



Quality Report

2012/13

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

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Note:

The requirements to report in line with the 2012/13 Detailed Guidance for External Assurance on Quality Reports published by Monitor have been satisfied as follows:

Part 1 - Statement on quality from the Chief Executive	page 2
Part 2 – Priorities for improvement and statements of assurance from the Board	
Priorities for improvement – plans for 2013/14	This information can be found at the end of the reports for the three domains of quality (patient safety, patient experience and clinical effectiveness). See pages 20, 34 and 44
Statements of assurance from the Board	Page 50
Part 3 – Other information	
Review of quality performance	This information can be found in the reports for the three domains of quality. See pages 8 - 44
Overview of the quality of care based on performance in 2012/13 against indicators mandated for inclusion in Quality Accounts/ Reports	Page 4
Performance against key national priorities	Page 45

Statement on quality from the Chief Executive



Welcome to this, our fifth annual report describing our quality achievements. The Quality Report provides an open and honest assessment of the quality of services for which the Trust Board is accountable.

Each year, our quality objectives reflect a mixture of national and local priorities – many of which reflect priorities expressed in the NHS Outcomes Framework. In the pages of this Quality Report, you will read about some notable success stories and also some of the challenges we have faced. I am proud of the fact that the University Hospitals Bristol NHS Foundation Trust (UH Bristol) continues to have a consistently low overall mortality rate: this means that more patients survive in our care than would normally be expected for the severity of their condition. I am also delighted that 96% of inpatients say that they would recommend our services to their friends and family. Despite many successes during the year, we have also faced considerable challenges. We are disappointed that in 2012/13 we exceeded the targets we had been set for MRSA infections: we have implemented a comprehensive plan to improve our performance. We also continue to work closely with our partner organisations to understand and respond to patterns of increasing demand on emergency department services, both in Bristol and beyond.

At the request of our governors, we have made this year's Quality Report a little shorter than last year's in order to make it more accessible. This means that a small number of the quality themes we reported last year have not been repeated for 2012/13 (for example, safeguarding and single sex accommodation). However each of the 17 corporate quality objectives we set ourselves has been reported comprehensively, along with a wider assessment of our progress in the areas of patient safety, patient experience and clinical effectiveness. We have also returned to a key theme that we last reported in 2009/2010 – mortality following paediatric cardiac surgery.

During the past year, we have continued to work closely with the Care Quality Commission (CQC), the official body that monitors whether the Trust meets essential quality and safety standards. In 2012/13 we received a total of six visits from the CQC, including a scheduled inspection of our main site in June 2012 and the opening of the new South Bristol Community Hospital. The CQC expressed concerns about our staffing levels in maternity services and on Ward 32 in the Bristol Royal Hospital for Children. We took prompt and appropriate action. The CQC has re-inspected both areas: a warning notice relating to Ward 32 has been lifted and we are also now compliant for maternity services. We continue to be vigilant with local monitoring of compliance with all of the CQC's standards.

Looking ahead to 2013/14, we recognise that there is still much work to do. These remain challenging times for the NHS: at UH Bristol, we will continue to transform care by maintaining a relentless focus on the quality of our services, whilst making necessary efficiency and productivity savings. Robert Francis QC's final report into

failings at Mid Staffordshire NHS Foundation Trust is a painful reminder of the consequences of putting financial efficiencies before care and compassion. Dr Sean O'Kelly, our Medical Director, is currently developing our Board's response to the detailed recommendations of the inquiry. In the context of the Francis Report, the importance we place on our core values of respecting everyone, embracing change, recognising success and working together, becomes ever more apparent.

I would like to thank everyone who has contributed to this year's report, including our governors, commissioners, local councils, and the outgoing Local Involvement Networks. To the best of my knowledge the information contained in this Quality Report is accurate. If you have any comments about how we might further improve the presentation of this report in future years, I would be pleased to hear from you.

A handwritten signature in black ink, appearing to read 'R Woolley', with a stylized flourish at the end.

Robert Woolley
Chief Executive

Overview of 2012/13



The University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of general and specialist hospitals, employing around 7,000 staff and with a turnover of approximately £500m. We are also the major medical research centre in the South West of England. During 2012/13, the Trust provided treatment and care to around 68,000 inpatients, 57,500 day cases and 113,300 attenders at our emergency departments. We also provided half a million outpatient appointments. Our goal has been that each and every one of these patients should be safe in our care, have an excellent experience of being in our care, and the right clinical outcome. Ensuring that the Trust delivers high quality services is at the heart of the business of our Board, which every month receives a comprehensive report describing the quality of patient services. This report begins with a patient's story and the focus is always on organisational learning. The monthly Board quality report includes a detailed 'dashboard' of indicators, many of which are described in this Quality Report. If performance fails to meet agreed targets, the Board expects to receive exception reports describing the issues and the steps being taken to recover performance. The Board's responsibilities for monitoring quality continue to be supported by its Quality and Outcomes sub-committee. Appendix B of this report, taken from the Trust's Quality Strategy for 2011-2014, explains how the Trust assesses the quality of its services, seeks to make improvements where required, and provides assurance to the Board and its regulators.

Last year, we set ourselves 17 quality objectives: we fully achieved eight of these and partially achieved eight more. In the pages which follow, you will be able to read a detailed account of how we got on. Each objective has been assigned a 'traffic light' or 'RAG' rating:

	RED	Not met
	AMBER	Partially met
	GREEN	Fully met

Table 1 on the next page provides an overview. Table 3 on page 6 – Quality objectives at a glance – summarises the quality improvement themes we have been focussing on in recent years, and introduces the ones we will be prioritising in 2013/14.

We wanted to...		How did we get on?
1	Meet our targets for participation in the NHS South West Quality and Safety Improvement Programme	 AMBER
2	Implement and develop use of NHS Patient Safety Thermometer	 GREEN
3	Embed high quality nutritional care	 GREEN
4	Implement a proactive clinical audit programme in Histopathology	 GREEN
5	Reduce recorded complication, misadventure and re-admission rates in gynaecological surgery	 AMBER
6	Implement our Patient Experience and Involvement Strategy	 GREEN
7	Reduce patient-reported noise at night	 AMBER
8	Ensure patients are treated with kindness and understanding	 GREEN
9	Improve communication with patients: in particular about waiting times in clinic and making sure patients know who to speak to if they have worries or concerns	 AMBER
10	Reduce numbers of complaints and respond to complaints as quickly as possible	 AMBER
11	Reduce incidence of discrimination at work	 GREEN
12	Ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke unit	 RED
13	Develop the use of service-specific standardised mortality ratios	 AMBER
14	Implement our dementia action plan	 GREEN
15	Ensure patients with an identified need, including those with a learning disability, have a risk assessment and patient-centred care plan in place	 AMBER
16	Develop the use of enhanced recovery for all surgical areas	 GREEN
17	Re-focus on ensuring compliance with published NICE guidance including the targeted use of clinical audit	 AMBER

In February 2012, the Department of Health and Monitor announced a new set of mandatory quality indicators for all Quality Accounts and Quality Reports. The Trust's performance in 2012/13 is summarised in the table below. Where relevant, reference is also made to pages of our Quality Report where related information can be found. The Trust is confident that this data is accurately described in the Quality Report. A Data Quality Framework has been developed by the Trust which encompasses the data sets which underpin each of these indicators and addresses the following dimension of data quality: accuracy, validity, reliability, timeliness, relevance and completeness. The framework describes the process by which the data is gathered, reported and scrutinised by the Trust. Further details are available upon request.

Mandatory indicator	UH Bristol 2012/13	National average 2012/13	National best 2012/13	National worst 2012/13	UHB 2011/12	Page ref.
Venous thromboembolism risk assessment ¹	96.7%	93.8%	100%	85.5%	93.2%	11
Clostridium difficile rate per 100,000 bed days (patients aged 2 or over)	Comparative data for 2011/12: UH Bristol rate 19.6; England average 21.8; low zero; high 51.6. Comparative data is not currently available for 2012/13 from the Health & Social Care Information Centre. Our report, based on numbers of C Diff cases, can be found on page 15.					
Rate of patient safety incidents per 100 admissions ²	8.28	6.44	1.37 (lowest) ³	24.88 (highest)	6.66	17
Percentage of patient safety incidents resulting in severe harm or death (see footnote 2)	0.8%	0.5%	0%	2.5%	1.2%	17
Responsiveness to inpatients' personal needs ⁴	Comparative data for 2011/12: UH Bristol score 69.9; England median 66.9; low 56.5; high 85.0. Comparative data is not currently available for 2012/13 from the Health & Social Care Information Centre; UH Bristol's score for 2012/13 was 72.4					
Percentage of staff who would recommend the provider	71%	62%	86%	35%	75%	32
Summary Hospital-level Mortality Indicator (SHMI) value ⁵ and banding	91.1 Band 2	100	68.5	121.1	96.4 Band 2	38
Percentage of patient deaths with specialty code of 'Palliative medicine' or diagnosis code of 'Palliative care' ⁶	19.4%	18.9%	Min 0.2%	Max 43.3%	17.5%	N/A
Patient Reported Outcome Measures	Comparative groin hernia data for 2011/12: 55.8% of UH Bristol patients reported an improved EQ-5D score (national average 51.0%); 39.0% of UH Bristol patients reported an improved EQ-VAS score (national average 38.3%). Comparative data is not currently available for the full year 2012/13 from the Health & Social Care Information Centre.					42
Emergency readmissions within 28 days of discharge: • age 0-15 • aged 16 or over	Comparative data is not available for 2012/13. Latest comparative data available from the Health & Social Care Information Centre is for 2010/11: UH Bristol 0-15 rate = 8.26% (England average 10.15%; low 0%; high 25.8%). UH Bristol 16+ rate = 11.90% (England average 11.42%; low zero; high 53.3%).					43

Table 2

¹ Latest nationally published data covers April-December 2012 only; UH Bristol score for full financial year is 94.6%.

² Published (validated) data is for the first six months of the financial year only.

³ National data, i.e. not UH Bristol peer group; low reporting rate is not necessarily positive (i.e. not "best").

⁴ This is the national patient experience CQUIN.

⁵ In-hospital deaths plus deaths within 30 days of discharge: October 2011 – September 2012 (latest 12 month data available); data quoted for '2011/12' covers the period October 2010 – September 2011.

⁶ Specialty 315, diagnosis Z515: October 2011 – September 2012 (latest 12 month data available).

Quality objectives at a glance

Quality domain	2009/10	2010/11	2011/12	2012/13	2013/14
Patient Safety	Patient Safety First campaign	Antibiotic prescribing compliance	South West Quality and Patient Safety Programme	South West Quality and Patient Safety Programme, including inpatient falls, pressure ulcers, medication errors and hospital acquired thrombosis	Harm-free care (NHS Safety Thermometer – includes falls, ulcers, VTE, UTI)
	Healthcare acquired infections	Healthcare acquired infections	Inpatient falls	NHS Safety Thermometer	Healthcare acquired infections
	Human factors training in high risk procedures	High risk medication errors which cause actual harm	Medication errors	Nutritional care	Medication errors
		Hospital acquired thrombosis	Hospital acquired thrombosis	Gynaecological surgery	Medicines reconciliation
			Histopathology	Histopathology audit	Escalation of deteriorating patients
			Pressure ulcers		72 hour nutritional review
Patient Experience	Learning from McKinsey patient experience project	Patient feedback systems	Patient feedback systems	Patient Experience Strategy	Patient Experience Strategy (focus on maternity)
			Carer feedback	Kindness and understanding	Kindness and understanding
			Patient-reported noise at night	Patient-reported noise at night	Friends and Family Test
			Help at mealtimes	Communication with patients	Explaining medication side effects
			Ward-based information	Complaints	
			Customer care training	Discrimination against staff at work	
Clinical Effectiveness		NICE Quality Standard for dementia	Cancer survival rates	Service-specific mortality data	Clinical outcomes baseline
			Stroke	Stroke	Stroke
			Dementia	Dementia	Dementia
			Spontaneous vaginal births	Risk assessment for learning disabilities	Risk assessment for learning disabilities
				Enhanced recovery	Diabetes
				NICE implementation and audit	Hip fractures

Table 3

Patient Safety



Our Commitments

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

Report on our patient safety objectives for 2012/13

OBJECTIVE 1

We wanted to meet our targets for participation in the NHS South West Quality and Patient Safety Improvement Programme.



The Trust has been participating in this regional patient safety programme for adult services since 2009. The programme, supported by the Institute for Healthcare Improvement (Boston, USA), aims to deliver sustainable improvement over a five year period which is due to end in October 2014. The overall objective is a 15% reduction in patient mortality (as measured using the Hospital Standardised Mortality Ratio) and a 30% reduction in adverse events compared with the start of the programme in 2009. A 15% reduction in mortality rate (from a baseline HSMR of 86.83 to 73.81) means that approximately one further death will be avoided out of every ten expected. There are five distinct work streams within the programme: leadership, perioperative care (care given before during and after surgery), the general ward, medicines and critical care.

At the end of 2012/13, the Trust had achieved an overall score of 3.0 points out of a possible five on the programme's assessment scale, against a target of 4.0. This is because we only succeeded in making the planned level of improvements in three out of our five work streams (leadership, perioperative care and critical care). Recovery plans are in place for the remaining two workstreams. The Trust's headline mortality rates, HSMR and SHMI (see pages 39-40), continue to be better than the NHS average, and we are already achieving the overall programme objective of a 15% reduction in patient mortality.

Key achievements in the work streams have included:

- Patient safety walk-rounds led by executive directors becoming embedded practice.
- Perioperative measures being sustained at 95% compliance, including new theatres opened at South Bristol Community Hospital. These measures include: keeping a patient's temperature at 36 degrees or higher, ensuring diabetic patients have their blood glucose kept within the range of 5 and 11 millimols and carrying out a safety briefing at the start and finish of every theatre list. In 2013/14, we will be monitoring whether these changes lead to an overall reduction in the number of adverse events, infections and cardiovascular events that can happen following an operation.
- Significant progress in the critical care workstream (moving from a score of 1.5 to 3.5 during 2012/13). 100% of patients have received a multi-disciplinary ward round and had daily goals set for them during their time on the adult intensive care unit.
- In the general ward work stream we have improved recognition of the deteriorating patient for five out of the last six months of 2012/13. 100% of patients in our case note review audit sample had complete observations (target 95%). There is further work to do to ensure that all patients receive an appropriate response when their observations indicate this is required and we will be focussing on this in 2013/14.

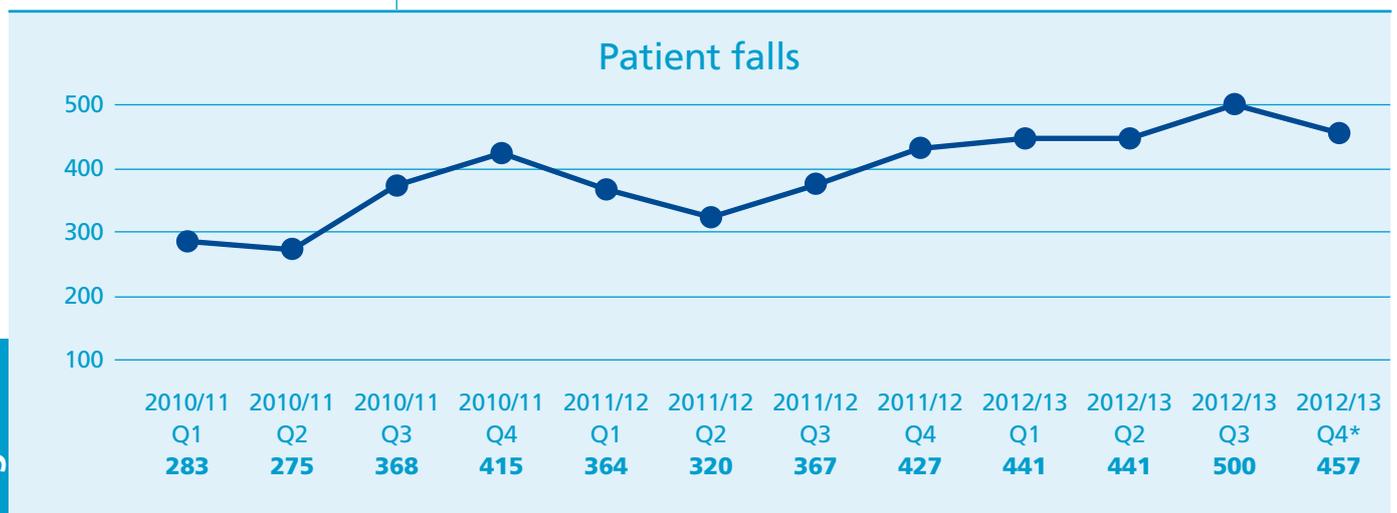
As part of our participation in the programme, we are also targeting improvements in reported patient falls, pressure ulcers, medication errors and hospital acquired thrombosis. We have seen a reduction in medication errors and good performance in venous thromboembolism risk assessment, however falls and pressure ulcers have been significant challenges for the Trust throughout the year. We have provided a short commentary below on our performance in each of these areas in 2012/13.

Patient falls

Patient falls are the most commonly reported safety incident in the NHS inpatient setting and occur in all adult clinical areas. Falls in hospital lead to injury in about 30% of cases, with 1-5% leading to serious injury. Up to half of all falls involve a degree of cognitive impairment, with 75%⁷ of falls occurring in patients aged 65 or over. The number of elderly patients admitted by the Trust is rising steeply: we are currently developing an approach to estimating the impact the age of our patients has on the incidence of inpatient falls. The majority of falls are not witnessed and a significant number occur in the early hours of the morning; not all falls can be prevented.

Source: Ullyses Safeguard system

Figure 1



Our target for 2012/13 was to achieve a total number of reported patient falls of less than the national average of 5.6 per 1,000 bed days (National Patient Safety Agency data): disappointingly, our rate of reported patient falls was 6.04 per 1,000 bed days. This represents 1,905 falls, including 158 incidents where the patient was assisted to the floor. This compares with a total of 1,429 falls in 2011/12 (5.01 falls per 1,000 bed days). In 2012/13, 22 falls were recorded as serious incidents involving fractures.

⁷ National Patient Safety Agency, 2007 data

In August 2012, clinical leads for falls were identified within the Trust to co-ordinate and support the work of the Falls Steering Group to reduce the incidence of falls and subsequent harm to patients in our care. In November, the Trust implemented the Royal College of Physicians (RCP) fallsafe care bundle package across three pilot wards led by the clinical leads. Fallsafe was developed from a quality improvement project which sought to prevent inpatient falls in hospital by 'closing the gap' between the evidence base for effective care and the care that patients actually receive. Our pilot ended in February 2013, demonstrating a sustained reduction in falls where the care bundles were fully implemented. Following evaluation of this project, a phased implementation will take place across the Trust between May and September 2013. Other work has included a revised patient information leaflet which encourages a partnership approach to the prevention of falls in hospital: it explains to patients, carers and relatives what they can do to help us and what we can and cannot do to prevent falls in hospital. 'Falling Star' magnets have also been introduced as a way of identifying patients who have been assessed as being at risk of falls to prompt multi-professional management.

Pressure ulcers

Pressure ulcers range from being small areas of sore or broken skin to the more serious type of skin damage that can lead to life-threatening complications. Our focus on pressure sore prevention and management reflects the priorities of our staff, carers, governors and commissioners. The reduction of newly acquired grade 3 and 4 pressure ulcers is a national quality priority within the NHS Outcomes Framework.

Pressure ulcers



Source: Ullyses Safeguard system

Figure 2

Our target for 2012/13 was to achieve a total incidence of pressure sores (grades 2-4) of less than 0.651 per 1,000 bed days (based on a percentage reduction of a previous NPSA benchmark). We achieved a rate of 1.28 per 1000 bed days.

Data for the period January - June 2012 showed that despite positive actions taken up to that point, the overall incidence of hospital acquired pressure ulcers had not changed significantly. An external review was commissioned by the Chief Nurse. The review took place in August 2012: the reviewing team produced ten key recommendations which have formed the basis of a recovery plan.

Actions taken in 2012/13 included:

- Repair and replacement of foam mattresses following an annual Trust-wide audit: a system is now in place to ensure that all foam mattresses are checked in between

- patients and repaired or replaced immediately if necessary.
- Completion of work to upgrade the existing bed store: a robust system for managing mattresses across the Trust has been agreed.
- Development with the University of the West of England of a package for trained nurses to educate them and increase their skills in pressure ulcer prevention and management.
- The division of Medicine is trialling new masks for non-invasive ventilation⁸ patients – the masks have a gel seal instead of silicone. Learning from this will be shared across all Divisions.
- All divisions continue to be required to complete and submit detailed recovery plans to our Executive Director-led quarterly reviews. These plans are monitored at a monthly performance meeting attended by the Chief Nurse or Deputy Chief Nurse.

We are encouraged that our score in March 2013 (0.85 pressure ulcers per 1,000 bed days) was the best we have achieved for two years⁹.

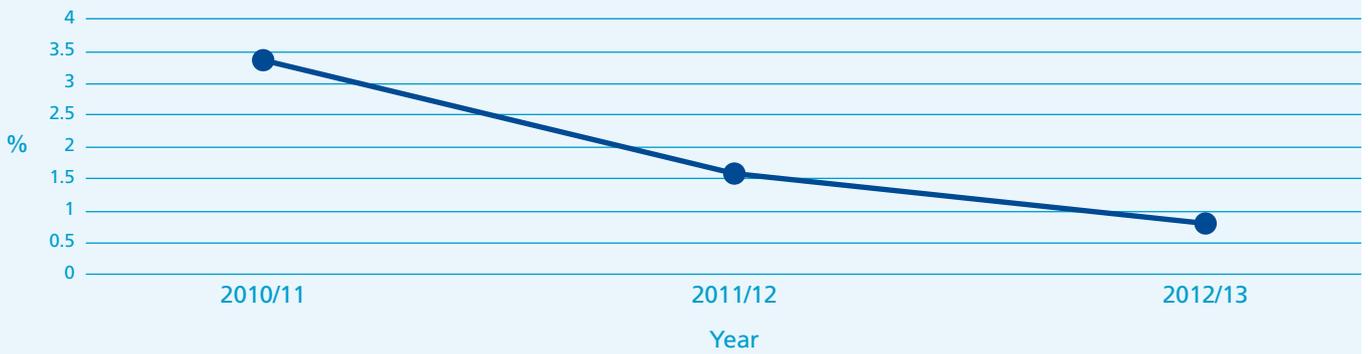
Medication errors

In 2012/13, we continued to monitor an objective we set ourselves in both 2010/11 and 2011/12 to reduce the proportion of medication incidents classified as causing 'moderate', 'major' or 'catastrophic' harm. The reduction of medication errors causing serious harm is a national quality priority within the NHS Outcomes Framework.

