NHS

University Hospitals Bristol
NHS Foundation Trust

Quality Report 2018/19

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents

1.1 Statement on quality from the chief executive

Welcome to this, our 11th 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 important way 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 Trust's performance during the last year, its successes and the challenges we face.

Quality is our key consideration when planning and delivering patient services at University Hospitals Bristol; it is what matters most to the people who use our hospitals and what motivates and unites everyone who works for the Trust. Our renewed Trust Strategy "Embracing Change, Proud to Care - Our 2025 Vision", launched in May 2019, makes clear our continued commitment to improving the quality of our care and maintaining our outstanding clinical services, whilst working smarter to maximise finite resources. The Trust's Board and Senior Leadership Team have a critical role in leading a culture of learning which promotes the delivery of high quality services; this requires both vision and action to ensure all of our efforts are focussed on creating an environment which enables and encourages continuous learning and improvement. As I write to you, we are in the middle of our latest inspection by the Care Quality Commission. We understand that the CQC's report about our services will be published in August.

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 pleased to introduce the University Hospitals Bristol NHS Foundation Trust Quality Report for 2018/19. The report shows how we have continued to deliver high quality care that is:

- safe, where people are protected from avoidable harm and abuse and when mistakes occur, lessons are learned
- effective, where the treatment and care people receive achieves the consistently excellent outcomes, promotes quality of life, and is based on the best available evidence
- caring, where patients are treated with compassion, dignity and respect, and are equal partners in their care
- equitable, where patients receive high quality care regardless of their gender, race, disability, age, sexual orientation and religion.

We have strong foundations to build on but there is also much more for all of us to do; we are proud to work within a team that is constantly striving to improve quality.

Carolyn Mills
Chief nurse

William Oldfield
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 2018/19

Twelve months ago, the Trust identified eight specific areas of practice where we committed to improve quality in 2018/19. A progress report is set out below, including a reminder of why we selected each theme, the improvement objective/s and an overall 'RAG' (Red/Amber/Green) rating of the extent to which we achieved each ambition. Overall, we achieved our stated quality improvement objectives in six areas and made significant progress in another. In the case of our final objective – improving the safe prescribing and use of insulin – our investigations identified a data error which had misdirected the Trust in selecting this objective.

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 marked the second 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?	During 2018/19, we wanted to 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 were four key areas of focus in 2018/19: **Customer service staff training and development** Our aim for this work stream was to support the training and development of UH Bristol staff in delivering effective customer service. We wanted to embed UH Bristol's Principles of Excellent Customer Service, which were developed in collaboration with service users, staff, governors and external experts during the first year of this quality objective, into the following training and development activities: • corporate induction • customer service training • volunteer induction • apprenticeship programme • nursing preceptorship programme. We also committed to developing and piloting an advanced customer service training module, based on a successful model developed by Sheffield Teaching Hospitals NHS Foundation Trust.

We wanted to develop a way to test our services against established best practice in customer service, which we refer to as customer service accreditation. This is an ambition in the Trust's Quality Strategy (2016-2020) and would help us recognise wards and departments in our hospitals that achieve this standard. By the end of 2018/19 our aim was to have scoped out and developed the accreditation process for piloting and formal roll-out during 2019/20 onwards.

Communications
We recognised the 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 wanted our staff and service users to see our organisation as one that's increasingly focused on delivering consistently excellent customer service. To this end, our third work stream was to develop a communications strategy. This included a further staff workshop to be held 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 by responsive, competent and friendly staff. We wanted to review the Trust's Outpatient Service Standards to incorporate the UH Bristol customer service principles. Staff recruitment and competency evaluation processes were also to be reviewed to incorporate a customer service element. Finally, to ensure that we are monitoring customer service satisfaction effectively, we committed to re-designing the Trust's outpatient satisfaction survey around key points of contact with our organisation (known as customer service "touch points").

Telecommunications
This work stream was about ensuring that people who phone the Trust receive an efficient response from our staff. In 2017/18, the Trust's Transformation Team undertook detailed analyses to identify good practice, key barriers and "hot-spots" around the Trust. In 2018/19, using this insight, the Transformation Team set out an ambition to work with ten UH Bristol departments that required specific support to enhance their telephone management.

| How did we get on? | Following the development of UH Bristol's Principles of Excellent Customer Service in the first year of this corporate quality objective (2017/18), we have been embedding the Principles into Trust recruitment, training and induction programmes, including: |

• Nursing assistant assessment centres
• Volunteer assessment centres, induction and competencies
• Corporate induction
• Customer service training
• Preceptorship programme
• Administration update days
• Relevant apprenticeship programmes
• Trust standard competency-based interview template (to commence during Quarter 1 2019)

The customer service Principles also form the basis of a new one-day training course that has been designed for Trust staff in roles involving daily transactions with service users (e.g. ward clerks, clinic coordinators). In September 2018 we piloted a training day facilitated by an external expert who developed a successful customer service training course with Sheffield Teaching Hospitals NHS Foundation Trust. Feedback from attendees was positive and we have developed a proposal for implementing this training at UH Bristol during 2019/20. We are currently seeking funding for this proposal.

We reviewed options for a customer service accreditation programme and discussed this at the staff workshops in 2018/19. We decided that the most effective approach to reach a breadth of services would be to develop a set of easy-to-use customer service resources - rather than undertake a formal accreditation programme. These resources will be housed on the Trust's intranet and aimed primarily at managers and service leads. They will set out steps to achieve consistently excellent customer service (based on our learning from national accreditation programmes and customer service experts), along with case studies and support tools. This collection of resources will be developed and promoted during 2019/20.

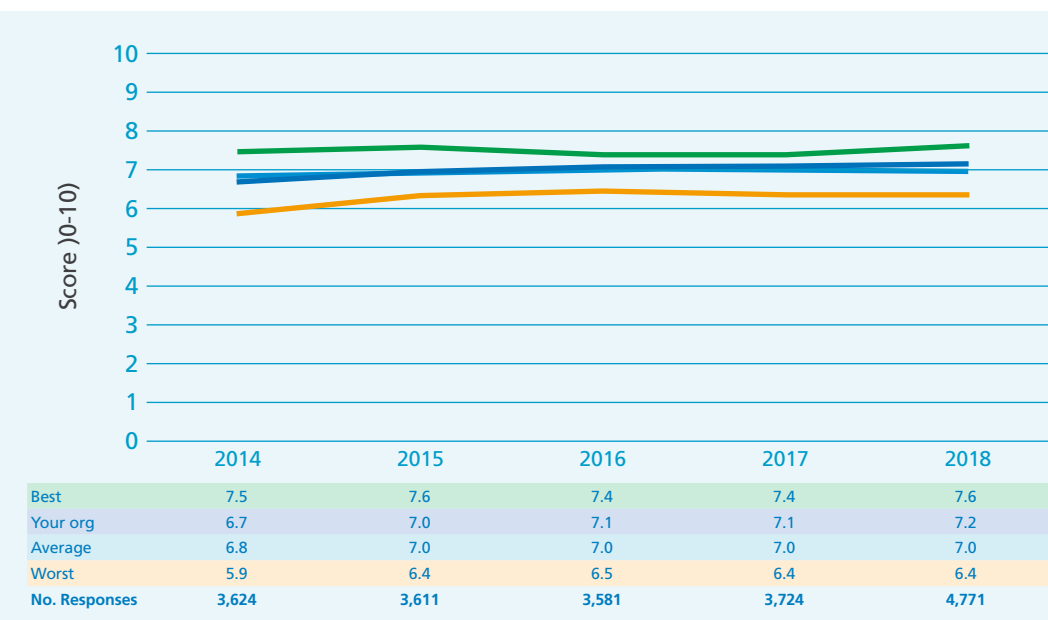|	
	To maximise the impact of this quality objective, we have worked with a professional design agency to develop promotional materials for the customer service work streams. These are an extension of the Trust's new "Here to help" imagery that was recently launched to promote patient feedback opportunities. Thus, our work streams have become our key mechanism for ensuring that we deliver on our "Here to help" promise to service users. Using the new designs, the UH Bristol Principles of Excellent Customer Service were formally launched to staff in Quarter 4 2018/19 via Trust-wide multimedia communications (internally referred to as the "Here to help" programme). To ensure our outpatient services reflect a customer service approach, we identified channels and processes to incorporate our Principles. These include outpatient standard operating procedures, audit templates and new competencies for administrative staff (which were developed in 2018 for a separate project). These changes will be complete by the end of Quarter 1 2019/20. We have also re-designed the Trust's main outpatient experience survey to better monitor key customer service experiences – from pre-appointment information through to finding the clinic and explaining what will happen next. We published our first data set from this survey in Quarter 3 and it provided a useful new way of understanding our patients' experience. This data will now build up over time to provide us with insight to monitor and improve our outpatient services. This objective has included a specific work stream to improve the Trust's responsiveness to inbound telephone calls. The strapline "#TakePhonership" was originally developed at Bristol Dental Hospital and was subsequently adopted to market the campaign across the Trust. This campaign receives regular promotion via the Trust's internal communication channels and provides staff with newly-developed good practice guides and case studies. Our Transformation Team has also directly supported areas of the Trust where call management has been a particular challenge, especially in high volume services. Between April 2018 and March 2019 our poorest performing departments received 53 per cent fewer complaints and queries about telecommunications than in the same period in 2017/18. Trust-wide, we received 32 per cent fewer complaints and queries about telecommunications in the same comparison period. We are currently developing a governance strategy to embed routine monitoring within the Trust's Clinical Divisions.
RAG rating	**Green** – We delivered the majority of our customer service project milestones for the year and have seen significant improvements in patient-reported experience of telephoning into the organisation.

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 acute trusts to work for.
What did we say we would do?	Our plans for 2018/19 included: • A bespoke leadership development programme for our 'Top' 100 leaders to 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 also said we would prioritise our efforts and interventions to improve our lower ranking scores within the NHS Staff Survey as follows: • Introduce mandatory "how to be a manager" training for new joiners and staff who are promoted into management roles. • Review the quality of non-mandatory training across the Trust. • Continue to focus on improving staff motivation through the 'Improving staff engagement plans' which are delivered at Divisional level to encourage positive cultural change. • Use 'You said… We did week' in May 2018 to focus on the topic of how we can continue to improve staff communications. Finally, we said we would 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 year on year improved staff engagement score as measured by the National Staff Survey. At the start of the year, this meant working towards a score of 7.6 by 2020 – however, as explained below, the national scoring system has changed this year.
How did we get on?	Key achievements: • A review and relaunch of our management and leadership development offer took place in January 2018; implementation has continued throughout 2018/19. The strategic approach is to influence and bring consistent leadership across the organisation by delivering a leadership and management journey that engages in the development of our managers and leaders, builds confident and competent work force, and delivers succession and stability. • The Trust ran an inaugural Executive Leadership Development programme with over 20 multi-professional leaders; the programme ran for six days over three months and has been positively evaluated. • In August 2018, the Trust mandated a management and leadership development programme for all newly appointed and promoted managers; during 2018/19, over 700 managers attended one of the available programmes. • Over 500 staff attended two events to launch the NHS long service badges as part of the NHS 70 celebrations. • The Trust ran a senior leaders workshop to further develop its Dignity at Work programme and ensure good practice is further introduced into the organisation. • The Happy App staff feedback tool was refreshed in March 2019 with an improved reporting system enabling local managers to better understand and respond to real-time feedback data (see our quality objectives for 2019/20). • Our focus on engagement work has included using 'You said… We did' weeks on a six-monthly basis to ensure staff are clear that their voice is being heard and the organisation is responding in a timely way **The 2018 NHS Staff Survey:** Overall: • This year, the National Co-ordination Centre has reframed how the survey results are presented, adopting a 0-10 scale. Our overall staff engagement score has risen 7.2, which places us in the top 20 NHS acute Trusts, which is our stated ambition (the best score by an acute Trust was 7.6).

Staff engagement

- Our score for whether staff would recommend the Trust as a place to work improved to 70.7 per cent, from 68.6 per cent in 2017; our score for whether staff would recommend a friend or relative to receive treatment provided by the organisation also improved to 84.8 per cent from 82.9 per cent in 2017.
- The number of Trust respondents to the survey also increased by 28 per cent – in itself another positive indication of staff engagement.

Staff engagement scores, calculated under the framework, for the past five years are as follows:

Source: Datix system

	2014	2015	2016	2017	2018
Best	7.5	7.6	7.4	7.4	7.6
Your org	6.7	7.0	7.1	7.1	7.2
Average	6.8	7.0	7.0	7.0	7.0
Worst	5.9	6.4	6.5	6.4	6.4
No. Responses	3,624	3,611	3,581	3,724	4,771

Quality and patient safety measures:
- 33.3 per cent of staff said that in the last month they had seen errors, near misses or incidents that could have hurt patients /service users (this compares with 28.6 per cent in 2017, and the 2018 NHS average of 30.3 per cent)
- 89.2 per cent of staff said that the Trust encourages them to report errors near misses or incidents (this compares with 88.5 per cent in 2017, and the 2018 NHS average of 88 per cent).

Equality measures:
- 24 per cent of staff said that they had experienced harassment and bullying or abuse from colleagues, which is an unchanged result compared to 2017. The comparable reported experience of BAME (Black, Asian and Minority Ethnic) staff improved slightly from 28 per cent in 2017 to at 26.5 per cent in 2018.
- 84.6 per cent of our staff said that they believed that the organisation provides equal opportunities for career progression or promotion, compared to a national average of 83.9 per cent and a Trust score of 88 per cent in 2017. The score for BAME staff was 67.5 per cent in 2018 compared to 69 per cent in 2017 (previously 77 per cent in 2016); the average score in our benchmark group in 2018 was 72 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.

And finally, in line with the commitment we made at the start of the year, we identified 'hot spots' within the Trust where staff were dissatisfied with opportunities for flexible working. We offered supportive intervention which included ensuring managers have a clear understanding of the use of the flexible working policy and that they give consideration to flexible working patterns when making workforce changes. Early signs are positive: our national survey score in 2018 imiproved to 50.2 per cent compared to 48.5 per cent in 2017.

| RAG rating | **Green** – We implemented our plan for 2018/19. Our NHS staff engagement rating has continued to improve and is above the national average for acute trusts. |

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 had 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 and a lower proportion of high volume higher performing cancer sites such as breast. The Trust had made significant improvements in performance and achieved the 85 per cent threshold in Quarter 3 of 2017/18. However, following surgical cancellations due to winter pressures and other unavoidable factors (patient choice and late referrals from other providers) performance had dropped to around 80 per cent in the final quarter of 2017/18.
What did we say we would do?	Key actions in our plan to deliver improved performance included: • 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 were: • 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 did we get on?	The Trust has achieved and exceeded the first part of the objective, with the 85 per cent standard delivered in eight months out of 12. We achieved >85 per cent against the 62 day standard for 'non-shared' patients in every quarter.
RAG rating	**Green** – We implemented our key actions and met our targets.

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.
What did we say we would do?	We said that during 2018/19 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, we planned that a programme of mystery shopping would be developed for the interview team; to have begun by the end of 2018, with an initial evaluation of the programme taking place at the end of 2018/19. We said that a second work stream would focus on exploring the potential to develop more in-depth mystery shopping, such as patients giving detailed feedback after a planned hospital appointment (with an initial focus on elective care). We recognised that this needed to be carefully scoped out with a range of stakeholders, including senior clinical leads and staff-side representatives.

How did we get on?	Working with colleagues from the Customer Services Steering Group, the Trust's outpatient services manager and staff side representatives, we co-designed a process and protocol for mystery shopping called, "My Journey." Working with Trust staff and volunteers, the "My Journey" process follows a patient journey to an outpatient setting and combines traditional mystery shopping techniques with the NHS 15 Step methodology; and, in doing so, encompasses a variety of patient and carer touch points. Part of the co-design process included testing the methodology as part of the Trust's apprenticeship programme and subsequently with the Trust's Face2Face team in the Bristol Eye Hospital and Bristol Dental Hospital. In collaboration with the Trust's Outpatient Steering Group, the "My Journey" process was launched in March 2019 with a focus on Dermatology and Cardiac outpatient departments. A review and evaluation of the process will take place in April 2019. In addition, we undertook a scoping exercise to explore how other Trusts have developed a more in-depth mystery shopping process whereby patients or carers are recruited to give detailed feedback following a real-time planned hospital appointment. This form of mystery shopping is less common in the NHS and it has become evident that developing this approach will require further detailed scoping with stakeholders. These discussions will be taken forward within the Trust's medical director's team during 2019/20.
RAG rating	**Green** – We successfully planned and launched the "My Journey" programme during the year, including the establishment of appropriate protocols; this has provided a firm foundation for us to build on in 2019/20.

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 had also reported nine Never Events in 2017/18: • One retained piece of swab following a dental procedure • One misplaced nasogastric tube • Two wrong lens implants (ophthalmology) • 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 investigate all serious incidents thoroughly; examples of learning from these Never Events were outlined in last year's annual Quality Report. In addition, we learned that a number of serious incidents were caused by human error which had occurred in situations where there was a difficulty or change in plan before or during the procedure.
What did we say we would do?	In 2018/19, we said we would: • Hold multidisciplinary summits for staff to share learning from incident themes and look for organisational improvements. • 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. • 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. • 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. • 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. • Develop additional information resources to tell patients and families about how they can help keep themselves/their loved ones safer in hospital.

Measurable target/s for 2018/19	Completion of the above agreed actions to improve learning from serious incidents and never events.
How did we get on?	• In 2018/19, there have been no invasive procedure Never Events in ophthalmology or dental services and there have been no Never Events involving midazolam and misplaced nasogastric tubes. Section 3.1 of this report provides further information regarding serious incidents and Never Events which were reported in 2018/19. • At our request, in April 2018, NHS Improvement conducted an external review of Never Events in dental services and provided some helpful insights and recommendations to support further learning. Staff at Bristol Dental Hospital (BDH) responded to these in 2018/19 by strengthening team briefs prior to an operating list, and by introducing 'time outs' prior to every clinical procedure which are protected from interruptions. BDH also have introduced human factors awareness simulation training for multi-disciplinary clinical teams and focussed on improving safety culture and engagement though a sequence of events and initiatives to support more effective communication and teamwork. • We have held three successful multi-disciplinary summits in 2018/19 (see section 3.1.5). • We have amended our root cause analysis template to include a guide to enable investigators to assess the strength of actions identified in response to learning from investigations, to encourage the development of actions likely to have the most impact. • We introduced an audit of the quality of our daily safety briefs as a vehicle for local sharing of learning from incidents and are now in the process of reviewing the results to identify best practice which can be shared with all clinical areas. We will take this continuous improvement forward in 2019/20 and beyond. • We held our third annual safety conversations week with staff across the Trust during the national Sign up to Safety campaign's "National Kitchen Table Week" in March 2019, which was well received by front line staff. We are currently collating their comments and ideas to take forward in 2019/20. • Spreading Learning from Excellence is part of the leadership and culture work stream of our patient safety improvement programme from 2019 to 2021 (see sections 3.1.1 and 3.1.5). • We sourced patient information leaflet "Making your stay with us safe"[1] and have been distributing widely to our wards and departments. These leaflets provide information to patients and families about eight simple steps they can take to help keep themselves/their loved one safe in hospital. We also have sourced a complimentary video[2] and are working with our IT department and communications team to show this on large screens in public and outpatient areas in our hospitals.
RAG rating	**Green** – We implemented our plan for the year and had no further invasive procedure Never Events in ophthalmology or dental services, and no Never Events involving midazolam and misplaced nasogastric tubes. We did, however, have other Never Events in 2018/19, which are described in Section 3.1 of this report.

