxygen prescription cards have been implemented in the medical admissions unit, and guidelines for the administration of oxygen have been updated
- a quality improvement project focusing on oxygen prescription is underway.

College of Emergency Medicine audits
- education and training around the management of patients with renal colic has been delivered to doctors and nurses within the emergency department at the BRI. This audit stressed the importance of pain control and the use of the urology referral form to capture required information. The department 'message of the week' was used to highlight learning from the audit
- fluid balance forms have been made available in the resuscitation area of the emergency department in the BRI to improve the management of patients with severe sepsis/septic shock.

National Cancer Audits
- data completeness has improved significantly (most key fields above national average) and full clinical checks for all audits in 2014
- the oesophago-gastric cancer audit was included in the centrally managed programme successfully for first time in 2014
- there has been an increase in proactive data collection; the majority of this work is now delegated to MDT coordinators and teams, supported by full guidance and data completeness trackers
- the Trust's cancer services manager continues to take lead role in advising the Cancer Register on configuration to support successful data collection, and is closely involved in national discussions regarding the future direction of the DAHNO (Data for Head and Neck Oncology) audit.

National Cardiac Arrest Audit (NCAA)
- further emphasis is being placed on DNACPR (do not attempt resuscitation) and TEPP (treatment escalation personalised plans) during resuscitation teaching sessions, with continued education about recognising deteriorating patients
- the Trust is now submitting data on paediatric cardiac arrests as well as adult.

National Diabetes Audit – Pregnancy in Diabetes
- a database or spreadsheet is to be created, which will allow capture of specific baseline data (for example folic acid prescribing) at the first clinic visit, and facilitate analysis of UH Bristol specific data
- liaison with primary care and education regarding pre-conception counselling regarding glycaemic control, folic acid use etc. is underway; discussions include a focus on the increasing proportion of women with Type 2 diabetes becoming pregnant, including high risk ethnic minority groups and obese women. The endocrine antenatal team will continue to run training days for community midwives

- the endocrine team is fully engaged with the established South West diabetes in pregnancy regional network to support regional service development, sharing of data and ideas, and agreeing consensus on best practice
- the capacity of the antenatal endocrine service is currently being reviewed, with a view to increasing the frequency of contact with patients to support improved glycaemic control.

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme

- the Trust's admission pro forma is being redesigned to help record the required patient data relating to their COPD exacerbation. This will include the ability to record the patient's DECAF (dyspnoea, eosinopenia, consolidation, acidaemia and fibrillation) score
- smoking cessation and referral to pulmonary rehabilitation is now a matter of course after introducing the formal discharge bundle of care
- the Trust is in the process of purchasing portable spirometers for its three respiratory wards and the medical assessment unit.

Falls and Fragility Fractures Audit Programme

- a new theatre improvement project is underway, specifically focused on orthopaedic theatre utilisation and efficiency
- job plan changes have been agreed that will improve the spread of trauma time across the week, and enable an additional hip fracture case to be undertaken at the start of planned limb reconstruction theatre lists
- new guidelines are being introduced for anaesthetising patients undergoing hip fracture repair.

The reports of 244 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2014/15; summary outcomes and actions reports are reviewed on a bi-monthly basis by the clinical audit group. UH Bristol has taken appropriate action to improve the quality of healthcare provided – full details will be published in the Trust's Clinical Audit Annual Report for 2014/15[9].

2.2.3 Participation in clinical research

We are proud of the research we lead and take part in, and of our contribution to the evidence that improves the care the NHS provides.

We are committed to offering patients the opportunity to take part in research when they are receiving relevant health services provided or sub-contracted by UH Bristol. The number of patients receiving relevant health services provided by University Hospitals Bristol NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 11,000; this was an increase over the previous year of 17 per cent. Of these patients, 86 per cent were recruited into research on the National Institute for Health Research (NIHR) portfolio. As of 31 March 2015, we have 725 active research projects, 67 of which are our own sponsored studies. They include clinical trials of investigational medicinal products, and interventional trials such as surgical trials.

Number of active non-commercial (portfolio) projects	431
Number of active non-commercial (non-portfolio) projects	138
Commercial studies registered	116 (89 portfolio studies)
Number of recruits in non-portfolio non-commercial trials	1,120
Number of recruits in portfolio non-commercial trials	9,896
Number of recruits in commercial trials	368

Over the last year, we have focused on a number of areas, including: developing high quality grant applications so our clinicians can contribute directly to how patient care is delivered through the evidence they generate; giving access to research for patients by opening important trials; increasing our efficiency in setting up grants; opening and recruiting into trials to make best use of the funding we receive; and encouraging industry partners to bring research to the UK.

Our collaborative working is very important to us. As a University Hospital, teaching, research and clinical care are strengthened by our NHS clinicians working alongside clinical academics

[9] Available via the Trust's internet site from July 2015

in our hospitals and across the city. We work closely with university colleagues to develop and deliver world class, pioneering research, with particular strength in surgical trials, through our two registered UK Clinical Research Collaboration Clinical Trials Units – the Royal College of Surgeons Bristol Centre for Surgical Research, and the Medical Research Council ConDuCT-II Methodology Research Hub.

Our key areas of NIHR grant activity in 2014/15 have been across a range of specialties, including: cardiovascular disease; diet, lifestyle and nutrition; ophthalmology; surgery; emergency medicine; rheumatology and infection.

One year into our relationship as host for the NIHR Clinical Research Network: West of England, our children's research staff have made a successful transition from the previous research network structures into a new divisional team within the Women's and Children's Division. This will broaden the opportunities for patients in those services to take part in research. Also a year old, NIHR CLAHRC West (Collaboration for Leadership in Applied Health Research & Care) is now established. It is working with clinicians and academics to change the way services are delivered across the region, focusing particularly on projects that improve the management of chronic diseases, public health interventions, and population health.

One of our most exciting achievements during the year was agreeing the first research CQUIN nationally. Designed to make research more widely available, we recruited our target number of patients with myeloma, tumours of the brain, coronary artery disease, and heart failure, broadening access to research for these patient groups in oncology and cardiology.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The amount of potential income in 2014/15 for quality improvement and innovation goals was approximately £9.63m based on the sums agreed in the contracts.

The delivery of the CQUINs is overseen by the Trust's clinical quality group. Further details of the agreed goals for previous years are available electronically at http://www.uhbristol.nhs.uk/about-us/how-we-are-doing/.

The CQUIN goals were chosen to reflect both national and local priorities. 24 CQUIN targets were agreed, covering more than 45 measures. There were three nationally specified goals: Friends and Family Test (staff FFT, early implementation in outpatients and day case, increase or maintain FFT response rate on wards and emergency departments), NHS Safety Thermometer (reduce the incidence of falls, and joint work with the community on pressure ulcers and infection control) and dementia care (improve case finding and referral for emergency admission, provide clinical leadership and education, provide support to carers).

The Trust achieved 18 of the 24 CQUIN targets and six in part, as follows:

- Friends and Family Test
- NHS Safety Thermometer
- dementia (partial)
- end of life
- discharge summaries
- deteriorating patient (partial)
- reduction in incidence of sepsis
- nursing and midwifery staffing
- cancer treatment summaries
- seven day working (partial)
- weight management support in maternity for obese women (partial)
- chronic heart failure
- implementation of COPD discharge bundle
- structured diabetes education programme for qualified nursing staff
- older people's rehabilitation (partial)
- quality dashboards

- Pelvic Floor Database
- highly specialised services clinical outcomes collaborative audit meeting
- increased clinical trial enrolment
- NICU – improved access to breast milk
- cardiac surgery – inpatient waits within seven days
- endocrinology outpatient coding
- medicines management audit/re-attendance rates
- perinatal pathology reporting times (partial).

2.2.5 Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The Trust received one CQC inspection during 2014/15.

Between 10 and 12 September 2014, the CQC carried out a comprehensive inspection of services at the Trust's Main Site[10], South Bristol Community Hospital and the Central Health Clinic. This was the first inspection the Trust had received under the CQC's new system of inspections; it included a review of compliance actions dating from previous CQC inspections of the Bristol Royal Hospital for Children in November 2013 and the Main Site in January 2014, as reported in last year's Quality Report.

Much of the CQC's report was positive; at our Main Site, emergency, maternity, end of life and critical care, and services for children and young people all received a good rating,; whilst medical, surgical and outpatient services were identified as requiring improvement. The leadership of maternity services and the effectiveness of services for children and young people were both highlighted by the CQC as outstanding. South Bristol Community Hospital and the Central Health Clinic[11] received ratings of good for all aspects of care.

Here are some examples for what our inspectors said:

"Safety was a priority for the Trust at every level"

"A shared sense of ambition for the Trust together with an energy and passion for improvement"

"Clear lines of responsibility and accountability from Board to ward"

"Well established frameworks and structures for risk management and quality measurement"

"Staff spoke consistently about the priority given to the quality and safety of patient care"

"Staff talked with real pride about their colleagues and the services that they provided"

In his report, Professor Sir Mike Richards, Chief Inspector of Hospitals, wrote:

"Every service at each location was found to be caring. We observed caring staff providing kind and compassionate care and treatment... There was evidence that staff regularly 'go the extra mile' in providing care."

In total, 44 out of 56 ratings were good or better, and no ratings were inadequate; however, the Trust's overall rating was requires improvement[12]. Areas identified by the CQC for improvement included staff training compliance, outpatient services, and the 'flow' of patients into hospitals and back out into the community. The Trust is working internally and with our partners in health and social care to reduce delays for ambulances arriving at the emergency department, and to ensure effective and timely discharge planning. The Trust's full CQC inspection report can be read at http://www.cqc.org.uk/provider/RA7.

[10] The Main Site is a registration term used by UH Bristol to encompass the following hospitals on its city centre campus: Bristol Royal Infirmary (including the Bristol Heart Institute), Bristol Royal Hospital for Children, St Michael's Hospital, Bristol Eye Hospital, Bristol Dental Hospital and Bristol Haematology and Oncology Centre

[11] The Central Health Clinic provides sexual health services

[12] Approximately 80% of NHS Trusts inspected under the new system have received this rating

Table 4

CQC ratings for UH Bristol Main Site

	Safe	Effective	Caring	Responsive	Well-led	OVERALL
Indicator	Good	Not Rated	Good	Requires Improvement	Good	Good
Medical care	Requires Improvement	Good	Good	Requires Improvement	Req Improvement	Requires Improvement
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical care	Good	Good	Good	Requires Improvement	Good	Good
Maternity and family planning	Good	Good	Good	Good	★ Outstanding	Good
Services for children and young people	Good	★ Outstanding	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients	Requires Improvement	Not Rated	Good	Requires Improvement	Requires Improvement	Requires Improvement
OVERALL	Req Improvement	Good	Good	Req Improvement	Req Improvement	

Note: We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients and diagnostic imaging.

Table 5

CQC ratings for South Bristol Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	OVERALL
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not Rated	Good	Good	Good	Good
OVERALL	Good	Good	Good	Good	Good	Good

Table 6

CQC ratings for Bristol Central Health Clinic

	Safe	Effective	Caring	Responsive	Well-led	OVERALL
Outpatients	Good	Not Rated	Good	Good	Good	Good
OVERALL	Good	Not Rated	Good	Good	Good	Good

[13] CQC Intelligent Monitoring draft report

The CQC has not taken enforcement action against the Trust in 2014/15 or issued any formal outlier alerts. UH Bristol's most recent CQC Intelligent Monitoring report lists the Trust in Band 5[13].