Source: Ulysses Safeguard system

Figure 3

Medication errors resulting in moderate or greater actual harm



99% of reported medication incidents at our Trust in 2012/13 did not result in major harm to patients (22% of incidents were low harm, 58% negligible harm (defined as no obvious harm or damage to the patient) and 19% were identified as a 'near miss'). Our target was to improve on our 2011/12 performance when 1.61%¹⁰ (21/1,301) of reported medication incidents involved moderate, major or catastrophic harm to patients. In 2012/13, 0.88% (14/1,594)¹¹ of medication related incidents resulted in moderate (13/14), major (0/14) or catastrophic (1/14) harm, representing a year-on-year improvement which we continuously strive for.

Our Medicines Safety Group continues to meet on a monthly basis to review reported medication incidents and ensure lessons are learned to achieve a sustainable reduction in the proportion of medication incidents resulting in moderate, major or catastrophic harm.

We also set ourselves two new goals. Firstly, we wanted to reduce omitted doses of critical medicines. It is important to patient safety and quality of care to ensure that the patient receives the maximum benefit from their medicines. From a baseline of 4.3% of patients having a non-purposeful omitted dose (measured by sampling methodology in over 500 patients each month, monitoring the previous three days of treatment), our target was to achieve less than 3.75%. Performance was assessed in the period October 2012 to March 2013. We were successful in reducing the percentage of omitted doses of critical medicines to 2.59%. In 2013/14 we plan to further reduce the proportion of omitted doses of medicines.

⁸ i.e. the delivery of ventilation to a patient that does not involve a tube into the wind pipe, e.g. different types of oxygen masks

⁹ April 2011 (0.721%)

¹⁰ This figure differs marginally from the one indicated in the 2011/12 Quality Report (1.54%) – this follows the validation of 2011/12 incident data which had not taken place at the time of the publication of the 2011/12 Quality Report)

¹¹ Incident data validated 5/7/13

Secondly, we wanted to improve medicines reconciliation (getting the medicines right). We set a target to carry out complete medicines reconciliation within one working day for more than 95% of patients admitted to our hospitals via our three main admission wards and for more than 90% of patients admitted to three of our cardiac wards (from baseline data of 77% in the second quarter of 2012). We met both of these targets, achieving 97% on our admission wards and 91% on our cardiac wards. In 2013/14, we plan to extend the monitoring of medicines reconciliation to cover other wards that may receive direct patient admissions.

Venous thromboembolism
(Mandatory indicator)

Venous thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health. It is estimated that there are 25,000 deaths from VTE each year in hospitals in England: reducing incidence of VTE is a national quality priority within the NHS Outcomes Framework. We wanted to sustain improvements in venous thromboembolism (VTE) prevention by continuing to screen patients for risk of VTE and ensuring patients at risk receive appropriate thromboprophylaxis. The Trust achieved a 90%+ target for VTE risk assessment in every month during 2012/13. For the year as a whole, 96.4% of inpatients received a risk assessment. This compares with 97.4% in 2011/12.

Source: PAS system and local audits, reported as part of South West Quality and Patient Safety Improvement Programme

Figure 4

**Patients with completed VTE risk assessment on admission
All adult wards**



We also achieved a 90%+ target for appropriate thromboprophylaxis for seven of the 12 months during 2012/13: in Quarter 4 we did not achieve our target, and data was unavailable for two other months¹². For the year as a whole, 94.6% of inpatients identified at risk received appropriate thromboprophylaxis. This compares with 93.2% in 2011/12.

The Trust considers its VTE risk assessment data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. Although the Trust does not currently collect VTE risk assessment data for all patients, we use a robust weekly audit methodology, the results of which are submitted by our information team to the Department of Health via the Unify system. Full details of our data quality framework for this indicator are available upon request.

The Trust has taken the following actions in 2012/13 to sustain 90%+ compliance with VTE risk assessments, and so the quality of its services:

- Revising the prescription chart containing an integrated VTE risk assessment to make it easier for staff to risk assess and prescribe appropriate thromboprophylaxis for VTE prevention.

¹² This was because of vacancies in the post of VTE nurse.

- Extending the provision of a VTE project nurse to sustain and embed focus on VTE prevention and provide supplementary training by targeting teams and staff groups with reduced levels of compliance or where, through reported patient safety incidents, patients have been identified as having acquired a VTE in hospital.
- Continuing to focus on VTE prevention training, including induction, update sessions and e-learning.

OBJECTIVE 2

We said we would implement and develop the use of the NHS Safety Thermometer



The goal of the NHS Safety Thermometer is to increase the number of patients who are free from harm. The safety thermometer measures four types of harm: pressure ulcers, falls, urinary tract infection and venous thromboembolism. The Trust is already collecting detailed information about the four types of harm, and many others, as part of the South West Quality and Patient Safety Improvement Programme, however the NHS Safety Thermometer provides an additional opportunity for national benchmarking and cross provider working to reduce the levels of harm to patients. In 2012/13, as part of the CQUIN framework, our target was to implement the safety thermometer, achieving at least 25% coverage in Quarter 2, at least 75% in Quarter 3 and 100% in Quarter 4. Since June 2012, we have audited 100% of eligible patients each month, significantly exceeding the requirements of the national CQUIN. 91.3% of patients audited were receiving harm free care; that is, they did not have any of the four harms measured by the safety thermometer, either existing or upon admission (old harm) or since (new harm). 95.7% of patients had no new harms; that is, none of the four types of harm had been acquired since admission. For 2013/14, we will be agreeing a CQUIN¹³ with commissioners to reduce one of the four types of harm as measured by the NHS Safety Thermometer.

OBJECTIVE 3

We wanted to continue to embed high quality nutritional care across the Trust



In last year's Quality Report, we described actions that we had taken to improve nutritional care following an inspection by the Care Quality Commission (CQC). We are delighted to report that when the CQC carried out an unannounced inspection of our main site (the Bristol Royal Infirmary and other hospitals in the city centre precinct), they found that the Trust was compliant with Outcome 5 (Meeting nutritional needs). Similar positive feedback was received from the CQC when they visited South Bristol Community Hospital in August 2012.

Over the course of the last year, 90.9% of adult inpatients received a fully completed nutritional assessment within 24 hours of admission, against a target of 90%. However in the second half of the year, we achieved in excess of 93% compliance; performance in children's services was 84%. Protected mealtimes were observed in audits of adult wards on 93.8% of occasions, against a target of 95%; performance in children's services was 100%. If a patient is assessed as being at risk of malnutrition, this risk is highlighted to members of the ward team by ticking a cutlery sign behind their bed to ensure they receive the right level of care. Throughout the year we have monitored whether this has been completed in nutrition audits: the cutlery sign was ticked for 85% of patients who needed it. Audits have also demonstrated that we are consistently ensuring patients are given the opportunity to wash their hands before meals (94% of adult patients during 2012/13) and recording patients' likes and dislikes of food (91.5%).

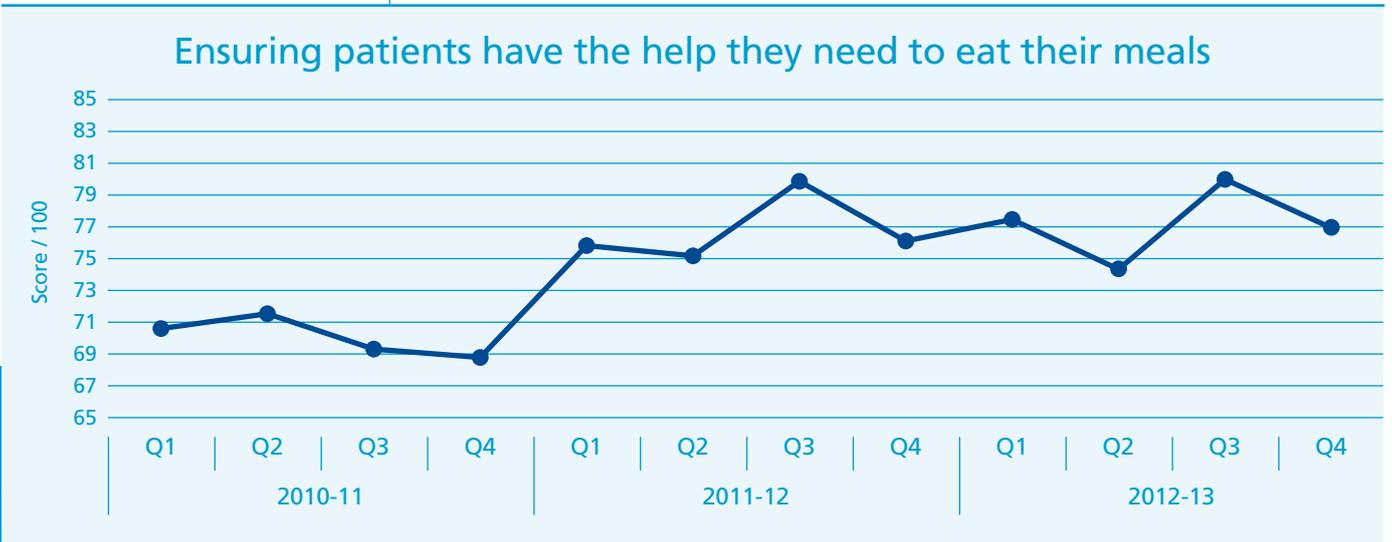
¹³ The Commissioning for Quality and Innovation (CQUIN) payment framework is a developmental process which enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. See page 58.

Since 2011, the Trust has been recruiting a team of volunteers who help patients at mealtimes, complementing nursing care. The role of the volunteers is to encourage and assist patients who for a variety of reasons find eating and drinking difficult, which can have a detrimental effect on their wellbeing and may delay their recovery. Our volunteers help by making the ward environment more conducive to the mealtime experience by tidying tables and helping with hand wiping. They also help to serve food and most importantly give encouragement and assistance to those patients who are less able. At the time of writing (May 2013), we have 39 volunteers who are assisting patients in this way and a further 21 volunteers who are working towards achieving the necessary competencies. Feedback from our patient survey (see Figure 5 below) suggests that our volunteers' efforts are making a genuine difference to patient care.

Finally, in April 2012 we introduced a three day (72 hour) review of food charts. This review facilitates appropriate support, such as referral to the dietitian for advice if food intake is continually low. Over the course of the year we have provided ten minute 'micro' teaches to 350 ward-based nursing staff and highlighted the importance of the three day review in our nutrition study days. Compliance has improved from 29% in April 2012 to 81% in March 2013. We have specified three day nutritional review as one of our corporate quality objectives for 2013/14.

Source: UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys.

Figure 5



OBJECTIVE 4

We committed to implementing a proactive clinical audit programme for histopathology

In our last two Quality Reports, we have reported on the Trust's response to the recommendations of an Independent Inquiry into Histopathology Services in Bristol. In our 2011/12 Quality Report we reported that members of the inquiry panel had returned to the Trust and found a genuine commitment to implement their recommendations and evidence of real progress. As part of our ongoing focus on the quality of histopathology services, we said that in 2012/13 we would develop and deliver a comprehensive programme of clinical audit. A total of 13 audits were identified by the Joint Clinical Lead for Histopathology as priorities (see table on the following page).

Title	Sub-Speciality
Audit of supplementary reports issued after multi-disciplinary team meetings to identify discrepancies across all cancer specialties in UH Bristol	All specialties
Correlation of breast tumour grading between core biopsies and resection specimens in a screened population	Breast
Audit of The Reporting of Cutaneous Malignant Melanoma at UH Bristol	Dermatopathology
Audit of turnaround time for skin cancers: September 2011 - 2012	Dermatopathology
Reporting of high grade endometrial cancer	Gynaecology
Reporting of vulval carcinomas	Gynaecology
Appropriate indeterminate classification of Inflammatory Bowel Disease*	Paediatric
Audit of microbiology sampling in stillbirth post mortems	Perinatal
Quality of perinatal autopsy in South West of England	Perinatal
Histological reporting of lung specimen	Pulmonary pathology
Audit on double reporting of lung pathology cases is in progress	Pulmonary pathology
Bowel Cancer Screening Programme-detected colorectal cancer resection specimens: a comparison of reporting between three trusts	Upper GI
Renal tumour reporting	Uro-pathology

All of these projects have been completed. A number of the audits demonstrated good adherence to standards. Other audits identified a need for improvement. In these cases, action plans have been produced and will be monitored throughout the year ahead. A number of actions relate to changes to staff working arrangements including training more biomedical scientists in skin cut up technique and the reorganisation of working practice to allow them to provide increased support to consultants. Other audits have resulted in the introduction of actions to support improved sub-specialty input into complex cases. Elsewhere, a pro forma has been introduced to ensure that minimum datasets are recorded and reported accurately, providing the necessary information to inform diagnosis.

During 2013/14, joint histopathology clinical audit meetings will be held between UH Bristol and North Bristol NHS Trust to allow the sharing of results and practice between the two trusts. The first joint meeting took place in April 2013.

OBJECTIVE 5

We wanted to see improvements in rates of complications, misadventures and re-admissions following gynaecological surgery

In February 2011, the Trust's Quality Intelligence Group received a report from CHKS (the Trust's provider of clinical benchmarking data) which highlighted complications, misadventures and re-admissions following gynaecological surgery as statistical outliers that warranted further local investigation/monitoring. The most recent CHKS data (which is for 2012) shows that the Trust's mortality and misadventure rates are now similar to its clinical peer group (0.06% UH Bristol v 0.08% peer for mortality; 0.45% v 0.43% for misadventures). Our re-admission rate remains higher than our peer group (7.3% v 5.5%), however there is a downward trend and case note reviews have identified that a significant number of the 're-admissions' are either gynaecology oncology patients (when beds in the Bristol Haematology and Oncology Centre are unavailable) or post-operative ward review cases on occasions when no gynaecology follow up outpatient slots have been available. In respect of the three

- project changed to measure turnaround times for IBD biopsies.

measures described, we are therefore assured that the data is either around the statistical norm (mortality and misadventures) or that there is a valid explanation for variation (re-admissions).

Benchmarking reports continue to indicate that the Trust is an outlier for complications following gynaecological surgery. The Trust has an active Gynaecology Morbidity and Mortality (M&M) meeting where cases of morbidity identified by CHKS are reviewed in depth in order to learn lessons and improve quality and safety of care; learning from case note reviews has been disseminated within the service. We have also found that some 'complications' identified by CHKS are not complications but are a standard part of the operative procedure, e.g. adhesiolysis appropriately carried out at a laparotomy. Further investigation and case note review is required. We will continue to monitor all of these indicators during 2013/14 and will report on progress in next year's Quality Report.

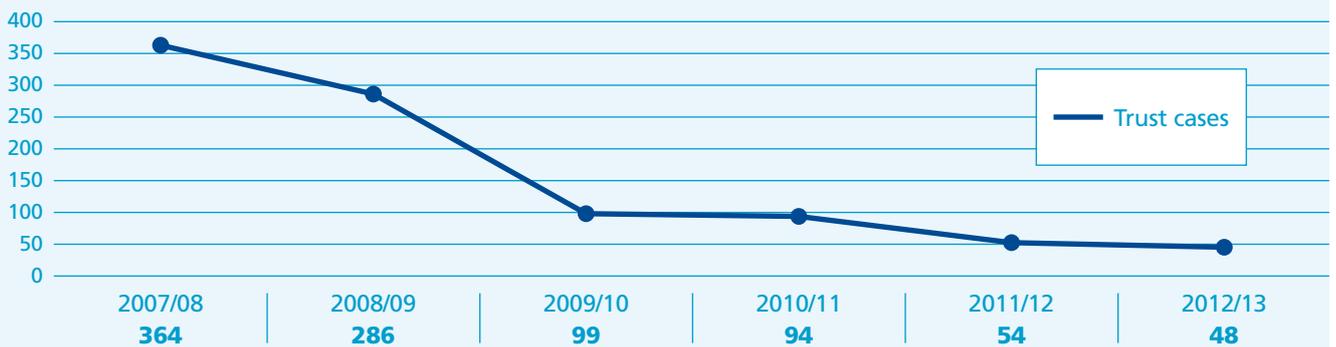
REVIEW OF PATIENT SAFETY 2012/13

This section explains how the Trust performed during 2012/13 in a number of other key areas relating to patient safety, which are in addition to our stated annual objectives.

Healthcare acquired infections
(Mandatory indicator – Clostridium difficile)

Although not a formal quality objective, the focus on preventing healthcare acquired infections (HCAIs) has remained a key priority for the Trust in 2012/13 and will remain so in future years. In 2012/13, we achieved national targets for Clostridium difficile. The Trust reported 48 cases of infection in 2012/13, six fewer than the target for the year of 54. Historically, the number of C. diff cases shows a strong seasonal profile, with around 60% of cases being reported in the first half of each year. In the first two quarters of the year, the Trust reported a higher number of cases than Monitor's 'flat phasing' of the annual target, however, significant reductions in cases were seen in Quarters 3 and 4 to bring the Trust back within target at year end. This is the second consecutive year that our performance has been better than our target.

Clostridium difficile trend



The Trust considers its Clostridium difficile data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the collection and validation of the data and its submission to a national database (full details are available upon request).

The Trust has taken the following actions in 2012/13 to achieve reductions in Clostridium difficile infection and so improve the quality of its services:

- Patients are nursed in a separate cohort area and are not admitted back into the general patient population for their duration of stay in hospital.

Source: Public Health England
Data Capture System

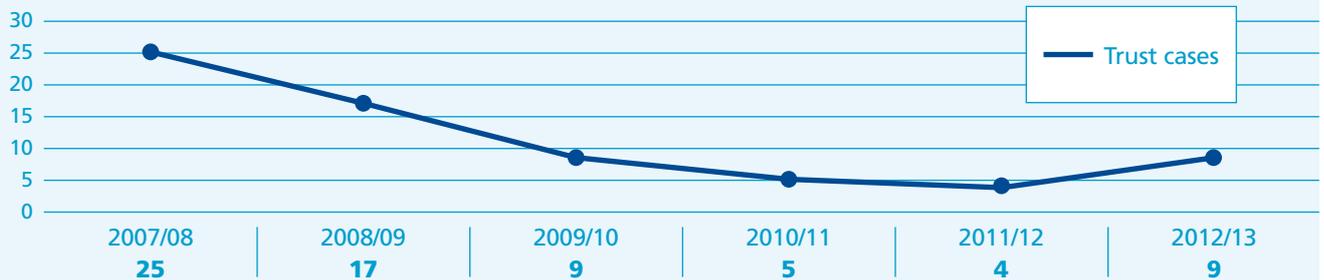
Figure 6

- Patients are monitored on a daily basis by the infection control team. When patients are discharged, patients' rooms are deep-cleaned. A hydrogen peroxide vapour is used for added assurance of cleaning.
- Antibiotic prescribing is monitored, and staff undertake 'saving lives' care bundles and hand hygiene audits each month. If the required standard is not reached, audits are repeated weekly until three consecutive weeks at the required standard are achieved.
- Patients are clinically managed by gastro intestinal consultants and infection control doctor.

Improvements in testing, specimen sending guidance and overall management of *Clostridium difficile* will put us in a strong position to achieve our target of 35 cases for 2013/14.

Disappointingly however, our target of two cases of MRSA (Meticillin Resistant *Staphylococcus Aureus*) bacteraemia was not achieved – ten cases were reported. The root cause analysis identified an emerging theme of intravenous lines (IVs) being the route of infection in a majority of cases. An action plan was implemented in the latter half of the year which focused on improvements in IV line care management. Since the implementation of the plan, a further two bacteraemias have been reported. The most recent bacteraemia was in an immuno-compromised patient and was not related to IV line care. The Trust is using the learning from this case, and from one of the highest performing trusts in the country, to further enhance its recovery plan, with the aim of meeting the Department of Health's target of having no MRSA bacteraemias in 2013/14.

MRSA bacteraemia cases



Elsewhere, MRSA bacteraemias continue to fall year on year, although we exceeded our set target of 27 cases by nine.

We continue to train all staff in infection prevention and control – at the end of March 2013, 86% of our staff were compliant with initial or update training. Hand hygiene has remained a priority. Regular auditing on wards has shown that hand cleaning takes place on 96.2% of occasions when it is needed, meeting our 95%+ target for 2012/13. Hand hygiene facilities continue to be upgraded where necessary and alcohol hand gel is widely available close at the point of patient care and at the entrances to wards and departments in response to requests from the public and visitors.

Norovirus continues to present a challenge. We have seen three peaks during the year, in May, November and February (consistent with regional trend). In total, 88 areas were closed (30 ward and 58 bay closures) but improved management has meant wards remained closed for an average of seven days, which is two days fewer than in 2011/12.

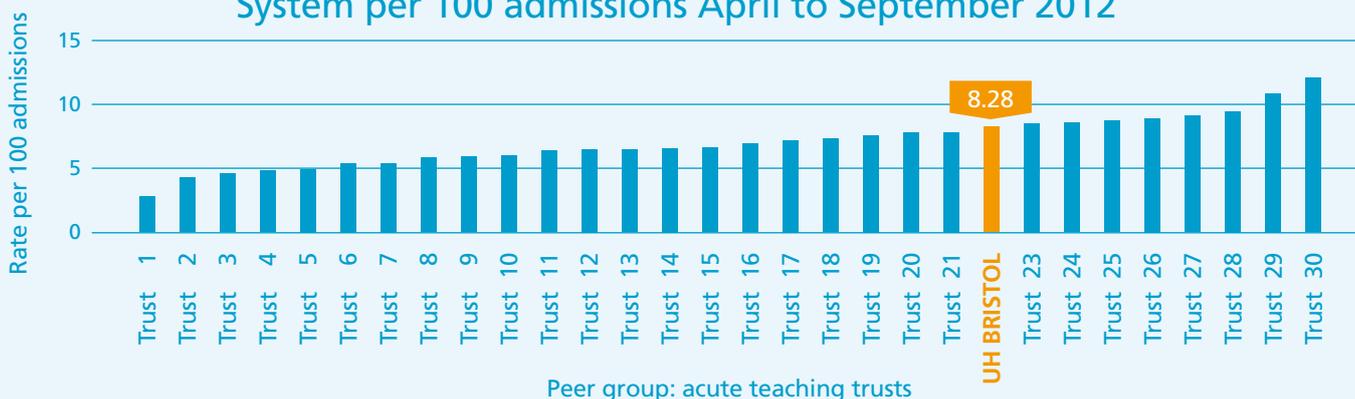
Rate of patient safety incidents reported and proportion resulting in severe harm or death
(Mandatory indicator)

We are pleased that we are reporting more patient safety incidents and seeing fewer incidents which result in severe patient harm. Reporting of incidents at University Hospitals Bristol NHS Foundation Trust (UH Bristol) has increased steadily since 2009/10. The Trust is ranked in the top 50% of its peer group, improving its position to just below the best quartile. It is widely recognised that organisations that report more incidents usually have a better and more effective safety culture: you cannot learn and improve if don't know what the problems are.