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 section 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)[3], however we 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 did we say we would do?	We said we would use a multi-faceted approach to improving the confidence of junior doctors in recognising the dying patient. We said we would use a pro-forma to ask the screening question "is this patient so unwell they might die on this admission?" for all admissions through the emergency department and acute medical unit. We also planned to adapt the existing weekend sticker to ask the question "For patients at ceiling of treatment, when should a move to end of life care be considered?"
Measurable target/s for 2018/19	We said that our measure of success would 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 is in use for longer. We said we would collect baseline data in April 2018.
How did we get on?	Baseline data was collected as planned in April. Data on the use of the end of life tool is now routinely gathered for all adult deaths in the Trust, irrespective of Division, each month, for the first seven days of that month. We have used the data to plot run charts and look for trends. During the course of the year, we became aware of similar historical data, previously collected by palliative care nurses, which suggests a gradual shift in the care of dying patients, so that a smaller proportion may now be missing out on appropriate symptom relief. Between April 2016 and July 2017, 55 per cent of patients whose death was anticipated were on the end of life care tool; in the period October 2018 to February 2019, this had increased to 75 per cent.

We piloted the screening question, "is this patient so unwell they might die on this admission?" in over 150 patients admitted through the Bristol Royal Infirmary Emergency Department (ED). Use of the screening question has since continued in ED and has been extended to all admissions to Ward A300 (AMU) and A400 (OPAU). There is statistical evidence that the response to the question used on inpatient wards and in ED has been an accurate predictor of whether a patient has died.

Uptake of the weekend sticker was variable, confirmed by a snapshot audit. This is, in part, because wards continue to have stocks of old stickers to use up. There has also been variable senior input to the information that is written on the stickers. The additional end of life part of the sticker was meant to prompt a move to end of life care if required, but cannot be used by junior doctors to make judgements if they have been poorly written. We are aiming to enlist the help of a Care of the Elderly registrar to help promote the effective use of the sticker.

Other relevant progress:
• We are currently considering the use of magnets to flag up on morning board rounds any patient who has been reviewed overnight to ensure senior review in the morning; this may prompt end of life decisions based on the developments overnight.
• We have explored the use of NEWS2 stickers to flag the deteriorating patient earlier.
• As part of the 'Dying matters' project, posters are being produced to empower patients as well as clinical staff; we hope to launch these posters in May 2019.

Overall, although some progress has been made towards achieving this objective, we have been hampered by staffing issues (the project lead left the Trust and her successor later went on maternity leave). Engaging junior doctors with the project has also proved more difficult than anticipated.

We said that our measure of success would be an increase in the length of time for which the end of life care tool is used for patients. Use of the tool has increased, so that approximately 75 per cent of dying patients benefit from at least partial use of the tool, however, we need to not only sustain this change but encourage further uptake.

During 2019/20, we are working with partners in the West of England Patient Safety Collaborative to implement Recommended Summary Plan for Emergency Care and Treatment (ReSPECT[4]) which will improve advanced care planning in the future. |
| RAG rating | **Amber** – We made progress towards our goal but the project was hampered by key staff availability during the year |

[4] ReSPECT is a process that creates personalised recommendations for a person's clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person's care and treatment. ReSPECT can be complementary to a wider process of advance/anticipatory care planning

OBJECTIVE 7	To improve patients' experiences of maternity services
Rationale and past performance	Our maternity services were rated as the best in the 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 was designed to explore what improvements we needed to be making in order to return to the top of the pack in the 2019 survey and beyond.
What did we say we would 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 the birth of the child. In addition, we set out 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, we planned that the maternity department and LIAISE[5] service would replicate this event at St Michael's Hospital. • '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. We committed to holding further workshops in 2018/19 to draw in staff who had 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 therefore committed to undertaking a specific review of discharge processes in maternity services during 2018/19.
Measurable target/s for 2018/19	At the time of writing this objective, targets for the BNSSG transformation plan were in development, however a key system-wide target was for 20 per cent of all women across BNSSG to receive continuity of care by a team of midwives by March 2019. Ultimately, our goal is to return a top quartile performance in the 2019 national maternity survey.
How did we get on?	BNSSG-wide improvements: • Throughout 2018/19, the maternity service continued to work with our commissioners to deliver the Maternity Transformation Plan for BNSSG. The five BNSSG work streams are all in place in order to implement the transformation plan for Better Births. • UH Bristol has become a pilot site for continuity of care: 278 UH Bristol patients were placed on a continuity of care pathway when the pilot commenced in March 2019, contributing significantly to achievement of the over BNSSG target (28.5 per cent of women were on a continuity of care pathway in March 2019).

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

	• Paperwork to be included in the hand-held yellow notes is still being developed to enable the documentation of personalised choice for women and to encourage women to write more freely in their notes. This is currently being developed across BNSSG, Swindon, Bath, Gloucester and Salisbury maternity services. • The use of electronic discharge information between wards and community midwives has been piloted and rolled out to all bases within BNSSG. • Other work streams include the bereavement care pathway and postnatal ward experience. At St Michael's Hospital: • A central booking system is now in place for women to book their antenatal appointment (previously, women contacted their community midwife directly). • 'Patient Experience at Heart' workshops were held in January 2019 - feedback from the workshops is currently in the process of being analysed and written up. Whilst we would expect the quality improvements we have carried out this year to be reflected, later on, in the National Maternity Survey scores for 2019 (published in 2020), there was also positive news in the 2018 results: • UH Bristol's scores were particularly positive in the section of the survey relating to care during labour and birth, with a "better than national average" rating across this aggregate set of questions. There were also positive results in respect of giving women a choice of where to give birth (achieving the best score nationally) and enabling partners to stay overnight (which has been an improvement focus for the service). • No UH Bristol scores were worse than the national average.
RAG rating	**Green** – We have been closely involved in BNSSG system-wide service improvements and have implemented local service improvements over and above this. Our survey scores in the latest national maternity survey were better than the national average for patient experience during labour and birth.

OBJECTIVE 8	To improve the safe prescribing and use of Insulin
Rationale and past performance	Last year, we reported that whilst the Trust had put in place a number of measures in recent years to improve the safety of insulin prescribing and administration, this had not led to a reduction in numbers of reported insulin-related incidents. These improvements had 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 did we say we would do?	In 2018/19, we said we would: • Roll-out Medway electronic prescribing (EPMA) to adult wards (timescale was anticipated as 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 was that unintentional omission of insulin prescribing on the Acute Medical Unit (Ward A300) and Older People's Assessment Unit (Ward A400) would 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 did we get on?	The 2017/18 baseline data was determined to be 12 occurrences of omitted insulin prescriptions at medicines reconciliation, as recorded by pharmacy staff during the process of obtaining a medication history and reconciliation. Our target for 2018/19 was therefore to have no more than nine occurrences, representing a 25 percent reduction in unintentional insulin omission on admission. Patients who had insulin omitted on admission were identified electronically from Medway medicines notes, where pharmacy staff record medicines reconciliation. The number of cases identified in the period April to November 2018 was 22; this was significantly higher than anticipated, prompting an investigation to validate the findings. The investigation has identified over reporting of omitted doses of insulin. Of 12 cases reviewed to date, only two instances of actual insulin omission have occurred, with no documented harm; an assessment which is consistent with insulin incidents recorded on our Datix risk management system. Over-reporting occurred because of a flaw in data collection methodology: specifically, the use of the word 'omitted' as a search field did not distinguish between those patients whose insulin had been unintentionally omitted from the drug chart (the target data), and those patients who regularly took insulin but were currently having other treatment e.g. with intravenous insulin, so their insulin, although recorded as omitted, was actually 'held' or 'withheld' on purpose while they received an alternative treatment. The anomaly in data recording prompted the introduction of a standardised set of data definitions; this information was disseminated in December. There were no reported omitted doses of insulin on admission in the three months following the introduction of the standardised data definitions. The analysis of the target data also drew into question the validity of the baseline data that was used to set our target. The 12 reported incidences of omitted insulins at medicines reconciliation in 2017/18 have also been reviewed, and it has been verified that there were only two confirmed omitted doses of insulin on admission in that year.
RAG rating	**Not applicable.** Our investigation identified over-reporting occurred resulting from a flaw in our data collection methodology. Based on the corrected baseline data, this topic would not have been selected as a corporate quality objective. Nonetheless, the actions taken by the Trust in 2018/19 will have strengthened patient safety and reduced the likelihood of omitted insulin doses in the future.

2.1.2 Quality objectives for 2019/20

The Trust is setting eight quality objectives for 2019/20.

Two of these objectives – reducing the risk of Never Events, and improving staff engagement (this year, specifically through use of the Happy App tool) – represent a continuation of existing annual quality objectives. In addition, we have agreed six new quality objectives for 2019/20.

All of 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 2019 (an annual consultation event aimed at our Involvement Network, Trust members and governors);
- feedback from an online survey which was open to our staff, members and governors in February 2019
- review of performance against key quality performance metrics over the last year.

OBJECTIVE 1	Enabling improvements in patient safety through the use of digital technology
Rationale and past performance	In 2016, UH Bristol was selected as a 'digital exemplar' site, trialling pioneering digital technology to drive radical improvements in the care of patients. For 2019/20, we have identified three specific patient safety themes where we believe digital technology can play a vital role in improving patient safety. These themes are: **Improving the management of intravenous cannulas** Until now, intravenous cannulas have been documented on drug charts, with inspections carried out once per shift. In reality, practice has been inconsistent, with no reporting mechanism to enable visibility of those cannulas that need a check and those that are due for removal. Documenting all intravenous cannulas in our Vitals e-observation system enables this visibility. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** Performance used to be sampled as a monthly audit via the patient safety thermometer, however, implementation of the Vitals system supports a full sample of all patients in real time, highlighting patients who do not get their observations taken on time as recommended by the NEWS2 escalation plan and ensuring that there is the correct oversight of observations by registered nurses. **Improving compliance with VTE (Venous thromboembolism) assessment** Previously, VTE assessment compliance has been measured from paper records when patients are discharged; we recognise that this has not provided a true measure of VTE assessment compliance rates. Use of an electronic VTE risk assessment in Medway on admission will support a full sample survey of all patients in real time.
What will we do?	**Improving the management of intravenous cannulas** During 2019/20, we will implement the use of the electronic system Vitals to document all peripheral intravenous cannulas. By using real time data, we will improve compliance with IV line monitoring, line related infection surveillance and reduce the number of line infections. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** During 2019/20, we will work to embed the routine use of the e-observation system including improving ward managers' understanding of the ability to monitor patients' NEWS in real time and to identify any overdue observations. We will also work at divisional level and Trust level to ensure that prompt action is taken in response to any overdue observations. **Improving compliance with VTE (Venous thromboembolism) assessment** During 2019/20, we will implement and embed the use of the proposed digital tool to improve performance. We will also embed the use of dashboards and ward-view screens to highlight any patients who need a VTE assessment.

Measurable target/s for 2019/20	**Improving the management of intravenous cannulas** We will measure the number of cannulas/lines that are left in beyond the date for removal and will reduce and the number of infections related to cannulas left in beyond the time they should have been. **Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores)** We will reduce the number of incidents where adverse variations in observations have not been acted on as per Trust policy. **Improving compliance with VTE (Venous thromboembolism) assessment** We will meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment.
How progress will be monitored	Progress will be monitored by the Trust's Infection Prevention and Control Committee, and through the Divisional Review process. Improving the management of intravenous cannulas – Chief Nurse Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores) – Chief Nurse Improving compliance with VTE (Venous thromboembolism) assessment – Medical Director
Implementation lead	Improving the management of intravenous cannulas – Heads of Nursing Improving compliance with taking patient observations on time as recommended by NEWS2 (National Early Warning Scores) – Heads of Nursing Improving compliance with VTE (Venous thromboembolism) assessment –Consultant Haematologist Lead for VTE, and Chief Clinical Information Officer

OBJECTIVE 2	**Reducing the risk of Never Events**
Rationale and past performance	Never Events are defined as "serious incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers" (NHS Improvement January 2018). Recent serious incident investigations, including those conducted by the independent Healthcare Safety Investigation Branch (HSIB), have concluded that the implementation of guidance and safety recommendations does not, on its own, prevent certain Never Events because of the human elements and human interactions within the system designed to prevent them happening. In 2018/19, 496 never events were reported nationally across the NHS. There were five Never Events which were reported by UH Bristol during 2018/19: • Retained broken off tip of a central venous line guidewire (child) (August 2018) • Alleged retained vaginal swab -occurring during care by a sub-contracted third party provider (November 2018) • Wrong side nerve block for a hip procedure (December 2018) • Wrong side laparoscopic testicular surgery (child) (December 2018) • Left ovary removed during laparoscopic hysterectomy when the plan was to conserve both ovaries (March 2019)
What will we do?	We will: • Work with surgical teams / Local Safety Standards for Invasive Procedures work stream leads to identify guidance for when additional "stop checks" time outs should be called. "Stop checks" are where the team pauses and refocuses, for example reconfirming the patient, procedure and laterality if a team member changes or an unexpected event happens during a procedure.

	• Incorporate into patient safety training awareness of the impact of hierarchical behaviours on calling time outs. By hierarchical behaviours we mean behaviours that belittle or embarrass team members and juniors, leading to, for example, them not feeling able to speak up if they see something that might be about to go wrong. • Training in high risk specialties about high risk Never Events, e.g. laparoscopic procedures where laterality is relevant, to include foresight and simulation training. • Test physical barriers to proceeding with nerve blocks until 'Stop before you Block' has been completed, and implement if effective barrier identified. • Commence three year work stream to understand and reduce the frequency and impact of interruptions and distractions on human error. • Conduct a "review and check" exercise to proactively revisit and recheck implementation of patient safety alerts designed to reduce the risk of Never Events. • Conduct a "review and check" exercise to ensure Local Safety Standards for Invasive Procedures incorporate the latest local learning and HSIB investigations. • Participate in system-wide collaborative work on reducing Never Events.
Measurable target/s for 2019/20	We will judge success by the completion of the above actions.
How progress will be monitored	The 2019/20 Never Events action plan will be updated quarterly and reported to Trust's Clinical Quality Group.
Board sponsor	Medical director
Implementation lead	Head of quality (patient safety) and associate medical director for patient safety

OBJECTIVE 3	Improving the provision of information and support to meet the needs of young carers across the Trust
Rationale and past performance	Following the re-launch of UH Bristol's carers strategy in 2018, this objective sets out to re-focus and improve support provided to young carers at UH Bristol. The objective also supports a pledge made in the NHS Long Term Plan (2019) to maintain the focus on identifying and supporting carers.
What will we do?	During 2019/20, we will: • Work to identify young carers as early as possible when they are in contact with our services. • Review the information and signposting available for young carers across the Trust. • Review the information available to young carers on the Trust's website and through social media. • Re-launch carers awareness training across the organisations. • Continue to work with Bristol Young Carers' Voice support group. • Work in partnership with young carers to improve our understanding of their experiences of our services • Deliver a UH Bristol site tour for young carers from Young Carer Voice to attend. • Plan and deliver a Health Matters event on the topic of supporting carers including young carers in secondary care.
Measurable target/s for 2019/20	We will measure success by delivery of the actions listed above.
How progress will be monitored	Via quarterly reports to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Senior nurse quality and patient and public involvement lead

OBJECTIVE 4	Driving positive staff engagement through expanded use of the Happy App
Rationale and past performance	This is the fourth consecutive year that the Trust has set a quality objective relating directly to staff experience. This is because we fundamentally believe that great staff experience goes hand in hand with great patient care. One of the specific improvement goals of our Quality Strategy 2016-2020 has been to roll out the 'Happy App' to measure real-time staff experience in all clinical teams by 2020.

	Launched in the autumn of 2016, Happy App serves as an anonymous, self-reporting communication tool to collect and measure mood and morale, and to capture inter-team experience via anecdotal comments. This platform allows colleagues to voice opinions without fear of retribution and enables managers to gain insight and understanding on colleagues' behaviour, values, motives, intent, actions, frustrations, goals and desires.
What will we do?	We want to extend and improve the organisational reach, functionality and reporting capability of Happy App. Specifically, we will: • Introduce an 'Insights' text analysis tool to search keywords within any data range. This tool will enable us to generate word clouds based on five reporting categories: Emotion Lens; Employers Branding; System Themes; Benchmarking; and Improvement. • Supplement current dashboard report with longitudinal data analysis to help identify and deliver appropriate local engagement and improvement activities within each Division. • Explore additional report functionality with system provider. • Develop and deliver a communications plan to ensure high levels of awareness and engagement with Happy App across all staff groups, including targeted promotion with hard-to-reach teams. • Consult with internal stakeholders to identify and exploit opportunities to promote the Happy App and to resolve staff engagement issues raised. Evaluate the effectiveness of marketing efforts and internal advertising channels of Happy App.
Measurable target/s for 2019/20	In 2019/20, our target is to increase the number of clinical and non-clinical teams registered for Happy App by 10 per cent against a baseline which we will measure on or around 1st June 2019, i.e. three months on from our refresh of the system. We will also be monitoring moderator responses to comments as a measure of the effectiveness of the feedback process.
How progress will be monitored	Via People Committee
Board sponsor	Director of people
Implementation lead	Head of organisational development

OBJECTIVE 5	Improving the availability of information about physical access to our hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities.
Rationale and past performance	The hospitals which make up UH Bristol's main site are built on a hill and have grown and developed over the past hundred years. We receive consistent feedback that our estate can be challenging to navigate, particularly for patients and visitors with a physical disability. In January 2019, we held a 'Quality Counts' engagement event; this year, the event had an equality theme and the issue of difficult physical access for some patients/visitors was highlighted as an area that had a negative impact on patients' experience and should be improved.
What will we do?	We will improve the information that we provide to patients and visitors on how to get to the various hospital sites on the main campus and within the sites. As part of this work we will identify where we should be prioritising our resources to improve physical access to our hospitals in the future.
Measurable target/s for 2019/20	We will measure the success of this objective by the creation of: • a detailed web-based access guide for patients and the public, providing visual and descriptive information about our estate. • a 'recommendations matrix' to guide decisions about how and where we could improve access, as and when funds permit this.
How progress will be monitored	Via Patient Inclusion and Diversity Group, reporting to Patient Experience Group
Board sponsors	Chief nurse
Implementation lead	Patient experience and involvement team manager

OBJECTIVE 6	Improving patient experience through roll out of the real time outpatients initiative
Rationale and past performance	We recognise the inconvenience and stress caused to patients when there are delays to communication and booking of next steps following an outpatient clinic attendance. From a Trust operational perspective, delays in sending out the clinic letter also result in failure to meet the national seven-day clinic letter turnaround target. Missing or incorrect outcomes and delays in booking next steps increase the risk of breaching referral and treatment targets and the possibility of the patient coming to harm. The real time outpatients (RTOP) initiative is designed to allow all of the administrative tasks relating to a patient's clinic appointment to take place on the day of the visit. This means that patients will leave the clinic knowing what the next step in their treatment is, and when that will take place. It will significantly reduce waste within the system by shortening the turnaround time for clinic letter production, enabling diagnostics, follow- up and 'to come in' (TCI) dates to be booked in a more timely manner. Finally, it will enable the appointment outcome, next steps on the patient pathway, and discharge (if applicable) to be confirmed as correct, known as validation in real time. Real time outpatients has been agreed as a corporate objective for the Trust and the aim is to roll out to all specialities and Divisions by 2021. This will: • Ensure the clinic letter turnaround time meets the national seven-day target; performance in January 2019 was only 70 per cent across the Trust. Where possible letters will be dictated, checked and approved within 24 hours of the appointment. • Allow patients to have plain film X-Ray and blood tests on the same day as their appointment and book a date for complex imaging before they leave the hospital. • Ensure all outcomes are accurately recorded on the day of clinic and updated following approval of the letter, ensuring patients' next steps are booked in a timely manner. This will reduce the time spent validating missing or inaccurate outcomes, and hopefully reduce the 'Did not attend' rate in participating specialities, by improving patients' understanding of the importance of their appointment.
What will we do?	During 2019/20, we will roll out real time outpatients to a number of specialities within each division. Cardiology went 'live' in November 2018, as did Rheumatology in April 2019, whilst discussions are ongoing with Women's and Children's services, Surgery, and Diagnostics and Therapies to identify early adopters. All Divisions have signed up to the initiative and have included real time outpatients in their operating plans for 2019/20. Each Division has identified a real time outpatients champion within the management team to support the central outpatients team. Each speciality will have an implementation plan. Real time outpatients will also support further digitalisation of outpatient clinics and administrative processes. Roll out in each Division will include the following: • Ensuring that clinic letters are dictated on the same day as clinic, either after each patient or at the end of the clinic. • Ensuring there is secretarial support linked to the clinic so that the letter can be checked and ready for approval on the same day. • Approving letters between patient appointments, or soon after clinic. • Direct booking at reception of all follow-ups within six weeks. • Discharging the patient from Medway (the Trust's patient administration system) by the secretary if a discharge letter is proof-read. • Checking that any complex scans are booked on ICE (our radiology booking system) by the secretary when proof-reading the letter. • Accurately recording the outcome when the patient leaves clinic; checked by the secretary. We will also work with radiology to pilot and then formally introduce booking of radiological scans immediately following an outpatient appointment; we will begin by trialling this with adult CT scans.

