University Hospitals Bristol
NHS Foundation Trust

Quality Account 2019/20

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Part 1

1.1 Statement on quality from the Chief Executive

The coronavirus pandemic was declared as the year 2019/20 was drawing to a close, since which time the NHS has faced the greatest challenge in its history. I am humbled every day by what I see from teams across our hospitals and the lengths they go to, to provide compassionate high-quality care. My wholehearted thanks and admiration go out to our staff for their commitment, bravery and professionalism in these most challenging of times.

Whilst the impact of the pandemic has overshadowed much of what went before, it is important to register some significant achievements in the course of 2019/20 through the pages of this report, where you will once again read about what we have been doing to keep patients safe, to provide world-class clinical treatments and to give patients the best possible experience when they need hospital care.

Our mission as a Trust continues – to deliver exceptional care, teaching and research every day. Our five year strategy *Embracing Change, Proud to care – our 2025 vision* sets out our ambition: to grow our specialist hospital services and our position as a leading provider in south west England and beyond, work more closely with our health and care partners to provide more joined up local healthcare services and support improvement in the health of our communities, and become a beacon for outstanding education and research and our culture of innovation.

I am hugely proud to be part of this organisation and I was delighted that the Trust was rated Outstanding by the CQC in August 2019 for the second time in a row. Our staff are very special people, and I was thrilled that their hard work was recognised in this way.

Our plans in 2019/20 encompassed our growing partnership with Weston Area Health NHS Trust, which involved me taking a dual Chief Executive role across Bristol and Weston from 1 September 2019 and culminated in a successful merger on 1 April 2020. The merger has helped to bring stability to Weston General Hospital and created a new organisation with a greater shared purpose. When we merged we became University Hospitals Bristol and Weston NHS Foundation Trust – a sign of our determination to ensure that Weston General Hospital has a bright and certain future at the heart of its local community. Together we now have more than 13,000 staff, working together to deliver exceptional healthcare services.

The benefits of our merger and the extent to which our services have been affected by the pandemic will both feature in next year's report. In the meantime, I commend our Quality Account for 2019/20 to you. As ever, my thanks go to those who have prepared and contributed to this report, including Healthwatch, our commissioners and our governors. I am pleased to confirm that the Board of Directors has reviewed this 2019/20 Quality Account and I confirm that it is an accurate and fair reflection of our performance.

Robert Woolley
Chief Executive

Part 2

Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

2.1.1 Update on quality objectives for 2019/20

In early 2019, the Trust identified eight specific areas of practice where we committed to improve quality in 2019/20. A progress report is set out below, including a reminder of why we selected each theme, our 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 four areas and made significant progress in the others.

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 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 did we say we would do?	**Improving the management of intravenous cannulas** In 2019/20, we said that we would implement the use of the electronic system Vitals to document all peripheral intravenous cannulas. By using real time data, we would 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) In 2019/20, we said that we would 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 would 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** In 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 said that we would measure the number of cannulas/lines that are left in beyond the date for removal and will reduce 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 said we would 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 said that we would meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment.
How did we get on?	<u>Intravenous cannulas:</u> Electronic monitoring has been implemented in all adult areas apart from ED, theatres and the Queen's Day Unit. Real-time monitoring of IV line compliance is in place. However, issues have been identified with inconsistent recording of IV line insertion which, in turn, leads to inconsistent clinical practice (if you don't record the insertion on Vitals, you won't receive electronic prompts to check the patient). Historical baseline data is not available and there are currently some challenges relating to extracting data from the system which shows the patient's most recent IV line check, but not the full history of compliance. We are actively working to resolve. A standard operating procedure has been devised to support a consistent approach to IV line insertion documentation; this has been trialled in ward areas across each division to ensure that the SOP meets the needs of all areas. Theatres are awaiting training to enable them to use E-Obs however cannula insertion is currently captured on Blue Spier. Further scoping is ongoing with ED. Progress will continue to be monitored via the Digital Clinical Operational Group. <u>Timely observations:</u> Baseline data gathered in Q4 2018/19 showed that full observations were taken on time on 140,085 occasions, and were late on 79,333 occasions (breached and overdue combined), i.e. 63.8 per cent taking place on time. This measure was across all sites (BRI, BHOC, SBCH, STMH, BEH) and excluded patients under 18. In 2019/20, timeliness of observations improved by only 3 per cent compared to baseline. This poor compliance with NEWS2 protocols suggests a continuing gap in implementation of NEWS2 guidelines at ward level. A new digital implementation group chaired, by the

	Chief Nurse, has been established and is working on methods to improve understanding and monitoring of the timeliness of observations. We are now able to share real time reports at ward, specialty and divisional level and the plan is to incorporate review of performance at divisional executive reviews. <u>VTE assessment:</u> Electronic VTE risk assessment in Medway (the Trust's patient administration system) was implemented in August 2019, enabling the collection of accurate, real-time data. This also means that VTE risk assessments are completed in full with digitally recorded date, time and the name of the person completing them. Following an intensive work programme, monthly performance in the second half of 2019/20 was consistently around 80 per cent (against the national target of 95 per cent). Significant barriers to compliance included the fact that VTE risk assessment is a "stand alone" task in Medway and not currently integrated into another routine process (such as admission or prescribing). We had anticipated that a fully integrated system with a 'force' function (enabling full compliance with the national standard) would become available during the year, however this was delayed due to issues with our external system supplier. Extreme pressures on capacity in the Trust have also been an issue, particularly in the emergency and assessment units. Compliance on wards responsible for acute admissions has been disappointing. These areas present a particular challenge due to the high turnover of patients, multiple members of staff being involved and the volume of tasks which need to be completed on admission. By streamlining workload, we are optimistic of achieving improvements going forward. Towards the end of the year, consultant and junior doctor-led Quality Improvement projects have been initiated in acute medicine and surgery. We also plan to incorporate digital VTE risk assessment into routine pre-op assessment to improve compliance for elective surgical patients. The roll out of digital risk assessment to children 16 years and over at Bristol Royal Hospital for Children and the Bristol Eye Hospital commenced as planned in February 2020, but was subsequently paused due to the Covid-19 pandemic.
RAG rating	Amber – we made important progress towards achieving this objective in 2019/20, but further work is needed, particularly in respect of meeting the national VTE standard during 2020/2021

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), had 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 did we say we would do?	We said that we would: • 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. • Provide 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 said that we would judge success by the completion of the above actions.
How did we get on?	There were four surgical procedure never events in 2019/20 as reported in the patient safety section of this report. In 2019/20 we have: • Completed work with surgical teams to identify guidance for when additional "stop checks" time outs should be called. This work has determined that it is not possible to develop specific guidance due to the multiplicity and complexity of situations when an additional time out would be appropriate. • Incorporated into patient safety training awareness of the impact of

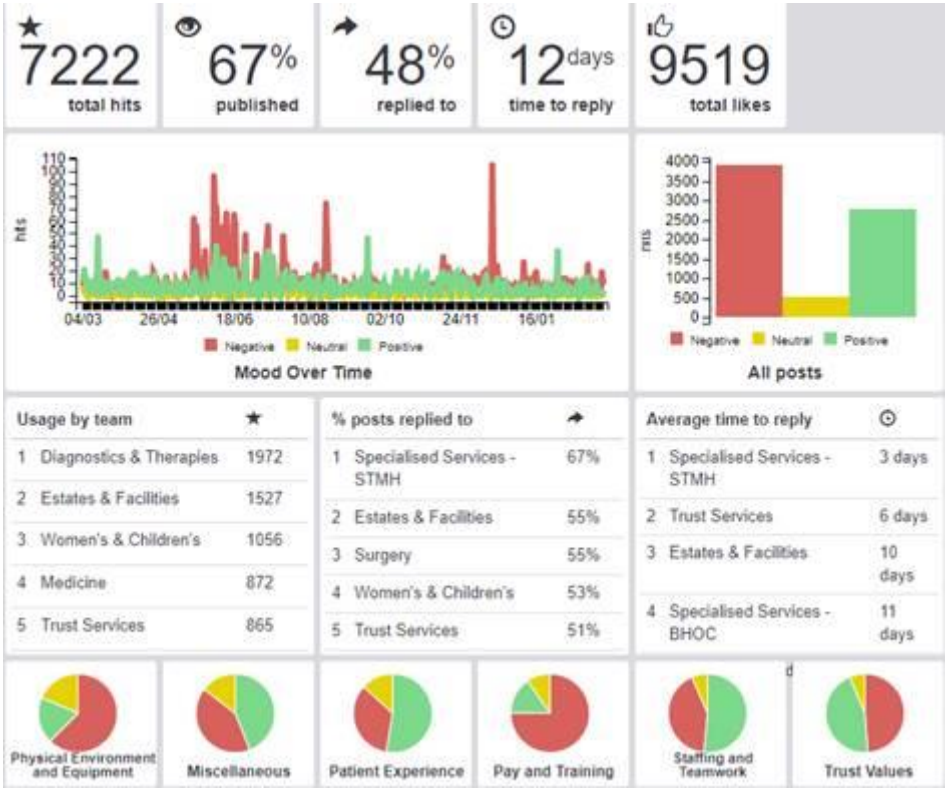
	hierarchical behaviours on calling time outs. By hierarchical behaviours we mean behaviours that belittle or embarrass team members and juniors, leading to, for example, them not feeling able to speak up if they see something that might be about to go wrong. • Provided on-going simulation training in high risk specialties about high risk never events and were planning work with system partners to develop system-wide foresight training, but the funding bid for this was unsuccessful. • Tested and implemented physical barriers to proceeding with nerve blocks until 'Stop before you Block' has been completed. • Started a three year work stream to understand and reduce the frequency and impact of interruptions and distractions on human error, but this work remains paused due to the Covid pandemic. • Conducted a "review and check" exercise to proactively revisit and recheck implementation of patient safety alerts designed to reduce the risk of never events. An action plan has been developed in response to this review and is being taken forward. • Conducted a "review and check" exercise to ensure Local Safety Standards for Invasive Procedures incorporate the latest local learning and HSIB investigations. An action plan has been developed in response to this review and is being taken forward. • Participated in system-wide collaborative work on reducing never events.
RAG rating	Amber – we completed the majority of our planned improvement actions, however we still reported four Never Events in 2019/20

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 set out to re-focus and improve support provided to young carers at UH Bristol. The objective also supported a pledge made in the NHS Long Term Plan (2019) to maintain the focus on identifying and supporting carers.
What did we say we would do?	In 2019/20, we said we would: • 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 said we would measure success by delivery of the actions listed above.
How did we get on?	Following a successful visit to the Adult Emergency Department, by members of the Bristol Young Carers support Group – to consider the young carers experience in the department a number of improvement priorities were

	identified by the Young Carers, and actions agreed with department staff, including: • Develop posters to inform and raise awareness to Young Carers - How to Identify/recognise a Young Carer and what to do for them - completed • Plan training and resources to be delivered to Pharmacists and other health care teams – in progress • Raise carer awareness through the Trust Youth Involvement Group The online information available to young carers on the Trust website has been reviewed and updates identified. Carer awareness training for staff has been updated and delivered virtually by the Carers Liaison Team. This includes contributions to the preceptorship programme pre-social distancing requirements. The Health Matters event was postponed but eventually took place in October 2020 due to the impact of Covid-19. This was a well-attended event supported by Trust Governors with many carers in attendance who shared their perspectives on what matters most to carers attending hospital. Looking ahead, this work has helped define a closer working relationship with the Carers Support Centre enabling us to understand and respond to the needs of people with caring responsibilities more effectively. Both UHBW and North Bristol NHS Trust intend to re-launch the joint Carers Charter in early 2021 to reflect our joint commitment to carers as partners in care.
RAG rating	Green – we made good progress in 2019/20 and although our Health Matters event was delayed by the pandemic , this has now also taken place

Objective 4	**Driving positive staff engagement through expanded use of the Happy App**
Rationale and past performance	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. 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 online 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 did we say we would do?	We wanted to extend and improve the organisational reach, functionality and reporting capability of the Happy App. Our plan for 2019/20 included: • Implementation of a stakeholder communications and engagement plan to achieve high level awareness and usage with the Happy App across all staff groups, including targeted promotion within hard-to-reach teams. • Consultation with colleagues Trust wide to identify and exploit opportunities to further promote usage of the Happy App and to resolve staff engagement issues raised. • Exploring additional report functionality with the system provider to include supplementing the current dashboard reports used by Divisions to help to identify and deliver engagement and improvement activities to meet requirement.

	• Introduction of a text analysis tool to search for keywords contained within the comments posted by colleagues, within any data period required. This has enabled managers to generate word clouds based on any of five reporting categories: *Emotion Lens; Employers Branding; System Themes; Benchmarking; and Improvement.* This helps Divisional or team leaders to know where to focus efforts in terms of staff experience and engagement. • Evaluation of the effectiveness of internal marketing efforts and internal advertising channels used to promote the Happy App.
Measurable target/s for 2019/20	In 2019/20, our target was to increase the number of clinical and non-clinical teams registered for Happy App by 10 per cent against a baseline which we measured on 1st June 2019, i.e. three months on from our refresh of the system. We also said that we would more closely monitor moderator responses against the comments posted by their as a measure of the effectiveness of the feedback process.
How did we get on?	Key achievements in 2019/20: • The Trust exceeded its target to increase the number of teams registered for the Happy App by 10 per cent. We the end of 2019/20, we had 215 teams and 340 moderators* registered onto the system with a commitment to continue to increase engagement throughout next year. • Communication and engagement activities outlined in the annual stakeholder communications and engagement plan continue to sustain awareness and widespread usage within clinical and non-clinical environments. • The number of comments (hits) posted by colleagues saw a significant increase from 3,668 in 2018/19 to 7,222 in 2019/20, as can be seen from the dashboard report below. **Happy App Dashboard Report: 4th March 2018 – 3rd March 2019** 

	Happy App Dashboard Report: 4th March 2019 – 3rd March 2020  • Each Division has introduced a mechanism for reviewing Happy App use at local level, to include review by senior leads. This feedback is used to inform the direction of staff engagement provision required by the respective workforce. • The Trust staff engagement score, as measured by the 2019 NHS staff survey is higher than the national average. The Happy App is considered to be a positive contributor to this success. • Service leads have begun to use the Happy App to meet the needs of their users for example, the Trust Library promote the Happy App as a means to gain feedback and suggestions for improvement. During national 'Values' week, colleagues across the organisation were invited to pledge their personal values via the Happy App whereby they can select 'values' as one of the theme options. * Moderators are team leads e.g. line managers who are responsible for regular responses to posts for an individual team.
RAG rating	Green – we implemented our stakeholder communications and engagement plan for 2019/20; overall usage of the Happy App has continued to improve and we will continue efforts to maintain high level engagement across each Division

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 which 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 did we say we would do?	We said we would 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 wanted to 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 said that our measures of success would be 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 did we get on?	The year began with a series of exploratory conversations with stakeholders, including the director of AccessAble, a nationally recognised provider of web and app-based access guides, and exploration of potential funding sources. By the end of the year, we had secured funding thanks to the generosity of our charitable trustees, Above & Beyond, and agreed to enter into partnership with AccessAble. Since the end of 2019/20, we have also secured additional funding from the League of Friends of Weston General Hospital to enable our access guides to be extended into the new Weston Division. Comprehensive site surveys in Bristol and Weston will be required to gather the information required to produce the access guides – this work remains scheduled for 2020/21 but has been impacted by the coronavirus pandemic.
RAG rating	Amber – in 2019/20 we successfully secured charitable funding to enable the Trust to partner with AccessAble to develop access guides

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, RTOP enables 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 was agreed as a corporate objective for the Trust and the aim is to roll out to all specialities and Divisions by 2021.