2.2.6 Data quality

UH Bristol submitted records during 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 99.4 per cent for admitted patient care; 99.7 per cent for outpatient care; and 96.0 per cent for accident and emergency care (these values are the same as in 2013/14)
- which included the patient's valid general practice code was: 100 per cent for admitted patient care; 100 per cent for outpatient care; and 99.7 per cent for accident and emergency care. (These are an improvement on 2013/14 validity scores).

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2014 - January 2015 as at Month 10 inclusion date).

UH Bristol's information governance assessment report overall score for 2014/15 was 66 per cent and was graded Level 2.

UH Bristol has not been subject to a national Payment by Results Audit in 2014/15, as the accuracy of clinical coding is within accepted norms.

In 2014/15, the accredited auditor for the Trust's clinical coding team undertook an audit of 100 Finished Consultant Episodes in cardiac surgery and cardiology. The following levels of accuracy were achieved:

- primary procedure accuracy: 98.9 per cent
- primary diagnosis accuracy: 90.0 per cent.

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

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

- the data quality programme involves a number of regular data quality checks and audits throughout the year, including checking against patient notes. This takes place across the Trust and all issues with data quality are reported back to the information risk management group for appropriate action
- internal audit has audited a sample of outpatient areas to check the accuracy of outpatient data on the Medway patient administration system this year. It recommended that there should be more checking of key patient data with the patient when presenting in clinic, particularly for GP practice details. It also recommended updating processes with systems to keep GP practice data updated. This has been completed, and the Trust has now achieved 100 per cent for valid GP practice code for admitted patients.

3 Review of services in 2014/15

3.1 Mandated quality indicators

In February 2012, the Department of Health and Monitor announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2014/15 is summarised in the table below. Where relevant, reference is also made to pages of our Quality Report, where related information can be found. The Trust is confident that this data is accurately described in this Quality Report. A Data Quality Framework has been developed by the Trust, which encompasses the data sets that underpin each of these indicators and addresses the following dimension of data quality: accuracy, validity, reliability, timeliness, relevance and completeness. The Framework describes the process by which the data is gathered, reported and scrutinised by the Trust. Further details are available upon request. (Comparisons shown are against a benchmark group of all acute Trusts, with the exception of patient safety incidents, where the benchmark group is acute teaching hospitals only).

Table 7

National comparative indicators

Note: historical data published by the HSCIC has been adjusted during the last 12 months – this accounts for discrepancies between data listed in this table and corresponding figures published in last year's Quality Report.

Mandatory indicator	UH Bristol 2014/15	National average 2014/15	National best 2014/15	National worst 2014/15	UH Bristol 2013/14	Page ref.
Venous thromboembolism risk assessment	98.0% Apr-Dec14	96.0% Apr-Dec14	100% Apr-Dec14	87.7% Apr-Dec14	98.0%	28
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)	14.6 Apr14-Jan15	15.0 Apr14-Jan15	0 Apr14-Jan15	60.5 Apr14-Jan15	14.6	29
Rate of patient safety incidents reported per 1,000 bed days	54.80 Apr14-Sep14	35.38 Apr14-Sep14	94.84[14] Apr14-Sep14	0.24 Apr14-Sep14	46.28	35
Percentage of patient safety incidents resulting in severe harm or death	0.44% Apr14-Sep14	0.49% Apr14-Sep14	0% Apr14-Sep14	4.2% Apr14-Sep14	0.36%	36
Responsiveness to inpatients' personal needs	Comparative data for 2013/14 (2012/13 in brackets): UH Bristol score 71.7 (72.4); England median 68.1 (67.4); low 54.4 (57.4); high 84.2 (84.4). Comparative data for 2014/15 will not be available from the Health & Social Care Information Centre until August 2015).					N/A
Percentage of staff who would recommend the provider	70.5% 2014 Staff Survey	67.5% 2014 Staff Survey	92.8% 2014 Staff Survey	38.2% 2014 Staff Survey	74.1% 2013 Staff Survey	47
Summary Hospital-level Mortality Indicator (SHMI) value and banding	95.8 (Band 2 'As Expected') Jul13-Jun14	100 Jul13-Jun14	54.1 Jul13-Jun14	119.8 Jul13-Jun14	96.1 (Band 2 'As Expected') Apr13-Mar14	52
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'	21.7% Jul13-Jun14	24.8%	0%	49.0%	22.3% Apr13-Mar14	N/A
Patient Reported Outcome Measures	Comparative groin hernia data for 2013/14: 88.9% of UH Bristol patients reported an improved EQ-5D score (national average 50.6%); 33.3% of UH Bristol patients reported an improved EQ-VAS score (national average 37.3%). UH Bristol PROM data for varicose veins does not meet the publication threshold due to small sample size.					56
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for 2012/13, 2013/14 or 2014/15 from the Health & Social Care Information Centre.*					59
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for 2012/13, 2013/14 or 2014/15 from the Health & Social Care Information Centre.*					59

* this is the same data we reported last year – at the time of writing, more recent data is not available from the Health & Social Care Information Centre.

[14] High levels of reporting are indicative of a positive patient safety culture; the aim is to achieve high levels of reporting accompanied by low levels of incidents resulting in severe harm or death (the goal being zero)

3.2 Patient safety

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

What our patients said in our monthly survey

"The treatment and care I received was absolutely first class - excellent all round care. All the staff were highly professional and caring. I felt completely in safe hands."

3.2.1 Patient falls

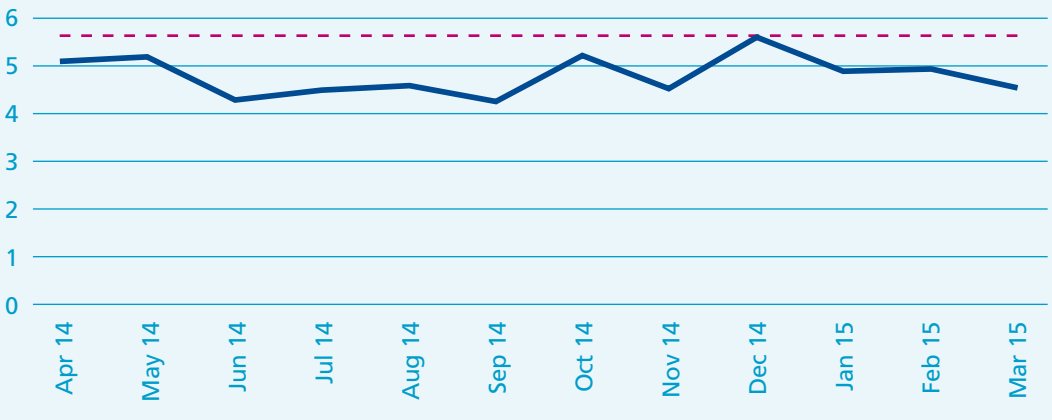
Falls and fractures are a common and serious problem affecting older adult inpatients. Over 250,000 falls are reported each year from hospitals in England alone, resulting in significant personal and financial consequences (Royal College of Physicians 2012).

In 2014/15, we continued to focus on reducing the numbers of inpatient falls and incidences of harm. Common themes identified during the year were that the majority of falls were unwitnessed and age related, with over half of falls occurring in people with a degree of cognitive impairment.

Actions to prevent falls recommended in the Royal College of Physicians Fallsafe report (an evidenced based, multi-professional approach to managing and preventing avoidable falls in hospital) continued to be embedded into clinical practice at UH Bristol in 2014/15, resulting in a reduction in falls over the course of the year. UH Bristol's falls assistant was able to offer bespoke, face to face training in those areas reporting a higher numbers of falls.

Figure 1

Rate of falls per 1000 bed days, Trust total



Rate of falls per 1000 bed days
Target

Source: Falls Base data, UH Bristol

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.

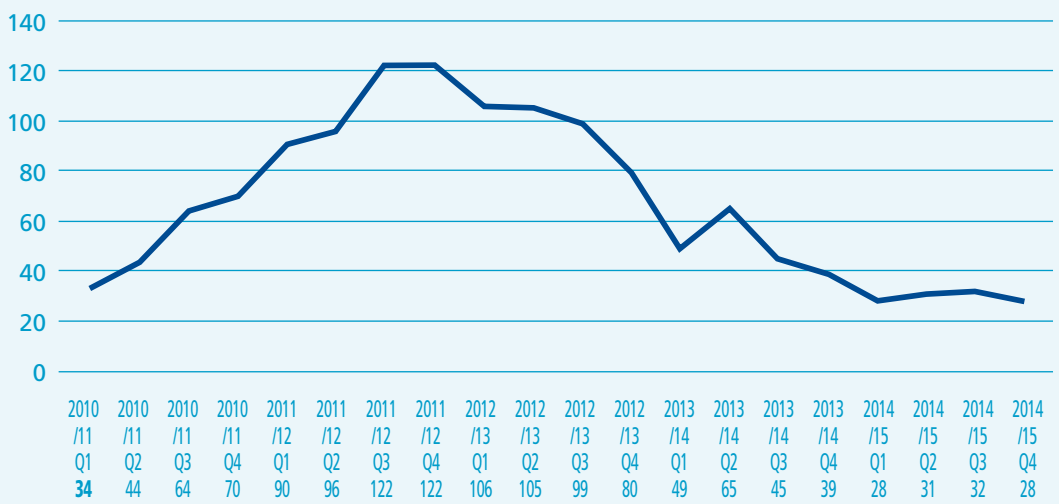
3.2.2 Pressure ulcers

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)

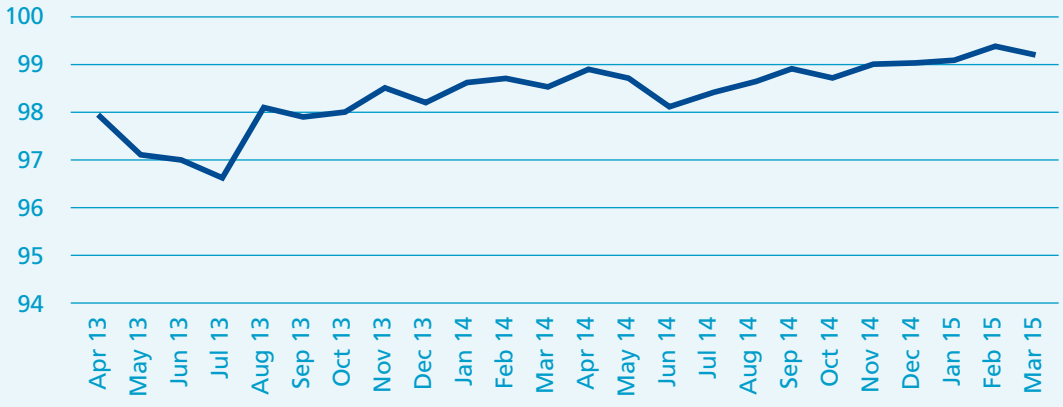
In 2014/15, we have consolidated on our strong performance in 2013/14 and have consistently achieved the required target of greater than 95 per cent of adult inpatients being risk assessed for risk of venous thromboembolism (VTE). For the year as a whole, we achieved 98.8 per cent[15]; this compares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

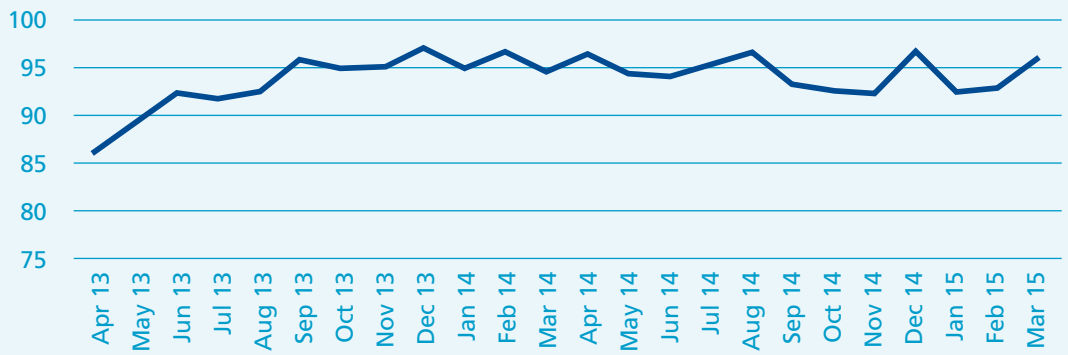
The Trust considers its VTE risk assessment data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework.

