



Quality Report

2013/14

Respecting everyone
Embracing change
Recognising success
Working together
Our hospitals.

Contents

Statement on quality from the Chief Executive	2
Overview of 2013/14	4
Patient Safety	8
Patient Experience	21
Clinical Effectiveness	33
Objectives for 2014/15	44
Performance against key national priorities	46

Appendices

A: Statements of assurance from the Board	51
B: Feedback about our Quality Report	58
C: Performance indicators subject to external audit	67
D: Statement of Directors' responsibilities	68
E: External audit opinion	69

Note:

The requirements to report in line with the *2013/14 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 2014/15	page 2
Statements of assurance from the Board	page 51
Part 3 – Other information	
Review of quality performance	This information can be found in the reports for the three domains of quality. See pages 7 - 43
Overview of the quality of care based on performance in 2013/14 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 sixth annual report describing our quality achievements. Our mission is to provide exceptional healthcare, research and teaching every day.

The Quality Report (also known as the Quality Account) is one of the key ways that the Trust demonstrates that its services are safe, clinically effective and that we are providing treatment in a caring and compassionate environment. The report is an open and honest assessment of the last year, its successes and challenges.

Last year we set a large number of quality objectives, the majority of which we achieved. I am particularly pleased to be able to report significant improvements in hospital-acquired healthcare infection (reductions in reported cases of *Clostridium difficile*, MRSA and MSSA) and pressure ulcer prevention. I am also reassured by the Trust's overall mortality rate which continues to be lower than the national average: this means that more patients survive in our care than would normally be expected for the severity of their condition. But there is no room for complacency: there are other aspects of care described in this report where we would have liked to make more progress. For example, despite our concerted efforts, too many patients still say that they were not told about potential side effects of medicines when they were discharged from hospital – an area where we will continue to seek improvements in 2014/15.

Overall, 97% of patients consistently report that the care they receive from us is good, very good or excellent and our monthly scores in the new NHS Friends and Family Test are better than the national average. I am likewise encouraged that 71% of staff, compared to a national average of 62%, say that they would recommend us as a place to work or receive treatment, although our aspiration must be to improve this score further in the future.

Looking ahead to 2014/15, we have taken a different approach to the process of selecting our quality objectives. We began 2014 by hosting an open event where members of the public were able to tell us about the things about hospital care that mattered most to them. At the same time, the Trust has been experiencing unprecedented operational pressures on its services: the number of very sick patients requiring emergency admission to hospital has increased and a higher proportion of them are over 85 years old. This has had a significant impact on the number of beds needed for emergency medical patients and that, in turn, has increased the number of operations cancelled on the day of surgery. Taking all of this into account, we have chosen a set of objectives for 2014/15 which are focused on patient 'flow' through our hospitals and designed to be truly transformational: reducing cancelled appointments, making sure that patients are treated on a ward appropriate to their clinical condition, and eradicating the practice of moving patients out-of-hours for non-clinical reasons. We have also added a fourth objective which is about refreshing our approach to public engagement and involvement, providing continued assurance

that when we consult people about changes to services, the process is open and candid and that as an organisation we listen to and act upon people's views and concerns.

In 2013/14, we received three inspections from the Care Quality Commission, each of which highlighted aspects of care that we could improve. You can read more about this in the appendix to this report. Inspections are opportunities for us to learn and also to receive external validation of the high quality of our services, many of which are described in this Quality Report. At the time of writing, we have just received notice that the CQC will be visiting us in September to carry out a comprehensive review of our services and, no doubt, to check that we have made the improvements that we said we would. Going into this inspection, I am pleased to report that University Hospitals Bristol is rated by the CQC as being in a select group of hospitals considered to be at lowest risk of non-compliance with care quality standards.

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.



Robert Woolley
Chief Executive

Overview of 2013/14



The University Hospitals Bristol NHS Foundation Trust is a dynamic and thriving group of general and specialist hospitals, employing around 7,000 whole time equivalent staff and with a turnover of approximately £500 million. We are also the major medical research centre in the South West of England. During 2013/14, the Trust provided treatment and care to around 72,000 inpatients¹, 57,000 day cases and 115,000 attenders at our emergency departments². We also provided approximately 447,000 outpatient appointments³.

















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: the hallmarks of a quality service. Last year, we set ourselves 16 quality objectives: we are delighted to have fully achieved 11 of these, partly achieved four more and to have made significant improvements in other important aspects of quality which are documented in this report.

In the pages which follow, you will be able to read a detailed account of our performance in 2013/14. 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.

- ¹ Elective, emergency, maternity and births
² Bristol Royal Infirmary, Bristol Royal Hospital for Children, and Bristol Eye Hospital
³ 145,000 new outpatient attendances; 302,000 follow-up attendances

We wanted to...		How did we get on?
1	Increase harm free care as measured via the NHS Safety Thermometer	 GREEN
2	Reduce hospital acquired healthcare infections	 GREEN
3	Reduce medication errors	 GREEN
4	Extend medicines reconciliation ('getting the medicines right')	 GREEN
5	Improve the early identification and escalation of care of deteriorating patients	 GREEN
6	Improve levels of nutritional screening and specifically 72 hour nutritional review of patients	 AMBER
7	Implement the NHS Friends and Family Test	 GREEN
8	Ensure that patients continue to be treated with kindness and understanding on our wards	 GREEN
9	Explain medication side effects to inpatients when they are discharged	 RED
10	Focus on improving the experience of maternity patients	 AMBER
11	Ensure that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward	 AMBER
12	Achieve the best practice tariff for hip fractures (this involves achieving eight indicators including surgery within 36 hours of admission to hospital)	 GREEN
13	Ensure patients with diabetes have improved access to specialist diabetic support	 GREEN
14	Ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan	 GREEN
15	Continue to implement our dementia action plan	 AMBER
16	Commence a baseline review of available clinical outcome data	 GREEN

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 2013/14 is summarised in the table below. Where relevant, reference is also made to pages of our Quality Report where related information can be found. The Trust is confident that this data is accurately described in this Quality Report. A Data Quality Framework has been developed by the Trust which encompasses the data sets 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. (Comparisons shown are against a benchmark group of all acute trusts with the exception of patient safety incidents where the benchmark group is acute teaching hospitals only).

Mandatory indicator	UH Bristol 2013/14	National average 2013/14	National best 2013/14	National worst 2013/14	UH Bristol 2012/13	Page ref.
Venous thromboembolism risk assessment ⁴	97.7%	95.6%	100%	80.3%	96.3%	9
<i>Clostridium difficile</i> rate per 100,000 bed days (patients aged 2 or over) ⁵	17.1	15.0	0.0	30.7	18.4	11
Rate of patient safety incidents per 100 admissions ⁶	10.04	7.9	12.8	4.9	8.78	18
Percentage of patient safety incidents resulting in severe harm or death	0.2%	0.4%	0.0%	0.9%	0.8%	18
Responsiveness to inpatients' personal needs	Comparative data for 2012/13: UH Bristol score 72.4; England median 67.4; low 57.4; high 84.4. (Comparative data for 2013/14 will not be available from the Health & Social Care Information Centre until August 2014)					N/A
Percentage of staff who would recommend the provider	71%	64%	89%	40%	71%	32
Summary Hospital-level Mortality Indicator (SHMI) value ⁷ and banding	95.7	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' ⁸	19.4%	20.9%	44.9%	0%	17.6%	N/A
Patient Reported Outcome Measures	Comparative groin hernia data for 2012/13: 70.6% of UH Bristol patients reported an improved EQ-5D score (national average 50.2%); 41.2% of UH Bristol patients reported an improved EQ-VAS score (national average %). Comparative data is not currently available for the full year 2013/14 from the Health & Social Care Information Centre. UH Bristol PROM data for varicose veins does not meet the publication threshold.					44
Emergency readmissions within 28 days of discharge: age 0-15	Comparative data for 2011/12: UH Bristol score 7.8%; England average 10.0%; low 0%; high 47.6%. Comparative data is not currently available for 2012/13 or 2013/14 from the Health & Social Care Information Centre.					45
Emergency readmissions within 28 days of discharge: age 16 or over	Comparative data for 2011/12: UH Bristol score 11.15%; England average 11.45%; low 0%; high 17.15%. Comparative data is not currently available for 2012/13 or 2013/14 from the Health & Social Care Information Centre.					45

⁴ Latest nationally published data covers April 2013 – January 2014; UH Bristol score is for full financial year

⁵ Latest nationally published data covers April-December 2013

⁶ Published (validated) data is for the first six months of the financial year only – NRLS acute trusts group

⁷ In-hospital deaths plus deaths within 30 days of discharge: October 2012 – September 2013

⁸ Specialty 315, diagnosis Z515: October 2012 – September 2013

Patient Safety



Our ongoing commitment

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.

OBJECTIVE 1

We wanted to increase harm free care as measured by the NHS Safety Thermometer



The NHS Safety Thermometer is a national tool used to measure and benchmark the level of harm experienced by patients due to pressure ulcers, falls, venous thromboembolism and catheter associated urinary tract infections. The Safety Thermometer involves conducting monthly point prevalence audits of all eligible inpatients (approximately 750 patients per month) and assessing whether they have experienced any of these four types of harm. The tool measures “new” harm likely to have occurred since the patient was admitted to one of our hospitals and “old” harm likely to have occurred prior to admission. The audits are conducted by front-line nursing staff, providing real-time feedback to the team about areas of good practice and areas for improvement.

Harm free care

Our chosen measure for this is the percentage of patients with no new harm. For 2013/14, we set an improvement target that by Quarter 4 of 2013/14 at least 97.7% of patients would experience none of the four harms described above. This target was based on the best performing trusts in our acute teaching trust peer group in the final quarter of 2012/13⁹ using national NHS Safety Thermometer data¹⁰. We achieved 98.0%. Our progress in increasing the proportion of patients with no new harm throughout 2013/14 is shown in Figure 1. The improvement in this measure has been largely achieved by the reduction in hospital acquired pressure ulcers from 39 in Quarter 4 2012/13 to 14 in Quarter 4 2013/14. Our Safety Thermometer audits also

⁹ This is the same acute teaching trust peer group used by NHS England for benchmarking patient safety incident data submitted to the National Reporting and Learning System. 97.7% was the threshold for the upper quartile.

¹⁰ Source: Health and Social Care Information Centre

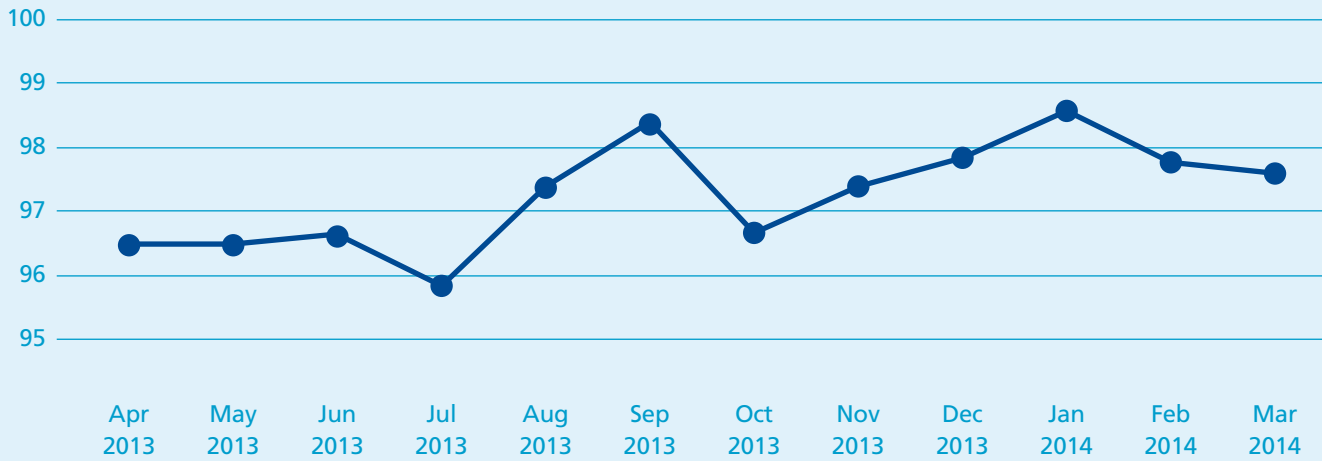
show that we have reduced the number of falls resulting in patient harm from 42 in Quarter 4 2012/13 to eight in Quarter 4 2013/14.

In 2014/15 we intend to increase our annual target by rebasing it with reference to our improved performance in 2013/14.

Percentage of our patients with no new harms

Source: NHS Safety Thermometer

Figure 1



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 approximately 30% of cases, with up to 5% leading to serious injury. As many as half of all falls involve a degree of cognitive impairment, with 75%¹¹ of falls occurring in patients aged 65 or over. The number of elderly patients admitted to the Trust is rising steeply. 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. During 2013/14, we developed a method for estimating the impact the age of our patients has on the incidence of inpatient falls and used this to compare the number of expected falls with the number of actual falls.

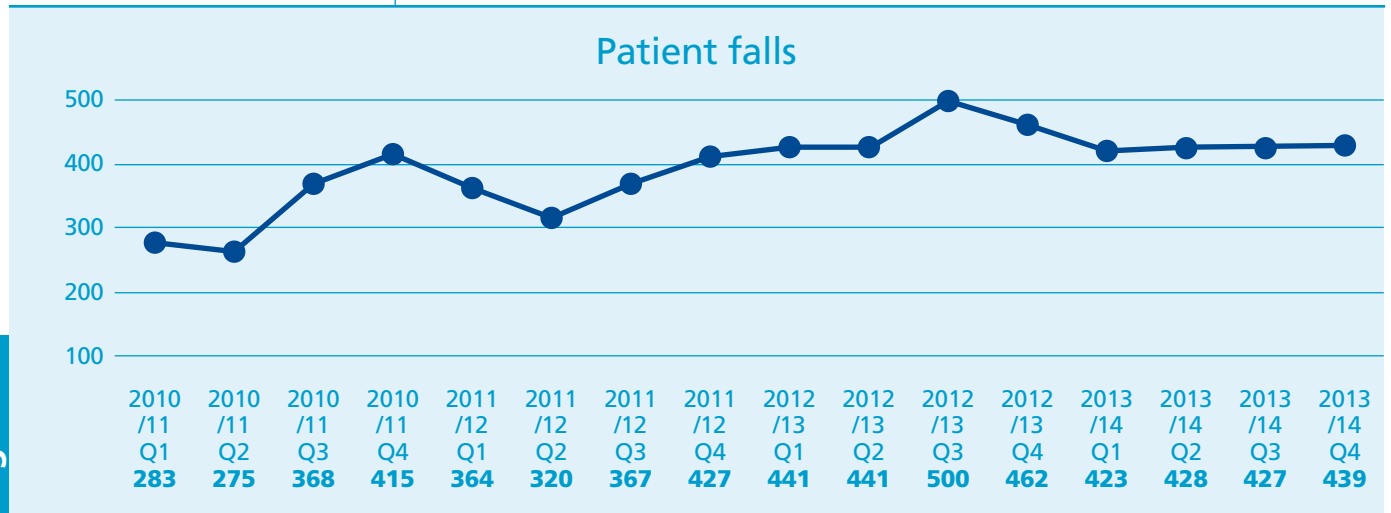
Our target for 2013/14 was to achieve a total number of reported patient falls of less than the national average of 5.6 per 1,000 bed days (National Patient Safety Agency data). We achieved this target in four out of 12 months and an overall rate of 5.7 falls per 1,000 bed days. This compares to two months and a rate of 6.0 in 2012/13. Cases where inpatient falls had a 'major' impact reduced from 17 in 2012/13 to 14 in 2013/14: this was despite a significant rise in the number of 'at risk' patients in the 75 year plus age group being admitted to our hospitals. Further work is required to achieve this target consistently and ensure the level of harm to patients as a result of falls continues to decline.

In 2012, the Royal College of Physicians published 'Fallsafe', an approach to the management and prevention of avoidable falls in hospital. The Trust piloted Fallsafe at the end of 2012 and then implemented the approach across 28 wards during 2013/14. Fallsafe involves educating, inspiring and supporting clinical staff to deliver assessments and interventions through a care bundle approach, supported by a falls assistant project post. Divisions report regularly on their progress to the Trust's Falls Steering Group.

¹¹ National Patient Safety Agency, 2007 data

Figure 2

Source: Ulysses Safeguard system

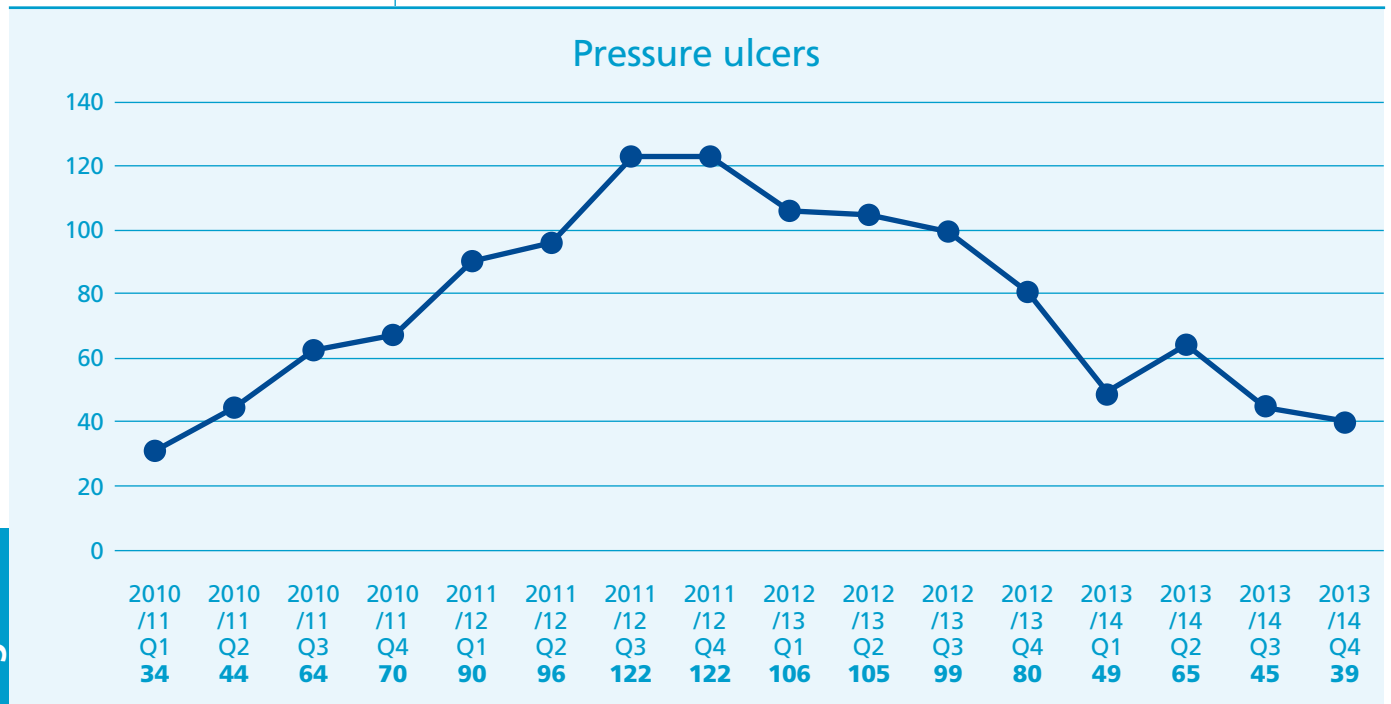


Pressure ulcers

Pressure ulcers range from being small areas of sore or broken skin to more serious skin damage that can lead to life-threatening complications. In 2013/14, a national Commissioning for Quality and Innovation (CQUIN)¹² indicator was mandated for reduction of one of the four types of harm measured by the NHS Safety Thermometer. We agreed a CQUIN target with our commissioners to reduce the number of hospital acquired grade 2-4 pressure ulcers by 15%¹³ which equated to no more than 25 grade 2-4 hospital acquired pressure ulcers per month on average during 2013/14. For the purposes of the CQUIN, pressure ulcers were measured as a monthly average in six monthly blocks: we achieved an average of 19 cases per month for the first half of 2013/14 and an average of 14 per month for the second half of the year, i.e. we achieved the CQUIN.

Figure 3

Source: Ulysses Safeguard system



¹² 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 measured through robust incident reporting rather than the point prevalence methodology of the NHS Safety Thermometer.

In 2013/14, we also set an internal Trust target 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 0.656 per 1,000 bed days. This compares with a rate of 1.264 in 2012/13. Examples of actions taken in 2013/14 to achieve this improvement include:

- Monthly review of pressure ulcers and feedback to each division through steering group.
- New wound assessment documentation (to meet requirement of NICE clinical guideline 29).

- New dressing formulary to standardise treatment Trust-wide.
- Launch of monthly formal training for all registered nurses on pressure care and wound assessment; training also provided for nurse assistants.
- New Trust-wide contract for dynamic mattresses, achieving a better specification of dynamic mattress and cost savings at the same time.
- Revised root cause analysis tool for pressure ulcers to enable clearer identification of causes of pressure ulcers, as per external review recommendation.

Additional actions planned for 2014/15 include a review of our contract for topical negative pressure equipment, new static foam mattresses for trolleys in theatres and emergency departments and the development of a pan-Avon dressing formulary to standardise treatment in acute and community setting, achieving cost savings and improved access to dressing treatments.

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.

In 2013/14, we wanted to sustain improvements in VTE prevention by continuing to screen patients for risk of VTE and ensuring patients at risk receive appropriate thromboprophylaxis.

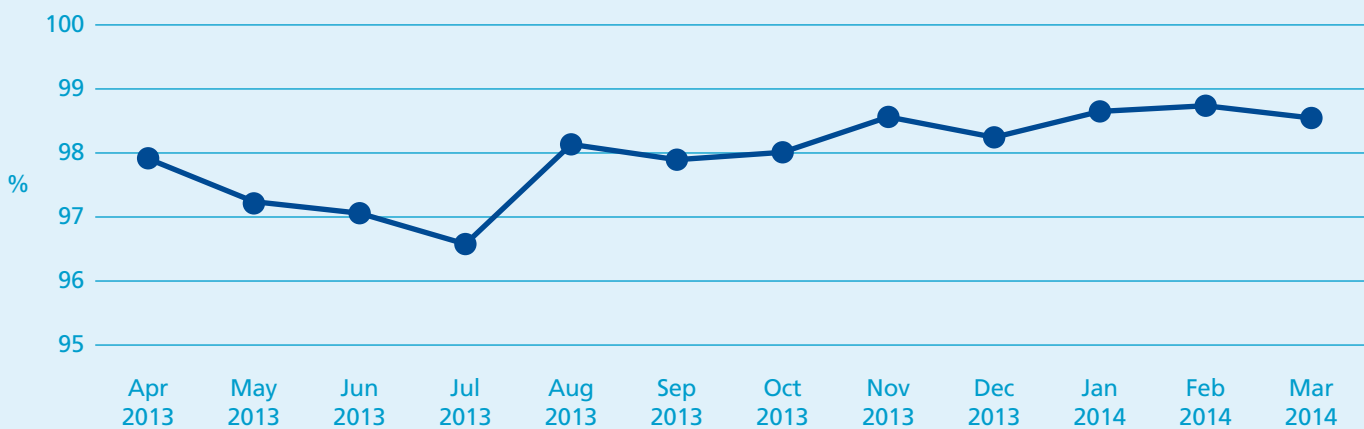
We achieved a national CQUIN target of 95%+ compliance with VTE risk assessments. The CQUIN was measured quarterly, but in fact the Trust achieved a 95%+ target for VTE risk assessment in every month during 2013/14, as shown in Figure 4. For the year as a whole, 98.0% of inpatients received a risk assessment. This compares with 96.4% in 2012/13.

We also achieved a 90%+ target¹⁵ for appropriate thromboprophylaxis for ten of the 12 months during 2013/14 as shown in Figure 5. For the year as a whole, 93.4% of inpatients identified as being at risk received appropriate thromboprophylaxis. This compares with 94.6% in 2012/13.

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. Full details of our data quality framework for this indicator are available upon request.

