Inspected and rated
Outstanding ☆
CareQuality Commission

NHS
University Hospitals Bristol
NHS Foundation Trust

Quality Report 2017/18

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents

1.1 Statement on quality from the chief executive

Welcome to this, our tenth annual report describing our quality achievements. Our mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates to the public and its stakeholders that its services are safe, effective, caring and responsive. The report is an open and honest assessment of the last year, its successes and its challenges.

The Care Quality Commission (CQC) commended our staff for their commitment to our patients when they rated the Trust as Outstanding in March last year and their dedication shone through in 2017/18. At UH Bristol we believe wholeheartedly that our staff are central to the care that we provide to our patients and their families. We want to improve their experience as staff members and support them to do their roles to the best of their ability and to stay well and healthy. It was therefore encouraging to see that the latest NHS Staff Survey results demonstrate that our work is continuing to bear fruit.

During 2017/18, the Care Quality Commission published the results of the 2016 national survey of adult inpatients, which ranked us as the top equal acute trust in the country for patient experience. The equivalent surveys for emergency services and for children's and parents' experiences of care also place University Hospitals Bristol in the top 20% of NHS Trusts. This hugely positive feedback from the people who use our services chimes with the CQC's own observations from their last inspection when they commented on the humanity and compassion of the care they witnessed.

In this report, you will read about the progress we have made towards achieving the goals we set ourselves 12 months ago. These include the successful creation of a Quality Improvement Academy to give our staff the tools they need to put their good ideas into practice, and the introduction of a new mortality review programme so that we take every possible opportunity to learn from deaths in hospital (one of our quality objectives for 2018/19, improving early recognition of when patients are nearing the end of life, relates directly to early findings from this programme).

I am proud that we have delivered these and other improvements in the context of the significant challenges we have faced throughout the year to meet key national access standards and to continue to tackle long-standing pressures around demand, capacity and patient flow. While I am encouraged that we achieved the 62 day GP cancer waiting time standard during the third quarter of the year, and the six week diagnostic waiting standard in February, we have a lot more work to do.

During this year, it has become increasingly apparent to me that we will only continue to make progress as an organisation by working in collaboration with our partners for the greater good of the people we serve. As always, I would like to thank everyone who has contributed to this year's Quality Report, including our staff, governors, commissioners, local councils, and local Healthwatch. To the best of my knowledge, the information contained in this Quality Report is complete and accurate.

Robert Woolley
Chief executive

1.2 Introduction from the medical director and chief nurse

We are proud to be leaders in a Trust where staff dedicate themselves to continually improving the quality of care for patients. This Quality Report includes a number of great examples of quality improvement. Even relatively small-scale changes can lead to significant quality benefits for patients.

The potential benefit is even greater if quality improvement (QI) techniques are applied consistently across organisations and systems. In this report you will read about the Trust's approach to QI, which supports frontline staff to make improvements, and the shared responsibility for quality which exists between staff and leaders at all levels of our organisation and beyond.

Thank you to all our staff who are constantly doing that little bit extra every day to help patients and their families and who contribute to the Trust's reputation for providing high quality care.

Carolyn Mills
Chief nurse

Dr Mark Callaway
Acting medical director

2 Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2017/18

Twelve months ago, we identified eight specific areas of practice where we wanted to see improvements in 2017/18. These were a combination of ambitions we had not fully realised in 2016/17 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 achieved four objectives and made significant progress in three more.

OBJECTIVE 1	To create a new Quality Improvement Academy
Rationale and past performance	The Trust's Quality Strategy (2016-2020) describes our plans to link up a number of strands of current activity that fall within our shared understanding of quality improvement, creating a learning environment to promote and encourage quality improvement. This includes clinical audit, research and innovation, patient safety and transforming care. All of these existing programmes continue to demonstrate huge value to the organisation, however we recognise that there are opportunities to work together more closely to support innovation and improvement across all areas of the Trust. A key part of this is the development of a new Quality Improvement (QI) Academy.
What did we say we would do?	At UH Bristol, we want to promote and encourage innovation and improvement, so that staff with good ideas can bring them to life for the benefit of patients, staff, the Trust and the wider NHS. Within this ambition, we set out three aims in last year's report: • To support and connect people with our existing quality improvement programmes • To provide support to staff with good ideas outside these programmes • To build capability to support staff to lead improvement independently of these programmes. To create ownership and to build capacity to change, we need to encourage staff with ideas to implement their ideas themselves. To drive and encourage this we are committed to providing staff with support and education to give them the skills to lead improvement themselves. Last year, we said that a key part of this would be the creation of a new QI Academy to provide a broad range of staff with the quality improvement skills and tools they will need. As part of our plan, we said we would establish a quarterly innovation forum to bring together the leaders of QI projects in a structured event to share learning. We also committed to further strengthen our partnership with the West of England Academic Health Science Network.

Measurable target/s for 2017/18	Our target was for 100 members of staff to attend the QI Academy 'Bronze' programme during 2017/18.
How did we get on?	We successfully implemented the 'bronze' and 'silver' level training programmes in our QI Academy. Bronze training provides participants with an introduction to quality improvement methodologies and tools. In addition to regular monthly sessions open to all staff, training has also been delivered to a number of teams and staff groups including the adult emergency department team, dental students, psychologists, foundation doctors and core medical trainees. To date, nearly 200 members of staff have completed the bronze programme with an overall satisfaction rating on feedback of 4.7/5. Our silver programme has also begun, providing staff with hands-on support to develop their QI project ideas. The first students will 'graduate' in April and a second cohort has already started. In July, we held our inaugural QI Forum, giving all staff an opportunity to display their QI work. Over 70 posters were received and displayed and the top three posters received a trophy on the day. The QI Hub has been launched, enabling staff to submit ideas for innovation and improvement projects. Staff who submit ideas to the Hub receive initial advice and direction about how they might best be taken forward. There is now a steady growth in the numbers of submissions month-on-month; in each case, the submission is discussed and a member of the QI Faculty will meet with the team to determine the level of support required. Finally, our QI website continues to grow and houses resources to support staff with QI methodology. In developing our QI Academy and QI approach we engaged with a wide range of stakeholders, including the West of England Academic Health Science Network (WEAHSN), whose advice was invaluable, particularly in pointing us to other trusts in the region who had developed successful QI programmes. We have continued to maintain close contact with the QI team at the WEAHSN to ensure continued alignment of our work with their role in supporting QI across the region. In 2018/19, our goals are for at least 300 staff to attend QI bronze training and to support a minimum of 20 QI projects through the silver programme. By the end of the year, we will also have defined and developed our gold QI offer.
RAG rating	**Green** – We have successfully implemented QI training programmes and developed a range of other QI resources and initiatives, creating a consistent framework to enable staff to undertake quality improvement activity. The number of staff attending our bronze programme was double our initial target.

OBJECTIVE 2	To establish a new mortality review programme
Rationale and past performance	The purpose of this mortality review programme is to further underpin the established work at UH Bristol around patient safety, assessing standards of care provided to inpatients. Where areas of excellent and good care are established, this can be highlighted and learning fed back. Learning from poorer aspects of care can form the basis of developing quality improvement programmes which will lead to improvement in the provision of inpatient care. This programme replaces the previous inpatient mortality review which was established in 2014.
What did we say we would do?	In response to national guidance published in March 2017, and as part of a national pilot, the Trust has redesigned the way it undertakes mortality review. Twelve months ago, we were at a point where we had assembled a multi-disciplinary team to review all inpatient adult deaths. The review process would involve an initial screening assessment, leading to a structured case note review wherever a death has followed an elective procedure or, for example, has involved a patient with learning difficulties or severe mental illness, or where a family has expressed concerns about a patient's care. We said that we would use methodology introduced by the Royal College of Physicians, anticipating that this would highlight aspects of both good and potentially poor care.
Measurable target/s for 2017/18	National guidance sets out measures that needed to be reported to our Trust Board by the third quarter of 2017/18. This included the total number of the Trust's inpatient deaths (including emergency department deaths for acute trusts) and those deaths that the Trust has subjected to case record review. Of those deaths subjected to review, trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.
How did we get on?	We introduced the new mortality programme as planned and have screened all 1,315 adult inpatient deaths within UH Bristol. Twenty-two per cent of these cases were subsequently identified as meeting the criteria for a structured review. These reviews indicated that the majority of care provided to these patients had been of an acceptable, or good, standard. We have identified one potentially avoidable death. We have changed the Trust's bereavement leaflet to make families and friends aware that, if they have concerns about the deceased patient's last episode of care, these can be raised with the Trust, and that the process of raising the concerns automatically triggers a structured case note review. This group of patients currently accounts for the largest number of structured case note reviews. We have identified two significant themes for learning: 1. The need to improve early recognition of the dying patient. This has been agreed as a corporate quality objective for 2018/19 (see section 2.12 of this report) 2. The importance of senior clinical staff involvement in the decision to move patients from physiological monitoring to symptomatic control at the end of their lives Since 20 November 2017, we have also been reviewing the care of patients who died within 30 days of discharge from hospital. An initial analysis of these cases has identified 16 patients whose death was unpredicted or unexpected. This group will now further undergo review using structured case note review.
RAG rating	**Green** – We introduced our new mortality review programme as planned. Early learning from the programme has resulted in one of our quality improvement objectives for 2018/19.

OBJECTIVE 3	To develop a consistent customer service mind set in all our interactions with patients and their families
Rationale and past performance	Customer service is a thread running throughout our Quality Strategy for 2016-20. UH Bristol is a caring organisation: we know from our surveys that the vast majority of patients (97 per cent+) have a positive experience of care in our hospitals, but we also acknowledge that this isn't true of everyone. Aimed squarely at addressing issues which give rise to "the three per cent", this objective marks the first year of an ongoing project aimed at embedding the consistent understanding and application of customer service principles across our organisation.
What did we say we would do?	We said we had identified three levels of intervention to target future improvement activities: • Individual and team behaviours that demonstrate and support a customer service mind set • Establishing a set of customer service principles that can be held up as a mirror to proposed service changes and programmes of work • Initiating specific improvement programmes that directly support excellence in customer service (e.g. telephones, letter, receptions, complaints handling). In the first quarter of the year, we said we would: • hold a workshop targeted at a broad range of hospital staff to explore the concept of customer service within healthcare and to test staff appetite for developing future programmes of work supporting this objective • engage with an external consultant with international experience in leading customer care programmes • achieve sign-up from our Transformation Board for our direction of travel.
	In the second quarter of the year, we said we would: • continue with staff and patient engagement activities, enabling us to define what customer service means for UH Bristol and to begin to develop our set of customer service principles • identify key customer service "touchpoints" within the organisation • mobilise an executive-led steering group to finalise priorities and objectives and ensure clear ownership for our year one activities • agree at least four work streams supporting excellence in customer service, including measurable improvement targets; we agreed that this would include a telecommunications work stream, carried forward from the previous year's objectives • agree how existing improvement programmes (e.g. outpatients transformation) would support our customer service objective. In the second half the year, we said we would begin to deliver the products and programmes of work described above, some of which we recognised would need to continue into 2018/19 and beyond.

How did we get on?	In 2017/18, following engagement with staff, patients, stakeholders, and an external customer service expert, we identified the following work streams: • Agreeing and embedding customer service principles • Enhancing the Trust's provision of customer service training for staff • Aligning the Trust's key outpatient survey so that it better measures the touch points and customer service principles identified through our staff / patient engagement work during 2017/18 • Telecommunications improvement project • Developing an internal communications strategy around the programme The development of a set of customer service principles for UH Bristol was a particularly important step. These principles set out what excellent customer service looks like in a large acute trust, and they now form part of the Trust's induction programme and customer service training. We are also in the process of incorporating the principles into the Trust's volunteers' induction and apprenticeship programmes. Further opportunities for embedding the principles in recruitment, competencies, evaluation and training processes will be pursued in 2018/19. This year, as part of the telecommunications work stream of this quality objective, we carried out an extensive review of complaints, survey and telecoms data and were able to identify ten areas of the Trust that require direct support to ensure effective answering of telephone calls (taken together, these areas account for around 70 per cent of complaints made to the Trust about this issue). The Trust's Transformation Team has begun to work with these teams to identify and address contributing factors, adopting models of good practice evident in high performing areas. Outcome measures for this project have been developed and will continue to be refined as this work continues. Our plans for the second year of this objective are set out in section 2.1.2 of this report.
RAG rating	**Green** – There have been a range of successful activities and developments in the first year of this programme, including the establishment of a set of customer service principles for the organisation. This has provided a firm foundation to build on in 2018/19.

OBJECTIVE 4	**To improve staff-reported ratings for engagement and satisfaction**
Rationale and past performance	Our Quality Strategy sets out our ambition that, by 2020, we will be recognised as one of the top 20 NHS trusts to work for. The 2015 and 2016 NHS Staff Survey results had shown incremental improvements in our score for staff engagement (3.69 in 2014, 3.78 in 2015 and 3.83 in 2016). We need to maintain focus in order to realise our 2020 ambition: a staff engagement score of at least 4.00.
What did we say we would do?	Our plans for 2017/18 included: • Implementation of a new E-Appraisal system • Developing a new framework to support line managers to consistently display positive leadership behaviours • Continuing to deliver established and successful health and wellbeing initiatives • Revising our Tackling Bullying and Harassment policy and further developing our tackling bullying advisory service • Developing local improving staff experience plans, in response to the findings of the 2016 NHS Staff Survey.

Measurable target/s for 2017/18	Our target was to achieve year-on-year improvements in the following areas of staff-reported experience: • Staff Friends and Family Test scores (this asks whether staff would recommend the Trust as a place to work and receive treatment) • Overall staff engagement (a 'basket' of measures covering staff motivation, involvement and advocacy) • The percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month. We said we would measure improvement via our annual all-staff census (this takes place in the third quarter of the year) and our quarterly Friends and Family Test survey.
How did we get on?	In 2017/18, we: • Implemented the new E-Appraisal system, a revised policy and E-Learning training to support both staff receiving an appraisal and managers who are responsible for undertaking the appraisal. The Trust has experienced significant challenges with the functionality of the E-Appraisal system during its implementation – this continues to be addressed with the supplier and we are committed to ensuring the system improves the appraisal experience for staff going forward. • Launched our Leadership Behaviours in August, led by our Executive Directors. These behaviours are an integral part of our management training and leadership development programmes. • Launched the new dignity at work policy during 'Anti-bullying' week in November. This roadshow week promoted the policy and additional support available to staff across the organisation including our advisory service. • Worked in partnership with divisional teams to mobilise our 'improving staff experience' plans in response to the findings of the 2016 NHS Staff Survey. This has included focus groups, bespoke training, targeted away days, and coaching interventions. • Made progress with our Workplace Wellbeing Strategy and Delivery Plan. The provision of psychological services and initiatives continues to be a strategic priority for supporting colleagues' wellbeing. • Signed the 'Time to Change' employer pledge and made progress with the accompanying action plan. • Achieved our CQUIN target (also see section 2.2.4) for seasonal influenza vaccination uptake – 70 per cent for front-facing staff - and are projecting full achievement of the CQUIN indicator for healthy food and drink. In the 2017 NHS Staff Survey: • Our score for staff engagement improved from 3.83 in 2016 to 3.85 in 2017 and we now rank ahead of the national average for acute trusts (3.79). • Our score for whether staff would recommend the Trust as a place to work or receive treatment has also improved from 3.90 in 2016 to 3.95 in 2017; again better than the national average for acute trusts (3.75). • The percentage of staff 'witnessing potentially harmful errors, near misses or incidents in last month' was 32 per cent, unchanged from 2016. There was also no change to the proportion of staff 'reporting errors, near misses or incidents witnessed in the preceding month' which as with the 2016 results; this remained at 92 per cent[1] (better than the national average of 90 per cent).

[1] Reporting errors is indicative of a positive patient safety culture – a high score is good

	• The percentage of staff reporting 'fairness and effectiveness of procedures for reporting errors, near misses and Incidents' also remained the same as the previous year's findings at 3.78 per cent. This is also better than the national average of 3.73 per cent. • Twenty-four per cent of our staff said that they had experienced harassment and bullying or abuse from other staff[2], compared to a national average of 25 per cent and a Trust score of 23 per cent in 2016. Black And Minority Ethnic (BAME) staff experience is unchanged at 28 per cent. • Eighty-eight per cent of our staff said that they believed that the organisation provides equal opportunities for career progression or promotion[3], compared to a national average of 85 per cent and a Trust score of 89 per cent in 2016. The score for BAME staff was 69 per cent in 2017 compared to 77 per cent in 2016 (national average in 2017 was 75 per cent). We will be carrying out a more detailed analysis of the BAME survey data in order to identify any 'hot spot' areas within the Trust to target our efforts to improve the experience of BAME colleagues. In our own all-staff Friends and Family Test (measured in the first quarter of the year): • Sixty-nine per cent of staff said that they would recommend UH Bristol as a place to work compared to 70 per cent in 2016/17. • Eight-nine per cent of staff said that they would recommend UH Bristol as a place to receive treatment, compared to 86 per cent in 2016/17.
RAG rating	**Green** – We implemented our plan for 2017/18. Our staff engagement rating has improved for the fourth consecutive year and is now ahead of the national average for acute trusts.

OBJECTIVE 5	**To reduce cancellations of outpatient appointments and to reduce waiting times in clinic**
Rationale and past performance	We recognise the inconvenience and stress caused to patients by altering their planned appointments. From a Trust operational perspective, changing appointments is an inefficient use of our administrative team's resources; there is also evidence to suggest that it contributes to overall Did Not Attend (DNA) performance. In 2016/17, we cancelled 12.8 per cent of consultant-led clinics and 11.6 per cent of all outpatient appointment. This is also the third year we have set the objective of reducing waiting times in clinic.
What did we say we would do?	**Reducing cancelled appointments:** Working with the Trust's Information Management and Technology team, we said we would improve the reporting of reasons for cancellation. We also wanted to extend the notice period for booking of annual leave by consultants from six weeks to eight weeks in order to help reduce the number of clinics being cancelled. Most significantly, we anticipated that improved management of the Trust's electronic referral system would lead to a reduction in the number of patients being cancelled and rebooked because they have been booked into the wrong clinic initially. Planned activity included a full review of the directory of services available to referrers, improved management of capacity and reduction in unavailability of appointment slots – all part of a national CQUIN (also see section 2.2.4). **Reducing waiting times in clinic:** We said we would complete the installation and upgrade of all waiting times boards and 'you said-we did' boards in outpatient departments, and embed the daily management of them into the outpatient standards and monthly quality visits. We also committed to continue to pursue objective measurement of in-clinic waits using the Medway-based tracker that follows patients through their outpatient visit.
Measurable target/s for 2017/18	**Reducing cancelled appointments:** Using CHKS[4] benchmarking information which compares us with a group of 50 other hospitals, we set a target of two per cent improvement in both hospital and patient cancellation rates.

[2] Indicator KF26 in the NHS staff survey
[3] Indicator KF21 in the NHS staff survey
[4] CHKS is a provider of healthcare intelligence and quality improvement services

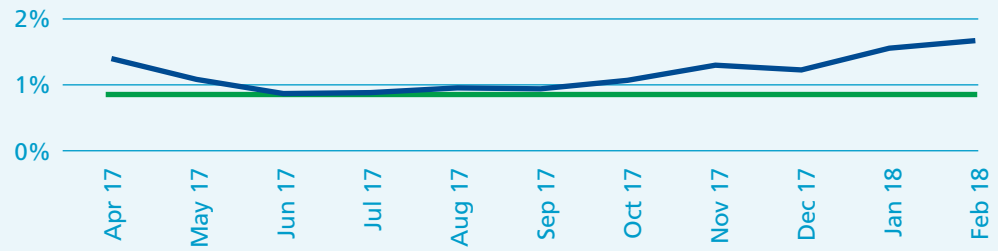
	Reducing waiting times in clinic: We said we would continue to pursue the stretching targets for patient-reported experience that we set ourselves in 2016/17, and complete the implementation of all standardised boards and processes.
How did we get on?	In 2017/18 so far (based on data up to February 2018) we cancelled 12 per cent of consultant led appointments and 10.7 per cent of all outpatient appointments. This represents an improvement on 2016/17, when we cancelled 12.8 per cent of consultant-led clinics and 11.6 per cent of all outpatient appointments. Of the appointments that were cancelled, patients cancelled 13.1 per cent of consultant led appointments and 13.6 per cent of all appointments. This represents a proportional increase compared to 2016/17 when patients cancelled 12.4 per cent of consultant led appointments and 12.9 per cent of all appointments. During 2017/18, the coding of reasons for cancellations has been added as a regular agenda item for the Trust's outpatient steering group. This is enabling a monthly review of which reasons are being used and whether the codes available to staff are providing the insight we need to improve the service. For example, the category of 'hospital cancellation' has been removed as this was felt to be too vague, whilst 'short notice leave' has been added. A decision on the proposal to change clinicians' leave notice period from six to eight weeks is still awaited and the matter has been escalated to the Trust's Workforce and Organisational Development Board. Work is progressing to transfer the booking of all outpatient appointments to the Trust's appointment centre. As this includes the use of partial booking, whereby the patient can choose which appointment they would like at the time of booking, it is hoped this will help reduce the number of patient cancellations in 2018/19. Paper 'switch off' for GP referrals into consultant-led clinics will go live on 4 June 2018. Currently 92 per cent of services are available for patients to book into via the Trust's electronic referral system. Work is ongoing to reach 100 per cent by the end of May 2018, following which the focus will move to all services who receive GP referrals. We hope that giving patients a further opportunity to choose the appointment date and time will reduce patient cancellations. Further work is planned for 2018/19 as part of the productivity work stream within our outpatient transformation programme to reduce hospital and patient cancellation rates. In 2017/18, patient-reported feedback about the timeliness of outpatient appointments was largely unchanged from 2016/17. The same proportion of outpatient attendees told us that their appointment had started on time (that is, within 15 minutes of the appointed time - 72 per cent) and that they had seen a display board with waiting time information on it (47 per cent). However, a larger proportion of outpatient attendees said that they were told how long they would have to wait in-clinic (43 per cent compared to 37 per cent in 2016/17). Audits of outpatient areas found that all clinics had boards present (with the exception of those clinics where it had been previously agreed not to have boards). In most cases, these had been recently updated at the time of the audit, although there were some clinics where the board had only partially been updated. Feedback was given to the sisters and matrons for each area. The use of boards was also checked during Delivering Best Care in Outpatients Week, between 26 February and 2 March 2018. Further work is being piloted with System C (suppliers of the Trust's electronic referral system, Medway) to develop real-time clinic waiting time reports. This will allow the nurses and receptionists to give accurate updates to patients regarding current waiting times in clinics. It is hoped to pilot this and then roll out within 2018/19. Looking ahead to 2018/19, our plan is to improve patient choice by increasing the use of electronic referrals for first appointments and partial booking for follow-ups.
RAG rating	**Amber** – There were fewer cancelled appointments in 2017/18, however the reduction of around one per cent fell short of our two per cent target. More patients said they had been told how long they would have to wait in clinic, but our other patient-reported measures were unchanged from 2016/17.