Source: Public Health England Data Capture System

Figure 8

Rate of incidents reported to the National Reporting and Learning System per 100 admissions April to September 2012



Based on the latest available data from the National Reporting and Learning System for the six month period April to September 2012, the rate of patient safety incidents reported at UH Bristol is 8.28 per 100 admissions (5273 incidents). This represents an increase in reporting when compared to the previous six month period (7.26 per 100 admissions, 4662 incidents) and to the same period in 2011/12 (6.66 per 100 admissions, 4274 incidents). The national average for incidents per 100 admissions in the corresponding period of 2012 was 6.44. The provisional¹⁴ rate of patient safety incidents for 2012/13 as a whole was 8.84 per 100 admissions.

The percentage of reported incidents resulting in severe harm is 0.7% (35 incidents) for the period April-September 2012. This represents a reduction compared both to the previous six months (1.0%, 46 incidents) and the corresponding period in 2011/12 (1.1%, 47 incidents) as reported in our 2011/12 Quality Report. The percentage of reported incidents resulting in death remains at 0.1% (four deaths), the same rate reported in 2011/12 and below the average rate of our peer group (0.15%). The provisional percentage of reported incidents resulting in severe harm or death was 0.63% (66 severe harm incidents; and four potentially avoidable deaths) for 2012/13 as a whole. The Trust considers its incident reporting data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. This framework governs the identification and review of incident data prior to submission to the National Reporting and Learning System (full details are available upon request).

In 2013/14, the Trust intends to take the following actions to continue to reduce harm from avoidable patient safety incidents:

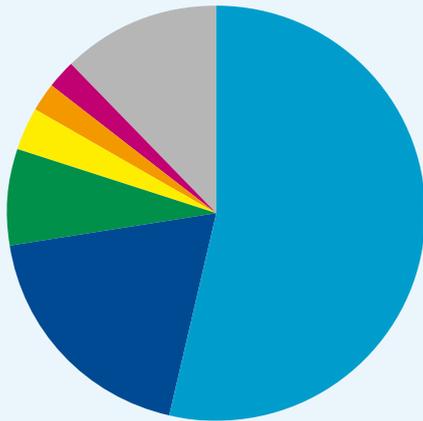
- Continuing to implement the South West Quality and Patient Safety Improvement Programme.
- Investigating incidents proportionally to their level of harm or risk, learning and sharing lessons and taking action to reduce the chance or impact of the same kind of incident happening again.
- Focussing on improving key patient safety issues for the Trust such as reducing the number of non-purposeful omitted doses of critical medicines, reducing pressure ulcers and in-patient falls and improving the identification of the deteriorating patient and ensuring prompt review by a senior clinician.

¹⁴ Verified data for October 2012 – March 2013 is not available from the NRLS until September 2013.

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 2012/13, the Trust Board was informed of serious incidents via its monthly quality dashboard. The total number of serious incidents for the year was 91, of which five were either downgraded or a downgrade request has been made at the time of writing (April 2013). A breakdown of the themes from these incidents is provided in Figure 9 below.

Serious incidents 2012/13



Grade 3 or 5 pressure ulcers 49

In-patient falls 17

Unexpected death 7

Black escalation 3

Sub-optimal care of deteriorating patient 2

Emergency department queuing 2

Other 11

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

Completed serious incident investigations will have robust action plans which are being implemented to reduce the risk of recurrence. Actions taken by the Trust to reduce falls and hospital acquired pressure ulcers are documented on pages 9-11 of this report.

Never Events

'Never events' are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. They are incidents where there is clear potential for causing severe harm or death. "Never" is an aspiration: these errors should not happen and all efforts must be made to prevent these mistakes from being repeated. This means that the overriding concern for the NHS in implementing the national never event policy framework is to discuss these events when they occur and to learn from the mistakes that were made (Department of Health 2010). One 'never event' occurred in UH Bristol in 2012/13 which involved a retained swab following an instrumental delivery in the obstetric theatre. Whilst there is a robust Standard Operating Procedure (SOP) in place to ensure all swabs, instruments and needles are counted at the end of a procedure, this was not followed in this case. Theatre staff have been reminded of their roles and responsibilities in relation to the Standard Operating Procedure. A process of continuous audit of compliance with the SOP has been introduced in obstetric theatres and the Central Delivery Suite.

National Patient Safety Agency Alerts

The two outstanding National Patient Safety Alerts for University Hospitals Bristol reported in our Quality Report for 2011/12 have been closed. At the end of 2012/13, there were no outstanding alerts relating to UH Bristol.

**Patient Safety Objectives
for 2013/14**

- To increase harm free care as measured via the NHS Safety Thermometer.
- To reduce hospital acquired healthcare infections.
- To reduce medication errors.
- To extend medicines reconciliation ('getting the medicines right').
- To improve the early identification and escalation of care of deteriorating patients.
- To improve levels of nutritional screening and specifically 72 hour nutritional review of patients.

These objectives have been agreed with staff in our clinical divisions and with our governors. The themes broadly reflect a continuation of previously stated goals and our ongoing commitment to participation in the South West Quality and Patient Safety Programme. Our governors have proposed that reducing hospital acquired healthcare infections should be a standing annual quality objective.

Specific targets will be agreed with commissioners through the CQUIN process.

The Chief Nurse and Medical Director will be the executive directors responsible for achieving these objectives. Progress will be monitored during the year by the Trust's Clinical Quality Group, Trust Management Executive and by the Quality and Outcomes Committee of the Board.

Patient Experience



Our Commitments

We want all our patients to have a positive experience of healthcare. All our patients and the people who care for them, are entitled to be treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support. Our staff should be afforded the same dignity and respect by patients and by their colleagues. Our commitment to 'respecting everyone' and 'working together' is enshrined in the Trust's values. Through our core patient surveys, we have a strong understanding of the things that matter most to our patients: these priorities continue to guide our choice of quality objectives. Our Clinical Divisions continue to be focused on providing a first class patient experience.

Report on our patient experience objectives for 2012/13

OBJECTIVE 6

We wanted to implement the first year of our Patient Experience and Involvement Strategy for 2012 - 2015



By implementing our previous patient experience strategy for 2010 - 2012, we established a comprehensive system for routinely gathering feedback from patients about the quality of our services. This consisted of ward-based interviews and comment cards, and a monthly post-discharge survey, in addition to a comprehensive annual outpatient survey. We have continued this model in our strategy for 2012 - 2015. For 2012/13 – the first year of our new strategy – we identified five groups of people whose experience of service we wanted to improve: emergency patients, children, carers, patients with a learning disability, and frail elderly patients including patients with dementia and those in end of life care.

Emergency patients

The Trust's adult emergency department sees approximately 200 patients each day, ranging from minor injuries to very complex cases. The department aims to treat and then admit, transfer or discharge all patients within four hours. Understanding patient experience is key to helping us develop the quality of our service. We achieved excellent results in the 2012 National Accident and Emergency survey with 16 scores classed as statistically "better" than the national average and eight of these scores being the highest scores nationally. During 2012/13 we have worked closely with representatives from the Red Cross which has a team located within the emergency department to assist with patient discharge. We have also actively involved patients in conversations about the redevelopment of the Bristol Royal Infirmary so that the final designs reflect their needs.



What our patients said in our monthly survey:

“In A&E, the doctors and nurses were absolutely brilliant.”



Children

The Bristol Royal Hospital for Children provides a local service for Bristol children and a referral service for specialist care for families across the South West of England and nationally. It is important to us that we engage and involve children in the planning and delivery of services that matter to them. Over the last two years, we have been developing teen zones, ‘young people friendly’ environments with (restricted) access to the internet, books, magazines and health information targeted at this age group. After a successful pilot at the Bristol Eye Hospital, a second teen zone area has been opened in the Children’s Hearing Centre at St Michael’s Hospital. Signage for the zones has been designed by members of the UH Bristol Youth Council and young people from the Knowle West Media Centre. Elsewhere, the Youth Council undertook a ‘mystery shopping’ exercise in October 2012 to test front-of-house services in various areas of the Trust. This involved visiting the main reception areas and evaluating the service provided, including whether it was young person-friendly. The Disabled Children’s Working Group (DCWG) ran a “You Said, We Did” event at the @Bristol centre for a second year running, aimed at families with children who have disabilities or complex needs. Based on feedback from this event, the DCWG has developed a specialist assessment for children with disabilities.



What our patients said in our monthly survey:

“My child has a disability and had a hospital passport. This was brilliant and made the whole experience much better for him than previous ones had been.”



Carers

Carers have a unique and valuable role to play in the provision of healthcare, particularly if the person they care for is in hospital. Carers are, in effect, our “expert partners in care”. Engaging carers is an ongoing activity which we remain committed to with our partners at the Carers’ Support Centre, our Carers’ Reference Group and colleagues at North Bristol NHS Trust, with whom we have established a joint Carers’ Charter. By the end of March 2013, approximately 3,000 staff had received care awareness training. From May 2013, this training will be extended to ward-based and dementia befriending volunteers. We hope that this will enable more ‘hidden carers’ to be identified through volunteers’ work with patients on wards. A new Carer Liaison and Development worker was appointed and from January 2013 has been working on wards 4, 7 and 23 to support carers and staff, particularly around the discharge process. Towards the end of 2012/13, a new carers’ strategy and action plan was approved by the Trust’s Patient Experience Group.

In the National Inpatient survey 2012, UH Bristol scored ‘better than most other trusts’ for ensuring that the patient’s family / someone close to them got all of the information they needed to care for the patient.

Patients with a learning disability

The Learning Disabilities Steering Group is committed to ensuring that the Trust improves the experience of care amongst patients with learning difficulties and their carers, and in doing so meets its obligations to patients with a learning difficulty within the current legislative framework, i.e. with regard to the Equality Act (2010), the Mental Capacity Act (2005) and implementation of the Confidential Inquiry into the premature deaths of people with learning disabilities within an acute setting (2010 - 2013).

In 2012/13:

- We have continued to work closely with user groups such as Health First, People First, Health work group.
- We have implemented the University Hospitals Bristol NHS Foundation Trust and North Bristol NHS Trust Carers Charter as a commitment to ensuring a greater focus on carers.
- The Trust has developed an admission pack including use of staff photographs, information about accommodation, facilities and car parking.
- We have introduced a differentiated inpatient comments card in an 'Easy Read' format.
- We have launched a selection of accessible information leaflets.
- We are developing patient and carers' appointment letters in Easy Read formats, to include: appointment letters, hospital admission letters and change of appointment letters.
- We have launched the 'Hospital Passport' across the Trust, supporting regional plans for a single patient record. The passport is accessible for download from the Trust external web page and can be emailed via a secure link direct to the learning disabilities nurse in preparation for admission.
- We have "recruited" over 40 link nurses in adult services across the Trust supporting the role of the hospital liaison nurse and raising awareness about the needs of patients with learning difficulties.

Also see information about risk assessment of patients with a learning disability on page 36 of this report.

Frail elderly patients including patients with dementia and those in end of life care

In 2012/13, we undertook a comprehensive Trust-wide audit of end of life care, with a key objective to establish whether patients at the end of their lives were recognised as dying, enabling the delivery of a uniform standard of care on an agreed care pathway. This project was linked to a CQUIN target that at least 45% of all adult deaths occurring on our wards should have their care directed by the Trust's End of Life tool. The audit identified that 65% of the deaths included in the audit were directed by the End of Life tool; 18% of deaths were sudden and could not have been anticipated; whilst the remaining 17% could have been anticipated but the tool was not used. Since that time we have continued to monitor the use of the tool and to investigate reasons why wards might not use the tool.

Also see detailed report on dementia care on page 35 of this report.

OBJECTIVE 7

We wanted to reduce patient-reported noise at night from staff

What our patients said in our monthly survey:

"Staff are excellent, very caring, informative and supportive - would help any way they could. The only thing would be the noise at night. Some things are unavoidable but general chat should be kept at low level."

"On the adolescent ward, the doors on the bays shut slowly to start, then bang!"

We chose this objective as a continuation of a goal we set ourselves for 2011/12. We currently measure performance through a question in our monthly post discharge patient survey. In 2011/12, we improved our score from a baseline of 78 points out of 100¹⁵, to 82: a statistically significant change. This year we scored 83 points¹⁶: a small

¹⁵ In this instance, the score means that 78% of patients had not been disturbed by noise at night from staff. The baseline was Quarter 4 2011/12.

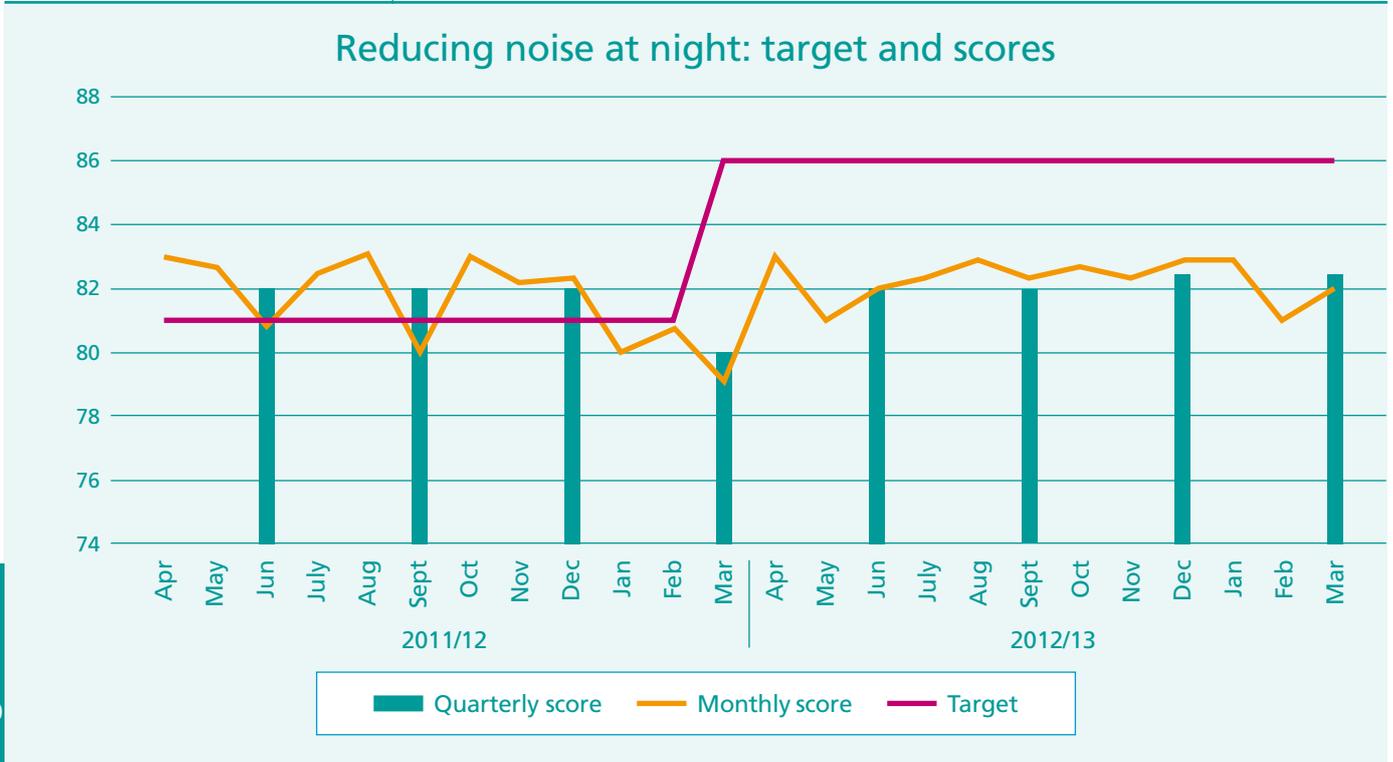
¹⁶ The CQUIN was based on patient feedback in the third quarter of 2012/13.

¹⁷ Sound Ears are monitors which display a warning light when a pre-determined noise level (decibels) is breached.

improvement, although we did not achieve our CQUIN target (84-86 points). Actions taken in 2012/13 to improve noise at night included further purchases of silent-closing bins and the use of 'Sound Ear' noise monitors on our wards¹⁷. Our corresponding score in the 2012 National Inpatient Survey was 84 points (categorised as statistically 'about the other same' as other NHS trusts). This compares with a 66 point score for noise at night caused by patients (also 'about the other same' as other NHS trusts), i.e. patients are more likely to be disturbed at night by other patients than by staff.

Source: UH Bristol monthly inpatient survey (patients aged 16 and over)

Figure 10



OBJECTIVE 8

We wanted to ensure that patients are treated with kindness and understanding

What our patients said in our monthly survey:

“My midwife who delivered my baby was excellent, she was kind, friendly, helpful and made me feel a million times better in my situation as it was my first time in labour.”

The three yearly National Maternity Survey includes a question about whether mums felt that they had been treated with kindness and understanding – an important part of what ‘compassionate care’ looks and feels like in practice. In the first instance, we wanted to improve our maternity score. This followed a disappointing score for this question in the 2010 National Maternity Survey¹⁸. We therefore agreed a related CQUIN target with our commissioners (85/100 points), to be measured in the third quarter of the year. We achieved this score, and therefore the CQUIN. At the same time, we decided that kindness and understanding was something we wanted to measure across all inpatient services. We started to do this in the second quarter of the year and have achieved quarterly scores in excess of 90 points. One of our ambitions for 2013/14 is to sustain this Trust-wide score.

¹⁷ Sound Ears are monitors which display a warning light when a pre-determined noise level (decibels) is breached.

¹⁸ our score of 74 points was on the borderline of being in the “worst 20%” of NHS trusts.

Kindness and understanding on postnatal wards (with Trust comparison)

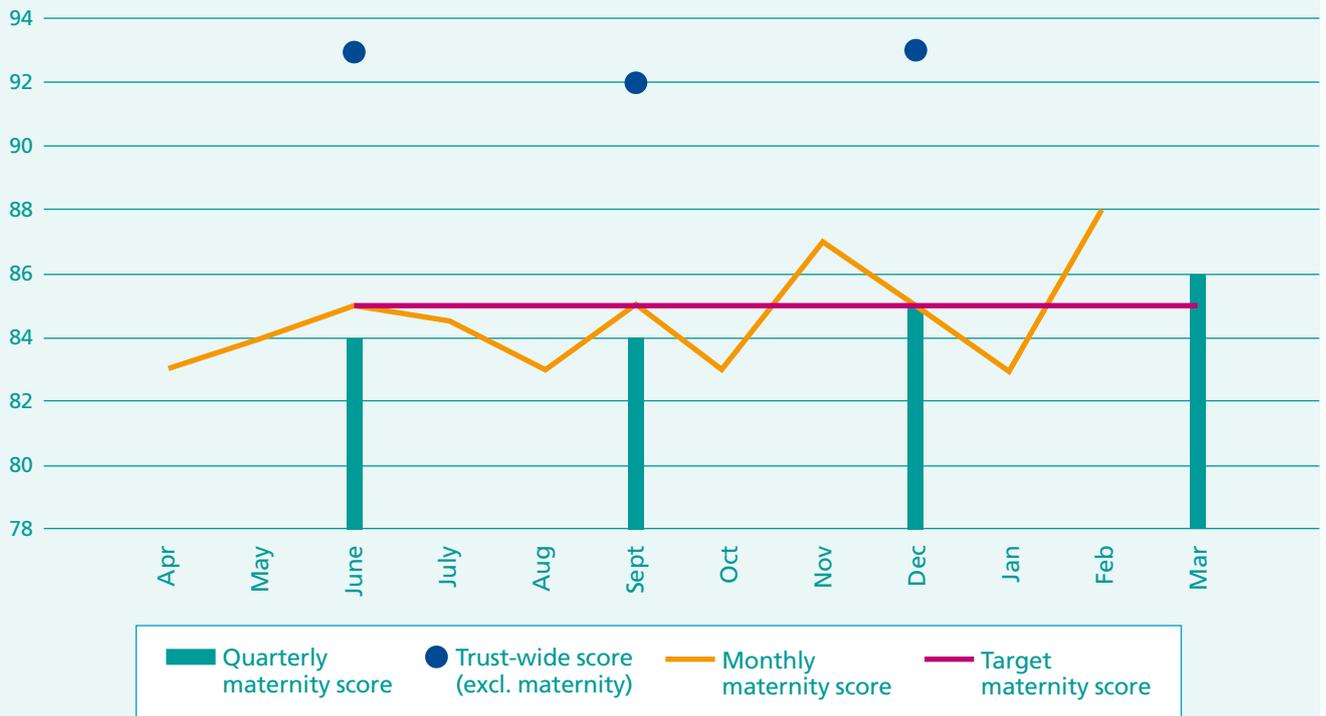


Figure 11

Source: UH Bristol monthly maternity survey; UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys. Data shown is for the year 2012/13. To avoid duplication with the National Maternity Survey, we did not undertake a local maternity survey in March 2013.

OBJECTIVE 9

We wanted to improve specific aspects of communication with patients

What our patients said in our monthly survey:

“I have received very professional care, staff were very warm and helpful. However, I felt as a patient I should receive more precise information about my situation.”