¹⁵ Based on the previous year's CQUIN target

Percentage of patients with a VTE risk assessment



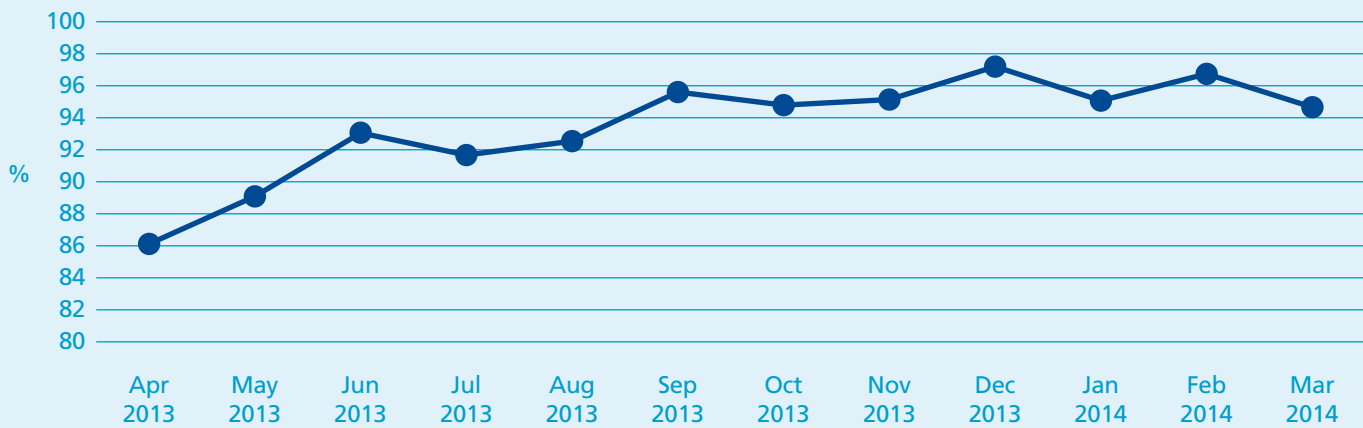
Source: Ulysses Safeguard system

Figure 4

Source: Ulysses Safeguard system

Figure 5

Percentage of patients who received appropriate thromboprophylaxis



The Trust has taken the following actions in 2013/14 to sustain 95%+ compliance with VTE risk assessments, and so the quality of its services:

- Extending the provision of VTE project nurses to sustain and embed focus on VTE prevention and provide supplementary training by targeting any teams and staff groups where there is evidence of 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.

Also during 2013/14, we agreed with our commissioners details of a nationally mandated CQUIN to investigate hospital associated thrombosis. We agreed to conduct a modified root cause analysis investigation for at least 90% of all identified hospital associated thrombosis in 2013/14. Root cause analysis enables us to learn from these incidents and take action to help prevent future similar incidents where modifiable factors are identified which have contributed to the incident. There were no modifiable factors identified in the majority patients (39 out of 52) who developed hospital associated thrombosis in quarters 1-3 of 2013/14 i.e. the thromboses were deemed unavoidable. Investigations for those identified in quarter 4 will be completed by the end of May 2014.

Learning from root cause analyses has highlighted the need for additional guidance for continued pharmacological thromboprophylaxis (usually by administration of blood thinning injections) for an extended period following discharge from hospital for additional groups of patients with specific kinds of lower limb fractures. We have also identified the need for more education on the use of anti-embolic stockings and that the use of sequential compression devices¹⁵ may help reduce hospital associated thrombosis in some stroke patients for whom pharmacological thromboprophylaxis is too risky in the early days following a stroke. As a result of this, sequential compression devices are now available on the stroke unit and staff are being trained in their use. They will also be implemented in Ward 200 at South Bristol Community Hospital.

For 2014/15, our goal is to sustain over 95% of patients being risk assessed for VTE, to continue to focus on increasing the proportion of our patients who receive appropriate thromboprophylaxis and to continue our analyses of hospital acquired thrombosis to identify any further opportunities for learning.

¹⁵ sequential compression devices involve sending pressure pulses of air into these sleeves (baggy stockings) to stimulate circulation: the devices are for high risk stroke patients only and are used from assessment through to discharge including during rehabilitation.

OBJECTIVE 2

We wanted to reduce hospital acquired healthcare infections



Clostridium difficile
(Mandatory indicator)

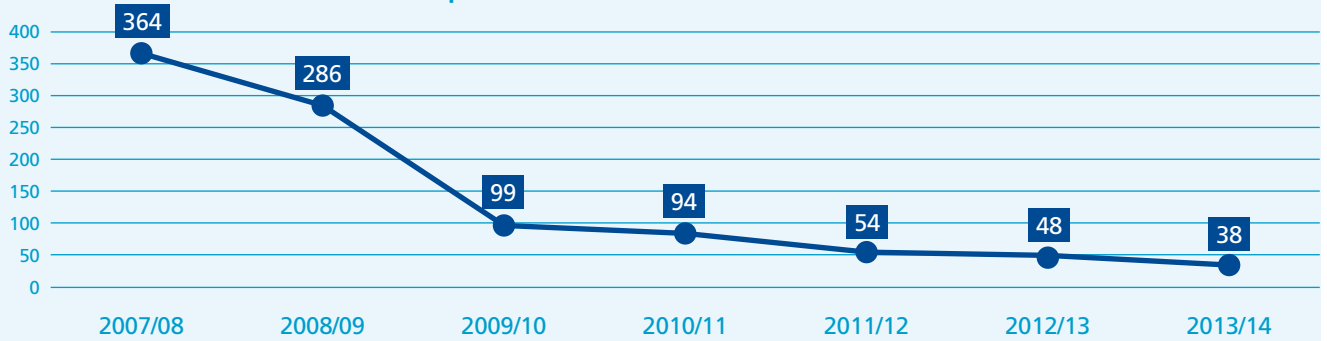
The Trust's focus on preventing healthcare acquired infections (HCAIs) is constant and ongoing. In 2013/14, we were disappointed that we exceeded our nationally determined target for *Clostridium difficile* (the Trust reported 38 cases against a target of 35) but nonetheless very pleased to have achieved a 21% reduction in reported cases compared to 2012/13.

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

Source: Public Health England Data Capture System

Figure 6

Number of reported cases of *Clostridium difficile*



The Trust has taken the following actions in 2013/14 to achieve reductions in *Clostridium difficile* infection and so improve the quality of its services:

- Patients continue to be nursed in a separate cohort area and are not admitted back into the general patient population for their duration of stay in hospital.
- 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.
- Hand hygiene audits are undertaken each month. If the required standard is not reached, audits are repeated weekly until three consecutive weeks at the required standard are achieved.
- Patients with *Clostridium difficile* are managed by gastro intestinal consultants and an infection control doctor.
- Study sessions have been delivered to general practitioners and nursing home managers to improve community management of *Clostridium difficile*.
- The introduction of Procalcitonin testing of acute admissions, to reduce the antibiotic use and duration of antibiotic treatment.

Meticillin resistant *Staphylococcus aureus* (MRSA)

The Trust had two cases of MRSA in 2013/14, which represents a significant improvement compared to 2012/13 (10 cases). Root cause analysis of cases reported in 2012/13 showed there were issues with intravenous (IV) line management and practice. An IV access coordinator post was therefore agreed by the Trust and as a result, we have:

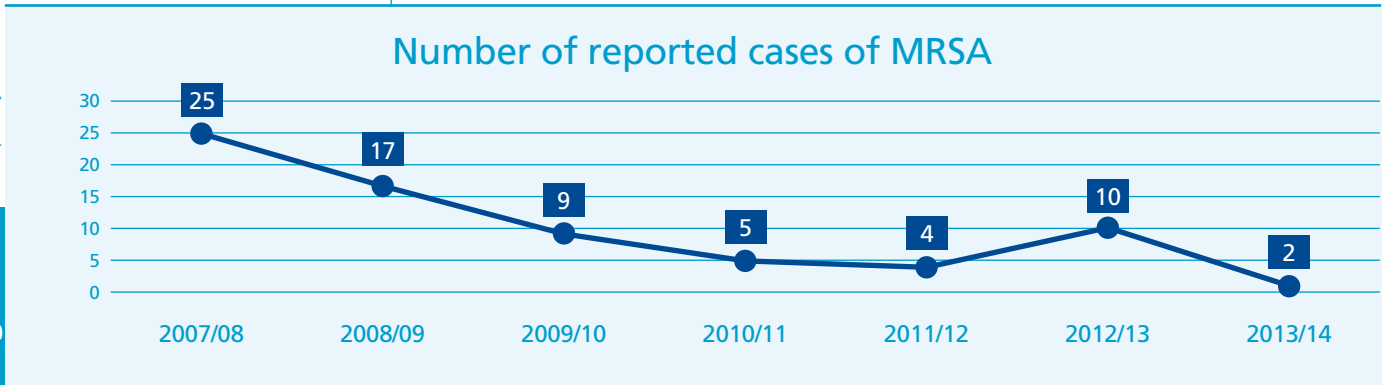
- Established the current level of line management and practice by undertaking clinical shifts and auditing aseptic non touch technique (ANTT) practice across adult areas.

- Made ANTT a part of essential training for all new clinical staff.
- Coordinated the setting of Trust-wide care standards regarding vascular access.
- Developed a Trust-wide central line complications protocol.
- Reviewed Trust-wide IV line databases to ensure a consistent approach to data capture.
- Developed and rolled out a Trust-wide IV device selection matrix.
- Reduced blood culture contamination rates.

Neither of the two MRSA cases in 2013/14 was IV line related.

Source: Public Health England Data Capture System

Figure 7



<p>Meticillin susceptible <i>Staphylococcus aureus</i> (MSSA)</p>	<p>In 2013/14, the Trust recorded 27 cases of MSSA bacteraemia. This was better than our target (29) and an improvement on previous years (36 in 2012/13; 39 in 2011/12). The same actions are in place to reduce MSSA bacteraemia as for MRSA.</p>
<p>Norovirus</p>	<p>In 2013/14, the Trust had a total 47 ward or bay closures (16 and 31 respectively) as a result of norovirus. This compares to 88 closures in 2012/13. The average (mean) length of time for a ward closure was nine days: two days more than 2012/13 but the same level as in 2011/12. We continue to follow national norovirus guidelines and report outbreaks through the Public Health England hospital norovirus outbreak reporting system.</p>
<p>Hand hygiene and antibiotic compliance</p>	<p>We continue to train all staff in infection prevention and control measures. In March 2014, our monthly hand hygiene audit showed 98% compliance. Antibiotic compliance (checking the appropriateness of the antibiotic; whether start and stop dates are recorded; the prescriber's name is legible) is monitored on a monthly basis. In March 2014, the Trust achieved its target of 90% compliance (90.7% of 946 cases audited). The Trust introduced a new antibiotic guideline smartphone app into adult services in February 2014 and we anticipate that the equivalent app for paediatric services will be made available later in 2014.</p>

OBJECTIVE 3

We wanted to reduce medication errors



In 2013/14, for the third consecutive year, we set ourselves the objective of continuing to drive down levels of medication errors which cause 'moderate', 'major' or 'catastrophic' harm to patients. The reduction of medication errors causing serious harm is a national quality priority within the NHS Outcomes Framework.

Once again, more than 99% of reported medication incidents at our Trust in 2013/14 did not result in major harm to patients (18.4% of incidents were low harm,

61.2% negligible harm (defined as no obvious harm or damage to the patient) and 19.7% were identified as a 'near miss'. Our target was to improve on our 2012/13 performance when 0.88% (14/1,594) of reported medication incidents involved moderate, major or catastrophic harm to patients.

In 2013/14, 0.68% (13/1,910) of medication related incidents resulted in moderate (10/13), major (2/13) or catastrophic (1/13) harm. This represents an improvement on our performance in 2012/13 (0.88%). Changes in 2013/2014 which have contributed to this include a face to face session with all clinical staff at induction on safer medicines management and the successful implementation of a multidisciplinary action plan to reduce omitted doses, along with ongoing work from the learning and feedback from reported incidents.

Source: Ulysses Safeguard system
Figure 8

Medication errors resulting in moderate or greater actual harm



In 2014/15, our aim is to comply with the Patient Safety Alert NHS/PSA/D/2014/005 (Improving medication error incident reporting and learning), whilst ensuring the level of moderate or greater harm resulting from medication errors is kept to a minimum.

As in 2012/13, we also set ourselves the goal of reducing omitted doses of critical medicines. This 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 2.59% 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 2.25%. We were successful in reducing the percentage of omitted doses of critical medicines to 1.91% (sampling around 1,000 patients per month) – a 26% reduction, following successful implementation of a multidisciplinary action plan. In 2014/15, our aim is to maintain this low level of omitted doses of critical medicines.

OBJECTIVE 4

We committed to extend the practice of medicines reconciliation ('getting the medicines right')



Medicines reconciliation (locally termed 'getting the medicines right') is a process recommended by NICE¹⁶ which is designed to prevent medication error at hospital admission. Medicines reconciliation involves reviewing and documenting a patient's medicines against the best available sources of information, such as GP records or medicines brought in from home. UK-based evidence indicates that medicines reconciliation is effective in reducing medication errors and resulting patient harm.

In 2013/14, we agreed a CQUIN target with our commissioners to carry out medicines reconciliation within one working day for at least 95% of patients admitted to our hospitals, averaged across identified assessment and cardiac wards. We also

¹⁶ The National Institute for Health and Clinical Excellence - Patient Safety Guidance Number 1 (December 2007)

committed to extend medicines reconciliation to our oncology, haematology and gynaecology wards, with a target of at least 85% averaged across those areas. Table 3 shows performance by ward and that our targets were achieved.

Source: ward based audits

Table 3

Ward	2012/13			2013/14		
	Number of patients reviewed	Medicines reconciliation carried out within one working day	Aggregate percentage	Number of patients reviewed	Medicines reconciliation carried out within one working day	Aggregate percentage
2	318	95.3%	94.6%	265	99.6%	98.0%
17	140	99.3%		255	98.0%	
CCU	125	97.6%		260	98.5%	
51	120	90.0%		255	96.1%	
51	127	90.6%		265	97.0%	
53	167	93.4%		255	98.8%	
61	0	N/A	N/A	220	94.5%	92.0%
62	0	N/A		189	97.9%	
78	0	N/A		200	83.5%	

In 2014/15, our aim is to maintain coverage in all admissions wards with similar percentages to those achieved in 2013/14. We aim to utilise the national medication safety thermometer risk assessment tool in identified hospital wards to highlight and trend potential medication risks which need to be communicated to primary care clinicians with a view to reducing the incidence and severity of risk. We also aim to evaluate patient re-attendance rates and identify any interventions to mitigate future risk and any common themes.

OBJECTIVE 5

We said we would improve the early identification and escalation of care of deteriorating patients



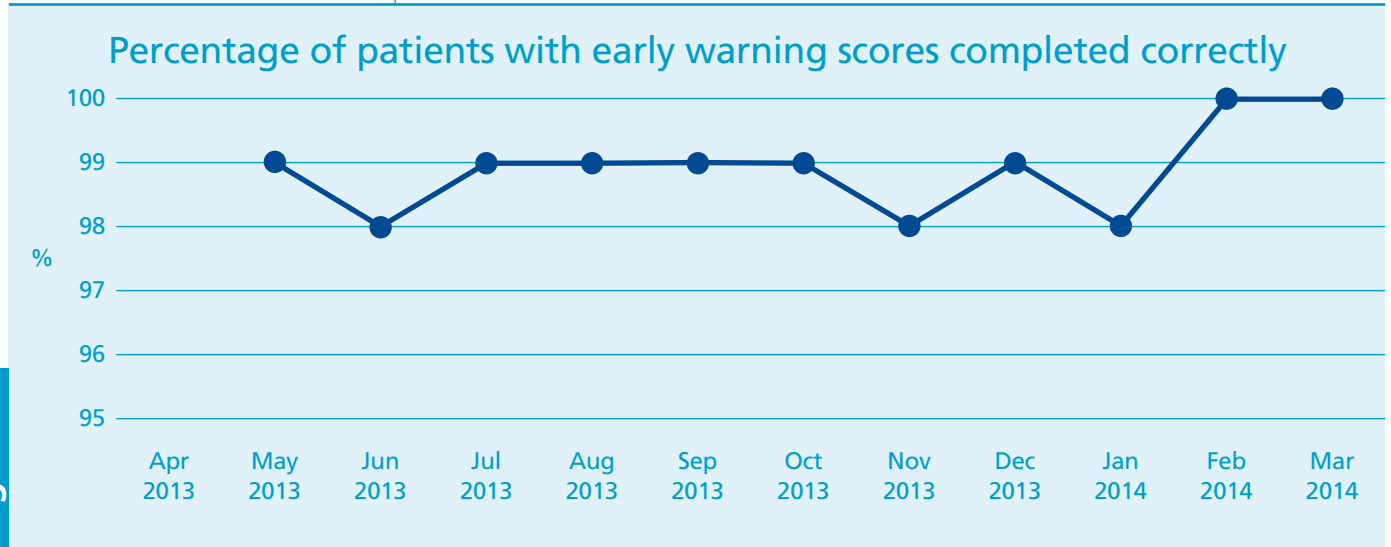
As well as using nursing skills and experience to assess the condition of our patients, we also use objective measurements of vital signs, called "observations". This includes, as a minimum, measuring the temperature, pulse, respiration rate and blood pressure of the patient.

These are plotted on our "Bristol Observation Chart" and when individual measurements are outside of the normal parameters, a score is assigned depending on how abnormal they are. The individual scores are then added up to produce an early warning score or "EWS". Generally, the higher the EWS, the more sick the patient is and a pattern of increasing EWS indicates a deteriorating patient. Agreed EWS scores trigger actions by nurses in response to this early warning. A EWS of four is the default point at which a patient is identified as requiring review by a senior nurse or doctor within 15 minutes, known as escalation, although patients with a lower EWS can be escalated if there is additional cause for concern. When this escalation takes place, nurses are required to use a structured communication tool known as "SBAR" (Situation, Background, Assessment and Recommendation) to

give the senior nurse or doctor information about the patient in a clear succinct and accurate way so that they can respond promptly as needed.

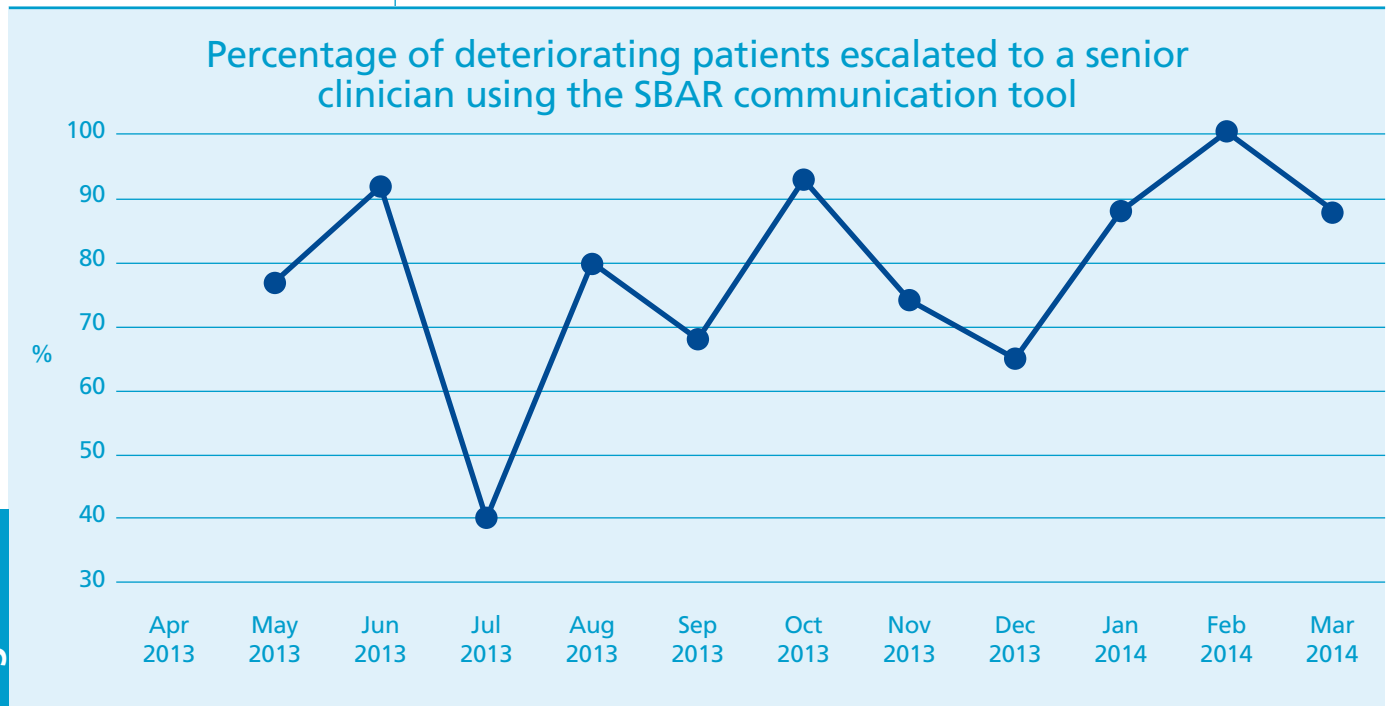
We agreed a local CQUIN target with our commissioners to ensure that 95% of observations of vital signs were measured correctly and the EWS was correctly calculated, and that the SBAR tool would be used to escalate at least 70% of deteriorating patients with a EWS of four or more in the third quarter of the year, increasing to 80% in the final quarter. Each month, we audited 500-600 patients; in 11 out of 12 months, at least 98% of patients had their early warning scores completed correctly every month (the score for January was 97.8).

Source: monthly audit
Figure 9



Use of the SBAR communication tool to escalate deteriorating patients for review by a senior clinician has taken time to become established practice. The monthly fluctuations shown in Figure 10 are also due in part to the small numbers deteriorating patients, i.e. small changes in patient numbers can lead to significant changes in percentage compliance. Figure 10 does however show an overall improvement throughout 2013/14 and we achieved 90.5% for quarter 4 against our 80% target.

Source: monthly audit
Figure 10



In 2014/15 we aim to sustain the improvements in identifying deterioration and acting on this for the sickest patients, and in addition we will focus on improving responses to less sick patients who may be in earlier stages of deterioration.

OBJECTIVE 5

We wanted to improve levels of nutritional screening and specifically 72 hour nutritional review of patients

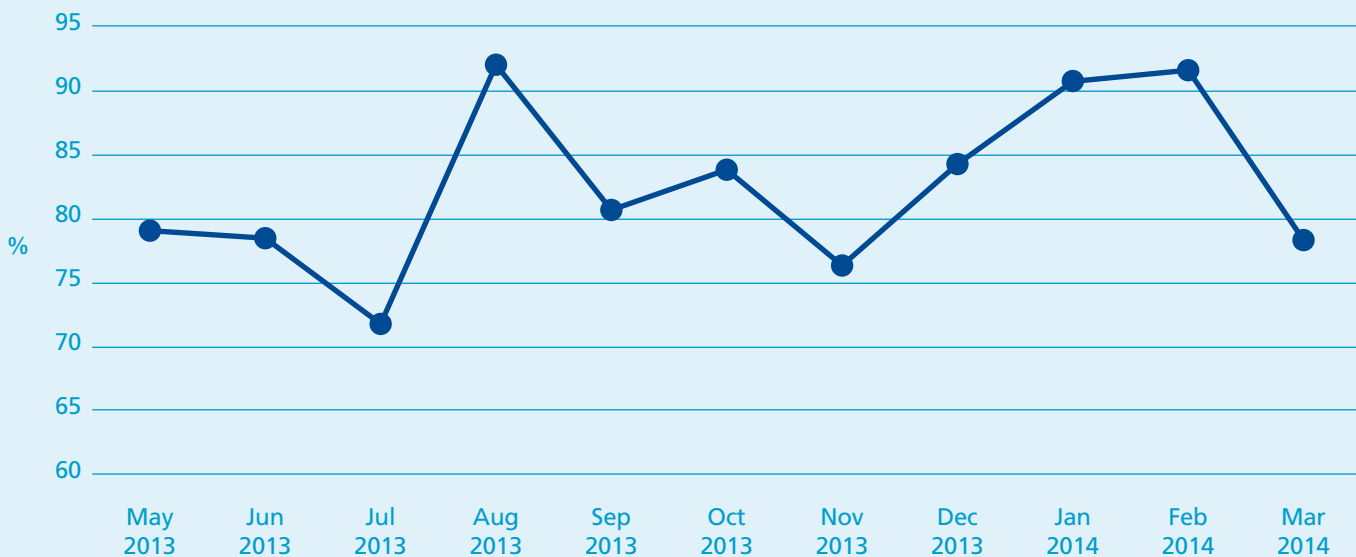


In previous Quality Reports, we have explained how we have used feedback from the Care Quality Commission to improve the quality of nutritional care that patients receive, and how we are using volunteer staff to support patients who need help at mealtimes. All patients are screened for risk of malnutrition when they are admitted to hospital. If a patient is identified to be at risk, a number of agreed actions follow, including the requirement to complete a food chart and to formally review this 72 hours after admission. For 2013/14, we agreed a CQUIN target with our commissioners that in the final quarter of the financial year, at least 90% of adult patients who had initially been assessed as being at risk of malnutrition would receive a nutritional review after 72 hours. Performance against this indicator is monitored via the NHS Safety Thermometer; results form part of the supervisory sisters' key performance indicators and are reported to the monthly Nutrition Steering Group. Actions and improvements for wards that are not achieving the required levels of nutritional review are a standing agenda item for the group.