OBJECTIVE 6	To improve the management of sepsis
Rationale and past performance	Sepsis is recognised as a major cause of mortality and morbidity in the NHS. We made significant strides in the recognition and rapid treatment of sepsis during 2016/17, but we know there is more to be done.
What did we say we would do?	In 2017/18, we said we would: • Update the Trust's sepsis guidelines following their initial implementation in August 2016 • Implement NICE sepsis guidance • Complete mini-Root Cause Analysis investigations to gain a better understanding of the reasons why inpatients are not appropriately screened for sepsis and/or receiving timely antibiotics. Learning from these will be fed back to the clinical teams. • Undertake training and education in sepsis for all new staff at induction • Provide targeted education to foundation doctors, core trainees and higher specialist trainees in medicine, surgery, emergency medicine and anaesthesia/intensive care • Provide Face2Face ward based sepsis education for ward teams • Review SHMI, HSMR and ICNARC data to ensure that sepsis associated mortality continues to be lower than average.
Measurable target/s for 2017/18	Our goal was to achieve locally agreed targets for the national sepsis CQUIN (also see section 2.2.4), the four elements of which are: • Timely identification and treatment of patients with sepsis in emergency departments • Timely identification and treatment of patients with sepsis in acute inpatient settings • Timely antibiotic review for patients confirmed as having sepsis (measured for patients who remain in hospital 72 hours after antibiotic treatment commenced) • Reduction in antibiotic consumption per 1,000 admissions
How did we get on?	In 2017/18: • Two patient safety nurses have been in post throughout the year, with an additional half-time post based in the emergency department from August 2017. • The Trust sepsis guidelines have been updated in line with NICE Sepsis guidance to make them easier to use and understand. The guidelines focus on ongoing patient care as well as acute recognition and treatment of sepsis. • Patient safety thermometer data was used to highlight patients in inpatient areas who require screening for sepsis and early treatment if sepsis is identified. Five mini root cause analyses were undertaken where sub-optimal sepsis patient care had occurred (i.e. failure to administer intravenous antibiotics within one hour of recognition). Written feedback has been received positively by ward nursing and medical teams via local morbidity meetings. • Sepsis education has been delivered face-to-face on the wards and in ED. Targeted sepsis education was given at quality and improvement meetings for Thoracic Surgery, Trauma and Orthopaedic teams. Specific sepsis teaching sessions have been held for Foundation doctors, Core trainees in acute medicine, and higher specialist trainees in emergency medicine, anaesthesia and intensive care. • Sepsis education at induction is occurring for all clinical staff with a special focus on August-starting Foundation doctors. • An electronic patient observation system, has been rolled out in Medicine and Surgery, incorporates sepsis screening, which has resulted in a much improved screening rate for inpatient sepsis • Intensive Care national audit data demonstrates that patients with sepsis are being referred and admitted promptly to the Intensive Care Unit (ICU) with mortality rates for sepsis lower than national averages. Intensive Care National Audit and Research Centre (ICNARC) nationally validated data demonstrates that patients with sepsis were admitted to ICU much earlier in 2016/17 (the latest year for which data is currently available) than in previous years. • A maternity sepsis guideline is in place and was audited in 2017/18. • In respect of our CQUIN targets, we fully achieved the part of the CQUIN relating to antibiotic review and partially achieved the other three elements. • The latest hospital mortality data (SHMI – also see section 3.3.1) indicates a falling mortality index of around 80 for all sepsis patients at UH Bristol in 2016/17 compared with an index of 110 in 2014/15 and 90 in 2015/16. This improvement puts UH Bristol's sepsis outcomes in the top 20 per cent of all NHS Trusts.

	Specifically in relation to children: • A guideline is being developed for febrile infants under the age of three months; this group of patients poses the biggest challenge for early appropriate antibiotic therapy as they require full investigation before antibiotics are administered. • A children's sepsis pathway was approved and is being piloted with a focus on education in paediatric outreach teams and on inpatient paediatric wards, including the use of simulation exercises. • Automated screening at triage in the children's emergency department means that the department is now achieving a screening rate of 100 per cent. The delivery of antibiotics within one hour to children with a diagnosis of suspected sepsis continues to be challenging, however antibiotic delivery within two hours has been 100 per cent, with the majority of one hour breaches missing the target by less than 15 minutes. In addition, in those who children who are unstable (and require resuscitation) on initial assessment, antibiotic administration target of 100 per cent is being met. In 2018/19, we will maintain our focus to achieving our targets for sepsis screening and antibiotic administration. In adult services, we will complete the implementation of electronic observations throughout UH Bristol which incorporates mandated sepsis screening for all patients with a highly elevated National Early Warning Score (NEWS[5]) score ('NEWS 2' implementation will also take place during this year). In children's services, we will pilot and roll-out the inpatient sepsis screening tool.
RAG rating	**Amber** – we made significant progress in the effective management of sepsis but only partially achieved our CQUIN goals.

OBJECTIVE 7	**To implement a new, more responsive, system for gathering patient feedback at point of care**
Rationale and past performance	Implementation of the new system was postponed from 2016/17 and carried forward into 2017/18.
What did we say we would do?	During 2017/18, as part of a wider focus on delivering responsive care, we said that we would procure a new in-hospital patient feedback system to run alongside our existing post-discharge surveys. We want more patients and carers to give feedback about quality of care whilst the patients are still in hospital, thereby increasing our opportunities to address any issues or concerns quickly.
Measurable target/s for 2017/18	Our stated target was to achieve a significantly improved score in the 2018 National Inpatient Survey (by virtue of when the survey takes place), in relation to whether patients say that they have been asked about the quality of their care whilst they have been in hospital. In the meantime, we said we would measure progress through our own monthly survey.
How did we get on?	In April 2017, funding was secured to procure the new feedback system and this was followed in May 2017 by approval from the Trust's Information Management and Technology (IM&T) Department Management Group to proceed to tender. Unfortunately, there were significant delays in the procurement process, resulting in the tender not going "live" until February 2018. At the time of writing, a preferred supplier for this system has been identified through the tender process and is pending approval. It is anticipated that the contract will be awarded in May 2018. In conjunction with the procurement process, a professional design agency has been commissioned to develop "marketing" around the new system. This will include the development of posters in wards and clinics encouraging patients and visitors to give feedback, signage for the new touchscreen feedback points that will be located around our hospitals, and a re-design of existing feedback materials including comments cards. A key part of our plans was to enable more effective use of service-user feedback, by creating a data "hub" to better utilise this insight within our organisation. We have been able to progress this work stream by utilising the Trust's own "Infoweb" data warehouse, which is available to all staff on the UH Bristol intranet. The production of the Trust's key survey measures is now fully automated to ensure their efficient and accurate use in key management reports. The next stage in this development for 2018/19 will be to produce more effective ward and Divisional-level reporting.
RAG rating	**Amber** – Progress has been made during 2017/18, and implementation of the new system will take place during the first quarter of 2018/19.

[5] NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving patient outcomes.

OBJECTIVE 8	To reduce the number of last minute cancelled operations
Rationale and past performance	We understand the impact that the last minute cancellation of operations can have on patients – particularly those who require urgent treatment – and their families, creating uncertainty and adding to worry. This was the fourth consecutive year we have set this objective. In 2016/17, 0.97 per cent of operations were cancelled at the last minute, against a target of no more than 0.92 per cent.
What did we say we would do?	We will conduct a detailed review of 2016/17 data to understand reasons for cancellations and will ensure that our action plan is directed towards areas where the greatest improvement is needed. In particular, we will adopt a new approach around the key themes of staffing, scheduling, capacity (linked to wider issues of bed occupancy and escalation) and improved understanding of the risks and impacts of cancelling operations.
Measurable target/s for 2017/18	We are retaining our existing target to reduce the percentage of operations cancelled at the last minute for non-clinical reasons to no more than 0.92 per cent.
How did we get on?	We are disappointed to report that, in 2017/18, 1.19 per cent of operations were cancelled at the last minute. This represents deterioration on 2017/18 and falls short of both our current annual target (0.92 per cent) and the national target (0.8 per cent). This means that 919 patient operations were cancelled on the planned day of surgery during the year, compared to 734 in 2016/17. Over one third of cancellations in 2017/18 were attributed to a lack of suitable bed (22 per cent due to no ward bed being available, and 17 per cent were due to no High Dependency Unit / Intensive Care Unit bed being available). Twenty three per cent of cancellations were the result of another patient being prioritised, whilst 16 per cent were due to lack of staff. March was a particularly difficult month due to two episodes of severe weather and continued winter demand. At the beginning of 2018/19, we will be taking this analysis a stage further by looking at reasons for cancellations at specialty level, and will use any insight this provides to inform a refreshed improvement plan for the year.
Last minute cancellations as a percentage of admissions	
RAG rating	**Red** – Our performance in 2017/18 was worse than in previous years and did not meet our target.

2.1.2 Quality objectives for 2018/19

The Trust is setting eight quality objectives for 2018/19.

Two of these objectives – **developing a customer service mind set, and improving staff engagement and satisfaction** – represent a continuation of existing annual quality objectives. The staff engagement objective has been included once again for 2018/19 in response to staff and patient feedback.

We have agreed six new annual quality objectives for 2018/19, four of which address commitments we have previously made in our Quality Strategy for 2016-2020, namely:

- **improving our performance in respect of achieving the NHS 62-day standard for GP referral to treatment;**
- **improving learning from Serious Incidents (including Never Events);**
- **reducing medication incidents involving insulin resulting in moderate or severe harm; and**
- **introducing a programme of mystery shopping[5].**

The mystery shopping programme will be closely linked to our customer service objective.

The first of our remaining two objectives for 2018/19, **improving early recognition of the dying patient**, builds directly on early learning from our mortality review programme. Finally, **maternity services** were rated as the best in country in the 2016 national maternity patient survey, but our position dropped to being in line with national average in the 2017 survey – so our eighth objective is designed to explore what improvements we need to be making in order to return to the top of the pack in the 2019 survey and beyond.

OBJECTIVE 1	**To develop a consistent customer service mind set in all our interactions with patients and their families**
Rationale and past performance	Customer service is a thread running throughout our Quality Strategy for 2016-2020. This objective marks the second year of an ongoing project aimed at embedding the consistent understanding and application of customer service principles across our organisation.
What will we do?	During 2018/19, we will build on the developmental work undertaken during the first year of this quality objective, to begin embedding a customer service mind set in key Trust programmes and activities. There are four key areas of focus in 2018/19: **Customer service staff training and development** This work stream will support the training and development of UH Bristol staff in delivering an effective customer service. UH Bristol's principles of excellent customer service, which were developed in collaboration with staff, patients and stakeholders during the first year of this quality objective, will be incorporated into the following training and development activities: • corporate induction • customer service training • volunteer induction • apprenticeship programme • nursing preceptorship programme. In addition, an advanced customer service training module will be developed, based on a successful model developed by Sheffield Teaching Hospitals NHS Foundation Trust. Using the outcomes from the Trust's Delivering Best Care week in February 2018, teams will be identified as pilot sites for this advanced training.

[6] Mystery shopping is a research methodology used to measure the quality of services. The mystery shopper's identity is not known to the service being evaluated.

	We will also develop a plan to undertake service level customer service accreditation at UH Bristol, which is an ambition contained in the Trust's Quality Strategy (2016-2020). The accreditation scheme will be a way of testing ourselves against established best practice in customer service and giving recognition to wards and departments in our hospitals that achieve this benchmark. By the end of 2018/19 we will have scoped out and developed the accreditation process for piloting and formal roll-out during 2019/20 onwards. **Telecommunications** This work stream is about ensuring that people who phone the Trust receive an efficient and effective response from our staff. In 2017/18, the Trust's Transformation Team undertook detailed analysis of telecoms, survey and complaints data. This enabled good practice, key barriers and "hot-spots" around the Trust to be identified. In 2018/19, using this insight, the Transformation Team will work with ten UH Bristol departments that require specific support to develop their telephone handling/management practice. During 2018/19, there will also be a Trust-wide focus on communicating good practice and troubleshooting around telephone handling, via UH Bristol's internal communication channels. The Transformation Team will also develop a resource and best practice guidance pack, for teams to use across the Trust. **Communications** We need to get the customer service message across to our staff, clearly and effectively, particularly regarding UH Bristol's Principles of Excellent Customer Service. We also want our stakeholders, including the people who use our services, to see our organisation as one that's increasingly focused on delivering consistently excellent customer service. To this end, our third work stream will be to develop a communications strategy. We will begin by holding a stakeholder workshop in May 2018. **Customer Service in outpatient services** UH Bristol's Principles of Excellent Customer Service support the objectives of the Outpatients Transformation Programme, such as enhancing patient satisfaction by delivering consistently outstanding services provided by responsive, competent and friendly staff. We will review the Trust's Outpatient Service Standards to incorporate the UH Bristol Customer Service Principles. Staff recruitment and competency evaluation processes will also be reviewed to incorporate a customer service element. Finally, to ensure that we are monitoring levels of customer service satisfaction effectively, the Trust's outpatient satisfaction survey will be re-designed around the key customer service "touchpoints".
Measurable target/s for 2018/19	**Project milestones to be delivered:** • Stakeholder workshop • Communications strategy • Incorporation of UH Bristol Customer Service Principles into key training and development programmes • Design and piloting of advanced customer service training • Development of an accreditation scheme for UH Bristol • Review of outpatient standards, recruitment and competency processes **Measurable target to be achieved:** We aim to reduce the number of complaints about telecommunications in the identified top ten departments by 25 per cent by the end of September 2018, and by 50 per cent by the end of March 2019, compared to the same period for 2017/18.
How progress will be monitored	Progress will be monitored via the Trust's Transformation Board.
Board sponsor	Chief nurse
Implementation lead	Director of transformation

OBJECTIVE 2	To improve staff-reported ratings for engagement and satisfaction
Rationale and past performance	Our Quality Strategy sets out our ambition that, by 2020, we will be recognised as one of the top 20 NHS trusts to work for. Successive NHS staff survey results have shown incremental improvements in our score for staff engagement (3.69 in 2014, 3.78 in 2015, 3.83 in 2016, and 3.85 in 2017). We need to maintain focus in order to realise our 2020 ambition: a staff engagement score of at least 4.00.
What will we do?	Our plans for 2018/19 include: • A bespoke leadership development programme for our 'Top' 100 leaders which will include a re-launch of our leadership behaviours • A review of our performance management culture with a view to more closely aligning this to an annual cycle where objectives are set and cascaded through the organisation in a more transparent way • Using this year's NHS 70 celebrations to launch our new staff badge as part of our recognition strategy for staff with more than 10 years' service. • Further development of our Dignity at Work programme to focus on decreasing bullying and harassment in the organisation • Wider spread of the use of the 'Happy App' across the organisation We will also prioritise our efforts and interventions to improve our lower ranking scores within the NHS Staff Survey as follows: • We will introduce mandatory "how to be a manager" training for new joiners and staff who are promoted into management roles • We will review the quality of non-mandatory training across the Trust • We will continue to focus on improving staff motivation through the 'Improving staff engagement plans' which are delivered at Divisional level to encourage positive cultural change • We will use 'You said… We did week' in May 2018 to focus on the topic of how we can continue to improve staff communications • We will identify areas within the Trust where staff have expressed dissatisfaction with opportunities for flexible working and explore the potential for local solutions.
Measurable target/s for 2018/19	Our goal is to achieve a staff engagement score of at least 3.90 in the 2018 NHS Staff Survey.
How progress will be monitored	Divisional board meetings, Workforce and Organisational Development Board, Trust Board.
Implementation lead	Divisional directors, supported by corporate organisational development team

OBJECTIVE 3	To improve compliance with the 62 day GP referral to first definitive cancer treatment standard
Rationale and past performance	The 62 day standard for first treatment after GP referral for suspected cancer (hereafter '62 day GP') is a high priority nationally and is seen as a benchmark of good cancer services. The standard has been non-compliant nationally in 2017/18 and the Trust had not achieved quarterly compliance since 2012. The Trust has a very challenging case mix with a high proportion of more complex cancer types that perform poorly at a national level, and a lower proportion of high volume higher performing cancer sites such as breast. The Trust has made significant improvements in performance and achieved the 85 per cent threshold in quarter three of 2017/18. However, following surgical cancellations due to winter pressures and other unavoidable factors (patient choice and late referrals from other providers) performance dropped to around 80 per cent in quarter four (final figure not yet available).
What will we do?	Key actions in our plan to deliver improved performance include: • reducing and minimising the impact of cancellations through critical care capacity review, theatre productivity and effective winter planning; and • working with other providers to reduce late referrals via a virtual waiting list meeting and ongoing thorough waiting list management.
Measurable target/s for 2018/19	Our targets are: • to achieve 85 per cent compliance in six out of 12 months in 2018/19 (we achieved the target for two months in 2017/18, so achievement of this target would represent a significant step forward in performance). • to achieve 85 per cent compliance for non-shared patients (those seen at UH Bristol only) in every quarter during 2018/19.
How progress will be monitored	Performance against the standards is reported monthly, nationally and internally. Informal monitoring reports are produced weekly and distributed internally.
Board sponsor	Chief operating officer
Implementation lead	Deputy chief operating officer

OBJECTIVE 4	To introduce a 'mystery shopping' programme within the Trust
Rationale and past performance	The Trust's Quality Strategy (2016-2020) includes a commitment to introduce mystery shopping as a technique to supplement the variety of ways that we already gather information about patient-reported experience of care in our hospitals, e.g. surveys, interviews and observation techniques. This methodology will also directly support the Trust's work around developing a more consistent customer-service mind set in all our interactions with patients and families (see objective 1, above).
What will we do?	Our initial work stream will focus on training members of the UH Bristol's *Face2Face* volunteer interview team to carry out mystery shopping exercises at key touch points around the Trust, primarily "front of house" services such as receptions, and telephone contacts. In collaboration with the Customer Service Steering Group, a programme of mystery shopping will be developed for the interview team. This will have begun by the end of 2018, with an initial evaluation of the programme taking place at the end of 2018/19. A second work stream will focus on exploring the potential to develop more in-depth mystery shopping, such as patients giving detailed feedback after a planned hospital appointment (our initial focus will be on elective care). This needs to be carefully scoped out with a range of stakeholders, including senior clinical leads and staff-side representatives. If, following these discussions, it is agreed that this approach can be taken forward, the Trust's Patient Experience and Involvement Team will develop and oversee a process for recruiting, training and supporting patients for this role.
Measurable target/s for 2018/19	Completion of the above agreed actions to introduce a mystery shopping programme.