Failures in communication with patients are at the heart of many reported complaints from patients and their families. This is true for our Trust and across the wider NHS. For 2012/13, we agree two specific aspects of communication that we wanted to improve: keeping outpatients informed about waiting times in clinics, and making sure inpatients are able to find someone to speak to if they have worries or fears.

Explaining reasons for delays in outpatient clinics was UH Bristol’s lowest score in the 2011 National Outpatient Survey. Our score of 25/100 was also on the borderline of being among the worst 20% of NHS trusts, albeit that the best score achieved by an NHS trust was only 49 points. The methodology of the National Outpatient Survey is such that the patient sample is skewed towards a small number of high volume outpatient clinics (e.g. ophthalmology, audiology, radiology) rather than being representative of the experience across all clinics. When we asked the same question in our own 2011 outpatient survey – replicating the national survey methodology but using a much larger patient sample with a more even distribution across our clinics, we scored 38/100: better, but still the lowest-rated of 30 questions in the survey. 59% of patients said that they had not been told how long they would have to wait.

Improving our performance for this aspect of patient experience has been one of the objectives of a major outpatient improvement programme known as the 'Productive Outpatient' project. Status boards have been placed in outpatient clinics, with the exception of the Bristol Eye Hospital (BEH), with colour-coded displays to show if the clinic is running late and if so by how long. Staff are also encouraged to re-enforce this message verbally at regular intervals during the clinic. The results of our 2013 local outpatient survey show a virtually unchanged patient-rated performance (score of 38/100; 58% had not been told how long they would have to wait). We know that the practice of nurses giving verbal updates to patients varies considerably between outpatient clinics and that further work is required with our matrons and nurse managers to ensure that giving a verbal update as part of the process of updating the status board becomes a core responsibility of the nurse in charge. The BEH is currently seeking to procure an electronic patient queue and calling system as we have found that clinic status boards are not effective in this location due to the large number of different waiting rooms for patients.

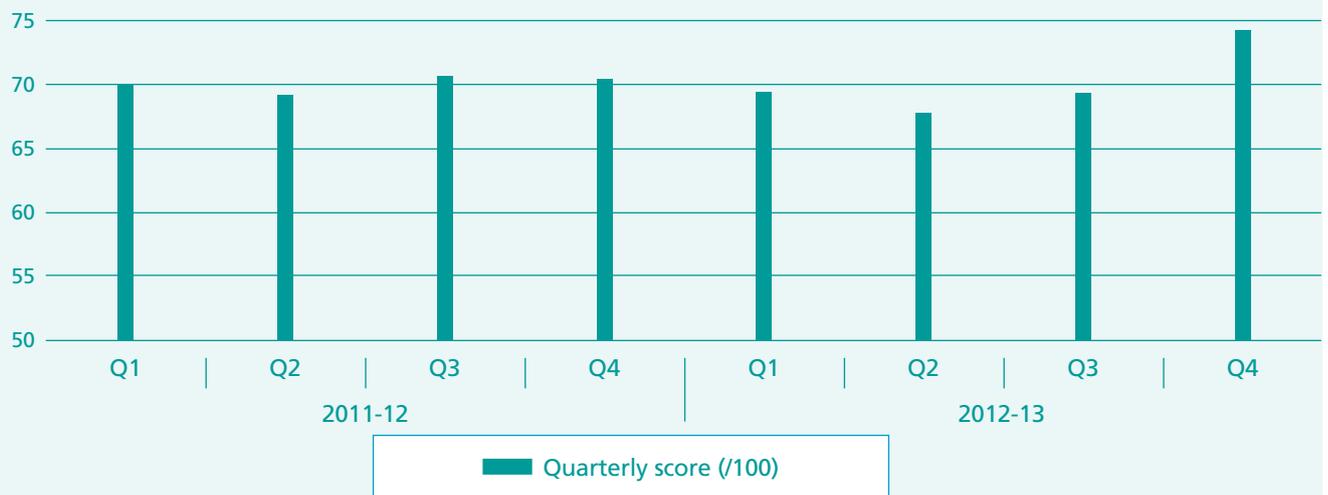
In the 2011 National Inpatient Survey, when patients were asked whether they could find someone to talk to about their worries and fears, we received an overall score of 62/100. This was statistically 'about the same' as other NHS trusts but some way short of the best score for an NHS trust, which was 79. Our score in the 2012 National Inpatient Survey was 63. Once again, this was statistically 'about the same' as other NHS trusts (the best score was 78). We have also monitored this question via our own monthly inpatient survey: Figure 12 shows a statistically consistent pattern throughout the year, with scores varying slightly around a mean of 70 points¹⁹ and indications of an improvement in the fourth quarter of the year.

¹⁹ Since 2012, the Care Quality Commission has presented national survey scores out of a maximum of ten points rather than 100. We have presented all scores out of 100 in this report to enable comparison of national and local survey data (i.e. scores reports in national patient survey reports have been multiplied by ten).

Source: UH Bristol monthly inpatient (patients aged 12 and over) and parent surveys.

Figure 12

Were patients/parents able to find a member of staff to talk to about their worries or fears?



OBJECTIVE 10

We wanted to reduce numbers of complaints, and respond as quickly as possible if people do complain



In last year's Quality Report, we explained that we had received significant numbers of complaints about delayed or cancelled appointments at the Bristol Eye Hospital and the Bristol Royal Infirmary Trauma and Orthopaedic Department; also that urology and lower and upper gastrointestinal services received the largest number of complaints about cancelled or delayed surgery. We explained that this would be addressed through the Trust's 'Transforming Care' programme, which seeks to improve patient experience through better use of beds, booking and waiting list improvements, clinical process redesign, urgent care improvement and the use of enhanced recovery²⁰. A great deal of work has taken place throughout 2012/13 and we are confident that this will be reflected in reductions in reported complaints in 2013/14.

Overall in 2012/13, 1,651 complaints were received by the Trust, representing a 12.7% rise compared to the 1,465 complaints received in 2011/12 (1532 in 2010/11). This equates to 0.257% of all patients episodes, against a target of <0.21%. Figure 13 demonstrates that complaints peaked during May 2012: this was at least partly attributable to the introduction of the Trust's new patient administration system, Medway, and to cancelled and delayed outpatient appointments and operations. By the final quarter of 2012/13, our rate of complaints was tracking consistently lower than in the equivalent quarter of the previous year. Analysis of the cause of complaints has not revealed any significant new trends.

²⁰ See page 37.

Complaints as a proportion of total patient activity



Source: UH Bristol Ulysses Safeguard system

Figure 13

We have a target that there should be no more than three complainants each month who tell us that they are dissatisfied with the quality of our response: in 2012/13, we achieved this target in 10 out of 12 months (annual total 25 cases). Learning from complaints is shared at Trust and divisional board meetings, and at the Trust's Patient Experience Group.

In 2012/13, we reported to the Board that 95.2% of complaints had been responded to within a timescale agreed with the complainant (compared with 91.1% in 2011/12) however as part of the process of producing this Quality Report, we have identified an administrative error which affects the validity of this data. Unfortunately, the indicator

has been measured using as its end-point the date when the clinical division completes its investigation and prepares a response to the complainant; not the date when the response letter is sent to the complainant, which generally occurs two or three days later. It has not been possible to retrospectively recalculate data for 2012/13. However from April 2013 onwards, we will ensure that the appropriate end point is recorded, and that this indicator is correctly measured and reported to the Board.

From May 2013 onwards, if an agreed timescale for a response to a complaint is breached, or if a complainant is unhappy with the quality of our response to a complaint, the relevant Trust division will be required to complete an exception report, firstly in order to validate the data, but more importantly to consider what steps could be taken to prevent a recurrence.

Finally, from April 2013, the Trust's Patient Support and Complaints Team has temporarily relocated to the Bristol Dental Hospital. The service will return to the Bristol Royal Infirmary later in 2013/14 following the completion of planned refurbishment works and will be a key part of the new Welcome Centre.

OBJECTIVE 11

We wanted to reduce reported incidence of discrimination against staff

We chose this objective at the request of our non-executive directors in response to the results of the 2011 National Staff Attitudes Survey: we were concerned that 14% of respondents had said that they had experienced discrimination at work in the previous 12 months: this was an increase of 3% from the previous year and worse than the national average.

In 2012/13, we took a range of actions in support of this objective, including:

- Continuing to deliver Equality and Diversity and 'Respecting Everyone' training for staff and managers; 'Living the Values' training is also being rolled out to all staff in UH Bristol.
- Using clear signage to communicate to patients and visitors the expectation to treat staff appropriately and with respect.
- Strengthening our processes, procedures and policy to tackle harassment and bullying in the workplace, including a revised and simplified Violence and Aggression Policy which follows NHS Protect guidance.
- Developing a joint Equality and Diversity and Health and Wellbeing Steering Group to drive forward the equalities and wellbeing agenda.

In the 2012 National Staff Attitudes survey, 12% of staff stated that they had experienced discrimination at work during the previous 12 months: a decrease of 2% from the 2011 survey, although remaining slightly above an 11% average for acute trusts in England (but within statistical margins of error).

- 7% of respondents (29 people) stated that they had personally experienced discrimination at work from patients/service users/relatives/other members of the public: a reduction of 1% from 2011.
- 8% of respondents (35 people) stated that they had personally experienced discrimination at work from their manager, team leader or other colleagues: an encouraging reduction of 3% from 2011.

Although the Trust score for staff receiving equality and diversity training in the previous 12 months had slightly decreased since 2011 and, at 50% was below the national average, 88% of respondents said that they had received this training either in the past 12 months or more than 12 months ago – which is 2% above the national average. 90% of respondents stated that they believed that the Trust provided equal opportunities for career progression/promotion, which is above the national average of 88%.

REVIEW OF PATIENT EXPERIENCE 2012/13

This section explains how the Trust performed during 2012/13 in a number of other key areas relating to patient experience, which are in addition to the specific objectives that we identified.

What our patients said in our monthly survey:

“All the staff I came into contact with during and after my op were amazing. NHS at its best. Well done.”

“At no time did I feel anxious or afraid in your hospital. The staff (from consultant, doctors, nurses, catering, cleaning), were all courteous, helpful and caring.”

Board assurance about patient experience

Each month, our Trust Board reviews data for three ‘global’ indicators which provide assurances about patient-reported experience of care: an aggregate survey score based on the national patient experience CQUIN; an aggregate tracker score based on some of the key things our patients have told us matter to them when they are in hospital; and a local measure of the ‘net promoted score’ (similar to the question which will be used in the NHS Friends and Family Test in 2013/14).

National Patient Experience CQUIN²¹
(Mandatory indicator)

The national patient experience CQUIN uses an aggregate score based on responses to a ‘basket’ of five questions:

- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition and treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Our official CQUIN score is based on the results of the annual National Inpatient Survey, which reflects the experience of a relatively small sample (400+) of our patients during the month of July each year. In 2012/13, we achieved a score of 72.4 points, compared to our minimum target of 71.9²². This compares well with our peers and is an improvement over our scores for 2011/12 and 2010/11 (69.9 and 70.4 respectively). The 2012/13 and 2011/12 scores are marked as dots in Figure 14.

However, we also monitor this indicator using our own monthly survey – this survey replicates the methodology of the national survey, so the scores are broadly comparable. Figure 14 shows our performance against this indicator measured across the last two years using our own survey data. The ‘zig-zag’ line reveals encouraging signs of improvement in patient-reported experience towards the end of 2012/13, a pattern which is mirrored in Figures 15 and 17.

The Trust considers this data is as described because of the data quality checks that are undertaken, as detailed in the Trust’s data quality framework. The framework governs the selection of patients who are invited to participate in these surveys. The collection and analysis of feedback is outsourced to an approved contractor; and in the case of the official national CQUIN score, the results (from the National Inpatient Survey) are independently published by the Care Quality Commission. Our local monthly survey largely replicates the methodology of the National Inpatient Survey²³.

In 2012/13, a number of the themes which contribute to this national indicator have been reflected in patient experience action plans developed by our clinical divisions. In 2013/14, this national indicator will be replaced by the NHS Friends and Family Test.

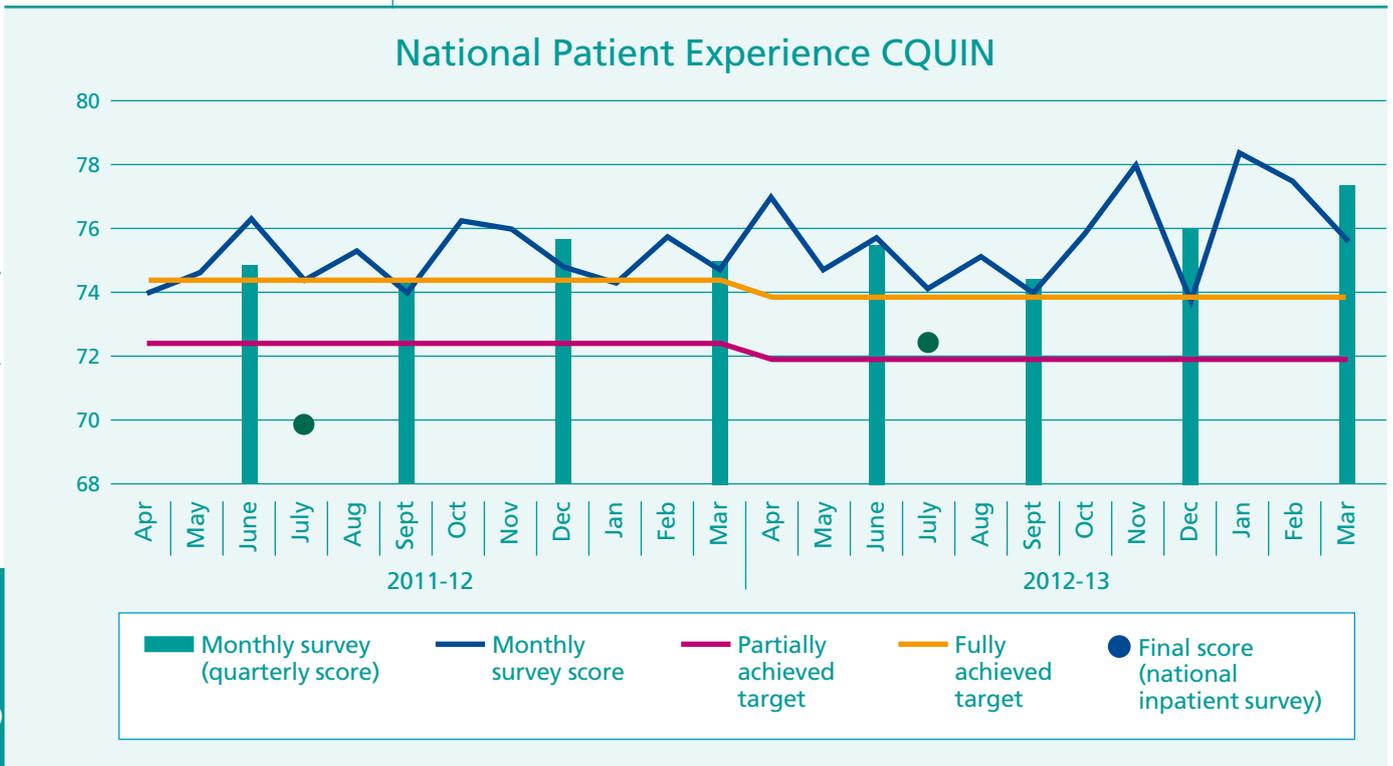
²¹ Referred to in list of mandatory reportable indicators as “Responsiveness to inpatients’ personal needs”.

²² Our target for maximum CQUIN value was 73.9 points.

²³ The key differences are that our survey goes out to the patient much sooner after their discharge from hospital, we include parents and patients aged 12 and over (the national survey is 16+ years only) and we send one survey reminder letter rather than two.

Source: UH Bristol Monthly inpatient survey (patients aged 16 and over); 2012 National Inpatient Survey (for final score).

Figure 14



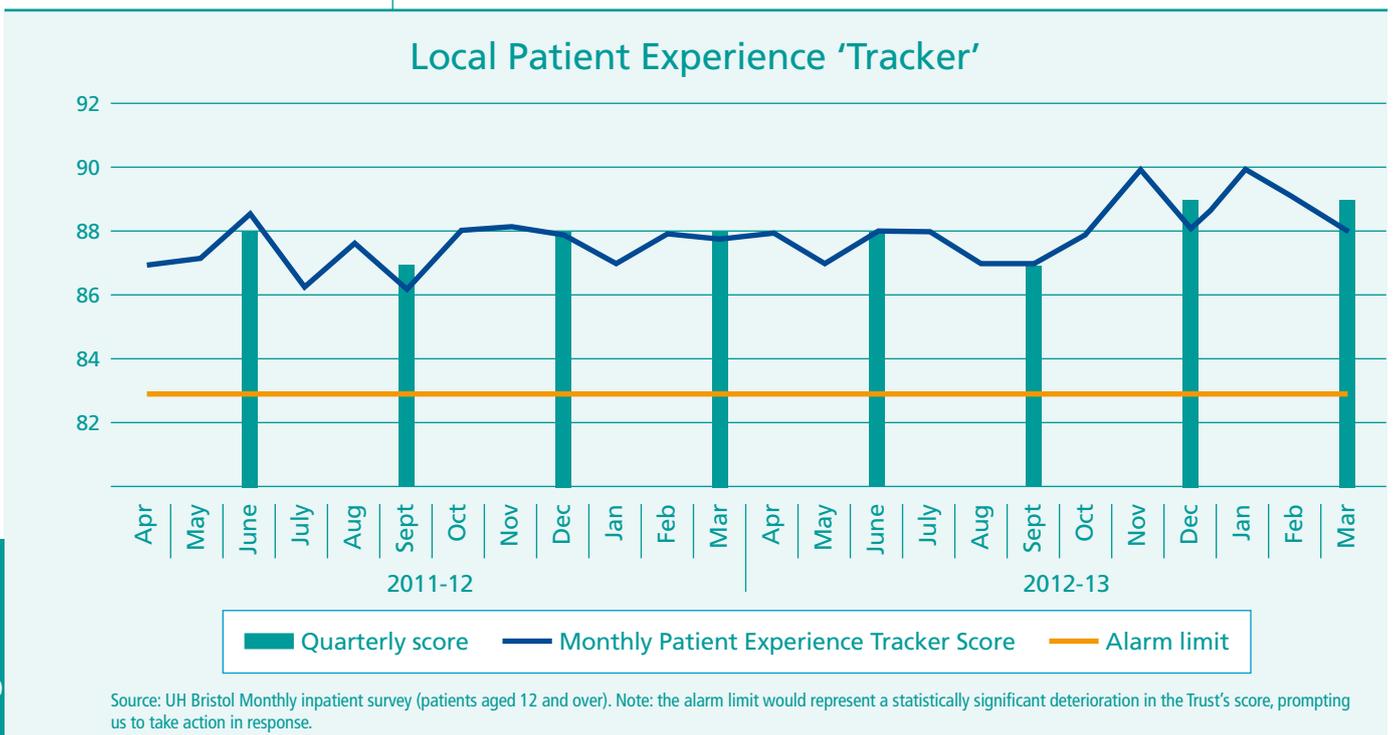
Local patient experience 'tracker' score

Our local patient experience tracker is based on the following aspects of care that our patients have said (through previous surveys) matter most to them:

- Involvement in decisions about care and treatment
- Being treated with respect and dignity
- Doctors and nurses giving understandable answers to the patient's questions (i.e. communication)
- Ward cleanliness

Figure 15 shows a similar pattern of improvement in patient-reported experience during the second half of 2012/13.

Figure 15



Source: UH Bristol Monthly inpatient survey (patients aged 12 and over). Note: the alarm limit would represent a statistically significant deterioration in the Trust's score, prompting us to take action in response.

Net promoter score

The 'net promoter score' asks patients whether they would recommend the Trust to their friends or family. In 2012/13, 96% of patients said they would either "definitely" or "probably" recommend us. An NHS-wide equivalent of this question, known as the Friends and Family Test (FFT), was introduced nationally on 1 April 2013. During 2013/14, we will continue to publish our own survey measure alongside FFT data to enable continuity and assist the Board's understanding of reported FFT scores.

% of patients who would probably or definitely recommend the Trust to friends and family



Figure 16

Source: UH Bristol Monthly inpatient (patients aged 12 and over) and parent surveys. Note: the alarm limit would represent a statistically significant deterioration in the Trust's score, prompting us to take action in response.

Finally, our Patient Experience Group also monitors a fourth global measure of patient experience: how people rate their hospital experience overall. In 2012/13, 96% of inpatients described their experience of care as "excellent", "very good" or "good", the same as in 2011/12 (see Figure 17). Last year, we published this data by ethnic group and we have repeated the exercise this year. All of the year-to-year changes noted in Figure 18 are within normal margins of statistical error, i.e. they are not statistically significant.

Source: UH Bristol Monthly inpatient (patients aged 12 and over) and parent surveys.

Figure 17



Source: UH Bristol Monthly inpatient survey (patients aged 12 and over).

Figure 18



National Staff Survey 2012

As in previous years, in line with the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual National Staff Survey which have a bearing on quality of care. Relevant results from the 2012/13 survey are presented below. Questionnaires were sent to a random sample of staff across the Trust (this includes only staff employed directly by the Trust): 455 staff at UH Bristol took part in this survey, representing a response rate of 55%, which is above average for acute trusts in England.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated respectfully and with dignity and compassion at every stage of their care. It is also vital for us to ensure that our staff are treated and treat each other in line with the Trust's values, and with the same level of dignity and respect which we expect for our patients. These values (respecting everyone, embracing change, recognising success and working together) are a guide to our staff about how they are expected to behave towards patients, relatives, carers, visitors and each other. The values are embedded in recruitment and staff induction and are clearly and regularly communicated.

'Key finding'	UH Bristol score 2012	UH Bristol score 2011	UH Bristol score 2010	National average score 2012	National best score 2012
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	79%	74%	76%	78%	89%
Percentage of staff agreeing that their role makes a difference to patients	92% Highest (best) 20% ²⁴	92%	92%	89%	95%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (to other staff or to patients)	39% Highest (worst) 20%	39%	39%	34%	20%
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	91%	96%	91%	90%	96%
Staff recommendation of the Trust as a place to work or receive treatment (Mandatory indicator ²⁵)	3.66	3.65	3.68	3.57	4.08

²⁴ i.e. this score was in the upper quintile (best 20%) of NHS trusts.