Despite a considerable amount of work at ward level, the CQUIN was not achieved. We met the required target in January and February 2014, but a dip in performance in March pulled our quarterly score down to 87.2%. Nonetheless, Figure 11 points to a positive trend in recent months and we are focussing on restoring this pattern of improvement at the start of 2014/15. Overall compliance for the period May 2013¹⁷ – March 2014 was 82.5%.

¹⁷ This is when data collection began

Trust 72 hour Food Chart Review



Source: NHS Safety Thermometer

Figure 11

REVIEW OF PATIENT SAFETY 2013/14

This section explains how the Trust performed during 2013/14 in a number of other key areas relating to patient safety, which are in addition to our stated annual objectives.

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

The percentage of reported incidents resulting in severe harm is 0.2% (12 incidents) for the period April-September 2013. This represents a reduction compared both to the previous six months (0.5%, 31 incidents) and the corresponding period in 2012/13 (0.7%, 35 incidents) as reported in our 2012/13 Quality Report. The percentage of reported incidents resulting in death remains at 0%¹⁸ (1 death) for the period April-September 2013. This represents a reduction compared both to the previous six months (0.1%, three deaths) and the corresponding period in 2012/13 (0.1%, four deaths) as reported in our 2012/13 Quality Report, and is below the average rate of our peer group (0.1%). The provisional percentage of reported incidents resulting in severe harm or death was 0.34% (39 severe harm incidents; and 2 potentially avoidable deaths) for 2013/14 as a whole¹⁹. 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 2014/15, the Trust intends to take the following actions to continue to reduce harm from avoidable patient safety incidents:

- Complete our five year proactive patient safety improvement programme (renamed Safer Care Southwest) in October 2014 and participate in the safety improvement work of the new regional patient safety collaborative/s.
- Continue to investigate incidents proportionally to their level of harm or risk, and improve how we share learning and take action across the organisation to reduce the likelihood or impact of the same kind of incident happening again.
- Build on our improvements in 2013/14 for key patient safety issues for the Trust such as reducing the medication errors, reducing inpatient falls and improving the identification of the deteriorating patient and ensuring prompt review by a senior clinician.
- Pilot and, if successful, implement a system for systematic review of adult mortality.²⁰

Also see the Trust's quality objectives for 2014/15 on page 47 of this report.

¹⁸ technically 0.000166% (1/6012)

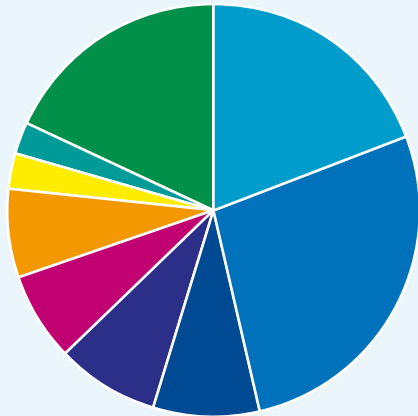
¹⁹ Consisting of data for first six months of 2013/14 which has been validated by NRLS, and data for the second six months of the year which is sourced from the Trust's Ulysses Safeguard system

²⁰ There already exists a well-established Child Death Review Process

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 2013/14, the Trust Board was informed of serious incidents via its monthly quality dashboard. The total number of serious incidents reported for the year was 73 compared to 91 in 2012/13. Of the 73 initially reported, five were either downgraded or a downgrade request has been made at the time of writing (April 2014). A breakdown of the themes from these incidents is provided in Figure 12 on the next page.

Serious incidents 2013/14



Pressure ulcers	14
Falls	20
Black escalation	6
Safeguarding	6
Information governance	5
Drug incident	5
Never event	2
Power loss	2
Other	13

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

Source: UH Bristol Serious Incident Log

Figure 12

All serious incident investigations have robust action plans which are implemented to reduce the risk of recurrence. Actions taken by the Trust to reduce falls and hospital acquired pressure ulcers are documented elsewhere in this report. Serious incidents are governed by national definitions through NHS England.

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).

Two never events occurred in University Hospitals Bristol in 2013/14:

1. A case of wrong site surgery: an emergency procedure was commenced on the wrong side. The mistake was identified shortly after the start of the procedure, remedial action was taken and then the procedure took place on the correct side. The patient came to minor harm; they were informed of the mistake afterwards and a sincere apology was offered. This incident was not prevented by the WHO²¹ surgical safety checklist which was completed prior to the procedure starting. The root cause analysis investigation identified, among other things, that making the site of surgery visible within the surgical field after the patient was draped (covered with sterile sheets to reduce the risk of infection during the operation) would probably have prevented this incident. This change in practice will be implemented and a further serious incident panel investigation has been commissioned by the medical director to identify further broader systemic and organisation-wide recommendations.
2. A retained foreign object following emergency surgery: a removable part of a disposable instrument became inadvertently detached during use and was left inside a patient. The patient required a further minor procedure to remove the object. The patient and family were informed of the retained object when its presence was identified and an apology was offered. An immediate action was instigated to ensure all disposable items are included in surgical counts. A serious incident panel investigation was commissioned by the medical director to identify any systemic and organisation-wide learning.

²¹ World Health Organisation

For 2014/15, a proactive Trust-wide review of systems in operating theatres is already underway to identify further risk-reduction actions which can be taken to prevent surgical never events. In February 2014, NHS England published a report of its Never

Events Taskforce which was commissioned in response to the recognition that surgical never events are the most commonly reported types of never events. The report identified NHS-wide actions to be taken to with the aim of eradicating surgical never events. Recommendations from the report will form part of the Trust's proactive review, as described above.

NHS England's provisional data for 2013/14 shows that a total of 312 never events occurred in NHS trusts, of which 132 involved a retained foreign object and 89 involved wrong site surgery. At least one never event was reported by 159 NHS trusts, with the maximum number reported by any single trust being eight. Never events are governed by national definitions.

**NHS England Patient
Safety Alerts**

At the end of 2013/14, there were no outstanding alerts relating to University Hospitals Bristol NHS Foundation Trust.

Patient Experience



Our ongoing commitment

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 2013/14

OBJECTIVE 7

We were required to implement the Friends and Family Test in adult inpatient, emergency department and maternity services



The Friends and Family Test (FFT) is a national survey designed to give patients an opportunity to comment on the care they have received and to help people to make decisions about where they have their NHS treatment in the future. The FFT was launched nationally in adult inpatient and emergency department (ED) services on 1st April 2013, and was subsequently extended to maternity services on 1st October 2013. Patients are asked whether they would recommend the care they received to their friends and family. At University Hospitals Bristol, inpatients and ED patients are given an FFT card as part of their discharge from hospital. In maternity services, women are asked to complete the FFT on up to four occasions in relation to their antenatal community midwifery care, their experience in hospital giving birth and/or on the postnatal ward, and in respect of the postnatal care provided by their community midwife.

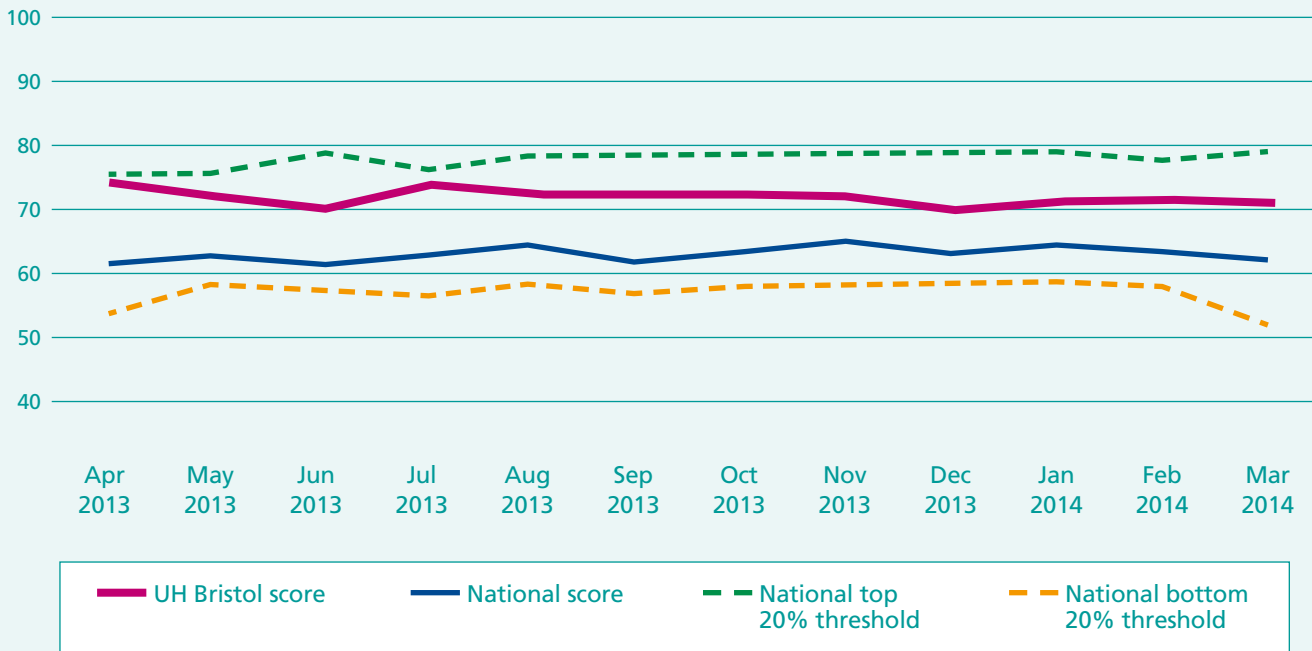
In last year’s Quality Report, we published “net promoter scores” (the technical term for the scores generated by the FFT question) from our own monthly survey. This year, we are replacing this with the official national FFT data. To date, the Trust’s FFT scores in the inpatient and ED elements of the survey have been consistently better than the national average (see Figure 13).

There were two national Commissioning for Quality and Innovation (CQUIN) payments associated with the FFT survey in 2013/14²². The Trust met the first element of this CQUIN, having implemented the FFT in adult inpatient wards, emergency departments

²² Note: there is another element of this CQUIN which is associated with a score in the NHS National Staff Survey

and maternity services as per the Department of Health's guidance. We also secured half of the value of the second element: although we achieved a 24.6% response rate in the final quarter of the year (against a target of 20%), we had previously underachieved in the first quarter of the year (8.4% against a target of 15%).

Family and Friends test score (inpatient and emergency department) with national benchmarks



Source: UH Bristol Friends and Family Test survey / NHS England

Figure 13

National benchmarks for the maternity FFT have recently been released: we are achieving above national average scores in the community midwifery and care during birth elements of the survey (see Table 4). The Trust's FFT score relating to care on postnatal maternity wards has fluctuated around the national average, influenced by the relatively low number of responses being collected on the maternity wards at present. The Trust has agreed a set of actions to improve the response rates in these areas.

Maternity FFT scores	October	November	December	January	February	March
UH Bristol antenatal community midwifery score	73	72	66	75	77	65
Overall national score	64	65	63	67	67	Not available
UH Bristol care during birth score	92	91	68	92	92	86
Overall national score	76	77	75	78	75	Not available
UH Bristol postnatal wards score	50	69	30	76	59	62
Overall national score	65	66	66	65	64	Not available
UH Bristol postnatal community midwifery score	90	80	78	84	82	79
Overall national score	71	72	78	75	75	Not available

Source: ward based audits

Table 4

In 2014/15, all NHS hospital trusts will be required to extend the FFT into outpatient and day case care and there will be a new national FFT for staff. The required response

rates for the inpatient and emergency department FFT CQUINs will increase in 2014/15. We are developing plans to ensure that all of these targets are achieved.

OBJECTIVE 8

We wanted to ensure that patients continue to be treated with kindness and understanding on our wards.



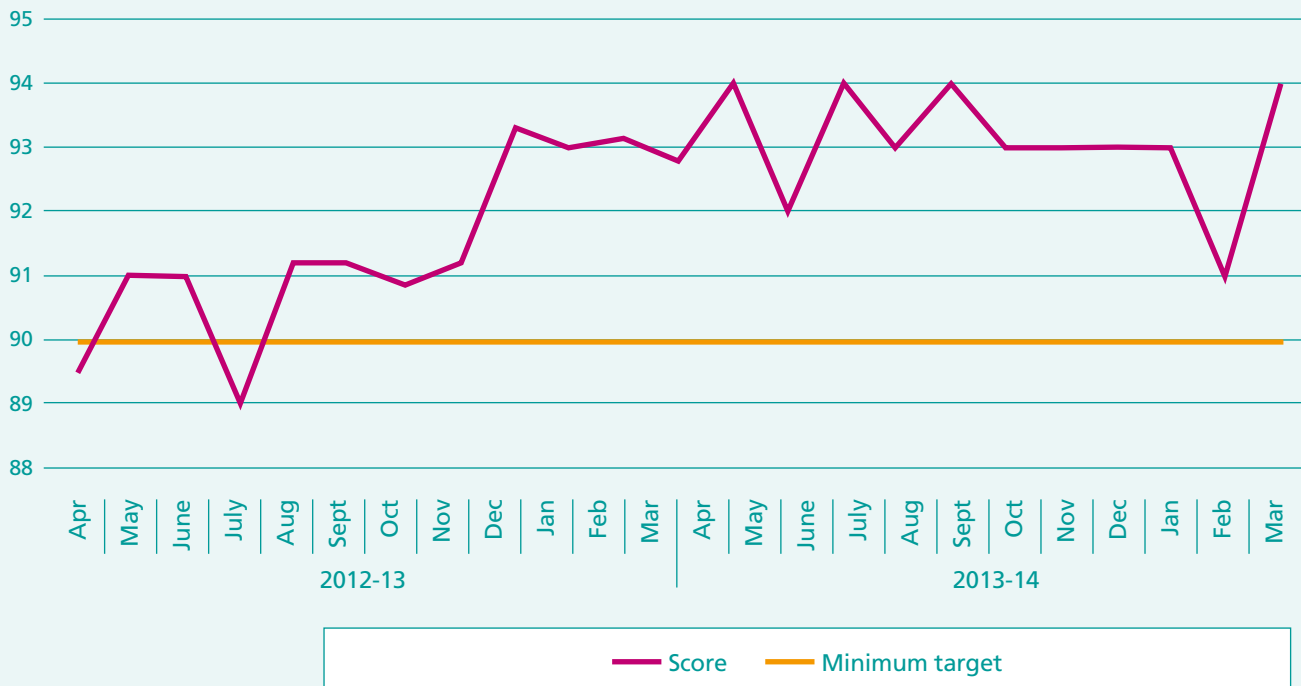
As well as asking patients whether they would recommend us, another important measure of patient experience is whether people feel that they have been treated with kindness and understanding – a hallmark of compassionate care. Last year, we achieved excellent scores on this patient-reported measure and set an objective to sustain this in 2013/14. We are delighted to report that we succeeded: our survey scores have been consistently above 90 points throughout 2013/14 to date (see Figure 14). The Board will continue to monitor our monthly kindness and understanding score in 2014/15.

What our patients said in our monthly inpatient survey:

“Every time I’ve been in the Bristol Royal Infirmary, I have found everyone, from consultants, doctors, nurses, catering staff and even cleaners kind, helpful and polite. I could not fault anyone.”

“I had a bad heart attack and had some memory loss, but after the fifth day I started to get back to my old self, all I can think of was how great all the staff in the BRI treated me and made me very at ease. In one of the most scariest and hardest times of my life if it was not for the great care I received and not just medical, I don’t think I would be here now, they helped in so many ways I would like to thank everyone of them for their great care and understanding.”

Patient ratings of kindness and understanding on UH Bristol’s ward



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

Figure 14

OBJECTIVE 9

Explain potential medication side effects to inpatients when they are discharged



Telling patients about the potential side effects of the medications that they are taking away with them from hospital is an important aspect of patient experience and patient safety. Although the Trust's performance is similar to most other NHS trusts, as measured in the national inpatient survey, it is an aspect of care where almost all NHS trusts have considerable scope for improvement.

What our patients said in our monthly inpatient survey:

"When I left hospital there was no advice on any side effects or pain issues to be expected."

"Give more explanation of side effects and what you may expect during recovery both whilst in the hospital and when you get home. I had some issues and problems which were normal but would have been less stressful if warned in advance."

Despite our best efforts, our performance in 2013/14 has remained disappointing – albeit still in line with the national average. A new e-tool has also been developed by our pharmacy department to enable ward staff to provide each patient with a tailored list of potential medication side effects for the medication they are leaving hospital with. The system has been successfully piloted on a small number of wards and in the new discharge lounge, and will now be rolled out across the Trust. Informing patients about medication side effects will also form part of the Trust's new inpatient discharge checklist, due to be rolled out in early 2014/15.

Although there was evidence of an improvement in patient experience between May and July 2013, the subsequent data pattern suggests that this improvement was most probably due to natural statistical variation (see Figure 15).

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

Explaining potential medication side effects to patients when they are discharged

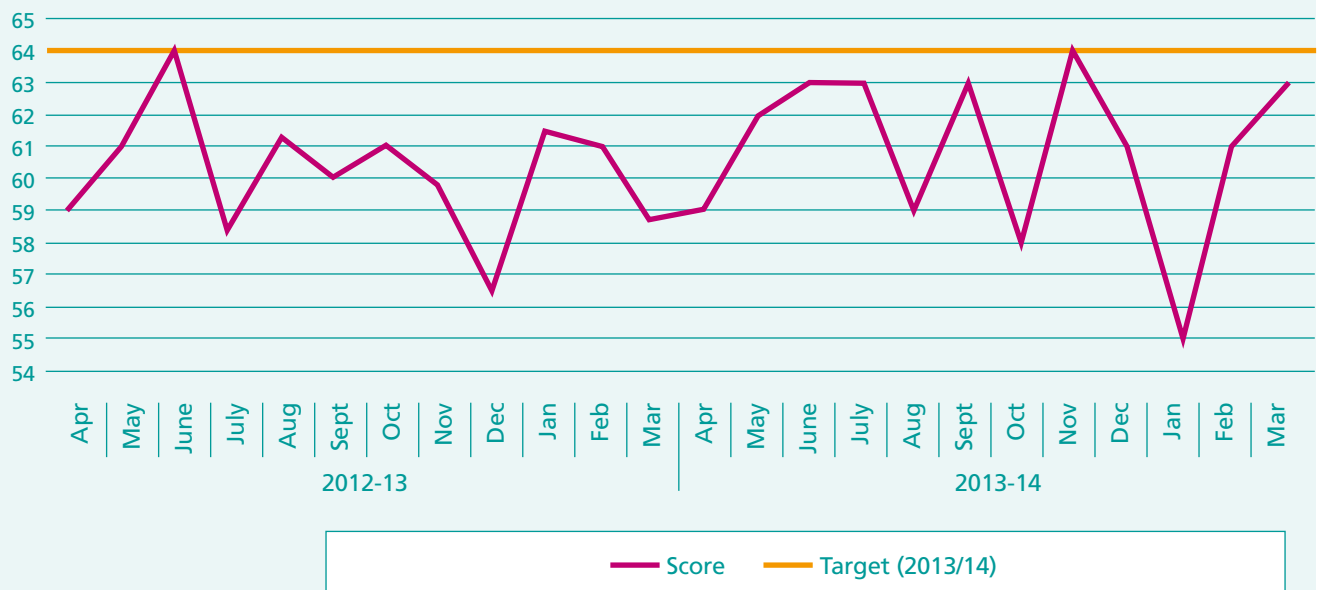


Figure 15

OBJECTIVE 10

We wanted to improve the experience of maternity patients

Patient experience ratings on postnatal wards are generally lower than other inpatient wards. This is a national trend which is reflected at University Hospitals Bristol NHS Trust. Since 2012/13, the Trust has made a concerted effort to improve the experience of people who use our maternity service and postnatal care in particular. Developments in 2013/14 have included three projects supported by the Trust's patient experience and involvement team:

- improving the patient experience of women who have an induced labour;
- holding patient experience workshops for newly recruited midwives focussing on how their role impacts on patient experience; and
- identifying and supporting a consultant-level patient experience champion who will lead patient experience and involvement initiatives in postnatal care.

Elsewhere, a new midwifery-led unit has been opened at St Michael's Hospital and antenatal ward staffing is being reconfigured to improve patient experience, especially for induction of labour. Funding has been secured for three band 7 posts to focus on breast feeding and bereavement services. Previously in 2012/13, we ran a series of "Patients at Heart" workshops for maternity staff at St Michael's Hospital, which has contributed to a reduction in complaints.

“
What our patients said in our monthly maternity survey:

“The care I received from staff at St Michael's both during my pregnancy, the birth and post natal 6 day stay was excellent.”

“Midwifery Led Unit at St Michael's – excellent care and a wonderful overall experience. Would highly recommend to anyone having a baby.”

“Faultless care on delivery suite...very caring and personable. Disappointed with ward care.”

Our scores in the 2013 national maternity survey were excellent²³: the Trust was rated as being [statistically significantly] better than the national average, having previously been on the threshold of being in the worst 20% of trusts nationally in 2010. However our own monthly survey of maternity patients has shown fluctuating scores relating to kindness and understanding on postnatal maternity wards (see Figure 16). In the third quarter of 2013/14, our score deteriorated during a time of adjustment for the service: postnatal wards were being reconfigured and a number of new midwives were appointed. These changes will have a positive effect on postnatal ward experience and our scores from November 2013 have started to reflect this.

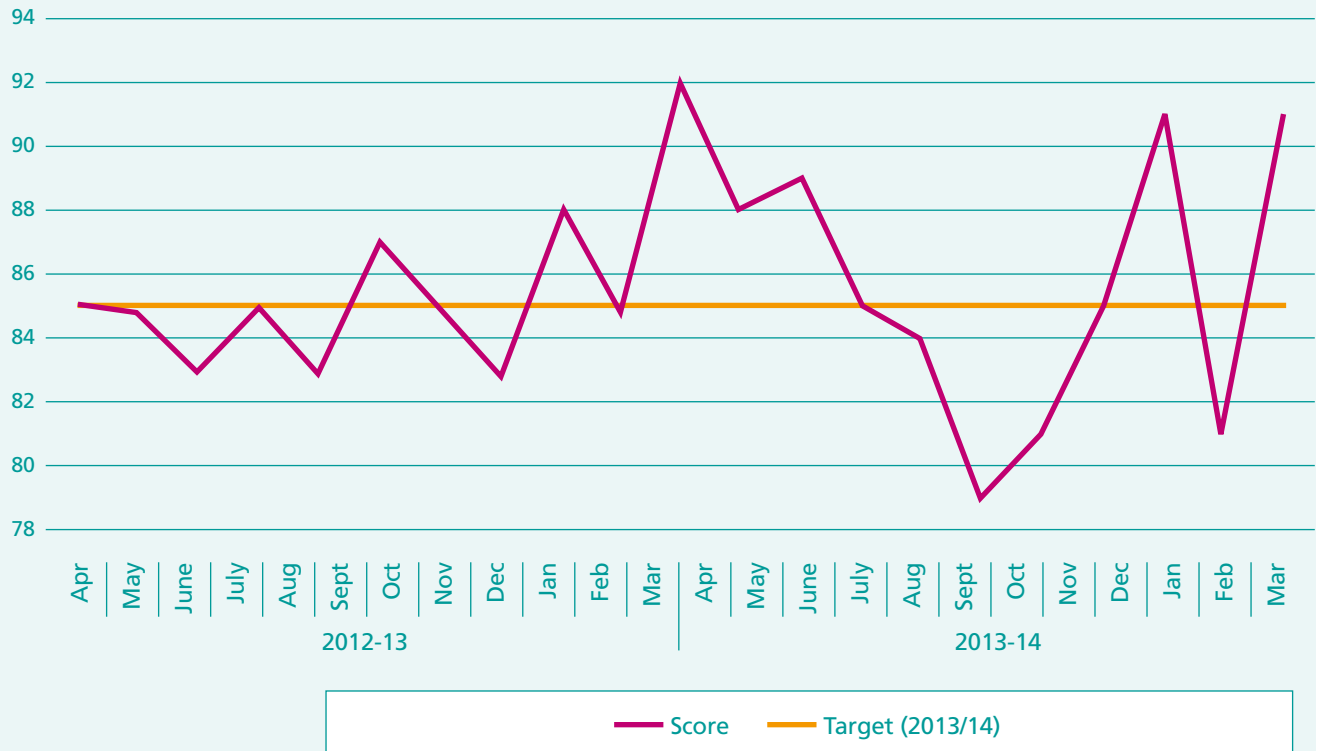
In 2014/15, the maternity service will continue to focus on improving patient experience on the wards by evaluating and acting upon patient feedback. As part of this, our supervisors of midwives will be going onto the wards and into other patient areas to talk to women about their experiences of midwifery and obstetric care. In response to previous patient feedback, we are also planning to introduce the practice of allowing some partners to stay on the wards.