How progress will be monitored	Progress will be monitored by the Trust's Patient Experience Group, which meets on a quarterly basis.
Board sponsor	Chief nurse
Implementation lead	Tony Watkin, patient and public involvement lead

OBJECTIVE 5	**To improve learning from Serious Incidents and Never Events**
Rationale and past performance	It is a stated aim in our Quality Strategy (2016-2020) that we want to improve learning from serious incidents. We also reported nine Never Events in 2017/18.
What will we do?	In 2018/19: • We will hold multidisciplinary summits for staff to share learning from incident themes and look for organisational improvements. • We will strengthen our action plans resulting from serious incident investigations to focus on fewer, stronger actions by introducing an objective assessment of strength of actions for each incident. • We will audit the quality of our daily safety briefs to ensure lessons arising from incidents are being shared with front-line staff, and make any changes if required.
	• We will hold "patient safety conversations" (focus groups) with front-line staff to gather and share good practice in response to learning from incidents and to identify blocks that prevent front-line staff from acting to keep people safer. • We will introduce a Trust wide system for learning from excellence. Safety in healthcare has traditionally focused on avoiding harm by learning from errors, however this approach may miss opportunities to learn from excellent practice. Studying excellence in healthcare can create new opportunities for learning and improve staff resilience and morale. • We will develop additional information resources to tell patients and families about how they can help keep themselves/their loved ones safer in hospital.
Measurable outputs for 2018/19	Completion of the above agreed actions to improve learning from serious incidents and never events.
How progress will be monitored	Via quarterly reports to Clinical Quality Group.
Board sponsors	Chief nurse and medical director
Implementation lead	Head of quality (patient safety) Associate medical director for patient safety

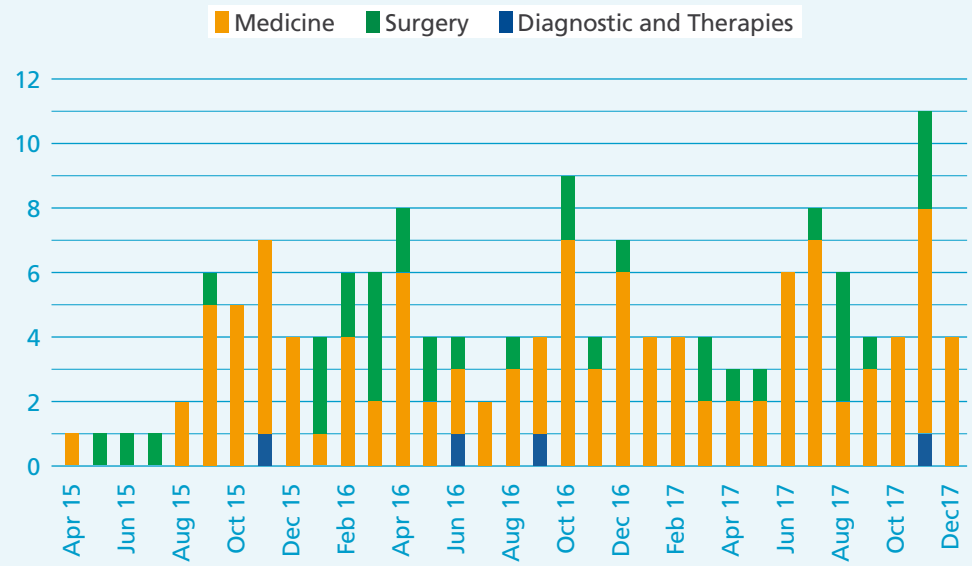
OBJECTIVE 6	To improve early recognition of the dying patient
Rationale and past performance	One of the early major themes to arise from the Trust's systematic review of patient deaths (see sections 2.1.1 and 3.3.2) has been that we are sometimes slow to recognise that a patient is dying. A patient typically has several reviews out-of-hours because of raised National Early Warning Scores (NEWS)[6], however we have identified that junior doctors can be inclined to request an investigation or to try a potentially futile intervention before the patient is eventually recognised as dying and the focus is changed to end of life care. This matters for several reasons: • during the time the patient is dying but not being palliated they may have pain or breathlessness • late recognition does not allow the patient to make a choice about where they die • patients might be left with 'unfinished business'.
What will we do?	We are going to use a multi-faceted approach to improving the confidence of junior doctors in recognising the dying patient. Initially this will include the use of a pro-forma asking the question "is this patient so unwell they might die on this admission?" for all admissions through the emergency department and acute medical unit. We are also adapting the weekend sticker to ask the question "For patients at ceiling of treatment, when should a move to end of life care be considered?". We also fully expect that further new ideas will emerge during the course of this quality improvement project.
Measurable target/s for 2018/19	Our measure of success will be an increase in the length of time for which the end of life care tool is used for patients, since earlier recognition will mean the end of life tool will be in use for longer. We are planning to collect baseline data in April and then repeat after each intervention is introduced.
How progress will be monitored	Progress will be monitored by the Trust's Mortality Review Group.
Board sponsor	Mark Callaway, acting medical director
Implementation lead	Drs Colette Reid (specialist palliative care), Amanda Beale (gastroenterology) and Rebecca Maxwell (emergency department)

OBJECTIVE 7	To improve patients' experiences of maternity services
Rationale and past performance	Our maternity services were rated as the best in country in the 2016 national maternity patient survey, but our score in the 2017 survey was in line with the national average – so our objective is designed to explore what improvements we need to be making in order to return to the top of the pack in the 2019 survey and beyond.
What will we do?	The provision of hospital and community maternity services at UH Bristol is part of a wider network of maternity care that stretches across Bristol, North Somerset, and South Gloucestershire (the "BNSSG" area). This includes GP practices, commissioning organisations, health visitors, community midwifery / support services, and providers of hospital care. Transformational change needs to occur across these settings to have a significant impact on the whole maternity experience of our service-users. The BNSSG Maternity Transformation Plan, to implement "Better Births", a national 'must do', is an ambitious programme of activity with a particular focus on improving the following aspects of maternity care: • Integrated information technology across and within service providers, to offer women more choice and joined-up care • Review of the initial midwifery "booking" appointment to identify opportunities to free up time for more meaningful conversation and a genuinely personalised care plan • Continuity of carer during the antenatal period, to reduce the number of different midwives women see for their antenatal care • Improved postnatal hospital care, for example through better infant feeding support, staff training, and a review of the bereavement care pathway • Improved mental health care during pregnancy or in the first year following birth of the child. In addition, there will be a number of UH Bristol-specific initiatives to support this quality objective during 2018/19: • Following the success of #conversations week at the Bristol Royal Hospital for Children, which engaged staff, patients and families in discussions about their experiences of care, the maternity department and LIAISE[7] service will replicate this event at St Michael's Hospital during the first half of 2018/19. • Patient Experience at Heart is an approach used previously with great success at St Michael's Hospital, which invites staff at all levels of the service and patients to share their respective experiences. The aim is to identify any barriers to providing a high quality service, which the management team can then address. Further workshops will be held during 2018/19 to draw in staff who have joined the hospital since the programme was last run. • Feedback from our ongoing local survey of women's experiences of maternity care tells us that discharge from hospital is a key area for us to make improvements. We will therefore undertake a specific review of discharge processes in maternity services during 2018/19.
Measurable target/s for 2018/19	The action plan and targets associated with the BNSSG transformation plan are currently in development and will be finalised during the first half of 2018/19. However, these targets will include 20 per cent of all women across BNSSG having continuity of care by a team of midwives. Ultimately, our goal is to return a top quartile performance in the 2019 national maternity survey.
How progress will be monitored	Progress will be monitored through the Postnatal Working Party at St Michael's Hospital, reporting to quality assurance meeting in the Division of Women's and Children's Services.
Board sponsor	Chief nurse
Implementation lead	Head of midwifery

[7] LIAISE is the 'PALS' service (Patient Advice and Liaison Service) for Bristol Royal Hospital for Children

OBJECTIVE 8	To improve the safe prescribing and use of Insulin
Rationale and past performance	The Trust has put in place several measures in recent years to improve the safety of insulin prescribing and administration but this has not led to a reduction in numbers of reported insulin-related incidents.

Insulin related incidents



Source: Datix system

Eighty two per cent of 112 insulin-related incidents reported since April 2015 have been reported as 'no harm'; only 18 percent have resulted in any potential harm.

Recent improvement measures have included:

- The increased use of Connecting Care to allow diabetes nurse specialists and junior doctors to access GP medication information 24 hours a day for Bristol, North Somerset and South Gloucestershire (BNSSG) patients
- The inclusion of specific insulin sections in the adult paper prescription charts
- Revisions to the patient self-administration procedure for insulin to allow easier patient assessment by nursing staff
- Training of nurses by diabetes nurse specialists
- Information to asset prescribers with insulin choice and recognition at admission
- Provision of specific guidance for prescribers and nursing staff for high risk products such as 500 unit/ml insulin
- Aligning insulin drug naming in pharmacy and electronic prescribing systems to match national recommendations

What will we do?	In 2018/19, we will:

- Roll-out Medway electronic prescribing (EPMA) to adult wards (timescale expected to be August-October 2018 for acute medicine and care of the elderly wards)
- Review all electronic prescribing systems in the Trust with regard to insulin prescribing to identify any safety gaps and discuss these with system providers
- Implement, via Connecting Care, a one click link within Medway (our patient administration system) electronic prescribing, to ensure GP information is readily available at the point of admission
- Undertake a themed analysis of insulin-related errors
- Develop insulin-related safety metrics that can be produced automatically from EPMA and clinical notes
- Work with our Emergency Department, Acute Medical Unit (Ward A300) and Older People's Assessment Unit (Ward A400) teams to identify other areas of potential improvement
- Collect baseline data of insulin omissions as recorded by pharmacy medicines reconciliation electronic records
- Work with West of England Academic Health Science Network patient safety collaborative and BNSSG Clinical Commissioning Group on the quality of insulin prescription-related information at transfers of care.

Measurable target/s for 2018/19	Our goal is that unintentional omission of insulin prescribing on the Acute Medical Unit (Ward A300) and Older People's Assessment Unit (Ward A400) will be 25 per cent lower by the end of 2018/19 when compared with a 2017/18 baseline mean. These wards represent the main admission points for adult patients; medicines reconciliation on admission is a key area of focus to ensure that patients are on the right medication at the start of their time in hospital.
How progress will be monitored	Progress will be monitored by the Diabetes Steering Group.
Board sponsor	Medical director
Implementation lead	Pharmacy manager, clinical services

2.1.2.1 How we selected these objectives

These objectives have been developed, following consideration of:

- the quality priorities of our Trust Board as set out in our quality strategy for 2016-2020;
- views expressed by attendees at our 'Quality Counts' evening in January 2018 (a consultation event aimed at our Involvement Network and Trust members); and
- feedback from an online survey which was open to our staff and any member of the public during March 2018.

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2017/18, UH Bristol provided relevant health services in 70[8] specialties via five clinical divisions (Medicine; Surgery; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2017/18, the Trust Board has reviewed and selected high-level quality indicators covering the domains of patient safety, patient experience and clinical effectiveness as part of monthly performance reporting. Sufficient data was available to provide assurance over the services provided by the Trust. The Trust also receives information relating to the review of quality of services in all specialties via, for example, the Clinical Audit Annual Report. The income generated by UH Bristol services reviewed in 2017/18 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2017/18.

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's clinical audit programme. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of percentage participation and case ascertainment. The detail which follows relates to this list.

During 2017/18, 41 national clinical audits and five 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 93 per cent (38/41) of national clinical audits and 100 per cent (4/4) of the national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2017/18, and whether it did participate, are as follows:

Table 1

Name of audit / Clinical Outcome Review Programme	Participated
Acute	
Case Mix Programme (CMP)	Yes
Fractured Neck of Femur (care in emergency departments)	Yes
Major Trauma Audit	Yes
National Emergency Laparotomy Audit (NELA)	Yes
Pain in Children (care in emergency departments)	Yes
Procedural Sedation in Adults (care in emergency departments)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes

[8] 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).

Blood and Transplant	
Audit of red cell & platelet transfusion in adult haematology patients	Yes
Management of patients at risk of Transfusion Associated Circulatory Overload	Yes
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Yes
Cancer	
Bowel cancer (NBOCAP)	Yes
Head & Neck Cancer (HANA)	Yes
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Heart	
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes
Adult Cardiac Surgery	Yes
Cardiac Rhythm Management (CRM)	Yes
Congenital Heart Disease (CHD)	Yes
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Heart Failure Audit	Yes
Long-term conditions	
Endocrine and Thyroid National Audit	No
Inflammatory Bowel Disease (IBD) programme	No
National Audit of Dementia	Yes
National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	Yes
National Diabetes Core Audit (Adult)	Yes
National Diabetes Foot Care Audit (NDFA)	Yes
National Diabetes Inpatient Audit	Yes
National Ophthalmology Audit	Yes
National Pregnancy in Diabetes Audit	Yes
Older People	
Fracture Liaison Service Database (FLS)	Yes
National Audit of Inpatient Falls (NAIF)	Yes
National Hip Fracture Database (NHFD)	Yes
National Joint Registry (NJR)	Yes
UK Parkinson's Audit	No
PROMs	
Elective Surgery (National PROMs Programme)	Yes
Women's & Children's Health	
Diabetes (Paediatric) (NPDA)	Yes
National Maternity and Perinatal Audit	Yes
National Neonatal Audit Programme (NNAP)	Yes
Neurosurgical National Audit Programme	Yes

National Diabetes Core Audit (Adult)	Yes
Outcome Review Programmes	
Child Health Clinical Outcome Review Programme	Yes
Learning Disability Mortality Review Programme (LeDeR)	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme	Yes
Medical and Surgical Clinical Outcome Review Programme	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 2017/18, 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	
Acute	
Case Mix Programme (CMP)	100% (1231)
Fractured Neck of Femur (care in emergency departments)	100% (50)
Major Trauma Audit	>100% (408)**
National Emergency Laparotomy Audit (NELA)	139*
Pain in Children (care in emergency departments)	102*
Procedural Sedation in Adults (care in emergency departments)	67*
Sentinel Stroke National Audit programme (SSNAP)	>90% (492)
Blood and Transplant	
Audit of red cell and platelet transfusion in adult haematology patients	>100% (58)**
Management of patients at risk of Transfusion Associated Circulatory Overload	100% (40)
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	15*
Cancer	
Bowel cancer (NBOCAP)	>100% (218)**
Lung cancer (NLCA)	69% (214)
Oesophago-gastric cancer (NAOGC)	238*
Heart	
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	845*
Adult Cardiac Surgery	100% (1309)
Cardiac Rhythm Management (CRM)	100% (1042)
Congenital Heart Disease (CHD)	100% (1189)
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions	100% (2175)
National Cardiac Arrest Audit (NCAA)	69*
National Heart Failure Audit	568*
Long term conditions	
National Audit of Dementia	23*

National Chronic Obstructive Pulmonary Disease Audit programme (COPD)	226*
National Diabetes Core Audit (Adult)	510*
National Diabetes Foot Care Audit (NDFA)	49*
National Diabetes Inpatient Audit	74*
National Ophthalmology Audit	100% (4503)
National Pregnancy in Diabetes Audit	30*
Older People	
Fracture Liaison Service Database (FLS)	1530*
National Audit of Inpatient Falls (NAIF)	26*
National Hip Fracture Database (NHFD)	317*
National Joint Registry (NJR)	87% (37)
PROMS	
Elective Surgery (National PROMs Programme)	34*
Women's & Children's Health	
Diabetes (Paediatric) (NPDA)	511*
National Maternity and Perinatal Audit	100% (5467)
National Neonatal Audit Programme (NNAP)	100% (2648)
Neurosurgical National Audit Programme	682*
Paediatric Intensive Care (PICANet)	100% (708)
Outcome Review Programmes	
Child Health Clinical Outcome Review Programme	3*
Learning Disability Mortality Review Programme (LeDeR)	Data not available
Maternal, Newborn and Infant Clinical Outcome Review Programme	60*
Medical and Surgical Clinical Outcome Review Programme	7*

* 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 11 national clinical audits were reviewed by the provider in 2017/18. University Hospitals Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

College of Emergency Medicine Audits

- To appoint a 'sepsis champion' and further educate staff in the recognition and management of sepsis through the introduction of posters within the emergency department
- To review and update the departmental asthma guidelines in view of new British Thoracic Society (BTS) guidance
- To conduct a local in-depth audit looking at the process of consultant sign off for different age groups prior to discharge

National Diabetes Foot Care Audit (NDFA)

- To arrange for nurses to administer patient information and consent forms on arrival at clinic and put up posters to remind clinic staff to complete forms
- To compare the Trust's process for recording newly healed but reoccurred ulcers with other trusts for learning purposes
- To review our processes in order to increase the number of patients who are included in this audit
- To establish whether key quality measures used in the audit can be reported on a more frequent basis from our own outpatient data
- To extract results for local trusts from national data so team can compare practice
- To move towards ongoing electronic data collection and review/streamline current clinic pro forma on Medway (the Trust's patient administration system) in light of this.

National Diabetes Audit – Pregnancy in Diabetes

- To complete the national diabetes preconception pilot and liaise with commissioners regarding local provision of services. The Team is registered with National Pregnancy in Diabetes Quality Improvement Collaboration
- For the endocrine antenatal team to continue to deliver teaching and training for primary care staff via annual midwifery teaching courses
- To complete a local audit looking at preterm delivery rates for women with Type 1 and 2 diabetes to try and clarify why the UH Bristol data is higher than national figures

National Audit of Inpatient Falls

- To develop a ward-based checklist to assess the vision of inpatients who are at risk of falls on admission
- To organise and deliver a falls awareness week to increase awareness and training to all staff groups across the Trust
- To devise a business case to support an activities coordinator to work across the Trust
- To identify a patient or carer of someone who has fallen in UH Bristol to become a representative on the Falls Steering Group
- To review and update falls e-learning and intranet information pages
- To conduct a post falls audit locally to determine compliance with the current post falls guideline and implement any actions based on these findings
- To roll out the post falls medical proforma across the Trust and carry out an audit to determine compliance
- To conduct a re-audit of SWARM[9] documentation across the Trust to determine compliance and implement any actions based on these findings.
- To conduct a bed rails and bumpers documentation audit of new risk assessments across the Trust to determine compliance.

National Heart Failure Audit

- To introduce increased outreach services to medicine. This will have the additional benefit of increasing the number of heart failure patients we include in the audit
- To introduce a process of local validation comparing Hospital Episode Statistics (coded) data with data collected by heart failure nurses to increase data capture.

National Maternity and Perinatal Audit

- To introduce midwife-run workshops for couples who have had one previous caesarean section, to help them understand the risks and benefits of vaginal birth after caesarean section (known as VBAC) versus elective caesarean section
- To audit water-births and perineal tears on the Midwifery Led Unit
- To conduct a survey of women's reasons for choice of mode of delivery.

National Emergency Laparotomy Audit (actions completed by October 2016)

- To introduce an Emergency Laparotomy Enhanced Recovery Pathway which will standardise peri-/post-operative care with the aim of safely reducing length of stay
- To educate surgical and anaesthetic trainees regarding the need to better document pre-operative consultant review of high risk patients
- To undertake an audit of CT reporting for NELA patients

Sentinel Stroke National Audit Project

- To increase the role of specialist stroke nurses in facilitation of the pathway
- To undertake further education of clinical staff regarding the importance of the stroke pathway
- To introduce an information stamp which will be used in the notes to make it clear when patients have been discharged from occupational therapy.

National Audit of Dementia

- To improve the assessment of delirium by adding the 4AT assessment to admission clerking proformas
- To increase awareness of the 'This is me' document to help capture the personal needs and information of patients with dementia
- To participate in the dementia wellbeing pre-hospital project (working with primary care) to better understand the personal needs and information of patients before they are admitted
- To introduce a specific continence care plan
- To introduce additional twice yearly dementia/delirium awareness sessions for staff
- To introduce roll specific dementia/delirium e-learning for staff.

[9] SWARM is a multidisciplinary tool used to investigate when a patient falls

The outcome and action summaries of 212 local clinical audits were reviewed by University Hospitals Bristol NHS Foundation Trust in 2017/18; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Trust's Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2017/18.[10]

Clinical Outcomes Publication (COP)

Previously the Consultant Outcomes Publication, the Clinical Outcomes Publication (COP) is an NHS England initiative, managed by the Healthcare Quality Improvement Partnership (HQIP) to publish quality measures at the level of individual consultant doctors using National Clinical Audit and administrative data. COP began with ten national clinical audits in 2013, with two further audits/registries added in 2014. Those that published in the inaugural year have 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 clinical specialties/societies that report consultant outcomes and whether the Trust submitted data to the required national audit/registry in 2017/18.

Table 3

Specialty	*Clinical audit/registry title*	*Specialist Association*	*Submitted*
Adult cardiac surgery	National Adult Cardiac Surgery Audit ***Open heart surgery***	Society for Cardiothoracic Surgery	Yes
Bariatric surgery	National Bariatric Surgery Register ***Surgery concerning the causes, prevention and treatment of obesity***	British Obesity & Metabolic Surgery Society	N/A
Colorectal surgery	National Bowel Cancer Audit Programme ***Surgery relating to the last part of the digestive system***	The Association of Coloproctology of Great Britain and Ireland	Yes
Head and neck surgery	National Head and Neck Cancer Audit ***Surgery concerning the treatment of head and neck cancer***	British Association of Head and Neck Oncology	Yes
Interventional cardiology	Adult Coronary Interventions ***Treatment of heart disease with minimally invasive catheter based treatments***	British Cardiovascular Intervention Society	Yes
Lung cancer	National Lung Cancer Audit ***Treatment of lung cancer through surgery, radiotherapy, and chemotherapy***	British Thoracic Society and SCTS	Yes
Neurosurgery	National Neurosurgery Audit Programme	Society of British Neurological Surgeons	Yes
Orthopaedic surgery	National Joint Registry ***Joint replacement surgery***	British Orthopaedic Association	Yes
Thyroid and endocrine surgery	BAETS national audit ***Surgery on the endocrine glands to achieve a hormonal or anti-hormonal effect in the body***	British Association of Endocrine and Thyroid Surgeons	No[11]
Upper gastro-intestinal surgery	National Oesophago-Gastric Cancer Audit ***Surgery relating to the stomach and intestine***	Association of Upper-gastrointestinal Surgeons	Yes
Urological surgery	BAUS cancer registry ***Surgery relating to the urinary tracts***	British Association of Urological Surgeons	N/A
Vascular surgery	National Vascular Registry ***Surgery relating to the circulatory system***	Vascular Society of great Britain and Ireland	N/A

All data can be found on the individual association websites and is also published on NHS Choices (MyNHS).

