University Hospitals Bristol NHS
NHS Foundation Trust

Quality Report 2015/16

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents

1.1 Statement on quality from the chief executive

Welcome to this, our eighth 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 to the public and its stakeholders that its services are safe, effective, caring and responsive. The report is an open and honest assessment of the last year, its successes and its challenges.

In 2015/16, we made an early commitment to a new national campaign – Sign up to Safety – that aims to make the NHS in England the safest healthcare system in the world and to halve avoidable harm in the NHS, saving 6,000 lives as a result. As part of this, we have worked to understand and develop our patient safety culture, asking every staff member who has contact with patients and their families to provide insights and information. As part of a robust patient safety culture we must ensure we learn from all incidents. You'll find more information about Sign up to Safety in this report.

This year, I am particularly delighted that the Care Quality Commission's national survey has recognised our maternity services as one of the best in the country. In the areas of care during labour and birth, UH Bristol attained nine survey scores that were better than the national average by a statistically significant margin. These are particularly pleasing results because they reflect the enormous amount of work carried out by our maternity staff to improve the experience of women who use their services. In recent years, this has included investment in new midwifery posts, a reconfiguration of postnatal wards based on feedback from service-users, and various "co-design" projects where the maternity team has worked in partnership with people who have experienced maternity services, in order to understand what works well and identify aspects of care that could be improved. It shows that when we say we want the best for the people of Bristol and the West Country, we really can achieve it.

On the subject of working with patients and our partners, I have been encouraged by the development of our new Involvement Network: based on the concept of a citizen's assembly, "IN" is part of our broad and ambitious programme to refresh the way in which we deliver our patient and public involvement work. IN is about creating new opportunities for people to have their say about how healthcare is developed and provided at UH Bristol. To date, IN members have helped inform the Trust's quality priorities for 2016/17 and commented on the quality of information patients receive about outpatient appointments.

After the difficulties that the NHS experienced in the winter of 2014/15 we planned extensively for last winter both within our hospitals and services but also with our partners across our health and social care community. We invested over £3 million of 'resilience' funding before winter in additional core beds at the Bristol Royal Infirmary with permanent staff, radiology

and therapy staffing on Saturdays and theatre staff for more weekend trauma operating. We also invested in capacity in the Bristol Royal Hospital for Children, including an extra paediatric intensive care bed. Despite our careful preparations, however, the extended period of high emergency demand has meant that, while we have kept our patients safe, our services have not always been as responsive as we would wish. The fact that overall patient-reported experience has remained high in 2015/16 is credit to everyone who works in the Trust and evidence of their commitment to deliver best care.

We have also continued the essential process of renewing our estates and facilities. In 2015/16 this included the opening of a new pre-operative department in the Bristol Royal Infirmary, for the first time bringing together the surgical admissions suite and pre-operative assessment clinic, co-locating surgical, critical and trauma care.

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.

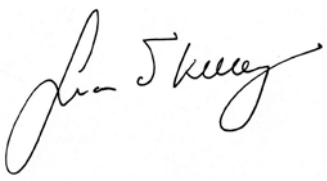
Robert Woolley, chief executive

1.2 Introduction from the medical director and chief nurse

As an organisation, our key challenge is to maintain and develop the quality of our services. The Trust is committed to and expects to provide excellent health services that meet the needs of our patients and their families and provide the highest quality standards.

The Board and Senior Leadership Team of UH Bristol have a critical role in leading a culture which promotes the delivery of high quality services. This requires both vision and action to ensure all efforts are focussed on creating an environment for change and continuous improvement. The Trust's annual quality delivery plans set out the actions we will take to ensure that this is achieved.

We have much to be proud of. The Trust's quality improvement programme in 2015/16 has shown us what is possible when we have a relentless focus on quality improvement. Healthcare does not stand still. In the year ahead, we will continue to seek out new and better ways of providing the highest quality services which are safe, enable a better patient experience and improved patient outcomes. Never has there been a greater need to ensure we get the best value from all that we do.



Dr Sean O'Kelly
Medical director

Carolyn Mills
Chief nurse

2 Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2015/16

Twelve months ago, we identified nine specific areas of practice where we wanted to see improvements in 2015/16. These were a combination of patient 'flow' objectives carried forward from the previous year, and new objectives aimed at improving different aspects of patient experience. A progress report is set out below, including a reminder of why we selected each objective and an overall 'RAG' rating of the extent to which we achieved each ambition. Overall, we fully achieved two objectives and made significant progress in six more.

Objective 1	To reduce the number of cancelled operations
Rationale and past performance	Cancelled operations waste time and resources; the impact of cancelling operations is often distressing and inconvenient for patients and their families. We set this objective to reduce cancelled operations in 2014/15, but did not achieve our goal. Our target in 2014/15 had been to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to 0.92 per cent; we achieved 1.08 per cent.
What did 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 sorts of things do nothing for patients' mental and psychological wellbeing."
What did we say we would do?	Review standard operating 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	We said that the indicator would be the number of operations cancelled on the day of operation/ admission for non-clinical reasons, with a goal of achieving last year's target – 0.92 per cent.
How did we get on?	Overall, we achieved 1.03 per cent, which represents a marginal improvement on 2014/15. We achieved our targets in the second and third quarters of the year but failed them in the first and fourth quarters. Performance in March 2016 had a particularly adverse effect on our overall performance: there were 108 last minute cancellations in this month, representing 1.84 per cent of operations (overall, we achieved 0.95 per cent across the previous 11 months of the year).

The total number of cancelled operations in 2015/16 was lower than in 2014/15: 713 compared with 749. However, there has been a marked increase in the percentage of cancelled operations caused by lack of available beds: 42 percent in 2015/16, compared with 29 percent in 2014/15. Lack of available beds was also the primary reason for us missing our targets in the first and fourth quarters (40 per cent and 62 per cent of cancelled operations respectively) although the specific causes were different: in quarter 1, our performance was affected by capacity pressures in our Cardiac Intensive Care Unit and at the Bristol Royal Hospital for Children, whereas our challenges in quarter 4 were related primarily to adult surgical services. The operational pressure on adult services beds in quarter 4 was unprecedented with adult services seeing an increase in attendance through our emergency departments (14 per cent higher than the same period in 2014/15), higher levels of acuity (i.e. higher levels of dependency and severity of sickness) in patients, and increasing numbers of patients awaiting discharge.

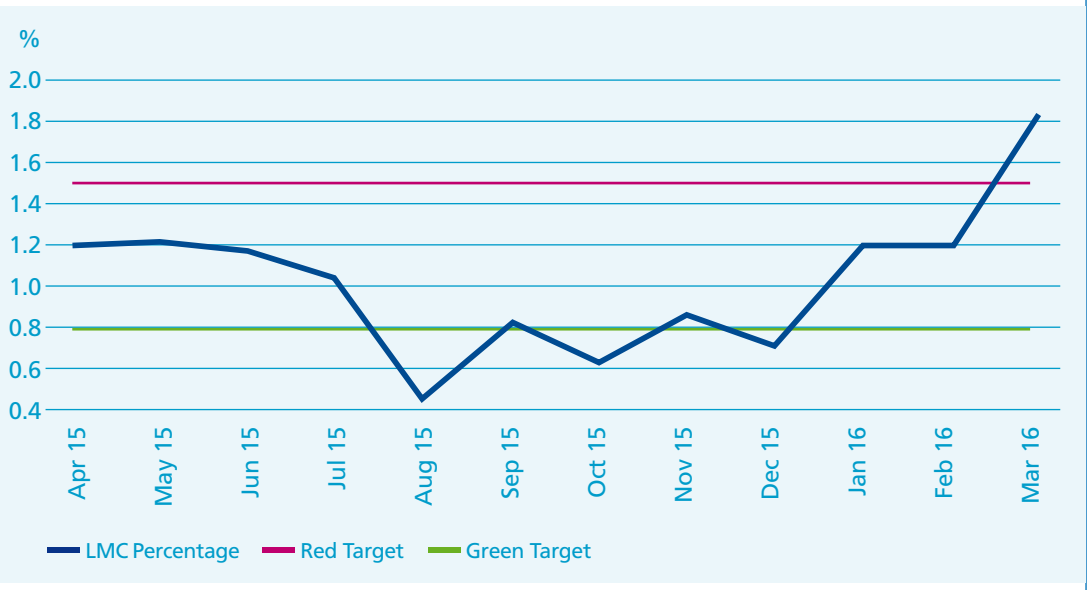
However, on a positive note and in contrast to 2014/15, the Trust met the 0.8 per cent national standard for last-minute cancelled operations in two quarters of 2015/16 (i.e. quarters 2 and 3).

Continued improvements in performance are expected to be delivered in 2016/17 through further focus on ward discharge processes, planned work on pathways for which admissions may be avoided or lengths of stay reduced, and by commissioning an independent provider, Orla Healthcare, to deliver a community based "virtual ward". The latter service is expected to commence in July 2016 and be fully operational from January 2017 with capacity for 35 patients. This service will not only enable improvements in hospital bed occupancy, but will also provide 'winter flex' capacity in quarter 4 when it is typically most needed. This should help to reduce bed occupancy and the risk of cancellation of elective operations during the busiest time of the year.

In addition to high occupancy levels in general wards beds, a large number of cancellations in quarter 4 were attributable to a lack of critical care beds; this is of particular note as it often results in cancellation of patients with cancer. A plan to address this has been developed and this will be a key focus in 2016/17.

The Trust was issued with a Contract Performance Notice by Bristol Clinical Commissioning Group and subsequently developed an improvement plan which is managed by nominated leads across the divisions and overseen through our Emergency Access Performance Improvement Group.

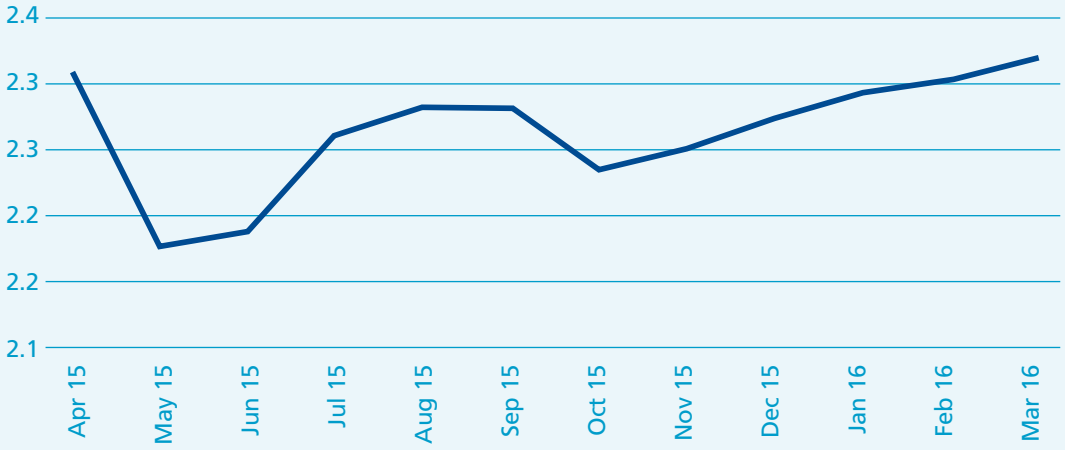
Last minute cancellations as a percentage of admissions

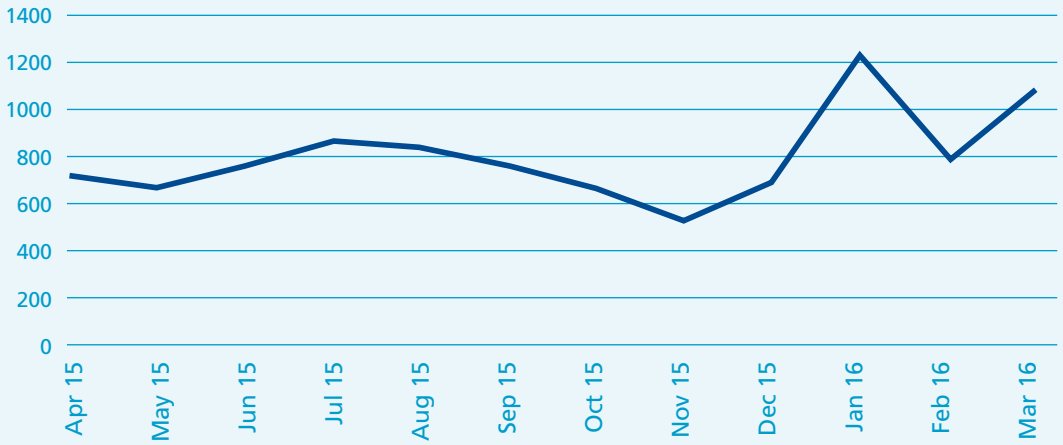


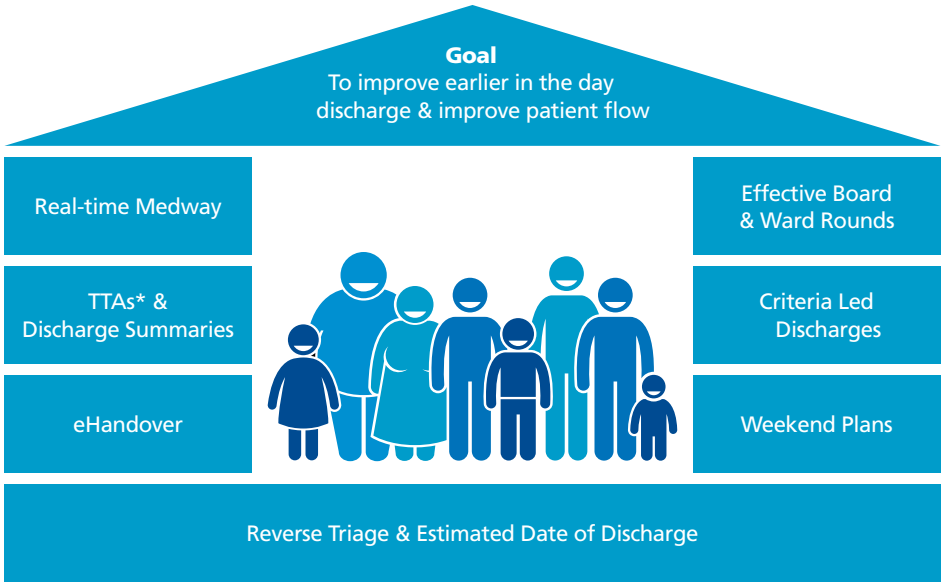
Reducing cancelled operations will continue to be a corporate quality objective in 2016/17.

RAG rating

Amber – we made significant strides during 2015/16, but operational pressure on adult services beds in quarter 4 was unprecedented, resulting in a deterioration in performance at that time.

Objective 2	To minimise inappropriate patient moves between wards (time and place)
Rationale and past performance	We set this objective in 2014/15, but did not achieve our goal. Our target in 2014/15 had been to reduce the average number of ward moves per patient to 1.92. We achieved 2.32, which represented a deterioration compared with 2013/14. An "inappropriate" patient move is one which happens for reasons which are not related to that patient's clinical circumstances.
What did 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."
What did we say we would do?	Implement a standard operating procedure to govern this area of practice.
Measurable target/s for 2015/16	We said that the indicator would be the average number of ward moves per patient, for patients staying a minimum of two nights, with a goal of achieving last year's target – an average of no more than 1.92 moves per patient (for patients staying a minimum of two nights).
How did we get on?	Disappointingly, we did not meet our target. Overall, during 2015/16, we achieved 2.26 moves per patient, which is only marginally better than in 2014/15. Our best performance was in May and June (2.18 and 2.19 respectively) when the hospital had good flow through services. Not surprisingly, there is a direct correlation between this indicator (average number of moves per patient) and bed occupancy levels. During 2015/16, we established a number of new patient pathways which resulted in ward moves to ensure patients were cared for in the most appropriate place. An example of this was the creation of a ward for patients whose discharge is delayed. As a result of doing the right thing for patients, additional moves have been introduced, which have negatively impacted performance against our target.
Average number of wardstays per spell	
	Although minimising inappropriate patient moves between wards will not be a formal quality objective in 2016/17 for the reasons outlined above, the issue will continue to receive significant attention as we seek to fully realise the benefits of redevelopment and an alternative measure (outlier beddays) will be used to identify patients in inappropriate wards.
RAG rating	**Red** – disappointingly, we did not achieve our target for 2015/16

Objective 3	To ensure patients are treated on the right ward for their clinical condition
Rationale and past performance	We set this objective in 2014/15, but did not achieve our goal, which had been to reduce the total number of outlier bed days to 9,029. We reported 11,216, which represented a deterioration compared with 2013/14.
What did our patients say?	"I was an inpatient for three weeks and 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 three times before I went to the right ward."
What did we say we would do?	Link into pathway review work and urgent care programme
Measurable target/s for 2015/16	We said that the indicator would be the total number of bed days patients spent outlying from their correct divisional ward, with a goal of achieving last year's target – no more than 9,029 outlier bed days in total, with seasonally adjusted quarterly targets.
How did we get on?	At year end, the total number of outlier bed days was 9,588 which fell short of our target, but nonetheless represented a significant improvement on the previous year (11,216 in 2014/15). Quarterly targets were achieved in quarters 1 and 3, but missed in quarters 2 and 4. The development of clear patient pathways and appropriate capacity, through assessment areas and into specialist wards as a result of the Bristol Royal Infirmary redevelopment has helped to deliver the overall reduction in outlier bed days.
Number of outlier beddays	
RAG rating	**Amber** – although we fell short of our target, our performance in 2015/16 was significantly better than in 2014/15

Objective 4	Improving patient discharge
Rationale and past performance	We were not achieving our SAFER[1] bundle standards or timely discharge planning.
What did 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 did we say we would do?	Ensure more patients are discharged in a timely manner, adhering to all aspects of our discharge 'bundles' – delivering our discharge standards every time.
Measurable target/s for 2015/16	We said that at least 1,100 patients per month would be discharged between 7am and 12 noon, noting that this would be a stretching target (the highest monthly total during 2014/15 was 992).
How did we get on?	We have addressed timely discharge through the rollout of a programme of ward processes improvement. The programme has been rolled out by having a multi-disciplinary team workshop with each ward, where the topics are covered:  * 'To Take Away' medications This Ward Processes package was designed to support achievement of the SAFER bundle of standards (of which discharge standards are a part). Each topic maps to standards within the bundle, raising awareness of and embedding good practice in daily routines. In the workshops, the key areas of discussion have been: • reverse triage (a discharge planning tool used on the wards to show a patient's progress against their discharge plans, coded in way which identifies any blocks or delays) and estimated date of discharge • effective board rounds • planning for discharge (a review of all patients on the ward with the multidisciplinary team to progress plans for discharge) This project is aimed at increasing the number of earlier-in-the-day discharges and use of the Bristol Royal Infirmary Discharge Lounge, as well as improving patient experience.

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

In quarter 1, we commenced the project in our Division of Medicine: for example, Ward B404 achieved an increase of 18 per cent of discharges before noon during a pilot week. In subsequent quarters, we rolled out the approach across all divisions, holding ward-based workshops to identify improvement priorities and to develop improvement plans; weekly follow up meetings are then held to review progress.

What our staff said:

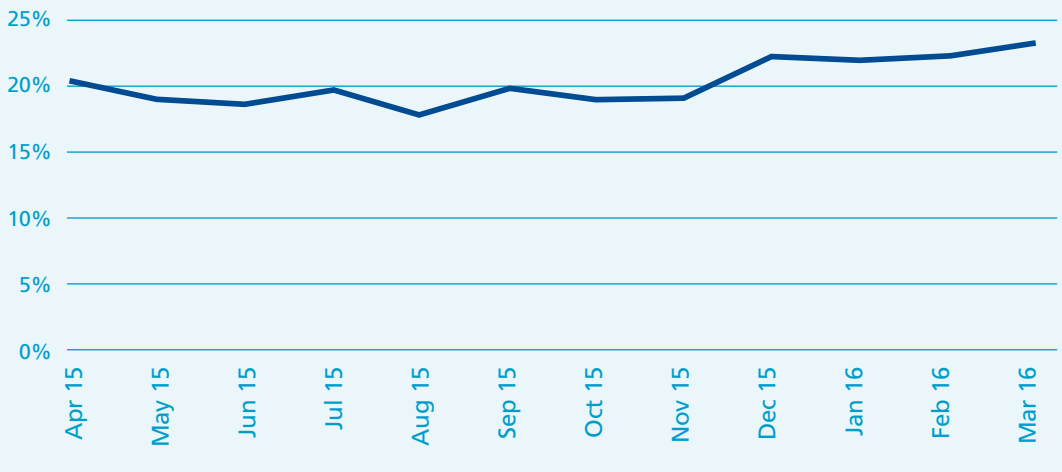
> "It has been so worthwhile to work on a project that focuses on revisiting current processes and allows ward teams to review these. Even when you feel you are doing things properly there is always room for further improvements. Working together as a multi-disciplinary team, we have been able to identify how we can increase our team communications. We now have afternoon board rounds to ensure we all catch up with what has happened during the day. Our patients' discharge plans are refined day by day and all have their tablets to take home organised in advance. Communication has improved so much that we wanted to look at spreading this benefit over the weekends; we now have a nurse led board round both Saturday and Sunday which really helps organise the staff allocation and workload and so ensuring patient safety. It's not just the Sister leading and understanding the ward processes, it's the whole team understanding and being engaged too."

A Trust-wide sharing event was held in November 2015 with over 50 attendees, allowing teams which had been involved in the ward processes work to share their achievements, benefits, challenges, next steps and top tips.

Progress in completing the workshops fell behind plan during the winter period, largely due to the operational pressures on ward teams. However, we have now held ward processes workshops and follow up meetings with all adult inpatient areas, and will complete children's wards by the summer of 2016.

As a result of this initiative, our timely discharge performance has improved across the year, but has fallen short of the stretching target we set ourselves. Over the course of the year, 10,444 patients were discharged between 7am and 12noon – a 6.5 per cent increase on the 9,804 achieved in 2014/15. This equates to a monthly average of 870 discharges between 7am and 12noon, increasing to 942 in the final quarter of the year and giving cause for optimism as we move into a new financial year. In March 2016, 22.3 per cent of patients were discharged between 7am and 12noon, which is the highest proportion recorded in the past three years.

Timely discharges - as a percentage of all discharges



RAG rating

Amber – although we did not achieve our stretching target, we made encouraging progress, both in improvement in early discharges and in the implementation of the SAFER bundle based Ward Processes programme, particularly in the final quarter of the year. Timely discharges as a proportion of all discharges increased during the year.

Objective 5	To improve the quality of patient appointment letters
Rationale and past performance	We know that 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 commissioned a Trust-wide improvement project which would last for at least two years.
What did our patients say?	"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."
What did we say we would do?	We said that in 2015/16, we would focus on improving the quality of appointment letters sent to patients.
Measurable target/s for 2015/16	Our goal was to review and standardise all appointment letters that are sent to patients (electronically and non-electronically generated). We said that we would write these letters in Plain English and would test this through proactive engagement with patients (for example via surveys or focus groups).
How did we get on?	A working group was formed with representation from across our hospitals, with an initial focus on letters generated by our Medway patient administration system. The task of reviewing and improving the letter templates was significant because of the volume and variety of letter templates in use. The group held a 'Letters Champions Week' in August 2015 when staff and volunteers met with patients in a number of outpatient areas across the Trust to discuss the quality of the letters they had received. Two thirds of patients were happy overall with the content and timeliness of the letters they had received, however common issues included a lack of details to inform patients' expectations for their appointment, and confusing use of abbreviations and acronyms. The working group used this feedback to develop a quality standard for patient letters and tested draft letter templates for readability. As a result, a significant amount of information has been removed from letters and included instead in accompanying patient information leaflets. The new approach, involving letters written deliberately in Plain English, is being piloted in cardiology outpatients and with the surgery admissions team, and a further 'Letters Champions Week' is planned to evaluate the letters. Learning from the pilot will inform the Trust-wide roll out of the new letter templates during the remainder of 2016. A further development is that patients can now to opt to receive their Medway letter by email instead of through the postal service. This will improve the timeliness of letters being sent, reduce costs and provide a more flexible option for patients with visual impairment.
RAG rating	**Green** – we have made good progress towards our goal and are currently piloting our new letters, prior to a wider roll-out which will take place in 2016/17

Objective 6	To improve the quality of written complaints responses
Rationale and past performance	Too many complainants were telling us that they were dissatisfied with our complaints responses: 84 in 2014/15 compared with 62 in 2013/14.
What did our patients say?	"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 did we say we would do?	We said we would roll out training to our staff, introduce a good practice checklist for all complaints, and make changes to the Trust's response letter template, embracing learning from the Patients Association.
Measurable target/s for 2015/16	We agreed a target that fewer than five percent of complainants would be dissatisfied with our response in the second half of 2015/16 (with an 'amber' target of less than 10 per cent). We define a dissatisfied respondent as someone who replies to us to say that they are unhappy with one or more aspects of our response to their concerns. Replies which merely ask additional questions are not classified as dissatisfied.
How did we get on?	Training sessions have been successfully delivered to staff in each of our clinical divisions. The tone of the Trust's standard template for writing complaints responses has been re-written in a way that encourages investigating managers to respond with greater openness and empathy, and a final 'checklist' has been produced to guide divisions when submitting draft responses. Draft response letters have also received additional corporate scrutiny from the quality team prior to approval by an executive director. Levels of dissatisfaction with our complaints responses reported to the Board in the second half of 2015/16 (our target period) were as follows:
RAG rating	**Amber** – we have made significant strides in improving the quality of our written complaints responses, however we have not met our target of less than 5 per cent dissatisfied respondents

Month	Dissatisfied responses*	Total responses	%
Oct-15	5	56	**8.9**
Nov-15	2	42	**4.8**
Dec-15	4	63	**6.3**
Jan-16	1	40	**2.1**
Feb-16	3	39	**7.7**
Mar-16	3	36	**8.3**

* The indicator is calculated as a proportion of complainants who are sent a response letter in a given month.

We have, however, identified that our current method of recording numbers of dissatisfied responses is resulting in under-reporting of the true figure. Data is currently 'frozen' six weeks after the end of each reporting month. Taking 2015/16 as a whole, 59 complainants expressed dissatisfaction with our investigation of their concerns. This represents 9.1% of the 647 formal response letters sent by the Trust and therefore an improvement on 2014/15 when we received 84 dissatisfied responses.

Looking ahead to 2016/17, we will continue to deliver training to key managers focussing specifically on complaints response writing skills. We will also review each dissatisfied complaint we receive and make a judgement about whether we could have responded in a way which would have avoided the need for the complainant to contact us again – any learning from this will be shared with the Trust's patient experience group. We will also be adjusting the way we measure our performance, allowing an additional month for complainants to respond before we report this information to the Board.