	This would: • 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 are 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 reduces time spent validating missing or inaccurate outcomes, and hopefully reduces the 'Did not attend' rate in participating specialities by improving patients' understanding of the importance of their appointment.
What did we say we would do?	In 2019/20, we said we would 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 had signed up to the initiative and included real time outpatients in their operating plans for 2019/20. Each Division had identified a real time outpatients champion within the management team to support the central outpatients team. Each speciality would have an implementation plan. The plan was that real time outpatients would also support further digitalisation of outpatient clinics and administrative processes. Roll out in each Division was planned to 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 also wanted to work with radiology to pilot and then formally introduce booking of radiological scans immediately following an outpatient appointment; the plan was to begin by trialling this with adult CT scans.
Measurable target/s for 2019/20	Our targets were: • 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 did we get on?	2019/20 was a busy year for the real-time outpatients project, with more than its fair share of successes and challenges. For example: At Bristol Royal Hospital for Children, there were some examples of excellence – in November and December 2019, Spinal surgery turned 100% of letters around in 7 days. The Paediatric Trauma and Orthopaedic service joined the project in January 2020. However, turnaround times in Paediatric Rheumatology returned to previous baseline performance. IT challenges delayed roll-out in Adult Respiratory and Sleep services, however pilot schemes ran in a number of areas including Thoracics, Dermatology and Gynaecology. Elsewhere, Radiology built a module within CRIS (the Radiology booking system) to enable CT and MRI scan appointments to be booked before they have been vetted by a radiologist. Heading into winter 2019/20, the rate of expansion of real-time outpatients inevitably slowed as teams faced winter pressures. A roll out options appraisal was presented to the Trust's Transformation Board in February 2020, however events were subsequently overtaken by the Covid-19 pandemic.
RAG rating	Amber – in 2019/20 we took important steps towards implementing real-time outpatients into a number of clinical specialties, however progress was impacted by staff vacancies and sickness, IT systems, winter pressures, and ultimately the Covid-19 pandemic

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) was being introduced to provide support for bereaved families and to improve patient safety. Overseen by a National Medical Examiner, MEs are specifically trained independent senior doctors from any speciality. They scrutinise all deaths that do not fall under the coroner's jurisdiction. The introduction of MEs supported our aims for transparency and improving the experience of patients and their families at the end of life. Implementation would provide opportunity to consider further ways of improving our services. At the same time, we recognised 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 did we say we would do?	In 2019/20, we said we would: • Work closely with local Trusts within the Academic Health Service Network to agree a standardised implementation strategy for the ME system; this would 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 wanted to 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	Our target was that, by the end of 2019/20, we would have successfully implemented the new Medical Examiners system, in partnership with local acute Trusts. We will wanted to complete our scoping exercise for adult bereavement care as a platform for future service improvement.
How did we get on?	<u>Medic al Examiners:</u> 2019/20 was a year of collaborative working with North Bristol NHS Trust and Weston Area Health NHS Trust (as-was), to successfully implement Medical Examiners across the three organisations. The project, which was overseen by a small team of staff based at Southmead Hospital (part of NBT), was also supported by the Avon Coroner and the Academic Health Service Network. Medical staff engagement was vital: initially sharing information, then receiving expressions of interest in the Medical Examiner role and helping to shape the business plan. A Lead Medical Examiner and Lead Medical Examiners Officer have been appointed and their respective teams of MEs and MEOs have also been recruited to. A significant amount of time has also been invested in establishing key working relationships with the Trust's existing Patient Affairs Team (bereavement office), which is complementary to the new ME service. <u>Bereavement support in adult services:</u> Alongside the implementation of Medical Examiners, our additional local scoping exercise identified a number of 'best practice' ideas and opportunities from other NHS trusts, which UHBW could explore in the future: 1. Creating an on-site death registration service, e.g. as per Southmead Hospital. 2. Introducing 'Bereavement Cafés', where people can meet others who may have been through a similar bereavement. 3. Creating a dedicated single point of contact for each family following death, e.g. if a family had questions – likely role for Medical Examiner. 4. Creating a new bereavement policy to sets out the parameters of bereavement care for the Trust; the Trust currently has various SOPs but no overall policy document. 5. Reviewing and expanding the Trust's Bereavement Books given to families following a death, e.g. to include information about Medical Examiners and learning from deaths; also improving signposting to bereavement care provided by other agencies and support groups. 6. Sending personalised bereavement letters to every family, e.g. from a consultant or ward; current practice varies throughout the Trust. 7. Systematically offering support to staff affected by a patient death as part of health and well-being. We will begin to explore some of these ideas with ME colleagues once the ME service is fully established.
RAG rating	Green – the Medical Examiner service was successfully implemented and the additional scoping exercise relating to adult bereavement support was

	completed

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 set out to influence and develop the practice of lay partner involvement (also known as lay representation) 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 did we say we would do?	To realise our ambition to improve how we work with and support lay representatives we undertook work across three themes: • Lay representation recruitment process • Lay representation training and development • Working with others **Lay representation recruitment process** Our aim for this work stream was to improve the way in which we attract and recruit lay representatives to join the Trust to include a review of the application and recruitment process for lay representatives. **Lay representation training and development** We recognised the need to invest in our lay representatives so that they are supported and able to develop their own skills to function well in their roles. We made a commitment to 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. **Working with others** As part of a wider network of health care providers in the area we recognised the need to explore how we could work with other local providers so that the training and approach to lay representation was shared across organisations.
How did we get on?	Following a mapping exercise to understand the full extent of lay representation in steering groups, committees and networks across the Trust we were able to work with existing lay representatives to learn from their experiences of working in the Trust. This helped us understand more about what mattered most to them in terms of their recruitment, support and development. This process included a lay representative survey, survey of managers working with lay representatives and an event at which lay representatives were able to discuss their roles in greater depth. This insight was matched with learning from other patient leadership work the Trust had undertaken namely the Healthcare Change Maker Programme, and best practice from NHS England. This information has been used to further improve the application and recruitment processes to ensure greater clarity and expectations about the

	roles. To support this we have aligned our recruitment process to that used by the Trusts Volunteer Services so that newly recruited lay representatives benefit from the support offered by that service. We have also used this insight to plan how an on-going support and development programme for lay representatives will look. The programme will balance personal support with skills development such as, how to work together effectively and dealing with difficult or sensitive situations. This programme will be formally launched in 2020/21 as part of an on-going focus on this work. In addition, there will be further work done to explore how these developments can support lay representatives in other local providers and in doing so offer a greater degree of consistency in the health community.
RAG rating	Green – we delivered the majority of our lay representative project milestones for the year and have established a significant improvement in the application and recruitment process for lay representatives

2.1.2 Quality objectives for 2020/21

In view of the merger of University Hospitals Bristol NHS Foundation Trust (UH Bristol) with Weston Area Health NHS Trust (WAHT) on 1st April 2020 to form University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), it was agreed that the Trust's quality objectives for 2020/21 would focus on four areas where UH Bristol did not fully achieve its goals in 2019/20, and that these quality objectives would apply across the merged organisation. It was further agreed that any outstanding annual quality objectives for WAHT would be taken forward via the annual operating plan for the newly created Weston Division. It should be noted that these objectives were agree prior to the Covid-19 pandemic.

Objective 1	**Improving compliance with VTE (Venous thromboembolism) assessment**
Rationale and past performance	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 was implemented in August 2019 to support a full sample survey of all patients in real time. Compliance initially improved markedly to 79%, then fell away, before returning to a similar level by the end of 2019/20. Compliance needs to be optimised by support from divisions / specialities / consultants. Current significant barriers include that Medway is not used for other functions yet in some specialities and ward rounds are not done using mobile computer devices, although these are available. The extreme pressures on capacity in the Trust are also an issue, as is a culture that VTE risk assessment is a low priority and there are no consequences for staff if it has not been done. Phase 2 (to include 16-18 year olds and Bristol Eye Hospital) is due to be rolled out later in 2020.
What will we do?	To improve compliance, the Medical Director has established a performance management process to encourage individual teams to be responsible for their own compliance and development of solutions for improvement. This has already had a positive impact on completion of risk assessments, and the potential to appoint a dedicated VTE prevention nurse is being explored. Compliance has been particularly poor in the wards responsible for acute admissions. These areas are a challenge due to the high turnover of patients, multiple members of staff involved and other tasks to be completed on admission. A number of new initiatives led by key clinicians have now commenced and we expect performance, through streamlining workload, to

	improve the efficiency and completion of VTE risk assessments going forward. We now have designated consultants and junior doctors doing quality improvement projects in acute medicine and surgery. We also plan to incorporate digital VTE risk assessment into routine pre-operative assessment which will improve compliance for elective surgical patients. Lastly, planned VTE work streams at Bristol Eye Hospital and for 16-18 year old patients at the Bristol Royal Hospital for Children will be delayed due to the COVID-19 pandemic.
Measurable target/s for 2020/21	Although our target continues to be to meet the national standard, which requires at least 95 per cent of appropriate inpatients to have a VTE risk assessment, we do not anticipate this will be happen until such time as there is a digital fully integrated system with a force function (a force function means that staff cannot complete a subsequent step of a process without completing a preceding step), but unfortunately, the introduction of this facility has been delayed. We also expect the COVID-19 pandemic to negatively influence compliance due to staff working in unfamiliar settings.
How progress will be monitored	Progress will be monitored by the Trust's Infection Prevention and Control Committee, and through the Divisional Review processes, led by the Medical Director.
Board sponsor	Medical director
Implementation lead	Consultant haematologist lead for VTE, and chief clinical information officer

Objective 2	**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 the Trust's Bristol site 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 2019/20 we successfully secured charitable funding to enable the Trust to partner with an organisation called AccessAble.
What will we do?	In 2020/21, working with AccessAble, we will create a detailed web-based access guide for patients and the public, providing visual and descriptive information about our Trust estate, including Weston General Hospital (WGH). Note: at the start of 2020/21, however, the project is temporarily on hold until COVID-19 restrictions enabling surveyors to come on site. In the meantime, a quotation is being sought to extend the project roll-out to WGH.
Measurable target/s for 2020/21	Success will be measured by implementation of the project, including production of a 'recommendations matrix' to guide future decisions about how and where we could improve access, subject to future funding.
How progress will be monitored	Via Patient Inclusion and Diversity Group, reporting to Patient Experience Group
Board sponsor	Chief nurse
Implementation lead	Patient experience and involvement team manager

Objective 3	**Improving patient experience through roll out of the Trust's outpatients strategy and guiding principles**
Rationale and past performance	We continue to 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. In 2019/20, we took important steps towards implementing RTOP into a number of specialties, however various factors limited progress, e.g. staff vacancies and sickness, IT systems, winter pressures, etc. As part of the Trust's response to COVID-19, we have taken the opportunity to redesign elements of outpatient pathways, deploying e-RS (electronic referral service) advice and guidance. This service allows GPs and consultants to discuss and plan referrals making the most out of outpatient referrals. We have also deployed non-face-to-face video conferencing services, enabling attendance anywhere. This deployment has been Trust-wide and at scale. These changes represent significant improvements in the digitisation of the outpatient pathway and improved communication with patients and primary care.
What will we do?	During 2020/21, we will take a new approach to RTOP, incorporating it into our broader strategic approach to the outpatients programme. These changes will be reflective of the overall national strategy and guiding principles of BNSSG CCG for the delivery of outpatients. This strategy will include further digitisation of outpatient pathways, which will include improvements in the production of letters, clinical triage, outcomes, patient communications and appointment bookings. This will include a review of outpatient service delivery in Weston General Hospital and alignment of service access where possible.
Measurable target/s for 2020/21	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. • Achieve seven day turn around for advice and guidance requests.
How progress will be	Via Outpatient Steering Group

monitored	
Board sponsor	Deputy chief executive / chief operating officer
Implementation lead	Outpatient services manager (Trust-wide)

Objective 4	**Supporting and developing the participation of lay representatives 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. In 2019/20, we completed a mapping exercise to identify which UH Bristol groups, formal networks, and committees have "lay representatives" on them and, in doing so, identified new opportunities for lay representation, including maternity services and the Learning Disabilities Steering Group. We also successfully piloted our new lay representative training programme; the aim of the training is to develop and support lay representatives as patient leaders in the thinking and planning processes of Trust groups and in doing so enable better dialogue and joint working.
What will we do?	During 2020/21 we will: • Ensure that all of our lay representatives have attended our new training session • Develop and run a six-monthly update training and support programme • Develop an internal communications plan to more effectively publicise and promote the value of working with lay representatives and the processes for recruitment/training • Update our internal guidance for staff who are considering recruiting lay representatives • Undertake a mapping exercise of lay representation and networks at Weston General Hospital, including the existing Patient Council, with a view to implementing our new training there • Explore opportunities to partner with local health and social care providers so that UHBW training can be shared across organisations. Note: at the start of 2020/21, however, patient and public involvement activity at the Trust has temporarily been suspended due to COVID-19.
Measurable target/s for 2020/21	Our targets for 2020/21 are: • For all Trust lay representatives to attend introductory training • To develop and deliver an internal communications plan, to be launched in Quarter 3 2020/21 • To design and launch a half-yearly training update programme by the end of 2020/21
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 2019/20, UH Bristol provided relevant health services in approximately 70 specialties via five clinical divisions (Medicine; Surgery; Women's and Children's Services; Diagnostics and Therapies; and Specialised Services).

During 2019/20, 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 2019/20 therefore, in these terms, represents 100 per cent of the total income generated from the provision of relevant health services by the Trust for 2019/20.

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 2019/20, 52 national clinical audits and four 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 96 per cent (50/52) of national clinical audits and 100 per cent (4/4) of the national confidential enquiries of which it was eligible to participate in.