[10] Available via the Trust's internet site from July 2018

2.2.3 Participation in clinical research

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

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 6,925. This compares with 5,521 in 2016/17.

As of 31 March 2018, the Trust had 730 active studies, 46 of which are sponsored by UH Bristol. At the equivalent point 12 months before, the Trust had 684 active studies. Our sponsored research includes trials of investigational medicinal products, investigational devices and surgical interventions.

In a snapshot taken on 31 March 2018, the number of research studies and recruited participants were as follows (March 2017 comparator in brackets):

Table 4

Number of active non-commercial (portfolio) studies	480 (429)
Number of active non-commercial (non-portfolio) studies	112 (121)
Commercial studies registered	138 (142)
Number of recruits in non-portfolio non-commercial trials	1,001 (564)
Number of recruits in portfolio non-commercial trials	5,640 (4,539)
Number of recruits in commercial trials	284 (418)

In the last year, we have further improved the delivery of both commercial and non-commercial trials to time and target which will remain the focus for 2018/19. Examples include:

- In the Bristol Eye Hospital, we have recruited over 1,200 patients into a study seeking to improve decision-making and calibrating health utilities for cataract surgery
- In the Bristol Royal Hospital for Children, we recruited the first patient in the UK to a number of different trials, demonstrating improved efficiencies in trial set up and delivery
- In the Bristol Haematology and Oncology Centre, we recruited the first patient globally to a commercial phase I trial in adults with steroid-resistant Acute Graft versus Host Disease, an achievement which was recognised with a letter to the principal investigator from the chief executive of the National Institute for Health Research Clinical Research Network.

In 2017/18, we achieved an increase in research activity in two medical specialties. We aim to go on and open more research in the sexual health speciality during 2018/19, and to consolidate our activity in stroke, where we increased our recruitment from 48 to 207 patients over the past year

We have continued to open new commercial studies in a broad range of specialties, and have been exploring several opportunities to develop closer working relationships with individual sponsors. We are involved in an increasing number of early phase commercial trials and those involving Advanced Therapy Investigational Medicinal Products, providing opportunities for our patients to have access to cutting edge treatments. Our performance in delivering commercial trials to time and target continued to improve throughout the year, enhancing our reputation as a reliable site. We have maintained our commercial income to levels seen in the last three years, managing a specialist portfolio of rare diseases research and looking to increase the number of higher recruiting trials alongside this during 2018/19, which will generate further income that can be reinvested in research in the Trust.

UH Bristol currently holds National Institute for Health Research (NIHR) grants bringing in a total research income of over £7 million per year. Our NIHR Biomedical Research Centre, for which we were awarded £20.8m over five years, has just completed its first year. The funding allows us to build on our existing programmes in cardiovascular disease, and nutrition, diet and lifestyle including obesity. Alongside these, our new themes in surgical innovation, reproductive and perinatal health and mental health have been set up and work is under way in these areas. Working in close partnership with the University of Bristol, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust, Bristol's novel approach in drawing together

[11] Unlike the other programmes listed in Table 3, participation in the BAETS national audit is not mandatory. Surgeons are only able to participate if they are members of the British Association of Endocrine and Thyroid Surgeons; the majority of our surgeons are not members.

population studies, laboratory science and patient-based research will benefit our patients and the local population over the next several years.

After successful completion of recruitment and/or other deliverables, three UH Bristol grants have closed or are nearing the end:

- Reducing arthritis fatigue: clinical teams using cognitive-behavioural approaches (RAFT) led by Professor Sarah Hewlett, was awarded through an NIHR commissioning brief that asked us to test whether a simplified psychological intervention that could be delivered widely in the NHS reduces rheumatoid arthritis fatigue and is an efficient use of NHS resources. Professor Hewlett and her team are now working on a training package "RAFT" to before roll out in the NHS.
- Can skin grafting success rates in burn patients be improved by using a low friction environment? A feasibility study (SILKIE), led by Dr Amber Young. The aims of this NIHR research for patient benefit feasibility study are in part to determine whether patients can be recruited and the study be run in an NHS setting. Once all data have been analysed the team will decide whether the study warrants a full scale clinical trial.
- Transmission - Radiotherapy Active Pixel System (TRAPS): Towards a Clinical Prototype for Real-Time 2D Verification of Intensity Modulated Radiotherapy. This NIHR-Invention for Innovation grant was led by Diane Crawford at UH Bristol, building on work done in collaboration with the University of Bristol School of Physics. The grant achieved its outcomes, and the team is now in discussions with potential commercial partners about taking forward the technology.

We have been awarded three new NIHR project grants in 2017/18, plus an NIHR doctoral fellowship. We continue to work with our staff to develop high quality grants that will help answer important clinical questions and improve patient care. Twice a year we invite applications for small pump priming grants together with Above and Beyond (the official charity for UH Bristol), to encourage newer researchers, and provide preliminary data for the larger NIHR grant applications.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust income in 2017/18 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 value of the national CQUIN scheme is set at 2.5 per cent for all commissioned services, other than for prescribed specialised services commissioned by NHS England. As lead provider of Hepatitis C virus (HCV) Operational Delivery Networks, a CQUIN value of 2.8 per cent is offered alongside a further CQUIN value of 2.0 per cent of the applicable contract value of our specialised services. The amount of potential income in 2017/18 for quality improvement and innovation goals was approximately £11.05m based on the sums agreed in the contracts (this compares to £10.74m in 2016/17).

For the first time, CQUINs have been set as a two year scheme, providing greater certainty and stability regarding CQUIN goals. It is intended to deliver clinical quality improvements and drive transformational change. The following 16 CQUIN targets were agreed, with the Trust estimating to achieve 92.6 per cent of the £11.05m total potential income:

- Supporting engagement with Sustainable Transformation Partnerships
- Local financial sustainability - risk reserve
- Improving staff health and wellbeing
- Reducing the impact of serious infections (antimicrobial resistance and sepsis)
- Improving services for people with mental health needs who present to A&E
- Offering advice and guidance
- E-referrals
- Supporting proactive and safe discharge
- Improving HCV (Hepatitis C) treatment pathways through Operational Delivery Networks
- Clinical Utilisation Review
- Hospitals medicines optimisation
- Complex device optimisation
- Nationally standardised dose banding for adult intravenous anticancer therapy
- Haemtrack
- Automated exchange transfusion for sickle cell care
- Dental managed clinical networks

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 2017/18. The Trust was not subject to an inspection of its core services during 2017/18, having been rated as 'Outstanding' following an inspection in November 2016. All actions required by the CQC as a result of the 2016 inspection have been completed.

During 2017/18, representatives from the Trust participated in a CQC workshop to share best practice in meeting the challenge of maintaining quality and safety in Emergency Departments whilst managing increasing service demand. The CQC's findings, published in November 2017, included examples of notable practice at UH Bristol. In February 2018, we also welcomed Ted Baker, the Chief Inspector of Hospitals at the CQC, on a visit to our adult ED.

2.2.6 Data quality

UH Bristol submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records:

- which included the patient's valid NHS number was: 99.5 per cent for admitted patient care; 99.6 per cent for outpatient care; and 97.25 per cent for accident and emergency care.
- which included the patient's valid general practice code was: 99.9 per cent for admitted patient care; 100 per cent for outpatient care and 100 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2017 - December 2017 as at month nine inclusion date)

UH Bristol's information governance assessment report overall score for 2017/18 was 67.0 per cent.

There are no longer any national Payment by Results audits undertaken in England and it has been delegated to each Trust to organise its own clinical coding audit programme.

In May 2017, the accredited auditor for the Trust's clinical coding team undertook an audit of 100 Finished Consultant Episodes (FCEs) across a range of paediatric specialties. The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 96.0 per cent
- Primary procedure accuracy: 91.9 per cent

In July 2017, the clinical coding team also carried out an audit of 100 FCEs in Obstetrics, Gynaecology, Special Care Babies, ENT, Well babies, Midwifery and Gynaecology Oncology.

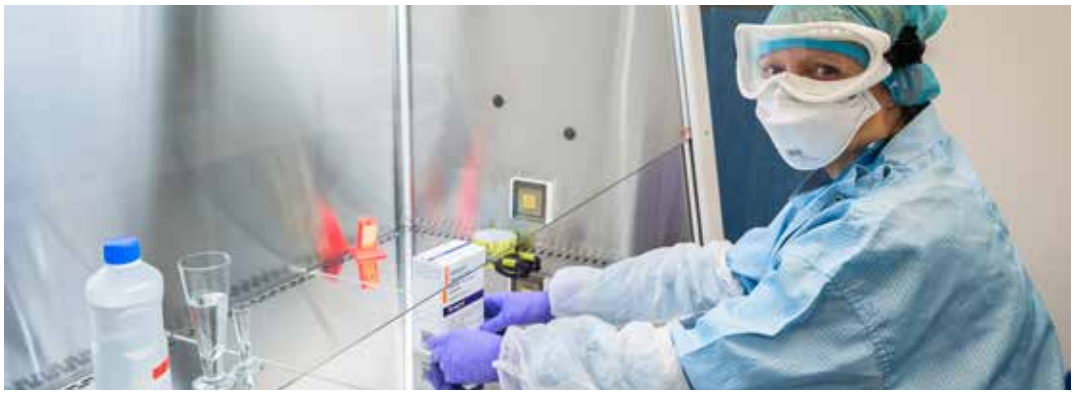
- Primary diagnosis accuracy: 95.0 per cent
- Primary procedure accuracy: 96.5 per cent

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

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

- The data quality programme involves a regular data quality checking and correction process. This involves the central information system team creating and running daily reports to identify errors and working with the Medway support team and users across the Trust in the correction of those errors (this includes checking with the patient for their most up to date demographic information).
- The Trust has installed self-check-in devices across the Trust in outpatient clinics to assist outpatient reception staff and 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 2017/18 (or, in some cases, latest available information which predates 2017/18) is summarised in the table below. The Trust is confident that this data is accurately described in this Quality Report. The Trust maintains a data quality and reporting framework which details what the measures are, where data comes from and who is responsible for it.

Table 5

Mandatory indicator	UH Bristol 2016/17 (or most recent)	National average	National best	National worst	UH Bristol 2015/16
Venous thromboembolism risk assessment	98.4% Apr17-Mar18	95.2%	100%	69.5%	99.1% Apr16-Mar17
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)*	15.6 Apr16-Mar17	12.9	0.0	82.7	15.8 Apr15-Mar16
Rate of patient safety incidents reported per 1,000 bed days	55.97 Apr17-Sep17	42.8	111.69	23.5	56.83 Oct16-Mar17
Percentage of patient safety incidents resulting in severe harm or death	0.28% Apr17-Sep17	0.40%	0.0%	2.0%	0.24% Oct16-Mar17
Responsiveness to inpatients' personal needs	73.4 Apr16-Mar17	68.1	85.2	60.0	71.4 Apr15-Mar16
Percentage of staff who would recommend the provider	83% 2017 survey	70%	86%	47%	81% 2016 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	100.0 (Band 2 "As Expected") Oct16-Sep17	100	72.7	124.7	99.4 (Band 2 "As Expected") Oct15-Sep16
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	28.4% Oct16-Sep17	31.6%	59.8%	11.5%	27.6% Oct15-Sep16

Patient Reported Outcome Measures	Comparative groin hernia data for 2016/17 (the most recent complete validated data available) shows that 50% of UH Bristol patients reported an improved EQ-5D score compared to the national average of 51.3%; 65.2% of UH Bristol patients reported an improved EQ-VAS score compared to the national average of 39.2%. An increase in EQ-5D or EQ-VAS scoring indicates that patients felt that their quality of life had improved after surgery. UH Bristol does not carry out any other procedures covered by the national PROMs programme.
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12*: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12*: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for subsequent years from the Health & Social Care Information Centre.

* NHS Digital state "Please note that the planned update of the emergency readmissions to hospital within 28 days of discharge indicators has been delayed whilst we review the methodology", therefore the latest published data is still for financial year 2011/12.

3 Review of services in 2017/18

3.1 Patient safety

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

In 2017/18, we have continued to sustain high quality performance in a number of key patient safety indicators as shown in Table 6, in particular achieving an improvement in response to deteriorating adult patients, from 92 per cent in 2016/17 to 96 per cent in 2017/18 , and a reduction in the number of falls with harm from 36 in 2016/17 to 25 in 2017/18, despite the incidence of falls per 1,000 bed days increasing slightly from 4.23 in 2016/17 to 4.59 in 2017/18. Disappointingly, there have been nine Never Events in the Trust in 2017/18 despite high levels of

WHO[12] checklist compliance in theatres (99.7 per cent). Also disappointingly, the Trust exceeded the threshold for MRSA bacteraemia (five in total). There are ongoing discussions with our commissioners regarding the allocation of some of these cases to the Trust. Additional work has been undertaken to review local policy and practice, as a result of which, the Trust's infection control team has delivered focused micro teaching sessions to staff, amendments have been made to the post-infection review process and the Trust's MRSA screening standard operating procedure has been revised.

During the past year, UH Bristol's work to improve the safety of patients has been recognised in being shortlisted for the following national awards:

- Patient safety category of the British Medical Journal (BMJ) awards 2018 – for quality improvement work on paediatric resuscitation in the Bristol Royal Hospital for Children
- Patient safety category of the BMJ awards 2018 and the Health Service Journal Patient Safety awards 2018 – we have been contributors to the West of England Academic Health Science Network's system-wide work on the deteriorating patient and sepsis
- HJS Patient Safety awards 2018, in the clinical governance and risk management category – for leading the West of England Academic Health Science Network's collaborative work on Learning from Deaths
- BMJ Awards 2018, HSJ Patient Safety awards 2018 and HSJ Value awards 2018 – for our adult emergency department High Impact User Team's work to support people who frequently access the emergency department.

The first three of these initiatives are described in more detail below.

3.1.1 Our Patient Safety Improvement Programme 2015-2018

UH Bristol 'signed up to safety'[13] in 2014 by making our pledges under five national themes:

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

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

Our current three year Patient Safety Improvement Programme will come to an end this summer. We will evaluate progress against all the quality improvement measures in our programme and review learning points from the implementation. We will also conduct a further analysis of our recent quality information, including patient and staff feedback, to inform our patient safety improvement priorities for the next three years.

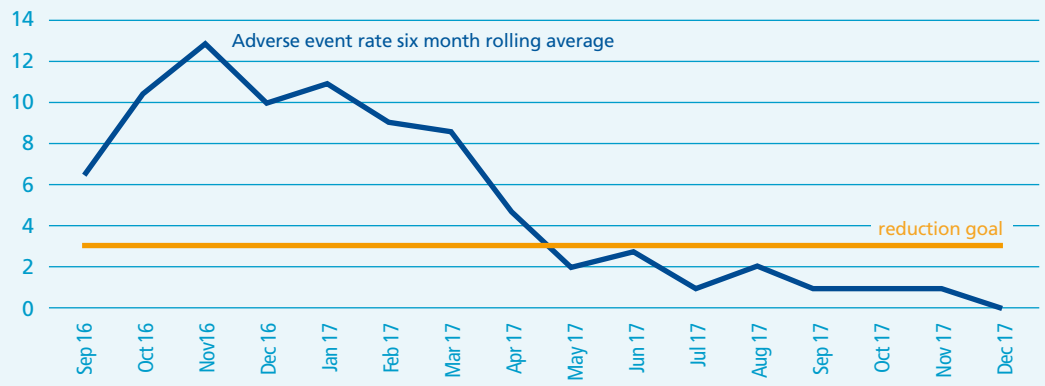
In line with the national Sign up to Safety initiative, the overall aim of our programme is to reduce mortality and harm to patients. For mortality, we are aiming to achieve and sustain an upper quartile ranking of English NHS trusts for the Summary Hospital Mortality Indicator published quarterly by NHS Digital. Please see sections 3.3.2 of this report for more details of progress on mortality reduction and our learning from deaths process.

For harm reduction, we are aiming to achieve and sustain a reduction to 3.23 adverse events per 1,000 bed days over a three year period, which ends this summer. We have sustained achievement of this improvement goal since May 2017 as shown in the figure below.

[12] World Health Organisation
[13] Sign up to Safety is an NHS campaign designed to help NHS staff and organisations achieve their patient safety aspirations and care for their patients in the safest possible way

Figure 1

Adverse event rate six month rolling average



Source: Monthly Global Trigger Tool Audits

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

3.1.1.1 Safety Culture work stream

Culture is a 'collective mindfulness' which defines how people behave and interact with others. In healthcare, the development of a positive patient safety culture ensures that staff have a constant and active awareness of the potential for things to go wrong and are enabled to acknowledge mistakes, learn from them, and take action to put things right. We chose to use a safety culture assessment tool based on the Manchester Patient Safety Framework[14] for acute trusts.

What we have done in 2017/18

We have completed our programme of face-to-face feedback to over 100 clinical teams regarding what they said about their team's and the Trust's safety culture, as reported in last year's Quality Report. Each Board – divisional and Trust – and clinical team selected one or two safety culture areas to develop depending on the detailed feedback received. We developed a safety culture toolkit containing information and resources to support teams in the areas they have chosen to develop. At the end of February 2018, we launched an online survey to repeat the safety culture assessments carried out in 2015/16 to see if there has been a difference.

What we will do in 2018/19

We will:

- Complete analysis of our repeat safety culture assessments.
- Feed back the repeat safety culture assessments to clinical teams.
- Review this work stream as a part of the overall evaluation of our Patient Safety Improvement Programme.
- Introduce a system for Learning from Excellence throughout the Trust.

3.1.1.2 Peri-procedure never events work stream

We are aiming to reduce the incidence of peri-procedure Never Events relating to wrong site surgery, retained foreign objects and wrong implants/prostheses by the introduction of a Trust-wide process that staff can use to identify and mitigate any risk associated with the procedure being carried out. Our improvement goal is to have no never events for a year. Much work has been done in previous years and, in 2017/18, we focused on improving and spreading our local safety standards for invasive procedures (LocSSIPs) in response to learning from incidents, making LocSSIPs more accessible for frontline staff in 'out-of-theatre' settings. Unfortunately, in 2017/18, we have had seven confirmed peri-procedure never events. Please see section 3.1.3 for further details.

What we have done in 2017/18

We have:

- Made LocSSIPS for ward-based procedures integral to equipment packs required to carry out the procedure
- Integrated LocSSIPS into electronic systems in intensive care units

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

- Conducted an awareness raising campaign for out of theatre procedures using banners in clinical areas
- Refined our WHO surgical safety checklists to include "stop before you block" for dental procedures requiring a nerve block
- Conducted 'mystery shopper' audits of the quality of how we conduct WHO checklists, and shared the results with teams to support them in making improvements in areas where required
- Worked to embed local safety standards for invasive procedures in a number of 'out of theatre' procedures such as chest drain insertion, central line insertion, ascitic tap, lumbar puncture, endoscopy, nerve block
- Improved the use of LocSSIPs in two 'out of theatre' procedures (lumbar puncture, and abdominal paracentesis) but have been less successful for endoscopy and pleural aspiration procedures. Please note the run charts below relate to an audit sample of a small number of cases.

What we will do in 2018/19
We will:

- Continue to implement and embed LocSSIPS for all invasive procedures
- Develop a human factors approach to reducing the risk of never events in dental services and ophthalmology
- Review this work stream as a part of the overall evaluation of our Patient Safety Improvement Programme

3.1.1.3 Deteriorating patient work stream

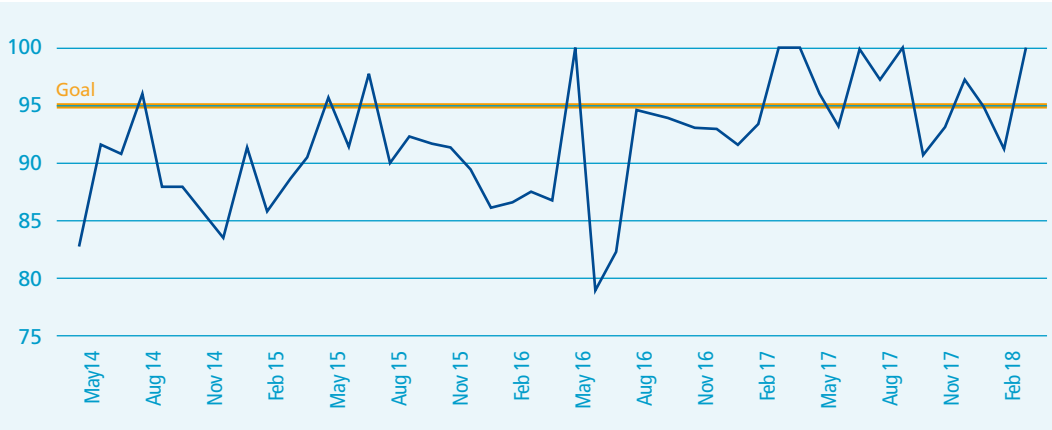
Recognition and management of deterioration in adult patients.
Last year we reported that we had been working with our system-wide partners in the West of England Academic Health Science Network to use the National Early Warning Score (NEWS) as a common language for individual patients at the points of transfer of care to help ensure the sickest patients are prioritised for clinical review, are accommodated in the most suitable environment, and have the best chance of a good outcome. We also use NEWS and as a trigger for sepsis screening.