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.
What did we say we would do?	Our goal was to achieve the national sepsis CQUIN for 2015/16.
Measurable target/s for 2015/16	The national CQUIN targets were as follows: • In Q4, at least 90 per cent of eligible patients to be screened for sepsis • In Q4, at least 90 per cent of eligible patients to receive antibiotics within one hour of presentation
How did we get on?	**Adult services:** There have been significant improvements in sepsis care in the adult Emergency Department (ED) and Acute Medical Unit (AMU) in 2015/16. The focus has been on the ED, which is where approximately 80 per cent of adult sepsis patients present to. Screening did not take place in 2014/15 (and 2015/16 Q1) but more than 90 per cent of patients were screened in quarter 4. Antibiotic administration rates within one hour of hospital presentation have also markedly improved at over 70 per cent during quarters 3 and 4, however this aspect of the CQUIN has not been achieved. The appointment of two part-time sepsis nurses in September 2015 via CQUIN funds has transformed our ability to implement improved sepsis care during 2015/16. Achievements during year include the following: • A sepsis question is now on the hospital discharge summary; this improves communication with primary care, facilitates accurate coding and increases sepsis awareness • Our sepsis management pathway has been updated and implemented in ED and AMU • The implementation of National Early Warning Scores (NEWS) since December 2015 will facilitate the early recognition of patients with sepsis as the new NEWS observation chart includes sepsis prompts; we therefore expect sepsis screening rates and antibiotic administration rates to improve further in 2016/17 • Continual education is taking place in ED, AMU and the Surgical Trauma Assessment Unit for nursing and medical staff; these are the key admission areas for adult admissions with sepsis at UH Bristol. • Medical teaching for Foundation doctors, core surgical trainees, core medical trainees and anaesthetic/intensive care trainees Looking ahead to 2016/17, our sepsis plans include the continuation of trust-wide clinical teaching events and the implementation of a sepsis screen saver for Trust computers as a visual reminder to all staff. **Children's services:** There has been significant improvement in the identification of potentially septic children at triage with enhanced awareness throughout the nursing staff group regarding the need to escalate children meeting the sepsis screening criteria. **Positive actions in 2015/2016:** • The paediatric emergency nurse educator has continued to work with all nursing staff involved in undertaking triage to make them aware of the sepsis screening process and its rationale. She is continuing to provide "refresher" sessions when working in the triage area. • A presentation has been produced by Dr Christian, paediatric sepsis lead, for nursing staff and medical staff to make them aware of the background to the 'sepsis 6' programme and why the identification of potentially septic children in the Children's Emergency Department (CED) is so important. This will be rolled out at nursing training sessions and with the junior doctors in the department alongside ongoing teaching sessions to raise awareness of the sepsis guidelines amongst CED trainees • All junior doctors from the last intake undertook the Royal College of Paediatrics and Child Health's module for recognising seriously ill children

	Our quarter 3 sepsis audit showed that, as a result of these and other measures, screening at triage had increased to 90 per cent of all eligible patients. This audit confirmed that staffing ratios and crowding in the CED remain significant challenges to the recognition and treatment of sepsis. At times of peak demand, our ability to triage patients rapidly (within 15 minutes) is compromised which potentially may delay the recognition of the septic child. A triage workstream has been set up to look at ways of improving this process in terms of efficiency / flow. It is likely that the sepsis screening criteria will be incorporated into the triage process as a way of identifying patients who are likely to have sepsis. The audit demonstrated that, for those children who presented with features of septic shock, antibiotics were consistently administered within an hour of triage. The Bristol Royal Hospital for Children is also planning to convene a group to examine the implications of the NICE sepsis guidance when it is published in July as this is likely to have major implications for practice in the CED.
RAG rating	**Amber** – we have made significant progress during the year however we only partially achieved our CQUIN target (also see section 2.2.4)

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 did 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 did we say we would do?	We said that the Trust would deliver an 18 month improvement programme, the core elements of which would 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, to carry out a series of patient engagement and involvement activities with cancer patients, to fully understand their experience of our services • to 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 • to monitor the actions identified, and wherever possible undertake regular measurement to provide assurance of progress, completion and impact.
Measurable target/s identified for 2015/16	We noted that a key measure of success would be the Trust's scores in the next national cancer patient experience survey, however we noted that this survey had been delayed until 2016. In the meantime, we said we would: • 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 did we get on?	Throughout 2015/16 we have been delivering our cancer patient experience improvement plan. Patient involvement / listening activities and collaborative work with the Patients Association were completed by May 2015, as a result of which we were able to identify key principles that influence the experience of cancer patients at our Trust, namely: • receiving 'shared care' across more than one organisation increases the potential to negatively impact on patients' experience • having a negative experience at the start (e.g. a delayed diagnosis, receiving a diagnosis in an insensitive manner, or having your operation cancelled) will in most cases negatively impact the whole pathway experience thereafter • access to a clinical nurse specialist (CNS) is paramount • the importance of the Trust doing what we say we are going to do, recognising that, by and large, it is the Trust that sets patients' expectations. Following our disappointing results in the 2014 national cancer patient experience survey, the Trust was 'buddied' with South Tees NHS Foundation Trust (a high performing cancer patient experience Trust) as part of an NHS England national cancer patient experience improvement programme. The programme ran from February to November 2015. Learning from all of the above has been channelled into our local cancer improvement plans. Important developments in 2015/16 included:

	• creation of four additional CNS posts following an internal review of CNS cancer pathways • a further review of CNS cancer pathways across the SWAG (Somerset, Wiltshire, Avon and Gloucester) cancer network • expansion of our trained cancer volunteer workforce, with additional roles in the chemotherapy day unit and radiotherapy department at the Bristol Haematology and Oncology Centre (BHOC) • the commencement of feasibility discussions about the potential to build a UH Bristol Holistic/ Support Centre adjacent to BHOC • training for over one hundred waiting list office and administration staff about how to deal sensitively with difficult conversations when operations have to be cancelled or delayed, or when changing chemotherapy appointments • plans to create a small cancer information hub in the Welcome Centre of the Bristol Royal Infirmary (BRI) following the securing of a grant from Macmillan, with additional cancer information also installed on BRI wards A700 and A800 • significant progression of the cancer 'recovery package' to support people from diagnosis onwards, including electronic holistic needs assessments, health and wellbeing days, and treatment summaries being sent to GPs • development of a 'Big Conversation in BHOC' (talking to service users, to ensure patients' views are at the heart of any future development decisions we make – the first event, which involved over 60 patients, took place in April 2016, and will be repeated every six months). During the year, it was announced that the National Cancer Patient Experience Survey would be repeated in 2015 (a sample of UH Bristol Cancer inpatients seen during April-June 2015 received questionnaires in November and December 2015). In light of this, a decision was taken by the Trust not to repeat our planned in-house survey as this would have coincided with the national survey and risked poor response rates to both surveys.
RAG rating	**Green** – we are confident that we have made significant improvements to the experience of cancer patients. This has been reflected in conversations with patients and anecdotal feedback received during the year. We are therefore optimistic of improved scores in the National Cancer Patient Experience Survey when the latest result are published in July 2016.

Objective 9	To reduce appointment delays in outpatients, and to keep patients better informed about any delays
Rationale and past performance	Reducing waiting times, and improving communication about delays in clinic are things that our patients consistently tell us that we can do better.
What did our patients say?	"I had to wait for 1 and a half hours to be seen for approximately seven minutes! It seemed the consultant was totally overbooked." "Whilst this visit was very on time other visits have not been. Sometimes up to one hour wait."
What did we say we would do?	We said that we would adopt a multi-faceted approach to improving communication with patients about any delays they are likely to experience whilst waiting for a clinic appointment.
Measurable target/s for 2015/16	We set measurable 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 did we get on?	The Trust's outpatient manager is currently working with the performance team to identify clinics where appointments are delayed on a regular basis. Live reporting from Medway has been piloted effectively within Bristol Dental Hospital and is now being rolled out Trust-wide as a tool to identify problem areas. This system of reporting records how long each patient spends in the different steps of their journey through the outpatient clinic. Disappointingly, patient-reported experience of waiting times in clinic fluctuated over the year without showing sustained improvement: our score for the final quarter of the year was only fractionally better than the first. We are anticipating an improvement in patient-reported experience once the live reporting tool is implemented more fully and we will continue to work with individual clinical teams where delays are more prevalent.
RAG rating	**Amber** – we have made significant changes which we believe will reduce clinic waiting times and keep patients better informed about any delays, however the impact of these changes has yet to be seen in patient-reported experience and so this will remain a focus for 2016/17.

Question	Response	Q1	Q2	Q3	Q4
How long after the stated appointment time did the appointment start?	On time / within 15 minutes	74%	71%	68%	75%

The use of whiteboards to display information about clinic running times has been reviewed across the Trust. Initial reinforcement of best practice amongst clinic staff had a positive impact, but following quality audits in November 2015, it was agreed that standardisation of the layout of the boards was required to improve the quality and consistency of the way information is presented to patients. A standardised board design was approved following consultation with patients, sisters and the Trust's patient experience leads, and a standard operating procedure was developed to ensure all staff responsible for communications within clinic are aware of the process for keeping patients informed. Regular spot checks are carried out by the outpatient manager to monitor process. A longer term solution involving display screens is also under consideration.

Disappointingly, patient-reported experience of being told about waiting times in clinic has been unchanged (in terms of statistical significance) throughout the year:

Question	Response	Q1	Q2	Q3	Q4
Were you told how long you would have to wait?	All "Yes" responses	40%	38%	37%	38%

2.1.2 Quality objectives for 2016/17

The Trust is setting 12 quality objectives for 2016/17. Five of the objectives relate to ambitions we have only partially realised in 2015/16: reducing cancelled operations; ensuring patients are treated on the right ward for their clinical condition; improving the timeliness of patient discharge; reducing appointment (in-clinic) delays in outpatients, and keeping patients better informed about any delays; and improving the management of sepsis.

In addition, we have identified seven new objectives, which take account of feedback from patients, members, governors, staff, and our commissioners and regulators. Once again, these objectives include a focus on improving different aspects of how we communicate with patients. In particular: we want to ensure that patients are kept properly informed about the next steps in their treatment and care, right through to discharge; we want to improve the quality, relevance and consistency of information that visitors find displayed throughout our hospitals; we plan to make some significant changes and improvements to how we gather feedback from patients whilst they are in hospital; and our ambition is that these changes will contribute towards fewer complaints being made about poor communication.

Objective 1	To reduce the number of last minute cancelled operations
Rationale and past performance	We set this objective for the last two years, but did not achieve our goal. Our target in 2015/16 – as per 2014/15 - was to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent. In 2015/16, we achieved 1.03 per cent.
What do our patients say?	"Any operation is a big deal but when it's cancelled and, in my case, cancelled twice the impact is devastating - I had cancer and was really worried this would affect the success of the operation when it finally happened."
What will we do?	We will embed a revised standard operating procedure across all our divisions and amend our escalation plan to ensure that everyone is aware of the current Trust-wide state-of-play relating to cancellations and that decisions to cancel are recorded through escalation 'Silver meetings'. Our divisions will review the reasons why operations are cancelled at the last minute and will agree a plan which sets out specific actions to reduce cancellations further related to the cause of breach. Given that the most common cause for cancellation is lack of a ward or critical care bed, most of these actions will be linked to the more general actions to support flow.
Measurable target/s for 2016/17	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 reporting and oversight at the Emergency Access Performance Improvement Group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 2	To ensure patients are treated on the right ward for their clinical condition
Rationale and past performance	We set this objective for the last two years, but did not achieve our goal. Our target in 2015/16 was to have no more than 9,029 outlier bed days in total; we achieved 9,588.
What do our patients say?	"I went into hospital to have a mastectomy. After surgery I was put on a ward for the elderly where nurses did not know how to help which was not a good experience but it also knocked my confidence in the staff looking after me."
What will we do?	We will continue our work focussing on improving flow through our hospitals and, by doing so, improving occupancy. In 2016/17, we will roll out our ward processes to all wards and implement our new out of hospital acute model of care (Orla Healthcare) which has biggest single contribution to make to occupancy.
Measurable target/s for 2016/17	As in 2015/16, 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	Through divisional reporting and oversight at the Emergency Access Performance Improvement Group.
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 3	To improve timeliness of patient discharge
Rationale and past performance	Despite huge efforts, we have yet to achieve our goal of increasing the number of discharges before noon. This impacts on the number of cancelled operations, as they cannot start if a bed hasn't been identified, as well as being a source of frustration for patients who may spend many hours awaiting their discharge.
What do our patients say?	"I was required to wait for a letter of discharge I saw the doctor at approximately 8.30am. My letter of discharge was given to me at 3pm." "I think the discharge process could be a lot more organised."
What will we do?	We will continue our work focussing on improving flow through our hospitals and, by doing so, improving occupancy. In 2016/17, we will roll out our ward processes to all wards and implement our new out of hospital acute model of care (Orla Healthcare) which has biggest single contribution to make to occupancy.
Measurable target/s for 2016/17	As in 2015/16, our target will be for at least 1,100 patients per month to be discharged between 7am and 12noon. Our target is also to increase the number of patients discharged at weekends by 20 per cent.
How progress will be monitored	Via transformation board
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 4	To reduce appointment (in-clinic) delays in outpatients, and to keep patients better informed about any delays
Rationale and past performance	We set this objective last year and have more work to do.
What do our patients say?	"Staff treated me well and with respect, but my appointment time was delayed, and no-one informed us of this until my wife asked at the reception desk. Then we had a 90 minute delay, but the sign over the desk area indicated no delays."
"I think the discharge process could be a lot more organised."	We will continue our work focussing on improving flow through our hospitals and, by doing so, improving occupancy. In 2016/17, we will roll out our ward processes to all wards and implement our new out of hospital acute model of care (Orla Healthcare) which has biggest single contribution to make to occupancy.
What will we do?	We will complete Trust-wide implementation of our new standardised layout for information boards in outpatient departments and a standard operating procedure will be embedded to ensure teams proactively inform patients about any delays. Associated work reviewing clinic productivity and utilisation will lead to improved booking practices and scheduling to help minimise delays. Each quarter, we will also carry out a '15-step'[2] senior management walk around to ensure our redesigned clinic status boards are being used correctly.
Measurable target/s for 2016/17	We will ask patients about their experience using our monthly survey, setting minimum targets which would represent a statistically significant improvement on our patient-reported performance in 2015/16. The questions we will use and our minimum target scores are as follows: • How long after the stated appointment time did the appointment start? (78%) • Were you told how long you wold have to wait? (50%) • Did you see a display board in the clinic with waiting time information on it? (55%) In addition to asking patients about their experiences, we will also develop our own real-time objective measurement of clinic running times (currently being piloted in the Bristol Dental Hospital).
How progress will be monitored	Reports to outpatient steering group
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

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

Objective 5	To improve the management of sepsis
Rationale and past performance	Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these, 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, and is a continuation of a quality objective we set ourselves in 2015/16.
What do our patients say?	"During my three months after suffering sepsis, the treatment I received was first class, the doctors and surgeons saved my life. I would like to put on record that all staff at BRI are fantastic." "The ward did not recognise how unwell my wife was (viral sepsis) and at first did not manage her symptoms very well."
What will we do?	Continuation and development of activities described in section 2.1.1 of this report.
Measurable target/s for 2016/17	Our goal is to achieve the national sepsis CQUIN: timely identification and treatment of sepsis in emergency departments, and acute inpatient settings.
How progress will be monitored	Monitoring by the National Early Warning Scores (NEWS) implementation / deteriorating patient group, and the Patient Safety Group; additional monthly CQUIN reporting to the Trust's Clinical Quality Group
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

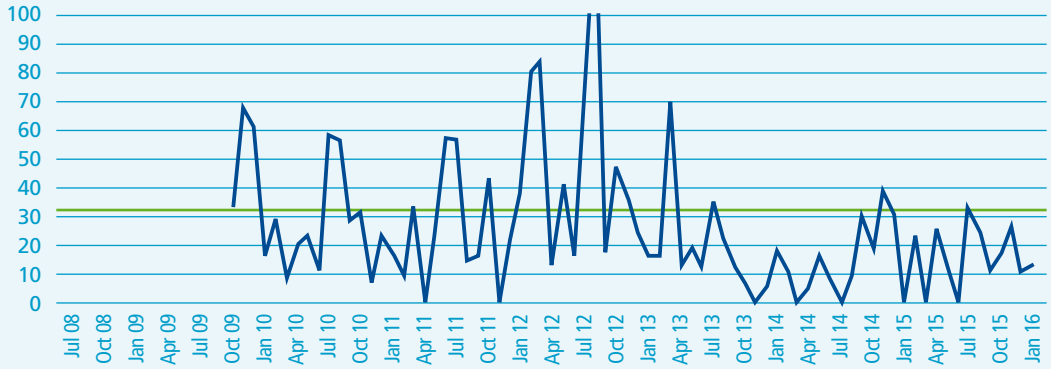
Objective 6	To ensure public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible
Rationale and past performance	The objective forms part of the Trust's previous two year commitment to improve key aspects of communication with patients. The issue was raised via the Trust's consultation on quality priorities.
What will we do?	We will: • Produce guidelines for all staff about the standard of information that should be displayed in public areas and advice on how to get support to produce it • Work with areas to professionally produce and print any materials that arise from this process • Continue to provide good quality corporate posters, publications and other materials for display in public areas – ensuring they communicate key information and messages.
How progress will be monitored	A monthly walk round public areas by a member of the communications team to take down any materials that do not meet the standard and to identify where new materials need to be professionally produced.
Board sponsor	Deputy chief executive
Implementation lead	Head of communications

Objective 7	To reduce the number of complaints received where poor communication is identified as a root cause
Rationale and past performance	Identified by Trust Board as an improvement area – we know that failures in communication account for a significant proportion of complaints received by the Trust.
What do our patients say?	"The information relayed by doctors was vague and the language that they used was jargon." "My experience was a very positive one and this has not been the case in some other hospitals I have used. The big difference was UH Bristol provided clear, timely communication."
What will we do?	Analysis of complaints data reveals that in 2015/16, the Trust received a total of 320 complaints relating to the following categories: • Telecommunications and failure to answer phones (97) • Administration including waiting for correspondence (64) • Communication with patients and relatives (159) In 2016/17, we will be rolling out the changes to patient letters described in section 2.1.1 of this report. We will also be running a transformation project to improve the quality of telephone communications. Finally, during quarter 1, we will conduct further analysis of complaints previously received within the 'communication with patients and relatives' category, to see whether common themes and opportunities can be identified.
Measurable target/s for 2016/17	Our target is to achieve a reduction in complaints received in the categories described above.
How progress will be monitored	Reports to patient experience group
Board sponsor	Chief nurse

Objective 8	To ensure inpatients are kept informed about what the next stage in their treatment and care will be, and when they can expect this to happen
Rationale and past performance	Identified in discussion with Involvement Network as an important marker of positive patient experience when in hospital.
What do our patients say?	"I was kept informed at all times, from the cleaners to the doctors, and had excellent treatment." "I would like to see more communication between doctors and patient keeping them informed of what is happening with treatment."
What will we do?	During the first half of the year, we will carry out targeted 'Face to Face' interviews with inpatients to gain a clearer understanding of their needs and expectations around being kept informed, the ways in which patients are kept informed, and opportunities to do this better.
Measurable target/s for 2016/17	To be determined by chief nurse and medical director following scoping work described above
How progress will be monitored	Reports to patient experience group
Board sponsors	Chief nurse and medical director
Implementation lead	To be determined by chief nurse and medical director following scoping work described above

Objective 9	To fully implement the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted
Rationale and past performance	This is a key national standard which has the potential to make a significant difference to patients with disabilities who are cared for in our hospitals. Fits with the Trust's ambitions to do more to meet the needs of patients from defined equalities groups, which will form part of the Trust's quality strategy.
What do our patients say?	"Some nurses didn't know my child was disabled." "This operation was for my 15-year-old son who is deaf. We never got help from anyone who could sign to him and, if I wasn't there, he would have been lost. No-one could talk to him. They knew that he was deaf."
What will we do?	We will develop and implement a Trust-wide plan to address the requirements of the standard.
Measurable target/s for 2016/17	To be agreed
How progress will be monitored	To be determined as part of development of Trust-wide plan
Board sponsor	Chief operating officer
Implementation lead	Associate director of operations

Objective 10	To increase the proportion of patients who tell us that, whilst they were in hospital, we asked them about the quality of care they were receiving
Rationale and past performance	All trusts perform relatively poorly on this measure in the National Inpatient Survey; UH Bristol particularly so, because our current surveys are geared largely towards asking patients to reflect on their care post-discharge. In 2016/17, we will implement a new system of routinely capturing and responding to patients' experiences of care whilst they are in hospital. This will form an important part of our new strategy for improving patient experience, which will be focussed on the theme of responsive care.
What do our patients say?	"Please remember that you (midwives/doctors etc.) do this daily, patients don't, so don't forget to take a moment however busy you are, to mean it when you ask a patient if they are okay and listen. Too often the question is asked but the reply is unheard."
What will we do?	During 2016/17, we will procure a new in-hospital patient feedback system to run alongside our existing post-discharge survey. This will enable staff to routinely ask patients about the quality of care they are receiving whilst they are still in hospital, at point of care, as part of a wider theme of delivering responsive care. In the meantime, during the first half of the year, we will carry out targeted 'Face to Face' interviews with inpatients to gain a clearer understanding of their needs and expectations around being asked about quality of care and raising anything they are unclear or concerned about.
Measurable target/s for 2016/17	To achieve significantly improved scores in this measure in the 2017 National Inpatient Survey (by virtue of when the survey takes place), but in the meantime, to see consistent progress through our own monthly survey.
How progress will be monitored	Reports to patient experience group
Board sponsor	Chief nurse
Implementation lead	Patient experience programme manager

Objective 11	To reduce avoidable harm to patients
Rationale and past performance	Reducing avoidable harm is a stated aim of our 'Sign up to Safety' Patient Safety Improvement Programme 2015-2018 and aligns with our vision 'to be among the best and safest places to receive healthcare' and the national 'Sign up to Safety' campaign's aims and objectives. Avoidable harm reduction is a longer term goal over several years. In our previous Safer Care Southwest Patient Safety Improvement Programme[3] 2009-2015, we set an improvement goal to reduce our adverse event rate[4] by 30 per cent. The graph below shows that over a five year period we achieved our goal to reduce our adverse event rate to below 31.74 per 1,000 patient days and sustain this.
UH Bristol NHS FT (SP-2) A03: adverse event rate per 1000 patient days - adverse event rate for whole of the Trust Goal : **31.74**	
What will we do?	We will broaden the scope of our adverse event rate audit tool to include additional types of adverse events not previously included. We will test this new tool during quarter 1 of 2016/17. We predict that the new tool will initially increase our adverse event rate so we will use it to establish a new baseline over quarters 2 and 3 and will then set an improvement target of 50 per cent reduction to be achieved over the next three years.
Measurable target/s for 2016/17	Completion of testing of the new audit tool in quarter 1 and establishing a new baseline by the end of quarter 3. Setting a new improvement goal of 50 per cent reduction in quarter 4.
How progress will be monitored	Progress will be monitored through quarterly reports to our Patient Safety Programme Board and our non-executive Quality and Outcomes Committee.
Board sponsor	Medical director
Implementation lead	Head of quality (patient safety)

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

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

Objective 12	To improve staff-reported ratings for engagement and satisfaction
Rationale and past performance	Although our 2015 staff survey results were better than the previous year, we still need to make considerable improvements if we are to achieve our ambition of being rated as one of the best teaching hospitals to work for.
What will we do?	Our plans for 2016/17 include: a focus on improving two way communication between staff and management; recognition events and team building; a review of the Trusts appraisal process; training programmes for line managers; health and wellbeing initiatives, with a specific focus on stress related illness, reduction in staff seeing errors and near misses and an increase in reporting where they are seen to increase lessons learned from the reporting; a piloted employee assistance programme; targeted action to address harassment and bullying; a revision and re-launch of the 'Speaking Out' policy; and support for staff forums and reverse mentoring.
Measurable target/s for 2016/17	Our target is to achieve improvements in the following areas of staff-reported experience: • Staff Friends and Family Test scores (this asks whether staff would recommend the Trust as a place to work and receive treatment) • Overall staff engagement (a 'basket' of measures covering staff motivation, involvement and advocacy) • The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month We will measure improvement via our annual all-staff census (this takes place in the third quarter of the year). We will also track progress via our quarterly Friends and Family Test survey (different staff groups are surveys each quarter: scores for each quarter are directly comparable to the equivalent survey 12 months previously).
How progress will be monitored	Divisional Board meetings and Trust Board
Board sponsor	Director of workforce and organisational development
Implementation lead	Divisional directors supported by corporate human resources

2.1.2.1 How we selected these objectives

These objectives have been developed, following consideration of:

- our desire to maintain our focus on any quality objectives that were not achieved in 2015/16
- views expressed by our members of our Involvement Network at a meeting in January 2016
- feedback from our governors
- feedback from staff and members of the public via an online survey
- feedback from patients via ongoing surveys
- the views and quality priorities of the Trust Board and our commissioners
- the Government's mandate to NHS England for 2016/17

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2015/16, UH Bristol provided relevant health services in 70[5] specialties via five clinical divisions (Medicine; Surgery, Head and Neck; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2015/16, 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 2015/16 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2015/16.

2.2.2 Participation in clinical audits and national confidential enquiries

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

During 2015/16, 38 national clinical audits and three national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, University Hospitals Bristol NHS Foundation Trust participated in 100% (38/38) national clinical audits and 100 per cent (3/3) of the national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2015/16, and whether it did participate, are as follows:

[5] 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 NHS Improvement)

Table 1

Name of audit / Clinical Outcome Review Programme	Participated
Acute	
Case Mix Programme (CMP)	Yes
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes
National emergency laparotomy audit (NELA)	Yes
National Joint Registry (NJR)	Yes
Procedural Sedation in Adults (care in emergency departments)	Yes
VTE risk in lower limb immobilisation (care in emergency departments)	Yes
National Complicated Diverticulitis Audit (CAD)	Yes
Emergency Use of Oxygen	Yes

Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Yes
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	Yes
Cancer	
Bowel cancer (NBOCAP)	Yes
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes
Cardiac Rhythm Management (CRM)	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes
Coronary Angioplasty/National Audit of PCI	Yes
National Adult Cardiac Surgery Audit	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Heart Failure Audit	Yes
Long term conditions	
National Diabetes Audit (Adult) ND(A)	Yes
National Diabetes Foot Care Audit (NDFA)	Yes
Diabetes Inpatient Audit	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
National Ophthalmology Audit	Yes
UK Cystic Fibrosis Registry	Yes
Older people	
National Hip Fracture Database (NHFD)	Yes
National Audit of Inpatient Falls (NAIF)	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes
UK Parkinson's Audit	Yes
Other	
Elective surgery (National PROMs Programme)	Yes
Women's and Children's Health	
Vital signs in children (care in emergency departments)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric Asthma	Yes
Paediatric intensive care (PICANet)	Yes
Child Health Clinical Outcome Review Programme	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes

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

Table 2

Name of audit / Clinical Outcome Review Programme	% Submitted
Acute	
Case Mix Programme (CMP)	100% (1332/1332)
Major Trauma: The Trauma Audit & Research Network (TARN)	80% (327/408)
National emergency laparotomy audit (NELA)	64% (145/228)
National Joint Registry (NJR)	45*
Procedural Sedation in Adults (care in emergency departments)	100% (50/50)
VTE risk in lower limb immobilisation (care in emergency departments)	100% (50/50)
National Complicated Diverticulitis Audit (CAD)	30*
Emergency Use of Oxygen	22*
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	42% (8/19)
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	100% (88/88)
Cancer	
Bowel cancer (NBOCAP)	120 (188/157)**
Lung cancer (NLCA)	148*
Oesophago-gastric cancer (NAOGC)	>90% (211*)
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	833
Cardiac Rhythm Management (CRM)	840*
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (744/744)
Coronary Angioplasty/National Audit of PCI	100% (1690/1690)
National Adult Cardiac Surgery Audit	100% (1411/1411)
National Cardiac Arrest Audit (NCAA)	98*
National Heart Failure Audit	318*
Long term conditions	
National Diabetes Audit (Adult) ND(A)	613*
National Diabetes Foot Care Audit (NDFA)	23*
Diabetes Inpatient Audit	83*
Diabetes (Paediatric) (NPDA)	100% (1567/1567)
Renal replacement therapy (Renal Registry)	66*

Rheumatoid and early inflammatory arthritis	18*
UK Cystic Fibrosis Registry	371*
Older People	
National Hip Fracture Database (NHFD)	100% (315/315)
National Audit of Inpatient Falls (NAIF)	100% (30/30)
Sentinel Stroke National Audit Programme (SSNAP)	>90% (466*)
UK Parkinson's Audit	54*
Other	
Elective surgery (National PROMs Programme)	60% (103/173)
Women's & Children's Health	
Vital signs in children (care in emergency departments)	100% (50/50)
Neonatal intensive and special care (NNAP)	100% (721/721)
Paediatric Asthma	100% (25/25)
Paediatric intensive care (PICANet)	100% (775/775)
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	100% (59/59)

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

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

The reports of 13 national clinical audits were reviewed by the provider in 2015/16. University Hospital Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

British Thoracic Society (BTS) Emergency Oxygen Audit

- introduce a Patient Group Direction to allow senior nurse practice nurses to prescribe oxygen; ward-based education in oxygen prescribing has also been introduced.

National Emergency Laparotomy Audit (NELA)

- 'Boarding' and 'landing' cards have been introduced to help prompt decisions around pre and post-operative care and to improve the standardisation of care in theatres.

College of Emergency Medicine Audits

- the operating hours of the mental health liaison team will be increased to reduce the time patients wait to be reviewed; the Mental State Examination (MSE) will also be incorporated into the matrix assessment form
- fluid balance forms are to be made available in the resuscitation area to improve the management of patients with severe sepsis/septic shock
- a flow chart/decision aid will be designed to aid management from the early stage of triage of patients presenting with a paracetamol overdose
- follow-up arrangements for fitting patients presenting to the Emergency Department will be clarified and improved through the introduction of a new guideline and care record proforma; a 'Fits, Faints and Funny Turns' leaflet is also being produced to raise parental awareness
- a wheeze care record proforma is being developed to better manage patients presenting with moderate and severe asthma; Trust guidance is also being revised in line with national recommendations.

National Cancer Audits

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

National Heart Failure Audit

- an outreach heart failure service from cardiology to medicine has been established
- consultant and nursing capacity has been increased to manage additional referral activity
- electronic alert and referral systems have been set up within Medway (the Trust's patient

administration system) to identify patients admitted with heart failure and improve their management
- an electronic data capture system has been designed in Medway to improve the capture of data required for the national audit.

National Adult Inflammatory Bowel Disease (IBD) Audit
- extra IBD specialist nurses are to be recruited and our clinical guidelines for the management of IBD are to be re-written.

National Diabetes Inpatient Audit (NADIA)
- further diabetes inpatient specialist nurse roles are to be recruited to and an inpatient diabetes steering group is being established to improve the care of diabetic patients.