²³ The national maternity survey results reflected the experience of women who gave birth at the Trust in March 2013. The results were released in December 2013.

Source: UH Bristol monthly maternity survey

Figure 16

Kindness and understanding on postnatal wards



REVIEW OF PATIENT EXPERIENCE 2013/14

This section explains how the Trust performed during 2013/14 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:

“I was taken care of in a manner that was very caring and professional. I did not have a single complaint. They saved my life and took excellent care of me.”

Local patient experience ‘tracker’ score

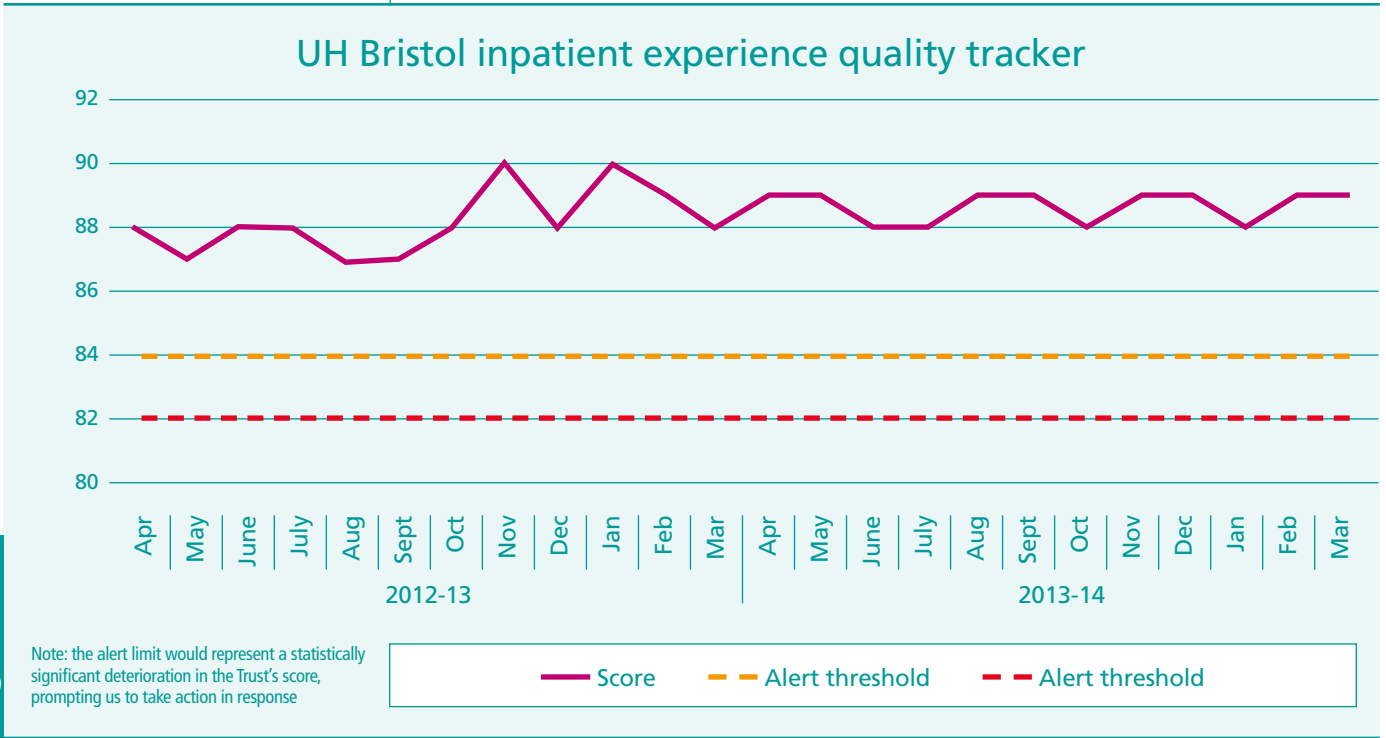
Our local patient experience tracker is based on the following aspects of care that our patients have told us (through previous surveys) matter most to them:

- 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

This is a key quality assurance indicator that is reported to our Trust Board each month. If standards were to begin to slip, this would be identified in the survey and actions would be taken to remedy this. Throughout 2013/14, our tracker score has been consistently above our minimum target. The Board will continue to monitor the monthly tracker score in 2014/15.

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

Figure 17



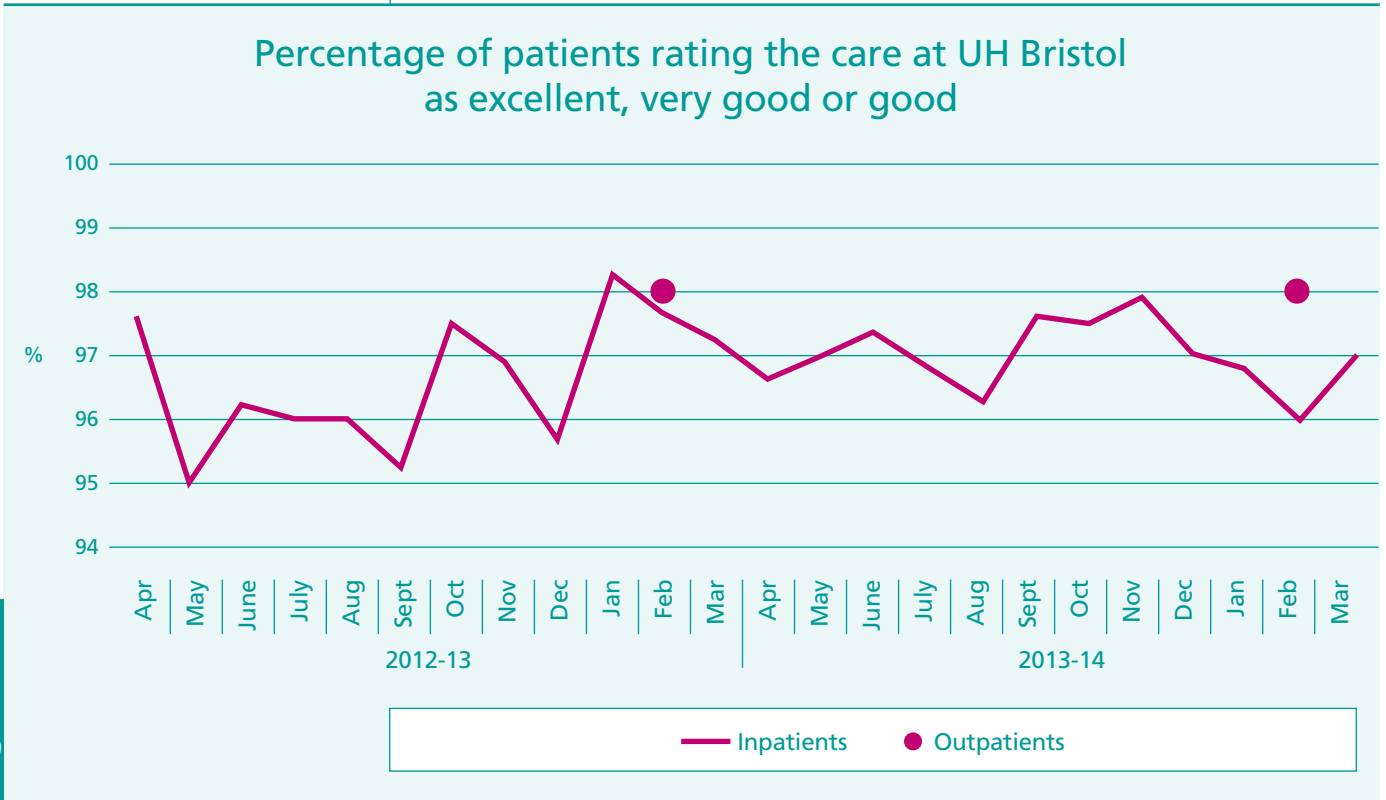
Overall care ratings

²⁴ provisional data

Another way of measuring overall experience of care is to pose that question directly to patients. In 2013/14 (to January 2014), 97% of all survey respondents aged 12 and over rated the care they received at the Trust as excellent, very good, or good (see Figure 18). A similar score (98%²⁴) was achieved for outpatient services in the Trust's annual outpatient survey.

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

Figure 18

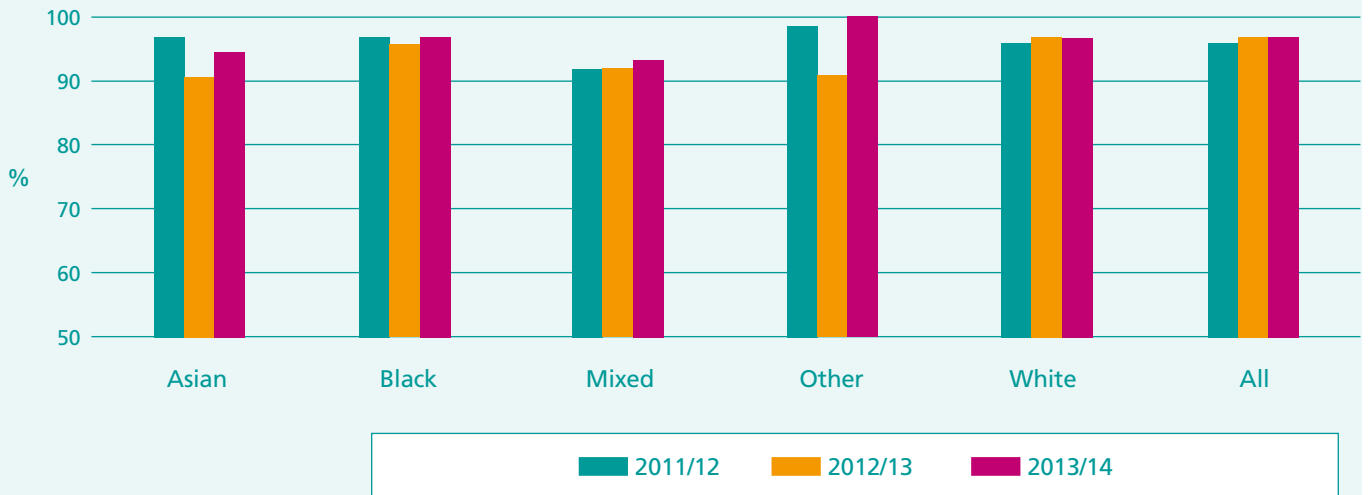


We continue to monitor patient-reported experience data to ensure that there is no evidence of statistically significant variation in reported experience according to the ethnicity of our patients. The differences shown in Figure 19 are not statistically significant, i.e. they are most likely caused by chance fluctuations in the data.

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

Figure 19

Percentage of patients rating their care as excellent, very good or good by ethnic group



Complaints

In 2013/14, 1,442 complaints were reported to the Trust Board, compared with 1,651 in 2012/13, 1,465 in 2011/12 and 1,532 in 2010/11). This equates to 0.21% of all patient episodes, against a target of <0.21%.

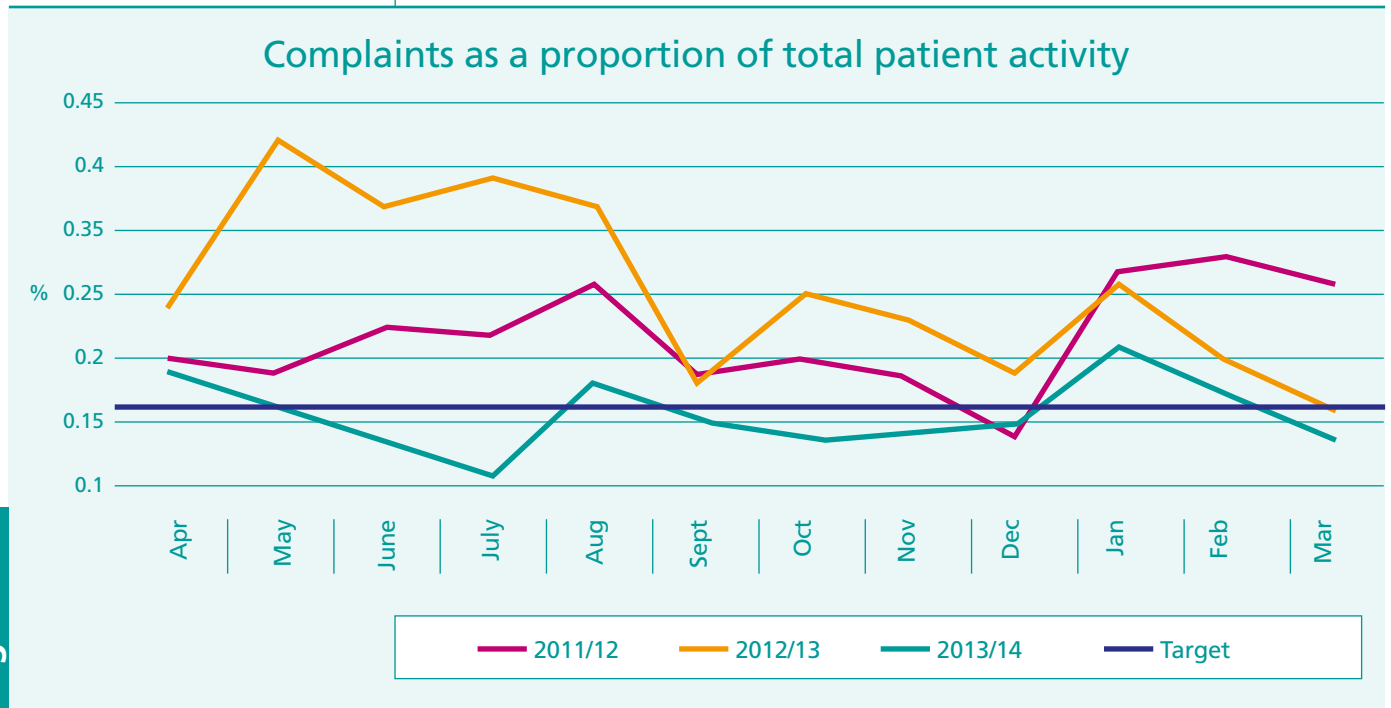
Figure 20 demonstrates shows the number of complaints received each month as a proportion of patient activity. The volume of complaints received throughout the year has remained steady. The sharp increase in complaints in March 2014 was largely attributable to the cancellation of routine surgery and outpatient clinics during a period when the Trust was experiencing significant pressures on services, including an increase in emergency admissions. 40% of complaints received in March were attributable to appointments and admissions.

Staff in our Trust work hard to ensure that complaints are investigated thoroughly and that our response letters are open, honest and comprehensive. Our target for 2013/14 was that no more than 47 complainants would tell us that they were dissatisfied with the quality of our response. In the event, 62 complainants told us that they remained unhappy: a significant and disappointing increase compared to the 20 cases we reported in 2012/13. All response letters are carefully checked by our Patient Support and Complaints Team before being sent to the Chief Executive's office for further checking and then signing. We continue to educate and train staff in response-writing skills: a recent example being collaborative training events with the Patients' Association. In 2014/15 we plan to introduce a new system of routinely asking complainants to confirm the key objectives of making their complaint, in order to ensure that the Trust provides responses which reflect the complainant's core concerns.

Last year, we reported that we had identified an administrative error affecting the validity of data about whether the Trust was responding to complaints within agreed timescales. This error affected our historic data, so it is not possible to provide accurate comparative data for years prior to 2013/14, suffice to say that the true picture will have been notably worse than the one previously reported. The error was identified in May 2013, after which concerted effort was put into improving response times, including improvements in our internal monitoring of the progress of complaints investigations. As a result, Figure 21 below shows significant improvement during 2013/14. We are confident that we will see this pattern of improvement sustained in 2014/15. In 2013/14 as a whole, 76.4% of complaints were responded to within the timescale agreed with the complainant, against a target of 98%.

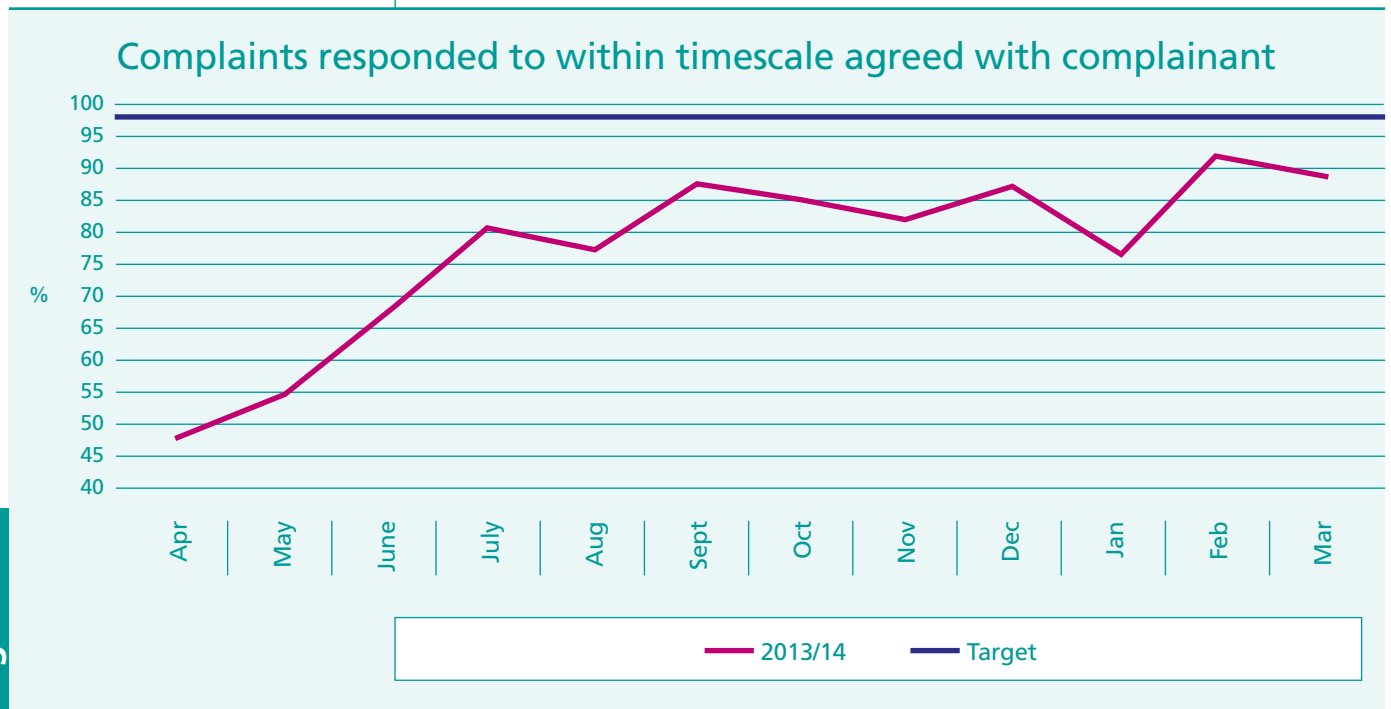
Source: UH Bristol Ulysses Safeguard system

Figure 20



Source: UH Bristol Ulysses Safeguard system

Figure 21



2013/14 has been a year of change for our Patient Support and Complaints team. In December 2013, the team relocated from its temporary home in the Bristol Dental Hospital to a prominent location in the new Bristol Royal Infirmary Welcome Centre. Complaints management has had a high profile across the whole of the NHS in 2013/14, partly as a result of the Francis Report into failings at Mid Staffordshire NHS Foundation Trust, partly in response to the subsequent Clwyd-Hart Report, and also following important recommendations published by the Parliamentary and Health Service Ombudsman. Our action plan in response to these various publications was presented to our Trust Board in January 2014 and will be implemented throughout 2014/15. One of the early actions in this plan is the above-mentioned collaborative project with the Patients Association (ongoing at the time of writing), the overall objective of which is to gain a better understanding of, and learn from the experience of people who complain about our services.

More detailed information about complaints themes and learning will be published in the Trust's annual complaints report later in 2014.

Improving patient experience in outpatients services

The Trust has been working hard in 2013/14 to improve its outpatient services. An outpatients improvement programme, led by the Director of Finance, has involved the majority of outpatient departments across the Trust, focussing on productivity, efficiency and improving patient experience.

First and foremost, we have been listening to our patients. One of the things that patients have complained about is not being able to speak to outpatient staff to enquire about their appointment or to book and rebook their appointment, leading to frustration, anxiety and appointment slots being wasted. In order to address this, the Trust has invested in a central appointment centre, located in the new Bristol Royal Infirmary Welcome Centre and manned by experienced call handlers who work to a target of 95% of calls being answered within 60 seconds. This has significantly improved patient access and has seen a marked reduction in complaints. We aim to continue to extend the appointment centre service in 2014/15 to cover the majority of outpatient services in the Trust.

We have also been working to reduce waiting times in clinic, another significant source of patient complaints. In particular, we have been working with staff at the Bristol Eye Hospital to smooth out the flow of appointments and reduce queues and waits in clinic.

We understand that it is not always easy for patients to get into the city for their appointment, so – where clinically appropriate – we have been offering telephone appointments where a clinician can consult with a patient over the phone.

Finally, we have been working hard to reduce the number of patients who do not turn up for their appointment. In 2013/14, approximately 62,000 patients “did not attend”. This represents 7% of appointments: a significant improvement compared to almost 10% in 2012/13. The Trust has invested in an appointment reminder system that sends a text message to the patient seven days and 24 hours before their appointment (or an automated call reminder to their landline). We will continue to improve the productivity and efficiency of our outpatient services in 2014/15 to ensure we offer the public value for money and patients a better experience of our outpatient services.

National Staff Survey 2013

As in previous years, in line with the recommendations of the Department of Health, we are including in our Quality Report a range of indicators from the annual NHS Staff Survey which have a bearing on quality of care. Relevant results from the 2013 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): 439 Trust staff took part in this survey, representing a response rate of 52% (around the average for acute hospital trusts in England). This compares with a 55% response rate in 2012.

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 values-based recruitment, in staff induction, through training, and are clearly and regularly communicated.

Table 5
Source: NHS Staff Survey

'Key finding'	UH Bristol Score 2013	UH Bristol score 2012	UH Bristol score 2011	UH Bristol score 2010	National average score 2013	National best score 2013
Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	74% Lowest (worst) 20% ²⁵	78% (average)	74%	76%	79%	86%
Percentage of staff agreeing that their role makes a difference to patients	91% (average)	92% highest (best) 20% ²⁶	92%	92%	91%	95%
Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (to other staff or to patients)	39% highest (best) 20%	39% highest (best) 20%	39%	39%	33%	18%
Percentage of staff stating that they or a colleague had reported potentially harmful errors, near misses or incidents in the last month	90% Average	91%	96%	91%	90%	97%
Staff recommendation of the Trust as a place to work or receive treatment (Mandatory indicator ²⁷)	3.76 Above (better than) average	3.66	3.65	3.68	3.68	4.25

²⁵ i.e. this score was in the lower quintile (worst 20%) of NHS acute trusts

²⁶ i.e. this score was in the upper quintile (best 20%) of NHS acute trusts

The score for staff recommending the Trust as a place to work or receive treatment is a statistical aggregation of responses to four related questions in the annual survey, as detailed below:

Table 6
Source: NHS Staff Survey

Question / statement	UH Bristol score 2013	National average (median) score for acute trusts 2013	UH Bristol score 2012
"Care of patients / service users is my organisation's top priority"	69	68	63
"My organisation acts on concerns raised by patients / service users"	72	71	72
"I would recommend my organisation as a place to work"	60	59	60
"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	74	64	71
Staff recommendation of the trust as a place to work or receive treatment	3.76	3.68	3.66

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 survey²⁸, which the Trust participates in through an approved contractor, adhering to guidance issued by the Department of Health.