Table 1 lists the national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2019/20 and whether it did participate:

Table 1

Name of audit / programme	**Participated**
Acute, urgent and critical care	
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	Yes
Care of Children in Emergency Departments	Yes
Case Mix Programme (CMP) – Intensive Care	Yes
Mental Health (Care in Emergency Departments)	Yes
Major Trauma Audit (TARN)	Yes
National Audit of Seizure Management in Hospitals (NASH3)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Emergency Laparotomy Audit (NELA)	Yes
Perioperative Quality Improvement Programme (PQIP)	Yes
Sentinel Stroke National Audit programme (SSNAP)	Yes

Society for Acute Medicine Benchmarking Audit (SAMBA)	Yes
Blood and infection	
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	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	
Endocrine and Thyroid National Audit	No
National Audit of Breast Cancer in Older People (NABCOP)	Yes
National Bowel Cancer Audit (NBOCA) – part of NGICP[1]	Yes
National Lung Cancer Audit (NLCA)	Yes
National Oesophago-Gastric Cancer (NAOGC) – part of NGICP[1]	Yes
National Prostate Cancer Audit (NPCA)	Yes
Elderly care	
Fracture Liaison Service Database (FLS) – part of FFFAP[2]	Yes
National Audit of Inpatient Falls (NAIF) – part of FFFAP[2]	Yes
National Hip Fracture Database (NHFD) – part of FFFAP[2]	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) – part of NCAP[3]	Yes
Cardiac Rhythm Management (CRM) – part of NCAP[3]	Yes
Myocardial Ischaemia National Audit Project (MINAP) – part of NCAP[3]	Yes
National Audit of Cardiac Rehabilitation (NACR)	Yes
National Audit of Percutaneous Coronary Interventions (PCI) – part of NCAP[3]	Yes
National Congenital Heart Disease Audit (NCHDA) – part of NCAP[3]	Yes
National Heart Failure Audit (NHF) – part of NCAP[3]	Yes
Long term conditions	
National Asthma Audit – part of NACAP[4]	Yes
National COPD Audit – part of NACAP[4]	Yes
National Early Inflammatory Arthritis Audit (NEIAA, formerly NCAREIA)	Yes
National Diabetes Core Audit (NDA)	Yes
National Diabetes Foot Care Audit (NDFA) – part of NDA	Yes
National Diabetes Inpatient Audit (NaDIA) – part of NDA	Yes
National Pregnancy in Diabetes Audit (NPID) – part of NDA	Yes
National Ophthalmology Audit (NOD)	Yes
National Smoking Cessation Audit	Yes
UK Cystic Fibrosis Registry	Yes
UK Parkinson's Audit	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	Yes
Paediatric Intensive Care Audit Network (PICANet)	Yes
Confidential enquiries/outcome review programmes	
Child Health Clinical Outcome Review Programme	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

[1] NGCIP: National Gastro-Intestinal Cancer Programme
[2] FFFAP: Falls and Fragility Fractures Audit Programme
[3] NCAP: National Cardiac Audit Programme
[4] NACAP: National Asthma and COPD Audit Programme

Of the above national clinical audits and national confidential enquiries, those which published reports during 2019/20 are listed in Table 2 alongside the number of cases submitted to each, where known. Where relevant, this is presented as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2

Name of audit / programme	
Acute, urgent and critical care	
Assessing Cognitive Impairment in Older People (Care in Emergency Departments)	120*
Care of Children in Emergency Departments	158*
Case Mix Programme (CMP)	100% (2750)
Major Trauma Audit (TARN)	91-100%
Mental Health (Care in Emergency Departments)	130*
National Emergency Laparotomy Audit (NELA)	84% (132)
National Audit of Seizure Management in Hospitals (NASH3)	32*
Sentinel Stroke National Audit programme (SSNAP)	≥90% (470)
Blood and infection	
Surgical Site Infection Surveillance Service	148*
Cancer	
National Audit of Breast Cancer in Older People (NABCOP)	39*
National Bowel Cancer Audit (NBOCA)	108% (193)**
National Lung Cancer Audit (NLCA)	235*
National Oesophago-Gastric Cancer (NOGCA)	75-84% (133)
Elderly care	
Fracture Liaison Service Database (FLS)	111% (1549)**
National Hip Fracture Database (NHFD)	89% (278)
National Audit of Dementia (NAD)	102% (51)**
National Joint Registry (NJR)	68% (>16)

End of life care	
National Audit of Care at the End of Life (NACEL)	41*
Heart	
Cardiac Rhythm Management (CRM)	1110*
Myocardial Ischaemia National Audit Project (MINAP)	138% (1574)**
National Audit of Percutaneous Coronary Interventions (PCI)	1857*
National Congenital Heart Disease Audit (NCHDA)	1192*
National Heart Failure Audit (NHF)	60% (262)
Long term conditions	
National Asthma Audit	90*
National COPD Audit	515*
National Early Inflammatory Arthritis Audit (NEIAA, formerly NCAREIA)	166*
National Diabetes Core Audit (NDA)	80*
National Diabetes Foot Care Audit (NDFA)	60*
National Diabetes Inpatient Audit (NaDIA)	74*
National Pregnancy in Diabetes Audit (NPID)	105*
National Ophthalmology Audit (NOD)	99% (3958)
Women's & Children's Health	
National Maternal and Perinatal Audit (NMPA)	5657*
National Neonatal Audit Programme (NNAP)	100% (1022)
National Paediatric Diabetes Audit (NPDA)	464*
Paediatric Intensive Care Audit Network (PICANet)	99.9% (2159)
Confidential enquiries/outcome review programmes	
Medical and Surgical Clinical Outcome Review Programme	14*
Child Health Clinical Outcome Review Programme	2*
Maternal, Newborn and Infant Clinical Outcome Review Programme	100% (45)

*No case requirement outlined by national audit provider/unable to establish baseline
** Case submission greater than expected (e.g. estimated from Hospital Episode Statistics (HES) data)

The reports of 10 national clinical audits were reviewed by the provider in 2019/20. University Hospital Bristol NHS Foundation Trust has taken or intends to take the following actions to improve the quality of healthcare provided:

National Neonatal Audit Programme
A local project was conducted to gather further data on thermoregulation of neonates on admission to the Neonatal Intensive Care Unit, following performance in the previous audit report that, while better than the national average, left room for improvement. A bundle of measures has been identified to improve the numbers of neonates with a normal temperature on admission.

Fracture Liaison Service Database
A Fracture Clinic Quality Improvement Project was established to improve patient engagement in the FLS service and osteoporosis treatment. Internal IT processes have been reviewed to improve efficiency.

National Maternal and Perinatal Audit
A working group has been set up to look at how to manage the increase in the rate of induction of labour.

National Audit of Dementia
Training on delirium and its relationship to dementia has been included in the existing dementia training at induction and delirium e-learning has been produced.

National Pregnancy in Diabetes
The Trust is one of 20 teams across the UK participating in the national Quality Improvement Collaborative focusing on improving pre-conception care of women with diabetes.

RCEM Venous Thromboembolism (VTE) Risk in Lower Limb Immobilisation
Changes were made to the Virtual Fracture Clinic referral forms on the Medway system to ensure that clinicians complete a VTE risk assessment when referring.

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 2019/20, the Trust reviewed the following benchmarking summaries:

- Intensive Care – Case Mix Programme (CMP)
- Trauma Audit (TARN)
- National Lung Cancer Audit (NLCA)
- National Oesophago-Gastric Cancer Audit (NAOGC)
- Adult Cardiac Surgery (ACS)
- Myocardial Ischaemia National Audit Project (MINAP)
- National Heart Failure Audit (NH)
- National Chronic Obstructive Pulmonary Disease Audit
- National Ophthalmology Database Audit (NOD)
- National Joint Registry (NJR)
- National Audit of Inpatient Falls (NAIF)

2.2.3 Participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by UH Bristol in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 7,011. This compares with 10,236 in 2018/19.

2.2.4 CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2019/20 was conditional on 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.

A radically different approach to CQUINs was introduced in 2019/20. The value of the national CQUIN scheme for both CCG and PSS schemes was reduced by half to 1.25 per cent with a corresponding increase in core prices. As lead provider of Hepatitis C virus (HCV) Operational Delivery Networks, a top up of 0.3 per cent was included within the PSS CQUIN scheme, making

a total value of 1.55 per cent. The amount of potential income in 2019/20 for quality improvement and innovation goals was approximately £6.92 million based on the sums agreed in the contracts (this compares to £11.85 million in 2018/19). The following 11 CQUIN targets were agreed, with the Trust estimating to achieve 82.5 per cent of the £6.92m total potential income:

- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People, Antibiotic Prophylaxis in colorectal surgery
- Staff Flu Vaccinations
- Alcohol and Tobacco – Screening, Tobacco and Alcohol Brief advice
- Three high impact actions to prevent hospital falls
- Same Day Emergency Care – Pulmonary Embolus, Tachycardia with Atrial Fibrillation, Community Acquired Pneumonia
- Medicines Optimisation
- Towards Hepatitis C Virus (HCV) Elimination
- Cystic Fibrosis Self-Care
- Clinical Utilisation Review
- Dental Managed clinical networks
- Bowel Screening Workforce Development Plan – Public health screening programmes

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 did not take enforcement action against the Trust in 2019/20.

A planned CQC core services inspection took place at UH Bristol between March and May 2019. The Trust retained its previous 'Outstanding' rating. Detailed ratings are presented below:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency Care	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Requires improvement →← May 2019	Good ↓ May 2019	Requires improvement ↓ May 2019
Medical Care (including older people's care)	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Surgery	Good →← May 2019	Good →← May 2019	Outstanding →← May 2019	Outstanding ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019
Critical care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Requires improvement Dec 2014	Good Dec 2014	Good Dec 2014
Services for children and young people	Good →← May 2019	Outstanding →← May 2019	Good →← May 2019	Good →← May 2017	Outstanding ↑ May 2019	Outstanding ↑ May 2019
End of life care	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014	Good Dec 2014
Maternity	Requires improvement May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Outpatients and diagnostics	Good Mar 2017	Not rated	Good Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Overall trust	Requires improvement ↓ May 2019	Good ↓ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding →← May 2019	Outstanding →← May 2019

2.2.6 Data quality

UH Bristol submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES), which are included in the latest published data.

The percentage of records:

- which included the patient's valid NHS number was: 99.5 per cent for admitted patient care; 99.8 per cent for outpatient care; and 97.5 per cent for accident and emergency care.
- which included the patient's valid general practice code was: 99.5 per cent for admitted patient care; 99.9 per cent for outpatient care and 98.9 per cent for accident and emergency care.

(Data source: NHS number, Trust statistics. GP Practice: NHS Information Centre, SUS Data Quality Dashboard, April 2019 – March 2020 extracted 21/04/2020)

UH Bristol completed 106 of 116 mandatory requirements in the 2019/20 Data Security and Protection Toolkit and submitted an Improvement Plan to NHS Digital to achieve the remaining requirements. NHS Digital approved this Improvement Plan and UH Bristol's Data Security and Protection Toolkit Assessment is "Standards Not Fully Met – Plan Agreed".

National Payment by Results audits have ceased in England and it has been delegated to each Trust to organise its own clinical coding audit programme.

In March 2020, the Trust commissioned an External Clinical Coding Audit to fulfil the DS&P Toolkit requirement. The Audit reviewed a total of 200 episodes from the Specialities of Ophthalmology, Respiratory Medicine and General Medicine. The episodes audited were randomly selected from September – December 2019 data. The audit focussed on primary diagnoses and procedures as well as completeness of codes including comorbidities. These percentages achieved meet the mandatory level of attainment for an Acute Trust in line with HSCIC's Data Quality Standard 1 and exceed that for Standard 3 Training.

The following levels of accuracy were achieved:

- Primary diagnosis accuracy: 96.0 per cent
- Primary procedure accuracy: 94.6 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 2019/20 (or, in some cases, latest available information which predates this) is summarised in the table below. The Trust is confident that this data is accurately described in this Quality Report.

Table 3

Mandatory indicator	**UH Bristol Most Recent**	**National average**	**National best**	**National worst**	**UH Bristol Previous**
Venous thromboembolism risk assessment	77.9% 2019/20 Q3	95.3%	100%	71.6%	85.3% 2019/20 Q2
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over). Total Cases	29.2 2018/19	34.9	0.0	168	32.7 2017/18
Rate of patient safety incidents * reported per 1,000 bed days	76.3 Oct19-Mar20	50.66**	110.2**	27.5**	60.1 Oct17-Mar18
Percentage of patient safety incidents* resulting in severe harm or death	0.39% Oct19-Mar20	0.33**	0.0%**	0.86%**	0.35% Oct17-Mar18
Responsiveness to inpatients' personal needs	71.3 2018/19	67.2	85.0	58.9	71.2 2017/18
Percentage of staff who would recommend the provider	85.4% 2019 survey	70.5%	87.4%	39.7%	84.9% 2018 survey
Summary Hospital-level Mortality Indicator (SHMI) value and banding	96.4 (Band 2 "As Expected") Jul19-Jun20	100.0	67.6	120.7	104.6 (Band 2 "As Expected") Jul18-Jun19
Percentage of patient deaths with specialty code of 'palliative medicine' or diagnosis code of 'palliative care'	34% Jul19-Jun20	37%	60%	9%	34% Jul18-Jun19
Emergency readmissions within 30 days of discharge: age 0-15	10.2% 2018/19	13.1%	1.8%	69.2%	10.0% 2017/18
Emergency readmissions within 30 days of discharge: age 16 or over	13.3% 2018/19	12.3%	2.1%	57.5%	13.3% 2017/18

* Incidents meeting criteria for reporting to the National Reporting and Learning System include some incidents categorised locally as health and safety incidents

**National Reporting and Learning System acute non-specialist trust peer group

Part 3

Review of services in 2019/20

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 achieve this by successfully implementing proactive patient safety improvement programmes and by working to better understand and improve our safety culture. We will continue to conduct thorough investigations and analyse 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 the care we have provided.

3.1.1 Our Patient Safety Improvement Programme 2019-2021

#DeliveringSaferCare

Our new Patient Safety Improvement Programme commenced in 2019. The purpose of the Trust's Patient Safety Improvement Programme is to provide a framework and structure to take forward quality and safety improvements across the trust, focus on internal and external improvement opportunities identified from systematic learning and new developments. The programme underpins the Trust's commitment to continuous improvement and stated aims of the Quality Strategy 2016-2020: to deliver safe and reliable care, improve outcomes and decrease mortality.

The aims of the Patient Safety Improvement Programme 2019-2021 are:

- To systematically improve safety and quality across the trust to reduce risks to patients and drive harm reduction.
- To align with the priorities of NHS Improvement's emerging patient safety strategy and national and regional programmes, such as the National Maternity and Neonatal Health Improvement programme and the West of England Patient Safety Collaborative programme.

We set our patient safety priorities for 2019-2021 by gathering information from several sources to identify what our priorities should be for the next three years.