National Diabetes Audit – Pregnancy in Diabetes
- a database/spreadsheet is to be created which will allow capture of specific baseline data (e.g. folic acid prescribing) at the first clinic visit and facilitate analysis of UH Bristol specific data moving forwards
- liaison with primary care and education about 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 team is fully engaged with the established south west diabetes and pregnancy regional network to support regional service development, sharing of data and ideas and agreeing consensus best practice
- the antenatal endocrine service provision and capacity will be reviewed in order to increase frequency of contact with patients to support improved glycaemic control.

National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme
- the Trust's admission proforma is being redesigned to help capture and 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 & Fibrilation) score.
- smoking cessation and referral to pulmonary rehabilitation referral is now a matter of course after introducing the formal discharge bundle of care
- portable spirometers for the three respiratory wards within the Trust and for the Medical Assessment Unit are in the process of being purchased.

Childhood Epilepsy Audit (Epilepsy 12)
- care pathways, guidance and care proforma will be amended to help improve the management of children with epilepsy
- secondary care epilepsy clinics will be introduced and a transition service set up
- a questionnaire will be designed to capture the parental issues relating to behavioural, developmental and emotional issues of the children.

Neonatal intensive and special care (NNAP)
- further targeted local audits have been identified to help improve practice.

The outcome and action summaries of 218 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2015/16; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2015/16[6].

2.2.3 Participation in clinical research

As a research active trust providing specialist care to patients in Bristol and across the South West, we recognise the importance of research in gathering the evidence to improve the care the NHS delivers.

We are proud of the research that takes place in UH Bristol, and that we can give patients the opportunity to participate in a trial relevant to their condition, receive gold-standard clinical care which is provided or sub-contracted by UH Bristol, and to play a part in generating research evidence. The number of patients receiving relevant health services provided by University Hospitals Bristol NHS Foundation Trust in 2015/16 that were recruited during

[6] Available via the Trust's internet site from July 2016

that period to participate in research approved by a research ethics committee was 4,429. As of 31st March 2016, we have 756 active research projects. They include clinical trials of investigational medicinal products, and interventional trials such as surgical trials.

Table 3

Number of active non-commercial (portfolio) projects	457
Number of active non-commercial (non-portfolio) projects	144
Commercial studies registered	155 (125 portfolio studies)
Number of recruits in non-portfolio non-commercial trials	555
Number of recruits in portfolio non-commercial trials	3,524
Number of recruits in commercial trials	350

Over the last year, we have focused on a number of specific areas. We continued to support researchers to develop high quality grant applications and then setting up grants and recruiting more quickly, to ensure the funding is used most effectively. We have opened trials in new areas, notably obstetrics and ear nose and throat, and are working collaboratively with new local partners to deliver their trials successfully. We continue to be committed to the rapid set-up and effective delivery of high quality commercial research at UH Bristol. These trials allow us to offer new treatments to our patients, which may otherwise not be available. They also provide an income stream to build capacity to deliver more trials at UH Bristol. In 2015/16 we recruited first patients to a number of trials – both nationally and internationally, and six of our Principal Investigators were recognised for the successful delivery of commercial research within the NHS by the chief medical officer as part of a National Institute for Health Research (NIHR) event.

We recognise that a well trained workforce is one of the keys to success, and have worked with partner organisations to make NIHR training accessible to staff across the research network. A group of our research staff are now trained to deliver a wide range of courses to their peers, including The Fundamentals of Clinical Research, Let's Talk Trials, Paediatric Communication and Consent, and Valid Informed Consent, in addition to the International Conference on Harmonisation of Good Clinical Practice (ICH-GCP).

2015/16 saw the close of an international trial, in which the effectiveness of two drugs in reducing swelling of the macula for patients with diabetic macular edema was assessed. This was the first trial to come to the UK through a formal consortium agreement between the NIHR Moorfields Biomedical Research Centre, for which UH Bristol leads on inflammation and immunotherapeutics, and the National Institutes of Health (NIH) in the USA. UH Bristol recruited nearly two thirds of the 66 patients recruited in the trial, across the UK and USA. As a result of this successful collaboration we have been in discussions with the NIHR and NIH regarding four potential new trials we hope to bring to Bristol.

It is important to demonstrate that research has an impact on the health care the NHS delivers. Evidence from one of our sponsored trials was confidentially shared with NHS England ahead of its publication, in order for a prescribing recommendation to be made. As a result, NHS England published an interim clinical commissioning policy on the use of a biologic for children with severe refractory uveitis, recommending its use for patients who meet the clinical criteria it sets out. The policy will benefit children for whom uveitis threatens their sight, and for whom other treatments have proven ineffective.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2015/16 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 2015/16 for quality improvement and innovation goals was approximately £9.77m based on the sums agreed in the contracts (this compares to £9.63m in 2014.15).

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. 22 CQUIN targets were agreed, covering more than 35 measures. There were three nationally specified goals: acute kidney injury, sepsis (screening and timely provision of antibiotics) 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 22 CQUIN targets and four in part, as follows:

- Acute kidney injury
- Sepsis (partial)
- Dementia (partial)
- Improving diagnosis recording in A&E
- SHINE[7]
- Reduction in alcohol dependence and planned alcohol withdrawal
- Discharge summaries
- Reducing late inter provider cancer referrals
- Cancer treatment summaries
- End of life
- Ask 3 questions
- The Care Act - 'Making Safeguarding Personal'
- Care homes
- Organisational patient safety culture
- Transition
- BMT: comorbidity scoring of patients
- OncotypeDX
- Highly specialised services clinical outcomes collaborative audit meeting
- Hepatitis C
- Reduce delayed discharge from intensive care unit to ward level care by improving bed management in wards (partial)
- 2 year outcomes for infants <30 weeks gestation
- Standardised and equitable transition preparation across all patient groups
- Neonatal Unit Admissions (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 CQC has not taken enforcement action against the Trust in 2015/16.

The Trust's most recent comprehensive inspection took place between 10 and 12 September 2014, the outcome of which was reported in last year's Quality Report. UH Bristol was not subject to a CQC comprehensive inspection or any responsive reviews in 2015/16 – our CQC status therefore remains 'requires improvement'. The Trust did however participate in a CQC thematic review of integrated care for older people, and a review of health services for children looked after and safeguarding in South Gloucestershire.

The Trust received two outlier alerts from the CQC during 2015/16. In December 2015, the Trust received a maternity outlier alert for maternal non-elective readmissions within 42 days of delivering, and in March 2016, the Trust received a mortality outlier alert in respect of coronary atherosclerosis and other heart disease. The Trust responded to the CQC within the agreed timeframes for these alerts.

2.2.6 Data quality

UH Bristol submitted records during 2015/16 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: 99.5 per cent for admitted patient care; 99.8 per cent for outpatient care; and 96.8 per cent for accident and emergency care (these are all improvements on the 2014/15 data: 99.4 per cent for admitted patient care, 99.7 per

[7] SHINE is a patient safety checklist which brings together in an easy to use tool a list of all essential tasks, grouped by time from presentation. These require a time and signature as they are completed. Patients with service needs either related to or peripheral to their presentation have these recognised and have referrals made into the correct services. These are safeguarding, mental health, domestic or sexual violence, alcohol and drugs. Patients with conditions that require being on a pathway are recognised and that pathway commenced, specifically stroke, diabetic ketoacidosis, fractured neck of femur, gastro-intestinal bleed and sepsis. The tool minimises written information and facilitates easy, accurate handover between staff, particularly during busy periods.

cent for outpatient care and 96.0 per cent for patients in accident and emergency care)
- which included the patient's valid general practice code was: 99.9 per cent for admitted patient care; 99.9 per cent for outpatient care; and 99.9 per cent for accident and emergency care (the accident and emergency score is an improvement on 99.7 in 2014/15; the admitted patient care and outpatient care scores both declined by 0.1 per cent compared with validated 2014/15).

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2015 - January 2016 as at Month 10 inclusion date)

UH Bristol's information governance assessment report overall score for 2015/16 was 72 per cent and was graded Level 2. This is an improvement on our score of 66 per cent in 2014/15.

UH Bristol has not been subject to a national payment by results audit in 2015/16 as the accuracy of clinical coding is within accepted norms.

In 2015/16, the accredited auditor for the Trust's clinical coding team undertook an audit of 100 Finished Consultant Episodes (FCEs) in cardiac surgery and cardiology. The following levels of accuracy were achieved (2014/15 results in brackets):

- primary procedure accuracy: 100% (98.9%)
- primary diagnosis accuracy: 99.0% (90.0%)

In March 2015/16, the clinical coding team also carried out an audit of 50 FCEs in ophthalmology. The results showed an increase in accuracy for diagnoses and procedures (2014/15 results in brackets):

- primary diagnosis accuracy: 98.0% (96.0%)
- primary procedure accuracy: 98.0% (93.9%)

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

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

2.3 Mandated quality indicators

In February 2012, the Department of Health and NHS Improvement announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2015/16 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).

Mandatory indicator	UH Bristol 2015/16	National average 2015/16	National best 2015/16	National worst 2015/16	UH Bristol 2014/15	Page ref.**
Venous thromboembolism risk assessment	98.8% Apr-Dec15	95.7% Apr-Dec15	100% Apr-Dec15	80.6% Apr-Dec15	98.0%	39
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)	16.7 Apr15-Jan16	15.3 Apr15-Jan16	0 Apr15-Jan16	63.4 Apr15-Jan16	20.5	41
Rate of patient safety incidents reported per 1,000 bed days	54.64 Apr15-Sep15	38.23 Apr15-Sep15	117.00[8] Apr15-Sep15	15.90 Apr15-Sep15	54.80	51
Percentage of patient safety incidents resulting in severe harm or death	0.37% Apr15-Sep15	0.42% Apr15-Sep15	2.92% Apr15-Sep15	0% Apr15-Sep15	0.44%	51
Responsiveness to inpatients' personal needs	Comparative data for 2014/15 (2013/14 in brackets): UH Bristol score 69.4 (71.7); England overall 68.9 (68.7); low 59.1 (54.4); high 86.1 (84.2). Comparative data for 2015/16 will not be available from the Health & Social Care Information Centre until August 2016).					59
Percentage of staff who would recommend the provider	77.0% 2015 Staff Survey	75.0% 2015 Staff Survey	86.1% 2015 Staff Survey	55.4% 2015 Staff Survey	70.5% 2014 Staff Survey	69
Summary Hospital-level Mortality Indicator (SHMI) value and banding	97.8 (Band 2 "As Expected") Oct14-Sep15	100 Oct14-Sep15	65.2 Oct14-Sep15	117.7 Oct14-Sep15	96.1 (Band 2 "As Expected") Apr14-Mar15	76
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care'	23.5% Oct14-Sep15	26.6%	0.2%	53.5%	22.3% Apr14-Mar15	N/A

Patient Reported Outcome Measures	Comparative groin hernia data for 2014/15: 72% of UH Bristol patients reported an improved EQ-5D score (national average 50.7%); 45.5% of UH Bristol patients reported an improved EQ-VAS score (national average 38.1%). UH Bristol PROM data for varicose veins does not meet the publication threshold due to small sample size.	81
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.*	83
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.*	83

* 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.
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.

**page numbers indicate where in this report the indicators are discussed, or where there is related content

[8] 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 Review of services in 2015/16

3.1 Patient safety

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

What our patients said in our monthly survey

"I found the stay in hospital really good. I felt secure and very safe."

"I felt safe, comfortable and cared for. I do not feel I could have received better if I had gone to an expensive private facility. St Michael's Hospital is highly recommended in my view."

3.1.1 Patient falls

Falls and fractures are a common and serious problem affecting older adult inpatients, with over 240,000 falls reported each year from hospitals in England and Wales; resulting in significant personal and financial consequences (Royal College of Physicians 2015).

In 2015/16, we continued to focus on reducing the numbers of inpatient falls and incidences of harm caused by a fall. Common themes identified during the year were that the majority of falls were unwitnessed, age related, with over half of falls occurring in people with a degree of cognitive impairment.

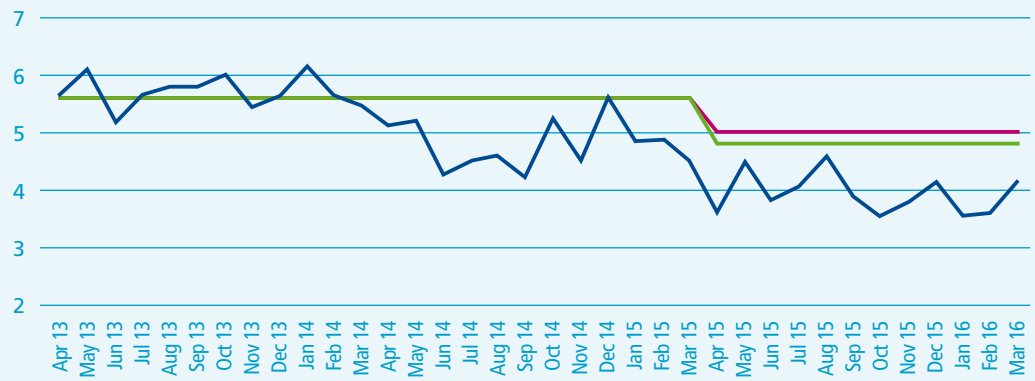
Our target for the year was to achieve fewer falls than the average 5.6 per 1,000 bed days (National Patient Safety Agency). Having achieved green status for 11 consecutive months in 2014/15, it was agreed by the Trust's Patient Safety Group that the target would be lowered to 4.8 per 1,000 bed days. As seen in Figure 1 we have consistently performed below (better than) the new target.

This reduction in falls has continued through a combination of focused work by our falls steering group. The promotion of initiatives such as the "Eyes on Legs" Campaign has helped embed the concept of falls being everyone's responsibility, regardless of role. Our bespoke falls training now incorporates an element on dementia and supporting patients with a cognitive impairment, as this group of patients are more susceptible to falls.

The Trust's clinical leads for falls continue to offer bespoke, face to face training in those areas reporting a higher numbers of falls or who have a fall with harm. Falls awareness forms part of the Trust's staff induction programme and clinical update days.

Figure 1

Patient falls per 1,000 bed days



Rate of falls per 1000 bed days
Green threshold of 4.8
Red 'Alarm' trigger of 5.0

Source: Falls base data, UH Bristol

Note: Prior to April 2015, the Trust used the old NPSA target of 5.6 falls per 1,000 bed days. Since April 2015, in a spirit of continuous improvement, we have adopted a green threshold of 4.8 (equal to our average falls rate in 2014/15), with an 'alarm' trigger of 5.0.

The falls steering group was proud to receive the 'Quality Champion' award at the annual Trust Recognising Success Awards in November 2015. In 2016/17, the group will continue to focus on reducing the level of harm to patients as a result of a fall. Additional actions are planned including:

- development of the Trust falls champions role and enhanced training for these staff members

- supporting the roll out of activity boxes for patients who are on 1:1 enhanced observation
- piloting the use of coloured tags on walking aids to identify the level of support needed for patients when walking
- increasing use of call bells through specific posters to highlight use to patients and carers.

Targeted promotional work will also take place during national falls awareness week in September 2016.

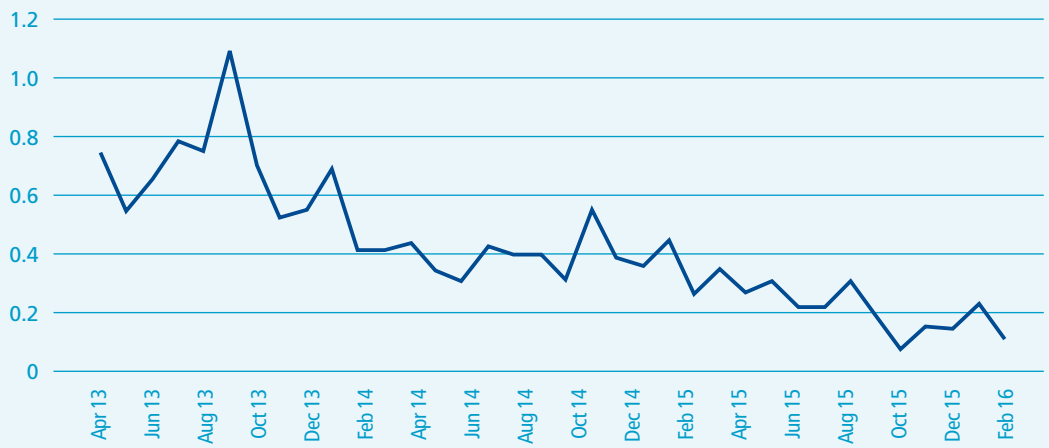
3.1.2 Pressure ulcers

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 2015/2016, the Trust's target was to achieve fewer than 0.4 category 2 to 4 hospital acquired pressure ulcers per 1,000 bed days. The target of 0.4 per 1,000 bed days was a reduction from the 2014/2015 target of 0.651 per 1,000 bed days. The Trust achieved 0.23 per 1,000 bed days during 2015/2016, achieving our target and a reduction from 2014/2015's figure of 0.398. This figure represents a reduction in the number of grade 2 and 3 hospital acquired pressures ulcers, with no grade 4 pressure ulcer seen over the last two years.

Figure 2

Number of hospital acquired pressure ulcers per 1,000 beddays



Source: Ulysses Safeguard and Datix® systems

The importance of achieving and sustaining pressure ulcer prevention and the impact this has on our patients' experience is recognised across the Trust. Good practice is well embedded and is underpinned by national guidance. Achievements during 2015/2016 include:

- implementing patient-centric pressure ulcer prevention care plans throughout the Trust
- working with community partners, implementing patient information leaflets throughout the Trust to ensure a consistent message is communicated across acute and community settings
- implementation and roll-out of a Trust-wide dressings formulary in order to standardise dressings across both acute and community settings
- developing a second generation interactive e-learning programme, which is specific to adult, maternity and paediatric clinical settings
- publication of an article and presentation of a poster at a national tissue viability conference
- six-monthly reviews of all grade 3 pressure ulcers to identify themes and ensure learning and actions are disseminated and captured on the work plan.

Planned actions for 2016/2017 include:

- introducing wound care and pressure ulcer prevention competencies throughout the Trust to compliment and link theory to practice training
- developing focussed work on reducing hospital acquired pressure ulcers, which are linked to pressure from medical devices
- reviewing our dynamic mattress contract to ensure it meets the needs of patients and is cost effective.

3.1.3 Venous thromboembolism (VTE)

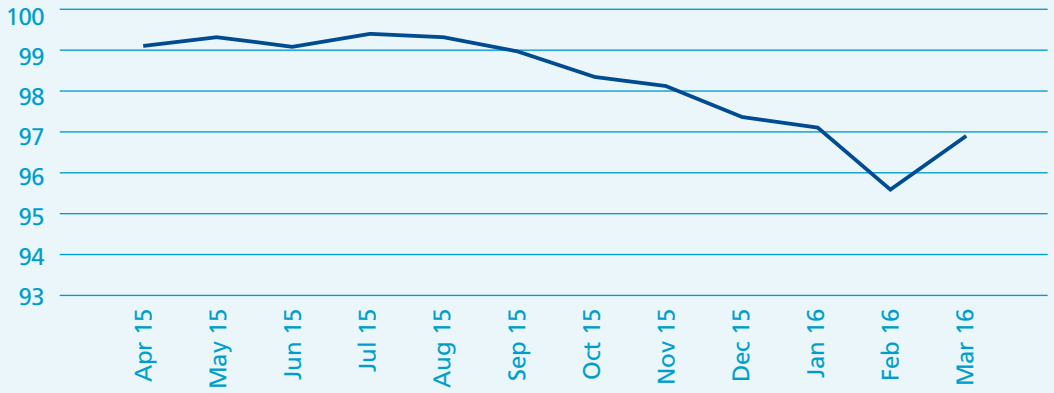
(Mandatory indicator)

In 2015/16, we aimed to sustain our good performance for 2014/15 by adhering to our locally set stretch target (99 per cent) for VTE risk assessment and 95 per cent for appropriate thrombo-prophylaxis.

We have consistently achieved the required national 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 98.2 per cent[9]; this compares with 98.8 per cent in 2014/15. From October 2015, there was a decline in performance below our 99 per cent stretch target which we have subsequently found to mainly be a data entry issue following a change of staff in the discharge lounge where large numbers of VTE risk assessments are recorded. Training was provided in this area in March 2016 and performance seems to have started to recover. We have however, remained above the national target of 95 per cent for the whole of 2015/16.

Figure 3

Percentage of patients receiving VTE risk assessment



Source: UH Bristol Medway 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 2015/16 to sustain more than 95 per cent compliance with VTE risk assessments: hospital associated VTE are subject to a modified root cause analysis (RCA) investigation[10], and should there be any learning regarding the timeliness or appropriateness of the VTE risk assessments and appropriate thrombo-prophylaxis, this is shared across the organisation.

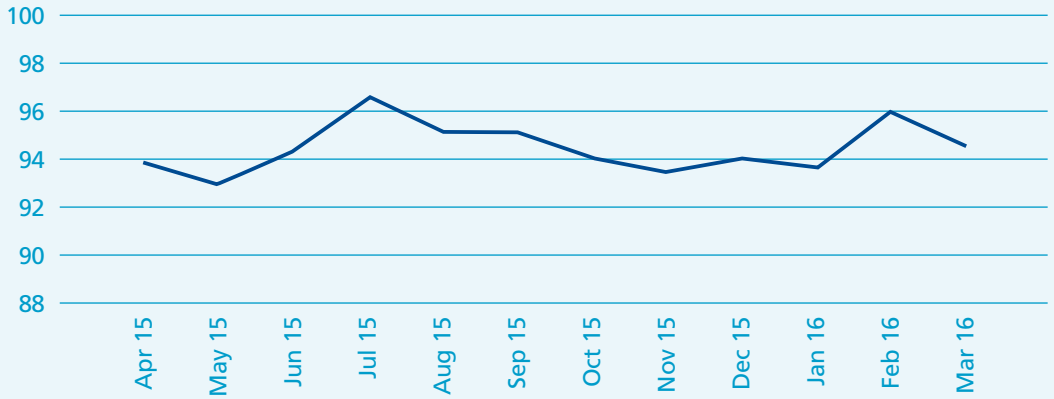
In 2015/16, 94.6 per cent of patients at risk of VTE received appropriate thrombo-prophylaxis, compared with 94.4 per cent in 2014/15 and 93.4 per cent in 2013/14. See Figure 4 below.

[9] This figure differs from the 98.0 per cent quoted in Table 4, which is from the Health & Social Care Information Centre and covers the first three quarters of the year only

[10] This is a requirement of our commissioners

Figure 4

Percentage of patients who received appropriate thrombo-prophylaxis



Source: Pharmacy ward audits

During the last year, there have been 76 cases of hospital associated thrombosis (compared with 66 in 2014/15), 11 of which were deemed potentially avoidable. At the time of writing, the Trust is finalising the investigations into all hospital associated thrombosis for the whole year.

There has been one serious incident which occurred in 2015/16 (but which was identified and reported in 2016/17) where a patient was unexpectedly found to have a pulmonary embolus on post mortem. The patient did have risk factors that would indicate a need for prophylactic enoxaparin; however, the VTE risk assessment was not completed and prophylactic enoxaparin was not given during the patient's admission. It is believed that had enoxaparin been administered, this may have reduced but not eliminated the patient's risk of pulmonary embolus. Following this incident, we have issued a further Trust-wide safety bulletin regarding VTE risk assessments entitled "Don't be a clot - Assess all patients for their venous thromboembolic risks" to raise awareness about what happened in this incident. There has also been some local learning regarding routes of admission for patients into the relevant specialty which are being reviewed and a plan to look at standardising ward rounds in the speciality.

3.1.4 Infection control

3.1.4.1 Clostridium difficile

(Mandatory indicator)

Clostridium difficile infection remains an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment. The Trust has made great strides over the years to reduce the numbers of *Clostridium difficile* infections; however there was a rise in cases during 2014/15 and the rate of improvement has slowed. It is important to note that some detected cases of *Clostridium difficile* are a consequence of factors such as clinical condition and are beyond the Trust's control. This has been acknowledged nationally and means that we need a greater understanding of individual cases. Accordingly, we changed our reporting methodology in 2014/15. The Trust and its commissioners (Bristol CCG) are now required to assess each case to see if there were lapses in care of each patient who acquires *Clostridium difficile* in the Trust, to determine whether these lapses in care contributed to their infection, and whether the *Clostridium difficile* infection was 'avoidable or unavoidable'. The limit for avoidable cases for 2015/16 was set at 45 by Public Health England. During the year, the Trust reported 17 avoidable cases.

Table 5

	Total Number of *Clostridium difficile* cases	Avoidable infections
2014/15	50	8
2015/16	40	17

Possible reasons for the slowing of improvement in the total number of Clostridium difficile infections include:

- a gradual increase in the mean age of patients, which increases the risk of development of significant co-morbidities and immobility
- 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.

The Trust has taken the following actions in 2015/16 to manage Clostridium difficile infection and to improve patient safety:

- patients are assessed by an infection control nurse, medical microbiologist and anti-infective pharmacist when a positive result is received
- patients are monitored by the infection prevention and control team on a daily basis
- all cases are assessed to determine if their infection was 'avoidable' or 'unavoidable '
- antibiotic prescribing continues to be monitored.

[10] This is a requirement of our commissioners

Figure 5

Number of reported cases of *Clostridium difficile*

Source: South West Public Health England Centre healthcare associated infection data

3.1.4.2 Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia

The National target of zero tolerance to avoidable MRSA (Meticillin-resistant Staphylococcus aureus) bacteraemia infection continues year on year. UH Bristol had three MRSA cases reported in 2015/16; an improvement from 2014/15 when five cases were reported and attributed to the Trust. Post infection reviews have been undertaken and have shown that all the cases were clinically complex and challenging. Two recurrent themes were identified:

- MRSA decolonisation washes were not continued for the duration of stay of the patient in the hospital as per Trust policy
- Documentation such as stool charts and risk assessments were not being fully completed.

Action plans have been agreed to ensure these concerns are addressed and infection control clinical focus ward rounds have been commenced weekly by the infection control team to help to focus on these issues.

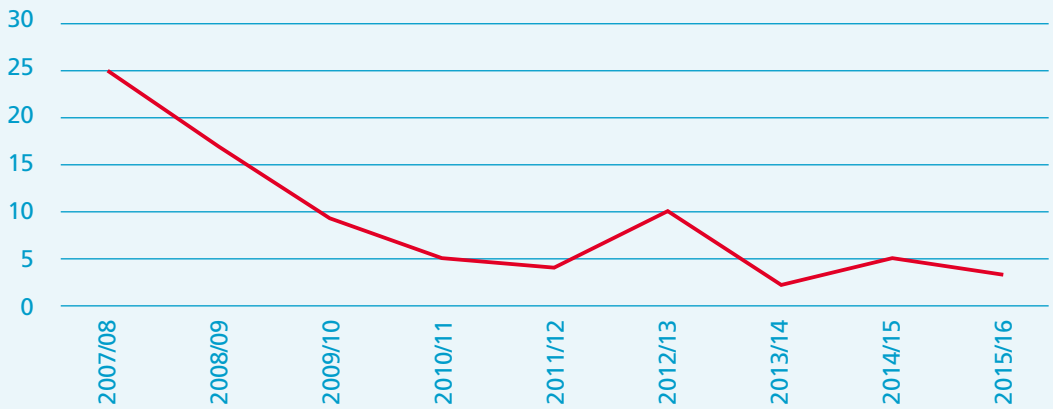
3.1.4.3 Peripheral and central line care

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 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 2015/16 include the following:

- ANTT is now part of essential training
- an ANTT compliance audit is now available on the Trust's intranet; to be completed quarterly
- the introduction of bio patches - chlorhexidine impregnated disks that fit around the catheter and sit on the skin of the patient - in our medical division has coincided with a decrease in line infections; our specialised services division has also implemented bio patches and seen a reduction in catheter related blood stream infections (CRBSI)
- we plan to evaluate Posiflush - a ready to use sterile pre-filled syringe for flushing vascular access devices - in the Bristol Haematology and Oncology Centre to further reduce infection rates
- all clinical areas have now implemented Microclave - clinically-proven needlefree technology designed to reduce the risk of bacterial contamination and improve patient outcomes
- the Trust is reviewing intravenous dressings to improve infection rates.

Figure 6

Number of reported cases of *MRSA*



Source: Public Health England Data Capture System

3.1.4.4 Meticillin susceptible Staphylococcus aureus (MSSA) bacteraemia
The Trust's MSSA bacteraemia target for 2015/16 (set by the Trust) was 25 cases. The number of cases reported was 26. Actions to prevent MSSA are similar to those for MRSA. There is no national guidance indicating widespread screening of MSSA at the present time. The number of people who harmlessly carry MSSA (approximately one third) is far greater than MRSA.