A key priority for the Trust is to ensure that our patients not only receive excellent clinical treatment but are treated with dignity, respect 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 with the same level of dignity and respect we expect for our patients.

Whilst the 2013 staff survey results are positive in terms of overall staff engagement and the recommendation of the Trust as a place to work or receive treatment, the overall results are mixed. Key actions for 2014/15 will therefore include:

- Working with leaders to share the Trust's vision and mission
- Reviewing our staff appraisal system and the quality of appraisals
- Setting clear expectations for leaders in the organisation and supporting their development
- Developing a Trust-wide work related stress action plan
- Reviewing e-learning package to support managers in addressing work-based discrimination
- Implementation of the NHS Family and Friends Test for staff and other 'pulse checks' to gauge staff perceptions on a regular basis
- 360 degree feedback on lived values for all senior leaders.

²⁷ 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".

²⁷ Important note: the UH Bristol figures quoted for 2010 and 2011 and 2012 are those which will be found in the 2010, 2011 and 2012 NHS Staff Attitude Survey reports. The 2010 figures may differ slightly from the 2010 figures quoted in the 2011 NHS Staff Attitude Survey report; the 2011 figures may differ slightly from the 2011 figures quoted in the 2012 report and the 2012 figures may differ slightly from the 2012 figures quoted in the 2013 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.

Clinical effectiveness



Our ongoing commitment

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

Report on our clinical effectiveness objectives for 2013/14

OBJECTIVE 11

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 reduces patient mortality, disability and the likelihood of requiring institutional care following stroke. There is a national standard which states that at least 80% of stroke patients should be treated for at least 90% of the time on a dedicated stroke unit. Our local stretch objective is that 90% of patients should spend 90% of their time on ward 15, our dedicated stroke unit. The Trust operates with a protected bed standard operating procedure for stroke care, designed to ensure that a direct admission bed is always available on ward 12 to support direct admissions. In 2012/13, we were disappointed that only 79.3% of stroke patients spent at least 90% of their time on ward 12: we therefore retained this as a quality objective for 2013/14.

In 2013/14, we reviewed and reissued our stroke pathway, emphasising the importance of direct admissions. As a result of this review, 'sit rep'²⁹ meetings are now used to discuss whether a protected bed for stroke admissions is available and if not, what plans in place to address this. In 2013/14 to date (data to February 2014) we are pleased to have improved our performance to 84.0% - better than the national target, but still short of our own. We achieved our 90% target in one month during the year. Our performance reflects the operational challenges of protecting a dedicated stroke bed at all times as there are occasions when all the stroke beds are occupied and therefore an empty bed is not available. In 2014, the stroke unit will increase its bed base to 25 beds from 19 currently to reflect activity and support delivery of this ambition.

²⁹ Twice daily clinical operations meetings where all bed-holding divisions and the clinical site managers meet to review predicted and actual patient activity, designed to ensure the smooth flow of patients into and out of hospital



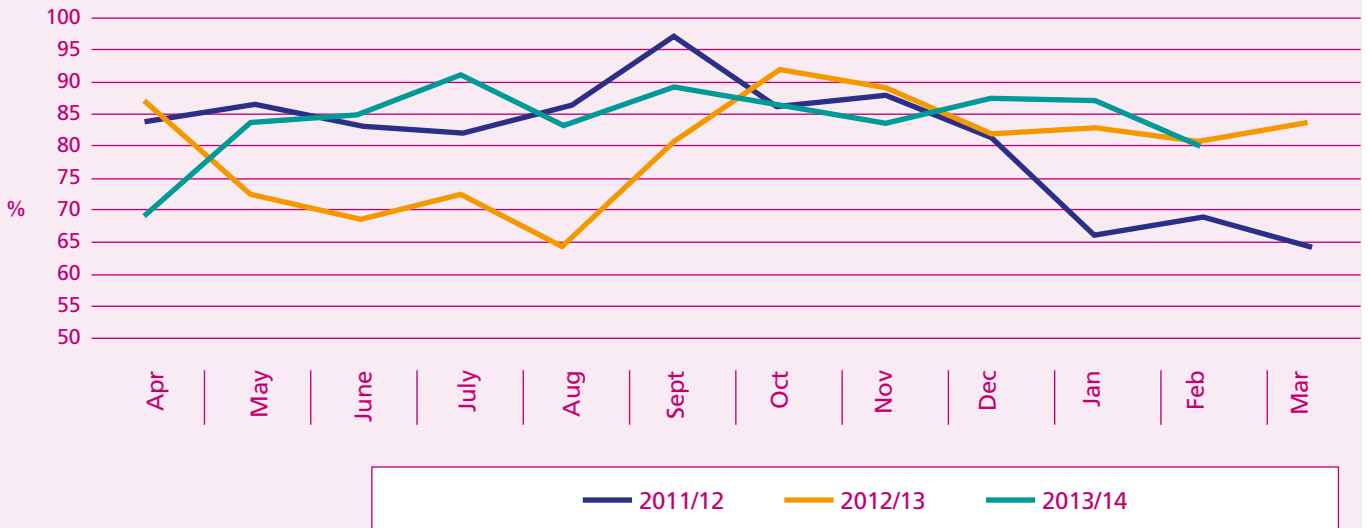
What our patients said in our monthly survey:

“My father had previously had a stroke two years ago and at times he finds it difficult to understand what people are saying but all the staff he encountered during his stay went out of their way to make sure that he understood what was being done and why. He cannot praise your staff at the BRI highly enough and would recommend to anyone the BRI hospital.”

Source: weekly discharge data validated by consultant

Figure 22

Percentage of patients spending at least 90% of time on stroke unit



OBJECTIVE 12

We wanted to achieve the best practice tariff for hip fractures

Best Practice Tariffs (BPTs) help the NHS to improve quality by reducing unexplained variation between providers and universalising best practice. Best practice is defined as care that is both clinical and cost effective: to achieve the BPT for hip fractures, trusts have to meet eight indicators of quality as recorded in the national hip fracture database. The indicators are:

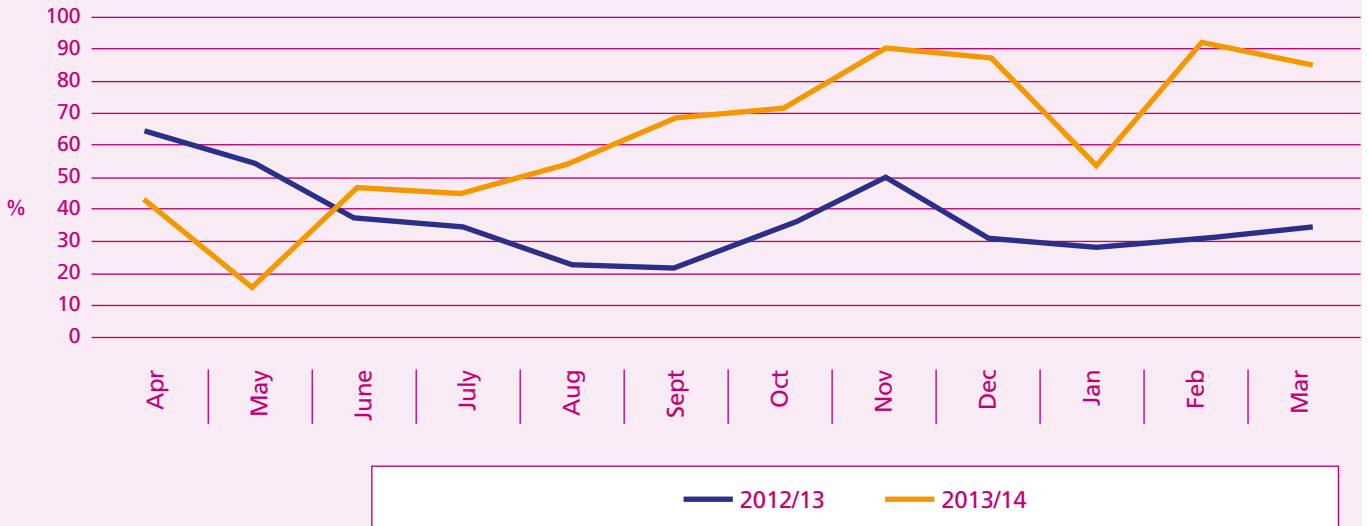
- Surgery within 36 hours from admission to hospital
- Ortho-geriatric review within 72 hours of admission to hospital
- Joint care of patients under a trauma and orthopaedics consultant and ortho-geriatrician consultant
- Completion of a joint assessment proforma
- Multidisciplinary team (MDT) rehabilitation led by an ortho-geriatrician
- Falls assessment
- Bone health assessment
- Abbreviated mental test done on admission and pre-discharge.

We are pleased to report that University Hospitals Bristol NHS Trust’s performance against the national best practice tariff for hip fracture management has significantly improved in 2013/14, compared to 2012/13 as shown in Figure 23. In November 2013 and February 2014, we achieved our target: more than 90% of cases achieved the BPT. Overall performance for 2013/14 was 59.7% (to February 2014): significantly better than in 2012/13 (36.5%), but we know that there is much work still to do. The Trust has historically struggled to achieve the BPT due to poor performance against time to theatre and ortho-geriatric review, despite consistently achieving over 90% for the other six indicators. The improvement in 2013/14 performance has been as a result

of increased access to trauma theatre, with a daily consultant-led trauma list running since April 2013; and the appointment of two consultant ortho-geriatricians since November 2013.

Despite the increased investment in resources, delivering best practice consistently remains a challenge, especially during times of peak demand, as demonstrated in Figure 23. Time to theatre performance is affected by overall trauma admissions, and by occasions when more than three hip fracture patients are admitted in a 24 hour period.

Hip fracture best practice tariff



Source: National Hip Fracture Database

Figure 23

In 2014/15, our Hip Fracture Steering Group will be focussing on delivering best practice in a sustainable way by improving the utilisation of trauma theatre sessions to reduce delays in patients undergoing surgery.

OBJECTIVE 13

We wanted to ensure patients with diabetes have improved access to specialist diabetic support



Previous studies have identified that at least 15% of the Trust's inpatient population at any one time is likely to have diabetes. We know that specialist input and advice for this group of patients, over and above the treatment and care they receive for the cause of their admission, can improve clinical outcomes and longer term health.

In 2013/14, funding was agreed to expand the Trust's diabetes inpatient specialist nurse (DISN) team. We appointed 3.5 whole time equivalent diabetes inpatient specialist nurses and agreed a CQUIN target with commissioners that at least 39% of patients with diabetes in our Division of Surgery, Head and Neck services would be reviewed by a DISN during their stay in hospital and at least 22% in our Division of Medicine and Division of Specialised Services, measured across the final two quarters of the year. We were delighted to achieve this CQUIN: 42% for Surgery, Head and Neck; and 22.1% for the combined Divisions of Medicine and Specialised Services.

Looking ahead to 2014/15, funding has been secured to make the DISN post in Surgery, Head and Neck services into a permanent position, and discussions are currently ongoing in other divisions in the hope of achieving similar longer term appointments. Funding has also been secured to develop, organise and deliver a Trust-wide diabetes educational programme in 2014/15.

“
What our patients said in our monthly survey:

“I am now in regular telephone contact with the [Diabetes Inpatient Specialist Nurse] team... I am hugely grateful for these services and convinced they have kept me out of hospital. As a diabetic I feel that much closer liaison with DISN team is essential to get well whilst in hospital and after discharge.”

OBJECTIVE 14

We wanted to ensure that ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan



The Trust's learning disabilities steering group is committed to ensuring that we constantly seek to improve the experience of care amongst patients with learning disabilities / autism and their carers, and that in doing so we meet our legislative obligations, for example with regards to the Equality Act (2010) and Mental Capacity Act (2005). This includes 'reasonable adjustments' to the ways in which services are delivered, including the removal of physical barriers and/or providing extra support for people during their time in hospital.

Recent developments include:

- An admission pack including staff photographs, information about accommodation, facilities and car parking.
- Differentiated inpatient comments cards using an 'easy read' format.
- Accessible patient information leaflets for Avon Breast Screening and the Congenital Heart Team at the Bristol Heart Institute.
- The ongoing development of patient and carers' appointment and admission letters in easy read formats.
- The launch of a 'Hospital Passport' across the Trust – this is a document which patients complete prior to admission and which moves with them as their care is transferred. 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.
- The recruitment of over 100 link nurse in adult services throughout the Trust supporting the role of the hospital liaison nurse and raising awareness about patients with learning disabilities.
- Development of an online referral system which will be launched in 2014.

Our quality objective for 2013/14 was to ensure that patients with an identified learning disability and additional health needs or conditions such as autism were risk assessed within 48 hours following admission, and that they received full reasonable adjustments.

For the year to February 2014, 86.3%³⁰ of adult patients with a learning disability were risk assessed within 48 hours, therefore meeting our target of 85%. We consistently achieved – and bettered – this target throughout the second half of 2013/14.

83.1% of adult patients with a learning disability received full reasonable adjustments during their stay in hospital (significantly exceeding our board-reported target of 58%³¹). When performance dipped notably in July 2013 (50%), recovery actions were immediately and successfully put in place including additional staff training and support, and identifying link nurses in underperforming areas.

³⁰ Data source – audit of learning disability and autism risk assessment and reasonable adjustment documentation

³¹ Target agreed with commissioners using baseline audit data



What our patients said in our monthly survey:

“My daughter has a severe learning disability so we completed the hospital passport prior to admission. This proved to be invaluable and provided her with a specialist bed and enabled both my husband and I to stay with her at all times.”

OBJECTIVE 15

We committed to continuing to implement our dementia action plan

The term “dementia” covers a range of progressive, terminal brain conditions which currently 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 2013/14, 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 November 2013 our lead nurse for dementia received a national award in the category of “Best Dementia Nurse Specialist / Dementia Lead” in recognition of the Trust’s progress in improving care for people with dementia. By the end of the financial year, 93% of relevant staff had attended “An Hour to Remember” training. All new staff receive dementia awareness training as part of their induction to the Trust.

Progress in relation to the South West Dementia Standards in 2013/14 has been evidenced by our annual dementia care audit, which has demonstrated an increase in compliance in the use of:

- The visual identification system (“Forget-me-not”) used to identify patients with cognitive impairment / dementia
- The “This is me” booklet, which is designed to give staff a better understanding of who the patient is, in order to facilitate person-centred care
- Cognitive screening undertaken upon admission to identify baseline cognitive function and the identification of delirium or possible dementia.

The lead nurse for dementia co-ordinates this work through approximately 130 dementia “champions” across the Trust. A local conference for dementia champions is held twice a year, one of which is organised jointly with North Bristol NHS Trust.

We have established a befriending scheme pilot project using 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 and has received positive feedback from staff and patients. We are currently developing a ward-based volunteer model to sustain this service in the longer term. Elsewhere, the environmental work undertaken on ward 4, funded by the Prime Minister’s Challenge fund has provided a dementia-friendly environment which has influenced the new build and refurbishment work plan in the Bristol Royal Infirmary. This includes the use of way-finding cues, i.e. appropriate signage, use of colour, artwork and hand rails.

The expansion of the older person’s assessment unit (OPAU) in January 2014 has assisted in minimising unnecessary moves and transfers of our most complex frail patients whilst facilitating timely comprehensive assessment by our older adult care physician team. In October 2013, we achieved a score of 100% in our “transfer” audit, i.e. no patient with cognitive impairment was moved unnecessarily between the hours of 8pm and 8am. This audit will be repeated at the end of April 2014.

The national CQUIN for dementia continues to challenge us: we partially achieved the CQUIN for 2013/14. Plans are underway to develop an electronic data capture

solution by the autumn of 2014 to help us to identify, assess and refer patients with dementia³².

Finally, on 22 January 2014, the Care Quality Commission undertook an unannounced dementia themed inspection. Inspectors observed care on the older person's assessment unit, as well as visiting the medical assessment unit and the emergency department. The inspection team identified a range of practice: some excellent, some inconsistent. Trust has developed an action plan to address the issues identified.

“
What our patients said in our monthly survey:

“As a nurse/health visitor myself I was delighted to observe the care and compassion shown by the nursing, medical auxiliary staff to two elderly women: one lady with dementia, another in significant pain. The staff, although busy, were calm, positive, smiled and listened.”

“The care I received was excellent. The only comment I have to make was that another patient on my ward was suffering with dementia and the staff did not seem to know how to deal with her behaviour. I own a nursing home specialising in dementia care and feel staff training in this area would be beneficial.”

OBJECTIVE 16

We committed to commence a baseline review of available clinical outcome data



As part of the Trust's Clinical Effectiveness and Outcomes Strategy for 2013-2016, The Trust committed to undertaking a baseline review of available clinical outcomes data in all major clinical specialities. An initial meeting, chaired by the medical director, took place in September 2013. In October 2013, the Clinical Effectiveness Group agreed that a pilot scoping exercise should be undertaken to better understand the current clinical, process and patient-reported outcomes currently available within the Trust. A selection of clinical areas were chosen for this to be explored in more detail and discussed with clinical staff. Current national clinical audits were also reviewed to establish the type of outcomes reported.

National clinical audits focus largely on process measures. Around half of the national audits in which the Trust is currently participating also report clinical outcomes, focused largely around mortality/survival rates. Only three collect Patient Reported Outcome Measures (PROMs) or patient-reported experience measures (PREMs), although newly commissioned projects are increasingly planning to incorporate these measures.

Locally, more in-depth discussions have been held with physiotherapy, dermatology, rheumatology and respiratory medicine. The Trust's physiotherapy department has already developed a clinical outcomes group to take this work forward and has a system in place for the collection and reporting of outcome measures according to each clinical pathway. This work is in its early stages but pathway leads have been identified and possible PROMs identified (a combination of EQ5D and other condition-specific measures). An electronic system has been developed to capture health status before intervention/treatment and the team is now working on capturing data post-intervention. In dermatology, rheumatology and respiratory medicine, disease severity scoring systems are used pre and post intervention, however this data is not captured electronically for aggregation and analysis. Elsewhere, surgical specialties participate in relevant national PROMs (see page 42).

By coincidence, the Trust has therefore seemingly been through a very similar thought process to the Care Quality Commission who have developed 'intelligent monitoring'³³ during the last year, based to a large extent on mortality measures. From the work

³² Our aim has been to use case-finding questions with at least 90% of patients aged 75 years within 72 hours of emergency admission to hospital, in order to identify dementia; to assess and investigate at least 90% of those patients who have been assessed as at-risk of dementia from the case finding question and/or presence of delirium; and to refer at least 90% of clinically appropriate cases to a general practitioner to alert that an assessment has raised the possibility of the presence of dementia.

³³ At the time of writing, the CQC's intelligence monitoring places the Trust in Band 6, which indicates the lowest level of risk of non-compliance

we have undertaken so far, it is clear that there is enthusiasm from clinical staff to understand outcomes in more depth. The Trust will continue to explore this area, looking at how electronic systems might contribute to this agenda. We will also continue to publish outcome data as part of NHS England's 'Consultant Level Outcome' requirements.

REVIEW OF CLINICAL EFFECTIVENESS 2013/14

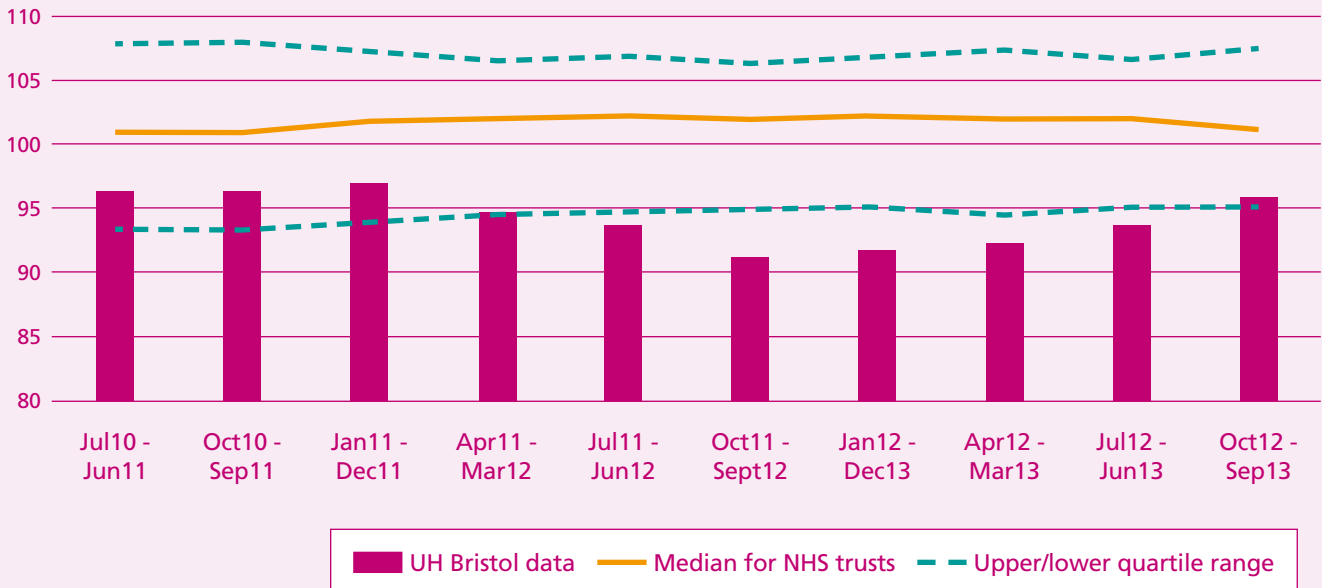
This section explains how the Trust performed during 2013/14 in a number of other key areas relating to clinical effectiveness, which are in addition to the specific objectives that we identified.

Summary Hospital-Level Mortality Indicator (SHMI)
(Mandatory indicator)

The Summary Hospital-Level Mortality Indicator (SHMI) is a measure of all deaths in hospital, plus those deaths occurring within 30 days after discharge from hospital. It should be noted that SMHI does not provide definitive answers: rather it poses questions which trusts have a duty to investigate.

In simple terms, the HSMR 'norm' is a score of 100 – so scores of less than 100 are indicative of trusts with lower than average mortality. In Figure 24, the blue vertical bars are University Hospitals Bristol NHS Trust data, the green solid line is the median for all trusts, and the dashed red lines are the upper and lower quartiles. The graph shows that patient mortality at UH Bristol, as measured using SHMI, is consistently lower than the national norm. The most recent comparative data available to us at the time of writing is for the period October 2012 to September 2013 and shows the Trust as having a SHMI of 95.7.

Summary Hospital Mortality Indicator (SHMI)



Source: CHKS benchmarking

Figure 24

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

Adult Cardiac Surgery Outcomes

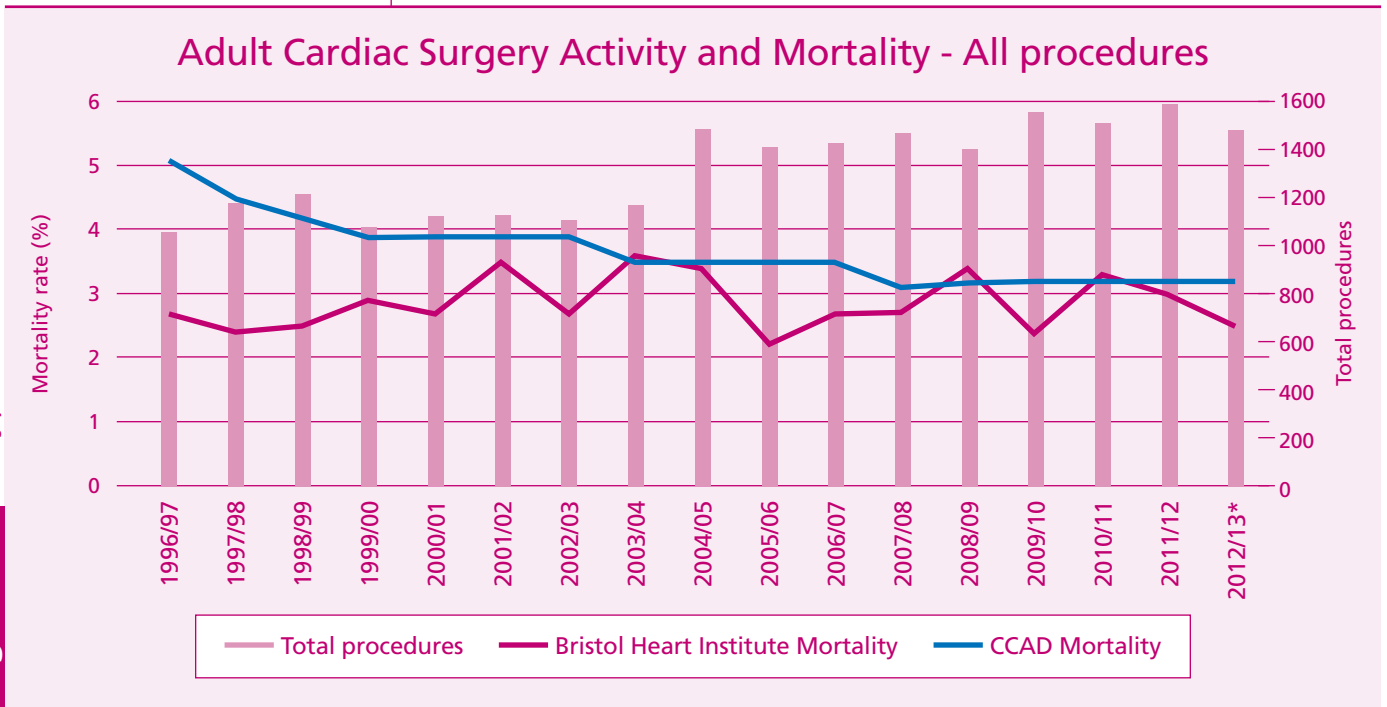
The Bristol Heart Institute is one of the largest centres for cardiac surgery in the United Kingdom. The centre currently performs approximately 1,500 procedures per annum. The Trust has supported a cardiac surgical database

for more than 20 years which now contains information relating to clinical outcomes for more than 25,000 patients. This is an extremely valuable resource for research and audit, service planning and quality assurance. An annual analysis of cardiac outcomes is published and can be viewed in detail on the trust website (<http://www.uhbristol.nhs.uk/about-us/key-publications>).