Measurable target/s for 2019/20	Our targets are to: • Achieve seven day turnaround for all appropriate letters in specialities where real-time outpatients is implemented. • Improve the number of letters that are dictated checked and approved within 24 hours of the clinic appointment. • Reduce the number of letters sent out 14 days after clinic. • Reduce the number of missing outcomes (at the end of each appointment, an outcome must be recorded on the Trust patient administration system Medway; this is how the next step for the patient is booked) and the time spent by staff validating outcomes each month. • Reduce the 'Did not attend' rate for outpatient clinics.
How progress will be monitored	Via Outpatient Steering Group
Board sponsor	Deputy chief executive / chief operating officer
Implementation lead	Outpatient services manager (Trust-wide)

OBJECTIVE 7	Planning and overseeing implementation of the Medical Examiner System
Rationale and past performance	From April 2019, a national system of Medical Examiners (MEs) is being introduced to provide support for bereaved families and to improve patient safety. Overseen by a National Medical Examiner, MEs will be specifically trained independent senior doctors from any speciality. They will scrutinise all deaths that do not fall under the coroner's jurisdiction. The introduction of MEs in this Trust will support our aims for transparency and improving the experience of patients and their families at the end of life. Implementation will provide opportunity to consider further ways of improving our services. At the same time, we know that support for families in adult care is not of the same level as the wrap-around support offered in, for example, children's services.
What will we do?	During 2019/20, we will: • Work closely with local Trusts within the Academic Health Service Network to agree a standardised implementation strategy for the ME system; this will include provisions for outside office hours to take account of religious requirements for burial within a set timeframe. • Meet with interested medical staff initially as an engagement and information sharing event, but then to help shape the business plan and understand how to provide the required ME service by job planning. • Visit and learn from early implementation sites. • Ensure that the current bereavement office is suitably prepared and equipped for the introduction of MEs and Medical Examiners Officers (MEOs) to work alongside existing systems, staff and roles. • Train and prepare our existing bereavement officers in the role of MEOs via the completion of online training modules. • Consider the introduction of a bereavement survey to compliment ME conversations with families to ensure we are obtaining feedback and providing an excellent service. As part of this objective, we will also use the year to develop our understanding of what outstanding bereavement care and support looks like in the adult service setting, learning from trusts who are rated by the CQC as outstanding in this area of practice; we will also consider how learning might be applied from our own children's services.
Measurable target/s for 2019/20	By the end of the 2019/20, we will have successfully implemented the new Medical Examiners system, in partnership with local acute Trusts. We will also have completed our scoping exercise for adult bereavement care as a platform for future service improvement.
How progress will be monitored	Progress of implementation of Medical Examiners to be monitored via Clinical Quality Group. Scoping exercise in adult bereavement care to be reported via Patient Experience Group.
Board sponsor	Medical director
Implementation lead	Associate medical director for patient safety (ME implementation), chaplaincy team leader (scoping of bereavement care)

OBJECTIVE 8	Developing and implementing a training programme for Trust lay representatives to support and develop their participation in Trust groups and committees
Rationale and past performance	This objective sets out to influence and develop the practice of lay partner involvement in UH Bristol as part of a growing move in the NHS to develop the concept and practice of patient leadership. This represents a continuation of a journey which commenced in 2016 with the patient and community leadership programme, "Healthcare Change Makers", which was a collaboration between UH Bristol, North Bristol NHS Trust and Bristol Community Health, with additional input from the local Clinical Commissioning Group and Healthier Together, with facilitation provided by the Centre for Patient Leadership and The King's Fund.
What will we do?	During 2019/20, we will: • Review the process for recruiting lay representatives and use this as the basis upon which to develop a new approach to working with lay representatives in the Trust. • Map existing lay representation in steering groups and committees across the Trust. • Scope out the core features and learning objectives for a training package, drawing from the Healthcare Change Makers patient and community leadership model and other models of good practice including The King's Fund. This will include an assessment of resource implications and how such training may be accredited. • Explore opportunities to partner with other local providers so that the training is shared across organisations. • Design, deliver, evaluate and review training. • Establish an annual on-going support and development process for lay representatives in the Trust.
Measurable target/s for 2019/20	Our targets for 2019/20 are: • Delivery of a training programme to Trust lay representatives including an annual ongoing support and development process. • Creation of at least six new opportunities for lay representation in Trust groups and committees.
How progress will be monitored	Via quarterly reports to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient and public involvement lead

2.2 Statements of assurance from the Board

2.2.1 Review of services

During 2018/19, UH Bristol provided relevant health services in 70[6] specialties via five clinical divisions (Medicine; Surgery; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2018/19, 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 2018/19 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2018/19.

2.2.2 Participation in clinical audits and national confidential enquiries

For the purpose of the Quality Report/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 2018/19, 51 national clinical audits and six 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 98 per cent (50/51) national clinical audits and 100 per cent (6/6) 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 2018/19, and whether it did participate, are as follows:

Table 1

Name of audit / programme	Participated
Acute, urgent and critical care	
Sentinel Stroke National Audit programme (SSNAP)	Yes
Adult Community Acquired Pneumonia	Yes
Case Mix Programme (CMP)	Yes
Feverish Children (care in emergency departments)	Yes
Major Trauma Audit (TARN)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Emergency Laparotomy Audit (NELA)	Yes

[6] 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)

Seven Day Hospital Services	Yes
Vital Signs in Adults (care in emergency departments)	Yes
VTE risk in lower limb immobilisation (care in emergency departments)	Yes
Blood and infection	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes
Use of fresh frozen plasma and cryoprecipitate in neonates and children	Yes
Management of massive haemorrhage	Yes
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	Yes
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes
Surgical Site Infection Surveillance Service	Yes
Cancer	
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Bowel Cancer Audit (NBOCA)	Yes
National Lung Cancer Audit (NLCA)	Yes
National Oesophago-gastric Cancer (NAOGC)	Yes
National Prostate Cancer Audit (NPCA)	Yes
Elderly care	
Fracture Liaison Service Database (FLS)	Yes
National Audit of Inpatient Falls (NAIF)	Yes
National Hip Fracture Database (NHFD)	Yes
National Audit of Dementia (NAD)	Yes
National Joint Registry (NJR)	Yes
End of life care	
National Audit of Care at the End of Life (NACEL)	Yes
Heart	
Adult Cardiac Surgery (ACS)	Yes
Cardiac Rhythm Management (CRM)	Yes
Myocardial Ischaemia National Audit Project (MINAP)	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Percutaneous Coronary Interventions (PCI)	Yes
National Congenital Heart Disease (CHD)	Yes
National Heart Failure Audit (NHF)	Yes
Long term conditions	
National Asthma Audit	Yes
National COPD Audit	Yes
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes
National Diabetes Core Audit (NDA)	Yes
National Diabetes Foot Care Audit (NDFA)	Yes
National Diabetes Inpatient Audit (NaDIA)	Yes

National Pregnancy in Diabetes Audit (NDIP)	Yes
National Ophthalmology Audit (NOD)	Yes
UK Cystic Fibrosis Registry	Yes
Non-Invasive Ventilation	Yes
Inflammatory Bowel Disease programme / IBD Registry	No
Women's & Children's Health	
National Audit of Seizures and Epilepsies in Children and Young People	Yes
National Maternity and Perinatal Audit (NMPA)	Yes
National Neonatal Audit Programme (NNAP)	Yes
National Paediatric Diabetes Audit (NPDA)	Yes
Neurosurgical National Audit Programme (NNAP)	Yes
Paediatric Intensive Care (PICANet)	Yes
Confidential enquiries/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
Mental Health Clinical Outcome Review Programme	Yes
National Mortality Case Record 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 2018/19, 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 / programme	
Acute, urgent and critical care	
Sentinel Stroke National Audit programme (SSNAP)	>90% (473)
Case Mix Programme (CMP)	100% (2314)
Feverish Children (care in emergency departments)	100% (121)
Major Trauma Audit (TARN)	100% (589)
National Cardiac Arrest Audit (NCAA)	84*
National Emergency Laparotomy Audit (NELA)	>85% (131)
Seven Day Hospital Services	100% (215)
Vital Signs in Adults (care in emergency departments)	100% (173)
VTE risk in lower limb immobilisation (care in emergency departments)	100% (127)
Blood and infection	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	100%
Use of fresh frozen plasma and cryoprecipitate in neonates and children	35*
Management of massive haemorrhage	8*

Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	673*
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	100% (19)
Surgical Site Infection Surveillance Service	1413*
Cancer	
National Audit of Breast Cancer in Older People (NABCOP)	158*
National Bowel Cancer Audit (NBOCA)	>100% (235)
National Lung Cancer Audit (NLCA)	196*
National Oesophago-gastric Cancer (NOGCA)	61-70% (142)
Elderly care	
Fracture Liaison Service Database (FLS)	99% (1573)
National Hip Fracture Database (NHFD)	100% (278)
National Audit of Dementia (NAD)	100% (50/50)
National Joint Registry (NJR)	60% (33)
End of life care	
National Audit of Care at the End of Life (NACEL)	39*
Heart	
Adult Cardiac Surgery (ACS)	100% (1259)
Cardiac Rhythm Management (CRM)	100% (1419)
Myocardial Ischaemia National Audit Project (MINAP)	805*
National Audit of Percutaneous Coronary Interventions (PCI)	100% (2183)
National Congenital Heart Disease (CHD)	100% (1130)
National Heart Failure Audit (NHF)	300*
Long term conditions	
National COPD Audit	575*
National Diabetes Core Audit (NDA)	393*
National Diabetes Foot Care Audit (NDFA)	64*
National Pregnancy in Diabetes Audit (NDIP)	32*
National Ophthalmology Audit (NOD)	100% (3960)
UK Cystic Fibrosis Registry	Data unavailable
Women's & Children's Health	
National Neonatal Audit Programme (NNAP)	100% (1022)
National Paediatric Diabetes Audit (NPDA)	100% (485)
Neurosurgical National Audit Programme (NNAP)	Data unavailable
Paediatric Intensive Care (PICANet)	100% (787)
Confidential enquiries/outcome review programmes	
Child Health Clinical Outcome Review Programme	2*
Learning Disability Mortality Review Programme (LeDeR)	47% (7/15)
Maternal, Newborn and Infant Clinical Outcome Review Programme	100% (66)
Medical and Surgical Clinical Outcome Review Programme	3*
Mental Health Clinical Outcome Review Programme	Data unavailable

*   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 eight national clinical audits were reviewed by the provider in 2018/19. University Hospital Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

BTS Paediatric Pneumonia audit
Local pneumonia guidelines have been reviewed and disseminated. The team are liaising with the paediatric emergency department to establish processes to limit initial investigations to patients with severe or complicated disease, and with general paediatrics to agree thresholds for chest x-rays at follow-up.

National Neonatal Audit Programme
Changes have been made to the Badger and Phillips (electronic patient record) systems to ensure that the details of parental discussion are recorded appropriately, along with education to junior doctors to highlight the importance of these discussions.

Falls and Fragility Fracture Audit Programme: Physiotherapy Hip Fracture Sprint Audit
A Sunday physiotherapy service will be established to increase the number of patients seen on the weekend and on day one post operation.

National Audit of Inpatient Falls (NAIF)
A high risk falls medication list and cognitive assessment/delirium care plan is in development and the Trust's fall e-learning has been updated. Falls awareness week was used to highlight current issues to staff. The Trust falls steering group has agreed further work as part of the group work plan.

British Association of Dermatologists (BAD) National Clinical Audit on Bullous Pemphigoid
Baseline and monitoring checklists are to be updated to reflect the BAD guidance and clinic proformas will be developed to capture information on new and follow up patients.

National small bowel obstruction audit
A nutrition assessment is to be built into the enhanced recovery pathway for emergency laparotomy patients.

National Chronic obstructive pulmonary disease (COPD) Audit
Dedicated resource has been agreed to improve data capture and entry into the audit and the Medway clinical note has been redesigned to capture the new dataset. A new respiratory inpatient referral has been implemented on Medway to improve the referral process to respiratory nurses.

National Audit of Dementia
A new cognitive impairment care plan is being developed. This will reflect a more holistic approach to cognitive impairment and is in line with the frailty project work which is being developed. The Abby Pain Score has been relaunched and is part of the new electronic observation system and awareness of its use raised through additional trainings / board rounds / communications. The Trust dementia steering group has agreed further work as part of the group work plan.

National Clinical Audit Benchmarking (NCAB)
The Healthcare Improvement Partnership (HQIP) produce benchmarking information based on the data that trusts submit to national audits. Along with the national reports produced, this allows trusts to see how they compare to national results and those of other organisations. In 2018/19, the Trust reviewed the following benchmarking summaries:

• National Emergency Laparotomy Audit
• Intensive Care Audit
• National Bowel Cancer Audit
• National Hip Fracture Database
• National Lung Cancer Audit
• National Oesophago-Gastric Cancer Audit
• National Prostate Cancer Audit
• Paediatric Intensive Care Audit

- National Maternity and Perinatal Audit
- National Audit of Dementia

The outcome and action summaries of 241 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2018/19; 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 2018/19[7].

2.2.3 Participation in clinical research

UH Bristol is a top-20 research-intensive teaching hospital, working closely with its partner universities. Its mission is to improve the health of the people we serve by delivering exceptional care, teaching and research every day. In pursuit of improving the care the NHS provides, we strive to offer patients the opportunity to take part in research routinely.

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 10,236. This compares with 6,925 in 2017/18.

As of 31 March 2019, the Trust had 746 active studies, 37 of which are sponsored by UH Bristol. At the equivalent point 12 months before, the Trust had 730 active studies. Our sponsored research includes trials of investigational medicinal products, investigational devices and surgical interventions.

In a snapshot taken on 31 March 2019, the number of research studies and recruited participants were as follows (March 2018 comparator in brackets):

Table 3

Number of active non-commercial (portfolio) studies	498 (480)
Number of active non-commercial (non-portfolio) studies	122 (112)
Commercial studies registered	143 (138)
Number of recruits in portfolio non-commercial trials	8,370 (5,640)
Number of recruits in non-portfolio non-commercial trials	1,565 (1,001)
Number of recruits in commercial trials	301 (284)

We have continued to develop our relationships with the National Institute for Health Research (NIHR) Local Clinical Research Network (LCRN) core team and partner organisations. With new leadership in the LCRN there has been renewed focus on performance in delivering portfolio research, including increasing the number of participants recruited to research. This financial year, by early March we had recruited well over 8,000 participants, a 25 per cent increase over last year. This has been achieved through a huge effort by our research teams across the Trust. In particular, we saw very high recruitment in paediatric immunology, cardiac surgery, dementia research, and as part of the 100,000 genomes study. Research improves the care we provide and our aim is for research to be consistently embedded across all our clinical divisions.

We continue to work closely with industry partners and strive to increase our contract commercial activity, as this brings novel treatments to our patients and generates income that we can use flexibly to support non-commercial research. We approved more than 50 new contract commercial studies in 2018/19, increasing our activity by a fifth over last year's figures. Our research teams successfully recruited the first UK patient to ten different contract commercial studies this year, a significant achievement in an environment where we are measured on our set-up times and time to recruit participants. One of those patients was the first in Europe to be recruited to a global trial looking at immuno-therapy, specifically LN-145 from Iovance, which works by attacking cancer cells directly through the patient's own immune system to effectively fight the cancer. LN-145 is made from the patient's own cells, referred to as tumour-infiltrating lymphocytes or TIL. The Trust has recruited five patients and is currently the joint top recruiter in Europe for this global study. We have a second trial with LN-145 looking at a different group of cancer patients currently in set-up.

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

We also completed recruitment to our first commercial trial in adult immunology, surpassing our target of 50 and recruiting 65 participants into the CONSTANT Hepatitis B vaccine trial, which our Medical Research Team is still carrying out.

Some of our flexible income generated last year through delivery of contract commercial research was used to 'pump prime' posts in areas identified for growth. One example is funding staff time within the Sexual Health Team which has allowed us to deliver three NIHR-adopted studies: PREP Impact, CHOP and Safe Text; for all of these we successfully exceeded our initial recruitment targets. We hope to continue to support specialties where we have potential to increase our research activity, such as sexual health, through collaboration and business planning with the LCRN.

We have recently completed the second year of our NIHR Biomedical Research Centre (BRC), which draws on the expertise of clinicians and academics to translate novel ideas into health benefits. Our five year award allows us to invest in the BRC's five programmes of research in cardiovascular disease and nutrition, diet and lifestyle, surgical innovation, reproductive and perinatal health and mental health, exploiting our local partnerships' strengths in population studies, laboratory science and patient-based research to benefit our patients and the local population.

The total value of our NIHR grant income (£8.2 million in 2018/19) continues to increase year on year, comprising the NIHR BRC, NIHR Collaborations for Leadership in Applied Health Research and Care (CLAHRC) West, 15 NIHR project or programme grants and two NIHR Fellowships.

New grants starting in 2018 have included:

- A Feasibility Study of No Routine Gastric Residual Volume measurement in mechanically ventilated Infants and Children: the GASTRIC Study.
- The development of a one-to-one fatigue self-management intervention delivered by nurses in the rheumatology team to patients with inflammatory arthritis.
- A prestigious NIHR Doctoral Fellowship: Development of an intervention to reduce distress during and after brachytherapy for locally advanced cervical cancer.
- Effectiveness and cost-effectiveness of INSPIRatory musclE training (IMT) for reducing postoperative pulmonary complications (PPC): a sham-controlled randomised controlled trial (RCT) (INSPIRE).

In 2018/19 we have worked with researchers to submit 11 grant applications for NIHR funding, and whilst not all will be successful, this is a measure of the Trust's engagement with research. Two particular highlights are:

- RAFT clinical trial, which ended in 2018.

"Reducing Arthritis Fatigue – clinical Teams using cognitive-behavioural approaches (RAFT)" was a £1.3 million grant funded by the National Institute for Health Research, and collaboration between UH Bristol, University of the West of England and University of Bristol. The study aimed to determine whether a group course delivered by rheumatology teams using cognitive-behavioural approaches could reduce the impact of fatigue in patients with rheumatoid arthritis (RA), a lifelong inflammatory condition affecting most joints, with fluctuating pain and swelling leading to joint damage and disability. The recently published conclusions from the study are that multiple measures of fatigue in patients with rheumatoid arthritis can be improved by the CBT intervention. Next steps will be to implement the practice and train clinicians across the UK.

- PReCePT2 trial, which started in 2018.