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.

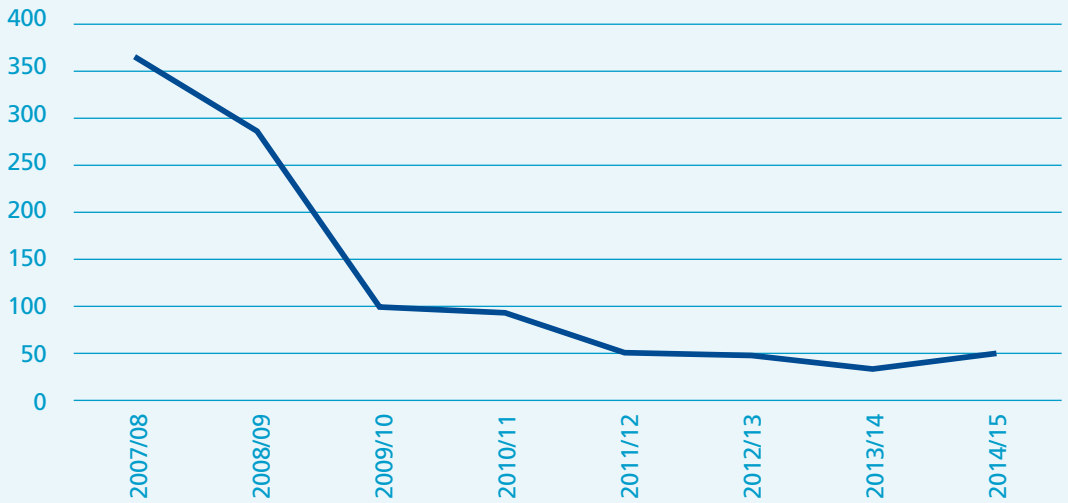
Possible reasons for the increase in the total number of *Clostridium difficile* infections include:

- 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

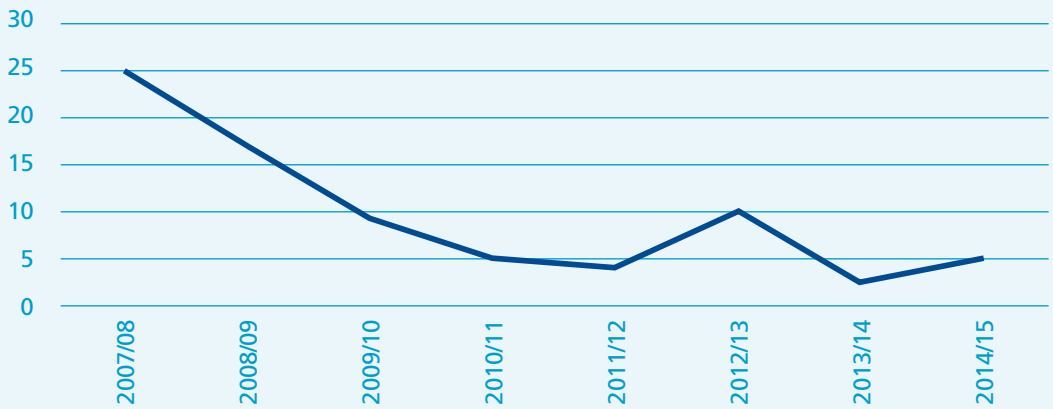
Disappointingly, the target of zero MRSA (Meticillin-resistant Staphylococcus aureus) bacteraemias was not achieved in 2014/15, with five cases being reported; an increase on the two cases reported in 2013/14. Of these five cases, three were patient infections. One case was confirmed to be a contaminated 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.

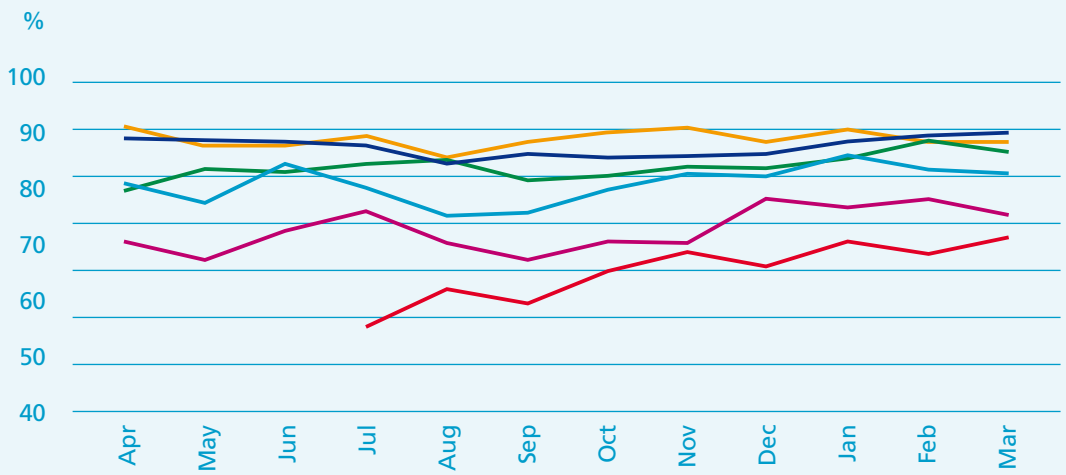
[17] An indwelling catheter, cannula, or other instrument used to obtain venous or arterial access

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.

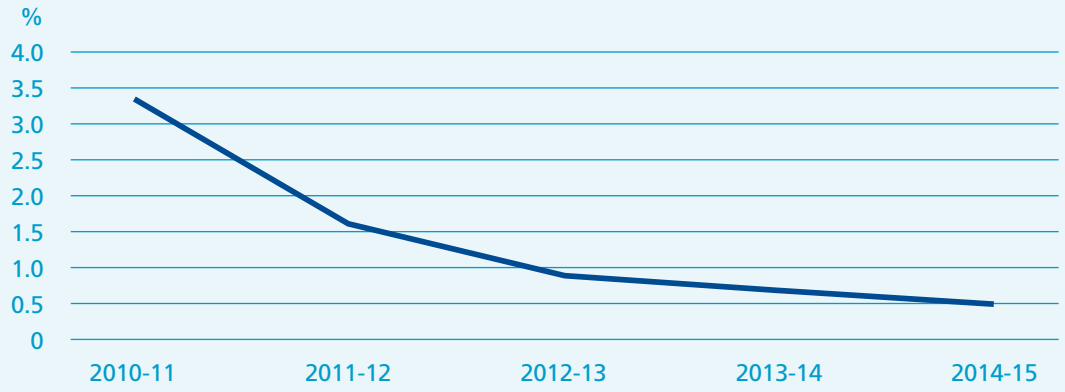
Patient Safety Alert NHS/PSA/D/2014/005 focused upon effective reporting of medication error incidents, and ensuring that lessons are learned within the organisation. This alert was implemented in a timely manner, with a Trust medication safety officer assigned to co-ordinate the regular review of all 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

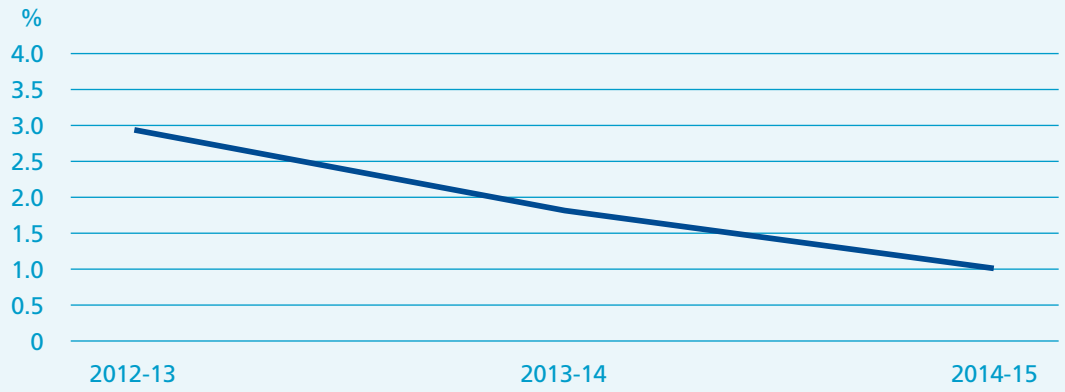
As in 2013/14, we set ourselves the goal of reducing omitted doses of critical medicines. This is important to patient safety and quality of care, to ensure that the patient receives the maximum benefit from their medicines and avoids harm. From the improved baseline at the end of 2013/14 (1.91 per cent 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

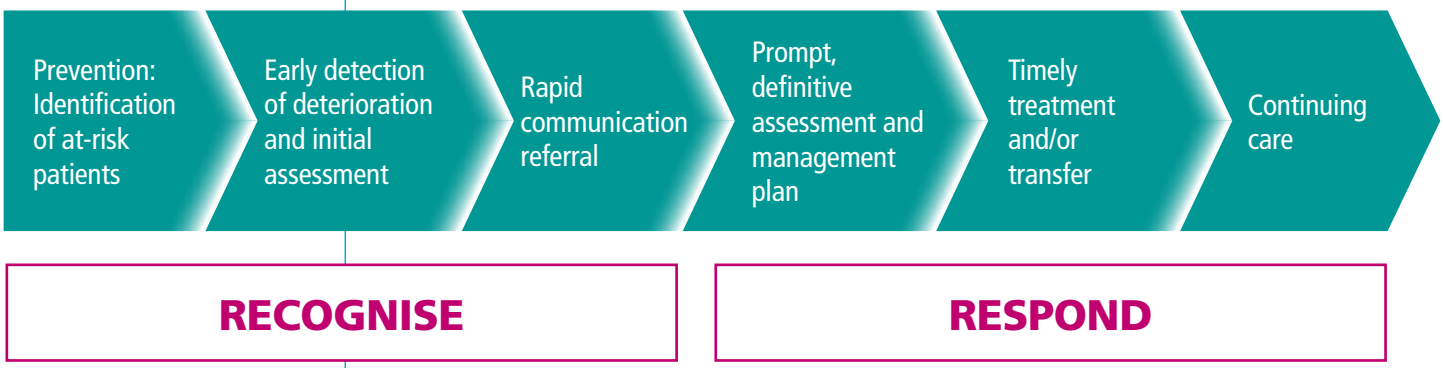
Percentage of patients with one or more critical medicines missed



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

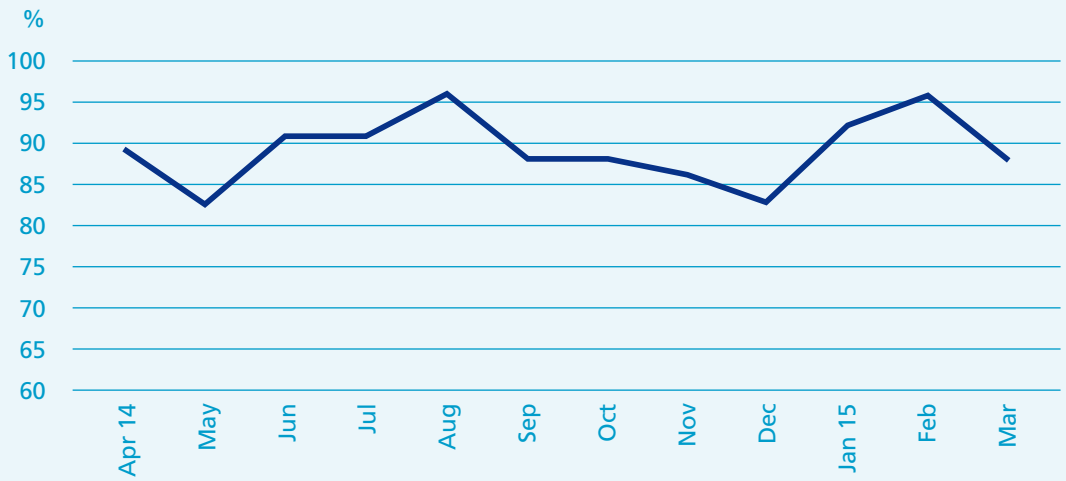
[20] Treatment escalation plans recognise that disease processes towards the end of life can be complex with varying elements of reversibility, and that 'do not attempt resuscitation' decisions can be too blunt an instrument in some circumstances.