In general, our adult cardiac outcomes measured in terms of mortality have been better than the UK average for all procedures. Figure 25 shows a pattern of increasing activity and a crude mortality rate which is below the national average. It should be noted that the 2013/2014 data is preliminary at the time of writing (April 2014) as the discharge status of some patients is still awaited.

Source: Central Cardiac Audit Database / Patient Analysis Tracking System

Figure 25



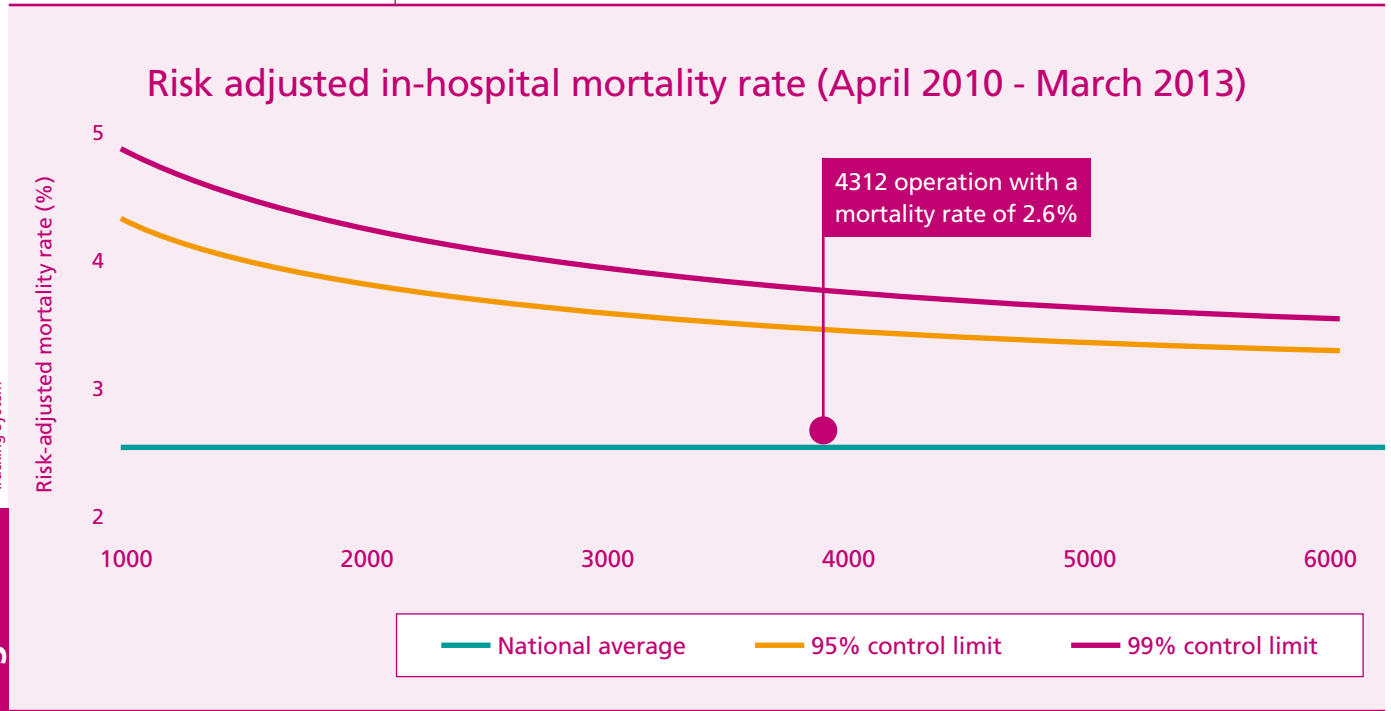
Cardiac surgical outcomes data is collected and analysed under the auspices of the National Institute for Cardiovascular Outcomes Research (NICOR) at University College London. NICOR publishes reports on national cardiac surgery outcomes periodically and these can be viewed at <http://www.ucl.ac.uk/nicor/audits/adultcardiac/reports>. On an annual basis, NICOR provide data for individual surgeons and for the organisation as a whole using national contemporary comparators.

Figure 26 is a funnel plot of crude mortality for all cardiac surgical operations. This data is analysed in three year epochs to ensure the cohort is of adequate size. Alert lines are included at various levels to draw attention to levels of mortality which might be of concern. The outcomes predicted are adjusted to compensate for differences in the risk profile of different centres. Figure 26 shows that for the period 2010-2013, for all cardiac surgical operations and with appropriate risk adjustment, outcomes for patients at UH Bristol was very close to UK average performance.

Adult paediatric surgery outcome data is governed by nationally agreed definitions through NICOR.

Source: Central Cardiac Audit Database / Patient Analysis Tracking System

Figure 26



Paediatric Cardiac Surgery Outcomes

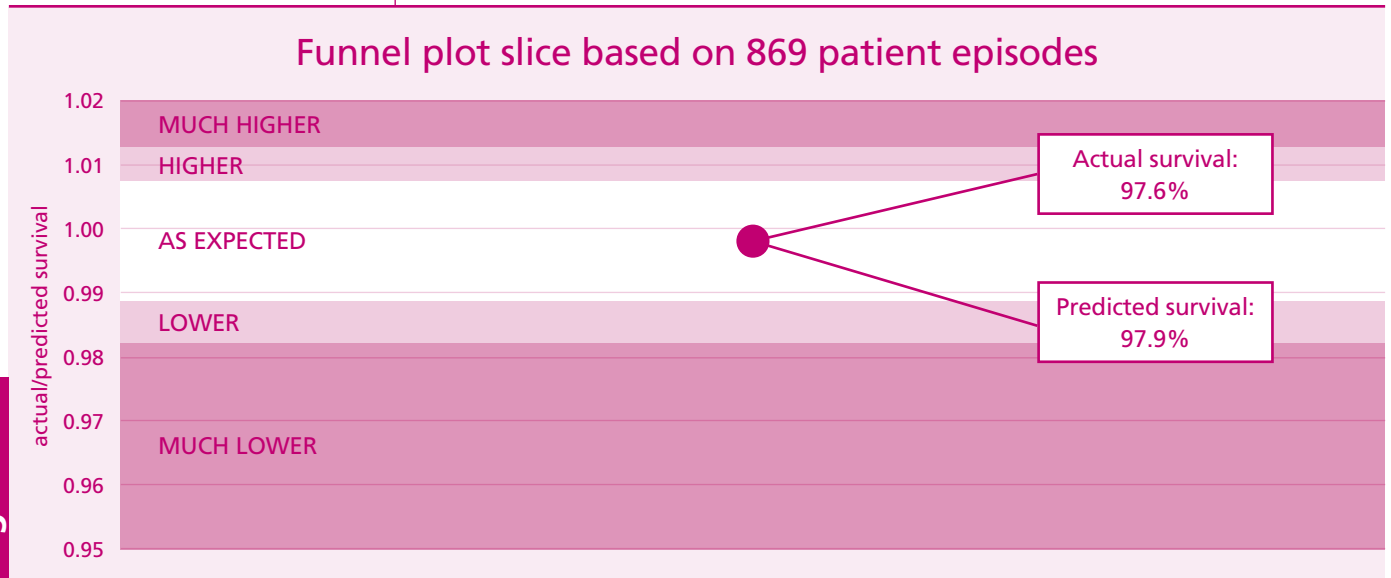
The Bristol Royal Hospital for Children (BRHC) provides a congenital cardiac service to the whole of the South West of England and South Wales serving a population of 5.5 million people functioning as a network with the cardiac centre at University Hospital of Wales in Cardiff with the Welsh consultants also providing sessions in BRHC. The pathway starts in the antenatal period with close collaboration with fetal cardiology and fetal medicine and transitions into the adult congenital cardiac services provided at the adjacent Bristol Heart Institute.

Patient safety is our priority. We actively seek to learn from incidents and have a positive reporting culture. Mortality from cardiac surgery remains very low and is well within expected limits. Each child death is subject to a child death review to enable any aspects of care to be scrutinised and recommendations made to ensure that we can continually improve our care. We report each death to the Child Death Overview Panel for further scrutiny and where appropriate to the Coroner.

We have seen approximately 325 surgical cases in each of the last four years. Crude survival has remained constant at approximately 98% which is the same average survival reported over all centres in the country. This has been achieved despite the continuing increase in complexity of cases. Crude survival is however a very coarse demonstration of the quality of outcomes because children born with congenital heart disease frequently have associated co-morbidities that influence their clinical outcome as much as the cardiac defect. Consequently, as risk profiles vary between centres, direct comparison between units is inappropriate. Recently, more sophisticated statistical analysis has been introduced by the National Institute for Cardiovascular Outcomes Research (NICOR) that includes risk-stratification using a scoring system called the PRAiS score. In this analysis, the overall risk of a child dying following cardiac surgery is considered in the context of the risks of a number of independent co-morbidities and this risk is then compared against the centre's own risk profile rather than a pooled national average. The most recent analysis is shown in Figure 27; essentially the expected survival rate following cardiac surgery in Bristol in the period 2010-2013 is exactly what would be expected from the risk profiles of the cases treated.

Paediatric surgery outcome data is governed by nationally agreed definitions through NICOR.

Figure 27



The last year has seen cardiac services in Bristol Royal Hospital for Children come under scrutiny. In 2013, we opened a high dependency area on ward 32 as part of a continual development in service provision and in response to concerns raised previously by the Care Quality Commission. Prior to this, high dependency care was provided on PICU and supported by the PICU outreach team on the ward. An independent review into paediatric cardiac services in Bristol was announced in February 2014 by Professor Sir Bruce Keogh, medical director of NHS England, after he met with a group of families who have expressed concerns about their experience of care in Bristol. Although the precise nature of the review is still to be confirmed, the Trust has welcomed it and hopes that it will restore trust and confidence in the service. Our aim is to work in partnership with the review team and the families themselves, to demonstrate the safety and quality of the service today, and to address any residual concerns that the review may highlight.

³⁴ Data for 12 months prior to and including December 2013

Our ongoing monthly survey of parents of children cared for on ward 32 shows that 98% of parents consistently rate their experience of care as good, very good or excellent³⁴.

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. 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 2012/13 (provisional). The number of UH Bristol patients who underwent varicose vein surgery and returned PROM questionnaires was too small for the data to be publishable due to inherent statistical unreliability and to protect patient confidentiality. In 2012/13, 17 patients returned groin hernia PROM questionnaires in this time period, 70.6% of whom (12/17) scored more highly on the EQ-5D index after surgery than before; this compares with 50.2% in England (10,113/20,161).41.2% of UH Bristol patients (7/17) scored more highly on the EQ-VAS scale after surgery than before; this compares with 37.7% in England (7775/20642).

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. The Trust recognises that gaps in staff and process from October 2012 until November 2013 have meant that PROM participation rates are lower than expected. These issues have been addressed and we are hopeful of improving our response rate for the groin hernia PROM. However, based on the number of varicose vein operations currently being performed at the Trust, it is doubtful whether publishable data will become available for this PROM in the future.

28 day readmissions
(Mandatory indicator)

The Trust monitors the level of emergency readmissions within 30 days of discharge from hospital. Readmission within 30 days is used as the measure, rather than 28 days, to be consistent with Payment by Result rules and contractual requirements. The level of emergency readmissions within 30 days of a previous discharge from hospital was lower in 2013/14 than in the previous year (2.70% in 2013/14 v 3.03% in 2012/13). The most recent national risk adjusted data (2011/12) for the 28-day emergency 'indirectly standardised' readmission rates for patients aged 16 years and above, shows the Trust to be better than average for our peer group (acute teaching trusts). Of the 23 acute teaching trusts for which data is available, the Trust is ranked sixth best (i.e. the sixth lowest readmission rate), with an indirectly standardised emergency readmission rate of 11.15% compared to the median for the group of 11.87% (lower and upper confidence intervals of 10.80% and 11.51% respectively). For patients under the age of 16, the Trust has a standardised readmission rate of 7.8%, which is lower (i.e. better) than the national median readmission rate of 8.4%, despite the Trust's case-mix being biased towards the more complex cases. The readmission rates for both age groups are significantly lower than that of the previous reported year, with the readmission rate for patients aged 16 years and over dropping from 11.93% in 2010/11 to 11.15% in 2011/12, and from 8.2% in 2010/11 for patients under the age of 16 to 7.8% in 2011/12.

The Trust considers its readmission data is robust because of the data quality checks that are undertaken, as detailed in the Trust's data quality framework. These includes checks on the completeness and quality of the clinic coding, checks conducted of the classification of admission types and lengths of stay as recorded on the patient administration system, and the reviews undertaken of the data quality returns on the commissioning data sets received from the secondary uses service.

The Trust continues to review specialty-level benchmarking data through its Quality Intelligence Group, to monitor and improve readmission rates, and so the quality of its services. Where specialties are identified as having higher readmission 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 readmissions.

Objectives for 2014/15



We have applied a different approach this year in determining our annual quality objectives. In recent years, we have set ourselves a large number of goals, many of which we have achieved. In some cases, objectives have been continued from one year to the next as part of continuous improvement. This year we felt that these recurring objectives should be seen as “business as usual” and that we should instead focus on a much smaller number of objectives that have the potential to genuinely transform patient care. Following a public consultation event in January 2014, an on-line survey which attracted over 200 responses (including from staff) and in discussion with our governors, we have agreed five objectives:

Reducing numbers of cancelled operations

Cancelled operations are a waste of time and resources; and the process of cancelling operations is distressing and inconvenient for patients. Our aim is to significantly reduce the number of last minute cancellations (i.e. on the day of admission) for non-clinical reasons.

Minimising patient moves between wards, including out of hours

Risks of healthcare associated infection are greatly increased by the extensive movement of patients. We also know from patient feedback that moves between wards for non-clinical reasons impact adversely on their experience of care. Our aim is to reduce the average number of ward moves per patient (excluding assessment and observation wards), measured using a baseline which we will establish using data gathered in the first quarter of 2014/15. We also want to ensure that no patients are moved out-of-hours other than for clinical reasons.

Ensuring patients are treated on the right ward for their clinical condition

There is emerging evidence of a correlation between increased mortality and the practice of ‘outlying’ patients³⁵. Our aim is to reduce the number of days patients spend as ‘outliers’ using a baseline which we will establish using data gathered in the first quarter of 2014/15.

Ensuring no patients are discharged from our hospitals out of hours

Our aim is to ensure that no patients are discharged out of hours, as defined in our hospital discharge policy³⁶.

We will achieve these four objectives through implementation of five key executive-led transformation projects:

³⁵ NHS Institute for Innovation and Improvement

³⁶ Currently 10pm – 7am

- Creation of integrated discharge services, co-locating organisations responsible for managing patients with complex care needs
- Commissioning of out of hospital transitional care beds
- Earlier supported discharge pathways; a Trust-wide review of critical care services
- Implementation of an operational model which enables elective and urgent tertiary activity to continue during periods of high demand for acute medical care through the emergency department.

Reviewing and refreshing the Trust's approach to patient and public partnership

The Trust has a strong record of patient and public involvement, but we recognise that this involvement is not always systematic and mainstreamed within the organisation. In 2014/15, we will undertake at least two significant pieces of work, one of which will focus on the experience of a 'seldom heard' patient group (to be determined during quarter 1 of the year), and use these as a basis for developing a new model of engagement for wider implementation.

How we will monitor our quality objectives

The four objectives relating to patient flow will be owned by the Trust's transformation board. The objectives about patient and public partnership will be overseen by the Trust's patient experience group. Progress in achieving all five quality objectives will additionally be monitored via the Board Assurance Framework and detailed quarterly reports to the Trust's Clinical Quality Group and the Quality and Outcomes Committee of the Board.

Performance against key national priorities



Summary of performance against national priorities and access standards

In the 2013/14 Annual Plan, risks to compliance with the Accident and Emergency 4-hour standard, the *Clostridium difficile* quarterly trajectory and the Referral to Treatment Time (RTT) Non-admitted standard were declared. This gave the Trust an Annual risk rating of Amber-Red. The Trust held an Amber-Red Governance Risk Rating during the first two quarters of the year. Following the introduction of the new Risk Assessment Framework, which came into effect on the 1st October 2013, the Trust achieved a Green rating in quarter 3. Disappointingly, the Trust triggered the criteria for potential escalation in quarter 4, with a Service Performance Score of 4.0 and repeated failure against three standards (*Clostridium difficile*, A&E 4-hours and RTT Non-admitted standard). At the time of this report, the Trust is awaiting the outcome of this anticipated escalation.

Last year proved to be another challenging year for the Trust, although improvements in performance against the national standards continued to be made in some key areas, in particular healthcare associated infections. Whilst the target reduction in the annual number of *Clostridium difficile* infections was not achieved, there has been a 21% reduction in *Clostridium difficile* infections in 2013/14 compared with 2012/13. Although the Department of Health target of zero MRSA (Meticillin Resistant *Staphylococcus Aureus*) bacteraemias was not achieved in 2013/14, material reductions in the number of cases were also realised, from the 10 reported in 2012/13 to one confirmed case in 2013/14³⁷.

The waiting times standards for the treatment patients within 18 weeks of referral (Referral to Treatment Times - RTT) were achieved in each month of the year for patients requiring an admission as part of their treatment (admitted pathways), and also for those patients not yet treated and waiting at month-end (ongoing pathways). However, the standard for patients not requiring an admission for their treatment within 18-weeks (non-admitted pathways) was only achieved in the first quarter of the year. This was due to a combination of long waiting times for patients that were transferred to the Trust as part of the Head & Neck service transfer from North Bristol NHS Trust, but also lengthening waits in a number of specialties for first outpatient appointments, due to rising demand. Overall, performance against the cancer waiting times standards remained strong, with seven of the eight national standards being achieved in every quarter. The 62-day wait from referral to treatment for patients referred by their GP with a suspected cancer, was not achieved in quarters 2 and quarter 4. The standard was achieved in quarters 1 and 3 with agreed reallocation of breaches of standard to other providers, following late referral. Further details of the analysis of the causes of the failure of this standard are provided in extended narrative section of this report. A programme of rapid improvement work was

³⁷ Although two MRSA bacteraemias were formally reported in 2013/14, one was a contaminated sample, with the patient being confirmed as negative for MRSA on repeated testing.

instigated at the end of quarter 2 to address the leading causes of breaches of cancer waiting times standards, as identified through reviews of individual breaches. This work will continue to be progressed in 2014/15. Following the work undertaken in 2012/13 to reduce delays to specialist screening practitioner appointments and colonoscopy diagnostic procedures, significant improvements in performance were seen against the 62-day standard for screening referred patients in 2013/14, with the standard being achieved in every quarter.

Disappointingly, the Trust failed to achieve maximum 4-hour wait in A&E for at least 95% of patients in three quarters of the year, but did achieve the national standard in six individual months. The failure to achieve the 95% standard for the year as a whole was despite a significant programme of improvement work undertaken on patient flow during the year. Improvements in key measures of patient flow and patient experience have, however, been demonstrated. These include a reduction in ambulance hand-over delays (46% reduction in delays in December, and a 60% reduction in delays in January, compared with the same month last year), 33 fewer last-minute cancellations due to ward bed availability in 2013/14 compared with 2012/13, and a 26% reduction (between October and March) in the number of days patients spent outlying from their correct specialty ward, compared with the same period in the previous year.

In quarter 4 the Trust launched a programme of seven projects to be taken forward as part of the Trust's 2014/15 operating model, led by the Trust's senior leadership team. These projects build upon the work already undertaken as part of the patient flow programme. The Trust did not achieve the national standard for operations cancelled at the last minute for non-clinical reasons, but unlike last year, reductions in cancellations were realised, primarily through improved ward bed availability. The planned programme of work on patient flow should significantly improve bed availability, which was the leading cause of last-minute cancellations of surgery in those months when the 0.8% national standard was not achieved.

Full details of the Trust's performance in 2013/14 compared with 2013/12 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 and other key targets is provided overleaf.

Extended narrative about national access targets

18 weeks Referral to Treatment (RTT)

The Trust achieved a maximum wait of 18 weeks from Referral to Treatment for over 90% of patients requiring an admission for treatment, in every month in 2013/14. In addition, the Trust achieved the target for patients whose RTT clock had not yet stopped, with over 92% of patients waiting less than 18 weeks at each month-end. The Trust only achieved the standard of at least 95% of patients that don't require an admission as part of their treatment waiting less than 18 weeks from referral, in quarter 1 in 2013/14. This dip in performance followed the transfer of the Head & Neck service from North Bristol NHS Trust in March 2013, with more patients transferring, and more patients having a longer waiting time than expected, at the point of transfer. In addition, there was a significant rise in the level of outpatient referrals during 2013/14, which has resulted in waiting times for first outpatient appointments lengthening. During quarter 4, work has been undertaken to re-assess the level of capacity required to meet this new level of demand. Target waiting times for new outpatient appointments have also been reviewed, from which weekly activity plans have been generated. These plans will be enacted during quarters 1 and 2, following which the non-admitted standard should be achieved again from the start of quarter 3.

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. As in 2012/13, performance was below the national standard in quarters 1, 3 and 4. Despite the failure to achieve the 4-hour standard in these three

Performance against national standards

National standard	2011/12	2012/13	2013/14 target	2013/14 ³⁸	Notes
A&E maximum wait of 4 hours	96.0%	93.8%	95%	93.7%	Target met in 1 quarter in 2013/14 (Q2)
A&E Time to initial assessment (minutes) 95th percentile within 15 minutes	26	57	15 mins	15	Target met in 3 quarters in 2013/14 (not Q1)
A&E Time to Treatment (minutes) median within 60 minutes	20	53	60 mins	52	Target met in every quarter in 2013/14
A&E Unplanned re-attendance within 7 days	1.7%	2.6%	< 5 %	1.6%	Target met in every quarter in 2013/14
A&E Left without being seen	1.0%	1.9%	< 5%	1.8%	Target met in every quarter in 2013/14
MRSA Bloodstream Cases against trajectory	4	10	Trajectory	2	One of the two cases was a contaminated sample only
C. diff Infections against trajectory*	54	48	Trajectory	38	Cumulative target failed in each quarter in 2013/14
Cancer - 2 Week wait (urgent GP referral)	95.9%	95.0%	93%	96.6%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (First treatment)	98.1%	97.0%	96%	96.9%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Surgery)	96.7%	94.9%	94%	95.1%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Drug therapy)	99.9%	99.8%	98%	99.8%	Target met in every quarter in 2013/14
Cancer - 31 Day Diagnosis To Treatment (Subsequent Radiotherapy)	99.3%	98.7%	94%	97.6%	Target met in every quarter in 2013/14
Cancer 62 Day Referral To Treatment (Urgent GP Referral)*	87.0%	84.1%	85%	80.7%	Target met in 2 quarters in 2013/14 (not Q2 or Q4)
Cancer 62 Day Referral To Treatment (Screenings)	94.4%	90.0%	90%	93.7%	Target met in every quarter in 2013/14
18-week Referral to treatment time (RTT) admitted patients	91.7%	92.6%	90%	92.7%	Target met in every month in 2013/14
18-week Referral to treatment time (RTT) non-admitted patients	97.9%	95.7%	95%	93.1%	Target met in every month in 1 Q1 2013/14
18-week Referral to treatment time (RTT) incomplete pathways	N/A	92.2%	92%	92.5%	Target met in every month in 2013/14
Number of Last Minute Cancelled Operations	0.87%	1.13%	0.80%	1.02%	Target failed in each quarter in 2013/14
28 Day Readmissions (following a last minute cancellation) ³⁹	93.3%	91.1%	95%	89.6%	Target failed in each quarter in 2013/14
6-week diagnostic wait	99.5%	89.7%	99%	98.6%	Target failed in 3 quarter in 2013/14 (achieved in Q3)
Primary PCI - 90 Minutes Door To Balloon Time	91.0%	91.7%	90%	92.9%	Target met in every quarter in 2013/14
Infant Health - Mothers Initiating Breastfeeding ⁴⁰	76.2%	80.6%	76.3%	81.6%	Target met in every quarter in 2013/14

Table 6

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

* defined in Appendix C

³⁸ Due to the timing of this report the figures shown in the above table are for the year to date ending March 2014, with the exception of cancer and primary PCI, which are up to and including February 2014.