A Health Foundation Scaling up Improvement award of £457,000 was received for PReCePT2: Reducing brain injury through improving uptake of magnesium sulphate in preterm deliveries. Preterm birth is the leading cause of brain injury and Cerebral Palsy (CP) with lifelong impact on children and families. A previous clinical trial had shown that magnesium sulphate given to mothers during preterm birth is an effective treatment for protecting the babies' brain, and showing that CP can be reduced in a third of cases. However, two-thirds of UK babies were not receiving this effective and low cost treatment (approximately £1 per dose). A quality improvement package, PReCePT1, was co-designed with patients and staff and implemented

across five maternity units in West-England, increasing average uptake of magnesium sulphate from 21 per cent to 85 per cent. A Scaling up Improvement award means that PReCePT2 will be extended to 10 maternity units across the UK. The study is a 'flagship' collaboration with NIHR CLAHRC West and the NIHR West of England Academic Health Science Network aimed at maximising and evaluating adoption across the UK.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)
A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2018/19 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 was 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 was 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 2018/19 for quality improvement and innovation goals was approximately £11.85 million based on the sums agreed in the contracts (this compares to £11.05 million in 2017/18).

CQUIN was set as a two year scheme in 2016/17 however a number of schemes were removed and new schemes introduced. The following 12 CQUIN targets were agreed, with the Trust estimating to achieve 85 per cent of the £11.85m total potential income:

• supporting local areas
• 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
• preventing ill health by risky behaviours – alcohol and tobacco
• improving HCV (Hepatitis C) treatment pathways through Operational Delivery Networks
• nationally standardised dose banding for adult intravenous anticancer therapy
• optimising Palliative Chemotherapy Shared Decision making
• clinical Utilisation Review
• hospitals medicines optimisation
• 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 2018/19. The Trust was not subject to an inspection of its core services during 2018/19, having been rated as 'Outstanding' following an inspection in November 2016.

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: 99.3 per cent for admitted patient care; 99.7 per cent for outpatient care; and 97.81 per cent for accident and emergency care.
• which included the patient's valid general practice code was: 99.8 per cent for admitted patient care; 100 per cent for outpatient care and 99.8 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2018 – January 2019 as at month ten inclusion date)

University Hospitals Bristol's Information Governance Assessment report is no longer available and the system has been replaced by the "Data Security & Protection Toolkit (DSP Toolkit). The new toolkit demonstrates that the Trust is working towards the 10 National Data Guardian's data security standards as set out in the Data Security and Protection Standards for health and care. There are no longer attainment levels, instead the toolkit works on either 'standards met'

or 'standards not met'. All organisations are expected to achieve 'Standards Met' on the DSP Toolkit. With this being the first year of the DSP Toolkit Standard, NHS Foundation Trusts have been allowed to publish a DSP Toolkit if they are approaching a level of 'Standards Met' in all but a few areas. University Hospitals Bristol's toolkit publication for 2018/19 was "Standards not met". Due to this, we were required to provide an Improvement plan of how we are going to bridge the gap between our current position and meeting the DSP Toolkit 'Standards Met'. NHS Digital has reviewed and agreed this plan, and our publication is displayed as "Standards not fully met (Plan Agreed)".

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 February 2019, the Trust commissioned an External Clinical Coding Audit. The audit reviewed a total of 300 episodes from three hospital sites: St Michael's Hospital, Bristol Royal Hospital for Children and Bristol Royal Infirmary. The audit reviewed April to June 2018 data, focussing on depth of coding including comorbidities in addition to primary diagnoses and procedures. These percentages achieved meet the mandatory level of attainment for an acute trust in line with HSCIC's Data Security Standard 1. The following levels of accuracy were achieved:

• Primary diagnosis accuracy: 90.67 per cent
• Primary procedure accuracy: 90.80 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 clinical coding team have a plan in place to follow through on the recommendations from the External Audit to improve the quality of coding.

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 2018/19 (or, in some cases, latest available information which predates 2018/19) 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 4

Mandatory indicator	UH Bristol Most Recent	National average	National best	National worst	UH Bristol
Venous thromboembolism risk assessment	98.3% Apr18-Dec18	95.6%	100%	70.9%	98.4% Apr17-Mar18
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)*	13.1 Apr17-Mar18	13.2	0.0	91.0	11.6 Apr16-Mar17
Rate of patient safety incidents reported per 1,000 bed days	60.1 Oct17-Mar18	43.6	17.6	158.3	56.0 Apr17-Sep17
Percentage of patient safety incidents resulting in severe harm or death	0.35% Oct17-Mar18	0.40%	0.0%	1.55%	0.30% Apr17-Sep17
Responsiveness to inpatients' personal needs	71.2 2017/18	68.6	85.0	60.5	73.4 2016/17
Percentage of staff who would recommend the provider	85% 2018 survey	72%	95%	41%	83% 2017 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	105.0 (Band 2 "As Expected") Oct17-Sep18	100.0	69.2	126.8	105.6 (Band 2 "As Expected")
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	31.3% Oct17-Sep18	33.8%	59.5%	14.3%	29.2% Jul17-Jun18

Patient Reported Outcome Measures	UH Bristol does not carry out any procedures covered by the national PROMs programme: hip and knee replacements
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%.
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%.

* 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. "Please note that this indicator was last updated in December 2013. There is an ongoing review by NHS Digital of emergency readmissions indicators across frameworks, and it is intended that the Compendium of Population Health readmissions indicators will be updated and published in April/May 2019. As part of the update, certain elements of the existing specification will be updated to align with other frameworks (NHS Outcomes Indicator Set and CCG Outcomes Indicator set), e.g. length of time to readmission will be 30 days and mental health admissions will not be excluded.

3 Review of services in 2018/19

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.

3.1.1 Our Patient Safety Improvement Programmes

3.1.1.1 Sign up to Safety Programme 2015 to 2018
UH Bristol 'signed up to safety'[8] in 2014 by making our pledges under five national themes:

[8] Sign up to Safety was 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

Sign up to SAFETY

- 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 2015-2018 Patient Safety Improvement Programme came to an end in July 2018.

This section of our Quality Report summarises the key achievements from this programme and our patient safety improvement priorities for our next three-year programme which will run from 2019 to the end of 2021. Straddling the timeframe of both our "old" and "new" patient safety improvement programmes is our three-year Maternity and Neonatal Collaborative Health Safety Improvement Programme which commenced in April 2017.

A summary of the key safety and quality achievements of our 2015-2018 Patient Safety Improvement Programme follows.

a) Overarching aims:
We did not achieve our mortality reduction improvement goal of best (lower) quartile for English Trusts for Summary Hospital Mortality Indicator with a SHMI of 101.7 in the 12 months to December 2018 against a lower quartile of 95.3. However, we achieved, exceeded and sustained our improvement goal for adverse event rate reduction to below 3.23 per 1,000 beddays with a rate of zero since July 2017.

Figure 1

Adverse event rate per 1,000 bed days rolling average
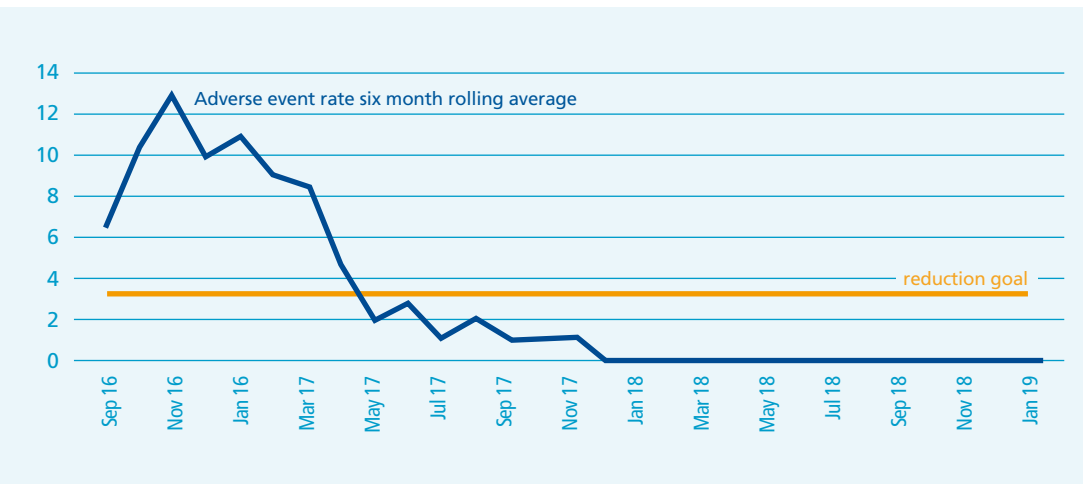
Source: Monthly Global Trigger Tool Audits

b) Improving the management of the deteriorating patient:
Assessment of a patient's physiological status, recognition of deterioration and obtaining a prompt response from a more senior healthcare professional continues to be one of the foundations of healthcare provision. Use of early warning scores calculated from measurement of physiological parameters is one of the tools used help detect underlying deterioration, even if a patient may appear relatively well.

Key achievements in 2018/19:

- While not in our original plan, the achievement of Global Digital Exemplar status for our Trust during meant that we could introduce an e-observations system. This allows patients' physiological parameters to be recorded electronically and automatically calculates an early warning score. A raised score triggers an electronic prompt for action by staff, including for the patient to be reviewed by a more senior clinician. This replaces the need for manual recording of observations on paper charts and removes the risk of miscalculation of an early warning score. We successfully completed implementation of an e-observations system in 2018/19 in adult inpatient ward areas.

- We also achieved the switch to the new National Early Warning Score (NEWS2) in October 2018, following publication of the improved NEWS2 tool by the Royal College of Physicians. NEWS2 standardises scoring adjustments for some patients with altered respiratory physiology and reduces the risk of over-oxygenation for these patients.
- We achieved and sustained our improvement goal of 95 per cent of patients having observations taken and early warning scores correctly added up. We also achieved our improvement goal of 95 per cent of deteriorating patients being escalated appropriately.

Figure 2

Early warning scores acted upon appropriately
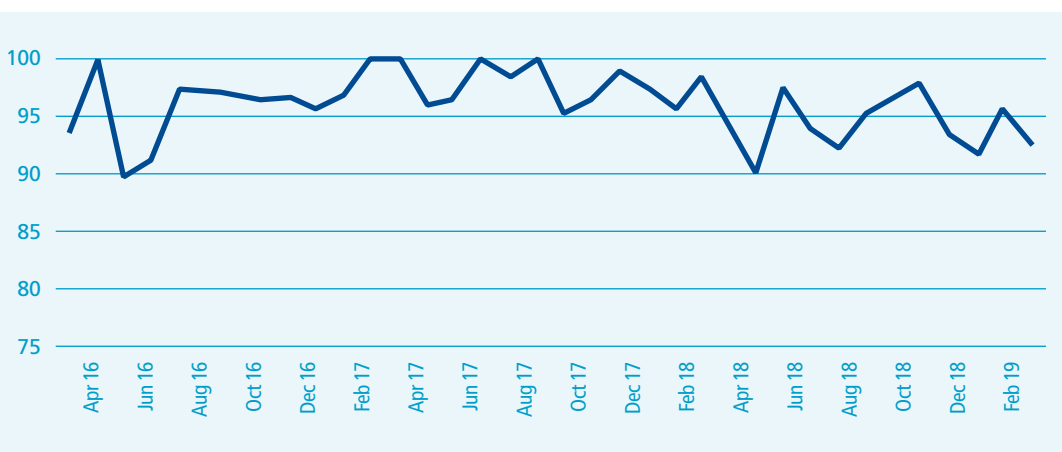
Source: Monthly Safety Thermometer Audits

- We did not consistently achieve our 95 per cent improvement goal for the use of SBAR for escalating deteriorating patients, but in our 2019-2021 programme we plan to implement a system for automatic electronic escalation of deteriorating patients.
- In 2018/19, the Bristol Royal Hospital for Children undertook significant quality improvement projects improving the care of the deteriorating child, including developing new age-specific observation charts with integral Paediatric Early Warning Scores and instigated Rapid Review Calls for deteriorating children. Our new observation charts are being implemented in children's wards across the South West region to reduce risks of miscommunicating how poorly a child is when being transferred between hospitals.
- Maternity services continued to improve use of the Maternity and Obstetrics Early Warning Score and neonatal services started work to introduce the Newborn Early Track and Trigger Tool.

c) Improving the early recognition and treatment of patients with sepsis:
"Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally, our immune system fights infection – but sometimes, for reasons we don't yet understand, it attacks our body's own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics."
UK Sepsis Trust

It is important to note that some patients with sepsis will die from organ failure despite early recognition and prompt, appropriate treatment. There is a close link between early recognition and general deterioration of patients and the early recognition and treatment of sepsis; indeed the latest evidence-based trigger for sepsis screening in adults is a raised NEWS score.

Key achievements in 2018/19:

- By the end of 2018/19, we achieved our 90 per cent improvement goals for sepsis screening, delivering antibiotics within an hour and 72 hour review of antibiotics. Screening inpatients with raised NEWS scores for sepsis has been improved by prompts from our e-observations system.
- Across the West of England Academic Health Science Network we reduced mortality in patients with suspicion of sepsis from around seven per cent to below six per cent.
- We also implemented sepsis screening and a sepsis pathway in our children's emergency department and maternity services, and we are developing inpatient sepsis pathways for children.

d) Improving medicines safety

Nationally, up to 600,000 (11 per cent) of non-elective hospital admissions are due to medicines and 20 per cent of people over 70 years old take five or more medicines. Locally, in our West of England Academic Health Science Network region, data suggests there are 10,938 admissions related to medicines (four per cent of total hospital bed capacity) with a projected annual cost of £20.6 million.

In 2018/19, we built on previous improvement work and put in place several measures to improve the quality of medicines information at handovers and transfers of care to allow accurate reconciliation of medicines at these transfers, for example:

- We introduced an electronic means of recording a patient's medication history and subsequent reconciliation with the patient's currently prescribed medication.
- We have developed a patient dashboard to allow the easy tracking of newly admitted patients who require their medication history to be checked and reconciled.
- We implemented an electronic system to refer patients with complex medicines to community pharmacies on discharge to help ensure they continued to take their medicines correctly and safely.
- We commenced implementation of an electronic prescribing and medicines administration system to standardise prescribing practice and implement safety checks.
- We achieved, exceeded and sustained our improvement goal of less than 0.75 per cent for reduction in non-purposeful omitted doses of critical medicines.

Figure 3

Percentage of non-purposeful missed doses of critical medications
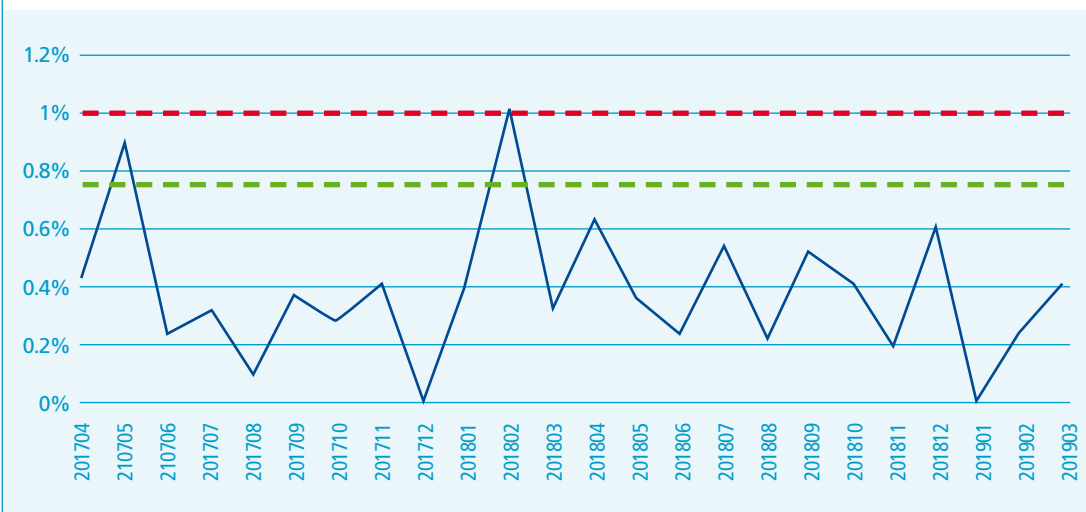
Red dotted line represents original CQUIN 2013/14 target; green line was the Trust's original stretch target

Source: Monthly UH Bristol pharmacy audit

e) Reducing peri-procedure Never Events:

- We further developed and strengthened our WHO checklists in theatres and interventional environments in response to national drivers and learning from incidents and sustained over 98 per cent improvement in their use.
- We implemented Local Safety Standards for Invasive Procedures in endoscopy and out of theatre settings such as wards, ITUs, Central Delivery Suite, and ambulatory care settings.
- Unfortunately we had a number of peri-procedure never events during the programme's lifetime therefore did not achieve our "days between" improvement goal of 365 days. Further details of never events which occurred in 2018/19 are provided in section 3.1.3.

f) Leadership for improving safety

- We did not sustain our previously achieved improvement goal of conducting at least six executive director-led patient safety walk rounds per month; we completed an average of five walk rounds per month, and those areas which did not benefit from a walk round in 2018/19 have been prioritised for early 2019/20.
- We achieved our 80 per cent improvement goal of completing actions from walk rounds within two months.

g) Maternity and Neonatal Health Safety Collaborative programme
- We achieved a reduction in term admissions to Neonatal ICU.
- We achieved a reduction in the number of babies needing neonatal input for respiratory problems, active or passive cooling and suspected hypoxic ischaemic encephalopathy.
- We achieved an improvement in the measurement of Symphysis Fundal Height to monitor babies' growth during pregnancy and support early support and intervention.

Figure 4

Term babies needing Neonatal input for respiratory problems, active or passive cooling, suspected HIE 2018-19

Source: National neonatal database (Badger) monthly UH Bristol audit. As part of the ATAIN project (avoiding term admissions into neonatal units)
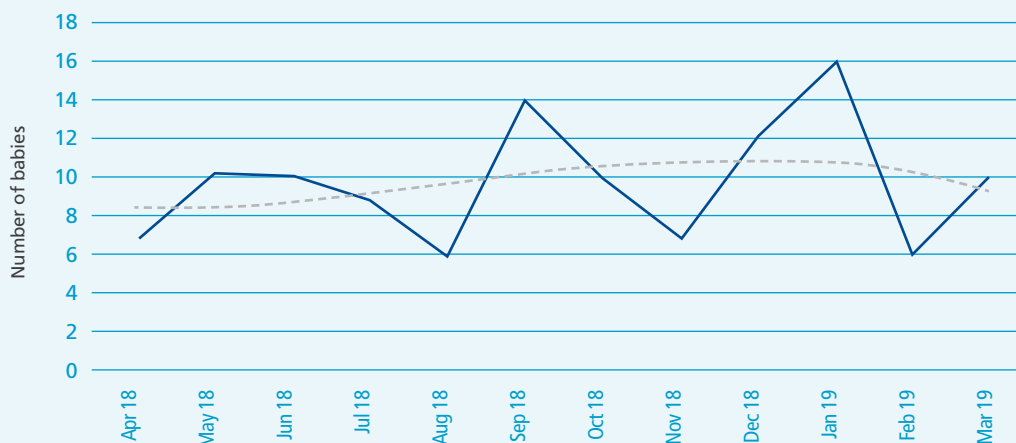
h) Developing our Safety Culture
- We held our annual "safety conversations" event as part of National Kitchen Table Week with front line staff in adults children's and maternity services as detailed in section 2.1.1.
- We also developed a system for "Learning from Excellence" as detailed in section 2.1.1.
- We sustained our upper quartile position in NHS Improvement's "acute teaching trust" peer group, indicating an open reporting culture where our staff feel able to report errors without fear of recrimination and understand the value of learning and making improvements from reported incidents.