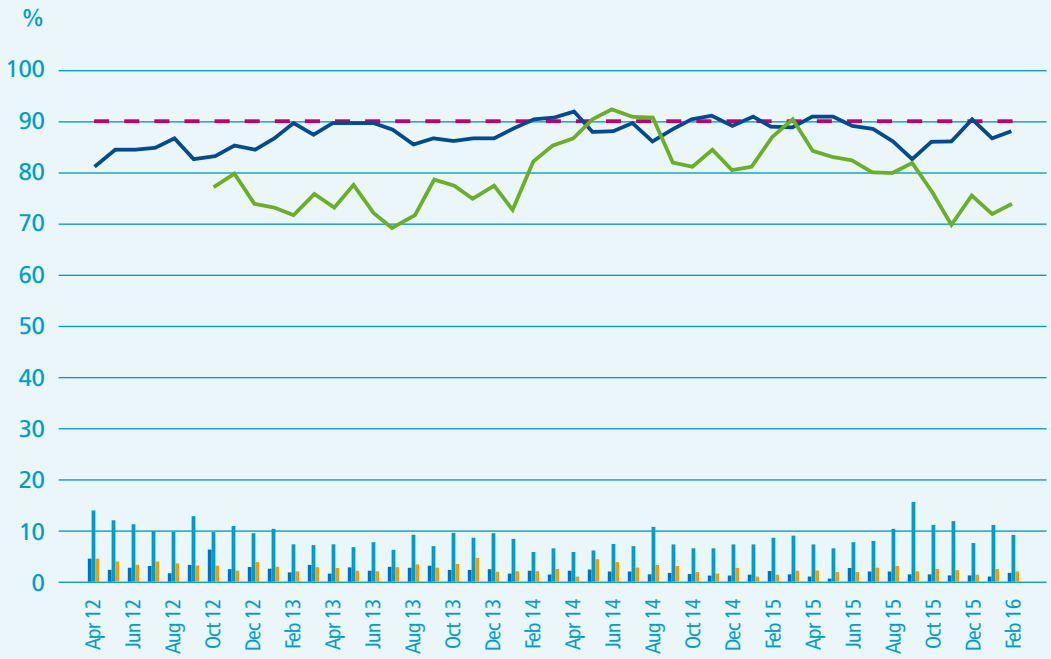
There were 11 MSSA cases relating to vascular access devices during 2015/16. This equates to a reduction of four cases from the previous year. Work continues on care pathways for vascular access devices and standardisation of care. Education and awareness has increased, and aseptic non-touch technique continues to be a focus for infection control link practitioners throughout the Trust.

3.1.4.5 Norovirus
Norovirus cases are being managed more effectively following the opening of the new Bristol Royal Infirmary ward block and a 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. In 2015/16, there were a number of bays closed for short periods throughout the year but there was only one full ward closure. Up to the end of February (the latest data available at the time of writing) there were five bay closures and 18 bed days lost; a significant improvement over the year.

3.1.4.6 Pharmacy
Antibiotic compliance began favourably in 2015/16, meeting our 90 per cent target, however the departure of the pharmacy data manager resulted in a gap of four months when data was not communicated to divisions. This was associated with a very significant fall in compliance which had not been seen since 2012. This serves to underline the importance of feedback. Prescriber legibility (being able to read the signature of the prescriber) has also declined over the past year (87.7 per cent). Anti-infective ward rounds are currently being reviewed with an aim to improve compliance.

Figure 7

Antimicrobial stewardship reviews: Trustwide



Source: University Hospitals Bristol pharmacy department

3.1.5 Reducing medication errors

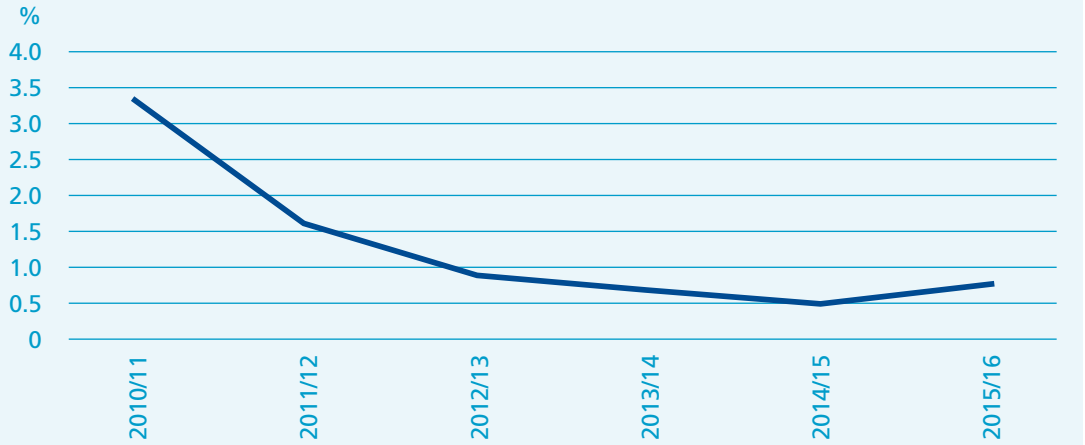
In 2015/16, our aim was to continue overall improvement in medication safety, ensuring that medication related harm was minimised. Our focus of attention has been on keeping the number of medication incidents with a level of moderate or greater harm (as defined in the National Patient Safety Agency's model matrix) to a minimum, continuing to improve on the low level of omitted doses of critical medicines, and improving the safe use of medicines when patients are transferred from hospital to their home environment.

In 2015/16, we continued to give particular attention to patient safety alert NHS/PSA/D/2014/005, the subject of which was effective reporting of and learning from medication errors. In August 2015, the Trust changed its incident reporting system to Datix®. Since this time, the number of medication incidents and adverse drug reactions reported has increased compared with previous years. We view this as a positive development. The system is empowering more staff to report medication incidents and near misses, as a result of which we know more about what goes wrong and how to prevent recurrence. All reported medication errors and near misses are reviewed by a member of the pharmacy medication safety team irrespective of level of harm caused to the patient, and incidents are selected for formal review and 'sharing the learning' through the medication safety group. In the last year, we have seen an increase in the number of incidents reported which are non-preventable, for example adverse drug reactions to the first dose of a medicine (our assumption is that this has resulted from a reporting system which is quicker and easier to use).

In 2015/16, 19/2373 (0.8 per cent) of medication related incidents were reported with a level of moderate, major or catastrophic harm caused to the patient. The breakdown by level of harm is moderate (16/19), major (2/19) and catastrophic (1/19). This compares to 2014/15, when 10/2007 (0.5 per cent) of medication related incidents resulted in moderate (8/10), major (1/10) or catastrophic (1/10) harm. The Trust's progress over the last six years in reducing harm from medication related incidents is shown in Figure 8.

Figure 8

Percentage of medication incidents causing moderate or greater harm



Source: Datix® Incident Reporting System

Although our reported performance in 2015/16 has not improved compared to 2014/15, further analysis of the 17 reported cases of moderate, major or catastrophic harm reveals that eight of these incidents cannot be attributed to preventable harm, i.e. errors of practice or patient safety incidents. Five of the reported incidents (causing moderate harm) were as a result of adverse drug reactions to a first dose of a medicine. These incidents, while unfortunate for the patients concerned, cannot be predicted or prevented (we note these adverse reactions in the medical notes in order to avoid the patients being given the same drug again). Two incidents (also moderate harm) involved extravasation injuries (this is where medication given by injection directly into the vein leaks out of the vein and irritates the surrounding tissue). The medical notes from both of the patients that suffered these extravasation injuries suggest that the actual harm caused to the patient was minor rather than moderate (extravasation injuries are treated similarly to burns and the patients had no long lasting effects). One further incident (moderate harm) described an omitted dose of a baby's medicine: the dose was not given because a second consultant had stopped the medicine on the drug chart.

These six incidents of non-preventable harm are of a type that has not been reported prior to the introduction of the Datix® system. For purposes of direct comparison, Figure 9 has therefore been adjusted to show the percentage of preventable medication incidents that resulted in moderate or greater harm when compared to data from previous years.

Figure 9

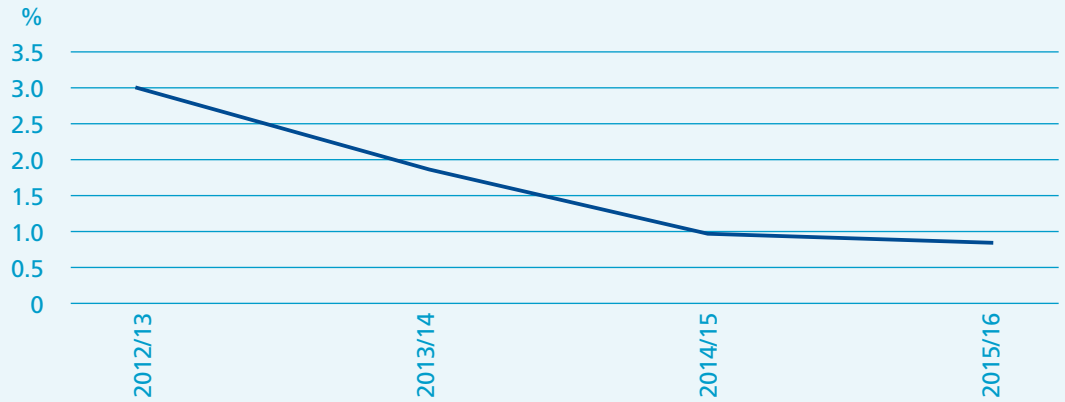
Percentage of *preventable* medication incidents resulting in moderate or greater actual harm

Source: Datix® Incident Reporting System

As in 2014/15, we set ourselves the goal of further reducing the number of unintentional omitted doses of critical medicines. This is important to patient safety and quality of care and to ensure that medicines use is optimal. Using the same data collection methods as previous years (sampling methodology involving approximately 1,000 patients per month, monitoring the previous three days treatment), we were successful in reducing the percentage of omitted doses of critical medicines to 0.87 per cent: a 14 per cent reduction compared to 2014/15 and a total 70 per cent reduction in the number of unintentional omitted doses of critical medicines since we started monitoring our performance in 2012. The results are shown in Figure 10.

Figure 10

Percentage of omitted doses of critical medicines

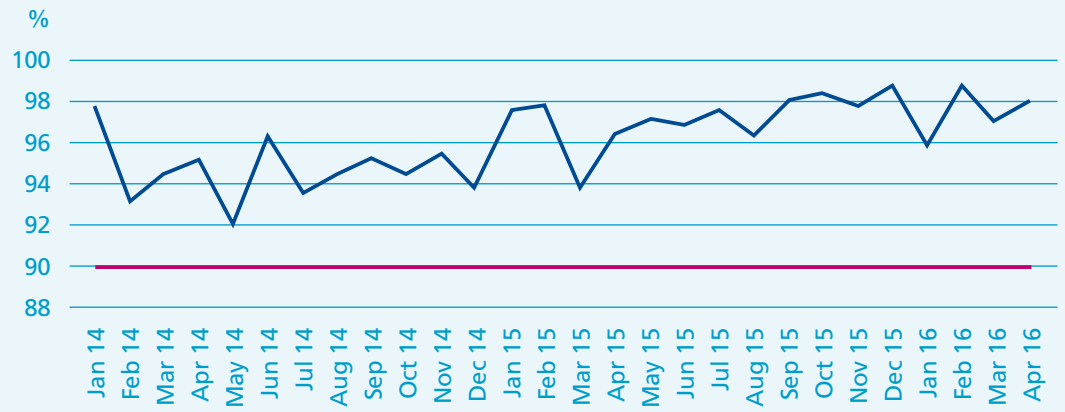


Source: Pharmacy medicines safety data

Our work to improve medicines safety when patients are transferred home has focussed on improving the time it takes to supply patients' medicines when they are discharged from hospital. Since 2011, we have had internal Trust target that at least 90 per cent of discharge medicines prescriptions will be available within two hours. We are now exceeding this target, with the result that patients' transfer of care is now more streamlined and there are fewer delays at discharge due to medicines not being ready. Results are shown in Figure 11.

Figure 11

Percentage of TTAs ready within 2 hours



Source: UH Bristol Webtracker data

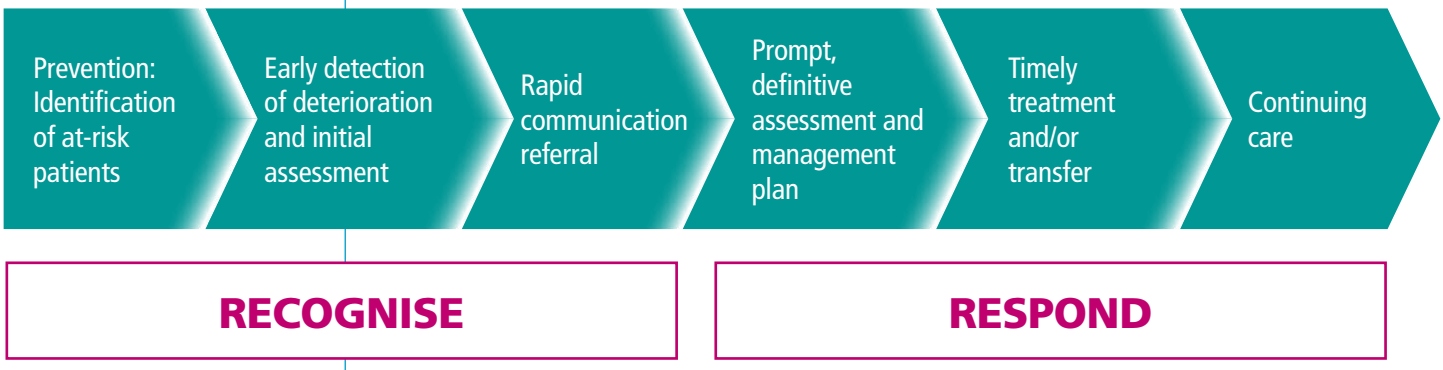
In 2016/17, in addition to our on-going focus on the areas of practice described above, we will be commencing a pilot of electronic prescribing and administration. Our aim is to scrutinise the prescribing and administration of all medicines to ensure they are given as they are intended, when they are intended. We anticipate that this electronic system will alert us when medicines have been omitted or delayed so this will provide us with further information and intelligence on medication usage.

We will also participate in two new patient safety projects coordinated by the West of England Academic Health Science Network. The theme of the first of these projects is insulin safety, whilst the second project involves supporting patients with their medication when they are discharged from hospital. Work to date on the latter project includes the introduction of the 'PharmOutcomes' system which will engage community pharmacies in the ongoing support of their patients.

A further priority area, identified from our incident reporting and learning, is that there is scope for improving the quality of medication second checking at the point of medicines administration. We will therefore also be focussing attention on this as an area of safety in which to improve within the next year.

3.1.6 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 achieved our 'outcome' improvement goal for deteriorating patients by reducing the number of validated cardiac arrest calls for adult inpatients in general ward areas. We also described the actions we had taken to improve the escalation of deteriorating patients; this resulted in some improvement in 2014/15, however we did not manage to sustain our 95 per cent improvement goal.

Knowing we have more work to do, we have included the continued focus on early identification and escalation of deteriorating patients in our Sign up to Safety Patient Safety Improvement Programme (2015-2018) as described in section 3.1.13 of this report.

One of the key elements of the programme in 2015/16 has been the development and implementation of a new adult observation chart incorporating the National Early Warning Score (NEWS),[11] in conjunction with North Bristol NHS Trust. Following testing of a number of prototypes in defined areas in both Trusts, the new observation chart was introduced on 17th December 2015. This has meant a change for front line staff in how the early warning score is calculated and in the escalation of deteriorating patients for senior clinical review. Implementation was supported by a training programme and resources delivered by a training and education manager experienced in the implementation of NEWS, provided by the West of England Academic Health Science Network.

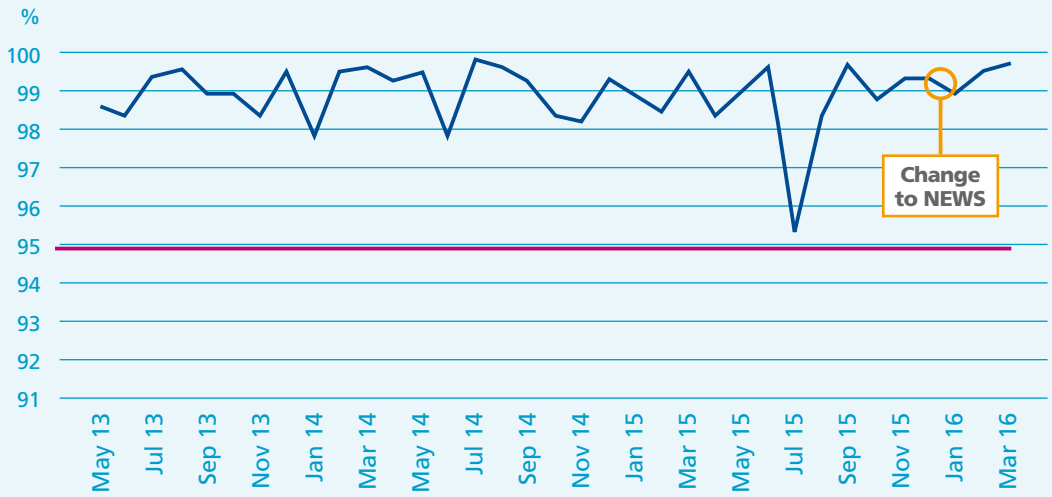
Throughout 2015/16, we have continued our monthly process measures of accuracy of completion of early warning scores, the appropriate response to a deteriorating patient and the use of a structured communication tool to escalate the patient for senior clinical review. We have also continued to monitor the cardiac arrest outcome measure described above. We anticipated the potential for an initial slight reversal of the previous improvements we had made in the aftermath of this change, as people became used to the new calculation of early warning scores and escalation protocol, therefore a risk assessment was conducted and mitigating action put in place.

Figure 12 shows that we have sustained over 95 per cent achievement in completeness and accuracy of early warning scores, following the introduction of the new adult observation chart incorporating the NEWS score.

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

Figure 12

Percentage of TTAs ready within 2 hours



Source: UH Bristol Webtracker data

Table 6

Percentage of early warning scores correctly calculated, 2015/16

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
98.4	99.0	99.6	95.3	98.4	99.7	98.7	99.3	99.3	98.9	99.5	99.7

Figure 13 shows that in the early part of 2015/16 there were signs of improvement towards our 95 per cent improvement goal for appropriate response to trigger scores, however performance tailed off towards the end of 2015 prior to the introduction of NEWS. Additional training is being targeted to the areas where greatest improvement in needed and we are also testing a revised escalation protocol designed to make it easier for staff to escalate the sickest patients.

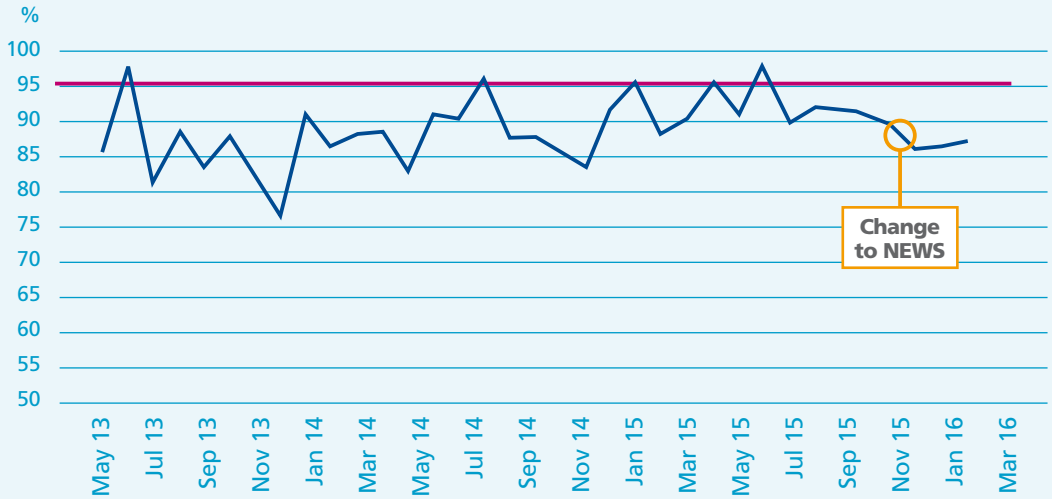
The change to NEWS has afforded us the opportunity to get beneath the reasons why patients are not always escalated (or why this is not always recorded) and to address any underlying causes that prevent this happening. It has also identified a training need for doctors in resetting triggers and to consider treatment escalation plans for appropriate patients.

Figure 14 shows variation in the use of the SBAR structured communication tool to escalate deteriorating patients, partly due to the relatively small numbers of patients involved. The increased sensitivity of NEWS to trigger deteriorating patients has meant that the number of patients requiring SBAR communication to escalate has approximately doubled from 10-15 patients to 30-35 patients in any 24 hour period. We will use the additional NEWS training to remind staff to use SBAR as well as getting beneath the reasons why this does not always happen.

[12] SBAR: Situation, Background, Assessment, Recommendation - a structured communication tool

Figure 13

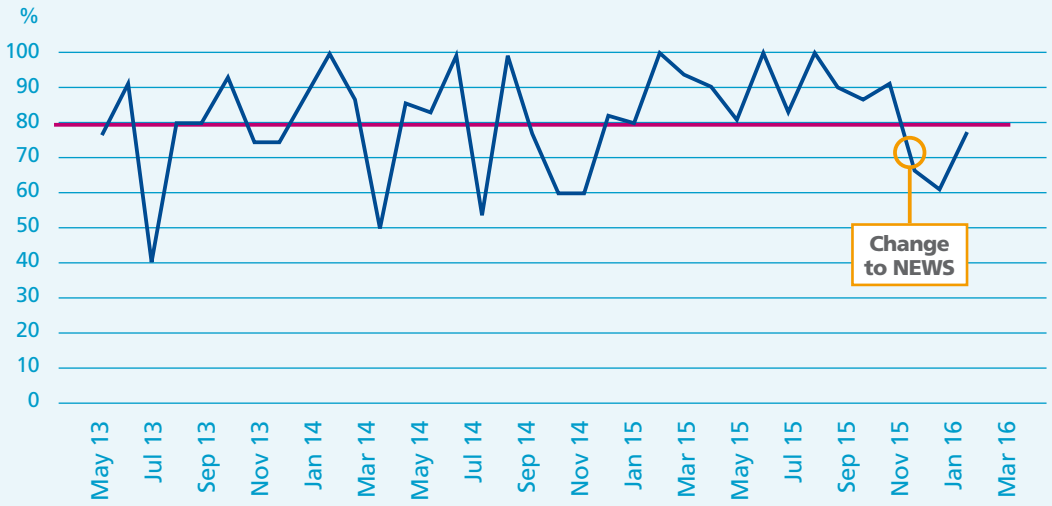
Percentage of patients who had a documented appropriate response to a triggering early warning score



Source: monthly audit

Figure 14

Percentage of patients who had a documented appropriate response to a triggering early warning score

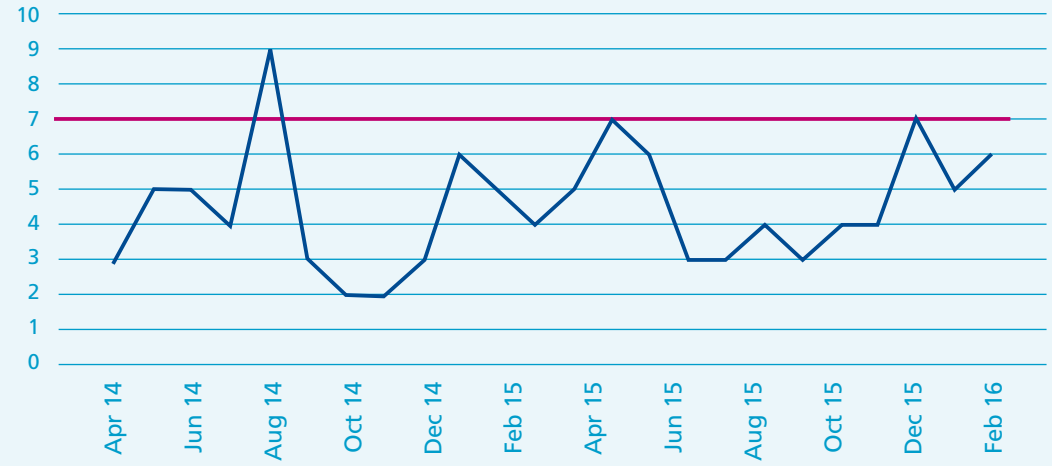


Source: monthly audit

Finally, Figure 15 below shows that, in 2015/16 we have sustained our 2014/15 improvement goal of reducing the number of validated cardiac arrest calls from adult inpatient wards. We achieved our target of no more than seven validated cardiac arrest calls in any given month. In 2016/17, we expect our sustained progress to be strengthened by the introduction of NEWS. We are also looking to include additional outcome measures to assess the effectiveness of our improvement actions.

Figure 15

Cardiac arrest calls from adult in-patient areas



Source: monthly audit

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

(Mandatory indicators)

The data for 2015/16 presented in this section of the report are a combination of NHS England's National Reporting and Learning System (NRLS) data, released in April 2016 covering the period from April to September 2015, and provisional data submitted to the NRLS by UH Bristol for the period from October 2015 to March 2016; the final data for this period will be published by the NRLS in November 2016.

The data shows that the total number of incidents reported in April to September 2015 was 6,789, which equates to a rate of 54.64 incidents per 1,000 bed days. Provisional data for the second six months of 2015/16 shows the number of reported incidents to the NRLS was 7,162; an estimated rate of 57.64 incidents per 1,000 bed days. For 2015/16 as a whole, this gives a provisional total number of 13,951 incidents and an estimated rate of 56.14 incidents per 1,000 bed days.

The percentage of reported incidents at UH Bristol resulting in severe harm[13] during April to September 2015 was 0.3 per cent (17[14] incidents), similar to the previous six months (0.3 per cent, 22 incidents) and to the corresponding period in 2014 (0.3 per cent, 21 incidents). The percentage of reported incidents resulting in death was at 0.1 per cent (eight deaths) for the period of April to September 2015. This represents an increase from the previous six months (0.08 per cent, five deaths) and the same period last year (0.1 per cent, seven deaths).

Provisional data sent to the NRLS by UH Bristol for the period October 2015 to March 2016 indicates that 0.32 per cent of reported incidents in that period resulted in severe harm or death (20 severe harm incidents and three potentially avoidable deaths out of 7,162 incidents).

The provisional percentage of reported incidents resulting in severe harm or death in 2015/16 as a whole was therefore 0.26 per cent (27 severe harm events and 11 deaths). This compares with 0.38 per cent in 2014/15 (38 severe harm events and 12 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 2016/17, the Trust intends to continue with the implementation of our Sign up to Safety Patient Safety Improvement Programme (described in section 3.1.13 of this report), to reduce harm from avoidable patient safety incidents. Other patient safety sections of this report describe further work underway within the Trust to prevent or reduce the risk of harm to patients. We will also 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.

3.1.8 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 made by an executive director. Throughout 2015/16, 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 69, compared to 78 in 2014/15. Of the 69 serious incidents initially reported, two were subsequently downgraded. Nine investigations remain in progress at the time of writing (April 2016). A breakdown of the categories of the 69 reported incidents is provided in Figure 16 below.

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

In January 2016, the Trust was served with a Contract Performance Notice by Bristol Clinical Commissioning Group for failing to achieve compliance with requirements set out in the Serious Incident (SI) Framework (NHS England, March 2015) relating to the timelines of reporting and investigating serious incidents. The Trust has put in place a robust action plan with a recovery trajectory to achieve 100% compliance by July 2016.