³⁹ 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

⁴⁰ The Infant Health standard shown is a target set by the Trust

quarters, there have been some demonstrable improvements in key aspects of patient flow, including a reduction in ambulance hand-over delays, the number of last-minute cancellations due to ward bed availability, and the number of bed-days patients spend outlying from their correct specialty ward. The Trust also achieved each of the A&E clinical quality indicators, in particular showing an improvement in performance against the 15-minute Time to Initial Assessment for patients arriving by ambulance.

During each month in 2013/14, the level of ambulance arrivals was significantly higher than the same month in the previous year, averaging a 9% increase year-on-year. However, the level of emergency admissions remained similar to that in previous years within the Bristol Royal Infirmary, which is thought to be a result of the ambulatory care unit being able to manage appropriate patients without an admission to hospital. Although the number of emergency admissions did not increase, the proportion of over 75 year olds being admitted rose during the winter of 2012/13 and remained at these levels into quarter 1 2013/14. A further 8% increase on the 2012/13 winter levels was experienced during the winter of 2013/14. 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 was a main contributor to the dip in performance in each quarter in 2013/14.

In the Bristol Royal Hospital for Children, the increased level of ambulance arrivals was associated with an increase in emergency admissions via the emergency department, with levels increasing by an average of 39% across November and December 2013, relative to the same period in the previous year. This level of increase in emergency admissions is exceptional and resulted in record high levels of admissions. This was due to the high levels of respiratory illness in the community, which mirrored the national picture. This led to significant bed pressures, which heavily contributed to the failure to achieve the A&E 4-hour standard in quarter 3 at a Trust level.

The Trust's senior leadership team has initiated a review of the Trust's operating model for adult services, which includes seven projects aimed at improving the efficiency with which the Trust operates. This programme of work focuses on a range of initiatives aimed at improving patient flow, including the development of discharge services integrated with Bristol City Council and Bristol Community Health, to promote better ways of working between the three organisations responsible for managing patients with complex health needs, the commissioning of more out of hospital beds, establishing early supported discharge pathways, and a Trust-wide review of Critical Care. This work programme will not only help to reduce extended stays in hospital and demand for beds, especially from elderly patients that have the most complex of care needs, but it will also help to improve quality of care and patient experience. Reducing pressure on beds will also improve flow through the front door of the hospital, and in so doing support the Trust in recovering performance against the A&E 4-hour target.

Cancer

As reported in the summary section above, performance against seven of the eight key national cancer waiting times standards remained strong in 2013/14, with full achievement of these seven standards in every quarter of the year. The 62-day wait from GP referral with a suspected cancer to treatment failed to be achieved in quarter 2 or quarter 4. This was due to a combination of high volumes of the more 'unavoidable' causes of breaches of standard, such as late referrals from other providers, clinical complexity, and patient choice to delay diagnostics and treatments, but also some more avoidable causes of breaches, such as elective cancellations due to critical care capacity, delays in outpatients for certain specialties and delays to admitted diagnostic procedures being booked due to capacity constraints. Unlike in 2013/14, the 62-day wait from referral to cancer treatment for patients referred from one of the three national screening programmes was, however, achieved in each quarter. This follows the sustained reduction in waiting times for the initial specialist screening practitioner appointments (SSP), and colonoscopy diagnostic procedures, as a result of work undertaken to reduce delays in the latter half of 2012/13. Following the transfer-out of the high performing breast and urology cancer services,

and the transfer in of the head and neck cancer service at the end of 2012/13, the Trust now has a more complex portfolio of cancer services. In combination with increasing levels of breaches due to late referral by other providers, medical deferral and patient choice to delay pathways, consistent achievement of the 62-day standard will require performance significantly above the national average in most tumour sites. A rapid improvement group was established at the end of quarter 2 in order to effect improvements in those pathways for which breach analysis had identified avoidable causes of breaches. Improvements in performance were demonstrated in quarter 3, across a range of tumour sites. However, there was a deterioration in performance during quarter 4. This was primarily due to a further increase in the number and proportion of breaches attributed to unavoidable reasons, increasing from 49% in quarter 2 to 69% in quarter 4. Further improvement work will be undertaken in 2014/15, using the information gained from the monthly review of the causes of breaches, and learning from other organisations obtained from telephone interviews conducted with better performing equivalent providers.

Other standards

During 2013/14, the Trust cancelled 1.02% of operations on the day of the procedure for non-clinical reasons, such as bed availability and emergency patients need to take priority. This represents an improvement on 2012/13 when 1.13% of procedures were cancelled. This improvement was primarily due to a reduction in cancellations due to the lack of a ward bed being available, and reflects the significant programme of work on improving patient flow, implemented during the year. However, the lack of a ward bed resulted in higher levels of cancellations in January and February 2014 in particular. The lack of a critical care bed also resulted in a high level of cancellations relative to that seen in previous years. The programme of work developed to support the 2014/15 operating model should further improve both ward and critical care bed availability in 2014/15 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 Bristol Clinical Commissioning Group. This made reference to the failure to achieve the RTT, 4-hour and cancer standards, as outlined in the summary above, but also the failure to consistently meet the standard of 99% of diagnostic tests being carried-out within six weeks of referral. Significant improvements in performance have been realised in 2013/14, with performance against the 6-week diagnostics standard increasing from 89.7% in 2012/13 to 98.6% in 2013/14. This was a result of service capacity for gastrointestinal endoscopies being increased to meet the higher level of demand. Following further work to increase capacity in services such as cardiac stress echo and cardiac MRI scanning, which have also seen a significant recent growth in demand, the 99% standard was achieved for quarter 3 2013/14 as a whole. However, further work is being undertaken to ensure a more consistent performance against the standard in 2014/15.

In 2013/14, the Trust reported further improvements in the percentage of mothers initiating breast feeding, from 80.6% to 81.6%. Improvements were also reported in the door to balloon 90 minute reperfusion standard. The reperfusion standard relates to a procedure that is carried-out to improve blood flow to the heart. A catheter is inserted into a blood vessel in the groin or arm and then moved up to near the heart, through which a small balloon is inflated to squash the fatty plaques or deposits in the blood vessel to improve blood flow to the heart. 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, 92.9% of patients received reperfusion within the 90 minute standard, compared with 92.4% in 2012/13. The call to balloon times 150 minute standard measures the time from the call for professional help through to the commencement of reperfusion treatment. As in 2012/13, the Trust failed to meet the 90% local stretch target. However this continued to reflect 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 2013/14, University Hospitals Bristol NHS Foundation Trust provided clinical services in 70⁴¹specialties via five clinical Divisions (i.e. Medicine; Surgery, Head & Neck Services; Women's & Children's Services; Diagnostics and Therapy; and Specialised Services).

During 2013/14, the Trust Board has reviewed selected high-level quality indicators (e.g. infection control, SHMI) 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 2013/14 therefore, in these terms, represents 100% of the total income generated from the provision of NHS services by the Trust for 2013/14.

⁴¹ 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)

2. Participation in clinical audits and national confidential enquiries

For the purposes of Quality Accounts and Reports, the Department of Health publishes an annual list of national audits and confidential enquiries, participation in which is seen as a measure of quality of local clinical audit programmes. This list is not exhaustive, but rather aims to provide a baseline for trusts in terms of percentage participation and case ascertainment⁴². The information which follows relates to this list.

During 2013/14, 39 national clinical audits and three national confidential enquiries covered NHS services that University Hospitals Bristol NHS Foundation Trust provides. During that period, the Trust participated in 95% (37/39) 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 2013/14 are as follows:

⁴² i.e. the number of individual patents we submit data on compared to how many we should have submitted data on (usually outlined through Hospital Episode Statistics or similar)

Name of audit / Clinical Outcome Review Programme	Eligible	Participated
Acute		
Case Mix Programme (CMP)	Yes	Yes
Emergency use of oxygen (British Thoracic Society)	Yes	No
Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death	Yes	Yes
National Audit of Seizures in Hospitals (NASH)	Yes	Yes
National emergency laparotomy audit (NELA)	Yes	Yes
National Joint Registry (NJR)	Yes	Yes
Paracetamol overdose (care provided in emergency departments)	Yes	Yes
Severe sepsis and septic shock	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
Cardiac Rhythm Management (CRM)	Yes	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	Yes
Coronary angioplasty	Yes	Yes
National Adult Cardiac Surgery Audit	Yes	Yes
National Cardiac Arrest Audit (NCAA)	Yes	Yes
National Heart Failure Audit	Yes	Yes
National Vascular Registry	Yes	Yes
Long term conditions		
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)*	Yes	Yes
Diabetes (Paediatric) (NPDA)	Yes	Yes
Inflammatory bowel disease (IBD)	Yes	Yes
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Yes	Yes
BTS Paediatric bronchiectasis (British Thoracic Society)	Yes	No
Renal replacement therapy (Renal Registry)	Yes	Yes
Rheumatoid and early inflammatory arthritis**	Yes	Yes
Older people		
Falls and Fragility Fractures Audit Programme (FFFAP)	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 clinical outcome review programme (CHR-UK)	Yes	Yes
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes
Moderate or severe asthma in children (care provided in emergency departments)*	Yes	Yes
Neonatal intensive and special care (NNAP)	Yes	Yes
Paediatric asthma	Yes	Yes
Paediatric intensive care (PICANet)	Yes	Yes

* Organisational aspects only

The Trust did not participate in two national audits under the auspices of the British Thoracic Society and is undertaking relevant local audit activity instead.

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 2013/14, 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	
Case Mix Programme (CMP)	1190*
National Audit of Seizures in Hospitals (NASH)	100% (30/30)
National Joint Registry (NJR)	98% (49/50)
Paracetamol overdose (care provided in emergency departments)	100% (50/50)
Severe sepsis & septic shock	100% (50/50)
Severe trauma (Trauma Audit & Research Network, TARN)	68% (200/294)
Blood and Transplant	
National Comparative Audit of Blood Transfusion programme	38*
Cancer	
Bowel cancer (NBOCAP)	94% (162/173)
Head and neck oncology (DAHNO)	90*
Lung cancer (NLCA)	80% (144/180)
Oesophago-gastric cancer (NAOGC)	99% (149/150)
Heart	
Acute coronary syndrome or Acute myocardial infarction (MINAP)	985*
Cardiac Rhythm Management (CRM)	100% (792/792)
Congenital heart disease (Paediatric cardiac surgery) (CHD)	100% (742/742)
Coronary angioplasty	100% (1423/1423)
National Adult Cardiac Surgery Audit	100% (1481/1481)
National Cardiac Arrest Audit (NCAA)	133*
National Heart Failure Audit	100% (403/403)
National Vascular Registry	98% (145/148)
Long term conditions	
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	99% (100/101)
Diabetes (Paediatric) (NPDA)	1354*
Inflammatory bowel disease (IBD)	100% (40/40)
Older people	
Falls and Fragility Fractures Audit Programme (FFFAP)	345*
Sentinel Stroke National Audit Programme (SSNAP)	100% (121/121)
Other	
Elective surgery (National PROMs Programme)	27% (33/122)
Women's & Children's Health	
Moderate or severe asthma in children (care provided in emergency departments)	100% (50/50)
Neonatal intensive and special care (NNAP)	100% (2739/2739)
Paediatric intensive care (PICANet)	100% (671/671)

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

The reports of ten national clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2013/14. The Trust is taking the following actions to improve the quality of healthcare provided:

College of Emergency Medicine (CEM) audits

- The Medway system has been altered to allow better electronic capture of data relating to consultant review or discussion.

- Monthly reporting against the CEM quality standard has been introduced to inform further actions required by pinpointing times / days when standards are less likely to be adhered to.

National Audit of Dementia

- A care pathway for frail older people which incorporates people with a dementia will be developed. Access to intermediate care services to allow people with dementia to be admitted to intermediate care directly will be part of this review.
- A review of the model of care for the older adult admissions wards is to be undertaken.
- A clinical guideline is being developed to ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation using a recognised tool (confusion assessment method).
- An electronic discharge summary for all patients who are 75 years and over will be developed which contains mandatory fields to include abbreviated mental test score, cause of cognitive impairment, symptoms of delirium, and behavioural and psychological symptoms of dementia.

National Cancer Audits

- Significant progress has been made with the lung, bowel and head and neck audits in 2013. All three audits returned their best ever standard of submission in terms of data completeness and quality.
- Easy format written guidance on data entry has been produced, along with reports that allow multidisciplinary team coordinators to easily identify and rectify data gaps, and their managers to monitor this. This system has received positive feedback from coordinators and clinicians.
- All national audit submissions have undergone clinical quality assurance prior to submission. Monthly submission has been introduced along with a robust system for identifying 'rejected' records enabling these to be quickly fixed.
- The Trust's cancer manager continues to work closely with the Somerset Cancer Register to ensure the best use of the register and influence its development.

National Diabetes Audit (NADIA)

- Increased diabetes specialist nursing input was allocated via CQUIN funding to help improve the care that diabetic patients receive as inpatients.

National Cardiac Arrest Audit (NCCA)

- All cardiac arrests are now reported on the Trust incident reporting system (Ulysses Safeguard) to enable learning from these incidents.

Falls and Fragility Fractures Audit Programme - National Hip Fracture Database

- The appointment of a specialist hip fracture nurse (and audit nurse responsible for data) has resulted in a significant improvement in data quality, and patient care as a whole.
- A business case was approved and implemented to increase ortho-geriatrician input, increase trauma theatre allocation and implement direct access beds.

National Vascular Registry

- A written pathway of care for Transient Ischaemic Attacks (TIAs) and non-disabling stroke for Bristol Bath and Weston Vascular Network is being developed to ensure that the agreed protocol for referral is followed to help avoid any unnecessary delay.

National Neonatal Audit Project

- A preterm breast feeding project has been started aiming to improve rates of breastfeeding at discharge.

The outcome and action summaries of 205 local clinical audits were reviewed by University Hospital Bristol NHS Foundation Trust in 2013/14; summary outcomes and actions reports are reviewed on a bi-monthly basis by the Trust's Clinical Audit Group. Details of the changes and benefits of these projects will be published in the Trust's Clinical Audit Annual Report for 2013/14⁴³.

⁴³ Available via the Trust's internet site from July 2014

3. Participation in clinical research

Developing and delivering research of the highest quality to improve outcomes for patients is at the centre of what we do at University Hospitals Bristol NHS Trust. Research is embedded within the care we provide and our aim is to offer the chance to participate in research to as many of our patients as we can. As evidence of our continued commitment to providing research to our patients, the number of patients receiving relevant health services provided or sub-contracted by University Hospitals Bristol NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 9739 and 86% of these were recruited into NIHR research. We currently have 775 active research projects, 85 of which are our own sponsored trials which include clinical trials of investigational medicinal products and other interventional trials in areas such as surgery. We recognise that the speed with which research is set up impacts on how quickly we can gather the evidence to change patient care. We have been working hard to improve our set up times: as testament to this, there were three international studies in 2013/14 where the Trust was first to recruit patients.

We believe that strong collaborations underpin our ability to deliver effective healthcare through research across our region. We were therefore delighted that UH Bristol was selected as the host NHS Trust for the new Clinical Research Network: West of England, which launched in April 2014 and will be the local branch of the NIHR for the region. We also saw further exciting developments with UH Bristol awarded the hosting of the CLAHRC West (Collaboration for Leadership in Applied Health Research & Care), which will bring £9 million in new funding to the region. CLAHRC West will increase the scale and pace of translating research into practice and implementation of novel applied health research findings, and will support clinicians and researchers in changing the way services are provided across the region.

Alongside our two biomedical research units – Cardiovascular and Diet, Lifestyle and Nutrition - which support the translation of basic research into patients, UH Bristol-led research continued to grow in 2013/14 with seven project and programme grants awarded and two grants opened to recruitment. This included the work of Sarah Hewlett, Arthritis Research UK Professor of Rheumatology Nursing. Her work on fatigue associated with rheumatoid arthritis which patients had considered to be an overwhelming problem that was previously ignored by health care teams, has led to international consensus that fatigue must be measured in all clinical trials of rheumatoid arthritis treatments, putting it firmly on the international research agenda. As a continuation of this the research team is currently recruiting to a multi-site research trial led from UH Bristol to test a potential therapy for reducing arthritis fatigue.

4. CQUIN framework (Commissioning for Quality and Innovation)

A proportion of University Hospitals Bristol NHS Foundation Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between University Hospitals Bristol NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The amount of potential income in 2013/14 for quality improvement and innovation goals was approximately £10.32 million, based on the sums agreed in the contracts.

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/>.

In line with national guidance, in order to qualify for CQUIN payments in 2013/14, the Trust had to satisfy at least 50% of the pre-qualification criteria applicable to the Trust, namely demonstrating that plans/trajectories were in place for: intra-operative fluid management, international and commercial activity, Digital First, and carers for people with dementia. Commissioners confirmed that the Trust had met these criteria.

The CQUIN goals were chosen to reflect both national and local priorities. Twenty

seven CQUIN targets were agreed, covering more than 60 measures. There were four nationally specified goals: Friends and Family Test (expand coverage; improve response rate and improve performance on staff test), NHS Safety Thermometer (reduce incidence of pressure ulcers); venous thromboembolism (increase percentage of patients risk assessed and ensure a root cause analysis performed in all hospital acquired cases); dementia care (improve case finding and referral for emergency admission; provide clinical leadership and education; provide support to carers).

The Trust achieved 19 of the 27 CQUIN targets and eight in part, as follows:

- NHS Safety Thermometer
- Venous thromboembolism (VTE)
- Intra operative fluid management (High Impact Innovation)
- Digital First (High Impact Innovation)
- End of life care: preferred place of death
- Medication errors
- Cancer treatment summaries
- Deteriorating patient
- Inpatient diabetes specialist nurse
- Adult learning disability
- Children's learning disability
- Quality dashboards
- Neonatal breast feeding
- Paediatric Intensive Care Unit: minimise number of patients accidentally extubated
- Paediatric Intensive Care Unit: prevention of unplanned readmissions in 48 hours
- BMT donor acquisition measures
- Cardiology access to catheter laboratory within 24 hours
- Radiotherapy increased access to Image Guided Radiotherapy (IGRT)
- Haemophilia, ensuring patients have joint scores
- Friends and Family Test (in part)
- Dementia (in part)
- Patientflow measures (in part)
- System flow measures (in part)
- Nutrition and dietetics (in part)
- Enhanced recovery (in part)
- Transition (in part)
- Cardiac inpatient waits less than 7 days (in part)

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 three CQC inspections during 2013/14.

On 26 April 2013, the CQC inspected maternity services (St Michael's Hospital) and Ward 32 (Bristol Royal Hospital for Children) in order to check that the Trust had implemented action plans and achieved compliance following a previous scheduled inspection (Outcome 13, staffing, in maternity services) and responsive review (Outcome 4, care and welfare of people who use services and 14, supporting staff, on Ward 32). The Trust was found to be compliant.

On 19 November 2013, the CQC undertook a responsive review of theatres and adjacent areas in the Bristol Royal Hospital for Children. The CQC concluded that the Trust was non-compliant with Outcome 8 (cleanliness and infection control) and Outcome 16 (assessing and monitoring quality of service provision). The subsequently agreed action plan has been completed and the Trust is currently awaiting re-inspection to test compliance.

On 22 January 2014, the CQC visited the Trust's main site as part of a national themed inspection of dementia care. The CQC inspection team's report noted a number of areas of good practice, but also that practice in some aspects of dementia care was inconsistent. The CQC concluded that the Trust was

non-compliant with Outcome 4 (care and welfare of people who use services). An action plan has been submitted to the CQC with the majority of actions scheduled for completion by the end of June 2014.

The CQC has not taken enforcement action against the Trust in 2013/14 or issued any formal outlier alerts. University Hospitals Bristol NHS Trust's most recent CQC Intelligent Monitoring report lists the Trust in Band 6, i.e. the CQC's lowest (best) inspection risk band.

6. Data quality

University Hospitals Bristol NHS Foundation Trust submitted records during 2013/14 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: 99.4% for admitted patient care; 99.7% for outpatient care; and 96.0% for accident and emergency care (these values are the same as in 2012/13 for outpatients but higher for both admitted patients and A&E which improved from 93.7% in 2012/13).
- which included the patient's valid General Practice code was: 99.9% for admitted patient care; 99.9% for outpatient care; and 99.4% for accident and emergency care.

(Data source: NHS Information Centre, SUS Data Quality Dashboard, April 2013 - January 2014 as at Month 10 inclusion date)

The Trust's 2013/14 score for Information Quality (Secondary Use Assurance) in the Information Governance Toolkit was 87%. The Information Governance Assessment Report overall score was 85% and was graded green.

University Hospitals Bristol NHS Foundation TRUST was subject to the Payment by Results clinical coding audit during 2013/14 by Capita Health (which has replaced the Audit Commission).

The audit covered 200 Finished Consultant Episodes. The audit was for 100 admissions in the single Healthcare Resource Group (HRG) of CZ (Mouth, Head, Neck and Ear) and 100 cases admitted via A&E with a length of stay of zero days. The following levels of accuracy were achieved:

- Primary procedure accuracy: 94.5%
- Primary diagnosis accuracy: 95.5%

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

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

- The data quality programme involves a 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 Risk Management Group for appropriate action.
- Internal Audit has audited a sample of outpatient areas to check the accuracy of outpatient data on the Medway Patient Administration System this year. Results to be finalised.

APPENDIX B

Feedback about our Quality Report

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

The Council of Governors again welcomes the opportunity to make comment on the Trust's quality report on patient safety, patient experience and clinical effectiveness for all service users.

Governor involvement

The Trust's Council of Governors receives reports relating to quality issues from its governor groups and challenges the Trust Board to account for any failings in the quality of care.

Early in 2014 the governors Quality Project Focus Group contributed suggestions on the format and content of the report. The group is chaired by the Deputy Chief Executive with the Medical Director and the Chief Nurse also in attendance. It meets every two months and reviews the Trust's quality and access performance as a standing agenda item using the data in the most recent board reports together with any views from personal observation and reports from members and users of our services.

Comments about the Quality Report

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. This Quality Report examines the Trust performance against the targets it set itself last year. The final section outlines objectives for further service improvement during next year, 2014/15. We think that this is the right approach in that it facilitates comparisons year to year.

Overview

Opening paragraph could state the relationship UH Bristol has with the two Universities, in terms of teaching, learning, education and research / clinical based evidence practice. Quality objectives are set out on page 4 of the report and shows an overall improvement in quality, which is to be commended. A further breakdown of each of the 16 quality objectives has been provided on subsequent pages of the report. From the initial presentation of how UH Bristol performed against each of quality indicators, it is pleasing to see an overall improvement in care, particularly in:

- Reduce hospital-acquired healthcare infections (although the *Clostridium difficile* average for UH Bristol is still above the national average (table 2)).
- Reduce medication errors.
- Improve the early identification and escalation of care of deteriorating patients (particularly post-Francis / Keogh etc).
- Ensure that patients continue to be treated with kindness and understanding on our wards.
- Achieve best practice tariff for hip fractures management.
- Patients with diabetes have improved access to specialist support.
- Patient centred care is offered to those patients who may require it the most.
- Establish a baseline for clinical outcome data within the Trust.