A key measure of success is escalation of deteriorating patients in accordance with protocol. Figure 2 shows that we reached our 95 per cent goal in March 2017 but have not managed to sustain this improvement throughout 2017/18 (fluctuating between 90% and 100%).

The purpose of improving recognition and escalation of deteriorating patients is to ensure prompt treatment so that patients do not go on to have a cardiac arrest. Our improvement goal is to sustain less than seven cardiac arrests per month which we have achieved as shown in Figure 3. The latest quarterly report from the National Cardiac Arrest Audit shows a continuing comparatively low incidence of in-hospital cardiac arrests in our Trust with a better than national indicator outcome.

Figure 2

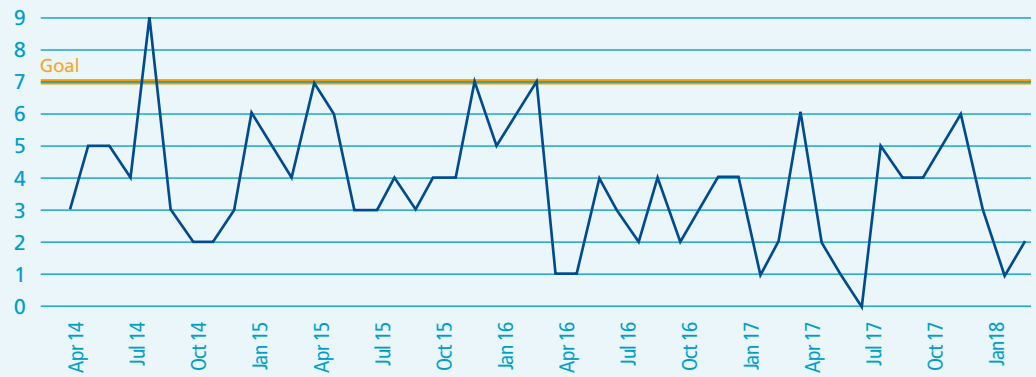
NEWS responded to as per escalation protocol



Source: monthly safety thermometer point prevalence audit

Figure 3

Cardiac arrests in general adult wards



Source: cardiac arrest audit

What we did in 2017/18

- We reported last year that we would procure and begin implementing an electronic observations system. We have procured a system called 'Vitals' which, among other things, allows for electronic recording of physiological observations, automatic calculation of NEWS, identification of deteriorating patients and sepsis screening. At the time of writing (April 2018), this has been implemented in the majority of adult medical and surgical wards, with a plan to implement in the remainder of adult wards (excluding maternity) by May 2018
- The Vitals function for automatic escalation of deteriorating patients has been configured to work with the Careflow electronic communication system when we are ready to implement
- We have mapped out-of-hours coverage for adult specialities and identified where further action is needed in preparation for using Careflow for automatic escalation of deteriorating patients
- We have embedded the use of NEWS in the adult Emergency Department Safety Checklist and worked with our system partners to communicate NEWS at the point of transfer of care
- We have continued targeted education on prompt recognition and escalation of deteriorating patient and the prompt recognition and management of sepsis
- We have implemented a maternal sepsis screening tool and pathway to improve early recognition and treatment of maternal sepsis
- Please see section 2.1.1 for further information about what we did to achieve our sepsis quality objective for 2017/18.

Recognition and management of deteriorating children

What we did in 2017/18

- We developed five new age-specific paediatric early warning observation charts in line with published evidence for use in acute trusts across the West of England and South West Academic Health Science Network footprint. At the time of writing (April 2018) these charts have been implemented in the Bristol Royal Hospital for Children (BRHC) and a number of other acute trusts across these two geographical areas.
- Mobile Resuscitation Carts have been launched for use throughout the BRHC, to improve compliance and competence with key skills. It is known that resuscitation skills begin to depreciate after three months following completion of a life support course. Therefore, everyone in BRHC will now have access to use the carts so they can all keep their CPR and bag-valve mask ventilation skills up-to-date
- We introduced Paediatric Rapid Review calls. This initiative formed part of a larger paediatric resuscitation quality improvement project and has improved the management and escalation process of deteriorating patients throughout the hospital. The calls enable a deteriorating child to be reviewed within 15 minutes by senior doctors and nurses. The team who introduced the rapid review system were shortlisted in the patient safety category British Medical Journal awards 2018
- We have developed and tested age specific sepsis pathways for children
- We have implemented a new-born tracker and trigger tool (NEWTT) to improve the early recognition and response to deterioration in neonates.

What we plan to do in 2018/19 (adults and children)

- We will complete the implementation of Vitals in adult areas, including the emergency department
- We will transfer from NEWS to NEWS2 for adults (excluding maternity) following the recent publication of an updated tool by the Royal College of Physicians
- We will configure and implement Vitals for Maternal and Obstetric Early Warning Scores
- We will plan implementation of Vitals for Paediatric Early Warning Scores
- We will start to implement automatic escalation of deteriorating patients using Careflow
- We will work with our system partners to implement NEWS2 in a co-ordinated fashion to preserve, as far as is possible, a common language for deteriorating patients
- We will continue with our point of care simulation training about deteriorating patients
- We will complete testing and implement an acute kidney injury pathway for adults
- Please see section 2.1.1 for information about our sepsis quality objective for 2017/18.

3.1.1.4 Medicines safety work stream

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

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

What we did in 2017/18

Community pharmacy referral

- We have embedded the linking of our electronic pharmacy noting system with communications to community pharmacies for patients with complex medicines
- We now refer patients taking the anticoagulant warfarin within compliance aids to their community pharmacist to confirm changes of dosage
- We have referred, on average, 40 patients each month to community pharmacies for ongoing review.

Insulin safety

- We continued to analyse insulin-related safety incidents in conjunction with the Diabetes Steering Group, to determine potential trends and identify areas to concentrate resource
- We implemented a series of guidelines and protocols to assist prescribers and nursing staff with insulin prescribing and recognition, particularly at admission
- The protocol to assess suitability for patients to self-administer their insulin was re-designed
- We standardised the nomenclature for insulin prescribing in our electronic prescribing systems to match national requirements
- We have implemented electronic prescribing and medicines administration in one adult specialty (the Bristol Heart Institute).

What we plan to do in 2018/19

We will take the following steps to further develop community pharmacy referrals:

- We will roll out electronic prescribing and medicines administration (EPMA) to all adult specialties in the Trust
- We will work with the Academic Health Science Network to explore further opportunities to develop referral to community pharmacies and other teams
- We will develop a business case to fund the integration required to automate community pharmacy referrals from our Medway patient administration system.

We will also take the following actions to make insulin prescribing and administration safer:

- We will audit the quality of general practice insulin prescribing information at hospital admission
- We will work together with local acute trusts and commissioners to harmonise insulin protocols and choices
- Please see section 2.1.2 for information about our insulin quality objective for 2017/18.

3.1.2 Maternity and Neonatal Patient Safety Collaborative

In 2017/18 we joined the first wave of a new national maternity and neonatal health collaborative which aims to reduce maternal deaths, stillbirths, neonatal deaths and brain injuries that occur during or soon after birth by 20 per cent by 2020, and by 50 per cent by 2030. Supported by NHS Improvement, we have developed a programme of work focusing on four national themes:

- Leadership and safety culture
- Clinical excellence
- Systems and processes
- Person-centred care

What we did in 2017/18

- Leadership and safety culture
  - We ran a week-long human factors workshop identifying the areas that need attention in St Michael's Hospital
  - We provided a human factors study day for staff working in maternity and neonatology.

- Clinical excellence
  - We reduced term admissions to the Neonatal Intensive Care Unit by two per cent by introducing training on management of respiratory issues in the early neonatal period
  - We developed a guideline for management of hypoglycaemia in the neonatal period
  - We achieved compliance with four care bundles of the Saving Babies Lives initiative.

- Systems and processes
- We implemented improved fetal monitoring in labour (to reduce neonatal morbidity) by:
  - A "fresh eyes" approach to reviews of Cardiotocograph traces
  - Improving the management of uterine hyperstimulation
  - Launching an updated fetal monitoring guideline

- We improved assessment of fetal growth by:
  - Increasing staff awareness of the importance of measuring and plotting Symphysial fundal height (SFH)
  - Introducing the practice of raising women's awareness to expect SFH measurement at each antenatal visit.

- Person-centred care
  - We improved patient experience and patient flow when discharged from hospital by introducing patient information regarding processes involved prior to them being discharged from hospital
  - We are developing ways to enable women to be more involved in caring for babies on our Neonatal Intensive Care Unit (NICU).

What we plan to do in 2018/19

- Leadership and safety culture
  - We plan to hold six-monthly human factor study days
  - We will take part in the SCORE patient safety culture survey in March 2019

- Clinical excellence
  - We will introduce a new hypoglycaemia guideline and review its impact.

- Systems and processes
  - An audit of care of women undergoing continuous fetal monitoring in labour is planned for July 2018.
  - A further audit of symphysial fundal height measurement and plotting is planned for May 2018.

- Person-centred care
  - We will review our audit findings to improve the postnatal discharge pathway.
  - We will train staff in supporting parents to care for babies on NICU.

3.1.3 Never Events

Despite the work we are doing on preventing peri-procedure never events, there were nine confirmed never events reported in our Trust in 2017/18:

- One retained piece of swab following a dental procedure
- One misplaced naso-gastric tube
- Two wrong lens implants
- One mis-selection of high strength midazolam
- One wrong side dental nerve block
- Two wrong tooth removals
- One retained nylon tape following a cardiac surgery procedure

We have investigated these cases thoroughly and have learned that a number were caused by human error which had occurred in situations where there was a difficulty or change in plan before or during the procedure.

In autumn 2017, we proactively invited NHS Improvement to conduct an independent and objective review of our dental never events. At the time of writing (April 2018) a formal report is awaited but initial informal feedback suggested no significant concerns were identified and that our focus should continue to be on cultural and human factors.

Examples of improvements we have made as a result of our investigations include:

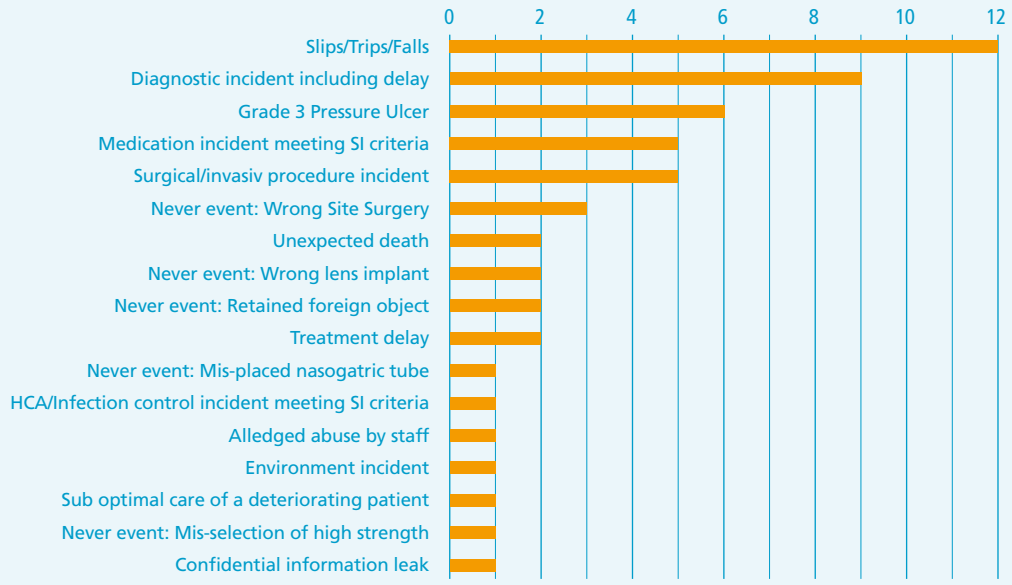
- Refining our WHO surgical safety checklists to include "stop before you block" for dental procedures requiring a nerve block.
- Increasing the direct supervision of dental students administering dental nerve blocks and developing competencies for student assessments.
- Introducing an alternative when small pieces of swabs are required in dentistry.
- Developing a human factors approach to reducing the risk of never events in dental services and ophthalmology.
- Requiring all medical staff to complete e-learning on interpretation of X-rays to confirm naso-gastric tube placement.
- Blocking the supply of high strength midazolam in theatres.
- Changing the sterile container used for soaking nylon tapes used in surgery.
- Providing simulation training for theatre staff for surgical counts.

3.1.4 Serious incidents

The purpose of identifying and investigating serious incidents, as with all incidents, is to understand what happened, learn and share lessons, and take action to reduce the risk of a recurrence. The decision that an event should be categorised as a serious incident is usually made by an executive director. Throughout 2017/18, 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 57, compared to 50 in 2016/17. Of the serious incidents reported, two were subsequently downgraded and 15 investigations were still under way at the time of writing (April 2017). A breakdown of the categories of the 55 confirmed serious incidents is provided in Figure 4 below.

Figure 4

Serious incidents



Source: UH Bristol serious incident log

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).

3.1.5 Learning from serious incidents and never events

Trust-wide learning and actions arising from falls and pressure ulcer serious incidents are included in annual work plans to reduce the risk of recurrences of these types of incidents across all clinical areas.

Reducing peri-procedure never events is the aim of one of the work streams in our patient safety programme as described in section 3.1.1.2. In October 2017, we invited NHS Improvement to conduct a review of never events which had occurred in dental services. This review took place on 3 April 2018 (see section 3.1.3).

Examples of learning themes from other serious incident investigations in 2017/18 have included:

- Changes to processes in two clinical specialties for tracking patients who are at higher risk of developing cancer because of a related existing condition.
- Changes to communicating prescribing and checking of drugs given in the theatre environment to include strength and dose and not just volume.

Learning from serious incidents and never events is one of UH Bristol's quality objectives for 2018/19 (see section 2.1.2).

3.1.6 Duty of Candour

In 2017/18, we further developed our communications and systems for being open for patients and families who use our adult services. In particular, we have changed our policy to make it clearer how patients and families can be involved in an investigatory process if they want to be. We have also updated our patient information leaflet to provide more information about different investigatory processes which might be triggered after an event, e.g. a single event might trigger a complaint, incident and safeguarding investigation, as well as a mortality review and an inquest. Figure 5 below illustrates ways in which patients, their families and carers can get involved in an incident investigation involving them or their loved one if they wish to.

Figure 5

Involvement of patients/ families/carers in incident investigations

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

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

3.1.8 Overview of monthly board assurance regarding the safety of patients 2017/18

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the safety of patients in our care. Where there are no nationally defined targets for safety of patients or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement or sustain already highly benchmarked performance. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some patient safety metrics and targets in Table 6 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2016/17" may vary slightly from the equivalent data in our 2016/17 Quality Report due to finalisation of provisional data.

Table 6

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (Public Health England)	1	0	1	0	2	1	4
Number of Clostridium difficile Cases	National Infection Control data (Public Health England)	31	No set target	11	11	5	8	35
Number of MSSA Cases	Trust Infection Control system (MESS)	37	25	4	3	10	9	26
Hand Hygiene Audit Compliance	Monthly audit	96.60%	>=95%	98.30%	97.00%	97.10%	97.80%	97.60%
Antibiotic prescribing Compliance	Monthly audit	88.30%	>=90%	88.30%	84.30%	86.40%	86.60%	86.40%

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Infection control and cleanliness monitoring								
Cleanliness Monitoring - Overall Score	Monthly audit	95%	>=95%	96%	96%	96%	96%	96%
Cleanliness Monitoring - Very High Risk Areas	Monthly audit	97%	>=98%	98%	98%	98%	97%	98%
Cleanliness Monitoring - High Risk Areas	Monthly audit	95%	>=95%	96%	97%	96%	95%	96%
IPatient safety incidents, serious incidents and Never Events								
Number of Serious Incidents	Local serious incident log	52	No set target	14	17	9	15	55*
Serious Incidents Reported Within 48 Hours	Local serious incident log	94.20%	100%	100%	100%	100%	100%	100%
Serious Incidents - 72 Hour Report Completed Within Timescale	Local serious incident log	90.40%	100%	93.00%	100%	80%	100%	94.70%
Serious Incident Investigations Completed Within Timescale	Local serious incident log	98.00%	100%	91.70%	100%	100%	92.30%	96.10%
Total Never Events	Local serious incident log	2	0	3	1	2	3	9*
Number of Patient Safety Incidents Reported	Datix	14866	No set target	3848	3766	3836	4026	15656
Patient Safety Incidents Per 1000 Bed days	Datix/Medway	47.82	No set target	50.27	49.25	49.82	54.04	50.86
Number of Patient Safety Incidents - Severe Harm[2]	Datix	95	No set target	26	20	22	24	92
Falls								
Falls Per 1,000 Bed days	Datix/Medway	4.23	4.8	4.55	4.77	4.26	4.78	4.59
Total Number of Patient Falls Resulting in Harm	Datix	36	24	9	3	9	4	25
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.148	0.4	0.118	0.17	0.117	0.244	0.162
Pressure Ulcers - Grade 2	Datix	40	No set target	7	10	9	19	45

WHO checklist	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Pressure ulcers developed in the Trust								
Pressure Ulcers - Grade 3 or 4	Datix	6	0	2	3	0	0	5
Venous Thromboembolism								
Adult Inpatients who Received a VTE Risk Assessment	Medway	99.10%	>=99%	98.80%	98.20%	98.20%	98.20%	98.40%
Percentage of Adult In-patients who Received Thrombo-prophylaxis	Monthly local pharmacy audit	96.40%	>=95%	96.30%	94.70%	94.50%	94.10%	95%
Number of Hospital Associated VTEs	ICE Order Communications/ Clinical validation	63	No set target	13	9	11	19	52
Number of Potentially Avoidable Hospital Associated VTEs	Monthly local pharmacy audit	7	0	1	0	1	0	2*
Nutrition								
Nutrition: 72 Hour Food Chart Review	Monthly local safety thermometer audit	89.60%	>=90%	89.70%	94.50%	91.30%	93%	92.10%
Fully and Accurately Completed Nutritional Screening within 24 Hours	Quarterly local dietetics audit	86.90%	>=90%	92.20%	92%	88.90%	86.30%	89.90%
WHO checklist								
WHO Surgical Checklist Compliance	Medway/Bluespier	99.10%	100%	99.70%	99.80%	99.60%	99.90%	99.70%
Medicines								
Medication Incidents Resulting in moderate or greater harm	Datix	0.37%	<0.5%	0.46%	0.64%	0.97%	0.23%	0.66%*
Non-Purposeful Omitted Doses of the Listed Critical Medication	Monthly local pharmacy audit	0.59%	<1%	0.53%	0.25%	0.24%	0.57%	0.40%

WHO checklist	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Safety Thermometer								
Harm free care	Monthly local safety thermometer audit	97.90%	>=95.7%	97.70%	97.40%	98.20%	98.40%	97.90%
No new harms	Monthly local safety thermometer audit	98.90%	>=98.3%	98.60%	98.60%	99%	98.90%	98.80%
Deteriorating patient								
National Early Warning Scores (NEWS) Acted Upon	Monthly local safety thermometer audit	92%	>=95%	96%	99%	94%	95%	96%
Timely discharges								
Out of Hours Departures (20:00 to 07:00)	Medway PAS	7%	No set target	7.10%	9.70%	9.20%	8.60%	8.70%
Percentage of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	22.30%	>25%	22.70%	22.90%	23%	21.10%	22.40%
Number of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	11063	No set target (percentage target set above)	2761	2854	2897	2626	11138
Staffing levels								
Nurse staffing fill rate combined	National Unify return	103.70%	No set target	103.70%	97.90%	97.60%	98.50%	99.3%*

* Provisional data

3.2 Patient experience

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

3.2.1 National patient surveys

Each year, the Trust participates in the Care Quality Commission's national patient experience survey programme. These national surveys reveal how the experience of patients at UH Bristol compares with other NHS acute trusts in England. UH Bristol achieved consistently good results in the patient survey reports released during 2017/18. In particular, the 2016 national inpatient and children's surveys represent a positive step-change for UH Bristol:

- In the national inpatient survey, UH Bristol's performance was among the best trusts nationally, with 20 out of 65 scores being classed as better than the national average. The Trust also received the best score of any general acute trust on the survey question relating to patients' overall rating of their experience
- In the national children's survey, the Trust was recognised by the CQC as achieving among the best parent-reported experience ratings in the NHS. In particular, within the sub-group of parents of children aged 0-7 years, UH Bristol achieved the joint top score nationally on the survey question relating to whether parents felt that they were treated with respect and dignity
- In the national A&E survey, nine out of 35 UH Bristol scores were classed as being better than the national average, putting us among the top 10 of all English trusts on this measure of patient-reported experience. UH Bristol achieved the top score nationally in the section of the survey relating to the quality of care provided by doctors and nurses

Table 7 summarises the number of scores that UH Bristol had above, below, or in line with the national average in each set of national survey results that were released during 2017/18. Figure 6 provides an indication of UH Bristol's performance relative to the national average.