3.1.8.1 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 2015/16 include:

- the need for continued improvement in the recognition and response to deteriorating patients in 2016/17; this will happen as part of our 'Sign up to Safety' improvement programme as described in section 3.1.13
- the need to further strengthen our processes to prevent peri-procedure never events in 'out-of-theatre' environments; this aligns with the work we are already undertaking to comply with the National Safety Standards for Invasive Procedures published towards the end of 2015 and will happen as part of our 'Sign up to Safety' improvement programme

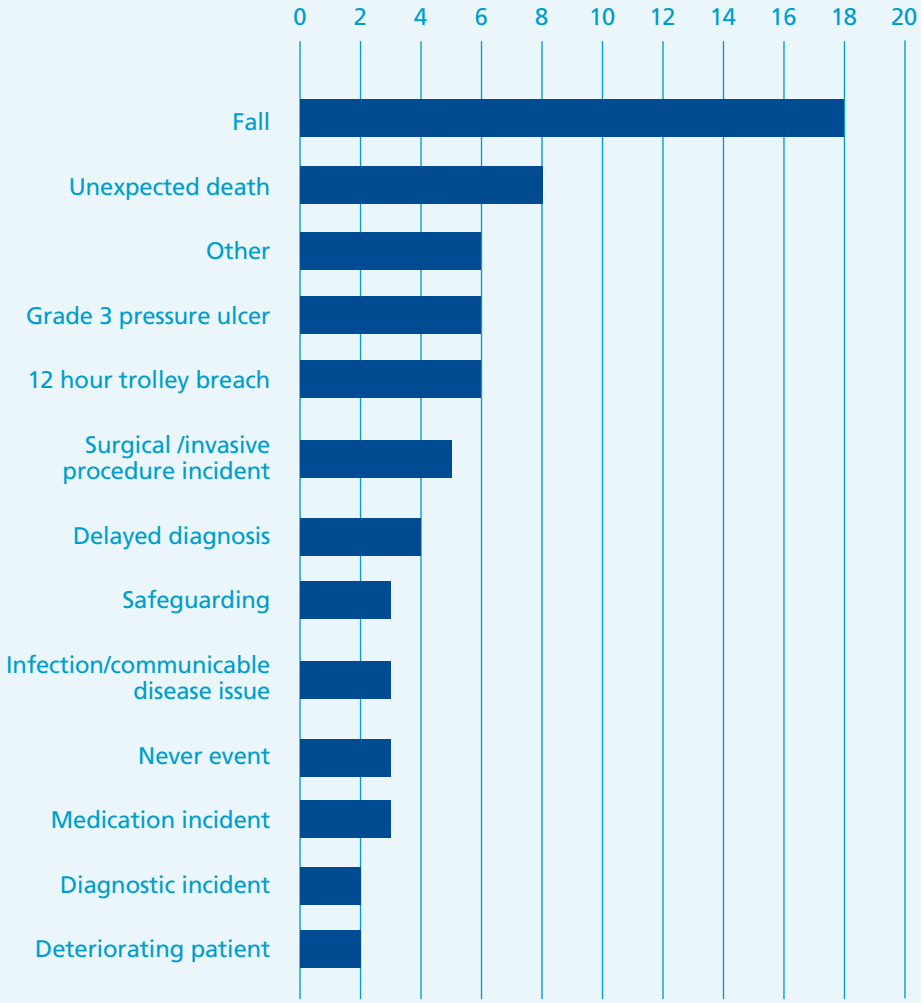
[13] The level of harm for reported incidents can be subject to change following full investigation. For investigations which are completed after the NRLS cut-off date the information contained within local incident reporting system when interrogated at a future date may be different.

[14] This number has subsequently reduced to nine incidents following investigation.

- reviewing procedures for children who make an unscheduled return with the same condition to the emergency department including the involvement of senior clinicians on the second and any subsequent attendances.

Figure 16

Serious incidents by type 2015/16



Source: UH Bristol Serious Incident Log

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

3.1.9 Never events

A 'never event' is a particular type of serious incident that is wholly preventable and has the potential to cause serious patient harm, where there is evidence that the type of never event has occurred in the past, and it is easily recognised and clearly defined as such (NHS England 2015)[15].

There were three confirmed never events reported by UH Bristol in 2015/16.

Wrong site surgery, private provider

One never event occurred in August 2015 in the category "Wrong site surgery", whereby the wrong mole was removed on an out-patient. The patient's treatment was subcontracted to a private provider. Using a mirror, the surgeon and the patient together identified a mole on the patient's back that was of concern to the patient and was situated in the area described in the notes, which they thought was the one to be removed. At follow up, it was identified that the suspicious mole the dermatologist had intended to be removed was in fact a different one that had been in the same vicinity. The patient was informed of the error as soon as it was identified and an apology was given. The patient has since had the originally intended mole removed; the surgery was performed uneventfully.

The learning from this incident included: the need for photographs taken in dermatology and marked with the lesion to be removed to be made available for other providers who

[15] Revised Never Events Policy and Framework March 2015

are treating our patients; also the need for the lesion to be inked in the context of the body region so that it can be located effectively in relation other skin markings.

Wrong route medication, Bristol Royal Hospital for Children
In November 2015, an oral solution of sodium bicarbonate was administered intravenously to a child. The child came to no harm as oral and intravenous preparations of sodium bicarbonate are the same (apart from the intravenous preparation being made with sterile water) and, fortunately, the infection risk the incident posed did not materialise. The child's parents were informed of the error and an apology given.

The investigation identified that the independent checking procedure – which in this instance had involved three nurses – had failed. Learning arising from the incident included: the appointment of a clinical skills facilitator for the ward to educate and support new and junior staff (including regarding independent checking of medicines); a review of ward skill mix; and the need to improve communication and to support staff to feel confident to escalate concerns.

Wrong tooth extracted, Bristol Dental Hospital
In December 2015, an outpatient at the Bristol Dental Hospital required two dental extractions, one of which was the second lower left permanent molar (lower left 7), for caries. Having performed all the safety checks put in place as described in last year's Quality Report, including the marking of the teeth to be extracted on the dental bib, the correct tooth for extraction was identified. Following the start of the procedure, there was a need for the dental student to request suction; they then re-counted the teeth from back to front (8, 7, 6) and placed the forceps on the first lower left permanent molar (lower left 6) to complete the extraction. The third permanent molar (lower left 8) was horizontally impacted and partially erupted. There was also a lack of direct vision secondary to the presence of blood.

The patient was immediately informed of the error and the lower left 6 tooth was re-implanted in an attempt to save it. The root cause was determined to have been human error and the learning from the investigation included:

- if there is "ANY DOUBT" regarding any aspects of the proposed treatment during delivery then a "TIME OUT/STOP" should be called and the clinical situation reassessed prior to continuing with the planned procedure
- teeth should be re-counted by the operator and a second person prior to repositioning the instrument for extraction if the operator is required to stop the procedure for an unplanned reason.

Action was taken immediately following this incident so that no dental undergraduates were permitted to undertake any oral surgical procedures including tooth removal on a patient unless under the direct supervision of a registered dental surgeon with a level of experience above that of a dental core trainee.

3.1.10 NHS England Patient Safety Alerts
At the end of 2015/16, there were no outstanding patient safety alerts relating to UH Bristol.

3.1.11 Safe staffing
In last year's report, at the request of our governors, we included some information about how we ensure that our wards and services are safely staffed. During 2016/17, the re-configuration of our medical wards resulted in a major review of nurse staffing establishment and skill mix appropriate for the new layouts/speciality mix. The Trust Board has continued to receive six monthly reports on nurse staffing levels for all adult inpatient areas (including midwifery and the children's services). In addition, the Quality and Outcomes Committee of the Board has received detailed information each month. This reporting has provided the Board with assurance that the right actions are being taken to ensure that UH Bristol has the right number of staff in place with the right skills.

3.1.12 Duty of candour
Being open and honest when things go wrong has been an integral part of incident management and patient safety culture development since the advent of the Being Open Framework developed by the National Patient Safety Agency in 2009. The reports by Robert

Francis QC (2010 and 2013) and Professor Don Berwick (2013) following the events which took place at Mid Staffordshire NHS Foundation Trust between 2005 and 2009 led to more formal arrangements in this respect: first, a contractual obligation (in 2013) and subsequently, a statutory obligation for duty of candour (in 2014). This was followed by explicit requirements of a professional duty of candour published jointly by the General Medical Council and Nursing and Midwifery Council in 2015.

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

- training for staff on induction and in clinical updates on the formal and professional requirements of duty of candour
- information on induction and clinical updates regarding a 'just culture' to assist staff to feel supported in being open and honest
- development of and intranet page with information and resources to support staff in complying with duty of candour
- amending our '72 hour report' and root cause analysis templates to prompt early and subsequent compliance with duty of candour
- development of a patient information leaflet entitled 'Guide for patients and families about patient safety incidents', explaining what they can expect in this regard
- developing our incident reporting system with prompts for duty of candour
- testing the use of a duty of candour sticker for patients' notes to facilitate recording of duty of candour conversations with patients and their families
- 'Difficult conversations' training made available within the Trust.

Our next steps are:
- to continue training and education regarding duty of candour
- to evaluate our first test of the duty of candour sticker
- to complete an analysis-by-team of safety culture assessments and take these forward as described in the Sign up to Safety Programme section of this report
- to start a longer term piece of work, working with front line staff and families, to develop an open disclosure framework which recognises that the needs of individuals (patients, families and staff) require a more flexible approach to being open, based on where they are at particular times of the post-incident or grieving process.

3.1.13 Sign up to Safety

UH Bristol 'signed up to safety' in 2014 by making our pledges under five national themes, which aligned with the aims of our existing patient safety strategy:

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

Following this, we developed our Patient Safety Improvement Programme for 2015-2018 which was officially launched on 31st July 2015 with the assistance of Professor Jane Reid, the Sign up to Safety lead for the South of England. Our 'Sign up to Safety' programme builds on our previous involvement in the Safer Care South West programme and has overarching ambitious aims in line with the national Sign up to Safety campaign: to reduce mortality by a further 10 per cent and halve avoidable harm. We conducted a thematic analysis of incidents, complaints, claims, serious incidents and consulted with staff and members on our quality and patient safety priorities. We also worked closely with colleagues in the West of England Patient Safety Collaborative to identify and develop opportunities for system wide safety improvements and to share and learn from each other.

Running through our whole programme is a continued focus on leadership for safety and developing the engagement of staff and patients in developing safety and quality

improvements. We have chosen four key areas to focus on:

- improving the recognition, escalation and response to deteriorating patients, including focusing on improving the care and management of patients with sepsis (also see sections 2.1.1 and 2.1.2 of this report) and acute kidney injury, both common causes of deterioration
- improving medicines safety (see section 3.1.5 of this report), specifically insulin safety and medicines safety at the point of transfer of care
- improving our processes to prevent peri-procedural[16] never events in environments where surgery and invasive procedures take place (the publication of the National Safety Standards for Invasive Procedures by NHS England in September 2015, and the associated patient safety alert to develop Local Safety Standards for Invasive Procedures by September 2016, supports this locally selected priority)
- understanding and developing our safety culture.

Highlights of what we have achieved so far:

- we have developed, tested and introduced a safety checklist for adult patients queuing to enter the emergency department; this is now being adopted by a number of emergency departments in the West of England Patient Safety Collaborative, and has attracted wider national interest
- working with colleagues from North Bristol NHS Trust, we have designed and implemented a new adult observation chart based on the National Early Warning Score[17] (also see section 3.1.5); this work supports the aim of the West of England Patient Safety Collaborative to introduce a single early warning score across all providers in all sectors of the local health system so that we all understand how sick our patients are by talking the same language when referring and transferring patients between providers
- we have improved the screening of patients for sepsis in admission and assessment areas and the administration of antibiotics within an hour for appropriate patients
- we have improved the identification of patients with acute kidney injury and the frequency of reviews of nephrotoxic[18] medication for these patients to help prevent worsening acute kidney injury
- we have completed the local safety standards for invasive procedures for theatre environments and are testing similar standards in interventional suites and the emergency department
- we have audited the quality of how our surgical safety checklist procedure is performed in order to ensure that all required staff are present and attentive; this will continue and extend to 'out-of- theatre' environments
- within the West of England Patient Safety Collaborative, UH Bristol has a leadership role in the medicines safety work stream; a number of learning events have taken place to agree system-wide priorities and safety improvements to be tested, and we are already sharing learning from insulin related incidents
- we have completed our first safety culture assessments of our organisation as a whole and 130 individual teams have assessed their safety culture.

Our plans for next steps as we go into 2016/17 are:

- to further embed the use of the National Early Warning Score and responses to escalating patients; this will include further training and support for front line teams as well as looking at the human factors that inhibit appropriate escalation and responses
- to develop an escalation protocol for deteriorating patients in the emergency department to ensure a senior clinician from the receiving specialty is aware of, and prepared to receive into their care, those patients who are sickest
- to embed and spread the sepsis work to include patients who develop sepsis during an inpatient stay and, working with colleagues in the West of England Patient Safety Collaborative, adapting our sepsis care pathway in the light of new guidance due to be published in July 2016
- learning from North Bristol NHS Trust, who are leading the testing and development of an acute kidney injury care bundle, to test and implement this within our inpatient areas and focus our safety improvements where monitoring and audit direct us
- to standardise fluid balance monitoring and recording for adult patients in general ward areas
- to test a 'patient's own drugs' scheme for patients using insulin and to engage enablers and front line staff across the system in medicines safety improvements at transfers of care (focussing on insulin safety in the first instance)

[16] i.e. occurring soon before, during, or soon after a procedure

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

[18] Nephrotoxic medicines are those which are known to cause or contribute to acute kidney injury

- to test a 'patient's own drugs' scheme for patients using insulin and to spread the PharmOutcomes system across the West of England Patient Safety Collaborative' s foot print
- to complete the implementation of local safety standards for invasive procedures for all areas where these take place, including wards and outpatient departments, and to spread existing quality audits to all areas
- to complete the analysis of safety culture assessments at divisional and team level and to provide facilitated face-to-face feedback to enable teams to understand their current team safety culture and to identify and own their plans to develop this further.

3.2 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 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.

Patient experience can only be fully understood by asking patients what they think about the care that they received in our hospitals (Darzi, 2008). At UH Bristol, our core patient surveys give us a strong understanding of the things that matter most to our patients; these priorities continue to guide our choice of quality objectives. In 2015/16, we significantly expanded our patient feedback programme to include new day case, paediatric, and outpatient surveys. Alongside this, we also recognise the importance of actively engaging with patients and the public as partners in our planning and decision-making processes. 2015/16 has seen significant developments in our approach to patient and public involvement, in particular the establishment of our new "Involvement Network", which builds on the interest Trust members, Governors, community groups, other patients and carers have shown in taking a more active role in the work of the Trust.

3.2.1 Overall patient experience

What our patients said in our monthly survey

> ***"I received outstanding care throughout my stay, very professional and friendly staff, excellent experience."***
>
> ***"Since I was last a patient in the BRI in 2009, there has been a vast improvement - a huge blessing… clean, airy, bright, friendly, personal. The staff have a much more 'I can help' attitude and seem happier too."***

Local patient experience 'tracker' scores

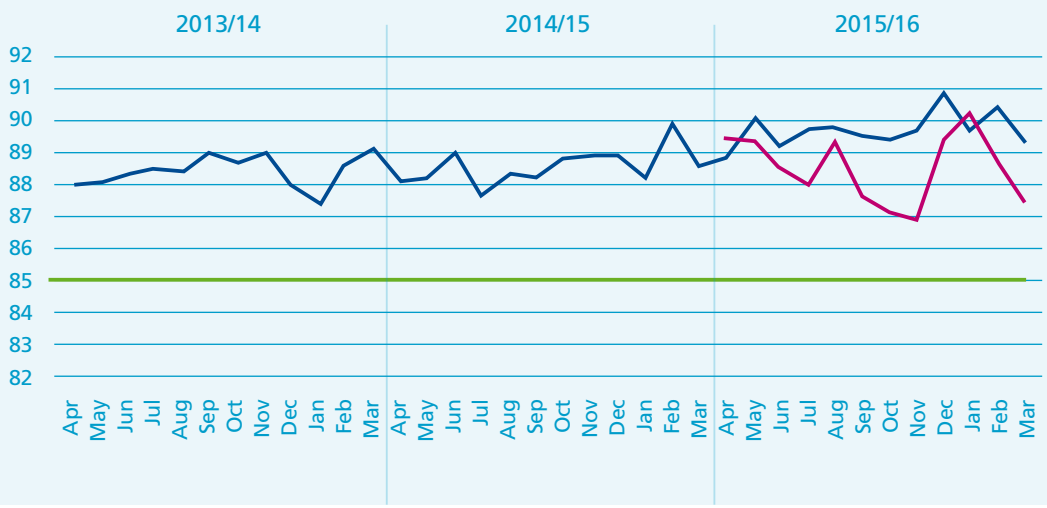
The patient experience tracker scores are generated from our monthly outpatient and inpatient postal survey programme. We combine a number of survey questions to generate these scores, based on the aspects of care that our patients have told us matter most to them:

- Being treated with respect and dignity
- Receiving understandable answers to questions (in other words, communication)
- Being treated in a clean ward / clinic
- Being involved in decisions about care and treatment (inpatients only)
- Waiting times in clinic (outpatients only).

The tracker scores are 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 2015/16, our tracker score has been consistently above our minimum target (see Figure 17). The Board will continue to monitor the monthly tracker score in 2016/17.

Figure 17

Inpatient experience quality tracker score (/100)



Source: UH Bristol monthly inpatient and parent survey

Notes: (1) 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; (2) scores have been recalculated based on end-of-year data, and therefore will differ slightly from previously-reported data to the Trust Board; (3) During the 2013-14 year there was a single "communication" relating to both doctors and nurses, from 2014-15 this was split into two questions about communication (one relating to doctors and one to nurses)

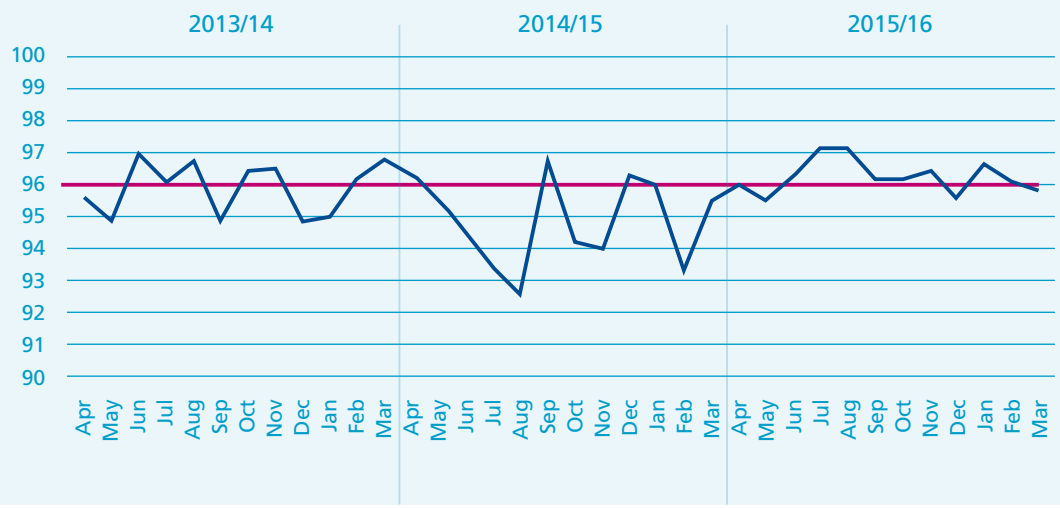
Friends and Family Test

The Friends and Family Test (FFT) focuses on one main question: whether the patient would recommend the hospital ward to friends and family if they needed similar care or treatment. During 2015/16, UH Bristol's Friends and Family Test scores for the inpatient / day case and maternity surveys have been in line with national norms (see Figures 18 and 19). In contrast, the Trust's Emergency Department (ED) scores in the Bristol Royal Infirmary (BRI) and Bristol Royal Hospital for Children were below national benchmarks (see Figure 20). We believe this has resulted from a change in methodology introduced during the year, rather than a decline in quality of care (the BRI ED achieves consistently high scores in the national survey): electronic touchscreens were introduced in waiting rooms and observation wards, which means that patients are giving us feedback during their journey through ED, rather than at the end, when they are more likely to be feeling positive about their experience. We will continue to experiment with appropriate methodologies in these settings during 2016/17, including trialling the use of SMS (text messaging) to ask the "recommend" question. FFT scores for the ED at Bristol Eye Hospital, where a card-based approach continues to be used, have remained relatively unchanged in 2015/16.

During 2015/16, the Trust was served with a contract performance notice by Bristol Clinical Commissioning Group, for not achieving the agreed target of a 30 per cent response rate in the combined inpatient and day case Friends and Family Test survey. UH Bristol's inpatient element of this survey routinely meets this target, but day case response rates have been significantly below 30 per cent since this survey commenced in April 2015, which has "dragged down" the overall response rate. An action plan is in place to resolve these issues and bring the response rate in line with agreed targets.

Figure 18

Friends and family test score (inpatient and day case wards)



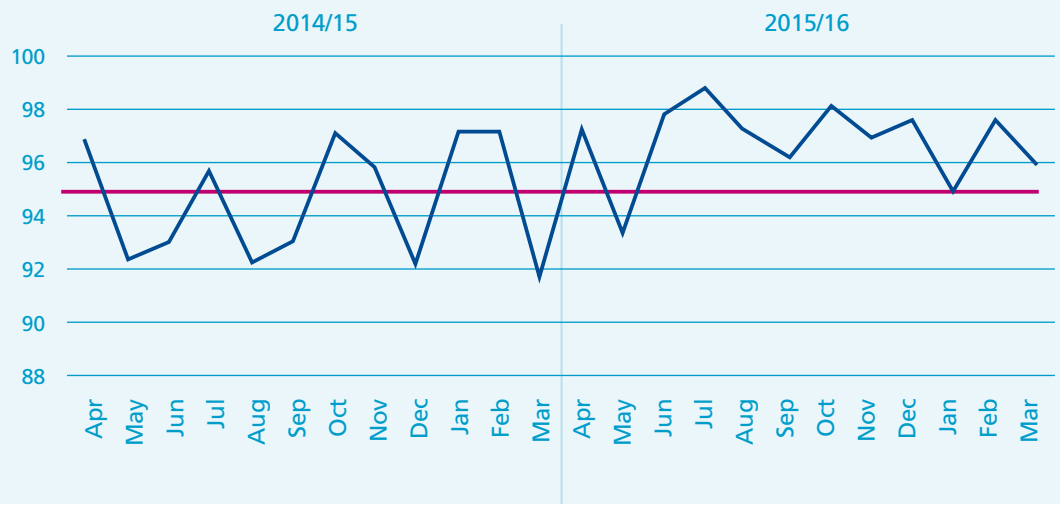
UH Bristol
National

Source: UH Bristol Friends and Family Test survey.

Notes: (1) day case and paediatric services were included in the survey from April 2015; (2) the national benchmark is the national-level score from February 2016

Figure 19

Friends and family test score (maternity services)



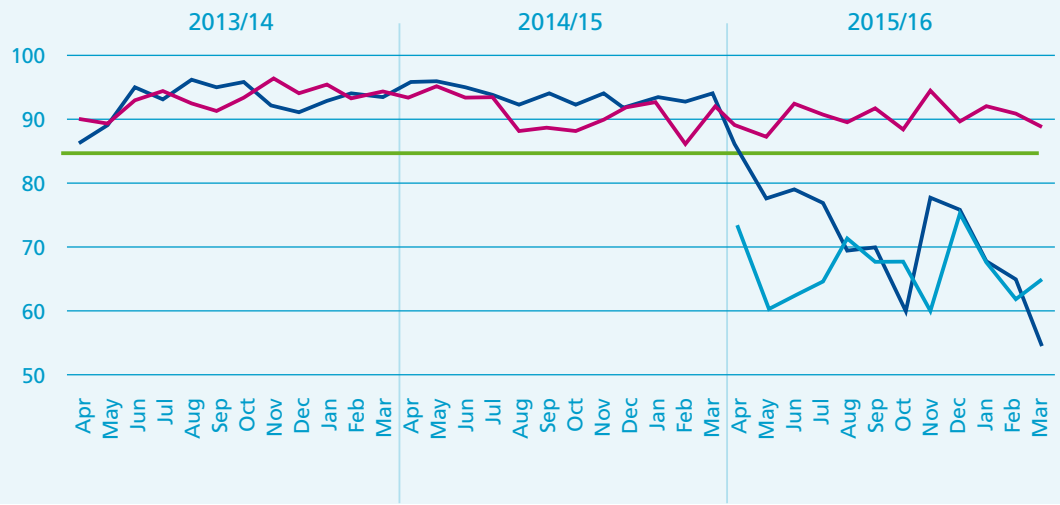
UH Bristol
National

Source: UH Bristol Friends and Family Test survey.

Note: the national benchmark is the national-level score from February 2016

Figure 20

Friends and family test score (emergency departments)



BRI ED
BEH ED
BRHC ED
National

Source: UH Bristol Friends and Family Test survey.

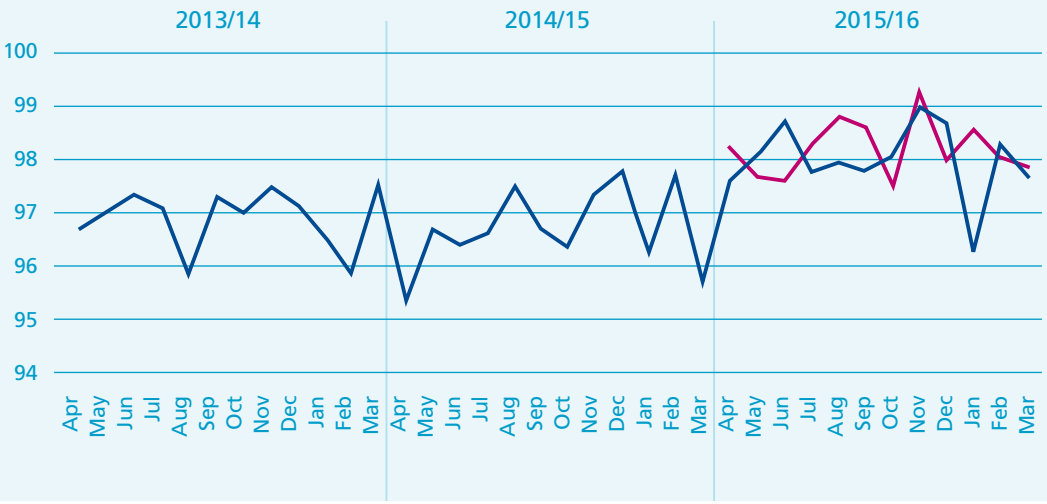
Note: the national benchmark is the national-level score from February 2016

Overall care ratings

Another way of measuring overall experience of care is to pose that question to patients directly. In 2015/16, 98 per cent of all survey respondents rated the care they received at the Trust as excellent, very good, or good (see Figure 21).

Figure 21

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

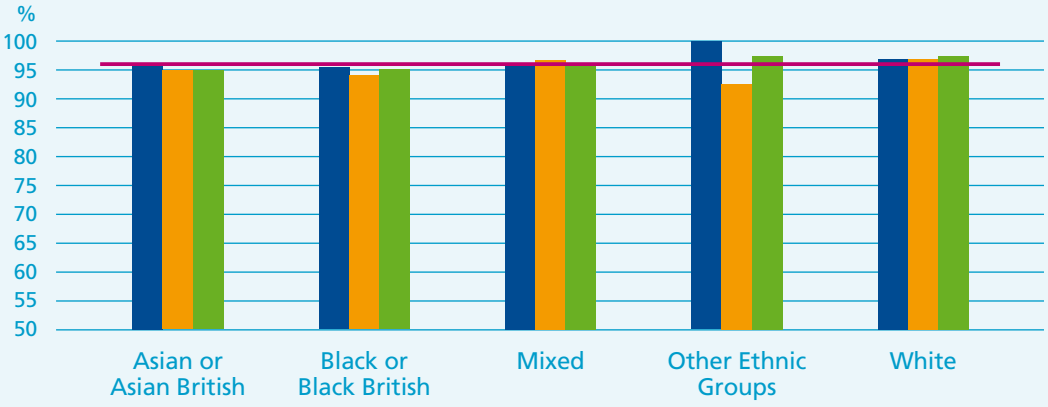


Source: UH Bristol monthly inpatient / parent survey; UH Bristol monthly outpatient survey

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 22 (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 22

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



Source: UH Bristol monthly inpatient and parent survey

3.2.2 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 2015/16 we received the results to three national surveys:

- the national inpatient survey (2014)[19]
- the national children's survey (2014)
- the national maternity survey (2015)

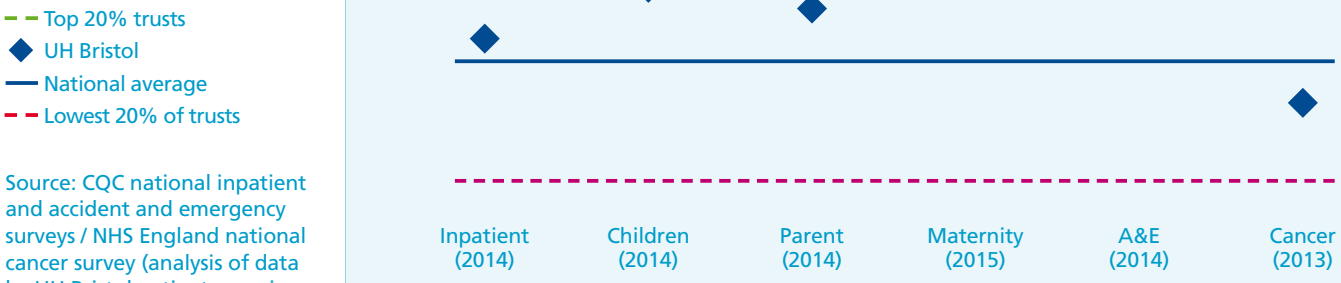
Overall, UH Bristol tends to perform in line with or better than the national average in national patient surveys (Figure 23 and Table 7). In 2015/16 we received an outstanding set of national maternity survey results. The experience ratings we received from our service users in this survey were recognised by the Care Quality Commission as being the best in the country. In the areas of care during labour and birth, UH Bristol attained nine survey scores that were better than the national average. A further "better-than-average" score was received for kindness and understanding on postnatal wards. These are particularly pleasing results because they reflect significant ongoing work carried out by our maternity staff to improve the experience of women who use their services. In recent years, this has included

[19] Published in April 2015 and referenced in last year's quality report. At the time of writing (May 2016), the results of the 2015 survey have yet to be published

investment in new midwifery posts, a reconfiguration of postnatal wards (based on feedback from service-users), and various "co-design" projects where the maternity team has worked in partnership with people who have experienced maternity services, in order to understand what works well and identify aspects of care that could be improved. One particularly successful element of this broad programme of work has been the "patient experience at heart" workshops. These multi-disciplinary workshops are attended by staff in the maternity service, providing an opportunity to reflect on the delivery of a high quality experience of care. The Trust is currently looking at how this programme can be rolled out more widely in our hospitals.