A thematic analysis of the information gathered identified the following key themes on which to focus our improvement work for 2019 to 2021. These workstreams are as follows:

a) Deteriorating Patients and Sepsis
b) Medication Safety
c) Peri-operative Never Events
d) Leadership and Culture
e) Paediatrics
f) Maternity and Neonatal care
g) ReSPECT
h) Interruptions and Distractions

A summary of the key safety and quality achievements of our 2019/2020 Patient Safety Improvement Programme follows.

3.1.1.1 Improving the management of the deteriorating patient:

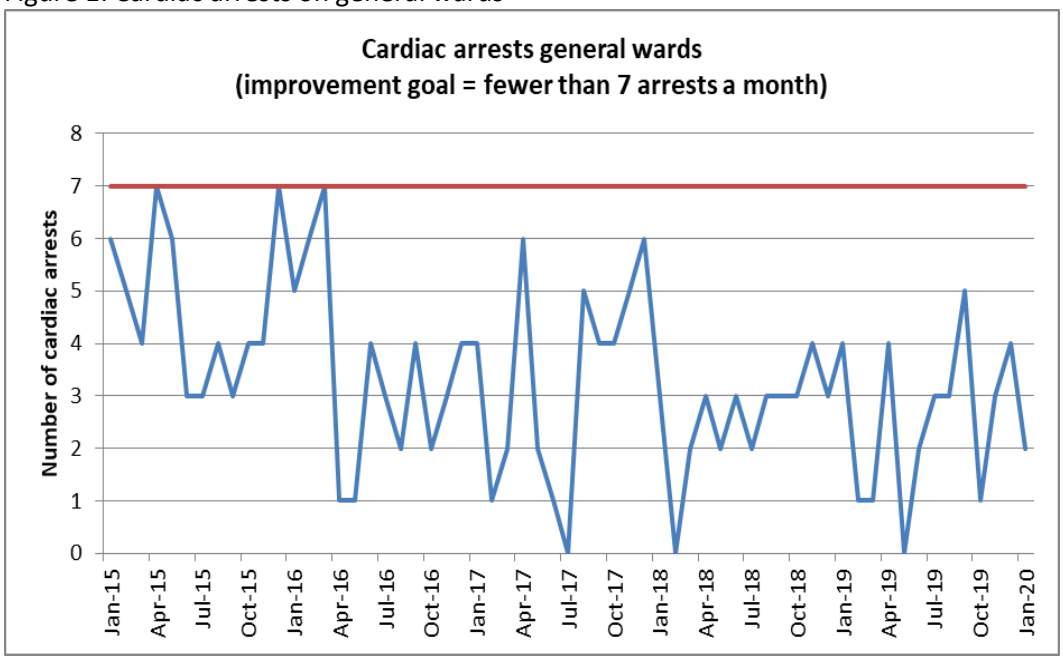
Assessment of a patient's physiological status, recognition of deterioration and obtaining a prompt response from a more senior healthcare professional continues to be one of the foundations of healthcare provision. Use of early warning scores calculated from measurement of physiological parameters is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

Our aim by end of 2021, to achieve 365 "days between" an adult patient coming to moderate or above harm as a result of failure to recognise and respond to deterioration or to enact ceiling of care/ end of life decision. To sustain fewer than seven adult cardiac arrests per month on general wards.

Key achievements in 2019/2020:

- We continually meet our improvement goal to sustain fewer than seven adult cardiac arrests on general wards, see Figure 2 for the data. This is due to the early recognition of deterioration of our patients.

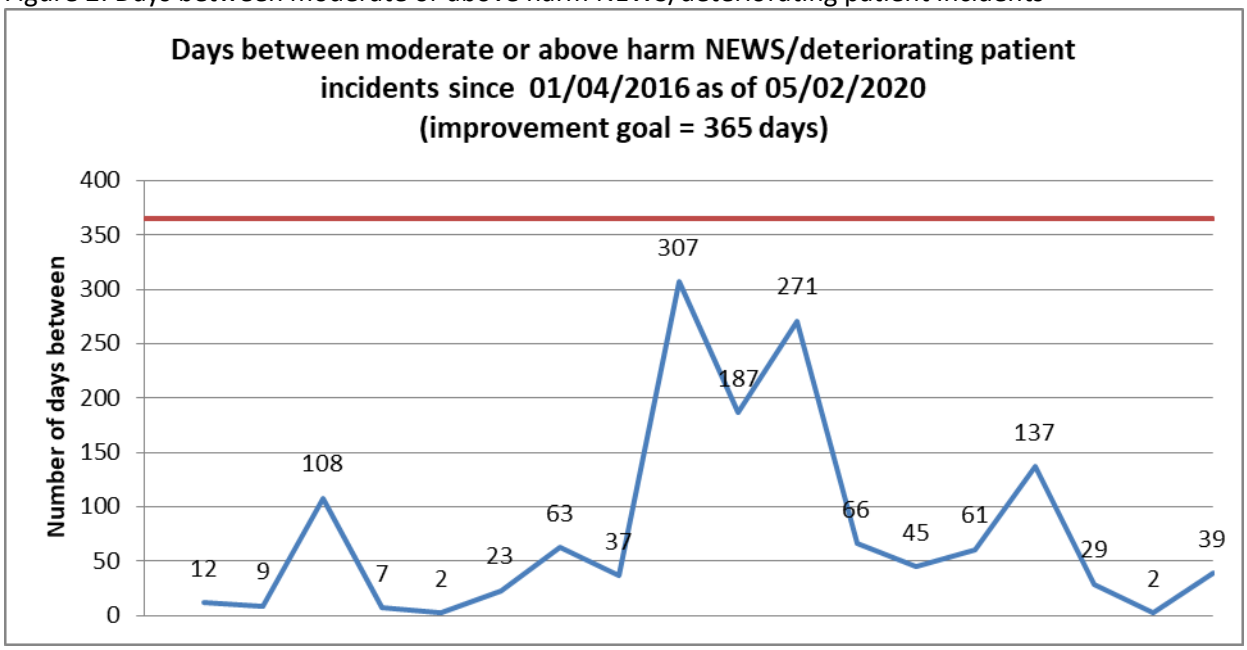
Figure 1: Cardiac arrests on general wards



Source: Monthly UH Bristol Resusication team

- We have not achieved our 'Days between' moderate or above harm incidents related to failure to recognise deterioration improvement goal. Our 2019-2021 programme plans is to implement a system for automatic electronic escalation of deteriorating patients.

Figure 2: Days between moderate or above harm NEWS/deteriorating patient incidents



Source: UH Bristol Datix Risk Management System

- Data is showing we have not achieved our improvement goal of 365 days between NEWS/deteriorating patient incidents resulting in moderate or above harm. Deteriorating patient incidents were particularly notable around December 2019 /January 2020 with many resulting in no harm due to the preventative actions of staff.

3.1.1.2 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 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.

We aim to increase survival rates for emergency suspicion of sepsis (SOS) admissions to 94 per cent and Summary Hospital-level Mortality rate (SHMI)[1] less than 90 by December 2021.

[1] The SHMI data is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Key achievements in 2019/2020:

- By the end of 2019, we achieved our 90 per cent improvement goals for sepsis screening, delivering antibiotics within an hour and 72-hour review of antibiotics. Screening in patients with raised NEWS scores for sepsis has been improved by prompts from our e-observations system.
- We implemented sepsis screening and a sepsis pathway in our children's emergency department and maternity services, and are developing inpatient sepsis pathways for children.

3.1.1.3 Improving medicines safety:

There are an estimated 66 million potentially significant medication errors per year in the UK, 29 per cent of these in secondary care. There are currently around 350 reported medication incidents per month in the Trust.

We have drawn from local and national strategies (NHS Patient safety Strategy [Medicines Safety Improvement Programme], Academic Health Science Networks (AHSN) Medication safety project & Patient Safety Collaborative, Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together work programme and the World Health Organisation (WHO) Medication Without Harm campaign) to build on previous improvement work and put in place measure to improve medication safety.

Key achievements in 2019/2020:

- We implemented a team-based approach to ward clinical pharmacy services and the development of an electronic dashboard to facilitate patient prioritisation. This has enabled us to target patients more effectively and increase the number of patients for whom we can reconcile their medication within 24 hours of admission.
- We introduced a Pharmacy dashboard revised to show thromboprophylaxis recommendations from the Medway risk assessment.
- Unfortunately, Medway electronic prescribing and medicines administration (EPMA) has been ceased on all adult wards unlikely to be implemented until autumn 2020 – spring 2021. Due to an essential upgrade of the IT systems needed before we can go live for all adult services.

3.1.1.4 Reducing Peri-procedure Never Events:

Our longstanding aim of this workstream is to reduce the incidence of peri-procedure never events: wrong-site surgery, retained foreign object and wrong implant/prosthesis.

We have continued to achieve this by the implementation of the National Safety Standards for Invasive Procedures (NatSSIPs) and focusing on improving engagement of clinical teams in use of the WHO surgical safety checklist. To reduce the risks inherent in providing invasive procedures in ward, ITU and Theatre environments, the use of WHO and LocSSIP checklists are advised although the effectiveness and consistency of their use is not clearly identified in all associated departments across the Trust.

Key achievements in 2019/2020:

- We are further working on ensuring the World Health Organisation (WHO) and Local Safety Standards for Invasive Procedures (LocSSIP) checklists fit for purpose and their use to be universal in all departments carrying out invasive procedures.

- We successfully implemented LocSSIP for Abdominal Paracentesis and Lumbar Puncture procedures carried out on the wards. LocSSIP use is embedded within the Trust. Our improvement goal aim is 80 per cent we have sustained average completion across the Trust.
- We, unfortunately, have not sustained our improvement goal of 80 per cent compliance for LocSSIP chest drain completion; this remains a focus of the workstream with attendance through the QI silver[2] academy programme, working with the ward areas to review their systems and processes.
- Unfortunately, we have not achieved our improvement goal of number of days between peri-procedure never events our improvement goal of 365 days. Further details of never events which occurred in 2019/2020 are provided in section 3.1.3.

3.1.1.5 Improving Leadership and culture:

- We took part in the first-ever World Patient Safety Day on the 17th September 2019; the World Health Organisations (WHO) global campaign to create awareness of Patient Safety. Our Patient Safety Teams held a week-long programme to promote patient safety within the Trust.
- We have made the decision to refresh executive director walk rounds into 2020/21 as leadership walk rounds in conjunction with the Wellbeing Team and Weston Area Health Trust as part of the merger between our two organisations.
- We successfully audited the quality of ward safety briefings and shared with divisions. The key findings were overall safety briefings were standardised across the trust, well attended and embedded in daily practices and compliance of the safety brief were good.

3.1.1.6 Paediatric workstreams:

Since our new Improvement Programme commenced in 2019 Paediatric services have continued to engage and build on their workstream with achievements throughout the programme. The paediatric workstreams echoes the Patient Safety Improvement Programme and Patient Safety Priorities in following the adult workstreams:

- Deteriorating patient and Sepsis
- Medication safety
- leadership and culture
- Peri-operative never events workstream

Key achievements in 2019/2020:

- The deteriorating patient workstream has implemented Mobile Resuscitation Carts (see picture below) which have been fully implemented throughout the hospital to improve compliance and competence with key resuscitation skills. The carts offer training on four

[2] The QI silver programme is part of the QI Academy which focuses on teaching people how to implement improvement ideas through practical workshops, an innovation and improvement toolkit, mentorship from 'improvement coaches', skills training in audits and R&D, and certification upon completion of the academy silver and bronze programmes.

key skills: teenage and infant chest compressions and ventilation. Each skill takes three to five minutes to complete and will reduce the need for face-face training.

- The deteriorating patient workstream showed that the unplanned admissions to PICU have significantly decreased (93 unplanned admissions in 2018 verses 58 unplanned admissions in 2019).
- The leadership and culture workstream have successfully launched Greatix 'learning from excellence tool"[3] across the BRHC. The number of teams using the Greatix tool continues to increase.

3.1.1.7 Maternity and Neonatal Health Safety Collaborative Programmes:

We are working with the Maternal and Neonatal Health Safety Collaborative (MNHSC) a National three-year Quality Improvement Programme that was launched in February 2017 and is led by NHS Improvements Patient Safety team. We are focusing on smoking cessation, venous thromboembolism (VTE) compliance and pain reassessment according to Trust standards as improvement goals.

Key achievements in 2019/2020:

- We are working on reducing the percentage of mothers smoking at time of delivery; this remains a key focus of our workstream.
- We have sustained our improvement goal of the percentage of patients that had had their moderate or severe pain reassessed within an hour post analgesic administration. January 2020 data showed 100 per cent compliance.
- We have not yet achieved our improvement goal of 95 per cent however the QI team at STMH, maternity wards and gynaecology team have focused on this improvement. See Figure 3 below.

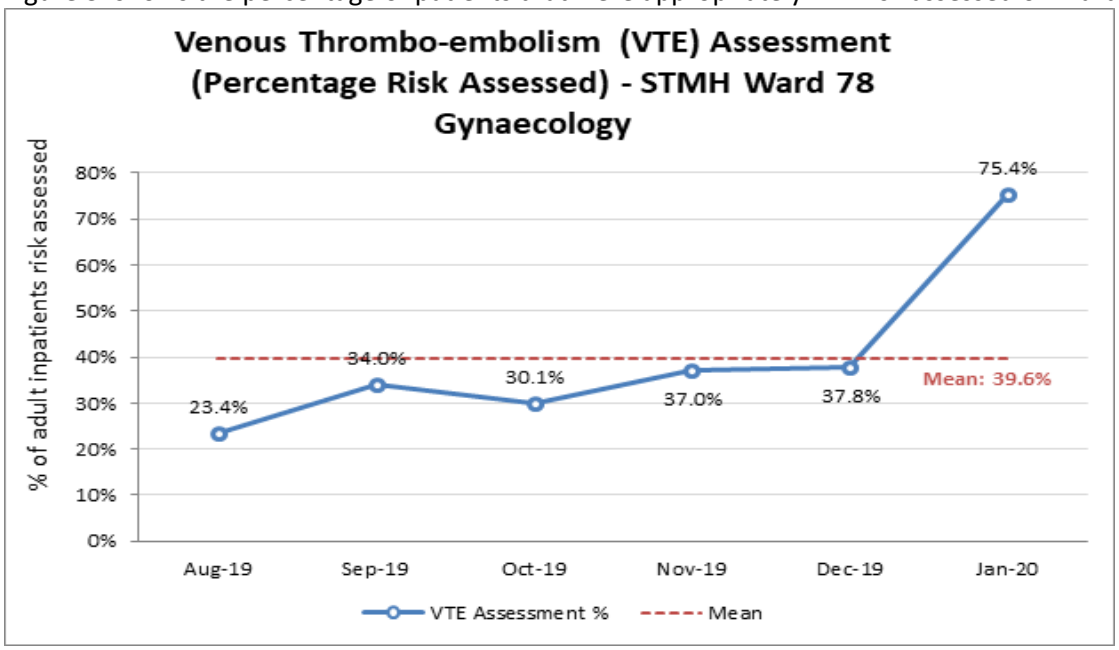
3.1.1.8 ReSPECT (Recommended Summary Plan for Emergency Care and Treatment):

ReSPECT was implemented in The West of England Academic Health Science Network (AHSN) in spring 2019 for documentation of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions but also advanced care planning decisions. The ReSPECT is a process to plan a person's clinical care in the event of a future emergency when they might be unable to make or express choices.