²⁵ In the NHS Staff Attitude Survey, trusts receive a score out of a maximum of five points for each question: this score equals the average response given by their staff on a scale of 1-5 where 5 means that they 'strongly agreed' with the statement "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation". The mandatory indicator on p5 of this report, made available by the National NHS Staff Survey Co-ordination Centre, analyses the same data in a slightly different way: in this instance, the indicator measures the percentage of staff who said that they either 'agreed' or 'strongly agreed' with the statement, "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

The Trust considers that this data is as described because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. The reported data is taken from a national survey, which the Trust participates in through an approved contractor, adhering to guidance issued by the Department of Health. In 2013/14, the Trust and each of its divisions will develop action plans to address key areas of improvement arising from the NHS Staff Attitude Survey.

²⁶ Important note: the UH Bristol figures quoted for 2010 and 2011 are those which will be found in the 2010 and 2011 NHS Staff Attitude Survey reports. The 2010 figures differ from the 2010 figures quoted in the 2011 NHS Staff Attitude Survey report; and the 2011 figures differ from the 2011 figures quoted in the 2012 report. This is because the Picker Institute, which runs the surveys, re-calculates the data each year. The Picker Institute has advised that either version of the data is appropriate for publication: we have chosen to use the original data for purposes of consistency and transparency.

Patient experience objectives for 2013/14

These objectives have been agreed with staff in our clinical divisions and with our governors. The Friends and Family Test is a major new development for all NHS hospitals in 2013/14: although we have been reporting a slightly different version of the 'net promoter score' to our Board for some time, the challenge of giving all inpatients, A&E attenders and maternity patients the opportunity to say whether or not they recommend us will be a considerable one. We have retained the 'kindness and understanding' objective because we see this as fundamental to the quality of patient experience. Our overall score in 2012/13 was good, so our objective in 2013/14 is to achieve a score which is at least as good as this. Explaining medication side effects to patients was not one of our stated quality objectives for 2012/3, however it was a CQUIN agreed with our commissioners. Although results from the 2012 National Inpatient Survey show that we do relatively well compared to the rest of the NHS, in absolute terms our performance is not what we would hope for. We have therefore included this as an objective for 2013/14. Finally, improving the experience of maternity patients is the stated objective of the second year of our Patient Experience and Involvement Strategy.

The Chief Nurse will be the executive director responsible for achieving these objectives. Progress will be monitored by the Trust's Clinical Quality Group and by the Quality and Outcomes Committee of the Board.

Clinical effectiveness



Our Commitments

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

Report on our clinical effectiveness objectives for 2012/13

OBJECTIVE 12

We wanted to ensure that at least 90% of stroke patients were treated for at least 90% of the time on a dedicated stroke ward



Improving the care of stroke patients is a national priority within the NHS Outcomes Framework. There is extensive evidence to show that care on a dedicated stroke unit care reduces patient mortality, disability and the likelihood of requiring institutional care following stroke. In last year's Quality Report, we reported that we had established such a unit in Ward 12 of the Bristol Royal Infirmary. Patients suspected as suffering from a stroke should be directly admitted to the Stroke Unit from the Emergency Department, although in some cases patients are only identified as suffering from a stroke once they have been admitted to the Medical Assessment Unit or an inpatient ward.

There is a national standard which states that at least 80% of stroke patients must be treated for at least 90% of the time on a dedicated stroke unit: for 2012/13, we retained the previous year's stretch objective that 90% should spend 90% of their time on Ward 12. We achieved the national target (80%+) for the last seven months of 2012/13, narrowing missing the target for the year as a whole (79.3%). Operational challenges similar to those we reported for 2011/12 – admitting patients directly to the unit, and protecting beds for use by stroke patients during times of increased patient activity in our hospitals – prevented us from achieving the 90% stretch target. It has been agreed that we will continue to pursue this target in 2013/14.

This year, our governors have asked us to include a comment about how the Trust seeks to achieve effective continuity of care when stroke patients are discharged from hospital. The Trust has funded an early supported discharge team to enable early discharge from hospital by providing specialist care at home. During the period April 2012 - January 2013, the team took home 42% of stroke patients admitted from the Bristol area (the national target is 40%). The team is resourced to cover South Bristol patients and the Trust is currently exploring the resource implications of extending the service into North Somerset. Patients who do not require ongoing therapy are discharged to their GP: all patients (where physically appropriate) are offered a follow up appointment with a

consultant in the Bristol Royal Infirmary, or at South Bristol Community Hospital where we run a monthly multidisciplinary clinic. This appointment is usually six weeks after discharge, at which time any ongoing specialist care is individually assessed.

OBJECTIVE 13

We wanted to develop the use of service-specific standardised mortality ratios to monitor clinical outcomes



Information about the Trust's headline mortality rates can be found on pages 39-40 of this report. During 2012/13, we experimented with the inclusion of divisional SHMI (Summary Hospital-level Mortality Indicator) data in divisional quality dashboards, however this information was withdrawn after concerns were expressed by clinicians about misleading conclusions which could be drawn from the use of non-risk-adjusted data (i.e. data which has not been adjusted to account for the relative severity of a patient's condition) with large confidence intervals. Condition-specific benchmarking data, including mortality rates, is reviewed regularly by the Trust's Quality Intelligence Group (working in partnership with CHKS benchmarking) however this data does not necessarily map neatly to clinical specialties or divisions. A robust process is in place to ensure that any alerts are investigated, initially through a coding review and then if required, by clinical case note review/audit. We have also agreed a corporate quality objective for 2013/14 to commence an exercise to scope out the current availability of outcomes data across all clinical specialties.

OBJECTIVE 14

We committed to continuing to implement our dementia action plan



In 2013/14, for the fourth consecutive year, the Trust has included care of dementia patients as a corporate objective, underlining the importance we place on meeting the needs of this group of patients. The term dementia covers a range of progressive, terminal brain conditions which affects more than 73,000 people in the South West of England. Enhancing the quality of life of people with dementia is a priority of the NHS Outcomes Framework.

In 2012/13, we made significant progress both in relation to meeting the requirements of the NICE Quality Standard for Dementia (Statements 1, 5 and 8) and the South West Dementia Standards. In February 2013, the Trust received a very positive dementia peer review site visit as well as encouraging results from the second round of the National Audit of Dementia. We continue to work collaboratively with North Bristol NHS Trust to ensure that people with a dementia receive care that is consistent across the city of Bristol. By the end of the financial year, 56% of relevant staff had attended 'An Hour to Remember' training and we are on schedule to achieve our target of 90% compliance by August 2013.

Progress in relation to the South West Standards in 2012/13 has included the appointment of a lead nurse for dementia to co-ordinate this work and the identification of 125 'Dementia Champions' across the Trust both in clinical and non-clinical roles. 'This is me' documentation has been rolled out across the Trust, enabling a greater understanding of patients' wishes about their treatment and care, and the 'Forget me not' used to identify patients with dementia / cognitive impairment has been adopted across the Trust, ensuring a consistent approach with North Bristol NHS Trust where the symbol is already in use.

We have established a befriending scheme pilot project utilising volunteers to offer activities and companionship to frail older adult inpatients and frail older adults with a dementia. The scheme was launched in October 2012 with the appointment of a project lead supported by the WRVS. Elsewhere, the Trust secured £15,000 funding from the Prime Minister's Challenge fund to improve the environment on Ward 4, utilising the King's Fund principles of design: we have been able to provide a separate seating area with a television, handrails in the walkway corridor, bright colours to define each bay / cubicle and suitable signage to improve wayfinding.

A challenging national CQUIN for dementia was set for 2012/13 in three parts: finding/ identifying people with a dementia, assessing them, and referring them to their GP. Latest available data for February 2013 shows that the Trust is achieving 62.8% compliance for stage 1 (finding) and 100% compliance for stages 2 and 3 (assessing and referring). We anticipate that stage 1 compliance will increase following the implementation in May 2013 of an electronic discharge summary for patients aged 75 years and above.

OBJECTIVE 15

We wanted to ensure that patients with a learning disability received a prompt risk assessment and patient-centred care plan



Patients with a known learning disability should receive an assessment within 48 hours of admission to an inpatient bed. The purpose of the risk assessment is to ensure that patients with learning disabilities have reasonable adjustments made following inpatient admission to ensure their care needs are identified early.

The Trust's local target for 2012/13 (based on a previous CQUIN) is 85% compliance. Over the year as a whole, we were disappointed to achieve 81.2%, albeit that this was an improvement on our performance in 2011/12 (76.5%). We were however encouraged by our year-ending score of 91.3% in March 2013. During the year, a number of exceptions have been in the adult Emergency Department observation unit where patients with a known learning disability who have attended the Emergency Department and do not need admission to an inpatient bed are accommodated for a short period of time (a few hours) whilst their safe discharge is arranged.

During the fourth quarter of the year, we have focused on identifying the areas requiring additional support within the Division of Medicine, such as the Medical Assessment Unit (MAU) and provide training and guidance to staff within these clinical areas, whilst maintaining effectiveness throughout the other divisions.

OBJECTIVE 16

We wanted to develop the use of enhanced recovery



Enhanced recovery seeks to improve patients' experience of surgery by providing better education and effective management of expectations, and to improve clinical outcomes by ensuring patients are in optimal condition for surgery and post-operative recovery. There are four nationally accepted principles of enhanced recovery:

- All patients should be on a pathway to enhance their recovery. This enables patients to recover from surgery, treatment, illness and leave hospital sooner by minimising the physical and psychological stress responses.
- Patient preparation ensures the patient is in the best possible condition, identifies the risk and commences rehabilitation prior to admission or as soon as possible.

- Pro-active patient management components of enhanced recovery are embedded across the entire pathway; pre, during and after operation/treatment.
- Patients have an active role and take responsibility for enhancing their recovery

This initiative, part of the Trust's Transforming Care programme, has two specific objectives: to reduce patients' recovery period in hospital, and ensure there is no increase on current levels of re-admissions in each speciality. By the end of 2012/13, the following surgical specialties had adopted enhanced recovery principles: thoracic, gynaecology, oesophagectomy, colorectal and cardiac. Planning is underway for the following specialties to join the programme: maxillary facial surgery and obstetrics (elective caesarean sections). Data relating to re-admissions and recovery times is currently being validated.

OBJECTIVE 17

We committed to re-focusing on ensuring compliance with guidance published by the National Institute for Health and Clinical Excellence

There were two elements to this objective, which had been proposed by our Director of Pharmacy: timely implementation of NICE Technology Appraisal Guidance (TAGs) within three months of publication, and of NICE-related clinical audits agreed with the Bristol North Somerset and South Gloucestershire (BNSSG) Commissioning College.

18 relevant TAGs were issued for implementation by NICE during 2012/13: 15/18 (83%) had implementation plans agreed with the Commissioning College within the three month timescale. 25 clinical audit priorities were identified by the Commissioning College (later revised to 24). At the end of the financial year, 20/24 (83%) projects were either in progress or had been completed (an improvement from 63% in 2011/12). Three of the four audits which had not been commenced were in specialties where other priority NICE audits were being undertaken. We have agreed with the Commissioning College that the remaining audits will be prioritised by the Trust in our 2013/14 programme. The full list of 2012/13 clinical audits is as follows:

Speciality	Ref	Title	Current status
Cardiology	TA95	Arrhythmia - implantable cardioverter defibrillators	In progress
Dermatology	TA177	Alitretinoin - hand eczema (chronic)	Complete
	TA103	Psoriasis - etanercept	Complete
	TA146	Psoriasis - adalimumab	Complete
	TA180	Ustekinumab - psoriasis	In progress
	TA134	Psoriasis - infliximab	Not yet commenced
Endocrinology	TA188	Growth failure in children - human growth hormone	In progress
	TA203	Diabetes (type 2) - liraglutide	In progress
	TA151	Diabetes - Insulin pump therapy	Not yet commenced
ENT	TA166	TA166 Hearing impairment - cochlear implants	In progress
Gastroenterology	TA187	Hearing impairment - cochlear implants	In progress
Oncology	TA70	Leukaemia (chronic myeloid) - imatinib	Complete
	TA171	Multiple myeloma - lenalidomide	Complete
	TA34	Breast cancer - trastuzumab	In progress
	TA65	Non-Hodgkin's lymphoma - rituximab	In progress
	TA109	Breast cancer (early) - docetaxel	In progress
	TA129	Multiple myeloma - bortezomib	In progress
	TA193	Leukaemia (chronic lymphocytic, relapsed) rituximab	Not yet commenced
	TA192	Lung cancer (non-small-cell, first line) - gefitinib	No longer required by BNSSG CC

Speciality	Ref	Title	Current status
Ophthalmology	TA155	Macular degeneration (age-related) - ranibizumab and pegaptanib	In progress
Rheumatology	TA143	Ankylosing spondylitis - adalimumab, etanercept and infliximab	Complete
	TA130	Rheumatoid arthritis - adalimumab, etanercept nfliximab	In progress
	TA161	Osteoporosis - secondary prevention including strontium ranelate	In progress
	TA204	Denosumab - osteoporotic fractures	In progress
Vascular Surgery	TA167	Abdominal aortic aneurysm - endovascular stent-grafts	Not yet commenced

REVIEW OF CLINICAL EFFECTIVENESS 2012/13

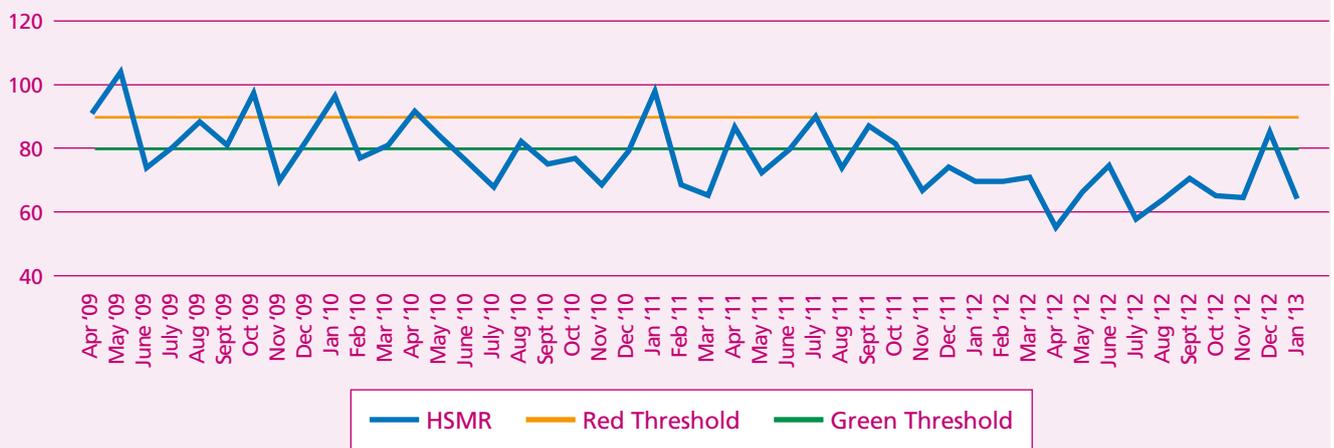
This section explains how the Trust performed during 2012/13 in a number of other key areas relating to clinical effectiveness, which are in addition to the specific objectives that we identified.

Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-Level Mortality Indicator (SHMI)

The Trust Board actively monitors two 'global' measures of patient mortality: the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-Level Mortality Indicator (SHMI). Based on a subset of diagnoses which give rise to 80% of in-hospital deaths, the HSMR is a broad measure covering the majority of hospital activity where risk of death is significant. As such, it is an effective screening tool for identifying where there may be problems with avoidable mortality. HSMR is calculated using routinely collected Hospital Episode Statistics: this data is analysed by Imperial College London, who publish a benchmark mortality standard which Trusts can compare against. Data is available two months in arrears to allow for this benchmarking process to take place. It should be noted that the HSMR does not provide definitive answers: rather it poses questions which Trusts have a duty to investigate. In simple terms, the HSMR 'norm' is a score of 100 – so scores of less than 100 are indicative of Trusts with lower than average mortality. University Hospitals Bristol NHS Foundation Trust (UH Bristol) continues to have a very low overall HSMR.

²⁷ It should be noted that the data in this graph uses a 2009/10 baseline. We report HSMR in this way in order to track progress of the South West Quality and Patient Safety Improvement Programme. The HSMR will have been re-based in subsequent years by Dr Foster, so the HSMR score credited to the Trust in the annual Dr Foster Hospital Guide (for example) will be higher than stated here.

Hospital Standardised Mortality Ratio (HSMR)



Source: NHS South Strategic Health Authority²⁷ - derived from HES data. The upper (red) and lower (green) thresholds are set by the Trust.

Figure 19

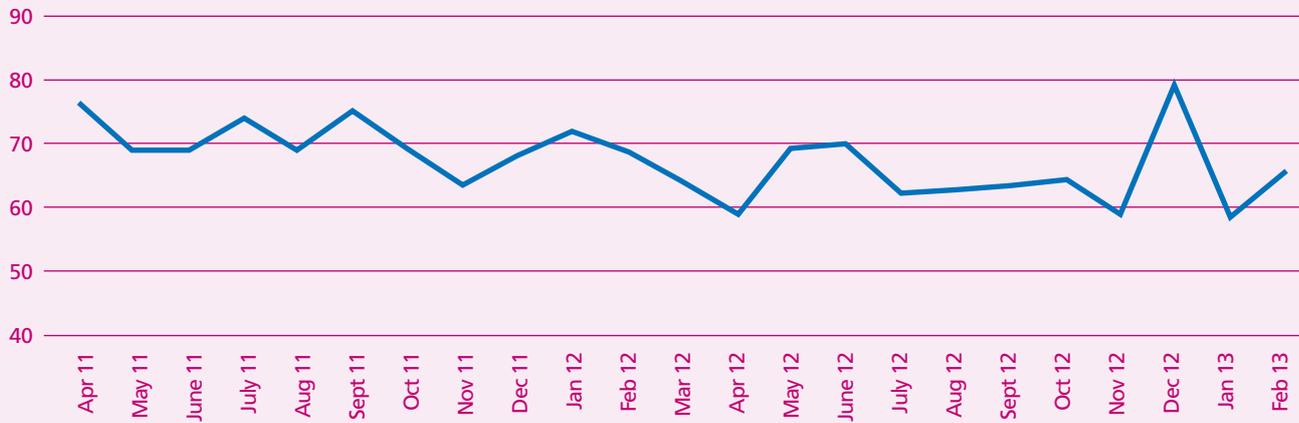
(Mandatory indicator)

Unlike HSMR, the dataset used to calculate SHMI includes all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. As per HSMR, the 'norm' is represented by a figure of 100, with scores of less than 100 representing better outcomes.

Source: CHKS benchmarking, in-hospital deaths only²⁸.

Figure 20

Summary Hospital Mortality Indicator (SHMI) - In-Hospital Deaths



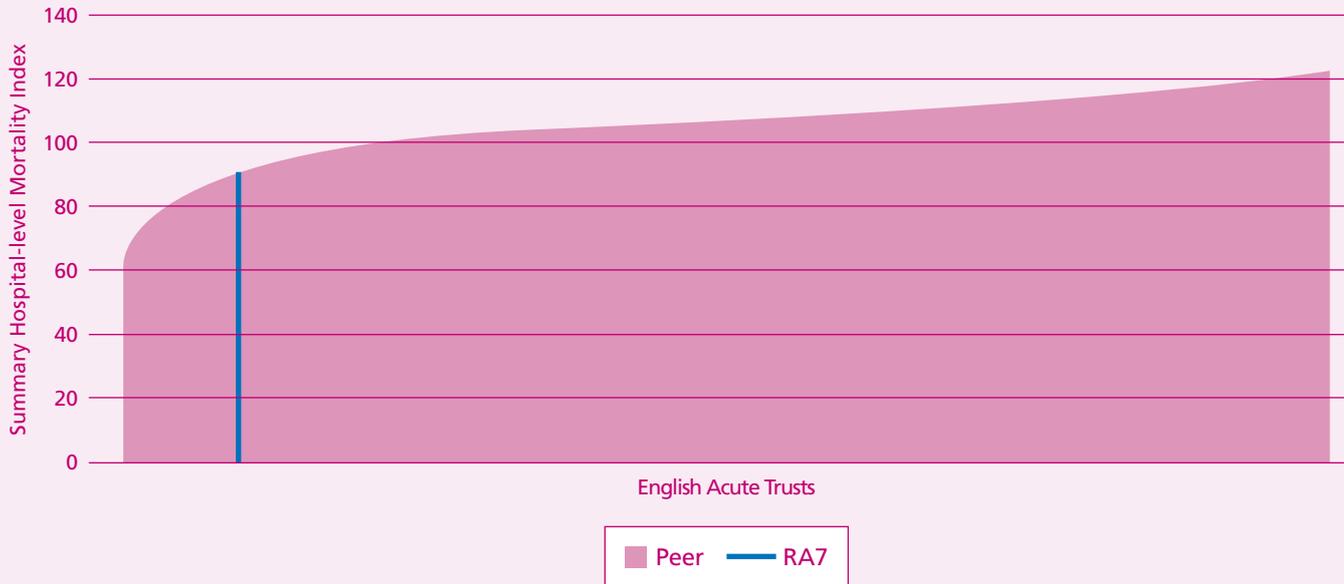
²⁸ Nationally, SHMI also includes death within 30 days of discharge.

²⁹ Calculated as 1,663 actual deaths divided by 1,826 'expected' deaths (total cases 75155).

Figure 20 shows the Trust's SHMI scores for in-hospital mortality only, using 2012 baseline data. This information is made available to us, two months in arrears, by our provider of clinical benchmarking data, CHKS. 'True' SHMI however also includes deaths within 30 days of discharge from hospital. The most recent data currently available to us is shown in Figure 21, covering the period October 2011 to September 2012. This shows UH Bristol (referenced as 'RA7') as having a SHMI of 91.1²⁹.

Source: CHKS benchmarking

Figure 21



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

Adult Cardiac Surgery Outcomes

The Bristol Heart Institute is one of the largest centres for cardiac surgery in the United Kingdom. Cardiac surgery outcomes at the Trust have been openly published since the 1990s: with rare exceptions, the Bristol Heart Institute’s mortality figures have been better than the UK average for all procedures since data has been available. Data is published annually and can be viewed in detail on the Trust’s website (<http://www.uhbristol.nhs.uk/about-us/key-publications>).