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

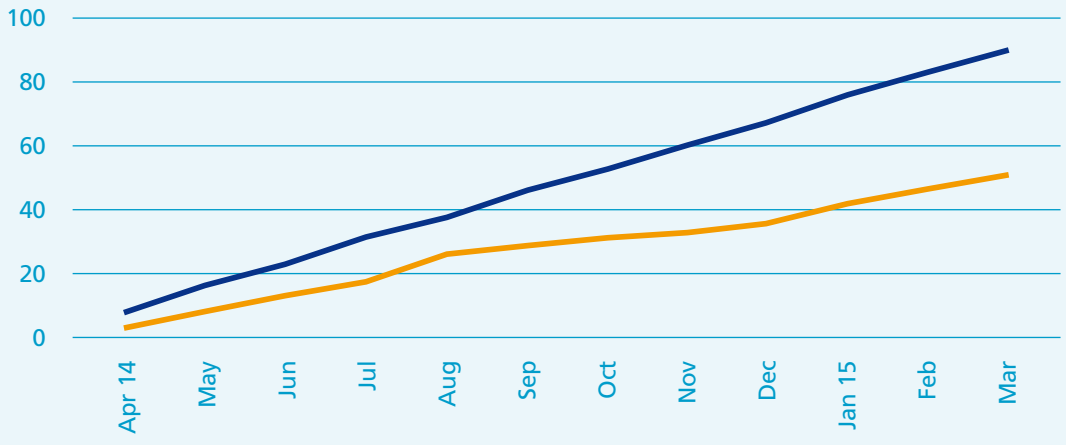
Percentage of adult patients who had a documented response to an Early Warning score of 2 or more



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.

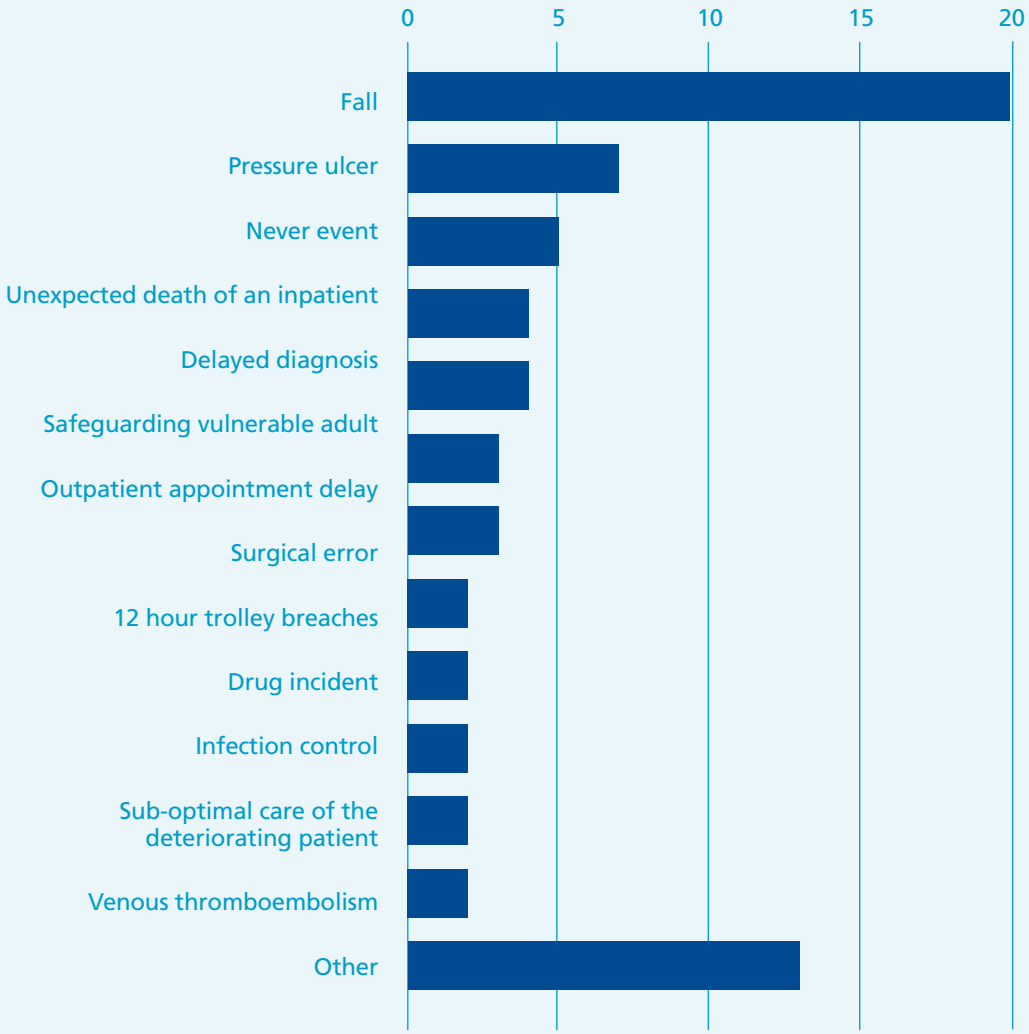
3.2.8.1 Learning from serious incidents

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.

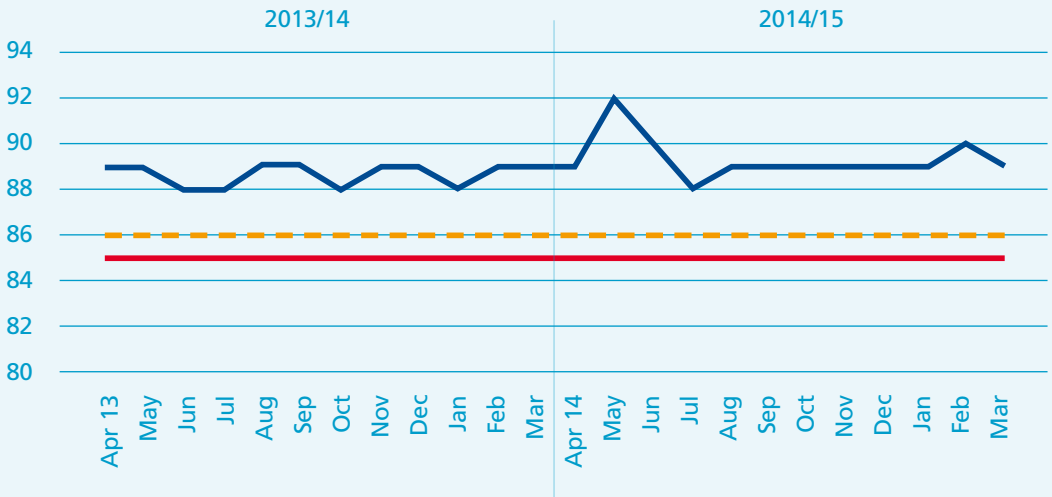
This is a key quality assurance indicator that is reported to our Trust Board each month. If our high standards were to begin to slip, this would be identified in the survey, and actions would be taken to remedy this. Throughout 2014/15, our tracker score has been consistently above our minimum target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



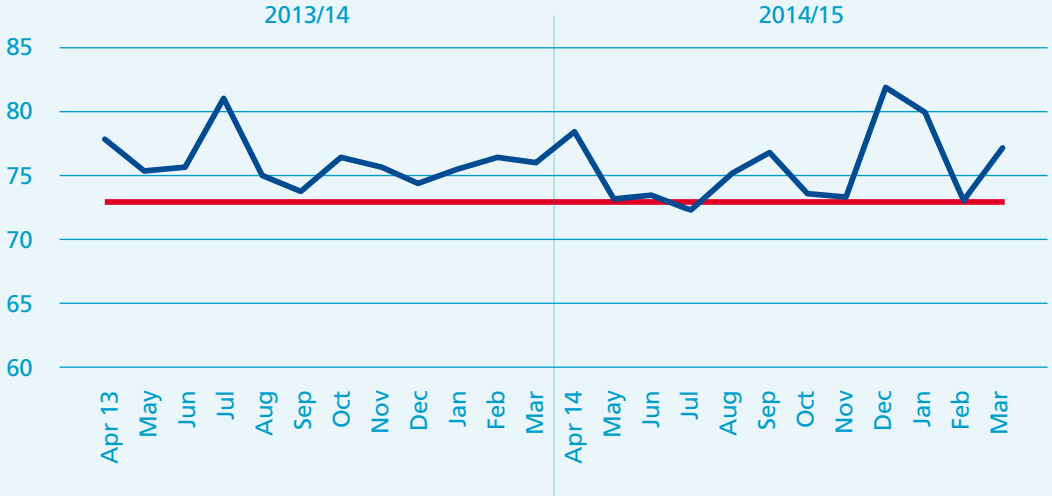
Inpatient experience tracker score
Alert threshold (amber)
Alert threshold (red)

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)



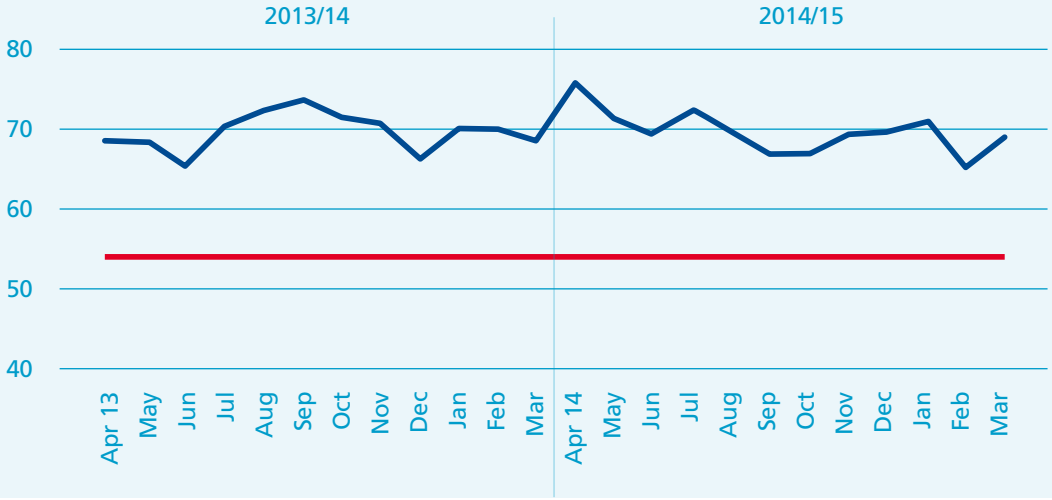
UH Bristol
National average (14/15)