In October 2019, the ReSPECT process was successfully implemented across the WEAHSN for documentation of DNACPR decisions but also for advanced care planning decisions.

[3] 'Learning from Excellence' is an innovation that focuses on capturing and learning from episodes of excellence in healthcare in an attempt to further improve the quality and safety of care that we provide.

Figure 3: shows the percentage of patients that were appropriately VTE risk assessed on ward 78



Source: UH Bristol InfoWeb system

3.1.1.9 Interruptions and Distractions:

The delivery of healthcare occurs within an increasingly complex and pressured system, meaning staff more frequently find themselves in situations which increase the chance of human error occurring. The aim for this workstream is to reduce and/or mitigate the impact of interruptions and distractions on staff, thereby reducing the risk of human error leading to an incident.

This workstream remains in the scoping phase we are working with clinical teams to understand and assess frequency and types of interruptions and distractions via focus groups, reporting of medication errors and the 'clicker challenge'[4].

3.1.2 Freedom to Speak Up

The Trust has a Freedom to Speak Up Guardian (FTSUG) to whom all staff can raise concerns. To support the work of the Guardian, more than 50 staff 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 FTSUG 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 FTSUG 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.

[4] Clicker challenge is a workplace analysis of the frequency interruption and distractions that take place on a normal clinical working day.

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 FTSUG is only one mechanism through which staff can raise concerns. The Trust also has the following groups or processes which can assist staff:

- Bullying 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;
- A video explaining 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 how to contact the FTSUG; and
- The FTSUG and Advocates attend meetings with staff groups to personal relay messages and answer questions about Speaking Up.

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

3.1.3 Never Events

Despite the work we continue to do on preventing peri-procedure never events, there were four such Never Events reported in our Trust in 2019/20:

- Wrong type of intrauterine device fitted (June 2019)
- Laser eye surgery performed in outpatients on the wrong patient (July 2019)
- An additional tooth extracted ten teeth in total instead of nine (August 2019)
- A historic incident from 2014 where it appears that a fallopian tube was removed in addition to a planned ovarian cyst removal (December 2019)

Investigations from all four never events have been completed. Examples of improvements we have made as a result of our investigations include:

- Changes to the checking process for intrauterine device insertions to clarify whether the device being fitted contains copper or a hormone
- Changes to the GP referral form to make it clear which type of intrauterine device the patient is being referred for
- Development of a bespoke WHO checklist for laser eye surgery to include a 'time out' to check again the patient's identity, consent, procedure, laterality and patient's record
- Change in practice for the operator to vocalise each tooth to be extracted at the point of placing the instrument and for the assistant to confirm the tooth is to be extracted
- Changes to sedation monitoring during dental extractions

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 2019/20, 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 73, compared to 70 in 2018/19. Two serious incidents were downgraded and one serious incident was requested to be downgraded. A breakdown of the categories of the 71 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 continue to focus on reducing pressure ulcers, some those reported in 2019/20 have developed underneath plaster casts and splints and some more recent incidents have been associated with delays in obtaining pressure relieving equipment. Actions to reduce risk of patients developing pressure ulcers in hospital and sustaining falls are contained with annual work plans and we are also introducing digital clinical risk assessments for patients to improve visibility and prompt timely updates.

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).

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 share learning from incidents within patient safety update sessions for staff.

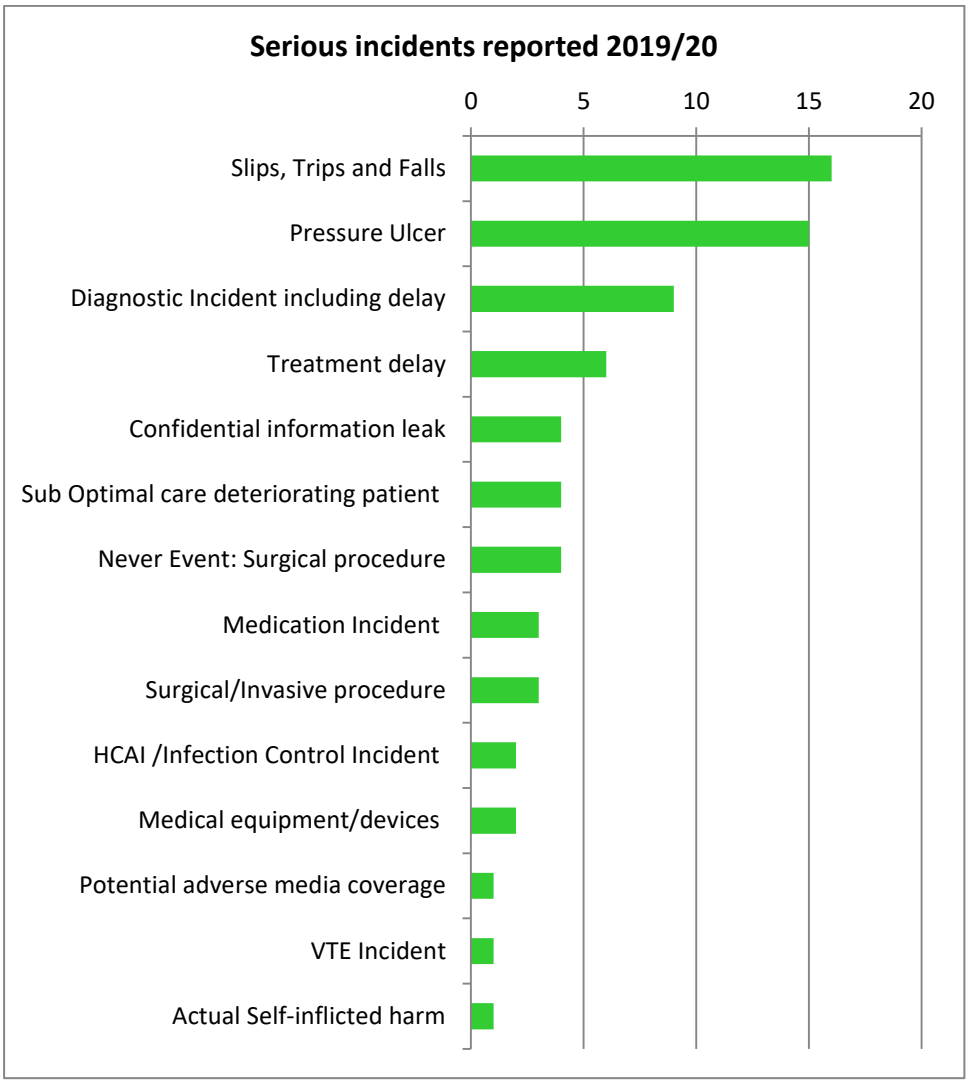
3.1.6 Duty of Candour

We continue to comply with the statutory and regulatory requirements for Duty of Candour as evidenced in each of our serious incident investigation reports and local audits.

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/.

Figure 4



Source: UH Bristol Serious Incident Log

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.

Table 4

Quality measure	Data source	Actual 2018/19	Target 2019/20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Infection control and cleanliness monitoring								
Number of MRSA Bloodstream Cases	National Infection Control data (PHE)	6	0	0	1	0	3	4
Number of *Clostridium difficile* Cases	National Infection Control data (PHE)	31	< 57	8	14	13	6	41
Number of MSSA Cases	Infection Control system (MESS)	34	< 25	15	15	10	8	48
Hand Hygiene Audit Compliance	Monthly audit	97.1%	≥ 95%	95.9%	97.6%	97.7%	97.6%	97.2%
Antibiotic prescribing Compliance	Monthly audit	78.9%	≥ 90%	79.1%	84.5%	73.5%	79.1%	77.9%
Cleanliness Monitoring - Overall Score	Monthly audit	95.0%	≥ 87%	95.7%	96.0%	96.3%	94.5%*	95.7%*
Cleanliness Monitoring - Very High Risk Areas	Monthly audit	97.0%	≥ 98%	98.0%	97.7%	98.0%	98.5%*	98.0%*
Cleanliness Monitoring - High Risk Areas	Monthly audit	96.0%	≥ 95%	96.3%	96.0%	96.7%	97.5%*	96.5%*
Serious incidents and Never Events								
Number of Serious Incidents Reported	Local SI Log	70	No set target	18	23	17	15	73
Serious Incidents Reported Within 48 Hours	Local SI Log	98.6%	100%	100%	100%	100%	100%	100%
72 Hour Report Completed Within Timescale	Local SI Log	94.3%	100%	94.4%	91.3%	100%	100%	95.9%
Serious Incident Investigations Completed Within Timescale	Local SI Log	96.8%	100%	100%	100%	100%	92.3%	98.5%
Total Never Events	Local SI Log	5	0	1	2	1	0	4
Patient safety incidents								
Number of Patient Safety Incidents Reported	Datix	16,269	No set target	5,069	5,215	5,385	5,091	20,760
Patient Safety Incidents Per 1000 Bed days	Datix/Medway	58.52	No set target	64.84	66.99	66.78	67.17	66.44
Number of Patient Safety Incidents - Severe Harm**	Datix	78	No set target	26	47	43	34	150
Patient falls								
Falls Per 1,000 Bed days	Datix/Medway	4.55	< 4.80	4.48	4.30	4.35	4.95	4.52
Total Number of Patient Falls Resulting in Harm	Datix	24	< 24	3	4	7	12	26
Pressure ulcers developed in the Trust								
Pressure Ulcers Per 1,000 Bed days	Datix/Medway	0.295	< 0.40	0.128	0.180	0.174	0.251	0.182
Pressure Ulcers - Grade 2	Datix	80	No set target	9	9	13	18	49
Pressure Ulcers - Grade 3 or 4	Datix	10	0	1	5	1	1	8
Venous Thromboembolism (VTE)								
Adult Inpatients who Received a VTE Risk Assessment	Medway	98.3%	≥ 95%	98.3%	85.3%	77.9%	87.9%	87.4%
Number of Hospital Associated VTEs	Monthly local pharmacy audit	47	No set target	9	16	5	8*	38*
Number of Potentially	Monthly local	5	0	1	2	0	0*	3*

Avoidable Hospital Associated VTEs	pharmacy audit							
Nutrition								
Fully and Accurately Completed Nutritional Screening within 24 Hours	Quarterly local dietetics audit	91.1%	≥ 90%	84.4%	86.9%	87.9%	88.2%	86.9%
WHO checklist								
WHO Surgical Checklist Compliance	Medway/Bluespier	99.8%	100%	99.8%	100%	99.9%	99.9%	99.9%
Medicines								
Medication Incidents Resulting in Harm	Datix	0.29%	< 0.5%	0.37%	0.80%	0.14%	0%	0.33%
Non-Purposeful Omitted Doses of the Listed Critical Medication	Monthly local pharmacy audit	0.37%	< 0.75%	0.37%	0.14%	0.30%	0.92%	0.41%
Timely discharges								
Out of Hours Departures (20:00 to 07:00)	Medway PAS	8.7%	No set target	8.3%	7.3%	7.4%	8.2%	7.8%
Percentage of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	23.9%	≥ 25%	22.7%	22.2%	23.2%	22.9%	22.8%
Number of Patients With Timely Discharge (07:00-12 noon)	Medway PAS	9815	No set target	2,259	2,236	2,524	2,192	9,211
Staffing levels								
Nurse staffing fill rate combined	National Unify return	99.3%	No set target	100.9%	99.2%	100.0%	101.2%	100.3%

*excludes data for March 2020 as manual audits paused during the first wave of the Covid pandemic
** data subject to manager's harm validation after each month end or following an investigation.

3.2 Patient experience

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

3.2.1 National patient surveys

Each year, the Trust participates in the Care Quality Commission's national patient experience survey programme. These national surveys reveal how the experience of patients at UH Bristol compares with other NHS acute trusts in England. UH Bristol achieved the following successes in the national survey results published during 2019/20[5]:

- In the 2018 National Inpatient Survey, fourteen of UH Bristol's scores were better than the national average to a statistically significant degree; with the overall experience rating from patients being the best of any acute non-specialist trust nationally
- Our 2018 National Cancer Patient Experience Survey results showed an improvement for the fourth 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 2019 National Maternity Survey, we achieved a "better than national average" rating for the experience that women have at our St Michael's Hospital during their labour and birth - including the best score nationally on women being treated with respect and dignity during this time.
- In the 2018 national children's survey, the Bristol Royal Hospital for Children received an overall hospital experience rating from both children and parents that was amongst the best 20 per cent of trust scores nationally.

Table 5 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 2019/20. Figure 5 provides an indication of UH Bristol's performance relative to the national average.

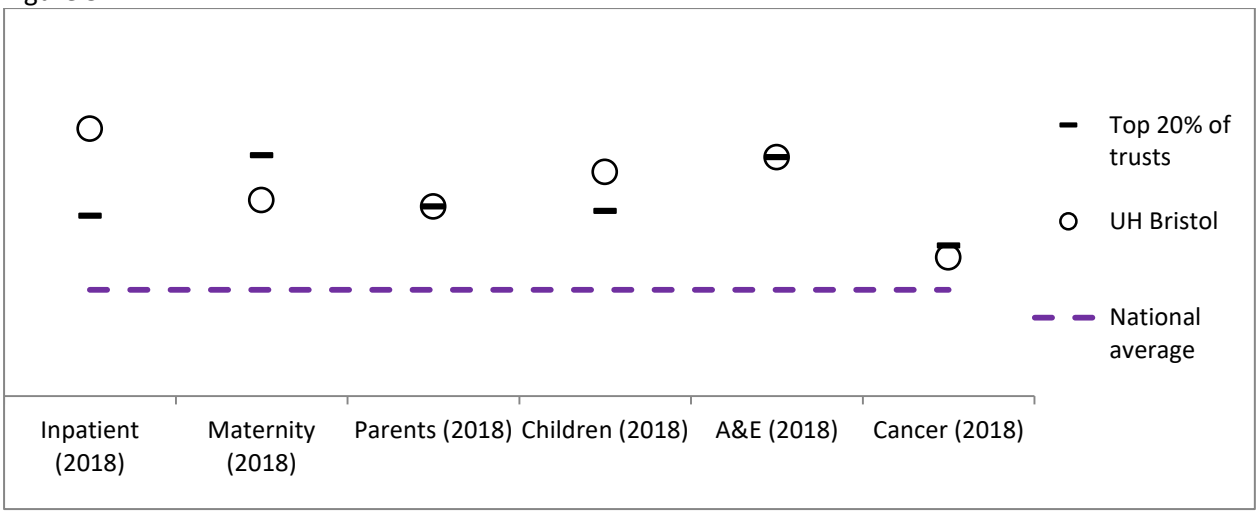
Table 5: Results of national patient surveys received by the Trust during 2018/19 (number of scores above, in line with, or below the national average)

		Comparison to national average		
	Date patients attended	Above (better)	Same	Below
2018 National Cancer Survey	April-June 2018	5	44	0
2018 National Children's Survey	November to December 2016	6	58	1
2019 National Maternity Survey	February 2019	6	46	0
2018 National Inpatient Survey	July 2018	14	49	0

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

[5] The national surveys tend to be published around ten months after the participating patients attended hospital.

