University Hospitals Bristol
NHS Foundation Trust

Freedom of Information Request Ref: UHB 19-672

20 November 2019

By Email

Dear Sir/Madam

Thank you for your request for information under the Freedom of Information Act 2000. The Trust's response is as follows:

1. How many patient falls were recorded in the BRI in each of the last 3 years?

   The rate of falls per 1,000 bed days for the whole Trust is publically available on our website in the Board papers in the monthly Quality and Performance Reports (http://www.uhbristol.nhs.uk/about-us/how-we-are-managed/trust-board/trust-board-meetings/)as well as in the Annual quality report 2018/19 (http://www.uhbristol.nhs.uk/media/3600119/00856_uhb_quality_report_2018_19_web.pdf). The raw numbers behind these figures are as follows:
   2019/20 to date (up to and including September 2019): 685.
   2018/19: 1364.
   2017/18: 1413.

2. How many of these took place in the same ward/location that my grandmother is recorded as having fallen (A528, Bed 3)?

   The numbers that follow relate to falls, which occurred on Ward A528, but not specifically Bed 03. To review each one to identify whether a specific location on Ward A528 is mentioned in the incident report/patients notes would take the Trust more than 18 hours to complete and is therefore exempt from disclosure under Section 12 of the Freedom of Information Act.
   2019/20 to date (up to and including September 2019): 19.
   2018/19: 47.
   2017/18: 43.

3. In relation to both questions above, how many were investigated as a serious incident?

   The overall number falls investigated as a serious incident in 2017/18 and 2018/19 is publically available on our website in our annual quality reports. For 2019/20 to date (up to and including September 2019) there have been six falls investigated as serious

incidents.
With regard to A528:
2019/20 to date (up to and including September 2019): 2.
2018/19: 1.
2017/18: 0.

4. How many falls were recorded as taking place in a bathroom when the patient was left unattended?

   The number of falls which are recorded on our incident reporting system as having taken place in a bathroom is as follows.
   2019/20 to date (up to and including September 2019): 240.
   2018/19: 468.
   2017/18: 459.

   To identify if they whether the patient was left unattended, would take the Trust more than 18 hours to complete and is therefore exempt from disclosure under Section 12 of the Freedom of Information Act.

5. And, how many resulted in an injury to the patient?

   The number of falls resulting in moderate or above harm is publically available on our website in the Board papers in the monthly Quality and Performance Report.

6. How many patient falls in each of the last three years resulted in some form of hip fracture?

   2019/20 to date (up to and including September 2019): 4.
   2018/19: 13.
   2017/18: 9.

7. Of these how many were not operated upon?

   2019/20 to date (up to and including September 2019): 1.
   2018/19: 1.
   2017/18: 0.

8. Of those that were operated upon, how many subsequently died?

   We have interpreted this question as how many patients subsequently died in hospital during the same admission as the fall occurring i.e. did not leave our hospitals alive.
   2019/20 to date (up to and including September 2019): 3 operated on, 0 died.
   2018/19: 12 operated on, 6 died.
   2017/18: 9 operated on, 5 died.

9. How many patient deaths were reported to the coroner by the hospital in each of the last three years where an injury resulting from a patient fall was recorded as a factor?

   All deaths where a fall occurred in hospital during that admission and where the fall

resulted in a fracture would be reported as a matter of course to the Coroner. Therefore, the answer given in question 8 is the same for question 9.

10. How many patient deaths were reported to the coroner by the hospital in each of the last three years where a hospital acquired illness was recorded as a factor?

    Hospital acquired illness, is a very common cause or contributing factor in many deaths reported to the Coroner. However, this does not have the same implications of some form of culpability on the hospital part as these types of illnesses are largely unavoidable and common in the end stages of many patients lives.
    Nevertheless, to identify those cases the Trust would need to read every Coroner's submission. This would take the Trust more than 18 hours to complete and is therefore exempt from disclosure under Section 12 of the Freedom of Information Act.

11. How many patient falls in each of the last three years happens to a patient who was previously identified as having a risk of falling?

    The figures below are taken from our incident reporting system for reported patient falls incidents. Please note this field is a supplemental question and is non-mandatory so may not be a true reflection of the numbers. To review each patient's notes to obtain a more accurate response would take the Trust more than 18 hours to complete and is therefore exempt from disclosure under Section 12 of the Freedom of Information Act.
    2019/20 to date (up to and including September 2019): 183.
    2018/19: 240.
    2017/18: 183.

12. How many complaints has the hospital received in each of the last three years in relation to patient falls?

    01/04/2016 to 31/03/2017 = 5.
    01/04/2017 to 31/03/2018 = 3.
    01/04/2018 to 31/03/2019 = 4.