Figure 22 below shows a pattern of increasing levels of surgical activity, and a combined crude mortality rate which is below the national average. It should be noted that the 2012/13 data is preliminary at time of writing (April 2013) as the discharge status of some patients has yet to be verified/validated.

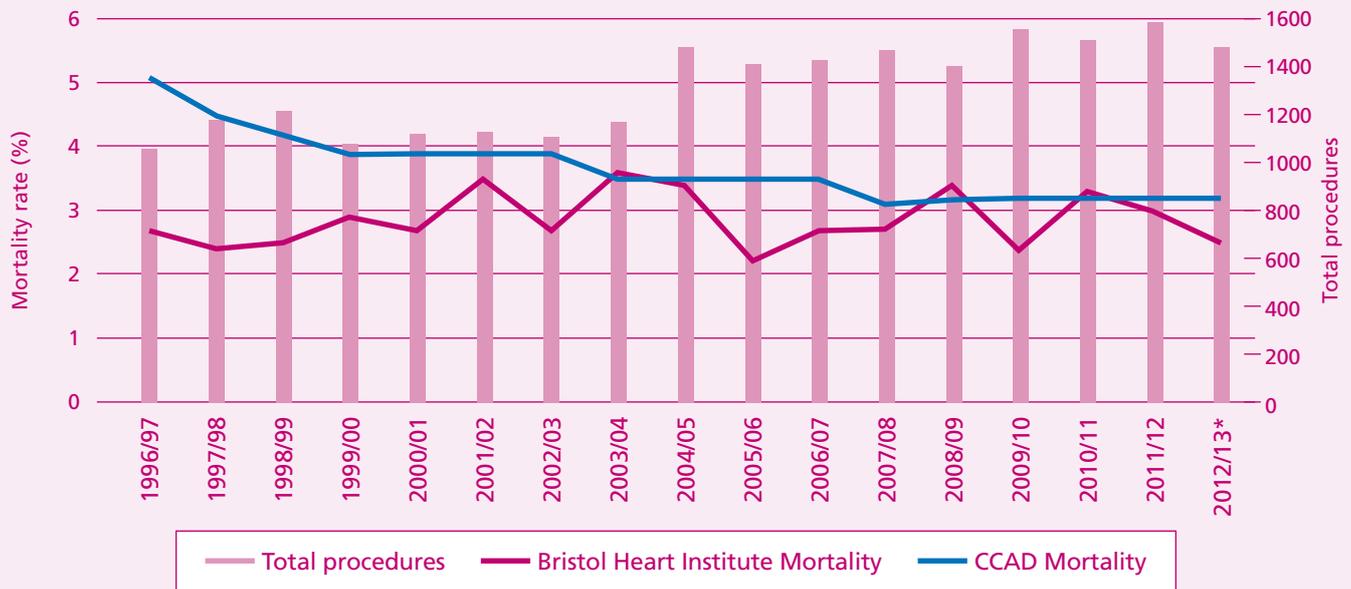
During the financial year, responsibility for the management of national cardiac audit data passed to the National Institute of Cardiac Outcomes Research (NICOR). NICOR will be changing the way that mortality rates are calculated: for this reason, the national benchmark figure used in Figure 22 (CCAD Mortality) is the most recent nationally verified marker available (relating to mortality up until 2010) and is taken from the latest NICOR annual report published in 2013. Further information about the work of NICOR can be found at <http://www.ucl.ac.uk/nicor>.

As of July 2013, consultant level data relating to the outcomes of patients undergoing cardiac surgical procedures will be published via the Society for Cardiothoracic Surgery as part of an NHS England initiative known as Everybody Counts. This data will be made available via the Trust’s website.

Source: Central Cardiac Audit Database / Patient Analysis Tracking System. * Latest available data, yet to be fully verified.

Figure 22

Adult Cardiac Surgery Activity and Mortality - All procedures



Paediatric Cardiac Surgery Outcomes

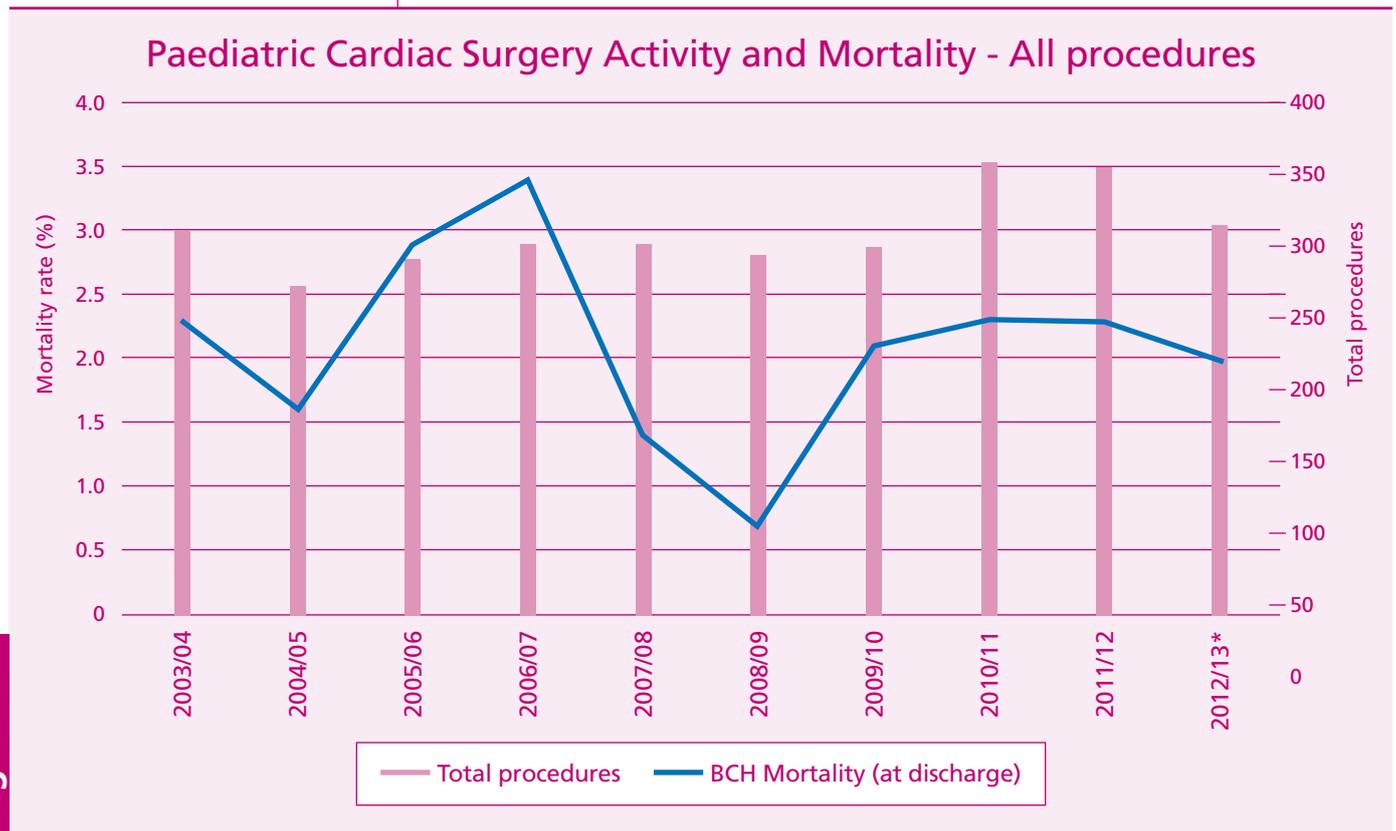
The Bristol Royal Hospital for Children provides a paediatric congenital cardiac service to the South West of England and South Wales. The paediatric cardiac units in Bristol and Cardiff operate as a single provider: consultants from Cardiff also have sessions in Bristol.

Crude mortality within 30 days of paediatric cardiac surgery has reduced over the course of the last decade (see Figure 23). Despite the increasing complexity of procedures, our mortality rate has been around 2%, which reflects the national norm³⁰.

³⁰ National Institute for Cardiovascular Outcomes Research data: detailed national comparative data not available.

Source: Central Cardiac Audit Database / NICOR.

Figure 23

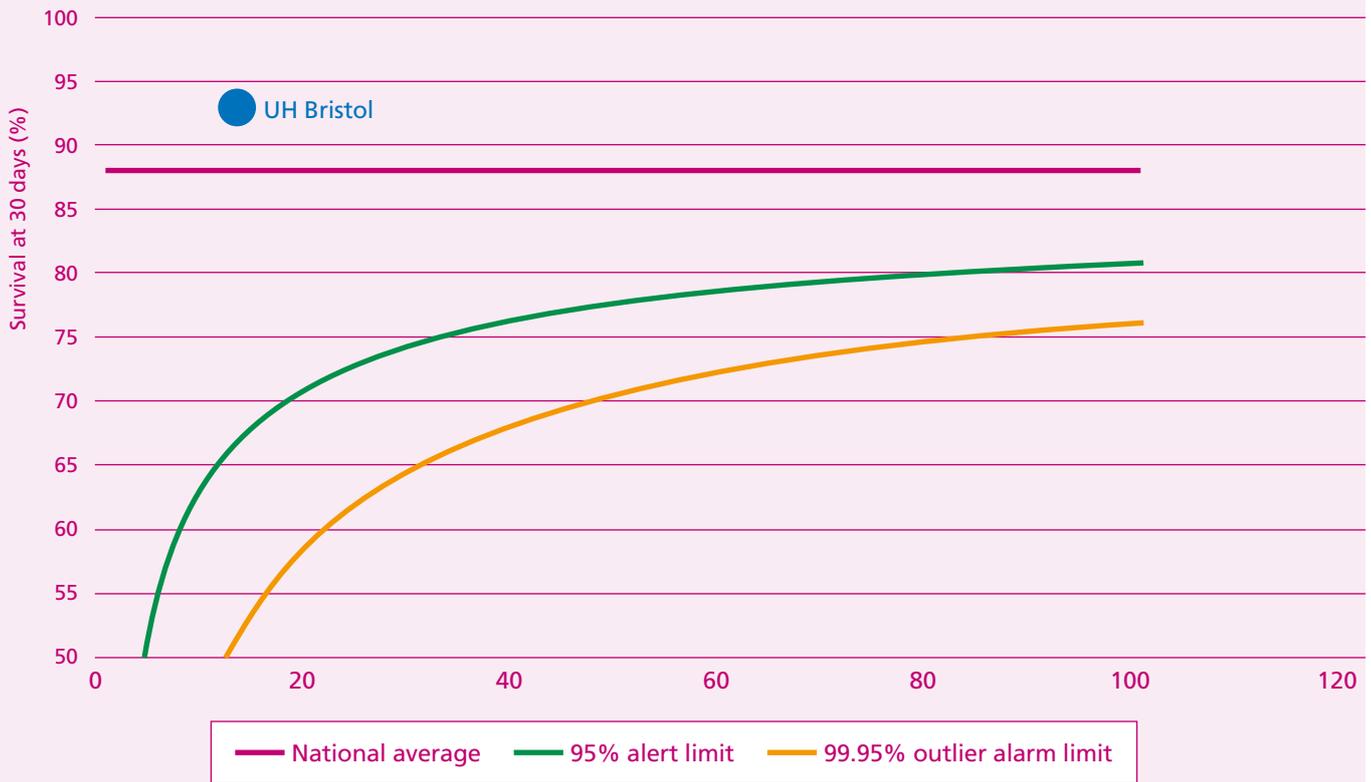


A word of caution is necessary when interpreting this data. Crude mortality data can be misleading as it does not account for case mix, i.e. a cardiac centre that only performed easy cases would appear to perform very well when compared with centres that deal with complex cases (such as this Trust). Furthermore, unlike adult cardiac surgery, where there are a small number of well-defined operations, it is hard to standardise a congenital unit's practice as there are many different types of operation performed. Although a child may be born with a particular heart abnormality, they may have many other congenital abnormalities. In order to compare the relative performance of two centres, we therefore need a means of assessing the contributions of the risk presented by these other abnormalities to the heart abnormality. This is a highly complex process and is being addressed by a number of groups both nationally and internationally. The Trust is involved in a centrally supported³¹ research project which aims to improve the differentiation of risk between individuals by 'risk-stratification'. These considerations are particularly pertinent in understanding the crude mortality data presented above for the last two years. In each year, following cardiac surgery, two sets of parents requested discontinuation of ongoing care as their child had other major congenital abnormalities that were incompatible with life. These outcomes are included in the data above as discontinuation occurred within 30 days of the surgery.

In 2009, after careful preparation, we introduced a programme for dealing with children born with 'hypoplastic left heart syndrome'. It is recognised that these are some of the sickest children that congenital cardiac surgical teams deal with and therefore require the highest quality of care from every element of the team. Figure 24 is based on the most recently available data. Bristol is marked as number 4, with performance better than the national average. Further information is available at <http://www.ccad.org.uk/congenital>.

³¹ National Institute for Health Research grant application.

Norwood procedure 2009-2012



Source: CCAD national database.

Figure 23

Patient Reported Outcome Measures (PROMs)
(Mandatory indicator)

Since 2009, Patient Reported Outcome Measures (PROMs) have been collected by all NHS providers for four common elective surgical procedures: groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. Two of these procedures - groin hernia surgery and varicose vein surgery - are carried out at the Bristol Royal Infirmary, part of the University Hospitals Bristol NHS Foundation Trust (UH Bristol). PROMs comprise questionnaires completed by patients before and after surgery to record their health status. Outcomes are measured in three ways: a tool called the 'EQ-5D index' asks patients questions about things like mobility, activities and pain levels; patients also rate their health on a scale of 0-100 using a 'visual analogue scale' (VAS); and finally (in the case of varicose veins) patients are asked questions about the specific condition for which they are having surgery.

The most recent full year data available from the NHS Health and Social Care Information Centre is for 2011/12. This shows that fewer than 30 UH Bristol patients who underwent varicose vein surgery returned PROM questionnaires: this data is therefore not publishable due to inherent statistical unreliability. 77 patients returned groin hernia PROM questionnaires, 55.8% of whom (43/77) scored more highly on the EQ-5D index after surgery than before; this compares with 51.0% in England (11327/22211). 39.0% of UH Bristol patients (30/77) scored more highly on the EQ-VAS scale after surgery than before; this compares with 38.3% in England (8516/22221).

Early 2012/13 PROM data for varicose veins and groin hernias is currently not publishable due to low numbers of patients.

The Trust considers its groin hernia PROM data to be as described. The Trust follows nationally determined PROM methodology and outsources administration to an approved contractor. Based on the number of varicose vein operations currently being performed at UH Bristol, it is highly unlikely that publishable data will become available for this PROM. We will however seek to improve our response rate for the groin hernia PROM to enable continuing publication of data above the threshold of 30 cases.

28 day readmissions
(Mandatory indicator)

The Trust monitors the level of emergency re-admissions within 30 days of discharge from hospital. Re-admissions within 30 days is used as the measure, rather than 28 days, to be consistent with Payment by Result rules and contractual requirements. The level of emergency re-admissions within 30 days of a previous discharge from hospital was lower in 2012/13 than in the previous year (3.0% in 2012/13 v 3.4% in 2011/12). The most recent national risk adjusted data (2010/11) shows the 28-day emergency re-admission rates for the Trust to be just above the national range for adults (16 and over year olds), with a national average of 11.42% and a Trust re-admission rate of 11.90% (with 95% confidence that the Trust's rate is between 11.54% and 12.27%). Although these figures are standardised for patient age, sex, diagnosis and procedure, it is likely that the risk adjustment does not take full account of the complexity and co-morbidities of the patients treated by the Trust. The risk adjusted figures for readmissions for patients under the age of 16 shows the Trust to have a significantly lower rate than the national average, with a re-admission rate of 8.26% (with 95% confidence that the Trust's rate is between 7.65% and 8.90%), against a national average of 10.15%.

The Trust considers its re-admission data is robust because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. These include checks on the completeness and quality of the clinic coding, checks conducted of the classification of admission types and lengths of stay as recorded on the Patient Administration System, and the reviews undertaken of the data quality returns on the Commissioning Data Sets (CDS) received from the Secondary Uses Service (SUS).

The Trust continues to review specialty-level benchmarking data through its Quality Intelligence Group, to monitor and improve re-admission rates, and so the quality of its services. Where specialties are identified as having higher re-admission rates than expected, relative to the national and/or clinical peer group, in-depth case notes reviews are conducted to identify any underlying causes of the increased levels of re-admissions.

Clinical effectiveness objectives for 2013/14

- We will ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward.
- We will achieve the best practice tariff for hip fractures (this involves achieving eight indicators including surgery within 36 hours of admission to hospital).
- We will ensure patients with diabetes have improved access to specialist diabetic support.
- We will ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan.
- We will continue to implement our dementia action plan.
- We will commence a baseline review of available clinical outcome data.

These objectives have been agreed with staff in our clinical divisions and with our governors. The themes reflect a continuation of previous commitments (dementia and learning disabilities), an improvement priority identified by our governors (hip fractures), an improvement area identified through quality reporting during the past year (diabetes), and a developmental objective (clinical outcomes) which aligns with national directions expressed in the Francis Report and NHS Outcomes Framework.

The Medical Director will be the executive director responsible for achieving these objectives. Progress will be monitored by the Trust's Clinical Quality Group and by the Quality and Outcomes Committee of the Board.

Performance against key national priorities



Summary of performance against national access standards

Last year proved to be a challenging year for the Trust, although improvements in performance against the national standards continued to be made in some key areas. In particular, the achievement of the target reductions in the annual number of Clostridium difficile (C. diff) cases, along with sustained performance against all 18-week Referral to Treatment Times (RTT) standards, including the new standard for incomplete pathways, stood out as significant achievements for the year. Year-on-year improvements were also seen for reperfusion times for patients suffering a heart attack (door to balloon times), and rates of mothers initiating breast feeding.

The 18-week RTT standards were achieved in each month of the year for admitted and non-admitted pathways. A new 18-week RTT standard came into effect on the 1st April 2012, which the Trust also achieved on a monthly basis. Overall, performance against the cancer standards remained strong, with six of the eight national cancer standards being achieved in every quarter. The 62-day wait for treatment for patients referred from a screening programme was not achieved in Quarter 3, and the 62-day wait for GP referred patients was not achieved in Quarter 4. However, the issues leading to the dips in performance in these two standards were addressed in the year, and the Trust is expecting full achievement of the cancer standards again going forward.

Disappointingly the Trust failed to achieve the 95% A&E four-hour standard in three quarters of the year. However, in Quarter 4 the Trust launched a significant programme of ten projects on patient flow, which should put the Trust on a strong footing for achievement of the national standard in 2013/14. The focus will primarily be on alleviating the bed pressures which caused the deterioration in performance, especially in the last quarter of the year. This will also help to reduce the numbers of patients being managed in the Bristol Royal Infirmary (BRI) Emergency Department, which should enable more consistent achievement of the 15-minute target for initial assessment.

The Trust did not achieve the national standard for operations cancelled at the last minute for non-clinical reasons, despite the improvements made in the previous years. The planned programme of work on patient flow should significantly improve bed availability, which was the leading cause of last minute cancellations in the year. The target reduction in MRSA (Meticillin Resistant Staphylococcus Aureus) bacteraemia cases also proved to be very challenging this year for the Trust. However, from the themes emerging from the root cause analysis, an action plan was implemented in the latter half of the year, with a strong focus on improvements in line care management. Continued focus on maintaining exacting standards for line care management along with the implementation of the good practice being identified in the highest performing trusts, should effect reductions in bacteraemias in 2013/14.

Full details of the Trust's performance in 2012/13 compared with 2011/12 are set out in the table below, which shows the cumulative year to date performance. Further commentary regarding the 18 week RTT, A&E 4-hour, cancer, healthcare associated infections and other key targets is provided overleaf.

Extended narrative about national access targets

18 weeks Referral to Treatment (RTT)

The Trust achieved an 18-week Referral to Treatment Time (RTT) for over 90% of admitted patients, and 95% of patients not requiring an admission as part of their treatment, in every month in 2012/13. In addition, the Trust achieved the target for incomplete pathways, which came into effect from April 2012, with over 92% of patients waiting less than 18 weeks at each month-end. In so doing, the Trust met all the 18-week RTT standards in Monitor's 2012/13 Compliance Framework. In 2013/14 there will be further focus on achievement of these standards at a specialty level.

A&E 4-hour maximum wait

The Trust failed to meet the 95% national standard, for the percentage of patients discharged, admitted or transferred within four hours of arrival in one of the Trust's Emergency Departments. Performance was below the national standard in Quarters 1, 3 and 4. The primary cause of the failure to achieve the 95% standard varied across the three quarters. The lack of a ward bed to admit emergency patients to was a consistent theme across quarters, although for different reasons.

During the first half of Quarter 1 we saw a significant increase in the length of stay for emergency medical patients who had been admitted to the Bristol Royal Infirmary (BRI). At the same time there was a significant increase in the number of over 75, and over 90 year olds, attending the Bristol Royal Infirmary (BRI) Emergency Department (ED), and an increase in delayed discharges (i.e. patients medically fit for discharge but needing support services, such as a care package, or placement in a residential home to be in place before they could be discharged). Older patients often have more complex health conditions and need more intensive medical input before they can leave hospital. This steep rise in the age of patients being admitted to hospital, which has continued through much of 2012/13 and also contributed to the dip in performance in Quarter 4, may represent a significant change in the demand for the Trust's services for future years which will need to be reflected in service planning.

In Quarter 3, performance against the 4-hour standard was unexpectedly lower than in previous years due to a significant influx of paediatric patients with respiratory problems. In the local community, the levels of bronchiolitis were unusually high in November and December 2012. This mirrored the national peak in respiratory conditions during the same period. Although the numbers of children admitted via the Bristol Royal Hospital for Children's ED was not higher than in previous seasons, the children needing admission were particularly unwell and required intensive management in the ED along with longer stays in hospital.