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)

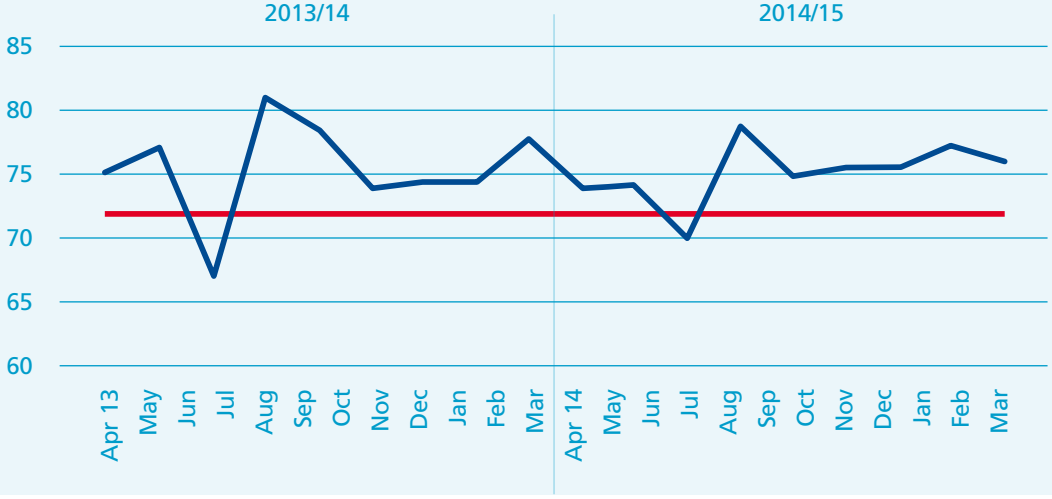


UH Bristol
National average (14/15)

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)

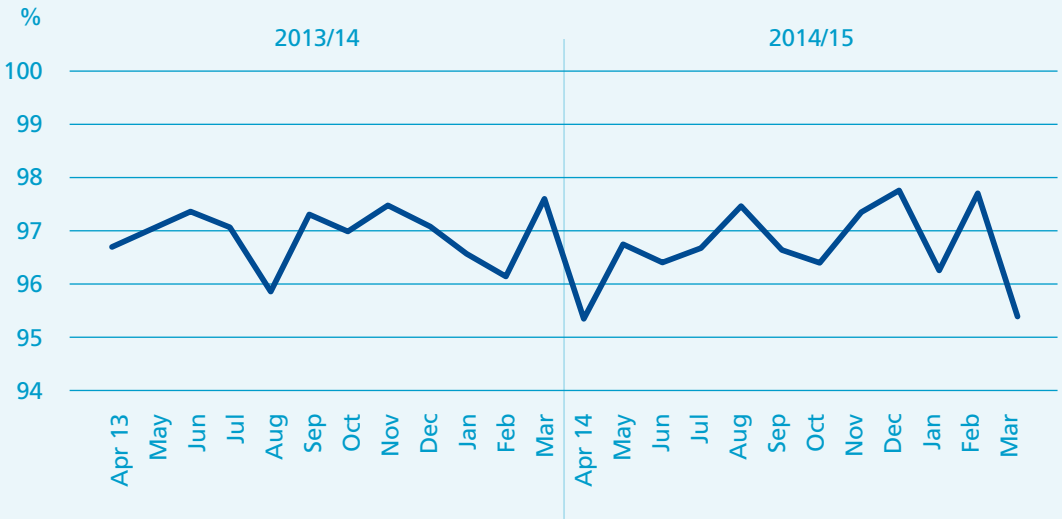
Source: UH Bristol Friends and Family Test survey

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

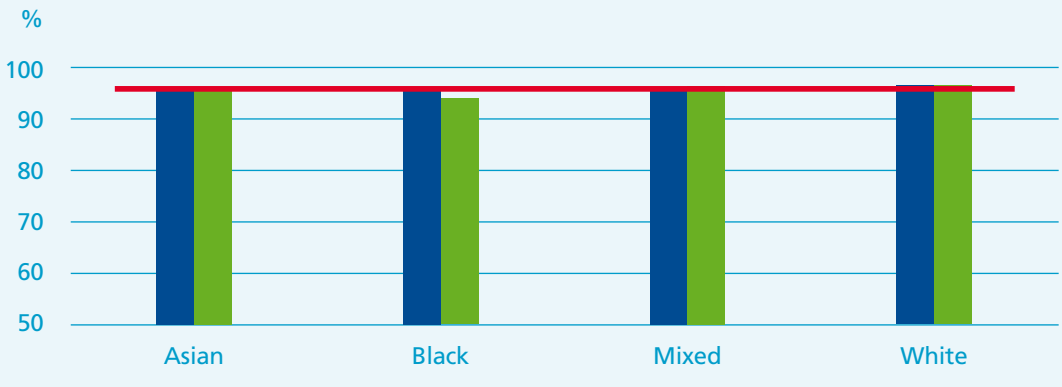


Source: UH Bristol monthly inpatient and parent survey

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

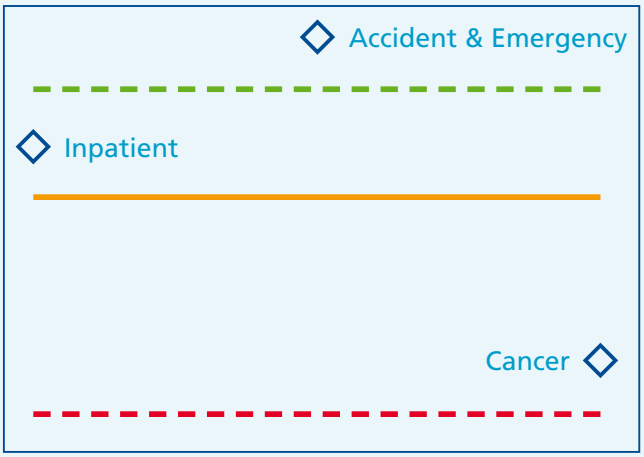
	Comparison to national average		
	Above (better)	Same	Below
National inpatient survey (2013)	0	59	1
National A&E survey (2014)	2	33	0
National cancer survey (2013)	2	30	28

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)

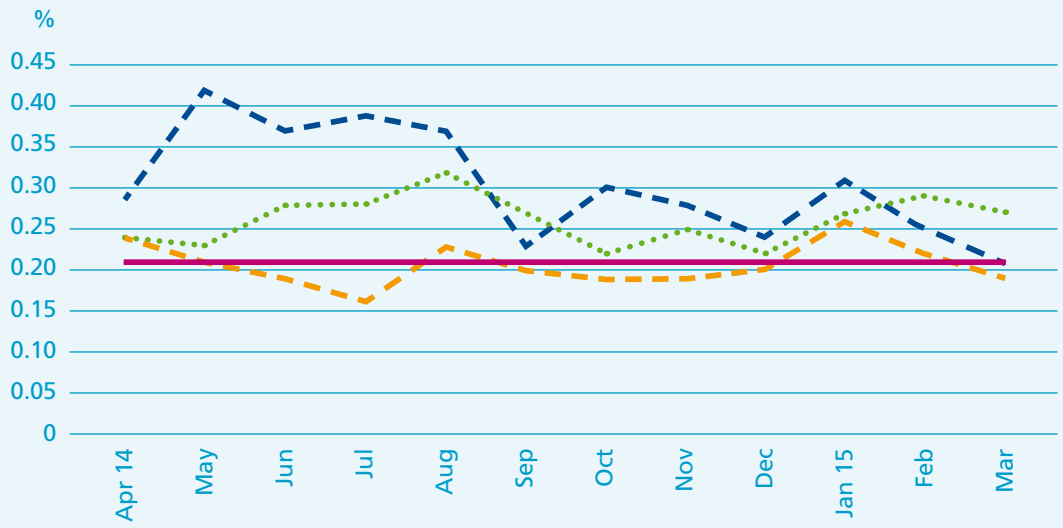
3.3.3 Complaints

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

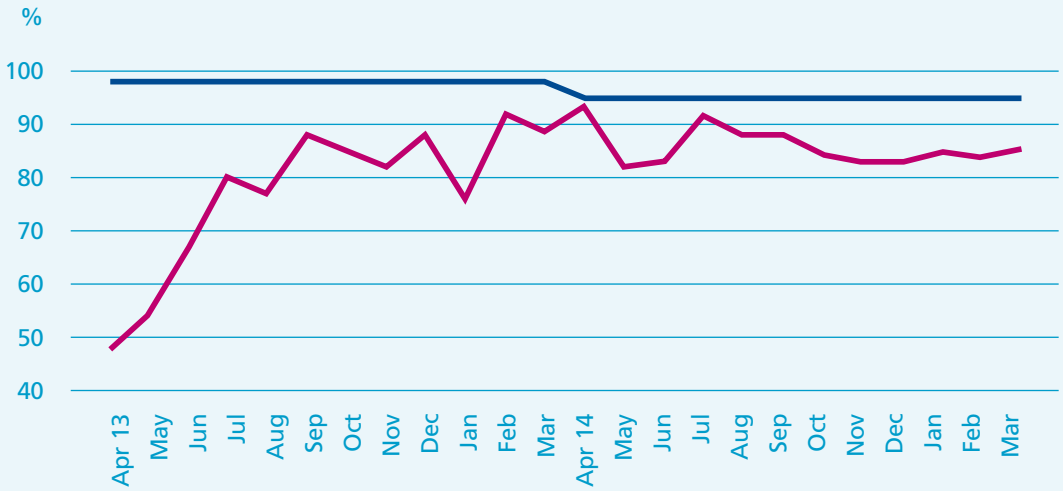
Source: UH Bristol Ulysses Safeguard system

[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



Target
Actual performance

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

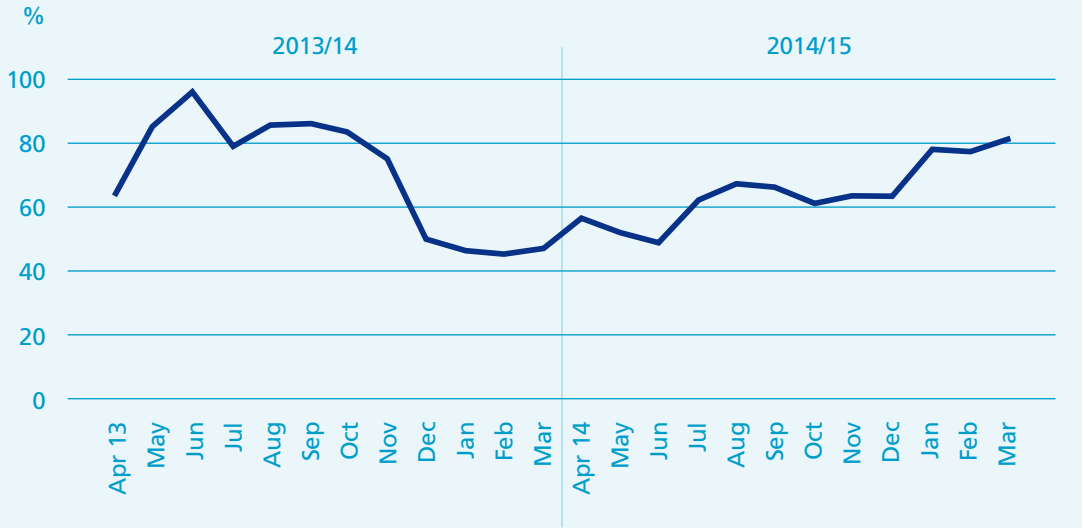
with dementia and their carers. We hold a champions' conference each year jointly with North Bristol NHS Trust, plus an annual UH Bristol dementia conference to celebrate good practice and share learning.