Figure 23

Comparions of UH Bristol patient satisfaction to the national average



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)

Table 7

Results of national patient survey reports received by the Trust in 2015/16

	Comparison to national average		
	Above (better)	Same	Below
2014 National inpatient survey (patients who were discharged during July 2014)	2	57	1
2014 National Children's inpatient and day case survey (patient or their parents who attending during August 2014)	1	36	0
2015 National Maternity survey (women who gave birth during February 2015)	10	9	0

What our patients said in our monthly survey

"The two midwives I had were amazing. I cannot fault their care and assistance during labour. It is an experience made more memorable for me because they were so engaging, respectful and caring to me. Thank you."

Although there were no national cancer survey results available in 2015/16, we continued to carry out a large number of activities with a view to improving these survey scores (see section 2.1.1).

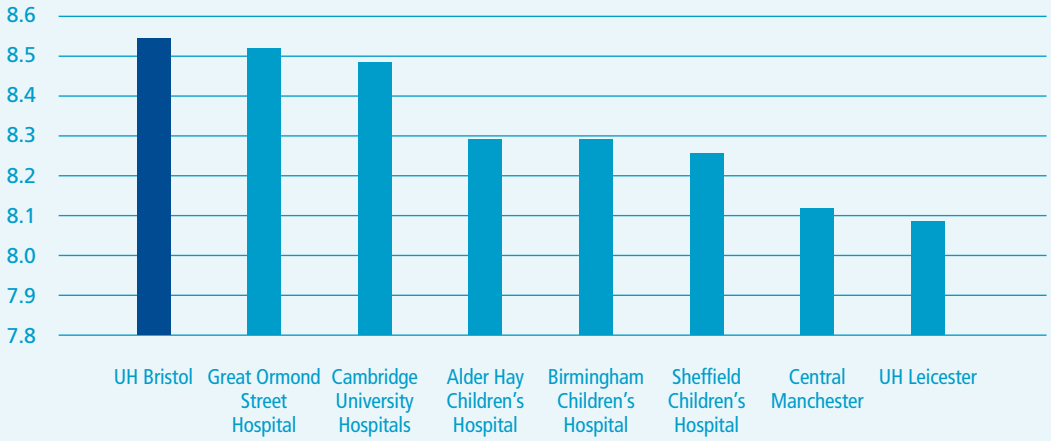
During 2015/16, we also received our results for the first national children's inpatient and day case survey. This survey showed that UH Bristol broadly performed in line with the national average for patient experience in paediatric services. However, UH Bristol is one of a relatively small number of specialist children's hospitals in England and is a regional centre. When we carried out our own analysis to assess our scores against directly comparable trusts, our results emerged very favourably (Figure 24).

3.2.3 Patient and public involvement

UH Bristol actively seeks contributions from patients and the public in the planning, evaluation

Figure 24

Overall hospital experience rating from children aged 8-15 years old



Source: Care Quality Commission national children's survey data; cohort derived via CHKS healthcare intelligence tool

and development of our services. This includes hosting community events and discussion forums, and having patient and public representation on some of our management groups. Each month, we also take the opportunity to share a patient story at the start of each Trust Board meeting, to set the context for the discussions that are held there. Some examples of our patient and public involvement work during 2015/16 include:

Involvement Network
The UH Bristol Involvement Network ("IN") is part of a broad and ambitious programme to refresh the way in which we deliver our patient and public involvement work. IN is about creating new opportunities for people to have their say about how healthcare is developed and provided at UH Bristol. IN members have helped inform the Trust's Quality Priorities for 2016/17 and commented on the quality of information patients receive about outpatient appointments.

Patient letters
Patients were involved in a "patient letters week" to understand how the quality of patient letters could be improved (see section 2.1.1 of this report). A set of standards was agreed with patients and new letters are currently being piloted.

Paediatric cardiac surgery
We have continued to work with the families of children who have had cardiac surgery to understand their experience of the care they received. This has resulted in improvements to the process of consent and information about services. This work will continue into 2016/17 and has informed new work to establish a family involvement group for the Paediatric Intensive Care Unit.

Rheumatology and Sleep Unit services
Patients have been working with staff as part of plans to re-locate services within the Trust in autumn 2016. This has included a "walk through" to identify associated access improvements such as signage, additional seating and enhanced information about vehicle drop off points.

Patients and doctors as partners in learning
Patients have taken part in a new initiative whereby they share their patient experiences as part of the ongoing development of our Foundation Level 2 doctors.

People approaching the end of life
As part of a service development initiative, a focus group was held in association with St Peter's Hospice with patients who are recognised as approaching the end of life. Patients were able to share their experiences of the care they received from the Trust and suggest ways in which the training and development of staff involved in end of life care could be improved.

Maternity Services
Women at St Michael's Hospital have taken part in conversations about their expectations of the discharge process from our maternity wards. This work will continue in 2016/17 with repeat interviews during which the women will reflect on their actual experience.

3.2.4 Complaints

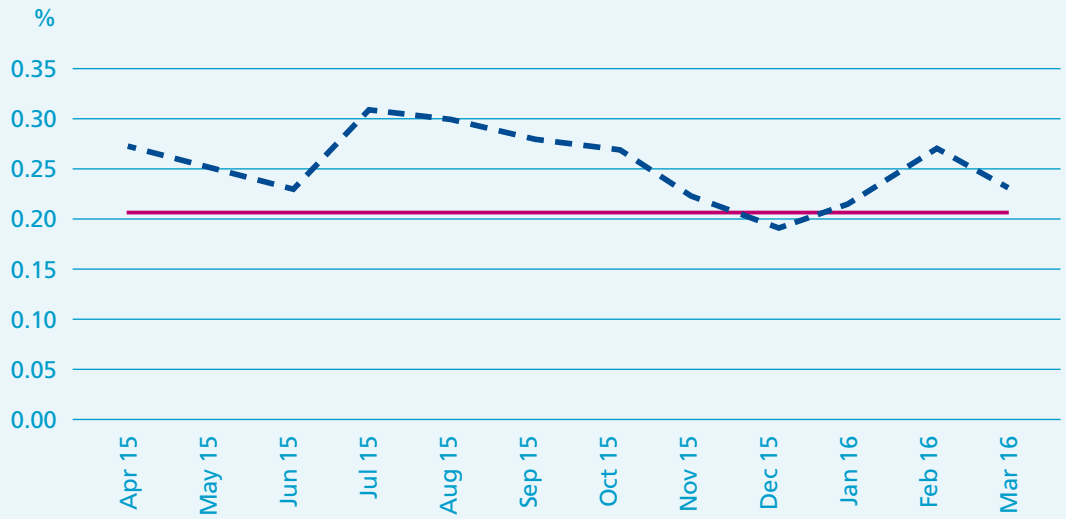
In 2015/16, 1,941 complaints were reported to the Trust Board, compared with 1,883 in 2014/15[20]; this is an annual increase of 3.1 per cent. 647 of these complaints - exactly one third - were investigated under the formal complaints process; two thirds of complaints were addressed through informal resolution.

This volume of complaints equates to 0.25 per cent of all patient episodes, against a target of <0.21 per cent. Figure 25 shows the number of complaints received each month as a proportion of patient activity; complaints received in each month of 2015/16 were higher than in seven of the corresponding months of the previous year. In contrast, the Trust's patient experience inpatient 'tracker' survey ratings in 2015/16 improved compared to the previous year (see section 3.2.1).

In 2015/16, the Trust agreed a quality objective to improve the quality of our written response letters. During 2015/16, we carried out staff training, and implemented changes to the way that complaints responses are written and reviewed prior to sending. You can read more about this in section 2.1.1 of this report. We said that we would measure progress by measuring the numbers of complainants who expressed dissatisfaction with our response: at the time of writing, 59 complainants have expressed dissatisfaction with complaints responses sent out during 2015/16[21].

Figure 25

Complaints as a proportion of total patient activity



Source: UH Bristol Ulysses Safeguard and Datix® systems

In 2015/16, we carried out complaints investigations and replied to complainants within agreed timescales in 75.2 per cent of cases; a reduction from the 85.9 per cent achieved in 2014/15. This has largely been a consequence of the introduction of more robust processes for checking draft response letters. Performance has been steadily recovering since December 2015, as shown in Figure 26.

Looking ahead to 2016/17, key themes in our complaints work plan include:

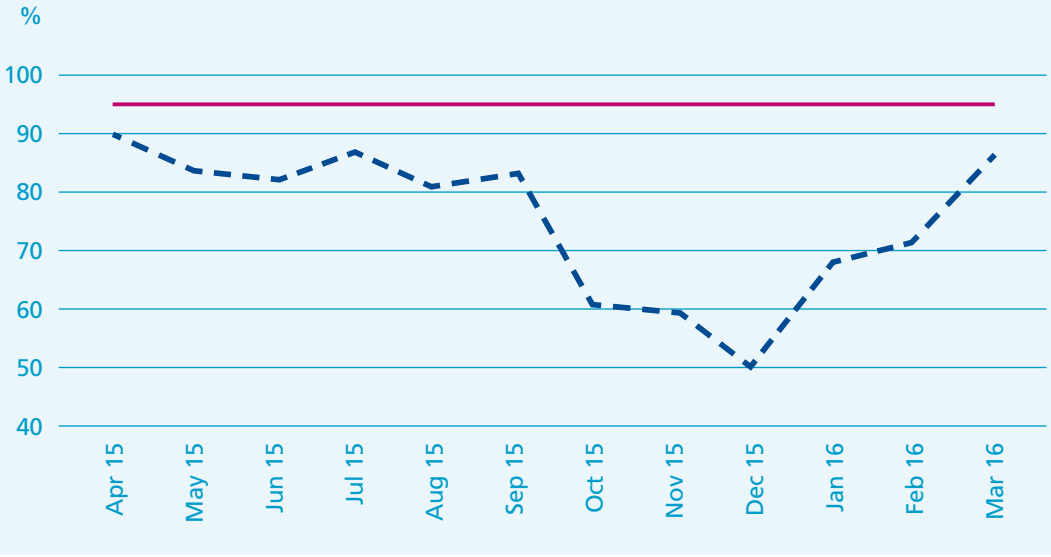
- implementing a routine follow-up survey of all complainants to better understand their experience of using our complaints service – this will be for all formal resolution cases, three months after our final response letter has been sent. At the same time, the patient support and complaints team will send an updated action plan to the complainant (where applicable) confirming progress in implementing any outstanding actions arising from their complaint.
- providing further training to managers in all our divisions specifically aimed at improving skills in writing complaints response letters
- routinely considering and recording whether there are opportunities for complainants to be involved in developing the solutions to the issues they have highlighted through their complaints
- strengthening our processes for ensuring that potential incidents and serious incidents are systematically identified from complaints (in response to the Ombudsman's report, A review into the quality of NHS complaints investigations, published in December 2015).

[20] Previously 1,442 in 2013/14, 1,651 in 2012/13, and 1,465 in 2011/12

[21] Note: this figure differs from data reported to the Board during 2015/16 (38). The reason for this discrepancy is explained in section 2.1.1 of the report (2015/16 objective 6)

Figure 26

Responses to complaints within agree timescales 2015/16



Source: UH Bristol Ulysses Safeguard and Datix® systems

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2016.

During 2015/16, in addition to receiving and handling complaints, the patient support and complaints team dealt with 389 enquiries for help and information and received 198 compliments on behalf of the Trust[22].

3.2.5 NHS Staff Survey 2015

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.

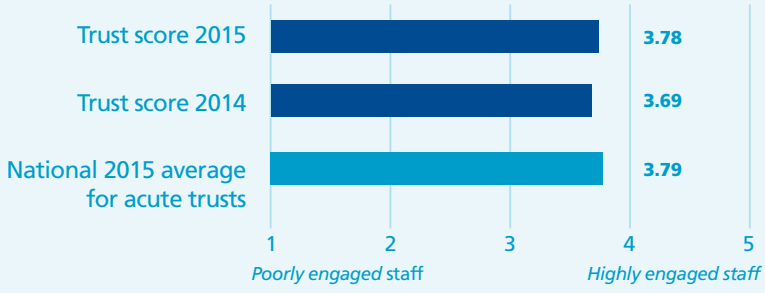
Questionnaires were sent on a census basis to all substantively employed staff across UH Bristol: 3,625 staff responded – a response rate of 44 per cent. This is three per cent better than the national response rate, but compares with a 47 per cent response rate in this Trust in the 2014 survey.

A variety of research has demonstrated clear links between levels of staff engagement and a range of outcomes for trusts, including patient satisfaction, patient mortality, trust performance ratings, staff absenteeism and turnover. The more engaged a workforce is, the better the outcomes for patients.[23]

The NHS Staff Survey provides an overall indicator of staff engagement, calculated using responses to questions relating to staff members' willingness to recommend the Trust as a place to work or receive treatment; the extent to which they feel motivated and engaged in their work; and their perceived ability to contribute to improvements at work.

Figure 27

Overall staff engagement (the higher score the better)



The Trust's overall score for staff recommendation of the organisation as a place to work or receive treatment is arrived at by aggregating the scores in the areas shown in Table 8 below.

[22] 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 received directly by individual wards and departments.

[23] West, M. A., Dawson, J. F., Admasachew, L., & Topakas, A. (2011). NHS Staff Management and Health Service Quality: Results from the NHS Staff Survey and Related Data. Report to the Department of Health. http://www.dh.gov.uk/health/2011/08/nhs-staff-management/
West, M. A., & Dawson, J. F. (2012). Employee engagement and NHS performance. Paper commissioned for The King's Fund review Leadership and engagement for improvement in the NHS. http://www.kingsfund.org.uk/document.rm?id=9545
Powell, M., Dawson, J. F., Topakas, A., Durose, J., & Fewtrell, C. (2014). Staff satisfaction and organisational performance: evidence from a longitudinal secondary analysis of the NHS staff survey and outcome data. Health Services and Delivery Research, 2, 1-336.

Table 8

	UH Bristol score 2015	Average (median) score for acute trusts 2015	UH Bristol score 2014
'Care of patients / service users is my organisation's top priority'	77%	75%	70%
'My organisation acts on concerns raised by patients / service users'	72%	73%	71%
'I would recommend my organisation as a place to work'	61%	61%	56%
'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation'	77%	70%	70%
Staff recommendation of the organisation as a place to work or receive treatment. (mandatory indicator[24])	3.81	3.76	3.68

[24] 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 in Table 4 is made available by the National NHS Staff Survey Co-ordination Centre and 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".

In last year's Quality Report, our colleagues from Healthwatch North Somerset raised a particular concern about our 2014 NHS Staff Survey score for the percentage of staff who witnessed potentially harmful errors, near incidents or misses in the last month. In the 2015 survey, our score improved by five points, but remains in the worst 20 per cent of trusts. As documented elsewhere in this report, the Trust continues to work tirelessly to eradicate potentially harmful errors. The introduction of new incident reporting software (Datix®) has provided an additional opportunity for raising awareness and capability with regard to reporting. A risk assessment and incident campaign took place in the first quarter of 2015/2016, delivered through health and safety briefings, site-wide poster campaigns and via the health and safety website.

Table 9

	UH Bristol score 2015	Average (median) score for acute trusts 2015	UH Bristol score 2014
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	34% Highest (worst 20%)	31%	39% Highest (worst 20%)
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	90% (average)	90%	91% (average)

The Trust's values (respecting everyone, embracing change, recognising success and working together) embody not only how we expect staff to treat patients, but how they can themselves expect to be treated. Mindful of this, the Trust is paying particular attention to the staff survey findings about harassment and bullying and equal opportunities for career progression. As required by the workforce race equality standard, these results are split between white and black and minority ethnic (BME) staff.

Table 10

		UH Bristol in 2015	Average (median) for acute trusts	UH Bristol in 2014
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	25%	25%	26%
	BME	34%	28%	40%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	89%	89%	90%
	BME	73%	75%	63%

Following the 2014 survey results, the Trust embarked on an extensive staff experience plan, including an appraisal improvement project, increased involvement of staff in the transformation of services, staff listening events, and the implementation of a number of health and wellbeing initiatives with a particular focus on work related stress. These have seen improved results in staff recommending the Trust as a place to work, staff satisfaction with their level of responsibility and involvement, and a reduction in the percentage of staff suffering work-related stress in the last 12 months. Whilst these are all positive results, the Trust recognises that significant improvement is still required. Building on last year's engagement activities, we will continue to focus on staff satisfaction with the quality of work and patient care they are able to deliver, effective team work and actions to tackle harassment and bullying. The Trust's Speaking Out policy has undergone substantial revision in response to recommendations from the Francis Freedom to Speak Up review and has been available to staff since November 2015. A major re-launch and awareness raising campaign will take place in April 2016.

Note: To meet the needs of participating organisations and associated bodies, the questionnaire, Key Findings and benchmarking groups all underwent substantial revisions for 2015. The NHS Staff Survey Co-ordination Body has therefore recommended that the results of certain Key Findings are not comparable with results from 2014. This includes these two indicators, reported on in 2014: Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver, and, Percentage of staff agreeing that their role makes a difference to patients. For information, the Trust's scores for these indicators remain in the lowest (worst) 20 per cent and below (worse than) average, respectively, when compared with all acute trusts in 2015. It is further recommended that comparisons are only made between data which appears in the same report (for example, 2014 data included in the 2015 report); the Trust has therefore not included comparisons with data from years prior to 2014 in this year's report.

3.2.6 Carers strategy

Our governors have requested the inclusion of an update on the ongoing implementation of our carers strategy.

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.

During 2015/16, we have updated our joint carers charter with North Bristol NHS Trust to reflect our ongoing support for, and commitment to, carers and their rights (including recent changes to legislation). The charter was re-launched on 20th November 2015, Carers' Rights Day.

Over the past 12 months, key developments in identifying and supporting carers have included a focus on young carers, including:

- the production of a young carers' hospital leaflet to support the work of improving the identification, support and information for young carers (adapted from the original leaflet 'Is This You?' used at GP surgeries by the GP team from the Carers Support Centre)
- the creation of a young carers' 'Hospital experience' training film clip, designed to support hospital staff in understanding what the issues and needs for young carers are and what difficulties they face in hospitals
- ongoing work to create a young carers' identity card, which would be recognised across both Trusts.

Elsewhere, a carer liaison service has been established at South Bristol Community Hospital and our hospital admissions paperwork has been updated to include questions that are carer-related: the forms ask whether the patient has a carer and, if so, staff are prompted to consider whether referral to the carer liaison worker is appropriate.

In 2015/16, the carers liaison workers have continued to support carers by:
- signposting carers to alternative support services e.g. Samaritans, Mindline, Bristol Stroke Society, Cancer Information & Support Centre, St Peter's Hospice and Red Cross
- informing carers of their rights and referring carers for carers assessments
- providing advice on benefits and how to access social services
- attending discharge planning meetings
- explaining hospital processes and procedures to carers
- liaising with hospital staff and social workers around discharge planning
- meeting Trust staff to discuss the 'discharge to access' scheme.

The Trust's carers strategy steering group continues to have good engagement from staff across the Trust and benefits from carer governor representation bringing issues to discuss and actions to address. A carer reference group continues to review any new documentation and brings issues for onward discussion at the strategy steering group. We also continue to work with the Carers Support Centre (a local third sector organisation) in the delivery of our carers' support programme. The Trust's carers' liaison worker team has expanded to three members of staff who follow up referrals from both Trusts providing five day cover, responding to carers and their needs in a timely manner.

Looking ahead to 2016/17, we will be:
- working with the South Bristol Community Hospital to embed the systems and processes there and develop new services including a potential 'stroke café'
- progressing our young carers work, as described above
- raising the profile, identification and support for BME carers across the trusts
- introducing a locally recognised carers logo across both Trusts
- developing a comfort box[25] for carers and exploring the use of lanyards as another way of identifying carers
- training our volunteers to identify, support and refer carers to the carers liaison service
- exploring the purchase of chairs that convert into beds at the bedside of patients where carers wish to stay.
- supporting Trust employees who are carers.

The case study below provides an example of the difference that our Carer Liaison Service makes:

Mrs A contacted the carer liaison worker during her husband's admission to hospital. Her husband had dementia and some other conditions that were making caring for him at home increasingly difficult. He could no longer do very much or make decisions for himself. Mrs A felt she could no longer look after Mr A at home as it was impacting on her life and health.

Mrs A and the carer liaison worker talked about the situation in detail including her rights as a carer and her realisation that she was unable to continue her caring role and the feelings and emotions that accompany such a decision. We put together

[25] A comfort box is a pre-prepared box of items that will enhance the stay of a carer during their time with us which includes tissues, wipes, flask, tea/coffee/biscuits and other comfort items to support their protracted stay on the wards

a list of her concerns and why she felt that she could no longer care. The carer liaison worker found out who the social worker for the patient was and made Mrs A's concerns clear. The carer liaison worker encouraged the social worker to speak directly to the carer. The carer liaison worker also encouraged the carer to be clear about her worries and concerns with the hospital staff and social worker. The carer liaison worker also came along to some of these meetings to support the carer.

Although it was a difficult choice for Mrs A, a decision was made that Mr A should move to residential care. The carer liaison worker supported Mrs A by providing information about funding for care homes, and information and inspection reports about each of the homes offered. Following her husband's move, the carer liaison worker contacted Mrs A to see how she was and to let her know about other services available to support her now her caring role had come to an end.

A case study written by the hospital carer liaison worker

3.2.7 End of life care

This report on end of life care has been included at the request of our governors.

The Trust takes the care of patients approaching the end of life, and care in the last few days of life very seriously. We have an executive director with special responsibility for end of life care (Carolyn Mills, chief nurse), a consultant end of life lead (Karen Forbes, consultant in palliative medicine) and an end of life steering group chaired by the deputy chief nurse (Helen Morgan) which reports to the Trust Board. End of life care is viewed within the Trust as everyone's business, since patients will die in ward and care areas of all of its hospitals, however the Trust's supportive and palliative care team (SPCT) lead on service improvement work to ensure current high standards of care and to develop these further, delivered through the Trust's end of life steering group to all divisions. The Trust's privacy and dignity group links closely with the end of life steering group.

The Trust uses the pathway indicated in the Department of Health's end of life care strategy (2008) which suggests that 'end of life care' should encompass the last 6-12 months of life and have particular recognition or action points along this 'pathway': recognition that the patient is dying; assessment, care planning and review; coordination of care; delivery of high quality care; care in the last days of life; care after death.

SPCT staff are involved in ongoing work to improve care around recognition, care planning and review, and coordination of care through specific initiatives:

- encouraging teams to recognise when their patients with long term conditions may be entering the last 6-12 months of life
- helping with the development of the advanced communication skills needed to talk to patients and their carers about poor prognosis and to review their expectations and wishes for future care
- facilitating communication with community services through the development of a 'poor prognosis letter' which is sent to the patient's GP.

The SPCT has been involved in the introduction of the Trust's treatment escalation personalised plan which helps teams record conversations with patients about what care they should or should not receive should they deteriorate. When a patient is recognised as dying, the patient's care is reviewed and led by the Trust's end of life care tool, which contains:

- a series of prompts for medical and nursing staff to review and prioritise the patient and carers' needs
- guidance for prescribing for junior doctors to ensure that patients have access to medication to control common symptoms at the end of life
- a symptom observation chart so that patients' comfort continues to be monitored and recorded.

All staff are committed to patients' comfort, privacy and dignity at the end of life. The move of most wards into new builds or refurbished areas of the Trust has provided far more patients with single rooms when they are dying, should they wish for them. The palliative care team and end of life lead nurses provide support to colleagues in recognising when patients should be referred to the team and providing high quality end of life care. This support is provided through training ward end of life nurse champions and ward and Trust-based education. Work is ongoing within the Trust around supporting carers (also see section 3.2.6), including open visiting when a patient is dying, access to family rooms and chaplaincy support, and the provision of carer 'comfort boxes' containing toiletries, drinks, etc.

The Trust performed above (better than) the national average in the majority of indicators for end of life care in the recent national care of the dying audit which examined the care documented in the notes of patients who had died during May 2015. 85 per cent of UH Bristol patients had a holistic individualised plan of care documented (national average 66 per cent). Patients' common end of life symptoms were controlled 83-96 percent of the time, depending on the symptom, in comparison with 55-79 per cent of the time for other participating hospitals. In 80 percent of cases, the fact that the patient was likely to die was discussed with a carer (79 percent nationally); in 97 percent of cases the patient had an opportunity to have their concerns listened to (84 per cent nationally) and in 64 per cent of cases the needs of the person(s) important to the patient were asked about (56 per cent nationally). We are encouraged by these results which validate our current approach. There is always room for improvement however and we continue to develop initiatives to maintain and enhance high quality end of life care within the Trust for patients and their carers.

3.3 Clinical Effectiveness

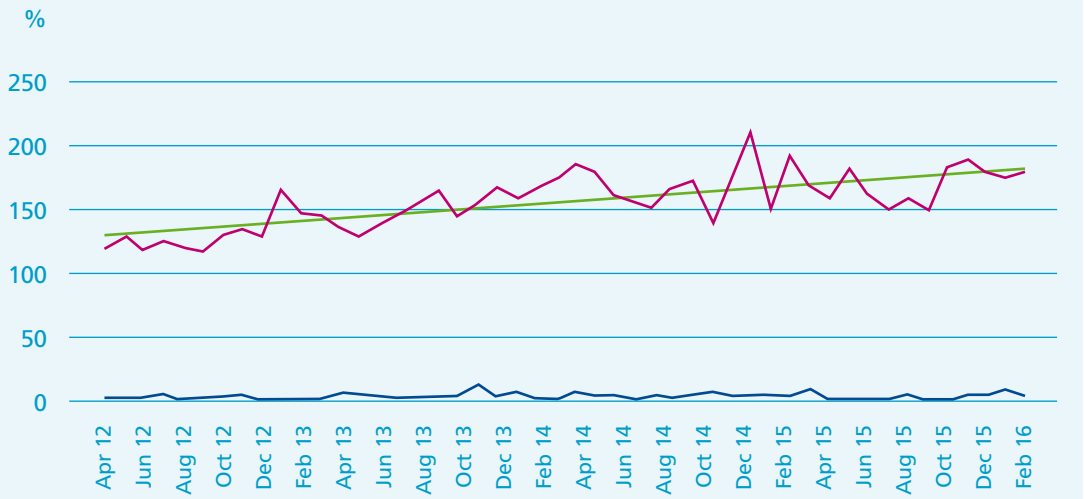
We will ensure that the each patient receives the right care, according to scientific knowledge and evidence-based assessment, at the right time in the right place, with the best outcome.

3.3.1 Dementia

Dementia is an umbrella term for a set of symptoms that may describe 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 are affected, with this expected to increase significantly over the next twenty years (Alzheimer's Society, 2015). Figure 28 demonstrates that increasing numbers of patients with a confirmed diagnosis of dementia have been admitted to UH Bristol's hospitals since 2012 (2,035 patients in 2015/16).

Figure 28

Admissions of patients with confirmed dementia diagnosis to UH Bristol hospitals since 2012



Source: UH Bristol Medway system

The Trust has achieved the National Dementia CQUIN for this year (also see section 2.2.4). This has been achieved through the hard work of our divisional teams, dementia project nurse and dementia support worker.

Education and training remains high on our agenda. All staff and volunteers undertake a dementia awareness session at their corporate induction; the materials we use in this training are reviewed each quarter to ensure the guidance continually reflects best practice. The lead practitioner and dementia team continue to provide bespoke training sessions for clinical teams, ward team away days, and also for individuals.

As of the end of 2015/16, there are 121 dementia champions in place across the Trust: these are staff who act as advocates for patients with dementia and their carers. Our dementia champions come from a variety of clinical and non-clinical backgrounds, but all share the common goal of improving care for patients with dementia.