Figure 5



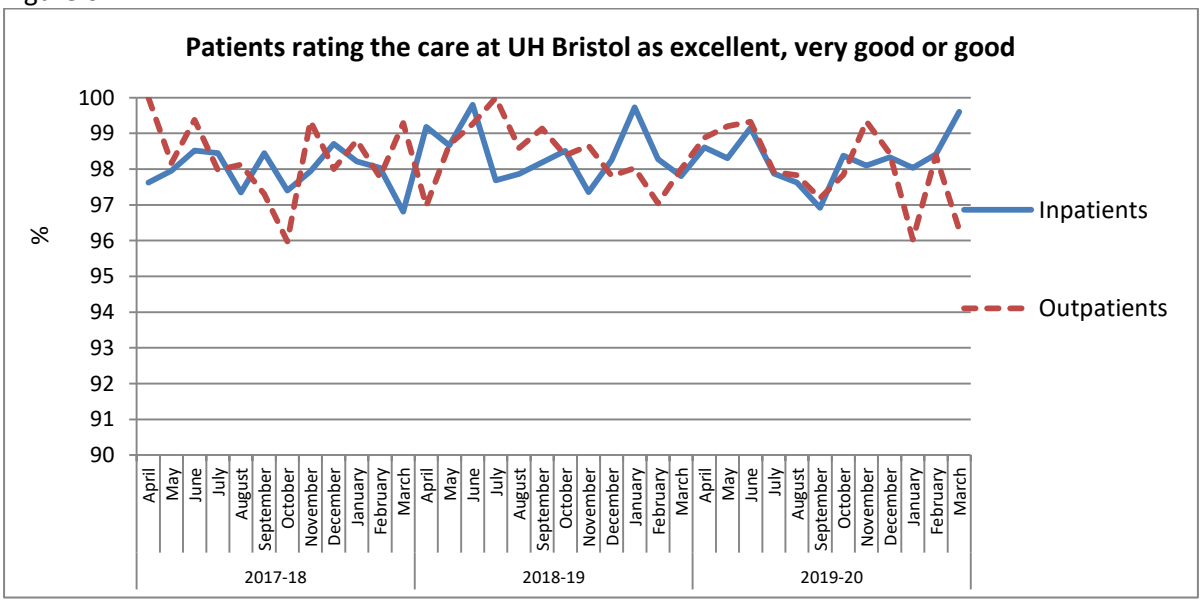
Source: UH Bristol Patient Experience and Involvement Team analysis of Care Quality Commission data

3.2.2 UH Bristol patient survey programme

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

The Trust continues to receive very positive feedback from service-users in our monthly postal surveys (Figure 8). Over the 2019/20 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 remains by far the most frequent form of feedback that we receive.

Figure 6



Source: UH Bristol postal survey

Our extensive patient feedback processes provide us with important insights from patients and people who visit our hospitals about how we can continually improve our services. During 2019/20 we extended our programme further, with the roll-out of our new electronic feedback and reporting system. This allows patients, visitors and carers to provide feedback in real-time and raise any issues or concerns with us.

We have also carried out a range of improvement activities with the aim of providing a consistently excellent "customer service" across our hospitals. This included securing funding for an advanced customer service training course that will be implemented in 2020/21. This course will target all administrative staff in "front of house roles" (e.g. ward clerks, receptionists, telephone operatives).

As part of a corporate quality objective (see section 2.1.1), we have also strengthened the training and support that we provide for lay representatives on UH Bristol's groups and committees. This will help to ensure that the people who contribute to the development of our services are fully supported to do so and that the benefits of their involvement are maximised.

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 some highlights from this activity in 2019/20:

- The Cardiology and Cardiac Surgery teams carried out patient focus groups to hear about the social and psychological impact of invasive and non-invasive heart procedures. Attendees also contributed to a review of the cardiac surgery pathway being carried out by the management team.
- Patients attending the Bristol Haematology and Oncology Hospital participated in a partnership project with the South West Cancer Alliance to discuss their experiences of social and emotional support as part of their care package.
- The Bristol Eye Hospital management team worked with the Bristol Sight Loss Council on refurbishment plans for the hospital.
- Representatives of the Bristol Physical Access Chain met with the Trust's Operations Transport and Green Travel Manager to influence proposals to improve the arrangements for disabled parking, drop off points, bus and taxi services to the entrance of the Bristol Royal Infirmary.
- Members of the UH Bristol Involvement Network Group joined Trust Members and representatives of the Trusts Young Person's Involvement Group in our annual Quality Counts event.
- A young people's involvement event was held at the Trust's Simulation Centre as part of the Trust's approach to promoting career opportunities in the health service and consisted of hands on simulation activities, workshops and a careers marketplace.
- Members of the Trust's Involvement Network contributed to the revised Trust Complaints Policy as part of the Equality Impact Assessment linked to the policy.
- The Trust's "Face-to-face" volunteer team were actively engaged in a range of patient experience projects again this year, including mystery shopping in our Chemotherapy, Opthalmology and Rheumatology services, and carrying out an interview-based travel survey.

3.2.4 Equality and diversity

The Trust carried a range of activities with the aim of ensuring that we deliver equitable care and services to all sections of the community that we serve. Some of the activities in this respect included:

- Continuing to develop and embed the work of our Patient Inclusion and Diversity Group (PIDG - established in 2018) and its Divisional working sub-group. These groups are the Trust's main vehicle for equality and diversity issues affecting patients and service users.
- Working with representatives from the Transgender community to design and deliver Transgender awareness training sessions for doctors and nurses
- Implementing a process by which appointment letters produced by our external printing provider can be produced in accessible formats
- Procuring a new provider of our external spoken language interpreting services in collaboration with Weston Area Health NHS Trust and North Bristol NHS Trust – to help ensure a degree of consistency for patients across key acute hospital providers
- Extending our remote British Sign Language video interpreting service to more locations around our Trust
- Carrying out a tender for our external translating and interpreting services. This was in collaboration with other local NHS trusts to help develop more seamless support for patients as they move between organisations. Our work on this tender has been used as a national best practice case study by Crown Commercial Services.
- Taking a lead role in the establishment of the Bristol Deaf Health Partnership and the Bristol Visual Impairment Partnership, both of which act as a single forum for sharing information and improving the quality of care for patients and their carers.
- Commissioning an external access audit of the Trust's hospital sites which will provide patients and carers with detailed information about physical access to our hospitals - enabling them to plan their journeys better.
- The Bristol Eye Hospital working in collaboration with the Bristol Sight Loss council on development plans for hospital estate

3.2.5 Complaints received in 2019/20

In 2019/20, 1,785 complaints were reported to the Trust Board, compared with 1,879 in 2018/19[6]. 552 (30.9 per cent) of these complaints were investigated via the formal complaints process, with the remainder addressed through informal resolution.

In addition, the Patient Support and Complaints Team dealt with 903 other enquiries, including compliments, requests for support and requests for information and advice; this represents a 6.4 per cent decrease on the 965 enquiries dealt with in 2018/19. The team also received and recorded an additional 618 enquiries which did not proceed after being recorded (the same amount as in 2018/19). In total, the team received 3,306 separate enquiries into the service in 2019/20; a slight decrease on the 3,428 reported the previous year.

In 2019/20, the Trust had 14 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO), representing a significant 54.8 per cent decrease on the 31 cases referred the previous year. During the same period, coincidentally, 14 cases were closed by the PHSO. Of these 14 cases, none were upheld, one was partly upheld, and the remaining 13 fell into the category designated by the PHSO whereby they carried out an initial review but then decided

[6] Previously 1,874 in 2016/17, 1,941 in 2015/16 and 1,883 in 2014/15

not to investigate and closed their file, citing 'no further action'. At the end of the year 2019/20, 13 cases were still under investigation by the PHSO.

758 complaints were responded to via the formal complaints process in 2019/20 and 88 per cent of these (667) were responded to within the agreed timescale. This is similar to the 87 per cent achieved in 2018/19, which does not meet the Trust target of 95 per cent. A total of 1,004 complaints were responded to in 2019/20 via the informal complaints process and 89.3 per cent of these (897) were responded to within the agreed timescale, an improvement on the 83.5 per cent achieved the previous year.

At the end of the reporting year, 9.1 per cent of complainants had expressed dissatisfaction with the formal response they had received. This represents a total of 62 of the 680 first formal responses sent out during the reporting period and compares with 9.5 per cent in 2018/19 and 9.7 per cent in 2017/18.

3.2.6 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 6

Quality measure	Data source	Actual 2018/19	Target 2019/20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Monthly patient surveys								
Patient Experience Tracker Score	Monthly postal survey	91	≥ 87	91	92	92	91	91
Kindness and Understanding	Monthly postal survey	96	≥ 90	96	96	95	96	96
Outpatient Tracker Score	Monthly postal survey	90	≥ 85	90	90	90	90	90
Friends and Family Test (coverage)								
Inpatient Coverage	Friends and Family Test	35.1%	≥ 30%	37.7%	36.7%	34.1%	32.7%	35.5%
ED Coverage	Friends and Family Test	16.4%	≥ 15%	16.8%	16.9%	16.4%	16.0%	16.6%
Maternity Coverage	Friends and Family Test	18.3%	≥ 15%	27.7%	25.9%	26.6%	25.3%	26.5%
Friends and Family Test (score)								
Inpatient Score	Friends and Family Test	98.2%	≥ 90%	98.4%	98.9%	98.5%	98.9%	98.7%
ED Score	Friends and Family Test	82.1%	≥70%	82.0%	83.3%	84.6%	87.5%	84%
Maternity Score	Friends and Family Test	97.3%	≥92%	97.4%	97.4%	98.0%	97.9%	97.6%
Patient complaints								
Number of Patient Complaints	Patient Support and Complaints Team	1,845	No set target	511	442	445	444	1,842
Complaints Responded To Within Trust Timeframe	Patient Support and Complaints Team	86.1%	≥ 95%	95.5%	83.6%	88.3%	85.0%	88.0%
Complaints Responded To Within Divisional Timeframe	Patient Support and Complaints Team	85.5%	No set target	96.6%	88.3%	90.3%	89.2%	91.0%
Percentage of Responses where Complainant is Dissatisfied	Patient Support and Complaints Team	9.1%	< 8%	9.5%	8.8%	6.6%	6.9%	8.0%

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

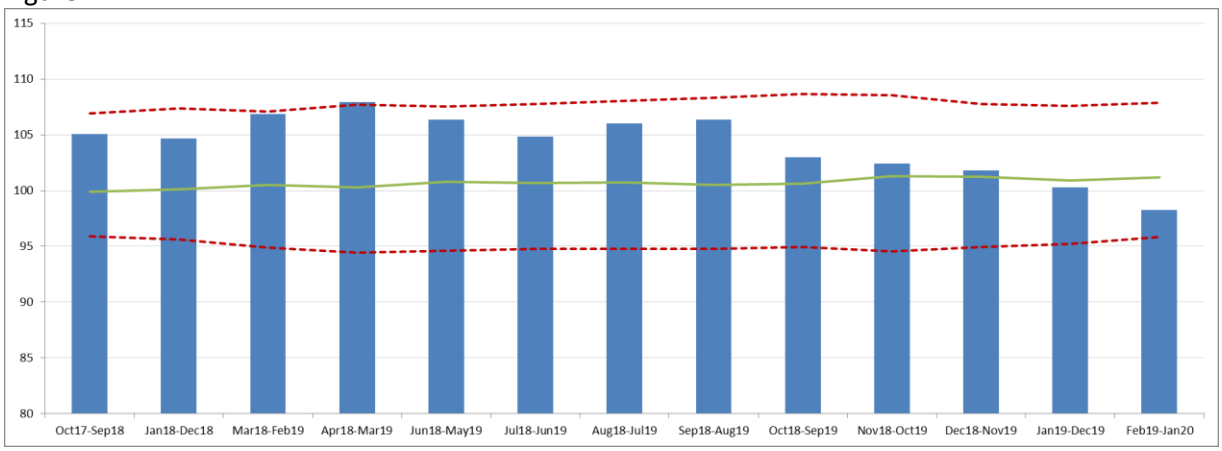
The Trust continues to monitor the number of patients who die in hospital and those who die within 30 days of discharge. This is done using the two main tools available to the NHS to compare mortality rates between different hospitals and trusts: Summary Hospital Mortality Indicator (SHMI) produced by 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 8, 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 February 2019 to January 2020 shows that the Trust remains in the 'as expected' category. In this period the Trust had 1,685 deaths compared to 1,715 expected deaths; a SHMI score of 98.25.

Figure 7



Source: CHKS benchmarking

The latest HSMR data available (published January 2020) shows 93 patient deaths at UH Bristol, compared to 98 expected deaths: an HSMR of 94.5

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. QIG is chaired by the Medical Director.

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3.3.2 Learning from deaths (local mortality review)

During the period of April 2019 to March 2020, 1,352 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:

- 325 in the first quarter
- 294 in the second quarter
- 336 in the third quarter
- 357 in the fourth quarter.

By 31 March 2020, 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:

- 33 in the first quarter
- 46 in the second quarter
- 17 in the third quarter
- 25 in the fourth quarter

Any deaths identified as potentially avoidable are referred for a second review by the medical director team; there was one such case during 2019/20. No patient's deaths during 2019/20 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, integrated into Medway PAS.

Internal processes

The Learning from Deaths process has been established within the organisation; all adult deaths, excluding out of hospital cardiac arrests, continue to be screened. This process allows the quality of patient care to be assessed and where the patient notes trigger the need for a Structured Case Note Review (SCNR), these are then are distributed to the relevant Division for further assessment and in- depth reviews.

The Trust is now only reviewing the deaths within mandatory categories and this has led to a reduction in the number of notes requiring a full SCNR. This follows on from our extensive previous audit which demonstrated that although screening additional categories produced a large quantity of data, it did not identify any further potentially avoidable deaths. This system is more in line with neighboring Trusts and means there is consistency within the system as we move to developing the cross-Bristol Medical Examiner system which will provide an initial screen of all notes and replace the work of the lead mortality nurse.