Levels of norovirus within the community remained a challenge for the Trust, especially in Quarter 4, with a number of wards having to be closed during a two-week period in the last quarter of the year in the BRI and Bristol Heart Institute (BHI). This coincided with higher levels of emergency admissions, which put additional pressure on bed availability and led to black escalation being declared. The Trust has recently launched a wide-ranging programme of work on patient flow with the aim of reducing any unnecessary emergency admissions and reducing lengths of stay in hospital. This should help to improve bed availability and the Trust's responsiveness to meet fluctuations in levels of emergency demand. This work will also help to ensure full achievement of the Accident and Emergency quality of care indicators.

Cancer

Performance against six of the eight key national cancer waiting times standards remained strong in 2012/13, with full achievement in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved

Performance against national standards

National standard	2010/11	2011/12	2012/13 Target	2012/13	Notes
A&E maximum wait of 4 hours	94.98%	96.0%	98%	93.8%	Target met in 1 quarter in 2012/13 (Q2)
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes		26	15 mins	57	Target met in 3 quarters in 2012/13 (not Q1)
A&E Time to Treatment (minutes) median within 60 minutes		20	60 mins	53	Target met in every quarter in 2012/13
A&E Unplanned re-attendance within 7 days		1.7%	< 5 %	2.6%	Target met in every quarter in 2012/13
A&E Left without being seen		1.0%	< 5%	1.9%	Target met in every quarter in 2012/13
MRSA Bloodstream Cases against trajectory	5	4	Trajectory	10	
C. diff Infections against trajectory	94	54	Trajectory	48	Cumulative target failed in Q1 and Q2 in 2012/13
Cancer - 2 Week wait (urgent GP referral)	95.6%	95.9%	93%	95.0%	Target met in every quarter in 2012/13
Cancer - 2 Week wait (symptomatic breast cancer not initially suspected)	93.3%	98.2%	93%	96.8%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (First treatment)	98.2%	98.1%	96%	97.0%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	95.5%	96.7%	94%	94.9%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.8%	99.9%	98%	99.8%	Target met in every quarter in 2012/13
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	99.7%	99.3%	94%	98.7%	Target met in every quarter in 2012/13
Cancer 62 Day Referral To Treatment (Urgent GP Referral)	86.2%	87.0%	85%	84.1%	Target met in 3 quarters in 2012/13 (not Q4)
Cancer 62 Day Referral To Treatment (Screenings)	90.9%	94.4%	90%	90.0%	Target met in 3 quarters in 2012/13 (not Q3)
18-week Referral to treatment time (RTT) admitted patients	93.0%	91.7%		92.4%	Target met in every month in 2012/13
18-week Referral to treatment time (RTT) non-admitted patients	98.3%	97.9%		95.7%	Target met in every month in 2012/13
18-week Referral to treatment time (RTT) incomplete pathways		N/A	92%	92.2%	Target met in every month in 2012/13
GUM Offer Of Appointment Within 48 Hours	100%	100%	98%	100%	Target met in every month in 2012/13
Number of Last Minute Cancelled Operations	1.31%	0.87%	0.80%	1.13%	Target met in every quarter in 2012/13
28 Day Readmissions (following a last minute cancellation) ³³	91.0%	93.3%	95%	91.1%	
Primary PCI - 150 Minutes Call To Balloon Time ³⁴	80.4%	84.0%	90%	83.1%	
Primary PCI - 90 Minutes Door To Balloon Time ²		91.0%		92.4%	
Infant Health - Mothers Initiating Breastfeeding ³⁵	76.3%	76.2%	76.3%	80.6%	Target met in every quarter in 2012/13

Table 4

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

³³ IMPORTANT NOTE: this indicator must not be confused with the mandatory indicator reported elsewhere in this Quality Report which measures readmissions to hospital within 28 days following a previous discharge.

³⁴ The Primary Percutaneous Coronary Intervention (PCI) Call to Balloon standard shown is a local network target; figures shown for both Primary PCI targets are for April 2012 to February 2013.

³⁵ The Infant Health standard shown is a target set by the Trust.

in Quarter 4. This was due to a combination of high volumes of late referrals from other providers, clinical complexity, patient choice, but also higher levels of cancellations of non-emergency surgery during exceptional levels of emergency pressures and the norovirus outbreak which led to black escalation being declared. The 62-day standard for screening referred patients also failed to be achieved in Quarter 3. The delays were within the bowel screening service, with longer waiting times for specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures, during October and November 2012. The waiting times for SSP appointments increased due to the departure of a number of members of staff at the same time, which severely limited capacity. The waiting times for colonoscopies increased as a result of a general increase in demand for the procedure which could not be responded to quickly due to delays in the opening of additional service capacity at South Bristol Community Hospital. However, both issues that contributed to delays in 62-day screening pathways were addressed at the end of Quarter 3 and performance improved significantly towards the latter half of Quarter 4. Both 62-day cancer standards are expected to be met again in 2013/14.

To consolidate the achievement of the national standards, the Trust will continue to carry out quarterly reviews of the reasons why the cancer standards are not met for individual patients. This will inform the quarterly improvement plans. Being a specialist provider of cancer treatment, the Trust receives many complex cases each year. These patients are often managed across a number of providers (hospitals and other facilities) and may require more tests to diagnose and treat their cancer, which can introduce delays. The Trust will therefore continue to focus on ways of minimising delays to cancer patient pathways which are within the control of the Trust, to ensure the cancer waiting times standards continue to be met despite the inevitable challenges that our patient group brings.

Other standards

During 2012/13, the Trust cancelled 1.1% of operations on the day of the procedure for non-clinical reasons. Disappointingly, this was higher than the cancellation rate in the previous year. The robust process for escalating potential cancellations of surgery to the divisional management teams, which was put in place in 2011/12 and helped the Trust achieve the 0.8% national standard in March 2012, continues to be operated. The escalation process remains very effective in reducing the levels of cancellations by supporting operational teams in finding ways of avoiding the cancellation. However, the primary cause of the higher levels of cancellations this year was a ward bed not being available to admit a patient to. This reflected the significant emergency pressures seen in the latter half of the year. The programme of work that has been launched which is focusing on patient flow should improve bed availability in 2013/14 and reduce the last minute cancellation rate. This should also help the Trust readmit patients within 28 days of their operation being cancelled, as achievement of this standard is very dependent upon the level of cancellation of operations at any point in time.

During Quarter 3, the Trust received a performance notice from NHS Bristol in relation to the failure to meet the standard of 99% of diagnostic tests being carried out within six weeks. A remedial action plan was agreed in response, with a target trajectory for improvements in performance. The main diagnostic tests for which the six week target wait was not being met was endoscopic gastrointestinal diagnostic procedures, including colonoscopies and gastroscopies. This was due to a significant rise in demand for the procedures, which is a pattern that has been seen both regionally and nationally. The rise in demand could not be responded to quickly due to delays in the opening of additional facilities at South Bristol Community Hospital. However the remedial action plan included a range of options for increasing capacity, including putting on additional weekend sessions and using other capacity across the community. At the end of March, the Trust was one month ahead of its target trajectory to achieve the 99% standard by the end June 2013.

In 2012/13, the Trust reported a significant improvement in the percentage of mothers initiating breast feeding. Improvements were also reported in the door to balloon 90 minute reperfusion standard. The door to balloon time measures the time from the

arrival of the patient in the Trust through to the time when the reperfusion treatment commences (i.e. balloon inflation in the blood vessel). During the year, 92.4% of patients received reperfusion within the 90 minute standard. The call to balloon times 150 minute standard measures the time from the call for professional help through to the commencement of reperfusion treatment. The Trust failed to meet the 90% local stretch target, however this mainly reflected the time it took for the patient to get to the hospital (call to door time), rather than the time from arrival to treatment.

APPENDIX A

Statements of assurance from the Board

1. Review of services

During 2012/13, University Hospitals Bristol NHS Foundation Trust provided clinical services in 63³⁷ specialties via five clinical divisions (i.e. Medicine; Surgery Head & Neck Services; Women's & Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2012/13, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, HSMR) as part of monthly performance reporting. The data reviewed covered the three dimensions of quality i.e. patient safety, patient experience and clinical effectiveness. 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 University Hospitals Bristol NHS Foundation Trust services reviewed in 2012/13 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2012/13.

2. Participation in clinical audits and national confidential enquiries

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

During 2012/13, 41 national clinical audits and three national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides.

During that period University Hospitals Bristol NHS Foundation Trust participated in 90% (37/41) national clinical audits and 100% (3/3) national confidential enquiries of which it was eligible to participate in.

The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust was eligible to participate in during 2012/13 are as follows:

³⁷ Based upon information in the Trust's Statement of Purpose, which is in turn based upon the Mandatory Goods and Services Schedule of the Trust's Terms of Authorisation with Monitor.

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Acute		
Adult community acquired pneumonia (British Thoracic Society)	Yes	No
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes
Emergency use of oxygen (British Thoracic Society)	Yes	Yes
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes
National Joint Registry (NJR)	Yes	Yes
Non-invasive ventilation - adults (British Thoracic Society)	Yes	Yes
Renal colic (College of Emergency Medicine)	Yes	Yes
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes
Blood and Transplant		
National Comparative Audit of Blood Transfusion programme	Yes	Yes
Potential donor audit (NHS Blood & Transplant)	Yes	Yes

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Cancer		
Bowel cancer (NBOCAP)	Yes	Yes
Head and neck oncology (DAHNO)	Yes	Yes
Lung cancer (NLCA)	Yes	Yes
Oesophago-gastric cancer (NAOGC)	Yes	Yes
Heart		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes
Adult cardiac surgery audit (ACS)	Yes	Yes
Cardiac arrhythmia (HRM)	Yes	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	Yes
Coronary angioplasty	Yes	Yes
Heart failure (HF)	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Vascular Registry	Yes	Yes
Long term conditions		
Adult asthma (British Thoracic Society)	Yes	No
Bronchiectasis (British Thoracic Society)	Yes	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes
Diabetes (Paediatric) (NPDA)	Yes	Yes
Inflammatory bowel disease (IBD)	Yes	Yes
National Review of Asthma Deaths (NRAD)	Yes	Yes
Pain database	Yes	Yes
Renal replacement therapy (Renal Registry)	Yes	Yes
Older people		
Carotid interventions audit (CIA)	Yes	Yes
Fractured neck of femur (College of Emergency Medicine)	Yes	Yes
Hip fracture database (NHFD)	Yes	Yes
National audit of dementia (NAD)	Yes	Yes
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes
Other		
Elective surgery (National PROMs Programme)	Yes	Yes
Women's and Children's Health		
Child health programme (CHR-UK)/ Child Health Clinical Outcome Review Programme (CH-CORP)	Yes	Yes
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes
Maternal, infant and newborn programme (MBRRACE-UK)* / Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP)	Yes	Yes
Neonatal intensive and special care (NNAP)	Yes	Yes
Paediatric asthma (British Thoracic Society)	Yes	Yes
Paediatric fever (College of Emergency Medicine)	Yes	No
Paediatric intensive care (PICANet)	Yes	Yes
Paediatric pneumonia (British Thoracic Society)	Yes	No

* This programme was previously also listed in our 2010/11 and 2011/12 Quality Accounts as 'Perinatal Mortality'.

Of those national audits that the Trust did not participate in, the reasons/details of future participation are outlined below:

- British Thoracic Society audit programme – Other national asthma audit undertaken.
 - Paediatric fever (College of Emergency Medicine) – Data collection period missed.
- The national clinical audits and national confidential enquiries that University Hospitals Bristol NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Name of audit / Clinical Outcome Review Programme	% Cases Submitted
Acute	
Adult community acquired pneumonia (British Thoracic Society)	
Adult critical care (Case Mix Programme – ICNARC CMP)	100% (1212/1212)
Emergency use of oxygen (British Thoracic Society)	8*
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	88% (8/9)
National Joint Registry (NJR)	58% (19/30)
Non-invasive ventilation - adults (British Thoracic Society)	18*
Renal colic (College of Emergency Medicine)	100% (50/50)
Severe trauma (Trauma Audit & Research Network, TARN)	27*
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	232*
Potential donor audit (NHS Blood & Transplant)	
Cancer	
Bowel cancer (NBOCAP)	89% (164/185)
Head and neck oncology (DAHNO)	89% (52/71)
Lung cancer (NLCA)	72% (130/180)
Oesophago-gastric cancer (NAOGC)	100% (142/142)
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	100% (866/866)
Adult cardiac surgery audit (ACS)	100% (1452/1452)
Cardiac arrhythmia (HRM)	765*
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (766/766)
Coronary angioplasty	100% (1331/1331)
Heart failure (HF)	384*
National Cardiac Arrest Audit (NCAA)	106*
National Vascular Registry	98% (45/46)
Long term conditions	
Adult asthma (British Thoracic Society)	
Bronchiectasis (British Thoracic Society)	17*
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	100% (89/89)
Diabetes (Paediatric) (NPDA)	382*
Inflammatory bowel disease (IBD)	100% (40/40)
National Review of Asthma Deaths (NRAD)	100% (2/2)

Name of audit / Clinical Outcome Review Programme	% Cases Submitted
Long term conditions (continued)	
Pain database	145*
Renal replacement therapy (Renal Registry)	
Older People	
Carotid interventions audit (CIA)	100% (46/46)
Fractured neck of femur (College of Emergency Medicine)	100% (50/50)
Hip fracture database (NHFD)	100% (342/342)
National audit of dementia (NAD)	100% (40/40)
Sentinel Stroke National Audit Programme (SSNAP)	100% (111/111)
Older	
Elective surgery (National PROMs Programme)	70% (168/239)
Women's and Children's Health	
Child health programme (CHR-UK)/ Child Health Clinical Outcome Review Programme (CH-CORP)	100% (1/1)
Epilepsy 12 audit (Childhood Epilepsy)	100% (59/59)
Maternal, infant and newborn programme (MBRRACE-UK)* / Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP)	N/A
Neonatal intensive and special care (NNAP)	795*
Paediatric asthma (British Thoracic Society)	100% (17/17)
Paediatric fever (College of Emergency Medicine)	
Paediatric intensive care (PICANet)	100% (682/682)
Paediatric pneumonia (British Thoracic Society)	

* No case requirement outlined/unable to establish baseline from HES data.

2. Participation in clinical audits and national confidential enquiries

The reports of ten national clinical audits were reviewed by the provider in 2012/13. University Hospital Bristol NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

College of Emergency Medicine audits

- A joint sepsis protocol has been developed with the Emergency Department and the Medical Admissions Unit.
- Teaching sessions have taken place to highlight need for cultures and lactate measurement and the early use of antibiotics.
- A process for the rapid assessment and triage of patients has been implemented.

Epilepsy 12 audit (Childhood Epilepsy)

- Children with a new diagnosis of epilepsy are to be prioritised for referral to the Epilepsy Specialist Nurse.
- An 'appropriate first clinical assessment' proforma is being developed to help ensure developmental and emotional/behavioural assessments are undertaken.

National Cancer Audits

- To improve the quality of cancer data, a 'data entry guide' will be created to help identify the correct places for key cancer information to be recorded on the Somerset Cancer Registry.
- Regular checks for missing gaps in datasets will be conducted through the use of formal data quality reports created via the information team.
- A review of administrative services for cancer (including data collection resources) is taking place and a business case for a data co-ordinator has been put forward.

National Cardiac Arrest Audit (NCCA)

- It has been agreed that all cardiac arrests will be reported on the Trust incident reporting system (Ulysses Safeguard) to improve data quality and to enable learning from these incidents.

National comparative re-audit of platelet transfusion

- The Trust has developed a Standard Operating Procedure for quick reference to pre transfusion checking / patient identity / care of transfused patients to improve practice in transfusion care.

The reports of 197 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust (UH Bristol) in 2012/13; summary outcomes and actions reports were reviewed on a quarterly basis by the Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2012/13³⁸.

3. Participation in clinical research

Our researchers lead and contribute to world class research which helps us to understand diseases better and develop new treatments for the benefit of patients and the NHS. Providing healthcare, research and teaching of the highest quality to improve outcomes for patients is at the centre of what we do at UH Bristol. Research is embedded in the care we provide, and we aim to offer the chance of taking part in research to as many of our patients as we can. We work with our university and NHS partners to develop and deliver high quality, peer-reviewed, externally funded research, as well as research which is funded locally or carried out by students as part of their training and qualifications. We hold grants from the National Institute for Health Research (NIHR) and other organisations, and carry out hosted research across our specialties. Research led from UH Bristol includes studies in cardiovascular disease, nutrition, eye disease, emergency medicine, surgery, cancer, paediatrics, rheumatology, respiratory medicine, health services research and medical physics. In 2012/13, we recruited 5,971 patients into non commercial studies, of whom 5,099 were into NIHR portfolio studies.

Our two NIHR Biomedical Research Units (BRUs) opened on 1 April 2012. The units are in cardiovascular disease, and nutrition, diet and lifestyle. Projects in the Nutrition BRU include investigations of nutrition in cancer, long term childhood conditions, surgery and sedentary behaviour in people with diabetes. In the Cardiovascular BRU, we are continuing thematic work around improving the outcomes in cardiac surgery and translating laboratory research into clinical trials.

Number of active studies

Non-Commercial NIHR Portfolio ³⁹ Studies	350
Non-Commercial, Non-Portfolio Studies	148
Commercial Portfolio Studies	71
Commercial, Non-Portfolio Studies	34

Recruitment

Non-Commercial Portfolio Studies	5099
Non-Commercial, Non-Portfolio Studies	872
Commercial Studies	406

The number of patients receiving relevant health services provided or sub-contracted by University Hospitals Bristol NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 6,505.

³⁸ Available via the Trust's internet site from June 2013.

³⁹ The National Institute for Health Research Clinical Research Network (NIHR CRN) Portfolio is a database of high-quality clinical research studies. Non-commercial NIHR portfolio studies are eligible for support from the NIHR Clinical Research Network or through other NIHR infrastructure funding in England.

4. CQUIN framework (Commissioning for Quality and Innovation)

The amount of potential income in 2012/13 for quality improvement and innovation goals was £6.961 million, based on the sums agreed in the contracts. Associated payments in 2012/13 totalled £6.483 million, including the guaranteed payment agreed by BNSSG commissioners. Total payments in 2011/12 amounted to £3.372m .

An explanation of the factors contributing to the failure to earn all of the potential CQUIN rewards is provided at the end of this section. A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The delivery of the CQUINs is overseen by the Trust's Clinical Quality Group. Further details of the agreed goals for 2012/13 and 2013/14 are available electronically at <http://www.uhbristol.nhs.uk/about-us/how-we-are-doing/>.

The CQUIN goals were chosen to reflect both national and local priorities. Thirty one CQUIN targets were agreed, including four nationally specified goals: reduce avoidable death, disability and chronic ill health from Venous thromboembolism (VTE); improve responsiveness to personal needs of patients, to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside, and to incentivise the measurement of harm from pressure ulcers, falls, urinary tract infections in patients with catheters and VTE, using the NHS Safety Thermometer.

The Trust has achieved 18 of the 31 CQUIN targets and 7 in part, as follows:

- Venous thromboembolism (VTE) risk assessment (in part)
- Patient experience (in part)
- Dementia (in part)
- NHS Safety Thermometer
- High Impact Innovations (in part)
- Enhanced Recovery Programme (Surgery Head and Neck, and Cardiac Surgery)
- Nutrition (in part)
- Medication errors
- Emergency Theatre waiting times
- Diabetes care for surgical patients
- Acute oncology (in part)
- Cardiac surgery
- Paediatric disability
- Improvement in spontaneous vaginal deliveries (possibly in part – to be confirmed)
- Histopathology
- Quality dashboards
- Neonatal CONS infections
- Increasing the number of babies receiving timely TPN
- Paediatric Intensive Care Unit (PICU) - unplanned extubation
- PICU – unplanned readmissions within 30 days of cardiac surgery
- PICU – reduction of acquired line sepsis
- Increasing proportion of cardiac patients access catheterisation laboratory procedures
- Cystic fibrosis.

CQUINs which were not achieved include increasing the percentage of patients going direct to the appropriate assessment area/ward; referrals to GP Support Unit and ambulatory care; time to antibiotics for patients with neutropenic fever; and improving compliance in the use of the Situation, Background, Assessment and Recommendation (SBAR) communication tool. At the time of writing, completion of Early Warning Scores (EWS) is 93.3% against a target of 95% as measured by the Trust's Quality in Care Tool, however further data needs to be included in the analysis to ensure complete coverage of adult areas for the purposes of this CQUIN – it is therefore not yet possible to report whether the 95% target has been achieved.

⁴⁰ Bristol, North Somerset and South Gloucestershire.

⁴¹ A provisional total of £3.363m had been published in the 2011/12 Quality Report.

There has been an on-going concerted effort across the Trust to improve patient flow and pathways, ensuring patients are seen at the appropriate place and time. The direct admission and admission avoidance CQUINs were introduced for the first time in 2012/13. The targets were challenging to deliver and whilst the CQUIN wasn't achieved, it did direct a focus on this area and work will continue to ensure improvements continue. VTE prophylaxis CQUIN was not achieved due to a notable fall in achievement in Q4, the quarter being measured, due to the departure of the VTE nurse.

The neutropenic fever related CQUIN was linked primarily to improvements in recording and, whilst some progress was made during the year, it did not meet the level required to meet the CQUIN. Whilst it will not remain in place for 2013/14 as a CQUIN work will continue to focus on this area going forward.

For the EWS and SBAR CQUINs, data available from the Quality in Care Tool for the three months September to November 2012 indicates a very positive performance. However this did not include data from all wards and as such has not been used to assess overall CQUIN performance. These CQUINs will remain in place for 2013/14 and robust measurements are in place to ensure a continued focus on this important area of patient safety.

The planning, training and facilities improvements required for the neonatal breastfeeding CQUIN took longer than planned so this was not achieved. This CQUIN is being taken forward into 2013/14. Bed and staffing issues have resulted in not achieving the cardiac surgery CQUIN. Cancer data field compliance is partial due to ongoing issues with completion of cancer staging data.

(Also see pages 29-30 for information regarding the national Patient Experience CQUIN).

5. Care Quality Commission registration and reviews

University Hospitals Bristol NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered without compliance conditions'. The Trust received four CQC inspections during 2012/13. The CQC has taken enforcement action against University Hospitals Bristol in 2012/13 in respect of Outcome 13 (Staffing).