3.1.1.2 Patient safety improvement programme 2019 to 2021
Our new patient safety improvement programme will commence in Quarter 1 of 2019/20. We set our patient safety priorities for 2019-2021 by gathering information from a number of sources in order to identify what our priorities should be the next three years. These sources included:

- A survey of staff on their top five patient safety concerns
- Analysis of reported incidents
- Analysis of serious incidents
- The Learning from Deaths process
- Claims data
- Priorities for joint working with the West of England of England Patient Safety Collaborative
- NHS Improvement national priorities
- Themes from safety conversations events which have taken place in our hospitals

We also conducted a thematic analysis of the information gathered and identified the following key themes on which to focus our improvement work for 2019 to 2021:

a) Medication safety
b) Deteriorating patient including sepsis and acute kidney injury
c) Maternity and neonatal care
d) Leadership and culture
e) Human factors elements of incidents/never events/distractions/interruptions
f) Communication particularly regarding handover and discharges and interface with IT systems

The resulting overall structure for our adults programme is shown in Figure 5 below:

Figure 5

Patient Safety Improvement Programme ADULTS
- Leadership and Culture
- Deteriorating Patients
  - Sepsis
  - Respect
- Medicines Safety Adults
- Invasive Procedures Never Events
- Interruptions & Distractions

Training & Education
Interface with digital solutions to improve Patient Safety
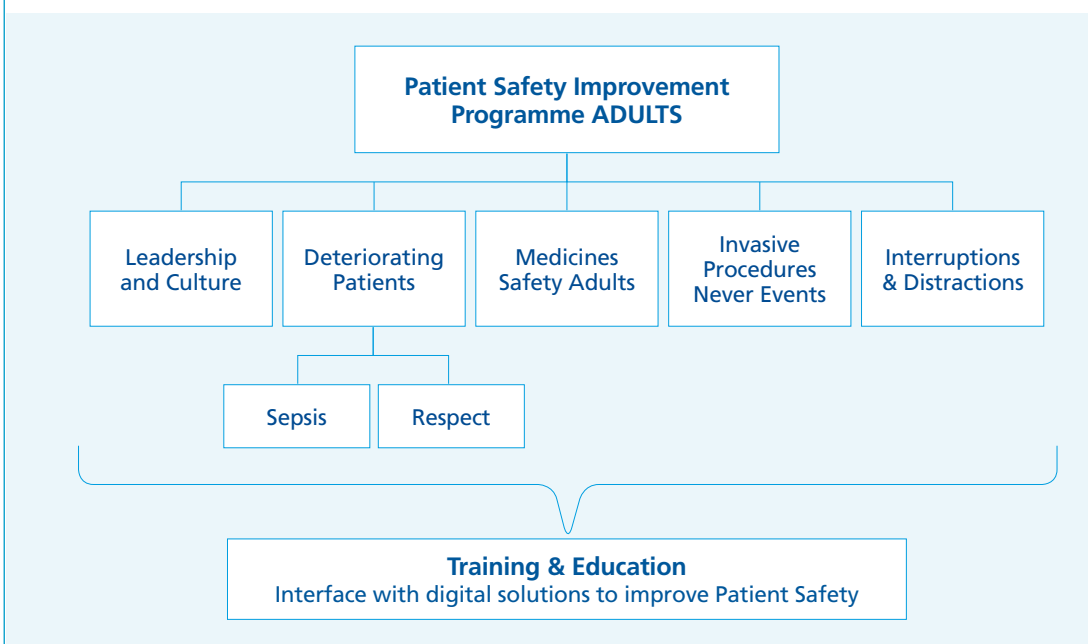
3.1.2 Freedom to Speak Up

In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS foundation trusts in England to report annually on staff who speak up (including whistle-blowers). Ahead of such legislation, NHS trusts and NHS foundation trusts have been asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment.

The Trust has appointed a Freedom to Speak Up (FTSU) Guardian to whom all staff can raise concerns. To support the work of the Guardian, over 30 Speaking Up Advocates have been recruited to help raise awareness of speaking up and to provide more local support for concerns. To date, all individuals who have raised concerns have been supported personally by the Guardian and have received feedback following the investigations into their concerns. Overall feedback has been positive in relation to whether individuals would speak up again. The Guardian also works to ensure that individuals who raise concerns do not suffer detriment as a result of speaking up and, to date, no-one has identified that they have suffered detriment. In recognising that detriment may not occur immediately after speaking up or an investigation being completed, the Guardian has committed to following up with individuals approximately three months after providing feedback in cases where there is a risk of detriment, to check that nothing has arisen.

Where there are concerns relating to patient safety, these are immediately escalated to the Medical Director and Chief Nurse to investigate and take appropriate action.

However, the Guardian in only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can assist staff:

- Bulling and harassment advisors
- Joint Union offices
- Occupational health
- Employee services
- Safeguarding team
- Patient Safety team

The key challenge is to ensure that staff are aware of the FTSU programme and the role of the Guardian. To support this:

- The Trust has used a FTSU message as a desktop background for all PCs;
- There are regular communications about Speaking Up in the weekly newsletter to all staff (Newsbeat), with case studies on each of the Advocates;
- Speaking Up is included in Trust induction for all new starters;
- There are posters and other materials around the Trust which describe what Speaking Up is; and
- The Guardian and Advocates attend meetings with staff groups to personal relay messages and ask questions about Speaking Up.

The Board and its People Committee receive a quarterly update on the FTSU programme which is delivered by the Guardian. Included in the updates are reviews to consider the learning from the National Guardian Office's case reviews of other Trusts, with learning identified for UH Bristol where appropriate.

3.1.3 Never Events
Despite the work we continue to do on preventing peri-procedure never events, there were five such Never Events reported in our Trust in 2018/19:

- Retained broken off tip of a central venous line guidewire (child) (August 2018)
- Alleged retained vaginal swab - occurring during care by a sub-contracted third party provider (November 2018)
- Wrong side nerve block for a hip procedure (December 2018)
- Wrong side laparoscopic testicular surgery (child) (December 2018)
- Left ovary removed during laparoscopic hysterectomy when the plan was to conserve both ovaries (March 19) – still under investigation.

At the time of writing, investigations have been completed for four of these cases, including one within the sub-contracted third party provider.

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

- We have strengthened our Local Safety Standard for peripherally inserted central venous catheters to more explicitly check that the guidewire is complete on removal.
- The third party provider has identified action to strengthen leadership, to enhance and adhere to their swab counting policy, to review competencies and staff roles, and to ensure staff are clear about their role and responsibilities and are not acting outside the scope of their limitations.
- A number of investigations identified distractions and interruptions as contributory factors, so we have included a work stream in our 2019-2021 Patient Safety Programme to try to understand/quantify and reduce the frequency and impact of interruptions and distractions on clinical care.
- We will identify circumstances where additional "stop checks" on top of those required as part of the WHO safety checklist could occur in surgical procedures and implement accordingly.
- We have also included embedding the "stop before you block" check designed to prevent wrong site block in our invasive procedure Never Events work stream for 2019-2021 by engendering collective responsibility, ownership and empowerment. In addition, we will investigate options for using physical aids/barriers/prompts to prevent injection before the "Stop before you block" check.

During 2018/19, a contract performance notice was service by our commissioners regarding the number of Never Events which had occurred in 2017/18 into 2018/19. A remedial action plan was developed by the Trust and the majority of actions have been completed at the time of writing. Further information about learning from serious incidents and Never Events is provided in section 3.1.5.

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 2018/19, 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 70, compared to 57 in 2017/18. Of the serious incidents reported, two were subsequently downgraded following investigation, two occurred in a service provided by a third

party provider and 15 investigations were still under way at the time of writing (April 2019). A breakdown of the categories of the 68 confirmed serious incidents is provided in Figure 6 below.

Hospital acquired grade 3 pressure ulcers, patient falls resulting in major harm and diagnostic incidents remain the most frequently reported serious incidents, despite implementing actions to reduce their number. We have renewed our focus on reducing pressure ulcers, some of which have been unavoidable, including those relating to pressure caused by essential medical devices. Our investigations have also identified that, in some cases, all possible steps to prevent a patient falling were taken, however we have relaunched an education campaign to prompt staff to make and document a mental capacity assessment when patients request to be left alone for privacy and dignity reasons and to re-iterate their risk of falling whilst unattended. We have also implemented a new pathway for communicating incidental radiology findings following a multidisciplinary safety summit involving key staff members.

From April 2018, certain maternity incidents are being independently investigated by the Healthcare Safety Investigation Branch (HSIB) as part of the National Maternity Safety Strategy published by the Secretary of State for Health. This includes cases of intrapartum stillbirth, early neonatal deaths and some incidents where severe brain injury has been diagnosed in the first seven days of life which fit the HSIB criteria.

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

Figure 6

Number of serious incidents reported in 2018/19 by type
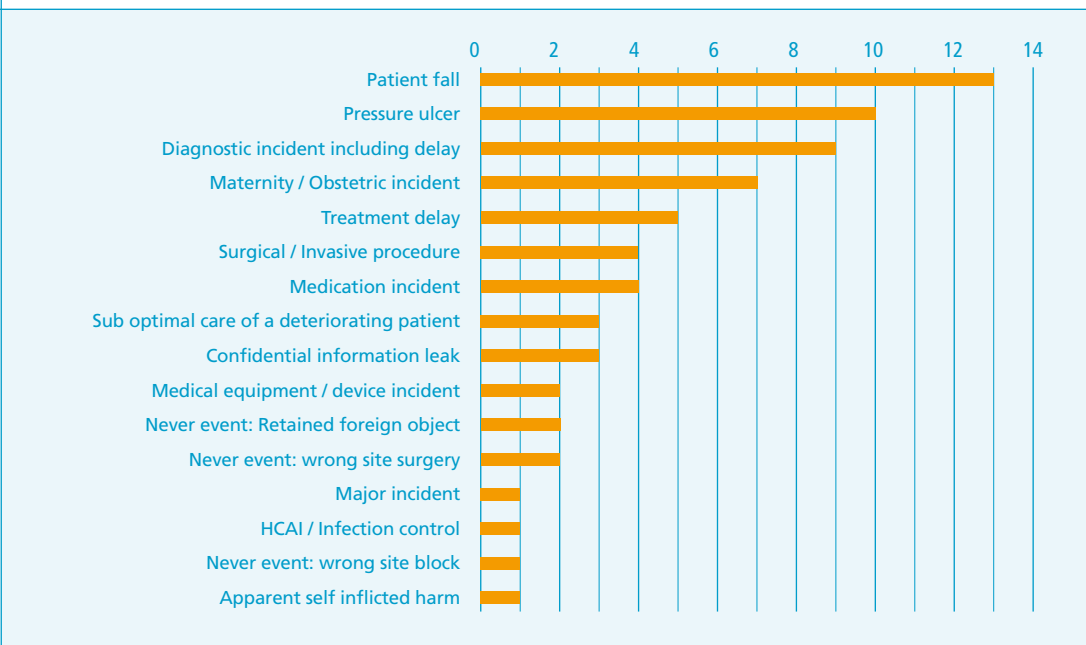
Source: UH Bristol serious incident log

3.1.5 Learning from serious incidents and Never Events

Internally, we have local and Trust-wide systems to learn from serious incidents and Never Events, including safety briefs, (Learning After Significant Event Recommendations (LASER) posters, governance and specialty meetings, clinical audit days, newsletters, and safety bulletins. We also incorporate learning from incidents into patient safety training sessions.

In line with our quality objective for 2018/19 to improve learning from serious incidents and Never Events, we introduced multidisciplinary safety summits.

We have held three successful summits in 2018/19. Topics included: prevention of invasive procedure never events (April 2018), conscious sedation, including use of midazolam (June 2018) and managing incidental radiology findings that require follow up (November 2018).

As a result, we have aligned policies for conducting the surgical count (a count of all countable items e.g. swabs, instruments and needles repeated at key points in all surgical procedures to prevent unintended retention of foreign objects) and have achieved organisation wide

agreement on the role of the named supervising consultant in theatres for doctors in training. We are also working on a set of professional standards for the supervising consultant and are undertaking a scoping exercise to improve the assessment competence of surgical trainees working with the Severn Deanery in Health Education England.
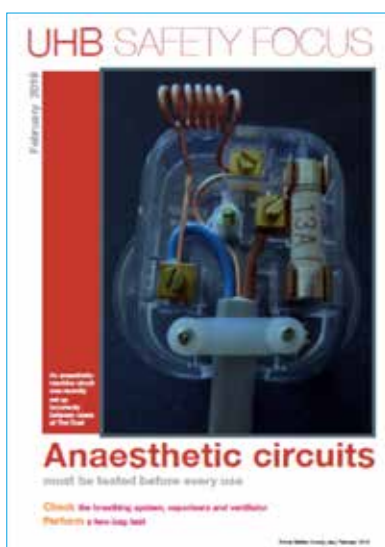
As well as completing actions in response to specific learning from the reported Never Event involving midazolam, our conscious sedation summit identified variation of requirements for competency assessment for conscious sedation among Royal Colleges, and therefore an opportunity to align practice with that considered the most comprehensive.

We have also strengthened our systems for communicating and acting on incidental radiology findings and developed a new standard operating procedure making this clear and explicit.

We have also developed and implemented a system called Greatix for staff to report 'learning from excellence'. This is currently working well in the Paediatric Intensive Care Unit, children's emergency department, adult intensive care unit and Heygroves Theatres. Advice from other organisations is to promote and encourage uptake and let it grow organically so that it becomes a locally owned and valued tool to support a positive culture of safer team working.

We have also used external opportunities to learn from other organisations. We have set up an informal network of anaesthetists nationally regarding Local Safety Standards for Invasive Procedures (LocSSIP) development and linked in with South West Patient Safety network in this regard.

We have strong links with medical Royal Colleges, including our Deputy Medical Director and Associate Medical Director for Patient Safety currently occupying key positions to influence improvement on a wider scale and bring back new initiatives into our organisation. We also have good links into Academic Health Science Networks and the Health Foundation's Q Community.

3.1.6 Duty of Candour
We continue to comply with the statutory and regulatory requirements for Duty of Candour as evidenced in each of our serious incident investigation reports. During 2018/19 we further developed electronic recording of Duty of Candour in our Datix system. This was to ensure a consistent record of evidence of compliance with Duty of Candour for all incidents that met the criteria of moderate or a higher level of harm, including those which were not designated serious incidents. After this change we sought further independent assurance that we had good compliance with Duty of Candour through an internal audit. The internal audit report concluded there was more comprehensive documentation of Duty of Candour processes for serious incidents and gave an overall satisfactory rating; recommendations were for divisions to undertake quarterly spot checks on Duty of Candour to provide more timely evidence of compliance and to ensure this is reported into their divisional boards and into corporate governance structures.

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 2018/19
The table below contains key quality metrics providing assurance to the Trust Board each month regarding the safety of the 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 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 5

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (Public Health England)	4	0	3	1	1	1	6
Number of Clostridium difficile Cases	National Infection Control data (Public Health England)	35	<=44	8	12	9	5	34
Number of MSSA Cases	Trust Infection Control system (MESS)	25	<=25	12	6	7	5	30
Hand Hygiene Audit Compliance	Monthly audit	97.6%	>=95%	97.3%	97.6%	96.8%	96.5%	97.1%
Antibiotic prescribing Compliance	Monthly audit	86.4%	>=90%	82.5%	79.6%	77.6%	73.8%	79.4%
Cleanliness Monitoring - Overall Score	Monthly audit	96%	>=95%	95%	95%	95%	96%	95%
Cleanliness Monitoring - Very High Risk Areas	Monthly audit	98%	>=98%	97%	97%	98%	98%	97%
Cleanliness Monitoring - High Risk Areas	Monthly audit	96%	>=95%	96%	95%	96%	97%	96%
Patient safety incidents, serious incidents and Never Events								
Number of Serious Incidents Reported	Local serious incident log	57	No set target	17	20	18	15	70
Number of Confirmed Serious Incidents[1]	Local serious incident log	53	No set target	17	19	11		47

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Patient safety incidents, serious incidents and Never Events								
Serious Incidents Reported Within 48 Hours	Local serious incident log	100%	100%	100%	100%	94.4%	100%	98.6%
72 Hour Report Completed Within Timescale	Local serious incident log	94.7%	100%	100%	95%	83.3%	100%	94.3%
Serious Incident Investigations Completed Within Timescale	Local serious incident log	96.2%	100%	92.9%	100%	100%	93.3%	96.8%
Total Never Events	Local serious incident log	8	0	0	1	3	1	5
Number of Patient Safety Incidents Reported	Datix	15,656	No set target	4,184	4,615	4,399	3,071	16,269
Patient Safety Incidents Per 1000 Bed days	Datix/Medway	50.86	No set target	55.92	60.81	57.33	60.76	58.52
Number of Patient Safety Incidents - Severe Harm[2]	Datix	92	No set target	29	17	21	11	78
Falls								
Falls Per 1,000 Bed days	Datix/Medway	4.59	4.8	3.93	4.85	4.46	5.16	4.55
Total Number of Patient Falls Resulting in Harm	Datix	25	<=24	7	8	5	4	24
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.162	0.4	0.134	0.277	0.495	0.317	0.306
Pressure Ulcers - Grade 2	Datix	45	No set target	8	19	33	15	75
Pressure Ulcers - Grade 3 or 4	Datix	5	0	2	2	5	1	10
Venous Thromboembolism								
Adult Inpatients who Received a VTE Risk Assessment	Medway	98.4%	>=99%	98.3%	98.5%	98.2%	98.1%	98.3%
Percentage of Adult In-patients who Received Thrombo-prophylaxis	Monthly local pharmacy audit	95%	>95%	93.8%	92.9%	91.1%	90%	92.4%
Number of Hospital Associated VTEs	Monthly local pharmacy audit	50	No set target	10	13	10	7	40

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Venous Thromboembolism								
Number of Potentially Avoidable Hospital Associated VTEs	Monthly local pharmacy audit	2	0	1	0	0	0	1
Nutrition								
Nutrition: 72 Hour Food Chart Review	Monthly local safety thermometer audit	92.1%	>=90%	92.1%	93.7%	93.1%	89.4%	92.2%
Fully and Accurately Completed Nutritional Screening within 24 Hours	Quarterly local dietetics audit	89.9%	>=90%	92.0%	90.4%	92.1%	88.9%	91.1%
WHO checklist								
WHO Surgical Checklist Compliance	Medway/Bluespier	99.7%	100%	99.7%	99.8%	99.8%	99.8%	99.8%
Medicines								
Medication Incidents Resulting in moderate or greater harm	Datix	0.55%	<0.5%	0.42%	0%	0.46%	0.77%	0.34%
Non-Purposeful Omitted Doses of the Listed Critical Medication	Monthly local pharmacy audit	0.4%	<1%	0.43%	0.4%	0.39%	0.13%	0.37%
Safety Thermometer								
Harm free care	Monthly local safety thermometer audit	97.9%	>=95.7%	97.3%	97.5%	97.4%	97.1%	97.4%
No new harms	Monthly local safety thermometer audit	98.8%	>=98.3%	98.6%	98.6%	98.3%	97.9%	98.3%
Deteriorating patient								
National Early Warning Scores (NEWS) Acted Upon	Monthly local safety thermometer audit	96%	>=95%	88.5%	86.7%	92.3%	86.3%	88.4%
Timely discharges								
Out of Hours Departures (20:00 to 07:00)	Medway PAS	8.7%	No set target	9.3%	9.7%	8.9%	7.2%	8.9%
Percentage of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	22.4%	>25%	21.5%	21.4%	21%	19.8%	21%

Quality measure	Data source	Actual 2016/17	Target 2017/18	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2017/18
Timely discharges								
Number of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	11,138	No set target	2,672	2,730	2,813	1,649	9,864
Staffing levels								
Nurse staffing fill rate combined	National Unify return	98.9%	No set target	99.2%	98.2%	99.9%	100%	99.3%

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. In 2018/19, there were a number of positive results in these surveys for UH Bristol, including:

- In the 2017 National Inpatient Survey, patients gave UH Bristol the second highest overall experience rating nationally amongst non-specialist acute trusts.
- Our 2017 National Cancer Patient Experience Survey results showed an improvement for the third consecutive year – reflecting the positive effects of the comprehensive improvement plan that we have in place after disappointing results in the survey up to 2014.
- In the 2018 National Maternity Survey, we achieved a "better than national average" rating for the experience that women have during the labour and birth of their child.