A new system overseeing the method of certification of death is being rolled out in England. This system is dependent on the appointment of Medical Examiners (ME) who will review all adult deaths within acute providers and discuss each case with both the clinical team and next of kin prior to the issuing of a death certificate. Both Trusts, UHBW and NBT, approved the business plan for the appointment of a Lead Medical Examiner (LME) for Bristol and Weston and a Lead Medical Examiner Officer. This work is ongoing and has developed over the year (see section 2.1.1 of this report).

During 2019/20, the Learning Disabilities Mortality Review (LeDeR) process for coordinating, reviewing and assessing deaths in patients with learning Difficulties has been refined and embedded into the learning from deaths process. The number of deaths in patients with learning difficulties is being cross reference with the LeDeR team and the reviews of patients with learning difficulties who have died is now being coordinated by a single team with active participation in the Mortality Surveillance group.

During 2019/20, the Senior Leadership team supported the proposal to include a structured Case Note review into the Supporting Professional Activity of all consultants caring for Adults. The philosophy supporting this decision was that it allowed all doctors to review the care being provided within the organisation. There are several outstanding reviews that have spent a long time allocated to reviewers; we are currently working with all the Clinical Divisions to ensure all consultants deliver on their professional responsibilities with regard to the Learning from Deaths process. This work is being coordinated via the MD office and remains ongoing.

With the introduction of the Medical Examiners, there have been or are several changes in personnel in the Learning from Deaths team, and as such, a piece of work is being conducted this autumn, in collaboration with both the lead Medical Examiner and the Divisions to refresh the process of SCNR and learning from deaths as the new system is introduced.

3.3.3 Clinical standards for seven day hospital services

The Seven Day Hospital Services (7DS) Programme was developed to support 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.

The 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.

During 2019/20, a board assurance model replaced the bi-annual self-assessment survey previously used to measure progress against the four priority standard. As required by NHS England and NHS Improvement, case note review and assessment were reported to the Board in June and November 2019.

In November 2019, the Trust declared and accepted non-compliance (standard met in <90% 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 2 was met in 76% of cases and Clinical Standard 8 was met in 52% of cases for those patient requiring a daily review and 100% of cases where the patient required twice daily review.

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 but, to date, recruitment has been unsuccessful in spite of multiple attempts.

Service development proposals to address the gaps in seven day coverage in other areas have been discussed with commissioners through contract negotiations in 2017/18, 2018/19, and 2019/20. Commissioners indicated that the proposed investments were not affordable 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. We have therefore agreed derogation of the standards in our contract with our commissioners.

Since the last submission to NHS England and NHS Improvement in November, the Trust has had no further contact from the national Seven Day Service Team in relation to this work.

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 7

Quality measure	Data source	Actual 2018/19	Target 2019/20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Actual 2019/20
Mortality								
Summary Hospital Mortality Indicator (SHMI)	NHS Digital	107.2	< 100	105.9	105.1	102.1		
Hospital Standardised Mortality Ratio (HSMR)	CHKS	105.0	No set target	91.0	90.6	92.3		
Re-admissions								
Emergency Readmissions Percentage		3.30%	< 3.26%	3.67%	3.54%	3.36%		
Fracture Neck of Femur								
Patients Treated Within 36 Hours	National Hip Fracture Database	56.3%	≥ 90%	49.2%	52.1%	36.7%	45.9%	45.6%
Patients Seeing Orthogeriatrician > 72 Hours	National Hip Fracture Database	97.5%	≥ 90%	98.3%	97.2%	100%	90.6%	96.3%
Patients Achieving Best Practice Tariff	National Hip Fracture Database	51.3%	≥ 90%	49.2%	52.1%	36.7%	38.8%	43.5%
Stroke Care								
Percentage Receiving Brain Imaging Within 1 Hour	Medway PAS & Radiology Information System	51.1%	≥ 80%	46.1%	50.8%	54.8%		
Percentage Spending >90% Time On Stroke Unit	Medway PAS & Radiology Information System	84.2%	≥ 90%	76.5%	75.4%	69.4%		
High Risk TIA Patients Starting Treatment Within 24 Hours	Medway PAS & Radiology Information System	58.6%	≥ 60%	50.0%	77.1%	72.0%		
Dementia Care								
FAIR Question 1 - Case Finding Applied	Local data collection	83.0%	≥ 90%	85.8%	88.5%	83.3%	76.3%	83.2%
FAIR Question 2 - Appropriately Assessed	Local data collection	94.3%	≥ 90%	92.9%	86.0%	88.1%	90.7%	89.6%
FAIR Question 3 - Referred for Follow Up	Local data collection	85.7%	≥ 90%	81.8%	100%	71.4%	100%	85.2%
Ward outliers								
Bed Days Spent Outlying.	Medway PAS	7,708	< 9,029	1,989	2,079	2,591	3,033	9,692

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) four 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:

- 95 per cent for A&E four hour waits
- 85 per cent for 62 day GP cancer
- 92 per cent for RTT incomplete pathways
- 99 per cent for six week diagnostic waiting times.

Performance against the 62 day cancer standard was achieved for seven of the twelve months and was achieved for each of the four quarters overall.

Referral to Treatment performance achieved the NHSI recovery trajectory at end of April and May 2019 but not since. The 92 per cent standard has not been achieved at any month-end in 2019/20. The total list size started the year below the March 2018 level of 29,207 (total list size was 28,763 as at end of Apr 2019) but was above that level for the remainder of 2019/20, peaking at 34,739 at the end of November 2019. The waiting list size finished at 32,832 at end of March 2020.

A&E performance did not achieve the NHSI improvement Trajectory, which was 0.5 per cent above the 2018/19 performance level for the corresponding month.

The six week wait for diagnostics has remained below the national standard of 99 per cent and plans to recover by end of Quarter 4 were submitted, but are was not achieved following a loss of Endoscopy capacity.

Table 8: Performance against the agreed trajectories for the four key access standards in 2019/20 during each quarter

Access Key Performance Indicator		Quarter 1 2019/20			Quarter 2 2019/20			Quarter 3 2019/20			Quarter 4 2019/20		
		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
A&E 4-hours Standard: 95%	Actual	78.3%	78.0%	81.5%	81.9%	84.8%	81.4%	82.4%	80.3%	76.1%	81.8%	78.4%	81.0%
	Trajectory	84.5%	90.5%	90.5%	90.5%	90.5%	85.5%	89.7%	84.7%	83.5%	85.0%	81.6%	81.7%
Cancer 62-day GP Standard: 85%	Actual (Monthly)	86.8%	86.0%	84.0%	86.8%	85.8%	83.6%	85.4%	87.0%	83.9%	80.8%	82.0%	91.0%
	Actual (Quarterly)	85.7%			85.4%			85.4%			85.5%		
	Trajectory (Monthly)	85%	85%	85%	83%	85%	85%	85%	85%	85%	85%	85%	85%
	Trajectory(Quarterly)	85%			85%			85%			85%		
Referral to Treatment Standard: 92%	Actual	89.0%	88.1%	87.5%	86.5%	84.3%	83.6%	83.0%	83.0%	82.5%	83.2%	82.4%	78.3%
	Trajectory	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	87.9%	86.9%	86.9%	86.9%	87.9%
6-week wait diagnostic Standard: 99%	Actual	95.3%	93.4%	93.5%	96.2%	95.1%	96.2%	95.9%	96.7%	96.1%	95.2%	95.4%	85.7%
	Trajectory							96.0%	96.5%	96.5%	97.0%	98.0%	98.0%

GREEN rating = national standard achieved
AMBER rating = national standard not achieved, but STF trajectory achieved
RED rating = national standard not achieved, the STF trajectory not achieved

Performance against these four SOF standards is covered in detail in the performance report. A summary of the Trust's performance in 2019/20 against the wider range of national access and other Key Performance Indicators is also included in the performance report.

3.4.2 Referral to Treatment (RTT)

The national standard for Referral to Treatment (RTT) is 92 per cent. This has not been achieved for the whole of 2019/20. During April and May 2019 the improvement Trajectory of 88 per cent was achieved.

At the start of 2019/20, the total list size was 28,481 with 89 per cent waiting under 18 weeks. At the end of the year (31st March 2020) the total list size was 32,832 with 78 per cent waiting under 18 weeks

The backlog growth in the main related to Dental, Ophthalmology and Paediatric Trauma and Orthopaedic (T&O). The Dental and Ophthalmology growth was a result of a number of staff vacancies and long term sickness. The Paediatric T&O growth occurred from patients referred into the Referral Assessment Service (RAS) and the lack of clinic capacity to book these patients in.

Significant national developments that impeded recovery of the backlog during the year were the changes to the pension tax and the rates paid for waiting list initiatives, both of which resulted in very poor uptake from staff to do extra sessions to support recovery of the backlog positions.

The Trust's commitment to achieve zero 52-week breaches by September 2019 was not achieved and the Trust reported five 52-week breaches. The 52-week wait position continues to deteriorate due to the impact of cancellations of routine patients during the winter pressures and the lack of HDU/ITU and ward beds. At end of March 2020, the Trust reported thirty 52-week waiters.

In August 2019, the Trust became one of the twelve hospitals who are taking part in the national pilot for Referral to Treatment average weeks waiting. During this period, it was agreed with NHS Improvement that the Trust would focus on achieving an average wait of 10.1 weeks, with

a stretch target of 9.1 weeks. UH Bristol is currently achieving 10.4 average weeks wait. The Trust has been invited to continue this pilot during 2020/21.

3.4.3 Cancer

The Trust achieved the 62 day GP referral to treatment standard in seven months in the financial year and was achieved for each quarter overall. This was in the context of continued national non-compliance with the standard. The main cause of non-compliance was the impact of cancellations and capacity restrictions due to emergency pressure within the Trust, especially over the winter months. The Trust has robust diagnostic pathways and is in a good position to achieve the initial 70 per cent threshold for the faster diagnosis standard being introduced in April 2020.

The Trust met the first appointment standard for cancer in the majority of months but saw a short period of non-compliance in August and September following an unprecedented surge in dermatology demand (33 per cent up on demand in the same period 2018/19). Even with additional capacity it was not possible to meet the standard for all patients, however delays were small and recovery rapid with compliance regained in October and sustained thereafter.

Compliance with the 31 day decision-to-treat to treatment standards was affected by two factors. In the first part of the year, specialised cleaning of the linear accelerators following a major fire caused delays to radiotherapy treatments. This cleaning was concluded and compliance with the subsequent radiotherapy standard regained in July and sustained thereafter.

3.4.4 Diagnostic waiting times

The month end performance for diagnostic waiting times varied between 85.7 per cent and 96.7 per cent, averaging 94.6 per cent at each month end.

As at end of March 2020:

- CT was at 97.0 per cent with challenges in CT Cardiac. These examinations are complex and require the following resource to be available: Radiologist, Registrar, 2 x CT radiographers, Nurse, Radiographic Assistant. Outsourcing options were in place during Quarter 4.
- MRI was at 85 per cent with the main risk being in Paediatric MRI services where the backlog is with children requiring General Anaesthetic. Insourcing through GLANSO is being trialled in Quarter 4 to clear the backlog.
- Adult Endoscopy which is at 52 per cent due to endoscopy capacity being used to provide emergency escalation capacity. The service also lost one of its two new Clinical Fellows to at the end of Quarter 3, who took up a consultant post elsewhere, meaning 10 sessions (40-50) patients per month were lost from the capacity. In/outsourcing options were put in place in Quarter 4, but this did not deliver a recovered position.

3.4.5 Outpatients

In response to the Long Term Plan, pathway redesign work has commenced to reduce the number of follow up appointments and increase the number of follow up appointments delivered non-face to face.

Non-face to face telephone clinics have been piloted in lung nodules and dental biopsy. Progress has been made with video conferencing services with a number of specialties expressing interest in developing attend anywhere pilots. Advice and guidance continues to be progressed in the Trust with nine specialties using the service to triage referrals received from primary care. Plans are in progress to review the outpatient blended Tariff with the CCG and Healthier Together for 2020/21.

The outpatient services DNA rate has reduced further to 6.2 per cent following the continued roll out of the text messaging reminder service to additional clinics. At the end of 2019/20, the service was live in around 70 per cent of clinics. Work has also been progressed on the information provided in the text messages providing patients with more information of the clinic location they are booked to attend and the financial impacts of non-attendance. In support of cost effectiveness and allowing patients to receive information about their appointments in a method that they prefer, email appointment letters was launched in 2019/20. 1,000 letters a month are now sent to patients through email.

The Trust's CQC inspection in March 2019 identified the use of Outpatient reception staff uniforms as an improvement to make staff more easily identifiable for patients. All patient-facing administration staff now wear a standard uniform. In addition, outpatient administration teams have been engaged in delivery of standards of conduct and service delivery standards. This has contributed to a reduction in complaints relating to telephones of 32 per cent trust wide and 53 per cent in the poorest performing departments.

Real Time Outpatients continues to make progress within the Trust (also see sections 2.1.1 and 2.1.2 of this report). Valuable learning has been acquired through this project and it has become apparent that there is a broad requirement for standardisation of service delivery across outpatients and further digitisation of information pathways. Plans are in progress to review and reprioritise the delivery of outpatient service projects linking a number of improvements to the Medway system and dictation software.

Table 9: Performance against national standards

National standard	Target	2017/18	2018/19	2019/20
A&E maximum wait of four hours	95%	86.5%	86.3%	80.4%
A&E Time to initial assessment (minutes) percentage within 15 minutes	95%	97.7%	95.6%	97.2%
A&E Time to Treatment (minutes) percentage within 60 minutes	50%	52.2%	49.3%	50.2%
A&E Unplanned re-attendance within seven days	<5%	2.8%	3.3%	3.6%
A&E Left without being seen	<5%	1.9%	1.7%	1.6%
Cancer - Two week wait (urgent GP referral)	93%	94.3%	95.3%	93.4%
Cancer - 31 Day Diagnosis To Treatment (First treatment)	96%	95.8%	97.2%	95.8%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	94%	92.0%	96.1%	92.5%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	98%	98.6%	98.4%	98.6%
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	94%	96.3%	95.8%	94.6%
Cancer - 62 Day Referral To Treatment (Urgent GP Referral)	85%	81.7%	85.6%	85.5%
Cancer - 62 Day Referral To Treatment (Screenings)	90%	74.8%	66.7%	71.1%
Cancer - 62 Day Referral To Treatment (Upgrades)	85%	85.4%	83.7%	86.6%
18-week Referral to Treatment Time (RTT) incomplete pathways	92%	89.6%	89.0%	83.2%
Number of Last Minute Cancelled Operations	<0.8%	1.19%	1.31%	1.73%
Last Minute Cancelled Operations Re-admitted within 28 days	95%	94.2%	93.4%	92.9%
Six week diagnostic wait	99%	98.3%	96.7%	95.2%
Primary PCI - 90 Minutes Door To Balloon Time	90%	93.2%	92.5%	87.0%

APPENDIX A – Feedback about our Quality Account

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

The publication of a Quality Account is an annual requirement for all NHS Trusts, providing an opportunity for them to present the public with a review of their performance in key areas of Quality and Performance over the past year. Within this feedback section the governors of Foundation Trusts are then asked to provide comment on whether the account offers a fair representation of the trust's achievements during that time.