The Trust received a Scheduled Inspection of its main site on 21 June 2012. In an otherwise very positive report (Outcomes 1, 4, 5, 6, 7, 14 and 16), the Trust was found to be non-compliant with Outcome 13 (Staffing), specifically in relation to the regulated activity 'maternity and midwifery services'. The Trust submitted a detailed action plan to the CQC on 30 August 2012; a re-inspection took place on 26 April 2013 and the Trust was found to be compliant.

South Bristol Community Hospital received a CQC Dignity and Nutrition inspection on 15 August 2012, confirming compliance with Outcomes 1 (Respecting and involving people who use services) and 4 (Care and welfare of people who use services).

On 5 September 2012, the CQC undertook a responsive review of Ward 32 at the Bristol Royal Hospital for Children. The Trust was found to be non-compliant with Outcomes 4 and 14 (Supporting Staff) and was issued with a Warning Notice in respect of Outcome 13. Action plans were submitted to the CQC and the Warning Notice was lifted following a positive re-inspection on 19 November 2012. A further re-inspection took place on 26 April 2013, confirming compliance with Outcomes 4 and 14.

Finally, on 4 October 2012, the Trust received a CQC re-inspection at Central Health Clinic. This inspection confirmed that the Trust had addressed previous non-compliance associated with completion of documentation pertaining to the 1968 Abortion Act.

During 2012/13, the Trust received two Outlier Alerts from the CQC. Outlier Alerts are triggered when data received by the CQC suggests that a healthcare provider's clinical performance (typically mortality or complication rates following surgery) is found to be

significantly different to that of other providers. An Alert does not draw conclusions – it is a prompt for the provider to make further investigations.

On 16 August 2012, the Trust received a maternity alert for 'readmissions within 42 days of delivery'. We undertook a detailed investigation, attributing the cause of the outlier status to incorrect coding – however opportunities to improve other aspects of clinical practice were identified and acted upon. This alert has been closed by the CQC (i.e. the CQC is satisfied with our explanation and response).

On 8 February 2013, we received a maternity outlier alert for 'puerperal sepsis and other puerperal infections within 42 days of delivery'. This was a repeat of a previous alert received in August 2011. The Trust undertook a comprehensive review, identifying over-diagnosis and treatment of urinary tract infection as a possible cause. A detailed action plan was submitted to the CQC. The alert was closed by the CQC on 1 May 2013.

6. Data quality

University Hospitals Bristol NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 99.1% for admitted patient care; 99.7% for outpatient care; and 93.7% for accident and emergency care (these values are the same as in 2011/12 except for A&E which had slight decrease in 2012/13).
- which included the patient's valid General Practice code was: 100% for admitted patient care; 100% for outpatient care; and 100% for accident and emergency care (this is the second year running that the Trust has achieved 100% in all areas).

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2012 - January 2013 as at Month 10 inclusion date)

UH Bristol's 2012/13 score for Information Quality and Records Management in the Information Governance Toolkit was 69%. The Information Governance Assessment Report overall score was 68% and was graded red. The Information Quality and Records Management section in the Information Governance Assessment Report was graded green.

UH Bristol was not subject to the Payment by Results clinical coding audit during 2012/13 by Capita Health (which has replaced the Audit Commission).

UH Bristol commissioned an external company to provide an Information Governance Clinical Coding audit of 1,000 Finished Consultant Episodes. The audit covered a random sample of admitted patients across both surgical and medical specialties and the following levels of accuracy were achieved:

- Primary procedure accuracy: 91.6%
- Primary diagnosis accuracy: 92.6%.

(Please note that these results should not be extrapolated further than the actual sample audited)

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

- The data quality programme involves a number of regular data quality checks and audits throughout the year including checking against patient notes. This takes place across the Trust and all issues with data quality are reported back to the Information Governance Management Group for appropriate action.
- The Trust's Data Quality Framework is in the process of being finalised, with completion due in Quarter 1, 2013/14. The framework details the processes by which the Trust assures the quality of data used to monitor key performance indicators

(KPIs), including the validation process, 'freeze' dates and ownership of the data. The framework includes an assessment - for each KPI - of the level of assurance against the Six Dimensions of Data Quality, following the recommendations of the Audit Commission (Audit Commission: Figures you can trust: A briefing on data quality in the NHS, March 2009).

APPENDIX B

Extract from UH Bristol Quality Strategy 2011-2014

How the Trust assesses,
seeks improvements in and
assurances about quality of
services:

ASSESS

- Annual Divisional self-assessment based on available quality data including: patient stories, feedback and complaints; clinical audit evidence; compliance with NICE guidance, NHSLA standards, CQC Outcomes and NCEPOD recommendations; PROMs data
- Taking account of: high-level Trust Quality Objectives for 2011-2014; NHS Outcomes Framework; CQUIN priorities and contract specifications; Clinical Services Strategy
- Working with: Board, Governors, commissioners, other Divisions
- Supported by: corporate Governance Team
- Resulting in: Divisional quality ambitions which are measurable, stretching and achievable
- Common themes informing: choice of trust-wide annual quality objectives in Quality Accounts
- Process open to: independent scrutiny through peer review and internal audit

IMPROVE

- Divisions tasked with delivery
- Working in partnership with corporate services
- Awareness and management of risks to non-achievement
- Integration with Transformation workstreams
- Supporting achievement of CQUINs, and compliance with CQC registration and NHSLA standards compliance

ASSURE

- Monthly quality reports to Divisional boards, aligned to Divisional quality objectives
- Utilising local clinical audit
- Progress monitored by Executives via Divisional Review process
- Progress monitored by Trust Board through the Quality and Outcomes Committee
- Key outcomes of care published in annual Quality Report (Account), with web-based progress reports available during the year
- Open to scrutiny from external audit, CQC, NHSLA, Monitor and the public

APPENDIX C

Feedback about our Quality Report

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

The Council of Governors welcomes the opportunity to make comment on the Trust's Quality Report. The content is the result of extensive consultation, auditing and assurance processes in relation to patient safety, patient experience and clinical effectiveness.

The Trust has an overarching objective of putting quality at the heart of everything it does and has demonstrated a determined approach to this throughout what has proved to be a very difficult year. Corporate objectives were affected by higher than expected levels of activity, acuity and the increased numbers of elderly patients needing treatment. The inability to discharge to suitable providers of care in the community put severe pressures on bed availability.

Governor involvement

Last year, the Trust's Council of Governors received regular reports relating to quality issues from its governor groups and challenged the Trust Board to account for any failings in the quality of care.

The governors' Quality Report Focus Group contributed to the development of the Quality Report early in 2013 with suggestions on format and content. The governors are aware that the order in which the content of the Quality Report appears deviates from that recommended by the Department of Health and Monitor, however we think that this is the right approach in order to make the report readable and accessible.

Comment on progress with the quality objectives in the Quality Report

There were five objectives in this section, three were fully achieved and two partially achieved.

We did not meet our target for reducing patient falls and numbers were higher than last year despite various initiatives. The Fallsafe pilot projects have shown that further reductions this year are possible.

A similar situation exists with the objective of reduction in the incidence of hospital acquired pressure ulcers where the Trust failed to meet its target overall, however recent figures indicate an improving trend.

Medicine safety data indicates steady progress in the reduction of errors and missed doses.

The Trust has continued to put in a strong performance above target for venous thromboembolism patient assessment and prophylaxis with new initiatives introduced to sustain performance.

Last year we commented on the steady progress on meeting the nutritional needs of patients and it is good to see that further care improvements have resulted in an excellent outcome.

The Trust's histopathology service was the subject of clinical audit as part of a continuing process of improvement and all 13 projects were completed satisfactorily.

National data indicated that our Trust was underperforming in rates of complication, misadventure and re-admissions following gynaecological surgery. Investigation highlighted certain anomalies in data sets so the service will be monitored again next year.

The review of patient safety for 2012/13 includes information about hospital acquired infections. The target for Clostridium difficile was achieved but not the target for MRSA blood stream infections. The target was no more than two cases but ten cases were recorded, so the Trust introduced an intravenous line care management programme which we hope will reduce the number of cases to nil, which is next year's target. Governors have asked that control of hospital acquired infections is kept as a standing item for reporting every year.

We note that our Trust is reporting more patient safety incidents but has had fewer incidents resulting in severe harm or death. There were four deaths as a result of safety incidents during the reporting period which was the same as last year 2011/12. This rate is below the rate for similar hospitals.

Patient Experience

There were six objectives in this section, three were fully achieved and three partially achieved.

The Trust implemented its Patient Experience and Involvement Strategy with the aim of gathering feedback on the quality of services provided. The governors welcome this proactive approach of routine survey targeting specific groups with the feedback provided helping to improve service. This is especially the case with our Emergency Department where we scored better than average in the 2012 National Accident and Emergency Survey.

We note and commend the various initiatives to improve the experiences of patients and carers at the Bristol Royal Hospital for Children with the development of young people friendly environments, patient reception testing by the members of the Trust's Youth Council and the development of a specialist assessment system for families with children having disabilities or special needs. Coupled with this is the emphasis the Trust has placed on supporting carers with one aspect being their roll out of care awareness training for staff.

There are new initiatives to help patients with learning difficulties together with a programme of prompt risk assessment (a clinical objective) which we commend.

We continued a project to reduce night time noise in wards and although we achieved a marginal improvement over last year we did not meet the target set.

We did achieve the target set for treating mothers with care and understanding in our maternity unit. This target was set to deal with the poor result achieved in the 2010 National Maternity Survey. It was decided to extend this measure to all inpatient services and excellent results were recorded although these suggested more work is needed to bring the maternity services result closer to our general inpatient score.

Two national surveys indicated areas where we should improve communication with patients so this objective measured the quality of information given at outpatient clinics especially that related to waiting times and the availability of staff to talk to about any fears or worries they might have. The results from this last survey would suggest that there is more work to do and the productive outpatient project is helping to improve the outpatient communication process.

In relation to the objective to reduce numbers of complaints and to respond quickly when they do occur the governors are able to draw on their experiences of contact with patients and relatives and can confirm that they usually indicate a high level of satisfaction with the care received so the increase of 12.7% in the number of complaints is disappointing. However, there are still issues relating to administration and efficiency in such areas as outpatient administration, cancelled appointments/operations and communication failures. We hope that the productive outpatient project will address these failures together with further progress in the Transforming Care programme.

Although our Trust was rated above average for staff engagement in the 2011 National Staff Attitude Survey we scored badly on incidence of discrimination against staff with a 3% increase in reported cases. The 2012 result showed an improvement of 2% which we commend but note that we are still worse than the national average. We are pleased that the Trust associates quality of care with staff attitudes and effective engagement and the recent survey has indicated improvements in job satisfaction.

We are also encouraged by signs of a possible upward trend in patient-reported experience of inpatient services in the second half of 2012/13.

Clinical Effectiveness

There were six objectives in this section, two were achieved, three were partially achieved and one was not achieved.

We did not achieve our stretch target of 90% of stroke patients spending 90% of their time on a stroke unit. Stroke beds are only protected and available when the demand for beds is not affected by red and black escalation processes. Governors were anxious to know how the Trust managed effective continuation of care of discharged stroke patients in the community. We note that they have set up an early supported discharge scheme to provide specialist care at home and, although still short of the national target, significant progress has been made.

The objective to develop service specific standardised mortality ratios was not fully realised due to concerns about the use of non-risk adjusted data. Overall however, the Trust continues to enjoy below average mortality rates by comparison with national data (measured by HSMR and SHMI). As in previous years, we are pleased to note that our Trust had significantly fewer deaths than the national average.

It is obvious from the report that a great deal of effort has been channelled into improvements in dementia care. There has been substantial progress towards meeting national targets. Training initiatives plus the key appointment of a lead nurse with dementia champions throughout the Trust should ensure that we will be well placed to deal with future challenges.

Another important clinical objective was the drive towards the development of enhanced recovery centred on educating and informing the patient and taking steps to ensure their condition is optimal pre and post operatively. This was fully achieved as part of the Transforming Care programme.

Adult cardiac surgery at the Trust's Bristol Heart Institute has maintained its good record with a mortality rate which is below the national average. Paediatric cardiac surgery mortality rates at our Trust are running at levels similar to the national average but the Trust has a complex case mix with some children presenting with severe congenital defects making successful outcomes less likely.

Performance against key national priorities

Most waiting time targets were met during the year but the achievement is tarnished by non-achievement of Accident and Emergency waiting times, MRSA bloodstream infections and some cancer targets. We also have problems with last minute cancelled operations and re-admissions. The fourth quarter of the year carries an annual risk of underachievement in some standards due to ward closures, staff sickness and a higher level of activity. We make the comment that there should be greater attention paid to planning for this period of the year to ensure that it is sufficiently resourced and that we should not take the view that it is a problem for all trusts and therefore acceptable.

Summary

We commend this report for its transparency and thoroughness and feel that it is an accurate representation of the Trust's position on quality issues. Progress on quality objectives has been achieved during the year but the rate of improvement has slowed and, as stated at the beginning of this commentary, there are factors at play which can only be mitigated by additional resources (or reduced activity) either

internally generated (by further efficiency savings) or through initiatives by our external healthcare partners. The Trust will have a delicate balance to manage with the challenges to its quality agenda by increasing levels of activity, greater sickness in the community it serves, the increasingly elderly patient profile, and funding. We state again that we would like to see more attention paid to demand management in the fourth quarter in years to come.

17th May 2013

b) Statement from Bristol Local Involvement Network (disbanded 31 March 2013)

Bristol LINK welcomes the opportunity to contribute to the Quality Report prepared by University Hospitals Bristol NHS Foundation Trust (UH Bristol). The LINK notes a positive and constructive working relationship with the Trust, and the continued willingness throughout the year to discuss issues raised by LINK participants through three working groups (the Acute Hospital Working Group, the Older People's Working Group and the South Bristol Community Hospital Working Group). In addition, LINK participants have been able to access clear and timely responses to reports resulting from our listening events and ad hoc requests for information.

The activity LINK has undertaken over the past year includes:

- Supporting the opening of the South Bristol Community Hospital and making representations on behalf of LINK participants concerning signage, transport and access issue.
- Understanding the impact on patient care of the Trust's productive wards programme.
- Receiving a presentation on and participating in the design plans for the redevelopment of the Bristol Royal Infirmary and in particular the Welcome Centre.
- A visit to UH Bristol to observe the nutritional care received by patients following work undertaken by LINK last year.
- A workshop and site visit to UH Bristol to discuss the Trust's progress in improving the discharge process for adults.
- Participation in the Bristol Health and Social Care Overview and Scrutiny workshop at UH Bristol.
- An assessment of the British Red Cross A&E Assisted Discharge Service Pilot at the Trust's adult Emergency Department.
- An assessment of the ambulatory screens used at the Trust's adult Emergency Department.

The LINK wishes to note the support given to the Bristol and South Gloucestershire LINK Pathfinder Programme by the Trust during the transition period to Healthwatch.

c) Statement from South Gloucestershire Local Involvement Network (disbanded 31 March 2013)

South Gloucestershire LINK welcomes the opportunity to contribute to the Quality Report prepared by University Hospitals Bristol NHS Foundation Trust. The LINK hopes that, with advent of Healthwatch, a stronger relationship will emerge between the Trust and those communities in South Gloucestershire who use the healthcare services provided at UH Bristol. The LINK notes, however, the opportunities it has had to contribute to the South Bristol Community Hospital, the planned transfer of children's services from Frenchay Hospital to the Bristol Royal Hospital for Children and the joint work it has undertaken with Bristol LINK at UH Bristol, in particular joint enter and view events, ambulance screening and hospital discharge.

The LINK wishes to note the support given to the Bristol and South Gloucestershire LINK Pathfinder Programme by the Trust during the transition period to Healthwatch.

d) Statement from South Gloucestershire Health Scrutiny Select Committee

The Trust was invited to a meeting of the South Gloucestershire Public Health & Health Scrutiny Committee on 17th April to present its draft Quality Report 2012-13. Due to timing issues it was not possible for the committee to receive the full Quality Report so instead the Trust was asked to give a ten minute presentation and focus on

areas of concern, what its priorities are going forward and how it is performing in terms of infection control.

The committee was pleased to receive information about the Trust's priorities and actions plans, which included actions to reduce inpatient falls and work to further reduce hospital acquired pressure ulcers.

In terms of infection control the committee noted the downward trend in cases of *Clostridium difficile* and the steady reduction in MRSA cases over the previous five years, although there was a slight increase from 2011/12. In response to whether patients are swabbed when they transfer between wards, the Trust reported that its compliance rates for screening / swabbing are very high and it meets the national standard, which is to ensure that all patients are swabbed upon admission to hospital. However, in addition to this, the Trust is exploring whether to swab patients when they transfer between wards. This was welcomed by the committee.

In response to questioning about recent cancellations of planned procedures, the Trust reported that during February there was a period of 'black escalation', which meant it had been difficult to avoid emergency patients taking up ward beds and some elective surgery being postponed. However, the Trust aims to be rigorous with patient discharge in order to avoid elective postponements wherever possible.

The Trust was asked about staff hours and some staff working long shifts. In response the Trust reported that last year in consultation with staff and the trade union it had reviewed shifts and they were due to be reviewed again shortly.

The committee commented on the importance of good patient nutrition, particularly as the Trust has documented that there is a close link between poor nutrition and pressure ulcers.

e) Statement from Bristol Health and Adult Social Care Scrutiny Commission

The Scrutiny Commission received a presentation at its meeting of 22nd April 2013 summarising the key issues that will be included in UH Bristol's Quality Report.

The scrutiny commission is pleased to see that dementia is being addressed across the Trust and welcomes the news that there are dementia champions on each ward. However members are very concerned to note that the number of patient falls has significantly increased and are keen that the Trust increases its efforts to address this.

The commission is alarmed to see the rise in hospital acquired pressure ulcers. Whilst acknowledging that the increasing number of elderly patients is a factor in this, members are interested to see the core themes arising from the root cause analyses, and wish to see ongoing investigation of these in order to support a sustained reduction in numbers.

Despite this being marked as an objective that has been achieved, councillors have had complaints about the food provided in hospital and given the importance of good nutrition for patients request that this continue to be given attention.

f) Statement from NHS Bristol Primary Care Trust (abolished 31 March 2013)

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Report 2012/13 is made by Bristol Clinical Commissioning Group following a review by the Director of Quality and Governance for the Bristol, North Somerset and South Gloucestershire Primary Care Trust Cluster up to 31 March 2013.

It is considered that the report for 2012/13 provides a fair reflection of the work of the Trust and includes the mandatory elements required.

All of the data presented has been reviewed and we are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with data provided and reviewed as part of contract performance management.

Bristol Clinical Commissioning Group continues to work with the Trust to ensure that patient safety, data accuracy and information governance remains a key priority at all times. We welcome the approach of the monthly quality report to the board beginning with a patient story.

The account identifies significant progress in relation to:

- Inpatients' confidence in the services reflected in a high number saying they could recommend the services to their family and friends.
- Improvements in nutritional care across the Trust.

We support the ongoing work to improve the patient experience and reduce the incidence of pressure ulcers.

We will continue to work closely with the Trust to:

- Improve performance and deliver the improvement plan in relation to MRSA infections and ensuring that targets are met.
- To provide further assurance in relation to staffing levels for paediatric cardiac surgery (Ward 32 and paediatric intensive care) following the risk summit and CQC inspection.
- Mitigate the risks to patients resulting from the pressures on emergency admissions and unscheduled care.
- Revitalise involvement in the patient safety improvement programmes.

The ongoing engagement of clinicians working closely with the commissioner will remain crucial in 2013/14 and it is anticipated will be strengthened as the result of the establishment of clinical commissioning groups.

The Quality Report follows the Quality Accounts toolkit framework.

Lindsey Scott

Director of Nursing and Quality

NHS England: Bristol, North Somerset and South Gloucestershire Area Team

APPENDIX D

Statement of Directors' Responsibilities

2012/13 Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- 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 2012 to May 2013;
 - Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
 - Feedback from the commissioners received 20/05/2013;
 - Feedback from governors dated 17/05/2013;
 - Feedback from Bristol Local Involvement Network⁴² received 30/04/2013;
 - Feedback from South Gloucestershire Local Involvement Network received 30/04/2013;
 - The Trust's complaints data as reported to the Board for the period April 2012 to March 2013.
 - The 2012 National Inpatient Survey published 16/04/2013;
 - The 2012 National Staff Attitude Survey published 28/02/2013;
 - The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/2013;
 - Care Quality Commission quality and risk profile dated 31/03/2013;
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations, published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

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

By order of the Board



John Savage Chairman
29 May 2013



Robert Woolley Chief Executive
29 May 2013

⁴² On 1st April 2013, Local Involvement Networks were succeeded by local Healthwatch organisations.

APPENDIX E

External audit opinion

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

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 in the Quality Report that have been subject to limited assurance consist of the following national priority indicators as mandated by Monitor:

- Number of Clostridium difficile infections; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the "specified indicators".

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the assessment criteria referred to in on page 64 of the Quality Report (the "Criteria"). The directors are also responsible for the conformity of their criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to the date of signing this limited assurance report (the period);
- Papers relating to quality reported to the Board over the period April 2012 to the date of signing this limited assurance report;
- Feedback from the commissioners [NHS Bristol Primary Care Trust] received 20/05/2013;
- Feedback from governors dated 17/05/2013;

- Feedback from Bristol Local Involvement Network received 30/04/2013;
- Feedback from South Gloucestershire Local Involvement Network received 30/04/2013;
- The trust's complaints data as reported to the Board for the period April 2012 to March 2013;
- Feedback from other stakeholders involved in the sign-off of the Quality Report; the South Gloucestershire Health Scrutiny Committee and the Bristol Health and Adult Social Care Scrutiny Commission received 14/05/2013;
- The latest national patient survey dated 16/04/2013;
- The latest national staff survey dated 28/02/2013;
- Care Quality Commission quality and risk profiles dated 31/03/2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/2013.

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of University Hospitals Bristol NHS Foundation Trust as a body, to assist the Council of Governors in reporting University Hospitals Bristol NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and University Hospitals Bristol NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Limited testing, on a selective basis, of the data used to calculate the specified indicators back to supporting documentation.
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result

in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Directors' interpretation of the Criteria in page 66 of the Quality Report.

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2013,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.

PricewaterhouseCoopers LLP Chartered Accountants
Bristol
29 May 2013

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