13. How many complaints has the hospital received in each of the last three years in relation to care of an elderly patient?

    The Trust has identified 281 complaints over the three-year period made by patients over the age of 60. Please note that for 696 complaints the patients' age is not available because the complaint was not made on behalf of the patient so the complainant's age is displayed instead.
    This data therefore relates to those 281 complaints for which the information is available.

    Checking the date of birth of the patient for the above-mentioned 696 cases, would involve going through every case individually to extract this information, which would take the Trust more than 18 hours to complete and is therefore exempt from disclosure under Section 12 of the Freedom of Information Act.

Of the 281 cases described above, the number of complaints relating to “elderly” patients is as follows (using 60 years or over as the definition of “elderly”):
01/04/2016 to 31/03/2017 = 115.
01/04/2017 to 31/03/2018 = 86.
01/04/2018 to 31/03/2019 = 98.

8. Please can I see copies of reports reviewed by the board during the past 2 years in that cover the subject of patient falls and oversight of serious incident investigations into them?

   High-level falls reporting for the whole Trust is publically available on our website in the Board papers in the monthly Quality and Performance Report.

9. What performance measures in relation to patient safety incidents are reviewed by the Board and/or its sub committees?

   Data on reported incidents and serious incidents is publically available on our website in the Board papers in the monthly Quality and Performance Report. Incident reporting is not performance managed. As with all healthcare providers, incident reporting is encouraged to develop an open culture where staff feel able to report incidents with no fear of reprisals and to maximise opportunities for learning and implementation of risk reduction measures for patients and families. Timeliness of incident management is performance managed. For serious incidents, this data is publically available on our website in the Board papers in the monthly Quality and Performance Report. For all incidents, this is reported to our Patient Safety Group and on to our Clinical Quality Group chaired by the Chief Nurse and Medical Director.

10. What information does the board receive about avoidable deaths that occurred within the hospital?

    The Board receives a quarterly “Learning from deaths” report in line with national guidance (https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf).

11. How many of these were self reported by the hospital to the CQC or another relevant independent scrutiny body rather than just the coroner to ensure that matters of care quality receive proper independent and objective oversight?

    All incidents are reported to the CQC via the National Reporting and Learning System (NRLS). All serious incidents are reported to the CQC, our commissioners and NHS Improvement via the national Strategic Executive Information System (STEIS). Certain types of incidents and serious incidents are also reported to other external bodies. Commissioners provide independent scrutiny of our serious incident investigations. The CQC and NHS Improvement can and do contact us if they require further information on any of our reported incidents or serious incidents, including requesting full investigation reports

12. What assurance mechanisms has the organisation got in place to ensure that recommendations or lessons identified within RCA investigations are implemented and result in the changes/improvements they are intended to bring about? How is this monitored?

    The actions arising from all serious incident investigations are monitored by the Trust Patient Safety Group. The serious incident is not closed until all the actions have been completed. Any actions which breach their due date are reported by exception to our Clinical Quality Group, Senior Leadership Team and the Quality and Outcomes Committee (a Non-Executive sub-committee of the Board). For incident investigations, which are not serious incidents, a similar governance process within each clinical division takes place with sign off of completed actions by the Divisional Board or a delegated governance group for safety and quality.

13. What governance arrangements are there for the board to properly oversee the quality, efficacy of process and outcomes of RCA investigations?

    The Quality and Outcomes Committee (a Non-Executive sub-committee of the Board) receives detailed serious incident reports. This Committee also receives either the full RCA document or a summary RCA document for all serious incident investigations. The summary RCA documents include the incident details, investigation findings, conclusions, lessons learned, recommendations, duty of candour and full action plan. This Committee reports any issues for escalation to the full Trust Board.

This concludes our response. We trust that you find this helpful, but please do not hesitate to contact us directly if we can be of any further assistance.

If, after that, you are dissatisfied with the handling of your request, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to:

Director of Corporate Governance
University Hospitals Bristol NHS Foundation Trust
Trust Headquarters
Marlborough Street
Bristol
BS1 3NU

Please remember to quote the reference number above in any future communications.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

Publication

Please note that this letter and the information included/attached will be published on our website as part of the Trust's Freedom of Information Publication Log. This is because information disclosed in accordance with the Freedom of Information Act is disclosed to the

public, not just to the individual making the request. We will remove any personal information (such as your name, email and so on) from any information we make public to protect your personal information.

To view the Freedom of Information Act in full please click here.

Yours sincerely

FOI Team
UH Bristol NHS Foundation Trust