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*

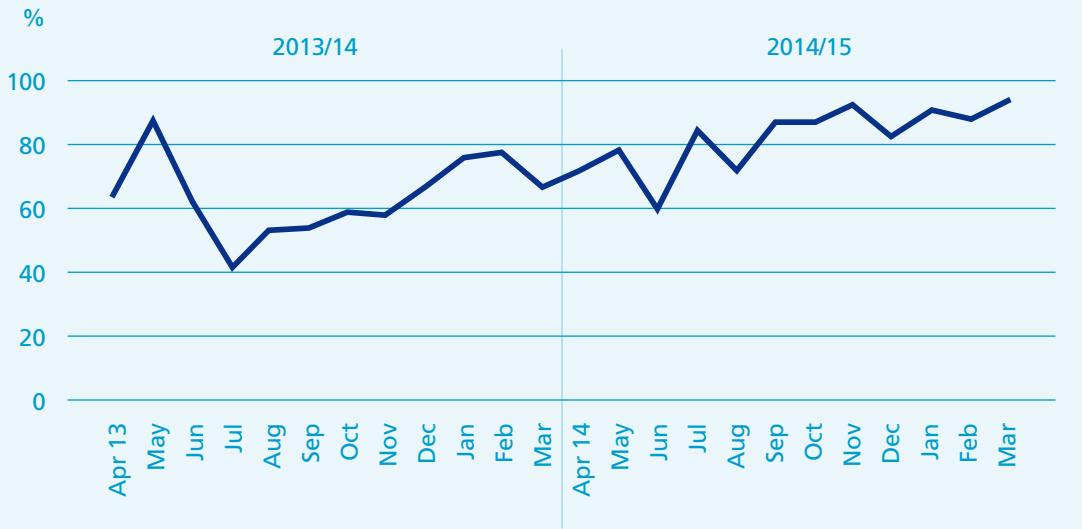


Source: UH Bristol eHandover system

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:

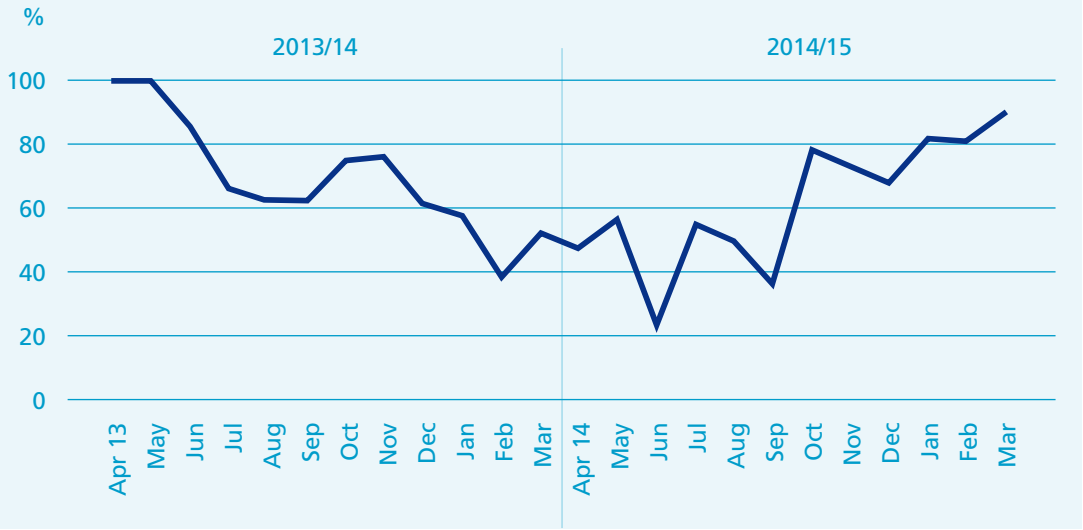
"I feel very supported by all staff members!"

"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.

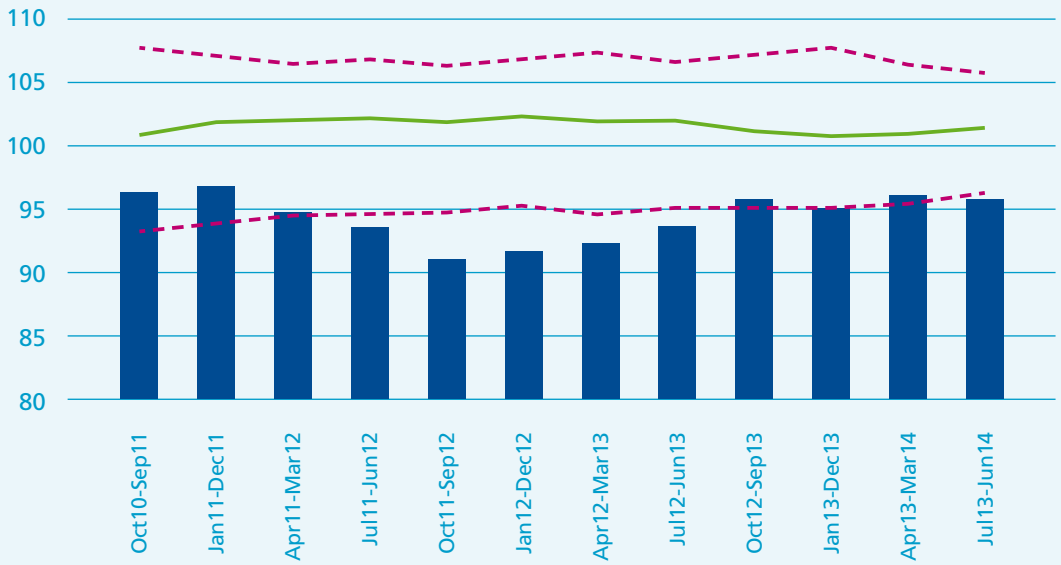
The number of paediatric cardiac cases performed in the children's hospital has remained constant over the last five years, at approximately 325 cases per year. Over this time, crude survival following cardiac surgery in our unit has continued to improve, and in 2014/15 was 98.8 per cent. This is well 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

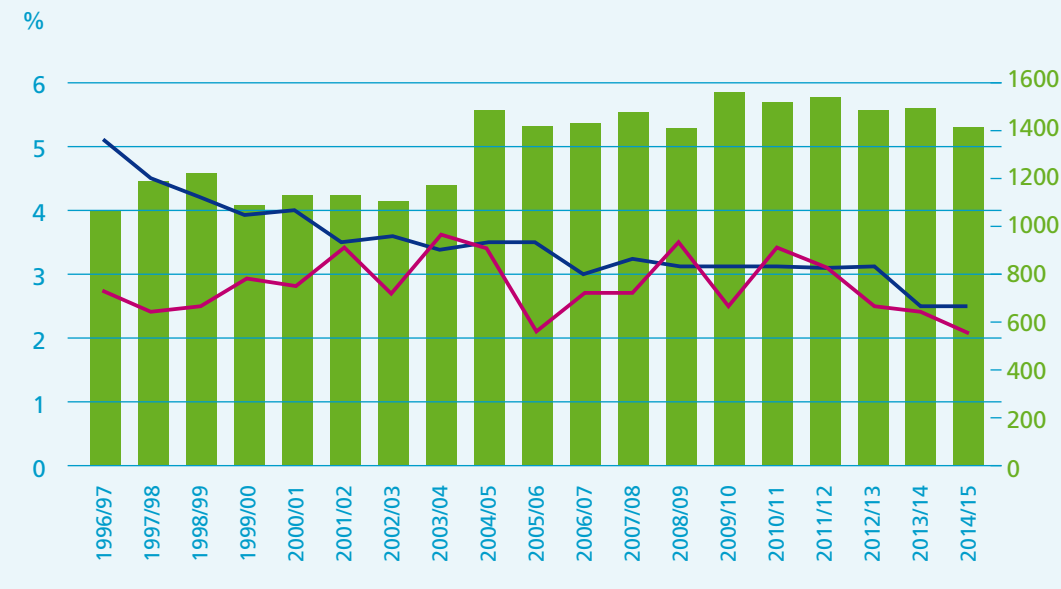
Summary Hospital-level Mortality Indicator (SHMI)



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,

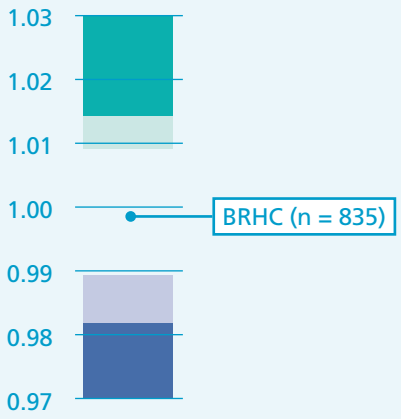
we revised and modified the department's website in accordance with suggestions from parents; our information leaflets have similarly been revised and sent out to parents for review and comment. At the most recent listening event, we focused on the issue of consent for treatment: making sure that parents 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



Survival much higher than predicted
Survival higher than predicted
Survival lower than predicted
Survival much lower than predicted

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.

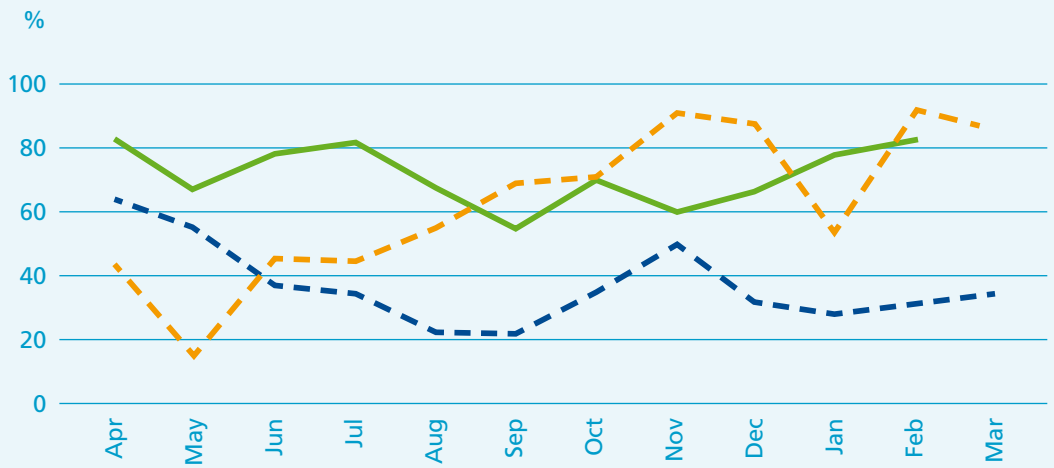
Expansion of the workforce supporting ortho-geriatric review has led to significant improvements in this aspect of practice, with the 90 per cent standard being exceeded in 2014/15 at 94 per cent, compared to 78.8 per cent in the previous year.

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.

C

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.

University Hospitals Bristol NHS
NHS Foundation Trust

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

Item 12c – Quality Objectives for 2015/16

Purpose

Purpose

The purpose of this report is to provide governors with an update on the achievement of corporate quality objectives for 2015/16.

Key issues to note

In May 2015, the Board approved the Trust's Quality Report for 2014/5, which included a number of specific quality objectives for 2015/16. Progress towards achieving these objectives is tracked by the Board in the monthly quality dashboard (where appropriate) and also via more detailed quarterly updates, the first of which is presented here.