Table 6 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 7 provides an indication of UH Bristol's performance relative to the national average.

The survey results also provide us with important insights from patients about how we can continually improve our services. During 2018/19 we procured a new feedback and reporting system to allow patients, visitors and carers to provide us with feedback in real-time and raise issues or concerns. We have also carried out a range of improvement activities under the customer service corporate quality objective (see section 2.1.1) with the aim of providing a consistently excellent patient experience across our hospitals.

Table 6

Results of national patient surveys received by the Trust during 2018/19 (number of scores above, in line with, or below the national average)

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

		Comparison to national average		
	Date patients attended	Above (better)	Same	Below
2016 National Accident and Emergency Survey	September 2016	9	26	0
2017 National Cancer Survey	April-June 2017	8	40	0
2016 National Children's Survey	November to December 2016	20	43	0
2018 National Maternity Survey	February 2018	3	47	0
2017 National Inpatient Survey	July 2017	4	53	1

Figure 7

UH Bristol's hospital based patient-reported experience relative to national benchmarks
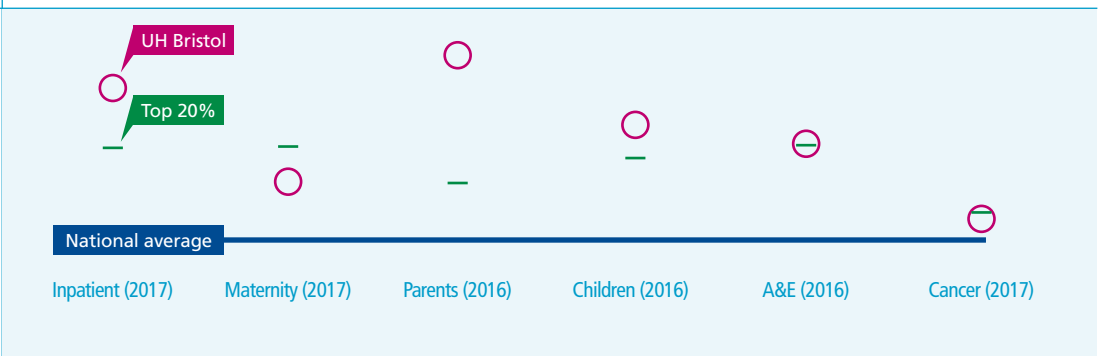
Source: UH Bristol Patient Experience and Involvement Team analysis of Care Quality Commission data

Inpatient (2017) Maternity (2017) Parents (2016) Children (2016) A&E (2016) Cancer (2017)

### 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 in our monthly postal surveys (Figure 7). Over the 2018/19 financial year, 98 per cent of inpatient and outpatient survey respondents rated the care they received at UH Bristol as excellent, very good, or good. Praise for our staff is by far the most frequent form of feedback that we receive.

Figure 8

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

— Inpatients
— Outpatients
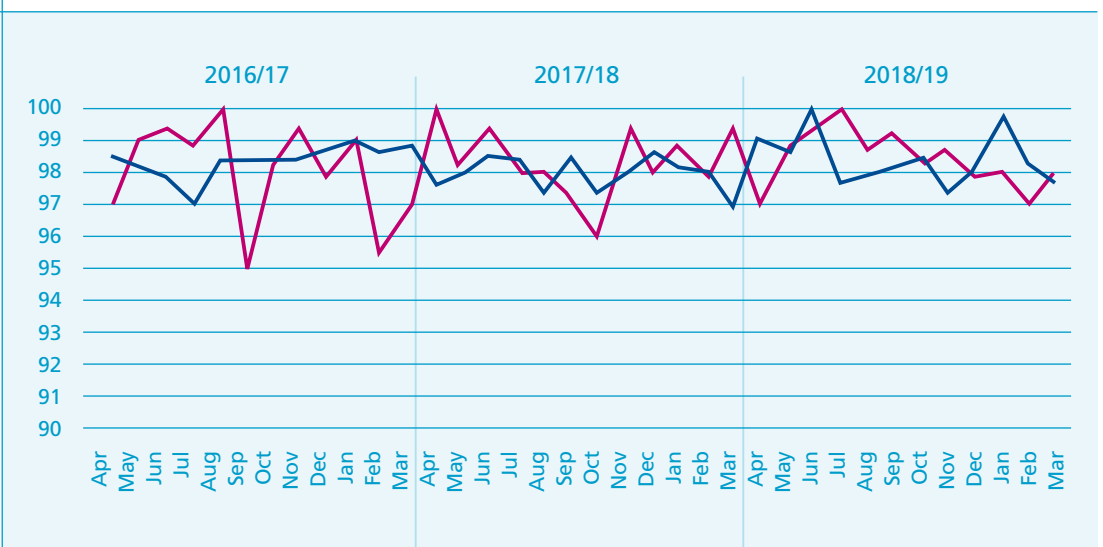
Source: UH Bristol postal survey

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.

The following are highlights from this activity in 2018/19:

• In March 2019, "My Journey" was launched (see section 2.1.2 of this report)
• In partnership with Healthwatch, North Bristol NHS Trust, Bristol Community Health and voluntary sector partners we established the Bristol Deaf Health Partnership. The Partnership allows for a single voice to ensure that we, along with other healthcare providers, respond appropriately to the needs of the deaf community and those patients who are hard of hearing.
• In collaboration with the adult Ear, Nose and Throat team and the University of Bristol, patient focus groups were held to inform the design of a novel implantable artificial larynx. Patients who had undergone the removal of their larynx and the separation of the airway from the mouth, nose and oesophagus were invited to participate.
• An analysis of demographic data from the Trust's postal survey programme suggested that people from the Sikh community were giving slightly lower hospital satisfaction ratings than people from other faith groups. Whilst this difference was not statistically significant, the Trust's Patient Experience and Involvement Team engaged with the Bristol Sikh community to explore this finding. Overall, the feedback about UH Bristol was very positive and a number of suggestions and insights have been put forward by the community.
• The UH Bristol Carers' Strategy Steering Group was re-launched in October 2018. Participants from across the Trust were joined by an NHS England lead for Carers, representatives from the Carers Support Centre, UH Bristol Governors. The re-launch included a discussion about the national context in which this work is framed and re-affirmed both the content of our existing strategy and the commitment of staff to work together to deliver its ambition. Also see section 2.2.2 of this report.
• In January 2019, thirty Foundation 2 (F2) level doctors met with a group of six patients and parent carers to discuss the importance of the relational aspects of care. This is an annual conversation jointly run by the Patient Experience and Involvement team and Clinical Fellows working in the Trust's Medical Education team, and is part of the core training and development programme for F2 doctors. There is an emerging plan to extend the initiative into the paediatric care setting.
• In partnership with Macmillan Cancer Support, a patient and carer listening event was held as part of an evaluation of the Macmillan Treatment and Therapy Service. Patient and carer involvement in the evaluation was seen as a key element in determining the success of the Service which is hosted at UH Bristol and is part of the living with and beyond cancer initiative.
• And, in partnership with the Bristol Heart Institute, patient and carer focus groups were held to explore the social and psychological impact of less invasive heart procedures on patients and their families. This was part of a larger piece of work to inform how psychological services for patients can be developed in the future.
• Along with Healthwatch Bristol, the Trusts Patient and Public Involvement Team supported an event in collaboration with the Bristol Dental School, which reviewed the current student dentist curriculum. A key outcome of this work was that interpersonal-skills will be given a renewed emphasis in the curriculum alongside clinical skills.

3.2.4 Complaints received in 2018/9

In 2018/19, 1,879 complaints were reported to the Trust Board, compared with 1,817 in 2017/18[9]. 584 (31.1 per cent) of these complaints were investigated via the formal complaints process, with the remainder addressed through informal resolution.

A total of 85.1 per cent of formal complaints were responded to within the timescale agreed with the complainant: an improvement on the 83 per cent we reported last year. 83.5 per cent of informal complaints were responded to within the timescale agreed with the complainant – this has not been reported previously but has been included for the first time as the majority of the complaints we receive are now investigated via this informal route.

Of complaints responded to via the formal process between April and December 2018, 9 per cent resulted in a dissatisfied response. This compares favourably with the 11.2 per cent recorded for

the equivalent period in 2017. Dissatisfaction with complaints responses is necessarily measured in arrears because we need to allow people time to respond; full year data will be published in our annual complaints report later in 2019.

In 2018/19, the Parliamentary and Health Service Ombudsman (PHSO) accepted 31 complaints from UH Bristol patients for investigation. At the time of writing, none of these cases have been upheld, whilst one case has been partly upheld. Summary information about cases referred to the PHSO is published by the Trust in its quarterly complaints reports.

Improvements to the complaints service in 2018/19 have included:

• Successful completion of two forms of complaints review panels. Firstly, we completed a series of panels where lay representatives retrospectively reviewed a range of complaints and shared points of learning with the lead divisions for those complaints. We also completed a series of monthly reviews of all dissatisfied complaints to determine whether or not – in our opinion – the Trust could have achieved a better outcome for all parties involved; again, we shared learning with the relevant divisions, and we will use the data from the reviews to set our board-reported target for 2019/20.
• Introduction of a new complaints survey, based on questions used by the Picker Institute.
• Delivery of complaints training to staff at all levels, Trust-wide. Sessions include 'Investigating and Responding to Complaints' and 'Handling Complaints with Confidence'. Attendance numbers have been high and feedback has been used to further improve the content and delivery of the training.

Looking ahead to 2019/20, our plans include:

• A renewed focus on achieving our 95 per cent target for timely complaints responses, including the introduction of a new Key Performance Indicator (KPI) in relation to the timely resolution of informal complaints.
• Introduction of an addition to the Datix complaints database to enable us to record the severity of complaints and use this information to inform reporting.
• A review of the Executive sign-off process for formal complaint letters in order to help improve the timeliness of responding to complaints by the deadline agreed with the complainant.
• A review of the Trust's application of NHS Regulations and PHSO guidance in respect of the '12 month rule' for investigating complaints and what exceptions should be applied, if any.

The Trust will be publishing a detailed annual complaints report, including themes and trends, later in 2019.

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

Here are some examples of positive action taken in response to complaints and patient feedback:

• In the Ultrasound Department, clerical staff have been reminded of the importance of following the correct protocol when following up a patient who has not attended their appointment.
• Cardiac Surgery Advanced Nurse Practitioners have been reminded to ensure medication is prescribed promptly on our electronic prescribing and medicines administration (EPMA) system in the event that a patient's surgery is postponed (patients may be required to temporarily stop taking certain medications prior to planned surgery).
• One of our Cardiology Consultants has updated guidelines for routinely performing stress echocardiograms before surgery.
• A training session has been delivered to staff in our Division of Surgery on the key factors to look for with regard to urine retention when looking after patients post-surgery.
• Plastic surgeons have been consulted and a local guideline developed for use in Children's Emergency Department in respect of the types of sutures to be used.
• Following an investigation into a complaint about a brain tumour being missed on an MRI scan by a radiologist, two neuro-radiologists will now always report on imaging in complex cases.
• Our Endocrinology team has developed a standard operating procedure for monitoring cortisol levels. Patients who need to have these levels monitored are now being managed at their GP practice and they receive full endocrine support during admissions to the Trust.
• To help respond to an increasing demand for capacity at the Bristol Haematology and Oncology Centre (BHOC), a dedicated room has been set aside for venepuncture, blood tests, line care and injections.

- A patient attended hospital and had an enema prior to a sigmoidoscopy, only to be told he could not have the procedure that day due to the medication he had been taking. As a result of this this complaint, the medicines policy has been recirculated to all nursing staff on the ward in question to remind staff about allergies and medication that can prevent a procedure taking place.
- In response to complaints about the main ENT (Ear Nose and Throat) reception area sometimes being closed when patients arrive for appointments, reception is now be covered during lunchtimes to ensure that patients can be booked in and directed to the correct waiting area.
- In response to survey data that suggested many patients didn't see information about how to give feedback or make a complaint during their hospital stay, we worked with a professional design agency to develop more effective messaging about these opportunities. The new posters that we developed have recently been introduced on our wards and departments. We have also starting installing touchscreen "feedback points" in our hospitals, for our service-users to give feedback and raise issues in real-time.
- The Trust ran an improvement programme focussed on reducing noise at night on our wards – which is a common theme in our patient feedback.
- We received patient feedback that boredom was a key issue for our long-stay patients at South Bristol Community Hospital. The hospital management team has recently been working with the Trust's Arts Director to explore how patients can remain engaged and mentally active during their stay. New links are also being developed with a local college to attract more students into volunteering roles at the hospital.
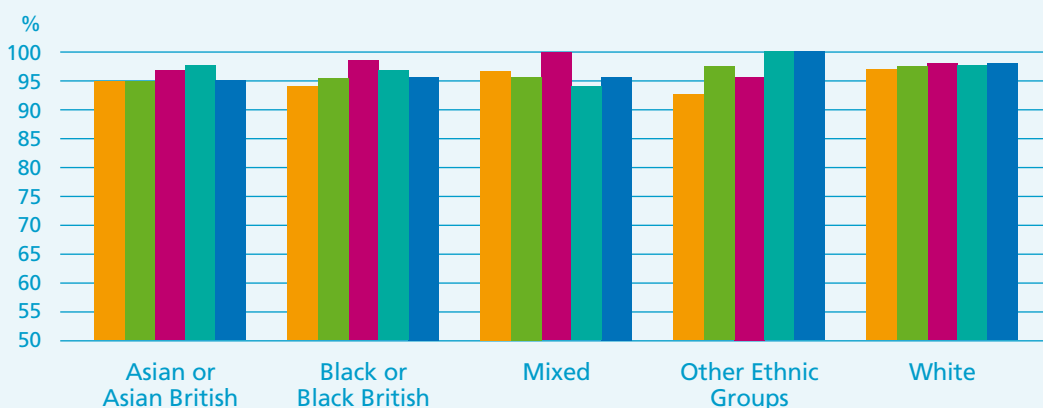
3.2.6 Equality and diversity
Figure 9 below shows results from the Trust's post-discharge patient survey according to ethnicity. This data indicates that patient experience at UH Bristol is consistently positive across different ethnic groups.

Figure 9

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

- 2014/15
- 2015/16
- 2016/17
- 2017/18
- 2018/19

UH Bristol postal survey

In January 2018, the Trust established the Patient Inclusion and Diversity Group (PIDG). This group acts as the Trust's key group in relation to all equality and diversity issues affecting patients and service users. A divisional working group of PIDG exists to bring a practical focus to the work of PIDG.

The group meets quarterly and is charged with monitoring compliance against the NHS Accessible Information Standard. This year, for example, we re-designed the relevant pages of our external website to better signpost our patients, carers and visitors to the accessible information and communication support they can receive from our Trust; in response to public feedback, we also purchased a portable hearing loop for use at UH Bristol focus groups and engagement events).

PIDG also offers oversight and assurance in respect of the development and delivery of our translating and interpreting services. For example, this year we procured British Sign Language remote video interpreting software to help ensure that we can provide an interpreter for our patients and families, should they require it.

In 2018/19, the group has pursued a particular focus on reasonable adjustments for patients, and on understanding the experiences of the transgender community when accessing our services.

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 7 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 7

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91.5	>=87	92	91	92	91	91
Kindness and Understanding	Monthly postal survey	95.5	>=90	96	96	96	97	96
Outpatient Tracker Score	Monthly postal survey	89	>=85	89	90	90	90	90
Friends and Family Test – coverage								
Inpatient Coverage	Friends and Family Test	35%	>=30%	37.2%	33.5%	34.1%	36.1%	35.1%
ED Coverage	Friends and Family Test	17.30%	>=15%	17.6%	17.2%	15.1%	15.6%	16.4%
Maternity Coverage	Friends and Family Test	19%	>=15%	14.8%	15.6%	21.6%	21.6%	18.1%
Friends and Family Test – score								
Inpatient Score	Friends and Family Test	97.7%	>=90%	97.3%	98.5%	98.5%	98.6%	98.2%
ED Score	Friends and Family Test	81%	>=70%	81.9%	82.9%	84.1%	80.7%	82.6%
Maternity Score	Friends and Family Test	96.9%	>=92%	96%	96.9%	97.6%	98.6%	97.3%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,815	No set target	446	443	463	322	1,674
Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	83%	>=95%	85.9%	86.1%	87.1%	82.9%	85.8%
Complaints Responded To Within Divisional Timeframe	Patient Support and Complaints Team	83.8%	No set target	82.2%	84.4%	87.6%	86.3%	85%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	10.68%	<5%	10.33%	8.89%	7.83%	-	9.02%

3.3 Clinical effectiveness

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

3.3.1 Understanding, measuring and reducing patient mortality

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

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

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

In figure 10, 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 2017 to June 2018 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 2017 to September 2018[10]. In this period, the Trust had 1,833 deaths compared to 1,745 expected deaths; a SHMI score of 105.

---

[10] Figure 8 is sourced from CHKS Limited and does not yet include data for the period October 2017 to September 2018

Figure 10

Summary Hospital-level
Mortality Indicator
(SHMI)

■ UH Bristol
- - Upper quartile
— Median
- - Lower quartile

Source: CHKS benchmarking
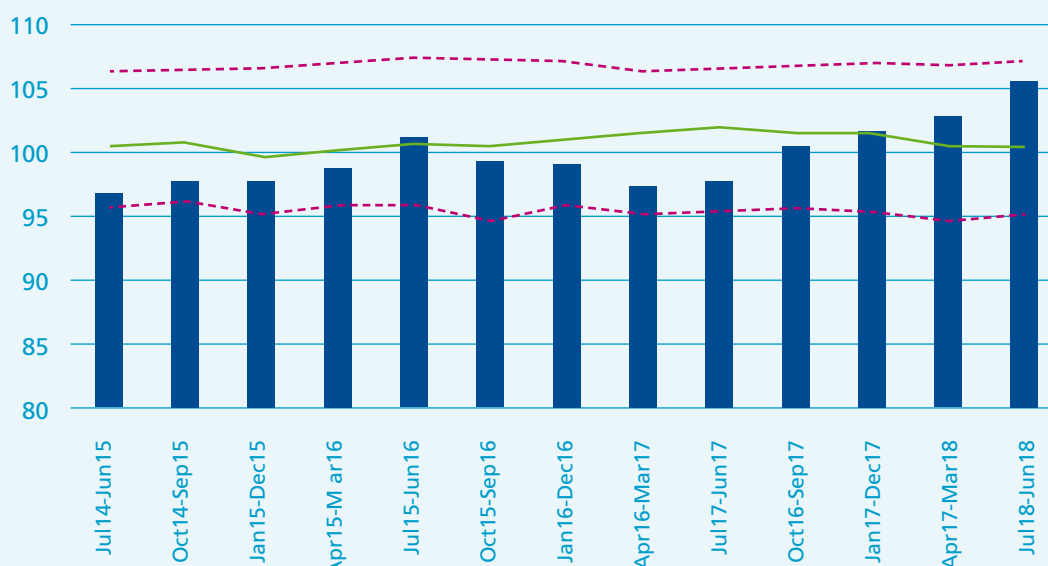
The latest HSMR data available at the time of writing is for the period January 2018 to December 2018. This shows 1,096 patient deaths at UH Bristol, compared to 1,057 expected deaths: an HSMR of 103.6

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 (local mortality review)
During the period of April 2018 to March 2019, 1325 of University Hospitals Bristol NHS Foundation Trust patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period:

• 335 in the first quarter
• 228 in the second quarter
• 332 in the third quarter
• 370 in the fourth quarter.

By 31 March 2019, 366 case record reviews and nine investigations have been carried out in relation to 1,325 deaths. In nine cases, a death was subjected to both a case record review and a formal investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

• 60 in the first quarter
• 70 in the second quarter
• 107 in the third quarter
• 129 in the fourth quarter.