Table 7

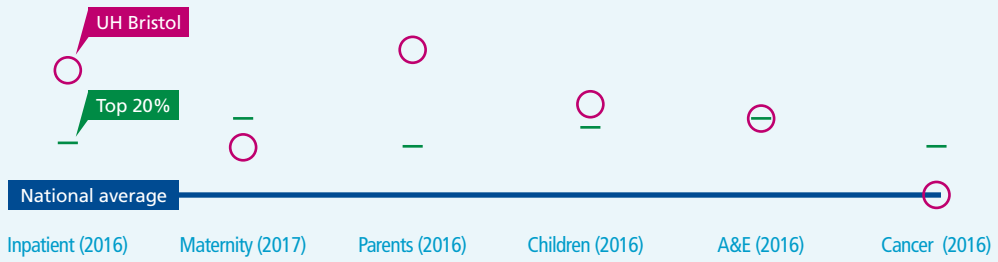
Results of national patient surveys received by the Trust during 2017/18 (number of scores above, in line with, or below the national average)

	Date patients attended	Comparison to national average		
		Above (better)	Same	Below
2016 National Accident and Emergency Survey	September 2016	9	26	0
2016 National Cancer Survey	April-June 2016	2	47	3
2016 National Children's Survey	November to December 2016	20	43	0
2017 National Maternity Survey (Labour and Birth)	February 2017	1	18	0
2017 National Maternity Survey (Community Midwifery)	February 2017	3	28	1
2016 National Inpatient Survey	July 2016	20	45	0

Source: Care Quality Commission Benchmark Report (www.nhssurveys.org)

Figure 6

UH Bristol's hospital based patient-reported experience relative to national benchmarks



Source: UH Bristol Patient Experience and Involvement Team analysis of Care Quality Commission data

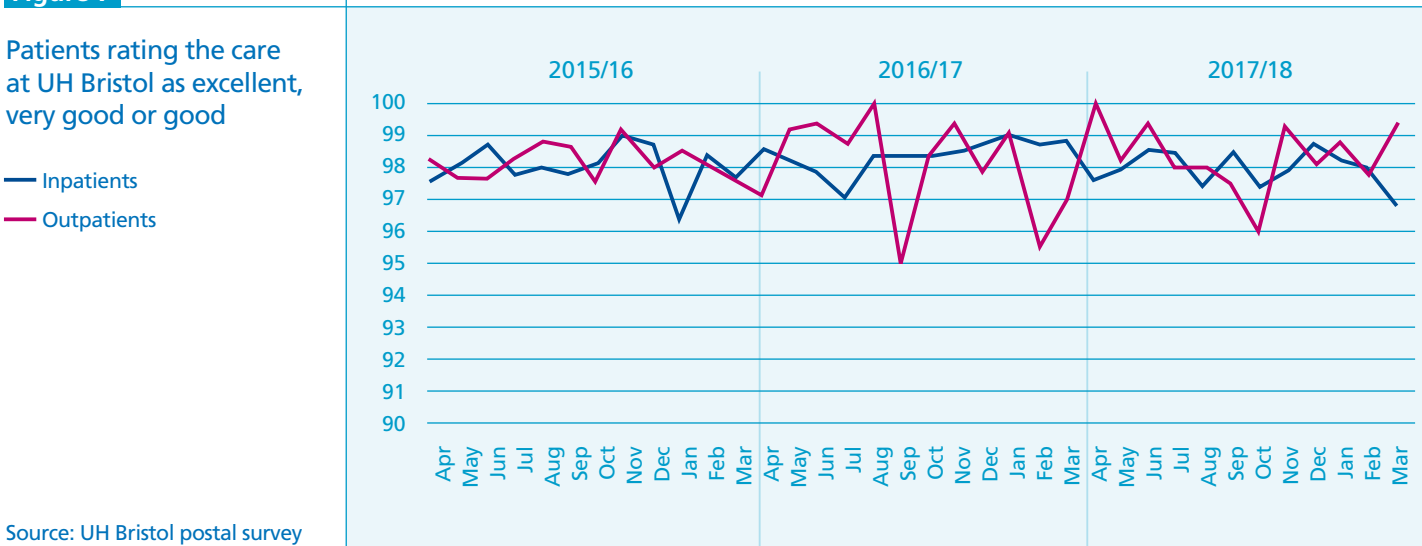
3.2.2 UH Bristol patient survey programme

UH Bristol has a comprehensive local survey programme to ensure that ongoing and timely feedback from patients forms a key part of our quality monitoring and improvement processes.

The Trust continues to receive very positive feedback from service-users, consistently achieving overall care ratings in excess of 95 per cent in our monthly postal surveys (Figure 7). Praise for our staff is by far the most frequent form of feedback that we receive.

Figure 7

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



Source: UH Bristol postal survey

3.2.3 Patient and Public Involvement

In addition to our surveys, we also carry out a range of engagement activities with our patients, visitors and the public. We do this in a number of ways, for example via focus groups, interviews carried out by our volunteer Face2Face Team, and our Involvement Network which reaches out to a wide range of community groups across Bristol and the surrounding areas. There were a number of highlights from this activity in 2017/18:

- With support from The King's Fund, UH Bristol, Bristol Community Health and North Bristol NHS Trust jointly led a patient and community leadership programme which has provided training and support to members of the public who want to shape local healthcare services. This work continues to evolve, with the development of the "Healthcare Change Maker" forum, which is now working in an advisory role to commissioners and the local Sustainable Transformation Partnership (STP). In addition, UH Bristol is directly benefiting from the programme, having placed participants in a number of roles, including our new complaints review panel, and the paediatric cardiac review steering group.
- A group of sixth form students from Ashton Park School visited UH Bristol in November. The students all had some degree of learning disability or additional educational need. Over the course of a day-long visit, these "hospital detectives" were able to give our Patient Experience and Involvement Team insights into what it feels like to visit clinical and non-clinical areas of the Trust.
- The Trust has continued to engage with the local deaf community by playing a leading role in the establishment of a new Bristol-based deaf patient experience group with input from a range of stakeholders.
- Patients and relatives were involved in the successful design of the Trust's new "butterfly" end of life personalised care plan.

In 2017/18, we were delighted that several of our patient experience initiatives were recognised in national awards:

- Our "#conversations" project at Bristol Royal Hospital for Children was a finalist in the Patient Experience National Network Awards (PENNA) in the partnership working category. This ongoing initiative which encourages staff, patients and families to develop mutual understanding on key subjects is now being extended to our maternity hospital, St Michael's.
- The Trust's Patient Experience and Involvement Team and Maternity Services were shortlisted for a Health Services Journal Value in Healthcare award, for their collaborative work on the "Patient Experience at Heart" project. Patient Experience at Heart involved a series of workshops with maternity staff, where staff were able to explore the impact of their role on delivering a positive service-user experience.
- The Trust's patient and public involvement lead and the medical director's lead for training and development designed a new approach to learning called "Patients and Doctors as Partners in Care". These workshops, which brought together junior doctors and patients to explore the relational aspects of care giving from the perspective of both parties, were shortlisted for an award by Health Education England.

3.2.4 Complaints received in 2017/8

In 2017/18, 1,817 complaints were reported to the Trust Board, compared with 1,874 in 2016/17[15]. 674 (37.1 per cent) of these complaints were investigated via the formal complaints process, with the remainder addressed through informal resolution.

Eighty-three per cent of formal complaints were responded to within the timescale agreed with the complainant: a deterioration on the 86.1 per cent we reported last year. To date (12 April 2018), 67 complainants have expressed dissatisfaction with one or more aspects of our response to their concerns (formal complaints), which is slightly more than at the equivalent point in time last year (65 cases), but represents an improvement when measured as a proportion of formal complaints (9.7 per cent in 2017/18, compared with 11.8 per cent in 2016/17).

Improvements to the complaints service in 2017/18 have included:

- The introduction of regular complaints panels where lay representatives retrospectively review complaints and how the Trust responded. Points of learning from these panels are shared with all divisions.

[15] Previously 1,941 in 2015/16, 1,883 in 2014/15, 1,442 in 2013/14 and 1,651 in 2012/13

- Actively encouraging complainants to take up the option of meeting with Trust staff to discuss the findings of complaints investigations.
- Routinely asking complainants if they would like to be involved in designing and implementing any improvements identified as a result of their complaint.
- Changes to the Trust's formal response letter template based on feedback from dissatisfied complainants and from the Patients Association

During 2017/18, the Trust has also been working with the Patients Association to develop a best practice toolkit to help staff to respond to complaints more effectively. This toolkit includes advice and guidance about objectivity when investigating complaints. Work on the toolkit is due to be completed by the end of June 2018.

Looking ahead to 2018/19, our plans include:

- A refocus on achieving our 95 per cent target for timely complaints responses.
- A comprehensive review of our complaints training programme.
- A review of how the severity of complaints is recorded and how this information might be used to inform reporting.
- Introducing quarterly reporting to the Trust's Patient Inclusion and Diversity Group of any complaints which highlight themes

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2018.

3.2.5 Turning feedback and complaints into positive action: examples of improvements to patient care in 2017/18

Examples of positive action taken in response to complaints and patient feedback include:

- Delirium leaflets are now given out on the wards at the Bristol Heart Institute (BHI) and in pre-operative assessment to warn patients that, following cardiac surgery, they may experience delirium for a short period of time. Cascade training of staff is taking place.
- Staff at the BHI are being trained to carry out assessments of patients' limbs following cath lab procedures in order to prevent problems with circulation. In addition, staff on our coronary care unit will be trained to use Doppler ultrasound tests instead of a manual assessment for all patients.
- A call bell system is being installed in the outpatient department at Bristol Eye Hospital (BEH).
- Silent closing bins have been checked and repaired on Ward H304 at BEH in response to patient feedback about noise at night. Projects to reduce noise at night are also being taken forward by our Coronary Intensive Care Unit and Women's Services.
- New signage has been installed in the Bristol Royal Infirmary (BRI) Emergency Department, to convey information about waiting times and how the department works, so that patients have a better understanding of how the "queuing" system works. Signage for visitors to BEH has also been improved.
- Staff dealing with Radiology appointment bookings now telephone patients for short notice appointments around Easter and Christmas (when post can take longer than usual) to ensure that these appointments are not missed.
- In Women's Services, staff have developed a traffic light poster to explain the hospital discharge process to patients and help manage expectations around this.
- Staff at Bristol Royal Hospital for Children (BRHC) have reviewed how they ensure parents of children with disabilities are made aware of the Hospital Passport on their first presentation to the BRHC; signage in the Emergency Department has been changed as part of this. 'Listening to Parents' posters are also now displayed in prominent locations throughout BRHC.

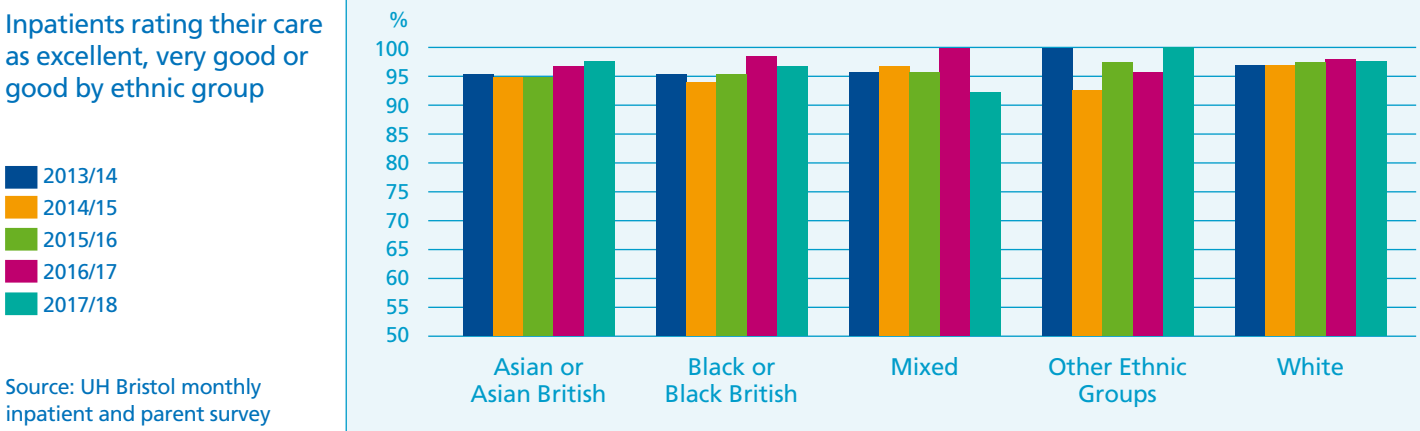
3.2.6 Equality and diversity

In a notable development for UH Bristol, 2017/18 saw the creation of a new Patient Inclusion and Diversity Group within the Trust. The focus of the Trust's existing Equality and Diversity Group is largely on workforce matters, so it was agreed to create a new 'sister' group to provide a more appropriate platform for discussion of equality issues that impact upon patients. The group met for the first time in January 2018, and has recently agreed an annual work plan for 2018/19 which will, for example, include work to strengthen the Trust's compliance with the Accessible Information Standard.

Figure 8 below shows results from the Trust's post-discharge patient survey according to ethnicity. This data indicates that patient experience at UH Bristol is consistently positive across different ethnic groups.

Figure 8

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



Source: UH Bristol monthly inpatient and parent survey

3.2.7 Overview of monthly board assurance regarding patient experience

The table below contains key quality metrics providing assurance to the Trust Board each month regarding patient experience. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some patient experience metrics and targets in Table 8 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2016/17" may vary slightly from the equivalent data in our 2016/17 Quality Report due to finalisation of provisional data.

Table 8

Quality Measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91.5	>=89	91	92	91	92	91.5
Kindness and Understanding	Monthly postal survey	95.3	>=92	96	95	95	96	95.5
Outpatient Tracker Score	Monthly postal survey	89.3	>86	88	89	90	89	89
Friends and Family Test – coverage								
Inpatient Coverage	Friends and Family Test	35.50%	>=30%	36.80%	35.40%	33.90%	33.70%	35%
ED Coverage	Friends and Family Test	16.40%	>15%	17.60%	18%	16.90%	16.80%	17.30%
Maternity Coverage	Friends and Family Test	22.50%	>15%	20.70%	18.60%	19%	17.80%	19%
Friends and Family Test – score								
Inpatient Score	Friends and Family Test	97.20%	>=92%	97.30%	97.60%	98%	98%	97.70%
ED Score	Friends and Family Test	78.20%	No set target	81.70%	81%	80.50%	82.50%	81.30%
Maternity Score	Friends and Family Test	96.80%	>=92%	96.60%	96.80%	98%	95.60%	96.90%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,875	No set target	555	430	407	423	1815
Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	86.10%	>=95%	80.20%	83%	85.40%	82.30%	83%
Complaints Responded To Within Divisional Timeframe	Patient Support and Complaints Team	86.60%	No set target	79.40%	85.70%	85.40%	83.40%	83.80%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	11.41%	<5%	18.32%	10.99%	12.68%	4.57%	11.25%*

3.3 Clinical effectiveness

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

3.3.1 Understanding, measuring and reducing patient mortality

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

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

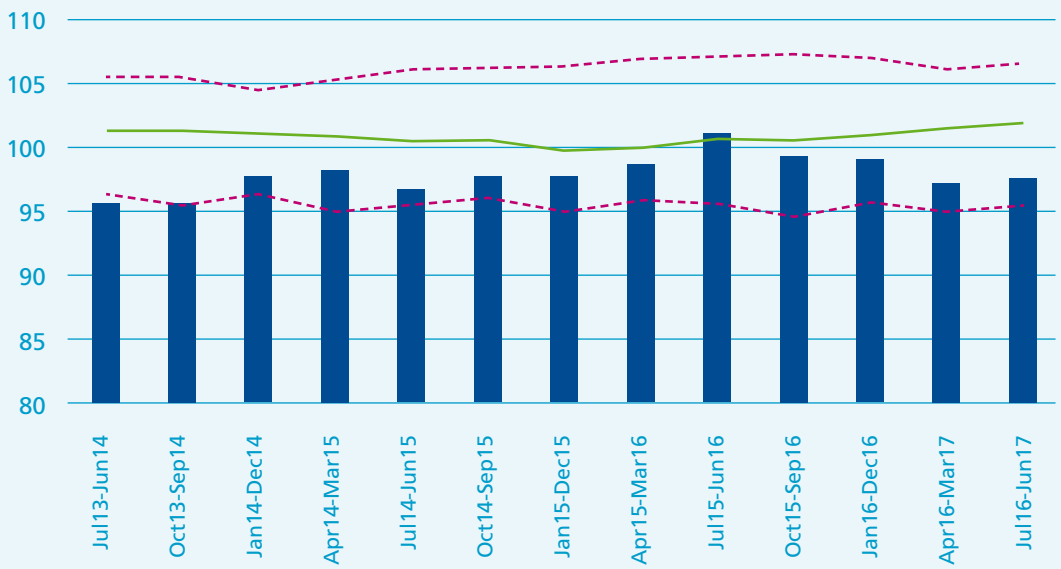
In simple terms, the SHMI 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. The score needs to be read in conjunction with confidence intervals to determine if the Trust is statistically significantly better or worse than average. NHS Digital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

In Figure 9, the blue vertical bars represent UH Bristol SHMI data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles (top and bottom 25 per cent). Comparative data from July 2016 to June 2017 shows that the Trust remains in the 'as expected' category. The most recent comparative data available to us at the time of writing is for the rolling 12 month period October 2016 to September 2017[16]. In this period the Trust had 1,693 deaths compared to 1,686 expected deaths; a SHMI score of 100.4.

[16] Figure 9 is sourced from CHKS Limited and does not yet include data for the period October 2016 to September 2017.

Figure 9

Summary Hospital-level Mortality Indicator (SHMI)



Source: CHKS benchmarking

The latest HSMR data available at the time of writing is for the period January 2017 to December 2017. This shows 1,030 patient deaths at UH Bristol, compared to 1,127 expected deaths: an HSMR of 91.4.

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

3.3.2 Learning from deaths

Section 2.1.1 of this report includes a description of the implementation of a new system for reviewing and learning from patient deaths. The information which follows here relates to that system and is a reporting requirement of NHS Improvement.

During the period of April 2017 to March 2018, 1,281 of University Hospitals Bristol NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 301 in the first quarter
- 277 in the second quarter
- 372 in the third quarter
- 331 in the fourth quarter

Of these 1,281 deaths, by 31 March 2018, 330 had been identified as requiring case records reviews, and 141 of these reviews had been completed.

The number of deaths in each quarter for which a case record review was carried out was:

- 53 in the first quarter
- 42 in the second quarter
- 46 in the third quarter
- 8 in the fourth quarter

In 11 cases, a death was subjected to both a case record review and a serious incident investigation.

Three of the patient deaths during the reporting period were judged more likely than not to have been due to problems in the care provided to the patient. This represents 0.23 of the 1,281 patients who died. In relation to each quarter, this consisted of:

- 2 in the first quarter (representing 3.8 per cent of the 53 deaths reviewed)
- 1 in the second quarter (2.6 per cent of 38 deaths reviewed)
- 0 in the third quarter (of 33 deaths reviewed)
- 0 in the fourth quarter (of 3 deaths reviewed)

These numbers have been calculated using the records of case note reviews held by the Medical Director's office at UH Bristol.

The Trust's new process for reviewing learning from deaths was instigated on 1 April 2017; no deaths prior to this date had case note reviews completed in 2017/18.

The major themes identified from case note reviews during 2017/18, also described in section 2.1.1 of this report, are:

- The need to improve early recognition of the dying patient. This has been agreed as a corporate quality objective for 2018/19 (see section 2.1.2 of this report)
- The importance of senior clinical staff involvement in the decision to move patients from physiological monitoring to symptomatic control at the end of their lives

Following the identification of these themes, a project has been instigated via the Trust's Quality Improvement Academy to implement Trust-wide learning around the provision of end of life care. Our plans are described in section 2.2.2 of this report. Feedback from the Trust's Mortality Surveillance Group is also being disseminated through our Divisional structures.

3.3.3 Seven day services

We assess ourselves against the core NHS seven day working standards (that is, standards 2, 5, 6 and 8) via six-monthly audits. This process has helped us target our work on specific areas in developing our plans to provide seven-day services. The most recent completed audit in September 2017 highlighted where compliance gaps remain. Our clinical Divisions have undertaken work to close the gaps identified within the audit.

We can confirm compliance against the November 2017 requirement for urgent care network specialist services for paediatric major trauma, heart attack and children's critical care services and we are not the local provider for major trauma or vascular services. We have, however, identified that further service developments are required to meet the standards for stroke services and also within our interventional radiology service, which contributes to the vascular network standards.