The Council of Governors here at UHB FT are happy to comply with this request as we feel both well supported and well informed within our roles at the trust; and have the opportunity to explore Quality and Performance issues at regular intervals and in some depth.

This Quality Account covers the financial year 2019/20 which precedes the merger with Weston Area Health NHS Trust; and as the Covid-19 pandemic only began in the later stages of the final quarter of 2019/20 its impact on the University Hospitals Bristol NHS Foundation Trust (UHBW) is not included.

The report clearly identifies both the trust's significant achievements and areas where performance could be improved, along with recognition of the challenges they faced in pursuing some of their key objectives. Importantly, as we commented last year, the trust has continued to demonstrate evidence of learning from experience, listening to public and patient concerns and taking action in response to all serious incident investigations.

Governor involvement with Quality and Performance at UHBW

As elected Governors of the trust it is our duty to continuously monitor the trust's performance and hold the Non-Executive Directors (NEDs) to account for it. We review Quality and Performance at the trust every two months at our Quality Focus Group (QFG) meetings, attended by the NED Chair of the Quality and Outcomes Committee, the NED Chair of the People Committee, the Medical Director and the Chief Nurse. The QFG is chaired by a governor and the agenda includes presentations on quality issues by senior staff, a review of the questions placed on our Governors' Log and discussion about all the regular trust reports on quality topics. The Focus Group then reports back to the full Council of Governors.

The Governors' Log provides an opportunity for any governor to raise formal questions (often at the behest of members of the public) with the trust at any time. These are allocated to appropriate Executive Directors within the trust and both questions and answers are then available to the public within the papers for the Public Board Meetings

At the two-monthly Public Board Meetings, governors have the opportunity to witness the full board discussions that take place on all their regular agenda topics, including quality and performance, and can raise questions at the end of these discussions. The Governors also meet informally as a group every two months, followed by a joint meeting with the NEDs at which we can raise specific topics or concerns that we want to pursue in greater depth. The Chair and all NEDs at the trust are fully supportive of the governors offering both comment and challenge in this way, and our questions are always handled in an open, engaged atmosphere.

The combination of these activities, quarterly governor development seminars and nationally organised governor training sessions has offered governors the knowledge, tools and

opportunity to raise questions and offer challenges on many of the topics included in this Quality Account.

It should also be noted that during this particular year, the trust underwent a Care Quality Commission (CQC) inspection (in May 2019) following which it retained its previous "Outstanding" rating. The Council of Governors was invited to participate in this inspection and several governors met with the inspection team to talk about their involvement with the trust. Following the publication of the full CQC report in August 2019, this was reviewed in our Quality Focus Group.

Priorities for Quality Improvement

An extensive and wide-ranging number of quality improvement activities take place within the trust, supported in recent years by the development of the Quality Improvement Academy and celebrated in the annual presentation of projects at the trust's Quality Forum.

This Quality Account reports on the eight specific, priority quality objectives set by the trust for 2019/20 and then describes the four objectives set for 2020/21. Of the four objectives set for this year the trust has successfully achieved four of them and been partially successful with the other four. A huge amount of effort has gone into this work and the reasons for limited or delayed achievement of the four objectives rated amber have been identified and acknowledged, allowing for further progress over the coming year. Thus, in setting the four specific objectives for our newly merged trust (University Hospitals Bristol and Weston NHS Foundation Trust) in 2020/21, the need for continued improvement in these areas is recognised.

The governors are aware of the considerable effort and enthusiasm that trust staff put into pursuit of these objectives and we celebrate both the completed work and the commitment to pursue the partially completed objectives across the entire merged organisation during 2020/21.

Review of services

Part 3 of the Quality Account covers a review of trust services under three key headings (Patient Safety, Patient Experience and Clinical Effectiveness) and then describes the trust's performance against national priorities and access standards.

There is clear evidence of the trust's commitment to maintaining, and continuously striving to improve, high standards of patient safety and clinical effectiveness alongside a readiness to acknowledge and learn from all adverse events and comments. The inclusion of structured case note reviews within the Supporting Professional Activity of all consultants caring for adults, as a part of the Learning from Deaths process, is an excellent example of this. The governors can confirm the priority given to these topics at the trust and have been reassured that the latest "Outstanding" rating from the CQC has not resulted in any sense of complacency. Similarly, a generally 'better than average' scoring for the trust in a range of local and national patient surveys is to be commended: but it remains important for the trust to note, and respond to, the specific areas in which it has not scored so well. Further improvement is clearly possible and the trust is committed to continue to review performance in these areas in order to achieve it.

Performance against the national priorities and access standards has been variable over this year and is clearly described, along with the factors that have impacted adversely on this performance. The specific recovery and improvement plans that have been identified are also outlined in this Quality Account, particularly in relation to outpatient services. The governors welcome all the commitments described, while recognising the ever increasing pressures on all these services.

Issues of special interest to the Council of Governors during 2019/20.

Recruitment and retention of staff continues to be a huge challenge throughout the NHS and must be a top priority for any trust. The People Committee at UHBW has become firmly established and the governors welcome the work it is doing in identifying the areas of greatest need and initiating strategies for tackling these. The shortage of junior doctors within many areas of the trust's hospitals, challenges in achieving the expected levels of attendance at staff training, the need to improve staff appraisal rates, and efforts to ensure that the annual staff survey is truly accessible for all staff within the trust, have all been highlighted in our discussions. At the governors' request, we have receivede presentations at our Quality Focus Group on progress to date with the Diversity and Inclusion Strategy and on Tackling Bullying and Harassment at the trust – topics that are hugely important and have been identified as priorities throughout the NHS. The governors have also taken a keen interest in progress with the Freedom to Speak Up initiative at the trust and welcome the recruitment of more than 50 staff advocates to help raise awareness of this and support staff more locally with their concerns.

Discharge
The discharge process is a key part of any patient's journey and can vary greatly in complexity depending on people's individual needs and circumstances. The governors at UHBW have a long-established interest in this and welcomed the development of the Integrated Care Bureau back in October 2018 as a route to centralising resources and integrating planning across all hospital and community services to support the discharge of patients. Full recruitment to this service at UHBW was achieved during 2019/20 and governors were updated on the work of the bureau in May 2019, when we welcomed the evidence of improved joint working across organisations but noted the on-going challenges involved in accessing community care assessments and services. Governors also continued to monitor discharge timing and the factors that impact on this, particularly transport provision.

Wider integration and transformation of healthcare services across our area
The trust has continued to play a full and leading role in the Bristol, North Somerset and South Gloucestershire (BNSSG) Healthier Together programme over the course of this year – aiming to achieve greater integration and transformation within all our care services across this area. Governors have been regularly updated on this work and are fully supportive of the programme and the work of our trust Chief Executive, Robert Woolley, as a Joint Lead Executive for the BNSSG programme.

Merger with Weston Area Health NHS Trust
Work on the proposal for UHBW to merge with Weston was a major priority for the trust and the Council of Governors over the course of 2019/20. An enormous amount of trust time, effort and commitment went into the preparation of the detailed proposal and the governors have been given regular and thorough updates on this, along with every opportunity to raise queries or seek further information.

The level and detail of the due diligence pursued over many months clearly impressed the trust's NEDs and allowed all Board members and the Council of Governors to vote for the merger to go ahead.

Trust staff and board members have continued to prioritise Quality and Performance at UHBW throughout this process and we look forward to a continued emphasis on these areas across the merged trust.

Council of Governors November 2020

b) Joint statement from Healthwatch Bristol, South Gloucestershire and North Somerset

Thank you for the opportunity for respond to your draft Quality Account.

Healthwatch Bristol, North Somerset and South Gloucestershire welcome the Quality Account as an opportunity to see evidence of a learning culture, that UBHW priorities reflect real people's experiences, gain assurance that priorities for improvement are sufficiently challenging and are clear how they will be measured and finally we hope to see triangulation between your evidence and ours about areas that need improvement.

This Quality Account looks back at the performance of the Trust for the year 2019/20. The start of the Covid-19 pandemic, and the formal merger of UHBW with Weston Area Health NHS Trust took place at the end of the final quarter of this period. Therefore, the substantial influence of these two events, not discussed in this account will no doubt will be addressed in next year's Quality Account when we look forward to hearing measures that have been considered from learning during the pandemic.

We are pleased to see that the use of the Happy App to drive staff engagement (objective 4) has had good uptake by the workforce. We would like to know more about the interventions implemented based on the outcomes of learning from this feedback as notably it is indicated that it has informed the "Values" theme.

We note the performance data against each objective, and suggest that this evidence would be even more beneficial if it were provided against the different protected characteristics to ensure that the needs of each demographic is being met. We would like to see measures being taken to achieve this in future Quality Accounts. This would be a suitable response to local and national reports on inequalities. Added quality objectives to address the issues raised in reports that detail health inequalities found in Bristol would also be welcomed.

Developing and implementing a training programme for Trust lay representatives to support and develop their participation in Trust groups and committees is to be commended. How have you been able to ensure that these are representative of the City's demographic relating to Age, Gender, Ethnicity, Religion, Disability, Sexual Orientation and Gender reassignment? Equally, your patient related groups involved in UHBW are of great interest to us, and we would like to hear ways in which you use 'Expert Patients' in your processes.

Freedom to Speak Up is one mechanism through which staff can raise concerns and others in place offer support such as bullying and harassment advisors, Joint Union officers, Occupational Health, Employee services, Safeguarding team and the Patient Safety team. It would be helpful to know how many people use these services and how you measure the success of their support?

You have made efforts to improve the availability of information about physical access to your hospitals to ensure patients and visitors know how to get to services in the easiest possible way, particularly patients with disabilities. The account would benefit from a measure of your performance currently for access for people with disabilities.

We appreciate the efforts to which the Trust has gone to provide this account in trying times. We wish to pass on our sincere thanks to all staff for their continued commitment to patients and quality across the Trust.

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

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2019/20 is made by Bristol, North Somerset & South Gloucestershire (BNSSG) Clinical Commissioning Group (CCG).

BNSSG CCG welcomes UH Bristol's quality account, which provides an overall reflection on the quality performance during 2019/20. The data presented has been reviewed and is in line with data provided throughout year, predominantly via the monthly Integrated Performance Report (IPR) and reviewed through the monthly quality contract performance meetings.

BNSSG CCG notes the achievements against the eight quality objectives identified for 2019/20. Four were rated as green, achieved and four were rated as amber, partially achieved. The CCG acknowledges that the final quarter of 2019/20 was a particular challenging period for UH Bristol, with the pending merger of the trust with Weston Area Health NHS Trust (WAHT) and the onset and response to the COVID-19 pandemic.

With regards to Objective 2, enabling improvements in intravenous cannulas, NEWS 2 and VTE through the use of digital technology provided a timely focus on some core areas of patient safety (rated as amber), the CCG notes that VTE risk assessment remains below the expected standard and welcomes the further focus to improve performance in 2020/21. The CCG acknowledges the continuing work planned in 2020/21 on deteriorating patients which will incorporate NEWS2, but would welcome a further narrative on intravenous cannula, noting the current version of the quality account is a draft version.

In respect of Objective 2, reducing the risk of Never Events (also rated as amber), the number of Never Events has reduced in recent years from nine in 2017/18, to five in 2018/19 and four for 2019/20, and will remain a focus for further improvement work, which the CCG supports. The CCG will work to support system learning amongst all providers with regard to Never Events.

The CCG notes the chosen four quality objectives for 2020/21, which are continuing objectives from 2019/20, whilst acknowledging that University Hospitals Bristol and Weston NHS Foundation Trust (UHBW) is continuing with a number of improvement work streams and continues to align functions with Weston General Hospital, also referred to as the Weston Division.

We welcome and thank the trust for its continuing engagement in national audits and national enquiries, contributing to national datasets and associated guidance.

The CCG welcomes the reporting of metrics that demonstrate the continuing improvement in patient experience ratings across a range of national surveys. The CCG notes that the delayed publication of the Quality Account for 2019/20 means that 2019 national inpatient survey data is now available. The Friends and Family Test scores for inpatient areas consistently exceeded 98% (Table 6); this is a familiar rating tool for our population, but not referenced in the narrative.

Falls and pressure injuries are the two highest themed serious incidents for the both the system and UH Bristol (as-was). A reduction in the number of grade 2 pressure injuries is welcomed from 80 to 49, with an associated reduction in the rate per 1000 bed days. A reduction in grade 3 and 4 injuries is also noted, with one case in each of the last two quarters of 2019/20.

The total number of patient falls resulting in harm increased and quarter 4 of 2019/20 appears as a particularly challenging period. We are pleased to acknowledge that you have maintained

the previous improvements in patients receiving an ortho-geriatrician review within 72 hours following a Neck of Femur fracture, but the percentage of patients treated within 36 hrs has deteriorated, as has the achievement of the best practice tariff. A further narrative and fuller reference to an improvement plan is encouraged. The CCG recognises that this may require a system approach.

The Trust achieved compliance with the C. difficile target. The total number of cases exceeded the 2018/19 position, which may be due to multiple factors including changes to national assignment definitions. A reduction in MRSA bacteraemia cases from six to four is noted and welcomed, however, a significant increase in MSSA cases is highlighted in your reporting, and we would have welcomed a metric around E.coli bacteraemia given the national reduction plan. More detail on the management of healthcare associated infections in next year's report would be very helpful.

On a final note we welcome and commend your work around staff engagement and the use of the Happy App, and your engagement and partnership working with regard to the Medical Examiners project, further promoting patient safety.

BNSSG CCG acknowledges the good work within the Trust. We note the areas that have been identified by the Trust for further improvement and we look forward to working with the Trust in 2020/21 to deliver those improvements. Significant challenges most certainly lie ahead but we are confident that by working together on these priorities you will continue to deliver safe, effective, compassionate and patient focused care for the people of Bristol, North Somerset and South Gloucestershire.

Our review is based on the draft report shared with the CCG, noting that the final version will go to UHBW's Board in January 2021.

d) Please note that the following will receive this year's Quality Account, but are not formally commenting:

- Bristol City Council People Scrutiny Commission
- South Gloucestershire Health Scrutiny Committee
- North Somerset Health Overview and Scrutiny Panel (QA Sub Committee)

APPENDIX B – 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 is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2019 to March 2020
    - papers relating to Quality reported to the board over the period April 2019 to March 2020
    - feedback from commissioners
    - feedback from governors
    - feedback from local Healthwatch organisations
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
    - the national patient survey
    - the national staff survey
- 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
28th January 2021

Robert Woolley, Chief Executive
28th January 2021