Any deaths identified as potentially avoidable are referred for a second review by the medical director team. No patient's deaths were during 2018/19 were judged as more likely than not to have been due to problems in the care provided to the patient.

These numbers have been calculated from the Trust's Mortality Review Database, now fully integrated into Medway PAS (from 1 September 2018).

The major themes identified from case note reviews during 2018/19 have been:

• The need for prompt initiation of end of an end of life care pathway
• The importance of timely review by senior clinical staff.

All consultants are now expected to undertake SCNR as part of the patient safety assessment of their supporting programme activities. Involvement of the entire adult consultant body means that, although important, this process will have a minimal impact on any single individual. This process started from the beginning of December 2018, and has meant that all outstanding reviews have now been allocated to a consultant for review.

The appropriate initiation of an end-of-life care pathway was agreed as a corporate quality objective for 2018/19. Progress against this can be found in section 2.1.1 of this report. The overarching identified themes are closely aligned to those found in other Trusts in the region. The Academic Health Science Network are supporting the roll of the ReSPeCT process across the health care system, this will improve the advanced care planning in the future.

3.3.3 Clinical standards for seven day hospital services
This year, providers of acute services have been asked to include a statement regarding progress in implementing the priority clinical standards for seven day hospital services in their Quality Reports.

The seven day hospital services (7DS) programme was developed to help providers of acute services to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency. Ten 7DS clinical standards were originally developed by the NHS Services' seven days a week forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges. Four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

A board assurance model is in the process of replacing the previous bi-annual self-assessment survey, which had previously been used to measure progress against the four priority standards; through a combination of case note reviews and self-assessment.

In February 2019, the Trust declared non-compliance (i.e. standard met in <90 per cent of cases) with two of the four standards:

• Clinical Standard 2 – First consultant review within 14 hours
• Clinical Standard 8 – Ongoing consultant directed review.

Clinical standard two was met in 82 per cent of cases (78 per cent of patient admitted on a weekday and 94 per cent of patients admitted at the weekend). Clinical Standard 8 was met in 90 per cent of cases for those patient requiring a daily review (94 per cent if admitted on a weekday; 78 per cent if admitted on the weekend) and 73 per cent of cases where the patient required twice daily review (81 per cent if admitted on a weekday; 50 per cent if admitted on the weekend).

Both non-compliance issues relate to consultant provision and job planning. Funding has been identified to increase the number of consultants in acute medicine to support compliance however, to date, recruitment has been unsuccessful in spite of multiple attempts.

Further service development proposals to address the gaps in seven day coverage in other areas were discussed with commissioners through contract negotiations in 2017/18 and 2018/19, and are being reviewed during current negotiations for 2019/20. Commissioners indicated that the proposed investments were not affordable within the 2017/18 and 2018/19 planning rounds, and accepted that the Trust may not be able to meet all the standards until opportunities to improve compliance through service reconfiguration / commissioners re-prioritisation are assessed, despite the mitigation and service redesign being undertaken. We have agreed derogation of the standards in our contract with our commissioners due to the commissioner decision that plans to address these gaps in service are not affordable.

3.3.4 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 8 may therefore have changed from those published in last year's Quality Report. Values in the column "Actual 2017/18" may vary slightly from the equivalent data in our 2017/18 Quality Report due to finalisation of provisional data.

Table 8

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	100.6	<100	105.6	105	-	-	105.3
Hospital Standardised Mortality Ratio (HSMR)	CHKS	106.4	No set target	107.8	104.8	97.2	-	103.2
Re-admissions								
Emergency Readmissions Percentage		3.62%	<3.26%	3.55%	3.43%	3.36%	2.85%	3.38%
Management of Sepsis								
Percentage of Patients Meeting Criteria Screened for Sepsis (Inpatients)	Casenote review	51.1%	>=90%	95.7%	100%	100%	-	99%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Inpatients)	Casenote review	77.4%	>=90%	57.1%	100%	100%	-	75%
Sepsis Patients Percentage with a 72 Hour Review (Inpatients)	Casenote review	93.3%	>=90%	100%	100%	100%	-	100%
Percentage of Patients Meeting Criteria Screened for Sepsis (Emergency)	Casenote review	83.4%	>=90%	89.3%	98%	96%	-	94.4%
Sepsis Patients Percentage Commencing Antibiotics Within 1 Hour (Emergency)	Casenote review	85.5%	>=90%	81.1%	86.9%	86.7%	-	85.1%

Quality measure	Data source	Actual 2017/18	Target 2018/19	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2018/19
Management of Sepsis								
Sepsis Patients Percentage with a 72 Hour Review (Emergency)	Casenote review	93.1%	>=90%	94.9%	98.8%	100%	-	97.7%
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	64.20%	>=90%	64%	58.3%	59.1%	43.9%	57.9%
Patients Seeing Orthogeriatrician within 72 Hours	National Hip Fracture Database	61.60%	>=90%	97.3%	96.7%	97%	100%	97.5%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	34.80%	>=90%	54.7%	55%	56.1%	41.5%	52.9%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	62.6%	>=80%	51.6%	44.8%	53.2%	51.1%	50.4%
Percentage Spending >90% Time On Stroke Unit	Medway PAS & Radiology Information System	85.8%	>=90%	82.8%	88.5%	83.1%	80%	84%
High Risk TIA Patients Starting Treatment Within 24 Hours	Medway PAS & Radiology Information System	54.6%	>=60%	46.5%	47.5%	63.3%	65.5%	54.2%
Dementia Care								
FAIR Question 1 - Case Finding Applied	Local data collection	89.3%	>=90%	83.6%	78%	84.7%	87.3%	83.2%
FAIR Question 2 - Appropriately Assessed	Local data collection	96.2%	>=90%	92.2%	94.9%	91.8%	96.9%	93.7%
FAIR Question 3 - Referred for Follow Up	Local data collection	92.9%	>=90%	50%	100%	100%	80%	90.5%
Percentage of Dementia Carers Feeling Supported	Local data collection	60%	No target set	100%	-	-	-	100%
Ward outliers								
Bed Days Spent Outlying.	Medway PAS	9,098	<9,029	2288	1735	1857	1261	7141

3.4 Performance against national priorities and access standards

3.4.1 Overview

NHS Improvement's single oversight framework (SOF) has four patient access metrics:
- Accident and Emergency (A&E) 4-hour waiting standard
- 62 day GP cancer standard
- Referral to treatment (RTT) incomplete pathways standard
- Six week diagnostic waiting times standard.

The national standards are:
- 95per cent for A&E 4 hour waits
- 85 per cent for 62 day GP Cancer
- 92 per cent for RTT incomplete pathways
  - Additional requirement to maintain total wait list below March 2018 levels
- 99 per cent for six week diagnostic waiting times.

Provider Sustainability Fund (PSF) 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.

Performance against the 62 day cancer standard was achieved for eight months in a row and also achieved for quarters two and three overall. Referral to treatment performance consistently achieved the NHSI recovery trajectory each month and the total wait list has remained below the March 2018 level of 29,207. A&E performance achieved the improvement trajectory in quarters one, two and three. The six week wait for diagnostics has remained below the national standard but plans are in place with a trajectory to return to achieving the standard in Quarter 2 of 2019/20.

Table 9: Performance against the agreed trajectories for the four key access standards in 2018/19 during each quarter

Table 9

Access Key Performance Indicator		Quarter 1 2018/19			Quarter 2 2018/19			Quarter 3 2018/19			Quarter 4 2018/19		
		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
A&E 4-hours Standard: 95%	Actual	83.96%	91.14%	92.84%	90.26%	90.07%	85%	89.16%	84.24%	83.05%	84.5%	81.05%	81.23%
	"Trust Footprint" (Year To Date)	92.05%			91.77%			90.84%			89.84%		
	Trajectory	90%	90%	90%	90.53%	91.26%	90.84%	90.06%	90.33%	87%	84%	87%	90%
	"Trust Footprint" Trajectory	90%			90%			90%			95%		
Cancer 62-day GP Standard: 85%	Actual (Monthly)	84.1%	82.4%	86%	85.7%	88.9%	87.4%	85.5%	87.9%	86.5%	85.1%	83.5%	82.9%
	Actual (Quarterly)	84.2%			87.3%			86.6%			83.8%		
	Trajectory (Monthly)	81%	83%	79%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory (Quarterly)	82.5%			85%			85%			85%		
Referral to Treatment Standard:92%	Actual	88.2%	89.1%	88.6%	88.9%	88.7%	88.5%	89.6%	90.1%	89.3%	89.4%	89.1%	89.2%
	Trajectory	88%	88%	88.5%	88.5%	88.7%	88.5%	88.5%	88%	87%	86%	87%	87%
6-week wait diagnostic Standard:99%	Actual	96.8%	97.6%	97.8%	97.9%	97.1%	98.1%	98.4%	96.9%	93.8%	93.3%	96.9%	95.5%
	Trajectory	97.9%	97.9%	97.9%	98.4%	99%	98%	98%	98%	98%	98%	99%	99%

Legend:
- National standard achieved
- National standard not achieved, but STF trajectory achieved (with Walk In Centre uplift for A&E 4 Hour standard)
- Neither STF or national standard achieved

Note on A&E "Trust Footprint"
In agreement with NHS England and NHS Improvement, each Acute Trust was apportioned activity from Walk In Centres (WIC) and Minor Injury Units (MIU) in thier region. This apportionment is carried out and published by NHS England as "Acute Trust Footprint" data. This data is being used to assess whether a Trust achieved the recovery trajectory for each quarter. The A&E "Trust Footprint" data above relates to Trust performance after WIC and MIU data has been added.

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 standard for Referral to Treatment (RTT) is 92 per cent. During the commissioning contract period for 2017/18 and 2018/19, we agreed with our local commissioners (CCG) a month-by-month trajectory for Trust compliance during 2018/19. This trajectory was delivered across twelve consecutive months from April 2018 to March 2019.

The number of patients on our waiting list is monitored and reported on a monthly basis to NHS Improvement and NHS England. At the end of each month in 2018/19, the total waiting list size was required to remain below the March 2018 level of 29,207, for eight months of the annual year the waiting list size was below this level and at year end of March 2019 final reported 28,481 and achieved the target set.

3.4.3 Accident & Emergency four-hour maximum wait
The Trust did not meet the national 95per cent standard for the number of patients discharged, admitted or transferred within four hours of arrival in our emergency departments. For the three emergency departments:
- Bristol Royal Hospital for Children (BRHC) achieved the 95 per cent standard in five months, and achieved 93.0 per cent for the year.
- Bristol Eye Hospital (BEH) achieved the 95 per cent standard in eleven months, and achieved 97.4 per cent for the year
- Bristol Royal Infirmary (BRI) did not achieve the 95 per cent standard in any month of 2018/19, and achieved 78.4 per cent for the year.

For the financial year 2018/19, PSF improvement trajectory in place with NHS Improvement. This combined Trust data with data from local walk-in centres to give an "acute trust footprint" performance figure. This data was published by NHS England and was then used by Trusts and NHS Improvement to assess whether a Trust had achieved the trajectory.

For UH Bristol, the trajectory required the organisation to achieve 90% performance, year-to-date, at the end of each quarter. The Trust achieved this trajectory in quarters one, two and three.

	Trust Level	Footprint Level
Quarter 1 (Apr-Jun)	89.3%	92.1%
Quarter 2 (Apr-Sep)	88.9%	91.8%
Quarter 3 (Apr-Dec)	87.7%	90.8%
Quarter 4 (Apr-Mar)	86.4%	89.8%

Overall, A&E attendance levels were up 6.5 per cent in 2018/19 compared to 2017/18; a 3.5 per cent increase at BRI, 11.2 per cent increase at BRHC and 7.0 per cent at BEH. However, the proportion of patients admitted to an inpatient bed as a result of their A&E attendance remained the same at 26 per cent (35 per cent at BRI and 23 per cent at BRHC). The proportion of patients arriving by ambulance remained steady at 26 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 the emergency departments. This figure rose from 6,215 in 2017/18 to 6,988 in 2018/19, which is a 12 per cent increase.

During this financial year, the Trust has supported Weston General Hospital's (WGH) A&E service; patients who would have attend WGH's A&E from 10pm each evening have been re-directed for care to UH Bristol and other local providers. Analysis of the 2018/19 data shows:
• 153 ED additional attendances at UH Bristol, on average, per month
• 88 ED admissions, on average, per month (58% conversion rate)

The number of Delayed Transfers of Care (DToC) patients reduced this year. In 2017/18, DToC patients averaged 32 at each month-end; 2018/19 averaged 25. Total bed days lost to DToC patients fell from 11,572 to 9,344.

3.4.4 Cancer
The Trust achieved the 62-day GP referral to treatment standard in eight months during the 2018/19 financial year (June 2018 to January 2019). This is the best performance since 2012, when changes to services left the Trust with a high proportion of complex cancer and treatment types. This achievement is in the context of non-compliance with the standard at national level. February and March saw an increase in delays at other providers impacting on the Trust's position, causing non-compliance in those months despite ongoing good internal performance of 92.8 per cent for quarter four.

In May 2018, a major fire in the Bristol Haematology and Oncology Centre (BHOC) caused some treatments to be delayed, and lower compliance with the standards in Quarter one. BHOC recovered impressively from this major incident, although specialist deep cleaning following the fire took place over winter and has affected our performance in Quarter four. The minimal impact of this unprecedented event and rapid recovery from it highlight the strong processes in-place within the Trust to manage cancer pathways and ensure patients are treated promptly whenever possible.

The 31-day standard for first and subsequent cancer treatments were met in Quarters two, three and four. The two-week-wait standard for first appointment after GP suspected cancer referral was met in every quarter of the year. The Trust is preparing to submit data from April 2019 for the new standard of 28 days from referral to diagnosis or ruling out of cancer; this standard will be measured from April 2020.

The main cause of 'breaches' of the 62-day standard remains late referrals from other providers, which usually accounts for around half of all breaches of this standard and resulted in a downturn in performance in quarter 4, which the Trust is predicting will recover in quarter 1 of 2019/20. Around 30 per cent of breaches are due to cases being clinically complex or are due to patient choice, whilst approximately 20 per cent are due to operational pressures and capacity issues within the organisation; these breaches are spread across specialties and causes with no single theme accounting for breaches that are within the control of the Trust.

New national rules for allocating the performance accountability between providers were

expected in October 2018, but have been delayed until April 2019. These rules should benefit the Trust's performance by more fairly reflecting the amount of a patient's pathway each provider involved was accountable for.

3.4.5 Diagnostic waiting times
This covers the top 15 high volume diagnostic tests. The standard is that, at each month-end, 99 per cent of patients waiting for one of these tests should have been waiting under six weeks. Month-end performance varied from 93.3 per cent to 98.4 per cent across 2018/19 and the average month-end performance was 96.7 per cent.

As at end of March 2019, neurophysiology, audiology, dual-energy X ray absorptiometry (DEXA) scans and sleep studies are currently achieving the 99 per cent standard, with MRI slightly below at 98.9 per cent. Endoscopy services (gastroscopy, flexi sigmoidoscopy and colonoscopy) are at 95 per cent.

A reduction in staffing capacity through vacancies and staff absence prevented achievement of the standard for endoscopy services, non-obstetric ultrasound and echocardiographies. These services are using additional capacity through waiting list initiative sessions whilst staffing levels are restored. The services expect the standard to be achieved by quarter two 2019/20. Computed tomography (CT) services are not achieving the standard due to cardiac CT experiencing a 30% per cent growth in referrals (October-January 2018/19 compared with April-September 2018). A new CT scanner is planned for end of quarter two.

The Trust has submitted a recovery trajectory to NHS Improvement showing compliance with the 99 per cent standard by end of September 2019.

3.4.6 Outpatients
The Trust has an active programme of transformation within outpatients; this is overseen by the outpatient steering group which is sponsored by the deputy chief executive and chief operating officer.

During 2018/19, a significant validation programme was undertaken to improve patient pathways and reduce delays and to instil, on a monthly basis, active and responsive validation of all patient pathways beyond a six-month time period.

On 1 October 2018, NHS England changed the standard contract to mandate that all GP referrals must be received via e-referral service (e-RS) into consultant-led first outpatient appointments, or the Trust will not be paid for the appointment. All GP referrals to first outpatient appointments are now being received via e-RS. This enables patients to choose where and when they would like to be seen. Consultant-led first outpatient appointments accounted for £30million income to the Trust in 2018/19.

The Trust has been exploring ways to improve the outpatient experience for patients - focusing on "doing today's work, today". A real-time outpatient project was launched on 12 October 2018, which is focused on making sure that everything is done on the day of a patient's appointment where possible, rather than notes and letters being typed up in the following days. The objective is to turn clinic letters around on the day, booking follow-up appointments or diagnostics (if within six weeks) in person at reception following clinic, and performing blood tests and plain film X rays on the day.

In 2018/19, a patient journey training video was designed, which gives new staff an insight into all the steps in the patient journey from referral to treatment and then discharge. This will form part of the induction package for all new administrative staff and may be rolled out to newly-qualified clinical staff.

Performance against
national standards

Table 10

National standard	Target	2015/16	2016/17	2017/18
A&E maximum wait of 4 hours	95%	85.0%	86.5%	86.3% Ⓐ
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.4%	97.7%	95.6%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.6%	52.2%	49.3%
A&E Unplanned re-attendance within 7 days	<5%	2.6%	2.8%	3.3%
A&E Left without being seen	<5%	2.2%	1.9%	1.7%
Cancer - 2 Week wait (urgent GP referral)	93%	94.8%	94.3%	95.3%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	96.7%	95.8%	97.2%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	94.4%	92.0%	96.1%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.7%	98.6%	98.4%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	96.6%	96.3%	95.8%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	79.3%	81.7%	85.6% Ⓐ
Cancer - 62 Day Referral To Treatment (Screenings)	90%	69.4%	74.8%	66.7%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	87.9%	85.4%	83.7%
18-week Referral to treatment time (RTT) incomplete pathways	92%	91.7%	89.6%	89.0%
Number of Last Minute Cancelled Operations	<0.8%	0.98%	1.19%	1.31%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	90.8%	94.2%	93.4%
6-week diagnostic wait	99%	97.8%	98.3%	96.7%
Primary PCI - 90 Minutes Door To Balloon Time	90%	91.7%	93.2%	92.5%

🟩 Achieved for the year and each quarter	🟧 Achieved for the year, but not each quarter	🟥 Not achieved for the year
⬜ Target not in effect	Ⓐ Data subjected to external audit scrutiny as part of the process of producing this report	

A

APPENDIX A
Feedback about our Quality Report

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

This Quality Report is an annual NHS requirement for University Hospitals Bristol NHS Foundation Trust (UH Bristol) to present the public with an account of their quality and performance in providing NHS acute hospital services during the past year. In this section we, the Council of Governors, are requested to provide our opinion on whether this Quality Report provides a fair representation of their achievements.

The report clearly identifies both the Trust's successes and areas of weaker performance. Importantly, the Trust has continued to demonstrate evidence of appropriate response in reaction to public and patient concerns. The report also identifies learning from experience and taking appropriate action in investigating all serious incidents.

The Trust has performed well over the last year, even though they have the same national issues to deal with as all other NHS acute hospitals throughout the UK. These issues include budgetary constraints, staff shortages and increasing demand. There also was the fire at Bristol Haematology and Oncology Centre in May 2018, which, thanks to all staff involved, was restored to provide a quality service to patients within a very short time.

Governor involvement throughout the past year
During the year, the Governors have seen the effort that the Trust Board puts into finding out what is working and not working across the nine hospitals that make up the Trust. As elected Governors of UH Bristol, it is our duty to continuously monitor the Trust's performance on your behalf. The governors review the Trust's quality and performance at Quality Focus Group meetings held every two months, chaired by a Governor and attended by the Medical Director or the Chief Nurse, Governors, and the Non-Executive Director Chair of the Trust's Quality and Outcomes Committee. At this meeting, Governors ask questions about the quality reports and receive presentations on quality issues from other senior Trust staff. This Focus Group reports back to the full Council of Governors.