We are committed to supporting carers of people with dementia. We actively promote and support 'John's Campaign' for carers to have the same rights as parents of children in hospital. This campaign encourages carers to visit their loved ones at any time of the day, remaining with them for as long as they wish. Involving a family carer from the moment of admission to hospital until the moment of discharge has been proved to give better quality of care and improved outcomes. Hospital staff are professionals with a wide, generalised knowledge, however the family carer is the 'expert' for each individual: if they are accepted as part of the care team they can provide insight, facilitate communication (and informed consent) and ensure continuity of care. This includes the right of the carer to continue to provide care in hospital and access to open visiting if this is desired.

Our dementia support café opened in August 2015. The café takes place twice a month, in the restaurant of the Bristol Royal Infirmary. Anyone can attend (patients, carers or staff) to get information about dementia, seek support or to just have an informal chat over a cup of tea. The Trust dementia team lead the café, with support from the carer's liaison worker and a dementia navigator from the Bristol Dementia Well-Being service.

When the Care Quality Commission 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 continue to work to embed this tool into practice to ensure its consistent use. The CQC also highlighted the need for regular review to ensure that the needs of dementia patients are being met – we are achieving this via monthly and annual audits, with appropriate action plans to improve practice where gaps are identified.

The following patient engagement and experience projects for dementia have been developed during 2015/16:

- activity boxes which include games, reminiscence cards and painting have been introduced in

two pilot sites (a general medicine ward and a trauma and orthopaedic ward)
- a trial of the use of iPad technology for patients with dementia, funded by the Trust's Above & Beyond charity ('Alive!', a Bristol-based charity, has provided training for this initiative, which uses music, film clips and Skype to help keep patients connected to their normal routines and family).

One of the Trust's corporate quality objectives for 2015/16 has been to minimise unnecessary patient moves within our hospitals. This is particularly important for patients with dementia, as moves can add to confusion and disorientation, and is supported by Standard 4 of the South West Strategic Health Authority Dementia Action Plan. We therefore consciously aim not to move patients with a cognitive impairment for non-clinical reasons between the hours of 8pm and 8am. In our "transfer" audit in December 2015, we achieved 92 per cent which is above (better than) our local target of 90 per cent.

The examples of feedback given above underline the fact that whilst we have made considerable progress, there is still much to do. The involvement of the dementia clinical leads in the design of the new build at the Bristol Royal Infirmary and refurbishment of wards has helped ensure they are environmentally friendly areas for people with dementia. This work will continue into the next phase of our redevelopment work: the refurbishment of out-patient services. Other plans for improving dementia care in 2016/17 include:
- Working jointly with other agencies to run focus groups for patients with dementia and their carers to identify their needs, ideas for improving care
- Creating a UH Bristol specific e-learning package for staff
- Opening up the dementia champions' conference – run jointly by UH Bristol and North Bristol NHS Trust – to the wider Bristol health community, to share good practice and learning across the Dementia pathway.

Feedback about dementia care received via our monthly carers' survey:

"Happy with staff and they are speedy, have a laugh and take the time to speak with the patients"

"I couldn't fault any of the staff at any level. Extremely clean - saw cleaning auditor come around. Doctors approached family as did social work and have felt supported"

"Always someone walking with patient which helps with his anxiety."

"X wishes there were more activities on the ward - has been bored."

"Frustrated at repeating situation and still not knowing what's happening next, feels out of control. Hard to keep track of who knows what about his situation."

"Ward move was 'sprung' on the patient and really upset her, increased anxiety and upset."

"Staff need to be reminded the person they see now isn't the person they were."

3.3.2 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 which 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 29, 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 April 2014 to March 2015 and shows the Trust as having a SHMI of 98.3.

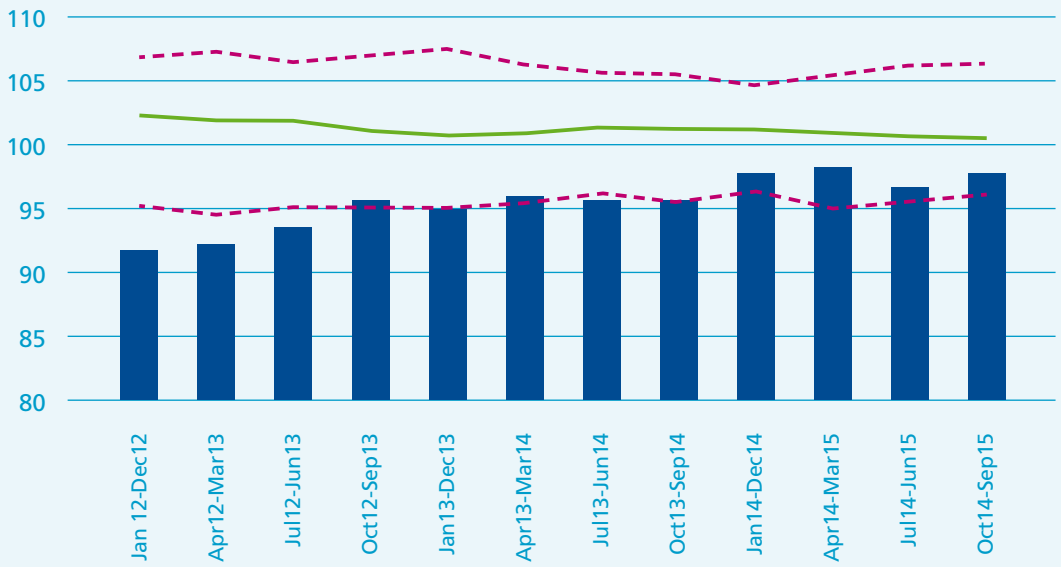
The Trust considers its SHMI data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework (full details are available upon request). This includes data quality and completeness checks carried out by the Trust's IM&T systems team. SHMI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

3.3.3 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

Figure 29

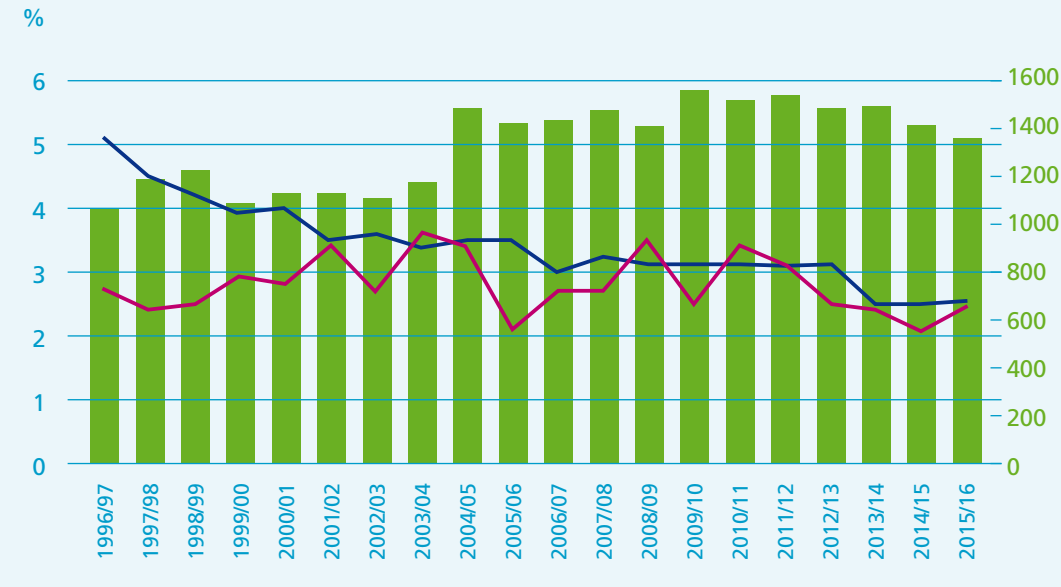
Summary Hospital-level Mortality Indicator (SHMI)



Source: CHKS benchmarking

Figure 30

Adult cardiac surgery activity and mortality – all procedures



Source: Central Cardiac Audit Database / Patient Analysis Tracking System

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.

In general, our adult cardiac outcomes measured in terms of mortality have been better than the UK average for all procedures. Figure 30 shows a pattern of relatively static activity and a crude mortality rate which is below the national average.

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 the 2015/2016 data is currently awaited from the NICOR/SCTS collaboration to enable us to benchmark our performance further against other centres in the UK.

What our patients said in our monthly survey

"I received great care from the moment we dialled 999 until I was discharged."

3.3.4 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 and its Welsh consultants providing sessions in BRHC. Following recommendations from a national review of congenital cardiac services the Trust has decided to manage the area as a formal network; the manager and clinical director have recently been appointed. This will enable effective integration, both clinically and from a governance perspective, of the 19 centres (nine in South West England, and ten through our Cardiff partnership) in the area we serve, allowing us to provide cardiology care closer to where patients live.

The number of paediatric cardiac cases performed at BRHC has increased over the last year by approximately 12 per cent to 365. This is in large part due to an increase in theatre capacity with an extra operating day per week. Crude 30-day survival following cardiac surgery in our unit has continued to improve and in 2015/16 was 98.9 per cent; this is well within expected limits. 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 (PRAiS), more sophisticated analysis of the outcomes following surgery at BRCH has been possible, allowing us to monitor our results in real time and demonstrate a progressive improvement in our outcomes. Figure 31 shows verified NICOR data for the three year period April 2012 to March 2015 (i.e. the most recent reporting period available). This compares very favourably with data from the other centres in the country.

The independent review into paediatric cardiac services in Bristol announced in February 2014 by Professor Sir Bruce Keogh, medical director of NHS England following some complaints from parents, is drawing to its conclusion. The Trust welcomes the ongoing review and the opportunity the review insights will afford the Trust to further improve our care to children and their families. We recognise that for some families they have lost trust and confidence in the service and we hope the review findings and the Trust's response to them will go some way to restoring this position. We recognise that treating children with congenital heart disease is about 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. Since 2014, we have held a number of patient engagement events that we have called 'listening events' so that we can learn directly from parents and young people about what we can do to help and support them better through a very stressful time in their lives. Initial discussions led to us

[26] Ward 32 is a 16 bedded unit at BRHC where patients between the ages of 0-18 are admitted for investigation, assessment and treatment of cardiac conditions or for management of other conditions, which may impact on their cardiac status.

[27] UH Bristol inpatient experience survey for the 12 month period up to and including February 2016

rewriting information sheets and redesigning our website. More recently, we focused on the issue of consent for treatment to find out if parents and patients have enough information in a form that's accessible to them. This has led to us redesigning this part of our care pathway and at the last event we received very positive feedback that the steps we have taken are meeting the needs of families. Our new approach has since been shared at a national meeting as a model that other centres can learn from.

The Trust welcomes feedback and families. Our Trust's monthly survey shows that in 2015/16, 100 per cent of parents (of children up to 11 years old) and children (aged 12 and above) rated their overall experience of care on ward 32[26] good, very good or excellent[27].

Figure 32

Paediatric Surgery 2012-2015 final validated

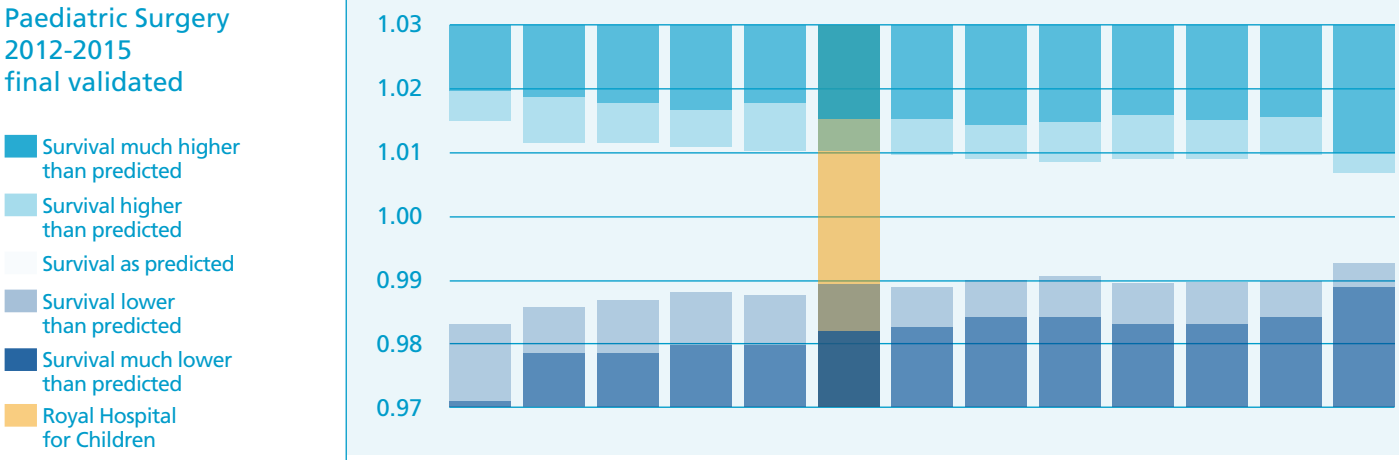


Table 11

Hospital	Code	Surgical episodes	Actual Survival	Predicted Survival	Actual/ predicted	Survival Summary
Bristol Royal Hospital for Children	BRC	835	98.30%	97.60%	1.008	As expected

What our patients said in our monthly survey

"I was kept informed about what was going to happen and the doctor was coming in and explaining everything. The nurses were coming in and checking to see if I was OK. I think my stay was very good."

3.3.5 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. One these procedures - groin hernia surgery is carried out at the Bristol Royal Infirmary.

PROMs comprise questionnaires completed by patients before and after surgery to record their health status. For hernia surgery, outcomes are measured in two ways; a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; and patients also rate their health on a scale of 0-100 using a 'visual analogue scale' (VAS). The Trust follows nationally determined PROM methodology and outsources administration to an approved contractor.

The most recent full-year data available from the NHS Health and Social Care Information Centre (HSCIC) is for 2014/15. Although provisional, this shows that 25 patients returned groin hernia PROM questionnaires in this time period, 72 per cent of whom (18/25) scored more highly on the EQ-5D index after surgery than before (i.e. the surgical procedure had resulted in an improvement); this compares with 50.7 per cent in England (10,304/20,312). 22 patients completed and returned the EQ VAS section of the PROMs questionnaire. 45.5 per cent (10/22)

of UH Bristol patients scored more highly on the EQ-VAS scale after surgery than before; this compares with 38.1 per cent (7,980/20,951) in England.

The latest unpublished participation figures from the HSCIC for 2015/16 (as at February 2016) show that 42.4 per cent of patients returned the pre-operative questionnaire (64/151); this compares with 57.3 per cent (36,356/63,472) nationally. To enable a change in healthcare status to be measured, patients must also return a post-operative questionnaire. Latest figures show that 51.3 per cent (20/39) of UH Bristol patients have done so; this compares to 53.5 per cent (13,889/25,974) nationally.

3.3.6 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 clinical and cost effective. To achieve the BPT for hip fractures, trusts are required to meet eight indicators of quality as recorded in the national hip fracture database. The indicators are:

- surgery within 36 hours from 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.

Overall performance for 2015/16 is 68 per cent, compared to the national average of 61.8 per cent (see Figure 32). The Trust has historically struggled to achieve the BPT due to poor performance against the indicators relating to time to theatre and ortho-geriatric review, despite consistently achieving over 90 percent for the other six indicators.

Recent improvement work has included the implementation of a 'live' trauma board to help focus on prioritisation of patients and increased staffing in theatres and within the ortho-geriatric team. Delivering BPT continues to be a challenge however: a key priority for 2016/17 is to move towards an integrated model of care. This includes our ongoing efforts to recruit middle grade ortho-geriatric doctors, of which there is a national shortage.

To help us better understand how we can improve hip fracture care at UH Bristol, the Trust has also invited a multidisciplinary team from the British Orthopaedic Association to assess our current service and review all aspects of care against National Hip Fracture Database Best Practice.

Figure 32

Percentage of patients meeting best practice tariff criteria

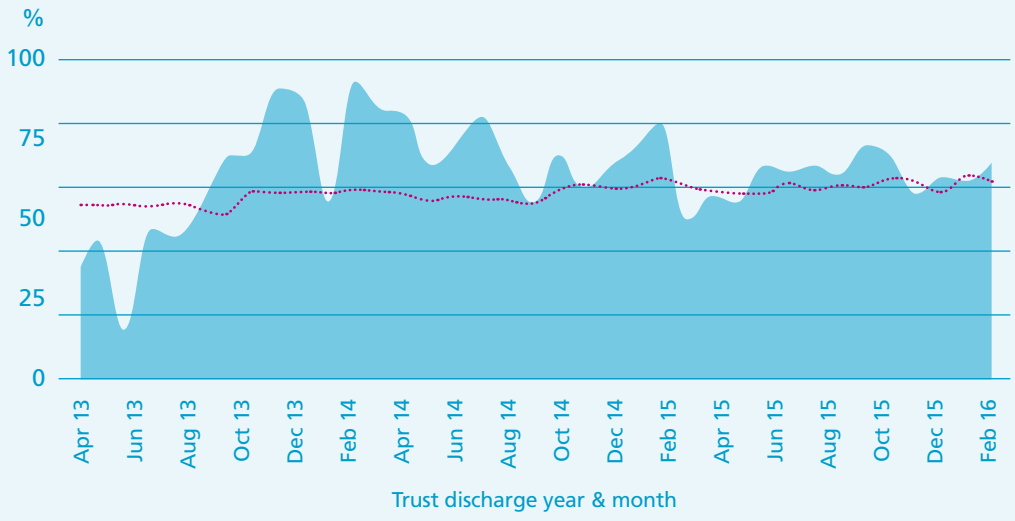


Table 12

Specialty	Clinical audit/registry title	Specialist Association	Submitted
Adult cardiac surgery	National Adult Cardiac Surgery Audit	Society for Cardiothoracic Surgery	Yes
Bariatric surgery	National Bariatric Surgery Register **Surgery concerning the causes, prevention and treatment of obesity**	British Obesity & Metabolic Surgery Society	N/A
Colorectal surgery	National Bowel Cancer Audit Programme **Surgery relating to the last part of the digestive system**	The Association of Coloproctology of Great Britain and Ireland	Yes
Thyroid and endocrine surgery	BAETS national audit **Surgery on the endocrine glands to achieve a hormonal or anti-hormonal effect in the body**	British Association of Endocrine and Thyroid Surgeons	Yes
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	N/A

3.3.7 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 ten National Clinical Audits in 2013, with two further audits/registries added in 2014. Those that published in the inaugural year have continued to build on and develop the number of procedures and quality measures covered including team-based or hospital measures.

The table below shows the medical specialties/societies that reported consultant outcomes within 2015/16 and whether the Trust submitted data to the required national audit/registry.

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

3.3.8 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 2015/16 than in the previous year (2.86 per cent in 2015/16 compared to 2.80 per cent in 2014/15 – both figures quoted year to date March to February). 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 (i.e. the sixth lowest readmission rate), with an indirectly standardised emergency readmission rate of 11.15 per cent compared with 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 (i.e. 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 clinic coding, checks conducted of 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.

3.3.9 Seven day services

A report on seven day services has been included this year at the request of our governors.

In 2013, the NHS Services Seven Days a Week Forum developed ten clinical standards describing the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

Following discussions between NHS England and the Academy of Medical Royal Colleges, the following four standards have been identified as having the greatest potential impact on reducing weekend mortality and have therefore become the immediate focus for improvement across the NHS. These are:

- Standard 2: time to consultant review
- Standard 5: access to diagnostics
- Standard 6: access to consultant-directed Interventions[28]
- Standard 8: on-going review

[28] Defined by NHS England as Critical Care, Percutaneous Coronary Intervention (PCI), Cardiac Pacing, Thrombolysis, Emergency Surgery, Interventional Endoscopy, Interventional Radiology, Renal Replacement Therapy and Urgent Radiotherapy.

At the end of July 2015, NHS providers were asked to support the establishment of a robust baseline showing the extent to which these standards are being met nationally, by completing the online NHS Improving Quality Seven Day Service Self-Assessment Tool. Self-assessment was carried out via audit of case-notes and completion of specific questions relating to the operation of diagnostic services. Trust performance again the measures published by NHS England are outlined below.

Table 13

Standard	2	5	6	8
	Inpatients seen by a consultant within 14 hours	Diagnostic services available seven days per week	Interventional services available seven days per week	Ongoing review of patients by consultants
University Hospitals Bristol NHS Foundation Trust	5 out of 10 specialties reported that patients are seen within 14 hours 90 per cent or more of the time	11 out of 14 diagnostic services are available seven days per week	7 out of 9 consultant-directed interventions are available seven days per week	6 out of 13 relevant clinical areas reported that patients receive a review by consultants at appropriate intervals

During 2016/17, in order to improve performance against these standards, consultant cover will be increased within surgical specialties so that more patients are reviewed within 14 hours, seven days of the week. Work is also underway to increase staffing capacity within the Trust's interventional radiology service to help ensure that key diagnostic services are available seven days a week.

The Trust is currently in the process of submitting data for the second round of assessment; results are expected to be published in May 2016.

3.4 Performance against national priorities and access standards

3.4.1 Overview

In its 2015/16 operational plan, the Trust declared risks to five of the standards against NHS Improvement's risk assessment framework. The five standards (with the service performance score shown in brackets) not forecast to be achieved in one or more quarters were as follows:

- A&E 4-hour waiting standard (1);
- 62-day GP and 62-day screening cancer standard (combined score of 1);
- RTT non-admitted pathways standard (1);
- RTT admitted pathways standard (1); and
- RTT incomplete/ongoing pathways standard (no score - RTT standards failure capped at 2).

Table 14 below shows the planned performance against those standards not expected to be achieved in 2015/16, as declared in the 2015/16 annual plan, along with the actual reported performance for the quarter. Please note that the RTT admitted and RTT non-admitted pathway standards were removed from NHS Improvement's risk assessment framework during quarter one in 2015/16 and for this reason are not shown in the reported position for any quarters.

Table 14

Performance against access standards in 2015/16

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Standards not forecast to be met	RTT non-admitted RTT admitted RTT incomplete 62-day GP cancer 62-day screening cancer	RTT non-admitted RTT admitted RTT incomplete 62-day GP cancer 62-day screening cancer	RTT non-admitted RTT admitted 62-day GP cancer 62-day screening cancer	RTT admitted A&E 4-hours 62-day GP cancer 62-day screening cancer
Forecast score	3	3	3	3
Standards declared not met in the quarter	RTT incomplete A&E 4-hours 62-day GP cancer 62-day screening cancer	RTT incomplete A&E 4-hours 62-day GP cancer 62-day screening cancer	RTT incomplete A&E 4-hours 62-day GP cancer 62-day screening cancer	A&E 4-hours 62-day GP cancer 62-day screening cancer
Actual score	3	3	3	2
Governance Risk Rating	GREEN	GREEN	GREEN	GREEN[29]

Although annual performance against the access standards in 2015/16 was similar to that in 2014/15, there were some notable improvements in performance across many of the national standards. These included: achievement of the 92 per cent referral to treatment (RTT) incomplete pathways standard at the end of March 2016, achievement of the 99 per cent national standard for the 6-week diagnostic wait for six of the last seven months of the year; and achievement of the 0.8 per cent national standard for cancellation of operations at last minute for non-clinical reasons, for two quarters in the year.

The Trust achieved five of the seven core national cancer waiting times standards in every quarter of 2015/16. In addition, the aggregate annual performance for the 31-day first definitive and 31-day subsequent surgery standards showed an improvement on our 2014/15 performance. The 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer, was not achieved in 2015/16; 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 34 per cent of breaches each month. Performance for solely internally managed pathways was above 85 per cent in all quarters in 2015/16. The 62-day wait from referral to treatment for patients referred from one of the national screening programmes failed to be achieved in any quarter of 2015/16; 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 4-hour wait in A&E for at least 95 per cent of patients in every quarter of the year. However, the Trust met three of the four other national A&E clinical quality indicators in the period. The level of ambulance hand-over delays was also lower than in 2014/15, despite increasing pressure on the Trust's Emergency Departments.

Performance against the primary percutaneous coronary intervention (PCI) heart revascularisation 90-minute door to balloon standard remained strong in 2015/16 and above the 90 per cent standard for each quarter of the year.

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 the RTT incomplete pathways standard, 62-day GP cancer, A&E 4-hours, last-minute cancelled operations, the six-week diagnostic standard and ambulance hand-over delays. Remedial action plans and associated recovery trajectories were agreed.

Full details of the Trust's performance in 2015/16 compared with the previous two years are set out in Table 15 below. The table includes performance in controlling healthcare acquired

[29] To be confirmed in June 2016

infections which is described in detail in section 3.1.4 of this report; further information about 28 day readmissions can be found in section 3.3.8; and extended commentary regarding the 18 week RTT, A&E 4 hour, cancer and other key targets is provided below.

3.4.2 18 weeks Referral to Treatment (RTT)

As planned, the Trust made significant progress during 2015/16 in reducing the number of patients waiting over 18 weeks from Referral to Treatment (RTT). Performance was restored to above the 92 per cent national standard at the end of March 2016. At the start of the year 3,339 patients were waiting over 18 weeks for treatment. By the end of March 2016, the backlog of long waiters had dropped by 29 per cent to 2,397. More than half of this reduction related to patients waiting for an elective procedure, with the number of patients waiting over 18 weeks on an admitted pathway reducing from 1,513 at the end of March 2015 to 937 at the end of March 2016. Demand for outpatient appointments was above plan in 2015/16 for several of the high volume RTT specialties, resulting in slower progress being made during the first half of the year in reducing the number of patients waiting over 18 weeks on non-admitted pathways. The level of activity required to support ongoing achievement of the RTT incomplete pathways standard has been agreed with commissioners for 2016/17.

3.4.3 Accident & Emergency 4-hour maximum wait

In 2015/16, 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. System pressures continued to be evident in 2015/16 with levels of emergency demand at the Bristol Royal Hospital for Children (BRHC) being significantly above plan for the majority of the year. During the first six months of 2015/16, levels of emergency admissions via the Bristol Royal Hospital for Children's Hospital Emergency Department were 15.2 per cent above the same period in the previous year, reaching average 2014/15 winter levels in May and September. This increase in demand was a significant driver of the Trust's underperformance against the 4-hour standard during the year. Work with our commissioners to understand the reason for the higher than expected levels of paediatric emergency demand continues.

Following improvements early in 2015/16, the Trust experienced a significant increase during much of the year in the number of medically fit patients whose discharge from the Bristol Royal Infirmary (BRI) was delayed, with levels at their peak reaching more than double those seen at the start of the year. This was primarily due to a lack of sufficient domiciliary care packages as a result of providers taking time to reach their planned operating capacity, following the recommissioning of these services by Bristol City Council during quarter 2. An acute shortage of social workers also contributed to the increase in delayed discharges.

Consistent with other parts of the country, the last quarter of the year has seen exceptional pressures on both the adult and paediatric Emergency Departments, with significant increases in emergency department attendances, emergency admissions and patient acuity leading to a significant deterioration in 4-hour performance. The combination of these system pressures on both the adult and paediatric emergency services led to the failure to achieve the 95 per cent A&E 4-hour standard in each quarter of 2015/16.

3.4.4 Cancer

The Trust continued to perform well in 2015/16 against the majority of the national cancer waiting times standards, achieving the 2-week wait for GP referral for patients with a suspected cancer, the 31 day wait for first definitive treatment, and the three 31-day standards for subsequent treatment (i.e. surgery, drug therapy and radiotherapy) in each quarter in 2015/16. Despite the 62-day GP standard not being achieved in any quarter, performance against the standard improved over quarters 2 and 3, with the 85 per cent standard being met in December 2015 for the first time since June 2014. The Trust achieved its improvement trajectory (monthly in quarter 3 and in aggregate for quarter 4), which was agreed as part of a national submission of 62-day GP cancer improvement plans in August 2015.

The Trust failed to achieve the 62-day referral to treatment standard for patients referred by their GP with a suspected cancer. The three top causes of breaches of the 62-day GP cancer standard were: late referrals from, or pathways delayed by, other providers (34 per cent), medical deferral/clinical diagnostic complexity (20 per cent), and delayed outpatient appointments (9 per cent). Delayed outpatient appointments featured as one of the top three causes of breaches of the 62-day GP standard in 2015/16. The main reasons for this were

firstly, a capacity constraint within one particular service, which has now been sustainably addressed with the appointment of an additional consultant, and secondly a delayed step in an administrative process for another service, which has now been revised to minimise the likelihood of a delay. The main risks to other avoidable causes of pathway delays were addressed in 2015/16 through the development of ideal timescale pathways, with pathways being designed and pre-planned as far as possible around core pathway events such as multi-disciplinary team meetings. For some tumour sites this redesign work has taken a week out of the length of a 62-day GP pathway.

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 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 continues to require performance significantly above the national average in most tumour sites. The Trust is expecting to continue to make improvements against the 62-day GP cancer waiting times standard in 2016/17 through the ideal timescale pathways which were implemented in the latter half of 2015/16.