Table 9

	2	5	6	8
Standard	Percentage of patients who had an initial consultant review within 14 hours of admission*	Percentage of diagnostic tests available to patients**	Percentage of consultant directed interventions available to patients**	Percentage of patients that received ongoing daily consultant reviews*
University Hospitals Bristol NHS Foundation Trust	April 2017: 76% of patients were reviewed within the require timeframe (of 209 emergency admissions; September 2017: 58% (of 204 emergency admissions)	100% (6 out of 6) diagnostic tests are available seven days a week	April 2017: 89% (8 out of 9) consultant directed interventions are available seven days a week	April 2017: 88% of patients were appropriately reviewed (daily or twice daily depending on clinical need)

* measured by audit using methodology stipulated by NHS England
** measured by self-assessment

Our improvement plans are summarised below alongside our plans to achieve the 2020 goal for the broader roll out of seven-day services to all relevant specialties. It is also of note that a review of the model for stroke services is currently a priority project within the BNSSG (Bristol, North Somerset and South Gloucestershire) sustainability and transformation partnership; the affordable provision of seven-day services within this urgent care specialist service may be provided through a cross-system solution.

Our plans – which are subject to the necessary investment – include:

- Standard 2 (Time to consultant Review): Provision of additional consultant capacity within general surgery, trauma and orthopaedics and gynaecology services to ensure full compliance with the standard.
- Standard 5 (Access to Diagnostics): Formalisation of interventional vascular radiology arrangements with North Bristol NHS Trust and development of an in-house non-vascular interventional radiology service. A formal rota to provide in-house non-vascular intervention on a seven-day basis is being instigated.
- Standard 6 (Access to Consultant-directed Interventions): Investment in consultant capacity to allow for the delivery of two additional weekend endoscopy lists, to address the gap in our service for lower gastrointestinal endoscopy.
- Standard 8 (On-going Review): Proposals under standard 2 will provide capacity to close gaps in capability in the surgical areas specified.

Service development proposals to address the gaps in seven-day coverage have been discussed with our commissioners – Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group – via contract negotiations. Commissioners have indicated that the proposed investments will not be affordable within the 2017/18 – 2018/19 planning round and accept that the Trust will not be able to meet the standards until opportunities to improve compliance through service reconfiguration and commissioners' re-prioritisation are assessed.

The Trust currently has multiple work streams dedicated to the delivery of improved patient flow through the organisation. Whilst many services are delivered on a seven-day basis, in other service there remains a differential between week days and weekends. There is however clear clinical commitment to move towards seven-day services within our Divisions.

We have invested in three new consultant acute physicians and three consultant emergency physicians in order to close the gap to meeting the seven-day standards. The three new acute physicians have already been appointed and started employment. The additional ED consultants are due to start in August 2018 and will increase the presence of senior decision-makers to 16 hours per day, seven days a week, enabling the introduction of rapid assessment and triage.

3.3.3 Overview of monthly board assurance regarding clinical effectiveness

The table below contains key quality metrics providing assurance to the Trust Board each month regarding the clinical effectiveness of the treatment we provide. Where there are no nationally defined targets or where the Trust is already exceeding national targets, local targets or improvement goals are set to drive continuous improvement. These metrics and their targets are reviewed annually to ensure they remain relevant, challenging and achievable. Some clinical effectiveness metrics and targets in Table 10 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2016/17" may vary slightly from the equivalent data in our 2016/17 Quality Report due to finalisation of provisional data.

Table 10

Quality Measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	99.2	<100	97.6	100.4	Data not available	Data not available	99*
Hospital Standardised Mortality Ratio (HSMR)	CHKS	91.4	No set target	87.5	87.4	102.8	95.1	93.1*
Re-admissions								
Emergency Readmissions Percentage		2.66%	<2.70%	3.45%	2.71%	2.35%	2.16%	2.71%
Management of Sepsis								
Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	Casenote review	21.60%	>=90%	38.10%	29.70%	35.50%	79.70%	51.10%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatients)	Casenote review	65.70%	>=90%	71.40%	88.90%	75%	75%	77.40%
Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	Casenote review	100%	>=90%	100%	100%	71.40%	100%	93.3%*
Percentage of Patients Meeting Criteria Screened for Sepsis (Emergency)	Casenote review	74.40%	>=90%	80%	94%	75.80%	87.30%	83.40%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Emergency)	Casenote review	56.30%	>=90%	76.70%	90%	90%	83.80%	85.50%
Sepsis Patients Percentage with a 72 Hour Review (Emergency)	Casenote review	94.30%	>=90%	100%	100%	87.70%	92.90%	93.60%
Maternity								
Percentage of Low Weight Babies	Medway PAS	2.70%	No set target	2.20%	2.70%	2.50%	2.80%	2.50%
Number of Low Weight Babies	Medway PAS	137	No set target	26	32	29	32	119

Quality Measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	70.50%	>=90%	76.30%	77.80%	47.50%	54.80%	64.20%
Patients Seeing Orthogeriatrician within 72 Hours	National Hip Fracture Database	74%	>=90%	69.70%	39.50%	60%	79.50%	61.60%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	51.90%	>=90%	48.70%	28.40%	26.30%	37%	34.80%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	58.60%	>=80%	64.90%	68.50%	59.10%	59.40%	63.5%*
Percentage Spending 90%+ Time On Stroke Unit	Medway PAS & Radiology Information System	90.20%	>=90%	84.30%	85.40%	88.20%	88.40%	86.4%*
High Risk TIA Patients Starting Treatment Within 24 Hours	Medway PAS & Radiology Information System	66.80%	>=60%	62.50%	55.90%	62.90%	34.20%	54.60%
Dementia Care								
FAIR Question 1 - Case Finding Applied	Local data collection	90.40%	>=90%	88.30%	91.50%	89.60%	88.20%	89.30%
FAIR Question 2 - Appropriately Assessed	Local data collection	97.20%	>=90%	98.30%	98.60%	96.90%	92%	96.20%
FAIR Question 3 - Referred for Follow Up	Local data collection	94.70%	>=90%	88.90%	100%	87.50%	100%	92.90%
Percentage of Dementia Carers Feeling Supported	Local data collection	75%	No target set	100%	Data not available	Data not available	50%	60%
Dementia Care								
Bed Days Spent Outlying.	Medway PAS	8,854	<9,029	1994	1409	1787	3908	9098

3.4 Performance against national priorities and access standards

3.4.1 Overview

NHS Improvement's Single Oversight Framework (SOF) has four performance metrics:

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

The national standards are:

- 95 per cent for A&E 4 hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent for RTT incomplete pathways
- 99 per cent for 6-week diagnostic waiting times

Sustainability and Transformation Funds (STF) targets were agreed for each indicator at the start of the financial year; these were submitted to NHS Improvement as part of their monthly monitoring of acute Trusts.

In summary, the Trust improved and sustained A&E performance across half of the year, whilst maintaining relatively good performance in November and December as winter demand began to have an impact. Cancer performance has stabilised across the entire year, culminating in compliance with the national standard in the third quarter of the year. Joint working arrangements with neighbouring acute trusts have been established for 2018/19, with a focus on new cancer reporting data sets and appropriate allocation of breaches. Improved reporting and monitoring of diagnostic services has led to strong performance in 2017/18; we achieved the national standard in February 2018 and anticipate sustained compliance into 2018/19. Our RTT performance fell short of the national standard through 2017/18, however we have made significant changes to our reporting methodology; the launch of the Medway 4.8 patient administration system has been accompanied by comprehensive data validation review and a drive to reduce the time patients spend awaiting follow up appointments.

Table 11

Access Key Performance Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
A&E 4-hours	Actual	82.3	84.2	87.9	90.5	91.3	90.8	90.1	90.3	85.3	82.7	83.2	78.9
	Traj.	82.5	83.5	85	90	90	90	90	90	90	90	92	95
62-day GP cancer	Actual	76.5	77.8	81.7	75.0	85.2	80.2	84.3	88.6	82.9	78.4	81.3	87.3
		78.8			80.1			85.4			82.4		
	Traj.	81	81	81	83.6	83.6	83.6	82.5	82.5	82.5	82.6	82.6	82.6
RTT	Actual	91.1	91.1	91.0	90.2	89.9	89.4	90.0	88.9	88.3	88.1	88.4	87.0
	Traj.	92	92	92	92	92	92	92	92	92	92	92	92
6-week diagnostic	Actual	98.6	98.8	98.6	98.5	97.6	97.7	98.2	98.3	97.6	97.8	99.2	98.5
	Traj.	99	99	99	99	99	99	99	99	99	99	99	99

Performance (%) against the agreed trajectories for the four key access standards in 2017/18 during each quarter.

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

Performance against these four SOF standards is covered in more detail in the following sections of the report.

3.4.2 Referral to Treatment (RTT)

The national compliance standard continued to be that at least 92 per cent of patients should be waiting less than 18 weeks between referral to treatment. During the year 2017/18, the volume of patients waiting over 18 weeks for treatment grew in a number of our specialities and the overall standard was not delivered in any single month. Our non-compliance has resulted from a growth in outpatient referrals and the high volume of elective cancellations during the prolonged winter pressure period.

The management of unanticipated growth and the change in RTT compliance for 2018/19 will be monitored weekly through our RTT, Diagnostic and Cancer performance meetings. Guidance from our regulators requires a steady state to be delivered month-on-month and the Trust has committed to deliver a performance percentage month-on-month of no less than 87 per cent, whilst striving to deliver an aggregate performance across all Divisions of 92 per cent.

3.4.3 Accident & Emergency 4-hour maximum wait

The Trust failed to meet the national A&E 95 per cent standard for the proportion of patients discharged, admitted or transferred within four hours of arrival in our emergency departments, in any month in 2017/18. For the three emergency departments:

- Bristol Royal Hospital for Children achieved the 95 per cent standard in six out of 12 months, and achieved 94.9 per cent for the year as a whole
- Bristol Eye Hospital achieved the 95 per cent standard in five months, and achieved 96.6 per cent for the year
- Bristol Royal Infirmary did not achieve the 95 per cent standard in any month, and achieved 79.6 per cent for the year

This year, a Sustainability and Transformation Fund (STF) improvement trajectory was put in place with the aim of getting performance up to the required standard by March 2018. For quarters 2 and 3, the target trajectory was 90 per cent at Trust level. The Trust achieved 90.9 per cent in quarter 2 and so achieved the associated funds for that quarter. For quarter 3, the Trust achieved 88.6 per cent; however, in agreement with NHS England and NHS Improvement, each acute trust was apportioned activity from Walk-In Centres and Minor Injury Units in their region (this was to enable more accurate comparisons to be made with areas of the country where this activity is owned by acute trusts). For the Trust, this was for the Bristol, North Somerset and South Gloucestershire (BNSSG) region. The result of this apportionment was published by NHS England

as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the STF target for quarter 3. The Trust's performance after apportionment was 92.8 per cent, therefore, for the purposes of assessing achievement at national level, the Trust achieved the STF target of 90 per cent for quarter 3. The Trust achieved 81.5 per cent in quarter 4; apportionment for quarter 4 has yet to be published, however the Trust will not achieve the 90 per cent target.

Overall, A&E attendance levels were up 2.7 per cent in 2017/18 compared to 2016/17 (a 3.5 per cent increase at the BRI and a 2.4 per cent increase at BRHC). However, the proportion of patients admitted to an inpatient bed as a result of their emergency department attendance remained the same at 25.5 per cent (34 per cent at BRI and 24 per cent at BRHC). The proportion of patients arriving at A&E by ambulance remained steady at 26.5 per cent (39 per cent at BRI and 19 per cent at BRHC).

There was a significant increase in emergency admissions to inpatient beds coming via direct GP referrals, as opposed to through A&E. This figure rose from 3,890 in 2016/17 to 5,672 in 2018/19. This 45 per cent increase was driven by changes in the Acute Physician model and the use of the Acute Medical Unit (A300) to accept increased numbers of GP expected patients. One four bed bay in AMU was converted to initially four, and then six trolleys to support expected patients being assessed and, where possible, discharged home in the same day, resulting in a rise in short stay (<24 hours) admissions. Following the overnight closure of the A&E department at Weston General Hospital, we received additional ambulance activity during the overnight period: on average, six attendances and three admissions to adult services.

The number of Delayed Transfers of Care (DToC) patients rose slightly in 2017/18. Last year, on average, there were 32 DToC patients at each month-end compared to 33 this year. Total bed days lost to DToC patients fell from 12,399 to 11,572, however bed days lost to patients from Bristol City Council area rose slightly from 9,520 to 9,675.

This year, there was continued focus on ensuring that as many patients as possible were managed in the correct specialty ward. The number of bed days spent outlying rose from 8,854 to 9,098. Outlier bed days showed an almost two-fold increase in January-March 2018 due to winter pressures. Looking at quarters 1 to 3 only, the reduction this year compared to last year was near to 15 per cent. Ward A518 was added to the Trust's inpatient bed base in Medicine to offset the withdrawal of the virtual ward model and the impact of Weston's overnight closure, however this meant there was no additional inpatient capacity to open to support winter demand, leading to running at high levels of occupancy. Broadly in line with expectations, we relied heavily on extreme escalation capacity, particularly the Medical Rehabilitation Unit and Queen's Day Unit.

3.4.4 Cancer

The Trust performed well against the 31 day subsequent treatment standards for radiotherapy and chemotherapy, and the two week wait first appointment standard. These were achieved in every quarter of the year. The 31 day first definitive treatment standard was achieved in quarters two and three, but fell below the 96 per cent threshold in the first and last quarters of the year. This was due primarily to cancellations of surgery, which remains a significant challenge for the Trust. Likewise, the 31 day subsequent surgery standard was non-compliant in quarters one and four for the same reason.

The 62 day standard for treatment after a GP referral for suspected cancer was subject to a contract performance notice in July 2017 following a challenging start to the year. The impact of cancellations again was a significant factor, along with a number of other more minor issues. The Trust case-mix for this standard remains very challenging compared to the average provider, due to the absence of breast surgical and diagnostic services, and the high proportion of complex services such as those for thoracic surgery, specialist head and neck cancer, and specialist upper gastrointestinal cancer. This is acknowledged by our commissioners.

Following the performance notice, a recovery trajectory and targeted action plan were put in place and delivered good results. The trajectory was achieved in every month up to and including December and in quarter three the national 85 per cent standard was achieved for the first time since 2012. This was a significant achievement by the organisation, particularly in a quarter where nationally only 82.9 per cent was achieved. Quarter four saw a rise in cancellations, along with other factors including high levels of patient choice after Christmas, which in February

manifested itself as an unusually high proportion of late referrals from other providers. These factors caused a dip below the recovery trajectory and the national standard. The organisation is now focussing on improving performance back to the 85 per cent standard, through rapid recovery from cancellations and work with other providers through a virtual waiting list meeting to reduce late referrals.

The 62 day standard for treatment following referral from a screening programme was compliant in quarter two only. This standard has extremely low numbers and most breaches are unavoidable – commonly due to patient choice to delay diagnostics. Again, an unusual case-mix hampers the Trust, with the majority of cases being colorectal screening and very few of the naturally high performing breast and cervical screening cases.

Overall, whilst significant challenges are still present for achievement of the cancer standards, during 2017/18 the Trust has made positive steps to improving performance against these targets and has strong plans to build on this during 2018/19. A corporate quality objective has been agreed for the year (see section 2.1.2).

3.4.5 Diagnostic waiting times

This standard covers the top 15 high volume diagnostic tests. The expectation is that, at each month-end, 99 per cent of patients waiting for these tests should have been waiting for less than six weeks. The Trust achieved this standard at the end of February 2018, but did not achieve it for any of the other months during 2017/18. However, the following test areas did achieve the standard for each month: Audiology, Echocardiography, DEXA Scans, Peripheral Neurophysiology, Colonoscopy, Flexi Sigmoidoscopy and Cystoscopy. The Trust averaged 98.3 per cent at each month-end across 2017/18.

Sleep Studies experienced higher demand than expected and this test area averaged 83 per cent for the year. Demand management plans are being developed with commissioners and additional capacity is being developed through use of GPs with a Special Interest[17], additional consultant capacity and in-house waiting list initiatives. Computed Tomography (CT) averaged 96 per cent, with increase in Cardiac demand (24 per cent average growth in the last three years), long-term sickness in the department and general radiographer staff vacancies resulting in under performance against the standard. Magnetic Resonance Imaging (MRI) averaged 98.7 per cent with loss of capacity and increased acuity in paediatric General Anaesthetic cases contributing to under-performance and also high demand for Cardiac MRI tests. Non-obstetric Ultrasound achieved for the year on average, but saw a drop in performance from quarter four due to loss of capacity due to adverse weather and sonographer absences.

[17] A general practitioner with additional training and experience in a specific clinical area who takes referrals for patients who may otherwise have been sent directly to a secondary care consultant, or one who provides an enhanced service for particular conditions or patient groups.

Performance against national standards

Table 11

National standard	Target	2015/16	2016/17	2017/18	Notes
A&E maximum wait of 4 hours	95%	90.4%	85.0%	86.5% (A)	Target not met in each quarter
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	99.0%	97.6%	97.9%	Target met in each quarter
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.8%	52.6%	52.2%	Target met in each quarter
A&E Unplanned re-attendance within 7 days	<5%	3.0%	2.6%	2.8%	Target met in each quarter
A&E Left without being seen	<5%	2.4%	2.2%	1.9%	Target met in each quarter
Cancer - 2 Week wait (urgent GP referral) *	93%	95.9%	94.8%	94.5%	Target met in each quarter
Cancer - 31 Day Diagnosis To Treatment (First treatment) *	96%	97.5%	96.7%	95.8%	Target met in Quarter 2 and 3
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery) *	94%	96.8%	94.4%	92.8%	Target met in Quarter 2 and 3
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy) *	98%	98.9%	98.7%	98.6%	Target met in each quarter
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy) *	94%	97.1%	96.6%	96.3%	Target met in each quarter
Cancer - 62 Day Referral To Treatment (Urgent GP Referral) *	85%	80.6%	79.3%	81.2%	Target met in Quarter 3
Cancer - 62 Day Referral To Treatment (Screenings) *	90%	68.6%	69.4%	78.1%	Target met in Quarter 2
Cancer - 62 Day Referral To Treatment (Upgrades) *	85%		87.9%	84.9%	Target met in Quarter 1 and 4
18-week Referral to treatment time (RTT) incomplete pathways	92%	91.3%	91.7%	89.6% (A)	Target not met in each quarter
Number of Last Minute Cancelled Operations	<0.8%	1.03%	0.98%	1.19%	Target not met in each quarter
Last Minute Cancelled Operations Re-admitted within 28 days	95%	88.7%	90.8%	94.2%	Target met in Quarter 2
6-week diagnostic wait	99%	98.97%	97.79%	98.29%	Target not met in each quarter
Primary PCI - 90 Minutes Door To Balloon Time	90%	93.3%	91.7%	93.3%	Target met in each quarter

* Cancer data does not include March 2018 data, so Quarter 4 is incomplete

Achieved for the year and each quarter

Achieved for the year, but not each quarter

Not achieved for the year

Target not in effect

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

A APPENDIX A
Feedback about our Quality Report

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

The Council of Governors welcomes this annual opportunity to comment on the Trust's quality report, which covers all key aspects of patient safety and experience, clinical effectiveness, the trust's performance against national priorities and its own key quality objectives. In doing so we acknowledge the increasingly challenging environment in which all NHS Trusts currently operate and the recent prolonged period of winter pressure experienced at UH Bristol.

We believe that this is an open and comprehensive report that clearly identifies both the trust's successes and areas of weaker performance over the last 12 months. Importantly, the trust has continued to demonstrate evidence of robust response to concerns raised as a result of public and patient consultation and independent enquiries; while also identifying learning and appropriate actions following internal investigations into all serious incidents.

Governor involvement
There is a Public Meeting of the Trust Board held every month, with a review of the Quality and Performance report for the previous month along with a report from the Non-executive Director Chair of the Trust Quality and Outcomes Committee on the agenda every time. Governors attend these meetings as observers and have the opportunity to raise questions following the board's own discussion on each topic.

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

Last summer we experienced a considerable turnover in our Council of Governors with a significant number of very experienced governors coming to the end of their terms of office and a reciprocal number of new governors joining the trust. The framework outlined above, along with our quarterly governor development seminars, has supported these new governors in their learning about quality and performance issues and their desire to raise questions and offer challenges about many of the issues referred to in this report.

Quality objectives
This report examines the trust's performance against the quality objectives it set itself at the beginning of the year and outlines the key objectives for service improvement over the next year. The successful creation of a Quality Improvement (QI) Academy over 2017/18, along with the higher-than-target staff attendance levels for the bronze programme, offers cause for celebration. Governors were among the attendees at the trust's first QI Forum last July and were able to see for themselves the impressive range and standard of posters on display. The on-going development of QI resources and encouragement of staff initiative and innovation in QI should now become embedded in the day-to-day workings of the trust.

The introduction of the new mortality review programme has also been a success and we welcome the fact that learning from this has fed directly into the objectives for the coming year. However, it is clearly disappointing to note the deterioration in last minute cancellations of operations for 2017/18 and this will require continued close scrutiny over the coming year along with on-going effort around cancellations of outpatient appointments and the management of sepsis. In addition, it is to be hoped that the delayed procurement and implementation of a new system for gathering patient feedback at the point of care will move forward smoothly in early 2018/19 and produce the more effective reporting that is sought.