Quarter 1 performance :

We said we would:	Q1 progress	Year-end prediction
1. Reduce the number of cancelled operations	**RED**	**AMBER**
2. Minimise inappropriate patient moves between wards (time and place)	**RED**	**GREEN**
3. Ensure patients are treated on the right ward for their clinical condition	**GREEN**	**GREEN**
4. Improve patient discharge	**RED**	**AMBER**
5. Improve how the Trust communicates with patients	**GREEN**	**GREEN**
6. Improve the quality of written complaints responses	**AMBER**	**GREEN**
7. Improve the management of sepsis	***Not rated***	***Not rated***
8. Improve the experience of cancer patients	**GREEN**	**GREEN**
9. Reduce appointment delays in outpatients, and keep patients better informed about delays	**AMBER**	**GREEN**

Recommendations

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

Report Sponsor or Other Author

Sponsor – Chief Nurse, Carolyn Mills

Author – Chris Swonnell, Head of Quality (Patient Experience & Clinical Effectiveness)

Appendices

Appendix A – Quarter 1 Review of Quality Objectives

University Hospitals Bristol NHS
NHS Foundation Trust

Subject: **Quarter 1 update on Corporate Quality Objectives**

Report to: **Quality & Outcomes Committee**

Author: **Chris Swonnell, Head of Quality (Patient Experience and Clinical Effectiveness)**

Date: **22nd July 2015**

Introduction

In May 2015, the Board approved the Trust's Quality Report for 2014/5, which included a number of specific quality objectives for 2015/16. Progress towards achieving these objectives is tracked by the Board, in the monthly quality dashboard (where appropriate), and also via more detailed quarterly updates, the first of which is presented here.

Quarter 1 performance

We said we would:	Q1 progress	Year =end prediction
1. Reduce the number of cancelled operations	**RED**	**AMBER**
2. Minimise inappropriate patient moves between wards (time and place)	**RED**	**GREEN**
3. Ensure patients are treated on the right ward for their clinical condition	**GREEN**	**GREEN**
4. Improve patient discharge	**RED**	**AMBER**
5. Improve how the Trust communicates with patients	**GREEN**	**GREEN**
6. Improve the quality of written complaints responses	**GREEN**	**GREEN**
7. Improve the management of sepsis	***Not rated***	***Not rated***
8. Improve the experience of cancer patients	**GREEN**	**GREEN**
9. Reduce appointment delays in outpatients, and keep patients better informed about delays	**AMBER**	**GREEN**

Quality objectives

Objective 1	**To reduce the number of cancelled operations**
Rationale and past performance	We set this objective last year, but did not achieve our goal. Our target in 2014/15 was to reduce the percentage of operations cancelled at the last minute for non-clinical reasons. Performance in 2013/14 was 1.02 per cent; our target for 2014/15 was 0.92 per cent; we achieved 1.08 per cent.
What do our patients say?	"The biggest problem is the cancellation of operations. I sat nervously all day in my op gown all ready to go to be informed by an anaesthetist that my op had been cancelled, and I was to await more information. It never came and a staff nurse had to go and find out for me. I had the op the following day. These sort of things do nothing for patients' mental and psychological well- being." "I had mentally prepared myself for the operation I had which was major surgery and there was the possibility of a number of complications during and after surgery. On two occasions my operation was cancelled whilst I was in the admissions ward - the first time after a seven hour wait and the second time after an 8 hour wait. On both occasions I had pre-op procedure and nil by mouth 9 hours before arriving at the hospital. This I found to be quite upsetting mentally, although a number of reasons for the cancellation were given."
What will we do?	Review standard operation procedure; audit reasons for last minute cancellations and develop plan according to findings; link into Urgent Care work programme.
Measurable target/s for 2015/16	The indicator will be the number of operations cancelled on the day of operation/admission for non-clinical reasons. Our goal is to achieve last year's target – 0.92 per cent.
How progress will be monitored	Through divisional performance reporting.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	Q1 performance of 1.19% was above (worse than) the target of 1.02%. This was due to the following exceptional causes of cancellations. These exceptional causes were: 1) Cardiac Intensive Care Unit (CICU) bed availability impacting on April and May (11 cancellations in April and May combined, compared with an average of 2.5 in the previous four months) – due to patient acuity and associated difficulties staffing all possible CICU beds; 2) Bristol Royal Hospital for Children's bed availability in May and early June (14 cancellations in May, compared with an average of 2.3 per month in the four previous months) – due to emergency admissions being 18% above the same period last year; this is an increase above the baseline levels that include the impact of Centralisation of Specialist Paediatrics and Frenchay Emergency Department transfer. 3) Consultant off sick for one day, for two high volume surgical lists, which unusually resulted in nine last-minute

	cancellations in April. Adjusted performance, excluding the exceptional levels of cancellations as detailed above, equates to a cancellation rate of 0.95% for April and May. A specialty level action plan has been developed to reduce both underlying levels of cancellation and cancellations identified as being exceptions to the norm.
RAG - Q1 performance	**RED**
RAG - End of year prediction	**AMBER**

Objective 2	**To minimise inappropriate patient moves between wards (time and place)**
Rationale and past performance	We set this objective last year, but did not achieve our goal. Our target in 2014/15 was to reduce the average number of ward moves per patient. Performance in 2013/14 was 2.26; our target for 2014/15 was 1.92; we achieved 2.32. An "inappropriate" patient move is one which happens for reasons which are not related to that patient's clinical circumstances.
What do our patients say?	"I was woken in the middle of the night to be moved to another room, I wasn't happy about it, but did understand that my bed was needed by someone who needed constant supervision." "I moved wards more than once and more from South Bristol to BRI. Communication of these moves should have prepared me better - at times I had less than 1hr. My friends were not sure what hospital or ward I was on (don't have a mobile) and staff too busy to organise mobile phone."
What will we do?	Agree inclusion and exclusion criteria and develop a standard operating procedure.
Measurable target/s for 2015/16	The indicator will be the average number of ward moves per patient, for patients staying a minimum of two nights. Our goal is to achieve last year's target – an average of no more than 1.92 moves per patient.
How progress will be monitored	Progress with this objective will be monitored through emergency access steering group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	Q1 performance (to date) of 2.22 moves per patient was above (worse than) the target of 1.92. However, progress is being made and lower bed occupancy was achieved in Q1. The layout of the wards and the increase in single rooms in the new build have decreased the necessity to move patients to address gender, specialty, acuity and isolation requirements. The increase of Medical beds has enabled a lower occupancy ratio for the Division. This has resulted in a number of vacant beds in the assessment areas and specialty wards, allowing patients to be placed in the right bed for their specialty.

	The Ward Moves Tracking report is now available to the Clinical Site Management Team. The report allows the team to identify the number of ward moves that an individual has made during their current episode of care. Work is in progress to map the Surgical patient pathways to decrease length of stay and to achieve 'Right Patient, Right Bed'.
RAG - Q1 performance	**RED**
RAG - End of year prediction	**GREEN**

Objective 3	**To ensure patients are treated on the right ward for their clinical condition**
Rationale and past performance	We set this objective last year, but did not achieve our goal. Our target in 2014/15 was to reduce the total number of outlier bed days. Performance in 2013/14 was 10,622; our target for 2014/15 was 9,029; we reported 11,216 outlier bed days for 2014/15 as a whole. There was a significant reduction in outlier bed days in February and March 2015 as expected.
What do our patients say?	"I was an inpatient for 3 weeks I was only on the ward I should have been on for one of those weeks. I would have been much happier if I could have been on the correct ward for the whole of my stay as I felt I was just being put anywhere. I was moved 3 times before I went to the right ward."
What will we do?	Link into pathway review work and urgent care programme
Measurable target/s for 2015/16	As in 2014/15, the indicator will be the total number of bed days patients spent outlying from their correct specialty ward. Our goal is to achieve last year's target – no more than 9,029 outlier bed days in total, with seasonally adjusted quarterly targets.
How progress will be monitored	Progress with this objective will be monitored through emergency access steering group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	There has been good progress in reducing the number of outlier bed days – average of 685 per month in Q1 compared to target of 814. The bed modelling in the Divisions of Medicine and Surgery identified the capacity requirements for each quarter. Subsequent ward changes, resulting in an increased Medicine bed base, have seen the number of medical outliers reduce significantly in Q1. Work is in progress to map the surgical patient pathways to decrease length of stay and to achieve 'Right Patient, Right Bed'. Work continues to reduce the number of delayed transfer of care patients in the Trust which will release acute beds further.
RAG - Q1 performance	**GREEN**
RAG - End of year prediction	**GREEN**

Objective 4	**Improving patient discharge**
Rationale and past performance	Not achieving our SAFER[1] bundle standards or timely discharge planning.
What do our patients say?	"My overall experience of the stay in hospital was very good. Only thing that could have been better was the time it took in the discharge lounge to receive the medication." "It would be helpful to know of your discharge the day before, with the understanding that the final decision is made by the doctor on the day." "Even though we were aware of discharge date and confirmation was given that morning we waited hours for a discharge letter."
What will we do?	We will ensure more patients are discharged in a timely manner. We will adhere to all aspects of our discharge 'bundles' – delivering our discharge standards every time. The recent Breaking The Cycle Together (BTCT) week had a significant focus on patient discharge; it is proposed that the detail of this objective will be finalised as part of the BTCT programme review process, and may become a transformation project for 2015/16.
Measurable target/s for 2015/16	1. At least 1,100 patients per month to be discharged between 7am and 12 noon (this will be a stretching target – the highest monthly total during 2014/15 was 992; performance in March 2015 was 887). 2. Percentage of wards in scope that complete the Trust's ward processes implementation project (target 100%).
How progress will be monitored	Via transformation board (to be confirmed).
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	The ward processes work stream continues throughout the Division of Medicine. The key areas of focus are: • Reverse Triage and EDD • Effective Board Rounds • Planning for Discharge This project is aimed at achieving a pro-active approach to discharge planning to improve the number of earlier in the day discharges and use of the Discharge Lounge as well as improving the patient experience. The "2ward processes" pilot on ward B404 has demonstrated the impact of this approach – the ward achieved an increase of 18% of discharges before noon in the pilot week. Roll out of the pilot to all medical wards is now underway. 845 patients were discharged between 7am and noon during April, 838 in May and 864 in June.
RAG - Q1 performance	**RED**
RAG - End of year prediction	**AMBER**

[1] Senior review, Assessment, Flow, Early discharge and Review

Objective 5	**To improve how the Trust communicates with patients**
Rationale and past performance	A large proportion of complaints and informal feedback received by the Trust relate to the poor quality of written and telephone communications patients and carers have with the Trust. In response to this, the executive team has commissioned a Trust-wide improvement project to identify key areas of improvement required, and leads/project groups to deliver the required improvement in specific areas. The project will last for at least two years.
What do our patients say?	"The automatic appointment system left me extremely anxious. NO indication as to which ward I should report to, level or who for my pre-op appointment which came out of the blue - a real shock. I finally had to telephone my referral doctors secretary to get the name of your surgeon to find out who to contact. The appointment line was having 2 days training session so had to wait until after the weekend - day before at 7.30am appointment to find out. I am sure with everything else so well run you would like to look into this system." "Letter referred to MDT. What is that? Plain language would help. Previous letters have been very tardy in being signed/posted or on one occasion, not received at all." "I had to phone for my follow up appointment, I am receiving that 2 weeks later than I was told. I would still be waiting if I had not contacted them. This is not the first time this has happened, I feel your clerical side needs looking into."
What will we do?	In 2015/16, we will focus on improving the quality of appointment letters sent to patients. We will: - define the scope of the project - establish a project steering group and specific project groups/individuals to lead workstreams - monitor delivery against the actions identified and, wherever possible, undertake regular measurement to provide assurance of progress, completion and impact.
Measurable target/s for 2015/16	This is a developmental objective. Our goal is to improve the quality of, and standardise the format of, all appointment letters that are sent to patients (electronically and non-electronically generated). We will test this through proactive engagement with patients (for example via surveys or focus groups).
How progress will be monitored	Via steering group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	The central project within scope for 2015/16 will be a review of patient letters. A new Patient Letters Group has been formed to take this work forwards and will meet for the first time on 6th July 2015. Additional communication projects for 2015/16 will include: - Development of the Trust's web site - Trust responses to feedback posted via social media - Evaluation of way-finding project to ensure that our hospital estate is easy to navigate for patients