The Trust failed to achieve the 62-day referral to treatment standard for patients referred by the national screening programmes in 2015/16. In each quarter of 2015/16, the majority of the breaches of this standard were outside of the Trust's control, including: patient choice, medical deferral and breaches at other providers following timely referral. Following the transfer-out of the Avon Breast Screening service, the majority of treatments the Trust reports under this standard are for bowel screening pathways, which nationally perform significantly below the 90 per cent standard. This is largely due to high levels of patient choice to defer diagnostic tests, which continues to be the main cause of breaches of this standard for the Trust.

Table 15

Performance against national standards

National standard	2013/14	2014/15	2015/16 Target	2015/16[30]	Notes
A&E maximum wait of 4 hours	93.7%	92.2%	95%	90.4% Ⓐ	Target failed in every quarter in 2015/16
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	15	15	15 mins	34	Target failed in every quarter in 2015/16[31]
A&E Time to Treatment (minutes) median within 60 minutes	52	54	60 mins	57	Target met in every quarter in 2015/16
A&E Unplanned re-attendance within 7 days	1.5%	2.3%	< 5 %	3.0%	Target met in every quarter in 2015/16
A&E Left without being seen	1.8%	1.8%	< 5%	2.4%	Target met in every quarter in 2015/16
Ambulance hand-over delays (greater than 30 minutes) per month	100	107	Zero	92	Target failed in every month in 2015/16
MRSA Bloodstream Cases against trajectory	2	5	Trajectory	3	Zero cases in quarter 4
C. diff Infections against trajectory	38	50[32]	Trajectory	40	Target met in every quarter in 2015/16
Cancer - 2 Week wait (urgent GP referral)	96.8%	95.5%	93%	95.8%	Target met in every quarter in 2015/16
Cancer - 31 Day Diagnosis To Treatment (First treatment)	97.1%	96.9%	96%	97.4%	Target met in every quarter in 2015/16
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94.8%	94.9%	94%	97.0%	Target met in every quarter in 2015/16
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.8%	99.6%	98%	98.9%	Target met in every quarter in 2015/16
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	97.4%	97.6%	94%	96.9%	Target met in every quarter in 2015/16
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	80.1%	79.3%	85%	80.2%	Target failed in every quarter in 2015/16
Cancer 62 Day Referral To Treatment (Screenings)	93.8%	89.0%	90%	68.2%	Target failed in every quarter in 2015/16
18-week Referral to treatment time (RTT) admitted patients	92.7%	84.9%	90%	N/A	Target no longer in effect
18-week Referral to treatment time (RTT) non-admitted patients	93.1%	90.3%	95%	N/A	Target no longer in effect
18-week Referral to treatment time (RTT) incomplete pathways	92.5%	90.4%	92%	91.3%	Target met at the end of quarter 4 2015/16
Number of Last Minute Cancelled Operations	1.02%	1.08%	0.80%	1.03%	Target met in two quarters in 2015/16
28 Day Readmissions (following a last minute cancellation)[33]	89.6%	89.8%	95%	88.7%	Target failed in every quarter in 2015/16
6-week diagnostic wait	98.6%	97.5%	99%	99.0%	Target met in quarter 3 (and 6 of the 7 last months in 15/16)
Primary PCI - 90 Minutes Door To Balloon Time	92.7%	92.4%	90%	93.8%	Target met in every quarter in 2015/16

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

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

[30] Figures shown are up to and including March 2016 for all figures, except the cancer waiting times standards and primary PCI, which are up to February 2016.

[31] The 15 minute standard was achieved in the Bristol Royal Infirmary Emergency Department, but due to a data quality/data capture issue for the Bristol Royal Hospital for Children (BRCH) that could not be resolved, was not achieved at a Trust level; local validation of figures provides assurance that the 15 minute standard is being met in the BRCH.

[32] Please note, the figures quoted for 2015/16 are the total number of cases reported. However, of these, nine were deemed to be potentially avoidable (up to the end of quarter 3 – quarter 4 still to be confirmed) against the limit of 45. For this reason this indicator is RAG rated Green.

[33] 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
This is an honest, transparent report which carries enhanced credibility due to extensive public and patient involvement activities carried out through focus groups and other stakeholder events during the year before quality objectives are agreed. Governors contribute to this process as part of their duty to represent the interests of the members who elected them.

Overall this is a comprehensive report that identifies strengths and areas for improvement over the last twelve months. There is evidence of consultation in the setting of the nine corporate quality objectives at the beginning of 2015/16. Some of the results themselves are disappointing with a failure to fully achieve seven of the nine set corporate quality objectives but an accompanying narrative which highlights some of the challenging conditions that the Trust has faced over the last twelve months. Increasing patient acuity and demand for services means that effective collaboration with our local healthcare partners continues to be vital. Maintaining patient flow through the hospital has been difficult due to insufficient community provision delaying discharge and consequent pressure on waiting time targets. Despite these pressures, it is gratifying to note that some key quality targets have been achieved consistently throughout the year, notably the control of pressure ulcers and patient falls, dementia care, and medicines safety.

We believe that our staff are key in the provision of high quality harm-free care and excellent patient experience. A major staff engagement initiative was continued throughout the year with listening events, improvements to the appraisal system and new staff development opportunities. We feel that these initiatives are important for staff retention. Recruitment of appropriately qualified staff has been a problem for most NHS trusts and our Trust has worked hard to streamline its recruitment processes. It is encouraging to see that our staff vacancy rate had been reducing throughout the year and that safe staffing levels have been maintained.

Performance against 2015/16 quality objectives
Of nine objectives set for last year, six were partially achieved and two fully achieved, the one failure being the excessive number of inappropriate ward moves. We understand that part of the reason for non-achievement of the target was the creation of an additional discharge ward to ease patient flow problems but such moves are disorientating for patients, particularly for those with cognitive impairment and are also upsetting for patents and family where there is an end of life situation.

Reducing the number of cancelled operations remains a challenge and is amber rated although performance was better than last year. Patients tell us how stressful it can be and inconvenient in terms of wasted time and inability to plan ahead. Again, the lack of beds and emergency pressures contribute to this problem. Creating bed availability has been an ongoing ambition for the Trust and the provision of a discharge lounge was just one of the initiatives which brought some success. The Trust is now looking at a new model of care at home for selected patients who do not need to be kept in an acute hospital. This service is provided by Orla Healthcare Ltd and the Trust plans to set up a “BRI at home” service in the summer of 2016. We are naturally concerned to ensure that this service provides consistent, high quality harm-free care.

Patients treated in the right ward for their condition was set as a quality target and although not fully achieved and amber rated, results were better than last year so continuing improvement is welcomed.

Improving patient discharge is an aspiration that we fully support so that patients and family/friends are not kept waiting for discharge letters and prescriptions. Progress is amber rated but performance improved when compared to last year. The reverse triage initiative has also

helped to improve the overall discharge of patients and understand potential blockages along the way.

The Governors welcome the Trust's initiative to improve the quality of written correspondence and commends the 'Letters Champions Week'. On the subject of letters, the Governors welcome progress towards greater empathy and candour in responding to complaints.

Improving the management of sepsis has significant potential for saving lives. CQUIN targets were not fully achieved, however the Governors agree that important improvements have been made, especially with the overall screening of patients, the employment of additional staff, a specific sepsis management pathway and further education and training within the Trust. The Governors also welcome the transparency and early warning of the impact of the new NICE sepsis guidance on practice in the children's emergency department.

The Governors are particularly supportive of the Trust's ambitions to improve cancer patients' experience, including early diagnosis and treatment. We welcome to addition of four cancer clinical nurse specialists but we would emphasise the need to join up care pathways with other providers. In this respect, we praise the Trust for its collaborative review of cancer nurse specialist cancer pathways across the Somerset, Wiltshire, Avon and Gloucester cancer network and the expansion of our trained cancer volunteer workforce, with additional roles in the chemotherapy day unit and radiotherapy department at the Bristol Haematology and Oncology Centre. In terms of the on-going education of front line administrative staff, the Governors welcome the introduction of training for over one hundred waiting list office and administration staff about how to deal sensitively with difficult conversations when operations have to be cancelled or delayed, or when changing chemotherapy appointments. In addition, the significant progression of the cancer 'recovery package' to support people from diagnosis onwards, including electronic holistic needs assessments, health and wellbeing days, and treatment summaries being sent to GPs is also welcomed as part of the Trust's approach to providing support to patients.

Delays in outpatients cause anxiety and stress for patients and waste their time. The Governors agree that standardisation of the layout of the boards was required to improve the quality and consistency of the way information about clinic running times is presented to patients.

Quality objectives for 2016/17

The Governors are pleased to see the continuation of a number of previous objectives which have been under-achieved. We welcome new targets related to improving communication with patients, carers and families and specifically the provision of better public facing information and keeping patients informed about their treatment with a renewed emphasis for patients with special needs. It is also good to see the inclusion of an objective for improving staff engagement and job satisfaction.

The objectives set out in the quality report are open and honest and use quotations from patients. A clear rationale has been provided in terms of why the 12 objectives have been selected and how they will be measured moving forward.

Statements of assurance from the board

We are impressed that the Trust actively completed 38 national clinical audits (with 100% participation in each) and three enquiries. The list of clinical audits is also very helpful and demonstrates the breadth and depth of these activities of the Trust. The Governors are reassured with the actions being taken by the Trust in response to audits, all of which will undoubtedly have a positive impact on future patient services.

The Trust is to be commended on its active involvement in research. It was really positive to see six of the Trust's principal investigators being recognised for the successful delivery of commercial research within the NHS by the chief medical officer as part of a National Institute for Health Research (NIHR) event.

Patient safety

The Governors welcome the continued reduction in patient falls in 2015/16. The introduction of the "Eyes on Legs" campaign has helped embed the concept of falls being everyone's responsibility. The introduction of bespoke falls training now incorporates an element on

dementia and supporting patients with a cognitive impairment, as this group of patients are more susceptible to falls. The Trust is to be commended on the 'Quality Champion' award received by the falls steering group at the annual Trust Recognising Success Awards in November 2015 and this demonstrates the commitment by the Trust to the continued work around reducing falls within its hospitals.

A further reduction in the incidence of pressure ulcers has been reported in 2015/16 and builds upon previous years' work. This progress is to be commended, along with the further actions planned in 2016/17, and again demonstrates a clear commitment by the Trust and the staff to eradicating pressure ulcers.

With regards to VTE, the Trust has maintained excellent standards. The on-going action plans also reflect the Trust's commitment to ensure further learning and prevention of VTE.

Whilst numbers of Clostridium difficile cases reduced in 2015/16, the number of avoidable infections has doubled compared to the previous year. The introduction of the aseptic non-touch technique training techniques is welcomed along with Posiflush and Microclave procedures.

The Governors welcome the transparency of the medication error data presented in the report and acknowledge the overall reduction of medicines related incidents over the last five years. The Governors also note a 70 per cent reduction in the number of unintentional omitted doses of critical medicines since 2012. The Governors welcome this positive outcome and progression with the pharmacy dispensing for inpatients should also be commended, in terms of speeding up patient discharge and improving the overall patient experience, whilst making more effective use of resources / bed occupancy within the Trust. The Governors also welcome the Trust's participation in new patient safety projects coordinated by the West of England Academic Health Science Network.

The Trust has sustained over 95 per cent achievement in completeness and accuracy of early warning scores, following the introduction of the new adult observation chart incorporating the NEWS score and this is welcomed by the Governors, as is the reduction in reported incidents resulting in severe harm or death. On-going education and training and the Trust's Sign up to Safety programme will also offer more support in the future.

Patient experience

It is reassuring to see the patient experience tracker above the set target. Results from some aspects of the Friends and Family Test (for example, emergency departments) have been variable, although we note the methodological issues described in the report. There are some good examples of practice / evidence, and areas for improvement. The report provides further evidence of effective patient and public involvement. The total number of complaints to the Trust increased slightly in 2015/16, with the trend reflecting increasing numbers of patient attendances and increasing pressures on services. Governor representatives have been involved in the work of the Trust's patient experience group throughout the year.

It is pleasing to see the development of a carers strategy, which had previously been requested by the Governors, as is the introduction of carer liaison staff within the Trust. Looking forward, there are positive steps being put into place to provide more support for carers, which the Governors welcome.

The inclusion of a narrative around end of life care strategy, again as requested by the Governors, is welcomed.

Clinical effectiveness

The Trust's partial achievement of the national dementia CQUIN was encouraging and the growth in the number of Dementia Champions across the Trust is to be commended, along with the positive approach and communications strategy underpinning the Trust's activities in this area. A lot of work has been undertaken by staff within the Trust and by volunteers, working with charities and patient groups. The launch of the dementia café in 2015 is an excellent example of bringing people together and promoting a better understanding. The Governors welcome the use of the Abbey pain scale for use with patients with dementia.

The latest overall performance against the hip fracture best practice tariff in 2015/16 was 68 per cent, compared to the national average of 61.8 per cent, which is an improvement, but still relatively low as an overall figure. Improvement plans are acknowledged and welcomed by the Governors going forward.

An overall reduction in readmissions has been reported year on year and this is welcomed by the Governors. The presentation of data and narrative related to the positioning of seven day services within the Trust is also welcomed, as is the methodology / implementation process.

Performance against national priorities and access standards:
It was disappointing to see the Trust failing to achieve maximum 4-hour wait in A&E in every quarter of the year. The Governors do however note that the Trust met three of the four other national A&E clinical quality indicators in the period. There are also other mitigating circumstances that have been presented in the quality report.

The Governors are pleased to see an improvement in the overall cancer referral to treatment figures, however the Trust failed to achieve the 62-day referral to treatment standard for patients referred by their GP with a suspected cancer. The accompanying narrative is helpful in terms of explaining the underlying reasons for the Trust's performance.

Dr Marc Griffiths,
Appointed Governor
20 May 2016

Clive Hamilton,
Governor
20 May 2016

b) Statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and South Gloucestershire support the focus in several of UH Bristol's quality priorities on improving the ways in which information is shared with patients regarding their treatment both before an appointment or admission, during the treatment and leading up to and at the point of discharge. Lack of clear information about treatment is a recurrent theme in the feedback Healthwatch gathers from members of the public about their experiences of health and social care services across the region. Similarly, the focus on the reduction in waiting times and cancellation of operations will hopefully address another negative theme identified in feedback gathered by Healthwatch across a range of providers. The draft Quality Report that Healthwatch has commented on does not give detail of how all the targets will be achieved or measured and Healthwatch urges UH Bristol to include patient participation and feedback in the evaluation of all targets. Healthwatch Bristol and South Gloucestershire welcome further opportunities to work with UH Bristol, for example via enter and view visits (as carried out in spring 2016 to the Bristol Royal Infirmary discharge lounge) and engagement in patient participation events as planned by UH Bristol and Healthwatch.

Comments on performance against 2015/16 objectives:

Reducing the number of cancelled operations
Healthwatch encourages UH Bristol to ensure the integration of care provided in the hospital and by Orla Healthcare in people's homes. As this project is beginning and throughout its duration it is essential that service users, their family and carers are consulted and their feedback taken into account in how the service is delivered. Healthwatch asks UH Bristol to consider and respond to the following questions: Will consultation with patients be undertaken by Orla Healthcare or by UH Bristol? Will patients receiving Oral Healthcare services be entitled to support from UH Bristol's patient support and complaints service?

Minimising inappropriate patient moves between wards (time and place)
Commentators tell Healthwatch that they would like any changes to their care, including moving between wards, to be explained to them by staff. Family members, carers and visitors have also reported finding it distressing to arrive at a ward to visit and find their loved one is no longer there, but to be unable to get information about where they have moved to. Although UH Bristol has not selected this as a priority in 2016/17, Healthwatch urges the Trust to ensure staff are consistently providing patients and their support networks with timely information about any changes to ward.

Improving patient discharge
Healthwatch has recently carried out an 'enter and view' visit to the Bristol Royal Infirmary Discharge Lounge and the report will be shared with UH Bristol once completed.

Improving the quality of patient appointment letters
Healthwatch staff and volunteers are happy to help with the promotion of the planned 'Letters Champions Week' and participate where appropriate. The Accessible Information Standard also enforces the need for health and social care services to provide information in an appropriate format for people with additional communication needs. Healthwatch Bristol is working with local service providers, commissioners and voluntary and community sector groups to develop ways of working with people with learning disabilities to ensure health and social care services are accessible. UH Bristol has been invited and is encouraged to take part and share learning from the work they have already undertaken. For work with North Bristol NHS Trust (NBT), Healthwatch is aware that NBT is also reviewing its patient letters. Healthwatch encourages both Trusts to work together to ensure patients, who are often using services at both UH Bristol and NBT, are receiving consistent and clear information regardless of where their treatment is taking place.

Comments on proposed 2016/17 objectives:

Reducing the number of last minute cancelled operations
Healthwatch supports this as a priority. Commentators contacting Healthwatch stress the importance of any changes to or cancellations of operations being communicated clearly and in as much advance of the operation as possible. In developing the priority, Healthwatch urges UH Bristol to consider how information about the reasons for cancellations of operations will

be relayed to the patient and how the Trust will ensure patients are supported during the additional waiting time for the rearranged operation.

Improving timeliness of patient discharge
Delays in discharge, lack of information about when and how the patient will be discharged and a lack of information about accessing support are common themes in feedback received from members of the public about their experiences of hospital treatment. Healthwatch, therefore, supports the decision to include this as a priority. Healthwatch Bristol is currently producing a survey to gather feedback from people who have recently been discharged from secondary care services about their experiences. Healthwatch welcomes UH Bristol to work with us to cascade this survey and learn from the feedback received.

Reducing appointment (in-clinic) delays in outpatients, and keeping patients better informed about any delays
This priority supports patient feedback regarding waiting times and Healthwatch is pleased to see it included as a priority.

Ensuring public-facing information displayed in our hospitals is relevant, up-to-date, standardised and accessible
The Accessible Information Standard should be considered within the plans for this priority to ensure information is accessible to people with additional communication needs (including people with learning disabilities and sensory impairments). Healthwatch receives feedback about the importance of clear signage within health and social care services and encourages UH Bristol to consider the needs of patients who have communication needs, low literacy levels and/or do not speak English as their first language.

Reducing the number of complaints received where poor communication is identified as a root cause
Poor communication is a recurrent theme in the feedback Healthwatch gathers regarding health and social care services. Healthwatch is delighted to see this as a priority.

Implementing the Accessible Information Standard, ensuring that the individual needs of patients with disabilities are identified so that the care they receive is appropriately adjusted Healthwatch Bristol is working with The Hive, a local voluntary organisation, Birchwood Medical Practice and local health and social care providers to collectively produce resources and models of working to improve accessibility for people with learning disabilities. UH Bristol has been invited to take part.

Increasing the proportion of patients who tell the Trust that, whilst they were in hospital, they were asked about the quality of care they were receiving
Healthwatch is happy to see that gathering patient feedback is a priority for UH Bristol. Healthwatch urges UH Bristol to consider how patients will be supported to give their feedback and how patients will be signposted to alternative feedback options including PALS, advocacy and Healthwatch. Healthwatch also urges UH Bristol to consider the nine protected characteristics in the Equality Act and reflect on whether feedback received is representative of people within the protected characteristics. If not, UH Bristol should undertake work to ensure all patients are enabled and encouraged to give their feedback.

c) Statement from Healthwatch North Somerset

Healthwatch North Somerset is pleased to have the opportunity to comment on the draft University Hospitals Bristol NHS Foundation Trust Quality Report for 2015/16. Healthwatch North Somerset acknowledges the report and notes that although there was good progress, of the nine objectives outlined for 2015/16, seven were not fully achieved. We welcome the Trust's commitment to continue towards a number of these objectives in 2016/2017 alongside new ambitions.

We recognise the number of clinical audits and clinical research the Trust has participated in which provide an effective mechanism for clinical governance for improving the quality of care patients receive.

It is noted that the Trust has improved its performance in patient safety for falls, pressure ulcers and VTE alongside a reduction in Clostridium Difficile and MRSA. It is disappointing

that there were 18 bed days lost due to norovirus during the year. We note that there has not been a discernible improvement in medication incidents when compared with the previous year but acknowledge the comments regarding non-preventable incidents and harm. We also commend the Trust for the reduction in the number of serious incidents compared to 2014/15. The number of patient safety severe harm incidents however remains comparable with the previous year and it is hoped that the Sign up to Safety programme will reduce the risk of severe harm to patients.

The evaluation of patient experience is central to the functions of Healthwatch and therefore we commend the steps taken by the Trust to involve patients through the new Involvement Network. The level of Friends and Family Test responses (other than maternity) were often lower than the national benchmark, although we acknowledge the comments about methodologies. It was disappointing to note there was an increase in the number of complaints received compared to the previous year, however we acknowledge the adjustments made to ensure that complaints are dealt with satisfactorily. It would be useful to see the data regarding the type of complaints received, although we note that this information is published by the Trust in regular quarterly reports.

We commend the Trust for the five point staff experience improvement programme but note that there is more work to be done: the figures relating to staff experiencing harassment, bullying or abuse from all staff are of great concern. We seek assurance that a robust plan of action is in place to resolve these concerns and that additional work is undertaken to understand and respond to the comparatively poor reported experience of BME staff. We commend the Trust on the support provided for carers and the plans to build on the steps already undertaken.

The data in the draft quality report for clinical effectiveness is partially incomplete at the point we are reviewing it, however we note that the dementia CQUIN has been achieved and the struggle to achieve the hip fracture tariff. There are a number of performance standards that have not been met including the 62 day wait for referral to treatment for cancer and the 4 hours wait for A&E, however we acknowledge that system pressures and demand have been above predicted levels.

This response was complete with the support of Healthwatch North Somerset Volunteers.

d) Statement from South Gloucestershire Health Scrutiny Select Committee

The Health Scrutiny Committee's comments are based on its engagement with UH Bristol during 2015/16. During this time the Committee scrutinised one matter which involved UH Bristol and that was in January 2016 in relation to the Severn Pathology Service. The subject has a long history dating back to an Independent Inquiry into histopathology services in 2010. Whilst it was felt that progress had taken a long time, the Committee was pleased to learn of significant developments, which included the centralisation of histopathology laboratory services on North Bristol NHS Trust's Southmead Hospital site whilst maintaining clinical relationships through continued multi-disciplinary team meetings on both NBT and UH Bristol sites. The Committee also received an invitation to visit the new laboratory ahead of the official opening in mid-summer 2016, which was warmly received by members. Looking ahead, UH Bristol has accepted an invitation to attend committee in June 2016 to present highlights from its Quality Report and answer members' questions.

Councillor Toby Savage
Chair,
Health Scrutiny Committee

Councillor Sue Hope
Lead Member,
Health Scrutiny Committee

Councillor Ian Scott
Lead Member,
Health Scrutiny Committee

e) Statement from Bristol City Council People Scrutiny Commission

The Commission will formally receive UH Bristol's Quality Report at a joint meeting with South Gloucestershire Health Scrutiny Select Committee on 8th June 2016.

f) Statement from Bristol Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Report 2015/16 is made by Bristol Clinical Commissioning Group following a review by members of its Quality and Governance Committee and responses from South Gloucestershire and North Somerset CCGs.

Bristol CCG welcomes UH Bristol's quality report, which provides a comprehensive reflection on the quality performance during 2015/16. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

Bristol CCG noted that of the nine quality objectives for 2015/16 only two were fully achieved and six partially met. The CCG notes the work put in place for these objectives and is pleased to note that five of the objectives that were either not or only partially achieved have been put forward along with seven new quality objectives for 2016/17.

The inclusion of patients' feedback to support the rationale for why these objectives have been chosen is positive and the CCG supports the chosen areas for quality improvement for 2016/17.

Within the quality report, UH Bristol has demonstrated continued good progress in reducing the number of inpatient falls, pressure ulcers and sustaining compliance with VTE assessments, all of which are to be commended. The Trust achieved compliance with the C Difficile target and demonstrated an improvement from the previous year. However, the CCG would have welcomed more detail on how UH Bristol plans to work collaboratively and proactively with community and primary care partners to support further reduction in the number of C Difficile infections.

UH Bristol's performance against achieving the quality improvement and innovation goals (CQUINs) is noted in the quality report, but as with the previous year's report there is little narrative to explain why there was non-achievement of those schemes either partially or not met other than via a web link.

Bristol CCG notes the ongoing work to support families and carers and the use of patient stories to highlight the positive work to support carers. We also would like to acknowledge the positive approach taken by UH Bristol in the management and care of end of life patients and their families.

Bristol CCG notes the ongoing reduction in the number of missed medicine doses and supports the Trust's plans to implement a pilot for electronic prescribing and administration, which should provide further intelligence to support the reduction in omitted or delayed administration of medicines. However, the CCG noted there is little supporting information around the decline in aspects of antimicrobial stewardship and would support a continued focus on this in 2016/17.

Bristol CCG expects concerns about services to be shared openly and honestly in annual quality reports. We welcome the acknowledgement of the paediatric cardiac services independent review and would expect the Trust make more detailed reference to the outcomes of this review in next year's report.

Going forward, Bristol CCG will continue to work closely with the Trust in areas which need either further improvement or development. These include:

- improvement in performance against the best practice tariff for patients who have sustained a fractured neck of Femur
- improvements in the Friends and Family Test response rates for inpatient areas specially day case and outpatient areas

- closer working with primary care and community partners to help support the reduction in incidences of healthcare associated infections, namely C Difficile Infection and MRSA
- developing meaningful priorities to work with primary care to improve quality either through learning from experiences or in developing pathways
- improvement in the Trust's response in communicating with us in a timely way about specific areas of interest/concern; we would want them to do this more consistently in 2016/17
- joint working with partner agencies on the emerging priorities of the sustainability and transformation plans to support service improvement.

Bristol CCG acknowledges the good work going on in the Trust and the quality report clearly demonstrates this. We also note where further improvement work is needed and we look forward to working with UH Bristol in 2016/17.

B APPENDIX B
Performance indicators subject to external audit

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

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

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

Denominator
The total number of unplanned A&E attendances.

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

Indicator format
Reported as a percentage.

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

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

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

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

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

Indicator format
Reported as a percentage.

C

APPENDIX C
Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. Monitor[34] 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 2015/16 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  - board minutes and papers for the period April 2015 to March 2016
  - papers relating to Quality reported to the board over the period April 2015 to March 2016
  - feedback from commissioners received 19/5/2016
  - feedback from governors received 20/5/2016
  - feedback from local Healthwatch organisations received 13/5/2016 and 18/5/2016
  - feedback from Overview and Scrutiny Committee received 16/5/2016 and 18/5/2016
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[35]
  - the 2014 national patient survey published 8/4/2014[36]
  - the 2015 national staff survey published 22/3/2016
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 26 May 2016

- 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 manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

John Savage, Chairman
25 May 2016

Robert Woolley, Chief executive
25 May 2016

[34] On 1st April 2016, Monitor became part of NHS Improvement
[35] This report is due to be received by the board in July 2016
[36] The 2015 survey results have not yet been published

D APPENDIX D External audit opinion

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

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2016 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

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 101 of the Quality Report
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	As detailed on page 101 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 2015/16" 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 2015/16";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "2015/16 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 the "Detailed requirements for quality reports 2015/16; 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 and papers for the period April 2015 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2015 to the date of signing this limited assurance report;
- Feedback from Bristol Clinical Commissioning Group dated 19/05/2016;
- Feedback from Governors dated 20/05/2016;

- Feedback from Healthwatch Bristol and Healthwatch South Gloucestershire dated 13/05/2016 and 18/5/2016;
- Feedback from Overview and Scrutiny Committee dated 16/05/2016 and 18/05/2016;
- The latest national inpatient survey dated 21/07/2015;
- The latest national children's survey dated 01/07/2015;
- The latest national maternity survey dated 15/12/2015;
- The latest national staff survey published 22/03/2016;
- Care Quality Commission Intelligent Monitoring Reports dated May 2015; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 24/05/2016.

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

Our Independence and Quality Control
We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report
This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospital 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 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2015/16";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

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

deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the "Detailed requirements for quality reports 2015/16 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.

Basis for Adverse Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
In our testing of the Incomplete 18 Weeks indicator, based on the waiting time of each patient who has been referred to a consultant but whose treatment is yet to start, we have found an unacceptable level of errors. These related to the incorrect inclusion of patients in the dataset where treatment had already commenced or the incorrect exclusion of patients from the data set following the date of referral. This resulted in the incorrect classification as either a breach or non-breach.

Conclusions (including adverse conclusion on percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period)
In our opinion, because of the significance of the matters described in the Basis for Adverse Conclusion paragraph, the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator has not been prepared in all material respects in accordance with the criteria.

Based on the results of our procedures nothing else has come to our attention that causes us to believe that for the year ended 31 March 2016,

- 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 2015/16";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator has not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "Detailed guidance for external assurance on quality reports 2015/16".

PricewaterhouseCoopers LLP
Bristol
27 May 2016

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