In setting the objectives for 2018/19, we note that the trust is carrying forward two key objectives relating to the development of a 'customer service mind set' and further improvement in staff engagement and satisfaction. Success has been achieved in these objectives over the past year, but we acknowledge the continued importance of both as the trust pursues its efforts to offer a genuinely individual, effective and caring approach to all patients and staff. Indeed, the governors have given a great deal of attention to all data relating to staff recruitment, retention, engagement and training over the past year and are aware that the newly appointed Director of People has identified a number of priority actions to pursue over the coming year.

Among the new objectives for 2018/19 we particularly welcome the aims to improve learning from Serious Incidents and Never Events and to improve early recognition of the dying patient. We know how important it is for patients and families that have been involved in serious incidents to believe that learning will be gained from the investigations into such incidents and that future patients will benefit from this. Work to improve the recognition of patients approaching the end of their life and, thereby, to achieve appropriate choices for them and their families is also of key importance. Within the mandated quality indicators (see 2.3) this should also result in an increased percentage of UH Bristol patient deaths with 'palliative medicine' or palliative care' within their coding in future reports.

Patient safety

UH Bristol is due to complete the current three-year Patient Safety Improvement Programme this summer and must be congratulated on the reduction in adverse events per 1000 bed days that has been achieved. Rigorous evaluation of progress against all the relevant quality improvement measures within the programme, as planned, must now inform the setting of patient safety improvement priorities for the next three years. Sustaining the positive safety culture that is referred to in this report will clearly require on-going two-way communication with the clinical teams; and the commitment to repeating and feeding back on safety culture assessments is very welcome.

The timing and thoroughness of investigations following serious incidents and never events continue to be closely monitored by the Quality and Outcomes Committee, and evidence has been regularly presented over the past year of learning from these investigations leading to the necessary action plans. Further emphasis on such learning within the quality objectives for the coming year should, therefore, become apparent within this committee.
Continued emphasis on the recognition and management of deteriorating patients (both adults and children), supported by further implementation of electronic observation systems and pathways, demonstrates a sustained commitment to improvement in this area. Similarly, the roll out of electronic prescribing and medicines administration to all adult specialties and planned actions to make insulin prescribing and administration safer also demonstrates an on-going emphasis on supporting the safer management of medicines both in hospital and following discharge.

Patient experience

Listening to previous, current and potential patients in a variety of settings has continued via the patient stories presented at the Public Board Meetings, the work of the Face2Face volunteer interview team, patient focus groups, national and local patient surveys and visits from external organisations.

Governors continue to place considerable emphasis on these activities and regularly volunteer to participate when appropriate. In addition, we now have two governor representatives attending the Patient Experience Group meetings and giving feedback from these meetings to the Quality Focus Group. Over the past year, we have also appreciated the opportunity to review the trust's results within the most recent National Inpatient Survey and National Cancer Patient Experience Survey via presentations from senior members of staff at the Quality Focus Group. As noted in this report, the national inpatient and children's surveys demonstrated that UH Bristol's performance was among the best in the country in a significant number of the scores .

The specific projects pursued over the past year to achieve further engagement with the local deaf community and people with learning disability are very welcome, as are the involvement of patients in the design of the trust's new end of life personalised care plan and in workshops bringing together patients and junior doctors. The reported deterioration in response times for formal complaints will clearly require attention over the coming year; while the plan to

introduce quarterly reporting to the trust's Patient Inclusion and Diversity Group of complaints which highlight themes should offer an opportunity for further action.

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

Disappointingly, the performance of the trust in relation to the Best Practice Tariff for Fractured Neck of Femur continues to cause significant concern and is under close scrutiny at the Quality and Outcomes Committee and the governors' Quality Focus Group. Stroke Care also requires on-going scrutiny over the coming year. Governors have regularly raised questions about the actions plans relating to these topics and will continue to challenge them if progress is not achieved.

Failure to achieve the planned target for outlying bed days is, perhaps, not surprising given the increased number of patients presenting at the trust over the past year and on-going difficulties with appropriate discharge arrangements resulting in persistently high numbers of 'green to go' patients on the wards. We must hope that work will be achieved within the Sustainability and Transformation Plan for Bristol, North Somerset and South Gloucestershire that will support progress with all of these issues.

The trust continues to demonstrate impressive levels of participation in national clinical audits, national confidential enquiries and clinical research, all of which strongly supports innovation and professional development within the clinical teams. Governors have been delighted to have the opportunity to hear about the wide range of research being pursued at the trust annual research showcase event and via research newsletters.

Performance against national priorities and access standards
The data relating to the trust's performance against the four key nationally determined standards clearly demonstrates increasing periods of time when these could not be achieved, as has been the case for many acute trusts across the country. Trajectories for these targets have been affected by increasingly high levels of overall demand, emergency admissions and increased numbers of elderly patients with complex needs, as was the case last year. In addition, the trust faced a prolonged winter pressure period this year.

The inability to discharge treated patients to suitable care in the community has continued, despite the development of an integrated discharge team at the trust in collaboration with community service providers. These targets will require continued focus and regular review over the coming year and are likely to continue to offer considerable challenge.

Summary
The governors share the deep sense of pride felt by our chief executive, Robert Woolley, and the whole Board at UH Bristol in the achievements of all staff at the trust over the past year. In addition we have felt particular admiration and gratitude for the remarkable resilience shown by staff during the severe weather conditions experienced earlier this year during the height of the winter pressure period.

The Quality and Outcomes Committee has continued to sharpen their focus on, and strengthen the trust's responses to, key areas of performance across all areas of the trust. Monthly quality and performance reports that contain Increasingly detailed data supports them in this work, and the governors also receive these reports. New governors who were elected last summer have put a great deal of effort into developing their understanding of these reports in order to enable them to offer informed and appropriate challenges to the trust's Non-executive Directors. Further plans are in place to build on the governors' current awareness and understanding of quality and performance issues in the coming year and we will continue to strive to offer both support and challenge to the trust. In reflecting on all the work completed or on-going over 2017/18 we believe this report is honest and open in acknowledging the objectives that proved challenging to meet alongside those for which the outcomes were successfully achieved.

Progress on quality has clearly been achieved during the year. However, there are areas where the data is disappointing and we are well aware that financial pressures, national requirements and ever-increasing patient numbers and complexity can only increase the challenges faced

by everyone at the trust. Collaboration with our partners in the Bristol, North Somerset and South Gloucestershire Sustainability and Transformation Plan may provide further integration and innovation within services to ease the current and anticipated pressures; but this work also requires an input of time and money. Similarly, our partnership work with other local acute trusts must continue to develop but adds to the workload of senior trust staff.

In acknowledging these many challenges the governors continue to recognise that the trust's quality agenda is ultimately delivered by dedicated staff. They offer a hugely impressive commitment to their patients every day and must be valued for this and constructively supported in every way possible.

Carole Dacombe (current chair of the Quality Focus Group)
Rashid Joomun
(in consultation with their fellow governors)

May 2018

b) Joint statement from Healthwatch Bristol and Healthwatch South Gloucestershire

Healthwatch Bristol and Healthwatch South Gloucestershire agreed that University Hospitals Bristol NHS Foundation Trusts (UH Bristol) performance against their 2017/2018 quality priorities had been very good. We agreed that the document evidences a culture of learning from the experiences and feedback of patients and the public. It was good to see that objectives from 2017/2018 that had been only partly met were being carried through to the 2018/2019 Quality Account. Healthwatch Bristol and Healthwatch South Gloucestershire believe the trust's quality objectives for the coming year are ambitious enough to drive improvement.

Healthwatch Bristol and Healthwatch South Gloucestershire made the following comments and recommendations about UH Bristol's Quality Account 2017/2018. The document suggested that quality improvement at UH Bristol's had been good with four of the eight priorities for 2017/18 being RAG rated green. For example:

- UH Bristol had more than doubled their initial target for creating a new Quality Improvement Academy with nearly 200 members of staff completing the 'Bronze' programme. A good green RAG rating.
- The introduction of the new mortality programme is RAG rated green, Healthwatch are interested to follow the implementation and find out more about how patients are reviewed following discharge.
- UH Bristol have developed a set of 'Customer Service Principle' and Healthwatch are keen to follow how this firm foundation will be built on in 2018/19.
- Healthwatch noted that despite the green RAG rating the BAME staff experience is unchanged at 28 per cent, higher than the national average and hope that this can be addressed in the coming year.
- Healthwatch are interested to view the breakdown of outpatient appointments cancelled and note that the amber RAG rate reflects that the target for this was not met during the year.
- Sepsis is a national concern and Healthwatch congratulates UH Bristol on the improvement to put the Trust in the top 20 per cent of all NHS Trusts. The amber RAG rating reflects the partial achievement of the CQUIN goals.
- The red rating is disappointing for the objective to reduce the number of last minute cancelled operations as Healthwatch often hear that the consequences for the patient can be drastic.
- The implementation of the new system to gather patient feedback at the point of care has been delayed giving an amber rating, Healthwatch look forward to seeing how this will change over the coming year.

Healthwatch Bristol and Healthwatch South Gloucestershire noted the Quality objectives for 2018/19:

- Healthwatch would like to see better tele communication in the coming year, particularly around the appointment system at the Dental Hospital.
- Healthwatch welcome the objective to improve compliance with the 62 day standard from GP referral to first definitive cancer treatment
- The Mystery Shopper programme is a great idea and Healthwatch look forward to the evaluation at the end of 2018/19.

- Never events should never happen, Healthwatch welcome the improvements being made through the learning to ensure that the event will never happen again in the future.
- In improving the early recognition of the dying patient, Healthwatch noted that the 'weekend sticker' term was used. A breakdown of how this system works will be useful for patient and public understanding.
- Healthwatch noted the objective to explore maternity services, where the standard has dropped, Healthwatch are very aware that maintaining excellence is difficult and welcome the monitoring of this service.

Healthwatch has found UH Bristol to be a high performing local provider with a Care Quality Commission (CQC) rating as 'Outstanding' and note there were no further CQC actions in 2017 – 2018.

Healthwatch are aware that UH Bristol recognises serious incidents as their weaknesses and wonder how many of the slips, trips and falls could have been prevented. The high incidence of grade three pressure ulcers is also a concern.

The term Duty of Candour may need an explanation for patient and public awareness so that everyone knows that every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care, and how this can cause harm or distress for patients, families and carers.

Healthwatch welcomes the paragraph on patient experience as it shows the Trust has a commitment to improving the patient experience.

The Trust is pursuing comprehensive and innovative consultation and engagement activities, involving the communities and groups they serve in the development of their services. Healthwatch were delighted to see the range of Patient and Public Involvement highlights from 2017/18.

Working with the Patient Association to develop a best practice tool kit to help staff respond to complaints more effectively is to be commended and Healthwatch will look forward to seeing the completed toolkit at the end of June 2018.

Healthwatch are hoping to see improvement in the Bristol Royal Infirmary achievement to meet the four hour wait in accident and emergency in 2018/19.

Healthwatch Bristol and Healthwatch South Gloucestershire welcome further opportunities to work with UH Bristol, for example Accident and Emergency may be an area where Healthwatch can both observe the service and talk to patients in the coming year.

26 April 2018

c) Statement from Healthwatch North Somerset

Healthwatch North Somerset welcomes the opportunity to provide a statement in response to the University Hospitals Bristol NHS Foundation Trust Quality Account produced by for the year 2017/2018.

Overall the UH Bristol Quality Account provides a comprehensive reflection on quality performance during 2017/18 and demonstrates a good listening and learning approach. We note the quality objectives for 2017-18 and commend the fact that four of them were directly related to the patient experience. Some of the objectives were rated as amber or red in achievement but we note the continued commitment of UH Bristol to achieving those objectives.

The Quality Account evidences a culture of collecting, reflecting upon and learning from the experiences and feedback of patients and the public. Patient feedback data overall indicates that patients are reporting good levels of care and positive experiences. We welcome that for 2018-19 that there is ongoing commitment to improving the patient experience including the first stated priority to "develop a consistent customer service mind set in all our interactions with patients and their families" and hope that significant progress will be achieved on this over the year.

Healthwatch North Somerset collects feedback from patients in North Somerset and experience

of hospitals within the UHB group during 2017-18 based on public feedback was:

- 43 positive comments commending care quality, staff attitudes, co-ordination of care, continuity and communication
- 26 negative comments citing:
  - Cancelled operations and waiting times in ED and clinics (8)
  - Concerns about quality of care (7)
  - Communications and complaints (5)
  - Discharge concerns (3)
  - Transport and access issues (3)

d) Statement from Bristol City Council People Scrutiny Commission

The Bristol City Council People Scrutiny Commission holds the statutory health scrutiny function for Bristol City Council. The Commission received a presentation on the 8th May and Members were satisfied with the contents of the University Hospitals Bristol NHS Foundation Trust Quality Report.

Members commended UHB for its staff development programmes and for its progress with staff wellbeing initiatives; and Members welcomed the creation of the Quality Improvement Academy which enabled innovations such as the Virtual Fracture Clinic. This demonstrated that UHB was open to working in different ways, empowering and investing in its staff.

Members noted that operational targets in respect of bed occupancy had worsened, but understood the role that winter pressures had played as well as the national context around delayed discharge and bed occupancy. However, Members expressed particular concern that issues linked to levels of bed occupancy have an adverse impact on the causes of last minute cancelled operations.

e) Statement from South Gloucestershire Health Scrutiny Committee

The South Gloucestershire Health Scrutiny Committee received a presentation on UH Bristol's draft Quality Account at a meeting in common with the Bristol People Scrutiny Commission on 8th May 2018. Members of the Committee also visited the Trust on 1st May 2018 to learn about the QI programme and examples related to tissue donation, as well as a visit to the Bristol Children's Hospital to hear about staff engagement.

These comments are based on matters raised by Members of the South Glos Committee at the meeting in common. Members were interested in changes to the optimisation of the BRI Acute Fracture Clinic and noted that the assessment of fractures after the initial operation could now be managed at home, resulting in reduced clinic waiting times for those that do not have to return to hospital. Information was received on the reSPECT process involving the collaboration of 6 Trusts, noting that this involved person-centred decision making in emergency situations and at the end of life. Members wished to ensure medicine allocation procedures were stringent and effective. Information on learning and development for staff was noted. Assurances were sought and given that appropriate business continuity plans are in place as part of the move to electronic patient records.

In addition, the Committee engaged with the Trust at a meeting in common with the Bristol People Scrutiny Commission on 30th January 2018. UH Bristol's Chief Executive attended to update Members on the Trust's actions in response to the 'Independent Review of Children's Cardiac Services in Bristol'; and the 'Independent investigation into the management response to allegations about staff behaviours related to the death of a baby at Bristol Children's Hospital'. The South Glos Health Scrutiny Committee was satisfied that the review of services had been conducted thoroughly and in great depth by the CQC and through the independent specialist investigation by Verita. Members were satisfied that families had taken part in the review process. They noted the progress in implementing the recommendations identified by the Trust and noted that many of them had been completed and were already part of standard practice. The Committee expressed every sympathy with the family and wished to be kept informed of progress following the outcome of on-going litigation, professional review by the GMC and an independent investigation by the PHSO. A further meeting in common was requested, to reconvene in 12 months' time.

Councillor Marian Gilpin, Chair
Councillor Sue Hope, Lead Member
Councillor Ian Scott, Lead Member

f) Statement from North Somerset Health Overview and Scrutiny Panel (QA Sub Committee) Response to United Hospitals Bristol Trust QA

Overall the Health Overview and Scrutiny Panel were very encouraged by the closer relationship with Weston General Hospital.

It was noted that the Trust seeks to build on earlier programmes and there is a case for more opportunities to work together to support innovation and improvement. The Panel would like to know more about how this it to be implemented.

The Panel were particularly encouraged by the 97% positive experience of care as indicated by the feedback forms from patients and their friends and families but would be interested to hear the reasons for dissatisfaction.

In conclusion, the Panel felt that the Trust had made good progress against its 2017/18 priorities and that the priority areas identified for 2018/19 were appropriately targeted.

Roz Willis
Chairman, Health Overview & Scrutiny Panel
North Somerset Council

2 May 2018

g) Statement from Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Report 2017/18 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes UH Bristol's quality account, which provides a comprehensive reflection on the quality performance during 2017/18. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

BNSSG CCG noted that of the eight quality objectives for 2017/18 four were fully achieved and three partially achieved though noting significant progress in elements within these three. The CCG acknowledges the work put in place for these objectives and is pleased to note the plans to continue this work for most of the objectives into 2018/19. The CCG supports the chosen areas for quality improvement for 2018/19, especially the inclusion of an objective that works across primary care to improve patient safety and experience. However we would question why the objectives to reduce late cancellation of operations, which was not achieved in 2017/18, is not being taken forward for 2018/19.

BNSSG CCG commends the excellent quality improvement work relating to the 'Sign up to Safety' programme of work, including recognition and management of the deteriorating patients, embedding a patient safety culture and medicines safety. UH Bristol's partnership working as demonstrated through the trust's engagement with the West of England Academic Health Science Network's (AHSN) Patient Safety Collaboratives is also noteworthy.

Within the quality account UH Bristol have demonstrated continued good progress in reducing the number of inpatient falls, pressure ulcers and sustaining compliance with VTE assessments against the national target, all of which are to be commended. The CCG also acknowledges the continued work in the early identification and management of sepsis and welcomes the continued focus on sepsis for 2018/19. The trust achieved compliance with the C Difficile target, however, as noted in the 2016/17 statement by Bristol CCG, BNSSG CCG again would have welcomed more detail on the management of healthcare associated infections particularly in relation to the MRSA blood stream infections performance this year and the trust's plans to improve on this for 2018/19. The CCG also notes there is minimal analysis regarding the fractured neck of femur poor performance as this has not improved over the year. The high number of reported Never Events during 2017/18 was also noted, and the CCG supports the plans to learn from these to prevent further occurrences.

BNSSG CCG commends the excellent performance regarding the NHS inpatient survey and CQC patient survey results and notes the ongoing patient experience work within the Trust, acknowledging the significant amount of positive feedback that is received from service-users. The CCG is aware that patient stories are regularly presented to the Trust Board and would encourage

the Trust to include these in the annual Quality Account to highlight the patient experience work.

UH Bristol's performance against the quality improvement and innovation goals (CQUINs) is noted and the high level of achievement is acknowledged and commended.

BNSSG CCG is aware of the considerable work undertaken by UH Bristol during 2016/17 and 2017/18 to action the outcomes and recommendations from the Independent Review of Children's Cardiac Services, however we would like to have seen this referenced in this year's Quality Account noting the improvements made as a result.

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

- Closer working with primary care and community partners to help support the reduction in incidences of healthcare associated infections, namely MRSA, C Difficile Infection, and E coli bacteraemias.
- Improvement in performance against the best practice tariff for patients who have sustained a fractured neck of Femur.
- Focused work to review themes and embed learning arising from Serious Incidents and Never Events to improve patient safety.

BNSSG CCG acknowledges the good work within the Trust and the quality account clearly demonstrates this. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust in 2018/19 to deliver those improvements.

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.

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. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2017 to March 2018
  - papers relating to Quality reported to the board over the period April 2017 to March 2018
  - feedback from commissioners received 16/5/2018
  - feedback from governors received 9/5/2018
  - feedback from local Healthwatch organisations received 9/5/2018 and 10/5/2018
  - feedback from Overview and Scrutiny Committees received 14/5/2017 and 16/5/2017
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[18]
  - the 2016 national patient survey published 31/5/2017[19]
  - the 2017 national staff survey published 6/3/2018
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 24 May 2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and 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.

Jeff Farrar, Chairman
26 May 2018

Robert Woolley, Chief executive
26 May 2018

[18] This report is due to be received by the board later in 2018
[19] The 2017 survey results have not yet been published

D APPENDIX D External audit opinion

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

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

Scope and subject matter
The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement ("NHSI")):

Specified indicators	Specified indicators criteria
Percentage of incomplete pathways within 18 weeks for patients with incomplete pathways at the end of the reporting period	See Appendix B to the Quality Report, page 74
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	See Appendix B to the Quality Report, page 74

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by NHSI.

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

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the financial year, April 2017 and up to the date of signing this limited assurance report (the period);
- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report (the period);
- Feedback from the Commissioners Bristol, North Somerset and South Gloucestershire CCG dated 16 May 2018;
- Feedback from Governors dated 9 May 2018;

- Feedback from Local Healthwatch organisations Healthwatch North Somerset dated 9 May 2018 and Healthwatch Bristol and Healthwatch South Gloucestershire dated 8 May 2018;
- Feedback from Overview and Scrutiny Committee dated 16 May 2018;
- The 2016 national and local patient survey dated 31 May 2018;
- The 2016 national and local staff survey dated 26 April 2018;
- Care Quality Commission inspection, dated 2 March 2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16 May 2018.

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

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

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

Use and distribution of the report
This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

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

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

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

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

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

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

Basis for Disclaimer of Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
The 18 week indicator is calculated each month based on a snapshot of incomplete pathways. In our testing we found two instances of a patient being included in monthly reporting which did not meet the inclusion criteria and three cases where patients were not included in an applicable month in error. Additionally, for three pathways tested, no evidence was found of the relevant clock start date.

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

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

Based on the results of our procedures, nothing else has come to our attention that causes us to believe that for the year ended 31 March 2018,

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator has not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

PricewaterhouseCoopers LLP
Bristol
29 May 2018

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