	- Improving the standards of patient information letters - Re-tendering for translating and interpreting services, including support for deaf patients - Improving the quality of complaints responses (see separate quality objective below)
RAG - Q1 performance	**GREEN**
RAG - End of year prediction	**GREEN**

Objective 6	**To improve the quality of written complaints responses**
Rationale and past performance	Too many complainants tell us that they are dissatisfied with our complaints responses. Our response letters are consistently detailed and professional, but they often lack empathy and occasionally fail to address key issues. The choice of objective is supported by feedback from Bristol Clinical Commissioning Group (CCG) quarterly reviews and the findings of an independent review by the Patients Association. In 2013/14, 62 complainants contacted us because there were aspects of our complaints response that they were dissatisfied with; in 2014/15, this figure had increased to 84.
What do our patients say?	"Language barrier and many people scared to complain because it's very difficult if person can't explain exactly the situation. I explained my situation, but when I get response I ignore letter because was too complicated and too many things I didn't understand." "The reply letter I received was quite defensive. It gave me the impression they were responding just because they had to rather than genuinely apologising for my upset." "The letter in fact said in some cases 'This is obviously unacceptable and we apologise' but it didn't say what action they would then take."
What will we do?	We will: - roll out targeted training to all divisions - continue to deliver complaints training as part of the Leadership for Leaders course - introduce a good practice checklist to be completed for all complaints - update the Trust's standard operating procedure for how to write a good response letter - identify where there are opportunities for complainants to be involved in developing the solution to the issues they have identified - implement changes to the Trust's response letter template, incorporating advice from the Patients Association and identified good practice from peer Trusts.
Measurable target/s for 2015/16	To be confirmed: the target will be to achieve a rate of less than 5 per cent of dissatisfied complainants in the second half of 2015/16, with an 'amber' target of less than 10 per cent. This will require a change to how we report our performance to the Board in future; measured in this way, our performance for 2014/15 was 11.1 per cent. Informal benchmarking with other NHS Trusts suggests that rates of dissatisfied complainants are typically in the range of 8 to 10 per cent.
How progress will be	Implementation of the actions described here will be monitored via

monitored	the patient experience group (reports due in June and October 2015, and February 2016). The impact of these changes will be monitored by the Board via numbers of dissatisfied complainants; randomly selected responses will also continue to be reviewed at joint quarterly review meetings with Bristol CCG.
Board sponsor	Chief nurse
Implementation lead	Head of quality (patient experience & clinical effectiveness) and patient support & complaints manager)
Progress during Q1	During Q1, the Patient Support and Complaints Team has continued to roll out complaints response training to key staff and managers in Divisions. The following areas have now received training: Women & & Children, Medicine, Specialised Services, and Estates & Facilities. Draft complaints response letters now receive additional scrutiny prior to being sent for executive sign-off: all drafts are reviewed by the Patient Support and Complaints Manager, and a random sample receive an additional review from the Head of Quality (Patient Experience and Clinical Effectiveness). A revised template for complaints response letter has been drafted and is awaiting executive approval. Our target from April to September is for less than 10% of complainants to report that they are dissatisfied with our response (with a 'red' threshold of 15% or more). From October onwards, the target will be reduced to less than 5% ('red' threshold 10% or more). Of the 57 responses sent by the Trust during April, one complainant was dissatisfied (1.8%); of the 62 responses sent by the Trust during May, two complainants were dissatisfied (3.2%).
RAG - Q1 performance	**GREEN**
RAG - End of year prediction	**GREEN**

Objective 7	**To improve the management of sepsis**
Rationale and past performance	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually; of these, some estimates suggest 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis nationally are thought to contribute to the number of preventable deaths from sepsis. Locally, we have identified – through mortality reviews and incident investigations into deteriorating patients – that we can improve our management of patients with sepsis. Therefore, this is one of the sub workstreams of our patient safety improvement programme for 2015 to 2018. In 2014/15, we agreed a multifaceted sepsis CQUIN (Commissioning for Quality and Innovation) with our commissioners, with an overall aim to sustain mortality from sepsis at 16 per cent or below. We achieved a mortality rate of 15.2 per cent.
What will we do?	We are currently discussing with commissioners details of a sepsis

	CQUIN for 2015/16. This will inform our sepsis quality achievement and the initial sepsis improvement focus of our patient safety improvement programme.
Measurable target/s for 2015/16	Details of national CQUIN targets are being discussed with commissioners at the time of writing.
How progress will be monitored	To be agreed
Board sponsor	Medical director
Implementation lead	Adult services – Dr J Bewley, consultant in intensive care Children's services – Dr W Christian, consultant in paediatric medicine
Progress during Q1	National CQUIN targets for 2015/16 are: - In Q4, at least 90% of eligible patients will have been screened for sepsis - In Q4, at least 90% of eligible patients will have received antibiotics within one hour of presentation Quarterly audits are planned during the year (the first of these has yet to take place). Actions taken in adult services: 1. Focus is on the new pan Bristol NEWS (National Early Warning Score) Bristol observation chart which will follow patient from primary care to tertiary care. This plan has been agreed. Chart is being tested at present, ahead of planned implementation in the autumn. This will assist in recognition of the deteriorating patient. 2. This chart will link up with sepsis screening and management with prompts to guide medical and nursing staff (anticipated Quarter 4). 3. A bid has been approved for 1 WTE Band 6 sepsis nurse from CQUIN funding to educate and train staff in the use of this chart and improve sepsis patient care. Appointment during Quarter 2. 4. Medical education continues at Foundation doctor, Surgical and Medical core trainee level. 5. Discussions with adult Emergency Department (following Quarter 1 audit) have taken place re embedding NEWS and EWS within patient escalation pathway in a transparent and visible fashion.
RAG - Q1 performance	*Not RAG rated (quarterly audits are not due yet)*
RAG - End of year prediction	*Not RAG rated*

Objective 8	**To improve the experience of cancer patients**
Rationale and past performance	The Trust achieved disappointing results in the 2014 national cancer patient experience survey. These results were significantly at variance with those achieved by the Trust in other national patient surveys.
What do our patients say?	"It was very efficient, but, somewhat, I felt disjointed, as I started at Southmead Hospital then went to the oncology at Bristol. I'm not always sure now where to go if I have a medical problem i.e. GP, breast care nurse." "The hospital needed someone who could hold my overall treatment

	who I could readily contact." "The nurses and staff are very understanding and friendly. Always willing to listen to patients and are helpful when needed."
What will we do?	The Trust will deliver an 18 month improvement programme, the core elements of which will be to: - repeat an 'in-house' survey of recent UH Bristol cancer patients (completed January to March 2015) - working in collaboration with the Patients Association, carry out a series of patient engagement and involvement activities with cancer patients, to fully understand their experience of our services - work with high-performing acute NHS Trusts, local health and social care partners, patient advocate organisations, and our own staff to identify and implement improvements to our cancer services - monitor the actions identified, and wherever possible undertake regular measurement to provide assurance of progress, completion and impact.
Measurable target/s for 2015/16	The key measurement will be the Trust's scores in the next national cancer patient experience survey; however, this has been delayed until 2016. In the meantime, we will: - complete planned listening exercises and thematic analysis - track progress of the Trust's existing comprehensive action plan, in line with the agreed 18 month timescale - repeat the Trust's 'in-house' cancer patient experience survey in quarter 3 of 2015/16.
How progress will be monitored	Quarterly reports to cancer steering group.
Board sponsor	Chief operating officer
Implementation lead	Cancer lead nurse
Progress during Q1	Cancer 'listening exercises' have been completed as planned: • Repeat in-house cancer patient survey, 309 responses (62%), April 2015 • 5 patient Focus Groups and 4 telephone interviews – independently facilitated and thematically analysed by the Patient's Association, April 2015 • 35 telephone interviews – conducted by UHBristol, May 2015 • UH Bristol facilitated 'listening' event , April 2015 • Staff 'cancer care' survey, May/June 2015. Key drivers of good experience have been identified as: • Compassionate care (kind reliable staff, access to Clinical Nurse Specialists) • Efficient processes (avoiding waits and cancellations) • Information (personalised information, right time, right format) Continued progress in NHS IQ national cancer patient experience 'buddy' improvement programme. UH Bristol has been buddied with South Tees NHS Foundation Trust (high performer in National Cancer Patient Experience survey). Three UH Bristol staff (including Lead Cancer Nurse) visited South Tees in June 2015. Initial findings presented to Cancer Steering Group 08/06/15, Patient

	Experience Group 25/06/15, Quality and Outcomes Committee 26/06/15. Including: • Overall (in direct contrast to the National Cancer Patient Experience Survey) UH Bristol can take encouragement, as this additional activity has comprehensively shown that the Trust's hospitals provide a high-quality experience to cancer patients. • 'Shared care' across providers creates the potential to impact negatively on patient experience. • A negative experience at the start of a cancer pathway (eg. delayed diagnosis or cancelled operation) in most cases will have a lasting negative impact on the whole pathway experience. • Identification of and access to a key worker (e.g. clinical nurse specialist, cancer support worker, specialist radiographer) is key in determining a positive experience. A detailed combined thematic analysis is currently being carried out across all these activities to draw out consistent themes and inform the development of a detailed action plan. On schedule for detailed action plan to be presented in August 2015.
RAG - Q1 performance	**GREEN**
RAG - End of year prediction	**GREEN**

Objective 9	**To reduce appointment delays in outpatients, and to keep patients better informed about any delays**
Rationale and past performance	A large number of recommended improvement actions arising from the Trust's CQC inspection are about outpatient services. There is consensus amongst senior Trust staff that this should be reflected in our corporate objectives – and communication about waiting times is something that our patients consistently tell us that we can do better (also reflected in feedback from our online survey).
What do our patients say?	"I had to wait for 1 and a half hours to be seen for approx. 7 minutes!! It seemed the consultant was totally overbooked." "Whilst this visit was very on time other visits have not been. Sometimes up to 1hr wait."
What will we do?	An action plan will be developed via the Trust's outpatient steering group. This will include a multi-faceted approach to improving communication with patients about any delays they are likely to experience whilst waiting for a clinic appointment. We will establish baseline targets during quarter 1 of 2015/16.
Measurable target/s for 2015/16	To be confirmed: the intention is to set achievable patient-reported targets based around four survey questions that appear in the National Outpatient Survey: - how long after the stated appointment time did the appointment start? - were you told how long you would have to wait? - were you told why you had to wait? - did you see a display board in the clinic with waiting time information on it?

How progress will be monitored	Reports to outpatient steering group
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations
Progress during Q1	The Trust has a good understanding of the issues and has a plan to address them. A Trust-wide Outpatients Manager has been appointed (in post from 10/06/15). An Outpatient Steering Group has been created and will meet for the first time in July 2015 – this group will focus on all aspects of the patient journey through our Outpatients Departments. Working Groups will be created via the Outpatients Steering Group to focus on particular aspects of Outpatients. Patient experience is as yet unaffected - hence the amber rating for Q1 progress.
RAG - Q1 performance	**AMBER**
RAG - End of year prediction	**GREEN**