Governors also attend the Trust Board meetings held in public every two months at the Trust Headquarters in central Bristol, which any members of the public are also welcome to attend. The various reports discussed at these meetings can be obtained by the public from the Trust website before the meeting, and remain available afterwards.

The Governors question the Non-Executive Directors by meeting with them regularly and raising specific topics so that they can be examined in greater depth. Governors' questions have been answered well by the Trust, in an open and team-working atmosphere.

Governors also have the facility to raise formal questions in writing to the Board via what is referred to as "The Governors Log". During the past year, Governors have raised 20 formal questions via the Governors Log. The questions and the Trust's formal written answers are available to the public within the papers on the website associated with the public Board meetings.

The activities outlined above, along with our quarterly governor development seminars, have equipped the governors with the tools to raise questions and offer challenges about many of the quality and performance issues referred to in this Quality Report.

Priorities for Improvement
The Governors recognise that there are many activities taking place within the Trust every day, and that staff do their best to make improvements all the time. Each year, the Trust sets out a number of specific areas for improvement to focus on. For the 2018/19 year, the Trust set eight objectives within its Priorities for Improvement. This Quality Report records that it succeeded in six of these, made some improvement in one additional area, and found that one was based on an incorrect assumption that improvement was needed. The Governors are aware of the efforts that Trust staff

put into these objectives and are pleased to be able to recognise their successes.

Eight highly relevant new objectives have been set for the coming year, and your Governors will be taking a close interest in their progress.

Review of Trust Services
In Section 3.0 of this Quality Report, the Trust details its performance under three principal headings: Patient Safety, Patient Experience and Clinical Effectiveness. These are the areas uppermost in the public mind when judging a provider of healthcare services. This section expresses in a clear way the importance the Trust places upon these areas. The Governors can confirm that these subjects are under constant review by the Trust and recognise the improvements described.

Areas of special interest to the Council of Governors during the past year

Staffing
The Governors have welcomed the creation by the Trust of a specific Board subcommittee called "the People Committee". This was formed with the intention of increasing the Trust's focus on staff retention and staff satisfaction. The Trust wishes to become "the employer of choice" within the NHS in order to attract staff to Bristol and to retain them. It is recognised that, during the current shortage of staff at all levels within the NHS, this is the best way to achieve the numbers of staff required to operate a quality service.

The Governors are specifically interested in the Trust's actions to promote equality and diversity and eliminate bullying. We are monitoring the effectiveness of the provision of a "Freedom to Speak up Guardian" and the supporting network of advocates. This provides a protected route, available to all staff, through which they can express concerns without fear of repercussions.

There is also a Guardian of Safe Working Hours, specifically to oversee the hours worked by junior doctors. The Governors have been made aware that the Trust is looking into the various shift planning processes in use across the Trust with the intention of ensuring that best practice is adopted universally.

Adoption of IT solutions
The Governors welcome the Trust's introduction of electronic prescribing, in which all prescriptions made by Trust qualified staff can only be made using the Trust computer systems. This has reduced errors and delays experienced with the previous paper system and improved efficiency and control.

The Governors support the Trust's efforts in continually exploring the use of IT across all Trust activities where implementation might allow more time to be spent in caring for patients.

Improvement in Telephone communications
The Governors welcome the Trust's approach to improving telephone communication with the public. It has been a source of complaints and it would appear that results have been good.

Fractured Neck of Femur and Stroke Care
Disappointingly, the performance of the Trust in relation to the Best Practice Tariff for Fractured Neck of Femur continues to cause significant concern. The Tariff sets out strict timetables for early review by specialist consultants and for speedy surgery, and these have been difficult to achieve, partly for staffing reasons. The situation is under close scrutiny at the Quality and Outcomes Committee and the Governors' Quality Focus Group. Stroke Care is similarly a long-standing area needing improvement. Governors have regularly raised questions about the action plans relating to these and will continue to challenge the Trust if progress is not achieved.

Diagnostic Waits
Performance against the 6 week standard for diagnostic waits has fallen short of the NHS target for the last three years. The Trust has identified the cause as the shortage of skilled staff needed associated with the complex diagnostic equipment. The Governors appreciate the Trust's willingness to discuss this and other similar matters openly and to hear of the actions being taken to improve matters.

Timely Discharge

The discharge of patients at a time when it is most beneficial to the patient has been under constant review. Ideally, the time spent by a patient in a bed at the Trust is minimised, consistent with successful treatment and the avoidance of physical de-conditioning of the patient caused by inactivity. The Trust, working with other healthcare providers and community services has improved the discharge process to get patients home more quickly. Further improvements are to be made as there have been a few cases when patients have been discharged late in the day or at night.

"Timely Discharge" is defined as being discharged between the hours of 7:00am and 12:00 noon. The majority of in-patients (70%) are discharged between noon and 8:00pm. "Out of Hours discharge" is between 20:00hrs and 7:00am and is to be avoided. The reasons for discharge late at night are various. Some are due to the organisation of a satisfactory destination, and some are due to the patient's own arrangements or choice. The Governors will be reviewing future discharge activity in an attempt to reduce the numbers of patients discharged out of hours.

Trust Participation in the Transformation of Healthcare Provision in our Region

The Trust has taken an active part in working with the Bristol, North Somerset, and South Gloucestershire Clinical Commissioning Group (BNSSG CCG) in their task of re-organising the provision of health and social care in our region. This process has been named "Healthier Together", and has the aim of improving the provision of healthcare in our region while working within budgetary constraints. It brings together 13 local health and care organisations to consult with the public and to collaborate in the implementation of new practices.

The Trust has kept the Governors informed regarding intentions and progress with these partners. The Governors endorse the Trust's commitment to wider healthcare planning including the development of closer working relationships with North Bristol NHS Trust and Weston Area Health NHS Trust. Progress is expected to continue for at least another 12 months.

Overall Governors Assessment of the 2018/19 Quality Report

The Governors consider that this Quality Report accurately represents the performance of the Trust over the past year and that this performance has been good, with the Trust recognising that there are always areas where performance can be improved.

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 2018/2019 quality priorities is very positive. We agreed that the document evidences a culture of learning from the trust managers and staff. Healthwatch Bristol and Healthwatch South Gloucestershire believe the trust's eight quality objectives for the coming year are addressing identified need.

Healthwatch Bristol and Healthwatch South Gloucestershire made the following comments and recommendations about UH Bristol's Quality Report 2018/2019. The document suggests that quality improvement had been good, with six of the eight priorities for 2018/19 being RAG rated green. For example:

- Complaints about telephone communications fell by 63% in the thirteen poorest performing departments.
- The score for staff who would recommend the trust as a place to work improved in 2017. Healthwatch would like to see the figures for staff who use the 'Happy app' to identify how the relaunch is going.
- Healthwatch welcomes the slight improvements in BAME staff experience and look forward to seeing the more detailed analysis. Healthwatch are still concerned that 24% of staff have experienced harassment and bullying or abuse from colleagues.
- The trust has made significant improvement in performance for the 62 day GP referral to cancer treatment with just a small dip to 80% in the final quarter of 2018/19 despite the effort put in by all the staff.
- Healthwatch welcome the 'My Journey' programme and will be pleased to see the development in 2019/20.
- Healthwatch applaud the trust for their open and honest approach to recording the serious incidents and never events and the learning from these issues.
- Healthwatch understands the constraints and looks forward to hearing more about the early recognition of the dying patient, that has an amber rating at present.

- Healthwatch would like to hear more feedback from the 'Patient Experience at Heart' workshops held in January 2019 with regard to improving patients' experience of maternity services.
- Healthwatch are pleased that the improvement of safe prescribing and the use of insulin has been recognised as a problem and note the difficulties in reporting on this.

Healthwatch Bristol and Healthwatch South Gloucestershire noted the eight quality objectives the trust has set for 2019/20:

- Healthwatch look forward to hearing more about the improvements in patient safety using digital technology, as the year progresses.
- Healthwatch note the five never events that occurred during 2018/19 and welcome the learning from these including the implementation of multidisciplinary safety summits.
- Healthwatch welcome the objective to support the needs of young carers across the trust and wonder how the trust will be measuring the benefits to young carers.
- The 'Happy app' is a great way to measure real time staff experience, Healthwatch are interested in how managers can support staff who have anonymously contributed?
- Improving physical access is paramount and Healthwatch hope to hear more when funding is in place to take this forward. Healthwatch would like to see recognition from the trust that not all patients and public are web users or have English as their first language when improving the physical access information.
- The implementation of the Medical Examiner system is welcomed by Healthwatch; it is reassuring that this objective is being implemented.
- Healthwatch are disappointed that the originally proposed objective for improving outpatients communication through use of SMS text messaging about appointments could not be included this year.
- The development of training for Trust lay representatives is welcomed by Healthwatch, who would like to be reassured that lay representatives are recruited to represent the nine protected characteristics.

Statements of assurance from the board

Healthwatch applaud the Trust's participation in a range of clinical audits and national confidential enquiries and note the eight national clinical audits reviewed in 2018/19.

The trust has great track record of participation in clinical research and Healthwatch are pleased to see the trust working with researchers to submit applications for funding to continue research.

Healthwatch asks whether the twelve CQUIN targets are in priority order, noting that improving staff health and wellbeing is number two on the list.

Of the mandatory indicators, Healthwatch would appreciate seeing updated comparative figures for Emergency readmissions, but note that this is still the latest published data available.

It was disappointing to read that the trust did not meet the mortality reduction improvement goal and Healthwatch ask how this could be rectified?

In improving the management of the deteriorating patient, both physiological status recognition and staff understanding of the patient's mental health including dementia and learning disability should be to be taken into account.

In sepsis screening, Healthwatch were pleased to see the 90% improvement goals and wonder what is the national average? Is the trust above average on this achievement?

Healthwatch welcomes the 'Freedom to Speak Up' and asks whether advocates have been recruited from both staff and lay representatives?

The rise from fifty seven serious incidents in 2017/18 to seventy in 2018/19 is disappointing, Healthwatch are aware of the learning that the trust takes from these incidents.

Healthwatch are pleased to see a clear chart tabling infection control monitoring, against previous years recordings and note the six cases of MRSA when the target was to have no cases.

Healthwatch applaud the trust for the ongoing commitment to patient and public involvement through a range of engagement activities.

It is always useful to see Equality and Diversity within the Quality Report. Healthwatch would be happy to assist the trust with their Equality Delivery System 2. It is important to provide translation for the BME community and for staff to have cultural understanding of patients and family situations.

Meeting the four hour wait in Accident and Emergency is a difficult challenge and Healthwatch know the staff work hard to meet the target; we would like to see some improvement on the figures for Bristol Royal Infirmary for 2019/20.

It would also be useful to have an appendix with a glossary of terms for the lay person reading the Quality Account.

Healthwatch Bristol   Healthwatch South Gloucestershire

c) Statement from Healthwatch North Somerset

Introduction

This comprehensive Quality Report (also known as the Quality Account) is robust and covers progress against eight quality objectives identified by the Trust as areas for improvement, outlines quality objectives in the current year, and, gives an overview of service reviews undertaken in 2018/9.

The Quality Report has been reviewed by Healthwatch North Somerset (HWNS). Our review is informed by feedback received by Healthwatch North Somerset on local services and is reported within the context of the Trust's *Quality Strategy 2016-20* and *Embracing Change, Proud to Care, our 2025 Strategy.*

It is clear from the draft Quality Report that a learning culture is evident within the Trust and that it is listening to people's experiences to inform its practice.

Quality Objectives 2018/19

1. Customer Service Mindset

HWNS recognises that opting for the development of a toolkit on customer services rather than working to achieve a recognised standard is a less intensive option. We recommend that this is evaluated from the outset and reported on next year. It is good to see that patient's experience of telephoning into the organisation has improved significantly. This is mirrored by HWNS received intelligence which shows that in the past we have received complaints but none in recent months.

2. Staff reported ratings for engagement and satisfaction

HWNS recognises that an engaged workforce reflects well on the patient experience. We are interested in the relaunch of the Happy App for staff and in the results being generated by this real-time mechanism. HWNS welcomes its inclusion as a Quality Objective for 2019/20.

3. Compliance with 62-day referral indicator for cancer

HNWS is happy to see improvements against this standard.

4. Mystery Shopping Programme

The My Journey programme has been rolled out successfully. HWNS is keen to see the end project report once completed. We recommend that Face2Face volunteers are involved in discussions about the implementation of a more detailed mystery shopping programme.

5. Improved learning from Never Events and serious incidents

HWNS welcomes the commitment to this and has received no reports to the contrary.

6. Improve early recognition of the dying patient

HWNS welcomes continued improvements planned for this area of practice.

7. Improve patient experience of maternity services

HWNS welcomes the Trust's aim to become the best again in the national Maternity Patient's Survey, and its continued involvement in BNSSG-wide developments and improvements in this key area.

8. Improve the safe prescribing and use of insulin
HWNS has received no intelligence from the public in this area. We recognise that is not applicable to rate this using self-assessed RAG criteria. We welcome the actions taken by the Trust in 2018/19 to strengthen patient safety and reduce the likelihood of omitted insulin doses in the future.

Quality Objectives 2019/20
We note the quality objectives for 2019-20 and commend the fact that five of them are directly related to the patient experience. We are particularly interested in the support for young carers as we recognise this to be a 'hidden population'. HWNS has also identified digital innovation and inclusion as a current priority work area and would be happy to support the Trust in assessing patient experiences of new developments. HWNS will ensure our staff and volunteers are familiar with the current objectives and will continue to monitor public intelligence.

Patient Experience
HWNS notes that extensive work is being undertaken to understand and improve the patient experience. We welcome the in-house UH Bristol Patient Experience programme and its positive results particularly in relation to staff. Of note, is the important contribution made, in achieving positive results, by the Face2Face team and the Patient Involvement Network.

Overview
The Quality Report 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.

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 13th May and Members were satisfied with the contents of the University Hospitals Bristol (UH Bristol) NHS Foundation Trust Quality Report.

Members welcomed UH Bristol's innovative approach to its 'Here to Help' customer service programme and welcomes the rollout of the electronic feedback points throughout the Trust sites. The 'Here to Help' demonstrated that UH Bristol are committed to taking a person centred approach to their service development.

The People Commission thanked UH Bristol for the open and transparent relationship with scrutiny.

e) Statement from South Gloucestershire Health Scrutiny Committee

South Gloucestershire Council is holding local elections this year and as such we are now in Purdah. The Health Scrutiny Committee will therefore be unable to comment this year.

f) Statement from North Somerset Health Overview and Scrutiny Panel (QA Sub Committee)

Thank you for submitting a PowerPoint presentation outlining UH Bristol's Quality Account to North Somerset Council's Health Overview & Scrutiny Panel Quality Accounts Sub-Committee. Unfortunately a number of issues beyond our control have come together this year such that providing a formal response has not been possible. Due in part to the close proximity of Local Elections at the time, the sub-committee was inquorate on the day of its meeting to review Quality Accounts. The Panel will be reviewing its approach to the annual Quality Accounts and I am aware that Members recognise the need to rationalise the process going forward.

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

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2018/19 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 2018/19. 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 the achievements against the eight quality objectives for 2018/19, six were fully achieved and one partially achieved. The CCG noted that for objective 1 the rating was classed as not applicable as the baseline data was found to be flawed. However, the CCG recognises that reported insulin-related incidents will not only be missed doses and it would have been useful to have explanation of the planned actions taken to strengthen patient safety and their results that are mentioned in the explanation of the RAG rating.

The CCG acknowledges and congratulates the Trust for the improved and sustained performance against the 62-day standard for first treatment after referral that is above the national average for the standard.

We do however, share concern over the diagnostics standard and how this may then impact on other standards including cancer standards. The CCG are committed to continue working with the Trust to improve this position through work with all providers to ensure all the available capacity for diagnostics is maximised to support performance.

The CCG welcomes learning from serious incidents and Never Events, noting the significant amount of work undertaken to address the nine Never Events that had occurred in 2017/18. Whilst the CCG notes no further Never Events in the areas that gave rise to concerns, it is disheartening that a further 5 Never Events were reported in 2018/19. The CCG supports the inclusion of this objective as an area for further work in 2019/20.

The CCG supports the chosen areas for quality improvement for 2019/20, particularly enabling improvements to digital technology with a focus on antibiotic stewardship, management of intravenous cannulas, NEWS and VTE, however we would like further narrative on how this will be used and how the Trust will ensure that an arm's length review does not replace patient reviews and prescriber education. We would also question why the objective to improve early recognition of the dying patient is not being taken forward.

Similarly to 2017/18, BNSSG CCG commends the excellent quality improvement work relating to the patient safety improvement programme of work, and UH Bristol's continued partnership working with the West of England Academic Health Science Network's (AHSN) Patient Safety Collaborative is also noteworthy.

Within the quality account UH Bristol has demonstrated continued good progress in improving patient experience, noting continued achievement of the national target for both sample size and response rate for the Friends and Family Test and the early identification and management of sepsis.

In reviewing the data in relation to pressure ulcers the CCG notes a deterioration across all three metrics in comparison to 2017/18; pressure ulcers per thousand bed days and pressure injuries grade 3 and 4 and the CCG would have liked to have seen some narrative in this respect. The metrics relating to the management of neck of femur fractures continues to be a challenge for the Trust in terms of treatment within 36 hours and achieving the best practice tariff. The CCG

recognises that this may require a system approach and again would like to see the improvement plan described. We note the significant improvement in patients receiving an Ortho-geriatrician review within 72 hours.

The Trust achieved compliance with the C. difficile target, however, as noted in the previous year's statement by BNSSG CCG we 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 2019/20 as current activity has exceeded both the national threshold and the Trust outcome figure for the previous year. MSSA cases have also exceeded the 2018/19 target. During 2018/19 the national E. coli ambition reduction target has been a challenge to achieve and again the CCG would have welcomed some narrative around this to include the introduction of the Urinary Catheter Passport during 2019/20.

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 bacteraemia.
• 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 2019/20 to deliver those improvements.

Jan Baptiste Grant
Interim Director of Nursing & Quality

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.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor
PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

Data definition
All cancer two-month urgent referral to treatment wait.

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05).

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).

C
APPENDIX C
Statement of Directors' Responsibilities

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. 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 2018/19 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 2018 to March 2019
  - papers relating to Quality reported to the board over the period April 2018 to March 2019
  - feedback from commissioners received 14/5/2019
  - feedback from governors received 2/5/2019
  - feedback from local Healthwatch organisations received 2/5/2019 and 16/5/2019
  - feedback from [Bristol] Overview and Scrutiny Committee received 17/5/2019
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009[11]
  - the 2017 national patient survey published 13/6/2018[12]
  - the 2018 national staff survey published 29/3/19
  - the Head of Internal Audit's annual opinion over the trust's control environment dated 24 May 2018

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Jeff Farrar, Chairman
24 May 2019

Robert Woolley, Chief executive
24 May 2019

[11] This report is due to be received by the board later in 2019
[12] The 2018 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 2019 (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 patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	Page 72 of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Page 72 of the Quality Report

Respective responsibilities of the Directors and auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

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 2018/19';
- 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 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; 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 consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to 24 May 2019 ("the period");
- Papers relating to quality reported to the Board over the period;
- Feedback from the Commissioners dated 14 May 2019;
- Feedback from Governors dated 2 May 2019;
- Feedback from local Healthwatch organisations dated 2 May 2019 and 16 May 2019;

- Feedback from the Bristol Overview and Scrutiny Committee dated 17 May 2019;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2017 national patient survey dated 13 June 2018;
- The 2018 national staff survey dated 29 March 2019; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2019.

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 complied with 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) 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 2019, 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 2018/19';
- 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.

imitations

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 criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

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.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

• 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 2018/19';
• The Quality Report is not consistent in all material respects with the documents specified above; and
• The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

PricewaterhouseCoopers LLP
Bristol
24 May 2019

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.