It is also helpful to have some background in terms of the rationale behind the inclusion of table 2 (page 5) and it is acknowledged that this table is still incomplete at the point of publication of version 2.

Patient safety - The NHS Safety Thermometer: Objective 1:

The Trust reported achievement of its objectives in delivering improvements in harm free care in respect of the incidence of pressure ulcers, patient falls, venous thromboembolism and catheter related urinary tract infections. We note that target achievement is based on harm free care being delivered to not less than 97.7% of patients overall using benchmarking from similar best performing trusts.

It would be helpful to know what the annual target values for harm free care will be for the Trust in 14/15, it is unclear at present what the rebase value is. The graph (figure 1) is however helpful and it is encouraging to see the work being undertaken by staff to reduce the incidence of patient falls. There is an important statement around the incidence of falls amongst patients in the 75 plus age group, which does have significance, along with the introduction of the 'Fallsafe' initiative across the Trust, which reports to the falls steering group. It would be helpful to have some of the key findings / themes from the Fallsafe initiative included within the report, even if it just some headlines.

The achieved results for pressure ulcer management are good and the Trust has achieved its target set in line with commissioners. It is also helpful to see some qualitative examples of actions that have been undertaken to reduce the incidence of pressure ulcers within the Trust. Having projected actions for 2014/15 was also helpful, in particular the introduction of a pan-Avon dressing formulary, which could be brought to a future Governors meeting, in terms of providing an educational session.

Screening for VTE prevention continues to improve within the Trust along with the introduction of a root cause analysis for patient who had experienced incidence of VTE. Greater education and the introduction of sequential compression devices is to be commended and as such good practice is now being disseminated out to South Bristol Community Hospital.

Patient safety- Reduce hospital-acquired healthcare infections: Objective 2:

Clostridium difficile target was not met as part of the Trust's focus on preventing HCAs, however it should be noted that achieving an overall reduction of 21% in reported cases is a significant improvement. Figure 6 (page 12) is very helpful in demonstrating how significant the results are over a seven year period and the ongoing actions to further reduce this figure.

MRSA incidences have also significantly improved and the Governors welcome the use of root cause analysis to identify the base of the two reported cases. Investment in an IV access co-ordinator post within the Trust demonstrates commitment to further resolving any potential future cases and also to promote effective / standardised practice across the Trust.

MSSA and norovirus results show an improvement compared with the previous year's report and it is pleasing to see the Trust achieve its target of 90% for hand hygiene and antibiotic compliance. The governors have requested that this is a standing item on report.

Patient safety- Reduce medication errors: Objective 3:

Improvement on the 2012/13 quality report with reference to the reduced moderate / major medication related incidents. The reason behind this reduction is provided and it is pleasing to see that learning and feedback from reported incidents forms part of the quality enhancement process. The trend presented in figure eight is helpful in terms of further highlighting the significant improvements made over the last four years in terms of reducing the incidence of medication errors within the Trust. It is also pleasing to see that the Trust will aim to comply with the PSA and the 2013/14 Trust quality report will benchmark against this external quality standard. The governors have however specifically asked for this indicator to be included as they had highlighted it as a performance issue during the current year.

Patient safety – Extend medicines reconciliation: Objective 4:

Medicines reconciliation figures for 2013/14 are improved and the Trust should be commended for exceeding their set CQUIN target. It would be helpful if wards 61, 62 and 78 (table 3) could be labelled (i.e. are these the oncology, haematology and gynaecology wards?). It would also be useful if an actual target could be set for 2014/15, rather than stating a 'similar percentage'. This will help to quantify the improvements made year on year, especially for the new wards that have come on-line this year as part of the quality review process.

Patient safety – Improve the early identification and escalation of care of deteriorating patients: Objective 5:

The background to the use of an EWS is helpful, especially in the context of how care is initially provided, mapped against the implementation of SBAR, where required. It is pleasing that the Trust's CQUIN target of 95% has been exceeded and the use of the SBAR communication tool has been effective overall. It would be useful to provide some further explanation as to why it has taken some time for the SBAR tool to become established practice. Is there, for example, the need for greater education and training?

Patient safety – Improve levels of nutritional screening and specifically 72 hour nutritional review of patients: Objective 6:

Why was the agreed CQUIN target of 90% (for patients who had initially been assessed as being at risk of malnutrition would receive a nutritional review after 72 hours) only introduced in the final quarter of the financial year? The overall compliance is disappointing and it would be useful to know what additional measures are being put into place for 2014/15. Were there any particular patient groups that were more at risk than others with reference to malnutrition when admitted to hospital?

It is reassuring that the rate of patient safety incidents reported and proportion resulting in severe harm or death has reduced and the actions for 2014/15 are encouraging. There is also appropriate linkage to the Trust's quality objectives for 2014/15, which is provided towards the end of the document.

The case studies presented under the sub heading of 'Never events' are useful and highlight the subsequent actions / investigation process. It may be helpful to have some examples of what the proactive review would look like (mentioned on page 20 of the Quality Report).

Patient experience:

The experience of maternity patients was an indicator in last year's quality report and was included as a focus for action as a result of some poor results in the previous national survey. Obviously, some progress was made because the national survey in 2013 recorded some excellent results, with some deterioration in the third quarter. Medication side effects are not consistently explained on discharge, disappointing in common with most trusts.

The Productive Outpatient Project is helping to improve the outpatient communication process and is worth a mention. Table 5 on page 31 is disturbing and suggests that conditions at work for staff have deteriorated such that we now find ourselves in the bottom 20% of trusts but then the same survey gives a better than average score for staff recommending the Trust as a place to work or receive treatment.

Patient experience - Implement the friends and family test: Objective 7:

It is pleasing to see that the results for the FFT initiative are higher than the national average for the Trust, although it would be helpful to state why there was underachievement in the first quarter of the year with the response rate (8.4% against a target of 15%). The actions being proposed in terms of capturing additional feedback from maternity wards is encouraging, along with the increased response rates for emergency departments and inpatients for 2014/15. What is the payment from meeting the CQUIN targets used for? Is it re-invested in training for example?

Patient experience - Ensure that patients continue to be treated with kindness and understanding on our wards: Objective 8:

It is really pleasing to see the survey scores consistently above 90% throughout the year. Inclusion of qualitative information is useful, but this could have been expanded upon. I would have personally put three or four qualitative statements in this section. This is a real achievement for the Trust and it should be celebrated.

Patient experience - Explain potential medication side effects to inpatients when they are discharged: Objective 9:

Are there any plans to have additional training and education for staff and / or patient forums, in order to further promote the available knowledge and understanding around potential medication side effects? This has been recorded as 'red' on the performance dashboard and there probably a need for a sentence around commitment to training / education etc.

Patient experience - Improve the experience of maternity patients: Objective 10:

This has been recorded as 'amber' on the performance dashboard; however it is good to see the creation of the three specific projects within the Trust. Improving the patient experience on the wards should ideally build upon the initial findings of the three specific projects.

Looking at figure 20 (complaints as a proportion of total patient activity) there appears to be a cyclic trend with the data (i.e. in terms of peaks when complaints are made). The governors are encouraged that the Trust will be continuing to work collaboratively with the Patients Association in 2014/15. It is acknowledged that 2013/14 has been a year of change for the Patient Support and Complaints team and there is reference to reports such as the Francis inquiry and making sure that dealing with patient complaints is more high profile than in previous years.

The provision of a central appointment centre is seen as being a positive move by the Governors, which will hopefully alleviate patients' and carers' anxieties around appointments and access to services. Furthermore the use a text messaging service to remind patients about their forthcoming appointment is also a positive move by the Trust, with the hope of further reducing the DNA rates within the Trust.

With reference to the results presented in table 5 (page 31 / 32) it is a concern that 39% of staff have witnessed potentially harmful errors, near misses or incidents in the last month. This figure is the same as the last three consecutive years and the Trust should consider how they should look to action this key finding.

The proposed actions for 2014/15 are welcomed, particularly the expectations for leaders within the organisation, a Trust wide stress action plan and the implementation of an e-learning package to support managers in addressing work based discrimination.

Clinical effectiveness - 90% of stroke patients were treated for at least 90% of their time of a dedicated ward: Objective 11:

We share the disappointment at the figures related to this particular outcome (79.3% vs a local stretch objective of 90%). The review of reissuing of the Trust's stroke pathway is welcomed and improvements appear to be under way and the data presented in figure 22 for 2013/14 indicates less fluctuation throughout the months of the year, compared to previous years. This should be seen as a positive outcome for the Trust. These results are the same as last year probably for the same reason – protected beds not always available due to black escalation bed pressures. Note: to be carried forward to next year's objectives.

Clinical effectiveness - Achieve best practice tariff for hip fractures: Objective 12:

The overall improvement in achieving BPT for this particular objective is welcomed, however (as stated in the report) there is still work to be done. It would be helpful to know more details of the objectives set for the Hip Fracture Steering Group,

particularly for the pressure points during the year in terms of being able to meet the BP. The Governors highlighted this as a performance issue for action during the year.

Clinical effectiveness - Ensure patients with diabetes have improved access to specialist diabetic support: Objective 13:

It is pleasing to see that this CQUIN target has been met and DISN post in SNH services will now be permanent. Positive feedback statement from a patient example is helpful.

Clinical effectiveness - Ensure that patients with an identified special need, including those with a learning disability, have a risk assessment and patient-centred care plan: Objective 14:

The recent developments within the Trust in relation to this particular objective are welcomed. In addition the target set by the Trust for adult patients with a learning disability being risk assessed within 48 hours was exceeded, which is pleasing.

Commitment to continuing to implement our dementia action plan: Objective 15:

It is pleasing to see the inclusion of the award given to the Best Dementia Nurse Specialist / Dementia Lead within the Trust. The introduction of the 'hour to remember' scheme has also been a positive move for the Trust. The increased use of the visual identification scheme (linking with the SW Dementia Standards) is pleasing, as is the provision of a local conference, in conjunction with North Bristol NHS Trust. Would it be useful to involve the city's two universities in future conferences, with a view to including healthcare students and academic staff who are involved in education and training?

The qualitative comments included within this section of the report are helpful and reflects the hard work of staff within the Trust, however there is no presentation of results as to the current position of the Trust in terms of how the CQUIN target is being met. From board reports the governors know that the Trust fell a long way short of our target for assessment and follow up here. Governors have just raised it as a performance issue (last quality project focus group). It would be useful to know what specific actions will be taken in 2014/15 to address this particular objective.

Commitment to commence a baseline review of available clinical outcome data: Objective 16:

It is pleasing to see this being introduced across all major clinical specialities.

Review of clinical effectiveness 2013/14:

It is pleasing to see that the overall patient mortality rates within the Trust are significantly lower than the national norm. The same is true for the adult cardiac outcomes and the data within figure 26 (funnel plot) is really useful, as is the data within figure 27. It demonstrates transparency to include the independent review of paediatric cardiac services within the Trust and the governors see this as a positive step. The figure of 98% for parents of children feedback on the care received whilst at the BRH for Children is also a very positive reflection of the overall delivery of care by staff within the Trust.

Objectives for 2014/15:

It is really helpful to have a summary of the objectives for the 2014/14 quality cycle within the Trust. These are clear and transparent objectives that resonate with the areas of improvement required within the Trust. The review and refresh of the Trust's approach to patient and public partnership is also welcomed by the governors. Again, it would be good if the two Universities were also asked to be involved in this work stream.

Summary of performance against national priorities and access standards:

This is helpful, however there are challenges with meeting national standards (that have been highlighted in previous governor reports), particularly access targets (pages 48-53).

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 theme of clinical research is present within the report, which should also be commended.

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. Demand management in the fourth quarter is still a problem.

The Council of Governors will explore any questions raised in this statement via the governors' quality project focus group.

**b) Statement from
Healthwatch Bristol
and Healthwatch South
Gloucestershire**

Healthwatch Bristol and Healthwatch South Gloucestershire welcome the opportunity to comment on the University Hospitals Bristol Quality Account and applaud the Trust on its overall financial and clinical health. Healthwatch Bristol and Healthwatch South Gloucestershire fully support the Trust's identification of its "hallmarks of quality" and notes the full achievement of 11 of the 16 quality objectives. Healthwatch also finds the document well structured and likely to be informative and helpful to the general reader. By and large the document is balanced and readable although rather lengthy. Figures tend to be supported by annotations and descriptive and explicatory passages in the text, which again is helpful to lay readers. The footnotes are also a useful and helpful support for the public understanding of sometimes rather difficult data.

Healthwatch Bristol and Healthwatch South Gloucestershire applaud the overall green light on the NHS Safety Thermometer and commend the Trust's participation in the piloting of 'Fallsafe' and the efforts of the Trust's Falls Steering Group. In this respect, as falls are an ever present concern of the public, Healthwatch appreciates the imaginative formula for calculating and comparing expected and actual falls and applauds the strenuous efforts that the Trust has made and its achievement of its goals in this area in four out of 12 months. It strongly supports the participation of staff in clinical applied research and complements the Trust on the long overdue acquisition by Bristol and hosting of a CLAHRC at UH Bristol attracting substantial new funds and recommends appropriate public participation in such research projects.

Healthwatch Bristol and Healthwatch South Gloucestershire also commend the reduction achieved in HCAs and share the Trust's disappointment that it did not achieve its stated target for *Clostridium difficile*. It notes the commendable achievements in hand hygiene and antibiotic compliance. Conversely, Healthwatch can only express its concern at the occurrence of two never events and although infinitesimal in statistical terms reminds the Trust that for each such patient the effect is 100%. It notes with satisfaction the rigour and robustness of the Trust's proactive review. Similarly with the SHMI indicator it strongly applauds the fact that the score is substantially better than the national median score but notes that it is far from the national best.

Healthwatch Bristol and Healthwatch South Gloucestershire compliment the Trust on its above average achievements in the community midwifery and care during birth elements of the survey. They also applaud the Trust's achievement in compassionate care, a reflection of basic values in a Trust. Perhaps Figure 13 and Table 4 could have been a little clearer in helping lay readers to separate out response rates and scores based on respondents.

Healthwatch Bristol and Healthwatch South Gloucestershire note with some concern that almost 30% of staff would apparently not recommend the provider but takes some

comfort from the fact that this achievement is substantially higher than the 2013/14 national average. It is disappointing also to note that more than one fifth of staff do not feel happy with the quality of work and patient care they are able to deliver and to note the statistically fairly steady score in this regard over the last couple of years. Healthwatch notes the slight improvement in the score staff recommending the Trust as a place to work but also notes the relative immobility of that score over the past few years. (The flow-over of Table 5 makes it rather difficult to read.)

Given the very positive results on the experience of care quality tracker, Healthwatch Bristol and Healthwatch South Gloucestershire share the Trust's disappointment that explanation of the side effects of medication to inpatients when they are discharged was not satisfactorily achieved, and it notes with resigned sadness that this was in line with the national average. It welcomes the remediation strategy proposed, including the new e-tool and it looks forward to improvement over the coming year, whilst noting the need for such a strategy to take account of vulnerable populations, such as but not exclusively older persons and those with learning difficulties. In this respect Healthwatch commends the Trust on its evolving strategies and action plans in its approach to those with special needs and dementia. In spite of the amber result on nutritional screening, Healthwatch commends the innovatory approach using volunteer staff and the achievement of universal screening of patients on entry. Prudent caution is needed when assessing the number of complaints, which can be a very fluid indicator, elusive in its interpretation and reflecting to some extent the ease and security, with which complaints can be made, as well as affording a genuine reflection of dissatisfaction on the part of patients. Although the number of complaints is tiny compared with the volume of patients, it is an important dimension of the perceived reputation of the Trust and the Trust is to be commended for its continuing efforts to improve its performance in the area and to give satisfaction to patients, as reflected for example in the agreed timescale response scores.

Finally Healthwatch thanks the Trust for the professional transparency and openness of the Quality Account combined with its accessibility and informative format. Healthwatch strongly supports the Trust's approach to continuous improvement of quality and staff professional development. It also supports the chosen five objectives for 2014/15 and looks forward to their achievement.

c) 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 23 April to give a short presentation on the highlights of its draft Quality Report 2013/14 and answer members' questions.

⁴⁴ Later revised to 11 in light of year-end data which had been unavailable at the time of this meeting

The Committee welcomed the news that of the 16 objectives set last year, the Trust had achieved 14⁴⁴, which included reducing hospital acquired infections, reducing medication errors and ensuring patients with an identified special need, including those with a learning disability, have a risk-assessment and a patient-centred care plan.

The Trust provided more detail on the two objectives that it had not made as much progress on as it would have liked: ensuring that at least 90% of patients who suffer a stroke spend at least 90% of their time on a dedicated stroke ward; and explaining medication side effects to inpatients when they are discharged. In relation to the latter issue a member suggested that the patient or carer could be asked to sign a document to confirm they have been advised of side effects or the potential consequences of not taking a medicine. The Trust acknowledged this point and responded that it would consider the introduction of a tick sheet to record that contact had been made.

The Committee probed further about the objective for 2014/15 "Making sure patients are cared for on the right ward for their clinical condition" and whether this relates to the objective in the previous quality account about the cancellation of planned procedures due to emergency patients being admitted onto wards. In response it was confirmed that this has been a challenge for the Trust and a lot of work has already been done to reduce the impact on planned operations.

In addition the Trust was asked for more information on how patient panels and patient experience drive improvements, to which the Trust reported that its patient survey work helps develop its patient experience plans and allows it to formulate objectives.

In response to a question about whether the Trust had any concerns with local commissioners not supporting bids / business cases the Trust stated that it had no concerns and was working collaboratively with commissioners.

Finally, the Committee would like to make one comment on its scrutiny of pathology services. At a meeting earlier this year members were disappointed to learn that University Hospitals Bristol had withdrawn from Severn Pathology, a joint venture with the North Bristol NHS Trust. The Committee felt that good progress had been made and was, therefore, concerned about this decision. A further scrutiny meeting will take place in due course.

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

At its meeting of 15 April the Commission received a presentation setting out the Trust's progress against its 2013/14 priorities, and its proposed priorities for 2014/15. There was general consensus amongst members that the priorities chosen were appropriate. The Commission was particularly pleased to note the progress made against the Objectives for 2013/14, especially those listed under Achieved/targets met. Members were disappointed about the 2013/14 Objective for stroke patients only being partially achieved. They supported more resources being put into this service. Members had concerns about the 2013/14 Objective relating to medication side effects being underachieved. Members supported the Quality Objectives for 2014/15.

e) Statement from Bristol Clinical Commissioning Group

This statement on the University Hospitals Bristol NHS Foundation Trust's Quality Account 2013/14 is made by Bristol Clinical Commissioning Group following a review by the governing body.

Bristol CCG welcomes UH Bristol's quality account, which provides a comprehensive reflection on the quality performance during 2013/14. The data presented has been reviewed and is in line with data provided and reviewed through the monthly quality contract performance meetings.

The CCG is pleased to note UH Bristol's improved achievement against its objectives for 2013/14 with 11 of the 16 objectives met. The CCG also supports the plan to see these objectives as 'business as usual' for the coming year, and welcomes the approach to focus on a smaller number of transformational objectives to support improved patient care and patient experience following wide public consultation.

The quality account identifies progress in relation to:

- Early identification of the deteriorating patient and appropriate escalation of their care
- Reduction of hospital-acquired healthcare infections. We note that the targets for both MRSA and *Clostridium difficile* were not met, however, the CCG acknowledges the significant reduction in the number of these infections and the work undertaken to support improvements to clinical environments following a Care Quality Commission unannounced inspection to children's cardiac theatres.
- Improving patient experience in outpatients. The CCG supports the learning implemented in this specific area which has led to improved patient experience and increased productivity and efficiency in the outpatient services.
- Successful implementation of the Friends and Family Test within adult inpatient, emergency department and maternity services and achievement in both the response rate and net promoter targets.
- Comprehensive monthly patient experience surveys demonstrating a high percentage of positive responses.

The CCG is pleased to see how UH Bristol has improved specialist diabetic support for patients and would welcome the continued focus on this area going forward into 2014/15 in line with one of the CCG priorities.

The quality account also demonstrates the improvements made in the management of patients suffering from a stroke and the CCG supports the ongoing work in this area to achieve further improvements.

The CCG will continue to work closely with the Trust in areas which need further improvement:

- Nutritional screening
- Dementia action plan implementation
- Experiences of maternity patients
- In delivering the eight indicators of quality for best practice tariff for hip fractures
- With improvement plans to support staff engagement and wellbeing including the implementation of the NHS Friends and Family Test for staff.

We would welcome seeing in the 2014/15 objectives greater identification on learning from complaints and experiences of both patients and staff and the presentation of the data by service level. We would also welcome strong reference to effective partnership working across the community and good communication and engagement with key stakeholders with the aim of improving and developing patient safety and quality centred clinical pathways within the 2014/15 objectives.

Having reviewed the quality account we welcome the improvements and progress made by the Trust and acknowledgement of where further improvement work is needed and we look forward to working with UH Bristol in 2014/15.

APPENDIX C

Performance indicators subject to external audit

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

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- The indicator is expressed as a percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer;
- An urgent GP referral is one which has a two week wait from date that the referral is received to first being seen by a consultant;
- The indicator only includes GP referrals for suspected cancer (i.e. excludes consultant upgrades and screening referrals and where the priority type of the referral is National Code 3 – Two week wait);
- The clock start date is defined as the date that the referral is received by the Trust; and
- The clock stop date is the date of first definitive cancer treatment as defined in the NHS Dataset Set Change Notice. In summary, this is the date of the first definitive cancer treatment given to a patient who is receiving care for a cancer condition or it is the date that cancer was discounted when the patient was first seen or it is the date that the patient made the decision to decline all treatment.

Clostridium difficile

Trust uses the following criteria for measuring the indicator for inclusion in the Quality Report:

- Infections relate to patients aged two year old or more;
- A positive laboratory test result for *Clostridium difficile* recognised as a case according to the Trust's diagnostic;
- Positive results on the same patient more than 28 days apart are reported as separate episodes, irrespective of the number of specimens taken in the intervening period, or where they were taken; and
- The Trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one).

APPENDIX D

Statement of Directors' Responsibilities

2013/14 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 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 NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- 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 2013 to April 2014
 - Papers relating to Quality reported to the board over the period April 2013 to April 2014
 - Feedback from the commissioners dated 14/5/2014
 - Feedback from governors received 16/05/14
 - Feedback from Local Healthwatch organisations received 15/5/14
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009⁴⁵
 - The 2013 national patient survey (published 8/4/2014)
 - The 2013 national staff survey (published 25/2/2014)
 - The Head of Internal Audit's annual opinion over the trust's control environment dated 28/05/2014
 - CQC quality and risk profiles dated 31/07/2013⁴⁶
- 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.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual)).

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
28 May 2014



Robert Woolley Chief Executive
28 May 2014

⁴⁵ This report is due to be received by the Board in July 2014

⁴⁶ After which, QRPs for acute trusts were replaced by Intelligence Monitoring Reports (commencing October 2013)

APPENDIX E

External audit opinion

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

We have been engaged by the Council of Governors of University Hospitals Bristol NHS Foundation Trust to perform an independent assurance engagement in respect of University Hospitals Bristol NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 in the Quality Report that have been subject to limited assurance (the "specified indicators") consist of the following national priority indicators as mandated by Monitor:

Specified indicators	Specified indicators criteria
<i>Clostridium difficile</i>	Appendix C of the Quality Report
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers	Appendix C of the Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2013/14" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

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

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2013/14";
- 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 and the six dimensions of data quality set out in the "2013/14 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and 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 2013 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2013 to the date of signing this limited assurance report;

- Feedback from the Bristol Clinical Commissioning Group dated 14/5/2014;
- Feedback from Governors dated 16/05/2014;
- Feedback from Healthwatch Bristol and Healthwatch South Gloucestershire dated 15/5/2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- The 2013 national patient survey dated 08/04/2014;
- The 2013 national staff survey dated 25/02/2014;
- Care Quality Commission quality and risk profiles dated 31/07/2013; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 27/05/2014.

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 2014, 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:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2013/14";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading 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.

<p>Limitations</p>	<p>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.</p> <p>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 Criteria referred to above.</p> <p>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.</p> <p>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.</p>
<p>Conclusion</p>	<p>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 2014:</p> <ul style="list-style-type: none"> • The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2013/14”; • 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 and the six dimensions of data quality set out in the “2013/14 Detailed guidance for external assurance on quality reports”. <p>PricewaterhouseCoopers LLP Chartered Accountants Bristol</p> <p>28 May 2014</p> <p>The maintenance and integrity of the University Hospitals Bristol NHS Foundation Trust 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.</p>